Notifiable incident

Incident ID	5519
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	02/08/2018 02:20 PM (WST)
Notification date	02/08/2018 04:30 PM (WST)
NOPSEMA response date	02/08/2018 04:47 PM (WST)
Received by	[redacted]
Nearest state	WA
Initial category type *(based on notification)*	Dangerous Occurrence
Initial category *(based on notification)*	Other kind needing immediate investigation
3 Day report received	05/08/2018
Final report received	31/08/2018
All required data received	31/08/2018
Final category type *(based on final report)*	Dangerous Occurrence
Final category *(based on final report)*	Other kind needing immediate investigation
Brief description	OHS-OKNI - Floodlights found connected to incorrect circuit breaker
Location	Process deck
Subtype/s	Electrical
Summary *(at notification)*	Two floodlights were found to be switched on after the circuit breaker these were connected to, was switch off and placed out of service as part of a future EHA (equipment in hazardous areas) maintenance campaign. The operator investigated this by checking the distribution board and drawing it was found that the correct circuit breaker was isolated, however the floodlights in question were found to be connected in a different circuit breaker indicated in the drawing as spare. No related work or permit related to this finding was undertaken at the time. No safety consequence to personnel was experienced from this event. Focal point inspector [redacted] on board the facility during a planned inspection is aware of this finding.

Details *(from final report)*	Two floodlights were found to be switched on after the circuit breaker these were connected to, was switch off and placed out of service as part of a future EEHA (electrical equipment in hazardous areas) maintenance campaign. The operator investigated this by checking the distribution board and drawing it was found that the correct circuit breaker was isolated, however the floodlights in question were found to be connected in a different circuit breaker indicated in the drawing as spare. No related work or permit related to this finding was undertaken at the time. No safety consequence to personnel was experienced from this event. Focal point inspector [redacted] on board the facility during a planned inspection is aware of this finding. On checking power distribution board S-789-DB-183-01, it was found that the isolator for circuit N15 was locked Out of Service (OOS) as per the OOS Register, it was also found that the adjacent circuit N14 which is identified on the Single Line Diagram as a SPARE was the actual power supply for these lights: S-789-LT-183-01-N15 and S-789-LT-183-02-N15. • N15 circuit was isolated by means of turning the isolator switch to the off position and it being locked 'Out of Service'. This task did not pose a risk to personnel. • N14 Circuit (Actually in use) was considered a SPARE circuit in the Single Line Diagrams and should not have been terminated in Korea. Therefore it is not likely to have posed a risk to personnel as scheduled or repair work would not be carried out on this circuit. At the time of this event, there was no permit under issue or work being undertaken on these lights systems. At no time did a 'Release of Energy' occur, or was there a mechanism for injury in this event. No personnel were injured as a result of this event. Actions: Floodlighting equipment S-789-LT-183-01-N15 and S-789-LT-183-02-N15 to be switched OFF and de-energised and locked Out of Service. An Electrical Isolation Certificate (EIC) is to be applied to NORMAL LIGHTING AND SMALL POWER DISTRIBUTION BOARD S-789-DB-183-01 to ensure that the circuit is isolated. Note: EIC 25341 applied to circuit. Raise a Notification in SAP to rectify the incorrect wiring on S-789-DB-183-01-N15. Note: SAP Notification 10013193 raised to rectify. Review all similarly designed distribution boards on CPF and FPSO and check spare circuits against schematic drawings to ensure alignment. Evidence of inspection to be provided. Review Commissioning documentation to determine if testing of the circuits (S-789-LT-183-01-N15 and S-789-LT-183-02-N15) were completed as per the procedure and that checklists were documented and completed.
Immediate cause/s	Floodlights connected to the incorrect circuit breaker. On checking the distribution board and the drawings it was found that the correct circuit breaker was isolated, however the lights were connected to a different circuit breaker, indicated on the drawing as a spare.
Root cause/s	HPD - PROCEDURES - Followed incorrectly - details NI
Root cause description	Incorrect wiring of circuit – not in accordance with drawing

Duty inspector recommendation	
Date	03/08/2018
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	06/08/2018
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	07/08/2018
Inspector	[redacted]
Risk gap	Moderate
Type of standard	Established
Initial strategy	Investigate

Recommended follow up strategy	
Recommended strategy	Investigate
Supporting considerations	Consequence - serious - ignited LoC and MAE. Benchmark likelihood - remote. Actual likelihood - possible, given that the EEHA status of the floodlights and associated fittings is yet to be verified. Established standard - EEHA, as per scope of validation. Relevant enforcement history - IN 673 & IN 707 (CPF Ichthys Explorer related to electrical issues). Relevant incidents (FPSO only) - 5293 & 5344. Escalated investigation not recommended because inspection reports relating to these issues are currently being written for both CPF & FPSO, and they are well understood in NOPSEMA. Recommend an investigation to follow up this issue at the next PI in December 2018.

Non-major investigation decision	
Date	07/08/2018
RoN	[redacted]
RoN review result	Agree with recommendation
Strategy decision	Investigate
Supporting considerations	

Associated inspection	
Inspection ID	1794