

JANUARY AND FEBRUARY 2008

COMMISSION DECISIONS

There were no decisions by the Commission for January and February

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JANUARY AND FEBRUARY 2008

There were no cases in which REVIEW was either granted or denied.

ADMINISTRATIVE LAW JUDGE DECISIONS

FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

OFFICE OF ADMINISTRATIVE LAW JUDGES
601 New Jersey Avenue, N.W. Suite 9500
Washington, DC 20001-2021

January 10, 2008

CONSOL OF KENTUCKY, INC.	:	CONTEST PROCEEDING
Contestant	:	
v.	:	Docket No. KENT 2007-351-R
	:	Order No. 6643961; 06/25/2007
	:	
SECRETARY OF LABOR,	:	
MINE SAFETY AND HEALTH	:	Mine: Jones Fork E-3
ADMINISTRATION, (MSHA),	:	Mine ID 15-18589
Respondent	:	

DECISION

Appearances: R. Henry Moore, Esq., Jackson Kelly, PLLC, Pittsburgh, Pennsylvania, on behalf of the Contestant;
Mary Sue Taylor, Esq., Office of the Solicitor, U.S. Department of Labor, Nashville, Tennessee, on behalf of the Respondent.

Before: Judge Melick

This case is before me pursuant to section 107(e)(1) of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 801 et seq., the "Act," upon the contest by Consol of Kentucky, Inc., (Consol) of "imminent danger" withdrawal Order No. 6643961 issued to Consol, pursuant to section 107(a) of the Act.¹ The order alleges as follows:

¹ Section 107(a) provides as follows:

If, upon any inspection or investigation of a coal or other mine which is subject to this Act, 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an order requiring the operator of such mine to cause all persons, except those referred to in section 104(c), to be withdrawn from, and to be prohibited from entering, such area until an authorized representative of the Secretary determines that such imminent danger and the conditions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 104 or the proposing of a penalty under section 110.

An explosive atmosphere exists inby 3 North Seals (Seal Set 8), the oxygen content is between 15.1-16.5 percent and methane between 10-12 percent. The 3 North Seals are adjacent to the primary and secondary escapeways for active MMU 002-0 and 004.0 sections. An oral 107(a) imminent danger order was issued to Freddie Crockett, foreman, at 1500 hours on this date.

Randy Newsome, an inspector for the Department of Labor's Mine Safety and Health Administration (MSHA), issued the subject order on June 25, 2007. Newsome is a registered professional mine engineer and has industry experience in underground mining as a section boss and project engineer. Newsome was directed by his supervisor, Garrett Robinson, to perform a spot inspection of the seals at the subject mine. The inspection was the result of an emergency temporary standard (ETS) issued by MSHA.²

The particular issue herein involves seal set No. 8. The No. 8 set is one of three sets of seals that separate part of the northern portion of the mine from the active workings of the mine. There are six seals in the set. One of the seals has a sampling pipe that extends 15 feet behind the seal. These seals were built in June 2006 under 30 C.F.R. 75.335(a) (2006). Once an area is sealed no ventilation is provided to that area. It is expected that the atmosphere behind the seals will become inert as methane levels rise above the explosive range and oxygen levels fall below that range. However, the area immediately inby the seals may, on occasion, contain lower levels of methane than generally present throughout the sealed area because of leakage across the seals from the active areas.

² Following the Sago and Darby mine disasters, where miners were killed as a result of methane explosions originating in sealed areas of mines, MSHA acted to require mine operators to monitor the atmosphere in such areas and to address potentially hazardous conditions. MSHA issued Program Policy Bulletin No. P06, on July 19, 2006, which required operators to assess the atmosphere behind alternative seals, and to take remedial action if concentrations of methane from 3 percent to 20 percent were present. On May 22, 2007, MSHA issued an ETS, pursuant to section 101(b) of the Act. 72 FR 28796-28817 (May 22, 2007). The ETS, which became effective upon publication, amended 30 C.F.R. § 75.335, by increasing strength requirements for newly constructed seals. It also required mine operators to develop and submit for approval protocols for monitoring and maintaining inert the atmosphere in sealed areas where the seals were not constructed to withstand 120 psi of overpressure.

The ETS further provided:

(4) When oxygen concentrations are 10.0 percent or greater and methane concentrations are from 3.0 percent to 20.0 percent in a sealed area, the mine operator shall take two additional gas samples at one-hour intervals. If the two additional gas samples are from 3.0 percent to 20.0 percent and oxygen is 10.0 percent or greater – (i) The mine operator shall implement the action plan in the protocol; or (ii) Persons shall be withdrawn from the affected area, except those persons referred to in section 104(c) of the Act.

The Jones Fork Mine at issue liberates approximately 1.4 million cubic feet of methane per day. Without ventilation in the sealed area, the methane levels in the sealed area continue to rise above the upper explosive limit and the oxygen levels decrease past levels that would support an ignition of methane. The explosive range of methane in a normal atmosphere is 5-15%. Above 15% methane is not explosive in a normal atmosphere containing 20.5% oxygen. The level of oxygen necessary to support a methane ignition is 12%. As methane approaches the upper explosive limit and oxygen approaches the 12% level, the mixture of air becomes less susceptible to ignition.

The seals that were constructed in the No. 8 set are solid concrete block seals known as Mitchell-Barrett seals. They are "hitched" into the ribs and floor in that a notch is cut into the ribs and into the floor to increase the perimeter strength of the seal. There are two cribs in front of and behind each seal in the No. 8 set to provide additional roof support in the areas of the seals. Each seal also has a pilaster, which provides support in the middle of the seal. The seals were built in June 2006, following an incident involving a set of alternative omega block seals at a different location in the mine. Once those damaged seals were replaced, Consol constructed new Mitchell-Barrett seals at the Nos. 6,7, and 8 locations consistent with guidelines developed by MSHA expert Clete Stephan.

As previously noted, one seal in each set is required to have a sampling pipe that extends 15 feet into the sealed area. At the No. 8 set, the sampling pipe is at the No. 1 seal. In June 2007, Consol and other operators were required to begin sampling through this pipe behind each set of seals. Leakage at seals may occur through the seals and the surrounding strata. Depending on the barometric pressure as well as other factors in the mine, seals may "ingass" or "outgas." If the seal is ingassing, air from the active portion of the mine leaks into the sealed area. If the seal is outgassing, air from the sealed area leaks into the active portion of the mine.

The ETS requires operators to take samples through the sampling pipe to establish a 14-day baseline. If the seals are ingassing, sampling is not required. The No. 8 seals were outgassing. The results of the baseline sampling for the No. 8 set of seals indicated that the atmosphere immediately behind the seals contained methane above 5% and below 15% and oxygen above 12%. The No. 7 set of seals were ingassing. The methane levels at the No. 8 set of seals were apparently affected by the leakage at the No. 7 set of seals. A thin layer of the leaked air would travel across the most southern of the entries in the sealed area. The rest of the sealed area would remain inert.

Upon arriving at the mine, Inspector Newsome initially met with Mine Superintendent Lloyd Shomo. He informed Mr. Shomo that he would be checking the atmosphere behind the seals. Newsome then reviewed the baseline and seal sampling records from June 15-22, 2007. He observed that on June 18, the No. 8 seals had a methane level of 17% and an oxygen level of 12.4%. These levels fell within the "action range," defined by the ETS as between 3% and 20% for methane and above 10% oxygen. Inspector Newsome discussed this situation with his supervisor, Garrett Robinson, before he went underground. He also informed Mr. Shomo that if his inspection produced results similar to the levels reported on June 18, Shomo would have to withdraw people from the mine or he would issue a "Section 107(a)" order.

Inspector Newsome went to the No. 8 seals, accompanied by Shomo. Chief engineer Jon Hale, engineer Steve Hicks, and mine examiner Joey Sammons were present when Inspector Newsome and Shomo arrived at the No. 8 seals. Between the time Inspector Newsome took his second and third samples, mine foreman Freddie Crockett arrived. Upon arriving at the No. 8 seals on June 25, 2007, Inspector Newsome noted that they were outgassing. He took samples at the sampling pipe with an ATX620 gas detector. He also took a "bag sample" which was sent to MSHA's laboratory for more precise analysis. Newsome observed initial readings from the gas detector at 1:00 p.m. of 11% methane and 16.5% oxygen.

Under the ETS, he was required to take two additional samples, for a total of three, spaced an hour apart, to confirm his initial readings. The samples at around 2:00 p.m. indicated 11% methane and 15.8% oxygen. The samples at around 3:00 p.m. were 12% methane and 15.1% oxygen. Based on these results, Inspector Newsome verbally issued a "Section 107(a)" order. The written order followed and is at issue herein. In concluding that an imminent danger existed, Inspector Newsome testified that he considered the readings indicating what he believed was an explosive mixture of methane and oxygen behind seal set No. 8, that there had been nearby roof falls, that the area behind the No. 8 set of seals was pillared and that there had been lightning the day before somewhere in eastern Kentucky and he speculated that the weather could produce lightning at any time. Newsome also speculated, as part of his rationale, as to the possibility that electrical equipment and cables could have been left in the sealed area and the effect of "human error" in situations involving explosive mixtures.

Section 3(j) of the Act defines "imminent danger" as the "existence of any condition or practice in a coal or other mine which could reasonably be expected to cause death or serious physical harm before such condition or practice can be abated." As previously noted, Section 107(a) of the Act provides for the issuance of an order requiring the withdrawal of persons in areas of a mine who are exposed to such an imminent danger. "Imminent danger orders permit an inspector to remove miners immediately from a dangerous situation, without affording the operator the right of prior review, even where the mine operator did not create the danger and where the danger does not violate the Act or the Secretary's regulations. This is an extraordinary power that is available only when the 'seriousness of the situation demands such immediate action.'" *Utah Power & Light Co.*, 13 FMSHRC 1617, 1622 (October 1991) (quoting from the legislative history of the Federal Coal Mine Health and Safety Act of 1969, the predecessor to the 1977 Act).

An imminent danger exists "when 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." *Wyoming Fuel Co.*, 14 FMSHRC 1282, 1290 (August 1992) (quoting from *Rochester & Pittsburgh Coal Co.*, 11 FMSHRC 2159, 2163 (November 1989)). While the concept of imminent danger is not limited to hazards that pose an immediate danger, "an inspector must 'find that the hazardous condition has a reasonable potential to cause death or serious injury within a short period of time.'" *Cumberland Coal Resources, LP*, 28 FMSHRC 545, 555 (August 2006). Inspectors must determine whether a hazard presents an imminent danger without delay, and a find of an imminent danger must be

supported “unless there is evidence that [the inspector] had abused his discretion or authority.” *Rochester & Pittsburgh Coal Co.*, 11 FMSHRC at 2164.

While an inspector has considerable discretion in determining whether an imminent danger exists, that discretion is not without limits. An inspector must make a reasonable investigation of the facts, under the circumstances, and must make his determination on the basis of the facts known, or reasonably available to him. As the Commission explained in *Island Creek Coal Co.*, 15 FMSHRC 339, 346-347 (March 1993):

While the crucial question in imminent danger cases is whether the inspector abused his discretion or authority, the judge is not required to accept an inspector’s subjective “perception” that an imminent danger existed. Rather, the judge must evaluate whether, given the particular circumstances, it was reasonable for the inspector to conclude that an imminent danger existed. The Secretary still bears the burden of proving [her] case by a preponderance of the evidence. Although an inspector is granted wide discretion because he must act quickly to remove miners from a situation that he believes to be hazardous, the reasonableness of an inspector’s imminent danger finding is subject to subsequent examination at the evidentiary hearing.

An inspector “abuses his discretion...when he orders the immediate withdrawal of miners under section 107(a) in circumstances where there is not an imminent threat to miners.” *Utah, Power & Light Co.*, 13 FMSHRC at 1622-23.

The critical question in determining whether an accumulation of methane presents an imminent danger is whether there is a ignition source that might reasonably be expected to cause an explosion resulting in death or serious injury within a short period of time. In *Island Creek*, the Secretary conceded that explosive accumulations of methane in a longwall gob would create an imminent danger only if an ignition source presented a significant danger. 15 FMSHRC at 347. Similarly, on the related question of whether a methane accumulation hazard presented a reasonable likelihood of an injury causing event, the Commission has focused on the presence of an ignition source. *Texasgulf, Inc.*, 10 FMSHRC 498, 501 (April 1988) (critical question for significant and substantial determination is likelihood of explosive concentrations of methane coming into contact with an ignition source). The Commission has held that statements that certain events “could” occur, are not sufficient to support a finding that there was a reasonable likelihood of an ignition of methane for a significant and substantial determination. *Zeigler Coal Co.*, 15 FMSHRC 949, 953-54 (June 1993).

Within the above framework of law and the evidence of record, I am constrained to find that an imminent danger did not exist and that the issuing inspector abused his discretion in issuing the order at bar considering the facts known, or reasonably available, to him. Indeed, the Secretary’s own expert in explosions and ignitions, Clete Stephan, opined based on the facts presented at hearings by Inspector Newsome, that the potential for an explosion behind the seals was “unlikely” (Tr. 209). Consol’s experts, Mssrs. Fertall and Mucho agreed with Stephan. Specifically, when

asked his opinion of the conditions behind the No. 8 seals, Mr. Stephan testified as follows:

Well, I believe that based on the information [Inspector Newsome] had, that he - he could have correctly made the assumption that an explosive mixture - to what extent he didn't know, but an explosive mixture existed behind those seals. And that just in the unlikely event that those explosive mixtures would have - would have exploded they could have easily compromised the seals (Tr. 209; emphasis added)

Aside from the Secretary's own principal expert witness opining that an ignition was an "unlikely" event, the uncontradicted evidence which should have been known to the issuing inspector, or was reasonably available to him, fully corroborates that opinion. The issuing inspector herein cited several potential sources of methane ignition including lightning and roof falls. As for lightning being a potential source of ignition MSHA's Bleeder and Gob Manual states that from 1959-1994, lightning has been determined to be an ignition source in only two mine explosions (Exh. R-28 p.23). Mr. Stephan also noted that before the Sago mine accident in January 2006, all explosions in sealed areas attributed to lightning had the commonality of having a conduit into the sealed area. Inspector Newsome could not identify any such conduit at the Jones Fork mine. In other words, prior to the Sago accident, there had never been an explosion caused by lightning without a conduit - - and the Jones Fork mine had no conduit to the sealed area.

As for roof falls being a potential source of ignition, the MSHA training manual developed by its experts states that only 0.7% of methane ignitions and explosions in United States mines between 1959 and 1994 could be attributable to roof falls (Exh. R-28 p. 23).³ The training manual concludes that "[c]onsidering that thousands of roof falls occur annually in the United States, the ignition of methane caused by roof falls is unlikely" (Exh. R-28, p. 23). The issuing inspector had been trained on this information and the subject manual was available in his office. Consol's expert, Mr. Mucho, also testified that, historically, roof falls have proven to be highly unlikely sources of ignition. This was especially true according to Mucho where the roof consists of shale as in the sealed areas of the Jones Fork mine

While Inspector Newsome also speculated as potential ignition sources the possible failure of roof supports, the possibility that electrical equipment and cables could have been left in the sealed area and human error, the credible record evidence does not support this speculation. No one was working in the sealed area and speculation that "human error" could cause an imminent danger is so vague as to be without probative value. Moreover, no authoritative studies were presented to support his opinion that roof supports could be a source of ignition of methane. Indeed, according to Mr. Stephan, laboratory testing by the Bureau of Mines would not support such a conclusion. Moreover, Consol's expert, Thomas Mucho, explained that the most recent research showed that the failure of roof support materials in fact cannot generate enough heat to cause an ignition. Finally,

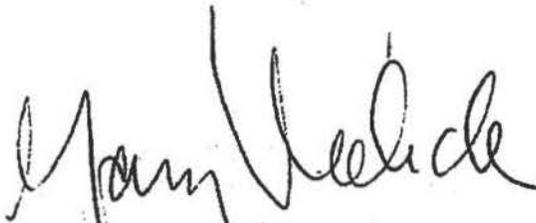
³ In a recent case, an MSHA ventilation expert also essentially conceded that a roof fall was an unlikely ignition source. *Cumberland Coal Resources, LP*, 27 FMSHRC 295, 319-20 (March 2005)(ALJ) (aff'd in part rev. in part, 28 FMSHRC 545 (August 2006)).

there is no credible evidence that any electrical equipment or cables were left in the sealed areas. The only evidence in this regard was from mine Foreman Crockett that, indeed, no electrical equipment was left behind when the areas were sealed. In any event, as previously noted, the Commission has held that such speculative statements that certain events "could" occur are not sufficient to even support a finding that there was a reasonable likelihood of an ignition of methane. *Ziegler*, 15 FMSHRC at 933-4.

Under all the circumstances it is apparent that an actual ignition of the explosive atmosphere behind the seals at issue was, at best, a theoretical possibility. The evidence clearly does not support the issuance of a "section 107(a)" imminent danger order.

ORDER

Order No. 6643961 is hereby vacated.



Gary Melnik
Administrative Law Judge
(202) 434-9977

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/lh

FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION
601 New Jersey Avenue, NW, Suite 9500
Washington, DC 20001-2021

January 10, 2008

SHAWN JOHNSON,	:	DISCRIMINATION PROCEEDING
Complainant	:	
	:	
v.	:	Docket No. WEVA 2007-235-D
	:	HOPE CD 2006-04
	:	
DAVID HUFFMAN TRUCKING INC.	:	No. 10 A Mine
Respondent	:	Mine ID 46-08852 FVV

DECISION

Appearances: Mark L. French, Esq., Criswell & French, PLLC, Charleston, West Virginia, on behalf of the Complainant;
Daniel R. Schuda, Esq., Schuda & Associates, PLLC, Charleston, West Virginia, on behalf of the Respondent.

Before: Judge Melick

This case is before me upon the complaint by Mr. Shawn Johnson pursuant to Section 105(c)(3) of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 801 et seq., the "Act." Following hearings, a decision was issued on August 27, 2007, finding that David Huffman Trucking, Inc., (Huffman Trucking) discharged Mr. Johnson in violation of Section 105(c)(1) of the Act. The parties were directed to confer regarding the possibility of settlement of damages and attorney fees, however, they were unsuccessful and hearings were held on those issues on November 29, 2007. At these hearings, the parties agreed to submit additional information regarding these issues and to again confer regarding possible settlement. On December 11, 2007, counsel for the Complainant submitted additional information regarding the issues and reported that he and counsel for the Respondent were unable to reach any agreement. Huffman Trucking responded on December 20, 2007, and the Complainant filed a rebuttal on December 27, 2007.

Damages

No damages other than back pay (and attorney fees) are claimed by the Complainant. The statutory authority for the award of back pay is derived from Section 105 of the Act, which empowers the Commission to remedy discrimination by such affirmative action to abate the violation as the Commission deems appropriate, including, but not limited to, the rehiring or reinstatement of the miner to his former position with back pay and interest. *Secretary on behalf of Dunmire and Estle v. Northern Coal Company*, 4 FMSHRC 126, 142 (February 1982). Under normal employment circumstances back pay is the sum equal to the gross pay the employee would have earned but for the discrimination less his actual net interim earnings. *Northern Coal Company* at 144.

Mr. Johnson's employment history with Huffman was intermittent as a result of significant absenteeism. The calculation for Johnson's back pay award will therefore be made by taking Mr. Johnson's average gross earnings using the bi-weekly payroll periods of Huffman Trucking. In this regard it is noted that during the 25 two-week pay periods that Johnson was employed by Huffman Trucking, he earned a total of \$21,750.55. This is based upon the payroll summaries for the years 2005 and 2006 for Mr. Johnson reflecting his gross pay as well as information as to each of the individual bi-weekly paychecks received by Mr. Johnson during that period. His average gross pay for each two week period was therefore \$870.02.

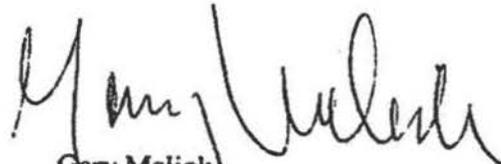
There is no dispute that Mr. Johnson's employment with Huffman Trucking ended on April 14, 2006, and that he left the labor market on January 19, 2007, to become a full time student. During this period he worked for Kenton Meadows Co., Inc. (Kenton Meadows), from July 27, 2006, through January 18, 2007. Johnson's back pay award must therefore be based upon 41 weeks or 20.5 bi-weekly pay periods (less net interim earnings). 20.5 pay periods at \$870.02 equals \$17,835.41. At Kenton Meadows, Johnson worked 804 regular time hours at a rate of \$9.00 per hour and 107.5 overtime hours at a rate of \$13.50 per hour.¹ Accordingly Johnson's interim earnings amounted to \$8,687.25. Johnson is therefore entitled to back pay of \$9,148.16, plus interest paid to the date of payment in accordance with the Commission's decision in *United Mine Workers of America v. Clinchfield Coal Company*, 10 FMSHRC 1493, 1504-1507 (November 1988).

Attorney Fees

For the reasons stated in the memorandum issued this date as an appendix to this decision under seal for privacy reasons, counsel for the Complainant is hereby awarded attorney fees and expenses of \$8,984.09.

ORDER

David Huffman Trucking Inc., is hereby directed to pay to the Complainant Mr. Shawn Johnson within 30 days of the date of this decision back pay of \$9,148.16, plus interest through the date of payment to be calculated in accordance with the Commission decision in *United Mine Workers of America v. Clinchfield Coal Company*, 10 FMSHRC 1493, 1504-1507 (November 1988). In addition, David Huffman Trucking Inc., is directed to pay to Mark L. French, Esq., attorney fees and expenses of \$8,984.09, within 30 days of the date of this decision.


Gary Melick
Administrative Law Judge

¹ It is assumed that the Complainant has correctly provided data to the Commission for his net interim earnings consistent with Commission precedent. See *Northern Coal Company Supra*, at 144.

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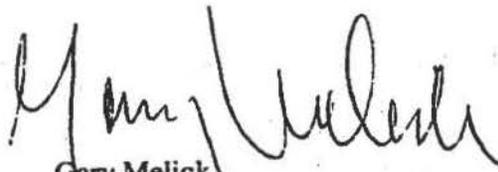
FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION
OFFICE OF ADMINISTRATIVE LAW JUDGES
601 New Jersey Avenue, N.W., Suite 9500
Washington, D.C. 20001

January 14, 2008

BANNER BLUE COAL COMPANY,	:	CONTEST PROCEEDING
Contestant	:	
v.	:	Docket No. VA 2006-57-R
	:	Citation No. 7316850; 09/07/2006
	:	
SECRETARY OF LABOR,	:	
MINE SAFETY AND HEALTH	:	Apollo Mine
ADMINISTRATION (MSHA),	:	Mine ID 44-03317
Respondent	:	

DEFAULT DECISION

On October 4, 2007, a show cause order was issued in this case for the Secretary's failure to respond to an order of the undersigned judge and requiring a response on or before October 26, 2007. To date, no response has been received. Wherefore this contest is granted and Order No. 7316850 is hereby vacated.



Gary Melick
Administrative Law Judge
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FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

OFFICE OF ADMINISTRATIVE LAW JUDGES
601 NEW JERSEY AVENUE, N.W., SUITE 9500
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January 17, 2008

SECRETARY OF LABOR,	:	CIVIL PENALTY PROCEEDING
MINE SAFETY AND HEALTH	:	
ADMINISTRATION (MSHA),	:	Docket No. WEST 2007-124-M
Petitioner	:	A.C. No. 24-01879-101509 R83
	:	
v.	:	
	:	
J.S. REDPATH CORPORATION,	:	East Boulder Mine
Respondent	:	

DECISION

Appearances: John Rainwater, Esq., U.S. Department of Labor, Denver, CO, on behalf of the
Petitioner
Karen L. Johnston, Esq., Jackson Kelly PLLC, Denver, CO, on behalf of the
Respondent

Before: Judge Barbour

This is a civil penalty proceeding brought pursuant to sections 105 and 110 of the Federal Mine Safety and Health Act of 1977 ("Mine Act or Act") (30 U.S.C. §§ 815, 820). The Secretary of Labor ("Secretary"), on behalf of her Mine Safety and Health Administration (MSHA), petitions for the assessment of civil penalties for an alleged violation of a reporting standard, a standard applicable to all mine operators, and for an alleged violation of a safety standard, a standard applicable to underground metal and nonmetal mine operators. The alleged violations are set forth in citations issued pursuant to section 104(a) of the Mine Act. 30 U.S.C. § 814(a).¹

¹Section 104(a) states in pertinent part:

If, upon inspection or investigation, the Secretary or his authorized representative believes that an operator of a . . . mine subject to this Act has violated . . . any mandatory health or safety standard . . . or regulation promulgated pursuant to this Act, he shall, with reasonable promptness, issue a citation to the operator.

In the first citation, the Respondent, J.S. Redpath Corporation (“Redpath”), is charged with a violation of 30 C.F.R. § 50.10, for failing to “immediately contact . . . MSHA” after “an accident occur[red].”² In the second citation, the company is charged with a violation of 30 C.F.R. § 57.14100(b) for failing to “[correct] in a timely manner” a defective mine telephone.³ The Secretary further charges the violations were unlikely to result in injuries and that they were caused by Redpath’s moderate negligence.

The allegations regarding the asserted late reporting of the alleged accident arose out of an incident involving a delay in two of Redpath’s miners coming down and out of a raise in the East Boulder Mine, an underground palladium, platinum, and iridium mine (Tr. 150) owned by Stillwater Mining Company and located in Sweet Grass County, Montana.⁴ The allegations regarding the telephone arose out of the non-functioning state of the telephone’s speaker located near the bottom of the same raise. Following the issuance of the citations – and as required by the Act – the Secretary assessed a civil penalty for each alleged violation. 30 U.S.C. § 110(a). Redpath contested the proposed assessments, the Secretary notified the Commission of the contest, and the case was assigned to me. It was heard on July 11, 2007. 30 U.S.C. § 105(d).

STIPULATIONS

Prior to going on the record the parties agreed to the following stipulations:

1. At all times relevant to this proceeding, Redpath was an independent contractor performing services at the East Boulder Mine . . . and is therefore an “operator” as defined by Section 3(d) of the . . . [Mine Act]

²Section 50.10 states in pertinent part:

If an accident occurs, an operator shall immediately contact the MSHA District Office having jurisdiction over its mine.

³Section 57.14100(b) stated in pertinent part:

Defects on any equipment . . . that affect safety shall be corrected in a timely manner to prevent the creation of a hazard to persons.

⁴A “raise” is defined as: “A vertical or inclined opening in a mine driven upward from a level to connect with the level above.” American Geological Institute, *Dictionary of Mining, Mineral, and Related Terms* 443 (2d ed.1997).

2. At all times relevant to this proceeding, Redpath was an independent contractor performing services at the East Boulder Mine, and its mining services affect interstate commerce.^[5]
3. Redpath is subject to the jurisdiction of the Mine Act.
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 Redpath on the dates and places stated therein and may be admitted into evidence for the purpose of establishing their issuance, and not for the truthfulness or relevancy of any statements asserted therein.
6. The exhibits . . . offered by Redpath 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. Redpath demonstrated good faith in abating the violations.
8. On August 8, 2006, Redpath was driving a ventilation raise at the Stillwater Mine (the "Brownlee Raise").^[6]
9. On August 8, 2006, the length of the Brownlee Raise was approximately 1600 feet.
10. The Brownlee Raise was round, with a nominal diameter of 11 feet, 3 inches.
11. When completed, the Brownlee Raise was 1635 feet in length and, at that time, was the longest . . . ventilation raise in the world driven by air-powered raise climbers, such as those used by Redpath. [*See also* Tr. 217.]

⁵Terrence ("Terry") Cook, Redpath's project superintendent, described Redpath as one of mining's "premier companies." Tr. 210. The company, which is based in Canada, has had construction projects involving approximately 60 raises all over the world. However, until recently, the company has had only a few construction projects in the United States. Tr. 211.

⁶Work on the raise began in October 2005, and the raise was completed on August 22, 2006. Tr. 217. Once finished, the raise connected an underground portion of the mine with the surface.

12. The primary raise climber in use on August 8, 2006, was a double drive unit with three motors.
13. The secondary raise climber in use on August 8, 2006, was a double drive unit with three motors.
14. The Alicab rescue unit was available for use on August 8, 2006, as a backup unit in the event of an emergency.
15. Redpath Project Manager, Mark Ahlborn, reported the incident at issue in Citation No. 6323250 [the incident involving the delay,] to MSHA's Rocky Mountain District Office on August 9, 2006, at approximately 8:00 a.m.
16. In the event that the Secretary proves an accident occurred as alleged in Citation No. 6323250, then Redpath stipulates that it did not provide immediate notification of the accident to MSHA.
17. There was a mine phone physically present in the Redpath work area located at the bottom of the Brownlee ventilation raise ("the nest") on August 29, 2006.
18. The mine phone referenced . . . [immediately above] had a speaker attachment that allowed for [oral] messages to be broadcast in the nest.

Joint Exh. 1; Tr. 7-10.

The parties also stipulated a civil penalty of \$60 is appropriate for any violation(s) found. Tr. 205.

THE RAISE CLIMBER AND ITS BRAKING SYSTEMS

Joseph ("Joe") Macias is Redpath's lead raise miner at the East Boulder Mine. At the time of the hearing, Macias had worked for Redpath for over two years and had been a lead raise miner for approximately a year and a half. Tr. 25. On August 7 and 8, 2006, his duties were "to make sure all . . . equipment [was] running properly." Tr. 26-27. Also, he was responsible for ensuring "communication[s] were understood and production [was] done safely." Tr. 27. As the lead raise miner, Macias was authorized to direct work while in the raise.⁷ Macias was

⁷Terry Cook, who trained Macias, described Macias as possessing "excellent leadership qualities" (Tr. 216) and as a miner with a good safety record. Tr. 217.

responsible for his and his co-workers' safety. Two other miners usually worked with him in the Brownlee Raise, but Macias was the person in charge. On August 7, his shift began at 7:00 p.m. and continued past midnight on August 8. Tr. 27-28.

Macias described the Brownlee Raise as a "[v]entilation raise" or shaft used to bring air out of the mine. Redpath specialized in the construction of such raises. Most ranged from 500 feet to 800 feet in length. Tr. 29. However – and as the stipulation states – the Brownlee Raise was to be 1635 feet long when measured from the mine floor to the surface. Tr. 28; Stip. 11.

The raise was being driven from the mine floor upward. Connected to the raise shaft was an area called the "nest." The "nest" was where equipment used in the construction of the raise was kept. The "nest" was located about 60 feet from where the raise began its vertical ascent toward the surface.⁸ Tr. 30. On August 8, the raise had been driven approximately 1600 feet up from the bottom and had approximately 35 more feet to go to reach the surface. Tr. 30-31.

Miners constructed the raise while working in a "raise climber" or "climber." As described by Macias, the raise climber consisted of several parts. One part was the "man basket" or cage. A miner or miners occupied the man basket as the climber moved up the raise. The raise climber moved on sprockets that slid into a rail or track running along the wall of the raise. As the raise moved upward, the rail was extended. Tr. 30, 97; *see* Resp. Exh. 3.

When not in use, the climber was kept in the nest in a horizontal position. Tr. 33-34; *see* Gov't Exh. 1. When in use, the climber moved out of the nest into the bottom of the raise where the climber swung to a vertical position. Tr. 34. A miner or miners entered the man basket in the nest. At first, the miner or miners were in a horizontal position, but they swung to a vertical position as the climber rotated after entering the raise. Tr. 34-35.

The climber was "powered" by compressed air. The air was pumped to the climber's motors through a hose, the "bull hose," that served to connect the climber and the mine floor compressor. The bull hose was stored in a roll located on the raise climber. Tr. 36-37; Resp. Exh. 3. The hose also supplied air to the climber's braking system. The hose had a flexible metal cable inside it. The cable helped to keep the hose open by restricting its tendency to close when the hose was stretched as the climber moved up the raise. Tr. 61; *see also* Tr. 220.

A circular work deck was located above the cage. The deck was reached by a miner climbing up and through an opening in the deck once the climber reached its designated work elevation. Above the deck was a grate-like canopy. The canopy was round (about 7 feet in diameter), and it was supported by four posts. The canopy protected miners from falling materials. Tr. 37-38, 50-51; *see* Resp. Exh. 3. Once on the work deck, the miners operated drills

⁸The nest had to be located some distance from the bottom of the raise because of construction noise and because, as Marcias explained, "[w]hen you blast [in the raise], the waste comes straight down . . . and settles at the bottom." Tr. 31.

and other equipment through openings in the canopy's grate. Tr. 50-51.

To ascend the raise, a miner in the basket pulled a hand lever. Macias called it a "plunger." The plunger allowed compressed air to flow through the climber's hoses. The compressed air activated the climber's motors. The compressed air was supplied by the compressor located in the nest and traveled to the hoses leading to the motors via the bull hose. As compressed air was applied to the motors, the motors drove the climber up the rail. Tr. 41-42

Macias explained there were multiple braking systems on the raise climber. There were two air-powered centrifugal brakes that were engaged by pulling a hand brake lever or by activating a foot brake. In addition, there was an emergency brake, the G-5 brake. The hand and foot brakes could control the rate of descent even if air to the raise climber was cut off. Tr. 41. In that case, the climber descended due to gravity (a "controlled descent" or a "free wheel descent") and the brakes could be used to slow it. Tr. 46-47. Under these circumstances, if the climber descended at too great a speed, the G-5 brake was automatically engaged. Tr. 45, 98.

THE EVENTS OF AUGUST 7 AND 8

On August 7, Macias was working with Dan Elliott, another raise miner. Tr. 42-43. Macias began his workday by inspecting the raise climber for wear and tear. Next, he checked to determine if he needed equipment and supplies. *Id.* When everything appeared in order, Macias and Elliott climbed in the raise climber's basket. The climber moved out of the nest and past the curve. At the bottom of the raise, the climber lifted to a vertical position and began its ascent. As it moved up the raise, Macias and Elliott inspected the rail and the walls for signs of damage from prior blasts.⁹ Tr. 43-44, 48. Judging from past ascents, Macias believed reaching the top of the raise would take between 50 minutes to two hours. It depended on whether he and Elliott needed to stop and make repairs to the rail as they moved up. Tr. 43-44; *see also* Tr. 48-49. As the climber ascended, Macias did not notice any problems with the climber's bull hose. In addition, the climber's motors operated as usual. Tr. 49.

Upon reaching the top of the raise, Macias and Elliott scaled loose material off the face of the raise and off of the ribs. The face was advanced four to eight feet by each blast. To cover the distance the face advanced after the most recent blast, the miners installed another section of rail. The new rail allowed the raise climber to keep pace with the advancing face. Tr. 50.

The miners now were approximately 1600 feet above the floor of the raise. Tr. 49-50. The bull hose was hanging from the climber to the mine floor. Tr. 61. After the miners bolted the rail in place, they scaled the face of the raise and then drilled into the face and installed bolts and some wire mesh. The mesh covered parts of the face. Tr. 51-52. The mesh was intended to hold loose material so it wouldn't fall on any miners working below. Tr. 52.

⁹The raise was excavated by explosives.

At first, when Macias and Elliott scaled the face, not much loose material fell, and that which did was small in size. However, it soon became obvious to the men that larger pieces of rock were loose. Macias and Elliott began to pull the larger pieces down and one of the pieces fell on top of the canopy. The rock was jagged, sharp, and thick. Macias estimated the rock on the canopy weighed between a ton and a ton-and-a-half. Tr. 55. Because the rock blocked many of the holes through which the miners could work, it prevented Macias and Elliott from installing many more bolts and completing the rest of the mesh work. Tr. 53-54. The only thing the miners could do was put a few random bolts in the face, drill holes in the sides of the raise and fill the holes with dynamite. The miners wanted to blast rock that protruded too much into the raise. The protruding rock made the raise "tight" for the raise climber. Tr. 56-57.

After the dynamite was loaded in the holes, the miners attached detonators to the explosives. Tr. 58. The detonator mechanism included spooled cord, which transmitted a charge to the explosives. After the detonator mechanisms were in place, Macias and Elliott started to bring the climber down. As the climber descended, the cord unwound from the spool. Macias stood on the work deck to make sure the cord did not snag on the deck or otherwise tangle. Tr. 58-59. Finding all was in order, Macias climbed down into the man basket. Elliott controlled the climber's descent in the usual way, by applying the compressed air operated braking system. Tr. 59.

The climber descended approximately 200 feet when, according to Macias, "a piece of [falling] loose material . . . cut [the] bull hose," including the cable inside the hose. Tr. 60, 62. Macias wasn't sure from where the material came. He speculated it was "[e]ither off the deck or somewhere in the raise." Tr. 60. The bull hose fell to the bottom. With the bull hose severed, the climber's compressed air source was cut off, and the climber came to a stop. Tr. 62. This was the first time Macias experienced a situation where both the bull hose and the cable in the hose were severed. Tr. 63.

At this point, Macias decided not to further lower the climber. Tr. 72. He stated, "I made the decision not to come down the raise in a controlled descent on gravity."¹⁰ *Id.* Macias determined he would wait at approximately the 1400 feet level of the raise until the mechanic, Arthur Bravo, could assist him. *Id.*, Tr. 78; 83. Macias had made two previous controlled descents. However, on neither occasion was the bull hose completely severed nor was there loose rock on the climber's deck. *See also* Tr. 125. In addition, in neither situation was he 1400 feet above the mine floor. Tr. 138.

Later, Macias wrote a brief statement describing what had happened. Tr. 64.

When we lost [the] bull hose, I made the call not to free wheel down [the] raise. Because of loose [rock] on the

¹⁰By a "controlled descent," Macias was referring to one controlled by the hand brake and foot brake. Tr. 110-111.

deck unit [the raise climber] could get out of hand on the way down raise. Like loose breaks. Too much weight.

Gov't Exh. 4; Tr. 70.¹¹

Macias believed he wrote the statement on August 10. When he was deposed about one month prior to the hearing, Macias stated Cook, Redpath's project manager, asked him to write what "happened . . . the day I was in the raise and why I chose to stay in the raise so . . . [MSHA] would have a better understanding of what was going on in the raise." See Tr. 66. Macias later maintained the statement was not a full statement. It did not include everything about why he decided to stay put, because he "had no reason to believe . . . the incident was that important." Tr. 67. For example, he testified he did not mention he was unwilling to put wear and tear on the equipment and to cause extra work for the oncoming crew. Tr. 115-116. Rather, he chose to emphasize the loss of the bull hose at 1400 feet and the weight of the rock on the deck. Tr. 125-126.

Macias testified even though he elected to remain in place, he was certain a raise climber operator never would lose control of a climber during a controlled descent. If the speed of the descent became excessive, the G-5 emergency brake would automatically bring the climber to a "[d]ead stop." Tr. 111. Macias did not regard use of the G-5 as a "catastrophic situation" because of the total reliability of the brake. Tr. 127. Nonetheless, he described the G-5 braking system as a "final system . . . to protect the people in the raise climber from falling all the way to the bottom of the raise." Tr. 143.

After Macias stopped the climber's descent, mechanic Arthur Bravo became aware of the situation and decided to bring a second raise climber up the raise to help Macias and Elliott. Tr. 78. Macias knew the mechanic was on his way. Macias could hear noise made by the second climber as it ascended. Macias also could feel vibrations on the rail.¹² Tr. 79.

The second climber moved up the raise, but stopped prior to reaching Macias and Elliott. Macias believed one of its motors malfunctioned. Tr. 80. The second climber then began to

¹¹The letters and words within the brackets have been added for clarity. That they convey what Macias intended is made clear by his testimony.

¹²There were ways in which miners in the two climbers could communicate. Macias testified that a phone line could be dropped from the upper climber to the lower climber. In addition, part of the raise could be illuminated and miners in the upper climber could drop color coded objects down the raise to indicate what they needed. Tr. 113-114. However, Macias stated he did not attempt to communicate with Bravo on August 8, because once Bravo saw the "significant amount of hose in the [bottom of the] raise . . . he [was] smart enough to know what [was] going on." Tr. 114-115. According to Macias, "It's just common sense We're on the same page." Tr. 115.

descend, but it stopped again. *Id.* This was not unusual. Macias explained:

Maybe you've got condensation in your air motors and it builds up ice. Sometimes when you drop down certain feet – maybe 6, 10 feet . . . it throws . . . [the] ice out of your air motors and . . . [the climber] can continue to climb up.

Tr. 81. Shortly thereafter, Macias heard the second climber resume its descent. Macias stated he believed Bravo returned to the bottom to pick up the oncoming crew so they could help him install another air motor on the second climber. Tr. 83. The place where Bravo picked up the crew was about 15 minutes from the nest. *Id.* Meanwhile, Macias waited at the 1400-foot level of the raise. *Id.*

After about 45 minutes, Macias again heard the second climber begin to come up the raise. Tr. 84. The climber reached Macias and Elliott, and the bull hose was repaired. Macias estimated it took between a half hour and 40 minutes for the second climber to reach the first climber and for the mechanic then to fix the bull hose. Tr. 84-85. Macias knew the hose was repaired when he heard the second climber descending and shortly thereafter compressed air started coursing through the hose. Tr. 85. According to Macias, the second raise climber was in the raise a total time of “over an hour” on the second occasion. *Id.*

As best as Macias could recall, the bull hose was cut between 4:30 a.m. and 5:15 a.m. on August 8, and the bull hose was not repaired and the air restored until between 9:00 a.m. and 9:30 a.m. on the same day. Tr. 89-90.

Macias was asked repeatedly why he chose to stay in place rather than lower the raise climber to the bottom. He testified while the second raise climber was below him, he did not want to move because he feared rock from his climber might “fall down on top of the other unit.” Tr. 86; *see also* Tr. 102, 131. In addition to falling rock, he was concerned bolts on the work deck could fall if they weren't stored properly. Tr. 87-88, 132. Further, if he had come down the raise on a controlled descent, he was sure to put “wear and tear” on the raise climber's parts. However, he stated he could have moved the climber out of the raise had he wanted to. Tr. 100, 120.

Macias did not believe staying in place compromised his and his co-workers' safety. In his opinion, there was no “need to come down out.”¹³ Tr. 107. It made more sense to Macias to

¹³He stated it was not at all unusual for the climber to remain in place for several hours when the miners in the climber were working at the face or maintaining the rails. Tr. 120. He added, “If there was an emergency . . . I'm coming down the raise. It would take me a while but I'll be there.” *Id.* Moreover, in the event of an emergency he would not worry about wear and tear because, “Money's no object then.” Tr. 121.

have the mechanic bring the broken end of the hose up to the raise climber and make the repair. After the break, approximately 200 feet of hose was still attached to the climber, and if Macias descended, the attached hose would pile up and tangle on top of the cut hose at the bottom. Tr. 108.

