Wyo

FATALITY NARRATIVE

Philip Pepper
True Drilling
D6780//307813261/100980820

Date & Time of Accident:
12/22/04 at approximately 10:45 PM.

Notification:
Arland Taylor, Safety Manager for True Drilling, reported the fatality to OSHA on 12/22/04 at 11:29 PM.

The Investigation:
On Thursday, 12/22/04 following notification of the fatality and assignment of the case, investigators John Watterson and Ken Lantta from Wyoming Workers' Safety contacted Arland Taylor, Safety Manager for True Drilling, to arrange to meet at the location to begin the investigation. The rig was located approximately 60 miles West of Rawlins, off I-80 on Red Desert Road near Wamsutter. The rig was located on the North side of I-80 approximately 3 miles from the highway. The rig was identified as True Rig # 31 Red Desert. Upon arrival on location (11:15 AM), I was met by Arland Taylor, company Safety Manager for True Drilling. I confirmed that the rig had been secured since the accident. All operations had ceased pending the arrival of OSHA investigators. While waiting for investigator Lantta to arrive, I conducted the opening conference with Arland Taylor and Tool Pusher Robert Schilling. I learned during the opening conference that the well owner is True Companies, being drilled by True Drilling. A consulting company, Directional LLC, was contracted by True Companies to provide a drilling consultation service on site, representing the owner. The consultation company's on site representative was Jack Hout. There were no other subcontractors on site at the time of the accident. During the opening conference, I explained the investigation process. Arrangements were made to interview employees who may have been involved with or had knowledge of the events leading to and including the accident. While waiting for investigator Lantta to arrive, I began the interview process starting with Arland Taylor, Safety Manager for True Drilling.

After investigator Lantta arrived on site and upon receiving verbal permission from Arland Taylor, Safety Manager for True Drilling, investigators took still photos and video of the accident scene. Further interviews were conducted with employees that were available on site. At 5:30 PM on 12/23/04, the site was released for work to resume. We continued interviews into the evening at the man camp at Table Rock. In trying to accommodate crews working three rotating shifts, we continued interviews at the man camp the following morning. Further interviews with True Drilling management were conducted in Casper on 01/20/05.

A Coroner's Report with photos, toxicology report, and Sweetwater County Sheriff's report were obtained and are included in this investigation file.

The photos, videos, reports and testimony are on file at the Wyoming Workers' Safety office in Cheyenne.

Points of Clarification:
There are three companies involved with this fatality investigation.
They are:

1. True Companies: Owner of the well and prime contractor on location.
Henceforth referred to as: True Companies

2. True Drilling Company: Drilling company drilling the natural gas well for True Companies (a subcontractor for True Companies).
Henceforth referred to as: True Drilling

3. Directional LLC: Drilling Consultants (subcontractor for True Companies).
Henceforth referred to as: Directional LLC

Definitions:
*Note: This is not an attempt to give detailed in-depth descriptions of the entire functions of personnel or equipment, just a brief description of basic functions.

Derrick
Uppermost structure of drilling rig used to support Drawworks, Blocks and Drilling Line

Boards
This is a platform that is installed within the rig derrick that provides the Derrickman a place to stand while he is positioning the drilling pipe in preparation for making the connection. While he is on this platform, he must be protected by fall protection equipment.

Drawworks
This is the working heart of the drilling rig. It is basically a very large vertical winch system that resembles the working characteristics of a large crane. All tools used in the drilling operation are raised, lowered, or held in position by the drawworks.

Blocks
The blocks are attached to the lower most portion of the drawworks. It is a very large heavy duty lifting device. It has several sheaves that allow for the lifting cable that is operated by the drawworks to be threaded through. The cable from the drawworks run through these sheaves are called parts or multiple part lines. Each time additional parts are added, the lifting capacity of the drawworks is increased. At the bottom of the blocks is a large lifting hook, where all of the tools used in the drilling operation are hung.

Stand
This is a section of pipe, which can be of different lengths or diameters. A collar is attached to each stand of pipe and is used to connect separate stands of pipe together. The collar is attached to the derrick end of each stand.

V door
This is an opening on the Rig Drilling Floor where all Stands of pipe pass through as they are pulled and lifted from the ground up the Beaver Slide onto the Drilling Floor.

Beaver Slide
45-degree platform that allows pipe to be winched from ground level to Drilling Floor.

Personal fall arrest system

A system used to arrest an employee in a fall from a working level. It consists of an anchorage, connectors, body harness and may include a lanyard, deceleration device, lifeline, or suitable combinations of these.

