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SOL (MSHA) V. FLUOR DANIEL INC.  
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FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

OFFICE OF ADMINISTRATIVE LAW JUDGES  
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FALLS CHURCH, VIRGINIA 22041

SECRETARY OF LABOR, : CIVIL PENALTY PROCEEDING  
MINE AND SAFETY AND HEALTH :  
ADMINISTRATION (MSHA) : Docket No. SE 94-92-M  
Petitioner : A.C. No. 38-00626-05502  
v. :  
: Ridgeway Mine  
FLUOR DANIEL INCORPORATED, :  
Respondent :

DECISION

Appearances: Leslie John Rodriguez, Esq., Office of the  
Solicitor, U.S. Department of Labor, Atlanta,  
Georgia, for the Petitioner;  
Carl B. Carruth, Esq., McNair & Sanford, P.A.,  
Columbia, South Carolina, for the Respondent.

Before: Judge Feldman

This matter is before me as a result of a petition for civil penalty filed by the Secretary of Labor pursuant to section 105(d) of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. 801 et seq., (the Act). This proceeding concerns three citations issued to the respondent, Fluor Daniel Incorporated (Fluor Daniel), as an independent contractor performing services at the Ridgeway Mine. The Secretary has proposed a total civil penalty of \$15,000.00 in this matter. Fluor Daniel has stipulated that it is subject to the jurisdiction of the Mine Act in that it is a "mine operator" as contemplated by section 3(d) of the Act, 30 U.S.C. 802(d).

The hearing in this case was conducted on June 2, 1994, in Charlotte, North Carolina. Mine Safety and Health Administration (MSHA) Inspector Ronald Lee Lilly and Robert M. Friend, Supervisory Mine Inspector of MSHA's North Carolina Field Office, testified on behalf of the Secretary. The respondent called former employees Steven Crapps, William A. Reynolds and Roland C. Caldwell. The respondent also called Bruce E. Sellars, its regional safety manager for the southeast region, as well as George M. Canady III, its site superintendent at the Ridgeway Mine. (Tr. 24). The parties' posthearing briefs are of record.

Preliminary Findings Of Fact

This case involves an April 21, 1993, fatal forklift accident that occurred at the Ridgeway Mine, an open pit gold mine located near the town of Ridgeway in Fairfield County, South Carolina. The Ridgeway Mine is operated by the Kennecott Ridgeway Mining Company (Kennecott). Fluor Daniel is a publicly held corporation based in Irvine, California. (Tr. 25-26). At the time of the accident, Fluor Daniel was an independent contractor of Kennecott engaged in the performance of surface construction work at the Ridgeway mine site. (Tr. 68-69).

The cause of the accident was brake failure on a Komatsu Model No. FD135-5 forklift truck owned by Kennecott and operated on April 21, 1993, by Fluor Daniel. The forklift was routinely used by Kennecott and all of Kennecott's on site contractors, including Fluor Daniel. (Tr. 191). Kennecott contracted with the Edwards Warren Company to perform on site forklift maintenance and repair. Work that could not be performed by Edwards Warren was performed by a local Komatsu dealer. (Tr. 174). Fluor Daniel had authority to "tag out" (remove from service) the forklift if it failed to operate properly. The accident occurred when the brakes failed immediately after the engine on the Komatsu forklift had been turned off.

The basic facts surrounding the accident are not in dispute and can be briefly stated. On April 21, 1993, William Reynolds, an employee of the respondent, operated the subject forklift intermittently during the period from 9:00 a.m. until approximately 2:00 p.m. Reynolds testified that, prior to operating the forklift that morning, he tested the service and parking brake systems with the engine running and found them to be working properly. (Tr. 75-81). Reynolds testified that the respondent had a policy of pre-operation inspections of the forklift by each operator although the policy was not always enforced. (Tr. 86-87). The respondent's site superintendent George Canady also testified about the company's pre-operation inspection policy. (Tr. 291, 293). Bruce Sellars, the respondent's regional safety director testified about the company's safety program. (Tr. 285-288).

