

FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

OFFICE OF ADMINISTRATIVE LAW JUDGES
601 New Jersey Avenue, N.W., Suite 9500
Washington, D.C. 20001

March 7, 2007

SECRETARY OF LABOR,	:	CIVIL PENALTY PROCEEDING
MINE SAFETY AND HEALTH	:	
ADMINISTRATION (MSHA),	:	Docket No. SE 2006-12
Petitioner	:	A. C. No. 01-01247-66219
	:	
v.	:	
	:	
JIM WALTER RESOURCES, INC.,	:	No. 4 Mine
Respondent	:	

DECISION

Appearances: Thomas A. Grooms, Esq., Office of the Solicitor, U.S. Department of Labor, Nashville, Tennessee, on behalf of the Secretary of Labor;
Guy W. Hensley, Esq., Jim Walter Resources, Inc., Brookwood, Alabama, on behalf of Jim Walter Resources, Inc.

Before: Judge Zielinski

This case is before me on a Petition for Assessment of Civil Penalties filed by the Secretary of Labor (“Secretary”), pursuant to section 105 of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 815 (“Act”). The petition alleges that Jim Walter Resources, Inc., (“Jim Walter”) is liable for four violations of the Secretary’s regulations applicable to underground coal mines, and proposes the imposition of civil penalties in the amount of \$18,714.00. A hearing was held in Birmingham, Alabama, and the parties filed briefs after receipt of the transcript.¹ The parties agreed to settle one of the alleged violations during the course of the hearing, and made an oral motion to approve the settlement. That motion will be granted. For the reasons set forth below, I find that Jim Walter committed two of the three remaining alleged violations, and impose civil penalties in the amount of \$9,300.00 for those

¹ Respondent’s reply brief included references to portions of a deposition transcript that were not in evidence. The Secretary moved to strike that text and a footnote alluding to the absence of charges under section 110(c) of the Act. The paragraph beginning on the bottom of page seven of Respondent’s reply brief and carrying over onto page eight is hereby stricken. The motion as to the footnote is denied. The Secretary had requested leave to supplement the record with portions of Woods’ deposition, but did not timely do so. The Secretary’s motion for an extension of time, and Respondent’s motion to supplement the record with portions of Church’s deposition, were denied by Order dated December 4, 2006.

violations.

Findings of Fact - Conclusions of Law

Jim Walter operates an underground coal mine, the No. 4 Mine, near Tuscaloosa, Alabama. Like most mines in the area, it is “gassy,” liberating over seven million cubic feet of methane per day. As a result, it is subject to 5-day spot inspections by the Secretary’s Mine Safety and Health Administration (“MSHA”), pursuant to section 103(i) of the Act. 30 U.S.C. § 813(i). On June 8, 2005, John M. Church, an MSHA inspector, conducted a spot inspection at the No. 4 Mine. He was accompanied by Steven E. Womack, an inspector-in-training.

After meeting with management officials and reviewing pertinent documents, including preshift reports, Church and Womack entered the mine. They were accompanied by Arnold G. Loggins, a miners’ representative, and Jimmy E. Brackner, Jim Walter’s associate safety supervisor. Church knew from prior experience that the No. 8 section, or mechanized mining unit, was being mined with an experimental piece of equipment, and that the mining method created difficulties in maintaining proper ventilation. He determined to inspect the No. 8 section, and proceeded to that location.

The “experimental” miner was a Voest-Alpine combination continuous miner and roof bolter. Jim Walter was trying the machine out in the hope that it would be more efficient in developing longwall mining sections. It was a “full face” miner, which made turning corners while mining more difficult, and required that working faces be ventilated with an auxiliary fan and tubing, rather than line curtain. Because of the properties of the Alpine miner, a modified mining procedure was used on the No. 8 section. Only three entries were driven, instead of the usual four, and entries were driven 240 feet deep before connecting crosscuts were mined. Appended to this decision is a copy of exhibit G-8, a sketch depicting the layout of the section as it existed at the time of the inspection. The far right entry, #3, was first driven in by 240 feet from the last open crosscut. While mining in the #3 entry, the auxiliary fan was located on the right side of the section, and 20-inch diameter ventilation tubing was maintained within 10 feet of the face. After that entry was mined, line curtain was installed to maintain face ventilation, and the auxiliary fan was moved to the #1 entry. Ventilation tubing was placed in the #1 and #2 entries. The #1 entry was driven, and the next crosscut, referred to as the #1R entry, was partially driven.² The Alpine miner was then moved into the #2 entry and line curtain was installed in the #1 and #1R entries. As noted below, the line curtain in the #2 entry, as depicted on the exhibit, was not installed until after the Alpine miner had broken down and it was apparent that the auxiliary fan would be turned off.

Primary ventilation was supplied by multiple main mine fans, which forced nearly 70,000 cubic-feet-per-minute (“CFM”) of air through the section. Intake air flowed in the #2 and #3

² The #1R entry, the beginning of the next crosscut, was also referred to as the No. 1 to 2 entry.

entries. A check curtain was placed in the #2 entry, outby the last open crosscut, to force the intake air into the #3 entry. At the time of the inspection, line curtain had been installed in the #3 entry to direct the intake air to the face. It then flowed outby on the left side of the #3 entry into the last open crosscut. Because the auxiliary fan had been turned off, check and line curtains had been installed to channel the air inby to the face in the #2 entry, then to the #1 entry and over to the #1R face and the #1 face. It then flowed outby on the left side of the #1 entry to the last open crosscut and out the #1 return entry.

