Safety Alert

PORT SKILLS & SAFETY

Ref No: SA-011-2023

25 July 2023

Injury resulting in amputation

What happened:

During operations to load a container to a vessel deck, a ground lock was seen to have moved at the loading location under an incoming container. The vessel Hatch Foreman instructed the crane operator to lift the container such that the lock could be adjusted.

As the Foreman was attempting to adjust the lock, the other end of the container came free from its locks causing the container to land trapping the Foreman's hand / fingers. He called immediately for the container to be lifted.

Emergency response (ER) measure were implemented, and the Foremen was transferred to hospital.

The outcome was the amputation of an index finger.

Response Actions:

ER personnel were informed, and they made their way to the vessel. The Hatch Foreman was then driven directly to A&E at a local hospital.

The crane operator stood down to take some time to get over the occurrence.

The vessel Master was informed of the accident and the necessary paperwork completed.

Key findings:

The Hatch Foreman was wearing full and correct PPE at the time of the accident.

The onsite investigation is ongoing; however, the nature of this event suggests certain behavioural / operational approaches need further consideration in such activities:

- Operative personnel should never, under any circumstances, place themselves or body parts "in the line of fire" (i.e., in a potential impact or crush position)

- Time should always be taken to review if a task is being carried out in the safest way.
- Work in progress should be stopped if a higher risk is presented with potential to harm to personnel or damage to equipment.
- Jammed or misplaced twist-locks should never be adjusted unless the container has been moved in a safe area. If the container needs to be removed from the area, it should be positioned a minimum of three boxes away from the location of operation.