How Shell Directors failed to prevent the continued falsification of performance tests on Emergency Shutdown Valves (ESDV) and allowed 12 offshore installations to operate with ESDV in a failed State. These operations continued with 1284 fire and gas, toxic gas, and general platform alarm systems on 14 offshore installations known to be inhibited for prolonged periods, or were not subject to routine examination or testing and had thus no performance history, or were tested wrongly, so their reliability was questionable and thus may not have been available immediately in an emergency.

Attached documentation covering ESDV and Fire and Gas and other sensors or equipment

(1) Letter copied to Directors including the Managing Director on 20th Oct. 1999 trying to get them to act because there are issues which present a direct exposure that require quick action and where he states that he is not convinced that they are taking an effective approach

(2) Minutes of the interview with the Brent Asset Manager where ESDVs are covered

(3) Ditto the interview notes with the Deputy Asset Manager who was visibly shaken with what he heard on the 15th October which he took up immediately with the MD

(4) Summary of the Fire and Gas detection system faults across the oilfield

(5) Summary of the ESDV status across the oilfield, note that Bravo principal ESDV in same condition as discussed on the 15th October

(6) On 3rd August 2006 where the CEO of Royal Dutch Shell he completely dismisses the findings of his own Auditors by stating there was NO evidence of falsification of maintenance records

(7) On 20th November 2006 Greg Hill contradicts his boss when he accepts falsification of maintenance records had gone on, read the Case Against Malcolm Brinded to observe the punishment imposed on the journalists for copying me with these facts

(8) A summary of the technical integrity failures found by the post fatalities review presented to OSD officials shortly after the Review report was finalised

(9) Copy of the HSE policy on Enforcement ensuring action is taken immediately to deal with serious risk and ensuring those who breach the Law are held to account

(10) How the then Head of OSD and the HSE Technical Director interpreted their own Enforcement Policy

(11) Historical data on Enforcement showing that OSD took no formal Enforcement action re the 12 offshore installations that had ESDV that were inhibited from operating, or the records of which had been falsified or were otherwise potentially unreliable. The records also show 14 installations where safety critical fire and gas systems are assessed as being unreliable, i.e. in a fail to danger condition

(12) Letter sent to commons and Lords refer to para, 7 where the corruption of OSD officials is fully discussed

(13) E -mail to Chris Flint where I ask if I am ever going to get a copy of the internal investigation into misconduct by OSD officials following an investigation by the Procurator Fiscal Anne Currie, in this I also suggest he gets a copy of the report on how the structure of the utility shaft would have reacted should the vapour cloud had expanded

(14) Explosion Hazard Analysis, HSE Buxton

For paragraphs 1 through 7 the attachments are self-explanatory

Paragraph 8:

This summary of Technical Integrity failures covers 18 offshore installations of variation both in type, size and population of occupants. But if we average out the Persons on Board as 100 per installation, we total 18 installations where the integrity of the installation could not be assured either through installation of temporary repairs, inhibited or degraded, and with unreliable fire and gas detection systems. All installations had Safety Cases confirming that they would operating at the stated risk levels related to the individual risk per annum (IRPA), the potential loss of life (PLL), and the frequency of Temporary Refuge impairment. None of these installations would have been operating at these levels and on some the risks must have been in the intolerable region. In total we are talking daily of 1800 workers at risk, doubling this to 3600 to account for two shifts and with an extra 200 for visitors making it circa 3800. None of these workers were made aware of the risks they were taking by simply being on the installation. OSD had all this information by November 2003 slightly over two months after the fatalities, but OSD to cover up their collusion with Shell, prosecuted no person and issued neither Prohibition or Improvement Notices. To do so would have alerted offshore workers that OSD had failed to follow up the repeated concerns from workers from 1999 onwards that equipment offshore was not being maintained.

Some worst case examples

Gannet had repeated ESDV failures with no follow up to correct the situation, it had 32 temporary repairs on hydrocarbon piping, and 317 fire and gas systems in a fail to danger condition. The IRPA is estimated to be circa 5 fatalities per annum (or 10,000 times higher than that stated in its Safety Cases, and the TR impairment frequency once per annum, or 1000 times higher than the Safety Case level. Ditto Auk and Fulmar.

You should realise that even if the installation had fully functioning ESDVs, they will just sit there doing nothing unless it gets a signal from the fire and gas safeguarding system which could be responded to a loss of containment from one of the many unlawfully applied temporary repairs. But on detecting High Level gas it was either inhibited, or unreliable, unable to send a signal, so the ESDV, crucial to restrict fuel supply to a major conflagration would be unresponsive at the very time it was needed.

Paragraph 9:

The HSE Enforcement Policy that we taxpayers think and hope they will apply with gusto when they find criminal negligence on an industrial scale with the conditions known about and accepted by Directors.

Paragraph 10:

Refer to email from Ian Whewell at that time Head of OSD in Aberdeen. What did they do when they were made aware immediately by Shell of its Technical Integrity Review? It appears nothing actually, nothing that is but **seek assurances**. **The Enforcement Policy doesn't cover seeking assurances does it?**

Whewell sent me this email the day after I visited Lord Cullen House by invitation to discuss these issues. Present was Kevin Myers HSE Technical Director and Jake Molloy of RTU as a witness. The 1999 Audit stuff I had passed to OSD on 28th October 2003 only days after the fatalities. That was three years previously and I knew from the internal investigation into the conduct of Malcolm Brinded in 1999 that the investigators reported in my presence on 25 July 2005 that there was No evidence that the immediate risk reduction measures recommended to Directors on 22nd Oct 1999

so I asked Whewell, when did they stop using the fire pumps unlawfully to augment water supplies to Drilling? He replied he was not aware if anything was done. When did they stop using the Test Separator whilst it was in a dangerous condition, same answer? Then turning to the Review finding they had received three years earlier. When was the principal ESDV on Brent Bravo repaired, put back in good working order, what enforcement actions did you take on the eight temporary repairs which were found to be in the same materially defective condition as the one that contributed to the deaths, I have no knowledge of an Notices issued, when did you issue a Prohibition Notice on the FPSO Anasuria after all it had its ESDV frigged and that was three years ago, none to my knowledge and so it went on with the 11 other ESDV impaired installations and those with a total of 1284 Fire and Gas etc systems in a fail to danger condition, no actions taken. In summary nothing was done. He must have thought more of it after the meeting hence the email as a sort of get out clause which of course.

Paragraph 11 confirms lack of enforcement

This research of the HSE Enforcement database (6 pages) both before the fatalities and specifically after shows for Brent Bravo No enforcement actions post 2003 other than those associated with the deaths (2) and a non-related notice about drilling equipment. Nothing else either for Bravo for the defects they were made aware of on 18 other installations.

Paragraph 12 letter to Commons and Lords

Refer to section 7 of the letter, the Justice Committee can get the whole sordid story of the involvement of Helen Liddell, the misleading of the Fiscal Barbour, and the continued collusion of OSD official with Shell. They can obtain a copy. OSD are a public authority, and the evidence withheld was from me, but although disclosure legislation protects citizens, or should, who have a right to see what is held in government files, as yet after 30 days of trying it is still not in my hands. I discuss this with OSDR, **refer to Paragraph 13** an email dated 6th December.

Finally, Paragraph 14: the potential damage and destruction of the support structure provided by the Utility Shaft and the cellar deck transmission area

In document 13 I postulate on what I think was the case, based on a report issued to me from Shells Thornton Research Centre, I was at 1990 the Asset Manager for Cormorant Alpha where an explosion occurred in the Column C4 in 1989, when at that time the eminent Professor Chamberlain was employed at Thornton, refer to the FAI report.

I discuss the input received from Shell at that time elsewhere. In the early 80s I was the Topside Facilities Design Engineer for that installation, also a condeep but with four support columns not three as was the case with Brent Bravo. In document 14 the HSE write about industry practice and make it clear that equipment congestion has a significant effect on the severity of the blast. In the 70s, over 45 years ago the design of the Bravo support column, and the transmission area where the column mates with the topsides would have been deemed structurally capable of withstanding the instantaneous overpressure from an ideal mixture of methane in air by volume of 9.5 %, the most explosive region and the Utility shaft vents sized accordingly. But this was done as if the Utility Shaft was empty of equipment, the effects of turbulence were not understood until the late 80s and possibly later. Studies have shown that turbulence in equipment congested areas increases the velocity of the pressure wave and with this increase in velocity there is a proportionate increase in the instantaneous overpressures inflicted on the structure, perhaps doubling it according to researchers. The study results shown to Sheriff Harris but evidence not led at the FAI would not have taken account of the blocking of the vents by marine containers as discussed in That Fateful

Day. The bottom line is the installation with 156 persons on board could have toppled of its axis and have fallen into the seas probably in less than two seconds from the ignition of this huge vapour cloud.

