Notifiable incident

Incident ID	**5184**
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	16/12/2017 05:30 PM (WST)
Notification date	16/12/2017 06:50 PM (WST)
NOPSEMA response date	16/12/2017 07:00 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	19/12/2017
Final report received	19/12/2017
All required data received	19/11/2017
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 GA triggered by false MAC point activation
Location	Deck
Subtype/s	Alarm, Muster
Summary *(at notification)*	The GA was triggered by activation of the Manual Call Point in Module 2 level 3. The call point was examined and found to be in the inactivated position and there were no persons in the area.
Details *(from final report)*	The GA was triggered by activation of the Manual Call Point in Module 2 level 3. The call point was examined and found to be in the inactivated position and there were no persons in the area. A GPA was triggered due to indication of MAC point activation on M02 Level 3; Tag number S832 DMC 003 F. The MAC activation was due to moisture ingress as a result of the incorrect sealing face of the MAC point. This caused the electrical short across the micro switch, closing the contact and initiating the GPA. FPSO Venturer and accommodation support vessel Jascon 25 facilities mustered, all persons were accounted for. FPSO Venturer facility returned to normal status at15:44 WST, followed a short time later by the Jascon 25.
Immediate cause/s	TBA
Root cause/s	ED - TOLERABLE FAILURE
Root cause description	Moisture ingress as a result of the incorrect sealing face of the MAC point caused the electrical short across the micro switch, closing the contact and initiating the GPA.

Duty inspector recommendation	
Date	18/12/2017
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	18/12/2017
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	19/12/2017
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	The facility muster, personnel accounted for and there was no anomalies at the process module where the MAC is located. Final report indicates moisture ingress to the MAC button (S832 DMC 003 F) through incorrect sealing face of casing face plate and body of unit[redacted] The facilities previously muster due to false alarms including unintended activation of MAC[redacted]

Non-major investigation decision	
Date	18/12/2017
RoN	[redacted]
RoN review result	Agree with recommendation
Strategy decision	Inclusion in annual report stats / data analysis
Supporting considerations	

Associated inspection	
Inspection ID	