

SAFETY ALERT - #24 - 2009

Hydraulic Annular Control Valve Failure Release Date: November 30, 2009

Function: Production Operations	Incident Date: October 2, 2008
Incident Type: Equipment Failure	Country and Region: Western Canada

Summary:

During the removal of a coil tubing string, blast joint and centralizer, a completions work over crew lost well control resulting in a blowout.

Description of Incident:

A hydraulic annular control valve, similar to the one shown below, was being used as the primary well control device immediately above the wellhead. A combination of overpressure on the hydraulic annular control valve and mechanically induced movement of the coil tubing siphon string resulted in a failure of the annular bag. Tools across the master valve prohibited its use as a well control device in this circumstance.

Other important well information:

- This was a multi-zone gas well with a packer between the completion intervals (Class II).
- A one inch steel coil tubing single string was installed into the well bore secured by an annular control valve, tubing hanger and access cap.
- The coil tubing string had a fluted centralizer and blast joint(s) to facilitate the safe production of the well.

Recommendations for Preventing Future Incidents:

The company reporting this incident identified important prevention recommendations for completions workovers on multi-zone completions:

- Hydraulic annular control valve assemblies are not recommended as the primary well control Blowout Preventer.
- The hydraulic annular control valve is not designed for continuous use for tubular isolation. There must be a secondary well control device in place.
- Well control devices should be positioned as close to the wellhead as physically possible.
- Well control set up and installations should be aligned with current industry recommended practices and identified in the following:
 - o ERCB Directive 37 Directive 37
 - Well Service BOP Manual Chapter 4
 - o IRP 21 pending issuance in 2009 IRP 21 Coiled Tubing



4" Ported

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DISCLAIMER:

This Safety Alert is designed to prevent similar incidents by communicating the information at the earliest possible opportunity. Accordingly, the information may change over time. It may be necessary to obtain updates from the source before relying upon the accuracy of the information contained herein. This material is presented for information purposes only. Managers and supervisors should evaluate this information to determine if it can be applied to their own situations and practices.