Notifiable incident

Incident ID	5293
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	15/01/2018 09:00 AM (WST)
Notification date	16/02/2018 10:30 AM (WST)
NOPSEMA response date	26/02/2018 12:56 PM (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	16/02/2018
Final report received	16/02/2018
All required data received	16/02/2018
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 Isolation Issue
Location	
Subtype/s	Electrical, Near miss / high potential

Summary *(at notification)*	An electrician was tasked with removing multiple preservation bridges within low voltage (LV) Safety Integration System (SIS) relays, receiving power from a 230V switchboard. The task was to be completed under "own isolation" protocols and an approved Own Isolation Certificate and Hot Work (2) Permit was in place. The individual was working through his approved sequential isolation list when he discovered an existing isolation on a circuit breaker that he had planned to isolate. The individual tested the load side of the circuit breaker "for dead" and found that it was energised. He ceased work and reported the issue to the Permit Office. Internal INPEX incident investigation commenced, in accordance with the INPEX Event Reporting & Investigation Procedure. Delay in reporting justified as follows: [redacted] I tried to call you yesterday and this morning. We are preparing a written incident report to submit, addressing an event which occurred on the FPSO in January. The event was initially ranked as low potential, and hence was not categorised as high potential or reported to NOPSEMA as a dangerous occurrence, however in concluding and reviewing the incident investigation we have reclassified this as a high potential incident. The event involved an electrical work scope, the electrician conducted a 'test for dead' prior to commencing his tasks and found that the system was energised, he ceased his work and reported the situation to the permit office. We will submit the written report shortly, I just wanted to explain why we did not provide a verbal notification at the time and there was a delay between the event date and the report being submitted. Let me know any queries, [redacted]

Details *(from final report)*	An electrician was tasked with removing multiple preservation bridges within low voltage (LV) Safety Integration System (SIS) relays, receiving power from a 230V switchboard. The task was to be completed under "own isolation" protocols and an approved Own Isolation Certificate and Hot Work (2) Permit was in place. The individual was working through his approved sequential isolation list when he discovered an existing isolation on a circuit breaker that he had planned to isolate. The individual tested the load side of the circuit breaker "for dead" and found that it was energised. He ceased work and reported the issue to the Permit Office. Internal INPEX incident investigation commenced, in accordance with the INPEX Event Reporting & Investigation Procedure. Delay in reporting justified as follows: [redacted] I tried to call you yesterday and this morning. We are preparing a written incident report to submit, addressing an event which occurred on the FPSO in January. The event was initially ranked as low potential, and hence was not categorised as high potential or reported to NOPSEMA as a dangerous occurrence, however in concluding and reviewing the incident investigation we have reclassified this as a high potential incident. The event involved an electrical work scope, the electrician conducted a 'test for dead' prior to commencing his tasks and found that the system was energised, he ceased his work and reported the situation to the permit office. We will submit the written report shortly, I just wanted to explain why we did not provide a verbal notification at the time and there was a delay between the event date and the report being submitted. Let me know any queries, [redacted]
Immediate cause/s	Inspection found that two jumper cables were installed within a Variable Speed Drive (VSD) cabinet which linked the circuit with a secondary power source. This was unknown to persons involved at the time. Single line drawings utilised to develop associated Isolation Lists did not depict the jumper cables.
Root cause/s	HPD - QUALITY CONTROL - QC NI - inspection techniques NI
Root cause description	During commissioning, the work party did not remove the jumper cables which had been installed by the vendor.

Duty inspector recommendation	
Date	26/02/2018
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	26/02/2018
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	26/02/2018
Inspector	[redacted]
Risk gap	Moderate
Type of standard	Established
Initial strategy	Investigate

Recommended follow up strategy	
Recommended strategy	Investigate
Supporting considerations	The facility 240 V system is protected by RCD (Stated in the Safety Case). The likelihood of fatal electrocution is low. The fact that the incident was re-calibrated to HPI, we should follow up the incident in the next facility inspection together with the thoroughness of the investigation process / report . [redacted]

Non-major investigation decision	
Date	27/03/2018
RoN	[redacted]
RoN review result	Agree with recommendation
Strategy decision	Investigate
Supporting considerations	

Associated inspection	
Inspection ID	1759