Notifiable incident

Incident ID	**5344**
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	01/04/2018 02:40 PM (WST)
Notification date	01/04/2018 08:20 PM (WST)
NOPSEMA response date	01/04/2018 09:40 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	03/04/2018
Final report received	01/05/2018
All required data received	01/05/2018
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 - work carried out on a pump that was not isolated - 2 workers involved
Location	Process deck
Subtype/s	Electrical, Near miss / high potential
Summary *(at notification)*	Two Workers working on pump that was not isolated. A work party on Ichthys Venturer removed drive coupling on primary pump C, median heat pump. After the work was completed the supervisor found the work had been completed on the wrong pump - it should have been the cooling median pump. The pump worked on was not isolated - hence risk of death or injury.
Details *(from final report)*	Two Workers working on pump that was not isolated. A work party on Ichthys Venturer removed drive coupling on primary pump C, median heat pump. After the work was completed the supervisor found the work had been completed on the wrong pump - it should have been the cooling median pump. The pump worked on was not isolated - hence risk of death or injury.
Immediate cause/s	Inadequate work direction and control resulted in working on non-isolated equipment
Root cause/s	HPD - MGMT SYS - Stds, policies, admin controls NI - not strict enough, HPD - WORK DIRECTION - Preparation - walk-through NI, HPD - HUMAN ENGINEERING - Human-machine interface - labels NI
Root cause description	Inadequate job preparation including walk-through of the job by the supervisor, equipment label need to clear and prominent to the workers.

Duty inspector recommendation	
Date	01/04/2018
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	01/04/2018
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	03/04/2018
Inspector	[redacted]
Risk gap	Moderate
Type of standard	Established
Initial strategy	Investigate

Recommended follow up strategy	
Recommended strategy	Investigate within 45 days
Supporting considerations	Consequence - serious injury or death. Likelihood with functional PTW system - remote; actual - possible. Risk gap - moderate. Standard - established - industry accepted PTW system - ISSoW used on Inpex facilities. Enforcement related to PTW - IN 673 (at CPF), issued 17/08/2017. Relevant notifications 5293 (15/01/2018); 4987 (14/07/2017). Strategy upgraded to investigate within 45 days.

Non-major investigation decision	
Date	04/04/2018
RoN	[redacted]
RoN review result	Agree with recommendation
Strategy decision	Investigate within 45 days
Supporting considerations	Repeat failure of a critical work system with potential to impact across all work fronts.

Associated inspection	
Inspection ID	1759