

So far, I've been bragging about the program we put on. Now, let me tell you what this proved to us. The unsafe practices reported to us were mostly violations on which the employee positively had a good knowledge even before he came to work for us—such as, in the removal of steel slivers, using a personal knife rather than going to First Aid. Another violation we found too frequently was employees using a transporter to ride like a sidewalk scooter. We found all kinds of employee unsafe acts and horseplay. Far too many reports indicated that after all these years, foremen found employees in the act of operating revolving spindles while wearing loose fitting clothing.

Now, how's that for hanging out your dirty linen? It's a little embarrassing, but in this program, we were not only being given the cold, hard facts, but at the same time, we were getting proof that we were doing something about it. By this time, you're probably ready to ask—what has it done for you? As the politicians say, "Let's look at the record."

First, here is a typical example of a completed D. C. form: Our foreman recorded, "Observed millwright making adjustments to conveyor without locking power out." Then—just a simple statement of how he corrected this unsafe practice he had detected—"Pointed out the danger of this, and instructed the employee never to do it again." If this seems like an insignificant thing to ask a foreman to do as a part of a safety program, then I should tell you what a recent review of the corporation's safety bulletins revealed. Even at this late date, after years of emphasizing the importance of locking out the power while working on machinery, this unsafe act accounts for about 20 per cent of those disabling injuries bulletinized.

By the 11th of July, 1962, we had recorded 40,565 unsafe practices that had been detected and corrected. The startling discovery from the 40,565 that we had received up to July 11 was that in many instances the circumstances outlined on the D. C. returns were absolutely identical to those that had actually given us disabling injuries in the past. For example:

1. Wearing jewelry, rings, watches, etc. around machinery. Supervisors have detected

and corrected 294 unsafe practices like these since the D. C. program started.

2. Wearing gloves and loose fitting clothing around revolving machinery. Supervisors have detected and corrected 273 unsafe practices like these since the D. C. program started.

3. Making adjustments to machinery with the power on. Supervisors have detected and corrected 923 unsafe practices like these since the D. C. program started.

4. Unsafe practices involving mobile power equipment. Supervisors have detected and corrected 1,054 unsafe practices like these since the D. C. program started.

Since it is always difficult to say convincing believable things about an accident that didn't happen, we decided to use the following means to illustrate the worth of the D. C. program. Photos were assembled of actual accidents that had occurred, brief copy of the original Safety Bulletins were excerpted and the number of instances was recorded wherein foremen had detected and corrected, since the program began, situations identical to those resulting in disabling injuries in the past. This figure was inset in red over the black and white picture. This is called the "Safety Idea Exchange Bulletin."

If you looked at the bulletin, you would agree that the effect of the D. C. program is specific and direct in accident prevention. It is specific in that it deals exclusively with a foreman's detecting an unsafe practice *at the time it occurs*; it is direct in that he *corrects it with the employee involved*, and all this takes place *before an accident occurs*.

A program this size could never be carried out without some humorous sidelights. I suppose, and ours was no exception. For instance, in regard to the overlapping D. C. which we used on the forms as a trademark or a symbol of the program, we had a number of plays on the meaning of D. C. Did it mean direct current or dry charge (this came from the battery plants, of course)? Did it stand for a name like Don Collins (we have a supervisor by that name in one of our plants)? Did it stand for "darned corny" or did it mean "drunken character"? Let them call it what they want as long as they keep talking about it and working at it.

The Chairman of the Management Labor Relations Committee asked for one of our D. C. tie bars for each member of the team. When it was learned that some of them hadn't caught up with the meaning of D. C., Les Stanley in our office refused to honor their request until all of them reviewed the material and each one was at least conversant with it. We were flattered when some of our management people were in Hawaii visiting a pineapple plant. The safety director there was boasting of their safety program to detect and correct unsafe practices which they called "D. C." When our medical director said it had a familiar ring and asked where they got the idea, the reply was "Stole it from Delco-Remy."

Now if some of you are convinced, as we are, that judgment errors must be eliminated and you believe, as we do, that this approach is effective, here are six fundamental steps we recommend for you to tailor a program suitable for your plant to help detect and correct your "Fernando's Hideaways."

1. Sell top management—Getting back to point number one of the seven basic principles of a safety program, as set forth by our President of General Motors, Mr. John F. Gordon, "Provide active top management support." You simply can't be completely successful in any safety program without it.

2. Get the support of all supervision—If you have point number one well covered, it will certainly go a long way toward making this easy. But, you can do a lot to help them understand fully the need for such a program and visualize how this approach can answer that need.

3. Don't expect too much—every supervisor today will tell you he's busy. Don't ask him to write a book about each thing he finds and fixes. Tell him to keep it simple—giving you just enough of an idea in writing of the potential accident he discovered

so you can circulate it to others who might search their departments for similar situations.

4. Dramatize—Use all methods available to make the program impressive. Don't overlook the effectiveness of photos, bulletin boards and examples that illustrate the worth of the program. Use every means at your disposal.

5. Exercise—There's a lot of good old-fashioned hard work connected with this program, the same as there is in anything else worthwhile. Keep it rolling!

6. Follow up—I don't mention this last because it is the least in importance. On the contrary, we believe this program, perhaps even more than the ordinary program of this type, calls for excellent follow up: Follow up on participation, follow up on circulation of ideas from one foreman to another, follow up on *all* the points it took to get the program started.

The program I have outlined here has worked for us throughout our multiple plants in Anderson and each of the battery plants as well. It would work at McKinnon in Canada, Vauxhall Motors in England, or any other plant regardless of size, location, or type of operation as well as it works in Olathe, Kansas; New Brunswick, New Jersey; Anaheim, California; or Muncie, Indiana. I am certain if you take ideas from it and tailor them to suit your needs, it will work for you! It will do much to help combat the "human factor" and will help round out your accident prevention program.

Such activity will create a mental image among all who know your plant that it is a good place to work because it is a safe place to work. Remember that we said a satisfactory company is one that has provided a safe working environment, but that this was only half the picture. Now here is the other half of the picture—a careful worker, Mr. "D. C." Worker!