Positioning device system

A body belt or body harness system rigged to allow an employee to be supported on an elevated vertical surface, such as a stabbing board, and work with both hands free while leaning. This is classified as a work positioning system only and is not a fall protection system.

Self-retracting lifeline (Retractable Lanyard)

A deceleration device containing a drum-wound line which can be slowly extracted from, or retracted onto, the drum under slight tension during normal employee movement, and which, after onset of a fall, automatically locks the drum and arrests the fall. This is designed as a fall protection device, where in the event of an actual fall the device will limit the fall to less than six (6) feet. This device is referred to as a Sala Block on the rig.

Cat Walk
Ground level platform where pipe is rolled from Pipe Rack in preparation for being winched up Beaver Slide to rig floor.

Pipe Racks
Where Stands of pipe are stored/staged at ground level prior to being used in drilling operation.

Deceased:
Philip Lynn Pepper (43 years old)

Address:
847 Moccasin
Rock Springs, Wyoming 82901

Occupation:
Derrickman

Employer:
True Drilling

Accident Site:
Rig # 31 Red Desert
Baxter Fed. 32-22
SW NE SEC. 22, T20N R95W
SWEETWATER CO., WYO
WYW 0178661

Employees Present at the time of the Accident:

Name	Firm	Job Title
Robert Schilling	True Drilling	Rig Manager/Toolpusher
Brian Bence	True Drilling	Driller
Shane Ford	True Drilling	Motor Hand
Gary Wood	True Drilling	Floor Hand
Larry Smith	True Drilling	Chain Hand
Philip Pepper	True Drilling	Derrickman
Jack Hout	Directional LLC	Drilling Consultant

Employees Interviewed During the Investigation:

Name	Firm	Job Title
Gary Hoggatt	True Drilling	Drilling Superintendent
Arland Taylor	True Drilling	Safety Manager
Rodney Warner	True Drilling	Toolpusher
Robert Schilling	True Drilling	Rig Manager/Toolpusher
Travis Smith	True Drilling	Driller
Brian Bence	True Drilling	Driller
Robert Saunders	True Drilling	Driller
Marc Lowe	True Drilling	Derrickman
Larry Smith	True Drilling	Chain Hand
Shane Ford	True Drilling	Motor Hand
Gary Wood	True Drilling	Floor Hand

** Note: Jack Hout was not interviewed because he had no direct knowledge of the accident.

Events Leading up to the Accident:

Rig 31 was rigged up on 12/09/04. During rig up, the retractable lanyard (Sala Block) attached to the derrick was damaged. The retractable lanyard is the anchor attachment point that the derrickmen attach their personal fall arrest system to while working in the derrick. The damaged retractable lanyard was removed from the derrick. Rodney Warner, Toolpusher, reported the damaged retractable lanyard to Arland Taylor, Safety Manager. Taylor said the problem was reported to him on 12/13/04. Warner said he reported the issue to Taylor on 12/10/04. There were also conflicting statements as to the extent of the damage to the retractable lanyard, who actually placed the order for the replacement, and if it was in stock at the time of order or if it was backordered. An invoice from Tool Pushers Supply shows the retractable lanyard was ordered on 12/13/04 and delivered to True Drilling's shop on the same day.

On 12/13/04, Taylor drove to Vernal, Utah. While loading his pickup for the trip, he noted a spare retractable lanyard in the bed of the truck. Taylor passed within 3 miles of the mishap rig on his way to and from Vernal, Utah. However, he didn't stop at the rig and deliver the spare retractable lanyard he had in the back of his truck.

On 12/21/04, Relief Tool Pusher Robert Schilling obtained the replacement retractable lanyard and delivered it to the mishap rig at 7:00 AM on 12/22/04. He made the decision not to install the retractable lanyard due to adverse weather conditions. However, drilling operations did not stop and men were allowed to climb the derrick and work in the derrick without the benefit of a personal fall arrest system.

On the evening tour (10:00 PM – 6:00AM) of 12/22/04, the crew assembled at Rig # 31 located at Baxter Fed. 32-22. Driller Brian Bence and Floorhand Shane Ford carpooled together and arrived on site prior to the rest of the crew. Due to slick roads, Derrickman Philip Pepper, Chainhand Larry Smith, and Floorhand Gary Wood, who also carpooled together, arrived on site about 10 minutes late for work. All of the men changed out of their street clothes and reported to the rig floor for work. Shift change was 15 minutes late due to part of the crew showing up late for work. Bence explained to the crew that the task for the evening was to trip back into the hole. Bence briefly explained to the crew that the day shift had "dropped the ball and should have already had the pipe back in the hole". The day shift was short handed and did not have an experienced derrickman.

