Notifiable incident

Incident ID	6591
Duty holder:	Shell Australia Pty Ltd
Facility/Activity:	Prelude FLNG
Facility type:	Floating liquefied natural gas facility

Incident details	
Division	Occupational Health and Safety
Notification type	Incident
Incident date	20/06/2020 03:00 PM (WST)
Notification date	20/06/2020 08:44 PM (WST)
NOPSEMA response date	20/06/2020 08:49 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	23/06/2020
Final report received	23/06/2020
All required data received	23/07/2020
Final category type *(based on final report)*	Dangerous Occurrence
Final category *(based on final report)*	Damage to safety-critical equipment
Brief description	OHS-DSCE-Galley fire shutter not functioning
Location	Accommodation and amenities
Subtype/s	Other
Summary *(at notification)*	Operator advised that during testing the mechanical release mechanism for the galley fire shutter did not operate. It was eventually made to release but further investigation/maintenance is being undertaken.

Details *(from final report)*	Operator advised that during testing the mechanical release mechanism for the galley fire shutter did not operate. It was eventually made to release but further investigation/maintenance is being undertaken. ** As Supplied by Duty Holder** Brief description of incident - During routine maintenance (function testing) of the galley fire shutter, a logic force was applied in the control system to release the shutter. The solenoid activated on the shutter mechanism, however the mechanical mechanism failed to release the shutter. Work or activity being undertaken at time of incident - Routine maintenance What are the internal investigation arrangements? A 5 whys investigation will be conducted into the cause of the shutter operation failure. Action taken to make the work-site safe - Corrective maintenance was undertaken immediately to rectify. Shutter was made operational within the shift. Galley staff were aware of the issue and Galley shutter has a manual release to use as a mitigation while the repair took place. Details of any disturbance of the work site - No disturbance, repair of the galley shutter mechanism took place. Immediate action taken/intended, if any, to prevent recurrence of incident - Investigate and repair faulty Galley Shutter. Responsible - Prelude MITL. Completion Date - 25/06/2020 Has the investigation been completed? Yes Root cause 1 - The break release pin was loose in its mounting Root cause 2 - Unknown as to how the pin became loose Full Report: During annual preventative maintenance (function test) on the galley fire roller shutter, a logic force was applied in the control system to release the shutter. The solenoid activated on the shutter mechanism, however the mechanical mechanism failed to release the shutter. Equipment inspection identified the break release pin was loose in its mounting and once tightened the pin and the shutter functioned as required. The cause of the break release pin to become loose is unknown as the Kitchen is a low vibration area and the equipment is not subjected to damage, or high-volume operation. However, as the unit is only operated in routine maintenance (simulation of a kitchen fire), the small and complex mechanical components for the release mechanism are identified as potentially problematic when demand is created only once per year. Actions to prevent recurrence of same or similar incident - Increase the frequency of the maintenance assurance task for galley shutter test to 1 Monthly, to be included as part of the monthly fire damper testing. Responsible - [redacted]. Completion Date - 27/07/2020
Immediate cause/s	TBC
Root cause/s	
Root cause description	Root cause 1 - The break release pin was loose in its mounting Root cause 2 - Unknown as to how the pin became loose

Duty inspector recommendation	
Date	21/06/2020
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	21/06/2020
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	23/06/2020
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	Impairment of Galley Fire Shutter was discovered during routine testing and repaired immediately (within shift). No risk gap. Purpose of testing was to identify and rectify dangerous undetected failures. There is no prior history of dangerous occurrences being report of the galley fire shutter. No investigation required.

Non-major investigation decision	
Date	24/06/2020
RoN	[redacted]
RoN review result	Agree with recommendation
Strategy decision	Inclusion in annual report stats / data analysis
Supporting considerations	

Associated inspection	
Inspection ID	