(2) An electrical engineer was killed as a result of his endeavouring to put on a belt; the power had been shut off, but the motor had not ceased running; he was thrown forward, receiving injuries to his head.

(3) A sawmill-worker was struck in the stomach and killed by a flitch of timber which had jammed in the saw. It was considered by the Inspector of Machinery that had a proper wedge been used to ease the cut the accident would not have occurred.

(4) A metal-worker's assistant was killed by a crane-jib which had fallen owing to the clutch gear becoming disengaged; had the crane-brake (which was found to be in order) been promptly applied by the driver the accident would not have occurred. The Inspector of Machinery has instructed that certain alterations be made to the clutch gear to prevent further slipping.

(5) Two workers were seriously injured as a result of burns caused by the back-firing of a boiler-furnace; this was considered to be due to the existence of a chamber between the firebox and the chimney-stack, intended to be used later for the installation of economizers; the accumulation of gases in this chamber had caused a back-fire when the forced draught was turned on. The chamber has now been filled in and other improvements effected to prevent any similar occurrence in the future.

(6) An engineer in a brewery fell through a trap-door in the floor, receiving fatal injuries. At the instance of the Inspector of Factories suitable guard-rails have now been erected.

(7) A freezing-works employee engaged at an open hatchway fell through the opening and was killed; it was considered difficult to guard the opening whilst work was proceeding; at the request of the Inspector of Factories, however, the company has now erected safeguards on three sides of the opening, but it is considered doubtful whether this precaution would have prevented the accident in question.

(8) A sheet-metal worker in charge of a cellar used as a store fell through an open trap-door leading to the cellar and received fatal injuries; the attention of the employer had previously been drawn by the Department to the danger of this opening, and instructions were given that the door be kept locked except when being used by the worker.

(9) A freezing-works engineer received fatal injuries due to falling from a ladder which was being used for climbing to the top of the boilers; it is believed that the deceased did not set the foot of the ladder against one of the stop-blocks provided for the purpose and that the ladder slipped back to the block, the jerk causing deceased to fall.

(10) An apprentice motor mechanic (15½ years of age) was carrying outside a tin of petrol which had caught fire, when some of the liquid spilled on his clothing, resulting in burns, from which he died some weeks later. Instructions were given that petrol must not be left in an uncovered container.

(11) A motor mechanic was assisting to stack by means of a crane cases containing motor-cars, when the snapping of a sling-chain caused a case to fall upon him, resulting in injuries from which he died; the cause of the accident was a defective link in the chain. Inquiry showed that, in any case, the method of handling the cars was considered to be unsafe, and instructions were given to the firm to adopt safer methods.

(12) A freezing-works hand was engaged in handling heavy carcasses, when he collapsed and died. The post-mortem examination revealed that the worker had been suffering from long-standing disease of the heart.

(13) A fireman was firing the furnace at a freezing-works when a blow-back occurred, resulting in severe burns, from which he died. The "blow-back" was ascribed to the wind and to the fact that there was not sufficient draught in the furnace.

There was only one lad concerned in the above serious accidents (see No. 10), and no women or girls.

Factory Hygiene and Welfare Work.

Attention has again been given to the welfare of female workers in factories, shops, and hotels by the Women Factory Inspectors in the chief centres. They report an increase in such facilities as rest-rooms, washing-conveniences, seating-accommodation, protective clothing, and covering of floors; other firms have provided for libraries, sports clubs, and for benevolent funds.

Dermatitis amongst Bakers.

Inquiries were made by the Department throughout New Zealand during the year in conjunction with the Medical Officers of Health, into a number of statements that bakers were suffering from dermatitis. The inquiries were also made in other factories where food is prepared. Only two cases were discovered, and these were not considered serious by the Medical Officers of Health: one of them was transferred to work away from the bakehouse, while the other discontinued work as a baker pending treatment. Two other suspected cases of dermatitis were found, and the workers were advised as to proper treatment: one of them was discovered in a chocolate-making factory; she is undergoing treatment and in the meantime has not been employed in a factory where food is handled: the other has also undergone treatment.

It may be mentioned that dermatitis is not infectious or contagious. The various bakehouses and other places where food is prepared are, however, being kept under observation by the Department in conjunction with the Medical Officers of Health.