Step Change Safety Alert Template

Alert Title

Gas leak from drilling into live line

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

Incident Date

26th May 2014

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

Location Type

Fixed Installation

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

Specific Equipment Involved

Metering skid

Give as much detail as possible about the equipment involved

Description of What Happened

On Monday 26th May at 16:24 a gas release occurred whilst destructing the redundant flow streams of the metering package. The flow lines were being cut into sections before being removed by the platform crane. A drill was being utilised to create a pilot hole to enable a powered saw to cut the pipework. The drill operative was working ahead of the saw operator and had drilled a series of holes into the redundant pipework when he positioned himself next to the live gas line stub end. A 6mm hole was drilled into the adjacent live line and there was a release of hydrocarbon.
The drill operator raised the alarm and the platform was shut in and topsides vented. The platform export pressure at the time was 19 PSIG.

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

Cause of Incident

The drill operative physically drilled into an adjacent live line whilst removing redundant flow lines which were not marked as redundant; the redundant lines were not identifiable from the live lines. The Operator was also new to the offshore work environment and this had not been acknowledged via the onshore process, meaning that provisions for new personnel were not robust. There was no work pack or written instruction for the phase of the work as per phase 1 – the job was to be carried out at a later date, however the team on the platform had the resource and additional time to commence phase 2 and proceeded to deconstruct the pipework without a method statement. Human error recognition was not taken into account and hazard identification was deficient.

Build from OIR/12 checklist

Incident Consequences

Actual consequence was hydrocarbon gas release for approx. 20 seconds at 19psig and no personnel injury – however the potential consequences could have been much more severe had the pressure been higher for serious injury and uncontrolled release of hydrocarbon.

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

Lessons Learned

- *The Marking up of redundant pipework so that it is identifiable from live pipework.*
- *Ensure comprehensive risk assessments are carried out at site, communicated to the work party and documented.*
- *Verification of the experience of the personnel on your platform – eg new starts to industry, ensure the hi-viz hat cover policy adhered to.*
- *Ensure suitable supervision to the level of experience on board.*
- *Ensure sufficient training of Control of Work processes and hazard identification processes.*

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

Recommendations/Actions

- Provision of comprehensive decommissioned/redundant equipment register.
- Marking up of redundant lines to identify them from live plant & verification of labelling on regular basis.
- Enhance quality of workpacks to ensure all aspects of the work is captured inclusive of risk assessment (marking up of redundant pipework should have been captured in phase 1 of the work).
- Ensure a comprehensive and robust Management of Change procedure is in place and all who are working to it are trained.
- Verify the process to ascertain contractor competency.
- Enhance resources to ensure that appropriate supervision is provided for workscopes inclusive of NUI installations.

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