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Federal Mine Safety and Health Review Commission
Office of Administrative Law Judges

SECRETARY OF LABOR, MINE SAFETY AND HEALTH ADMINISTRATION (MSHA), PETITIONER	CIVIL PENALTY PROCEEDING Docket No. LAKE 85-4 A.C. No. 12-00337-03521
V.	Lynnville Strip Mine
PEABODY COAL COMPANY, RESPONDENT	

Appearances: Miguel J. Carmona, Esq., Office of the Solicitor, U.S. Department of Labor, Chicago, Illinois, for Petitioner;
Michael O. McKown, Esq., St. Louis, Missouri, for Respondent.

DECISION

Before: Judge Steffey

Pursuant to a notice of hearing dated January 14, 1985, a hearing in the above-entitled proceeding was held on February 14 and 15, 1985, in Evansville, Indiana, under section 105(d), 30 U.S.C. 815(d), of the Federal Mine Safety and Health Act of 1977.

After the parties had completed their presentations of evidence and had made their respective closing arguments, I rendered a bench decision, the substance of which is set forth below (Tr. 414-443):

In a civil penalty case, the issues are whether violations occurred and, if so, what penalties should be assessed, based on the six criteria set forth in section 110(i) of the Act.

Although counsel for the Secretary of Labor seemed to be asking me in his closing argument to make a ruling on whether the order was valid or not, in a civil penalty case, the validity of the order is not considered to be an issue. The Commission so held in Wolf Creek Collieries Company, a decision which is not included in the Commission's reports, but which was issued on March 26, 1979, in Docket No. PIKE 78-70-P. In that case, the Commission cited the decisions of the former Board of Mine Operations Appeals in Plateau Mining Co., 2 IBMA 303 (1973), Buffalo Mining Co., 2 IBMA 327 (1973), and North American Coal Corp., 3 IBMA 93, 120

(1974), in which the Board had made similar rulings. The Commission reiterated that ruling in Pontiki Coal Corp., 1 FMSHRC 1476 (1979).

For the above reason, I shall make findings as to whether violations occurred, and if I find a violation, I shall assess a civil penalty, but I shall not rule on whether the order was a technically valid order issued under section 104(d) of the Act.

The parties entered into some joint stipulations, which I think should be a part of the decision. Those are as follows:

1. Peabody Coal Company owns and operates the Lynnville Strip Mine in Lynnville, Warrick County, Indiana.

2. The Lynnville Strip Mine is subject to the Federal Mine Safety and Health Act of 1977.

3. The Federal Mine Safety and Health Review Commission has jurisdiction over this proceeding.

4. On April 4, 1984, Dennis Springston, a miner working at the Lynnville Mine, was killed during an accident at that mine.

5. On April 5, 1984, Inspector Joseph L. Hensley, a duly authorized representative of the Secretary of Labor, issued Citation No. 2322072 and Order of Withdrawal No. 2322073, in reference to the above-mentioned accident.

6. During the calendar year prior to the issuance of the citations involved in this case, the Lynnville Strip Mine had a production of approximately 3,287,102 tons of coal.

7. During the calendar year prior to the issuance of the citations involved in this case, the controlling entity had a production of approximately 51,660,483 tons of coal.

8. Payment of the penalties assessed by the Mine Safety and Health Administration for the citation and order of withdrawal involved in this case would not affect the ability of Peabody Coal Company to remain in business.

The evidence in this proceeding supports the following findings of fact, which I shall set forth in enumerated paragraphs:

1. Citation No. 2322072, which is Exhibit 1 in this proceeding, was issued on April 5, 1984, under section 104(d)(1) of the Act, citing a violation of 30 C.F.R. 77.1006(a). The citation alleged that men were working in an area near and adjacent to an unstable and dangerous highwall. One

hundred seventy-four feet of loose, unconsolidated material of the highwall collapsed and covered up a KW Dart 110-ton truck that was being loaded with coal. The driver of the KW Dart truck was fatally injured. The collapse of the highwall covered up a pickup truck and also damaged the 170(L) loader, and another pickup truck. Citation No. 2322072 was terminated on April 6, 1984, pursuant to a subsequent action sheet issued that day, as modified by another subsequent action sheet dated December 3, 1984.

