

# Notifiable incident

**Incident ID** [5610](#)

**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	
<b>Division</b>	Occupational Health and Safety
<b>Notification type</b>	Incident
<b>Incident date</b>	16/09/2018 01:00 AM (WST)
<b>Notification date</b>	04/10/2018 04:11 PM (WST)
<b>NOPSEMA response date</b>	04/10/2018 04:19 PM (WST)
<b>Received by</b>	
<b>Nearest state</b>	WA
<b>Initial category type</b> <i>(based on notification)</i>	Dangerous Occurrence
<b>Initial category</b> <i>(based on notification)</i>	Could have caused death or serious injury
<b>3 Day report received</b>	07/10/2018
<b>Final report received</b>	07/10/2018
<b>All required data received</b>	07/10/2018
<b>Final category type</b> <i>(based on final report)</i>	Dangerous Occurrence
<b>Final category</b> <i>(based on final report)</i>	Could have caused death or serious injury
<b>Brief description</b>	OHS-DODSI-Live terminals found in equipment after electrical isolation
<b>Location</b>	Accommodation and amenities
<b>Subtype/s</b>	Electrical
<b>Summary</b> <i>(at notification)</i>	<p>Operator advised that an electrical technician had electrically isolated a deep fat fryer in the galley to conduct routine maintenance. However when he tested for 'dead' he found that two terminals were still live (240V). He replaced the cover on the equipment and reported to this supervisor.</p> <p>The operators justification for late notification was due to internal discussion about categorisation based on potential outcomes.</p>
<b>Details</b> <i>(from final report)</i>	<p>Operator advised that an electrical technician had electrically isolated a deep fat fryer in the galley to conduct routine maintenance. However when he tested for 'dead' he found that two terminals were still live (240V). He replaced the cover on the equipment and reported to this supervisor.</p> <p>The operators justification for late notification was due to internal discussion about categorisation based on potential outcomes.</p> <p>Electrical Technician was carrying out a 12 monthly planned maintenance inspection on galley deep fat fryer. Before commencing the inspection the technician tested for dead and found 2 live terminals.</p> <p>The Electrical Technician developed Own Isolation in accordance with the available electrical single line drawings. The schematic drawing identified a second cable however it did not identify that it was a 230VAC supply. The schematic inferred there was a shunt trip from the distribution board to the ANSUL firefighting unit which then sent a contact to the fryer to isolate power on release. It was not identified on the available drawings as a power supply and could have reasonably been assumed to be a dry or Extra Low Voltage (24VDC) contact from the unit.</p>
<b>Immediate cause/s</b>	The schematic drawing used to isolate the deep fat fryer identified a second cable, however it did not identify that it was a 230VAC supply.

<b>Root cause/s</b>	HPD - MGMT SYS - Stds, policies, admin controls NI - prints NI, HPD - HUMAN ENGINEERING - Human-machine interface - labels NI
<b>Root cause description</b>	<p>Secondary supply was not identified on the drawings normally used to develop isolations (Single line &amp; schematic) - The Electrical Technician developed Own Isolation in accordance with the available electrical single line drawings. The schematic drawing identified a second cable however it did not identify that it was a 230VAC supply. The schematic inferred there was a shunt trip from the distribution board to the ANSUL firefighting unit which then sent a contact to the fryer to isolate power on release. It was not identified on the available drawings as a power supply and could have reasonably been assumed to be a dry or Extra Low Voltage (24VDC) contact from the unit.</p> <p>No labelling at the fryer to indicate a dual supply</p>

**Duty inspector recommendation**

<b>Date</b>	05/10/2018
<b>Duty inspector</b>	██████████
<b>Recommendation</b>	Do not conduct Major Investigation
<b>Reasoning</b>	Does not meet MI threshold based on information received
<b>Supporting considerations</b>	

**Major investigation decision**

<b>Date</b>	05/10/2018
<b>Decision</b>	Do not conduct Major Investigation
<b>Reasoning</b>	Does not meet MI threshold based on information received
<b>Supporting considerations</b>	

**Non-major investigation review and recommendation**

<b>Date</b>	08/10/2018
<b>Inspector</b>	██████████
<b>Risk gap</b>	Moderate
<b>Type of standard</b>	Established
<b>Initial strategy</b>	Investigate

**Recommended follow up strategy**

<b>Recommended strategy</b>	Investigate
<b>Supporting considerations</b>	<p>The facility has previously reported life cables after equipment isolation. Previous case was black start air compressor.</p> <p>The isolation of equipment via EIC / circuit diagrams for electrical equipment as based on As built SDL/ circuit diagrams. There obviously as-built errors. The facility has established procedure to ensure positive isolation of electrical equipment prior to working on isolated equipment i.e. test for dead. The Electrician followed due process and the work was suspended and reported to his supervisor upon discovery.</p> <p>Potentially single fatality is possible if the electrician has not followed procedure. This incident is identical to notification 5611.</p> <p>Operator has conducted a number of inspection in equipment packages since the black start air compressor life cables and to date there were no findings of as-built errors.</p> <p>I suggest that this incident to be followed up in next planned inspection ██████████</p>

**Non-major investigation decision**

<b>Date</b>	09/10/2018
<b>RoN</b>	[REDACTED]
<b>RoN review result</b>	Agree with recommendation
<b>Strategy decision</b>	Investigate
<b>Supporting considerations</b>	Agreed.

**Associated inspection**

<b>Inspection ID</b>	1845
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