MAY 1983

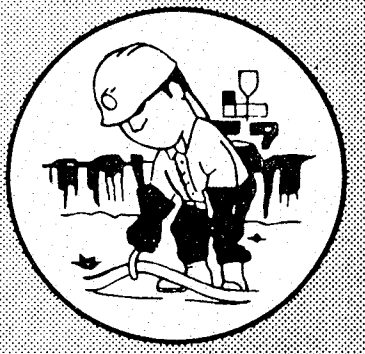
HOLMES SAFETY ASSOCIATION

E PLURIBUS UNUM

SAFETY EFFICIENCY

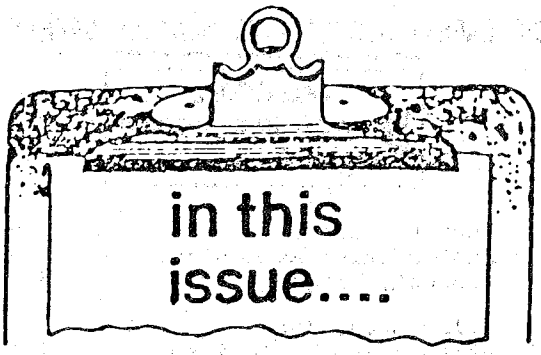
MINERAL INDUSTRIES

BULLETIN



BE ACCIDENT FREE IN "83"