It is s all very worrying, but not worrying enough for the Sheriff, and the Lord Advocate, and the Scottish Parliament to demonstrate openness and transparency because the general inquiry that Harris recommended never took place and the questions, I asked Holyrood to raise about this issue, as to why such an Inquiry was not going to be held, were never put.

Bill Campbell

December 8th 2018

(1)

Strictly Confidential

From	Gerbrand Moeyes	UEFA	**Tel**	ext. 630 2821
To	Chris Finlayson	UED	**Date**	20/10/99
	Tom Botts	UEG		

Subject:
Platform Safety Management Review Briefing Note

Please find attached a briefing note highlighting the main issues emerging from the Platform Safety Management Review of which you are the sponsors. The review has identified some significant concerns. Some suggestions for immediate actions that can be taken by the BU's to address the most pressing of these concerns, that may have direct exposure, are made at the end of the note. The review team is still working on the Draft PSMR report, which will contain the full set of DRAFT recommendations.

To date, there has been limited feedback of the results of the review to senior management. The meeting held on 5/10/99 was an interim feedback to a limited audience with the primary purpose of clarifying some of the issues that had arisen around the NBU. In view of the sensitivity and potential management implications, I believe that an in-depth session with UED, UEG, UE and the GM's is needed. This should cover the full perspective of the concerns and also address the best way forward.

Some of the issues, which present a direct exposure, require quick action and I understand that UEDN and UEDC have already started to address these. I am also aware that UEDN is preparing follow-up activities on the underlying causes and related organisational and management aspects. However, I am not convinced that an effective approach is being taken. In view of the sensitivity of the review, we need to agree with you how the follow-up and communication can be planned and conducted in the most expedient and effective manner.

PS:
IN DEPTH SESSION WITH UE, BRINDED NEVER TOOK PLACE, INSTEAD HE HAUTED THE AUDIT PROCESS LAMBASTING AND THREATNING ITS AUDITORS

UE is the MD, Malcolm Brinded
Refer TO THE 'CASE AGAINST BRINDED'

(2)

Interview with Brent Asset Manager

	Present
EPT-OM	Bill Campbell (Chair)
UEDN	David Bayliss (DB)
UEFA	Ken Merry
A/UEFA	Keith Mutimer
Location	Seafield House
UEFA	File in UEFA safe storage, Phase 3, Tullos

EPT-OM	*We found Brent Bravo operating in appalling conditions with risks levels clearly in the intolerable range. UEFA has already discussed our concerns with UED and I asked Finlayson to contact and discuss with UE. I would like to go through the Technical Notes highlighting our principal concerns, at the end of this discussion we will ask you if you agree with what we have covered and if the findings are disputed by you, or not*
EPT-OM	*Operation of the Test Separator to augment production whilst is in a dangerous condition, that is in breach of design codes, Expro codes of practice and such an operation is not allowed in the Manual of Permitted Operations (MOPO).*
DB	*Agreed with a shrug, no defense put forward*
EPT-OM	*Operating a Fire pump continually when it is connected through a manual x-over valve into the service water ring main This way of operating since you lost the Drilling service water pump into the sea. This is bad enough, but the PCV on the service water main is defective, failed in fully open position. Should the platform trip on high level gas for example and you need the fire pumps in anger there will be insufficient water to supply seawater deluge systems and hydrants. Not only is this unlawful but it raises the risks to people also risks to the impairment of the temporary refuge (TR).*
DB	*Agreed, no defense*
EPT-OM	*We heard from Ian Tope UESE that tests on ESDV are being falsified. Our findings support this and it is yet another example where production dominates any concerns about risk. The records are being completed as No Fault Found when if fact the LOT results at 20 scm/m are 20 times greater than that set in your Safety Case. Despite complaints from onshore system custodians you are acting autonomously with no regard to the advice from the functional specialists, you appear to treat them, including the independent PFEER inspector, who is more or less banned from getting access to you, and from ever going offshore, with contempt. The PFEER inspector informed us that some time ago you pressurized him to sign off - as in good order- a whole tranche of fire and gas systems on Delta, but when he eventually got out to Delta, he found all the line of sight gas detectors isolated, is this true?* ESDV
UEDN	*Agreed yet again with no denial and also no argument to support what he was doing*
EPT-OM	*Spoke earlier about how you are operating Test Separator, in this condition there is a high risk of gas breakthrough from the vessel into the storage cell because you cannot control the liquid level in the vessel. From my experience an explosion in an enclosed column is very bad news, on. Cormorant A in 1989 the effects of that explosion was mitigated when the explosion relief device operated, but on Bravo the explosion relief cover has two marine containers with a combined TARE of some 20 tones sitting almost permanently atop the cover. Spoke to the toolpusher, Walter Allan, he was with me on Brent A, he is aware he should not use this spot but with so much going on there is extremely restricted space on the skid deck*
EPT-OM	*You are recording for August 96% completion for safety critical maintenance but we have gone through the data in SAP in these offices and the actual completion was 14%. This false reporting is prevalent on Bravo but also on your other 3 installations. This behavior is as direct result of your instruction, the so-called Touch F All memo sent to all OIM's. UED Finlayson claimed in September in an interview with Colin Wight of BBC North and others that TFA was just a misunderstanding, the claims by unions were exaggerated etc., but in reality, your TFA instruction has led to a situation where almost nothing is getting done, you just can't carry on like this, you need to retract that instruction. Finlayson told us his reply to the media was based on assurances he got from Berget. Were you involved in all this public deception?*
DB	*No, the TFA thing was never intended to have the effect that it has, the platforms were tripping because of carelessness carrying out inspections and tests, these caused us considerable downtime, I had to do something, I was getting it in the neck from Brinded*

(2)

Platform Safety Management Review Sept to Oct 1999

EPT-OM	***Dave, this TFA is having another effect, Permits are not getting raised because the permit would be used against the culprits, as you see them anyway, if the platform tripped spuriously. This is what happens when the offshore guys are scared shitless of you Dave, and the brutal regime you are running. This is a common theme that Ken and I ran into, everything that is being done, the separator, the Fire pumps the violations of PTW etc, is being done in your name, why is this happening? This would not have been possible only a few years ago when I left, can you imagine Brian Ward and Keith Allan putting up with this***
DB	***Yes Bill, but its all changed since your day, we have to answer to Brinded now***
EPT-OM	***Dave that's the third time you've blamed Brinded for your ills. You're the bloody Asset Manager its up to you to stand your ground, the truth appears to Ken and me is that you are perfectly happy to do your masters bidding, you seem more interested in being in the McKinsey top quartile, in truth Dave you don't seem to care a hoot for the 1600 or so crew working in your brutal regime, Foaming at the mouth and blaming Brinded isn't going to save you should the inevitable happen, your streetwise enough to know that***
EPT-OM	***One more item and then I will sum up. We have been at this for almost 3 hours and we will schedule in another meeting there is more we want to raise especially your unacceptable treatment of your staff and the independent inspectors. Change Control, I wont insult you by explaining to you what the codes of practice say on change control, As Asset Manager you are not authorized to instruct offshore staff to make physical changes to plant & equipment without the prior approval of a competent person onshore, are you? I take that as a No. We came across at least 14 temporary repairs, clamps and patches almost half on hydrocarbon pipes. This is against your Codes of Practice and SIEP rules, the plant must be shut down until a spool piece is fitted and hydrotested in situ, you simply should not be doing this. None of these patches were approved, also not listed on a register, the fact is Dave if you aggregate the risks to the POB we have the separator, the fire pumps, the isolation of fire and gas sensors, the overrides and inhibits in the CCR, the goal widening of performance criteria for Safety Critical Equipment (SCE), the false reporting of maintenance compliance, the falsification of ESDV tests, restricted explosion venting from the columns, unapproved temp repairs and on top of that a crew conditioned by you to do your bidding, avoid using the PTW system and other chronic violations, all driven by your TFA slogan My point, and which I will take yet again up the line to the Hague if necessary, is nobody has the big picture that I have just fed back to you. From technician to OIM people know a little of what's going on in their sphere but putting it all together required this audit. My rough estimate is that individual risk per annum on Bravo may be higher than 1000+ times the value in your Safety Case, and TRIF of the same order***
DB	***Bill you can report what you like, I guarantee when your report is gathering dust I will still be here and you'll be gone, they need me to run these four big beasts, its all that bastard Brinded's fault, he even has the cheek to ask me to get more involved in all this Enhance Expro shit, its unbelievable, I'm under a great deal of stress, I'm doing what he wants me to do, big numbers and straight lines, your living in the past Bill, this is today's reality,***
EPT-OM	***David, its obvious you are under stress\ you appear unbalanced in your decision making, remote from your decisions with an apparent lack of empathy for the guys working for you, I seriously suggest you seek medical advice, I'm sure Ken will agree***
All	***These discussions were read back to the Asset Manager and agreed to be an accurate representation of our three-hour discussion***

