Notifiable incident

Notification ID	NTF11765
Duty holder	Woodside Energy Ltd
Facility/Activity	Vincent
Nearest state	WA
Incident	OHS-DSCE - Failure of fire suppression system

Basic information provided at time of notification	
Notification type	Incident
Incident date	12/09/2022 05:00 PM (AWST)
Notification date	12/09/2022 05:30 PM (AWST)
NOPSEMA response date	12/09/2022 05:45 PM (AWST)
Received by	[redacted]

Summary of information provided	
Brief descriptive title	OHS-DSCE - Failure of fire suppression system
Incident location	Accommodation and amenities
Subtype/s	Other
Summary *(provided at notification)*	Failure of galley fire suppression system. Firing pin did not activate due to faulty O ring in CO2 firing system. Has been repaired and is functioning again. Did not comply with F19 performance standard. Had a 6 monthly check in March and had passed.

Request permission to disturb the site	
Permission given	Not Applicable
Permission given by	
Permission given on	

Initial spill and release amounts	
Gas (kg)	
Liquid (L)	
Release type	
More information	

Details of person providing information to NOPSEMA	
Full name	[redacted]
Job title	[redacted]

Initial notification category	
Initial category type *(based on notification)*	Dangerous Occurrence
Initial category *(based on notification)*	OHS - damage to safety-critical equipment

Running sheet
There are no running sheet entries for this notification

Decision	
Escalate to level 1	Yes
Inspector	[redacted]
Escalated on	13/09/2022 11:53

Final notification category	
Final category type *(based on final report)*	Dangerous Occurrence
Final category *(based on final report)*	OHS - damage to safety-critical equipment

Immediate causes	
Details	Initial investigation has identified a perished "O"ring in the firing circuit.

Initial report	
Due date	15/09/2022
Received date	14/09/2022
Reviewed date	16/09/2022
Reviewed by	[redacted]
Additional details provided by duty holder	Brief description of incident During function testing of the galley wet chemical testing the firing pin failed to activate which was a failure of Performance standard F19. Work or activity being undertaken at time of incident: 6 monthly F19 galley maintenance wet chemical system Inspection and function testing What are the Internal Investigation Arrangements: Internal investigation in accordance with Woodside "Health Safety and Environment Event Reporting, Investigating and Learning Procedure" Action taken to make the work-site safe: Action taken Investigation and fault finding commenced to identify root cause and reinstate functionality. Details of any disturbance of the work site: Activities associated with investigating and rectifying the defect Was an emergency response initiated? No Was anyone killed or injured? No Immediate action taken/intended, if any, to prevent recurrence of incident. Action Investigate and fault find potential root cause of failure. Responsible party [redacted] Completion date 12-Sep-2022 Actual or Intended Actual Action Review SAP history to identify any previous issues with firing system. Responsible party [redacted] Completion date 12-Sep-2022 Actual or Intended Actual

Final report	
Due date	12/10/2022
Received date	20/09/2022
Reviewed date	27/09/2022
Reviewed by	[redacted]

Additional details provided by duty holder	Full Report: Describe investigation in detail, including who conducted the investigation and in accordance with what standard/procedure - Investigation completed by [redacted] in accordance with Woodside "Health Safety and Environment Event Reporting. During retune 6 monthly testing under WO 2200598997 the Wiltrading vendor was conducting the wet chemical dry fire of the system. When tested the mechanism for initiating the release functioned correctly but when the CO2 canister was released, the CO2 was released to atmosphere instead of being contained in the control tubing and initiating the firing pin. The Vendor investigated the CO2 firing mechanism and found an O-ring had perished causing the CO2 to be released to atmosphere. The O-ring was replaced and retested as per testing procedure which was successful. On Review of the Vendor maintenance program this O-ring was not part of any monthly or 6monthy inspection routines and was not listed as a material to be replaced while servicing. Actions to prevent recurrence of same or similar incident: Action 1 - O-ring replaced Responsible party - [redacted] Completion date - 12-Sep-2022 Actual or Intended - Actual Action 2 - Maintenance PRT updated to inspect O-ring during 6 monthly routine inspection and testing. Responsible party - [redacted] Completion date - 15-Sep-2022 Actual or Intended - Actual

Final spill and release amounts	
Gas (kg)	0.00
Liquid (L)	0.00
Release type	
More information	

Root causes	
Code	
Description	Has the investigation been completed? Yes Root Causes - Analysis Factor: EQ5-0 Equipment Tolerable Failure Comments - Investigation found O-ring in firing system is original and has never been replaced and not included in vendor service to replace

All data received	
Date	12/10/2022