HOLMES SAFETY ASSOCIATION



May 1983

HOLMES SAFETY ASSOCIATION MONTHLY SAFETY TOPIC

May 1983

E and D Coal Company
No. 13
Hurley, Virginia

Consolidation Coal Co
Loveridge No. 22
Fairview, W Virginia

Tamroy Mining Inc
No. 2 Surface
Bradley, W Virginia

B and LS Contracting Inc
Apraw
Washington, Indiana

Rogers Energy
Arlen No. 1
Bloomington, Indiana

Green Construction
of Indiana Inc-Graber
Cannelburg, Indiana

Fab Coal Corp
Fab Coal
Steele, Kentucky

L G Coal Co Inc
L G Coal
Clintwood, Virginia

Environmental Mine
Services Inc
Grundy, Virginia

D and J Testing Service
D and J
Grundy, Virginia

Maiden Mining Co
Maiden Mine
Maidsville, W Virginia

Maidsville Coal Co
Maidsville Tipple
Maidsville, W Virginia

Deans Fuels
Dean Mine
Maidsville, W Virginia

Sierra Mining Co
Sierra Mining
Maidsville, W Virginia

Morgantown Energy Export
Morgantown Mine
Maidsville, W Virginia

E and B Energy
No. 1
Clintwood, Virginia

Ivy Branch Coal Co Inc
Ivy Branch Coal
Prater, Virginia

Austin Sales Inc
Austin Sales/Explosives
Vansant, Virginia

Atlas Sales Inc
Atlas Sales/Explosives
Vansant, Virginia

Yogi Mining Co Inc
Yogi Mining
Grundy, Virginia

C and S Coal Co Inc
C and S Coal
Vansant, Virginia

Dow Coal Inc
Dow Coal
Richlands, Virginia

C C and P Coal Co
C C and P Coal
Oakwood, Virginia

C and R Coal Inc
C and R Coal No. 2
Cedar Bluff, Virginia

Fray Mining Inc
Fray No. 11
Oakwood, Virginia

B P and R Coal Corp
B P and R No. 1
Richlands, Virginia

Harman Brothers Coal Co Inc
No. 1
Pounding Mill, Virginia

Robinson Fork Coal Corp
Robinson Fork Coal
Cedar Bluffs, Virginia

L and R Mining Corp
No. 5
Mavisdale, Virginia

R and R Coal Co Inc
No. 1
Raven, Virginia

C and R Coal Inc
No. 3
Cedar Bluffs, Virginia

Dorothy Mae Coal Co
No. 16 Mine
Keen Mountain, Virginia

Sow Branch Coal Co Inc
Sow Branch Coal
Hurley, Virginia

MSHA/Mt. Hope
Field Office
Mt. Hope, W Virginia

L A S Coal Corp
L A S
Grundy, Virginia

R and H Coal Co
R and H
Hurley, Virginia

UMWA
District 4
Masontown, Pennsylvania

Paramont Coal Co
"J.A. Brown Sr" Commem
Wise, Virginia

Shell-Ray Mining Inc
Shell-Ray
Iaeger, W Virginia

Bethlehem Mines Corp
No. 81 Mine
Drennen, W Virginia

Maw B Coal Co
Maw B
Pennington Gap, Virginia

Bobs Branch Coal Co Inc
No. 11 Mine
Haysi, Virginia

Blue Eagle Coal Corp
No. 2 Mine
Birchleaf, Virginia

Alvy Creek Coal Co Inc
No. 1 Mine
Abingdon, Virginia

Dominion Coal Corp
Young's Branch No. 15
Vansant, Virginia

Little Elkhorn Coal Co
No. 4
Printer, Kentucky

V and M Coal Co
No. 3 Mine
Paintsville, Kentucky

V and M Coal Co
No. 1 Mine
Stanville, Kentucky

Little Elkhorn Coal Co
No. 2 Mine
Printer, Kentucky

A and K Coal Co Inc
A and K Coal
Stanton, Kentucky

Rolon Coal Co Inc
No. 1 Mine
Inez, Kentucky

W Va Solid Energy Inc
No. 4 Mine
Paintsville, Kentucky

Gum Branch Coal Co
No. 27 Mine
Paintsville, Kentucky

Gum Branch Coal Co
No. 32 Mine
Paintsville, Kentucky

Gum Branch Coal Co
No. 32A Mine
Paintsville, Kentucky

L and M Coal Co
No. 4 Mine
Matewan, W Virginia

Peerless Eagle Coal Co
No. 2A Mine
Summersville, W Virginia

Peerless Eagle Coal Co
No. 3 Mine
Summersville, W Virginia

Peerless Eagle Coal Co
No. 1 Prep Plant
Summersville, W Virginia

Perry and Hylton Inc
Gango No. 1 Surface
Beckley, W Virginia

Perry and Hylton Inc
Garden Ground Tipple
Beckley, W Virginia

Perry and Hylton Inc
Imgram Branch Tipple
Beckley, W Virginia

Horne and Riggs Coal Corp
Horne and Riggs Coal
Wise, Virginia

Mercury Coal Co
No. 1 Mine
Pennington Gap, Virginia

Intercontinental Elec Corp
Tucson/Contractors-Mines
Tucson, Arizona

Iva Marcia Mining Coal Inc
Iva Marcia Mine
Forest Hill, Kentucky

Dotson Enterprises
No. 1 Mine
Phelps, Kentucky

Big Pound Coal Co
Big Pound Coal
Majestic, Kentucky

Omega Coal Co
Omega Coal
Bristol, Virginia

V and M Coal Co
V and M Coal
McCarr, Kentucky

Dept of Labor/MSHA
Sophia Field Office
Sophia, W Virginia

Health & Safety Training
Health & Safety/Training
Beckley, W Virginia

Whitesville A & S Coal Co
Frances No. 1 Surface
Beckley, W Virginia

Austin Powder Co
Austin Powder/Explosives
Cleveland, Ohio

Mine Services Co
Instruction/Training
Columbus, Ohio

Freeport Gold Co
Freeport Gold
Elko, Nevada

4-A Coal Corp
4-A Coal Mine No. 2
Hurley, Virginia

4-A Coal Corp
4-A Coal Mine No. 4
Hurley, Virginia

Mabo Coal Co Inc
No. 3 Mine
Cedar Bluffs, Virginia

Mabo Coal Co Inc
No. 5 Mine
Cedar Bluff, Virginia

Henderson Coal Co
No. 1 Mine
Morgantown, W Virginia

Long Branch Energy
No. 4 Mine
Madison, W Virginia

Pine Grove Coal Co
Pine Grove Coal
Richlands, Virginia

Mack Coal Co Inc
Mack Coal
Grundy, Virginia

Chaves County Road Dept
Amarante Lucero/Const
Roswell, New Mexico

Interstate Commercial
