## MAY AND JUNE 2007

### COMMISSION DECISIONS AND ORDERS

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### ADMINISTRATIVE LAW JUDGE ORDERS

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MAY AND JUNE 2007

Review was granted in the following cases during the months of May and June:


Empire Iron Mining Partnership v. Secretary of Labor, MSHA, Docket No. LAKE 2006-60-RM. (Judge Barbour, April 13, 2007)


No cases were filed in which Review was denied during the months of May and June
COMMISSION DECISIONS AND ORDERS

On April 16, 2007, the Commission received from Rex a motion to set aside the order of default. Rex states that it filed an answer on October 23, 2006. Attached to its motion was a copy of its Answer. The Secretary has indicated that she does not oppose Rex’s request.

The judge’s jurisdiction in this matter terminated when his decision was issued on April 2, 2007. 29 C.F.R. § 2700.69(b). Relief from a judge’s decision may be sought by filing a petition for discretionary review within 30 days of its issuance. 30 U.S.C. § 823(d)(2); 29 C.F.R. § 2700.70(a). We deem Rex’s motion to constitute a timely filed petition for review, which we grant. See, e.g., Middle States Res., Inc., 10 FMSHRC 1130 (Sept. 1988).

Rex allegedly submitted an answer in October 2006 to the Secretary’s petition for assessment of penalty. However, the Commission apparently did not receive Rex’s answer at that time. Accordingly, the judge entered a default judgment against Rex. Based on the present
record, we are unable to determine whether Rex timely submitted its answer, and if so, why it apparently was not received.

Having reviewed Rex's request, in the interest of justice, we remand this matter to the Chief Administrative Law Judge, who shall determine whether relief from default is warranted, and for further proceedings as appropriate.

Michael F. Duffy, Chairman

Mary Lu Jordan, Commissioner

Michael G. Young, Commissioner

29 FMSHRC 356
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FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

601 NEW JERSEY AVENUE, NW
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May 4, 2007

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

v.

MARCO CRANE & RIGGING COMPANY

BEFORE: Duffy, Chairman; Jordan and Young, Commissioners

ORDER

BY THE COMMISSION:

This matter arises under the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 801 et seq. (2000) ("Mine Act"). On April 9, 2007, the Commission received from Marco Crane & Rigging Company ("Marco") a motion from its counsel requesting to reopen a penalty assessment that had become a final order of the Commission pursuant to section 105(a) of the Mine Act, 30 U.S.C. § 815(a).

Under section 105(a) of the Mine Act, an operator who wishes to contest a proposed penalty must notify the Secretary of Labor no later than 30 days after receiving the proposed penalty assessment. If the operator fails to notify the Secretary, the proposed penalty assessment is deemed a final order of the Commission. 30 U.S.C. § 815(a).

On December 20, 2006, the Department of Labor’s Mine Safety and Health Administration ("MSHA") issued proposed penalty assessment No. 106324 to Marco. Marco did not contest the assessment, and on March 22, 2007, MSHA sent Marco a notice that the penalty in the assessment was delinquent. Marco asserts that the March 22 notice was the first notification that it received of the penalty assessment. On that basis, Marco requests that the Commission reopen the proceeding. The Secretary states that she does not oppose Marco’s request to reopen the penalty assessment.

29 FMSHRC 358
We have held that in appropriate circumstances, we possess jurisdiction to reopen uncontested assessments that have become final Commission orders under section 105(a). *Jim Walter Res., Inc.*, 15 FMSHRC 782, 786-89 (May 1993) ("JWR"). In evaluating requests to reopen final section 105(a) orders, the Commission has found guidance in Rule 60(b) under which, for example, a party could be entitled to relief from a final order of the Commission on the basis of inadvertence or mistake. See 29 C.F.R. § 2700.1(b) ("the Commission and its Judges shall be guided so far as practicable by the Federal Rules of Civil Procedure"); JWR, 15 FMSHRC at 787.

Having reviewed Marco’s request, in the interests of justice, we remand this matter to the Chief Administrative Law Judge for a determination of whether good cause exists for Marco’s failure to timely contest the penalty proposal and whether relief from the final order should be granted. If it is determined that such relief is appropriate, this case shall proceed pursuant to the Mine Act and the Commission’s Procedural Rules, 29 C.F.R. Part 2700.

Michael F. Duffy, Chairman

Mary Lu Jordan, Commissioner

Michael G. Young, Commissioner

29 FMSHRC 359
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29 FMSHRC 360
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May 4, 2007

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

v.

Docket No. WEVA 2007-378
A.C. No. 46-01271-105367

EASTERN ASSOCIATED COAL CORP.

A.C. No. 46-01271-103170

BEFORE: Duffy, Chairman; Jordan and Young, Commissioners

ORDER

BY THE COMMISSION:


Under section 105(a) of the Mine Act, an operator who wishes to contest a proposed penalty must notify the Secretary of Labor no later than 30 days after receiving the proposed penalty assessment. If the operator fails to notify the Secretary, the proposed penalty assessment is deemed a final order of the Commission. 30 U.S.C. § 815(a).

On August 16, 2006, the Department of Labor’s Mine Safety and Health Administration (“MSHA”) issued Order No. 7256017 to Eastern. Eastern contested the order, and that proceeding was stayed by the assigned judge. On November 14, 2006, MSHA sent Eastern a proposed penalty assessment relating to the order. On December 11, 2006, Eastern sent to MSHA the assessment form indicating the contest of the proposed assessment for Order No. 7256017. Eastern then received a letter from MSHA stating that the order had been assessed in error and that a new assessment would be issued. On December 12, 2006, MSHA sent a second proposed penalty assessment covering Order No. 7256017. Eastern asserts that it failed to file a second contest after it received the second assessment because the second assessment was

29 FMSHRC 361
inadvertently misplaced. Eastern further alleges that failure to file the second penalty contest was also a result of miscommunication within the operator's organization. The Secretary states that she does not oppose Eastern's request to reopen the penalty assessment.

We have held that in appropriate circumstances, we possess jurisdiction to reopen uncontested assessments that have become final Commission orders under section 105(a). *Jim Walter Res., Inc.*, 15 FMSHRC 782, 786-89 (May 1993) ("JWR"). In evaluating requests to reopen final section 105(a) orders, the Commission has found guidance in Rule 60(b) under which, for example, a party could be entitled to relief from a final order of the Commission on the basis of inadvertence or mistake. See 29 C.F.R. § 2700.1(b) ("the Commission and its Judges shall be guided so far as practicable by the Federal Rules of Civil Procedure"); JWR, 15 FMSHRC at 787.

Having reviewed Eastern's request, in the interests of justice, we remand this matter to the Chief Administrative Law Judge for a determination of whether good cause exists for Eastern's failure to timely contest the second penalty proposal and whether relief from the final order should be granted. If it is determined that such relief is appropriate, this case shall proceed pursuant to the Mine Act and the Commission's Procedural Rules, 29 C.F.R. Part 2700.

Michael F. Duffy, Chairman

Mary Lu Jordan, Commissioner

Michael G. Young, Commissioner

29 FMSHRC 362
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Washington, D.C. 20001
This matter arises under the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 801 et seq. (2000) ("Mine Act"). On April 12, 2007, the Commission received from George Reed, Inc. ("Reed") a letter from its counsel requesting to reopen a penalty assessment that had become a final order of the Commission pursuant to section 105(a) of the Mine Act, 30 U.S.C. § 815(a).

Under section 105(a) of the Mine Act, an operator who wishes to contest a proposed penalty must notify the Secretary of Labor no later than 30 days after receiving the proposed penalty assessment. If the operator fails to notify the Secretary, the proposed penalty assessment is deemed a final order of the Commission. 30 U.S.C. § 815(a).

On August 30, 2006, the Department of Labor’s Mine Safety and Health Administration ("MSHA") issued Citation Nos. 6387811 and 6387812 to Reed. MSHA subsequently sent the proposed penalty assessment covering those citations to Reed at its address of record indicated on the MSHA Legal Identity Report Form 2000-7. Reed did not contest the assessment in a timely manner. Reed asserts that, prior to the issuance of the proposed penalty assessment, it requested that MSHA send to its counsel copies of all correspondence with regard to the citations. Reed also states that, at the same time, it informed MSHA of its intent to contest the citations and related proposed assessments. On those bases, Reed requests that the Commission reopen the proceeding. Although the Secretary does not oppose the request to reopen, she notes for the record that all proposed penalty assessments are sent by MSHA’s computerized
assessment system and that all assessments are sent to the operator’s address of record on the legal identity form.

We have held that in appropriate circumstances, we possess jurisdiction to reopen uncontested assessments that have become final Commission orders under section 105(a). *Jim Walter Res., Inc.*, 15 FMSHRC 782, 786-89 (May 1993) ("JWR"). In evaluating requests to reopen final section 105(a) orders, the Commission has found guidance in Rule 60(b) under which, for example, a party could be entitled to relief from a final order of the Commission on the basis of inadvertence or mistake. *See* 29 C.F.R. § 2700.1(b) ("the Commission and its Judges shall be guided so far as practicable by the Federal Rules of Civil Procedure"); *JWR*, 15 FMSHRC at 787.

Having reviewed Reed’s request, in the interests of justice, we remand this matter to the Chief Administrative Law Judge for a determination of whether good cause exists for Reed’s failure to timely contest the penalty proposal and whether relief from the final order should be granted. If it is determined that such relief is appropriate, this case shall proceed pursuant to the Mine Act and the Commission’s Procedural Rules, 29 C.F.R. Part 2700.

Michael F. Duffy, Chairman

Mary Lu Jordan, Commissioner

Michael G. Young, Commissioner

29 FMSHRC 365
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29 FMSHRC 366
May 18, 2007

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

v.

U.S. SILICA COMPANY

BEFORE: Duffy, Chairman; Jordan and Young, Commissioners

ORDER

BY THE COMMISSION:


Under section 105(a) of the Mine Act, an operator who wishes to contest a proposed penalty must notify the Secretary of Labor no later than 30 days after receiving the proposed penalty assessment. If the operator fails to notify the Secretary, the proposed penalty assessment is deemed a final order of the Commission. 30 U.S.C. § 815(a).

On July 11, 2006, the Department of Labor’s Mine Safety and Health Administration ("MSHA") issued Citation Nos. 6040003 and 6040006 to U.S. Silica. MSHA subsequently sent proposed penalty assessments covering those citations to U.S. Silica. The assessment forms contain boxes that operators must check to indicate their desire to challenge particular penalties. U.S. Silica asserts that it inadvertently left the boxes unchecked on the contest form, but that it had written on the form that it was contesting those two proposed penalties. U.S. Silica further states that the penalties were inadvertently paid at a later date. On those bases, U.S. Silica requests that the Commission reopen the proceeding. The Secretary does not oppose the request to reopen the proposed penalty assessments.
We have held that in appropriate circumstances, we possess jurisdiction to reopen uncontested assessments that have become final Commission orders under section 105(a). *Jim Walter Res., Inc.*, 15 FMSHRC 782, 786-89 (May 1993) ("JWR"). In evaluating requests to reopen final section 105(a) orders, the Commission has found guidance in Rule 60(b) under which, for example, a party could be entitled to relief from a final order of the Commission on the basis of inadvertence or mistake. See 29 C.F.R. § 2700.1(b) ("the Commission and its Judges shall be guided so far as practicable by the Federal Rules of Civil Procedure"); *JWR*, 15 FMSHRC at 787. We have also observed that default is a harsh remedy and that, if the defaulting party can make a showing of good cause for a failure to timely respond, the case may be reopened and appropriate proceedings on the merits permitted. See *Coal Prep. Servs., Inc.*, 17 FMSHRC 1529, 1530 (Sept. 1995).

Having reviewed U.S. Silica's request, in the interests of justice, we remand this matter to the Chief Administrative Law Judge for a determination of whether good cause exists for U.S. Silica's failure to timely contest the penalty proposal and whether relief from the final order should be granted. If it is determined that such relief is appropriate, this case shall proceed pursuant to the Mine Act and the Commission's Procedural Rules, 29 C.F.R. Part 2700.

Michael F. Duffy, Chairman

Mary Lu Jordan, Commissioner

Michael G. Young, Commissioner

29 FMSHRC 368
Distribution

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601 NEW JERSEY AVENUE, NW
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May 18, 2007

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

v.

TRI-STATE STONE & BUILDING SUPPLY, INC.

BEFORE: Duffy, Chairman; Jordan and Young, Commissioners

ORDER

BY THE COMMISSION:


Under section 105(a) of the Mine Act, an operator who wishes to contest a proposed penalty must notify the Secretary of Labor no later than 30 days after receiving the proposed penalty assessment. If the operator fails to notify the Secretary, the proposed penalty assessment is deemed a final order of the Commission. 30 U.S.C. § 815(a).

On March 23, 2006, the Department of Labor's Mine Safety and Health Administration ("MSHA") issued Citation No. 6038707 to Tri-State. Tri-State timely filed a notice of contest of the citation pursuant to section 105(d) of the Mine Act, 30 U.S.C. § 815(d). On January 16, 2007, MSHA issued a proposed penalty assessment covering the citation. Tri-State did not contest the proposed assessment under section 105(a) and subsequently received a delinquency notice from MSHA. Tri-State asserts that, because the citation had already been contested, it failed to realize that the penalty contest form also had to be returned to MSHA. Tri-State requests that the Commission reopen the proceeding on the basis of inadvertence and mistake.

29 FMSHRC 370
The Secretary states that she does not oppose Tri-State's request to reopen the penalty assessment proceeding.

We have held that in appropriate circumstances, we possess jurisdiction to reopen uncontested assessments that have become final Commission orders under section 105(a). *Jim Walter Res., Inc.*, 15 FMSHRC 782, 786-89 (May 1993) ("JWR"). In evaluating requests to reopen final section 105(a) orders, the Commission has found guidance in Rule 60(b) under which, for example, a party could be entitled to relief from a final order of the Commission on the basis of inadvertence or mistake. *See* 29 C.F.R. § 2700.1(b) ("the Commission and its Judges shall be guided so far as practicable by the Federal Rules of Civil Procedure"); *JWR*, 15 FMSHRC at 787.

Having reviewed Tri-State's request, in the interests of justice, we remand this matter to the Chief Administrative Law Judge for a determination of whether good cause exists for Tri-State's failure to timely contest the penalty proposal and whether relief from the final order should be granted. If it is determined that such relief is appropriate, this case shall proceed pursuant to the Mine Act and the Commission's Procedural Rules, 29 C.F.R. Part 2700.

Michael F. Duffy, Chairman

Mary L. Jordan, Commissioner

Michael G. Young, Commissioner

29 FMSHRC 371
Distribution

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601 New Jersey Avenue, N.W., Suite 9500
Washington, D.C.  20001-2021
BY THE COMMISSION:


Under section 105(a) of the Mine Act, an operator who wishes to contest a proposed penalty must notify the Secretary of Labor no later than 30 days after receiving the proposed penalty assessment. If the operator fails to notify the Secretary, the proposed penalty assessment is deemed a final order of the Commission. 30 U.S.C. § 815(a).

On November 21, 2006, the Department of Labor's Mine Safety and Health Administration ("MSHA") issued proposed penalty assessment No. 103872 to Aker Kvaerner. On December 19, 2006, MSHA issued proposed penalty assessment No. 106188 to Aker

1 Pursuant to Commission Procedural Rule 12, on our own motion, we hereby consolidate docket numbers WEST 2007-394-M and WEST 2007-395-M, both captioned Aker Kvaerner Industrial Constructors, Inc. and both involving similar procedural issues. 29 C.F.R. § 2700.12.

29 FMSHRC 373
Kvaerner. With respect to proposed penalty assessment No. 106188, Aker Kvaerner asserts that it first received notice of the proposed penalty assessment when it received a notice of delinquency in March 2007. It alleges that the proposed assessment was mailed to a former, incorrect address. With respect to proposed penalty assessment No. 103872, Aker Kvaerner asserts that it first learned of the proposed penalty assessment from a subsequent discussion with MSHA informing it that the penalty was also delinquent, apparently because the proposed assessment had also been sent to the same incorrect address. Aker Kvaerner further states that MSHA indicated that it would re-mail the notice of the proposed assessment and “re-set” the 30 days in which to request a formal hearing. Aker Kvaerner alleges that it returned the contest of the proposed penalty upon receipt but that it subsequently learned from MSHA that it needed to contact the Commission to reopen the proceeding. On those bases, Aker Kvaerner requests that the Commission reopen the proceedings. The Secretary states that she does not oppose Aker Kvaerner’s request to reopen.

We have held that in appropriate circumstances, we possess jurisdiction to reopen uncontested assessments that have become final Commission orders under section 105(a). *Jim Walter Res., Inc.*, 15 FMSHRC 782, 786-89 (May 1993) (“JWR”). In evaluating requests to reopen final section 105(a) orders, the Commission has found guidance in Rule 60(b) under which, for example, a party could be entitled to relief from a final order of the Commission on the basis of inadvertence or mistake. See 29 C.F.R. § 2700.1(b) (“the Commission and its Judges shall be guided so far as practicable by the Federal Rules of Civil Procedure”); *JWR*, 15 FMSHRC at 787. We have also observed that default is a harsh remedy and that, if the defaulting party can make a showing of good cause for a failure to timely respond, the case may be reopened and appropriate proceedings on the merits permitted. See *Coal Prep. Servs., Inc.*, 17 FMSHRC 1529, 1530 (Sept. 1995).
Having reviewed Aker Kvaerner's request, in the interests of justice, we remand this matter to the Chief Administrative Law Judge for a determination of whether good cause exists for Aker Kvaerner's failure to timely contest the penalty proposals and whether relief from the final orders should be granted. If it is determined that such relief is appropriate, this case shall proceed pursuant to the Mine Act and the Commission's Procedural Rules, 29 C.F.R. Part 2700.

Michael F. Duffy, Chairman

Mary Lu Jordan, Commissioner

Michael G. Young, Commissioner

29 FMSHRC 375
Distribution

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May 22, 2007

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

v.

Docket No. KENT 2007-266
A.C. No. 15-18370-107844

PREMIER ELKHORN COAL COMPANY

BEFORE: Duffy, Chairman; Jordan and Young, Commissioners

ORDER

BY THE COMMISSION:


Under section 105(a) of the Mine Act, an operator who wishes to contest a proposed penalty must notify the Secretary of Labor no later than 30 days after receiving the proposed penalty assessment. If the operator fails to notify the Secretary, the proposed penalty assessment is deemed a final order of the Commission. 30 U.S.C. § 815(a).

On January 11, 2007, the Department of Labor's Mine Safety and Health Administration ("MSHA") issued proposed penalty assessment No. 107844 to Premier Elkhorn. Premier Elkhorn asserts that it inadvertently sent the contest of the proposed penalties, along with payment of uncontested penalties, to MSHA's Pittsburgh office rather than to the correct MSHA office located in Arlington, Virginia. Premier Elkhorn requests that the Commission reopen the proceeding based on its inadvertence and mistake. Although the Secretary does not oppose the request to reopen the proposed penalty assessment, she notes that in recent months Premier Elkhorn has previously filed two motions to reopen on the very same grounds of sending the contest to the wrong MSHA office and suggests that Premier Elkhorn take steps to ensure that future contests are sent to MSHA's Civil Penalty Compliance Office in Arlington, Virginia.

29 FMSHRC 377
We have held that in appropriate circumstances, we possess jurisdiction to reopen uncontested assessments that have become final Commission orders under section 105(a). *Jim Walter Res., Inc.*, 15 FMSHRC 782, 786-89 (May 1993) ("JWR"). In evaluating requests to reopen final section 105(a) orders, the Commission has found guidance in Rule 60(b) under which, for example, a party could be entitled to relief from a final order of the Commission on the basis of inadvertence or mistake. See 29 C.F.R. § 2700.1(b) ("the Commission and its Judges shall be guided so far as practicable by the Federal Rules of Civil Procedure"); *JWR*, 15 FMSHRC at 787. We have also observed that default is a harsh remedy and that, if the defaulting party can make a showing of good cause for a failure to timely respond, the case may be reopened and appropriate proceedings on the merits permitted. See *Coal Prep. Servs., Inc.*, 17 FMSHRC 1529, 1530 (Sept. 1995).

Having reviewed Premier Elkhorn's request, in the interests of justice, we remand this matter to the Chief Administrative Law Judge for a determination of whether good cause exists for Premier Elkhorn's failure to timely contest the penalty proposal and whether relief from the final order should be granted. If it is determined that such relief is appropriate, this case shall proceed pursuant to the Mine Act and the Commission's Procedural Rules, 29 C.F.R. Part 2700.

Michael F. Duffy, Chairman

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Federal Mine Safety & Health Review Commission
601 New Jersey Avenue, N.W., Suite 9500
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Under section 105(a) of the Mine Act, an operator who wishes to contest a proposed penalty must notify the Secretary of Labor no later than 30 days after receiving the proposed penalty assessment. If the operator fails to notify the Secretary, the proposed penalty assessment is deemed a final order of the Commission. 30 U.S.C. § 815(a).

On August 10, 2006, the Department of Labor’s Mine Safety and Health Administration ("MSHA") issued proposed penalty assessment No. 000095341 to Rockhouse, covering 43 citations and orders. According to Rockhouse, it marked the assessment form to contest 27 of the penalties proposed. However, the assessment form that Rockhouse forwarded by telecopier to its counsel omitted a page of the assessment. Consequently, Rockhouse’s counsel only contested 16 of the penalties, in a proceeding presently pending in Docket No. KENT 2006-500. Rockhouse now requests that the 11 other proposed penalties on the missing page that it intended to contest be reopened. The Secretary states that she does not oppose Rockhouse’s request to reopen.
We have held that in appropriate circumstances, we possess jurisdiction to reopen uncontested assessments that have become final Commission orders under section 105(a). Jim Walter Res., Inc., 15 FMSHRC 782, 786-89 (May 1993) ("JWR"). In evaluating requests to reopen final section 105(a) orders, the Commission has found guidance in Rule 60(b) under which, for example, a party could be entitled to relief from a final order of the Commission on the basis of inadvertence or mistake. See 29 C.F.R. § 2700.1(b) ("the Commission and its Judges shall be guided so far as practicable by the Federal Rules of Civil Procedure"); JWR, 15 FMSHRC at 787. We have also observed that default is a harsh remedy and that, if the defaulting party can make a showing of good cause for a failure to timely respond, the case may be reopened and appropriate proceedings on the merits permitted. See Coal Prep. Servs., Inc., 17 FMSHRC 1529, 1530 (Sept. 1995).

Having reviewed Rockhouse's request, in the interests of justice, we remand this matter to the Chief Administrative Law Judge for a determination of whether good cause exists for Rockhouse's failure to timely contest the penalty proposals and whether relief from the final order should be granted. If it is determined that such relief is appropriate, this case shall proceed pursuant to the Mine Act and the Commission's Procedural Rules, 29 C.F.R. Part 2700.

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Mary Lu Jordan, Commissioner

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29 FMSHRC 382
FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

601 NEW JERSEY AVENUE, NW
SUITE 9500
WASHINGTON, DC 20001

June 14, 2007

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

v.
Docket No. WEST 2007-51-M

CHEMICAL LIME COMPANY OF ARIZONA, INC.

DIRECTION FOR REVIEW AND ORDER

This matter arises under the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 801 et seq. (2000) (“Mine Act” or “Act”). On May 10, 2007, Chief Administrative Law Judge Robert J. Lesnick issued a Decision Approving Penalty and Order of Dismissal in this civil penalty proceeding. In his decision, the judge stated that the Commission had been informed by the Secretary of Labor that the penalty in this case had been paid. He approved the $625 penalty assessment and dismissed the case.

On June 6, 2007, the Commission received from Chemical Lime Company of Arizona (“Chemical Lime”) a petition for discretionary review. In the petition, Chemical Lime asks that the judge’s decision be set aside and the case remanded for further proceedings before the judge.

The judge’s jurisdiction over this case terminated when he issued his decision on May 10, 2007. 29 C.F.R. § 2700.69(b). Relief from a judge’s decision may be sought by filing a petition for discretionary review within 30 days of its issuance. 30 U.S.C. § 823(d)(2)(A)(i); 29 C.F.R. § 2700.70(a). Chemical Lime’s petition has been timely filed and is hereby granted.

On September 14, 2006, the Department of Labor’s Mine Safety and Health Administration (“MSHA”) issued proposed penalty assessment No. 000098576 to Chemical Lime. In its petition, Chemical Lime alleges that it contested the underlying citation and answered the Secretary’s petition for assessment of penalty. It explains further that in October 2006, it issued a check to MSHA as payment for a different proposed penalty assessment, No. 000091132. According to Chemical Lime, it subsequently learned that $625 of this payment was applied to the proposed penalty for penalty assessment No. 000098576, which is the subject of this penalty proceeding. It states that MSHA has now updated its records to reflect that Chemical

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Lime has not paid the proposed penalty for penalty assessment No. 000098576, and attaches a current MSHA Data Retrieval System notice indicating that the penalty has not been paid. See Exhibit D to Petition for Discretionary Review. The Secretary states that the factual representations in the petition for discretionary review are accurate, and that she does not oppose the operator's request that the Commission set aside the judge's order of dismissal and remand the case to the judge for further proceedings.

Based on the present record, it appears that the judge may have prematurely dismissed the proceeding. In the interest of justice, we vacate the judge's May 10 decision and remand this matter to the judge for further proceedings as appropriate. See RBS, Inc., 26 FMSHRC 751, 752 (Sept. 2004).

Michael F. Duffy, Chairman

Mary Lu Jordan, Commissioner

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29 FMSHRC 385
FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

601 NEW JERSEY AVENUE, NW
SUITE 9500
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June 22, 2007

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

v.

DON ERICKSON, employed by
RAYMOND SAND & GRAVEL, INC.

BEFORE: Duffy, Chairman; Jordan and Young, Commissioners

ORDER

BY THE COMMISSION:

This matter arises under the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 801 et seq. (2000) ("Mine Act"). On May 31, 2007, the Commission received from Don Erickson, the President of Raymond Sand & Gravel, Inc. ("RS&G"), a motion made by counsel to reopen a penalty assessment against Erickson under section 110(c) of the Mine Act, 30 U.S.C. § 820(c), that had become a final order of the Commission pursuant to section 105(a) of the Mine Act, 30 U.S.C. § 815(a).

Under the Commission’s Procedural Rules, an individual charged under section 110(c) has 30 days following receipt of the proposed penalty assessment within which to notify the Secretary of Labor that he or she wishes to contest the penalty. 29 C.F.R. § 2700.26. If the individual fails to notify the Secretary, the proposed penalty assessment is deemed a final order of the Commission. 29 C.F.R. § 2700.27.

On February 12, 2007, the Department of Labor’s Mine Safety and Health Administration ("MSHA") issued proposed penalty assessment No. 00110978A to Erickson, pursuant to section 110(c) of the Mine Act, for three orders and one citation for which RS&G had already received, and contested, proposed penalties in a separate proposed assessment. Shortly thereafter, the Secretary filed and served RS&G with a petition for assessment of penalty for the penalties it was contesting. Erickson, acting pro se at that time, mistakenly assumed that the petition also

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included the penalties MSHA was seeking to collect from him as an individual, and consequently did not separately contest those penalties. The Secretary states that she does not oppose Erickson's request to reopen the penalty assessment.

We have held that in appropriate circumstances, we possess jurisdiction to reopen uncontested assessments that have become final Commission orders under section 105(a). Jim Walter Res., Inc., 15 FMSHRC 782, 786-89 (May 1993) ("JWR"). In evaluating requests to reopen final section 105(a) orders, the Commission has found guidance in Rule 60(b) under which, for example, a party could be entitled to relief from a final order of the Commission on the basis of inadvertence or mistake. See 29 C.F.R. § 2700.1(b) ("the Commission and its Judges shall be guided so far as practicable by the Federal Rules of Civil Procedure"); JWR, 15 FMSHRC at 787. We have also observed that default is a harsh remedy and that, if the defaulting party can make a showing of good cause for a failure to timely respond, the case may be reopened and appropriate proceedings on the merits permitted. See Coal Prep. Servs., Inc., 17 FMSHRC 1529, 1530 (Sept. 1995).

Having reviewed Erickson's request, in the interests of justice, we remand this matter to the Chief Administrative Law Judge for a determination of whether good cause exists for Erickson's failure to timely contest the penalty proposal and whether relief from the final order should be granted. If it is determined that such relief is appropriate, this case shall proceed pursuant to the Mine Act and the Commission's Procedural Rules, 29 C.F.R. Part 2700.

Michael F. Duffy, Chairman

Mary Lu Jordan, Commissioner

Michael G. Young, Commissioner

29 FMSHRC 387
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601 New Jersey Avenue, N.W., Suite 9500
Washington, D.C.  20001-2021
June 22, 2007

SECRETARY OF LABOR, MINE SAFETY AND HEALTH ADMINISTRATION (MSHA) v. STATE OF ALASKA DEPARTMENT OF TRANSPORTATION AND PUBLIC FACILITIES

BEFORE: Duffy, Chairman; Jordan and Young, Commissioners

ORDER

BY THE COMMISSION:

This matter arises under the Federal Mine Safety and Health Act of 1977, 30 U.S.C. §§ 801 et seq. (2000) ("Mine Act"). On May 29, 2007, the Commission received from counsel for the Alaska Department of Transportation and Public Facilities ("ADOT & PF") a letter requesting reconsideration of the response by the Department of Labor’s Mine Safety and Health Administration ("MSHA") to ADOT & PF’s request that it be granted a hearing on a penalty assessment that had been issued to ADOT & PF. We construe the letter as a motion to reopen the assessment, which ADOT & PF believes had become a final order of the Commission pursuant to section 105(a) of the Mine Act, 30 U.S.C. § 815(a).

Under section 105(a) of the Mine Act, an operator who wishes to contest a proposed penalty must notify the Secretary of Labor no later than 30 days after receiving the proposed penalty assessment. If the operator fails to notify the Secretary, the proposed penalty assessment is deemed a final order of the Commission. 30 U.S.C. § 815(a).

On December 7, 2005, MSHA issued proposed penalty assessment No. 000074414 to ADOT & PF. On December 26, 2005, ADOT & PF filed a timely notice of contest. According to ADOT & PF, it heard nothing further on the matter until it realized that the proposed penalty was included among several penalties that a collection agency was seeking to collect from ADOT & PF on behalf of MSHA. The Secretary states that she does not oppose reopening, and concedes that ADOT & PF filed a timely notice of contest.

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Having reviewed ADOT&PF's motion and the Secretary's response, we conclude that the proposed assessment at issue has not become a final order of the Commission because ADOT&PF timely contested it. We deny ADOT&PF's motion as moot and remand this matter to the Chief Administrative Law Judge for further proceedings as appropriate pursuant to the Mine Act and the Commission's Procedural Rules, 29 C.F.R. Part 2700. See Lehigh Cement Co., 28 FMSHRC 440, 441 (July 2006).

Michael F. Duffy, Chairman

Mary Lu Jordan, Commissioner

Michael G. Young, Commissioner

29 FMSHRC 390
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Chief Administrative Law Judge Robert J. Lesnick
Federal Mine Safety & Health Review Commission
601 New Jersey Avenue, N.W., Suite 9500
Washington, D.C. 20001-2021
POWDER RIVER COAL, LLC,  
Contestant

v.

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

POWDER RIVER COAL, LLC,  
Respondent

CONTEST PROCEEDINGS  
Docket No. WEST 2006-433-R  
Citation No. 7609689; 05/17/2006

Docket No. WEST 2006-434-R  
Order No. 7609690; 05/17/2006

Docket No. WEST 2006-435-R  
Order No. 7610075; 05/17/2006

North Antelope Rochelle Mine  
Mine ID 48-01353

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

v.

POWDER RIVER COAL, LLC,  
Respondent

CIVIL PENALTY PROCEEDING  
Docket No. WEST 2007-026  
A.C. No. 48-01353-97471

North Antelope Rochelle Mine

DECISION


Before: Judge Manning

These cases are before me on three notices of contest filed by Powder River Coal, LLC, ("Powder River") and one petition for assessment of civil penalty filed by the Secretary of Labor, acting through the Mine Safety and Health Administration ("MSHA") 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"). Powder River contested a citation and two orders of withdrawal issued by the Secretary under section 104(d)(1) of the Mine Act. An evidentiary hearing was held in Gillette,
Wyoming. The parties introduced testimony and documentary evidence and filed post-hearing briefs.

I. THE CITATION AND ORDERS AT ISSUE

Powder River owns and operates a large surface coal mine known as the North Antelope Rochelle Mine in Campbell County, Wyoming. The mine has over 1,000 employees and also employs many contractors. The mine operates twenty-four hours a day, seven days a week and produced about 88.5 million tons of coal in 2006.

Powder River operates an electric mining shovel designated as Shovel No. 104, which is a P&H 4100 shovel. Electric power is supplied to this shovel by a 7200-volt trailing cable that is attached to the rear of the shovel’s car body. This type of shovel is the largest manufactured shovel in the mining industry. It is no exaggeration to say that it is about the size of a small ship. (Ex. G-1, p. 11). On April 19, 2006, the shovel was undergoing preventive maintenance (“PM”). Eight maintenance technicians, including both mechanics and electricians, were assigned to the shovel. During a PM, technicians periodically leave the shovel and depart in their vehicles to obtain parts or to work on other projects. The technicians assigned to this PM came and went as needed. (Tr. 117). While the PM was underway, there were a number of maintenance and service vehicles parked behind and on the right side of the shovel. There was no production operator assigned to the shovel during the shift and no production crew was present. The maintenance crew was also performing a center pin adjustment, which required that the bucket be in a raised position and that power to the shovel not be locked out.1 On that same day, a safety audit team, made up of five members of mine management, conducted a safety audit of the shovel. The alleged actions of the members of this audit team are the subject of the citation and orders at issue.

On May 3, 2006, the MSHA Gillette field office received an anonymous complaint that someone at the mine had walked under a suspended load. MSHA Inspectors Scott Markve and Todd Jaqua investigated the complaint. After touring the mine and talking to people they decided that they had insufficient information to substantiate the complaint.

On May 9, 2006, a second complaint was filed that provided more details about the alleged incident. The complaint stated that someone walked under a suspended load during a center pin adjustment on Shovel No. 104 on April 19, 2006. The inspectors resumed their investigation upon receipt of this complaint. At the conclusion of their investigation, they issued a citation and two orders.

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1 The shovel pivots or swings around the center pin. During the center pin adjustment, which is also referred to as the center nut adjustment and the tightening of the center pin nut, mechanics enter the house on the shovel, remove the guards from around the center pin, and tighten the center pin down. The bucket must be in the raised position to balance the weight of the shovel around the center pin.
Inspector Markve issued Citation No. 7609689 under section 104(d)(1) of the Mine Act alleging a violation of section 77.409(a) as follows, in part:

The [No. 104] shovel, located in the Boltz pit, was operated in the presence of persons exposed to a hazard from its operation. While the bucket was raised to perform adjustments, a member of the Mine Audit team (made up of five members of mine management) was observed by three miners within the swing radius and under the raised bucket of the shovel. In addition, four members of the team had also boarded the shovel without notifying the operator of the shovel.

Inspector Markve determined that an injury was highly likely and that any injury resulting from the violation is likely to be fatal. He determined that the violation was of a significant and substantial nature ("S&S") and that Powder River’s negligence demonstrated reckless disregard. He also determined that the violation was a result of Powder River’s unwarrantable failure to comply with the safety standard. The safety standard provides, in part, that “[s]hovels . . . shall not be operated in the presence of any person exposed to a hazard from its operation . . . .” The Secretary proposes a penalty of $9,700.00 for this citation.

Inspector Markve also issued Order No. 7609690 under section 104(d)(1) of the Mine Act. This order alleged a violation of section 48.31(a) because the five people on the audit team had not been provided with hazard training prior to performing the audit on the No. 104 shovel on April 19, 2006. At the hearing the Secretary agreed to modify the order to a section 104(a) non-S&S citation with moderate negligence. (Stip. 8). The number of persons affected by the violation was modified to one and Powder River agreed to pay a penalty of $463.00 for the violation.

Inspector Jaqua issued Order No. 7610075 under section 104(d)(1) of the Mine Act alleging a violation of section 77.1607(f) as follows, in part:

The equipment operator was present on the [No. 104] shovel and was not notified before members of a mine management safety audit team boarded . . . . The audit team, consisting of five members in management, approached from the rear of the shovel unannounced. All members were out of the operator’s field of vision while maintenance was being performed on the center pin. Adjustments to the center pin required the operator to be in control of all shovel operations with the exception of the swing motion. The bucket was raised off the ground as part of the manufacturer’s standard operating procedures to balance the weight of the shovel off the center pin. During the adjustment at least four members of the audit team boarded the shovel.
Inspector Jaqua determined that an injury was reasonably likely and that any injury resulting from the violation was likely to be fatal. He determined that the violation was S&$ and that Powder River's negligence was high. He also determined that the violation was a result of Powder River's unwarrantable failure to comply with the safety standard. The safety standard provides that "[w]hen an equipment operator is present, men shall notify him before getting on or off equipment." The Secretary proposes a penalty of $6,000.00 for this order.

II. SUMMARY OF THE TESTIMONY

The citation and orders were issued because of the manner in which the audit team conducted the safety inspection. MSHA contends that, because the safety audit team approached the shovel without alerting the equipment operator, the members of the team exposed themselves to several hazards associated with the operation of the machine. Therefore, MSHA asserts, there were clear violations of the above-cited standards. In contrast, Powder River argues that, because the coal shovel at issue was down for preventive maintenance at the time of the audit team's arrival, there was no hazard created by the shovel and therefore no violations of the safety standards. All of the evidence relates to the events of April 19, 2006, at the shovel. Neither MSHA inspector was present at the time of the alleged violations.

During his investigation, Inspector Markve interviewed employees and managers at the mine site and examined the coal shovel. As a result of the investigation, MSHA concluded that the shovel was operated in the presence of persons exposed to a hazard from its operation. Inspector Markve testified that three miners told him that, while the bucket of the shovel was raised to perform adjustments, a member of the safety audit team walked within the swing radius of the boom of the shovel and under the raised bucket of the shovel. (Tr. 49, 50-51, 59, 68-71). Inspector Markve was also advised by the maintenance crew making the center pin adjustment on the shovel that the audit team approached unseen from the rear during this adjustment without notice. (Tr. 59-61). Markve was told by the person operating the shovel that he first realized that the audit team was present when a team member opened the door to his cab. (Tr. 54-55). In addition, Inspector Markve said that, according to all of his interviews, the power to the shovel was on at the time, meaning that the power cord to the shovel was energized and the machine was capable of movement. (Tr. 52-53). Inspector Markve testified that, when members of the audit team asked why the power was not locked out during the procedure, the mechanics told the audit team that power to the machine was necessary when adjusting the center pin. (Tr. 55, 66).

Inspector Markve testified that he issued Citation No. 7609689 to Powder River Coal Company because members of the audit team were exposed to hazards from the shovel's operation. Markve testified that the shovel operator Steve Davis, electrician Dustin Freed, and maintenance worker Layton Villalobos observed Mark Bunney of the audit team walk underneath the sticks, boom, and bucket of the shovel.2 (Tr. 75-77; Ex. G-1). These men said they were able

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2 The two sticks, which are attached to the back of the bucket, connect the bucket with the boom of the shovel and are used to move the bucket in and out. (Tr. 352-53; Ex. G-1(6)).

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to identify Bunney because of the clothing he was wearing. (Tr. 76). He testified that he designated the violation as S&S because the manner in which the mine audit team arrived unannounced and dispersed throughout the area around the shovel put the team in danger of serious injury. (Tr. 87-88). He also testified that people have been killed by exposure to moving equipment at other mines. (Tr. 88, 95-96, 111; Ex. G-9). In addition, Markve testified that MSHA has issued several warnings to mine operators on how to avoid pedestrian injuries resulting from equipment operation. (Tr. 90-94; Exs. G-7 through G-9). Finally, Inspector Markve mentioned that the North Antelope Rochelle safety rules prohibit miners from being within the swing radius of a shovel or under a suspended load and that managers from the mine had attended an MSHA meeting at which similar dragline and shovel hazards were discussed (Tr. 101-02, 104-05, 109; Exs. G-6, G-11). He admitted that, although the trailing cable to the shovel was energized, the shovel would need to be turned on before it could move. He also testified that when the shovel’s ladder is down and the shovel is turned off, the shovel cannot swing, the sticks that operate the boom for the bucket cannot move, and the bucket cannot be raised or lowered. (Tr. 122-23).

Steven Davis, the maintenance technician who was assigned to be in the cab of the shovel on April 19, testified that a center pin adjustment requires at least three mechanics. Typically, the mechanics clear the area of any unnecessary personnel, remove the guards that are around the center pin, and attempt to tighten the center pin nut. If the nut cannot be turned, then the shovel is turned on and the bucket is raised to balance the weight of the shovel around the pin. Often the shovel operator will bounce the bucket up or down so that the shovel’s weight shifts allowing the pin to be tightened. (Tr. 162-67). The mechanic who operates the shovel during the center pin adjustment must stay in the cab at all times and he depends on the mechanics in the house to tell him what he needs to do to assist them.

Davis testified that he arrived at the shovel in a boom truck on April 19 to do some welding. When the center pin adjustment was started, the electricians left the shovel because power to the shovel needs to be locked out when performing electrical work. Davis was assigned to sit in the cab during the center pin adjustment and the mechanics in the house shouted up the stairs to the cab whenever they needed him to take some action. When the mechanics asked him to raise the bucket, he honked the horn, pushed the start button on his console, released the brakes for the boom, and hoisted the bucket into the air. (Tr. 177-78). He put the bucket in the fully extended position so as to balance the weight of the shovel on the center pin. When a mechanic told him that they could not tighten the center pin, Davis shook the shovel by moving the bucket up and down in an attempt to reposition the machine. (Tr. 181-82). He had to bounce the shovel several times.

While waiting for further instructions from the mechanics, two people from the audit team opened the door to his cab and told him they were there for a safety audit. Davis testified

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3 The boom truck was also referred to as the “service truck,” “knuckle truck,” and “welding truck” at the hearing.
that nobody from the audit team radioed him to announce that they were boarding the shovel. Davis stated that he believes that this action was dangerous because, if he had been asked to bounce the shovel again or if he had released the brakes for the sticks or bucket, they could have been injured by the sudden movement. (Tr. 186).

Mr. Davis also testified that while he was waiting for further instructions, an electrician walked up to him and pointed out a guy walking under the bucket. On direct examination, Davis testified that he saw a man walk from the left side of the shovel, under the right corner of the bucket, to the boom truck parked to the right of the bucket. (Tr. 193-96, 215-16; Ex. G-15). He stated that this was dangerous because loose material on the bucket could fall. Davis stated that, based on the clothes the man was wearing as well as his frame, he believes that the man he observed under the bucket was Mark Bunney. He wrote out a statement to that effect. (Ex. G-16 (2)). The power was turned off when he saw Mr. Bunney walk under the bucket. (Tr. 224).

Dustin Freed, an electrician, testified that he was at the shovel on April 19 to perform a minor adjustment on the switch for the shovel's ladder. He testified that while he was waiting for the mechanics to complete the center pin adjustment, he saw a man under the raised bucket of the shovel. (Tr. 247, 250). More specifically, he stated that he looked down from the cab of the shovel to see a man checking the chock blocks on the boom truck. Freed testified that the man backed up to a point where he was "pretty close to being under [the bucket]." (Tr. 249). At this point, he asked Mr. Davis whether it appeared that he was under the bucket. He believed that the man in question was a member of the audit team. (Tr. 250).

Layton Villalobos, a mechanic, testified that while he was in the house on the shovel with another mechanic adjusting the center pin, three or four members of the audit team arrived and asked why the power to the shovel was not locked out. Villalobos replied that they needed the power so that the bucket could be raised during the center pin adjustment. He stated that when he left the house and walked out on the catwalk, he saw a man looking at the back of the boom truck. He believed that the man was "under the sticks, in between where the bucket would be and the tracks" of the shovel. (Tr. 265-67). When Villalobos was at the bottom of the shovel's ladder he saw the man under the sticks walking parallel to the boom truck. (Tr. 263-64, 268-69). The man was walking a few feet from the boom truck, toward the front of that truck. (Tr. 270-72). The bucket did not move when he saw the man near the boom truck. If the bucket had been lowered at that time, Villalobos believed that it could have hit the man and the boom truck.

Inspector Todd Jaqua testified that he issued Order No. 7610075 because the audit team did not notify the operator of the shovel that they were going to be on and near the shovel. (Tr. 278-79). He also concluded that three of the five audit team members boarded the shovel while the bucket was extended in the air. The failure to notify the equipment operator that people would be approaching the shovel leaves those approaching without proper notice of the hazards that might be present in or around such equipment. In this instance, the members of the audit team were exposed to hazards because they were unsure about whether the shovel was powered and whether it was capable of movement. (Tr. 281). The common practice is to get visual
confirmation of one’s presence from an operator prior to approaching. If such confirmation is not possible, then it is standard practice to get audio confirmation by radio or other means. He believes that this is required with respect to active equipment that is in production and equipment that is under maintenance if an equipment operator is present. (Tr. 283). He testified that he designated the violation as S&S because five people entered the area without knowledge of the specific hazards that might be present. Inspector Jaqua admitted that with the ladder down, the shovel could not swing. He was not sure if it could propel with the ladder down. (Tr. 298-99).

Roger Rasmussen testified for Powder River. Mr. Rasmussen was the Field Maintenance and Electrical Coordinator at the mine. He testified that a PM is typically performed on coal shovels every two weeks. During a PM, maintenance workers park their vehicles close to the shovel and they enter and exit the shovel throughout the day via the ladder. (Tr. 334-335). He testified that it has never been the mine’s practice to notify the potential operator of a shovel that is down for a PM prior to boarding because “it’s not practical . . . [and the shovel’s] not in operation.” (Tr. 336). Shovel No. 104 was scheduled for an all day PM on April 19 and several maintenance procedures were scheduled to be performed.