The Accident:

Bence watched Pepper put on his safety harness and visually observed that all the straps and belts were buckled and secure. Bence further observed Pepper proceed up to the board, latch up to the positioning rope, proceed to the edge of the board to test his positioning rope, go back to get his collar rope, and put the collar rope around the first collar to go back into the hole. When Pepper pulled the first collar back to the board, the collar hit the elevator horns. So, he tried to pull it back a little harder to get the collar around the elevator horns. This caused the rope on the right hand side to slip allowing the collar to fall to the left hand side of the board (drillers side). After that happened, Larry Smith asked Bence if he wanted him to go up and help Pepper pull the collar back. Bence told Smith, "Pepper is an

experienced hand and he should be able to handle it". Bence had Ford attach the air chugger to the collar, tie it off to the A leg on the right side of the boards and pull the collar back to the board. Pepper then placed the collar rope back around the collar but the collar again slipped, this time falling to the right side of the derrick. This time it fell all the way back into the corner of the derrick pulling Pepper with it. Pepper's feet were still just barely touching the board with him stretched out near parallel to the board. Bence stated, "It looked like his derrick belt or his tie off rope slipped, because he should not have been out that far".

Pepper then hollered for help pointing down with one hand to Smith telling Smith to come up and help him. Smith turned to Bence and asked Bence if he wanted him to put a belt on prior to proceeding to the board. Bence told Smith to put a belt on and to hurry up to help Pepper. At this time, Pepper was suspended out from the board past the point of being able to recover. Ford then started up to the board without any fall protection. Concerned with Ford's actions, Bence was watching him going up the ladder when he heard a thud and a joint of pipe fall off the beaver slide and hit the cat walk. Bence proceeded to the V door, looked down and observed Pepper lying on the ground next to the pipe rack.

The crew immediately went to his aid. Smith was the first to reach Pepper and found him unconscious but still breathing. The crew covered him with coats and blankets. Life Flight was contacted, but refused to fly because of weather conditions, so Wamsutter ambulance was contacted. Within a few minutes, Pepper stopped breathing. He was turned over and the chest, arm, and leg straps on his harness were loosened. This was when the crew noticed that the waist belt was not buckled.

Smith attempted CPR with no success. The Sweetwater County Sheriff and Sweetwater County Coroner were then notified.

Findings:

- Mr. Pepper was 43 years old.
- Mr. Pepper had only worked for True Drilling for 4 days prior to the accident.
- True Drilling was working three 8-hour tours at the time of the accident.
- True Drilling had 6 employees on site.

- Shift change had just taken place.
- Weather was cold, windy, and had been snowing previously.
- Mr. Pepper was an experienced Derrickman, with 24 years experience in the oil field.
- Mr. Pepper was working under the direct supervision of Driller Brian Bence, at the time of the accident.
- When the crew rolled Mr. Pepper over to start CPR, they noticed that the waist belt strap on the safety harness was not buckled. The unbuckled waist strap allowed the D ring on the waist strap, where Mr. Pepper attached his positioning rope, to be pulled off the waist strap by the force of the fall.
- The D-ring from the harness waist belt strap was found still attached to the positioning rope that was still attached to the derrick.
- Examination of the safety harness and associated straps found no damage.
- A retractable lanyard was not rigged in the derrick for use by the derrickmen.
- The derrickmen were not afforded fall protection via a personal fall arrest system while handling pipe from the derrickman's platform.
- The distance from the platform to the derrick floor was approximately 90 feet.
- The retractable lanyard was missing from the derrick from the time of rig up through a workplace fatality involving a derrickman falling from the derrick fourteen days later.
- The well was spudded on 12/11/04 per Wyoming Oil & Gas Conservation Commission records.
- The fatality occurred on 12/22/04.
- During this interim period while drilling activity was being conducted, on at least three occasions a derrickman worked from the derrick platform while handling pipe.
- Company supervisory personnel were aware of the missing fall protection equipment and associated regulations, but did not abate the hazard.
- The derrick was rigged up on 12/09/04.
- During rig up, the retractable lanyard was damaged.
- The damage was noted by the Toolpusher, Mr. Rodney Warner.
- The Toolpusher reported the damage to Mr. Taylor on:
    a. According to Mr. Taylor's statements on 12/13/04
    b. According to Mr. Warner's statements on 12/10/04
- Invoice from Tool Pushers Supply shows replacement retractable lanyard was ordered on 12/13/04 and delivered to True Drilling's shop on the same

day.

