

February 2014

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Review was granted in the following cases during the month of February 2014:

Secretary of Labor, MSHA v. Jim Walter Resources, Inc. Docket No. SE 2012-681-R (Judge Gilbert, January 23, 2014)

Secretary of Labor, MSHA v. Kentucky Fuel Corporation, Docket Nos. KENT 2011-1557, KENT 2011-1558, KENT 2013-698. (Judge Miller, January 16, 2014)

Secretary of Labor, MSHA v. The American Coal Company, Docket No. LAKE 2010-408-R. (Judge Miller, January 16, 2014)

No case was filed in which Review was denied during the month of February 2014.

COMMISSION DECISIONS

FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION
1331 PENNSYLVANIA AVENUE, NW, SUITE 520N
WASHINGTON, D.C. 20004-1710

February 12, 2014

SECRETARY OF LABOR,	:	
MINE SAFETY AND HEALTH	:	
ADMINISTRATION (MSHA)	:	
	:	
v.	:	Docket Nos. WEVA 2006-891-R
	:	WEVA 2007-288
	:	WEVA 2007-421
BLACK CASTLE MINING COMPANY and	:	
MICHAEL VIRA, employed by	:	
BLACK CASTLE MINING COMPANY	:	

BEFORE: Jordan, Chairman; Young, Cohen, Nakamura, and Althen, Commissioners

DECISION

BY: Jordan, Chairman; Young, Nakamura, and Althen, Commissioners

The Department of Labor’s Mine Safety and Health Administration (“MSHA”) cited Black Castle Mining Company and proposed penalties against the operator and its supervisor Michael Vira. The enforcement actions at issue here resulted from MSHA’s investigation into a fatal accident involving a bulldozer operator whose dozer came into contact with, and ruptured, a gas line. The citation alleged that Black Castle and Vira failed to adequately comply with the requirement to examine active working areas each shift for hazardous conditions.¹ These consolidated cases arise under the Federal Mine Safety and Health Act of 1977, 30 U.S.C § 801 et seq. (2012) (“Mine Act” or “Act”).

¹ 30 C.F.R. § 77.1713(a) provides:

At least once during each working shift, or more often if necessary for safety, each active working area and each active surface installation shall be examined by a certified person designated by the operator to conduct such examinations for hazardous conditions and any hazardous conditions noted during such examinations shall be reported to the operator and shall be corrected by the operator.

The administrative law Judge vacated the citation. He assumed the accident occurred in an active working area. 32 FMSHRC 132, 135 (Jan. 2010) (ALJ). He concluded, however, that: (1) because the gas line had been present on the mine for at least 10 years, was marked by a right of way edged by trees, and was well known by everyone at the mine, the gas line did not constitute a reportable “hazardous condition” under section 77.1713(a), and (2) neither the fatally injured miner nor anyone else had given Black Castle an indication that the actual location of the gas line needed to be marked. 32 FMSHRC at 137, 144. The Commission granted the Secretary’s petition for discretionary review and, for the following reasons, we affirm the Judge’s decision in result.

I.

Factual and Procedural Background

Black Castle is the operator of a large surface coal mine in West Virginia which contains a 16-inch-wide and 32-mile-long natural gas pipeline operated by Equitable Resources. 32 FMSHRC at 133, 136; Tr. 78-80. In early 2006, Black Castle began preparations to conduct additional mining operations at a location known as the East of Stollings Amendment area. 32 FMSHRC at 133. This site has five coal seams and Black Castle intended to mine the Stockton seam using a method known as contour mining. Tr. 137-38, 315-16. To accomplish this, Black Castle needed to build an access road from the Judy Low Gap area to the Clarion coal seam (the seam of coal above the Stockton in elevation), expose the Clarion seam around the hillside, and create a “drill bench” (a flat area on a hillside) along the Clarion seam. Tr. 131. From this bench, Black Castle intended to drill holes down to the Stockton coal seam, load the holes with explosives, and blast material to reach the Stockton coal. *Id.* at 140.

Black Castle identified Paul Moss, who was classified as a “master dozer operator,” as the individual to perform this work. Tr. 326, 614. Management officials subsequently met with Moss to explain the assignment, and during these meetings, the location of the pipeline right of way was also discussed.

On the morning of January 31, 2006, Moss began constructing the access road uphill from the Judy Low Gap area in order to locate the Clarion coal seam. 32 FMSHRC at 133. He had not reached the Clarion seam when he stopped for the day. *Id.* The following morning, February 1, Moss returned to the area to continue construction. *Id.* Tragically, sometime after 2:00 p.m. his bulldozer ruptured the gas line, which burst into flames, and Moss was fatally injured. *Id.* at 133-34. After conducting an accident investigation, MSHA issued a citation to Black Castle, alleging that it had violated section 77.1713(a) because, *inter alia*, “[a]n active 16-inch diameter gas line was buried and was not adequately marked in the area where the bulldozer was being operated” and “[t]he presence of the unmarked gas line constituted a hazardous condition which should have been reported and corrected during the required daily

inspection.” Gov. Ex. 1. A subsequent special investigation pursuant to section 110(c) of the Act resulted in Vira being charged personally with a knowing violation of the same standard.²

II.

Disposition

As a threshold matter, we conclude that the mere presence of a well-known gas pipeline at the mine is not necessarily a hazardous condition that must be regularly noted in the examination book pursuant to section 77.1713(a). The gas line at this mine had been in place for at least ten years, and the right of way containing the gas line was generally marked off with certain identifying features. As the Judge noted, everyone working at the mine knew that there was a gas line on the East Stollings Amendment area. 32 FMSHRC at 137, 142. Moreover, MSHA had never previously cited Black Castle for failing to report the presence of the gas line in an on-shift examination report.

Nonetheless, a hazardous condition may exist when markings fail to sufficiently indicate a gas line’s location - a situation which the Secretary argues was present here. The regulation the Secretary alleges Black Castle violated, however, imposes a requirement to examine for and correct hazardous conditions only as to “each active working area.” Therefore, to prove a violation of section 77.1713(a), the Secretary must demonstrate that the operator failed to examine, report or correct a hazardous condition in the “active working area.” See 30 C.F.R. § 77.1713(a). In other words, an examiner at this mine seeking to comply with section 77.1713(a) is not required to examine the entire gas pipeline; he or she need only determine whether the pipeline is adequately marked in the “active working areas.” Such examiner would be required to confirm that the markings sufficiently informed a miner of his or her location relative to the gas line. If the markings were not adequate, the examiner would be required to note that fact, and the operator would be required to take corrective action.

² Section 110(c) of the Mine Act, 30 U.S.C. § 820(c), provides that:

Whenever a corporate operator violates a mandatory health or safety standard or knowingly violates or fails or refuses to comply with any order issued under this Act or any order incorporated in a final decision issued under this Act, except an order incorporated in a decision issued under subsection (a) or section 105(c), any director, officer, or agent of such corporation who knowingly authorized, ordered, or carried out such violation, failure, or refusal shall be subject to the same civil penalties, fines, and imprisonment that may be imposed upon a person under subsections (a) and (d).

Although compliance with section 77.1713 is dependent upon an adequate examination of “the active working area,” that particular term is not defined in either the statute or regulations. In his post-hearing brief below, the Secretary urged that the term “active working area” should be read to include all areas where it is reasonably foreseeable that miners will work or travel when carrying out their work-related tasks. S. Post-Hearing Br. at 29. We also note that there is a definition of “active workings” at 30 C.F.R. § 77.2(a), which states that the term “means any place in a coal mine where miners are normally required to work or travel.” For the reasons set forth below, we conclude that the area in which the accident occurred was not an active working area under either Section 77.2(a) or the Secretary’s proffered definition.

Assuming *arguendo* that the gas line did constitute a hazardous condition at the accident site, one must still determine whether this hazard should have been detected and corrected during the February 1 examination required by section 77.1713(a).³ An affirmative answer would require a determination that the accident site was located in “the active working area.” Even were we to apply the Secretary’s suggested definition of that term, we must ask whether it was reasonably foreseeable that a miner would be in the accident area when carrying out his or her work related tasks during the shift(s) covered by the operator’s examination.

The Judge concluded that “Black Castle had no reason to anticipate that Moss would go above the Clarion seam because it had nothing to do with his work assignment.” 32 FMSHRC at 143. This finding is amply supported by the record.⁴

The evidence demonstrates that the accident location was not a part of Moss’ assigned work area and that management and miners alike were surprised that Moss had moved to the area where he struck the gas line. *Id.* At the time of the accident, Moss was 265 vertical feet from his assigned work area. *Id.* at 142. Moreover, because he could not go straight uphill, he had actually trammed 500 feet from the Clarion seam. *Id.*, citing Tr. 711, Resp. Ex. 3. In addition, Jackson Woodward, a dozer operator who was working on a hill opposite from Moss at the time of the accident, testified that he was surprised to see Moss moving toward the gas line around 2:30 p.m., because Moss was far away from the place that he was benching. 32 FMSHRC at 143.

Attempting to characterize the accident site as a place that Moss could be expected to work, the Secretary suggests that Moss might have been removing material such as felled trees

³ Vira performed a preshift examination at approximately 4:30 am on February 1. Tr. 161. He performed a second examination around 8:30 am that morning. *Id.* The regulation only required the on-shift examination, but state regulations required a preshift examination, so Vira conducted both. 32 FMSHRC at 136 n.2.

⁴ The Judge nevertheless assumed, for purposes of his decision, that the accident location was part of the “active working area.” 32 FMSHRC at 136. He concluded, however, that the Secretary failed to prove the existence of a hazardous condition. *Id.* at 137.

from above the Clarion seam, possibly believing that such material might have posed a hazard to miners and equipment during the removal of coal from the Stockton seam. S. Br. at 26. The Secretary also argues that it would have been an accepted practice for the bulldozer operator to create access roads to the next higher coal seam. *Id.* at 26-27.

The Judge rejected these contentions, stating “[t]here is no evidence to support these theories.” 32 FMSHRC at 142. He relied on production manager William Marcum’s testimony that in performing the benching area on the Clarion seam, Moss would have had no need to remove trees far above that seam for safety purposes. 32 FMSHRC at 143, *citing* Tr. 645-46. In addition, Michael Boothe, Moss’ immediate supervisor, testified that he did not anticipate that Moss would go to the area where the accident occurred because he and Moss decided that constructing an access road was not feasible at that time, and Moss knew that Boothe had no intention of creating a second access road. Tr. 679-80.

Lastly, the Secretary asserted that the material found pushed up in the blade after the explosion demonstrates that Moss was pushing material when the accident occurred. S. Br. at 26; S. Post-Hearing Br. at 29. This contention was rebutted by Marcum’s testimony that bulldozer operators will often drop their blades when preparing to go downhill to control the speed of the descent. Tr. 644-45.

It, thus, appears that even under the Secretary’s proposed interpretation of the term, the area in which Moss was working at the time of the accident could not reasonably be considered an “active working area” of the mine, so as to bring it under the purview of section 77.1713(a). That being the case, the area was not required to be examined for hazardous conditions as part of the on-shift inspection of February 1. Even assuming, therefore, that the pipeline was not sufficiently marked in the area of the accident, as the Secretary alleges, the operator was not required to detect and correct this condition in accordance with section 77.1713(a).

In maintaining that the gas line was not adequately identified, the Secretary’s case focused almost exclusively on the lack of identifying markers at the accident site. The Secretary presented evidence, for example, indicating that the closest carsonite marker was 250 to 300 feet away from the accident site, and that the orange pin flags were not visible from the accident site. S. Br. at 20, *citing* Tr. 85, 413, 730. Although Black Castle explained that it left a row of trees along the gas line right of way to help identify its location, the Secretary presented photographic evidence of the accident site showing no trees standing in the immediate area of the accident. S. Br. at 20, *citing* Tr. 122. Based on this evidence, one might well conclude that a miner located where Moss was when the accident occurred would not have been able to ascertain his or her location relative to the gas line, and this section of the gas line could, therefore, be considered a hazardous condition. However, as explained above, this evidence does not prove the existence of a hazard in an active working area.

Despite the Secretary’s emphasis on the presence of hazards near the scene of the accident, our inquiry does not end there. We have also reviewed the record evidence and the parties’ arguments regarding hazards in the area where Moss was assigned to work on

February 1, before he moved to the accident site. This is the relevant inquiry, as it goes to the question of whether there was a hazardous condition (such as an inadequately marked pipeline) in the active working area that Vira should have noted when he conducted his examinations that morning.

The Judge found that the gas line was marked, at a minimum, by a mowed or muddy right-of-way edged by trees, and that this was one reason why the pipeline was not perceived as a hazardous condition. 32 FMSHRC at 137. In effect, the Judge made a finding that the gas line was adequately marked. Although this finding did not pertain specifically to the area where Moss was working on February 1, before he left for the accident site, it is a finding that we view as pertaining to the gas line in its entirety on the mine property, and thus, encompasses this area. The Judge ultimately concluded that the Secretary failed to prove the existence of a hazardous condition.

The Judge's factual finding is reviewed under a substantial evidence standard of review. 30 U.S.C. § 823(d)(2)(A)(ii)(I). Substantial evidence means "such relevant evidence as a reasonable mind might accept as adequate to support the [Judge's] conclusion." *Consolidation Coal Co.*, 35 FMSHRC 2326, 2328 n. 3 (Aug. 2013) (citations omitted). In assessing whether a finding is supported by substantial evidence, the record as a whole must be considered, including evidence in the record that "fairly detracts" from the finding. *Prairie State Generating Co., LLC*, 35 FMSHRC 1985, 1991 n.9 (July 2013) (citations omitted).

We conclude that there is substantial evidence in the record to support the Judge's finding as it applied to the area where Moss was assigned to work on the morning of February 1 before he went to the accident site. First, William Marcum, the Black Castle production manager, testified that, as a general matter, such pipelines are marked with yellow stakes and a clear right of way. 32 FMSHRC at 136; Tr. 624. More specifically, Marcum testified that the gas line at issue had plastic markers staked in the ground by the gas company, and that some of those markers were in the area between the Low Gap area and the area where the dozer was located after the accident. Tr. 627.

Marcum also testified that there was a right-of-way along the pipeline approximately 30 or 40 feet wide with an all-terrain vehicle trail. Tr. 625-26. This is supported by the testimony of Rejean Boulet, a contractor from East Cumberland hired to cut trees along the pipeline. He testified that he left a row of trees on each side of it. Tr. 286. Brian Miller, superintendent of pipelines for Equitable Resources, also testified that there was a right of way with clear vegetation around the gas line. Tr. 99, 107. Miller testified that the entire pipeline had been mowed earlier that year and that the vegetation on the right of way was considerably smaller than any of the wood line on either side. Tr. 107.

In addition to the evidence regarding the presence of markers and a clear right-of-way, there was testimony regarding whether Moss was aware of the location of the pipeline (which could be an indication of whether it was adequately marked). Michael Boothe, the Black Castle drill blast foreman and Moss' supervisor, testified that on February 1, he spoke with Moss by CB

radio and later went to see him. Tr. 390, 392-93. Boothe stated that during these conversations, Moss did not mention the gas line and, in fact, never expressed any fear about the gas line to Boothe. Tr. 394, 673. The Judge noted that there was nothing to indicate that Boothe was not credible. 32 FMSHRC at 142.

The Secretary did elicit testimony from witnesses regarding a statement by Moss that he was not certain where the pipeline was located. While it might be possible to infer from such a statement that the pipeline was not adequately marked, we conclude that the record in this case does not suffice as a basis for us to overturn the Judge's finding to the contrary.

The evidence includes testimony from Kenneth Smith, who stated that as he and Moss were driving to work on February 1, Moss said he was not sure where the gas line was. Tr. 199-200. Smith also testified that he heard Moss talking on the CB radio to Vira around 9:00 a.m. that day and that Moss stated he was concerned he might be getting too close to the gas line. Tr. 207-09. The Secretary also offered the testimony of Elmer Bishop (an East Cumberland contract employee clearing trees at the mine). Tr. 291-307. He stated that around 8:00 a.m. on February 1, he heard Moss call Vira and that Moss hollered at Vira and told him he did not know where the gas line was, or he didn't have any idea where it was. Tr. 296. However, Vira categorically denied that Moss had asked him about the location of the gas line. Tr. 768-69. Moreover, the Judge found that "[t]o the extent that Bishop's statements cannot be reconciled with the other witnesses, I find that he is not credible." 32 FMSHRC at 141.

Finally, Lonnie L. Wood (survey lineman for Black Castle) testified that he was assigned to mark 400-500 feet of the gas line in the Low Gap area. Tr. 564. He stated that Moss asked him twice about the location of the gas line in the Low Gap area, although he was no longer working there. The second conversation took place at approximately 9:00 a.m. on February 1. Tr. 566-74. The Judge concluded that when Moss talked with the surveyors, "while he expressed some curiosity about where the gas line went, he did not state any concerns or ask them to proceed to where he was working and show him where the gas line was." 32 FMSHRC at 141.

In his decision, the Judge reviewed and discussed all of this testimony at length. 32 FMSHRC at 137-42. He made credibility determinations, either expressly or implicitly, and concluded that "[t]here certainly is no evidence that [Moss] said anything to the affect [sic] of - 'I don't know where the gas line is, how can I stay 100 feet from it?' or, 'Have someone mark it for me,' or anything like that." 32 FMSHRC at 141.⁵

Our inquiry is limited to whether it is reasonable to accept the operator's evidence (as set forth above) as sufficient to support the Judge's conclusion that the gas line was adequately marked (and that consequently there was not a need to report a lack of markings as hazardous,

⁵ A Judge's credibility determinations are entitled to great weight and may not be overturned lightly. *Consolidation Coal Co.*, 35 FMSHRC at 2329 (citations omitted).

and that therefore the examinations conducted February 1 were adequate). Even considering the Secretary's evidence that arguably "fairly detracts" from this finding, we nonetheless conclude that there is substantial evidence in the record to support the Judge's finding.⁶

We also affirm the Judge's conclusion that Vira did not violate section 77.1713(a). *Id.* at 144. As discussed above, substantial evidence supports the Judge's finding on the adequacy of the on-shift examination. We therefore conclude that the civil penalty proceeding brought against Vira under section 110(c) was properly dismissed by the Judge.

/s/ Mary Lu Jordan

Mary Lu Jordan, Chairman

/s/Michael G. Young

Michael G. Young, Commissioner

/s/ Patrick K. Nakamura

Patrick K. Nakamura, Commissioner

/s/ William I. Althen

William I. Althen, Commissioner

⁶ Besides a mandatory once a-shift examination, section 77.1713(a) also requires that inspections be conducted "more often if necessary for safety." 30 C.F.R. § 77.1713(a). Therefore, we have carefully considered the Secretary's argument that the Judge shifted the responsibility for preventing unsafe conditions from the operator to the miner. After finding that the on-shift examination was adequate because there was no need to report a hazardous condition that everyone was aware of and that was adequately marked, the Judge specifically considered whether Moss put Black Castle on notice of a need for another examination. He considered Moss' conversations with Marcum, Boothe, Smith, Vira, and surveyors who were marking the gas line in the Judy Low Gap area. 32 FMSHRC at 137-44. The Judge determined that "Moss did not give Vira or Black Castle management any reason to believe that the gas line needed to be marked better than it was." *Id.* at 141. He emphasized that "up until the time of the accident, neither Moss nor anyone else had given Vira or any other Black Castle person in authority an indication that marking of the actual gas line was necessary." *Id.* at 143. He concluded, therefore, that management had not been made aware of any reason to conduct an additional on-shift examination. *Id.* at 144. That decision is supported by substantial evidence.

The evidence supporting the Judge's determination that the pipeline was adequately marked also supports this additional finding. In particular, we note that the only assertion that Moss' concerns were expressed to mine management was the testimony regarding Moss' statements to Vira. This testimony, however, was contradicted by Vira, and the Judge made a credibility determination that Moss had expressed no such concerns to him. 32 FMSHRC at 141.

Commissioner Cohen, concurring:

I join my colleagues in result for the reason that as an appellate body, the Commission must affirm an administrative law judge's decision if it is supported by substantial evidence. In this case, I must conclude, albeit reluctantly, that the judge's findings, based on credibility determinations, are supported by substantial evidence. I write separately in order to address several lingering questions, as well as reservations I have about the accounts provided by certain Black Castle witnesses regarding the events leading up to Paul Moss' fatal accident.

On February 1, 2006, Paul Moss was fatally injured when the bulldozer he was operating at Black Castle Mining Company's surface mine in Boone County, West Virginia, contacted and ruptured a 16-inch low-pressure, high-volume natural gas line, which burst into flames. Following an investigation, MSHA found a violation of section 77.1713(a) of the regulations, 30 C.F.R. § 77.1713(a), alleging that "[a]n adequate daily examination for hazardous conditions was not made of the active working area . . . of the mine." Gov. Ex. 1. MSHA issued proposed penalty assessments against Black Castle, and also against its Mine Superintendant Michael Vira under section 110(c) of the Mine Act. The pivotal questions posed by this case are: (1) whether the site of the explosion was part of the "active working area", and (2) whether the gas line was "adequately marked". To answer the first question, it is important to know why Moss was so far from the Clarion seam when the accident occurred.

Active Working Area

The judge determined that the work being performed by Moss and the proximity of the gas line right-of-way to the access road, at least in the Low Gap area, was sufficient to deem the accident site part of the active working area. 32 FMSHRC 132, 136 (Jan. 2010) (ALJ). My colleagues, however, have concluded that because Black Castle had no reason to anticipate that Moss would travel above the Clarion seam, the accident site was not an "active working area" under 30 C.F.R. § 77.2 or the Secretary's proffered definition. Slip op. 4-5. I am not so convinced.

The explosion that killed Moss occurred some 265 vertical feet away from the outcrop of the Clarion coal seam where Moss had been assigned to construct a bench. Moss had actually trammed his dozer 500 feet from the Clarion seam to reach the place where he died. Tr. 710-11, Resp. Ex. 3. Although Black Castle management testified that Moss had no reason to tram so far away from the Clarion seam, it appears to me that the distance he traveled was too far to be inadvertent. There are three possibilities for why Moss was so far from the Clarion seam: 1) Moss was off on a lark, totally unrelated to his instructions from management; 2) (as the Secretary contends) Moss traveled above the seam to clear material from the top of the future highwall

which would be created when overburden was removed from above the Stockton coal seam,¹ or to carve an access road to another level; or 3) Moss was given direction by a supervisor that caused him to be up on the ridge near the gas line.

I find the first scenario unlikely. By all accounts, Moss, a master dozer operator, was highly experienced and safety conscious. Tr. 177-78, 217, 229-30, 294, 377. Production Manager William Marcum testified that he was probably the best dozer operator at the mine – a go-to guy and one of Black Castle’s best employees. Tr. 326. Michael Boothe, Moss’ immediate supervisor, and Michael Vira stated that Moss was probably the most experienced dozer operator at the mine. Tr. 177-78, 372, 376-77. Kenneth Smith and Jackson Woodard, fellow dozer operators, testified that Moss was safety conscious and not a risk taker. Tr. 217, 230. He was also known to follow directions. Tr. 217, 377. Therefore, in light of this overwhelming testimony, it is reasonable to conclude that reckless behavior – tramming 500 feet from where he should have been in defiance of his orders – would be out of character for Moss and, therefore, highly improbable.

The second scenario, however, is plausible, despite the judge’s rejection of this theory as speculative. 32 FMSHRC at 142-43. According to the Secretary’s theory, which is supported by Woodard’s undisputed testimony, it is not uncommon for dozer operators during the benching process to work outside of the coal seam to remove debris from the pathway, material from the highwall, or to create an access road. Tr. 244-49. Woodard testified that dozer operators are given wide discretion in the manner in which they complete their assigned tasks. Tr. 249-50. Thus, it would seem reasonably foreseeable that Moss might work above the Clarion bench as he deemed necessary, as part of his assignment. This would make the accident site part of the “active working area.”

The last scenario, that management directed Moss up on the ridge, is also possible. The judge’s statement that “no one knows why Moss took the bulldozer where he did,” may not necessarily be accurate. *See* 32 FMSHRC at 142. The evidence suggests that Moss may well have been directed to the ridge. Woodard testified that on the morning of the accident, Moss did not know on what level he was supposed to start benching, so Woodard sent a message to have Boothe “get with” Moss. Tr. 234. Boothe made a quick stop at Moss’ work site shortly thereafter, left, then returned just before noon. Tr. 234. Woodard stated that after a 15 minute meeting with Boothe, Moss made a ramp to a higher level where he began benching until sometime after 2:00 p.m. Tr. 235. Woodard then looked over and saw Moss coming towards the gas line, which struck him as “funny” that Moss was so far away from where he had been benching. Tr. 235-36, 255-56. Woodard, unsuccessfully, tried to call Moss because he wondered if his orders had been changed. Tr. 236, 255, 262. When questioned by Respondent’s counsel whether Woodard knew that Moss, being up on the ridge, was beyond his work area, Woodard answered:

¹ The reason Moss was constructing a bench at the Clarion coal seam outcrop was to enable Black Castle to bring in drilling equipment to blast away the part of the mountain overlying the Stockton coal seam (i.e., the “overburden”) so as to mine the coal in the Stockton seam. The blasting away of the overburden would create an 80-foot highwall. Tr. 139-41.

Well, I did not know that. . . . I knew that he was supposed to be working up [on the Clarion seam], but I had no idea what conversation that he and Mike Boothe had. Mike Boothe could have changed his orders or --- I mean, I didn't know. That's the reason, you know --- I thought it was strange was the reason I called.

Tr. 262. Clearly, Woodard recognized that Boothe might have given Moss additional instructions that placed him at the accident site. However, the judge credited Boothe's account that Moss made no mention of the gas line during these conversations, and that only Moss' slow progress was discussed. Tr. 394, 396-97. Had the judge credited Woodard's testimony, it would not have been a leap to have concluded that Boothe, at the very least, instructed Moss on where to bench. Such a conclusion would also indicate that the two discussed more than Moss' slow progress.

However, we lack the testimony of Mr. Moss, who could have explained the circumstances leading to the accident that claimed his life. We also lack conclusive evidence that might explain why such an experienced dozer operator would apparently stray off course in a dangerous area of the mine. In view of the judge's finding that the Secretary's theory is "speculative", and without substantial record evidence to support the two most plausible scenarios, I am constrained to stand with the majority's determination that the area in question was not an active working area and, therefore, that no on-shift examination was required of that area.

Adequate Markings

I am not persuaded that the gas line beyond the Low Gap area was adequately marked. As set forth by the majority opinion, a hazardous condition exists when markings fail to sufficiently indicate a gas line's location in an "active working area." Slip op. at 3. Therefore, compliance with section 77.1713 here required that the on-shift examiner, Vira, determine whether the pipeline was adequately marked in the "active working area," and if not, to make a notation and take corrective action. See Slip op. at 3.

Although the judge found that the gas line was marked, at a minimum, by a mowed or muddy right-of-way edged by trees, 32 FMSHRC at 137, the Commission majority interpreted it as a finding that the gas line was "adequately" marked, and concluded that it applied to the entire gas line on mine property. Slip op. at 6. I not only question the judge's finding, but the majority's application of it to the pipeline.

Photographs of the accident site clearly show an absence of trees in the area where the dozer was found. Gov. Exs. 4-1, 4-3. They also show the dozer sitting just outside of the right-of-way, which indicates that the gas line did not actually run *within* the right-of-way at all times, as generally believed by mine personnel. *Id.*; 32 FMSHRC at 142; Tr. 175. There is also no evidence that there were markers in the immediate area where the accident occurred. Slip op. at 6; Tr. 180-81; Gov. Ex. 4-3. In fact, the closest carsonite marker was 250 to 300 feet away, and the orange flags that were placed in the Low Gap area were not visible from the accident site. Tr.

85, 127, 182-83. In addition, the markers were located on the opposite side of the right-of-way from where Moss was operating the dozer. Tr. 183, 189; Gov. Exs. 4-28, 4-29. Boothe even admitted that beyond the Low Gap area, the exact location of the gas line was unknown. Tr. 386.

Perhaps the strongest indication that the markings may have been inadequate comes from the testimonial evidence that Moss was unclear about the location of the gas line. As we know, Vira denied that Moss ever expressed concern or asked about the gas line's location. Tr. 768-69. He testified that Moss only asked how far to stay away from the gas line, and that he, Vira, told him to keep a distance of 100 feet.² Tr. 768. However, according to Smith, Moss told him that he was not sure of the gas line's location when they were driving to work together on the day of the accident. Tr. 199-200. At around 9 a.m. that morning, Smith overheard Moss tell Vira over the CB radio that he "was concerned he might be getting too close to the gas line." Tr. 207-09. Similarly, Elmer Bishop, a foreman for East Cumberland, the contractor hired by Black Castle to cut and clear trees, testified that Moss called Vira that morning and "hollered at [Vira] and told him he didn't know where the gas line was at, or he didn't have no idea where it was at." Tr. 291-92, 296. Furthermore, Lonnie Wood, a survey lineman for Black Castle, stated that Moss asked him twice on the day of the accident about the location of the gas line.³ Tr. 573-74.

Although Vira's instruction to stay 100 feet away from the gas line was corroborated by Smith and Woodard, his description of what Moss initially expressed to him (i.e., "how far he needed to stay away from the gas line", Tr. 177, 768) was not. *See* Tr. 209, 234. In fact, Smith's and Bishop's testimony demonstrate that, contrary to Vira's account, Moss expressed confusion to Vira as to the location of the gas line. *Id.* Nonetheless, relying heavily on Vira's testimony, the judge found that Moss gave no indication to management that additional markings were

² The judge found that "if Moss had followed Vira's guidance and stayed 100 feet from the right-of way, this unfortunate accident would not have happened." 32 FMSHRC at 142. First, I reiterate that Moss was known to follow directions. Second, it was impossible for Moss to follow this guidance because from the start, his path of operation brought him within 75 feet of the gas line, a situation which Vira as Mine Superintendent should have known. Tr. 735; Resp. Ex. 3.

³ The judge concluded that Moss "really did not express concern or ask many questions." 32 FMSHRC at 142. He diminished Moss' concerns by characterizing his statement to Smith as a "remark" rather than "an expression of serious concern," and his questions to Wood as expressions of "curiosity." 32 FMSHRC at 138, 140-42. In light of the record in its entirety, I see no reason to doubt the seriousness or urgency of Moss' concern.

necessary.⁴ 32 FMSHRC at 141. He construed Smith's testimony as reconcilable with Vira's, and discredited the testimony of Bishop. 32 FMSHRC at 141.

Additionally, it does not follow that, because everyone knew the general location of the gas line, markers identifying its specific location were unnecessary.⁵ Even though Black Castle had mined coal within the vicinity of the gas line for years, it was well-known by management that mining in the East of Stollings Amendment Area, a virgin area of the mine, would bring miners in closer, more dangerous proximity to the gas line. This posed a hazard that required Black Castle to implement additional safety measures. At a minimum, the operator was required to ensure that the entire gas line was clearly marked before allowing miners to work in that area, especially because heavy equipment was involved. Moreover, ordinary human carelessness should not be ignored, which is all the more reason to clearly delineate the gas line.⁶ When a condition is so hazardous as to likely result in death, identification of that hazard must be indisputably clear.

As stated by my colleagues, "it might be possible to infer . . . that the pipeline was not adequately marked." Slip op. at 7. I think that such an inference makes sense from the evidence in the record. However, the judge saw it differently.

⁴ I do not agree that Moss should have done more to notify Black Castle that additional markers were necessary. *See* 32 FMSHRC at 141. Even if Moss had said nothing whatsoever, it was Black Castle's responsibility to ensure that the gas line was marked in such a way that any miner working in its immediate vicinity could safely avoid contact with it. As the Commission has stated, quoting the Congressional declaration in section 2(e) of the Mine Act, "the operators of . . . mines with the assistance of the miners have the primary responsibility to prevent the existence of [unsafe and unhealthful] conditions and practices in such mines. 30 U.S.C. § 801(e)." *Consolidation Coal Co.*, 16 FMSHRC 201, 205 (Feb. 1994).

⁵ On some level management knew this because Marcum made the minimal effort of surveying the gas line and identifying it with orange flags in the Low Gap area. But even this was insufficient, because Moss' path of operation required that he bench the length of the Clarion seam, which moved beyond the Low Gap and through the greater East of Stollings Area. As such, Black Castle should have had the gas line surveyed and marked in the entire area, not just the Low Gap.

⁶ The Commission interprets mandatory safety standards to take into consideration "ordinary human carelessness." *Thompson Bros. Coal Co.*, 6 FMSHRC 2094, 2097 (Sept. 1984). In *Thompson*, the Commission held that the guarding standard must be interpreted to consider whether there is a "reasonable possibility of contact and injury, including contact stemming from inadvertent stumbling or falling, momentary inattention, or ordinary human carelessness." *Id.* An objective interpretation of such a standard cannot "ignore[] the inherent vagaries of human behavior. Even a skilled employee may suffer a lapse of attentiveness, either from fatigue or environmental distractions. . . ." *Great Western Electric Co.*, 5 FMSHRC 840, 842 (May 1983).

The Test of Substantial Evidence

Under the Mine Act, the Commission must affirm the factual findings of the judge if they are supported by substantial evidence. Substantial evidence is “such relevant evidence as a reasonable mind might accept as adequate to support [the judge’s] conclusion.” *Rochester & Pittsburgh Coal Co.*, 11 FMSHRC 2159, 2163 (Nov. 1989) (citing *Consolidation Edison Co. v. NLRB*, 305 U.S. 197, 229 (1938)). Moreover, the Commission has recognized that a judge’s credibility determinations are entitled to great weight and may not be overturned lightly. *Farmer v. Island Creek Coal Co.*, 14 FMSHRC 1537, 1541 (Sept. 1992); *Penn Allegh Coal Co.*, 3 FMSHRC 2767, 2770 (Dec. 1981).

The judge overwhelmingly credited the self-serving testimony of Vira and Boothe – both management representatives of Black Castle, and, in the case of Vira, the subject of the section 110(c) proceeding which is part of this case. On the contrary, he discredited the testimony of Bishop, and did not make what would have been reasonable inferences from the testimony of Smith and Woodard. However, the judge’s credibility determinations and the inferences he drew were not so unreasonable as to be reversible. The weight of the evidence supporting the Secretary’s position detracts from the evidence supporting the judge’s factual determinations, but not to the degree as to render them unsupported by “substantial evidence” within the scope of *Rochester & Pittsburgh Coal*. If the judge had made different credibility determinations, we could just as easily affirm the citations issued to Black Castle and Vira. However, under our substantial evidence standard of review, I must, with reluctance, stand with my colleagues in affirming the judge’s decision in result.

/s/ Robert F. Cohen, Jr.

Robert F. Cohen, Jr.,
Commissioner

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COMMISSION ORDERS

FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

1331 PENNSYLVANIA AVENUE, NW, SUITE 520N
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February 6, 2014

BRODY MINING, LLC

v .

SECRETARY OF LABOR,
MINE SAFETY AND HEALTH
ADMINISTRATION (MSHA)

Docket Nos. WEVA 2014-82-R et al.

ORDER

These matters arise under the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 801 et seq. (2012). On January 30, 2014, Chief Administrative Law Judge Robert J. Lesnick issued a Certification of Interlocutory Ruling pursuant to Commission Procedural Rule 76, 29 C.F.R. § 2700.76(a)(1)(i). In his order, the Judge certified for interlocutory review by the Commission his ruling that the Secretary of Labor's pattern of violations regulation is valid and was not applied to Brody Mining, LLC in an impermissibly retroactive manner. Unpublished Order at 3-4 (Jan. 30, 2014).

Commission Procedural Rule 76(a) provides that interlocutory review is a matter of sound discretion of the Commission, and that the Commission may grant interlocutory review upon a determination that the Judge's interlocutory ruling involves a controlling question of law and immediate review will materially advance the final disposition of the proceeding. 29 C.F.R. § 2700.76(a).

Upon consideration of the Judge's certification, we hereby grant review of the Judge's order of January 30, 2014, with regard to: (1) whether the Secretary's pattern of violations rule, 30 C.F.R. § 104, promulgated at 78 Fed. Reg. 5056, and effective March 25, 2013, is valid on its face and as applied in these proceedings; (2) whether the Mine Safety and Health Administration's pattern of violations screening criteria are invalid because notice and comment rulemaking was required; and (3) whether MSHA impermissibly applied the pattern of violations rule retroactively.

Brody's opening brief is due to be filed within 30 days of the date of this order, and remaining briefs shall be filed in accordance with the Commission's Procedural Rules, 29 C.F.R. § 2700.75. In their briefs, the parties should address, among other issues, the question of whether the Commission has jurisdiction to rule upon the validity of the regulations referenced above.

The petition for interlocutory review filed by the operator is denied as moot.

/s/ Mary Lu Jordan
Mary Lu Jordan, Chairman

/s/ Michael G. Young
Michael G. Young, Commissioner

/s/ Robert F. Cohen, Jr.
Robert F. Cohen, Jr., Commissioner

/s/ Patrick K. Nakamura
Patrick K. Nakamura, Commissioner

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ADMINISTRATIVE LAW JUDGE DECISIONS

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February 11, 2014

UNITED TACONITE, LLC	:	CONTEST PROCEEDINGS
Contestant,	:	
	:	Docket No. LAKE 2011-392-RM
	:	Order No. 6553379; 01/24/2011
v.	:	
	:	Docket No. LAKE 2011-393-RM
SECRETARY OF LABOR	:	Order No. 6553380; 01/24/2011
MINE SAFETY AND HEALTH	:	
ADMINISTRATION, (MSHA),	:	Mine: United Plant
Respondent,	:	Mine ID 21-03404
	:	
	:	
SECRETARY OF LABOR	:	CIVIL PENALTY PROCEEDING
MINE SAFETY AND HEALTH	:	
ADMINISTRATION, (MSHA),	:	Docket No. LAKE 2012-687-M
Petitioner,	:	A.C. No. 21-03404-289745-01
	:	
v.	:	Docket No. LAKE 2012-841-M
	:	A.C. No. 21-03404-296882
	:	
	:	
UNITED TACONITE, LLC	:	
Respondent.	:	Mine: United Plant

DECISION AND ORDER

Appearances: James M. Peck, U.S Department of Labor, Office of the Solicitor, Duluth, MN for the Secretary

Dana Svendsen, Esq., & R. Henry Moore, Esq., Jackson Kelly, PLLC, Denver, CO and Pittsburgh, PA respectively for Respondent

Before: Judge Lewis

STATEMENT OF THE CASE

These cases are before the undersigned Administrative Law Judge on Petitions for Assessment of Civil Penalty filed by the Secretary of Labor against Respondent, United Taconite ("Respondent" or "United Taconite"), pursuant to Sections 104 and 105(d) of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. §815(d). A hearing was held in Duluth, Minnesota on August 27, 2013. The parties subsequently submitted post-hearing briefs.

PROCEDURAL HISTORY

On January 24, 2011, MSHA Inspector Thaddeus J. Sichmeller issued a 107(a) Imminent Danger Order and a corresponding 104(d)(1) Citation for an alleged safety violation at United Taconite's United Plant ("Plant") in St. Louis County, Minnesota. On April 26, 2011, Inspector Sichmeller issued a 104(a) citation for another alleged safety violation at the Plant. United Taconite contested these violations and all three issuances were brought to hearing.

STIPULATIONS

The parties have entered into several stipulations, admitted as Parties Joint Exhibit 1. Those stipulations include the following:

1. United Taconite LLC is engaged in mining operations in the United States, and its mining operations affect interstate commerce
2. United Taconite LLC is the operator of the United Plant, MSHA I.D. No. 21-03404. United Taconite LLC is an "operator" as defined in Section 3(d) of the Federal Mine Safety and Health Act of 1977, as amended (Mine Act), 30 U.S.C. 803(d).
3. United Taconite LLC is subject to the jurisdiction of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. §801 *et. seq.*
4. The Administrative Law Judge has jurisdiction in this matter.
5. The subject citations and orders were properly served by a duly authorized representative of the Secretary upon an agent of United Taconite LLC on the dates and places stated therein, and may be admitted into evidence for the purpose of establishing their issuance.
6. The exhibits to be offered by United Taconite LLC and the Secretary are stipulated to be authentic but no stipulation is made as to their relevance or the truth of the matters asserted therein.
7. The penalties, if affirmed, will not impair United Taconite LLC's ability to remain in business.
8. The Certified Assessed Violation History Report reflecting the history of the violations of the Respondent is an authentic copy and may be admitted into evidence as a business record of MSHA.
9. The operator demonstrated good faith in abating the conditions cited in Citation No. 6559833.

10. MSHA Inspector Thaddeus J. Sichmeller was acting in his official capacity and as an authorized representative of the Secretary of Labor when aforesaid citations and order were issued.

Joint Exhibit 1¹ (*see also* Transcript at 6).²

LAKE 2012-687-M

I. ISSUES

With respect to LAKE 2012-687-M, the issues to be determined are whether Respondent's alleged actions on January 24, 2011 constituted an imminent danger as charged in Order No. 6553379 and whether the violation alleged in the related 104(d)(1) Citation, Citation No. 6553380, was significant and substantial ("S&S"), whether it was reasonably likely to result in fatal injury, whether it was the result of high negligence, whether it was an unwarrantable failure, and the appropriate penalty.

II. SUMMARY OF TESTIMONY

On January 24, 2011, Inspector Thaddeus J. Sichmeller issued an imminent danger order, No. 6553379, after observing Mickey Krempich standing on the edge of a structure without required fall protection.³ (GX-1).

Earlier that day, at 2:00 p.m., Lucas Greschner⁴ attended a meeting where he learned that a hydro separator at Respondent's Plant was overflowing and making a mess. (Tr. 240). The

¹ Hereinafter the Joint Exhibits will be referred to as "JX" followed by the number. Similarly, the Secretary's Exhibits will be referred to as "GX" and Respondent's Exhibits will be referred to as "RX."

² Hereinafter the transcript will be cited as "Tr." followed by the page number.

³ At hearing, Inspector Thaddeus J. Sichmeller was present and testified for the Secretary. (Tr. 16). At that time, Inspector Sichmeller was a metal/non-metal mine inspector and accident investigator for MSHA and had worked for the administration for over ten years. (Tr. 16-17). In that capacity he conducted examinations of working areas in up to 65 mines in a year. (Tr. 17). Sichmeller took classes and had journeyman training at the Mine Academy in Beckley, West Virginia. (Tr. 17). He also received accident investigation training. (Tr. 17-18). He had an associate's degree in applied science from Marshall University. (Tr. 17). Before MSHA, Sichmeller worked as a millwright at Woodville Mine in Idaho for seven to eight years. (Tr. 18).

⁴ At hearing, Lucas Greschner was present and testified for Respondent. (Tr. 237). At the time of the hearing he was a section manager but when the citation was issued he was an operation supervisor at the crusher and concentrator. (Tr. 237-238). He previously worked at a U.S. Steel pellet plant. (Tr. 238). He earned a bachelor's degree in business management and

(continued...)

hydro separator or concentrator contained a rod mill floor, ball mill, grade floor, basement, and “Mexico” where the conveyors fed into the building. (Tr. 239). The mills crushed the ore into powder, turned the powder into slurry, and then sent the slurry to the pellet plant. (Tr. 239-240). There were seven ball mills. (Tr. 240). There were five concentrator mill lines and they all have boxes like the one in the cited area. (Tr. 258).

When Greschner went to fix the condition, he met up with an hourly employee, Krempich. (Tr. 241). He told Krempich that they had to move water between the thickeners. (Tr. 241). Greschner had never seen it done before, but had seen similar plugs pulled. (Tr. 241, 252, 256). Krempich worked at Respondent for 20-25 years and for 15 years with concentrators. (Tr. 259).

Krempich went to the hydro separator, where the order was later issued, and Greschner went to the overflowing one. (Tr. 241-242, 253). Both separators had thickeners with two boxes and the boxes had chain hoist setups to remove plugs. (Tr. 253-254). Greschner tried to use the chain but it came off the plug. (Tr. 242). At first he did not know what was wrong; he just could not lift the plug. (Tr. 254). Greschner inspected the plug to determine if the hook or chain was broken or if a new chain could be added. (Tr. 242). These chains break or slip off the plug on occasion. (Tr. 254-255). While he was working he stood on a step stool, or moving staircase, and reached up because the box was not high off the ground.⁵ (Tr. 243). Greschner did not wear fall protection while he was on the step stool. (Tr. 243).

While Greschner was working on that separator, Krempich was working on a different one. (Tr. 243). Greschner did not know what Krempich was doing, only that he was diverting water. (Tr. 244). Greschner could not see Krempich from his position on the movable stairs. (Tr. 244-245). At some point, Greschner went to look for Krempich. (Tr. 244).

At around the same time, Inspector Sichmeller conducted a health and safety inspection at Respondent’s Plant. (Tr. 147-158). During the inspection, Sichmeller travelled with Safety Manager Del Savela and Bryan Sandnas looking for structural issues.⁶ (Tr. 160, 200-201, 212).

⁴(...continued)

marketing at the University of Wisconsin at Eau Claire. (Tr. 238-239). Before the instant citation, Respondent received a citation because Greschner did not receive annual 500023 refresher training when he transferred from Minntac. (Tr. 257). He was trained but did not have a record. (Tr. 257). Minntac would not give out the information because he quit. (Tr. 257).

⁵ Instead of climbing on top of the separator, miners commonly used a rolling stairwell. (Tr. 232, 234). The stairs have railings and a platform with railings. (Tr. 232). A miner could roll the stairs up to the side of the tank and use the chain jack. (Tr. 232-233).

⁶At hearing, Del Savela was present and testified for Respondent. (Tr. 55). At the time of the hearing, Savela had worked in the mining industry for over 36 years. (Tr. 56). He had worked for U.S. Steel and Respondent, the latter for over six years. (Tr. 56). At U.S. Steel he served as a millwright for 15 years and a safety engineer for 15 years. (Tr. 56). Savella passed

(continued...)

The inspection group embarked from the main office and traveled toward the hydro-separator tanks. (Tr. 160). It was likely that they traveled together in a single-file line with Sichmeller in the front and Savela in the rear. (Tr. 216-217).

At around the time that Greschner reached the separator where Krempich was working, the inspection group entered the corridor where the tanks were located. (Tr. 160-161, 250, 258). Inspector Sichmeller saw Greschner standing at the base of a set of stairs and looking up. (Tr. 160-161). Inspector Sichmeller did not know what Greschner was looking at. (Tr. 199, 201). Initially, Sichmeller's line of sight was blocked by pipe structure, as shown in the photograph marked GX-6-B. (Tr. 199-200). As he drew closer, Sichmeller followed Greschner's gaze and saw Krempich, standing on top of the tank. (Tr. 160-161, 179).

Krempich was standing on the edge of the open-topped hydro separator box, reaching over a convertor box, and pulling plugs. (Tr. 158-160, 220, 223). Krempich had both feet on the grate near the edge and one hand on the chain hoist. (Tr. 175, 189, 221). Sichmeller did not know where the other hand was located because it was too fast. (Tr. 189). Savela believed the second hand may have been on the chain, but he was not sure because the hoist could be operated with one hand. (Tr. 220-223, 233). Krempich had three or four "points of contact." (Tr. 220). The miner was only wearing his hard hat, safety glasses and safety shoes. (Tr. 160). Savela did not know why Krempich was not using a movable stairway. (Tr. 234).

Greschner was about 50 yards away from Krempich. (Tr. 162, 170, 179-180). Greschner was leaning against the railing and looking up at the employee. (Tr. 170, 178-179, 217, 224-225, 229). Sichmeller believed that Greschner could see what was happening on top of the tank from where he was standing, as depicted in the photograph marked GX-6-H. (Tr. 178-179, 186-187). However, Savela believed that Greschner would be unable to see Krempich because a structure was in the way. (Tr. 218, 226). He believed GX-6-H was not taken from the correct location. (Tr. 226-227). Greschner testified that he could not see Krempich because beams, piping, and a launderer were in the way, as depicted in the photograph marked RX-38. (Tr. 245-249).

Sichmeller testified that he observed Greschner looking for 20-30 seconds but did not know how long he was there. (Tr. 170, 199, 202). Savela believed the inspection group and Greschner had converged on the area at the same time, but was uncertain. (Tr. 225, 230).

⁶(...continued)

the U.S. Steel millwright apprenticeship program, had an associate's degree in human services, a bachelor's degree in social work, and a master's degree in industrial safety. (Tr. 56). He received his Master's Degree from the University of Minnesota-Duluth. (Tr. 57). In 2011 Savela was the plant safety manager for Respondent and his duties included advising personnel on safety policies, procedures, systems, industrial hygiene issues, and fire protection. (Tr. 55-56, 83). He accompanied inspectors and corporate audit teams. (Tr. 56). He had been doing so for 20 years and felt well-versed in policy and procedure. (Tr. 57). At Respondent's plant, he accompanied inspectors as a union representative for a few months and then, from September 2007, he did so as a salaried employee. (Tr. 57). During an MSHA inspection, Savela would coordinate, accompany inspectors, create work orders, and rectify situations. (Tr. 57).

Greschner testified that he saw Krempich for about five seconds before the inspection crew arrived and did not know Krempich was on the top of the tank before that time. (Tr. 250, 258).

Sichmeller believed that Krempich's location posed a high degree of danger. (Tr. 159, 173). He issued an imminent danger order, Order No. 6553379 (GX-1), because Krempich was not wearing fall protection and was in danger of falling. (Tr. 157-158). The most likely place for a fall was the diverter box because Krempich was standing on the middle edge of the tank, reaching the chain hoist. (Tr. 158-159, 162). The inspection crew was about 30-50 feet away from Krempich when the order was issued. (Tr. 216-218, 250). Sichmeller believed that miner could have fallen into the diverter box and drowned or fallen onto the metal grating and received head and body trauma. (Tr. 159). The miner could have fallen into the box or onto the walkway below.⁷ If a miner fell into the tank when the plugs were pulled, the suction would pull him to the bottom. (Tr. 169).

Sichmeller testified that the area may have been wet from splashing. (Tr. 188-189). (Tr. 158). Savela testified that the photographs marked RX-30 to RX-32 showed that the grate was largely dry. (Tr. 213-214, 227-228). Greschner testified that the grate was dry, but he did not inspect it because he did not have fall protection. (Tr. 255-256).

In order to issue the imminent danger order, Sichmeller had to wait for Savela to come up. (Tr. 161, 202). Then he pointed to the condition and told Sandnas and Savela that he was issuing an imminent danger order. (Tr. 161-162). Savela told Krempich to get down. (Tr. 161-162). Sichmeller did not spell out the imminent danger, but Savela immediately realized the problem. (Tr. 205-206). Sichmeller did not tell the miner to get down because, by law, he could not direct the work force; he had to issue an order to have something done. (Tr. 204-206). If Sichmeller had identified Greschner he would have issued the Order to him. (Tr. 207).

Savela did not think there was an imminent danger of falling. (Tr. 222). There was solid structure above the grating (depicted in the photograph marked RX-32) that could have broken the fall from the grating before a worker hit the floor or tank. (Tr. 192-193, 195, 231-234). However, once the plugs were lifted, the chain may have been able to move. (Tr. 235). There might also be a possibility of striking the structure in a fall. (Tr. 235). Sichmeller estimated the gap between the grating and the edge of the solid structure at three to four feet; enough space for a miner to fall through. (Tr. 185-188). However, Greschner testified that distance was measured only 21 inches at the widest point. (Tr. 252-253). Regardless of the structure, Savela conceded

⁷ Sichmeller could not measure the convertor box because he had no harness and could not reach the chain hoist, but he estimated its depth at three or four feet in the center (the box tapered at the sides). (Tr. 167, 184). The box was too deep to reach in and pull the plug. (Tr. 190). The outside of the tank was 65 inches deep. (Tr. 167). The opening was large enough for someone to fall in. (Tr. 167). However, the miner was taller than 5'11. (Tr. 188). The fall to the floor was 75 inches. (Tr. 166-167, 194). Sichmeller felt that any fall danger from this height was an imminent danger, as he had been trained to do. (Tr. 193-194). He has issued citations for less than six-foot falls including a 46 inch fall on a conveyor. (Tr. 194-195). A policy document issued after this Order and signed by Neil Merrifield, the MSHA administrator for metal/non-metal, states that individuals citing imminent dangers for falls have discretion. (Tr. 194-195).

that if he was going to conduct this task, he would wear fall protection. (Tr. 230). Employees and supervisors would also be required to wear it. (Tr. 230-231).

Respondent conducted annual training courses, which discussed fall protection. (Tr. 208-209). Savela believed, but was not sure, that Krempich took the refresher course in 2010. (Tr. 209, 222, 230). Savela knew that Greschner received the training. (Tr. 230). Savela reviewed the presentation on fall protection shown to Respondent's employees (RX-36). (Tr. 209, 212). The presentation was made by Respondent's parent company, Cliff's Natural Resources, based on MSHA's Rules to Live By. (Tr. 211). The second slide showed fall protection was required on elevation and also mentioned using three points of contact for stability. (Tr. 209-210). Fall protection was available in the maintenance room and in the safety department. (Tr. 210). Many crews had their own fall protection. (Tr. 210-211).

After the order was issued, Savela ordered Krempich down (terminating the Order) and Krempich made an "aw shucks" motion with his arms. (Tr. 163, 170-171, 223). Krempich knew he should have been wearing fall protection. (Tr. 221-222). A written warning was placed in his file. (Tr. 222). In the past, Savela had removed contractors from the property for failing to wear fall protection and had seen miners be disciplined for the same. (Tr. 223).

After termination, the inspection team spoke with Greschner about fall protection and his role in the violation. (Tr. 163, 170-171). Greschner was "meek" and did not answer questions. (Tr. 171). Sichmeller pointed out safety signs and Greschner shrugged his shoulders. (Tr. 171). The signs next to the convertor box near the stairway on the main walkway said "prior to entering, fall protection must be worn within six feet of the tank edge." (Tr. 162-163, 169, 229). Photographs 6-C and RX-34 depicted the safety sign located on the middle of the separator tank. (Tr. 175, 215). A miner would have to go past the sign to access the area. (Tr. 175). Savela could not recall if the signs were posted at his direction. (Tr. 215, 228). They were installed because miners often go out on the walkways away from the structure in the cited area, and fall protection would be needed. (Tr. 228-229). Savela stopped the inquiry and said they wanted to talk to counsel before answering questions. (Tr. 171). When the miner came down, Savela talked to him. (Tr. 173). That miner sometimes acted as a relief coordinator and did so just days after this Order was issued. (Tr. 172).

Sichmeller issued Citation No. 6553380 (GX-3) for the same condition. (Tr. 163-164). It was issued under § 56.15005, which requires safety belts and lines to be worn near fall dangers. (Tr. 164-165). The gravity of this citation was marked as "reasonably likely" because a worker could fall into the tank or onto the floor and receive an injury. (Tr. 165). The injury was marked "fatal" because a majority of mining fatalities are caused by fall trauma. (Tr. 165). There was also the danger of drowning in the box from the suction caused by pulled plugs. (Tr. 165). This condition was marked "S&S" because there was a discrete safety hazard that could result in a fatality. (Tr. 166). Only one miner was affected. (Tr. 169). The citation was a 104(d)(1) citation because it was an unwarrantable failure. (Tr. 170).

The negligence was marked as "high" and as an unwarrantable failure because it was an open and obvious condition and a foreman was watching. (Tr. 166, 170-173). In fact, the foreman's gaze is what caused Sichmeller to see the condition. (Tr. 166). No one indicated that

fall protection was present and no mitigation was offered. (Tr. 169, 171). Sichmeller believed signs should have warned the miner about fall protection but it did not mitigate the negligence because Greschner was in the area looking at the miner and did not tell him to stop. (Tr. 202-203). However, Greschner testified that in the short time he observed Krempich he was unable to determine if the miner was wearing fall protection. (Tr. 250-251, 258).

The violation history shows that there were two violations in the previous 24-months. (Tr. 172, 197). Sichmeller issued one of those in 2010. (Tr. 197-198). The violation was not in the cited area. (Tr. 198). In that case, a contractor was loading a semi and was standing on a garbage bin inside the truck; there was no water hazard in that case. (Tr. 198). MSHA's does not consider anything "repeated" until there have been at least five prior citations in a 15-month period. (Tr. 203). However, patterns with the same person, area, or condition are a problem even if it is just a single repeat. (Tr. 203-204). Sichmeller had never issued a citation for this condition to Greschner or the miner or on this grating before. (Tr. 204).

III. FINDINGS OF FACT AND CONCLUSIONS OF LAW

The findings of fact are based on the record as a whole and the Administrative Law Judge's careful observation of the witnesses during their testimony. In resolving any conflicts in the testimony, the Administrative Law Judge has taken into consideration the interests of the witnesses, or lack thereof, and consistencies, or inconsistencies, in each witness's testimony and between the testimonies of the witnesses. In evaluating the testimony of each witness, the Administrative Law Judge has also relied on his demeanor. Any failure to provide detail as to each witness's testimony is not to be deemed a failure on the Administrative Law Judge's part to have fully considered it. The fact that some evidence is not discussed does not indicate that it was not considered. *See Craig v. Apfel*, 212 F.3d 433, 436 (8th Cir. 2000) (administrative law judge is not required to discuss all evidence and failure to cite specific evidence does not mean it was not considered).

1. The Secretary Has Carried His Burden Of Proof By A Preponderance Of Evidence That The Cited Condition Constituted An Imminent Danger

On January 24, 2011, Inspector Sichmeller issued an imminent danger order, Order No. 6553379 to Respondent. Section 8 of that Order, Condition or Practice, reads as follows:

CONCENTRATOR: One employee was standing on top of the #4 Tails Hydro Separator Tank at the southwest side Hydro Convertor Box using a chain hoist to pull plugs for the Convertor Box. The employee was exposed to a fall hazard into the open top slurry filled box or a fall to the walkway below by not being protected due to lack of railings or fall protection in this area. The convertor box was 65 inches in depth and (sic) the height from the top of the Hydro Separator Tank to the metal grated walkway below was 75 inches. An oral 107(a) imminent danger order was issued to Del Savelle, Plant Safety in this area at this time and date. Citation 6553380 was issued in conjunction with this order.

(GX-1).

Section 107(a) of the Mine Act provides the following:

If, upon any inspection or investigation of a coal or other mine which is subject to this chapter, an authorized representative of the Secretary finds that an imminent danger exists, such representative shall determine the extent of the area of such mine throughout which the danger exists, and issue an order requiring the operator of such mine to cause all persons, except those referred to in section 814(c) of this title, to be withdrawn from, and to be prohibited from entering, such area until an authorized representative of the Secretary determines that such imminent danger and the conditions or practices which caused such imminent danger no longer exist. The issuance of an order under this subsection shall not preclude the issuance of a citation under section 814 of this title or the proposing of a penalty under section 820 of this title.

30 U.S.C. § 817(a).

Section 3(j) of the Act defines “imminent danger” as “the existence of any condition or practice in a coal mine or other mine which could reasonably be expected to cause death or serious physical harm before such condition or practice can be abated.” 30 U.S.C. § 802(j). This definition has not changed from the definition contained in the Coal Mine Health and Safety Act of 1969, 30 U.S.C. § 801 *et. seq.* (1976) (amended 1977) (the “Coal Act”).

Imminent danger orders are not limited to situations where hazards pose an immediate threat; rather an imminent danger exists where “the condition or practice observed could reasonably be expected to cause death or serious physical harm to a miner if normal mining operations were permitted to proceed in the area before the dangerous condition is eliminated.” *Rochester & Pittsburgh Coal Co.*, 11 FMSHRC 2159, 2163 (Nov. 1989)(citations omitted); *see also Cumberland Coal Res., LP*, 28 FMSHRC 545, 555 (Aug. 2006).

An inspector retains “considerable discretion” in determining whether an imminent danger exists because an inspector must “act with dispatch to eliminate conditions that create an imminent danger.” *Wyoming Fuel Co.*, 14 FMSHRC 1282 (Aug. 1992), *citing R&P*, 11 FMSHRC at 2164 and *Utah Power & Light Co.*, 13 FMSHRC 1617, 1627 (Oct. 1991). In reviewing an inspector's finding of imminent danger, the Administrative Law Judge must support the inspector's finding “unless there is evidence that he has abused his discretion or authority.” *Cumberland Coal*, 28 FMSHRC at 55, *citing R&P*, 11 FMSHRC at 2164; *Old Ben Coal Corp. v. Interior Bd. of Mine Op. App.*, 523 F.2d 25, 31 (7th Cir. 1975).

In the instant proceeding, Inspector Sichmeller issued an imminent danger order because Krempich was standing on a raised platform without a railing or any fall protection. (GX-1). A preponderance of the evidence supports the issuance of this Order. It is uncontested that Krempich was standing on a raised platform without fall protection of any kind. (Tr. 158, 189, 217, 220, *Respondent's LAKE 2012-687 Post-Hearing Brief* at 3, 9). Inspector Sichmeller determined, and the evidence supports, that Krempich was standing near a 65-inch deep slurry

box and also a 75-inch precipice that dropped to the grated walkway below. (Tr. 167, 194). Inspector Sichmeller credibly testified that in this position, it could reasonably be expected that Krempich would fall into the box or onto the walkway and suffer a serious, perhaps fatal, injury. (Tr. 165). In fact, such a danger from a fall is so likely that MSHA promulgated a standard, 30 C.F.R. § 56.15005, to specifically address the use of fall protection when working in elevated areas where falls are possible. Krempich was working with a chain hoist and essentially leaning out over the precipice. Under normal continued mining operations it would be reasonably likely that he could fall and that such a fall could cause broken bones, concussion, or drowning. Therefore, the 107(a) imminent danger order was appropriate.

Respondent offered several arguments to show that Krempich was not in imminent danger and that Inspector Sichmeller abused his discretion. However, most of these arguments were without any legal merit.

First, Respondent argued that Krempich was not in danger of falling because he had between three and four “points of contact” at all times while he was working. (*Respondent’s LAKE 2012-687 Post-Hearing Brief* at 9). Nothing in the Act, regulations, or case law provides an exception to the rule based on points of contact. Respondent cites to no legal authority for the proposition that three or four points of contact eliminates an imminent fall danger. In fact, the only evidence regarding points of contact produced at hearing comes from Respondent’s internal PowerPoint presentation, which Savela testified mentions using three points of contact to improve stability. (Tr. 210). Inspector Sichmeller credibly testified that, even with the use of at least three points of contact, Krempich was in danger of falling. There is no evidence to undermine that testimony.

Further, Respondent completely ignores the standard under 107(a), which requires the inspector to consider the danger *in light of continued mining operations without abatement*. Assuming, *arguendo*, that there was some validity to Respondent’s three points of contact safe harbor, it was still reasonably likely that under normal mining conditions the situation would change. While Krempich had at least three points of contact when Inspector Sichmeller issued the Order, if the Order was not issued, Krempich would have released the chain hoist once the plugs were pulled. At that point, Krempich would have only two points of contact. The same was likely true when Krempich was walking towards the chain hoist. At any number of instances while working, it is reasonably likely Krempich would have fewer than three points making a fall imminent even under Respondent’s own terms.

Respondent’s second argument was that the risk of drowning was slight because Krempich was taller than the slurry box and that the slurry was not even at the top of the box. (*Respondent’s LAKE 2012-687 Post-Hearing Brief* at 9). The evidence, including evidence developed by Respondent, showed that the area cited contained a large amount of equipment and structure. (Tr. 184, 189, 195, 231-234, 239, 245-246). It is likely that in the event of a fall into the slurry box, Krempich would have hit his head on this structure. He could have also fallen backwards and hit his head on the walkway before slipping into the slurry. Finally, he could have fallen head first into the box, hitting his head on the side or the bottom of the box. In any of these situations, Krempich could have been knocked unconscious or simply disoriented and drowned, regardless of the depth of the box. Further, even if Krempich did not strike his head,

he could have been disoriented and drowned. The Secretary also raised the possibility that suction from removing the plugs could hold Krempich at the bottom of the slurry box. Finally, the height of the slurry box in no way changes the fact that Krempich could have fallen 75 inches to the walkway below. The height of the slurry box does not lessen the imminent danger here.

Respondent's third argument was that Inspector Sichmeller believed it was within his discretion to treat every fall hazard as an imminent danger. (*Respondent's LAKE 2012-687 Post-Hearing Brief* at 10). Respondent argued that this belief was not consistent with the Mine Act or MSHA policy. (*Id.*). Inspector Sichmeller's beliefs about falls in general are irrelevant. The issue is whether in this particular instance, the condition or practice could reasonably be expected to cause death or serious physical harm before being abated. As discussed *supra*, with respect to the instant Order, that was the case.

Respondent also argued that a slip was unlikely because the floor was dry. (*Respondent's LAKE 2012-687 Post-Hearing Brief* at 10). The preponderance of the evidence shows that a fall hazard existed whether or not the floor was wet. Specifically, Sichmeller testified only that the floor "may" have been wet but was clear that a fall hazard existed. (Tr. 158-159, 188-189). Even if the floor was dry, a fall was still reasonably likely.

Finally, Respondent argued that Krempich had only been in the cited area for a short time. (*Respondent's Lake 2012-687 Post-Hearing Brief* at 10). Once again, the issue is whether Krempich faced a reasonably likelihood of death of serious physical harm under continued mining conditions. It is totally irrelevant how long the condition had existed or would exist but if at any time Krempich would face an imminent danger.

Therefore, in light of the facts discussed *supra*, the Administrative Law Judge finds that Inspector Sichmeller did not abuse his discretion in issuing the 107(a) Order.

2. The Secretary Has Carried His Burden Of Proof By A Preponderance Of The Evidence That 30 C.F.R. § 56.15005 Was Violated.

On January 24, 2011, Inspector Sichmeller issued a 104(d)(1) Citation, Citation No. 6553380 to Respondent. Section 8 of that Order, Condition or Practice, reads as follows:

CONCENTRATOR: The employee was standing at the edge of the Line #4 Hydro Separator Tank pulling the drain plug for the southwest side convertor box for the separator. The employee was not protected from a fall in this area due to the lack of fall protection, railings, or coverers to the open convertor box. The height of the top of the Hydro Separator Tank to the metal grated walkway below was 75 inches, and the depth of the slurry filled box was 65 inches. The company does have warning signs posted in this area at the access point for fall protection when within six feet of the edge. The Cold Side Shift Coordinator was in this area observing the employee conducting the work activity. The Coordinator engaged in aggravated conduct constituting more than ordinary negligence. This violation is an unwarrantable failure to comply with a mandatory standard. This citation was issued in conjunction with 107(a) imminent danger order #6553380

(sic). Standard 56.15005 was cited 4 times in two years at min 2103404 (2 to the operator, 2 to Contractors).⁸

(GX-3).

The cited standard, 30 C.F.R. § 56.15005 (“Safety Belts and Lines”), provides the following:

Safety belts and lines shall be worn when persons work where there is danger of falling; a second person shall tend the lifeline when bins, tanks, or other dangerous areas are entered.

30 C.F.R. § 56.15005.

As Judge Simonton noted in discussing a 30 C.F.R. § 56.15005 violation, “the Commission has held that a danger of falling exists when an informed, reasonably prudent person would recognize a danger of falling warranting the wearing of safety belts and lines.” *Hunt Martin Materials, LLC*, 2013 WL 1856613, *5 (Sept. 2013)(ALJ Simonton), *citing Great Western Electric Co.*, 5 FMSHRC 840, 842 (May 1983).

Respondent did not contest Inspector’s Sichmeller’s finding that Krempich was not wearing fall protection. (Tr. 158, 189, 217, 220, *Respondent’s LAKE 2012-687 Post-Hearing Brief* at 3, 9). Therefore, the only issue is whether a reasonably prudent person would recognize the fall danger.

Sichmeller credibly testified that the danger of a fall was readily apparent. (Tr. 166, 170-173, 205-206). This clear danger was discussed at length in the discussion on the imminent danger order *supra*. In addition, when Sichmeller pointed out the cited condition without speaking, Savela instantly knew why the imminent danger order was issued, specifically that there was a fall risk. (Tr. 205-206). It was obvious to Respondent’s safety director the instant that he saw Krempich leaning over the slurry box that the condition posed a threat. Therefore, the Administrative Law Judge finds that a reasonably prudent person would have realized that standing on an elevated walkway without fall protection or a railing would constitute a fall hazard.

Respondent essentially argues that there was no fall hazard here. As discussed with respect to the imminent danger order, Respondent argues that Krempich had at least three points of contact, that he was taller than the slurry box, that Sichmeller misunderstands fall danger, that Krempich was in the position for a short time, and that the area was dry. For the same reasons discussed *supra*, the Administrative Law Judge rejects these arguments and finds that the Citation was validly issued.

⁸ On the same day, Inspector Sichmeller issued an amendment to this Citation to reflect the fact that the imminent danger order was given Order No. 6553380, not No. 6553379. (GX-3).

3. Considering The Record *In Toto* And Applying Applicable Case Law, The Violation Was Reasonably Likely to Result in a Fatal Injury And Was Significant And Substantial In Nature

Inspector Sichmeller marked the gravity of the cited danger in Citation No. 6553380 “Reasonably Likely” to result in “Fatal” injury to one person. (GX-3). These determinations are supported by a preponderance of the evidence.

The Mine Act requires that “gravity of the violation” be considered in assessing a penalty. 30 U.S.C. § 820. The Secretary promulgated a three-factor inquiry to determine the gravity of a citation for purposes of determining the penalty. Those factors are:

[T]he likelihood of the occurrence of the event against which a standard is directed; the severity of the illness or injury if the event has occurred or was to occur; and the number of persons potentially affected if the event has occurred or were to occur.

30 C.F.R. § 100.3(e).

The event against which the instant standard, 30 C.F.R. § 56.15005, is directed is a fall. For the reasons discussed *supra*, a fall was reasonably likely. Furthermore, as discussed at length with respect to the imminent danger order, a fall from the walkway could have resulted in a fatal injury from drowning in the slurry box or from severe head or back trauma from a fall to the walkway. Finally, the evidence shows that only Krempich would be affected.

Respondent’s arguments regarding the likelihood of a fall or the gravity of the injury that would result were considered, and rejected, in the discussion of the imminent danger order *supra*. As a result, the Administrative Law Judge finds that the Secretary proved the alleged gravity of this violation by a preponderance of the evidence.

Well-settled Commission precedent sets forth the standard used to determine if a violation is S&S. A violation is S&S “if, based upon the particular facts surrounding the 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., National Gypsum Co.*, 3 FMSHRC 822, 825 (April 1981). The Commission later clarified this standard, explaining:

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).

With respect to the first element, the underlying violation of a mandatory safety standard, it has already been established that Respondent violated 30 C.F.R. § 56.15005.

With respect to the second element of *Mathies*, a discrete safety hazard – that is a measure of danger to safety – contributed to by the violation, the record is likewise clear. In fact, finding that this citation was valid required a finding that a specific hazard, specifically a fall hazard, existed. As noted, Krempich’s failure to wear fall protection on an elevated walkway created the possibility of a fall either to the walkway or into the slurry box.

The third element of the *Mathies* test – a reasonable likelihood that the hazard contributed to will result in an injury – is also supported by the record and applicable case law.

The Commission clarified the third element of the *Mathies* test in *Musser Engineering, Inc., and PBS Coal Inc.*, 32 FMSHRC 1257, 1280-81 (Oct. 2010) (“PBS”) (affirming an S&S violation for using an inaccurate mine map). The Commission held that the “test under the third element is whether there is a reasonable likelihood that the hazard contributed to by the violation, i.e., [in that case] the danger of breakthrough and resulting inundation, will cause injury.” *Id.* at 1281. Importantly, we clarified that the “Secretary need not prove a reasonable likelihood that the violation itself will cause injury.” *Id.* The Commission concluded that the Secretary had presented sufficient evidence that miners who broke through into a flooded adjacent mine would face numerous dangers of injury. *Id.* The Commission also emphasized the well-established precedent that “the absence of an injury-producing event when a cited practice has occurred does not preclude a determination of S&S.” *Id.* (citing *Elk Run Coal Co.*, 27 FMSHRC 899, 906 (Dec. 2005); *Blue Bayou Sand & Gravel, Inc.*, 18 FMSHRC 853, 857 (June 1996)).

As discussed *supra*, if Krempich were to fall from the elevated walkways he could suffer serious traumatic injury from the fall or even drown in the slurry box. As a result, the evidence shows that the third element of the *Mathies* test is met.

Respondent made several arguments attempting to show that there is no likelihood of injury from a fall. These arguments are, to say the least, not compelling.

First, Respondent argued that there was no likelihood of injury because Krempich maintained three or four points of contact at all times. (*Respondent’s LAKE 2012-687 Post-Hearing Brief* at 19). As discussed *supra*, Respondent’s insistence on “points of contact” has no basis in law and does not decrease the likelihood of accident. More importantly, whether Krempich had any points of contact is completely irrelevant to this discussion. Respondent patently misunderstands the third element of *Mathies*. The issue at this stage of the inquiry is whether the hazard contributed to by the violation, in this case a fall, would result in injury. The third element presupposes that the fall, is realized and asks whether an injury would be expected to result. Respondent’s frivolous argument does not aid the Administrative Law Judge in determining whether a fall would, or would not, result in an injury and is therefore disregarded.

Second, Respondent argues that merely being on an elevated surface does not create the likelihood of injury. (*Respondent’s LAKE 2012-687 Post-Hearing Brief* at 19-20). Once again Respondent does not understand the third element of *Mathies*. The issue is whether a fall from

the cited location would be likely to result in injury, not whether the fall itself is likely. This argument is likewise frivolous and disregarded.

Finally, Respondent argues that if someone were to slip from the elevated walkway, there was structure in the way that would break the fall. (*Respondent's LAKE 2012-687 Post-Hearing Brief* at 20). This is a more appropriate argument with respect to the third element of *Mathies*, but the preponderance of evidence shows that an injury was still likely. Sichmeller credibly testified that even with the structure in place, there was a gap between the grating and the structure where a miner could fall. (Tr. 185-188). He also testified that if the plugs had come undone, the chain hoist could have moved, exposing the miner to a fall. (Tr. 235). Further, under continued normal mining operations, Krempich may have moved away from the structure to complete his tasks. While it is true that the placement of the structure probably decreased the likelihood of an injury, the Administrative Law Judge still believes that an injury was reasonably likely. As a result, The Secretary has met his burden with respect to the third element of *Mathies*.

Under *Mathies* the fourth and final element that the Secretary must establish is that there was a “reasonable likelihood that the injury in question will be of a reasonably serious nature.” *Mathies Coal Co.*, 6 FMSHRC at 3-4; *U.S. Steel*, 6 FMSHRC at 1574. As the Administrative Law Judge found that an injury from fall could result in broken bones or even death, this element is clearly met.⁹

⁹ While the hazard here included the possibility of death from drowning, there was also the risk of serious injury from the fall as well. See Judge Bulluck’s discussion regarding the risks associated with a fall in *Granite Rock Company*:

In *Great Western Electric*, the Commission explained that a miner's “position twelve feet above the ground presented a substantial height from which to fall.” 5 FMSHRC 840, 843 (May 1983); see also generally *Molton Co., LP*, 31 FMSHRC 427 (Mar. 2009) (ALJ) (crediting an inspector's testimony that fatal falls have occurred from heights of 10 feet or less, and finding an S&S violation where a miner was working without fall protection at a height of approximately 7 feet); *Cantera Green*, 21 FMSHRC 310 (Mar. 1999) (ALJ) (finding S&S, safe access violations where workers were working 8, 10, and 12 feet above ground); *Laramie Cnty. Road & Bridge*, 17 FMSHRC 902 (June 1995) (ALJ) (crediting an inspector's testimony that miners have been seriously injured and killed as a result of falling from heights of 8 to 12 feet, and finding an S&S violation). Moreover, the Commission has acknowledged that “[e]ven a skilled employee may suffer a lapse of attentiveness, either from fatigue or environmental distractions, which could result in a fall.” *Id.* at 842. Based on the evidence, I find that a fall from 8 to 12 feet would reasonably result in serious injuries ranging from broken bones and head trauma, possibly death. Therefore, I conclude that the violation of section 56.15005 was S&S.

34 FMSHRC 261 (January 2012) (ALJ Bulluck).

As a result, the Administrative Law Judge finds that the Secretary proved the violation was S&S by a preponderance of the evidence.

4. Respondent's Conduct Did Not Display "High" Negligence And Was Not The Result Of An Unwarrantable Failure To Comply With the Standard.

In the citation at issue, Inspector Sichmeller found that the operator's conduct was highly negligent in character. (GX-3).

Standard 30 C.F.R. § 100.3(d) provides the following:

(d) Negligence. Negligence is conduct, either by commission or omission, which falls below a standard of care established under the Mine Act to protect miners against the risks of harm. Under the Mine Act, an operator is held to a high standard of care. A mine operator is required to be on the alert for conditions and practices in the mine that affect the safety or health of miners and to take steps necessary to correct or prevent hazardous conditions or practices. The failure to exercise a high standard of care constitutes negligence. The negligence criterion assigns penalty points based on the degree to which the operator failed to exercise a high standard of care. When applying this criterion, MSHA considers mitigating circumstances which may include, but are not limited to, actions taken by the operator to prevent or correct hazardous conditions or practices.

In 30 C.F.R. § 103(d), Table X, the category of high negligence is described thusly: "The operator knew or should have known of the violative condition or practice and there are no mitigating circumstances." Conversely, moderate negligence is shown when "[t]he operator knew or should have known of the violative condition or practice, but there are some mitigating circumstances." Low negligence is served for situations where there are "considerable" mitigating circumstances.

The Administrative Law Judge finds that while Respondent should have known about the violation, there were several mitigating factors. With respect to knowledge, well-settled Commission precedent recognizes that the negligence of an operator's agent is imputed to the operator for penalty assessments and unwarrantable failure determinations. *See Whayne Supply Co.*, 19 FMSHRC 447, 451 (Mar. 1997); *Rochester & Pittsburgh Coal Co.*, 13 FMSHRC 189, 194-197 (Feb. 1991); and *Southern Ohio Coal Co.*, 4 FMSHRC 1459, 1463-1464 (Aug. 1982). An agent is defined as someone with responsibilities normally delegated to management personnel, has responsibilities that are crucial to the mine's operations, and exercises managerial responsibilities at the time of the negligent conduct. *Martin Marietta Aggregates*, 22 FMSHRC 633, 637-638 (May 2000) *see also* 30 U.S.C. §802(e) (an agent is "any person charged with responsibility for the operation of all or part of a...mine or the supervision of the miners in a...mine.").

With respect to the instant violation, evidence shows that Respondent's manager Greschner was not actually aware of the cited condition. The Secretary argued that Greschner, had actual knowledge of the violation because he was standing at the bottom of the stairs, looking up toward Krempich while the miner was working without fall protection. (*Secretary's*

Post-Hearing Brief at 13-14). Greschner credibly testified that he had arrived at the location a few moments before the inspection crew. (Tr. 245-251). Further, he credibly testified that from the bottom of the stairs he was initially unable to see Krempich and that he did not have enough time after seeing the miner to determine whether he was wearing fall protection. (Tr. 245-246). Therefore, the Administrative Law Judge finds that Greschner, and hence Respondent, was not actually aware of the cited condition until Inspector Sichmeller cited it.¹⁰

However, while Greschner did not know that Krempich was working without fall protection, he should have known. At the time of the violation Greschner was a supervisor. (Tr. 237-238). He was assigned to fix a unique problem and specifically sought out Krempich for assistance. (Tr. 241). He directed and oversaw Krempich work on the hydro separator, even if he did not watch Krempich the entire time. (Tr. 241, 244). As his supervisor, Greschner should have known that Krempich was violating the standard and taken actions to correct the problem. As a result, the Administrative Law Judge finds that Respondent was negligent.

While the Administrative Law Judge affirms the inspector's finding that Respondent was negligent, the evidence does not support a finding that this negligence was high; there were mitigating circumstances. Specifically, Respondent noted that it had posted signs encouraging miners to wear fall protection on the elevated walkway. (Tr. 202-203, 228-229, 256). The existence of these signs is not contested. This showed that Respondent was aware of the danger and that it had taken some action to ensure compliance.

Also, the evidence shows that while there was no railing or fall protection, there was structure near the miner. (Tr. 187-188, 231-234). This structure could break a miner's fall in case of a slip. Even inspector Sichmeller admitted as much. (Tr. 192-193, 195). Furthermore, the structure ensured that the area where the miner could fall would be limited. While the miner should have been wearing fall protection, management may have reasonably believed that this structure provided some protection.

Finally, the possible fall, at its highest, was around seven feet. (Tr. 194). While this height could be extremely dangerous (*see* gravity discussion *supra*), Respondent may have believed that the danger was limited at that elevation. As a result, its negligence may have been somewhat lessened.

In light of these mitigating circumstances, Respondent's actions are best characterized as showing "Moderate" rather than "High" negligence.

The Commission has recognized the close relationship between a finding of unwarrantable failure and a finding of high negligence. *San Juan Coal Co.*, 29 FMSHRC 125, 139 (Mar. 2007) (remanded because a finding of high negligence without a corresponding finding of unwarrantable failure was "seemingly at odds.") *see also Consolidation Coal*

¹⁰ The Secretary also asserted that Krempich occasionally acted as a supervisor, creating liability on the part of Respondent for his actions. (*Secretary's Post-Hearing Brief* at 14). However, the miner was not acting as a supervisor at the time of the violation. This point is not contested. Therefore, his actions were not imputable to Respondent.

Company, 22 FMSHRC 340, 353 (2000) (holding that if there is mitigation, an unwarrantable failure finding is inappropriate). *Emery Mining Corp.*, defines an unwarrantable failure, as “aggravated conduct constituting more than ordinary negligence.” *Emery Mining Corp.*, 9 FMSHRC 1997, 2002 (Dec. 1987). Such conduct may be characterized as reckless disregard, intentional misconduct, indifference, or serious lack of reasonable care. *Id.* at 2004; *see also* *Buck Creek Coal*, 52 F.3d 133, 135-136 (7th Cir. 1995). The Commission formulated a six factor test to determine aggravating conduct. *IO Coal Co., Inc.*, 31 FMSHRC 1346, 1350-1351 (Dec. 2009). The Administrative Law Judge will consider each of those factors in turn:

1. Extent Of The Violative Conditions

This particular condition dealt with a single miner failing to wear fall protection. (Tr. 169). There is no evidence that other miners were exposed or that this condition occurred regularly. In fact, Respondent posted signs encouraging miners to wear fall protection. (Tr. 202-203, 228-229, 256). Therefore, the violation in this matter was not particularly extensive.

2. The Length of Time the Violation Existed

Greschner credibly testified that Krempich had been in the area for only a short period of time before the citation was issued. (Tr. 250). Sichmeller testified that he saw the miner for a few minutes before the citation was issued but could not say how long the miner was exposed in general. (Tr. 170, 199, 202). Therefore, the violation had not existed for a lengthy period.

3. Whether the violation is obvious or poses a high degree of danger

The violation at issue here posed a considerable danger. As discussed *supra*, this condition was reasonably likely to result in serious, perhaps fatal, injuries to the miner. Whether the condition was obvious is a more complicated question. The miner was not wearing fall protection and that condition was immediately visible to Inspector Sichmeller and Savela during the inspection. (Tr. 158, 166, 170-173, 189, 217, 220). However, as noted, the condition had not existed for very long and visibility from other areas in the plant was not as clear. (Tr. 170, 250, 199, 202, 245-246). Therefore, the condition posed a high degree of danger but was something less than obvious.

4. Whether the operator had been placed on notice that greater efforts were necessary for compliance or that this condition was an issue.

Respondent’s violation history indicates that in the 18 months preceding this violation the Plant was cited four times for this condition. (GX-3). Two of those citations were issued to Respondent while two were issued to contractors. (*Id.*). No evidence was presented of any other notice provided to Respondent. The Administrative Law Judge finds that Respondent did not have meaningful knowledge that this condition required particular attention.

5. The operator's efforts in abating the violative condition

Respondent abated the condition immediately after Inspector Sichmeller issued the imminent danger order.

6. Operator's knowledge of the existence of the violation

"It is well-settled that an operator's knowledge may be established, and a finding of unwarrantable failure supported, where an operator reasonably should have known of a violative condition." *IO Coal Co.*, 31 FMSHRC at 1356-1357 (citing *Emery*, 9 FMSHRC at 2002-2004). A supervisor's knowledge and involvement is an important factor in an unwarrantable failure determination. See *Lopke Quarries, Inc.*, 23 FMSHRC 705, 711 (July 2001) citing (*REB Enterprises, Inc.*, 20 FMSHRC 203, 224 (Mar. 1998) and *Secretary of Labor v. Roy Glenn*, 6 FMSHRC 1583, 1587 (July 1984). As discussed above, the preponderance of the evidence shows that while Respondent did not have actual knowledge of the cited condition, it should have known of the violation.

In light of the isolated nature of the violation, short length of time the cited condition existed, the limited notice that greater efforts were needed, Respondent's efforts at abatement, and the fact that Respondent's negligence is better characterized as "moderate," the Administrative Law Judge holds that a finding of unwarrantable failure would be inappropriate.

5. Penalty

Under the assessment regulations described in 30 CFR §100, the Secretary proposed a penalty of \$11,597.00 for Citation No. 8553380. A recent Commission decision, *Sec. v. Performance Coal Co.*, (Docket No. WEVA 2008-1825 (8/2/2013) reaffirmed that neither the ALJ nor the Commission is bound by the Secretary's proposed penalties. (see also 30 U.S.C. §820(i) and 29 C.F.R. §2700.30(b)). However, the Commission in *Performance Coal*, also held that, although there is no presumption of validity given to the Secretary's proposed assessments, substantial deviation from the Secretary's proposed assessments must be adequately explained using §110(i) criteria. (*Id.* at p. 2). (see also *Cantina Green*, 22 FMSHRC 616, 620-621 (May 2000)). The ALJ finds that a substantial deviation from the Secretary's proposed assessment is warranted herein and will evaluate the factors contained in 30 U.S.C. § 820(i) to explain that deviation. Those factors are as follows:

(1) The Operator's history of previous violations – in the 18 months preceding this violation the Plant was cited four times for this condition. (GX-3). Two of those citations were issued to Respondent while two were issued to contractors. (*Id.*).

(2) The appropriateness of the penalty compared to the size of the Operator's business – United Plant has 592,779 yearly mine hours and Respondent has 2,179,873 yearly controller hours. According to MSHA's penalty assessment guidelines this gives United Plant nine "mine

size points” out of a possible 15 and Respondent seven “controller size points” out of a possible 10. *see* 30 CFR § 100.3(b). Thus, Respondent is a large operator with an above-average sized plant.

(3) Whether the Operator was negligent – As previously shown, the operator exhibited moderate negligence, rather than the high negligence and unwarrantable failure cited by the Secretary.

(4) The effect on the Operator’s ability to remain in business – The parties have stipulated that the Orders at issue here would not affect Respondent’s ability to remain in business. (JX-1)

(5) The gravity of the violation – As previously shown, this violation was reasonably likely to result in fatal injuries to one person.

(6) The demonstrated good-faith of the person charged in attempting to achieve rapid compliance after notification of a violation – The evidence shows the condition was abated rapidly and in good faith.

In light of the Administrative Law Judge’s decision to modify the negligence from “High” to “Moderate” and to eliminate the unwarrantable failure designation, a reduction in the assessed penalty is appropriate. Therefore, Respondent is hereby **ORDERED** to pay a civil penalty in the amount of \$7,000.00.

LAKE 2012-841-M

I. ISSUE

With respect to LAKE 2012-841-M, the issues to be determined are whether Respondent’s alleged actions on April 26, 2011 were a violation of § 56.20003(b) and, if so, whether that violation was significant and substantial (“S&S”), whether it was reasonably likely to result in lost workday/restrict duty injury, whether it was the result of high negligence, and the appropriate penalty for the violation.

II. SUMMARY OF TESTIMONY

On April 26, 2011 at 1:34 p.m., Inspector Sichmeller issued a Citation, No. 6559833, after observing a build-up of oil and oil saturated pads on walkways leadings to a compressor in an unloading area. (Tr. 19-20). The citation was issued under §56.2003(b), which requires all working places be clean and kept dry. (Tr. 20). The cited conditions were not noted in that workplace examination. (Tr. 50-51).

The cited area was in a separate room inside the pelletizing building. (Tr. 50). The pellet plant was roughly 460 feet long, 370 feet wide, and 110 feet high. (Tr. 58). It was five stories tall and the compressor was on the bottom floor. (Tr. 59, 95-96). The compressor room was 15 feet square. (Tr. 59). It was used to boost air pressure for moving additives (limestone, soda ash). (Tr. 59, 95-96). The high pressure air pushed the additives through a 3.5-inch hose to

unload trucks. (Tr. 61-62, 95-96). Shari McGregor testified that a truck would pull up to the outside of the room, hook up to the hose, the compressor would be started, the material would unload, and then the hose would be unhooked and the compressor shut off.¹¹ (Tr. 95-96, 99). The room contained a motor, compressor, incoming and outgoing pipe, and disconnect.¹² (Tr. 59). The controls for the compressor were located on the outside of the room where trucks were parked, 40 feet away, because the room was noisy. (Tr. 60, 97).

The compressor ran for the entire day shift (7 a.m. to 3 p.m.) when the trucks were unloading. (Tr. 98-98). It sometimes, though rarely, ran in the afternoon. (Tr. 99). The compressor only ran when unloading, so it was occasionally off. (Tr. 99). Only one truck could unload at a time. (Tr. 117). McGregor did not know how many trucks were unloaded during a shift, but it took an average of an hour and a half to unload a truck. (Tr. 117).

At the beginning of each shift, the compressor room would be accessed by the material unloader. (Tr. 60, 98, 116, 121). No one other than the material unloader would be there on a normal day. (Tr. 121). That individual would perform an exam, top off the oil, and make sure the cooling water was on.¹³ (Tr. 21, 60, 98, 116, 121). Attendants would enter the filling area from the north side of the compressor. (Tr. 66-67). There was a north-to-south pathway around the compressor. (Tr. 63-64). The exam would be completed with the compressor off and no

¹¹ At hearing, Shari McGregor was present and testified for Respondent. (Tr. 93). At the time of the hearing she had been a miner since 1999 and worked at “every mining facility in Northern Minnesota.” (Tr. 93). She had completed a millwright program at Eveleth Technical College. (Tr. 93). She worked through Millwright Local 1348’s call-out hall. (Tr. 93). McGregor began working for Respondent in June of 2008 or 2009 as the pellet plant maintenance planner. (Tr. 94). At the time of the hearing she was the fines crusher maintenance planner. (Tr. 94). In that capacity she managed work orders as they came in off the floor, bought the parts necessary to make fixes, and helped schedule jobs in the order she saw fit. (Tr. 94). McGregor did not have any recollection of working on the instant citation. (Tr. 115).

¹² The compressor room was not a “wet process” room. (Tr. 74-75). Savela only saw moisture from a small amount of water on a drain pipe. (Tr. 75). That drain was outside of the walking and working surfaces where no one would walk. (Tr. 90-91).

¹³ Take Five is a Cliff’s Natural Resources policy that encourages miners to clean up and look for potential hazards before starting a job. (Tr. 101, 126-127).). It is a five-step process that all managers and miners are taught. (Tr. 127). When an individual would approach a task he would first try to think out the issue that may arise. (Tr. 101-102, 127). For the shift examination, Take Five might entail planning the strategy for the exam. (Tr. 101-102). The individual would think about tools or measures that could eliminate or reduce risks. (Tr. 127, 141). Then he would work safely while constantly re-evaluating safety. (Tr. 127). For larger jobs, it might entail looking to at the area, determining how to make the fix and strategizing the task before entering the area. (Tr. 102). Supervisors would explain each step in a project, whether a single day or something larger. (Tr. 106). Take Five information was posted in every room of the plant. (Tr. 105-106). As a planner, when McGregor would hand out Take Five slips with work orders. (Tr. 106). All of the miners were aware of the program. (Tr. 106).

trucks present. (Tr. 61, 100). After the exam, no one would need to be in the room because the compressor could be operated from outside. (Tr. 60-61).

In addition to the daily shift examinations, two mechanics made a weekly pump route check of the area. (Tr. 100, 117). These mechanics would make quick fixes if possible and draft work orders for larger jobs. (Tr. 101, 121). Miners might also work on problems in the room while the compressor was running. (Tr. 99). Given the importance of running the compressor, there would be an “A” work order written, so work would be done immediately. (Tr. 101).

Sichmeller never saw anyone adding oil to the compressor, but he knew that in order to do so, an individual would have to stand right beside it. (Tr. 41). The area to add oil and operate the valves was on the south side of the compressor.¹⁴ (Tr. 26, 41). The working floor surface was directly below the oil filling cap. (Tr. 70). Savela testified that an attendant would not walk to the far side, as it is a dead end blocked by a large pipe. (Tr. 67).

McGregor and Savela testified that the compressor needed to be re-filled daily because it placed oil into the lines to lubricate the machine, thereby “burning” the oil.¹⁵ (Tr. 88, 98). However, Savela conceded he was not familiar with what happened to the oil and that he did not know what was causing the leaks. (Tr. 91-92). The oil often spilled because the compressor was repeatedly overfilled. (Tr. 73). McGregor testified that the oil overflowed because it was cold when filled, resulting in expansion when heated. (Tr. 103). In addition to oil expansion, leaks could also occur from vibrations. (Tr. 103, 116, 118). Savela testified that leaks occurred because the examiner would fill the compressor until the oil overflowed. (Tr. 74). The oil did not affect the attendant’s ability to access the area. (Tr. 74). McGregor testified that the miners knew the oil was there, that they were not supposed to walk in it, and that they were to clean before working. (Tr. 104, 107, 121).

Sichmeller believed the compressor had hemorrhaged the oil into the walkways. (Tr. 23, 26, 29, 52). This was because there was oil all over the compressor, dripping, building up underneath, and spilling out into the walkway floor. (Tr. 23). However, Sichmeller conceded that he never determined the cause of the leaks. (Tr. 23, 43). If he were able to do so, he would have issued a citation under a different standard. (Tr. 43). He did not speak to the maintenance department to determine the source of the oil. (Tr. 45). He also did not recall if he talked to the attendant about the procedures for filling the compressor with oil or for placing pads. (Tr. 44). If he had, he probably would have included it in the citation. (Tr. 44). He had spoken with the attendant about those issues during an earlier inspection. (Tr. 45).

¹⁴ Sichmeller testified that the light on the south side of the compressor was blinking, possibly affecting illumination. (Tr. 22). However, Sichmeller conceded that there was also a string of lights on the north side of the compressor room. (Tr. 46). Savela believed the lighting was adequate; sodium vapor lights on the south wall and half a dozen 120-volt lights. (Tr. 62, 68).

¹⁵ The machine was filled each shift with a one-quart “tea pot.” (Tr. 73-74). Savela disagreed with McGregor that a sight glass was available to determine how much oil was needed. (Tr. 73-74, 98).

To stop leaks, maintenance would tighten lines and, if it was a small leak, set down pads. (Tr. 104, 108-109, 116). Spills larger than five gallons would require a work order. (Tr. 108). Absorbent pads were the same as having a dry floor. (Tr. 107). Pads sat behind the compressor or in a cabinet outside. (Tr. 107-108). They were disposed of in an oil containment area in the room and near the loading area. (Tr. 108).

Sichmeller testified that the instant spill stretched 10 inches into the 27-inch wide walkway on the south side of the compressor. (Tr. 23). On the north side, the spill was 20-by-24 inches in size and stretched underneath the compressor and out into the walkway. (Tr. 23). The walkway tapered to 20 inches at the north because of the compressor and piping. (Tr. 23-24, 28). The compressor could only be accessed from the north, meaning that entering and leaving would require travel through both spills. (Tr. 24). However, McGregor testified there was a clear path around the backside of the motor and compressor to reach the working area. (Tr. 104-105). A miner would return using the same path. (Tr. 105). Miners stood behind the compressor while filing it with oil. (Tr. 105). Savela testified that the floor was dry and oil free. (Tr. 64-65, 80).

In addition to the walkway, Sichmeller testified there was oil saturation around the compressor's pedestal. (Tr. 27). Oil was on the pedestal because leaks on the compressor were building up. (Tr. 27, 52). Savela testified that the pedestal was reminiscent of a curb, and it held leaked oil.¹⁶ (Tr. 70). Sichmeller did not believe there was a curb around the pedestal. (Tr. 42).

Sichmeller testified that there were two to four layers of absorbent pads on the spills. (Tr. 21-22, 26-28). These pads were in the middle of the walkway on the north side. (Tr. 29). Savela testified that the pads were not in the walkway. (Tr. 65, 73). He also testified that the pad in the working area had created a dry floor, so there was no need for additional pads. (Tr. 67-68). He further stated that the pads on the north side were only by the discharge pipe. (Tr. 73).

Pads were also placed on the floor on the south side of the compressor, in the containment area, and along the oil reservoir/manifold. (Tr. 73). On the south side, Savela testified there were three pads on the floor. (Tr. 66). Savela did not believe the pads were stacked and saw no puddles on the floor. (Tr. 67, 85). Savela also testified that there were pads in the containment area, but not on the working floor. (Tr. 72). He believed miners were not exposed to the pads in the containment area because the area was covered by the motor and compressor. (Tr. 71-72). Miners would not access this area and would not tamp the pads down with their feet. (Tr. 87). To contact the pads here, someone would have to put their hand or foot in the space between the equipment. (Tr. 72).

Sichmeller believed the pads added to the hazard as waste accumulation and as a slip hazard. (Tr. 22, 47). Oil had built up on the walkways to the point that the pads were saturated and no longer effective. (Tr. 26, 52). Someone saw the condition and added more pads. (Tr. 26-

¹⁶ Savela testified that the pedestal was a steel enclosed rectangle fastened to the compressor. (Tr. 70). It created a containment area near the fill point. (Tr. 70-71). The compressor sat on one side and the motor was on the other, with pads below the shaft that connected them. (Tr. 72-73). This containment area was eight feet by three feet and prevented oil from getting into the walkway. (Tr. 71).

27). Savela agreed that it was not normal to use layers of pads, but conceded that there were layers in the cited area. (Tr. 84, 92). It was not Respondent's policy to stack layers of pads. (Tr. 119). Sichmeller believed the top-layer pad was ineffective and leaking. (Tr. 29). Savela testified that the top pad was not saturated, though there was some oil on it. (Tr. 84-85). McGregor testified that pads were replaced when saturated. (Tr. 107).