Energy No. 1 Mine
Big Stone Gap, Virginia

Lynn Coal Co Inc
Lynn Coal
Grundy, Virginia

J and J Boyd Coal Co
J and J Boyd
Doran, Virginia

Estep Coal Corp
Estep Coal
Grundy, Virginia

Gardner Coal Corp
Loading Dock
Honaker, Virginia

Roger Brown Coal Co
No. 1 Mine
Swords Creek, Virginia

Ann Marie Mining Co Inc
No. 2 Mine
Swords Creek, Virginia

Federal Mining Inc
Federal Mining
Elkhorn City, Kentucky

Pentagon Coal Inc
Pentagon Coal
Phelps, Kentucky

Comer Davidson Coal Co
No. 2 Mine
Pikeville, Kentucky

Blue Ridge Coal Corp
No. 4 Mine
Phelps, Kentucky

Thacker Energy Inc
No. 2 Mine
Vansant, Virginia

Preece Coal Co Inc
No. 3 Mine
Turkey Creek, Kentucky

Preece Coal Co Inc
No. 4 Mine
Turkey Creek, Kentucky

McGinnis Coal Co
No. 2 Mine
Warfield, Kentucky

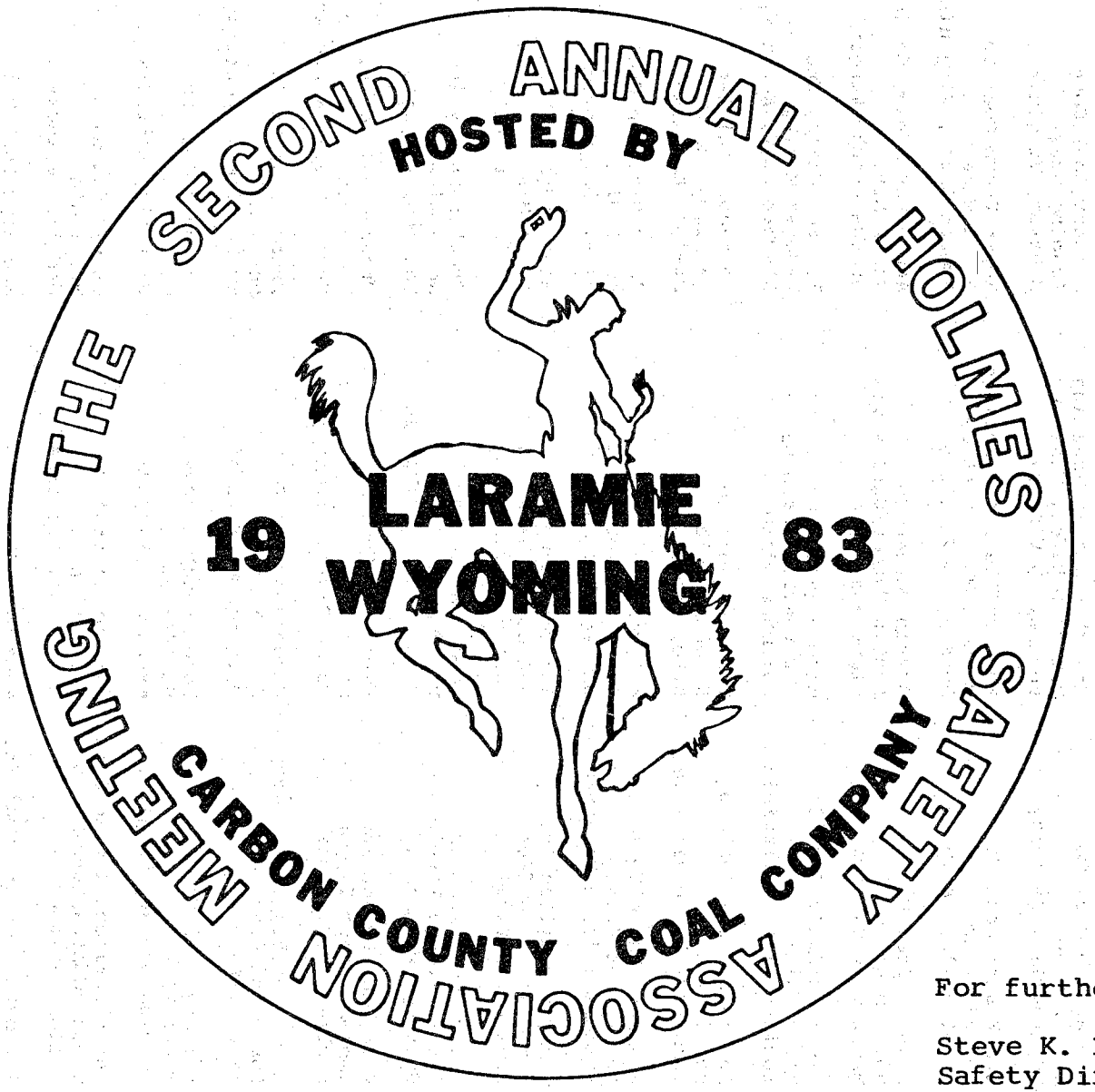
Shield Mining Co
No. 1 Mine
Steele, Kentucky

Red Hawk Coal Corp
No. 1 Mine
Williamson, W Virginia

J and H Coal Co
No. 12 Mine
Hatfield, Kentucky

Price Coal Co
No. 1 Mine
Hatfield, Kentucky

Road Side Coal Co Inc
No. 2 Mine
Turkey Creek, Kentucky



For further information contact:

Steve K. Lipe
Safety Director
307/325-9471
Carbon County Coal Company

May 1983

HOLMES SAFETY ASSOCIATION MONTHLY SAFETY TOPIC

Overcome The Trend

Statistics show that falling materials injure and kill far more underground miners than do mine fires, explosions, and flooding.

Blasting, electricity, fast moving trips and belt conveyors can all be dangerous, but all these hazards have not produced as many injuries and deaths as have roof falls.

Year after year, 50 percent or more of the total underground lost-time serious and fatal injuries are attributed to roof and rib falls. And roof falls are again on the rise--52 miners have been killed by fallen material during 1982. Why?

By working together we can overcome this trend. For example, at the close of 1979, 66 fatalities were reported, from falls of roof, face, and rib. This aroused grave concern among all segments of the coal-mining industry, so in 1980, an intensive drive was programmed to stop this wantonless killer. At the end of 1980, the figure dropped to 32 and we seemed to be headed in the right direction.

Unfortunately, roof and rib fall fatalities increased the following year; 41 miners were reported killed at the end of 1981.

Let us keep one thought in mind. Often violations of the adopted roof control program and plans can be a camera-shot threat of a possible serious lost-time or fatal accident. When these conditions are observed, personal contact with the workers involved should be taken into consideration with a brief discussion of the possible hazards connected with said violation.

Until we get to the point where we consider all roof to be dangerous and insist that it be properly supported and found, without a doubt, to be safe before any work is done, we can expect roof-fall injuries and fatalities to continue. The roof may look good and smooth and have the appearance of being sound, but may drop at the slightest warning. The only safe course is to observe, test, and above all, timber to standard, before commencing any other type of work--continuing the process as work progresses. It has been proven, regretably, time and time again, that the law of averages prevails--your next trip under unsupported roof may be your last.

Enforcement of law is prestigious; however, what we need is vigilant safety education at the grass-roots level.

ABSTRACT FROM FATAL ACCIDENT

May 1983

HOLMES SAFETY ASSOCIATION
MONTHLY SAFETY TOPIC

Roof-Fall Accident

General Information: A roof-fall accident occurred resulting in the death of a general utilityman. The victim had four years and five months experience in mining.

Discussion of Accident: Under the supervision of the assistant section foreman, the crew arrived on the section at about 4:30 p.m. After the foreman had completed his examinations of the section, the crew began their normal duties. About an hour later,the victim entered the first left break to relieve the continuous-mining machine crew. The continuous-mining-machine helper began operating the continuous-mining machine with the victim assuming the duties of continuous-mining-machine helper.

After the continuous-mining machine had completed the mining of the face, the operator trammed the machine out of the face area when he observed a hump in the mine floor. He then trammed the machine back into the face to cut the hump out of the mine floor. After he finished, he trammed the continuous miner out of the face area, shut the machine off and went to the last row of permanent roof supports to see if the hump in the mine floor had been cut out.

