Review of HSE involvement with Shell Expro prior to the fatal accident onboard Brent Bravo offshore installation 11 September 2003

18th November 2004

Shell during 2003, presented opportunity for OSD to take action that might have prevented the tragic loss of life on 11 September 2003. We found no evidence that OSD could have changed the outcome, because the failings by Shell were so gross, but the following recommendations are made:

1	HSE should vigorously pursue the proposed amendment of the Safety Case Regulations to enable them to be a practical tool to promote further improvement by offshore duty holders and to reduce the assessment process for HSE.
2	Where there are common issues between installations, consideration should be given to devising a system where, during safety case assessment, they are only assessed once on a company wide basis.
3	HSE should review the requirements for the description of the safety management system in the Offshore Safety Case Regulations compared to COMAH, decide what their requirements are, and consider if greater alignment would be appropriate.
4	For multi installation duty holders, consideration should be given to permitting submission of a single safety case for common topics such as the SMS, with installation specific information only as required.
5	HSE should consider whether the Offshore Safety Case Regulations, or guidance to them, should be clearer in describing when a material change, particularly to the SMS, is of such a nature as to require a revision to be sent to HSE.
6	The Strategic Duty Holder Planning process, described in the Inspection Manual, is not working as intended, particularly regarding the larger duty holders. It should be reviewed to make the process more manageable. We recommend that the existing practice of appointing a focal point inspector should be developed. For large companies, such as Shell, the focal point should be at an appropriate level. A rolling corporate (rather than installation) inspection plan should be considered which contains key risk control topics, generated from national inspection programmes, safety case assessment, duty holder incident history and other sources of intelligence. To make this work it may be necessary to limit the level of consultation both internally and with the duty holder. The plan should be flexible and seen as a continuous process susceptible to change, to reflect HSE priorities and new information.
7	When carrying out review meetings with the senior management of large duty holders, the key issues and actions should be more systematically recorded and arrangements agreed between OSD and the company for implementation.
8	Current inspection planning documents (AIPs) do not permit easy monitoring of historic progress against plan. OSD should consider whether a revised format to include a rolling record of actions against plan is more appropriate. This may be of particular assistance for corporate inspection planning for large duty holders. Consideration should be given to whether common planning documents could be used by both OSD and HID CI.

2. Introduction

The accident

2.1 On the 11 September 2003 two workmen, one employed by Shell Expro, and one by contractors, Wood Group, were killed while working in the utility leg of Shell's Brent Bravo offshore installation. The men had entered the leg purportedly to inspect a temporary repair to a pipe. While in the leg condensate began to escape from the pipe and the men were overcome by the narcotic effect of the condensate.

2.2 A number of specific issues appear to be relevant to the accident:

- A temporary pipework repair had not been technically approved for use and did not conform to Shell's technical standards
- The repair had been in place for a considerable time
- Pipework repairs were not monitored by Shell management
- Operations personnel became accustomed to delays in management action and took shortcuts
- Utility leg entry - safe system of work: lack of clarity over first line maintenance definition and operation of permit to work system
- Failure to assess the risks arising from the known failure of isolation valve EZV 44715 to close, combined with other passing valves.
- Control room operations
- Failure of back up systems including standby generators and Uninterruptible Power Supply (UPS) system leading to communications difficulties.

2.3 Two other issues – namely toxicity of condensate (where a claim was made in the safety case that there were no foreseeable major hazard toxic events) and escalation potential are not covered by this report as they both involve the application of hindsight.

Appendix A:

Press Release to Employees and Media on behalf of Malcolm Brinded Executive Director of Royal Dutch Shell upstream operations on June 16th 2006

The following was Royal Dutch Shell response to the Upstream article on Shell concerning North Sea Safety on 16th June 2006, and the BBC Scotland 'The Human Price of Oil' aired on 14th June that year. This message was sent to the thousands of Shell employees in the Upstream business worldwide, and also formed the basis for media releases at the same time.

You may be aware that the Upstream trade magazine has today published an article making a number of very serious allegations against Shell in its operation of the Brent field and some **very personal, and completely unjustified**, attacks on current and former members of Shell's staff and management.

Shell strongly refutes these allegations.

Safety is Shell's foremost priority at all times and we absolutely reject any suggestion that we would compromise safety offshore. In 1999, Shell initiated the Platform Safety Management Review, in which Mr Campbell was asked to participate, **and responded vigorously to its findings.** A follow up implementation audit conducted at the end of 2000 **confirmed significant progress had been made on both asset integrity and management systems. This contributed to the continuous improvement in Shell's safety performance that has been achieved since 1999 in the North Sea.**

In late 2004, Mr. Campbell made allegations to Shell about his perception of a lack of follow-up to the PSMR. Shell took his claims very seriously. **A thorough investigation concluded that his perceptions were not supported by the evidence. Neither was the serious allegations concerning individuals.** We are currently reviewing our legal position and reserve all our rights in respect of resorting to legal action to protect our reputation and that of our current and former staff.

Safety is, and will remain our first priority at all times.

PS:
This statement was not supported at the time by Greg Hill the then Production Director, both he and the 1999 internal Audit Team protested to Greg Hill who led the Shell Crisis Management Team. As part of the evidence that would have been provided to Grampian Police in 2008, was the transcript of a recorded conversation between the Author and the RDS Chief Internal Auditor Jakob Staushom. Staushom informed me that Hill at first, refused to issue the statement, he had no part in writing it, it had been composed by Brinded and his legal counsel Keith Ruddock, but under threat he reluctantly did. He and Stausholm were sent to Coventry (Singapore actually) about as far away from the Hague as geography permits, they both left Shell some months later.

Appendix B: