Green Oil & Field Service, Inc.
NARRATIVE #308304328

Nature/Scope Inspection:

This was a fatality called in by the employer after the 8 hour reporting requirement. Employer reported that employee had been struck by the crank-arm of an oil pumping rig. The inspection commenced the same day that the employer reported. That being 13Apr06.

Opening Conference:

CSHO opened the inspection in Roundup at the office of Green Oil & Field Service, Inc. CSHO made appropriate introductions; presented credentials; and discussed scope and purpose of inspection -- the fatality. Employees were not available on the day of the opening as they were not required to report for work that day, as a result of the loss of their friend. They were interviewed the following day, Friday, 15Apr06.

Note for Reader: Appendix for completing OSHA 36 embedded in this narrative.
Note for Reader: EEP Appendix A & B located at end of narrative.

Workplace Observations:

The events unfold that morning of 6Apr06 with a work assignment at the pumping unit. Three persons traveled to the job site. Foreman Carlson, [Mr. Dawson (deceased)] and Ex. 7(C) — They reported working on both ends of pumping unit. Around 11 the finished activities on motor and went to get parts for pump. Unit was operational. When they returned to work on motor, Foreman Carlson reported that he view Mr. Dawson in contorted and unnatural movements and this observation motivated him to yank on the brake. This was in the 11:30 to 11:45 range. The victim was pinned between ground and under counter weight. The local ambulance responded first, approximately 15 minutes after the event and they called for more support for the Flight for Life from Billings. The Flight for Life crew is reported to have arrived approximately 30 minutes after the local crew. The Flight for Life crew determined that the transition of the deceased was complete.

This inspection unfolds in three parts: the opening at the office in Roundup; the investigation of the scene of the event out in the oil field; and interviews the following day. The opening and the investigation of the scene of the death occurred on 13Apr06. The interviews of employees were conducted on the next day, 14Apr06.

At the office, CSHO learned the particulars for that establishment. After, we traveled to the site of the oil well, which was fairly remote, generally reported to be 12 miles E & 2 miles N of Melstone, MT. Mr. Elbert Carlson, Jr. and I traveled to the site in separate vehicles. The rig was not in operation. Mr. Carlson explained what he and directed in terms of the work to be accomplished at the rig and what he understood to have happened. He was in Red Lodge at the time of the event. The work crew of three persons was directed by his foreman, Mr. Guy Carlson.

CSHO looked to the guarding around the pump and observed that it was in place. Much of the discussion centered on the rescue effort, which involved local ambulance service and the Flight for Life had been dispatched from Billings, too. They crew from the Flight for Life reported/ pronounced the victim dead shortly after their arrival.

Their rescue efforts were hampered by the fact that the crank-arm not only struck the victim but pinned him to the ground. The rescue personnel had to devise a means of pulling or straining the crack arms and counter-balances which are very heavy to retrieve the body.

What they were to be doing:
The crew was assigned to fix a motor on one end of the pumping unit and repair a pump at the other near the horse head. They reported that they had finished the work on the motor and had traveled (all three) in a vehicle to get another part and returned to work on the pump. Members of the crew reported it was the work or the conclusion of the work on the pump, when the incident happened. The foreman, Mr. Guy Carlson reported that there was no reason for the victim to have been in the area. Mr. Guy Carlson also reported that he remembered seeing the victim failing with un-natural human body motion and believes that the victim may have been struck twice. Mr. Carlson reported running from the truck parked near by to pull the brake. Naturally, anything that heavy with momentum continued to travel and eventually landed in such a manner that the victim was pinned between the crank-arm and the ground.

Everybody agreed that at the time the accident transpired that crank arms were rotating. The company did not have a written lock tag out program. Mr. Elbert Carlson, Jr. told me that LO/TO does not apply to the oil patch.

During the interviews with the foreman, CSHO learned that this company works in environments that contain H_2S and that they work in confined spaces and they used supplied air while working inside tanks with a diameter of six feet and they weld and engage in abrasive blasting, as well.

CSHO has used 3 outside documents from the American Petroleum Institute to learn about the processes involved and the fatality CPL for guidance:

1. API Recommended Practice 54 Third Edition, August 1999
2. API Recommended Practice 49, Third Edition, May 2001
3. API Recommended Practice 11ER (RP 11ER) Second Edition, January 1, 1990

Mechanical Power Transmission:	Citation proposed.
Machine Guarding:	N/A (See Mechanical Power Transmission above.)
Hazard Communication Program:	Citation proposed.