At about this time he heard the roof fall. He rushed toward the face and observed that the roof had fallen on the continuous-miner helper. The victim died from crushing injuries received.

Findings of Fact: Evidence observed during the investigation revealed the approved roof control plan was not being complied with at the time of the accident. The victim was struck by falling roof when he advanced 12 feet inby permanent roof support.

Conclusion: The fatality occurred because a miner proceeded into an area of known loose roof before the roof was taken down or supported. Normal mining procedures required that the roof be cut out by the continuous-mining machine, if visual observation indicated the draw rock could not be adequately supported. The victim had been cautioned about going inby supported roof on previous occasions; however, normal company procedure had not been followed in that a written warning was not issued on those occasions.

ABSTRACT FROM FATAL ACCIDENT

May 1983

HOLMES SAFETY ASSOCIATION
MONTHLY SAFETY TOPIC
Fall-Of-Highwall

General Information: A fall-of-highwall accident occurred in the pit of a surface mine resulting in the death of the bulldozer operator. The victim had six years of mining experience.

Description of Accident: The foreman conducted the required on-shift examinations and then assigned two bulldozer operators to push loose shot material from the area near the highwall into an adjacent area where the coal had been removed. The victim was assigned to work immediately adjacent to the highwall and to trim the highwall as the overburden was removed.

Several hours later, the victim was tramming the bulldozer in reverse when a portion of the highwall fell covering the bulldozer. The foreman heard the highwall fall, rushed to the area and found that the victim was pinned between the rollover protection (cab) and the operator's seat.

Discussion and Evaluation: The foreman stated that he examined the highwall about 6 p.m., a half-hour after the shift began. Two other dozer operators stated that small amounts of dirt and rock dribbled from the wall before nightfall.

According to these two dozer operators, the highwall could not be observed after nightfall while they were operating their bulldozers because their visibility was limited by the rollover protection (cabs) and because adequate illumination was not provided in the working area.

During the investigation, observation of the highwall indicated that while trimming the highwall the victim undercut portions of the highwall.

Findings of Fact: Loose, hazardous, unconsolidated material had not been stripped back to a safe distance and safety benches were not provided to protect persons from fallen materials--a violation of Section 77.1001.

Proper illumination was not provided at the work area--a violation of Section 77.207.

Proper examinations were not being made in that loose, hazardous material was present in the pit and the conditions were not recorded in the daily record book--a violation of Section 77.1713-a.

The record book was not properly maintained in that the report had not been countersigned by a person designated in this section--a violation of Section 77.1713-d.

May 1983

HOLMES SAFETY ASSOCIATION MONTHLY SAFETY TOPIC

REPETITION OF SUPERVISOR FATALITIES ?

YEAR	1977	1978	1979	1980	1981	1982	1983	1984
TOTAL	139	106	144	133	155	122		
SUPV.	24	11	23	22	25	10		
%	17%	10%	16%	17%	16%	9%		

Looks like we have the train back on the track and in the right direction. Of the 122 coal mine fatalities reported in 1982, 10 or 9 percent, were in the supervisory level. This represents a significant drop over 1981. So, let's continue what we're doing, keep the train on the track, in the right direction, and 1983 will be a more successful year fatality-wise.

The attitude of employees and supervisors, with respect to observing safe working practices, is most important in accident prevention. A hazardous job can be accomplished with reasonable safety by giving proper thought to the hazards involved and providing the necessary protection. On the other hand, carelessness in performing relatively safe tasks will likely result in injuries.

Reckless employees are a reflection on the effectiveness of management--either they should never have been hired or they should be fired before serious accidents occur. Careless employees are only careless because they are improperly supervised.

Supervisors have a greater responsibility for preventing accidents than any other group of persons. Good supervision is necessary to obtain efficient production. To be successful, the supervisor must have the confidence, respect, and cooperation of each employee.

To a large extent, the success in avoiding accidents and injuries depends on the interest of and example set by the supervisor. Without setting a proper example, the supervisor cannot expect the employees to follow safe procedures. On the other hand, if the supervisor not only believes in safety but also practices it, the employees will follow leadership and do their work safely and efficiently.

The supervisor is the personal contact between top management and labor--the so-called "key" in the mining industry. A safety program cannot succeed without the whole-hearted support and good leadership of the supervisor.

"Look! Do I ask you what happened at home today?"

May 1983

HOLMES SAFETY ASSOCIATION MONTHLY SAFETY TOPIC

Motivation For Improvement

Why is our lost-workday injury and fatality incident rate still at an unacceptable level? I am sure we could blame part of it on the problem of considering the effects of old and young work forces -- tightening labor market, technological development, or our age of anxiety. This is not altogether true!! It is not whether you have a tough problem -- But whether it is the same problem you had last year.

Let's look at the picture. I am sure you can recall all hazardous conditions you have encountered last year. Well, how about those near-miss accidents you've experienced? Did you attempt to study why it was a near miss, or did you just shrug your shoulders and forget it? Think about it -- that near-miss accident could have been the direct-line panic button to a forthcoming lost time or serious accident. Many injuries happen not because of lack of knowledge but failure to use all the knowledge at your command.

You know the old score -- 329 to 1; for every 300 near misses, we have 29 lost-time accidents and every 29 lost-time accidents, 1 fatal.