2. Section 77.1006(a), which was alleged to have been violated in Citation No. 2322072, reads as follows: "Men, other than those necessary to correct unsafe conditions, shall not work near or under dangerous highwalls or banks."

3. Order No. 2322073, which is Exhibit 3 in this proceeding, was issued on April 5, 1984, under section 104(d)(1) of the Act, citing a violation of section 77.1001, and alleging that "[l]oose, hazardous and overhanging material on the highwall of the 1150 No. 2 Pit was observed on the entire length of the approximately 2,800 foot highwall. This condition was observed during an investigation of a fatal accident."

4. Section 77.1001, which was alleged to have been violated in Order No. 2322073, reads as follows: "[l]oose, hazardous material shall be stripped for a safe distance from the top of pit or highwalls, and the loose unconsolidated material shall be sloped to the angle of repose, or barriers, baffle boards, screens, or other devices be provided that afford equivalent protection."

5. A modification of Order No. 2322073 was issued on April 10, 1984. That modification stated that it was issued to reflect the following change (Exhibit 3, p. 3):

> Loose hazardous and overhanging material on the highwall of the 1150 No. 2 Pit begins at the north end of the pit and extends approximately 1,090 feet southeast on the highwall, for a total length of 1,090 feet. Area No. 2 begins at a point 110 feet south of the center of the entrance road, at the pit floor, then extends south approximately 380 feet, for a total length of 380 feet.

6. A subsequent action sheet was written on April 16, 1984, and that sheet terminated the order with the statement that "[t]he north end of the pit, approximately 1,090 feet, was posted, and workmen were removed from the area. Area No. 2, 380 feet south of the center of the entrance road at the pit floor, berms were installed approximately 8 feet in height and approximately 30 feet from the highwall" (Exhibit 3, p. 4).

7. Inspector Hensley, who issued both the citation and the order initially, but who did not modify or terminate them, examined the highwall from the pit area and from the top of the highwall, and concluded that there was a large amount of unconsolidated or loose material. He observed cracks in the wall which were gapped open from 4 to 6 inches. He also observed 14 charged holes in which explosives had not been detonated. Two such bags of explosives are shown in the photograph, which is Exhibit 11 in this proceeding. He believed that the violations of sections 77.1006(a) and 77.1001 were associated with a high degree of negligence because Peabody had failed to keep miners away from the highwall, which management knew was unsafe because of the large number of entries in the onshift books showing the pit foremen's comments about the bad conditions observed in the highwall (Exhibit 13). He also expressed the belief that the violations were very serious because a fatal accident had occurred as a result of them. He believed that management should have constructed a berm at the base of the highwall to catch falling material when there was an indication of loose material in the highwall, as indicated in the onshift book, and he thought that the berms would have kept both miners and equipment away from the dangerous highwall.

8. Inspector Ritchie investigated the accident by interviewing miners and foremen who were working when the accident occurred. The interviews of Peabody's miners, foremen, and mine officials have been transcribed and are a part of Exhibit B in this proceeding. Inspector Ritchie also prepared a report of the accident, which is Exhibit 4. Based on his examination of the accident site, he concluded that the violations of sections 77.1006(a) and 77.1001 had occurred. The inspector agreed, on cross-examination, however, that he cannot be certain that Peabody could have determined that a fall was imminent, based on an examination of the highwall prior to the occurrence of the accident.

9. Charles Hester is a pit foreman who made some of the entries in the onshift book, Exhibit 13, and he referred to the highwall as being "ragged" on many pages of the onshift book, but he insisted that his use of that term merely indicated that the wall was uneven and did not mean that he thought the wall was unsafe for work to be performed in close proximity to the wall.