Macias also explained, prior to the incident he and the mechanic had agreed on the procedure to follow if the hose broke:

We had an understanding depending on the amount of hose in the bottom of the raise . . . And the agreement was for us to sit there and wait for him to do the repair until we got more air. I know where I'm at in the raise. I know if I'm that high there is going to be a significant amount of hose in the bottom. So I'm going to sit and wait. If he knows I'm lower in the raise, it would be easier for me just to drop down far enough for him to do the repair in the nest. . . .

Tr. 109. Macias testified, in view of this agreement, "There [was] no reason for me to come down the raise." Tr. 131.

Project supervisor, Terry Cook, also testified about the incident. According to Cook, he reached the mine around 7:00 a.m. on August 8. Upon his arrival, he realized Redpath's miners from the shift on which Macias worked had not exited the mine. Cook was not concerned. It was not unusual for miners to miss the mantrip, and no one had called out to report any problems. Tr. 232.

Cook proceeded underground. He traveled to the nest area where he was met by Bravo, who told Cook the bull hose on the raise climber "had broken and he tried to take the . . . broken end up into the raise, but blew an air motor, noticed it was quitting time, [and] came" to meet Cook "because he knew . . . [there was] no way of getting up to the raise." Tr. 233. Cook testified he asked Bravo whether Macias and Elliott had dropped the phone line down the raise, and Bravo said "no." Tr. 234. The fact the miners had not dropped a phone line signified to Cook they were all right. *Id.* ("If they're not sending the phone line down, I guess they're comfortable." *Id.*)

Cook then accompanied Bravo into the nest, where Bravo and others installed a new air motor on the second raise climber. Tr. 234. The severed bull hose was placed on the work platform of the second raise climber. Another lead miner and his helper took the hose up to Macias's climber and repaired the hose. Cook believed the repairs were completed and the second climber returned between 9:30 a.m. and 10:00 a.m. Tr. 236. Once the hose was repaired and Macias and Elliott were down, no one from Redpath called MSHA to report the incident.

Cook explained he did not call because he did not believe Macias and Elliott were trapped. Tr. 236. They could have lowered the raise climber “at anytime if they wanted.” *Id.* In Cook’s opinion, Macias made the right decision to stay in place. It is Redpath’s policy to have the primary raise climber stay put when a second raise climber is in the raise and there is no communication between the two climbers. Tr. 252-253. On August 8, there was no communication between Macias, Elliott, and Bravo. Tr. 253. Cook maintained all of Redpath’s lead miners know when they feel the presence of another climber on the rail below, they don’t move until it is clear. This is to avoid inadvertently dropping or causing something to drop on the climber below. (“You don’t want to drop your wrench or your water bottle or . . . have a nut or little bolt [drop]. After 100 feet that little bolt is just like a bullet.” Tr. 238.)

Cook was adamant a raise climber descending without its motors could not drop in a free fall. In addition to the hand and foot brakes used during a controlled descent, the G-5 brake would stop the descent if the hand and foot brakes failed and control was lost. He explained:

The G-5 . . . has its own sprocket . . . that rides on the rail. It . . . has a little brain in there that once that sprocket starts hitting a certain revolution, it locks that G-5 brake in.

Tr. 230-231.

EVENTS OF AUGUST 9 AND MSHA’S INVESTIGATION

The day following the incident, Redpath employee Mark Ahlborn, the project’s general manager, reported the incident to MSHA. Stip.15. Ahlborn called after a Stillwater employee complained that the incident had not been reported. Cook quoted the employee telling Ahlborn, “Boy, we’re going to get in trouble . . . You need to make the phone call right now.” Tr. 240. Cook described the Stillwater employee as “very excited.” Tr. 254. Cook agreed the employee “may have” described the events of August 8 as an “accident.” Tr. 255.

Garry Stauffenberg is an MSHA metal/non-metal mine inspector. Prior to August 8, he had inspected the East Boulder Mine at least 12 times. Tr. 149-150. Stauffenberg first became aware of the incident on August 9, when he was told by his “supervisor that an entrapment of two miners in [the Brownlee] raise occurred at the . . . mine.” Although he never had operated a raise climber or been trained to do so (Tr. 171), Stauffenberg was “assigned to . . . conduct an investigation” of the incident. Tr. 151-152. The investigation took two-and-a-half days.

On August 10, 2006, Stauffenberg went to the mine and met Terry Cook, Mark Ahlborn, and others. Tr. 152. During the course of the meeting, Terry Cook described what had happened. After hearing Cook’s explanation, Stauffenberg told Cook he did not think there was an entrapment, but he would check with his field office and would continue the investigation until he had all of the necessary information. Tr. 169; *see also* Tr. 242.

Subsequently, Stauffenberg spoke with Macias and Bravo. Stauffenberg also was given Macias's signed statement. Gov't Exh. 4; *see* Tr. 155. As a result of what he learned, Stauffenberg changed his opinion regarding Macias's and Elliott's "entrapment" and issued Citation 6323250, charging Redpath with a violation of section 50.10. Gov't Exh. 5; Tr. 155-156. He noted the standard requires an operator to immediately contact MSHA "[i]f an accident occurs" (30 C.F.R. § 50.10) and that one of the definitions of "accident" is "[a]n entrapment of an individual for more than 30 minutes." 30 C.F.R. §50.2(h)(3); *see* Tr. 156. Macias and Elliott were in place at the 1400-foot level of the raise for much longer than 30 minutes. Therefore, the "entrapment" should have been reported to MSHA.

Stauffenberg recognized nothing mechanical prevented the miners from lowering the climber using controlled descent procedures. Tr. 173. However, in Stauffenberg's view, other factors overcame the fact the climber could have descended and warranted finding an entrapment. He noted the raise was one of "the world's longest" and being stopped at the 1400-foot level "ha[d] a definite relevance." Tr. 158. Stauffenberg further took into consideration the fact that a ton-and-a-half of rock was on top of the raise climber. Tr. 159. Based on his interview with Macias, Stauffenberg believed Macias "recognized the potential hazard of trying to descend [from 1400 feet] . . . with that additional weight on top [of the canopy]." *Id.* In addition, the loss of the bull hose was critical to his finding of entrapment because "when you lose your primary bull hose, you lose the control to drive anything with air" (Tr. 160), and Stauffenberg recalled Macias saying he was afraid of losing control of the climber if he tried to descend without air. Tr. 162.

Stauffenberg believed Macias did the right thing by deciding to stay in place. The only thing wrong was the failure of Redpath to report the incident. Tr. 157.

THE ISSUES

The issues are whether Redpath violated sections 50.10, and, if so, whether the inspector's findings regarding the gravity of the violation and Redpath's negligence are sustainable. If a violation is found, the parties agree the resulting penalty should be \$60; but, to assess such a penalty, I also must consider whether the statutory civil penalty criteria as a whole support that amount. Tr. 250.

<u>CITATION NO.</u>	<u>DATE</u>	<u>30 C.F.R. §</u>	<u>PROPOSED PENALTY</u>
6323250	8/15/06	50.10	\$60

Citation No. 6323250 states:

The person in charge of the . . . Redpath operation at this mine site failed to notify . . . [MSHA] of the delay in two miners . . . com[ing] down out of a raise. Alimak unit is driving a ventilation raise from

7200 +108 access to the surface. The bull hose blew completely in half that supplies air for the tramming motors. This was approximately four hundred feet from the climbing unit, which stopped the unit approximately fourteen hundred feet from the bottom of the raise. This occurred on August 8 . . . at approximately [4:30 a.m.]. The miners were in the raise until [9:30 a.m.] of the same day. A call was received from the project manager at approximately . . . [8:00 a.m.] to the Denver district [MSHA] office on August 9, 2006.

Gov. Exh. 5

THE VIOLATION

As noted previously, section 50.10 states in part: "If an accident occurs, an operator shall immediately contact the MSHA District or Subdistrict Office having jurisdiction over its mine." 30 U.S.C. §50.10. Section 50.2(h)(3) defines an "accident" as "[a]n entrapment of an individual for more than 30 minutes." 30 C.F.R. §50.(h)(2). There is no regulatory definition setting forth a definition for "immediately," but it has long been accepted that the "immediateness" of an operator's notification under section 50.10 must be evaluated on a case-by-case basis taking into account the nature of the accident and all of the relevant variables affecting reporting.

The issue of whether the incident of August 8 constituted an "accident," revolves around whether the incident was an "entrapment." There is no indication "entrapment" is used in the regulation to connote anything other than its plain meaning – to be caught "as if in a trap." *Websters Third New International Dictionary* (2002) at 758. In like manner, the plain meaning of trap is "something by which one is unsuspectingly or surprisingly caught or stopped in an action or progress." *Id.* 2431.

As is clear from the testimony, the events leading to the alleged violation were triggered by severance of the raise climber's bull hose. The bull hose was the only conduit by which compressed air was supplied to the raise climber. The air had two primary functions: (1) It activated the motors that allowed the raise climber to ascend (Tr. 41-42), and (2) it activated the centrifugal braking systems, the raise climber's primary braking systems, the systems usually used and the ones allowing the climber to descend in an indisputably safe and measured manner. Tr. 224-225.

When the bull hose was severed, the raise climber lost the principal means by which it could unquestionably descend safely. While the record establishes the climber could descend without air by using the foot and the hand brakes (a "controlled descent") (Tr. 71, 75, 77), the availability of this other means of descent does not *ipso facto* negate finding an entrapment.

An “entrapment” within the meaning of the standard certainly can signify a total lack of escape from a situation that has “unsuspectingly or surprisingly caught or stopped” miners’ actions or progress, but it also can encompass a situation in which miners reasonably conclude, given all of the circumstances within their knowledge, it is safer to stay in their existing situation and location than to extricate themselves via an available means. Here, the question of whether Macias and Elliott were “entrapped” turns on whether the record supports finding they chose to remain in place because they reasonably feared it would be more hazardous to undertake a controlled descent.

After considering all of the testimony and documentary evidence, I find Macias and Elliott were in fact entrapped on August 8. In reaching this finding, I give great weight to the statement Macias wrote immediately after the incident in which he described the reasons why he chose to stay in place rather than to descend. When he wrote the statement, the events of August 8 and his reaction to them were freshest in his mind, and a fair reading of the statement, when coupled with his oral explanation of what he then meant, indicates Macias was concerned 2,000 to 3,000 pounds of rock that had fallen on the canopy of the climber would cause the climber to “get out of hand on the way down the raise.” Tr. 73. In other words, he was concerned the added weight would impede a safe descent. Gov’t Exh. 4, Tr. 70, 72-73. To be more specific, Macias feared the brakes used in a controlled descent would become inadequate – would become “loose” (Gov’t Exh. 4) – as their brake pads wore down. Tr. 75, 77.

When it is remembered he was located 1400 feet above the mine floor and no controlled descent from that height ever had been attempted by Macias (or by anyone else for that matter), his fear about the effect of the added weight on the brakes he would have had to use repeatedly over so great a distance was reasonable, as was his resulting decision to stay where he was.

Moreover, once the second climber was in the raise, Macias had another concern. If he started downward, he believed the rock on the canopy might fall and strike those directly below. Tr. 86, *see also* Tr. 102. In addition, he worried about bolts falling from the work deck. His concerns were valid. After all, it was Cook, his supervisor, who stated falling material like bolts could become “just like . . . bullet[s].” Tr. 238.

In reaching the conclusion Macias and Elliott were entrapped, I recognize both Macias and Cook testified the G-5 brake (the emergency brake) would act to bring the climber to a halt if the speed at which the climber descended became excessive. Tr. 111, 230-231. However, in my view, this has no bearing on the reasonableness of Macias’s decision to stay rather than to descend. The existence of a “last gasp” system designed to prevent a plunge to the floor below (Tr. 143), does not make unreasonable Macias’s decision to forego totally relying on it to prevent his and Elliott’s certain deaths. Moreover, there is no indication on August 8 the existence of the G-5 brake played any role in Macias’s decision to stay put. Certainly, he did not mention it in his written statement. Nor did he testify its existence played a part in his decisional process.

For these reasons, I conclude the incident of August 8, 2006, constituted an accident within the meaning of section 50.10. The parties have stipulated that if I find an accident

occurred, Redpath did not immediately notify MSHA. Stip. 16. Therefore, I conclude Redpath violated the standard as charged.

GRAVITY

In assessing the gravity of the violation, I note inspector Stauffenberg's testimony the citation was issued solely for Redpath's failure to report the accident. Tr. 157. I also note Stauffenberg found the violation had no likelihood of producing an injury. Gov't Exh. 5. Based on this testimony, I find, as did the inspector, the violation was not serious.

NEGLIGENCE

Inspector Stauffenberg found the failure to report the accident was due to Redpath's "moderate" negligence. Gov't Exh. 5. Cook arrived at the mine at 7:00 a.m. on August 8. Tr. 233. Shortly thereafter, he traveled underground where Bravo advised him of the situation. Tr. 233-234. Cook testified once he knew of the miners' predicament, he did not think Macias and Elliott were in any danger, because they had not communicated otherwise. Tr. 234, 236. I take Cook at his word. However, when Macias and Elliott were out of the raise and in the nest, it was Cook's duty, as the project superintendent and Redpath's person in charge, to undertake an immediate investigation to discover why the miners had chosen to remain at the 1400-foot level. Had such an investigation been conducted, Cook would have determined Macias chose to stay in place because of his well-founded fear it would have been more hazardous to make a controlled descent, and the incident could have been timely reported. In other words, had Cook exercised the care required of him by the circumstances, the violation would not have occurred. I, therefore, conclude Inspector Stauffenberg was correct when he found Redpath was moderately negligent.

EVENTS OF AUGUST 29 AND THE INOPERABLE MINE PHONE

John O'Brien is an MSHA inspector who, on August 29, 2006, was working in the Helena, Montana, MSHA office.¹⁴ O'Brien was familiar with the East Boulder Mine. Prior to August 29, O'Brien inspected it approximately six times. Tr. 184. On August 29, he conducted another inspection. When he reached the nest located at 72-670 + 98, work was ongoing and Redpath's employees were carrying out assigned tasks. Tr. 198-199, 269. O'Brien inspected the equipment in the nest, including the page telephone.

The phone mechanism was square in shape. The mechanism included what O'Brien described as a "regular receiver" and an external speaker. Tr. 186-187. The speaker was located in the open above the receiver. Tr. 187. O'Brien was unsure who provided the phone. Tr. 198. However, it was in an area of the mine for which Redpath was responsible.

¹⁴Inspector O'Brien's name is misspelled in the transcript as, "O'Brian."

O'Brien requested a supervisor call "the surface and [ask] the surface to call . . . back." Tr. 187. The supervisor called the surface twice. Although the supervisor could reach someone on the surface, when the person on the surface tried to respond, the underground party could not hear the response over the speaker. O'Brien examined the speaker. He stated, "That's when we observed that the speaker was not plugged in." *Id.* This meant the nest area could not receive a message from the surface or from any other area of the mine in which page phones were used for communication. Tr. 188.

O'Brien testified page phones were located in others area of the mine, as well as in the 72-670 +198 nest. Tr. 189. Information regarding emergencies (*e.g.*, mine fires or medical information for sick miners) could be conveyed from the surface to the miners underground on page phones. In addition, underground miners could initiate conversations with those on the surface regarding mine conditions by using page phones. Tr. 188-189. O'Brien described the phones as "one of the most necessary parts of the mine" (Tr. 188) and as "a primary source of information" for miners. *Id.*

Cook did not disagree with O'Brien's description of the uses to which the page phones were put. As for the phone in the 72-670 +198 nest, Cook stated it was located in the nest so Redpath personnel could contact the mine dispatcher and coordinate their work with the work of Stillwater personnel. Tr. 259.

Despite the importance of the page phone system, Cook described the page phone in the 72-670 +198 nest as unreliable. ("We constantly had trouble with that phone. I don't know if that was the third phone or the fourth phone that was put in there." Tr. 259; *see also* Tr. 262.) Cook quoted Redpath's employees as stating that although they could detect when someone was speaking over the speaker, they could not tell what he or she was saying. Tr. 264. Redpath personnel had asked their Stillwater counterparts to fix the page phone in the nest so Redpath's employees could hear it. Tr. 260-261. Because of the unreliability of the page phone, Cook testified Redpath employees relied on another underground system – the "leaky feeder" phone system. *Id.*

O'Brien believed the non-working condition of the speaker violated section 57.14100(b), in that the phone was defective and the defect was not corrected in a timely manner.¹⁵ O'Brien did not find the violation was S&S. He noted the presence of the alternative means of communication. However, like Cook's concern about the page phones, O'Brien did not think the leaky feeder phones were totally reliable. ("[They] could go in and out[.]" (Tr. 190)). Due to the amount of noise in the nest, it was possible miners would not hear the leaky feeder phones' signals. Tr. 192.

¹⁵Section 57.14100(b)(1) applies to "equipment, machinery and tools that affect safety." O'Brien believed the page phone's parts constituted two of the enumerated things: "equipment" and "tools." He stated, "The phone would be a piece of machinery to receive, and the speaker would be a tool." Tr. 195-196.

O'Brien believed the lack of a working page phone speaker was due to Redpath's moderate negligence, because a Redpath official told O'Brien the page phone had been inspected earlier by a Redpath employee – O'Brien understood on August 28 – and was not found inoperable. Tr. 194-195, 202. (In completing the inspection report, the Redpath miner described the nest page phone as "okay." Tr. 203.) O'Brien, therefore, assumed the speaker had not been unplugged for very long, although he did not know when the speaker became unplugged, nor whether the Redpath inspector actually looked at the wire when he inspected the phone. Tr. 199, 202-203.

Finally, O'Brien testified he issued the citation to Redpath because Redpath "was the direct contractor for this area and there [were] no Stillwater employees . . . working in [the] area." Tr. 203-204.

THE ISSUES

The issues are whether Redpath violated section 57.14100(b) and, if so, whether the inspector's findings regarding the gravity of the violation and Redpath's negligence are sustainable. If a violation is found, the parties agree the resulting penalty should be \$60, but to assess such a penalty, I must conclude the statutory civil penalty criteria as a whole support the amount. Tr. 250.

<u>CITATION NO.</u>	<u>DATE</u>	<u>30 C.F.R. §</u>	<u>PROPOSED PENALTY</u>
6324326	8/29/06	57.14100(b)	\$60

Citation No. 6324326 states:

The provided mine phone located at the 72-670+198 eagles nest would not page when tested. The standard requires that defects on any equipment, machinery, and tools that affect safety shall be corrected in a timely manner to prevent the creation of a hazard to persons.

Gov. Exh. 6

THE VIOLATION

As the citation states, section 57.14100(b) requires "defects on any equipment that affect safety" to be "corrected in a timely manner to prevent the creation of a hazard to persons." There is no doubt on August 29, 2006, the page phone at the 72-679+198 eagles nest was not fully operational. Both O'Brien and a mine supervisor tried to have someone on the surface call the nest. The phone would not page because its speaker was not plugged in. Tr. 185, 187. The page phone was "equipment" within the meaning of the standard. "Equipment" is not defined in the regulation, but in common usage, the word signifies "implements (as machinery or tools) used in

an operation or activity.” *Webster’s Third New International Dictionary* (2002) 768. Cook and O’Brien testified the page phone could be used by the mine dispatcher to contact miners in the nest area. Tr. 188, 259. In addition, based on Cook’s testimony, I find the cited phone was used, among other things, to coordinate work underground. Tr. 259. Because the phone was an implement used in mining activity, it was “equipment” within the meaning of the standard.

Further, the phone had a “defect”, *i.e.*, “an irregularity . . . that . . . causes failure.” *Webster’s* at 591. In this instance, the defect was uncomplicated; the phone’s speaker was unplugged. Nonetheless, the defect caused one of the phone’s primary functions to fail.

The standard required Redpath to “correct [the defect] in a timely manner to prevent the creation of a hazard.” To prove this mandate was violated, the burden was on the Secretary to show the cited defect (the unplugged speaker) was not timely corrected. It is impossible to determine the timeliness of Redpath’s failure unless the Secretary has established outright or through reasonable inference how long the page phone speaker was unplugged and when Redpath personnel should have found and corrected the defect. O’Brien testified he did not know when it was unplugged (Tr. 202-203), but he was told the phone was inspected by a Redpath employee on August 28, and he agreed Redpath’s inspectors did “good work.” Tr. 194. Moreover, the Redpath inspector described the phone as “okay.”

The most reasonable inference to draw from all of this is that the speaker was plugged in on August 28, and that sometime between the August 28 inspection and O’Brien’s August 29 observations the speaker became unplugged. When O’Brien saw the phone, Redpath’s next scheduled inspection of the phone after August 28 had yet to occur. Tr. 194. The Secretary did not establish when the phone next should have been inspected. Nor did she establish when Redpath otherwise should have known about the condition of the phone. Without a way to infer or otherwise conclude when Redpath should have known of the page phone’s unplugged condition, I have no basis for concluding whether Redpath failed to correct the condition in a “timely manner.” As a result, the Secretary’s allegation of a violation must fail.

Therefore, I conclude the Secretary has not proven the alleged violation of section 57.14100(b), and I will vacate the citation at the close of this decision.

REMAINING CIVIL PENALTY CRITERIA

HISTORY OF PREVIOUS VIOLATIONS

In view of the parties’ agreement as to the amount of the appropriate civil penalties should violations be found, the Secretary elected to forego the submission of evidence regarding Redpath’s history of previous violations. Tr. 205-206.

SIZE

Perhaps because of the same agreement, no specific evidence was offered by the Secretary regarding Redpath's size. I note that although Redpath is a large international mine construction company, as Cook testified, until recently only a few of its projects have been located in the United States. Tr. 210-211.

GOOD FAITH ABATEMENT

The parties stipulated Redpath demonstrated good faith in abating the cited conditions. Stip. 7.

ABILITY TO CONTINUE IN BUSINESS

No evidence was offered that any penalty assessed will affect Redpath's ability to continue in business, and I find it will not.

CIVIL PENALTY ASSESSMENT

<u>CITATION NO.</u>	<u>DATE</u>	<u>30 C.F.R. §</u>	<u>PROPOSED PENALTY</u>
6323250	8/15/06	50.10	\$60

I have agreed with Inspector Stauffenberg the violation was not serious and was the result of Redpath's moderate negligence. Given these findings and the other civil penalty criteria, I also agree with the parties that a civil penalty of \$60 is appropriate.

ORDER

The Secretary has proven the violation of section 50.10 alleged in Citation No. 6323250, and Redpath **SHALL PAY** a civil penalty of \$60 for the violation within 40 days of the date of this decision. The Secretary has failed to prove the violation of section 57.14100(b) alleged in Citation No. 6324326, and the citation **IS VACATED**. Upon payment of the penalty, this proceeding **IS DISMISSED**.¹⁶

David F. Barbour
David F. Barbour
Administrative Law Judge

¹⁶I commend counsels on the manner in which they prepared, presented and briefed this case. Their use of the tools of litigation and argument represented an admirable balance of efficiency and effectiveness. The Secretary, Redpath, and the Commission were well served.

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DFB/ej

FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

1244 SPEER BOULEVARD #280
DENVER, CO 80204-3582
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January 22, 2008

SECRETARY OF LABOR,	:	CIVIL PENALTY PROCEEDINGS
MINE SAFETY AND HEALTH	:	
ADMINISTRATION (MSHA),	:	Docket No. WEST 2007-241
Petitioner	:	A.C. No. 42-02335-105746
	:	
v.	:	Docket No. WEST 2007-449
	:	A.C. No. 42-02335-115973
C. W. MINING COMPANY,	:	
Respondent	:	Bear Canyon #4 Mine

DECISION

Appearances: Kristi Henes, Esq., Office of the Solicitor, U.S. Department of Labor, Denver, Colorado, for Petitioner;
Carl E. Kingston, Esq., Salt Lake City, Utah, for Respondent.

Before: Judge Manning

These cases are before me on two petitions for assessment of civil penalty filed by the Secretary of Labor, acting through the Mine Safety and Health Administration ("MSHA"), against C. W. Mining Company ("C. W. Mining"), 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"). C. W. Mining owns and operates the Bear Canyon #4 Mine, an underground coal mine in Emery County, Utah. It contested six citations issued by the Secretary, but the Secretary vacated two of these citations prior to the hearing. An evidentiary hearing was held in Salt Lake City, Utah.

**I. DISCUSSION WITH FINDINGS OF FACT
AND CONCLUSIONS OF LAW**

A. Citation No. 7282952

On April 20, 2006, MSHA Inspector Donald E. Durrant issued Citation No. 7282952 under section 104(a) of the Mine Act alleging a violation of section 75.400 as follows:

Accumulations of loose coal, coal fines, much of which were dry in nature was allowed to exist along the #1 belt conveyor entry from the head pulley to the belt tailpiece, some 900 feet away. The accumulations ranged from 6 feet to upwards of 8 feet in width, and varied from 4 inches deep to about 27 inches deep beneath the

rollers (ant piles). These accumulations were obvious and extensive, even to the most casual of observers.

Inspector Durrant determined that an injury was reasonably likely and that any injury resulting from the violation was likely to result in lost workdays or restricted duty. He determined that the violation was of a significant and substantial nature ("S&S") and that C. W. Mining's negligence was moderate. The safety standard provides that "[c]oal dust, including float coal dust deposited on rock-duster surfaces, loose coal, and other combustible materials, shall be cleaned up and not be allowed to accumulate in active workings, or on diesel-powered and electric equipment therein." The Secretary proposes a penalty of \$1,566.00 for this citation.

Inspector Durrant inspected the #1 beltway area of the mine, which begins at approximately crosscut three and runs to about crosscut ten or eleven, and observed accumulations of loose coal, coal fines, and float coal dust present for the entire length of the belt entry. (Tr. 19-20). He was carefully examining the belt entries in the mine because MSHA's district manager had initiated a "belt initiative" following the January 2006 belt fire at the Aracoma Alma Mine. (Tr. 15-16; Ex. G-15). Most of the accumulations were located underneath the conveyor belt. (Tr. 125). Float coal dust was also seen on the electric motors and cables. Inspector Durrant determined that the loose coal and coal fines were dry in nature making it more volatile and able to burn more easily. (Tr. 24). His determination as to the dryness was based upon physically touching and squeezing them for moisture. The loose coal and coal fines were black in color indicating a higher content of carbonaceous material. (Tr. 24). He stated that he did not take a sample to test for combustibility as this is not a requirement under the standard and the accumulations were black in color. (Tr. 25, 119-20). However, he did measure the areas of accumulation and found they ranged from four inches deep to twenty-seven inches deep and from six to eight feet wide. (Tr. 26-28; Ex. G-5).

Inspector Durrant determined that this violation was significant and substantial. He felt that a discrete safety hazard was present that was reasonably likely to cause a serious accident or injury to a miner as two of the three elements for fire were present (oxygen and fuel). (Tr. 36). Potential ignition sources were present including electrical equipment, conductors, power cables, electric motors, electric controls for the belt starter, pump cables, power center, and a belt conveyer. (Tr. 37). The potential for a mine fire was present and the potential for injuries to miners would be great. There were 20 miners working in the mine on the day of inspection and all would be affected by a mine fire. He also determined that moderate negligence was present and that injury or illness was reasonably likely to result in lost workdays or restricted duty due to the violation.

C. W. Mining was given until 6:00 p.m. on April 20, 2006, to abate the citation. Inspector Durrant felt this was a reasonable abatement time based on the hazard posed to the miners. (Tr. 46). On April 21, 2006, at approximately 12:50 p.m., Inspector Durrant went back to the mine to attempt to terminate the citation. He determined that minimal effort had been made to remove the accumulations of loose coal and coal fines, and that additional rock dust had

not been applied. (Tr. 48). Moreover, he did not observe anyone in the area cleaning the accumulations and estimated that the job was less than fifty percent complete. *Id.* In his opinion, a diligent effort had not been made to abate the citation. As a consequence, he issued Order No. 7282964 under section 104(b) of the Mine Act. (Ex. G-12). After the issuance of this order, the citation was abated as the area was cleaned and dusted and the float coal was removed from the equipment. (Tr. 51)

Patrick Peterson testified on behalf of the operator. At the time of this inspection, Peterson was responsible for monitoring the belts and he supervised two to three miners. He also performed the preshift examinations. He stated that the ant hills underneath the belt were moist or even wet. (Tr. 162). An "ant hill" is simply a narrow area where coal fines and coal dust have accumulated under a belt from a single point. Neither the belt nor the rollers were rubbing on the accumulations. (Tr. 165, 182). He explained that the belt is equipped with water sprays and, as the belt returns back, droplets of water with coal residue fall from the belt to form the piles. He estimated that the piles were no wider than the belt itself (48 inches). He also stated that there was groundwater present in the area making the accumulations moist as well. (Tr. 164). Peterson did not observe any float coal dust that had not been rock dusted. He described the rock dust used at the mine as light gray in color and that it can become darker when wet. Peterson testified that he noted the accumulations in his personal notebook as something that needed attention, but he did not record the conditions in the official record because he did not believe that the accumulations created a hazard. (Tr. 167-68).

Peterson was involved in the cleanup process necessary to terminate the citation. He and the other miners cleaned up the ant hills, but it was not satisfactory to Inspector Durrant. (Tr. 166). He described Inspector Durrant poking his stick into the ground and if the ground wasn't hard, the inspector determined that it needed to be cleaned regardless of whether it was mud, dirt, or an accumulation. He also stated that part of the belt was in a rock tunnel. The miners were instructed by Inspector Durrant to clean the rock tunnel area even though the accumulations were mostly mud. Buckets were used to remove the material because it was sloppy and wet. (Tr. 167). Some of the coal handling equipment got plugged up because of all the mud that had to go through the system. *Id.* Randy Defa, the shift foreman, also testified on behalf of the operator and reiterated Peterson's testimony regarding the cleanup process. (Tr. 189-191). He testified that much of this material was fire clay. (Tr. 190). He believes that all of the combustible material had been removed before the section 104(b) order was issued. (Tr. 193).

Ken Defa, the mine superintendent, also testified on behalf of the operator. He believed that the accumulations cited by the inspector did not create a hazard because the majority of them were extremely wet and they all had quite a bit of moisture in them. (Tr. 216-17). The water was coming off the belts from water sprays and out of the floor from the ground. (Tr. 217, 262). He testified that the conditions were similar along the number three and five belt entries that were being inspected by another MSHA inspector. (Tr. 218). The other inspector did not issue any citations for violations of section 75.400. (Tr. 218-19). His testimony is similar to Mr. Peterson's with respect the conditions that existed when the inspector returned to the mine on

April 21. (Tr. 219-21). He said that the material that remained was mud and fire clay but that the inspector required the mine to remove it. (Tr. 221-22).

Mr. Defa also testified that he did not see accumulations of float coal dust in the area. (Tr. 223). The mine has a rock dusting program with a rock dust pipeline running down the length of the belt which periodically pumps rock dust through the belt entryway. (Tr. 224). This system was operational at the time of the alleged violation. He described the rock dust as being gray in color, similar to that of float coal dust. Defa stated that they were using this darker rock dust because the plant where they used to purchase rock dust was no longer in operation. He also stated that this dust was MSHA-approved and that other mines were also using it. Defa estimated that the top of the ant hills were at least two feet below the belt so that no moving parts would have rubbed on the accumulations to start a fire. (Tr. 225-226). In addition, all electric equipment in the area was in good condition. The belt line is equipped with an automatic fire suppression system. (Tr. 226-27).

In rebuttal, MSHA Inspector Donald Gibson testified that he accompanied Inspector Durrant and saw the accumulations. He agreed with Durrant's characterization of the conditions and testified that there was dry float coal dust on the belt structures and the speed reducer. (Tr. 279-82).

I accept the testimony of Inspectors Durrant and Gibson on this citation and affirm the citation as written. Based on Inspector Durrant's testimony and the notes from his inspection, the accumulations were extensive as they ranged from four inches to twenty-seven inches deep and from six to eight feet wide. (Tr. 26-28; Ex. G-5). Inspector Gibson also observed accumulations, including float coal dust on the belt structure, the motor, speed reducer and crosscuts. (Tr. 279). Both inspectors stated that they touched the accumulations and felt that they were dry. (Tr. 24, 279). However, both noted that not all areas were dry, but some were damp. The characterization of wet or damp accumulations, in and of itself, does not negate a violation.

The Commission has held that a construction of section 75.400 "that excludes loose coal that is wet or that allows accumulations of loose coal mixed with noncombustible materials, defeats Congress' intent to remove fuel sources from mines and permits potentially dangerous conditions to exist." *Black Diamond Coal Mining Co.*, 7 FMSHRC 1117, 1121 (August 1985).

Williams Brothers Coal Co., Inc., 22 FMSHRC 57, 63 (January 2000) (ALJ).

Moreover, a sample to test for combustibility does not need to be taken under 75.400. The Commission has held that "section 75.400 does not by its terms require testing." *Harlan Cumberland Coal Company*, 20 FMSHRC 1275, 1290 (Dec. 1998). Commission precedent

holds that violations of the accumulation standard can be established by inspector observation and I find that the observations of Inspectors Durrant and Gibson established this violation.

The citation was not abated in a timely manner. The issuance of the section 104(b) order of withdrawal was reasonable as the accumulations that were not cleaned were still combustible and presented a danger to the miners. While some of the area that was required to be cleaned may, in fact, have contained mud, it needed to be cleared to assure removal of all accumulations in the area. The areas in the rock tunnel needed to be cleared for the same reason.

A violation is classified as S&S "if based upon the 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." *National Gypsum Co.*, 3 FMSHRC 822, 825 (April 1981). In *Mathies Coal Co.*, 6 FMSHRC 1, 3-4 (January 1984), the Commission set out a four-part test for analyzing S&S issues. Evaluation of the criteria is made assuming "continued normal mining operations." *U. S. Steel Mining Co.*, 6 FMSHRC 1573, 1574 (July 1984). The question of whether a particular violation is S&S must be based on the particular facts surrounding the violation. *Texasgulf, Inc.*, 10 FMSHRC 498 (April 1988). The Secretary must establish: (1) the underlying violation of the safety standard; (2) a discrete safety hazard, 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 Secretary is not required to show that it is more probable than not that an injury will result from the violation. *U.S. Steel Mining Co.*, 18 FMSHRC 862, 865 (June 1996).

I find that the elements of the *Mathies* test have been established by the Secretary. The underlying violation has been established above. The discrete safety hazard present is the coal accumulations that can act as a fuel for a fire. "The fact that some of the coal accumulations were wet is not determinative of whether the violation is S&S, because "damp coal dries in the presence of fire." " *Utah Power & Light Co.*, 12 FMSHRC 965, 970 (May 1990). There were several potential sources of ignition present in the area where the fines were located including electrical equipment, conductors, power cables, electric motors, and conveyor belts. A mine fire could cause devastating injuries. The Secretary proved that there was a reasonable likelihood that the hazard contributed to by the violation would result in an injury of a reasonably serious nature.

B. Citation No. 7282953

On April 20, 2006, MSHA Inspector Donald E. Durrant issued Citation No. 7282953 under section 104(a) of the Mine Act alleging a violation of section 75.1722(a) as follows:

An opening that measured to be about 4 inches high by 10 inches wide was present in the 2 inch mesh guarding thus exposing the output shaft of the speed reducer on the #1 drive. In addition, the

opening was only 20 inches from the walk, which was cluttered with large chunks of coal and a large turn buckle that was anchoring the unit, increasing the likelihood that a miner would come in contact with the moving parts.

Inspector Durrant determined that an injury was reasonably likely and that any injury resulting from the violation was likely to be permanently disabling. He determined that the violation was S&S and that C. W. Mining's negligence was moderate. The safety standard provides, in part, that "[g]ears; sprockets; chains; drive, head, tail, and takeup pulleys; flywheels; couplings; shafts . . .; and similar exposed moving machine parts which may be contacted by persons and which may cause injury to persons shall be guarded." The Secretary proposes a penalty of \$217.00 for this citation.

Inspector Durrant testified that he walked around the off-walk side¹ of the conveyor belt and noticed the guard was made of welded wire screening and there was an opening near the output shaft of the speed reducer measuring about four inches high and ten inches wide. (Tr. 52-53). The opening was large enough that if a miner inadvertently reached in there or stumbled, he could come into contact with the component parts. (Tr. 57). He also observed large pieces of coal on the ground and a turnbuckle that could be a trip and fall hazard to a miner. (Tr. 54; Ex. G-14). The inspector measured the distance between the walkway and the moving machine parts behind the screening at 20 inches. (Tr. 53, 60, 132-33, 146-47, 149). The moving part he was concerned about was a turning shaft that was not smooth. (Tr. 59-60).

The citation was abated within a few minutes after Inspector Durrant showed the cited condition to Ethan Tucker, an outby foreman. Tucker patched the area of the guarding. Inspector Durrant stated that Mr. Tucker agreed that a hazard was present that needed to be corrected. (Tr. 63-64)

Ken Defa, the mine superintendent, testified on behalf of the operator. Defa stated that the shaft in the area of the missing guard was a smooth shaft and did not have rough features on it that could catch a miner. (Tr. 210). It was about 20 inches between the walkway and the existing guard. *Id.* He testified that neither a miner's hand nor his clothing could become entangled in the smooth shaft. It was an additional 20 inches to the closest pinch point where the belt comes over the top of the drive pulley. (Tr. 211). As a consequence, it was about 40 inches from the walkway to a moving machine part that could cause injury to a person. The off-side walkway was four feet wide. (Tr. 213).

Inspector Gibson testified that the cited condition created a hazard because the opening was large enough for a person's extremity to pass through the opening. (Tr. 285). There were

¹ The off-walk side of the conveyor belt is the side that is closer to the mine walls or ribs. (Tr. 52-53). However, this area is still accessible to miners for maintenance and inspection purposes.

tripping hazards in the area. He thought that the moving machine part was only a few inches behind the existing guard. (Tr. 285-86).

I find that the Secretary did not meet her burden of proof with regard to this violation and the citation is vacated. The evidence presented by the Secretary is contradictory. Inspector Durrant testified that the distance between the walkway and the moving machine parts was about 20 inches (Tr. 53, 60, 132-33, 146-47, 149), but he later said it was 20 inches from the walkway to the guard and then another 20 inches from the cited opening to the moving machine part. (Tr. 148-49). While I do recognize that tripping hazards were present in the area, the evidence presented regarding the distance from the walkway to the moving parts does not adequately support the violation. It appears that the moving machine parts may have been recessed behind the existing guard to such an extent that it did not present a hazard. Therefore, I find that the Secretary did not meet her burden and the citation should be vacated.

C. Citation No. 7282959

On April 20, 2006, MSHA Inspector Durrant issued Citation No. 7282959 under section 104(d)(1) of the Mine Act alleging a violation of section 75.360(b)(10) as follows, in part:

Inadequate preshift examinations are being conducted along the belt conveyor entries Accumulations of loose coal, coal fines and float coal dust were present on numerous flights of belts, 13 permanent ventilation controls were damaged or in need of repair, fire fighting equipment at one location was not available at a permanent pump and electrical hazards were found to exist, none of which were identified by the mine examiners nor reported in the book maintained at the surface location. DT&Is that were present along the areas traveled today were inconsistent with what would be expected regarding thorough examinations. All conditions found and cited were obvious and extensive, even to the most casual of observers.

Inspector Durrant determined that an injury was reasonably likely and that any injury resulting from the violation was likely to result in lost workdays or restricted duty. He determined that the violation was S&S and that C. W. Mining's negligence was high. The safety standard provides, in part, that "[t]he person conducting the preshift examination shall examine for hazardous conditions, test for methane and oxygen deficiency, and determine if the air is moving in its proper direction at . . . areas where work or travel during the oncoming shift is scheduled prior to the beginning of the preshift examination." The Secretary proposes a penalty of \$3,400.00 for this citation.

Inspector Durrant stated that he examined the mine's preshift examination book and observed that none of the examinations over several shifts noted the violative conditions cited by

MSHA inspectors. He explained that the mine is a dynamic environment and the person responsible for countersigning the book should have known that the continuous use of the phrase "none observed" in that book meant there was a problem. (Tr. 86). Moreover, he expressed concern that the examiner had signed off as having examined areas within a very short time of each other and it appeared suspicious to him that the examiner would be able to do this given the distances involved. (Tr. 77-78). The citation lists twelve citations that were issued by MSHA inspectors that day. (Ex. G-7). He testified about the seriousness of these conditions and the fact that the conditions were obvious. (Tr. 66-79).

Inspector Durrant designated this violation as S&S as he felt that the numerous conditions that were cited were serious and were "basic and fundamental to mine examiners." (Tr. 90, 91-92). Miners rely on competent and complete preshift examinations. The level of negligence was found to be high and an unwarrantable failure to comply with the standard. (Tr. 92-93). The inspector believed that "the conditions that [MSHA inspectors] found and cited demonstrated . . . a serious lack of reasonable care" on the part of the mine examiners. The conditions should have been recorded in the record book and corrected. Inspector Durrant testified that he issued C. W. Mining eight citations for violations of section 75.360 during the previous five years. (Tr. 93-97, 137-38). The citation was terminated after the operator provided additional hazard recognition training to the miners that were conducting the preshift examinations.

Patrick Peterson, the preshift examiner, testified on behalf of the operator. Peterson stated that he conducted the examination pursuant to an MSHA document, "Definition of Hazardous Condition - Workplace Examination" which contained the following information: "For the purpose of workplace examinations, hazards are considered to be conditions that are likely to cause death or bodily injury to persons exposed to such conditions. . . . Requiring the mine examiner to look for all violations could distract . . . the examiner from the more important aspects of the examination." (Tr. 154; Ex. R-1). Peterson had been conducting preshift examinations for about six months as of April 20, 2006. He performed the preshift on a daily basis in the morning and stated that it took normally about an hour and a half to complete. (Tr. 155)

Peterson did not agree with the inspector's findings in the citation. (Tr. 156) He stated that he felt that the conditions cited at the mine did not meet the definition of hazardous conditions that would cause bodily injury or death and therefore he was not required to note them in the book. (Tr. 153-56). He makes notes of items that he believes need to be corrected, but only records "hazards" in the official book. (Tr. 160). Peterson did notice the ventilation leaks, but stated that he felt they were really small, would not harm anyone, and were not a hazard by definition. (Tr. 177). However, he did admit that if a fire occurred it was possible smoke could get into this area depending on the location of the fire. (Tr. 157). Peterson also stated that he had noted the conditions cited in his personal notebook, but did not include them in the official examiner's book. (Tr. 160). He also explained that some of the areas were only about 20 feet apart and that is why he initialed the tags minutes apart. (Tr. 168).