James Single, the Production Coordinator, testified that a safety audit team consists of a group of supervisors who go through a work area looking for safety infractions. (Tr. 396). On April 19, he assembled an audit team and decided to visit the 104 shovel because it was down for a PM. He drove the team to the Boltz Pit in a van. He stopped the van about 400 feet behind the shovel for observation and then followed a vacuum truck up to the back of the shovel and parked. Several trucks were parked behind and to the right of the shovel, including a boom truck directly to the right of the shovel’s raised bucket, a pickup truck with an attached trailer that was parked at the base of the shovel’s ladder, several pickup trucks behind the shovel, and the vacuum truck. (Tr. 401-03; Ex. R-1). Single testified that with the ladder down, the shovel could not propel or swing. (Tr. 403-04, 406). Consequently, he believes that it was safe for vehicles to park around the shovel and for miners to enter and exit the shovel.

When the audit team got out of the van, two people walked up the ladder and entered the shovel house to see if there were any accumulations of grease. The shovel is quite loud when it is running so he knew that it was not running at that time. (Tr. 416-17). He talked to mechanics who were doing some work on the ceiling in the shovel house and he talked to the mechanics who were tightening the center pin. He followed another audit team member, Kathy King, into the cab of the shovel. Single discussed whether the power should be locked out during a center pin adjustment and Davis explained that it cannot be locked out because he needs to be able to move the bucket. Later, a mechanic came up to the cab to tell Davis that the bucket should be lowered to the ground as they had finished the center pin adjustment. Davis then turned on the shovel, honked the horn, lowered the bucket, and turned the shovel off again. (Tr. 413-415). The bucket did not strike or come close to the boom truck, which was 10 to 20 feet to the right of the bucket, when the bucket was lowered.
Mark Bunney, the Warehouse Manager, testified that he was on the safety audit team on April 19. When the team arrived at the Boltz Pit, he got out of the van and looked at the shovel. He stated that he knew that the shovel was off because he could not hear the fans and the ladder was down. (Tr. 436-37). He saw Dustin Freed and told him that they were there for a safety audit. Mr. Freed did not warn the audit team that it was unsafe to board the shovel. Bunney testified that he walked around the vehicles parked on the right side of the shovel looking for safety problems. He noticed that the chock on the rear driver’s side of the boom truck was out of place. (Tr. 444-45). He re-aligned the chock and inspected the cab of the vehicle. He stated that he then walked toward the ladder of the shovel and that at no time did he walk along the left side of the shovel. (Tr. 449). After he boarded the shovel, he talked to the mechanics. Soon thereafter, the mechanics advised the team that the shovel was about to be started and they should leave the house. Bunney testified that he went down the ladder and proceeded to the rear of the shovel. The audit team left the shovel area shortly thereafter.

Mr. Bunney testified that, later that day, he heard that Mr. Davis accused him of walking under the bucket. Bunney stated that he immediately denied doing so to Rick Case, who was foreman for Davis’s crew. (Tr. 449-50). Other members of the audit team told Mr. Case that Bunney had never walked along the left side of the shovel. The driver of the vacuum truck, who worked for an independent contractor, also told Case that Bunny had walked along the right side of the shovel when he inspected the boom truck. Bunney also testified that he never walked under the sticks or under the bucket when he was inspecting the boom truck and he did not see anyone else doing so. Later that same day, Bunney talked to Davis about his accusation. Bunney testified that Davis apologized to him and said that he did not see Bunney walk under the bucket. (Tr. 453).

III. DISCUSSION WITH FINDINGS OF FACT AND CONCLUSIONS OF LAW

As stated above, power is supplied to the shovel via a trailing cable that enters at the back of the shovel. Inside the cab on this shovel there is a red start button. That button must be pushed to energize the main transformer on the shovel. Once the transformer is energized, it supplies power to the 600-volt bus bar which, in turn, energizes various motors and fans on the shovel. The fans create a significant amount of noise, between 90 and 100 decibels in the house. (Tr. 346). Anyone in a parked vehicle near the shovel can hear the fans.

The shovel is designed to propel forward and backward on tracks. It can also swing, which rotates everything on the shovel that is above the tracks. The shovel operator can raise and lower the bucket and he can crowd the bucket, which is moving the bucket toward and away from the house on the shovel. The shovel’s sticks are used during this crowding function. The controllers for all of these movements are located in the cab of the shovel which is about 20 feet above the ground. The shovel is equipped with propel, swing, hoist, and crowd brakes and the release buttons for these brakes are also in the cab.
The above-described brakes on the shovel cannot be released until the shovel is turned on using the red start button. In addition, the shovel will not propel or swing when the ladder is in the down position. Only the bucket hoisting and crowding functions can operate with the ladder down. The operator of the shovel cannot raise or lower the ladder from the cab. To raise the ladder, someone must go to the top of the ladder to switch on the motor that lifts up the ladder.

In order for the shovel operator to move the bucket (hoist or crowd), he must turn on the shovel, sound a horn, and depress either the hoist release or crowd release button, or both, in the cab. When the shovel is turned off with the bucket in a raised position, the hoist brake is automatically applied. The shovel operator has a good view of the ground in front of the shovel, especially to the right. Visibility is not as good to the front-left side of the shovel.

On April 19, 2006, there was maintenance activity on the shovel at the time the audit team arrived. There was an operator in the cab, the bucket was in a raised position, and the ladder was down. The shovel operator, Mr. Davis, was trained to operate the shovel for limited operations, known as “start-up, move, and shut down” procedures (“SMS”). Thus, Davis is known as an SMS operator because he never operates the shovel during production. About six vehicles were parked to the rear and to the right of the shovel. No vehicles were parked on the shovel’s left side.

When the safety audit team arrived at the shovel, its members knew that the shovel was undergoing a PM and was not in production. Mr. Single, the audit team leader, saw that the ladder was down and saw at least one maintenance technician come down the ladder. The only time that the shovel operator turned on the shovel during the safety audit was to lower the bucket after the center pin was tightened. The team members were warned that the bucket would be lowered.

A. Citation No. 7609689; §77.409(a)

I find that the Secretary did not establish a violation of section 77.409(a). The citation charges that the shovel was operated in the presence of the audit team members and that they were exposed to a hazard from its operation. Specifically, it states that “[w]hile the bucket was in a raised position to perform adjustments, a member of a mine audit team (made up of five members of mine management) was observed by three miners within the swing radius and under the raised bucket of the shovel.” The citation further alleges that “four members of the team had also boarded the shovel without notifying the operator of the shovel.” The safety standard states:

Shovels, draglines, and tractors shall not be operated in the presence of any person exposed to a hazard from its operation and all such equipment shall be provided with an adequate warning device which shall be sounded by the operator prior to starting operation.
Powder River first argues that, because the shovel was in a PM mode rather than in production, the safety standard does not apply. I reject this argument because the safety standard is not so limited. It also argues that, if the standard does apply, it was not provided with adequate notice that the standard was applicable to shovels that are down for a PM. I also reject this argument. The phrase "should not be operated" cannot be interpreted to only mean "should not be operated for the purposes of production." Such an interpretation is illogical since someone can be exposed to a hazard from a shovel's operation even if it is not digging coal. I find that the standard applies to situations where someone is exposed to a hazard from the operation of the shovel while it is undergoing maintenance.

The Secretary maintains that at the time the audit team arrived at the shovel, the shovel was being operated by the maintenance crew. This crew was "managing the [shovel], because they were directing, governing, and controlling it." (S. Br. 9). At the time of the audit, the mechanics were conducting a center pin maintenance operation, the shovel was not locked out, the main power source was on, the bucket was in the raised position, and the operator was in the cab in control of the shovel's hoist and crowd functions. As a consequence, she argues that the shovel was operating at the time of the safety audit.

I reject these arguments. The Secretary bases her argument on a dictionary definition of "operate" as "to manage or use (a machine, device, etc.)." (S. Br. 8) (citation omitted). From there, she argues that "manage" means "to handle, direct, govern or control." (S. Br. 9) (citation omitted). There is no dispute that there was a PM occurring at the time of the audit so that someone was in "control" of the shovel. I find the Secretary's logic stretches the term "operated" beyond recognition. When the shovel is turned on it is clearly being "operated," but the fact that people are on the shovel performing maintenance does not mean that the shovel is being operated. The evidence makes clear that the shovel was not turned on while the audit team was at the shovel except near the end of their inspection when the bucket was lowered and the audit team was warned of this fact prior to its movement. I find that the shovel was not being operated while the audit team was present until it was turned on by the shovel operator.

The Secretary also contends that the audit team was subjected to hazards during the center pin adjustment. Her primary argument in this regard is that the team failed to notify the shovel operator that they had boarded the shovel and the team members did not know what work was being performed on the shovel. They also lacked experience with the center pin adjustment process. The shovel operator could have started the shovel and moved the bucket without knowing that audit team members were on the shovel or in the vicinity of the shovel. Consequently, she argues that the team members were exposed to various hazards on the shovel, including a stumbling or tripping hazard if the bucket was moved, and unspecified electrical hazards.

I find that the Secretary's argument with respect to the lack of notice given to the shovel operator is relevant to the order of withdrawal, discussed below, but that it has limited relevance to this citation. I agree that there was a potential that Mr. Davis would turn the shovel on and
move the bucket when the audit team first arrived. If that had occurred, there was a potential that a team member walking up the ladder could stumble, for example. The other hazards relied upon by the Secretary have nothing to do with the operation of the shovel or are too vague to considered. Inspector Markve admitted that he had no basis to believe that there were any electrical hazards on the shovel. (Tr. 132-33). The audit team was given notice before the shovel was started to lower the shovel. Although the shovel was operated to bounce the bucket at least twice during the center pin adjustment, that occurred before the audit team arrived at the shovel. The Secretary did not establish that the shovel was operated in the presence of any person exposed to a hazard from its operation.

The Secretary introduced evidence that one member of the audit team walked under the bucket during his examination of vehicles on the ground. Nevertheless, I credit the testimony of Mr. Bunney that he did not walk under the bucket or sticks of the shovel. Inspector Markve based his determination that someone walked under the bucket on the statements of miners. These statements and the accompanying testimony are inconsistent. For example, Mr. Villalobos testified that if the bucket had been lowered at the time he saw someone under the sticks, it could have potentially hit the man and the boom truck. (Tr. 271; Ex. G-16 p. 4. It is clear from the evidence that the boom truck was parked some distance away from the bucket and when Davis subsequently lowered the bucket it did not hit or come close to the boom truck. Indeed it was Mr. Davis who parked the boom truck at that location when he first arrived at the shovel at the beginning of the shift. A person's visual perspective can be off when looking at the bucket and sticks when standing on the catwalk or cab of the shovel.

I find that the Secretary did not establish that any member of the audit team walked under the sticks or bucket of the shovel. First, because there were no vehicles on the left side of the shovel, there would have been no reason for anyone to have walked on the left side of the shovel or to have approached the boom truck from the left side and walked under the boom. I credit Bunney's testimony as to his activities at the shovel that day. He looked over the pickup and trailer parked near the ladder and then walked up the right side of the shovel to adjust the chock on the boom truck. When he was inspecting the boom truck, it is likely that he backed up a little on the truck's left side, but that would not have placed him under the sticks or the bucket as the truck was parked 10 to 20 feet from the bucket. Davis testified that he thought he saw Bunney walk from left to right between the shovel and bucket. Mr. Freed testified that he thought he saw someone getting pretty close to being under the bucket near the boom truck. I note that Inspector Markve did not issue a citation for anyone walking under raised equipment under section 77.1607(k) or any other standard and he testified that he was not able to definitively determine during his investigation whether anyone had actually walked under the bucket or the sticks. (Tr. 142). The Secretary did not establish that anyone walked under the bucket or sticks and, moreover, the shovel was not operating at the time.

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4 Mr. Davis testified that if you are in the house on the shovel when the bucket is bounced, it will not knock you over but it feels like a sonic boom. (Tr. 213).
Inspector Markve also relied on the fact that members of the audit team were within the swing radius of the shovel during their audit. As stated above, the shovel could not swing with the ladder down and the shovel operator could not lift the ladder from his cab. The fact that the shovel operator had parked the hoist truck within the swing radius near the bucket demonstrates that he was not going to swing the shovel during the PM.

**B. Order No. 7610075: §77.1607(f)**

I find that the Secretary established a violation of section 77.1607(f). The citation charges that the audit team members approached the shovel unannounced from the rear of the shovel so that the shovel operator was not aware of their presence. The bucket was off the ground, the shovel was not locked out, and the shovel had been operated during the PM. The safety standard states:

> When an equipment operator is present, men must notify him before getting on or off equipment.

I find that the safety standard required, under the particular circumstances of this case, that the audit team notify the shovel operator that they were getting ready to board the shovel. I agree that this requirement may not be applicable every time that there is a PM, but in this case the bucket was in a raised position which should have alerted the audit team that an equipment operator was present. During many if not most PMs there is no SMS operator on the shovel and the power is locked out. In such an instance, the safety standard would not apply.

As with the previous citation, Powder River argues that the safety standard did not apply because the shovel was not in a “production mode, and [was] not turned on or capable of being moved at the time the equipment [was] boarded.” (P.R. Br. 27). “The plain language of the cited standard limits its application to those situations where loading and haulage equipment is being operated, not where a shovel is removed from production work and is down for preventive maintenance.” *Id.* It relies on the fact that the safety standard is in Subpart Q of Part 77, which is entitled “Loading and Haulage” and that section 77.1607 is entitled “Loading and haulage equipment; operation.” Powder River argues that it is illogical to interpret the safety standard to require notification when the equipment is shut off and is down for maintenance. I disagree. The standard clearly states that notification is required whenever an equipment operator is present. Although the gravity of the hazard may be less when the equipment is under repair, a hazard is still present. Although it did not occur in this case, an individual might board a piece of equipment under repair without the knowledge of the equipment operator just as the operator is about to move the equipment. The operator may have cleared every person known to be present out of harm’s way but, because he did not know that the intruder was present, his movement of the equipment could injure that person. The Secretary’s interpretation of this standard is logical and it does not achieve an “absurd result,” as alleged by Powder River. *Id.*
Powder River also argues that it was not the practice at the mine to notify SMS operators when getting on or off a shovel during a PM. This practice has existed for over 20 years. (P.R. Br. 28). It states that there have never been any injuries to anyone, who did not notify the operator, when getting on equipment down for a PM. Mr. Single knew that the shovel was down for a PM, that it was not turned on, and that the ladder was down. He knew that, with the ladder down, the operator could not swing or propel the shovel. Based on these facts, Powder River argues that it was reasonable for Mr. Single and the other team members to assume that boarding the shovel did not pose any hazards. I find that Powder River's arguments ignore the fact that the equipment operator knew that experienced maintenance technicians were present, but he did not know that there were five other individuals present who were not part of the crew. That knowledge is important information for the equipment operator since he is in control of the shovel. It is important to note that several of the team members lacked experience with the operation and maintenance of large mining equipment and one member had not received hazard training. As a consequence, it was especially important for the shovel operator to know that they were present.

Powder River also notes that at the time the audit team members boarded the shovel, another team member spoke to Mr. Freed, an electrician, and told him that they were going to be inspecting the shovel. Powder River argues that because Freed did not alert the team to any hazards on the shovel or warn them not to board the shovel, it was reasonable for the team to proceed. I find that this argument puts the cart before the horse. It was not Freed’s obligation under the safety standard to warn the audit team of hazards; rather, it was the obligation of the team under the standard to take steps to ensure that the shovel operator knew that they were present. Compliance with this safety standard is not difficult. For example, a team member could have told Freed or another miner to go tell Davis of their presence before they began their inspection. In the alternative, when the team drove into the pit in their van, Mr. Single may have been able to park the van in a spot where the shovel operator would have seen them. He could have also notified Mr. Davis on the radio. It is important to remember that the shovel is a huge piece of equipment and the operator has limited visibility. It is crucial that he know what individuals are in and around the shovel.

I find that the Secretary established that the violation was S&S. 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).

The Secretary established all four elements of the *Mathies* test. The key question is whether she established that there was a reasonable likelihood that the hazard contributed to by the violation would result in an injury. At the time the audit team arrived, the shovel was turned off, vehicles were parked within the swing radius of the shovel, and the bucket of the shovel was raised in the air. Two audit team members entered the house on the shovel and other team members walked near the shovel. There was a reasonable likelihood that the hazard contributed to by the violation would result in an injury, because the operator of the shovel had no idea that the audit team was present. Several of the team members held positions with Powder River that did not involve them in the actual mining process. For example, Mr. Bunney was the warehouse manager and Lee Hays was the purchasing manager for Powder River. None of the audit team members had received any task training on the shovel and Mr. Hays had not received any hazard training. It has been the mine’s practice to allow managers or other individuals who were not particularly knowledgeable of the hazards associated with shovels to board and walk near a shovel when an SMS operator is present without first notifying the operator. There were numerous obvious and latent hazards present. Mr. Davis could have started the shovel at any time before he was notified of the audit team’s presence. The mechanics had removed guards in the house and were tightening down the center pin. I note that the area under the bucket was not barricaded to prevent anyone from walking under it. Powder River trains its miners to barricade the area under the bucket and sticks whenever the bucket is in a raised position. (Tr. 378; Ex. G-5). Although I determined that the Secretary failed to establish that anyone was actually under the raised bucket, there was nothing on the ground to warn team members not to walk through the area. An inexperienced, untrained person on the audit team could have done so without the shovel operator’s knowledge and exposed himself to a hazard.

I find that any injury would be of a reasonably serious nature. Although bouncing the bucket will not generally knock someone down, if a team member were walking up the ladder when the bucket was bounced, he could stumble or fall. Material stuck on the bottom of the bucket could have fallen onto a team member walking under the bucket. Davis testified that, because he did not know that the audit team was present, he could have released the brake for the boom and dropped the bucket on an audit team member. (Tr. 186). If this had occurred, the injury would have been serious or fatal. Consequently, I find that this violation was S&S and that the gravity was serious.

Inspector Jaqua determined that Powder River’s negligence was high and that the violation was a result of its unwarrantable failure to comply with the safety standard. 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 the violation was obvious. Inspector Jaqua testified that whenever he has inspected a mine, the company escort has always notified the equipment operator before boarding a piece of equipment, even if it was not in production. He noted that the audit team’s failure to notify the shovel operator violated Powder River’s safety rules. (Tr. 287-291; Exs. G-5 and G-6). Powder River states that two of the company safety rules cited by the Secretary are rules that prohibit entry into the swing radius of a shovel or other equipment without prior communication and clearance. It argues that the record makes clear that these safety rules only apply when the equipment is in a “production mode.” (P.R. Br. 42; Tr. 377, 423-26, 430-31; Ex. G-6). Another rule (Rule 11) provides that “[p]rior to boarding any piece of equipment, permission must be granted by the operator.” (Ex. G-6 p. 66). Mr. Single testified that this rule has never been applied when equipment is undergoing maintenance. (Tr. 423-26, 430-31).

I find that the Secretary did not establish that the violation was the result of Powder River’s unwarrantable failure to comply with the safety standard. The practice at the mine has been to make contact with the equipment operator when the equipment is operating. Inspector Jaqua agreed that this had been the mine’s practice. (Tr. 315-16). Jaqua admitted that MSHA never advised Powder River that this practice violated section 77.1607(f) and that Powder River had never been cited for a violation. (Tr. 316-17). At his deposition, the inspector stated many mines probably do not provide any notification when boarding equipment that is undergoing maintenance. (Tr. 317).

As stated above, during many if not most PMs at this mine there is no operator on a shovel. In this particular instance, because the bucket was raised, Mr. Single should have known that an SMS operator might be present. Nevertheless, I find the team’s failure to notify the SMS operator that its members would be boarding the shovel did not amount to aggravated conduct constituting more than ordinary negligence. Although I find that the audit team’s conduct was negligent, it did not amount to “reckless disregard,” “intentional misconduct,” “indifference,” or the “serious lack of reasonable care.” The record reveals that Powder River genuinely believed that it was complying with the safety standard. Consequently, it did not know that greater efforts were necessary to comply with the safety standard. I find that Powder River’s negligence was moderate. This order is modified to a section 104(a) citation.

IV. APPROPRIATE CIVIL PENALTIES

29 FMSHRC 407
Section 110(i) of the Mine Act sets out six criteria to be considered in determining appropriate civil penalties. The mine had a history of about 47 paid violations in the two years prior to May 17, 2006. (MSHA’s Data Retrieval System). Powder River is a large operator and the mine is large. All of the violations were abated in good faith. The penalties assessed in this decision will not have an adverse effect on Powder River’s ability to continue in business. My gravity and negligence findings are set forth above. Based on the penalty criteria, I find that the penalties set forth below are appropriate.

V. 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:

<table>
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<tr>
<th>Citation/Order No.</th>
<th>30 C.F.R. §</th>
<th>Penalty</th>
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<tbody>
<tr>
<td>7609689</td>
<td>77.409(a)</td>
<td>Vacated</td>
</tr>
<tr>
<td>7609690</td>
<td>48.31(a)</td>
<td>$463.00</td>
</tr>
<tr>
<td>7610075</td>
<td>77.1607(f)</td>
<td>2,500.00</td>
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<tr>
<td><strong>TOTAL PENALTY</strong></td>
<td></td>
<td><strong>$2,963.00</strong></td>
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Accordingly, the Citation No. 7609689 is VACATED, and Order Nos. 7609690 and 7610075 are AFFIRMED as MODIFIED above, and Powder River Coal, LLC, is ORDERED TO PAY the Secretary of Labor the sum of $2,963.00 within 30 days of the date of this decision. Upon payment of the penalty, these proceedings are DISMISSED.

Richard W. Manning  
Administrative Law Judge

29 FMSHRC 408
Distribution:

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RWM
May 22, 2007

SECRETARY OF LABOR,
MINE SAFETY AND HEALTH ADMINISTRATION,
on behalf of THOMAS F. WILSON,
Complainant

UNITED MINE WORKERS OF AMERICA,
Intervenor

v.

OAK GROVE RESOURCES, LLC, and JAMES E. SIKO,
Respondent

DISCRIMINATION PROCEEDING
Docket No. SE 2006-176-D
BIRM CD 2006-03

Mine ID 01-00329
Concord Prep Plant/Oak Grove Mine

DECISION


Before: Judge Hodgdon

This case is before me on a Discrimination Complaint brought by the Secretary of Labor, acting through her Mine Safety and Health Administration (MSHA), on behalf of Thomas F. Wilson, against Oak Grove Resources, LLC, and James E. Siko, pursuant to section 105(c) of the Federal Mine Safety and Health Act of 1977, as amended, 30 U.S.C. § 815(c). A trial was held in Birmingham, Alabama. For the reasons set forth below, I find that neither Respondent discriminated against the Complainant.
Background

Oak Grove Resources operates the Oak Grove Mine, an underground coal mine, and the Concord Preparation Plant near Adger, Alabama. The company's corporate headquarters are located at the South Point complex, outside of Canonsburg, Pennsylvania. James E. Siko is Vice President of Operations and the top management official at the Oak Grove Mine and preparation plant.

Oak Grove's miners are represented by the United Mine Workers of America (UMWA). Thomas F. Wilson is employed by the UMWA as an International Health and Safety Representative and is a representative of miners at the Oak Grove Mine and Concord Preparation Plant. His office is in Hueytown, Alabama. He does not work for Oak Grove Resources.

On Saturday, January 14, 2006, Wilson conducted a UMWA safety inspection of the Concord Preparation Plant, under the terms of the collective bargaining agreement. He was accompanied on the inspection by Thomas Henson, an employee of Oak Grove and the president of the local UMWA union, and Gary McGough, an Oak Grove Safety Coordinator. Wilson provided a copy of his inspection report to Oak Grove management on January 15. On Tuesday, January 17, he filed a copy of the report with the MSHA District Office as a hazard complaint under section 103(g) of the Act, 30 U.S.C. § 813(g).  

In response to Wilson's complaint, MSHA Inspector Jarvis Westery conducted an inspection of the preparation plant that same day. At 10:15 a.m. he issued Order No. 7687445 alleging a violation with regard to the coal thermal dryer facility. This resulted in closing down the facility until the order was terminated at 3:15 p.m., after Oak Grove had abated the cited condition.

Siko was underground in the Oak Grove mine on the morning of January 17 when he was informed of the order shutting down the thermal dryer facility and that a 103(g) complaint had been filed. He left the mine and went to the preparation plant sometime after 1:30 p.m. to oversee the abatement of the order and to discuss it with the inspector.

Sometime on January 18, a second 103(g) complaint, concerning the underground mine, was called into the local MSHA office by an anonymous miner. As a result, MSHA Inspector Russell Weekly conducted an inspection of the mine on the 18th and issued four citations to the company.

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1 Section 103(g) provides that: "Whenever a representative of the miners ... has reasonable grounds to believe that a violation of this Act or a mandatory health or safety standard exists, or an imminent danger exists, such ... representative shall have a right to obtain an immediate inspection by giving notice to the Secretary ...."
Wilson filed his discrimination complaint with MSHA on February 2, 2006, concerning statements alleged to have been made by Siko. One was alleged to have been made to Ralph Erwin, an hourly employee, on the night of January 17. The other was purported to have been made to John Cupps, an hourly employee and chairman of the UMWA Mine Committee at the preparation plant, over the telephone on the afternoon of January 18.

**Findings of Fact and Conclusions of Law**

Section 105(c)(1) of the Act, 30 U.S.C. § 815(c)(1), provides that a miner, or representative of miners, cannot be discharged, discriminated against or interfered with in the exercise of his statutory rights because: (1) he "has filed or made a complaint under or related to this Act, including a complaint . . . of an alleged danger or safety or health violation;" (2) he "is the subject of medical evaluations and potential transfer under a standard published pursuant to section 101;" (3) he "has instituted or caused to be instituted any proceeding under or related to this Act or has testified or is about to testify in any such proceeding;" or (4) he has exercised "on behalf of himself or others . . . any statutory right afforded by this Act."

In order to establish a *prima facie* case of discrimination under section 105(c)(1), a complaining miner, or representative of miners, must show: (1) That he engaged in protected activity; and (2) That the adverse action he complains of was motivated in any part by that activity. *Driessen v. Nevada Goldfields, Inc.*, 20 FMSHRC 324, 328 (Apr. 1998); *Secretary on behalf of Robinette v. United Castle Coal Co.*, 3 FMSHRC 803 (Apr. 1981); *Secretary on behalf of Pasula v. Consolidation Coal Co.*, 2 FMSHRC 2786 (Oct. 1980), rev'd on other grounds *ex nomen Consolidation Coal Co. v. Marshall*, 663 F.2d 1211 (3rd 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 2799-800. If the operator cannot rebut the *prima facie* case in this manner, it, nevertheless, may defend affirmatively by proving that it was also motivated by the miner's unprotected activity and would have taken the adverse action for the unprotected activity alone. *Id.* at 2800; *Robinette*, 3 FMSHRC at 817-18; see also *Eastern Assoc. Coal Corp. v. FMSHRC*, 813 F.2d 639, 642 (4th Cir. 1987).

In this case, there is no dispute that Wilson engaged in protected activity. It differs from most discrimination cases, however, in that the issue is whether there was any adverse action taken by the Respondents, not whether the adverse action was motivated by the protected activity. The Complainant asserts that Siko made statements to Erwin and Cupps that would have a chilling effect on miners' willingness to make safety complaints. Siko denies making such statements.

For the most serious of the statements, the one supposed to have been made to Cupps, the evidence is in direct conflict and cannot be reconciled. Cupps and Wilson contend that Siko
made threatening statements over the telephone. Siko denied making the statement and denied talking on the telephone to Cupps at all during the time when the statement was supposed to have been made.

Concerning the statement to Erwin, Erwin and Siko were essentially in agreement about what was said. On the other hand, the rest of the witnesses who testified about their understanding of Siko’s statement described a different statement than the one related by Erwin and Siko.

Obviously, either the Complainant and his witnesses were not telling the truth, or the company witnesses were not telling the truth. However, for most of the witnesses, it was not obvious from the manner and demeanor of the witness that he was being untruthful. Nor was it obvious from the accounts themselves which was false. Further, this is not a case where one side has an evident motive to lie and the other does not. In the final analysis then, inconsistencies and the fact that the burden is on the Complainant to prove the case have provided the reasons for the decision in this case. A discussion of those reasons is set forth below.

The Complaint

Wilson’s complaint, filed on February 2, 2007, stated as follows:

On January 18, 2006 (specifically) and other dates (in general), myself, other miners and miners representatives have heard Oak Grove Resources, Inc. Vice President James E. Siko make threats of discharge against all employees that engage in protected activities under the 1977 Mine Health and Safety Act and/or supported Tom Wilson exercising his protected activities under said Mine Act. This verbal threat specifically spelled out that it was being addressed against all UMWA employees at both the Oak Grove Mine and the Concord Mine.

(Jt. Ex. 6.) When the Discrimination Complaint was filed with the Commission, the allegation was that:

Respondents Oak Grove and James E. Siko discriminated against and interfered with the statutory rights of Thomas Wilson as a “representative of miners” and those miners employed at the Concord Mine, Preparation Plant, and Oak Grove Mine, when Respondent James E. Siko made statements to miners’ representatives and miners in which he threatened to retaliate against any miners who made safety complaints to Oak Grove; who filed complaints with MSHA under Section 103(g) of the Mine Act; or who assisted or supported miners and miners’
representatives who made safety complaints or filed complaints under Section 103(g) of the Mine Act.

(Comp. at 3.)

As can be seen, it is only by construing Wilson’s “other dates (in general)” remark to include the alleged statement to Erwin and the fact that the Secretary assigned no dates to the allegations in the Complaint, that the statement to Erwin is included in this proceeding at all. Nevertheless, evidence concerning it was produced at the hearing and the parties have discussed it in their briefs, so it is being considered part of the complaint.

The Statement to Erwin

On the afternoon of January 17, Siko made arrangements for miners from the mine to be sent to the preparation plant to assist in abating the violations found by Inspector Westery and the deficiencies set out in Wilson’s inspection report. He left the mine in the evening and returned to the preparation plant around 10:30 or 10:45 p.m. He encountered Erwin, a stationary equipment operator, in the lunch room of the preparation plant building. According to Erwin, Siko “shook my hand and asked me how I was doing.” (Tr. 97.)

Erwin testified that Siko then said, “that these 103’s were going to kill the Company, and that whoever was calling in the 103(g)’s might as well have gone ahead and committed suicide because they were killing their jobs.” (Tr. 98.) Erwin stated that he replied that he did not know anything about “the 103’s.” (Tr. 99.)

Siko’s recollection of the conversation was similar. He testified that he said:

Well, I’m not doing very well. The violations and the (g)’s are tearing us apart. The guy who’s filing these, that’s not the way to get it done, that’s more like suicide. We’ve got to get better, we’ve got to – jobs are at stake if we don’t improve here, and the Government will shut us down, and they’ve told us this, you know, that unless we improve, that’ll happen.

(Tr. 305.)

Erwin related that after talking to Siko, he completed his rounds and then went back up to the control room, located a short way down the hall from the lunch room, to warn Tommy Henson that Siko was “mad” and that “he needed to be careful what he said around Mr. Siko while he was upset.” (Tr. 99-101.) Erwin said that he relayed to Henson exactly what Siko had said to him. (Tr. 116.) However, Henson claimed that Erwin told him that Siko “said that he couldn’t stand all the 103(g)’s, and if he found out who filed the 103(g)’s, that they might as well put a gun to their head and committed suicide.” (Tr. 45-46.)
The next morning, Henson called Wilson from his home and “told him exactly what Ralph told me.” (Tr. 48.) Wilson called Henson back and told him that they had a meeting with MSHA Special Investigator Jim Boyle at 3:00 p.m. at Steve’s Grocery. At the meeting, when Boyle learned that the statement had not been made to Henson, but to another miner, it was decided that Wilson would go to the preparation plant and talk to the miner.

Wilson and Erwin met in the bathhouse shortly before the afternoon shift began at 4:00 p.m. Erwin testified he that talked with Wilson for about a minute and a half. He told Wilson what Siko had said to him and when Wilson asked him if he wanted to pursue a 105(c) complaint, he said no. (Tr. 102, 126.)

Wilson testified that when he spoke with Erwin, “[i]t was a very short conversation. Ralph confirmed that Mr. Siko had made statements to him, but he also excused it as Mr. Siko having a bad day.” (Tr. 223-24.) Wilson maintained that Erwin told him that Siko had said that “whoever was filing 103(g)’s might as well commit suicide. And there was something about, ‘his ass is mine,’ or something to that effect.” (Tr. 224.) He later testified that: “My best recollection of what the man told me, is that whoever’s filed the 103(g) might as well go ahead and commit suicide, pull the trigger, his ass is mine, when I find him.” (Tr. 255.) Wilson also declared that when Erwin related this, he used a gesture of his hand as a gun and put his finger in his mouth. (Tr. 256.)

Cupps testified that when he was leaving work on January 20, Henson asked him to come into the control room and when he arrived, Henson told Erwin to tell him what he had heard. He recounted that “Ralph said, well, I done told you, Mr. Henson, you just tell him, and then if you need it changed, I’ll make it correct. He said, okay. So Tommy told me.” (Tr. 152.) He said that Tommy told him:

Well, he had told me, which I didn’t know anything about it at the time ‘til they told me there in that room. And he said, well, he said that he had talked to Mr. Siko, and said Mr. Siko told him that whoever called that 103(g) in, that might as well put a gun, I thought he said, in the roof of his mouth, and pull the trigger, in other words, just might as well kill yourself. Because if he found out who it was, his you-know-what was his, referring to your backside.

(Tr. 153.) Cupps further stated that when Henson had finished, Erwin “told us everything that he said, it was true, and he was real nervous.” (Tr. 153.)

2 Wilson concluded after talking with Erwin that there were “no grounds to pursue a 105(c).” (Tr. 225, 256.)

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There is a big difference between what Erwin testified that Sileo said to him and what Henson, Wilson and Cupps claimed Erwin told them Sileo said to him. In addition, Erwin also testified that Sileo never made a hand as a gun gesture and put it in his mouth, or to his head. (Tr. 109, 118.) And he further testified that he did not make such a gesture when he told Henson, Wilson and Cupps what Sileo had said. (Tr. 118.) Furthermore, Erwin testified that he told Cupps verbatim what Sileo had said to him. (Tr. 103-04.) He did not say anything about letting Henson do his talking for him. Indeed, he did not even mention Henson being present when he talked to Cupps.

Henson testified that when Erwin told him about the conversation, Erwin did not say or demonstrate that Sileo had made any hand gestures. (Tr. 65.) Henson also stated that when he related the conversation to Wilson he did not mention that Sileo had made any hand gestures. (Tr. 74.) Yet, Wilson maintained that everyone who told him what Siko had said used the hand as gun gesture, testifying that "[m]y memory is that’s the only version I’d ever heard . . . ." (Tr. 241.)

I find that the only credible versions of what Sileo said to Erwin were offered by Siko and Erwin. The rest were based on second and third hand hearsay. At best, they demonstrate how information becomes garbled as it is passed from person to person. At worst, they evidence deliberate fabrication. It is not necessary to decide which in this instance.

Siko admitted at the trial that he had forgotten the discussion with Erwin, until Erwin was deposed. (Tr. 374-76, 382.) He further admitted that when he was deposed on July 18, 2006, in response to the question of whether he had "any conversation with a UMWA member who had, and had indicated anything about, talked anything about 103(g) complaints on the 17th [of January]," he answered that he had not. (Tr. 375-76.) He explained that after Erwin was deposed, "I went through my notes, my personal records of production, line people back to the plant, etcetera, etcetera, and realized that I was there and did talk to Ralph that night." (Tr. 382.)

His lack of memory and denial that he talked with anyone about the 103(g) complaints on January 17 are not significant. The failure to remember an offhand remark made while exchanging pleasantries with a miner some six months prior does not demonstrate duplicity. Nor does answering "no" to an open-ended question as whether he had talked to any miner about the complaints. As Siko testified: "I had no memory of that one event, because I was in, dropped off the letter, the note of what we were going to do, spoke to the foreman, passed Ralph, and out the door I went." (Tr. 385.) He went on to say: "I move around a lot, and talk to a lot of people, and I got a lot of things going on there." (Tr. 385.) Consequently, I find that Siko’s credibility is not adversely affected by these apparent inconsistencies.

Moreover, with regard to the statement to Erwin, Siko’s credibility makes little difference since relying solely on what Erwin related that Siko said, there was no violation of the Act. In some circumstances, what Siko said could have a chilling effect on miners; for instance, if he said it to the miner who had made the complaint, or to a group of miners, or to union
representatives. Here, however, the statement was made spontaneously and without apparent forethought in response to Erwin asking him how he was doing. While it expressed his frustration, it was made in the context of venting to one of the miners he thought he knew and was friendly with, not as a threat that it should not happen again.

Certainly, Erwin did not take it as a threat. He testified that he thought Siko was talking about the company as a whole being at risk, rather than about taking actions against individual employees. (Tr. 111.) He further stated that he told Henson what had happened only to warn him that Siko was in a bad mood; he did not say to Henson, or anyone else, that Siko was threatening miners. Thus, while statements can be violations of the Act if they have a chilling effect on miners exercising their rights under the Act, this was not such a statement and did not have such an effect. Accordingly, I conclude that this statement was not a violation of section 105(c).

**The Statement to Cupps and Wilson**

Cupps, who in January 2006 was Central Control Room Operator working the day shift, testified that Siko routinely called him two or three days a week, or more, to check on how the shift had gone and what the production was. (Tr. 142.) He said that on January 18, at about 3:55 p.m., Siko called him to ask about production. (Tr. 143.) At this point in his testimony, in response to an innocuous question, Cupps gave the following monologue:

Q. Let me stop you. Did you ask him about his day, did he ask about your day, was there any small talk beforehand?

A. Oh, he asked me about the plant, yeah, just small talk, then he went in about this 103(g). I told him – yeah, he asked me how the plant was doing, I told him it was doing good, because we’d had a good run that day. You know, we’d had a good yield, good run and everything. I told [him] it was good.

And he said, well, things ain’t going that good with me. And I said, sir? He said, things are not going that good with me. I said, what are you talking about? He said, relating to these 103(g)’s and these Orders I got up there at the plant, he said, I don’t think it’s going too good at all.

And up until we’d went down with the dryer, you know, we’d done good. And then he just, like he changed into another gear, you want to say, or something. And he started saying these tactics and about Mr. Wilson.

And about that time Mr. Wilson stepped in the door. And I
asked him, I said, well, Mr. Siko, I said you related to Mr. Wilson, do you want to talk to him, he just entered the room. He said, no, I don’t want to talk to him, he’d better not be up there.

I said, well, Mr. Siko, I’m going to tell you again, he’s here, do you want to talk to him. He said, I done told you, John, I don’t want to talk to him and he’d better not be in there.

In the meantime, I’d motioned for Mr. Wilson to come over there. I felt like if the man was going to bring Mr. Wilson’s name up, Mr. Wilson needed to hear the conversation. Because he was relating to him in an aggravated voice, and he was raising his voice.

And then, I went into attach [sic] them, and he told me, said, let me tell you something about that 103(g) and them orders up there at the plant. He said, like a red light/green light issue, John, I’m going to put it to you that way. He said, the people that follows after Mr. Wilson and his tactics, files these 103(g)’s in, and things of that, and causes problems towards this Company, is interfering with the operation on the safety issues, he said, them red light people, they’ll no longer be employed here, they’ll not work for us. He said only green light people that go through the green light that don’t cause no problems, keeps their mouth shut, don’t cause no problems with safety, he said, them kind of people will work here.

And it was a real aggravated voice. I mean, he was raising his voice. You could have heard him as far as from here to you, just about, in that room. The room’s not that big, but you could have heard it probably that far.

(Tr. 143-46.)

Cupps asserted that the call lasted until 4:10 p.m. or 4:12 p.m. (Tr. 175.) He said that Siko was so loud that Wilson could have heard him over by the door he had come in. (Tr. 186-87.) He further related that when Wilson came over by him, he turned the handset receiver so that Wilson could also listen. (Tr. 186-87.) He was adamant that he did not put the call on the speaker phone. (Tr. 177.) He also testified that his foreman came into the control room during the telephone call to ask for the performance sheet that Cupps’ fills out at the end of the shift. (Tr. 148.)
Wilson testified that he went upstairs to the control room at 4:00 p.m. looking for Cupps. (Tr. 225-26.) He said he first stuck his head in the foremen’s office and said: “Where’s Cupps?” (Tr. 260.) Then, he recounted that he went through an open door into the control room and saw Cupps on the telephone. (Tr. 228.) He said that he heard Cupps refer to him, then Cupps motioned him to come over and as he approached Cupps he could hear someone, whose voice he recognized as Siko’s, screaming on the phone. (Tr. 228-29, 267.) At that point, he asserted that the call was put on the speaker phone. (Tr. 229.) He testified that he heard Siko say:

I want to talk to you about these 103(g)’s and safety complaints.

And there’s two types of people, red light people are the people that file safety complaints or support Tom Wilson in his filing of complaints, and green light people, which are people that keep their mouths shut. And when all is said and done, only green light people will work for this company.

That went through two rounds of the same thing being said twice.

(Tr. 229-30.) Wilson estimated that the call ended at 4:05 p.m. and that it lasted no longer than four or five minutes. (Tr. 266.)

Siko testified that he did not normally call the control room operator at the end of the shift to get the production report. (Tr. 283.) He said that he called the foremen’s office to get that information. (Tr. 283-84.) He stated that if he called the control room operator for such information, it would be in the middle of a shift. (Tr. 284, 361-62.)

Siko denied making a telephone call to Cupps in the control room on January 18. (Tr. 316-17.) He testified that he was in the underground mine with Benjamin Statler, President and CEO of the company, Barry Dangerfield, COO of the company, and Michael McLaughlin, Mine Superintendent for the underground mine, from about 8:00 a.m. until about 5:45 p.m. on that day. (Tr. 313-16, 330-31.) He said that from about 2:00 p.m. the group “spent the rest of our afternoon in that return [11 West Section], trying to get that return rock dusted so we could start that section back up. And that lasted until about 4:30, quarter until 5:00.” (Tr. 314.) He estimated that the closest telephone to where they were was “900 to 950 feet away.” (Tr. 342.)

Siko’s testimony was supported by Dangerfield and McLaughlin. McLaughlin testified that Siko did not mention having to make a telephone call, did not remove himself from the group and did not make a telephone call at 4:00 p.m. on the 18th. (Tr. 456.) Dangerfield testified that the nearest telephone “was almost a thousand feet away, at the top end of that section.” (Tr. 487-88.) He said there was no doubt in his mind that Siko did not make a telephone call to the prep plant at 4:00 p.m. because “[t]here’s no way Jim could have made a call. There’s no phones there. We were in the return.” (Tr. 488.)

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I credit the testimony of Siko over that of Cupps and Wilson. His testimony is corroborated by witnesses who are not directly involved in the complaint. It is plausible and not inherently incredible. Except for Cupps and Wilson, it is not contradicted by any other witness, either directly or indirectly. In addition, he has been in the mining business for 37 and a half years and is familiar with section 105(c). (Tr. 323-24.) It is difficult to believe that he would commit such an obvious violation of the Act by making overt threats to the chairman of the local union mine committee.

On the other hand, there are inconsistencies in the testimony of Wilson and Cupps. Further, portions of their testimony are contradicted by other witnesses and documentary evidence. Finally, Cupps’ manner and demeanor while testifying, specifically, his verbosity, his admitted embellishments and exaggerations, his false modesty and his propensity for answering questions not asked, further diminish his credibility.

Wilson’s and Cupps’ testimony had some obvious incompatibilities. Cupps said he let Wilson listen in on the handset, Wilson said the call was on the speaker phone. Wilson said the call only lasted about five minutes, Cupps claimed it lasted 15 to 17 minutes. These are not matters on which disagreement would normally be expected.

Furthermore, not only was the testimony of Wilson and Cupps inconsistent, but Henson, the control room operator who followed Cupps on the afternoon shift, testified that he arrived in the control room at 4:00 p.m. on January 18 and that Cupps was not there. (Tr. 78-80.) This testimony is substantiated by Oak Grove’s timekeeping system. A printout of the Kronos Timekeeping System shows that Cupps clocked out at 3:57 p.m. and Henson clocked in at 3:47 p.m.³ (Tr. 530, Resp. Ex. 1.)

On cross-examination during the Complainant’s case-in-chief, Cupps testified that he usually clocks out at 4:00, that he could not remember whether he had already clocked out before receiving Siko’s call, but that normally, once he clocks out he leaves. (Tr. 176.) However, after the timekeeping evidence was introduced, Cupps was recalled in rebuttal. He first testified that there was a variance between the time clock and the clocks on the computers in the control room, with the clocks in the control room being “behind, and either when you first started out it would be fifteen minutes faster or slower, and it just varies both ways, really.” (Tr. 573.) Later, he was asked if he had any recollection of clocking out and then returning to the control room and he

³ The Secretary objected to the timekeeping evidence on the grounds of surprise in that the Respondent had not furnished a copy of it prior to trial. The objection was overruled. (Tr. 534.) The Secretary objects to it again in her brief. (Sec. Br. at 30.) This is the only completely objective evidence in the trial. If counsel for the Respondent was aware of it prior to the trial, he should have furnished it to the Secretary. Nevertheless, the possibility of such evidence should have been obvious to the Secretary, and could have been requested prior to trial. There is no indication that the exhibit was either not authentic or fabricated. Consequently, the objection is again overruled.

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answered: "Probably did. I probably went down the hall and clocked out and made a phone - or something - went back up there and answered the phone. You know it could have very well happened that a way." (Tr. 579.) This testimony, to the extent it makes any sense at all, is not credible.

Additionally, Michael Blevins, Oak Grove Resources Safety Director, testified that he was on the second floor of the preparation plant sometime between 3:45 p.m. to 3:55 p.m. and stopped in the control room. He said that Henson was in the control room, but Cupps was not. (Tr. 411.) He further testified that he was on the second floor until 4:15 p.m. or 4:30 p.m. and he never saw Wilson. (Tr. 411-12.)

Lastly, Kenneth Young, the maintenance foreman, testified that he was in the foremen’s office at 4:00 p.m. on January 18 and did not see Wilson in the area. (Tr. 515-16.) Young also testified that Siko called the foremen for production information and only called the control room "at times." (Tr. 521.) Another foreman, Dave Walters, testified that he was filling in for the superintendent and was working between the superintendent’s office, which is also on the second floor a short distance from the foremen’s office, and the foremen’s office at 4:00 on January 18. He said that he did not see Wilson on the second floor at all that day. (Tr. 557.) He further testified that he did not go into the control room to get the performance report from Cupps. (Tr. 561.) Finally, both Young and Walters testified that they did not hear any "screaming" coming from the speaker phone in the control room. (Tr. 520, 569.)