10. Cecil O'Dell is an MSHA field office manager who assigns work to inspectors and evaluates their work. He believed that use of the word "ragged" meant that the highwall was very unreliable and that the use of terms like "some bad areas", shown in the onshift book, indicated that Peabody's foremen were expressing existence of unsafe conditions. He thought that the onshift reports showed that the foremen had

failed to take proper corrective action, such as keeping the miners away from the highwall, or eliminating the hazards by barricading or constructing berms at the foot of the highwall.

11. Gaylon Leslie is a shooter and has been for 10 1/2 years. He is also chairman of the safety committee, and he said there was overhanging material on the day of the accident, because he saw it. He had received complaints from miners regarding the 1150 No. 2 Pit. He examined the basis for their complaints and agreed with their belief that the highwall was hazardous, especially because of the practice of blast casting, which is a method of using explosives to throw overburden into the pit rather than just to shake it loose by lifting overburden straight up, as is done in conventional shooting. Leslie was with Inspector Bryant, who made a spot inspection of the 1150 No. 2 Pit on the day before the fatal accident. He said that Inspector Bryant did not cite any violations as to the highwall, but Bryant was close to the No. 4 Panel, shown on the mine map (Exhibit A), rather than the northern end of the pit, where the accident occurred. Bryant also testified that he saw no conditions requiring issuance of a citation on the day before the accident even though he did inspect the very same area where a berm had to be constructed in order to abate Order No. 2322073.

12. Leonard Hughes was superintendent at the time of the fall of the highwall. He has 38 years of experience, 13 of them being at Lynnville. He stated that highwall conditions vary and can go from a safe condition to an unsafe condition as the result of rain, wind, freezing, and thawing. He had not seen a fall of the magnitude of the one which occurred on April 4, which was about 170 feet long and 15 feet thick. The term "ragged", used in the onshift book, to him, means "uneven", but not necessarily hazardous. He said that they were having problems with the highwall and with the spoil bank, so they went to blast casting as an alternative which they hoped would improve both production and safety. Nevertheless, in his interview by MSHA investigators, as shown in Exhibit B, he recognized that a sloping highwall would have prevented the magnitude of the fall which occurred on April 4.

13. Tom Hughes is a blasting foreman. He examines the top of the highwall which has about 4 to 5 feet of dirt on top. He drills from sites on top of the highwall as well as from locations down in the parting in the pit, and has to evaluate the condition of the highwall from both the top and the pit. His entries in an onshift book, which is restricted to the drill area, and which is Exhibit 14 in this proceeding, show that on at least one occasion, he instructed his crew to leave 25 to 30 feet of parting in the pit in order to stay away from the highwall (Exhibit 14, p. 21). He also explained

how a change in placement of blasting caps overcame the problem of explosives failing to go off, so that problem ceased to exist after the accident on April 4. He claimed that failure of the third row of holes to explode on April 4 made the highwall more solid than if they had exploded, because there was less breaking of the rock at the rear of the highwall than would have occurred if all the charges had exploded as was intended.

14. Charles Bellamy is a safety supervisor of the entire mine, and he believed, from his interviews of personnel present at the time of the accident, that foremen and miners could not have anticipated the fall based on an examination of the wall. He was with Inspector Hensley on April 5, when the citation and order here involved were written, and he does not think that the inspector properly described the area of the loose rock. He stated that they constructed the berm to get the order terminated, but that he did not believe the wall had loose materials on it.

15. Bob Hart is Peabody's Indiana drilling and blasting manager. He testified that they went to the blast casting method because they had reached a point that it was uneconomic to mine coal if they had to move more than 15 cubic yards of overburden to obtain one ton of coal. Doubling the amount of explosive moves more overburden with blasting and increases the yardage obtained by use of the dragline. He agreed that after the accident, Peabody went to using angle drilling so that blast casting could continue to be used to achieve economy, while leaving an increased slope on the highwall to improve safety of the highwall's condition.