TEMP REPAIRS

ESDV

PTW

WM Campbell. W Campbell

Signed: on 1/10/99

SIEP EPT-OM
Lead Auditor on behalf of UEFA

Bill Campbell
B.Sc. MIEE C.Eng
RTL Global Consultant

Shell International Exploration and Production B.V.
Technology Applications & Research
Volmerlaan 8, Postbus 60
2280 AB Rijswijk, The Netherlands
Tel +31 (0)70 311 3511
Fax +31 (0)70 311 2085
Mobile +31 (0)6 5512 5295
Email w.campbell@siep.shell.com

Strictly Confidential

Meeting with Deputy Brent Asset Manager at Seafield House

	Present
EPT-OM	Bill Campbell (Chair)
UEDN/1	Graham Birnie
UEFA	Keith Mutimer
UESE	Peter Wyatt – Head of Safety Department
UEFA	File in UEFA safe storage, Phase 3, Tullos

Intro	*Graham we welcome Peter along to listen to the discussion, and contribute as he sees fit, he has been requested to attend on behalf of UED and UE*
EPT-OM	*Graham, we had a 3-hour interview with Dave on 1st October since then he has been on sick leave, have you heard from him?*
UEDN/1	*No, just from HR that he is suffering from stress and anxiety, we do not know when he will return*
EPT-OM	*The formality of the Audit process as I explained at the recent preliminary meeting on the 5th October is that the Asset Manager has accepted the findings but since he is absent, we need to clarify a couple of points again with you, and for Peter. Also, if there are some other issues of importance, or which are bothering you, for example the conduct of the PSMR etc, please feel free to get it off your chest. As far as Brent is concerned this should be our last interview, phase one of the PSMR will complete after the upcoming Management presentation and then we will go onto to develop meaningful recommendations with you and the other Asset Manages involved in Northern and Central fields*
UEDN/1	*Understood, nothing to add*
EPT-OM	*The three biggest risk concerns re hardware are (1) the continual operation of the Fire pumps, we recommend you cease Drilling and close the valve connection from the firewater main to the service water main, at the same time with Drilling suspended ensure pressure relief pots above cellar deck of columns are unrestricted. This X-over valve closure will allow Fire pumps to brought back to good condition ready immediately in an emergency as is your legal commitment. At some point in the near future repair the PCV on the seawater discharge to sea. Before commencing Drilling, you should repair the corroded caisson and reinstall a pump to supply drilling in future, understood? (2) Stop the constant use of the Test Separator to augment production and repair the LCV and upstream and downstream XCV and ESDV failing we understand due to sand erosion, understood. Using it in the manner being done is in breach of the design codes API 14 and API15G, the DnV technical codes and your own codes of practice. This eliminates any risk of gas blow by from the Separator into the storage cells with potential gas leakage above the Column's gas tight floor, understood? (3) Sand erosion as you are aware as a Maintenance Engineer seems to be the principal failure mode on your hydrocarbon piping, its only gong to get worse over time. Stop installing temporary repairs on hydrocarbon lines it breaks every rule in the Shell rules book, understood?*
UEDN/1	*Yes, to points (1, (2) and (3)*
EPT-OM	*Thank you for that, we seem to be making progress, Peter any comments, No*
EPT-OM	*There is much evidence, not just on Bravo, that the performance criteria of ESDV are being amended in an unauthorized way, in fact one ESDV is now sitting with a leak off rate of 20 scm/min which is 20 times higher than the limit stated in your Safety Case. This has to stop. Before you change the performance standards for any safety critical equipment including ESDV you must seek PRIOR approval from the technical authority this being in writing, understood?*
UEDN/1	*Yes*
EPT-OM	*We have reviewed the records by sampling a number of ESDV records in the field after being informed by one of Peter's engineers Ian Tope that ESDV maintenance records are being falsified. With respect to Bravo it is noted that the principal ESDV valve on the gas*

TEMP REPAIRS

ESDV

ESDV

	riser failed its LOT and was now operating at circa 4 scm/m although the maintenance records entered into SAP state quote No Fault Found unquote. Graham this is a very serious offence an it has to stop, understood
UEDN/1	*Yes understood*
EPT-OM	*We could spend the rest of the day discussing the behavioral problems caused by what we legitimately call a brutal regime. It will need a concerted campaign from UE down to correct what you have developed over the last 5 years into a totally negative safety culture where your crewmembers offshore are conditioned to break every rule in the book to keep production going at all costs. This was evident under interview from technician to OIM and is also prevalent in these offices. Since Dave is the architect of this demise and since you support him and your boss Berget also, I will recommend at the final presentation that you all are suspended pending and investigation into your unacceptable behavior, understood?*
UEDN/1	*Yes, understood he said with a smile!*
All	*These minutes were read back to the Production Director and agreed to be an accurate representation of our discussions*
UESE	*After the meeting was suspended asked Peter Wyatt for his opinion in Mutimer's presence* *Peter you look visibly shaken, is the situation as a as we reported to UED, Yes Bill, but its worse much worse*
EPT-OM	*Peter will you ensure that your concerns are made known to Chris Finlayson and Malcolm Brinded*
UESE	*Yes, Bill absolutely, you a count on that*

ESDV

WM Campbell ..... Signed: ..... on 15/10/99 .

SIEP EPT-OM

Lead Auditor on behalf of UEFA,

4F5

Expro
F&G & ESD Systems

Health Check
Nov 2003

(4)

F&G Health (Sept 2003)

FIRE & GAS

Platform		Comments
BA		Gas heads calibration regime not as per CoP EA/081 and currently changing to CoP regime, given as amber as an interim measure.
BB		Only Utilities leg reviewed.
BC		Some inadequate SAP histories, or preconditioning such as cleaning reported before carrying out tests. Detectors inhibited for lengthy periods of time before corrective actions. Gas heads calibration regime not fully as per CoP EA/081.
BD		Some inadequate SAP histories, or preconditioning such as cleaning reported before carrying out tests. Detectors inhibited for lengthy periods of time before corrective actions. Gas heads calibration regime not fully as per CoP EA/081. No deviation.
CA		Some inadequate SAP histories for flammable gas detectors.
DA		Gas heads calibration regime not fully as per CoP EA/081. No deviation.
TA		ZG30 barrier faults that is not fail safe giving faults on GPA functions. Asset are aware of this fault. Gas heads calibration regime not fully as per CoP EA/081. No deviation.
EA		A single detector WO corrective work RAMed out. Gas heads calibration regime not fully as per CoP EA/081. No deviation.
NC		
AA		No or inadequate SAP histories, or preconditioning such as cleaning reported before carrying out tests. Gas heads calibration regime not fully as per CoP EA/081. No deviation.
AN		No or inadequate SAP histories, or preconditioning such as cleaning reported before carrying out tests. Gas heads calibration regime not fully as per CoP EA/081. No deviation.
FA		No or inadequate SAP histories, or preconditioning such as cleaning reported before carrying out tests. Detection inhibited for lengthy periods of time (e.g. flame). Gas heads calibration regime not fully as per CoP EA/081. No deviation.
GA		No or inadequate SAP histories, or preconditioning such as cleaning reported before carrying out tests. Gas heads calibration regime not fully as per CoP EA/081. No deviation.
SW		No or inadequate SAP histories, or preconditioning such as cleaning reported before carrying out tests. Some detectors appear not to have been successfully tested for over 2 years.
Nelson		No SAP records for calibration tests for flammable gas detectors. Gas heads calibration regime not fully as per CoP EA/081. No deviation.

(5)

ESD Health (NOV, 2003)

Platform		Comments
BA		BA-XEV-970 leak at 25bar in 5min in 2001, WO for correctives cancelled as has the routine to LOT valve. Other gas riser closure and LOT tests have also been cancelled.
BB		WO signed off as OK when test not carried out. WOs signed off as Ok when using wrong test method and known fault on system. WOs cancelled for corrective with faults still present (e.g. valves). Riser ESDV measure leak accepted for average value not the maximum value which is the criteria, if maximum used valve fails test.
BC		Some inadequate SAP histories. Histories for gas riser valve do not show that the valves meet the leak off criteria. HP sep EZVs slow to close, no follow up actions, other valve failures not corrected when identified.
BD		Riser ESDV closure time greater than criteria. Gas valve LOT and seal failure. Failed valve not being tested properly but reported as OK for WO closure. Corrective WOs cancelled.
CA		Some inadequate SAP histories. Sticking valves identified during ESD test in 2002, corrective WO raised but not released for remedial actions.
DA		F&G inputs to ESD not tested as there are no input inhibits at ESD system, but routines being signed off or cancelled. Tests signed off as successful even when failures noted.
TA		ZG30 barrier faults that is not fail safe giving drift on ESD functions. Asset are aware of this fault. Hudson overpressure protection ESD valve not meeting required performance, known to Asset.
EA		Last LOT on riser ESDV is a good model for history as give pressures temperature, etc.
NC		Fixed format not used for ESD-2/2S test results.
AA		Some WOs that were completed months ago are still awaiting history.
AN		Repeated valve failures. Valve recorded as frigged before test, not tested and left in frigged state after test.
FA		Some inadequate SAP histories. Riser ESDV closure and LOT results not always in SAP. Failed valves (?) with no follow up identified.
GA		Riser ESDV closure and LOT results not in SAP. Repeated valve failure
SW		Some inadequate SAP histories. Riser ESDV performance changed from 2001 with closure time doubled.
Nelson		Riser ESDV closure and LOT results not in SAP.