In weighing this evidence, I find that a preponderance of the credible evidence supports the Respondent’s case, rather than the Complainant’s. Accordingly, I conclude that Siko did not call Cupps (and Wilson) as alleged and that there was no violation of section 105(c) of the Act.

The Statement to Henson

The Secretary argues that Siko also made a statement to Henson that was a violation of section 105(c). Little attention was paid to the alleged statement by the parties at the trial or in their briefs. Indeed, it is questionable whether it was part of the complaint. Nonetheless, since it was mentioned, it is discussed below.

Henson testified that on either the 18th or the 19th, he was not sure which, Siko called him at the first part of the shift to ask "how much raw, how much clean, we’d run." (Tr. 51-52.) He then averred that Siko said that "we couldn’t live with all the federal violations and 103(g)’s that was being called, and that he [sic] was either going to have to be with the [sic], for the Company or against the company. And the ones that was going to be against the Company wasn’t going to stay there." (Tr. 52.)

Siko testified that he did not make such statements to Henson at any time during the week of January 15. (Tr. 319.) He said: "I don’t remember having any [conversation with Henson], because it was a very outstanding or marked week at the preparation plant with the series of

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events that transpired over there.” (Tr. 320.) Although this statement is confusing, or it was not transcribed accurately, the inference drawn from it is that Siko remembered that he did not make such a statement because the week stood out in his mind.

I find that the Complainant has not proved that Siko made the alleged statement. Henson was the local union president. He was closely involved with Wilson in the safety inspection, in investigating the situation involving Erwin, and in filing the 105(c) complaint. Yet this allegation was not included in the complaint. It could be argued that the incident with Erwin was only alluded to in the complaint because Erwin did not want to be involved, but no such reason exists for the omission of the Henson allegation. Unless it did not occur.

Contrary to Henson’s and Cupps’ testimony, it does not appear that Siko routinely and frequently called them for production information and that, therefore, his calling them was not out of the ordinary.4 More credible is the testimony of Siko and his foremen that he only called the control room at unusual times, such as the middle of the shift, or on his way to work in the early morning, or when he could not reach any one else.

This purported statement appears to have been an afterthought at the trial and in the Complainant’s proposed findings. In a 39 page brief, the Complainant spent fewer than four paragraphs discussing it. Even more significantly, it is not mentioned in the Intervenor’s brief at all.

Consequently, for all of these reasons, I conclude that Siko did not make the alleged threatening statement to Henson.

Conclusion

As mentioned at the beginning, there is no way to reconcile the testimony of Wilson, Cupps and Henson with that of Siko and the other management witnesses. One side or the other was not telling the truth, but, for the most part, neither side’s presentation was implausible or incredible. Furthermore, both parties had reason to fabricate. It will serve no purpose to speculate on the motive for such untruths. It was apparent from the trial, however, that management and the union seem to have a very adversarial relationship at this operation. Consequently, in arriving at a decision in this matter, I have relied on the inconsistencies in the testimony and the fact that the Complainant has the burden of proving its case by a preponderance of the evidence. Applying those factors, I conclude that the Complainant has failed to prove that the company violated section 105(c) of the Act in any of these instances.

4 Incredibly, if the call to Henson was made on the 18th, the testimony of Henson and Cupps is conflicting, unless one believes that Siko called Cupps at the end of his shift, and then called Henson at the beginning of his following shift, to ask for the same information which he had supposedly already gotten from Cupps.
Order

The Complainant, Thomas F. Wilson, has not established that James E. Siko made statements which constituted adverse action under the Act. Accordingly, his Discrimination Complaint filed against Oak Grove Resources, LLC, and James E. Siko, under section 105(c) of the Act is DISMISSED.

T. Todd Hodgdon
Administrative Law Judge

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May 30, 2007

SECRETARY OF LABOR,
MINE SAFETY AND HEALTH
ADMINISTRATION (MSHA), on behalf
of LAWRENCE PENDLEY,
Complainant

v.

HIGHLAND MINING COMPANY, LLC,
Respondent

TEMPORARY REINSTATEMENT
PROCEEDING
Docket No. KENT 2007-265-D
MADI CD 2007-05
Mine ID 15-02709
Highland No. 9 Mine

Appearances: Jonathan Hammer, Esq., James Brooks Crawford, Esq., U.S. Department of Labor, Arlington, Virginia, on behalf of the Complainant
Melanie J. Kilpatrick, Esq., Rajkovich, Williams, Kilpatrick & True, PLLC, on behalf of the Respondent

Before: Judge Barbour

ORDER OF TEMPORARY REINSTATEMENT

On March 22, 2007, Lawrence L. Pendley filed a discrimination complaint with the Secretary of Labor’s Mine Safety and Health Administration (MSHA). The complaint alleged Highland Mining Company (“Highland”) discharged Pendley as the result of “[c]ontinuous harassment from filing [a] safety complaint in October 2006.” Appl. for Temp. Reinstat’t, Exh. B 2. The complaint was investigated by MSHA Senior Special Investigator Kirby Smith, and on April 25, 2007, the Secretary filed an Application for Temporary Reinstatement. The application seeks Pendley’s reinstatement as a maintenance(parts delivery person, the position he held on March 21, or to an equivalent position at the same rate of pay and with the same benefits.

In the application the Secretary expanded on Pendley’s complaint and asserted Pendley was discharged “because the company apparently believed . . . based upon [Pendley’s] previous protected activity . . . [he also] was making safety complaints regarding the condition of the mining equipment in the . . . mine, including complaining . . . coal had accumulated on the 3C belt in depths from 12-24 inches.” Appl. 2. The allegation about a prohibited accumulation

1The complaint lists March 21, 2007, as the “Date of Discriminatory Action.” Appl. for Temp. Resinst’r, Exh. B at 1. Pendley was suspended with an intent to discharge on March 21 and was discharged on March 26.

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referred to an oral complaint telephoned to MSHA on March 21 by an unidentified miner. The telephoned complaint resulted in an inspection pursuant to section 103(g) of the Act (30 U.S.C. § 813(g))\(^2\) and to the citation of Highland for a violation of 30 C.F.R. § 75.400.\(^3\)

The case was assigned to me on April 25, 2007. On the following day, in a conferenced telephone conversation with counsels and Pendley, counsel for Highland stated the company desired a hearing on the application. I replied I would be unable to hear the matter within the ten days specified in Commission Rule 45(c). 29 C.F.R. § 2700.45(c). The first date I could hear the case was May 22, 2007, and I offered to request the case be reassigned to another judge. Counsels and Pendley advised me they were willing to waive the rule’s timelines and go forward on May 22. The matter was heard on that date in Evansville, Indiana. At the close of the hearing, counsel for Highland moved the application be dismissed. I deferred ruling. For the reasons stated below, the motion is DENIED and the Secretary’s application is GRANTED.

THE LAW

When a discharged miner lodges a discrimination complaint, the Secretary shall investigate the complaint, and if she “finds the complaint was not frivolously brought” she may apply for the complainant’s reinstatement pending a final order on the complaint. 30 U.S.C. § 815(c)(2). If a hearing is held on the application, “the scope of... [the] hearing... is limited to a determination as to whether the... complaint was frivolously brought.” 30 C.F.R. 2700.45(d); see 30 U.S.C. § 815(c)(2). In Jim Walter Resources, Inc. v. Federal Mine Safety and Health Review Commission, 920 F. 2d 738-747 (11th Cir. 1990), the court described a “not frivolously brought” determination as a finding the complaint was “not insubstantial or frivolous” and “not clearly without merit.” 920 FMSHRC at 747 and n.9.

As I noted in a letter addressed to counsels prior to the hearing, while the burden of proof is on the Secretary, the burden is light. Commission Judge Arthur Amchan well described how a judge should analyze whether the Secretary has carried the burden. If the judge concludes it is “possible, but by no means certain, that the Secretary could prevail in a discrimination proceeding,” then the application should be granted. Secretary on behalf of Loy Peters, etc. v. Thunder Basin Coal Co., 15 FMSHRC 2290, 2293 (November 1993); aff’d 15 FMSHRC 2415

\(^2\)Section 103(g) in pertinent part provides that a miner with reasonable grounds to believe a violation of a mandatory safety standard exists may file a complaint with MSHA and, upon receipt of the complaint, the agency shall conduct a special investigation “as soon as possible.” 30 U.S.C. § 813(g). The section also provides the complaint be reduced to writing and a copy be given to the operator no later than the time of inspection. The section further mandates the name of the miner making the complaint shall not appear in the copy. Id.

\(^3\)Section 75.400 prohibits accumulations of coal dust, loose coal and other combustible materials in the active workings of a mine.
(December 1993). The conclusion must be made within the framework of the elements of proof of a Mine Act discrimination proceeding, which means, among other things, the judge must determine whether the Secretary has shown the complainant engaged in protected activity, and that the adverse action was motivated in part by that protected activity. Secretary ex rel. Pasula v. Consolidation Coal Co., 2 FMSHRC 2786 (October 1980), rev’d on other grounds sub nom. Consolidation Coal Co. v. Marshall, 663 F. 2d 1211 (3rd Cir. 1981); Secretary ex rel. Robinette v. United Castle Coal Co., 3 FMSHRC 803 (April 1981).

**PROTECTED ACTIVITY AND REINSTATEMENT**

At the heart of the contention Pendley’s discharge violated the Act is the allegation Pendley was let go because of his past discrimination complaints and because Highland’s management believed he filed the section 103(g) complaint with MSHA. The filing of complaints under sections 105(c) and 103(g) is protected. An operator cannot discharge an employee because he or she engaged in protected activity. The operator can, however, prevail by showing the discharge was in no part motivated by protected activity, or by proving it also was motivated by the miner’s unprotected activity and the operator would have taken adverse action for unprotected activity alone. Pasula 2 FMSHRC at 2800; Robinette, 3 FMSHRC at 817-818; see Eastern Assoc. Coal Corp. v. FMSHRC, 13 F. 2d 639, 642 (4th Cir. 1987).

There is no doubt Pendley engaged in protected activity by filing a complaint with the Secretary pursuant to section 105(c)(1) prior to his discharge. The Secretary investigated that complaint and, on September 25, 2006, she filed a complaint on behalf of Pendley alleging he was suspended for three days without pay for making safety complaints to MSHA. The September complaint involved the hazardous sudden stopping of the mine hoist while it was bringing Pendley underground. Pendley believed the incident involved Jack Creighton, a fellow miner. Pendley also claimed Creighton harassed him in various ways and that the harassment was a safety risk. The Secretary’s complaint was docketed as KENT 2006-506-D.4

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4 As the parties and I are well aware, the docket has a convoluted history. After the complaint was filed, it was the subject of a settlement agreement between the Secretary and Highland, a settlement I approved. Order Approving Settlement (January 18, 2007). Pendley objected to the settlement, claiming he was not a party to the agreement. The Commission treated the objection as a petition for review. It vacated the order approving the settlement, reopened the case and remanded the matter to me for “appropriate proceedings.” 29 FMSHRC ___(April 3, 2007). Prior to to and at the temporary reinstatement hearing, counsels, Pendley and I discussed the nature of the further “appropriate proceedings.” We agreed the remanded case should effectively be stayed pending a decision by the Secretary whether to file a complaint on Pendley’s behalf based on Pendley’s March 22, 2007, complaint (the complaint which initiated the temporary reinstatement application). We further agreed if a discrimination proceeding is filed following the completion of the Secretary’s investigation of the March 22 complaint, Docket No. KENT 2006-506 will be consolidated with that proceeding and the cases will be disposed of together. With this in mind, it is imperative the Secretary promptly complete her
I grant the application for temporary reinstatement because I find it is “possible, but by no means certain” (Peters, 15 FMSHRC at 2293; aff’d 15 FMSHRC 2415 (December 1993)) the Secretary could prevail on the allegation Pendley was suspended “based on previous protected activity.” Appl. for Temp. Reinstat’t at 2. The Commission has recognized, “Direct evidence of motivation is rarely encountered; more typically, the only available evidence is indirect.” Secretary of Labor on behalf of Chacon v. Phelps Dodge Corp., 3 FMSHRC 2508, 2510 (November 1981), rev’d on other grounds, 709 F. 2d 86 (D.C. Cir. 1983). In Chacon the Commission listed some of the common circumstantial indicia of discriminatory intent: (1) the knowledge of the protected activity; (2) hostility or animus toward the protected activity; (3) coincidence in the time between the protected activity and the adverse action; and (4) disparate treatment of the complainant. See also Secretary of Labor on behalf of Baier v. Durango Gravel, 21 FMSHRC 953, 957 (September 1999).

Here, the company obviously knew of the prior complaint involving the hoist and the alleged harassment of Pendley by Creighton. Pendley’s suspension on March 21, 2007, and his termination of March 26 followed another run-in with Creighton, a confrontation also involving the hoist. Thus, the March 21 incident with Creighton again raised for the company the alleged problems with the hoist and Pendley’s prior complaints about Creighton’s alleged harassment. On the same day as the March 21 events, Pendley was suspended with an intent to discharge. There was a clear coincidence in time between the protected activity and Pendley’s discharge.

In addition, there was apparent disparate treatment handed out to Pendley in that following the disagreement with Creighton after the hoist incident on March 21, Pendley was suspended with an intention to discharge and then was fired. One of the reasons the company gave for terminating Pendley’s employment was he assaulted Creighton. Resp. Exh. 2. (The “assault” involves a disputed push or shove Pendley allegedly gave Creighton when Pendley encountered Creighton at the hoist control panel on March 21. At the time, Creighton was allegedly participating in a safety test of the hoist.) The company maintained this was one of the reasons for terminating Pendley, because after a prior incident with Creighton – an incident about which Pendley complained – Pendley had been given a “last and final warning” by the company because he “threatened violent behavior.” Exh. R-1. However, Creighton, who agreed he had difficulties involving Pendley, was not subject to the discipline given Pendley. Creighton was reprimanded, but never was given a “last and final . . . warning,” even though he agreed he had threatened to shove a gun down Pendley’s throat.

The fact Pendley was terminated following another occurrence involving the hoist and Creighton, while Creighton was not given a last and final warning even after he “threatened violent behavior,” leads me to conclude Pendley’s complaint was not frivolous and it is possible the Secretary could prevail.

The possibility of prevailing is enough to warrant Pendley’s temporary reinstatement.

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However, the holding should not be taken as an indication the Secretary ultimately will prove the company violated section 105(c)(1) of the Act. 30 U.S.C. § 815(c)(1). The company argues, and may well establish, even given Pendley’s protected activity, Pendley still would have been discharged. The company alleges one reason for his discharge is that he harassed and orally abused the company’s controller, Sheila Gaines; its payroll clerk, Sharon Hubbert; and its mine account manager, Roger Wise. It further alleges the March 21 incident involving the hoist and Creighton actually constituted interference by Pendley with a safety procedure and a physical assault on Creighton. See Exh. R-2. However, the merits of these contentions are beyond the scope of this order. Rather, they constitute at least part of a defense the company will presumably put forward at a hearing if a discrimination complaint is filed by the Secretary.

Finally, although in seeking temporary reinstatement the Secretary alleged the filing of a section 103(g) complaint and the resulting issuance of a violation based on that complaint was a reason for Pendley’s dismissal, she essentially offered little evidence to link the complaint and the citation with the allegedly prohibited suspension with intent to discharge. Given my finding the evidence regarding Pendley’s prior protected complaint, his March 21 conflict with Creighton and his subsequent suspension and termination is sufficient to send Pendley temporarily back to work, I do not need to decide if the allegations regarding the section 103(g) complaint and the resulting citation are valid reasons for Pendley’s reinstatement. I note, however, the Secretary’s evidence is what can charitably be described as “weak.” Indeed, a review of the record confirms the Secretary established little more than the section 103(g) inspection and the resulting citation occurred the same day as Pendley’s suspension with intent to discharge. Should a section 105(c)(2) (30 U.S.C. § 815(c)(2)) complaint be filed by the Secretary, more than what was offered will have to be shown to establish the section 103(g) complaint and the citation are reasons to find Highland discriminated against Pendley. At this point, however, such concerns are matters for another day. The only issue now before me is whether Pendley’s complaint was frivolously brought, and I conclude the Secretary has established it was not.

ORDER

Highland IS ORDERED to reinstate Lawrence Pendley to the position from which he was suspended with intent to discharge on March 21, 2006, or to an equivalent position, at the same rate of pay and with equivalent duties.
Distribution: (Certified Mail and by Facsimile)


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/ej
June 1, 2007

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

v.

CENTRAL APPALACHIA MINING, LLC,
Respondent

DECISSON

Appearances: Mary Sue Taylor, Esq., U.S. Department of Labor, Nashville, Tennessee, on behalf of the Petitioner
Mark Heath, Esq., Spilman, Thomas & Battle, PLLC, Charleston, West Virginia, on behalf of the Respondent

Before: Judge Barbour

This case is before me on a petition for the assessment of civil penalties filed by the Secretary of Labor on behalf of her Mine Safety and Health Administration (MSHA) against Central Appalachia Mining, LLC (Central Appalachia or the company) pursuant to sections 105 and 110 of the Federal Mine Safety and Health Act of 1977 (the Mine Act or Act) (30 U.S.C. §§ 815, 820). The Secretary alleges Central Appalachia is responsible for two violations of the Secretary's safety standards for surface coal mines. She also alleges the violations were significant and substantial contributions to mine safety hazards (S&S) and were caused by the company's moderate negligence. The Secretary seeks civil penalties totaling $5,228. The company denies the allegations. The case was tried in Pikeville, Kentucky. The parties have submitted helpful briefs.

The citations involve events surrounding the blasting of a highwall at Central Appalachia's Hunts Branch Freeburn Mine, a surface coal mine located in Pike County, Kentucky. The highwall was drilled, loaded and blasted by Virginia Drilling, the company's independent contractor. The blast went awry, sending flyrock into the area below and in front of

1Roger Cantrell, Central Appalachia's safety director, testified Virginia Drilling contracts "to do the drilling and the blasting for surface coal mines in different areas of [Kentucky]." Tr. 202. At the mine, Virginia Drilling did everything with regard to explosives. In Cantrell's opinion, it provided a "complete turn key job." Tr. 203; see also Tr. 203-204.

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the highwall ("the pit"), an area where miners were working. A miner was struck and injured. MSHA investigated and, as a result of the investigation, the agency alleged the company's ground control plan failed "adequately [to] provide precautions . . . to prevent flyrock or to remove miners to a safe location" and the company failed to give "an ample warning" to miners in the pit prior to the blast. Gov't Exh. 7, Gov't Exh. 6.

THE ACCIDENT AND THE INVESTIGATION

Robert Bellamy works for MSHA as a mining engineer in the agency's Pikeville, Kentucky, office. As a member of the Roof Control and Impoundments Department, his duties include reviewing mining plans submitted to MSHA, plans dealing with roof control, impoundments, and ground control. He also investigates accidents for the agency. Tr. 26. Prior to joining MSHA, Bellamy worked for three to four years as a certified blaster. Tr. 27, 115.

On July 13, 2005, Bellamy learned there had been an accident at the company's mine. He was assigned to investigate it, and on the following day he went to the mine. Tr. 30-31. On July 14, the accident site was essentially the same as on July 13, the day the accident occurred. Tr. 32. Bellamy took several photographs of the site. He took a photograph from the top of the high wall. Tr. 35, 38. Gov't Exh. 1. The photograph shows several pieces of equipment in the pit. Two are red in color. The largest of the two is the highwall miner. It is the piece of equipment closest to the highwall. Tr. 36-37; Gov't Exh. 1. The smaller piece of equipment pictured to the right of the highwall miner is the generator. Tr. 37; Gov't Exh. 1. Behind the miner and sloping away from the highwall is a ramp of coal. Tr. 38; Gov't Exh. 1.

Bellamy also took a second photograph from the top of the highwall, but from a location closer to the equipment. The photograph shows the same equipment and the same coal ramp depicted in the first photograph (Gov't Exh. 1). Tr. 39-44; Gov't Exh. 2.

Bellamy took a third photograph from the floor of the pit. The photograph depicts the highwall miner and a blue supply truck. The supply truck is next to the highwall miner. The photograph also depicts a yellow loader to the left of the miner and a white pickup truck to the right of the miner. Tr. 45, 49-50; Gov't Exh. 3. Although the damage is not visible in the photograph, Bellamy testified the highwall miner, the blue supply truck, the yellow loader and the white pickup truck were hit and damaged by flyrock. Several pieces of flyrock are visible in the photograph. Tr. 49; Gov't Exh. 3.

"Flyrock" is defined in part as, "The rock fragments which are thrown and scattered during quarry . . . blasting." U.S. Department of the Interior, A Dictionary of Mining Mineral, and Related Terms 1968 at 450 (D.M.M.R.T.).

The pickup truck was used by then pit foreman, Dave Nichols. Tr. 51. At the time of the hearing, Nichols no longer was employed by Central Appalachia. Tr. 186.
A fourth photograph shows the side of the highwall miner. To the left of the miner the rear end of the blue supply truck is visible, as are pieces of the truck's front fender. The fender was hit by flyrock, some of which is depicted. Tr. 46-47, 50; Gov't Exh. 4.

A fifth, and final, photograph shows the front of the blue supply truck. In addition to the damaged fender, the photograph reveals "extensive damage" (Bellamy's words, Tr. 51) to the truck's engine compartment. Tr. 47-48; Gov't Exh. 5. The white pickup truck is pictured in back of the supply truck. Its passenger side door is damaged. Tr. 51; Gov't Exh. 5.

Bellamy "informally" interviewed and questioned those working in the pit at the time of the accident. Tr. 52. Bellamy learned the shot causing the accident consisted of approximately 48,000 pounds of AN-FO. Tr. 52. He also learned the highwall miner was moved into the pit six days before the accident. Once the miner was in the pit, two shots were fired. The shots were closer to the highwall miner than the July 13 shot, which meant on July 13, material from the previous shots was piled in front of the July 13 shot area. Tr. 126-127. No flyrock traveled into the area of the highwall miner during either of the pre-July 13 shots, which is one reason neither Virginia Drilling nor the company anticipated flyrock problems on July 13. Tr. 53.

Central Appalachia's foreman, Dave Nichols, testified on July 13, Jay Stewart, Virginia Drilling's blaster, spoke with him shortly before 4:05 p.m. As Nichols recalled, Stewart told him the blasters were "going to put a shot off[,] that . . . [Nichols and his crew] were not in the blast area, that . . . [they] were safe, [but] to . . . [stay clear of] the highwall in case . . . [the shot] shook the ground and something loose fell off." Tr. 190, Tr. 123-124. Nichols was sure Stewart did not say to remove miners from the area in front of the highwall. Tr. 123,190. Nichols was not surprised by this because the shot on July 13 was farther away from the highwall miner than the previous shots. Tr. 190.

After talking to Stewart, Nichols advised his crew Virginia Drill was going to fire a shot and to watch for rocks coming off the highwall after the shot. Tr. 134, 191. When Nichols spoke to the crew, the engines of the generator, the highwall miner and the loader were running. Tr. 192. Nevertheless, Nichols believed the crew heard what he said. However, after the accident, he learned the crew did not hear him. Tr. 192.

Nichols then went to the tailgate of his pickup truck. The shot was fired shortly thereafter. Tr. 56. Miners Steven Tackett and Travis Tackett were working near the highwall miner changing the miner's air compressor. Tr. 56. Steven Tackett told Bellamy they were not advised the shot would be detonated. There was no warning signal. They first learned about the shot when the AN-FO exploded. Tr. 55.

Upon detonation of the shot, Steven Tackett jumped behind the miner, and Travis Tackett dove under the supply truck. Travis Tackett was not fast enough. He was struck in the leg by

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4AN-FO is defined as "Amonium nitrate fuel oil blasting agents." D.M.M.R.T. at 38.

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flyrock. Tr. 58. He suffered a compound fracture. Tr. 58.5

Although affected miners in the pit did not hear a warning, Bellamy learned that five minutes prior to the shot, Virginia Drilling sounded an initial warning signal. Then, one minute before the shot, Virginia Drilling sounded a second signal. Bellamy agreed Virginia Drilling was responsible for signaling miners to warn them when a shot was about to go off. Tr. 123-124. The signal was required so miners in the blasting area could leave or take cover. Tr. 66. To meet its responsibility, Virginia Drilling used a truck-mounted siren. Tr. 63. During the investigation, Bellamy asked Virginia Drilling personnel to position the truck where it had been on July 13, and to sound the siren when the equipment in the pit was running. When this was done, he could not hear the siren. Tr. 60-63, 135; see Gov't Exh. 4.

Nichols also did not hear the five-minute and one-minute warnings. Tr. 195. Nichols testified this was because of the noise level in the pit. Tr. 196. Because it was not unusual for the noise in the pit to mask the sound of the siren, Nichols testified he relied on oral warnings from the blasters. He never questioned what they told him. Tr. 197, 200.

As to whose responsibility it was to move the miners out of the blast area on July 13, Bellamy stated “a lot of responsibility ... [went] to ... [Virginia Drilling and its] blaster.” Tr. 103. He agreed, under the laws of the Commonwealth of Kentucky, “the ... blaster [was] actually in charge of the blasting operation.” Tr. 117. Therefore, when asked who should make the decision to pull miners out of the blast area in order to “get away from a shot,” Bellamy stated, “I think the blaster should. And I think it is state law.” Tr. 117.

State officials also investigated the accident, in part to determine the source of the flyrock. They concluded the rock originated in the right corner of the shot area, adjacent to a previously shot area. Joint Exh.1; Tr. 147-148. Bellamy testified there are various causes for flyrock. It can be caused by joints in the rock which direct the rock to “blow out,” weak areas in the rock strata, or by a misfired shot. Tr. 79-80. Bellamy cautioned, “[E]very shot ... is not going to go off exactly as ... intended.” Tr. 79-80.6

THE CITATIONS

As a result of the investigation, Bellamy issued Citation No. 7416150 to the company. The citation alleged a violation of section 77.1000, a mandatory standard requiring an operator to “establish and follow a ground control plan for the safe control of all highwalls.” Under the

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5Because of the injury, Bellamy could not interview Travis Tackett. Tr. 57.

6Bellamy did not find fault with the way Virginia Drilling laid out the shot on July 13. Tr. 168. The shot was set up to produce the result Central Appalachia wanted - i.e., to break “the rock up into sizes that can be handled by ... [Central Appalachia’s] equipment in order to excavate ... and remove it.” Tr. 77

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standard, the plan must also “insure safe working conditions.” 30 C.F.R. § 77.1000; Gov’t Exh. 7; see Tr. 89-90. Bellamy believed Central Appalachia’s established ground control plan did “not adequately provide precautions . . . to prevent flyrock or to remove miners to a safe location prior to blast detonations.” Gov’t Exh. 7; see also Tr. 96.

Bellamy explained, after the citation was issued, Central Appalachia supplemented its plan by requiring, among other things, the highwall mine foreman and production foreman to withdraw all miners in the affected blasting area to a safe distance. Tr. 100-101. The purpose of the supplement was to take “some of the guesswork” out of withdrawing miners from a blast area by outlining Central Appalachia’s “responsibilities as far as making sure . . . people are out of the way of the blast.” Tr. 102.

With regard to Central Appalachia’s ground control plan, Bellamy noted section 77.1000 requires the agency to “acknowledge” the plan, and he described the process MSHA follows. Tr.

Four procedures were specified in the supplement:

1. A certified blaster will directly notify the Highwall Miner Foreman and Production Foreman of the impending blast.

2. Upon receiving notification, the Highwall Miner Foreman and Production Foreman will withdraw highwall miners and other employees in the affected blasting area to a safe distance.

3. The horn or siren used by the certified blaster shall be of a sufficient decibel level to be heard by employees in the affected blast area.

4. The blast will not be detonated until all employees within the affected blast area have been withdrawn.

Gov’t Exh. 9 at 3.

Subsequent to the accident, items 3 and 4 were suggested to all surface operators in the district for inclusion in their ground control plans. Tr. 157; see also Tr. 217. In addition, they were added to the ground control plan form MSHA makes available to operators. Tr. 104-105, 155-156.
29. The MSHA District Manager “just acknowledges that the plan [is] submitted. [The plan has] ... not really gone through a real thorough review or an onsite investigation.” Tr. 30. If MSHA believes things should be added or changed, MSHA representatives advise the operator and arrange a conference to discuss the matter. Tr. 152.

In Bellamy’s opinion, the purpose of a ground control plan is to ensure the stability of highwalls, spoil banks and pits and, thus, to ensure safe working conditions. See Tr. 90. Therefore, he believed an adequate ground control plan should address “various aspects ... [of] highwall configuration” Tr. 93.\(^8\)

The plan in effect at the mine on July 13 was submitted to MSHA on June 2, 2005. It was acknowledged by the MSHA District Manager on June 7. Tr. 153; Gov’t Exh. 8. At the time, MSHA did not express any concerns. Tr. 153. Nevertheless, MSHA advised Central Appalachia the plan was open to re-evaluation if experience established it was in any part inadequate or if conditions developed that were not addressed in the plan. Tr. 94-95. Bellamy identified a cover letter sent by MSHA District Manager Kenneth Murray to Cantrell. Gov’t Exh. 9, Tr. 95. The letter stated in part, “[T]his plan will be evaluated any time there is a question of the adequacy of the ... Ground Control Plan.” Gov’t Exh. 8.

Bellamy also issued Citation No. 7416151 to the company for an alleged violation of section 77.1303(h). Gov’t Exh. 6. Section 77.1303(h) requires: “All persons shall be cleared and removed from the blasting area unless suitable blasting shelters are provided to protect men endangered by concussion or flyrock from blasting.” Bellamy believed this requirement was violated. He concluded the miners were in a blasting area because “of the orientation of the location of the employees relative to the shot.” Tr. 64. They were “in the direction of the free face of the shot.” Tr. 64.\(^9\) In Bellamy’s opinion, “any time you’re in front of that shot, in front of the free face of it, you’re in the blast area.” Tr. 64, see also Tr. 66, 81. Therefore, the miners should have been removed or been provided with shelters.

Bellamy further maintained flyrock always has to be taken into consideration. He stated, “[J]ust because you didn’t have flyrock on the previous shot, that doesn’t necessarily mean

\(^{8}\)Although an operator is not required to use an MSHA-provided form for its plan, Bellamy testified the agency encourages them to do so. “It makes it easier for both the operators and for ... [MSHA] ... to have certain information ... [MSHA] ... want[s] ... in the plan.” Tr. 97. Once in possession of the form, an operator can supplement it by including its “own sketches of [its] highwall and any particular thing ... [it] think[s] needs to go in the plan.” Tr. 97, 151.

\(^{9}\)According to Bellamy, the “free face” was an “area that ha[d] been already blasted in the past,” an area where “the rock had already been removed.” Tr. 68,
you’re not going to have it on . . . [the next] one.” Tr. 81; see also Tr. 73. “Once you set a blast up . . . [y]ou have to take all precautions to remove the people from the blast[ing] area.” Tr. 65-66.

Bellamy could not say how far miners should withdraw to be outside the blasting area. He explained, “it’s going to depend on a lot of different factors. The size of the shot, how much explosives are being used, how the shot’s laid out, . . . the type of rock that’s being shot, [and] the hardness [of the rock].” Tr. 66-67, 117.

Section 77.1303(h) also requires an “[a]mple warning . . . be given before blasts are fired.” Bellamy believed the requirement was violated because although warning signals were sounded, they were not heard by the crew in the pit; nor was the crew warned of the shot by the foreman. Tr. 55, 63.

Bellamy issued the citation to Central Appalachia because Nichols, who failed to effectively warn the miners, acted for the company. As the foreman, he was responsible for the safety of those working under him. Tr. 83. In Bellamy’s opinion, Nichols should have removed the employees from the blasting area or given them warning of the shot so they could take cover. Tr. 83. Nichols was wrong to rely on Stewart. Tr. 85-86. Nichols should not have taken the chance he and those under his supervision would be safe. Rather, he should have said to Stewart, “we’re getting out of here.” Tr. 87. Leaving himself and his miners positioned in front of the shot “was a dangerous place to be.” Tr. 88.

THE VIOLATIONS

CITATION NO. 7416150

Citation No. 7416150 states:

The ground control plan established by the operator does not insure safe working conditions. On July 13, 2005, a non-fatal accident occurred when an employee of the highwall miner crew was struck by flyrock from a nearby blast detonation. The ground control plan does not adequately provide precautions to be taken by the operator to prevent flyrock or to remove miners to a safe location prior to blast detonations.

Gov’t Exh. 7.

As previously noted, section 77.1000 in part requires each operator to:

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Establish and follow a ground control plan for the safe control of all highwalls, pits and spoil banks... which shall be consistent with prudent engineering design and will insure safe working conditions.

The Secretary asserts section 77.1000 places a ground control plan “under the specific control of the operator.” Sec. Br. 8. In the Secretary’s view, “The fact Nichols felt... it was not his responsibility to assure the safety of his crew... demonstrates... the... plan was inadequate to assure the safety of the highwall crew.” Sec. Br. 8.

Central Appalachia responds it did not violate any provisions of the plan in effect on July 13. To draft the plan, the company used forms provided by MSHA, and there was nothing on the forms requiring information regarding the control of flyrock. The company notes that prior to the accident the agency never raised concerns regarding blasting security in the context of the company’s ground control plan. Cent. Ap. Br. 7. Central Appalachia also states it knows of no other instance in which an operator has been cited for failing to have an adequate plan after its plan was “acknowledged” by MSHA. Cent. Ap. Br. 12. Moreover, it argues section 77.1000 does not address blasting procedures but rather focuses on the “safe control of all highwalls, pits and spoil banks.” Cent. Ap. Br. 12 (quoting section 77.1000). In Central Appalachia’s view, section 77.1000 “is simply inapplicable to the acts MSHA alleges have been committed.” Cent. Ap. Br. 13. It is the Secretary, not the operator, who “ultimately bears responsibility for a mine plan’s silence...” Id. 13.

I am not persuaded by the company’s arguments. As I read the standard, among its requirements is the provision all surface coal mine operators, of whom Central Appalachia is one, submit a ground control plan “which... will insure safe working conditions.” The requirement to “insure safe working conditions” is a mandate over and above the particular requirements contained in the plan itself, which means although an operator may comply with all parts of its submitted and acknowledged plan, it may still be in violation of the standard if the plan does not provide a safe workplace. While it is true the Secretary must acknowledge the plan, it is the operator first and foremost who must make certain the plan “insure[s] safe working conditions,” and if the plan does not, the operator violates the standard.

It is clear Central Appalachia’s plan did not “insure safe working conditions,” because it did not require miners in the blasting area to be removed to a safe location or to be provided with shelter prior to the shot. As the testimony establishes, on July 13 those working in the pit had no knowledge the shot was about to be fired. As a result, they scrambled for cover as flyrock flew toward them. With no provision to insure the miners were out of the affected area or were otherwise out of the way of possible flyrock prior to the shot’s detonation, safe working conditions were not insured, the plan was defective and section 77.1000 was violated.

29 FMSHRC 437
I have no doubt it is exasperating for an operator to submit a ground control plan by essentially completing a form provided by MSHA, to have the plan acknowledged by the MSHA district manager, and then to learn, based on a subsequent event, the acknowledged plan does not meet the requirements of the standard. However, the scenario does not contravene the Act. The burden of compliance is the operator's, not, as counsel for the company incorrectly implies (Cent. Ap. Br. 15), the Secretary's. Moreover, it is far from unusual for a post-event investigation to result in the issuance of a citation for something neither the operator nor the agency contemplated. Just as post-event revelations inform our everyday lives, so knowledge growing out of an investigation informs the agency's ongoing enforcement activities. This stated, the fact neither party anticipated the company's section 77.1000 compliance responsibilities revealed as necessary by the accident is not without a consequence, for while the lack of foresight does not excuse the violation, it impacts the negligence attributable to Central Appalachia.

S&S AND GRAVITY

An S&S violation is a violation "of such nature as could significantly and substantially contribute to the cause and effect of a . . . mine safety or health hazard." 30 U.S.C. § 814(d). A violation is properly designated S&S, "if, based upon the particular facts surrounding 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 (April 1981). To establish the S&S nature of a violation, the Secretary must prove: (1) the underlying violation; (2) a discrete safety hazard — that is, a measure of danger to safety — contributed to by the violation; (3) a reasonable likelihood the hazard contributed to will result in an injury; and (4) a reasonable likelihood the injury will be of a reasonably serious nature. Mathies Coal Co., 6 FMSHRC 3-4 (January 1984); accord Buck Creek Coal Co., Inc. 52 F. 3d 133, 135 (7th Cir. 1995); Austin Power Co., Inc. v. Sec'y of Labor, 81 F. 2d 99,103 (5th Cir. 1988) (approving Mathies criteria).

It is the third element of the S&S criteria that is the source of most controversies regarding S&S findings. The element is established only if the Secretary proves "a reasonable likelihood the hazard contributed to will result in an event in which there is an injury." U.S. Steel Mining Co., Inc., 7 FMSHRC 1125, 1129 (August 1985). Further, an S&S determination must be based on the particular facts surrounding the violation and must be made in the context of continued normal mining operations. Texasgulf, Inc., 10 FMSHRC 1125 (August 1985); U.S. Steel, 7 FMSHRC at 1130.

Finally, the S&S nature of a violation and the gravity of a violation are not synonymous. The Commission has pointed out that the "focus of the seriousness of the violation is not necessarily on the reasonable likelihood of serious injury, which is the focus of the S&S inquiry, but rather on the effect of the hazard if it occurs." Consolidation Coal Co., 18 FMSHRC 1541, 1550 (September 1996).
Given my conclusion the Secretary established a violation of section 77.1000, the first of the Nat’l Gypsum factors has been met. Next is the question of whether the record supports finding the failure to ensure miners were out of the affected area or were otherwise out of the way of flyrock prior to the detonation of a shot posed a discrete safety hazard. There is no doubt it did. The hazard was the subject of the miners to possible injury from flyrock. In other words, the hazard was exactly what happened. Moreover, as the July13 incident showed, the failure to ensure the miners were removed or otherwise protected prior to detonation was reasonably likely to result in a serious, if not a fatal, injury. Once flyrock was set in motion, miners in the affected area had but seconds to react and protect themselves as best they could. Given the amount of flyrock that could be produced, the short time miners had to react and the limited areas within which they could take cover, I conclude there was a reasonable likelihood failure to ensure miners were out of the area before the detonation or were otherwise protected would result in an injury or injuries of a reasonably serious nature. Indeed, in the instance at hand, Travis Tackett was lucky he was not killed. For these reasons, I find the violation was S&S.

I also find the violation was serious. The effect of the failure to ensure the miners were removed from the affected area or were otherwise protected prior to the detonation was the direct result of Travis Tackett’s injury, and others in the affected area of the pit were fortunate to escape his fate.

NEGLIGENCE

Inspector Bellamy found the violation was due to Central Appalachia’s “moderate” negligence. Gov’t Exh. 7. I conclude, however, the company’s negligence was low. While it is true the gravity of the likely injuries caused by flyrock warranted preventative vigilance on the company’s part, a finding of negligence must take into consideration all of the circumstances surrounding the violation. Those circumstances include the fact Central Appalachia reasonably believed the care it exercised met the circumstances it faced.

First, Central Appalachia believed its ground control plan, as acknowledged my MSHA, was adequate. The agency provided Central Appalachia with the MSHA-made form for its plan and, once the plan was submitted, the agency acknowledged without comment the plan’s receipt. In addition, as Bellamy admitted, prior to July 13, MSHA did not require anything dealing with flyrock to be included in an operator’s ground control plan. Only after the accident did MSHA require provisions ensuring miners hear warning signals and be removed from a blast site before a detonation. Tr. 98-99. All of these things gave the plan as submitted and acknowledged MSHA’s imprimatur and lead to the company’s good faith, reasonable belief it was in compliance.

Second, MSHA did not dispute the testimony of Cantrell regarding the services provided the company by its contractor, Virginia Drilling (Tr. 202-204). It is clear from the testimony Virginia Drilling was completely in charge of the blasting operation. Tr. 203. The contractor
provided everything with regard to explosives. It also is clear prior to the accident MSHA understood Virginia Drilling’s role at the mine, including the contractor’s determination of the blasting area and its sounding of the siren prior to detonation. Despite this knowledge, and its knowledge of the contents of the plan, MSHA did not express a single safety concern to Central Appalachia. See Tr. 215.

Given the lack of concern by MSHA prior to the accident and the reasonable reliance by Central Appalachia on its plan as acknowledged and on Virginia Drilling, I find the company’s lack of care is greatly mitigated.

CITATION NO. 7416151

Citation No. 7416151 states:

An ample warning was not given to the miners working on the highwall miner crew in the . . . pit on July 13, 2005, on the second shift prior to a blast detonation which produced flyrock that caused an injury to a miner. The miners were not removed from the affected area and a warning signal which was audible to the high-wall miner crew was not given.

Gov’t Exh. 6.

Section 77.1303(h) requires:

Ample warning [shall be] given before blasts are fired. All persons shall be cleared and removed from the blasting area unless suitable blasting shelters are provided to protect men endangered by concussion or flyrock from blasting.

The Secretary argues the standard should be interpreted from the standpoint of “a reasonable person with knowledge of the particulars of the shot.” Sec. Br. 9. She states a reasonable person in Nichols’ position would have “consider[ed] all possible consequences and outcomes including where flyrock might land during . . . [the] blast.” Id. 10. She argues Nichols failed to consider whether flyrock might occur and where the affected area would be if it occurred. Based on what actually happened, the Secretary finds it “clear” Nichols did not act reasonably. Id.
The Secretary also observes Nichols was unaware crew members did not know when the explosion would occur. This, too, was not in keeping with the "reasonable person" standard. Sec. Br. 10. The Secretary sums up:

A reasonable surface foreman . . . would have known first that there are signals which are required to be sounded to assure that persons in the blast area know about a forthcoming blast and second that miners working in the zone where flyrock could occur should be given that warning or removed from the danger zone. Nichols did neither of these things.

Tr. 11.

Central Appalachia concentrates its argument on the definition of "blasting area." The company points to the Commission's holding in Hobet Mining and Construction Company:

To establish a violation of . . . [section 77.1303(h)], based on a failure to clear and remove all persons from the blasting area, the Secretary must prove that an operator has failed to clear and remove all persons from the "blasting area," as that term is defined in section 77.2(f). This requires the Secretary to establish the factors that a reasonably prudent person familiar with mine blasting and the protective purposes of the standard would have considered in a determination under all of the circumstances posed by the blast in issue. The Secretary must prove that the factors were not properly considered or employed.

9 FMSHRC 200, 202 (February 1987) (citations omitted).

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10 "Blasting area" is defined in section 30 C.F.R. §77.2(f) as, "the area near blasting operations in which concussion or flying material can reasonably be expected to cause injury." 30 C.F.R. § 77.2(f).

29 FMSHRC 441
Under this holding, the company argues a "blasting area" can be based on several factors including: the results of prior shots, the amount and type of explosives used, the depth of holes constituting the shot, and the topography. Cent. Ap. Br. 16-17. Virginia Drilling's blasters determined the affected miners were not in a blast area based on the fact two prior shots had been detonated closer to the highwall miner pit without incident and rubble from the prior shots created a buffer between the shot and the crew. Id. 17. Thus, according to Central Appalachia, the decision of the blasters as to what constituted the blasting area was reasonable.

The company also argues the Secretary did not establish the lack of an "ample warning" to the affected miners. In the company's view, since there is no regulatory definition of "ample warning," the term must be defined in the context of the facts of the case. Central Appalachia notes the blaster sounded two siren warnings before the blast, in accordance with state law. In addition, Stewart told Nichols the shot would be fired and Nichols, in turn, told his crew. It is Central Appalachia's contention the siren's soundings and the oral warning taken together constitute an "ample warning" and come within the meaning of the standard. Cent. Ap. Br. 18.

The Blasting Area

The citation charges the July 13 detonation produced flyrock and "miners were not removed from the affected area." Gov't Exh. 6. The company does not dispute the allegations. It also agrees blasting shelters were not provided for the miners. The unresolved question is whether the miners were in a "blasting area."

The Secretary bears the burden of proof when alleging a violation. As the Commission has pointed out and as Central Appalachia has noted, when the Secretary charges miners were not removed from a "blasting area," she must establish what reasonably could have been expected to constitute the area. Hobet Mining, 9 FMSHRC 200, 202 (February 1987). It is not enough to reply on the fact flyrock landed in the area. 9 FMSHRC at 202-203. Rather, the Secretary must consider "the results of prior shots . . . [and] a number of variables . . . includ[ing], but . . . not limited to, the amount and type of explosive used, the depth of the hole that constitute the shot, the topography, and the expertise of the blaster." 9 FMSRHC at 202-203.

Although inspector Bellamy testified the blasting area has to be "defined for each individual shot," and a determination as to what constitutes a blasting area has to be "based on a lot of different factors" (Tr. 80), such as "[t]he size of the shot, how much explosives are being used, how the shot's laid out, . . . the type of rock that's being shot, [and] the hardness [of the rock]" (Tr. 66-67, see also Tr. 117), the Secretary presented no cogent testimony linking such factors to what reasonably could have been expected to occur on July 13. For example, Bellamy noted 48,000 pounds of AN-FO were used in the shot (Tr. 52), but there was no follow-up testimony as to what this might (or might not) signify. Bellamy also testified he did not conduct a complete investigation of how the holes containing the explosives were arranged; nor did he thoroughly investigate other details of the shot. Tr. 168. In addition, there was no testimony regarding the specific topography of the shot area and its impact, if any, on a reasonable
determination of the extent of the blasting area, except for Bellamy’s agreement that material from two prior shots had piled between the affected miners and the site of the detonation. Tr. 127, 130. Moreover, the Secretary did not subpoena the blasters, so there was no direct testimony from those who knew best about how the blasting area was determined.