Motivation for improvement is related to achievement -- and to achieve a reduction in lost-time injuries and better the frequency rate, we should first review our accident-prevention program.

HOW GOOD IS YOUR PROGRAM? IF YOU ARE NOT SURE -- IT'S TIME TO CHECK!

(Insert "How Good is Your Accident-Prevention Program?")

One Very important area to check is the Supervisor.

1. Check areas for improvement
   - A. Supervisor the leader
   - B. Supervisor's ability to "sell" ideas and methods to workers.
   - C. Supervisor encourages acceptable behavior
   - D. Supervisor's ability to train crew to safely maintain a production output
     1. This is the supervisor's biggest job.
   - E. To succeed, time and effort must be spent to know each member of the crew
   - F. One of the greatest motivating factors is the situation that presents a challenge
   - G. One example is the amount of interest created
     1. The amount of interest and recognition shown when an operation has done an outstanding job -- and has a large number of accident-free days.

-MORE-

H. The challenge is to encourage an enthusiastic attitude to accident prevention and overcome lack of interest and unconcern.

I. Sincerity of supervisor in accident prevention

J. Workers follow examples set by their supervisors, and if this is just "lip service" to safety -- the crew will react the same way.

K. Sincerity a planned course
   1. Planning
   2. Controlling
   3. Influencing

L. The time and effort it takes for the supervisor to get to know each crew member as an individual may be many times repaid.

HOW GOOD IS YOUR ACCIDENT-PREVENTION PROGRAM?

Is your answer "Yes" to each of the following questions? If you are not sure, or your answer is "No," then there are yet worlds to conquer for safety.

1. To help prevent accidents, do you train and instruct everyone in safe work methods?

2. Do you have accident-prevention inspections to find unsafe conditions and then correct them?

3. Do you investigate all accidents so that they won't be repeated?

4. Do you have suitable mechanical guards and good protective equipment?

5. When new equipment goes into operation, are its hazards known and is protection provided from them?

6. Does every injury get the proper first aid?

7. Do you keep a record of your accidents and your progress in accident prevention?

8. Do you have safety standards which everyone knows?

9. Does your safety work keep moving and moving toward greater control over accidents?

10. Do you make continuous efforts to create safety-mindedness?

11. Do you reach everyone personally with safety encouragement in the work of preventing accidents?

May 1983

HOLMES SAFETY ASSOCIATION MONTHLY SAFETY TOPIC

Fatal Heart Attacks Reported to The Health and Safety Analysis Center, Mine Safety and Health Administration 1972 - 1981

The Health and Safety Analysis Center (HSAC) of the Mine Safety and Health Administration (MSHA) receives reports of most injuries, illnesses, and certain noninjury accidents that occur in the U.S. mining industry. The reports are classified, coded, and processed into ADP Files for summarization and analysis. Because of the relative severity of the incident, those reports involving fatalities usually are more complete than reports on incidents resulting in nonfatal injuries or illnesses.

From 1972 through 1981, a total of 537 deaths were reported in which the immediate cause of death was cardiovascular insufficiency. After careful consideration of all observed circumstances concerning the deaths, MSHA Concluded that 533 resulted solely from preexisting physical deficiency and were not chargeable to the mining industry as being work related.

According to information published by the National Safety Council, heart disease is the leading cause (38 percent) of death in the United States. Of all deaths reported to MSHA as being in some way associated with the mining industry, only 16.2 percent are identified as having heart disease as the primary cause of death. This proportion seems reasonable because heart attacks occurring off the job are rarely reported and it is highly unlikely that all heart attacks occurring on the job are reported, even though death might result at a later date. A report is supposed to be sent to MSHA concerning any death of an individual at a mine or any injury that has a reasonable potential to cause death. As a result of this requirement, many reports are received in HSAC on deaths that are not work related and are not chargeable as a mine injury or illness statistic. (The determination of chargeablility concerning marginal cases is made by an MSHA committee.)

This study was done because the information is currently available but may be lost over time. It was thought that some useful information might emerge as a result of summarizing the data. Nothing was found to indicate that further study was justified. The following tables present a summary of some factors associated with fatal heart attacks as reported to MSHA.