Reynolds turned the forklift over to respondent employee Steven Crapps at approximately 2:00 p.m. (Tr. 81, 92). Crapps testified the forklift was on "a very little" incline when he took it from Reynolds. (Tr. 49). Crapps could not remember the degree of incline and did not recall thinking the size of the incline was pertinent to the accident investigation. (Tr. 50). Crapps stated he conducted a walk-around inspection but did not perform any specific test on the brakes. Crapps intended to use the forklift to install 500 feet of electrical cable, which was coiled around a reel or spool, from the top of the south pit to the bottom. The spool of cable was to be loaded onto a pickup

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truck in the laydown yard with the forklift. After the electrical cable was transported to the top of the pit by the pickup, the cable was to be unloaded with the forklift. Crapps drove the forklift to the laydown yard where he loaded the pickup. He then followed the pickup with the forklift to the top of the pit where he unloaded the cable. The total trip was approximately one mile or more. Crapps testified that he did not notice any problem with the brakes. (Tr. 62-63).

Upon arriving at the top of the highwall at approximately 2:30 p.m., Crapps unloaded the cable from the back of the pickup truck and positioned it near the edge of the pit. Crew member Johnny Ray was positioned in front of the forklift between the forks attempting to guide the cable to the edge of the berm. (Tr. 38-39). As Crapps positioned the cable, he put the forklift in neutral and set the parking brake. He then shut off the engine and the forklift started to roll forward. Crapps applied the brakes and put the forklift in gear to try to stop it, but to no avail. (Tr. 39-40). The forklift traveled approximately 15 feet down a 5 to 6 per cent grade pushing Ray over the berm to the second bench about 86 feet below. The forklift was prevented from going over the highwall by the berm. Ray was evacuated by helicopter to a local hospital but he did not survive. (Ex. P-6).

An accident investigation was initiated by MSHA beginning on the morning of April 22, 1993. During the period April 22 through April 23, 1993, three citations were issued to Fluor Daniel. Combined Citation/Imminent Danger Order No. 4094231 was issued for an alleged defect of the forklift service brakes; Citation No. 4094232 cited an alleged failure of the forklift's parking brake system; and Citation No. 4094234 specified an alleged failure to inspect mobile equipment prior to placing such equipment in service.

The forklift was removed from mine property by MSHA on April 24, 1993. The forklift's brake system was thoroughly inspected on May 26, 1993, at Industrial Truck Company, Incorporated, in Greensboro, North Carolina. Generally speaking, when the engine of a Komatsu forklift truck is running, the service brake system relies on a brake pump to maintain the requisite hydraulic pressure. An examination of the service brake system with the subject forklift's engine operating revealed the warning alarm was functioning properly, there was an adequate supply of brake fluid, and there was hydraulic pressure of 1500 p.s.i., which was within the manufacturer's specifications.

When the engine on a Komatsu forklift is turned off the brake pump no longer operates. The accumulator serves as an alternative brake system when the engine is not running. An accumulator is a container that holds approximately 300 cubic

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centimeters of brake fluid. When the brake is depressed when the forklift engine is off, a valve opens forcing brake fluid into the brake system. (Tr. 98). The accumulator permits the brakes to be depressed approximately 5 to 10 times with the engine off. (Tr. 129).

During the course of the May 26, 1993, tests, a pressure gauge was connected to the accumulator on the subject forklift. When the brake pedal was depressed with the engine off the gauge indicated zero pressure. The brakes failed to perform as designed with the engine off due to a malfunction of the accumulator.

The May 26 inspection of the forklift's parking brake revealed it was ineffective due to a combination of three factors. There was no adjustment left at the top of the park brake lever. In addition, an oil seal between the park brake assembly and the differential was leaking, which allowed oil to enter the drum, saturating the shoes. Finally, the thickness of the shoe pad ranged from 0.150 inch to only 0.125 inch. The manufacturer's recommended replacement specification was 0.130 inch.

At the hearing, the parties entered into the following fundamental stipulations of material issues of fact:

1. The service brakes functioned adequately with the engine running on the forklift but did not function adequately with the engine off. (Tr. 357).
2. Although the respondent is not responsible for maintenance of the equipment [owned by Kennecott], it was authorized to tag out equipment if it was not functioning properly. (Tr. 198, 358).
3. Failure to have operational emergency [parking] brakes or operational service brakes when the vehicle is not running are conditions involving violations that are properly characterized as significant and substantial in nature. (Tr. 223, 358).

#### Further Findings and Conclusions

Citation/Order No. 4094231

Combined 104(a) Citation and 107(a) Imminent Danger Order No. 4094231 was issued to the respondent by MSHA Inspector Ronald Lilly on April 22, 1993, for a cited violation of the mandatory safety standard in section 56.14101(a)(1), 30 C.F.R.

56.14101(a)(1). In considering whether the facts support section 56.14101(a)(1) violation it is helpful to examine the

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provisions of sections 56.14101(a) and 56.14101(b). These sections provide:

56.14101

(a) Minimum requirements. (1) Self-propelled mobile equipment shall be equipped with a service brake system capable of stopping and holding the equipment with its typical load on the maximum grade it travels. This standard does not apply to equipment which is not originally equipped with brakes unless the manner in which the equipment is being operated requires the use of brakes for safe operation. This standard does not apply to rail equipment.

(2) If equipped on self-propelled mobile equipment, parking brakes shall be capable of holding the equipment with its typical load on the maximum grade it travels.

(3) All braking systems installed on the equipment shall be maintained in functional condition.

(b) Testing. (1) Service brake tests shall be conducted when an MSHA inspector has reasonable cause to believe that the service brake system does not function as required, unless the mine operator removes the equipment from service for the appropriate repair; (2) The performance of the service brakes shall be evaluated according to Table M-1.

\* \* \* \* \*

(5) Where there is not an appropriate test site at the mine or the equipment is not capable [of] traveling at least 10 miles per hour, service brake tests will not be conducted. In such cases, the inspector will rely upon other available evidence to determine whether the service brake system meets the performance requirement of this standard.

Table M-1 sets forth the maximum allowable stopping distances for vehicles of different gross weights traveling at speeds varying from 10 to 20 miles per hour.

The term "service brake system" in section 56.14101(a)(1) must be read in the context of the service brake test provisions of section 56.14101(b). In so doing, it is evident that the requisite condition of service brakes contemplated by section 56.14101(a)(1) relates to the service brakes' effectiveness in stopping moving (in service) vehicles in that tests to support

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violations of this mandatory standard are conducted on moving vehicles in accordance with the standards contained in Table M-1. In fact, section 56.14101(b)(5) provides that where equipment is not capable of traveling at least 10 miles per hour, service brake tests will not be conducted.

In this case, combined Citation/Order No. 4094231 was issued by Inspector Lilly on April 22, 1993, following his on-site inspection. Lilly testified that his April 22, 1993, testing of the subject forklift revealed that the service brake pedal was low and that the service brake would not stop the machine with the engine running. (Tr. 138-139, 144-145). However, Lilly's preliminary conclusion with respect to the service brakes was not supported by the subsequent May 26, 1993, tests performed under MSHA's direction. In this regard, MSHA Supervisory Inspector Friend testified the service brakes could pass the Table M-1 test with the engine running and that there was no evidence of any significant hazard posed by the condition of the service brakes. (Tr. 251-254). Moreover, the Secretary's stipulation that the service brakes functioned adequately with the engine running is dispositive of this issue. (Tr. 357).

Under these circumstances, section 56.14101(a)(3), which refers to brake systems in general, is the applicable mandatory safety standard for the accumulator malfunction. While I am mindful that Inspector Lilly's April 22, 1993, inspection revealed the brake system was defective with the engine off (Tr. 147), Lilly did not cite the respondent for a violation of section 56.14101(a)(3). Moreover, at trial, the Secretary expressly withdrew any allegations of a section 56.14101(a)(3) violation. (Tr. 17-21). Accordingly, the Secretary has failed to establish that there was a violation of the cited mandatory safety standard in section 56.14101(a)(1) as the service brakes performed with the engine running. Consequently, Citation No. 4094231 must be vacated.

With respect to the remaining 107(a) imminent danger order, imminent danger orders permit an inspector to remove miners immediately from a dangerous situation. See 30 U.S.C.

817(a). Here, the gravity of the hazard posed by the inoperable accumulator and defective parking brake is indisputable. Therefore, the forklift clearly constituted an imminent danger. An imminent danger order requiring the immediate removal of hazardous equipment is appropriate even if the withdrawal order is not caused by a violation of the Act or of the Secretary's mandatory safety standards. Utah Power and Light Company, 13 FMSHRC 1617, 1622 (October 1991). Thus, severing and vacating the 104(a) citation from combined 104(a) Citation/107(a) Order No. 4094231 where the cited section 56.14101(a)(1) violation has been vacated does not, alone, invalidate the 107(a) imminent danger order.

