Notifiable incident

Incident ID	**5336**
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	26/03/2018 03:55 PM (WST)
Notification date	26/03/2018 05:44 PM (WST)
NOPSEMA response date	26/03/2018 07:03 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	28/03/2018
Final report received	06/04/2018
All required data received	06/04/2018
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 - Indication of Manual Release of Process Deluge
Location	Process deck
Subtype/s	Muster, Alarm, Emergency response
Summary *(at notification)*	An operator advised that a manual release of a process deluge was indicated. This resulted in a GA and Muster. The ERT was deployed and the manual switch which was indicating as having been actuated was found intact. All crew stood down and further investigation to be undertaken. [redacted] tried to call the operator back to get additional information on a number of occasions but could not get through.
Details *(from final report)*	An operator advised that a manual release of a process deluge was indicated. This resulted in a GA and Muster. The ERT was deployed and the manual switch which was indicating as having been actuated was found intact. All crew stood down and further investigation to be undertaken. [redacted] tried to call the operator back to get additional information on a number of occasions but could not get through. Indication of multiple manual release deluge activations in the process area, unplanned GA, Process Area deluge activation and Muster. FPSO Venturer facility mustered and all persons were accounted for. ERT mobilised to investigate activation of indicated deluge release signals and found no evidence of manual activation. (Manual push button(s) were confirmed as not being activated either in the field or at the FOGP). FPSO Venturer facility returned to normal status at16:39 hrs 26.03.18 WST.

Immediate cause/s	The General Alarm (GA) was triggered due to Indication of manual deluge released in process area – Unplanned event. Most likely cause is spurious activation of four FGOP push buttons. EVENT – Deluge / watermist release (26/03/18; 15:53.10:680 hrs) 1. EVENT - ICSS FGS received indication of four (4) manual release pushbuttons (S830DEM256, S830DEM330, S830DEM331 & S830DEM332) activated simultaneously at 15:53:10.630 hrs. No work was being conducted on any of the loops which gave indication of activation. 2. Indication of S833SDF601A safety bar tripped, deluge SOV REL S790DFV908, S790DFV868, S790DFV867 received at 15:53:10.717 hrs. 3. The four FGOP manual release pushbuttons (S830DEM256, S830DEM330, S830DEM331 & S830DEM332) return to normal simultaneously at 15:53:10.759 hrs. 4. Activation of S830DEM256, S830DEM331 & S830DEM332 led to deluge release in fire zone 5/6 & FZ2. 5. Activation of S830DEM330 would have resulted in a water mist Release in AFT HPU Room FZ4, however the auto inhibit was active at the time. 6. PAGA alarm enunciated at 15:53.10:979. 7. FPSO Proceeded to muster. Note: Three of the FGOP push buttons are connected to S830MAR505 in IER2P via cable S-810-FGOP—001-J6 The remaining FGOP PB is connected to S830MAR505 via cable S-810-FGOP—001-J4. All signals share the same MAR, FTA (TBDI03), system cable, "backplane" and modules (Rack 6 modules 11 and 12 in same system cabinet).
Root cause/s	None Identified
Root cause description	Unknown – Most likely cause is spurious activation of four FGOP push buttons.

Duty inspector recommendation	
Date	26/03/2018
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	26/03/2018
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	27/03/2018
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	[redacted] spoke to the facility OIM at 1415 on 27/03/2018 - early indications are a "card fault", causing 4 x activation switches to activate together. The facility crew have done rounds of the topside and determined that there appears to be no damage as a result of the deluge activation. 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	