INTERNATIONAL HARVESTER

accidents AND THEIR prevention

SAFETY SECTION • EDUCATION AND PERSONNEL DEPARTMENT

Accident Report Circular No. 32
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TO ALL HARVESTER SUPERVISORY PERSONNEL:

We got off to a bad start in the new year when another fatality occurred at one of our works (see below) on the first working day. It is hoped that every operation will double its efforts in accident prevention so that it will show a decided improvement in SAFETY performance instead of the downward trend evident these past months.

During the recent safety supervisors' conference here in Chicago, tremendous emphasis was placed on the importance of SAFETY as it concerns the employe, management, and the employe's family, centering it around four areas of activity: information, education, recognition, and participation. Through these media we can accomplish much in accident prevention.

The following accidents and their prevention should be reviewed and checked for possible occurrence at your plant, then given wide publicity so that similar incidents will not happen. Like preventive maintenance programs, accident-preventive measures must receive constant attention.

FATAL CASE

MILWAUKEE WORKS

Crushing injuries to left leg, followed by shock and death - On the morning of January 4 the operator of a 4-inch Acme header and his helper (both with many years of experience at this type of work) finished setting up a 4-stage die ($16\frac{1}{2}$" wide by $33\frac{1}{2}$" high) in the machine to forge 360169R couplings. This header is individually motor-driven, has the necessary start-and-stop buttons and disconnect switch, and is equipped with an air-type clutch which is controlled by an air-actuated foot treadle. The treadle switch was adequately guarded from the top, but was open on three sides, and was provided with a manually controlled safety dog or cam which, when placed in the proper position, would make the foot treadle or the switch inoperative.

After a few forgings were run, because of the critical nature of the job, several members of supervision in the forging department checked the pieces for quality and size. It was determined that certain adjustments had to be made, and the operator tightened the saddle bolts for the tool holder or ram on top of the machine, while his helper was using a wrench to tighten the set screws on the back punches. In this position the helper was standing on his right foot on the bed of the machine, with his leg dangling in the $4\frac{1}{2}$" opening between the dies. About 10:30 the operator descended from the top of the machine, walked around to the front to see how his helper was progressing, and inadvertently stepped on the foot treadle, setting the header in motion and crushing the helper's left leg between the dies.

Following the accident the employes were reinstructed to use the safety devices provided for their protection, and supervision was again alerted to its responsibility for enforcing the rule on shutting down of equipment before adjustments,

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