

Notifiable incident

Incident ID [5157](#)

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	26/11/2017 08:30 AM (WST)
Notification date	26/11/2017 06:47 PM (WST)
NOPSEMA response date	26/11/2017 09:30 PM (WST)
Received by	[REDACTED]
Nearest state	WA
Initial category type <i>(based on notification)</i>	Dangerous Occurrence
Initial category <i>(based on notification)</i>	Could have caused incapacitation >= 3 days LTI
3 Day report received	29/11/2017
Final report received	22/12/2017
All required data received	22/12/2017
Final category type <i>(based on final report)</i>	Dangerous Occurrence
Final category <i>(based on final report)</i>	Could have caused incapacitation >= 3 days LTI
Brief description	OHS - DOLTI - Test plug released due to incorrect opening of isolation valve
Location	Process deck
Subtype/s	Individual performance, Near miss / high potential
Summary <i>(at notification)</i>	<ul style="list-style-type: none">- Incident occurred during leak testing of flanges with Nitrogen and Helium test pack;- test being conducted on train to LP condensate and LP separator (Modules 9 & 10);- test being carried out by [REDACTED];- leak test technician [REDACTED] (incorrectly) opened an isolation valve inside the test boundary;- this resulted on a pressure of 1200 Kpa applied on test flange;- test flange fitted test plug with released within the test pack boundary due to the applied pressure;- no one was injured as result of the event;- OIM described [REDACTED] leak tech technician as the person who was probably exposed to impact from test plug;- OIM mentioned that reasons for tech opening the valve not yet known,- OIM said that INPEX is mobilizing an onshore team to conduct full investigation into this event;- OIM mentioned that incident classified a "Near miss" however incident potential not yet determined;and- at this stage incident has been entered as "Could have caused incapacitation >3 days LTI". <p><More detailed information will be provided in 3 day report.></p> <p>Note: Notification displayed on duty phone at around 21:15 hrs on 26/11/2017 when duty inspector called the facility twice at 21:30 hrs with no response.</p> <p>Duty inspector spoke to OIM on 27/11/2017 at 08:04 hrs.</p>

<p>Details (from final report)</p>	<ul style="list-style-type: none"> - Incident occurred during leak testing of flanges with Nitrogen and Helium test pack; - test being conducted on train to LP condensate and LP separator (Modules 9 & 10); - test being carried out by [REDACTED]; - leak test technician [REDACTED] (incorrectly) opened an isolation valve inside the test boundary; - this resulted on a pressure of 1200 Kpa applied on test flange; - test flange fitted with test plug released within the test pack boundary due to the applied pressure; - no one was injured as result of the event; - OIM described [REDACTED] leak tech technician as the person who was probably exposed to impact from test plug; - OIM mentioned that reasons for tech opening the valve not yet known, - OIM said that INPEX is mobilizing an onshore team to conduct full investigation into this event; - OIM mentioned that incident classified a "Near miss" however incident potential not yet determined; and - at this stage incident has been entered as "Could have caused incapacitation >3 days LTI". <p><More detailed information will be provided in 3 day report.></p> <p>Note: Notification displayed on duty phone at around 21:15 hrs on 26/11/2017 when duty inspector called the facility twice at 21:30 hrs with no response.</p> <p>Duty inspector spoke to OIM on 27/11/2017 at 08:04 hrs.</p> <p>During probing of flanges for leaks on a Nitrogen Helium Test Pack (Train2 MP Condensate and LP Separator), a Leak Test Technician opened a manual valve inside the test boundary. This resulted in a release of pressure of 1200 kpa at the test flange.</p> <p>During leak testing of the FPSO Train 2 MP Condensate & LP Separator system it was reported a Leak Test technician had inadvertently opened a valve allowing a pressure release that caused a plug to be ejected from the tapped flange aperture of the valve. The leak testing was immediately suspended, the area around the event location segregated, and an investigation of the event commenced. Assessment of the tapped flange aperture found no thread damage and inspection of the area around the valve location failed to find a plug. Witness statements provided subsequent to the event also clarified that the object ejected from the tapped flange aperture was a small piece of leak test tape – not a plug. As a result it was concluded that a plug was not ejected from the tapped flange. No one was injured and no equipment / assets were damaged as a result of the ejection of this leak test tape. The investigation of this event was as specified by the INPEX Event Reporting and Investigation Procedure (0000-AH-PRC-60005). A root cause analysis was conducted using the Taproot® methodology. The Investigation was conducted by a team of 6 INPEX and Leak Test Contractor personnel lead by the INPEX Commissioning Technical Support Lead and facilitated by a Taproot trained HSE Advisor.</p>
<p>Immediate cause/s</p>	<p>Incorrect opening of isolation valve caused overpressure on test plange/test plug. Initial findings are that the release occurred following the operation of a manual valve.</p>
<p>Root cause/s</p>	<p>HPD - PROCEDURES - Not used / followed - no procedure, HPD - COMMS - No comm or not timely - late communication</p>
<p>Root cause description</p>	<p>Management of flange post connection of OPP / leak test in Korea not as required by INPEX. Specifically – the tapped flange associated with valve S222-MV-0001 should have been replaced with a correct blind flange, or the tapped flange aperture plugged, the joint assessed and a Joint Connection Certificate (JCC) issued, prior to the flange being taped and lagged. Change in valve status from required position of open to closed not communicated as required by Leak Testing Contractor.</p> <p>On identifying the valve to be in a closed position rather than the required open position, and despite not being tasked with valve management, the IP cracked the valve from closed to open without first discussing with and / or getting authorisation from his Supervisor.</p>

Duty inspector recommendation	
<p>Date</p>	<p>27/11/2017</p>
<p>Duty inspector</p>	<p>[REDACTED]</p>
<p>Recommendation</p>	<p>Do not conduct Major Investigation</p>
<p>Reasoning</p>	<p>Does not meet MI threshold based on information received</p>
<p>Supporting considerations</p>	

Major investigation decision	
Date	27/11/2017
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	27/11/2017
Inspector	
Risk gap	Moderate
Type of standard	Established
Initial strategy	Investigate

Recommended follow up strategy	
Recommended strategy	Investigate within 45 days
Supporting considerations	<p>The Venturer incident is a breakdown of the PTW system where it appears that a hazardous activity (opening of isolation valve), not covered in the permit, could have resulted in a serious incident. The Venturer does not have relevant enforcement history, but the Ichthys Explorer has been served with an Improvement Notice (see notification 673) in relation to its Permit to Work system. Both facilities have the same operator - INPEX Operations Australia and on that basis recommend escalate to investigate within 45 days.</p>

Non-major investigation decision	
Date	27/11/2017
RoN	
RoN review result	Agree with recommendation
Strategy decision	Investigate within 45 days
Supporting considerations	

Associated inspection	
Inspection ID	1695