

# Step Change Safety Alert Template



## Alert Title

Hydrocarbon release in D4CN

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

## Incident Date

20<sup>th</sup> June 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

2" line from the Flare knock out drum to Osprey produced water flash drum

*Give as much detail as possible about the equipment involved*

## Description of What Happened

Hydrocarbon release occurred in D4CN on line 2"-D-891-A11440X from the flare knock out drum to Osprey produced water flash drum. Once identified the control room was informed. The system was isolated and the area ventilated at this time. A total release volume of 10 litres of condensate was estimated. Subsequent to the incident, a calculation by the Process Technical Authority determined the gas volume to be at 0.0008Kg.

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

## Cause of Incident

A 5mm hole in the pipe work was attributed to internal corrosion caused as a result of the following factors: 1). Pipe is on a dead leg due to operational line up. 2). Pipe material/lining specification unsuitable for service. 3). SRBs were present in the pipe work.

*Build from OIR/12 checklist*

## Incident Consequences

No personnel involved. Release volume was limited. Platform preparing for planned Shutdown at the time of incident. No lost time as a result.

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

## Lessons Learned

- Pipe on dead leg – Operation line up created dead leg.
- Pipe material/lining unsuitable for service - Original design may not have taken account of increased levels of SRBs during later platform life.
- SRBs present in pipe work – Inadequate implementation of controls. Topside process had previously been routinely biocided but this had not been carried out for some considerable time.
- Pipe not inspected – Insufficient inspection to prevent pipe failure.

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

## Recommendations/Actions

- Review dead leg survey to determine whether operational dead legs have been included.
- Identify correct piping material for current service. Ensure replacement spool is suitable for service.
- Confirm suitability of current biociding regime and amend if necessary.
- Review inspection frequency for this pipe work. Amend if necessary.
- Ensure Flare Gas Knock Out Drum drain pipe work is on inspection program.

*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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