Finger injury during loading operations

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IMCA has received a report of an incident wherein a worker's finger was crushed.

What happened?

The injury occurred during an operation when a large heavy axle, weighing some 250 kg, was being removed from a reel by two operatives employing a fork-lift truck. The axle moved in an unexpected way, catching one operative's hands between the axle and the fork-lift truck, as he attempted to steady the axle movement.

The operator was given first aid on-site and taken to the local doctor as soon as possible, where analysis revealed a broken finger and cut nerves. A further appointment the following morning with a more senior medical expert led to the operative being taken to hospital, where he underwent surgery, resulting in his keeping his damaged finger.

What were the causes?

The company involved performed an analysis of the incident and noted the following:

- The work was conducted without the designated lifting gear and without a supporting forklift. The method utilised was to pull the axle out of the reel by usage of a rope and a forklift. At the end of the operation, it was anticipated by the operator that the axle, once out of the reel, would tilt slightly upwards. The opposite occurred, and, as the axle tilted downwards, the operator tried to prevent this movement using his hand. Unfortunately the little finger on his right hand was crushed as the moving axle met the forklift.

- The operatives were wearing all of the required personal protection equipment – the use of gloves was noted as having provided protection in this incident, to some extent at least.

- Job safety analysis and toolbox talks had been performed for the operation.

- Work of this sort had been taking place on a daily at the site for ten years without previous accident. It had, however, been recognised as a time consuming and risky (in terms of HSE) activity and an investment program had recently been applied for to change to a more efficient and safe system.

- No written procedures or work instructions exist on the specifics of the axle operations. 'Best practice' methodology for removing axles was not utilised. There was no written instruction or information which described best practice

for this operation.

- The persons involved were both experienced operators, having served at the worksite for several years; they were familiar with the unwritten best practice. The best practice was not utilised due to their judgment that the chosen method was good enough, and was not imposing risks which could not be handled. The chosen method may also have seemed quicker at the time.

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