## **Notifiable incident**

Notification ID NTF11728

Duty holderWoodside Energy LtdFacility/ActivityCWLH OKHA FPSO

Nearest state WA

Incident OHS-DSCE: Aft crane slew encoder developed an 8 degree offset, impacting the collision

avoidance system.

Basic information provided at time of notification	
Notification type	Incident
Incident date	26/08/2022 05:30 PM (AWST)
Notification date	27/08/2022 07:50 AM (AWST)
NOPSEMA response date	27/08/2022 11:00 AM (AWST)
Received by	

Summary of information provided	
Brief descriptive title	OHS-DSCE: Aft crane slew encoder developed an 8 degree offset, impacting the collision avoidance system.
Incident location	Deck
Subtype/s	
Summary (provided at notification)	Failure of safety critical component. The aft crane slew encoder was identified with an 8 degree offset after lifting. The offset alters the programmed and mapped collision avoidance system. Crane not operating within defined limits is a failure of performance standard P20. The aft crane is now out of service pending investigation and repair.

Request permission to disturb the site	
Permission given	Not Applicable
Permission given by	
Permission given on	

Initial spill and release amounts	
Gas (kg)	
Liquid (L)	
Release type	
More information	

Details of person providing information to NOPSEMA	
Full name	
Job title	

Initial notification category	
Initial category type (based on notification)	Dangerous Occurrence
Initial category (based on notification)	OHS - damage to safety-critical equipment

Decision	
Escalate to level 1	Yes
Inspector	
Escalated on	29/08/2022 10:58

Final notification category	
Final category type (based on final report)	Dangerous Occurrence
Final category (based on final report)	OHS - damage to safety-critical equipment

Immediate causes	
Details	Slew encoder error.

Initial report	
Due date	29/08/2022
Received date	29/08/2022
Reviewed date	29/08/2022
Reviewed by	
Additional details provided by duty holder	Brief description of incident The aft crane slew encoder was identified with an 8 degree offset post lifting activities.  This offset alters our programmed & mapped collision avoidance zones and constitutes a failure of our performance standard P20.2 which states lifting appliances shall operate within defined limits.  Work or activity being undertaken at time of incident Aft crane lifting operations  What are the Internal Investigation Arrangements Internal investigation in accordance with the Woodside "Health, Safety and Environment Event Reporting, Investigating and Learning Procedure"  Action taken to make the work-site safe:  Action taken: Aft crane parked in safe position and taken out of service.  The Okha manual of permitted operations details this failure and is currently in force.  Details of any disturbance of the work site Investigation launched to ascertain root cause and implement corrective actions  Was an emergency response initiated? No Was anyone killed or injured? No  Immediate action taken/intended, if any, to prevent recurrence of incident:  Action - Aft crane parked in safe position and taken out of service. The Okha manual of permitted operations details this failure and is currently in force.  Responsible party  Completion date 26-Aug-2022  Actual or Intended Actual

Final report	
Due date	25/09/2022
Received date	05/09/2022

Reviewed date	07/09/2022
Reviewed by	
Additional details provided by duty holder	Full Report:
	Describe investigation in detail, including who conducted the investigation and in accordance with what standard/procedure
	Investigation completed by OKHAFLC, OKHAHSEC and HSR in accordance with Woodside Health Safety and Environment
	Event Reporting.
	After completing lifting activities, the AFT crane boom was being returned to boom rest. When approaching boom rest, the
	collision avoidance system activated preventing further movement of the boom. This entails the collision avoidance alarm
	activating and movement of the boom halted - automatically. The slew angle indicator was not reading correctly, resulting in a
	shift of the collision zone mapping. When slewing around to 360 degrees, the slew angle reading was out by 2 degrees. On
	further investigation the shaft key from 1st gear that runs along the slew bearing was absent. This would have had the ability
	to slip over time which would have caused the crane slew encoder feedback to be incorrect.
	Actions to prevent recurrence of same or similar incident:
	Action Replace Slew Encoder on W/O 2100350768
	Responsible party
	Completion date 29-Aug-2022
	Actual or Intended Actual
	Action Replace 1st gear key and complete Slew Encoder calibration and collision
	checks on completion of current servicing
	Responsible party
	Completion date 30-Sep-2022 Actual or Intended Intended
	Actual of Interided Interided
	Action Inspect FWD and Midships crane Slew Encoder assemblies for similar faults.
	Responsible party
	Completion date 30-Sep-2022
	Actual or Intended Intended

Final spill and release amounts				
Gas (kg)	0.00			
Liquid (L)	0.00			
Release type				
More information				

Root causes				
Code				
Description	Has the investigation been completed? Yes			
	Root cause analysis: Root Causes: Analysis Factor: EQ3-0 Equipment Predictive/Preventative Maintenance Comments 1st Gear shaft key was absent and could not be located. Unknown as to whether it has worked loose or absent from last installation of gear. This caused the slew angle indicator to read incorrectly, resulting in a shift of the collision zone mapping.			

All data received	
Date	05/09/2022