

IMCA Safety Flashes summarise key safety matters and incidents, allowing lessons to be more easily learnt for the benefit of all. The effectiveness of the IMCA Safety Flash system depends on members sharing information and so avoiding repeat incidents. Please consider adding [safetyreports@imca-int.com](mailto:safetyreports@imca-int.com) to your internal distribution list for safety alerts or manually submitting information on incidents you consider may be relevant. All information is anonymised or sanitised, as appropriate.

## 1 Inspection notice from Crosby on certain products

The Crosby Group has asked that IMCA circulate the following information as part of a Safety Flash. Crosby has been made aware (March 2023) of a few instances of hoist rings that have an important assembly component missing. In those instances, the retaining pins used to secure the hinge pins were not in place and allowed a hinge pin to come out during unloaded condition. Internal testing has confirmed that these hoist rings can sustain the working load limit with only one hinge pin in place. However, Crosby recommends the listed hoist rings **be immediately inspected** to confirm the retaining pins are in place. The inspection is simple and can be completed quickly with the hoist rings installed and unloaded.

<b><u>INSPECTION NOTICE</u></b>		
<b>USERS OF THE BELOW CROSBY PRODUCT:</b>		
Description	Stock Numbers	Production Identification Codes (PICs) found on body
HR-125/125M Frame 2 Hoist Ring	1016624, 1016635, 1016644, 1016909, 1016912, 1016920, 1016924, 1016931, 1016935	7S*, 7U*, 7V*, and 7Y* * Designates all production runs of year
HR-125/125M Frame 3 Hoist Ring	1016657, 1016668, 1016942, 1016946, 1016953, 1016957, 1016964, 1016969	
<b>PLEASE CAREFULLY REVIEW AND ACT UPON THE FOLLOWING INSTRUCTIONS.</b>		

Crosby requests you perform the inspection on the above listed products with the listed production identification codes (PICs) found on the body. Crosby has prepared the below instructions to perform the necessary inspection. The inspection uses a small flat tool to gently pry the hinge pins outward, to confirm they are positively secured. If any hoist rings are found with inadequately secured hinge pins, please remove from service, and notify Crosby Technical Support at 1-800-220-8509 or [crosbytechsupport@thecrosbygroup.com](mailto:crosbytechsupport@thecrosbygroup.com) for immediate replacement.

Please inform your customer(s) of this Inspection Notice, or if you know of other users of the HR-125/125M Hoist Rings, please pass this notice on to that user, company, or firm. To ensure further circulation of this inspection notice to potential users of the products, it is being provided to safety minded industry organizations for posting on their safety notification sites.

We regret the inconvenience this may cause you and your organization and thank you for your cooperation. We are committed to providing you with the absolute best in Crosby quality.

Sincerely,

THE CROSBY GROUP

IMCA store terms and conditions (<https://www.imca-int.com/legal-notices/terms/>) apply to all downloads from IMCA's website, including this document.

IMCA makes every effort to ensure the accuracy and reliability of the data contained in the documents it publishes, but IMCA shall not be liable for any guidance and/or recommendation and/or statement herein contained. The information contained in this document does not fulfil or replace any individual's or Member's legal, regulatory or other duties or obligations in respect of their operations. Individuals and Members remain solely responsible for the safe, lawful and proper conduct of their operations.

## Inspection Procedure: HR125 & HR125M Hoist Ring

### Hinge Pin Check

**NOTE:** The inspection for the presence of the hinge pin retaining pins can be completed without disassembly of the HR-125 / 125M Hoist Ring. The inspection can be completed with the hoist ring installed while threaded into the work piece and fully torqued or uninstalled. The bail must be in **unloaded** condition, and the bail should be free to pivot easily on the hinge pins.

Video Demonstration of this inspection can be found at this link: [Hinge Pin Inspection.mp4](#)



Locate hoist ring assembly and visually inspect for any issues.

Note: It is recommended to periodically inspect per Crosby Hoist Ring Warnings and Applications Instructions, and ANSI B30.26 Rigging Hardware



The inspection can be accomplished by taking a small flat rigid object (such as a thin pry bar) that can be inserted under the head of the hinge pin and prying outwardly on the hinge pin.

Alternately, the inspection can be accomplished by grabbing the head of the hinge pins (with small pliers) and pulling outwardly while twisting.

A small amount of axial movement of approximately 0.04" (1mm) may be detected, but the hinge pins should not come out of the bail and body of the hoist ring. Additionally, the hinge pins should not rotate relative to the body. Perform the inspection on both hinge pins.



After the inspection, the hoist rings should have an identifier added, that indicates the inspection was performed and found to be acceptable.

In this case we placed a blue paint pin dot next to the E-Clip.

If any hoist rings are found with inadequately secured hinge pins, please remove from service, and notify Crosby Technical Support at 1-800-220-8509 or [crosbytechsupport@thecrosbygroup.com](mailto:crosbytechsupport@thecrosbygroup.com) for immediate replacement.

## 2 Uncontrolled movement of spreader bar

### What happened

A vessel was set up alongside a barge in preparation for the subsea deployment of a 16" (40cm) spool. The spreader bar sea-fastenings were removed by the deck crew and as the crane raised the rigging, the spreader bar rotated uncontrollably causing it to fall from its supports, with the forward end landing on deck and aft end landing on the spool.

The potential for rotation was unforeseen; a rigger who was nearby had to move quickly to get out of the line of fire. There were no injuries.

