

## Step Change Safety Alert



### Alert Title

Hydrocarbon release when BOP upper pipe rams were opened to perform a flow check.

### Incident Date

9<sup>th</sup> May 2013.

### Location Type

Fixed Production Platform.

### Specific Equipment Involved

BOP

### Description of What Happened

Work was underway on a well slot recovery. As part of this scope a pressure test took place of the 9 5/8" casing against a deep set plug set in the well. The pressure was increased in stages to 2000psi where it was held for 30 minutes. A successful test was achieved. Following the pressure test, the pressure was bled off and the well was lined up to the production test separator via the donor well.

At approximately 1300hrs, with the upper pipe rams still closed, circulation commenced to the donor well to pump away all contaminated water in the pits. After pumping approximately 400bls (more than 3 times the well volume), a decision was made to stop pumping and carry out a visual flow check of the well.

(Note: Due to pumping from the drilling pits with returns going to the production separator, hole monitoring for potential gains and losses was not possible, for this reason a flow check was deemed necessary to establish all was well).

An instruction was given to perform a flow check on the well at approximately 1430hrs. Pumping was stopped and checks were made on the SIDPP (Shut In Drill Pipe Pressure) and SICP (Shut In Casing Pressure), which were both reading zero. The upper pipe rams were opened to allow observation of the well and an individual went to the rotary table to observe the well and witnessed a bubble of gas percolating through the fluids. Immediately after, 3 gas heads activated (2 of which went to high alarm) automatically sounding the GPA. Shortly afterwards a fourth gas head activated and the OIM took the decision to manually initiate a process shutdown.

### Cause of Incident

Inadequate risk assessment.  
Inadequate procedure.  
Inadequate communication.

### Incident Consequences

Hydrocarbon release and emergency shutdown action.

### Lessons Learned

- Due to the fact that pressure gauges indicated zero it was assumed that no gas would be in the fluids and therefore no hazard of hydrocarbon release was present.
- The procedure did not include the possibility of small quantities of gas being trapped and venting off.
- Communication was inadequate between those performing the task and site management. This resulted in the OIM manually imitating a process shutdown.

### Recommendations/Actions

If applicable amend procedures for well slot recovery programmes to ensure they capture the requirement to open the through choke to the poorboy degasser prior to opening any closed BOP function.

**Contact Details (Optional)**

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