Notifiable incident

Incident ID	**5333**
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	22/03/2018 08:06 AM (WST)
Notification date	22/03/2018 02:40 PM (WST)
NOPSEMA response date	(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	23/03/2018
Final report received	29/03/2018
All required data received	22/03/2018
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 activation due to fault
Location	Accommodation and amenities
Subtype/s	Alarm, Muster
Summary *(at notification)*	The operator advised that the GA activated due to a fault which was later identified as being caused by a technician tripping an incorrect circuit breaker. All crew mustered on the Venturer and Jascon 25. The system was reset and all crew stood down.
Details *(from final report)*	The operator advised that the GA activated due to a fault which was later identified as being caused by a technician tripping an incorrect circuit breaker. All crew mustered on the Venturer and Jascon25. The system was reset and all crew stood down. Unplanned GA and muster. At 08:06 hours the General Alarm (GA) sounded due to a PAGA fault alarm in the TER2 (Telecomms Equipment Room) in the AFT M/S, Deck 'A'. FPSO Venturer facility and Jascon ASV personnel mustered and all persons were accounted for. Confirmation received of an accidental initiation of the PAGA fault alarm. Confirmation of full muster across both facilities, muster arrangements stood-down and the FPSO Venturer facility returned to normal status at08:35hrs WST. The ERT was not mobilised. There was no loss of power generation. There was no impact to personnel, environment and facility.
Immediate cause/s	Circuit breaker switch was accidentally switched off by technician whilst opening swing frame door on PAGA cabinet.
Root cause/s	Not Applicable
Root cause description	Inadvertent switching off of circuit breaker - alarm tripped as designed - no dangerous occurrence

Duty inspector recommendation	
Date	22/03/2018
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	22/03/2018
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	26/03/2018
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	No credible consequences from this event, therefore no risk gap.

Non-major investigation decision	
Date	27/03/2018
RoN	[redacted]
RoN review result	Agree with recommendation
Strategy decision	Inclusion in annual report stats / data analysis
Supporting considerations	

Associated inspection	
Inspection ID	