16. Conny Postupack is an official with Atlas Powder Company, and he explained that blast casting was begun in 1935, and then became somewhat unfashionable because explosives lost their economic advantage to the increased economies of scale accompanying the use of draglines, until the increasing labor and material costs associated with mechanical overburden removal were overcome by economies in the manufacturing of explosives. Consequently, blast casting is now in vogue and is being used in Pennsylvania, West Virginia, Ohio, Kentucky, Wyoming, New Mexico, and Alaska. He emphasized that unconsolidated materials are not subject to blast casting, as there must be good integrity of the formation being shot.

17. Curtis Ault is a supervising geologist who works for the Indiana Geological Survey. He has been working for the last 7 years in studying faults and joints in Indiana. A fault is a crack with slippage between the materials making

up the sides of the fault, whereas joints are cracks without any slippage of the materials. His studies are based on examinations of exposed outcroppings of bedrock and rock exposed by mining in coal mines or construction. He expressed the belief, based on testimony of witnesses Hart and Leslie, and pictures made by MSHA, especially Exhibits 7, 8, 11, and 12, that the fall of the highwall in the 1150 No. 2 Pit was caused by joints. He cannot be certain of that belief because he did not personally examine the Lynnville Mine here involved. Moreover, his testimony shows that the joints he observed in the pictures were not parallel to the slice of rock which fell, and that would mean that Peabody was constructing the highwall in the direction which would have been recommended in order to prevent a fall as a result of the presence of joints in the overburden which had been blasted.

I believe that those findings cover the important aspects of the evidence which was introduced in this proceeding.

The Secretary's attorney asked me to find that the violations, alleged in Citation No. 2322072 and Order No. 2322073, occurred.

Counsel for Peabody argues that his evidence shows that the violations did not occur, and he also pointed out that when there is a fatality and MSHA conducts an investigation, there is a considerable amount of pressure on the inspectors to find something wrong, and he feels that that gives them a motivation to be more critical after such an accident than they would be otherwise.

I agree with Peabody's counsel that such pressure undoubtedly exists and that is one of the reasons that I asked a great many questions during the hearing which were intended to bring out all the good aspects that Peabody was trying to present, because it always worries me in a case of this nature that MSHA may unfairly cite violations because of the pressure of finding a problem when a fatality has occurred. I have reviewed the evidence in great detail and I believe that there is probably a middle ground between what MSHA has presented and what Peabody has introduced, and that is often the case in these proceedings.

I was at first disposed to find no violations, but Mr. McKown introduced the transcript from MSHA's investigation, and I read that in great detail last night. That is Exhibit B in this proceeding and that exhibit is made up of testimony of the miners and foremen who were present when the fatality occurred. That exhibit contains some statements by the witnesses which motivated me to believe that there was considerable support for the inspectors' belief that violations had occurred.

The difficulty about finding a violation of section 77.1006(a) is that all of the witnesses to this fall of the highwall stated that the wall, just before it fell, looked as well as it had for some time, and that they did not see anything that would indicate that it was about to fall. So if one takes that testimony, by itself, then he would conclude that there is no way that Peabody could have been aware that men were working near a highwall which was hazardous.

The Commission has held that an operator is liable without regard to fault for the occurrence of a violation. United States Steel Corp., 1 FMSHRC 1306, 1307 (1979). Consequently, Peabody may be held liable for the violation despite the fact that the record contains evidence tending to show that Peabody may not have been at fault for occurrence of the violation. In addition to the statements, referred to above, of witnesses who said that they could not have determined from looking at the wall, prior to its fall, that a massive rock fall was about to occur, there is testimony by the superintendent, Leonard Hughes, and by the explosives expert, Bob Hart, to the effect that the company went to the blast casting method in order to achieve economies, and it did so based on the fact that blast casting had been done at other Peabody mines without any apparent problems. The evidence discussed above makes it difficult to say that management was necessarily at fault for using blast casting at the 1150 No. 2 Pit, particularly since mine officials had tried that method at the 5900 Pit and had had no problems, but that was a different kind of operation, with a shovel instead of a dragline.