ESD = EMERGENCY SHUTDOWN VALVE

6

Subj: **Email of 21 July to Mr. Van der Veer**
Date: 03/08/2006 12:15:27 GMT Daylight Time
From: I.Mohsen@shell.com
To: Cambell1944@aol.com

Dear Mr Campbell,

Thank you for your email of 21 July, to which Mr. Van der Veer has asked me to reply.

I do not feel it appropriate to respond to all the specific points you have raised, but I would like to stress that I do not believe that we have given false or misleading information about this matter.

With regard to your specific concern about falsification, this was thoroughly examined at the time and during our investigation in 2005 . The investigation team looked at the falsification allegation but were unable to find any definitive evidence to support it. We therefore do not accept there was deliberate falsification of records.

Let me assure you that safety is Shell's foremost priority at all times and we absolutely reject any suggestion that we would compromise safety offshore.

Best Regards,

Imad

Imad Mohsen

P.A. to J. van der Veer, Chief Executive Royal Dutch Shell plc
Shell International B.V.
Carel Van Bylandtlaan 16, 2596 HR The Hague, The Netherlands

Tel: +31 (0) 70 377 4817
Mob: +31 (0) 652 580 400
Email: i.mohsen@shell.com

SUCH WAS THE DESPARATION TO DENY FALSIFICATION OF RECORDS COVERED BY CARL MORTISHED : LONDON TIMES TERRY MCALLISTER : MANCHESTER GUARDIAN LET ALL HERE WE HAVE THE CEO OF EUROPES LARGEST COMPANY IN DENIAL OF HIS OWN AUDIT FINDINGS BOTH IN 1999 AND 2003

SHELL DIRECTOR ACCEPTS THAT IN 1999 ONWARDS ESDV PERFORMANCE RECORDS WERE FALSIFIED.

Subj: **RE: Help**
Date: 20/11/2006 20:17:35 GMT Standard Time
From: ANDREW.MCFADYEN@ITN.CO.UK
To: Cambell1944@aol.com
Bill,

The Editor of Frontline Scotland, Dorothy Parker, and myself met with Greg Hill at Broadcasting House, Glasgow, on April 24th, 2006. I kept a short-hand note of the meeting and the account that follows is based on my original notes.

Hill confirmed that the PSMR had taken place in 1999 and said that it had resulted in 40 separate actions. The first broad area related to asset integrity and management systems, the second to behaviour. He said there was significant leadership and management training.

Towards the end of 2000 a follow-up audit was conducted. He said it found great progress on a lot of fronts. but there was a recognition that "the behavioural journey was a long one". When pressed on whether Shell had responded adequately to the findings of the PSMR, Hill told us:

"There were 40 separate actions as a result of PSMR. The review in 2000 found significant progress but with hindsight it did not go far enough or deep enough. The safety journey is about learning and improving."

At another point in the conversation, he also admitted that "with the benefit of hindsight the recommendations of PSMR could have gone deeper". (At the time I interpreted this as a comment on Shell's response to the PSMR, but my notes suggest he was actually saying the report itself could have gone further.)

In relation to falsified maintenance records, Hill accepted that it had gone on. His explanation was that Shell employs five thousand people and some individuals occasionally "do things we don't want them to." He continued. "where that happens we take disciplinary action, but it can be difficult to prove."

Hill denied absolutely that falsification of maintenance records – or any other breaches of safety regulations – were implicitly tolerated by Shell's senior management. He said that Shell had implemented a process of "deep learning" after 2003. Since then, much had changed and he personally would not operate an unsafe platform.

This meeting was conducted on the basis of "background" – this means that we could use the information to inform our report but we weren't allowed to identify the source or quote anything directly. It would therefore be helpful if you didn't forward this e-mail to any third parties.

It is worth noting that Shell's official statement for use in the programme flatly contradicted much of what Greg Hill told us.

Let me know if there are any points that need clarification or further explanation.

Kind regards

Andrew

ITN NEWS

ANDREW MCFADYEN
PRODUCER, CHANNEL 4 NEWS

200 GRAY'S INN RD
LONDON
WC1X 8XZ
UNITED KINGDOM
T +44 (0)20 7430 4601
F +44 (0)20 7430 4607
M +44 (0)7771 673793
E ANDREW.MCFADYEN@ITN.CO.UK
www.channel4.com/news

IN NOVEMBER 2006 THE THEN PRODUCTION DIRECTOR GREG HILL, WHO REPLACED CHRIS FINLAYSON BEFORE THE FATAL ACCIDENT ON 11 SEPT 2003 ADMITS TO BBC REPORTERS, PRODUCER & DIRECTOR THAT YES INDEED ESDV RECORDS HAD BEEN FALSIFIED

(10)

(8)

SUMMARY OF TECHNICAL INTEGRITY FAILURES: ESDV's IN 2003 PRESENTED TO HSE AFTER FATALITIES BUT NEVER PROVIDED TO F.A.I.

OFFSHORE INSTALLATION	Status of ESD Valves	No of Unapproved Temporary Repairs	Number of Safety Critical Fire and Gas sensors in failed to danger condition
Brent Alpha	Riser ESD valves fail leak-off tests but corrective WO cancelled	9	20
Brent Bravo	WO signed off as OK when test not carried out	16	16
Brent Charlie	Gas riser ESDV does not meet leak-off criteria	30	30
Brent Delta	Failed ESD valves not being tested properly but reported as OK for WO closure	41	41
North Cormorant		5	• nil
Dunlin Alpha	ESD valve tests signed off as OK even after failures noted	6	6
Cormorant Alpha	Sticking ESD valves identified, WO raised but never issued	10	10
Tern	Hudson Overpressure ESD valve does not meet performance criteria	18	18
Eider		3	3
Gannet	Repeated ESD valve failures with no follow-up identified	32	317
Auk		19	265
Fulmar	Failed ESD Valves but no follow-up identified	15	434
Shearwater	ESD closure time doubled with no reference to a technical authority	4	37
Nelson	ESD valve historical performance data not in SAP computer	17	27
Kittiwake		9	
Anasuria FPSO	Repeated ESD Valve failures, valves left Frigged after testing carried out	18	60
Leman		10	
Sean		2	

MC ON BEHALF OF SIEP

264 1284

1.7 Local Authorities also enforce health and safety law in workplaces allocated to them. Their inspectors are also required to follow this policy when taking enforcement action. Other regulators, including the Office of Road and Rail and the Office for Nuclear Regulation, also enforce health and safety law, but they have their own enforcement policy statements.

2.0 Our Enforcement Policy Statement

2.1 We believe in firm, but fair, enforcement of the law. It is our policy that all enforcement action should be proportionate to the health and safety risks and to the seriousness of any breach of law.

2.2 We consider that appropriate use of our enforcement powers is important, both to secure compliance with health and safety law and to ensure that those who have a legal duty (duty holders) are held to account for significant failures.

2.3 The following sections describe:

- the purpose of enforcement;
- the principles of enforcement;
- the enforcement methods available to our inspectors; and
- how our enforcement principles relate to investigations and prosecutions.

3.0 The purpose of enforcement

3.1 We take enforcement action to prevent harm by requiring duty holders to manage and control risks effectively. This includes:

- ensuring action is taken immediately to deal with serious risks;
- promoting and maintaining sustained compliance with the law; and
- ensuring that those who breach the law, including individuals who fail in their responsibilities, may be held to account (this includes bringing alleged offenders before the courts in England and Wales, or recommending prosecution to the COPFS in Scotland).

You can find out more about this on the regulation and enforcement homepage on our website.[6]

4.0 The principles of enforcement

4.1 We apply the following principles when conducting our enforcement activities:

- proportionality in how we apply the law and secure compliance;
- targeting of our enforcement action;
- consistency of our approach;

[6] See: http://www.hse.gov.uk/enforce/index.htm

10

Subj: **Role of OSD**
Date: 09/08/2006 14:08:02 GMT Daylight Time
From: Ian.Whewell@hse.gsi.gov.uk
To: Cambell1944@aol.com
CC: Kevin.Myers@hse.gsi.gov.uk, Kerry.Tyrer@hse.gsi.gov.uk

Bill,

I have now had a chance to consider the questions you posed in your e-ma of 26/07/06. I have attempted, where I am able to provide you with an adequate response, but as ever recognise that written communications oft have shortcomings and are often unsatisfactory when dealing with comple matters. With this in mind I wonder if it would be helpful to you to meet Kevin Myers the Director of HSE's Hazardous Installations Directorate who HSE Board responsibilities include the Offshore Industry.