Rather than provide evidence regarding the variables the Commission stated go into the making of a blasting area determination, the main thrust of the Secretary’s testimony centered on Bellamy’s assertion the location of the affected employees in front of the free face virtually guaranteed they were in the blasting area. See, e.g., Tr. 64 (miners were in the blasting area “because of the orientation of the location of the employees relative to the shot”); See also Tr. 64 (miners working in front of a free face are in the blast area); and see Tr. 81 (flyrock can occur “on any shot,” and miners should not “work in front of [a] shot.”) It may be that considering an area in front of a shot to be the sole or nearly sole determinant of a “blasting area” is a perfectly reasonable way to construe the standard. However, without more testimony regarding why that determinant should override other potential determinants and why the determinant makes the others irrelevant, there is an insufficient evidentiary basis to conclude all persons were not “cleared and removed from the blasting area” as required by section 77.1303(h).

Ample Warning

The question remains whether an “ample warning [was] . . . given before [the blast] was fired.” The citation charges it was not, because there was no “warning signal which was audible to the highwall miner crew.” Gov’t Exh. 6. I agree. Although “ample” is not defined in the regulations or the Act, its meaning is commonly understood to connote something that is “marked by extensive or more than adequate size, volume, space or room.” Webster’s Third New International Dictionary (1993) 74. In the context of the regulation, the warning signal must be “more than adequate,” which, among other things, means it must be heard. Here, there is no dispute the signals given on July 13 – the sirens and Nichols’ vocal message to the miners – were not heard by the miners. Tr. 55, 59, 63, 122, 192. Therefore, the warning signals were not “ample,” and Central Appalachia violated this part of the regulation.

S&S AND GRAVITY

I have found the failure to provide the miners in the pit a warning they could hear prior to detonation of the shot was a violation of section 77.1303(h). I also find the violation created a
discrete safety hazard in that the miners were not given notice of the detonation and, therefore, could not take precautions to protect themselves from the shot’s possible consequences. This subjected the miners to the hazard of being unable to react fast enough to avoid flyrock by leaving the affected area or by taking cover prior to the shot. Lack of notice of the shot also made it reasonably likely miners would be injured because it drastically reduced the time they had to protect themselves from the effects of the blast. Finally, as the injury to Travis Tackett showed, there was a reasonable likelihood injuries caused by the violation would be of a reasonably serious nature.

In addition to being a significant and substantial contribution to a mine safety hazard, I find the violation was serious. The effect of the failure to provide an ample warning to the miners left Travis Tackett and the others to scramble for cover as the flyrock flew toward them. Broken bones and abrasions are the least that reasonably could have been expected.

**NEGLIGENCE**

Bellamy believed the company was moderately negligent. Gov’t Exh. 6. I find, however, its negligence was high. Nichols was the foreman. He acted on Central Appalachia’s behalf. He was responsible for the safety of those he supervised. He was on site. He was aware of the noise produced by the highwall miner and by other equipment in the pit. Nichols did not hear the five-minute and one-minute sirens. Tr. 195. Nichols admitted, because of the pit noise, it was not unusual to be unable to hear such warnings. Tr. 196. Nonetheless, Nichols knew a shot was coming because the blaster told him. Tr. 190. Nichols was under an obligation to make sure those working under his supervision knew as well. It was not enough for Nichols to “tell” the miners if they could not hear him, and in view of his knowledge noise in the pit often covered other sounds, he was obligated to ensure his words were heard and understood. The potential deadly hazard faced by those he supervised required he meet a high standard of care. It was an obligation he and, thus, the company, failed to meet.

**REMAINING CIVIL PENALTY CRITERIA**

**HISTORY OF PREVIOUS VIOLATIONS**

The Secretary entered into evidence, over the objection of counsel for the company, a computer printout titled “Assessed Violation History Report.” Gov’t Exh. 10. The printout lists a total of 16 prior violations at the mine in the two years preceding the accident. Gov’t Exh. 10 at 19-20. It also lists more than 300 other violations that occurred at other mines operated by companies controlled by Wexford Capitol, LLC, Central Appalachia’s controlling entity. In objecting to the report, counsel for Central Appalachia pointed out the exhibit lists mines from around the country, that some of the listed violations predated the existence of Central Appalachia, and that one of the companies whose violations are included, CAM Mining, LLC, is an entirely different entity than Central Appalachia. Tr. 109-113. I admitted the exhibit subject to its being explained and subject to its consideration being argued on brief.
Counsel for the Secretary has not discussed the exhibit or the issue of its consideration. Counsel for Central Appalachia has renewed his objections to the exhibit and stated his belief “all penalties should be calculated on the history of any previous violations at Hunts Branch [Freeburn Mine] only.” Cent. Ap. Br. 11 n. 2.

Without further explication from the Secretary, and noting that both the printout and Exhibit A of the Secretary’s petition indicate the mine has a small history of previous violations, I find, based on the record in this case, the applicable history of previous violations is small. The finding is made on these specific circumstances and is not a global pronouncement as to what constitutes an appropriate history of previous violations.

SIZE

In proposing penalties for the alleged violations, the Secretary noted Central Appalachia was of medium size. Petition for Assessment of Penalty, Exh. A. There being no evidence to the contrary, I find this is in fact the case.

ABILITY TO CONTINUE IN BUSINESS

There is no evidence the size of any penalties assessed will adversely affect Central Appalachia’s ability to continue in business, and I find they will not.

GOOD FAITH ABATEMENT

The violations were abated in good faith by Central Appalachia and in a timely fashion. Gov’t Exh. 6, Gov’t Exh. 7.

CIVIL PENALTY ASSESSMENTS

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<td>7/14/05</td>
<td>77.1000</td>
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I have found the violation was serious. I also have found that the company’s negligence was low and much of its lack of care was excusable. Given these findings and the other civil penalty criteria, I conclude a penalty significantly reduced from that which is proposed is warranted. I find an assessment of $2,000 is appropriate.

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<td>7/14/05</td>
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I have found the part of the alleged violation that was proven was serious. I also have found the company’s negligence was high. Given these findings and the other civil penalty
criteria, I find a penalty significantly higher than that which is proposed is warranted. I conclude an assessment of $500 is appropriate.

ORDER

Central Appalachia SHALL pay total civil penalties of $2,500 within 40 days of the date of this decision, and upon payment of the penalties this proceeding IS DISMISSED.

David F. Barbour
Administrative Law Judge
(202) 434-9980

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/ej
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 L. C. Curtis & Son, Inc., 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 violation of the Secretary’s mandatory health and safety standards and seeks a penalty of $60.00. A hearing was held in Athens, Georgia. For the reasons set forth below, I vacate the citation.

Background

L. C. Curtis & Son, Inc., operates the Watkinsville Mine in Watkinsville, Georgia. The mine is a small sand operation. Sand is sucked from a pond by a dredge, pumped to a station where it is washed and then is stockpiled until it is sold to customers. The mine has three employees, a dredge operator, a loader operator and Alex Curtis, son of John L. Curtis.

On September 17, 2006, MSHA Inspector Gerald Smith, went to the mine to perform the regular semi-annual inspection. During the inspection, he issued Citation No. 7773909 under section 104(a) of the Act, 30 U.S.C. § 814(a), which is the subject of this proceeding.
Findings of Fact and Conclusions of Law

The citation alleges a violation of section 56.14107(a) of the Secretary's regulations, 30 C.F.R. § 56.14107(a). The “Condition or Practice” alleged to result in this violation was stated to be:

The coupling and keyed shaft for the packing water pump were not properly guarded to prevent contact with the coupling and keyed shaft. A grease fitting was located within 4 inches of the coupling. Persons exposed to this condition could injure fingers and hand if contacted.

Section 56.14107(a) requires that: “Moving machine parts shall be guarded to protect persons from contacting gears, sprockets, chains, drive, head, tail, and take-up pulleys, flywheels, couplings, shafts, fan blades, and similar moving parts that can cause injury.”

Inspector Smith testified that he observed a pump that was “partially guarded.” (Tr. 14.) In fact, the pump was guarded across the top, down the side and across the front as far down as where the shaft entered the pump. (Govt. Ex. 2.) The shaft was behind the guard. The Inspector said that he wrote the citation because the shaft was not completely guarded and a miner could come in contact with the shaft while greasing the pump. (Tr. 18.) He also said, when pressed by his representative, that a miner might go to the pump “to see if it’s running, to prime the pump” or “doing a workplace exam.” (Tr. 18.) He admitted on cross examination, however, that “if there were no [grease] fitting there, I don’t believe there would be exposure.” (Tr. 29.)

The company presented evidence that the pump is greased four times a year and the entire plant is shut down on those maintenance days. (Tr. 48, 53.) Furthermore, the inspector verified that in the normal course of business, greasing is not performed while machinery is operating. (Tr. 40.)

In addition, the operator asserted that the pump had been inspected for over sixteen years and not been cited. (Tr. 8.) Inspector Smith confirmed that in his review of the previous inspections of the mine, made before conducting his inspection, there had been no citation of the pump for a guarding violation. (Tr. 37-38.)

The chances of a miner inadvertently coming in contact with the spinning shaft, while not impossible, were extremely unlikely. There is no evidence that the company greased the pump while it was operating. There were only three miners in the entire operation, so the chances of one of them checking the pump, doing a workplace inspection, or just walking by, falling and getting his hand under the guard and coming in contact with the shaft or coupling were remote at best.
Moreover, even if it is assumed that the shaft was not adequately guarded, the operator did not have notice that it was not properly guarded. The Commission has held, with regard to notice, that in determining whether a broadly worded standard that is intended to be applied to many factual situations, applies to a specific situation, "it is appropriate to evaluate the evidence in light of what a 'reasonably prudent person, familiar with the mining industry and the protective purpose of the standard, would have provided in order to meet the protection intended by the standard."' Ideal Cement Co., 12 FMSHRC 2409, 2415 (Nov. 1990) (citations omitted). Applying this standard to the facts in this case, it is apparent that a reasonably prudent person would not have done anything differently than this operator.

The Secretary argued that the fact that other pumps on the property were properly guarded shows that the operator, as a reasonably prudent person, should have known that the pump in question was not suitably guarded. (Tr. 59.) To the contrary, this evidence leads to an opposite conclusion.

The pumps which the inspector found to be properly guarded demonstrate that the operator was aware of the requirements of the regulation. As does the fact that this mine has had very few violations. It had been cited once in the previous two years, only four times since the company had been in business, and never for guarding violations. (Tr. 5-6, 37-38.)

The pump in question was guarded. It had been inspected numerous times in the past and not been cited. Thus, the operator, a person familiar with the mining industry and the protective purpose of the standard, had guarded the pump in a manner that he deemed appropriate and had never been informed that there was anything wrong with it. Consequently, until the operator was advised by a new inspector that he believed additional guarding was needed, there was no way that the operator knew, or should have known, that his guarding was inadequate.

In summary, if there was a violation in this case, it was a violation in only the most technical sense. However, even if there were a violation, the operator did not have adequate notice that it was a violation. Accordingly, the citation will be vacated. Nonetheless, whether there was a violation or not, the bottom line is that the safety of miners has been enhanced because the pump is now guarded in a manner satisfactory to both MSHA and the operator.

1 In addition, there is evidence that these pumps were belt driven, rather than shaft driven, and, thus, different than the pump at issue. (Tr. 26-27.) Consequently, the type of guarding required was also different.
**Order**

In view of the above, it is **ORDERED** that Citation No. 7773909 is **VACATED** and that this case is **DISMISSED**.

T. Todd Hodgdon  
Administrative Law Judge

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/sr
I. Statement of the Case

This case is before me based on a Petition for Assessment of Civil Penalty filed by the Secretary of Labor ("Secretary") alleging violations by Elk Run Coal Company ("Elk Run") of 30 C.F.R. §§ 77.501, 77.704-1(a), and 77.1710(c) respectively. Subsequent to notice, the case was heard in Charleston, West Virginia on December 12, 2006.

II. Introduction

Elk Run operates the Black Knight II Coal Mine. A belt line transports coal from underground to a silo on the surface. A high voltage line attached to various poles supplies electricity to operate the belt motors. Two sets of transformers on the poles convert the electricity down to 480 volts. Three disconnects are located under the transformers. In normal operations, the disconnects are closed creating a circuit and allowing electricity to flow in a three phase lead that runs from the transformers to four cabinets or compartments. ("Motor Control Center") Three phases enter Compartment No. 1 (Gx. 22) at the top of the cabinet.

Each compartment contains a set of three fuses and disconnects. The cabinets are covered by an outer door and a metal grate. When the outer door is removed, it is possible to access a handle to open a disconnect switch, breaking contact to the fuses inside the box, and removing power to wires and components downstream from that point. Three phases leave the compartments and lead to various motors including the belt motors.
On the midnight shift of May 19, 2004, Ricky Bryson noticed a spillage in the area of the silo where it dumped coal on the belt, and heard a sound in one of the motors which indicated to him that only one phase was in operation. The belt stopped and Bryson made various attempts to restart it, but was unable to do so. At approximately 5:30 a.m., Bryson informed the mine foreman, Charles Roach that he was unable to get the belt system to run. Roach, in turn, contacted two electricians on the next shift, Michael Wayne Clay and Darrell Shivley. Shivley and Clay inspected the belt motor, and concluded that either the motor was defective, or there was a problem with a fuse. They were unable to further test the grounding at the motor because of excessive tape. Shivley traced the leads coming into Compartment No. 1, and since they looked like the same size as wiring to the motor junction box, he concluded that these were the motor leads. They then went to the Motor Control Center, removed the outer door to the cabinet compartment at issue, turned the disconnect switch to open, and visually confirmed it was open. Shivley and Clay next took off the grating, and removed two fuses. Shivley tested the fuses, and one of the fuses indicated "... it was blown." (Tr. 148). Shivley brought the fuse to Roach and suggested that the latter contact Ron Plumley, maintenance chief or Nicholas Thompson, line-crew foreman to locate another fuse. Roach was able to contact the latter but not the former. When Thompson arrived, Roach showed him the fuse, and Thompson indicated that he did not have a replacement.

Shivley and Clay went back to the cabinet, and attempted to test the grounding in the lower portion of the cabinet. Shivley placed one end of a lead-meter on a copper bar, to which one of the phases was attached, (Gx. 16, 17), and attempted to attach the other lead to a grounding bar at the bottom of the cabinet. Neither Shivley nor Clay wore any protective gloves when they performed this task. A loud explosion was heard and the meter exploded. Shivley was observed being knocked down, and he suffered a loss of hearing.

Later that day, Marcus Smith, an MSHA electrical engineer for 18 years, and a specialist accident investigator for the last two years, arrived on the site to investigate the accident. He interviewed Thompson, Clay, and Roach, and spoke with Shivley over the telephone. Based on his investigation, Smith issued Elk Run a Section 104(d)(1) Citation (No. 7224658) alleging a violation of Section 77.704-1(a), and two Section 104(d)(1) orders, (Nos. 7224659 and 7224660) alleging, respectively, violations of 30 CFR §§ 77.501, supra, and 77.1710(c), supra.

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1 The parties stipulated that Clay and Shivley were non-supervisory employees of Elk Run, and were not the latter's agents.

2 The third fuse normally located in that area had been removed, and was by-passed by a wire.
III. Violations

A. Citation No. 7224658 (Section 77.704-1(a), supra.)

Section 77.704-1(a), supra, provides as pertinent as follows:

No high-voltage line shall be regarded as deenergized for the purpose of performing work on it, until it has been determined by a qualified person (as provided in § 77.103) that such high-voltage line has been deenergized and grounded. Such qualified person shall by visual observation (1) determine that the disconnecting devices on the high-voltage circuit are in open position, and (2) insure that each ungrounded conductor of the high-voltage circuit upon which work is to be done is properly connected to the system grounding medium. ...

Thus, according to Section 77.704-1(a), supra, in order for work to be performed on high voltage lines, a qualified person must determine by visual observation that the disconnecting devices on the circuit are in the open position.

It was stipulated by the parties that both Shivley and Clay were qualified persons as provided in Sections 30 CFR § 77.103. They visually observed that the disconnecting devices inside the cabinet box were open, which would have broken the circuit downstream from that point. However, the cabinet was not deenergized inasmuch as the disconnect at the transformer on the power pole was still closed, allowing power to flow from the transformer to a point upstream from the disconnect device inside the cabinet. Accordingly, I find that it has been established that Elk Run was not in compliance with Section 77.704-1(a), supra.

B. Order No. 7224659 (Section 77.501, supra)

1. Order No. 7224659 as duplicative of Order No. 7224658

Elk Run argues that Order Nos. 7224659 (Section 77.501), and 7224658 (Section 77.704-1(a), supra, are duplicative, as the standards cited in the orders impose the same obligation. Section 77.704-1(a), supra, in essence, requires that a qualified person determine that high-voltage lines be deenergized and grounded before work is performed on them. Section 501, supra, provides that “disconnecting devices [shall] be locked out and [suitably] tagged out by the [persons who perform] such work ....” Elk Run asserts that “...locking out implies and necessarily requires a deenergization of a circuit.” (Elk Run’s Proposed Finding of Fact and Conclusions of Law, p. 33). (“Findings of Fact”) Elk Run argues that an operator who fails to deenergize as required by Section 77.704-1(a), supra, will thus be in violation of both standards, since their duties are not separate and distinct.

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However, a reading of the plain, unambiguous language of both sections reveals that separate and distinct duties are required. 30 CFR § 77.704, supra, requires that all high-voltage lines shall be deenergized before work is performed on them. Section 77.704-1(a), supra, provides that a high-voltage line shall not be regarded as deenergized until a qualified person makes this determination based on visual observation "... that the disconnecting devices on the high-voltage circuit are in the open position...

Thus, Section 77.704, supra, imposes a duty to deenergize. Section 77.704-1(a), supra, provides that in order for a line to be deenergized a duty is imposed on a qualified person (1) to determine (2) by observation that (3) the disconnecting devices on the high-voltage line "are in the open position...", thus imposing a duty to open these devices prior to the performance of work. In contrast, Section 77.501, supra, requires that disconnecting devices be (1) locked out, and (2) suitably tagged by a qualified person. Thus, the two standards impose separate duty requirements and are not duplicative (See, Tonopah Mining Corp., 15 FMSHRC 367, 378 (1993). See also, Blue Diamond Coal Co., 25 FMSHRC 570, 583 (2004) (ALJ).

2. Violation of Section 77.501, supra

There is not any evidence that, prior to their commencement of the work in the cabinet at issue, Shivley or Clay locked and tagged the relevant disconnecting device that was located below a set of transformers on the power pole. Accordingly, I find that Elk Run was not in compliance with Section 77.501, supra.

C. Order No. 7224660 (Violation of 30 CFR § 77.1710(c))

Section 77.1710, supra, provides as follows:

Each employee working in a surface coal mine or in the surface work areas of an underground coal mine shall be required to wear ...

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(c) "[p]rotective gloves when handling materials or performing work which might cause injury to the hands; however, gloves shall not be worn where they would create a greater hazard by becoming entangled in the moving parts of equipment.

Since Clay and Shivley were working on equipment that had not been deenergized, they should have been wearing protective gloves to insulate them from contact with energized parts.3

3The record does not contain any evidence that the wearing of gloves in the situation at bar would have "... create[d] a greater hazard by becoming entangled in the moving parts of

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Accordingly, since they were not wearing gloves, I find that Elk Run did violate Section 77.1710(c), \textit{supra}.

Therefore, based on all the above, I find that the Secretary has established that Elk Run violated Section 77.1010(c), \textit{supra}.

**IV. Significant and Substantial**

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

In \textit{Mathies Coal Co.}, 6 FMSHRC 1, 3-4 (January 1984), the Commission explained its interpretation of the term "significant and substantial" as follows:

In order to establish that a violation of a mandatory safety standard is significant and substantial under \textit{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.

In \textit{United States Steel Mining Company, Inc.}, 7 FMSHRC 1125, 1129 (August 1985), the Commission stated further as follows:

We have explained further that the third element of the \textit{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." \textit{U. S. Steel Mining Co.}, 6 FMSHRC 1834, 1836 (August 1984). We have emphasized that, in accordance with the language of section 104(d)(1), it is the \textit{contribution} of a violation to the cause and effect of a hazard that must be significant and substantial. \textit{U. S. Steel Mining Company, Inc.}, 6 FMSHRC 1866, 1868 (August 1984); \textit{U. S. Steel Mining Company, Inc.}, 6 FMSHRC 1573, 1574-75 (July 1984).

The record clearly establishes the first two elements set forth above, i.e., that Elk Run did violate mandatory standards (Sections 77.501, \textit{supra}, 77.704-1(a), \textit{supra}, and 77.1710(c), \textit{supra}.

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equipment." (Section 77.1710(c), \textit{supra}).

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and that the violations contributed to the risk of a hazardous condition, i.e. a person being subject to electrical shock and injuries. Further, Shivley and Clay were working around exposed metal parts in a relatively confined area that was energized with at least 480 volts, and they were not wearing protective gloves. I also note that when Shivley was testing in Compartment No. 1 when the accident at issue occurred, his meter exploded. Thus, I find, given the continuation of the normal operations of their work, that it was reasonably likely that the violations herein would have led to serious injury or electrical shock. Hence, the fourth element of Mathies, supra, has been met. I conclude that Citation No. 7224658 and Order No's 7224659 and 7224660 were significant and substantial.

V. Unwarrantable Failure

A. Smith’s testimony

Smith found each of the violations alleged in Order Numbers 7224659 and 7224660 to constitute an unwarrantable failure. Smith based his opinion on Thompson’s negligence, referring to the latter’s extensive experience at Elk Run as an electrician, and his position as a line-crew foreman. According to Smith, “[h]e’s the one that installed the transformers on the pole.” (Tr. 92). Smith further testified that Thompson “... was also aware that electrical work was going to be performed in this specific compartment and he was aware that the disconnecting and deenergization device was closed on the pole. ... he was also aware that opening a disconnecting device on the equipment to be worked on is not sufficient.” (Tr. 57).

Based on his interviews with Roach, Thompson, Clay and Shivley, Smith concluded that when Thompson exited his vehicle and left the area used for parking adjacent to the cited area, he would have seen that the pole disconnects were in the closed position. According to Smith, the pole disconnects were between a foot to 18 inches long, 3/4 to one inch in diameter, and were in a “conspicuous location” (Tr. 50), approximately ten to 15 feet above the ground.

Additionally, Smith indicated that Thompson met with Clay and Shivley prior to their commencement of testing at the cabinet at issue; that Thompson “... stands ... in front of the motor control center[;]... [and that] he sees in the open compartment the open upper area and lower area, and, most importantly, the incoming high-voltage termination area, and he also ... still has a plain sight view of these disconnects on the pole in the closed, energized position.” (Tr. 51). Smith opined that Thompson, as a foreman, was required to be on the alert for hazards whether or not the miners exposed to the hazards reported directly to him. Smith asserted that

4According to Smith, in discussions Clay and Shivley had with Thompson regarding the situation of the broken fuse, the former indicated that they would check for a grounded phase in the motor. Smith indicated that Clay and Shivley “discussed” with Thompson that they were going to check “grounds on the motor ... in the Compartment 1 lower level incoming high-voltage termination compartment. (Compartment 1, Gx. 22) (Tr. 85, 86).
Thompson should have been aware that the disconnects on the pole were closed, and therefore should have required the work site to be safe, prior to the commencement of work on the cabinet at issue by Clay and Shivley.

**B. Shivley’s Testimony**

Shivley testified when he examined Compartment No. 1, he went behind it to see where the power lines entered the cabinet, and “[i]t looked like the incoming power was rather high in through the box or the compartment.” (Tr. 137). Shivley indicated, based on his approximately 30 years experience as an electrician, that leads supplying power to a starter box or compartment usually enter it at the top. According to Shivley, the wires going to the bottom of the compartment appeared to be the same size as the motor junction box located on the motors.

Shivley indicated that once it was determined that there was a bad fuse in the compartment at issue, he told the mine foreman, Charles Roach that he needed to get in touch with either Ron Plumley, the maintenance superintendent, or Nick Thompson, who he referred to as “the high line installer”, to obtain a fuse. (Tr. 150).

When Thompson arrived he (Shivley) told the latter that a fuse had blown on the belt motor. According to Shivley, Thompson, who was not directing the repairs or supervising him, asked if he had a device to check the insulation on the motor, as he (Thompson) did not have one with him. Shivley indicated that he had his own meter, and told Thompson that he was going to check if the belt motor was grounded. After completing this task, Shivley returned to the starter box cabinet. He indicated that Thompson was no longer there.

**C. Clay’s testimony**

According to Clay, when he and Shivley discussed the bad fuse with Thompson he (Clay) said that there must be a short in the belt motor. Thompson did not tell them to open the disconnects on the power pole, nor did he suggest that gloves be worn before working on “... that compartment[.]” (Tr. 179-180). According to Clay, there were not any insulated gloves in the area.

Clay and Shivley went to the belt motor, and observed a lot of tape on various leads. Clay thought it was best to test for grounding at the starter belt cabinet, rather than at the motor. Clay indicated that Thompson did not direct them to do any testing at the cabinet.

**D. Thompson’s testimony**

Thompson testified that on the date in issue he was not in charge of any repairs that Clay and Shivley were making, nor did he direct their work. He said he received a telephone call from Tommy Green, who told him that he thought there was an overload problem at No. 1 silo, and
asked him (Thompson) to go there "... to see if I could assist them."\(^5\) When Thompson arrived at the area in question, Shivley and Clay had already removed fuses from the compartment at issue, and determined that one had blown. The fuses were tested in his presence along with Roach, Shivley and Clay. Thompson observed that the compartment at issue had been opened, and he saw that the disconnect had been pulled, which normally would offer protection. He indicated that he did not ensure that power was not coming into the cabinet, nor did he ask Clay or Shivley if they had pulled the disconnects at the power pole. Thompson had a discussion with Clay and Shivley relating to testing the power lines leading to the belt motors.

After Clay returned from testing the belt motors, he told Thompson that the leads on the motor were taped. Thompson told Clay that he could test at the motor starter and get the same reading as testing the motors. According to Thompson, he did not tell Clay where to go to perform the testing. Thompson indicated that as he was leaving the area to return to his duties, he heard a "bang." \(^{186}\)

E. The Secretary’s Position

Essentially, it is the Secretary’s position that Thompson, an experienced electrician, who is a high-line crew supervisor, and in general is responsible for safety, should have noticed, upon his arrival at the area in question, that the “conspicuous” disconnects on the power poles were in the closed position, and that he should have ensured that power would not flow to the power center where men were working. \(^{15}\) Also, it is argued that Thompson knew that Clay and Shivley were working in a cabinet that was connected to a high-voltage lead,\(^6\) but did not ensure the cabinet was deenergized, nor did he instruct them to wear gloves.

It is further argued that Thompson should have ensured that power was not flowing into the compartment before he inspected the fuses and suggested that the motor control center be tested.

The Secretary argues that Thompson, as a “foreman”, is an agent of Elk Run \(^{15}\), and is held to a high standard of care. Accordingly, his nonfeasance constituted high negligence which is imputed to the company. As a result, it is asserted that the

\(^{5}\)Earlier, Shivley had told Roach that he had a bad fuse and suggested that Ron Plumley, the head of maintenance, or Thompson, be contacted to see if they had a fuse. Roach testified that he then called the mine office, and asked Green, the belt-man, to contact Plumley or Thompson.

\(^{6}\)The Secretary in her reply to Elk Run’s proposed findings of fact, refers to \(1\) Thompson’s testimony on cross-examination, that he knew that Clay and Shivley “had” worked inside the cabinet at issue, \(^{201}\) and \(2\) Smith’s testimony, in essence, that Thompson was fully aware that electrical measurements were going to be taken in the compartment at issue.
violations resulted from Elk Run’s unwarrantable failure.

The Secretary relies on Capitol Cement Corporation, 21 FMSHRC 883, (1999), Midwest Material Company, 19 FMSHRC 30 (1997) and Lion Mining Company, 19 FMSHRC 1774, (1997), as supporting a finding of unwarrantable failure, arguing that Thompson’s failure to ensure power would not flow to the power center where Clay and Shivley were working is similar to the circumstances found to constitute unwarrantable failure in these cases.

F. Discussion

1. Case law

In Virginia Slate Co., 23 FMSHRC 482 (2001) the Commission summarized case law pertaining to unwarrantable failure as follows:

Regarding unwarrantable failure, that terminology is taken from section 104(d) of the Mine 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); see also Buck Creek Coal, Inc. v. MSHA, 52 F.3d 133, 136 (7th Cir. 1995) (approving Commission’s unwarrantable failure test).

Whether conduct is “aggravated” in the contest of unwarrantable failure is determined by looking at all the facts and circumstances of each case to see if any aggravating factors exist, such as the length of time that the violation has existed, the extent of the violative condition, whether the operator has been placed on notice that greater efforts are necessary for compliance, the operator’s efforts in abating the violative condition, whether the violation is obvious or poses a high degree of danger, and the operator’s knowledge of the existence of the violation. See Consolidation Coal Co., 22 FMSHRC 340, 353 (Mar. 2000), appeal docketed, No. 01-1228 (4th Cir. Feb. 21, 2001) (“Consol”); 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.,

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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.

Virginia Slate Co., supra, at 486.

The negligence of a rank-and-file miner is not imputable to the operator for purposes of penalty assessment or unwarrantable failure. Whayne Supply Company, 19 FMSHRC 447, 451-453, (1997), U.S. Coal, Inc., 17 FMSHRC 1684, 1686. However, the negligence of an operator's agent is imputable (See, Whayne, supra at 451, Rochester and Pittsburgh Coal Company, 13 FMSHRC 189, 194-197 (1991)) U.S. Coal, supra, at 1686.

2. Thompson as an Agent of Elk Run

The parties stipulated that Clay and Shivley were rank-and-file employees of Elk Run. Therefore, their negligence may not be imputed to Elk Run. (Whayne, supra).

Section 3(e) of the Federal Mine Safety and Health Act of 1977 defines an "agent" as "any person charged with responsibility for the operation of all or part of a ... mine or the supervision of the miners in a ... mine ... ." (30 USC § 802(e)). In this connection, in considering whether an employee is an operator's agent, the Commission has relied upon "... his function, [and whether it] was crucial to the mine's operation and involved a level of responsibility normally delegated to management personnel." (U.S. Coal, Inc., 17 FMSHRC 1684, 1688 (Oct. 1995); See also, Ambrosia Coal & Construction Company, 18 FMSHRC 1552, 1560 (1996) (holding that an employee of the operator was an agent because "... the functions performed by [the employee] were crucial to the mine's operation and demonstrated an exercise a responsibility normally delegated to management personnel.").) Ambrosia, supra, at 1561 (emphasis added).

There is not any evidence regarding Thompson's specific duties as line crew foreman. 7 However, Thompson had been an electrician working on a line crew until he assumed his position as foreman approximately three months prior to the incident at issue. Since Clay and Shivley, both electricians, were rank-and-file employees, it would appear that, as a foreman, Thompson was no longer a rank-and-file employee. Of more significance, is the testimony of Roach, the mine foreman, who agreed that it would be a duty of a foreman to have safety hazards eliminated. Thus, it would appear that the scope of Thompson's duties as foreman are those normally performed by operators. (See, Ambrosia, supra at 1561; See also, Section 2(e)(f) of the

7Thompson indicated that he is often called upon to address problems with high-voltage relating to power lines or transformers.
Mine Act (Congressional declaration that mine operators “have the primary responsibility to prevent unsafe conditions”). Therefore, it appears that Thompson, in general, is to be considered an agent of Elk Run.

3. Thompson’s Feasance or Nonfeasance as a Basis for Unwarrantable Failure

It is clear that the violations at bar constituted a high degree of danger, and it was obvious that the pole disconnects had not been pulled, and that Clay and Shivley were not wearing gloves. The key issue is whether Thompson, as Elk Run’s agent, knew of the existence of the violations.

The record establishes that Thompson knew that Clay and Shivley had worked inside the cabinet at issue; that they had opened the cabinet door; and that the disconnect inside the cabinet was in the open position. Also, he knew that opening the disconnect inside the cabinet would not disconnect power coming into the cabinet, but he did not ensure that the disconnects on the power pole had been pulled, and that the visible disconnects were tagged and locked. Nor did he require Clay and Shivley to wear protective gloves.

Smith opined, that Thompson was aware that electrical measurements were going to be taken in the compartment at issue. His testimony indicates that this opinion was based upon his investigation which revealed that Clay and Shivley discussed in Thompson’s presence that they were going to check for a grounded phase in the motors which, according to Smith, would require that electrical measurements be taken. (Tr. 52-53). However, not much weight was accorded this hearsay testimony as it was not corroborated by any of the declarants. Moreover, it is unclear how knowledge that Clay and Shivley intended to check motors for grounding, leads to an inference of Thompson’s knowledge of testing to be done in the compartment at issue.

Further, even if Thompson knew that Clay and Shivley were intending to work at this cabinet there was not any evidence in the record that he was aware of a violative condition i.e., that the disconnecting device had not been pulled open at the power pole. Although he may have passed the pole on his path to the area at issue, he did not have knowledge or notice then of any condition or practice that would have alerted him to check this disconnect.

In general, Thompson, as a supervisor, had a high duty to ensure safe conditions. However, in the context of unwarrantable failure, the scope of the inquiry is not the degree of care required of Thompson based on his position of foreman per se, but rather, as applied to his supervisory responsibility for the specific violative acts, his actions relative to the violative conditions, and his observations and knowledge of them. (c.f., Capital Cement Corp., supra).

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8Thompson indicated that when addressing a high-voltage problem, the first step is to ensure the disconnects are pulled and work will be performed on the deenergized side of the disconnects.
There is not any evidence that he was responsible for repair or maintenance of the compartment at issue. He was a line-crew foreman, and did not direct or supervise electricians Clay and Shivley. Nor did Thompson direct any of the work at issue performed by Clay and Shivley. Further, he did not receive any directive to perform or supervise any of the work at issue. He was at the site only because Roach, having been informed by Shivley that a fuse was bad, asked Green, a belt-man who was in the mine office, to contact either Plumley the maintenance chief, or Thompson. Green informed Thompson that there was an overload problem at silo No. 1 and asked him to go there “... to see if [he] could assist them.” (Tr. 195).

Thompson’s actions at the site at issue were extremely limited. The weight of the evidence establishes that he assisted in the testing of a defective fuse with a meter along with Shivley and Clay, and subsequently discussed with Roach where fuses may be obtained. Also, he talked to Clay and Shivley about testing motors. When Clay informed him about the presence of tape on the leads at the belt motor, Thompson told him that he could get the same reading at the motor starter. However, he did not direct Clay where to go to do any testing at the motor starter. Moreover, there is not any evidence that the motor starter was located in the cabinet at issue.

Thompson had not performed any work relating to the compartments at issue, was not responsible for them, and did not know their electrical layout. Also, there is not any evidence that he received any training regarding the electrical layout. Further, it has not been established that Thompson knew or was aware of work to be performed at the compartment at issue. Moreover, he did not witness the violative acts at issue.

The Secretary relies on Capital Cement, supra, (aggravated conduct was found where a trained shift supervisor responded to a safety concern that a crane was shaking, operated the crane and began to work on the craneway; but failed to lock out any power sources to the crane or, to wear a safety belt while working on the craneway); Midwest Material Co., supra, (a serious lack of care and indifference was found where the actions of a foreman, designated to be in charge of a boom extension project, failed to lower the crane boom in accord with proper procedures, and did not warn a miner working with him of the danger of the actions the latter took to disassemble the crane boom was found to constitute a lack of care and indifference “... given his experience and familiarity with [the] task ...” (Midwest Material, supra, at 35) and Lion Mining Co., 19 FMSHRC 1774 (1997), (relied on the Secretary’s Post-Hearing Reply Brief) (affirmed the trial judges’ determination that the conduct of the section foreman who observed

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9 According to Thompson’s uncontradicted testimony, he builds and maintains power lines and is called on to address problems with the high-voltage lines or transformers, but not relating to the compartments at issue.
the miner operator starting to take a cut without installing roadway posts in violation of the roof control plan, was a factor tending to establish an unwarrantable failure). 10

Thus, in each of these cases, the basis for a finding of unwarrantable failure was (1) conduct of a supervisor who was actually performing or supervising the repair work at issue, (Capital Cement, supra, Midwest Material, supra) or (2) the observations of a section foreman that a violation was taking place and his failure to stop the operation.

In contrast, in the case at bar, Thompson did not either perform or supervise the repair work at issue. Nor did he observe a violation actually taking place.

Within the context of all the above, and considering the presence of significant mitigating factors, I find that it has not been established that the level of Thompson's negligence regarding Citation No. 724658 and Order Nos. 7224659 and 7224660 reached the level of aggravated conduct. Thus, I find that it has not been established that these violations were as the result of Elk Run's unwarrantable failure. (See, Emery Mining Corp., supra).

G. Penalty

I find, for the reasons set forth above, (II, infra), that the level of gravity in each of the violations herein was relatively high, as serious injuries could have resulted as a consequence of employees not wearing protective gloves, while working in close proximity to energized equipment. Also, essentially for the same reasons as discussed above (V, infra), and noting the lack of evidence that Elk Run had provided training to Clay and Shivley regarding the wiring of the cabinet at issue, I find that the negligence in each of the violations to have been moderately high. Taking into account the remaining factors in Section 110(i) of the Act as stipulated to by

10 The Secretary in a Post-Hearing Reply Brief (“Reply Brief”) also relies on Wilmot Mining Company, 9 FMSHRC 684 (1987). The Secretary asserts that Wilmot, supra, held that it is sufficient for a supervisor to allow a hazard to remain uncorrected to justify a finding of unwarrantable failure (Reply Brief at 3). It is argued that accordingly, Wilmot, supra, supports its position that the Commission has never held that a foreman must actively supervise the work being performed to support a finding that his or her actions or inaction constitute an unwarrantable failure. (Id.). However, Wilmot, supra, does not support the Secretary's position. In Wilmot, supra, contrary to the Secretary's assertion, the issue was not unwarrantable failure, but whether the operator was negligent and whether its supervisor's negligence should be imputed to the operator, or if it was unforeseeable. It thus is not applicable to the issues presented in the case at bar.

The Secretary also relies on Mountain Cement Co., 15 FMSHRC 1418 (1993), (ALJ), and Peabody Western Coal Co., 25 FMSHRC 293 (ALJ) (2003). Inasmuch as these are decisions by fellow Commission judges, I am not bound by them. To the extent that they are not consistent with the decision reached in this proceedings, I choose not to follow them.

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the parties, the lack of evidence justifying either an increase or decrease in penalty based on the operators’ good faith abatement, and history of violations, and placing significant weight on the high level of gravity for each of the violations, I find that a penalty of $8,000 for each violation is appropriate.

ORDER

It is Ordered that Citation No. 7224658 and Order Nos. 7224659 and 7224660 be amended to Section 104(a) citations that are significant and substantial. It is Further Ordered, that within the thirty days of this decision, Elk Run pay a total civil penalty of $24,000 for the violations found herein.

Avram Weisberger
Administrative Law Judge

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29 FMSHRC 464
June 5, 2007

SPARTAN MINING COMPANY, INC., Contestant

v.

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

CONTEST PROCEEDINGS

Docket No. WEVA 2004-117-RM
Citation No. 7224650; 04/13/2004

Docket No. WEVA 2004-118-RM
Citation No. 7224651; 04/13/2004

Docket No. WEVA 2004-119-RM
Citation No. 7224652; 04/13/2004

Docket No. WEVA 2004-120-RM
Citation No. 7224654; 04/13/2004

Docket No. WEVA 2004-121-RM
Order No. 7228963; 04/13/2004

Docket No. WEVA 2004-122-RM
Order No. 7228964; 04/13/2004

Ruby Energy
Mine ID 46-08808

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

v.

SPARTAN MINING COMPANY, INC., Respondent

CIVIL PENALTY PROCEEDINGS

Docket No. WEVA 2005-34
A.C. No. 46-08808-41145

Docket No. WEVA 2005-53
A.C. No. 46-08808-45208

Ruby Energy

DECISION

Appearances: Keith E. Bell, Esq., Office of the Solicitor, U.S. Department of Labor, Arlington, Virginia, for the Petitioner;
Mark E. Heath, Esq., Spilman Thomas & Battle, PLLC, Charleston, West Virginia, for the Respondent.

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Before: Judge Feldman

These consolidated proceedings, consisting of six contest and two civil penalty matters, arise under the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 801 et seq. (2000) ("Mine Act"). The hearing was conducted on January 31 and February 1, 2007, in Charleston, West Virginia. The petitions for assessment of civil penalty filed by the Secretary of Labor against the respondent, Spartan Mining Company, Inc., pursuant to section 110(a) of the Mine Act, 30 U.S.C. § 820(a), sought to impose a total civil penalty of $128,460.00 for six alleged violations of the Secretary’s mandatory safety standards. The violations were identified as a result of a Mine Safety and Health Administration (MSHA) investigation of a February 5, 2004, fatal electrical accident that occurred at Spartan’s Ruby Energy Mine. The accident occurred when the victim, Kenneth A. McNeely, a 33 year old electrician with six years mining experience, was electrocuted while repairing a continuous miner trailing cable that had been struck by the continuous miner’s ripper head. (Gov. Ex. 10).

At the hearing the parties advised that they had settled two of the six citations and orders in issue. Specifically, the parties agreed to settle 104(a) Citation No. 7224654 and 104(d) Order No. 7228964 that are subjects in the civil penalty proceeding in Docket No. WEVA 2005-53. The parties’ settlement agreement was approved on the record and is discussed below. This decision concerns the remaining two 104(a) citations, one 104(d) citation, and one 104(d) order.

I. Statement of the Case

At approximately 1:04 p.m. on February 5, 2004, a continuous mining machine ran over its high voltage distribution trailing cable causing a phase to phase fault that immediately de-energized the continuous miner and caused a loss of power to the entire mine facility, including an interruption of mine fan ventilation.1 McNeely was killed when the continuous miner’s circuit breaker was closed by Spartan’s foreman while McNeely was attempting to repair the trailing cable. As a result of the accident, Spartan was cited for failing to withdraw miners from the working section after stoppage of the mine’s ventilation fan; failing to protect the trailing cable from damage by mobile equipment; failing to remove the continuous miner from service; and failure to lock out the high-voltage trailing cable prior to performing repairs. Spartan has stipulated that the trailing cable was not locked out at the time of the accident. (Tr. 53).

1 Both the mine’s carbon monoxide sensor data base and the Appalachian Electric Power Company’s (Appalachian’s) metering base monitoring system reflect power was interrupted for 14 minutes. The carbon monoxide sensor reflects that power was lost from 1:04 p.m. until 1:18 p.m. (Tr. 116-18). Appalachian’s meters reflect a drop in mine milliwatt consumption at 1:01 p.m. and a return to normal electrical consumption at 1:15 p.m. (Gov. Ex. 10, p.7). For the purposes of this decision, the period of power loss is determined to be from 1:04 p.m. until 1:18 p.m. as reflected by the carbon monoxide sensor.

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An important issue in these civil penalty matters is the degree of negligence that is directly attributable to Spartan for each of the contested violations, and whether the negligence of Spartan’s hourly employees should be imputed to Spartan based on inadequate supervision and control of its mine personnel. In its post-hearing brief, the Secretary, noting that Commission judges make de novo findings with respect to the appropriate civil penalty based on the evidence adduced at trial, requests that consideration should be given for the imposition of higher civil penalties than those initially proposed by the Secretary. (Sec'y br. at pp.28-29).

II. Background

A continuous mining machine “cuts or rips coal from the face and loads it onto conveyors or into shuttle cars in a continuous operation.” Am. Geological Institute, Dictionary of Mining, Mineral, and Related Terms 122 (2d ed. 1997). The ripper head of a continuous miner is the cutting drum that extracts the coal from the face. It contains angled steel tooth bits that are analogous to a circular saw. (Tr. 98-99). A continuous mining machine is a heavy piece of equipment weighing as much as several tons. (Tr. 157).

The continuous miner is energized by a high powered 995 VAC alternating three phase system trailing cable. The outer rubber jacket of the trailing cable houses the three insulated phase wires that carry the alternating current. (Tr. 87-90). The trailing cable also contains a metallic monitor wire and a ground wire. (Tr. 85-86, 93-94).

The trailing cable is connected at the power center by inserting the plug, also known as a “cathead,” at the end of the trailing cable to a wall receptacle. (Tr. 103). Next to the wall receptacle is a circuit breaker and a toggle switch that renders the circuit breaker ineffective. The circuit breaker trips in the event of a short circuit. The toggle switch also trips along with the circuit breaker in the event of a phase to ground fault.

At the time of the accident the continuous miner was located in the No. 3 entry approximately six crosscuts inby and 1½ entries to the right of the power center. By way of measurement, facing in an inby direction at the power center, the continuous miner was 380 feet inby and 40 feet to the left of the power center. (Tr. 111-13; Gov. Ex 1).

A short circuit phase to phase power failure occurs when two phase wires come in contact with each other tripping (opening) a circuit breaker. (Tr. 125). A ground fault occurs when one phase connects with the ground. While a short circuit phase to phase failure trips a circuit breaker, it does not render the circuit breaker inoperable in that the circuit breaker can be closed restoring power to the shorted cable. (Tr. 134-35). A ground fault involving the monitor or ground wire also trips the toggle switch at the power center rendering the circuit breaker ineffective in that it cannot be closed. (Tr. 94).

The lock out procedure consists of removal of the trailing cable plug, or cathead, from the power center receptacle by the individual performing repairs. After the trailing cable is

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unplugged from the power source, that individual places a padlock in a specially designed ring or lip at the end of the plug. Placing the padlock at the end of the plug prevents anyone from connecting the cable to the power source while the cable is being repaired. (Tr. 102-03).

As evidenced by the fatality, a damaged high power electrical cable poses an extreme danger to anyone coming in contact with exposed wires. In recognition of this electrocution hazard Spartan has a policy of protecting cables that consists of maintaining cables against ribs to keep them out of the path of mobile equipment. Spartan also has a policy of disciplining personnel who fail to ensure that trailing cables are protected. (Tr. 159-60).

MSHA Inspector James Humphrey described the proper actions a mine operator should take if a trailing cable is run over, even if there is no interruption of power. Humphrey explained:

[i]he proper action that the mine operator should take once being made aware of this condition, he should have a certified electrician de-energize the power from that cable and have it checked, the ground, the ground fault and the phases, and see if there’s any problems in [the cable].

(Tr. 466-67).

Similarly, Steven Neace, Spartan’s Ruby Energy Mine Superintendent, testified:

Neace: If a cable’s run over and they determine it is unsafe, they’re to pull the cathead, have the electrician check it and check it with a meter, see if its grounded. If its not grounded, then they can go back to resume operations, put the cable back in service, put that equipment back in service.

