



## **Sheriffdom of Grampian, Highland and Islands at Aberdeen**

### **Fatal Accident Inquiry**

into the deaths of

**Sean Scott McCue and Keith Scot Moncrieff**

**Sheriff Colin John Harris QC**

**18<sup>th</sup> July 2006**

**A fatal accident inquiry determination into the deaths, on the 11<sup>th</sup> September 2003, of Sean Scott McCue and Keith Scot Moncrieff on board the Brent Bravo Offshore Platform situated in the United Kingdom sector of the North Sea, has been issued today. Both men were working within the utility shaft when there was a release of liquid hydrocarbons from a temporary repair on the closed drain degasser rundown line. The released liquid evaporated, forming vapour in the shaft and as a direct consequence of inhalation of the vapour, both men died.**

The scope of a fatal accident inquiry is limited by the terms of section 6 of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 which requires the Sheriff to:

- Make a determination setting out the circumstances of the death so far as they have been established;
- where and when the death and any accident resulting in the death took place;
- the cause or causes of such death and any accident resulting in the death;
- the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided;
- the defects, if any, in a system of working which contributed to the death or any accident resulting in the death; and
- any other facts which are relevant to the circumstances of the death.

The inquiry, which was ordered by the Procurator Fiscal for the District of Aberdeen, sat on 38 days, during which the evidence of 61 witnesses was taken. Following submissions on behalf of each of the parties represented, the inquiry concluded on the 25<sup>th</sup> January 2006.

### **Summary of the Main Finding**

Shortly after 3.30 pm on the 11<sup>th</sup> September 2003 Keith Moncrieff and Sean McCue entered the utility shaft. A reasonable inference from the evidence is that the men entered the utility shaft with the intention of replacing the leaking temporary repair patch on the closed drain degasser rundown with another piece of rubber. The evidence established that the work of removing the existing neoprene patch and replacing it with another piece of rubber was work which required to be carried out under the permit to work system.

### **The inquiry found that one of the men knowingly undertook tasks within the utility shaft without first raising the permit to work procedure.**

The permit to work system is based on hazard management and is necessary to safeguard persons doing the work, personnel on board the platform, the platform itself and to comply with the relevant legislation. The work must be controlled and co-ordinated in a manner that meets all these requirements and the system is applicable to all Shell Expo locations, including the Brent Bravo Offshore platform, and *it is mandatory*.

A permit to work is required for all work in the Brent Bravo utility shaft which is not normally undertaken as part of watchkeeping duties. . Had a permit to work been raised it would have required an isolation of that section of the closed drain degasser rundown line prior to work commencing.

Since the accident on Brent Bravo, Shell Expo have upgraded the permit to work system to ensure that it is fully computerised and faster to set up and developed a tighter regime governing temporary repairs to the pipe work. (page 55)

### **The accident which resulted in the deaths of Sean Scott McCue and Keith Scott Moncrieff might reasonably have been prevented if:**

- (i) an appropriate temporary repair had been applied to the hole on the closed drain degasser rundown line, such as a fully engineered repair, and not a repair using a neoprene patch and jubilee clips;
- (ii) the temporary repair had been appropriately managed in order that a replacement spool could have been fitted within a reasonable time on a section of a safety critical line which was known to be corroding;
- (iii) the permit to work system had been followed which would have involved a risk assessment resulting in an isolation and drain down of that section of the closed drain degasser rundown line prior to any attempt to remove the neoprene patch;

### **Defects in the system of working which contributed to the accident which resulted in the deaths were;**

- (i) a failure to clearly set out the limits which applied to the work which could be carried out in the utility shaft under the operations umbrella, and a

failure to ensure that personnel on board the Brent Bravo offshore platform clearly understood those limits;

- (ii) a failure to carry out a robust risk assessment of the possible consequences of starting up the platform on 22 August, 2003 in the knowledge that emergency shutdown valve EZV 44715 had failed to operate within specification when tested during the annual platform shutdown.

During the course of the inquiry it became apparent that evidence relating to the condition of certain valves on the platform might be relevant to the cause of the deaths of the two men, or have contributed to the incident which resulted in their deaths. However certain evidence, such as the possible consequences to the structure of the platform and its crew, of the ignition of vapour within the utility shaft, while of consequence to the offshore oil industry and those who work on it, was beyond the scope of the 1976 Act and more appropriate for consideration at an inquiry of a more general nature.

**NOTE**

**This summary is provided to assist in understanding the Court's decision. It does not form part of the reasons for that decision. The full report of the Court is the only authoritative document.**

The full Fatal Accident Inquiry report will be available from 10.00 am today on the Scottish Courts Website at this location:

<http://www.scotcourts.gov.uk/opinions/FAIMCCUE.html>

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