

Step Change Safety Alert Template



Alert Title

Minor hydrocarbon release after wireline snapped

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

Incident Date

January 2011

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

Location Type

Fixed production installation

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

Specific Equipment Involved

Wire line equipment

Give as much detail as possible about the equipment involved

Description of What Happened

Whilst attempting to disperse a hydrate from the well, methanol was pumped into the riser above a suspected hydrate plug up to the required pressure. After a one hour soak period, the operator observed the wire parting down hole resulting in the wire being ejected from the stuffing box. This resulted in a small hydrocarbon release (gas) prior to the ball check of the stuffing box sealing. No gas detection came into alarm. The BOP's were closed immediately and the well secured. No personnel were in the vicinity at the time of the incident as the drill floor was barriered off at the time. The total quantity of hydrocarbon released has been estimated at 0.41kg.

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

Cause of Incident

Subsequent investigation revealed that seawater was pumped into the well rather than 65% methanol as the tote tanks had been used for other purposes whilst the intervention team were not on the platform. This injection of seawater will have further contributed to the hydrate formation. In addition, the pressure maintained above the hydrate formation was 2200 psi greater than below as per procedure. This pressure differential, combined with the increasing hydrate formation will have caused increased tension on the wireline, which ultimately resulted in the wire line parting from the down hole tool.

Build from OIR/12 checklist

Incident Consequences

Hydrocarbon release

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

Lessons Learned

- Fluids should be sampled prior to pumping into a well on future interventions.
- Any changes to a well intervention programme should be fully reviewed, risk assessed and documented. This risk assessment should cover all potential "what if" scenarios.

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

Recommendations/Actions

- Procedures to be modified to include testing of fluids to confirm contents prior to pumping into wells.
- Installation of hard piping and additional signage to prevent contamination of tanks with other fluids.
- Review procedure for management of change during wells intervention operations.

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

Contact Details (Optional)

If you would like your submission to be anonymous, leave this section blank