

Safety Alert

Number: 16-01

Published: 28/01/2016

Subject: Loss of End of Thumb

What Happened / Narrative

A vessel has reported an incident which highlights how the negative effects of complacency and routinization lead to accidents. Unfortunately for this crew member, the result was the loss of the end of his thumb.

During the installation of an additional security gate at the top of the gangway in way of the pilot boarding position on the vessel's port side, the IP was holding the gate in position while a second crew member located the bolts. To access one of the securing bolts the second crew member closed the pilot door without warning trapping the IP's finger between the gate and the pilot door. The second crew member was unaware of the IP's position due to the pilot door in the ships side blocking his field of view.

As a consequence the IP lost the top of his right thumb above the first knuckle line. He was immediately taken to the ships hospital and the master informed. The Chief Officer was in attendance and immediately applied pressure and initial first aid.

Long term there should be no affect upon his ability to work after repatriation for rest and recovery.

Why Did it Happen / Cause

Inadequate work planning or programming – The work was viewed as everyday which resulted in an inadequate risk assessment.

The lack of guards or barriers was due to the task being thought of as a low risk, everyday work so no formal Risk Assessment was undertaken. Holding up a gate appeared to be inconsequential as a hazard.

Lack of communication between the two parties involved in the task; a basic and simple warning that something was going to change would have sufficed and an accident would have been avoided – “watch out, I'm closing the door”.

Corrective Actions Taken / Recommendations

Requirement to undertake adequate Risk Assessment – The importance of adequately assessing risk needs to be emphasized. Though this task appeared innocuous it has resulted in serious injury.

Crew should remain alert to memory lapse or lack of awareness.

If they had carried out an adequate Job Assessment Safety Process they would have most likely recognised and addressed the hazard

Photographs / Supporting Information

