Notifiable incident

Incident ID	**5428**
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	27/05/2018 03:00 PM (WST)
Notification date	27/05/2018 06:17 PM (WST)
NOPSEMA response date	27/05/2018 06:50 PM (WST)
Received by	[redacted]
Nearest state	WA
Initial category type *(based on notification)*	Dangerous Occurrence
Initial category *(based on notification)*	Unplanned event - implement emergency response plan
3 Day report received	30/05/2018
Final report received	30/05/2018
All required data received	30/05/2018
Final category type *(based on final report)*	Dangerous Occurrence
Final category *(based on final report)*	Unplanned event - implement emergency response plan
Brief description	OHS - UPE - GA activated due to false indication of water mist system release
Location	
Subtype/s	Alarm, Emergency response, Muster
Summary *(at notification)*	Notification message from facility OIM provides the following information: - GA activated due to false indication of water mist system release at aft machineary space, fire water pump C. - Event ocurred during downloading of software into ICSS system. - Inmediate actions taken: > Full mustered achived; > confirmed no fire or smoke within the space; and > confirmed water mist system was not released. Duty inspectors attempted contacting the facility (OIM back) at the following times with no success: 27/5/18 at 18:50 hrs, 19:01 hrs, 20:06 hrs and 20:53 hrs. 28/5/18 at 07:20 hrs and 07:57 hrs.

Details *(from final report)*	Notification message from facility OIM provides the following information: - GA activated due to false indication of water mist system release at aft machineary space, fire water pump C. - Event ocurred during downloading of software into ICSS system. - Inmediate actions taken: > Full mustered achived; > confirmed no fire or smoke within the space; and > confirmed water mist system was not released. Duty inspectors attempted contacting the facility (OIM back) at the following times with no success: 27/5/18 at 18:50 hrs, 19:01 hrs, 20:06 hrs and 20:53 hrs. 28/5/18 at 07:20 hrs and 07:57 hrs. The FPSO ICSS Engineer and FPSO HSE Advisor conducted an investigation in accordance with the INPEX Event Reporting & Investigation Procedure. The ICSS Fire and Gas System (FGS) update software was being downloaded and implemented. During the update there was indication of a water mist release on S794PAHH821 which was false. No water was released in the room. The water mist had been isolated in preparation for the download as these issues were a possibility and prepared for. The issue was the PAGA A bypass force had not been fully applied during the ICSS logic bypass process. The ICSS Engineer advised that for the download over 500 logic bypasses had to be applied. Applying a bypass force is a two-step process. In this instance, the bypass force for PAGA A, only one step had been applied. The second step had been missed. During the event the Emergency Response Team was deployed and confirmed no smoke or fire and that the water mist had not been released.
Immediate cause/s	False indication of water mist system release. Indication of water mist system release in Firewater Pump C room.
Root cause/s	HPD - HUMAN ENGINEERING - Complex system - monitoring too many items
Root cause description	The Public Address General Alarm (PAGA) “A” bypass force had not been fully applied during the ICSS logic bypass process. The ICSS Engineer advised that for the download, over 500 logic bypasses had to be applied. Applying a bypass force is a two-step process. In this instance, the bypass force for PAGA A, only one step had been applied. The second step had been missed. Human Engineering Complex System – Monitoring too many items

Duty inspector recommendation	
Date	28/05/2018
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	28/05/2018
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	28/05/2018
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	Relevant incident history - NMI 5417 - inadvertent discharge of Inergen on ESD; NMI 5383 - GA due to false fire alarm; NMI 5336 - GA due to false indication of deluge discharge. There is a pattern of false alarms and inadvertent activation of fire systems. It is considered that these failures to a safe condition and that investigation is not currently required. Facility is in commissioning and no HC has been yet introduced. No risk gap identified. Established standard - as per scope of validation.

Non-major investigation decision	
Date	28/05/2018
RoN	[redacted]
RoN review result	Agree with recommendation
Strategy decision	Inclusion in annual report stats / data analysis
Supporting considerations	

Associated inspection	
Inspection ID	