Ken Defa also testified regarding the training of Peterson. (Tr. 227-28). He stated that Peterson had been given the proper training to conduct preshift examinations. He felt that Peterson's job performance had been good thus far. Defa did not agree with Inspector Durrant that the preshift had been inadequate and agreed with Peterson that the cited conditions were not hazards requiring notation in the book. Mr. Defa further testified that some of the sealant around stoppings had come loose, but there was little if any air leaking through the stoppings. (Tr. 231-35, 240-44). There are hundreds of stoppings in the mine and having a few leaks does not create a reportable hazard. He also testified that the other conditions used to justify this citation were not as hazardous as contended by Inspector Durrant. (Tr. 236-39, 244-51; Ex. G-7). Many MSHA inspectors would not write citations for these conditions.

In rebuttal, Inspector Gibson testified that he was on the committee that helped train miners performing preshift examiners when the safety standard was amended. (Tr. 287-88). The intent was that "[a]ll violations may not necessarily be hazards but most hazards are truly violations." (Tr. 287). A condition that is not S&S can still be a hazard that must be recorded. Something that is listed in a mine's "to-do list" may also be a hazard that must be recorded. The question is whether a condition could become a hazard before it is corrected under normal mining conditions. (Tr. 290). The conditions he observed as well as the conditions observed by Inspector Durrant should have been recorded in the mine's preshift book. (Tr. 290-91, 293-302). For example, Inspector Gibson issued a citation for accumulations along the No. 3 belt. He noted that there was about an eighth of an inch of float coal dust on top of the speed reducer and the surface temperature of the speed reducer was extremely hot to the touch. (Tr. 301). The beltman told Gibson that he was in that area almost every day.

I credit the testimony of the MSHA inspectors and affirm the citation as written. The Commission has determined that preshift examinations are fundamental in assuring a safe work environment for the miners. *Enlow Fork Mining Co.*, 19 FMSHRC 5, 15 (January 1997); *Buck Creek Coal Co.*, 17 FMSHRC 8, 15 (January 1995). Preshift examinations have been a statutory mandate dating back to the Federal Coal Mine Safety Act of 1952, 30 U.S.C. § 471 et. seq. (1955) and is present in the current Mine Act. *See Enlow Fork* at 15. "The preshift examination is intended to prevent hazardous conditions from developing." *Id.* The preshift examiner must look for all conditions that present a hazard and this responsibility is not restricted to S&S conditions. *Id.* at 14. It is not violations that the examiner is required to find, it is conditions that present a potential hazard to miners. The types of conditions identified by the inspector and not recorded by the preshift examiner have generally been found to be hazardous. *See Id.* at 15.

I also find that this violation was properly designated as S&S. Accumulations are a hazardous condition as discussed above and could reasonably result in serious injury. Peterson missed several other conditions and his careless preshift examination could reasonably be expected to result in serious injury to the miners who depended on him to make sure their working environment was safe.

The term "unwarrantable failure" is defined as aggravated conduct constituting more than ordinary negligence. *Emery Mining Corp.*, 9 FMSHRC 1997, 2004 (Dec. 1987). Unwarrantable failure is characterized by such conduct as "reckless disregard," "intentional misconduct," "indifference," or the "serious lack of reasonable care." *Id.* 2004-04; *Rochester & Pittsburgh Coal Co.*, 13 FMSHRC at 193-94. A number of factors are relevant in determining whether a violation is the result of an operator's unwarrantable failure, such as the extensiveness of the violation, the length of time that the violative condition has existed, the operator's efforts to eliminate the violative condition, whether an operator has been placed on notice that greater efforts are necessary for compliance, the operator's knowledge of the existence of the violation, and whether the violation is obvious or poses a high degree of danger. *Mullins & Sons Coal Co.*, 16 FMSHRC 192, 195 (Feb. 1994); *Windsor Coal Co.*, 21 FMSHRC 997, 1000 (Sept. 1999); *Consolidation Coal Co.*, 23 FMSHRC 588, 593 (June 2001).

I credit the testimony of the MSHA inspectors that the conditions referenced in the citation were extensive and obvious. For example, the accumulations were 6 to 8 feet wide and 4 to 27 inches deep and little effort had been made to remove them. Clearly, this did not develop overnight and had not been noted in the preshift examination book as a condition that needed to be corrected. C. W. Mining has been issued quite a few citations under 75.400 and 75.360 in the past and should be aware that greater efforts were necessary. (See Ex. G-11). C. W. Mining's conduct constituted a serious lack of reasonable care and I am affirming the unwarrantable failure designation.

D. Citation No. 7282965

On April 21, 2006, MSHA Inspector Durrant issued Order No. 7282965 under section 104(d)(1) of the Mine Act alleging a violation of section 75.360(a)(1) as follows, in part:

The preshift examination that was to be conducted and completed between the hours of 0500 and 0800 for the day shift employees on 04/21/2006 was not completed until 0930 hours, some 90 minutes late. The mine operator has established a preshift schedule based on the 8 hour intervals. The mine examiner was aware of the schedule and completion time but stated he got a late start and was unable to complete the examination in the required time. The superintendent and mine foreman knew that the examination was late yet made no effort to remove the miners from the underground workings.

Inspector Durrant determined that an injury was unlikely but that any injury resulting from the violation was likely to result in lost workdays or restricted duty. He determined that the violation was not S&S and that C. W. Mining's negligence was high. The safety standard provides, in part, 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 . . . remain in any underground area unless a preshift examination have been completed for the established 8-hour interval.” The Secretary proposes a penalty of \$3,000.00 for this citation.

Inspector Durrant stated that he and Inspector Gunderson went into the mine and noticed that several of the tags where the preshift examiner signed off had times listed after 8:00 a.m. The last time he observed was 9:30 a.m. which would have been 90 minutes after the preshift examination should have been entered into the book kept on the surface.² (Tr. 102). Inspector Durrant testified that he talked to Patrick Peterson, the preshift examiner, to determine why the examination was late. According to Durrant, Peterson replied that he had gotten a late start due to a meeting that was held to address the citations issued the previous day. (Tr. 103-04). Additionally, Durrant was told that Peterson knew he would not finish the examination by the required time. Durrant also spoke with Ken and Randy Defa regarding the late preshift examination to determine if they knew that the examination would be late. Ken replied that he realized it around 8:30 or 9:00 a.m. and that at this point it was too late to withdraw the miners. Randy said he felt by the time withdrawal of the miners occurred the preshift examination would have been completed. (Tr. 108-109). Miners had traveled underground at 7:00 a.m. and the most recent preshift examination would have been completed at midnight. (Tr. 107).

Inspector Durrant did not believe that the violation was S&S because no significant hazards were present, other than the accumulation that had not yet been totally cleaned up. (Tr. 140-44). He designated the negligence as high because the operator knew the examination was late and did nothing to withdraw the miners. (Tr. 112-113, 115). He believed that the company only offered a “lame excuse” for not completing the examination on time or removing the miners. *Id.* He determined that the operator’s conduct was aggravated negligence. The risk of injury or illness was unlikely.

Patrick Peterson testified on behalf of the operator. He stated that he conducted the preshift examination on April 21, 2006. He got a late start that morning due to a meeting. The entire crew was at the meeting to discuss safety and the actions that needed to be taken to abate the citations that had been issued the day before. (Tr. 178-80). He stated that he probably started just before 7:00 a.m. (Tr. 158-159). Peterson stated that he took longer than normal to complete the inspection as he was trying to satisfy the inspector. He did complete the examination of the areas where the miners were working by 8:00 a.m. Men were shoveling and cleaning along the one, two and four belts. (Tr. 159-60, 161). He needed to finish the tail end of three belt, five belt, and the intake coming back out. (Tr. 161). He does not believe that men were working in those areas. *Id.* When Ken Defa called him to inquire into the status of his preshift, he was almost done. (Tr. 169, 181).

² An operator has designated preshift interval times during which the preshift examination must be conducted. The interval relevant here is from 5:00 a.m. to 8:00 a.m. The preshift examination should be completed and logged into the book by 8:00 a.m. (Tr. 100)

Ken Defa testified that he did everything he could to remove the miners once he learned that the preshift had not been completed in the outby areas. (Tr. 253). The preshift examination had been timely completed for the working sections. (Tr. 251). When he talked to Peterson by radio, he learned that the preshift had been completed for the belts and that Peterson was examining the intakes. This final portion of the examination would take about 10 to 15 minutes. (Tr. 252). Defa called his son, Randy, and told him to get the men out of the mine. He also stated that no hazard was presented by the violation because the men were working in areas that had already been preshifted. (Tr. 254-55). Randy Defa testified that Ken Defa had radioed him to get everybody out of the mine because the preshift was not complete. (Tr. 192). Randy explained that he was not near his truck nor any of the miners, so he attempted to contact them by phone and radio but was unsuccessful.

I find that the Secretary established the violation and I affirm the citation. Peterson testified that he did not complete the examination by 8:00 a.m. as he was required to do. (Tr. 159). However, I do find that the examination of the working sections and other key areas had been completed by 8:00 a.m. I conclude that the violation was not the result of the operator's unwarrantable failure to comply with the standard. I enter a finding of moderate negligence. Peterson simply got a late start due to the safety meeting and lost track of time. Attempts were made by Ken and Randy Defa to contact the affected miners to remove them from the mine. He was not successful in doing so. This violation did not demonstrate aggravated conduct under the Commission's unwarrantable failure test.

II. APPROPRIATE CIVIL PENALTIES

Section 110(i) of the Mine Act sets forth six criteria to be considered in determining appropriate civil penalties. The mine has a history of 116 paid violations in the two years prior to April 20, 2006. (Ex. G-11). The Bear Canyon #4 mine is of a medium size and C. W. Mining is a large coal mine operator. The penalties assessed in this decision will not have an adverse effect on C. W. Mining's ability to continue in business. With the exception of Citation No. 7282952, the citations were rapidly abated. My gravity and negligence findings are set forth above. Based on the penalty criteria, I find that the penalties set forth below are appropriate.

III. ORDER

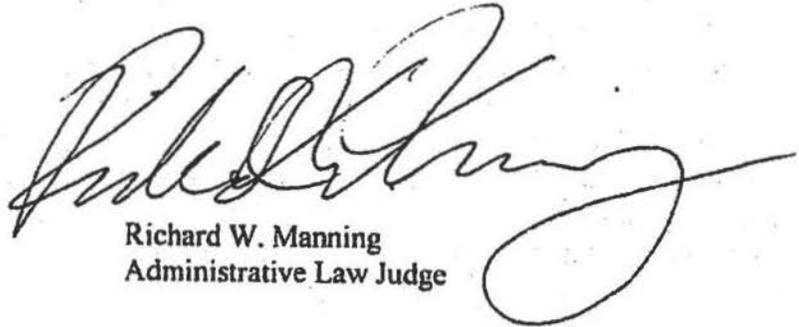
Based on the criteria in section 110(i) of the Mine Act, 30 U.S.C. § 820(i), I assess the following civil penalties:

Citation/Order No.	30 C.F.R. §	Penalty
WEST 2007-241		
7282952	75.400	\$2,000.00
7282953	75.1722(a)	Vacated

WEST 2007-449

7282959	75.360(b)(10)	3,500.00
7282965	75.360(a)(1)	1,000.00
7283064	75.400	Vacated
7283065	75.380(d)(1)	Vacated

For the reasons set forth above, the citations are **AFFIRMED, MODIFIED**, or **VACATED** as set forth above and C. W. Mining Company is **ORDERED TO PAY** the Secretary of Labor the sum of \$6,500.00 within 30 days of the date of this decision. Payment should be sent to the new address: U.S. Department of Labor, Mine Safety and Health Administration, P.O. Box 790390, St. Louis, MO 63179-0390.



Richard W. Manning
Administrative Law Judge

Distribution:

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RWM

FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

OFFICE OF ADMINISTRATIVE LAW JUDGES
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Washington, D.C. 20001
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January 25, 2008

MCELROY COAL COMPANY, Contestant	:	CONTEST PROCEEDING
	:	
	:	Docket No. WEVA 2005-243-R
	:	Order No. 7124782; 08/11/2005
v.	:	
	:	
SECRETARY OF LABOR, MINE SAFETY AND HEALTH ADMINISTRATION (MSHA), Respondent	:	McElroy Mine
	:	Mine ID 46-01437
	:	
SECRETARY OF LABOR, MINE SAFETY AND HEALTH ADMINISTRATION (MSHA), Petitioner	:	CIVIL PENALTY PROCEEDING
	:	
	:	Docket No. WEVA 2006-465
	:	A.C. No. 46-01437-85760
v.	:	
	:	
MCELROY COAL COMPANY, Respondent	:	McElroy Mine

DECISION

Appearances: Joanne Jarquin, Esq., Office of the Solicitor, U.S. Department of Labor, Philadelphia, Pennsylvania, on behalf of the Secretary of Labor; Rebecca J. Oblak, Esq., Bowles Rice McDavid Graff and Love, LLP, Morgantown, West Virginia, on behalf of McElroy Coal Company.

Before: Judge Zielinski

These cases are before me on a Notice of Contest, filed by McElroy Coal Company ("McElroy"), and a Petition for Assessment of Civil Penalties filed by the Secretary of Labor ("Secretary"), pursuant to section 105 of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 815 ("Act"). The petition, which includes the contested order, alleges that McElroy is liable for four significant and substantial and unwarrantable failure violations of the Secretary's Mandatory Safety Standards for Underground Coal Mines, and for Surface Areas of Underground Coal Mines, and proposes the imposition of civil penalties totaling \$23,300.00. A hearing was held in Wheeling, West Virginia, and the parties filed briefs after receipt of the

transcript.¹ For the reasons set forth below, I find that McElroy committed the violations, but that two of them were not unwarrantable failures, and impose civil penalties totaling \$18,400.00.

Findings of Fact - Conclusions of Law

McElroy operates an underground coal mine and surface preparation plant located in Marshall County, West Virginia. The alleged violations at issue in these proceedings arose out of inspections conducted by the Secretary's Mine Safety and Health Administration ("MSHA") on December 1 and 22, 2004, February 23, 2005, and August 30, 2005.

Order No. 7123909

Order No. 7123909 was issued on December 1, 2004, by MSHA inspector James C. Preece, and alleges a violation of 30 C.F.R. § 75.360(f), or in the alternative § 75.360(a)(1),² which provide, in pertinent part:

(a)(1) [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. . . .

¹ The record consists of the transcript of the hearing testimony, the exhibits admitted into evidence at the hearing, excerpts of deposition transcripts that were submitted after the hearing, and final stipulations submitted by letter dated August 7, 2007. The Secretary's deposition excerpts, exhibits G-21 through G-28, and G-33, were submitted on June 29, 2007. McElroy's deposition excerpts, exhibits R-3 (Preece) and R-16 (Yudaz), were submitted, untimely, on July 9, 2007, and were re-submitted on July 18, 2007, along with a motion to allow late-filing. Although it was noted that the Secretary was opposed to the motion, no opposition was submitted. The motion is granted, and McElroy's deposition excerpts are admitted as part of the record. The Secretary's counter designations were submitted on July 13, 2007, and are also admitted.

² The Order, as issued, cited a violation of section 75.360(f). Prior to the hearing, the Secretary moved to amend the Order to include, in the alternative, that the conditions found by Preece constituted a violation of section 75.360(a)(1). Respondent opposed the motion, arguing that it raised potential new issues, specifically, whether a preshift examination had actually been conducted, whether the examiner had the appropriate qualifications, and whether the examination was done timely. The Secretary stipulated that no such issues were being raised, and argued that the facts stated in the Order, i.e., that "mine examiners . . . fail[ed] to identify and correct [or record] hazardous conditions," had been found to have been in violation of both regulatory provisions. On the basis of the Secretary's stipulation and argument, the motion to amend was granted. Tr. 16-21.

(f) *Recordkeeping.* A record of the results of each preshift examination, including a record of hazardous conditions and their locations found by the examiner during such examination and the results and locations of air and methane measurements, shall be made on the surface before any persons, other than certified persons conducting examinations required by this subpart, enter any underground area of the mine. . . .

Preece was conducting a regular inspection of the McElroy Mine. He found several hazardous conditions in the area of the head roller in by the take-up pulley of the No. 10 conveyor belt, and issued citations for the conditions charging that they violated various safety standards. The hazardous conditions had not been reported on the record of the results of the preshift examination that had been performed before the start of the shift. Ex. G-19. Preece believed that the conditions existed at the time the preshift examination had been conducted, and should have been identified and recorded on the report of the preshift examination.

He determined that it was reasonably likely that the violation would result in an injury involving lost work days or restricted duty, that the violation was not significant and substantial, that one employee was affected, and that the operator's negligence was high. The Order was issued pursuant to section 104(d)(2) of the Act, and alleges that the violation was the result of McElroy's unwarrantable failure to comply with the standard.³ A civil penalty in the amount of \$4,800.00 has been proposed for this violation.

The Violation

The preshift examination for the 8:00 a.m. to 4:00 p.m. shift on December 1, 2004, was conducted by Bruce M. Kinser, a certified preshift examiner, from 5:36 a.m. to 7:43 a.m., and was called to the surface at 7:45 a.m. Ex. G-19. The only hazardous conditions or violations recorded for the No. 10 belt were a rib roll at location "44-1/2 s/s" and an area that needed to be rock dusted from "16 to 26." Ex. G-19. Preece inspected the No. 10 belt drive between 10:00 and 11:00 a.m. In the area of the first three crosscuts traversed by the belt, which he referred to as "10-0 to 10-2," he found what he believed to be violations of safety standards for which he issued citations.⁴ The area is traveled by preshift examiners three times a day. A belt attendant works in the area one shift per day, and a belt examiner travels the area once per day. Tr. 616-18.

³ The parties stipulated that there was no intervening "clean inspection" between the time of the issuance of the orders at issue in this proceeding and the previous section 104(d)(1) order issued on January 9, 2004.

⁴ When it was explained that there is no section of the belt designated 10-0, Preece clarified that it was the first three crosscuts. Tr. 539. The area was considerably removed from the areas where problems had been noted on the preshift report.

The guarding on the "solid side" of the take-up unit consisted of five-by-five-foot metal frames to which metal, chain link fence-like, material had been welded. The guard panels were about six inches away from the moving belt and take-up rollers, and two feet away from the rib. Corrosion and general wear and tear had resulted in two "holes" in the guarding, one was three-by-five feet and the other was two-by-three feet. The preshift examiner had traveled that side of the belt. A card attached to the guard close to the location of the holes bore his initials and a time of 6:59 a.m. Tr. 373. The guarding material had dust on it, and it could be pushed in to touch the belt. Tr. 366. Preece issued Citation No. 7123907, alleging a significant and substantial violation of the applicable guarding standard. Ex. G-8. A civil penalty was subsequently assessed for the violation, and was paid by Respondent. Upon payment, the violation became a final order of the Commission and the "assertion of violation contained in the citation is regarded as true." *Old Ben Coal Co.*, 7 FMSHRC 205, 209 (Feb. 1985).

Preece found deposits of coal dust, including float coal dust, around the belt drive from the head roller to the end of the take-up unit. An area extending 200 to 300 feet was black in color. There were trash bags, trash and other miscellaneous items throughout the area. Tr. 359. Two of four water sprays used by Respondent to control dust were not working.⁵ He issued Citation No. 7123905, charging a significant and substantial violation for the combustible accumulations. Ex. G-6. Respondent paid the civil penalty that was assessed for that violation.

Preece also observed that the fifth roller from the end of the top, track-side, of the take-up unit was hot and throwing off sparks. This was in the area that had accumulations of coal dust and other combustible materials. A ribbon had been tied to the guarding next to the roller. Both the ribbon and the roller were covered with coal dust. Citation No. 7123906 was issued, charging a significant and substantial violation for failure to maintain equipment, and the assessed civil penalty was paid by Respondent. Ex. G-7. The belt was shut down, and the roller was changed. It was sufficiently hot that the crew changing it couldn't handle it. Ex. R-3 at 183.

Preece also found a violation related to firefighting equipment. Two fire extinguishers located at the drive did not have tags showing that they had been examined within the past six months. Tr. 373. He issued Citation No. 7123903, charging a non-significant and substantial violation as to the fire extinguishers.⁶ Ex. G-5. The civil penalty assessed for that violation was paid by Respondent.

The Secretary contends that these conditions existed at the time of the preshift examination, and should have been identified and recorded on the report of that examination.

⁵ Spraying water on the belt to control dust is not required by federal regulations.

⁶ Preece also issued Citation No. 7123908 for inadequate firefighting equipment. Ex. G-9. However, that equipment was located in the track haulage area, which is not in the same preshift examination area as the No. 10 belt, and the Secretary does not rely upon that condition as proof of the instant violation. Tr. 393.

McElroy contends that the conditions were not hazardous, and that any conditions observed by Preece did not exist at the time the preshift examination was conducted some three hours earlier.

The fact that the conditions, as cited by Preece, existed at the time of his inspection is not disputed, either factually or legally. Frederick T. Blizzard, a miners' representative who traveled with Preece during the inspection, confirmed the existence of the conditions. He testified that there was a "lot of coal dust," about 1 inch thick, black in color, that extended at least from the head pulley past the take-up unit of the No. 10 belt. Tr. 581-82. He also confirmed that there were holes in the guarding on the solid side near the take-up roller, that there was a sparking roller, and that two of the four dust control water sprays were working. Tr. 583-87. McElroy did not present evidence challenging the existence of the conditions. Moreover, its payment of the civil penalties assessed for the violations established their existence as a matter of law.

McElroy argues that the conditions were not hazardous, contending, e.g., that the "openings in the guarding could have been avoided with the use of reasonable care; therefore, they did not constitute a hazardous condition." Resp. Rpy. Br. at 9. The argument hardly merits a response. One of the basic tenets of enforcement of guarding and other safety standards has been the fact that miners do not always exercise caution, and that hazards must be guarded to prevent "contact stemming from inadvertent stumbling or falling, momentary inattention, or human carelessness." *Thompson Bros. Coal Co.*, 6 FMSHRC 2094, 2097 (Sept. 1984). The belt attendant on December 1, had been temporarily assigned to that job for a few days. He was a very large individual, who had to move sideways through the narrow passage between the guarding and the rib. Tr. 606-07. In addition, the citations issued for the inadequate guarding, the accumulations and the defectively maintained roller, now final orders of the Commission, were significant and substantial, i.e., reasonably likely to result in a reasonably serious injury under continued normal mining operations.

The critical question is whether the conditions existed at the time of the preshift examination, i.e., at approximately 7:00 a.m. on December 1, 2004. The "holes" in the guarding resulted from corrosion and general wear and tear. Preece believed that the worn and corroded guarding took multiple shifts to deteriorate. Tr. 384. Michael A. Conjeski, the mine foreman, testified that the guarding was probably at least eight years old, and that it does deteriorate. Tr. 637-38, 655. It is highly likely that the holes existed at the time of the preshift examination, probably considerably longer. What is not clear is how obvious they were. As noted above, Preece stated that the guarding could be pushed in to touch the belt. Tr. 366. He later testified that the condition was pretty obvious. "[I]t's pretty obvious when you hit the screen or you touch the screen it's moving. You walk by it. You can see it move." Tr. 525-26.

While the size of the "holes" was described, their appearance was not. Despite their characterization, it appears that they were not actual holes, i.e., the fence-like material was not completely missing. Rather it was hanging in place, and could be pushed in with minimal force. The guarding was woefully inadequate. However, it may not have appeared to have been defective, unless touched or moved. Conjeski opined that the preshift examiners generally

walked the other side of the belt and may have missed the guarding defects. Tr. 636. However, the examiner on the midnight shift, consistent with McElroy policy, walked the "solid side," and would have been in a better position to observe the hazards. Tr. 645, 654. Nevertheless, unless he pushed or touched the loose screen, the condition may not have been obvious.

Preece believed that the coal dust accumulations had existed for more than one shift, because, in his experience, having performed inspections in that particular area, "it would have been difficult to get that black within two hours."⁷ Tr. 362, 366. He opined that "if [the area] got that black in a couple hours you've probably got a problem." Tr. 362. The appearance of the dust, a dull black color, also lead him to believe that it had been there for some time, because fresh coal dust is shiny and sparkly. Tr. 385-86. Conjeski agreed that it would normally take days for black coal dust to accumulate. However, if the water sprays weren't functioning, it wouldn't take that long. Tr. 667. Chad Deloma, a McElroy safety inspector at the time the order was issued, stated at his deposition that he'd never seen a clean area go black in one shift. Normally, it wouldn't happen in two shifts, "it would take a long time. Something would have to go very wrong for that to happen." Ex. G-25 at 33-34.

There is no evidence that there was an unusual problem in the area, or that something had gone "very wrong," that could have caused an unusual rapid build-up of dust. Two of the four water sprays were functioning at the time of the inspection. It is highly likely, from the nature and appearance of the condition, that there was a significant accumulation of coal dust at the time of the preshift examination.

Preece did not believe that it was possible that the roller went bad after the preshift examination had been conducted, because it had been tagged with the ribbon, and the ribbon had old damp rock dust on it. Tr. 178-82. While he did not know what the condition of the roller was at the time of the preshift examination, he believed that it "did not wear out in two hours and wear the metal away and the bearings away on this roller." Tr. 527. However, at his deposition, Preece conceded that the roller may not have been hot at the time the preshift examination had been conducted. Ex. R-3 at 182.

Conjeski and Deloma described McElroy's policy with respect to "hot" rollers. They were changed immediately, and anyone in the area had the authority to shut the belt down so that a hot roller could be changed. If a roller was starting to go bad, e.g., its bearings were beginning to fail causing it to squeak, it would be tagged with a ribbon and a new roller would be spotted next to it. The roller would then be replaced on the weekend, when the belt was not operating. Tr. 627-32. December 1, 2004, was a Wednesday. The roller could have been showing signs of wear, and been tagged two days earlier. Accumulations of dust on the ribbon and roller do not establish that the roller was hot and/or throwing off sparks at the time of the preshift examination.

⁷ Preece entered the area about 10:00 a.m., two hours after the shift began, and three hours after the preshift examination had been conducted.

Upon consideration of all of the above factors, I find that at the time of the preshift examination there was an accumulation of coal dust and other combustible materials that should have been identified as a hazardous condition and recorded on the preshift report. I also find that, while the roller may not have been hot and sparking at the time of the examination, it was obviously a roller that was breaking down, and had the potential to become hot and dangerous in a short period of time, such that increased attention should have been paid to accumulations and the sufficiency of fire fighting equipment. The guarding near the take-up unit was clearly defective at the time of the examination. While it may not have been as obvious as Preece related, I credit his testimony, and find that it should have been discovered and reported during a proper preshift examination.⁸

I find that there was a violation. Because it was the examiner's failure to identify the hazardous conditions, rather than simply a failure to record them, I find that section 75.360(a)(1) was the provision violated. I also find that the failure to identify the conditions, and note them on the report of the preshift examination, resulted in at least one miner entering and working in the area before the hazardous conditions were corrected, and that it was reasonably likely that an injury would have occurred resulting in lost work days or restricted duty.

Unwarrantable Failure - Negligence

In *Lopke Quarries, Inc.*, 23 FMSHRC 705, 711 (July 2001), the Commission reiterated the law applicable to determining whether a violation is the result of an unwarrantable failure:

The unwarrantable failure terminology is taken from section 104(d) of the Act, 30 U.S.C. § 814(d), and refers to more serious conduct by an operator in connection with a violation. In *Emery Mining Corp.*, 9 FMSHRC 1997 (Dec. 1987), the Commission determined that unwarrantable failure is aggravated conduct constituting more than ordinary negligence. *Id.* at 2001. 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) ("R&P"); see also *Buck Creek [Coal, Inc. v. FMSHRC]*, 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, such as the length of time that the violation has existed, the extent of the violative condition, whether the operator has been placed on

⁸ The missing tag on one fire extinguisher, and the tag that failed to show that another fire extinguisher had been serviced within the past six months, were also items that should have been noted and recorded on the report of the preshift examination.

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 1988). All of the relevant facts and circumstances of each case must be examined to determine if an actor's conduct is aggravated, or whether mitigating circumstances exist. *Consol*, 22 FMSHRC at 353. Because supervisors are held to a high standard of care, another important factor supporting an unwarrantable failure determination is the involvement of a supervisor in the violation. *REB Enters., Inc.*, 20 FMSHRC 203, 225 (Mar. 1998).

The Secretary argues that the violation was the result of an unwarrantable failure because the conditions were extensive, obvious and existed for more than one shift, that they posed a high degree of danger, and that the failure to note or record them on the preshift report evidenced an indifference to safety. Sec'y. Br. at 34. Had the evidence justified a finding that the conditions, as Preece found them, had existed at the time of the preshift examination, the Secretary's argument might be well-founded. However, there are significant mitigating factors. There is insufficient evidence to justify a finding that the roller was "hot" and sparking at the time of the preshift examination. While the accumulations of coal dust were such that they should have been reported, they would most likely have been somewhat smaller in volume and/or extensiveness three hours before Preece observed them. As to the "holes" in the guarding, it appears from Preece's description, that the fence-like material was hanging in place, and that the "holes" may not have been obvious unless the examiner made contact with the loose material.

Based upon all of the above factors, and considering the fact that the Secretary has the burden of proof on all elements of a violation, I find McElroy's negligence with respect to this violation to have been moderate, and not the result of an unwarrantable failure.⁹ Accordingly, the Order will be modified to a citation issued pursuant to section 104 of the Act.

⁹ In an enforcement proceeding under the Act, the Secretary has the burden of proving all elements of an alleged violation by a preponderance of the evidence. *In re: Contests of Respirable Dust Sample Alteration Citations*, 17 FMSHRC 1819, 1838 (Nov. 1995), *aff'd*, *Sec'y of Labor v. Keystone Coal Mining Corp.*, 151 F.3d 1096 (D.C. Cir. 1998); *ASARCO Mining Co.*, 15 FMSHRC 1303, 1307 (July 1993); *Garden Creek Pocahontas Co.*, 11 FMSHRC 2148, 2152 (Nov. 1989); *Jim Walter Resources, Inc.*, 9 FMSHRC 903, 907 (May 1987).

Order No. 7124015

Order No. 7124015 was issued by Preece on December 22, 2004, and alleges a violation of 30 C.F.R. § 75.512, which requires that:

All electric equipment shall be frequently examined, tested, and properly maintained by a qualified person to assure safe operating conditions. When a potentially dangerous condition is found on electric equipment, such equipment shall be removed from service until such condition is corrected. A record of such examinations shall be kept and made available to an authorized representative of the Secretary and to the miners in such mine.

Preece inspected a power center located in a crosscut in the 1 Left, 5 South Tailgate section of the mine. He observed several defects that he believed presented a potential for serious injury, and which appeared to have been present for at least one shift. He determined that the power center ("PC") was not being maintained in safe operating condition, and issued the Order pursuant to section 104(d)(2) of the Act, alleging that the violation was the result of McElroy's unwarrantable failure to comply with the standard. Ex. G-3. He also determined that it was highly likely that the violation would result in a fatal injury, that the violation was significant and substantial, that one employee was affected, and that the operator's negligence was high. A subsequent review resulted in a modification of the Order, specifying that it was reasonably likely, not highly likely, to result in an injury. A civil penalty in the amount of \$6,600.00 has been proposed for this violation.

The Violation

The PC in question was approximately eight feet wide, 20 feet long and four feet high. It was located in the center of a crosscut that was about 15 feet wide, leaving approximately two-to-three feet on each side. It was energized and was being used to charge a piece of mobile equipment. Tr. 307. The high voltage end of the PC, where a cable supplied 12,470 volts of power, was facing the track entry. The PC is depicted in several photographs taken at the time of the inspection. Ex. G-17A-F.

Preece found multiple defects in the PC, virtually all of which were confirmed by Charles B. Racer, McElroy's representative, who accompanied Preece on the inspection, and took photographs of the conditions. The first problem that Preece noticed was on the end of the PC facing the track entry. Located close to where the power supply cable enters the PC, there was a glass observation port, oval in shape, approximately five-to-six inches wide and 18 inches high. It was held in place by a rubber grommet. The lower end of the glass had been pushed in about two and one-half inches, and it appeared that there was an imprint of a boot or shoe on the top of a rock dust bag, located such that the toe of a boot would have been against the lower part of the glass. Tr. 298-300. The Secretary introduced pictures of the condition as first observed by Preece, and with the rock dust bag removed showing the displaced glass more clearly. Ex. G-

17C, 17F. Preece testified that a conductor associated with the 12,470-volt power cable was visible through the opening, and it was possible that high voltage could “track” to anything inserted into the opening, such as a steel-toed boot, or a piece of metal like the slate bar shown in pictures leaning against that end of the PC. Tr. 303-10; ex. G-17C and F.

On the upper-left side of the high voltage end of the PC, Preece found a damaged cover for a low voltage pilot circuit. The cover, which is depicted in a photograph taken at the time, was ajar at about a 45-degree angle, and would not close. Ex. G-17C. A terminal strip, supplying power for safety devices, was located under the defective cover, and was partially exposed. Preece tested the circuit and found in excess of 50 volts. Tr. 322. He later determined, after learning that the resistance of the grounding circuit at the mine was 166 ohms, that the pilot circuit could deliver 302 milliamps at 50 volts. Tr. 489-91. At 96 volts, which was the most likely voltage of the circuit, it could deliver nearly 600 milliamps. Tr. 562.

The PC has four-to-five lids, or covers, each about four feet by eight feet, which, by design, are to be secured by bolts on each end. All of the lids’ bolts were missing.¹⁰ The lids weigh 50-to-100 pounds. A person could grasp the handles, lift one end of the lid and slide it over. Tr. 480. The lids on the high voltage end of the PC had “whisker switches,” that would deenergize the PC if the lids were lifted. However, the lids on the lower voltage end did not have such switches. Tr. 481-84. Preece has seen miners lift the lids on power centers for no particular reason, and has found drinking water and parts stored in other power centers. Tr. 316-19. Lifting a lid on the lower voltage end of the PC would expose energized electrical components and create a potential for something to fall in and create an arc or fire. Tr. 312.

The PC had several 480-volt receptacles, to which cables could be connected. The ground pins on three of the receptacles were displaced at an angle. Preece testified that the pins were broken, or would become broken if someone attempted to attach a cable to the receptacle. Tr. 325-29; ex. G-17D. He explained that, even though the pins were broken and at an angle, miners could screw a connector onto the receptacle. The PC was designed to prevent energizing of a receptacle if the ground circuit was not intact. However, Preece explained that the broken ground pin could show sufficient continuity to allow the receptacle to be energized, but that the marginal connection would not be adequate to provide an effective ground. Tr. 330-33. An electrocution hazard would then be created if there was a short circuit to the frame of a piece of equipment.

The Secretary contends that these conditions violated the standard because the PC had not been maintained to assure safe operating conditions.¹¹ McElroy disputes that the conditions

¹⁰ PC lids, handles and missing bolts are shown in a picture introduced by the Secretary. Ex. G-17A.

¹¹ Preece had included another defect in his Order, but realized during his deposition, that he had been mistaken. Item numbered 2 in the Condition or Practice section of the Order is

violated the standard. As to the displaced glass, it contends that there was no opening, and that any opening was not large enough or located such that it presented a hazard to anyone other than a person intent on committing suicide. Resp. Br. at 28, Rpy. Br. at 3-4. However, the existence of the opening cannot be seriously disputed. McElroy's safety inspector, Racer, confirmed that the conditions described by Preece existed. Tr. 692, 722, 745. One of the pictures he took clearly shows the opening created by displacement of the glass. Tr. 685; ex. G-17F.

McElroy argues that the missing lid bolts presented no hazard because all lids had safety switches on them, it would take two people to remove one of the lids, and even if bolts had been present a miner could have removed them. The fact that a miner could have removed lid bolts, if he had access to a wrench or other appropriate tool, does little to diminish the significance that unsecured lids presented ready opportunities for miners to lift and move them. The remaining arguments are based upon an overly optimistic reading of Racer's testimony. While he did state that it "takes two people, one on each side, to actually remove the lid fully," he acknowledged that he could raise one side, and did not contradict Preece's testimony that one miner could lift one end of the lid and slide it over. Tr. 701-02. In addition, while he first testified that the "lids all have switches," he promptly clarified that that was his "understanding," and later stated that he didn't know "one way or the other" whether the PC had switches on all of its lids. Tr. 701-02, 737. Preece testified that he looked at this PC, and not all of the lids had switches. Tr. 481. He also testified that PC's that he had worked on as an electrician did not have switches on the low voltage side. Tr. 482. I accept the testimony of Preece, a certified electrician, and find that not all of the lids had safety switches.

McElroy argues that Preece did not test the integrity of the grounding circuits for the receptacles. The hazard described by Preece was that the ground pins were broken, but that a cable could still be attached to the receptacle, and the grounding circuit could give a false positive test result. It is unclear whether the test referred to would have confirmed the existence of the hazard. In addition, there is no claim by McElroy that it could not have tested the grounding circuits. It apparently chose not to do so, or if it did, chose not to offer the results of such tests into evidence. The case cited by McElroy in support of its argument is inapposite. *Consolidation Coal Co.*, 10 FMSHRC 745 (June 1988) (ALJ).

McElroy's arguments as to the pilot circuit are similarly deficient. It advances a number of contentions, none of which have merit. The first argument is that the door covering the terminal strip was only bent and ajar, and that its integrity was not compromised. Resp. Br. at 10. This argument also is based upon a misreading of Racer's testimony. Tr. 706-07. As noted above, Racer confirmed the existence of the conditions found by Preece. Tr. 745. A picture that Racer took of the end of the PC shows that the door that was designed to cover the terminal strip was bent and ajar at approximately a 45-degree angle. Ex. G-17C. The "integrity" of the door to perform its intended function, preventing inadvertent contact with the terminal strip, was substantially compromised. McElroy argues, citing Racer's testimony, that there was only a

incorrect and is not relied upon in support of the alleged violation. Tr. 336-38; ex. G-3.

“very small voltage” on the strip, and that Preece did not measure the voltage. Resp. Br. at 10. However, Racer made clear that that was only his “understanding,” and that he did not know how much voltage was present. Tr. 706-07. It is true that Preece did not measure the voltage. However, he did check it with an instrument, and confirmed that there was at least 50 volts present. Tr. 322. McElroy is also critical of the fact that Preece did not know, at the time he issued the Order, how much resistance was on the grounding circuits and, consequently, the amount of amperage that could be generated. Preece obtained that information on a return visit to the mine in preparation for the hearing. Tr. 489-91. Whether Preece knew those facts when he issued the Order is immaterial.

Significant and Substantial

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

The Commission has explained that:

In order to establish that a violation of a mandatory safety standard is significant and substantial under *National Gypsum*, the Secretary of Labor must prove: (1) the underlying violation of a mandatory safety standard; (2) a discrete safety hazard--that is, a measure of danger to safety--contributed to by the violation; (3) a reasonable likelihood that the hazard contributed to will result in an injury; and (4) a reasonable likelihood that the injury in question will be of a reasonably serious nature.

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

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

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

Mining Co., Inc., 6 FMSHRC 1866, 1868 (August 1984); *U.S. Steel Mining Co., Inc.*, 6 FMSHRC 1573, 1574-75 (July 1984).

This evaluation is made in terms of "continued normal mining operations." *U.S. Steel Mining Co., Inc.*, 6 FMSHRC at 1574. The question of whether a particular violation is significant and substantial must be based on the particular facts surrounding the violation. *Texasgulf, Inc.*, 10 FMSHRC 498 (Apr. 1988); *Youghiogheny & Ohio Coal Co.*, 9 FMSHRC 2007 (Dec. 1987).

As is frequently the case, whether this violation was S&S depends upon whether it was reasonably likely that an injury producing event would occur under continued normal mining operations. The fact of the violation, and the existence of several hazardous conditions contributed to by the violation have been established. It is also not disputed that any injury resulting from contact with the 12,470-volt circuit, an improperly grounded 480-volt circuit, or even the low voltage on the terminal strip could be expected to result in a reasonably serious injury. Preece testified that the 302-to-600 millivolts that would be delivered by contact with the terminal strip could result in a serious injury or a fatality. Tr. 552.

McElroy advances several arguments against the S&S designation. It's chief contention is that miners who are in proximity to the PC know that it is a piece of electrical equipment associated with high voltage and are unlikely to come into contact with any of the hazards. Racer testified that he believed that miners are aware of the hazards presented by such electrical equipment, they work with it every day, and use caution around it. Tr. 698. He did not believe that anyone would place something in the opening created by the displaced safety glass, and it "would take a suicide attempt" for a miner to be injured by that condition. Tr. 714. McElroy reiterates its argument that the unsecured lids posed no hazard because all of them had safety switches that would deenergize the PC if the lid was lifted, and that the broken ground pins on the receptacles did not present a hazard because there was a secondary system that would prevent the receptacle from being energized if the ground circuit was not intact. McElroy also claims that it established, through Racer's testimony, that the voltage on the terminal strip was too low to be a hazard. Resp. Br. at 29.

Some of McElroy's arguments are based upon erroneous factual premises, and they otherwise do little to rebut the Secretary's evidence. The gap created by the displaced safety glass was at the bottom of the oval-shaped opening, where the approximately five-to-six-inch-wide glass was pushed in two and one-half inches. McElroy misperceives the nature of the hazard. It was not necessary to insert a body part or conductive rod through the opening such that it came into physical contact with a component bearing 12,470 volts in order to cause an injury. As described by Preece, an experienced and certified electrician, high voltage can "track" to something close by, possibly to a steel toed boot inadvertently placed against the pushed-in glass. Certainly, an inadvertent placement of something like the slate bar into the opening would have produced a disastrous result. There were numerous possibilities for inadvertent contact. There were miners in the area, traveling past the PC, and using it to supply power to other

equipment. Clothing, lunch pails, and numerous other items were stored on top of the PC, all of which were accessed by miners. Someone placed a steel slate bar against the PC. Under continued mining operations, it is reasonably likely that someone or something would get in close enough proximity to the high voltage components that a serious injury could result.