He is currently on leave but has said he would be able to meet you at a convenient location towards the end of August. If you would like to meet Kevin please let me know your availability at the end of August/beginning of September and I will set up a meeting.

Dealing with the questions you have raised:

(a) As I feared when I sent my initial response our records do not contain the detailed information you asked for in the technical questions (a) (1)-(5). I therefore regret that I am unable to confirm when the actions you referred to were implemented by Shell.

(b) The comparative analysis provided by you was, as I understand it, for the purpose of demonstrating linkage between the issues identified by you team in 1999 and similar types of failures contributing to the Brent B double fatality. OSD's view was and still is that there were undoubtedly similarities in the types of issues identified and in the nature of generic problems. This confirmed our own findings, which were covered in the prosecution, that Shell were not at the time managing key aspects of plant maintenance and integrity.

(c) As originally requested we drew the attention of the procurator fiscal to the information you had provided. Unfortunately I can find no trace of any request from you that we proactively forward or encourage forwarding your correspondence to the Lord Advocate. I have to say however that it would not normally be appropriate for HSE to intervene directly in the decisions of the Crown Office.

(d) HSE already was fully aware of the outcomes of the Technical integrity review and the Shell internal investigation and had copies of some of the documents before receiving your correspondence in November 2005. HSI role in the FAI was strictly controlled and unless the PF requested discussions about the documents you sent him we would not have proacti initiated such discussion. I can assure you that once OSD became aware o the outcome of the Technical integrity review immediate action was taken confirm that Shell had put in place mitigation and control measures pendin action to deal with matters found. I hope that answers you question.

(e) OSD was made aware immediately when the Technical integrity review report was produced. I'm sorry if you have been given any other impression.

(f) OSD has progressively built contacts with the verification bodies and has had a number of meetings with them. We are also reviewing the effectiveness of our use of companies internal audits and intend to extend our current integrity management initiative from April 2007 to focus particularly on the dutyholders effective use of audit in management of integrity.

Operating with dangerously high levels of risk as a result of lack of essential management controls resulting in almost continual failure to comply with legal obligations from 1999 to 2007

CHRONOLOGY OF MAJOR EVENTS LEADING UP TO THE FATALITIES ON THE 11TH OF SEPTEMBER 2003

Note that this data (before and after the fatalities) is wholly owned by the enforcing authority the OSD division of the HSE. The enforcement actions from 2002 are taken from their website, the serious incidents, evacuation of employees, gas releases etc are held in HSE databases and have been communicated to the public at the time by Newspaper reports. The prosecution history is also on public record. Prior to 2002 the enforcement history was supplied to the author by Ian Whewell, currently Head of OSD in Aberdeen. The immediate events surrounding the fatalities are provided also and are directly taken from the Inquiry Findings and are such the wholly owned by the Crown Office in Scotland.

	A summary of Enforcement Actions, High Potential Incidents, Prosecutions etc	
December 1999 till September 2003	Before the fatalities there were 15 enforcement notices served, 13 Improvement Notices and Two Prohibition Notices. In addition Shell have been prosecuted on 5 occasions for serious breaches of the Health and Safety at Work Act in the period 1999 through till end of 2006	A persistent and continual failure to comply with legal requirements with serious breaches of Offshore legislation
December 2003	HSE serve an improvement Notice on Cormorant Alpha Quote there are serious failures in the safety critical equipment verification scheme - Unquote	A breach of Offshore legislation
Sept 2000	A fire developed in the fire-pump room on Leman. The deluge system failed to protect the pump and maintenance, which should have been carried out in 1999, had been neglected.	Potential major accident event which may have escalated due to maintenance being neglected
Sept 2000	Some 93 non-essential crew members from Brent Delta were evacuated after prolonged loss of all life support systems	Caused by maintenance being neglected
October 2000	The Dunlin Alpha platform had to be evacuated after build up of hydrocarbons in its Utility Shaft	Potential major accident
Nov 2000	The newly commissioned Shearwater platform which handles extremely high pressure, high temperature hydrocarbons, was evacuated after higher than normal pressures were recorded at the wellheads	Ditto
Feb 2001	The Kittiwake platform was evacuated after the loss of control on an oil well	Ditto
June 2001	In relation to Auk and Fulmar HSE raise concerns that 5 releases of hydrocarbons due to corroded pipework had occurred over the previous 12 month period	Ditto
October 2001	The HSE write to Shell Expro complaining that progress on Improvement Notices issued related to the verification schemes on Cormorant A and Dunlin A in 1999 and 2000 and the North Sea generally, are significantly overdue - the Company has been in continual breach of these Regulations for over 18 months The HSE request that to give this the attention and priority it deserves that their letter be discussed at corporate level in the organisation - the seeds fell on stony ground, for after the letter was received a further five Improvement Notices related to verification schemes were served prior to the fatal accident in Sept. 2003 see below	Failure to comply with legal requirements. Failure of Shell Directors to take remedial action although they have been notified that they are in breach of Regulations endangering the lives of persons offshore
January 2002	100 non essential crew were evacuated from Brent Charlie after a leak of Hydrogen Sulphide into its Utility Shaft	Potential major accident event
6th March 2002	Despite the serious concerns about failure in the verification schemes highlighted to Directors in October 2001 a further five improvement notices are served related to the same failures in the Verification schemes on Anasuria, Auk, Fulmar, Gannet and Kittiwake Quote the verification scheme currently in existence on these installations are not a suitable verification scheme these installations Unquote	Failure of Shell Directors to take remedial action although they have been notified that they are in breach of Regulations endangering the lives of persons offshore

26th March, 2002	HSE issue an improvement Notice on North Cormorant Quote - You have failed to provide an effective system of work for the maintenance of plant Unquote	A further breach of Offshore legislation
18/12/02	HSE issue an Improvement Notice - there was an uncontrolled release of flammable or explosive substances on the Shearwater installation that released from abnormal activities during a process isolation that had not been subject to suitable and sufficient risk assessment	Potential major accident event caused by loss of containment
	Initiating Events leading to the fatalities on 10th September	
17th August 2003	On Brent Bravo a temporary repair and unauthorized repair was carried out on a safety critical line in the Utility Shaft whose failure could cause, or substantially contribute to, a major accident. The leakage from the line had caused gas alarms to be activated. The platform was started up on 22nd August despite this observed degradation in technical integrity and the forewarning that gas was present in a line where it should not have been under normal operations	Enhanced risks as approval from a technical authority was not obtained prior to carrying out the repair. Operators failed to analyze why Gas was present in such apparent volumes in this oily-water line
17th August 2003	Before the shutdown it was known that the HP Flare KO Vessel had been operating in violation of its design codes. The LCV on the Process Drains De-gasser Vessel could not maintain its liquid level. The platform started up in this condition after the shutdown in August 2003	The failure of the LCV contributed to the significant amount of gas entering the Utility Shaft on 11th Sept
17th August 2003	During the annual maintenance shutdown in August 2003 ESD valve EZV 4415 on the outlet of the HP Flare KO Vessel failed to close during routine testing. During the same shutdown some 14 other valves failed to operate within specification. The OIM considered the failure of ESD valve EZV 4415 did not prevent the start up of the platform on 22nd of August - it should be note that under the Shell technical change control procedure the OIM did not have the authority to take that decision. The total amount of hydrocarbon vapour cloud released into the Utility Shaft via the leaking temporary patch was estimated at 6280 cubic metres. A significant factor which contributed to the extent of the vapour cloud was the failure of ESD valve EZV 4415 to close in the emergency	The failure of the ESD valve contributed to the significant amount of gas entering the Utility Shaft on 11th Sept
11th September	The two deceased enter the Utility Shaft to repair the leaking repair without raising a permit. The also do not follow the shaft entry procedures fully. The execution of work under the 'operations umbrella' instead of via the PTW had become custom and practice so reported the Technical Integrity Review team set up immediately after the accident. These failure are also cover in the Inquiry report and its determinations	Endemic weakness in the application of the PTW and other control procedures

AFTER THE FATALITIES

CHRONOLOGY OF MAJOR EVENTS AFTER THE FATALITIES AS A DEMONSTRATION THAT THE FATALITIES HAVE NOT IMPROVED SAFETY PERFORMANCE OR CREATED A MORE POSITIVE SAFETY CULTURE - RATHER THE SITUATION DETERIORATES FURTHER WITH A THREEFOLD INCREASE IN THE ISSUANCE OF ENFORCEMENT NOTICES BY THE REGULATOR

