Notifiable incident

Incident ID	**5423**
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	24/05/2018 09:18 AM (WST)
Notification date	24/05/2018 11:58 AM (WST)
NOPSEMA response date	24/05/2018 12:26 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	27/05/2018
Final report received	27/05/2018
All required data received	27/05/2018
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- Inadvertent operation of helideck fire water (DIFF) system
Location	Accommodation and amenities
Subtype/s	Alarm, Emergency response, Helicopter, Muster
Summary *(at notification)*	- At 9:18 hrs activation of the Helideck Fire Water (DIFF) System was detected by the ICSS (Control Room); - activation was located at push button located in forward staircase; - suspect a fault in push button and currently being investigated; - No personnel was in the vicinity of the area when activation occurred. - Activation triggered GA and Full Muster was achieved. Second helicopter was inbound and diverted to CPF. remaining helicopters (2) were received at Jascon-25. The OIM mentioned that does not appear as restriction to receive future Helicopter at the facility and troubleshooting will continue on the faulty button.

Details *(from final report)*	- At 9:18 hrs activation of the Helideck Fire Water (DIFF) System was detected by the ICSS (Control Room); - activation was located at push button located in forward staircase; - suspect a fault in push button and currently being investigated; - No personnel was in the vicinity of the area when activation occurred. - Activation triggered GA and Full Muster was achieved. Second helicopter was inbound and diverted to CPF. remaining helicopters (2) were received at Jascon-25. The OIM mentioned that does not appear as restriction to receive future Helicopter at the facility and troubleshooting will continue on the faulty button. The FPSO ICSS Engineer, FPSO Inlec and FPSO HSE Advisor conducted an investigation in accordance with the INPEX Event Reporting & Investigation Procedure. On investigation the Heli deck manual push button deluge release S-794-DEM-603 on the FWD emergency escape stairs of the Heli deck was found to have water ingress into the button enclosure causing the false activation. There are another 2 x Heli deck manual push button deluge release buttons (S-794-DEM-601 & S-794-DEM-602) on each of the Port and Starboard emergency escape stairs of the Heli deck, both have been inspected and found fit for service.
Immediate cause/s	Fault in push button activated helideck DIFF System. Heli deck deluge push button point S794DEM603 false activation.
Root cause/s	ED - Rpt Failure - MGMT SYS - Corrective action - CA NI
Root cause description	On investigation the manual push button S-794-DEM-603 on the FWD emergency escape stairs of the Heli deck was found to have water ingress into the button enclosure causing the false activation. Equipment difficulty – Repeat failure

Duty inspector recommendation	
Date	24/05/2018
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	24/05/2018
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	25/05/2018
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	Health and safety consequences to members of the workforce are not credible from the described event. Likelihood remains at negligible. Therefore no risk gap. Established standard - CAP 437.

Non-major investigation decision	
Date	28/05/2018
RoN	[redacted]
RoN review result	Agree with recommendation
Strategy decision	Inclusion in annual report stats / data analysis
Supporting considerations	

Associated inspection	
Inspection ID	