Notifiable incident

Incident ID	**5302**
Duty holder:	INPEX Operations Australia Pty Ltd
Facility/Activity:	Ichthys Venturer
Facility type:	Floating production storage and offloading facility

Incident details	
Division	Occupational Health and Safety
Notification type	Incident
Incident date	23/02/2018 09:20 PM (WST)
Notification date	03/03/2018 01:37 PM (WST)
NOPSEMA response date	03/03/2018 01:52 PM (WST)
Received by	[redacted]
Nearest state	WA
Initial category type *(based on notification)*	Accident
Initial category *(based on notification)*	Incapacitation >= 3 days LTI
3 Day report received	05/03/2018
Final report received	23/03/2018
All required data received	23/03/2018
Final category type *(based on final report)*	Accident
Final category *(based on final report)*	Incapacitation >= 3 days LTI
Brief description	OHS - DOLTI - Crew member suffered laceration on right thumb
Location	
Subtype/s	Injury
Summary *(at notification)*	At 21:10 hours (WST) on 23 February 2018 on the Ichthys Venturer FPSO the IP was conducting a mechanical line-up inspection within Module 9 Level 4, and was required to operate and bleed valve S222- MV0104. When operating the valve handle the IP caught his hand on an exposed perforated stainless steel heat shielding sharp edge and sustained a laceration to the right hand which required 3 sutures. The IP was wearing gloves at the time of the event. IP returned to normal duties. Over a period of three (3) days the IP was monitored by the Doctor offshore who recommended that the IP see a Specialist on 28 February as a medical procedure may be required. The IP departed the facility on 27 February, by routine transfer helicopter where he subsequently saw a Specialist who advised a medical procedure was required. In view of this development, the Facility OIM at 13:51 hours (WST) on 3 March 2018 verbally notified NOPSEMA that this event was being reclassified as a lost time injury. There was no activation of the FPSO Emergency Response Plan. An investigation commenced. This incident was not originally notified to NOPSEMA on the date of occurrence as it was seen as Medical Treatment (MTC). Since then, the IP injury didn't improve and a medical procedure has been recommended elevating the classification to LTI.

Details *(from final report)*	At 21:10 hours (WST) on 23 February 2018 on the Ichthys Venturer FPSO the IP was conducting a mechanical line-up inspection within Module 9 Level 4, and was required to operate and bleed valve S222- MV0104. When operating the valve handle the IP caught his hand on an exposed perforated stainless steel heat shielding sharp edge and sustained a laceration to the right hand which required 3 sutures. The IP was wearing gloves at the time of the event. IP returned to normal duties. Over a period of three (3) days the IP was monitored by the Doctor offshore who recommended that the IP see a Specialist on 28 February as a medical procedure may be required. The IP departed the facility on 27 February, by routine transfer helicopter where he subsequently saw a Specialist who advised a medical procedure was required. In view of this development, the Facility OIM at 13:51 hours (WST) on 3 March 2018 verbally notified NOPSEMA that this event was being reclassified as a lost time injury. There was no activation of the FPSO Emergency Response Plan. An investigation commenced. This incident was not originally notified to NOPSEMA on the date of occurrence as it was seen as Medical Treatment (MTC). Since then, the IP injury didn't improve and a medical procedure has been recommended elevating the classification to LTI.
Immediate cause/s	IP caught his hand on an exposed perforated stainless steel heat shielding sharp edge and sustained a laceration. The IP did not identify the sharp edges to the exposed perforated heat shield mesh that had been exposed during a previous task.
Root cause/s	HPD - HUMAN ENGINEERING - Work environment - equipment guard NI
Root cause description	Equipment Guard Needs Improvement: Heat shielding mesh had not been reinstated after completion of leak testing campaign

Duty inspector recommendation	
Date	06/03/2018
Duty inspector	[redacted]
Recommendation	Do not conduct Major Investigation
Reasoning	Does not meet MI threshold based on information received
Supporting considerations	

Major investigation decision	
Date	06/03/2018
Decision	Do not conduct Major Investigation
Reasoning	Does not meet MI threshold based on information received
Supporting considerations	

Non-major investigation review and recommendation	
Date	06/03/2018
Inspector	[redacted]
Risk gap	Moderate
Type of standard	Interpretative
Initial strategy	Investigate

Recommended follow up strategy	
Recommended strategy	Investigate
Supporting considerations	Consequence - significant (hand operation and LTI). Benchmark likelihood - remote, actual likelihood (as demonstrated) - possible. Risk gap = moderate. Interpretive standards in relation to guarding, PPE, ergonomics. An investigation is justified to understand the prevalence of this risk and how the operator has generalised their investigation findings.

Non-major investigation decision	
Date	06/03/2018
RoN	[redacted]
RoN review result	Agree with recommendation
Strategy decision	Investigate
Supporting considerations	

Associated inspection	
Inspection ID	1759