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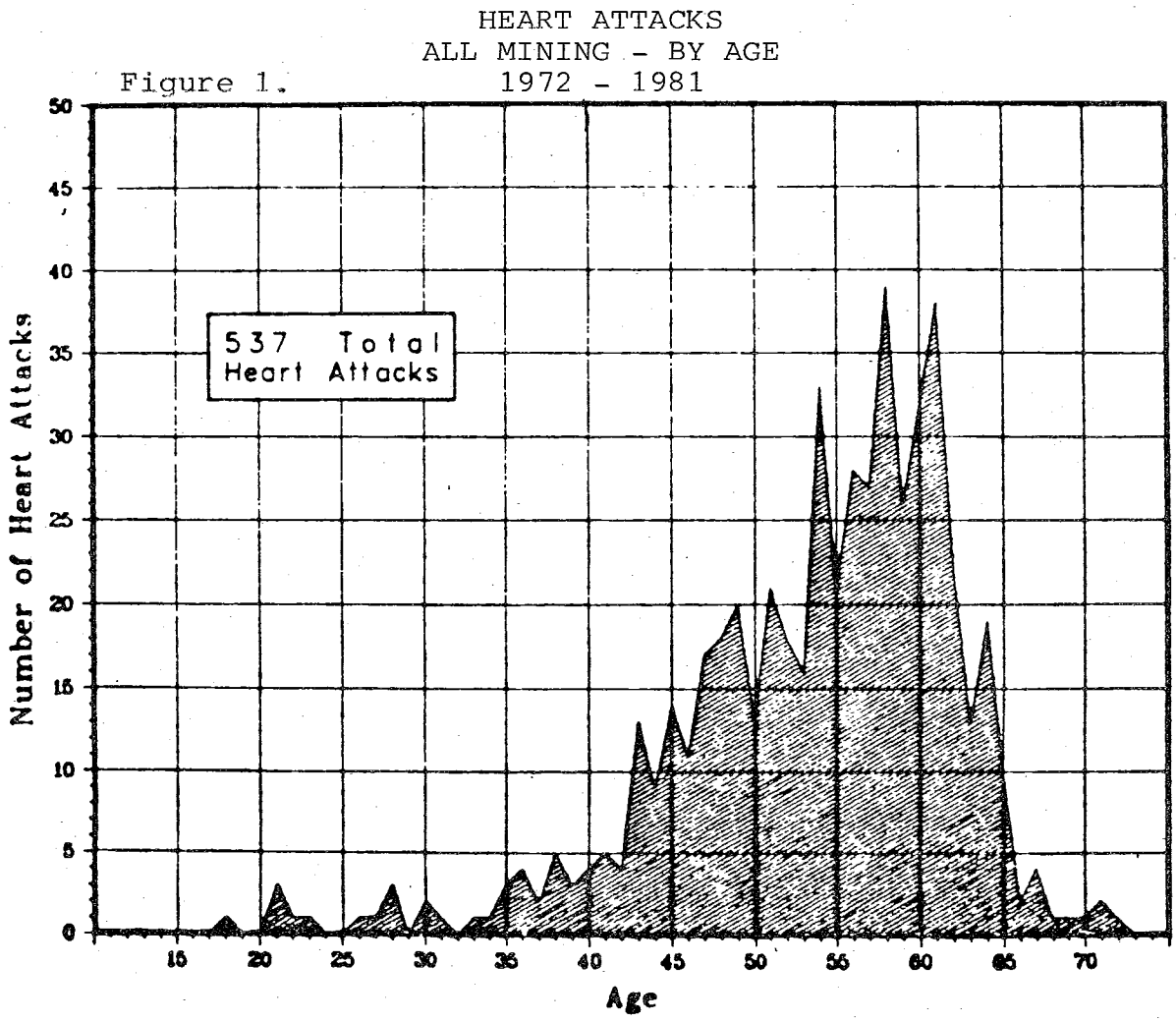
Table 1. - Job Classification of Employees at the Time of the Fatal Attack

	Job Classification	Total
1.	Equipment Operator (Surface: 74 Underground: 70	144
2.	Mechanic/Repairman	69
3.	Foreman/Supervisor/Superintendent	64
4.	General Laborer/Utilityman	51
5.	Truck Driver	37
6.	Plant/Mill Operator	29
7.	Conveyor Belt Attendant	19
8.	Electrician	17
9.	Office Personnel	16
10.	Drill Operator	13
11.	Shot Firer	8
12.	Welder	8
13.	Oiler	7
14.	Nightwatchman	7
15.	Pumper	6
16.	Supply/Toolroom Man	5
17.	Hoist Operator	4
18.	Rib/Roof Scaler	4
19.	Bit Grinder	3
20.	Timberman	3
21.	Lamphouse Attendant	3
22.	Pipeman	3
23.	Dump Spotter	2
24.	Trackman	2
25.	Bratticeman	2
26.	Miscellaneous (Dispatcher; rockduster, sandbagger, etc.)	11
	TOTAL	537

Table 2. - Number of Reported Fatal Heart Attacks as Compared to Job Experience and Total Experience at the Time of the Attack

Years of Job Experience	No. of Attacks	Years of Total Experience	No. of Attacks
<1	71	<1	11
1 - 4	116	1 - 4	17
5 - 9	77	5 - 9	23
10 - 14	38	10 - 14	22
15 - 19	34	15 - 19	47
20 - 24	36	20 - 24	62
25 - 29	22	25 - 29	64
30 - 34	9	30 - 34	49
35 - 39	3	35 - 39	35
>39	1	>39	24
Unspecified	130	Unspecified	183
TOTAL	537		537

Figure 1.



-MORE-

Table 3 depicts the time the heart attacks occurred during the shift. Based upon these data, there does not appear to be any positive indication that heart attacks are more likely to occur during any specific portion of a shift. An evaluation of shifts (day, evening, and graveyard) indicates 67.4 percent of the heart attacks occurred during the day shift, 66.3 percent of which occurred on the surface. A conclusion cannot be drawn on the distribution shown on these tables because the normal distribution of the workforce by age, age on a particular shift, and age at surface and underground is not available in the HSAC file.

