Notifiable incident

Incident ID <u>5596</u>

Duty holder: INPEX Operations Australia Pty Ltd

Facility/Activity: Ichthys Venturer

Facility type: Floating production storage and offloading facility

Incident details	
Division	Ossupational Health and Safaty
	Occupational Health and Safety
Notification type	Incident
Incident date	26/09/2018 12:13 PM (WST)
Notification date	26/09/2018 12:56 PM (WST)
NOPSEMA response date	26/09/2018 01:59 PM (WST)
Received by	
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	29/09/2018
Final report received	29/09/2018
All required data received	29/09/2018
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 and Muster
Location	Accommodation and amenities
Subtype/s	Alarm, Muster
Summary (at notification)	Facility GA and muster following suspected fire in the galley. CCTV showed no fire in galley. ERP team achieved full muster then employed to investigate, no evidence of fire. Occurred due to function testing of the galley hood fire suppression system. Bypass on confirmed package fire however alarm activated in hood and initiated the GA and muster. Currently investigating.
Details (from final report)	Facility GA and muster following suspected fire in the galley. CCTV showed no fire in galley. ERP team achieved full muster then employed to investigate, no evidence of fire. Occurred due to function testing of the galley hood fire suppression system. Bypass on confirmed package fire however alarm activated in hood and initiated the GA and muster. Currently investigating. At 12:13 WST on the 26 September 2018 the General Alarm (GA) sounded and people commenced mustering on the facility. The alarm was indication of fire in Galley Hood Enclosure. CCTV confirmed no fire in Galley Hood Enclosure. Facility mustered, all persons were accounted for. Emergency Response Team Leader was mobilised to investigate. There was no evidence of fire. Function testing was being performed on the ANSUL galley hood extinguisher package. A bypass had been placed on the confirmed fire from package for the testing but not the confirmed release and this is what activated the GA. Facility returned to normal status at 12:27 WST investigation commenced.

Immediate cause/s	Occurred due to function testing of the galley hood fire suppression system. Bypass on confirmed package fire however alarm activated in hood and initiated the GA and muster.
	Function testing was being performed on the ANSUL Galley Hood extinguisher package. A bypass had been placed on the confirmed fire from package for the testing but not the confirmed release and this is what activated the GA.
Root cause/s	HPD - TRAINING - Understanding NI - instruction NI
Root cause description	Correct bypass not applied for function testing of ANSUL galley hood fire extinguisher package. Function testing was being performed on the ANSUL galley hood fire extinguisher package. A bypass had been placed on the confirmed fire from package for the testing but not the confirmed release and this is what activated the GA. Correct bypasses applied and function tested completed.

Duty inspector recommendation	
Date	26/09/2018
Duty inspector	
Recommendation	Do not conduct Major Investigation
Reasoning	Does not meet MI threshold based on information received
Supporting considerations	Awaiting three day report.

Major investigation decision	
Date	27/09/2018
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	28/09/2018
Inspector	
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	Consequences - no credible consequences from this occurrence. Likelihood is unchanged, therefore no risk gap. Established standards - as per scope of validation. Relevant incident history - there have been a number of these false activations across different fire and gas detection systems at the facility during the commissioning period.

Non-major investigation decision	
Date	28/09/2018
RoN	
RoN review result	Agree with recommendation
Strategy decision	Inclusion in annual report stats / data analysis
Supporting considerations	Agreed.

Associated inspection	
Inspection ID	