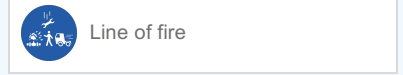


## Diver lifted off seabed

Safety Flash Published on 6 March 2025 Generated on 16 March 2025 IMCA SF 04/25

A diver was lifted off the seabed when their umbilical was caught by a diving bell clump weight adjustment prior to bell recovery.

IOGP Life Saving Rules:

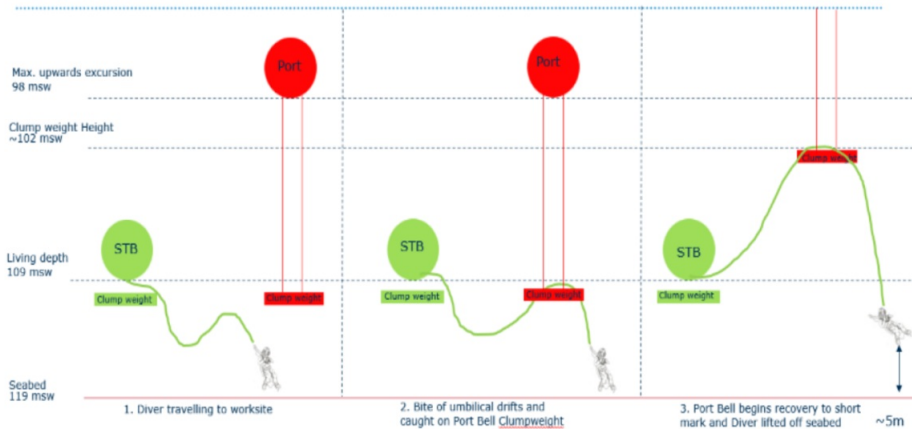


### What happened?

When moving from the bell to the worksite, a bite of the Starboard Diver 2's umbilical fouled on the port bell clump weight. When the port bell was raised to a short mark (approximately 10m from deployed position) by the Diving Supervisor, Starboard Diver 2 was lifted off the seabed to a height of approximately 4-5m due to the caught umbilical.

Upon recognition that the diver had been lifted off the seabed, the Diving Supervisor called an ALL STOP and the port bell clump weight was lowered until Starboard Diver 2's umbilical was cleared. The diver returned to the bell, where he and his equipment was assessed. At no point did the diver lose any of his services. Diver 2 was cleared to return to work using Diver 3's equipment. (The bell in use was configured to having 3 working divers out of the bell in addition to the bellman).

### Incident Presentation



Schematic of the actual and potential excursions related to the work and the operation.

[Open image in newtab to see larger version.](#)

### What went wrong?

- The route taken by the diver from the Starboard bell to the worksite meant that his umbilical was close to the port bell and its clump weight;
- The risk of snagging of the umbilical on the clump weight had not been recognised.

## Lessons to learn

- Given that the diver from the starboard bell had to pass close to the port bell, the observation ROV should have been designated to focus on diver umbilical;
- Divers required to pass close to objects to be lifted or moving from one workplace to another should be monitored by a second diver or by an ROV.

A Time Out For Safety (TOFS) was held in Dive Control, with all on shift divers in attendance to recognise, to discuss and communicate the near miss which had occurred with. Further discussion was held by Offshore Managers and supervisors.

Matters to discuss included:

- Behaviours - Line of Fire:
  - Tidal effects and current on umbilical slack;
  - The path that the diver takes and proximity to objects to be lifted;
  - Umbilical drifting;
- Personal Factors – Inattention: the possibility of the snagging of the umbilical could have been recognized prior to lifting;
- Use of the observation ROV to focus on the diver during his path to the worksite or between worksites.

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