As to the terminal strip, Racer's testimony fell far short of establishing that the voltage was too low to create a hazard. As noted above, Racer conceded that he did not know how much voltage was present, and that he didn't know what effect whatever voltage was on the terminal strip could have on the human body. Tr. 706, 743. In contrast, Preece testified that 50 volts could produce 302 milliamps of current, and 96 volts could produce nearly 600 milliamps of current, which could produce a fatality.

The hazard presented by the bent/broken ground pins on the receptacles was more insidious. The broken pins could falsely indicate a ground circuit competent enough to satisfy the safety system, but not sufficient to provide an adequate ground. The potential electrocution hazard identified by Preece would not be precluded by the safety circuit under the circumstances he described.

As noted above, a miner could lift the lids, not all of which were equipped with safety switches. Consequently, there was a possibility that something could fall into the PC and create a short circuit resulting in an injury. Preece had seen miners at McElroy lift lids on PCs and store items in PCs. Racer also had seen miners lift lids on PCs at the mine. Tr. 302, 736.

Considering the number of hazards presented by the deficient maintenance of the PC, I find that it was reasonably likely that an injury producing event would have occurred under continued normal mining operations, and that the violation was S&S.

Unwarrantable Failure

The hazardous conditions were, with the exception of the displaced safety glass, obvious and in plain view. Tr. 504-05, 721. Preece felt that the nature of the conditions, including the condition of the rock dust bag near the safety glass, indicated that they had existed for some time. Tr. 308, 350. As he stated, the PC "didn't get this way overnight . . . [it] took a lot more than a shift." Tr. 501. The PC had been at that location since at least the day before. Tr. 502, 708. McElroy was required to inspect the PC weekly for permissibility, and three times a day during preshift examinations of the area. Tr. 340, 731-32. Preece reviewed the preshift examination records and found that no hazardous conditions had been noted with respect to the PC. Tr. 341. He attempted to review the records of weekly examinations at McElroy's electrical department, but none were provided. Tr. 340, 731-32; ex. G-31. He felt that the PC had been examined by agents of McElroy several times, and that none of the obvious hazardous conditions had been corrected, i.e., that "some agents of the operator did look at the power center and left it this way." Tr. 347-50, 504-05.

McElroy contends that the conditions were “barely detectable,” were not extensive or hazardous, and may have occurred during a recent power move. Resp. Br. at 30. Its principal arguments have been rejected above. Whether or not the condition occurred during a power move is not relevant. Racer was unable to specify when such a move may have occurred, and had not seen a power center damaged during a move. Tr. 687-90. McElroy also attempts to make much of the fact that another MSHA inspector had conducted an inspection of the area the previous day. Tr. 708. Citations had been issued for conditions in the area, including the presence of trash and combustible materials throughout the section, but not for the PC. Tr. 709. Perhaps Preece, being a certified electrician, paid more attention to the PC. In any event, any suggestion that the conditions were not open and obvious for at least one day, is effectively rebutted by the pictures and other evidence of record. I find that the conditions, as depicted in the photographs, existed for at least one day, and that they were open and obvious.

For the reasons identified by Preece, I find that the violation was the result of an unwarrantable failure to comply with the standard. The hazardous conditions were, with one exception, open and obvious. They had existed for at least one day, most likely considerably longer than that. They were not identified and corrected as a result of preshift examinations conducted by agents of the operator, and there were no records of weekly permissibility examinations which might also have resulted in elimination of one or more of the conditions. The combination of hazardous conditions presented a serious risk of injury to miners working in the area.

Order No. 7124560

Order No. 7124560 was issued by Preece on February 23, 2005, during a regular inspection of the mine, and alleges a violation of 30 C.F.R. § 77.502, which requires that:

Electric equipment shall be frequently examined, tested, and properly maintained by a qualified person to assure safe operating conditions. When a potentially dangerous condition is found on electric equipment, such equipment shall be removed from service until such condition is corrected. A record of such examinations shall be kept.

Preece inspected the Run of the Mine Master Control Station (“MCS”), a small, 20 foot by 30 foot, rectangular building housing electrical equipment located approximately 100 yards from McElroy’s preparation plant. Two rows of electrical cabinets run lengthwise in the building, creating an aisle approximately five feet wide. The cabinets house starter panels for conveyor belts in that area of the property. A blower motor, which drove cooling fans for the No. 10 belt starter panel, had ceased functioning. In order to cool the equipment, the cabinet doors had been opened, and a 20-to-24-inch diameter fan, mounted on a floor pedestal, had been placed between them. The cabinet doors were about seven feet high and 20-to-24 inches wide. They were hinged at the outer edges of the cabinet and latched at the center, where a three-to-four-inch wide post ran from the bottom to the top of the cabinet. Energized components,

carrying 600 volts, are located inside the panel. Preece believed that a person walking down the aisle could fall and come into contact with the energized components, either directly, or indirectly by knocking the fan into them. He determined that the starter panel was not being maintained in a safe operating condition in violation of the regulation. The violation was abated promptly by removal of the fan and closing the panel doors. The condition had been in existence for about three weeks, and a replacement blower motor had been ordered. The replacement motor arrived and was installed "fairly quickly" after the order was issued, possibly "within the day." Tr. 548.

Preece determined that it was reasonably likely that the violation would result in a fatal injury, that the violation was significant and substantial, that one employee was affected, and that the operator's negligence was high. The Order was issued pursuant to section 104(d)(2) of the Act, and alleges that the violation was the result of McElroy's unwarrantable failure. A civil penalty in the amount of \$6,600.00 has been proposed for this violation.

The Violation

The layout of the building, showing the aisle, fan and open panel doors, is depicted on a sketch drawn by Preece. Ex. G-16. The panel doors, shown in a closed position, are depicted in photographs taken at a later point in time. Ex. R-10, R-10A. There are two entrances to the building. A single door on the East end, opens into the aisle, approximately five feet from the subject panel. The aisle extends to the West end of the building, where there is a set of double doors and an access to a room on the North side of the building, where a bench is located. Neither the doors to the building, nor the electrical cabinets, are locked. The MCS, and others like it on the property, need to be open because persons have to have access to the electrical controls, and to a monitor/screen that displayed the status of the belts. According to Jeffrey A. Seckman, the general plant foreman, and the electrical foreman at the time of the violation, the double doors are the main access to the building. Tr. 838. He also testified that, at some point, caution tape had been strung across the open cabinet, but was unable to recall how it was placed. Tr. 779, 831. Preece did not recall seeing any warning signs or caution tape around the panel doors or fan. Tr. 244-45.

Seckman agreed that any contact with the 600-volt conductors in the panel would likely be fatal. Tr. 804. However, he did not feel that the condition presented a hazard, because people entering the building were aware of the electrical equipment, caution tape had been strung, and the fan had been placed outside the cabinet doors, so that if it was moved toward the cabinet, it would push the doors closed. Tr. 763-64, 782-85. However, he conceded that the MCS could be, and had been, accessed by rank and file miners, who had limited familiarity with electrical equipment. Tr. 811-15, 817. In addition, the evidence does not support his claims that caution tape had been strung, at least as of the time of the inspection, or that the fan would have pushed the cabinet doors closed.

The cabinets needed to be accessed when work was performed on the conveyor belt. It is highly likely that any caution tape placed initially would have been removed when subsequent access was needed, and Preece did not see any caution tape. I find that there was no caution tape present at the time the Order was entered. I also find that the cabinet doors were adjacent to, not in front of the fan. If the doors had been in front of the fan, the fan would have tended to blow them shut. Seckman testified that the doors are heavy. However, they appear to be made of sheet metal and, even if they are relatively heavy, they most likely would have been blown shut by a 24-inch diameter fan.

The fan, and its pedestal extended about two feet into the aisle, significantly reducing its width. It is certainly possible that a miner passing the fan, which was located only a few feet inside the East door, could have inadvertently contacted the doors and/or fan and fallen, and that he could have come into contact with the energized electrical components, either directly or through contact with the metal fan. I find that the regulation was violated.

S&S

Whether the violation was S&S depends upon whether it was reasonably likely that the hazard contributed to by the violation would result in an injury producing event. The Secretary argues that an injury producing event was reasonably likely because "mining personnel were present in the MCS throughout the work day and walk in the hallway directly in front of the No. 10 belt starter panel." Sec'y. Br. at 10-11. The evidence does not support so broad a statement. Preece conceded that, despite his familiarity with the McElroy mine, having done general inspections, he had no idea how many people traveled in the MCS, and did not ask anyone about that. Tr. 419, 448. He did not see anyone in the MCS the day he issued the order, until he called McElroy personnel because of the violation. Tr. 416, 447. There is no one assigned to work in the building. Tr. 763. It is accessed by qualified electrical personnel to control the starter panels, e.g., to deenergize and lock out power to conveyor motors so that repair or maintenance work can be performed. Tr. 765, 770-71, 816. Miners also access the building to look at the monitor/screen displaying the status of the belts. An electrician is required to inspect the building once per month, and also handles cleaning chores.

Seckman was quite candid about the presence of miners. He stated that, at least on one occasion, he had seen more than one miner in the MCS, and had seen miners go into the MCS for breaks. Tr. 770, 813-14. He agreed that, because access to the building was not restricted, virtually anyone could enter the building. However, it is not in a highly traveled area and is about 100 yards away from the preparation plant. Tr. 769-70.

Preece was not concerned about the presence of qualified electrical personnel. He testified that he would not have issued the order if access to the building had been restricted to authorized persons. Tr. 278, 409. It is the miner who had no official business in the MCS, and who would not be as aware of the potential electrical hazards, that would pose the most significant risk of injury. While such miners apparently have entered the MCS on occasion, there

is very little evidence as to the frequency of such visits. Nor is there evidence that such persons would be likely to walk down the hallway in question, i.e., that they would enter or exit the MCS by the single East door. Similarly, there is very little evidence of the frequency that miners entered the MCS to check the status of the belts. The double doors on the West were the main entrance to the MCS. The monitor/screen and access to the North side of the building, the area most likely to be used for breaks, were at the West end of the building. There is no direct evidence of the frequency of travel down the subject hallway by persons who would not have been authorized to be in the building. In addition, the condition was eliminated immediately and was permanently corrected within a day after the Order was issued.

Based upon all of the factors discussed above, I find that the Secretary has failed to carry her burden of proving that it was reasonably likely that an injury producing event would have occurred under continued normal mining operations. The violation was not S&S.

Unwarrantable Failure

The condition had existed for about three weeks. Seckman, the electrical foreman at the time, an agent of McElroy's, had known about the condition, and had ordered a replacement part. Seckman honestly believed that the condition did not present a hazard, primarily because only qualified electricians would have any reason to access the electrical control panels arrayed along the subject hallway. While he knew that access to the building was unrestricted, and had seen miners in the building in the past, he also knew that the area was not highly traveled. The main entrance to the building was at the West end, where the double doors were located. Access to the area on the north side of the building, which would most likely be used for breaks, was also at that end of the building, as it appears, was the monitor/screen. As noted above, there is very little evidence of the frequency with which miners entered the MCS, and virtually no evidence that any miner actually traveled the hallway, much less did so with some frequency. While there was no caution tape at the time of the inspection, there may well have been caution tape strung around the open doors during a portion of the three-week period. The hazardous condition was corrected immediately, and permanent repairs were made within a day. At the hearing, Preece related his belief that the unwarrantable failure designation was enhanced by the fact that the replacement blower motor had been delivered the day before the inspection, but had not been installed. Tr. 455-57. His belief was based on examination of a printout of a purchase order that indicated a February 22, 2005, delivery date for the replacement motor. Ex. R-21. However, Seckman explained that the delivery date stated on the form was only an estimate, not an actual delivery date, and that if the motor had arrived on February 22, it would have been installed that day. Tr. 790-95.

Considering all of these factors, I find that the violation was not the result of McElroy's unwarrantable failure, but that its negligence was high.

Order No. 7124782

Order No. 7124782 was issued on August 30, 2005, by MSHA inspector, Joseph R. Yudaz, and alleges a violation of 30 C.F.R. § 75.321(a)(2), which requires that "air in areas of bleeder entries and worked-out areas where persons work or travel shall contain at least 19.5% oxygen." Yudaz had inspected the "5 South-Left side bleeder travelway, from the South approach at the bottom of the 5 South 1 Left Bleeder fan shaft to the MP-1," an area required to be examined every seven days, and discovered that the air had an oxygen content below the required 19.5%. Ex. G-1. Yudaz determined that it was reasonably likely that the violation would result in an injury involving lost work days or restricted duty, that the violation was significant and substantial, that one employee was affected, and that the operator's negligence was high. The Order was issued pursuant to section 104(d)(2) of the Act, and alleges that the violation was the result of McElroy's unwarrantable failure to comply with the standard. A civil penalty in the amount of \$5,300.00 has been proposed for this violation.

The Violation

Inspector Yudaz was conducting a regular quarterly inspection of the mine. He reviewed McElroy's weekly examination book, in which the results of required seven-day examinations of bleeder travelways were recorded, and noticed that the most recent report, dated August 25, 2005, showed that only 17.9% oxygen was present at the "1 Left 5 South Bleeders MP-1 [Measuring Point #1]." Ex. G-11. He noticed that several other entries also reported less than 19.5% oxygen at that location. He proceeded underground and entered the bleeder travelway near the bleeder fan shaft. He soon encountered oxygen below the required level. His hand-held atmospheric monitor alarmed, and showed oxygen at a concentration of 18.5%. Located in close proximity was an air measuring station, where examiners recorded the results of their measurements. That record showed that the quantity of air in the bleeder entry had been steadily falling since February 2005. Concentrations of oxygen had also been falling, and had been below the required 19.5% since April 28, 2005. Tr. 71-79; ex. G-12. Rather than proceed the remainder of the 1,200-to-1,300 feet to MP-1, he retreated, and issued the Order.

McElroy does not dispute the fact of the violation. Its examiners had recorded low oxygen readings for numerous past examinations dating back to April 28, 2005. Jack Price, a McElroy management representative, traveled with Yudaz during the inspection and confirmed the oxygen reading of 18.5% that Yudaz measured in the bleeder travelway. Tr. 69. McElroy argues that the violation was not S&S, because the oxygen concentrations were not low enough to pose a reasonable possibility of injury.

S&S

The fact of violation has been conceded, and it contributed to an obvious hazard, an atmosphere with low oxygen concentration.¹² Any injury resulting from the hazard would most likely be serious, possibly fatal. Whether the violation was S&S depends upon whether the Secretary established a reasonable likelihood that the hazard would result in an injury if normal mining operations continued. Her theory of injury, as explained by Yudaz, is that oxygen levels below 19.5% can cause a person to breath deeper and faster. Tr. 121, 128. They can also lead to dizziness and impaired judgment, which could result in a slip and fall incident and resulting injury.

Yudaz testified that he had voluntarily entered locations with oxygen concentrations as low as 17.9%, and did not feel any noticeable effects. Tr. 129-33. He was "cautious" when he entered such conditions, and did not stay in them long or travel any significant distance. Tr. 129-33; ex. R-16 at 112. He would not travel as far as 1,300 feet in 18.0% oxygen and, on the day of the inspection, when the oxygen concentration was 18.5%, he did not travel to MP-1. Tr. 139; ex. R-16 at 127-30. William F. Newman, a McElroy ventilation foreman at the time, was a certified weekly examiner who generally traveled the bleeder in question, and recorded a majority of the sub-standard oxygen readings reflected on McElroy's records. He testified at the hearing and at deposition that he had no concerns traveling in oxygen concentrations as low as 17.0%, because he had been in such conditions and they didn't seem to have any effect on him. Tr. 935; ex. G-28 at 21, 30. Although he testified at his deposition that he would be concerned if the oxygen concentration dropped to 17.9%, at the hearing he stated that he later reviewed an MSHA publication on the effects of low oxygen and learned that that level "shouldn't be a problem." Tr. 945.

None of the witnesses that testified at the hearing had any expertise on the effects on human beings of particular levels of oxygen concentrations. Yudaz's assessments were based upon "general knowledge." Ex. R-16 at 131-32. McElroy's examiners were not trained on the effects of low oxygen levels. Tr. 877. The most authoritative evidence on that issue is an MSHA publication, Program Information Bulletin No. P07-05 ("PIB"), issued on March 27, 2007. Ex. G-14. That document notes generally that "oxygen concentrations below 19.5 percent can have adverse physiological effects, and atmospheres with less than 16 percent oxygen can become life threatening." Ex. G-14 at 1. It also contains the following table:

¹² McElroy contends that there was no hazardous condition. Resp. Br. at 36. However, the sub-standard oxygen concentrations, under conditions that were highly susceptible to adverse changes, clearly constituted a hazardous condition.

<u>Percent Oxygen in Air</u>	<u>Effect</u>
17	Faster, deep breathing
15	Dizziness, buzzing in ears, rapid heartbeat
13	May lose consciousness with prolonged exposure
9	Fainting, unconsciousness
7	Life endangered
6	Convulsive movements, death

Ex. G-14 at 3.

The PIB appears to validate the opinion of the mine foreman, Michael Conjeski, that the oxygen concentrations that were being experienced in the travelable bleeder entry were not low enough to produce an injury causing event, considering that the only persons entering the area were experienced examiners who carried two atmospheric monitors and were well-aware of the ongoing problem. Tr. 877-99. However, witnesses for both parties agreed that there could be unexpected drops in oxygen concentrations caused by roof falls, a stopping crushing out, or a drop in barometric pressure. Tr. 106, 178-80 (Yudaz); 945-47 (Newman). The Secretary's argument is that the examiners travel the bleeder alone, and must traverse approximately 1,300 feet to the MP-1 location. An unexpected drop in oxygen concentrations from the 17.9% level, could have resulted in conditions that would have produced dizziness, making a slip and fall or other injury causing event reasonably likely. These were more than theoretical possibilities, because there is evidence that roof falls affecting airflow in the bleeder travelway were common and could be expected. Yudaz was aware that McElroy was having airflow problems in the bleeder travelway. Tr. 173-74; ex. R-16 at 30-33, 145-46. Conjeski conceded that McElroy had not supported the roof in the tailgate side "mixing chamber" entry very well, and that roof falls were making it "tight" for air flow in the bleeder. Tr. 861, 864-74.

On the particular facts of this case, I conclude that the violation was S&S. The ongoing problems with the poorly supported tailgate bleeder entries, made it reasonably likely that a roof fall or similar event would occur under continued mining operations, and that the already sub-standard level of oxygen concentration would be reduced to the point that an examiner would experience dizziness and impaired judgement. The examiners carried two atmospheric monitors with them. However, the monitors would have begun to sound an alarm upon entry into the bleeder travelway, and would have continuously alarmed while the examiner traversed the 1,300 feet to MP-1 and back. Consequently, he would have had to visually monitor the oxygen concentration readings to detect any changes, and he was also obligated to examine the roof and other conditions in the entry, as well as navigate around or through puddles of water that were present. An examiner concentrating on other conditions could easily fail to perceive a reduction in oxygen concentration caused by an unexpected event until it had a significant impact upon him. I find that the low oxygen concentrations, and the likelihood of unpredictable events that could drive them lower, rendered an injury producing event reasonably likely, and that the violation was S&S.

Unwarrantable Failure

There is ample evidence to sustain the allegation that the violation was the result of McElroy's unwarrantable failure. The violation was known to and tolerated by high levels of management. Conjeski, the mine foreman, talked to the examiners, signed most of the examination reports, and was well-aware that examiners were traveling in oxygen deficient atmosphere for several months. Tr. 849, 860; ex. G-11. While Conjeski did not feel that McElroy had done anything wrong, no corrective action was taken as of June 2, even though examiners had been traveling in sub-standard oxygen concentrations for over one month. Tr. 900; ex. G-12, G-26 at 67. Conjeski claimed that McElroy had been working "religiously" on the problem, and had been trying to get more air into the bleeder travelway, putting air in slowly and monitoring it. Tr. 900, 907-08. None of the claimed corrective actions were documented, even though documentation of corrective action is required by regulation. 30 C.F.R. § 75.364(h). Conjeski explained that the attempts to address the problem were unsuccessful, and that there was no need to document that ongoing process. Tr. 904-05. While he claimed, at his deposition that he didn't want his examiners going into atmospheres with oxygen concentrations less than 19%, and acknowledged that such conditions were not safe even though he did not know the effects on the human body, he continued to tolerate examiners traveling in oxygen concentrations below 19%, and even as low as 17.9%. Ex. G-26 at 70-72.

It may be that McElroy was taking steps in an effort to increase the air flow and oxygen concentrations in the bleeder travelway, and that Yudaz was told about them. However, it is obvious that any such attempts had proven ineffective, and that, as of the August 30 inspection, the condition had not improved significantly. Yet examiners were still traveling the bleeder in deteriorating conditions, and there is no indication that anything would have changed if Yudaz had not issued the Order.¹³ The condition was substantially improved within two days by

¹³ There are two written records of oxygen concentrations in the bleeder entry. Examiners first recorded conditions at the air measuring station at the end of the entry close to the bleeder fan. Ex. G-11. Conditions were also measured and recorded at MP-1, some 1,300 feet up the entry. Ex. G-12. Yudaz and Newman agreed that the oxygen content at the two measuring points should not have varied by more than one or two tenths of one percent. Tr. 88, 951. A comparison of the records confirms the consistency of the measurements, with one notable exception. On June 23, 2005, Newman recorded oxygen concentrations of 18.7% at the measuring station and 19.8% at MP-1. A relatively high reading of 19.7% was also recorded at MP-1 on June 30, but there is no corresponding record for that date at the measuring station. The entries of acceptable oxygen concentrations are suspect. The June 23 entry is substantially at variance with that recorded at the other measuring point. Moreover, Conjeski did not describe any actions being taken that would have had a substantial effect on the quality of air flow. Rather, he stated that air was being added to the system "slowly." Tr. 908. Conjeski signed the weekly examination record maintained at the surface, which showed the higher readings. However, he also talked to the examiners, and should have been aware that, even though an acceptable level of oxygen had been recorded for the MP-1 measuring point on June 23, that at

removal of a stopping, which resulted in measurements of 19.2-to-19.3% oxygen on September 1, 2005. Tr. 116-17, 881-82; ex. G-1. When Yudaz returned on October 5, oxygen levels had been increased to 19.5-to-19.6%, and the order was terminated. Ex. G-1. McElroy claimed that the stopping could not have been removed in June, because the longwall face had not advanced far enough. Tr. 881-82. However, assuming that was true, there is no explanation as to why that, or some comparable corrective action, could not have been taken in July or August, prior to issuance of the Order, and Conjeski indicated that it possibly could have been. Ex. G-26 at 124-26.

The involvement of an operator's agent, typically a supervisor, is particularly significant because the negligence of an agent can be imputed to the operator for purposes of unwarrantable failure and civil penalty assessment. *E.g., Capitol Cement Corp.*, 21 FMSHRC 883, 893 (Aug. 1999) (citing *R&P*, 13 FMSHRC at 194-97). "Managers and supervisors in high positions must set an example for all supervisory and non-supervisory miners working under their direction. Such responsibility not only affirms management's commitment to safety but also, because of the authority of the manager, discourages other personnel from exercising less than reasonable care." *Id.* at 892-93 (quoting from *Wilmot Mining Co.*, 9 FMSHRC 684, 688 (Apr. 1987)).

Here, the reaction of McElroy's high level managers to the long-standing violation exhibited the type of indifference that easily satisfies the test for unwarrantable failure.

The Appropriate Civil Penalties

The parties stipulated to many of the factors that are to be considered in establishing the amount of any civil penalty.¹⁴ McElroy is a large mine operator that produced 8,357,061 tons of coal in 2004. It is controlled by a very large entity, Consol Energy, Incorporated, which produced 64,516,367 tons of coal in 2004. For the period September 1, 2003 to August 31, 2005, McElroy was assessed approximately 1,426 violations in the course of 1,090 inspection days, a moderate history of violations record. McElroy demonstrated good faith in abating the violations, and the imposition of the proposed penalties would not affect McElroy's ability to remain in business. The gravity and negligence associated with the violations have been discussed above.

Order No. 7123909 is modified to a citation issued pursuant to section 104(a) of the Act, with moderate negligence. A civil penalty of \$4,800.00 was proposed by the Secretary. The reduction of the negligence factor, from high and unwarrantable failure to moderate, justifies a significant reduction in the proposed penalty. I impose a penalty in the amount of \$2,000.00, upon consideration of the above and the factors enumerated in section 110(i) of the Act.

least part of the entry remained out of compliance with the standard.

¹⁴ Final stipulations were submitted by letter dated August 7, 2007.

Order No. 7124015 is affirmed as a significant and substantial and unwarrantable failure violation. A civil penalty of \$6,600.00 was proposed by the Secretary. I impose a penalty in the amount of \$6,600.00, upon consideration of the above and the factors enumerated in section 110(i) of the Act.

Order No. 7124560 is modified to a citation issued pursuant to section 104(a) of the Act, The operator's negligence was high. However, the violation was not significant and substantial. A civil penalty of \$6,600.00 was proposed by the Secretary. I impose a penalty in the amount of \$4,500.00, upon consideration of the above and the factors enumerated in section 110(i) of the Act.

Order No. 7124782 is affirmed as a significant and substantial and unwarrantable failure violation. A civil penalty of \$5,300.00 was proposed by the Secretary. I impose a penalty in the amount of \$5,300.00, upon consideration of the above and the factors enumerated in section 110(i) of the Act.

ORDER

Order Nos. 7124015 and 7124782 are **AFFIRMED**, and Order Nos. 7123909 and 7124560 are **AFFIRMED, as modified**, and Respondent is directed to pay a civil penalty of \$18,400.00 within 45 days.



Michael E. Zielinski
Administrative Law Judge

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FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

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

January 28, 2008

SECRETARY OF LABOR,	:	CIVIL PENALTY PROCEEDINGS
MINE SAFETY AND HEALTH	:	
ADMINISTRATION (MSHA),	:	Docket No. SE 2006-40
Petitioner	:	A.C. No. 01-01322-71461
	:	
	:	Docket No. SE 2006-123
	:	A.C. No. 01-01322-76460
	:	
	:	Docket No. SE 2006-221
	:	A.C. No. 01-01322-87101
	:	
v.	:	No. 5 Mine
	:	
	:	Docket No. SE 2006-187
	:	A.C. No. 01-01247-81979
	:	
	:	No. 4 Mine
	:	
	:	Docket No. SE 2006-222
	:	A.C. No. 01-01401-87100
	:	
JIM WALTER RESOURCES, INC.,	:	Docket No. SE 2006-308
Respondent	:	A.C. No. 01-01401-92559
	:	
	:	Docket No. SE 2007-77
	:	A.C. No. 01-01401-100002
	:	
	:	Docket No. SE 2007-117
	:	A.C. No. 01-01401-94880
	:	
	:	No. 7 Mine

DECISION

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

Before: Judge Feldman

These civil penalty proceedings concern petitions for assessment of civil penalties filed pursuant to section 110(a) of the Federal Mine Safety and Health Act of 1977 (the Mine Act), 30 U.S.C. § 820(a), by the Secretary of Labor (the Secretary), against the respondent, Jim Walter Resources, Inc., (JWR). The petitions seek to impose a total civil penalty of \$28,817.00 for 33 alleged violations of mandatory safety standards in 30 C.F.R. Parts 75 and 77 of the Secretary's mandatory safety regulations governing underground coal mines.

These matters were heard from October 23 to October 25, 2007, in Birmingham, Alabama. At trial, the parties advised that they had reached a settlement agreement with respect to 27 of the 33 cited violations in these proceedings. The parties settled Docket Nos. SE 2006-221, SE 2006-187, SE 2007-77 and SE 2007-117 in their entirety. There were partial settlements in Docket Nos. SE 2006-123 and SE 2006-308. The record was left open for the parties to submit the terms of their agreement in writing. The settlement terms were filed on December 13, 2007, at which time the record was closed. The parties' settlement terms are approved herein.

The evidentiary hearing concerning the remaining issues consisted of, in the order in which they were heard, three 104(a) citations in Docket No. SE 2006-222; two 104(a) citations in Docket No. SE 2006-308; one 104(a) citation in Docket No. SE 2006-40; and one 104(d)(2) order that alleges an unwarrantable failure in Docket No. SE 2006-123. All of the cited violative conditions were designated as significant and substantial (S&S) in nature.¹

The parties were advised that I would defer my ruling pending post-hearing briefs, or, issue a bench decision if the parties waived their right to file post-hearing briefs. The parties elected to waive post-hearing briefs in favor of a bench decision. (Tr. 1110-13). This decision, adjudicating the six citations and one order in these proceedings, contains the edited bench decisions that are supplemented with pertinent case law. The citations and order will be addressed in this decision in the order in which they were presented at trial.

¹ Generally speaking, a violation is S&S if it is reasonably likely that the hazard contributed to by the violation will result in an accident causing serious injury. *Cement Division, National Gypsum*, 3 FMSHRC 822, 825 (April 1981).

I. Pertinent Penalty Criteria

The bench decision applied the statutory civil penalty criteria in section 110(i) of the Act, 30 U.S.C. § 820(i), to determine the appropriate civil penalty to be assessed. In determining the appropriate civil penalty, section 110(i) provides, in pertinent part:

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.

JWR is a large mine operator that is subject to the jurisdiction of the Mine Act. The proposed penalties will not affect JWR's ongoing business operations and JWR promptly abated the cited violations. It has neither been contended nor shown that JWR's history of violations is an aggravating factor in determining the appropriate civil penalty to be assessed in these proceedings. The remaining civil penalty criteria will be addressed in the disposition of these matters.

II. Relevant Case Law

a. Significant and Substantial

The bench decision applied the Commission's standards with respect to what constitutes a significant and substantial (S&S) violation. A violation is properly designated as S&S in nature if, based on the particular facts surrounding that violation, there exists a reasonable likelihood that the hazard contributed to by the violation will result in an injury or an illness of a reasonably serious nature. *Cement Division, National Gypsum, supra*, at 825. In *Mathies Coal Co.*, 6 FMSHRC 1 (January 1984), the Commission 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 [by the violation] will result in an injury; and (4) a reasonable likelihood that the injury in question will be of a reasonably serious nature. 6 FMSHRC at 3-4.

See also Austin Power Co. v. Secretary, 861 F.2d 99, 104-05 (5th Cir. 1988), *aff'g* 9 FMSHRC 2015, 2021 (December 1987) (approving *Mathies* criteria).

In *United States Steel Mining Co., Inc.*, 7 FMSHRC 1125, 1129 (August 1985), the Commission explained its *Mathies* criteria as follows:

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

The Commission subsequently reasserted its prior determinations that as part of any “S&S” finding, the Secretary must prove the reasonable likelihood of an injury occurring as a result of the hazard contributed to by the cited violative condition or practice. *Peabody Coal Company*, 17 FMSHRC 508 (April 1995); *Jim Walter Resources, Inc.*, 18 FMSHRC 508 (April 1996).

b. Unwarrantable Failure

The Commission has determined that unwarrantable failure is aggravated conduct constituting more than ordinary negligence and encompasses conduct characterized as “reckless disregard,” “intentional misconduct,” “indifference,” or a “serious lack of reasonable care.” *Emery Mining Corp.*, 9 FMSHRC 1997, 2001, 2003-04 (Dec. 1987); *Rochester & Pittsburgh Coal Co.*, 13 FMSHRC 189, 194 (Feb. 1991); *see also Buck Creek Coal, Inc. v. FMSHRC*, 52 F.3d 133, 136 (7th Cir. 1995) (approving Commission’s unwarrantable failure test). The Commission has recognized that whether conduct is “aggravated” in the context of unwarrantable failure is determined by considering the facts and circumstances of each case to determine if any aggravating or mitigating circumstances exist. *See Consolidation Coal Co.*, 22 FMSHRC 340, 353 (Mar. 2000).

III. Findings and Conclusions

a. Docket No. SE 2006-222

i. Citation No. 7687031 - Coupling Device

During the day shift on January 17, 2006, Mine Safety and Health Administration (MSHA) Inspector John Thomas Terpo observed a track mounted diesel operated locomotive on the main haulage track. Although the locomotive had been used to transport haulage cars earlier in the shift, the locomotive was not connected to any haulage cars at the time of the inspection. Haulage cars can be connected to either end of the locomotive so that they can be pulled in either direction. Consequently the locomotive is equipped with automatic and manual coupling/decoupling devices on each end.

The automatic coupler enables the locomotive operator to decouple haulage cars by pulling a tab in the cab of the locomotive. The manual decoupling device consists of inserting a

bar into a decoupling release from the side of the locomotive. Both the automatic and manual coupling devices enable the locomotive operator to disengage haul cars without his exposure between cars.

Terpo determined that both the automatic and manual coupling device was inoperative on one end of the locomotive. Consequently, haulage cars could only be coupled or uncoupled on that end by hand, by stepping between the locomotive and the haulage car. Terpo was concerned that, given the unevenness of the mine floor, a car could roll causing serious injury to a miner who was positioned between cars.

As a result of his observations, Terpo issued Citation No. 7687031 citing a violation of the Secretary's mandatory safety standard in 30 C.F.R. § 75.1405. (Gov. Ex. 2). This standard requires all haulage equipment to be equipped with automatic couplers that do not require miners to go between cars. Terpo considered the violation to be significant and substantial (S&S) because he believed there was a reasonable likelihood that a miner positioned between cars will sustain serious finger or hand injuries. Terpo attributed the cited violation to a moderate degree of negligence. The Secretary has proposed an \$838.00 civil penalty for Citation No. 7687031.

At trial, JWR stipulated to the fact of occurrence of the cited violation. (Tr. 22). However, JWR disputes the S&S characterization. Keith Plylar, JWR safety supervisor, testified that haul cars also have decoupling devices that can be utilized as an alternative to the locomotive's decoupler. Plylar also opined that the locomotive could be turned around so that the functional coupler on the other end of the locomotive could be used. Terpo stated that not all haulage cars have coupling devices, and, that those that do, are sometimes inoperative.

Citation No. 7687031 Bench Decision

The following is a summary of the bench decision, with editorial additions including supporting case law, that was issued upon completion of the relevant testimony :

Section 75.1405 requires automatic decoupling devices to prevent individuals from exposure to injury between haulage cars. JWR has stipulated to the fact of the violation. Consequently, the remaining issues are S&S, gravity and the appropriate civil penalty.

Violations are properly designated as S&S if there is a reasonable likelihood that the hazard contributed to by the violation will result in an event in which there is a serious injury. *Mathies* 6 FMSHRC at 3-4; *U.S. Steel Mining*, 6 FMSHRC at 1836; *U.S. Steel Mining*, 6 FMSHRC at 1868. Here the hazard caused by the violation is exposure of extremities between a locomotive and a haulage car. Given the varying grades of a mine floor, in the context of continuing mining operations, it is reasonably likely that a haulage car will roll while a miner is attempting to manually decouple, resulting in serious crushing or amputation

injury to the fingers or hands. *Halfway Incorporated*, 8 FMSHRC 8, 12 (January 1986) (S&S determinations viewed in the context of continued mining operations).

JWR attempts to mitigate the hazard by asserting that decouplers on haulage cars may be used as an alternative to the automatic decoupler on the locomotive. Putting aside the issue of whether there is a decoupler on a haulage car, or whether it is operational, reliance on the vagaries of human conduct for the proposition that a safe alternative method will be used, to mitigate the hazard posed by the cited violation, is not persuasive. In this regard, the Commission has held that “[w]hile miners should, of course, work cautiously, that admonition does not lessen the responsibility of operators, under the Mine Act, to prevent unsafe conditions.” *Eagle Nest, Inc.*, 14 FMSHRC 1119, 1123 (July 1992). Thus, the Commission concluded the exercise of caution does not mitigate the S&S nature of a violation. *Id.* With respect to gravity, since the hazard posed by the cited violation exposed miners to serious injury, the violation is serious in gravity.

Turning to the issue of negligence, although Terpo vaguely testified about previous accidents during manual decoupling, Terpo was unable to establish that a relevant accident had occurred at a JWR mine to place it on a higher state of awareness. In addition, the evidence does not reflect that JWR was aware of this condition because there is no evidence that the malfunctioning coupling device had been noted during pre-shift examinations. The Secretary proposes a civil penalty of \$838.00. Giving JWR the benefit of the doubt that its management personnel lacked actual knowledge, I will attribute the violation to no more than a moderate degree of negligence. **Accordingly, a civil penalty of \$700.00 shall be assessed for Citation No. 7687031.**

(Tr. 101-110).

ii. Citation No. 7687034 - Bushing

On January 24, 2006, Terpo examined the No. 6 Section electrical starter box for the winch motor on the belt drive. The winch is used to tighten and adjust the conveyor belt. Power measuring 480 volts AC is supplied to the electrical box by an incoming cable. Power from the electrical box is supplied to the winch by an outgoing electrical cable that is protected by a thick rubber insulated jacket.

The outgoing supply cable contains three distinct wire leads that are also protected by rubber jackets. The rubber insulation on each wire lead is only approximately 1/8 to 1/4 inch thick. (Tr. 115-16). The outgoing supply cable is connected to the electrical box by stripping small sections of the outer rubber insulation at the end of the supply cable and at the end of each wire lead. Each wire lead is attached to a connector inside the electrical box that transfers energy

through the supply cable that is connected from the electrical box to the winch. The electrical box does not remain stationary. Rather, it is moved when the location of the winch is changed.

Exposed wire leads create an electrical hazard if the internal wires come in direct contact with the metal electrical box. To avoid this hazard, the wire leads are inserted into the box through a rubber bushing that surrounds the metal opening in the box. The rubber bushing is held securely in place by a clamp that is installed at the opening where the cable enters the box. The opening in the bushing is designed to be small so that the supply cable fits snugly in the bushing, protecting the internal separated wire leads from exposure and contact.

Terpo noted that approximately 1 to 1½ inches of the of the insulated wire leads on the winch starter box were exposed through the bushing on the outside of the box. (Tr. 117-18, 123). Terpo stated that the exposed insulation on each wire lead was intact. (Tr. 145). Terpo surmised that someone had stepped on the cable pulling the lead wires through the bushing.

As a result of his observations, Terpo issued Citation No. 7687034 citing a violation of the Secretary's mandatory safety standard in 30 C.F.R. § 75.515. (Gov. Ex. 4). This standard requires, in pertinent part, "[w]hen insulated wires other than cables pass through metal frames, the holes shall be substantially bushed with insulated bushings."

Terpo believed that movement of the lead wires ultimately would result in deterioration of the their rubber insulation that would create an electrocution hazard because of exposure of the leads to contact with the metal box. Consequently, Terpo designated the violation as significant and substantial (S&S).

Plylar without contradiction, that the bushing remained in place secured to the metal opening by a clamp. (Tr. 181-82). However, Plylar admitted the opening in the bushing was too large to maintain the lead wires snugly in place within the electrical box. (Tr.186). Plylar believed that miners are protected by circuit breakers in the unlikely event bare metal wire contacted the metal electrical box. (Tr. 183).

Citation No. 7687034 Bench Decision

The following is the edited bench decision for Citation No. 7687034:

The regulatory standard in section 75.515 requires holes in metal boxes shall be "substantially bushed." It is well settled that the Secretary has the burden of proving the fact of a violation. *Jim Walter Res., Inc.*, 9 FMSHRC 903, 907 (May 1987). Keith Plylar candidly conceded that the opening in the bushing was too large to keep the lead wires within the electrical box. Since approximately one inch of the insulated wire leads protruded from the box and were exposed through the bushing, it cannot be said that the winch starter box was substantially bushed. Consequently, the evidence supports the fact of a section 75.515 violation.

Turning to the issue of S&S, a significant and substantial determination must be based on the particular facts surrounding the violation. *Lion Mining*, 18 FMSHRC 695, 699 (May 1996). Here the focus is on the likelihood of a confluence of factors that are necessary to create an electrocution hazard. *Texasgulf, Inc.*, 10 FMSHRC 498, 501 (Apr. 1988). The Secretary does not contend that the wire lead connections inside the electrical box were loose or otherwise exposed to metal. There was only approximately one inch of exposure, and the rubber insulation on the wire leads was intact. Significantly, the evidence does not reflect that the bushing did not remain securely in place in the hole in the electrical box. Thus, there is no evidence that the lead wires could contact the metal opening.

The occurrence of the electrical hazard of exposure of leads to metal requires the unlikely confluence of deterioration of the rubber jackets exposing the lead wires, as well as the displacement of the rubber bushing that is held securely in place by a metal clamp. Although I am cognizant that S&S determinations should be made in the context of the continuing existence of violative conditions in the face of continued mining operations, I am unpersuaded that it is reasonably likely that this confluence of events will occur creating an electrical hazard. Thus, I am unable to conclude that the hazard posed by the condition of the bushing will contribute to an event in which there is an electrocution accident. *See eg., Mathies* 6 FMSHRC at 3-4. Accordingly, the S&S designation in Citation No. 7687034 shall be deleted.

The Secretary has proposed a \$1,238.00 civil penalty. **In view of the modification of Citation No. 7687034 to non-S&S, a civil penalty of \$600.00 shall be assessed for the subject citation.**

(Tr. 1118-25).

iii. Citation No. 7687036 - Brow

JWR's No. 7 mine is a twin seam (double seam) mine. The seam consists of a lower coal seam known as the Blue Creek seam, and an upper coal seam known as the Mary Lee seam. The lower Blue Creek seam is approximately four feet wide. The smaller Mary Lee seam is approximately one foot in width. The coal in these seams is considered to be soft. The Blue Creek and Mary Lee seams are separated by approximately five feet of rock referred to as "the middleman." (Tr. 291). The middleman rock is somewhat harder in consistency than the rock in the mine roof. In vicinity of the No. 6 section battery charger station where Citation No. 7687036 was issued, the combined height of the striated seam is approximately ten feet. Thus, a rib in the battery charging area is approximately ten feet high consisting of three striations from mine floor to roof - - the Blue Creek seam, the middleman rock, and the Mary Lee seam.

Terpo inspected the No. 6 section battery station on January 25, 2006. Terpo was accompanied by Keith Plylar. Terpo observed that sloughage at the corner of a ten feet high rib had created a corner rib brow. Terpo noted that a battery to be charged was partially located under the brow. Terpo's cap light was the source of illumination for his observations. (Tr. 319). Terpo described the condition in his contemporaneous hand written notes. (Gov. Ex. 7, pp. 14-20). Terpo's notes reflect, in pertinent part:

"An area of rib - (brow) located on the corner of an entry x-cut . . . was not adequately supported The mine height in this area is approximately 10 ft. The exposed brow measured 42" at its widest point. . . . The battery was partially located (30") under the rib."

