

UK SA10/2025 – 09.10.2025

SAFETY ALERT

MTC - CONTRACTOR THUMB TIP FRACTURE

DETAILS OF THE INCIDENT

While operating a power hoist, a trained and experienced contractor momentarily trapped the tip of his left thumb between the hoist body and the boss above the hook.

At the time, he was focused on guiding the load, when the left thumb (non-dominant) became trapped when he operated the hoist pendant using his other hand. He was able to lower the hoist immediately to free off his hand. He was working on the Climafuel Pfister hopper in the PHT. Initially, the incident was reported at the weekend as a first aid treatment, and the individual continued to attend work since.

However, it was later informed that he sustained a small fracture to the bone at the very tip of the thumb.

In line with CEMEX reporting criteria, this incident was reclassified as a Medical Treatment Case.

Safe Systems	Work was being carried out as part of the kiln major overhaul. Work was authorised via a permit to work. The team were briefed and had read through the RAMS. The permit contained additional assessment and controls. Take 5 completed.
Competency	The IP joined his employment company on 07/9/21 and had extensive experience of working on this type of task and was appropriately trained.
PPE	All required PPE was worn, including suitable ‘riggor’ and cut proof protective gloves for the task.
Standards	A ‘CM Lodestar’ electric hoist, recently installed by Cemex, was being used to assist with the safe removal of Climafuel Pfister components. This setup included a lifting beam and trapdoor arrangement. The hoist unit, which is virtually new, was inspected and found to have no faults. At the time of the incident, the load being lifted was well within the system’s Safe Working Load (SWL) capacity. Note: This hoist had been installed in response to a risk identified by the maintenance team during previous work on the Pfister. The hoist eliminates a manual handling task and supports the EMEA regional 2025 strategic focus on reducing manual handling interventions.

HOW COULD THIS HAVE BEEN AVOIDED?

The injury occurred when the injured person (IP) attempted to manually guide the load by holding the hook during hoisting. A moments loss of concentration resulted in the IP’s left thumb becoming trapped.

A contributing factor to the incident was the design of the lifting beam and hoist setup. Due to space constraints caused by surrounding equipment, the chain lift point cannot be centrally aligned with the trap door, requiring the IP to manually guide the load into position. Additionally, the hoist was mounted at head height (again due to space constraints), creating an accessible nip point between the hook and the casing.

Lifting hoist:
PHT Climafuel Pfister

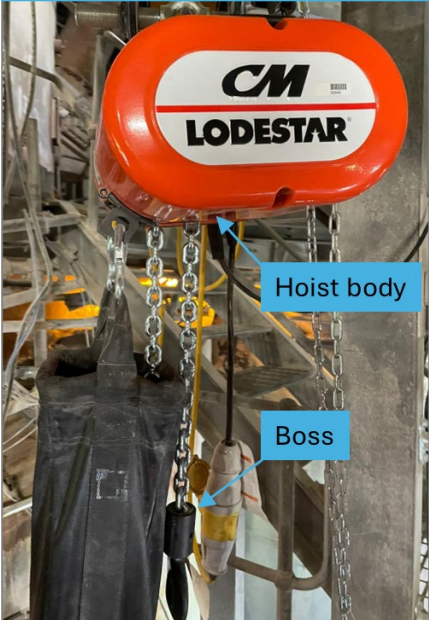




Photo showing the relative height of the beam – space is very restricted in the area!

The boss shown in its upper trip position between the shoulders of the casing. The illustration shows how, despite the ‘safety gap’, the thumb can still be nipped (see blue arrow opposite)



Display Until
09.11.2025



Hierarchy of Control

E Eliminate
R Reduce
I Isolate
C Control
P Protect

Look after yourself and each other

Don't let anyone act unsafely, always stop unsafe practices.

Tools and Equipment

Use the right, well maintained, tools/ equipment for the job. Never make do.



STOP THINK ACT