Table 3. - Percentage of Time-Into-Shift When Attack Occurred

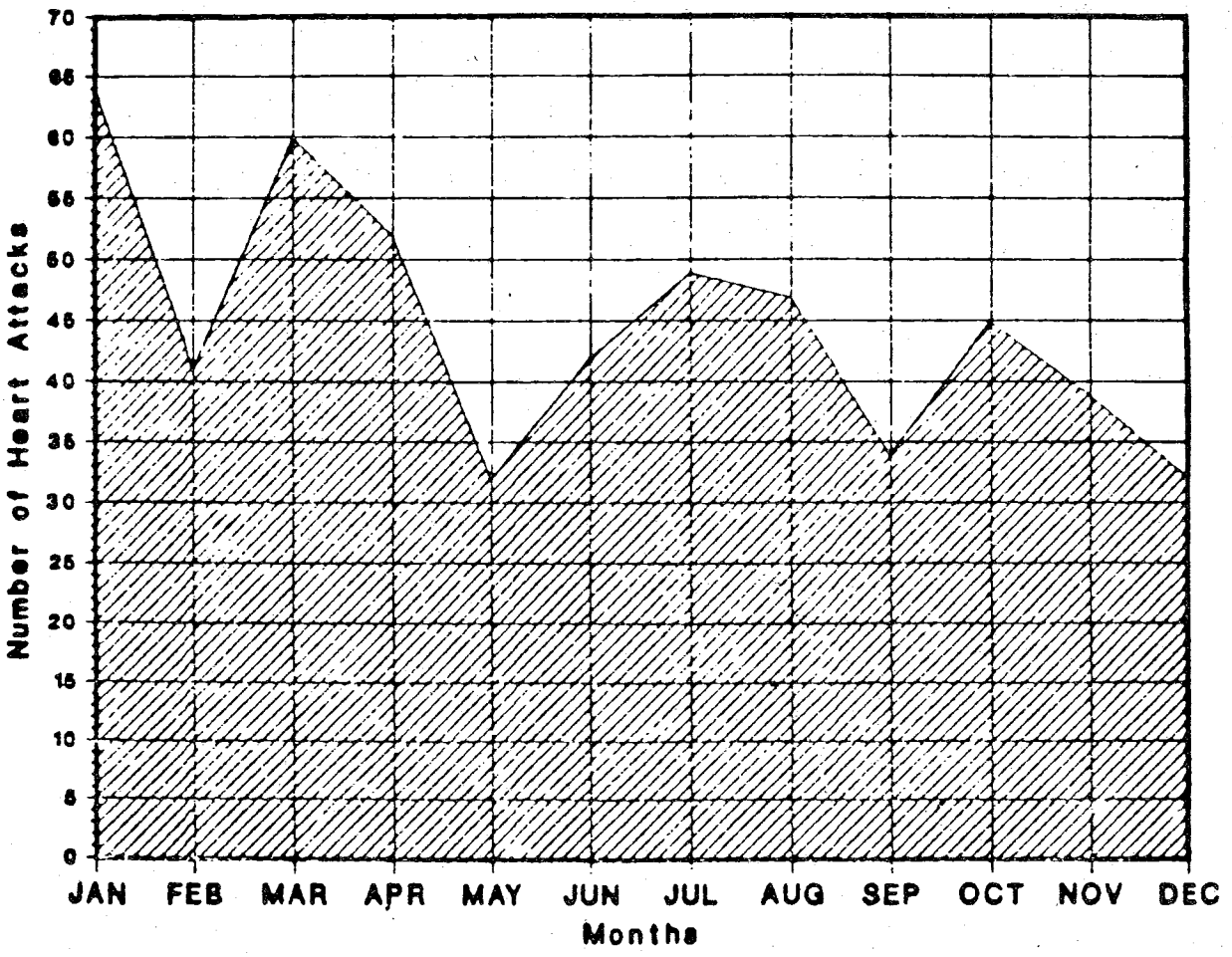
Percentage of Time-Into-Shift	No. of Heart Attacks	Percent
0 - 20	125	23.3
21 - 40	112	20.9
41 - 60	106	19.7
61 - 80	96	17.9
81 - 100	78	14.5
Unspecified	20	3.7
TOTAL	537	100.0

The plot of heart attacks, by month, shown in Figure 2 indicates an increase during the month of January. This may correlate with the fact that over 66 percent of the heart attacks occurred on the surface where exposure to the weather is greater.

HEART ATTACKS BY MONTH

537 Heart Attacks, 1972-1981

Figure 2.



One-hundred-and-four of the heart attacks involved some form of strenuous activity as listed in Table 4. It should be noted, however, that except for the three traumatic experiences, these are everyday activities within the mining industry. Table 5 depicts the number of instances where the victim had a known cardiovascular condition. In making a comparison of victims included in both Tables 4 and 5, it was found that 31 of those who had heart attacks involving strenuous activities also had a known heart condition.

Table 4. - Heart Attacks Involving Strenuous Activities

Activity being Performed	No. of Attacks
Clean-up with Hand Shovel	43
Climbing Stairs/Ladder	16
Handcarrying Supplies/Equipment	14
Walking To/From Job Site	9
Moving Trailing Cable Manually	6
Unplugging Chutes	6
Using Sledge Hammer	5
Following Traumatic Experience (Rib roll, Caught arm in drill, Fighting mine fire)	3
Coupling/Uncoupling Locomotive	2
TOTAL	104

Table 5. - Cardiovascular Conditions of Reported Heart Attack Victims

Prior Cardiovascular Condition	Number of Attacks	Percentage
Heart Condition - Nonspecific	71	13.2%
Previous Heart Attack	56	10.4
High Blood Pressure	55	10.2
Arteriosclerosis	20	3.7
Heart Surgery	7	1.3
Other (Murmur, Angina, Congenital Defect, etc.)	18	3.4
Not Specified	310	57.7
TOTAL	537	100.0%

SUMMARY

In general, no positive trends were noted which would indicate an unusual or unexpected problem. The age of most heart attack victims is over 50 years, and many had a prior heart condition. Higher-than-average incidences were noted for the day shift, surface mining, and the month of January. However, as previously stated, data necessary to evaluate the significance of these trends are unavailable in HSAC.