### Underlying causes

- The roll potential was identified by the onshore mobilisation team; however, it was not communicated to the offshore team;
- The procedure and lift plan did not detail the correct sequence for sea-fastening removal and lifting;
- There was a failure to identify and manage change requirements;
- The design / drawings presented at the risk review were not detailed enough to allow robust assessment of associated risks;
- The hazard of roll potential was not identified at design stage and was not detailed in design requirements.



Applicable  
Life Saving  
Rule(s)



Line of Fire

### Learnings

- Emphasise requirement to carry out a tool-box task before starting a task, and after a worksite inspection, so that all participants are made aware of all foreseeable hazards and implement suitable and sufficient control measures;
- Perform post-task debriefs, considering the following:
  - What went well?
  - What was different than planned or expected?
  - What could have gone better?
  - What surprised you?
  - What changes were made to address the issue or condition discovered?
  - What hazards/safeguards/issues still require follow up?
  - What would you change or do differently next time?
- Ensure sea fastening design requirements and the need for suitable technical review of full lifting operation is communicated.

Members may wish to refer to:

- [Uncontrolled movement of a riser](#)
- [UK HSE: uncontrolled movement of fabrication caused injury](#)
- [Uncontrolled movement of crane block and pennant during lifting operations at sea](#)

### 3 Equipment starts unexpectedly

#### What happened

Three mechanics obtained a Lock-out/Tag-out (LOTO) for a High voltage AC unit, and were performing routine maintenance on the unit. As one of them went to lubricate the bearings, the machine started unexpectedly. Work was stopped and a review was conducted. It was discovered that a linkage was broken in the circuit breaker handle and the breaker did not actually shut off when arranging the LOTO. The plant electricians repaired the linkage, the LOTO was rehung, and the work was completed.

#### What went right and/or wrong?

- What went right: no one was in the line of fire when the machine restarted and there were no injuries;
- What went wrong: equipment failure - the linkage in the breaker handle was broken.

#### Lessons learned

- Carefully check that equipment is de-energized before working on it – prove that it is “dead”;
- Ensure a full and thorough understanding of isolation and ensure the proper sources of energy are isolated when equipment is upgraded or modified.

#### IOGP Life-Saving Rules applicable

- **Energy Isolation:** the mechanics did not:
  - Identify all energy sources;
  - Confirm that hazardous energy sources were isolated, locked, and tagged;
  - Check there was zero energy; did not test for residual or stored energy.
- **Work Authorisation:** the mechanics did not:
  - Confirm that hazards were controlled or that it was safe to start

Members may wish to refer to:

- [LTI: person crushed in watertight door](#)
- [Serious injury caused by energy isolation failure](#)
- [Agitator started moving during mud tank cleaning – leading to injury](#)

Applicable  
Life Saving  
Rule(s)



Energy  
Isolation



Work  
Authorisation



## 4 Near Miss: steam and water released from filter

### What happened?

A mechanic was given a work order to clean out strainers from a boiler circulation pump. The mechanic was got to loosening the last two bolts, and stopped to wait to hear a “pop” indicating the lid coming up. The “pop” was a little bit more than was expected. As the mechanic waited for approximately 10 seconds, it was noticed that the pressure started getting more volatile with more air and water coming out. The mechanic moved out of the way, and called the control room to let them know what was going on. An operator and a supervisor responded and went to a valve that they thought might still be partially open. They attempted to try and close it. The supervisor tried with a bigger valve wrench and was able to turn the valve two more turns to close it off.

### What went right

- The employee moved out of the way when they noticed increased pressure from the filter;
- The supervisor was able to close the valve two more revolutions after the incident.

### What went wrong?

- The valve did not fully close when operations attempted to isolate it.

### Lessons learned

- Procedures were changed so as to open the bypass on the filter first, then isolate the inlet and outlet of the filter. Open drain valves upstream and downstream and then open the purge upstream and downstream, ensuring zero energy is exhausting.

Members may wish to refer to:

- [Crewman badly scalded during tank cleaning](#)
- [LTI: person crushed in watertight door](#)



## 5 Maintenance and control of fire doors

### What happened?

A member has discovered instances of mandatory fire doors onboard their vessels being in a poor state of maintenance, and in some cases modified to alter the closing mechanism or tied back to prevent closing.

Our member notes that in recent months there have been repeated internal and external audit findings related to inadequate maintenance, unapproved modification and the incorrect functioning of fire doors onboard their vessels. This has included Port State Control Inspection deficiencies that have raised safety concerns and been communicated to the Flag State Authorities.

### What was wrong

Inadequate maintenance and unapproved modifications reduce the effectiveness of fire and smoke boundaries significantly, with potentially serious consequences during a fire and increased risk to crews and assets.

- Fire doors have been found to not close and seal properly;
- Fire doors have been modified to alter the speed of closure;
- Fire doors have been tied back to prevent closure.



**Fire Doors and Closing Mechanism**

### Actions to take

- Ensure that no fire doors are modified or tied back to prevent closure or modify the speed of closure;
- Ensure all fire doors close automatically, by the self-closing mechanism and seal completely, including any hose ports;
- Ensure that routine maintenance and inspection regimes are followed;
- Ensure that where any defects are found, these are reported immediately.

Members may wish to refer to:

- [Fire door left wedged open](#)
- [Incidents relating to hatches and doors](#)
- [Disabled audible alarm on fire alarm panel](#)
- [Watertight doors left open at sea](#)

Applicable  
Life Saving  
Rule(s)



Bypassing  
Safety  
Controls