Sichmeller observed multiple foot prints in the oil. (Tr. 22-23, 47). The only warning sign in the area instructed employees to check the oil and listed the type of oil needed. (Tr. 30). Sichmeller did not see other warnings. (Tr. 30). However, Savela testified that when installing a pad, someone might use their boot to step on it and make it adhere and absorb. (Tr. 66, 87).

The citation was marked as "reasonably likely" because miners accessed this area at least once a day to check equipment and add oil. (Tr. 20). It was marked "lost workdays or restricted duty" because the area where the compressor was reached and maintained was congested with lots of piping. (Tr. 20, 52). The plant had multiple levels; the floors could be wet so oil on a boot was extremely slippery. (Tr. 52). Miners could slip and fall and get sprains, strains, and broken bones. (Tr. 20). Savela reviewed a material safety data sheet for the oil used in the compressor room (RX-8). (Tr. 81). The form cautioned on page 3, "[p]revent small spills and leakage to avoid slip hazard." (Tr. 86). McGregor testified that the oil was tacky rather than slippery. (Tr. 119). She also testified that oil that collected on someone's boot would wear off or be covered in dust because it was sticky. (Tr. 119). She stated that spills were cleaned to prevent stepping in oil, getting it on miners' hands, and for environmental reasons. (Tr. 119).

Sichmeller believed that friction from mechanical parts also created fire hazard. (Tr. 51). Worn out bearings could cause hydraulic fires and electrical short circuits. (Tr. 51). The pads added to that danger "like a candle wick," when saturated. (Tr. 51). Miners could inhale smoke if the oil caught fire. (Tr. 20). However, there was water on the machine to keep it cool. (Tr. 51). Further, Sichmeller conceded that he did not know what type of oil was used and that hydraulic oil of the type he would expect to find in the compressor room had a high flash point. (Tr. 46). According to the material safety data sheet, there was very little flammability hazard.¹⁷ (Tr. 82). The flash point was 453 Fahrenheit. (Tr. 82). The oil would not ignite unless it was twice as hot as boiling water. (Tr. 82). Also, no mechanical conditions were cited in the compressor room, despite the fact that Sichmeller inspected the room for those conditions. (Tr. 53-54). Savela was not aware of any fires or slip-and-falls occurring in the room. (Tr. 90).

Sichmeller marked the citation as "S&S" because it was a violation of a mandatory safety standard, it posed a discrete hazard, people were exposed, and there was a violation history. (Tr. 21). Further, the walkways were totally flooded. (Tr. 21). The citation was marked as affecting one person, because only one person would go into this area. (Tr. 24-25).

¹⁷ Savela testified that the safety sheet showed the NFPA and HMIS flammability scale rating for this oil (Tr. 82). Both scales showed the oil to be a 1 out of 4. (Tr. 82). Presumably a lower score denotes a lower level of flammability, but Savela did not elaborate on the scales.

This citation was marked “high” negligence because Sichmeller had cited the same compressor two other times and knew about a third violation.¹⁸ (Tr. 33). He had also spoken with management in 2007 and 2011 about the importance of the oil leak issue. (Tr. 33-34). He spoke with them about the degree of negligence because of the number of oil leak citations. (Tr. 34). He spoke about this issue during pre-shift inspection conferences and closeout conferences. (Tr. 34). Violation history is a big factor in negligence. (Tr. 34). Mine management saw the leaks and did not prevent recurrences. (Tr. 34). Sichmeller spoke with the safety manager and the miners’ representatives about the fact that no changes were made as reflected in his notes. (Tr. 45). However, while he discussed oil leaks in general, he did not specifically talk about this room. (Tr. 47). Respondent could have brought up mitigation at any time. (Tr. 45). However no mitigation was brought to Sichmeller’s attention. (Tr. 35).

Savela, McGregor, and Sichmeller reviewed Citation No. 6553335 (GX-11) which was issued on January 6, 2011 for conditions similar to the instant citation. (Tr. 36, 38, 78-79, 109). Savela was present when that condition was cited. (Tr. 78). It was also marked S&S, “lost workdays or restricted duty,” and “high” negligence. (Tr. 36). The negligence designation was the result of violation history and the fact that he had spoken to Respondent about this issue. (Tr. 36-37). Further, the area was a mess and the condition was obvious. (Tr. 37-38). On cross examination, Sichmeller conceded that this citation was issued for the entrance, not the filling area. (Tr. 42).

Savela testified that the oil spill in that citation was caused by a faulty pressure relief valve. (Tr. 79). At that time, when the relief valve was released, a mist of oil was generated. (Tr. 80). McGregor sent mechanics to the cited area to repair the condition under a Priority A work order. (Tr. 109, 110, 114). A pipe was installed to capture the oil in a lidded-pail, two valves were replaced (a rare and major fix), and the area was cleaned. (Tr. 80, 88, 111, 113-114). Sichmeller testified he saw this repair on the day of the instant citation. (Tr. 28). The cleanup included tightening fittings and placing a pan under the machine for overfill.¹⁹ (Tr. 113-114). She did not know how long it would take for a valve to malfunction. (Tr. 114). The repairs took four to six hours, with a little more time for clean-up. (Tr. 114-115). These conditions were no longer present in April 2011. (Tr. 80).

Sichmeller also reviewed Citation No. 6193967 (GX-15), which he issued on August 16, 2007 under 56.20003(b). (Tr. 38-39). It was issued in the compressor room for oil saturated pads on the floor. (Tr. 39). Savela was not with Sichmeller when he issued this citation; he was on the plant floor. (Tr. 48). The citation was marked as “reasonably likely,” “lost workdays or restricted duty,” and “high” negligence for the same reasons as the others. (Tr. 39). He was deposed with respect to this citation on November 15, 2010. (Tr. 40). In the deposition he stated

¹⁸ Citation No. 6559833 referred to Citation Nos. 6553335 (issued during the first regular inspection), 6193967 (issued in 2007), and 6192368 (issued by another inspector). (Tr. 35-36).

¹⁹ In a photograph from the instant citation marked GX-10 A, McGregor could not tell if there was an oil pan for overfill. (Tr. 120). The photograph marked GX-10 B showed the same area, only closer, and she could not tell if the pan was there. (Tr. 120). She may have seen the outline of a pan. (Tr. 121). However, she found the pan was visible in the photograph marked GX-10 H. (Tr. 123).

that he had no problem with the use of these pads and that the practice was not against MSHA policy. (Tr. 40). Sichmeller reviewed a photograph depicting the conditions seen in Citation No. 6139367 (GX-18 A). (Tr. 48). There were more pads, three layers, in 2007 than in the instant citation where there were only two layers. (Tr. 48-50). The conditions in 2007 were much worse than in April 2011. (Tr. 50). However, Sichmeller believed this only showed that Respondent did not take precautions to correct the condition and had a history saturated pads. (Tr. 49).

The citation was terminated when Respondent removed all the oil-saturated pads, cleaned the oil, and cleaned the compressor components to show where the leaks originated. (Tr. 30-31, 81). The area underneath the compressor and pedestal as well as the valves were cleaned the pads removed. (Tr. 31). Respondent used degreaser to remove the oil from the walkway. (Tr. 30-31). Sichmeller did not know if they fixed any leaks. (Tr. 32-33). After the compressor was degreased it was no longer hemorrhaging oil. (Tr. 43). Savela testified that no oil leaks or hemorrhaging were found after cleaning. (Tr. 81, 90).

Several weeks after the citation was terminated, Respondent tested the cited surface to determine if it was as slippery as MSHA believed. (Tr. 76, 128). The slipperiness of the area was not tested the day of the citation, but rather six months later. (Tr. 145-146). The testing was conducted by certified tribometrist, Jeffery Jarvela.²⁰ (Tr. 128). Tribometry is the measure of friction or traction on floor surfaces.²¹ (Tr. 127). A slip meter or tribometer, here a Brungraber Mark II, provides a reading of both vertical and horizontal forces at the same time with the slip meter “shoe” on the surface.²² (Tr. 131). This mimics the heel striking the floor. (Tr. 131). The slip tester then gives a measurement of the slip resistance in the form of a “slip index.” (Tr. 127-128, 131). The slip index was a range between 0 and 1.1. (Tr. 131). A reading

²⁰ At hearing, Jeffrey Jarvela was present and testified for Respondent. (Tr. 124). He was employed as the safety program manager by Cliff’s Natural Resources, Respondent’s parent company, and had been employed there for over two years. (Tr. 124-125). In that capacity he performed safety support for mines sites including program development, implementation, training, and other needs. (Tr. 125). He primarily worked in Minnesota for Respondent, Hibbing Taconite, and Northshore Mining. (Tr. 125). Jarvela had a bachelor’s degree in industrial technologies and a master’s degree in industrial safety from Minnesota-Duluth. (Tr. 125). He was a certified safety professional and occupational health and safety technologist. (Tr. 125). An occupational health and safety technologist does the technical aspects of mine safety. (Tr. 125-126). He was certified in 1998 by the Board of Certified Safety Professionals. (Tr. 126). A safety professional is the highest certification in the field and deals with management. (Tr. 126). Jarvela had 13 years of experience in manufacturing including airlines, chemical manufacturing, and electronics’ manufacturing under OSHA jurisdiction. (Tr. 126).

²¹ The Secretary objected to the introduction of this evidence as MSHA does not recognize this measurement. (Tr. 142-143). MSHA does not determine slipperiness. (Tr. 147-148).

²² Jarvela did know when the machine was sent for external calibration, but it was calibrated prior to testing. (Tr. 145). He could not say whether it was properly calibrated. (Tr. 145).

of 0.5 or less was slippery, 0.5-0.6 was acceptable, and 0.6 or higher was not slippery.²³ (Tr. 132-133, 148).

At the hearing, Jarvela reviewed the slip meter assessment for the plant dated October 17, 2011 (RX-4). (Tr. 129). He was present for the test and had contracted with Liberty Mutual to conduct it. (Tr. 129, 138). Perry Pastir, a senior consultant with the loss advisory group Helmsman Management Services conducted the test. (Tr. 129-130). Neither Liberty Mutual nor Pastir had any relationship with Respondent. (Tr. 138-139). Twenty-four measurements were taken in the plant, some in the compressor room. (Tr. 130-131). The average readings in the room were between 0.62 and 1.1, meaning the walking surfaces were non-slippery. (Tr. 132).

The first tests occurred on the floor of the compressor room.²⁴ (Tr. 129, 133-135, 146). The floor was clean, so oil had to be added. (Tr. 134-135). The average reading in that location was 0.62. (Tr. 135-136).

A second test was conducted with saturated pads on the floor. (Tr. 136). The pads were sticky because the oil had high viscosity. (Tr. 136). The pads were brown from stepping on them to soak in oil. (Tr. 137). The results were 0.88. (Tr. 136).

Respondent conducted another tests with the pads excessively soaked in oil. (Tr. 137). The results on these tests were the highest possible rating, 1.1, or not slippery. (Tr. 137-138). The more oil added, the less slippery the pads and floor. (Tr. 138, 147). However, Jarvela conceded they would clean up oil because of the slip risk and the area should be clean. (Tr. 147).

In another test, the slip test shoe was coated in oil to simulate someone stepping in oil. (Tr. 139). Generally, before testing the shoe was cleaned and sanded. (Tr. 151). The result was a reading of 0.64, which was not very slippery. (Tr. 139-140, 151).

Another test was taken in Savela's office and the report shows that the linoleum tile floor had a reading of 0.53 – more slippery than the compressor room. (Tr. 148-150). They did not test oil on a shoe in the office. (Tr. 150).

Jarvela and the other testers concluded that the rough surface of the compressor room with the dry dusty material was not slippery. (Tr. 140). The surface in that area was similar to other areas in the plant, except one area (the pump row) which tested below 0.5 (Tr. 140). Respondent contracted with a company to grind the pump row floor to increase the resistance. (Tr. 140-141). No similar changes were recommended for the compressor room. (Tr. 141).

²³ Page 2 of Jarvela's report contained some bullets at the top which stated that 0.5 to 0.6 values are "generally unacceptable." (Tr. 143-144). However, Jarvela testified this was a typo. (Tr. 144). Another bullet stated, "[t]he slip shoe on the device penetrated the oil pads or got caught on the sticky surface during the measurements of the staged oil-soaked pad test and readings may be more slippery than indicated." (Tr. 144-145).

²⁴ A series of photographs was taken of the test. The photographs show the time they were taken, with the first at 11:37 and the last at 11:46. (Tr. 146-147).

III. FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. The Secretary Has Carried His Burden Of Proof By A Preponderance Of The Evidence That § 56.20003(b) (Citation No. 6559833) Was Violated.

On April 26, 2011, Inspector Sichmeller issued a 104(a) Citation, Citation No. 6559833 to Respondent. Section 8 of that Order, Condition or Practice, reads as follows:

PELLET PLANT: the walkways in the Limestone/Bentonite unloading compressor area was not being maintained in a clean condition. Oil and oil saturated absorbent pads were found built up on the walkways on both side (sic) of the main travel routes for accessing the compressor creating the hazard of slip/fall type injuries to person accessing this area. This area is accessed at least once per shift by operators for checking the compressor. The company does have a history of violation to this standard and in this area for these conditions on citations 6553338, 6193967, 6192368. Oil leaks and control of leaks have been addressed by MSHA to management

(GX-1).

Standard 30 C.F.R. § 56.20003(b) (“Housekeeping”) provides the following:

(b) The floor of every workplace shall be maintained in a clean and, so far as possible, dry condition. Where wet processes are used, drainage shall be maintained, and false floors, platforms, mats, or other dry standing places shall be provided where practicable

30 C.F.R. § 56.2003(b).

With respect to the instant citation, Inspector Sichmeller credibly testified that the walkways in the bentonite compressor room at the Pellet Plant were covered in oil. (Tr. 23, 26, 29, 52). Further, Sichmeller credibly testified that while pads were placed in the area to absorb this oil, the pads had become saturated to the point that they were no longer keeping the area clean and dry. (Tr. 21-22, 26-28, 47, 52). The photographic evidence provided by the Secretary supports a finding that the floor of the compressor room contained oil and saturated mats. (GX-10, A through J). In fact, Respondent’s witnesses conceded that the compressor was routinely overfilled, causing the oil to leak out of the machine. (Tr. 73-74, 103). A preponderance of the evidence shows that the walkways were allowed to become wet with oil and that the pads used to collect the oil were saturated and ineffective.

Respondent offered several arguments to show that the instant citation was not validly issued. However, these arguments were not compelling.

First, Respondent argued that the areas cited were not walkways and that an open path existed on the walkway to allow safe travel. (*Respondent’s LAKE 2012-841 Post-Hearing Brief* at 8). Specifically, Respondent argued that on the north side of the compressor the spilled oil

was not in the walkway but instead underneath pipes and that miners did not enter the south side. (*Id.* at 9-10). It argued that the cited areas were not intended for travel. (*Id.* at 9). Respondent alleged that the dry path was shown in the photograph marked RX-3-1. (*Id.* at 9). Further, Respondent cited to ALJ Manning's decision in *Beco Construction Co., Inc.*, 23 FMSHRC 1182, 1194 (Oct. 2001) for the proposition that a citation for housekeeping should be vacated when a clear footpath is available and the area is relatively clean and orderly.

In a related argument, Respondent asserted that two of the areas cited areas were not working areas because they were under the oil reservoir and beneath the coupler shaft. (*Respondent's LAKE 2012-841 Post-Hearing Brief* at 9-10). Respondent argued that they were not "working places" within the definition of 30 C.F.R. §56.2 ("...any place in or about a mine where work is being performed."). Respondent claims that people would not go into these areas.

In short, Respondent argued that all of the areas cited could either be avoided by taking the clear path or were non-working areas that were inaccessible.

A preponderance of the evidence shows that some of the oil in this room was underneath equipment or within the "curb" built around the compressor to contain oil. (Tr. 27, 52, 70). However, the Administrative Law Judge is also convinced that a large amount of the oil was in the walkway where miners performed the work of filling the compressor. Sichmeller credibly testified that oil was in the walkway and that miners would have to enter these areas when filling the compressor or engaged in an inspection. (Tr. 23-24, 26, 29, 52). While some of the oil was in non-working areas and some of the walkways were clear, the Administrative Law Judge finds that there was enough oil in the working areas to constitute a violation of the cited standard.

Respondent also presented several arguments related to the use of pads. Specifically, it argued that the pads in the walkway were largely dry (just a little oily) and were not saturated. (*Respondent's LAKE 2012-841 Post-Hearing Brief* at 10-11). Also, Respondent asserted that the pads were necessary to prevent intermittent leaks and that Sichmeller agreed that the use of pads was not, *per se*, impermissible. (*Id.* at 11). Finally, Respondent claimed that the pads did not need to be removed because they were not saturated and did not pose a hazard. (*Id.*).

Nothing in the standard indicates that the use of pads, in general, is disfavored. In fact, the standard specifically calls for "mats" and other dry places for standing when wet processes are used. 30 C.F.R. § 56.20003(b). Therefore, the issue is not whether the general use of pads was appropriate, but instead whether the area, even with the pads, was maintained in a clean manner. A preponderance of the evidence shows that it was not. While Respondent appropriately used pads to collect leaks, Inspector Sichmeller credibly testified that those pads had become completely saturated to the point that they no longer served their valuable function. (Tr. 26, 52). Sichmeller and Savela testified that pads were saturated and more pads were simply stacked on top of them. (Tr. 21-22, 26-28, 84-92). The Administrative Law Judge finds that a preponderance of the evidence shows that the working areas and walkways were not maintained properly as there were both oil and oil saturated pads on the floor.

2. Considering The Record *In Toto* And Applying Applicable Case Law, The Violation Was Reasonably Likely to Result in a Fatal Injury And Was Significant And Substantial in Nature

Inspector Sichmeller marked the gravity of the cited danger in Citation No. 6559833 “Reasonably Likely” to result in “Lost Workday/Restricted Duty” injury to one person. (GX-1). These determinations are supported by a preponderance of the evidence.

The event against which the instant standard, 30 C.F.R. § 56.20003(b), is directed is injury caused by poorly maintained working areas. Inspector Sichmeller credibly testified that the existence of oil on the walkways in the compressor created a slip-and-fall hazard that could result in sprains, strains, and broken bones. (Tr. 20, 52). Further, the evidence shows that only one miner at a time would likely be in this area. (Tr. 60, 98, 116, 121).

Respondent provides several arguments asserting that an accident was unlikely. However these arguments are not compelling.

First, Respondent argued that the cited area was only minimally accessed and that there were no tripping, electrical, or mechanical hazards in the area. (*Respondent’s LAKE 2012-841 Post-Hearing Brief* at 11-12). The evidence supports Respondent’s contention that the area was only accessed once a day when the miner entered to service the compressor. (Tr. 60, 98, 116, 121). However, the citation already states that only one person would be affected. (GX-1). Even granting that exposure was limited, the preponderance of the evidence supports the citation as issued with respect to persons affected. Also, while there were no electrical or mechanical hazards in the area; the evidence supports a finding that the oil and saturated pads alone constituted a slipping hazard. (Tr. 20, 53-54). Further, the tight confines of the compressor room and the various pieces of equipment and piping contained therein support a finding that when a miner fell, it would result in lost working or restricted duty type injuries. (Tr. 20, 52).

Second, Respondent argued that the oil pads worked as intended and that the walkway was oil free. (*Respondent’s LAKE 2012-841 Post-Hearing Brief* at 12). As already discussed with respect to validity *supra*, a preponderance of the evidence supports a finding that the walkways were somewhat oily and that the pads were saturated with oil.

Finally, Respondent argued that even if there was oil in the walkway, the oil was sticky rather than slippery and that walking surface was less slippery with the oil than without. (*Respondent's LAKE 2012-841 Post-Hearing Brief* at 12-13). Respondent cites to the tribometry testing conducted by Jarvela to support this assertion. (*Id.*). The Administrative Law Judge does not find the tribometric evidence nor the testimony related thereto to be particularly probative.²⁵ Jarvela did not test the cited condition with the tribometer, he merely tested the area weeks later after placing oil on the floor. (Tr. 76, 128, 134-135). Jarvela's tests did not analyze conditions at the time of the citation and therefore are only partially credible. Perhaps more importantly, the Material Data Safety Sheet provided by the manufacturer of this oil warns customers to "[p]revent small spills and leakage to avoid slip hazard." (RX-8). Therefore, Respondent's assertion that increasing the amount oil on the floor decreased the slip hazard is not only counter-intuitive but also counter to the safety data provided by the manufacturer. Beyond that, a sticky floor could be just as much of a tripping hazard as a slippery floor. Finally, the record showed that MSHA and OSHA do not recognize tribometry for the purposes of workplace safety. (Tr. 142-143). As a result, the Administrative Law Judge finds that the oil was a slip hazard.

In addition to the slip hazard, the Secretary also asserts that the cited condition constitutes a fire hazard. (*Secretary's Post-Hearing Brief* at 15). Essentially, the Secretary notes that the oil in the cited area was flammable and could have ignited, causing burn injuries to miners. A preponderance of the evidence does not support this claim. As Respondent's witnesses noted, this oil had a flash point well above the temperatures to be expected in the compressor room. The Material Data Safety Sheet confirms that the flash point of this oil was around 453 degrees Fahrenheit. (RX-8). The likelihood of a fire in this area was low.

Therefore, the Administrative Law Judge finds that the cited condition was reasonably likely to result in lost workday/restricted duty injuries to one miner as a result of slip and fall hazard but that there was virtually no hazard of fire.

²⁵ The Administrative Law Judge fully recognizes the necessity for expert testimony in many of the cases before the Commission. However, there is abundant case law indicating why expert opinion evidence may in and of itself be problematic. Indeed, many states' juror instructions contain the following or similar language:

In evaluating the credibility of the witness, you should consider their interests in the outcome of the case; that is, whether that interest in any fashion affected their testimony. The testimony of an expert witness is merely an opinion. An opinion is what someone thinks about something and the thought may be precisely accurate or totally inaccurate and yet represent the absolute, honest conviction of the person who expressed it. Because of this, opinion evidence is generally considered of inferior or low grade and not entitled to much weight against positive testimony of actual facts.

Fay v. Philadelphia, 344 Pa. 439, 441-43, 25 A.2d 145, 146-147 (1942); *Kutchinic v. McCrory*, 439 Pa. 314, 226 A.2d 723 (1970). Though not bound by said jurisprudence the undersigned, as trier-of-fact, believes such contains sage cautionary advice regarding the evaluation of expert opinion.

Citation No. 6559833 was also marked as S&S. (GX-1). It has already been established that the first element of the *Mathies* S&S analysis, the underlying violation of a mandatory safety standard, has been established with respect to this citation. As discussed *supra*, Respondent violated 30 C.F.R. §56.20003(b).

With respect to the second element of *Mathies*, a discrete safety hazard – that is a measure of danger to safety – contributed to by the violation, the preponderance of the evidence shows that the oil and oil-saturated pads constituted a slip and fall hazard. As discussed *supra*, a miner stepping onto an oily floor surface or oil-saturated pads could lose his footing and fall. Once again, there was no credible fire hazard created by this condition.

Respondent produced several arguments for the proposition that this condition posed no hazards, none of which are compelling.

First, Respondent argued that the absorbent pads worked as intended and that they did not themselves constitute a slip hazard. (*Respondent's LAKE 2012-841 Post-Hearing Brief* at 14). As discussed, Inspector Sichmeller credibly testified that the pads were saturated and no longer providing a stable place to stand. (Tr. 26, 52). The oily pads were a slip hazard and no longer served to clean and stabilize the area. Even if sticky, the pads and floor could have been a trip hazard.

Respondent also argues that the saturated pads were not located in the travelway. (*Respondent's LAKE 2012-841 Post-Hearing Brief* at 14). Again, a preponderance of the evidence shows that while some of the pads were outside of work areas, there was sufficient oil in the walkways to violate the standard and present a slip and fall hazard. (Tr. 20). In light of these facts, the Administrative Law Judge finds that the second prong of *Mathies* is met.

The third element of the *Mathies* test – a reasonable likelihood that the hazard contributed to will result in an injury – is also supported by the record. A miner slipping on wet pads or an oily walkway in the compressor room would be reasonably likely to suffer broken bones, head injury, contusions, or other lost workday/restricted duty injuries.

The fourth element - a reasonable likelihood that the injury in question will be of a reasonably serious nature – is also supported by the record. The slip and fall related injuries that would occur would be of a reasonably serious nature. See e.g. *Oak Grove Resources, LLC*, 35 FMSHRC 3039, 3052 (Sept. 2013) (ALJ Zielinski); *Oil-Dri Production Company*, 32 FMSHRC 1761 (Nov. 2010) (ALJ Manning); and *Mach Mining, LLC*, 32 FMSHRC 213 (Feb. 2010) (ALJ Weisberger).

As a result, the Administrative Law Judge finds that the Secretary proved the violation was S&S by a preponderance of the evidence.

3. Respondent's Conduct Was Not Reasonably Designated As Being "High" In Nature but instead showed "Moderate" Negligence.

In the citation at issue, Inspector Sichmeller found that the operator's conduct was highly negligent in character. He credibly testified that Respondent knew, or should have known, about the cited condition. First, the condition was obvious as the room contained a large amount of oil and soaked oil pads. (Tr. 21-23, 26-28). The compressor itself was soaked in oil. (Tr. 23). Further, an employee entered the compressor room every day to examine the area and service the machines. (Tr. 60, 98, 116, 121). Also, Respondent had been cited for the condition of the compressor room in the past, though Sichmeller conceded previous conditions were more serious. (Tr. 33, 49-50). Finally, Respondent noted that some spillage was unavoidable when filling the machine but did not take sufficient action to prevent hazards from arising from that spillage. (*Respondent's LAKE 2012-841 Post Hearing Brief* at 14-15 and Tr. 73). Therefore, the Administrative Law Judge finds that Respondent knew or should have known the condition existed.

However, the evidence does not support the Secretary's contention that there were no mitigating circumstances in this case. Several factors served to mitigate Respondent negligence with respect to the instant citation. First, Respondent had taken measures after the earlier citations to correct conditions in the compressor room. Specifically, a bucket was added to the compressor to collect discharge and a curb was placed to create a containment area. (Tr. 80, 88, 111, 113-114). While these measures did not eliminate the hazard here, they show that Respondent was making some effort to correct the conditions. The same is true of the pads. While Respondent allowed the pads to become saturated and improperly stacked the pads, the fact that it was using the pads shows it was aware of the condition and was attempting to alleviate it.

In light of these mitigating circumstances, a finding of "high" negligence is inappropriate. Respondent's actions are better characterized as showing "moderate" negligence.

4. Penalty

As with the previous citation, the Administrative Law Judge finds that a substantial deviation from the Secretary's proposed assessment of \$16,867.00 is warranted herein. Once again, the factors contained in 30 U.S.C. §820(i) will be used to explain that deviation. Those factors are as follows:

(1) The Operator's history of previous violations – in the 18 months preceding this violation the Plant was cited 3 times for this condition. (GX-1).

(2) The appropriateness of the penalty compared to the size of the Operator's business – As discussed with respect to the previous citation, Respondent is a large operator with an above-average sized plant.

(3) Whether the Operator was negligent – As previously shown, the operator exhibited moderate negligence, rather than the high negligence cited by the Secretary.

(4) The effect on the Operator's ability to remain in business – The parties have stipulated that the citation at issue here would not affect Respondent's ability to remain in business. (JX-1)

(5) The gravity of the violation – As previously shown, this violation was reasonably likely to result in lost workday/restricted duty injuries to one person.

(6) The demonstrated good-faith of the person charged in attempting to achieve rapid compliance after notification of a violation – The evidence shows the condition was abated rapidly and in good faith.

In light of the Administrative Law Judge's decision to modify the negligence from "High" to "Moderate" a reduction in the assessed penalty is appropriate. Therefore, Respondent is hereby **ORDERED** to pay a civil penalty in the amount of \$10,000.00 with respect to this violation.

ORDER

It is hereby **ORDERED** that Order No. 6553379, Citation No. 6553380 (LAKE 2012-687) and Citation 6559833 (LAKE 2012-841) are **AFFIRMED** as modified herein.

Respondent is **ORDERED** to pay civil penalties in the total amount of \$17,000.00 within 30 days of the date of this decision.²⁶

/s/ John Kent Lewis
John Kent Lewis
Administrative Law Judge

²⁶ Payment should be sent to: MINE SAFETY AND HEALTH ADMINISTRATION, U.S. DEPARTMENT OF LABOR, PAYMENT OFFICE, P. O. BOX 790390, ST. LOUIS, MO 63179-0390

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FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

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February 12, 2014

SECRETARY OF LABOR,	:	CIVIL PENALTY PROCEEDING
MINE SAFETY AND HEALTH	:	
ADMINISTRATION, (MSHA),	:	Docket No. KENT 2013-989
Petitioner,	:	A.C. No. 15-10753-327883
	:	
v.	:	
	:	
MAXXIM REBUILD COMPANY, LLC,	:	
Respondent.	:	Mine: Mine #1

DECISION AND ORDER

Appearances: Mary Sue Taylor, Office of the Solicitor, U.S. Department of Labor, Nashville, TN on behalf of the Secretary of Labor;
R. Henry Moore, Jackson Kelly, PLLC, Pittsburgh, PA on behalf of Respondent.

Before: Judge Miller

This case is before me on a petition for assessment of civil penalty filed by the Secretary of Labor, Mine Safety and Health Administration (“MSHA”) against Maxxim Rebuild Company, LLC, pursuant to sections 105 and 110 of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. §§ 815 and 820. The docket involves two citations issued by MSHA under section 104(a) of the Mine Act at Maxxim’s fabrication shop at Mine No. 1, located in Sidney, Kentucky.

I. FINDINGS OF FACT AND CONCLUSIONS OF LAW

On October 23, 2013, I issued a decision, after hearing, regarding several citations at the Maxxim Rebuild fabrication shop. 35 FMSHRC 3261 (October 2013). The primary issue in that case was whether the fabrication shop was subject to MSHA jurisdiction. The parties presented testimony and evidence at hearing, and submitted post-hearing briefs. I issued a decision finding that jurisdiction was proper and addressed the various violations. The operator appealed the case to the Commission and a decision has not yet been issued by the Commission. Shortly thereafter, this docket was assigned to me and the same issue of jurisdiction was raised by Maxxim.

During a conference call about this case, the parties agreed that the central issue was identical to the jurisdiction issue pending before the Commission in the Maxxim case decided in October, 2013. The parties further agreed that they would stipulate to the facts surrounding the violation so that a decision could be issued and the mine operator would preserve the issue of jurisdiction for purposes of appeal. On January 24, 2014, the parties filed joint stipulations,

which are marked as a joint exhibit and are the basis for this decision. In addition, the facts and circumstances of the earlier case, which are identical here, are the basis for my determination that MSHA does properly maintain jurisdiction of the Maxxim fabrication facility. This case, therefore, should be consolidated, or otherwise decided along with the case on appeal to the Commission.

a. Jurisdiction

In the first Maxxim decision, the mine asserted that the Secretary did not have jurisdiction in this matter because the facility is not a “mine” as contemplated by the Act, its activities are too remote from the mining process, the facility repairs and rebuilds mining equipment for Alpha Resources and on a limited basis for other mine operators, and MSHA has inconsistently applied jurisdiction over the site and similarly situated repair shops. In response, the Secretary argued that, due to the nature of the work performed at the facility, it is a “mine” and, accordingly, is within the jurisdictional reach of the Act. I agreed with the Secretary and found that the fabrication facility is a mine, relying primarily on *Jim Walters Resources*, (“JWR”), 22 FMSHRC 21 (Jan. 2000) in which the Commission addressed a situation similar to the instant one. Given that this Maxxim fabrication shop is the one addressed in the earlier Maxxim decision, the reasoning and findings in the earlier case are applicable here and I find that the Maxxim facility is subject to MSHA jurisdiction.

b. Citation No. 8289289

On June 19, 2013, Inspector Randal Thornsby issued Citation No. 8289289 to Maxxim for a violation of section 77.505 of the Secretary’s regulations. The cited standard requires that cables “[s]hall enter metal frames of motors, splice boxes, and electric compartments only through the proper fittings...” 30 C.F.R. § 77.505. The citation alleged that “[p]ower leads of the 480 volt AC Co. No. 2 heater ...are not properly entranced into the metal framing”. Thornsby determined that an injury was unlikely to occur, that one employee was affected, and that the negligence was moderate. A civil penalty in the amount of \$100.00 has been proposed for this violation.

According to the stipulations of the parties, Maxxim does not dispute the facts of the violation and only disputes the jurisdiction over the facility. The parties agree that the \$100.00 penalty as proposed is appropriate pursuant to the criteria set forth in Section 110(i) of the Act. (Joint Stip. 9,10.) Therefore, I affirm the violation as issued and assess a \$100.00 penalty.

c. Citation No. 8289290

Inspector Thornsby issued Citation No. 8289290 to Maxxim for an alleged violation of section 77.502 of the Secretary’s regulations. The cited standard requires that electrical equipment “shall be frequently examined, tested and properly maintained by a qualified person...” 30 C.F.R. §77.502. The citation alleged that the Lincoln 600 volt MIG welder was not being maintained because the insulated outer jacket of a positive lead was damaged. Thornsby determined that an injury was unlikely to occur, that one employee was affected and

that the negligence was moderate. A civil penalty in the amount of \$100.00 has been proposed for this violation.

The mine operator has agreed and stipulated that there is no dispute as to the fact of the violation and that the operator only disputes the jurisdiction over the facility. (Joint Stip. 12.) The parties further agree that the \$100.00 penalty is appropriate under the criteria set forth in Section 110(i) of the Act. (Joint Stip. 13.) Accordingly, I find that the violation occurred as cited, the citation is affirmed and a penalty of \$100.00 is assessed.

II. PENALTY

The principles governing the authority of Commission Administrative Law Judges to assess civil penalties de novo for violations of the Mine Act are well established. Section 110(i) of the Mine Act delegates to the Commission and its judges “authority to assess all civil penalties provided in [the] Act.” 30 U.S.C. § 820(i). The Act requires that, “in assessing civil monetary penalties, the Commission [ALJ] shall consider” six statutory penalty criteria which includes the previous history of violations, the size of the operator, the negligence, gravity and good faith abatement.

The history of assessed violations was not addressed in the stipulations but the MSHA website indicates very few violations at this mine. The operator has stipulated that the penalties as proposed will not affect its ability to continue in business. The gravity and negligence of each violation is discussed above and the operator demonstrated good faith in abatement. As noted above, I assess a total penalty of \$200.00.

III. ORDER

Based on the criteria in section 110(i) of the Mine Act, 30 U.S.C. § 820(i), I assess the penalties listed above for a total penalty of \$200.00. Maxxim Rebuild Company, LLC is hereby **ORDERED** to pay the Secretary of Labor the sum of \$200.00 within 30 days of the date of this decision.

/s/ Margaret A. Miller
Margaret A. Miller
Administrative Law Judge

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FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

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February 13, 2014

SECRETARY OF LABOR	:	CIVIL PENALTY PROCEEDING
MINE SAFETY AND HEALTH	:	
ADMINISTRATION, (MSHA),	:	Docket No. KENT 2012-438
Petitioner,	:	A.C. No. 15-02132-275499
	:	
v.	:	
	:	
WEBSTER COUNTY COAL, LLC,	:	Mine: Dotiki Mine
Respondent.	:	

DECISION AND ORDER

Appearances: Thomas Motzny, Office of the Solicitor, U.S. Department of Labor,
618 Church Street, Suite 230, Nashville, TN 37219 for Petitioner

Tyler H. Fields, Alliance Coal, LLC
771 Corporate Drive, Suite 500 Lexington, KY 40503 for Respondent

Before: Judge Simonton

This case is before me on a petition for assessment of civil penalty filed by the Secretary of Labor, acting through the Mine Safety and Health Administration, against Webster County Coal, LLC pursuant to sections 105 and 110 of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. §§ 815 and 820 (the “Mine Act” or “Act”). This docket originally involved 34 contested violations with a total proposed penalty of **\$71,623.00**. The parties settled 31 of the contested violations prior to hearing. The parties presented testimony and documentary evidence on the remaining 3 citations at hearing in Madisonville, Kentucky commencing on November 13, 2013.

I. ISSUES FOR ADJUDICATION

At hearing, the parties contested the following main issues. For Citations No. 8503536 and 7656891, did the Secretary show that automatic dump dust skirts were missing from roof bolting machines for more than one maintenance shift in violation of the mine’s approved ventilation plan? If not, did the Secretary demonstrate that WCC’s ventilation plan required immediate repair of completely missing automatic dump dust skirts? Did the Secretary demonstrate that the missing dust skirts were Significant and Substantial (S&S) violations of 30 CFR § 73.370(a)(1) and WCC’s ventilation plan?

For Citation No. 7656922, did the Secretary demonstrate that the roof bolter hydraulic oil leak violate separate and distinct duties under the Mine Act, allowing the Secretary to cite WCC for violations of both 30 CFR § 75.400 and 30 CFR CFR § 75.1725 (a)? Was the hydraulic oil leak an S&S violation that exposed miners to a reasonable likelihood of suffering a significant injury?

II. BACKGROUND

Webster County Coal, LLC, (“WCC”) operates the Dotiki mine (the “mine”) in Hopkins County, Kentucky. The mine is an underground bituminous coal mine subject to regular quarterly inspections by the Secretary’s Mine Safety and Health Administration (“MSHA”) pursuant to section 103(a) of the Act. 30 U.S.C. § 813(a). The mine is classified as a large mine by MSHA and produced 3.6 million tons of coal in 2011. The parties stipulated that Webster County Coal is the operator of the mine, that its operations affect interstate commerce, and that the mine is subject to the jurisdiction of the Mine Act. The mine utilizes the room and pillar system of mining.

The three remaining contested violations in Docket KENT 2012-438 include two citations for alleged failures to comply with the mine’s mandatory ventilation plan, and one citation for an alleged failure to maintain equipment in a safe operating condition. MSHA inspectors designated all three of these 104(a) citations as “Significant and Substantial” or S&S violations of the Mine Act.

III. CITATION Nos. 8503536 and 7656891

On May 18, 2011, MSHA Inspector Alan Frederick issued Citation No. 8503536 to WCC for a violation of Section 73.370(a)(1) of the Secretary’s regulations. The citation alleges in part that:

The approved ventilation and dust control plan was not being followed on the # 2 unit, MMU-027-0, 2nd Southeast Sub mains. The skirt for the automatic roof dust systems on the opposite operator side of the DBT roof boofbolter, CO# 6047 was missing. Page #2, item 21 of the plan states that these bolters will be equipped with skirts on the automatic dump...

Ex. 1, 1.

Inspector Frederick found that an injury was reasonably likely to occur and would result in a permanently disabling injury, that the violation was S&S, that two persons would be affected, and that the violation was the result of moderate negligence on the part of the operator. Ex. 1, 1.

On June 6, 2011, MSHA Inspector Ronnie Rich issued Citation No. 7656891 to WCC for a violation of Section 73.370(a)(1) of the Secretary’s regulations. The citation alleges that:

The approved ventilation and dust control plan was not being followed on the 1 2 unit, MMU-031-0 4th S.E. Panel. The skirts for the automatic roof dust dump system on both the operator and opposite operator sides of the DBT double boom roof bolter, Co. #6043 were missing. Page #2, item 21 of the plan states that these bolters will be equipped with skirts on the automatic dump...

Ex. 4, 1.

Inspector Rich found that an injury was reasonably likely to occur and would result in a permanently disabling injury, that the violation was S&S, that two persons would be affected, and that the violation was the result of moderate negligence on the part of the operator. Ex. 4, 1.

A. Statement of Law

1. The Regulation

30 CFR § 75.370 (a)(1) states in part that:

The operator shall develop and follow a ventilation plan approved by the district manager. The plan shall be designed to control methane and respirable dust and shall be suitable to the conditions and mining system at the mine...

30 CFR § 75.370 (a)(1).

The relevant part of the Dotiki Mine ventilation plan in effect at the time of the citation required that:

Roof bolters will be equipped with skirts on the automatic dump. If this skirt becomes damaged it will be repaired on the next maintenance shift.

Ex. 3: Part B, 2.

2. Interpretation

Mandatory site specific safety plans, including ventilation plans, are enforceable as mandatory standards. *UMWA v. Dole*, 870 F. 2d 662, 671 (D.C. Cir. 1989); *Ziegler Coal Co. v. Kleppe*, 536 F. 2d 298, 409 (D.C. Cir. 1976); *Energy West Mining Co.*, 17 FMSHRC 1313, 1317 (Aug. 1995).

Because MSHA-required site specific safety and health plan provisions are enforceable as mandatory standards,

the operator is entitled to the due process protection available in the enforcement of regulations... When a violation of a regulation

subjects private parties to criminal or civil sanctions, a regulation cannot be construed to mean what an agency intended but did not adequately express. Laws must give the person of ordinary intelligence a reasonable opportunity to know what is prohibited, so that he may act accordingly

Energy West Mining Co., 17 FMSHRC 1317-18 (internal citations omitted).

However, the Secretary is not required to provide the operator actual notice of its interpretation of a mandatory site specific safety standard, rather,

the Commission has applied an objective standard of notice, i.e., the reasonably prudent person test. The Commission has summarized this test as ‘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.’

Energy West Mining Co., 17 FMSHRC 1318 (internal citations omitted).

3. Burden of Proof

The Commission has long held, “In an enforcement action before the Commission, the Secretary bears the burden of proving any alleged violation.” *Jim Walter Resources, Inc.*, 9 FMSHRC 903, 907 (May 1987); *Wyoming Fuel Co.*, 14 FMSHRC 1282, 1294 (August 1992).

The Commission has described the Secretary’s burden as:

“the burden of showing something by a ‘preponderance of the evidence,’ the most common standard in the civil law, simply requires the trier of fact ‘to believe that the existence of a fact is more probable than its nonexistence.’”

RAG Cumberland Res. Corp., 22 FMSHRC 1066, 1070 (Sept. 2000); *Garden Creek Pocahontas Co.*, 11 FMSHRC 2148, 2152 (Nov. 1989).

The Secretary may establish a violation by inference in certain situations. *Garden Creek Pocahontas Co.*, 11 FMSHRC 2153. Any such inference, however, must be inherently reasonable, and there must be a rational connection between the evidentiary facts and the ultimate fact inferred. *Mid-Continent Resources*, 6 FMSHRC 1132, 1138. (May 1984).

If the Secretary has established facts supporting the citation, the burden shifts to the respondent to rebut the Secretary’s prima facie case. *Construction Materials*, 23 FMSHRC 321, 327 (March 2001) (ALJ Feldman).

4. Significant and Substantial

A violation is S&S “if based upon the particular facts surrounding the violation there exists a reasonable likelihood that the hazard contributed to will result in an injury or illness of a reasonably serious nature.” *Cement Division, National Gypsum Co.*, 3 FMSHRC 822, 825 (Apr. 1981).

In order to uphold a citation as S&S, the Commission has held that 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).

B. Testimony and Party Arguments

1. The Secretary

MSHA Inspector Alan Frederick testified that he issued citation No. 8503536 approximately 4 hours into the morning production shift on May 18, 2011. Tr. 14-16. Frederick stated that he observed a missing dust dump skirt on the opposite operator side of the # 6047 DBT roofbolter while it was parked. Tr. 15-16. Based on his observations at the time of the citation, Frederick did not believe that the roof bolter had been operated during that production shift. Tr. 15. Frederick acknowledged that he did not have direct evidence for this conclusion, but stated that the dusty color of the exposed dump column indicated that the skirt had been missing for some time. Tr. 28, 57.

Frederick further testified that when he asked roof bolter operators how long the skirt had been missing, the operators replied that they didn't know. Tr. 19. Frederick stated that the shift before this day production shift had been a maintenance shift. Tr. 20.

Frederick testified that the skirt acted to control dust dumped from the automatic roof bolter stab jack after a bolt hole had been drilled. Tr. 18. Frederick described the automatic dump as located within a foot and a half of the bolter operator. Tr. 20. Frederick stated that at the Dotiki mine, the dust skirt was constructed of flexible ventilation curtain attached to the dump with a hose clamp. Tr. 19.

Frederick further explained that the opposite operator side of the roofbolter was a designated area that MSHA dust sampling inspections had previously determined to present elevated respiratory hazards. Tr. 22-23. Frederick stated that a roof bolter could drill up to 200 bolts in a standard shift. Tr. 21. Frederick testified that he had rarely observed roof bolt operators use dust masks or respirators at the Dotiki mine. Tr. 16. On cross examination, Frederick acknowledged that the DBT roofbolter was equipped with a cyclone vacuum system designed to filter smaller respirable dust into a protected dust box so that the dust dumped out of the automatic dump was “less respirable.” Tr. 29-30.

Frederick believed that the Dotiki ventilation plan required operators to replace missing skirts immediately as the plan required that roof “bolters will be equipped with a skirt or skirts on the automatic dump.” Tr. 18. Frederick stated that according to his interpretation of the Dotiki ventilation plan, WCC had until the next maintenance shift to repair present but damaged skirts, but must immediately replace completely absent skirts. Tr. 26. Frederick stated that regardless of whether a skirt was damaged or missing, the standard method of “repair” for both conditions was to install an entirely new skirt. Tr. 25-26, 65. On cross-examination, Frederick conceded that a badly damaged skirt was no more effective at controlling dust than a completely missing skirt. Tr. 34.

Frederick based his gravity designations on the close proximity of the automatic dust dump to the roof bolter operator and concern that exposure to elevated levels of respirable dust would lead to silicosis and pneumosilicosis. Tr. 21-22.

MSHA Inspector Ronnie Rich testified that he issued Citation No. 7656891 towards the end of the midnight maintenance shift on early Monday morning June 6, 2011 at approximately 4:00 am. Tr. 78. Rich stated that he observed that both the operator and opposite operator side automatic dump skirts were missing on the # 6043 DBT roofbolter. Tr. 78-79. Rich stated that as this inspection occurred during the Sunday/Monday midnight maintenance shift, WCC had worked several maintenance shifts since the last production shift on the previous Friday day production shift. Tr. 76. Rich based this conclusion on conversations with WCC maintenance supervisors, in which they told Rich that they worked every mechanic available through the weekend maintenance shifts. Tr. 76-77.

When Rich asked the mechanic in the area if he was going to fix the missing skirt, the mechanic replied, “It’s not on my list.” Tr. 82. Rich further testified that to his knowledge, standard procedure on maintenance shifts was to provide every mechanic with an identical unit wide list of necessary repairs. Tr. 84.

Rich stated that this roof bolter was an older model that ran “hot”, a condition that in his experience, led roof bolters to not wear respirators and to breathe more rapidly. Tr. 87. Rich testified that the return side of all roof bolters were designated areas, due to previous excessive respirable dust levels or high quartz content results. Tr. 89-90. Rich also noted that the Dotiki mine was the only mine he inspected that used the ventilation skirt/hose clamp configuration to provide dust skirts on the automatic dump. Tr. 125. Rich based his gravity designations for Citation No. 7656891 on the proximity of the automatic dump to the bolter operator, the high number of bolts drilled in a production shift, and the possibility of miners developing black lung from exposure to respirable dust. Tr. 87-89.

MSHA Health Specialist Hubert Wright testified regarding the hazards of respirable dust in underground coal mines. Wright described respirable dust as any dust particle 10 microns or smaller. Tr. 135. At that small size, respirable dust can be breathed deeply into the lungs to where it damages small air sacs and prevents oxygen exchange. Tr. 135. Wright explained that respirable dust is associated with both pneumoconiosis and silicosis. Pneumoconiosis is commonly referred to as black lung, and the negative effects of the disease can be halted but not cured by removing affected miners from exposure. Tr. 136. Silicosis is caused by the exposure to

silica particles, commonly referred to as quartz. Tr. 136. Silicosis results in a progressively worsening illness as hardened crystalline particles are drawn deeper and deeper into the lungs even without continued exposure. Tr. 136.

Wright stated that roof bolters generate significant amounts of respirable dust, including silica, during the drilling process. Tr. 137. On cross-examination, Wright acknowledged that dust produced by continuous miners could have previously led MSHA to designate roof bolters as designated areas. Tr. 151. However, Wright stated that if the automatic dump skirts are not present, a significant dust cloud is generated and that dust can enter the air stream of the roof bolter. Tr. 140. Wright testified that automatic dump dust contained respirable dust, as the cyclone vacuum system on roof bolters was not a 100% effective system in removing respirable dust from the automatic dump. Tr. 140. Wright primarily based this conclusion upon a National Institute of Occupational Safety and Health article that found roofbolter automatic dump dust in underground Appalachian coal mines contained respirable dust in concentrations from 5 to 35 percent. Tr. 143-144; Ex. 9, 5. Wright further stated that this article had been prepared in response to a rise in respiratory illnesses in coal miners in Appalachia. Tr. 142.

Wright acknowledged that the NIOSH article did not study mines in western Kentucky where the Dotiki mine is located.¹ Tr. 144. However, he stated that the basic geologic composition of coal seam roofs are fairly consistent, formed by layers of shale, limestone, and sandstone. Tr. 143. On cross-examination, Wright conceded the Dotiki mine was located in a different geologic region, the Illinois Basin, as compared to the Southern Appalachia region studied in the NIOSH article. Tr. 154. Wright also conceded that the article studied a different brand of roof bolter and cyclone vacuum system than used at the Dotiki mine. Tr. 157. Still, Wright did not believe that distinction diminished the relevance of the NIOSH article, as both systems used a similar design and sought to control the same hazard: dust produced by drilling into the coal seam roof. Tr. 161. Wright also stated he was not aware of the specific roof composition of either the Dotiki mine or the mines studied in the NIOSH article. Tr. 155. Nonetheless, Wright believed the NIOSH article was still “good information,” as both Dotiki and the NIOSH study area were bituminous type coal mines. Tr. 167.

In his post-hearing brief, the Secretary first asserts that the language of the ventilation plan required WCC to immediately replace missing dust skirts as the first sentence states, “Roof bolters will be equipped with skirts on the automatic dump.” Sec’y Br. 4. According to the Secretary’s interpretation, the second sentence allowing WCC until the next maintenance shift to repair “damaged” skirts only operates if at least some part of the dust skirt is physically present. Sec’y Br. 5.

¹ The NIOSH Article included mines in MSHA Coal districts encompassing Central Kentucky, Eastern Kentucky, South Central West Virginia, and all of Tennessee, North Carolina, South Carolina, and the Commonwealth of Virginia. Immediately prior to hearing the Respondent attempted to exclude consideration of this study in this case via a Motion in Limine. On November 12, 2013 I denied Respondent’s motion for reasons detailed in both the Order and as discussed below.

The Secretary also argues that regardless of how the ventilation plan is interpreted, evidence indicates the skirts had been missing for more than a full maintenance shift in both citations. Sec'y Br. 7. The Secretary notes that although Inspector Frederick issued Citation No. 8503535 only several hours into a production shift that followed a full maintenance shift, the roof bolter operator was not aware how long the skirt had been missing. Sec'y Br. 7; Tr. 19. The Secretary also points out that when Inspector Rich issued Citation No. 7656891 during a maintenance shift that followed another maintenance shift, the mechanic in the area stated that replacing the skirt was not on the shift maintenance list. Sec'y Br. 7; Tr. 83-84.

2. WCC

Shift Maintenance Foreman Bobby Nall testified about standard maintenance procedures and the operation of the roofbolter automatic dump system. Nall stated that the dust skirts were a common maintenance item that were routinely replaced during the maintenance shift. Tr. 209. Nall explained that the skirts were not recommended by the roof bolter manufacturer and had been retro-fitted per MSHA instruction. Tr. 222. Nall described that as the cyclone vacuum system switched on and off during the drilling/dump cycle, the tube the skirt was attached to contracted and expanded, loosening the hose clamp and eventually causing the skirt to fall off. Tr. 216-17. Nall explained that the maintenance department tried fabricating different attachment methods, but were unable to find a design that kept the skirt on consistently. Tr. 217. Nall did not believe there was any difference between a damaged skirt and a missing skirt, and stated he did not believe even an intact skirt did any good. Tr. 221.

Nall described the skirt replacement procedures in detail. Replacing the dust skirts safely required tramming the bolter to an intersection where the operator could swing the booms out fully. Tr. 219. Once the operator had swung the booms, the operator would de-energize the bolter to allow miners to replace the skirts without being exposed to dangerous pinch points. Tr. 220. Replacing dust skirts on a maintenance shift allowed repairs to be made without exposure to the shuttle car and scoop traffic present on production shifts. Tr. 220-21.

On cross-examination, Nall stated that he was not present during either of the citations and did not have any specific knowledge of when the skirts had gone missing. Tr. 227-28. Nall also confirmed that the mechanics on each unit worked off an identical maintenance to do list. Tr. 238. However, Nall stated that if a maintenance mechanic found a repair item not on the official list, he would either repair the issue himself or add it to the next shift's list. Tr. 239-40. Nall explained that while anyone could theoretically repair a missing skirt, many production workers focused on their normal tasks and would most likely add a missing skirt to the maintenance shift repair list. Tr. 248-49.

WCC Safety Director Gunn testified on the equipment inspection procedures in place at the Dotiki mine. Gunn stated that certified mechanics conducted detailed weekly permissibility exams while roofbolter operators conducted dust parameter checks before beginning production on each shift. Tr. 263. Gunn confirmed that a weekly permissibility exam was conducted for the # 6047 roof-bolter on May 11, 2011, seven days before Citation No. 8503536 was issued. Tr. 263; Ex. B, 1. Gunn also confirmed that a weekly permissibility exam was conducted for the # 6043 roof-bolter on June 2, 2011, four days before Citation No. 7656891. Tr. 267; Ex. C, 1.

Gunn stated that for each permissibility exam, the certified mechanic affirmed that there were no hazardous dust conditions found during the permissibility exam. Tr. 268. According to Gunn, the mechanic would have noted missing dust skirts if they had been missing at the time of the permissibility inspection. Tr. 268.

On cross-examination, Gunn conceded that the permissibility exams did not specifically require a check on the dust skirts. Tr. 293. Gunn also confirmed that multiple maintenance and production shifts had occurred between the last permissibility exam and the time citations were issued for both Citation Nos. 8503536 and 7656891. Tr. 298-299. However, Gunn stated that a dust skirt check was required as part of the dust parameter exam. Tr. 308. Gunn explained that no official record of dust parameter checks were kept, and that dust parameter exams were only tracked underground on a chalkboard at an underground maintenance shack. Tr. 265. Gunn also stated that while pre-shift and on-shift exams were officially recorded, they did not record issues with dust-skirts. Tr. 311.

Gunn stated that the automatic dust dump was located outby or behind the roofbolt operator in relation to the face of the cut. Tr. 258. Gunn also testified that the Dotiki ventilation system and roof bolter blower fans pulled air away from the roof bolter operator and made it unlikely that operators would be exposed to automatic dump dust. Tr. 273, 275.

Gunn interpreted the Dotiki ventilation plan as allowing WCC until the next maintenance shift to repair/replace damaged *or* missing skirts. Tr. 276-77. Gunn stated that prior to these citations, he had observed MSHA inspectors allow WCC until the next maintenance shift to replace missing skirts. Tr. 278-79.

In their post-hearing brief, WCC argues the Dotiki ventilation plan did not require them to replace missing skirts immediately, but allowed them until the next maintenance shift to replace missing skirts, just as they were allowed until the next maintenance shift to replace damaged skirts. Respondent's Br., 4. WCC points out that the text of the ventilation plan does not state it is necessary to replace missing skirts immediately, and contends that "missing" is commonly defined as a type of damage. Respondent's Br., 5. WCC also argues that given MSHA's past acceptance of repairing missing skirts on the next maintenance shift at the Dotiki mine, and the absence of any prior explicit instructions regarding this provision, this court should decline to give the Secretary's current interpretation any deference. Respondent's Br., 7.

WCC states that MSHA Inspectors Frederick and Rich could not establish when the dust skirts went missing from the roof-bolters. Respondent's Br. 6; Tr. 28-29; Tr. 107-108. WCC further states that no evidence supports an inference that the skirts were missing prior to the last maintenance shift before the citations were issued. Respondent's Br. 6. WCC finally asserts that it would be improper burden shifting for this court to sustain these violations on a finding that WCC did not establish that skirts were attached after the last maintenance shift prior to these citations. Respondent's Br., 6.

3. Relevance of the NIOSH Article

At hearing, the Secretary entered the NIOSH article into evidence in an attempt to demonstrate that automatic dump dust contained a respirable dust component and note a recent increase of respiratory illnesses in other underground bituminous coal mining areas. Prior to hearing and during cross-examination, WCC contested the relevance of the NIOSH study to these proceedings. In summary, WCC argues that the article's findings are not relevant to these proceedings because Dotiki is located in a different geologic region from the article study area.

I find WCC's distinction unconvincing. The NIOSH article was conducted in underground bituminous coal mines, including mines in central Kentucky and Tennessee. Ex. 9, 3. The Dotiki Mine is an underground bituminous coal mine in western Kentucky. Thus, the study examined similar types of roof bolter machines in similar underground bituminous coal mines in areas adjacent to the western Kentucky region. Although it has presented hypothetical examples of possible variations, WCC has not presented any evidence of significant differences between the study area and the Dotiki Mine. Tr. 154-155; 167. Therefore, I find it reasonable to consider the general finding of the NIOSH article, that roofbolter automatic dump dust contains significant amounts of respirable dust, while determining the validity and gravity of these citations.

Furthermore, the connection between respirable dust and respiratory illnesses is far from a novel concept to the Commission. In 1980, a Commission ALJ explained,

Coal workers' pneumoconiosis--black lung disease--affects a high percentage of American coal miners with severe, chronic, and crippling respiratory impairment. The disease, which in its advanced form is inevitably fatal, is caused by long-term inhalation of respirable mine dust, including coal dust...

Black lung disease is an occupational disease that afflicts the lives of thousands of miners and their families. Various studies show that between 10 and 30 percent of all working bituminous coal miners have some form of the disease. Every miner lives under the threat of black lung and thousands die of it every year. ... more than 11 miners each day wheeze away their final breath as a result of black lung.

Kanawa Coal, 2 FMSHRC 1658, 1659 (June 1980) (ALJ Kennedy).

This description of the pervasive effects of black lung throughout the coal industry, particularly among bituminous coal miners, indicates that respiratory illnesses and respirable dust are not anomalous or particularly region specific hazards. While the coal-mining industry has certainly made significant strides in preventing respiratory illnesses in the decades since this ruling, the mechanisms of black lung and silicosis remain unchanged. As such, I have considered the general findings of the NIOSH article in my holdings while taking the alleged variances between the study area and the Dotiki mine into account in terms of the article's weight.

C. Findings

1. Ventilation Plan Interpretation

WCC argued at great lengths that the Dotiki ventilation plan did not explicitly require immediate replacement of missing dust skirts and contended that missing skirts could be replaced on the next maintenance shift following the damage per the plan. The Secretary argued that when read as a whole, the ventilation plan required immediate replacement of missing skirts, as the ventilation plan required automatic dump skirts to be “equipped” with dust skirts. For the reasons stated below, I find that even under its own interpretation of the dust skirt provision, WCC failed to repair the missing skirts in the next maintenance shift following the damage. Therefore, I decline to determine the proper interpretation of the ventilation plan in effect at the time of the citation, as this interpretation is not necessary to my ultimate findings.

2. Citation No. 8503536

MSHA Inspector Frederick credibly testified to the following regarding Citation No. 8503536:

- 1.) The citation was issued at 10:00 AM on Wednesday May 18, 2011. Tr. 15.
- 2.) The citation was issued approximately four hours into a production shift that immediately followed a regularly scheduled midnight maintenance shift. Tr. 20.
- 3.) An automatic dump dust skirt was missing on the #6047 DBT roof-bolter machine. Tr. 16.
- 4.) The roof bolter was parked and not running at the time of the citation. Tr. 15.
- 5.) The unit roof-bolter operators did not know how long the dust skirt had been missing. Tr. 19.
- 6.) The exposed dump column was noticeably dusty where the skirt would normally be. Tr. 57.

WCC has not disputed any of these factual descriptions. WCC has disputed Inspector Frederick’s conclusion that the roofbolter machine had not been operated during the May 18 morning production shift. WCC points out that Frederick could not recall whether or not the bolter was parked at an intersection or was located at an active face. Tr. 45-46. WCC also contends that it was possible for the exposed dust column to have taken on the dusty color during the morning production shift. Tr. 60-61.

WCC personnel testified that weekly permissibility exams, pre-production dust parameter checks, pre-shift exams and on-shift exams were all regularly conducted by WCC personnel in order to identify dust hazards including missing or damaged skirts. Tr. 263. WCC relies upon these inspections to argue that the dust skirt was most likely on the roof-bolter at the beginning of the May 18 morning production shift and somehow fell off before Inspector Rich inspected the roof-bolter. Tr. 28.

However, I find that WCC’s arguments do not effectively rebut the evidence presented by the Secretary. According to WCC personnel, of the four inspection types listed by WCC, only the dust parameter exam included a specific check for dust skirts. Tr. 293, 311. Additionally, WCC personnel stated that they did not keep an official written record of the dust parameter exam. Tr. 265. The permissibility exam entered into evidence by WCC for the #6047 roofbolter

did not indicate a specific check for dust skirts and was conducted several maintenance shifts in advance of this citation. Tr. 298-99. As such, I give the permissibility exam very little weight in determining whether or not the dust skirt was present on the roof-bolter at the beginning of the May 18 morning production shift.

While the Secretary has not produced direct evidence of when the skirt fell off, several undisputed factual descriptions support the Secretary's conclusion that the skirt was not in place at the beginning of the May, 18, 2011 morning production shift. The #6047 roofbolter was parked and not running at the time of the inspection, decreasing the likelihood that the skirt had recently been knocked off during active roof-bolting or tramming activities. Tr. 15. Similarly, the exposed dump column was noticeably dusty, indicating that the skirt had been missing for at least some amount of time. Tr. 57. Given that the roofbolter was parked and not bolting, I find Inspector Frederick's statement that it was unlikely for the column to become dusty in just a few hours to be a reasonable conclusion. Tr. 61.

The statement from the roofbolter operators that they did not know how long the dust skirt had been missing undercuts WCC's contention that dust parameter and pre-shift exams would have ensured that the dust skirt was in place at the beginning of the production shift. If the dust skirt had been on at the beginning of the production shift as required, and the roof bolter operators had conducted a thorough dust parameter exam that morning, the operators would have had some idea of when the dust skirt had fallen off. Instead, when asked by Inspector Frederick how long the skirts had been missing, the operators replied that they didn't know. Tr. 19.

The parked condition of the roof-bolter, the dusty color of the dump column, and the roof-bolter operators' inability to provide a timeframe for when the skirt fell off, all support the Secretary's assertion that the dust skirt was not on the roof bolter at the beginning of the May 18 morning production shift. As the previous shift was a regularly scheduled maintenance shift, I find that the dust skirt likely fell off during a prior production shift and WCC failed to replace the missing skirt during the intervening maintenance shift. I make this finding after determining that the Secretary produced sufficient evidence to establish a prima facie case of a violation and concluding that WCC did not present convincing evidence to the contrary.

In doing so, I am not discounting WCC personnel testimony regarding extensive maintenance and inspection efforts in general. Both Foreman Nall and Gunn testified credibly and competently regarding their efforts to ensure compliance with the dust skirt provision of the ventilation plan. Tr. 209, 263. However, the Mine Act is a strict liability statute and the operator's genuine efforts to comply with the standard do not shield it from liability if the Secretary demonstrates a dust skirt was indeed missing for more than one maintenance shift without being repaired.

As such, I hold that WCC did in fact violate 30 CFR § 75.370 (a)(1) and its ventilation plan in failing to repair a damaged dust skirt in the next maintenance shift following the damage.

I also find that Citation No. 8503536 was an S&S violation of WCC's duties under the Mine Act. As noted earlier, the ventilation plan provision operates as a mandatory safety standard and is enforceable as such. If not replaced, the missing dust skirts would expose

roofbolter operators to an increased amount of respirable dust, a discrete safety hazard. As discussed above, there is a reasonable likelihood that this over-exposure to respirable dust will result in injury as respirable dust has been consistently linked to respiratory illnesses such as black lung and silicosis. Additionally, black lung and silicosis far exceed the definition of an injury of a reasonably serious nature, as they are irreversible illnesses that result in debilitating respiratory complications and even death. For these reasons, I find that the Secretary has shown that this violation meets the four element *Mathies* test for S&S violations.

For the reasons just discussed regarding the likelihood and severity of permanently disabling respiratory illnesses, I find the likelihood of injury as “Reasonably Likely” and the severity of injury to be “Permanently Disabling.” I find that 2 miners were affected by this violation, as Inspector Frederick credibly testified that the missing dust skirts allowed roof bolter dump dust to circulate within several feet of the two operators that manned the automatic roof bolting machine. Tr. 20, 24.

While the testimony at hearing indicates that the skirts had been missing for at least one entire maintenance shift, I also note that WCC personnel credibly testified that the dust skirts were partially enclosed during operations and difficult to replace without opening up the roof bolting booms. Tr. 20, 219. For these reasons, I find that Citation No. 8503536 was the result of “Moderate” negligence on the part of WCC.

After making these findings and reviewing the six penalty criteria set forth in set forth in section 110(i) of the Act, I uphold the Secretary’s originally assessed civil monetary penalty of \$2,473.00 for Citation No. 8503536.

3. Citation No. 7657891

MSHA Inspector Ronnie Rich testified credibly to the following regarding Citation No. 7656891.

1. The citation was issued at 3:35 AM on Monday June 6, 2011. Tr. 78.
2. The citation was issued approximately six hours into a regularly scheduled midnight (3rd shift) maintenance shift. Tr. 78.
3. The last production shift before this maintenance shift had occurred on Friday evening (2nd shift) June 3, 2011. Tr. 76.
4. WCC management had worked several maintenance shifts over the June 4-5 weekend. Tr. 76-77.
5. Both the operator and the opposite operator side automatic dump dust skirts were missing on the #6043 DBT roofbolter. Tr. 78-79.
6. A unit mechanic in the area informed Inspector Rich that replacing the missing skirts was “Not on my list.” Tr. 82.

WCC has not disputed any of these factual descriptions. WCC has argued that the maintenance shifts that occurred during the weekend of June 4-5 were not regularly scheduled maintenance shifts. Tr. 97-98. WCC also contended on cross-examination that the Dotiki

ventilation plan allowed WCC the entire next maintenance shift after a production shift to repair damaged/missing skirts. Tr. 112.

WCC's reliance on these arguments is misplaced. The ventilation plan requires WCC to replace damaged skirts on the "next maintenance shift" and makes no reference or allusion to so called "regularly scheduled" maintenance shifts discussed by WCC during hearing. Inspector Rich credibly testified that WCC management informed him they had worked every available mechanic over several shifts on the weekend of June 4-5. Tr. 76-77. As such, I find that WCC had worked at least one full maintenance shift after the Friday June 3rd evening production shift before the Sunday/Monday midnight maintenance shift in question even started. Thus, the evidence presented by the Secretary indicates that WCC failed to replace missing dust skirts during the next maintenance shift following a production shift as required by their ventilation plan.

Furthermore, while it is not critical to my ultimate holding, I do not fully accept WCC's contention that MSHA could not cite WCC for failure to replace a missing dust skirt until the entire maintenance shift has elapsed and a new production shift had begun. I do agree with WCC that it would be unreasonable for MSHA to cite WCC for failure to replace a damaged skirt if only a small amount of the maintenance shift had passed and WCC demonstrated a specific plan to replace that missing skirt. However, this is not the set of circumstances I have before me in this citation.

In this case, nearly six hours of the eight hour Sunday/ Monday midnight maintenance shift had elapsed and the WCC mechanic in the area indicated he had no plans of replacing the missing skirts when he informed Inspector Rich that replacing the skirt was "Not on my list." Tr. 78, 82. As the ventilation plan allowed WCC to work up to two production shifts before repairing damaged/ missing skirts on the next maintenance shift following damage, MSHA Inspector Rich was right to evaluate the likelihood of WCC replacing the missing skirts during the maintenance shift based upon his interaction with the WCC mechanic.

As discussed for Citation No. 8503536, I am not discounting Shift Foreman Nall's and Safety Director Gunn's credible testimony regarding WCC maintenance and inspection procedures as without merit. However, the only documented inspection presented to this court regarding the # 6043 roofbolter was a permissibility exam conducted on Thursday June 2, 2011 four days prior to the inspection leading to issuance of the citation. Tr. 267; Ex. C, 1.

Even if I take this permissibility inspection as conclusive evidence that the automatic dust dumps were equipped with dust skirts on this date despite the fact the permissibility exam does not specifically require a check on the dust skirts, the obvious fact remains that dust skirts were not on the #6043 roofbolter on the early morning of the Sunday/ Morning midnight maintenance shift. As such, the dust skirts must have fallen off during the Friday production shifts, remained off through the maintenance shifts worked during June 4-5, and continued to remain off the roofbolter for six hours of the Sunday/Monday midnight maintenance shift without being noted on the unit repair list or being brought to the attention of the mechanic in the area. For these reasons, I find that a full maintenance shift had passed since the last production shift and WCC

had still not, at the time of the inspection, identified the missing skirts as a hazard requiring repair.

As such, I hold that WCC did in fact violate 30 CFR § 75.370 (a)(1) and its ventilation plan in failing to repair a damaged dust skirt in the next maintenance shift following the damage.

I also find that Citation No. 7656891 was an S&S violation of WCC's duties under the Mine Act. As noted earlier, the ventilation plan provision operates as a mandatory safety standard and is enforceable as such. If not replaced, the missing dust skirts would expose roof-bolter operators to an increased amount of respirable dust, a discrete safety hazard. As discussed above, there is a reasonable likelihood that this over-exposure to respirable dust will result in injury as respirable dust has been consistently linked to respiratory illnesses such as black lung and silicosis. Additionally, black lung and silicosis far exceed the definition of an injury of a reasonably serious nature, as they are irreversible illnesses that result in debilitating respiratory complications and even death. For these reasons, I find that the Secretary has shown that this violation meets the four element *Mathies* test for S&S violations.

For the reasons just discussed regarding the likelihood and severity of permanently disabling respiratory illnesses, I find the likelihood of injury as "Reasonably Likely" and the severity of injury to be "Permanently Disabling." I find that 2 miners were affected by this violation, as Inspector Rich credibly testified that the missing dump skirt allowed respirable dust to circulate across the two roof bolt operators. Tr. 88- 89.

While the testimony at hearing indicates that the skirts had been missing for at least one entire maintenance shift, I also note that WCC personnel credibly testified that the dust skirts were partially enclosed during operations and difficult to replace without opening up the roof bolting booms. Tr. 76-77, 219. For these reasons, I find that Citation No. 7656891 was the result of "Moderate" negligence on the part of WCC.

After making these findings and reviewing the six penalty criteria set forth in set forth in section 110(i) of the Act, I uphold the Secretary's originally assessed civil monetary penalty of \$2,473.00 for Citation No. 7656891.

IV. CITATION No. 7656922

On June 7, 2011, MSHA Inspector Michael Dillingham issued Citation No. 7676922 to WCC for a violation of 30 CFR § 75.1725(a), alleging in part that:

The Bucyrus America Inc. Roof Bolter, CO # 6050, located on # 3 Unit, 030-) MMU was not being maintained in a safe operating condition in that oil had been allowed to accumulate in the operators control deck. When measured it was 32 inches in length, 24 inches width and ranged from 0-.25 inches in depth...

Ex. 6, 1.

Inspector Dillingham found that an injury was reasonably likely to occur and would result in lost workdays or restricted duty, that the violation was S&S, that 2 persons would be affected, and that the violation was the result of moderate negligence on the part of the operator. Ex 6, 1.

On the same day Inspector Dillingham issued Citation No. 7677922, he also issued Citation No. 8503660, not directly at issue in this docket, alleging that the pooled oil on the operator deck of roofbolter CO # 6050 violated 30 CFR § 75.400 and presented a hazardous accumulation of combustible materials. Tr. 177. WCC has subsequently accepted and paid Citation No. 8503660 in full. Resp. Br, 9.

A. Statement of Law

1. The Regulations

30 CFR § 75.1725 (a) requires that:

Mobile and stationary machinery and equipment shall be maintained in safe operating condition and machinery or equipment in unsafe condition shall be removed from service immediately.

30 CFR § 75.1725 (a).

In relevant part, 30 C.F.R. § 75.400 requires that :

... combustible materials, shall be cleaned up and not be permitted to accumulate in active workings, or on diesel-powered and electric equipment therein.

30 C.F.R. § 75.400.

2. Interpretation

The Commission has provided the following guidelines for evaluating an alleged violation of 30 CFR § 75.1725:

Under section 75.1725(a), in deciding whether machinery or equipment is in an unsafe operating condition, the alleged violative condition is measured against the standard of whether a reasonably prudent person ...would recognize a hazard warranting corrective action...

Alabama By-Products Corp., 4 FMSHRC 2128, 2129 (Dec. 1982).

3. Duplication

The Commission has ruled that the Secretary may properly assess multiple citations for a single condition so long as the regulatory standards cited in each violation impose separate and distinct duties upon the operator. *Cyprus Tonopah Mining Corp.*, 15 FMSHRC 367, 378 (March 1993); *Western Fuels-Utah, Inc.*, 19 FMSHRC 994, 1003-05 (Rev. Comm. June 1997).

However, the Commission has vacated citations issued upon the same factual basis under different standards when the Secretary failed to show that the cited condition violated multiple duties. *Western Fuels Utah Inc.*, 19 FMSHRC 1005.

4. Significant and Substantial

A violation is S&S “if based upon the particular facts surrounding the violation there exists a reasonable likelihood that the hazard contributed to will result in an injury or illness of a reasonably serious nature.” *Cement Division, National Gypsum Co.*, 3 FMSHRC 822, 825 (Apr. 1981).

In order to uphold a citation as S&S, the Commission has held that 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).

B. Testimony and Party Arguments

1. The Secretary

At hearing, Inspector Dillingham testified that the Bucyrus roof bolter had significant oil leaks that caused oil accumulations to build up on the roof bolting machine, the operator’s control deck, and the operator himself. Tr. 179-180. Dillingham stated that the oil accumulation on the control deck and operator’s gloves could cause the operator to slip off the controls. Tr. 181. Dillingham acknowledged that he had never heard of an operator losing control of a roof bolter due to oil accumulations, and that a “deadman pedal” had to be pressed for three seconds before the operator could begin to tram the roofbolter. Tr. 200-201.

Dillingham also testified that the oil accumulations made it likely that operators entering and exiting the control deck could possibly slip, bump their elbows and head, or get cuts and bruises. Tr. 185. Dillingham testified that he had never actually heard of an injury resulting from a trip and fall from accumulated oil on a roof bolter control deck. Tr. 200. Dillingham stated that he issued two separate citations after observing the oil accumulation because the pooled oil was both a fire hazard and a slip hazard. Tr. 178, 180.

The Secretary argued in his post-hearing brief that Citation No. 7656922 is not duplicative of Citation No. 8503660 that WCC has already accepted and paid in full. Sec’y Br.,

9. The Sec'y notes that 30 CFR § 75.1725(a) requires operators to maintain equipment in safe operating order while 30 CFR § 75.400 requires operators to prevent fire risks through controlling accumulations of combustible materials. Sec'y Br., 9-10. The Secretary states that a broken tie rod will violate 75.1725(a) but not 75.400, while an accumulation of oily rags will violate 75.400 but not 75.1725. Sec'y Br., 10. The Secretary also restated Inspector Dillingham's concerns of the oil accumulations creating a slip hazard or causing an error in equipment operation. Sec'y Br., 8.

2. WCC

WCC Shift Foreman Nall and Safety Director Gunn testified for WCC on the operation of the Bucyrus roofbolter machine. Tr. 220, 279. Nall stated that the operator deck was shielded by a canopy and operators swung themselves into the cab at a 45 degree angle from a handle mounted on the canopy. Tr. 223. Gunn described the canopy handle as located three and a half feet above the mine floor while the operator's seat was just three inches above the mine floor. Tr. 281, 283. Both Nall and Gunn testified that the "deadman" pedal on the control deck had to be depressed for a full three seconds before the operator could move or "tram" the roof bolter with a separate joystick control. Tr. 225, 280.

Gunn testified that the low height of the canopy deck, the available handle, and small confines of the operator deck made it unlikely for an operator to injure himself if he were to slip on accumulated oil on the operator deck. Tr. 282-283. Gunn also stated that the deadman switch made it improbable that a slip would lead to an error in roofbolter operation. Tr. 282. Gunn testified that he had never heard of oil accumulations on a roofbolter causing either a slip and fall injury or loss of control over the roofbolter. Tr. 281, 283.

In their post-hearing brief, WCC states that Citation Nos. 8503660 and 7656922 were issued at the same time, on the basis of the same pool of accumulated oil, on the same roof bolter. Respondent's Br., 8-9. WCC describes 30 CFR § 1725(a) as a "general" regulation that cannot be used as the basis for a citation based on the same factual circumstances as a citation based on a "specific" standard. *Western Fuels Utah Inc.*, 19 FMSHRC at 1004 n. 12. WCC argues that the mine's duty with respect to the roofbolter was simply to keep it free from the accumulation of oil. Respondent's Br., 9. WCC further states that separate and distinct duties were not present in these two citations and as such Citation No. 7656922 should be vacated as duplicative.

WCC also argues that even if the oil accumulation constitutes a violation of 30 CFR § 1725(a), the Secretary has not established the necessary elements to sustain an S&S designation. Respondent's Br., 9. WCC states that the configuration of the operator deck and dead man pedal control make it clear that the oil accumulation was highly unlikely to lead to either a slip and fall injury or a potential loss of roof bolter control. Respondent's Br., 10. As such, WCC argues that the Secretary has failed to demonstrate a reasonable likelihood that the hazard contributed to by the violation will result in injury. Respondent's Br., 9. From this contention, WCC argues that Citation No. 7656922 should be modified to non-S&S. Respondent's Br. 10.

3. Findings

Inspector Dillingham testified credibly that the Bucyrus roof bolter had an oil leak that caused oil accumulations to build up on the operator deck and upon the roof bolter operator himself. Tr. 179-80. Dillingham recorded the oil accumulation on the operator deck as measuring 32 inches long, 24 inches wide and a ¼" deep. WCC has not contested these basic factual descriptions and in fact concedes that the oil accumulation constitutes a violation of a mandatory standard. Respondent's Br., 9.

Therefore, I initially find that a prudent miner would have recognized extensive oil accumulations as a potential slip hazard and I hold that the Sec'y has established that the oil accumulation constituted a violation of 30 CFR § 75.1725(a).

However, WCC argues that the Secretary has sought to impose improper duplicative penalties by citing WCC twice for the same condition. *Id.*

WCC is incorrect. Citation Nos. 8503660 and 7656922 were indeed both based on the same oil accumulation on the Bucyrus roofbolter. Tr. 195. However, Inspector Dillingham issued the two citations under two separate standards that regulate entirely different hazards. Tr. 178, 180. 30 CFR § 75.400 prohibits accumulation of combustible materials in an effort to prevent fires and explosions. 30 CFR § 75.1725(a) broadly mandates the "safe operating condition" of equipment, seeking to prevent miners from suffering direct injuries from malfunctioning or improperly maintained equipment.

As such, WCC's reliance on *Western Fuels* is misguided. Respondent's Br. 8. In *Western Fuels*, the Commission vacated one of two citations when the Sec'y sought to impose penalties on an operator for both 1) failing to provide an adequate number of reservoirs on a dry chemical fire suppression system and, 2) failing to install a dry chemical powder fire suppression system to protect each belt drive. *Western Fuels-Utah, Inc.*, 19 FMSHRC 994, 1004. Both of these two standards clearly and exclusively regulated potential fire hazards and were based on the identical lack of proper reservoirs. Therefore, the Secretary in *Western Fuels* failed to meet the Commission's requirement that citations based on the same factual circumstances impose separate duties upon the operator. *Cyprus Tonopah Mining Corp.*, 15 FMSHRC 378.

However, as discussed above, the testimony presented at hearing reveals that Citation No. 7656922 is not analogous to *Western Fuels* as WCC claims. The cited standards in this case imposed separate duties upon WCC to both prevent fire hazards and maintain equipment in a safe condition for miners to access and operate. As the Commission has previously held, the fact that the oil accumulation violated both of these distinct duties does not excuse it of liability from either. *Cyprus Tonopah Mining Corp.*, 15 FMSHRC 378.

As such, I hold that Citation No. 7656922 is not duplicative of Citation No. 8503660 and proceed to determining the gravity of the citation. Inspector Dillingham testified that he believed the oil accumulations on the operator deck and on the operator's gloves could cause an operator

to lose control of the machine during operation, or slip and fall while entering the operator's deck. Tr. 181, 185.

MSHA Inspector Dillingham, Foreman Nall, and Safety Director Gunn all testified that it was impossible to tram the roof bolter without first depressing the deadman pedal for three seconds. Tr. 200-01, 220, 279. All three of these witnesses similarly testified that they had never heard of an operator losing control of a roofbolter due to oil accumulations. Tr. 200, 226, 283. For these reasons, I hold that it was highly unlikely for an operator to lose control of the roofbolter due to oil accumulations and thus decline to consider struck by or caught between injuries as a component of this citation.

Still, Inspector Dillingham did present credible testimony that the entire floor of the operator deck was coated with a 1/4" deep layer of hydraulic oil. Thus, I find that the slick nature of hydraulic oil could cause the operator to lose his footing as he entered or exited the operator deck. Nonetheless, Foreman Nall and Safety Director Gunn testified earnestly that even if the operator slipped momentarily, the canopy handle, small dimensions of the operator deck compartment and low height of the operator seat all greatly decreased the likelihood of any resulting injury. Tr. 223, 282-83. In fact, Dillingham himself testified that he had never heard of an operator suffering an injury from a slip and fall within the operator's deck. Tr. 200.

Thus, due to the configuration of the cab and absence of any history of injuries resulting from similar conditions, I hold that the violation was not reasonably likely to contribute to an injury. For these reasons, I hold that gravity designations of Citation No. 7656922 should be modified to "Unlikely" for chance of injury, to "No Lost Workdays" for type of injury, and to Non-S&S.

However, I do find that the oil leak was an obvious condition, as it coated the entire operator deck and the operator himself. Tr. 179-80. As such, I find that the violation was the result of "Moderate" negligence on the part of WCC. Additionally, as the oil leak was spraying oil across a large portion of the roof bolter, the operator deck and one of the operator's clothing and shoes, I find that two miners were affected by this violation as both roof bolt operators working on this machine had to work on the oil coated roof bolting machine. Tr. 188.

Therefore, after reviewing the six penalty criteria set forth in section 110(i) of the Act, I reduce the civil monetary penalty for Citation No. 7657922 to \$250.00.

V. SETTLEMENT

The Secretary has filed a motion to approve settlement of 31 of the violation involved in this matter. I acknowledge and accept the explanation for the agreed upon settlement contained in the parties' settlement motion and amendments. The originally assessed amount for these 31 citations was **\$65,265.00** and the proposed partial docket settlement is for **\$44,500.00**. The parties have moved to approve the proposed settlement as follows:

Citation No.	Originally Proposed Assessment	Settlement Amount	Modification
KENT 2012-438 (Partial)			
8504120	\$540.00	\$540.00	
7656897	\$1,304.00	\$1,304.00	
7657047	\$585.00	\$585.00	
7657049	\$634.00	\$634.00	
7657050	\$585.00	\$585.00	
7657051	\$585.00	\$585.00	
7657053	\$207.00	\$207.00	
7657055	\$3,405.00	\$3,405.00	
8499894	\$392.00	\$392.00	
7657125	\$807.00	\$807.00	
7657127	\$5,503.00	\$2,500.00	Reduce Monetary Penalty
7657128	\$1,657.00	\$1,657.00	
7657282	\$2,901.00	\$2,901.00	
8502593	\$1,530.00	\$1,530.00	
8502594	\$5,503.00	\$1,857.00	Reduce Monetary Penalty
8502595	\$4,689.00	\$1,819.00	Reduce Monetary Penalty
7657184	\$1,795.00	\$1,795.00	
7657185	\$1,795.00	\$1,795.00	
8502599	\$1,304.00	\$1,304.00	
8502458	\$3,143.00	\$3,143.00	
8502602	\$2,106.00	\$2,106.00	
8502603	\$745.00	\$745.00	
8498982	\$1,412.00	\$1,412.00	
8499873	\$3,996.00	\$2,900.00	Reduce Number of Miners Affected from "10" to "8"
7657060	\$3,996.00	\$1,795.00	Reduce Likelihood of Injury from "Reasonably Likely" to "Unlikely" Remove "Significant and Substantial" Designation
7657131	\$3,143.00	\$1,412.00	Reduce Likelihood of Injury from "Reasonably Likely" to "Unlikely" Remove "Significant and Substantial" Designation
8499896	\$3,143.00	\$1,412.00	Reduce Likelihood of Injury from "Reasonably Likely" to "Unlikely" Remove "Significant and Substantial" Designation
7656997	\$1,530.00	\$687.00	Reduce Likelihood of Injury from "Reasonably Likely" to "Unlikely"

			Remove "Significant and Substantial" Designation
8502596	\$1,111.00	\$499.00	Reduce Likelihood of Injury from "Reasonably Likely" to "Unlikely"
			Remove "Significant and Substantial" Designation
7657008	\$1,530.00	\$687.00	Reduce Likelihood of Injury from "Reasonably Likely" to "Unlikely"
			Remove "Significant and Substantial" Designation
8502600	\$3,689.00	\$1,500.00	Reduce Likelihood of Injury from "Reasonably Likely" to "Unlikely"
			Remove "Significant and Substantial" Designation
SubTotal	\$65,265.00	\$44,500.00	

V. ORDER

For the three citations contested at hearing, I rule as follows.

It is **ORDERED** that Citation No. 8503536 is **UPHELD** as written and assessed with a monetary penalty of \$2,473.00.

It is **ORDERED** that Citation No. 7656891 is **UPHELD** as written and assessed with a monetary penalty of \$2,473.00.

It is **ORDERED** that Citation No. 7656922 is **MODIFIED** to "Unlikely," "No Injury," "Non-S&S" and assigned a reduced monetary penalty of \$250.00.

Additionally, I have considered the submitted settlement documents and I conclude that the proposed settlement is appropriate under the criteria set forth in section 110 (i) of the Act. The motion to approve settlement is **GRANTED** and the citations contained in this agreement are **MODIFIED** as set forth above for a partial settlement total of \$44,500.00.

Therefore, Webster County Coal, LLC is **ORDERED** to pay the Secretary of Labor a total sum of **\$49,696.00** within 30 days of this order.²

/s/ David P. Simonton
David P. Simonton
Administrative Law Judge

² Payment should be sent to: MINE SAFETY AND HEALTH ADMINISTRATION, U.S. DEPARTMENT OF LABOR, PAYMENT OFFICE, P. O. BOX 790390, ST. LOUIS, MO 63179-0390

Distribution: (First Class U.S. Mail)

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FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

721 19TH STREET, SUITE 443
DENVER, CO 80202-2500
303-844-5267/FAX 303-844-5268

February 13, 2014

SECRETARY OF LABOR	:	CIVIL PENALTY PROCEEDING
MINE SAFETY AND HEALTH	:	
ADMINISTRATION, (MSHA),	:	Docket No. WEST 2013-766-M
Petitioner,	:	A.C. No. 02-00024-317732
	:	
v.	:	
	:	
FREEPORT-MCMORAN MORENCI,	:	Mine: Freeport-McMoRan Morenci, Inc.
INC.,	:	
Respondent.	:	

DECISION

Appearances: Robert D. Ankeney, CLR, MSHA, U.S. Department of Labor, Denver, Colorado and Luis Garcia, Office of the Solicitor, U.S. Department of Labor, Los Angeles, California for Petitioner;

Brian Lamana, Sr. Safety Specialist, Freeport-McMoRan Morenci, Inc., Morenci, Arizona for Respondent.

Before: Judge Miller

This case is before me on a petition for assessment of civil penalty filed by the Secretary of Labor, Mine Safety and Health Administration ("MSHA") against Freeport-McMoRan Morenci, Inc., pursuant to sections 105 and 110 of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. §§ 815 and 820. This docket involves two citations, with penalties assessed pursuant to section 110(i) of the Mine Act, which are in dispute. The parties presented testimony and evidence at a hearing held on January 22, 2014 in Phoenix, AZ.

The parties agree that Freeport-McMoRan Morenci, Inc., is an operator as defined by the Act, and is subject to the jurisdiction and provisions of the Mine Safety and Health Act. A stipulation has been reached regarding Citation No. 8755004, leaving Citation No. 8596482 for decision.

I. FINDINGS OF FACT AND CONCLUSIONS OF LAW

Inspector Ernesto Vasquez issued Citation No. 8596482 on January 11, 2013. The Secretary asserts that the Respondent violated 30 C.F.R. §56.11002, which requires stairways to

be of substantial construction and maintained in good condition. The citation states, in pertinent part, as follows:

The stairway located at the P-5 conveyor, adjacent to the drive motors, was found not being maintained in good condition. The eighth step, (from top to bottom), was found to be showing damage, in that the outside edge was bent downward approximately three quarters of an inch for approximately twenty five inches alongside the outer edge of the step.

Inspector Vasquez indicated that the violation was significant and substantial and the negligence was moderate. The proposed assessed penalty amount is \$1,111.00.

The mine does not dispute that the step was in the condition described by the inspector, and agrees that the violation occurred as cited. The parties agree that the stairway was of substantial construction, was provided with handrails, and that the step at issue was the eighth step from the top. Moreover, they agree that, for approximately twenty-five inches along the outside edge of the step, it was bent downward approximately $\frac{3}{4}$ of an inch. The condition is shown in Sec'y Ex. 2. The area is used as a passageway and is accessible 24 hours a day, seven days a week. The stairs were free of mud and other slippery conditions at the time the citation was issued. Hence, I find that violation of the cited standard existed.

While the Respondent does not dispute the fact of violation, it does dispute that the condition is significant and substantial. A "significant and substantial" violation is described in section 104(d)(1) of the Mine 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." 30 U.S.C. § 814(d)(1). A violation is properly designated significant and substantial "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 Division, National Gypsum Co.*, 3 FMSHRC 822, 825 (Apr. 1981).

In *Mathies Coal Co.*, 6 FMSHRC 1, 3-4 (Jan. 1984), the Commission explained its interpretation of the term "significant and substantial" to be:

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.

The difficulty with finding a violation S&S normally comes with the third element of the *Mathies* formula, in which the Secretary must establish that there is a reasonable likelihood that

the hazard will result in an injury. The Commission has explained that the third element of the 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 (Aug. 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 1573, 1574 (July 1984). In addition, the question of whether a particular violation is S&S is a circumstantial inquiry that must be based on the particular facts surrounding the violation. *Texasgulf, Inc.*, 10 FMSHRC 498 (Apr. 1988); *Youghiogeny & Ohio Coal Co.*, 9 FMSHRC 2007 (Dec. 1987).

Mine Inspector Ernesto Vasquez had been an inspector for two years and, prior to that time, he worked in the mining industry for 15 years. Vasquez explained that Morenci is a large copper mine that he has inspected a number of times. Morenci is a surface, open pit mine with approximately 2,500 employees. Vasquez was at the mine with a number of other inspectors on January 11, 2013 when he issued this citation for the bent step that he observed. Vasquez went up the steps with a safety representative from the mine and, when he returned down the steps, he stepped on the bent step and felt himself lose his balance. He grabbed the handrail and did not fall, but testified that he lurched forward and that the step made a significant difference in his ability to safely move down the steps. He did not notice the bent step when he first traveled up the stairway. However, on his return trip down, he lost his balance and subsequently turned turned to look at the step, took photographs, Sec’y Ex. 2 pp. 1-5, and took measurements. Vasquez explained to the representatives from the mine that the step was a problem and that he would issue a citation. He did not know how long the step had been bent, but he surmised that something very heavy had to have been dropped on the step to bend it in such a fashion.

As illustrated by the photograph in Sec’y, Ex. 2, pp. 1-5, the step is made of a heavy wire mesh and is 36 inches wide. The middle 23- inch portion of the step was bent down and was uneven. Each step is eight inches apart from the step above and below it. If a miner were aware that the step was uneven in the middle, that portion of the step could be avoided by stepping along the side. However, as Vasquez explained, a miner would have to remember that it was bent each time he went down in order to avoid the damaged part. The miner would also be required to hold the handrail in order to avoid tripping on the step. Vasquez observed a number of miners, often carrying tools or equipment, walking up and down steps without holding on to the rail.

The step that was damaged was about three-quarters of the way up the set of stairs, and a slip and fall would result in a tumble ten feet to the bottom of the steps. Anyone who fell would fall into those walking down ahead, which in turn would cause the others to fall some distance. A miner using this set of stairs expects the step to be flat and even. Vasquez opined that if you step down, and are not prepared to step on a damaged step, it is easy to fall. The inspector does not know how long the condition existed but the step was not closed off or barricaded and it was available for use. Given that the stairs are used every shift to access the conveyor and drive motors, miners carry tools up and down, do not always use the handrail, and cannot avoid the damaged step unless fully concentrating on walking to the side, Vasquez believed that the condition would inevitably lead to an accident resulting in a serious injury.

Sullivan Heber, a member of the Morenci safety department, accompanied Vasquez when he observed the step. Heber did not believe it was likely that someone would fall as a result of the damaged step. Instead, he explained that there are other ways to access the work platform, even though he agreed that these stairs are used on a regular basis for maintenance. Heber said that the inspector paused, but did not fall, and then continued down the stairs before turning to look at the step. Heber had not noticed the damaged step prior to the time the inspector paused on his way down, and he had no idea how or when the step was damaged. Heber explained that there is a light above the stairway, a handrail, and only the middle portion of the step was damaged, leaving the edges for someone to safely step around. He believed that the stairs and handrail were in sound condition, there were no obstructions or work being done on the steps, and he did not feel unsafe in using the steps.

Based on Heber's testimony, the arguments made at hearing, and the documents submitted after hearing, the mine argues that this violation is not S&S for several reasons. First, there is a handrail that would prevent a fall and, second, the $\frac{3}{4}$ inch bend did not affect the safety of the entire step and, rather, there were several inches on each side of the step to use safely. The mine also points out that the bend in the step was not significant, there are several access routes to the conveyor, the remaining steps were in good condition, the inspector did not fall, it is unlikely that ice or debris would build up on the step because it is of grate construction, there is ample light, few tools are carried each day, and the defect was likely in place for only a short period of time since there were no signs of rust.¹ There is no question that the stair was substantially constructed, and that the handrails were in place and in good condition. Further, there were no other obstructions on the steps. However, the many factors listed by the mine are not enough to take away from the gravity of the violation. Additionally, the allegedly mitigating conditions noted by the company are required in many instances by other MSHA standards.

The Commission has determined that an experienced MSHA inspector's opinion that a violation is significant and substantial is entitled to substantial weight. *Harland Cumberland Coal Co.*, 20 FMSHRC 1275, 1278-79 (Dec. 1998); *Buck Creek Coal Inc. v. MSHA*, 52 F.3d 133, 135 (7th Cir. 1999). Vasquez reaffirmed that environmental conditions, along with complacency in not using the handrail, as well as the expectation by miners that the step would be flat and even, lead him to believe that it is likely that an accident will occur. He lurched forward when he stepped down and, although he did not fall, it is reasonably likely that someone would. The step is six feet above the ground, but the distance down the steps is about ten feet, and a fall from ten feet would result in broken bones, cuts, or even trauma to the head or back. The resulting injury was reasonably likely to result in an injury that would be permanently disabling.

Other Commission judges have found that a bent stair was a significant and substantial violation. In *Lakeview Rock Products*, 19 FMSHRC 321 (Feb. 1997) (ALJ), the judge found that the company committed an S&S violation for failing to maintain two sets of stairs leading down

¹ A number of these issues were not addressed by the testimony of the witness and, therefore, are technically not in evidence. However, because the operator appeared pro se, I have considered all arguments raised in making my decision.

to a cone crusher and screen plant. The judge found that, given the bent condition of the steps, it was reasonably likely that a worker would fall. The Courts and the Commission have addressed the matter of other safety precautions, similar to those raised here by the mine, and found that, even though “after-the-fact safety systems” were in place, the existence of other safety measures to deal with the violation does not mean the violation is not a serious safety hazard. *Buck Creek Coal, Inc.*, 52 F.3d 133, 136 (7th cir. 1995); *See Black Beauty Coal Co. v. Federal Mine Safety and Health Review Com’n*, 703 F.3d 553 (D.C. Cir. 2012), affirming *Black Beauty Coal Co.*, 33 FMSHRC 1482 (June 2011) (ALJ). The Commission, likewise, determined that a violation was S&S in spite of the operator’s arguments that the violation was not S&S because of the presence of other safety devices. *AMAX Coal Co.*, 19 FMSHRC 846 (May 1997).

I credit Inspector’s Vasquez’ description of the defects and associated hazards. While there were no adverse conditions on the day Vasquez was at the mine, anything from an untied shoe to simple inattention, combined with the bent and uneven stair, would easily result in a fall of ten feet down the stairs. I find that there is a violation and that the condition cited, the bent and damaged stair, would cause someone to stumble and fall as they descend the stairs. The stairs are used daily, and there is no indication that the mine had a plan to repair the stair, leading me to believe that it would have remained in that bent condition for some time. Falling the ten feet down the stairs would result in a broken bone, or a head or back injury, which are very serious injuries. Therefore, I find that the violation is significant and substantial.

II. PENALTY

The parties have agreed to settle Citation No. 8755004 by reducing the gravity to non-S&S and the penalty amount from \$1,657.00 to \$249.00. At hearing the parties agreed that the Respondent would have presented evidence that the back brace on the ladder was bent, but it was otherwise in good condition and used only in the shop. Therefore, it is not likely that a miner would be hurt using the ladder and, as a result, the parties agree to amend the citation to remove the “Significant and Substantial” designation, to modify the gravity of injury from “Reasonably Likely” to “Unlikely,” and reduce the proposed penalty from \$1,657.00 to \$249.00. I accept the stipulations of the parties and assess a penalty of \$249.00.