Jim Walter followed a work schedule called “hot seating” on the No. 8 section. The midnight, or owl, shift started at 11:00 p.m. Rather than leave the work area at 6:00 or 6:15 a.m., the miners would continue working until the day shift personnel arrived and took over operation of the equipment. The day shift started at 7:00 a.m., and the owl shift did not normally get out of the mine until about 8:00 a.m. However, this schedule was not followed on June 8, 2005. The Alpine miner broke down around 3:30 a.m., and attempts to repair it were unsuccessful. The manufacturer’s representative was contacted and was scheduled to arrive later that morning. Since no mining could be done, Tommy L. Spencer, the section coordinator, directed the owl shift to leave after a regular eight-hour shift, rather than stay over for the arrival of the day shift. Tr. 252, 309.

Because the owl shift would be leaving the section before the day shift arrived, for more than one hour no miners were scheduled to be on the section. Applicable regulations require that when no one is present, auxiliary fans and other mechanized equipment must be deenergized, and line brattice (curtain) or other face ventilation control devices must be used to maintain ventilation to affected faces. 30 C.F.R. § 75.331. Jim Walter’s approved ventilation plan required that air flow of at least 3,000 CFM be maintained at each idle face. Tr. 53-54; ex. G-3.

James E. Woods, the owl shift foreman, testified that he conducted a preshift examination of the No. 8 section between 4:37 and 5:22 a.m. Tr. 301-08; ex. G-7. At that time, the auxiliary fan was operating, required ventilation was being maintained at the faces, and no unusual or hazardous conditions were found. Thereafter, he talked to Spencer, and was advised that the owl shift would be leaving before the next shift arrived. Tr. 309. He instructed the miners under his supervision, a total of 12 men, to install line curtain in the #2 entry, and to tie down the check curtains in the #2 entry and the last open crosscut.³ Tr. 311-12. He then instructed the electrician to deenergize the auxiliary fan. Tr. 318. At 6:10 a.m., he called the control room and reported the results of his earlier preshift examination, which were recorded in the fire boss book. Tr. 302. Woods testified that, as the men were finishing their assigned tasks and preparing to leave, he again traveled to the faces, found no hazardous conditions, and believed that required air flow was being maintained. Tr. 318-19. He left the section at 6:15 - 6:20 a.m. and, after exiting the mine, signed the book entry of the results of his preshift examination. Tr. 303, 315, 334, 343;

³ The first portion of the line curtain running up an entry, the part that spanned the last open crosscut, was referred to as check curtain. Tr. 312.

Ex. G-7.

Church and the rest of the inspection party reached the section about 8:00 a.m., shortly after the day shift personnel arrived. The day shift foreman was Ed Hosmer, and his crew consisted only of a laborer and an electrician, a reduced “idle” crew, because mining could not be done.⁴ Hosmer followed Jim Walter’s established practice of having his crew wait outside the section, while he traveled to the faces to check for hazardous conditions and planned the work for the shift.⁵ He discovered poor ventilation flow at the faces, and high levels of methane in the #2 and #1 and #1R faces, which he reported to the crew upon his return. He instructed the electrician to deenergize the power center and instructed the men to work on ventilation controls, i.e., to instal and tighten up check and line curtains, in order to increase ventilation to the faces and alleviate the hazardous conditions. Tr. 369-70, 375. Church and Womack had inspected a battery charger, and were in the vicinity of the power center when Hosmer returned. However, neither of them heard Hosmer relate that he had found high levels of methane.

The inspectors proceeded across the section to the belt tailpiece in the #3 entry, and traveled inby toward the #3 face. When they got to the face, it was apparent that there was virtually no air flow. Church attempted to take an airflow reading with an anemometer, but there was not enough velocity to turn the blades of the meter. Tr. 50. He determined that the 3,000 CFM of ventilation required by the approved ventilation plan was not being maintained, and issued Citation No. 7682300 for that violation.⁶ Ex. G-13. The line curtain in the #3 entry was poorly hung, with gaps at the top and bottom and at seams. Tr. 59. This allowed air to “short circuit” from the intake side to the return side without going to the face. Brackner began to assist on the curtain work. Loggins had gone to the #2 entry to work on curtains. Tr. 384-85. Church remained in the #3 entry, in the hope that ventilation could quickly be restored and he could terminate the citation. After about 20 minutes, he decided to move on to the #2 entry, in part, because he suspected that there were other ventilation problems. When he arrived he saw that new line curtain had been hung across the last open crosscut up to the #2 face, and two miners were leaving the face. Tr. 68. They told him that they had just hung new curtain in the #2 entry.⁷ Air flow at the #2 face was adequate, and there were no hazardous atmospheric conditions.

Church and Womack proceeded into the #1 entry and traveled inby, turning into the

⁴ Hosmer passed away prior to the hearing.

⁵ The crew waited at the “kitchen,” a lunch table that was set up outby the second-to-last open crosscut. Tr. 369.

⁶ Jim Walter did not contest that citation or the civil penalty that was assessed for it. It is not at issue in this proceeding.

⁷ The new curtain had been hung over some older, ineffective curtain that had been placed there by the owl shift. Tr. 374, 385.

incomplete crosscut, the #1R entry. They noticed poorly hung line curtain, similar to that they had seen in the #3 entry. They both carried “Solaris” meters that continuously monitored the concentrations of five substances in the atmosphere. Their meters were set to provide visual and audible warnings when the concentration of methane reached 1% and/or when the concentration of oxygen dropped below 19.5%. About half way to the #1R face, Church’s and Womack’s meters alarmed, and showed methane at or above 5% and oxygen content of 15.9-16.0%, both extremely hazardous conditions.⁸ Church attempted to take an air flow measurement, detected no flow, and immediately departed the area. Spencer arrived on the section about 9:45 a.m., with the Alpine representative, and immediately began to assist on the curtain work. Church and Womack encountered Spencer as they reached the #1 entry, where Church issued an imminent danger withdrawal order pursuant to section 107(a) of the Act.⁹ They then returned to the #1R entry and took bottle samples of the atmosphere. The power center had been deenergized, and the crew continued to work on the line and check curtains in an effort to remedy the ventilation problems. Ventilation was restored in the #3 entry, and that citation was terminated at 10:05 a.m. Ex. G-13. The required flow of 3,000 CFM could not be achieved in the #1R entry. Tr. 183, 392. However, the flow was sufficient to clear the methane. The power center and auxiliary fan were then reenergized, which supplied 5,700 CFM to the #1R face. Ex. G-11 p. 14. The citations and imminent danger order were terminated at 10:43 a.m. Ex. G-2, G-4, G-5.

Church issued citations based upon the conditions in the #1 and #1R entries, alleging that Jim Walter failed to follow its approved ventilation plan and failed to maintain the required level of oxygen in places where persons work or travel. He also issued a citation alleging that Jim Walter failed to conduct a proper preshift examination, because he felt that the conditions should have been discovered and corrected by Woods before he left the section. The fourth citation, which the parties have settled, pertained to a defective main mine fan door, and is not related to the other violations. The citations are discussed below in the order that they were presented at the hearing.

Citation No. 7682297

Citation No. 7682297 alleges a violation of 30 C.F.R. § 75.370(a)(1), which requires that mine operators “develop and follow a ventilation plan approved by the [MSHA] district manager.” Church described the violation in the “Condition or Practice” section of the citation as follows:

The ventilation plan was not being followed on the Number 8 Section at this mine in that adequately installed controls were not in place so as to dilute, render harmless and carry away methane gas. The line brattice installed in the Number 1 and Number 1 to 2 [# 1R] working places did not reach the mine floor, gapped

⁸ The maximum concentration of methane reportable by the meters was 5%.

⁹ Jim Walter did not contest the imminent danger order.

open along the top, had tears, and was open at the corner of the last open crosscut thus not allowing at least 3,000 cubic feet per minute of air to reach the working faces to remove a concentration of methane gas measured to be in excess of five (5) percent. When air readings were attempted in these places the vanes of the anemometer would not turn.

Ex. G-2.

Church determined that it was highly likely that the violation would result in a permanently disabling injury, that the violation was significant and substantial, that four employees were affected, and that the operator's negligence was high. A civil penalty in the amount of \$8,300.00 has been proposed for this violation.

The Violation

At the time of the inspection, ventilation controls in the #1 and #1R entries were in such poor condition that there was virtually no air flow at the faces, which resulted in the build-up of high levels of methane. Hosmer had told his day-shift crew that he found high concentrations of methane in those areas, and in the #2 entry, when he conducted his inspection at the beginning of the shift. Tr. 369. He told Brackner and Loggins the same thing when he met them in the #2 entry at the time Church and Womack arrived. Tr. 382, 406. The newly hung line curtain in the #2 entry had remedied the condition in that entry before Church arrived, but the condition continued to exist when Church inspected the #1 and #1R entries. Tr. 73, 81-87. Brackner confirmed that his detector also alarmed at those locations, and showed high levels of methane and low oxygen content. Tr. 409. A bottle sample taken by Church in the #1R entry contained 24.29% methane, well above the explosive range of 5-15%, and 15.81% oxygen, well below the required 19.5%. Tr. 81-85; ex. G-12. Air flow was woefully inadequate, and did not approach the 3,000 CFM required by the ventilation plan. Jim Walter does not dispute the fact that ventilation was inadequate in the #1 and #1R entries. The regulation was clearly violated.

Significant and Substantial

A significant and substantial ("S&S") violation is described in section 104(d)(1) of the Act as a violation "of such nature as could significantly and substantially contribute to the cause and effect of a coal or other mine safety or health hazard." A violation is properly designated S&S "if, based upon the particular facts surrounding that violation, there exists a reasonable likelihood that the hazard contributed to will result in an injury or illness of a reasonably serious nature." *Cement Div., Nat'l Gypsum Co.*, 3 FMSHRC 822, 825 (Apr. 1981).

The Commission has explained that:

In order to establish that a violation of a mandatory safety standard is significant and substantial under *National Gypsum*, the Secretary of Labor must

prove: (1) the underlying violation of a mandatory safety standard; (2) a discrete safety hazard--that is, a measure of danger to safety--contributed to by the violation; (3) a reasonable likelihood that the hazard contributed to will result in an injury; and (4) a reasonable likelihood that the injury in question will be of a reasonably serious nature.

Mathies Coal Co., 6 FMSHRC 1, 3-4 (Jan. 1984) (footnote omitted); *see also*, *Buck Creek Coal, Inc. v. MSHA*, 52 F.3d 133, 135 (7th Cir. 1999); *Austin Power, Inc. v. Secretary*, 861 F.2d 99, 103-04 (5th Cir. 1988), *aff'g Austin Power, Inc.*, 9 FMSHRC 2015, 2021 (Dec. 1987) (approving *Mathies* criteria).

In *U.S. Steel Mining Co., Inc.*, 7 FMSHRC 1125, 1129 (Aug. 1985), the Commission provided additional guidance:

We have explained further that the third element of the *Mathies* formula "requires that the Secretary establish a reasonable likelihood that the hazard contributed to will result in an event in which there is an injury." *U.S. Steel Mining Co., Inc.*, 6 FMSHRC 1834, 1836 (August 1984). We have emphasized that, in accordance with the language of section 104(d)(1), it is the *contribution* of a violation to the cause and effect of a hazard that must be significant and substantial. *U.S. Steel Mining Co., Inc.*, 6 FMSHRC 1866, 1868 (August 1984); *U.S. Steel Mining Co., Inc.*, 6 FMSHRC 1573, 1574-75 (July 1984).

This evaluation is made in consideration of the length of time that the violative condition existed prior to the citation and the time it would have existed if normal mining operations had continued. *Elk Run Coal Co.*, 27 FMSHRC 899, 905 (Dec. 2005); *U.S. Steel Mining Co., Inc.*, 6 FMSHRC at 1574. The question of whether a particular violation is significant and substantial must be based on the particular facts surrounding the violation. *Texasgulf, Inc.*, 10 FMSHRC 498 (Apr. 1988); *Youghiogheny & Ohio Coal Co.*, 9 FMSHRC 2007 (Dec. 1987).

Jim Walter's failure to comply with its approved ventilation plan directly resulted in extremely hazardous conditions, concentrations of methane that had reached the explosive range, and serious oxygen deficiencies in locations where persons were scheduled to travel and work.¹⁰ Any injury that might result from an ignition of methane or exposure to oxygen deficient air would be serious, and potentially fatal. Consequently, it is the third *Mathies* criteria that is determinative of whether the violation was S&S, i.e., whether it was reasonably likely that the hazard would result in an injury.

¹⁰ The methane most likely originated near the #1R face, in a very high concentration. Because of the virtually non-existent air flow, it remained heavily concentrated. However, as it migrated out the entry, it mixed with the existing atmosphere, at some point passing through the explosive range of 5-15%. Tr. 86.

Jim Walter's primary argument that the violation was not S&S is that it was not shown that an ignition of the methane was likely because there is no evidence of an ignition source in the section or in proximity to the methane concentration. Respondent also argues that it discovered the deficiencies in the normal course of mining operations, and that appropriate corrective action had been initiated before Church arrived. Consequently, the hazardous condition existed for a limited period of time, and would have been corrected in the normal course of operations without significant risk of injury, whether or not MSHA had appeared on the scene.¹¹ The Secretary counters that the conditions were extremely hazardous and posed grave risk of serious or fatal injuries to miners and other persons in the vicinity, including the inspectors, who were not informed of the conditions and entered the affected area.

Jim Walter's S&S argument is focused on the methane hazard, most likely because Church based part of his assessment of gravity on the possibility of an ignition. Tr. 165-67. However, as Church made clear, the hazard contributed to by the violation was a dual one, explosive levels of methane and low levels of oxygen, both of which he considered to be very serious conditions. Tr. 79-80, 101.

Church was, understandably, very concerned about explosive levels of methane on an active mining section, and was aware of previous methane ignition disasters at Jim Walter mines. Tr. 93-94; ex G-10 at 15. In analyzing the hazard presented by methane, the critical question is whether there was any likelihood of explosive concentrations of methane coming into contact with an ignition source. See *Texasgulf, Inc.*, 10 FMSHRC 498, 501 (April 1988). The Secretary points to several potential ignition sources, including the auxiliary fan, the battery charger, mobile equipment and a power center. Tr. 93-94. However, the fan, and presumably the continuous miner, were permissible pieces of equipment, and power to the fan and the miner had been cut prior to the owl shift's departure. The power center was deenergized immediately after Hosmer found the hazardous conditions. Moreover, both the battery charger and the power center were located outby the section in the intake air courses. The Secretary offered no explanation of how the methane accumulation, which would eventually be swept out the #1 return entry, could possibly come into contact with those pieces of equipment. In addition, the auxiliary fan was located outby the last open crosscut in the #1 entry. The stoppings separating the #1 entry from the #2 entry assured that, regardless of the condition of the ventilation curtains, nearly 70,000 CFM of air would be flowing in the last open crosscut between the #1 and #2 entries and out the #1 entry past the fan. Even if power somehow might have been restored to the fan, it is highly likely that the apparently limited amount of methane in the #1R entry would have been diluted well below any hazardous level as soon as it reached the last open crosscut. Whether the violation was S&S due solely to the methane hazard would be a close call. However, the violation contributed to a second hazardous condition, low oxygen levels.

¹¹ The hazardous condition most likely arose shortly after the auxiliary fan was turned off, i.e., about 7:00 a.m. It appears that Hosmer, the day-shift crew, and other personnel acted appropriately in discovering and responding to the hazard, and that it was abated by 10:43 a.m., with the assistance of Loggins, Brakner and Spencer. Ex. G-2, G-5.

Respondent argues, with respect to the S&S designation on Citation No. 7682298, which cited low oxygen levels, that no one was exposed to the hazard until the inspectors found it. It further asserts that “there is no proof that [Hosmer traveled there] or, if he did, that he would have done so in an unsafe manner.” Resp. Br. at 27. However, pursuant to Respondent’s claimed policy, Hosmer traveled to the faces to check for hazards and plan work for the shift. He found excessive methane (and presumably low oxygen levels) in the #1 and #2 entries. In its arguments on negligence and S&S, Respondent makes much of its policy and the fact that it found and was addressing the hazards. Hosmer was clearly exposed to the hazard, as were Church and Womack. Those persons were experienced and well-trained, and were equipped with monitoring devices that were able to detect the hazardous conditions. However, that does not eliminate the possibility of injury. It is also possible, although less likely, that other miners who were not equipped with monitoring devices might have been exposed. The ventilation flow, although extremely limited, would cause the dangerous atmosphere to migrate out the #1 entry where miners were working on the line curtains. Tr. 104-06.

The low oxygen levels posed an insidious hazard, to which at least three persons were actually exposed. Church was particularly concerned about the low oxygen levels, because at concentrations below 17% persons can become confused, and if they stay in such conditions fatalities can result. Tr. 101-02. He also was concerned that continued accumulation of methane might further reduce the level of oxygen, and make the condition extremely hazardous.¹²

Considering the nature of the hazards, the high level of danger posed by each, the fact that virtually everyone on the section was exposed to injury from the hazardous methane condition, and the actual exposure of three persons and the potential exposure of others to the oxygen deficiency, it was reasonably likely that a reasonably serious injury would occur. I find that the violation was S&S.

Negligence

Woods testified that he made another inspection of the section after the auxiliary fan had been turned off, and his crew had installed line curtain to the #2 face and made adjustments to other line and check curtains. All of the curtains were properly hung and weighted, were straight up and down, and were channeling the ventilation air as they were intended to do. Tr. 313-15.

¹² Respondent argues that a printout of readings from Church’s Solaris meter showed that he did not regard the conditions as serious, because he remained in the substandard atmosphere for five minutes. Resp. Br. at 27; ex G-9. However, both Church and Womack testified that they left the area immediately upon encountering the conditions. Tr. 87, 141-45, 219. Womack’s field notes also indicate that they promptly left the area, but returned to take bottle samples. Ex. G-11 at 8. The printout relied upon by Respondent does not establish that they remained in the area, but shows that they were in substandard atmospheric conditions at three times, the latter two being less than two minutes apart. The printout is consistent with Church’s and Womack’s testimony.

He found no hazardous conditions. Tr. 318-19. However, there is no doubt that at the time the day-shift foreman arrived on the section, about ninety minutes after Woods left, the ventilation controls, notably the line curtain in all of the entries and the check curtains in the #1 and #2 entries, were woefully inadequate to maintain required ventilation, and that hazardous levels of methane had accumulated as a result.

Woods testified that after he departed “any number of things” could have happened to impair the efficacy of the ventilation controls. Tr. 316-18. He cited as examples, a rib roll that could have torn down up to 70 feet of curtain, or curtain tearing from supporting structures. Tr. 316-18, 352. However, Brackner testified that he had no recollection of seeing evidence of a rib roll that would have knocked line curtain down, and there is no other evidence of such an occurrence. Tr. 412. Spencer explained that pressure generated by the main mine fans can tear curtains loose. However, he also agreed that curtains should be installed properly such that they would not be damaged by normal ventilation pressure, and he had no explanation as to how the ventilation became inadequate after Woods claimed to have verified proper ventilation after the auxiliary fan had been turned off. Tr. 274-76. There is no evidence of pressure surges, or other unusual pressures that might have produced significant damage to ventilation controls. Moreover, several witnesses described numerous defects that were clearly the result of improper installation. There were gaps of two feet or more where the curtain did not extend to the footwall in the #1 and #3 entries. Tr. 59, 70-71, 390, 411. The check curtain at the #1 entry was partially missing and the remainder was not weighted or attached to the footwall, rendering it virtually useless. Tr. 61, 215-16. There was no evidence that timbers or weights were present, from which curtains might have torn.

Woods could not have inspected the entries and found properly installed curtains, as he claimed. It is also virtually impossible that Woods could have made an inspection of the faces after the auxiliary fan had been deenergized and found adequate air flow. I find that he did not do so. He knew, from his preshift inspection, that there were deficiencies in the curtains. He should have known that the effect of those deficiencies would be exacerbated when the auxiliary fan was turned off, particularly in the #1 and #1R entries, where the curtains would then become the only means of providing ventilation. As noted below, ventilation at the #3 face must have been marginal when he conducted the preshift inspection, which should have been a signal that it would be difficult to achieve the required ventilation flow with the condition that the curtains were in.¹³

Upon consideration of the above, and the fact that, as a section foreman, Woods’ negligence is attributable to Respondent, I agree with Church’s assessment and find that Respondent’s negligence was high.

¹³ I accept the fact that Woods has a history of working in safety-related positions, and was well aware of the hazards posed by poor ventilation in gassy mines, having lost friends in previous methane explosions. Tr. 287-90. Nevertheless, the evidence that he did not conduct the second inspection that he claimed to have done is nearly overwhelming.

Citation No. 7682298

Citation No. 7682298 alleges a violation of 30 C.F.R. § 75.321(a)(1), which requires that “air in areas where persons work or travel . . . contain at least 19.5 percent oxygen.” Church described the violation in the “Condition or Practice” section of the citation as follows:

On the Number 8 Section in the Number 1 to 2 working place and working face an oxygen concentration of at least 19.5 percent is not being maintained. When measured with an approved detector, it was determined that only 15.9 percent of oxygen was present.

Ex. G-5.

Church determined that it was reasonably likely that the violation would result in an injury involving lost work days or restricted duty, that the violation was significant and substantial, that one employee was affected, and that the operator’s negligence was moderate. A civil penalty in the amount of \$1,500.00 has been proposed for this violation.

The Violation - S&S

As is evident from the discussion of the violation alleged in Citation No. 7682297, there is no dispute that oxygen concentrations in the range of 16% existed in the #1 and #1R entries, places where persons normally worked or traveled. The regulation, which specifies that air in such places be composed of at least 19.5% oxygen, was violated. Jim Walter argues that the low oxygen levels occurred because the oxygen was displaced by methane. It challenges the fact of violation, citing cases that recognize that an operator typically has no control over the release of methane and that the mere presence of methane does not establish that mandatory health and safety standards have been violated.¹⁴ Accepting the premise that the low oxygen concentration was the result of displacement by methane, Jim Walter’s argument is unavailing because it was responsible for the ventilation controls on the section, and its negligence in maintaining those controls lead directly to the accumulation of methane and the low oxygen levels.

Respondent also argues that this citation is duplicative of the ventilation plan citation, because the requirement for 3,000 CFM of ventilation was designed to ensure adequate oxygen levels and that the same actions abated both conditions. This argument too, must be rejected.

Citations and orders alleging violations of different standards arising out of the same, or related, conduct are not duplicative, as long as the standards involved impose separate and distinct legal duties on an operator. *Western Fuels-Utah, Inc.*, 19 FMSHRC 994, 1003-05 (June 1997) (citing *Cyprus Tonopah Mining Corp.*, 15 FMSHRC 367, 378 (Mar. 1993); *Southern Ohio*

¹⁴ *Drummond Co.*, 25 FMSHRC 767, 770 (Dec. 2003)(ALJ) citing *Mid-Continent Coal and Coke Co.*, 8 IBMA 204 (1977).

Coal Co., 4 FMSHRC 1459, 1462-63 (Aug. 1982); and *El Paso Rock Quarries, Inc.*, 3 FMSHRC 35, 40 (Jan. 1981)). In *Western Fuels-Utah*, the Commission held that a charge of violating a specific standard was duplicative of a charge of violating a more general standard. However, the Commission made clear that its decision was not based solely upon the premise that every violation of the more specific standard would also be a violation of the more general one. Rather, it looked to whether the operator had been cited for more than one specific act or omission. Had there been evidence of additional deficiencies that violated the general regulation, such that that allegation would not have been based upon the identical evidence used to support the violation of the more specific standard, the charges would not have been found duplicative. 19 FMSHRC at 1004 n.12.

Here, the respective provisions impose entirely separate duties, one to maintain a specific volume of air flow at the faces, the second to assure adequate oxygen content of air wherever persons are scheduled to work or travel. The evidence supporting each violation is separate and distinct, and a violation of one standard would not necessarily entail a violation of the other. The virtually non-existent air flow in the #3 entry did not result in hazardous atmospheric conditions. Conversely, as Respondent points out in its methane displacement argument, high methane concentrations, resulting in low oxygen concentrations, can occur despite air flow of 3,000 CFM or even 60,000 CFM. Tr. 111-12, 283-84, 322. Citation No. 7682298 is not duplicative of Citation No. 7682297.

I also find that the violation was S&S. As noted above, the insidious nature of oxygen deficient air, coupled with the actual exposure of at least three persons, and possible exposure of others, made it reasonably likely that the hazard contributed to by the violation would result in a reasonably serious injury. I also find that the operator's negligence was high, rather than moderate. I see no reasonable distinction between the degree of negligence attributable to Citation No. 7682297 and this one. I also find, as indicated above, that more than one person was exposed to the hazard. However, despite the rejection of Respondent's duplication argument, it is clear that the violations overlap to some extent. The oxygen deficient air was one of the hazards contributed to by the ventilation plan violation, and was instrumental in sustaining the S&S determination with respect to that citation. The proposed penalty will be reduced to reflect the fact that the hazard contributed to by this violation was substantially factored into the gravity findings with respect to the ventilation plan violation.

Citation No. 7682299

Citation No. 7682299 alleges a violation of 30 C.F.R. § 75.360(b), which requires that preshift examinations be conducted in areas where miners are scheduled to work or travel, and that the certified person conducting the examination "shall examine for hazardous conditions, test for methane and oxygen deficiency, and determine if the air is moving in its proper direction." Church described the violation in the "Condition or Practice" section of the citation as follows:

An adequate pre-shift examination was not conducted for the Number 8 Section for the day shift of 06/06/2005. The conditions called outside and recorded in the examination booklet do not reflect the actual condition of the section ventilation. Upon the day shift maintenance crew arriving on the section no changes were made to the section ventilation controls, as stated by the day shift foreman, prior to arrival on the section by MSHA to conduct a 5-day spot ventilation inspection (E02). The following conditions were found.

(1) No airflow in the Number 3 working face due to poorly installed line brattice which took a considerable amount of time to correct. Approximately 260 feet of line curtain is in place and needed to deliver sufficient airflow into the Number 1 working face.

(2) Poorly installed line brattice in the Number 1 and Number 1 to 2 working places allowed an accumulation of methane gas in excess of five (5) percent to be present and an oxygen content of only 15.9 percent. The Number 1 face is approximately 248 feet in by the last open crosscut and the Number 1-2 crosscut is mined to a depth of 115 feet off the Number 1 entry.

The line curtain mentioned was hung in such a manner that it did not touch the mine floor, had large gaps at the top and where sections of the curtain ended and another started, was open at the corner of the last open crosscut, and was torn in many locations. An adequate examination would have shown these conditions which are obvious to a casual observer much less a trained and certified pre-shift examiner. The section auxiliary fan when turned off as was the case in hand presents considerable changes to the section ventilation which must be addressed by use of line curtain. Pre-shift examinations are conducted and report[ed] so as to alert management and on-coming workers that either no hazards exist or that areas are not safe to enter which requires corrective action to be taken. This mine liberates in excess of seven (7) million cubic feet of methane gas every 24 hours. Therefore, an adequate pre-shift examination showing accurate conditions of the ventilation controls and atmosphere is essential to the health and safety of miners entering these areas.

These conditions are contributing factors to the issuance of imminent danger order No. 7682296 being issued on 06/08/2005. Therefore no abatement time was set.

Ex. G-6.

Church determined that it was highly likely that the violation would result in a permanently disabling injury, that the violation was significant and substantial, that four employees were affected, and that the operator's negligence was high. A civil penalty in the amount of \$8,300.00 has been proposed for this violation.

The Violation

The Secretary's "final legal position" on this violation is that Woods conducted an inadequate preshift examination because he "failed to identify and to correct the hazards set forth in the body of the citation, most importantly the poor condition of the line curtains, which failed to provide sufficient ventilation to the Number 3 and Number 1 right working faces." Sec'y Reply Br. at 5-6. Respondent contends that Woods' preshift examination was timely and accurately reflected that no hazardous conditions existed at the time the examination was made.

Woods conducted a preshift examination of the section between 4:37 a.m. and 5:22 a.m., which was timely under the regulation.¹⁵ He found positive air flow, no hazardous conditions, and the highest concentration of methane detected was 0.3%. Ex. G-7. He called the results of his inspection out at 6:10 a.m., they were recorded in the fire boss book, and he signed the book entry after exiting the mine. There is no evidence that any of Woods' observations were inaccurate or erroneously recorded. Church did not feel that the report of the examination had been fabricated. Tr. 119. The examination was performed while the auxiliary fan was operating, which assured that substantial volumes of air were supplied to the #2, #1 and #1R entries and faces. Tr. 319-20. Ventilation at the #3 face, which should not have been affected significantly by the auxiliary fan, was most likely marginal.¹⁶ However, there was no methane accumulation in the #3 entry at the time of Church's inspection, and there is no evidence that hazardous conditions existed in the #3 entry when Woods inspected it at about 5:05 a.m. Ex. G-7. Church acknowledged that it was possible that ventilation was adequate when Woods left the section, i.e., even when the auxiliary fan had been turned off. Tr. 117.

At the time Woods conducted the preshift examination, the line curtains in the #3 entry and in the #1 and #1R entries were most likely in poor condition, essentially as Church found them several hours later. Woods himself stated that they "weren't perfect, but [they were] doing the job [they were] supposed to do." Tr. 312. Indeed, the check and line curtains could have supplied adequate ventilation, even if they were in relatively poor condition, because only 3,000 CFM of air, less than 5% of the air flow supplied by the main mine fans, was required at the faces. While Woods should have, and apparently did, observe the obvious defects in the line curtains, those defects were not, in themselves, hazardous conditions, and had not produced hazardous conditions at the time of his inspection. Church testified that defects in ventilation control devices, like line curtains, need not be included in the report of a preshift examination, as long as the required ventilation is being supplied. Tr. 122-23.

¹⁵ The regulation requires that the preshift examination be conducted "within 3 hours preceding the beginning of any 8-hour interval during which any person is scheduled to work or travel underground." 30 C.F.R. § 75.360(a)(1).

¹⁶ Church and Spencer testified that the auxiliary fan would not have had much impact on ventilation in the #3 entry. Tr. 174, 259.

The hazardous conditions most likely developed, as Church believed, shortly after the auxiliary fan had been deenergized. Tr. 116-17. He noted in the citation that the shutting off of the auxiliary fan would result in “considerable” changes to the section ventilation. It was his position that, in order to accurately reflect the conditions on-coming workers would confront, a preshift examination should have been conducted after the fan had been turned off, even if an earlier preshift examination had been conducted. Tr. 121; ex. G-6.

The logic of Church’s “second examination” theory, which the Secretary embraced in her original brief,¹⁷ cannot be disputed. However, the failure to conduct a second preshift examination to assess conditions that may have changed after a proper preshift examination has been completed, is not a violation of the regulation. As noted by Judge Hodgdon in *Independence Coal Co.*, 26 FMSHRC 520 (June 2004) (ALJ), a preshift examination, which must be conducted within three hours of the scheduled start of the succeeding shift, typically will be completed well before the next shift arrives. Thus, the regulation contemplates that mining will continue in the interim and any number of conditions might change. However, “there is no requirement in section 75.360 that a preshift examiner revisit areas that he has already examined.”¹⁸ 26 FMSHRC at 534.

As noted above, I have found that Woods did not conduct a second examination of the faces after the auxiliary fan had been deenergized. His failure to address the obvious problems with the check and line curtains resulted in violations of Respondent’s ventilation plan and other regulatory provisions. However, it did not violate the regulation pertaining to preshift examinations, as alleged by the Secretary. The hazardous conditions noted in the citation did not exist at the time the preshift examination was done.

The Appropriate Civil Penalties

Jim Walter is a large operator, as is its controlling entity. Jim Walter does not contend that payment of the penalties would impair its ability to continue in business. All of the violations were promptly abated in good faith.

Respondent’s history of violations is set forth in exhibit G-1. Respondent objected to the admission of the exhibit on grounds that it improperly included violations issued at Jim Walter mines other than No. 4. Tr. 98-100. The exhibit was admitted over objection, and the parties were advised that they would be required to specifically address the history of violation penalty criteria in posthearing briefs. A Supplemental Briefing Order, issued on December 26, 2006, directed the parties to address the following:

¹⁷ Sec’y Br. at 31 n.6, 36.

¹⁸ While that decision is not binding, I agree with Judge Hodgdon’s rationale.