(Gov. Ex. 7 at p. 14, 16).

Terpo's notes do not reflect the distance from the mine floor to the brow. Contrary to JWR's contention that the brow was suspended 4 feet off of the mine floor, Terpo testified the brow was 8 ½ to 9 feet above the mine floor reflecting that a substantial portion of the rib had deteriorated leaving a residual one foot outcrop hanging from the roof. (Tr. 277). However, Terpo's testimony is inconsistent with sloughage of the entire three striations of the seam. In this regard, Terpo described the brow condition as "sloughage . . . underneath the brow where the coal seam is. There is an area that had sloughed off - partially sloughed off. So it allowed that cavity there." (Tr. 200). Thus, Terpo's notes reflect a battery was under the cavity.

The "cavity" caused by the 'partial sloughage' described by Terpo is consistent with JWR's assertion that the brow was suspended approximately 48 inches from the mine floor as a result of sloughage of the Blue Creek seam. In support of its contention, JWR proffered photographs that depict the brow's height and testimony by Parker and Plylar that they took measurements that indicated the subject brow was 44 to 48 inches from the ground. (Resp. E's. 2, 3; Tr. 308, 335).

JWR's roof control plan required ribs to be pinned at intervals of five feet. However, JWR installed additional pins by pinning the ribs three feet on center. (Tr. 323). Terpo testified that he did not see additional roof bolts in the brow. Parker and Plylar testified that two additional rib bolts were installed into the brow in opposite directions. (Tr. 290, 320, 325). These bolts penetrated the middleman rock and Mary Lee seam and were anchored into the mine roof. (Resp. Ex. 1). The bolts were installed with yield tubes that are designed to compress to reveal rib movement due to stress. (Tr. 328). However, Plylar testified that the yield tubes remained intact reflecting that the brow was securely supported. (Tr. 328).

Terpo spoke to Parker about his observations of the brow after he returned to the surface. Terpo learned that the brow had been supported by a wood post that had been dislodged the week before. (Tr. 208). Parker and Plylar opined that the supplemental wooden support was installed in an abundance of caution, although they believed the brow was adequately supported. Both

Parker and Plylar admitted that the wood support was not installed at the time of Terpo's inspection. (Tr. 294, 320-21).

As a result of his observations, Terpo issued Citation No. 7687036, citing an alleged violation of 30 C.F.R. § 75.202(a). This mandatory safety standard requires roof, face and rib areas where persons work or travel to be adequately supported to protect against hazards associated with falls of the roof, face or ribs and coal or rock bursts. Citation No. 7687036 states:

The corner rib brow of the # 6 section of the battery charging station was not adequately supported where persons have to work or travel. A battery was partially located under the brow and due to the approximate rib height of 10 feet, miners connecting or disconnecting the battery in this area could be struck in the event it were to fall. The corner rib had separated from the roof 5 inches and had fractures on both sides.

(Gov Ex. 6).

Terpo designated the cited condition as S&S because he was concerned about the likelihood of serious injury to individuals working in the battery charging area in the event that the brow fell. Terpo attributed the violation to a moderate degree of negligence. The citation was terminated shortly after it was issued after timbers were reinstalled as supplemental support.

Citation No. 7687036 Bench Decision

The following is the edited bench decision for Citation No. 7687036:

The threshold issue is the fact of the occurrence of the alleged violation. Section 75.202(a) requires rib areas to be adequately supported to protect against the hazards posed by a rib roll or fall. I credit the testimony of Parker and Plylar that the brow was suspended approximately four feet from the mine floor. This conclusion is supported by Terpo's testimony that the brow created a "cavity" caused by 'partial sloughage.' Terpo's description is consistent with sloughage of the Blue Creek seam that is four feet in width. The testimony and photographs presented by JWR reflecting that the brow was approximately four feet off of the ground outweighs Terpo's inconsistent testimony and equivocal notes on this issue.

I note the uncontradicted testimony of Parker and Plylar that there were a greater number of pins in the rib than required by the roof control plan. They also testified about two additional roof bolts that were installed in the brow through the middleman and Mary Lee seam into the mine roof. Terpo, on the other hand, testified he did not see additional roof bolts in the brow. The area observed by Terpo was illuminated with cap light. Under these circumstances, the flash

photography evidence in Respondent's Exs. 1 - 3, that supports the testimony of Parker and Plylar with respect to additional roof bolts, outweighs Terpo's testimony. However, resolving the issue of the height of the brow, and the support measures that were installed, does not resolve the issue of whether the subject rib was adequately supported to protect persons against the hazards of a rib fall as required by section 75.202(a).

In this case, JWR has admitted that additional support was prudent by virtue of the fact that it had installed timbers. Having recognized and installed additional support, JWR assumes the risk of liability for a section 75.202(a) violation if the timbers are dislodged and not reinstalled. Thus, JWR's failure to reinstall the additional support warrants the conclusion that it failed to take the steps required to ensure that miners were protected from the hazards associated with a rib brow fall. Accordingly, the Secretary has satisfied her burden of demonstrating a violation of the cited mandatory standard.

Turning to the issue of significant and substantial, while a brow fall will undoubtedly expose miners to serious or fatal injury, whether the violation was properly designated as S&S is based on whether it was reasonably likely, given the rib and brow support measures in place, that the brow would fall. Pinning the rib three feet on center, in addition to roof bolting the brow through the middleman into the mine roof, significantly mitigated the likelihood of a brow failure. Thus, on balance, the Secretary has not shown that it was reasonably likely that the hazard posed by the failure to reinstall the timbers will result in an event, *i.e.*, a brow fall, that will cause serious injury. *Mathies 6 FMSHRC at 3-4.* Thus, the S&S designation from Citation No. 7687036 shall be deleted.

With respect to negligence, Terpo attributed the degree of JWR's culpability as moderate. The Secretary has proposed a civil penalty of \$1,238.00 for Citation No. 7687036. The degree of negligence is an important factor in considering the appropriate civil penalty. Once JWR undertook to further support the brow with timbers it was obliged to ensure that the timbers remained in place. JWR's failure to reinstall the timbers evidences a high degree of negligence that negates any significant reduction in the proposed penalty that would otherwise occur because the violation has been reduced to non-S&S in nature. Accordingly, Citation No. 7687036 shall be modified to reflect the cited condition was a non-S&S violation that was attributable to a high degree of negligence. Consequently, a civil penalty of \$1,000.00 shall be assessed for Citation No. 7687036.

(Tr. 1126-37).

iv. Final Disposition of Docket No. SE 2006-222

The Secretary proposed a total civil penalty of \$3,314.00 for the three citations in issue in Docket No. SE 2006-222. Based on this decision, a total civil penalty of \$2,300.00 shall be assessed for the three subject citations.

Total Proposed Penalty: \$3,314.00

Total Assessed Penalty: \$2,300.00

b. Docket No. SE 2006-308

i. Citation No. 7687073 - Safeguard

Safeguards are issued pursuant to 30 C.F.R. § 75.1403 to notify mine operators that actions are required to “minimize hazards with respect to transportation of men and materials” at a particular mine site. After a safeguard is issued, 30 C.F.R. § 75.1403-1 requires the mine operator’s continued compliance with the terms and conditions of the safeguard.

During an inspection of JWR’s No. 7 Mine that occurred several years earlier on February 16, 1995, Inspector John Terpo observed 12 track rails that were stored between the main haulage track 300 feet outby the longwall section tail track. At that time, JWR was engaging in retreat mining. The track rails were stacked in between the track after they were removed as the track entry retreated. Terpo was concerned that the track rails could shift and cause a derailment of the man-trip causing injuries to its miner occupants. As a result of his observations, Terpo issued Safeguard No. 4476297 on February 16, 1995, requiring JWR to remove the 12 track rails from the track bed. (Gov. Ex. 13).

On March 20, 2006, eleven years after the issuance of Safeguard No. 4476297, Terpo noted two track rails located on the metal cross ties in between the track in the No. 3 Section. The rails were located one crosscut outby the end of the track. Unlike the earlier safeguard that was issued during retreat mining, in this case JWR was advancing the track entry. Plylar testified, without contradiction, that the track rails were placed between the track at the end of the shift in preparation for advancement of the track by personnel on the following shift. (Tr. 412, 423). Once again, Terpo was concerned that the rails in between the track could cause a derailment that would result in serious injury. Consequently, on March 20, 2006, Terpo issued 104(a) Citation No. 7687073 citing an S&S violation of Safeguard No. 4476297. (Gov. Ex. 12).

Citation No. 7687073 was abated after Terpo required JWR to remove the rails and place them along the track entry rib. I note, parenthetically, that the safeguard standard in 30 C.F.R. § 75.1403-8 requires clearance space on all track haulage roads to be kept free of loose rock, supplies, and other loose materials.

Citation No. 7687073 Bench Decision

The following is the edited bench decision for Citation No. 7687073
As Inspector Terpo testified, safeguards are issued to protect miners from transportation hazards, that are unique to a particular mine, that are not otherwise

addressed in the Secretary's mandatory safety standards. Citation No. 7687073 alleges an S&S violation of the safeguard issued on February 16, 1995. That safeguard was issued after JWR had stored 12 track rails in between the track during retreat mining. The Secretary proposes a civil penalty of \$524.00 for Citation No. 7687073.

The earlier safeguard is distinguishable from the underlying facts in Citation No. 7687073. There were only two track rails between the track rather than the 12 rails cited in the underlying safeguard. This is significant because the two rails, located near the end of the track, were placed there in preparation for installation during the following shift as the track entry progressed. Thus, the cited rails were placed between the track for installation rather than for the purpose of storage.

It is significant that the Secretary's regulations recognize that the necessity of equipment in working sections is a relevant consideration in determining the applicability of her safety requirements. In this regard, section 75.380, 30 C.F.R. § 75.380, governing escapeways ordinarily requires escapeways to be maintained at least six feet wide. However, in instances where there is "mobile equipment near working sections, and other equipment essential to the ongoing operation of longwall sections," the Secretary permits a narrower escapeway width, as long as the width is sufficient to allow miners, including disabled persons, to escape quickly in an emergency. 30 C.F.R. § 75.380(d)(4)(iv).

Thus, obstructions that might otherwise constitute a safety violation may be permissible if they are limited in scope and occur during the normal mining cycle. Here, the two rails were placed near the end of the track in contemplation of installation, rather than for the purpose of storage. Consequently, the safeguard that, in effect, prohibited storage of rails between track, was not violated by the facts in this case.

In reaching this conclusion I am not trivializing the hazard posed by long-term storage of rails in track beds. The propriety of the short term placement of the rails is limited to the facts in this case. I urge JWR to note their intent to advance the track during the next shift in pre-shift reports if these circumstances should reoccur. **Accordingly, Citation No. 7687073 shall be vacated.**

(Tr. 1137-45).

ii. Citation No. 7687054 - Seal

Citation No. 7687054 concerns whether a cementitious ventilation control seal was being maintained so that it achieved its intended purpose. As a general matter, seals separate abandoned areas of a mine from active workings. Properly maintained seals serve two purposes.

First, they separate unventilated, methane contaminated air in abandoned areas from active areas of the mine. When barometric pressure is low the direction of air infiltration in a mine is from abandoned areas into active areas. Although it is not abnormal for seals that maintain their structural integrity to allow small concentrations of contaminated air to infiltrate into active workings based on barometric pressure, seals must be maintained to prevent leakage of methane into active mine areas through cracks or other structural deficiencies. The Secretary contends the cited seal constituted a violation of her regulatory standard because it was leaking.

The second purpose of a seal is to withstand the lateral force of an explosion to prevent the escape of gases from abandoned areas into active areas. The Secretary does not contend that the cited seal was structurally deficient with respect to its ability to withstand lateral forces.

Cementitious seals are constructed by pumping a cementitious foam material into wood forms. The dimensions of the wood forms are the length and height of the entry to be sealed. The depth of the wood form is usually about four feet. To provide additional infiltration protection, curtains are attached to the wood forms in front of the faces of the seals on both the active and abandoned sides of the form.

Prior to entering the No. 7 Mine on February 22, 2006, Terpo received a complaint from a miner that there were high levels of methane concentrations at the northeast intake seals. The miner was particularly concerned when there was a low pressure system. Since there was a low pressure weather system that day, Terpo decided to inspect the seals.

The No. 43 cementitious seal located in the main right intake air course was approximately 20 feet long, 7 feet high and 4 feet in depth. There was approximately 30 thousand cubic feet per minute coursing the right intake air entry. (Tr. 701). As is common in most mines, check curtains were installed diagonally from the main right intake ribs to the face of the seals, including the No. 43 seal, to ventilate the seals by diverting the 30,000 CFM intake air along the face of the seals. Thus, the check curtains serve to dilute any contaminated air that infiltrates through the seals. (Resp. Ex. 4; Tr. 673-78).

As Terpo approached the No. 43 seal he could hear the sound of blowing air. At a distance of approximately ten feet from the seal, Terpo obtained methane monitor reading concentrations ranging from two to four percent. The explosive range of methane begins at fifteen percent.

At the seal, Terpo noted an opening in the curtain in front of the face of the seal that was approximately 9 inches long by 2 inches high. The opening was located 7 inches from the roof and 24 inches from the right side rib. Terpo inserted his hand in the opening in the curtain and determined there was an indentation, or hole, in the cementitious material that was approximately 6 inches deep. Terpo agreed that the remaining depth behind this 6 inch cavity was 42 inches (3½ feet). (Tr. 502). He also admitted that it was possible that this 42 inch remaining depth was intact and solid. (Tr 609-10). Terpo testified that he was afraid that sticking his hand further into the hole may have resulted in additional unconsolidated material

falling and trapping his arm. (Tr. 503). Terpo did not use a probe to determine the nature and extent of the indentation behind the curtain.

Terpo obtained two bottle samples of air. The first sample (# K9220) was taken at an arms length distance downwind from the seal. Terpo estimated this bottle sample was taken approximately two feet from the opening. Laboratory analysis revealed a methane concentration of 9.68 percent and an oxygen concentration of 15.70 percent. Terpo obtained another bottle sample (# K9290) approximately 6 feet downwind from the seal. This bottle sample revealed concentration levels of 1.85 percent methane and 19.61 percent oxygen. (Gov. Ex 10).

Terpo testified that oxygen levels of less than 19.5 percent are unsafe. However, Terpo conceded that the atmospheric conditions at the No. 43 seal did not require any safety precautions such as an oxygen mask. In other words, with the exception of inhaling the contaminated air directly from the hole in the curtain, there was no respiratory hazard.

As a result of his observations, Terpo issued Citation No. 7687054 alleging a violation of the mandatory safety standard in 30 C.F.R. § 75.333(h). This mandatory standard requires seals to be maintained in order "to serve the purpose for which they were built." Terpo designated the cited condition as S&S because an examiner travels this area on a weekly basis. In addition, Terpo was concerned that the leakage, although substantially diluted with intake air, flows into the main right intake air course that ultimately is directed to track entries and working sections where there are ignition sources. Terpo attributed the cited violation to a moderate degree of negligence.

The citation initially was terminated by Terpo approximately five hours after it was issued after "a polyurethane foam (RHH - Vers Foam) was applied to the hole filling the hole keeping air from traveling through the seal." (Gov. Ex. 8, p.1). Terpo withdrew his termination of the citation two days later on February 24, 2006, because "polyurethane foam (RHH-VERSA FOAM) has been determined not to be an approved means to correct the problem that exists on the No. 43 seal." (Gov. Ex. 8, p.3). The citation was ultimately terminated on March 1, 2006, after a new cementitious seal was installed in front of the existing seal. (Gov. Ex., p. 5; Tr. 637).

JWR supervisor Richard Parker accompanied Terpo during his inspection of the No. 43 seal. Parker stated that some material fell out of the hole when Terpo lifted the flap on the curtain. Parker related that, upon lifting the flap, Terpo stated "the seal wasn't doing what its supposed to." (Tr. 721-22). Parker testified that Terpo began "digging at the material, scraping it." (Tr. 721-22). Parker believed Terpo created the indentation by scraping his fingers on the face of the seal. (Tr. 721).

Ty Olsen, JWR's Outby Area Manager at the No. 7 Mine, described the cementitious seal construction process. Olsen described how yellow curtains are attached to the active and abandoned sides of the forms. The curtains remain in place after the seal is poured and the cement cures. Olsen stated there are approximately 100 seals in the No. 7 Mine, the majority of which are cementitious seals. Olsen reported that there have been no curing problems with seals.

Olsen stated the method of determining if a seal is structurally defective is to probe the seal with a metal rod.

Olsen testified that, although he did not accompany Terpo during his inspection, he observed the No. 43 seal immediately after it was cited. Olsen agreed there was a 9 inch by 2 inch cut in the outer curtain through which air flow could be felt. Olsen described the outer curtain as a plastic perimeter or barrier that was essentially air tight. He also described the surface of the seal directly behind the curtain hole as dry and granular in nature. Olsen believed the indentation found by Terpo was the result of probing that had been done by Terpo, and/or others, who had attempted to discover the source of the leak. Olsen believed the air flow was coming from leakage along the right hand rib line that was concentrated between the curtain and the seal and escaping through the opening in the curtain.

Olsen attempted to abate the cited violation by applying polyurethane foam on the right rib line and on strata several feet from the seal. (Tr. 638). He also applied polyurethane foam to close the hole in the curtain. However, as noted above, the application of polyurethane was deemed to be inadequate and a new cementitious seal ultimately was installed in front of the existing seal.

On February 28, 2006, four days after the issuance of the citation, Danny Hagood, a member of JWR's Six Sigma Department's engineering staff, probed the indentation behind the opening in the curtain with a straightened cable hanger. Hagood found an area approximately ½ inch in diameter located about six inches from the left corner of the curtain flap that was "somewhat softer than the surrounding material." (Resp. 6).

Citation No. 7687054 Bench Decision

The following is the edited bench decision for Citation No. 7687054:

Citation No. 7687054 alleges a violation of section 75.333(h) that requires seals to be maintained to achieve their intended purpose - - to prevent leakage from abandoned areas. A civil penalty of \$1,238.00 is proposed for this citation.

As a threshold matter, leakage must be distinguished from normal migration of air flow due to barometric pressure. The Secretary maintains the condition of the No. 43 seal did not prevent leakage of contaminated air from inactive into active workings. The evidence undeniably reflects that the air flow cited by Terpo was attributable leakage. I reach this conclusion based on the nature and extent of the air flow described by Terpo, as well as the testimony of Olsen and Parker.

Olsen credibly testified that the 2 inch by 9 inch hole in the curtain, through which contaminated air leaked, was abnormal. Thus, it obvious that the condition of the seal supports the conclusion that it was not being maintained to enable it to achieve its intended purpose, *i.e.*, to keep leakage from penetrating into active workings. **Consequently, the evidence supports the fact of the violation of section 75.333(h) and the moderate degree of negligence attributed to JWR by the Secretary.**

Resolving whether the condition of the seal constituted a significant and substantial violation must be based on the particular facts in this matter. Thus, the source of the leakage must be identified to determine if the seal was significantly compromised. The evidence does not support the Secretary's case that the leakage was due to a defect in the face of the seal that was located directly behind the flap in the curtain. The indentation was not probed by Terpo. Moreover, it is doubtful that Terpo would have initially terminated the citation based on the application of polyurethane foam if he believed there was a four feet deep hole through the seal, or, if he believed the seal was so compromised that his arm could become entrapped.

Rather, the evidence reflects that the only connection between the hole in the curtain and the indentation described by Terpo is that the irregularity in the face of the seal occurred after manual probing to determine the source of the leakage. The credible evidence reflects the source of the contaminated air flow was cracking in the vicinity of the right ribline, that was further concentrated between the face of the seal and the curtain, and ultimately released through the hole in the curtain. This contaminated air was immediately diluted by the check curtains that swept 30,000 CFM of intake air across the face of the seal. Viewing the facts in their entirety, the nature and extent of the leakage, the immediate dilution by the check curtains, and the absence of ignition sources in the immediate vicinity of

the seal, do not support the Secretary's view that a suffocation or ignition event is reasonably likely. **Accordingly, the S&S designation in Citation No. 7687054 shall be deleted. In view of the modification of the citation to reflect a non-S&S violation, a civil penalty of \$850.00 shall be assessed for Citation No. 7687054.**

(Tr.1149 -61).

iii. Settlement Terms in Docket No. SE 2006-308

The Secretary initially proposed a civil penalty of \$963.00 for Citation No. 7687085, the remaining citation in Docket No. SE 2006-308. The parties have agreed that JWR shall pay a reduced civil penalty of \$500.00 for this citation. The terms of the parties' settlement are approved.

iv. Final Disposition of Docket No. SE 2006-308

The Secretary proposed a total civil penalty of \$2,725.00 for the three citations in issue in Docket No. SE 2006-308. Based on the disposition of Citation Nos. 7687073 and 7687054 in this decision, and the settlement of Citation No. 7687085, a total civil penalty of \$1,350.00 shall be assessed for the three subject citations.

Total Proposed Penalty: \$2,725.00

Total Assessed Penalty: \$1,350.00

c. Docket No. SE 2006-40

i. Citation No. 7686313 - August 31, 2005 Blast

Section 103(g) of the Mine Act, 30 U.S.C. § 813(g), confers on miners the right to obtain an immediate inspection by notifying the Secretary that they have reason to believe that an imminent danger exists, or that a violation of a mandatory safety standard has occurred. An anonymous complaint (# 05-176) was received on September 1, 2005, in MSHA's District 11 Field Office that JWR failed to warn four miners who were in a blast zone prior to the detonation of a blast that occurred at the No. 5 Mine at approximately 6:30 p.m. on the evening of August 31, 2005. Two additional complaints (# 05-178 and 05-181) were received on September 2, 2005, that blasting occurred on consecutive days (Wednesday, August 31 and Thursday, September 1, 2005) at the No. 5 Mine without warning miners who were working nearby. (Gov. Ex. 19).

MSHA Inspector Steven Womack was dispatched to the No. 5 Mine on the afternoon of Friday, September 2, 2005, to investigate Complaint ID 05-176 and 05-178. Womack was not aware that a third complaint (05-181) had been received. Upon arriving at the mine, Womack met with mine manger Greg Franklin and Ricky Parker, who was then an hourly safety committeeman. Womack informed them that 103(g) complaints had been received concerning

blasts that had occurred on the previous two days. Franklin and Parker identified the miners that were on site at the time of those blasts.

Womack went underground to examine the blast area. Womack noted that the roof conditions were "horrible" and that many of the entries had roof falls. (Tr. 864). Womack observed that additional support, consisting of wooden cribs and metal cross beams, was installed against the belt entry roof. (Tr. 864-66). After observing the vicinity of the blasts, Womack interviewed eight miners who were present during the blasts who were also working on the afternoon of September 2, 2005.

Womack determined that both blasts occurred in the No. 1 East Rehabilitation area at survey station 1143 in a crosscut between the track and belt entries where future seal E30 was to be installed. (Gov. Exs. 28A, 28B). The blasts contained approximately 50 to 70 sticks of dynamite. (Tr. 872). Although both blasts occurred in the vicinity of the future E30 seal, Parker testified that the Wednesday blast was in the direction of the track entry and the Thursday blast was in the direction of the crosscut. (Gov. Ex. 29; Tr. 926).

Terry Mabe was the shift foreman in charge of the Wednesday, August 31, 2005, shot. Stanley Downs was the shot blaster. At the time of the Wednesday blast, there were three hourly employees and one supervisor that were located in close proximity to the blast. The supervisor was foreman Jerry Dixon. The hourly employees were Jeremy Beavers, Derrick Burger and Ernie Breasscale. Terry Mabe told Womack that, at the time of the Wednesday blast, he sent Ralph Sadler to notify everyone that the blast was about to occur. Mabe stated Sadler informed him that the area was clear.

Jerry Dixon initially informed Womack on September 2, 2005, that, on Wednesday, he, Beavers, Burger and Breasscale were working in the crosscut near the belt entry clearing rock from the vicinity of the E24 seal. (Gov. Exs. 28A, 28B, 29). The E24 seal is located, one entry outby, in the same crosscut as the blast site at the future E30 seal. (Gov. Ex 29).

Beavers told Womack that neither he nor his fellow crewmen were warned prior to the August 31 blast. Beavers stated his supervisor, Jerry Dixon, also was unaware that the blast was about to occur. Beavers related that he was startled when the roof shook and flaked. Beavers confronted Terry Mabe after the blast. Mabe told Beavers he was not to blame because he was unaware anyone was working in the area.

Both Breasscale and Burger told Womack they were working at the No. 24 seal during the blast. Breasscale stated dust, flaky roof material and the smell of explosives came into their work area. Breasscale stated miners usually were warned to evacuate blast areas prior to blasting.

Burger stated he was shaken by the blast. He wanted to leave the area, but Jerry Dixon required him to stay and continue working. Burger later confronted Mabe about the blast. Mabe told Burger that Supervisor Randy Dixon (no relation to Jerry Dixon) had notified him that

everyone was accounted for and it was safe to proceed with the shot. Randy Dixon, who was present, told Burger, if anyone was to blame, he was responsible because he thought all of the beltmen had been accounted for. Specifically, Randy Dixon told Womack he mistakenly believed the miners were working at the belt head, approximately 840 feet further outby in the belt entry, a safe distance away from the blast. (Tr. 854-58, Gov. Exs. 28A, 28B).

Since the area where Jerry Dixon and his crew were working was in the same crosscut as the Wednesday blast, Womack believed the men, situated approximately 125 feet in a direct line from the blast site, were exposed to fly rock. (Tr. 873; Gov. Ex. 23, p.6, Gov. Ex. 29). Womack determined that, with the exception of those four men, all miners were located at a safe distance outby the blast area in an area known as "the dinner hole." (Tr. 874-76; Gov. Exs. 28A, 28B). The "dinner hole" is an area that provides protection to miners because of its distance from the blast site and because it is located behind a solid block of unmined coal. (Tr. 878-80).

Based on his findings, Womack issued 104(d)(2) Order No. 7686312 citing a violation of the mandatory standard in 30 C.F.R. § 75.1325(c)(1). (Gov. Ex. 20). This mandatory standard requires all persons to withdraw from a blast area, and each adjacent working place where a hazard would be created by the blast, to an area that is around at least one corner from the blast area. In other words, this standard clearly prohibits miners from being in the direct line of a blast.

After Womack's initial interviews, JWR advised Womack that the exact location of the miners at the time of the Wednesday blast was in doubt. Consequently, Womack re-interviewed Jerry Dixon, Beavers, Breasscale and Burger on September 8, 2005. The subsequent interviews continued to reflect that the miners were not notified prior to the blast. However, the miners recanted their prior statements with regard to their exposure to the blast. Dixon and his crew now indicated they were around the corner in the belt entry under roof beams, rather than being directly exposed in the crosscut. Consequently, Womack superceded 104(d)(2) Order No. 7686312 with 104(d) (2) Order No. 7686313 citing a violation of the safety standard in 30 C.F.R. § 75.1325(c)(2) instead of a violation of 30 C.F.R. § 75.1325(c)(1). Section 75.1325(c)(2) requires a qualified person to determine that all persons are a safe distance from the blasting area before blasting.

Order No. 7686313 states:

Based upon information received during a 103(g) investigation (Complaint ID 05-176 and 05-178) it has been determined that the qualified person did not ascertain that all persons were a safe distance from the blasting area.

On the 1 East Rehabilitation Area on 8/31/05 at approximately 6:30 p.m. a shot was fired in the crosscut at survey station 1143 (Track Entry) where future seal E29 was to be erected. In the adjacent entry (Belt Entry) directly across from the blast area at survey station 1175 three hourly and one salary worker were performing clean-up on the beltline. The 4 workers were not aware that a shot

was to take place and were not notified. The only barrier between the workers and the blast was gob placed in the crosscut. The foreman in charge at the blast area did not make a diligent effort to see that all persons were in a safe area away from the blast. The workers encountered smoke and dust from the blast and small pieces of falling material from the mine roof.

The mine operator has engaged in aggravated conduct constituting more than ordinary negligence. This violation is an unwarrantable failure to comply with a mandatory standard.

(Gov. Ex. 21).² Although the negligence attributable to JWR initially was characterized as high supporting an unwarrantable failure, Womack lowered the degree of negligence to moderate and modified Order No. 7686313 to a 104(a) citation on September 15, 2005. The removal of the unwarrantable failure was based on the new information that the miners were situated in the belt entry rather than being directly exposed to flyrock in the crosscut.

Citation No. 7686313 Bench Decision

The following is the edited version of the bench decision for Citation No. 7686313:

Although the Secretary initially charged JWR with a violation of the safety standard in section 75.1325(c)(1) that requires all persons to leave a blast area and to seek shelter in an area that is around *at least* one corner from the blast area, she subsequently superceded the citation by modifying the cited standard to a section 75.1325(c)(2) violation. This safety standard requires a qualified person to determine that all persons are a safe distance from the blasting area before blasting. A civil penalty of \$614.00 for Citation No. 7686313 is proposed.

As a threshold matter, I note that both section 75.1325(c)(1) and 75.1325(c)(2) require all persons to be evacuated from the blast area prior to detonation. Section 75.1325(c)(1) requires, *at a minimum*, that miners are at least around one corner from the blast area. If miners are situated around a corner, but the corner is in proximity to the blast site, section 75.1325(c)(1) may still be violated if miners have not retreated to a safe location. Thus, the dispositive issue is whether foreman Jerry Dixon and his crew were at a safe distance from the blast area when they were working around a corner in the belt entry, approximately 125 feet away from the August 31 blast.

² The mine map erroneously labels the site of the blast at the E29 rather than the E30 seal. (Gov. Exs. 28A, 28B). Consequently, Citation No. 7686313 identified the blast area as future seal E29 based on Womack's reliance on the mine map. The blast area was at the future location of the E30 seal. (Tr. 819).

JWR does not dispute that it failed to warn the miners prior to the August 31 shot. The falling roof material, the fright of the miners, and the admissions by JWR management personnel, support the conclusion that the miners were not evacuated from the blast area.

Hearsay is admissible in this proceeding. 29 C.F.R. 2700.63(a); *REB Enterprises, Inc.*, 20 FMSHRC 203, 206 (Mar. 1998); *Mid-Continent Resources, Inc.*, 6 FMSHRC 1132, 1135 (May 1984). Beavers, Breasscale and Burger all recounted to Womack how they were exposed to dust, flaking roof material and the odor of explosives. Both Beavers and Burger related that they were startled and shaken by the unanticipated blast. In fact, Burger was so distraught that he requested to be relieved of duty. One can only imagine the shock to the nervous system caused by an unexpected nearby explosive blast. The fact that supplemental roof support was installed in the belt entry does not negate the fact that the miners were not warned and evacuated prior to the blast.

JWR now claims the miners were not in the blast area when they were working in the belt entry because they were protected from the direct line of the blast. JWR's assertion is undermined by several of its admissions to the contrary. An admission is a statement that is offered against a party that discredits, and is inconsistent with, its present claim in an adjudicative proceeding. 2 *McCormick on Evidence* § 254 at 179 (6th ed. 2006). Admissions have probative value and are received as substantive evidence of the facts admitted. *Id.* at 179, 180.

Terry Mabe, the shift foreman in charge of the August 31 blast, admitted that he was unaware of anyone in the vicinity of the belt entry because he had been assured by Sadler that the area was clear. More importantly, foreman Randy Dixon, who apparently authorized Mabe to proceed with the blast, admitted he was responsible because he thought all of the beltmen had been accounted for. Section 75.1325(c)(2) requires all persons to be evacuated from the blast area prior to detonation. Thus, both Mabe and Randy Dixon admitted that they failed to ensure that the blast area was clear of personnel. JWR has offered no evidence to rebut the admissions made by its management personnel. **Accordingly, the evidence supports the fact of occurrence of a section 75.1325(c)(2) violation.**

With regard to S&S, a violation is properly designated as significant and substantial if there is a reasonable likelihood that the hazard contributed to by the violation will result in an injury or an illness of a reasonably serious nature. *National Gypsum*, 3 FMSHRC at 825; *Mathies Coal Co.*, *supra*. It is difficult to imagine how the failure to clear a blast area could be deemed a non-significant and substantial violation, particularly in this case when the blast was unexpected. In other words, the fact that the miners were in the belt entry was fortuitous because, unaware of the imminent explosion, they could have wandered into a

direct line of the blast at any moment. Moreover, the shock, alone, could cause serious physical trauma including cardiac arrest. **Consequently, the violation was properly designated as S&S.**

Finally, although initially attributing the violation to a high degree of negligence, the citation ultimately was modified to reflect a moderate degree of negligence. While I am inclined to believe the negligence was high because foreman Jerry Dixon should have been aware of the impending blast that posed a significant safety hazard to him and his crew, I will not disturb the Secretary's assertion of moderate negligence. *Midwest Material Co.*, 19 FMSHRC 30, 35 (Jan. 1997) (supervisors are held to a higher standard of care). Consequently, the civil penalty proposed by the Secretary for Citation No. 7686313 shall be sustained. **Thus, a \$614.00 civil penalty shall be assessed for Citation No. 7686313.**

(Tr. 1162-72).

ii. Final Disposition of Docket No. SE 2006-40

Docket No. SE 2006-40 is a single citation case. The Secretary proposed a civil penalty of \$614.00 for Citation No. 7686313 which JWR shall be ordered to pay.

Total Proposed Penalty: \$614.00

Total Assessed Penalty: \$614.00

d. Docket No. SE 2006-123

i. Order No. 7686314 - September 1, 2005 Blast

A second blast occurred in the crosscut at the future E30 seal during the day shift at approximately 3:30 p.m. on Thursday, September 1, 2005, just as the evening shift was arriving for duty. The day shift foreman was Phillip Miles. The day shift shot fireman was Ronnie Hyche. The evening shift foreman was Terry Mabe. Although the evening crew had arrived on the section, the night shift miners were not advised that the shot was about to take place. Jerry Dixon had not yet informed Miles about the incident concerning his crew's exposure in the blast area the previous evening.

As the night shift arrived, Mabe and his crew gathered in the vicinity of the dinner hole that was approximately 1,000 feet outby the blast site. Mabe left the dinner hole area and walked to the blast site where Miles and Hyche were preparing the explosives.

Jerry Dixon was unaware that the blast was about to occur. At approximately 3:30 p.m., shortly before Mabe returned to the dinner hole area from the blast site, Jerry Dixon sent night shift miners Jeremy Beavers and Paul Aaron to the belt entry in the vicinity of the No. 22 seal to examine the roof conditions where the belt was about to be installed. (Gov. E's. 28B, 29, p.3).

As Beavers and Aaron passed the dinner hole at the intersection of spad 91, they encountered a group of miners. However, the miners did not mention that a blast was about to occur.

Mabe and Miles traveled back to the dinner hole area and warned everyone that the blast was about to occur. Before blasting, Mabe assigned guards in the crosscuts that intersected the track entry at Spad Nos. 191 and 194 to ensure that the blast area remained unoccupied. (Tr. 1068, 1082, 1086; Gov. E's. 28A, 28B). The guards prevented persons from traveling to the belt entry. (Tr. 1069-71, 1077-78).

Mabe also assigned Nathan Mason to guard the feeder area to prevent access to the belt entry. Mabe sent Ralph Sadler to the belt head to make certain that the belt entry had been evacuated. Sadler apparently could not see Beaver and Aaron's cap lights inby because of the downward slope of the belt entry. (Tr. 1052-53). Sadler reported that the area was clear.

The No. 22 seal is located at a crosscut of the belt entry that is approximately 219 feet outby from the crosscut with the future E30 seal. The center of the belt entry where it intersects with the crosscut containing the future E30 seal is approximately 120 feet from the blast site. (Gov. Ex. 29, p.3). At approximately 3:30 p.m., Beavers and Aaron felt the force of the blast when they were in the belt entry near the 22 seal.

Charles Dickey has been a blasting supervisor and manager since 1985. (Tr. 1067). On Thursday, September 1, 2005, Dickey was JWR's section manager. He was with Miles and Hyché when they prepared the Thursday shot. Dickey conceded that, by allowing Beavers and Aaron to travel the belt entry, they were not kept outby the guarded perimeter that had been established as the area of safety. (Tr. 1070-72, 1077-78, 1081-86). Similarly, Ricky Parker admitted more could have been done on September 1, 2005, to make sure the blast area was cleared before the shot. (Tr. 1053).

As a result of his investigation Womack issued 104(d)(2) Order No. 7686314 citing a significant and substantial violation of the mandatory safety standard in 30 C.F.R. § 75.1325(c)(2) that requires a qualified person to determine that all persons are a safe distance from the blasting area before blasting. The Order states:

Based upon information receipt during a 103G investigation (Complaint ID 05-176 and 05-178) it has been determined that the qualified person did not ascertain that all persons were a safe distance from the blasting area.

On the 1 East Rehabilitation Area on 9/1/2005 at approximately 3:30 P.M. a shot was fired in the crosscut at survey station 1143 where future seal E29 is to be erected and from the heading proceeding inby toward survey station 1144 (Two Shots). The Day Shift Foreman and the Evening Shift Foreman were both present and directing the work force at the blast location. Two evening shift workers entered into the adjacent belt entry and were proceeding toward the blast area near survey station 1372 when the shot was set off. The workers were not notified that

a blast was about to take place and no one was station[ed] out by the blast area as is normal practice to restrict persons from entering the area.

On the previous evening (8/31/05) a shot was set off with workers in close proximity to the same blast area without warning and the same Evening Shift foreman present at the blast location and in charge of the work force. The foreman was notified of the 8/31/05 incident by the workers involved and took no action to prevent a re-occurrence. The previous occurrence has been cited under this event number.

The mine operator has engaged in aggravated conduct constituting more than ordinary negligence. This violation is an unwarrantable failure to comply with a mandatory standard.

(Gov. Ex. 22).³ Womack characterized the violation as S&S because of the serious hazard created by exposing persons to a blast zone. He attributed the violation to an unwarrantable failure because of JWR's repeated failure to keep all persons at a safe distance from the blasting area before blasting.

Order No. 7686314 Bench Decision

The edited version of the bench decision for Order No. 7686314 follows:

104(d)(2) Order No. 7686314 cites a violation of section 75.1325(c)(2). This safety standard requires a qualified person to determine that all persons are a safe distance from the blasting area before blasting. The Secretary proposes a civil penalty of \$4,100.00 for Order No. 7686314.

The threshold question is whether Beavers and Aaron were kept a safe distance from the blasting area. Once again we are presented with the concept of admissions. Admissions are words or *acts* of a party that are offered as evidence by the opposing party. 2 *McCormick on Evidence, supra*, § 254 at 178. Admissions can be expressed as statements. *Id.* There are also admissions of conduct. *Id.* at 179. As previously noted, admissions are received as substantive evidence of the facts admitted. *Id.* at 180.

JWR has admitted that Beavers and Aaron were not kept a safe distance from the blast because they were permitted to travel in an area that was supposed to be guarded to prevent entry prior to the blast. Although JWR's conduct is an admission that the belt entry at the No. 22 seal was an unsafe area, JWR asserts

³ As noted in fn. 2, *supra*, although Order No. 7686314 identified the blast area as having occurred at seal E29, the correct location was in the vicinity of future seal E30. (Tr. 819).

that the location of Beavers and Aaron was not unsafe because they were around a corner and approximately 220 feet from the crosscut that was the site of the explosion. Once again, this assertion is unavailing as their location was fortuitous in that their unawareness of the imminent explosion could have led them into a direct path of flyrock. Finally, both Parker and Dickey have conceded that these miners were in a prohibited location. Accordingly, the evidence conclusively establishes a violation of the cited standard as Mabe and Miles failed to determine that all persons were at a safe distance from the blast on September 1, 2005.

The issue of significant and substantial is self-evident. Exposure to post-blast roof falls and flyrock resulting in serious injury or death is a likely possibility when blast areas are not cleared.

With regard to whether aggravated or unjustifiable conduct occurred as a basis for an unwarrantable failure, the Commission has determined that relevant factors are: whether the mine operator is aware of the violation; whether it has been placed on notice that greater efforts for compliance are necessary; and whether the violation poses a high degree of danger. *Virginia Slate Company*, 24FMSHRC 507, 512-13 (June 2002) (citations omitted). All of these factors exist in the current case. Both Jerry Dixon and Terry Mabe were aware of the incident on the previous evening, yet they allowed it to reoccur. As a supervisor directing the location and activities of subordinates, Jerry Dixon's repeated failure to know that blasts were scheduled to occur is inexcusable. There is no evidence that any additional measures were taken after the August 31 incident to ensure that miners were kept a safe distance from future blasts. As noted, the high degree of danger posed by this repeated failure is obvious. Accordingly, the Secretary has shown that this violation is attributable to unwarrantable conduct.

The Secretary concluded that JWR's conduct constituted high negligence. Ensuring that blast zones remain free of personnel is not a trivial pursuit. Although the August 31 incident could be properly characterized as conduct evidencing a moderate or high degree of negligence, the same cannot be said when the behavior repeats itself the following day. Rather, JWR's September 1 failure to effectively ensure that its personnel were prevented from entering blast zones constitutes a reckless disregard of the serious hazards associated with the use of explosives.

The Commission has noted that the *de novo* assessment of civil penalties does not require "that equal weight must be assigned to each of the penalty assessment criteria." *Thunder Basin Coal Co.*, 19 FMSHRC 1503 (Sept. 1997). Rather, the judge must qualitatively analyze each of the penalty criteria to determine the appropriate civil penalty to be assessed. *Cantera Green*, 22 FMSHRC 616, 625-26 (May 2000). **JWR's reckless disregard warrants a civil penalty that is**

higher than the Secretary's initial proposal. Accordingly, the unwarrantable failure in 104(d)(2) Order No. 7686314 shall be affirmed and JWR shall pay a civil penalty of \$5,500.00 for the cited violation.

(Tr. 1172-77).

ii. Settlement Terms in Docket No. SE 2006-123

The Secretary proposed a civil penalty of \$11,225.00 for the remaining 12 citations in issue in Docket No. SE 2006-123. The parties have agreed that JWR will pay a reduced civil penalty of \$7,764.00 in satisfaction of the 12 citations. The reduction in proposed penalty is based on a reduction in the gravity of the cited violative conditions.

I have considered the representations and documentation submitted in support of the parties' settlement agreement and I conclude that the proffered agreement is appropriate under the criteria set forth in Section 110(i) of the Mine Act. Accordingly, the parties' settlement terms shall be approved.

iii. Final Disposition of Docket No. SE 2006-123

Total Proposed Penalty: \$15,325.00

Total Assessed Penalty: \$13,264.00

e. Docket No. SE 2006-221

i. Settlement Terms in Docket No. SE 2006-221

The Secretary proposed a civil penalty of \$1,125.00 for the three citations in issue in Docket No. SE 2006-221. The parties have agreed that JWR will pay a reduced civil penalty of \$370.00 in satisfaction of the three citations. The settlement terms include deleting the significant and substantial designation from Citation Nos. 7687171 and 7687200.

I have considered the representations and documentation submitted in support of the parties' settlement agreement and I conclude that the proffered agreement is appropriate under the criteria set forth in Section 110(i) of the Mine Act. Accordingly, the parties' settlement terms shall be approved.

ii. Final Disposition of Docket No. SE 2006-221

Total Proposed Penalty: \$1,125.00

Total Assessed Penalty: \$370.00

f. Docket No. SE 2006-187

i. Settlement Terms in Docket No. SE 2006-187

The Secretary proposed a civil penalty of \$1,423.00 for the three citations in issue in Docket No. SE 2006-187. The parties have agreed that JWR will pay a reduced civil penalty of \$690.00 in satisfaction of the three citations. The settlement terms include deleting the significant and substantial designation from Citation No. 7687571.

I have considered the representations and documentation submitted in support of the parties' settlement agreement and I conclude that the proffered agreement is appropriate under the criteria set forth in Section 110(i) of the Mine Act. Accordingly, the parties' settlement terms shall be approved.

ii. Final Disposition of Docket No. SE 2006-187

Total Proposed Penalty: \$1,423.00

Total Assessed Penalty: \$690.00

g. Docket No. SE 2007-77

i. Settlement Terms in Docket No. SE 2007-77

The Secretary proposed a civil penalty of \$2,581.00 for the five citations in issue in Docket No. SE 2007-77. The parties have agreed that JWR will pay a reduced civil penalty of \$905.00 in satisfaction of the five citations. The settlement terms include deleting the significant and substantial designation from Citation Nos. 7687869 and 7687877.

I have considered the representations and documentation submitted in support of the parties' settlement agreement and I conclude that the proffered agreement is appropriate under the criteria set forth in Section 110(i) of the Mine Act. Accordingly, the parties' settlement terms shall be approved.

ii. Final Disposition of Docket No. SE 2007-77

Total Proposed Penalty: \$2,581.00

Total Assessed Penalty: \$905.00

h. Docket No. SE 2007-117

i. Settlement Terms in Docket No. SE 2007-117

The Secretary proposed a civil penalty of \$1,710.00 for the two citations in issue in Docket No. SE 2007-117. The parties have agreed that JWR will pay a reduced civil penalty of \$850.00 in satisfaction of the two citations. The reduction in proposed penalty is based on a reduction in the gravity associated with the cited violative conditions.

I have considered the representations and documentation submitted in support of the parties' settlement agreement and I conclude that the proffered agreement is appropriate under the criteria set forth in Section 110(i) of the Mine Act. Accordingly, the parties' settlement terms shall be approved.

ii. Final Disposition of Docket No. SE 2007-117

Total Proposed Penalty: \$1,710.00

Total Assessed Penalty: \$850.00

ORDER

Consistent with this Decision, **IT IS ORDERED** that 104 (a) Citation Nos. 7687031, 7687034 and 7687036 in Docket No. SE 2006-222 **ARE AFFIRMED. IT IS FURTHER ORDERED** that the significant and substantial designation in Citation Nos. 7687034 and 7687036 shall be deleted, and that Citation No. 7687036 shall be modified to increase the degree of negligence from moderate to high.

IT ORDERED that, 104(a) Citation No. 7687073 in Docket No. SE 2006-308 **IS VACATED. IT IS FURTHER ORDERED** that the significant and substantial designation in 104(a) Citation No. 7687054 in Docket No. SE 2006-308 shall be deleted and that the citation **IS AFFIRMED** as modified.

IT IS FURTHER ORDERED that 104(a) Citation No. 7686313 in Docket No. SE 2006-40 **IS AFFIRMED.**

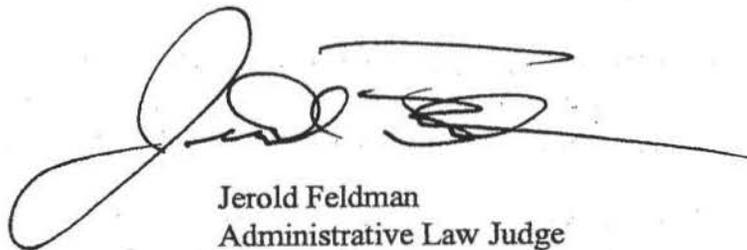
IT IS FURTHER ORDERED that 104(d)(2) Order No. 7686314 in Docket No. SE 2006-123 is modified to reflect that the cited violation is attributable to a reckless disregard and that Order No. 7686314 **IS AFFIRMED** as modified.

IT IS FURTHER ORDERED that the parties' motion to approve settlement with respect to the remaining citations in issue in these proceedings **IS GRANTED.**

Consistent with this decision and the parties' settlement terms, **IT IS ORDERED** that Jim Walter Resources, Inc., **shall pay a total civil penalty of \$20,343.00** in satisfaction of the 104(a) citations and 104(d) order that are the subject of these civil penalty proceedings. The sum total of \$20,343.00 represents the following civil penalty payments for each of the docketed cases in these matters:

Docket No.	Proposed Penalty	Assessed Penalty
SE 2006-222	\$3,314.00	\$2,300.00
SE 2006-308	\$2,725.00	\$1,350.00
SE 2006-40	\$614.00	\$614.00
SE 2006-123	\$15,325.00	\$13,264.00
SE 2006-221	\$1,125.00	\$370.00
SE 2006-187	\$1,423.00	\$690.00
SE 2007-77	\$2,581.00	\$905.00
SE 2007-117	\$1,710.00	\$850.00
TOTAL	\$28,817.00	\$20,343.00

Payment is to be made to the Mine Safety and Health Administration within 40 days of the date of this Decision. **IT IS ORDERED** that upon timely receipt of payment, the captioned civil penalty matters **ARE DISMISSED**.



Jerold Feldman
Administrative Law Judge

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/sr

FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

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

January 29, 2008

SECRETARY OF LABOR,	:	CIVIL PENALTY PROCEEDING
MINE SAFETY AND HEALTH	:	
ADMINISTRATION, (MSHA),	:	Docket No. PENN 2007-163
Petitioner	:	A.C. 36-01818-110700-02
	:	
v.	:	
	:	
R S & W COAL COMPANY, INC.,	:	R S & W Drift
Respondent	:	

DECISION

Appearances: Patrick M. Boylan, Conference and Litigation Representative, Mine Safety and Health Administration, Department of Labor, Wilkes-Barre, Pennsylvania, and John M. Strawn, Esq., Office of the Solicitor, U.S. Department of Labor, Philadelphia, Pennsylvania, for Petitioner;
Randy Rothermel, R S & W Coal Company, Schuylkill, Pennsylvania, *Pro Se*, for Respondent.

Before: Judge Hodgdon

This case is before me on a Petition for Assessment of Civil Penalty brought by the Secretary of Labor, acting through her Mine Safety and Health Administration (MSHA), against R S & W Coal Company, pursuant to section 105 of the Federal Mine Safety and Health Act of 1977, as amended, 30 U.S.C. § 815. The petition alleges a single violation of the Secretary's mandatory health and safety standards and seeks a penalty of \$76.00. For the reasons set forth below, I modify the citation and assess a penalty of \$35.00.

Background

The R S & W Drift Mine is owned and operated by R S & W Coal Company, Inc. The company mines anthracite coal at this Schuylkill, Pennsylvania location. The mine employed an average of 6 employees for the first three quarters of 2007. There has been no production at the mine since the beginning of September 2007.

Ronald G. Pinchorski, Coal Mine Safety and Health Inspector, conducted a mandatory inspection at the R S & W Drift Mine on October 17, 2006. During the inspection, he issued Citation No. 7009043, under section 104(a) of the Act, 30 U.S.C. § 814(a), which was contested at trial.

Findings of Fact and Conclusions of Law

The citation alleges a violation of section 77.1605 of the Secretary's regulations, 30 C.F.R. § 77.1605, because: "The left side door window on the Caterpillar Model 966C, rubber tired front-end loader (Sn#76J940) was not maintained in good condition, in that the window was broken (Section Missing). This condition caused the possibility of injuries to occur due to sharp edges." (Govt Ex. 1.) Section 77.1605(a), 30 C.F.R. §77.1605(a), provides that: "Cab windows shall be of safety glass or equivalent, in good condition and shall be kept clean."

Inspector Pinchorski testified that the window was located on the left side door. (Tr. 13.) This is the side of the Caterpillar that the operator would mount and dismount. (Tr. 13.) Inspector Pinchorski believed that the broken Plexiglas window contained sharp edges. (Tr. 13.) According to him, the handle of the door was located several inches away from the broken part of the window. (Tr. 39.) Timely abatement of the citation occurred when the window was removed. (Tr. 15.)

Randy Rothermel, owner of the company, testified that the window, which he brought with him to the trial, was broken about an inch from the top. (Resp. Ex. A, Tr. 52.) He said that he did not believe it was a violation because "it's impossible to get hurt the way that window was installed in the loader." (Tr. 43.) He estimated that the window had been in the same condition between three and five years. (Tr. 43.)

It is undisputed that the window was broken. However, based on an examination of the window, I conclude that it was broken about an inch from the top and not a third of the way up as the inspector recollected. Regardless, since the window was broken, it was not in good condition and I conclude that the operator violated section 77.1605(a) as alleged.

Significant and Substantial

The inspector found this violation to be "significant and substantial." A "significant and substantial" (S&S) violation is described in section 104(d)(1) of the Act, 30 U.S.C. § 814(d)(1), as a violation "of such nature as could significantly and substantially contribute to the cause and effect of a coal or other mine safety or health hazard." A violation is properly designated S&S "if, based upon the particular facts surrounding that violation, there exists a reasonable likelihood that the hazard contributed to will result in an injury or illness of a reasonably serious nature." *Cement Division, National Gypsum Co.*, 3 FMSHRC 822, 825 (Apr. 1981)

In *Mathies Coal Co.*, 6 FMSHRC 1 (Jan. 1984), the Commission enumerated four criteria that have to be met for a violation to be S&S. See also *Buck Creek Coal, Inc. v. FMSHRC*, 52 F.3d 133, 135 (7th Cir. 1995); *Austin Power, Inc. v. Secretary*, 861 F.2d 99, 103-04 (5th Cir. 1988), *aff'g Austin Power, Inc.*, 9 FMSHRC 2015, 2021 (Dec. 1987) (approving *Mathies* criteria). Evaluation of the criteria is made in terms of "continued normal mining operations." *U.S. Steel Mining Co., Inc.*, 6 FMSHRC 1573, 1574 (July 1984). The question of whether a particular violation is S&S 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).

In order to prove that a violation is S&S, the Secretary must establish: (1) a violation of a safety standard; (2) a distinct safety hazard 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*, 6 FMSHRC at 3-4.

The inspector testified that since the loader was mounted and dismounted numerous times a day, he felt as if an injury was reasonably likely. (Tr. 14.) He further testified that possible injuries included slipping or falling into the broken part of the window and lacerating a wrist, hand, or arm. (Tr. 15.) On the other hand, Rothermel did not believe it was possible to cut one's self on the broken part of the window. (Tr. 44.)

While it appears unlikely that the broken window would cause a laceration, it makes little difference because it is even more unlikely that someone could inadvertently come in contact with the break. The door is opened before the operator climbs up to enter the cab. (Tr. 38.) The handle used to climb up into the cab is about a third of the way up the window and some 20 inches below the break. If someone slipped while entering the cab, they would fall into the open cab. If they grabbed for the handle and missed, they would either hit the window well below the break or stick their hand in the open cab. If the door were shut and they slipped and grabbed for the handle they would still be well below the break.

I find that the third *Mathies* criterion has not been met. There is no reasonable likelihood that the broken window would result in an injury. Accordingly, I conclude that the violation was not "significant and substantial" and will modify the citation accordingly.

Civil Penalty Assessment

The Secretary has proposed a penalty of \$76.00 for this violation. However, it is the judge's independent responsibility to determine the appropriate amount of penalty in accordance with the six penalty criteria set out in section 110(i) of the Act, 30 U.S.C. § 820(i). *Sellersburg Stone Co. v. FMSHRC*, 736 F.2d 1147, 1151 (7th Cir. 1984); *Wallace Brothers, Inc.*, 18 FMSHRC 481, 483-84 (Apr. 1996).

In connection with these criteria, the parties have stipulated that the Respondent demonstrated good faith in attempting to achieve compliance after notification of the violation. (Tr. 7.) In addition, the evidence shows that this is a small mine and that the operator has a good history of previous violations. (Govt. Exs. 5, 6 and 7.) Further, the operator has not demonstrated that the payment of the assessed penalty will adversely affect his ability to remain in business.

With regard to gravity, I find that this was a non-serious, technical violation of the rule in that the broken part of the window was so high up that it posed little hazard. I further find that, for this reason, the operator's negligence concerning this violation was "low." The citation will be modified accordingly.

Taking all of these factors into consideration, I conclude that a penalty of \$35.00 is

appropriate for this violation.

Order

In view of the above, Citation No. 7009043 is **MODIFIED** by changing the likelihood of injury from "Reasonably Likely" to "Unlikely," the "Significant and Substantial" designation from "Yes" to "No" and the level of negligence from "moderate" to "low" and is **AFFIRMED** as modified. R S & W Coal, Inc., is **ORDERED TO PAY** a civil penalty of **\$35.00** within 30 days of the date of this decision.



T. Todd Hodgson
Administrative Law Judge

Distribution:

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/sr

FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

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DENVER, CO 80204-3582
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January 29, 2008

SECRETARY OF LABOR,	:	CIVIL PENALTY PROCEEDING
MINE SAFETY AND HEALTH	:	
ADMINISTRATION (MSHA),	:	Docket No. WEST 2006-451-M
Petitioner	:	A.C. No. 48-00004-087217
	:	
v.	:	
	:	Guernsey Quarry
RINKER MATERIALS WESTERN, INC.,	:	
Respondent	:	
	:	
SECRETARY OF LABOR,	:	CIVIL PENALTY PROCEEDING
MINE SAFETY AND HEALTH	:	
ADMINISTRATION (MSHA),	:	
Petitioner	:	Docket No. WEST 2007-113-M
	:	A.C. No. 48-00004-099221A
	:	
v.	:	
	:	
WILLIAM E. REFFALT, employed by	:	Guernsey Quarry
Rinker Materials Western, Inc.,	:	
Respondent	:	

DECISION

Appearances: Kristi Henes, Esq., Office of the Solicitor, U.S. Department of Labor, Denver, Colorado, for Petitioner;
Katherine Shand Larkin, Esq., Jackson Kelly, PLLC, Denver Colorado, for Respondents.

Before: Judge Manning

These cases are before me on petitions for assessment of civil penalty filed by the Secretary of Labor, acting through the Mine Safety and Health Administration ("MSHA"), against Rinker Materials Western, Inc., doing business as Guernsey Stone Company ("Rinker") and William E. Reffalt, pursuant to sections 105 and 110 of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. §§ 815 and 820 ("Mine Act"). The petitions allege that Respondents violated 30 C.F.R. § 56.9200(d). An evidentiary hearing was held in Cheyenne, Wyoming, and the parties filed post-hearing briefs.

I. BACKGROUND AND SUMMARY OF THE EVIDENCE

Rinker operates the Guernsey Quarry, a quarry that produces crushed limestone, in Platte County, Wyoming. On December 19, 2005, MSHA received a hazard complaint from a miner working at the quarry. As set forth on MSHA's notification form, the complaint was as follows:

The boss, Bill [Reffalt], told an employee to ride in the front-end loader all day with another employee to task train him. The trainer didn't have a seat belt or seat to sit in while doing the training. A chair was put in the loader to use but it is still unsafe.

(Ex. G-5). MSHA Inspector Thomas A. Markve traveled to the quarry on December 20, 2005, to investigate the hazard complaint. (Tr. 31). At the conclusion of his investigation, Inspector Markve issued Citation No. 7913458 under section 104(d)(1) of the Mine Act alleging a violation of 30 C.F.R. § 56.9200(d). The body of the order provides as follows:

It was established that employees are being task trained in the 980C and 980H front-end loaders without making provisions for secure travel of the second person in the cab. The unsafe work practice was accomplished in the 980C front-end loaders by having the second person sit on the arm rest. The unsafe work was accomplished in the 980H by providing a folding chair and the second person sat in that while the equipment was operating. Bill [Reffalt], superintendent, engaged in aggravated conduct constituting more than ordinary negligence in that he admitted to knowing about and assigning employees to accomplish task training by the above-mentioned means.

The inspector determined that an illness or injury was reasonably likely, that any accident could be fatal, that the violation was of a significant and substantial nature ("S&S"), and that the violation was the result of the operator's unwarrantable failure to comply with the standard. The cited standard provides that "[p]ersons shall not be transported – (d) outside cabs, equipment operators' stations, and beds of mobile equipment, except when necessary for maintenance, testing, or training purposes, and provisions are made for secure travel." The Secretary proposes a penalty of \$2,000.00 against Rinker and a penalty of \$750.00 against Mr. Reffalt.

Inspector Markve testified he read the allegations contained in the complaint to Quarry Superintendent William Reffalt. In response, Mr. Reffalt replied "[w]ell, we did it, but I don't know how else I am going to do it. I am not going to turn over a \$500,000 loader to an 18-year old kid." (Tr. 33). Markve also spoke to Kevin Kolar, the miners' representative and task trainer, regarding the complaint. Kolar had been the task trainer on December 9, 2005, the date of the incident in the complaint. Markve stated that Kolar read the complaint and they discussed the use of the 980H loader with a folding chair. (Tr. 35). Markve said that Kolar volunteered the

information that when he task trains on the 980C the second man sits on the armrest. (Tr. 35; Ex. G-3) During this conference, Markve also asked Reffalt if he was aware of this practice. He replied that he was and that he assigned it. (Tr. 36). Markve also noted in his notes that Reffalt was visibly upset for his job and felt he may be fired. (Tr. 37-38). Markve was able to terminate the citation after Reffalt assured him that they would no longer be training in this manner. (Tr. 38)

Markve testified that the complainant told him that the training occurred in the production cycle and that there was no separate area designated for training. (Tr. 43). The complainant also indicated that there were hazards present in the area, including a large hole next to the fines stockpile where the training was taking place. (Tr. 44).

Special Investigator Markve issued the citation because a second person was being transported outside of the operator's station and was not secured. He determined that high negligence was present and that injury or illness was reasonably likely to result in a fatality due to the violation. (Ex. G-2) He made this determination because there are many starts, stops, and turns in a confined area that could cause an unsecured person to hit the glass. (Tr. 50-51). This citation was designated as an unwarrantable failure because Reffalt told Markve that this is the way Rinker task trains front-end loader operators and the company has been task training in this manner for about 30 years. (Tr. 52-53). Markve also noted that he later spoke with MSHA Inspector Joel Tankersly who told him that about a year earlier Reffalt had asked about having a second person in the loader and that Tankersly told Reffalt that it was prohibited. (Tr. 54).

Markve spoke with other mine operators located in the area regarding their training procedures. (Tr. 57). He was told that the trainee sits at the controls while the trainer goes over what the controls are for. Once the trainee feels comfortable with the controls, the trainer leaves the cab and uses radio contact to instruct the trainee on the various tasks necessary for the training. He was also told that training was not done during production, but rather in a remote area.

According to Markve, the operator's station consists of the manufactured seat that is anchored down with a seat belt. (Tr. 48). In his opinion, secure travel in a front-end loader requires an anchored seat and a seatbelt and that no other methods of secure travel will work in this type of machine. However, he did state that in other pieces of mobile equipment there are often other means of secure travel, such as in a road grader.

Monte Morlock, an employee of FMC Corporation, testified on behalf of the Secretary. Morlock has been with FMC for 32 years and does general maintenance, is the union president, and is on the safety committee. He described the training procedures used at FMC. He stated that the operating manual is discussed including the safety aspects and dangers of the equipment. (Tr. 103). The trainer would then show the trainee the operating levers and how the machine functions. After this is complete, the trainer would take the trainee to a place where there is plenty of room to practice without the potential for endangering anyone or damaging property.

The trainer would decide when the trainee was able to operate the equipment on his own. Additionally, Morlock testified that in his 32 years in the business he has never heard about or observed two people riding in the cab of a front-end loader. (Tr. 106). He also stated that the operator's station is the seat where the steering wheel and controls are located so that the equipment can be operated.

Joel Tankersly, a former MSHA Inspector, also testified on behalf of the Secretary. Tankersly testified that he had been to the Guernsey Quarry many times on inspections and complaints. (Tr. 119). He stated that he had a discussion with Reffalt regarding the appropriate procedures for front-end loaders. He stated that he was asked by Reffalt whether it was allowable to put two people in the cab of a loader for training purposes and that he replied no. (Tr. 120). Tankersly noted the conversation in the inspection justification/comments section of his report by writing that Reffalt had asked questions regarding the Mine Act and safe work procedures. (Tr. 122; Ex. G-13). Tankersly described the operator's station as the seat where the operator sits. (Tr. 123).

Ronald Goldade, MSHA Specialist for the Rocky Mountain District, testified on behalf of the Secretary. Goldade stated that he has never issued a citation for two people riding inside the cab under section 9200(d). (Tr. 145). Goldade testified that based on his years of experience and through his knowledge of generally accepted industry standards, the operator's station consists of the area where the operator sits with access to the controls that operate the equipment. (Tr. 151). He also stated that the operator's station and the cab are not the same thing as the cab is the structure that surrounds the operator's station. (Tr. 152). Additionally, he stated that secure travel consists of the manufactured seat and seatbelt. Goldade spoke to several people in the industry to ascertain their training technique for front-end loaders and found that nobody had two people in the cab during the training. (Tr. 163).

William Reffalt, the mine superintendent, testified on behalf of the company. Reffalt described the training process for front-end loaders that the company uses. He stated that in the 980H, a folding chair was put in the cab for the trainee to sit on. The training took place in the fines area that was big and flat and about 400 feet wide and 7,800 feet long. (Tr. 220-21). There were 6 ½ to 7 foot berms surrounding the area. Reffalt stated that he was at the quarry on the day of the alleged training violation, that he was aware the training was going on, and that he approved the training being conducted in this manner. (Tr. 221). He also explained that the folding chair fit neatly between the door and the armrest. According to Reffalt, he and Tankersly never had a conversation regarding having two people inside the cab of the loader, but rather discussed an incident involving a driller who was hanging out a half open door in the loader. (Tr. 228). He also described the training used on the 980C loader. There was not enough room for a chair in this model, so one of the men sits on the armrest while instruction takes place.

Reffalt remarked that he was very concerned at the time for his job due to the unwarrantable failure designation in the citation. He also felt that the company was conducting the training in what it believed was the safest way possible. (Tr. 231). Reffalt felt this way

because many of the trainees have never even see a loader and a lot of the training process requires the trainer to actually be able to see the expressions on the trainee's face. The trainer can see what is going on with the trainee and can put the machine into neutral and stop it if necessary. Reffalt also stated that in his opinion the cab and the operator's station were the same thing. (Tr. 234). Reffalt also noted that this practice has been going on for his entire 31 years at the quarry and MSHA has never cited this condition. (Tr. 235).

Kevin Kolar, equipment operator and trainer, also testified on behalf of the company. Kolar operates the 980C and 980H front-end loaders at the Guernsey Quarry. Kolar was trained on the 980C in the same manner when he came to work for the company. (Tr. 278). Kolar had three years experience before he began working at Guernsey Quarry. He stated that he trained in the fines area and he was in the cab by himself. He later rode in the cab with the trainer to learn how to load the train at the train yards. Kolar stated that he was on the armrest while his trainer drove and was instructing him.

Kolar was the trainer involved in the incident that led to the alleged violation. He testified that he took the trainee to the fines area to conduct the task training on the 980H. He stated that he got the folding chair and put it in position. Kolar drove and the trainee was in the folding chair. Kolar said that there was sufficient room inside the cab to accommodate the chair. (Tr. 286). After 30 minutes of training with Kolar driving, the two switched places to allow the trainee to try to operate the loader. Kolar estimated he spent four hours training. Kolar does not agree that the training should be conducted through the use of radio communication. (Tr. 302). He does not feel this is a safe way as the trainee already has his hands full learning how to use the controls of the loader so trying to use the radio at the same time would be unsafe.

Vernon Gomez, a mine consultant, testified on behalf of the operator. Gomez is a former MSHA administrator for the metal/nonmetal division, the highest ranking non-political position in that division. Gomez stated that he was very familiar with the regulatory history of the standard in question. At the time this regulation was being proposed, Gomez was a district manager and stated that members of the committee would call district managers on occasion to ask about regulations that were being considered. (Tr. 318). Based on his knowledge of the regulation and its history, Gomez did not feel that a violation had occurred. He stated that the operator is the person who has the seat and seatbelt and that there was nothing in the regulation requiring anyone else to have a seatbelt. He also stated that the word "accommodate" used in the regulation replaced the word "overcrowded" and that accommodate means that there is room for a person to be in the cab. (Tr. 321).

Gomez also testified that he never cited anyone for a violation of the standard for this type of practice and said that if he knew operators were being cited for this he would have stopped it. (Tr. 322). Gomez said that in his time as an inspector, he actually rode in equipment, including front-end loaders. He also went to the Guernsey Quarry prior to the hearing to test out the company's new MSHA-mandated training procedures. He stated that he stood 10, 15, and 35 feet away from the loader and all he could see was the steering wheel.

II. DISCUSSION WITH FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Summary of the Parties' Arguments Regarding Rinker's Liability.

The Secretary argues that it is beyond dispute that the 980H and 980C loaders were not designed to accommodate more than one person, the equipment operator. Haul trucks and other vehicles often include two seats equipped with seat belts in the cab. She contends that the testimony presented at the hearing supports her interpretation of the safety standard. The term "equipment operators' station" used in the standard is not synonymous with the term "cab." The equipment operator's station consists of the seat used by the equipment operator because he has access to all of the loader's controls from the seat. This space is designed by the manufacturer for use by the equipment operator. The cab is what surrounds the equipment operator's station. If the drafters of the standard had wanted to ensure that no miners are transported outside cabs, the reference to the equipment operator's station would have been unnecessary. The Secretary also argues that, to the extent that the standard is not clear on its face, her interpretation is entitled to deference. The record makes clear that mine operators understand what the standard requires because other operators in Wyoming do not task train employees to operate loaders by having the trainer sit on the armrest or on folding chairs inside the cab.

Rinker argues that the language of the safety standard is clear and unambiguous. The ordinary meaning of the words "cabs" and "operators' stations" with respect to a front-end loader are the same. Any "ordinary person would understand that the cab of a front-end loader is the equivalent of the operator's station." (G. Br. 5). The operator's station takes up the entire space within the cab and it is undisputed that nobody was being transported outside the cab. The Caterpillar Operational and Maintenance Manual clearly equates the cab of the front-end loader with the operator's station. (Exs. G-9 and R-2).

B. Analysis of the issues.

The language of the safety standard can be broken down as follows:

Persons shall not be transported outside:

- (1) cabs,
- (2) equipment operators' stations, and
- (3) beds of mobile equipment,

except when necessary for

- (1) maintenance,
- (2) testing, or
- (3) training purposes,

and provisions are made for secure travel.

The first issue is whether the language of the safety standard is clear on its face. "In statutory interpretation, the ordinary meaning of the words must prevail where that meaning does not thwart the purpose of the statute or lead to an absurd result." *Emery Mining Corp.*, 9 FMSHRC 1997, 2001 (December 1987) (citation omitted). This same principle applies to the interpretation of the Secretary's safety standards. Where the language of a standard is clear, the terms of that standard must be enforced as written unless MSHA clearly intended the words to have a different meaning or unless such a meaning would lead to absurd results. *Eastern Associated Coal Corp.*, 27 FMSHRC 238, 242 (March 2005).

I find that the language of the Secretary's safety standard is not clear on its face. As relevant here, the standard states that miners are not permitted to ride outside of cabs or outside of equipment operators' stations unless they are performing one of the listed functions. The term "equipment operators' stations" is not defined by the Secretary. There is nothing in the language of the standard that would logically lead to the conclusion that the Secretary intended "cabs" and "equipment operators' stations" to be interpreted synonymously. Without getting too ensnared into the question of what exactly is an "equipment operators' station," one can think of examples where such a station is not the same as the cab. In a cherry picker, for example, the boom can be controlled from the cab of the truck and from the basket at the end of the boom. Clearly, the basket fits within the concept of an equipment operator's station but it is not within a cab. The difficulty comes when the equipment operator's station is within a cab. Rinker contends that when an equipment operator's station is within a cab that is designed with only one seat, the cab and operator's station become one and the same. The problem with that interpretation is that it allows others to ride inside the cab without being secured. I note, however, that no MSHA standard specifically requires that all passengers in mobile equipment be seated or secured with a seat belt.

Under the Secretary's interpretation of the standard, on the other hand, it would appear that a violation would be established if anyone other than the equipment operator were to ride inside the cab of mobile equipment unless the other person were present for purposes of maintenance, testing, or training. For example, if the operator of a pickup truck were transporting a miner in the passenger seat to another area of the mine, the transported miner would be outside of the equipment operator's station, as that term is interpreted by the Secretary, and his presence would be prohibited under the standard unless his presence was necessary for maintenance, testing or training even if he were wearing a seat belt. Thus, the language of the safety standard, as interpreted by the Secretary in this case, would appear to prohibit operators from using trucks or other mobile equipment to transport employees within the mine, if the miners were in secured seating, because they would be outside the equipment operator's station.

I find that this safety standard is ambiguous, confusing, and very poorly drafted. When faced with an ambiguous safety standard, the Commission grants deference to the Secretary's reasonable interpretation of the standard. *Eastern Associated Coal Corp.*, 27 FMSHRC at 242. The Secretary's interpretation must be accepted as long as it is not plainly erroneous or inconsistent with the language or purpose of the regulation. *Energy West Mining Co. v.*

FMSHRC, 40 F.3d 457, 460-61 (D.C. Cir. 1994). A statute or regulation that is intended to protect the health and safety of individuals must be interpreted in a broad manner to actually achieve that goal. *Sec. of Labor v. Cannelton Industries, Inc.*, 867 F.2d 1432, 1435 (D.C. Cir. 1989).

A look at the regulatory history provides some clarification. The term “equipment operators’ stations” was added when the standard was modified in 1988.¹ The Secretary added that term in her proposed rule. Some of the comments to the proposed rule from mine operators were concerned that the “proposed rule’s use of the term ‘equipment operators’ stations’ could prohibit the transportation of persons in cabs that are designed to accommodate more than just the operator of the equipment.” (Ex. G-4; 53 Fed. Reg. 32499 (August 25, 1988)). At this point, the Secretary should have modified the language of the proposed rule to make it clear. Instead, the Secretary simply stated in the preamble to the final rule that “MSHA did not intend to restrict the use of such cabs and the final rule includes the term ‘cabs’ to remove any ambiguity.” *Id.* Thus, although this preamble statement is quite clumsy, when the safety standard is read in conjunction with the preamble to the final rule, the requirements of the safety standard are reasonably clear. A mine operator may use mobile equipment to transport miners as long as they are inside the cab and are secured, notwithstanding language in the standard. This Federal Register notice also indicates, by implication, that the Secretary intended that pieces of mobile equipment that were not designed to “accommodate” anyone other than the equipment operator are subject to the requirements of the safety standard. Thus, the Secretary requires all passengers to be secured.

I find the Secretary’s interpretation of the term “equipment operators’ stations” in the safety standard to be reasonable and entitled to deference. It is clear that one of the purposes of this safety standard is to ensure that people being transported in mobile equipment are secured. Typically, that involves sitting in a seat equipped with a seatbelt.² The Secretary’s interpretation of the standard to require that anyone in the cab of mobile equipment be secured is reasonable because it helps achieve the goal of promoting safety. Riding in a moving vehicle while sitting on an armrest or in a folding chair creates a hazard. For example, the equipment operator could unexpectedly slam on the brakes and cause the miner sitting on the armrest to be thrown into the windshield. An interpretation of the term “equipment operator’s station” that distinguishes that term from the term “cab” is reasonable. Thus, the Secretary’s interpretation of the term equipment operator’s station to mean the area where the operator sits and operates the controls is reasonable. Under this interpretation, a person sitting on the armrest or on a folding chair in the cab of a loader is clearly not sitting in the equipment operator’s station. I note, however, that the confusion engendered by this case could have been avoided if the Secretary more clearly set forth

¹ Prior to 1988, the safety standard at 56.9-40 provided that persons “shall not be transported: (c) outside the cabs and beds of mobile equipment, except trains.”

² Section 56.14130(g) requires all equipment operators, except grader operators, to wear seatbelts.

her intentions in the safety standard. In conclusion, although the safety standard is confusing and the preamble to the final rule is rather awkwardly written, I defer to the Secretary's interpretation of the standard because it is consistent with the language and purpose of the regulation.

Rinker also argues that the Secretary did not provide the mining community with fair notice of the requirements of the standard, especially her interpretation of the term "equipment operators' stations." It argues that the Secretary has never provided notice that everyone riding in mobile equipment must be seated and that they must wear seatbelts. It also contends that the preamble language in the Federal Register clarifies nothing because the comment concerning "cabs that are designed to accommodate more than just the operator of the equipment" is itself ambiguous. (R. Br. at 10; Ex. G-4 emphasis added). Rinker argues that the Secretary incorrectly interprets the term "accommodate" to mean "seated with a seatbelt." Such an interpretation is neither reasonable nor clear from the language. The cab of the loader could easily "accommodate" the trainer even though he was not secured by a seat belt. The dictionary definition of "accommodate" is "to make room for." (R. Br. at 10). Former Metal/Nonmetal Administrator Gomez testified that the word "accommodate" means "there is room for somebody to get in there, for a person to be in there." (Tr. 321). Indeed, section 56.9200(f) provides that persons shall not be transported "[t]o and from work areas in over-crowded mobile equipment." The interpretation of accommodate offered by Mr. Gomez is consistent with this language. Because it was reasonable for Rinker to assume that the cabs on the loaders could "accommodate more than just the operator of the equipment," it was also reasonable for it to assume that its method of task training did not violate the cited safety standard. Finally, Rinker argues that MSHA has issued only a few citations alleging similar violations. The present case "reveals an attempt by MSHA to engage in [a] new and completely insupportable enforcement direction beginning several months prior to the date of the contested matter." (R. Br. at 11). Rinker notes that the citations MSHA has issued for having two persons inside the cab of mobile equipment were issued within two months of the instant citation. (R. Br. at 11-12).

The Secretary is required to provide fair notice of the requirements of a broadly written safety standard. The language of section 56.9200 is "broadly adaptable to myriad circumstances." *Kerr-McGee Corp.*, 3 FMSHRC 2496, 2497 (November 1981); *Alabama By-Products Corp.*, 4 FMSHRC 2128, 2130 (December 1992). Such broadly written standards must afford notice of what is required or proscribed. *U.S. Steel Corp.*, 5 FMSHRC 3, 4 (January 1983). In "order to afford adequate notice and pass constitutional muster, a mandatory safety standard cannot be 'so incomplete, vague, indefinite, or uncertain that [persons] of common intelligence must necessarily guess at its meaning and differ as to its application' " *Ideal Cement Co.*, 12 FMSHRC 2409, 2416 (November 1990) (citation omitted). A standard must "give a person of ordinary intelligence a reasonable opportunity to know what is prohibited, so that he may act accordingly." *Lanham Coal Co.*, 13 FMSHRC 1341, 1343 (September 1991).

When faced with a challenge that a safety standard failed to provide adequate notice of prohibited or required conduct, the Commission has applied an objective standard, *i.e.*, the reasonably

prudent person test. The Commission recently 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.”

Id. (citations omitted). To put it another way, a safety standard cannot be construed to mean what the Secretary intended but did not adequately express. “The Secretary, as enforcer of the Act, has the responsibility to state with ascertainable certainty what is meant by the standard he has promulgated.” *Diamond Roofing Co. v. OSHRC*, 528 F.2d 645, 649 (5th Cir. 1976).

I find that adequate notice of the requirements of the standard was provided to mine operators. It is important to recognize that Rinker’s method of task training operators of front-end loaders is not typically used by mine operators. Former MSHA Inspector Joel Tankersly, Inspector Markve, and Inspector Goldade had never observed the practice of operators task training with two people inside the cab of a front-end loader. (Tr. 56, 122, 127, 145-46, 174, and 190-91). Goldade testified that he talked to a number of mine operators and none of them trained equipment operators with two people in the cab of a loader. (Tr. 157-63; Ex. G-14). Indeed, Goldade testified that the industry representatives he talked to said that such a practice would be unacceptable under the standard. (Tr. 163). Monte Morlock testified that in his 32 years in the business he has never heard of or seen two people riding in the cab of a front-end loader. (Tr. 106). Thus, the evidence of record indicates that most operators understand the requirements of the standard. It appears that few citations have been written for similar violations because the practice is rare. I find that the notice arguments made by Rinker parse the words of the standard too closely, especially its arguments concerning the use of the word “accommodate” in the preamble. It is not logical to believe that the cab of a loader can “accommodate” a second person because he can sit on the armrest or on a folding chair. I agree that the language of subsection (f) of the standard confuses the issue somewhat, but I hold that fair notice of the requirements of subsection (d) was provided to the mining community. A reasonably prudent person familiar with the mining industry and the protective purposes of the standard would have recognized that Rinker’s method of task training loader operators was prohibited by the standard.

It is undisputed that two people were inside the cab of front-end loaders when miners were being task trained on the equipment. The 980H and 980C loaders were not designed to seat more than one person inside the cab. The person who was seated on the armrest or in a folding chair was outside the equipment operator’s station. As a consequence, Rinker violated the standard unless the situation presented is covered by one of the exceptions provided in the standard.

The relevant exception within the standard provides that a miner may be outside the equipment operator’s station when necessary for training, but only if provision is made for secure travel. In this case, the miner who was outside the operator’s station was not secure. As stated above, in the event of an accident, he could have been thrown about in the cab because he was

not wearing any type of restraining device such as a seat belt. On this basis, I find that the Secretary established a violation.

C. Significant and Substantial

A violation is classified as S&S “if based upon the 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.” *National Gypsum Co.*, 3 FMSHRC 822, 825 (April 1981). In *Mathies Coal Co.*, 6 FMSHRC 1, 3-4 (January 1984), the Commission set out a four-part test for analyzing S&S issues. Evaluation of the criteria is made assuming “continued normal mining operations.” *U. S. Steel Mining Co.*, 6 FMSHRC 1573, 1574 (July 1984). The question of whether a particular violation is S&S must be based on the particular facts surrounding the violation. *Texasgulf, Inc.*, 10 FMSHRC 498 (April 1988). The Secretary must establish: (1) the underlying violation of the safety standard; (2) a discrete safety hazard, 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 Secretary is not required to show that it is more probable than not that an injury will result from the violation. *U.S. Steel Mining Co.*, 18 FMSHRC 862, 865 (June 1996).

I credit the evidence presented by Rinker as to the conditions that were present during training. Two miners were in the cab of the front-end loaders during task training on the top of the fines pile. This fines pile was about 400 feet wide and 7,800 feet long. It was flat and was surrounded by berms, with no drop offs. The training was conducted at slow speeds (first and second gear), with no other traffic in the area. (Tr. 220-226, 281-301; Ex. R-10). Inspector Markve based his S&S finding on the fact that the trainees loaded trucks. (Tr. 50). Mr. Reffalt testified that a trainee would only load a few trucks during his training. (Tr. 239). Mr. Kolar testified that the trainee would load a train for about 30 minutes. (Tr. 277-80; Ex. R-1). The area where this loading took place was flat, with limited traffic.

Rinker argues that when testifying about his S&S determination, Inspector Markve consistently stated that the violation was S&S because of events that could occur. Testimony that an injury “might” or “could” occur is not sufficient for an S&S finding because it does not meet the “reasonably likely” aspects of the Commission’s *Mathies* test.

I find that the Secretary established that the violation was S&S. Operating the loader during training requires numerous starts and stops, changing of gears, and traveling in reverse. Mr. Kolar admitted that a trainee might turn too fast, drive too fast, panic, and hit the wrong levers. (Tr. 312-13). The loader could tip over if the trainee were to run up onto a stockpile in a panic. Fatal accidents have occurred under such circumstances. (Ex. G-6). As stated above, if the miner operating the loader were to slam on the brakes, it is reasonably likely that the passenger sitting on the armrest or in a folding chair would lose his balance or fall forward. A serious injury would be likely in such an event. Finally, it is well known that the center of

gravity of a loader changes when the bucket is raised, especially if it is full of material. In such an instance, the trainee could lose control of the loader and tip the loader over. (Tr. 253-54). The Caterpillar manuals and Rinker's safety handbook warn against operating the loader with the bucket raised. (Exs. G-8, G-9). I find that the evidence establishes that, if this practice had not been stopped, there was a reasonable likelihood that the hazard contributed to by the violation would have resulted in an injury of a reasonably serious nature.

D. Unwarrantable Failure

Unwarrantable failure is defined as aggravated conduct constituting more than ordinary negligence. *Emery Mining Corp.*, 9 FMSHRC 1997, 2004 (Dec. 1987). Unwarrantable failure is characterized by such conduct as "reckless disregard," "intentional misconduct," "indifference," or the "serious lack of reasonable care." *Id.* 2004-04; *Rochester & Pittsburgh Coal Co.*, 13 FMSHRC at 193-94. A number of factors are relevant in determining whether a violation is the result of an operator's unwarrantable failure, such as the extensiveness of the violation, the length of time that the violative condition has existed, the operator's efforts to eliminate the violative condition, whether an operator has been placed on notice that greater efforts are necessary for compliance, the operator's knowledge of the existence of the violation, and whether the violation is obvious or poses a high degree of danger. *Mullins & Sons Coal Co.*, 16 FMSHRC 192, 195 (Feb. 1994); *Windsor Coal Co.*, 21 FMSHRC 997, 1000 (Sept. 1999); *Consolidation Coal Co.*, 23 FMSHRC 588, 593 (June 2001).

