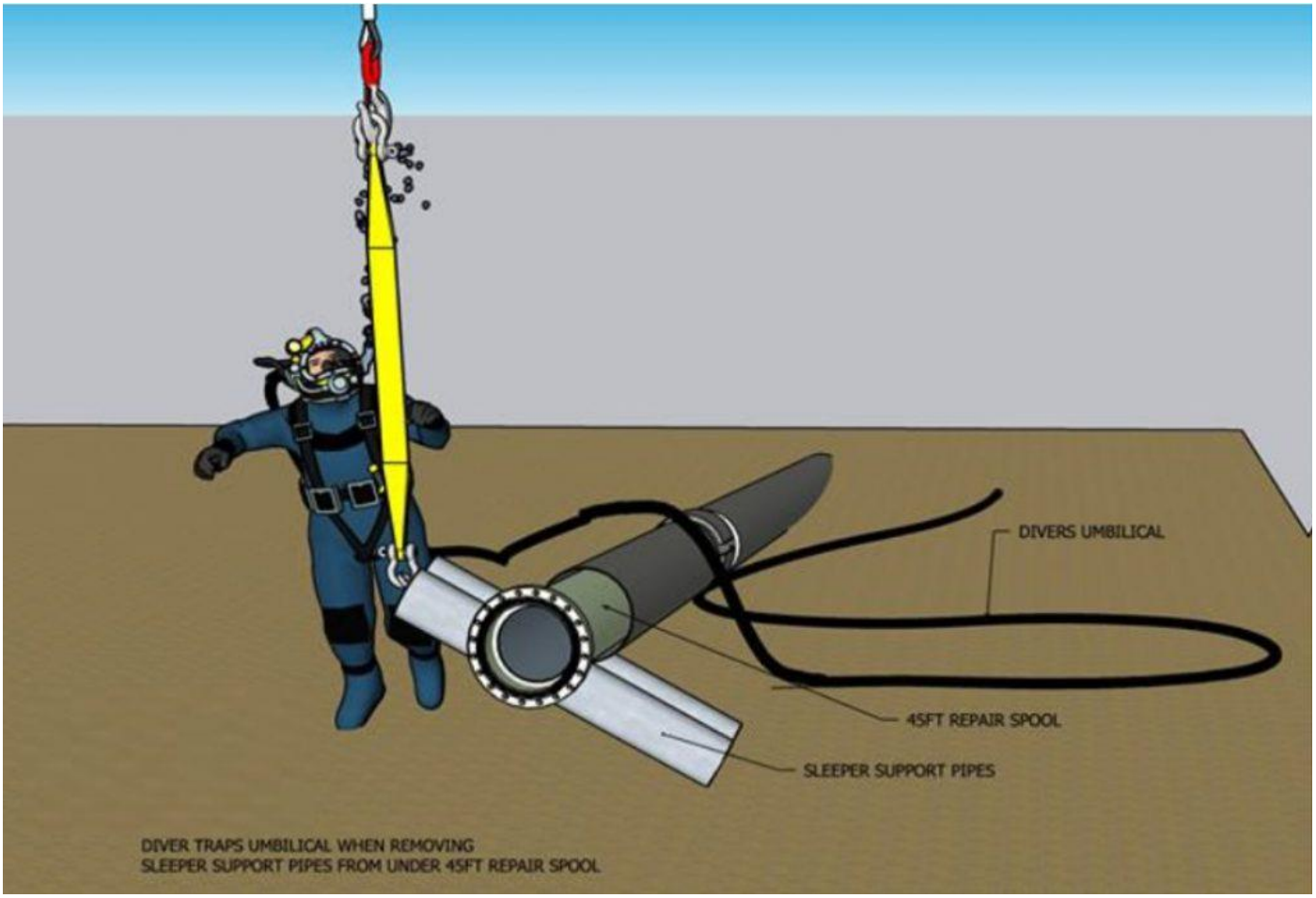
CDAS SAFETY FLASH 2023-02 |

Information sourced from IMCA

Umbilical management – near miss

What happened

A diver was working with the barge crane to remove two sleepers from under a newly installed 16" x 45 ft (40cm x 13.5m) repair spool. The crane was rigged directly onto the sleepers to be moved. Once the sleepers cleared, the pipeline moved and rolled over a section of the divers umbilical. The diver discovered that his umbilical was trapped and was able to free it himself. Visibility was excellent, it was daylight, and the diver was able to move his umbilical over to a suspended section of pipe, and was unharmed.



What went right

- Both diver and supervisor were very experienced and were able to work very quickly on a solution;
- This was a decompression dive that did not exceed the planned bottom time.

What were the causes

- Procedural – no procedure existed for the sleeper removal, due to an oversight during the project planning phase;
- Human Performance – the diver did not recognize the line of fire umbilical management hazard;
- Human Performance – the Dive supervisor did not call an “all stop”, due to a lack of full procedural understanding. No MoC (management of change) was created.

Corrective Actions

- Develop a removal procedure to include the removal of the diver’s umbilical from the bottom, before starting the operation;
- Review with the entire crew the Umbilical Management process and sleeper removal procedure.