

HSE Alert Form



Alert Number: 2015.13

eSafe No	INC-1120655	Location	Townsville	Date	6 February 2015
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Description of Hazard/Incident (What happened?)

Flashover when fuse replaced on faulty LV cable

Extent of Impact (Details of injury, environmental harm, equipment damage, etc.)

Employee PPE sustained flash marks.

Key Facts (What are the key facts?)

No final conclusions have been drawn as to the cause/s of this incident. In the interests of safeguarding our employees, we request everyone to read this information to reinforce our safety focus on controls and to improve our safety awareness.

- A response team on call was dispatched to a fault call from a customer advising that the pole opposite this address just went bang.
- Crew arrived onsite, discussed the fault log and completed a DTRMP.
- The crew proceeded to go aloft to visually check both the potheads on Low Voltage and High Voltage underground cables installed up the pole and connected to padmount transformer.
- Crew found no visual evidence of a fault on either cable pothead.
- Crew proceeded to padmount transformer located three metres from base of pole and using a volt meter, tested the line and load side of low voltage fuses, and tests indicated that there was a blown LV fuse.
- It was documented on the DTRMP that the single phase fuse assembly was old and that it was necessary to disconnect the LV load before removing the fuse cartridge.
- OCCN to advise of required forced outage.
- Crew opened LV links supplying the overhead open mains at pole top to disconnect LV load from padmount transformer and removed all three LV fuse cartridges and replaced the 400A blown fuse.
- Employee had reinserted two of the LV fuses into the fuse holders and when he was reinserting the third LV fuse a flash was observed.
- The Safety Observer withdrew from the doorway of the padmount LV cabinet and confirmed the other employee was ok.
- The employee who had inserted the fuse received soot marks on his insulated gloves, leather outer gloves and protective shirt sleeve of his right arm. The other employee did not sustain any injury as a result of the incident.
- WGL was notified of the incident and OCCN was contacted to receive clearance to isolate HV UG cable supplying padmount transformer.
- The crew isolated the LV cable by removing LV fuses and placed DNOBs padmount transformer to ensure LV UG cable was made electrically safe for further investigation of cause of fault.

Actions (Information on corrective actions implemented that may prevent harm and or assist others in preventing a similar occurrence)

Managers/Supervisors to brief crews on the importance of considering the reason for fuse/s blowing and mitigation strategies required to minimise risk to field staff at site during fault finding and supply restoration

Contact for further Information

Name: Mark Biffanti

Position: Customer Delivery Manager Herbert

IMPORTANT NOTES:

This advice is provided in confidence for distribution to ENA members for information only. This advice has not been modified by ENA.

The issuing company must refer to the "Guidelines for the notification and distribution of ENA Significant Incident Advice" before issuing this Significant Incident Advice.

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Page 1 of 1

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