SECRETARY OF LABOR,

Complainant,

v.

KEY ENERGY SERVICES, INC., and its successors,

Respondent.

OSHRC Docket No. 99-1530 & 99-1993
(CONSOLIDATED)

APPEARANCES:

For the Complainant:
Brian A. Duncan, Esq., Suzanne Dunne, Esq., Office of the Solicitor, U.S. Department of Labor, Dallas, Texas

For the Respondent:
George R. Carlton, Jr., Esq., Godwin, White & Gruber, Dallas, Texas

Before: Administrative Law Judge: James H. Barkley

DECISION AND ORDER

This proceeding arises under the Occupational Safety and Health Act of 1970 (29 U.S.C. Section 651 *et seq.;* hereafter called the "Act").

Respondent, Key Energy Services, Inc., and its successors (Key), at all times relevant to this action maintained a place of business at the Garcia Lease Well #5, 3.5 miles west of FM 2221 & 7 Mile Road, where it was engaged in servicing an oil well. Respondent admits it is an employer engaged in a business affecting commerce and is subject to the requirements of the Act.

Following an explosion resulting in a fatality at the work site on April 8, 1999, the Occupational Safety and Health Administration (OSHA) began an inspection of Key's work site at the Garcia Lease Well. OSHA's investigation was initiated on April 9 and was completed on May 7, 1999. On August 6, 1999, as a result of the inspection and investigation, Key was issued citations alleging violations of the Act together with proposed penalties. An additional citation was issued under a second docket

number on September 8, 1999. By filing a timely notice of contest Key brought these proceedings before the Occupational Safety and Health Review Commission (Commission).

The citations were consolidated for hearing, and on June 7, 2000, a hearing was held in Corpus Christi, Texas. The parties have submitted briefs on the issues and these matters are ready for disposition.

Docket # 00-1993, Alleged Violation of §5(a)(1)

Serious citation 3, item 1 alleges:

Section 5(a)(1) of the Occupational Safety and Health Act of 1970: The employer did not furnish employment and a place of employment which were free from recognized hazards that were causing or likely to cause death or serious physical harm to employees in that employees were exposed to a fire/explosion and struck-by hazards:

> At the Garcia Lease Well #5 during well workover operations in April 1999, the employer did not protect employees from the recognized hazard of performing work on the well without positive well control and then not working safely with a well under pressure, as referenced in the API Recommended Practice 54 (1992), Paragraph 5.3.4 which states, "Prior to initiating well servicing operations, the well shall be checked for pressure and if pressure is indicated, the operator's authorized person shall be notified; then proper steps should be taken to remove pressure or to operate safely under pressure before commencing operations." During the work an employee was fatally struck by flying parts from Vacuum Truck No. 402 where the cargo tank exploded while catching an overflow of petroleum oil/gas via direct connection to the casing side of the well.
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> Among others, one feasible and acceptable abatement method to correct these hazards would be to circulate the oil/gas mixture to stabilize pressures throughout the well (i.e. between down hole and the surface) and halt all work until positive well control has been established and maintained. Wells with the potential for oil/gas pressure surges should not be directly connected to unrated pressure tanks (closed systems).

Facts

It is undisputed that the Garcia Lease Well #5 was operated by Mueller Engineering prior to and including April 7 and 8, 1999 (Tr. 7, 10, 76). On April 7, 1999 Key Energy Services, formerly Dawson Production Services (Tr. 23, 102-03), began a "workover" operation on the well, converting it from a gas-lift well, wherein the operator injects gas into the ground, pressurizing the well and forcing the oil in the ground formation up the well bore, to a pump well (Tr. 6, 10, 17, 32, 42).

Damacio Pena, Jr. has been an oil rig supervisor with Key since 1981, and has worked in the oil field since 1974 or '75 (Tr. 24, 76). Pena testified that the gas-lift supply to the well bore had been shut off, and any gas remaining in the well was being bled down when the Key crew arrived at the Well #5

work site on April 7, 1999 (Tr. 33, 76-79). Pena stated that although Mueller had removed the pressure gauge from the needle valve, he could hear the gas escaping through the valve as it was bled off (Tr. 34). Pena stated that he could gauge, by the pitch of the whine of the gas passing through the needle valve, how much pressure was in the well (Tr. 34). Pena testified, that, as the well didn't have much pressure, they removed the bull plug with the needle valve, and bled down to atmosphere within five or ten minutes (Tr. 35). Key began working about 8:00 a.m., erecting their rig, and installing blowout preventers (Tr. 35, 80; Exh. C-12). The Key crew then ran 22 stands of pipe into the hole (Tr. 36-37). Pena testified that at some point during the operation, a small amount of residual gas and oil worked its way to the surface and began to come over the blow-out preventers (Tr. 36, 38, 81). Pena testified that a well that is "gassing" will continue to flow, spilling oil and emanating vapors which are both flammable and toxic if inhaled (Tr. 30). Pena acknowledged that gas coming out of the #5 well on April 7, 1999 was a safety hazard, and that it was important to "kill" a well before working on it (Tr. 29, 38). Pena stated that, consequently, the decision was made to kill the well, by dumping oil down the bore; the oil would create a hydrostatic cap and contain whatever gas and oil might be rising out of the well (Tr. 37-38). Between 5:00 and 6:00 p.m. Pena dumped 60 barrels of oil down the casing to keep the well from "kicking"[1] (Tr. 35, 40; Exh. C-12). Pena testified that the addition of oil or salt water to kill a well is standard practice in the industry (Tr. 38, 96).

The Key crew found no pressure on the well when they arrived on the work site on April 8, 1999 (Tr. 44). Rather, the fluid level in the well had dropped, creating a slight vacuum (Tr. 84). Pena testified that his crew finished going into the hole with their pipe, and took down their blowout preventers and set up the pump (Tr. 45; Exh. C-13). Pena stated that there was no evidence that any pressure was coming off the well (Tr. 45). Pena's crew then ran fifteen 25' x 3/4" rods down the pipe (Tr. 46). During this period oil began to flow out of the pump casing valve (Tr. 46; Exh. C-16). Pena testified that, based on his experience, because the well bore was full to the top, every time they ran a rod into the hole, oil was displaced, and was backing up into the pump casing (Tr. 46). Pena stated that he could see the oil welling up the rod stripper as the rods were going in; the oil level would then fall as the oil dribbled out the valve, which was lower on the pump casing (Tr. 47). Pena stated that whenever

[1] While Pena used "kick" to describe the result of gas rising to the surface of the well bore, Complainant's expert witness, Randy McClay, defined a "kick" as the entry of fluids from the surrounding formation into the well bore at the bottom of the hole (Tr. 150). Key's expert, Ronald Britton, described a "kick" as "drill[ing] into an unexpected high-pressure zone" (Tr. 290-91).

they stopped running rods, the oil would stop leaking out (Tr. 47, 85, *See also,* testimony of Pena's operator, Ruben Duron, Tr. 129, 144).

Pena admitted that a well that was previously under control might re-pressurize (Tr. 67, 69). Pena testified that he keeps an eye on the well for signs that it is going to kick, such as an uncontrolled flow (Tr. 67, 93). In this case, Pena stated that if the #5 well had been under pressure, he would have expected some gas to migrate to the surface overnight (Tr. 68). Pena testified that the #5 well never gave any indication that it was going to kick, or was under any pressure not controlled by the 60 barrels of oil he had put into the well (Tr. 82).

The Citation

Citation 3, item 1 alleges a violation of the general duty clause, §5(a)(1) of the Act. In order to prove a violation of §5(a)(1) the Secretary must show that: (1) a condition or activity in the workplace presented a hazard to an employee, (2) the hazard was recognized, (3) the hazard was likely to cause death or serious physical harm, and (4) a feasible means existed to eliminate or materially reduce the hazard. The evidence must show that the employer knew, or with the exercise of reasonable diligence could have known, of the violative conditions. *Tampa Shipyards, Inc.*, 15 BNA OSHC 1533, 1991-93 CCH OSHD ¶29,617 (Nos. 86-360, 86-469, 1992).