Sept/Nov 2003	Shell conduct a post fatalities technical integrity review showing appallingly bad conditions on many of the 15 offshore installations, hundreds of unapproved pipework repairs, thousands of fire and gas sensors in fail to danger state, criminal neglect re the maintenance of ESD valves and as importantly indications of an ingrained a persistent negative safety culture. PTW violations were common including doing much work under the operations umbrella rather than through a PTW, this was a contributory factor in the fatal accident. Neglect of maintenance and knowingly operation plant in a dangerous condition had become the norm	All this is ignored in the June 2006 press release's and the internal communiqué to Shell employees worldwide, another example of Society as a whole being mislead and given a false account of the truth regarding the failures of its Directors from 1999 to 2003
15/09/03	Prohibition Notice served on Brent Bravo Quote Potential hydrocarbon leaks from the degasser rundown pipework in close	A further breach of Offshore legislation

	proximity to level control valve LCY 6600 could harm platform personnel if it is not repaired or renewed Unquote	
17/09/03	Prohibition Notice served on Brent Bravo Quote the palfinger and grab assembly have not been maintained in order to prevent the inadvertent opening of the pipe grab jaws Unquote	A further breach of Offshore legislation
18/09/03	Prohibition Notice served on Brent Bravo Quote Integrity standards of Utility Shaft hydrocarbon facilities and related safety systems are not being adequately maintained and operated so far as is reasonably practicable, to prevent harm to platform personnel Unqrote	A further breach of Offshore legislation
28/9/03	Improvement Notice served on Lowestoft: Quote - Shell have failed to demonstrate, that for Major Capital Brown Field Projects, the organisation and systems which are in place effectively control the preventive and protective measures required to assure compliance with the requirements and prohibitions placed upon them by or under the relevant statutory provisions associated with Major Hazards - Unquote	A further breach of Offshore legislation
Nov 2003	The results of the post fatalities technical integrity review was presented to the Head of the OSD (HSE) in Aberdeen by the Production Director Greg Hill and his MD Tom Botts. HSE officials confirmed to me at a meeting on 31st August last year that Hill was shocked and horrified by what his integrity review team had unfolded. The Review had used as a starting point the 1999 PSMR audit and found many consistencies between that audit and what they found. Despite Shell informimg HSE of over circa 300 unapproved temporary repairs, of ESD valves known to be functionally impaired or with falsified terst results, and of some 1200 safety critical sensors on fire and gas systems being in a fail to danger condition on 17 offshore installations **no enforcement notices were issued or prosecutions sought other than on Brent Bravo**	When Van der Veer and Brinded authorised the public statements in June 2006 they purposefully neglected to inform the media about this situation and the HSE involvement in same. The HSE have also kept this meeting secret. This was a deliberate act to mislead the media, employees, trade unions and Society in general
06/02/04	Prohibition Notice served on Brent Alpha Quote - You have failed to provide adequate guards or other measures to prevent persons coming into contact with the dangerous parts of the HVAC Extract fans ME16 and ME17 – Unquote	A further breach of Offshore legislation
09/02/04	Improvement Notice served on Brent A – Qrote - It is possible for persons to come into contact with dangerous part of HVAV fans ME16 and ME17 whilst the fans are in motion - unquote	A further breach of Offshore legislation
10/03/04	Prosecutions to which Shell Pled guilty under the various Provisions of the Health and Safety at Work act Brent Alpha	A further breach of Offshore legislation
25/03/04	Prohibition Notice served on Brent Delta Quote - The aforementioned fans are not so guarded as to prevent anyone from coming into contact with the dangerous parts – Unquote	A further breach of Offshore legislation
May 2004	64 non-essential personnel evacuated from Brent Delta after a gas leak in the Utility Shaft	Potential major accident event
01/06/04	Improvement Notice served on Tern Alpha Quote - That during a high pressure water jetting undertaking a person not in your employment, operating the equipment, was struck by the high pressure jet which penetrated his unsuitable safety footwear, causing a major injury to his foot – Unquote	A further breach of Offshore legislation
August 2004	A gas leak occurred in a Utility Shaft of Dunlin Alpha	Potential Major accident
October 2004	A gas leak occurred on Cormorant Alpha	Potential major accident
08/10/04	Improvement Notice served on Cormorant Alpha Quote - That you have failed to prevent an unplanned escape of fluids from the well in that there was a major release of gas from a faulty flexible hose on well CA26 on the 28th Sept 2004 - Unquote	A further breach of Offshore legislation
08/10/04	Improvement Notice served on Cormorant Alpha Quote - That you have failed to maintain the diesel fire pump 7250 in an efficient state, in an efficient working order and in good repair, in that the prime mover is subject to overheating in foreseeable emergencies - Unquote	A further breach of Offshore legislation
27/10/04	Improvement Notice served on Auk Quote - That you have failed to maintain the integrity of the fabric of the installation in that there are severely corroded gratings and handrails on the installation - Unquote	A further breach of Offshore legislation
28/10/04	Prosecutions to which Shell Pled guilty under the various Provisions of the Health and Safety at Work act Brent Delta	A further breach of Offshore legislation

02/11/04	Improvement Notice served on Brent C Quote - You have failed to ensure that equipment, namely the platform's instrument air supply system supplying the Temporary Refuge Heating and Ventilation System Fire Dampers is maintained in an efficient state, efficient working order and in good repair - Unquote	A further breach of Offshore legislation
16/11/04	Prohibition Notice served on Fulmar Quote - The current design of the equipment is inadequate and the operation is unsafe - Unquote	A further breach of Offshore legislation
26/11/04	Improvement Notice served on Brent Bravo Quote - You have failed to provide such information, instruction and training as was necessary to ensure the health and safety of your employees and others, in that whilst work was being undertaken at the 101 m level of the **Utility Shaft,** access to the dangerous parts of machinery of the lift mechanism was possible – Unquote	A further breach of Offshore legislation – this is **a serious repeat offence** since the deaths on BB related to procedural anarchy displayed at that time and lack of training etc to persons working in Utility Shafts
26/11/04	Improvement Notice served on Clipper Quote - Your ship collision avoidance performance standard and procedure do not provide sufficient warning to enable effective emergency response and are not adequately controlled by a management system and do not therefore constitute a safe system of work - Unquote	A further breach of Offshore legislation
26/11/04	Prohibition Notice served on Brent Bravo Quote - You have failed to prevent persons coming into contact with the dangerous parts of the **Utility Shaft** lift machinery – Unquote	A further breach of Offshore legislation
08/12/04	Improvement Notice served on Dunlin Alpha Quote - Improvements are required for breathing apparatus self rescue set training for **Utility Shaft** authorised and leg competent personnel within confined space legs with potential for a hydrocarbon or toxic gas atmosphere is inadequate as it does not require these personnel to don the self rescue sets (or training sets) over their heads and breathe through them while in a realistic escape scenario - Unquote	A further breach of Offshore legislation – this is a **serious repeat offence** since the deaths on BB related to procedural anarchy displayed at that time and lack of training etc to persons working in Utility Shafts
28/02/05	Improvement Notice served on Brent Alpha Quote - You are failing to ensure that work equipment is maintained in an efficient state, in efficient working order and in good repair in that, the cable supports in the pallet deck area are severely corroded and are not providing adequate support for the electrical systems and the Ex electrical lighting in the same area was showing signs of water ingress - Unquote	A further breach of Offshore legislation
17/03/05	Prohibition Notice served on Inde Quote - Shell has not taken all reasonable practical steps to maintain a safe place of work - Unquote	A further breach of Offshore legislation
24/03/05	Improvement Notice served on Inde Quote - Your present maintenance regime is not maintaining the integrity of the Juliet installation, and will not maintain integrity throughout the remaining life cycle of the installation – Unquote	A further breach of Offshore legislation
01/04/05	Improvement Notice served in Brent Bravo Quote - The water deluge system in Modules D3W and D3E is not maintained in an efficient state as was demonstrated by the failure of parts of the system to meet the relevant performance standard when tested on 21 and 22 March 2005 respectively – Unquote	A further breach of Offshore legislation
28/04/05	• Three prosecutions to which Shell Pled guilty under the various Provisions of the Health and Safety at Work act related to the fatal accident event on 11th September 2003	These failings to comply with the Law directly contributed to the deaths
14/06/05	Improvement Notice served on N Cormorant Quote - Numerous process system valves and numerous other safety critical system valves have no unique identifying number marked or labelled on them	A further breach of Offshore legislation
20/06/05	Improvement Notice served on Gannet: You have failed to ensure doors for use in an emergency are so fastened that they can readily be opened by any person who may require to use them in an emergency. Further, this violation has compromised the integrity of the TR. TR boundary air lock door at the smoking area lounge was wedged off its seal by the use of a square block	A further breach of Offshore legislation
August 2005	85 non essential personnel were evacuated from Brent Bravo after an oil leak in the **Utility Shaft**	Potential major accident event
August 2005	Less than two weeks later 71 non-essential personnel were evacuated from Brent Bravo following a gas leak	Potential major accident event
12/11/05	Prohibition Notice served on Clipper Quote - You have not carried out a suitable and sufficient task risk assessment, and implemented	A further breach of Offshore legislation

