Notifiable incident

Incident ID	**5584**
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	20/09/2018 09:45 AM (WST)
Notification date	20/09/2018 10:35 AM (WST)
NOPSEMA response date	20/09/2018 10:45 AM (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	23/09/2018
Final report received	19/10/2018
All required data received	19/10/2018
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 - General alarm and Muster
Location	Deck
Subtype/s	Alarm, Muster
Summary *(at notification)*	General alarm and muster occurred following fire and gas detection of confirmed fire in the VOC compressor #1. Full muster was obtained. Vendor indicated a software download was taking place. Emergency response team was deployed and confirmed there was no fire. Initially considered a false alarm and a investigation has commenced.

Details *(from final report)*	General alarm and muster occurred following fire and gas detection of confirmed fire in the VOC compressor #1. Full muster was obtained. Vendor indicated a software download was taking place. Emergency response team was deployed and confirmed there was no fire. Initially considered a false alarm and a investigation has commenced. During a software upgrade on the Volatile Organic Compound Recovery Compressor (VOC) a General Alarm was activated due to a 'Confirmed Fire' signal on VOC package. All personnel commenced mustering and a full muster was obtained. Emergency Response Team (ERT) deployed and confirmed no fire. Implementation of the VOC Recovery package software modification was taking place on the Unit Control Panel (UCP) and safety Programmable Logic Controller (PLC), this triggered a false alarm, there was no fire. The investigation was led by the FPSO HSE Superintendent and included Health & Safety Representatives in the investigation team. The investigation was conducted in accordance with the INPEX Event Reporting & Investigation Procedure, using the 5 Whys process. 1. Why did the alarm sound? While carrying out work in the VOC A package an incorrect download program was used. 2. Why did the work party execute the work this way? There was misunderstanding by the work party, and failure to follow the job step sequence and agreec methodology. The Subject Matter Expert (Project HIMA) was not engaged by the work party prior to commencement of the download. 3. Why was the work sequence and methodology not followed? There were differences in understanding of priorities, risks and scope between stakeholders involved. 4. Why was there misunderstanding and misalignment between stakeholders? The Permit to Work was not specific or sufficiently detailed to outline a clear methodology for the work. Actions: Review and split the permit to work package to ensure scope is suitably defined, and risks identified, managed and communicated. New Starter Roles & Responsibilities sessions to be facilitated by the HSE team (Buddy system).
Immediate cause/s	Implementation of the VOC Recovery package Software Modification on the UCP and safety PLC initiated the false alarm leading to unplanned General Alarm (GA) and muster.
Root cause/s	HPD - WORK DIRECTION - Preparation - work package / permit NI
Root cause description	Permit did not cover the work executed.

Duty inspector recommendation	
Date	20/09/2018
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	20/09/2018
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	20/09/2018
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	Consequences - no credible consequences from this occurrence. Likelihood is unchanged, therefore no risk gap. Established standards - as per scope of validation. Relevant incident history - there have been a number of these false activations across different fire and gas detection systems at the facility during the commissioning period.

Non-major investigation decision	
Date	20/09/2018
RoN	[redacted]
RoN review result	Agree with recommendation
Strategy decision	Inclusion in annual report stats / data analysis
Supporting considerations	

Associated inspection	
Inspection ID	