On the other hand, there is considerable evidence to support a conclusion that Peabody ought to be held at fault for the violation of section 77.1006(a). For example, when MSHA was conducting its investigation, the coal loader operator, Raymond Speicher, said that he did not like vertical walls; that they have given a lot of trouble. He specifically stated that after they started using blast casting, there was "ragged looking highwall, rocks breaking out every now and then. I always like a sloped bank myself" (Exhibit B, p. 41). Speicher also was of the opinion that rain had gone into a crack behind the large hunk of wall that fell out and had weakened it, and that that accounted for the fact that it fell.

Mike Denton, the oiler on the coal-loading machine, also stated that he prefers the slope, and it seems that the slope is a safer wall (Exhibit B, p. 42).

Ron Sutton, the tractor operator, stated that he does not like the vertical highwall at all. He said they had a slide just after that highwall was opened up, and they had to go back and reclean it. He also pointed out about the bags of powder that he found unexploded. He stated that he was afraid to haul the explosives on his tractor and that he put

them off in a separate place by themselves. He said he had worked with the tractor under the highwall more than anyone, and that he had seen 50 slides on slopes, but the way it is now, with the vertical walls, you cannot get away if you are sitting next to that wall, because the whole wall will come down. He stated that he is against vertical walls. He said that Peabody used to remove the dirt at the top of the highwall, but Peabody does not do that any more. Sutton stated that the dirt collects rain and that increases the burden on the top of the highwall. The dirt soaks up the water and results in slides, or in complete collapse of the wall, as occurred on April 4 (Exhibit B, pp. 46-48).

Fred Leatherland, the water boy, stated that the slope is less dangerous, and he feels they have a better chance of getting out of the way if materials fall (Exhibit B, p. 52). He said that he does not like the ragged, vertical highwall that they have been having (Exhibit B, p. 54).

When the superintendent, Leonard Hughes, was interviewed, he stated unequivocally, and repeated it twice, that if the highwall had been sloped on April 4, the wall would not have toppled down (Exhibit B, pp. 59-60). He also stated that they had been having trouble with the highwall ever since 1971 (Exhibit B, p. 63).

When Bob Hart, Peabody's drilling and blasting manager, was interviewed, he stated that he had not talked directly to the people who work in the pit, and that he did not know what their opinion was (Exhibit B, p. 74).

Finally, Gaylon Leslie stated that he thinks blast casting works all right in the 5900 Pit, but that he does not think it works with the 1150 No. 2 Pit, and he said until somebody can show him a good highwall in that pit, he will be against use of blast casting in that area (Exhibit B, p. 74).

I believe that when one reviews all the testimony of the people who were down there exposed to the highwall, that Peabody cannot successfully argue that it did not know that that highwall was hazardous. If Peabody's management did not know it, it should have known it, because Bob Hart should have known and found out what the men felt who were working in that pit. For the reasons I have given, I find that a violation of section 77.1006(a) occurred. Having found a violation, it is necessary that I assess a penalty. Tazco, Inc., 3 FMSHRC 1895 (1981).

With respect to the six criteria, the parties' stipulations deal with two of those criteria. One of them is the size of the operator's business. Paragraphs 6 and 7 of the joint stipulations, which have been quoted above, show that a

large operator is involved. Therefore, under the criterion of the size of the operator's business, a penalty in an upper range of magnitude would be appropriate.

Paragraph 8 of the joint stipulations stated that payment of civil penalties would not adversely affect Peabody's ability to continue in business. Consequently, the penalty does not have to be reduced under the criterion that payment of penalties would cause the operator to discontinue in business.

There was a statement by one of the inspectors to the effect that Peabody showed a good-faith effort to achieve rapid compliance after the violation was cited. It has been my practice not to increase a penalty under that criterion unless a lack of good faith is shown, and it has been my practice not to reduce a penalty under that criterion unless there is some outstanding effort made to achieve compliance. If there is normal effort to achieve compliance, which appeared to be the situation in this case, then the penalty should neither be raised nor lowered under the criterion of good-faith effort to achieve compliance.

