Unsecured sheave pin fell from crane

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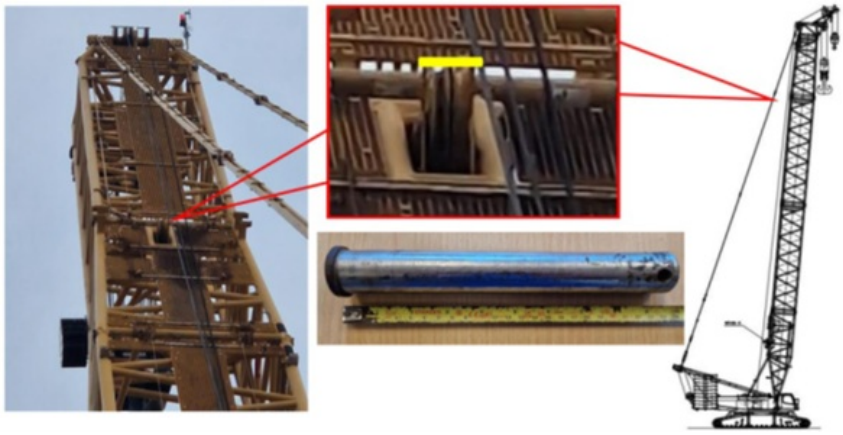
A sheave pin weighing 1.3 kg was found on deck.

IOGP Life Saving Rules:

Line of fire

What happened?

It fell from a 600 tonne crawler crane supplied by a third party. The pin likely fell from 30m height after the crane wire came into contact with its split pin, causing it to snap or to become dislodged. No-one was in the line of fire at the time, and there were no injuries. However, the incident posed a significant potential risk.



What went wrong?

- The sheave was not required for the crane's operational configuration and was not referenced in the assembly documentation.
- Assembly instructions did not cover the sheave assembly, and securing methods were not reviewed for this configuration.
- During assembly, it had been verbally agreed to leave the sheave in a raised position, but this agreement was not documented.
- There was no secondary retention present for the pin.

Lessons to learn

- Are all components, including those not required for the current configuration, considered in assembly and operational drawings, procedures and risk assessments.
- How might changes or omissions in equipment setup lead to hazards, such as dropped objects?
- Ensure there is a written record of all configuration justifications during assembly, especially when deviating from standard procedures or

manuals.

- Don’t forget the importance of additional safeguards (such as secondary retention) for pins and other parts that could become dropped objects.
- Subcontracted equipment does not mean subcontracted risk ownership – have a clear understanding of risks, roles and responsibilities when dealing with sub-contracted third-party equipment.

A causal factor in all the following incidents is that complex equipment being used was not correctly described in the drawings or documentation.