- The damaged retractable lanyard was removed from the rig and placed in the toolpusher's trailer on 12/09/04.
- The Toolpusher, Rodney Warner, did not report the retractable lanyard as defective to the Drilling Superintendent or Assistant Superintendent. Taylor was the senior company official who knew of the defective fall protection equipment.
- Mr. Taylor drove to Vernal, UT on 12/13/04. While loading his pickup for the trip, he noted a spare retractable lanyard in the back of the pickup.
- Mr. Taylor left the spare retractable lanyard in the back of his pickup during his trip to and from Vernal.
- Mr. Taylor passed within 3 miles of the rig enroute to and from Vernal. He did not stop at the rig or deliver the spare retractable lanyard.
- The replacement retractable lanyard ordered from Toolpushers Supply was available to True Drilling on 12/13/04. It was actually picked up on 12/21/04 by Robert Schilling who drove to Rawlins that afternoon, and to the rig location arriving at 7 AM on 12/22/04.
- Drilling logs show activity associated with employees in the derrick during the following tours & dates:
  a. 12/22/04 (tripping out of hole) from 1200 hrs. –1400 hrs. with Robert Saunders as the Driller and Mike Beguart as the Derrickman.
  b. 12/22/04 1400 hrs. - 2200 hrs. with Troy Smith as the Driller and Marc Lowe as the Derrickman.
  c. 12/22/04 (going back in the hole) 2200 hrs. - 2210 hrs. (time of accident) with Brian Bence as the Driller and Philip Pepper (deceased) as the Derrickman.
- Derrickman Marc Lowe, who was on the tour immediately prior to the mishap, said during recorded interview that he knew the retractable lanyard was not available. Further, he said he did not like to use them and would not have hooked up to it even if it had been available.
- Driller Brian Bence was on Mr. Pepper's tour. During recorded interview, he acknowledged he knew the retractable lanyard was not available in the derrick. He said he did not stop operations – the Derrickman climbed to the boards.
- Driller Troy Smith on another tour (with Derrickman Marc Lowe) acknowledged he knew the retractable lanyard was not in the derrick but did not stop operations.

- The Drillers (Bence, Saunders, Smith) did not stop operations due the following reasons per recorded interviews:
  a. They felt that they did not have the authority.
  b. Feared repercussions if they shut down operations.
- The Lead Toolpusher for the rig, Rodney Warner, acknowledged during recorded interview that he did not stop operations involving men in the derrick even though he knew the retractable lanyard was not present.
- The Relief Toolpusher, Robert Schilling, brought the replacement retractable lanyard to the rig when he arrived at 7 AM on 12/22/04. He said during the recorded interview that he made the decision to not install the new retractable lanyard in the rig due to weather considerations. He said he did not stop drilling operations and allowed men to climb the derrick to continue with tripping operations.
- Mr. Pepper's first time into the derrick was on the mishap tour. The tours prior he had not climbed the derrick since drilling was being conducted.
- Mr. Pepper arrived at the drilling rig for his tour about 15 minutes late on the evening of 12/22/04. He rode out to the rig with Larry Smith and Gary Wood who were other members of his crew.
- Upon arrival at the rig, Mr. Pepper donned the personal fall arrest system body harness and ascended the rig to the boards. He was not told by either the driller or pusher that a retractable lanyard was not rigged.
- Mr. Pepper worked in the derrick for about 10 minutes before falling to his death.
- Mr. Pepper had not been provided with a medical evaluation during his employment with True Drilling as required per the company respiratory protection program for employees wearing respirators.
- Mr. Pepper had not had respirator fit testing during the period of his employment with True Drilling.
- The company hired Mr. Pepper after drilling began at this location. He was hired due an unplanned vacancy resulting from an employee quitting.
- The well was spudded on 12/11/04. Mr. Pepper was hired on 12/18/04.
- After being hired, Mr. Pepper did not turn in any new employee documents including a company job application, IRS W-4 form, INS W-9 form, next of kin information, etc.
- Mr. Pepper was deemed an experienced derrickman from the interview conducted with the Toolpusher, Rodney Warner, and the Tour Driller, Brian Bence.

