

# Shell UK fined £560,000 following major hydrocarbon release

A large offshore oil and gas company has been sentenced and fined £560,000 after failing to properly maintain pipework for seven years.

Pipework on Shell UK's Brent Charlie platform in the North Sea deteriorated to such an extent that contained hydrocarbon fluids escaped, forming a potentially catastrophic explosive and flammable mixture that could have ignited.

In addition to the release, ventilation fans designed to prevent, control or mitigate the effects of escaped hydrocarbon gas did not function properly as they were also not suitably maintained. This led to a large release of mixed phase crude oil and gas from the corroded pipework.

Aberdeen Sheriff Court heard on Tuesday 25 November 2025 how, on 19 May 2017, there was an uncontrolled hydrocarbon release incident from a Return Oil Line (ROL) pipework inside concrete leg Column 4 of the Brent Charlie offshore installation. The release involved 200kg of gas and 1,550kg of crude oil – the largest uncontrolled hydrocarbon release on the UK Continental Shelf reported to HSE in 2017.

The release placed over 170 platform personnel at risk from a potentially catastrophic fire and explosion had the escaping hydrocarbon gas ignited inside the concrete leg.

An HSE investigation found that deficiencies in Shell's safety management system led to the release. The ROL pipework in Column 4 was not properly maintained for several years. The pipework was installed for short-term use and was due to be removed in 2010 but remained in place for seven years, during which time it suffered corrosion damage. It failed on 19 May 2017 and a large volume of gas was uncontrollably released into the leg. Ventilation extract and supply fans designed to prevent and mitigate this major accident hazard were also inadequately maintained, which exacerbated the risk to the 176 people on the platform.

HSE were involved in the production of the Energy Institute's [Guidance for corrosion management in oil and gas production and processing](#), as well as several other topic-specific documents. Extensive guidance and resources for the oil and gas industry are available on HSE's website here [Offshore oil and gas – HSE](#).



Spool with the corrosion failure identified.

Shell UK Limited pleaded guilty to two charges under the Offshore Installations (Prevention of Fire and Explosion, and Emergency Response) Regulations 1995 (PFEER). Sheriff Ian Duguid, in his sentencing remarks, observed that Shell UK “ought to have recognised that the temporary carbon steel spool was not suitable for such a line and should have been replaced.” After considering mitigating factors, Shell was fined £560,000.

Speaking after the hearing, HSE Offshore Health and Safety Inspector Dozie Azubike said: “At more than 1,750kg, Shell Brent Charlie’s hydrocarbon release was the largest reported to HSE in 2017. This release occurred in a confined space with limited access – it is simply fortunate that no one was in the leg at the time, or they could have been asphyxiated from the hydrocarbon-rich atmosphere, quite apart from any fire and explosion risk.

“Although the offshore industry has managed to reduce its overall number of hydrocarbon releases, in most years there are still several which, if

ignited, would result in potentially catastrophic consequences.

“This case highlights the importance of oil and gas dutyholders reviewing their current management of change processes for temporary spools and their subsequent removal, strengthening inspection regimes to identify potential internal corrosion within pipework, and ensuring that inspection frequency of safety-critical equipment considers full analysis of the equipment’s maintenance history.”

#### **Further Information:**

1. [The Health and Safety Executive](#) (HSE) is Britain’s national regulator for workplace health and safety. We are dedicated to protecting people and places, and helping everyone lead safer and healthier lives.
2. More information about the [legislation](#) referred to in this case is available.
3. Further details on the latest [HSE news releases](#) is available.
4. Relevant guidance can be found here [Offshore oil and gas – HSE](#)
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## **[Fine for company after man seriously injured at wind farm](#)**

- Incident happened at Tom Nan Clach Wind Farm near Inverness.
- Worker was seriously injured following electrical flashover.
- HSE guidance is available.

A wind farm management services company has been fined £80,000 after a worker was seriously injured by an electrical flashover.

Natural Power Services Limited had sent the then 38-year-old to carry out maintenance work in an electrical substation within the Tom Nan Clach Wind Farm, near Inverness on 23<sup>rd</sup> June 2020. His injuries resulted in him sustained life-changing injuries that have required multiple surgeries.

An investigation by the Health and Safety Executive (HSE) found that the incident happened following a departure from the prepared switching

programme. This meant work was allowed to be carried out on one of the two electrical cabinets while the other remained live, allowing part of the electrical system to be energised during the maintenance work.

The HSE investigation found that had the initial switching programme prepared by Natural Power Services Limited been correctly followed, the incident would not have occurred. The company did not have a suitable system or process in place to check or review switching programmes to ensure that the procedures were correctly observed at all times, or to approve any changes to the initial switching programmes.

Free guidance for employers is available on the HSE website, [hse.gov.uk](https://www.hse.gov.uk), about [electrical safety](#) and [managing health and safety](#).