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The final issue for resolution is whether the imminent danger order was properly issued to the respondent, the operator of the defective forklift, rather than to the forklift's owner Kennecott Ridgeway Mining Company. The testimony reflects that the respondent had exclusive control of the forklift from 9:00 a.m. on April 21, 1993, until approximately 2:30 p.m. when the fatal accident occurred. It is conceivable that employees of the respondent could have continued to be exposed to the risk caused by this defective equipment. Therefore, Lilly's issuance of 107(a) Order No. 4094231 was appropriate and shall be affirmed.

Citation No. 4094232

Inspector Lilly issued 104(a) Citation No. 4094232 on April 22, 1993, for a violation of section 56.14101(a)(2) after he determined that the parking brake was incapable of holding the forklift on grades it was called upon to travel. At the time of the accident, Crapps testified that he engaged the parking brake but it failed to prevent the forklift from rolling down the six per cent grade. (Tr. 139). Lilly and Friend's on-site tests on April 22, 1993, confirmed that the parking brake had no resistance and was ineffective. (Tr. 138, 182, 219, 237, Ex. p-2). Repeat tests by Kennecott Ridgeway Mining Company on April 23, 1993, also revealed the parking brake could not hold the forklift. (Tr. 148-149, 344-348, Ex. P-10). Finally, the MSHA supervised May 26, 1993, extensive inspection and testing demonstrated that the parking brake was defective. (Tr. 171-172, 200, 202, 204, 210, 219, Ex P-6).

In the face of this record evidence, the respondent ". . . does not dispute that at the time of the accident the parking brake was not capable of holding the forklift as required." (Resp. posthearing brief at p.26). Rather, the respondent argues that immediately ". . . prior to the accident the parking brake worked fine and the sudden and unexpected failure of the parking brake could not have been anticipated or prevented by the Respondent." Id.

The respondent's assertion of a sudden brake failure without any opportunity for prior warning is unconvincing and unsupported by the record. As a threshold matter, Reynolds' testimony regarding the nature and extent of his pre-operation inspection of the forklift and Canady's testimony concerning the respondent's rigid enforcement of its pre-operation inspection program are exculpatory statements that are afforded little evidentiary value. Moreover, Crapps testified that although he noted the brakes to be "o.k." on the company walk-around inspection checklist, he performed no specific tests on the brakes because he assumed they were working as the forklift had been previously driven. (Tr. 53-54). Crapps' testimony that the parking brake apparently held on a "very little" dip in the road does not evidence that it was functioning properly shortly before

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the accident. (Tr. 49). Significantly, while Crapps testified that it was the respondent's policy to require completion of a pre-operation walk-around inspection sheet, he also testified, "[i]t was never really enforced, though." (Tr. 58). Although Reynolds testified that the respondent's walk-around inspection policy "was supposed to be" enforced, he stated "[he] couldn't say it was enforced" rigorously. (Tr. 86-87).

Thus, the evidence reflects that the purported pre-operation inspections were, at best, perfunctory in nature. Therefore these inspections provide little support for the respondent's contention that the parking brake was determined to be functional shortly before the accident.

Finally, the respondent's assertion of a sudden parking brake malfunction is belied by the May 26, 1993, inspection of the forklift. The inspection findings included leaking oil seals saturating the brake shoe and drum as well as worn parking brake linings. These conditions are not indicative of an acute mechanical failure.

In view of the above, it is apparent that the Secretary has established the fact of occurrence of the cited violation of section 56.14101(a)(2). The respondent has stipulated to the significant and substantial nature of this violation. (Tr. 223, 358). With respect to the appropriate civil penalty to be imposed, the respondent's attempted mitigation, i.e., sudden unanticipated brake failure, is unsupported. In applying the penalty criteria in section 110(i) of the Act, 30 U.S.C.

820(i), I note the degree of negligence manifested by the respondent in this matter is high given the fact that the pre-operation inspection procedure was ineffective in view of the longstanding nature of the parking brake defects. In addition, I credit the testimony of Crapps that the respondent's pre-shift inspection policy was not enforced. Considering the gravity of the violation and its contribution to a fatality, and, the fact the respondent is a large publicly held corporation, I am assessing a civil penalty of \$7,500 for Citation No. 4094232.

Citation No. 4094234

104(a) Citation No. 4094234 was issued by Inspector Lilly on April 23, 1993, for an alleged violation of section 56.14100(a). This mandatory safety standard provides: "Self-propelled mobile equipment to be used during a shift shall be inspected by the equipment operator before being placed in operation on that shift."

As noted above, the evidence manifested by the testimony of Reynolds and Crapps reflects that the respondent's pre-operation inspection program was perfunctory and deficient. As this mandatory standard only requires one inspection per shift, the

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failure of Reynolds, who took control of the forklift at 9:00 a.m., to detect any parking brake or accumulator malfunctions at the beginning of the April 21, 1993, morning shift constitutes a violation without regard to the adequacy of Crapps' pre-operation walk-around inspection. My conclusion, as noted above, is based on the longstanding nature of the defective parking brake and accumulator which should have been discovered if an adequate pre-shift inspection had been performed.

Although the inadequacy of the preshift inspection provides a sufficient basis for establishing the violation, there is an independent justification for finding that section 56.14100(a) has been violated. A primary cause of this fatal accident was the defective and inoperable accumulator. The function of an accumulator which permits a multi-ton construction vehicle to be stopped or to be prevented from rolling when the engine is turned off is not an obscure mechanical concept. Inspectors Lilly and Friend testified that it is "standard procedure" to test accumulators and that all equipment manufactured in the last several years have functional brake systems when the engine is off. (Tr. 95-99, 162, 182, 236). Such a malfunction could easily result in a runaway construction vehicle in the event of an engine stall.

Industry recognition of the importance of this auxiliary brake system is demonstrated by the Komatsu Operation & Maintenance Manual for its forklift truck Model Nos. FD100/115-5 and FD135/150E-5 wherein detailed instructions are provided for a pre-operation testing procedure to ensure that the brake accumulator is properly functioning. (Ex. P-1, p.25).(Footnote 1) It is a simple two step test. The operator pumps the brake repeatedly with the engine off until the hydraulic brake fluid in the accumulator is depleted and a buzzer sounds. The engine is then started. If the buzzer goes off after a few seconds it indicates the accumulator has been refilled and the reservoir is not defective. If the buzzer does not go off it means the accumulator is malfunctioning and cannot be refilled.

The respondent has admitted that the Komatsu accumulator test was not performed because the procedure was unknown.

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The Komatsu forklift in issue was Model No. FD135-5. The Komatsu maintenance manual identified and admitted in evidence as Petitioner's Exhibit No. 1 was received despite the respondent's objection. It is clear on its face that this manual relates to forklift Model No. FD135-5, the model in question, as well Model Nos. FD150E-5, FD100-5 and FD115-5. Moreover, Komatsu furnished the manual in response to the Secretary's request for the pertinent manual for the subject Model No. FD135-5 forklift truck that was tested under MSHA's supervision on May 26, 1993, in Greensboro, North Carolina. (Tr. 121-128, Ex. P-1).

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Reynolds and Crapps knew nothing about testing the brakes with the engine off. (Tr. 43-44, 84-86). George M. Canady III, the respondent's superintendent at the Ridgeway Mine site, testified that neither he nor Phil Boughtman, the supervisor responsible for training forklift operators, was familiar with Komatsu's accumulator test procedure. (Tr. 47, 299-302).

The explanation given for the respondent's lack of knowledge with respect to the accumulator's function and testing was that Fluor Daniel had requested the Komatsu forklift maintenance manual from the Kennecott Ridgeway Mining Corporation but it had not been provided. (Tr. 291). In essence, the respondent continued to operate this heavy piece of construction equipment despite the fact that it had never read the operational instruction manual. For example, Crapps testified that he had driven the Komatsu forklift "off and on for five years." (Tr. 63). Kennecott's reported failure to provide the forklift's operational manual does not absolve the respondent from its responsibility to read it. As evidenced in this case, the respondent's failure to acquaint itself with the manufacturer's operational and testing instructions for the forklift prior to its continued use is inexcusable and highly negligent.