The principles governing the authority of Commission administrative law judges to assess civil penalties de novo for violations of the Mine Act are well established. Section 110(i) of the Mine act delegates to the Commission and its judges “authority to assess all civil penalties provided in [the] Act.” 30 U.S.C. § 820(i). The Act delegates the duty of proposing penalties to the Secretary. 30 U.S.C. §§ 815(a), 820(a). Thus when an operator notifies the Secretary that it intends to challenge a penalty, the Secretary petitions the Commission to assess the penalty. 29 C.F.R. § 2700.28. The Act requires, that “in assessing civil monetary penalties, the Commission [ALJ] shall consider” six statutory penalty criteria which include the history of violations, the size of the operator, the negligence, gravity, the ability to continue in business and good faith abatement. 30 U.S.C. § 820(i). In keeping with this statutory requirement, the Commission has held that “findings of fact on the statutory penalty criteria must be made” by its judges. *Sellersburg Stone Co.*, 5 FMSHRC 287, 292 (Mar. 1983), *aff’d*, 736 F.2d 1147 (7th Cir. 1984). Once findings on the statutory criteria have been made, a judge’s penalty assessment for a particular violation is an exercise of discretion, which is “bounded by proper consideration of the

statutory criteria and the deterrent purpose[s] . . . [of] the Act. *Id.* at 294; *Cantera Green*, 22 FMSHRC 616, 620 (May 2000).

In the instance case, for Citation No. 8596482, the operator is large, has no unusual history of these types of violations, and abated the condition in good faith. The inspector indicated that the negligence was moderate and, given the facts as discussed above, I agree. I have discussed the gravity and S&S nature above and find that the \$1,111.00 penalty proposed by the Secretary is appropriate in these circumstances.

Given my above findings, I assess a total penalty of \$1,360.00 for both the stipulated citation and citation addressed at hearing. Freeport-McMoRan Morenci Inc. is hereby **ORDERED** to pay the Secretary of Labor the sum of \$1,360.00 within 30 days of the date of this decision.

/s/ Margaret A. Miller
Margaret A. Miller
Administrative Law Judge

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FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

OFFICE OF ADMINISTRATIVE LAW JUDGES
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February 18, 2014

SECRETARY OF LABOR,	:	CIVIL PENALTY PROCEEDING
MINE SAFETY AND HEALTH	:	
ADMINISTRATION (MSHA),	:	Docket No. CENT 2013-332-M
Petitioner	:	A.C. No. 23-00141-315058
	:	
v.	:	
	:	
MARTIN MARIETTA MATERIALS,	:	Mine: Greenwood Quarry
INC.,	:	
Respondent	:	

ORDER DENYING SECRETARY'S MOTION FOR SUMMARY DECISION

Before: Judge Rae

This docket is before me on a petition for assessment of penalty filed by the Secretary pursuant to Section 105(d) of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 815 et seq. (2000) (the "Act"). On January 8, 2014, I granted the Secretary's motion to plead in the alternative alleging a violation of 30 C.F.R. §56.14100(b) as originally cited by the Mine Safety and Health Administration ("MSHA") inspector as well as a violation of 30 C.F.R. §56.14100(c) in the alternative. This single citation docket arises from an inspection conducted by Rickie Knupp on October 23, 2012 at the Greenwood surface limestone quarry operated by Martin Marietta Materials, Inc. ("Martin Marietta") in Greenwood, Missouri. The facts surrounding the alleged violation as set forth below are uncontested by the parties and on January 31, 2014 the Secretary filed a Motion for Summary Decision in accordance with Section 2700.67 of the Federal Mine Safety and Health Review Commission's Procedural Rules, 30 C.F.R. § 27.00.67 which the Respondent has opposed. For the reasons set forth herein, I DENY the Secretary's Motion and VACATE the sole citation.

Summary Decision Standards

Commission Rule 67 sets forth the guidelines for granting summary decision:

(b) A motion for summary decision shall be granted only if the entire record, including the pleadings, depositions, answers to interrogatories, admissions, and affidavits shows:

(1) That there is no genuine issue as to any material fact; and

(2) That the moving party is entitled to summary decision as a matter of law.

29 C.F.R. §2700.67(b).

The Commission “has long recognized that [] ‘summary decision is an extraordinary procedure,’ and has analogized it to Rule 56 of the Federal Rules of Civil Procedure, under which the Supreme Court has indicated that summary judgment is authorized only ‘upon proper showings of the lack of a genuine, triable issue of material fact.’” *Hanson Aggregates New York, Inc.*, 29 FMSHRC 4, 9 (Jan. 2007) (quoting *Energy West Mining Co.*, 16 FMSHRC 1414, 1419 (July 1994)). In reviewing the record on summary judgment, the court must evaluate the evidence in “the light most favorable to...the party opposing the motion.” *Hanson Aggregates* at 9 (quoting *Poller v. Columbia Broad. Sys.*, 368 U.S. 464, 473 (1962)). Any inferences “drawn from the underlying facts contained in [the] materials [supporting the motion] must be viewed in the light most favorable to the party opposing the motions.” *Hanson Aggregates* at 9 (quoting *Unites States v. Diebold, Inc.*, 369 U.S. 654, 655 (1962)).

The issues presented in this penalty proceeding are whether the defective head lights on a skid steer loader violated either subsection (b) or (c) of mandatory standard section 56.14100. Subsection (b) requires the operator to correct in a timely manner defects on equipment that affect safety while subsection (c) requires the operator to remove from service defective equipment when continued operation of such would be hazardous. Subsection (a) of that standard requires the operator to inspect all self-propelled mobile equipment to be used during a shift before it is placed in operation. 30 C.F.R. §56.14100.

Findings of Fact and Legal Analysis

The undisputed facts are that on October 23, 2012, MSHA inspector Rickie Knupp was conducting an inspection at the Greenwood quarry. While accompanied by Martin Marietta personnel, Harry Danforth and Chris Bollinger, he inspected the cited Case 1840 skid loader located in the equipment shop. He found that the headlights were not functioning on the loader at that time. The loader had been used the day before and the headlights had worked properly. The loader had not been put into use on the day of the inspection and Knupp was informed by Lambert that it had not yet been inspected for use that day. It was not locked or tagged out to prevent use when Knupp inspected it. A faulty switch was found to be the culprit, which was replaced by Danforth and the violation was abated by Knupp when he rechecked it the following day. The loader is used to clean up the primary and secondary crusher areas of the mine during the day. The mine does not operate a night shift.

The Secretary alleges a violation of subsection (b) of the cited standard based upon the theory that the Act imposes strict liability for this violation even taking into consideration the “timely manner” language incorporated into this subsection. He argues that because the lights did not work when inspected, although working the day before, the operator should have known about the faulty switch and corrected it or taken it out of service “at least after a pre-shift examination.” Sec’y’s Motion. He cites several cases in support of his position but does not present any evidence to ascertain when the operator first knew or should have known of the defect as required by law. *See Lopke Quarries, Inc.*, 23 FMSHRC 705 (July 2001) (ALJ

properly vacated a citation where the Secretary could not prove a defect was known to operator, how long it existed and that it was not corrected in a timely manner); *Barrett Paving Materials, Inc.*, 15 FMSHRC 1999 (Sept. 1993) (citation vacated where there was no evidence of length of time defect existed or equipment examined); *Sweetman Construction Co.*, 21 FMSHRC 101 (Jan. 1999) (ALJ) (violation established because defective truck was in use at the time the inspector found the defect); *Walker Stone Company*, 20 FMSHRC 1225 (Oct. 1998) (ALJ) (violation established where the operator had been using equipment without functioning headlights for a long period of time due to a lack of knowledge that MSHA required them).

The undisputed evidence is that the lights had functioned the day before the inspection. The equipment had not yet been put into service that day and the pre-use inspection had not yet been done. The Secretary, under these set of facts, cannot establish that the operator knew or should have known of the defect or that it would not have fulfilled its duties under subsection (a) of the standard and performed the pre-use inspection, thereby identifying and repairing the defect in a timely manner before the loader was put to use.

The Secretary argues in the alternative that the facts establish a violation of subsection (c) because at “some point, the non-functioning headlights on the skid loader would rise to the level of a hazardous defect.” The loader was still available for use as it lacked a tag or other indication that it should not be used in its present condition. Again, the Secretary cites several cases in support of his position which in fact do not support it. First he cites *LaFarge North America*, 35 FMSHRC 2472 (Dec. 2013) in which the Commission remanded the case where the ALJ vacated a citation issued in section 56.14100(c) for lack of notice of the standard of measurement to be used for play in ball joints. The “continued operation” of defective equipment was not at issue in this case. It next cites *North Idaho Drilling, Inc.*, 35 FMSHRC 2472 (Aug. 2013) (ALJ). This case is illustrative of the significance of the language “continued operation” contained in subsection (c) of this standard and why it does not apply in the instant case. Judge Manning found a violation where the outrigger float on a crane was damaged and could have led to its capsizing and endangering miners. The crane had been in use for 45 minutes when the inspector cited it. Judge Manning found that the “respondent used the crane while the damage to the float and outrigger existed....” Similarly, Judge Miller found a violation of this subsection where a faulty brake light had been recorded repeatedly in the pre-use examination book and had been found in service when cited. *Boart Longyear Co.*, 34 FMSHRC 2715 (Oct. 2012).

As the Respondent correctly argues, there is no evidence of “continued operation” as required by the standard and as underscored by cases cited above. The headlights had functioned the day before, the skid loader had not yet undergone its pre-use inspection and it had not been used since its headlights ceased to function. There is no evidence that the operator would have failed to conduct this required inspection identifying the defect and repairing it before placing it into operation. There was no instance in time at which the operator could have known or should have known that the defect existed nor is there any evidence that the loader would have been used again in its defective condition.

For the reasons set forth herein, the citation is VACATED and the matter is DISMISSED.

/s/ Priscilla M. Rae
Priscilla M. Rae
Administrative Law Judge

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FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

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February 18, 2014

SECRETARY OF LABOR	:	CIVIL PENALTY PROCEEDING
MINE SAFETY AND HEALTH	:	
ADMINISTRATION (MSHA),	:	Docket No. SE 2012-416
Petitioner	:	A.C. No. 01-00851-285172
	:	
v.	:	
	:	
OAK GROVE RESOURCES, LLC ,	:	Mine: Oak Grove Mine
Respondent	:	

DECISION

Appearances: Jennifer Booth-Thomas, U.S. Department of Labor, Nashville, Tennessee,
on behalf of the Secretary of Labor

Patrick Dennison, Jackson Kelly, PLLC, Pittsburgh, Pennsylvania, on
behalf of Oak Grove Resources, LLC

Before: Judge Zielinski

This case is before me upon a Petition for Assessment of Penalty under section 105(d) of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 815(d). The petition alleges that Oak Grove Resources, LLC (“Oak Grove”), is liable for four violations of the Secretary’s Safety Standards for Underground Coal Mines, and proposes the imposition of penalties in the amount of \$125,100.00. A hearing was held in Birmingham, Alabama. The parties settled two citations prior to the hearing and a Decision Approving Partial Settlement was issued. At the hearing, the parties settled the two remaining citations, Order Nos. 8521202 and 8521203. Afterwards, the parties submitted a joint motion to approve settlement as instructed. For the reasons that follow, I impose civil penalties in the amount of \$88,125.00.

SETTLEMENT TERMS

The terms of the settlement are as follows:

Order No.	Proposed Penalty	Settlement Amount	Modifications/Explanations
8521202	\$70,000.00	\$44,062.00	The Respondent argues that the cited condition was not a violation of Section 75.400, and was not the result of an unwarrantable failure or high negligence on the part of Oak Grove. Further,

			the Respondent argues that the material cited consisted of wet sloppy material and was not combustible. Pre-shift mine examiners had noted conditions in pre-shift examinations and persons were assigned to complete work in the cited area. Additionally, the Respondent argues that maintenance had been conducted on shifts prior to the inspection. The Secretary proposes that the penalty be modified in light of the contested evidence and mitigating circumstances.
8521203	\$47,100.00	\$44,063.00	The Respondent argues that the cited condition was not a result of the operator's unwarrantable failure to comply with a mandatory safety standard because the pre-shift examination report included all of the potentially hazardous conditions that were in the area at issue in this violation. The Secretary proposes that the penalty be modified in light of the contested evidence and mitigating circumstances.
Total	\$117,100.00	\$88,125.00	

I have considered the representations and documentation submitted in this case, and I conclude that the proffered settlement is appropriate under the criteria set forth in Section 110(i) of the Act.

WHEREFORE, the motion to approve settlement is **GRANTED**.

ORDER

It is **ORDERED** that the operator pay a total penalty of \$88,125.00 within 30 days of this decision.¹

/s/ Michael E. Zielinski
Michael E. Zielinski
Senior Administrative Law Judge

¹ Payment should be sent to: MINE SAFETY AND HEALTH ADMINISTRATION, U.S. DEPARTMENT OF LABOR, PAYMENT OFFICE, P. O. BOX 790390, ST. LOUIS, MO 63179-0390.

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February 19, 2014

SECRETARY OF LABOR	:	CIVIL PENALTY PROCEEDING
MINE SAFETY AND HEALTH	:	
ADMINISTRATION (MSHA),	:	Docket No. CENT 2012-906-M
Petitioner	:	A.C. No. 41-04510-298298
	:	
v.	:	
	:	
MILLER SPRINGS MATERIAL, L.L.C.,	:	Mine: Cove Quarry
Respondent	:	

ORDER GRANTING RESPONDENT'S CROSS-MOTION FOR SUMMARY DECISION

Before: Judge Feldman

This case is before me upon a petition for assessment of a civil penalty filed by the Secretary of Labor (“the Secretary”) against the Respondent, Miller Springs Material, LLC (“Miller Springs”), pursuant to section 105(d) of the Federal Mine Safety and Health Act of 1977, as amended. 30 U.S.C. § 815(d). This matter concerns Citation No. 8628189, the single citation at issue, which alleges a violation of 30 C.F.R. § 56.1000. This mandatory reporting standard states in relevant part that “when any mine is closed, the person in charge shall notify the nearest [Mine Safety and Health Administration (“MSHA”)] district office . . . and indicate whether the closure is temporary or permanent.” The Secretary seeks to impose a \$100.00 civil penalty for Citation No. 8628189. The Secretary has filed a Motion for Summary Decision in this matter. Relying solely on joint stipulations, Miller Springs opposes the Secretary’s Motion.

Cove Quarry, the subject site in this proceeding, is a crushed limestone, rock and gravel facility. (Jt. Stip. 2). The question presented is whether a mine may be deemed to be “closed” pursuant to section 56.1000 during a period in which the Secretary concedes Miller Springs periodically continued to fill orders from an existing stockpile in response to the needs of its customers. (See Jt. Stip. 13). The Secretary argues that the mine must be considered closed because there were no ongoing production-related activities. (Sec’y Mot. at 4-5).

I. Background

On January 11, 2012, Miller Springs notified MSHA’s San Antonio field office that the Cove Quarry mine was on intermittent, producing status. (Jt. Stip. 12). On June 28, 2012, MSHA Inspector Homer Pricer arrived at Cove Quarry to conduct an inspection. At that time, he found no mine personnel or production activities at the site. (Jt. Stip. 10). Pricer contacted the plant manager, who informed him that production had stopped in December 2011, although

orders were continuing to be filled from existing stockpiles throughout 2012. (Stip. 13 of Ex. 2, *Declaration of Inspector Pricer*; Jt. Stip. 13). Based on his observation of a lack of activity at the mine, and on the information he received from the plant manager that the crusher had been removed for repairs since December 2011 although intermittent loading activities had continued, Pricer concluded that Miller Springs had violated the reporting requirements of section 56.1000 because it had failed to notify the MSHA district office that the mine was closed. (Jt. Stip. 10, 15). The alleged failure to report was designated as non-significant and substantial, and attributable to a low degree of negligence.

On December 6, 2013, the Secretary filed a Motion for Summary Decision, with joint stipulations of material fact. On January 7, 2014, Miller Springs represented by email that it did not oppose disposition by summary decision, although it declined to file a brief in opposition to the Secretary's Motion for Summary Decision. I construe Miller Springs' acquiescence to disposition by summary decision as a Cross-Motion for Summary Decision.

As discussed below, the Secretary's assertion that a mine is deemed closed despite ongoing stockpile operations is inconsistent with analogous ALJ Decisions concerning the substantive significance of loading activities. In addition, the Secretary's apparent willingness to relinquish MSHA oversight of stockpile loading activities is contrary to the authority delegated to MSHA to conduct inspections to ensure that mobile loading equipment and stockpiles are maintained in safe condition. Accordingly, the Respondent's Cross-Motion for Summary Decision shall be granted. Consequently, Citation No. 8628189 shall be vacated.

II. Joint Stipulations

The parties have stipulated to the following facts for purposes of summary decision:

1. Miller Springs Materials LLC ("Respondent") owns and operates the Cove Quarry (Mine ID 41-04510) in Kempner, Texas ("the Mine").
2. The Mine is a crushed limestone, rock, and gravel operation.
3. Respondent is engaged in mining operations in the United States and the company's operations affect interstate commerce.
4. The Mine is subject to the Federal Mine Safety and Health Act of 1977 ("The Act"), 30 U.S.C. § 801 et seq.
5. The Mine is subject to regulation by the Mine Safety and Health Administration ("MSHA").
6. The Federal Mine Safety and Health Review Commission has jurisdiction over the Mine, the parties and the subject matter of this proceeding.
7. The proposed penalty will not affect Respondent's ability to continue to do business.
8. Respondent demonstrated good faith in abating the cited conditions.

9. MSHA Inspector Homer Pricer (“Inspector Pricer”) was acting as an authorized representative of the Secretary of Labor (“Secretary”) at the time of the inspection at issue in this case.
10. On June 28, 2012, Inspector Pricer arrived at the Mine to conduct a regular E01 inspection. There were no mine personnel or production activities on site.
11. Inspector Pricer instead conducted an E16 inspection.
12. On January 11, 2012, Respondent notified the San Antonio field office that the Mine was on intermittent, producing status.
13. *Respondent filled orders at the Mine from the existing stockpile of material throughout 2012.*
14. Inspector Pricer Issued Citation No. 8628189 for a violation of 30 C.F.R. § 56.1000.
15. Citation No. 8628189 states:

The mine operator failed to notify the nearest District, Sub district, or Field Office of the Mine Safety and Health Administration of their intent to close (permanently or temporarily) the mine. Plant Manager stated that the crusher which had been moved for repairs has not operated at this location since December 2011. Failure to notify MSHA of the mine status is a violation of a mandatory standard.
16. Respondent terminated the citation by notifying MSHA on June 28, 2012 of its non-producing status.

(Jt. Stip. 1-16) (emphasis added).

III. Procedural Framework

Disposition by summary decision is appropriate provided the entire record establishes that there is no genuine issue as to any material fact, and that the moving party is entitled to summary decision as a matter of law. 29 C.F.R. § 2700.67(b). *See, Missouri Gravel Co.*, 3 FMSHRC 2470, 2471 (Nov. 1981); *Celotex Corp. v. Catrett*, 477 U.S. 317, 327 (1986).

The parties agree that no material facts remain at issue in this matter. Section 56.1000 requires that operators notify the nearest MSHA office when a mine closes. It is uncontested that at the time of the June 28, 2012, inspection, the Cove Quarry Mine was on record with MSHA’s San Antonio office as “intermittent, producing” rather than “closed.” (Jt. Stip. 12). It is also uncontested that, although no production activities were occurring on site on June 28, 2012,

Miller Springs continued to fill customer orders from a stockpile at the Cove Quarry Mine throughout 2012.¹ (Jt. Stip. 10, 13). As noted above, the issue to be resolved is whether a mine is properly deemed “closed” when the only activity occurring on-site is loading from a stockpile.

IV. Discussion and Evaluation

The operative language in section 56.1000 requires mine operators to notify MSHA “when any mine is closed.” The Commission has recognized:

“When the meaning of the language of a statute or regulation is plain, the statute or regulation must be interpreted according to its terms, the ordinary meaning of its words prevails, and it cannot be expanded beyond its plain meaning.” *Western Fuels-Utah, Inc.*, 11 FMSHRC 278, 283 (Mar. 1989); *Consolidation Coal Co.*, 18 FMSHRC 1541, 1545 (Sept. 1996). It is a cardinal principle of statutory and regulatory interpretation that words that are not technical in nature “are to be given their usual, natural, plain, ordinary, and commonly understood meaning.” *Western Fuels*, 11 FMSHRC at 283 (citing *Old Colony R.R. Co. v. Commissioner of Internal Revenue*, 284 U.S. 552, 560 (1932)). It is only when the plain meaning is doubtful that the issue of deference to the Secretary's interpretation arises. See *Pfizer Inc. v. Heckler*, 735 F.2d 1502, 1509 (D.C. Cir. 1984) (deference is considered “only when the plain meaning of the rule itself is doubtful or ambiguous”) (emphasis in original).

Akzo Nobel Salt, Inc., 21 FMSHRC 846, 852 (Aug. 1999) (holding that the term “two or more separate escapeways” is plain on its face and not subject to interpretation). The relevant plain meaning of “closed” is “to bring to an end; terminate,” “to stop the operations of permanently or temporarily.” *The American Heritage Dictionary* 349 (4th ed. 2009). Judge Manning has addressed the issue of “temporary closure” as it relates to section 56.1000 in *John Richards Construction*, 23 FMSHRC 1045, 1049-50 (Sept. 13, 2001) (ALJ). Judge Manning stated that section 56.1000 “is designed to cover situations where an operation closes permanently or is closing for some definite period of time.” *Id.* Consistent with Judge Manning, I believe that a mine may not be considered “closed” within the context of its plain meaning, when periodic ongoing loading activities dictated by the needs of customers continue to occur.

However, the Secretary contends that the word “closed” is ambiguous, given the fact that it is not defined in the Secretary's regulations. Hence, the Secretary maintains that a mine is “closed” when it is not engaged in the act of extracting or processing material. Consequently, the Secretary argues that activities solely related to filling orders from a preexisting stockpile do not render the mine “open.” (Sec'y Mot. at 4-5).

¹ The record does not reflect, nor does Miller Springs contend, that it engaged in any production activities at Cove Quarry after it notified the San Antonio Field Office on January 11, 2012, that it was on intermittent, producing status.

Where a statutory provision is ambiguous or silent, deference is owed to the Secretary's interpretation of the provision as long as that interpretation is reasonable. *Bill Simola, employed by United Taconite LLC*, 34 FMSHRC 539, 542-43 (Mar. 2012), citing *Chevron USA, Inc., v. Natural Res. Defense Council, Inc.*, 467 U.S. 837, 842-44; *Energy West Mining Co. v. FMSHRC*, 40 F.3d 457, 460 (D.C. Cir. 1994). Giving the Secretary the benefit of the doubt that there is ambiguity, the Secretary's proffered interpretation of the word "closed" must be rejected as unreasonable because it is inconsistent with previous ALJ decisions, as well as Commission decisions addressing the question of what constitutes "mining." Perhaps more importantly, the Secretary's position is contrary to the Mine Act's fundamental goal of fostering a safer working environment, given the absence of a showing of any feasible method by which personnel performing loading activities can be protected from hazardous equipment or mine conditions if Cove Quarry were deemed closed.

In arguing that the Secretary's interpretation is reasonable, the Secretary relies on *Nelson Quarries*, 32 FMSHRC 1422 (Oct. 7, 2010) (ALJ Rae). (Sec'y Mot. at 4-6). In *Nelson Quarries*, the operator had notified MSHA that a plant would be closed from February 2 to February 28, 2009. However, when the inspector arrived in May 2009, he determined that the site was still closed, and issued a citation for failing to provide MSHA with a corrected start date as required by section 56.1000. 32 FMSHRC at 1425. The parties stipulated that there had been no drilling, blasting, or extracting of materials in the intervening months. Moreover, Nelson Quarries failed to provide any documentation indicating that mechanics had been on-site to service equipment. Significantly, as distinguished from this case, the testimony as to whether customers had been loading trucks from a stockpile was inconclusive. *Id.* at 1426-28. Accordingly, the judge held that the mine was still closed as of May 2009, and the citation alleging a violation of section 56.1000 was affirmed. *Id.* at 1428. Thus, the Secretary's reliance on *Nelson Quarries* is misplaced, in that there was no definitive evidence of any activities occurring at the mine.

While *Nelson Quarries* does not support the Secretary's assertion that its interpretation is reasonable, there are ample Commission Judges' decisions that have held that loading from a stockpile constitutes sufficient activity for a mine to be designated as "open" as contemplated by section 56.1000. In *John Richards*, Judge Manning found that a sand pit was open on intermittent status where employees were only on site when customers requested loading assistance. 23 FMSHRC at 1049-50 (vacating an alleged violation of section 56.1000 for failing to notify MSHA of a mine shutdown). Similarly, in *Robert L. Weaver*, the judge found that a mine was operating intermittently where miners were not present when the inspector arrived, but came on-site to fill customer orders by loading material from the mine stockpile. 15 FMSHRC 2117, 2120-21 (Oct. 4, 1993) (ALJ Melick) (vacating an alleged violation of section 56.1000 for failing to notify MSHA of a temporary closure). *See also, Concrete Materials*, 35 FMSHRC 690 (March 26, 2013) (ALJ Manning) (finding a violation of section 56.1000 where a mine notified MSHA that it had closed, but in fact it was not closed because the mine had "maintenance and load-out activity throughout the winter as weather permitted").

Although jurisdictional status and operating status are admittedly distinct issues, the Commission's caselaw on jurisdiction is instructive. In this regard, the Secretary's contention that a mine must be considered closed if the sole activity is loading from a stockpile, because

filling customer orders is too far removed from the extraction process, is belied by Commission caselaw on jurisdiction. In determining whether an operation is properly classified as “mining,” the Commission has consistently looked to whether the activities being undertaken are usually performed by the operator and are undertaken to make the extracted material suitable for a particular use or to meet market specifications. *See Shamokin Filler Co., Inc.*, 34 FMSHRC 1897, 1902 (Aug. 2012), *citing Oliver M. Elam, Jr., Co.*, 4 FMSHRC 5, 7-8 (Jan. 1982).

Specifically, *Elam* involved a business entity that operated a commercial dock on the Ohio River. *Elam*’s customers were coal brokers who paid *Elam* to load and transport coal on barges leaving from the dock. The Commission noted that *Elam*’s activities with respect to coal related solely to loading it for shipment. Thus, the Commission concluded that *Elam*’s facility was not a mine subject to the Mine Act. In reaching this conclusion, the Commission stated:

Thus, inherent in the determination of whether an operation properly is classified as “mining” is an inquiry not only into whether the operation performs one or more of the listed work activities, but also into the nature of the operation performing such activities. In *Elam*’s operations, simply because it in some manner handles coal does not mean that it automatically is a “mine” subject to the Act.

4 FMSHRC at 7 (emphasis in the original).

While *Elam* dealt with a jurisdictional question, the case stands for the proposition that loading in response to a customer’s needs is not mining when the business entity performs no activities normally associated with the extraction and preparation processes. Here, Miller Springs’ loading activities in response to customer orders at the very site where the limestone, rock and gravel are extracted and crushed, cannot be disassociated from the mining process itself. In short, Miller Springs’ loading activities utilizing front end loaders and other relevant equipment at the Cove Quarry Mine, albeit intermittently, remain under MSHA’s jurisdiction to inspect and, as such, may not be considered evidence of inactivity justifying the characterization of the mine as “closed.”²

The primary purpose of the Mine Act is to preserve “the health and safety of its most precious resource – the miner.” 30 U.S.C. § 801(a). Inspections are the means by which this purpose is achieved. 30 U.S.C. § 813(a). Presumably, only mines listed as “open” are inspected. Requiring Cove Quarry to be listed as “closed” while loading activity is occurring on-site

² It is noteworthy that Congress has expressed that “what is considered to be a mine *and to be regulated under this Act* [should] be given the broadest possible interpretation, and . . . doubts [should] be resolved in favor of inclusion of the facility within the coverage of the Act.” S. Rep. No. 95-181, at 14 (1977), *reprinted in* Senate Subcomm. on Labor, Comm. on Human Res., *Legislative History of the Federal Mine Safety and Health Act of 1977* at 602 (1978) (emphasis added). The interruption of crushing and/or extraction, apparently due to repair of the crusher, does not alter MSHA’s continuing jurisdiction over Cove Quarry, given its intermittent loading activities. (*See* Jt. Stip. 15).

endangers the health and safety of the operators of the mobile equipment performing the loading activities. *See, e.g., Concrete Materials*, 35 FMSHRC at 692 (noting that allowing the mine to be classified as “closed” when activities were occurring onsite endangers the health and safety of personnel in the mine); *Hansen Truck Stop, Inc.*, 26 FMSHRC 293, 297 (March 9, 2004) (ALJ Zielinski) (noting that a mine operating on intermittent status is subject to MSHA scrutiny, while a mine listed as closed is not). The only way for MSHA to determine if stockpiles and mobile loading equipment are maintained safely is to retain MSHA oversight, rather than relinquishing inspection responsibility because a mine is considered to be closed.

In the final analysis, the motivation behind the Secretary’s assertion that the mine should be deemed closed is pragmatic rather than substantive. In this regard, in his brief, the Secretary states:

Due to the absence of equipment, personnel, and activity at the mine, Inspector Pricer was unable to determine whether Respondent operated the Mine in a safe manner. Instead, he unnecessarily expended MSHA resources to travel to a closed mine which failed to update its status as required by 30 C.F.R. § 56.1000.

(Sec’y Mot. at 5-6) (citation omitted).

It is difficult to distinguish the Secretary’s asserted hardship in inspecting mines in which activities are limited to periodic loading from the Secretary’s apparent acceptance of its responsibility to inspect mines that are designated with “intermittent status.” As noted, Miller Springs informed MSHA that the Cove Quarry mine was on intermittent status as of January 11, 2012. Miller Springs was cited for failing to notify MSHA that it was closed as a result of Pricer’s June 28, 2012, inspection that found no mine personnel at the mine at that time. The difficulty of complying with the notification requirements of section 56.1000 with regard to mine closure are self-evident in instances where activities are dictated by the demands of customers. Judge Manning addressed this very issue in *John Richards*:

In the case of this pit, it remained open all winter, but it had employees present only when there was a demand for its products. If Richards Construction had notified MSHA that it was closed at the end of December 1998, the standard would have required it to notify MSHA every time a customer called for sand. I do not read section 56.1000 imposing such a requirement on intermittent operations.

23 FMSHRC at 1050. While I understand MSHA’s dilemma, the problem is one of scheduling inspections rather than compliance with section 56.1000. The procedures best known to MSHA for efficiently inspecting intermittent mines should have prevented or minimized the possibility of Pricer’s unnecessary travel to the unattended Cove Quarry mine on June 28, 2012.

Consequently, the Secretary has failed to demonstrate by a preponderance of the evidence that the Miller Springs intermittent loading activities warranted changing the status of the Cove Quarry mine from “intermittent” to “closed,” as loading at a mine site constitutes mining. Accordingly, Citation No. 8628189 citing an alleged violation of the reporting requirements in section 56.1000 shall be vacated.

As a final note, this decision should be viewed in the context of the undisputed facts in this case. It is significant that the Secretary has stipulated that Miller Springs intermittently continued to fill orders from an existing stockpile throughout 2012.

ORDER

In view of the above, **IT IS ORDERED** that the Secretary’s Motion for Summary Decision **IS DENIED**, and the Cross-Motion for Summary Decision filed by Miller Springs Material, LLC, **IS GRANTED**.

Accordingly, Citation No. 8628189 **IS VACATED**, and the captioned civil penalty proceeding **IS DISMISSED**.

/s/ Jerold Feldman
Jerold Feldman
Administrative Law Judge

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/tmw

FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

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February 19, 2014

SECRETARY OF LABOR	:	CIVIL PENALTY PROCEEDINGS
MINE SAFETY AND HEALTH	:	
ADMINISTRATION, (MSHA),	:	Docket No. LAKE 2011-818-M
Petitioner,	:	A.C. No. 21-00831-255564
	:	
	:	Docket No. LAKE 2011-834-M
	:	A.C. No. 21-00831-258448
	:	
	:	Docket No. LAKE 2012-499-M
v.	:	A.C. No. 21-00831-283699
	:	
	:	Docket No. LAKE 2012-536-M
	:	A.C. No. 21-00831-283699
	:	
	:	Docket No. LAKE 2012-728-M
	:	A.C. No. 21-00831-292533
NORTHSHORE MINING COMPANY	:	
Respondent.	:	Mine: Northshore Mining Company

DECISION AND ORDER

Appearances: Timothy Turner, Esq., U.S Department of Labor, Office of the Solicitor,
Denver, CO for the Secretary

Arthur Wolfson, Esq., Jackson Kelly, PLLC, Pittsburgh, PA for
Respondent

Before: Judge Lewis

STATEMENT OF THE CASE

These cases are before the undersigned Administrative Law Judge on Petitions for Assessment of Civil Penalty filed by the Secretary of Labor against Respondent, Northshore Mining Company ("Respondent" or "Northshore"), pursuant to Section 104 of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. §815(d). A hearing was held in Duluth, Minnesota on August 27, 2013. The parties subsequently submitted post-hearing briefs.

PROCEDURAL HISTORY

Between April 2011 and May 2012, MSHA Inspectors William H. Soderlind, Steven E. Swenson, and Robert A. Marincel conducted several inspections of Northshore Mining Company and issued numerous citations. Northshore Mining Company contested many of these citations, 69 of which were placed in five civil penalty dockets (LAKE 2011-818, LAKE 2011-834, LAKE 2012-499, LAKE 2012-536, and LAKE 2012-728). The total assessed penalty for those civil penalty proceedings was \$146,290.00. On May 9, 2013 a hearing was set in this matter. As the date for the hearing approached, the parties settled 65 of the 69 citations (including all of the subject citation issued by Inspectors Swenson and Marincel). The parties filed a Motion to Approve Partial Settlement, which was granted on February 11, 2014. The remaining citations were Citation No. 6564267 (LAKE 2011-834), Citation No. 6564223 (LAKE 2011-818), Citation No. 6564235 (LAKE 2011-818), and Citation No. 6564248 (LAKE 2011-818). The total assessed penalty for the remaining citations was \$20,327.00. On August 28, 2013 a hearing was held on these remaining citations.

STIPULATIONS

The parties have entered into several stipulations, admitted as Parties' Joint Exhibit 1.¹ Those stipulations include the following:

1. Northshore Mining Company is engaged in mining operations in the United States, and its mining operations affect interstate commerce
2. Northshore Mining Company is the above-referenced mine. Northshore Mining Company is an "operator" as defined in Section 3(d) of the Federal Mine Safety and Health Act of 1977, as amended (Mine Act), 30 U.S.C. 803(d).
3. Northshore Mining Company is subject to the jurisdiction of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. §801 *et. seq.*
4. The Administrative Law Judge has jurisdiction in this matter.
5. The subject citations and orders were properly served by a duly authorized representative of the Secretary upon an agent of Northshore Mining Company on the dates and places stated therein, and may be admitted into evidence for the purpose of establishing their issuance.
6. The exhibits to be offered by Northshore Mining Company and the Secretary are stipulated to be authentic but no stipulation is made as to their relevance or the truth of the matters asserted therein.

¹ Hereinafter the Joint Exhibits will be referred to as "JX" followed by the number. Similarly, the Secretary's Exhibits will be referred as "GX" and Respondent's Exhibits will be referred to as "RX."

7. The assessed penalties, if affirmed, will not impair Northshore Mining Company's ability to remain in business.
8. MSHA Inspector William Soderlind was acting in his official capacity and as an authorized representative of the Secretary of Labor when aforesaid citations and order were issued.

Joint Exhibit 1 (*see also* Transcript at 6).²

Citation No. 6564267

I. ISSUES

With respect to Citation No. 6564267, the issues to be determined are whether Respondent's alleged actions on May 3, 2011 were a violation of §56.14112(a)(1) and, if so, whether that violation was significant and substantial ("S&S"), whether it was reasonably likely to result in lost workday/restrict duty injury to one miner, whether it was the result of moderate negligence, and the appropriate penalty for the violation.

II. SUMMARY OF TESTIMONY

On May 3, 2011 Inspector William Soderlind issued Citation No. 6564267 for a guard violation (GX-2).³ (Tr. 18). Soderlind issued Citation No. 6564267 because he observed a violation of 56.14112(a)(1) in the pellet plant which he believed could endanger the safety of miners. (Tr. 20). That standard states that guards must be constructed and maintained to withstand the vibration, shock, and wear to which they are subjected during normal mining operations. (Tr. 20).

² Hereinafter the transcript will be cited as "Tr." Followed by the page number.

³ At hearing, Soderlind was present and testified for the Secretary. (Tr. 13). At the time of the hearing, he had worked for MSHA's Duluth, Minnesota office as a metal/nonmetal mine safety and health inspector for four years. (Tr. 13). In that capacity he inspected 50-80 mines a year to ensure safety. (Tr. 13). Soderlind had been trained to become an inspector at the Mine Safety and Health Academy in West Virginia. (Tr. 14). He also received journeyman refresher training every two years. (Tr. 14, 82). Before working for MSHA, Soderlind worked construction for seven years. (Tr. 14-15, 83). Before that he was in the Marine Corps for over six years. (Tr. 15). His Marine Corps experience included work as crash, fire, and rescue personnel. (Tr. 15, 83). He also attended a structural firefighting academy in Orange County, California. (Tr. 15). Soderlind was certified as an EMT and a firefighter. (Tr. 15). Soderlind also had an English degree. (Tr. 15). He had never worked in a taconite plant. (Tr. 83).

Soderlind was at Respondent's plant during May and April of 2011 for a regular, full inspection.⁴ (Tr. 17). Respondent's employee Brian Hill accompanied Soderlind during the inspection.⁵ (Tr. 103). During the inspection Soderlind took handwritten contemporaneous notes, which he reviewed during the hearing (GX-3). (Tr. 19, 83). He also had general field notes (RX-17). (Tr. 83-84). When Soderlind observed a condition he would enter it into his general field notes and then turn to the back pages of his note book to write his citation notes. (Tr. 84).

The specific violative condition cited was a guard on the 124 conveyor that had come apart in places leaving jagged metal stuck out where it could cut a miner. (Tr. 20, 28, 103-104). This conveyor was in the pelletizer and elevated eight feet off the ground. (Tr. 104, 113). The hanging guard was four or five inches from another portion of the guard, which itself was six inches from the tail pulley. (Tr. 23-24). Originally, the guard had been temporarily welded, or "tacked," in place. (Tr. 22). Another guard had fallen completely off the 124 conveyor and was hanging partway into the walkway. (Tr. 20, 22). The cited condition exposed the pulley.⁶ (Tr. 22).

The guards could have come apart from the vibration of equipment, contact from spilled material, corrosion, improper construction, or other reasons. (Tr. 21). When the conveyor is running there is some vibration and shaking. (Tr. 112). It would be hard to say how much the pulley would vibrate when in operation. (Tr. 23). The area had wet processes, which could have caused the guard to corrode and separate. (Tr. 26). Water and oxygen cause guards to wear, so Respondent had to continually upgrade their guards. (Tr. 26).

During the inspection, the conveyor was running and the tail pulley was spinning. (Tr. 22-23, 112). A piece of the guard was hanging while the belt was running. (Tr. 112). If the hanging guard were to contact the tail pulley it could shoot out into the walkway or under the conveyor. (Tr. 24). The guard could get shot out after getting pulled into the pulley or it could

⁴ Respondent was owned by Cleveland Cliffs and the plant was located in Silver Bay, Minnesota. (Tr. 16). Respondent engaged in iron ore mining and creation of taconite pellets. (Tr. 16). There are roughly 400 miners at Respondent's plant. (Tr. 114). At the time of the hearing, Soderlind had inspected the plant a total of four times. (Tr. 15-16). His most recent inspection lasted 9-weeks and occurred two weeks before the hearing. (Tr. 16). The plant was inspected twice a year for between 9 and 14 weeks each time. (Tr. 16).

⁵ At hearing, Brian Hill was present and testified for Respondent. (Tr. 102). Both at the time of the hearing and May of 2011, Hill was on the day crew for pelletizer operations. (Tr. 102). At the time of the hearing he took care of precip, dust collectors, and other environmental pollution controls. (Tr. 102). When the instant citations were issued he was training and taking care of equipment (the furnace, the ball and drums, etc.). (Tr. 102). He had worked for Respondent for five and a half years and started in the mining industry in 1995. (Tr. 102-103). He spent 13 years as a belt contractor, but worked at the Plant as he did so. (Tr. 103).

⁶ The tail pulley was about two feet in diameter and three feet wide. (Tr. 23). There was a shaft through the pulley to the pillow block (which had a grease coming out of it). (Tr. 23).

just fall. (Tr. 85). The walkway was right next to the pulley. (Tr. 24, 85, 104). The walkway was about 30 inches wide and went all the way around the tail pulley. (Tr. 104). It would be traveled a couple of times per shift, mostly by operators. (Tr. 104).

Further, there was a pile of taconite pellets by the tail pulley. (Tr. 24-25). The walkway was grated so pellets should have fallen through. (Tr. 86, 113). However, sometimes the grates clog and accumulations occur. (Tr. 86-87). Soderlind had seen places in the plant where pellets had to be climbed over. (Tr. 33). He had issued citations for miners climbing past a tail pulley where pellets had spilled. (Tr. 33). Soderlind testified that pellets were removed by shoveling them out or onto the conveyor. (Tr. 25, 85). If a shovel contacted the pulley it could strike the miner, pull the miner in the pulley, or knock a miner down. (Tr. 25). Hill testified that pellets were removed with an air lance, not a shovel. (Tr. 113). The pellets that day were on a structured beam, not the floor. (Tr. 113-114). Soderlind had seen miners shoveling pellet next to an energized pulley, but not in this instance. (Tr. 25). Respondent sold the pellets, so they would try to get them out quickly. (Tr. 87, 96-97). It could be an arduous process to shut down the belt, lock it out, and tag it out. (Tr. 97). The belts are crucial to production and shutting down the belt could shut down a whole section of the mine. (Tr. 97). As a result, Soderlind testified that if the guards are in place, they just shoveled the product back on. (Tr. 86, 97-98).

Finally, Soderlind testified there was sharp metal sticking into the walkway. (Tr. 26). There was also an opening in the guard itself. (Tr. 28). The metal in these areas was sharp enough to break the skin if someone fell or rubbed against it. (Tr. 26, 28). Soderlind conceded that there were no tripping hazards in the area and there were handrails. (Tr. 86). A miner might contact the guard while cleaning, traveling, or greasing the pulley, possibly while carrying tools. (Tr. 27). Hill testified that the edge on the guarding did not protrude into the walkway. (Tr. 106). There would be no reason to contact the guarding edges. (Tr. 106). Soderlind testified that some miners wore latex gloves, but they did not provide protection. (Tr. 26-27). Hill testified that most of the miners, including operators, wore strong leather gloves. (Tr. 107, 114, 117). The guard would not easily puncture those gloves. (Tr. 107). They would only go through the leather if someone fell on the edges and there was no tripping hazard. (Tr. 107). Hill did not recall any lost-time injuries from hand cuts at the plant. (Tr. 108). Latex gloves were only used when hosing the swamp or in the lab. (Tr. 114). Respondent's employees were also trained to keep their hands and limbs away from moving equipment. (Tr. 106-107). However, the area could be hot and miners sometimes had exposed arms. (Tr. 118).

The citation was marked "reasonably likely" because the guard was damaged in several places and miners travelled in the area to apply grease, to examine belts, or to walk through. (Tr. 30, 87). The examinations were required under 56.18002, which applies to working areas. (Tr. 87-88). If the condition was not abated, it would get worse and a miner could contact the sharp edge, receiving a laceration. (Tr. 27, 30). It was possible, but less likely, that a miner could contact the shaft of the tail pulley. (Tr. 27, 30, 105). Hill stated the area was only traveled a couple of times a day, the walkway was adequate, and structure blocked everything except an 8-inch opening 20 inches off the walkway. (Tr. 105-106). Further, the tail pulley was recessed four or six inches behind the guarding. (Tr. 106).

The citation was also marked “lost workdays or restricted duty,” because someone could cut their hand or leg during a fall or get a puncture wound requiring a tetanus shot or medical attention. (Tr. 30-31). A miner contacting the rotating shaft could suffer permanently disabling injury. (Tr. 31). The citation was marked as affecting one person because it was unlikely that more than one person would injure themselves on the same guard at the same time. (Tr. 31).

The citation was marked S&S because there was reasonable likelihood of an injury that was at least lost workday/restricted duty. (Tr. 31). The specific hazard was the loose guard with jagged edges in the walkway. (Tr. 32). The deteriorating guard and the high traffic created the likelihood of injury. (Tr. 32). The guard had corroded, which was evidence that the condition had existed for months. (Tr. 32). Under normal mining conditions there was a strong likelihood that a miner would be injured. (Tr. 32-33). This is especially true in light of the pellets in the walkway. (Tr. 33).

The citation was marked as “moderate” negligence. (Tr. 33). Moderate negligence exists where there are some mitigating factors. (Tr. 33). Soderlind considered violation history, the location, visibility, and obviousness. (Tr. 34). Soderlind did not believe Respondent knew of this condition, but should have. (Tr. 34). Respondent’s miners are a “self-directed” workforce meaning the individual miners are supposed to tell management about any issues they come across. (Tr. 34). Low negligence would be in a remote area. (Tr. 34).

Respondent terminated the citation by replacing the guard with a one that was better constructed. (Tr. 34-35). The new guard had a large metal frame around it. (Tr. 28-29).

III. FINDINGS OF FACT AND CONCLUSIONS OF LAW

The findings of fact are based on the record as a whole and the Administrative Law Judge’s careful observation of the witnesses during their testimony. In resolving any conflicts in the testimony, the Administrative Law Judge has taken into consideration the interests of the witnesses, or lack thereof, and consistencies, or inconsistencies, in each witness’s testimony and between the testimonies of the witnesses. In evaluating the testimony of each witness, the Administrative Law Judge has also relied on his demeanor. Any failure to provide detail as to each witness’s testimony is not to be deemed a failure on the Administrative Law Judge’s part to have fully considered it. The fact that some evidence is not discussed does not indicate that it was not considered. *See Craig v. Apfel*, 212 F.3d 433, 436 (8th Cir. 2000) (administrative law judge is not required to discuss all evidence and failure to cite specific evidence does not mean it was not considered).

1. The Secretary Has Carried His Burden Of Proof By A Preponderance Of The Evidence That 30 C.F.R. §56.14112(a)(1) Was Violated.

On May 3, 2011, Inspector Soderlind issued a 104(a) Citation, No. 6564267, to Respondent. Section 8 of that Order, Condition or Practice, reads as follows:

Pellet Plant – The tail pulley guard for the 124 conveyor was corroded and falling apart in several areas. Sharp jagged metal edges where the expanded metal had

separated were found on all sides of the guard. This condition exposes miners to laceration type injuries due to unexpected contact with the jagged metal.

(GX-2).

The cited standard, 30 C.F.R. §56.14112(a)(1) (“Construction and Maintenance of Guards”), provides the following:

- (a) Guards shall be constructed and maintained to—
 - (1) Withstand the vibration, shock, and wear to which they will be subjected during normal operation; and

30 C.F.R. §56.14112.

Inspector Soderlind credibly testified that the cited guard was coming apart. (Tr. 20, 28, 103-104). Specifically, corrosion and vibration had caused the guard to break down. (Tr. 21). When cited, the guard had ragged edges and was no longer properly blocking the tail pulley. (Tr. 20, 22, 28, 103-104).

In its brief, Respondent did not argue against the validity of Citation No. 6564267. The Administrative Law Judge finds that Respondent conceded that it violated the standard. In light of this fact, and the evidence presented, the Administrative Law Judge finds that this citation was valid.

2. Considering The Record *In Toto* And Applying Applicable Case Law, The Violation Was Reasonably Likely to Result in a Lost Workday/Restricted Duty Injury And Significant And Substantial In Nature

Inspector Soderlind marked the gravity of the cited danger in Citation No. 6564267 as “Reasonably Likely” to result in “Lost Workday/Restricted Duty” injury to one person. (GX-2). These determinations are supported by a preponderance of the evidence.

The Mine Act requires that “gravity of the violation” be considered in assessing a penalty. 30 U.S.C. §820. The Secretary has promulgated a three-factor inquiry to determine the gravity of a citation for purposes of determining the penalty. Those factors are:

[T]he likelihood of the occurrence of the event against which a standard is directed; the severity of the illness or injury if the event has occurred or was to occur; and the number of persons potentially affected if the event has occurred or were to occur.

30 C.F.R. §100.3(e).

The event against which the instant standard, 30 C.F.R. §56.14112(a)(1), is directed is contact by a miner with moving conveyor pieces or with damaged pieces of the guard. The particular guard here was designed to prevent contact with the tail pulley of the 124 conveyor.

(GX-2). Inspector Soderlind credibly testified that given the state of the cited guard, contact with the conveyor, or the broken guard itself, was reasonably likely. Specifically, Soderlind testified that the cited area was next to a walkway where miners worked and traveled on a regular basis. (Tr. 104, 30, 81). In fact, the broken guard was sticking out into the walkway and miners shoveling pellets onto the belt could have contacted the belt with a shovel. (Tr. 20, 25, 28, 85-86, 97-98, 103-104). Given this exposure, the Administrative Law Judge finds that contact with the broken guard or moving pieces of the conveyor was reasonably likely to occur.

Soderlind also credibly testified that if a miner were to contact the conveyor or the broken guard, lost workday/restricted duty injuries would occur to one miner. Specifically, he testified that under continued normal mining conditions a miner could place his hand on the guard and receive a laceration. (Tr. 26-28). Further, miners often walked through the area in their shirtsleeves. (Tr. 118). As a result, miners could walk past the cited area and brush their arms against the damaged guard, resulting in lacerations. In addition to the risk from touching the guard, Soderlind credibly testified that as time passed and the guard's condition became worse, the guard could be pulled into the pulley and then shoot out into the walkway, injuring a miner. (Tr. 85). Finally, miners could be injured by their shovels when cleaning pellets. (Tr. 25). All of these conditions would only affect one miner. (Tr. 31). A preponderance of the evidence supports the Inspector's findings.

Respondent offered several arguments asserting that an accident was unlikely. However, as Respondent discussed those arguments in relation to the S&S designation, they will be discussed *infra*.

Well-settled Commission precedent sets forth the standard used to determine if a violation is S&S. A violation is S&S "if, based upon the particular facts surrounding the 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., National Gypsum Co.*, 3 FMSHRC 822, 825 (April 1981). The Commission later clarified this standard, explaining:

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).

With respect to the first element, the underlying violation of a mandatory safety standard, it has already been established that Respondent violated 30 C.F.R. §56.14112(a)(1).

With respect to the second element of *Mathies*, a discrete safety hazard – that is a measure of danger to safety – contributed to by the violation – Inspector Soderlind credibly

testified that the violation, a damaged guard, contributed to the safety hazard of a miner grasping or brushing the broken guard or coming into contact with the energized conveyor pulley.

The Secretary also argued that contribution to a discrete safety hazard should be considered in light of the frequency with which the cited area is accessed, the position of the now exposed part in relation to the miner, and the general condition of the walkway next to the moving part exposed by the faulty guard. (*Secretary's Post-Hearing Brief* at 11, citing *Carder, Inc.*, 27 FMSHRC 839, 844 (Nov. 2005)(ALJ Manning); *Bachman Sand & Gravel*, 34 FMSHRC 226, 231 (Jan. 2012)(ALJ Miller); and *Baker Rock Crushing Co.*, 2010 WL 3616493, *8 (Aug. 2010) (ALJ Barbour)). Inspector Soderlind credibly testified that the area experienced heavy foot traffic and was accessed regularly for examinations. (Tr. 30, 87). He also testified, and the photographs confirmed, that the exposed tail pulley was directly next to the walkway. (Tr. 22-24, 85, 104, 112)(GX-4, p.1). Finally, the inspector testified that there were slippery pellets in the walkway creating an additional tripping hazard. (Tr. 24-25, 33, 86-87, 113).

Respondent produced several arguments for the proposition that this condition did not contribute to a safety hazard, none of which are compelling.

First, Respondent argued under normal mining conditions, no one would contact the jagged edges of the guard. (*Respondent's Post-Hearing Brief* at 5-6). It argued that the edges did not protrude into the walkway, that edges were inside the waterline between the guarding and the walkways, and that there was no reason for a miner to reach toward these jagged edges. (*Id.* at 6). The Administrative Law Judge credits the Inspector's testimony that the jagged guard was exposed in the walkway and that miners could touch or brush the jagged edges. (Tr. 20, 22, 26). The photographs, specifically GX-4, p. 2, support this testimony. While it was possible that some of the jagged edges were behind the waterline, the Administrative Law Judge finds that under normal mining conditions miners would eventually contact these jagged edges.

Respondent also argued that miners were trained to stay away from moving parts. (*Respondent's Post-Hearing Brief* at 6). There is no reason to doubt Respondent's assertion that the miners received this training. However, even if it is true, that does not change the significant and substantial nature of this violation. If training were sufficient, properly maintained guards would not be required under 30 C.F.R. §56.14112(a)(1). The standard exists because MSHA determined that, even in light of the extensive training miners are given, miners could be injured by exposed moving parts. Whether through inadvertence or accident, even trained miners could contact the moving pieces if no guard were in place. As a result, the hazard still existed despite the training.

Finally, Respondent argued that there was no tripping hazard in the cited area. (*Respondent's Post-Hearing Brief* at 6 citing *Baker Rock Crushing Co.*, 32 FMSHRC at 976 and *Carder, Inc.*, 27 FMSHRC at 844). As discussed *supra*, there were pellets in the walkway in this area. (Tr. 24, 25, 86-87, 113). These marble-like pellets constituted a tripping hazard. However, even if there were no pellets in this area, this would still be S&S. The only requirement of the second prong of *Mathies* is that the violation *contribute* to a discrete safety hazard. While a tripping hazard may create a greater likelihood of the hazard being realized, the

fact that the guard was deficient had already made an accident more likely. Therefore, the second prong of *Mathies* is met.

The third element of the *Mathies* test – a reasonable likelihood that the hazard contributed to will result in an injury – was also met. The preponderance of the evidence establishes that the hazard contributed to in this matter would be reasonably likely to result in injury.

The Commission clarified the third element of the *Mathies* test in *Musser Engineering, Inc., and PBS Coal Inc.*, 32 FMSHRC 1257, 1280-81 (Oct. 2010) (“PBS”) (affirming an S&S violation for using an inaccurate mine map). The Commission held that the “test under the third element is whether there is a reasonable likelihood that the hazard contributed to by the violation, i.e., [in that case] the danger of breakthrough and resulting inundation, will cause injury.” *Id.* at 1281. Importantly, it clarified that the “Secretary need not prove a reasonable likelihood that the violation itself will cause injury.” *Id.* The Commission concluded that the Secretary had presented sufficient evidence that miners who broke through into a flooded adjacent mine would face numerous dangers of injury. *Id.* The Commission also emphasized the well-established precedent that “the absence of an injury-producing event when a cited practice has occurred does not preclude a determination of S&S.” *Id.* (citing *Elk Run Coal Co.*, 27 FMSHRC 899, 906 (Dec. 2005); *Blue Bayou Sand & Gravel, Inc.*, 18 FMSHRC 853, 857 (June 1996).

If the hazard contributed here were realized, specifically if a miner contacted the guard or moving parts, an injury would be reasonably likely. If the miner contacted the jagged edge of the guard, he would experience lacerations and perhaps infection. (Tr. 27, 30-31). If the guard were pulled into the tail pulley and shot out, a miner would experience puncture wounds or lacerations. Finally, if the miner’s shovel were to contact the belt, it would result in striking injuries.

Respondent made several arguments attempting to show that there is no likelihood of injury from the cited condition. None of those arguments are compelling.

First, Respondent argued that miners would not receive lacerations from contacting the jagged guarding because they wore leather gloves. (*Respondent’s Post-Hearing Brief* at 7). The Administrative Law Judge credits the testimony of Inspector Soderlind that miners often wore latex gloves, which would not provide protection from lacerations. (Tr. 26-27). Further, Respondent’s witness, Hill, testified that even wearing leather gloves, a miner could be injured if he fell onto the guarding, because the leather gloves could be punctured. Given the pellets littering the floor, a fall was a real possibility. Also, regardless of leather gloves, other parts of miners’ bodies, including their arms, were exposed without any protection. (Tr. 118).

Next, Respondent argued that there was no possible injury caused by the gap in the guarding exposing the tail pulley. (*Respondent’s Post-Hearing Briefs* at 7-8). Specifically, Respondent argued that the pellets shown in the photographs were shown on the pillow block inside of the guard and that in order to shovel the belt, the conveyor would have be de-energized. (*Id.*). The Administrative Law Judge credits the testimony of the Inspector that pellets accumulated in the cited area and that miners loaded the pellets onto energized conveyors. (Tr. 24-25, 85). Even if the pellets photographed were on the pillow block rather than the walkway,

under normal mining conditions pellets would eventually accumulate on the walkway and need to be shoveled.

Finally, Respondent argued that Soderlind's testimony regarding injury dealt solely with what "could" happen if the miner contacted the moving parts of the pulley. (*Respondent's Post-Hearing Brief* at 9). Specifically, when asked what would happen if the guard contacted the pulley, Soderlind said that the belt could shoot into the walkway, it could go under the conveyor, or anything could happen. (Tr. 24). It argues that something that merely could happen is not sufficient to support an S&S designation. (*Respondent's Post Hearing Brief at 9 citing Wolf Run Mining*, 32 FMSHRC 1669, 1677 (Dec. 2010), *Texasgulf* 10 FMSHRC 498, 500-1 (April 1998); and *Zeigler Coal*, 15 FMSHRC 949, 952-54 (Jun. 1993)). Respondent is correct that the Commission has consistently held that dangers that simply "could" happen are insufficient to support an S&S designation. While the Administrative Law Judge believes that it is somewhat likely that this guard would eventually contact the pulley and then shoot into the walkway, the evidence does not support a finding that such an event is reasonably likely. However, the S&S designation is not based solely on the danger posed by the guard shooting into the walkway. The Administrative Law Judge finds that an injury was reasonably likely to result from a miner falling on or grasping the broken guard or contacting the moving parts of the pulley. As a result, the cited condition meets the third prong of the *Mathies* test.

Under *Mathies*, the fourth and final element that the Secretary must establish is that there was a "reasonable likelihood that the injury in question will be of a reasonably serious nature." *Mathies Coal Co.*, 6 FMSHRC at 3-4; *U.S. Steel*, 6 FMSHRC at 1574. The Administrative Law Judge finds that the kinds of injuries expected here, lost workday/restricted duty injuries from lacerations or striking, are reasonable serious in nature. See e.g. *Carmeuse Lime & Stone, Inc.*, 29 FMSHRC 284, 295-296 (Mar. 2007)(ALJ Hodgdon) and *Lexicon, Inc.*, 24 FMSHRC 1014, 1022-23 (Nov. 2002)(ALJ Hodgdon).

Respondent argued that any lacerations that results from a miner contacting broken guarding would be minor. (*Respondent's Post-Hearing Brief* at 8). It noted there was no history of lost workday/restricted duty injury from cuts to the hand at the plant. (*Id.*). The Administrative Law Judge credits the testimony of the Inspector that the lacerations to be expected from a fall onto the guard would be of a reasonably serious nature. (Tr. 30-31). The fact that Hill was not aware of lost workday or restricted duty injuries at the plant does not change this determination. The issue is whether the danger here presented a possibility for serious injury, not whether there was a history of these accidents. Respondent's good fortune in avoiding injuries in the past does not affect the S&S nature of this citation.

As a result of these factors, the Administrative Law Judge finds that the Secretary proved the violation was S&S by a preponderance of the evidence.

3. Respondent's Conduct Displayed "Low" Rather than "Moderate" Negligence.

In the citation at issue, Inspector Soderlind found that the operator's conduct was moderately negligent in character. (GX-2).

Standard 30 C.F.R. §100.3(d) provides the following:

(d) Negligence. Negligence is conduct, either by commission or omission, which falls below a standard of care established under the Mine Act to protect miners against the risks of harm. Under the Mine Act, an operator is held to a high standard of care. A mine operator is required to be on the alert for conditions and practices in the mine that affect the safety or health of miners and to take steps necessary to correct or prevent hazardous conditions or practices. The failure to exercise a high standard of care constitutes negligence. The negligence criterion assigns penalty points based on the degree to which the operator failed to exercise a high standard of care. When applying this criterion, MSHA considers mitigating circumstances which may include, but are not limited to, actions taken by the operator to prevent or correct hazardous conditions or practices.

In 30 C.F.R. §103(d), Table X, the category of high negligence is described thusly: “The operator knew or should have known of the violative condition or practice and there are no mitigating circumstances.” Conversely, moderate negligence is shown when “[t]he operator knew or should have known of the violative condition or practice, but there are some mitigating circumstances.” Low negligence is reserved for situations where there are “considerable” mitigating circumstances.

With respect to the instant citation, Respondent did not have actual knowledge of the cited condition. Even Inspector Soderlind admitted as much. (Tr. 34). Therefore, the question is whether Respondent should have known the condition existed. A preponderance of the evidence shows that it should have.

Inspector Soderlind credibly testified that the cited condition was open and obvious. (Tr. 34). Further, he stated that routine checks of the area would have discovered this condition for correction. (Tr. 33-34). Finally, Respondent would have been aware that this guard was in a wet, vibrating location and that these conditions could cause corrosion. (Tr. 26). Therefore, Respondent should have known the condition existed.

Respondent argued that it should not have known the cited condition existed because the cited area was not a “working area” within the meaning of the Act and no examination of that area was necessary. (*Respondent’s Post-Hearing Brief* at 9). For the purposes of the Act, “working place” means any place in or about a mine where work is being performed.⁷ 30 CFR § 56.2. However, the Act also requires that “safe means of access shall be provided and maintained to all working places.” 30 C.F.R. § 56.11001. It is uncontested that a walkway went directly past the tail pulley. (Tr. 24, 85, 104). Even if Respondent is correct that the tail pulley was not a working area (a dubious claim), the fact remains that walkways between working places must also be examined and maintained. Therefore, Respondent should have known about the condition of the cited guard as it was directly next to a walkway.

While Respondent should have known about the condition of the cited guard, there are mitigating circumstances. Inspector Soderlind conceded that those mitigating circumstances

⁷ “Places” and “Areas” are terms that are apparently used interchangeably.

existed. Specifically, he testified that Respondent did not have actual knowledge of the cited condition and Respondent's employees were a self-directed workforce. (Tr. 34). The Secretary felt that these mitigating circumstances dictated a finding of "moderate" negligence. (GX-2). However, in addition to those cited by the inspector, the Administrative Law Judge finds another mitigating factor. While this was a working area of the mine and examinations were required, the area was still relatively remote. Miners were not working in this area constantly and when they were in the area they were passing through. As a result, these mitigating circumstances are better characterized as "considerable" and a finding of "Low" negligence is appropriate.

4. Penalty

Under the assessment regulations described in 30 CFR §100, the Secretary proposed a penalty of \$3,143.00 for Citation No. 6564267. A recent Commission decision, *Sec. v. Performance Coal Co.*, (Docket No. WEVA 2008-1825 (8/2/2013)) reaffirmed that neither the ALJ nor the Commission is bound by the Secretary's proposed penalties. (*see also* 30 U.S.C. §820(i) and 29 C.F.R. §2700.30(b)). However, the Commission in *Performance Coal*, also held that, although there is no presumption of validity given to the Secretary's proposed assessments, substantial deviation from the Secretary's proposed assessments must be adequately explained using §110(i) criteria. (*Id.* at p. 2). (*see also Cantina Green*, 22 FMSHRC 616, 620-621 (May 2000)). The ALJ finds that a substantial deviation from the Secretary's proposed assessment is warranted herein and will evaluate the factors contained in 30 U.S.C. §820(i) to explain that deviation. Those factors are as follows:

(1) The Operator's history of previous violations – Inspector Soderlind credibly testified that Respondent had a history of these violations. (Tr. 34). Respondent's violation history supports this testimony. (GX-1).

(2) The appropriateness of the penalty compared to the size of the Operator's business – Northshore Mining Company has 770,129 yearly mine hours and Respondent has 2,179,873 yearly controller hours. According to MSHA's penalty assessment guidelines this gives United Plant 10 "mine size points" out of a possible 15 and Respondent seven "controller size points" out of a possible 10. *see* 30 CFR § 100.3(b). Thus, Respondent is a large operator with an above-average sized plant.

(3) Whether the Operator was negligent – As previously shown, Respondent's negligence is better characterized as "Low" rather than "Moderate" negligence

(4) The effect on the Operator's ability to remain in business – The parties have stipulated that the Orders at issue here would not affect Respondent's ability to remain in business. (JX-1)

(5) The gravity of the violation – As previously shown, the gravity of the cited danger was reasonably likely to result in lost workday and restricted duty injuries to one miner. Further the condition was S&S.

(6) The demonstrated good-faith of the person charged in attempting to achieve rapid compliance after notification of a violation – The evidence shows the condition was abated rapidly and in good faith.

In light of the Administrative Law Judge’s decision to modify the negligence from “Moderate” to “Low” a reduction in the assessed penalty is appropriate. Therefore, Respondent is hereby **ORDERED** to pay a civil penalty in the amount of \$2,000.00 with respect to this violation.

Citation No. 6564223

I. ISSUE

With respect to Citation No. 6564223, the issues to be determined are whether Respondent’s alleged actions on April 6, 2011 were a violation of §56.20003(a) and, if so, whether that violation was significant and substantial (“S&S”), whether it was reasonably likely to result in lost workday/restrict duty injury to one miner, whether it was the result of moderate negligence, and the appropriate penalty for the violation.

II. SUMMARY OF TESTIMONY

On April 6, 2011 Inspector Soderlind issued Citation No. 6564223 (GX-6) for a violation of 56.20003(a) which requires working areas of the mine, travel ways, passageways, store rooms, and service rooms be kept clean and orderly.⁸ (Tr. 35-38). Specifically, the base of the #10 Silo was open, allowing miners to come into contact with old equipment and unsafe conditions for foot travel. (Tr. 37, 108, 122). Pellets were stored in the top of the silo and various tools and parts were stored on the shelves in the bottom of the silo. (Tr. 38, 43, 108, 114, 122, 144). There were also loose pellets on the ground. (Tr. 41). Pellets are slippery when spread out, less slippery (but still capable of causing falls) when piled up. (Tr. 41). There was no lighting in the silo. (Tr. 42). It would sometimes be lit by the sun, but three-quarters of the day would be dark. (Tr. 42). Tim Aijala conceded that the inside of the silo was a mess.⁹ (Tr. 124). There were pallets laying around and dried mud on the floor. (Tr. 124).

⁸ Hill accompanied Soderlind on this inspection. (Tr. 108).

⁹ At hearing, Tim Aijala was present and testified for Respondent. (Tr. 119). He had worked for Respondent for 15 and a half years. (Tr. 120). He worked for a year as safety inspector and spent 13 years loading boats and running heavy equipment. (Tr. 120). At the time of the hearing he was employed by Respondent to operate the railroad. (Tr. 119). At the time of the instant citations he was the safety inspector. (Tr. 120). As a safety inspector, he inspected the plant every day looking for safety hazards and writing work orders. (Tr. 120). He also accompanied MSHA inspectors. (Tr. 120). Before working for Respondent, Aijala spent eight years working at an underground copper mine in Michigan. (Tr. 120). Aijala did not accompany the inspector here, but went afterwards and looked at it before the abatement. (Tr. 121-122, 139-140).

If an area was sealed off, MSHA would not issue citations. (Tr. 49). MSHA requires operators to barricade an area if it wishes to keep miners out, but there is no specific standard for how to make the barrier. (Tr. 38-39). A barricade is supposed to physically prevent people from entering. (Tr. 98). Here, Respondent had two one-inch diameter metal bars four feet apart that were welded to the garage door for the silo to block access. (Tr. 39, 44, 109, 124). The top rail was about four feet high and the lower rail was about two feet high. (Tr. 50-51). The bars across the silo entrance were installed a year and a half to two years before the citation. (Tr. 123-124, 144). There was no sign saying that miners should not enter. (Tr. 44, 149). Aijala testified that miners would be less likely to enter an area with a sign, but believed the barrier would prevent entry. (Tr. 149). Soderlind testified that while the barrier was there, it was clear that it was not preventing miners from going inside. (Tr. 43-44, 98).

Soderlind knew the barrier was not working because he looked into the silo from the entrance and saw footprints on the ground.¹⁰ (Tr. 40-42, 98). Respondent intended to close the area and not have anyone in the silo. (Tr. 98, 109). However, the barricade did not indicate that people should not enter because there was no sign. (Tr. 98-99, 114). Hill and Aijala did not believe anyone entered the silo after it was closed and knew it was barred. (Tr. 109-110, 124). Everyone, including contractors, receive site specific training, MSHA training, and new miner training. (Tr. 116-117). However, Hill did not know if they were told not to enter the silo; that was not his job. (Tr. 116). Not going through the barricade was common sense. (Tr. 117, 124). Before the citation, Aijala believed that the two bars were enough to barricade the silo. (Tr. 148). At the hearing, he believed it was not. (Tr. 148).

To get inside, miners would have to crawl through the barrier. (Tr. 45). While climbing in or out they would be carrying something, as there was no other reason go there. (Tr. 45). There was a hose in the walkway and pallets with various items on them. (Tr. 43). Soderlind believed a miner would enter this silo, bent over, to get old idlers, come-alongs, belts, and hoses.¹¹ (Tr. 42-43, 51). However, Hill and Tim Aijala testified that nothing in the silo would be needed in the course of normal operations. (Tr. 110, 123, 149). Aijala knew the equipment was not in use because he had worked there 13 years and knew a new storage area was built. (Tr. 123). Respondent no longer had the equipment to use the idlers in Silo #10. (Tr. 123).

Hill testified that that the footprints were not on the equipment in the silo, but only on the ground. (Tr. 111). The ground was flat and smooth. (Tr. 111). Aijala testified that from the doorway he could not see footprints on equipment. (Tr. 125, 145-146). However, he reviewed the photograph marked GX-8, p. 1 and saw dried footprints on either a roll of rubber line techs or a small roll of old belt. (Tr. 146). He could not tell if there were more than one set of footprints in the photograph. (Tr. 146). The photograph marked GX-8, p. 2 showed many sets of footprints on the floor, but Aijala thought they were all old. (Tr. 147).

¹⁰ Soderlind did not go inside the silo. (Tr. 88).

¹¹ Soderlind believed he ask someone why miners would enter the silo. (Tr. 88). Such a conversation would be in his field notes. (Tr. 88). However, Soderlind was unable to find a record of such a conversation in either his field notes (RX-7) or citation notes (GX-7). (Tr. 89).

Soderlind believed the footprints had been left recently; around a week. (Tr. 40). He knew this because the door never closed and was exposed to the weather, including rain, snow, and wind. (Tr. 40-41). These conditions would cover the footprints. (Tr. 41). All the witnesses agreed this area was exposed to the elements. (Tr. 40-41, 115, 147-148). Soderlind believed miners entered this area a couple of times a month, but it was hard to say for sure. (Tr. 43).

Hill conceded there were footprints in the area. (Tr. 117). However, he believed the footprints were dried and not fresh. (Tr. 110). New prints would be in mud and then old tracks would dry up. (Tr. 110, 115). He believed footprints probably occurred in the fall when it was raining and then froze in winter. (Tr. 115-116). Hill also testified that the silo was close to the water and the weather could change often. (Tr. 116). Aijala observed some footprints hardened on the floor level. (Tr. 124-125). Aijala did not believe that the footprints were very recent. (Tr. 145). However, he could not say for certain if the footprints were from when the silo was a storage room. (Tr. 144). It was possible that they had occurred after the area was closed. (Tr. 144-145). In this area, mud usually occurred from water seeping from the water system. (Tr. 145). That system was shut down in November and kept off until spring. (Tr. 145). The footprints were at least from the previous fall, though he could not say for sure. (Tr. 145). If miners entered the previous fall, someone would have entered after the barrier was built. (Tr. 148-149).

The cited silo was along a roadway. (Tr. 90). Soderlind could not see the footprints while driving. (Tr. 90). If he had not seen footprints he would not have issued the citation. (Tr. 48). Respondent had a policy against miners going through barred areas. (Tr. 49). Bars were common at the mine and, if Soderlind had not seen the footprints, he would have assumed that, like other areas, no one entered. (Tr. 49). If miners had not entered, this would have been an acceptable barricade. (Tr. 50).

There was a pile of pellets (Respondent's product) in front of the silo. (Tr. 90-91). The silo was near the boat load-out area where the pellets were placed on ships for delivery. (Tr. 91). The piles of pellets would come and go. (Tr. 91). Hill testified that there was not a lot of traffic in this area because when boats were reloading, no one was permitted underneath the conveyors to the ship. (Tr. 108-109). Only five or six guys worked in that area. (Tr. 114).

The instant citation was marked "reasonably likely" because when miners access an area with clutter on the floor (pallets, hoses, boards) and no lighting it was reasonably likely that someone would trip and be injured. (Tr. 46-47).

The citation was marked "lost workdays or restricted duty," because a miner could sprain or strain a joint when falling in this area. (Tr. 47). The citation was also marked as affecting one person because it was likely only one person would be in that area at a time. (Tr. 47).

The citation was marked S&S. (Tr. 47). The specific hazard was the clutter in the walking and working space in the silo. (Tr. 47). The clutter in the silo and the fact that miners entered this area to get tools and parts created a tripping hazard. (Tr. 47-48). An injury from such a trip would be likely if the condition was not corrected. (Tr. 48).

The citation was marked as “moderate” negligence because there was an attempt to barricade the area. (Tr. 48). However, the condition was open and obvious and Respondent a history of housekeeping violations. (Tr. 48).

Aijala spoke with Inspector Soderlind about the citation.¹² (Tr. 125). He explained to the inspector that Respondent had put up the bars to keep people out, that the mud was hardened, and that it was hard to determine when someone was in the area. (Tr. 126).

Respondent terminated this citation by putting up caution tape between the bars and ribbon that showed the nature of the hazard. (Tr. 45-46, 50, 90, 125). They took expanded metal and welded it between the existing bars to prevent people from climbing into the silo. (Tr. 46, 125). The new barrier was sufficient and the silo and its contents could not be accessed. (Tr. 46, 90, 149-150). A sign was added. (Tr. 99, 125).

III. FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. The Secretary Has Carried His Burden Of Proof By A Preponderance Of The Evidence That §56.20003(a) Was Violated.

On April 6, 2011, Inspector Soderlind issued a 104(a) Citation, Citation No. 6564223 to Respondent. Section 8 of that Order, Condition or Practice, reads as follows:

Yards & Docks – Silo #10 had boot tracks through the fines on the ground indicating that this silo had been accessed. This silo had pallets, idlers, and various other debris and parts cluttered throughout the area. There is no walkway maintained and the silo is supposed to be barricaded by two bars across the door opening. These bars are easily defeated and the area can be accessed without much effort. There was no sign posted prohibiting entry, and no other warning tape or other hazard type of warning present. This condition exposes miners to trip and fall hazards resulting in injury

(GX-6).

Standard 30 C.F.R. §56.20003(a) (“Housekeeping”) provides the following:

(a) Workplaces, passageways, storerooms, and service rooms shall be kept clean and orderly;

30 C.F.R. §56.20003(a).

¹² Aijala took inspection notes that day. (Tr. 121, 140-141). He would take a notepad every day and compiles notes and then collect them in a bigger notebook. (Tr. 121-122). The next day, when the citations are issued with numbers, he transfers his notes from his notebook to a new set of notes. (Tr. 141-142). If a citation was issued when he is not present, he will talk with the person who was with the inspector and, if possible, look at the condition himself. (Tr. 141).

Inspector Soderlind credibly testified that the cited silo contained a large amount of debris and used equipment. (Tr. 37, 41, 108, 122). Respondent's witnesses conceded that the area was dirty and not maintained. Therefore, the only issue is whether the cited silo was a "storeroom" within the meaning of the standard or if this was a barricaded area where maintenance was not required.

A preponderance of the evidence supports a finding that this was a storeroom. Inspector Soderlind credibly testified that this silo was used to store old equipment and pallets. (Tr. 41). While he conceded that Respondent intended to close this area, he also credibly testified that miners entered this area either to retrieve equipment or to drop off old equipment. (Tr. 45, 98, 109). The fact that miners were entering the area was evidenced by the fact that foot prints were visible on the floor and equipment of the silo. (Tr. 40-42, 98). Respondent's witnesses conceded these points. (Tr. 111, 117, 146-147). Therefore, the Administrative Law Judge finds that the cited area was an active storeroom and that it was not being maintained in a clean and orderly fashion.

Respondent offered several arguments to show that the instant citation was not validly issued. However, these arguments are not persuasive.

First, Respondent noted that the degree of cleanliness in the given area of a mine is dictated by the amount of use that area receives. (*Respondent's Post-Hearing Brief* at 15 citing *Beco Construction Co.*, 23 FMSHRC 1182, 1194-95 (Oct. 2011)(ALJ Manning)). It argued that the cited area was closed and that no one needed to enter the silo. (*Id.*). Therefore, it argued that despite the debris on the floor, the floor was sufficiently maintained. (*Id.*). Further, it argued that the area was not in as great a disarray as Inspector Soderlind cited, as the floor was smooth, flat, and easily visible. (*Id.*). In short, Respondent argued that the condition of the silo was sufficient given its limited use.

There was some evidence supporting Respondent's contention that the cited silo was no longer in use. Specifically, it was uncontested that Respondent intended to close the cited silo. (Tr. 98, 109). Further, it was uncontested that if the area was closed, a citation would not have been appropriate. (Tr. 49). However, a preponderance of the evidence showed that the silo was in use. Specifically, it is uncontested that footprints were found inside the silo. (Tr. 40-42, 98, 111, 117, 146-147). This indicates that while Respondent may have intended to close the area, the silo was still in use. Respondent presented evidence that these footprints were old, perhaps from before the bars were placed on the silo. (Tr. 147). However, the Administrative Law Judge credits the Inspector's testimony that the footprints had been created relatively recently. (Tr. 40-43). Even Respondent's witnesses testified that the footprints, while old, occurred after Respondent intended to close the silo. (Tr. 145, 148-149). Finally, as discussed *supra*, the evidence supports a finding that the cited area was extremely disordered. Therefore, given the continued use of the silo and the level of debris found therein, the cleanliness of the cited area was insufficient.

Respondent also argued that most of those footprints inside of the silo were mostly on the floor, not the equipment or tools. (*Respondent's Post-Hearing Brief* at 15). A preponderance of

the evidence indicates that there were footprints on equipment and pallets as well as on the floor. (Tr. 40-42, 98, 111, 117, 146-147). Respondent's witness Hill testified that he could see footprints on the belts on the floor. (Tr. 117). Even if Respondent was correct and miners largely walked on the floor, equipment and pallets still constituted a tripping hazard within in the silo. As a result, the location of the footprints in the mine support the issuance of this citation.

Finally, Respondent argued that the issue of whether the barricade was adequate is completely irrelevant. (*Respondent's Post-Hearing Brief* at 16-17). It argued that under Section 56.20011 and the MSHA Program Policy manual, that the barricade need only prevent unintentional access to an area. (*Id.*). According to the Respondent, even if the barricade was inadequate, that does not necessarily create a violation of the cited standard here. (*Id.*).

Respondent is correct, as far as that goes. Respondent was not cited for an improper barrier and whether the barrier was adequate does not directly bear on the issue of Respondent's violation of 56.20003(a). The issue in this case is whether the silo was a storeroom and, if it was, whether the silo was maintained. As discussed *supra*, a preponderance of the evidence shows that the silo was actively used and inadequately cleaned. The state of the barrier is only relevant in that if the barricade was more solidly constructed, miners could not have used the silo. Having found that miners used the storeroom, the exact state of the barrier is entirely irrelevant.

2. Considering The Record In Toto And Applying Applicable Case Law, The Violation Was Unlikely to Result in a Lost Workday/Restricted Duty Injury And Was Not Significant And Substantial In Nature

Inspector Sichmeller marked the gravity of the cited danger in Citation No. 6564223 "Reasonably Likely" to result in "Lost Workday/Restricted Duty" injury to one person. (GX-6). These determinations are supported by a preponderance of the evidence.

The event against which the instant standard, 30 C.F.R. §56.2003(a) is directed is injury caused by poorly maintained working areas. Here the cited area was poorly maintained. (Tr. 37, 108, 122). Even Respondent's witnesses testified that there were pallets, tools, and equipment strewn throughout the poorly lit silo. (Tr. 37, 42, 108, 122, 142). However, the preponderance of the evidence shows that exposure to the cited condition was not frequent enough to justify a finding that the injury was "reasonably likely." Respondent's witnesses credibly testified that the cited area was located on a lightly used access road. (Tr. 108-109). Further, the evidence indicated that while some miners had clearly crossed through the barrier into the silo, many of the miners at the plant knew that two parallel bars indicated that the area was barred. (Tr. 49). This further limited exposure to the cited condition. Therefore, the Administrative Law Judge finds that there was some exposure to the cited condition, but that an injury was unlikely to occur.

If a miner were exposed to this danger, a preponderance of the evidence shows he would sprain or strain a joint when falling in this area. (Tr. 47). Only one person would be affected by the cited condition. (Tr. 47).

Having found that the exposure was limited and that an injury was unlikely, the Administrative Law Judge finds that the cited condition was not S&S. *see Florida Rock Industries, Inc.*, 34 FMSHRC 745, 751-753 (Mar. 2012)(ALJ Zielinski) (holding that if exposure is low and injury unlikely, a violation of 56.20003(a) is not S&S).

In light of the foregoing, the Administrative Law Judge finds that the cited condition was unlikely to result in lost workday/restricted duty to one miner and that the violation was not S&S.

3. Respondent's Conduct Displayed Moderate Negligence

In the citation at issue, Inspector Soderlind found that the operator's conduct was moderately negligent in character. A preponderance of the evidence shows that Respondent knew or should have known that the cited condition existed. The Administrative Law Judge credits the testimony of Soderlind that the condition was open and obvious. (Tr. 48). The footprints, which showed the miners were entering the silo, were clearly visible from outside. (Tr. 48) Therefore, Respondent should have known that the condition existed. Further, Respondent had a history of housekeeping violations, putting Respondent on notice that maintenance was an area of concern. (Tr. 48, GX-1). Therefore, Respondent was negligent.

Respondent argued that it did not know and should not have known about the cited condition. (*Respondent's Post-Hearing Brief* at 21-22). Specifically, Respondent argued that the footprints were not visible from the roadway. (*Respondent's Post-Hearing Brief* at 22). More broadly, it argued that it had no knowledge that people were entering the barricade. (*Id.*). While the administrative Law Judge credits Respondent's evidence that it did not have actual knowledge of the cited condition, it should have known. The Administrative Law Judge credited the testimony of Inspector Soderlind that the footprints were visible. (Tr. 48). Further, Respondent should have ensured that the barricade was honored and checked to make sure that miners were not using the area. Even a brief glance into the silo would have revealed the footprints and alerted Respondent to the cited condition. Respondent cannot simply overlook an area and then use this oversight to claim that it is not negligent. *See Freeport McMoran Morenci, Inc.*, 2013 WL 1187700, *8 (Jan. 2013)(ALJ Miller)(holding that a condition is not "hidden" simply because it is ignored.). While Respondent did not have actual knowledge of the conditions at the silo, it should have known about the instant violation.

While Respondent was negligent, there were mitigating circumstances. Specifically, Respondent exercised diligence in barricading the area and creating a policy against entering barred places. (Tr. 39, 44, 49-51, 109, 123-124). In light of these mitigating circumstances, a finding of "Moderate" negligence was appropriate.

4. Penalty

As with the previous citation, the Administrative Law Judge finds that a substantial deviation from the Secretary's proposed assessment of \$2,473.00 is warranted herein. Once again, the factors contained in 30 U.S.C. §820(i) will be used to explain that deviation. Those factors are as follows:

(1) The Operator's history of previous violations – Inspector Soderlind credibly testified that Respondent had a history of these violations. (Tr. 48). Respondent's violation history supports this testimony. (GX-1).

(2) The appropriateness of the penalty compared to the size of the Operator's business – As discussed with respect to the earlier citation, Respondent was a large operator with an above-average sized plant.

(3) Whether the Operator was negligent – As previously shown, Respondent's negligence is best characterized as "Moderate."

(4) The effect on the Operator's ability to remain in business – The parties have stipulated that the Orders at issue here would not affect Respondent's ability to remain in business. (JX-1)

(5) The gravity of the violation – As previously shown, the gravity of the cited danger was unlikely likely to result in lost workday and restricted duty injuries to one miner. Further the condition was not S&S.

(6) The demonstrated good-faith of the person charged in attempting to achieve rapid compliance after notification of a violation – The evidence shows the condition was abated rapidly and in good faith.

In light of the Administrative Law Judge's decision to modify the gravity of the cited danger from "Reasonably Likely" and "S&S" to "Unlikely" and "Non-S&S" a reduction in the assessed penalty is appropriate. Therefore, Respondent is hereby **ORDERED** to pay a civil penalty in the amount of \$1,000.00 with respect to this violation.

Citation No. 6564235

I. ISSUE

With respect to Citation No. 6564235, the issues to be determined are whether Respondent's alleged actions on April 11, 2011 were a violation of §56.12032 and, if so, whether that violation was significant and substantial ("S&S"), whether it was reasonably likely to result in fatal injury to one miner, whether it was the result of moderate negligence, and the appropriate penalty for the violation.

II. SUMMARY OF TESTIMONY

On April 11, 2011 Soderlind issued Citation No. 6564235 (GX-9) for a violation of §56.12032 which requires cover plates to remain securely in place on electrical junction boxes and

equipment unless under repair.¹³ (Tr. 51-54). The citation issued at the head end of the 67 conveyor outside of the plant. (Tr. 126). Here, the cover plate for an electrical junction box was hanging, exposing the inner-conductors and electrical terminals.¹⁴ (Tr. 54, 56-57). These were clearly visible and the inch-and-a-half terminals were bare. (Tr. 57, 133). Soderlind could not inspect the inner conductors, but they were covered in dust. (Tr. 58). Aijala saw that the condition was dusty, but this did not mean the plate had been off for a long time, without a tight seal equipment gets dusty quickly. (Tr. 153). He believed that the wires were protected with a rubber coating. (Tr. 133). Fewer than half of the 18 terminals were live. (Tr. 133).

The face plate could have fallen off from vibrations. (Tr. 62, 135). There were brackets to keep the cover plate in place. (Tr. 61). MSHA did not require that all the screws attaching the cover plate to the brackets be tightened, just that the plate be secure. (Tr. 62).

Soderlind testified that a cover plate dangling would be quite apparent. (Tr. 63). The cited area was in continuous use. (Tr. 63). In the cited area, material dropped down into trucks from chutes. (Tr. 63). There was also a conveyor that entered from the yard. (Tr. 63). Sometimes miners would add material from the yard onto the conveyor. (Tr. 63, 126). The material was then sent to the silos and kept there until the ships come. (Tr. 63). Soderlind conceded that the condition was behind a set of stairs. (Tr. 94). He could not recall if he could see the condition from the ground level, but he saw it as he was walking up the stairs to the area. (Tr. 94-95). Aijala testified that this area was very infrequently traveled. (Tr. 126). He stated no one was aware of the condition. (Tr. 135). If someone had been aware, they would have called an electrician to put the box back on. (Tr. 135).

Miners would be in the cited area to clean with the hose and to examine. (Tr. 55, 60). Hoses were used to clean out two chutes that feed two belts. (Tr. 55-56, 127). When miners were hosing, they stood near the chutes. (Tr. 155). These hoses were high pressure, powerful enough to knock a miner down. (Tr. 61). Only one miner would be using the hose at a time. (Tr. 61). The chutes were cleaned four times a year when a crushed pellet product called sinter was shipped. (Tr. 127-128, 152-153, 156). Sinter does not flow like pellets and can clog the chutes. (Tr. 128, 152). Cleaning out the chute occurs outside in the elements, so there could be rain or snow. (Tr. 153-154). Shipping occurred between late March and the middle of January. (Tr. 156). However, there was still snow and ice during the shipping season. (Tr. 156). No one would be in the area and no cleaning would occur during the non-shipping season. (Tr. 153). At the time of the citation, no sinter boars had been to the plant in 2011. (Tr. 152, 156).

There was also a hose lying in the walkway near the junction box. (Tr. 59, 126). A miner could trip over the hose if he was walking in the area and did not see it. (Tr. 59, 64). A miner entering area to reach the electrical box and might be carrying a shovel or tools. (Tr. 59). Soderlind testified the hose added to the hazard of the open box, making injury more likely. (Tr.

¹³ Aiajala accompanied Soderlind. (Tr. 126).

¹⁴ The junction box was about four and a half to five feet off the ground. (Tr. 57). There was a handrail under the box, 44-inches off the ground. (Tr. 57). The box was between a foot-and-a-half and two feet above the handrail. (Tr. 57).

59-60). Aijala testified that contact with these terminals was unlikely because someone would have to fall against the wires. (Tr. 134). A fall was unlikely because there was no tripping hazard. (Tr. 124). Contact with these terminals was unlikely because someone would have to fall against the wires. (Tr. 134). He stated the hose did not present a tripping hazard because it was coiled in a ball, the lighting was good (it was daylight), and there was room to walk around. (Tr. 132). At nighttime this area was well-lit with overhead sodium vapor lights. (Tr. 132). The floor in this location was grated. (Tr. 156).

There were controls mounted on the cover plate. (Tr. 55, 57). These controlled the ram and the limit switch.¹⁵ (Tr. 54). In order to use the controls a miner would put the plate back on the box. (Tr. 91). However, Soderlind believed it was possible to use the box while the face was hanging off. (Tr. 92, 100). Soderlind did not believe they would do so, it would make more sense to put the face back on. (Tr. 92). He conceded that tripping over the hose was the most likely hazard. (Tr. 92).

The citation was issued out in the yard and dock, the outside area of the mine. (Tr. 55, 58, 62). This increased the hazard because the box was exposed to the elements. (Tr. 58). Over time the jackets from the wires would wear out. (Tr. 58).

The box was energized. (Tr. 58). Soderlind testified that an electrician verified that this box was 110 volts, which is sufficient to kill a person. (Tr. 57, 60). In order to kill, 110 volts would just need a path through the body; the miner would need to touch the box and, with the other hand, some metal to complete the circuit. (Tr. 60). There were metal handrails, stairs, and other structure in the area. (Tr. 60). In Aijala's experience, 110 volts was not enough to prove fatal. (Tr. 134-135, 151). Someone would just be shocked and then pull away. (Tr. 135). However, he conceded he was aware that 110 volts could kill someone. (Tr. 151). That voltage was the most common voltage and it was the most common cause of electrical death. (Tr. 151).

Aijala testified that the cited control box was not in use for any reason, though it had been used before. (Tr. 128-129, 150). A new control box had been built behind the stairway near the cited location. (Tr. 129-130). As a result, there would be no reason to enter this area because the new box was installed. (Tr. 132-133). Accessing the new box would not require walking past the one cited. (Tr. 131). Upon coming up the stairway in the area, the cited box was on the left, the new box was on the right. (Tr. 131-132). Aijala conceded the old box was not being repaired and not being tested. (Tr. 150). The cover plate was not off for maintenance. (Tr. 54, 150). Aijala further conceded that the old box was still energized. (Tr. 151). Aijala told the inspector about the new box. (Tr. 135-136). However, while the box was no longer in use, people still entered the area to hose out the sinter. (Tr. 151-152). People doing this task would not be focused on the box. (Tr. 152).

¹⁵ Soderlind was not sure was the ram and limit switch were. (Tr. 55). The cited area was a truck dump area and he believed the switch was related to clearing the chute, but was not sure. (Tr. 55). Aijala testified that the controls were used to move the cylinder back and forth between the belts. (Tr. 128-129). If maintenance was working on one of the belts it would use the control box to direct the reclaimed pellets onto the other belt so one belt would continue to run while they worked. (Tr. 129).

The citation was marked “reasonably likely” because there was a hose in the walkway and the junction box was exposed to the elements and water from the hose. (Tr. 64). Water sprayed into the terminals may have increased the corrosion or tripped something. (Tr. 65).

The citation was marked “fatal” because this condition could lead to fatal electrocution, burns, or shocks. (Tr. 65). A shock of 110 volts could cause a person to lose control of his muscles and the ability to release something from his grip. (Tr. 65-66). Soderlind had read of these types of injuries, he has never seen one himself. (Tr. 66). The citation was marked as affecting one person because it was likely only one miner would be in the area. (Tr. 66).

The citation was marked S&S. (Tr. 66). The specific hazard was the electrical risk of the open cover plate. (Tr. 66). The hazard would be likely to occur because miners were in the area, the area was exposed to the elements, and there was dust in the box. (Tr. 66-67). The citation was issued in April, so there could have been ice or snow. (Tr. 67). Under continuing mining operations, an injury was reasonably likely. (Tr. 67).

The citation was marked as “moderate” negligence because the condition was in an open and obvious area of the mine, the area experienced a lot of foot and vehicle traffic, and it could be seen from outside. (Tr. 67-68). The office was nearby and all employees traveled through the area to get to the silos, the boats, or the yard. (Tr. 68). Further, the dust in the box and on the conductors inside indicated the condition had existed for some time. (Tr. 68).

To terminate the condition, Respondent screwed the four corners of the plate into the existing metal framing. (Tr. 62, 68).

III. FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. The Secretary Has Carried His Burden Of Proof By A Preponderance Of The Evidence That §56.12032 Was Violated.

On April 11, 2011, Inspector Soderlind issued a 104(a) Citation, Citation No. 6564235 to Respondent. Section 8 of that Order, Condition or Practice, reads as follows:

Yards & Docks – The cover plate for the ram and limit switch, with control switches mounted on the face, was dangling by live 110 volt inner conductors. This was located at the shuttle level below the head of the 67 conveyor. A 1 ½ inch water hose was also in the walkway, creating an additional tripping hazard (See Citation #6564236). This condition exposes miners to electrical hazards resulting in serious injury.

(GX-9).

Standard 30 C.F.R. §56.12032 (“Inspection and Cover Plates”) provides the following:

Inspection and cover plates on electrical equipment and junction boxes shall be kept in place at all times except during testing or repairs.

30 C.F.R. §56.12032.

In the instant case, it is uncontested that there was a cover plate loose from a junction box at the head of the 67 conveyor. (Tr. 51, 54, 56). There was no evidence that the box was being tested or repaired. (Tr. 150).

In its’ brief, Respondent did not argue against the validity of Citation No. 6564235. The Administrative Law Judge finds that Respondent conceded that it violated the standard. In light of this fact, and the evidence presented, the Administrative Law Judge finds that this citation was valid.

2. Considering The Record *In Toto* And Applying Applicable Case Law, The Violation Was Significant And Substantial In Nature And Reasonably Likely to Result in a Fatal Injury

Inspector Soderlind marked the gravity of the cited danger in Citation No. 6564235 “Reasonably Likely” to result in “Fatal” injury to one person. (GX-9). These determinations are supported by a preponderance of the evidence.

The event against which the instant standard, 30 C.F.R. §56.12032, is directed is electrocution by contact with live electrical equipment. In the instant case, the cited condition, the hanging cover plate, exposed miners to bare terminals and conductors. (Tr. 55, 60). The terminals were live. (Tr. 58). Inspector Soderlind credibly testified that, miners worked in this area and were exposed to the electrical hazard. Further, a hose located in the area creating a tripping hazard which increased the chances of contact with the junction box. (Tr. 59, 64, 126). As a result, the Administrative Law Judge finds that contact with the electrical equipment was reasonably likely. Soderlind also credibly testified that if a miner were to contact this electrical equipment, the 110 volt charge was sufficient to cause fatal injuries to one miner. (Tr. 57, 60).

Respondent provided several arguments asserting that an accident was unlikely and that a 110 volt shock would be unlikely. As Respondent addressed those arguments as they related to the S&S designation, they will be discussed *infra*.

Citation No. 6564235 was marked by Inspector Soderlind as S&S. (GX-9). It has already been established that the first element of the *Mathies* S&S analysis, the underlying violation of a mandatory safety standard, has been established with respect to this citation. As discussed *supra*, Respondent violated 30 C.F.R. 30 C.F.R. §56.12032.

The second element of *Mathies*, a discrete safety hazard – that is a measure of danger to safety – contributed to by the violation, is also met. The preponderance of the evidence shows there cited condition, a hanging cover for a junction box, contributed to the hazard of contacting

live electrical terminals. Specifically, the uncontested evidence showed that the cover of the junction box was off and that the terminals within were live. (Tr. 54, 56-58, 151). The fact that the wires were exposed increased the likelihood that a miner would be electrocuted.

Respondent produced several arguments for the proposition that this condition posed no hazards. None of these arguments are persuasive. First, Respondent argued that there was no reasonable hazard because miners rarely entered the cited area, limiting exposure. (*Respondent's Post-Hearing Brief* at 27-28 citing *Essroc Cement Corp.*, 33 FMSHRC 459, 467-68 (Feb. 2011)(ALJ Manning); *Buffalo Crushed Stone*, 16 FMSHRC 2154, 2158 (Oct. 1994)(ALJ Weisberger); *Danaco Exploration International*, 13 FMSHRC 1962, 1966 (Dec. 1991)(ALJ Morris); and *Higman Sand & Gravel, Inc.*, 27 FMSHRC 641, 643-44 (Sep. 2005)(ALJ Manning)). Respondent argued extensively that the instant citation is similar to the condition in *Higman Sand & Gravel, Inc.* In that case, the ALJ found that the cited condition was located in an area where, under normal mining conditions, no miners would ever enter. 27 FMSHRC at 643-644. Respondent argued that this was analogous to the instant situation wherein miners only entered the cited area four times a year. (*Id.*).

While it is true that miners were not always exposed to the cited violation, under continued normal mining conditions, exposure was certain. Unlike in *Higman Sand & Gravel, Inc.*, if the condition had not been abated, miners eventually would have been ordered into this area to clean out the chutes. This would have occurred at least four times a year. (Tr. 127-128, 152-153, 156). Therefore, there would have been exposure. When working on the chutes, miners would have been working in wet conditions and exposed to the elements in the direct vicinity of the cited box. (Tr. 153-154, 156). There would also have been tripping hazards in the area. (Tr. 54, 64). Therefore, unlike in *Higman Sand & Gravel, Inc.*, miners would actually be exposed to the junction box.

