



ANRARA

**Australian National Road Accident Rescue
Association**
ACN 077 705 054

P.O. Box 771
MT WAVERLEY
Victoria 3149
AUSTRALIA

61 3 9888 1073 AH
61 3 9684 6616 BH
61 3 9684 6659 Fax
paulj@ses.vic.gov.au

TECHNICAL BULLETIN No. 7/99

Issued: 14 August 1999

SUBJECT AMPUTATION USING CUTTERS

This report was received by ANRARA from contacts in England.

Fire crews attended the RTA involving a collision between a car and an articulated trailer. The "A" frame of the trailer's towing hitch had penetrated the car, resulting in the driver being severely trapped. Extrication commenced with roof and offside door removal. This was accomplished with the Hurst JL 150 'O' blade hydraulic cutting equipment.

The hydraulic cutting equipment appeared to be functioning normally. Following the final cut on the offside of the car and due to the confined working area, the Leading Firefighter instructed the cutters to be removed from the area. This involved the equipment being passed between 3 people. It was during this phase that an injury occurred. Sometime during this event a combination of things occurred. Whilst holding the cutters by the blades with his left hand, the blades of the cutters closed. The cutters were being supported by the handle, which is remote from the operating trigger. The gloved left hand of the Leading Firefighter was trapped between the blades- the result being 3 partially amputated fingers.

CONCLUSION: The brigade investigated the event;

- 1 It appears the trigger spring was missing.
- 2 After the accident it was found that the trigger could, be placed in OPEN or CLOSED and would not spring back to neutral position.
- 3 At the time of the accident the trigger must have been towards the close position. Inadvertent knocking of the tool could have been sufficient to push the trigger to close mode.
- 4 When the tool was being passed out of the confined working area, the hydraulic hoses became snagged. The Leading Firefighter reached behind and held the tool by the blades in order to pull it closer to the car and gain some slack on the hose. It was whilst this was happening that the blades closed.

RECOMMENDATIONS.

- Check equipment and procedures.
- Inform operations personnel of the incident
- Include the conclusions of this investigation in standard training packages.
- Review all risk assessments with RTA equipment.

Following the accident the Health and Safety Executive removed the equipment in order to conduct further investigations (outcomes still awaited).

SOURCE John Hardcastle
CONTACT hardcastle.john@virgin.net

This information is provided by ANRARA as a service to members. ANRARA does not guarantee its accuracy and wherever possible will quote the source of the information for further enquiries.