The Secretary argues that Bill Reffalt admitted to not only knowing about the method used to task train miners to operate loaders but also admitted to assigning the training to take place in this manner. This practice had been used at the mine for about 30 years, despite Inspector Tankersly's advice to Reffalt that this method of training was inappropriate and contrary to the safety standards. (Tr. 119-20, 235). Rinker's own safety handbook states that miners should not ride on mobile equipment "other than in the seat provided." (Ex. G-8, p.6). Further, the handbook further states, under the section on front-end loaders, "No passengers are allowed in the cab" and "[w]hen a new operator is being instructed, radio communication shall be used." *Id.* at 18. Both Reffalt and Kohler testified that they had not reviewed Rinker's task training plan for many years and they did not consult the company's safety handbook during task training. (Tr. 247, 305-06). Caterpillar manuals warn against allowing passengers in the cab. The manual for the 980H, for example, warns not to allow riders in the cab "unless the machine has an additional seat with a seat belt." (Ex. G-10 at 19).

Rinker argues that operators may conduct task training in any manner that is safe and consistent with the Secretary's safety standards. The cited standard does not prohibit the transportation of two individuals inside the cab or operator's station. The Secretary's safety standard does not mandate that everyone riding in equipment must wear a seatbelt. The only person required under her regulations to wear a seatbelt is the equipment operator. The recommendations in the Caterpillar manual and the Rinker handbook are not mandatory safety

standards. Rinker contends that it is not safe for a miner to be task trained on a loader without an experienced operator/trainer in the cab during the training.

I find that the Secretary did not establish that the violation was caused by Rinker's unwarrantable failure to comply with the safety standard. First, and most importantly, the language of the safety standard is not clear. Rinker sincerely believed that it was safer to have an experienced operator inside the cab of the loader during training. Rinker did not understand, from the language of the standard itself, that its task training methods were prohibited by the regulation. Although I determined that the regulation, when read with the preamble to the final rule, provided reasonable notice of its requirements, I find that these requirements were not clear to Rinker. Because the safety standard was poorly drafted and was not revised in the face of comments suggesting that the language was contradictory, I find that the violation in this instance was not obvious. Rinker's failure to comply with these requirements did not rise to the level of "reckless disregard," "intentional misconduct," "indifference," or the "serious lack of reasonable care."

The Secretary points to the fact that Rinker had been violating the standard for about 30 years. That point cuts both ways, however, because it can also show that Rinker did not believe that its task training methods were unlawful since they had never been called into question.

The Secretary also contends that Rinker had been put on notice that its method of task training loader operators violated the standard. Former MSHA Inspector Tankersly testified that he discussed several safety issues with Mine Superintendent Reffalt when he was at the mine investigating safety complaints during the previous year. Specifically, Tankersly testified that he told Reffalt that it was not permissible to have two people in the cab of a front-end loader for training purposes. (Tr. 119-20). Tankersly said that there could only be one person in the cab because there was only one seatbelt and one roll-over protective device. At the hearing, Bill Reffalt denied that anyone from MSHA ever advised him that it is a violation of the Secretary's safety standards to have two people in the cab of a loader during task training. (Tr. 235-36). He said that the complaint that was investigated by Tankersly involved blasting procedures. (Tr. 227-28). Reffalt testified that the discussion he had with Tankersly about front-end loaders that day concerned employees jumping on loaders and hitching a ride with the door half open. (Tr. 228). Tankersly never said that having a second person on a loader was prohibited during task training. *Id.*

Given the circumstances of the conversation between Tankersly and Reffalt, I conclude that Reffalt was not put on notice that its task training procedures violated the safety standard. I credit Reffalt's testimony that the safety complaint that Tankersly was investigating was unrelated to the training issue and that the conversation about riding in loaders was more in the nature of a passing comment. Reffalt told Tankersly that miners often forget what they are "supposed to do" and gave as an example a driller who jumped up on a loader to hitch a ride and was hanging out the door. (Tr. 228). Tankersly replied that it was a good thing that he did not see it or he would have issued a citation.

The Secretary also argues that Reffalt's own words on the day the citation was issued proves that he knew that Rinker's task training practices violated the safety standard. Inspector Markve testified that he designated the citations as an unwarrantable failure violation because, after he read the safety complaint that instigated the MSHA inspection to Reffalt, Reffalt replied:

Well, we did it. We did it, but I don't know how else I am going to do it. I am not going to turn over a \$500,000 loader to an 18-year old kid.

(Tr. 33, 52). Inspector Markve testified that he based his unwarrantable failure determination on this exchange because he believed that Reffalt's statement "meant that he knew he wasn't supposed to be doing it in the first place." (Tr. 70). Markve believes that Reffalt's statement at the closeout conference at the mine that, "[w]e won't conference it. We won't do it anymore" helps show that Reffalt knew that the task training procedure violated the safety standard. (Tr. 72). Markve testified that he took Reffalt's statements "as an admission," especially after Reffalt expressed concern that he could be terminated from his employment because of the unwarrantable failure determination. (Tr. 72-73, 92-93).

I find that Inspector Markve was reading way too much into Reffalt's statements when he based his unwarrantable failure determination on them. These statements should not be construed as an admission. Instead, the statements merely indicate that Reffalt did not dispute that the company task trained miners in the manner described in the safety complaint. The fact that he said, "we won't conference it," suggests that the company would not dispute that it task trained miners in the manner described in the citation.³ I cannot infer any admissions into Reffalt's statements.

Finally, the Secretary contends that notes from a company safety meeting held in November 2005 show that Reffalt was aware that a miner complained about the company's task training practices for front-end loaders. (Tr. 53). The Secretary maintains that this complaint put the company on notice that its task training procedures for loaders were unsafe. I cannot base an unwarrantable failure finding on this evidence because it does not directly relate to the question whether the training practices violated an MSHA safety standard. This complaint did not put Rinker on notice that greater efforts are necessary for compliance with the safety standard.

I hold that Rinker's negligence was low. I reach this conclusion because the language of the cited standard is ambiguous. In addition, the Secretary did not provide a definition of "equipment operators' stations," a key term in the standard, in a regulation or other interpretative material. It was not unreasonable for Rinker to believe that the equipment operator's station for the loader was the same thing as the cab.

³ Rinker ultimately did participate in a conference concerning this citation before an MSHA conference and litigation specialist.

E. Penalty Against William Reffalt

Section 110(c) of the Mine Act provides that, whenever a corporate operator violates a mandatory health or safety standard, any agent of such corporate operator who "knowingly authorized, ordered, or carried out such violation" shall be subject to a civil penalty. 30 U.S.C. § 820(c). The Commission held that "knowingly" means "knowing or having reason to know." *Kenny Richardson*, 3 FMSHRC 8, 16 (Jan 1981); *aff'd* 689 F.2d 623 (6th Cir. 1982). "A person has reason to know when he has such information as would lead a person exercising reasonable care to acquire knowledge of the fact in question or to infer its existence." *Richardson*, 3 FMSHRC at 16. "If a person in a position to protect employee safety and health fails to act on the basis of information that gives him knowledge or reason to know of the existence of a violative condition, he has acted knowingly and in a manner contrary to the remedial nature of the statute." *Id.* "In order to establish section 110(c) liability, the Secretary must prove only that the individual knowingly acted not that [he] knowingly violated the law." *BethEnergy Mines, Inc.*, 14 FMSHRC 1232, 1245 (August 1992).

The Secretary argues that she is not required to show that Reffalt acted willfully in violating the safety standard but only that he had reason to know that a hazardous condition existed. She maintains that Reffalt knew of the existence of the violative practice and that he assigned Kevin Kohler to task train miners using this practice. She notes Inspector Tankersly's warning to Reffalt that this practice was not permitted by the regulations. She also relies on his "admission" to Inspector Markve that he task trained in this manner and that he believed that his job was in jeopardy. Reffalt knew about the violative practice and he did nothing to stop or correct it. Indeed, he instructed quarry employees to task train miners in a manner that violated the safety standard. Finally, a miner had identified and complained of this unsafe practice a month before the citation was issued and Reffalt did not take any steps to stop the practice.

The Secretary cites *U.S. v. Gibson*, 409 F.3d 325, 336 (6th Cir. 2005), for the proposition that "mine superintendents or foremen can be said to have knowingly authorized, ordered, or carried out violations of the [Mine Act] when they enter mines and observe violations but do nothing to stop or correct them." (S. Br. 17). In that criminal case, a mine superintendent and foreman were charged with "authorizing, ordering, and carrying out the violation of the mining regulation that requires the mine operator to adopt and follow a ventilation plan." *Id.* Apparently, ventilation curtains were down at the face and throughout the mine so that there was insufficient ventilation at the face. *Id.* at 335.

Respondents argue that the evidence does not support a finding of knowing conduct on the part of Mr. Reffalt. He understood that no miners were allowed to ride outside the cab of the loader because that practice would be unsafe and in violation of the standard. He reasonably understood that the cab and the equipment operator's station were identical in a loader and that the task training methods used were both safe and in compliance with the safety standard. He also believed that task training a miner to operate a loader using a radio was unsafe because the trainee would have to hold the radio and operate the vehicle at the same time. (Tr. 231-32). He

acknowledged that radio communication could be used for training an experienced miner who had operated loaders at other mines or facilities. Reffalt did not know that the training practices at the mine violated the Secretary's safety standards. (Tr. 226). Indeed, he himself was task trained on loaders in the same manner when he first started operating them at the quarry. (Tr. 235). This practice had been in place for at least 30 years. Reffalt's actions demonstrate that he had a safety conscious attitude. Given the language in the standard, Reffalt had no reason to know that the task training method used at the quarry was in violation of that standard.

Rinker is a corporate operator and Mr. Reffalt was an agent of the corporation. As discussed above, the corporate operator violated section 56.9200(d). I find that Reffalt did not knowingly authorize, order, or carry out the violation of section 56.9200(d). I incorporate my findings with respect to the unwarrantable failure issue. In addition, the evidence shows that Reffalt reasonably believed that the method used to task train miners to operate loaders was safe. Trainees were closely supervised in a secluded, flat area and the loader was operated at low speeds. He believed that the risk of injury was no greater than if the trainer had communicated to the trainee via radio because the inexperienced miner would have had difficulty operating the controls and maneuvering the loader while using the radio. He said that the 980H loader is new with a lot of complicated features. (Tr. 222). It is powerful, quick, and the steering wheel is very responsive. (Tr. 223). The fact that one miner complained that this practice is unsafe does not mean that Reffalt's disagreement with that complaint amounted to a knowing violation. Because the violation at issue in *Gibson* would be obvious to anyone with even a casual understanding of underground coal mining, that case is not helpful here. For the reasons stated above, I find that Reffalt believed that the task training method used on loaders at the quarry did not violate section 56.9200(d). As stated above, the regulation is not clear on its face. Reffalt reasonably believed that Rinker's task training procedures for front-end loaders, which had been used at the quarry for about 30 years, were safe.⁴ Consequently, the case brought against Mr. Reffalt is dismissed.

III. APPROPRIATE CIVIL PENALTY

Section 110(i) of the Mine Act sets forth six criteria to be considered in determining appropriate civil penalties. The record shows that the Guernsey Quarry had a history of about six paid violations in the two years prior to December 20, 2005, all of which were designated as non-S&S. (Ex. G-1). The quarry worked about 47,200 hours in 2005 and employed 22 people. The

⁴ Reffalt's admission that he had not consulted Rinker's corporate safety handbook with respect to task training on loaders is troubling. He testified that the safety handbook contains general rules because it applies to all of Rinker's operations and that the provision stating that "[w]hen a new operator is being instructed, radio communication shall be used" is designed for new employees who have previous experience operating loaders. (Tr. 255-57). He also testified that a trainer is not a "passenger" as that term is used in the handbook. (Tr. 254-55). This testimony is not very convincing. Nevertheless, I find that Reffalt genuinely believed that the task training program used at the quarry was safe and in compliance with MSHA safety standards because, in part, this program had been used for years at the quarry without incident.

citation was abated in good faith. The violation was serious and Rinker's negligence was low. The penalty assessed in this decision will not have an adverse effect on Rinker's ability to continue in business. Based on the penalty criteria, I find that a penalty of \$500.00 is appropriate for this violation.

IV. ORDER

Based on the criteria in section 110(i) of the Mine Act, 30 U.S.C. § 820(i), I assess the following civil penalties:

WEST 2006-451-M (Rinker Materials Western, Inc.)

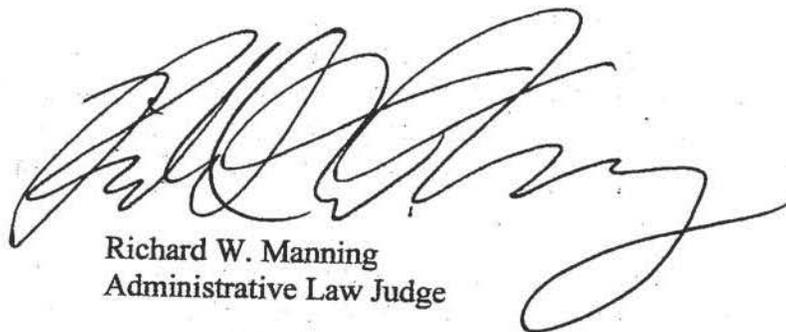
7913458	56.9200(d)	\$500.00
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WEST 2007-113-M (William E. Reffalt)

7913458	56.9200(d)	Penalty Vacated
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For the reasons set forth above, Citation No. 7913458 is **AFFIRMED** as **MODIFIED** in this decision. Rinker Materials Western, Inc., is **ORDERED TO PAY** the Secretary of Labor the sum of \$500.00 within 30 days of the date of this decision. Payment should be sent to the new address: U.S. Department of Labor, Mine Safety and Health Administration, P.O. Box 790390, St. Louis, MO 63179-0390.

For the reasons set forth above, the petition for assessment of penalty brought against William E. Reffalt in WEST 2007-113-M is **DISMISSED**.



Richard W. Manning
Administrative Law Judge

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RWM

FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

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

January 31, 2008

EMERALD COAL RESOURCES, LP,	:	CONTEST PROCEEDING
Contestant	:	
	:	Docket No. PENN 2007-192-R
	:	Order No. 7019863; 03/20/2007
v.	:	
	:	
SECRETARY OF LABOR,	:	Mine: Emerald Mine No. 1
MINE SAFETY AND HEALTH	:	Mine ID: 36-05466
ADMINISTRATION, (MSHA),	:	
Respondent	:	

**ORDER DENYING CONTESTANT’S MOTION FOR
SUMMARY DECISION, AND
GRANTING RESPONDENT’S MOTION
FOR SUMMARY DECISION**

This case is before me on a Notice of Contest filed by Emerald Coal Resources, LP (“Emerald”), challenging an order issued pursuant to section 103(k) of the Federal Mine Safety and Health Act of 1977 (“Act”), 30 U.S.C. § 813(k).¹ The parties have filed cross-motions for summary decision. For the reasons set forth below, I find that there exists no genuine issue as to any material fact, and that the Secretary is entitled to summary decision as a matter of law. Accordingly, Order No. 7019863 is affirmed.

Facts²

Emerald No. 1 Mine is located in Waynesburg, Greene County, Pennsylvania, and operated by Emerald Coal Resources, LP. On March 20, 2007, at 5:15 p.m., an unplanned roof fall occurred in the mine above the anchorage zone of the roof bolts in the Three Mains Left

¹ While the Act does not specifically provide for review of section 103(k) orders, the Commission has jurisdiction to review such orders under an abuse of discretion standard. *Eastern Ass. Coal Co.*, 2 FMSHRC 2467 (Sept. 1980).

² Emerald included in its motion a statement of facts, supported by documents attached as exhibits. The Secretary’s motion included a statement of facts, supported by declarations of MSHA inspector Thomas H. Whitehair II and supervisory inspector Russell J. Riley. Neither party contested facts asserted by the other party. Therefore, they shall be considered established for purposes of deciding the motions. 29 C.F.R. § 2700.67(d).

haulage track at the No. 14 room intersection. The fall was 20 feet long, 18 feet wide and 12 feet high. High voltage and communication cables were buried by the fall. No persons were injured. Three shifts of 150 miners each worked at the mine. The miners frequently traveled the track haulage under the area where the roof fall occurred. At the time of the fall, the majority of miners traveled in buses along the haulage. The track haulage also served as an escapeway.

The roof fall was reported to MSHA at 5:58 p.m. that same day. Shortly thereafter, MSHA's Ruff Creek Field Office Supervisor, Russell Riley, issued a verbal order to Emerald pursuant to section 103(k) of the Act. Later that day, MSHA Inspector Thomas Whitehair traveled to Emerald Mine No. 1 to investigate the incident. By the time Whitehair had arrived, all four sides of the fall had been timbered off, the power had been shut off, and the cable was being rerouted around the fall. The escapeway had also been redesignated and marked. Whitehair issued Order No. 7019863 pursuant to section 103(k) of the Act.³ The Order required that "only persons who are needed to conduct the investigation of the accident may enter or remain in the affected area." The Order was then modified to require that "prior to cleaning up the fall, the mine operator will submit and have approved by the MSHA District Manager a plan detailing this process." The modification required that the mine inform the inspector of the methods it intended to use to clean up the roof fall. Whitehair, who has 20 years of experience as an inspector, and 14 years of experience in the coal mining industry, including training and experience as a roof control specialist, determined that the information was necessary to ensure that the affected area could safely and effectively be returned to normal, and that the miners working in the area, including the miners engaged in clean-up, would be protected from hazards from additional roof falls. Whitehair stated that he was prepared to accept a handwritten plan in order to speed up the process. The operator did not supply a plan before Whitehair left the mine.

The initial clean-up plan submitted by the operator did not address the machinery that would be used or the method of clean-up. Whitehair was concerned about the safety and health of the miners working on the clean-up of the roof fall, and the length of time they would be exposed to the unsupported roof while setting temporary supports. He requested that the plan contain this specific information. On March 22, 2007, the 103(k) Order was terminated upon receipt of the new plan containing the requested information. Emerald continued to mine coal while the 103(k) Order was in effect.

³ Section 103(k) provides that "In the event of any accident occurring in a coal or other mine, an authorized representative of the Secretary, when present, may issue such orders as he deems appropriate to insure the safety of any person in the coal or other mine, and the operator of such mine shall obtain the approval of such representative, in consultation with appropriate State representatives, when feasible, of any plan to recover any person in such mine or to recover the coal or other mine or return affected areas of such mine to normal." 30 U.S.C. § 813(k).

Emerald's Motion for Summary Decision

The sole issue raised by Emerald in its motion, and its chief argument in opposition to the Secretary's motion, is that a roof fall above a roof bolt anchorage zone that does not result in an injury does not meet the definition of "accident" under the Act. Consequently, the MSHA inspector had no authority to issue the subject Order.

As defined in the Act, "'accident' includes a mine explosion, mine ignition, mine fire, or mine inundation, or injury to, or death of, any person." 30 U.S.C. § 802(k). The Secretary's regulations further define the term "accident," explicitly including an unplanned roof fall:

Accident means . . . [a]n unplanned roof fall at or above the anchorage zone in active workings where roof bolts are in use; or, an unplanned roof or rib fall in active workings that impairs ventilation or impedes passage.

30 C.F.R. § 50.2 (h)(8). Emerald contends that the regulation impermissibly expands the definition of the term accident, beyond the events itemized in the statute. The Secretary argues that the term "accident" should be broadly construed to implement the purpose of the Act, and Congress' use of the word "includes" in the statutory definition demonstrates that the incidents listed are merely examples, and therefore, not exclusive.

Emerald advances several statutory interpretation arguments, urging that the plain wording of the statute precludes inclusion of unplanned roof falls in the definition of an accident. The short answer to Emerald's argument is that the statute itself specifies that unplanned roof falls are accidents for purposes of section 103. Section 103(d) provides, in pertinent part:

(d) Accident Investigations; records

All accidents, *including unintentional roof falls* (except in any abandoned panels or in areas which are inaccessible or unsafe for inspections), shall be investigated by the operator or his agent to determine the cause and the means of preventing recurrence. . . . (emphasis added).

30 U.S.C. § 813(d). The statutory language is indeed plain. Unplanned roof falls in active workings of a mine are accidents under section 103, and satisfy the precondition for issuance of an order pursuant to section 103(k).

Emerald's restrictive statutory interpretation arguments must be rejected, and its motion will be denied.⁴ Emerald also makes arguments that are based on the conditions as they existed

⁴ In addition, the Commission has accepted the Secretary's argument that "the word 'includes' . . . is a term of enlargement [and] that an event not specifically listed in the definition

at the time Whitehair issued the Order.⁵ However couched, these arguments go to whether Whitehair abused his discretion when he issued the Order, and will be dealt with below.

The Secretary's Motion for Summary Decision

Section 103(k) gives an inspector the authority to issue a 103(k) order "as he deems appropriate to insure the safety of any person in the coal or other mine." 30 U.S.C. § 813(k). As observed in *Miller Mining Co. v. FMSHRC*, 713 F.2d 487, 490 (9th Cir. 1983), "[s]ection 103(k) gives MSHA plenary power to make *post-accident* orders for the protection and safety of all persons."

Whitehair issued the Order because he was concerned about the safety and health of miners working and traveling in the track haulage. Based upon his extensive mining experience, including training as a roof control specialist, he was also concerned about the safety and health of miners assigned to clean up the roof fall, including the length of time that miners would be exposed to unsupported roof while setting temporary roof supports. He modified the Order to require Emerald to supply information on the methods it intended to use in the clean-up process. When a plan was supplied, it did not identify the machinery to be used or the method of clean up. In order to assure the safety of miners, he needed to know the type of temporary roof support, the procedure to be used, and the type and length of roof bolt. When he obtained that information, and was satisfied that the plan sufficiently protected the safety and health of the miners involved, he terminated the order.

The Secretary contends that, in light of these facts, Whitehair did not abuse his discretion. Emerald argues that issuance of the 103(k) Order was an abuse of discretion because it conflicted with 30 C.F.R. § 75.212, and was contrary to MSHA policy. Those arguments are easily rejected.

Section 75.212 specifies procedures to be followed when rehabilitating areas where a roof fall has occurred or the roof has been removed by mining machines or blasting. It requires preparation of a plan, but not approval by MSHA. Emerald argues that the requirement in the 103(k) Order that MSHA approve the clean-up plan contradicts the regulation, and amounts to an error of law and an abuse of discretion. However, section 103(k) specifically requires that an operator obtain the approval of the Secretary's representative, i.e., an MSHA inspector, of any

falls within the definition of 'accident' if it is 'similar in nature or present[s] a similar potential for injury or death as a mine explosion, ignition, fire, or inundation.'" *Aluminum Company of America*, 15 FMSHRC 1821, 1825-26 (Sept. 1993) (*ALCOA*). Emerald's argument that an unplanned roof fall is dissimilar to the events itemized in the statutory definition is unconvincing.

⁵ Emerald correctly points out that the statute provides for the issuance of a section 103(k) order, "when the inspector is present" at the mine. Accordingly, it is Whitehair's issuance of the Order after he arrived at the scene that must be reviewed.

plan to recover coal or return an area affected by an accident to normal. Emerald cites to no authority that would suggest that the Secretary's promulgation of the regulation was intended to, or could, obviate the specific provision of the statute, or restrict an inspector's discretion to issue appropriate orders to assure the safety of miners in an area affected by an accidental roof fall. Clearly it does not.

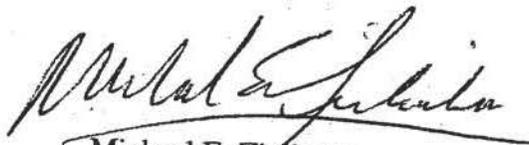
Emerald's "policy" argument is also flawed. It represents that MSHA's database, accessible through its web-site, contains "numerous recent reported roof falls in District 2 for which no 103(k) order was issued." Cont. Opp. at 17. It argues that the data shows that unplanned roof falls above the anchorage point routinely do not result in issuance of a section 103(k) order. Therefore, Whitehair's issuance of the order was unreasonable. It also argues that the data evidences a common agency practice, analogous to agency policy, and that Whitehair's decision was contrary to that policy and an abuse of discretion.

Assuming that Emerald has correctly interpreted the information available from MSHA, and that MSHA inspectors were on the scene of those roof falls, whether or not they chose to exercise their discretion and issue a section 103(k) order is hardly probative of whether Whitehair properly exercised his discretion here. This is particularly so when there is no information presented as to the circumstances any such inspectors might have been presented with.

Emerald's arguments are rejected. An unplanned roof fall occurred above the anchorage zone in the "active workings" of the mine, i.e., on a haulage track and escapeway. It was an accident within the meaning of section 103(k) of the Act. Whitehair personally inspected the fall area and determined that the Order and its subsequent modifications were necessary to ensure the safety and health of miners traveling in the area and working on the clean-up. He did not abuse his discretion in issuing the Order.

ORDER

Based on the foregoing, I find that there is no genuine issue as to any material fact, and that the Secretary is entitled to summary decision as a matter of law. Accordingly, Emerald's Motion for Summary Decision is **DENIED**. Respondent's Motion for Summary Decision is **GRANTED**, and Order No. 7019863 is **AFFIRMED**.


Michael E. Zielinski
Administrative Law Judge

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FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

OFFICE OF ADMINISTRATIVE LAW JUDGES
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February 4, 2008

HUBERT HOENCK,	:	DISCRIMINATION PROCEEDING
Complainant	:	
	:	Docket No. WEST 2006-495-DM
	:	A.C. NO. WE MD 2006 10
v.	:	
	:	A.R. Wilson Quarry
GRANITE ROCK COMPANY,	:	Mine ID 04-00119
Respondent	:	

DECISION

Appearances: Matthew Rafat, Esq., San Jose, California, **for the Complainant.**
Kevin Jeffery, Esq., Granite Rock Company, Watsonville, California, **for the Respondent.**

Before: Judge Weisberger

Statement of the Case

This case is before me based upon a complaint of discrimination filed by Hubert Hoenck, alleging that Granite Rock Company (“Granite Rock”) discriminated against him by reprimanding him on numerous occasions after his having expressed concerns related to a rented water truck, and subsequently suspending him for three days and eventually “wrongfully terminating” him.

On November 22, 2006, Granite Rock filed a Motion to Dismiss. On January 8, 2007, Hoenck filed a statement in opposition to the Motion to Dismiss. On January 16, 2007, Granite Rock filed a Reply to Hoenck’s Opposition to Motion to Dismiss. On January 18, 2007, an Order Denying Motion to Dismiss, Pre-Hearing Order, and Notice of Hearing was issued, denying the Motion to Dismiss and setting this case for hearing on March 13 – 15, 2007. On March 8, 2007, in a telephone conference call with attorneys for both parties, Hoenck’s counsel, who had just been retained, requested that the hearing dates be rescheduled and the request was not objected to by Granite Rock. This case was rescheduled and heard on May 8 – 9, in San Jose, California. Subsequent to a request for extensions of time, Complainant filed a Post-Trial Brief, and Granite Rock filed Proposed Findings of Fact and a Post-Hearing Brief. On October 20, Granite Rock filed Objections to Complainant’s Proposed Findings of Fact and a Reply to Complainant’s Post-Hearing Brief. On October 19, Complainant filed a Reply to Granite Rock’s Proposed Findings of Fact.

Findings of Fact and Discussion

I. Hoenck's Prima Facie Case

A. Case Law

Section 105(c) of the Mine Safety and Health Act of 1977 ("Mine Act") prohibits the discrimination against or discharge of a miner who made a complaint under or related to the Mine Act, including, "a complaint in notifying the operator or the operator's agent ... of an alleged danger or safety or health violation in a coal or other mine ... or because of the exercise by such miner ... on behalf of himself or others of any statutory right afforded by this act." 30 U.S.C. § 815 (c) (1) (2000).

Under established Commission law, the complainant in a section 105(c) proceeding establishes a prima facie case of a violation of section 105(c) if a preponderance of the evidence proves (1) that he engaged in a protected activity, and (2) that the adverse action was motivated in any part by the protected activity. Sec'y on behalf of Pasula v. Consolidation Coal Co., 2 FMSHRC 2786, 2799 (Nov. 1980), rev'd on other grounds sub. nom. Consolidation Coal Co. v. Marshall, 663 F.2d 1121 (3d Cir. 1981). The operator may rebut the prima facie case by showing either that no protected activity occurred or that the adverse action was in no part motivated by the protected activity. Pasula, 2 FMSHRC at 2799 – 2800. If the operator cannot rebut the prima facie case, it nevertheless may defend affirmatively by proving that it also was motivated by the miner's unprotected activities and would have taken the adverse action in any event based on the unprotected activities alone. Id. at 2800; Sec'y ex rel. Robinette v. United Castle Coal Co., 3 FMSHRC 803, 817 – 18 (Apr. 1981).

B. Hoenck's Evidence

1. Protected Activities

Granite Rock operates the A.R. Wilson Quarry. Hoenck was employed by Granite Rock from 1997 to January 2006, and worked primarily as a water truck operator. Hoenck indicated that he was a "safety-minded" employee and that "[he] would tell people don't do things, it was not safe. [sic]" (Tr. 146.)

According to Hoenck, on September 9, 2003, Martin Colmenares, who was being trained to become a manager, told him to drive a rented water truck. Hoenck told him, orally and in writing, that it was not safe. Hoenck indicated that about a week later, he complained to Colmenares about "having a driver that was not trained to drive that water pull. [sic]" (Tr. 166.)

Hoenck also testified that a few days prior to March 19, 2004, he complained to Treanor "[t]hat we need a way to check our tires like we used to do. In the past we had an employee that would -- our tire man and he'd check them and make sure we had the right air pressure. [sic]"

(Tr. 157.)

Subsequently, Hoenck told Brian Fortelka, a supervisor at the Quarry, that “there were certain procedures to go by [regarding blocking roads when blasting] and he [Fortelka] didn’t do them all. ... He was doing it the fast way.” (Tr. 162.)

Hoenck also testified that in August 2005, he told Tom Treanor, a preventative maintenance manager, that there was not anyone to check the tires on the water truck. Hoenck also asked Walt Shaw, the shop foreman, for an air gauge for this truck.

A few months later, Hoenck called Mike Herges, whom he described as “our” safety coordinator (Tr. 133.) whom he “assumed ... was the shop foreman.” (Tr. 134.), and talked to him “[a]bout the low tires. About air pressure. Not being checked. [sic]” (Tr. 173.)

On September 19, 2005, the Safety Incident Review Committee¹ (“Safety Committee”) issued a report to Fortelka regarding Hoenck’s hand injury sustained on August 1, 2005. The report indicates that the Safety Committee concluded, *inter alia*, that Hoenck had told “Ray in the shop that he needed the crank installed.” (Plaintiff’s Ex. 6 at 2.)

Hoenck indicated that he also had complained to MSHA, his union, and the National Labor Relations Board as to “what was happening to [him] at Granite Rock[.]” (Tr. 190.)

Within the above context, I find that Hoenck has established that he did engage in protected activities by making safety complaints to various supervisors about a rented water truck, the failure to train the water truck operator, the failure to have an employee to check the tire pressure on the truck, and the failure to follow safety procedures on blocking roads when blasting.

2. Adverse Actions

On October 20, 2003, Treanor issued Hoenck a WRITTEN WARNING - ATTENDANCE 10/20/2003, which alleges that Hoenck had reported to work an hour late on October 27, had not called his supervisor to advise that he would be a half hour late on August 20, 2003, and that on October 18, 2003, he left work at 11:30 a.m. Hoenck was warned that “[t]hese attendance issues are unacceptable” and that “[f]uture similar attendance issues will result in suspension, and finally termination.” (Def. Ex. 2 at 1.)

On October 23, 2003, Treanor issued a FINAL WRITTEN WARNING -

¹The Safety Committee reviews all incidents where an employee is injured. At least one member of the Safety Committee was a Granite Rock manager. The Safety Committee was responsible for implementing safety recommendations.

ATTENDANCE to Hoenck alleging that “[o]n Wednesday morning,” Hoenck did not report to work or call Treanor at the number he had previously provided Hoenck. The warning provided further as follows: “[i]n the future, if you do not notify me of a tardy or absence prior to you [sic] scheduled shift start, you will be suspended. Additional unauthorized tardies or absences will result in termination.” (Def. Ex. 3 at 1.)

Ben Inkster, a team leader at the Quarry and Hoenck’s supervisor, testified that on May 27, 2004, he disciplined Hoenck for not wearing a hard hat and ignoring his supervisor. On February 11, 2005, Inkster informed Hoenck that he was to be suspended for three days, from February 14 to 16, 2005.

On January 11, 2006, Hoenck was suspended for one day pending an investigation of an incident that occurred that day involving a truck bed driven by Hoenck. On January 13, 2006, Henry Ramirez, the Wilson Quarry manager, advised Hoenck that he was being terminated effective January 13, 2006.

Within the above context, I find that Granite Rock took action adverse to Hoenck.

3. Whether the adverse action was motivated in any part by Hoenck’s protected activities

Commission case law establishes that in evaluating whether the Secretary has proven a causal connection between protected activities and adverse action, the following factors are to be considered: (1) knowledge of the protected activity; (2) hostility or animus toward the protected activity; (3) coincidence in time between the protected activity and the adverse action; and (4) disparate treatment. Sec’y on behalf of Chacon v. Phelps Dodge Corp., 3 FMSHRC 2508, 2510 (Nov. 1981), rev’d on other grounds sub nom., Donovan ex rel. Chacon v. Phelps Dodge Corp., 709 F. 2d 86 (D.C. Cir. 1983).

a. Coincidence in time between protected activities and adverse actions

I note that for the first six years of Hoenck’s employment, Granite Rock did not issue any reprimands to Hoenck or take any disciplinary action. It thus is significant to note that the first warning given to Hoenck by Treanor was on October 20, 2003, approximately a month after he (Hoenck) had complained about an unsafe rented water truck and subsequently refused to operate it.² Further, I note that two months after Hoenck complained to Treanor in March 2004 about the need to check the tire pressure and to block roads during blasting, Inkster disciplined him

² According to Hoenck, after he complained to Colmenares on September 9, 2003 that the rented truck he was ordered to drive was unsafe, the latter told him that if he was not going to drive the truck that there was not anything for him to do and he should go home. Hoenck indicated he was not paid for that day.

(Hoenck) in May 2004 for not wearing personal protective equipment (“PPE”).

b. Disparate Treatment

According to Ramirez, during the time that he was the plant manager, from 1998 to 2003, two or three persons other than Hoenck were disciplined for attendance problems, and one of them was terminated for attendance issues.³ However, Ramirez indicated on cross-examination that between 2003 and 2006, he did not terminate any other persons “for reasons in the aggregate involving attendance, PPE and the bed truck incident[.]” (Tr. 239.)

Roland Sanchez, a haul truck driver employed by Granite Rock, testified that he was late for work approximately five times. According to Sanchez, his supervisors discussed these incidents with him, his excuses were accepted, and he was not disciplined. Sanchez also stated that he was involved in two accidents operating equipment on the site, and he was not disciplined for either incident.⁴

According to Sanchez, on one occasion when Hoenck was reprimanded by Inkster for not wearing a hard hat, there were others visible to Inkster who were not wearing hard hats but were not reprimanded by Inkster.

Roy Harrison, a water truck driver employed by Granite Rock who worked with Hoenck, indicated that on two occasions he saw Fortelka single out Hoenck for criticism for not wearing a hard hat or a protective vest.

Harrison also indicated that on one occasion the bed of the truck he was driving hit some power lines, and he was verbally disciplined. He indicated that management asked him to explain the accident. He said that he accepted responsibility for it. As a result he was not suspended, did not suffer any loss of pay, and did not suffer any disciplinary action.

³ Inkster was involved in an accident at the site involving his pickup truck, and Ramirez verbally reprimanded him. According to Ramirez, Inkster did not suffer any loss of pay. However, as a result of this incident, “[h]is pay wasn’t as high as it would have been without the accident.” (Tr. 323-324.) Edward Dotson, a haul truck driver employed by Granite Rock since 1995, testified that in June 1997, while driving a truck, the bed did not come down, causing extensive damage, and he was given a three day suspension.

⁴Edward Dotson, a haul truck driver since 1995, testified that in 1999 a truck driver, Norman Mealer, “rolled one euc and he pulled some power lines down with his bed up” (Tr. 114.), but was not disciplined. However, on cross examination it was elicited that it was determined that Mealer was not at fault.

c. Knowledge

Both Inkster and Ramirez testified, in essence, that they were not aware of Hoenck's safety complaints in September and March 2004 when they took action against him. However, according to Hoenck, in September 2003, he made safety complaints to (1) Colmenares, who was being trained as a manager, and (2) to Fortelka, a supervisor. Further, Hoenck testified that in March 2004, he made safety complaints to Treanor, a preventive maintenance manager. It is significant to note that Hoenck's testimony in these regards was not impeached or contradicted.

d. Discussion

Within the above framework, I find that Hoenck has adduced sufficient evidence of coincidence in time between safety complaints he had made in October 2003 and March 2004, and the disciplinary action meted out to him in the nature of warnings or reprimands. Further, Hoenck adduced evidence of disparate action by Granite Rock towards Hoenck by disciplining him for not wearing the proper PPE, whereas others were not disciplined. Also, Hoenck established that disciplinary action was taken against him for damage caused by his truck, whereas other employees were not similarly disciplined. Thus, I conclude that Hoenck has adduced sufficient evidence to establish a causal nexus between adverse action taken against him and protected activities. Accordingly, I find that Hoenck has established that the adverse actions taken against him were motivated, "in any part," on his protected activities. Thus, I find that Hoenck has established a prima facie case.

II. Affirmative Defense

A. Case Law

In Sec'y on behalf of Chacon v. Phelps Dodge Corp., the Commission explained the proper criteria for analyzing an operator's business justifications for an adverse action:

Commission judges must often analyze the merits of an operator's alleged business justification for the challenged adverse action. In appropriate cases, they may conclude that the justification is so weak, so implausible, or so out of line with normal practice that it was a mere pretext seized upon to cloak discriminatory motive. But such inquiries must be restrained. (Emphasis added)

The Commission and its judges have neither the statutory charter nor the specialized expertise to sit as a super grievance or arbitration board meting out industrial equity. Cf. Youngstown Mines Corp., 1 FMSHRC 990, 994 (1979). Once it appears that a proffered business justification is not plainly incredible or implausible, a finding of pretext is inappropriate. We and our judges should not substitute for the operator's business judgement our views on "good" business

practice or on whether a particular adverse action was “just” or “wise.” Cf. NLRB v. Eastern Smelting & Refining Corp., 598 F.2d 666, 671 (1st Cir. 1979). The proper focus, pursuant to Pasula, is on whether a credible justification figured into motivation and, if it did, whether it would have led to the adverse action apart from the miner’s protected activities. If a proffered justification survives pretext analysis ..., then a limited examination of its substantiality becomes appropriate. The question, however is not whether such a justification comports with a judge’s or our sense of fairness or enlightened business practice. Rather, the narrow statutory question is whether the reason was enough to have legitimately moved that operator to have disciplined the miner. Cf. R-W Service System, Inc., 243 NLRB 1202, 1203-04 (1979) (articulating an analogous standard).

3 FMSHRC 2508, 2516 – 17 (Nov. 1981), rev’d on other grounds sub nom., Donovan ex rel. Chacon v. Phelps Dodge, 709 F.2d 86 (D.C. Cir. 1983).

In Haro v. Magma Copper Co., the Commission further explained its holding in Chacon as follows:

Thus, we first approved restrained analysis of an operator’s proffered business justification to determine whether it amounts to a pretext. Second, we held that once it is determined that a business justification is not pretextual, then the judge should determine whether “the reason was enough to have legitimately moved the operator” to take adverse action.

4 FMSHRC 1935, 1938 (Nov. 1982).

In Haro, the Commission also elaborated on the scope of the judge’s examination of an operator’s business justification response as follows:

[W]e intend that a judge, in carefully analyzing such defenses, should not substitute his business judgement or sense of “industrial justice” for that of the operator. As we recently explained, “Our function is not to pass on the wisdom or fairness of such asserted business justifications, but rather only to determine whether they are credible and, if so, whether they would have motivated the particular operator as claimed.” Bradley v. Belva Coal Co., 4 FMSHRC 982, 993 (Jun. 1982) (emphasis added).

Id. at 1938.

B. Granite Rock's Evidence

Treanor, the Quarry plant manager from July 2003 to January 2005, indicated that in September 2003, when Hoenck complained about the truck being unsafe and subsequently refused to operate it, he was sent home because there was nothing else for him to do.

On October 20, 2003, Treanor issued a Written Warning- Attendance 10/20/03, advising Hoenck that it was being issued as a result of his arriving an hour late and failing to call his supervisor to inform him that he would be late on October 20. The warning also alleges that on August 27, 2003, Hoenck was a half hour late, that on October 18, 2003, Hoenck came to work at 4:00 a.m. rather than his scheduled start of 7:00 a.m. and left work at 11:30 a.m., and that as a result, there was excessive dust on the roads, and as a consequence the truck drivers had to be sent home at 1:00 p.m. The warning further advises as follows: "These attendance issues are unacceptable. You must come to work as scheduled. Future similar attendance issues will result in suspension, and finally termination." (Def. Ex. 2 at 1.)

On October 23, 2003, Treanor issued to Hoenck a Final Written Warning- Attendance, in which he informed Hoenck that he had been given a written warning on Tuesday, and on Wednesday morning Hoenck did not report to work and did not call him (Treanor). The warning further provided as follows: "This pattern is unacceptable. In the future, if you do not notify me of a tardy or absence prior to you [sic] scheduled shift start, you will be suspended. Additional unauthorized tardies or absences will result in termination." (Def. Ex. 3 at 1.)

Treanor admitted that he did not discipline anyone else aside from Hoenck for attendance violations "within a three-day span [.]" (Tr. 281.) However, it is significant to note that on February 20, 2004, only four months after Treanor had issued a warning and a final warning to Hoenck for attendance problems, he issued a WRITTEN WARNING-ATTENDANCE/ PERFORMANCE to Jim Pacillas for repeated early departures and performance issues, i.e. tardy in returning from lunch and talking on the telephone. This warning provided further as follows: "Further similar incidence will result in suspension and termination." (Def. Ex. 10 at 1.)