Respondent also argued that the cited box was old and no longer in use, thereby eliminating exposure to the cited condition. (*Respondent's Post-Hearing Brief* at 27-28). Respondent noted that Soderlind was not aware that there was a new box when he cited the exposed junction box. (*Id.*). However, the fact that there was a new junction box probably increased, rather than decreased, the chances that a miner would contact the bare terminals. Miners working in this area would know that there was a new junction box. Further, given the decrepit condition of the cited box, miners would reasonably conclude that the box was no longer in use and, as a result, no longer energized. Miners might touch the box or simply behave less cautiously around it believing that Respondent would not energize unnecessary electrical equipment, increasing the chances for exposure. In effect, an "old" energized junction box might have a greater chance of dangerous conduct than a "new" energized junction box.

Respondent also argued that miners working in this area would be using the hose, so it would not present a tripping hazard. (*Respondent's Post-Hearing Brief* at 30). Further, the hose was sprayed away from the cited box. (*Id.*). The Administrative Law Judge finds that a preponderance of the evidence supports a finding that the cited condition poses an S&S hazard even without a tripping hazard. There was an open junction box with live electrical terminals in an area where miners were working. (Tr. 51, 54, 56-59, 64, 126, 151). The possibility that there was a tripping hazard merely adds to that existing danger. Further, even if miners would be

using the hose and spraying away from the junction box, under normal mining conditions there would still be situations where the hose would be placed on the ground or when water was on the ground, creating tripping hazards. Respondent's argument in no way limits the hazard.

In light of the foregoing, the Administrative Law Judge finds that the second prong of *Mathies* is met.

The third element of the *Mathies* test – a reasonable likelihood that the hazard contributed to will result in an injury – is also met. In the event that a miner were to contact the electrical terminal, he would be electrocuted by 110 volts of electrical current. (Tr. 57, 60). There is no question that this would cause an injury.

The fourth element - a reasonable likelihood that the injury in question will be of a reasonably serious nature – is also met. There is no question that electrocution could cause serious injury or even death. (Tr. 57, 60, 151). The voltage in the cited junction box, 110 volts, has caused more fatal electrocutions than any other voltage. (Tr. 151). As a result, the fourth prong of *Mathies* is met.

The Administrative Law Judge finds that the cited condition was reasonably likely to result in a fatal injury to one miner. Further, the cited condition was S&S.

3. Respondent's Conduct Displayed Moderate Negligence

In the citation at issue, Inspector Soderlind found that the operator's conduct was moderately negligent in character. A preponderance of the evidence supports this determination. Respondent knew or should have known of the cited condition. The condition was open and obvious and was located near the office, the roadway and the truck load out area. (Tr. 63, 67-68). Further, Respondent knew that vibrations could cause junction boxes to become uncovered. (Tr. 135). Further, because it had ordered the junction box to be replaced, Respondent had to be aware that it had an energized junction box that was no longer being examined or maintained. As a result, Respondent was negligent.

Respondent offered several argument to show that it did not know and should not have known about the cited condition. First, Respondent argued that this was not a high traffic area and the condition was not readily visible. (*Respondent's Post-Hearing Brief* at 31). As noted *supra*, while miners may not have been at the cited junction box at all times, it was in a general area where miners and management would be traveling and working. Further, Respondent knew that it had an abandoned, but energized, junction box that was no longer being maintained and examined. As a result, it should have known that the box could pose a hazard and was negligent.

Respondent also argued that this condition was likely caused by vibrations, meaning that no one would notice it as it occurred. (*Respondent's Post-Hearing Brief* at 31). Respondent was clearly aware that vibrations could cause the cover plate to fall off. (Tr. 135). Therefore, it should have been aware that the cited condition was possible and acted affirmatively to prevent or correct it. Therefore, Respondent was negligent.

While Respondent was negligent, there were mitigating circumstances. Specifically, miners were not working in this area at all times. (Tr. 127-128, 152-153, 156). As a result, a finding of moderate negligence was appropriate.

4. Penalty

In light of the fact that the Administrative Law Judge has affirmed the Secretary's citation as issued, it is appropriate to affirm the assessed penalty as issued. Therefore, Respondent is hereby **ORDERED** to pay a civil penalty in the amount of \$11,306.00 with respect to this violation.

Citation No. 6564248

I. ISSUE

With respect to Citation No. 6564248, the issues to be determined are whether Respondent's alleged actions on April 18, 2011 were a violation of §56.20003(b) and, if so, whether that violation was significant and substantial ("S&S"), whether it was reasonably likely to result in lost workday/restricted duty injury to one miner, whether it was the result of moderate negligence, and the appropriate penalty for the violation.

II. SUMMARY OF TESTIMONY

On April 18, 2011 Soderlind issued Citation No. 6564248 (GX-12) for a violation of 56.20003(b) which requires every work area and passageway be kept clean, orderly, and dry. (Tr. 68-70). Here, the area behind the tail end of the 45 conveyor was wet, slippery, and had a buildup of taconite fines on the floor. (Tr. 70, 95, 138). He did not measure how deep it was. (Tr. 75). There was also a pellet spill nearby. (Tr. 70, 72). Loose pellets are like marbles. (Tr. 73). Some pellets were in the wet fines but others were in a different area. (Tr. 95). The condition could have occurred during a shift. (Tr. 75).

Soderlind knew this area was wet, muddy and slippery because he tested it with his foot. (Tr. 71, 75). He did not walk through the material. (Tr. 96). There was a lot of moisture and steam in the mine. (Tr. 74). Water could also spill in this area. (Tr. 74-75). The cited area was low in the mine and so water would settle there. (Tr. 75). Aijala believed that the fines were dry and had good traction because he drug his feet across them. (Tr. 137-138). He also did not walk through the fines. (Tr. 154).

Soderlind observed footprints in the muddy conditions on the floor, but he could not tell if there was more than one set. (Tr. 72, 80). Aijala believed that the footprints in the material showed good traction because they were well-defined, rather than showing a slip. (Tr. 137-138). There was no evidence anyone had slipped. (Tr. 138).

According to Soderlind, miners accessed this area on foot often, through a set of double doors, to access the plant. (Tr. 72-74). Miners would either go through the doors, climb the stairs, or take the walkway around the conveyor. (Tr. 74). When traveling through this area,

miners might be carrying tools or equipment. (Tr. 76). The cited conditions were about ten feet from the stairs. (Tr. 73). Aijala testified that the tail end of 45 conveyor was remote. (Tr. 136). He stated miners did not normally travel in this area during the normal routine. (Tr. 136-137).

At the plant, miners act as representatives for Respondent and identify, report, and correct hazards. (Tr. 80). Workers were to “clean through” meaning that if miners have to travel through an area with a hazard they have to stop and clean up. (Tr. 76). This was not a written policy. (Tr. 154). If a miner did not have time to clean, the area was barricaded off with danger tape and the condition recorded. (Tr. 76). The length of time between taping off and cleaning the condition would depend on the worker’s schedule. (Tr. 154-155). In the cited area, there was no barricade or danger tape. (Tr. 76, 154).

Soderlind testified that Respondent did not have a cleaning crew, but other similar mines hired a cleaning crew or a person to clean conditions constantly. (Tr. 81-82). Aijala testified that Respondent’s day crew cleaned the floors and there were workers on the shift who cleaned. (Tr. 138-139). He believed, under normal mining conditions, this area would be cleaned. (Tr. 139). Soderlind testified that it would take no more than ten minutes to clean the cited condition with a hose. (Tr. 75, 77-78). He had seen similar areas cleaned. (Tr. 75).

The citation was marked “reasonably likely” because there were footprints going through the condition and this was a high traffic area. (Tr. 78). Soderlind believed that someone would eventually slip on the fines or pellets and injure himself. (Tr. 78).

The citation was marked “lost workday/restricted duty” because this condition could lead to sprained or strained ankles, knees, elbows, wrists, or similar conditions. (Tr. 78). This citation was marked as affecting one person. (Tr. 79).

The citation was marked S&S. (Tr. 79). The specific hazard was slip and fall on the pellets or fines. (Tr. 79). Miners slipping on pellets was common. (Tr. 79). The hazard would be likely to occur because miners traveled this area often. (Tr. 79). Under continuing mining operations, an injury was reasonably likely. (Tr. 79-80).

The citation was marked as “moderate” negligence because Respondent had a history of housekeeping violations and because miners traveled through this area often. (Tr. 80). Soderlind had cited Respondent for similar violations and also seen others. (Tr. 81). The cited condition was not “high” negligence because he did not believe that management knowingly told miners to walk through the cited condition. (Tr. 81). However, it was not “low” negligence because it was open, obvious, and should have been addressed. (Tr. 81).

This citation was terminated when Respondent cleaned the cited condition. (Tr. 82). The area was sprayed down, cleared of all the slippery fine material, and the pellets were removed with a hose. (Tr. 77). Pellets could also have been cleaned with a shovel. (Tr. 77).

III. FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. The Secretary Has Carried His Burden Of Proof By A Preponderance Of The Evidence That §56.20003(b) Was Violated.

On April 18, 2011, Inspector Soderlind issued a 104(a) Citation, Citation No. 6564248 to Respondent. Section 8 of that Order, Condition or Practice, reads as follows:

Pellet Plant – The walkway around the tail end of the 45 conveyor was covered in wet, slippery fines material and pellets. The affected area was approximately 20 ft. long by 6 ft. wide with foot tracks coming and going through the entire length of the affected area. This condition exposes miners to slip/fall hazards resulting in injury.

(GX-12).

Standard 30 C.F.R. §56.20003(b) (“Housekeeping”) provides the following:

(b) The floor of every workplace shall be maintained in a clean and, so far as possible, dry condition. Where wet processes are used, drainage shall be maintained, and false floors, platforms, mats, or other dry standing places shall be provided where practicable; and

30 C.F.R. §56.20003.

In the instant case, it is uncontested that the walkway near the tail end of the 45 conveyor had an accumulations of fines. (Tr. 70, 72, 95, 138). The cited condition was 20 feet long by 6 feet wide. (Tr. 71-73).

In its’ brief, Respondent did not argue against the validity of Citation No. 6564248. The Administrative Law Judge finds that Respondent conceded that it violated the standard. In light of this fact, and the evidence presented, the Administrative Law Judge finds that this citation was valid.

2. Considering The Record *In Toto* And Applying Applicable Case Law, The Violation Was Significant And Substantial In Nature And Reasonably Likely to Result in a Lost Workday/Restricted Duty Injury

Inspector Soderlind marked the gravity of the cited danger in Citation No. 6564248 “Reasonably Likely” to result in “Lost Workday/Restricted Duty” injury to one person. (GX-12). These determinations are supported by a preponderance of the evidence.

The event against which the instant standard, 30 C.F.R. §56.20003(b), is directed is injury caused by poorly maintained working areas. With respect to the instant citation, the condition, an improperly maintained walkway, exposed miners to the possibility of injury. Inspector Soderlind credibly testified that the walkway was covered in an accumulation of mud

and pellets, creating a slip and fall hazard. (Tr. 70, 72, 95, 138). He knew the area was slippery because he tested it with his foot. (Tr. 71, 75). He also testified that this was a high traffic area. (Tr. 72-74, 79). In fact, he observed footprints through the cited condition, showing that miners were exposed to the condition. (Tr. 72, 80). Therefore, the Administrative Law Judge finds that it was reasonably likely that a miner would suffer a lost workday/restricted duty injury from a slip and fall.

Respondent provided several arguments asserting that an accident was unlikely. As Respondent addressed those arguments as they related to the S&S designation, they will be discussed *infra*.

Citation No. 6564248 was also marked as S&S. (GX-12). It has already been established that the first element of the *Mathies* S&S analysis, the underlying violation of a mandatory safety standard, has been established with respect to this citation. As discussed *supra*, Respondent violated 30 C.F.R. 30 C.F.R. §56.20003(b).

With respect to the second element of *Mathies*, a discrete safety hazard – that is a measure of danger to safety – contributed to by the violation, the preponderance of the evidence shows that the violation created a tripping hazard. Inspector Soderlind credibly testified that that the cited walkway contributed to the hazard of slipping and falling. (Tr. 73, 79). The walkway was covered in accumulations of slippery mud and taconite pellets. (Tr. 70, 72, 95, 138). Soderlind knew the condition was slippery because he tested it with his boot. (Tr. 71, 75). These conditions support a finding that the violation contributed to a discrete safety hazard. *See e.g. Imerys Pigments, LLC*, 28 FMSHRC 180, 182-184 (Mar. 2006)(ALJ Melick).

Respondent produced several arguments for the proposition that this condition posed no hazards. These arguments were not persuasive. First, Respondent argued that the cited condition was located in a remote area with little foot traffic. (*Respondent's Post-Hearing Brief* at 36). Respondent noted that where there was limited exposure, a finding of S&S was inappropriate. (*Id.* at 35 citing *Placerville Industries, Inc.*, 27 FMSHRC 115, 119-21 (2005)(ALJ Manning)). As noted *supra*, Inspector Soderlind credibly testified that miners traveled through this area regularly. (Tr. 72-74, 79). He testified at length about the various directions miners could travel from the walkway. (Tr. 72-74). Further, the fact that footprints were found in the accumulations shows that miners were accessing this area. (Tr. 72, 80). Therefore, the Administrative Law Judge finds that there was sufficient traffic in this area to find S&S.

Respondent also argued that the foot prints in the cited area were minimal and did not show that there was a “regular” hazard. (*Respondent's Post-Hearing Brief* at 36 citing *Patriot Mining*, 31 FMSHRC at 1470). While there may not, at that time, been a large number of footprints, that does not show that this hazard was not S&S. Under normal mining conditions, and without abatement, more miners would have been traveling through this area. (Tr. 79, 80). The fact that only a small number of miners, at the time of the citation, had traveled through the area attests to Respondent's good luck in being cited early, rather a limited amount of exposure.

Finally, Respondent testified that the cited condition was coarse and dry rather than slippery. (*Respondent's Post-Hearing Brief* at 36-37). Aijala testified that he tested the material with his feet and found that it was dry and had good traction. (*Id.*). Further, the "firm" footprints showed that the material was not slick. (*Id.*). The Administrative Law Judge credits the testimony of Inspector Soderlind that the material was wet and slippery. (Tr. 71, 73, 75, 79). The photograph evidence supports a finding that the walkway was slick. (GX-14, p. 1). Further, even if the material was largely dry, it would still make the walkway slippery and increases the likelihood of an injury. As a result, the Administrative Law Judge finds that the sector prong of *Mathies* is met.

The third element of the *Mathies* test – a reasonable likelihood that the hazard contributed to will result in an injury – is also met. In the event that a miner were to slip and fall on the walkway, injuries including sprains, strains, and broken bones would be expected. (Tr. 78).

Respondent argued that there was no evidence that an injury could result beyond the Inspector's experience. While it is possible that no slip and falls had ever caused injury at Respondent's plant, the Administrative Law Judge credits the inspector's testimony that such a fall could result in sprains, strains, and broken bones. (Tr. 78). The inspector's testimony regarding his experience constitutes evidence regarding the likelihood of an injury. *Buck Creek Coal, Inc. v. Federal Mine Safety and Health Admin.*, 52 F.3d 133, 135-136 (7th Cir. 1995) (holding that "no further evidence" beyond the Inspector's testimony is necessary to find that a violation was reasonably likely to result in injury and was S&S); *see also Harlan Cumberland Coal Co.*, 20 FMSHRC 1275, 1278-1279 (Dec. 1998). There is no requirement that the Inspector prove that an injury occurred in this particular case or testify directly regarding an identical situation. As a result, the Administrative Law Judge finds that the third element of *Mathies* is met.

The fourth element - a reasonable likelihood that the injury in question will be of a reasonably serious nature – As noted *supra*, an injury caused by slip and fall would be of a reasonably serious nature.

Respondent argued that a slip and fall type injury would not constitute an injury of a reasonably serious nature. (*Respondent's Post-Hearing Brief* at 37). Respondent cites *Placerville Industries, Inc.*, for the proposition that a slip and fall would not result in a reasonably serious injury. 27 FMSHRC at 121. However, slip and fall injuries are not, as a matter of law, always minor. There are several ALJ cases that find hazards that pose slip-and-fall risks to be S&S. *See e.g. Oak Grove Resources, LLC*, 35 FMSHRC 3039, 3052 (Sept. 2013) (ALJ Zielinski); *Oil-Dri Production Company*, 32 FMSHRC 1761 (Nov. 2010) (ALJ Manning); and *Mach Mining, LLC*, 32 FMSHRC 213 (Feb. 2010) (ALJ Weisberger). The determination of whether a violation is S&S, including whether it would result in a reasonably serious injury is based on the particular circumstances of that violation. *Texasgulf Inc.*, 10 FMSHRC at 501. Therefore, whether the slip and fall injuries expected here would result in a reasonably serious injury must be determined based on the specific circumstances surrounding this violation. The Administrative Law Judge finds the cited condition was extremely wet and slippery and also located in an area where there were staircases and a large amount of equipment. (Tr. 71-75, 79). As a result, a reasonably serious injury was reasonably likely.

The Administrative Law Judge finds that the cited condition was reasonably likely to result in a lost workday/restricted duty injury to one miner. Further, the cited condition was S&S.

3. Respondent's Conduct Displayed Moderate Negligence

In the citation at issue, Inspector Soderlind found that the operator's conduct was moderately negligent in character. A preponderance of the evidence supports this designation. Inspector Soderlind credibly testified that the cited condition was open and obvious. (Tr. 80). Further, Respondent had a history of housekeeping violations, placing them on notice that this type of issue would arise. (Tr. 80, GX-1). While it is likely that Respondent did not have actual knowledge of the cited condition, it should have known. Therefore, it was negligent.

Respondent argued that consideration of the history of housekeeping violations was inappropriate. (*Respondent's Post-Hearing Brief* at 39). Specifically, it noted that the only issue with respect to negligence is whether Respondent knew or should have known of the cited condition and that prior actions do not matter for this inquiry. (*Id.*). Respondent misunderstands the way in which past violations are used in determining negligence. Respondent is not being punished again for past violations, instead past violations are used to show Respondent had notice. *Black Beauty Coal Co. v. Federal Mine Safety and Health Review Com'n*, 703 F.3d 553, 561-562 (D.C.Cir. 2012)(holding that past violations provide awareness to a mine operator and are relevant for both unwarrantable failure and negligence determinations). Showing that Respondent had been cited for housekeeping issues in the past shows that Respondent knew these conditions could and would arise but failed to take proper precautions. As a result, the Administrative Law Judge considers the credible evidence submitted on that point to be relevant to determining Respondent's negligence.

Respondent also argued that it should not have known about the condition because the cited area was remote and rarely traveled. (*Respondent's Post-Hearing Brief* at 38). As discussed with respect to gravity *supra*, the Administrative Law Judge credits the testimony of the inspector that miners traveled with some regularity in this area. (Tr. 72-74, 79). Further, the footprints in the material attested to the fact that miners were required to walk in this area. (Tr. 72, 80). A preponderance of the evidence shows that miners worked in this area. As a result, the failure to maintain it constituted negligence.

While Respondent was negligent, there were mitigating circumstances. Specifically, Inspector Soderlind noted that the mine used a "clean through" program that allowed miners to inspect the mine. (Tr. 81-82). Therefore, management may not have been aware of the cited condition. Further, as Respondent argued, a cleaning crew at the mine was tasked with cleaning these areas. (*Respondent's Post-Hearing Brief* at 38). Eventually, this crew may have cleaned the cited condition even if Respondent had not been cited. As a result, a finding of moderate negligence was appropriate.

4. Penalty

In light of the fact that the Administrative Law Judge has affirmed the Secretary's citation as issued, it is appropriate to affirm the assessed penalty as issued. Therefore, Respondent is hereby **ORDERED** to pay a civil penalty in the amount of \$3,405.00 with respect to this violation.

ORDER

It is hereby **ORDERED** that Citation Nos. 6564267, 6564223, 6564235, and 6564248 are **AFFIRMED** as modified herein.

Respondent is **ORDERED** to pay civil penalties in the total amount of \$17,711.00 within 30 days of the date of this decision.¹⁶

/s/ John Kent Lewis
John Kent Lewis
Administrative Law Judge

Distribution:

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¹⁶ Payment should be sent to: MINE SAFETY AND HEALTH ADMINISTRATION, U.S. DEPARTMENT OF LABOR, PAYMENT OFFICE, P. O. BOX 790390, ST. LOUIS, MO 63179-0390

FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

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February 19, 2014

SECRETARY OF LABOR,	:	CIVIL PENALTY PROCEEDING
MINE SAFETY AND HEALTH	:	
ADMINISTRATION, (MSHA),	:	Docket No. WEST 2013-819-M
Petitioner,	:	A.C. No. 02-00740-321073
	:	
v.	:	
	:	
PAYSON CONCRETE & MATERIALS,	:	
INCORPORATED,	:	
Respondent.	:	Mine: Tonto Pit

DECISION

Appearances: Robert D. Ankeney, Office of the Solicitor, U.S. Department of Labor,
Denver, Colorado for Petitioner;
Tim Hughes, Safety Manager, Payson Concrete & Materials Inc. for
Respondent.

Before: Judge Miller

This case is before me on a petition for assessment of civil penalty filed by the Secretary of Labor, Mine Safety and Health Administration ("MSHA") against Payson Concrete & Materials Incorporated at its Tonto Pit location, pursuant to sections 105 and 110 of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. §§ 815 and 820. This docket involves fourteen citations with penalties assessed pursuant to section 110(i) of the Mine Act which are in dispute. The parties presented testimony and evidence at a hearing held on January 22, 2014 in Phoenix, AZ.

The parties agree that Payson Concrete & Materials Inc. is an operator as defined by the Act, and is subject to the jurisdiction and provisions of the Mine Safety and Health Act. These citations were issued at the Tonto Pit near Mesa, AZ. Citations 8591193, 8591194, 8591195, 8591196, 8591197, 8591198, 8591199, 8591200, 8598401, 8598402, 8598403, 8598404, 8598405, and 8598406 are at issue. The Secretary contends the Respondent repeatedly violated 30 CFR §50.30(a); where the Respondent failed to correctly report the hours worked by Mr. Randall on the quarterly employment reports. Respondent does not dispute that the regulation was violated, but contends that only one citation that covers all quarters should have been issued. MSHA issued a separate citation for each quarter in which hours were not reported and proposed a penalty of \$100.00 for each. The violations are not S&S and were cited as moderate negligence. After a hearing on the matter, I issued a decision on the record, which follows with a number of corrections to provide easier reading, while leaving the substance of the decision.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Taken from transcript:

This case involves 14 citations that were issued by Inspector Horning in March of 2013. The Secretary contends that the respondent repeatedly violated 30 CFR 50.30(a) on each of these 14 citations where the respondent failed to correctly report the hours worked by Mr. Randall on the quarterly employment reports, form 7000-2. Respondent does not dispute that the regulation was violated, but contends that only one citation or, fewer than 14 citations should have been issued. The violation is not at issue. The standard requires that Mr. Randall's hours, like all of those working at the mine, be reported, and they were not.

The issue is the number of citations that were written by Horning. The Secretary issued a citation, one for each quarter where the reporting was incorrect. MSHA contends, and the operator agrees, that Mr. Randall, who is one of the owners of the company and does various tasks at the mine, was omitted from the number of hours worked for 14 quarters, beginning with the first quarter of 2009 through the second quarter of 2012. Inspector Horning, from the MSHA field office in Mesa, Arizona, conducted a Part 50 audit of the mine in March of 2013 and found the violations with regard to the 7000-2 forms. He explained the error to Ms. Short, the company bookkeeper and she promptly corrected the error and continues to include Mr. Randall in the form as to this date.

MSHA not only issued a separate citation for each quarter in which Mr. Randall's hours were not reported, they also issued a proposed penalty of \$100.00 for each. The violations are not significant and substantial and originally were marked as a result of moderate negligence. But at hearing prior to the evidence that was submitted by each party, the parties agreed and stipulated that the negligence should be modified from moderate to low. I will modify the negligence in each of the 14 citations from moderate negligence to low negligence. The violation is not really at issue. There is a violation of 30 CFR 50.30 which requires that each -- this is 30 - 50.30(a), each operator of a mine in which an individual worked during any day of a calendar quarter shall complete an MSHA form 7000-2 in accordance with the instruction and criteria in section 50.30-1 and submit the original. And the standard goes on from there. The pertinent part is that all employees, including Mr. Randall, should have been included on the form 7000-2, and he was not. Therefore, I find that there is a violation of 30 CFR 50.30.

The primary issue raised by Respondent is whether or not there should be 14 citations or there should be some fewer number of citations. The second issue is the amount of penalty to be assessed to each of the citations. Mr. Hughes argues on behalf of Payson that the Secretary should have issued fewer than the 14 citations because the mine made a mistake and because the MSHA policy manual, in certain circumstances, directs inspectors to issue only one citation for a series of violations or combine certain kinds of violations into one citation. That's usually when the inspector finds, for example, a number of violations on one piece of equipment, and those violations would be cited under the same standard. They can be placed into one citation instead of issuing a separate citation for each. Respondent makes a good point and it is difficult to understand why -- in some cases, why there have to be 14 citations. However, from a legal standpoint, the standard specifically refers to quarterly reports when it says "each operator during

any day of the calendar quarter” shall report hours worked. I'm not sure MSHA could issue a citation for more than one quarter at a time because of the requirement in the standard itself. The Inspector Citation Writing Manual tells the inspector to issue a citation for each quarter.

Mr. Hughes makes a good point about why it should be different for a paperwork violation than for some safety violations, but that argument goes to the penalty, and that's something that can be dealt with in the penalty portion of this case as opposed to trying to combine more than one quarter into one citation. So I agree with MSHA that the 14 citations were appropriately issued, that one quarter in each citation is the appropriate way to do it.

As the Secretary pointed out, that's consistent with earlier decisions by the Commission ALJs, as well as one of my decisions in the *Eureka Rock*, 34 FMSHRC 476 (July, 2012) (ALJ) where I found that an owner of a mine must be included on the 7000-2 form and that issuing those citations for each quarter was appropriate in that case. I find it was appropriate in this case, as well, that the violation is shown that the 14 citations were appropriate.

PENALTY

What I would like to address is the penalty with regard to each of those 14 citations. The Secretary issued a \$100.00 penalty for each of the 14 violations, which is the minimum penalty under their Part 100 regulations for each of the citations in this case, making a total of \$1,400.00. I am not bound by the Secretary's Part 100 penalty criteria. I am bound by the law and by what the Commission has said and what the statute says about penalties. Section 100(i) of the Mine Act confers upon the Commission, the authority to assess all civil penalties provided under the Act. It further directs that the Commission, in setting penalties, and the Commission judges, shall consider the operator's history of previous violations, the appropriateness of such penalty to the size of the business of the operator, whether the operator was negligent, the effect on the operator's ability to continue in business, the gravity of the violation and the demonstrated good faith of the person charged in attempting to achieve rapid compliance with notification. The Commission reiterated that position recently in the case of *Mining & Property Specialists*, 33 FMSHRC 2961, (December 2011). In that case, the ALJ issued a penalty of \$1.00 for some recordkeeping violations. It was a violation where the mine simply did not have the records in the location where they were supposed to as opposed to another location. The judge issued a lower penalty, and the Commission, on appeal, sent the case back to the judge simply to look at the six criteria again. In reviewing the penalty amount, the Commission determined that under the clear statutory language, the Commission alone is responsible for assessing the penalties and neither the ALJ nor the Commission is bound by the Secretary's proposed penalties or by MSHA's Part 100 regulations. However, while there's no presumption of validity given to the Secretary's proposed assessments, the Commission has held that substantial deviations from the Secretary's proposed assessments must be adequately explained using the section 110(i) criteria. So while I don't need to make exhaustive findings, I have to provide some adequate explanation as to the basis for the penalty that I assess.

In this case, Payton is a small operator. There was definitely good faith abatement. As soon as Ms. Short learned about the problem, she immediately corrected it, and she continues to correct it to this day. The operator has made no issue of its ability to pay the penalty as assessed.

The history of assessed violations, which is Exhibit 20 in this case, shows that there is no history of violations at this mine. I didn't see any history of violations, and specifically no history of recordkeeping violations. So this would have been the first time that it was brought to the attention of the mine. As to the gravity, again, it's difficult to tell why this should be a serious violation. I think it's certainly not S and S. And leaving Mr. Randall off of the report, I didn't see anything from MSHA that would lead me to believe that would result in some serious safety and health or some serious problem for MSHA. I find the gravity in this case to be negligible. And, finally, the parties agree that the negligence was low, and when the Secretary assessed the \$100.00 penalty, she assessed it for moderate negligence, and it has now been changed to low, and I think rightly so. I think as the mine indicated, Ms. Short made a mistake. She had no idea she was doing it wrong, and until it was brought to her attention, she didn't know that she was doing it wrong and therefore the negligence is low.

Based on the six penalty criteria I've just explained and my reasoning for each of those six penalty criteria, I assess a penalty of \$25.00 for each of these 14 violations, and that means that the total penalty for this docket, then, would be \$350.00. So given my findings in this case, there is a violation. I don't find the violations to be very serious. I find the negligence to be very low. And based upon the six penalty criteria as I described, there's a total penalty of the docket of \$350.00. And I will put that in writing and send it to you, and then Payson will have 30 days from the date of that decision to pay the \$350.00.

(End of Transcript).

8591193, 8591194, 8591195, 8591196, 8591197, 8591198, 8591199, 8591200, 8598401, 8598402, 8598403, 8598404, 8598405, and 8598406 were each originally assessed a proposed penalty of \$100.00 for a total amount of \$1,400.00. As noted above, the negligence is modified in each citation to "low" and the penalty for each violation is modified to \$25.00.

Given my above findings, I assess a total penalty of \$350.00. Payson Concrete & Materials, Inc. is hereby **ORDERED** to pay the Secretary of Labor the sum of \$350.00 within 30 days of the date of this decision.

/s/ Margaret A. Miller
Margaret A. Miller
Administrative Law Judge

Distribution:

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Tim Hughes, Payson Concrete and Materials, Inc., 1900 E. Highway 260, Payson, AZ 85541

FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

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February 21, 2014

SECRETARY OF LABOR,	:	CIVIL PENALTY PROCEEDING
MINE SAFETY AND HEALTH	:	
ADMINISTRATION (MSHA),	:	Docket No. VA 2011-605
Petitioner	:	A.C. No. 44-04856-260893-01
	:	
v.	:	
	:	
CONSOLIDATION COAL COMPANY,	:	Mine: Buchanan No. 1
Respondent	:	

AMENDED DECISION AND ORDER

Appearances: Michelle Kim Vaughan, Esq., and Eric H. McMurray, Esq., U.S.
Department of Labor, Arlington, VA for Petitioner

Billy R. Shelton, Esq., Jones, Walters, Turner & Shelton PLLC,
Lexington, KY for Respondent

Before: Judge Rae

This civil penalty docket comes before me on a petition for assessment of civil penalties filed by the Secretary of Labor (“Secretary”), acting through the Mine Safety and Health Administration (“MSHA”), against Consolidation Coal Company (“Consol”) pursuant to sections 105 and 110 of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. §§ 815 and 820 (the “Mine Act” or the “Act”).

This docket contains a total of eleven 104(a) citations issued to Consol during inspections conducted from September 15, 2010 through February 2, 2011. Citation Nos. 8177785 and 8182529 were settled by the parties prior to hearing in a decision issued by me on February 11, 2013. The nine remaining citations carry a total proposed penalty of \$91,200.00. The parties presented testimony and documentary evidence at a hearing in Abingdon, Virginia. Post-hearing briefs were submitted by both parties.

After consideration of the evidence on record and post-hearing briefs submitted by the parties, I find that the Secretary has proven a violation of MSHA standards as alleged in Citation Nos. 81779589, 8178050, 8178068, 8178082, 8178092, 8185012, 8182533 and 8185034 as amended herein. I find the Secretary has not established a violation in Citation No. 8178100 and it is vacated.

This decision is based upon the entire record and my observations of the demeanor of the witnesses.¹

Finding of Fact and Conclusions of Law

At the time these citations were issued, Consol was operating the Buchanan Mine No. 1 located in Buchanan County, Virginia. This mine is a large bituminous coal mine employing 9,000 persons. Mining is done by the long wall method. The mine is considered one of the gassiest mines in the country, liberating in excess of ten million cubic feet of methane every twenty-four hours and was on a five day spot inspection schedule² at the time of this inspection. Tr. 15. Approximately 1,377 inspection days were logged in 2009 equating to four inspectors being on-site each day of the year, twenty-four hours per day. Tr. 17.

The parties stipulated that: Consol is an operator as defined by the Act, that Buchanan Mine No. 1 is a mine and subject to the jurisdiction of the Act, that the Federal Mine Safety Health and Review Commission and its judges have jurisdiction to adjudicate these matters, that the citations issued to Consol were done by an authorized representative of Petitioner and that the proposed penalties will not affect the Respondent's ability to continue in business. Ex. Ct. A.

Citation No. 8177959

Citation No. 8177959 was issued by MSHA inspector Buddy Stanley³ at 11:30 a.m. on September 15, 2010 alleging a violation of 30 C.F.R. §75.202(a) which states, "[t]he roof, face and ribs of areas where persons work or travel shall be supported or otherwise controlled to protect persons from hazards related to falls of the roof, face or rib and coal or rock bursts." The violation was described in the citation as follows:

The face and ribs are not being supported or otherwise controlled to protect persons from the hazards related to falls of the face or ribs in the No. 3 face on the Active 15 right mining section. This face has been undercut one ripper wide 36 inches deeper than the other side and 4 feet high from the mine

¹ In resolving conflicts in testimony, I have taken into consideration the demeanor of the witnesses, their interests in this matter, the inherent probability of their testimony in light of other events, corroboration or lack thereof of testimony given, and consistency or lack thereof within the testimony of a witness and between witnesses.

² Section 103(i) of the Mine Act provides that when a mine liberates in excess of one million cubic feet of methane during a 24-hour period, the Secretary shall perform a minimum of one spot inspection by his authorized representative during every five working days at irregular intervals.

³ Inspector Stanley has been employed by MSHA since October 2008. He received his Authorized Representative ("AR") card in October 2009. His prior experience consists of 22 years as a miner in positions as a section foreman, shift foreman, fire boss and operator of equipment. He attained certifications as a foreman, dust and gas detector and an accident investigator. He was a member of the mine rescue team. Tr. 21-24.

floor. The face has an overhanging brow with a visible crack. These two brows were taken down with very little effort. When measured, the lumps of coal that are on the mine floor are as follows: 2 feet wide by 30 inches long by 11 inches thick, there are three pieces, 20 inches wide by 20 inches long by 6 inches thick. The miner is in the No. 3 right crosscut. From the left rib of this face to the first rib bolt in this break is 24 ½ feet with no support. Miners are required to work in this area.⁴

Ex. S-8.

Stanley recorded on his citation that the operator had been cited 58 times in the previous two years for violations of the same standard. He assessed the violation as reasonably likely to result in lost workday or restricted duty injuries to one person and significant and substantial. He marked the negligence as moderate. The Secretary's proposed penalty is \$4,800.00.

For the reasons set forth below, I affirm the citation as written but modify the negligence to HIGH.

Stanley observed a three foot deep by four foot high cut had been made in the number three face. When the miner backed out, it left a void with two overhanging brows where he saw visible cracks and large pieces of coal and rock as a result. Tr. 27. The area was also improperly rib bolted. Two bolts were two feet from the face and one was between four feet nine inches and five feet nine inches from the face where the roof control plan required it to be within four feet of the face. Tr. 28-29. While it would not have been a violation if the area had been restricted from entry, there were two reflective ribbons hanging up to mark the face but they did not serve to danger off the area. All the face areas have these markers, but when the operator intends to danger off an area they hang multiple ribbons and stretch one across the entry rib to rib. Tr. 29-30. The ribbons were six to eight feet from the face on the last or next to last row of roof bolts, but there were no ribbons hanging from the brows themselves. Tr. 46. There was also no notation in the shift book that the area had been hazardous or closed off although it had been mined in this manner two days earlier and was not going to be mined again for several days. Tr. 57, 68-69, 71-72, 76.

This mine is known to have soft coal and is notorious for draw rock and loose ribs, according to Stanley. The mine roof is seven and one half feet high. When it is undermined in this manner, it is going to fall. Both brows and the ribs had visible cracks. Tr. 31. When a foreman took a slate bar and applied barely any pressure, both brows fell in large pieces landing up to five feet away. Tr. 32, 59-60. MSHA roof control specialists had been conducting meetings with Consol management about the roof and rib conditions every two to three weeks leading up to this inspection, one having taken place just the week before this citation was issued. Tr. 37. Because the conditions were poor, the operator had been advised to take only flush cuts and in the case of overhanging brows or cut out areas, additional supports such as timbers should be installed. Tr. 57-58.

⁴ Grammatical errors in the descriptions from the "Conditions or Practice" sections of the citations have been corrected.

Because the area had not been dangered off, Stanley believed miners would continue to work in and around this area, exposing them to grave danger. The area would be accessed by the foreman, roof bolters, scoop operator and gas checker. Tr. 34.

With regard to whether the standard was violated, the operator asserts only that the ribbons served as a warning not to travel beyond that point, the condition was not hazardous and that Consol's primary focus is on safety. Resp's. Brief. Respondent's witness, Terry Hamilton⁵, testified that the ribbons were placed on the second row of bolts back from the face when the bolting was completed. He confirmed that as the section foreman, he would still go into that area to conduct a pre-shift or on-shift examination or make gas checks. In fact, he confirmed that he would go past the reflectors to do this. Tr. 85. Consol's assistant superintendent, Stephen McBride⁶, testified that the ribbons are not the equivalent of dangering off the area and it does not necessarily mean that a dangerous condition is present; it just means one must exert some caution. Tr. 115-16.

I find the Respondent violated the standard.

Significant & Substantial

An S&S violation is a violation "of such nature as could significantly and substantially contribute to the cause and effect of a . . . mine safety or health hazard." 30 U.S.C. § 814(d). A violation is properly designated S&S, "if, based upon the particular facts surrounding the 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). As is well recognized, in order to establish the S&S nature of a violation, the Secretary must prove: (1) the underlying violation; (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 will be of a reasonably serious nature. *Mathies Coal Co.*, 6 FMSHRC 3-4 (Jan. 1984); *accord Buck Creek Coal Co., Inc.* 52 F. 3rd 133, 135 (7th Cir. 1995); *Austin Power Co., Inc. v. Sec'y of Labor*, 861 F. 2d 99, 103 (5th Cir. 1988) (approving *Mathies* criteria).

It is the third element of the S&S criteria that is the source of most controversies regarding S&S findings. The element is established only if the Secretary proves "a reasonable likelihood the hazard contributed to will result in an event in which there is an injury." *U.S. Steel Mining Co., Inc.*, 7 FMSHRC 1125, 1129 (Aug. 1985). An S&S determination must be based on the particular facts surrounding the violation and must be made in the context of continued normal mining operations. *Texasgulf, Inc.*, 10 FMSHRC 1125 (Aug. 1985); *U.S. Steel*, 7 FMSHRC at 1130. The Commission has emphasized that it is the contribution of a

⁵ Terry Hamilton has been a miner for 31 years, 25 of which he has been a certified foreman. He is also a certified electrician. He works as a section foreman for Consol. Tr. 78-79.

⁶ Stephen McBride began his mining career in 1974 and has worked as a utility foreman, section foreman, general mine foreman and currently as an assistant superintendent. Tr. 95.

violation to the cause and effect of a hazard that must be significant and substantial. *U.S. Steel Mining Co.*, 6 FMSHRC 1824, 1836 (Aug. 1984).

I have found the violation has been established. It contributed to a discrete safety hazard being a rib or roof fall in an area where miners work. Should a fall occur, there is a reasonable likelihood of a reasonably serious injury resulting. Roof and rib falls are known to be responsible for many fatal injuries in the mining industry. The third element of *Mathies* requires a reasonable likelihood of an injury causing event to which the violation contributed.

Stanley testified that the mine is notorious for soft coal, draw rock and loose ribs. Both brows had visible cracks and draw rock which he felt would certainly fall. Tr. 31. In support of his opinion was the fact that applying very little pressure to the brow with a slate bar caused the entire brow to fall in one large piece and then break into pieces as set forth in the written citation, landing on the travelway five feet away where miners work and travel. Tr. 32, 59-62. This fact was confirmed by McBride. Tr. 98, 104. The consensus of testimony was that cracks and loose ribs could develop rather quickly and without warning. This undercut had been made two days prior to the inspection and there were no plans to return to the area again for several more days. Tr. 57, 68-69, 71-72, 76. In the meantime, the foreman was required to travel to the area to make pre-shift and on-shift examinations and take gas readings. Tr. 85. It was extremely likely, therefore, that the roof or rib would fall with continued normal mining operations and that this violation contributed substantially and significantly to that hazard.

The Respondent, while not denying the fact that the material fell with ease over the travelway when lightly prodded with a slate bar, argues that the condition did not pose a hazard. The roof bolters, they contend, would be stationed in the machine on the opposite side from the overhang and not exposed to the danger. It argues that there was no reason for anyone to be in the area. Resp's. Brief. However, it presented no credible evidence that the area was supported, or dangered off, or that bolting was imminent. Instead, it presented its own witnesses who confirmed the section foreman would enter the area beyond the ribbons hanging from the second set of roof bolts at least twice a day to perform his examinations and gas checks, thereby exposing himself to this hazard. The Respondent's position is rejected and I find this violation is S&S.

Negligence

Stanley evaluated the negligence to be moderate. The operator has a history of roof violations, having been cited 58 times in the preceding two years. Tr. 37, Ex. S-8. MSHA specialists had been meeting with Consol personnel every two to three weeks to discuss the hazardous conditions in this mine; the most recent meeting having taken place the week before this inspection. Tr. 37. In fact, they had been told when making cuts that were not flush or where there is an overhanging brow, additional support would be needed. Tr. 58. They had special jacks designed for this purpose which Stanley saw piled up on the surface not being used. Tr. 38. The area had not been dangered off nor had the area been noted in the shift book, indicating to Stanley that the operator had no plans to address the situation. Tr. 68-69. The cut had been made two days prior to the inspection and regardless of whether the cracks developed immediately or sometime thereafter, the foreman had been across the face performing on-shift

examinations and gas checks from the time the cut was made until this condition was cited. However, this condition was neither mentioned to Stanley as he approached the area nor were corrections underway. *Id.*

Respondent did not deny that meetings with MSHA specialists had been taking place prior to and leading up to the date of this inspection as Stanley testified. It further confirmed through McBride that it did have timbers available. Tr. 121. Respondent alleges, however, that it was unaware of the cracks and draw rock until it was pointed out by Stanley. I do not find this claim to be credible. Even if it were true, the operator was put on sufficient notice that heightened awareness was necessary due to the history of roof violations and the rapidity with which cracks could develop and create a hazard. It was aware that this brow was left unsupported for an unreasonable period of time and there were no immediate plans to install additional support or scale it. It made no effort to comply with MSHA's warnings, use the supports readily available or to patrol the area with sufficient frequency to discover the hazard.

Moderate negligence is defined as a situation where "(t)he operator knew or should have known of the violative condition or practice, but there are mitigating circumstances." High negligence is defined as "(t)he operator knew or should have known of the violative condition or practice, and there are no mitigating circumstances." 30 C.F.R. §100.3(d) (Table VIII). In view of the facts, I find there are no mitigating circumstances and that the negligence is more properly assessed as HIGH.

Citation No. 8178050

Citation No. 8178050 was issued by inspector William Ratliff⁷ on October 12, 2010 at 9:30 p.m. for another alleged violation of 30 C.F.R. §75.202(a). The narrative portion of his citation reads:

The right rib at break No. 71 on the 3 East Mains was not adequately supported or otherwise controlled to protect miners from the hazards associated with falling ribs and rock. There was a loose rib with visible cracks over and throughout the rock at the top of the rib. The rock was pulled easily with a bar and measured 12 to 20 inches thick, 25 inches high above the coal, and extended for a distance of 20 feet. When the rock was pulled, several pieces fell on the track. This is the main travelway to all the working sections and is traveled each shift.

⁷ William Ratliff has been employed by MSHA since January 2007. He attained his Authorized Representative status in February 2008. He was in the mining industry for 24 years performing as a foreman, equipment operator, fire boss, explosives handler and roof bolter. He was a certified foreman. Tr. 126-30.

Ex. S-2.⁸

Ratliff assessed the violation as reasonably likely to produce a fatal injury to two persons, S&S, affecting two persons and the result of moderate negligence. The proposed penalty is \$8,400.00.

For the reasons set forth below, I affirm the citation as written but modify the negligence to HIGH.

The Respondent does not contest the violation. Resp's Brief. The facts as the inspector stated were that 3 East Mains is the main travelway. Miners enter and exit this mine by mantrips, both covered and uncovered, that travel along the rails through this area. Tr. 132-33. At break 71 he observed a loose rib with visible cracks measuring twenty feet long. Tr. 132. When pulled with a bar, rock pieces fell onto the track which would endanger miners traveling in a mantrip on that side of the travelway. Tr. 133. These facts adequately establish the violation.

S&S

Ratliff characterized the hazard as S&S because in his opinion, a rib roll or roof fall was reasonably likely to occur, producing serious crushing injuries to miners traveling in this area. The rock that fell when prodded measured up to 20 feet long and 12 to 20 inches thick. Should it fall on a miner traveling in an open mantrip, it could cause a crushed skull, broken bones or other serious injury. There are often as many as 50 mantrips in this area at any one time. The exposure to injury is great. Tr. 133-34. The likelihood of such a fall is also great, taking into consideration the soft coal and the amount of unstable draw rock throughout this area. The area had already been bolted as confirmed by foreman Timonthy Laforce⁹ but the rock had sloughed off creating a brow. Despite being bolted, cracks still developed and were pulled down with ease. Tr. 200-01. Raymond Kinder¹⁰, also acknowledged that the separation between the rock and the coal was readily visible. Tr. 194.

Respondent argues that the third prong of the *Mathies* test has not been met. It argues that the rocks that fell were small, would not strike a passing miner traveling six to eight feet from the rib and would not result in a serious injury. Resp's. Brief. Respondent presented

⁸ Secretary's Exhibit S-2, Citation No. 8178050 and William Ratliff's corresponding inspection notes, were omitted from the official transcript. A duplicate copy was obtained from the Secretary with notice provided to the Respondent and has been appended to the record of trial.

⁹ Timothy Laforce worked in the coal industry for some time in the late 1980s and then returned in 2001. In 2004 he became a member of management with Consol and in 2007 became a section foreman. He is currently a section coordinator. Tr. 196-97.

¹⁰ Raymond Kinder has been a miner for 33 years working as a shift foreman, section foreman, utility foreman and a superintendent. He is currently the assistant general mine foreman. Tr. 180-81.

testimony from Laforce who stated that the rock that was pulled down broke up into smaller chunks of “maybe 50 pounds, if that; you know, something easily a man could handle,” “nothing no big man couldn’t handle.” Tr. 199, 201. The remaining rock that could not be pulled down was bolted to “make it, you know, up to standards as far as our roof control and rib control.” *Id.* I find Laforce’s attitude to be appalling. Apparently, he believes that any **real man** should be able to withstand a 50 pound rock falling on his head without suffering a serious injury. Therefore such a situation is not a hazard that requires remediation unless of course an inspector is on the scene requiring them to bolt the area to “make it up to standards” to comply with the roof control plan.

Robert Baugh¹¹, Consol’s section foreman and safety inspector, testified that the rock came down in pieces ranging from three feet wide to four feet long and three to eight inches thick. Tr. 171. When pulled down, it bounced towards the track but would not hit a miner in a mantrip because there was a curve in the track which caused the rock to fall away from the track. Tr. 172-73. In his mind, the conditions were not hazardous and the rock did not need to be pulled. Tr. 174. However, he went on to say that when a rock is pried off, it must be pried in an upward motion so the person does not lean in towards the rock because the rock has a “tendency” to fall down. Tr. 177. Again, it is alarming that a manager responsible for safety is not concerned that a rock the length and width of a small desk and eight inches thick is a hazard to a miner walking below it. Additionally, I give little weight to Baugh’s recollection that the rocks did not fall on the tracks. Ratliff testified that it did and recorded it in his notes taken at the scene and stated it with specificity in his written citation issued shortly thereafter. Tr. 133, Ex. S-2.

Kinder testified that he also believes the rocks did not land on the track and the condition was not hazardous. Tr. 182-86. However, when asked on cross-examination if he considered a crack in an overhanging brow a hazard, he replied that it depended upon how the cracks are. He went on to say that they bolt areas where there are cracks in the brow to secure them. When pushed for an answer as to why they would install bolts where there was a crack in the brow, he admitted that it was because it was considered a hazard. Tr. 190-91. I find Kinder’s testimony was intentionally evasive and give his testimony little weight.

I find this violation is S&S.

Negligence

The inspector assessed the negligence as moderate, however, upon reconsideration; he felt the negligence was high due to the highly visible nature of the condition, the number of cracks in the rib and the fact that management had been put on heightened awareness of their roof and rib control problems through the ongoing meetings with MSHA. Tr. 152. I agree with Ratliff’s revised assessment of negligence for the same reasons and modify it to HIGH.

¹¹ Robert Baugh has been employed by Consol for 36 years as a roof bolter, miner operator, section foreman and safety inspector for the evening shift which is his current position. Tr. 165-66.

This citation was also issued by Ratliff for a violation of 30 C.F.R. §75.202(a). It was issued on November 16, 2010 at 3:30 a.m. and states as follows:

The right rib on the 4 North No. 1 belt flight at break No. 24 was not adequately supported or otherwise controlled to protect miners from the hazards associated with a rib fall. On the right inby corner at break 24 there was a loose rib with visible cracks over and throughout the rock at the top of the rib. When pulled with a bar the loose rib measured 12 to 18 inches thick, 27 inches high over the coal seam, and extended for a distance of 92 inches. When pulled a large piece of rock (18 inches by 32 inches) and a second piece that measured 6 inches by 40 inches landed on the rail of the track. This is the main supply route for the entire mine and is traveled by miners each shift. This exposes miners to falling rock that would enter mantrips and supply trams.

Ex. S-3.

This alleged violation was assessed as reasonably likely to result in a fatal injury affecting two persons, S&S and the result of moderate negligence. The proposed penalty is \$8,400.00.

For the reasons set forth herein, I affirm the citation but modify the negligence to HIGH.

Ratliff observed a loose rib with visible cracks throughout the rock and the top of the rib. The area was not supported in any manner. With just one pull on a pry bar, the rock easily came down in two pieces which he measured and recorded in his notes as set forth in the citation above. Tr. 208, 219. The slabs landed on the rail of the track of this supply route. This travelway is heavily traveled by the supply crew in mantrips and locomotives as well as on foot. Tr. 209. Ratliff could see rock dust behind the loose rock that had been blown in behind the cracks which indicated to him that the condition had been present for more than one day. *Id.*

Respondent contests this violation, stating that the rock was not likely to come down on its own. In support of this it states that Ratliff acknowledged that the coal rib and rock were flush with one another, citing page 214 of the record of trial. It also cites to page 215 of the record in support of the alleged fact that the coal rib was intact. Resp's Brief. These statements are inaccurate. Counsel for Respondent asked the inspector to confirm that "[t]he rock and the coal are flush one with another...." The inspector responded, "[n]ot to my knowledge...It's not a flush rib." Tr. 215. Ratliff went on to say that the rock had broken loose from the rib and fell out away from the rib. Tr. 215. Respondent's one witness, Richard Perkins¹² acknowledged that there were visible cracks in the rib. Tr. 234. It was his opinion, however, that the rock would not have fallen in the near future and that it took a considerable amount of force and pounding on

¹² Richard Perkins has been with Consol for nine years. He was certified as a foreman in 2001. He has been a miner for 26 years and currently holds the title of safety inspector for Consol. Tr. 231-32.

the rock with the pry bar to make it fall down. Tr. 234-37. I find these statements to be unsupported. Ratliff made notes simultaneously with the inspection in which he recorded that the rock was easily knocked down and landed on the track in large pieces, which he measured. Ex. S-3. I find Ratliff's testimony more credible and reliable as a result. The violation has been established.

S&S

For essentially the same reasons the prior violations were assessed as S&S, this one is S&S as well. The mine is known to have soft coal and a large amount of draw rock that deteriorates without warning in a short period of time resulting roof and rib falls. Under continued normal mining conditions, it was reasonably likely that the rock would have fallen on its own, being unsupported and in very poor condition. It is also reasonably likely, having fallen on the track where miners travel, that such a fall would be reasonably likely to result in reasonably serious injuries. This violation was appropriately assessed as S&S.

Negligence

Ratliff pointed out that this area was traveled frequently. In fact, there was a date, time and initial board within in ten feet of the cited condition that confirms this area was examined regularly and management personnel traveled the route on a daily basis. Tr. 211. In his opinion, the conditions in the mine are subject to rapid deterioration. This standard had been cited 52 times during the preceding two year period and meetings were held every two weeks to discuss these issues. Tr. 212-13. For these reasons, he assessed the negligence as moderate. However, he did not cite to any mitigating factors and I do not find any. I find the negligence is properly assessed as HIGH.

Citation No. 8178082

This citation issued by Ratliff is dated December 1, 2010 at 8:24 a.m. It is also an alleged violation of 30 C.F.R. §75.202(a) with similar conditions to those found at the other locations. This one relates to break No. 3 in by SS# 10763 where a loose rib had visible cracks extending beyond the rib with rock dust present behind the loose section of the rib. It was also easily pulled down and fell in sections measuring from seven to twelve inches thick, four feet high with one section being six feet long another two sections being four feet long. It was assessed as reasonably likely to result in permanently disabling injury to one person, S&S and the result of moderate negligence. The proposed penalty is \$4,800.00. Ex. S-4.

For the reasons set forth herein, I affirm the citation but modify the negligence to HIGH.

This area is also part of the supply route with a shop area nearby. It is located three breaks from the bottom of the mine. It is traveled often and there were footprints located within 12 inches of the cited rib. Tr. 250-53. The conditions stated in the narrative of the citation were

established through Ratliff's testimony and hearing notes. Tr. 250-55, Ex. S-5.¹³ Consol does not contest this violation. I find it has been established.

S&S

Consol argues that there is insufficient evidence that persons would be within the zone of hazard should a fall occur as miners walk towards the middle of the entry rather than beside the rib. Lambright also testified that there is little foot traffic in the area. Tr. 259, 266. For the same reasons the preceding Section 75.202(a) violations were assessed as S&S, Ratliff assessed this one similarly. The rock did not strike the rail when pulled down in this location, however, miners travel by mantrip and on foot within 12 inches of the rib in this area. This was confirmed by his observation of footprints located in the area and the presence of a shop area located nearby. Tr. 254, Ex. S-4, S-5. The rock fell in sizeable pieces up to six feet in length exposing miners in the area to serious injuries such as broken bones in the event of a rock fall. Tr. 254-55. The fact that miners may tend to walk more towards the center of the travelway rather than up against the rib does not lessen the likelihood of being injured by a rib roll of the size documented here. The fact that Ratliff could not say when the footprint was made does not disprove the fact that this area was traveled on foot. I find the S&S designation to be supported by the evidence.

Negligence

The citation was marked as moderate negligence; however, the inspector added that there had not been a pre-shift examination done of this area, for which he issued a citation not contested herein. There was not a date, time and initials board present anywhere to indicate the pre-shift had been done. The condition was obvious, it was located near the outby foreman's shop area and this violation has been cited dozens of time previously. For these reasons, the inspector felt the negligence should be high rather than moderate. For these reasons Ratliff cited and because of the ongoing meeting between MSHA and Consol management regarding roof and rib control problems, I agree and modify the negligence in this citation to HIGH.

Citation No. 8178092

This citation was issued by Inspector Ratliff on December 13, 2010 at 5:25 p.m. for an alleged violation of 30 C.F.R. §75.220(a)(1) which provides, "[e]ach mine operator shall develop and follow a roof control plan, approved by the District Manager, that is suitable to the prevailing geological conditions, and the mining system to be used at the mine. Additional measures shall be taken to protect persons if unusual hazards are encountered." It alleges that:

The approved Roof Control Plan was not being complied with on the 3 East Mains No. 4 belt flight and track. There were 4 timbers that are required by the plan along the No. 4 belt flight that had been dislodged by equipment that was

¹³ The inspector's notes for Citation No. 8178082 were made part of Exhibit S-5 which contains Citation No. 8178092. The document appended to Citation No. 8178082 at Exhibit S-4 is the approved ventilation plan which applies to Citation No. 8185012 found at Exhibit S-1 and Citation No. 8185043 found at Exhibit S-7.

hanging from the power cables and life line at break No. 145 to break No. 146. These 4 timbers were hanging over the 3 East No. 4 conveyor belt. This is the main travel way onto the working sections and is traveled by miners on each shift to and from the sections. There was 2 to 6 inches of draw rock in this area. This condition exposes miners to the hazards associated with loose draw rock falling when the timbers were dislodged and with the hazard of the timbers coming in contact with the moving conveyor belt and being propelled into the travelway.

Ex. S-5.

The condition was cited as reasonably likely to result in permanently disabling injuries to one person, S&S and the result of moderate negligence. The proposed penalty is \$5,200.00.

For the reasons set forth below, I affirm the violation, find moderate negligence but do not find the violation was S&S.

The belt entry had been mined to a width of 24 feet. The top consisted of two to six inches of draw rock. Due to these two factors, the roof control plan required timbers be installed every five feet to take some of the weight off the bolts and support the top. Ex. S-12 pg. 28. Ratliff found that four of these timbers adjacent to the track spanning twenty feet had been dislodged from the top and were leaning over the belt to within 10 inches of it. Tr. 551-55. According to Ratliff's notes taken at the scene, one timber had a single "J" hook on it holding it upright while the other three timbers were being held up by cables hanging from it. The timbers were four feet from the rail. Mantrips traveling nearby would be within 17 inches of the rail. Ex. S-5 pgs. 6-7. This created a hazard because a miner shoveling the belt as well as miners traveling in mantrips would be exposed to a roof fall. Tr. 555. The Respondent does not contest the violation. I find it has been established.

S&S

In the inspector's opinion, the draw rock would fall with continued normal mining operations. He did not, however, find the rock was in any immediate danger of falling and did not require it to be scaled. Tr. 560-61. The timbers had been knocked out of alignment on the previous shift when a piece of machinery was trammed through the track. Tr. 559. To abate the citation, the timbers were simply put back upright and wedged against the roof. Tr. 560. Had they fallen, Ratliff believed there was a likelihood that they would have fallen on the moving belt which could have catapulted them into the travelway. Tr. 566. In order for that to happen, the timber would have to fall on the belt, the cable would have to break and the timber would have to fall on a section of the belt where there was no metal structure below it preventing it from coming in contact with the moving belt itself. Tr. 568. There was no evidence that the remaining timbers inby and outby these four at issue were taking on additional weight. Tr. 590. There was also no evidence that the roof bolts were failing in any way, both indicating that the roof was in good condition in this area. I find that a roof fall in this entry with relatively stable roof conditions that was otherwise adequately supported by the bolts and other timbers was not reasonably likely. I also find the possibility of the timbers falling on the belt and being ejected

into the travelway by the moving conveyor too speculative to be considered reasonably likely. I do not find this violation to be S&S.

Negligence

The moderate negligence for this citation was based upon the fact that the foremen travel this area and the condition was obvious. Tr. 556. Roof control plan violations had been cited 42 times in the preceding two years. Tr. 558. I find that management was aware that equipment had recently trammed through the area that was too wide to fit through the travelway and dislodged the timbers. The foreman should have had it corrected immediately thereafter. I find, however, that the condition had existed for a relatively short period of time and would likely have been corrected on the on-coming shift in mitigation. I find that moderate negligence is appropriate.

Citation No. 8178100

This citation written by Inspector Ratliff was issued on January 3, 2011 at 9:45 a.m. under 30 C.F.R. §75.360(a)(1).¹⁴ The narrative section states:

The preshift examination conducted on the 16 Right Panel 011 MMU was not adequate to protect miners from the hazards associated with inadequate ventilation controls and a build-up of methane. In the No. 3 entry starting at break No. 74 and extending inby for a distance of approximately 90 feet there was inadequate ventilation and from 1.3 to 2.5 percent methane was found in this area. If the preshift examiner had examined the ventilation controls on 011 MMU he should have found this condition. This exposes all miners on the 011 MMU to the hazards associated with a methane buildup and ignition.

Ex. S-6.

The hazard was assessed as reasonably likely to result in a fatal injury to 15 miners, S&S and the result of moderate negligence. This standard was cited 13 times in the preceding two years. The proposed penalty is \$30,200.00.

For the reasons set forth below, I VACATE this citation.

Inspector Ratliff was accompanied by Reggie Lambright¹⁵ on his inspection of the #3 entry 16 right panel which is a 90 foot long entry with a brattice at one end. Ratliff noticed there

¹⁴ 30 C.F.R. §75.360(a)(1) states, in relevant part, “[e]xcept as provided in paragraph (a)(2) of this section, a certified person designated by the operator must make a preshift examination within 3 hours preceding the beginning of any 8-hour interval during which any person is scheduled to work or travel underground. No person other than certified examiners may enter or remain in any underground area unless a preshift examination has been completed for the established 8-hour interval.”

were blocks missing from the brattice and there was no air movement. The methane level in the area was 1.3% at the mouth and 2.5% at the back of the entry. Tr. 277. The level of methane was of concern because at 1.5%, the power needed to be shut off and at 2.5%, the main circuit breaker must be de-energized. Tr. 279. The pre-shift examination on this area had been made three hours prior to the start of the shift, at approximately 4:30 a.m. Ratliff and Tim Greene¹⁶ acknowledged that the pre-shift examination report noted methane at .4% with no hazardous conditions present. Tr. 280, 354. It was Ratliff's opinion that the missing blocks in the brattice created this situation where methane could build up quickly and pose an ignition hazard to miners working in the area. This should have been obvious to the foreman conducting the pre-shift examination and the fact that no hazards were noted during that examination led Ratliff to believe it was an inadequate examination. Tr. 286. Ratliff admitted that there was no activity in this area but denied any recollection of Lambright telling him that no one was scheduled to work in the area. Tr. 285. Lambright testified to this fact and that no one was working within 360 feet of this area. Tr. 312. Greene testified that it had been weeks since any work had been done in the area, contrary to Ratliff's belief that the area had been active the day before. Tr. 370, 286. Greene further stated that it was no surprise that the methane level rose from .4% the day before the inspection to 2.5% when Ratliff tested it. Tr. 367-68. Methane could have come out of the coal since the time the pre-shift was done. Tr. 358. Until the methane reached 1%, they are not required to take any corrective action. Tr. 364. Lambright testified that the methane level can rise very quickly and can be caused by a barometric pressure change. Tr. 316. It is undisputed that there were no ignition sources in the area and it had been rock dusted. Tr. 288, 290-92, 305-06, 355, 358.

There is insufficient evidence from which to conclude that an inadequate pre-shift examination had been done several hours before this citation was issued. A pre-shift examination had been conducted as confirmed by Ratliff and Greene. The only point of contention was whether the methane level was .4% as recorded in the examination book. Had the methane levels not been elevated, the inspector confirmed he would not have issued this citation. Tr. 287. In a mine that liberates 10 to 12 million cubic feet of methane every 24 hours, it is quite conceivable that the levels at the face rose from .4% to 2.5% between the time the pre-shift was done and Ratliff toured the area. I also find credible the testimony that this area was not one in which persons were working or traveling as required by the standard. The Secretary has not proven this violation and I hereby VACATE the citation.

Citation No. 8185012

On January 19, 2011 at 2:20 a.m., Inspector Ratliff issued this citation for an alleged violation of 30 C.F.R. §75.370(a)(1) which provides, "[t]he operator shall develop and follow a ventilation plan approved by the district manager. The plan shall be designed to control methane

¹⁵ Reginald Lambright started mining in 1972 as a general laborer for Consol. He has been involved in mine rescue for 25 years and has been a section foreman for ten years. He currently works in the safety department. Tr. 261-62.

¹⁶ Timothy Greene has 27 years of experience as a miner and has been a foreman since 1992. He is a section foreman. Tr. 348-49.

and respirable dust and shall be suitable to the conditions and mining system at the mine.” The condition cited states:

The approved Ventilation Plan was not being complied with on the 17 Right Panel 014 MMU. In the No. 3 entry inby SS#27740 there was 2856 cfm behind the line curtain in the idle place. The Ventilation Plan requires 6000 cfm behind the line curtain in all idle places when the development panel exceeds 5000 ft. This panel has been developed over 6,300 feet. There was 0.4 percent methane present in the 3 right crosscut at the end of the line curtain. This condition exposes miners to the hazards associated with a buildup of methane and ignition. Three miners were present doing repair work on a roof bolter in the No. 3 entry at this time.

Ex. S-1.

This violation was assessed as being reasonably likely to result in permanently disabling injuries to three miners, S&S and the result of moderate negligence. The same standard had been cited 90 times in the preceding two years. The proposed penalty is \$9,800.00.

I affirm this violation as written for the reasons set forth below.

In July 2010, the mine adopted a supplemental ventilation plan that required a minimum of 6,000 cubic feet per minute (“cfm”) of air in idle places when panels were driven in excess of 5,000 feet. Tr. 321, Ex S- 5. The cited gate entry had been mined to 6,300 feet and had only 2856 cfm of air when Ratliff took a measurement behind the line curtain located four feet from the right rib. Tr. 322, 338.

The Respondent argues that the reason the violation existed was because a piece of equipment had very recently moved through the area knocking down the fly curtain. Because the inspector did not give the operator the opportunity to correct the violation before taking the air reading, the citation should be vacated. Resp’s Brief. I reject this argument for two reasons. First, there is no credible evidence establishing the sequence of events as the Respondent portrays them, and second, such a requirement to correct a violation before a citation can be issued would undermine the purpose of the Mine Act.

Assistant Foreman James Mullins¹⁷ testified that although he was not with the inspector when the citation was issued, he signed a comment sheet recording the operator’s position with respect to this alleged violation. Tr. 379-79, Ex. R-16. He recalled “very vaguely” a piece of equipment came through this area but he “couldn’t recall” if it was a shuttle car, a miner or a roof bolter but he was “thinking” that the operator bumped a timber which pulled the curtain down. Tr. 382. He also could “remember vaguely” that he asked Ratliff or “that it was mentioned” if “they could reset the timber.” Tr. 384. He could not recall what the air reading was that Ratliff

¹⁷ James Mullins has been with Consol for 23 years. Prior to that, he worked for ten years at another mine. He holds certifications as an electrical repairman, maintenance foreman, qualified gas foreman and is currently the assistant shift foreman on the owl shift. Tr. 374-75.

had obtained behind the curtain as it was two years ago. Tr. 385. He never stated when the equipment operator supposedly came through and bumped the timber but he did state that he had not seen it happen. The equipment operator, he said, “told the people – when he backed out, he told us that he believed he knocked that timber out” about a minute or two before Ratliff took his air reading. Tr. 388-89. It was then that Mullins asked Ratliff if he could fix the curtain. Tr. 388. Although Mullins stated that he did not see the equipment strike the timber, he stated that Ratliff and Richard Perkins were already in the intersection and Ratliff was aware of it. Tr. 389. According to Mullins, Ratliff instructed him and Perkins not to touch anything when he asked if he could correct the curtain or at least he “do[es] vaguely remember don’t touch anything.” Tr. 392. Thereafter, Mullins testified that Perkins and Ratliff had already talked about the timber situation prior to Mullins’ arrival on the scene and Mullins did not have the time to speak with Ratliff to inform him that the timber had just been knocked down, contrary to his earlier testimony. Tr. 394. When Mullins confronted Perkins and Ratliff, the equipment had already been backed through the intersection and had been parked in the #3 entry and that “best that [he] can recall, he walked by the equipment and it had been parked. Tr. 395.

Perkins testified that he wrote the comments regarding this violation contained in Ex. R-16. Tr. 400. His version of the events is that immediately after a piece of equipment came through and knocked a timber, Ratliff wanted to take the air reading. Tr. 402. He and Ratliff actually saw the car come through and hit the timber and, contrary to Mullins’ first version of events, Perkins was the one who asked Ratliff if he could fix the curtain. Tr. 403. Despite having accompanied Ratliff to take the air reading, Perkins could not recall where the reading was taken. Tr. 407. The Respondent tried to establish through this witness that Ratliff had an agenda as the reason for not allowing the curtain to be realigned. Counsel asked “have you ever had any conversations with Mr. Ratliff where he indicated anything about, you know, issuing citations to Buchanan or, you know, we can afford to pay citations? Has he made comments about that?” Despite having been so blatantly led by counsel, the best Perkins could say was, “to be honest with you, the best I can recall, you know, he has spoke (sic) about, you know, the money the company has made. But he also said that if – to be honest, I can’t remember exactly. He would talk about this here is – he would tell me, he said, it don’t matter to me whether this citation is written or not, but he said I’m just holding up the law. That’s what he told me. That’s basically what he’d tell me.”

I find that the numerous inconsistencies in each of the Respondent’s statements individually as well as the contradictions between them make them unreliable. I further find that despite the insistence that both individuals supposedly asked Ratliff to repair a curtain that had just been knocked down in their presence, none of this information appears in the comments Perkins made on the day this citation was issued. Ex. R-16. Ratliff also denies this version of events and it does not appear in his notes. There is no credible evidence to establish the operator’s contention that the violation had just occurred in the inspector’s presence or that anyone from the operator had asked Ratliff to reset it.

Assuming *arguendo* that the evidence established that Ratliff saw the curtain being knocked down, and that Perkins and Mullins made such a request to Ratliff, there is no basis for finding Ratliff’s actions improper. Respondent offers no legal basis for its position and I find none. The Act requires that unannounced inspections of the mines be made and citations issued

for violations of mandatory standards as they are found. 30 U.S.C. § 813(a). The Act imposes strict liability for violations found regardless of their cause, in an effort to enforce compliance with safety and health regulations. *Sec'y of Labor v. Nat'l Cement of Cal, Inc.*, 573 F. 3d 788, 795 (D.C. Cir. 2009) (stating that strict liability means liability without fault; it does not mean liability for things that occur outside one's control or supervision). Affording the operator the opportunity to correct violative conditions before the inspector issues a citation would undermine the purpose of the Act. The length of time a violation has existed is more properly a factor taken into consideration in the assessment of the gravity of the violation. I find the violation has been established here.

S&S

It is undisputed that there was a roof bolter in the last open crosscut from the face that was being repaired by three miners at the time this citation was issued. Tr. 326. These miners would have been exposed to a methane buildup due to the lack of ventilation in Ratliff's opinion. *Id.* He was also concerned that the methane level could be at a dangerous level by the time it blew back to where the electricians were working and when the methane monitors would activate. If the bolter was activated at that time, the methane would likely ignite. Tr. 336-37. It is also undisputed that this mine liberates approximately 10 to 12 million cfm of methane every twenty-four hours, much of which is liberated at the faces, making it a gassy mine. Tr. 328. The methane level, as confirmed by the Respondent, can spike quickly at any given moment without warning. Tr. 316. The pre-shift examination done on this section prior to the start of the on-duty shift reported a .4% methane level. Tr. 329. The amount of air present would not be sufficient to off-gas the methane in the event of a spike presenting a significant hazard in the event of an ignition. Tr. 328. The condition was obvious in the inspector's opinion. It was his belief that this confluence of factors made it reasonably likely that an ignition would occur under continued normal mining operations and that serious injuries such as burns and smoke inhalation would be suffered by the three miners in the area making this violation S&S. Tr. 325, 328.

The Respondent refutes the third element of the *Mathies* criteria being met; the presence of an ignition source. It argues that the roof bolter, equipped with two methane spotters, was de-energized and locked and tagged out. Resp's Brief. This statement is not entirely supported by the record, however. Ratliff and Perkins both testified that the roof bolter was de-energized. Neither said it was locked or tagged out. Tr. 331, 379, 401. Only Mullins, who was not present when Ratliff and Perkins entered this area, said it normally would have been locked and tagged out which is not dispositive of it being locked and tagged out in this instance, particularly in light of his very poor memory of the events as set forth above. Tr. 381. Respondent also ignores the fact that the bolter could have been re-energized at any moment in order to test the success of the repair work being done, providing an ignition source for methane. Respondent also notes that the miners also were equipped with methane monitors. Tr. 331. However, as Ratliff credibly testified, he has noticed that at this mine the methane alarms on the spotters are often turned off. Tr. 331.

I find an ignition, fire or combustion was reasonably likely taking into consideration the factors present here. The methane level was .4% hours early when measured during the pre-shift examination. By the Respondent's witnesses' testimony, these two foremen were aware that a

piece of equipment had knocked out the ventilation curtain. That piece of equipment was already parked and left in a crosscut by the time Ratliff and Perkins arrived and yet the curtain had not been repaired although it was an obvious condition. There is no reason to believe that it would have been in the immediate future had the inspector not intervened. Methane levels can and do rise and spike without warning in this gassy mine, especially in areas near the face. The methane could reach significant levels before blowing back to the first open crosscut where miners were working on the roof bolter. The roof bolter was sufficiently close to the face to serve as an ignition source particularly as it was being repaired by electricians who would likely re-energize it at any moment to test the repairs. The presence of methane monitors does not diminish the likelihood of such an event occurring. The amount of air being directed by the curtain in violation of the ventilation control plan was insufficient to reduce the level of methane present. This violation was properly designated as S&S.

Negligence

Moderate negligence was assessed because Ratliff believed the condition had existed for less than one shift based upon the .4% methane reading obtained on the previous pre-shift examination with no hazardous conditions noted. Tr. 329. However, the operator was on heightened notice of the need for better ventilation control based upon the 90 previous violations in two years as well as the change in the ventilation plan being implemented in June 2010 requiring increased air to idle places. I find the relatively short duration of the violation and the rapid abatement (twenty-four minutes) sufficient mitigation to justify a finding of moderate negligence.

Citation No. 8182533

This citation was issued by Mark Hlywa¹⁸ on November 16, 2010 at 9:10 a.m. for an alleged violation of 30 C.F.R. §75.1725(a) which requires that “[m]obile and stationary machinery and equipment shall be maintained in safe operating condition and machinery or equipment in unsafe condition shall be removed from service immediately.” He cited this condition for the following condition:

The “Old Bunker” coal storage system currently in use is not being maintained in safe operating condition. The northwest pull cord emergency stop switch located along the bunker car track does not work properly. There is too much slack in the pull cord cable and when the 48” high pull cord was lowered to the ground, it would not de-energize the system. At another point along this same pull cord, the cord was so loose that it was lying on the mine floor, providing no protection. There are currently 3 contract employees working directly next to the

¹⁸ Inspector Hlywa has been employed by MSHA since June 2008 and received his AR card in November 2009. He attained his Bachelor of Science degree from Virginia Tech in 2002 in mine engineering. In addition to working part-time as a miner in 2001 and 2002 at the Consol Buchanan mine, he became a full-time employee of Consol in 2003 until 2005 as an industrial engineer and foreman. He then worked as a design engineer for a mining equipment manufacturer in 2007 and 2008. Tr. 435.

train car bunker system. It is reasonably likely that a miner would fall into the area between the coal cars and be crushed by the automated moving cars, resulting in fatal injuries. This mine had a fatality at this bunker under similar circumstances in 2001. The operator removed this bunker system from service.

Ex. S-10.

Hlywa marked the citation as S&S and the result of moderate negligence affecting one person. The proposed penalty is \$7,100.00.

I affirm the violation but modify it to non-S&S with low negligence.

The bunker system is an underground railway consisting of twenty-one 55-ton cars weighing up to 1,000 tons when fully loaded that automatically move back and forth along the track accepting and dispensing coal. There are four emergency stop cords, two on the north side of the track and two on the south side, that are mounted at waist-height on posts positioned every ten feet spanning the entire length of the track. The cords are approximately one to two feet away from the cars. Tr. 439-41. This electrical cord is attached to a spring loaded switch which remains closed until the cord is pulled thereby shutting off the power to the train. There are two switches on each side of the bunker with 300 feet of cord running from each one. Tr. 486. The only way to manually stop the train in the event of an emergency is to pull the cord and break the connection at the switch. Tr. 443. The train would be deactivated if a miner walked, fell or pushed on, or backed into the cord. Tr. 443. When Hlywa approached the north side of the track, he saw a section of the cord laying the ground. Because the cord cannot function when on the ground, he testified that he issued the citation at that point. Tr. 459-60. Thereafter he walked down the track and pushed the cord all the way to the ground with his foot in a second location and it still did not de-energize the system. Tr. 440; diagram Ex. S-24. He issued the citation under the cited mandatory standard because the cord is part of the mobile equipment, although the cord itself is electrical and is examined weekly as part of the electrical equipment inspection. Tr. 452.

Respondent contests the violation on the basis that the emergency stop cord is electrical cord, not a mobile or stationary piece of equipment, and therefore this mandatory standard does not apply. Because the cord is to be examined weekly, and Hlywa inspected this cord before the next regular weekly examination was due, there is no violation. Resp's Brief. No authority is cited for this most interesting argument by the Respondent. The cord is both a piece of equipment and an integral component of the mobile bunker system covered by the mandatory standard. The Secretary's interpretation of this mandatory standard is consistent with the purposes of the Act and not "plainly erroneous" and is therefore controlling. *Aver v. Robbins*, 519 U.S. 542, 561 (1997); *Western Fuels-Utah Inc.*, 900 F.2d 318 (D.C. Cir. 1990). In addition to finding that this cord fits within the definition of mobile or stationary equipment under this mandatory standard, I also reject the Respondent's position because it is the same argument raised in the previous violations except that it is stretched even thinner in this instance. That a violation cannot be cited before the operator has had an opportunity to perform the weekly electrical examination is rejected for the same reasons I rejected the argument above that the operator should be given an opportunity to correct a violation before a citation is issued. It

would frustrate the very purpose of the Act, expose miners to the dangers contemplated by the cited standard and ignores the strict liability foundation of the Act. In this instance, it would have subjected the miners to the dangers posed by the non-functional emergency stop cord for several more days which is absolutely preposterous. Judge Manning in his *SOL v. Solar Sources Inc.* (Dec. 13, 2013) (LAKE 2011-942, LAKE 2011-1038, LAKE 2012-0231, LAKE 2012-0295) decision similarly rejected the operator's argument that it should be allowed to perform its pre-operational examinations of equipment before a citation can be issued.¹⁹

The Respondent also contends that the cord was working properly. It presented evidence through Rockford Lambert²⁰ that Hlywa kicked the cord off its stand which is why it did not function. When Lambert pulled it, it worked perfectly well. Tr. 487-88. He stated that the cord was not on the ground as Hlywa claimed. Tr. 494. While Hlywa's notes taken contemporaneously with the inspection do not mention the cord being on the ground, they do state that "when the 48" high pull cord was lowered all the way to the ground, it would not de-energize the system." Ex. S-10. He also confirmed that he lowered the cord with his foot which is more credible than having "kicked" it from waist-height down to the ground as alleged by the operator. Hlywa also confirmed that the cord did function properly in all other locations except this one. This evidence would explain how Lambert could have found an area in which the cord did function properly, as he testified. Tr. 439. Lambert confirmed that to abate the violation, slack had to be taken out of the cord. Tr. 493. This supports the Respondent's position that the cable was not sufficiently slack to reach the floor but it also indicates that it was too loose to de-energize the system properly as Hlywa stated. I find that Hlywa's testimony coupled with his notes credibly establish that when he tested the cord, it did not trip the system to stop the bunker cars. The violation has been established.

S&S

The reason this citation was assessed as S&S was because miners regularly work along the walkway beside the tracks performing maintenance, rock dusting and cleaning. There were three miners working on the opposite side of the track cleaning an accumulation of mud, water and coal off the walkway when this citation was issued. Tr. 444-464. If one of them stumbled, they would be able to reach the pull cord and de-energize the bunker. However, if they moved to the other side where the cord was not functional, in the event one of the miners stumbled or lost his balance and fell onto track, it is reasonably likely that a fatal crush-type injury would occur from being struck by the railcar. Tr. 462, 443-44. A fatal accident occurred on June 20, 2002²¹ when a miner was crushed when entrapped between a bunker car and a beam at this same mine

¹⁹ In its recent order dated January 17, 2014, the Commission has denied discretionary review sought by the Respondent on this decision.

²⁰ Rockford Lambert has been a miner for 34 years. He has worked numerous tasks including laying track and working as a certified foreman. He has been certified as a foreman for 29 years. Tr. 478-79.

²¹ The inspector's written citation references a fatal accident that occurred in 2001, however, he corrected this error during his testimony and Ex. S-21 evidences that it occurred in 2002.

operating the same bunker system. The cause of the accident was due to the miner applying lubrication to the bearings of the bunker system while it was energized. Ex. S-21. Hlywa's concern here was not that miners were lubricating the bearings while the system was activated but that a miner could stumble or lose his balance and fall onto the tracks without the cord deactivating the bunker. Tr. 443-44. At the center of the bunker are overhead belts that allow pieces of coal and rock to fall, creating a significant pile of coal that three miners were cleaning up. Tr. 475. Because the inspector had only been to this bunker once before, he could not say how frequently spillage would occur. Tr. 476.

The Respondent maintains that there are no tripping or stumbling hazards that would cause a miner to fall onto the track. The walkway is well lighted, level and generally dry. Tr. 490-91, 476. Any spillage would be cleaned routinely. Tr. 498. None of these claims were refuted by the Secretary.

I find there is insufficient evidence to establish that it is reasonably likely that a miner would trip or fall onto the track; this violation is not properly assessed as S&S. Hlywa could not say how frequently spillage would occur creating a tripping hazard and did not disagree with Lambert that the area, except where a spill was being attended to, was dry, level and well lit. There is no basis upon which to find a trip or fall was likely to occur.

Negligence

Based upon the prior fatality at the old bunker system and the fact that a prudent pre-shift or on-shift examiner would have seen this condition, Hlywa assessed the negligence as moderate. Tr. 446-47. The root cause of the prior accident in this area, however, occurred as the result of an entirely different set of circumstances from those presented here. Based upon the evidence that the violation was abated by taking up only nine inches of slack, I find the condition was not as apparent as the Secretary proposes. I do not find sufficient evidence that the cord was lying on the ground as the inspector testified as his notes to not reflect this important detail. It appears from his notes that he issued the citation after he lowered the cord to the ground and found that it did not work. I also find that the operator was properly maintaining the area along the walkway to prevent the build-up of accumulations which could cause tripping hazards. For these reasons, I find the negligence is properly assessed as LOW.

Citation No. 8185034

This citation was issued by Inspector Ratliff on February 2, 2011 at 4:35 p.m. for a second alleged violation of the approved ventilation plan under 30 C.F.R. §75.370(a)(1). The narrative section of the citation reads:

The approved Ventilation Plan was not being complied with on the 17 Right Panel 013 MMU. In the No. 2 left face inby SS# 27796 there was only 748 cfm behind the line curtain. The 17 Right Panel has been developed over 7,000 feet deep and the Ventilation Plan requires at least 6,000 cfm in all idle places. There was 1.5 percent of methane found in the face of the 2 left crosscut. This

condition exposes miners to the hazards associated with a build-up of methane and an ignition. Two miners were working in the No. 2 entry at this time.

Ex. S-7.

The citation is assessed as reasonably likely to result in a fatality to two miners, S&S and the result of moderate negligence. The same standard had been cited 90 times in the preceding two years. The proposed penalty is \$12,500.00.

I affirm the violation as non-S&S with low negligence as explained below.

As the inspector was walking up the 2 left entry, a roof bolter was backing out of the 2 left crosscut coming from the face at the end of the shift. Tr. 512, Ex. S-7. The evening crew had just arrived on the section. Ratliff took an air reading at the face of the 2 left crosscut approximately 150 feet from where the roof bolter was located. Tr. 516, Ex. R-12. He measured 748 cfm behind the line curtain that extended up to the face in this area. Tr. 517, Ex. S-7. He noticed that the bottom of the curtain had been pulled against the rib which he surmised had happened when the roof bolter was backed out at the end of the previous shift according to his in-court testimony. Tr. 520-21. Ratliff also obtained a methane reading of 1.5 at the face. Tr. 517-18. As a result of these findings, he issued the citation.

The Respondent takes the position once again that it should have been given the opportunity to correct the violation prior to the issuance of the citation. Resp's Brief. Ronald Ratliff²² testified that the roof bolter located in the 2 left crosscut had dislodged a pogo stick holding the line curtain away from the rib when it backed out of the face. Tr. 533. At the time he and the inspector arrived at this location at 4:15 p.m., the second shift foreman had not yet had the opportunity to make his imminent danger run because he was conducting his safety meeting with the on-coming crew. Tr. 532. The pre-operational checks on the machinery would normally be done at 5 p.m., forty-five minutes after he and Ratliff arrived. Tr. 528-29. He stated that he could not be sure when the curtain had been dislodged but he felt it could have been on the off-going shift. Tr. 536. When he saw the dislodged curtain, he started to fix it but the inspector stopped him in order to take the air reading first. Tr. 530.

Gregory Smith²³ testified that his general practice at the start of the evening shift is to make an imminent danger run at the face taking methane and air readings and noting conditions that require corrections before production begins. Tr. 541. At the time the inspector and Ronald Ratliff arrived at the section, the crew had not begun production and he had not yet made his imminent danger run. Tr. 541. Had he been able to do so, he would have corrected the ventilation controls. Tr. 542. He further stated that there had been a similar instance in the past where Inspector Ratliff witnessed a fly pad being knocked down and he did not allow the

²² Ronald Ratliff is a mine foreman certified in 2000. He was a safety inspector at the time of the hearing. Tr. 525-26.

²³ Smith began his mining career in 2000 working on conveyor belts and then became a certified foreman in 2011. He is currently a section supervisor on the evening shift.

foreman to reinstall it before taking an air reading. He testified, “I think he may have wrote (sic) citation on low air at that time.” Tr. 544. Respondent mischaracterized this testimony in its post-hearing brief by stating that the witness confirmed there were other similar **occurrences** and that a violation **was issued**. The Respondent offered no evidence to confirm this alleged event or that a citation was issued. I find the testimony uncorroborated and unreliable.

For the same reasons I discounted the Respondent’s argument that it should have been given an opportunity to correct a violation before it was cited, I reject it in this instance as well. I find the violation has been established.

S&S

As previously stated, this mine is an extremely gassy mine with methane being liberated from the faces on a constant basis. Ratliff confirmed that there were no ignition sources present and the area was well rock dusted, however, he had no memory of whether the area was wet or dry. Tr. 518. The roof bolter was approximately 150 feet from the cited area and was de-energized. Under normal continued mining operations, production would not have commenced until the foreman had completed his imminent danger run, taken his air and gas readings, and the bolter operator had done his pre-operational checks. Both would have been done within approximately twenty minutes of the time the citation was issued. The lack of air velocity as well as the elevated methane reading would have been detected at that time and the curtain repaired. For this reason, I find that the possibility of an ignition or explosion was not reasonably likely.

Negligence

The Secretary’s position is that moderate negligence is appropriate because the foreman should have been aware of this violation. The equipment that caused the line curtain to become displaced had completed its move on the preceding night shift giving the Respondent sufficient time and opportunity to discover and correct the condition. Sec’y’s Brief. I do not find this position supported by the evidence. The inspector testified that the roof bolter that displaced the curtain was “at the mouth of the face, **backing** out of the face” when he arrived at the cited location. Tr. 512. He went on to say, without referencing his notes, that the roof bolter was already parked and denied that he had testified earlier that it was being moved when he arrived. Tr. 519. He stated that nothing was going on when he arrived at 4:35. *Id.* His notes taken contemporaneously with his inspection, however, clearly state that “[t]he day shift belt crew was backing the Fletcher Dual head roof bolter out of the 2 left crosscut **as I walked up the # 2 entry. 4:35pm.**” Ex. S-6 (emphasis added). I find the notes taken at the time of the violation are a more accurate recording of the events than the inspector’s memory at the time of the hearing. They establish that the violation had very recently occurred providing the operator with far less opportunity to become aware of the violation than the Secretary alleges.

The violation was also not entirely obvious. As the Secretary confirms, the curtain was not completely sucked in against the rib and it was not a foregone conclusion that there would be insufficient ventilation behind it. Sec’y’s Brief.

For these reasons I find that the operator's negligence is more appropriately assessed as LOW.

Civil Penalties

The Commission has reiterated in *Mize Granite Quarries, Inc.*, 34 FMSHRC 1760, 1763-64 (Aug. 2012):

Section 110(i) of the Mine Act grants the Commission the authority to assess all civil penalties provided under the Act. 30 U.S.C. §820(i). It further directs that the Commission, in determining penalty amounts, shall consider:

The operator's history of previous violations, the appropriateness of such penalty to the size of the business of the operator charged, whether the operator was negligent, the effect on the operator's ability to continue in business, the gravity of the violation, and the demonstrated good faith of the person charged in attempting to achieve rapid compliance after notification of a violation.

30 U.S.C. § 820(i).

The Commission and its ALJs are not bound by the penalties proposed by the Secretary nor are they governed by MSHA's Part 100 regulations, although substantial deviations from the proposed penalties must be explained using the section 110(i) criteria.²⁴ See *Sellersburg Stone Co.*, 5 FMSHRC at 293. In addition to considering the 110(i) criteria, the judge must provide a sufficient factual basis upon which the Commission can perform its review function. See *Martin Co. Coal Corp.*, 28 FMSHRC 247 (May 2006).

The parties have stipulated that the proposed penalties will not affect the Respondent's ability to continue in business. Ex. Ct.-A. The mine is large and I find the penalties assessed herein are appropriate to the size of the business. The history of violations is contained in Ex. S-16. There is no evidence to suggest that the operator did not abate the violations in good faith. The negligence of each violation is discussed at length above. I assess the following penalties:

1. Citation No. 8177959 is affirmed as S&S affecting one person. However, I have raised the negligence to high and I find the gravity of this violation is very serious. I assess a penalty of \$5,000.00.

2. Citation No. 8178050 is affirmed as S&S affecting two persons and I have raised the negligence to high and find the gravity is very serious. I assess a penalty of \$8,400.00.

²⁴ Respondent has raised an objection to the special assessments levied by the Secretary as being founded solely on the basis of the number of times the operator has been cited for a particular standard. My assessment of penalties is based upon all of the statutory criteria above as they relate to the facts of each violation as established by the record evidence. The special assessments levied by the Secretary are immaterial.

3. Citation No. 8178068 is affirmed as S&S affecting two persons and I have raised the negligence to high. I find the gravity is very serious and assess a penalty of \$8,400.00.
4. Citation No. 8178082 is affirmed as S&S affecting one person and I have raised the negligence to high. I find the gravity is very serious and assess a penalty of \$5,000.00.
5. Citation No. 8178092 is affirmed as a violation but I have modified it to non-S&S with moderate negligence affecting one person. I assess a penalty of \$750.00.
6. Citation No. 8178100 is VACATED.
7. Citation No. 8185012 is affirmed as S&S affecting three persons with moderate negligence. I find the gravity is serious. I assess a penalty of \$8,000.00.
8. Citation No. 8182533 is affirmed as a violation but I have modified it to non-S&S with low negligence affecting one person. I find the gravity is moderately serious. I assess a penalty of \$500.00.
9. Citation No. 8185034 is affirmed as a non-S&S violation with low negligence affecting two miners. I find the gravity to be moderately serious. I assess a penalty of \$500.00.

ORDER

Citation Nos. 8177959, 8178050, 8178068, 8178082, 8178092, 8185012, 8182533 and 8185034 are **AFFIRMED as modified**. Citation No. 8178092 is **VACATED**.

Consolidation Coal Company is ordered to pay civil penalties in the amount of \$36,550.00 within 30 days of the date of this decision.²⁵

/s/ Priscilla M. Rae
Priscilla M. Rae
Administrative Law Judge

²⁵ Payment should be sent to: Mine Safety and Health Administration, U.S. Department of Labor, Payment Office, P.O. Box 790390, St. Louis, MO 63179-0390.

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FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

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February 21, 2014

SECRETARY OF LABOR	:	CIVIL PENALTY PROCEEDING
MINE SAFETY AND HEALTH	:	
ADMINISTRATION (MSHA),	:	Docket No. WEVA 2009-1498
Petitioner	:	A.C. No. 46-09230-185272-01
	:	
v.	:	
	:	
REMINGTON LLC,	:	Mine: Winchester Mine
Respondent	:	

DECISION AND ORDER

Appearances: Joseph L. Gordon, Esq., U.S. Department of Labor, Office of the Solicitor, Philadelphia, PA, for Petitioner

Jonathan R. Ellis, Esq., Steptoe & Johnson, PLLC, Charleston, WV, for Respondent

Before: Judge L. Zane Gill

This case is before me upon a petition for assessment of a civil penalty under section 105(d) of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 815(d). This case involves one citation issued under 30 U.S.C. § 814(d) (1) and one order issued under 30 U.S.C. § 814(d) (1).

The Secretary seeks civil penalties of \$25,163.00 for Citation No. 8072231 and \$5,645.00 for Citation No. 8072232, requesting that they be affirmed as issued or modified to reflect increased severity of injury designations. Remington concedes the fact of a violation for Citation No. 8072231, but contests the Significant and Substantial (“S&S”), negligence, and unwarrantable failure designations and seeks to reduce the citation to a 104(a), non-S&S citation. With regard to Order No. 8072232, Remington argues that there was no violation and seeks to have the order vacated.

For the reasons listed below, I find that the violation for which Citation No. 8072231 was issued is S&S and constitutes an unwarrantable failure to comply with a mandatory standard. I uphold the violation cited in Order No. 8072232, and also find that the violation is S&S and unwarrantable. Finally, I find that a total penalty of \$30,808.00 is appropriate.

I. Procedural History

History

On March 24, 2009, MSHA Inspector Martin Carver issued Citation No. 8072231 and Order No. 8072232 at Remington's Winchester Mine, an underground coal mine located in Kanawha County, West Virginia. The Secretary of Labor filed a petition for the assessment of a civil penalty on July 15, 2009, and the operator, Remington LLC, filed an answer contesting the penalties on August 10, 2009. A hearing was held in Charleston, West Virginia on December 6, 2011.

Pretrial Motions

As a preliminary matter, I will memorialize my rulings on two pretrial motions. Both motions dealt with the Secretary's proffered expert, Dr. Sandin Phillipson, an MSHA geologist who was called to testify about the likelihood of a roof fall in one of the cited areas. I heard oral arguments on each motion before deciding these issues.

First, Remington moved to compel production of email communications between the Secretary and Dr. Phillipson or, alternately, a detailed privilege log. Remington argued that it was entitled to these messages because they contained factual information that the expert relied on in forming his opinion. The operator claimed that without this information, it would be prejudiced in its ability to cross-examine Dr. Phillipson. The Secretary contended that the emails were privileged, and that no privilege log was required under Rule 26 of the Federal Rules of Civil Procedure.¹ After reviewing Dr. Phillipson's pre-trial deposition and the parties' motions, I

¹ The Commission Procedural Rules do not address this issue, but Fed. R. Civ. P. 26(b)(4)(C) provides useful guidance. The rule reads as follows:

(C) Trial-Preparation Protection for Communications Between a Party's Attorney and Expert Witnesses. Rules 26(b)(3)(A) and (B) protect communications between the party's attorney and any witness required to provide a report under Rule 26(a)(2)(B), regardless of the form of the communications, except to the extent that the communications:

- (i) relate to compensation for the expert's study or testimony;
- (ii) identify facts or data that the party's attorney provided and that the expert considered in forming the opinions to be expressed; or
- (iii) identify assumptions that the party's attorney provided and that the expert relied on in forming the opinions to be expressed.

found that no information was missing the lack of which would prejudice Remington's ability to proceed effectively in this case. Remington's motion to compel was therefore **DENIED**.

Second, Remington moved to exclude Dr. Phillipson as a witness. Remington argued that Phillipson's use of illustrative rather than actual values in his mathematical models made his testimony irrelevant because it provided only relative assessments of the likelihood of a roof fall where an absolute assessment was needed. The operator further argued that Dr. Phillipson's testimony was ultimately lay testimony that stated common sense information, which cannot assist the trier of fact. Because Dr. Phillipson had never visited the Winchester Mine, Remington contended that his lay testimony was not based on his own perceptions and was therefore inadmissible. In response, the Secretary argued that Dr. Phillipson's expert opinions would present complex testimony that discussed the scientific reasons why the area in question was unique and at a higher risk of roof falls. Dr. Phillipson would also discuss how the unsupported roof's configuration increased the likelihood of a roof fall in the cited area. The Secretary contended that Phillipson's testimony would present scientific information that would be helpful to the trier of fact.

Commission Rule 63(a) sets the parameters for admissible evidence in Commission proceedings. 29 C.F.R. § 2700.63(a). The rule states that "Relevant evidence, including hearsay evidence that is not unduly repetitious or cumulative, is admissible." 29 C.F.R. § 2700.63(a). Although the Commission is not required to apply them, the Federal Rules of Evidence have value by analogy. *Mid-Continent Res., Inc.*, 6 FMSHRC 1132, 1136 n.6 (May 1984). The Commission discussed the qualification of expert witnesses in *In re: Contests of Respirable Dust Sample Alteration Citations*, stating that

"[W]e are guided by principles established under Rule 702 of the Federal Rules of Evidence: 'If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise.' Fed. R. Evid. § 702."

17 FMSHRC 1819, 1843 (Nov. 1995), *aff'd sub nom. SOL v. Keystone Coal Mining Corp.*, 151 F.3d 1096 (D.C. Cir. 1998) (emphasis added). The Commission further stated that

"Expert witnesses testify to offer their scientific opinions on technical matters to the trier of fact." *Cyprus Tonopah Mining Corp.*, 15 FMSHRC 367, 372 (March 1993), quoting *Asarco, Inc.*, 14 FMSHRC 941, 949 (June 1992). "Unlike an ordinary witness,... an expert is permitted wide latitude to offer opinions, including those that are not based on first-hand knowledge or observation." *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579, 113 S. Ct. 2786, 125 L. Ed. 2d 469, 482 (1993).

Id.