3. With respect to penalty factors, precisely identify the violation history deemed relevant, and the reasons therefor. Also indicate what effect the particular violation history relied upon, or relied upon by the opposing party, should have on the amount of any civil penalty, i.e., increase it, lower it, or none. If the pertinent consideration is the number of cited violations that have become final per inspection day, identify the particular evidence that you contend establishes the correct factor to be applied.

Despite this directive, the parties' posthearing briefs were less than helpful in shaping the issue, or in addressing the proper factors to be considered with respect to the history of violations penalty criteria. The Secretary reiterated her position that the Act requires that the violation history of the "operator" be considered, not that of a particular mine. Sec'y Br. at 37. She then presented the number of previously cited violations of the specific regulations at issue, characterized them as "excessive," "moderate" and "negligible," and argued that any penalty for a violation of the ventilation plan or the preshift regulation should be enhanced.¹⁹ While the Act requires that the violation history of the "operator" be taken into account in assessing a civil penalty, the remainder of the Secretary's argument misses the mark. It is the general history of previous violations, not the specific nature of prior violations, that is relevant to the penalty criteria. *Peabody Coal Co.*, 14 FMSHRC 1258, 1264 (Aug. 1992).

Respondent cited in its brief, 43 Fed. Reg. 23514-15, a May 30, 1978, publication of a final rule on the proposed assessment of civil penalties, and argued that it is the history of the particular mine involved that is the proper focus of the penalty criteria. However, as noted above, the Act requires that the violation history of the "operator" be taken into account. 30 U.S.C. § 820(i). Moreover, the Secretary's current rules for proposed assessments, which were published in 1982, refer to the violation history of the operator. 30 C.F.R. § 100.3. Respondent did not identify the particular evidence it relies upon for a proper evaluation of its history of violations. Nor did it explain how that factor should affect any penalty assessment.

The information provided in exhibit G-1 is of very limited value. It indicates that during the 24 month period preceding the violations at issue, a total of 2,387 violations had been cited at five separate mines operated by Respondent. Of those violations, 661 had been issued at the No. 4 Mine. The report apparently includes violations that are currently being contested, and citations that have been vacated. It contains no information as to the number of inspection days, but indicates that there has been no excessive history of violations.

¹⁹ No explanation was provided for the characterizations of "excessive" or "moderate," other than a reference to the raw numbers of cited violations, which include violations which have been contested by Respondent. References to raw numbers of violations, in the absence of some qualitative information upon which to evaluate the numbers, do not provide a proper basis for evaluating the history of violations penalty factor. *Cantera Green*, 22 FMSHRC 616, 623-24 (May 2000). *Hubb Corp.*, 22 FMSHRC 606, 613 n. 9. (May 2000).

Qualitative information was provided in the Proposed Assessment, filed as an exhibit to the Petition. It discloses that, for violations cited on June 8, 2005, there had been 608 violations issued over the course of 677 inspection days within the pertinent two-year period.²⁰ On the basis of the ratio of 0.9 violations per inspection day, eight out of a possible 20 penalty points were assigned, essentially a moderate violation history, which was taken into account by the Secretary in proposing penalties for the violations at issue. It is unlikely that that evaluation would change if it were based upon the total number of violations issued to Respondent.

On the basis of that information, it appears that Respondent has a moderate history of violations, and I so find. It also appears that that factor was appropriately taken into account in the Secretary's proposed penalties. Consequently, in considering the amount of the civil penalty to be imposed for the violations that were sustained, it will be considered a neutral factor for any penalties similar to those proposed.

Citation No. 7682297 is affirmed as an S&S violation. The gravity of this violation was serious, and the operator's negligence was high. A civil penalty of \$8,300.00 was proposed by the Secretary. In light of that consideration and the factors enumerated in section 110(i) of the Act, I impose a penalty in the amount of \$8,300.00.

Citation No. 7682298 is affirmed as an S&S violation. The gravity of this violation was serious, the operator's negligence was high, and at least three persons were exposed to the hazard. However, there was considerable overlap among Citation Nos. 7682297, 7682298 and 7682300. Essentially the same activity, restoration of the efficacy of the line and check curtains on the section, abated all three violations, and the hazardous condition contributed to by the violation charged in Citation No. 7682298 was a significant factor enhancing the gravity of the violation charged in Citation No. 7682297. A civil penalty of \$1,500.00 was proposed by the Secretary. I find that the mitigating factor outweighs the enhancement factors, and in light of that consideration and the factors enumerated in section 110(i) of the Act, I impose a penalty in the amount of \$1,000.00.

The Settlement

In the course of the hearing, the parties announced that they had negotiated a resolution of the violation alleged in Citation No. 7684427 and, by motion, sought approval of the settlement agreement. The Secretary agreed to modify the citation to specify that it was not significant and substantial. It was proposed that the penalty for that violation be reduced from \$614.00 to \$60.00. Respondent withdrew its notice of contest as to the citation, as amended. I have considered the representations and evidence submitted, and conclude that the proffered settlement is appropriate under the criteria set forth in section 110(i) of the Act.

²⁰ Curiously, the history of violations factor in the Proposed Assessment appears to be based only upon violations at the No. 4 mine, contrary to the Secretary's argument.

ORDER

Citation No. 7682297 is **AFFIRMED** and Citation No. 7682298 is **AFFIRMED**, as modified. Respondent is directed to pay civil penalties totaling \$9,300.00 for those violations. Payment shall be made within 45 days.

Citation No. 7682299 is hereby **VACATED**.

As to Citation No. 7684427, the motion to approve settlement is **GRANTED**, and Respondent is directed to pay a civil penalty of \$60.00 within 45 days.

Michael E. Zielinski
Administrative Law Judge

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