A recognized hazard has been defined as a practice, procedure or condition under the employers' control that is known to be hazardous either constructively, *i.e.*, by the industry in general, or actually, by the cited employer in particular. *Pelron Corporation*, 12 BNA OSHC 1833, 1986 CCH OSHD ¶27,605 (No. 82-388, 1986). Citation 3, item 1 states that the hazardous condition present at Key's work site was that of performing work on the well without positive well control, and of not working safely with a well under pressure. Complainant points to Key's Employee Safety Handbook, which states that "[p]ositive well control is to be established when the job first begins and maintained at all times" (Exh C-2), as evidence that Key recognized the cited hazard. The Complainant also points to American Petroleum Institute's (API) Recommended Practice 54 (1992), Paragraph 5.3.4 which states:

> Prior to initiating well servicing operations, the well shall be checked for pressure and if pressure is indicated, the operator's authorized person shall be notified; then proper steps should be taken to remove pressure or to operate safely under pressure before commencing operations.

(Tr. 238-40; Exh. C-3).

Key's employee handbook, and the testimony of Key's own witnesses, Pena and Britton, set forth below, establish that Key actually recognized the need to ensure positive well control, and to work safely with a well under pressure. However, Key maintains that on April 8, 1999 the #5 well was under

positive control, and that there was no pressure on the well. That is, Key argues that the described hazardous conditions were not present.

Expert Testimony

Randy McClay, a consulting chemical and petroleum engineer with experience in workover operations (Tr. 146-47, 149), testified for the Complainant. McClay testified that the #5 well was not under positive control on April 8, 1999 (Tr. 203). McClay testified that when a well is under positive control, there is a no flow condition in the well bore because of the static pressure at the bottom of the hole (Tr. 155). According to McClay, positive well control is established when no fluid enters the well bore, and none comes to the surface (Tr. 155). McClay testified that the mere fact that oil was coming out of the casing valve on April 8, 1999 should have alerted Key personnel that the #5 well was not under positive control (Tr. 182, 203-04).

McClay believed that if the #5 well was under positive control, the insertion of rods into the well tubing should have displaced fluid from the tubing into the reservoir at the bottom of the well. That fluid should have increased the pressure in the reservoir at the bottom of the bore; the pressure in the reservoir would then exceed the pressure exerted on it by the formation from whence the oil originally came, and the oil would be forced back into the formation through perforations in the bottom of the well bore (Tr. 168-74, 183, 201; Exh. C-16). McClay testified that the space between the tubing and the casing, called the annulus, is a separate system, and the pressure on the fluid in the annulus is independent of the pressure in the tubing (Tr. 157-58, *See also* testimony of R. Britton, Tr. 282; Exh. C-16). McClay opined that the rise in the fluid level in the annulus, which then leaked out the pump casing, was caused by a gas, or gas cut oil entering the bottom of the well bore (Tr. 151-52, 158, 174). According to McClay, a little gas bubble at the bottom of the bore would expand as it rose up the annulus, raising the level of the fluid in the annulus until it broke the surface (Tr. 151-52). McClay testified that had Key maintained positive control of the well, the pressure on the reservoir should have prevented any gas or gas cut oil from moving from the formation into the well bore (Tr. 201-03).

Ronald A. Britton trained as a mechanical engineer with options in petroleum and has more than 30 years of experience (Tr. 266-67). Britton is a board-certified forensic diplomat in engineering technology, and is the manager and general partner of an engineering consulting firm, Rohill Operating Company, for whom Randy McClay once worked (Tr. 266-68).

Britton agreed that it is the responsibility of the well servicing crew to continue to monitor the pressure of a well during a workover operation (Tr. 289). However, Britton testified that once the pressure on a well has been removed, it is sufficient to watch the well for signs that pressure may be

rebuilding (Tr. 289). It was Britton's opinion that the 60 barrels of oil Key dumped down the well on April 7, 1999 created a hydrostatic cap sufficient to overcome any pressure from the bottom of the well, as evidenced by the slight vacuum found on the well head on the morning of April 8 (Tr. 279, 300). It is not possible, Britton stated, that gas, or oil-cut gas entered the reservoir where the hydrostatic pressure of the cap was sufficient to push fluid back into the formation (Tr. 300-01). Britton testified that the pressure at the bottom of the well was in equilibrium on April 8, and that *because* it was in equilibrium oil being forced from the bottom of the tubing by the insertion of the 3/4" rods would, in fact, create a U-tube effect, forcing fluid around the bottom of the tubing and up into the annular space, which is not closed off by any physical means (Exh. 280-81, 302-03, 305; Exh. C-16). Britton testified that there is a set rate at which a formation can accept fluid back into it; Britton explained that when oil is forced into the reservoir in excess of that rate, the rods act like a plunger or syringe, forcing oil out the other end, or, in this case, out of the pump casing valve (Tr. 304, 309). Britton opined that is what was happening on April 8, 1999 (Tr. 309).

Britton testified that the observations of Key's crew on April 9 do not support Randy McClay's theory, in that a gas bubble expanding as it rose to the top of the bore would create an ever increasing flow of oil as more fluid is displaced in the annular space. The flow of oil would not start and stop with the addition of rods (Tr. 293, 306).

Discussion

This judge finds that Complainant did not carry its burden of establishing a violation of §5(a)(1) of the Act, in that it did not establish that Key failed to maintain positive control of the #5 well, or that Key did not perform its work safely given the amount of pressure on the well.

"Positive well control" is defined neither by Key's employee handbook, nor by the API; however, based on the expert testimony, and solely for the purpose of deciding this matter, this judge finds that positive control is established when the hydrostatic pressure exerted on the reservoir by the fluid in the well bore prevents gas, or oil-cut gas from entering the well from the formation.

According to Complainant's witness, McClay, the flow of oil from the pump casing proves that the hydrostatic pressure Key created by dumping 60 barrels of oil down the well was inadequate to prevent gas, or oil-cut gas from migrating into the reservoir and up through the annular space of the well casing. Key's expert maintains that the correlation of the flow of oil from the pump casing to the insertion of rods into the well bore proves that the pressure on the well bottom was static. Britton explained, to this judge's satisfaction, how the set rate at which the formation will accept, or reabsorb, fluids will result in a U-tube effect, forcing fluid up to the open space at the top of the well bore. Stated

differently, the spillage of one to one and a half barrels of oil at the rig was merely the result of displacement caused by insertion of the rods into the well, and was not the result of reservoir pressure forcing oil or gas up the well, or of a lack of positive control.

Key's expert credibly accounts for the flow of oil at the pump casing. Standing alone, the contrary opinion of Complainant's witness is insufficient to establish that the 60 barrels of oil placed into the well on April 7, 1999 was no longer positively controlling any pressure that might have been on the well on April 8, 1999.

Because Complainant failed to establish the existence of the cited hazard, citation 3, item 1 is vacated.

Docket # 99-1530 - Alleged Violation of §5(a)(1)

Serious citation 1, item 1 alleges:

Section 5(a)(1) of the Occupational Safety and Health Act of 1970: The employer did not furnish employment and a place of employment which were free from recognized hazards that were causing or likely to cause death or serious physical harm to employees in that employees were exposed to a fire/explosion hazard:

> At the Garcia Lease Well #5 during well workover operations, the employer did not protect employees from the recognized hazard of venting potentially flammable offgas vapors directly under the truck in close proximity to the immediate work area and potential ignition sources (e.g. truck engine and exhaust system). On April 8, 1999, an employee was fatally struck by flying parts from a vacuum truck where the cargo tank exploded while accepting an overflow of petroleum oil/gas mixture via direct connection to the well head.
>
> Among others, one feasible and acceptable abatement method to correct these hazards is to vent potentially hazardous offgas from vacuum truck tanks to a safe location, as referenced in the API Publication 2219 (1986), Paragraph 7.4 which states, "When volatile flammable or toxic liquids are loaded, the vacuum pump exhaust should be vented downwind of the truck by attaching a length of hose sufficient to reach an area that is free from hazards and personnel" (see 7. 1).