Insofar as the history of previous violations is concerned, Exhibit 15 in this proceeding shows that Peabody has not previously been cited for a violation of section 77.1006(a). Therefore, no portion of the penalty should be assessed under the criterion of history of previous violations.

The two criteria of gravity and negligence remain to be considered. As I have already indicated at some length, there is a considerable body of evidence showing that Peabody had a reasonable basis for assuming that if it adopted the blast casting method, which has been described above, there was no reason to assume that a highwall would fall and kill anyone.

The company had done that type of mining at mines in other geographical locations and it had also succeeded in using that method in the 5900 Pit at the Lynnville Mine here involved. Consequently, I do not think that I can agree with Inspector Hensley that there was a high degree of negligence in the occurrence of the violation.

I believe that there was some ordinary negligence, because as I have pointed out, I do believe that when Bob Hart was giving advice to the company about how to achieve economies with explosives, he should have followed up on his recommendations, after they were adopted, by discussing the experimental nature of blast casting with the miners who were exposed to any hazards associated with those experimental techniques, even though the method was adopted with a good-faith belief that it would be safe. I believe that additional care should have been taken in determining just what was going on

in the pit as a result of utilizing that method. For the above reasons, I find that there was some ordinary negligence which warrants assessment of an amount of $500 under the criterion of negligence.

When it comes to the criterion of the gravity of the violation, I must recognize the fact that the fall caused the death of one miner and completely covered up a 110-ton truck, as well as a pickup truck, along with doing some damage to a large shovel in the area. A fall of that magnitude is necessarily serious and I believe that a penalty of $1,000 should be assessed under the criterion of gravity, so that a total penalty of $1,500 is warranted for the violation of section 77.1006(a) alleged in Citation No. 2322072.

I shall now turn to the question of whether a violation of section 77.1001 occurred. Some conflicting evidence exists with respect to that violation because, as Peabody's counsel pointed out in his argument, Inspector Bryant was at the Lynnville Mine on April 3, 1984, prior to the occurrence of the accident on April 4, 1984, and prior to issuance of Order No. 2322073 on April 5.

It is a fact that Inspector Bryant on April 3 was in the same area, which was later the subject of construction of a berm 8 feet high to protect people from any falls from the highwall which had been cited on April 5 for existence of loose and hazardous materials. The aspect of the evidence that makes it difficult to find a violation of section 77.1001 is that if Inspector Bryant saw that same area on April 3 and did not think the loose and hazardous materials constituted a violation, why would existence of those materials suddenly be a violation on April 4, when all people seem to agree that a massive fall of rock 174 feet long would not have adversely affected the remainder of the highwall at a place which was a distance of at least 500 feet from the place where the highwall collapsed?

I do not know whether the preponderance of the evidence would support a finding of a violation of section 77.1001 except for the fact that Gaylon Leslie was present after the accident had occurred, and he said, unequivocally, that he saw loose and hazardous materials on the highwall. I do not think that he would have stated that he saw loose materials if they had not existed and I do not think Inspector Hensley would have either, for that matter.

Nevertheless, it is a fact that one inspector did not find loose material in a hazardous amount on April 3 and another inspector did find loose material on April 5. Another reason which supports the finding of a violation of section 77.1001 is that photographs were introduced in this case which show some portions of the highwall which were not

in the immediate vicinity of the fall (Exhibits 5 through 12). There are enough cracks and enough irregularities about the highwall shown in those pictures to support a finding that there were loose and unconsolidated materials on the highwall on April 5, 1984. Therefore, I find that there was a violation of section 77.1001.

Having found a violation, I must assess a civil penalty. In discussing the penalty assessment for the previous violation, I covered the two criteria of the size of respondent's business and the fact that payment of penalties will not cause respondent to discontinue in business.

