

Notifiable incident

Incident ID [6214](#)

Duty holder: Shell Australia Pty Ltd
Facility/Activity: Prelude FLNG
Facility type: Floating liquefied natural gas facility

Incident details	
Division	Occupational Health and Safety
Notification type	Incident
Incident date	24/10/2019 11:30 AM (WST)
Notification date	24/10/2019 01:00 PM (WST)
NOPSEMA response date	24/10/2019 12:00 AM (WST)
Received by	[REDACTED]
Nearest state	WA
Initial category type <i>(based on notification)</i>	Accident
Initial category <i>(based on notification)</i>	Incapacitation >= 3 days LTI
3 Day report received	26/10/2019
Final report received	25/11/2019
All required data received	28/01/2020
Final category type <i>(based on final report)</i>	Dangerous Occurrence
Final category <i>(based on final report)</i>	Unplanned event - implement emergency response plan
Brief description	OHS - LTI
Location	Accommodation and amenities
Subtype/s	Injury, Medivac
Summary <i>(at notification)</i>	<p>Worker sustained cut to finger and was medivaced.</p> <p>A worker was transitioning from work to aft main deck, and caught finger in closing door causing deep laceration to ring finger on right hand. He will be Medivac at approx 3PM today. Details - two workers had been damper testing in machinery space and on completion were accessing the aft main deck. First worker passed through door, but second worker was distracted and hand on door frame as door closed catching his finger. Following medical assessment the OIM advises that arrangements are in place to medivac injured worker. OIM stated that injured worker was wearing a glove at the time. OIM could not say whether the injury would involve 3 days or more LTI.</p>
Details <i>(from final report)</i>	<p>Worker sustained cut to finger and was medivaced.</p> <p>A worker was transitioning from work to aft main deck, and caught finger in closing door causing deep laceration to ring finger on right hand. He will be Medivac at approx 3PM today. Details - two workers had been damper testing in machinery space and on completion were accessing the aft main deck. First worker passed through door, but second worker was distracted and hand on door frame as door closed catching his finger. Following medical assessment the OIM advises that arrangements are in place to medivac injured worker.</p> <p>** as supplied by dutyholder **</p> <p>6. Brief description of incident - What happened:</p> <ul style="list-style-type: none"> • A two member work party were accessing the aft machinery space ventilation air intake room (Starboard side main deck) to carry out routine maintenance activities. • On entering the room, the IP opened the door and held it for their colleague to enter. The IP then followed and, whilst entering, rested their right hand on the door frame. The door

then closed causing a laceration to the IP's fourth finger on their right hand.

Additional information:

- Space is under slight negative pressure during normal operations which causes door to close by itself.
- Door is marine type door (see attached picture) with no dampening on closure.

7. Work or activity being undertaken at time of incident - Accessing damper room for fire damper testing (incident not related to work scope)

8. What are the internal investigation arrangements? - Preliminary internal investigation commenced immediately gathering data, pictures and documented evidence. NOPSEMA notified. Formal investigation to be conducted by onshore investigation team.

15. Action taken to make the work-site safe - IP was taken directly to the Medic.

16. Was an emergency response initiated - Yes.

How effective was the emergency response? - On Site treatment by medic; onshore duty doctor assessment then non-urgent medevac.

17. Was anyone killed or injured? Yes

IP occupation/job title - Inlec Technician

Contractor or core crew - Contractor

Details of injury - Deep laceration to fourth finger on right hand

Nature of injury -

c. Wounds, lacerations, amputations, internal organ damage

f. Joint, ligament, muscle or tendon injury

Part of body - G8. Other - Right Hand

Mechanism of Injury - G2. Being hit or trapped

Agency of Injury - 4. Non-power equipment

Details of job being undertaken - Entering Air Handling Trunk to collect tools post job completion

21. Immediate action taken/intended, if any, to prevent recurrence of incident. -

Action - safety stand down conducted for Maintenance department

Responsible party - Maintenance Coordinator

Completion date - 24th October

22. What were the immediate causes of the incident? - Lapse in situational awareness. (Investigation ongoing. This is still being established)

**** As Supplied by Duty Holder****

Has the investigation been completed? Yes

Root cause 1 Lack of situational awareness

Root cause 2 Door is heavy (Marine Door) and there is a slight vacuum which pulls door shut

Full Report: While entering the aft machinery space ventilation air intake room (via the Marine door - Starboard, main deck) to carry out routine maintenance activities, the injured party opened the door and held it open for their colleague to enter. The injured party then followed their colleague through the door.

While entering the injured party rested their right hand on the door frame. The door (marine type door with no dampening on closure) then closed causing a laceration to the IP's fourth finger on their right hand. Following medical review, the injured party was medevac'd to receive treatment onshore. Event resulted in a lost time injury.

Investigation identified that the space is under slight negative pressure during normal operations which causes the door to self-close.

Actions to prevent recurrence of same or similar incident:

Action - Complete assessment of what could be done to dampen doors with pressure differentials.

Responsible - Engineering Manager. Completion Date - February 2020.

Action - Increase employee awareness of hazards posed by heavy doors. Responsible - Prelude OIM.

Completion date - Completed

Immediate cause/s

.TBC

Root cause/s	
Root cause description	Root cause 1 Lack of situational awareness Root cause 2 Door is heavy (Marine Door) and there is a slight vacuum which pulls door shut

Duty inspector recommendation

Date	24/10/2019
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	24/10/2019
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	24/10/2019
Inspector	[REDACTED]
Risk gap	Moderate
Type of standard	Interpretative
Initial strategy	Investigate

Recommended follow up strategy

Recommended strategy	Investigate
Supporting considerations	Finger caught between door frame and door, due to distraction. Investigate at next inspection to ensure no systemic issues.

Non-major investigation decision

Date	29/10/2019
RoN	[REDACTED]
RoN review result	Agree with recommendation
Strategy decision	Investigate
Supporting considerations	Agreed. Operator confirmed that there will not be any permanent damage to the finger and that the IP had been discharged from hospital.

Associated inspection

Inspection ID	2051
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Runsheets entries

1	Event date	30/12/2019 10:12 AM
	Event	November report A707748. Add 24 days ADI. Total updated from 6 days to 30 days ADI. IP returned to full duties on 25 November 2019.
2	Event date	28/01/2020 10:31 AM
	Event	[REDACTED] queried the status of LTI reporting. Shell resubmitted their 30-day report changing the category from LTI<3 days to Unplanned event - implement ERP. See email A713026