- Mr. Pepper went to work immediately after reporting for work on his first tour. His tour worked from 10:00 p.m. to 6:00 a.m. seven days per week.
- The Safety Manager, Arland Taylor, had not visited the rig while Mr. Pepper was an employee.
- True Drilling "operates a fully accredited in-house drilling contractor program" per the International Association of Drilling Contractors Rig Pass ® website http://www.iadc.org/rigpasshse/schools.htm. Per the website:

  The HSE *RIG PASS* accreditation system was designed to meet two requirements:
  a. To identify core elements of training programs for new rig employees.
  b. To provide a means of recognizing programs that adhere to those elements.

  - The Rig Pass ® program includes an employee orientation checklist; available at: http://www.iadc.org/rigpasshse/sco-05.pdf
  - True Drilling had a workplace fatality in June 2001 when an employee fell from the derrickman's platform.
  - True Drilling includes the requirement for using fall protection equipment in the company written safety program. Interviews with other employees on the mishap rig revealed they did not use or desire to use fall protection equipment.
  - The autopsy report revealed that Mr. Pepper had a full beard.
  - The Derrickman's duties when not in the derrick include being the mudman – mixing the chemicals and water to form drilling mud.
  - Chemicals used in drilling mud include caustic soda, Baroid, Baro-trol, Polyac Plus, Pac-R, bicarbonate of soda, and Aquagel. Drilling reports show that caustic soda was mixed on Mr. Pepper's tour on 12/20/04 and 12/21/04. He was the Derrickman on these tours.
  - Mud mixing in the confines of the mudroom requires respiratory protection per the MSDS information.
  - Full beards and tight fitting, negative pressure respirators are not compatible due inadequate face sealing.
  - Mr. Pepper had not received training of any type between his date of hire and the fatal mishap – this included respiratory protection training, safety training, and new employee orientation training.
  - Drilling logs show the dates and tours when mud-mixing operations

occurred. Pepper was on tour on the following dates: 12/18/04, 12/20/04, 12/21/04, and 12/22/04, day of accident. Mud mixing occurred on these tours and Mr. Pepper was the Derrickman.

- In May 2005, True Drilling had personal air sampling of the mud mixing operation done at two of their rigs, one of which was Rig #31. The air sampling was stated to be representative of the mud mixing operations at all rigs. The results of the air sampling indicated that employees were not exposed to air contaminates above OSHA PELS. Based on these results, True Drilling stated they were removing respirators from their rigs.
- Autopsy findings indicate death was from multiple trauma. Toxicology report showed deceased was positive for amphetamines, methamphetamines, and THC.

Analysis and Conclusions:

During recorded interviews, it was established that the employer representatives were aware of the Wyoming Oil & Gas Drilling Rules fall protection requirements. The representatives included the drilling superintendent, the safety manager, the rig toolpushers (primary and relief), and three drillers. Further, the Wyoming Oil & Gas Drilling rules for fall protection had been incorporated into company written safety policy, which was also known by these employer representatives.

The condition of fall protection not being available occurred during rig up on 12/09/04, when the retractable lanyard system was damaged. Shortly after the retractable lanyard was damaged during rig up, the Primary Toolpusher notified the Safety Manager. Between the time the well was spudded and the fatal mishap on the night of 12/22/04, there were several occasions when Derrickmen were engaged in work from the derrick board. In each of these instances, the on- duty Tool Pusher and the Driller were aware of the fall protection deficiency and continued with the work. Even after the replacement retractable lanyard arrived on site at 7:00AM on 12/22/04, it was not immediately installed. The reason given was that the weather was too bad for the employee to climb the derrick to install the retractable lanyard. Yet, employees continued to climb the derrick to access and work from the derrick board.

When the Safety Manager was advised of the damaged retractable lanyard, he placed an order for a replacement part. He concurrently had a replacement part in his pickup truck, but did not expedite its delivery to the rig location. During the period when the part was on order and a replacement was in his pickup truck, the Safety Manager drove his pickup truck to a Utah site. He passed within a few miles of the rig when traveling to and from Utah. The Safety Manager did not deliver the replacement retractable lanyard he knew was in his truck to the rig. The Toolpushers and Drillers at the rig location continued with drilling operations which included having Derrickmen working from the derrick boards on several occasions without fall protection.

