Notifiable incident

Incident ID	**5140**
Duty holder:	INPEX Operations Australia Pty Ltd
Facility/Activity:	CPF Ichthys Explorer
Facility type:	Other platform with accommodation facilities when drilling/workover facilities are not in commission

Incident details	
Division	Occupational Health and Safety
Notification type	Incident
Incident date	11/11/2017 03:50 AM (WST)
Notification date	11/11/2017 04:30 AM (WST)
NOPSEMA response date	11/11/2017 06:00 AM (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	13/11/2017
Final report received	13/11/2017
All required data received	13/11/2017
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 - fire and gas Alarm
Location	Deck
Subtype/s	Alarm, Muster
Summary *(at notification)*	false alarm - fire and gas indication on west crane. ERT and Fire team mobilised and investigated - false alarm associated with maintenance. Brought mainpower back on and returned to normal opperations.

Details *(from final report)*	On the morning of 11/11/17 maintenance team were preparing to isolate the west crane for slew ring inspection. The technicians involved in isolating the crane pulled the knives on the 2 crane cabin HVAC gas detectors which initiated an ESD1A on total invalidity for those two detectors (B-871-DGC-003 and B-871-DGC-003). The Maintenance Override Switches (MOS's) were not in place prior to this work being executed. Facility ESD1A and GPA initiated. Facility muster followed. Investigations confirmed false alarm. Full muster achieved, facility stood down and all returned to work. False alarm - fire and gas indication on west crane. ERT and Fire team mobilised and investigated - false alarm associated with maintenance. Brought mains power back on and returned to normal operations. On the morning of 11/11/17 maintenance team were isolating the West crane for slew ring inspection. The technicians involved in isolating the crane pulled the knives on the 2 crane cabin HVAC gas detectors which initiated an ESD1A (non-hazardous) on total invalidity for those two detectors (B-871-DGC-003 and B-871-DGC-004). The MOS's were not in place prior to this work being executed. The technicians performing the work immediately notified the CCR alerting them of their actions and that no fire was present. Facility ESD1A (non-Hazardous) and GPA initiated. Facility muster followed. Full muster achieved, ERT were deployed whereby it was confirmed as a false alarm. The facility stood down and all returned to work. Work to re-establish normal power to the facility then commenced. The investigation uncovered the following: 1. Detectors had not been inhibited prior to the isolation of the associated knives 2. No bypass certificate (containing inhibits) had been issued to the technicians prior to isolation 3. A bypass certificate had been raised as a part of the scope which included the required inhibits. However, the certificate was still located with the permit pack at the time of isolation. 4. The bypass certificate had been structured as a parent to the permit and not to the electrical isolation. Therefore the MOS had not been isolated in the correct sequence (prior to the isolation taking place) and would only have had to have been in place prior to the issue of the permit. 5. Hierarchy section of the EIC and Bypass certificate had not been filled out correctly.
Immediate cause/s	Pulling knives on crane HVAC gas detectors without MOS's in place.
Root cause/s	HPD - PROCEDURES - Not used / followed - no procedure
Root cause description	Maintenance Override Switch (MOS's)'s not in place prior to commencement of task. The bypass certificate had been structured as a parent to the permit and not to the electrical isolation. Therefore the MOS had not been isolated in the correct sequence (prior to the isolation taking place) and would only have had to have been in place prior to the issue of the permit. Hierarchy section of the EIC and bypass certificate had not been filled out correctly.

Duty inspector recommendation	
Date	11/11/2017
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	13/11/2017
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	12/11/2017
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	Facilities (CPF & ASV) mustered in the past due to F&G alarm. There is no HC risk at the facilities in the current state. The event was confirmed as false alarm. NT

Non-major investigation decision	
Date	15/11/2017
RoN	[redacted]
RoN review result	Agree with recommendation
Strategy decision	Inclusion in annual report stats / data analysis
Supporting considerations	Agreed.

Associated inspection	
Inspection ID	