Notifiable incident

Incident ID	5199
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	25/12/2017 11:00 AM (WST)
Notification date	25/12/2017 03:15 PM (WST)
NOPSEMA response date	25/12/2017 04:10 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	28/12/2017
Final report received	28/12/2017
All required data received	28/12/2017
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 - electric shock
Location	
Subtype/s	Electrical
Summary *(at notification)*	Minor electric shock received by [redacted], on Ichthys Venturer, during the disconnection with the accommodation vessel. Under wet conditions due to rain, he touched an electric plug which was powering an ice machine. He received a shock but as the RCD tripped the shock was minor. He was treated on board, including an ECG to check heart function but it was determined that he had suffered no permanent ill effects.
Details *(from final report)*	Minor electric shock received by [redacted], on Ichthys Venturer, during the disconnection with the accommodation vessel. Under wet conditions due to rain, he touched an electric plug which was powering an ice machine. He received a shock but as the RCD tripped the shock was minor. He was treated on board, including an ECG to check heart function but it was determined that he had suffered no permanent ill effects. IP was evaluating the de-boarding of the scaffold in the Level 1, Module 1 hydration area when his arm brushed against an electrical cable & plug and he felt a minor electric shock. Due to recent heavy rain approximately 30 minutes earlier, the area was wet and the plug socket had partially filled with water. Local RCD tripped as per design at 30 mA. The investigation identified that water egress had occurred on the male coupling as it was not screwed tightly to female coupling. Even if couplings had been tightened, it is still possible that water may compromise the connection as couplings are of different brands and quality; male coupling is Clipsal Series 56, with IP rating 66 and female coupling is unknown / unbranded, does not appear to have adequate weather seals and IP rating is unidentifiable. As such, root cause has been identified as 'Quality Control Needs Improvement – Inspection / Instructions needs improvement' and corrective actions are as detailed in section 33 of this notification.

Immediate cause/s	Water egress to male coupling due to unrated connection. Coupling ends were not of same brand; female (unbranded) coupling did not appear to have adequate weather sealing and IP rating was not identifiable.
Root cause/s	ED - EQUIPMENT / PARTS DEFECT - QC
Root cause description	Quality Control Needs Improvement – Inspection / Instructions needs improvement

Duty inspector recommendation	
Date	28/12/2017
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	28/12/2017
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	28/12/2017
Inspector	[redacted]
Risk gap	None
Type of standard	Established
Initial strategy	Inclusion in annual stats/data analysis

Recommended follow up strategy	
Recommended strategy	Inclusion in annual report stats / data analysis
Supporting considerations	Individual received minor electrical shock from a power outlet that was protected by an RCD which operated as per design and reduced the magnitude of the electric shock to below the threshold that would cause harm to the person. A follow up ECG confirmed that no cardiac irregularities were sustained during this incident. Wet conditions caused water to track across a plug and socket connection that was being disconnected at the time of the incident. All electrical equipment operated as per design.

Non-major investigation decision	
Date	28/12/2017
RoN	[redacted]
RoN review result	Agree with recommendation
Strategy decision	Inclusion in annual report stats / data analysis
Supporting considerations	

Associated inspection	
Inspection ID	