Facts

Pena testified that between a barrel and a barrel and a half of oil spilled onto the ground (Tr. 64). Pena stated that he spoke to Charlie Montgomery, Mueller's company man (Tr. 25), asking him what he wanted to do about the oil, to keep it from making a mess on the ground (Tr. 48). Pena testified that, normally, Key uses its own open top skid tank to collect oil spills (Tr. 48-49, 54). In this case, however, Montgomery told Pena that he would get a vacuum truck; the truck would be hooked up to the casing valve to collect the oil that was spilling (Tr. 48). Pena testified that he has used the open

topped tank to collect oil overflows countless times; he has used a vacuum truck for that purpose two or three times in the past 19 years (Tr. 54-55).

A vacuum truck provided by J & R Valley Oil Field Services (Tr. 10), arrived at the well site after lunch that afternoon (Tr. 56). Pena testified that he could not recall whether it was he or Montgomery who explained the job to the driver, or whether the driver was specifically told he would be collecting oil (Tr. 56-57). Pena was sure the driver could see the spill, and knew he would be working with oil (Tr. 57). A hose was attached to the valve where the oil was leaking and fed into the vacuum truck (Exh. C-16). Pena testified that because the truck was sitting at a lower elevation than the pump valve, it was not necessary to turn on the vacuum pump, the oil would "gravity feed" into the tank (Tr. 65-66).

Pena testified that he told the driver to be sure his vent was open before they opened the valve on the pump casing (Tr. 59). Pena testified that the vent, or overflow valve, is connected to a line that goes through the tank to a dome in the top front of the tank (Tr. 61). The overflow valve prevents the tank from pressurizing as oil displaces the air in the tank (Tr. 61-63). The displaced air travels down the line and is vented underneath the tank (Tr. 60-63; Exh. C-18). *See also,* testimony of Ronald Britton (Tr. 274).

Both Pena and Duron believed that there was no gas in the oil coming out of the well and being fed into the vacuum truck (Tr. 95, 137). Pena testified that only displaced air was being vented out the overflow valve (Tr. 95). Duron knew, however, that the vacuum truck engine was running while the truck was hooked up to the wellhead (Tr. 132).

Randy McClay testified that the #5 well was producing light crude, which is a volatile fluid containing concentrations of hydrocarbons that are gaseous at standard atmospheric conditions, *i.e.*, methane, ethane, propane, butane (Tr. 184). McClay testified that before feeding light crude into a vacuum truck, one should draw out all the oxygen with the vacuum pump so as not to create an explosive mixture; the vacuum pump exhaust should be vented to a remote area downwind, away from personnel and ignition sources (Tr. 186-87). McClay stated that his analysis of the oil remaining in the hose of the vacuum truck, which is the subject of this citation, showed that there were "light ends" in the oil that was being fed into the truck, which would have vaporized when exposed to atmosphere (Tr. 194). McClay believed the vacuum pump should have been running, but stated that, even though it was not, the tank, which had a potential for collecting and emitting combustible vapors, should have been vented away into a safe area away from the pulling unit engine (Tr. 187-88, 193-94).

The Complainant also introduced the March 1999 API Publication 2219, ¶5.1.1 **Hazards of Vacuum Truck Operations**, which states:

> Although using vacuum trucks provides a fast, safe and efficient method of cleaning up spills and removing liquids, tank bottoms, solid materials and waste from tanks and vessels in petroleum facilities, incidents have occurred during vacuum truck operation.
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> * * *
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> Vacuum truck owners and operators, as well as facility personnel, should be aware of the numerous potential hazards associated with vacuum truck operations in petroleum facilities, including, but not limited, to the following:
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> a. *Sources of ignition, including vacuum truck engine and exhaust heat*; pump overheating; faulty or improper electrical devices; static electricity discharges; and outside ignition sources such as smoking, motor vehicles, stationary engines, etc.
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> b. Potential hazards including spills; flammable atmosphere within and around the vacuum truck, cargo tank, or source container; hose failures; and *discharges of flammable vapors to the atmosphere from the vacuum truck*, or the source, or the receiving container; and worker exposures to toxic vapors, liquids, or solids.
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> c. Potential hazards associated with the surrounding area and atmospheric conditions during the vacuum truck operations. There is a potential for discharged vapors to exceed PELs for exposed workers and/or to collect in low spots, particularly during atmospheric inversions and especially with high humidity when no wind is present. In addition, *vapors should not be discharged onto roadways or other areas where sources of ignition may inadvertently occur*. (emphasis added).

OSHA Compliance Officer (CO) Craig Weber testified that the 1986 API at ¶7.4 indicates that the petroleum industry specifically recognizes a hazard arising from the venting of gasses from flammable or toxic liquids into areas where personnel or ignition hazards are present. That paragraph provides:

> When volatile flammable or toxic liquids are loaded, the vacuum pump exhaust should be vented downwind of the truck by attaching a length of hose sufficient to reach an area that is free from hazards and personnel.

(Tr. 212-12; Exh. C-4).

Weber stated that he learned, through interviews with employees on the site, that no hose was attached to the tank vent (Tr. 217). Weber testified that vapor vented from the tanker could accumulate, forming a combustible vapor cloud (Tr. 220). Weber testified that the truck engine, which was running as the tank was being loaded, could have provided an ignition source (Tr. 219).

Ronald Britton acknowledged that the oil that was spilling from the #5 well would give off fumes (Tr. 285, 295). Britton stated that the fumes would accumulate in the vacuum tanker [instead of dissipating

"all over the location," as they would if the oil spill had been caught in an open tank] (Tr. 285, 295). Britton apparently assumed that the vapors would be vented from the truck, however, because he testified that the absence of a hose on the tank vent did not create a hazard. Britton believed that because the wind on the work site was coming from the southeast, it would have blown any gasses venting from the truck away from personnel, all of whom were working on the west side of the truck (Tr. 275).

Discussion

Key argues that the API paragraph specifically mentioned in the citation ¶7.4 is inapplicable to the cited situation because the vacuum pump was not in operation, and was not exhausting vapors from the tank. Key maintains that the Secretary failed to establish that the venting of the tanker through the overflow valve constituted a recognized hazard.

This judge agrees that ¶7.4 is not specifically applicable to the cited circumstances; however, Key is not charged with a violation of the advisory API standard at ¶7.4, it is charged with violating §5(a)(1). As noted above, a "recognized hazard" for purposes of establishing a violation of §5(a)(1) is any condition under the employers' control that is known to be hazardous either constructively, *i.e.*, by the industry in general, or actually, by the cited employer. *Pelron Corporation, supra.* The testimony of the expert witnesses provides ample evidence that the petroleum industry recognizes the potential for discharges of flammable vapors from crude oil. The provisions of the 1999 API warn both truck operators and facility personnel to be aware of the potential for discharges of flammable vapors from vacuum trucks. Its provisions are not limited to the vacuum pump exhaust. Finally, The API specifically recognizes the danger of discharging such vapors into areas where sources of ignition are present. Paragraph 5.1.1 of the 1999 API specifically recognizes vacuum truck engines and exhaust heat as ignition sources.

The Complainant has shown that a reasonable person familiar with the petroleum industry would recognize a hazard in the venting of potentially flammable offgas vapors directly under a truck in close proximity to the immediate work area and potential ignition sources, in this case a running truck engine and exhaust system.

The cited condition presented a hazard to Key's employees that was likely to cause death or serious physical harm. Key, through its supervisory personnel, Pena and Duron, knew both that the tanker was being vented at the bottom of the tanker, and that the vacuum truck engine was running. Key personnel should have known that, not only air, but flammable vapors coming off the crude being pumped into the tank would be vented through the overflow valve.