Finally, the respondent, in its posthearing brief, maintains that the standard in section 56.14100(a) is unconstitutionally vague. The Commission in *Ideal Cement Company*, 12 FMSHRC 2409 (November 1990), addressed a similar issue. In *Ideal*, the Commission considered whether the standard in section 56.9002, 30 C.F.R. 56.9002 (1987), was overly broad. Section 59.9002 provided: "Equipment defects affecting safety shall be corrected before the equipment is used." (Footnote 2) The Commission stated:

Section 56.9002 must be construed in light of its underlying purpose -- the protection of miners operating the equipment or exposed to the equipment's use. That purpose was plainly set forth in the Secretary's statement of purpose and scope of the Part 56 standards, which provided: "The purpose of these standards is the protection of life, the promotion of health and safety, and the prevention of accidents." 30 U.S.C. 56.1 (1987). (Section 56.1 has been carried forward unchanged in the Secretary's present Part 56 regulations.) Any overly narrow or restrictive reading of the scope of section 56.9002 cannot be reconciled with that statement of purpose or with the fundamental protective ends of the Mine Act itself, as set forth in section 2 of the Mine Act. See 30 U.S.C. 801(a), (d), & (e).

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The provisions of section 56.9002 are currently contained in section 56.7002, 30 C.F.R. 56.7002.

Thus, section 56.9002, which relates to the performance of equipment used in mines, must be interpreted and applied in a manner fostering the basic aim of protecting the health and safety of miners. (Emphasis added). 12 FMSHRC at 2414.

The Commission further stated:

However, in interpreting and applying broadly worded standards, the appropriate test is not whether the operator had explicit prior notice of a specific prohibition or requirement, but whether a reasonably prudent person familiar with the mining industry and the protective purposes of the standard would have recognized the specific prohibition or requirement of the standard. (Emphasis added). 12 FMSHRC at 2416.

The requirement of familiarizing oneself with the instruction manual for potentially dangerous self-propelled mobile equipment so that an adequate preshift brake system test can be performed, and, the requirement of performing meaningful preshift brake system tests, are readily discernible from the language of section 56.14100(a). Consequently, the respondent's contention that this standard is overly broad is rejected.

As a final matter, at trial, and in its posthearing brief, the respondent relies on the fact that it was not responsible for the forklift's maintenance and repair in an attempt to escape or mitigate liability. While I recognize that the respondent was not responsible for the forklift's maintenance and repair, it had a duty to ensure the safe operation of this potentially dangerous vehicle. While longstanding maintenance problems may have been a contributing factor, the respondent, who had possession and control of this vehicle on April 21, 1993, from 9:00 a.m. until the brake failure at approximately 2:30 p.m., had the opportunity to prevent this accident if proper unsophisticated preshift brake inspections had been performed. Having failed to perform such tests, the respondent must be held accountable. It should be noted that, while not the subject of this proceeding, Kennecott, as the forklift owner, was also cited by MSHA for its culpability in this matter. (Ex. P-6).

Thus, the evidence establishes a violation of the cited mandatory standard. As discussed above, the violation is attributable to a high degree of negligence by the respondent in that inadequately trained individuals were required to perform preshift inspections of mobile equipment. This lack of training contributed to ineffective preshift inspections and the resultant serious gravity of the violation. Given the penalty criteria of section 110(i) of the Act, which include consideration of the size of the respondent corporation, a publicly held company listed on the New York Stock Exchange, I conclude that \$20,000 is

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the appropriate civil penalty to be assessed for Citation No. 4094234.

ORDER

Accordingly, consistent with this decision, IT IS ORDERED that Citation No. 4094231 IS SEVERED from Order No. 4094231 and IS HEREBY VACATED. IT IS FURTHER ORDERED that Order No. 4094231 and Citation Nos. 4094232 and 4094234 ARE AFFIRMED. The respondent, Fluor Daniel Incorporated, SHALL PAY, within 30 days of the date of this decision, a total civil penalty of \$27,500.00 in satisfaction of Citation Nos. 4094232 and 4094234 affirmed herein. Upon receipt of payment, this matter IS DISMISSED.

Jerold Feldman  
Administrative Law Judge

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