Natural Power Services Limited pleaded guilty to breaching Sections 3(1) and Section 33(1)(a) of the Health and Safety at Work etc. Act 1974. The company was fined £80,000 at Inverness Sheriff Court on 25 November 2025.

Speaking after the hearing, an HSE spokesperson said: "This was a wholly avoidable incident caused by the failure of the company to implement a safe system of work.

"The company should have ensured there was a suitably rigorous process for checking and reviewing the work. This would have ensured those doing the work were adhering to switching programmes in a manner that was suitable and safe.

This would have been a reasonably practicable measure to address the risks arising from the subsequent introduction of additional parallel works that might interfere with the previously planned switching programme."

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# Roofing company fined £16,650 after employee fell through skylight opening

- Employee sustained serious injuries after fall from height
- Company failed to implement safety measures for work at height activities
- Kingsley Roofing Contractors Limited fined £16,650

A Northampton roofing company has been fined £16,650 after an employee suffered serious injuries when he fell through a skylight opening.

Ryan Robinson, 31, was working for Kingsley Roofing Contractors Limited to recover a flat roof of single-storey extension at a domestic property on Sywell Road in Northampton.

Covers that had been installed over two large skylight openings had to be removed as part of preparation. Mr Robinson fell through one of these openings whilst removing material from the other, falling over three metres to the ground. His injuries required surgery and long-term treatment.

An investigation by the Health and Safety Executive (HSE) found that Kingsley Roofing Contractors Limited failed to properly plan work at height activities and implement measures that would have prevented their employees from falling through the skylight openings.

HSE guidance states employers must ensure that work at height is properly planned, appropriately supervised and carried out in a manner that is, so far as is reasonably practicable, safe. This means that control measures must be in place to prevent or protect from falls. In this case, a crash deck or safety netting under the openings would have prevented serious injury from occurring. Further guidance for working at height can be found at [Health and safety in roof work – HSE](#).

Kingsley Roofing Contractors Limited of Chartergate, Clayfield Close, Moulton Park, Northampton pleaded guilty to breaching Section 3(1) of the Health and Safety at Work etc Act 1974. The company was fined £16,650 and ordered to pay £7,205 in costs and £2,000 victim surcharge at Birmingham Magistrates' Court on 20 November 2025.

HSE Inspector, Chris Bennet, said: "Falls from height are the most common kinds of fatal accidents, accounting for over a quarter of fatal injuries to workers in 2024/25. This could be avoided through proper planning and implementation of effective controls.

"The fine imposed on Kingsley Roofing Contractors should underline to everyone in the construction industry that the courts, and HSE, take a failure to plan works at height extremely seriously. It is the duty of employers to ensure that everyone working on a building site returns home safely."

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## **[Manufacturer fined £16,000 after 18-year-old breaks arm in workplace accident](#)**

- Workplace safety failure results in serious injury to young employee

- Health and Safety Executive (HSE) found that Isoma Limited had failed to carry out a suitable and sufficient risk assessment
- Isoma Limited fined £16,000

A conveyor systems manufacturer based in Swadlincote has been fined £16,500 after an 18-year-old employee broke his arm when he became entangled in a manual lathe while deburring with emery cloth.

The incident happened on 1 December 2023 at Isoma Limited's factory at George Holmes Business Park, Swadlincote. The young employee was deburring by hand without using a protective appliance when his arm became caught in the rotating lathe.

An investigation by the Health and Safety Executive (HSE) found that Isoma Limited failed to provide a safe system of work or a risk assessment for deburring components.



Manual lathe at Isoma Ltd Factory

HSE guidance states that employers must carry out a suitable and sufficient assessment of the risks from using emery cloth to polish, deburr or size a metal component while it is rotating in a manual lathe. The risk assessment should determine whether the use of emery cloth can be eliminated completely. Where this is not practicable, a safe method of using emery cloth on a rotating manual metalworking lathe must be implemented. Relevant guidance can be found at [HSE's website](#).

Isoma Ltd, of George Holmes Way, Swadlincote, Derbyshire, DE11 9DF pleaded guilty to breaching Section 2(1) of the Health and Safety at Work etc Act 1974. The company was fined £16,000 and ordered to pay £4,357.77 in costs and £2,000 victim surcharge at Chesterfield Magistrates' Court on 20 November

2025.

HSE investigating inspector Nicole Riley said: “Every year there are accidents involving the use of emery cloths on metalworking lathes, resulting in serious injuries. This incident could have been avoided if Isoma Limited had put in place a suitable safe system of work for employees deburring workpieces on manual lathes. There is clear guidance available to companies who undertake this work.”

This HSE prosecution was brought by HSE enforcement lawyer Andy Siddall and paralegal officer Lynne Thomas.

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