



CDAS SAFETY FLASH 2025-12

CDAS SAFETY FLASH 2025-12

Diver Injured Following Unexpected Activation of Vessel Propeller

Information compiled from a firsthand diver account and personnel involved with the job operation

(No official outcome from authorities at time of writing)

Summary

A diver sustained multiple injuries after the unexpected activation of a vessel's propeller during local diving operations. The diver received medical treatment and was hospitalised for several days.

This safety flash is issued for awareness; there is currently no official determination on the causes.

What Happened?

Two divers were conducting inspection/cleaning tasks near the stern of a vessel. Diver 1 was preparing to surface after handing off a waterjet, while Diver 2 was clearing his umbilical on the way to the deck.

According to Diver 1, he was positioned near the propeller area and communicating with topside when the vessel's propeller unexpectedly activated. He was pulled into rotational movement around the rope guard multiple times before the propeller stopped briefly. During this pause, he cleared his umbilical. As rotation began again, he managed to pull clear of the hazard.

He sustained impact injuries to his back, neck, and leg, along with internal bruising, and was hospitalised for observation.

Additional context shared by personnel on site

Some individuals involved in the operation indicated that no after-work report or end-of-job confirmation was communicated from the diving contractor to vessel personnel at the time the incident occurred. This meant that the vessel crew may not have had a clear indication of whether diving activities had fully concluded. This point is based solely on accounts from divers and parties present and is not a confirmed investigation finding.

The injured person and others present or involved with the diving operation later stated that LOTO procedures were performed by the overall in-charge diving supervisor; however, there is no official verification regarding the vessel-side status or actions. This information is included for context only.

What Went Wrong?

As no official findings exist, the following are potential contributing factors based on the narrative:

- Diver positioning within a high-risk line-of-fire area close to the propeller.
- Unexpected energisation or movement of vessel machinery.

“Safe Dives...Save lives....”



CDAS SAFETY FLASH 2025-12

- Possible communication gaps between the dive team and the vessel crew.
- Possible absence of a clear, confirmed “divers out of water / job completed” notification to the vessel.
- Complexity of multi-party operations and assumptions about the status of the diving operation.

These potential factors do not imply fault by any party.

Key Lessons & Actions for the Diving Community

1. Strengthen machinery isolation & verification

- Reinforce LOTO controls with vessel crew, including double-confirmation loops.
- Use written, visual, and bridge-level verification before entering propulsion hazard zones.

2. Mandatory end-of-work confirmation

- Always communicate a clear, logged, and acknowledged completion notice to vessel personnel.
- The vessel and dive team should both be required to confirm the status.
- Post-job reports should be formally signed off between both parties, and the Diving Supervisor should personally verify and decommission the LOTO.

3. Improve hazard zoning at vessel sterns

- Clearly identify propeller/rotating-equipment danger zones and require explicit authorisation to approach.

4. Communication clarity

- Ensure two-way confirmation between the dive supervisor, vessel bridge/engine room, and deck crew.

5. Umbilical management near moving equipment

- Maintain routing that avoids entrapment risk should unexpected movement occur.
- Train divers to recognise early hazard cues and take immediate action.

6. Emergency preparedness

- Regularly drill scenarios involving unexpected machinery activation.
- Ensure medical response plans consider worst-case impact injuries.

“Safe Dives...Save lives....”



CDAS SAFETY FLASH 2025-12

Closing Reminder

This incident underscores the significant risks associated with working near propulsion systems and emphasizes the importance of maintaining isolation, clear communication, and rigorous end-of-work confirmation protocols.

As there are no official findings yet, members are advised not to conclude until further information is available.

Contributor: Mr Leslie Kevin D Kruz



Mr. Leslie is a full-time Commercial Diving Assessor, Facilitator, and Senior Trainer at KBA Training Centre Pte Ltd, and he also serves as an elected EXCO Member of the Commercial Diving Association Singapore.

“Safe Dives...Save lives....”

COMMERCIAL DIVING ASSOCIATION SINGAPORE