Court: O.K. So it’s either remove it from service and check to see if the cable is damaged. And if the cable is not damaged, return it to service; right?

Neace: Right.

(Tr. 657-58).

Keith Hainer, a certified electrician employed by parent company Massey Coal Services as its Director of Maintenance, also testified regarding procedures to be followed when a trailing cable is struck by mobile equipment. Hainer opined that, “in my experience, I have seen cables with internal damage and the outer jacket intact.” (Tr. 718). Hainer described the method to “discern if there’s damage or not.” (Tr. 720). Hainer testified:
Well, I'm saying instead of cutting into [the cable], I may use other methods. For example, to go to the power center and use different electrical devices [meters] to test insulation integrity without physically cutting into the cable. And that's not uncommon to do.

(Tr. 722-23).

Thus, Humphrey, Neace and Hainer all agree the proper action after a cable is run over is to first immediately de-energize the cable at the power station and then check the cable by using meters to ensure that the cable is not damaged and unsafe. If the cable is damaged it must be kept out of service. As discussed below, Spartan failed to follow its own safety policy.

Section 75.313, 30 C.F.R. § 75.313, governs the evacuation procedures when power to a mine ventilation fan is interrupted. In the event of a mine fan stoppage, electrically powered equipment in each working section must be de-energized. Miners must immediately be withdrawn from the working section to a location outby the loading point where they may remain for 15 minutes.² If mine ventilation is not restored within 15 minutes, all miners must be evacuated to the surface. As discussed herein, McNeely and other crew members were not withdrawn from the working section despite a loss of mine fan power. Although the crew should have been required to retreat from the working section, the crew was not required to leave the mine because power was restored in less than 15 minutes.

III. Findings of Fact

The following factual summary primarily is based on stipulated facts that are supported by MSHA's investigative findings. Factual findings based on testimonial evidence are indicated by reference to the transcript.

Spartan's Ruby Energy Mine is located near Delbarton, in Mingo County, West Virginia. The mine utilizes the room and pillar method. On February 5, 2004, the 002 section crew, under the direction of section foreman Gilbert W. Sada, entered the mine at their regular starting time of 7:00 a.m., arriving at the 002 section at approximately 7:20 a.m. Sada's crew included electrician Kenneth McNeely, continuous miner operator Jamie Hatfield, shuttle car operator Kenneth Collins and scoop operator Charles Smith.

There were two continuous mining machines on the 002 section. The continuous miner on the left side of the section was used to mine a line of pillars from the No. 4 entry to the No. 1 entry. The continuous miner on the right side of the section mined pillars from the No. 8 entry to the No. 5 entry.

² Section 75.2, 30 C.F.R. § 75.2, of the Secretary’s regulations defines the “working section” as “all areas of the coal mine from the loading point of the section to and including the working faces.”
Hatfield began operating the left continuous miner in the No. 4 entry at approximately 7:35 a.m. Mining continued in the No. 3, No. 2 and No. 1 entries as the day progressed. Upon completion of the No. 1 entry, Hatfield backed the continuous miner two crosscuts outby the pillar line in the No. 3 entry for servicing. Hatfield and McNeely serviced the continuous mining machine while the right continuous miner was used to mine the next row of pillars from the No. 8 entry to the No. 5 entry. At the time power was lost at 1:01 p.m., the right continuous mining machine was in the No. 7 entry.

According to Hatfield, McNeely left the area in the No. 3 entry where the machine had been serviced. After McNeely left, Sada instructed Hatfield to move the continuous mining machine into the No. 4 entry to start mining. It was Spartan’s practice to keep the trailing cable against the rib to prevent damage from the continuous miner. (Tr. 538). Hatfield was unaware that one loop of the cable had migrated from the rib into the path of the continuous miner. (Tr. 526, 538). As Hatfield trammed the continuous miner a distance of approximately 21 inches, one of the bit lugs on the ripper head, also called the cutting drum, struck the trailing cable damaging the phase wire insulation, causing the phase wires to contact each other ultimately resulting in a phase to phase short circuit. (Tr.156-57, 174). The continuous miner immediately ceased to operate having lost power the instant the ripper head made contact with the trailing cable. At that time, it was also apparent that power had been lost for all section equipment at the power station. Ventilation was simultaneously interrupted as the mine fan ceased operating. The mine’s carbon monoxide sensor data base reflects that mine power was lost at approximately 1:04 p.m.

Although Hatfield now claims that, at the time of the accident, he believed the loss of power was caused by a widespread Appalachian Power Company outage, Hatfield reluctantly conceded his initial belief was that the continuous miner lost power because the trailing cable had been damaged. Hatfield testified:

Court: Okay. I just want to understand in my mind. When you say that the cable was not that bad, how do you mean that?

Hatfield: Well, it didn’t appear to me that it was hurt. Like I say, the outer jacket wasn’t even hurt. The bit lug, it didn’t smash through the cable. It was just -- barely had it caught to where I couldn’t pull it out. It wasn’t --.

Court: Did you have any reason to believe that the cable was damaged?

Hatfield: No.

Court: Did the power to the continuous miner go off at the same time that the bit lug hit the -- came into contact with the cable?

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When I went to tram backwards in order to reposition my miner, that’s when the power went off on the miner. I went walking toward the miner, and as I was walking toward the front of the miner to look at the cable, I noticed that all the power was off.

When I went backwards in order to reposition my miner, that’s when the power went off on the miner. I went walking toward the miner, and as I was walking toward the front of the miner to look at the cable, I noticed that all the power was off.

All right. Did you make a - - was there any connection in your mind between the power to the continuous miner going off and the ripper head hitting the cable?

When I was operating the miner, the first thought I had was that it was the cable problem. That’s what I thought first.

(Tr. 511-13).

Foreman Sada and shuttle car operator Collins were a few feet outby the continuous mining machine when contact with the ripper head occurred. (Joint Stip. No. 15). Sada described his position as “approximately 45 feet from the ripper head,” and he agreed that he was “in close proximity” to the ripper head when the cable was struck. (Tr. 550, 561). As Sada observed Hatfield tramming the continuous miner, the continuous miner lost power and there was a loss of power throughout the section. Sada asked Hatfield if he had struck the cable. Sada testified Hatfield responded that “I’m on it, but I’m barely on this cable.” (Tr. 557).

Sada admits he noticed the loss of power at the same time Hatfield told him the ripper head had contacted the cable. (Tr. 562, 563-64). Although Sada, like Hatfield, now claims that, at the time McNeely was electrocuted, he believed there was a wide spread utility company outage, he conceded that his “first instinct” was that the loss of power was attributable to the damaged cable. (Tr. 554).

Sada left Hatfield and Collins at the continuous miner and walked four crosscuts outby and one entry to the right arriving in the No. 4 entry where the section phone was located by the feeder. (Gov. Ex. 1). Sada phoned outside to the surface and spoke to superintendent Neace who informed Sada that all underground power, power to the preparation plant, and power to the mine fan were out.

Neace and Sada claim that Sada did not inform Neace that the trailing cable was struck when power was lost. Neace and Sada also claim Neace told Sada that “Appalachian’s got us out.” (Tr. 275-79). MSHA accident investigators interviewed Sada and Neace shortly after the accident during interview sessions conducted on February 8, February 10, and February 23, 2004. (Gov. Ex. 10). MSHA’s accident report did not find that Spartan was acting under the mistaken belief that a power company failure had occurred at the time of the accident. Id. Moreover,
it is significant that Neace does not assert that he told McNeely that the loss of power was due to a utility company failure when McNeely telephoned Neace moments after Neace had spoken to Sada.

Surprisingly, both Sada and Neace testified that, even with the benefit of hindsight, they still do not believe the striking of the cable and simultaneous loss of power should have alerted them that the cable was damaged. (Tr. 561, 648-53). In fact, despite a mandatory company policy of testing cables that have been run over for potential damage, Neace testified that he continues to believe that the loss of power at the exact time the cable was struck could have been “a coincidence” that occurred at the exact moment a utility company power outage occurred. (Tr. 652, 657-58).

At approximately 1:06 p.m., while Sada was at the feeder speaking to Neace on the phone, Hatfield and Collins attempted to remove the trailing cable from beneath the continuous miner’s ripper head. However, their attempts failed. Collins walked approximately six crosscuts outby to the section belt head to retrieve a scoop for the purpose of using the scoop to bump the ripper head from the trailing cable. Collins met scoop operator Charles Smith at the belt head. Collins and Smith brought the scoop back to the continuous miner.

As Sada left the area of the feeder where the section phone was located, McNeely approached the section phone. Between 1:07 p.m. and 1:08 p.m., McNeely phoned Neace who remained on the surface. Neace states that McNeely inquired what Sonny Vance, the chief electrician, had done to de-energize the high voltage. Neace stated he told McNeely that he did not know, and that all personnel would have to leave the mine if the ventilation fan did not resume operation within 15 minutes. (Joint Stip. No. 7). Significantly, as previously noted, Neace apparently did not tell McNeely that the loss of power was due to an Appalachian Power Company failure. 4

Sada returned to the continuous miner at approximately 1:09 p.m. As he approached he could see the scoop being operated in front of the continuous miner. At that time, McNeely had returned from the section phone and was sitting on a personnel carrier in the crosscut adjacent to

3 Reconstruction of the timing of events is based on Spartan’s chronology admitted into evidence as a DVD. (Tr 712-14; Resp. Ex. B). The record was left open for a written synopsis of the DVD summary of events. (Tr. 773-74). Spartan submitted the written summary on May 1, 2007.

4 McNeely phoned Neace at 1:07 p.m. McNeely began the repair shortly thereafter and was killed at approximately 1:18 p.m. Neace requested an ambulance at approximately 1:20 p.m. It is difficult to determine the purpose of McNeely’s telephone call if McNeely and Neace did not discuss the cause of the power loss only minutes before McNeely was to begin repairing the cable.

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Sada's position between the No. 3 and No. 2 entries. Sada states he told McNeely that the power was off, the mine fan was down, and that they would have to go outside in 15 minutes.

Smith bumped the scoop against the ripper drum, allowing Hatfield to pull the trailing cable free. According to Hatfield and Sada, at that time, Sada overheard Hatfield say the cable was freed, and, that the cable jacket "was not even busted." (Joint Stip. 11).

After Sada left to go to the right side of the section to inform miners that they may have to evacuate the mine, McNeely arrived at the continuous mining machine and told Hatfield and Collins "that he needed to check the damaged area of the cable." (Stip. No. 12). Although Hatfield and Sada deny they had any reason to believe the cable was damaged, it is apparent that McNeely immediately recognized the short circuit in the cable.

McNeely also informed Hatfield and Collins that they had 15 minutes until they had to leave the section. McNeely began cutting the outer jacket off the trailing cable "at the damaged area." (Joint Stip. 12).

Smith returned the scoop to the section belt head. After traveling to the right side of the section, Sada returned to the section mine phone.

McNeely and Hatfield continued repairing the cable as Collins pulled on the waterline, that was also stuck, in an attempt to remove it from under the ripper drum. McNeely cut about 14 inches of the outer jacket off the trailing cable, exposing the three power phases, a ground wire, and a monitor wire. Two of the power phases were burned and needed to be cut and spliced. The outer jacket on the third power phase was damaged and needed to be re-insulated. The ground and monitor wires were not damaged. McNeely walked to his personnel carrier to get tape and connectors. He returned on his personnel carrier, parking it behind the continuous mining machine.

As McNeely worked on the second power phase, Hatfield heard a humming noise and felt air movement. The mine carbon monoxide sensor data base reflects power was restored to the mine at 1:18 p.m., approximately 14 minutes after power was lost. McNeely asked Collins to go to the section power center to see if mine power had been restored. After repairing the first two phases, McNeely began work on the third phase. He cut the third phase apart and prepared both ends for the connector.

Sada was at the dumping point area at 1:18 p.m., waiting for a call from Neace, when the main re-closer switch located on the surface apparently was closed restoring power to the mine. Sada noticed air pressure on the back-up check curtains indicating that the mine fan was operating and he realized that mine power had been restored.

Sada went to the section power center and started closing the circuit breakers for all of the face equipment. All cable plugs were still attached to their receptacles on the power center.
Sada knew that the trailing cable had not been locked out because the cathead was plugged into the power station receptacle. (Tr. 602; Gov. Ex. 3K). Sada first closed the circuit breaker for the right continuous mining machine. At approximately 1:20 p.m., Sada next closed the circuit breaker for the left continuous mining machine. McNeely, who was still working on the third power phase, received a fatal electrical shock when the electrical energy was transferred through McNeely when the circuit breaker was closed. The trailing cable’s circuit breaker momentarily closed and instantaneously opened as the phase to ground fault tripped the ground fault toggle switch. Sada continued to engage the circuit breakers for the shuttle cars, scoop chargers, and pumps.

As Collins walked toward the power center to see if the power had been restored, he saw Sada closing the circuit breakers. Collins called out to Sada, telling him not to close the circuit breaker for the left continuous mining machine. Collins heard Sada say, “Oh, no.” (Joint Stip. 18).

Hatfield checked McNeely for vital signs and called for help. He immediately started performing CPR. Randy Mahon, the right continuous mining machine operator, who was in the No. 4 entry, heard Hatfield calling for help and called out to Sada and Collins to go to the left continuous mining machine. Mahon traveled to the mine phone at the section dumping point and called outside to Neace. He told Neace that a person had been electrocuted and that an ambulance was needed. Sada, Collins, Vance and other members of the crew helped with first aid and the transportation of McNeely out of the mine.

The ambulance service was notified by Neace at approximately 1:20 p.m. The ambulance arrived at the mine site at 1:35 p.m., just before McNeely was brought to the surface. The ambulance departed the mine with McNeely at 2:08 p.m., arriving at Williamson Memorial Hospital at 2:40 p.m., where it was determined that McNeely had died.

There is a re-closer, also known as a closure switch or main circuit breaker, located on the surface that feeds electrical power throughout the mine property on the surface and underground. Circuit breakers are tripped (opened) as a consequence of under-voltage or loss of power. Circuit breakers are designed with intentional delays of as little as hundredths of a second to allow the circuit breaker closest to the fault to open before the main mine re-closer senses a loss in power and de-energizes the entire mine. (Tr. 677). When the re-closer opens, all circuit breakers in the mine trip as a safety precaution, so that when the re-closer is closed and power is restored to the mine, equipment does not automatically re-energize. (Tr. 681-82).

An MSHA accident investigation team arrived at the mine shortly after the accident. The investigation team included MSHA Inspector James R. Humphrey and MSHA Electrical Engineer Marcus Smith, both of whom testified at the hearing. The accident investigators found that a bit lug on the right side of the ripper drum damaged the cable, bursting the inner voltage insulation, allowing two power phases to contact each other. Although such an event would normally only cause a loss of power to the mining machine at the power center, in this case, the
resulting phase-to-phase short circuit nearly burned through the conductors and caused the main mine re-closer that supplies electricity underground and on the surface to de-energize, resulting in a loss of power to entire underground mine, the mine fan and the preparation plant. The left side continuous mining machine circuit breaker also opened as a result of the fault. The opening of the main mine re-closer caused all other mine section circuit breakers to open.

The investigators determined the widespread power failure occurred because the tolerance, or timing, between the two breakers was close enough for the fault to pass through the circuit breaker for the continuous miner opening the re-closer. (Tr. 678-79). In other words, the short circuit response time of the re-closer was improperly set. (Gov. Ex. 10, p. 7). The malfunction was corrected by resetting the timing for the re-closer.

As previously noted, Spartan is contesting two 104(a) citations, one 104(d)(1) citation, and one 104(d)(1) order in these proceedings. Namely, Citation No. 7224651, issued under 104(a) of the Mine Act, cites a violation of the mandatory safety standard in 30 C.F.R. § 75.606 for failure to protect trailing cables from damage from mobile equipment; Citation No. 7224650, issued under section 104(a) of the Mine Act, cites a violation of the mandatory safety standard in 30 C.F.R. § 75.511 for failing to lock out high-voltage cables prior to repair; Citation No. 7224652, issued under section 104(d)(1) of the Mine Act, cites a violation of the mandatory safety standard in 30 C.F.R. § 75.1725(a) for failing to remove unsafe equipment from service; and Order No. 7228963, issued under section 104(d)(1) of the Mine Act, cites a violation of the mandatory safety standard in 30 C.F.R. § 75.313(a)(3) for failing to immediately withdraw mine personnel from the working section to a position outby the loading point when mine fan ventilation was interrupted. The merits of the citations and order, as well as their appropriate civil penalties, are addressed below.

IV. Further Findings of Fact and Conclusions

Before addressing the merits of the contested citations, it is helpful to address the underlying issues of negligence and the penalty criteria that apply in these matters. The issue of duplicative citations will also be addressed because the lock out procedure is required for both removal from service and for repair.

a. Imputation of Negligence

As a threshold matter, the degree of negligence attributable to a mine operator is an essential element of a civil penalty proceeding. While there are several contributing causes of this accident, the proximate cause of the fatality is the failure to lock out the trailing cable prior to performing repairs. Spartan attempts to diminish its responsibility by asserting that McNeely was a certified electrician familiar with tag and lock out procedures who had participated in annual training that emphasized the importance of following such procedures. (Spartan br. at p.14).
Obviously, McNeely’s failure to lock out was a grievous mistake. Sada told McNeely he would have to leave the mine in 15 minutes. McNeely attempted to repair the cable during this 15 minute period. McNeely continued to repair the cable even after he apparently realized that mine power had been restored. Perhaps McNeely, an experienced electrician, believed that the continuous miner would remain de-energized based on his conversations with Neace and Sada. In the final analysis, McNeely’s explanation for his conduct cannot be ascertained. Lacking the benefit of McNeely’s perspective, I am unable to conclude that McNeely’s failure to follow fundamental lock out procedures rose to the level of employee misconduct. In other words, given the facts in this case, it is inappropriate to place blame primarily on the victim.

Nevertheless, the Secretary’s regulation in 30 C.F.R. § 75.511 requires electrical equipment undergoing repair to be locked out only by “the persons who perform such work.” Thus, the Secretary’s mandatory safety standard clearly required McNeely to lock out the trailing cable. However, with respect to Spartan’s negligence and culpability in these proceedings, the analysis does not stop there.

Operators are liable without regard to fault for violations of the Mine Act. See e.g., Sewell Coal Co. v. FMSHRC, 686 F.2d 1066, 1071 (4th Cir. 1982); Allied Products Co. v. FMSHRC, 666 F.2d 890, 893-94 (5th Cir. 1982); Western Fuels-Utah, Inc., 10 FMSHRC 256, 260-61 (March 1988), aff’d on other grounds, 870 F.2d 711 (D.C. Cir. 1989); Asarco, Inc., 8 FMSHRC 1632, 1634-36 (Nov. 1986), aff’d, 868 F.2d 1195 (10th Cir. 1989). Thus, even in the event of serious employee misconduct, the Commission and the courts have also consistently held that a miner’s misconduct in causing a violation is not a defense to liability. See, eg. Allied Products, 666 F.2d at 893-94. In this regard, in Ideal Cement Co., 13 FMSHRC 1364, 1351 (Sept. 1991), the Commission noted that, “under the liability scheme of the Mine Act, an operator is liable for the violative conduct of its employees, regardless of whether the operator itself was without fault and notwithstanding the existence of significant employee misconduct.”

While a mine operator’s fault, or lack thereof, is not determinative on the issue of a fact of occurrence of a violation, it is an important factor to be considered in assessing a civil penalty. Asarco, Inc., 8 FMSHRC at 1636. Ordinarily, the conduct of rank-and-file miners is not imputable to the operator in determining the degree of negligence for penalty purposes. Southern Ohio Coal Co., 4 FMSHRC 1459, 1464 (Aug. 1982). Rather, the operator’s supervision, training, and disciplining of its miners is relevant. Id.; Western Fuels-Utah, Inc., 10 FMSHRC at 261.

As Spartan’s mine foreman, Sada was acting as Spartan’s agent at the time of the accident. Thus, Spartan is liable for Sada’s direct acts of negligence. For example, for degree of culpability purposes, Spartan can be properly charged with Sada’s direct acts of negligence such as Sada’s failure to order the withdrawal of personnel from the working section although he knew mine fan ventilation had been interrupted. Moreover, as discussed below, negligence
associated with the lock out failure can be directly attributable to Spartan as Sada concedes he knew the cathead had not been locked out when he closed the continuous miner’s circuit breaker. His spontaneous utterance of “Oh, no” when Collins cautioned him not to close the circuit breaker is evidence of Sada’s awareness that the trailing cable required repair.

Although McNeely was the person responsible for placing the padlock on the cathead, Hatfield apparently knew the trailing cable had not been tested for damage or otherwise locked out prior to repair. Notwithstanding the negligence that can be directly attributed to Spartan, the negligence of McNeely and Hatfield must also be imputed to Spartan as a consequence of Sada’s lack of supervision and control of his subordinates. Spartan cannot escape the imputation of negligence of rank-and-file personnel by asserting that its foreman was unaware of the actions of his crew. *Id.* In this regard, Spartan’s assertion: that Sada did not direct Hatfield and Collins to retrieve a scoop for the purpose of freeing the cable; that Sada did not direct Collins and Smith to use the scoop to bump the ripper head off of the cable; and that Sada did not know McNeely was repairing the cable; are aggravating rather than mitigating circumstances. Moreover, all of these activities were permitted to occur during a period when the loss of ventilation required the removal of everyone from the working section.

Finally, any claimed mitigation based on Spartan’s assertion that Sada had not informed Neace, the mine superintendent, of the potential hazard caused by the trailing cable is unavailing. It is well settled that the principal (Spartan) is charged with the knowledge of its agent (Sada).

b. Civil Penalty Criteria

Section 110(i) of the Mine Act 30 U.S.C. § 820(i), sets forth the statutory civil penalty criteria used to determine the appropriate civil penalty to be assessed. In this regard, 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.

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*5* Despite observing the immediate loss of power when the cable was struck, Hatfield and Sada now allege that they did not think the trailing cable was damaged because the ripper head had barely touched the cable and the outer jacket “did not look bad.” (Tr. 507-08). As discussed *infra*, it is difficult to imagine why Hatfield and Sada did not wait to tram the continuous miner off of the cable after power was restored if they believed the trailing cable was not damaged, instead of using the scoop to dislodge the cable.
Commission judges make *de novo* findings with respect to the penalty criteria in section 110(i) based on the record in adjudicatory proceedings, and they are not bound by the Secretary’s proposed civil penalties. *Sellersburg Stone Co.*, 5 FMSHRC 287, 291 (Mar. 1983), *aff’d*, 736 F.2d 1147 (7th Cir. 1984). Spartan is a large mine operator and the imposition of the civil penalties in this matter will not impede Spartan’s ongoing business operations. The history of violations and Spartan’s abatement efforts are not a material factor in determining the appropriate penalty liability. As a general proposition, the material considerations concern gravity and negligence. The magnitude of gravity associated with subject violations is self evident. As discussed below, the magnitude of negligence revealed by the trial testimony and documentary evidence that is attributable to Spartan, either directly or through imputation, requires the imposition of civil penalties that are higher than those initially proposed by the Secretary.

c. 104(a) Citation No. 7224651 - Protection of Cable

Citation No. 7224651 alleges a violation of the mandatory safety standard in section 75.606, 30 C.F.R. § 75.606. The citation states:

The 2/0 AWG trailing cable that provides 995 VAC power to the Joy 14CM15 left continuous mining machine, serial number 1408, was not protected to prevent damage by mobile equipment. When the mining machine, which was parked about 20 feet out by surveyor spad 3463, was trammed forward about 21 inches, the cutter head smashed the cable. This forced energized conductors from two phases to come into contact, creating a short circuit that caused a loss of electrical power to the entire mine. This violation is a contributing factor to the fatal accident which occurred on February 5, 2004, on the 001 MMU, 10th right section, at a location approximately 20 feet out by surveyor spad 3463 in the number 3 entry.

(Gov. Ex. 4). The citation was designated as significant and substantial (S&S) and it was alleged that it was reasonably likely that the hazard caused by the cited condition will result in a fatality. The gravity of the violation was characterized as severe in that a fatality had occurred. The degree of negligence attributed to Spartan by the Secretary was moderate. The Secretary proposed a civil penalty of $32,500.00 for Citation No. 7224651.

Section 75.606 of the Secretary’s regulations provides that “[t]ailing cables shall be adequately protected to prevent damage by mobile equipment.” Section 75.606 implements a miner safety statute. Thus, the goal of section 75.606 is to protect miners not cables. This mandatory standard furthers safety by requiring mine operators to protect miners from the hazard posed by damaged cables.

29 FMSHRC 478
Spartan argues that the facts do not support a violation of section 75.606 because Spartan has a policy to prevent cables from damage, as well as a personnel policy whereby persons causing damage to a trailing cable will be disciplined. (Spartan br. at p.9). Spartan summarized its policy in its post-hearing brief:

Ruby Energy’s policy is that, if a cable has been run over and it is determined to be unsafe, the electrician would remove the cathead, effectively removing it from service, and the electrician checks it to determine if it is grounded. (Tr. 657). If the cable is not damaged, the equipment may be placed back in service. (Tr. 658).

Id.

With respect to the fact of occurrence of the violation, as previously noted, the Mine Act is a strict liability statute. Substance governs over form. Thus, a policy of protecting miners from the hazard associated with damaged trailing cables does not insulate an operator from liability in the event of cable damage. The fact that the trailing cable was run over and damaged by the continuous miner is beyond dispute. Accordingly, the facts support a violation of section 75.606.

The degree of negligence that should be attributed to Spartan is a more complex issue. The evidence reflects Spartan tried to keep trailing cables out of the path of mobile equipment by keeping the cables against the ribs. In this instance, the cable was damaged because, unbeknownst to Hatfield who was tramming the continuous miner remotely, a portion of the cable had become dislodged from the rib and looped in front of the continuous miner. Thus, the act of running over the cable while tramming the continuous miner evidences, as the Secretary suggests, no more than a moderate degree of negligence. However, analysis of the degree of negligence issue does not stop here.

As Spartan recognizes, the section 75.606 obligation placed on mine operators to prevent damage to cables from mobile equipment includes the obligation to ensure that cables struck by mobile equipment are not damaged. In other words, operators cannot satisfy their responsibility of protecting cables by turning a blind eye after cables are struck. That is why Spartan admits it has a policy of removing a cathead from service and checking for damage if a cable is run over. However, Spartan failed to follow its own policy. The question is the degree of negligence that should be attributed to Spartan for its failure to follow its basic safety policy.

This brings us to the fundamental issue that is present throughout these proceedings. Namely, whether there is substantial evidence that Sada, as Spartan’s agent, knew or should have known that there was at least a reasonable likelihood that the trailing cable was damaged. The Commission has held that “the substantial evidence standard may be met by reasonable
inferences drawn from indirect evidence.” *Mid-Continent Res., Inc.*, 6 FMSHRC 1132, 1138 (May 1984). Inferences based on indirect evidence are “inherently reasonable” if there is a “logical and rational connection between the evidentiary facts and the ultimate fact to be inferred.” *Id.*

Sada’s assertion that he did not believe the cable was damaged is not supported by the facts. Sada was standing in close proximity to the continuous miner when he observed the instantaneous loss of power when the destructive and invasive ripper head of a multi-ton piece of equipment came to rest on top of the trailing cable. (Tr. 550, 557, 561). Both Sada and Hatfield concede they initially believed the loss of power was caused by the damaged trailing cable. (Tr. 511-13, 554, 562, 563-64). It is difficult to reconcile the purported subsequent belief of Hatfield and Sada that the trailing cable was not damaged, with the decision to bump the ripper head with the scoop to dislodge the cable, instead of waiting to tram the continuous miner off of the cable after power was restored. Rather, it appears that the use of the scoop was motivated by a desire to access the damaged portion of the cable so that it could be repaired. Sada and Hatfield’s exculpatory assertions to the contrary are entitled to little weight.

Finally, Spartan has not explained the discrepancy between McNeely’s immediate realization that the cable was damaged with Sada’s purported belief that the cable remained intact. In the final analysis, a person familiar with electrical equipment used in the mining industry should have appreciated the significance of the loss of power upon contact with the trailing cable. *Alabama By-Products Corp.*, 4 FMSHRC 2128 (Dec. 1982). The assertion that Sada did not have a substantial basis for believing the cable was damaged simply is not credible. 6

However, even if Sada believed the cable was undamaged despite the continuous miner’s loss of power, Sada still knew the trailing cable had been run over by the continuous miner. Under such circumstances, Sada’s failure to ensure that the cathead was disconnected from the power station and tested to determine if it had been damaged constituted a reckless disregard of an electrocution hazard. As its agent, Sada’s negligence is directly attributable to Spartan.

Resolution of the questions of significant and substantial and gravity are self-evident. 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. *Mathies Coal Co.*, 6 FMSHRC 1, 3-4 (Jan. 1984); *Nat’l. Gypsum Co.*, 3 FMSHRC at 825. The Commission has explained that an S&S finding requires the Secretary to establish a reasonable likelihood that the hazard contributed to will result in an event in which there is an injury. *U.S. Steel Mining Co., Inc.*, 6 FMSHRC 1834, 1836 (Aug. 1984). The Commission has also emphasized it is the

6 Obviously, Sada did not intend to harm McNeely. This was a tragic accident. One can only speculate why the trailing cable circuit was closed. It may have been closed by mistake during a moment of inattention while Sada was closing other section equipment breakers at the power station after the restoration of power.
contribution of a violation to the cause and effect of a hazard that must be significant and substantial. *Id.* at 1868. 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).

The hazard contributed to by failing to ensure that distribution cables remain undamaged is illustrated by this accident. When damaged electrical cables are ignored, they are not de-energized or otherwise isolated to prevent hazardous contact. In short, they present the hazard of electrocution. Accordingly, the violation of section 75.606 is properly designated as S&S. Obviously, the gravity of the violation is extreme as evidenced by the fatality in this case.

As noted, Spartan is a large mine operator. It has neither been contended nor shown that the imposition of the civil penalties in this case will pose a financial hardship that will interfere with Spartan’s continuing mining operations. Given the S&S nature of the violation, the extreme gravity, and the reckless disregard that gave rise to its occurrence, a civil penalty of $50,000.00 shall be imposed for Citation No. 7224651.

d. The Duplicate Citation Issue

Spartan has stipulated that the trailing cable was not locked out. Thus, it is undisputed that the continuous miner was neither removed from service nor locked out prior to repair. However, Spartan contends that Citation No. 7224650 citing a violation of 30 C.F.R. § 75.511 for failing to lock out high-voltage cables prior to repair, and Citation No. 7224652 citing a violation of 30 C.F.R. § 75.1725(a) for failing to remove unsafe equipment from service, are duplicate citations. In support of this argument, Spartan avers that both the repair of electric equipment and its removal from service require the equipment to be locked and tagged out. Thus, Spartan argues that these citations are duplicative because they do not impose separate and distinct legal duties on the mine operator.

It is well settled, as Spartan suggests, that citations are duplicative if the cited standards do not impose separate and distinct duties upon an operator. *Western Fuels-Utah, Inc.*, 19 FMSHRC 994, 1003-05 (June 1997); *Cyprus Tonopah Mining Corp.*, 15 FMSHRC 367, 378 (Mar. 1993). In determining if separate and distinct duties are required, the Commission looks to whether the cited mandatory standards require the same acts or omissions. *Cumberland Coal Resources, LP*, 28 FMSHRC 545, 553 (Aug. 2006).
Here, Spartan was obligated to choose between distinct alternative duties. It could have immediately locked out the continuous miner for the purpose of initiating repairs, or, it could have postponed repairing this unsafe equipment by removing it from service by means of locking and tagging it out. Spartan chose to do neither. Its inaction constituted separate and distinct acts of omission. Consequently, Citation Nos. 7224650 and 7224652 are not duplicative. A discussion of the merits of each citation follows.

e. 104(a) Citation No. 7224650 - Lock Out Procedure

Citation No. 7224650 alleges a violation of the mandatory safety standard in section 75.511, 30 C.F.R. § 75.511. The citation states:

The section electrician and the continuous mining machine operator performed electrical work on a distribution circuit while the disconnecting device was not locked out nor suitably tagged. They were splicing and repairing a damaged area in the 2/0 AWG trailing cable which provided 995 VAC power to the Joy 14CM15 left continuous mining machine, serial number 1408, while the cable plug was connected to the plug receptacle. While performing this work, the circuit breaker was closed, causing the section electrician to be electrocuted.

This violation is a contributing factor to this fatal accident which occurred on February 5, 2004, on the MMU, 10th right section, at a location approximately 20 feet out by surveyor spad 3463 in the number 3 entry.

(Gov. Ex. 6). The citation was designated as significant and substantial (S&S) and it was noted that the hazard caused by the cited condition resulted in a fatality. Thus, the gravity of the violation was characterized as severe in that a fatality occurred. The degree of negligence attributable to Spartan by the Secretary was moderate. The Secretary proposed a civil penalty of $32,500.00 for Citation No. 7224650.

Section 75.511 of the Secretary's regulations provides, in pertinent part:

No electrical work shall be performed on low-, medium-, or high-voltage distribution circuits or equipment, except by a qualified person or by a person trained to perform electrical work and to maintain electrical equipment under the direct supervision of a qualified person. Disconnecting devices shall be locked out and suitably tagged by the persons who perform such work.

Spartan has stipulated that the trailing cable's cathead was connected to the power center and not locked out at the time McNeely was performing repairs. Consequently, the facts demonstrate the fact of occurrence of a section 75.511 violation. With respect to negligence, it is true that the terms of section 75.511 required McNeely, as the certified electrician performing repairs, to lock out the cathead at the power source. McNeely's failure to do so was either a
careless act evidencing extremely high negligence, or a conscious omission based on his belief that power would remain off. In either event, McNeely’s conduct was highly negligent.

The question is whether the negligence associated with the failure to utilize basic lock out procedures can be either directly attributed to, or, imputed to Spartan. McNeely was the only electrician at the section. McNeely immediately realized the cable was damaged and in need of repair. As previously discussed, Sada knew the continuous miner had lost power the instant the ripper head contacted the trailing cable. Sada also admits he knew the trailing cable had not been locked out at the power center even though it had been run over by mobile equipment. (Tr. 602; Gov. Ex. 3K). As previously discussed, Sada had reason to know that the cable was damaged. Sada’s failure to respond to the potential hazard posed by a damaged cable constitutes a conscious disregard that is directly attributable to Spartan. As noted, even Sada’s mistaken belief that the cable was undamaged is not a mitigating circumstance because it was brought about by Spartan’s failure to follow its own safety procedures that would have confirmed the defective condition of the cable.

With respect to imputation, as previously noted, the negligence of a rank-and-file miner can be imputed to a mine operator if the miner is not properly supervised. As a threshold matter, proper supervision required withdrawal from the working section as a consequence of the interruption of mine ventilation. Thus, McNeely, Hatfield and Collins should have been ordered to withdraw from the working section rather than continue to work on the cable in an environment devoid of mine ventilation. Instead, Sada permitted McNeely, the only electrician at the section, to remain at the site of the damaged cable without ensuring that proper procedures were followed. Sada’s lack of supervision as evidenced by his asserted lack of knowledge of the activities of the members of his crew, including his electrician, when ventilation was interrupted and a trailing cable had been struck, warrants the imputation of an extremely high degree of negligence.

It is apparent that Citation No. 7224650 was properly designated as S&S in that it is reasonably likely that the failure to lock out a damaged distribution cable prior to performing repairs will result in a fatal electrocution accident. The contribution of the violation to a fatality reflects the extreme gravity of the cited violation. Given the S&S nature of the violation, the extreme gravity, and the reckless disregard that enabled a splicing repair to occur on a damaged cable that Spartan knew was not locked, a civil penalty of $50,000.00 shall be imposed for Citation No. 7224650.

f. 104(d) (1) Citation No. 7224652 - Removal From Service

Citation No. 7224652 alleges a violation of the mandatory safety standard in section 75.1725(a), 30 C.F.R. § 75.1725(a). The citation states:

The operator, after witnessing the creation of an unsafe condition on a piece of mobile equipment, failed to cause the equipment to be immediately removed from service. When the 995 VAC Joy 14CM15 left continuous mining machine (serial
number 1408) trammed onto its 2/0 AWG trailing cable, the section foreman was present and knew that the cable was damaged. He also witnessed the mining machine losing power when this occurred. Afterwards, the section foreman closed the circuit breaker, thereby energizing the trailing cable, without first:

(A) causing the cable plug to be immediately disconnected from its receptacle and
(B) instructing the section electrician to do the necessary troubleshooting, testing, and repair work on the cable to restore it to a safe condition. The section electrician, who was splicing and repairing the cable, was electrocuted.

(Gov. Ex. 5). The citation was designated as significant and substantial (S&S) and it was noted that the hazard caused by the cited condition resulted in a fatality. Thus, the gravity of the violation was characterized as severe in that a fatality occurred. The degree of negligence attributable to Spartan was high and the Secretary attributed the cited violation to an unwarrantable failure. The Secretary proposes a civil penalty of $56,000.00 for Citation No. 7224652.

Section 75.1725(a) of the Secretary’s regulations provides:

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

The thrust of the alleged violative act is Spartan’s failure to immediately remove unsafe equipment from service. The Commission has held that a mine operator should be charged with knowing that equipment was unsafe if a reasonably prudent person, familiar with the factual circumstances surrounding the allegedly hazardous condition, including any facts peculiar to the mining industry, would recognize a hazard warranting corrective action. Alabama By-Products, supra, 4 FMSHRC 2129. Despite Neace and Hainer’s description of a standard industry practice and company policy of removing an electrical cable from service that has likely been damaged by mobile equipment for testing and repair, Spartan failed to do so. It is obvious that the fact of occurrence of this cited violation is demonstrated by the circumstances in this case.

With respect to negligence, Spartan has been charged with an unwarrantable failure under section 104(d) of the Mine Act, 30 U.S.C. § 814(d). 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) (“Consol”).

29 FMSHRC 484
Aggravating factors include the length of time that the violation has existed, the extent of the violative condition, whether the violation is obvious or possess a high degree of danger, and the operator’s knowledge of the existence of the violation. See Consol, 22 FMSHRC at 353.

Sada knew the cable was struck by the ripper head. Sada also knew that power was lost the moment the trailing cable was struck. Just as a light switch opens a circuit and interrupts power to a light fixture, Sada knew or should have known that cable damage is manifest by an interruption in power to the continuous miner. Spartan concedes that a damaged electrical cable constitutes an extremely hazardous condition. Spartan’s failure under these circumstances to immediately remove the continuous miner from service by ensuring that the damaged trailing cable remained locked out and de-energized constituted a grievous departure from industry safety standards. There are no facts that mitigate these aggravating circumstances. In short, Spartan’s conduct was unwarrantable.

It is apparent that Citation No. 7224652 was properly designated as S&S in that the failure to lock and tag out a damaged distribution cable was the proximate cause of a fatal electrocution accident. The contribution of the violation to the fatality reflects the extreme gravity of the cited violation. Given the S&S nature of the violation, the extreme gravity, and the unwarrantable conduct that resulted in the violation, a civil penalty of $60,000.00 shall be imposed for Citation No. 7224652.

g. 104(d) (1) Order No. 7228963 - Withdrawal From Working Section

Order No. 7228963 alleges a violation of the mandatory safety standard in section 75.313(a)(3), 30 C.F.R § 75.313(a)(3). The citation states:

During an unplanned main mine fan stoppage the operator did not withdraw everyone from the working section. Air quality bottle samples taken [sic] last quarterly inspection results reveal 4320 CFM of methane is being liberated every 24 hours.

The trailing cable supplying power to the Joy 14CM1015 continuous mining machine serial number 1408 was damaged when the ripper head came in contact with the trailing cable, mashing the trailing cable between a bit lug and the mine floor. This condition caused the mine power to be deenergized at the closure switch which supplies electrical power to the entire mine property, which includes the preparation plant, mine office facilities, underground mine power and the underground mine ventilation fan.

The section foreman allowed the section electrician and several co-workers to perform electrical work on the trailing cable which is located 3 crosscuts inby the section dump point in the #3 entry, 20' outby survey station 2462, which is located one crosscut outby the pillar line during the power outage to the mine ventilation fan. The
electrical power [was] restored [at] approximately 1:15 p.m. to the underground mine and mine ventilation fan. The electrical circuit breaker that supplies power to the trailing cable is energized which results in an electrical fatal accident of the section electrician, who was allowed to work on this damaged trailing cable during the fan outage.

This violation was discovered during the investigation of the fatal electrical accident that occurred on February 5, 2004, and it has just been determined that this is a non-contributing violation.

(Gov. Ex. 9). The citation was designated as non-significant and substantial (non-S&S) because MSHA concluded that the violation did not directly contribute to McNeely’s death. The non-S&S designation was also based on the fact that the Ruby Energy Mine did not liberate large quantities of methane. It was noted that eight miners were affected by the failure to withdraw from the working section. The degree of negligence attributable to Spartan was high and the cited violation was attributed to an unwarrantable failure. The Secretary proposes a civil penalty of $3,700.00 for Order No. 7228963.

Section 75.313(a)(3) of the Secretary’s regulations requires, in pertinent part, that all miners must be withdrawn from the working section if a mine fan stops and there is no adequate back-up fan system. Section 75.313(c)(1) requires everyone to be withdrawn from the mine to the surface if mine ventilation is not restored within 15 minutes. In this case, the parties agree that the interruption of mine fan ventilation lasted 14 minutes. Consequently, section 75.313 required the miners to retreat from the working section, although they were not required to evacuate from the underground mine.

The fact of occurrence of the cited violation is readily apparent. There was a 14 minute interruption of mine fan ventilation. Although Sada told his crew that they would have to return to the surface if ventilation was not restored in 15 minutes, Sada admits that he did not order his crew to retreat from the working section at any time during the 14 minute mine fan stoppage. (Tr. 567-70).

With regard to the issue of S&S, it is difficult to understand why the Secretary would characterize this violation as one that could not significantly and substantially contribute to the cause and effect of a mine safety hazard that is reasonably likely to result in a significant injury. As demonstrated by the provisions of the cited mandatory standard, loss of mine ventilation is a very serious matter. Methane is not diluted and swept from the working faces. Consequently, any ignition source poses an explosive hazard. As evidenced in this case, the loss of ventilation can cause a chaotic situation that breeds poor judgement and a lack of due diligence if miners are not removed from the working section. If McNeely had been withdrawn from the working section, instead of being allowed to repair an electrical cable while mine fan power was lost, he would not have been electrocuted. Thus, the Secretary’s conclusion that Spartan’s failure to withdraw all miners from the working section did not contribute to the fatality is surprising.
However, the Commission’s role is adjudication rather than enforcement. The Commission does not have the authority to issue or modify citations. Thus, the Commission has concluded that its administrative law judges are not authorized to modify the Secretary’s non-S&S designations on their own initiative. *Mechanicsville Concrete, Inc.*, 18 FMSHRC 877, 879 (June 1996). Consequently, I am constrained by the Secretary’s non-S&S designation.

Turning to the issue of gravity, the Commission has recognized that the focus on the seriousness of a violation is on the effect of the hazard if it occurs rather than the likelihood of injury. *Consolidation Coal Company*, 18 FMSHRC 1541, 1550 (Sept. 1996). Permitting mine operations to continue during a hazardous period caused by an interruption of mine ventilation exposes miners to serious or fatal injuries. As previously noted, it enables miners to work under abnormal conditions rather than waiting for conditions to stabilize before returning to normal mining operations. In this case eight miners were affected and a fatality occurred. Consequently, despite its non-S&S designation, the failure to withdraw from the working section was an extremely serious violation.

Turning to the issue of negligence, Sada knew the mine fan had stopped. Yet, instead of ordering miners from the working section, Sada stood by while Hatfield initially tried to free the cable, and, subsequently, while Hatfield and Collins attempted to dislodge the ripper head with the scoop. Moreover, at a minimum, Sada knew McNeely remained in the vicinity of the trailing cable that was likely damaged. Although Sada advised his crew that they would have to evacuate the mine if fan power was not restored within 15 minutes, his failure to withdraw personnel from the working section was a reckless disregard of proper safety procedures. Consequently, the cited violation was correctly attributable to Spartan’s unwarrantable failure.

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). Thus, although the violation in Order No. 7228963 has been designated as non-S&S, greater weight must be accorded to the material facts that reflect that the cited condition affects the entire section’s personnel, that is indicative of extreme gravity, and that it is attributable to unjustifiable and inexcusable conduct. In the final analysis, the Secretary’s non-S&S designation cannot be allowed to unduly diminish the effects of extreme gravity and unwarrantable conduct that warrant a higher civil penalty.

Ensuring the rapid and safe withdrawal of miners faced with hazardous conditions is fundamental to mine safety. A conscious failure to withdraw miners immediately as a result of an interruption of mine fan ventilation warrants a significant civil penalty. Likewise the grave nature of the violation as well as the fatality that followed justify a substantial penalty. Although the Secretary has designated the violation as non-S&S, the failure to abide by the cited mandatory safety standard was not an insignificant violation. Accordingly, a civil penalty of $30,000.00 shall be assessed for Order No. 7228963.
h. Approval of Settlement

At the hearing the parties presented a settlement agreement concerning 104(a) Citation No. 7224654 and 104(d)(1) Order No. 7228964. The parties settlement agreement was approved on the record. (Tr. 20-23). This citation and order are subjects of Docket No. WEVA 2005-53. The settlement terms follow.

The Secretary initially proposed a civil penalty of $60.00 for 104(a) Citation No. 7224654. The citation, designated by the Secretary as non-S&S, cited a violation of the mandatory safety standard in section 75.310(b)(1) that requires a mine fan power circuit to operate independent of all other mine power circuits. The condition was attributed to a moderate degree of negligence. It was abated after the mine fan was separated from all other mine circuits. The parties have agreed to a reduced civil penalty of $50.00 in satisfaction of Citation No. 7224654.

The Secretary initially proposed a civil penalty of $3,700.00 for 104(d)(1) Order No. 7228964. The order, designated by the Secretary as non-S&S, cited a violation of the mandatory safety standard in section 75.3113(b) that specifies, if mine fan ventilation is restored within 15 minutes, certified persons must examine for methane in working places before work is resumed and before equipment is energized or restarted. The condition was attributed to an unwarrantable failure. The parties have agreed to a reduced civil penalty of $2,800.00 in satisfaction of Order No. 7228964.

i. Summary of Liability

Thus, the total settlement amount is $2,850. 104(d)(1) Order No. 7228963, that was assessed a civil penalty of $30,000.00 in this proceeding, is the remaining order in the civil penalty proceeding in Docket No. WEVA 2005-53. Spartan’s total civil liability for this docketed proceeding is $32,850.00.

