IMCA Safety Flash 19/18

September 2018

These flashes summarise key safety matters and incidents, allowing wider dissemination of lessons learnt from them. The information below has been provided in good faith by members and should be reviewed individually by recipients, who will determine its relevance to their own operations.

The effectiveness of the IMCA safety flash system depends on receiving reports from members in order to pass on information and avoid repeat incidents. Please consider adding the IMCA secretariat (imca@imca-int.com) to your internal distribution list for safety alerts and/or manually submitting information on specific incidents you consider may be relevant. All information will be anonymised or sanitised, as appropriate.

A number of other organisations issue safety flashes and similar documents which may be of interest to IMCA members. Where these are particularly relevant, these may be summarised or highlighted here. Links to known relevant websites are provided at www.imca-int.com/links Additional links should be submitted to info@imca-int.com

Any actions, lessons learnt, recommendations and suggestions in IMCA safety flashes are generated by the submitting organisation. IMCA safety flashes provide, in good faith, safety information for the benefit of members and do not necessarily constitute IMCA guidance, nor represent the official view of the Association or its members.

1 Diver Fatality During Subsea Lifting Operations

Note: This incident is still under investigation.

What happened?

During the removal of a spool at 172msw, divers were engaged in lift bag operations to relocate the spool to a wet store location. During the operation a series of events occurred, which resulted in one end of the spool rising off the seabed in an uncontrolled manner. The umbilical of one of the divers was caught in the lift bag rigging causing the diver to ascend with the spool until the spool's ascent was arrested.

Subsequent events resulted in the diver's umbilical being trapped between the spool and a seabed structure, which resulted in the diver losing his primary breathing gas supply. His secondary life support (SLS) was deployed and seems to have operated correctly, however this did not prevent the fatality.

Detailed and exhaustive investigations into the cause of the incident are ongoing in collaboration with the relevant authorities and the client.

Our member made the following interim recommendations:

All diving activities should be risk assessed and planned. The risk assessment and planning should include all key personnel involved in the work to be undertaken. Plans (methodology/working instructions) should be documented, unambiguous, authorised and communicated to everyone involved.

All aspects of the diving operations should be properly supervised. This includes ensuring that the risks involved, work to be done and emergency procedures are communicated to the divers before starting work at the dive site and thereafter, before each dive.

Ensure that the dive site is continuously monitored for changes to the task or conditions. If new hazards are identified or control measures are inadequate, work should be stopped, and the situation reassessed and, if necessary, amended, before starting again.

Review and reinforce individual and collective responsibilities with regard to the management of equipment safety lines/tie backs, lift bags (parachutes) and diver umbilical and every individual's duty to apply the 'stop work policy'.

Members should be aware that Guidance on open parachute type underwater air lift bags (IMCA D 016) addresses the operational use of open parachute type underwater air lift bags and the safety precautions that should be taken during their use.

Members may also wish to review Guidelines for Management of Change (IMCA SEL 001) and Guidance on Open Parachute Type Underwater Air Lift Bags (IMCA LR 007, D 016).

Further incidents involving lift bags can be found on the IMCA website.

A few of these are noted here:

- Incident During Lift Bag Operations (Feb 2003)
- Uncontrolled Ascent – Loss Of Lift Bag To Surface (May 2010)
- Uncontrolled Ascent Of Lift Bag (June 2012)
- Near Miss: Failure Of Subsea Lifting Equipment (July 2017)

2 Two 'Accident Advisories' Relating to Diver Fatalities

The Workplace Safety and Health Council of Singapore (WSHC) has released two 'accident advisory' notices relating to two recent diver fatalities.

Incident 1: diver struck by falling concrete pile

A diver was struck and subsequently killed by a falling concrete pile. Two divers were installing brackets onto a concrete pile underwater, when an adjacent concrete pile collapsed and struck one of them, pinning him against the seabed. He was rescued and conveyed to hospital, where he later died from his injuries.

Further information can be found on the WSHC website.

Incident 2: diver drowned

A commercial diver went missing while cleaning the hull of a vessel underwater. His body was eventually found two days later.

Further information can be found on the WSHC website.