

Uncontrolled ascent of lay-down head

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A Member has reported that a saturation diver in 120 m of water, preparing to move a pipeline lay-down head (LDH) using a lift bag, was struck in the back by the uncontrolled ascent of the LDH.

The LDH was being used as a deadman anchor to assist in aligning a pipeline.

What were the causes?

The resulting investigation concluded that:

- The lift bag affixed to the LDH had a higher rating than the load to be lifted – inaccurate use of LDH weight data provided in the procedure while making a field change.
- There had been inadequate communication – offshore personnel had not been appraised regarding the LDH's true weight.
- There were inadequate guards/protective devices – due to the distances involved in moving the LDH, the lift bag dump line and safety strap were not connected.
- There had been inadequate assessment of the level of change – the task had been carried out under a 'minor' management of change (MOC) procedure.

Lessons learnt

Our Member recommends that:

- Diving operations using lift bags should always follow the company's guidelines.
- Anchors should have a known measured weight or have their weight calculated for the condition of use.
- Lift plans should include the weights, weight calculations and methods of those calculations.
- The deletion of a dump valve's safety line constitutes a significant change, requiring the use of an appropriate MOC procedure.
 - When a safety device is disabled or a safe procedure is bypassed, a

task must be further risk-assessed, brought to a higher level and fully documented; this is true even in situations where a safety device might increase the risk of incident or injury.

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