	suitable controls to reduce risks to ALARP, and record significant findings – Unquote	
19/12/05	Improvement Notice served on Clipper Quote - You have failed to put in place controls to : clarify health & safety roles and responsibilities and to ensure persons understand clearly what they have to do to discharge them; ensure activities of everyone are well co-ordinated, and carry out on site active monitoring to ensure preventative and protective measures are in place and effective - Unquote	A further breach of Offshore legislation
23/12/05	Improvement Notice served on Clipper in relation to a fatality to improve the safe system of work and monitoring arrangements	A further breach of Offshore legislation
08/03/06	Prohibition Notice served on Anasuria – You have failed to take effective measures to prevent contact with dangerous parts of machinery	A further breach of Offshore legislation
22/05/06	Improvement Notice served on Brent Delta: Failing to ensure the health and safety of your employees and others by failing to ensure that the Utility Shaft cell fill lines have been maintained in an efficient state, in efficient working order and in good repair – Unquote **This work is till ongoing with a close out date of 30/11/07 so the risks associated with this offence still persist**	A further breach of Offshore legislation – this is a serious repeat offence since the deaths on BB in Sept 2003 related to loss of containment from a corroded line which had a materially defective temporary repair
22/05/06	Improvement Notice served on Brent Bravo Quote - Failing to ensure the health and safety of your employees and others by failing to ensure that the Utility Shaft cell fill lines have been maintained in an efficient state, in efficient working order and in good repair – Unquote **This work is till ongoing with a close out date of 30/11/07 so the risks associated with this offence still persist**	A further breach of Offshore legislation – this is a serious repeat offence since the deaths on BB in Sept 2003 related to loss of containment from a corroded line which had a materially defective temporary repair
May 2006	On 15th May a pinhole leak was found on the Brent Alpha oil import line	Potential major accident event due to loss of containment
June 2006	On the 5th of June there was a release of gas on Brent Bravo and around 20 - 60 litre of oil were spilled during pigging operations. The platform was shutdown whilst the module was safely isolated"	Ditto
June 2006	Work had to be stopped in the Brent Bravo Utility Shaft after an alert caused by a seep from a pipeline bringing seawater into the platform.	Ditto
26/07/06	Improvement Notice served on Brent Bravo Quote - You have failed to, ensure the health and safety of your employees and others by failing to ensure that the 12" Oil Export Pipework P-137-1106Y, so far as is reasonably practicable, has been maintained in an efficient state, in efficient working order and in good repair – Unquote	A further breach of Offshore legislation
27/07/06	An Improvement Notice was served on Brent Bravo - A report had been prepared which condemned the stairway in the Utility Shaft as unsafe for use due to severe corrosion. This report was subverted. The matter was only highlighted when the report contents in part were leaked to the OILC. The HSE intervened to raise an improvement notice stating yet again that Shell had failed its legal obligations	A further breach of Offshore legislation An example that despite the fatalities in 2003 three years later the negative safety culture persisted. It was onshore Management that covered up the inspection report
27/07/06	Improvement Notice served on Dunlin Alpha Quote - You have failed to prevent access to dangerous parts of machinery, specifically the Dunlin Utility Shaft C winch and the Dunlin Utility Shaft D winch. - Unquote	A further breach of Offshore legislation
01/09/06	Improvement Notice served on Leman A Quote - Lifting equipment was not being adequately controlled through the rigging loft. The AK gantry cranes were inadequately maintained and the on site control of lifting operations was seen to be inadequate - Unquote	A further breach of Offshore legislation
20/09/06	Prohibition Notice served on Cormorant Alpha Quote - Level 9 C4 Utility Shaft – Winch is inadequately guarded - Unquote	A further breach of Offshore legislation
06/11/2006	Improvement Notice served on Clipper Quote - Failure to comply with the Provisions for the Use of Work Equip Regulations 1998 - Unquote	A further breach of Offshore legislation
30/11/2006	Improvement Notice served on Clipper – Quote - Shell has failed to implement a suitably resourced maintenance regime to achieve	A further breach of Offshore legislation

	compliance with their own maintenance strategy. This has lead to excessive backlog of maintenance activities for safety critical equipment and non safety critical equipment leading to poor working order and repair of equipment – Unquote	
12/02/07	Improvement Notice served on Clipper in that Shell are required to implement a programme to clear unacceptable levels of safety critical maintenance backlog	A further breach of Offshore legislation
05/04/07	Improvement Notice served on Dunlin Quote - on the 30th March 2007 you failed to notify the relevant enforcing authority (HSE) that there had been a dangerous occurrence (a gas leak) – Unquote	A further breach of Offshore legislation – continuing example of bad behaviour (lies and cover-up) – **HSE has failed to prosecute this criminal offence**
14/05/07	Improvement Notice served on FPSO Anasuria - Shell failed to ensure the watertight integrity of the installation and the installations stability if that integrity were to be lost –	A further breach of Offshore legislation **this Notice has gone past its original completion date of 30/8/07 so the risks associated with this are still present. We are in the winter weather window and contuinue to operate a vessel of questionable integrity!**
29/06/07	Improvement Notice served on Dunlin Alpha - Shell failed to prevent or control exposure of employees to substances hazardous to their health – **this Notice is still ongoing so the risks associated with it are still present**	A further breach of Offshore legislation
07/07/07	Shell report gas release on its Eider offshore installation	Dangerous occurrence
07/08/07	Shell forced to evacuate 60 employees from its Brent Bravo installation due to prolonged loss of power	Indication of neglect of maintenance
25/09/07	Circa About 100 workers were evacuated from the North Cormorant installation after one of the two boilers broke down.	Indication of neglect of maintenance
25/09/07	Circa about 100 workers were evacuated from the Cormorant Alpha installation after one of the three power generators failed	Indication of neglect of maintenance
Nov/07	In relation to concerns raised by trade unions related to manning and competency levels on Shell offshore installations the HSE uphold all but one of the concerns raised by the workforce	It remains to be seen if enforcement actions or prosecution will follow
Nov /07	A fire is reported on North Cormorant, on the same day Cormorant Alpha suffers a prolonged outage of power due to failure of utility systems	It remains to be seen if enforcement actions or prosecution will follow

These enforcement Notices listed were to eliminate the risks of potential multiple fatality events, for example failure in essential management and supervisory controls to ensure the health and safety of all the employees on a specified offshore installation, for example failures in the application of the safety critical equipment performance verification schemes

These Enforcement Notices were to eliminate the risks of potential single fatality events, for example failure to guard machinery properly

---

Note:
Enforcement Notices i.e. either Prohibition or Improvement Notices are legal documents. Failure to comply with the Notice is an offence, which can lead to prosecution. The Notice when served requires the unacceptable risks identified in the Notice to be completely eliminated within the specified time on the said Notice

A Prohibition Notice when served takes immediate effect to prohibit the use of hardware, process or systems of working etc until such times as the unacceptable risks identified in the Notice are completely eliminated.

Until the actions required under the terms of the notice are completely implemented the risks to persons on board the installation effected by the notice remain above the statutory level ALARP as specified in the installation Safety Case

---

Prosecutions for which Shell pled guilty

High Potential incidents due to loss of technical integrity

ISSUED IN 2009

12

A Subject which Transcends Constituency Boundaries: The Safety of Royal Dutch Shell Offshore Employees

Criminal Investigation uncovers lies and deceit:

My name is Bill Campbell. I am a former Senior Operations and Maintenance Engineer who also acted as a Group Auditor for Shell International. **I previously wrote to UK MP's, and to the Lords, in July 2007. This letter is an update on what has happened since and also what happened to the concerns raise by a number of MP's at the time**. The key findings from the current investigation listed below are based on an update given to me by the Procurator Fiscal(s) on 18th February past.

Background

Some time ago the police in Aberdeen passed a report to the Procurator Fiscal. Subsequently a criminal investigation commenced led by Anne Currie, Area Procurator Fiscal for Grampian Region assisted by Andrew Grant, Area Procurator Fiscal for Central Region. The investigation has focussed to date on the role of HSE officials at the Offshore Safety Division of the HSE based in Aberdeen. The allegations against these officials were that they were unduly influenced by Shell, potential bribery and corruption, to cover up the full circumstances of a multiple fatality on the offshore installation Brent Bravo in September 2003, and the subsequent Fatal Accident Inquiry (FAI) held in Aberdeen.

What has the investigation established, the 7 key findings

1. HSE failed to pass vital evidence to the Procurator Fiscal in Aberdeen prior to the Fatal Accident Inquiry. HSE had obtained this evidence directly from Shell only days after the fatalities and by November 2003. Shell informed HSE that the Brent Bravo fatalities were not just an unfortunate, but isolated incident, but there was a general malaise offshore with chronic weakness in essential management controls evident across the oilfield. The Fiscal was made aware of this evidence by me at the commencement of the FAI. This was the time when I first became aware that HSE had not provided this evidence to the Fiscal. He then attempted to introduce this evidence belatedly, but the Sheriff desisted, due to the restrictions placed on him by the 1976 FAI Scotland Act.

