Notifiable incident

Incident ID	**5422**
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	23/05/2018 08:10 AM (WST)
Notification date	23/05/2018 05:48 PM (WST)
NOPSEMA response date	23/05/2018 05:57 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	25/05/2018
Final report received	13/06/2018
All required data received	13/06/2018
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-Switchboard flashover during maintenance
Location	
Subtype/s	Electrical, Near miss / high potential
Summary *(at notification)*	Operator advised that whilst an ABB vendor was winding in a breaker on switchboard S780SB741, located in the forward machinery space, deck B port side, a flashover occurred. The switchboard is an LV 690V board. The flashover was contained in the board as per design. The vendor was not injured but was examined by the medic and given the all clear. No fixed fire and gas detection equipment was activated. Upon investigation it appears a cable got trapped behind the breaker and cause a short circuit when it made contact with the bus bars.

Details *(from final report)*	Operator advised that whilst an ABB vendor was winding in a breaker on switchboard S780SB741, located in the forward machinery space, deck B port side, a flashover occurred. The switchboard is an LV 690V board. The flashover was contained in the board as per design. The vendor was not injured but was examined by the medic and given the all clear. No fixed fire and gas detection equipment was activated. Upon investigation it appears a cable got trapped behind the breaker and cause a short circuit when it made contact with the bus bars. Further information from final report: A flashover occurred inside switchboard S-780-SB-741 in the forward machinery space, deck B Port side switch room. Switchboard is 690 volts. The flashover was contained within the switch board as per design. An ABB vendor was winding in the bus-tie when the event occurred. During to the flashover, the ABB Vendors left forearm was exposed approximately40mm between his glove and shirt sleeve wrist cuff, which resulted in his forearm hair being singed. No injuries or electric shock was sustained. No fire and gas detection activated, and the general alarm was not raised.
Immediate cause/s	The racking in was almost complete when the flashover occurred. The cause was the control wiring loom had been dislodged from the cable ties holding it in place allowing it to drop down at the back of the breaker. While it was being racked in the wiring loom has contacted the bus bar causing the flashover.
Root cause/s	HPD - QUALITY CONTROL - QC NI - inspection techniques NI, ED - DESIGN - Design specs - specs NI
Root cause description	QC NI – Quality Control / Needs improvement Inspection techniques NI While the breaker was being racked in, the wiring loom was crushed into the busbar socket receptacle of the circuit breaker frame causing the flashover. Equip Difficulty Design – Design Specs - specs NI The manufacturer's inherent design allowed the wiring loom to be dislodged.

Duty inspector recommendation	
Date	23/05/2018
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	23/05/2018
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	24/05/2018
Inspector	[redacted]
Risk gap	Moderate
Type of standard	Established
Initial strategy	Investigate

Recommended follow up strategy	
Recommended strategy	Investigate
Supporting considerations	This notification has been assessed by [redacted] and it is concluded that a single fatality was a potential outcome. Subject to the 3 day report it appears that the elevated risk gap is aligned to a "build" deficiency than human error or SMS failure, so that an urgent investigation is not required. Established standard - as per the Scope of Validation.

Non-major investigation decision	
Date	24/05/2018
RoN	[redacted]
RoN review result	Agree with recommendation
Strategy decision	Investigate
Supporting considerations	

Associated inspection	
Inspection ID	1780