Dr. Phillipson holds a Ph.D. in Geology from the Colorado School of Mines, and his CV reflects extensive knowledge of roof control and geological hazards in mines. (Ex. S-21) He has 11 years of experience in the Roof Control Division of MSHA's Technical Support Branch. (Ex. S-21) After reviewing the motions and exhibits submitted by the parties, which included Dr. Phillipson's expert report and curriculum vitae as well as the transcript of his deposition, I determined that his background in geology and mine roof control qualify him as an expert in those areas. As such, he is not required to base his opinions on firsthand observation. Moreover, in keeping with my duty to admit only reliable scientific evidence², the expert report and the vigorous cross-examination during Dr. Phillipson's deposition convinced me that the scientific evidence Dr. Phillipson would present was reliable. Based on the expert's report submitted by the parties, I found that Dr. Phillipson's testimony would help me understand the evidence, and that it could therefore be presented at the hearing. Remington's motion to exclude Dr. Phillipson was **DENIED**. These preliminary rulings are affirmed here.

II. Findings of Fact³

Stipulations

1. Stipulation as to Jurisdiction

Respondent acknowledges jurisdiction under section 3(d) of the Mine Safety & Health Act, 30 U.S.C. § 802(d) ("the Act"). Respondent also acknowledges that the products of the Winchester Mine ("the Mine") entered the stream of commerce within the meaning and scope of Section 4 of the Act, 30 U.S.C. § 803.

2. Fact Stipulations

a) Remington, LLC ("Remington") is an "operator" as defined in § 3(d) of the Federal Mine Safety and Health Act of 1977, as amended ("Act"), 30 U.S.C. § 803(d), at the Mine at which the citations were issued.

² *Respirable Dust Cases*, 17 FMSHRC at 1843 (citing *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579 (1993)).

³ The findings of fact are based on the record as a whole, including my careful observation of the witnesses during their testimony. In resolving conflicts of testimony, I have taken into consideration the interests of the witnesses, corroboration or lack thereof, and consistencies or inconsistencies in each witness's testimony and among the testimony of the witnesses. In evaluating the testimony of each witness, I have also relied on his or her demeanor. Any failure to provide detail on each witness's testimony is not to be deemed a failure on my part to have fully considered it. The fact that some evidence is not discussed does not indicate that it was not considered. *See Craig v. Apfel*, 212 F.3d 433, 436 (8th Cir. 2000) (noting that an administrative law judge is not required to discuss all evidence and failure to cite specific evidence does not mean it was not considered).

- b) The operations of Remington at the Mine are subject to the jurisdiction of the Act.
- c) This proceeding is subject to the jurisdiction of the Federal Mine Safety and Health Review Commission and its designated Administrative Law Judges pursuant to Sections 105 and 113 of the Act.
- d) The individuals whose signatures appear in Block 22 of the citations at issue in this proceeding were acting in their official capacity and as authorized representatives of the Secretary of Labor, at the time that the citations at issue in this proceeding were issued.
- e) True copies of the citations at issue in this proceeding were served on Remington as required by the Act.
- f) Remington demonstrated good faith in the abatement of the citations at issue in this proceeding.

The Story

Remington, LLC's Winchester Mine is an underground coal mine located in Kanawha County, West Virginia. The mine operates around the clock in three shifts: a day shift that starts at 6:30 AM and ends between 3:30 and 4:00 PM; an evening shift that begins between 3:30 PM and 4:00 PM and ends at 1:30 AM; and a midnight shift that lasts from 11:00 PM to 7:00 AM. (Tr. 45:5-46:2) Pre-shift reports are conducted before the beginning of each shift and identify hazards that need to be corrected before anyone enters the mine for the eight-hour shift. (Tr. 54:6-55:7). On-shift reports are conducted during the shift by the supervisor or examiner. (Tr. 54:6-55:7) These reports identify hazards encountered during the shift and note whether they have been corrected. (Tr. 54:6-55:7)

Toward the end of the evening shift on March 23, 2009, while on his way to call his pre-shift report out to the surface, Foreman Frank Chambers encountered Continuous Miner Operator J.C. Rhodes in the 7 right cross-cut ("7 right"). (Tr. 310:22-311:12, 311:19-22) Seven right was the last cross-cut in by the face. (Ex. S-13) Rhodes was in the process of making the last cut of the night, a punch-through cut that would drive the 7 right cross-cut into the 8 entry. (Tr. 278:6-15, 281:21-282:3; Ex. S-13) At the Winchester Mine, it is fairly common for a cut to be made at the end of a shift and bolted the next day. (Tr. 272:20-273:6) Because the cut Rhodes was making was the last cut of the night and would remain unbolted until the March 24 day shift, Chambers asked Rhodes to hang reflectors around the unbolted area. (Tr. 310:16-21) Federal law requires the use of reflectors to warn miners of unbolted areas (Tr. 82:8-15), and the Winchester Mine's roof control plan required Remington to hang two or more reflectors to mark the second-to-last row of roof supports. (Tr. 86:24-87:22; Ex. S-23 at 6) Miners are trained that these reflectors signal hazards and rely on them to identify and avoid dangerous areas. (Tr. 117:16-118:10) It is common for continuous miner and roof-bolter operators to hang reflectors in punch-through cuts at Remington (Tr. 314:22-315:11), and Rhodes had put up reflectors in the past. (Tr.

318:7-9) Chambers called out the pre-shift report, which noted only that 7 right “needs cleaned and dusted,” at 10:44 PM on March 23. (Ex. S-7)

The cut left an unbolted area approximately 30 feet in length. (Tr. 97:2-20; Ex. S-24) The unbolted area started in 7 right, and it extended seven to eight feet into the 8 entry because three bolts in the first row of bolts in the intersection had been sheared off during the cutting process. (Tr. 92:11-15, 97:10-20; Ex. S-13, Ex. S-21 at 3) Because the unbolted area could have been approached from either 7 right or the 8 entry, reflectors should have been hung in both of those areas to prevent miners from inadvertently walking under unsupported roof. (Tr. 82:8-18; Ex. S-23 at 6) Rhodes, who had between six months and one year of mining experience (Tr. 317:9-19), only hung a single reflector after he finished the cut. (Tr. 316:6-12) This reflector was hung in 7 right, at the last row of bolts before the unbolted area. (Tr. 82:3-7) Rhodes later explained that he only hung one reflector because he only had one reflector with him at the time. (Tr. 311:13-18, 316:6-12) There were other reflectors available that Rhodes could have gone and gotten. (Tr. 316:13-18)

The area was left in this condition for the duration of the March 23 midnight shift, which is a non-production maintenance shift. (Tr. 299:2-7) Roof bolting is considered production, and therefore not performed on the midnight shift. (Tr. 273:7-16) Miners on the midnight shift may occasionally have reason to travel to the face, but most of the midnight shift work is performed outby the faces. (Tr. 299:23-300:9, 321:13-322:14) The midnight shift foreman, however, is required to take methane readings at each face every two hours during his shift. (Tr. 55:14-56:10; Ex. S-10) He also conducts a pre-shift inspection of the area where miners on the day shift will be working. Both of these tasks required traveling across the section and taking methane readings at each of the faces, and the pre-shift examination requires the foreman to travel throughout the working section. (Tr. 54:6-23) Midnight Shift Foreman Brian Lester’s Date, Time and Initials (“DTIs”) were found at all faces, including the 8 face, after the area was bolted. (Tr. 138:5-16) DTIs are the date, time, and initials left by an examiner to show he has been at a face. (Tr. 116:5-21) Remington’s records reflect that Lester conducted gas checks from midnight to 1:00 AM, from 2:00 AM to 3:00 AM, from 4:00 AM to 5:00 AM, and from 6:00 AM to 7:00 AM (Ex. S-10)

These records also show that Lester performed a pre-shift examination from 4:00 AM to 4:45 A.M, while he was doing his 4:00 AM methane readings. (Tr. 136:17-23; Ex. S-5) On Lester’s pre-shift report, he marked that 7 right was part bolted and listed “Ref.,” or “reflector,” as the action taken. (Ex. S-5) There was also an unbolted area near the 7 Face, which was noted on the pre-shift inspection as well. (Tr. 69:11, 78:18-22; Ex. S-5) This area had been properly marked with reflectors. (Tr. 78:18-22) The 8 entry, along with the 1, 2, 3, 4, 5, 6, and 9 entries and the 5 left cross-cut, was listed as having no hazards observed, although the pre-shift report indicates that Lester hung a reflector somewhere in one of those areas. (Ex. S-5)

On the morning of March 24, Inspectors Martin Carver and Edgar Hendrick inspected the Bays Mains 003/004 section of the Winchester Mine. (Tr. 58:3-59:6) Before going underground, the inspectors reviewed the mine map and the pre-shift and on-shift reports for the previous three shifts. (Tr. 47:6-48:7, 55:7-56:10) Carver and Hendrick inspected separate parts of the section. (Tr. 59:2-10)

Carver began his inspection with an imminent danger sweep across the faces, traveling through the last cross-cut in by the faces. (Tr. 58:18-22) Remington Foreman Tommy Hess accompanied Carver on his inspection. (Tr. 142:21-143:8) Hess conducted his daily on-shift inspection and took methane readings while Carver inspected the mine. (Tr. 58:18-22) In the cross-cut between the 6 and 7 entry, Carver encountered three men working near an energized roof bolter. (Tr. 59:7-60:2, 60:18-22, Ex. S-13) The roof bolter, which was in the last cross-cut in by the face, had been energized before the Foreman completed a required gas checks. (Tr. 60:17-22, 61:17-62:5, 63:7-16; Ex. S-12 at 2, 3) Unbeknownst to Carver, these men were working 20 to 30 feet away from the unmarked, unsupported roof. (Tr. 128:2-8) Carver spoke to them, then issued a citation to Hess for having energized equipment near the face before gas checks had been completed. (Ex. S-14) Remington did not contest the citation, and it is not one of the citations at issue in this case. (Tr. 66:18-20; Ex. S-22 at 2)

In the next cross-cut, between the 7 and 8 entry, Carver and Hess found two rows of bolts, followed by the unsupported roof. (Tr. 93:16-20; Ex. S-13, Ex. S-12 at 4) Carver and Hess observed that only a single reflector had been hung in the 7 right cross-cut. (Tr. 82:3-7) Carver nearly walked under the unsupported roof because reflectors were not hung in a way that indicated a hazard (Tr. 79:16-80:6, 82:1-18, 87:8-12; Ex. 12 at 12) At this point, around 7:30 AM, Carver issued Citation No. 8072231 for the missing reflector. (Tr. 88:8-12; Ex. S-11) To complete the imminent danger sweep and on-shift examination without traveling under unsupported roof, Carver and Hess traveled out-by to the next cross-cut, crossed over to the 8 entry, and proceeded in-by toward the unbolted 7-right cross-cut. (Tr. 88:4-12; Ex. S-13.) After arriving at the intersection, they observed that three roof bolts in the first row of bolts outside of the cross-cut had been sheared off. (Tr. 89:19-91:17.) No reflectors had been hung in the 8 entry. (Tr. 88:13-89:3.) Carver added this to citation No. 8072231. (Tr. 91:7-13) The citation was issued as an unwarrantable failure because the high degree of danger posed by unsupported roof and the minimal effort required to hang the reflectors showed a reckless disregard for miners' safety. (Tr. 120:4-13)

Carver confirmed that the 7 right cross-cut was not bolted by standing under the last row of bolts and looking down the 7 right cross-cut. (Tr. 89:4-90:10; Ex. S-13) Although it was impossible to see the entire length of the unbolted roof with the head lamps Hess and Carver wore (Tr. 98:7-14, 163:11-164:5), Hess testified that what he could see looked like good roof. (Tr. 271:9-15) Carver observed gob and loose coal in the middle of the 8 entry, and both sides of the intersection had loose coal and rock along their entire length. (Tr. 99:21-100: 15; Ex. S-13 3) This would have to be cleaned by a scoop operator as part of the mining process. (Tr. 100:19-23) The debris came from the push-through cleanup run, in which the continuous miner operator pushes coal that can't be loaded into the intersection. (Tr. 100:2-9) Carver also testified that roof can collapse at any time, even if it looks perfectly good. (Tr. 109:19-110:11)

Cross-cuts and entries at Remington are approximately 18 to 20 feet wide (Tr. 302:13-19; Ex. S-23 at 1), and unsupported area is measured from roof bolt to roof bolt. (Tr. 97:2-14) The distance from the last bolt in the cross-cut to the first bolt in the intersection was 30 feet. (Tr. 96:16-98:4; Ex. S-13, Ex. S-24) When roof falls occur, however, the falling area typically goes into the second row of bolts. (Tr. 81:1-8) I credit Carver's testimony that roof fall victims are not

always killed outright, but roof fall survivors tend to have serious injuries that require amputations. (Tr. 111:2-16)

During the inspection, Inspector Hendrick issued citations for two violations, neither of which are at issue in this case. (Tr. 131:18-23, 260:4-261:4) The first citation was a grounding violation issued because the power sled was missing a ground strap. (Tr. 260:23-261:4) The citation was assessed as “unlikely” to cause injury or illness, but any injury that occurred would be “fatal” because a miner would be electrocuted by 12,470 volts of electricity if he came into contact with the ungrounded sled. (Tr. 260:23-261:4; Ex. S-17) The second citation was a guarding violation, issued because a section of high-voltage cable was unguarded. (Tr. 260:16-19; Ex. S-16) Like the first citation, this was assessed as “unlikely” to cause injury or illness, but any injury that occurred due to the hazard would be “fatal.” (Ex. S-16) Remington did not contest these citations. (Tr. 262:5-263:3) Because these two violations were found during the inspection, in addition to the unsupported roof, Carver issued Order No. 8072232, which cited Remington for an inadequate pre-shift examination. (Tr. 131:11-23; Ex. S-15) Carver designated the order S&S because of the high degree of danger and the severity of the injuries that could occur because of the hazards that were not recorded on the pre-shift inspection. (Tr. 140:13-19) He issued the order as an unwarrantable failure to comply with a mandatory standard because he felt that the foreman who conducted the pre-shift examination was not really looking for hazards, but simply going through the pre-shift routine. (Tr. 140:20-141:11)

Remington investigated the failure to hang reflectors. (Tr. 309:8-13) Robert Hill, Remington’s Safety Manager (Tr. 307:18-22), interviewed Chambers, Rhodes, and Lester. (Tr. 309:14-18) He spoke to Chambers and Rhodes about the failure to hang reflectors. (Tr. 309:16-21) Chambers explained to Hill that he was on his way to call out an examination toward the end of the shift when he told Rhodes to hang the reflectors (Tr. 310:22-311:7), and Rhodes confirmed what Chambers said when Hill spoke to him. (Tr. 311:13-18) Neither Rhodes nor Chambers testified at the hearing. Chambers is no longer with the company, having been let go as part of an employee cut-back because he was “not a very good supervisor.” (Tr. 313:12-18) Rhodes has worked for Remington on and off between the time the citation was issued and the hearing date. (Tr. 316:19-23) There is no evidence that either Rhodes or Chambers was disciplined for the failure to hang reflectors on March 23, 2009. Hill further stated that a result of the investigation, he determined that the foremen were not looking as hard as they should have been on their pre-shift inspections. (Tr. 309:19-310:7) There is no evidence that Lester was disciplined by the company for the way he conducted his inspections.

Hess testified at hearing that although he did not find out about the missing bolts in the 8 entry until he made his on-shift examination (Tr. 288:19-22), he would have known to carefully check the intersection of 7 right and the 8 entry for hazards. He explained that taken together, the updated mine map he reviewed before going underground and the pre-shift report noting that 7 right was only partially bolted would have alerted him that a punch-through cut had been made. (Tr. 289:10-290:2) Although there were two unbolted areas in the Bays Mains section, Hess testified that the area in 7 right was the first thing he would address on the day shift. (Tr. 69:11, Tr. 274:16-23; Ex. S-5)

Dr. Sandin Phillipson, the Secretary's expert, testified at hearing with regard to the roof's stability over time. Phillipson has not visited the mine site, but he testified credibly that a visit to the mine site would not have been feasible, nor would it be necessary for his report and testimony. (Tr. 223:5-12, 224:9-16) He explained that the unsupported area's location at an intersection dramatically increased the likelihood of a roof fall in the area. Specifically, he testified that the removal of the 3 bolts in the cross-cut more than doubled the likelihood of a roof fall (Tr. 233:16-234:15, 237:16-238:15), and that a roof fall was most likely in the part of the unsupported area that extended into the intersection. (Tr. 227:18-228:3) Phillipson also discussed two roof falls that occurred in the Bays Mains section between the issuance of the citation and the hearing. A roof fall on July 25, 2011, was about 400 feet from the cited area, and a roof fall on August 7, 2009, was about 1,100 feet away from the cited area. (Tr. 240:19-241:8) Phillipson explained that having two roof falls in the vicinity of the unbolted area suggests that the roof quality in the unbolted area was poor. (Tr. 241:9-15)

III. Legal Principles

The citation and order at issue in this case were issued under section 104(d) (1) of the Mine Act, 30 U.S.C. § 814(d) (1).⁴ In order to uphold a citation issued under section 104(d) (1), the Secretary must prove that the violation would significantly and substantially contribute to the cause and effect of a safety or health hazard. The Secretary must also prove that the citation is an unwarrantable failure to comply with a mandatory standard.

⁴ Section 104 (d) (1) of the Mine Act, 30 U.S.C. § 814(d) (1), reads as follows:

If, upon any inspection of a coal or other mine, an authorized representative of the Secretary finds that there has been a violation of any mandatory health or safety standard, and if he also finds that, while the conditions created by such violation do not cause imminent danger, such violation is of such nature as could significantly and substantially contribute to the cause and effect of a coal or other mine safety or health hazard, and if he finds such violation to be caused by an unwarrantable failure of such operator to comply with such mandatory health or safety standards, he shall include such finding in any citation given to the operator under this chapter. If, during the same inspection or any subsequent inspection of such mine within 90 days after the issuance of such citation, an authorized representative of the Secretary finds another violation of any mandatory health or safety standard and finds such violation to be also caused by an unwarrantable failure of such operator to so comply, he shall forthwith issue an order requiring the operator to cause all persons in the area affected by such violation, except those persons referred to in subsection (c) of this section to be withdrawn from, and to be prohibited from entering, such area until an authorized representative of the Secretary determines that such violation has been abated.

The Commission has established a four-part test to determine whether a violation is S&S. To designate a violation S&S, judge must find “(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). The third and fourth factors will, as a practical matter, often be combined in a single showing. *Id.* at 4. To show a reasonable likelihood that the hazard will result in an injury, the Secretary is not required to prove that it is more likely than not that the hazard will result in an injury. *U.S. Steel Mining Co.*, 18 FMSHRC 862, 865-66 (June 1996). The S&S analysis must be made in the context of continuing mining operations. *Texasgulf, Inc.*, 10 FMSHRC 1125 (Aug. 1985); *U.S. Steel*, 7 FMSHRC 1125, 1130 (Aug. 1985).

Unwarrantable failure “refers to more serious conduct by an operator in connection with a violation,” *Martin Cnty. Coal Corp.*, 28 FMSHRC 247, 264-66 (May 2006), and the Commission has defined unwarrantable failure as “aggravated conduct, constituting more than ordinary negligence.” *Emery Mining Corp.*, 9 FMSHRC 1997, 2004 (Dec. 1987), *Buck Creek Coal v. FMSHRC*, 52 F.3d 133, 136 (7th Cir. 1995). Unwarrantable failure is characterized by such conduct as “reckless disregard,” “intentional misconduct,” “indifference,” or a “serious lack of reasonable care.” *Emery Mining*, 9 FMSHRC at 2003; *Rochester & Pittsburgh Coal Co.*, 13 FMSHRC 189, 194 (Feb. 1991); *see also Buck Creek Coal, Inc. v. MSHA*, 52 F.3d 133, 136 (7th Cir. 1995) (approving Commission's unwarrantable failure test).

Whether conduct is “aggravated” in the context of unwarrantable failure is determined by looking at all the facts and circumstances of each case to see if any aggravating factors exist. These factors often include (1) the extent of the violative condition, (2) the length of time that the violative condition existed, (3) whether the violation posed a high degree of danger, (4) whether the violation was obvious, (5) the operator's knowledge of the existence of the violation, (6) the operator's efforts in abating the violative condition, and (7) whether the operator had been placed on notice that greater efforts were necessary for compliance. *See Io Coal*, 31 FMSHRC 1346, 1351-57 (Dec. 2009); *Cyprus Emerald Res. Corp.*, 20 FMSHRC 790, 813 (Aug. 1998), *rev'd on other grounds*, 195 F.3d 42 (D.C. Cir. 1999). These seven factors are viewed in the context of the facts and circumstances of a particular case, and some factors may be irrelevant to the scenario at hand. *Consolidation Coal Co.*, 22 FMSHRC 340, 353 (Mar. 2000). Nevertheless, I must examine all of the relevant facts and circumstances of each case to determine if an operator's conduct is aggravated, or whether mitigating circumstances exist. *Id.*; *Io Coal*, 31 FMSHRC at 1351.

IV. Analysis and Conclusions of Law

Citation No. 8072231

Citation No. 8072231 was assessed as highly likely to cause permanently disabling injury or illness, and designated as S&S. (Ex. S-11) The inspector assessed the negligence as high. (Ex. S-11) The condition cited states that

[t]he operator failed to comply with the approved roof control plan on Bays Mains 003/004 mmu section. There was only one reflector hung in the #7 to #8 crosscut and no reflectors were in the #8 out-by the holed crosscut as required. This violation is an unwarrantable failure to comply with a mandatory standard.

(Ex. S-11) The citation was issued for a violation of 30 C.F.R. § 75.220(a) (1), which requires that

Each mine operator shall develop and follow a roof control plan, approved by the District Manager, that is suitable to the prevailing geological conditions, and the mining system to be used at the mine. Additional measures shall be taken to protect persons if unusual hazards are encountered.

Remington does not contest that a violation occurred, but contests the S&S, negligence, and unwarrantable failure designations.

Gravity and Significant and Substantial

To uphold a citation, the Secretary must prove the gravity designations set out in the citation and prove that the citation is S&S. Under *Mathies*, these showings are closely linked in that as long as a violation of a mandatory standard and a discrete safety hazard are proved, proof that a violation is highly likely, or even reasonably likely, to result in a serious injury would necessitate an S&S designation. As a result, it is appropriate to address the gravity and S&S determinations together.

The Secretary argues that the gravity and S&S designations should be upheld. According to the Secretary, Remington's failure to hang the reflectors exposed miners on the evening, midnight and day shifts to dangerous, unsupported roof because miners on all three shifts could have traveled in the unsupported area. He further argues that the failure to hang the reflectors contributed to the hazard by falsely signaling that it was safe to travel through the unbolted area. The roof was highly likely to fall because of the length of time the area remained unbolted and the fact that the unbolted area extended out into an intersection. The Winchester Mine's history of roof falls near the unbolted area further supports the conclusion that a roof fall was highly likely. If it occurred, a roof fall would result in a permanently disabling or fatal injury. For these reasons, the Secretary contends that Remington's failure to hang the reflectors was highly likely to result in at least a permanently disabling injury, justifying an S&S designation for this citation.

Remington argues that the facts show that the violation was not reasonably likely to result in an injury, making an S&S designation inappropriate for this citation. With regard to the likelihood of injury, Remington argues that the Secretary's evidence does not show that a miner was likely to be in the unbolted area, and that any miner traveling in that area would be alerted that the area was unbolted because the coal gob present in the area would indicate that the area had not been bolted or cleaned. Additionally, no one in 7 right or the 8 entry saw adverse roof conditions and the expert witness's testimony did not address how likely the roof in 7 right or the 8 entry was to fall. Finally, Remington points out that the inspector changed the citation from "reasonably likely" to cause injury to "highly likely" to cause injury after leaving the mine and changed his notes after changing the citation, arguing that the change constitutes evidence that the cited condition was not highly likely to result in an injury.⁵

Remington does not contest that only one reflector was hung before the beginning of the unsupported roof in 7 right, nor does it contest that no reflectors were hung around the sheared-off bolts in the 8 entry. This is a violation of Remington's roof control plan, which requires that two or more reflectors be hung at the next-to-last full row of roof bolts before an unsupported area. (Ex. S-23 at 6) Roof control plan provisions are enforceable as mandatory standards. *Martin Cnty. Coal*, 28 FMSHRC at 254-255. The violation therefore meets the first of the four *Mathies* criteria, the violation of a mandatory safety standard. The failure to hang reflectors contributes to a discrete safety hazard. Miners in the Winchester Mine are trained to rely on reflectors in order to recognize and avoid unsafe conditions. (Tr. 117:11-118:10) Failure to hang reflectors exposes miners to the hazard of unsupported roof because without these visual indicators, a miner could unknowingly enter the unsupported area.

The third element of the *Mathies* test requires the Court to consider whether the identified hazard—in this case, walking under unsupported roof—would result in an injury. *Mathies*, 6 FMSHRC at 3, 4. This prong of *Mathies* focuses on whether the safety hazard contributed to by the violation is likely to cause injury, not whether the violation itself will cause injury. *Musser Eng'g., Inc.*, 32 FMSHRC 1257, 1281 (Oct. 2010).

Secretary's expert testified that because the unbolted area extended into the intersection, the likelihood of a roof fall in the unbolted area more than doubled. (Tr. 233:11-234:15, 237:16-238:15) He was unable to assign a specific, actual value to the likelihood of injury, but the crux

⁵ I do not find Remington's argument about the changes to Carver's notes and penalty assessment persuasive. Carter convincingly explained his reasoning for making the changes at hearing, testifying that he most likely marked the citation "reasonably likely" while performing the inspection, then modified it after further consideration. Carver had the discretion to do this. Moreover, this change is analogous to an amendment to a citation, which is to be freely granted prior to hearing unless the operator can show prejudice. No such showing has been made here.

of his testimony was the dramatic increase in likelihood.⁶ Unsupported roof can fall at any time, and if a miner were under it, he would be injured. Moreover, because roof falls usually come into the second row of bolts (Tr. 80:18-81:8), a miner could be injured by a roof fall without walking directly underneath the unsupported area. This is particularly problematic for miners traveling in the 8 entry toward the face. The first row of bolts was 7 feet into the 8 entry, putting the second row of bolts 11 to 12 feet into the 8 entry based on the four-foot spacing requirements in the Winchester Mine's roof support plan. (Tr. 162:16-23; Ex. S-23) In an 18 to 20-foot wide entry, this dramatically increases the likelihood that a miner traveling in the 8 entry would be exposed to the hazard, especially if he or she were operating a large piece of machinery such as a scoop.

The cut that created the unbolted area was made toward the end of the shift, around 11:00 PM (Tr. 310:22-311:7; Ex. S-7; Resp. Br. 13), and the inspector issued a citation for the hazard during the on-shift inspection for the day shift the next day around 7:30 AM. (Ex. S-11) The area then remained unbolted for a period of eight and a half hours. During this period, at least five miners were exposed to the hazard. Lester, the midnight shift foreman, was exposed to the condition as he traveled throughout the section taking methane readings at each of the faces (Tr. 116:6-117:1) and conducting the pre-shift examination for the oncoming day shift. Lester would have had no reason to know to avoid the unbolted area until he found it on his pre-shift inspection, which was conducted during his third run across the faces, because the pre-shift report for the midnight shift does not mention the unbolted area in 7 right. (Ex. S-6) Second, Carver encountered three miners on the section who were working 20 to 30 feet away from the unbolted area. These men could easily have walked under the unsupported roof without reflectors to warn them away from it. Finally, Hess (along with Carver) was exposed to the hazard when he conducted his on-shift examination and nearly walked under the roof. Evening shift miners, who would have been working all over the section, were also likely exposed to the hazard at the end of their shift as they traveled back to the mantrips to exit the mine.

Carver testified credibly that he observed coal debris in the form of loose coal and rock in the middle of the intersection (Tr. 99:21-100:1, 100:10-15; Ex. S-13), which would have to be cleaned by a scoop operator as part of the mining process. (Tr. 100:19-23) In the course of continued normal mining operations, a scoop operator cleaning up the gob in the intersection would most likely have been exposed to the hazard.

Although gob and loose coal was found in the intersection, I am not persuaded that the gob alone would have alerted miners to the unsupported condition of the roof and prevented them from being exposed to the hazard. Carver testified credibly that loose gob indicates that an area has been mined and has not been cleaned yet, but not necessarily that the area is unsupported. (Tr. 165:13-22) Moreover, Foreman Lester's DTIs at the 8 face belie the effectiveness of the gob and loose coal as a deterrent to travel in the area.

⁶ Remington stresses Phillipson's inability to state exactly how likely the roof was to fall, pointing out in its reply brief that if the likelihood of a roof fall is zero, if the likelihood doubles it will still be zero. (Resp. Reply Br. at 2-3) Due to the multiple roof falls that occurred not far from the unbolted area between the violation and the hearing, I am not persuaded that the likelihood of a roof fall in the area was zero or close to it.

The injury sustained from a roof fall would most likely be serious. Roof falls are a leading cause of underground mining fatalities, and miners who survive roof falls often receive crushing injuries that result in amputations. (Tr. 111:2-20) In light of all the circumstances surrounding the violation, I find that third and fourth elements of the *Mathies* test are satisfied because the unsupported roof is highly likely to contribute to an injury, and the injury would be serious. I therefore affirm the citation's gravity and S&S designations as issued.

Negligence and Unwarrantable Failure

As discussed above, unwarrantable failure is "aggravated conduct, constituting more than ordinary negligence." *Emery Mining Corp.*, 9 FMSHRC at 2004; *Buck Creek Coal*, 52 F.3d at 136. Because making a negligence determination is an integral part of deciding whether the operator's conduct constitutes more than ordinary negligence, I will discuss my negligence and unwarrantable failure findings together.

The Secretary argues that Remington's negligence is best categorized as "high." First, although the continuous miner operator was asked to hang the reflectors after making the punch-through cut, it was ultimately the evening shift foreman's responsibility to ensure that reflectors were hung. Additionally, the Secretary argues that the midnight shift foreman was negligent in failing to detect the missing reflectors. Finally, Remington was allegedly negligent for entrusting foremen that it had little confidence in with important safety functions.⁷ The Secretary argues that Citation No. 8072231 involves aggravated conduct based on three aggravating factors, the first of which was the lengthy duration of the violation. The condition existed for parts of three shifts, during which multiple foremen had opportunities to abate the violation and multiple miners were exposed to the unsupported roof because of the missing reflectors. Second, the Secretary argues that the violation was extensive because only one of the four required reflectors was hung. Third, the missing reflectors exposed miners to extremely dangerous unsupported roof because neither of the two approaches to the unbolted area was effectively quarantined off.

Remington argues that the level of negligence is best described as low because it was not negligent to ask the miner operator to hang reflectors. Remington also argues that no one would be working in 7 right or the 8 entry during the midnight shift, making it unnecessary for the evening shift foreman to check the area for hazards. Remington therefore contends that a designation of "no negligence" or "low negligence" would be more appropriate for this citation. Remington further argues that the violation does not involve aggravated conduct constituting more than ordinary negligence, making the citation ineligible for an unwarrantable failure designation. In addition to its arguments about negligence and likelihood of injury, Remington stresses that the violation lasted for only one hour of production time, followed by a non-production shift in which no miners were in the area, and the condition was discovered before production started on the next production shift. The operator claims that it did not know of the existence of the violation because the foreman tasked the continuous miner operator, whose actions cannot be imputed to the operator, with hanging reflectors and expected those directions to be followed. Additionally, the evening shift foreman and the day-shift foreman were aware that 7 right needed to be bolted, and therefore aware of the hazard. Remington also contends that

⁷ I have considered this argument, but in light of all of the testimony presented it does not affect my decision with regard to the operator's negligence level for this citation.

the one reflector that was hung is a mitigating factor because it would have provided some warning to miners traveling the section. Finally, Remington argues that the Secretary presented no evidence that Remington was on notice that greater compliance efforts were necessary for hanging reflectors.

Section 110(i) of the Mine Act requires that in assessing penalties the Commission must consider, among other criteria, “whether the operator was negligent.” 30 U.S.C. § 820(i). Each mandatory standard carries an accompanying duty of care to avoid violations of the standard. An operator's failure to satisfy the appropriate duty can lead to a finding of negligence. Negligence “is conduct, either by commission or omission, which falls below a standard of care established under the Mine Act to protect miners against the risks of harm.” 30 C.F.R. § 100.3(d). “A mine operator is required to be on the alert for conditions and practices in the mine that affect the safety or health of miners and to take steps necessary to correct or prevent hazardous conditions or practices.” *Id.* “MSHA considers mitigating circumstances which may include, but are not limited to, actions taken by the operator to prevent or correct hazardous conditions or practices.” *Id.* Reckless negligence is present when “[t]he operator displayed conduct which exhibits the absence of the slightest degree of care.” *Id.* High negligence is when “[t]he operator knew or should have known of the violative condition or practice, and there are no mitigating circumstances.” *Id.* Moderate negligence is when “[t]he operator knew or should have known of the violative condition or practice, but there are mitigating circumstances.” *Id.* Low negligence is when “[t]he operator knew or should have known of the violative condition or practice, but there are considerable mitigating circumstances.” *Id.* No negligence is when “[t]he operator exercised diligence and could not have known of the violative condition or practice.” *Id.* This violation involved negligent omissions by two foremen. A foreman’s negligent acts are imputable to the operator. I find that taken together, their actions constitute high negligence.

I find that Chambers, the evening shift foreman, was negligent because he did not ensure that reflectors were hung in accordance with Remington’s roof control plan. Chambers told his continuous miner operator to hang the reflectors, something the miner operator was trained to do and had done in the past. (Tr. 314:22-315:11, 318:7-9) He then proceeded on his way to call out the pre-shift inspection for the oncoming midnight shift. Rhodes had one reflector with him and hung it up, but did not go get more reflectors and complete the job. (Tr. 316:6-18) “[W]here a rank-and-file employee has violated the Act, the operator's supervision, training and disciplining of its employees must be examined to determine if the operator has taken reasonable steps to prevent the rank-and-file miner’s violative conduct.” *S. Ohio Coal Co.*, 4 FMSHRC 1458, 1464 (Aug. 1982) (citing *Nacco Mining*, 3 FMSHRC 848, 850-851 (Apr. 1981)). While Rhodes’ training may have been adequate, his supervision and discipline were not. There is no evidence that Rhodes was disciplined for his actions, and the foreman negligently failed to supervise him.

I do not consider assigning a task to a rank-and-file miner to be mitigating evidence. Foremen are held to a heightened duty of care and are ultimately responsible for complying with MSHA’s safety regulations. “[C]onsideration of a foreman's negligence is proper in assessing a penalty against an operator.” *Nacco Mining Co.*, 3 FMSHRC at 850. Where a foreman's negligence is at issue, the Commission looks to whether the foreman acted with the care required by all of the circumstances surrounding the violation. *S. Ohio Coal Co.*, 4 FMSHRC at 1461. There is no evidence that Chambers followed up with Rhodes or took any further steps to ensure

that the reflectors were hung in front of the unbolted area, even though Rhodes had been working as a miner for less than a year. (Tr. 317:9-13) The cut was the last cut of the night, and the operator intended to bolt the roof on the next production shift. The intervening midnight shift was a non-production shift and miners were unlikely to be working at the faces. As a foreman, however, Chambers was undoubtedly aware that methane readings still had to be taken at the faces every two hours. This would require the midnight shift foreman to travel across the faces several times before the roof could be bolted on the day shift. Seven right was the last cross-cut inby the face, making it the logical route of travel for a foreman coming across the faces. Because he filled in and called out the pre-shift inspection form, Chambers would also know that the unbolted area was not marked on the pre-shift inspection, giving the midnight shift foreman no indication that he should avoid the 7 right cross-cut. I also credit Inspector Carver's testimony that miners would have been working all over the section at the end of a production shift, and would have needed to travel across the section to perform final tasks, gather their things and return to the surface. (Tr. 168:20-169:6) Additionally, Foreman Hess admitted on cross-examination that it was possible that miners on the midnight shift could have traveled to the faces. (Tr. 299:23-300:9) In light of the circumstances, Foreman Chambers' failure to ensure that the reflectors were hung is highly negligent.

The record in this case reflects that between the end of the evening shift and the beginning of the day shift, multiple gas checks were performed at the faces and a pre-shift inspection was conducted. During the gas checks, it would have been possible for a foreman traveling alone and focused on taking his readings to walk through the unbolted areas in 7 right and past the missing bolts in the intersection without noticing them. Seven Right was the last cross-cut inby the faces, and neither of the two ways to approach the area was appropriately marked to signal a hazard. Lester performed a pre-shift inspection, however, in which he noted that part of 7 right was not bolted. He did not bother to hang reflectors in 7 right or the 8 entry, even though he observed the unbolted area and listed "Ref" as the action taken. The pre-shift report proves that Lester observed the unbolted area and knew the actions needed to abate the roof control violation, but negligently failed to perform them.

Because of their status as foremen, both Lester's and Chambers' negligence is imputed to Remington. Both of these men knew or should have been aware of the missing reflectors—and Lester almost certainly was—but no effort was made to abate the problem in spite of the high degree of danger it posed. I find that Remington "knew or should have known about the violative condition or practice, and there are no mitigating circumstances." Thus, the Secretary's assessment of "high" negligence is appropriate.

Several aggravating factors are present with regard to the failure to hang reflectors, the first of which is the extent of the condition. The unbolted area was a large area, approximately 30 feet long (Tr. 97:2-20; Ex. S-24) and 18 to 20 feet wide (Tr. 228:17-21, 302:13-19; Ex. S-23 at 1), and could be accessed two ways: by entering the 7 right cross-cut and proceeding toward the 8 entry, and from the intersection of 7 right and the 8 entry. Only one of these areas had any kind of visual indicator that a hazard was present. The single reflector hung in 7 right was insufficient under the operator's roof control plan, which requires two reflectors. As previously discussed, roof falls usually come into the second row of bolts (Tr. 80:18-81:8), and the "unsupported area"

is considered to extend to the next-to-last bolt before the unbolted area. This further increases the extent of the hazard.

The missing reflectors posed a high degree of danger. Anyone traveling through the 7 right cross cut would have to walk under unsupported roof, which would cause fatal or permanently disabling injuries if it fell. The unbolted area extended into an intersection, which doubled the likelihood of a roof fall and made the unbolted area even more dangerous.

The duration of the condition is another aggravating factor. Remington stresses that the condition only existed for a brief period of production time, but this measurement does not accurately reflect the duration of the violation or the increased risks and exposure that resulted. Although the condition only existed for brief periods during the day and evening production shifts, the cut was completed sometime around 11:00 PM, and reflectors were not hung until after 7:30 AM the next morning. This increases the overall level of danger because an unbolted roof grows more unstable and more likely to fall as time passes. (Tr. 103:2-11, 235:15-19) The intervening midnight shift exposed at least one additional miner to the hazard. During this period a pre-shift inspection was conducted and methane measurements were taken three times in each working face. (Ex. S-5, S-10). To do this, the foreman was required to travel to each of the faces several times and inspected the entire section for safety hazards once.

In spite of multiple passes across the faces and a pre-shift inspection that specifically noted that 7 right was “part bolted,” no efforts were made to abate the condition before it was pointed out by Inspector Carver.⁸ This is especially egregious in light of the fact that the only action required to abate the condition would have been to get reflectors, which were available underground (Tr. 316:13-18), and hang them up. This would have taken only a few minutes. (Tr. 120:14-24)

The missing reflectors were obvious. The pre-shift inspection for the midnight shift noted that there was unbolted area in 7 right, showing that the hazard itself was observed. The roof control plan requires that each approach to the unsupported roof be marked with reflectors. Their absence would be conspicuous to a foreman conducting a pre-shift inspection, whose duty it was to note and correct hazards for the oncoming shift.

The evening and day shift foremen’s knowledge that the area needed to be bolted is not mitigating. It is not reasonable to infer awareness of the unbolted roof in the 8 entry based on a

⁸ It is not mitigating that the men found with the powered-up equipment near the face were working at a roof bolting machine. A finding that this evidence is mitigating would require inferring that the men at the machine were preparing to bolt 7 Right, which is not appropriate under these facts. At the beginning of the day shift, both the 7 face and the 7 Right cross-cut were unbolted. (Tr. 69:2-15) Reflectors were hung in the 7 face according to the roof control plan’s requirements, but reflectors were not hung properly in 7 Right. (Ex. S-13) Both of these areas were in close proximity to the powered-up equipment. Additionally, according to Hess, these men should have been waiting for him at the power center when Carver encountered them. (Tr. 274:3-15, 293:20-294:21) Because these men were found before Hess met with his crew and gave out work assignments, there is nothing in the record to suggest which area the miners intended to bolt, or that they were even aware that 7 Right needed to be bolted.

notation that 7 right needed to be bolted. The foremen would not necessarily have known about the sheared-off bolts just by seeing that notation, even in combination with the mine map showing that the cut had been punched through. The most that they could have done is exercise caution, and a miner's exercise of caution is not mitigating. *Eagle Nest, Inc.*, 14 FMSHRC 1119, 1123 (July 1992). Similarly, the fact that one reflector had been hung is not mitigating. Carver almost walked under unsupported roof in spite of the presence of the reflector, which belies its effectiveness as a warning device.

There is no evidence, however, that the operator was on notice that greater efforts were necessary for compliance with this part of the roof control plan. Although Remington had received multiple citations for roof control violations in the past 12 months, the roof control plan is extensive and there is no evidence about the reasons that the previous citations were issued. This is neither an aggravating nor a mitigating factor.

After considering all of the aggravating and mitigating factors, I find that Remington's conduct was highly negligent, and that the Secretary has proved aggravated conduct on the part of the operator that constitutes an unwarrantable failure to comply with a mandatory standard. The negligence and unwarrantable failure determinations in Citation No. 8072231 are therefore affirmed as issued.

Penalty

The factors to be considered in assessing a civil monetary penalty are set out in Section 110(i) of the Act, 30 U.S.C. § 820(i). I am required to consider six factors: (1) the operator's history of previous violations, (2) the appropriateness of such penalty to the size of the business of the operator charged, (3) whether the operator was negligent, (4) the effect on the operator's ability to continue in business, (5) the gravity of the violation, and (6) the demonstrated good faith of the person charged in attempting to achieve rapid compliance after notification of a violation. Commission case law requires that I explain substantial deviations from the Secretary's proposed penalties using these factors. *Mize Granite Quarries*, 34 FMSHRC 1760, 1763 (Aug. 2012) While "exhaustive findings" are unnecessary, I must discuss how the 110(i) factors contributed to my penalty assessments. *Id.* (citing *Cantera Green*, 22 FMSHRC 616, 622 (May 2000)).

The parties stipulated that Remington demonstrated good faith in the abatement of the citations at issue in this proceeding, and gravity and negligence have been discussed above. As to the remaining factors, I find that in the operator's history of previous violations does not merit an increase or decrease in penalty, and that the Secretary's proposed penalty is appropriate to the size of Remington's business and will not affect the operator's ability to continue in business. In light of all of these factors, I find that the Secretary's proposed penalty of \$25,163.00 is appropriate for this citation.

Order No. 8072232

Order No. 8072232 was issued under 30 U.S.C. § 814(d) (1). (Ex. S-15) The order was designated as reasonably likely to cause permanently disabling injury or illness, and the

negligence was assessed as high. (Ex. S-15) The citation was designated as S&S. (Ex. S-15) The condition cited states that

The inspection of Bays Mains has revealed several hazardous conditions not listed on the pre-shift examination conducted for the day shift this date. No reflectors were observed in #8 entry out-by an unsupported cross-cut and in the #7 to #8 cross-cut only 1 reflector was provided. The 12470 high-voltage cable was not provided with a guard where persons regularly travel at the section power center. The high-voltage sled was not provided with a ground strap.

This order was issued for an alleged violation of 30 C.F.R. § 75.360(a) (1), which requires that

...a certified person designated by the operator must make a preshift examination within 3 hours preceding the beginning of any 8-hour interval during which any person is scheduled to work or travel underground. No person other than certified examiners may enter or remain in any underground area unless a preshift examination has been completed for the established 8-hour interval. The operator must establish 8-hour intervals of time subject to the required preshift examinations.

With regard to Citation No. 8072232, the Secretary argues that Remington violated Section 75.360(a) (1) because the inspection that was performed was inadequate. The operator failed to correct or adequately advise the oncoming foreman of three hazards on the pre-shift inspection. The evening shift foreman did not document the areas of unsupported roof in the 8 entry. Although he noted that 7 right was part bolted, he did not hang the reflectors required by the roof control plan in either area in spite of his notation to the contrary on the pre-shift report. The evening shift foreman also failed to detect and document that the highest-voltage cable in the mine was not properly guarded, and that there was no ground strap between the power center and a high voltage sled. The Secretary also points out that the mere fact that an examination report was generated does not mean that the foreman actually conducted the required area-by-area inspection. If it was in fact conducted, the inspection was inadequate because the foreman not only failed to detect and properly record three hazards, but also failed to correct them or adequately advise the oncoming foreman about them.

Remington contends that the Secretary has not established a violation of the cited regulation. The operator argues that the regulation can only be violated if the Secretary proves one of three things: 1) no pre-shift examination occurred, 2) the person who conducted the examination was not properly certified, or 3) the examination was not conducted within three hours of the beginning of the shift. According to Remington, no violation occurred because it is undisputed that a pre-shift examination was completed by a certified person within three hours of the beginning of the day shift. Moreover, the inspection form was filled out in a way that would have warned the day shift foreman about the hazard in the 8 entry at the same time he corrected

the hazard in 7 right. Remington further argues that the law only requires that hazards be recorded, not remedied, and the foreman noted the unbolted roof, which was the biggest risk to miners.

A violation of 29 C.F.R. § 75.360(a) can be upheld if the inspector finds hazards that were present when the pre-shift inspection was conducted, but were not noted on the pre-shift inspection. *Enlow Fork Mining Co.*, 19 FMSHRC 5, 14-16 (Jan. 1997). When interpreting this statute, Commission Judges have rejected the argument that there was no examination violation because a pre-shift examination was conducted. *Consolidation Coal Co.*, 33 FMSHRC 283, 290 (Jan. 2011) (ALJ).

The pre-shift report for the March 24, 2009 day shift indicates that the 7 entry was not bolted, that 7 right was part bolted, and that the examiner hung reflectors around those hazards. (Ex. G-5) It also notes that no hazards were observed in the 8 entry, but that reflectors were hung somewhere in the 1, 2, 3, 4, 5, 5 left, 6, 8 or 9 entries during the pre-shift examination. (Ex. G-5) It is undisputed that when the inspector arrived at the scene, only one reflector was hung in 7 right. It is also undisputed that no reflectors were hung where 7 right had been punched through to the 8 entry, and that reflectors should have been hung there because the unsupported area extended out into the intersection. The degree of danger inherent in this condition has already been discussed at length. The pre-shift inspection not only failed to note the hazard of unbolted roof in the 8 entry, but misrepresented the state of the area by indicating no hazards existed in the 8 entry and the area was safe for travel. After evaluating all of the testimony presented, I am not persuaded that the pre-shift effectively warned Hess of the unbolted roof in the 8 entry.

Two other hazardous conditions were encountered during the MSHA inspection on March 24, 2009. The MSHA inspector issued citations for both conditions, and Remington did not contest these violations. (Tr. 262:8-18) The first such violation was a guarding violation. A segment of the mine's high-voltage cable was unguarded and hanging below the minimum required six and one-half foot height, and miners were seen walking under the unguarded cable. (Ex. S-16) The second violation was a grounding violation: there was no ground strap between the section power center and the high voltage sled. (Ex. S-17) Both citations were issued as "unlikely" to result in injury or illness but, in the event that an injury occurred, the injury would most likely be "fatal." (Ex. S-16, S-17) The Secretary put on evidence that the guarding violation could have been seen from 20 feet away, and that both of these violations were obvious and would have been seen by a pre-shift examiner.

The Secretary has proved that several violations were not noted on the pre-shift inspection. In light of this finding, Remington's argument that the law only requires violations to be recorded, not remedied, is irrelevant. It is undisputed that each of these conditions was present when the pre-shift examination was conducted. This is sufficient to uphold a violation of 29 C.F.R. § 75.360(a).

Gravity and Significant and Substantial

The Secretary contends that the violation is properly classified as S&S, arguing that the foreman's failure to detect these hazards can only be explained by concluding that he did not

inspect the areas where they were found, in violation of Section 75.360(a) (1). This exposed miners to discrete safety hazards in the form of electrocution and unsupported roof, and the balance of probabilities of injury from the guarding violation, the missing ground strap, and the unbolted roof make it reasonably likely that the hazards that the inadequate examination contributed to would have resulted in a permanently disabling injury. The Secretary further argues that increasing the designation from “permanently disabling” to “fatal” would be appropriate.

Remington argues that the alleged violation would not be reasonably likely to result in an injury, making an S&S designation inappropriate. The operator argues that none of the three conditions that caused the inspector to conclude that the pre-shift inspection was inadequate were likely to cause an injury.

The *Mathies* criteria set out previously apply here as well. The Secretary has established a violation of 29 C.F.R. § 75.360(a), which is a mandatory standard. Pre-shift inspections are meant to prevent hazardous conditions from developing. *Enlow Fork*, 19 FMSHRC at 15. The pre-shift examination conducted on the midnight shift had the opposite effect. It not only inaccurately represented that the unbolted roof in the 7 right cross-cut had been marked with reflectors, but also failed to alert anyone in the oncoming shift to the existence of three other dangers: unsupported roof in the 8 entry, an un-guarded, low-hanging high voltage cable, and another high-voltage cable that was missing a ground strap. In doing so, the inadequate pre-shift examination contributed to several discrete safety hazards. This satisfies the second *Mathies* requirement.

For a violation to be S&S, the hazards must be reasonably likely to result in an accident or injury. Although the guarding and grounding violations were designated as unlikely to lead to an injury, the unbolted roof was highly likely to lead to an injury. Because these hazards were not corrected or even noted, the day shift foreman and crew came onto the section with a false impression that only two hazards existed on the section, both of which had been marked with reflectors. As a result, Foreman Hess was exposed to the hazards of unsupported roof and possible electrocution as he performed his on-shift inspection. Inspectors Carver and Hendrick, who had reviewed the inadequate pre-shift report before going underground, were also exposed to the unsupported roof, as were the three day shift miners who roamed the section and powered up equipment before Hess completed his gas checks. This exposure elevates the likelihood of injury. I find that it is reasonably likely that taken together, the unguarded cable, the ungrounded sled, and the unmarked, unsupported roof would contribute to an accident or injury. Roof falls cause permanently disabling, if not fatal, injuries where miners are in the area, which was more likely to happen because the unbolted area in the 8 entry was not noted and the reflectors that miners rely on to avoid hazardous conditions were not in place. Additionally, the high voltage cables and sled, if contacted, can cause fatal electrocution. I therefore find the hazards contributed to by the inadequate pre-shift are reasonably likely to result in an accident or injury, and that serious injuries would result if an accident occurred.

I am required to evaluate whether this violation is significant and substantial in the context of continued normal mining operations. Remington argues that the cited conditions would have been corrected before any miners were exposed because the mining crew waits at the

power section while the foreman checks for hazards during his on-shift inspection. I find this argument unpersuasive because men were found on the section before the on-shift inspection was completed. This indicates that on a typical shift, men would not have been waiting at the power center, but instead would have been moving around the section, exposed to the unknown and uncorrected hazards. Second, even if the entire day shift crew had been waiting at the power center, foreman Hess would still have been exposed to the hazards before they were corrected. Hess, like Carver, walked right up to the last row of bolts before noticing the unbolted area, and could easily have walked under it. (Tr. 78:18-79:3) In light of this evidence, I find that the inadequate pre-shift violation is S&S.

Negligence and Unwarrantable Failure

The Secretary argues that the negligence is appropriately designated as “high” because the hazards involved were physically large and visually obvious, and the failure to detect them indicates that the foreman was not looking for hazards at all. The Secretary further argues that the inspection involved high negligence, and that the violation itself amounts to an unwarrantable failure to comply with a mandatory standard. To justify the unwarrantable failure designation, the Secretary lists two other aggravating factors in addition to the high negligence. First, the violation was extensive, exposing the miners to three major hazards. Second, the hazards posed a high degree of danger, as they were likely to lead to permanently disabling or fatal injuries. For these reasons, the Secretary argues that the citation should be designated as an unwarrantable failure to comply with a mandatory standard.

Remington argues that the negligence should not be designated as “high” because the midnight shift foreman reasonably believed that no one would be exposed to the hazard until the roof was bolted on the day shift, and he noted the hazards in the order that the foreman on the next shift would address them. The day shift foreman understood from the inspection notes that 7 right was only partially bolted. Based on these notes, the day shift foreman would have made bolting 7 right the first task and would have addressed the missing bolts in the 8 entry as part of the bolting process. Thus, according to Remington, both areas would be bolted before anyone went into the 8 entry and it was not necessary to note the unbolted area in the 8 entry on the pre-shift report. Additionally, Remington argues that the violation is not an unwarrantable failure. It was not obvious because no one could have known that the inspection was incomplete until the first inspection on the day shift, and Remington argues that the day shift inspection is a mitigating factor. Remington was not on notice that greater compliance efforts were necessary because it had received only one prior citation for a violation of Section 75.360(a) (1). Because there was no evidence that the conditions observed were likely to cause harm, Remington contends that the violation does not involve the “more than ordinary negligence” required for an unwarrantable failure designation.

The regulation I use as guidance in my negligence determinations is discussed in my findings for Citation No. 8072231, as are factors to be considered in determining whether a violation is an unwarrantable failure to comply with a mandatory standard. To uphold the Secretary’s assessment of “high” negligence, I must find that Remington “knew or should have known about the violative condition or practice, and there are no mitigating circumstances.” 30

C.F.R. § 100.3(d). Upholding the unwarrantable failure designation will require me to find that the balance of the aggravating and mitigating factors merit a finding of aggravated conduct.

The pre-shift examination notes only the largest and most obvious hazard found by the inspectors: the portion of the unbolted area in 7 right. (Ex. S-5) Additionally, by marking “Ref.” as the action taken, Lester’s pre-shift report suggests that the hazard has been abated, when in fact there was still only one reflector hanging near the unbolted area in 7 right. (Ex. S-5) Lester knew or should have known about the missing reflector on the 7 entry side of the unbolted area and, at the very least, noted it in his pre-shift report.

Moreover, because he marked on the pre-shift report that 7 right was unbolted, Lester either knew or should have known about the hazard in the 8 entry. Seven right was punched through into the 8 entry. I infer that Lester was aware of this aspect of the mine’s layout because his on-shift report shows that he traveled across the faces to take gas readings twice before beginning his pre-shift examination, once at midnight and once at 2:00 AM. (Ex. S-10) Because the cut had been punched through, there were two ways to approach the unbolted area. The 8 entry is a separate travelway from 7 right. Miners who were approaching the cross-cut from the 8 entry, or simply traveling down it to reach the 8 face, would be exposed to the unbolted roof. Upon observing an unbolted area in a cross-cut, a pre-shift inspector should have checked both approaches for hazards. Had Lester done this, he would have noticed the missing bolts in the intersection of 7 right and the 8 entry.

In addition to the unbolted roof in the 8 entry, two guarding violations were used as a basis for the inadequate pre-shift inspection violation. Although both of the guarding violations were assessed as “unlikely” to cause injury, Inspector Carver testified persuasively that the missing cable guard would have been readily visible if the pre-shift inspector was within 20 feet of the condition. This indicates that the foreman would have found this hazard if he had been looking for it. As such, the overlooked guarding citation is another indication that the pre-shift examination was perfunctory and inadequate.

Remington’s argument that the unbolted roof in 7 right and the 8 entry would be bolted before anyone entered the area is not persuasive. Although Hess testified that 7 right is the first area he would have bolted on the day shift, a foreman is required by law to do a gas check at each of the faces in a working section before mining equipment can even be powered up. (Ex. S-14) This would require the foreman to travel down the 8 entry. Additionally, the oncoming shift foreman would have to conduct his on-shift inspection in order to find the hazards in the first place, necessitating the foreman’s exposure to the unbolted roof, grounding violation, and guarding violation before any of the hazards could be corrected.⁹ Thus, I find that the way that Lester noted the hazard is not mitigating. Moreover, a Commission ALJ has persuasively rejected the argument that an employee does not need to record a condition that he believes it will be taken care of at a later time. *Emerald Coal Res. LP*, 33 FMSHRC 489, 499 (Feb. 2011) (ALJ).

⁹ As previously discussed, I am not persuaded that Hess was aware of the missing bolts in the 8 entry when he went underground.

In light of all of the evidence, I find that Lester, and therefore Remington, knew or should have known about the hazards, and that there are no mitigating circumstances. The level of negligence involved in this violation is, therefore, appropriately described as “high.”

In addition to the high degree of negligence, I find that several aggravating factors are present for this violation. The violative condition was extensive in that the failure to conduct an adequate pre-shift examination affected the entire section and missed three safety violations for which Remington was later cited. The hazards themselves varied from a two-foot stretch of unguarded cable to a thirty-foot long unbolted area that extended into the intersection of the 8 entry and 7 right.

This violation posed a high degree of danger. The failure to perform an adequate pre-shift examination meant that an entire crew of miners was sent into the mines with no warning about three major hazards that awaited them. All three undetected safety hazards could have caused serious injuries if they were not detected and corrected, and the unsupported roof was particularly dangerous. The failure to perform an adequate pre-shift examination was not obvious to anyone who reviewed the pre-shift paperwork. In this case, however, the fact that the violation was not obvious cuts in favor of a finding of aggravated conduct. The pre-shift paperwork, upon which the oncoming foreman and crew rely, completely failed to warn the oncoming shift of three serious hazards in the mine and misrepresented the state of one hazard that it did identify. The purpose of a pre-shift inspection is to warn the oncoming shift of hazards waiting for it, but Lester’s pre-shift inspection report required the day shift foreman to find and correct the hazards himself.

The level of obviousness of the hazardous conditions themselves varied. Regardless of their varied size, however, all of the hazards should have been obvious to someone tasked with inspecting a mine section for hazards. Hendrick testified that the operator would have been able to see the missing cover if he had come within 20 feet of the guarding violation. The unbolted area was thirty feet long and extended from the 7 right cross-cut into the 8 entry, creating dangerous conditions in both 7 right and the 8 entry. The lack of reflectors near the unsupported roof was obvious and extremely dangerous. Unsupported roof is something that anyone performing an examination should look for. Failure to note or correct this condition shows a serious lack of care by the operator, especially in light of the fact that miners rely on the reflectors as signals that an area is hazardous and should not be entered. Remington took the problem one step further, however, by falsely noting on the pre-shift inspection that reflectors had been hung around the hazard as a corrective action. (Ex. S-5) It is undisputed that the midnight shift foreman did not hang any reflectors during his pre-shift examination. This misrepresents the state of the hazardous condition, suggesting that it has been properly marked to warn miners away from the hazard when it in fact has not. The failure to note the sheared-off bolts in the 8 entry compounds the problem. The misrepresentation of the state of the 8 entry alone should be enough to justify a finding that the violation underlying Order No. 8072232 amounted to aggravated conduct constituting more than ordinary negligence.

The operator was aware of this violation. The pre-shift inspection was conducted by a foreman, and the negligent acts of a foreman are imputed to the operator. Additionally, Hess indicated that during his on-shift inspection, he tended to look more closely in certain areas if he

noticed certain things on the pre-shift reports. He testified that after reviewing the pre-shift report stating that 7 right was unbolted, in combination with a review of the mine map showing that 7 right had been punched through into the 8 entry, he knew that he should look carefully at that intersection to check for hazards. Hess's use of common sense does not mitigate Lester's negligence in failing to so much as note the full extent of the unbolted area on the pre-shift report, however. If anything, it is evidence that the operator knew that greater efforts were necessary for compliance with the pre-shift requirement. Although Remington had only been cited for a violation of this standard once before, Hess's testimony suggested that Remington had some idea that Lester's pre-shift reports were not completely reliable.

After the citation was issued, Remington conducted an investigation into the violation and determined that the foreman was not doing a good job on his pre-shift inspections. When considering the operator's abatement efforts for purposes of an unwarrantable failure analysis, Commission case law requires me to focus on efforts made before the citation or order was issued. *Io Coal*, 31 FMSHRC at 1356. There is no evidence of any abatement efforts prior to the violation's discovery by the inspector.

In terms of being an aggravating or mitigating factor, I find that the length of time that the violative condition existed is not relevant to this violation.

After weighing all of the aggravating and mitigating factors, I find that this violation constitutes an unwarrantable failure to comply with a mandatory standard. The foreman's failure to note several obvious violations suggests that he was not actually looking for hazards during his pre-shift inspection, which defeats the purpose performing a pre-shift inspection at all. The false information in the pre-shift report, which suggests that one of the two safety hazards that the foreman actually identified had been correctly marked with reflectors, actively misrepresents the status of the section. Taken together, these factors and tip the scales toward a finding of unwarrantable failure.

Penalty

The six penalty factors listed in the penalty discussion for Citation No. 8072231, above, apply to this order as well. As previously stated, the parties stipulated that Remington demonstrated good faith in the abatement of the citations at issue in this proceeding, and gravity and negligence have been discussed above in the S&S, Negligence, and Unwarrantable Failure analysis for this order. I find that in the operator's history of previous violations does not merit an increase or decrease in penalty, and that the Secretary's proposed penalty is appropriate to the size of Remington's business and will not affect Remington's ability to continue in business. In light of all of these factors, I find that the Secretary's proposed penalty of \$5,645.00 is an appropriate penalty amount for this order.

V. Order

It is **ORDERED** that Citation No. 8072231 is **AFFIRMED** as issued.

It is further **ORDERED** that Order No. 8072232 is **AFFIRMED** as issued.

It is further **ORDERED** that the Respondent pay a total penalty of \$30,808.00 within 30 days of the date of this decision.¹⁰

/s/ L. Zane Gill
L. Zane Gill
Administrative Law Judge

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/ms

¹⁰ Payment may be sent to: MINE SAFETY AND HEALTH ADMINISTRATION, U.S. DEPARTMENT OF LABOR, PAYMENT OFFICE, P.O., BOX 790390, ST. LOUIS, MO 63179-0390

FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

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February 25, 2014

SECRETARY OF LABOR	:	CIVIL PENALTY PROCEEDING
MINE SAFETY AND HEALTH	:	
ADMINISTRATION (MSHA),	:	Docket No. WEVA 2013-425
Petitioner,	:	A.C. No. 46-02805-309429
	:	
v.	:	Mine: Berkeley Plant
	:	
US SILICA COMPANY,	:	
Respondent.	:	

ORDER GRANTING U S SILICA COMPANY'S MOTION
FOR
SUMMARY DECISION

In this civil penalty proceeding arising under sections 104 and 110(i) of the Federal Mine Safety and Health Act of 1977, as amended (30 U.S.C. §§814, 820(I)), the Secretary of Labor ("Secretary") on behalf of his Mine Safety and Health Administration ("MSHA") petitions for the assessment of a civil penalty of \$100 for an alleged violation of 30 C.F.R. §56.12018, a mandatory safety standard for the nation's metal and nonmetal mines that requires the identification of certain power switches.¹ The Secretary alleges that on October 11, 2012, at the Berkley Plant of US Silica Company² ("US Silica" or "the company"), a breaker box in the plant's paint trailer "was not labeled to show what circuits they controlled."³ Citation No. 8705547. The inspector found that the cited condition was unlikely to result in injuries that could reasonably be expected to cause lost workdays or restricted duty and that the alleged violation was due to the company's moderate negligence. *Id.* US Silica answered by denying it violated the standard and asserting that Citation No. 8705547 should be vacated.

¹ The standard states:

Principal power switches shall be labeled to
show which units they control, unless
identification can be made readily by location.

30 C.F.R. § 56.12018.

² At the plant the company mines high quality sand that is used in manufacturing glass. The sand also is used in the production of natural gas through hydraulic fracturing. US Silica, *Locations*, <http://www.ussilica.com/locations/berkeley-springs-wv> (last visited Feb. 24, 2014).

³ Although the citation is awkwardly worded, it is clear from the pleadings that the inspector who cited US Silica used "they" to refer to the box's two unlabeled circuit breakers.

The Commission's Chief Administrative Law Judge assigned the matter to the Court, and the Court ordered the parties to confer regarding possible settlement. When it became clear that a settlement could not be reached, the Secretary's counsel, with the agreement of the company's counsel, suggested to the Court that the matter be resolved through cross motions for summary decision.⁴ The Court agreed. Counsels submitted their motions and, at the Court's request, provided the Court with additional information. Based on the motions and the additional information, the Court enters the following decision granting US Silica's motion and denying the Secretary's motion.

SUMMARY DECISION IN GENERAL

Pursuant to the Commission's rule, a party moving for summary decision is entitled to judgement in its favor if, based upon the record before the court, (1) there is no genuine issue as to any material fact; and (2) the moving party is entitled to a summary decision as a matter of law. 29 C.F.R. § 2700.67.

MATERIAL FACTS

Citation No. 8705547 states in part:

The Square D breaker box was not labeled to show what circuits they controlled. This was located in the paint trailer and created [a] shock hazard to employees in the event of an emergency and [the] circuit[s] could not be identified.

The material facts are contained in the parties' stipulations, the attachments to the parties' briefs and the additional information the parties supplied the Court. According to the stipulations, the cited Square D breaker box was located in an 8 feet wide by 36 feet long by 8 feet high paint trailer at the plant.⁵ Stip. 4. The breaker box controlled: (1) the overhead lighting for the main trailer; (2) an electrical power receptacle located below the breaker box; and (3) the overhead lighting for the paint storage area. *Id.* 5, Addit'l Stip. 2. The main electrical disconnect

⁴ E-mail from Courtney Przybylski, counsel for the Secretary, to Dhruva Mukherjee, law clerk to the Court (Aug. 28, 2013, 3:45 EST) (in official case file).

⁵ The parties agreed that the plant is a "mine" as defined by section 3(h) of the Mine Act, 30 USC. § 802(h), and that the products of the plant affect commerce. They further agreed that mine is subject to the Act. Stips. 1, 2.

controlling the breaker box was located directly below the box.⁶ Stip. 6. The main electrical disconnect was clearly labeled in compliance with 30 C.F.R. §56.12018. *Id.* 7. Exhibit A, attached to the stipulations, is an “accurate photograph showing the breaker box and the disconnects as they appeared at the time of the alleged violation.” *Id.* 8. The switch on the left side of the breaker box controlled the main trailer overhead lighting. Addit’l Stip. 1. The lights were connected to the breaker box by wiring entering the box toward the left side of the top of the box. *Id.*). The switch on the right side of the breaker box controlled the electrical receptacle and the paint storage room lighting.⁷ *Id.* 2. The electrical receptacle was connected to the breaker box by electrical wiring entering the box toward the right side of the bottom of the box. *Id.* The paint storage room lighting was connected to the breaker box by a conduit entering the box toward the right side of the box. *Id.* 2. Finally, the parties agreed as to the words that were written on the breaker box to abate the alleged violation. *Id.* 3-6.

THE PARTIES’ ARGUMENTS

The parties maintain that primarily the question before the Court is whether the Square D breaker box was a “principal power switch” within the meaning of section 56.12018. Counsel for US Silica argues for a “plain meaning” interpretation of the phrase “principal power switch” that excludes the box. Resp.’s Mot. For Sum Dec. 3-12. Counsel for the Secretary argues for a broader definition that includes the box. Sec.’s Op. to Resp.’s Mot. For Sum Dec. And Cross Mot. For Sum Dec. 2-12. As the parties are aware, questions regarding the meaning of the phrase “principal power switch” and whether particular cited equipment comes within the meaning have repeatedly been brought to the Commission’s judges. While the judges have decided whether certain equipment is covered by the standard based on the facts of the cases before them, a definitive meaning of the phrase “principal power switch” has yet to emerge. *See, e.g., Beverly Materials, LLC*, 35 FMSHRC 88, 95-97 (Jan. 2013) (Judge Moran); *Cemex Construction Materials of Florida, LLC*, 34 FMSHRC 170, 174 (Jan. 2012) (Judge Zielinski); *Omya Arizona, A Division of Omya Inc.*, 33 FMSHRC 2738, 2739-40 (Nov. 2011) (Judge Miller); *Blue Mountain Production Co.*, 32 FMSHRC 1464, 1473-74 (Oct. 2010) (Judge Miller); *Tide Creek Rock, Inc.* 19 FMSHRC 390, 399 (March 1996) (Judge Manning); *Walker Stone Co., Inc.*, 12 FMSHRC 256,264 (Feb. 1990) (Judge Fauver); *FMC Corp.*, 6 FMSHRC 1294, 1299 (May 1984) (Judge Vail) (decided under identically worded standard, 30 C.F.R. §57.12-18)⁸. This

⁶ Although not defined by the parties, the Court assumes that the main electrical disconnect is, as its name implies, the electrical device used to connect and disconnect all electrical circuits in the trailer.

⁷ The switches are best viewed in Exhibits A, B and C.

⁸ 30 C.F.R. Part 57 contains mandatory health and safety standards for the nation’s underground metal and nonmetal mines. 30 C.F.R. 56 contains mandatory health and safety standards for surface metal and nonmetal mines. 30 C.F.R. §57.12-18 and 30 C.F.R. §56.12-18 were worded the same as current standard 30 C.F.R. § 56.12018. When section 57.12-18 and
(continued...)

unbroken string of decisions without an agreed upon definition of the phrase will continue here, because the Court concludes that based on the stipulations and the information provided, the cited switches can be “readily identified by location”(30 C.F.R. §56.12018) and therefore come within the exception to the labeling requirement.

ANALYSIS

As previously noted, section 56.12018 provides, “Principal power switches shall be labeled to show which units they control, unless identification can be made readily by location.” The citation states, and US Silica agrees, that the subject breaker box was not labeled to show what the box’s switches controlled. *See* Resp.’s Mot. 2 (describing attached Exh. B). While the parties argue at length about the applicability of the standard to the breaker box, the Court concludes it need not resolve the arguments because assuming the box is a “principal power switch,” the box’s switches can be “identified readily by location” and therefore the box is exempt from the standard’s requirements.

The breaker box was located in the paint trailer as described in the stipulations. Jnt. Stip. 4. The box controlled the power supply to only three things: an overhead light for the trailer, an immediately adjacent electrical power receptacle and an overhead light for the paint storage area. Stip. 5, Addit’l Stips. 1, 2. It is clear from looking at the photographic exhibits submitted by the parties that the breaker box was mounted on a board that was attached to a wall of the trailer. The two switches in the box are aligned parallel to one another, slightly below the center of the box. Exhs. A, C, D. Visibly running from the box above the location of the left switch (when facing the box) is the wiring going to the overhead light for the trailer. *Id.*; Addit’l Stips. 1. Visibly running from the box below and slightly to the right of the right switch is the wiring going to the electrical receptacle that is in turn affixed to the board a short way below the breaker box. Exhs. A, C, D; Addit’l Stips. 2. Visibly running from the box to the upper right and above the right switch is a conduit going to the overhead light for the trailer’s paint storage area. *Id.* There is nothing “tricky” about the location of the wiring and the conduit. A person attempting to turn off the circuits to the lights or the receptacle or both would need to face the box and the board on which it is mounted. The alignment of each switch with its corresponding wiring and, in the case of the right switch, also with its corresponding conduit, would logically signaled to the most elementary observer, let alone to a knowledgeable miner, that the left switch controlled the overhead trailer light and the right switch controlled the receptacle and the paint storage area lighting. Only a blind person might be confused. The Court therefore finds that

⁸(...continued)

section 56.12-18 were renumbered in 1985, section 57.12-18 became section 57.12018, and section 56-12-18 became section 56.12018.

identification of the switches “can be made readily by location” (30 C.F.R. §56.12018) and that the standard does not apply to the box and the switches.⁹

This is a simple way to decide the case, but it is all that is necessary, and it is in line with the fact-based manner in which virtually all cases involving section 56.12018 have been resolved. It also is in accord with the Court’s belief that, tempting as it is to display the Court’s undoubted legal acumen, the Court should decide only issues that are absolutely necessary to reach a final outcome.

For the foregoing reasons, US Silica’s motion for summary decision is **GRANTED** and the Secretary’s cross motion for summary decision is **DENIED**. Citation No. 8705547 IS **VACATED**.

/s/ David Barbour
David Barbour
Administrative Law Judge

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⁹ The Court notes that its approach to resolving the case is similar to that adopted by Commission Administrative Law Judge August Cetti in *Pittsburg & Midway Coal Co.*, 14 FMSHRC 346, 351-352 (Feb. 1992). The *Pittsburg & Midway* case concerned an alleged violation of 30 C.F.R. 77.904, a standard requiring that at surface coal mines and surface areas of underground coal mines, circuit breakers “be labeled to show which circuits they control, unless identification can be made readily by location.” Judge Cetti, based on the factual record before him, found that the subject circuit “could be readily identified” by looking at the cited switch and therefore that “no violation [was] shown by the evidence.” 14 FMSHRC at 352.

FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

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February 26, 2014

SECRETARY OF LABOR,	:	CIVIL PENALTY PROCEEDING
MINE SAFETY AND HEALTH	:	
ADMINISTRATION (MSHA),	:	Docket No. WEST 2012-1484-M
Petitioner,	:	A.C. No. 04-02964-299562
	:	
v.	:	
	:	
TAFT PRODUCTION COMPANY,	:	Mine: Taft Production Company & Mines
Respondent.	:	

DECISION

Appearances: Pamela F. Mucklow, U.S. Department of Labor, Office of the Solicitor, Denver, Colorado, on behalf of the Secretary of Labor

Larry R. Evans, Oil Dri Corporation of America, Ochlocknee, Georgia, on behalf of Taft Production Company

Before: Judge James G. Gilbert

This case is before me upon a Petition for Assessment of a 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. § 815(d). The petition alleges that Taft Production Company (“Taft”) is liable for four violations of the Secretary’s safety and health standards for surface metal and nonmetal mines, and proposes the imposition of penalties in the total amount of \$3,321.00. A hearing was held in Los Angeles, California and both parties filed post hearing briefs.¹

I. Stipulations of Fact

1. Taft is engaged in surface metal/nonmetal mining at the Taft Production Company Mine in Kern County, California.
2. Taft’s mining operations affect interstate commerce.

¹ Prior to the hearing, Respondent filed a *Motion for Summary Decision* and the Secretary filed a response in opposition. I declined to rule on the pending motions at that time, and took the motions under advisement. The summary decision briefs are referred to in this opinion as Resp. Br. and Sec’y Br. Tr. 308. Each party was permitted to file a supplemental post-trial brief with additional arguments (referred to in this opinion as R. Resp. Br. and Sec’y Resp. Br.).

3. Taft is an operator as defined in section 3(d) of the Act.
4. Operations at the Taft Production Company mine are subject to the jurisdiction of the Mine Act.
5. The Administrative Law Judge has jurisdiction in this matter pursuant to section 105 of the Act.
6. The individual whose signature appears in block 22 of the citations at issue in this proceeding was acting in his official capacity as authorized representative of the Secretary of Labor when the citations were issued.
7. True copies of the citations at issue in this proceeding were served on Taft as required by the Act.
8. The total proposed penalties for the citations in this proceeding will not affect Taft's ability to continue in business.
9. The Secretary stipulates that Taft exercised good faith in terminating the citations in a timely manner.

Transcript (Tr.) 6-7.

II. Discussion

Taft Production Company Mine is located in Kern County, California and is a producer of cat litter. Tr. 16; Stipulation (Stip.) No. 1. MSHA Inspector David Cheney conducted a regular inspection of the mine from July 30, 2012, through August 2, 2012.² Tr. 16-17. He was accompanied by Nick Kingston, the process manager at Taft, during the inspection.³ Tr. 34. Cheney wrote four citations over the course of his inspection.

1. Citation No. 8689617

Citation No. 8689617 was issued by Cheney on July 31, 2012, at 4:40 a.m., pursuant to section 104(a) of the Act. Government's Exhibit No. 1 (Ex. G-1). It alleges a violation of 30 C.F.R. § 56.20003(a) which states that, "[a]t all mining operations – (a) Workplaces, passageways, storerooms, and service rooms shall be kept clean and orderly." The violation was described in the "Condition or Practice" section as follows:

² David Cheney has been an MSHA inspector for 11 years. Tr. 13. Prior to joining MSHA, Cheney was a miner at Riverside Cement, an open pit mine, for 23 years. Tr. 14.

³ Nick Kingston has been employed by Taft for 7 years. Tr. 193. He has held positions such as laborer, line leader, and order processor during that time and is currently the team leader of processing. Tr. 193.

At the top of the 102 silo was a spillage of material in front of the cat walked [sic]. This spillage consists of ½ inch rocks. This spillage was approximately 3 inches deep. Miners were exposed to a slip, trip, fall hazard. Miners are in this area once a month.

Standard 56.20003(a) was cited 3 times in two years at mine 04-02964 (3 to the operator, 0 to a contractor).

Ex. G-1.

Cheney determined that the violation was unlikely to result in a lost workdays or restricted duty injury, that one person was affected, and that the level of negligence was moderate. A civil penalty in the amount of \$176.00 was assessed for the violation.

A. Relevant Testimony

(1) Inspector David Cheney

Cheney testified that there was spillage on top of the 102 silo in front of the walkway. Tr. 19; Ex. G-2. A picture of the area taken by Cheney depicts soft powder with small granules on a flat surface, the roof of the silo, which leads up to a grated walkway.⁴ Tr. 20, 30, 136. He estimated that the powder was spread across an area of 10 feet by 10 feet and approximately 2 to 3 inches deep. Tr. 20, 28, 29, 138. A photograph taken after termination of the citation depicts a smooth, clean silo surface devoid of powder and granules. Ex. G-3.

Cheney considered the conditions to be a violation of the cited standard because miners walked through the area, making it a work area or passageway, and it was not clean and orderly. Tr. 33. He was unsure whether there was a dust collector at the top of the silo or other material such as screws, but what he did see indicated that miners would need to access the area for maintenance purposes. Tr. 33-34.

Cheney determined that the violation was unlikely to result in an injury to one miner because a miner would only visit the area rarely to do maintenance. Tr. 40, 48; Ex. G-1. He stated that Kingston estimated that maintenance was done once a month. Tr. 41. He also asserted that the cited standard was intended to prevent slip, trip, and fall hazards that could lead to lost workdays or restricted duty injuries, such as a twisted ankle, bumps, bruises, or cuts.⁵ Tr.

⁴ While the pictures introduced during the hearing depict dates on which the citations were not issued, Cheney testified that the batteries went dead on his camera and when the batteries were replaced, he did not modify the date. Tr. 22-23. He asserted that the photographs were actually taken on the dates that the citations were issued. Tr. 23-24. I find Cheney's explanation to be credible.

⁵ Cheney stated that he slipped on the material after stepping onto it. Tr. 139.

36, 38, 45-46. These are injuries that have reportedly occurred from slip, trip, and fall hazards in other mines and happen “all the time.” Tr. 46-47.

Cheney marked the level of negligence as moderate because the operator either should have known or did know of the violative conditions but there were mitigating circumstances. Ex. G-1; Tr. 48. The Secretary argued that while Kingston stated that he was not in and has not held a management position, he was nonetheless an agent of Taft. Tr. 193, 269-70.

(2) Nick Kingston

Kingston maintained that the spillage on top of the 102 silo was between a ½ inch and 2 inches thick. Tr. 194. He was not very familiar with all the uses of the silo, but stated that it was part of section 1 of the plant and that the spillage usually happens from an overload of elevator 101. Tr. 228, 250. The elevator is loaded with product at the base, where it is transported upward, and automatically fed down the pipes that lead to the silo. Tr. 252.

Access to the top of the 102 silo is gained by climbing up the 101 silo and walking across a catwalk. Tr. 248; Ex. G-4, 5. Kingston explained three reasons why a miner would access the top of the 102 silo. He testified that the one miner who is on-shift would not go to the top, except to take measurements of the silo tank once a month. Tr. 194-95, 229. Kingston also stated that maintenance may access the top of the silo to grease if section 1 was running, noting that this could happen as often as once a month or as little as every 6 months. Tr. 195-96, 242. The last reason is to change the gates. Tr. 252-53. Gates are changed when Taft wants to bypass the silo and divert the product to a different pipe that leads directly to a conveyor. Tr. 253. In order to change the gates, a miner must climb the stairs located at the top of the 102 silo that lead to the top of the elevator. Tr. 247-48.

Because the top of the 102 silo is seldom accessed, Kingston asserted that he was not aware of the spill until traveling there with Cheney and that the spill had not been reported by any miner. Tr. 194, 227.

B. Respondent’s Legal Arguments

Respondent argues that it did not violate the above standard because the area where the 102 silo was located should not be considered a mining operation, the area was not a passageway or a walkway, there was no fair notice of the meaning of clean and orderly, and the citations were duplicative.⁶

⁶ Respondent makes the same argument for the three citations discussed below as well. The issues of jurisdiction (Taft being a mining operation), fair notice, and duplication will be applicable to each citation in this proceeding. The issue of whether the area where the spill occurred was a workplace and/or passageway will be addressed in each individual citation discussion.

(1) Jurisdiction

Respondent argues that the cited areas were located in a milling operation, not a mining operation as the safety standard requires. Resp. Br. at 11-12. It also asserts that there is a marked difference between a mine operation and a mining operation. *Id.* at 12. However, Respondent stipulated that it is engaged in surface metal/nonmetal mining at the Taft Production Company Mine, that its “mining operations” affect interstate commerce, and that its operations are subject to the jurisdiction of the Mine Act. Stips. 1, 2, 4; Tr. 6. In addition, section 3(h)(1) of the Act states that a coal or other mine means “. . . structures, facilities, equipment, machines, tools, or other property... or used in, or to be used in, the milling of such minerals....” 30 U.S.C. § 3(h)(1).

Respondent stipulated to the fact that it is a mining operation engaged in surface metal/nonmetal mining. Its operations also fall under the purview of the Act as defined in section 3(h)(1). Accordingly, Respondent’s argument that the Secretary lacked jurisdiction to issue the citation is rejected.

(2) Definition of Workplace and Passageway

Respondent argues that the cited areas were not workplaces or passageways. Resp. Br. at 3-5. When defining terms, the Commission has first looked at the language of the definition. *National Cement Co.*, 27 FMSHRC 721, 726 (Nov. 2005). Workplace and passageway are not defined in the Act or in the definitions relating to section 56. In this case, the Commission then looks to the commonly understood definition of the term. *Id.* at 726; *Jim Walter Res., Inc.*, 28 FMSHRC 983, 987 (Dec. 2006); *Drillex, Inc.*, 16 FMSHRC 2391, 2395 (Dec. 1994) (stating that “[i]n general, absent express definitions, statutory terms should be defined according to their commonly understood definitions.”). However, the ordinary meaning of the words used in a statute cannot be applied to produce absurd results. *Jim Walter Res., Inc.*, 28 FMSHRC at 987; *National Cement*, 27 FMSHRC at 728.

Merriam Webster’s Online Dictionary defines workplace as “a place where work is done” and defines passageway as “a way that allows passage.” *Merriam Webster’s Online Dictionary*, <http://www.merriam-webster.com/dictionary/> (last accessed Jan. 26, 2014). Passage is defined as “way of exit or entrance: a road, path, channel, or course by which something passes.” *Id.* These definitions do not produce absurd results if applied in the context of section 56.20003(a).

In particular to Citation No. 8689617, Respondent argues that the top of the 102 silo is not a workplace or passageway because the clay was behind a pipe and underneath a stairway. Resp. Br. at 3. However, Government Exhibits 2 and 3 clearly show that the spillage was not directly behind a pipe, but spread out and up against the catwalk. Miners would access the 102 silo to take measurements of the tank and to grease if the section was running. Tr. 194-96, 229, 242.

In addition, in order to change the gates, a miner has to walk across the top of the 102 silo to reach the ladder that leads to the top of the elevator where they are located. Tr. 247-48; Ex. G-4. Not only was work done on the top of the 102 silo, but miners were required to walk across

it as a means to reach the top of the elevator. Accordingly, I find that the 102 silo was both a workplace and a passageway.⁷

(3) Fair Notice

Respondent argues that MSHA failed to provide fair notice of its interpretation of the standard's requirements, particularly "clean and orderly." Resp. Br. at 2. It has stated that the Secretary's interpretation is essentially that "[e]very spot in the entire mine must always be spotless or you could be cited for each spot" and that it is "absurdly broad."

"[D]ue process considerations preclude the adoption of an agency's interpretation which 'fails to give fair warning of the conduct it prohibits or requires.'" *LaFarge North America*, 35 FMSHRC __, slip op. at 4, No. CENT 2010-4-M (Dec. 11, 2013); *Gates & Fox Co. v. OSHRC*, 790 F.2d 154, 156 (D.C. Cir. 1986). "The Commission's test for notice under the Mine Act is '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.'" *Wolf Run Mining Co.*, 32 FMSHRC 1669, 1682 (Dec. 2010). A number of factors are relevant to this determination, including "the text of a regulation, its placement in the overall regulatory scheme, its regulatory history, the consistency of the agency's enforcement, and whether MSHA has published notices informing the regulated community with ascertainable certainty of its interpretation of the standard in question." *Id.*

The text of the regulation is clear: workplaces and passageways shall be kept clean and orderly. Respondent conceded that the language of the standard is not ambiguous. Resp. Br. at 1. The regulation is in place to prevent hazards, such as slipping, tripping, and falling that could lead to lost workdays or restricted duty injuries as Cheney stated above. There is no basis for Respondent's assertion that the Secretary's interpretation is that the areas must be spotless. A reasonably prudent person familiar with the mining industry would recognize that the accumulation of powder from several inches to up to 24 inches where miners work or walk by is prohibited under the standard. Ex. G-6, 11, 16. I find that Respondent had notice of the standard's requirements.

⁷ This determination is consistent with several other ALJ findings. *U.S. Silica Co.*, 32 FMSHRC 1699, 1706-08 (Nov. 2010) (ALJ) (affirming violations of section 56.20003 where there were accumulations on top of a bin that miners would access once a month to perform maintenance. There was an access ladder leading to the top of the bin, a catwalk leading to other bins, and footprints.); *USS, a Division of USX Corp.*, 13 FMSHRC 145, 153 (Jan. 1991) (ALJ) (affirming a violation of section 56.20003 and stating that "the standard applies to all workplaces and passageways, even though no work was being performed at the time of the cited violations, and even though the passageways were not designated or regularly used as such."); *Brubaker-Mann, Inc.*, 8 FMSHRC 1482, 1483 (Sept. 1986) (ALJ) (affirming a violation of section 56.20003 where there was a build-up of powdery fines that created a slip, trip, and fall hazard on a walkway that would only be accessed by a miner to perform maintenance.).

(4) Duplication

Respondent asserts that three of the four citations should be vacated because there should only be one citation for housekeeping per mine. R. Resp. Br. at 3. It cites MSHA's *Program Policy Manual* that states "where there are multiple violations of the same standard which are observed in the course of an inspection and which are all related to the same piece of equipment or to the same area of the mine, such multiple violations should be treated as one violation and one citation should be issued." 1 MSHA, U.S. Dep't of Labor, *Program Policy Manual* 21 (2003).

"The Commission has held that citations are not duplicative so long as the standards involved impose separate and distinct duties upon an operator. *Western Fuels-Utah, Inc.*, 19 FMSHRC 994, 1003-05 (June 1997); *Cyprus Tonopah Mining Corp.*, 15 FMSHRC 367, 378 (Mar. 1993)." *Cumberland Coal Res., LP*, 28 FMSHRC 545, 553 (Aug. 2006) *aff'd* 515 F.3d 247 (3d Cir. 2008). Additionally, in *Western Fuels*, the Commission focused on whether MSHA cited the operator on the basis of more than one specific act or omission. 19 FMSHRC at 1004 n.12.

In this case, the operator was cited for housekeeping violations because it failed to clean up accumulations of powder in four distinct areas of the mine that constituted a workplace and/or passageway: the top of the 102 silo; the base of elevator 101; underneath auger 6; and, the top of the fines tank. These four separate failures imposed four distinct duties on the operator to clean up the powder in each of these four locations. I find that the citations issued were not duplicative.

C. Findings and Conclusions

Taft failed to keep the top of the 102 silo, a workplace and passageway, clean and orderly by allowing material to accumulate up to 2 to 3 inches across a 10 foot by 10 foot area. I credit Cheney's testimony regarding the slipperiness of the powder and the slip, trip, and fall hazard that it created. This hazard could have reasonably caused twisted ankles, bruises, and cuts, resulting in lost workdays or restricted duty. In addition, I agree with Cheney's determination that one miner would be unlikely to suffer an injury because one miner is usually on-shift in the area and would access the top of the 102 silo once a month. Accordingly, I find that Taft violated section 56.20003(a).

As to the level of negligence, the Secretary attempted to establish at hearing that Kingston was an agent of Taft and his negligence was imputable to Respondent. Tr. 268. Pursuant to section 3(e) under the Act, an agent is defined as "any person charged with responsibility for the operation of all or part of a coal or other mine or the supervision of the miners in a coal or other mine." 30 U.S.C. § 802(e). The Commission has developed a multi-factor test to determine if a miner is also an agent which includes looking at the definition of agent under the Act, common law principles of agency, and distinctions between supervisors and employees under the National Labor Relations Act. *Martin Marietta Aggregates*, 22 FMSHRC 633, 637, 638 (May 2000). The Commission focuses on the miner's job functions, not title when making its determination. *Id.* at 637.

Kingston was an hourly employee who supervised mill 1, mill 2, and had four people on his team. Tr. 265, 282. He provided his team members with tasks to complete and he was their immediate supervisor. Tr. 266-67. If one of Kingston's team members was leaving for the day, the member would notify Kingston. Tr. 268. However, Kingston was not involved in the process of hiring or selecting his team, he took issues with team members to his boss, and he had never disciplined one of his members. Tr. 266-68.

These facts closely resemble a case previously decided by the Commission, affirming the judge's determination that the miner was not an agent where his job functions did not include hiring and firing employees, being given instructions for disciplining employees, and responsibility for an employee's performance and duties. *REB Enterprises*, 20 FMSHRC 203, 211-212 (May 1998). No evidence was presented that Kingston was responsible for the safety of his team or for ensuring compliance with mandatory safety standards.⁸ While Kingston did have the authority to task members of his team with assignments and supervises part of the plant, the aspects that are not part of his job weigh more heavily toward a rank and file miner. Therefore, I find that Kingston was not an agent of Taft.

Moderate negligence is appropriate when "[t]he operator knew or should have known of the condition or practice, but there are mitigating circumstances." 30 C.F.R. § 100.3. Low negligence requires considerable mitigating circumstances. *Id.* Taft should have known about the unsafe conditions. I find the fact that the top of the 102 silo was accessed as little as once a month to be a mitigating factor. Therefore, I find that Cheney properly determined the level of negligence to be moderate.

2. Citation No. 8689619

Citation No. 8689619 was issued by Cheney on July 31, 2012, at 5:00 a.m., pursuant to section 104(a) of the Act. It alleges a violation of 30 C.F.R. § 56.20003(a). The violation was described in the "Condition or Practice" section as follows:

Over at the bottom of the elevator 101 at Mill 2 was a spillage of material. This spillage was approximately 6 inches deep. This was located at the west side of the plant. Miners are in the area only as needed.

Standard 56.20003(a) was cited 4 times in two years at mine 04-02964 (4 to the operator, 0 to a contractor).

Ex. G-6.

Cheney determined that the violation was unlikely to result in a lost workdays or restricted duty injury, that one person was affected, and that the level of negligence was moderate. A civil penalty in the amount of \$176.00 was assessed for the violation.

⁸ He did check workplace exam records, but somewhat infrequently, and there was no direct testimony that he was in charge of safety and compliance measures. Tr. 283.

A. Relevant Testimony

(1) Inspector David Cheney

Cheney testified that there was spillage of material at the bottom of elevator 101. Tr. 52. A photograph depicts the spillage, which looks like powder piled up along a white structure representing the outside of the elevator. Ex. G-7; Tr. 54-55. The material was up to 6 inches deep in an area approximately 12 feet by 12 feet. Tr. 55, 60, 64. In the immediate vicinity of the material were a conveyor belt, an elevator, and a ladder. Tr. 65. Cheney asserted that the area was a workplace because a miner would have had to at least do maintenance on the elevator and conveyor belt. Tr. 65.

Cheney determined that the likelihood of injury was unlikely because he was told by Kingston that miners only go to the area once a month to grease bearings on the conveyor belt. Tr. 70, 74, 78; Ex. G-23. He posited that the same hazards as the previous citation, slip, trip, and fall, were present and that the same injuries could have occurred, resulting in lost workdays or restricted duty. Tr. 78.

Cheney marked the level of negligence as moderate because the cited standard had been cited four times in the previous two years and Respondent should have known about the spillage through conducting a workplace examination. Tr. 79, 81; Ex. G-6. He also stated that when Kingston was asked why the spill was not cleaned up, Kingston remarked that “he was shorthanded and that it just happened.” Tr. 66-67, 82.

(2) Nick Kingston

Kingston maintained that the spillage came from the elevator overloading, and that when the top of the 102 silo was cleaned off, the material fell in front of elevator 101, resulting in the citation. Tr. 200, 202, 273. He explained that to clean up the top of the 102 silo, the material was pushed off the side with a broom and barricades were set up at the ground level. Tr. 197. Kingston asserted that it was not possible to bring cleaning equipment to the top of the silo, so it is pushed off the side and picked up at the ground level with a scraper. Tr. 261. However, Kingston agreed that the amount of material at the base of elevator 101 looked like more material than what was pictured at the top of the 102 silo. Tr. 264; Ex. G-2, 7.

Kingston testified that the material consisted of a “fine-grade powder and a little bit of our course product.” Tr. 204. He did not think that injury would have resulted from walking through the spillage because it was not deep or on an incline. Tr. 204-05. However, he did agree that a miner could trip if he did not know the area or if there was a ledge of powder. Tr. 206.

Kingston stated that he walked through the area once a month to check safety equipment such as fire extinguishers. Tr. 206, 275. A miner would not be in the area to operate the conveyor belt because that was done from a block house located 50 to 60 feet from the 102 silo. Tr. 202-04. He posited that the tail pulley and conveyor belt would need to be checked but was

unsure how often. Tr. 278. Kingston also mentioned that a miner would do maintenance on the bag house once every 3 months and would need to use the ladder at the base of the elevator. Tr. 276.

B. Findings and Conclusions

I credit Kingston's testimony that he walked through the area where the spillage was located once a month to check safety equipment, that at least one miner would perform maintenance on the conveyor belt, and that at least one miner would use the ladder on the side of the elevator to perform maintenance on the bag house once every three months. Based on the above definitions, the area where the spillage was located was used both as a workplace and passageway. Taft failed to keep the area around elevator 101 clean by allowing a build-up of powder to occur that was up to 6 inches deep over an area of 12 feet by 12 feet.⁹ I find that Respondent violated section 56.20003(a).

As stated in the prior citation, the slipperiness of the powder created a slip, trip, and fall hazard. Even though the surface was flat, this hazard could have reasonably caused twisted ankles, bruises, and cuts, resulting in lost workdays or restricted duty. Although Kingston maintained that a miner would not be injured due to his familiarity with the area, the Act does not distinguish between a miner who knows the area and one that does not. In addition, I agree with Cheney's determination that injury is unlikely because one miner would check safety equipment in the area or grease bearings on the conveyor just once a month.

One miner only being in the area of the spillage once a month would be considered a mitigating factor supporting Cheney's determination of moderate negligence. However, Kingston's comment to Cheney about how the spill "just happened" and that "he was shorthanded," indicates to me that Kingston was aware of the spill and no clean-up was provided. Even if the accumulation included powder that was swept off the 102 silo, Kingston agreed that there was more powder present on the floor than what would have been swept off.

Taft should have known about the existing conditions. I do not consider being short-staffed a mitigating circumstance. However, since the area is seldom accessed, the spill that occurred prior to the sweeping of the 102 silo would likely not have been seen. Therefore, I find that the level of negligence was properly marked as moderate.

⁹ While there were discrepancies in the time when clean-up was done on the 102 silo and the time that the citation for elevator 101 was issued, Kingston acknowledged that the amount of build-up on the floor was more than what would have been swept off of the silo. In addition, there was no mention by either party of barricades in the area of the elevator that Kingston stated were put up when cleaning off the silo. This leads me to believe that the silo was not cleaned off until after this citation was issued.

3. Citation No. 8689620

Citation No. 8689620 was issued by Cheney on August 1, 2012, at 5:25 a.m., pursuant to section 104(a) of the Act. It alleges a violation of 30 C.F.R. § 56.20003(a). The violation was described in the “Condition or Practice” section as follows:

Over at Auger #6 they had a spillage of material. This spillage of material was approximately 24 inches deep. There were footprints all thought [sic] the spillage. Miners were exposed to twisted ankles or a slip, trip, fall hazard. This was located on the south side of the plant. Miners are in this area to do maintenance.

Standard 56.20003(a) was cited 5 times in two years at mine 04-02964 (5 to the operator, 0 to a contractor).

Ex. G-11.

Cheney determined that the violation was reasonably likely to result in lost workdays or restricted duty, that it was significant and substantial (S&S), that one person was affected, and that the level of negligence was moderate. A civil penalty in the amount of \$687.00 was assessed for the violation.

A. Relevant Testimony

(1) Inspector David Cheney

Cheney testified that there was spillage located at auger 6. Tr. 85. A photograph depicts the auger and powder spread out over the floor, some in a pile on the right side. Ex. G-12, 12-A, 13, 14; Tr. 87, 89.¹⁰ It does not capture the entire spill. Tr. 89. Cheney measured the powder at a depth of 3 to 6 inches, with some of the piles reaching 24 inches deep. Tr. 97, 157, 158. Miners were conducting maintenance work in the area on a pipe that had a hole. Tr. 103-04. In addition to fixing the pipe, Cheney posited that other types of maintenance would be done in the area because he viewed screws, ports, an electrical box, a chute, and stairs. Ex. G-15A; Tr. 105, 108-10.

(2) Nick Kingston

Kingston testified that the powder, fines from the mill, came from the relief valves of the auger 6. Tr. 209, 211. The valves were opened to relieve pressure when a blockage occurred, usually two to three times a week. Tr. 209-10, 293. In order to reach the valves, a miner would have to walk under the auger 6. Tr. 210. Kingston estimated that the ports and omnifit were opened between July 29 and July 31. Tr. 288, 293. He also stated that workplace exams were

¹⁰ Kingston clarified that in Exhibit 15A, the A marked by Cheney was not the auger but an omnifit, which is a conveyor. Tr. 287. The long horizontal pipe marked P is the auger. Tr. 288.

conducted in the area where the spillage was located when it was running because trucks were loaded near there. Tr. 290.