In his testimony, Inkster also described various problems he had encountered with Hoenck. Inkster indicated that, in general, it was difficult to contact Hoenck when he was driving his water truck, that Hoenck did not wear his PPE on a daily basis, and that Hoenck had a consistent tardiness problem.

On January 27, 2005, Inkster spoke with Hoenck about his tardiness. Also, Inkster expressed his concerns that Hoenck was taking time off for personal business, that he was not wearing his hard hat, and that he was breaking for lunch ten minutes early. On January 31, 2005, Inkster again told Hoenck that he needed to wear his hard hat.

On January 31, 2005, Inkster sent to Ramirez a memorandum of a conversation that he had with Hoenck on January 27, 2005. According to Inkster, in this conversation he informed

Hoenck that he noticed that the latter was not wearing his hard hat, and that he had just walked from his haul truck to a tower without wearing a hard hat. Inkster indicated that he also informed Hoenck that he was breaking for lunch ten minutes early, and that attendance problems and not wearing a hard hat are not expected to continue.

According to Inkster, on January 31, he had another conversation with Hoenck in which he again advised Hoenck of the need to wear his hard hat and that he does not expect the PPE problems to continue to occur. Inkster also advised Hoenck of an ongoing problem with attendance in 2004, citing his late arrivals, thirty minutes or more on five occasions, and his leaving work more than thirty minutes early on seven occasions. He also cited written warning notices issued to Hoenck on October 20 and 23, 2003, and his one-day suspension in March 17, 2004 because of continued absence problems. Inkster advised Hoenck that as a result of all of the above, it was decided to suspend him for three days, from February 14 – 16, 2005.⁵ He was further warned as follows: “if there are any future incidence of this nature, you will be subject to further disciplinary action including possible termination.” (Def. Ex. 23 at 2.)

On February 11, 2005, Inkster wrote to Hoenck referring to conversations he had with him on January 25 and 31, 2005. He also indicated that on February 2, 2005 he had a conversation with Hoenck, which he described as follows:

I first discussed the company safety policy that requires you to wear a hard hat at all times except when in equipment or a building. I had observed you not wearing your hard hat when walking from the haul truck to the Secondary Tower. During our conversation, you were reminded that anytime you are outside your equipment or a building, you must wear your hard hat. This includes when walking from your car in the parking lot to the haul truck at the fuel island.

We also discussed your failure to observe your work schedule. The meeting was prompted because you were not in the haul truck working and it was 10:50 a.m. It was apparent you were breaking for lunch ten minutes early. All the other haul truck drivers were still working. When I questioned you, your response was, “Sometimes I lose track of time”. [sic] You further stated your watch was an hour off “the other day” and you took lunch at 10:00 a.m. You failed to observe that all other members of the crew were still working. When you returned to your truck after your unscheduled lunch break, you sat in the truck because work could not be performed without the operators. In review of your time card, you did not deduct your “additional” lunch period off your time.

In addition we also talked about another incident in which you left work early to attend to personal business, and our on-going problem of you not reporting to work at your scheduled starting time. I reminded you how it was very important for every

⁵ The suspension was without pay.

team member to work their assigned work shift and that I didn't expect the attendance problems or failure to follow policies (i.e. hard hat) to continue.

Then, on January 31, 2005, I had another conversation with you about the exact same situations – not working the entire scheduled work shift, and not wearing your hard hat. I had observed you driving your haul truck to the fuel island 25 minutes before the quitting time. In addition, you were outside the Truck Shop without your hard hat on. I reminded you of the conversation we had 2 days earlier, and that I did not expect this type of behavior to continue.

On February 2, 2005, I had another conversation with you. During that conversation I observed your hard hat in your hand and instructed you to wear it. After an exchange of comments, I instructed you again to put your hard hat on. You refused to put in on and walked away from me while I was still talking to you.

After a review of your record and the fact that I had recently warned you on three separate occasions about not observing work rules and work schedules, it is evident that you have not changed your behavior. Your most recent actions and refusal to follow Graniterock policies shows that you are not willing to change your behavior.

Def. Ex. 23 at 1 – 2.

Inkster indicated that on May 25, 2005, he had a conversation with Hoenck and told him that haul truck drivers had complained that the roads were too dusty because they had not been sufficiently watered. According to Inkster, Hoenck then over-watered the road up to the ramp, and one of the trucks that subsequently came down the road slid into a berm.

Ramirez indicated that Inkster told him of Hoenck's performance issues relating to his attendance, and his suspension by Fortelka. Also, Ramirez noted that Inkster told him of Hoenck's failure to follow Fortelka's instructions when Hoenck drove on a road in the blast area (1) prior to the blast after Fortelka had told the team not to drive in that area, and (2) subsequent to the blast after Fortelka had announced that the road was closed.

On October 3, 2005, Fortelka advised Hoenck that as a result of an investigation of an incident that had occurred on September 28, 2005, and having met with him (Hoenck), it was concluded that (1) on September 26 and 27, he (Fortelka) had informed all the team members that a road at the bench area was closed, and there was a Do Not Enter sign blocking the entrance, and (2) Hoenck was observed driving his water truck through the area. Fortelka further informed Hoenck that, based on an investigation of the events on September 28, 2005, it was concluded that Fortelka had informed all the team members that the North Rim Road was closed and that, subsequent to that warning, Hoenck drove through that area. It was concluded that Hoenck's actions warranted a three day suspension, effective September 29, 30 and October 1, 2005.

On October 3, 2005, Fortelka sent Hoenck the following letter:

The basis for the suspension also included your pass performance problems. In review of your personnel file, you have received the following discipline in the past two years:

September 20, 2005 – Written warning. Did not report to work or call supervisor.

May 27, 2005 – Verbal warning. Poor judgment of over watering the road on swing shift.

February 11, 2005 – Three-day suspension. Not observing work rules and schedules including PPE, failure to observe work schedule, and attendance.

May 27, 2004 – Verbal warning. Refusal to wear PPE.

March 17, 2004 – One-day suspension. Attendance.

October 31, 2003 – Failure to follow instructions of supervisor.

October 30, 2003 – Talking on personal phone and with co-workers during working hours.

October 20, 2003 – Written warning. Attendance.

Clearly, such performance cannot continue. We have tried to mitigate the issues but we must inform you this will be your last and final warning. We will no longer tolerate any more incidents. You will be subject to possible termination if another incident occurs.

Def. Ex. 14 at 2.

A copy of this letter was sent to Ramirez.

Ramirez, who was the quarry manager at the Wilson Quarry since October 2004, indicated that he was responsible for the firing of Hoenck. He agreed that the accident that Hoenck had with his dump truck on January 11, 2006 was a “substantial factor” in his decision to terminate Hoenck. (Tr. 238 – 239.) He indicated that “[i]t was the final incident that caused his termination. I looked at his history in aggregate.” (Tr. 238.) He was asked why he fired Hoenck and he answered as follows: “Well, after several meetings, several attempts, several write-ups to try to mitigate the actions that Hubie had taken over time, nothing was working.” (Tr. 237.) He also indicated that he did not know that Hoenck had reported safety violations to Granite Rock.

Ramirez testified further that as a result of an investigation of the accident on January 11, 2006, it was determined that the accident was caused by Hoenck's inattention. He indicated that as a result of the accident, the plant was shut down for a week and a half while the conveyor was repaired. During this period, the company was not able to produce asphalt. At the conclusion of his review of the accident, Ramirez recommended termination of Hoenck. He was asked what factors he considered in making that determination and he answered as follows:

Well, we over the year and a half that we tried to mitigate all the things that were going on with Hubie. We had meetings with the shop steward, his business agent from the union, with the different supervisors involved, just trying to improve what was going on with Hubie. And nothing seemed to work. And the end result was this damage to the conveyor and just we tried to modify his behavior; just didn't work. Didn't seem like anything we tried to mitigate didn't work. So, this was our final conclusion that we couldn't do anything else.

Tr. 333 – 334.

C. Discussion

In essence, it is Granite Rock's position, as testified to by Treanor and Inkster, that the disciplinary actions taken against Hoenck in the nature of reprimands, warnings, and suspensions, were as a result of Hoenck's repeated attendance problems, PPE violations, and the failure to follow the directives of a supervisor.

In opposition to Granite Rock's affirmative defense, Hoenck argues that Granite Rock's assertion of a business justification for adverse action taken against Hoenck is not credible. In support of his argument, Hoenck refers to his termination on January 13, 2006 because of an accident which resulted in damage to the truck he had been driving. Granite Rock did not discipline other employees who had similar accidents because, as Granite Rock states, those employees took responsibility for their actions whereas Hoenck did not.⁶

Hoenck argues that this is not credible on the ground that no evidence was adduced that Granite Rock had asked Hoenck to take responsibility for his actions. Indeed, Hoenck testified that no one from Granite Rock ever asked him whether he accepted responsibility for any of these incidents. Hoenck also argues that termination predicated upon attendance and PPE violations is not credible, because no one else had been disciplined for these violations.

⁶ For example, Roy Harrison had an accident with a water truck, which caused over five hundred dollars in property damage (Plaintiff Ex. 1 at 1.), but when asked by Granite Rock personnel to explain the incident, Harrison took responsibility for the accident and was only verbally disciplined.

Inferences might be drawn based upon coincidence in time and disparate treatment that the alleged business justifications were pretextual. However, I accord more weight to the testimony of Inkster, Treanor, and Ramirez regarding their motivations in disciplining Hoenck. I observed their demeanor and found them to be credible witnesses. In essence, their testimony and documentary evidence of their communications to Hoenck indicate that the various disciplinary actions taken against Hoenck were based on his attendance problems, PPE violations for more than two years and in spite of numerous warnings, and the truck accident in July 2006.

More specifically, on Monday October 20, 2003, Treanor issued a written warning to Hoenck for his attendance problems, alleging that Hoenck was late on two occasions within the previous three months, and that he left early on October 18. Hoenck was warned that “[f]uture similar attendance issues will result in suspension, and finally termination.” (Def. Ex. 2 at 1.)

On Thursday, October 23, 2003, Treanor issued Hoenck a final written warning, alleging that Hoenck did not report to work on Wednesday, October 22, and that he (Hoenck) failed to notify him (Treanor) of this absence. Treanor advised Hoenck as follows: “[a]dditional unauthorized tardies or absences will result in termination.” (Def. Ex. 3 at 1.)

In an e-mail dated October 30, 2003, Colmenares stated that on October 27, 2003, he saw Hoenck talking on his cell phone during working hours. Colmenares also noted Hoenck’s general “bad attitude and poor performance.” (Plaintiff Ex. 15 at 1.) In another e-mail, dated October 31, 2003 and sent from Inkster to Colmenares, Maryanne Robinson, Dan Slavin, and Treanor, Inkster documented an incident on October 31, 2003 when Hoenck used the water truck to water the roads on a rainy day when the roads were already wet. Inkster indicated that he felt that Hoenck exercised poor judgment.

In an e-mail from Inkster to Ramirez dated January 31, 2005, Inkster documented a conversation he had with Hoenck on January 27, 2005, in which he told Hoenck that he must wear his hard hat. Inkster also told Hoenck that he was breaking for lunch too early, and he also pointed out to Hoenck that he was leaving work too early to attend to personal business. While acknowledging that unforeseen circumstances do arise at times, Inkster informed Hoenck that he must give one day of notice if he will not be able to work his shift. Inkster said that he would give Hoenck the benefit of the doubt this time.

On January 31, 2005, Inkster had another conversation with Hoenck about Hoenck’s failure to wear his hard hat on that day and his leaving twenty-five minutes early. Inkster informed Hoenck that he “[doesn’t] expect these kind of things to keep occurring.” (Def. Ex. 22 at 2.)

On January 27, 2005, Inkster suspended Hoenck for three days, from February 11 to February 16, based on Hoenck’s ongoing attendance problems and failure to observe work rules and policies. Hoenck was informed that, “if there are any future incidents of this nature, [he] will be subject to further disciplinary action including possible termination.” (Def. Ex. 23 at 2.)

On September 20, 2005, Hoenck received a written warning for failure to report to work and failure to notify a supervisor of the absence.

On September 28, 2005, Fortelka suspended Hoenck pending the completion of an internal investigation of an incident involving Hoenck's perceived failure to follow supervisor's instructions. On October 3, 2005, at the conclusion of the investigation, that suspension was formalized for the dates of September 29, 30, and October 1, 2005, because it was determined that Hoenck failed to follow instructions and subsequently put himself and company property in danger. Fortelka informed Hoenck that "[he] will be subject to possible termination if another incident occurs." (Def. Ex. 14 at 2.)

On January 11, 2006, Hoenck was suspended by Ramirez because of a truck accident in which Hoenck was involved. In a meeting after the accident with Hoenck, Ramirez told him that he would contact Hoenck but that "the outcome would not be good." (Def. Ex. 16 at 2.) Subsequently, on January 13, 2006, Ramirez sent Hoenck a letter informing him that he was terminated. Ramirez wrote that, "[c]learly your actions cannot be mitigated and termination is our only recourse." (Def. Ex. 18 at 1.)

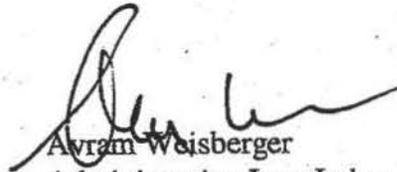
In this connection, I note that Hoenck, in the main, did not impeach or contradict evidence adduced by Granite Rock relating to his tardiness, PPE violations, and the truck accident in July 2006. I thus find that the asserted business justifications for the disciplinary actions taken against Hoenck were not "plainly incredible or implausible" Sec'y on behalf of Chacon v. Phelps Dodge Corp., 3 FMSHRC 2508, 2516 (Nov. 1981) (emphasis added).

I am guided by the principles established in Phelps Dodge, that since the business justification has survived pretext analysis, only "a limited examination of its substantiality" is appropriate. Id. In making this examination, I note that the judge's function is not to pass on the wisdom or fairness of the asserted business justification. See Haro, 4 FMSHRC at 1938. Rather, it must be determined that the alleged justification would have motivated Granite Rock. Id. I find based on the testimony of Inkster, Treanor and Ramirez, as well as supporting documentation, that the reasons given by Granite Rock for the termination were "enough to have legitimately moved that operator to have disciplined the miner." Id.

Therefore, for all of the above reasons, I find that Hoenck adduced sufficient evidence to establish a prima facie case. However, I find that Granite Rock prevailed in its affirmative defense. Therefore, I find that Hoenck has failed to establish that Granite Rock discriminated against him in violation of section 105(c) of the Mine Act.

ORDER

It is **Ordered** that this Complaint of discrimination be dismissed. It is further **Ordered** that this case be **Dismissed**.


Avram Weisberger
Administrative Law Judge

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/eb

FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

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

February 8, 2008

SECRETARY OF LABOR, : CIVIL PENALTY PROCEEDING
MINE SAFETY AND HEALTH :
ADMINISTRATION (MSHA), : Docket No. WEST 2007-16-M
Petitioner : A. C. No. 02-02988-98780
v. :
RINKER MATERIALS, : Rinker Materials 19th Ave.
Respondent :

DECISION

Appearances: Cheryl L. Adams, Esq., U.S. Department of Labor, Office of the Solicitor, San Francisco, California, on behalf of Petitioner; Katherine Shand Larkin, Esq., Laura E. Beverage, Esq., Jackson Kelly, PLLC, Denver, Colorado, on behalf of Respondent1

Before: Judge Zielinski

This case is before me on a Petition for Assessment of a Civil Penalty filed by the Secretary of Labor pursuant to section 105 of the Federal Mine Safety and Health Act of 1977 ("Act"), 30 U.S.C. § 815. The Petition alleges that Rinker Materials ("Rinker") is liable for one violation of the Secretary's mandatory safety and health standards applicable to surface metal and nonmetal mines. A hearing was held in Phoenix, Arizona, and the parties submitted briefs following receipt of the transcript. The Secretary proposed a specially assessed civil penalty in the amount of \$31,000.00 for the violation. For the reasons set forth below, I find that Rinker committed the alleged violation, but that its negligence was low rather than high, and impose a civil penalty in the amount of \$9,000.00.

Findings of Fact – Conclusions of Law

Rinker operates a metal/nonmetal mine, known as "Rinker Materials 19th Avenue," in Maricopa, Arizona. Mobile equipment, including front end loaders ("FELs") are used in the operation, and are serviced on-site by its mechanics. On January 4, 2006, major maintenance commenced on a Caterpillar ("CAT") Model 980C articulating FEL. The following day, a

1 Ms. Larkin represented Rinker at the hearing and filed the post-hearing brief. At the time of issuance of this Decision, she is no longer with the firm.

mechanic working on the FEL suffered fatal injuries when the rear part of the loader tilted, crushing him between the frame and left rear wheel. MSHA investigators were called to the scene, and commenced an investigation of the accident. Citation No. 6318499 was issued following the investigation, charging Rinker with a violation of 30 C.F.R. § 56.14105, which requires that: "Repairs or maintenance of machinery or equipment shall be performed only after the power is off, and the machinery or equipment blocked against hazardous motion." MSHA determined that the fatality occurred as a result of the violation, that it was significant and substantial ("S&S"), that one person was affected, and that Rinker's negligence was high.²

Facts

The CAT 980C articulating wheel loader is a 65,000 pound piece of mobile equipment, that consists of a front and a rear section. They are connected near the center of the machine by pivot joints that allow limited rotation around a vertical axis. The major components of the front section include the front axle, frame and bucket lift arms. The main components of the rear section include the rear axle, and the rear frame, on which are mounted the engine and operator's cab. The rear axle and frame are also connected by a pivot joint, which allows oscillation, or tilting, of the rear frame relative to the axle, up to 15 degrees to each side. When the front and rear sections are connected, and the rear axle is stationary on level ground, the vertical pivot joint joining the sections does not allow the rear frame to tilt. However, when the sections are disconnected, the rear frame can freely tilt 15 degrees to either side, unless it is blocked to prevent such movement.

In order to conduct the January maintenance, the front and back sections of the 980C were separated. Caterpillar's service manual for the 980C sets forth a procedure for separating the sections that involves moving the rear section away from the front section. Ex. G-3. A wheeled hydraulic jack is used to support the forward end of the frame, at the disconnected pivot joint. A fork-lift truck is then used to move the rear section away from the front section. The wheeled jack provides a single point of contact at the center of the forward end. In order to keep the rear frame from tilting to either side, it is necessary to place blocking between both sides of the rear frame and the rear axle housing. Ex. G-3 at 126, step 13.

Caterpillar also makes newer FELs similar to the 980C. Its 980G and 980H models, are based upon the same basic design as the 980C, but have somewhat larger engines and load capacities. The service manuals for those models specify a different procedure for separating the front and rear sections. The rear frame is blocked at four points and remains stationary, and the

² A significant and substantial violation is described in section 104(d)(1) of the Act as a violation "of such nature as could significantly and substantially contribute to the cause and effect of a coal or other mine safety or health hazard." A violation is properly designated S&S "if, based upon the particular facts surrounding that violation, there exists a reasonable likelihood that the hazard contributed to will result in an injury or illness of a reasonably serious nature." *Cement Div., Nat'l Gypsum Co.*, 3 FMSHRC 822, 825 (Apr. 1981).

front section is moved away from it. Ex. R-2. The counterweight at the back of the rear section has indentations at its back corners designed to accept 40,000-pound capacity jack stands. Cribbing is then placed on each side of the front part of the rear frame, on each side of the pivot joint.³ Most of the weight of the rear section remains on the rear axle and wheels, which are blocked against rolling. With the four-point supports in place, the rear frame cannot oscillate, or tilt. Consequently, the 980G and 980H manuals do not call for blocking between the rear frame and rear axle housing. Darrin Richards, Rinker's failure analysis expert, prepared step-by-step drawings, depicting the two different separation procedures specified for the 980C, and the 980G and 980H loaders.⁴ Tr. 149-51, 155-57; ex. R-11, R-12.

The front and rear section of the 980C loader were separated on January 4, 2006, by two of Rinker's mechanics, Mark Dewes, who had over 21 years of experience as a heavy equipment mechanic, and Doug Schafer. They did not follow the procedure set forth in the service manual for the 980C. Rather, they supported the rear section, and moved the front section away from it, essentially the procedure specified in the service manuals for the 980G and 980H models. They had been trained on that procedure. Tr. 172. They placed CAT jack stands, designed for the process, under the rear corners of the counterweight. They also placed 40,000-pound capacity screw jacks on each side of the front part of the rear frame. The rear section of the 980C, supported as it had been on January 4, 2006, is depicted in several pictures.⁵ Ex. G-2F, R-15A, R-15B. All witnesses agreed that when supported in this manner, with four points of contact, the rear frame was stable and could not tilt or oscillate. Tr. 91-93, 130-31, 157-58, 167-68. Dewes and Shafer did not place blocks between the rear frame and the rear axle housing. Dewes performed maintenance activities on the rear section of the 980C after it had been separated, in the course of which he climbed onto it more than once. Tr. 168. It was stable, and his activities produced no movement of the frame. Tr. 169.

On January 5, Chris Penzanter was assigned to continue the maintenance job on the 980C loader. Penzanter had also been trained on and performed the procedure Dewes and Shafer had used to separate the loader's sections. Tr. 172. Dewes was also going to work on the 980C, but initially had other duties to perform. Penzanter had begun the process of removing the right steering cylinder rod pack, when Dewes noticed that the loader's rear frame was leaning to the right. He knew that something was wrong and, as he approached, he saw Penzanter in the

³ Ex. R-2, 980G service manual at 7, 980H service manual at 6.

⁴ Richards is a senior professional engineer with Exponent, Failure Analysis Associates. His curriculum vitae was admitted into evidence. Ex. R-16.

⁵ Testing by MSHA after the accident included an effort to reconstruct, as near as possible, the position and support of the rear section as it existed before being worked on by the fatally injured miner. The post-accident reconstruction depictions differ from the pre-accident conditions in two respects, additional wheel chocks were placed against the tires, and wood blocking was placed under the forward portion of the frame between the screw jacks.

process of lowering the screw jack that supported the right front side of the rear frame. Tr. 171. Penzanter told him he was taking the jack out so that he could place an oil pan to catch hydraulic oil that would be released when he disassembled the steering cylinder. Tr. 171. Penzanter thought that the rear section was back-heavy, and would stand on three jacks. Tr. 171. Dewes told Penzanter that that was not a good idea, and that all four jacks had to be in place. Penzanter stepped back, and said "you're right." Tr. 172. Shafer also came over around that time, and hung on the loader's right-side handrail to stretch out. The loader frame moved a little bit. He expressed surprise and asked what was going on. Tr. 178. Dewes and Penzanter told him about the screw jack. Shafer then left, and they screwed the jack back up, restoring the four point support. Dewes left to perform other duties shortly after 9:00 a.m. Tr. 171-74.

Dewes returned to the 980C about 11:00 a.m. He discussed various tasks with Penzanter, who said that he was going to pull the left steering cylinder barrel. Tr. 174. Dewes did not notice anything unusual. He and Penzanter were standing near the ladder on the left-front of the rear section. Penzanter stepped up on the ladder and swung himself between the tire and rear frame, where he could start to disconnect the cylinder. Tr. 175. The rear section of the 980C then tilted to the left, pinning Penzanter between the frame and the tire. Tr. 175. The wheels did not move – the rear frame simply tilted to the left. Tr. 177.

Dewes reacted by pushing on the 980C's frame, and immediately called for help – several people responded. An overhead crane was positioned over the loader, and a chain was attached to the handrail near the operator's cab. Dewes went to get more jacking, in case it was needed. Tr. 176. As he came back, Penzanter had been removed, and placed on the floor. When the crane lowered the rear frame of the loader, the remaining screw jack was displaced, the pivot joint attachment went all the way to the ground, and the wheels moved slightly. Tr. 176. The accident scene, following the recovery operation, is depicted in several photographs. Ex. G-2A-E.

MSHA was notified of the accident, and immediately commenced an investigation. The accident scene was preserved and witnesses were interviewed. Thomas E. Barrington, an MSHA inspector with 14 years of experience, and 18 years of mining experience, headed the investigation. He had worked as a heavy equipment mechanic, and had worked on 980C loaders. Tr. 26-28. With the assistance of Ronald Medina, a mechanical engineer with the technical support group at MSHA's Approval and Certification Center, tests were conducted to determine whether the accident could have happened the way the witnesses had described it. Tr. 121. Wood blocking was placed under the forward part of the frame, to act as secondary support. There was no wood blocking material on the site, and it had to be obtained elsewhere. The rear frame was then placed on the four-point supports, per Dewes' explanation. There was a mark on the front right part of the frame that corresponded to the location that Dewes had said that screw jack had been installed. Tr. 126. The height of the screw jacks was set, based upon photographs that had been taken of the accident scene, which showed the number of screw threads exposed. Tr. 132.

The height of the screw jacks was varied to ascertain the effect on rear frame stability. The results of the tests indicated that, when the jacks were higher, the loader was stable, even with one of the jacks removed. However, when the jacks were placed at the height that they had been installed prior to the accident, removal of the left screw jack caused the frame to become unstable. It tilted, lifting the counterweight off of the right-rear jack stand. Tr. 140-41. MSHA determined that the accident could have happened as it had been described by Dewes and others. Tr. 121.

MSHA determined that the accident occurred because the rear frame of "the loader was not properly blocked against hazardous motion, in that, one of the two jacks supporting the loader's rear main frame had been removed. Also blocks had not been placed between the axle housing on both sides of the machine, to prevent side-to-side (oscillation) movement of the machine." Ex. G-1. Barrington issued Citation No. 6318499 on February 15, 2006, charging Rinker with a significant and substantial violation of 30 C.F.R. § 56.14105, and high negligence.

Discussion

Rinker does not contest the fact of violation, or that it was S&S. It contends that its negligence was no more than low, and that the proposed civil penalty is excessive.

Barrington interviewed Rinker's mechanics and found them to be well-trained and competent. Tr. 36. He also found that Rinker had a standard operating procedure ("SOP") for servicing the 980C, which involved using four-point support for the rear frame, two CAT jack stands under the rear counterweight and two screw jacks under the forward portion. Tr. 37-38. He asked David Chavez, Rinker's area safety director, for documentation of Rinker's SOP for servicing the 980C, and was provided with a copy of CAT's 980C service manual. Tr. 37. The mechanics stated that they were aware of the manual and were familiar with it. Barrington also interviewed John Essig, an hourly mechanic who had been put in charge that morning. Essig stated that he had spoken with Penzanter about his work on the 980C, and had looked at the left steering cylinder body sometime before the accident. Barrington concluded that, in that position, Essig should have been able to see whether a screw jack had been removed, but he did not notice anything. Tr. 41-42, 47; ex. G-2G.

Barrington outlined the factors that he considered in determining that Rinker's negligence was high. First, he reviewed the service manual for the 980C, which had been provided by Chavez. In his words, "everyone acknowledged that that book did exist, that everybody had looked at it, but nobody followed it." Tr. 58. Second, two people had told Penzanter not to remove a screw jack, and the "man in charge was actually looking in the barrel of the [cylinder] right next to where the jack had been removed and never said anything about it." Tr. 58. Third, there were two prior incidents where a loader had become unstable, and he did not believe that Rinker had changed its procedures in light of them. Tr. 58. Finally, he was concerned about lack of management oversight in general, and with respect to a job hazard analysis form that Penzanter had filled out. Tr. 58-59. He thought about issuing an unwarrantable failure

violation, but since Essig was not acting as Rinker's agent at the time, he did not believe that it was chargeable with reckless disregard. Tr. 59. The Secretary confirmed that she was not contending that Essig was Rinker's agent on the day in question.⁶ Tr. 77-78.

The Secretary argues that Rinker's negligence was properly assessed because its SOP, as described by the mechanics, deviated from the SOP set forth in the CAT 980C service manual in one critical respect, i.e., no blocking was placed between the rear frame and the axle housing. Such blocking would have prevented the oscillation which caused the accident. She also points out that there is no evidence that Rinker had service manuals for the 980G or 980H on site at the time of the accident, or that it was following the procedure specified in those manuals. It did not use cribbing to support each side of the front portion of the frame, as specified in the 980G and 980H manuals. In fact, there was no wood blocking or cribbing on the site. In addition, the Secretary argues that Rinker provided no supervision of the mechanics, because no agent of the operator was on site. She is also critical of the fact that Chavez did not know what procedure Rinker's mechanics followed in separating a 980C loader. He told Barrington that Rinker followed the 980C service manual, which clearly was wrong.

Rinker argues that Barrington's analysis contains errors and inconsistencies, and that the accident was solely the result of employee misconduct. The Secretary responds that there is insufficient evidence to support a finding that Penzanter removed a screw jack from beneath the front part of the loader frame. However, Barrington, after interviewing numerous individuals, investigating the scene and available evidence, and conducting reconstruction tests, concluded that Penzanter had removed the screw jack from the left forward portion of the rear loader frame, resulting in the accident. Tr. 74; ex. G-1.

Rinker's arguments are persuasive. As to the first factor, Barrington knew that the mechanics, who he determined were experienced, competent and well-trained, used a substantially different procedure to separate the loader's sections than was specified in the 980C service manual. They moved the front section, not the rear one, and used four-point supports for the rear section, which Barrington reluctantly acknowledged rendered it stable.⁷ The procedure

⁶ Essig was an hourly employee assigned to the day shift, who was temporarily placed in charge that day. He had worked as a foreman on a different shift, but switched back to hourly when he transferred to the day shift. Tr. 70-71.

⁷ Barrington was critical of Rinker's use of screw jacks instead of wood blocking, because he felt that wood provided more friction at the point of contact, and that screw jacks might more easily be displaced. Tr. 51, 56, 86. However, Richards testified that the screw jacks, with a capacity of 40,000 pounds, were designed to support mechanical equipment with metal-to-metal contact and were routinely used for such purposes. Tr. 153-54, 159. Barrington could not disagree, and conceded that there was no MSHA regulation prohibiting metal-to-metal blocking, or requiring the use of wood. Tr. 86-88, 91-92. Medina expressed similar concerns, and made similar concessions. Tr. 124, 129-31, 134-35, 139.

actually used was the same procedure specified in CAT's service manuals for the newer 980G and 980H models, except that screw jacks were used instead of cribbing. Rinker's failure analysis expert testified, without contradiction, that the 980C is structurally the same as the 980G and 980H, which have air-conditioned cabs, and slightly larger engines and load capacities. Tr. 159. Consequently, the procedure specified for the newer models was fully applicable to the 980C. Rinker contends that it was actually using the newer and safer procedure, and fully complied with it. Barrington was unaware of the newer procedure for separating the loader's sections, except to the extent that the mechanics told him that they had been trained on and used the procedure. He made no determination as to the propriety of Rinker's actions under the newer procedure. All of his analysis was based upon Rinker's obvious departures from the 980C service manual's procedure. As he explained, "That's all I had to go by." Tr. 108.

On the second factor, despite Barrington's conclusion that Essig was not Rinker's agent, his testimony indicates that he attributed Essig's actions to Rinker, at least to some extent.⁸ He explained that "Somebody in management gave Essig that authority to make sure that the jobs were . . . conducted safely . . . and he had the experience to do it . . . management put him in that position of being in charge." Tr. 70-71. Barrington also believed that Essig, "the man in charge," should have seen that Penzanter had removed the screw jack. Tr. 58, 74, 80. Essig's perusal of the job safety analysis form filled out by Penzanter was also one of Barrington's concerns. Tr. 58. The Secretary notes in her brief that the form was not detailed enough to have had an impact on the accident. Sec'y. Br. at 8-9.

On the third factor, Barrington was mistaken about his belief that Rinker had not altered its procedures in light of two prior incidents. The first incident, which occurred several years earlier, involved a situation in which a rear section of a loader fell to the ground. Barrington conceded that the mechanics working on that machine were employees of Caterpillar, that only two points of contact were being used at the time, and that Rinker then changed its procedure to require four points of contact. Tr. 102-04. He also acknowledged that the second incident, which occurred about two months before the accident, did not involve a loader that had been separated, and that Rinker had taken "proactive steps to institute changes to its policy to protect against the very hazards that occurred in . . . each [prior incident]." Tr. 104-05. Barrington's mistaken belief that Rinker had not taken action in response to the two prior incidents clearly was a factor in his negligence determination. Nevertheless, he testified that, even if Rinker had changed its procedures, he would not have considered it a factor in mitigating Rinker's negligence below "high." Tr. 82.

The Secretary also argues that, since there was no agent on site that day, that Rinker was negligent in failing to provide supervision to the mechanics working in the shop. As the

⁸ The involvement of an operator's agent, typically a supervisor, can be particularly significant because the negligence of an agent can be imputed to the operator for purposes of unwarrantable failure and civil penalty assessment. *E.g., Capitol Cement Corp.*, 21 FMSHRC 883, 893 (Aug. 1999).

Secretary notes, the negligence of rank and file miners cannot be imputed to an operator unless the operator failed to discharge its responsibilities with respect to training, supervision or discipline. *U.S. Coal, Inc.*, 17 FMSHRC 1684, 1686 (Oct. 1995). However, other than the absence of an operator's agent, the Secretary points to no failure on the part of Rinker. She does not directly challenge Rinker's decision to provide supervision by a non-agent, i.e., the experienced former foreman who had been temporarily placed in charge. Dewes, another experienced mechanic, corrected Penzanter's initial deviation from safe, established procedure. As to training, Barrington concluded that Rinker's mechanics were "very competent" and were safety conscious. Tr. 36-37. They, including Penzanter, had been trained on the procedures for disassembly and blocking of the loader and had performed that operation. Tr. 72-73, 80-81.

In an enforcement proceeding under the Act, the Secretary has the burden of proving all elements of an alleged violation by a preponderance of the evidence. *In re: Contests of Respirable Dust Sample Alteration Citations*, 17 FMSHRC 1819, 1838 (Nov. 1995), *aff'd*, *Sec'y of Labor v. Keystone Coal Mining Corp.*, 151 F.3d 1096 (D.C. Cir. 1998); *ASARCO Mining Co.*, 15 FMSHRC 1303, 1307 (July 1993); *Garden Creek Pocahontas Co.*, 11 FMSHRC 2148, 2152 (Nov. 1989); *Jim Walter Resources, Inc.*, 9 FMSHRC 903, 907 (May 1987).

As Barrington concluded as a result of MSHA's investigation, it was Penzanter's removal of the left-front screw jack that rendered the rear frame of the loader unstable, resulting in the S&S violation. The sections of the loader had been separated by Rinker's mechanics according to the SOP they had been trained on. The rear section had been left on stable four-point supports, and was securely blocked against hazardous motion. It was Penzanter's violation of Rinker's SOP that rendered the loader unstable and caused the accident.

I find that the Secretary has failed to carry her burden of proving that Rinker was highly negligent with respect to the violation. Rather, its negligence was low.

The Appropriate Civil Penalties

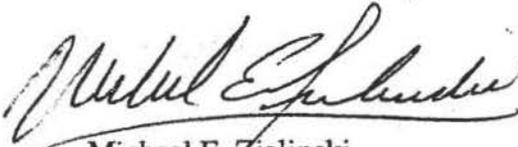
Rinker is a medium-to-small-sized operator, reporting 144,720 hours worked in 2004, and 76,857 hours in 2005. Ex. G-5. Its controlling entity is large. MSHA's computer database shows that, over the 24 month period preceding the accident, Rinker had seven paid violations over four inspection days, an unremarkable record considering the limited amount of data. Rinker has stipulated that imposition of the proposed penalty would not affect its ability to remain in business. The gravity and negligence associated with the alleged violation have been discussed above.

Citation No. 6318499 is affirmed as an S&S violation. However, the Secretary failed to establish that it was the result of the operator's high negligence. Rather, the operator's negligence was low. A specially assessed civil penalty of \$31,000.00 was proposed by the Secretary. Considering that an operator's negligence is the most important factor in MSHA's special assessment process, because it is the factor over which the operator has the most control,

I find that the substantial reduction in the degree of Rinker's negligence should be reflected in a substantial reduction in the amount of the proposed penalty. Upon consideration of the above and the factors enumerated in section 110(i) of the Act, I impose a penalty in the amount of \$9,000.00.

ORDER

Citation No. 6318499 is **AFFIRMED** as modified, and Respondent is directed to pay a civil penalty of \$9,000.00 within 45 days.



Michael E. Zielinski
Administrative Law Judge

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FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

OFFICE OF ADMINISTRATIVE LAW JUDGES
601 New Jersey Avenue, N.W., Suite 9500
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February 25, 2008

ROY G. PETERSON,	:	DISCRIMINATION PROCEEDING
Complainant	:	
	:	Docket No. CENT 2007-45-DM
v.	:	SC-MD 2006-12
	:	
ALCOA WORLD ALUMINA ATLANTIC,	:	Bayer Aluminum Plant
Respondent	:	Mine ID 41-00320

DISMISSAL ORDER

Before: Judge Feldman

This case is before me based on a discrimination complaint filed with this Commission pursuant to section 105(c)(3) of the Federal Mine Safety and Health Act of 1977, as amended, 30 U.S.C. § 815(c)(3) (the Act). The complaint was filed by Roy G. Peterson against Alcoa World Alumina Atlantic (Alcoa). Peterson's complaint, initially filed on September 1, 2006, with the Mine Safety and Health Administration (MSHA), concerns the company's refusal to place him on light duty on several occasions that occurred after several job related injuries in 2002 and 2004. In addition, Peterson complains about tools that he alleges were taken while he was on medical leave during this period. Finally, Peterson complains about the billing of his private insurance for treatment for a job related eye irritation that he sustained in June 2006. Peterson's complaint does not allege that he engaged in any protected safety related activities.

On November 2, 2006, shortly after MSHA advised Peterson that its investigation failed to reveal any violation of section 105(c) of the Mine Act, Peterson filed his discrimination complaint with this Commission. After several delays caused by Alcoa's failure to timely respond to Peterson's complaint, Peterson's response ultimately was filed with the Commission on April 12, 2007. This matter was assigned to me for disposition on April 20, 2007.

Alcoa seeks dismissal of Peterson's complaint because Peterson has failed to allege any activities protected by the Mine Act that allegedly motivated the actions he complains of concerning his medical treatment and/or the loss of his tools.

The following statutory and case law framework is applicable in a discrimination proceeding. Section 105(c)(1) of the Mine Act provides, in pertinent part:

No person shall discharge or in any manner discriminate against . . . any miner . . . because such miner . . . has filed or made a complaint under or related to this Act, including a complaint notifying the operator or the operator's agent . . . of an alleged danger or safety or health violation in a coal or other mine

30 U.S.C. § 815(c)(1). Section 105(c)(2) of the Act, 30 U.S.C. § 815(c)(2) requires a miner who believes he was the victim of discrimination to file a complaint within 60 days of the date of the alleged discrimination.

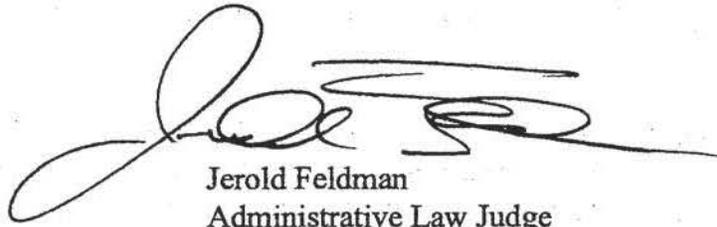
Peterson has the burden of proving a *prima facie* case of discrimination. In order to establish a *prima facie* case, Peterson must establish that he engaged in protected activity, and that the aggrieved action was motivated, in some part, by that protected activity. See *Sec'y of Labor o/b/o Pasula v. Consolidation Coal Co.*, 2 FMSHRC 2786, 2797-2800 (October 1980) *rev'd on other grounds sub nom. Consolidation Coal Co. v. Marshall*, 663 F.2d 1211 (3d Cir. 1981); *Sec'y of Labor o/b/o Robinette v. United Castle Coal Co.*, 3 FMSHRC 803, 817-18 (April 1981).

Alcoa may rebut a *prima facie* case by demonstrating, either that no protected activity occurred, or that the adverse action complained of by Peterson was not motivated in any part by protected activity. *Robinette*, 3 FMSHRC at 818 n.20. Alcoa may also affirmatively defend against a *prima facie* case by establishing that it would have taken the adverse actions complained of even if the protected activity had not occurred. See also *Jim Walter Resources*, 920 F.2d at 750, *citing with approval Eastern Associated Coal Corp. v. FMSHRC*, 813 F.2d 639, 642 (4th Cir. 1987); *Donovan v. Stafford Constr. Co.*, 732 F.2d 954, 958-59 (D.C. Cir. 1984); *Boich v. FMSHRC*, 719 F.2d 194, 195-96 (6th Cir. 1983) (specifically approving the Commission's *Pasula-Robinette* test).

In order to determine if Peterson has demonstrated, considering the facts most favorable to him, that he has a cause of action under the Mine Act, a telephone conference was conducted with Peterson and Alcoa's counsel on April 25, 2007. Peterson stated he was 61 years old and that he had worked for Alcoa as a mechanic for 31½ years. After a medical leave due to a job related shoulder injury, Peterson returned to work in August 2004 until he voluntarily retired on February 1, 2007. During the course of the telephone conference, it was explained to Peterson that worker's compensation issues, and union issues such as reimbursement for his lost equipment, do not give rise to Mine Act jurisdiction.

Putting aside the untimeliness of Peterson's complaint concerning the company's refusal to offer him light duty after his injuries in 2002 and 2004, Peterson did not claim that the company's decision was motivated by protected activity. Similarly, Peterson did not contend that either the loss of his tools, or his worker's compensation dispute concerning his eye condition, was in any way connected to any protected activity. In short, Peterson failed to allege any conduct by Alcoa that violated the anti-discrimination provisions of section 105(c) of the Mine Act.

In view of the above, since Peterson had not identified any protected activity that provided a statutory basis for his complaint, on April 30, 2007, Peterson was ordered to show cause, in writing, why his discrimination complaint should not be dismissed. 29 FMSHRC 352. Specifically, Peterson was requested to identify any protected activity he allegedly engaged in, and to explain why he believed the protected activity was related to the adverse employment conditions he was complaining of. Peterson was advised that his failure to respond would result in the dismissal of his complaint. Peterson has failed to respond to the Order to Show Cause. Accordingly, **IT IS ORDERED** that his discrimination complaint **IS DISMISSED** with prejudice.



Jerold Feldman
Administrative Law Judge

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