Step Change Safety Alert Template

Alert Title

DA38 Gas Release

What leaked and where from? E.g.: "Lube oil leak from compressor system open vent"

Incident Date

14th April 2012

The date on which the incident occurred, not when this form was completed

Location Type

Fixed Production

E.g. Floating/Fixed Production, Drill Rig, Vessel, etc.

Specific Equipment Involved

Well DA-38

Give as much detail as possible about the equipment involved

Description of What Happened

The incident resulted in a Hydrocarbon Gas Release calculated to be 3.54Kg. The release duration was approximately thirty seconds and dissipated naturally within ten minutes. The investigation report concludes that there was no impairment to the platform design pressure retaining envelope. The release occurred as a direct result of manual operation of a valve releasing pressure from a well annulus to atmosphere via a temporary hose.

Be as detailed as possible. Give equipment history and approximate time(s) of actions/occurrences related to the incident

Cause of Incident

The release occurred as a direct result of manual operation of a valve releasing pressure from a well annulus to atmosphere via a temporary hose. No ignition source/ignition did not occur. Non-compliance with procedure. Temporary use of equipment out with intended use. Platform was in maintenance mode at time of incident.

Build from OIR/12 checklist

Incident Consequences

On hearing the General Platform Alarm, the individual closed the valve and safely progressed to the Muster. It is credible the potential may have increased if the individual had not closed the valve prior to Mustering.

Include the release itself and any subsequent emergency actions/dangerous occurrences

Lessons Learned

- Decision to deviate from procedure – Group proceeded with a task for which there was no approved procedure.
- Insufficient controls recorded on work permit – inadequate assessment of risk, no work site visit.
- *Proceed with a task with insufficient resources – Initial planning resourced for three personnel. One of the original team was replaced by a specialist vendor for one task. On completion, the specialist vendor demobbed and the the third original team member was not replaced.*
- *No protection to prevent reverse flow between A annulus and Active Mud pit when valve was opened – Failed to identify the annulus pressure was greater than the hydrostatic head imposed by the seawater in the active mud pit and the relative elevation of the tank to the casing head.*

Include a few bullet points clarifying what was learned from the incident

Recommendations/Actions

- Tasks to have specific procedures/programs to include hazard identification and control measures.
- Adherence to risk assessment procedures to be reinforced.
- Review Control of Work procedure and permit meetings.
- Review effectiveness of permit auditing system.
- Review Well Maintenance and Pumping Operation resources and competences.
- Amend annulus top up procedure.

- Learning from this incident to be shared with Onshore and Offshore Teams.

Include a few bullet points stating any recommendations/actions that will be made/taken as a result of the lessons learned

Contact Details (Optional)

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