Notifiable incident

Incident ID	5468
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	25/06/2018 09:30 AM (WST)
Notification date	25/06/2018 11:21 AM (WST)
NOPSEMA response date	25/06/2018 11:28 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	28/06/2018
Final report received	25/07/2018
All required data received	25/07/2018
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 - Electrical shock received by two workers whilst testing cable
Location	Process deck
Subtype/s	Electrical, Emergency response, Injury, Medivac, Near miss / high potential
Summary *(at notification)*	- Facility OIM informed of two personnel out of a team of 5 from contractor GTS received an electrical shock; - at the time of the incident, the IPs were conducting cable testing between FPSO and CPF; - the two IPS were checked by the facility medic, ECG and examination conducted, - OIM mentioned that personnel affected appeared to be ok, as precautionary measure it has been decided to MEDIVAC personnel to an onshore medical facility for further examination; - all areas affected have been barricaded off awaiting an internal investigation from INPEX; - Duty inspector checked and confirmed by calling the OIM back that from NOPSEMA perspective, there was no requirement for requesting permission to disturb the site.
Details *(from final report)*	- Facility OIM informed of two personnel out of a team of 5 from contractor GTS received an electrical shock; - at the time of the incident, the IPs were conducting cable testing between FPSO and CPF; - the two IPS were checked by the facility medic, ECG and examination conducted, - OIM mentioned that personnel affected appeared to be ok, as precautionary measure it has been decided to MEDIVAC personnel to an onshore medical facility for further examination; - all areas affected have been barricaded off awaiting an internal investigation from INPEX; - Duty inspector checked and confirmed by calling the OIM back that from NOPSEMA perspective, there was no requirement for requesting permission to disturb the site.
Immediate cause/s	The Electrical Check Sheet tick-box that was related to the relocation of the screen earth was signed off by a Contractor Technician and INPEX Electrical Inspector who had not been present during the testing and reconnection of the 33kV phase cables, and therefore had not actually witnessed that the screens were connected correctly and their continuity had been verified.

Root cause/s	HPD - QUALITY CONTROL - No inspection - hold point not performed, HPD - MGMT SYS - Stds, policies, admin controls not used - accountability NI
Root cause description	The Electrical Check Sheet tick-box that was related to the relocation of the screen earth was signed off by a Contractor Technician and INPEX Electrical Inspector who had not been present during the testing and reconnection of the 33kV phase cables, and therefore had not actually witnessed that the screens were connected correctly and their continuity had been verified. While a Technical Query Deviation (TQD) was raised by INPEX Engineering and appropriately approved by the INPEX Electrical TA1 to replace the failed Junction Box with a splice repair, and also relocate the cable screen earth position to the switchboard, there was no further Site Change or Management of Change process applied by either the Project or Operations teams to evaluate the required work packs and completions documentation. This was attributed to the fact that the Site Instruction to complete the work scope had already been issued by INPEX to the Contractor, essentially short-cutting the evaluation process. Process flow relating to implementation of TQD and associated Site Change / Management of Change processes was unknown / unclear / not enforced to persons involved and therefore inadequately executed. Failure to implement the Site Change process then lead to the deficiencies in the work pack whereby the change in earthing arrangement was not identified and corrected prior to the 33kV phase cable conductor being insulation tested. The emphasis of the issued work pack for the scope was instead on the completion of the splice repair to the cable, not on the relocation and testing of the screen earth. Associated completions documentation also did not require a specific, robust verification of the screen earth.

Duty inspector recommendation	
Date	25/06/2018
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	25/06/2018
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	26/06/2018
Inspector	[redacted]
Risk gap	Extreme
Type of standard	Established
Initial strategy	Investigate ASAP

Recommended follow up strategy	
Recommended strategy	Investigate ASAP
Supporting considerations	The incident was classed as HPI involving 2 electrician. The source of the electrical shock is unlikely to come from 33 KV/ 11KV systems. We are following up the EEHA deficiency on CPF in PI 1821. I therefore recommending that we include this notification into the scope and to verify the control arrangement. [redacted].

Non-major investigation decision	
Date	26/06/2018
RoN	[redacted]
RoN review result	Agree with recommendation
Strategy decision	Investigate ASAP
Supporting considerations	

Associated inspection	
Inspection ID	1821