

FATAL ALERT

July 8, 2006

Two mechanics that worked for a Truck Stop Service Station were working on a weekend and were directed by management to cut the tops off 55 gallon metal barrels for trash cans. The metal barrels had previously contained a flammable material. The two mechanics started working on two barrels that had been placed at the east end of the building. The one mechanic who had been with the company for 2 years chose an air chisel to cut the top off one of the barrels and then cleaned the edges up using a cutting torch. The mechanic, who had been with the company for 6 years, chose to use a cutting torch to cut the top off the barrel.

After finishing cleaning up the first barrel with the cutting torch, the mechanic with 2 years in the shop went back to working on a truck that needed repair. The mechanic with 6 years in the shop relocated to the west end of the building and began cutting on the last two barrels with a torch. He successfully finished cutting the first barrel. About that time, a junior co-worker observing the activity asked the mechanic why he was using a torch on a barrel marked with a flammable label. The mechanic ignored the question and began to cut on the last barrel. Upon cutting through the barrel with the torch, the barrel exploded. The lid of the barrel struck the mechanic in the head. The mechanic received fatal injuries.

Significant Factors:

- No formal training was provided to the torch operator regarding welding/cutting processes associated with used barrels.
- The torch operator was not authorized to use the welding equipment for this type of task.
- The torch operator was authorized to cut damaged bolts/similar items during vehicle repair work.
- Managers for the maintenance shop were off duty at the time of the accident.
- The barrels originally contained a flammable material and were labeled with warnings.
- The barrels had not been cleaned prior to being delivered to the maintenance shop or prior to being cut on by the mechanics of the maintenance shop.
- The barrels' bung caps had not been removed to allow venting while being cut on.
- The senior employee ignored a question asked about the use of the cutting torch on a barrel marked flammable. The cutting torch operator continued to use the cutting torch, causing the barrel to explode.
- All existing metal barrels on site being used as trash cans had been cut using an air chisel or similar method and had not been cut using a cutting torch.
- The task of making trash cans out of 55-gallon drums was not a routine task.
- The employer did not have written policies relating to the use of welding equipment.

Recommendations:

- Brief all employees on the facts and circumstances of this fatal mishap.
- Ensure all employees performing welding tasks understand the Wyoming OSHA welding rules.
- Enforce the Wyoming OSHA welding rules and document all non-compliance.
- Document all training accomplished relating to welding activities.
- Evaluate handling procedures for used barrels to ensure they are properly handled in the future.
- Review the National Fire Prevention Association Standards for guidance to help establish fire control methods relating to the use of welding equipment.