Respondent argues that the citation should be vacated because maintenance was being done over the cited area. R. Resp. Br. at 4. This is not a valid defense. Pursuant to section 110(a) of the Act, “[t]he operator of a coal or other mine in which a violation occurs of a mandatory health or safety standard or who violates any other provision of this Act, shall be assessed a civil penalty by the Secretary. . . .” 30 U.S.C. § 820(a). “This provision has been held to impose liability for violation of a standard against an operator without regard to fault.” *Ames Construction, Inc.*, 33 FMSHRC 1607, 1611 (July 2011); *see also Allied Products Co. v. FMSHRC*, 666 F.2d 890, 893-94 (5th Cir. 1982); *Sewell Coal Co. v. FMSHRC*, 686 F.2d 1066, 1071 (4th Cir. 1982).

The area underneath the auger 6 was a workplace and Taft failed to keep the area clean and orderly by allowing piles of powder to accumulate up to 24 inches over a large area. Both witnesses stated that maintenance was being conducted in the immediate area of the spill. There were other objects in the area that would have required maintenance, and a miner had to travel underneath the auger in order to reach the relief valves. In addition, I credit Kingston’s testimony that workplace exams were conducted in the area of the spill and that trucks were loaded there. Accordingly, I find that Taft violated section 56.20003(a).

B. Findings and Conclusions

(1) Significant & Substantial

The Commission has reviewed and reaffirmed the familiar *Mathies* framework for determining whether a violation is S&S in *Cumberland Coal Resources*, 33 FMSHRC 2357 (Oct. 2011):

The S&S terminology is taken from section 104(d) of the Mine Act, 30 U.S.C. § 814(d), and refers to more serious violations. A violation is S&S if, based on the particular facts surrounding the violation, there exists a reasonable likelihood that the hazard contributed to will result in an injury or illness of a reasonably serious nature. *See Cement Div., Nat’l Gypsum Co.*, 3 FMSHRC 822, 825 (Apr. 1981). In *Mathies*, 6 FMSHRC 1, the Commission further explained:

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.

Id. at 3-4 (footnote omitted); accord *Buck Creek Coal, Inc. v. MSHA*, 52 F.3d 133, 135 (7th Cir. 1999); *Austin Power, Inc. v. Sec’y of Labor*, 861 F.2d 99, 103 (5th Cir. 1988) (approving *Mathies* criteria). An evaluation of the reasonable likelihood of injury should be made assuming continued normal mining operations. See *U.S. Steel Mining Co.*, 6 FMSHRC 1824, 1836 (Aug. 1984).

....

The Commission recently discussed the third element of the *Mathies* test in *Musser Engineering, Inc. and PBS Coals, Inc.*, 32 FMSHRC 1257, 1280-81 (Oct. 2010) (“*PBS*”) (affirming an S&S violation for using an inaccurate mine map). The Commission held that the “test under the third element is whether there is a reasonable likelihood that the hazard contributed to by the violation, i.e., [in that case] the danger of breakthrough and resulting inundation, will cause injury.” *Id.* at 1281. Importantly, we clarified that the “Secretary need not prove a reasonable likelihood that the violation itself will cause injury.” *Id.* The Commission also emphasized the well-established precedent that “the absence of an injury-producing event when a cited practice has occurred does not preclude a determination of S&S.” *Id.* (citing *Elk Run Coal Co.*, 27 FMSHRC 899, 906 (Dec. 2005); and *Blue Bayou Sand & Gravel, Inc.*, 18 FMSHRC 853, 857 (June 1996)).

Cumberland Coal Res., 33 FMSHRC at 2363-65.

The fact of the violation has been established. Cheney maintained that the spillage in the auger 6 area contributed to a discrete hazard, a miner slipping, tripping and falling. Tr. 113. The violation being S&S turns on whether the hazard was reasonably likely to result in an injury causing event and whether it was reasonably likely that an injury would be of a reasonably serious nature.

Cheney determined that injury was reasonably likely because there were miners in and around the area for the previous 2 days conducting maintenance activities and the area “had footprints all through it.” Tr. 97, 103-04, 114, 117. Specifically, he was told by one of the maintenance workers that they were preparing to go upstairs to fix a pipe that had a hole. Tr. 104. While caution tape was present in the area because of a crane being used to perform maintenance work the night before, the tape only spanned one side, and more tape was added once the citation was issued. Tr. 100, 155. Like the above citations, Cheney believed that the spillage created a slip, trip, and fall hazard that could have caused a twisted ankle, resulting in lost workdays or restricted duty. Tr. 113.

Kingston did not think that walking through the area would have been hazardous to a miner. Tr. 211. He maintained that caution tape was hung by maintenance when fixing a blockage in the auger, which usually took place above the floor area where the spillage was located. Tr. 213. He stated that the tape’s function was to block anyone from entering the area because miners were on ladders and sparks were flying from repairing the pipe. Tr. 214, 285.

The powder came from the relief valves of the auger, which Kingston testified were opened between July 29, 2012, and July 31, 2012. This means that the powder accumulations had been present for at least one shift, possibly more. There were also footprints throughout the spillage area, most likely those of the maintenance crew fixing the pipe. This indicates that the caution tape originally placed on one side of the area was insufficient to prevent miners from traveling through it. In addition, Cheney testified that he slipped on similar looking powder located on top of the 102 silo. Tr. 139. I find that the spillage contributed to a discrete safety hazard, a miner slipping, tripping, and falling, which could have resulted in twisted ankles, cuts, and bruises.

Based on these facts, I find that it was reasonably likely that one miner would suffer reasonably serious injuries that would result in lost workdays or restricted duty, and that Cheney properly determined the violation to be S&S.

(2) Negligence

Cheney marked the level of negligence as moderate because he was told by Kingston that the spill had just happened. Tr. 114-15. Cheney did not believe him and asserted that the spill had been present for “almost more than a shift.” Tr. 114-15. In addition, caution tape was present in the area because of a crane doing maintenance work the night before, not as the result of the spillage. Tr. 100. The tape, however, only spanned one side, and more tape was added once the citation was issued. Tr. 155.

Kingston would read the workplace exam records every 2 to 3 days but looked at the records for each day in between. Tr. 283. Section 5 on the exam record covered auger 6 which was located in mill 1. Tr. 285; Ex. G-26. On July 31, 2012, section 5 had housekeeping checked off as unsatisfactory and the comment reads “[a]ll taped off.”¹¹ Ex. G-26; Tr. 285. Kingston stated that the maintenance men would have cleaned up after finishing the repair on the pipe. Tr. 290.

Since the valves were opened between July 29, 2012, and July 31, 2012, the powder had been present for at least one shift. The spill was addressed in the workplace exam record on July 31, 2012, and the caution tape, although insufficient, would have at least alerted miners to the presence of the powder. I find that Cheney properly determined the level of negligence to be moderate.

¹¹ Roy Long signed off on this exam but it was not mentioned in the record if he was an agent of Taft. Tr. 282.

4. Citation No. 8689621

Citation No. 8689621 was issued by Cheney on August 1, 2012, at 5:50 a.m., pursuant to section 104(a) of the Act. It alleges a violation of 30 C.F.R. § 56.20003(a). The violation was described in the “Condition or Practice” section as follows:

At the top of the fines tank was approximately six inches of fines over the toe boards. There were maintenance welders working in this area to fixed [sic] a leak the day before. Footprints were all throughout this area. Miners were exposed to a slip, trip, fall hazard. This tank is approximately 60 foot [sic] off the ground.

Standard 56.20003(a) was cited 6 times in two years at mine 04-02964 (6 to the operator, 0 to a contractor).

Ex. G-16.

Cheney determined that the violation was reasonably likely to result in lost workdays or restricted duty, that it was S&S, that one person was affected, and that the level of negligence was high. A civil penalty in the amount of \$2,282.00 was assessed for the violation.

A. Relevant Testimony

(1) Inspector David Cheney

Cheney testified that there was a large spill, consisting of powder looking material, on the top of the fines tank. Tr. 118; Ex. G-17. The powder was over the toe boards, which was along the outer edge, and at the back side of the tank. Tr. 120. The depth of powder was approximately 6 inches deep, lower in the middle, and extended over an area of approximately 12 feet by 12 feet or 14 feet by 14 feet. Tr. 120, 125. There were also footprints in the powder. Tr. 118, 120.

Cheney asserted that the area was a workplace because two maintenance men were changing a pipe in the area at the time the citation was issued. Tr. 126, 127. There was also a dust collector in the area which Cheney maintained would require bag changes on a regular basis because the bags get clogged. Tr. 128, 129; Ex. G-18.

(2) Nick Kingston

Kingston confirmed that at the time that the citation was issued, there was a leak at the top of the fines tank and maintenance was in the process of fixing it. Tr. 215-16. He stated that maintenance had been working to replace the pipe since at least July 31. Tr. 298. Kingston maintained that generally, only maintenance would need to access the top of the fines tank to conduct inspections of the dust collector. Tr. 215. He was “pretty sure” the inspection was done once every 3 months. Tr. 215.

Respondent argues that the citation should be vacated because welding work justifiably delayed clean-up. R. Resp. Br. at 5. As stated above, the Act imposes strict liability for violation of a standard without regard to fault. *Ames Construction, Inc.*, 33 FMSHRC at 1611. That welding work delayed clean-up is not a valid defense.

Maintenance men were working on top of the fines tank to replace the leaking pipe at the time that the citation was issued and maintenance on the dust collector would have to be performed about once every 3 months. Work was clearly being conducted in the area, making it a workplace. Taft failed to keep the top of the fines tank clean and orderly by allowing powder to accumulate in a large area at depths of up to 6 inches. I find that Respondent violated section 56.20003(a).

Findings and Conclusions

(1) Significant & Substantial

Cheney maintained that the spillage contributed to a discrete hazard, a miner slipping, tripping, falling, or hitting his head on a pipe. Tr. 130. The violation being S&S turns on whether the hazard was reasonably likely to result in an injury causing event and whether it was reasonably likely that an injury would be of a reasonably serious nature.

Cheney determined that injury to one person was reasonably likely because miners were working in the area, walking through the powder, and no one had reported the spill. Tr. 129, 130. He posited that the spill created a slip, trip, and fall hazard that could have resulted in a twisted ankle or a miner hitting his head on one of the several pipes in the area, causing lost workdays or restricted duty.¹² Tr. 130; Ex. G-17.

At least two maintenance men had been working to replace the leaking pipe since July 31, 2012. They had been walking through the powder, which was up to 6 inches deep in some areas, and the spill had gone unreported at the time that the citation was issued. These conditions contributed to a discrete safety hazard, a miner slipping, tripping, falling, or hitting his head on a pipe. These hazards could have resulted in injuries such as a twisted ankle, cuts, bruises, or head trauma, resulting in lost workdays or restricted duty.

Based on these facts, I find that the violation was reasonably likely to result in an injury of a reasonably serious nature to one miner, and that Cheney properly determined that the violation was S&S.

(2) Negligence

Cheney marked the level of negligence as high because he believed that Respondent knew about the spill and took no action to clean it up. Tr. 130. He based this belief on the fact that Chris Atkins, the maintenance supervisor, told him that the pipe was being replaced over the

¹² Cheney also posited that a miner could have suffered a fatal injury if he slipped and fell through the railing. Tr. 129. No additional support to this theory was discussed and the occurrence appears highly unlikely.

last few days. Tr. 131, 224. Cheney stated that when he asked Atkins why the spill had not been cleaned up, Atkins had no response. Tr. 131. Cheney did not review the workplace exam records that covered the top of the fines tank. Tr. 131-32.

A finding of high negligence is appropriate when “[t]he operator knew or should have known of the violative condition or practice, and there are no mitigating circumstances.” 30 C.F.R. § 100.3.

Atkins, a supervisor and agent of Taft, had knowledge that the maintenance men were replacing a pipe and chose to remain silent when asked by Cheney why the spill was not cleaned. While this may imply that Atkins was aware of the spill, there was no direct testimony as to whether Atkins had actually visited the top of the fines tank, and Cheney failed to check the workplace exam records to confirm his belief. Nevertheless, since work was being conducted in the area, Respondent, at the very least, should have known about the violative condition. The fact that the top of the fines tank was usually accessed infrequently is not a mitigating factor since men were performing maintenance in the area at the time of the inspection and workplace exams were being conducted. Because neither the Secretary nor Respondent provided any additional information that would constitute a mitigating circumstance, I find that the level of negligence was properly marked as high.

III. Civil Penalty Criteria

Section 110(i) of the Act grants the Commission the authority to assess all civil penalties provided in the Act.

In assessing civil monetary penalties, the Commission shall consider the operator’s history of previous violations, the appropriateness of such penalty to the size of the business of the operator charged, whether the operator was negligent, the effect on the operator’s ability to continue in business, the gravity of the violation, and the demonstrated good faith of the person charged in attempting to achieve rapid compliance after notification of a violation.

30 U.S.C. § 820(i).

1. History of Previous Violations

Taft’s history of violations is reflected in a report from MSHA’s database, referred to as an R-17. Ex. G-21. The report reflects that 22 violations became final between April 2011 and July 2012. I accept the figures in the report as accurate, but there is no way to determine whether the numbers are high, moderate, or low. *See Cantera Green*, 22 FMSHRC 616, 623-24 (May 2000). The Secretary’s form reflecting the originally assessed penalty amounts for the litigated violations (Secretary’s Exhibit A)¹³, does however, give some qualitative information by assigning points for the number of violations. 30 C.F.R. § 100.3(c). For total violation history, points used in the penalty calculation are assigned on the basis of the number of violations per

¹³ The Secretary’s Exhibit A was filed with the penalty petition.

inspection day, ranging from 0 points for 0 to 0.3 violations per day to 25 points for in excess of 2.1 violations per day. The assessment form for the litigated violations in this case reflects an assessment of 19 points for overall violation history. I find that Taft's history of violations is fairly high.

2. Size of the Operator

The parties did not stipulate to the size of the operator, however, the forms reflecting calculations of the proposed penalties require a determination of the size of the mine operator. The size is calculated "by using both the size of the mine cited and the size of the mine's controlling entity." 30 C.F.R. § 100.3(b). The size of the mine and the size of the mine's controlling entity was assigned 6 points out of a possible 15 and 10 points respectively. As the operator did not contest this determination, I find the operator to be medium in size.

3. Ability to Continue in Business

The parties stipulated that payment of the proposed penalties in this case will not affect Taft's ability to continue in business, and I so find. Stip. 8.

4. Good Faith Abatement

The Secretary stipulated that Taft exercised good faith in terminating the citations in a timely manner, and I so find. Stip. 9.

Given the foregoing, I find the civil penalties assessed by the Secretary are appropriate.

IV. Civil Penalty Assessments

Citation No. 8689617 is **AFFIRMED** as issued.

Citation No. 8689619 is **AFFIRMED** as issued.

Citation No. 8689620 is **AFFIRMED** as issued.

Citation No. 8689621 is **AFFIRMED** as issued.

ORDER

It is **ORDERED** that the operator pay a total penalty of \$3,321.00 within 30 days of the date of this decision.¹⁴

/s/ James G. Gilbert
James G. Gilbert
Administrative Law Judge

Distribution (Certified Mail)

Pamela F. Mucklow, U.S. Department of Labor, Office of the Solicitor, 1999 Broadway, Suite 800, Denver, CO 80202

Larry R. Evans, Oil Dri Corporation of America, 28990 Georgia Highway 3N, Ochlocknee, GA 31773

¹⁴ Payment should be sent to: MINE SAFETY AND HEALTH ADMINISTRATION, U.S. DEPARTMENT OF LABOR, PAYMENT OFFICE, P.O. BOX 790390, ST. LOUIS, MO 63179-0390.

FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

OFFICE OF ADMINISTRATIVE LAW JUDGES
1331 PENNSYLVANIA AVE., N.W., SUITE 520N
WASHINGTON, D.C. 20004

February 28, 2014

SECRETARY OF LABOR,	:	CIVIL PENALTY PROCEEDINGS
MINE SAFETY AND HEALTH	:	
ADMINISTRATION (MSHA),	:	Docket No. KENT 2008-592
Petitioner,	:	A.C. No. 15-09636-139419
v.	:	
	:	Docket No. KENT 2008-784
	:	A.C. No. 15-09636-144081
BLUE DIAMOND COAL COMPANY,	:	
Respondent.	:	Mine: No. 77
	:	
SECRETARY OF LABOR,	:	CIVIL PENALTY PROCEEDING
MINE SAFETY AND HEALTH	:	
ADMINISTRATION (MSHA),	:	Docket No. KENT 2009-6
Petitioner,	:	A.C. No. 15-09636-161762A
v.	:	
	:	
GARY L. JENT, Agent of BLUE DIAMOND	:	Mine: No. 77
COAL COMPANY,	:	
Respondent.	:	

DECISION

Appearances: Christian Barber, Esq., and Willow Fort, Esq., Office of the Solicitor, Nashville, Tennessee, on behalf of the Secretary of Labor;

Melanie J. Kilpatrick, Esq., and Marco M. Rakjovich, Jr., Esq., Rakjovich, Williams, Kilpatrick & True, PLLC, Lexington, Kentucky, on behalf of Blue Diamond Coal Company;

Randall Scott May, Esq., Barret, Haynes, May & Carter, Hazard, Kentucky, on behalf of Gary L. Jent.

Before: Judge Paez

These cases are before me upon the petitions for the assessment of civil penalty filed by the Secretary of Labor (“Secretary”) pursuant to sections 105 and 110 of the Federal Mine Safety and Health Act of 1977 (“Mine Act”), 30 U.S.C. §§ 815, 820. In dispute are one section 104(d)(1) citation and three section 104(d)(2) orders issued to Blue Diamond Coal Company (“Blue Diamond”), each of which the Secretary contends is a “flagrant” violation under section 110(b)(2) of the Mine Act, 30 U.S.C. § 820(b)(2). Also in dispute is a companion section 110(c) penalty assessment issued to Gary L. Jent, alleging his personal liability as an agent of Blue

Diamond. To prevail, the Secretary must prove his charges “by a preponderance of the credible evidence.” *In re: Contests of Respirable Dust Sample Alteration Citations*, 17 FMSHRC 1819, 1838 (Nov. 1995) (citing *Garden Creek Pocahontas Co.*, 11 FMSHRC 2148, 2152 (Nov. 1989)), *aff’d sub nom.*, *SOL v. Keystone Coal Mining Corp.*, 151 F.3d 1096, 1106–07 (D.C. Cir. 1998). This burden of proof requires the Secretary to demonstrate that “the existence of a fact is more probable than its nonexistence.” *RAG Cumberland Res. Corp.*, 22 FMSHRC 1066, 1070 (Sept. 2000) (citations and internal quotation marks omitted), *aff’d*, 272 F.3d 590 (D.C. Cir. 2001).

I. STATEMENT OF THE CASE

Each of the four alleged violations occurred at Blue Diamond’s Mine No. 77. MSHA issued two section 104(d)(2) orders to Blue Diamond on April 5, 2007. Order No. 4220150 charges Blue Diamond with a violation of 30 C.F.R. § 75.370(a)(1) for failing to comply with its approved ventilation plan, while Order No. 7521758 charges Blue Diamond with a violation of 30 C.F.R. § 75.220(a) for failing to comply with its approved roof control plan. On May 9, 2007, MSHA issued section 104(d)(2) Order No. 7524542, charging Blue Diamond with another violation of 30 C.F.R. § 75.220(a). Nearly 6 months later, on November 2, 2007, MSHA then issued section 104(d)(1) Citation No. 7505299, charging Blue Diamond with yet another violation of 30 C.F.R. § 75.220(a). The Secretary designated each citation and order as significant and substantial (“S&S”)¹ and as the result of Blue Diamond’s unwarrantable failure² to comply with a mandatory health or safety standard. Additionally, in one of his first opportunities under the then-new Mine Improvement and New Emergency Response Act of 2006 (“MINER Act”), the Secretary designated each violation as “flagrant”³ and thus eligible for increased penalties. The Secretary proposes penalties of \$187,400.00 for Order No. 4220150, \$184,900.00 for Order No. 7521758, \$196,700.00 for Order No. 7524542, and \$154,500.00 for Citation No. 7505299, for a total civil money penalty of \$723,500.00. Lastly, the Secretary proposes that Jent pay a penalty of \$3,000.00 under section 110(c) of the Mine Act in connection with the ventilation violation in Order No. 4220150.

¹ The S&S terminology is taken from section 104(d)(1) of the Mine Act, 30 U.S.C. § 814(d)(1), which distinguishes as more serious any violation that “could significantly and substantially contribute to the cause and effect of a . . . mine safety or health hazard.”

² The unwarrantable failure terminology is taken from section 104(d)(1) of the Mine Act, 30 U.S.C. § 814(d)(1), which establishes more severe sanctions for any violation that is caused by an “unwarrantable failure of [an] operator to comply with . . . mandatory health or safety standards.”

³ Congress created the “flagrant” designation providing for enhanced civil penalties when it passed the MINER Act. MINER Act, Pub. L. No. 109-236, § 8, 120 Stat. 493, 501 (codified as amended at 30 U.S.C. § 820(b)(2)). The flagrant designation authorizes the assessment of increased civil penalties up to \$220,000.00 for any violation “deemed” to be “a reckless or repeated failure to make reasonable efforts to eliminate a known violation of a mandatory health or safety standard that substantially and proximately caused, or reasonably could have been expected to cause, death or serious bodily injury.” 30 U.S.C. § 820(b)(2).

This matter was originally assigned to two other Administrative Law Judges, during which the case was stayed pending MSHA's investigation under section 110(c) amidst the Commission's backlog following enactment of the MINER Act. Thereafter, Chief Administrative Law Judge Robert J. Lesnick assigned Docket Nos. KENT 2008-592, KENT 2008-784, and KENT 2009-6 to me, and I held a four-day hearing in Hazard, Kentucky.⁴ The Secretary presented testimony from MSHA Inspectors Patrick Stanfield, Burnice Sturgill, and Robert Ashworth, MSHA Roof Control/Ventilation Specialist Charlie Fields, and a roof control expert, MSHA Mining Engineer Michael Gauna. Blue Diamond presented testimony from Section Foreman Timothy Ray Shepard, continuous miner operator Darrell Cress, Mine Superintendent Charles Williams, and a roof control expert, Dr. David Alan Newman. Section Foreman Gary L. Jent also testified. After the hearing, I granted the parties' request to stay the briefing schedule in these cases pending the outcome of the Commission's decision on the appeal of *Stillhouse Mining, LLC*, 33 FMSHRC 778 (Mar. 2011) (ALJ), which applied the "flagrant" provisions under section 110(b)(2) of the Mine Act. A year later, the Commission vacated its order granting review of that decision, and I lifted the stay of the briefing order in these proceedings. The parties each filed closing briefs, and both Blue Diamond and Jent filed reply briefs.

II. ISSUES

The Secretary argues that the conditions at Mine No. 77 were properly cited as violations, that the allegations underlying the citation and orders are valid, and that the proposed penalties are appropriate. (Sec'y Br. at 96.) The Secretary also contends that his section 110(c) charges and proposed penalties are valid and appropriate. (*Id.*)

For its part, Blue Diamond first admits that one of the four conditions identified in Order No. 4220150 constituted a violation of its ventilation plan (Resp't Br. at 11), but contends that the Secretary has not proven any of the other three conditions violated its ventilation plan. (*Id.* at 7, 10, 12.) In particular, Respondent disputes the accuracy of certain air velocity measurements. (*Id.* at 2–10.) In addition, Respondent denies that the conditions were S&S, unwarrantable, or flagrant violations. (*Id.* at 12–21.) Jent also denies the section 110(c) charges against him. (Jent Br. at 2–3.)

Second, Respondent admits that conditions underlying Order No. 7521758 constituted a violation of its roof control plan, but denies that any of the conditions were S&S, unwarrantable, or flagrant violations. (Resp't Br. at 36–42.)

Third, Respondent admits that one of the two conditions identified in Order No. 7524542 constituted a violation, but denies that the other condition violated its roof control plan. (*Id.* at

⁴ In this decision, the hearing transcript, the Secretary's exhibits, and Blue Diamond's exhibits are abbreviated as "Tr.," "Ex. G-#," and "Ex. R-#," respectively. Jent introduced no exhibits at the hearing.

43–47, 53.) Specifically, Blue Diamond disputes the accuracy of the inspector’s measurements and contends that the Secretary improperly interpreted the terms of its roof control plan regarding extended cuts. (*Id.* at 44–49.) Respondent also denies that the conditions cited were S&S, unwarrantable, or flagrant violations. (*Id.* at 49–53.)

Fourth, Blue Diamond admits that one of the four conditions identified in Citation No. 7505299 violated its roof control plan, but denies that the other three conditions constituted violations. (*Id.* at 54–57.) Specifically, Respondent disputes the accuracy of certain entry measurements. (Resp’t Br. at 54–56.) Again, Blue Diamond denies that any of the cited conditions were S&S, unwarrantable, or flagrant violations. (Resp’t Br. at 57–61.)

Accordingly, the following issues are before me: (1) whether the Secretary’s air velocity measurements for Order No. 4220150 accurately reflected the flow of ventilating air; (2) whether the Secretary’s measurements accurately reflected conditions noted in Order No. 7524542; (3) whether the Secretary improperly interpreted Blue Diamond’s roof control plan provisions regarding extended cuts in Order No. 7524542; (4) whether the Secretary’s measurements accurately reflected conditions noted in Citation No. 7505299; (5) whether the record supports the Secretary’s S&S, unwarrantable, and flagrant designations for the Citation and all three of the Orders before me; (6) whether the record supports holding Gary L. Jent liable under section 110(c); and (7) whether the Secretary’s proposed penalties against Blue Diamond and Jent are appropriate.

For the reasons set forth below, Order No. 4220150 is **MODIFIED** to remove the S&S, unwarrantable, and flagrant designations, and to lower the cited level of negligence from “reckless disregard” to “moderate.” Order No. 7521758 is **AFFIRMED** as S&S, and **MODIFIED** to remove the unwarrantable failure and flagrant designations and to lower the cited level of negligence from “reckless disregard” to “moderate.” Order No. 7524542 is **AFFIRMED** as S&S and unwarrantable, and **MODIFIED** to remove the flagrant designation and to lower the cited level of negligence from “reckless disregard” to “high.” Citation No. 7505299 is **AFFIRMED** as S&S, and **MODIFIED** to remove the unwarrantable failure and flagrant designations and to lower the cited level of negligence from “high” to “moderate.” Finally, the section 110(c) penalty assessment against Gary L. Jent is **VACATED**, and the proceeding brought against him is **DISMISSED**.

III. FINDINGS OF FACT – OVERVIEW

A. Operations at Mine No. 77

Mine No. 77 is a room-and-pillar type underground coal mine located in Perry and Letcher Counties, Kentucky. (Ex. G–3; Ex. G–16; Ex. G–37.) When viewed from above, room-and-pillar type underground coal mines resemble a checkerboard containing long corridor-like entries and crosscuts driven through a seam of coal with square or rectangular pillars of coal

remaining in place to bear the weight of the rock and dirt between the mine's roof and the earth's surface. (Ex. G-16; Ex. G-17; Tr. 676-77, 938, 1111-12.)

Blue Diamond uses large machines, known as continuous miners, to cut through rock and extract coal from the mine. (Ex. G-29 at 22; Ex. R-25; *see, e.g.*, Tr. 420-24, 648.) Continuous mining machines include water sprays and scrubbers to cut down on dust created during mining. (Ex. G-29 at 22; Ex. R-25; Tr. 419-21, 901-02.) The continuous miner operator completes each cut in a series of parallel "lifts" because finished entries and crosscuts are wider than the continuous mining machine. (Tr. 425-26, 475, 584.) Starting on the left hand side of a new entry or crosscut, the continuous miner operator takes a "lift" by boring forward a specified distance into the coal face. (Tr. 475, 584.) After completing the left lift, the continuous miner operator pulls back and takes a parallel lift on the right hand side of the entry. (Tr. 425-26, 475, 584.) Taken together, these lifts are considered a cut.

Blue Diamond's Mine No. 77 operates on three shifts. (Tr. 60-61, 115, 129, 142, 804; Ex. G-28 at 1.) The day shift operates from 7:00 a.m. until 3:00 p.m., the second shift operates from 3:00 p.m. until 11:00 p.m., and the third shift operates from 11:00 p.m. until 7:00 a.m. (Tr. 60-61, 804.) The third shift is a maintenance shift that does not produce coal. (Tr. 1042.)

B. Roof Control at Mine No. 77

Mine roofs include two parts: the immediate roof and the main roof. The immediate roof is the first six to eight feet of rock immediately above the entry or crosscut corridor. (Tr. 46, 70-71.) The main roof is the rock between the immediate roof and the earth's surface. (Tr. 70-71.) Mine No. 77 is between 900 and 1,200 feet below the earth's surface, and the weight of that overburden creates downward pressure on the roof of the entry and crosscut corridors. (Tr. 77, 86, 140-41, 255, 311, 676-77, 689, 711, 926.) Rock roofs sag, fragment, and twist under this pressure, which may cause pieces of the roof to collapse and fall. (Tr. 77-78, 84-86, 99, 106, 119-20, 141-43, 157-59, 263, 307, 311-12, 351, 687-689, 717, 735-36, 739, 1105-06, 1110-12, 1117-20, 1125-26, 1147-48.) Longer and wider cuts are more likely to fall because they expose more geological material. (Tr. 731, 952, 1117-18.)

To protect miners from roof collapses and falling rock, MSHA enforces standards requiring mine operators to reinforce and strengthen mine roofs. *See* 30 C.F.R. §§ 75.200-.223. Under these regulations, MSHA approves roof control plans requiring mine operators to support their mine roofs in specific ways. *Id.* §§ 75.220-.223. At the time of each of the alleged roof control violations, Blue Diamond was operating under MSHA's approved roof control plan dated September 7, 2006 ("September 7 Plan"). (Ex. G-19; Ex. G-20; Ex. G-23; Ex. G-25.) A typical roof control plan requires several steps to maintain the integrity of mine roofs. (*See, e.g.*, Ex. G-20.)

First, roof bolts stabilize the immediate roof and secure it to the main roof. (Tr. 56, 85, 262-63, 275, 684, 713, 723, 751, 764, 1111.) Using a roof bolting machine, a roof bolt operator

inserts a long metal roof bolt into the mine roof, using resin glue (or grout) to hold the roof bolt in place. (Tr. 64–65, 67–68, 149, 462, 608–09, 678, 944.)

Blue Diamond used two types of roof bolts in Mine No. 77: five-foot resin bolts and ten-foot cable bolts. Resin bolts are rigid pieces of rebar that create a beam of solid rock and have a bearing plate on the bottom to secure draw rock⁵ to the immediate roof. (Tr. 680–85, 937.) In contrast, ten-foot cable bolts extend into the main roof. (Tr. 59, 85, 90, 262–63, 683–84, 937–38.) Acting as a tether, these cable bolts help to suspend the immediate roof from the more secure main roof. (Tr. 85, 89, 262–63, 682–84, 937–38.) Cable bolts are designed to compress the various layers of rock within the immediate roof to create a more secure, fixed beam of rock. (Tr. 683–84.)

Second, roof bolting plans limit delays in installing roof bolt support because mine roofs begin to sag and separate when an operator waits too long to install roof support. (Tr. 1110–11, 1119, 1147–48.) This sagging and separation makes a roof more likely to fall than if an operator bolts the roof immediately. (Tr. 1117–19.)

Finally, in some parts of the mine, roof control plans require additional support mechanisms, such as straps and cribs. Straps are flexible pieces of steel that are four-feet long and a quarter-inch to a half-inch thick, with holes on the ends that allow them to be affixed to the mine roof or rib. (Tr. 72–73, 241–42, 246–47, 697–98.) Cribs are wooden blocks stacked on top of each other to brace the mine roof. (Tr. 63–64, 121–22, 964–65.)

C. Mine Ventilation

Mining coal creates coal dust and liberates methane, which is an explosive gas at certain concentrations. (Tr. 427, 463–64.) Coal dust can also contribute to pneumoconiosis. (Tr. 435–36.) At the time of the violations, Mine No. 77 liberated between 250,000 and 500,000 cubic feet of methane in a twenty-four-hour period. (Tr. 417.) If not properly ventilated, coal dust and methane present a danger to miners.

Mine ventilation systems “sweep away noxious, harmful, [and] explosive gases and coal dust and rock dust produced by coal production.” (Tr. 426–27.) Mine operators use a variety of permanent devices as well as temporary devices—including burlap check (or brattice) curtains, line curtains, and deflector curtains, made of burlap—as ventilation controls that direct fresh air in a predetermined course through the mine. (Tr. 443, 450, 470–71, 808–09, 857, 861.) An anemometer is used to take air readings that measure the velocity of air flowing through a particular spot. (Tr. 471–72, 859, 868–69.)

⁵ Throughout the hearing, various witnesses consistently used the phrase “draw rock” to describe loose rock within the mine roof. Inspector Sturgill defined “draw rock” as “anything in the mine roof that’s not supported that could fall from the mine roof.” (Tr. 381.)

Under 30 C.F.R. § 75.370(a)(1), a mine operator must develop and follow an approved ventilation plan meeting certain requirements. At the time of the alleged ventilation violation in this case, Blue Diamond followed a ventilation plan approved on July 26, 2005 (“July 26 Plan”).

IV. PRINCIPLES OF LAW AND STATUTORY ANALYSIS

A. Section 110(c) of the Mine Act – Agent Liability

Corporate directors, officers, or agents are liable under section 110(c) when they know or had reason to know of a violative condition, and fail to act to correct the condition. *See* 30 U.S.C. § 820(c); *Cougar Coal Co.*, 25 FMSHRC 513, 517 (Sept. 2003). Section 110(c) liability “is generally predicated on aggravated conduct constituting more than ordinary negligence.” *Ernest Matney*, 34 FMSHRC 777, 783 (Apr. 2012).

B. 30 C.F.R. § 75.370(a)(1) – Ventilation Plans

Section 75.370(a)(1) requires operators to develop and follow an approved ventilation plan designed to control methane and respirable dust and suitable to the mine’s conditions and mining system; and consisting of the elements prescribed in section 75.371 and a map as prescribed in section 75.372. 30 C.F.R. § 75.370(a)(1). *See Peabody Coal Co.*, 16 FMSHRC 2199, 2203 (Nov. 1994) (affirming ALJ’s conclusion that a ventilation plan is violated when an operator does not follow its specific terms).

C. 30 C.F.R. § 75.220(a) – Roof Control Plans

Section 75.220(a)(1) requires operators to develop and follow an approved roof control plan that is suitable to the prevailing geological conditions and the mining system in place at the mine and to take additional measures to protect persons if unusual hazards are encountered. 30 C.F.R. § 75.220(a)(1). An operator violates section 75.220(a)(1) when it does not comply with the terms of its roof control plan. *See Harlan Cumberland Coal Co.*, 20 FMSHRC 1275, 1280–82 (Dec. 1998) (explaining how the Secretary must prove violations of roof control plans).

D. Significant and Substantial Violations

A violation is S&S “if, based on 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). To establish an S&S violation, the Secretary 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. Fed. Mine Safety & Health Admin.*, 52 F.3d 133,

135–36 (7th Cir. 1995) (affirming ALJ’s application of the *Mathies* criteria); *Austin Power, Inc. v. Sec’y of Labor*, 861 F.2d 99, 103 (5th Cir. 1988) (approving the *Mathies* criteria).

The Commission has also provided guidance to Administrative Law Judges in applying the *Mathies* test. The Commission indicated that “an inspector’s judgment is an important element in an S&S determination.” *Mathies*, 6 FMSHRC at 5 (citing *Nat’l Gypsum*, 3 FMSHRC at 825–26); *see also Buck Creek Coal*, 52 F.3d at 135 (stating that ALJ did not abuse discretion in crediting opinion of experienced inspector). The Commission has also observed that “the reference to ‘hazard’ in the second element is simply a recognition that the violation must be more than a mere technical violation—i.e., that the violation present *a measure* of danger.” *U.S. Steel Mining Co.*, 6 FMSHRC 1834, 1836 (Aug. 1984) (emphasis added) (citing *Cement Div., National Gypsum Co.*, 3 FMSHRC 822, 827 (Apr. 1981)). Moreover, the Commission has indicated “[t]he correct inquiry under the third element of *Mathies* is whether the hazard identified under element two is reasonably likely to cause injury.” *Black Beauty Coal Co.*, 33 FMSHRC 1733, 1742 n.13 (Aug. 2012). Finally, the Commission indicated an evaluation of the reasonable likelihood of injury should be made assuming continued mining operations. *U.S. Steel Mining Co.*, 7 FMSHRC 1125, 1130 (Aug. 1985) (quoting *U.S. Steel Mining Co.*, 6 FMSHRC 1573, 1574 (July 1984)).

E. Unwarrantable Failure of Operator to Comply with Mandatory Standards

In *Emery Mining*, the Commission determined that an unwarrantable failure is aggravated conduct constituting more than ordinary negligence. 9 FMSHRC 1997, 2001 (Dec. 1987). Unwarrantable failure is characterized by such conduct as “reckless disregard,” “intentional misconduct,” “indifference,” or a “serious lack of reasonable care.” *Id.* at 2003–04; *Rochester & Pittsburgh Coal Co.*, 13 FMSHRC 189, 194 (Feb. 1991); *see also Buck Creek Coal*, 52 F.3d at 136 (approving the Commission’s unwarrantable failure test).

Whether conduct is “aggravated” in the context of unwarrantable failure is determined by looking at all the facts and circumstances of each case to see if any aggravating factors exist, such as the length of time that the violation has existed, the extent of the violative condition, whether the operator has been placed on notice that greater efforts are necessary for compliance, the operator’s efforts in abating the violative condition, whether the violation is obvious or poses a high degree of danger, and the operator’s knowledge of the existence of the violation. *See Consolidation Coal Co.*, 22 FMSHRC 340, 353 (Mar. 2000); *Cyprus Emerald Res. Corp.*, 20 FMSHRC 790, 813 (Aug. 1998), *rev’d on other grounds*, 195 F.3d 42 (D.C. Cir. 1999); *Midwest Material Co.*, 19 FMSHRC 30, 34 (Jan. 1997); *Mullins & Sons Coal Co.*, 16 FMSHRC 192, 195 (Feb. 1994); *Peabody Coal Co.*, 14 FMSHRC 1258, 1261 (Aug. 1992); *BethEnergy Mines, Inc.*, 14 FMSHRC 1232, 1243–44 (Aug. 1992); *Quinland Coals, Inc.*, 10 FMSHRC 705, 709 (June 1998). These factors are viewed in the context of the factual circumstances of each case, and some factors may not be relevant to a particular factual scenario. *Consolidation Coal Co.*, 22 FMSHRC at 353. All relevant facts and circumstances of each case must be examined to determine if an actor’s conduct is aggravated or whether mitigating circumstances exist. *Id.*

F. Flagrant Violations

Section 110(b)(2) provides:

Violations under this section that are deemed to be flagrant may be assessed a civil penalty of not more than \$220,000. For purposes of the preceding sentence, the term “flagrant” with respect to a violation means a *reckless* or *repeated* failure to make reasonable efforts to eliminate a known violation of a mandatory health or safety standard that substantially and proximately caused, or reasonably could have been expected to cause, death or serious bodily injury.

30 U.S.C. § 820(b)(2) (emphasis added). Thus, section 110(b)(2) authorizes the Commission to assess a civil penalty of up to \$220,000.00 for any violation that is deemed to be flagrant. Violations may be deemed flagrant when an operator fails either (1) recklessly or (2) repeatedly to make reasonable efforts to eliminate a known violation.

1. Reckless Failure

In my decision in *Stillhouse Mining, LLC*, I closely examined the text of the MINER Act and its legislative history, and determined the statute to be ambiguous. 33 FMSHRC 778, 801 (Mar. 2011) (ALJ). To date, the Commission has not contradicted my interpretation of the “reckless” element or the second, third, and fourth elements of a flagrant violation. For the purposes of this decision, therefore, I adopt the interpretation of each of these elements as outlined in *Stillhouse*, including:

1. Reckless – “[A]n operator is reckless for the purposes of a flagrant violation when it consciously or deliberately disregards an unjustifiable, reasonably likely risk of death or serious bodily injury in failing to make reasonable efforts to eliminate a known violation of a mandatory health or safety standard.” *Id.* at 804.

2. Failure to Make Reasonable Efforts to Eliminate – “[A] ‘reckless or repeated failure to make reasonable efforts to eliminate a known violation of a mandatory health or safety standard’ occurs when, in light of all the facts and circumstances surrounding the violation, the operator does not take the steps a reasonably prudent operator would have taken to eliminate the known violation of a mandatory health or safety standard and consciously or deliberately disregards an unjustifiable, reasonably likely risk of death or serious bodily injury.” *Id.* at 805.

3. Known Violation of a Mandatory Health or Safety Standard – “[A] ‘known violation’ refers to the operator’s express or implied actual knowledge of the violation” and “need not have been previously cited by MSHA at the time the operator recklessly failed to eliminate it.” *Id.* at 807.

4. Reasonably Could Have Been Expected to Cause Death or Serious Bodily Injury – “[W]hen, based on all the facts and circumstances surrounding the operator’s reckless failure to make reasonable efforts to eliminate a known violation of a mandatory health or safety standard, the operator’s conduct was likely to bring about death or serious bodily injury.” *Id.* at 808.

2. Repeated Failure

Similarly, the Commission has not yet adopted a detailed definition of “repeated” failure. The Commission has stated that section 110(b)(2) plainly permits the Secretary to use an operator’s past violation history as evidence of a “repeated” failure under section 110(b)(2). *Wolf Run Mining Co.*, 35 FMSHRC 536, 541 (Mar. 2013) (“We conclude that the plain language of section 110(b)(2) does not support the Judge’s ruling that past violative conduct may not be considered in determining whether a cited condition represents a ‘repeated failure . . .’”). Nevertheless, the Commission limited its decision to whether the Judge had properly construed the “‘repeated failure’ language of section 110(b)(2) . . .” and did “not resolve which prior violations are relevant to the assessment of a ‘repeated failure’ violation.” *Id.* at 543 & n.15.

Thus, I may consider evidence of past violations to determine whether an operator’s conduct constitutes a repeated failure. Yet, the narrow, interlocutory nature of the Commission’s *Wolf Run* decision leaves open the level of similarity or pervasiveness necessary for past conduct to prove a present violation as a repeated failure under section 110(b)(2) of the Mine Act.

In his post-hearing brief, the Secretary presents a two-pronged definition for “repeated”:

[W]here [s]ection 110(b)(2)’s other criteria are satisfied, a “repeated failure” is established where the operator either: (1) failed more than once to make reasonable efforts to eliminate the violation alleged to be flagrant; or (2) failed to make reasonable efforts to eliminate at least one previous violation before failing to make reasonable efforts to eliminate the violation alleged to be flagrant.

(Sec’y Br. at 8 (citation omitted).) However, the Secretary does not rely on his first proposed interpretation—i.e., that Blue Diamond failed more than once to make reasonable efforts to eliminate the violation alleged to be flagrant. (Ex. G–19; Ex. G–23; Ex. G–25; Ex. G–27; Sec’y Br. at 37, 53, 63, and 87.) Indeed, the Secretary’s post-hearing brief points only to Blue Diamond’s history of previous violations. (Sec’y Br. at 37, 53, 63, and 87.) Consequently, the Secretary’s “repeated” failure allegations turn on his second proposed interpretation—i.e., Blue Diamond’s alleged failure to make reasonable efforts to eliminate at least one previous violation before failing to make reasonable efforts to eliminate the violation alleged to be flagrant.

The Secretary argues that where section 110(b)(2)’s *other* criteria are satisfied, an operator’s previous failure “to make reasonable efforts to eliminate” one prior violation is a

predicate upon which the *presently* cited failure to make reasonable efforts may be deemed a “repeated” failure. (See Sec’y Br. at 8.) According to the Secretary’s definition, a flagrant designation under the repeated prong of section 110(b)(2) includes the following elements:

1. A present failure to make reasonable efforts to eliminate the violation alleged to be flagrant;
2. That the present violation was a known violation of a mandatory health or safety standard;
3. That the present violation reasonably could have been expected to cause death or serious bodily injury; and
4. A prior failure to make reasonable efforts to eliminate a previous violation.

Ordinarily, a question regarding the meaning of “repeated” would require that I apply the familiar, two-step interpretive framework outlined in *Chevron, U.S.A., Inc. v. Natural Resources Defense Council*, 467 U.S. 837, 842 (1984). Given my factual findings and conclusions of law in this case, however, I need not make a detailed analysis of the meaning of “repeated” in section 110(b)(2). See discussion *infra* Part V.A.5, Part VI.B.5, Part VI.C.6, and Part VI.D.6. Instead, I will assume *arguendo* that the Secretary’s interpretation should be accorded deference.

V. ANALYSIS, FURTHER FINDINGS OF FACT, AND CONCLUSIONS OF LAW — VENTILATION VIOLATIONS

A. Order No. 4220150 – Ventilation Order – April 5, 2007

1. Background, Inspection, and Further Findings of Fact

a. Development of New Panel

On April 4, 2007, Blue Diamond began developing a new panel known as the 11 Section off the Daugherty Mains in Mine No. 77. (Tr. 31–34, 36, 805; Ex. G–16; Ex. G–17.) When facing the new panel, the 11 Section’s No. 1 entry was located on the left-hand side and the No. 6 entry on the right-hand side. (Tr. 34–35, 228; Ex. G–16; Ex. G–17.) Fresh air ventilated the new panel from the 11 Section’s No. 6 entry down the 11 Section’s last open crosscut to the No. 1 entry. (Tr. 852, 856–57; Ex. R–30.) As the panel was developed, Blue Diamond recorded air readings on its overnight and day shifts demonstrating sufficient air flow. (Tr. 833; Ex. R–18.)

That same day, Inspector Robert Ashworth began an inspection of the 11 Section. (Tr. 478–79; Ex. R–13 at 1–2.) While there, Ashworth completed an imminent danger run, examined the mine roof and test holes, took methane gas readings, and took bottle samples of air. (Tr. 479–85, 496–500; Ex. R–13 at 1–10; Ex. R–16; Ex. R–17.) He also measured the air velocity in the last open crosscut to be 14,706 cubic feet per minute (CFM), well above the 9,000 CFM required in Blue Diamond’s July 26 Plan. (Tr. 485, 496; Ex. R–13 at 10–10(b); Ex. G–29 at 8.) In addition, he examined ventilation curtains throughout the section and did not find any curtains missing or out of place. (Ex. R–13 at 12; Tr. 497, 504.)

b. Mining Operations and Code-A-Phone Complaints on April 5, 2007

Mining operations on the 11 Section continued through the second shift of April 5, 2007. (Tr. 773–75, 804–05.) When second-shift Section Foreman Jent arrived on the section that day, he spoke with day-shift Section Foreman Jody Roberts. (Tr. 807.) Roberts mentioned no roof control or ventilation concerns. (Tr. 807.) Jent then took an air reading in the last open crosscut between the No. 1 and No. 2 entries, and measured an air velocity of 13,500 CFM. (Tr. 784–86, 804, 806–10; Ex. R–29.)

By the time Jent completed that air reading, the continuous miner machine began cutting a crosscut between the No. 1 and No. 2 entries. (Tr. 423–25, 451–52, 811, 871; G–17; Ex. G–36.) As the miner operated, Jent took another air reading behind the line curtain in the No. 1 entry and found an air velocity of approximately 5,700 CFM, also above the 5,500 CFM that the July 26 Plan required behind line curtains. (Tr. 785, 798, 837; Ex. G–29 at 8.) The continuous miner operator, Darrell Cress, mined for approximately half an hour but stopped when he learned a shuttle car had broken down at the mine’s feeder. (Tr. 775–76, 797–98.) While backing the continuous miner out of the new crosscut, Cress noticed that the last shuttle car he loaded had torn down the line curtain in the No. 1 entry. (Tr. 775–78, 797.) Cress moved the curtain out of the way so he could back down the entry without destroying the curtain, with the intention of hanging it back up when finished. (Tr. 776–80, 797.)

Meanwhile, Jent had begun his on-shift exam and noticed that the roof bolter had moved from the No. 3 entry into the No. 2 entry. (Tr. 812.) Jent observed the roof bolter sitting on the line curtain for the No. 2 entry and instructed the roof bolter operators to re-hang the curtain. (Tr. 812, 814.) Relying on the bolter operators to do as instructed, Jent headed to the No. 3 entry to continue his on-shift exam. (Tr. 814–15.) Jent noticed that the roof bolter had torn down the curtain in the No. 3 entry when moving to the No. 2 entry. (Tr. 815.) Following his policy that miners re-hang any curtains they tear down, Jent instructed the roof bolter operators to re-hang the curtain in the No. 3 entry. (Tr. 815–16.) Jent then headed to the feeder to address the disabled shuttle car. (Tr. 36–37, 439, 522, 781, 816–18, 878; Ex. R–24A; Ex. R–29; Ex. R–30.)

At that point, Inspectors Robert Ashworth and Patrick Stanfield arrived on the 11 Section with Superintendent Williams. (Tr. 30, 414–15, 821; Ex. G–18 at 1; Ex. R–8 at 2.) That afternoon, MSHA had received safety complaints regarding conditions at Mine No. 77. (Tr. 29–30, 413–14, 881–82; Ex. G–18 at 2; Ex. R–8 at 2.) Although Inspector Ashworth had already worked a full shift inspecting Mine No. 77 that day, he returned to the mine with Inspector Stanfield to investigate those safety complaints, which included drug use at the mine, unsafe roof conditions, improper ventilation, extended cuts, and oil on mine machinery. (Tr. 29–30, 413–15, 881–82; Ex. G–18 at 1, 15–20.)

When Stanfield and Ashworth arrived on the 11 Section, the double-headed roof bolter was operating in the No. 2 entry and the continuous miner was energized in the No. 1 entry. (Tr.

36, 423–25, 438, 441–42, 452, 812–14, 816, 859; Ex. G–17.) After Ashworth and Stanfield completed a search of the miners for drugs and smoking materials and found nothing, they began their inspection with an imminent danger run through the 11 Section. (Tr. 34, 415–17.) Stanfield headed to the No. 6 entry, while Ashworth started in the No. 1 entry. (Tr. 34, 228, 233.) Stanfield estimated that eight miners were working on the 11 Section at the time. (Tr. 39.)

c. Order No. 4220150 – The Ventilation Violation

As Inspectors Ashworth and Stanfield gathered the miners to complete their search for drugs and smoking materials, Ashworth observed that required deflector curtains in the No. 2 and No. 3 entries were missing. (Ex. G–28 at 4.) Ashworth also observed continuous miner operator Darrell Cress step into the intersection of the last open crosscut and the No. 1 entry, and begin installing a line curtain. (Tr. 417–18, 781–82, 793, 797; Ex. G–28 at 5.) Ashworth “informed [Cress] that it was too late [to rehang the curtain]” and instructed him to back the miner up under the supported mine roof. (Ex. G–28 at 5; *see also* Tr. 793.) Ashworth further testified that he observed coal dust suspended in the air in the No. 1 entry.⁶ (Tr. 418–20, 423–24, 426.)

After Ashworth and Stanfield completed their search for drug and smoking materials and gave a safety talk, Ashworth next took air readings to measure the velocity of air flowing through Blue Diamond’s ventilation system. (Tr. 822; Ex. G–28 at 8–9; Ex. R–29.) Ashworth testified that he took three air readings between the first and second entry of the last open crosscut. (Tr. 440.) At approximately 7:30 p.m.—more than 12 hours after his work day began—Ashworth measured the air velocity to be 7,611 CFM, which is below the 9,000 CFM required in the July 26 Plan. (Tr. 445, 822; Ex. G–28 at 8–9.) Superintendent Williams contends that he told Ashworth that he was in the wrong place to take an air reading. (Tr. 858–59, 891–92.) Moreover, Jent testified that he told Ashworth that he had sufficient air on the section when he started work that shift. (Tr. 823–24.) At the time of the hearing, Ashworth did not recall either conversation. (Tr. 444–45, 528.)

According to Ashworth, at this point, Jent and the 11 Section crew “began to install[] ventilation controls across the section.” (Ex. G–28 at 11.) Meanwhile, Ashworth examined a previous garbage accumulation violation. (*Id.*) At 9:45 p.m., he took another air reading at the same location in the last open crosscut, which measured 7,718 CFM. (Tr. 830; Ex. G–28 at 9, 12.) Although Ashworth does not recall doing so, Shepard, Jent, and Superintendent Williams each credibly testified that Ashworth then directed Blue Diamond personnel to hang and relocate

⁶ Both Williams and Cress testified that they did not see any coal dust in the air; instead they asserted the substance was mist from the energized continuous miner’s water sprays. (Tr. 783–84; 871–72.) Further, Inspector Stanfield admitted that he saw no coal dust in the No. 1 entry when he arrived on the 11 Section or prior to the drug search. (Tr. 234.) Based on the evidence before me, I determine that the Secretary has not met his burden of proving that coal dust was present in the No. 1 entry when Ashworth and Stanfield arrived on the 11 Section.

certain ventilation curtains. (Tr. 555, 788–89, 799–800, 830–31, 887–88, 905; Ex. R–28; Ex. R–29; Ex. R–30.) Shortly thereafter, at 10:00 p.m., Ashworth took a third reading in that same location, measuring the air flow to be 9,648 CFM. (Tr. 446, 519; Ex. G–28 at 12, 15.)

After finding sufficient air in the last open crosscut, Ashworth then took an air reading at the end of the newly-installed line curtain in the No. 1 entry at 11:00 p.m. (Ex. G–28 at 13–15; Tr. 454.) He recorded an air velocity of 2,066 CFM. (Ex. G–28 at 14–15; Tr. 454.)

Based on his observations on the 11 Section, Inspector Ashworth issued Order No. 4220150 alleging a violation of 30 C.F.R. § 75.370(a)(1):

The operator is not complying with the Ventilation Plan, approved 07-26-2005 on the 011 MMU. The following hazards are present:

- 1). The operator is failing to maintain the minimum amount of air required in the last open crosscut, when measured with a[n] anemometer only 7,611 CFM was present[;]
- 2). The continuous miner was being operated in the No. 1 right crosscut approximately forty[-]five[-]feet inby the end of the line curtain. There is no perceptible air movement present behind the end of the line curtain. Visible suspended coal dust is present at the time this condition was observed. After repeated attempts to repair ventilation controls it took approximately 2 1/2 hours to achieve the minimum 9,000 [CFM] in the last open crosscut. After repairs were made on [sic] only 9,648 [CFM] was obtained. After an additional hour the minimum requirement of 5,500 [CFM] at the end of the line curtain could not be obtained. Only 2,066 [CFM] was measured at the end of the line curtain. When these conditions were initially observed a methane check with a hand held gas detector indicate[d] that .55% methane is present at the inby corner of the No. 1 right crosscut being mined.[;]
- 3). Both the No.2 and No.3 heading are not being provided with ventilating deflector curtains. The roof bolter is being operated in the No. 2 right crosscut which also requires a deflector curtain. The No. 2 heading is approximately 105 feet deep and the No. 3 heading is approximately 110 feet deep inby the last crosscut. A methane check with a hand held gas detector indicate[d] .25% methane is present in the No.2 at the last row of permanent roof supports, .05% methane is present in the face area of the No. 3 entry.
- 4).

No check curtains are present in the [N]o. 2 thru [N]o. 5 entries that are necessary to direct ventilation across the section.^[7] This mine is on a 15 day spot inspection requirement for excessive methane liberation. This mine has been cited numerous time[s] for similar conditions. All of the conditions present would be obvious to the most casual of observers. The foremen present on the active section is a certified foreman who is trained and skilled in the recognition of hazardous conditions. Management engaged in aggravated conduct constituting more than ordinary negligence by deeming production more important than the miners['] health. This violation is an unwarrantable failure to comply with a mandatory standard.

(Ex. G-27 at 1-2.) Ashworth marked “permanently disabling injuries” as “highly likely,” designated the violation as S&S, and characterized Blue Diamond’s negligence as a “reckless disregard.” (*Id.*) He also alleged that eight miners would be affected. (*Id.*)

d. Further Findings of Fact – Ashworth’s Last Open Crosscut Air Measurements

Inspector Ashworth measured the air velocity in the 11 Section’s last open crosscut three times, and his first two readings found insufficient velocity to satisfy Blue Diamond’s July 26 Plan requirements. Ashworth claims he took all three of these readings while positioned between the first and second entry of the new panel. (Tr. 440, 443-46, 511.) Ashworth’s inspection notes, however, indicate that he took his air reading between the second and third entry of the panel. (Ex. G-28 at 9.) According to Superintendent Williams and Section Foreman Jent, Ashworth was between the second and third entry when he took air readings. (Tr. 822-23, 858-59, 869-70; Ex. R-29; Ex. R-30.)

Ashworth, Inspector Stanfield, and Williams each testified that an inspector’s location within the last open crosscut affects the amount of air that is ultimately measured. (Tr. 226-27, 515-16, 893-94.) Ashworth also stated that an air reading between the second and third entries

⁷ During cross-examination, Ashworth admitted that the way he worded this fourth allegation was a “mistake.” (Tr. 543-44.) Although Ashworth testified that he would modify and “totally reword” that allegation (Tr. 543), the Secretary made no motion at the hearing or since to amend the citation. Accordingly, I dismiss the fourth allegation included in Order No. 4220150.

would result in a lower measured velocity than if taken between the first and second entries.⁸ (Tr. 515–16.) Yet, as Ashworth and Jent made clear, the proper location to measure air velocity is difficult to determine on a new section. (Tr. 516, 562, 828–29.) Thus, Ashworth’s position within the crosscut will critically affect the weight I afford those readings when assessing the Secretary’s allegations.

The testimony and evidence before me demonstrate that Ashworth took his first two air readings in the last open crosscut while positioned between the second and third entries. Most importantly, Ashworth’s own contemporaneous inspection notes also indicate that he took his air readings between the second and third entry of the panel. (Ex. G–28 at 9, 15.) At the hearing, Ashworth testified that his inspection notes incorrectly recorded the location where he took his air readings (Tr. 443–44, 511), and I believe that Ashworth was testifying to the best of his recollection. However, I note that Ashworth was the only person present who had worked double-duty that day. Thus, it seems likely that he might not accurately remember his location on the confusing, new 11 Section. Accordingly, I credit Ashworth’s contemporaneous notes over his testimony nearly four years after the alleged violation.⁹ Moreover, Williams and Jent’s testimony about Ashworth’s position corroborate what Ashworth himself wrote at the time of his inspection. Accordingly, I find that Ashworth’s first and second air readings were taken between

⁸ The parties disagree about the proper location for an air reading with the ventilation controls set up as they were when Ashworth and Stanfield arrived on April 5, 2007. (*See* Sec’y Br. at 70–71; Resp’t Br. at 6–7; Jent Br. at 4–5.) Given Ashworth’s admission that an air reading taken between the second and third entries would result in a lower measured velocity than an air reading taken between the first and second entries, I do not need to determine the proper position in which to measure air velocity in this case. Even using the Secretary’s theory of the case, a reading between No. 2 and No. 3 entries would decrease the measured velocity.

⁹ The Secretary argues that the commotion on the 11 Section and Ashworth’s long day at the mine made him more apt to make a mistake in his notes. (Sec’y Br. at 70 n7.) However, these same factors would also make Ashworth more likely to have been confused in the newly developed section, and to inaccurately recall his precise location for his air readings four years later.

I also reject the Secretary’s argument that Inspector Stanfield “corroborated” Ashworth’s testimony about his location within the crosscut when taking his air readings. (Sec’y Br. at 70 n.7.) Stanfield explicitly testified that he did not know exactly where Ashworth was when he took his air reading. (Tr. 216–17, 237–38.)

the No. 2 and No. 3 entries of the last open crosscut. I also find this location resulted in inaccurate air measurements.¹⁰

2. Violation of Ventilation Plan

By Blue Diamond's own admission, its failure to maintain deflector curtains in the No. 2 and No. 3 entries constitutes a violation of its July 26 Ventilation Plan. (Resp't Br. at 11.) The Secretary, however, alleges that two additional conditions violated the plan: (1) insufficient air flow in the last open crosscut of the 11 Section; and (2) insufficient air flow behind the line curtain in the 11 Section's No. 1 entry. (Sec'y Br. at 68–72.) Despite Blue Diamond's admission, I will address these two additional conditions because they have bearing on my conclusions regarding the Secretary's gravity, negligence, and flagrant allegations.

The Secretary relies solely upon Inspector Ashworth's air readings and observations to support his allegation that Blue Diamond did not maintain adequate air flow in the last open crosscut of the 11 Section. Yet, as I explained above, I find Ashworth's air readings were inaccurate and underestimated the velocity of air on the 11 Section. Most critically, the Secretary provides no other basis for me to infer that the 11 Section had insufficient air flow through the last open crosscut. Given the erroneous location of Ashworth's air readings and based on the testimony and evidence before me, I conclude that the Secretary has not met his burden of proving that air flow in the last open crosscut was insufficient.

Second, Ashworth's air reading behind the line curtain in the No. 1 entry demonstrates that the required 5,500 CFM of air was not present at the time Ashworth took his measurement. Blue Diamond does not dispute the accuracy of the measurement; instead, Blue Diamond contends that the ventilation controls in place at the time of Ashworth's line curtain measurement do not reflect the ventilation controls Blue Diamond had in place when Ashworth

¹⁰ Such a finding—and the inaccurate reading it would produce—would account for the great disparity with the earlier air readings recorded on the 11 Section, including Ashworth's own April 4 air reading. (Ex. R–13 at 10(b); Ex. R–18.) Mining is a dynamic process, and I recognize that recent compliance does not necessarily mean that conditions in the mine have not changed. However, the Secretary did not produce *any* evidence of changed conditions in Mine No. 77 that explain the great disparity between every *other* air reading taken April 4–5 and the substandard air measurements Ashworth took after responding to the April 5, 2007, safety complaint.

Moreover, prior to hearing, Blue Diamond raised collateral estoppel arguments regarding air flow in the last open crosscut, which I denied in a published order. (Tr. 14; Ex. R–1; Resp't Br. at 2); *see also Blue Diamond Coal Co.*, 32 FMSHRC 1511 (Sept. 17, 2010) (ALJ). Although Respondent re-raised the issue at hearing and in its post-hearing brief (Tr. 14; Resp't Br. at 2), I need not address the issue because I do not credit Ashworth's last open crosscut readings.

and Stanfield arrived on the 11 Section. (Resp't Br. at 10–11.) Thus, Respondent argues, Blue Diamond did not violate its ventilation plan. (*Id.*)

Blue Diamond's argument is appealing, and Ashworth's changes to Respondent's ventilation controls will bear on my analysis of gravity and negligence. However, the Mine Act is a strict liability statute, and operators are liable for violative conditions regardless of their level of fault. *See, e.g., Spartan Mining Co.*, 30 FMSHRC 699, 706 (Aug. 2008). Although Ashworth mandated changes to Blue Diamond's ventilation controls during his inspection, Respondent remains liable for the conditions found on the 11 Section of Mine No. 77. Thus, I determine that both Blue Diamond's failure to provide 5,500 CFM of air behind the line curtain in the 11 Section's No. 1 entry and the missing deflector curtains each violated its July 26 Plan. I therefore conclude that Blue Diamond violated 30 C.F.R. § 75.370(a)(1).

3. Gravity and S&S Determinations

Blue Diamond's violation of section 75.370(a)(1) establishes the first element of the *Mathies* test for an S&S violation. Inspector Ashworth credibly identified a methane explosion and pneumoconiosis as the hazards to which Blue Diamond's violation contributed. (Tr. 427, 435–37, 462, 464, 566). He also credibly testified that eight miners would be affected. (Tr. 468; *see also* Tr. 38–39; Ex. G–28 at 7.) I do not doubt that either of these hazards would be reasonably likely to cause permanently disabling or fatal injuries to all eight miners on the section.¹¹ Thus, I determine that the third and fourth *Mathies* elements are satisfied.

This case turns on whether Blue Diamond's violation contributed to a discrete safety hazard—in this case a possible methane explosion or pneumoconiosis. *See Black Beauty Coal Co.*, 34 FMSHRC 1733, 1739–43 (Aug. 2012) (discussing the second, third, and fourth elements of the *Mathies* test); *Musser Eng'g, Inc.*, 32 FMSHRC 1257, 1280 (Oct. 2010) (“The second element in *Mathies* requires consideration of whether a discrete safety hazard—that is, a measure of danger to safety—is contributed to by the violation. There is no requirement of ‘reasonable likelihood.’ The third element is whether there is a reasonable likelihood that the hazard contributed to will result in an injury.”) Here, the Secretary's evidence does not demonstrate that either the insufficient line curtain ventilation or missing ventilation curtains actually contributed to—or provided a measure of danger to safety—either of the hazards Ashworth identified in Order No. 4220150. *Cf. Big Ridge, Inc.*, 35 FMSHRC 1525, 1528 (June 2013) (affirming ALJ's determination that *Mathies* second element was satisfied where coal accumulations and an ignition sources were present).

¹¹ Blue Diamond contends that the violative conditions would only affect seven miners because the eighth—electrician Mike Pease—rode to the section with Inspector Ashworth, Inspector Stanfield, and Superintendent Williams on the day of the inspection. (Resp't Br. at 14 n.10.) However, Pease was late to work that day. (Tr. 881.) In the course of continued mining operations, I find that a ventilation violation would affect a full crew of eight miners.

First, the Secretary presented no evidence from which I can conclude that the insufficient air flow behind the line curtain would contribute either to methane explosion or pneumoconiosis. I recognize that Mine No. 77 liberated methane, that methane gas wells were located in the area, and that continuous miners generally produce coal dust in the course of normal mining operations. Yet the conditions under which Inspector Ashworth took his line-curtain measurement were *not* normal. Based on the credible testimony of Shepard, Jent, and Williams, I find that Ashworth's line curtain air measurement occurred *after* he had directed Blue Diamond to make several changes to its ventilation controls. *See* discussion *supra* Part V.A.1.c. By that point, Blue Diamond had not mined coal on the 11 Section for several hours. Although methane and coal dust might accumulate if production resumed with those reconfigured ventilation controls, there was no likelihood of that happening with Ashworth on the scene and having issued a section 104(d)(2) order. Consequently, the Secretary has not demonstrated that the insufficient air velocity behind the line curtain—taken after the inspector's own actions changed the ventilation controls—contributed to either the discrete safety hazard of a methane explosion or pneumoconiosis.

Second, the conditions on the 11 Section were not dangerous when Ashworth found the deflector curtains to be missing. Based on all the evidence, the Secretary has not met his burden of proving that *any* dangerous levels of respirable coal dust were present in *any* entry of the 11 Section, or that the measured methane levels on the 11 Section were abnormal on either April 4 or April 5. (Tr. 238, 461, 463, 504–05, 531.) Furthermore, Ashworth's methane readings from April 5 and 6 were below the explosive range for methane. (Tr. 431, 898–99.) As Ashworth explained, the April 5 and 6 readings were “well within the range of not requiring any additional measures.” (Tr. 531.) In addition, Jent had already identified the missing curtains¹² and had instructed the roof bolt operators to rehang these curtains. I therefore determine that the missing

¹² In his direct exam, Jent specifically characterized these curtains as “line curtains” rather than “deflector curtains.” (Tr. 814.) However, the record as a whole suggests that the nomenclature of curtains is a fluid concept. For example, Ashworth testified that only one line curtain exists, and it is located wherever the continuous miner is operating. (Tr. 471; *see also* Tr. 541–42 (conflating deflector curtains with line curtains).) Yet Williams characterized the curtains in the No. 4, No. 5, and No. 6 entries as “line curtains” when no continuous miner was present. (Tr. 857–58; Ex. G–17.) Likewise, miner operator Darrell Cress observed that the continuous miner was present in the No. 2 entry when he arrived. (Tr. 793–94.) He indicated that he tore down that “deflector curtain” when he moved the continuous miner into the No. 1 entry. (Tr. 793–94.) Based on the entirety of the record, I infer that the “line curtains” that Jent ordered to be rehung in the No. 2 and No. 3 entries were, in fact, the “deflector curtains” the Secretary claims were missing in those entries.

deflector curtains would have been rectified in the course of on-going mine operations before any coal dust or methane accumulated in the No. 2 or No. 3 entries.¹³ Inspector Ashworth's instructions to the contrary precluded that, and his changes to the ventilation controls at the end of a long workday created conditions that did not exist at the time of initial inspection.

Consequently, the Secretary has not proven that Respondent's inadequate line curtain ventilation or missing deflector curtains would contribute to methane explosion and pneumoconiosis hazards, and I determine that the Secretary has failed to satisfy the second element of the *Mathies* test. Accordingly, I conclude that this violation was not S&S and Order No. 4220150 is **MODIFIED** to remove the S&S designation.

4. Negligence and Unwarrantable Failure Determinations

The Secretary claims that Respondent's negligence in this case is a "reckless disregard" of its ventilation plan and characterizes its conduct as an unwarrantable failure. Blue Diamond asserts that Order No. 4220150 should be modified to a section 104(a) non-S&S citation and the level of negligence should be modified to "low." (Resp't Br. at 20–21, 64.)

The facts and evidence before me do not support the Secretary's reckless disregard and unwarrantable failure allegations. Looking at the Commission's aggravating factors for unwarrantable failure analysis, several weigh strongly in Blue Diamond's favor. First, the cited conditions were not highly dangerous given that no active mining was taking place at the time. The Secretary simply failed to demonstrate the presence of coal dust or dangerous levels of methane, and provided no rationale for believing these conditions would lead to accumulations of dust or methane in the course of continued mining operations. Second, the violative conditions at issue existed for a short amount of time. Third, the line curtain reading and deflector curtain conditions did not extend throughout the entire 11 Section. Fourth, both Cress and Jent took steps to abate violative conditions when they identified missing curtains. Finally, there is no indication that Blue Diamond's agents knew these conditions existed prior to Jent's discovery of the missing curtains in entry No. 2 and entry No. 3.

I recognize that the missing deflector curtains were obvious. Moreover, the Secretary presented evidence in the form of violation history reports and copies of past citations and orders that Blue Diamond has received many citations for ventilation- and curtain-related violations.

¹³ Pointing to a citation for trash that had not been abated, the Secretary also contends that the "culture at Mine [No.]77 greatly increased the likelihood that the violative conditions described in Order No. 4220150 would result in fatal injury to miners." (Sec'y Br. at 78; *see also* G–28 at 11; Tr. 466–67, 879.) Although Blue Diamond should have abated the citation, I refrain from drawing the inference that failing to clean a trash bucket represents a "culture" that would ignore ventilation controls.

(Ex. G-1; Ex. G-2; Ex. G-4; Ex. G-5; Ex. G-7; Ex. G-8; Ex. G-13; Ex. G-14.) These past violations suggest that greater efforts may be necessary to comply with its July 26 Plan. However, when weighing the mitigating factors above, I conclude that such evidence is insufficient to characterize Blue Diamond's conduct as an unwarrantable failure.

Likewise, the Secretary has not proven Blue Diamond's negligence to have been a "reckless disregard." The Secretary's standards define negligence as "conduct, either by commission or omission, which falls below a standard of care established under the Mine Act to protect miners against the risks of harm." 30 C.F.R. § 100.3(d). These standards indicate that "reckless disregard" is found where "[t]he operator displayed conduct which exhibits the absence of the slightest degree of care." *Id.* at Table X. Moreover, the standards prescribe moderate negligence where "[t]he operator knew or should have known of the violative condition or practice, but there are mitigating circumstances." *Id.*

Given the evidence before me, I conclude that the Secretary has not satisfied his burden of showing that Blue Diamond acted without the slightest degree of care. In fact, Blue Diamond's conduct in this case suggests the contrary. Inspector Ashworth took his line curtain reading *after he* directed specific changes to the ventilation controls. Operators are bound not to interfere with an inspector's instructions, and Blue Diamond's adherence to Ashworth's directions does not constitute a reckless disregard for its July 26 Plan. Further, Section Foreman Jent specifically directed his roof bolt operators to rehang curtains in entry Nos. 2 and 3 immediately after finding that the curtains had been inadvertently torn down, before Ashworth arrived on the section. Moreover, mere sources of methane or coal dust accumulation, alone, do not demonstrate the dangers the Secretary contends; otherwise, no operator would be able to work in any coal mine in light of these omnipresent dangers. Similarly, the mere existence of previous ventilation curtain violations does not prove indifference on the part of Blue Diamond.

Nonetheless, Blue Diamond had a responsibility to adhere to its July 26 Plan, no matter how common or uncommon it is for its machine operators to inadvertently tear down curtains. (*See Resp't Br.* at 11.) Although I do not impute the negligence of rank-and-file miners to Blue Diamond, its agents have a duty to ensure that training and procedures address this known problem. However, Jent's steps to immediately address that condition significantly mitigate Blue Diamond's negligence. Indeed, prompt action to abate a violative condition is precisely the type of behavior the Mine Act aims to encourage. Accordingly, I determine that Blue Diamond's conduct constituted "moderate" negligence.

Based on all of the above, Order No. 4220150 is **MODIFIED** to remove the unwarrantable failure designation and change the cited level of negligence to moderate.

5. Reckless and Repeated Flagrant Designations under Section 110(b)(2)

As I noted in *Stillhouse*, a finding of S&S and unwarrantable failure does not necessarily imply a "reckless" designation under section 110(b)(2) of the Mine Act. 33 FMSHRC at 800

(“The unwarrantable failure and S&S language of section 104(d)(1) of the Mine Act does not elucidate Congress’s intent on the meaning of a flagrant violation.”) Yet the converse may be true. In fact, my conclusion that Order No. 4220150 is neither S&S nor unwarrantable strongly suggests the Secretary has not satisfied his burden of proving his flagrant allegations. Indeed, it is difficult to envision sustaining a reckless or repeated flagrant allegation when the underlying violation is neither S&S nor unwarrantable.

Here, the Secretary has not demonstrated *any* of the elements of a reckless failure. Ashworth’s line curtain reading occurred after Blue Diamond complied with his direction to modify ventilation controls in response to the inspector taking his air readings in the wrong location of the mine. Likewise, Jent instructed roof bolt operators to rehang curtains in entry Nos. 2 and 3 before Ashworth’s arrival on the 11 Section. Both actions indicate Blue Diamond did not consciously or deliberately disregard risks associated with these conditions and took reasonable steps to address them. Moreover, the Secretary presented no evidence that Blue Diamond’s agents knew or should have known of these conditions until Jent discovered the missing deflector curtains. Further, there is no indication that any methane or coal dust had accumulated in the No. 2 and No. 3 entries. Accordingly, I determine that the Secretary has not demonstrated recklessness, a failure to make reasonable efforts, a known violation, or a reasonable expectation that the conditions would have caused death or serious bodily injury for the purposes of section 110(b)(2).

Although the Secretary introduced evidence of past ventilation violations at Mine No. 77 in support of his repeated failure designation, I need not address their relevance or probity. The Secretary’s definition of “repeated” conduct presupposes that section 110(b)(2)’s “other criteria” are satisfied. *See* discussion *supra* Part IV.F.2. Because the Secretary has not demonstrated that the conduct underlying Order No. 4220150 constituted a failure to make reasonable efforts to eliminate a known violation or reasonably could have been expected to cause death or serious bodily injury, I do not need to consider whether the Secretary’s evidence demonstrates a previous failure to make reasonable efforts to eliminate a previous violation. Even under his own definition, the Secretary cannot prove a repeated violation without demonstrating that the “other criteria” have been satisfied.

Based on the facts before me, I conclude that the Secretary has failed to prove Blue Diamond’s conduct was recklessly or repeatedly flagrant under section 110(b)(2) of the Mine Act. Accordingly, Order No. 4220150 is **MODIFIED** to remove the flagrant designation.

6. Penalty

Under section 110(i) of the Mine Act, I must consider six criteria in assessing a civil penalty, including the operator’s history of previous violations; the appropriateness of the penalty relative to the size of the operator’s business; the operator’s negligence; the penalty’s effect on the operator’s ability to continue in business; the violation’s gravity; and the

demonstrated good faith of the operator in attempting to achieve rapid compliance after notification of a violation.¹⁴
30 U.S.C. § 820(i).

The Secretary initially sought a penalty of \$187,500 for Order No. 4220150, and nothing in the record suggests the proposed penalty is either inappropriate for the size of Blue Diamond's business or would infringe on Blue Diamond's ability to remain in business. However, I have modified the citation to remove the S&S, unwarrantable, and flagrant designations. Moreover, I have concluded that Blue Diamond's negligence was moderate. Of the 914 number of violations in Respondent's history of violations report, 78 involved 30 C.F.R. § 75.370(a)(1). (Ex. G-1; Ex. G-2.) Moreover, once this order was issued, nothing suggests that Respondent failed to make a good faith effort to achieve rapid compliance with the safety standard. Indeed, Blue Diamond followed Ashworth's instructions. Considering all of the facts and circumstances set forth above, I hereby assess a civil penalty of \$3,000.00.

B. Section 110(c) – Gary Jent – Ventilation Order – April 5, 2007

The Secretary seeks a separate civil penalty against Section Foreman Gary Jent for his conduct in connection with Order No. 4220150. Based on the facts before me and my conclusions of law regarding Order No. 4220150, the Secretary has not proven that Jent is personally liable under section 110(b)(2).

First, I have found that Inspector Ashworth's air readings inaccurately measured the amount of air flowing through the last open crosscut on the 11 Section. Likewise, I have found that coal dust was *not* present in the No. 1 entry when Ashworth and Inspector Stanfield arrived on the section. In light of those facts, Jent would reasonably have believed the 11 Section was adequately ventilated. Moreover, his affirmative steps to address the problems he encountered demonstrate that he did not fail to act. Finally, Blue Diamond's insufficient line curtain ventilation did not occur until *after* Ashworth altered Respondent's ventilation controls. Accordingly, Jent had no reason to know of the violative condition.

Based on the above, the Secretary has not proven that Jent failed to act or engaged in any aggravated conduct. Thus, I conclude that Jent is not liable for civil penalties under section 110(c). This violation is **VACATED** and the proceeding is **DISMISSED**.

¹⁴ Blue Diamond suggests that the Secretary's specially-assessed penalties should be stricken from the record because they prejudice my penalty assessments in this case. (Tr. 570-73; Resp't Br. at 62-64.) Section 110(i) specifies the factors for me to consider and commits the penalty determination to my discretion. *See* 30 U.S.C. § 820(i). I have taken Blue Diamond's concerns under advisement, and the penalties I assess are appropriate based on the evidence before me and the criteria outlined in section 110(i).

VI. ANALYSIS, FURTHER FINDINGS OF FACT, AND CONCLUSIONS OF LAW — ROOF CONTROL VIOLATIONS

A. Roof Control Experts – Dr. Newman and Mr. Gauna – Credibility Determinations – Impact of Testimony

1. Witness Background

Blue Diamond presented testimony and an expert report from Dr. David A. Newman, who is the President of Appalachian Mining and Engineering. (Tr. 664; Ex. R-21.) In rebuttal, the Secretary presented the expert testimony and a report from MSHA Mining Engineer Michael Gauna. (Tr. 1063; Ex. G-30; Ex. G-31.) Both witnesses have advanced degrees in mining engineering and technology, and extensive experience involving roof control. (Tr. 664-70, 1063-66; Ex. R-21; Ex. G-31.) Each has also visited Mine No. 77 in the past, but neither examined the specific roof conditions at issue in any of the three roof control cases before me. (Tr. 671-73, 766-67, 1068-69.) In 1995, Newman also took a core sample of roof from Mine No. 77, which he called his KRP-7 core sample. (Tr. 671-73, 753, 755.)

2. Credibility determinations and impact of testimony

Citation No. 7505299 and Order Nos. 7521758 and 7524542 each allege dangerous violations of Blue Diamond's roof control plan. *See* discussion *infra* Parts VI.B, VI.C, and VI.D. As one might expect, Dr. Newman and Mr. Gauna reached contradictory conclusions regarding the hazards presented by nearly every item listed in each citation or Order. Each testified credibly to his interpretation of the condition or practice cited. Because neither expert observed any of the conditions firsthand or visited the parts of the mine where the alleged violations occurred, Newman and Gauna based much of their opinions on the text of the citation or orders, the Inspector's notes, the testimony of other witnesses, and their experience with mine roofs at Mine No. 77 and other mines. Their testimony regarding the mechanics of roof control is illustrative, but I accord little weight to the experts' ultimate opinions on any given condition because neither viewed the conditions in question. Such competing conjecture, no matter how well-intentioned and well-informed, is not a substitute for a credible, first-hand observation from an Inspector or miner trained to identify violative conditions and assess their gravity.

Yet, the parties' opinions were not all so limited. Dr. Newman provided an Analysis of Roof Bolting Systems (ARBS) and fixed beam examination of several items listed in the Secretary's Citation and Orders. (Ex. R-22; Ex. G-38.) Newman's report and testimony suggest that the conditions in question do not present roof fall hazards.

However, Gauna highlighted significant weaknesses in Newman's ARBS analyses. Most importantly, Gauna noted that Newman's ARBS input assumptions did not reflect the reality at Mine No. 77. According to Superintendent Williams and Section Foreman Shepherd, Blue Diamond used five-foot resin bolts that measured either five-eighths of an inch or three-fourths

of an inch in diameter. (Tr. 641, 922.) However, Newman's ARBS analyses assumed five-foot resin bolts that were seven-eighths of an inch in diameter, which are also known as "seven bar" bolts. (Tr. 1084; Ex. R-22 at. 2-5 (listing "Bolt diameter" as "#7 bar").) Gauna credibly testified that the roof bolt diameter input "make[s] a big difference [in an ARBS analysis because the ARBS values are] . . . directly proportionate with the strength of the bolt, which is dependent on the diameter of the bolt." (Tr. 1084-85.) He further explained that "a smaller bolt" would "greatly diminish[]" the "actual ARBS" values, and testified that the thicker diameter input would make Dr. Newman's analyses incorrect. (Tr. 1085, 1090.)

Given the evidence before me, I have significant doubts about the validity of Newman's ARBS findings. Although I believe Newman's analysis was made in good faith, his mistaken inputs—and their concomitant impact on his ARBS results—are sufficiently troubling that I am left with no choice but to accord them no weight.

I also have serious doubts about Newman's fixed beam analysis. First, Gauna suggested that fixed beam analysis is inappropriate for unbolted extended cuts. (Tr. 1120-21.) According to Gauna, fixed beam analysis is "designed to look at the span across an opening and that span has been used rib to rib, or cross[cut] to crosscut, pillar to rib. In other words, it's used to show what's actually being spanned." (Tr. 1120.) However, one end of Newman's longitudinal beam does not extend to a fixed point (like a coal pillar). (Tr. 1120-21, 1150.) Although fixed beam analysis is "very appropriate for going rib to rib span" it is "not appropriate to use it in the coal face to the row of bolts." (Tr. 1121; *see also* Tr. 1125, 1149.)

Second, Newman's fixed beam analysis only lists safety factors for beams of shale, black shale, and bolted roof. Yet it is unclear how closely this mirrors the roof composition in the case before me. As Newman himself admitted about the KRP-7 core sample: "It is representative of the Elkhorn Three [seam]. It may not be the immediate roof, I don't know that the immediate roof in that area is exactly that, and the thickness [or the right properties, I don't know them to be exactly that, but what it is for this type of analysis is the closest information I've got from an actual drill hole So, you know, essentially I'm using that in extrapolating into this area to say on a comparative basis." (Tr. 755.) For example, the 12 Section roof at issue in Order No. 7524542 was laminated sandstone, which is sensitive roof. *See infra* Part VI.C.4. Indeed, Gauna specifically suggested that the KRP-7 sample was not a proper comparison for the roof in Order No. 7524542 because it contained no components of laminated sandstone. (Tr. 1116-17.)

In view of the above, I have serious concerns about the qualitative credibility of Dr. Newman's fixed beam analyses. I recognize Dr. Newman is a qualified expert in roof control and testified that a fixed beam analysis is an appropriate method for measuring the danger of an unbolted roof. However, Gauna's explanation of fixed beam analysis, coupled with my reservations about the comparative utility of the KRP-7 core sample, weighs strongly against the probative value of Dr. Newman's fixed beam analyses. Given these concerns, I accord no weight to Dr. Newman's fixed beam analyses.

B. Order No. 7521758 – 16 Items/Roof Control – April 5, 2007

1. Findings of Fact

The same day Inspector Ashworth issued Order No. 4220150, *see supra* Part V.A.1, Inspector Stanfield also examined roof control conditions on the 11 Section. After completing his search for drugs and smoking materials, Stanfield began an imminent danger run in the 11 Section. (Tr. 34, 233–34, 417, 883–84.) While making his way across the section, Stanfield identified sixteen different items he believed violated Blue Diamond’s September 7 Roof Control Plan. (*See* G–19.) The items included conditions affecting roof bolt spacing, conditions involving roof and rib integrity, conditions involving missing equipment, and conditions involving permissible entry widths. (*Id.*; Ex. G–32; Ex. G–33; Ex. G–34; Ex. R–31.) Stanfield characterized these conditions as obvious. (Tr. 79–80, 90, 101–02, 119–20.) Depending on the item, these conditions had lasted from a few hours to several weeks. (Tr. 58–59, 89–90, 79–80, 102, 107, 109, 111, 115, 110.) He also observed no indications that Blue Diamond made any efforts to correct the cited conditions. (Tr. 79, 90, 101–02, 125.)

As a result of his inspection, Stanfield issued Order No. 7521758, alleging:

The operator failed to comply with the approved roof control plan (dated 09/07/2006) on the 011/MMU, in that;

(1) #6 entry at the intersection of the last open crosscut, a pressure crack (lateral displacement) is present in the immediate roof. This crack has not been strapped. A roof drill test hole in the area reflected a 10 inch crack. This is at Spad #3963^[15]

(2) Just adjacent to Spad #3963, in the #6 right crosscut a roof drill test hole reflected cracks in the mine roof at 49, 52, 63, and 65 inches. This area is bolted with 5’ [five foot] resin bolts.

(3) At the same location #6 right crosscut mobile equipment has torn metal straps out. These have not been replaced

(4) #1 right cross cut adjacent to Spad #3740, the width measured from 20 to 22 feet for approximately 20 feet. The approved plan requires widths to be maintained at 19 feet.

(5) At Spad # 3754, #3 entry, one of the 10 feet cable bolts has the head and bearing plate torn off. It has not been replaced.

(6) At Spad #3776, the 10 feet cable bolts have not been installed as required in the H pattern. The plan requires three to be installed across the center of the intersection, where the greatest roof stress occurs. Only one has been installed at the center of the intersection.

¹⁵ Spads are small, numbered pegs driven into the mine roof and used to show miners the proper direction to mine. (Tr. 620–21, 980–82.)

- (7) Adjacent to Spad #3776, in the #3 right crosscut, on the outby rib the distance between installed roof bolts measured 56 inches.
- (8) At the same location as cited in item #7, loose hanging draw rock of substantial size and weight is present. Most of this was pulled at the time of the inspection. Additional supports in the form of metal straps are needed to aid in controlling the draw rock at this location.
- (9) #5 right (just turned) the third row of bolts outby the face, on the left rib, the first installed bolt in the third row is 56 inches from the coal rib. The approved plan requires bolts to be installed 3 feet [36 inches] from the coal rib.
- (10) At the same location #5 right (just turned) the last two rows of bolts are installed only four in a row. The approved plan requires all bolts to be installed five in a row.
- (11) At the same location (#5 right crosscut-just turned) the distance between the installed bolts on the inby rib at the last two rows is 56 inches. The approved plan requires the distance between rows of bolts to be no more than 4 feet [48 inches].
- (12) #4 left at the last open crosscut along the outby rib, five bolts have been installed from 41 to 54 inches from the coal rib.
- (13) At the last open crosscut between the #2 and #3 entries, along the outby rib, 6 bolts measured 41 to 48 inches from the coal rib.
- (14) At the 14th crosscut of the #11 belt, on the left side, facing inby, a crib has not been installed
- (15) At the 15th crosscut of the #11 belt, the installed cribs (4) are not tight against the mine roof. Some of the crib blocks are turned up on the side using only four inches of the wood for support, instead of the 6 inches if it were used for maximum support.
- (16) #1 right, at the last open crosscut the outby rib is loose, (measuring approximately 3' x 15'). This loose rib could easily result in crushing injuries. This loose rib was taken down at the time of the inspection.

The operator has recently received similar violations (warnings from MSHA). This mine has a history of roof falls and problems with roof and ribs. The cited condition is obvious and extensive. The approved roof control plan only specifies the minimum roof supports to be installed. All supports required by the approved plan must be installed and properly maintained to fully protect miners from the hazards associated with the falls of roof and/or ribs. An agent of the operator conducts preshift and onshift examinations on the 011/MMU, on three shifts daily.

(Ex. G–19.) Stanfield marked “fatal” injuries as “highly likely,” designated the violation as S&S, and characterized Blue Diamond’s negligence as a “reckless disregard.” (*Id.*) He estimated the number of persons affected as 2. (*Id.*)

2. Violation of Roof Control Plan

In their post-hearing briefs, the parties sequentially address each of the sixteen items listed in this single order. (Sec’y Brief at 13–34; Resp’t Br. at 21–36.) However, Respondent’s post-hearing brief contends that Order No. 7521758 “should be modified to a [section] 104(a) non-S&S citation and the penalty should be substantially reduced.” (Resp’t Br. at 42.) Though Respondent disputes the S&S, unwarrantable failure, and flagrant designations, its contention that I modify the Order to a section 104(a) citation essentially concedes that Blue Diamond did not comply with the terms of its September 7 Plan.¹⁶ Rather than follow the parties’ lead in addressing each of these items individually, I therefore determine that Blue Diamond failed to follow its approved roof control plan. Thus, I conclude that Blue Diamond violated 30 C.F.R. § 75.220(a)(1).

3. Gravity and S&S Determinations

Blue Diamond’s violation of 30 C.F.R. § 75.220(a)(1) establishes the first element of the *Mathies* test. This case again turns on the second element: whether Blue Diamond’s violation contributed to a discrete safety hazard—in this case, a roof fall or falling draw rock. *See Black Beauty*, 34 FMSHRC 1733, 1739–43 (Aug. 2012) (discussing the second, third and fourth elements of the *Mathies* test). Sensing the importance of the safety hazards in this case, the parties each enlisted an expert. Yet, I find neither expert’s opinion dispositive. I am therefore left with the testimony and observations of Inspector Stanfield and Superintendent Williams¹⁷ to discern whether Blue Diamond’s roof control violation contributed—or provided a measure of danger to safety—to the hazards Stanfield identified.

As Stanfield specifically stated: “[T]he more areas that are not supported per the approved roof control plan increases the likelihood of an accident . . . [These conditions extend]

¹⁶ The only exceptions to Blue Diamond’s admission of a violation appear to be the ten-inch crack identified in Item No. 1 (Resp’t Br. at 23) and the roof bolts listed in Item No. 13 (Resp’t Br. at 34). Moreover, Blue Diamond’s argument against an S&S finding is that none of these individual items were dangerous because each was minor. *See* discussion *infra* Part VI.B.3. Yet, the flip side of Blue Diamond’s approach is that even if I concluded that Item Nos. 1 and 13 did not violate the September 7 Plan, neither determination would affect my overall conclusion regarding S&S. Accordingly, I need not determine whether items No. 1 and No. 13 were violations individually.

¹⁷ Both witnesses have extensive history working and inspecting coal mines, observed the items in question, and are familiar with the type of roof present in Mine No. 77. (Tr. 25–27, 78, 141, 143, 157–58, 162, 175–77, 840–46, 915–16, 919–20, 1032.)

throughout the 11 Section, and the more exposure, the more hazard, the more likelihood.” (Tr. 126.) In other words, Stanfield based his S&S designation on the cumulative contribution these items made to the hazards of a roof fall or falling draw rock, rather than each individual item’s individual contribution. Rather than quantifying the *amount* each condition contributed to a roof fall or falling draw rock hazard, Stanfield proceeded on the theory that these items contributed to a hazard when taken cumulatively.

Respondent’s defense amounts to a strategy of divide-and-conquer. Blue Diamond repeatedly suggests that the Secretary did not present evidence of poor roof conditions in the 11 Section and points to the Secretary’s inability to quantify the amount each individual item would contribute to a roof fall or falling draw rock. (Resp’t Br. at 22–36.) Thus, Blue Diamond hopes I will infer that no hazards exist. But Blue Diamond’s arguments fundamentally misunderstand Inspector Stanfield’s rationale for designating these conditions as S&S. Indeed, Williams’ testimony regarding the cited conditions missed the proverbial forest for the trees. Although he was present for Stanfield’s testimony, Williams simply did not address Stanfield’s opinion that these items, taken cumulatively, contributed to a hazard of roof falls and falling draw rock when considered cumulatively.

Moreover, Stanfield’s opinion is based on facts he observed, and his experience entitles that opinion to significant weight. *Cf. Harlan Cumberland Coal Co.*, 20 FMSHRC 1275, 1279 (Dec. 1998) (relying on inspector’s opinion to conclude that substantial evidence supported the ALJ’s S&S determination.) Further, the Secretary presented credible and uncontroverted evidence of roof falls adjacent to the 11 Section. (Tr. 50–51, 77, 108, 127; Ex. G–16.) In response, Blue Diamond made repeated reference to the roof conditions on an item-by-item basis. However, I note that “no Commission case has required the Secretary to show adverse roof conditions in a mine as a prerequisite to finding that a violation of a roof control plan is S&S.” *Elk Run Coal Co.*, 27 FMSHRC 899, 906 n.13 (Dec. 2005). Instead, poor roof conditions merely provide indirect evidence that a roof fall or falling draw rock was reasonably likely to occur. Thus, Mine No. 77’s history of roof falls very near to the 11 Section is similar, indirect evidence that a roof fall or falling draw rock is reasonably likely to occur in the 11 Section. Given Stanfield’s credible opinion and the history of roof falls in the area, I am convinced that the cited conditions contributed to a discrete safety hazard. I therefore determine that the Secretary met his burden of proof on the second element of *Mathies*.

As to the third and fourth elements of the *Mathies* test, Inspector Stanfield credibly testified that eight miners were present on the 11 Section at the time he issued Order No. 7521758. (Tr. 39, 106–07.) He also credibly testified that the hazards to which this violation allegedly contributed—roof falls and falling draw rock—would be reasonably likely to cause reasonably serious injuries. (Tr. 48, 56–57, 77, 86, 99, 105–06, 113, 124–26, 128, 211, 250.) That roof falls and falling rock are highly likely to cause permanently disabling injuries, let alone death, borders on tautology. I do not doubt that serious injuries or fatalities would occur if the mine roof or draw rock fell on a miner during continued mine operations. Given the far-flung conditions cited in Order No. 7521758, I also do not doubt that the violation affected at least two

of the eight miners present on the 11 Section. Thus, I determine that the Secretary has satisfied the third and fourth elements of the *Mathies* test and that at least two miners would be affected.

Based on my determination that the first and second elements have also been satisfied, I conclude that this violation was appropriately designated as S&S.

4. Negligence and Unwarrantable Failure Determinations

The Secretary designated Blue Diamond's conduct as an unwarrantable failure and characterizes its level of negligence as a reckless disregard. Based on the evidence before me, the Secretary has not met his burden of proof for either allegation.

Here, Inspector Ashworth traveled the 11 Section *on the day before* Inspector Stanfield issued Order No. 7521758 and examined the section for any "obvious" roof and rib hazards and checked test holes, entries, and faces for cracks. (Tr. 497–505; *see generally* Ex. R–13.) He also traveled with Section Foreman Jody Roberts as he checked test holes during his pre-shift exam. (Tr. 508–09; Ex. R–13 at 11.) Yet, after spending "his whole day on the section," Ashworth indicated that "[r]oof control measures appear to be adequate." (Tr. 505; Ex. R–13 at 12.)

Looking to the Commission's aggravating factors for determining unwarrantable failure, two factors strongly suggest that Blue Diamond's conduct was not aggravated. First, the cited conditions were not obvious. Ashworth's failure to cite any of the cited conditions a day earlier does not excuse Blue Diamond's roof control violations, but it *does* suggest that Blue Diamond need not have acted indifferently, recklessly, or with a serious lack of reasonable care to have overlooked the conditions at issue. Indeed, Ashworth's failure to cite *any* of the conditions on the 11 Section and his testimony that he was looking for obvious violations indisputably limits the alleged "obviousness" of the violative conditions. Second, the Secretary has not demonstrated any actual knowledge of the violative conditions, and Ashworth's failure to cite these conditions mitigates Blue Diamond's constructive knowledge of those conditions.

On the other hand, other unwarrantable failure factors point the other way. Although roof control plans are detailed, expansive documents with wide-ranging application throughout a mine, Blue Diamond's history of previous violations provided Respondent with notice that the Secretary required greater efforts at compliance. In addition, the conditions underlying Order No. 7521758 extended throughout the newly-developed 11 Section. Blue Diamond's violation was also S&S, which indicated a significant level of danger. Finally, Stanfield credibly testified that he saw no previous efforts to abate any of these conditions.

The Secretary suggests the length of time that some of these conditions may have existed should have allowed Respondent enough time to identify their existence. (Sec'y Br. at 36.) Although the Secretary's suggested inference is logical, Ashworth failed to previously identify these purportedly long-standing conditions on April 4. Again, MSHA's failure to previously cite these conditions does not excuse Blue Diamond's responsibility under the Mine Act's strict

liability scheme. However, it somewhat explains Blue Diamond's failure to readily identify those conditions. Indeed, Ashworth himself observed Section Foreman Roberts' on-shift exam, but identified no shortcomings. Thus, although the length of time these conditions existed is an aggravating factor, the failure of a trained MSHA inspector to observe what the Secretary has characterized as an "obvious" violation at least somewhat mitigates its impact.

I recognize the significant danger these conditions presented, the notice provided to Blue Diamond by its previous violations, and the extensive nature of these conditions. However, Ashworth's failure to identify or note even one of these conditions just one day beforehand convinces me that Blue Diamond's conduct does not rise to the level of recklessness, indifference, or serious lack of reasonable care that would constitute an unwarrantable failure.