When Mr. Pepper was positioned for CPR after he fell from the derrick, the crew noticed that the waist belt strap on his safety harness was not buckled. Bence stated that he watched Pepper put on his safety harness just prior to climbing up to the derrick board. Bence also stated that all the straps and belts were buckled and secure. Examination of Mr. Pepper's harness did not reveal any broken or defective parts. Given those observations, Mr. Pepper would have had to unbuckle the waist belt strap on his harness after he reached the derrick board. He may have done that because the waist belt was uncomfortable around his waist. Another reason is that he may have been trying to get a little more reach from the positioning rope in order to reach the pipe that he was having trouble catching. It is also possible that Mr. Pepper's judgment may have been impaired since the toxicology report indicated he was positive for amphetamines, methamphetamines, and THC. It is highly unlikely that he was able to unbuckle the waist belt on his safety harness after his body was stretched out near parallel to the derrick board, which was just prior to his falling. Regardless of why or how Mr. Pepper unfastened the waist belt on his safety harness, he would not have fallen had he been provided and used a personal fall arrest system for fall protection as required by Wyoming OSHA rules. Even with the waist belt unfastened, the safety harness would have stayed on Mr. Pepper. The reason is that the safety harness would have been connected to an overhead retractable lanyard at the D ring located between Mr. Pepper's shoulder blades. That D ring would have stayed on the harness, unlike the waist belt D ring which separated from the harness when Mr. Pepper fell.

It is also reasonable to conclude that had the waist belt on the safety harness been fastened properly, the positioning rope may have kept Mr. Pepper from falling more than the length of the rope. That would depend on the condition of the rope and whether it would hold the forces involved without failure. Since the positioning rope is not a fall arrest system, serious injury could still result from a fall where the only protection is the harness and positioning rope.

The following have been determined to be significant factors related to this fatality:

- When the crew rolled Philip Pepper over to start CPR they noticed that the waist belt strap on the safety harness was not buckled.
- The D-ring from the safety harness waist belt strap was found still attached to the positioning rope that was still attached to the derrick.
- High employee turnover.
- Lack of training for new employees.
- Failure by supervisors to replace damaged key safety equipment.
- Supervision not enforcing established company safety rules.
- Company not providing safe work environment to employees.
- Lack of a company pre-employment and random drug-screening program.
- The deceased should have hooked his fall protection harness to an overhead retractable lanyard, but the retractable lanyard was not available.
- Testimony from another derrickman working on the same rig stated that he would not and did not use the retractable lanyard when it was available. This reflects a lack of fall protection training and enforcement.
- Lack of safety awareness and breakdown in safety on this rig.
- Drillers on mishap rig indicated they didn't stop operations for safety problems because they didn't think they had the authority and feared repercussions from management.
- True Drilling Supervision did not inform all the members of the tours that the retractable lanyard was not available for use.
- Deceased's toxicology report showed he was positive for amphetamines, methamphetamines, and THC.

Recommendations

- All employees need to understand that production never takes precedence over safety and any employee can stop an operation that is unsafe without fear of repercussions.
- When problems arise, such as high employee turnover and subsequent lack of training, safeguards need to be implemented to ensure safety is never compromised.
- Establish policy that a detailed Job Safety Analysis (JSA) is done prior to starting any job.
- More training in the recognition and evaluation of potential hazards.
- Train personnel to do a new hazard assessment when plans are changed.
- Ensure that all personnel required to use fall protection equipment are properly trained.
- Provide a pre-work indoctrination to all personnel.
- Improve communications within the company to ensure safety issues are handled properly.
- Implement mandatory pre-employment drug screening.
- Implement aggressive random drug testing program.
- Duties of Safety Manager should be intensified and only be safety related, with adequate resources made available to provide for timely rig inspections and training of employees, especially new hires.
- An aggressive policy of holding all supervisors directly responsible for safety needs to be established and strictly enforced.
- Discourage any activity that encourages production over safety.
- Brief all employees on the facts and circumstances of this accident.
- Ensure that damaged safety equipment is replaced immediately.
- Ensure that work requiring the use of safety equipment is only allowed when the necessary safety equipment is in place and serviceable.
- Top management needs to become more involved to ensure that safety is a top priority in the culture of the organization.

This report, together with its incorporated findings, relates specifically to this particular incident. The employer and employees continue to have the responsibility for inspection and investigation towards compliance with safe operating practices as outlined in the applicable rules and regulations.

The above investigation and findings of the accident occurring to:

Philip Lynn Pepper
847 Moccasin,
Rock Springs, Wyoming 82901

Is set down and attested to this date:

Date: _____

_____
John R. Watterson
Safety Compliance Officer