Finally, the hazard could have been eliminated or materially reduced either by removing the ignition source, *i.e.*, shutting off the truck engine, and/or by venting the tanker away from potential ignition sources.

Though Key did not own the vacuum tanker or employ the truck's operator, Key's rig supervisor did exercise some control over the operation, directing the truck operator to be sure to open the tanker's vent. The record establishes that Key should have recognized the danger the running truck posed to its own employees and taken measures to protect those employees beyond relying on the wind to carry vapors away from the vacuum truck. The cited violation will be affirmed.

Penalty

A penalty of $5,000.00 has been proposed for this item. Key is a large company (Tr. 241). There can be no question that the explosion of a vacuum tanker gives rise to a "substantial probability" of death or serious physical harm including death, and so constitutes a "serious" violation under §17 of the Act. Seven Key employees were exposed to the fire and explosion hazards posed by the cited condition (Tr. 220-21). The gravity of the violation is high. CO Weber testified that no reductions in the size of the penalty were given for history or good faith, because Key had received other "serious" citations within the prior three years (Tr. 241).

Key introduced no evidence mitigating the Secretary's characterization of the violation. I find that the $5,000.00 penalty proposed is appropriate, and will be assessed.

Alleged Violation of §1910.1200(e)(2)(ii)

Serious citation 1, item 2 alleges:

29 CFR 1910.1200(e)(2)(ii): The employer did not develop, implement, and maintain at each workplace a written hazard communication program which included the methods the employer uses to inform the other employer(s) of any precautionary measures that need to be taken to protect employees during the workplace's normal operating conditions and in foreseeable emergencies:

> The employer did not develop and implement an effective written hazard communication program which addressed methods to inform other employers assisting in its operations of the hazards of handling, storing, and transporting crude oils generated/emitted during well workover operations on oil and gas wells.

Facts

CO Weber testified that Key failed to comply with the cited standard in that, if its hazard communication (Hazcom) program did contain provisions for informing other employers of the hazards associated with crude oil during normal operating conditions, those provisions were not implemented (Tr. 223). Weber believed that the driver from J & R knew he was going to be receiving crude oil (Tr. 247). However, Weber maintained, no one from Key ever met with the driver from J & R to discuss necessary precautions for the safe loading of the oil (Tr. 223). Specifically, Weber stated, Key should have discussed the safe venting of offgasses from crude oil with the driver (Tr. 226, 228).

Kenneth Houston, the Division Safety Director for Key, testified that Key has a Hazcom program, a copy of which was at the #5 well site (Tr. 258). Houston testified that the program contains a material safety data sheet (MSDS) for crude oil (Tr. 258). Houston stated that Key had a reasonable expectation that the driver for J & R had received training from his own employer, and was familiar with the hazards associated with crude oil (Tr. 259). Houston did not believe it was Key's responsibility to educate the employees of other service providers on the site (Tr. 260).

Discussion

The cited standard provides:

> *Multi-employer workplaces.* Employers who produce, use or store hazardous chemicals at a workplace in such a way that the employees of other employer(s) may be exposed. . . shall additionally ensure that the hazard communication programs developed and implemented under this paragraph (e) include the following:
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> * * *
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> (ii) The methods the employer will use to inform the other employer(s) of any precautionary measures that need to be taken to protect employees during the workplace's normal operating conditions and in the foreseeable emergencies;. . ..

Complainant alleges that Key's Hazcom program failed to comply with the cited standard in that it did not include methods for informing other employers of precautionary measures that they should take to protect their own employees. Key's Hazcom program was never introduced into evidence, however. Complainant maintains, that even if Key's Hazcom program was adequate, Key violated the cited standard in failing to *implement* their program by discussing safe means of loading crude oil into a vacuum truck with J & R's vacuum truck driver. Key does not address the adequacy of its Hazcom program, but maintains that, in any event, the cited standard does not require that it train the employees of other employers. This judge agrees.