The inspector indicated that a good-faith effort was made to correct the violation. Achieving compliance was a simple matter insofar as 1,090 feet of the highwall was concerned because that portion of the highwall was dangered off and the men were reinstructed concerning safe conduct near highwalls. Compliance was achieved with respect to the remainder of the highwall by the erection of an 8-foot berm at the bottom of the highwall. As I have already indicated above, since this was an instance of normal abatement, the penalty should neither be increased nor decreased under that criterion.

Insofar as the history of previous violations is concerned, Exhibit 15 shows that Peabody previously violated section 77.1001 once on May 17, 1982, and once on February 10, 1984. In the legislative history, Congress indicated that it wanted a civil penalty to be increased two or three times over a previous penalty for a violation of the same mandatory standard which is before a judge or the Commission for assessment of a civil penalty if that same standard has been violated several times immediately preceding the occurrence of the violation under consideration.(Footnote.1)

In this instance, since one of the previous violations occurred almost 2 years before the violation here involved was cited, I do not think that that one would merit assessment of any portion of the penalty under history of previous violations, but since one of the previous violations did occur on February 10, 1984, just 2 months before the violation cited here, I believe that I necessarily must assess some portion of the penalty under history of previous violations. Therefore, under that criterion, a penalty of $50 will be assessed.

The two criteria of gravity and negligence remain to be considered. In evaluating the criterion of negligence, it is appropriate to examine the entries regarding the highwall made by Peabody's foremen in the daily onshift report. The onshift report was introduced as Exhibit 13 in this proceeding. The

entry for the second shift on March 3, 1984, indicates existence of "some bad areas."

On March 4 for the first shift, there is an entry, "stable in some and some loose; rock falling due to rain". On the second shift, there is an entry, "unstable".

On March 5 for the first shift, there is an entry, "some areas have slides due to heavy rain". On the second shift, "several bad areas".

On March 6, first shift, "some slides, loose rock"; second shift, "some bad areas".

On March 7, first shift, "some areas fair; some have loose rock"; on the second shift, "some bad areas".

On March 8, on the first shift, "cleaned up slides; some areas not good"; second shift, "several bad areas".

On March 9, second shift, "some bad areas".

On March 12, the entry "ragged" appears. Charles Hester testified that an entry of "ragged" should not be interpreted to mean that the highwall was necessarily hazardous. Therefore, I am omitting from my discussion 17 references to the highwall as being "ragged".

On March 13, first shift, "some areas poor"; also on March 13, there is an entry "some small slides noticed during third shift; all men warned".

On March 14, first shift, "some areas poor; south end flagged and men warned on unstable highwall".

On March 15, first shift, "Squaw Creek truck refused to drive under highwall, so this area will be flagged and no personnel are to go under this wall until corrected".

On March 16, first shift, "keep all personnel away from highwall and loading spoil side only; poor condition; is not stable; area flagged"; second shift, "rocks falling from recent bad weather"; third shift, "very bad area; falling off due to heavy rain; all men warned of wall condition".

On March 17, first shift, "no one working under highwall; all operations will be performed under area of bad highwall". The foreman may have misstated himself in the entry just quoted, but that is the way the entry reads. The entry for the third shift on March 17 states existence of "bad rock slide but appears to be in stable condition".

On March 18, first shift, "highwall in south end bad and shift foreman was aware of this"; second shift, "highwall, north end stable--south end bad. All personnel made aware of this".

On March 19, first shift, "some areas appear to be not stable".

On March 20, first shift, "some areas not stable; men warned"; third shift, "highwall in south end of pit is very unstable due to rain. Men warned of said condition".

On March 21, first shift, "some areas poor. Inclement weather. Some areas not stable"; second shift, "poor in working area"; third shift, "poor in south end, but appears to be in a stable state".

On March 22, first shift, "some areas fair. Some areas have loose rock and slides". Third shift, "Poor conditions exist. All men warned of bad walls".