2. If the Procurator Fiscal(s) had been in possession of the evidence given by Shell to HSE in 2003, as they should have been, this would most likely have led the Lord Advocate to sanction a more General Inquiry into how Shell had operated across the oilfield in the prolonged period from 1999 till the deaths. And to how HSE had failed to reverse the degradation of facilities over this period despite issuing many Enforcement Notices and raising their ongoing concerns with Shell Directors.

3. Although Shell pled guilty to a number of serious breaches of legislation related to the deaths on Brent Bravo, their employees, and Society as a whole, were never made aware that similar breaches were apparent on 16 other offshore installations. The appalling conditions present on these installations raised risks to unacceptable levels but the workforce remained blissfully unaware of the risks they were taking, simply by being on these installations. Despite the conditions on these installations and in contravention of the HSC Enforcement Policy no formal enforcement actions were taken by HSE at the time and no attempt was made by Shell or HSE to assess the risks of continued operation. It is estimated that some 40 prohibition and/or improvement notices would have been required to cover some 80 serious breaches apparent at the time. Since 2003, Shell are on public record of expending to date some £800 million to return these facilities to the risk levels as stated in the offshore installation specific Safety Cases.

THIS IS THE REPORT I REQUESTED UNDER FOI, AS REF TO IN E MAIL TO OSDR

12

4. At the time the FAI results were made public the BBC in Scotland aired a TV programme on 14th June 2006 highly critical of Shell and HSE in relation to the deaths on Brent Bravo and this was picked up by Newspapers across the UK including the Times and the Guardian. In total contradiction with the facts Shell denied wrongdoing stating that in the period 1999 to the deaths in 2003 '*significant progress had been made on both asset integrity and management systems. This contributed to the continuous improvement in Shell's safety performance over that period* '.

5. HSE were aware that the Press Releases by Shell were false. I wrote to the HSE CEO complaining about this at the time, how could HSE stay mute when they were aware that the Shell statement was a pack of lies? He did not reply. The feedback from the ongoing investigation has confirmed that Geoffrey Podger, the CEO of the HSE, was aware that the statements made by Shell in their Press Releases of 2006 were false and misleading. His defence is that the Shell statement put HSE in a difficult position as their Policy does not allow them to comment on the health and safety performance of individual organisations.

6. With respect to the allegations of bribery of HSE officials by Shell over the period 1999 till 2003 the Procurator Fiscal(s) can find no physical evidence of this. They trawled through what records were currently still available looking at the degree and spread of hospitality given to HSE officials by Shell in this period. However the records for this period are no longer available being routinely destroyed after a 5-year lapsed period and were thus simply not available to examine.

7. The Procurator Fiscal(s) have reviewed the results of an internal investigation carried out to ascertain if HSE could, or should have been able to foresee and prevent the Brent Bravo fatalities with the information available to them between 1999 and 2003. The HSE internal investigation found essential weaknesses in their enforcement process resulting in 18 recommendations for improvement which have subsequently been implemented.

What happened to the concerns raised by MP's in 2007

In August 2007 around 12 MP's including the then Secretary of State for Scotland got involved and wrote to Bill McKenzie at that time a Parliamentary Under Secretary of State at Work and Pensions. In a process that apparently by-passed Geoffrey Podger and his Head of the Offshore Safety Division, the HSE officials, against whom the allegations were made, were allowed to draft a reply directly to McKenzie. The Procurator Fiscal(s) carrying out the current investigation have viewed the correspondence between HSE and Work and Pensions in 2007 and it is not contentious that the information provide to McKenzie by HSE officials was false and misleading. The MP's who had raised the matter were thus hoodwinked by a false account of events.

Bill McKenzie, who was provided with the same evidence in 2009 as currently held by the public investigators, wrote to me at that time, stating his satisfaction with the advice given to him by HSE officials in 2007. He did this despite being aware that a criminal investigation into the conduct of those officials had commenced in March that year. In the same letter he made clear that Geoffrey Podger did not authorise the advice given to him in 2007 and that there was no need for him to do so. I find that statement by the Under Secretary truly remarkable. The allegations raised by me and taken seriously by the Police and the Crown Prosecution Service in Scotland were that HSE officials had in 2003 purposefully covered up the criminal neglect of Shell, either for personal gain, or to mask from public scrutiny their failures to protect workers offshore from unacceptable risk. Could there be a more damming allegation. Yet the reply to the Secretary of State for Scotland and the other MP's in 2007 was not, it appears, worthy of the involvement of the HSE CEO.

Finally both Shell an HSE have been given write off reply to what is written here and have raised no legal, or other specific objections to it issue. For some time I have been pressing Anne Currie to make her investigation public. It is clearly in the public interest. Neither the Scottish nor UK Government finds argument with the proposal that in all matters related to the

13

From: William Campbell Cambell1944@aol.com
Subject: That Fateful Day
Date: 6 Dec 2018, 12:14:51
To: Dave.Salmon@hse.gov.uk, Chris.Flint@hse.gov.uk

Chris and David

You say OSDR are willing to participate in a public inquiry, difficult to say otherwise since HSE position to Justice Committee was to support fresh proceedings I was rather hopeful that you could add to your support by saying OSDR would welcome a public inquiry which they would willingly participate in, or words to that effect. Any comments on submission would be welcome, I will cc you on all the stuff sent into the system.

2009

THIS IS THE REPORT, PARA 7, ON LETTER TO PARLIAMENT IN

On my wish to receive the info from HSE as requested, I had also hoped that my openness and honesty,and respect for OSDR could be reciprocated, if I am not going to get how my complaint at the time was handled, just say so. Even government lawyers don't take 30 days to make their mind up, is it a yes or a no.

Coincidentally, communicated with the HSE lady who co-authored the report on how the structure would react to the explosive forces, she is no longer with HSE, works in Hong Kong. Her fellow Author is 72, along with Chamberlain. She has not replied.

You should read this report. The vent sizes for the utility shaft were appropriate at the time, this was early 70s when little was known about turbulence effects in enclosed equipment congested spaces. I had dealings with the Professor after the 1998 explosion in the C4 shaft of Cormorant A, in this explosion the vent cover blew off breaking its binding chain, in short if the vents had been covered the column may have collapsed. In the 70s the worst case scenario for the shaft was calculated on the ideal mixture circa 9.5% methane by volume in air in a confined vented space but no account was taken of turbulence because it was not fully understood till the early 90s, turbulence as you are aware increases the speed of e wave front significantly and overpressure is a function of wave front or flame front velocity.

WRT Bravo even if the vents had not been blocked catastrophic damage could have occurred from this Hugh vapour cloud estimated by Chamberlain to be in excess of 6000 cm. I assume this report is in your files, recommend you have a look. Think you will find my postulation is fundamentally accurate.

Bill

THIS REFERS TO EVIDENCE NOT LED AT BRAVO RE POTENTIAL STRUCTURAL DAMAGE IF VAPOUR CLOUD IN UTILITY SHAFT HAD IGNITED

14 HSE BUXTON : EXPLOSION HAZARD ASSESSMENT

- The application of uncertain 'symmetry arguments' or 'physical reasoning' to generate the cloud shapes and overpressure data for all the various leak scenarios of interest.
- Uncertainties associated with the generation of 'equivalent stoichiometric clouds' within some CFD models can offset any gains in accuracy arising from sophisticated gas dispersion modelling and explosion overpressure calculation.

- **Validation and verification**. There has been a lack of disclosure of validation data for some codes. This issue of auditability is of particular concern where codes are being regularly updated and new versions issued on a regular basis.

Industry practice

Explosion hazard assessments undertaken for offshore installations may vary widely from simple assessments using empirical models to complex analyses using multiple CFD simulations. Key issues identified from a review of industry practice in this area are as follows:

- Explosion hazard assessments are sometimes undertaken in detail for some installations then by 'difference' for others. This raises questions as to whether the installations in question are indeed comparable from an explosion hazard perspective.
- A common assumption made is that if the explosion analysis is undertaken on the basis of a module filled entirely with gas at stoichiometric composition that this must represent the worst case. This neglects the important influence of:
  - congestion in determining localised peak overpressures and that the turbulence associated with a realistic release case may give more severe overpressures (even if the gas does not completely fill the module);
  - in calculating explosion risks in relation to escalation and TR impairment, calculation of low frequency worst case explosions will potentially ignore higher frequency, lower overpressure incidents that are capable of significantly contributing to the overall explosion risk.
- In assessing realistic release cases, dutyholders may assume that explosion overpressures scale in a simple manner with gas cloud volume, but this again neglects the important influence of congestion.