Notifiable incident

Incident ID	4987
Duty holder:	INPEX Operations Australia Pty Ltd
Facility/Activity:	CPF Ichthys Explorer
Facility type:	Other platform with accommodation facilities when drilling/workover facilities are not in commission

Incident details	
Division	Occupational Health and Safety
Notification type	Incident
Incident date	14/07/2017 03:20 AM (WST)
Notification date	14/07/2017 06:45 AM (WST)
NOPSEMA response date	14/07/2017 08:50 AM (WST)
Received by	[redacted]
Nearest state	WA
Initial category type *(based on notification)*	Dangerous Occurrence
Initial category *(based on notification)*	Could have caused death or serious injury
3 Day report received	17/07/2017
Final report received	13/08/2017
All required data received	14/08/2017
Final category type *(based on final report)*	Dangerous Occurrence
Final category *(based on final report)*	Could have caused death or serious injury
Brief description	OHS - DODSI Cut through electrical cable
Location	Deck
Subtype/s	Electrical
Summary *(at notification)*	Electrical personnel cut through an incorrect electrical cable: Two people were working under permit to remove a 960V cable from temporary seawater lift Pump A, which is being removed to be replaced with the permanent pump. They mistakenly cut through the cable for Pump B, which was coincidentally isolated at that time, but not under the work permit. No injuries occurred, but the job was stopped and area made safe, full investigation now underway. Other similar jobs to remove cabling and replace equipment are on hold.
Details *(from final report)*	Decommissioning and removal of the temporary Sea Water lift pumps in preparation for the installation of the permanent Sea Water Lift pumps. The redundant cables were being removed at the time of the incident. During nightshift two electrical personnel were working under a permit/isolation to remove a 690 volt supply cable for Temporary Sea Water Lift Pump'A'. The cable routed to the 690 volt supply cable for Temporary Sea Water Lift Pump'B' was mistakenly cut through. This Sea Water Lift Pump B was isolated and locked in the open position, on a long term isolation (so the mistakenly cut cable was not live), but this isolation/permit was not linked to the work scope being progressed.
Immediate cause/s	Incorrect identification of the cable to be cut and removed.
Root cause/s	HPD - PROCEDURES - Followed incorrectly - equipment id NI, HPD - MGMT SYS - Stds, policies, admin controls NI - no SPAC, HPD - WORK DIRECTION - Supervision during work - no supervision
Root cause description	No process/procedure for removal of cabling and ensuring positive identification of cables at transits. No positive identification of the correct cable to be cut prior to cutting. No identification labelling on cabling either side of the transit.

Duty inspector recommendation	
Date	14/07/2017
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	17/07/2017
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	17/07/2017
Inspector	[redacted]
Risk gap	Substantial
Type of standard	Defined
Initial strategy	IInvestigate within 45 days

Recommended follow up strategy	
Recommended strategy	Investigate within 45 days
Supporting considerations	Inpex CPF facility has just connected up in the field recently and in IHUC phase. Being a new facility, there is no prior history on "Inspection" as well as "Attitude". The reported incident although no actual harm but could result in a single fatality. The work as described would require competent electrician and work execution controlled under ISSOW, system identification & isolation etc. Human factor can also be a factor. For this to happen, there obviously a gap in the system and Inpex has commenced internal investigation. It is recommended that PI 1482 (Inspectors will be on the facility on 26/7/2017) to follow up this incident. NT.

Non-major investigation decision	
Date	17/07/2017
RoN	[redacted]
RoN review result	Agree with recommendation
Strategy decision	Investigate within 45 days
Supporting considerations	

Associated inspection	
Inspection ID	1482