

Notifiable incident

Notification ID	NTF11778
Duty holder	Woodside Energy Ltd
Facility/Activity	CWLH OKHA FPSO
Nearest state	WA
Incident	OHS-DSCE - galley hood firefighting system failure

Basic information provided at time of notification	
Notification type	Incident
Incident date	24/09/2022 08:00 PM (AWST)
Notification date	25/09/2022 07:50 AM (AWST)
NOPSEMA response date	25/09/2022 09:00 AM (AWST)
Received by	

Summary of information provided	
Brief descriptive title	OHS-DSCE - galley hood firefighting system failure
Incident location	
Subtype/s	Fire
Summary <i>(provided at notification)</i>	During planned annual monthly maintenance and testing of the galley hood Wet chemical 6 firefighting system, the release mechanism failed to function as per design.

Request permission to disturb the site	
Permission given	Yes
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	
Job title	

Initial notification category	
Initial category type <i>(based on notification)</i>	Dangerous Occurrence
Initial category <i>(based on notification)</i>	OHS - damage to safety-critical equipment

Running sheet
<i>There are no running sheet entries for this notification</i>

Decision	
Escalate to level 1	Yes
Inspector	
Escalated on	29/09/2022 10:42

Final notification category	
Final category type <i>(based on final report)</i>	Dangerous Occurrence
Final category <i>(based on final report)</i>	OHS - damage to safety-critical equipment

Immediate causes	
Details	

Initial report	
Due date	27/09/2022
Received date	26/09/2022
Reviewed date	03/10/2022
Reviewed by	
Additional details provided by duty holder	<p>Brief description of incident During planned 1 yearly maintenance and testing of the Galley hood wet chemical fixed firefighting system, the release mechanism failed to function as per design.</p> <p>Work or activity being undertaken at time of incident: Routine maintenance inspection and testing of the equipment</p> <p>What are the Internal Investigation Arrangements: Internal investigation in accordance with the Woodside "Health, Safety and Environment Event Reporting, Investigating and Learning Procedure"</p> <p>Action taken to make the work-site safe</p> <p>Action taken: The Galley was not in operation at the time of testing and remained so until the system was returned to service.</p> <p>Details of any disturbance of the work site Investigation into the cause of the failure and the corrective work to return the system back to service</p> <p>Was an emergency response initiated? No Was anyone Kill or injured? No</p> <p>Immediate action taken/intended, if any, to prevent recurrence of incident. Action Investigation of the issue identified a failed o-ring in the firing system which was replaced. The system was fully tested to confirm the correct operation to the satisfaction of the attending vendor. Responsible party: Completion date 24-Sep-2022 Actual or Intended Actual</p>

Final report	
Due date	24/10/2022
Received date	07/10/2022
Reviewed date	11/10/2022
Reviewed by	

Additional details provided by duty holder	<p>Full Report:</p> <p>This investigation was completed by the From [REDACTED] and the [REDACTED] in accordance with the Woodside "Health, Safety and Environment Event Reporting, Investigating and Learning Procedure".</p> <p>During planned 1 yearly maintenance and testing of the Galley hood wet chemical fixed firefighting system, the release mechanism failed to function as per design. On release, the CO2 canister activated however its contents was released to atmosphere rather than to the wet chemical cylinder plunger. Investigation found an O-ring in the CO2 firing system had failed releasing the pressure intended for the firing control system. The O-ring was found to be degraded and was replaced. The system was successfully retested. The immediate cause was the failure of the O-ring in the CO2 control circuit for the firing pin. There are no records of this O-ring having been changed and this was never part of the inspection routine.</p> <p>Root cause: The planned maintenance and inspection of this specific equipment needs improvement. Actions below address this root cause to prevent reoccurrence.</p> <p>Actions to prevent recurrence of same or similar incident</p> <p>Action Update Procedure EH0000PM7255400 - 1Y F19 Wet Chemical Fire Suppression System Inspection and Test to include inspection of O-ring Responsible party [REDACTED] Completion date 06-Oct-2022 Actual or Intended Actual</p> <p>Action Update Procedure EH0000PM7255607 - 5Y F19 Wet Chemical Fire Suppression System Inspection and Test to include replacement of O-ring. Responsible party [REDACTED] Completion date 08-Nov-2022 Actual or Intended Intended</p> <p>Action Replace Galley wet chem pilot needle O-ring with OEM part. SAP WO # 2100352293. Responsible party [REDACTED] Completion date 15-Apr-2023 Actual or Intended Intended</p>
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Final spill and release amounts	
Gas (kg)	0.00
Liquid (L)	0.00
Release type	
More information	

Root causes	
Code	
Description	<p>Has the investigation been completed? Yes</p> <p>Root Cause Analysis: Root Causes Analysis Factor: HP4-2 Procedures - Wrong Comments The planned maintenance and inspection of this specific equipment needs improvement. There was no element of the inspection routine that required the O-ring to be inspected or replaced.</p>

All data received

Date	11/10/2022
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