Step Change Safety Alert Template

STEP CHANGE IN SAFETY

Alert Title

Gas released from open bleed valve on Gas Compressor

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

Incident Date

23/10/2013

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

Location Type

FPSO

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

Specific Equipment Involved

Bleed valve on a pressure transmitter instrumentation line

Give as much detail as possible about the equipment involved

Description of What Happened

Approximately 5 minutes into start up operations a hissing sound was heard. On investigation an open uncapped bleed valve on a pressure transmitter instrumentation line was found. It is thought the gas released to atmosphere is most likely to have been nitrogen as the system had previously been purged.

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

Cause of Incident

The bleed valve had been left open and uncapped despite being marked as closed on the drawing.

Build from OIR/12 checklist

Incident Consequences

The valve was immediately closed and subsequently capped.

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

Lessons Learned

Whilst the investigation team cannot be 100% certain they believe that the most probable cause was the valve was left open and uncapped because it failed to be identified this during start-up line walks. It is difficult to pinpoint a specific reason why line walkers missed this. There are a number of factors which could have contributed to the valve being open and the incident occurring; fading light and scaffolding obstructing certain areas making it difficult to clearly assess valve position. In addition, the incident occurred at a time of high workload for the individuals, coupled with elements of fatigue.

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

Recommendations/Actions

Learning from Incident alert raised and discussed at Safety meetings focusing the importance of line-walks including consideration of Human Factors risks during line-walking tasks

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

Contact Details (Optional)

NOT TO BE ENTERED

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