

FATALITY ALERT

On August 29, 2011

Two sub-contracted Company's were conducting work on a recently acquired well site accomplishing welding activities and excavation work to retrofit the site with a heater treatment unit. The retrofit required the re-routing of the current flow line from the well to the new heater treatment unit and then plumbing new lines to the two 400 barrel storage tanks.

A short time after well site acquisition the well owner and one of the sub-contracts met to discuss the general layout of the well location. This conversation was said to have been brief as the specifics of the installation were left up to the construction company that had been doing this work for the well owner some time. It was also communicated at the time that this project was a low priority and to direct assets for this construction as appropriate.

At the time of the accident the construction activities were nearing completion and there were 3 or 4 welds to be completed on lines to be tied into the back sides of the two storage tanks as well as backfilling of the trench excavation containing the newly installed lines. There were two employees from one company and one employee from another company on the well location at the time of the explosion. No one on the location at the time of the accident survived the explosion.

Due to the fact that there were no surviving witnesses to this accident, there is not a definitive explanation for the cause of this accident nor is there an explanation of events immediately leading up to the accident. Based on the physical evidence discovered at the accident location and the information derived during employee and employer interviews the following is a plausible scenario of the events leading to the accident.

Three employees were tasked to complete the tying-in of lines to the back of two 400 barrel storage tanks. Although the two companies represented by the three employees were charged with separate and distinctly different job functions, it was clear the company responsible to accomplishing the welding activities was providing direction to the other company's employees to ensure effective support was provided to the welder. It was not unusual for the employees to be working in the trench excavation as at least one weld per line had to be made in the trench during the tie in process. The tools and equipment that were discovered in the trench supported this activity.

The investigation discovered that the accident was not an occurrence resulting from a single event but rather a culmination of inadequate training of employees, poor communication, poor implementation of programs, and lack of management oversight to ensure proper program execution and implementation of programs.

Recommendations:

- Inform all employees on the facts and circumstances surrounding this fatal mishap.

- Provide all employees with adequate training that will provide them with a solid foundation for recognition and avoidance of unsafe conditions that are applicable to the work environment.
- Provide adequate training to employees deemed as competent that will deliver to them appropriate information that allows them to identify existing and predictable hazards in the working environment which are unsanitary, hazardous, or dangerous, and authorize them to take prompt corrective measures to eliminate the hazards.
- Enforce established policies and procedures.
- Ensure frequent and regular inspections of the workplace are conducted by a competent person as designated by the company.
- Effectively communicate to contractors both performance and safety requirements and expectations.
- Effectively communication to employees both performance and safety requirements and expectations.
- Provide adequate training to employees of the requirements and hazards associated with trench excavations, welding, and cutting (hot work).
- When working in remote areas with no reasonably immediate access to medical attention, ensure at least one employee on the work location is trained in first aid.