For these same reasons, I conclude that the Secretary has not met his burden of showing Blue Diamond's level of negligence was "reckless disregard." As with his S&S designation, Stanfield characterized Blue Diamond's level of negligence based on the order as a whole, the condition of the roof, and Blue Diamond's history of violations. (Tr. 299–303.) He also admitted that he would not have marked "reckless disregard" if he had issued a citation for any individual condition. (Tr. 303.) Although I credit Stanfield's aggregate S&S theory, I do not find his theory of aggregate "reckless disregard" similarly persuasive. An S&S analysis asks simply whether the cited conditions contributed to a safety hazard. In that context, an aggregate analysis is appropriate because the marginal impact of each individual item may not be capable of quantification. In contrast, a reckless disregard designation considers whether the operator acted "without the slightest degree of care." Accordingly, a "degree of care" on any given item would seem to preclude a reckless disregard designation.

Here, Ashworth observed Section Foreman Roberts completing Blue Diamond's examinations of the 11 Section *the day before* Stanfield's inspection, but neither identified any of the cited conditions nor suggested that Roberts' inspection was inadequate. Blue Diamond's regular, and apparently adequate, examinations convince me that it did not act "without the slightest degree of care." See 30 C.F.R. § 100.3(d) at Table X. Despite the extensive nature of these conditions and danger they presented cumulatively, I have also determined that these conditions were not obvious. Ashworth's failure to record any problems with Blue Diamond's roof controls the day before this order was issued significantly mitigates Blue Diamond's reason to know that these conditions existed and suggests that Respondent's negligence was moderate. Indeed, the Secretary's own standards call for moderate negligence where "[t]he operator knew or should have known of the violative condition or practice, *but there are mitigating circumstances.*" *Id.* (emphasis added). I thus conclude that Respondent's level of negligence was moderate.

Given the evidence before me, I therefore **VACATE** the Secretary's unwarrantable failure designation and **MODIFY** Respondent's level of negligence to moderate.

5. Reckless and Repeated Flagrant Designation under Section 110(b)(2)

Given my analysis of unwarrantable failure and negligence, I likewise determine that the Secretary has not met his burden of proof that Blue Diamond's conduct was either recklessly or repeatedly flagrant. The Secretary has demonstrated neither the conscious or deliberate disregard of the danger involved that would constitute recklessness nor the actual or implied knowledge necessary to characterize the cited conditions as a known violation. Inspector Ashworth spent the entire day on the 11 Section on April 4, but did not observe or record a single one of these violations. His failure to identify any of the cited conditions suggests strongly that Blue Diamond did not act with the conscious or deliberate disregard that section 110(b)(2) addresses. Although the Mine Act makes Blue Diamond responsible for ensuring miner safety, I cannot infer that Blue Diamond recklessly failed to follow its roof control plan or had implied or actual knowledge of the violative conditions when MSHA's own representative did not record a single one of these conditions, despite spending all day on the section and observing Blue Diamond's pre-shift exam one day beforehand. Instead, I infer that these conditions—while violations of the September 7 Plan—were sufficiently obscure that Blue Diamond's failure to identify them does not constitute a conscious or deliberate disregard of the risk of death or serious bodily injury. In addition, the Secretary has not demonstrated that this was a known violation. He has therefore failed to meet his burden of proving a "reckless failure" under section 110(b)(2).

Moreover, the Secretary's failure to demonstrate that the cited conditions were known violations also means that he has not proven a repeated failure. As I have explained, the Secretary's own definition of repeated failure requires that section 110(b)(2)'s *other* criteria be satisfied (i.e., that the present violation constituted a failure to make reasonable efforts, was a known violation, and could have reasonably been expected to cause death or serious bodily injury). Here, the Secretary falls far short of demonstrating that the conditions in Order No. 7521758 were a known violation. Based on the Secretary's own definition of "repeated," I therefore need not determine whether his evidence establishes a predicate *prior* failure to make reasonable efforts because he has not met his burden of proving that the *present* violation was a known violation.

In view of the above, I conclude that the Secretary has not proven Blue Diamond's conduct to have been flagrant under section 110(b)(2) of the Mine Act. Order No. 7521758 is therefore **MODIFIED** to remove the flagrant designation.

6. Penalty

The Secretary originally proposed a \$184,900.00 civil penalty for this violation. Again, nothing in the record suggests that the proposed penalty is inappropriate for the size of Blue Diamond's business or that it would infringe on Blue Diamond's ability to remain in business. I have found that this violation was properly designated as S&S, but I have modified

this order to “moderate” negligence and removed the unwarrantable failure and flagrant designations. Of the 914 violations in Respondent’s history of violations report, 42 involved 30 C.F.R. § 75.220(a)(1). In considering all of the facts and circumstances in this matter and the criteria of section 110(i), I hereby assess a civil penalty of \$18,490.00.

C. Order No. 7524542 – Extended Cuts Citation – Roof Control – May 9, 2007

1. Background – Inspection on May 9, 2007 and Order No. 7524542

A little more than a month after issuing Order No. 7521758, Inspector Stanfield returned to Mine No. 77 to continue an electrical inspection and terminate outstanding violations. (Tr. 131.) After arriving underground, he traveled to the 12 Section with Mine Foreman Burley Adams. (Ex. G-21 at 1-2, 11; Tr. 132, 1037.) At the time, the 12 Section was located in the New North Mains portion of Mine No. 77. (Ex. G-16; Tr. 132-33.) Nine entries, numbered from left to right, had been driven into the working face. (Ex. G-21 at 5, 15; Ex. G-22; Tr. 133.) The 12 Section was a “super section,” which includes two crews, two continuous miners, and separate splits of air to mine two areas simultaneously. (Tr. 324, 326-27, 627-28, 641; Ex. G-22.) Approximately six people work on each mining crew. (Tr. 327.)

When Stanfield arrived, the continuous miners were energized in the No. 2 and No. 8 entries, but Blue Diamond was not cutting coal. (Ex. G-21 at 13; Ex. G-22; Tr. 133, 135, 627-28, 641.) However, a single-head bolter was bolting in the No. 3 entry and a double-head bolter was bolting in the No. 7 right crosscut connecting the Nos. 7 and 8 entries. (Ex. G-21 at 10-11, 13, 15; Ex. G-22; Tr. 135-36.) Stanfield traveled from the No. 1 entry to the No. 9 entry on an imminent danger run, took air readings, and talked with miners. (Ex. G-21 at 2; Tr. 133.)

Stanfield testified that he found two different violations of the September 7 Plan. (Tr. 137, 147-49.) First, he identified a portion of entry No. 5 that was wider than permitted under the September 7 Plan. (Ex. G-21 at 5, 7, 9; Ex. G-22; Tr. 137.) The wide portion of the entry formed a triangular sliver cut into the right hand rib of the entry. (Ex. G-22; Ex. G-21 at 7.) This wide area was 12-feet long, four-feet wide at its widest point, and had been bolted with five-foot resin bolts. (Ex. G-22; Ex. G-21 at 7, Tr. 171-72.) Stanfield saw no draw rock or cracks in the area. (Tr. 172-73.) Second, Stanfield measured the length of Blue Diamond’s cuts in the No. 2 entry, No. 3 entry, No. 7 entry, the No. 7 right crosscut, and the No. 9 entry, and he concluded that the 12 Section had more than two extended, unsupported cuts. (Tr. 148-56, 163; Ex. G-21 at 10-11, 14-15; Ex. G-22.)

Based on his observations, Stanfield issued Order No. 7524542 for the alleged violation of 30 C.F.R. § 75.220(a)(1):

The operator failed to comply with the approved roof control (date 09/07/2006), on the 012/MMU in that;

(1) The entry width in the #5 entry exceeded the required 19 feet. Thirty [sic] inby spad #4037, located at the last open crosscut, the entry width measured from 20 to 24 feet wide for 12 feet

(2) Page 8 of the plan requires than [sic] no more than 2 extended cuts be left unsupported at any time. At the beginning of the second shift there were five cuts not bolted. These are; [sic] (1) #2 heading, (2) #3 heading, (3) #7 heading, (4) #7 right crosscut, and (5) #9 heading. After the cuts were bolted they were measured and the depths are; [sic] (1) #2 heading measured 18 feet deep, (2) #3 heading measured 22 feet deep, (3) #7 right crosscut measured 26 feet deep, (4) #7 heading measured 30 feet deep, and (5) #9 heading measured 20 feet and eight inches deep.

The operator has a history of recent similar violations. Three 104(d)(2) orders have been issued in the last year citing the same regulation. This mine has a history of poor roof and rib conditions, including roof falls. Failure to comply with the approved roof control plan, [sic] is a highly dangerous condition. The approved plan only specifies the minimum supports to be installed. The intent of the plan to allow no more than two extended cuts to be unsupported at any time is to assure that the roof is supported prior to it bending and breaking. The sooner the roof can be supported, the less likely than [sic] it will bend, break and fall. The immediate roof on the 012/MMU is laminated sandstone, which is often known to bend[,] break, and be hard to support. An agent of the operator was present on the 012/MMU while these cuts were being taken. The cited condition is an unwarrantable failure to comply with a mandatory regulation.

(Ex. G-23 at 1-2.). Stanfield alleged that four miners were affected and that fatal injuries were highly likely. (*Id.* at 1.) He also marked the order as S&S and the result of the operator's unwarrantable failure. (*Id.* at 1-2; Tr. 143-145, 157-159, 165.) Stanfield opined that the extended cuts had existed since at least the prior shift, which had ended at 3:00 p.m. (Tr. 159.)

2. Further Findings of Fact – Length of Unsupported Cuts

When Stanfield arrived on the 12 Section, he found five entries or crosscuts that were either partially or wholly unsupported (Stanfield's alleged measurements in parentheses): the No. 2 entry (18 feet), the No. 3 entry (22 feet), the No. 7 heading (30 feet), the No. 7 right crosscut (26 feet), and the No. 9 entry (20 feet, 8 inches).¹⁸ The September 7 Plan limited Blue Diamond to two unsupported cuts longer than 20 feet, also known as extended cuts. (Ex. G–20 at 8, 16–19; Tr. 147–48, 156.) Therefore, Stanfield's measurements bear on Blue Diamond's compliance with the September 7 Plan. Blue Diamond does not dispute the length of the No. 7 heading, but contends that Stanfield's measurements of entry No. 9, entry No. 3, and the No. 7 right crosscut are inaccurate. (Resp't Br. at 44–45.)

Although Stanfield measured the No. 9 entry at 20 feet, 8 inches in length, he measured this length from the back edge of the eight-inch bolt plate on the last row of roof bolts—in other words, the portion of the plate that was furthest from the face of the entry. (Tr. 630–32.) However, roof bolt plates play a role in securing the mine roof. I therefore find that the length of unbolted roof in entry No. 9 did not exceed twenty feet.

In entry No. 3, Stanfield testified that he marked the last row of completed bolts with rock dust, then waited to take his measurement until after the roof bolter finished bolting the entry. At the hearing and in its post-hearing brief, Blue Diamond suggested that Stanfield was unsure of the precise starting point for his measurement because he did not include it in his notes. (Tr. 185–86; Resp't Br. at 44.) However, I credit Stanfield's testimony that he marked the last row of bolts using rock dust and properly measured the distance. (Tr. 150–51.) Thus, I find that entry No. 3 had been cut to a length of 22 feet before Blue Diamond began bolting the roof.

Finally, Stanfield testified that he measured the left side of the No. 7 right crosscut “from the face back to the corner where the [left] rib of the crosscut intersected with the [No.] 7 heading.” (Sec'y Br. at 44; *see also* Tr. 155, 188–90; Ex. G–35.) Blue Diamond again disputed the accuracy of Stanfield's 26-foot measurement at the hearing and in its post-hearing brief. (Tr. 188–91; Resp't Br. at 45.) Yet, I see no reason not to credit Stanfield's No. 7 right crosscut measurement. Regardless of any estimation he made, I have no reason to believe his estimate would have overestimated the distance by six feet. I therefore find that the No. 7 right crosscut exceeded 20 feet prior to bolting. Consequently, three entries constituted extended cuts under the September 7 Plan: entry No. 3 (22 feet), heading No. 7 (30 feet), and No. 7 right crosscut (26 feet).

¹⁸ Stanfield testified that the conditions he found in the No. 2 entry suggested to him that Blue Diamond had quickly installed three rows of bolts in the No. 2 entry after he arrived at the mine. (Tr. 149–150; *see also* Sec'y 43–44.) However, he could not testify to any conversation he had with miners on the 12 Section that day indicating when entry No. 2 had been bolted. Thus, the Secretary has not demonstrated that any surreptitious bolting occurred.

3. Violation of Roof Control Plan – Wide Entry and Extended Cuts

The September 7 Plan specifically stated: “No more than 2 extended cuts shall be left unsupported at any time during [] normal production.” (Ex. G–20 at 8; Tr. 147–48.) The Secretary argues that Blue Diamond violated its roof control plan by having more than two extended cuts that were unsupported. Additionally, the September 7 Plan limited the “[m]aximum extracted entry width” to 19 feet. (Ex. G–20 at 6, 15–16, 18; Tr. 139.) The Secretary contends that the twelve-foot sliver in entry No. 5 exceeded the entry width permitted under the September 7 Plan.

Blue Diamond does not dispute the existence of the wide sliver in entry No. 5; instead, it claims the wide sliver was not dangerous and eventually became part of a crosscut. (Resp’t Br. at 49, 53.) I determine that the wide portion of the No. 5 entry did not comply with the terms of Blue Diamond’s September 7 Plan, and I conclude that Respondent violated 30 C.F.R. § 75.220(a)(1).

Nevertheless, Blue Diamond claims it complied with the September 7 Plan’s restrictions on extended cuts. (Resp’t Br. 44–49.) From Blue Diamond’s perspective, its active roof-bolting means that “the cut (no matter how long the depth) is no longer considered ‘left unsupported.’” (Resp’t Br. at 45.) Blue Diamond also argues that the September 7 Plan is ambiguous regarding the meaning of the term “unsupported,” and that the Secretary has the burden of establishing the meaning intended by the parties. (Resp’t Br. at 46.)

In support of this argument, Respondent indicates “cuts with less than [20] feet of unsupported roof” that were being “actively bolted” have never been cited as “an ‘extended cut left unsupported.’” (Resp’t Br. at 46–47.) Blue Diamond also points to Section Foreman Shepherd’s testimony that he had employed Blue Diamond’s proposed interpretation in the presence of Inspector Ashworth, and that Ashworth “never questioned the practice nor did he issue any citations.” (Resp’t Br. at 47.) I recognize that the Secretary presented no evidence of similar citations or orders, and I credit Williams’ testimony that no one from MSHA had previously informed him of Inspector Stanfield’s interpretation. Although these facts bear on Blue Diamond’s negligence, they do not indicate that the September 7 Plan was ambiguous.

Indeed, Blue Diamond’s strained attempt to muddy the waters about the September 7 Plan’s extended cut provision is unavailing. The provision clearly prohibits more than two extended cuts from being left unsupported “at any time,” and it is uncontroverted that portions of the No. 3 entry and No. 7 right crosscut were “left unsupported”—in that they had not yet been bolted—when Stanfield inspected the 12 Section. The plan’s terms were straightforward, and

Blue Diamond should have been on notice that it could not have more than two extended cuts that were unsupported at any time.¹⁹ Thus, I determine that the unsupported cuts in the No. 3 entry, the No. 7 heading, and the No. 7 right crosscut violated the terms of Blue Diamond's September 7 Plan.

Based on the above, I conclude that the wide sliver in the No. 5 entry and Respondent's three extended, unsupported cuts together constitute a violation of 30 C.F.R. § 75.220(a)(1).

4. S&S and Gravity Determinations

Blue Diamond's violation of 30 C.F.R. § 75.220(a)(1) establishes the first element of the *Mathies* test. Once again, my S&S determination in this case turns on whether the Secretary has proven that the wide sliver and extended cut conditions contributed to the safety hazard of a roof fall. Inspector Stanfield's S&S determination depends on two key factors: the sensitive nature of the mine roof and the impact of extended cuts at Mine No. 77. First, Stanfield stated that the laminated sandstone roof in the 12 Section contained "real small layers," which can bend and break with "the least bit of pressure" (Tr. 141), and MSHA Mining Engineer Gauna concurred that laminated sandstone was "very sensitive" and "very weak roof" that "can fail even after [it is] bolted." (Tr. 1114–15.)

Second, Stanfield stated that the September 7 Plan limited the number of extended cuts to minimize roof bending and breaking before roof support is installed. (Tr. 157–58.) He also explained that resin bolts build a beam of rock, so "the sooner [the beam is built] the less likely that those individual sheets of that laminated sandstone" are to bend and break. (Tr. 158.) Thus, leaving an unsupported, extended cut for any extended period limits the effectiveness of roof bolts in the short-term and long-term, because once "[the roof] bends and breaks . . . you're not doing a good job of building a satisfactory beam." (Tr. 157–58; *see also* Tr. 307.) Gauna concurred and indicated that an extended cut is particularly dangerous in laminated sandstone. (Tr. 1117–19; 1147–48, 1151.) Finally, Stanfield indicated the September 7 Plan's limitation of two extended cuts was "the smallest [number] of extended cuts we have" and reflected Mine No. 77's past history of roof falls and the "nature of the roof." (Tr. 158–159.) In comparison, other mines were allowed up to four extended cuts. (Tr. 158.)

For its part, Blue Diamond performs quick-and-dirty calculations to compare the surface area of unsupported roof that the September 7 Plan permitted for *non*-extended cuts (i.e., normal

¹⁹ In its brief, Blue Diamond advances a "fair notice" argument. (Resp't Br. at 47–49.) Because I have determined the September 7 Plan unambiguously prohibits more than two extended cuts that are not fully bolted, I dismiss Respondent's argument that it did not have fair notice of the conduct the roof control plan required.

20-foot cuts) with the amount of surface area Stanfield found in unsupported, extended cuts.²⁰ (Resp't Br. at 49.) Blue Diamond appears to hope I will infer that the latter unsupported extended cuts must not be dangerous if MSHA permits the former *non*-extended cuts. However, Blue Diamond's calculations do not account for the added danger any extended cut presents in the 12 Section.²¹

As for the wide sliver in entry No. 5, I recognize it had been bolted and Blue Diamond later turned a crosscut in that location. I also realize that Blue Diamond's roof bolters were actively bolting in both entry No. 3 and the No. 7 right crosscut when Stanfield arrived on the 12 Section. Both scenarios seem to limit the contribution these violative conditions would make to the discrete safety hazard of a roof fall in the 12 Section. However, Inspector Stanfield and MSHA's Gauna credibly explained why the 12 Section's laminated sandstone roof would bend and break under additional pressure. Despite Blue Diamond's attempts to discredit Stanfield's experience with laminated sandstone (*see* Tr. 734–35), it does not deny that the mine roof in the 12 Section is laminated sandstone. (*See also* Tr. 1152–54 (Gauna explaining why Stanfield's experience with laminated sandstone was more credible than Newman's KRP-7 core sample from several hundred feet away that contained no laminated sandstone).) Moreover, I find convincing Stanfield and Gauna's explanation that laminated sandstone is particularly sensitive. As Gauna succinctly noted: "Any bolts are better than no bolts. Yes, you do have that cut partially supported and it does help, but the fact remains that it's the issue of the depth of the cut is really prior to you getting there and actually doing the bolting. That's the issue." (Tr. 1122.)

Consequently, I determine that the wide sliver and the three extended cuts in entry No. 3, the No. 7 heading, and the No. 7 right crosscut contributed to a discrete roof fall hazard. Thus, I determine that the second *Mathies* element has been satisfied.

²⁰ Blue Diamond also points to a Roof Control Plan dated April 28, 2010 ("April 28 Plan"), which states that "[a] cut will not be considered unsupported if it is being bolted." (Ex. R-11 at 51.) However, Roof Control Specialist Charlie Fields credibly testified that his recommendation that MSHA approve the April 28 Plan reflected his review of the mine's accident history at the time and the mining conditions in which Respondent was advancing. (Tr. 1057–1062.) Thus, the roof conditions underlying the April 28 Plan tell me little about the roof conditions underlying the September 7 Plan. I therefore afford no weight to Blue Diamond's later April 28 Plan.

²¹ Indeed, Dr. Newman opined that "extended cuts do not create a hazardous situation under the circumstances that they can be safely taken. In other words, where the roof permits, where the strength and physical properties of the immediate roof are adequate, an extended cut does not create a hazardous condition." (Tr. 762.) Yet the converse would also seem to be true: where the strength and immediate roof are *inadequate*, an extended cut creates a hazardous condition. As I noted, both Stanfield and Gauna highlighted the danger of extended cuts in a laminated sandstone roof.

Stanfield credibly testified that these conditions could result in a roof fall hazard. (Tr. 141–43, 162–63). He also credibly testified that a roof fall was highly likely to result in fatal injuries to four of the ten miners located on the 12 Section. (Tr. 133–34, 162–63, 179–80.) As I noted in discussing Order No. 7521758, roof falls are highly likely to result in permanently disabling or fatal injuries to miners. I therefore determine that the third and fourth *Mathies* elements have been satisfied.

Given my determinations that the four *Mathies* elements have been satisfied, I conclude that Order No. 7524542 was properly designated as S&S.

5. Negligence and Unwarrantable Failure Determinations

The Secretary again alleges that Blue Diamond’s level of negligence was “reckless disregard” and that its conduct constituted an unwarrantable failure. Here, Inspector Stanfield alleged that Blue Diamond’s day shift foreman purposefully violated the September 7 Plan. (Tr. 161, 164–65.) According to Stanfield, miners on the 12 Section told him that mining more than two extended cuts was a common practice. (Tr. 160.) On cross-examination, he explained that he had not included his conversation in his notes because he feared the miners might be blackballed. (Tr. 184–85.) I believe Stanfield testified to his best recollection of that conversation, and I can understand and appreciate his concern for protecting the identity of the miners in question. However, Stanfield was testifying nearly four years after his inspection and had no notes about the conversation to refresh his memory. Intentional misconduct is a serious allegation, and I determine that Stanfield’s testimony is insufficient to establish that the day shift section foreman intentionally violated Blue Diamond’s roof control plan. Tellingly, the Secretary brought no section 110(c) case for this alleged intentional misconduct.

Looking to the remaining types of unwarrantable conduct, four aggravating factors support the Secretary’s position. First, I have concluded that the September 7 Plan unambiguously gave Respondent notice of the conduct it required. *See* discussion *supra* Part VI.C.2. Moreover, the unambiguous roof control plan made the violations obvious. Further, the Secretary presented violation history reports and citations for roof bolting violations, suggesting that greater efforts were necessary for compliance. Finally, I have found that the wide sliver and extended cuts were sufficiently dangerous to be designated as S&S.

On the other hand, three unwarrantable failure factors tilt in Blue Diamond’s favor. First, the length of time these conditions existed was relatively short. Second, Respondent had already bolted the wide sliver and was in the process of bolting the No. 3 entry and No. 7 right crosscut in an effort to abate the violative condition. Third, I determine that these violative conditions were not extensive because they existed in just four of the nine entries in the 12 Section.

Considering all of the facts and circumstances, this is a close case. Blue Diamond *did* bolt the wide sliver. Though its interpretation of the extended-cut provisions was misguided, Blue Diamond *was* bolting the unsupported, extended cuts. Furthermore, the Secretary’s *own*

evidence suggests an inconsistent interpretation: *none* of the previous roof control plan citations or orders the Secretary introduced into evidence mention problems with multiple extended cuts. (Ex. G-6; Ex. G-9; Ex. G-10; Ex. G-15.)

Yet, Blue Diamond had a responsibility to adhere to the September 7 Plan, including its limitations on entry width and the number of extended, unsupported cuts. In this case, Blue Diamond failed to adhere to entry width limitations, and the Secretary has presented evidence that entry widths are a continuing problem at Mine No. 77. (Ex. G-6; Ex. G-9; Ex. G-10; Ex. G-15.) No matter how well-intentioned, Blue Diamond's plan interpretation (that an extended, unsupported cut became a *non*-extended cut when Respondent began bolting it) of clear plan provisions was also simply incorrect. These are serious violations that put miners at risk, and Blue Diamond has not fulfilled its duty to protect miners. I therefore determine Respondent's conduct was unwarrantable.

However, the Secretary has not proven his negligence allegations for "reckless disregard." According to his own regulations, "reckless disregard" is appropriate when an operator's conduct "exhibit[ed] the absence of the slightest degree of care." 30 C.F.R. § 100.3(d) at Table X. Conversely, "high" negligence is appropriate when "[t]he operator knew or should have known of the violative condition or practice, and there are no mitigating circumstances." *Id.* Although Blue Diamond should have known that the September 7 Plan's clear plan provisions prohibited its interpretation, Respondent's efforts to bolt the wide sliver and extended cuts indicate that the operator exercised at least some care in this case. That said, I have found Blue Diamond to have exhibited a serious lack of reasonable care, and I found its conduct to be aggravated, constituting more than ordinary negligence.

Given my above analysis, I conclude that Blue Diamond's violations were appropriately designated as an unwarrantable failure and that its negligence was high in this case. Thus, Order No. 7524542 is **AFFIRMED** as to the unwarrantable failure designation and **MODIFIED** to change the cited level of negligence from "reckless disregard" to "high."

6. Reckless and Repeated Flagrant Designations under Section 110(b)(2)

In view of my S&S, unwarrantable failure, and negligence determinations, I note that the September 7 Plan's provisions were unambiguous and Respondent's unreasonable interpretation created dangerous conditions. Accordingly, I conclude Blue Diamond failed to make reasonable efforts to eliminate a known violation that reasonably could have been expected to cause death or serious bodily injury. Unlike Order Nos. 4220150 and 7521758, the Secretary has therefore demonstrated that section 110(b)(2)'s *other* criteria have been satisfied. Thus, the Secretary's flagrant designation will turn on whether Blue Diamond's conduct constituted the conscious or deliberate disregard that underlies a "reckless" allegation, and whether the Secretary's evidence demonstrates a predicate, *prior* failure to make reasonable efforts to eliminate a previous violation that would underlie a "repeated" allegation under section 110(b)(2).

Notwithstanding my other conclusions in this case, the Secretary comes up well short in proving either a “reckless” or “repeated” failure. First, the Secretary has not proven that Respondent acted with the conscious or deliberate disregard that would underlie a “reckless” failure. Here, the evidence demonstrates that Blue Diamond tried to comply with the September 7 Plan. Respondent *did* bolt the wide sliver. It *did* make efforts—misguided though they may have been—to bolt the unsupported, extended cuts.

Moreover, Blue Diamond presented credible evidence that it was unaware that the roof control plan meant that “active bolting” did not constitute supported roof. Although the September 7 Plan was unambiguous, Blue Diamond’s irrational or improper interpretation does not necessarily imply a conscious or deliberate disregard for safety. In fact, Superintendent Williams and Section Foreman Shepard credibly testified that MSHA—Inspector Ashworth in particular—had not previously enforced the extended cut provisions in the same fashion. Interestingly, the Secretary chose not to have Ashworth testify regarding Mine No. 77’s extended cuts. More interesting still, the Secretary’s *own* evidence corroborates this point: *none* of the previous roof control plan citations or orders the Secretary introduced into evidence mention problems with multiple extended cuts. (Ex. G–6; Ex. G–9; Ex. G–10; Ex. G–15.)

Indeed, the most natural inference is that Blue Diamond made an unreasonable mistake, but not a *deliberate* one. Although Respondent’s interpretation was clearly *wrong*, MSHA’s failure to enforce the extended cut terms of the September 7 Plan suggests Blue Diamond did not act outrageously in employing such an interpretation. Given the evidence before me, the Secretary has not satisfied his burden of proving that Blue Diamond’s conduct was reckless, because he has not demonstrated a conscious or deliberate disregard for the risk of a roof fall.

The Secretary also falls short of his burden of proving a predicate *prior* failure. Here, the Secretary points to two section 104(d)(2) S&S orders and thirteen section 104(a) S&S citations for violations of Blue Diamond’s roof control plan in the year prior to April 4, 2007. (Sec’y Br. at 53; Ex. G–6; Ex. G–9; Ex. G–10; Ex. G–15.) Yet Blue Diamond’s past S&S or unwarrantable failure citations and orders do not *per se* establish a past failure to take the steps a reasonably prudent operator would have taken to eliminate the known violation of a mandatory health or safety standard. As I noted in *Stillhouse*, the language in section 104 from which the terms S&S and unwarrantable failure are drawn “is quite different from the language that defines a flagrant violation.” 33 FMSHRC at 800; *compare* 30 U.S.C. § 814(d)(1) *with* 30 U.S.C. § 820(b)(2). Thus, the Secretary’s attempt to use prior S&S and unwarrantable orders as a stand-alone proxy for a failure to make reasonable efforts is inapposite.

In addition, Respondent's past citations and orders²² and Inspector Stanfield's vague testimony regarding Blue Diamond's violation history (Tr. 164, 206–10, 299) do not satisfy the Secretary's burden of proof. Flagrant designations are serious charges involving detailed analyses of multiple elements. None of the Secretary's proffered evidence provides sufficient details to establish a predicate, previous failure to make reasonable efforts to eliminate a previous violation. This was a fatal defect in the Secretary's case-in-chief.

Accordingly, I conclude that the Secretary has not proven Blue Diamond's conduct to have been recklessly or repeatedly flagrant under section 110(b)(2) of the Mine Act. Order No. 7524542 is therefore **MODIFIED** to remove the flagrant designation.

7. Penalty

The Secretary originally proposed a \$196,700.00 civil penalty for this violation. Again, nothing in the record suggests that the proposed penalty is inappropriate for the size of Blue Diamond's business or that it would infringe on Blue Diamond's ability to remain in business. Although I have found that this Order was properly designated S&S and unwarrantable, I have modified the order to "high" negligence and removed the flagrant designation. Of the 914 violations in Respondent's history of violations report, 42 involved 30 C.F.R. § 75.220(a)(1). In considering all of the facts and circumstances in this matter and applying the criteria in section 110(i) of the Mine Act, I hereby assess a civil penalty of \$49,000.00.

D. Citation No. 7505299 – Pillar Split Citation – Roof Control – November 2, 2007

1. Blue Diamond's "Dog Leg" Section

In the fall of 2007, Blue Diamond began to rehabilitate part of Mine No. 77 that a previous operator had mined twenty or thirty years earlier. (Tr. 325–26, 359–60, 968.) Located near the intersection of the Energy Mains and the AL West 2 areas of the mine, miners called this portion of Mine No. 77 "the dog leg" because of its unorthodox shape. (Ex. G–16; Tr. 325, 968–69.) Looking toward the face, the entries were numbered sequentially beginning with the No. 1 entry on the far left and the No. 9 entry on the far right. (Ex. G–16; Ex. R–3; Tr. 339.) The previous operator drove the last open crosscut of the section from two different directions, creating a point—or "knee" of the dogleg—at the No. 5 entry. (Tr. 971; Ex. R–3; Ex. G–16.) Because these slightly offset crosscuts came together at an angle, the panel, its crosscuts, and its

²² In his brief, the Secretary cites Commission dicta as a rationale for crediting copies of past citations. (Sec'y Br. at 10 (*citing Old Ben Coal Co.*, 7 FMSHRC 205, 209 (Feb. 1985)).) Even accepting as true the text of the citations and orders the Secretary presents, I accord scant evidentiary weight to the condition or practice section of any of these past citations or orders. Without more detail from the Secretary, such as testimony tying specific prior violations to the specific conditions found in this case, it is unclear whether these prior violations demonstrate a predicate failure for purposes of section 110(b)(2).

pillars were irregularly-shaped, rather than the typical square or rectangular shape of a coal pillar. (Ex. G-26 at 1; Ex. R-3; Tr. 971-72, 977-78.)

The previous mining activities in the dog leg did not meet Blue Diamond's height requirements for new coal production. (Tr. 325-26, 359-60, 968.) In addition, the previous operator's past mining activity anomalously stopped one crosscut short of the working face in the No. 6 entry. (Ex. G-26 at 1; Ex. R-3; Tr. 971-72.) The offsetting angles of the "dogleg" left an oversized and nearly trapezoidal pillar bounded by the No. 5 and No. 7 entries and the last open crosscut and second-to-last crosscut. (Ex. G-26 at 1; Ex. R-3; Tr. 972.)

On October 16, 2007, MSHA approved a supplement ("October 16 supplement") to Blue Diamond's September 7 Plan that permitted Respondent to extend the No. 6 entry through the middle of the anomalous, oversized pillar. (Ex. G-20; Ex. G-26 at 1; Ex. R-3; Tr. 329, 333, 341, 348, 350, 353-54, 385, 388.) According to the supplement, the entry could not exceed 18-feet wide or 20-feet long. (Ex. G-26 at 1; Tr. 976.)

Prior to beginning the pillar split, Superintendent Williams reviewed the October 16 supplement with Section Foreman Roberts and Blue Diamond's continuous miner operators. (Tr. 353-54, 370, 976-77.) Williams instructed the foreman and miners to make their cuts a foot shorter and narrower than permitted under the supplement. (Tr. 977.) Respondent began mining the No. 6 entry through the anomalous, trapezoidal pillar on November 1, and completed the pillar split on November 2. (Tr. 358-59, 978-80.)

Blue Diamond mined from the second-to-last open crosscut towards the working face of the section and completed the split in three cuts. (Tr. 343, 357-60, 978-980; Ex R-3.) Because the spads the miners used to line up their cut had been misaligned, Respondent's first two cuts were slightly off-center. (Tr. 980-83; Ex. R-3.) Blue Diamond compensated to the left on the third cut, resulting in a slightly wider entry.²³ (Tr. 983-85; Ex R-3.) Finally, the combined length of all three cuts was a total of 48 feet. (Tr. 1004.)

2. Inspection on November 2, 2007

On November 2, 2007, Inspector Vernus Sturgill and Superintendent Williams visited the dog leg portion of the mine, which was also known as the 11 and 12 Sections (or super section) of Mine No. 77. (Ex. G-24 at 1, 32.; Tr. 323-24, 370, 987.) At the time, Blue Diamond was "cutting bottom"—in other words, lowering the mine floor to create taller entries and crosscuts. (Tr. 325-26, 968-69, 988.)

²³ For a distance of ten feet, the entry measured nineteen feet wide. (Tr. 348; Ex. G-25 at 1-2.) Another ten-foot portion of the cut measured eighteen feet, six inches wide. (Tr. 348; Ex. G-25 at 1-2.)

Sturgill began with an imminent danger inspection of the 11 and 12 Sections, including the No. 5 and No. 6 entries. (Ex. G-24 at 6, 14-15, 19-32; Tr. 327-28, 339, 989.) As a result of his examination, Sturgill issued Citation No. 7505299 for the alleged violation of 30 C.F.R. § 75.220(a)(1):

The operator's approved Roof Control Plan (dated: 9-7-06) and supplement 77V-100-07 dated: 10-16-07) [sic] being complied with in the number 5 and 6 heading[s] of the 012 section. Beginning at the corner of the number 5 heading (inby survey station 4147),^[24] the number 5 heading has the following hazardous conditions present: the mine roof has loose unsupported draw rock located between the second and third roof bolts installed in the heading for approximately 20 feet and a loose rock brow that measures approximately 21 inches thick and by 28 feet in length. The rock brow has been created after the operator has mined the number 5 heading, the loose unsupported^[25] draw rock is an area the operator has mined through, (previously mined) . [sic] The number 6 heading is being created by the operator splitting a pillar, a pillar splitting plan was submitted and approved. An inspection of the number 6 heading revealed the last mined cut into the cross cut above it measures to be 30 feet in depth on the left side and approximately 25 feet on the right (looking toward the face). The previous cut mined measures in width 19 feet for 10 feet and 18.5 feet for 10 feet (distance of length are approximate) . [sic] The approved supplement limits the cut depth to a maximum of 20 feet and 18 feet wide. The width measurements taken are not due to rib

²⁴ Sturgill claimed that he made a typographical mistake in filling out Citation No. 7505299, contending that "4147" should have been "4129." (Tr. 330-31.) Regardless of where Sturgill observed the draw rock, he admitted that the draw rock had been supported. (Tr. 380.) His problem with the draw rock was that it had not been supported with straps as the September 7 Plan required. (Tr. 333-35, 380.) Accordingly, I find that the draw rock Sturgill identified in entry No. 5 was located in an area with roof bolt support. I also find that the draw rock in question had not been strapped or otherwise supported.

²⁵ Inspector Sturgill and Superintendent Williams disagreed whether Blue Diamond had previously bolted the rock brow in No. 5 entry. (Tr. 338, 1011.) However, Sturgill's contemporaneous inspection notes state: "The Number 5 heading has loose hanging draw rock and brow (rock) measuring approximately 21 inches thick by 28 feet in length on the right side approximately 20 feet [from the corner of the intersection with the last open crosscut]." (Ex. G-24 at 15.) That Sturgill's notes reference the rock brow in similar terms to the draw rock convinces me that the rock brow had also been bolted. Accordingly, I find that Blue Diamond bolted the rock brow at some point before Sturgill arrived. However, I credit Sturgill's testimony that the bolted rock brow remained loose.

sloughage but actual width of cut mined. The supplement and conditions found on the section limits the cut depth to a maximum of 20 feet. The heading adjacent to the number 6, number 5 heading when mined for a distance of approximately 12 feet has fallen and continues to fall to a height of approximately 8.5 to 9 feet, from falling draw rock and adverse roof conditions. These cited conditions are obvious to the most casual observer. The operator has been issued eleven violations for non-compliance of the approved Roof Control Plan from January 2007 until this date. Citation 7505297 for similar conditions of adverse roof on the 011 section. [sic] The 012 section is one side of a super-section. The foreman has engaged in aggravated conduct constituting more than ordinary negligence. This violation is an unwarrantable failure of the operator to comply with a mandatory standard. A condition of termination of this citation is that the operator as evidence[d] by signatures instructs miners employed at this mine for the production of coal of the operator's approved Roof Control Plan.

(Ex. G-25 at 1-2.)

According to Sturgill, these conditions created rock and roof fall hazards. (Tr. 335-36, 350-52, 372-73.) Based on his observations and experience as a miner, he characterized reasonably serious injuries to be reasonably likely to occur. (Tr. 336.) He also noted that he saw nothing suggesting Blue Diamond had taken any steps to correct the draw rock and rock brow conditions in entry No. 5, despite their obvious nature. (Tr. 337-38.) Further, Sturgill explained that Section Foreman Roberts should have identified those conditions during an on-shift examination. (Tr. 338.) Sturgill also characterized the conditions in entry No. 6 as obvious and indicated that the operator should have known of the violations. (Tr. 352-54, 370, 388.) In particular, Sturgill focused on Roberts' failure to comply with the pillar split roof control supplement despite Williams' explanation of the plan to Roberts and the miner operators the previous day. (Tr. 352-54, 370, 388.)

Based on his examination, Sturgill marked the citation as S&S and as the result of the operator's unwarrantable failure. (Ex. G-25 at 1-2; Tr. 370.) In addition, Sturgill alleged that one miner was likely to be affected. (Ex. G-25.)

3. Further Findings of Fact

a. Inspection of Entry No. 5

During his imminent danger run, Inspector Sturgill examined the No. 5 entry, which was approximately 30 feet long. (Ex. G-24 at 25; Tr. 332, 339, 990.) Roughly twenty feet of the entry had previously been mined and supported, but included loose draw rock between the bolts.

(Tr. 332–33, 377, 381–82.) Blue Diamond had not strapped or supported the draw rock, and Sturgill observed fallen roof debris on the mine floor. (Tr. 333, 379–81.) Blue Diamond had also mined approximately 12 feet in the face area of entry No. 5 that remained unsupported. (Tr. 332, 377–78.) Sturgill indicated that Respondent was “having trouble cleaning up to the point that they could actually support that unsupported area. When they would attempt to clean it up, [the roof] was falling in again to the point that they couldn’t get a roof bolter [into] that particular heading.” (Tr. 332.) In addition, Respondent had placed a danger flag in front of the 12 foot cut. (Tr. 379, 1009–10.)

Blue Diamond’s mining activities had also created a rock brow in the No. 5 entry that was approximately 20-feet, 21-inches wide and 28-feet long but of unspecified thickness. (Tr. 333, 335, 338.) No miners were actually working in the entry at the time. (Tr. 333, 378.)

b. Inspection of Entry No. 6 and Measurement of the Third Cut

The Secretary’s extended- and wide-cut allegations are based on the measurements Inspector Sturgill took in the new No. 6 entry that split the section’s anomalous and oversized pillar. Although Blue Diamond admits the pillar split inadvertently exceeded the width permitted under the October 16 supplement, it disputes the accuracy Sturgill’s length measurements.

When Sturgill and Williams arrived on the 11 and 12 Sections, Respondent had already holed through the ribline on the last open crosscut side of the pillar. (Tr. 343, 346, 355, 357, 979, 987, 1000.) By that point, Respondent had supported its first two cuts with roof bolts. (Tr. 341, 347, 359, 363, 394, 397–98, 992–94.) A roof bolter operator was also in the pillar split supporting the third cut. (Tr. 341, 345, 992–93.) Sturgill testified that the bolter had completed rows of two bolts on the left-hand side of the third cut; however, he had not yet bolted the right-hand side of the third cut. (Tr. 344–345, 348–49, 361–63.)

Sturgill claimed that he stood at the incomplete row of bolts second closest to the working face and measured the length of Blue Diamond’s third and final cut through the pillar to be 30 feet. (Tr. 342, 344–46, 397–98; *see also* G–24 at 20–21 (including measurements).) According to Sturgill, he extended the end of the tape measure until it reached the corner of the pillar split and last open crosscut. (Tr. 344–46, 397–98.) Sturgill also measured the right side of the cut but testified that on the right side he positioned himself at the second to last *completed* row of bolts, because the roof bolter had not yet begun bolting the right-hand side of the cut. (Tr. 355, 363, 366–67, 398.) Further, Sturgill stated that the right-hand side of the third cut

measured 25 feet.²⁶ (Tr. 355, 364, 366–67; G–24 at 20–21 (including measurements).) However, he neither verified that the end of his tape measure was at the corner of the newly created rib and last open crosscut, nor corroborated his measurements at any later time. (Tr. 367–69.)

Conversely, Williams claimed that the pillar split only included completed rows of roof bolts and that Sturgill took his left-hand side measurements from the *completed* row of roof bolts second closest to the working face. (Tr. 993–94; Ex. R–3.) Moreover, Williams claimed that Sturgill extended his tape measure well beyond the end of the third cut to at least the second row of bolts *in the last open crosscut* because the first bolt in the last open crosscut was loose. (Tr. 995–96.) In addition, Williams disputed Sturgill’s testimony about his position within the pillar split when measuring the *right-hand* side of the third cut. (Tr. 997.) According to Williams, Sturgill positioned himself *more* than two rows of roof bolts back from the unsupported roof because the roof bolting machine was in his way. (Tr. 997.)

Based on all the evidence, the Secretary has not satisfied his burden of proving that the third cut through the pillar exceeded twenty feet. Most importantly, it is uncontroverted that the total length of *all three pillar split cuts* was forty-eight feet. If I credit Sturgill’s measurements as accurate, Blue Diamond’s first two cuts would have covered a total of eighteen feet. I understand that poor roof conditions sometimes force operators to make shorter-than-normal cuts, but I do not believe an operator that had recently obtained approval of a pillar split supplement, then carefully shortened its first two cuts to accommodate dangerous conditions, would swiftly change course and ignore the cut length restrictions contained in the supplement. Sturgill’s measurements are simply inconsistent with the other evidence before me.

I also have significant questions about the accuracy of Sturgill’s measurements. Looking at the September 7 Plan, I note that rows of roof bolts are to be spaced four feet apart. (Ex. G–20 at 15–19.) Thus, if Stanfield measured to the *second* row of bolts in the last open crosscut (rather than the end of the pillar), he would have added approximately eight feet to his 30-foot measurement. Meanwhile, if Stanfield positioned himself more than two completed rows back on the *right-hand* side, he may have added four feet to his 25-foot measurement. Yet at the time, his only source of light to illuminate the far end of his tape measure was his cap lamp. (Tr. 367–68.) In my view, estimating the “zero point” of a tape measure from a distance of twenty feet might easily, and innocently, result in a foot or two of variance.

In view of the above, the Secretary has therefore not met his burden of proving that Blue Diamond’s final cut through the pillar exceeded 20 feet.

²⁶ The different measurements on left and right side of the entry is at least partially explained by the mining history of this part of the mine. The last open crosscut was mined at an angle, which created an irregular and trapezoidal pillar. (Ex. G–26 at 1; Ex R–3; Tr. 355, 971–72, 977–78, Tr. 1000–02.)

4. Violation of Roof Control Plan – Pillar Split

Citation No. 7505299 alleges that four different conditions in the No. 5 and No. 6 entries of Blue Diamond's 12 Section violated the September 7 Plan, as supplemented by the pillar split plan. I have found that the rock brow in the No. 5 entry had been previously bolted. In addition, I have found that the Secretary did not prove that Blue Diamond's final pillar split cut exceeded 20 feet in the new No. 6 entry. Accordingly, neither condition constitutes a violation of Blue Diamond's roof control plan.

Next, the Secretary contends that the loose draw rock in entry No. 5 violated the September 7 Plan requirement that Blue Diamond provide additional support for subnormal roof control conditions. As I noted, the cited draw rock in entry No. 5 had been bolted but not strapped or otherwise supported. I have also found that Blue Diamond previously bolted the rock brow, but I credit Sturgill's testimony that the brow remained loose. Given the September 7 Plan requirement that additional support be provided for subnormal roof control conditions, I determine that the draw rock and rock brow were violations of Respondent's roof control plan.

Finally, Blue Diamond does not dispute that the wide portion of the No. 6 entry existed; rather, Respondent explains that the wide portion was inadvertent and not dangerous. (Resp't Br. at 56–58.) Those explanations bear on gravity and negligence but not the fact of a violation. Indeed, the pillar split supplement prohibited Blue Diamond's pillar split from exceeding a width of 18 feet, and this cited condition plainly violated the requirements of the supplement.

In light of these determinations, I conclude that the unsupported draw rock in entry No. 5 and the wide portion of entry No. 6 each constitute a violation of 30 C.F.R. § 75.220(a)(1).

5. S&S Determination

Blue Diamond's violation of 30 C.F.R. § 75.220(a)(1) establishes the first element of the *Mathies* test. As to the second *Mathies* element, two factors convince me that the violative conditions contributed to a roof fall hazard in this case. First, Sturgill based the S&S finding on his long experience as a coal miner and his experience with roof conditions in Mine No. 77 in particular. Although I recognize that roof conditions and composition can vary widely within the same mine, I credit Sturgill's opinion that the violative conditions contributed to a roof fall hazard because of his experience and first hand observation of the roof conditions at the mine. *Cf. Harlan Cumberland Coal Co.*, 20 FMSHRC 1275, 1279 (Dec. 1998) (relying on inspector's opinions to conclude that substantial evidence supported the ALJ's S&S determination.)

Second, it is uncontroverted that Blue Diamond was having problems securing its newly-mined roof in the No. 5 entry. That difficulty corroborates Sturgill's concern that the mine roof in this area was sensitive and weak. In addition, Sturgill examined a test hole in the mine roof twenty feet away from Respondent's final cut and found cracks at 20 inches and 28 inches. (Ex. G–24 at 26; Tr. 347–48, 373–75.) According to Sturgill, these cracks demonstrated that some

separation had occurred in the immediate roof. (Tr. 375–76, 394–95.) Although the cracks he found in the test hole in entry No. 6 may have been located within the rock beam that Blue Diamond’s roof bolts created, they also suggest to me a sensitive or weak roof with an elevated likelihood of falling.

In this context, the increased marginal pressure created by the wide entry would add a measure of danger to safety over the four to six hours these conditions existed. Further, these types of roof conditions would make roof fall more likely. Moreover, Blue Diamond’s danger flags in the No. 5 entry might limit access to the entry but would not address the dangers of a weak roof. Based on the evidence before me, I therefore determine that the Secretary has met his burden of establishing the second element of the *Mathies* test.

Inspector Sturgill indicated that the conditions on the 12 Section would contribute to roof fall and that a roof fall is reasonably likely to result in reasonably serious injuries or death. (Tr. 335–36, 350–51.) As with each of the other three roof control violations at issue in these consolidated cases, I do not doubt that a roof fall is reasonably likely to result in permanently disabling injuries. As Sturgill’s notes succinctly observed: “Roof falls kill!” (Ex. G–24 at 34.) Thus, I determine that the third and fourth elements of the *Mathies* test are satisfied. I therefore conclude that Citation No. 7505299 was appropriately designated as S&S.

6. Negligence and Unwarrantable Failure Determinations

Based on the evidence before me, the Secretary has not met his burden of demonstrating that Blue Diamond’s conduct was unwarrantable or that it acted with high negligence. First, Superintendent Williams’ meeting with Section Foreman Roberts and the continuous miner operators to discuss the requirements of the pillar split supplement plan significantly mitigates Blue Diamond’s negligence. The Secretary presented no evidence or testimony suggesting that Roberts was present at the time the pillar split occurred, and I credit Williams’ testimony that rank-and-file miners inadvertently mined the area too wide. Indeed, Williams’s meeting regarding the pillar split supplement suggests an operator taking steps to comply with its plan and protect the safety of miners. These are precisely the types of affirmative steps an operator should take, and I determine that they weigh strongly in Blue Diamond’s favor. Second, I have found that Blue Diamond had already supported the rock brow in entry No. 5. Although the brow was loose when Sturgill arrived, Blue Diamond’s affirmative step to secure the brow and remedy the condition suggests Respondent was not operating with indifference, reckless disregard, or a serious lack of reasonable care.

Looking to the remaining unwarrantable failure factors, I note that the conditions at issue in this case were not extensive in that they were present in only two of the nine entries of the super section. I also note that the Secretary presented no evidence that any of Blue Diamond’s past roof control violations involved improper pillar splits, but two of the other Orders before me involve wide entries and draw rock. The violative conditions lasted between 4 to 6 hours, which suggests that Blue Diamond should have known about the looseness of the otherwise bolted

draw rock and rock brow. Although I recognize that the draw rock, rock brow, and wide portion of entry No. 6 were fairly obvious and have been properly designated S&S, in weighing the unwarrantable failure factors before me I determine that Blue Diamond's conduct was not aggravated.

These same factors convince me that Respondent did not act with high negligence. Blue Diamond had a responsibility to follow its roof control plan, and I have found this violation to be S&S. However, Respondent's affirmative steps to discuss the requirements of the pillar split plan and to bolt the rock brow indicate a concern for plan compliance and miner safety. I therefore determine that Blue Diamond's efforts mitigate its negligence.

Thus, I conclude that Blue Diamond's conduct was not an unwarrantable failure and its level of negligence was moderate. Citation No. 7505299 is hereby **MODIFIED** to remove the unwarrantable failure designation and to lower the level of negligence from "reckless disregard" to "moderate."

7. Repeated Flagrant Designation under Section 110(b)(2)

In view of my discussion above, the Secretary has likewise not carried his burden of proving that Citation No. 7505299 is a repeated failure. Based on his own definition, the Secretary must show that section 110(b)(2)'s "other criteria" have been satisfied. Yet the Secretary has not presented evidence demonstrating that Citation No. 7505299 represented a failure to make reasonable efforts to eliminate a known violation. Here, Superintendent Williams met with his section foreman and miners to discuss pillar split plans. Moreover, Blue Diamond had taken steps to bolt the rock brow. Although these steps did not ultimately prevent the violation at issue, they represent reasonable steps on the part of the operator.

Because the Secretary has not demonstrated that Citation No. 7505299 satisfied section 110(b)(2)'s other criteria, I need not examine his evidence of prior failures. I conclude that the Secretary has not proven Blue Diamond's conduct to have been repeatedly flagrant under section 110(b)(2) of the Mine Act. Order No. 7505299 is therefore **MODIFIED** to remove the flagrant designation.

8. Penalty

The Secretary originally proposed a \$154,500.00 civil penalty for this violation. Again, nothing in the record suggests that the proposed penalty is inappropriate for the size of Blue Diamond's business or that it would infringe on Blue Diamond's ability to remain in business. Although I have found that this order was properly designated S&S, I have modified the order to "moderate" negligence and removed the unwarrantable failure and flagrant designations. Of the 914 violations in Respondent's history of violations report, 42 involved 30 C.F.R. § 75.220(a)(1). In considering all of the facts and circumstances in this matter and applying the criteria of section 110(i), I hereby assess a civil penalty of \$15,450.00.

VII. ORDER

In light of the foregoing, I hereby **ORDER** the following:

1. Section 104(d)(2) Order No. 4220150 is **MODIFIED** to a section 104(a) citation by removing the S&S, unwarrantable, and reckless and repeated flagrant designations, and lowering the cited level of negligence from “reckless disregard” to “moderate.”
2. Section 104(d)(2) Order No. 7521758 is **AFFIRMED** as S&S and **MODIFIED** to a section 104(a) citation by removing the unwarrantable failure designation, removing the reckless and repeated flagrant designations, and lowering the cited level of negligence from “reckless disregard” to “moderate.”
3. Section 104(d)(2) Order No. 7524542 is **AFFIRMED** as S&S and as an unwarrantable failure, and **MODIFIED** to remove the reckless and repeated flagrant designations, and to lower the cited level of negligence from “reckless disregard” to “high.”
4. Section 104(d)(1) Citation No. 7505299 is **AFFIRMED** as S&S and **MODIFIED** to a section 104(a) citation by removing the unwarrantable failure designation, removing the repeated flagrant designation, and lowering the cited level of negligence from “high” to “moderate.”
5. Blue Diamond shall **PAY** a civil penalty of \$85,940.00 within 40 days of the date of this decision.
6. The section 110(c) penalty assessment case against Gary L. Jent is **VACATED**, and that proceeding is **DISMISSED**.

Given the multiplicity of issues and docket numbers involved in this decision, the follow chart summarizes the modifications and penalties associated with each of the violations before me:

Citation /Order No.	30 C.F.R §	KENT 2008-584				Type of Action	Penalty
		S&S	Negligence	Unwarrantable Failure	Flagrant		
4220150	75.370(a)(1)	Removed	To “Moderate”	Removed	Removed	To “104(a)”	\$3,000.00
7521758	75.220(a)(1)	Affirmed	To “Moderate”	Removed	Removed	To “104(a)”	\$18,490.00

7505299	75.220(a) (1)	Affirmed	To “Moderate”	Removed	Removed	To “104(a)”	\$15,450.00
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KENT 2008-784							
Citation /Order No.	30 C.F.R§	S&S	Negligence	Unwarrantable Failure	Flagrant	Type of Action	Penalty
7524542	75.220(a) (1)	Affirmed	To “High”	Affirmed	Removed	N/A	\$49,000.00

KENT 2009-6							
Vacated							

/s/ Alan G. Paez
 Alan G. Paez
 Administrative Law Judge

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FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

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February 28, 2014

SECRETARY OF LABOR	:	CIVIL PENALTY PROCEEDINGS
MINE SAFETY AND HEALTH	:	
ADMINISTRATION (MSHA),	:	Docket No. LAKE 2008-406-M
Petitioner	:	A.C. No. 47-00398-146216
	:	
	:	Docket No. LAKE 2010-153-M
	:	A.C. No. 47-00398-199574
v.	:	
	:	Docket No. LAKE 2010-154-M
	:	A.C. No. 47-00398-199574
	:	
BUECHEL STONE CORPORATION,	:	Mine: Chilton Quarry
Respondent	:	

DECISION

Appearances: Amanda K. Slater, Esq., U.S. Dept. of Labor, Office of the Solicitor, Denver, Colorado, for Petitioner;

Denise Greathouse, Esq., Michael Best & Friedrich, LLP, Waukesha, Wisconsin, for Respondent.

Before: Judge Bulluck

These cases are before me upon Petitions for Assessment of Civil Penalty filed by the Secretary of Labor (“Secretary”) on behalf of his Mine Safety and Health Administration (“MSHA”), against Buechel Stone Corporation (“Buechel”), pursuant to section 105(d) of the Federal Mine Safety and Health Act of 1977 (“Act”), 30 U.S.C. § 815(d). The Secretary seeks total civil penalties in the amount of \$29,482.00 for 18 alleged violations of his mandatory safety standards and one violation of the Act.

The parties reached an agreement that settled 12 citations prior to commencement of the hearing in Madison, Wisconsin. Five citations were the subject of the hearing.¹ The issues are: (1) whether Respondent violated 30 C.F.R. §§ 56.14107(a), 56.15020, 56.16009, 56.20003(a), and 46.9(a); (2) whether the violations were significant and substantial, where alleged; (3) whether the degree of negligence charged is appropriate; and (4) whether the violations were

¹ The hearing commenced with six violations at issue. Prior to close of the record, the parties reached a settlement of Citation No. 6414887 (Lake 2010-154-M). Tr. 292.

attributable to Buechel's unwarrantable failure to comply with the Secretary's safety standards, where alleged. The parties' Post-hearing Briefs are of record.

For the reasons set forth below, I **AFFIRM** the citations, as issued, assess penalties against Respondent, and approve the parties' Partial Settlement.

I. Stipulations

The parties stipulated as follows, respecting the five citations at issue:

1. Buechel is engaged in mining operations in the United States, and its mining operations affect interstate commerce.
2. Buechel is the owner and operator of the Chilton Quarry, MSHA ID No. M/NM 47-00398.
3. Buechel is subject to the jurisdiction of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 801 *et seq.*
4. The Administrative Law Judge has jurisdiction in this matter.
5. The subject citations were properly served by a duly authorized representative of the Secretary upon an agent of Respondent on the dates and places stated therein, and may be admitted into evidence for the purpose of establishing their issuance, but not for the truthfulness or relevancy of any statements asserted therein.
6. The exhibits offered by Respondent and the Secretary are stipulated to be authentic, but no stipulation is made as to their relevance or the truth of the matters asserted therein.
7. The operator demonstrated good faith in abating the violations.
8. Citation No. 6199159: The areas cited by Inspector Leppanen were workplaces and/or passageways for purposes of 30 C.F.R. § 56.20003(a).
16. Citation No. 6414879: The Wilson saw at issue in this citation has a moving machine part that could cause severe permanently disabling injuries.
18. Citation No. 6414885: There were no life jackets provided to the employees who work on water pumps in the lower east pond at the Chilton Quarry.
19. Citation No. 6414885: On the day of the inspection, the water in the pond was approximately 4 feet deep.

Sec'y Pre-hear'g Rep. at 1-3.

II. Factual Background

Buechel owns and operates the Chilton Quarry, a surface dimensional stone operation that cuts limestone for decorative use in the building construction industry, located between Brothertown and Chilton, Wisconsin. Tr. 14-15. The quarry employed approximately 67 workers in 2008 and operated two shifts, 6:00 a.m. to 2:30 p.m. and 2:30 p.m. to 11:00 p.m. Tr. 64.

On the morning of January 9, 2008, MSHA Inspector Robert Leppanen conducted a regular E-01 inspection of the Chilton Quarry, accompanied by mine maintenance engineer technician Steve Grossenbach. Tr. 16. Leppanen inspected the entire quarry, including the CMF (“Chilton Manufacturing Facility”) building where the Wilson saw is located, and took field notes as the inspection progressed. Tr. 16, 294.² As a result of observing accumulations of mud, water and saw cuttings on the travelway to the northeast and northwest of the Wilson saw, Leppanen issued a housekeeping citation to Buechel for the operator’s failure to keep the areas free of debris, posing a slip-and-fall hazard. Tr. 18-19; Exs. P-1, P-2.

On August 25, 2009, MSHA Inspector James Hautamaki, observed by MSHA Southeast Assistant District Manager Fred Gatewood, conducted a spot inspection of the Chilton Quarry. Tr. 124-26, 222-23, 256. According to Hautamaki, “a Buechel,” Steve Grossenbach, and site manager Jason Zahringer also traveled with him. Tr. 125-26, 263. Inspector Hautamaki issued several citations as a result of this inspection.

Although Hautamaki had inspected the Chilton Quarry on previous occasions, during this inspection, he became aware of three settling ponds on mine property that had never been inspected because they were not readily visible and because MSHA had not been advised that they existed. Tr. 128-29. Hautamaki took photographs of the ponds and, because no miners were working in the area, talked to Grossenbach about the work involved in maintaining them. Tr. 129-31. Based on his observations of the work environment, and Grossenbach’s description of seasonal maintenance work on the pumps submersed in the ponds, Hautamaki cited Buechel for failure to provide its employees with personal floatation devices. Tr. 126, 131-33; Exs. P-19, P-20.

Hautamaki inspected the CMF building and, although the Wilson saw was not running, he observed that no guarding was installed around the saw’s perimeter and cited Buechel for failure to prevent persons from contacting its moving parts when in operation. Tr. 181-82; Exs. P-12, P-13. The inspector also issued another citation in the CMF building for a miner’s failure to stay clear of a suspended load, after observing a forklift operator leave his cab and

² The Wilson saw is a gantry-type wet saw that cuts large blocks of stone into slabs of varying widths. Tr. 79. Splitters, also known as guillotines, located in front of the saw, chop the slabs into smaller lengths. Tr. 41.

position himself at or very near the edge of a large stone slab, propped up in mid-air by the tips of the forks. Tr. 189-90; Exs. P-15, P-16.

Hautamaki also inspected the mine's annual refresher and new miner training records and, finding the forms incomplete, cited the operator for failure to provide the information required by the Secretary's Part 46 Training Regulations. Tr. 198-200; Exs. P-23, P-24.

III. Findings of Fact and Conclusions of Law

A. Citation No. 6199159

1. Fact of Violation

Inspector Leppanen issued 104(a) Citation No. 6199159, alleging a "significant and substantial" violation of section 56.20003(a) that was "reasonably likely" to cause an injury that could reasonably be expected to result in "lost workdays or restricted duty," and was caused by Buechel's "moderate" negligence."³ The "Condition or Practice" is described as follows:

The northeast and northwest travel ways at the Wilson Saw were not kept neat and orderly. There was spilled fine saw cuttings, mud and water on the floor causing a slippery condition. If a person accessing this area were to slip and fall on this spilled material, lost time injuries could occur. These areas are accessed daily; there were several footprints traveling through the spilled material.

Ex. P-1. The citation was terminated the same day, after the cited material had been removed. Tr. 47, 68.

In order to establish a violation of one of his mandatory safety standards, the Secretary must prove that the violation occurred "by a preponderance of the credible evidence." *Keystone Coal Mining Corp.*, 17 FMSHRC 1819, 1838 (Nov. 1995) (citing *Garden Creek Pocahontas Co.*, 11 FMSHRC 2148, 2152 (Nov. 1989)).

The parties have stipulated that the areas cited by Leppanen were workplaces and/or passageways. Stip. 8. The Secretary takes the position, therefore, that he need only establish that they were not maintained in a clean and orderly manner in order to prove a violation of section 56.20003(a). According to him, the photographs of the areas, alone, establish the violation. Sec'y Br. at 5; Ex. P-2.

³ 30 C.F.R. § 56.20003(a) provides that at all mining operations, "workplaces, passageways, storerooms, and service rooms shall be kept clean and orderly."

Buechel argues that it is allowed a reasonable amount of time to clean the surrounding area after the Wilson saw has been operating, and that the Secretary has failed to refute that the saw had recently completed a project prior to the inspection. Resp't Br. at 5.

Leppanen, assigned to the Marquette, Michigan field office, and experienced in surface and underground mining and heavy equipment operation and maintenance, had worked for MSHA for almost nine years when the case was heard. Tr. 10-13. Leppanen described the accumulations of wet mud and saw cuttings around the Wilson saw as approximately one-eighth to one-half inch deep, with tracks and footprints indicating that equipment and pedestrians had traveled through them. Tr. 19-22, 46-47, 52-53; Ex. P-2. When asked his opinion as to how the materials got onto the floor, the inspector stated the following:

It appeared to me that they came from the saw cuttings. They use water to cool the saw blade and assist in the cutting of the stone. Also, when they bring the stones into the building, they'll bring 'em in with forklifts. So if it's a wet condition outside, the mud gets tracked-in in the treads on the forklifts, and it gets spilled onto the floor area.

Tr. 22. Leppanen estimated the accumulations to extend approximately 20 feet long, by 6 feet wide, and concluded that the cement floor was slippery by testing it with his foot. Tr. 22-23. He stated that about 20 employees were working in the CMF building, and that he observed employees running the guillotines in the general area of the saw, but not in the specific area where he cited the mud. Tr. 24. He also stated that a lunchroom and foreman's office are located in the building, and that a bathroom is near the muddy area. Tr. 25, 44, 46. He testified that the Wilson saw's controls are near the saw, but not where the mud had accumulated. Tr. 49. In Leppanen's opinion, it was reasonably likely that someone would fall on the slippery cement floor and suffer strains, sprains and broken bones, because the slippery areas were being traveled; he also noted that pedestrians would have had to have stepped over a curb before stepping down into the mud. Tr. 23-24; see 49-50. He also testified that he did not actually witness anyone traveling through the material, that it was not being cleaned when he arrived on the scene, that no warning signs or barriers blocked off the slippery areas, and that it had to have taken a substantial amount of time for the saw cuttings to have accumulated. Tr. 26. Leppanen explained that he ascribed moderate negligence to Buechel because the foreman should have seen the muddy accumulations from his office window and had them cleaned up. Tr. 26-27, 53-54; see 69. Finally, he stated that if there had been no evidence of foot traffic, he would not have cited the condition. Tr. 54-55, 69.

Maintenance engineer technician Steven Grossenbach worked at Buechel from about May 2007 until December 2009. Tr. 75. He testified that he had accompanied Leppanen when he inspected the Wilson saw, that he had observed footprints and forklift tracks in what he described as "kind of like a half-dried mud puddle," and that it was he who had called for someone in the area to clean up the material. Tr. 75-76, 79-80, 82, 83, 85, 88. Grossenbach explained that in 2008, the Wilson saw was run two to three times weekly, that it was typically

programmed in the afternoon to run through the night and, less frequently, into the morning hours, depending on the job. Tr. 78. When asked about procedures to clean up the “mess” created by operating the saw, Grossenbach explained that when the saw completes a cycle, the oncoming shift cleans the floor, then moves the product by crane, loader or forklift, depending on where the stone is needed. Tr. 79. He also stated that the Wilson saw operator may be in the area while it is operating or, if a splitter operator has programmed the saw, that worker will have moved on to the splitter. Tr. 81-82. Grossenbach placed the lunchroom about 100 feet from the northeast accumulation and, while he conceded only the possibility that someone would use the muddy area to get to it, he acknowledged having used the travelway, himself, to get from the CMF building to the saw shop and assumed that others did so as well. Tr. 84-85, 88-89.

Maintenance worker David Petrie also testified that the Wilson saw is not run every day, and that it operates at night and sometimes in the morning, depending on the product. Tr. 91. He stated that he has witnessed workers use a fireman’s style hose to clean the leavings around the saw. Tr. 92. When Petrie was shown a photograph of the cited northwest muddy area, he identified it as “a walkway by that splitter,” that is a frequently traveled area for the person who operates the saw. Tr. 93; Ex. P-2. He identified a second photograph, the northeast accumulation, as an infrequently traveled area along the north wall, and stated that it was used to access the hose to wash down the Wilson bay and to travel to the saw shop, the next building north of the CMF building. Tr. 93-94; Ex. P-2. Finally, Petrie conceded not knowing how frequently the area around the saw was cleaned. Tr. 95.

Buechel’s executive vice-president, Scott Buechel, corroborated that operation of the Wilson saw depends upon the orders - - daily to three times a week - - and that it is typically programmed during the day then, at the end of the shift, it runs at night and, occasionally, a couple of hours into the morning. Tr. 98-99. He described a drainage system, running east to west, that carries away much of the lime sediment prior to manual cleaning that occurs after the bunkers are removed, and opined that the saw operator would be working in the area where the footprints were observed in the sludge. Tr. 104, 107-08. Buechel gave a detailed description of the operator’s cleaning procedure:

So we’ll have the forklifts go in, pick up the stone, put it onto the splitter that’s right there; then the operator will go in with a crane, pick up the bunker, move it to a place where they can get at it comfortably and safely; and then after they’ve got that product out, then they will go in, and they’ll clean down the area so that they can get at everything at one time.

* * * * *

Typically they’ll use a water hose. Once in a while, if the sludge is a little thicker, they may go in with a shovel just to clean it, make it a little easier.

Tr. 99-100.⁴ According to him, “they’re supposed to clean it up right after they remove the stone out of there.” Tr. 100.

Scott Buechel testified that the company’s policy requires that the Wilson bay be cleaned immediately. Tr. 110. Buechel asserts that the sets of footprints were that of the Wilson saw operator preparing to clean the area after the saw had finished running. Resp’t Br. at 5. Scott Buechel’s reaction to the photograph of the accumulation to the northwest of the saw was that “it is a lime sludge . . . so the guys don’t want to walk there.” Tr. 107. His reaction to the northeast accumulation was that “the only reason somebody’d be back there is to grab the water hose to clean the floor.” Tr. 108; see 111. Petrie testified likewise, explaining that the saw operator would be the only traveler to the water hose, for the sole purpose of cleaning the Wilson bay.

Indeed, the Secretary has presented no evidence as to when the saw was last operated but, by the same token, neither has Buechel. The photographic evidence indicates that there was pedestrian activity in the muddy northwest area around the splitter, as well as the muddy northeast area near the water hose. Ex. P-2. If, however, as Buechel suggests, the saw had been recently run, according to its cleaning policy, Leppanen would have observed the Wilson bay being hosed-down. On the contrary, no evidence of cleaning or preparation for cleaning was taking place. Despite the fact that the Wilson saw is computer programmed prior to operating, it has been established that some foot traffic in the Wilson bay is necessary around the splitters but, since no hosing was occurring, Buechel has provided no explanation for the footprints around the hose. Furthermore, while it is unclear from the record whether the sets of footprints were that of one or multiple individuals, Grossenbach’s and Petrie’s credible testimony establishes that miners had been using the cited areas as a travelway to access the saw shop next door, and the footprints are consistent with a finding that more than occasional travel occurred through the hazardous muck. Because Buechel permitted the muddy, slippery areas around the Wilson saw to be used as a travelway, despite the fact that they may not have been intended as such, it is clear that the company’s cleaning policy was ineffective and subjected miners to slip-and-fall hazards. Therefore, I find that section 56.20003(a) was violated.

2. Significant and Substantial

In *Mathies Coal Company*, the Commission set forth four criteria that the Secretary must establish in order to prove that a violation is S&S under *National Gypsum*, 3 FMSHRC 822 (Apr. 1981): 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. 6 FMSHRC 1, 3-4 (Jan. 1984); see also *Buck Creek Coal, Inc. v. FMSHRC*, 52 F.3d 133, 135 (7th Cir. 1995); *Austin Power, Inc. v. Sec’y of Labor*, 861 F.2d 99, 103-04 (5th Cir. 1988), *aff’g* 9 FMSHRC 2015, 2021 (Dec. 1987) (approving *Mathies* criteria).

⁴ Buechel described a bunker as a 6' by 6' by 8' metal pallet, upon which a slab of stone is placed, that can be picked up by a crane and moved from place to place. Tr. 102.

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

We have explained 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.”

6 FMSHRC at 1834, 1836 (Aug. 1984). We have explained 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 (Aug. 1984); *U. S. Steel Mining Co., Inc.*, 6 FMSHRC 1573, 1574-75 (July 1984).

Evaluation of the third criterion, the reasonable likelihood of injury, should be made in the context of “continued normal mining operations.” *U.S. Steel Mining Co.*, 6 FMSHRC 1573, 1574 (July 1984). Moreover, resolution of whether a violation is S&S must be based “on the particular facts surrounding that violation.” *Texasgulf, Inc.*, 10 FMSHRC 498, 501 (Apr. 1998); *Youghioghney & Ohio Coal Co.*, 9 FMSHRC 2007, 2011-12 (Dec. 1987). More recently, the Commission clarified that the “the Secretary need not prove a reasonable likelihood that the violation itself will cause injury.” *Musser Eng’g, Inc.*, 32 FMSHRC 1257, 1281 (Oct. 2010). The Commission also emphasized the well-established precedent that “the absence of an injury-producing event when a cited practice has occurred does not preclude a determination of S&S.” *Id.* (citing *Elk Run Coal Co.*, 27 FMSHRC 899, 906 (Dec. 2005); and *Blue Bayou Sand & Gravel, Inc.*, 18 FMSHRC 853,857 (June 1996)).

The fact of violation has been established. The second criterion of the *Mathies* test has been met in that miners traveling through the muddy, slippery travelway were subjected to slip-and-fall hazards. The focus of the S&S analysis, then, is the third and fourth *Mathies* criteria, i.e., whether the hazard contributed to was reasonably likely to result in an injury, and whether the injury would be serious. Clearly, slips and falls on a cement surface are reasonably likely to result in musculoskeletal injuries such as strains, sprains and broken bones of a serious nature that are, at least, reasonably likely to result in lost workdays or restricted duty. Therefore, I find that the violation was S&S.

3. Negligence

The record makes clear that Buechel recognized or should have recognized its responsibility to maintain its workplace and passageways free of hazards, as evidenced by its policy that the Wilson bay be cleaned immediately following a production cycle. It is also evident that its policy lacked vigor, since the muddy byproduct of production was allowed to accumulate, and miners were permitted to move about in slippery, hazardous conditions. Furthermore, the maintenance shop foreman’s office provides a clear view of the work floor. Tr. 27. Accordingly, because the Secretary did not establish when the Wilson saw had last operated

and, therefore, how long the condition had existed, I find that Buechel was moderately negligent in violating the standard.

B. Citation No. 6414879

1. Fact of Violation

Inspector Hautamaki issued 104(a) Citation No. 6414879, alleging a violation of section 56.14107(a) that was “unlikely” to cause an injury that could reasonably be expected to be “permanently disabling,” and was caused by Buechel’s “high” negligence.⁵ The “Condition or Practice” is described as follows:

There were no guards provided around the Wilson saw in the CMF building to prevent an employee from contacting the saw when in operation. The 48" saw could cause severe injuries to a person if contacted.

Ex. P-12. The citation was terminated by erecting a post, cable and chain barricade around the Wilson saw. Ex. P-13.

The Secretary argues that Buechel knew that the Wilson saw required guarding, since the operator has five similar saws located in another building at the Chilton Quarry, which are guarded. Sec’y Br. at 17. Moreover, he points out that Buechel stipulated that the Wilson saw’s moving parts can cause severe permanently disabling injuries. Stip. 16.

It is undisputed that the Wilson saw was not running during the inspection, and Hautamaki opined that it had last been run the day before. Tr. 161. Buechel concedes that the Wilson saw was unguarded, but argues that it was not provided with fair notice of what the standard requires because MSHA had never cited it during prior inspections. Resp’t Br. at 6, 8. Furthermore, Buechel contends that the standard is broad and ambiguous, since its language neither specifies the extent of guarding required, nor how the moving parts shall be guarded. Resp’t Br. at 7.

Scott Buechel’s testimony is illuminating in resolving the issues raised by this citation. He stated that MSHA had provided the CMF building with a courtesy safety startup “pre-inspection” when the Wilson saw was installed in the summer of 2006 and that, between 2006 and 2008, the saw had been operating without any guards or barriers except a set of cement blocks that run perpendicular to the east-west movement of the saw. Tr. 293-98, 300-03; Exs. R-3, R-4, R-5, P-13. Buechel testified that, “on this particular saw, because we had inspectors

⁵ 30 C.F.R. § 56.14107(a) requires that “[m]oving machine parts shall be guarded to protect persons from contacting gears, sprockets, chains, drive, head, tail, and take-up pulleys, flywheels, couplings, shafts, fan blades, and similar moving parts that can cause injury.”

coming through and doing inspections on the entire building, on the saws, splitters, everything, because they didn't bring anything up, I thought we were in compliance." Tr. 304; see 305.

The guarding standard at issue may be broad, but it is not ambiguous. Buechel was not new to the limestone cutting business in 2006 when it installed a new Wilson saw. Its fair notice defense is unavailing, especially since, for several years, it had been operating five similar saws outfitted with the same post, cable and chain guarding that it installed around the Wilson saw to abate the hazard. Tr. 305-09. Indeed, Buechel's attempt to transfer responsibility for bypassing the standard's requirements to MSHA inspectors was laced with an admission that "[t]here's probably no good reason that we shouldn't have . . . put the guarding on." Tr. 309; see Tr. 306. In short, the Wilson saw has a blade four feet in diameter, and is capable of seriously maiming or killing a person upon contact. It is painfully obvious that it should have been provided with a barricade to ward off access during operation and, the fact that Buechel had not been cited previously does not absolve the operator of its responsibility to know and adhere to the safety standards designed to ensure a safe work environment for its employees. Therefore, I find that the Secretary has proven that Buechel violated section 56.14107(a).

2. Negligence

Despite the enormous size of the saws at the quarry and the obvious danger of contacting the blades during their operation, the evidence establishes that Buechel was on notice that the Wilson saw required guarding but, for some reason, took the calculated risk of relying upon MSHA's apparent oversight as a justification for its prolonged non-compliance. The low concrete barriers, while presenting some obstacle to direct contact, have been given minimal weight, given Buechel's years of operating five other saws with compliant guarding that dangers-off prohibited areas of contact. Considering the similarity of the saws, Buechel's actions raise a legitimate question as to why guarding was maintained on the other five if the company actually believed that it was an unnecessary component of operating the Wilson saw. Finding no mitigating circumstances that would justify Buechel's inconsistency, and also noting that, during the same inspection, Hautamaki also cited the operator for not having the area guarding in place on the other saws, I find that Buechel was lax in compliance and highly negligent in violating the standard. See Tr. 186-87.

C. Citation No. 6414880

1. Fact of Violation

Inspector Hautamaki issued 104(a) Citation No. 6414880, alleging an S&S violation of section 56.16009 that was "reasonably likely" to cause an injury that could reasonably be expected

to be “permanently disabling,” and was caused by Buechel’s “moderate” negligence.⁶ The “Condition or Practice” is described as follows:

The operator of the Linde fork lift Co. #C12015 had a slab of stone 6' by 8' by 6' that was propped up by the forks that were approximately four feet in the air. The stone was at approximately a 45 degree angle when he got out of the cab to clean the stone of dirt. The operator had to go close to the suspended load to clean it. If the load were to shift or the forks were to drop, the employee would suffer serious injuries.

Ex. P-15. The citation was terminated immediately because the forklift operator, upon sighting the MSHA inspector, lowered the slab from suspension, and management discussed safe work practices with him. Buechel has conceded the violation, but contests the S&S and negligence allegations. Tr. 180.

2. Significant and Substantial

The first two *Mathies* criteria have been met, in that the violation has been established, and it is obvious that standing in close proximity to the suspended limestone slab heightened the danger of the forklift operator sustaining serious injury were an accident to occur. Here, again, the focus shifts to the third and fourth *Mathies* criteria, to determine the reasonable likelihood of the hazard resulting in an injury, and whether the injury would be of a serious nature.

Hautamaki opined that the forklift operator was reasonably likely to be injured were the slab to have slipped and slid out from its propped-up position, or cracked and broken, or were the forks to have failed, or the brakes to have unexpectedly released. Tr. 196-97, 254. While he believed that Buechel had properly trained its employees to perform the work safely, he noted the presence of a supervisor in the area where the violation occurred and, in his opinion, Buechel was not enforcing its training. Tr. 198.

Buechel’s contest of the S&S designation relies heavily upon the fact that Hautamaki observed the forklift operator cleaning the stone from a distance of approximately 50 feet and, therefore, the operator contends that he could not see exactly how close the miner stood to the stone. Moreover, Buechel points out that the inspector was unclear as to whether the miner lowered the stone onto the ground or on top of another stone resting on a pallet. Resp’t Br. at 11; see Tr. 248; Ex. P-16. It follows, according to Buechel, that “since it is unclear whether there was a stone and a pallet under the stone in question at the time that the employee wiped off the dirt from the stone, there is a strong possibility that the employee was never in danger of dropping the stone on his feet.” Resp’t Br. at 12.

⁶ 30 C.F.R. § 56.16009 provides that “[p]ersons shall stay clear of suspended loads.”

Buechel's position lacks merit primarily because it is premised upon the assumption that injury was likely only if the miner's feet were situated under the slab. Indeed, its own witness, Zahringer, observed the forklift operator's conduct and recognized the danger since the "stone could slip off the forks or whatever." Tr. 291. Clearly, the forklift could have moved, if only slightly, the stone could have shifted from its base, or it could have fragmented and fallen. Any unforeseen movement of the equipment, its forks, or the stone was reasonably likely to result in broken bones or crush injuries to the feet, legs, arms or torso, and the injuries were reasonably likely to be permanently disabling. Therefore, I find that the violation was S&S.

3. Negligence

The Secretary contends that, despite adequate training of its employees, enforcement of Buechel's safety policies and procedures lacks vigor. Sec'y Br. at 22. Buechel argues that it should be charged with "low" rather than "moderate" negligence, because the forklift operator was fully aware that his conduct ran afoul of company safety policy, as evidenced by his haste in lowering the stone and returning to his cab upon his awareness of being observed by the inspection team. Resp't Br. at 12. The evidence establishes that Buechel adequately task trained its employees in safe work procedures, and that a supervisor was on-site when the violation occurred. However, because Buechel offered no evidence to rebut the appearance that it was lax in oversight of its safety policies, and because the miner's conduct was very dangerous, I find that the operator was moderately negligent in violating the standard.

D. Citation No. 6414885

1. Fact of Violation

Inspector Hautamaki issued 104(d)(1) Citation No. 6414885, alleging an S&S violation of section 56.15020 that was "reasonably likely" to cause an injury that could reasonably be expected to be "fatal," and was caused by Buechel's "high" negligence and "unwarrantable failure" to comply with the standard.⁷ The "Condition or Practice" is described as follows:

A life jacket or belt was not provided for miners who were required to work at the saw shop water ponds. One miner checked the ponds daily. Other miners changed out pumps and drained and cleaned out the ponds on an as-needed basis. One of the miners could fall into the water and would suffer serious injury. Management engaged in aggravated conduct constituting more than ordinary negligence in that they were aware miners worked at

⁷ 30 C.F.R. § 56.15020 provides that "[l]ife jackets or belts shall be worn where there is danger from falling into water."

the ponds and that they were not provided life jackets. This was an unwarrantable failure to comply with a mandatory standard.

Ex. P-19. The citation was terminated by providing life jackets for use by Buechel's miners, as needed. Tr. 139.

The parties have stipulated that life jackets were not provided to the employees who maintained the water pumps in the lower east pond, and that water in the pond on the day of inspection was approximately four feet deep. Stips. 18, 19.

The Secretary contends that periodic maintenance of the submersible pumps requires that miners access the pond by traveling down a sand and gravel embankment to the work platform, that the slope and platform are often slippery, and that a hose is positioned in the middle of the platform - - conditions that posed tripping hazards that heightened the likelihood of falling into the water and drowning. Sec'y Br. at 9-10; Ex. P-20. Furthermore, the Secretary asserts that changing-out the pumps requires a miner to "lean out over the water," clearly increasing the likelihood of accidental drowning. Sec'y Br. at 9.

Buechel makes several arguments to support its position that the citation should be vacated. It argues that it was not given fair notice of the requirements of the standard, and that its employees were using proper fall protection, but not any floatation device, which is not required by the standard. Resp't Br. at 13, 15. Furthermore, according to the operator, the standard does not specify exclusive use of floatation devices to prevent drowning. Resp't Br. at 16-17. Finally, the operator argues that the water is only six inches deep when maintenance is being performed, and "there is not a concern for an employee falling and drowning in six inches of water. If it is a concern, then even a life jacket cannot prevent an employee from drowning in six inches of water." Resp't Br. at 17.

Hautamaki explained that three settling ponds act as a filtration system for the sedimentary byproduct of operating the large saws, and provide recycled water for cooling and lubricating the saw blades during the stone cutting process. Tr. 128. According to him, he only learned of the ponds, located in a valley, after expressing doubt that the small concrete pond behind the CMF building had the capacity to feed the six saws operating at the quarry. Tr. 128-29, 146. He testified that no one was present at the cited lower east pond, and that Grossenbach explained to him that miners repair the submersible pumps when necessary, remove them in the Fall to keep them from freezing in place, then return them to service in the Spring, Upper Peninsula weather permitting. Tr. 130-31. Grossenbach did not mention the use of fall protection in his discussion with Hautamaki. Tr. 144, 152. Removing a pump entails working from a narrow platform, accessing a hatch, and attaching a chain hoist to the pump to lift it out of the water. Tr. 131; see Ex. P-20. Hautamaki expressed concern that seasonal weather conditions can make the slope going down to the pond, as well as the work platform, slippery. Tr. 132-33. He estimated that work is performed one foot above and within inches of the water, and opined that "[a]nybody working that close to the edge, you're concentrating on lifting the pumps out,

you could fall in, especially if it was icy or frost or dew or anything.” Tr. 133-34. Hautamaki was also told by Grossenbach that three maintenance workers, including himself, performed the work. Tr. 133. He also stated that, as a general rule of thumb, working within six feet of water’s edge requires a life jacket. Tr. 133.

David Petrie testified that he changes-out the submersible pumps up to three times a year with the assistance of a partner, either Grossenbach or Ryan Blindauer. Tr. 154-55, 157, 164. He explained that the pumps are sunk in a cement pit, 5 feet deep by 15 feet wide, located at the edge of the work platform. Tr. 156, 158. During maintenance, water is pumped from the pit back into the pond so as to keep the pit water level at six inches and, according to him, work is performed three feet away from the surrounding pond. Tr. 156-57. When asked whether he used fall protection, he responded that he wore a harness with a lanyard attached to the steel A-frame stationed on the work platform directly above the pit, used to support the weight of the pumps hoisted out of the pit with a hand winch. Tr. 155-56, 163-65. He testified that the harnesses are stored in the CMF building, that Grossenbach had also worn a harness when they had worked together, and that he, Petrie, had not been trained in using the harness. Tr. 159-61. Petrie estimated the A-frame to be six to seven feet tall, and the submersible pumps to weigh 100 pounds, but he was unable to estimate the A-frame’s weight capacity. Tr. 159. While he denied having fallen into the water, Petrie stated that the pumps are changed “year round, and I think once you pull the pump up, it gets icy, and it’s slippery. I never fell, but it’s slippery.” Tr. 160-61, 167. He testified that, as a result of the operator being cited, he has been using both harness and life jacket when performing his duties at the ponds. Tr. 161-62.

Grossenbach testified that he and Petrie had worked together to change-out the pumps, and that they, as well as Blindauer, had used a harness clipped onto the A-frame as fall protection, although he was not certain that fall protection was always used. Tr. 168-70. On cross-examination, Grossenbach acknowledged that he had written to the MSHA North Central District Office seeking review of the citation, and did not mention use of fall protection among the mitigation factors set forth to challenge the gravity of the violation. Tr. 172, 175; Sec’y Br., Ex. A. Moreover, he admitted to being unprotected on the work platform prior to tying onto the A-frame. Tr. 176-79.

Section 56.15020, a provision under the Personal Protection Subpart, specifically addresses the danger of falling into water, and is intended to prevent drowning. The plain meaning of “life jacket” is not in dispute. Contrary to Respondent’s contention that the standard does not provide fair notice of its requirements, comprehension of its terms only requires application of ordinary syntactical rules, and the term “life jacket” provides the modifier for the *alternative* floatation device, read as “life belt;” therefore, the standard is clearly intended to require use of one floatation device or the other.”⁸ This standard is distinguishable from the

⁸ A “life jacket” is defined as “a life preserver in the form of a sleeveless jacket or vest.” The American Heritage Dictionary of the English Language 1011 (4th ed. 2009). A “life
(continued...)

more general companion standard under the same Subpart, section 56.15005, which requires use of “safety belts” or “lines” to prevent injury from falling, without regard to any specific scenario. Because neither life jackets nor life belts were provided by Buechel for use by the maintenance crew servicing the settling ponds, I find that the standard was violated.

2. Significant and Substantial

The fact of violation has been established. The second criterion of the *Mathies* test has been satisfied, i.e., the lack of protection for maintenance workers, unequipped with personal floatation devices and exposed to working in slippery, wet conditions in close proximity to water, contributed to the hazard of drowning. The third and fourth *Mathies* criteria, the reasonable likelihood of injury and the seriousness of the injury, have also been met. The record belies Buechel’s contention that its maintenance crew used harnesses and lanyards. Grossenbach made no mention of fall protection when describing to Hautamaki how the ponds were maintained, nor did he mention it to MSHA as a mitigating factor in his written request for review of the citation. Petrie’s testimony that fall protection was used does little, if anything, to substantiate Buechel’s claim, especially given that this defense was not raised earlier and, according to Petrie, no training whatsoever was provided for use of fall protection equipment. Furthermore, even if fall protection had been used, the operator has not established that tethering to the A-frame prevented slips and falls into the water and, more importantly, drowning. Petrie testified that his estimated seven foot lanyard allowed him to stretch out at the edge of the platform to work. The actual length of the alleged lanyard was never established, nor the capacity of the A-frame to support the weight of the pump and hoisting gear, along with the added weight of two workers. As Hautamaki pointed out, seasonal weather conditions make the work treacherous at water’s edge and, a slip-and-fall on a concrete platform into the water is reasonably likely to involve a head or musculoskeletal injury, the water temperature may cause hypothermia, and any attempt at rescue by a workmate, also unprotected, subjects the rescuer to drowning as well. This is true whether miners were exposed to six inches of water in the pit or four feet of water in the pond. See Exs. P-22, P-23. Consequently, with or without fall protection, I find that the violation was S&S.

3. Negligence and Unwarrantable Failure

Unwarrantable failure is aggravated conduct constituting more than ordinary negligence. *Emery Mining Corp.*, 9 FMSHRC 1997, 2001 (Dec. 1987). Unwarrantable failure is characterized by such conduct as “reckless disregard,” “intentional misconduct,” indifference,” or a “serious lack of reasonable care.” *Id.* at 2001-04; *Rochester & Pittsburgh Coal Co.*, 13 FMSHRC 189, 194 (Feb. 1991); *see also Buck Creek Coal*, 52 F.3d at 136. The Commission has

⁸(...continued)
preserver” is defined as “a buoyant device, usually in the shape of a ring, belt or jacket, designed to keep a person afloat in the water.” *Id.* A “life belt” is defined as “a life preserver worn like a belt.” *Id.*

recognized the relevance of several factors in determining whether conduct is “aggravated” in the context of unwarrantable failure, such as the extensiveness of the violation, the length of time that the violation has existed, the operator's efforts in eliminating the violative condition, and whether the operator has been put on notice that greater efforts are necessary for compliance. *See Consolidation Coal Co.*, 22 FMSHRC 328, 331 (Mar. 2000); *Mullins & Sons Coal Co.*, 16 FMSHRC 192, 195 (Feb. 1994). The Commission has also considered whether the violative condition is obvious or poses a high degree of danger. *Windsor Coal Co.*, 21 FMSHRC 997, 1000 (Sept. 1999) (citing *BethEnergy Mines, Inc.*, 14 FMSHRC 1232, 1243-44 (Aug. 1992); *Warren Steen Construction, Inc.*, 14 FMSHRC 1125, 1129 (July 1992); *Quinland Coals, Inc.*, 10 FMSHRC 705, 709 (June 1988); *Kitt Energy Corp.*, 6 FMSHRC 1596, 1603 (July 1984)). Each case must be examined on its own facts to determine whether an actor's conduct is aggravated, or whether mitigating circumstances exist. *Eagle Energy, Inc.*, 23 FMSHRC 829, 834 (Aug. 2001) (citing *Consolidation Coal*, 22 FMSHRC at 353).

The record establishes that the large saws had been operating at the Chilton Quarry for several years and, therefore, the three settling ponds would have also been providing filtration to the saws during that time span. Buechel operated and maintained the ponds without MSHA’s knowledge and oversight until Hautamaki stumbled upon them, and provided no explanation as to why MSHA was not advised of their existence during prior inspections. Consistent with its conduct in failing to guard the Wilson saw, Buechel knowingly operated in a non-compliant manner so long as its behavior evaded detection on MSHA’s radar screen. Consequently, I do not find the operator’s lack of disclosure inadvertent, but rather a deliberate attempt to escape governmental scrutiny and regulation until it got caught. Other than the dubious testimony that fall protection was used by the maintenance crew, albeit without any training, the record is bereft of any indication that Buechel had a water safety policy or took water safety seriously, that it task trained its workers on servicing the pumps, or that it kept abreast of safe work practices and the requirements of the regulation. Moreover, Buechel’s conduct was highly negligent given that Grossenbach often performed the work with Petrie and, as the supervisor, should have appreciated the danger posed by the work environment, and assured that personal floatation devices were made available and used to perform the tasks safely. Therefore, I impute Grossenbach’s high negligence to the operator, and find that the Secretary has met his burden of establishing a serious lack of reasonable care by Buechel that constituted an unwarrantable failure to comply with the standard.

E. Citation No. 6414886

1. Fact of Violation

Inspector Hautamaki issued 104(a) Citation No. 6414886, alleging a violation of section 46.9(a) that was “non-significant and substantial,” with “no likelihood” of causing injury or illness,

reasonably expected to result in “no lost workdays,” and was caused by Buechel’s high negligence.⁹ The “Condition or Practice” is described as follows:

The Part 46 training record form used by the operator did not include the mine name, MSHA ID number, or location of the training. Several records had not been signed by the person responsible for training.

Ex. P-23. The citation was terminated after the annual refresher training records were completed and signed. Buechel has conceded the violation, but contests the negligence allegation.

Hautamaki testified that during an inspection four months earlier in May 2009, as a result of finding new miner and annual refresher training records incomplete, he spent an hour instructing Jason Zahringer as to the information required on the training forms and, therefore, how to comply with Part 46 training regulations. Tr. 198-200. According to the inspector, he found the records in the same shape when he returned in August, despite his warning to Zahringer that “you’ve got to get these records up to date because if you don’t, the next inspector is going to give you a citation for it.” Tr. 200. Hautamaki also pointed to several resources available to mine operators to assist in compliance with training standards, including MSHA’s website and Program Policy Manual. Tr. 200-01; see Ex. P-24.

Buechel contends that there were “minor problems” with its training forms, that Zahringer had been using forms completed by the former safety director as his guide, and that Hautamaki only instructed him to sign the forms during the earlier inspection. Resp’t Br. at 17-18.

According to Zahringer, he used old training forms as his model and, based on Hautamaki’s instruction during the May inspection, he signed them, although he was uncertain whether he had signed them all. Tr. 265, 280. Zahringer maintains that Hautamaki never pointed out any deficiencies other than lack of signatures, and that the deficiencies noted in August, such as lack of the mine ID number and location of the training, were never mentioned in May. Tr. 266-68, 279. Zahringer admitted unfamiliarity with MSHA’s website, characterizing it as “so hard to find what you want,” as well as MSHA’s Program Policy Manual. Tr. 266, 271, 278. In response to questions about the reasonableness of familiarizing himself with the standard pertaining to training records, Zahringer generally described Volume 30 of the Code of Federal Regulations as “very vague,” and testified that he did not recall seeing the regulation. Tr. 280-282.

⁹ 30 C.F.R § 46.9(a) requires that mine operators “record and certify on MSHA form 5000-23, or on a form that contains the information listed in paragraph (b) of this subsection, that each miner has received training under this part.” 30 C.F.R § 46.9(b) requires the form to include the following: (1) the name of the trainee; (2) the type of training; (3) the duration, date and name of competent trainer; (4) the mine name, ID, and training location; and (5) signed certification that training has been completed.

The training records reviewed by Hautamaki in May were the same that he reviewed in August. Tr. 269. Jason Zahringer had been the site manager responsible for maintaining the mine's training records since January 2008, more than a year before the earlier inspection. Tr. 265. The record is clear that in May, Hautamaki accepted the same excuse advanced in August, but elected to give Buechel an opportunity to cure the deficiencies in its record-keeping. By failing to avail itself of any readily available resource other than the existing, deficient records, Buechel continued to disregard its responsibility to familiarize itself with the standard. The duty falls on the operator to know and implement the regulations that govern its safe operation, not MSHA, and, consequently, MSHA is not required, metaphorically, to hold its hand. I find none of the excuses advanced by Buechel to constitute mitigating factors that would warrant lower negligence, especially because it failed to heed MSHA's warning that, with minimal effort, should have resulted in full compliance. Therefore, I find that Buechel was highly negligent in violating the standard.

IV. Penalties

While the Secretary has proposed a total civil penalty of \$29,482.00, the Judge must independently determine the appropriate assessment by proper consideration of the six penalty criteria set forth in section 110(i) of the Act, 30 U.S.C. § 820(i). *See Sellersburg Co.*, 5 FMSHRC 287, 291-92 (Mar. 1983), *aff'd* 736 F.2d 1147 (7th Cir. 1984). The penalty criteria are: the operator's history of previous violations; the appropriateness of the penalty to the size of the operator's business; whether the operator was negligent; the effect of the penalty on the operator's ability to continue in business; the gravity of the violation; and the demonstrated good faith efforts in achieving rapid compliance after notification of the violation. 30 U.S.C. § 820(i).

The parties stipulated that Buechel demonstrated good faith in abating the violations. Stip. 7. Buechel is a medium-sized operator and, in the absence of any contention by the operator of an inability to pay, I find that the penalty will not affect the operator's ability to continue in business. *See* Sec'y Pen. Pet., Ex. A. Buechel's relevant history of similar violations includes one prior housekeeping violation and one guarding violation, which I find does not constitute an aggravating factor in assessing appropriate penalties. Ex. P-28.

The remaining criteria involve consideration of the gravity of the violations and Buechel's negligence in committing them. These factors have been discussed fully, respecting each violation. Therefore, considering my findings as to the six penalty criteria, the penalties are set forth below.

A. Citation No. 6199159

It has been established that this S&S violation was reasonably likely to cause an injury that could reasonably be expected to result in lost workdays or restricted duty, and that it was timely abated. While I find that the violation was serious, without evidence establishing

when the Wilson saw had last operated and, therefore, how long the violation had existed, I find that Buechel was moderately negligent. Applying the civil penalty criteria, I find that a penalty of \$745.00, as proposed by the Secretary, is appropriate.

B. Citation No. 6414879

It has been established that this S&S violation was unlikely to cause an injury that could reasonably be expected to be permanently disabling, and that it was timely abated. Buechel's awareness of the requirements of the standard was demonstrated by its guarding of five similar saws. Because the operator knowingly failed to guard the Wilson saw, I find that it was highly negligent. Applying the civil penalty criteria, I find that a penalty of \$745.00 is appropriate.