The total liability for 104(a) Citation No. 7224651, 104(a) Citation No. 7224650 and 104(d)(1) Citation No. 7224652 that are the subjects of the civil penalty proceeding in Docket No. WEVA 2005-34 is $160,000. Thus, the total civil penalty for the six violative conditions in issue is $192,850.00.

ORDER

ACCORDINGLY, the parties’ settlement motion IS GRANTED. Pursuant to the parties’ agreement, Spartan Mining Company, Inc., IS ORDERED TO PAY $2,850.00 in satisfaction of 104(a) Citation No. 7224654 and 104(d)(1) Order No. 7228964.

Consistent with this Decision, IT IS ORDERED that 104(a) Citation Nos. 7224651 and 7224650, 104(d)(1) Citation No. 7224652, and 104(d)(1) Order No. 7228963 ARE AFFIRMED.
IT IS FURTHER ORDERED that Spartan Mining Company, Inc., shall pay a total civil penalty of $190,000.00 in satisfaction 104(a) Citation Nos. 7224651 and 7224650, 104(d)(1) Citation No. 7224652, and 104(d)(1) Order No. 7228963 that were adjudicated in these proceedings.

IT IS FURTHER ORDERED that Spartan Mining Company, Inc., shall pay a total civil penalty of $192,850.00 in satisfaction of the six citations and orders that are the subject of these contest and civil penalty proceedings. Payment is to be made to the Mine Safety and Health Administration within 40 days of the date of this Decision. Upon timely receipt of payment, the captioned contest and civil penalty matters ARE DISMISSED.

Jerold Feldman
Administrative Law Judge

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/mh
June 6, 2007

BUZZI UNICEM USA, Contestant

v.

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

C. Gregory Ruffennach, Esq., Washington, DC, for Buzzi Unicem USA; Thomas A. Paige, Esq., and Matthew P. Sallusti, Esq., Office of the Solicitor, U.S. Department of Labor, Dallas, Texas, for the Secretary of Labor.

Before: Judge Manning

These cases are before me on two notices of contest filed by Buzzi Unicem USA ("Buzzi") and one petition for assessment of civil penalty filed by the Secretary of Labor, acting through the Mine Safety and Health Administration ("MSHA") 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"). Buzzi contested a citation issued under section 104(a) of the Mine Act and an order of withdrawal issued by the Secretary under section 104(b) of the Mine Act. An evidentiary hearing was held in Pryor, Oklahoma. The parties introduced testimony and documentary evidence and filed post-hearing briefs.

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I. BACKGROUND WITH FINDINGS OF FACT

Buzzi operates Lone Star Plant, Mill & Quarry ("Plant"), an open-pit limestone quarry and cement plant, in Mayes County, Oklahoma. As relevant here, mined limestone is processed and sent to one of three kilns, which are rotating furnaces used to heat the processed limestone. The kilns are contained in long horizontal cylindrical tubes. The kilns rotate at varying speeds between 65 to 75 revolutions per hour. All three kilns burn coal, gas, and scrap tires for fuel. A two-tiered automatic conveyor system ("tire feeder" or "conveyor system") transfers the tires to the kilns. The tire feeder consists of eight separate conveyor belts and other devices that feed the tires to the kilns in coordination with the rotation of the kilns. This system was designed by an independent contractor, which specializes in the installation of tire feeding systems. The system was installed at the plant in 2003 and was expanded in 2004. All moving parts are protected by guards, and pull cords are located along the walkway of each conveyor that will de-energize it. MSHA conducted a compliance assistance visit ("CAV") after the system was installed and another CAV after the system was expanded.

Tractor trailers deliver the tires to the plant. The trailers are tipped to dump out the tires. The tires move along a walking floor to a singulator, which operates like a coin sorter. This singulator places the tires, single file, on the first of eight conveyor belts, which are numbered from start to finish. The conveyors vary in length between 7 and 74 feet. All of the tires move along the first three conveyors. Near the end of Conveyor No. 3, the tires are directed to one of the three kilns. Tires going to Kilns 1 or 2 are ejected onto Conveyor No. 4. Next, they travel on Conveyor No. 5 to an upper deck. At this level there are four additional conveyors that feed the No. 1 and 2 kilns via the No. 2 turntable. The tires that remained on the No. 3 conveyor go onto the No. 1 turntable that supplies tires to the No. 3 kiln. There are slots in the rotating kilns and the belts are coordinated so that a tire drops into the slot of each kiln about once a minute.

The burning of scrap tires was enabled by the adoption of automation technology, which permits the movement of the conveyors to be synchronized with the rotating kilns. The conveyor system is operated automatically using computer technology called the programmable logic controller ("PLC"). There are slots in the rotating kilns through which tires are dropped about once per minute. Buzzi tries to run the plant two shifts per day, 24 hours a day. If the system has been shut down, the conveyor operator starts the system from the control room using the computer’s mouse. The PLC automatically activates an audible alarm. The conveyors start in sequence and begin delivering tires to the kilns. Video cameras are positioned throughout the conveyor system with monitors in the control room. When the conveyor system is operating, individual belts independently cycle on and off as directed by the PLC. Electric eyes are positioned throughout the conveyor system that can sense the position of tires in the process. The PLC automatically starts and stops individual belts based on the information it receives from these electric eyes. During normal production, the three belts at the beginning of the system cycle on and off about eight times per minute while the belts on the upper deck at the end of the line cycle on and off less frequently. The longest cycle is approximately 30 seconds. The belts
start and stop individually as needed to feed tires to the kilns. No audible alarm sounds when these belts start during these cycles.

A miner known as the tire attendant is stationed at the conveyor system to monitor it. The tire attendant, who is normally on the ground at the singulator, coordinates with the conveyor operator by radio and he acts as the operator’s eyes and ears. One of the jobs of the tire attendant is to remove rejects from the conveyor system. Rejected tires are partial tires, usually sidewalls. These rejects are typically removed on the first three belts. The proper procedure for removing a sidewall is for the tire attendant to de-energize and lock out the belt, remove the guard, and remove the rejected tire. The switch used to de-energize and restart each belt is along the side of each conveyor. Tire attendants typically use a long hooked tool to remove the reject. The entire length of the conveyor is visible from that belt’s control switch. The tire attendant is aware that the belts cycle on and off and also knows that a red laser light is emitted by the photoelectric eye right before a belt starts. This red laser light is visible to the tire attendant.

On July 7, 2006, tire attendant Julie Rogers attempted to remove a reject tire from the No. 3 belt. Ms. Rogers did not de-energize the belt before attempting to remove the tire. Instead, she removed the guard from the head pulley and used the metal hook to remove the sidewall. She testified that she saw the red laser light come on but that she tried to get the sidewall with the hook before the belt started. (Tr. 356). The conveyor started before she could retrieve the sidewall and she suffered severe friction burns on her arm when the hook got caught in a pinch point and pulled her arm into it. The company investigated the accident with the participation of Boilermakers Local D414 (“union”). It was determined that the accident was caused by Ms. Rogers’ failure to follow proper lockout procedures. Buzzi retrained employees on lock out procedures, extended the pull cord at that location, and fabricated a shorter reject puller.

On July 26, 2006, MSHA Inspector Wesley Hackworth inspected the tire feed conveyor system. Buzzi had filed an accident report with MSHA and the inspector was aware of the injury suffered by Ms. Rogers. Inspector Hackworth issued a citation alleging a violation of 30 C.F.R. § 56.14105 because proper maintenance procedures were not followed. Inspector Hackworth also issued Citation No. 6204230 under section 104(a) of the Mine Act alleging a violation of section 56.14201(b), as follows:

The operator did not have a warning system installed for the conveyors at the whole tire system. Once the system is initially turned on these conveyors and conveying systems start and stop automatically and no warning is given of their startup. This condition created a hazard of an employee being injured should the conveyors start automatically without a warning being given.

Inspector Hackworth 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
of a significant and substantial nature ("S&S") and that Buzzi’s negligence was moderate. The safety standard provides:

Conveyor start-up warnings

(a) When the entire length of a conveyor is visible from the starting switch, the conveyor operator shall visually check to make certain that all persons are in the clear before starting the conveyor;

(b) When the entire length of the conveyor is not visible from the starting switch, a system which provides visible or audible warning shall be installed and operated to warn persons that the conveyor will be started. Within 30 second after the warning is given, the conveyor shall be started or a second warning shall be given.

Buzzi started working to abate the condition. The Secretary contends that Buzzi resisted complying with the requirements of the citation and that it tried to abate the violative condition by a means that clearly did not meet the requirements of the safety standard. Buzzi sought to install a visual and audible warning system that was not specifically coordinated with the movement of the belts. As a consequence, the Secretary issued a section 104(b) order of withdrawal on August 24, 2006. The Secretary proposes a penalty of $1,376.00 for the citation and order.

Buzzi maintains that changing the system to comply with the Secretary’s interpretation of the standard was a very complicated task because the computer codes had to be changed and the entire conveyor system had to be slowed down. It did not dispute that it tried several means of compliance but denies that it was not moving forward to comply with the Secretary’s interpretation of the safety standard.

II. SUMMARY OF PARTIES’ ARGUMENTS

The Secretary argues that the language of the standard plainly requires a warning whenever a conveyor is about to start regardless of who or what activates the conveyor. The standard’s requirements also apply to multiple conveyor systems and to conveyors that stop and start frequently. She contends that the safety standard does not distinguish between automated conveyors, like the tire feeder, and non-automated conveyors, like the other conveyors at Buzzi’s plant that do provide an audible or visible warning before starting.

The safety standard does not distinguish between belts that are started by a computer from belts that are started by humans. Because the conveyor operator at the Pryor Plant cannot see the entire belt system from the control room, an alarm sounds when the system is first activated. Once the conveyor operator selects “automatic,” however, and the PLC assumes control of the
conveyor system, there is no visual or audible warning before each belt starts moving as that belt cycles on and off. The conveyor operator cannot see these belts from the control room.

The Secretary maintains that neither the text of the standard nor the preamble support Buzzi’s argument that the tire feeder is exempt from the standard’s requirements because the belts are automatic and operate without human input. The “protective purposes of the standard are tailor made to fit [Buzzi’s] Tire Feeder precisely because it is automated: while a human being can distinguish between a tire and a human limb (like an arm), the PLC cannot . . . make that distinction.” (S. Br. 10).

In addition to the plain language of the standard, the Secretary relies on the preamble to support her position. She points to the fact that the preamble does not specify the minimum amount of time between the warning and the conveyor start-up. The preamble states that “sufficient time must be allowed, however, for the affected persons to leave the hazardous area.” (Ex. PX-15 p. 45; 53 Fed. Reg. 32496, 32514 (Aug. 25, 1988)). She notes that the Secretary declined to specifically address multi-conveyor systems in the preamble with the result that the rule applies to all belt systems. “Whether a single belt or several belts are involved in a conveyor system, the deciding factor determining whether a visual check or a warning device is required is the ability of the conveyor operator to see the entire length of the conveyor from the starting switch.” Id.

The Secretary also relies on the decision of Commission Judge Hodgdon in Tilcon Connecticut, Inc., 18 FMSHRC 90 (Jan. 1996). In that case, the operator used a multiple belt conveyor system to transport materials at the site. An alarm sounded when the system was started at the beginning of the shift. When a belt was shut down to remove blockage from a rock chute, however, an alarm did not sound when it was manually restarted by the operator. A miner was seriously injured because he was standing on a belt when it was restarted.

In Tilcon, the mine operator argued that its safety policies require the person who starts a belt after a maintenance procedure to shout out that the belt is about to start. It maintained that this procedure met the requirements of the standard. Judge Hodgdon affirmed the violation by holding that a “mechanical warning system is required by the standard.” Id. at 95. He stated that “[s]ince the regulation does not specifically state that a mechanical warning system is required, this conclusion is reached by evaluating it in light of what a ‘reasonably prudent person, familiar with the mining industry and the protective purposes of the standard would have provided in order to meet the protection intended by the standard.’ ” Id. (citation omitted).

The Secretary argues that a reasonably prudent person would have recognized that a warning must be given every time a belt starts in Buzzi’s tire feeding system. In this case, the operator provided no warning despite the fact that it provides such warnings at its conventional conveyor systems at the plant. The purpose of the standard is to protect miners from being injured when belts are started without notice. This underlying purpose cannot be ignored when applying the standard to the tire feeding conveyors. The purpose is to alert people of impending
belt movement. The Secretary also argues that, if the standard is deemed to be ambiguous, then her interpretation is entitled to deference because her interpretation fits within the terms of the standard and is compatible with its purpose.

Finally, the Secretary maintains that Buzzi was given fair notice of the requirements of the safety standard. The Secretary argues that the plain and clear meaning of the standard provided notice. She also relies on language in the Secretary’s Program Policy Manual.

Buzzi argues MSHA is attempting to enforce the standard in an illogical manner to require that warnings be provided for the automatic cycling of conveyors. It contends that the plain language of the standard only applies to the manual stopping and starting of conveyors and that MSHA’s position is totally unreasonable. Section 56.14201 is keyed to whether the length of a conveyor is visible to the conveyor operator. Thus, the standard is designed to apply to the manual operation of conveyors because alarms are required only when the operator cannot see the entire length of the conveyor. Indeed, the Secretary’s Program Policy Manual (“PPM”) states that the “standard requires that no conveyor is started unless the person starting it is certain that all persons are clear.” (B. Br. 15; Ex. PX 7; IV MSHA, U.S. Dep’t of Labor, Program Policy Manual, Part 56 at 62 (2003)). The preamble provides that where the “conveyor operator cannot view the entire conveyor length from the starting switch, a system which provides visible or audible warning of the impending conveyor movement is required.” (Ex. PX-15, p. 46). Thus, the standard was written to apply to situations where a belt is started by a human. Typically, a human will start a belt or system of belts at the start of the shift and after a belt has been shut down for maintenance. Belts that are stopped and started systematically by a computer are not covered by the safety standard.

Under the standard, there can be up to a 30-second delay between the warning and conveyor motion. Thus, under the regulation, people are given time to get away from the belt and they presumably will not forget that the belt will start during that 30-second period. With respect to the tire feeder, the belts start and stop automatically as quickly as every 8 seconds and at least every 30 seconds. Thus, these belts are constantly stopping and moving again when the conveyor system is running and its employees are not going to forget that fact. Everyone who works at the conveyor system knows that the belts continually stop and start whenever the conveyor system is operating.

Buzzi points out that it was required to slow down its entire tire feeder system to abate the citation. Because the belts stop and start so frequently, there was not enough time to provide a meaningful delay between the warning and belt movement. Buzzi had to modify its tire feeder system so that there would be at least five seconds between the warning and movement at each belt. MSHA has, in effect, enacted a prohibition against Buzzi’s automatic conveyor cycling system as a result of its interpretation of the standard. Because this prohibition was neither intended nor articulated by the drafters of the standard, MSHA’s interpretation is unreasonable. The performance of Buzzi’s conveyor system was seriously hindered by the abatement required
by MSHA’s interpretation of the safety standard because this system is closely coordinated with the rotation of the kilns.

Buzzi also argues that the Secretary’s interpretation does not advance safety. It initially used the system’s built-in alarm to comply with the standard. When the union president complained about the constant noise, Buzzi installed flashing strobe lights. The subject conveyor system does not occupy a large area. As a consequence, under the Secretary’s interpretation of the standard, there are now multiple overlapping warnings given during the automatic cycling of the belts. During normal production, there are as many as 18 separate warnings per minute on just the first three conveyor belts. Employees working in the area soon simply tune out these warnings because they are a constant annoyance.

Next, Buzzi maintains that, assuming the standard applies, the Secretary failed to establish a violation. First, it argues that the applicable “starting switch” referenced in the safety standard is the switch located at each conveyor used to stop and start the belt for maintenance or when a reject is removed. In every instance, the tire attendant can see the entire length of the conveyor from that switch. If Ms. Rogers had shut down the belt in accordance with company policy, she would have manually put it back into operation using the switch at the conveyor and she would have been able to see the entire length of the belt from the switch. There are no “starting switches” in the control room because the PLC automatically starts and stops the belts. The only starting switch in the control room is the switch used to turn the entire system on after it has been shut down.

Buzzi also maintains that its tire feeding system warned persons that the conveyor would be started. Ms. Rogers testified that the photoelectric eye system that was installed with the conveyors provided an effective warning that the conveyor would be starting. She testified that these photoelectric eyes emit a visible red light before the conveyor comes on and that “you can see them everywhere.” (Tr. 360-61).

Buzzi also argues that it was not provided with fair notice that the safety standard applied to conveyor systems that stop and start on a frequent basis as part of its normal operation. “MSHA’s attempt to extend [the safety standard] to automatic conveyor cycling, which involves neither a ‘conveyor operator’ nor a ‘start-up,’ creates an insurmountable fair notice problem for the agency.” (B. Br. 24). It maintains that a reasonably prudent person familiar with the mining industry and the protective purpose of the standard would not have recognized that the standard applied to the automatic movement of the belts in its tire feeding system.
III. DISCUSSION WITH FURTHER FINDINGS AND CONCLUSIONS OF LAW

A. Summary

I find that the Secretary did not establish a violation of section 56.14201(b). The language of the standard dates back to the regulations promulgated by the U.S. Department of the Interior under the old Federal Metal and Nonmetal Mine Safety Act. (See 30 C.F.R. § 56.9-6 (July 1, 1979)). Although the wording was slightly different in the prior standard, the requirements are the same. Thus, the cited safety standard was put into place well before the technology at use in the tire feeding system existed. The tire feeder belts start and stop automatically, without human intervention, on a very frequent basis. The standard was not written with this type of system in mind. The miners who work on and around the conveyor system are well aware that the belts stop and start on a continual basis. Miners do not need to be "warned" that the belts are going to start moving, except when the system is started after it has been shut down. The conveyor system is constantly operating, so that as each belt cycles on and off, it is not being "started" as that term is used in the safety standard. As discussed below, applying section 56.14201(b) to Buzzi's tire conveyor system is misplaced because it creates an absurd result and does not improve the safety of miners.

B. Language of the Safety Standard and MSHA's Interpretive Materials

The safety standard was written at a time when computer-controlled conveyor systems did not exist in the mining industry. As the preamble states, the standard "addresses the concern that persons be clear of conveyors before they are started." (Ex. PX 15 at 45). Multiple-conveyor systems existed at that time and the preamble states that, whether a single belt or multiple belts are involved, the deciding factor in whether a "visual check or a warning device is required is the ability of the conveyor operator to see the entire length of the conveyor from the starting switch." Id. Although the standard specifies the maximum amount of time before a belt starts after the warning is given, the preamble states that MSHA did not establish a minimum time but that sufficient time must be allowed "for affected persons to leave the hazardous area." Id.

MSHA's PPM allows both manual and automatic alarm systems. (Ex. PX 7). Thus, a conveyor system can be designed so that one switch activates the warning and then automatically starts the conveyor(s) within the 30-second time-frame. In the alternative, a conveyor system can be designed to require the conveyor operator to switch on the warning, wait the requisite time, and then turn another switch to activate the conveyor(s). (Tr. 35, 125). Finally, the PPM provides that an audible "warning must be positive and effective for each conveyor or series of conveyors capable of being shut down or started independently within the system." Id. Again, this contemplates someone shutting down or starting a system of conveyors or a single conveyor within the system.

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Clearly, if one of the conveyors in the tire feeding system is shut down and then restarted, a warning must be given unless the miner at the switch used to restart the conveyor can see the entire length of the conveyor. In this instance, however, I find that the belts are not “started” every time they start moving as part of their normal operating cycles. Instead, the belts are continuously operating once the system is started up. While it is true that the computer repeatedly stops and then resumes movement of the belts in order to feed tires to the rotating kilns, the system is operating continuously. The Secretary’s reliance on Tilcon is misplaced. In that instance, a miner shut down a conveyor for maintenance and then, when he restarted the belt, he failed to provide an adequate warning. The miner standing on the belt did not know that someone was going to start the belt. On the other hand, at the time Ms. Rogers was injured, she knew that the belt was going to automatically start right away. The belts at Buzzi’s tire feeding system are not “started,” as that term is used in the standard, every time they resume movement after stopping for less than 30 seconds during their normal operation. The tire attendants at the plant know that, when the conveyor system is operating, the individual belts constantly stop and move again to feed tires to the kilns. They also know that they are required to stay behind the guards until they de-energize and lock out the belt.

C. Plain Meaning and Deference to the Secretary’s Interpretation

When the language of a regulatory provision is clear, the terms of that provision must be enforced as they are written unless the regulator clearly intended the words to have a different meaning or unless such a meaning would lead to absurd results. See Alcoa Alumina & Chemicals, 23 FMSHRC 911, 913 (Jan. 2001) (citations omitted). If, however, a standard is ambiguous, I must give special weight to the Secretary’s reasonable interpretation of the regulation. An “agency’s interpretation of its own regulation is of controlling weight unless it is plainly erroneous or inconsistent with the regulation.” Sec’y of Labor v. Western-Fuels Utah, Inc., 900 F. 2d 318, 321 (D.C. Cir. 1990) (citations omitted).

I find that the language of the standard is not suited to the cycling of the belts in the tire feeding system at the plant. It is not clear that the standard contemplates that the requirement “to warn persons that the conveyor will be started” applies when belts resume movement after stopping for less than 30 seconds during normal operations. The standard clearly applies when someone makes an intentional decision to start or restart a belt. Indeed, subsection (b) of the standard only applies if the entire length of a conveyor belt is not visible to the person at the starting switch for that belt. In this case, a computer program controls the movement of the belts based on information it receives from the electric eyes located throughout the conveyor system. It is worth noting that the conventional conveyor systems at Buzzi’s plant are equipped with devices that warn miners when a belt or belts are starting, if the entire length of the conveyor is not visible from the starting switch. Thus, Buzzi was aware of the requirements of the standard and Buzzi’s management did not believe that the standard applied to the tire feeding system.

The Secretary argues that her interpretation is reasonable and that I owe deference to her interpretation. In this case, I find that the Secretary’s application of the standard to the tire feeding system at the plant is reasonable.
feeding conveyor system is inconsistent with the language of the standard and that her interpretation does not serve a “permissible regulatory function.” Gen. Elec. Co. v. EPA, 53 F.3d 1324, 1327 (D.C. Cir. 1995) (citations omitted). Her interpretation is not consistent with the language of the standard because the standard presupposes the intentional act of starting a conveyor. Here, once the conveyor system is started, the belts stop and move automatically on very short intervals. This fact is known by miners who work in and around the tire feeding system, so they are not at all surprised by the frequent cycling of the belts. There has been no showing that providing extra warnings on a virtually continual basis would improve the safety of miners or reduce the risk of an accident.

The Secretary’s witnesses stretched the meaning of the standard and MSHA’s interpretive material to support MSHA’s interpretation of the standard. Fred Gatewood, a staff assistant to the district manager who is on detail as the assistant district manager for the South Central region, testified with respect to the application of the standard to Buzzi’s tire feeding conveyors. He referred to the sentence in the PPM which states that the standard “has been uniformly interpreted by MSHA and its predecessor organizations to include both automatic and manual alarm systems” to support MSHA position. When he was questioned whether that sentence referred to automatic alarm systems rather than automatic conveyor systems, he replied that it could refer to both. (Tr. 207). He testified that this sentence in the PPM makes clear that the “standard applies to every conveyor or series of conveyors, whether it’s automatic, automated, or manual.” (Tr. 207). I find Mr. Gatewood’s interpretation of the PPM to be absurd and completely unreasonable. The cited language quite obviously provides that MSHA and its predecessors have always allowed mine operators to use automatic and manually operated alarm systems to comply with the safety standard’s warning requirement. The PPM does not even obliquely address conveyor systems that stop and move automatically as directed by a computerized operating system.

The Secretary failed to prove that Buzzi’s tire feeding system presented a hazard in need of correction. Ms. Rogers testified that she knew that the belt was about to start when she reached over with a tool to pick up a reject tire. She saw the red laser light flash. She admitted that she took a short-cut and tried to race the belt. Her actions are akin to someone driving over a railroad grade crossing when a train is rapidly approaching. The person driving the car is well aware of the oncoming train but he thinks he can beat it. If an audible or visible warning had been given before the belt moved in this instance, Ms. Rogers would not have had any greater knowledge of the impending movement than she already did. She knew that the belt would move again because of her knowledge of the design of the conveyor system and the fact that the laser light came on. If an individual belt is shut down and locked out before a miner removes the

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1 I recognize that the issue in this case is whether Buzzi violated section 56.14201 and not whether the alleged violation contributed to Ms. Roger’s accident. Nevertheless, it is clear to me that the warning that the Secretary seeks would not have averted this accident because Ms. Rogers knew that the belt was about to move again. Likewise, other tire handlers would have the same knowledge assuming they were properly trained. The Secretary has not shown how a visible or audible warning

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guard for the belt, there is no chance that the miner will be injured by the movement of the belt. (Tr. 82). That is the procedure required by Buzzi and Ms. Rogers had the means to lock out the belt. The switch for the belt was located but a few steps from where she was standing when she attempted to remove the sidewall. If she had shut down the belt to remove the sidewall, the requirements of section 56.14201 would have applied when she restarted the belt.

It is significant that the tire feeding system has been inspected by MSHA on several occasions while it was in operation and no citations have been issued. (Tr. 357). Indeed, the conveyor system was inspected in January 2006. It was also subjected to two CAVs and no suggestions were made that additional warnings were required. (Tr. 89-94). At least part of the tire feeder was operating during the CAV on April 28, 2004. (Tr. 94). Although it was obvious that no visible or audible warnings were given during the automatic cycling of the conveyors, no MSHA inspector suggested that such warnings were required. It also appears that as of the date the citation was issued, there had been no prior enforcement of section 56.14201 in this manner at other cement plants. Buzzi established that other limestone and cement plants use similar conveyor systems to feed tires into kilns without providing audible or visible warnings when belts automatically stop and start. The present case appears to be one of first impression.

D. Abatement of the Cited Condition and the Safety of Miners

Buzzi first attempted to abate the citation by reprogramming the conveyor’s alarm system to go off at 30-second intervals. Buzzi also installed signs at each belt that warned miners that the belt could start at any time. Miners complained that they were going home every day with severe headaches because of the constant alarms. The union president intervened on their behalf by sending a letter to the MSHA district manager. In this letter, the union president stated his position that Buzzi had been complying with the requirements of section 56.14201 before the citation was issued. (Ex. PX6, p. 40). He testified that the tire feeding system was completely safe before Inspector Hackworth issued the citation. (Tr. 365). He said that the frequent alarms irritate people working in the area. *Id.* He then states:

> While the Boilermakers wholeheartedly support effective safety and health programs, we feel that the audible alarm going off every 30 seconds offers nothing in the way of safety. In fact, as an irritant, it could become a safety hazard in that our people may begin to ignore warning alarms. Therefore, we recommend the audible alarm be reprogrammed back to its original startup setting. *Id.*

After this letter was received, MSHA started advising Buzzi that flashing lights may be a better solution. Buzzi attempted to abate the citation by installing strobe lights that constantly flash at each belt. MSHA would not accept this method to abate the citation because the flashing

will improve the safety of miners.
of the lights were not coordinated with the movement of the belts. Buzzi management did not initially believe that the program logic in the PLC could be modified to time the flashing of lights with the movement of the belts. (Tr. 65, 68). The plant manager told MSHA inspectors that Buzzi had tried to modify the system to comply with MSHA’s abatement requirement but that it would not work right. Buzzi’s electrical supervisor told MSHA Inspector Dana White on August 23, 2006, that he had been working on it but that there was a problem ramping up the voltage because the belts only operate for a few seconds and then they stop for five to six seconds. (Tr. 71; Ex. PX 6 p. 25).

On August 24, 2006, Brian Goepfert, MSHA’s Field Office Supervisor, visited the plant. The section 104(b) order was issued at the conclusion of his meeting with mine management. MSHA did not believe that the company was making sufficient progress to abate the cited condition. Buzzi had to modify its conveyor system in order to abate the citation. MSHA determined that the warning had to provide at least a five second delay between the start of the warning and the movement of the belt. In order to achieve this result, Buzzi had to slow down the cycling of the belts, which reduced the efficiency of its tire burning system. Buzzi hired a consultant to change the computer codes in the PLC in order to achieve abatement of the order of withdrawal.

The order was terminated on October 12, 2006, after Buzzi installed lights that flash five seconds before each belt begins to move as it cycles. A five second gap between a visible warning and belt movement is extremely short and its utility is doubtful. After this condition was abated, MSHA started issuing citations to other cement plants with tire feeding systems similar to Buzzi’s. Inspector White testified that each of these plants were able to abate the condition within about 30 days. (Tr. 77).

Because the entire conveyor system is in a relatively small area, the warnings are quite frequent and overlap from belt to belt. Not only does this cause miners to simply ignore the warnings, it is also likely to be confusing. I credit Buzzi’s evidence that the warning lights are required to flash up to 18 times per minute along the first three belts to comply with MSHA’s interpretation of the safety standard. As a consequence, there is a good chance that the abatement required by MSHA actually contributes to a mine safety hazard. The flashing strobe lights had to be bright enough to be seen in the daytime. The record makes clear that at night the tire handlers are frequently temporarily blinded by these lights because they are flashing virtually constantly in the vicinity of the first three conveyors. (Tr. 296, 369). Although the tire handlers spend most of their time on the ground near the singulator, they do walk along the walkways for the first three belts to remove rejects from time to time. If audible alarms had been installed, the noise level likely would have been intolerable to miners in the area. I find that the evidence fails to support the Secretary’s position that the warnings she believes are mandated by the safety standard has

2 The first three belts are immediately adjacent to each other and the singulator. (Ex. PX-3 p. 4). Belt No. 1 is about 12 feet long, Belt No. 2 is about 8 feet long, and Belt No. 3 is about 62 feet long. (Ex. PX-6 p. 45).
E. Fair Notice of the Requirements of the Safety Standard

The Secretary must provide fair notice of the requirements of a broadly written safety standard. 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). “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).

The Commission recently addressed this issue in Alan Lee Good d/b/a Good Construction, 23 FMSHRC 995 (Sept. 2001) (“Good Construction”). Although it was a split decision, the analysis to be used is summarized in the opinion of Commissioners Jordan and Beatty, as follows:

In applying the reasonably prudent person standard to a notice question, the Commission has taken into account a wide variety of factors, including the text of a regulation, its placement in the overall enforcement scheme, its regulatory history, the consistency of the agency’s enforcement, and whether MSHA has

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3 The Secretary should consider promulgating a new safety standard for conveyor systems that automatically stop and move in short cycles. The advantage of this approach is that the agency will be able to consider the comments of labor and industry.
published notices informing the regulated community with
"ascertainable certainty" of its interpretation of the standard in
question. Also relevant is the testimony of the inspector and the
operator's employees as to whether the practices affected safety.
Finally, we have looked to accepted safety standards in the field,
considerations unique to the mining industry, and the
circumstances at the operator's mine.

23 FMSHRC 1005 (citations and footnote omitted).

I find that the Secretary did not provide fair notice that she would start interpreting
section 56. 154201 to apply to the automatic movement of conveyor systems like the one in place
at Buzzi's plant. Neither the language of the safety standard nor MSHA's interpretive materials
gave notice that conveyor systems that stop and move automatically eight times a minute are
required to have visible or audible warnings every time the belt moves. My factual findings set
forth above are equally applicable to this issue.

The Secretary also relies on other information available to mine operators. Mr. Gatewood
testified about an article he wrote in MSHA's South Central District Newsletter. (Tr. 192). This
article was also published at MSHA's website. Mr. Gatewood testified that this article provided
notice to mine operators that automatic conveyor systems, like the one cited at Buzzi's plant, are
required to provide a visual or audible warning every time a belt moved. (Tr. 211-14).
Specifically, he stated that the following question provides such notice: "Is the system flexible
enough to provide a warning when restarting only a portion of the plant during the shift?" (Tr.
212-13; Ex. PX 10). I find that this question does not provide the notice that Gatewood
prescribes to it. Both parties agree that if a belt is shut down during a shift, a warning must be
given when it is restarted if the entire belt is not visible from the starting switch. The question
Gatewood refers to concerns the situation described in Tilcon. If a belt is taken out of production
for maintenance, a warning must be given before the belt is restarted. Miners need to be given a
warning whenever a belt is started after it has been shut down. The belts in the tire feeding
system at Buzzi's plant, on the other hand, repeatedly stop and then resume movement within
seconds throughout the shift while the conveyor system is in production. This cycling of the
belts at Buzzi's plant bears no resemblance to the situation contemplated in Mr. Gatewood's
article or under the facts in Tilcon.

I find that a reasonably prudent person familiar with the mining industry and the
protective purposes of the standard would not have recognized that a visible or audible warning
was required every time a belt in the tire feeding system starts moving again during the normal
cycling of the conveyors. The text of the safety standard, its placement in the overall
enforcement scheme, and its regulatory history do not provide the requisite notice. The Secretary
has also not published notices informing the regulated community with "ascertainable certainty"
of the interpretation of the standard that she presented in this case. Since this appears to be the
first time that MSHA has issued a citation for this type of conveyor system, there has not been
consistent enforcement of section 56.14201 in this manner. Indeed, several MSHA inspectors observed the tire feeder in operation prior to July 2006 without commenting that a warning system was required. In addition, a number of other cement plants in the United States have tire feeding systems similar to Buzzi’s. The evidence shows that the operators of these plants have not been required to install visual or audible warnings for their automated conveyor systems that activate whenever a belt starts moving. (Tr. 297, 370, 385-87, Ex. C-19)

F. Conclusions

I find that Citation No. 6204230 should be vacated because the Secretary did not establish that section 56.14201 applies to the automatic cycling of the belts in Buzzi’s tire feeding conveyor system. The language of the standard and MSHA’s interpretive materials do not support the Secretary’s position that the standard applies to the automatic cycling of belts. In addition, I find that the Secretary’s interpretation is not reasonable and it leads to absurd results. Having either lights flashing or alarms sounding on a virtually constant basis around the first three belts of the tire feeding system would not increase safety, as the union president makes clear, and may well result in a diminution of safety. It is important to understand that my conclusion in this regard was influenced by the fact that the belts stop and then resume movement on a very frequent basis. The belts that are closest to the duty station of tire attendants independently stop and move again about eight times a minute while the other belts cycle at various rates with the slowest being twice a minute. If a conveyor system has belts that automatically stop and start again every ten minutes, for example, a different analysis may be required.

It is also important to note that the only tire attendant who testified at the hearing stated that she knows when the belt is about to start. She knows that the belt will start by the location of the tires on the belts and, more importantly, she can see the electric eye activate before the belt starts. An additional warning would not serve the same safety function as a warning given before a belt is restarted after being shut down for maintenance as in Tilcon.

I also find that, even if the standard applies to the automatic movement of the belts, the citation should be vacated because fair notice was not provided to the mining community that the Secretary would be applying the requirements of section 56.14201 to such movement. The standard and MSHA’s interpretive materials do not address the issue. Various MSHA inspectors had observed the tire feeding system at the Pryor Plant without indicating that a warning system was required. In addition, no other limestone quarry or cement plant that used automatic tire feeding systems had ever been warned, prior to July 2006, that they were in violation of the safety standard.

4 I reject Buzzi’s argument that the activation of the electric eye serves as a visible warning, as that term is used in the safety standard. There simply is not enough evidence in the record to support its position on the issue.

29 FMSHRC 504
Because I have vacated Citation No. 6204230, Order of Withdrawal No. 6264178 issued under section 104(b) of the Act, is also vacated as moot.

IV. ORDER

For the reasons set forth above, Citation No. 6204230 and Order No. 6264178 are hereby VACATED and these proceedings are DISMISSED.

Richard W. Manning
Administrative Law Judge

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RWM
June 18, 2007

BELL COUNTY COAL CORPORATION,
Contestant

v.

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

CONTEST PROCEEDINGS

Docket No. KENT 2004-317-R
Citation No. 7538674; 08/18/2004

Docket No. KENT 2004-318-R
Citation No. 7538675; 08/18/2004

Docket No. KENT 2004-319-R
Citation No. 7538676; 08/18/2004

Docket No. KENT 2004-320-R
Citation No. 7538677; 08/19/2004

Docket No. KENT 2004-321-R
Citation No. 7538679; 08/19/2004

Docket No. KENT 2004-322-R
Citation No. 7538680; 08/19/2004

Docket No. KENT 2004-323-R
Citation No. 7524384; 08/17/2004

Docket No. KENT 2004-324-R
Order No. 7538681; 08/19/2004

Docket No. KENT 2004-325-R
Order No. 7538678; 09/19/2004

Docket No. KENT 2004-326-R
Order No. 7524383; 08/17/2004

Coal Creek
Mine ID 15-18058

29 FMSHRC 506
These cases are before me on Notices of Contest and Petitions for Assessment of Civil Penalties filed by the Secretary of Labor ("Secretary"), pursuant to sections 105 and 110 of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 815 ("Act"). The petitions allege that
Bell County Coal Corporation ("Bell County") is liable for 11 violations of the Secretary's regulations applicable to underground coal mines, and propose the imposition of civil penalties totaling $153,836.00. One Notice of Contest involves Bell County's contest of an imminent danger order. Petitions were also filed against five supervisors at the mine, alleging that they are each personally liable for two of the violations, and seeking the imposition of civil penalties against them in their individual capacities. Several of the alleged violations, for which substantial penalties are sought, are the outgrowth of an investigation of a massive roof fall at Bell County's Coal Creek mine, that occurred on June 16, 2004, and resulted in a fatal injury to a miner.

A hearing was held in London, Kentucky. Prior to the hearing, Bell County was permitted to withdraw its contest of four of the alleged violations and proposed penalties. At the close of the evidence, the citations as to individual Respondents Donnie Wright, the mine superintendent, and Jimmy Murray, the mine foreman, were vacated. The remaining parties filed briefs after receipt of the transcript. For the reasons set forth below, four of the alleged violations and the imminent danger order are vacated, and I find that Bell County committed three of the alleged violations and impose civil penalties totaling $6,900.00. I also find that the three section foremen are each liable for one violation, and impose civil penalties in the amount of $200.00 against each of them.

Findings of Fact - Conclusions of Law

Bell County Coal operated the Coal Creek mine, which was located near Middlesboro, Kentucky. The mine was accessed by five drift openings into the 60-inch thick Buckeye Springs coal seam, and had been producing coal since October, 1998. Coal was produced using the room and pillar method, and remote controlled continuous mining machines. The mine employed 42 underground and two surface workers. In addition, four surface and two underground contract workers were employed. Coal was produced on the 004/003 MMU super-section, essentially two four-entry sections operating side-by-side. The 004 MMU mined the Nos. 1 through 4 entries and the 003 MMU mined the Nos. 5 through 8 entries.

On June 16, 2004, retreat mining was being performed on the sections. The area which was being mined had been driven on advance a few weeks earlier. The second shift foreman was Jerry D. Belcher. Upon arriving on the section, Belcher traveled across the pillar line to conduct an examination. He noticed cracks or joints in the roof in the #5 entry, which he later referred to as seams. Ex. G-24. He checked test holes, which indicated no separations in the roof, and felt that the joints did not pose a hazard. He had concerns about other aspects of the roof, and warned the crew to watch the roof and move out if anything out of the ordinary happened. David Scott Goins, the continuous miner operator, took one cut from the pillar on the right side of the entry, and pulled back so that timbers could be set. Belcher then left and went over to the 004

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1 The Secretary's exhibits are designated "G-#," and Respondent's exhibits are designated "R-#."
section. Timbers were being set by James Ford and Donnie Lemarr, with the help of Edwin Pennington, a shuttle car operator, whose equipment had broken down.

Pennington, a contract worker, had brought a video camera into the mine in his lunchbox. He intended to record a roof fall to show his wife. He began recording after a cut had been taken from the left pillar in the #5 entry. Lemarr noticed a crack in the roof in a crosscut to the left of the #5 entry. He did not think it posed any immediate danger because it ran into and was supported by the pillars. Tr. 107. He inserted some cap wedges into the opening, to monitor any movement. If the wedges had dropped out, he would have watched the top more closely and pulled out of the entry faster. Tr. 66-67. The videotape, which was recovered after the accident, shows that some of the timbers set further inby had taken weight and were bent and/or broken. The miners talked about “slips” in the roof, referring to cracks or joints, and speculated that the roof would fall up to the timbers, or even further outby through the crosscut intersection. Ex. G-2 (6:54 p.m.).

After taking the third cut, the roof started “working” and the continuous miner operator, Goins, decided to back the miner outby to the crosscut. The top continued to work, with small pieces of rock falling from the roof. The miner was then moved back to the next crosscut intersection. Tr. 69. The crew moved back near the miner to watch the roof. The roof in the #5 entry then fell. The fall apparently started near the pillar line and proceeded more than 200 feet out the #5 entry. Pennington shouted “here it comes,” and he and Lemarr started running. Tr. 71. Lemarr, who was six-to-eight feet in front of Pennington, made it around the corner into the next crosscut. Pennington did not. He was struck and killed by the falling rock. The roof fall was massive. It ranged from four to more than six feet thick, 12 to 20 feet in width and approximately 210 feet in length, running from the cave point at the pillar line up the #5 entry for more than two breaks. Ex. G-11 at 1, 6.

State and federal officials immediately commenced recovery efforts, and assembled investigation teams. MSHA concluded that the roof fell between two parallel joints that ran up the #5 entry, that the joints were “hillsseams,” and that they had not been supported as required by Bell County’s Roof Control Plan. MSHA also determined that there were other hillsseams in the area that had not been identified or properly supported. Citations and orders were issued for those and related alleged violations, and for alleged violations for the use of nonpermissible electrical equipment within 150 feet of the pillar line. In addition to citing Bell County, the Secretary also assessed proposed civil penalties against five individual managers for two of the alleged violations, pursuant to section 110(c) of the Act. Mine superintendent Wright, mine foreman Murray, and three section foremen, Craig Davis, Darryl Bailey and Belcher, are alleged to have knowingly authorized the violations alleged in Citation Nos. 7538674 (failure to comply with the Roof Control Plan with respect to hillsseams in the #5 entry), and 7538678 (use of a nonpermissible chain saw within 150 feet of the active pillar line).
Part I – Violations Related to the Fatality

MSHA’s Report of Investigation of the June 16 fatal roof fall accident was issued on August 17, 2004. Ex. G-11. The violations related to the fatality were issued on August 18 and 19, 2004.

Citation No. 7538674

Citation No. 7538674 was issued on August 18, 2004, pursuant to section 104(d)(1) of the Act, and alleges a violation of 30 C.F.R. § 75.220(a)(1), which requires that mine operators “develop and follow a Roof Control Plan, approved by the [MSHA] District Manager that is suitable to the prevailing geological conditions, and the mining system to be used at the mine.” The violation is described in the “Condition or Practice” section of the citation as follows:

An investigation of the fatal fall of roof accident which occurred on June 16, 2004, determined that the approved Roof Control Plan, dated June 6, 2001, was not being complied with in the No. 5 entry on the 003 MMU. The roof fall ranged from 4 to 6+ feet in thickness, 12 to 20 feet in width, and approximately 210 feet in length from the pillar gob line. Parallel hillseams (vertical open joints) were present in the roof of the No. 5 entry that was supported during development with thin steel straps. The approved plan required that hillseams be supported with steel channels and the entry width be narrowed to 18 feet or less. Other hillseams were supported with thin steel straps which were present at various locations on the 004/003 MMU supersection. Additional safety precautions for retreat mining (pillaring) as stipulated in the plan also require that a roof evaluation shall be made when entering a previously mined area for the purpose of pillar recovery. When inadequate roof support is encountered the necessary corrective action shall be taken.

MSHA determined that the fatal accident occurred as a result of the violation, that it was significant and substantial, that one employee was affected and that the operator’s negligence was high. As noted above, the citation was issued pursuant to section 104(d) of the Act, because it is alleged that the violation was the result of Bell County’s unwarrantable failure to comply with the regulation. A civil penalty in the amount of $58,000.00 has been proposed for this violation.

2 The hearing was conducted in two parts. Part I involved Bell County and the individual Respondents, and addressed violations related to the fatality. Part II involved only Bell County, and alleged violations that were issued during a subsequent inspection and are not related to the fatality.

3 Text taken from citations and orders has been edited to correct spelling, punctuation and other errors.
violation.

The Violation

In order to prove a violation of a mine plan provision, the Secretary:

- must first establish that the provision allegedly violated is part of the approved and adopted plan. *Jim Walter Resources, Inc.*, 9 FMSHRC 903, 907 (May 1987).
- She must then prove that the cited condition or practice violated the provision. *Id.*
- When a plan provision is ambiguous, the Secretary may establish the meaning intended by the parties by presenting credible evidence as to the history and purpose of the provision, or evidence of consistent enforcement. *Id.*

*Harlan Cumberland Coal Co.*, 20 FMSHRC 1275, 1280 (Dec. 1998). This standard recognizes that due process entitles an operator to fair notice of the Secretary’s interpretation of plan provisions. *Energy West Mining Co.*, 17 FMSHRC 1313, 1317-18 (Aug. 1995). “The ultimate goal of the [plan] approval and adoption process is a mine-specific plan with provisions understood by both the Secretary and the operator and with which they are in full accord. ‘[A]fter a plan has been implemented (having gone through the adoption/approval process) it should not be presumed lightly that terms in the plan do not have an agreed upon meaning.’” *Jim Walter*, 9 FMSHRC at 907 (quoting from *Penn Allegh Coal Co.*, 3 FMSHRC 2767, 2770 (Dec. 1981)).

The Secretary established that the plan provisions referenced in the citation were included in Bell County’s approved Roof Control Plan at the time of the accident. It required that “pots, slips, horsebacks or hillseams” be supported either with crossbars and posts, or steel channels installed with roof bolts, if the roof structure provided adequate anchorage for roof bolts.4

Ex. G-10 at 5. It also provided that, where “subnormal roof conditions” were encountered, entries would be narrowed to 18 feet or less, which could be accomplished by mining entries less than the normally allowed 20-foot width or by setting posts or cribs on five-foot centers along an entry that had been mined wider than 18 feet. Ex. G-10 at 5.

MSHA’s Report of Investigation of the accident explains that the roof fell between “near vertical joint systems.” Ex. G-11 at 6. That much does not appear to be in dispute. What is disputed is whether those joints or joint systems were hillseams and/or whether they should have been recognized as hillseams prior to the accident. For the sake of clarity, the subject imperfections in the roof will be referred to herein as “joints.” It is undisputed that the joints in

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4 Steel channels are made of 3/16 inch thick material, bent to form roughly a “U” shaped beam approximately five inches wide and two inches deep. They are typically about four feet long, with pre-drilled holes for roof bolts at each end. Bell County also used thin steel straps, made of 16-gauge material, also about four feet long and pre-drilled. The Roof Control Plan provided that straps were to be used “for the sole purpose of controlling ‘draw rock’ or small isolated pots.” Ex. G-10 at 5.
the roof of the #5 entry, between which the roof fall occurred, had not been supported with beams or steel channels, and the width of the entry had not been reduced to 18 feet. Consequently, the question of whether the plan was violated turns on whether the joints were hillseams. The Secretary contends that the joints were obvious hillseams. Bell County contends that the joints were not hillseams, and that MSHA's definition of the term "hillseam" changed dramatically after the accident.

The term "hillseam" is not defined in the Roof Control Plan, or in the Secretary's regulations. Nor does the American Geological Institute's Dictionary of Mining Mineral and Related Terms (2d ed. 1997) contain a definition. It is a term used by eastern Kentucky miners to describe a certain type of joint found in that region. Despite the absence of an authoritative written definition, it appears that prior to the accident, Bell County and MSHA were in agreement on what was meant by the term.

Bell County's senior managers, who had extensive mining experience in the region, understood a hillseam to be a vertical weathered joint, near a coalbed outcrop, that had mud, water or some form of material that is not native to the strata of the top imbedded in it. Mine superintendent Wright, who had 33 years of mining experience, testified that a hillseam was an opening that "universally" had "mud or water, or some combination of both, or some form of material that's not that native to the strata of the top, embedded in it." Tr. 633, 702. He further explained that hillseams were encountered close to the outcrop and under low cover. Tr. 634. Mine foreman Murray, with over 25 years of experience, testified that hillseams were "mud, water, displacement, foreign material not of your normal roof conditions." Tr. 754. He explained that hillseams had been encountered near the outcrop in another section of the mine, and they were supported with Heintzmann Beams, which are superior to wooden crossbeams. Tr. 754. Pictures of one such hillseam, an obviously weathered joint, were introduced by Respondent. Ex. R-26, R-27, R-28, R-29.

Straps had been installed in many areas in the vicinity of the accident. Several photographs depict straps running from roof bolt to roof bolt apparently across the width of the entry and into adjoining crosscuts. Ex. G-3 at 2, 16-19, G-16, G-20. Some of the straps spanned the joints involved in the roof fall.

No party contends that the joints were pots, slips or horsebacks, which Cox described as isolated formations in a mine roof. Tr. 473-74.

The term has arisen infrequently in Commission litigation. See Gilbert v. Sandy Fork Mining Co., 9 FMSHRC 1327, 1329 n.2 (Aug. 1987) ("A 'hill seam' is a crack or fault in a mine roof that generally has mud or water emanating from it."); Shamrock Coal Co., 5 FMSHRC 845, 847 n. 3 (May 1983) ("There was some disagreement at the hearing as to the exact definition of a 'hillseam.' Everyone agreed that, basically, it is a crack in the roof, often filled with earth or mud. Some witnesses described it as a crack extending all the way to the surface.").

29 FMSHRC 512
Bell County introduced several publications discussing hillseams that are consistent with its understanding of the term. A U.S. Dept. of Interior, Bureau of Mines report, published about 1989, entitled “Hillseam Geology and Roof Instability Near Outcrop in Eastern Kentucky Drift Mines” contained several references to hillseams. Ex. R-31. “Hillseam is the eastern Kentucky miners term for weather-enlarged tension joints that occur in shallow mine overburden where surface slopes are steep. Hillseams are most conspicuous within 200 feet laterally of a coalbed outcrop and under 300 feet or less of overburden.” Ex. R-31 at 1. “Some evidence of weathering is necessary to distinguish hillseams from mining-induced cracks in the roof.” Ex. R-31 at 6. “In general, the hillseams occur mostly within 200 ft of coal outcrop and, therefore, under about 77 to 116 ft of overburden, given the hillside slope conditions of the district, which range from 21-30 degrees.” Ex. R-31 at 17. “Hillseams in eastern Kentucky are weather-enlarged tension joints that occur in shallow mine overburden where surface slopes are steep. They occur with the greatest frequency and severity within 200 ft laterally of the coalbed outcrop, then decrease in frequency and severity to about 700 ft inby outcrop under 300 ft or less of overburden. . . . Hillseams generally extend to the surface as indicated by the initial flow of mud and water into mines.” Ex. R-31 at 31.

An Information Circular published in 2003 by the National Institute for Occupational Safety and Health (“NIOSH”) described hillseams as “Systematic joint sets near outcrop” and noted that “[m]ost hilltop mines must leave at least 150 ft of barrier between the mine and outcrop.” Ex. R-32 at 20. A 2003 Report to Congress by MSHA’s Office of Surface Mining, dealing with coal waste impoundments, stated that “hillseam’ is a term used by miners for highly weathered joints that may be found near an outcrop.” Ex. R-39 at 11.

The joints in the roof of the #5 entry were not weathered; they had no mud, water or other foreign substance in them. Furthermore, they were some 1,500 feet from the outcrop, where the overburden was about 500 feet, i.e., a location where hillseams would not be expected. Under Bell County’s experience and understanding, the joints were not hillseams. Tr. 635. Prior to the accident, MSHA officials apparently agreed. An inspector and a field office supervisor had inspected the area where the alleged hillseams were located, and did not identify them as hillseams or raise any other issues with respect to Bell County’s compliance with its Roof Control Plan.

Mine maps, on which mining progress was recorded, show that the area where the accident occurred was mined on advance between May 16 and May 20, 2004, one month before the fatal accident. Bell County’s engineering department conducted surveys of the mine every second day, to assure that entries were driven straight, crosscuts were made at proper locations, and to get accurate figures on the amount of coal mined. Tr. 623-24. Spads, numbered markers driven into the roof of the mine, were set at various survey points, and the distances from the spads to the crosscuts and faces were recorded in the survey book. Tr. 714-15. Wright used the survey book to determine the locations of the faces on May 18 and 20, and drew them on a copy

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8 All witnesses who offered a description of the joints in the #5 entry testified that there was no mud or water in them. Tr. 107, 204, 271, 281-84, 595, 796-97; ex. G-15.
of an exhibit introduced by the Secretary showing the locations of various hillseams. Tr. 624-29; ex. R-23.

John Sizemore, an MSHA inspector, had inspected the 004/003 section on May 18 and 20, 2004. On the 18th he was accompanied by Murray and on the 20th by Murray and MSHA Field Office supervisor Jim Langley. On his inspections, Sizemore paid careful attention to roof conditions, and compliance with the Roof Control Plan. Tr. 731, 737, 743. His field notes from May 18 were consulted to determine where he traveled when he inspected the faces, power center, loadout point and belt line. Exhibit R-23 shows that, on May 18, Sizemore and Murray traveled through several critical areas of the mine where the Secretary contends that there were open and obvious hillseams. According to the map, Sizemore and Murray should have encountered hillseams in the #3 entry near the face, in the #5 entry near the face, in the #6 entry near the face, in the crosscut between the #6 and #7 entries, in the #7 entry outby as they traveled to the power center, in the #5 entry outby and in the #4 entry. Ex. R-23. Neither Sizemore nor Murray identified any hillseams, or any deviations from Respondent’s Roof Control Plan on May 18.

Wright performed the same process for May 20. He drew the locations of the faces, and indicated a route of travel that Murray, Sizemore and Langley would have followed that day. Sizemore, Langley and Murray should have encountered hillseams in the #7 entry and, possibly, the parallel hillseams in the #5 entry that eventually resulted in the roof fall. Ex. R-23. Langley had come to the mine on May 20 with a specific concern about hillseams, and was focusing on hillseams and compliance with the Roof Control Plan when he traveled on May 20. Tr. 523. Neither Sizemore nor Langley identified any hillseams, or any deviations from Respondent’s Roof Control Plan on May 20. Tr. 524, 530-31, 731, 742. Langley testified that the displacement on a hillseam will be wider than the displacement on a stress crack, and hillseams will “often” have mud and water in them. Tr. 532. He agreed that, in the absence of mud or water, it is “sometimes” not obvious that a crack is a hillseam. Tr. 532.

There is substantial evidence that MSHA’s definition of hillseams changed after the accident, at least as to the field office personnel who were responsible for enforcement at Bell

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9 Hillseams are preexisting conditions, not caused by mining activity. Consequently, the hillseams would have been present when the entries were mined on advance, and would have been present on May 18 and May 20. Tr. 439, 443, 459, 576.

10 The Secretary elicited only limited evidence to challenge Wright’s analysis. She argued that it was not accurate because it was “double hearsay,” and posited that Bell County did not call Sizemore as a witness to confirm the information because it “did not reflect the true route[s] that he traveled.” Sec’y Br. at 4. However, as Bell County pointed out in its Reply Brief, the business records and notes were not hearsay, which, in any event, is admissible in Commission hearings. 29 C.F.R. § 2700.63(a). Moreover, I find more indicative of the accuracy of the information, the fact that the Secretary did not attempt to elicit from Sizemore, either on cross-examination or by calling him as a witness on rebuttal, any testimony to counter Wright’s.
County's mine. Following the accident, Sizemore issued additional citations for improperly supported hillseams. Wright disagreed that the cracks were hillseams, and asked Sizemore for a definition of the term. Tr. 645-46. Sizemore did not provide one, but made a phone call and asked to speak to someone in technical support. He asked for a definition of the term hillseam. When he got off the phone, Sizemore told Wright that he had been told that they "wouldn't touch that one with a ten foot pole." Tr. 646-47. A couple of days later, Sizemore gave Wright a note that had three words written on it, "displacement, mud, water," and told Wright that that was a hillseam. Later, after citations were issued in August, Wright told Sizemore that he had never considered anything like a hairline crack to be a hillseam, and Sizemore responded that everything had changed because of the fatality and that every crack in the top had to be considered a hillseam. 11 Tr. 648.

Michael Guana, a mining engineer employed in the roof control division of MSHA's Tridelphia Safety and Health Technology Center, testified as an expert witness in the field of ground/roof control. He defined a hillseam as "a term used in the eastern mining region, eastern Kentucky, to describe an open joint." Tr. 558. Hillseams are formed over geologic time as a result of regional stresses, and are not caused by the mining process. Tr. 558. Guana explained that by "open joint" he meant a joint in the rock strata that "you could put your finger tips in or we could actually see up into . . . the roof a short distance in the order of six inches." Tr. 571. Guana distinguished a "crack" from a hillseam by explaining, that in MSHA's roof control division, a crack is a fault caused by the mining process. Tr. 559.

Guana disagreed with a number of statements in the Bureau of Mines publication. Tr. 580, 581, 584. He believes that hillseams do not have to be weathered joints, and do not have to occur near a coalbed outcrop or under shallow cover. Rather, they could occur anywhere in a mine. Tr. 579. He believes that the definition of hillseam has changed since 1989. Tr. 590. However, statements in the NIOSH and especially the MSHA publications, both from 2003, were essentially consistent with the 1989 publication, and he disagreed with the description in the MSHA publication. Tr. 586. Guana also testified that "there is no published definition" of the term "hillseam," and acknowledged that there is "no definition that's accepted across all aspects of academia." Tr. 596.

Lester Cox, Jr., the lead inspector on MSHA's investigative team, had 18 years of mining experience and 13 years of MSHA experience at the time of the investigation, and testified about hillseams. Tr. 371-74. He defined a hillseam as "a vertical fracture in the mine roof . . . that existed prior to the mining process . . . and . . . can extend to the surface area." Tr. 381. A hillseam is a type of crack and is "obvious." Tr. 381-82. "Most of the time the fracture crack can be jagged, like something that's been ripped, and a hillseam will be more or less smooth lines, straight lines." Tr. 382. He testified that a photograph taken during the investigation depicted a hillseam in the #5 entry that was not involved in the fall. Tr. 403-04; ex. G-19.

11 The Secretary did not call Sizemore as a witness either in her case in chief, or on rebuttal. He was called as witness by Respondents. The Secretary did not cross-examine him with respect to these conversations, and I conclude that Wright's descriptions are accurate.
He agreed that hillseams usually extend all the way to the surface, that there are cracks that are not created by the mining process that are not hillseams, and that hillseams are more likely to occur near the outcrop and under shallow depth of cover. Tr. 438-43. He also agreed that it would be important to know what the roof looked like before the rock fell in order to say whether or not a crack was a hillseam, and that use of the term hillseam may vary depending upon the locality and mining culture in which mining is done. Tr. 444. Cox did not agree that the Bureau of Mines publication could be interpreted to mean that hillseams would not occur more than 700 feet away from the outcrop or where there is more than 300 feet of overburden. Tr. 441-43. He saw hillseams in the videotape taken by Pennington, and observed hillseams out by the fall and in other areas during the investigation. Tr. 392-93. They were “obvious.” Tr. 393.

The Secretary’s broad definition of the term “hillseam,” i.e., an open joint anywhere in a mine, was not disclosed until after the accident. No publication or other documentation was offered to support the definition. The Secretary also did not offer any evidence in an attempt to prove that her definition was, or should have been, understood by Bell County because of either the history and purpose of the use of the term in the Roof Control Plan, or consistent enforcement. In fact, the only evidence as to enforcement prior to the accident is inconsistent with her definition. I find that Bell County’s Roof Control Plan was not ambiguous as to the term “hillseam,” and that the joints in the #5 entry, between which the roof fall occurred, were not hillseams within the meaning of the Plan. Consequently the Roof Control Plan was not violated, as alleged in Citation No. 7538674. The Secretary does not argue that any other plan or regulatory provision was violated.

The Secretary introduced significant evidence in support of her argument. However, ultimately, I find it unpersuasive. Both Guana and Cox testified that hillseams in the #5 entry were evident in the video tape taken by Pennington. As noted above, however, the joints in the #5 entry had no mud or water in them, and were not hillseams within the meaning of the Roof Control Plan. Moreover, it is highly likely that displacement, which Guana opined is the critical element in determining whether a joint is a hillseam, had been altered by mining done that evening prior to the depiction of the joints in the video. Retreat mining had begun in the #5 entry, and portions of the supporting pillars had been removed. The roof had been “working,” and dribbling had occurred along the joints, i.e., small pieces of rock had fallen out. By the time it was depicted in the video, the joint may well have appeared more dangerous than it had prior to the start of the shift.

The Secretary also relies heavily on a statement given by Belcher, in which he relates that prior to the accident, he “wasn’t aware of the requirements of the Roof Control Plan when hillseams were encountered.” Ex. G-24. He also stated that he “was aware of the two seams running down the #5 entry,” had “checked the test holes” and “didn’t have any reason for concern,” although he did have concerns about the roof where the crew was mining and “warned them to keep an eye” on it and move on if anything unusual happened. Ex. G-24. I do not find this statement to be as damaging as the Secretary urges. Belcher’s statement was reduced to writing on March 5, 2005, more than eight months after the accident. However, it appears to have been the product of an interview that was conducted during the investigation, which is
referred to in the narrative of another violation. Ex. G-8. There is no other evidence as to the
substance of the interview. The timing and circumstances under which the interview was
carried out are unknown. It is clear that MSHA was applying a very broad interpretation of
the term hillseam during and after its investigation. While it is apparent that Belcher was aware of
some features of the roof in the #5 entry prior to the accident, it is not so clear that, at that time,
he recognized the features to have been hillseams. Belcher apparently was shown several
photographs of cracks or joints and stated that, with one exception, he did not consider that any
of them depicted a hillseam. The photos were not included with the statement, and it unclear
exactly what he considered a hillseam, even at the time he gave the statement. In addition, he
believed that one reason that the joints in the #5 entry were not treated as hillseams was because
the “people on the section” did not think that the joints were hillseams. Ex. G-24 at 3.

Several miners testified that there were seams or hillseams in the #5 entry. Don Thomas,
who installed roof bolts in some portion of the #5 entry, testified that the entry had cracks,
hillseams or some combination of the two, because they were visible.12 There was no mud or
water in them. Tr. 281-84. Jonathan Shelton, who had at least five years of experience, testified
that a hillseam is a “separation in rock, not like a hairline crack, that you could see up into, and
goes through the whole coal seam, rock seam, roof and floor.” Tr. 263. He saw hillseams in the
#5 entry in the area where the accident happened, a couple of feet off the rib. Tr. 262, 264.
There was no mud or water in them. Tr. 271. However, he was also sure that an MSHA
inspector had been in that area and had not identified any hillseams. Tr. 270. Bill Wilder ran a
shuttle car in the #5 entry on June 16, 2004. He testified that the top was bad, because there were
two seams running up the entry for two to three breaks. Tr. 185-86. Hillseams are bad because
they tend to drop out. Tr. 208. He learned the term hillseam in Tennessee, where hillseams have
a crystalline or glassy substance in them. Tr. 209-10. He observed no mud or water in the seams,
but offered that “everything was a hillseam,” which Bell County contends is a post-accident
definition. Tr. 206. Lemarr identified what “looks like a hill seam crack” in the Pennington
videotape, pretty close to where the accident happened.13 Tr. 98-99. He recalled that the joint
ran between two pillars and he did not see any immediate danger because it was supported by the
two pillars. Tr. 107. The primary joints involved in the fall ran up the entry. However, it
appears that the one on the left may have been slightly within the pillar line in the area of the first
open crosscut.

Conversely, Bailey saw a crack in entry #5 on the left side, but determined that it was not
a hillseam because it had no mud or water in it. Ex. G-25. He also was sure that an MSHA
inspector had been in the area, and had not cited or called attention to improperly supported
hillseams. Ex. G-25. Bailey identified pictures of hillseams that had been encountered in
another part of the mine. Tr. 777-78; ex. R-26, R-27, R-28, R-29. David Cinnamon, a roof
bolter with 29 years of experience at several mines, testified that a hillseam was “anything that
had mud and water coming out of it.” Tr. 225, 246. Hillseams were large openings, “some as

12 Thomas is incorrectly identified in the hearing transcript as John Thomas.

13 My concerns about the condition of the joint at that time have been previously noted.

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big as your hand.” Tr. 246. He had never encountered one except within 200 to 300 feet of the outcrop, and would not expect to see one where there was 500 to 550 feet of overburden. Tr. 225, 245. Tr. 225, 237, 247. Anthony McCullough, with 17 years of experience, also testified that hillseams had mud or water running out of them. Tr. 830. Renee Smith drove a shuttle car on the section and traversed the #5 entry about 30 times shortly before the accident, paying particular attention to the roof. He testified that there was a crack in the #5 entry that did not have mud or water in it and was not a hillseam, 796-97. There was no discoloration around the crack, and he was confident that he knew the difference between a hillseam and a crack. Tr. 813. He also described a picture of a weathered joint in another part of the mine as an “obvious” hillseam. Tr. 813; ex. R-27.

These conflicting views, some of which may have been altered by post-accident events, illustrate how the term hillseam may be understood differently, even within the same mining community. The fact that some miners may have thought that the joints in the #5 entry were hillseams does not alter the fact that neither Bell County nor MSHA considered them hillseams prior to June 16, 2004.14

Citation No. 7538675

Citation No. 7538675 was issued on August 18, 2004, pursuant to section 104(a) of the Act, and alleges a violation of 30 C.F.R. § 75.360(b)(3), which requires that preshift examinations be made of all areas where any miner is scheduled to work and shall include ventilation controls and tests of the roof, face and rib conditions. The violation is described in the “Condition or Practice” section of the citation as follows:

An investigation of the fatal fall of roof accident which occurred on June 16, 2004, determined that the pre-shift examiner, for the on-coming second shift, failed to properly examine the 004/003 MMU supersection. Hillseams (vertical open joints) were present at various locations on the 004/003 MMU that were not adequately supported as required in the approved Roof Control Plan, dated June 6, 2001. The extensiveness of these hillseams should have prompted identification

14 Even if the joints had been treated as hillseams under the Roof Control Plan, it is questionable that the accident would have been prevented. Cox conceded that had steel channels been used, they would not have stopped the massive roof fall. Tr. 476. He also agreed that narrowing the entry width to 18 feet may, or may not have had an effect on the fall. The joints between which the fall occurred ran about two feet off the right side of the entry and five feet off the left side, looking inby. Tr. 478, 488. Had cribs or posts been installed on the left side of the entry, they would have had no effect on the fall. If they had been installed on the right side, they may have been partially under the fallen material, and might have impeded the fall somewhat and/or provided some warning. Tr. 476-77, 491. He did not rely upon any studies or engineering analysis designed to determine if cribs or posts could have supported the fallen material. Crib or posts also could have presented obstructions for the fleeing miners, forcing them out further into the entry. Tr. 482.
as being hazardous roof conditions and corrective actions should have been taken. Due to the hazards associated with mining, and specifically with pillar mining, measures should have been implemented to adequately support the mine roof to correct the hazardous conditions or the area should have been dangered off and the section pulled back. The pre-shift record book did not contain any entries identifying the roof cracks or adverse roof conditions.


MSHA determined that a fatal accident occurred as a result of the violation, that it was significant and substantial, that one employee was affected, and that the operator’s negligence was moderate. A civil penalty in the amount of $34,000.00 has been proposed for this violation.

The Violation

While the citation’s narrative contains broader wording, the assertion that a fatal accident occurred as a result, and the Secretary’s Brief make clear that this violation is also predicated upon the Secretary’s position that the near vertical joint systems in #5 entry were obvious hillseams. Sec’y Br. at 42-43. Bailey conducted the preshift examination at issue. He did not believe that there were any hillseams in the #5 entry or anywhere else on the section. As explained in the discussion of the previous violation, his belief was justified under Bell County’s and MSHA’s understanding of the definition of the term hillseam at the time. He was also aware that an MSHA inspector, apparently Sizemore, had traveled the area when it had been mined on advance, and did not identify any hillseams or violations of the Roof Control Plan. The Secretary has not carried her burden of proof as to this violation.

Citation No. 7538676

Citation No. 7538676 was issued on August 18, 2004, pursuant to section 104(a) of the Act, and alleges a violation of 30 C.F.R. § 75.363(a), which requires, in part, that hazardous conditions identified during an examination of working areas be posted with a conspicuous danger sign where anyone entering the areas would pass. The violation is described in the “Condition or Practice” section of the citation as follows:

An investigation of the fatal fall of roof accident, which occurred on June 16, 2004, determined that a hazardous roof condition identified by the second shift section foreman was not posted with a conspicuous danger sign where anyone entering the area would pass, and the hazardous condition was not corrected. The section foreman stated during an interview that while he was making his safety checks of the 004/003 MMU, he observed hillseams in the No. 4 and 5 entries outby the active pillar line. He stated he observed one hillseam in the No. 5 entry,
located on the left side, two crosscuts long, and which widened out in the crosscut outby the active pillar row, where the fatal fall of roof accident occurred.

Ex. G-8.

MSHA determined that a fatal accident occurred as a result of the violation, that it was significant and substantial, that one employee was affected, and that the operator’s negligence was moderate. A civil penalty in the amount of $34,000.00 has been proposed for this violation.

The Violation

The Secretary relies exclusively upon the Belcher statement, exhibit G-24, for proof of this alleged violation. Sec’y Br. at 43-44. As noted in the previous discussion of that statement, which was apparently a truncated portion of an interview taken several months earlier, it is not so clear that, at the time Belcher did his examination on June 16, 2004, he recognized the features or joints in the roof of the #5 entry as hillseams. See discussion, supra, at 11-12. I find that the Secretary has failed to carry her burden of proof with respect to this violation.

Order No. 7538678

Order No. 7538678 was issued on August 19, 2004, pursuant to section 104(d)(1) of the Act, and alleges a violation of 30 C.F.R. § 75.1002(a), which requires that “Electric equipment must be permissible and maintained in a permissible condition when such equipment is located within 150 feet of pillar workings or longwall faces.” The violation is described in the “Condition or Practice” section of the citation as follows:

An investigation of the fatal fall of roof accident which occurred on June 16, 2004, determined that a non-permissible electric-powered chain saw and a non-permissible Quasar Model VM-L153 Digital Video Camera were being used within 150 feet of the active pillar line. During the viewing of the videotape that was recovered from the roof fall that was filmed at the time retreat mining was being conducted in the No. 5 entry of the 003 MMU the chain saw was heard in the audio portion of the videotape. During interviews of workers it was disclosed that a non-permissible electric chain saw was used to cut timbers on the pillar line. The electric saw was also observed by members of MSHA’s recovery team during recovery efforts. A separate citation was issued for methane tests not being conducted at twenty minute intervals or more often while coal was being mined.

Ex. P-9.

MSHA determined that it was highly likely that an injury resulting in lost work days or restricted duty would occur as a result of the violation, that it was significant and substantial, that five employees were affected and that the operator’s negligence was high. The Secretary alleges that the violation was the result of the operator’s unwarrantable failure to comply with the
regulation. A civil penalty in the amount of $5,300.00 has been proposed for this violation.

The Violation

The two pieces of equipment that are the subject of this citation, the video camera and the electric chain saw, were not permissible. Tr. 424-26, 448, 510. The electrical plugs that were located on the scoops, which were used to supply power to the chain saws, were also nonpermissible. Tr. 803. The video tape recovered from the camera conclusively establishes that it was used within 150 feet of the pillar line. Ex. G-2. Testimony of witnesses confirms that fact. Tr. 65-68, 146. There was conflicting evidence on whether an electric chain saw was used within 150 feet of the pillar line. Several Bell County employees testified that it was a common practice to use electric chain saws within 150 feet of the pillar line to cut timbers, and that power was supplied to the saws by extension cords that were plugged into the scoops. Tr. 80-81, 141-45, 166-67, 170-71, 201-03, 215, 264, 282-84. An electric chain saw was found within 150 feet of the pillar line during the recovery effort, and the scoops were found to have had nonpermissible electric plugs installed on them. Other Bell County employees testified that they had not seen electric chain saws used within 150 feet of the pillar line. Tr. 228, 643, 786-87, 800-02, 831.

The most telling evidence is provided by statements given by two of the section foremen as a result of the investigation of the fatal accident. Bailey and Belcher both reported that it was common knowledge that electric chain saws were used within 150 feet of the pillar line. Ex. G-24, G-25. These were statements against interest. They were not repeated during the hearing because the foremen invoked their Fifth Amendment rights and refused to testify about the presence of electric chain saws. Several miners testified that they actually used the chain saws, and would have done so in the presence of management officials, but not MSHA inspectors. Tr. 176, 215, 268, 284.

Using a chain saw near the location that the timbers were actually being placed would have been considerably more convenient than taking measurements, proceeding more than 150 feet outby to the power center to cut timbers, and then transporting them back to the pillar line. Any timbers that had to be trimmed further would also not have to be cut by hand with a bow saw or brought back to the area of the power center, but could easily be trimmed and installed.

I find that the nonpermissible electric chain saw was used within 150 feet of the pillar line. This practice most likely was allowed to develop because of the virtual absence of methane in the mine. Cox testified that nonpermissible equipment could ignite methane, and that methane can come out of a coal seam, accumulate in a roof cavity, and be forced out by roof falls that occur during retreat mining. Tr. 428-29, 471-73. However, he conceded that his testing revealed no methane and that there was no record of any tests showing the presence of methane at any point in the subject area. Tr. 471-73. Several witnesses testified that methane checks done during imminent danger runs and preshift examinations always showed that no methane was present in the mine. Tr. 238, 346, 353, 644, 802, 820, 832-33. In addition, the continuous miners were equipped with methane monitors that were set to alarm if methane concentrations
reached 1%, and they never alarmed. Tr. 644-45, 821, 832-33. There is no evidence that methane in any concentration, much less approaching an explosive concentration of 5%, was ever found in the mine.

I find that the impermissible video camera and electric chain saw were used within 150 feet of the pillar line, and that the regulation was violated. The practice was long standing and was known and permitted by section foremen. The negligence of foremen, agents of the operator, is imputable to Respondent. Martin Marietta Aggregates, 22 FMSHRC 633, 636 (May 2000) (citing Whayne Supply Co., 19 FMSHRC 447, 451 (Mar. 1997)). The characterization of Respondent’s negligence with respect to this violation as “high” was clearly accurate.

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’d Austin Power, Inc., 9 FMSHRC 2015, 2021 (Dec. 1987) (approving Mathies criteria).

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

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

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

In analyzing whether a potential methane hazard is S&S, the critical question is whether there is any likelihood of explosive concentrations of methane coming into contact with an ignition source. See Texasgulf, Inc., 10 FMSHRC at 501. Here the impermissible equipment provided readily available ignition sources for any methane that might have been present at explosive concentrations. However, as noted above, there is no evidence that even low concentrations of methane were ever found in the mine. The possibility of methane coming out of a coal seam and accumulating in a roof cavity, that Cox testified to, was purely theoretical on the facts of this case. While, as Cox also observed, Respondent was not testing the atmosphere for methane every twenty minutes, all of the tests that were performed showed an absence of methane. MSHA’s Report of Investigation noted that “the mine liberates negligible methane.” Ex. G-11 at 2.

There is no evidence to establish that there was any likelihood of explosive levels of methane coming into contact with one of the ignition sources. I find that the Secretary has failed to carry her burden of proving that the violation was S&S.

Unwarrantable Failure - Negligence

Section 104(d)(1) of the Act, pursuant to which the order was entered, addresses violations that are both significant and substantial and the result of an unwarrantable failure to comply with the particular standard. Because this violation was not S&S, it is unnecessary to determine whether it was also the result of an unwarrantable failure. As previously noted, Respondent’s negligence was high.

Individual Liability

The Secretary assessed civil penalties against five managers of Bell County, in their individual capacities, mine superintendent Donnie Wright, mine foreman Jimmy Murray, and section foremen Craig Davis, Darryl Bailey and Jerry Belcher. Each is alleged to have knowingly authorized the violations alleged in Citation Nos. 7538674 (failure to comply with the Roof Control Plan with respect to hillseams in the #5 entry) and 7538678 (use of an

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nonpermissible chain saw within 150 feet of active pillarng). 15

The Act provides that a director, officer or agent of a corporate operator may be subject to civil penalties in his individual capacity for knowingly authorizing, ordering or carrying out a violation of the Act. 30 U.S.C. § 820(c). The legal standards governing individual liability were summarized in Maple Creek Mining, Inc., 27 FMSHRC 555, 566-67 (Aug. 2005):

Section 110(c) of the Mine Act provides that whenever a corporate operator violates a mandatory health or safety standard, a director, officer, or agent of such corporate operator who knowingly authorized, ordered, or carried out the violation shall be subject to an individual civil penalty. 30 U.S.C. § 820(c). The proper legal inquiry for determining liability under section 110(c) is whether the corporate agent knew or had reason to know of a violative condition. Kenny Richardson, 3 FMSHRC 8, 16 (Jan. 1981), aff'd on other grounds, 689 F.2d 632 (6th Cir. 1982), cert. denied, 461 U.S. 928 (1983); accord Freeman United Coal Mining Co. v. FMSHRC, 108 F.3d 358, 362-64 (D.C.Cir. 1997). To establish section 110(c) liability, the Secretary must prove that an individual knew or had reason to know of the violative condition, not that the individual knowingly violated the law. Warren Steen Constr., Inc., 14 FMSHRC 1125, 1131 (July 1992) (citing United States v. Int'l Minerals & Chem. Corp., 402 U.S. 558, 563 (1971)). A knowing violation occurs when an individual “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.” Kenny Richardson, 3 FMSHRC at 16. Section 110(c) liability is predicated on aggravated conduct constituting more than ordinary negligence. BethEnergy [Mines, Inc., 14 FMSHRC 1232, 1245 (Aug. 1992)].

Wright and Murray - Docket Nos. KENT 2005-416 and KENT 2005-411

The Roof Control Plan Violation - Citation No. 7538674

The finding that Bell County did not violate its Roof Control Plan, as alleged in Citation No. 7538674, precludes a finding of liability against the individual Respondents. However, at the close of the evidence, motions for entry of judgment on behalf of Wright and Murray were granted, and the citations, as to them, were vacated. Tr. 845-57. The following discussion explains the bases of those rulings.

As made clear in Kenny Richardson and BethEnergy, as a predicate to individual liability, an operator’s agent must be privy to knowledge or information that gives him reason to know of the existence of a violative condition under circumstances that his failure to act amounts to

15 The Secretary conceded that none of the individual respondents could be charged with knowledge of the presence of the video camera that the victim “smuggled” into the mine. Tr. 21, 462-63.

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aggravated conduct constituting more than ordinary negligence.

The Secretary failed to carry her burden of proof as to both of these high level managers. Wright, the mine superintendent, had responsibility for three mines at the time. Tr. 614. He had not been underground in the Coal Creek Mine since at least May 5, 2004, well before the area of the roof fall was mined on advance. Tr. 293, 712. Consequently, he was not in a position to have personally observed the alleged hillseams. While the Secretary contends that the alleged hillseams were obvious, there is little disagreement on the fact that, prior to the accident, neither Bell County nor MSHA believed that cracks in the roof of the #5 entry were hazardous unsupported hillseams, or thought that there was any other noncompliance with the Roof Control Plan. There was also no evidence that anyone informed Wright of a problem with hillseams or noncompliance with the Roof Control Plan. Hillseams had been encountered in another area near the outcrop, and had been appropriately dealt with. Heintzmann beams and channel straps were available, if needed. There was no information known to Wright, or of which he reasonably should have known, that should have put him on notice of a violative condition as to the Roof Control Plan.

The same holds true for Murray, except that on May 18 and 20, he was actually on the section in the vicinity of where the roof fall later occurred while it was being mined on advance. Consequently, he was in a position from which he arguably could have noted the existence of what the Secretary contends were hillseams in the #5 entry, and that they had not been addressed as required in the Roof Control Plan. However, Murray traveled with MSHA inspector Sizemore on May 18 and with Sizemore and MSHA field office supervisor Langley on May 20. Both of those experienced MSHA personnel were paying careful attention to roof conditions and compliance with the Roof Control Plan, with emphasis on hillseams on May 20. Neither Sizemore nor Langley observed any hillseams, or noted any other problems with roof conditions or possible violations of the Roof Control Plan. Tr. 521-31, 735, 742. Under such circumstances, any failure by Murray to observe hillseams and alleged violations of the Roof Control Plan could not have risen to the level of aggravated conduct constituting more than ordinary negligence.

Use of Nonpermissible Electric Chain Saw – Citation No. 7538678

The allegations with respect to the nonpermissible chain saw presented closer questions. As noted above, it was a common practice to use a nonpermissible electric chain saw within 150 feet of the pillar line. The practice was known to, and permitted by, section foremen. There was a permissible inference that Murray and Wright were aware of the practice, which was the Secretary’s argument on these allegations. The difficulty with the argument was that it was perfectly legal to use nonpermissible electric chain saws in most areas of the mine. The chain saws were typically used to cut timbers in the track and belt entries. Consequently, procurement and availability of electric chain saws would provide no indication that violations of regulations

16 The Secretary argued that “If the foremen knew, then both the mine superintendent and the mine foreman had to know.” Tr. 606.

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were occurring. It is only use of such nonpermissible equipment within 150 feet of the active pillar line that is prohibited by the regulation.

There was no evidence that Wright or Murray were present when the chain saws were used at the pillar line, and there is no evidence that they were informed of such use. While it is possible that it might have been mentioned, perhaps by one of the section foremen, it appears to have been such a common practice that it could easily have been viewed as unremarkable. Miners using the chain saws at the pillar line were well-aware that the practice violated MSHA regulations. Tr. 176, 215, 268, 284. It strikes me as unlikely that a miner or section foreman would inform Wright or Murray that MSHA regulations were being routinely violated. Nor did the fact that several miners stated that they most likely would not have stopped their illegal use of the chain saws in Wright’s or Murray’s presence lend much strength to the inference. It could merely have reflected their assumption that the foremen’s tolerance of the practice extended to higher levels of mine management.

In opposing the motions made at the close of the Secretary’s case and renewed after all parties rested, the Secretary argued that, as high management officials, Wright and Murray had “an absolute duty to ensure that the Roof Control Plan . . . was being followed,” and that they were obligated to go underground “as often as necessary to ensure that the Roof Control Plan is being followed, and that the regulations are being followed” even if that meant “every day.” Tr. 603, 608, 854. The core of the argument is that individual high-level managers are strictly liable for violations at mines over which they exercise authority. I rejected that argument as being inconsistent with the Act’s provisions on personal liability.

The Secretary failed to carry her burden of proof with respect to the allegations against Wright and Murray. She failed to establish that they were privy to information that gave them knowledge or reason to know of the existence of the allegedly violative conditions, and that their failure to act amounted to aggravated conduct constituting more than ordinary negligence. I declined to draw the inferences that the Secretary urged, because I found them unpersuasive, and clearly not strong enough to justify a finding of aggravated conduct.


The cases against the section foremen rest upon an entirely different footing. They were in the subject area of the mine virtually every working day, and had the responsibility to perform on-shift inspections to identify hazardous conditions. They were in a position to have had actual knowledge of conditions and practices occurring during the development and retreat mining phases of the subject sections. As to Citation No. 7538674, the finding that the Roof Control Plan was not violated precludes findings of liability against the individual Respondents.

However, there is ample evidence to justify a conclusion that the use of nonpermissible electric chain saws within 150 feet of the pillar line was a common practice, and that the section foremen knew of, and permitted, it. See the discussion of Citation No. 7538678. Bailey and
Belcher admitted knowledge of the practice in their written statements.\textsuperscript{17} Ex. G-24, G-25. While there is no direct evidence that Davis permitted the practice, I find that he also must have been aware of and allowed the use of electric chain saws within 150 feet of the pillar line. While Davis' third shift normally performed maintenance and similar functions, coal was occasionally produced when the other work was done. Tr. 309-11. Davis also occasionally filled in on other shifts, if one of the foremen was off. Tr. 788. Consequently, he was most likely aware of the common practice.

I find that Davis, Bailey and Belcher knowingly authorized the violation alleged in Citation No. 7538678, within the meaning of section 110(c) of the Act. However, as noted in the discussion of that citation, the violation was not S&S and the gravity was low. Civil penalties in the amount of $500.00 were proposed as to each of these Respondents for this violation. Considering that the violation was non-S&S and the lower gravity, and upon consideration of the factors enumerated in section 110(i) of the Act, I impose civil penalties upon Davis, Bailey and Belcher in the amount of $200.00 each.

Part II — Violations Unrelated to the Fatality

Sizemore returned to the mine on August 17, 2004, to conduct a regular quarterly inspection. Several orders and citations were issued in the course of the inspection. After all parties rested their cases on the violations related to the fatality, the individual Respondents were excused. Evidence admitted during Part I of the hearing forms part of the record as to the alleged violations discussed below. Evidence admitted during Part II of the hearing does not form a part of the record upon which the alleged violations related to the fatality were decided. Tr. 833-34.

Citation No. 7524384 and Imminent Danger Order No. 7524383

On August 17, 2004, Sizemore entered the mine with Murray and two state inspectors, traveling to the 004 section down the track entry, the #3 entry.\textsuperscript{18} Bell County was retreat mining at the time. About 10 crosscuts from the pillar line, Sizemore observed what he believed to be a hillseam on the right side of the entry. It ran down the entry for about two crosscuts, gradually crossing it, and entering the rib on the left side. Tr. 871; ex. G-40. About one crosscut further in from the start of the first hillseam, he noticed another hillseam running parallel to the first one, also extending about two crosscuts down the entry before entering the left rib. Tr. 872.

\textsuperscript{17} The Secretary requested that negative inferences be drawn because Belcher and Bailey asserted the Fifth Amendment and refused to testify regarding the use of electric chain saws within 150 feet of the pillar line. Sec'y Br. at 45-46,48. I decline to do so. Both individuals provided statements in which they admitted knowledge of the use of electric chain saws within 150 feet of the pillar line. The findings against them on this violation have ample evidentiary support without such inferences.

\textsuperscript{18} The 004 section was located in an area of the mine different from where it had been at the time of the June 16 fatality. Tr. 871.
crosscut further inby, he found two more hillseams. Tr. 874. Steel channels had been installed on a portion of one of the hillseams, but only straps were used on the remainder. Tr. 873-74. Sizemore described the hillseams as being “no less than one-half inch wide,” with smooth edges. Tr. 874. He agreed that there was no mud, water or other foreign substance in the openings, and that he had not traced the conditions to the surface. Tr. 890. Sizemore determined that the conditions violated Bell County’s Roof Control Plan, and that they presented an imminent danger. He cited the conditions and issued an imminent danger order.

Murray disagreed with Sizemore. He did not believe that the conditions were hillseams, and called Langley, the field office supervisor, to complain. Tr. 897. Langley, and Roger Dingess, a roof control specialist, went to the mine that afternoon and traveled with Murray to the scene. Tr. 899. Langley couldn’t remember what the conditions looked like, but recalled that he and Dingess agreed that the conditions had been properly cited. Tr. 900.

Bailey testified that the conditions cited were not hillseams, just cracks, with no mud, water or foreign substance in them. Tr. 925-26. Nevertheless, in order to terminate the citation and order, he directed two miners to timber the area off. The miners went to the area, but were unable to find the cited conditions, and Bailey had to go and point them out. Tr. 926. Benny Capps was one of the miners, and he corroborated Bailey’s testimony. Tr. 907. Capps believed that they were just stress cracks, only as wide as the thickness of a piece of paper, and he did not consider them to be bad conditions. Tr. 907-08. Murray had also asked Wright to look at the conditions. Wright went to the area, but he, too, was unable to find the alleged hillseams. Murray pointed out what Sizemore had cited. Wright testified that he could only see one small crack, that looked like a pencil line had been drawn on the mine roof. There was no displacement, and it was “nothing like a hillseam.” Tr. 944-46.

Citation No. 7524384 was issued pursuant to section 104(a) of the Act, and alleges a violation of 30 C.F.R. § 75.220(a)(1), which requires that mine operators develop and follow a Roof Control Plan approved by the MSHA District Manager. The violation is described in the “Condition or Practice” section of the citation as follows:

The operator has not followed the approved Roof Control Plan.
1. Steel straps were used in lieu of the required steel channels or wooden crossbars, to support hillseams and parallel hillseams in the No. 3 entry beginning at the approx. 10th crosscut outby the pillar line on the 004 section and extending parallel with the no. 3 entry to the approx. 7th crosscut inby.
2. The entry width had not been reduced to the required 18 feet when subnormal roof conditions are encountered.

Ex. G-33.

Sizemore determined that a fatal accident was highly likely to occur as a result of the violation, that it was significant and substantial, that one employee was affected and that the operator’s negligence was high. A civil penalty in the amount of $6,000.00 has been proposed
Order No. 7524383 was issued pursuant to section 107(a) of the Act, based upon
Sizemore’s finding that the cited conditions constituted an imminent danger. It required the
removal of miners from “The no. 3 entry, beginning at the approx 10th crosscut outby the pillar
line and extending to the approx. 7th crosscut inby.” Ex. P-34.

The Citation

Sizemore and Langley were somewhat uncertain in their descriptions of how wide the
alleged hillseams were. Langley did not recall, and Sizemore stated that they were “no less than
one-half inch wide.” Tr. 873-74, 900. In describing similar conditions that he cited on August
31, he used the same terminology. Tr. 883. As to those alleged hillseams, he acknowledged that
he couldn’t remember the exact width, and one-half inch was “just a guess.” Tr. 883, 892-93.
There are no recorded measurements, or other descriptions of the alleged hillseams in Sizemore’s
notes. Ex. P-40. The descriptions offered by Murray, Wright, Bailey and Capps were consistent.
I find that the conditions were crack-like openings, with very limited displacement,
i.e., approximately one-sixteenth of an inch. It is undisputed that they had no water, mud or
other foreign substance in them.

As noted in the discussion of Citation No. 7538674, at least up to June 15, 2004, MSHA
and Bell County were largely in agreement as to the definition of the term “hillseams” in the
Roof Control Plan. It did not include conditions like those that were the subject of Citation No.
7524384. MSHA’s Report of Investigation of the June 16 fatality was not issued until August
17, 2004, and the citations associated with it were issued on August 18 and 19. Because the
conditions cited were not hillseams within the meaning of Bell County’s Roof Control Plan,
support with steel channels and narrowing of the entry were not required. Bell County did not
violate its Roof Control Plan by failing to properly address hillseams.19

While Sizemore had issued citations for Roof Control Plan violations involving hillseams
on June 21 and July 12, 2004, there is no description of those conditions in the record.20
Consequently, there is no evidence that, prior to August 17, Bell County had been put on notice
that cracks or joints, without water, mud or some foreign substance in them, had to be treated like
hillseams under its Roof Control Plan, i.e., the June and July citations did not establish notice of

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19 There was no evidence of a conclusive method for determining whether a crack-like
opening in a mine roof is a near vertical joint or a stress crack. Witnesses described differences
in appearance, i.e., joints tend to be relatively straight and have significant displacement, whereas
 cracks caused by mining would be smaller and more jagged. Guana also stated that joints
typically would be open for a depth of six inches or more.

20 The citations were issued under section 104(a) of the Act. Ex. G-37, G-38.
MSHA’s new interpretation through consistent enforcement.\textsuperscript{21}

The Imminent Danger Order

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.” 30 U.S.C. § 802(j). Section 107(a) of the Act provides, in pertinent part:

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.


“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 Mine 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.” \textit{Utah Power \\& Light Co.}, 13 FMSHRC 1617, 1622 (Oct. 1991) (quoting from the legislative history of the Coal 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.” \textit{Wyoming Fuel Co.}, 14 FMSHRC 1282, 1290 (Aug. 1992) (quoting from \textit{Rochester \\& Pittsburgh Coal Co.}, 11 FMSHRC 2159, 2163 (Nov. 1989)). Inspectors must determine whether a hazard presents an imminent danger quickly and without delay, and a finding of an imminent danger must be supported “unless there is evidence that [the inspector] had abused his discretion or authority.” 11 FMSHRC at 2164. 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. An inspector may abuse his discretion if he issues a section 107(a) order

\textsuperscript{21} As of August 17, Sizemore was aware that MSHA was considering revisions to Bell County’s Roof Control Plan. He ascertained by phone that no changes had been made. A change was later issued on August 20, 2004. Tr. 869, 888; ex. G-46. The post-fatality amendment to the plan did not redefine the term hillseams, or require that cracks or joints be treated as hillseams. It provided that “Areas where near vertical joints are parallel within the same entry or crosscut will not be second mined.”