The cited standard states that when an employer produces, stores, or uses hazard materials on a work site, its Hazcom program must include methods for providing Hazcom information to other employers who will have employees working on the site. Complainant introduced no evidence establishing the contents of Key's Hazcom program. Nor did Complainant establish what, if any, information was possessed by, or provided to, J & R Valley Oil Field Services about the materials on the #5 well site. Instead, Complainant seeks to establish a violation by showing that Key did not discuss the hazards of working with crude oil directly with J & R's employee, the tanker driver. Insofar as Complainant bases its citation on any duty Key might have to train J & R's employees, this judge finds that the citation is contrary to the plain language of the standard, which requires only that J & R be supplied with any information it might need to train its own employees. Additionally, the Secretary's contention that "due diligence requires [Key] to develop and

implement a plan for ensuring that *all* individuals working near flammable oil and gas are advised of hazards and protected" is contrary to established case law in the Fifth Circuit, in which this case arises. The Court of Appeals in that circuit has held that the Act creates no duty to non-employees. *Melerine v. Avondale Shipyards, Inc.*, 659 F.2d 706 (5th Cir. 1981).

Because the Secretary failed to show, by a preponderance of the evidence, either that Key's Hazcom program was deficient, or that J & R was not provided with the required information, this item will be vacated.

Alleged Violation of §1910.23(c)(1)

Repeat citation 2, item 1 alleges:

29 CFR 1910.23(c)(1): Open sided floor(s) or platform(s) 4 feet or more above the adjacent floor or ground level were not guarded by standard railing (or the equivalent as specified in 29 CFR 1910.23(e)(3)(I) through (v)), on all open sides:

> At Garcia Lease Well #5 during well workover operations, employees were exposed to a fall hazard of 4 feet 7 inches from the rig floor to ground. The open floor on the east side was missing a guardrail entirely. The west side had a 38-inch gap between guardrail panels. The south side of the floor had a similar gap between guardrails.

The Dawson Production Services Rig #3016 was previously cited for a violation of this Occupational Safety and Health Standard or its equivalent Standard which was contained in OSHA Inspection #300234796, Citation #01, Item #C02, Issued on 03/25/98.

Facts

The evidence establishes that the workover rig platform was completely unguarded on the east side, and that there were unguarded gaps in the railing on the south and west sides (Tr. 70, 229-32; Exh. C-19, C-20). Both Pena and Duron testified that the east guardrails were removed to make it easier for the employees on the ground to pass rods up to the two Key employees working on the rig platform (Tr. 70-72, 139-40). Pena testified that they were not passing materials through the open space, or V-door, on the south, and that the opening should have been guarded with a chain (Tr. 73; *See also* Duron's testimony, Tr. 141-42). The third opening was intended for ladder access, however, Pena testified that their ladder was too long and was not installed (Tr. 87).

CO Weber testified that Key had been cited for the identical standard in 1998 (Tr. 234-35; Exh. C-5).

Discussion

The cited standard provides:

> Every opensided floor or platform 4 feet or more above adjacent floor or ground level shall be guarded by a standard railing (or the equivalent. . .) on all open sides except where there is entrance to a ramp, stairway or fixed ladder.. . .

While the evidence clearly shows that the opensided rig platform was inadequately guarded, the citation cannot be affirmed in the absence of evidence establishing that the rig platform was four feet or more above the ground. Because the Secretary failed to show that the platform was more than 4 feet above the adjacent ground, this judge cannot determine the applicability of §1910.23(c)(1), and the citation must be vacated.

ORDER

Docket 99-1530

1. Serious citation 1, item 1, alleging violation of §5(a)(1) is AFFIRMED, and a penalty of $5,000.00 is ASSESSED.

2. Citation 1, item 2, alleging violation of §1910.1200(e)(2)(ii) is VACATED.

3. Citation 2, item 1, alleging violation of §1910.23(c)(1) is VACATED.

Docket 00-1993

1. Citation 3, item 1, alleging violation of §5(a)(1) is VACATED.

/s/

James H. Barkley
Judge, OSHRC

Dated: August 28, 2000