Notifiable incident

Incident ID	**5630**
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	13/10/2018 06:00 AM (WST)
Notification date	13/10/2018 12:15 PM (WST)
NOPSEMA response date	13/10/2018 12:30 PM (WST)
Received by	[redacted]
Nearest state	WA
Initial category type *(based on notification)*	Dangerous Occurrence
Initial category *(based on notification)*	Damage to safety-critical equipment
3 Day report received	16/10/2018
Final report received	16/10/2018
All required data received	16/10/2018
Final category type *(based on final report)*	Dangerous Occurrence
Final category *(based on final report)*	Damage to safety-critical equipment
Brief description	OHS-DSCE - Failure of deluge system during routine planned testing.
Location	Process deck
Subtype/s	Valve failure, Facility integrity
Summary *(at notification)*	The OIM informed that approximately 06:00hrs on 13/10/2018 during planned routine deluge testing of the deluge system, the solenoid valve malfunctioned and failed to activate the deluge system on demand. This is a non conformance to the performance standard. The deluge can still be activated manually.
Details *(from final report)*	The OIM informed that at approximately 06:00hrs on 13/10/2018 during planned routine deluge testing of the deluge system, the solenoid valve malfunctioned and failed to activate the deluge system on demand. This is a non conformance to the performance standard. The deluge can still be activated manually. At approximately 06:00 on the 13th Oct during planned routine deluge testing, the AFT oxygen cylinder cage deluge solenoid failed to activate on demand (S-794-DFV-708) in accordance with performance standard S060-AH-PST-10043 section F.4.1. Investigation found slight water ingress into solenoid consistent with previous failure modes and Root Cause Analysis (RCA). The solenoid was refurbished, placed back in service and tested successfully.
Immediate cause/s	Deluge system solenoid failure due to water ingress.
Root cause/s	HPD - QUALITY CONTROL - QC NI - inspection techniques NI
Root cause description	Quality Control improvement during installation and inspection activities of the solenoid sealing gasket.

Duty inspector recommendation	
Date	15/10/2018
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	15/10/2018
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	15/10/2018
Inspector	[redacted]
Risk gap	Moderate
Type of standard	Established
Initial strategy	Investigate

Recommended follow up strategy	
Recommended strategy	Investigate
Supporting considerations	Consequence - serious, failure of an MAE control. Benchmark likelihood - remote. Potential likelihood increases to possible, due to loss of remote control of the deluges. Established standard - as per SoV. Relevant incidents - deluge solenoid failures - RMS 5586, 5591, 5598.

Non-major investigation decision	
Date	16/10/2018
RoN	[redacted]
RoN review result	Agree with recommendation
Strategy decision	Investigate
Supporting considerations	Agreed.

Associated inspection	
Inspection ID	1794