On March 23, first shift, "fair; some areas not good"; third shift, "poor".

On March 24, first shift, "Fair; some areas loose rock".

On March 25, first shift, "Appears stable in work areas at present time".

On March 26, first shift, "loose rock; fair; some areas not stable".

On March 27, first shift, "fair; some areas not stable".

On March 28, first shift, "water, mud, rocks coming off highwall due to heavy rain"; third shift, "appears to be in a stable condition".

On March 29, first shift, "fair; some areas poor"; third shift, "fair, but stable".

On March 30, first shift, "fair; some areas not real good"; third shift, "stable condition; men not working under highwall on third; also men warned of highwall condition".

On March 31, first shift, "fair; some areas poor".

All entries for April 1 and 2 indicated that the condition of the highwall was "fair"; one entry for the second shift on April 1 evaluated the highwall as "stable".

On April 3, first shift, the highwall was described as "fair" with "some rocks falling off due to rain".

The entries quoted above were made by the shift foremen during the entire month of March and right up to the day before the accident occurred when a huge portion of the highwall fell. There was a considerable amount of negligence in Peabody's failure to take some corrective action to assure that the highwall was maintained in a safer condition than it was. As I have indicated in my findings of fact, Peabody found, after the fatal accident, that it could continue to utilize the blast casting method and still manage to put a slope on the highwall so as to provide it with additional stability which would avoid the vertical state which contributed to the fact that a huge portion of the wall suddenly fell on April 4 without prior warning. In such circumstances, I believe that a penalty of $2,000 should be assessed under the criterion of negligence.

In considering the gravity of the violation, it is necessary to bear in mind that the violation here under consideration is the loose and unconsolidated material which existed on the portion of the highwall which did not fall, as opposed to the portion which did fall. Those people who had examined the portion of the highwall which did fall all seemed to agree that it did not look as if it would fall on that particular day. The loose materials, however, were not confined to just that portion of the wall which fell because the inspector cited an expanse of 2,800 feet as having loose and hazardous and overhanging materials on it. While the order was modified, as I have explained in the findings above, to reduce the extent of the loose materials to 1,090 feet that were dangered off and to indicate that a berm was constructed along an expanse of 380 feet, the fact remains that an area of over 1,400 feet of the highwall had loose and unconsolidated materials on it.

The entries of the foremen in the onshift book, as given in detail above, do not specify the location of the loose materials they are describing in their frequent references to "bad areas" and "loose rock". Some of the witnesses stated that they had never seen a "good" highwall and Tom Hart testified that he never rated any highwall as being better than "fair", and that "fair" meant to him that it was safe to work under the wall. The fact that the foremen on several occasions warned the miners that it was not safe to work near the highwall is a further indication that they believed that the loose materials were hazardous. The preponderance of the evidence, therefore, supports a finding that the violation of section 77.1001 was a serious violation and that a penalty of $1,000 should be assessed under the criterion of gravity.

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In the above discussion, I have indicated that a penalty of $50 should be assessed under the criterion of history of previous violations, that $2,000 should be assessed under the criterion of negligence, and that a penalty of $1,000 should be assessed under the criterion of gravity, making a total penalty of $3,050 for the violation of section 77.1001.

WHEREFORE, it is ordered:

Peabody Coal Company, within 30 days from the date of this decision, shall pay penalties totaling $4,550.00. The penalties are allocated to the respective violations as follows:

Citation No. 2322072 4/5/84	77.1006(a)	$1,500.00
Order No. 2322073 4/5/84	77.1001	3,050.00
Total Penalties Assessed in This Proceeding		$4,550.00

Richard C. Steffey
Administrative Law Judge

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Footnoes start here:-

~Footnote_one

1 S.REP. No. 95-181, 95th Cong., 1st Sess. 43 (1977), reprinted in LEGISLATIVE HISTORY OF THE FEDERAL MINE SAFETY AND HEALTH ACT OF 1977, 631 (1978).