C. Citation No. 6414880

It has been established that this S&S violation was reasonably likely to cause an injury that could reasonably be expected to be permanently disabling, and that it was timely abated. I find that the violation was very serious and, given that a supervisor was on-site, Buechel's safety policy lacked vigor. Because of evidence that the operator adequately trained its workers, I find that it was moderately negligent. The Secretary seeks a penalty substantially elevated from his originally proposed penalty of \$1,111.00 based on the fact that the violation occurred in an area where supervisors are frequently present. Sec'y Br. at 22. Applying the civil penalty criteria, because of the demonstrated ineffectiveness of its supervisory oversight, I find that a penalty of \$1,800.00 is appropriate.

D. Citation No. 6414885

It has been established that this S&S violation was reasonably likely to cause an injury that could reasonably be expected to be fatal, and that it was timely abated. I find that Buechel's failure to provide personal floatation devices for workers exposed to slips-and-falls into water, was due to high negligence and a serious lack of reasonable care that constituted an unwarrantable failure to comply with the standard. Applying the civil penalty criteria, I find that a civil penalty of \$8,209.00, as proposed by the Secretary, is appropriate.

E. Citation No. 6414886

It has been established that this record-keeping violation had no likelihood of causing an injury, and that it was timely abated. Buechel had been placed on notice during a previous inspection of the standard's requirements, and that its training records were incomplete. Because no significant effort to perfect the training records was made, I find that the operator was highly negligent. While the Secretary has proposed a penalty of \$108.00, applying the civil penalty criteria, I find that a penalty of \$200.00 is appropriate.

V. Approval of Settlement

The Secretary has filed a Motion to Approve Partial Settlement and Order Payment respecting thirteen of the seventeen citations involved in docket Nos. LAKE 2008-406-M and LAKE 2010-154-M. A reduction in penalty from \$18,564.00 to \$8,296.00 is proposed. The citations, initial assessments, and the proposed settlement amounts are as follows:

	<u>Citation No.</u>	<u>Initial Assessment</u>	<u>Proposed Settlement</u>
LAKE 2008-406-M	6199164	\$ 1,111.00	\$ 950.00
	6199172	\$ 1,944.00	\$ 1,499.00
	6199173	\$ 1,944.00	\$ 1,400.00
LAKE 2010-154-M	6414874	\$ 499.00	\$ 499.00
	6414875	\$ 224.00	\$ 224.00
	6414876	\$ 499.00	\$ 499.00
	6414877	\$ 150.00	\$ 150.00
	6414878	\$ 745.00	\$ 500.00
	6414881	\$ 224.00	\$ 224.00
	6414882	\$ 150.00	\$ 150.00
	6414883	\$ 8,209.00	\$ 0.00
	6414884	\$ 2,473.00	\$ 2,000.00
	6414887	\$ 392.00	\$ 300.00
TOTAL:		\$18,564.00	\$ 8,296.00

I have considered the representations and documentation submitted in these cases, and I conclude that the proffered settlement is appropriate under the criteria set forth in section 110(i) of the Act.

ORDER

WHEREFORE, it is **ORDERED** that Citation Nos. 6199159, 6414879, 6414880, 6414885 and 6414886 are **AFFIRMED**, as issued; that Citation No. 6414883 is **VACATED**; that Citation Nos. 6199164, 6199172, 6199173, 6414874, 6414875, 6414876, 6414877, 6414881, 6414882 and 6414884 are **AFFIRMED**, as issued; that the Secretary **MODIFY** Citation No. 6414878 to reduce the level of gravity to “unlikely” and “non-significant and substantial,” and Citation No. 6414887 to reduce the degree of negligence to “moderate;” and that Buechel **PAY** a civil penalty of \$19,995.00 within 40 days of the date of this Decision.

/s/ Jacqueline R. Bulluck

Jacqueline R. Bulluck

Administrative Law Judge

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FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

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February 28, 2014

SECRETARY OF LABOR,	:	CIVIL PENALTY PROCEEDING
MINE SAFETY AND HEALTH	:	
ADMINISTRATION (MSHA),	:	Docket No. WEVA 2011-940
Petitioner,	:	A.C. No. 46-01968-000243606
	:	
v.	:	Mine: Blacksville No. 2
	:	
CONSOLIDATION COAL, CO.	:	
Respondent.	:	

DECISION

Appearances: Bryan C. Shieh, Esq.; James, McClammer, Esq., Department of Labor, Philadelphia, PA for Petitioner;
R. Henry Moore, Esq.; Patrick W. Dennison, Esq., Jackson Kelly, PLLC for Respondent

Before: Judge Barbour

This civil penalty proceeding comes before the Court pursuant to sections 105 and 110 of the Federal Mine Safety and Health Act of 1977, as amended (“Mine Act” or “Act”). 30 U.S.C. §§ 815, 820. The Secretary of Labor (“Secretary”) on behalf of his Mine Safety and Health Administration (“MSHA”) petitions for the assessment of \$54,500 in civil penalties for one alleged violation of mandatory safety standard 30 C.F.R. §75.202(a) and two alleged violations of mandatory safety standard 30 C.F.R. § 75.220(a)(1). Section 75.202(a) requires in pertinent part that the roof and ribs of areas where persons work or travel be supported to protect miners from roof and rib falls.¹ Section 75.220(a)(1) requires mine operators to develop and follow a

¹ Section 75.202(a) states:

The roof, face and ribs of areas where persons work or travel shall be supported or otherwise controlled to protect persons from hazards related to falls of the roof, face or ribs and coal or rock bursts.

suitable roof and rib control plan approved by the MSHA District Manager.² The Secretary charges that the alleged violations occurred at the Blacksville No. 2 Mine, an underground bituminous coal mine owned and operated by Consolidation Coal Company (“Consol” or “the company”). The alleged violation of section 75.202(a) is cited in an order issued pursuant to section 104(d)(2) of the Act.³ The Secretary proposes a civil penalty of \$50,700 for the alleged violation. The two alleged violations of section 75.220(a)(1) are charged in citations issued pursuant to section 104(a) of the Act.⁴ The Secretary proposes a civil penalty of \$1,900 for each alleged violation. The Secretary further asserts that the alleged violation of section 75.202(a) was a significant and substantial contribution to a mine safety hazard (an “S&S” violation) and that it was caused by the company’s unwarrantable failure to comply with the standard and by the company’s high negligence. As for the two alleged violations of section 75.220(a)(1), the Secretary asserts that although they were unlikely to result in lost work days or restrictive injuries, they were the result of the company’s “high” negligence.

² Section 75.220(a)(1) states in pertinent part:

Each mine operator shall develop and follow a roof control plan, approved by the District Manager, that is suitable to the prevailing geological conditions and the mining system to be used at the mine.

It has long been recognized that violations of an approved plan are equivalent to violations of section 75.220(a).

³ Section 104(d)(2) states in part:

If a withdrawal order with respect to any area in a . . . mine has been issued pursuant to . . . [section 104(d)(1) of the Act] a withdrawal order shall promptly be issued by an . . . [inspector] who finds upon any subsequent inspection the existence in such mine of violations similar to those that resulted in the issuance of the withdrawal order under paragraph (1) until such time as an inspection of such mine discloses no similar violations.

30 U.S.C. §814(d)(2).

⁴ Section 104(a) states in part:

If, upon inspection . . . [an inspector] believes that an operator of a coal . . . mine . . . has violated . . . any mandatory . . . safety standard[,], . . . he shall, with reasonable promptness, issue a citation to the operator.

30 U.S.C. §814(a).

In answering the Secretary's petition, Consol denied that it violated the standards and challenged the inspector's S&S, unwarrantable and negligence findings. After the answer was received, the case was assigned to the Court, which ordered the parties to consult to determine if they could resolve their differences. When it became clear that they could not, a trial on the merits was scheduled.

At the hearing numerous stipulations were read into the record by the Secretary's counsel. Tr. 14-17. A written copy of the stipulations was also entered into evidence as a joint exhibit. Tr. 14-17; Jnt. Exh. 1.

STIPULATIONS

1. At all relevant times . . . ("Consol") was the "operator" of the . . . Blacksville No. 2 Mine[,] . . . within the meaning of the . . . [Mine Act,] specifically Section 3(d), 30 U.S.C. Section 802(d).
2. At all relevant times, [the mine] was a "coal or other mine" within the meaning of the Mine Act, specifically Section 3(h)), 30 U.S.C. Section 802(h).
3. At all relevant times, the products of . . . [the mine] entered commerce, or the operations or products of [the mine] affected commerce within the meaning of the Mine Act, specifically Sections 3(b) and 4 of the Mine Act. 30 U.S.C. Sections 802(b) and 803.
4. Consol is subject to the jurisdiction of the Mine Act.
5. This proceeding is subject to the jurisdiction of the Federal Mine Safety and Health Review Commission [(the "Commission")] and its designated Administrative Law Judge pursuant to Sections 104, 105, 110 and 113 of the Mine Act.
6. The citations and order contained in Exhibit "A" attached to the Secretary's Petition are authentic copies of the citations and order at issue in this proceeding.
7. The citations and order at issue, as well as any modifications thereto, were properly served by a duly authorized representative of the Secretary of Labor . . . upon an agent [of Consol] at the [mine] on the dates and [at the places] stated therein.
8. Consol demonstrated good faith in abatement of the alleged violations.

9. The Assessed Violation History Reports are authentic, and accurately reflect the history of violations at [the mine] during the time period that Consol operated . . . [the mine.]
10. Payment of the total proposed civil penalty in this matter will not affect Consol's ability to remain in business.
11. The parties stipulate to the authenticity of the exhibits referenced in the parties['] Prehearing Statements (with all amendments thereto) but not to the relevancy or the truth of the matters asserted therein. The following [proposed] exhibits are exempted from this stipulation:
- a. Exhibits 29, 31, 41, 42, 70 and 73 of [the Secretary's] Prehearing Statement, and Second Amended Prehearing Statement; and
 - b. Exhibit 1 of Respondent's First Amended Prehearing Statement.
12. Any formal . . . [MSHA] computer printout from MSHA's Mine Data Retrieval System is an authentic copy and may be admitted as a business record of . . . [MSHA.]
13. With respect to Citation No. 8025562, a solid side rib of 45 block, #3 entry of the 17 W section, MMU 068-0, was not rib bolted or flagged for a measured distance of 19 feet.
14. With respect to Citation No. 8025562, a violation of section 75.220(a)(1) occurred.
15. With respect to Citation No. 8025562, the citation was properly designated as "Unlikely."
16. With respect to Citation No. 8025562, the citation was properly designated as "Lost Workdays or Restricted Duty."
17. With respect to Citation No. 8025562, the citation was properly designated as "1 Person Affected."
18. The cited area referenced in Citation No. 8025562 was mined on July 16, 2010.
19. With respect to Citation No. 8025516, two sections of rib approximately 17 feet long and 15 feet long were not bolted nor

flagged on the left inby and outby corners of the #2 entry, 8 block intersection on the 14 W, MMU 064-0.
20.

If Respondent violated 30 C.F.R. Section 75.220(a)(1), then . . . Citation [No. 8025516] was properly designated as “Unlikely,” “Lost Workdays or Restricted Duty and “1 Person Affected.”

Jnt. Exh. 1; *see* Tr. 14-17.

As explained by the Secretary’s counsel, it is the Secretary’s belief that all three of the alleged violations resulted from Consol’s “continued failure to take the basic steps necessary to protect . . . [miners] from the hazards of ribs.” Tr. 19. Coal extracted at the mine is from the Pittsburgh Coal Seam, and the company knew that the coal was soft and prone to slough.⁵ In addition, two miners had been injured by rib falls, one miner in February 2010 and another in May 2010. Further, before he found the conditions that led him to issue the order in question, MSHA Inspector John Grimm lectured at the mine pursuant to MSHA’s Prevention of Roof and Ribs Outreach Program (the “PROP Initiative”).⁶

⁵ The word “slough” is used as a verb and as a noun. When used as a verb the word means the process of rib rock flaking, crumbling and falling away from a rib. When used as a noun the word and its synonym “sloughage” describe, “Fragmentary rock material that has crumbled and fallen away from the side of a . . . mine working.” American Geological Institute, *Dictionary of Mining, Mineral, and Related Terms, second edition* (1977) at 515 (“DMMRT”).

⁶ Inspector Grimm testified that the PROP Initiative was started in 1999 or 2000 and that its purpose was to get the industry to “pay particular attention to the roof and ribs to reduce the [accident] and fatality rate.” Tr. 126. According to Grimm, lectures given pursuant to the Initiative are yearly events which usually take place during the early summer because that is “when most of the roof and rib falls happen . . . due to humid weather.” *Id.* The Secretary introduced a document announcing implementation of the PROP Initiative for the summer of 2010. Gov. Exh. 63. The document is dated June 2, 2010. It was made available to mine operators and to the public on the Department of Labor’s website. Tr. 127. The document states in part:

Statistics show that more accidents and injuries occur during the summer months than at any other time of the year. As temperatures rise, humidity and moisture increase underground making it easier for a mine roof or rib to . . . fall.

Gov’t Exh. G-63; Tr. 128.

Implementation of the 2010 initiative involved a series of summer safety talks to heighten the awareness of management and of rank and file miners of the need to scale and adequately support the ribs. Management and miners were reminded to stay clear of the ribs as the miners worked and traveled in the mine. They were also instructed how to safely bring down loose and unstable ribs. Tr. 128-129. Grimm testified that he gave talks covering these subjects
(continued...)

MSHA also alerted Consol and all of its miners to the hazards of rib falls through MSHA's Rules to Live By Program.⁷ A primary goal of the Rules to Live By Program is to make miners and operators aware of the importance of compliance with section 75.202(a) and section 75.220(a). Tr. 20-22, 24.

Counsel for the Secretary acknowledged that Consol made some efforts toward heightened compliance with the standards. For example, after the May 2010 rib fall accident the mine's roof and rib control plan was amended to require additional rib bolting. However, according to counsel, the company exhibited a failure to follow the rib bolting part of its approved roof control plan. Tr. 20. In the Secretary's view, the PROP Initiative and the Rules to Live By Program should have caused Consol to be more diligent in preventing or correcting the type of conditions that led to the alleged violations. Tr. 21-22, 25-26, 28. The Secretary's counsel stated that MSHA therefore believed it was important to assess enhanced penalties to spur compliance with sections 75.202(a) and 75.220 (a)(1), which are among the "top five" most cited safety standards in the nation's underground coal mines. Tr. 30.

⁶(...continued)

at the mine. Tr. 130. He specifically recalled giving such a talk to approximately 305 miners on June 2, 2010. Mine management officials were present. Tr. 137-139 141-142; *See* Tr. 445. Three days later he gave the same talk to approximately 80 miners Tr. 139-140. He gave additional talks on June 7, June 8, June 9, June 14, June 15 and June 21. Tr. 141; Gov't Exh. 54. Between June 2, 2010, and July 2, 2010, Grimm estimated that out of a total of 27 PROP Initiative talks given at the mine, he delivered approximately 15. Tr. 242.

When William Devault, a counsel safety supervisor, was asked about the company's response to the PROP Initiative talks, DeVault responded that during daily meetings with employees on the working sections, company managers talked about roof and rib control "as part of the law." Tr. 446. He also stated that the company had and continues to have, a program of instruction, the Safe Work Instruction ("SWI") program, covering the roof and rib control. DeVault did not provide details of the program. Tr. 447-448.

⁷ Inspector Grimm testified that in late 2009 or early 2010, MSHA's Administrator identified standards whose disregard was most likely to contribute to a fatal accident. Tr. 122. Because roof and rib falls are a leading cause of injury and death in the nation's mines, the Administrator believed that all in the industry should be alert to the need to comply with the Secretary's mandatory roof and rib control standards. *Id.* The Administrator's Rules To Live By Program highlighting the need for roof and rib control was launched in February 2010. The first phase of the program emphasized education and outreach. After about a month of the first phase, MSHA launched the second phase, which included enhanced enforcement of the roof and rib control standards. According to Grimm, among other things, enhanced enforcement meant that when a violation of a Rules To Live By standard was found, the agency looked more closely at the operator's negligence. Tr. 124.

INSPECTOR GRIMM AND THE BLACKSVILLE NO. 2 MINE

Inspector Grimm began working in underground coal mining in 1976. He became a shift foreman in 1992. Grimm retired from mining in 2002, but in 2005 he was rehired and spent approximately 13 months as a section foreman at Consol's No. 84 Mine. Like the Blacksville No. 2 Mine, the No. 84 Mine extracts coal from the Pittsburgh Seam. Tr. 37. In fact, Grimm testified that all of his private underground mining experience took place in Pittsburgh Seam mines. Tr. 39.

Grimm joined MSHA in October 2006. He became an authorized mine inspector in July or August 2007. Tr. 39. In May 2011 he was promoted to an MSHA supervisory position. Tr. 41. At times, Grimm supervised up to 9 inspectors. *Id.* In addition to assuming supervisory duties, Grimm continued to inspect mines. Grimm estimated that approximately 90% of his inspections were in Pittsburgh Seam mines. Tr. 41. Grimm testified that he has been to the Blacksville No. 2 Mine a "[c]ouple hundred" times and that he is very "familiar with the rib and the roof" at the mine. Tr. 42.

Grimm explained that at the Blacksville No. 2 Mine coal is extracted on both longwall and conventional mining sections. Tr. 43. The average height of the mine's entries is seven to eight feet. *Id.* Grimm stated that the depth of the mine's overburden is significant in that the overburden impacts the size of the pillars that left are after the entries are driven. The overburden helps to dictate the type of roof support used at the mine. *Id.* In addition, according to Grimm, pressure from the overburden can cause the mine's ribs to deteriorate and slough. Grimm explained that "the more overburden, the more pressure on the coal seams" which in turn causes the ribs to "eat out [and] deteriorate."⁸ Tr. 44.

Grimm identified an agency Program Information Bulletin ("PIB") entitled "Protecting Miners from Hazards Related to Roof Falls." Govt. Exh. 62; Tr. 48. The PIB, which was issued after the order and citations in question, contains information about rib fall hazards including the agency's determination that 96 percent of rib fall fatalities occur where the floor to ceiling height is at least seven feet. Tr. 48; Gov't Exh. 62-at 1-2. The PIB further states that at least 78 percent of rib fall fatalities occur where the overburden is at least 700 feet. *Id.* Grimm noted that at the Blacksville No. 2 Mine, the seam height averages between 7 feet and 8 feet, and the overburden varies from 800 feet to 1,400 feet.⁹ Tr. 40

⁸ Counsel Foreman Kenneth Weiss essentially agreed with Grimm. Weiss explained that after the coal is removed at the mine, it is not long before the ribs start to slough. In Weiss's opinion, the cause of the sloughage is pressure from "the weight [that] is slowly coming down . . . onto the rib[s]." Tr. 553. In Weiss's view, the ribs need to be supported because they "can't take that kind of pressure." *Id.*

⁹ Grimm maintained that in the area where the subject order was issued the overburden was "close to 1,300 feet" (Tr. 50) and the entry height (also referred to as the seam height) averaged from 6 feet 8 inches to 7 feet. Tr. 49, *see also* Tr. 679. Consol did not dispute (continued...)

Grimm believed, and Consol did not dispute, that because the coal in the Pittsburgh Seam is soft, ribs in the mine are prone to sloughing. Tr. 53; *see also* Tr. 680. Grimm testified that the rate at which the ribs deteriorate is unpredictable. They can deteriorate “right away,” or they can stand for some time before they begin to slough. Tr. 54. Grimm stated, “[Y]ou [can’t] really predict when [a rib will] fall.” *Id.* Grimm noted that to protect miners assigned to bolt the ribs (the “rib bolters”), Consol installed “rib protectors” on its continuous mining machines (“continuous miners”). Tr. 55. The protectors are three fourths of an inch thick pieces of metal that are attached to hydraulic jacks. The metal plates are positioned against the ribs to shield the rib bolters from rib falls. Tr. 55-56.

THE JUNE 22, 2010, INSPECTION

On June 22, 2010, Grimm went to the mine. He arrived around 7:15 a.m.. Before proceeding underground he reviewed the pre-shift/on-shift examination book for the area he was going to inspect. Tr. 58, 169. He then went underground accompanied by the miners’ representative, Keith Craig¹⁰, and the company’s representative, James Wolfe.¹¹ Tr. 59. Later in the inspection Weiss, the shift foreman, also joined the inspection. Tr. 355-356.

Grimm, Craig and Wolfe headed for the Six North Parallel construction area of the mine. Tr. 169. Weiss explained that in this part of the mine, the company was sealing off certain previously mined areas. Tr. 535. The project started in March 2010. *Id.* As Weiss recalled, two to five miners a shift worked on the project. *Id.*

Upon entering the construction area, Grimm observed what he described as a “convergence problem.” Geologic pressures were forcing the mine roof down and the mine floor up. As a result, there was a “deterioration of the top and the ribs.” Tr. 215. Grimm believed that “the entire area . . . was becoming unsafe to travel.” *Id.*; Tr. 215. Grimm

⁹(...continued)
the accuracy of Grimm’s testimony regarding the entry height, but De Vault testified that the overburden in the cited area was 870 feet, not 1,300 feet. Tr. 487. The Court observes that under either scenario the overburden was above 700 feet.

¹⁰ Keith Craig, a general inside laborer, has worked at the mine since February 2006. Tr. 350, 352. Craig estimated the June 22 inspection was the second or third inspection in which he acted as the union’s “walkaround” and the first or second time he accompanied Grimm. Tr. 353-354.

¹¹ James Wolfe has worked for Consol for 12 years, always at the Blacksville No. 2 Mine. Prior to working for Consol, Wolfe had 26 years of experience working for other coal mining companies. Tr. 595-596. He holds mine foreman papers from Maryland and West Virginia. Tr. 596. At the time he testified, Wolfe worked as the mine’s safety mentor, a job that requires him to “go around and watch the men work [and] correct them for anything that they may be doing wrong or that possibility of them getting hurt[.]” Tr. 597. However, on June 22, 2010, his job was that of safety escort, which meant that he accompanied MSHA’s inspectors on a daily basis and represented the company to the inspectors. Tr. 597.

understood that sealing off some of the area would alleviate the problem because miners no longer would need to travel through the area. Tr. 215. While sealing some of the area was good mining practice, Weiss testified that because the project was complex, “a lot of people were a little bit queasy about [it].” Tr. 558.

Prior to reaching the area where the sealing was taking place, the inspection party traveled to the area’s dinner hole. The hole served as an entrance to the construction area.¹² Tr. 169. The dinner hole had been mined several years before the inspection (Tr. 215), and Weiss explained that when the company decided to seal the previously mined areas, the dinner hole and parts of the construction area were rehabilitated so they could be used during the project. Rehabilitation included scooping up debris and spot bolting the roof.¹³ Tr. 540.

Grimm was not the first MSHA inspector to visit the area. Weiss testified that on May 4, 2010, approximately seven weeks before Grimm’s inspection, MSHA Inspector Jan Lyall conducted an inspection that included the area adjacent to the entrance to the dinner hole. Robert Tozzi, then a safety escort at the mine, accompanied Lyall to the area.¹⁴ Tr. 650. According to Trozzi, Lyall did not issue any citations based on the condition of the roof and ribs in the vicinity of the dinner hole, rather he suggested that posts be installed next to the cribs that were already in place at the corners of the dinner hole entry. Tr. 653. Trozzi admitted, however, that on May 4, neither he nor Lyall entered the dinner hole. Tr. 671. Indeed, Tozzi could not say for sure whether Lyall even looked into the dinner hole. Tr. 671-673.

In contrast, on June 22, Grimm and the rest of the inspection party went into the dinner hole, which Grimm described as a “gathering place for the miners.” Tr. 66. He understood that miners used the area to eat lunch and to conduct meetings. *Id.*, Tr. 173. There was a picnic table in the center of the entry. In addition, mining supplies were stored in the entry.¹⁵ Tr. 66.

¹² Grimm circled in black the Sixth North Parallel construction area on a mine map. *See* Gov’t Exh. 18. The dinner hole was within the area. *Id.* Grimm stated that June 22 was the first time he had been to the dinner hole. Indeed, it was the first time he was anywhere in the Six North Parallel construction area. Tr. 68

¹³ The roof was originally supported with straps and cable roof bolts. When the area was rehabilitated, one-hole boards and more roof bolts were added. Tr. 542, Tr. 200.

¹⁴ At the time he testified, Robert Trozzi, who holds a business degree from Washington and Jefferson College, had worked for Consol for seven years as a safety escort and as a section foreman. Tr. 649-650. On May 4, 2010, Trozzi was a safety escort at the Blacksville No. 2 Mine. He also was “responsible for conferencing violations, [for] respirable dust [sampling, for] training employees, [and for] just making sure that [there] were safe work practices going on within the coal mine.” Tr. 650-651.

¹⁵ Weiss testified that the supplies were located “just beyond the picnic table . . . at the bottom of the rib on either side.” Tr. 554. The supplies consisted, *inter alia*, of “wedges, boxes of glue . . . [one-hole] boards.” *Id.* In notes he made on the day of the inspection, Wolfe wrote
(continued...)

The condition of the ribs on both sides of the dinner hole troubled Grimm. He believed that the ribs had “deteriorated” badly. Tr. 68. He described each rib as “ate out in the middle and sloughed off, leaving an overhanging brow.”¹⁶ Tr. 68-69; *see also* Tr. 373. In Grimm’s opinion, the ribs were loose and dangerously defective. *Id.*, 747. Grimm noted that although the usual width of mine’s entries is 16 feet, in the dinner hole the entry was 22 feet wide. Because of the added width Grimm thought that “a lot more” pressure was being put on the ribs, causing them to “deteriorate further.” Tr. 213. They were, he testified, very likely to fall. Tr. 93.

Grimm maintained that miners traveled and worked “in close proximity” to the hazardous ribs (Tr. 747), and shift foreman Weiss did not dispute Grimm’s assessment. Weiss recalled that some of the supplies were “sitting . . . on top of the [sloughage]” (Tr. 555), and Wolfe remembered that other supplies were lying “at the sloughage area,” close to the ribs. Tr. 633. Wolfe agreed that miners retrieving supplies could be close to the sloughed ribs. *Id.*

Grimm measured the defective ribs. One side had deteriorated for a length of 29 feet and the other for 31 feet. Tr. 69. The 29 feet long section of rib was undercut¹⁷ to a depth of 18 inches, and from the roof to the start of the undercut was a hanging rib (a brow) that measured 15 inches to 27 inches high.¹⁸ *Id.* On the other side, the rib was similarly undercut creating a similar brow.¹⁹ Tr. 70. Grimm stated that because the ribs were defective along “practically the entire area of the dinner hole,” the condition was “very obvious.” Tr. 100.

¹⁵(...continued)

that the supplies included a “mud tub, a pallet, a stack of one hole boards and 5 or 6 short straps.” Tr. 632; Consol. Exh. R-10. In addition, there were “[two] separate pieces of curtain laid out along the ribs.” Tr. 632,

¹⁶ Grimm described a brow as:

[O]verhanging material along the rib. [I]t’s been undercut underneath. The middle of the rib . . . [has] been eaten away, sloughed off, . . . and left with . . . material still hanging. [There is n]othing to support [the overhanging material.]

Tr. 71.

¹⁷ Grimm used the word “undercut” to describe the indentation in the rib line. Although strictly speaking the word connotes an indentation that is “cut” mechanically, the parties and the Court understood Grimm to be referring to an indentation caused by sloughing.

¹⁸ Grimm described the undercut rib as “ate out in the middle and left [with] the overhanging material. There was nothing underneath [the overhanging material.]” Tr. 70

¹⁹ Grimm, with Craig’s assistance, measured the deepest penetration of the undercuts and the distance from the ceiling to the point in the rib where the undercut started. Tr. 79-80, 81-82, 359. Grimm used a steel tape measure. Tr. 82. Grimm stated that he stood three or four feet from the brows and under the roof bolts closest to the ribs when he took the measurements. He added that in so doing, he made certain he was always under supported roof. Tr. 186-187.

According to Grimm, the sloughage was lying at the base of the ribs. Tr. 71. Like the Pittsburgh Seam in general, Grimm remembered the ribs in the dinner hole as “soft.” Tr. 71. He also remembered “some cracks in [the ribs].” Tr. 71. Although the cracks were small, they indicated to Grimm that the ribs were not solid and that they would “continue to deteriorate.” Tr. 76, *see also* Tr. 166. Equally troublesome, sloughing of the middle part of the ribs meant that there was nothing left to support the “unsloughed” top of the ribs— the brows.²⁰ *Id.*

While Craig agreed with Grimm’s description of both ribs. (Tr. 357), Grimm’s view of the hazardous nature of the ribs was not shared by the company safety escort, James Wolfe. Wolfe described the dinner hole as “just a typical area.” Tr. 601. Wolfe recalled that the roof in the dinner hole was bolted and strapped and that additional bolts had been placed between the straps and each rib. In addition, there were several one-hole boards that were located between the straps and next to the top of each rib. Tr. 601-602, 610. The purpose of the one-hole boards was to provide “extra support.” Tr. 602, 610. He described the ribs as “sloughed out from the coal seam a little bit on each side and [there] was sloughage on the bottom,” but he did not believe there was anything unusual about the condition of the ribs.²¹ Tr. 602.

Wolfe kept handwritten notes of what he observed during the inspection. Tr. 603-605. Later in the day, he typed more detailed notes. Although one such note stated, “The ribs are sloughed out . . . on both sides . . . in the middle of the rib[s]” (Resp. Ex. R-10), Wolfe did not believe the sloughing ribs posed a hazard because the ribs almost always slough, usually at a slow rate. Tr. 604-605. However, he acknowledged that sloughage can happen quickly (*Id.*) and that after a rib sloughs from the middle, the top of the rib is no longer supported by the coal that was in the middle of the rib. Tr. 618.

Wolfe measured the sloughed ribs, but whereas Grimm measured from the deepest points in the sloughed out ribs to determine how much the ribs had been undercut, Wolfe measured

²⁰ Grimm did not test the ribs by “sounding” them. (When a rib is “sounded,” it is hit with a metal object, often a pry bar or a hammer. A resulting “hollow” sound may indicate that the rib is unstable and loose.) Grimm explained, “I don’t sound the ribs when [the ribs are] bad” and the ribs in the dinner hole were “visually bad.” Tr. 167.

²¹ In general, Wolfe and Trozzi viewed the ribs in the Pittsburgh Seam as far less hazardous than did MSHA’s witnesses. While Trozzi agreed that a sloughed rib could present a danger, he added that it “would depend on how [the rib] sloughs out.” Tr. 675. Asked to elucidate, he added that in the Pittsburgh Seam and at the Blacksville No. 2 Mine:

Typically . . . the way the ribs slough out, they sort of slough out in an arc to where there’s not really an overhanging piece of coal. It’s just kind of a gradual arc that comes down. . . . There’s no real brow that would be . . . a loose piece that’s hanging or unsupported.

Tr. 675.

from the rib lines because “[T]hat’s where the coal rib was.” Tr. 606. Wolfe stated that he told Grimm that he, Wolfe, disagreed with measuring from the inside of the sloughed area when the original rib still existed at both the top and the bottom of the rib line. Tr. 608. Wolfe drew the original rib line on a photograph of the dinner hole area. Resp. Exh. R-1 at 4; Tr. 624-625. In Wolfe’s view, a potentially dangerous “brow” could be created only if the bottom of the rib also sloughed leaving nothing between the top of the rib and the mine floor. Tr. 615. (“A coal brow would exist if there was nothing under that brow.” *Id.* Wolfe added, “If you can set a post under the brow, that’s a coal brow.” Tr. 616.) Wolfe did not think coal brows existed in the dinner hole because there were remnants of the original ribs at the tops and bottoms of the rib lines. *Id.*

Counsel’s Safety Supervisor, William DeVault, acknowledged that he was not in the dinner hole during the inspection.²² Rather, he visited the area approximately one week later. Tr. 406, 472. While he agreed ribs “tend to be unpredictable,” DeVault contended that he did not see any coal brows. Tr. 406-407. He stated he thought that the ribs exhibited the result of “normal spalding.” Tr. 473. DeVault described “normal spalding” as “just flakes of material that had flaked off from the rib and hit the floor.” *Id.* DeVault did not know if the ribs were scaled²³ as part of abating the alleged violation, but Weiss thought that the ribs were too crumbly to be scaled. Tr. 565-566. He described them as “very soft . . . like graham cracker crust.” Tr. 566. Wolfe, who was in the dinner hole when the alleged violation was abated, testified that no scaling was done. Tr. 611-612. Rather, to abate the cited conditions the company chose to do nothing to the brows. Tr. 217. It set 15 floor to roof posts and jacks, seven on one side of the entry and eight on the other. Tr. 144; *see also* Tr. 361. All were set four to five feet apart, along the original rib line. *Id.*, *see also* Tr. 565, 583. In addition, mining supplies were removed from the entry. *Id.*, Tr. 209. Weiss stated the supplies had to be moved because they were lying at the base of the rib line where the posts and jacks were set. Tr. 584. According to Grimm, the posts and jacks, which were wedged at the top, supported the ribs well and prevented people from going under the ribs. Tr. 145, 147. Grimm considered setting the posts and jacks and removing the supplies to be “a very good solution.” Tr. 147. He did not know if the area continued to be used as a dinner hole after the condition was abated, but in his opinion it could have been, provided any supplies were stored at least 12 inches from the ribs so that miners would not have to go between the posts, jacks and the ribs to retrieve the supplies. Tr. 216.

Shift foreman Kenneth Weiss, who arrived at the dinner hole about 10 minutes after Grimm, testified that the ribs had “flaked off” or “sloughed off” in mostly softball size pieces starting about 18 inches above the floor. Tr. 542-544. Weiss described the ribs as indented “about two feet” and projecting toward the entry at their tops and bottoms. Tr. 543. In Weiss’s opinion, the ribs “were in no threat or danger of falling.” *Id.* He maintained that there was

²² At the time he testified, William DeVault had worked at the mine for 37 years. Tr. 470. He started as a general laborer and advanced through the ranks to become a section foreman and then, in 2008, a safety supervisor. *Id.* As a safety supervisor, he supervises a department of six people, five of whom are safety escorts who accompany MSHA’s inspectors. Tr. 471.

²³ A rib is “scaled” when loose coal and/or rock is removed from the rib. *See DMMRT* at 482.

“nothing out of the ordinary” about the ribs (Tr. 544), nor were there any brows. Tr. 551. Weiss “couldn’t believe [Grimm] was going to write [a] violation.” Tr. 543.

However, Grimm believed that because of the sloughed-out ribs, the areas on top of the ribs, which Grimm referred to as the “brows,” were inadequately supported on both sides of the entry. Tr. 86-87. (“[O]nce [the rib] was eaten out, it was all unsupported material.” Tr. 87.) Grimm explained that because the middle of the ribs had fallen out, the brows above the indentation were “left loose” and that the “hanging material [(i.e. the brows)] . . . [was] going to come down.” Tr. 95. He added that when a rib has “cracks and it’s soft . . . it’s going to fall. And that’s why we keep people out from underneath it.”²⁴ Tr. 95. Geologic forces were causing pressure to be applied to the roof, the floor and the ribs. Tr. 168. Because of the forces applied to the ribs and because gravity was pulling on the brows, “There [was] nothing . . . to support [the brows].” Tr. 207. Grimm acknowledged that there were several one-hole boards in the roof. Tr. 88, 89. However, he did not think they supported the coal brows and ribs. Tr. 207-208. Moreover, it was June and humidity in the mine was rising. Tr. 92. According to Grimm, when humidity seeps into the roof and ribs, they “fail a lot quicker because of the moisture,” which is why the number of roof and rib accidents “greatly increases” in the summer.²⁵ Tr. 92. For all these reasons, Grimm believed that the cited brows were “very likely” to fall. Tr. 94, *see also* Tr. 91.

Grimm found that the hazard caused by the violation was reasonably likely to result in a serious or even a fatal injury or injuries. In his opinion, miners were likely to be struck on the head or neck by falling pieces of the ribs. Tr. 93-94. Grimm explained, “[M]iners were spending time in close proximity [to the ribs] and underneath those ribs. . . [M]ining supplies [were] there. [Miners] were traveling there. They were spending a lot of time there. They were actually storing the supplies underneath that unsupported area.”²⁶ Tr. 91.

In Grimm’s opinion, the sloughed out ribs presented an obvious hazard. In addition, and as previously noted, mining supplies were stored in the area – things such as canvas, mining straps, a roll of flexible mesh, one-hole boards, caps and wedges, boxes of resin and pieces of cardboard. Tr. 77-78. Grimm remembered a majority of the supplies lying “right up against the rib, [lying] on the sloughage and underneath the coal brow[s].” Tr. 77-78, *see also* Tr. 171.

²⁴ Grimm’s belief that the brows were loose was based solely on visual observation. As previously stated, he considered it too dangerous to sound the ribs. Tr. 167.

²⁵ Consol’s view of the effect of moisture on the ribs was decidedly less alarming. DeVault agreed that moisture increased during the summer, but he believed the increased moisture at most caused the ribs to “flake” or to shed coal in “little pops,” a process that could be successfully countered by rockdusting, thereby sealing the ribs. Tr. 488, 505.

²⁶ DeVault agreed that in general, “All coal brows left unattended could be hazardous if not supported correctly.” Tr. 421. He also agreed that roof bolters, mechanics, shuttle car operators and foremen regularly used the dinner hole at lunchtime, at the end of the shift and sometimes for meetings. He further agreed that the exposure of miners to the dinner hole was “very high.” Tr. 424.

Laborer Craig's testimony regarding the supplies tended to corroborate Grimm's. Craig recalled that sloughage from the ribs resulted in "chunks of coal and stuff [lying] on the [roof] bolts and [other supplies.]" Tr. 356. He remembered roof bolting supplies stored along the left rib of the dinner hole and some mesh and cardboard stored along the right rib and at the corner of the dinner hole entry. Tr. 358. In addition, he stated that some of the roof bolting supplies were underneath the coal brows.²⁷ Tr. 358.

The presence of cardboard pieces or pads on the floor of the dinner hole signaled to Grimm that the miners were placing themselves in very hazardous positions by lying or sitting on the cardboard. Grimm called the cardboard pads "beds." Tr. 78. Although Grimm did not see miners actually lying or sitting on the beds (no miners were in the dinner hole during Grimm's inspection), Grimm could tell that miners had rested on some of the pads because of the imprint of their bodies on the cardboard.²⁸ Tr. 78, 174. In addition, some of the cardboard pieces had been used to form what Grimm described as "pads and seats and chairs." Tr. 174. Grimm testified that he saw approximately four "beds" and that they were "in close proximity" to the coal brows or directly underneath them. Tr. 79. Weiss thought that whether the cardboard "rest areas" were "beds" was "a subjective question," but he was sure that "nobody on [Weiss's] shift laid down or sat down on anything that was called a bed or a cardboard box." Tr. 555. He noted that miners usually sat at the picnic table. Tr. 555.

Wolfe agreed with Grimm that the cardboard pads were present. Wolfe speculated that although the cardboard might have served as seats for miners, the pads would not have been used as beds because the company does not condone sleeping underground. Tr. 634. DeVault also noted that it is against mine policy for miners to make beds and to place the beds against the ribs. Tr. 426. He was sure that miners would not sleep on the cardboard because if they did and they were discovered, the miners would be discharged. Tr. 486. Nor did DeVault think miners would sit on the cardboard while they ate lunch. Like Weiss, DeVault noted the presence of the picnic table in the entry. Tr. 487. Nonetheless, DeVault acknowledged that cardboard pads continued to "pop up" in the mine, especially in break areas like the dinner hole. Tr. 426-427.

In Grimm's view, the deterioration of the ribs should have been a visual "warning" to the company that the ribs were dangerous (Tr. 94), and he found that the condition of the ribs in the dinner hole was due to the company's "high negligence." Gov't Exh. 13. The finding was based on "a lot of facts." Tr. 95. He especially noted that there had been two "very serious" rib fall accidents at the mine prior to June 22, 2010. The accidents were within months of one another

²⁷ Later, Craig testified that the mesh and cardboard pads were lying along both ribs (Tr.360) and, while not as specific as Craig, Wolfe testified that cardboard pads were lying on both sides of the entry. Tr. 633.

²⁸ Grimm explained that he thought the ribs were so hazardous that if he had seen a miner sitting on cardboard under a brow, he would have issued an imminent danger order under section 107(a) of the Act. Tr. 174. Section 107(a) provides that an inspector, upon finding an imminent danger, must issue an order requiring the operator to cause all persons to be withdrawn from the area in which the imminent danger exists. 30 U.S.C. §817(a).

and as of the date of the hearing, the miner hurt in the last such accident had not yet returned to work. Tr. 95-96. Although none of the accidents produced a fatal injury (Tr. 201), Grimm believed the very fact the accidents happened “alone should have put [Consol] on a high degree of awareness.”²⁹ Tr. 96. Grimm also believed the company should have been on heightened alert because it had been reminded of summer rib hazards by MSHA’s PROP Initiative. *Id.* Further, the dinner hole had to be examined daily by the pre-shift and on-shift examiner. Therefore, the condition of the ribs should have been noted and corrected. *Id.* Grimm thought that the ribs had been defective for at least a month (Tr. 97) and that there were “no . . . signs . . . [the company] tried to take care of [the] condition.”³⁰ Tr. 96., 98, 210. In his opinion nothing mitigated the company’s disregard of its duty of care. Tr. 99. Despite two fairly recent rib fall accidents at the mine, prior citations issued for loose ribs at the mine, the PROP Initiative and MSHA’s Rules to Live By, the company still failed to take measures to prevent or correct the conditions.³¹ Tr. 99-100, 148. In Grimm’s view, the company clearly had a “problem” with compliance. Tr. 148

²⁹ The first accident occurred on February 13, 2010. A stage loader operator, one Mr. Wise, suffered multiple injuries, including a broken pelvis, when he was covered by a brow that fell. Tr. 113-114, 117, 118. On May 7, 2010, another miner, one Mr. Shaffer, a roof bolter, was injured when a rib fell on him without warning. Tr. 120. He suffered a broken collarbone and a bruised rib. *Id.* Grimm described the ribs that fell as being “in good shape” and as “normal ribs that were solid.” Tr. 115. Grimm testified that “They . . . gave no sign of falling.” *Id.*

³⁰ Grimm claimed that a section foreman told him, “They had been in there for a month,” which meant to Grimm that the dangerous ribs had existed for one month. Tr. 97; *see also* Tr. 177. Assuming the statement was made, the Court notes that the statement is ambiguous and that Grimm’s interpretation is but one thing that the foreman might have meant.

³¹ Concerning the prior violations of section 75.202(a), Grimm testified that in the two years before June 22, 2010, approximately 38 citations and orders were issued for violations of the standard at the mine. Of these, approximately 12 were “rib-related.” Tr. 100. (In fact, there appear to have been 13 that were “rib related.” Gov’t Exhs. 40-52; Tr. 107.) He acknowledged, however, that only one of the prior “rib-related” violations, cited in a section 104(d)(2) order (30 U.S.C. §814(d)(2)) issued to the company on August 11, 2009, related to coal brows. Gov’t Exh. 48; Tr. 107-108. According to Grimm, the company was cited on August 11 because the company allowed “quite extensive” parts of the ribs to deteriorate and fall leaving hanging coal brows. Tr. 108. Grimm described the conditions cited on August 11, 2009, as “relatively the same” as the conditions cited on June 22, 2010. *Id.*

On cross examination, Grimm acknowledged that section 75.202(a) is one of the most frequently cited of the mandatory standards. Tr. 163. He further stated that it represented 2.8% of the standards cited at the mine from June 22, 2008 to June 22, 2010. He agreed that nationally, violations of section 75.202(a) represent 4.39% of all violations cited at mines. Tr. 165-166.

THE MISSING PHOTOGRAPHS & THE TROZZI PHOTOGRAPHS

According to Grimm, during the inspection safety escort Wolfe took photographs of the ribs, the brows and the mining supplies in the dinner hole. Tr. 149. The miners' representative, Keith Craig, who was present in the dinner hole, agreed that Wolfe "took a lot of pictures." Tr. 362. Craig stated that it was the first and last time he saw a company representative photograph underground cited conditions. *Id.* Grimm testified while he saw Wolfe use his camera, he never saw the resulting photographs.³² Tr. 149. Nor did Craig. Tr. 362. At some point after the photographs were taken, they were lost. Grimm did not know what happened to them.³³

Trozzi testified that because Wolfe's photographs were lost, he and Weiss went to the dinner hole in December 2011 to take pictures of the cited conditions and to measure the ribs. This was the first time Trozzi was in the dinner hole.³⁴ Consol did not contact MSHA officials or union personnel about Trozzi's visit to the dinner hole so neither inspectors nor union representatives accompanied Trozzi and Weiss. Tr. 683. Trozzi maintained that the conditions he photographed on December 11, 2011, were "basically the same" as what he saw on May [5], 2010, when he was traveling underground with Lyall. Tr. 655-656. The only difference Trozzi noticed was that "the ribs had sloughed off more" in December. Tr. 664. Trozzi was certain that he did not see a brow either in May 2010 when he looked into the dinner hole, or in December 2011 when he actually entered the dinner hole. *Id.* Grimm, who was shown copies of Trozzi's photographs at the hearing, testified that they were not representative of what he saw almost one year and six months earlier. Tr. 153. He stated that he was not even "positive that [the photographs] were [of] the same area." *Id.* They did not show either the mining supplies or the

³² In an affidavit, Trozzi stated that Wolfe's photographs were stored on an SD card and that the card was given to DeVault by Wolfe. According to Trozzi, the card was then stored in DeVault's desk. Tr. 463; Gov't Exh. 66.

³³ The missing photographs were a major source of contention before, at and after the hearing. DeVault agreed that Wolfe gave him the SD card and that he put the card in his desk. Tr. 463. But DeVault was adamant that he never saw what was on the card. He was not even sure if he downloaded the photographs onto his computer, although he might have. Tr. 503. In any event, the SD card disappeared from his desk. Tr. 463-464. DeVault speculated that someone might have put the card back into a camera and deleted Wolfe's photographs by mistake. Tr. 463. In addition, and to complicate matters, he testified that in May 2011 his computer was replaced. Tr. 478; *see* Gov't Exh. 67. DeVault stated that although he hoped that the hard drive was not "wiped out" when the computer was switched, "It could've happened." Tr. 501. Of the missing photographs, DeVault stated, "They're gone. I cannot find them. I looked everywhere . . . [They] either got covered over, deleted or something, I do not know . . . I don't know how it happened. I don't." Tr. 465.

³⁴ The testimony revealed that the exact date of Trozzi's visit was December 11, 2011, almost a year and a half after Grimm's inspection. Tr. 666-667. December 11, 2011, also was the day that Trozzi discovered the photographs taken by Wolfe were lost. Tr. 683.

brows that were in the dinner hole on June 22, 2010. Nor did they show jacks and posts that were set to abate the violation.³⁵ *Id.*

THE MISSING NOTES

Like his photographs, the handwritten notes made by Wolfe during Grimm's inspection also went missing. Tr. 151-152, 460. When Consol decided to contest the order at issue, Wolfe gave the notes to Trozzi. Tr. 641-642. The notes then disappeared. Trozzi did not know what happened, but he speculated that they were lost during a subsequent office move. Tr. 688-689.

THE MISSING PRESHIFT AND ONSHIFT EXAMINATION RECORDS

Prior to the inspection Grimm checked the pre-shift on-shift examination records for June 22, 2010. Grimm also tried to check the pre-shift and on-shift records for June 4 through June 18, 2010, but neither he nor anyone from the company could find the records. Tr. 150-151. MSHA requires an operator to retain pre-shift and on-shift records for one year, but Grimm understood Consol's policy was to retain such records for five years. Tr. 151; *see also* Tr. 466-467 (DeVault's similar testimony). DeVault stated that he did not know why the records were missing. He explained that it was not just individual pages of reports that were missing, but rather that an entire book of reports was missing, a book that included the reports Grimm wanted to see. Tr. 483; *see also* Tr. 690. Of the missing reports, DeVault stated, "[W]e've looked. We've looked everywhere." *Id.*

DeVault observed that in the summer of 2011 the company contracted to have its safety department moved to a new office. The pre-shift/on-shift books were among the items moved. Tr. 484. Trozzi echoed DeVault. *See* Tr. 661. According to Trozzi, the missing reports disappeared in the lead-up to the move. He stated, "We had college students pack those books up. It's hard to tell. I really don't know [what happened]." Tr. 662. Weiss could not recall another instance in which pre-shift and on-shift examination reports vanished. He described the situation as, "[s]omewhat out of the ordinary." Tr. 585.

³⁵ The Court notes that Craig, who was in the dinner hole on June 22, 2010, also thought that in some respects Trozzi's pictures were not representative. Craig stated, "It's obvious that they had been in there [and] cleaned it all up. [T]hey scooped . . . the ribs or shoveled[.]. . . [a]nd there wasn't near [as many] . . . posts set in . . . [the photographs as] was put in there the day that I was there." Tr. 362. In fact, the Court finds that the conditions photographed and measured by Trozzi in December 2011 have not been shown to be sufficiently similar to those that existed a year and a half earlier that they can be relied upon. Accordingly, Trozzi's photographs will not be considered in deciding the issues regarding the contested order.

<u>ORDER NO.</u>	<u>DATE</u>	<u>30 CFR</u>
8025378	6/22/2010	§75.202(a)

The order states:

The operator failed to support or otherwise control to protect persons from hazards related to falls of the roof and/or ribs in the 6/North Parallel construction area of the 4-5 block #3 entry of the 5 West Mains. When measured the right inby rib was sloughed out creating a coal brow along the rib for a measured distance of 29 feet ranging from 15 inches to 27 inches high and undercut for a depth of 18 inches to 36 inches deep. This condition exposes the mine roof from the coal rib to the nearest permanent roof bolt of 79, 90, 77, 96, 75, 92, 77, 80, 70, and 64 inches respectively. The left outby rib has sloughed out creating a coal brow along the rib for a measured distance of 31 feet ranging from 12 inches to 28 inches high and undercut for a depth of 15 inches to 31 inches deep. This condition exposes the mine roof from the nearest permanent roof bolt of 86, 78, 76, 70, 67, 68, 65, 72, 64, 71, and 61 inches respectively. This area is being utilized by miners to store mining suppl[ies] including approximately 70 roof straps, 20 roof bolts, 4 boxes of resin, a roll of rib mesh, hydraulic hoses and wooden one hole boards. The mesh, roof bolts, resin and a portion of the roof straps are stored in close proximity [to] the unsupported ribs. The coal ribs contain small cracks and are soft. Falls of the roof and ribs are a leading cause of underground coal mine injuries and fatalities. It is reasonably likely that if normal mining were to continue and the condition[s] were left unabated that a fall of the coal rib would cause a miner to suffer fatal injuries. This violation is obvious and located in an area traveled by a certified examiner. This is an unwarrantable failure to comply with a mandatory standard. This standard has been cited 38 times in two years at this mine.

Gov't Exh. 13.

THE VIOLATION

The record establishes that the violation existed as charged. While the order describes the violative condition in terms of both rib and roof hazards in the dinner hole, the evidence presented by the Secretary almost exclusively focused on the conditions of the ribs, and they were indeed hazardous. The evidence fully supports the inspector's conclusion that the operator failed to support or otherwise control the cited ribs and in so doing, endangered miners who worked or traveled in the dinner hole. There is really no credible evidence that counters Grimm's eyewitness evaluation of the condition of the ribs. He described the ribs as having "deteriorated," and he backed up the description by testifying to the measurements he made during the inspection. His testimony establishes that the ribs on both sides of the dinner hole were "undercut" by at least a foot and a half and that the deterioration of the ribs left overhanging and inadequately supported brows 15 to 27 inches high. Tr. 69-70. Moreover, his testimony that the ribs on both sides of the dinner hole exhibited small cracks was not countered (Tr. 71), nor was his testimony that the ribs were composed of "soft" coal and therefore prone to sloughing. *Id.* Further, and as Grimm persuasively pointed out, as time went on, the soft coal ribs would continue to deteriorate leaving less and less to support the brows. Tr. 76.

Added to this is the fact that it was June and the humidity inside the mine was rising. Tr. 92. While the extent of deterioration of the ribs due to humidity was disputed by the parties, everyone agreed that sloughing increased in the summer. Tr. 92-94, 488, 505. Further, Consol did not challenge Grimm's testimony that rib fall accidents "greatly increased" in the summer because moisture from rising humidity seeps into the ribs. Tr. 92. The Court credits Grimm's testimony concerning the effect of humidity on the ribs and finds that in June and as mining continued throughout the summer, the increased humidity made the cited ribs more likely to fail.³⁶

Consol's eyewitnesses to the cited conditions agreed the ribs had sloughed. Indeed, Wolfe agreed that the ribs sloughed essentially as described and measured by Grimm. Tr. 613, 620, 622. Tellingly, Wolfe did not measure how much the ribs were "undercut," a critical measurement when determining the hazard posed by the brows created by the sloughage. Tr. 606. Wolfe's contention that a brow could only exist if the rib sloughed all the way to the floor is not persuasive (Tr. 615) and his implication that an overhanging rib created by sloughage in the middle of the rib is not hazardous because the sloughage has not continued to the bottom of the rib defies common sense. While there would be nothing left to support an overhanging rib if the rib sloughed from the overhang to where the rib met the floor, there also could be an inadequate amount of rib left to support an overhang if a rib sloughed only in the middle. As Grimm sensibly testified, when a rib sloughs in the middle, there is less to support the brow. Tr. 76. In short, the evidence establishes that a hazardous overhanging brow can be created by sloughage from the brow to the floor or by sloughage in the middle of the rib. The fact that in this case the sloughage occurred in the middle of the ribs does not negate the hazard.

³⁶ The Court observes that although DeVault testified that the effect of increased moisture on the ribs could be counteracted successfully by rock dusting, the record contains no evidence that rock dust applied to the cited ribs. Tr. 488, 505.

Weiss agreed that the cited ribs had sloughed so that they were indented “about two feet.” Tr. 543. Although he did not remember hazardous brows being created by the sloughage and although he described the ribs as “nothing out of the ordinary” (Tr. 544), Weiss’s recollection of what he saw and his assessment of the conditions as he remembered them are far outweighed by Grimm’s contemporaneous measurements of the sloughed ribs, measurements which fully support his contention that sloughage had created hazardous brows. Moreover, neither Wolfe nor Weiss disagreed with Grimm that the coal ribs were soft and that the ribs exhibited small cracks, two conditions that increased the hazards posed by the ribs.

By its terms, section 75.202(a) only can be violated if the cited conditions pose a fall hazard to miners. Therefore, to establish a violation the Secretary must prove not only that conditions at issue are hazardous, he also must prove that miners worked or traveled or rested in the immediate vicinity of the cited conditions. The Secretary proved exactly that. The record fully supports finding that a picnic table was present in the dinner hole, as were supplies and cardboard pads. Together these things are indicative of the ongoing presence of miners in the dinner hole. Moreover, Grimm’s testimony that at least some of the supplies were stored against the ribs and on the sloughage (Tr. 77-78) was, like the rest of Grimm’s description of the cited conditions, credible and worthy of belief. Craig recalled that in addition to being stored on the sloughage, some sloughage had fallen on top of the supplies. Tr. 356. The reason the supplies were stored in the dinner hole was because they were going to be used or moved. To use or move the supplies, miners had to retrieve them by coming into close proximity with the hazardous ribs. In addition, while there was much back and forth regarding whether miners used the cardboard pads as “beds” upon which to sleep (*see e.g.*, Tr. 426, 555, 634), whether or not they did is irrelevant. What is certain from Grimm’s testimony is that the pads were used to sit or lie upon. Grimm’s testimony that he could see the imprint of miners’ bodies on the cardboard was not challenged. Tr. 78, 174. The cardboard pieces were located in such a way that miners sitting or lying on them were endangered. Even Wolfe agreed that the pieces were located toward the sides of the entry. Tr. 633. The record thus confirms that miners worked, traveled and rested in the immediate vicinity of the cited ribs. Accordingly, the Court holds that the Secretary established that the cited ribs were not “supported or otherwise controlled to protect persons from hazards related to falls of the . . . ribs” and that Consol violated section 75.202(a) as charged.

S&S AND GRAVITY

The Court also finds that the violation was S&S.³⁷ Consol violated the safety standard and the violation created the discrete safety hazard of a rib fall injury. The Secretary established that it was reasonably likely the hazard contributed to would have resulted in an event in which there was a reasonably serious injury. All of the elements for a rib fall were present. There were

³⁷ The test for determining the S&S nature of a violation has been established, approved by the Courts, and relied upon by inspectors, operators and the Commission for almost 30 years. It need not be repeated here. *Mathies Coal Co.*, 6 FMSHRC 3-4 (Jan. 1984); *accord Buck Creek Coal Co., Inc.*, 52 F.3d 133, 135 (7th Cir. 1995); *Austin Power Inc. v. Sec’y of Labor*, 861 F.2d 99, 103 (5th Cir. 1988) (approving *Mathies* criteria).

inadequately supported brows along both ribs, there were cracks in the ribs, the ribs were soft and sloughing, and the geological forces putting pressure on the ribs were unremitting and would not lessen with time. Moreover, it was summer, and the likelihood of rib failure was increased due to the higher moisture content of the mine atmosphere. Further, as mining continued, deterioration of the cited ribs would have continued as sloughing ate away at the ribs, reducing support for the already precarious brows. Tr. 76, 91, 167, 205. The Court therefore concludes that, assuming continued normal mining operations, it was reasonable likely the cited ribs would fail and miners would have been seriously, perhaps fatally, injured, because, as found above, miners worked, traveled and rested in the dinner hole in the immediate vicinity of the cited ribs. The location of the stored supplies and of the cardboard pads meant that miners retrieving or moving supplies and miners sitting or lying on the pads were subject to being hit by pieces of the defective ribs and brows when the ribs failed and the brows fell, something that could happen at any time. Tr. 91, 179, 210; *see also* Tr. 630-631. A miner hit by falling pieces of a brow, at a minimum, was reasonably likely to suffer an injury of a reasonably serious nature. Indeed, as the prior rib fall accidents at the mine showed, a struck miner might well be off work or on restricted duty for months after such an accident. Tr. 449, 450-451. A fatality was also possible.

Finally, in view of the kind of injuries that were reasonably likely to happen if the hazard occurred and in view of the fact that an accident also could prove fatal, the Court finds that in addition to being S&S, the violation was very serious.

UNWARRANTABLE FAILURE AND NEGLIGENCE

The Court further finds that the violation was the result of Consol's unwarrantable failure to comply with section 75.202(a) and of its reckless disregard of the standard's mandate. The Commission has defined an unwarrantable failure as aggravated conduct constituting more than ordinary negligence including conduct that demonstrates a "serious lack of reasonable care." *Emery Mining Corp.*, 9 FMSHRC 1997, 2004 (Dec. 1987). The Commission has stated that whether a violation is an "unwarrantable failure" is a question to be evaluated based on the facts and circumstances in each case, and in light of each of the following factors: 1) the length of time that the violation has existed; 2) the extent of the violative condition; 3) whether the operator was placed on notice that greater efforts were necessary for compliance; 4) the operator's efforts in abating the violative condition; 5) whether the violation was obvious or posed a high degree of danger; and 6) the operator's knowledge of the existence of the violation. *See Consolidation Coal Co.*, 22 FMSHRC 340 (Mar. 2000); *IO Coal Co.*, 31 FMSHRC 1346 (Dec. 2009).

Grimm's finding that Consol unwarrantably failed to comply with section 75.202(a) was based on several factors. The sloughage, the overhanging brows, and the rib cracks were visibly obvious and should have been a "warning" to the company that the ribs were dangerous. Tr. 94. Further, the condition of the ribs deteriorated over time and therefore their condition was ongoing and not new. Tr. 97, 177. Moreover, the dinner hole had to be examined both before and during a shift, and the examiner should have seen the conditions and reported them for correction. Also, in Grimm's opinion, the company was on notice that it needed to pay particular attention to the condition of ribs in the mine due to the two fairly recent rib fall

accidents, the PROP Initiative, MSHA's Rules to Live By, and its history of prior citations at the mine for defective ribs. Tr. 99-100, 148.

The Court concludes that Grimm's reasoning was sound in the main. The defective condition of the ribs was indeed front and center for any and all to see (obviousness of the violation), and the evidence points to the fact that the ribs had been defective for some time (length of time the violation existed).³⁸ While the Court cannot find, as Grimm maintained, that the defective conditions existed for at least a month, the evidence certainly supports the conclusion that the ribs were defective at a time when the pre-shift and on-shift examiner should have noted the conditions and reported them for correction. The Court credits Grimm's testimony that some of the supplies were resting on top of sloughage, which signaled to Grimm, and which indicates to the Court, that the defective ribs were present when the supplies were moved into the dinner hole. Tr. 97-98, 176. The Court also credits Craig's testimony that there was some sloughage on top of the supplies. Tr. 356. Thus, it is clear to the Court, as it was to Grimm, that the hazard was ongoing. The dinner hole had to be preshift examined prior to that work and it had to be on-shift examined when the work took place. There is no indication in the record that the visually obvious conditions were noted by the examiners, reports that would have given notice to Consol of the existence of the conditions.³⁹ Further, as the Court has found

³⁸ The Court recognizes that Trozzi vehemently disagreed with Grimm's finding that the alleged violation was due to the company's unwarrantable failure. Trozzi stated:

[T]here was just no condition that was apparent
that would've been that obvious and extensive[,]

that would make someone . . . jump out and say,
gee, I need to do something about this. . . [I]t
was very , very typical of the rest of the area
as far as the rib sloughage and really, very
typical as to a large part of the mine.

Tr. 665-666.

Trozzi was not a dissembler, but the Court concludes that Trozzi's belief that there was nothing that would "jump out" at an observer, rather than indicate the lack of a hazard, suggests that the condition of the ribs was so reflective of rib conditions in general in the construction area that representatives of the company were inured to the hazards the ribs posed and could no longer recognize a hazardous violation when one stared them in the face.

³⁹ Of course, the missing examination book might (or might not) definitively answer whether an examiner noted the defective ribs, and the Secretary argued repeatedly and at great length that the Court should draw adverse inferences against Consol from the fact that the pre-shift and on-shift records (and Wolfe's photographs and notes) went missing. The Secretary also argued that if the Court declined to draw the inferences, the Court should nonetheless sanction Consol by striking the testimony of Wolfe and Weiss concerning the appearance of the cited
(continued...)

above, the violation was reasonably likely to cause a reasonably serious injury, even a fatality (the high degree of danger posed by the violation). For these reasons the Court concludes Grimm was correct when he found that Consol unwarrantably failed to comply with section 75.202(a).⁴⁰ Neither Grimm nor the Court made findings regarding all of the factors set forth by the Commission in *Consol* and *IO, supra*, but the Court does not read those cases as requiring findings on all six factors to validate an unwarrantable failure finding.

Moreover, although Grimm initially found Consol to be highly negligent, on reflection he concluded the company recklessly disregarded its duty to comply with the standard. Tr. 98. The evidence supports Grimm's latter conclusion. There is ample basis in the record to find that Consol "exhibit[ed] the absence of the slightest degree of care." *Aracoma Coal Co., Inc.* 32 FMSHRC 1639 (Dec. 2010). There is nothing indicating that the company made any meaningful effort to prevent and/or correct the specific conditions Grimm found in the dinner hole. The very fact that company management chose to make the area a dinner hole required the company to meet a high standard of care. As Consol officials well knew, by so designating the area and by placing a picnic table in the area they extended an open invitation to miners to gather and linger. Moreover, by placing supplies adjacent to the ribs, the company required some who worked in the area to do so in close proximity to the ribs. Management also knew, or should have known,

³⁹(...continued)

conditions on June 22. *See* Sec.'s Reply Br. 48 - 65. The Court declines to do either. Findings can be made and conclusions can be drawn resolving all issues based on the record as it stands without the inferences or sanctions argued for by the Secretary, and the Court is mindful that above all, restraint and at least a token amount of humility are called for. The essence of restraint is only to make findings and draw conclusions that are necessary to decide a case. The essence of humility is to recognize that like a physician, whenever possible, the Court should, "First, do no harm." Drawing adverse inferences and imposing sanctions can be precarious and potentially hurtful actions. They are especially worthy of caution when they involve assumptions of illicit motivation, assumptions that, given the limits of human intuition and the complexities of human causation, easily may be wrong but that once published never can be fully recalled. And this is all the more true where, as here, the witnesses' testimony regarding the missing documents and photographs has the color of credibility.

⁴⁰ In reaching this conclusion, the Court has not overlooked the fact the company's history of rib related violations prior to June 22 was a good one. In the two years prior to June 22, 2010, only 13 "rib-related" violations appear to have been issued at the mine and only one of those was charged in a section 104(d) order and for a condition that was "relatively the same" as that cited on June 22, 2010. Tr. 100. 107-108. The Court recognizes, as acknowledged by Grimm, that of all violations occurring at the mine, the percentage of violations of section 75.202(a) was below the national average. Tr. 165-166. While commendable, this history does not change the Court's conclusion that the violation cited on June 22 was the result of the company's unwarrantable failure. A litany of prior violations of a standard at issue is but one factor to be considered when determining unwarrantable failure. *Black Beauty Coal Co. v. FMSHRC*, 703 F.3d 553, 561 (D.C. Cir. 2012); *San Juan Coal Co.*, 29 FMSHRC 125. 131 (Mar. 2007). In addition, the particular history of violating a standard and the overall history of all violations is, of course, fully taken into account when a penalty is assessed.

that cardboard pads were located in the area, some very close to the ribs, and that the miners were using them as places to sit and to lie. Further, as Grimm made clear, the company should have recognized it had a problem with effective rib control. The soft nature of the coal, the rising humidity in June, the two relatively recent fall-related accidents, the reminders of the need for heightened awareness of rib conditions delivered by the government through the agency's PROP Initiative and its Rules to Live By messages should have raised Consol's awareness and prompted heightened compliance efforts. They did not. Although in the daily section safety meetings referred to by DeVault, miners were presumably generally reminded about the need to adequately support the roof and ribs of working sections and although the subject was part of the company's general program of instruction, the cited conditions belie the effectiveness of the programs and there is no evidence that the company went beyond general reminders to heighten the awareness of its miners and supervisors of the necessity of adequate rib control. Tr. 446-447. The company also knew the area's ribs sloughed and sloughage was an ongoing event. As the Court found, the evidence supports the conclusion that the ribs were in violation of the standard before Grimm's inspection. The area was, or should have been, preshift and on shift examined and the condition of the ribs should have been noted, reported and addressed. These things did not happen. In fact, with regard to correcting the condition of the ribs, nothing happened. The only conclusion the Court can reach is that Consol exhibited a complete absence of care and recklessly disregarded its duty to comply with the standard.

<u>CITATION NO.</u>	<u>DATE</u>	<u>30 CFR</u>
8025516	7/21/2010	§75.220(a)(1)

The citation states:

The operator failed to follow page 4a, paragraph 4, of the mine[']s approved roof control plan requiring [that] areas where crosscuts will be turned will be identified with flagging to warn workers of rib areas not rib bolted on initial mining. The left inby and outby corners of the #2 entry, 8 block intersection on the 14 W longwall set up section, MMU 064-0, which were previously mined are not flagged to warn miners of unbolted mine ribs.

This standard has been cited 30 times in two years at this mine.

Gov't Exh. 23.

Inspector Grimm issued Citation No. 8025516 on July 21, 2010. Tr. 227-228. Gov. Exh. 23. On that date he was inspecting the No. 14W area of the mine, an area where the company was "driving the back end of the bleeders . . . to set up [the] longwall."⁴¹ Tr. 229. Grimm was

⁴¹ The word "bleeders" is used as shorthand for the term "bleeder entries," which are defined as:

(continued...)

accompanied by the company's representative, Stanley Apanawicz, and by the miners' representative, Eric Greathouse. *Id.* In the No. 2 entry of Eight Block, Grimm saw an intersection where he believed the left inby corner and the left outby corner were not rib bolted as required by the mine's approved roof control plan. *Id.*; *See* Gov't Exh. 27. Grimm noted that on May 26, 2010, an addendum titled "Rib Bolting Plan for Continuous Miners" was added to the plan. Paragraph 4 of the addendum states in pertinent part:

Areas where crosscuts will be turned will be identified with flagging to warn workers of rib areas not rib bolted on initial mining. Any area[s] not rib bolted on initial mining, such as areas where crosscuts are mined through or where the distance inby or outby are not within standard cycle of every other roof strap will be bolted when the miner rib bolter or other rib bolter can be utilized

Gov't Exh. 20 at 4a; *see* Tr. 232-233.⁴²

Grimm identified a map of the general area in which the alleged violation was cited. Gov't Exh. 27; Tr. 230. Grimm circled the area where he found the alleged violation. *Id.* He explained that in the No. 2 Entry, "The left inby corner . . . [of the circled intersection] was not completely rib bolted according to the rib bolting plan." Tr. 231. When asked in what way the rib bolting plan was violated, Grimm replied, "The inby and outby corners were not flagged or rib bolted at that intersection." Tr. 235. As he recalled, 15 feet of the left inby corner and 17 feet of the left outby corner were not rib bolted or flagged. *Id.* Grimm depicted the area in his notes. Gov't Exh. 24 at 3 (page 8); Tr. 235-236. Grimm acknowledged the rib bolting plan stated that, "Any area not bolted on initial mining . . . will be bolted when the [continuous] miner rib bolter . . . can be utilized." Gov't Exh. 20 at 4(a); Tr. 236. When asked how he knew that the continuous miner rib bolter could have been utilized, Grimm responded, "Everything else on the section had been rib bolted. Everything that was required to be rib bolted was rib bolted and they were mining inby that point, and that area had been center bolted." Tr. 236. He explained that, "The area was mined with a full-face miner utilizing roof straps. And once they mine an

⁴¹(...continued)

[P]anel entries driven on a perimeter of a block of coal being mined and maintained as exhaust airways to remove methane promptly from the working [face] to prevent the build up of high concentrations either at the face or in the main intake airways. They are maintained, after mining is completed, in preference to sealing the completed workings.

DMMRT at 55.

⁴² Grimm speculated that Consol added the addendum because of the two prior rib fall accidents noted above. Tr. 291.

area and leave that entry or that cycle, they have 72 production hours to rib bolt.”⁴³ Tr. 237. He added that the section foreman told him the area had been mined approximately two weeks before Grimm’s visit. Tr. 236-237; *see* Gov’t Exh. 24 at 3 (page 9). The fact that the No. 2 Entry had been center bolted meant to Grimm that, “The roof bolting machine traveled past the cited area.” Tr. 238. The No. 1, No. 2, and No. 3 entries had been rib bolted in their entirety including crosscuts, but in bolting the entries, the company simply missed the subject intersection. Tr. 239.

Grimm acknowledged that the rib bolting plan specifically excluded some areas from its requirements, including “longwall setup entries.” Tr. 243; *See also* Tr. 262; Gov’t Exh. 20 at 4a. He described the longwall setup entry as “the entry that is driven at the back of a panel in order for . . . the operator to set up the longwall mining machine, the shearer, the shields, headgate drive, tailgate drive. That’s where the initial mining starts to retreat out of that section.” Tr. 243. He described the term “longwall setup entry” as a “common” term that is used to describe one entry of a longwall setup section. Tr. 244. Grimm identified an MSHA document entitled *Longwall Mining*, which lists and defines many terms. Tr. 245; Gov’t Exh. 28. In the document, the term “setup entry” is defined as an “[e]ntry developed for purpose of assembling the longwall equipment. This setup entry will become the longwall face after equipment is assembled and ready to operate.” Gov’t Exh. 28 at 11. He further identified a publication authored by West Virginia University professors Syd S. Peng & H.S. Chaing entitled *Longwall Mining*. Tr. 249; Gov’t Exh. 68. In describing longwall panel layouts, the professors state: “Longwall mining begins at the setup room or entry, SR, where all of the face equipment is set up.” Gov’t Exh. 68 at 12-13; Tr. 253. Grimm maintained that the authors’ definition of a “set up room” corresponds to his understanding of what constitutes a “setup entry.” Tr. 253.

With regard to Citation No. 8025516, Grimm pointed out that although the longwall setup section included the No. 1, No. 2, No. 3 and No. 4 Entries of the area he cited (*see* Gov’t Exh. 27), the plan does not exclude the entire setup section; rather it excludes the longwall setup entry. Tr. 256. The longwall set up entry is excluded because after the entry is driven, it has to be widened by about four feet in order to accommodate the shearer, the panline, the headgate drive, the tailgate drive and the shields. Tr. 257. If the entry is rib bolted after it is driven, the bolts have to be cut out when it is widened. *Id.* Referring to the map of the cited area (Gov’t Exh. 27), Grimm maintained that Entry No. 4 was the longwall setup entry, not Entry No. 2. *Id.* Therefore, Entry No. 2 and the cited intersection were not excluded from the requirements of the addendum.

⁴³ Grimm used the term “rib bolt” but stated that he had meant to say “center bolt.” In other words, he meant to say that the company had “72 hours to install a center bolt, which they do with a rib center bolting machine, which is capable of putting rib bolts in also.” Tr. 237. He described a center bolting machine as “a roof bolting machine . . . capable of putting either bolts in the mine roof or mine ribs.” Tr. 238. Grimm did not identify the basis for his belief that Consol had 72 production hours to install the required bolts, but the Court assumed at the time and continues to assume that Grimm was referring to a requirement of the mine’s approved roof and rib bolting plan.

Robert Trozzi disagreed. He maintained that the cited ribs were in a longwall setup entry and that they did not need to be rib bolted. Tr. 707; Gov't Exh. 20 at 4a. Trozzi acknowledged, however, that if the exclusion for the longwall setup entry was not in the rib bolting plan, the missing rib bolts at the intersection would constitute a violation of the plan. Tr. 708.

Because the ribs were in good condition, Grimm did not believe that the alleged violation was S&S. Tr. 273. Nonetheless, in his opinion the condition had existed for at least two weeks and the preshift examiners should have noticed and reported it. Tr. 274. Grimm found that the alleged violation was the result of the company's high negligence. When asked to explain why, Grimm stated that he based his finding on:

[T]he fact that [MSHA inspectors] were continually issuing citations on ribs, on the rib bolting plan, the accidents that were recent, the length of time that [the cited condition] existed and the operator's failure to act and also it's a Rules to Live By standard. . . . [Further,] we were going over the PROP [I]nitiative at that time. All [these] were pieces of the puzzle that just accumulated into . . . high negligence.

Tr. 239-240.

Grimm recommended that the alleged violation be specially assessed because it was "one of the Rules to Live By standards" and Consol had been "made aware of the Rules to Live By campaign and the need for extra steps and vigilance . . . to provide for the safety of the miners." Tr. 277. When Grimm's recommendation for a special assessment was reviewed by his supervisor, the supervisor agreed. The supervisor believed that Consol demonstrated a "high degree of negligence" based on "repetitive violations" of section 75.220(a)(1).⁴⁴ Tr. 279, 281.

THE VIOLATION

Section 75.220(a) requires the operator of an underground coal mine to develop a roof and rib control plan. The intent is to afford comprehensive protection against roof and rib collapse, a leading cause of injuries and deaths in the nation's underground coal mines. *See UMWA v. Dole*, 870 F.2d 662, 669 (D.C. Cir. 1989)). The standard's aim is to create a plan through a collaborative approval and adoptive process with provisions understood by both the Secretary and the operator. Moreover, "[A]fter a plan has been implemented (. . . gone through the adoption/approval process) it should not be presumed lightly that terms in the plan do not have an agreed upon meaning." *Jim Walter Resources, Inc.*, 9 FMSHRC 903, 907 (May 1987) (quoting *Penn Allegh Coal Co.*, 3 FMSHRC 2767, 2770 (Dec. 1981). In order to prove a violation of a mine plan provision, the Secretary, "must first establish that the provision allegedly violated is part of the approved and adopted plan. *Jim Walter*, 9 FMSHRC at 907

⁴⁴ Counsel for the Secretary advised the Court that if the alleged violation had not been specially assessed, a penalty of \$687 would have been proposed. The special assessment amount was \$1,900, almost three times as much. Tr. 280-281.

[He] must then prove that the cited condition or practice violated the provision.” *Harlan Cumberland Coal Co.*, 20 FMSHRC 1275, 1280 (Dec. 1998).

Much testimony was offered regarding the alleged violation, a substantial amount of which the Court found confusing and/or not on point. None the less, the issues are clear to the Court. The citation states that Consol, “failed to follow . . . page 4a, paragraph 4, of the mine[s] approved roof control plan requiring [that] areas where crosscuts will be turned will be identified with flagging to warn workers of rib areas not rib bolted on initial mining.” Gov’t Exh. 23. As previously noted, paragraph 4 of the mine’s “Rib Bolting Plan for Continuous Miners” was approved by MSHA as an addendum to the mine’s roof control plan. Gov’t Exh. 20 at 4a; *see* Tr. 232-233. Once adopted by Consol and approved by the Secretary, the company was required to comply with the addendum. The question is whether the Secretary proved the company violated the plan as the Secretary charged.

To reiterate, Paragraph 4 states:

Area[s] where crosscuts will be turned will be identified with flagging to warn workers of rib areas not rib bolted on initial mining. Any area[s] not rib bolted on initial mining, such as areas where cross cuts are mined through or [where] the distance inby or outby are not within standard cycle of every other roof strap will be bolted when the miner rib bolter or other rib bolter can be utilized. ([A]s noted in #1 statement.)[.]

Gov’t Exh. 20 at 4a.

The citation alleges that, “The left inby and outby corners of the #2 entry, 8 block intersection on the 14 W longwall set up section, . . . which were previously mined are not flagged to warn miners of unbolted mine ribs.” Gov’t Exh. 23. The citation clearly and specifically charges that the provision of the plan that Consol failed to follow is the first sentence of paragraph 4: “Areas where crosscuts will be turned will be identified with flagging to warn workers of rib areas not rib bolted on initial mining.” It is undisputed that there was no flagging in the cited area. It also is undisputed that the left inby and outby corners of the No. 2 entry were not rib bolted. The existence of the violation as described in the body of the citation thus turns on whether or not the Secretary established the cited corners were in an area “where crosscuts will be turned.” *Id.* He did not. The weight of the testimony is that in the cited area there was no crosscut to be turned. A review of Grimm’s testimony fails to reveal one instance in which he maintained there was such a crosscut. Nor did any other of the Secretary’s witnesses testify the cited ribs were located “where [a crosscut] will be turned.” Gov’t Exh. 20 at 4a. But this does not end the matter.

Although the body of the citation does not describe a violation of the second sentence of paragraph 4, Grimm did through his testimony. He stated that among the reasons he issued the citation was the fact that the inby and outby cited corners were not “rib bolted at [the subject] intersection.” Tr. 235. In Grimm’s opinion, the company simply neglected to properly place the

missing bolts when it initially bolted the ribs. Grimm recognized paragraph 4 did not specify a specific time when the company had to come back and install the missing bolts, but Grimm maintained that the condition existed for at least two weeks and during that time the company could have come back and corrected its initial error. He noted that the company rib bolted all of the other ribs required to be bolted on the section and that it was mining in by the cited corner. Tr. 236, 239.

Consol did not object to Grimm's testimonial expansion of the alleged violation, and far from claiming it was prejudiced by the allegation, the company responded with its own testimonial evidence. Nieman acknowledged the cited corners had to be rib bolted (Tr. 396) and Trozzi essentially agreed. Tr. 708. Therefore, the Court concludes that although the issue of whether Consol violated the second sentence of paragraph 4 was not charged in the body of the citation, it was admitted as an issue during the trial, and it is before the Court.

The Court finds that Grimm was right when he maintained that during the time between when the ribs were initially bolted and the citation was issued, the company should have installed the missing bolts. Grimm persuasively testified that the center bolter passed the area once and maybe twice. Tr. 303. The company could have and should have installed the missing bolts using the center bolter. Tr. 303. Neiman agreed. Tr. 387. Once left unbolted, the addendum required the cited ribs to be bolted within a reasonable time. By failing to bolt the ribs when it had the opportunity to do so, Consol violated the second sentence of paragraph 4 of the addendum and therefore violated section 75.220(a)(1).⁴⁵

GRAVITY

Even though bolts were missing on both sides of the entry, the ribs in the cited area were in good condition. Tr. 273, 333. Grimm did not think that the violation was serious (Gov't Exh. 23), and the Court agrees. *See also* Jnt. Exh 1, Stip. 20.

NEGLIGENCE

Grimm found that the violation was due to Consol's high negligence. Gov't Exh. 23. Grimm testified that he made the finding based on several factors. He stated that he considered

⁴⁵ The Court rejects any suggestion that compliance with the rib bolting plan was not required at the cited intersection because the No. 2 Entry was a "longwall setup entry" and therefore was specifically excluded from the requirements of the addendum by paragraph 1.C. ("The following areas are not included in this plan; longwall setup entries . . . unless conditions warrant rib bolting at the time of initial mining." Gov't Exh. 20 at 4a.) The Court accepts Grimm's sensible explanation that a longwall setup entry is the entry in which the longwall equipment is assembled (Tr. 256-257) and that such an entry is excluded because if it is required to be rib bolted, the bolts subsequently have to be cut out. Tr. 257. In the situation at hand, while the No. 2 Entry may have been part of the longwall setup section (*i.e.* the section on which the longwall was assembled), it was not the entry in which the longwall was assembled, and ribs in the No. 2 Entry were not excluded by the plan. *See* Tr. 256.

the two prior rib fall accidents, the fact that the violation existed for up to two weeks, and the fact that Consol knew MSHA was highlighting the need for enhanced rib control through its Rules to Live By and PROP Initiative. Tr. 239-240. While Grimm was correct in considering these factors, the Court finds that he also should have considered two significant mitigating circumstances. First, the extent of the violation was very limited. It was restricted to the ribs at the corners of one intersection in one entry. There were many other intersections and entries on the section and all of them were properly bolted. Second, the cited ribs were in good condition. Tr. 273-274. There was nothing about their condition to call out to a pre-shift and on-shift examiner that they might harbor a violation. Tr. 274. Thus, while there is no doubt the missing bolts should have been detected and installed, the conditions under which they were missing did not make their lack especially noticeable to mine management personnel or management's agents who traveled and examined the area. In other words, the missing bolts were very easy to miss. The Court concludes that Consol's negligence was moderate.

<u>CITATION NO.</u>	<u>DATE</u>	<u>30 CFR</u>
8025562	7/26/2010	§75.220(a)(1)

The citation states:

The operator failed to follow page 4(a), of the mine[']s approved roof control plan requiring areas where crosscuts will be turned [to] be identified with flagging to warn workers of rib areas not rib bolted on initial mining. The solid side rib of 45 block, #3 entry of the 17 W section, MMU 068-0, is not rib bolted or flagged for a measured distance of 19 feet. This condition has been cited 3 times within 7 days at this mine. Future violations of this condition may be looked at with a higher degree of negligence.

This standard was cited 31 times in two years at this mine.

Gov't Exh. 29.

Grimm testified that on July 26, 2010, he returned to the mine to survey the level of noise on the 17W section. Tr. 294. When he went underground he was accompanied by the company representative, Douglas Moyer, and the miners' representative, Hugh Nieman.⁴⁶ *Id.*

During the inspection Grimm issued Citation No. 8025562. Tr. 295; Gov't Exh. 29. He did so because he saw that a rib in the No. 3 entry on the 17W Section was not rib bolted for 19

⁴⁶ Nieman started working at the mine in 1981. Tr. 379. He estimated that he had about 20 years of experience setting up longwalls. Tr. 383. Nieman also worked as a roof and rib bolter, and at the time of the inspection, Nieman was working as a timberer building cribs and carrying out other tasks involving roof support. TR. 380

feet and the rib was not flagged. Tr. 295. Grimm described the cited area as a face area when it was driven. Tr. 300. As such, the area could not be accessed by the rib bolting mechanism on the continuous mining machine. Tr. 300-301. Therefore, after the continuous mining machine “pull[ed] out” leaving the area unbolted, the area “need[ed] to be flagged and then it need[ed] to be bolted with the center bolting machine.” Tr. 301. Grimm believed the operators of the center rib bolting machine had “a couple of different opportunities to install . . . [bolts in the area] over a . . . lengthy period of time” but failed to do so. Tr. 302; *see also* Tr. 303. In addition, Grimm maintained that after mining progressed on the section, it became possible for the continuous mining machine to return and rib bolt the area. Grimm contended the machine actually passed the area once, but did not install the missing bolt. Tr. 304.

Grimm found that in failing to bolt the rib, the company exhibited “high” negligence. Gov’t Exh. 29, Tr. 296-298. Although the rib was unbolted for only 19 feet, Grimm did not find that the company’s negligence was mitigated. Tr. 296-298.

It’s not a large area. However . . . with the accidents, with the PROP Initiative, with the safety talks, with the violations and talking to the operator, doing everything that I could get done, they were not taking it seriously.

Tr. 305-306.

Moyer, the company safety escort who traveled with Grimm, described the cited area as a “solid wall . . . [that] looked like . . . [it] was missing rib bolts.” ⁴⁷ Tr. 733. Nieman, the miners’ representative, also noted the missing bolt. There was, he stated, “an area of rib that wasn’t supported for . . . I think . . . 19 feet, no flagging and it was just . . . a violation.” Tr. 386. *see also* Tr. 738. Although the condition was abated by flagging, Moyer stated that “per the plan . . . we probably should’ve abated it with a bolt.” *Id.* Moyer noted that flagging was not needed in the area because, “It’s just a solid face.” Tr. 735.

Moyer did not recall speaking with Grimm about the plan’s rib bolting and flagging requirements. Tr. 735-736. Nor did he know how long the rib bolt was missing. Tr. 737. However, the parties stipulated the cited area was mined on July 16, 2010. Stip. 18. Grimm noted the period of time that had passed since the entry was mined. Tr. 304-305. He testified that if the mine had been working on its typical six days a week schedule, the cited area would have been subject to approximately 18 pre-shift/on-shift examinations before Grimm’s inspection. Tr. 305. Nieman believed the area was subject to even more scrutiny. He testified, “[A] fire boss goes there every two hours, so . . . in 10 days, you had a qualified person walk by there at least 100 times and no effort was made to either flag it or bolt it.”⁴⁸ Tr. 386.

⁴⁷ Moyer used the plural, “bolts,” but later confirmed that only one rib bolt was missing. Tr. 734.

⁴⁸ Robert Trozzi had another view. He testified that after the area was mined and before the citation was issued, the area would have been subject to a total of approximately 30 pre-shift (continued...)

Grimm recommended that the alleged violation be specially assessed because he “could not get it through to [Consol] how important it was that they comply with the rib control plan It just was not happening. I had to continually use whatever tools I could to get them to come into compliance. . . . I upped the negligence. I did as much as I could.” Tr. 315-316. He added, “I had to do whatever I had to do to ensure the safety of the miners, and to pull out all of the stops other than issuing each [alleged violation] as a [section 104] (d)(2) order and it was getting close to having to do that.”⁴⁹ Tr. 316. However, echoing Trozzi, Grimm agreed that although the area in which the condition existed would have been preshift and onshift examined, the examiners would have been looking for hazardous conditions and the cited condition was not dangerous. Tr. 328. Nonetheless, the fact that the rib bolting plan recently was added to the roof control plan meant to Grimm that the rib bolting plan “should have been fresh on everyone’s [mind.]” Tr. 306. He added, “when something’s added to the roof control plan, prior to being implemented, that part of the plan has to be gone over by everyone associated with either making examinations or working with that plan, including . . . anybody installing the rib bolts[.]” *Id.*

THE VIOLATION

The parties stipulated that the violation of section 75.220(a)(1) occurred as charged. Stip. 14.

GRAVITY

Grimm found that the violation was not S&S and that it was unlikely that an accident resulting in lost workdays or restricted duty would occur as a result of the missing bolt. Gov’t Exh. 29. Grimm explained that it was not reasonably likely the rib would have deteriorated and fallen because “at the time of the inspection the rib was solid. It did not show any deterioration.”

⁴⁸(...continued)

and on-shift examinations. Stip.18; *see also* Tr. 718, 720. Moreover, Trozzi observed that when the citation was issued, pre-shift and on-shift examiners were required to look for “hazardous” conditions, and he suggested a “non-S&S citation on a rib” would not be a hazard and therefore might not be noted during an examination. Tr. 719.

⁴⁹ Grimm’s testimony reflected a statement he wrote on MSHA’s Special Assessment Review Form, to wit:

This violation is one of the rules to live by standards.
The operator has been made aware of the rules to live
by campaign and the need for heightened awareness
to comply on their behalf to provide for the safety of
the miners. This condition has been cited 3 times in
7 days at this mine and a conference was held with mine
management on 7-[22]-2010 concerning this practice.

Exh. R-19.

Tr. 333. In fact, Grimm agreed that the cited condition was so devoid of danger that it was “probably not a hazard.” Tr. 328. The Court finds that the violation was not serious.

NEGLIGENCE

Grimm’s finding that the violation was due to Consol’s high negligence cannot be sustained. The Secretary defines “high negligence” as, “The operator knew or should have known of the violative condition . . . and there are no mitigating circumstances.” 30 C.F.R. § 100.3. In the Court’s opinion the record establishes a “mitigating circumstance,” one that has been recognized over and over. For example, the Commisison’s Chief Judge, Robert Lesnick, has quoted two well known commentators as stating: “The amount of care demanded by the standard of reasonable conduct must be in proportion to the apparent risk. As the danger becomes greater the actor is required to exercise caution commensurate with it.” W. Page Keeton, *et al*, *Prosser and Keeton on the Law of Torts* § 34 at 205 (5th ed. 1084) (*quoted in PBS Coals, Inc.*, 30 FMSHRC 1087, 1093 (Nov. 2008)). Here, where one rib bolt was missing in a solid rib that showed no sign of deterioration (Tr. 333), the duty of care was lower than it would have been had more bolts been missing and/or had the rib shown signs of failing. In the Court’s view, the minimal gravity of the violation – and the Court again notes Grimm’s agreement that the cited condition “[p]robably was not” a hazard (Tr. 328) – constituted a significant mitigating circumstance that lessened Consol’s duty of care. Therefore, under the Secretary’s own definition of “high” negligence, Consol’s failure to note and correct the single missing bolt did not rise to that level. 30 C.F.R. § 100.3.

The Court finds that the company exhibited moderate negligence. In making this finding the Court recognizes that the area in which the violation existed was visited by agents of the operator on numerous occasions and that despite this, the missing bolt was not detected and installed. The Court also recognizes that the company had been warned by the inspector that it “didn’t have forever to bolt [the ribs] in . . . places” like the one cited. Tr. 315. Moreover, the Court is cognizant of the fact that the violation was cited against a backdrop of two recent rib fall accidents at the mine and heightened emphasis by MSHA on the need for compliance with the dictates of the roof control plan as it related to the ribs. But even given these factors, the Court cannot divorce its finding from the particular facts of the violation and when, as here, those facts unquestionable establish that the violation was of a minimally hazardous nature, the Court cannot conclude that Consol’s duty of care was unmitigated and high.

REMAINING CIVIL PENALTY CRITERIA

SIZE OF THE OPERATOR

Neither party disputes that Exhibit A of the Secretary’s Proposed Assessment form indicates that the Blacksville No. 2 Mine is a large mine and Consol is a large operator. Gov’t Exh. 3, Exh. A; *see* 30 C.F.R. §100.3(b).

HISTORY OF PREVIOUS VIOLATIONS

Although the parties stipulate that the “Secretary’s Assessed Violation History Reports are authentic, and accurately reflect the history of violations at [the mine] during the time period that Consol operated . . . [the mine.]” (Stip. 9), beyond the stipulation the situation with regard to the company’s applicable history of previous violations is murky.

Concerning the violation of section 75.202(a) set forth in Order No 8025378, the Secretary argues that Consol “was assessed 705 violations over 1,174 inspection days.” Sec. Br. 79. The Secretary refers the Court to Exhibit A of his Petition for Assessment of Civil Penalty. *Id.* Exhibit A is Part of Government Exhibit 3. Exhibit A indeed indicates that in the 15 months prior to June 22, 2010, there were 705 assessed violations that had been paid, finally adjudicated or otherwise had become final orders at the mine and that they were cited during 1174 inspection days over the same period. *See* Gov’t Exh. 3, Exh. A. The Secretary also asserts that “[o]f those violations, 19 were repeat violations of [section] 75.202(a).” Sec. Br. 79. The Secretary further states that this “significant [number] of repeat violations [counsels] in favor of the Secretary’s proposed penalty assessment.” Sec. Br. 80. Exhibit A is not helpful in affirming the Secretary’s allegations with regard to the alleged repeat violations. It states “Special Assessment - See attached Narrative.” Gov’t Exh. 3, Exh. A. The Narrative, however, says nothing about “repeat violations.” The Secretary offers no citation for his assertion that the company had 19 repeat violations of section 75.202(a) in the 15 months between March 22, 2009 and June 22, 2010. However, the parties stipulated that the violation history reports (Gov’t Exh. 4, 5 and 6) are accurate. When the Court reviews the reports it finds that Government Exhibit 6, the last dated report, showed 21 violations of section 75.202(a) that occurred at the mine between March 22, 2009 and June 22, 2010. As best as the Court can determine, this represents a small, not large, number of repeat violations of section 75.202(a). 30 C.F.R. §100.3(c)(2). Based on these documents and on the Secretary’s penalty regulations as set forth in 30 C.F.R. § 100.3(a), the Court finds that Consol has a large overall history of previous violations and a small history of repeat violations of section 75.202(a). 30 C.F.R. 100.3(c)(1); 30 C.F.R. §100.3(c)(2).

With regard to the previous history concerning Citation No. 8025516 cited on July 21, 2010, Exhibit A indicates that 687 violations were cited at the mine over 1163 inspection days in the 15 months between April 21, 2010 and July 21, 2010 and Government Exhibit 7 indicates that during the same period of time there were 16 final violations of section 75.220(a) cited between April 21, 2009 and July 21, 2010. Gov’t Exh. 3 at 5 (Exh. A); Gov’t Exh. 7. Based on the Secretary’s regulations the Court concludes this represents a large overall history of previous violations and a small history of repeat violations of section 75.220(a).

Finally, with regard to the previous history concerning Citation No. 8025562 cited on July 26, 2010, Exhibit A indicates that 670 violations were cited at the mine over 1160 inspection days between April 26, 2009 and April 26, 2010, and Government Exhibit 7 indicates that during the same period of time there were 15 final violations of section 75.220(a) cited. Gov’t Exh. 3 at 5 (Exh. A); Gov’t Exh. 7. Based on the Secretary’s regulations, the Court

concludes this represents a large history of previous violations and a small history of repeat violations of section 75.220(a). 30 C.F.R. §§100.3(c)(1), 100.3(c)(2).⁵⁰

GOOD FAITH ABATEMENT

The parties stipulated that Consol demonstrated good faith in abatement of the alleged violations, and the Court so finds. Stip. 8.

ABILITY TO CONTINUE IN BUSINESS

The parties stipulated that Consol's payment of the total proposed civil penalty would not affect the company's ability to remain in business. Stip. 10. Given that the total payment of the civil penalty the Court will assess is less than that proposed, the Court concludes that the total payment will not affect the company's ability to continue in business.

PENALTY ASSESSMENTS

<u>ORDER NO.</u>	<u>DATE</u>	<u>30 CFR</u>	<u>PROPOSED ASSESSMENT</u>
8025378	6/22/2010	§75.202(a)	\$50,700

The Court has found that the violation was S&S and very serious. It further has found that the violation was due to the company's unwarrantable failure to comply with the standard and that it recklessly disregarded its duty to comply with the standard. These findings, as well as Consol's large size and the fact that the penalty assessed will not affect its ability to continue in business, lend support to the Secretary's proposed assessment. However, the Court also has found that while Consol's overall history of previous violations is large, its repeat violations of section 75.202(a) is small, a factor that in the Court's view warrants a slight reduction of the Secretary's proposed assessment. Accordingly, the Court concludes that a civil penalty of \$47,700 is appropriate.⁵¹

<u>CITATION NO.</u>	<u>DATE</u>	<u>30 CFR</u>	<u>PROPOSED ASSESSMENT</u>
8025516	7/21/2010	§75.220(a)(1)	\$1,900

The Court has found that the violation was not serious. It further has found that the violation was due to the company's moderate negligence. The fact that the violation was not serious, that Consol is large in size, that it will not be affected by the penalty assessed and the fact that the mine has a large overall history of previous violations all lend support to the Secretary's proposed assessment. However, the fact that the company's negligence was

⁵⁰ In addition, the Court notes that counsel for Consol established through questioning Inspector Grimm that with regard to the violation of section 75.220(a) cited in Citation No. 8025562, the frequency with which the standard was cited at the mine was below the national average. Tr. 279-280.

⁵¹ The Court views the fact that Consol demonstrated good faith in abating the violation as a neutral factor warranting neither an increase nor a decrease in the assessed penalty.

moderate and the fact that the company has a small history of repeat violations of section 75.220(a)(1) warrant a reduction in the Secretary's proposed assessment. Accordingly, the Court concludes that a civil penalty of \$800.00 is appropriate.⁵²

<u>CITATION NO.</u>	<u>DATE</u>	<u>30 CFR</u>	<u>PROPOSED ASSESSMENT</u>
8025562	7/26/2010	§75.220(a)(1)	\$1,900

The Court has found that the violation was not serious. It further has found that the violation was due to the company's moderate negligence. The fact that the violation was not serious, that Consol is large in size, that it will not be affected by the penalty assessed and the fact that the mine has a large overall history of previous violations all lend support to the Secretary's proposed assessment. However, the fact that the company's negligence was moderate and the fact that the company has a small history of repeat violations of section 75.220(a)(1) warrant a reduction in the Secretary's proposed assessment. Accordingly, the Court concludes that a civil penalty of \$800.00 is appropriate.⁵³

⁵² The Court views the fact that Consol demonstrated good faith in abating the violation as a neutral factor warranting neither an increase nor a decrease in the assessed penalty.

⁵³ The Court views the fact that Consol demonstrated good faith in abating the violation as a neutral factor warranting neither an increase nor a decrease in the assessed penalty.

ORDER

Within 40 days of the date of this decision, Consolidation Coal Company **SHALL PAY** a total civil penalty of \$49,300, and upon payment of the penalty this proceeding **IS DISMISSED**.⁵⁴

/s/ David F. Barbour
David F. Barbour
Administrative Law Judge

Distribution: (Certified Mail)

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⁵⁴ Payment shall be sent to: Mine Safety and Health Administration, U.S. Department of Labor, Payment Office, P.O. Box 790390, St. Louis, MO 63179-0390.