Notifiable incident

Incident ID 5050

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	15/09/2017 03:00 PM (WST)
Notification date	15/09/2017 03:35 PM (WST)
NOPSEMA response date	15/09/2017 04:00 PM (WST)
Received by	
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	18/09/2017
Final report received	12/10/2017
All required data received	12/10/2017
Final category type (based on final report)	Dangerous Occurrence
Final category (based on final report)	Damage to safety-critical equipment
Brief description	OHS-DSCE-Partial failure of Active Fire Protection System on engine system
Location	
Subtype/s	Facility integrity
Summary (at notification)	On inspection of an engine system, found low nitrogen pressure on a pilot activation cylinder for the Active Fire Protection System - which was a non conformance with an PS because fire Protection system not 100% available. Commencing investigation, The backup system is still operational and the system can still be operated manually. Currently Working to de-charge and then re-charge the nitrogen cylinder. Also looking to change over a cylinder , which if successful will restore operations with an hour (as advised at 1600 hrs 15/09/2017). Action taken to address safety - restricted access to the area protected by the system. No emergency response was initiated.

Details (from final report)	On inspection of an engine system, found low nitrogen pressure on a pilot activation cylinder for the Active Fire Protection System - which was a non conformance with a PS because fire Protection system not 100% available. Commencing investigation, The backup system is still operational and the system can still be operated manually. Currently Working to de-charge and then re-charge the nitrogen cylinder. Also looking to change over a cylinder, which if successful will restore operations with an hour (as advised at 1600 hrs 15/09/2017). Action taken to address safety - restricted access to the area protected by the system. No emergency response was initiated.
	The initial report states:- Following the previous incident on CPF relating to Inergen (5 August 2017), the FPSO Inergen systems have been placed in 'manual' release mode, allowing remote manual activation from the CCR during completion of hook-up and commissioning activities. On 14 September 2017 during an inspection of Inergen system on topsides (M01 switch room) low N2 pressure was identified on M01 main pilot activation cylinder and reserve valve selection cylinder. On further investigation it was found this may impact the release of the Inergen when requested from the CCR. However, the Inergen system was still available to be activated manually from the local Inergen skid on indication of fire.
	On the 15th September access to Topsides M01 switch room was restricted; the Inergen system was available to be activated manually from the Inergen local panel on indication of fire and monitoring of the CCR Fire and Gas panel for any potential alarms. The main pilot activation cylinder was replaced and the M01 switch room main Inergen system was available to be released when requested from the CCR at 18:30hrs on the 15th September. Investigation in to the N2 Pilot header of the control skid found that the fittings of both N2 bottles were overtightened and several leaks were identified.
Immediate cause/s	Low pressure in N2 cylinders.
Root cause/s	HPD - QUALITY CONTROL - QC NI - inspection techniques NI, HPD - WORK DIRECTION - Supervision during work - no supervision
Root cause description	Poor workmanship in the installation of the tubing Overtightening of fittings The inspection process did not identify leaking connections during commissioning of the system.

Duty inspector recommendation	
Date	15/09/2017
Duty inspector	
Recommendation	Do not conduct Major Investigation
Reasoning	Does not meet MI threshold based on information received
Supporting considerations	

Major investigation decision	
Date	18/09/2017
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	18/09/2017
Inspector	
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	There is no prior inspection / operator response history for Ichthys Venturer.
	The engine room fire protection system reported as not meeting performance standard is the inergen system. The facility will incremental engine room fire risk if the inergen system is not providing required fire suppression / protection. The backup system is still operational and the system can still be operated manually . The facility will have to consider / implementing additional risk control until such time that the PS can be re-stored.
	Contacted Inpex at 3 pm on 18/9/2017 - the N2 bottles have since re-charged and inergen system was normalised (i.e. meeting PS and inergen can be discharged remotely). Incident reported due to PS deviation as well as "incident that a reasonable operator needs to conduct investigation". Will wait for the 3 days report for further details 3 days report reviewed and the "recommended strategy" remain valid. 19/9/2017

Non-major investigation decision	
Date	20/09/2017
RoN	
RoN review result	Agree with recommendation
Strategy decision	Inclusion in annual report stats / data analysis
Supporting considerations	

Associated inspection	
Inspection ID	