Step Change Safety Alert Template

Alert Title

Liquid hydrocarbon leak from an IBC.

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

Incident Date

20th June 2014

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

Location Type

Fixed Platform

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

Specific Equipment Involved

The release was from an IBC that is used with the processing equipment on the platform to remove oil in water before it is discharge to sea.

Give as much detail as possible about the equipment involved

Description of What Happened

The operations team were working in accordance with the procedure, which stipulated that ullage should be available in the desander prior to draining down from Tr3 inlet separator. A sight glass installed on the base of the desander was checked indicating no level. The operations team made a further check by opening the bottom drain on the desander with no evidence of liquids. The work party proceeded to drop liquids to the desander. Subsequently, a high level was reported in the Oily Water Separator boot, this was investigated by the outside operator who confirmed the level in the IBC was also rising. The IBC subsequently overflowed through the lid.

The liquids emanating from the tank contained hydrocarbons; this initiated the adjacent gas detector CA G1, causing a full muster. Operational staff were in attendance at all times there was no potential for escalation since the spillage was contained and flushed down immediately, there was no environmental impact as a result.

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

Cause of Incident

The operations team thought there was no level in the desander by reference to the sight glass arrangement and checking of the bottom drain thus leading them to conclude that the desander was empty as per NRO requirements, the bottom take off point for the drain and sight glass were in fact blocked

Build from OIR/12 checklist

Incident Consequences

A small amount of liquid overfilled the IBC (~5L) and went to grade which activated the local Fire and Gas detector. Which subsequently led to a full muster being initiated.

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

Lessons Learned

- The potential for this type of incident to occur has been recognised as it was not considered in the original design given the venting arrangements in place.

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

Recommendations/Actions

- The design of the equipment used is to be reviewed and change as appropriate to prevent reoccurrence.
- Review the design of the level measurement on the desander vessel.

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

Contact Details (Optional)

Andrew Miller, Centrica Storage Limited

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