May 1983

HOLMES SAFETY ASSOCIATION MONTHLY SAFETY TOPIC

Spring Is Here!

Spring cleaning is an old American custom. It is during this activity that winter's ravages to our lawns and gardens are repaired. It is time for discarding the winter-long accumulations of odds and ends and for reviewing the family's safety thinking.

Before beginning your outside activities, you should inspect the lawn and garden tools to be sure they are in good condition. Give extra-special attention to the power mower, a potential source of injury to every member of the family. The mower should be sharp, properly adjusted, and adequately grounded. If you are shopping for a new mower, give special consideration to safety features of the various models that are on the market.

The following safety precautions for power mowers should be considered by yourself and also discussed with your families:

1. Know how to disengage the clutch or stop engine quickly.
2. Do not fill the fuel tank to top; overflow could result in possible fire or explosion.
3. Do not refill when engine is hot and always refill out-of-doors.
4. Stand firmly when starting mower and make certain your feet are in a safe position.
5. Inspect lawn for stones, sticks, wire, or other debris. Keep by-standers and pets away while mowing.

6. Keep in step with mower.
7. Cut hills and banks sideways, not up and down.
8. Disconnect spark plug or electric plug when working on underside of mower.
9. Do not use electric mower when grass is wet. Make certain power cord is safe and motor is grounded.
10. Do not allow children or inexperienced persons to operate the power mower.

The next action should be to check your garage, basement, attic and closets for old newspapers, magazines, books, clothing, and other odds and ends. Areas cluttered with these items are fire hazards and should be cleaned of all refuse. Resist your "string saver" tendencies and do not collect or save quantities of combustible materials. If you must keep such items, limit the quantity and store them neatly in the safest possible places to minimize the hazards of fires.

Your next field of endeavor should be to plan the family's summer recreational activities with safety in mind, which includes instructing all members of the family in specific rules they need

-MORE-

to know to prevent accidents and injury. Action on the following suggestions will help insure a safer summer for the entire family:

1. Instruct bicycle riders in elementary traffic rules.
2. Arrange for swimming lessons for nonswimmers in the family.
3. Know water-safety rules before boating or water skiing.
4. Teach family to recognize poisonous plants.
5. Emphasize controlled exposure to sun.

If you will put into effect, without delay, this springtime program you and your families cannot help but benefit through the coming months of spring and summer.

The Short Way To An Accident

Many of us share a trait that frequently leads to accidents; taking a shortcut instead of following the regular route in getting from one place to another. All of us have seen this being done in all kinds of places.

Why are some people in such a hurry to get to their cars when they are through with work? Or why do they think that it's a good idea to cut through a dangerous area, or hitch a ride on some kind of moving equipment, or crawl over a conveyor instead of walking a little distance to a safe crossover? Naturally, the company wants us to get things done promptly, but not at the expense of safety. When we don't follow established routes, we can find ourselves in trouble. Consider the following example:

An employee in a large factory decided he would hurry over to a canteen some distance away, across some railroad tracks. There was a long string of freight cars on one of the tracks, and the man decided he didn't want to take the trouble or didn't have the time to walk around the train, so he started to climb between two of the cars. These were special low cars, and he was able to step on the coupling in climbing over. Just at that moment, the train moved, the couplings tightened, and his foot was caught. Fortunately for him, he didn't fall and wasn't dragged under the train to his death. However, instead of getting to the canteen, he got to the hospital by way of an ambulance.

(Note to safety meeting leader: Discuss possible instances of taking shortcuts: crossing between standing trips of mine cars; crossing conveyors at unsafe locations; traveling through timbered-off abandoned workings; failing to use temporary support, and others.)

Shortcuts will eventually lead to misfortunes. By following the accepted and proven routes of travel and the safe job procedures in detail, you will greatly reduce the potential for injuries.

HOLMES SAFETY ASSOCIATION

May 1983

Footnotes*

How's this for a record?

District and Subdistrict Managers and field personnel of Coal Mine Safety and Health, Districts 3 and 4 in West Virginia and Maryland, established 432 safety chapters and 14 district councils. West Virginia takes the nationwide lead with an overall total of 579 safety chapters at the end of 1982.

District and Subdistrict Managers and personnel in District 5, Virginia, also organized 51 safety chapters and one district council during the same period. Virginia now has a total of 74 safety chapters at the end of 1982.

Personnel were also active in District 6 in Kentucky organizing 13 safety chapters for a total of 61 safety chapters at the end of the year.

Hats off to District Managers Keaton, Krese, Phillips and Ross and their field personnel for a job well done.

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ELECTRIC APPLIANCES: If you keep electric appliances near water, make sure they are unplugged when not in use, urges the Association of Home Appliance Manufacturers and Underwriters Laboratories. Coming into contact with a live electric appliance while you're wet can cause a fatal shock. An appliance has power in it whenever the plug is in, even if the switch is off.

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COLD-WATER DROWNINGS: If you ever have to try to revive a drowning victim, don't give up easily, especially if the accident occurred in cold water. That's the advice of the National Oceanic and Atmospheric Administration. When a person falls into water with a temperature of 70 degrees Fahrenheit or less, an involuntary response called the mammalian diving reflex may be triggered. This reflex automatically shuts down the flow of oxygen to all but the most vital areas--the heart, lungs and brain--sustaining life for remarkable periods without breathing. In one case, a college student survived without ill effects after being submerged for 38 minutes.

☆U.S. Government Printing Office: 1983—676-114/7