29 FMSHRC 530
Without determining that the condition or practice presents an impending hazard requiring the immediate withdrawal of miners. 13 FMSHRC at 1622-23.

While an inspector has considerable discretion in determining whether an imminent danger exists, that discretion is not without limits. As the Commission explained in Island Creek Coal Co., 15 FMSHRC 339, 347-48 (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.

The fact that the cited conditions were not a violation of Bell County’s Roof Control Plan is not dispositive of whether the imminent danger order was properly issued, because an imminent danger may exist in the absence of a violation of a mandatory health or safety standard. Utah Power & Light, supra. Although MSHA’s report on the investigation of the fatality was not issued until August 17, both Sizemore and Langley were aware of the conclusion that the fall had started at the pillar line and extended up the #5 entry between two parallel joint systems. They believed that the conditions that Sizemore found on August 17 were joints that presented a similar potential for a roof fall. Tr. 875-76, 900. As Langley stated, “I took into consideration that there was pulling down and they would soon be in that area and it would be the same situation that we had before, the roof could drop out suddenly.” Tr. 900.

While Sizemore and Langley had legitimate concerns about the potential for a roof fall similar to that that had occurred on June 16, there are several significant differences between the two situations that cast considerable doubt on whether the conditions that existed on August 17 constituted an imminent danger. The June 16 incident involved parallel joint systems that were typically less than 15 feet apart, and ran within and parallel to the entry up to the pillar line. The cave that started at the pillar line pulled down rock from between the joints until a secondary joint was encountered. Assuming that the conditions that Sizemore found on August 17 were “near vertical joints,” they ran diagonally across the entry and were most likely about 20 feet apart. They did not run, unsupported, all the way to the pillar/cave line. Rather, they ran from rib to rib, where they were supported by the pillars, and were seven to ten breaks away from the pillar line.

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22 Sizemore described the joints as running at an angle between the ribs of the 20-foot wide entry, crossing it in roughly two breaks. The second joint started about 50 feet in by the first. Estimating from a rough diagram, the joints would have been slightly less than 20 feet apart.

29 FMSHRC 531
While Sizemore was concerned that the retreat mining process put stress on the roof, he did not explain how any such stress could affect the roof in the cited area. It was a considerable distance from where mining was being done, and the joints were supported by several rows of pillars. Guana, MSHA's expert, had testified that offsetting entries, so that joint lines ran into pillars rather than continuing up entries, would have been a reasonable way to lessen the dangers posed by parallel joint systems. Tr. 565-66. Langley was concerned because “they would soon be in that area.” Tr. 900. He did not explain what he meant by “soon,” but it appears that it would have been more a matter of days, than hours, before the retreat mining process would have approached that area. The condition was abated, i.e., timbered off, before Sizemore left. Ex. G-40.

The cracks may have been joints, like those involved in the fatal roof fall. However, they were supported by pillars and did not run up to the cave line. They were the type of conditions that had not been cited by MSHA prior to the fatality. I find that they did not present an impending hazard at that time.

As noted above, the extraordinary power to remove miners immediately, without prior review, is available only when the seriousness of the situation demands such immediate action. I find that the Secretary has not carried her burden of proof with respect to the imminent danger order, i.e., that the conditions could reasonably be expected to cause death or serious injury before they could be abated.

The August 31, 2004, Orders

By August 31, 2004, Bell County had taken Sizemore's articulation of MSHA's expanded definition of hillseams to heart. Its foremen had been instructed that “everything was a hillseam.” Davis conducted the preshift examination for the day shift on August 31, and noted in entries #3 and #6 the presence of hillseams that had not been properly supported as required in the Roof Control Plan. Tr. 918-19. He identified cracks with no mud or water in them as hillseams because his supervisors had told him that “everything was a hillseam.” Tr. 919. He testified that the entries were timbered off, effectively prohibiting travel, and that he then called out the results of the examination and the corrective action to Bailey, who recorded it in the preshift report book. Tr. 920. A copy of the preshift report is consistent with his testimony, as was testimony by Bailey. Tr. 926-28; ex. G-39. Bailey stated that he had written all of the notations on the preshift report, including the corrective action, before Sizemore saw it. Tr. 933.

On August 31, 2004, Sizemore and MSHA inspector Peggy Langley were continuing the regular quarterly inspection, and were conducting a dust survey. Sizemore testified that when he examined the preshift report for the day shift, hillseams had been noted in the #6 and #7 entries (not the #3 entry), and that no corrective action had been entered. Tr. 879. He then went underground, accompanied by Bailey and Murray. After he installed a dust monitor on the intake side and issued a citation for a violation at the power center, he did an imminent danger run across the section. When he reached the #7 entry, he found what he believed to be a hillseam running across the last open crosscut. Tr. 883. It was not properly supported as required by the
Roof Control Plan, and had not been posted with warning signs. He told Murray that the area was “shut down, and it wasn’t dangered off or anything.” Tr. 883-84. He decided to issue an Order closing the area, pursuant to section 104(d)(2) of the Act, citing a violation of the Roof Control Plan. He then crawled over to the #6 entry, found a similar condition, and added it to the Order. Tr. 884. He stayed in the area until the conditions were timbered off, thereby abating the violation. He also issued an order citing a violation of the regulation governing preshift examinations. Sizemore’s contemporaneously recorded field notes are consistent with his testimony. Ex. P-41.

There are substantial conflicts in the evidence with respect to these alleged violations. The copy of the preshift report for the day shift, Petitioner’s exhibit G-39, was moved into evidence by Respondent. Tr. 948-49. It shows that a hillseam was reported in the #3 and #6 entries (not the #7 entry), and that corrective action had been taken. Both Davis and Bailey testified that the report was accurate, and that all of the entries, including the corrective action, were made at the time Davis called the report out. Sizemore testified that he saw a partially completed report that showed hillseams in the #6 and #7 entries, and an absence of corrective action. He believed that changes had been made to the report after he first saw it. Tr. 878.

These conflicts pose difficult issues. However, a comment by Bailey in his written statement suggests that some of the conflicts can be reconciled. For the reasons that follow, I find that Sizemore was mistaken about the preshift report entries, but that there were unsupported hillseams in the #7 and #6 entries.

I find that the copy of the preshift report is accurate. The exhibit purports to be a copy of a page from a record book, and was submitted as a proposed exhibit by the Secretary. Presumably, the Secretary had access to the actual record book during the investigation and prehearing discovery. Had a page been removed from the book, it is highly likely that the removal could have been detected. There are also no indications that the entries on the report were altered. The Secretary advanced no objection to admission of the exhibit on grounds that it had been fabricated. In addition, both Davis and Bailey were highly experienced foremen, who were well aware of the proper procedures for reporting the results of preshift examinations. It is highly unlikely that Davis would have reported hazardous conditions and not taken, or reported corrective action. It is also highly unlikely that Bailey would have recorded a reported hazardous condition, without assuring that corrective action was reported as well.

Bailey testified that he remembered the events of August 31 well, because he strongly disagreed with the cited violations and attempted to discuss them with Sizemore, and because he remembered that the #6 entry had been timbered off, which complicated removal of the continuous miner. Tr. 926, 930-35. Bailey’s written statement discusses the August 31 violations, and notes that the area that Sizemore cited was outby the area that Davis had

23 When Bailey saw the order citing the Roof Control Plan violation, he was surprised. He did not believe the conditions were hillseams, and followed Sizemore out to his vehicle to protest. He didn’t see the order citing the preshift violation until he returned. Tr. 932-35.

29 FMSHRC 533
identified in his report. Ex. G-25. I find that Davis found what he believed to be hillseams, under the new expanded definition of that term in the #3 and #6 entries, that he had those areas timbered off, and reported the results of his preshift examination to Bailey, who made the entries in the record book.

I also find that Sizemore discovered an improperly supported hillseam in the #7 entry, and that Davis had not identified, reported, or corrected it. When Sizemore discovered the condition, he pointed it out to Murray. Murray did not testify as to these alleged violations. Bailey also examined the condition. After issuing the order and requiring corrective action, Sizemore proceeded to the #6 entry and discovered that the hillseam ran through the pillar into the #6 entry. He then added that condition to the order. Davis had not discovered that condition in the #6 entry during his preshift examination, and did not report or correct it.

Order No. 7524394

Order No. 7524394 was issued on August 31, 2004, pursuant to section 104(d)(2) of the Act, and alleges a violation of 30 C.F.R. § 75.220(a)(1), which requires that mine operators develop and follow a Roof Control Plan approved by the MSHA District Manager. The violation is described in the “Condition or Practice” section of the citation as follows:

The operator has failed to follow the approved Roof Control Plan.
1. Steel channels or wooden crossbars were not used to support hillseams that ran diagonally across the intersections of the #6 and #7 entries, in the last open crosscut outby the pillar line on the 003 retreating section.
2. The entry widths had not been reduced to the required 18 feet when subnormal roof conditions (hillseams) were encountered in the intersections of the #6 and #7 entries, in the last open crosscut outby the pillar line, on the 003 retreating section.

Ex. G-35.

Sizemore determined that it was highly likely that a permanently disabling injury would occur as a result of the violation, that it was significant and substantial, that one employee was affected, and that the operator’s negligence was high. The Secretary alleges that the violation was the result of Respondent’s unwarrantable failure to comply with the standard. A civil penalty in the amount of $4,800.00 has been proposed for this violation.

The Violation

Davis testified that he conducted the preshift examination for the oncoming day shift on August 31, 2004, and that he did not see a hillseam in the #7 entry. Tr. 918-19, 922. He had discovered a hillseam in the #6 entry, and assured that it had been timbered off. However, that condition was further inby the condition cited by Sizemore. Bailey described the condition in the #7 entry as a small crack that ran a few feet into the rib. It was thinner than a knife blade, and had no mud or water in it. He did not believe it was a hillseam, or that corrective action was
needed. Tr. 931-32. Smith testified that, in response to Sizemore’s issuance of the orders, he was assigned to timber off the #6 and #7 entries, which he did. Tr. 912. He saw one thin crack across entries #6 and #7, which he did not believe was a hillseam. Tr. 913-17.

It is apparent from Bailey’s and Smith’s testimony that there was a thin crack or joint in the #7 entry that emerged in the #6 entry on the other side of the pillar. Neither Smith nor Bailey described any differences between the cracks in the #6 and #7 entries. While the joint had very limited displacement, and no mud or water in it, it apparently ran in a relatively straight line, and was not a mining-induced stress crack. I accept Sizemore’s testimony, and find that the crack or joint in the #6 and #7 entries was a hillseam that was not supported as required in the Roof Control Plan. Consequently, the regulation was violated as alleged in the order.

S&S

The Secretary has proven the violation of the standard. It is also clear that the violation contributed to a discrete safety hazard, i.e., the possibility that a miner would have encountered the conditions under continued mining operations, and have been subjected to a risk of an unplanned roof fall. Any injury caused by the hazard would have been serious. Consequently, the analysis of whether the violation was S&S focuses upon the likelihood that the hazard would have resulted in an injury. Mathies, supra.

Respondent was retreat mining at the time, and the cited conditions were at the location where mining was being done, i.e., the last open crosscut. The presence of a near vertical joint in the roof’s rock strata could render the planned roof falls of the retreat mining process less predictable, raising the possibility of a fall outside the intended area. While the presence of unsupported parallel joints would have presented an obvious hazard in light of the June 16 accident, it is doubtful that this single joint posed as much danger, particularly since it was supported by the pillar between entries #6 and #7. I find that it was reasonably likely, not highly likely, that the hazard would result in an injury. Consequently, the violation was S&S.

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. 29 FMSHRC 535
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 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 August 31 orders were the result of unwarrantable failures because Sizemore had “already issued three violations for the same or similar conditions between June 2004 and August 31, 2004,” and he had “found two sets of hillseams within one crosscut of the active pillar line.” Sec’y Br. at 50, 51. The evidence does not support either prong of her argument. Sizemore did not find two “sets” of hillseams. He found one hillseam in each of the entries, which appears to have been the same crack or joint. Tr. 883-84. The reference to violations for the “same or similar conditions” is most likely to the citations/orders issued on June 21, July 12, and August 17. While the August 17 violation involved conditions similar to those cited on August 31, there is no evidence in the record describing the conditions that were the subjects of the June and July violations. While those citations were addressed to hillseams, in the absence of some description of those conditions, it is unclear how much, if any, guidance those citations provided on MSHA’s new interpretation of the term.

Bell County argues that the cracks in the #6 and #7 entries were very thin, had no mud or water in them, were not hillseams, “and there certainly was no justification for high negligence, unwarrantable failure.” Resp. Br. at 27. The “no hillseam” argument has been rejected in the above discussion. However, the argument on negligence has merit.

Bell County was adjusting to MSHA’s newly expanded definition of the term hillseam. Cracks that had previously been treated as part of normal roof conditions, by both Bell County and MSHA, were treated as hazardous conditions on August 31, 2004. While the change may
have begun earlier, after the August 17 release of MSHA’s Report of Investigation of the fatal roof fall and Sizemore’s issuance of a citation and imminent danger order, the new definition was in place. Sizemore’s statement to Murray, that “everything is a hillseam,” was relayed to the mine foremen as a directive on interpretation of the Roof Control Plan.

Had the area been mined only a day or two earlier, and adequate roof support not been installed, the Secretary would have had a good argument that the violation was the result of an unwarrantable failure. However, the entries were mined on advance much earlier, at a time when the roof support was considered to be in compliance with the Roof Control Plan by both MSHA and Bell County.24 The conditions became non-compliant with the plan only after MSHA changed the plan’s definition of hillseams and established a record of consistent enforcement sufficient to put Bell County on notice that the term hillseam included such conditions. That occurred no earlier than August 18, 2004. I find that Bell County’s negligence in failing to have supported the hillseam, as specified in the Roof Control Plan, was no more than moderate. It was not the result of an unwarrantable failure to comply with the standard.

Order No. 7524395

Order No. 7524395 was issued on August 31, 2004, pursuant to section 104(d)(2) of the Act, and alleges a violation of 30 C.F.R. § 75.363(a), which requires, in part, that hazardous conditions identified during an examination of working areas be posted with a conspicuous danger sign where anyone entering the areas would pass. The violation is described in the “Condition or Practice” section of the citation as follows:

The operator did not conduct a proper preshift examination. Hazardous conditions (inadequately supported hillseams that ran diagonally across the intersections of the #6 and #7 entries in the last open crosscut outby the pillar line on the 003 retreating section) were recorded in the preshift book, but were not corrected or posted with danger signs.

Ex. G-36.

Sizemore determined that it was highly likely that a permanently disabling injury would occur as a result of the violation, that it was significant and substantial, that one employee was affected, and that the operator’s negligence was high. The Secretary alleges that the violation was the result of Respondent’s unwarrantable failure to comply with the standard. A civil penalty in the amount of $4,800.00 has been proposed for this violation.

The Violation

The purpose of required preshift and onshift examinations is to identify hazardous conditions and ensure that they are corrected. Hillseams that have not been supported, as

24 Bailey noted that the area had been mined about three years earlier. Ex. G-25.
required by the Roof Control Plan, are hazardous conditions that should have been discovered in a preshift examination, noted in the report, and immediately corrected or posted with conspicuous danger signs until they were corrected.

As noted in the discussion of the prior order, there was a hillseam that ran across the #6 and #7 entries that had not been supported as required in the Roof Control Plan. Davis failed to identify it as a hillseam when he conducted the preshift examination. This particular condition was not reported, and was not noted on the preshift examination report. Nor was it corrected or posted with warning signs. I find that the regulation was violated.

S&S

For the same reasons that the previous violation was found to have been S&S, I find this violation to be S&S. However, it was reasonably likely, rather than highly likely, that the hazard would result in an injury.

Unwarrantable Failure - Negligence

As noted above, as of August 31, Bell County was adjusting to MSHA’s newly expanded definition of the term hillseam in the Roof Control Plan. Davis was attempting to anticipate the breadth with which MSHA would interpret the term as he performed the preshift examination for the day shift on August 31. He identified such conditions in the #3 and #6 entries. He had them timbered off and reported them, even though he believed that they were “hairline cracks,” and should not have been regarded as hillseams. Tr. 919. He did not identify the thin joint in the #7 entry that extended into the #6 entry as a hillseam. Bailey and Smith did not believe that the crack in the #6 and #7 entries was a hillseam.

The Secretary argues that two witnesses called by Bell County to describe the conditions hadn’t examined the area closely. 25 Sec’y Br. at 51. However, Bailey testified that he “walked all the way over there and looked up underneath it, and looked at it that way as in from one side to the other.” Tr. 936. He described it as thin crack that he did not believe was a hillseam. Smith stated that he was about eight feet away from the crack when he made his observations. Tr. 916. Sizemore, whose recollection of the condition was admittedly vague, had stated that his estimate of the opening width being one-half inch was “just a guess.” Tr. 883, 892-93.

I find that the failure to identify the crack in the #6 and #7 entries as a hillseam reflected an honest disagreement over whether the condition fell within the newly expanded definition. Sizemore was most likely applying the definition broadly, erring on the side of inclusion. As Langley acknowledged, in light of the fatality he would look at suspect conditions “stronger than [he] normally would.” Tr. 904. Sizemore may well have taken an even more expansive view of

25 Sizemore explained the basis for his assessment of “high” negligence as to this order, i.e., he “had issued the same type of violation previously for improper pre-shift examination.” Tr. 887. No further explanation was offered.

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hillseams, since he had actually seen the conditions that later resulted in the fatality, and had not taken steps to address them.

Many of the factors typically used in evaluating whether a violation was the result of an unwarrantable failure have little application here. The condition existed for as long as three years. However, it had only recently become a violation, as MSHA’s expanded definition of the term hillseams became enforceable. It was not extensive. It was S&S, but it did not pose a high degree of danger. Because of its nature, the condition itself was not obvious, nor was it obviously a violation. While a supervisor was involved, and there had been other similar violations issued, the difficulty of differentiating between a common crack and a near vertical joint that was not weathered and did not have a foreign substance in it is a significant mitigating factor.

I find that Bell County’s negligence with respect to this violation was no more than moderate. The violation was not the result of an unwarrantable failure to comply with the standard.

The Appropriate Civil Penalties

Bell County is a medium-sized mine, and its controlling entity, James River Coal Company, is a large mining entity. The Secretary introduced a printout from MSHA’s computer database, an Assessed Violation History Report, showing that Respondent had 185 paid violations in the 24 month period from August 31, 2002, to August 30, 2004. Ex. G-43. Of those violations, 79 were single penalty assessments, 97 were regularly assessed, and 9 were specially assessed. The Proposed Assessment mailed to Respondent showed slightly different numbers. However, it appears that Respondent’s relevant violation history was moderate, or average. Bell County does not contend that payment of the penalties would impair its ability to continue in business. All of the violations were promptly abated in good faith. The gravity and negligence associated with the alleged violations have been discussed above.

Order No. 7538678 was affirmed. However, it was found not to have been S&S or the result of the operator’s unwarrantable failure. The violation was unlikely to result in an injury, and the operator’s negligence was found to have been high. Consequently, the order will be modified to a citation issued under section 104(a) of the Act. A civil penalty of $5,300.00 was proposed by the Secretary. Upon consideration of the above, and the factors enumerated in section 110(i) of the Act, I impose a penalty in the amount of $2,500.00.

Order No. 7524394 was affirmed as an S&S violation. However, the gravity was slightly lower than alleged, because a reasonably serious injury was reasonably likely, rather than highly likely, to occur. It was also found not to be the result of the operator’s unwarrantable failure, and the operator’s negligence was moderate. Consequently, the order will be modified to a citation issued under section 104(a) of the Act. A civil penalty of $4,800.00 was proposed by the Secretary. In light of the slightly lower gravity and the lower negligence finding, and upon consideration of the factors enumerated in section 110(i) of the Act, I impose a penalty in the

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amount of $2,000.00.

Order No. 7524395 was affirmed as an S&S violation. However, the gravity was slightly lower than alleged, because a reasonably serious injury was reasonably likely, rather than highly likely, to occur. It was also found not to have been the result of the operator's unwarrantable failure. The operator's negligence was moderate. Consequently, the order will be modified to a citation issued under section 104(a) of the Act. A civil penalty of $4,800.00 was proposed by the Secretary. In light of the slightly lower gravity and the lower negligence finding, and upon consideration of the factors enumerated in section 110(i) of the Act, I impose a penalty in the amount of $2,400.00.

Respondent Bell County withdrew its Notices of Contest and requests for hearing with respect to Citation Nos. 7538677, 7538679 and 7538680, and Order No. 7538681. It agreed to pay the proposed penalties for those violations, a total of $6,336.00. The Secretary concurred with the proposed settlement of those alleged violations. I have considered the representations and evidence submitted and conclude that the proffered resolution is appropriate under the criteria set forth in section 110(i) of the Act. Accordingly, the related Contest Proceedings will be dismissed and Bell County will be ordered to pay civil penalties in the amount of $6,336.00 for those violations.

ORDER

Citation Nos. 7538674, 7538675, 7538676 and 7524384, and Order No. 7524383 are hereby VACATED and the petitions as to those citations are hereby DISMISSED.

Order Nos. 7538678, 7524394 and 7524395 are AFFIRMED, as modified, and are further modified to citations issued pursuant to section 104(a) of the Act. Respondent Bell County Coal is directed to pay civil penalties totaling $6,900.00 for those violations. Respondents Davis, Bailey and Belcher are directed to pay civil penalties in the amount of $200.00 each. Payment shall be made within 45 days.

With respect to the three citations and one order as to which Respondent Bell County withdrew its Notices of Contest and requests for hearing, Docket Nos. KENT 2004-320-R, KENT 2004-321-R; KENT 2004-322-R and KENT 2004-324-R are hereby DISMISSED, and Bell County is ordered to pay civil penalties totaling $6,336.00 within 45 days.

Michael E. Zielinski
Administrative Law Judge

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/mh
June 27, 2007

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

v.

EMERALD COAL RESOURCES, LP,
Respondent

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

v.

CUMBERLAND COAL RESOURCES, LP,
Respondent

DECISION

Appearances: Stephen Turow, Esq., Gayle Green, Esq., Jonathan Hammer, Esq.,
U.S. Department of Labor, Office of the Solicitor, Arlington, Virginia, on behalf
of Petitioner;
R. Henry Moore, Esq., Jackson Kelly, PLLC, Pittsburgh, Pennsylvania,
on behalf of Respondents;
Judith Rivlin, Esq., for United Mine Workers of America, appearing as amicus
curiae.¹

Before: Judge Zielinski

These cases are before me on Referrals of Emergency Response Plan Disputes, by the
Secretary of Labor ("Secretary"), pursuant to section 316(b)(2)(G) of the Federal Mine Safety

¹ The United Mine Workers of America moved to appear as amicus curiae, for the
purpose of filing a post-hearing brief. The parties did not object. The motion is granted, the
brief is accepted for filing, and was considered in this decision.
and Health Act of 1977, 30 U.S.C. § 876(b)(2)(G) ("Act"). At issue are citations issued on May 25, 2007, charging each of the Respondents, Emerald Coal Resources, LP, ("Emerald") and Cumberland Coal Resources, LP, ("Cumberland") with violations of the Act by failing to adopt response and preparedness plans that timely provide supplies of post-accident breathable air. A hearing was held in Pittsburgh, Pennsylvania on June 12, 2007, wherein the parties submitted all relevant material regarding the dispute. For the reasons set forth below, the citations are affirmed.

Findings of Fact – Conclusions of Law

In response to a series of tragic accidents in which underground coal miners lost their lives, Congress enacted the Mine Improvement and New Emergency Response Act of 2006 ("MINER Act"). The MINER Act amended section 316 of the Mine Safety and Health Act of 1977, to require, inter alia, that underground coal mine operators develop and adopt response and preparedness plans (hereinafter "Emergency Response Plans" or "ERPs"), and submit them to the Secretary for approval and periodic review. The MINER Act became effective on June 15, 2006, and the initial ERPs were to be adopted and submitted by August 14, 2006. The Act requires that ERPs include several provisions intended to enhance the ability of trapped miners to survive an accident, including communication systems, a system for tracking miners, supplies of breathable air, and lifelines.

The requirements for post-accident breathable air are stated in section 316(b)(2)(E)(iii) of the Act:

Post-accident breathable air. -- The plan shall provide for —

(I) emergency supplies of breathable air for individuals trapped underground sufficient to maintain such individuals for a sustained period of time;

(II) in addition to the 2 hours of breathable air per miner required by law under the emergency temporary standard as of the day before the date of enactment of the Mine Improvement and New Emergency Response Act of 2006, caches of self-rescuers providing in the aggregate not less than 2 hours per miner to be kept in escapeways from the deepest work area to the surface at a distance of no further than an average miner could walk in 30 minutes.

2 P.L. 109-236 (June 15, 2006).

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Section 316(b)(2)(C) of the Act provides that, in reviewing and approving ERPs, the Secretary is required to:

take into consideration all comments submitted by miners or their representatives,
Approved plans shall –
   (I) afford miners a level of safety protection at least consistent with the existing standards, including standards mandated by law and regulation;
   (ii) reflect the most recent credible scientific research;
   (iii) be technologically feasible, make use of currently commercially available technology and account for the specific physical characteristics of the mine; and
   (iv) reflect the improvement in mine safety gained from experience under this Act and other worker safety and health laws.

Section 316(b)(2)(G) of the Act provides a mechanism for expeditiously resolving disputes between operators and the Secretary over the content of ERPs.

Plan dispute resolution
   (I) In general
   Any dispute between the Secretary and an operator with respect to the content of the operator’s plan or any refusal by the Secretary to approve such a plan shall be resolved on an expeditied basis.
   (ii) Disputes.
   In the event of a dispute or a refusal [by the Secretary to approve a provision of an ERP,] the Secretary shall issue a citation which shall be immediately referred to a Commission Administrative Law Judge. The Secretary and the operator shall submit all relevant material regarding the dispute to the Administrative Law Judge within 15 days of the date of the referral. The Administrative Law Judge shall render his or her decision with respect to the plan content dispute within 15 days of the receipt of the submission.

After considerable negotiation, and submission of several alternative proposals, Respondents submitted ERPs specifying that post-accident breathable air would be provided by locating refuge chambers within 2,000 feet of each working section, capable of providing 96 hours of breathable air for miners, and that “Purchase orders . . . will be submitted to MSHA within 60 days of the approval of the Emergency Response Plan.” Ex. G-13. Cumberland’s last proposed ERP was submitted on May 22, 2007, and Emerald’s was submitted on May 24, 2007.3

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3 Emerald and Cumberland are affiliated companies of Foundation Coal, and their efforts to comply with the MINER Act and interactions with MSHA have been substantially identical. Tr. 107, 209.

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Ex. G-13, G-25. The Secretary approved all parts of the ERPs’ post-accident breathable air provisions, except the quoted language specifying that purchase orders would be submitted within 60 days of approval. Ex. G-19, G-31.

On May 25, 2007, the Secretary’s Mine Safety and Health Administration (“MSHA”) issued citations to Respondents charging them with violations of section 316(b) of the Act. The citations, as amended, directed that the violations be abated within ten days, i.e., by June 4, 2007. On May 30, 2007, pursuant to the Act, and Commission Procedural Rule 24, 29 C.F.R. § 2700.24, the Secretary referred the plan content disputes to the Commission. The referrals pray that the citations be affirmed and that Respondents be ordered to amend their ERPs to establish a 10-day period within which to provide purchase orders. Respondents’ responses to the referrals pray that the citations be vacated and that the Secretary be directed to approve their ERPs with no provisions for purchase orders.

History of the Post-accident Breathable Air ERP Provisions

As noted above, the Act’s provisions requiring post-accident breathable air are phrased in general terms. ERPs, which were to be adopted and submitted for review by August 14, 2006, were required to provide for emergency supplies of breathable air sufficient to maintain

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4 Citation No. 7020004 was issued to Emerald, and Citation No. 7020005 was issued to Cumberland. Both contained substantially identical language. Citation No. 7020004 states, in the “Condition or Practice” section:

Emerald Coal Resources, L.P. violated 316(b)(2) of the Federal Mine Safety and Health Act (Mine Act), 30 U.S.C. 876(b)(2) by failing to develop, adopt, and submit to MSHA an emergency response plan (a/k/a “accident response plan”) that timely provides a means for providing post accident breathable air to individuals who may be trapped underground. After significant discussion, Emerald Resources has refused to promptly provide purchase orders for the refuge chambers contemplated in its May 24, 2007 ERP or, in the alternative, to specify other acceptable means for promptly providing post accident breathable air for trapped miners. MSHA and Emerald are in dispute concerning period that is reasonable for the operator to take actions necessary to implement the post accident breathable air portion of its ERP. Thus this citation is being issued pursuant to 104(a) and 316(b)(2)(G)(ii) of the Mine Act.

MSHA has approved all portions of Emerald’s May 24, 2007 ERP with the exception of the provisions in the Post-accident Breathable Air portion of the ERP that states the date on which Emerald will provide purchase orders for the refuge chambers.

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individuals trapped underground for a sustained period of time. On July 21, 2006, MSHA issued Program Policy Letter P06-V-8 which stated:

A. Maintenance of Individuals Trapped Underground

The ERP should address the amount of post-accident breathable air necessary to maintain individuals trapped underground for a sustained period of time. Oxygen, compressed air, or other alternatives may be used to meet this requirement.

The Agency will need to thoroughly review and evaluate alternatives to assure that all safety and health risks are taken into consideration. Additional time and information is needed to make decisions on the type, amount and location of post-accident breathable air to be furnished for trapped miners.

The Agency will solicit further information from the mining community through a Request for Information (RFI) to assist in assuring that ERPs provide safe and reliable post-accident breathable air supplies for trapped miners. Subsequent to the RFI, MSHA will provide additional guidance on an expedited basis to address the availability of readily accessible breathable air that would be sufficient to maintain miners trapped underground for a sustained period of time.

Stip. 17.5

The initial ERPs submitted by Respondents on August 14, 2006, addressed the post-accident breathable air requirement by citing the caches of Self-Contained Self-Rescuers ("SCSRs"), which provide up to five or six hours of breathable air. On August 30, 2006, MSHA published a request for information in the Federal Register and sought comments on post-accident breathable air by October 16, 2006. Stip. 19; ex. G-1. On October 24, 2006, MSHA published Program Information Bulletin P06-V-10 which stated in part:

On August 30, 2006, MSHA published a Request for Information (RFI) in the Federal Register seeking further information from the mining community on "topics related to post-accident breathable air that would be sufficient to maintain miners trapped underground for a sustained period of time." Once MSHA is able to review the information received, the Agency will provide additional guidance. In the meantime, however, mine operators shall gather information from available resources and provide for emergency supplies of breathable air.

Stip 20; ex. G-2. On February 8, 2007, MSHA issued Program Information Bulletin P07-03 ("PIB"), which included several attachments, and provided operators for the first time with comprehensive information concerning how to provide breathable air for individuals who may be trapped underground. Stip 21; ex. G-4, G-5, G-6, G-7. The PIB stated that it was advisory in

5 The parties submitted Joint Stipulations of Fact, which will be referred to as "Stip."
nature and identified several methods that might be used to provide post-accident breathable air in safe havens, including bore holes, compressed air lines, compressed air and oxygen cylinders, and chemical oxygen generators. Safe havens could be prefabricated refuge chambers, or pre-built or readily constructed barricades. It also specified that breathable air sources should be located within 2,000 feet of working sections, and that a 96-hour supply of breathable air should be provided for each miner, almost 20 times the air supply provided by SCSRs. The PIB established a deadline of March 12, 2007, as the date on which operators were required to submit revised ERPs for MSHA’s review. Shortly before that deadline, the State of West Virginia published a listing of refuge chambers that it had approved for meeting its post-accident breathable air requirements. Ex. R-109. MSHA accepted use of state-approved chambers in ERPs. Tr. 72.

In the absence of a feasible means of providing a continuous supply of fresh air, e.g., through a borehole or compressed air line, available options for supplying post-accident breathable air consist of self-contained refuge chambers or barricades stocked with compressed air, compressed oxygen and CO₂ scrubbing systems. While six models of chambers have been approved by West Virginia and accepted by MSHA, there are currently no manufactured refuge chambers commercially available. Tr. 131, 246. However, several vendors have demonstration models. Refuge chambers would be placed in crosscuts near escapeways within 2,000 feet of working sections. Barricades would be either pre-constructed, or materials for constructing them would be stored in appropriate locations, along with other necessary equipment and supplies. Most mines have barricade and other supplies on hand. The remainder of the items are readily available, although there are currently some delivery problems with CO₂ scrubbing systems. Tr. 76, 165-67, 174, 177.

On March 12, 2007, Cumberland and Emerald submitted ERPs that specified that refuge chambers would be used to provide breathable air for trapped miners. Stip. 24, 25. Respondents’ decisions to purchase refuge chambers, which are more expensive than barricade/supply systems, was based upon Foundation Coal’s assessment that a “turn key” system would be far more likely to function as planned. As John M. Gallick, its vice-president for safety and health, explained, there was concern that miners who had unsuccessfully expended considerable effort to escape, would not be able to effectively erect barricades, purge air, and perform other time and effort consuming actions while wearing SCSRs and working in a contaminated atmosphere under very high stress. Tr. 227-29, 265-67.

On March 28, Cumberland submitted a revised ERP specifying that refuge chambers would be “maintained within 2,000 feet of each working section capable of providing 96 hours of breathable air for miners working on that section (up to 30 miners).” Ex. G-9. Emerald submitted a substantially identical plan on April 2. Ex. G-22. Respondents’ ERPs specified that the chambers would be ordered within 60 days of MSHA’s approval of the chambers.⁶ MSHA

⁶ No refuge chambers have been tested by MSHA, and it has not approved any shelters for use in underground coal mines pursuant to its authority to approve equipment as suitable and

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told Cumberland and Emerald representatives that, while refuge chambers were an acceptable means of isolating miners from hazardous environments and providing breathable air, the agency would not approve a provision in an ERP without submission of purchase orders for equipment for the refuge chambers. On April 20, Respondents solicited bids on an expedited basis from three providers of refuge chambers, including the vendor previously identified. Foundation Coal had selected inflatable chambers because they would be more suitable for their mines in West Virginia, which mined coal seams 42 inches high and were not "gassy." They proposed to use the same shelters in the Emerald and Cumberland mines in order to remain consistent with equipment and training. Tr. 233. They have since reconsidered and believe that larger rigid refuge chambers would be more appropriate for their mines, which are in the gassy Pittsburgh seam where secondary explosions are more likely to occur. Tr. 235.

Further communications occurred between MSHA and Respondents. On April 28, Respondents submitted revised ERPs representing that they were "in the process of ordering refuge chambers" from a vendor, and further specifying a specific model number. Ex. G-10, G-23. The memorandum forwarding Cumberland's revised plan referred to prior correspondence and a meeting that occurred on April 17, and stated that a purchase order would not be able to be submitted by close of business. It represented that a "terms and conditions" package would be sent to the vendor in less than 48 hours, and that a purchase order would be written when the terms and conditions had been agreed to. Ex. G-15. MSHA believed that Cumberland would supply a purchase order within a few days. On May 3, no purchase order had been submitted, and Cumberland was requested to supply, within five working days, a purchase order and a scheduled delivery date. Ex. G-16.

Questions arose in mid-April with respect to CO₂ scrubbing systems that were being used in some shelters. As noted in the PIB, CO₂ scrubbing is essential to preserve a life sustaining atmosphere in shelters without a continuous supply of fresh air. CO₂ scrubbing can be accomplished through active (fan driven) or passive (curtain) systems using one of two compounds that absorb CO₂, soda lime or lithium hydroxide. However, both compounds are caustic, and MSHA determined that handling of bulk compounds in a closed environment would pose an unacceptable risk. Tr. 171. Soda lime was used in bulk for at least one system. Respondents also developed concerns about whether quantities of soda lime sufficient to last 96 hours were being supplied. By April 25, MSHA determined to advise its district managers not to approve any post-accident breathable air ERP provisions that used bulk soda lime for CO₂ scrubbing. Ex. R-47; tr. 85, 129-30. The chamber vendor and compound suppliers reacted promptly, encapsulated the soda lime, and eliminated the bulk compound problem within seven safe for use in mining environments. Stip. 28.

Most of MSHA's Districts, including District 4 in which Foundation's West Virginia mines are located, do not insist on the submission of purchase orders as part of the ERP. Stip. 26; ex. 45; tr. 123. They consider the issuance of a purchase order in determining whether to cite an operator for failure to timely implement its ERP.

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to ten days. Tr. 86-87; ex. G-37. There is some question as to whether, or when, Respondents were advised that the issue had been resolved. Tr. 317; ex. G-12, G-37.

Another question raised by Respondents deals with temperature. An attachment to the PIB, notes as a “Safe Haven Assumption” a maximum temperature of 95 degrees. Ex. G-5. It also notes that “Not all mines will be able to successfully adopt all of these recommendations due to their inherent mining conditions.” Ex. G-5 at 1. The reaction whereby lithium hydroxide absorbs CO₂ gives off more heat than does soda lime. Lithium hydroxide is typically impregnated into curtain material that is hung in the refuge area. It is a passive system, and simply absorbs CO₂ from the air. The heat generated produces convection air currents that make the curtains more efficient at scrubbing CO₂. Respondents were concerned that heat generation might result in excessive temperatures. However, there is no evidence that this is anything other than a theoretical problem. One such system has been tested in a chamber, apparently successfully. Tr. 242.

The CO₂ scrubbing questions prompted Respondents to reevaluate their plans to supply breathable air. The vendor they had been working with had been using a bulk soda lime scrubbing system. Tr. 260, 313. The State of West Virginia had requested that the National Institute of Occupational Safety and Health (“NIOSH”) conduct tests on shelters it had approved.8 Foundation Coal also decided to do its own testing of CO₂ scrubbing systems. On May 9, Cumberland submitted a revised ERP that represented that it was evaluating refuge chambers of three vendors, and represented that a purchase order would be issued once testing verified that the CO₂ scrubbing systems met the requirements of the PIB. Ex. G-11.

MSHA viewed Cumberland’s change in position, from submitting a purchase order for a specified chamber to evaluating several chambers with submission of a purchase order in 60 days, as a substantial retreat from any commitment to promptly implement its ERP. Tr. 104, 112. All of the mine operators in District 2 that had opted for chambers had already supplied purchase orders, and MSHA felt that Respondents should not be an exception. Tr. 105. On May 14, MSHA advised Cumberland that it would not approve the ERP, which committed to “purchase of essential protective mechanisms at an undetermined and distant future date,” and that “a purchase order for material/equipment necessary to comply with [the post-accident breathable air] provision must be obtained and provided.” Ex. G-17. Similar instructions on the requirement for a purchase order were communicated to Emerald on May 16. Both Respondents had also been previously advised of the requirement. Stip. 29, 30.

8 Section 13 of the MINER Act requires NIOSH to conduct research on refuge alternatives, including shelters, and submit a report by December 15, 2007. Within 180 days of receipt of the report, MSHA is required to provide a description of any actions the Secretary intends to take based upon the report. NIOSH circulated a draft protocol for its testing of refuge chambers on June 1, 2007. Stip. 27; ex. R-10. Testing was reportedly scheduled to commence on June 18 and be concluded by August 31. Tr. 249. Respondents had to abandon efforts to do their own testing because of delivery problems for CO₂ scrubbing materials. Tr. 276.
On May 18, both Respondents submitted revised ERPs indicating that they were in the process of evaluating shelters, and would submit purchase orders for shelters within 60 days of approval of their ERPs. Ex. G-12, G-24. The cover letters for the submissions requested information on commercially available CO₂ scrubbing systems, and protested the requirement for purchase orders. Stip. 31, 32; ex. G-14, G-29. On May 22, MSHA advised Cumberland that an impasse may have been reached with regard to its post-accident breathable air ERP provision, and requested clarification of the plan. Ex. G-18; stip. 33. On May 22, Cumberland submitted a revised plan, and again proposed to submit a purchase order within 60 days of plan approval. Stip. 34; ex. G-13. Emerald had similar communications with MSHA and submitted its revised ERP on May 24. Stip. 35, 36; ex. G-25. On May 23 and 25, MSHA notified Cumberland and Emerald respectively, that the post-accident breathable air portions of their latest ERPs were approved, with the exception of the 60-day purchase order submission, which had to be substantially shortened, e.g. to two days. Neither Respondent agreed to further reduce the period for submission of purchase orders, which triggered the instant citations and these proceedings.

Conclusions of Law - Further Factual Findings

The Secretary contends that the proper standard of review is whether the Secretary’s refusal to approve the 60-day purchase order provision of the ERPs, and her requirement that purchase orders be submitted within ten days, were arbitrary and capricious. She accepted the burden of proof on those issues. Sec’y Legal Statement at 3. Respondents contend that Section 316(b)(2) of the Act is unconstitutionally vague, that the Secretary’s use of the Program Information Bulletin to evaluate ERPs is contrary to law because it was not the subject of notice and comment rulemaking, and that the Secretary’s refusal to approve the ERPs was contrary to law. As to the latter point, they dispute applicability of the “arbitrary and capricious” standard, contending that it “ignores the statutory criteria and is too weighted in the Secretary’s favor.” Resp. Br. at 28 n.20. However, they do not offer an alternative.

The Scope of these Proceedings

Commission Procedural Rule 24 specifies that “The scope of [a hearing on an ERP dispute] is limited to the disputed plan provision or provisions.” Prior to the hearing, Respondents indicated a desire to litigate, in this proceeding, the validity of the citations’ special findings dealing with negligence and gravity, and the Secretary requested that civil penalties be imposed if the violations were affirmed. As noted at the hearing, those issues will not be addressed in this proceeding. Tr. 17-26. The process established in the MINER Act for expeditious resolution of plan disputes was intended to quickly resolve disputes concerning the specific contents of ERPs, so that the benefits of the Act could be realized by miners. Entertaining other issues would unduly complicate these special proceedings and would detract

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9 The Notice of Hearing required the parties to submit prehearing statements and memoranda of law addressing the issues to be decided, and the applicable legal standards, including burden of proof.

29 FMSHRC 550
from the fair and efficient resolution of plan content disputes.\textsuperscript{10}

For the same reasons, Respondents’ constitutional challenge to the legislation and their procedural challenge to the PIB will not be entertained.\textsuperscript{11} It should be noted that the PIB is the subject of a challenge as improper rulemaking in the United States Court of Appeals for the District of Columbia Circuit, Docket No. 07-1068. Stip. 23. Moreover, the Act’s expedited plan dispute resolution process is intended to resolve disagreements over plan contents that have been negotiated to an impasse. All aspects of the post-accident breathable air portions of the ERPs, with the exception of the 60-day purchase order submission provision were approved by the Secretary. There is no plan content dispute with respect to any aspect of the PIB.\textsuperscript{12}

I accept the Secretary’s formulation of the issues. She has the burden of proving that the refusals to approve the specific plan provisions at issue, and to require abatement within ten days, were not arbitrary and capricious. \textit{C.W. Mining Co.}, 18 FMSHRC 1740, 1746 (Oct. 1996) (absent bad faith or arbitrary action, the Secretary retains the discretion to insist upon the inclusion of specific provisions as a condition of the plan’s approval); \textit{Monterey Coal Co.}, 5 FMSHRC 1010, 1019 (June 1983) (MSHA’s withdrawal of impoundment plan approval was not arbitrary and capricious).

\textsuperscript{10} Respondents contested issuance of the citations pursuant to section 105(d) of the Act. Separate Commission case files have been established for those proceedings, \textit{Emerald Coal Resources, LP v. Secretary of Labor}, Docket No. PENN 2007-257-R; \textit{Cumberland Coal Resources, LP v. Secretary of Labor}, Docket No. PENN 2007-258-R. Challenges to the special findings, as well as the constitutional and other issues Respondents seek to raise, can be litigated in those cases, or in the course of any subsequent civil penalty proceeding.

\textsuperscript{11} I decline to reach Respondents’ constitutional challenge to the statute, which is couched in terms of fair notice. However, as to any fair notice, due process argument Respondents may be advancing as to the particular enforcement actions here, they clearly received actual notice of the district manager’s requirement that purchase orders were required in substantially less than 60 days, well before enforcement action was taken. Actual pre-enforcement notice of the Secretary’s position satisfies due process. \textit{Consolidation Coal Co.}, 18 FMSHRC 1903, 1907 (Nov. 1996); \textit{General Elec. Co. v. EPA}, 53 F.3d 1324, 1329 (D.C.Cir. 1995).

\textsuperscript{12} Respondents contend that a provision of the PIB, specifying that ERPs must be implemented within 60 days brings the validity of the PIB into question. I disagree. While the Secretary’s refusal to approve the disputed provisions was motivated by a desire to secure earlier implementation, the disputed plan provisions do not implicate the PIB. As Respondents note, the purchase order requirement was specific to ERPs that called for rescue chambers and was “contained in no writing other than the plan responses.” Resp. Br. at 25 n.18.
Resolution of the Emergency Response Plan Disputes

The standards for resolving plan approval disputes are well settled. While the Secretary of Labor retains the ultimate authority and responsibility to determine the contents of the plan, her discretion is not unbounded. In discussing disputed provisions of an operator’s ventilation plan, the Commission stated:

The requirement that the Secretary approve an operator’s mine ventilation plan does not mean that an operator has no option but to acquiesce to the Secretary’s desires regarding the contents of the plan. Legitimate disagreements as to the proper course of action are bound to occur. In attempting to resolve such differences, the Secretary and an operator must negotiate in good faith for a reasonable period concerning a disputed provision. Where such good faith negotiation has taken place, and the operator and the Secretary remain at odds over a plan provision, review of the dispute may be obtained by the operator’s refusal to adopt the disputed provision, thus triggering litigation before the Commission. *Penn Allegh Coal Co.*, 3 FMSHRC 2767, 2773 (Dec. 1981).

*Carbon County Coal Co.*, 7 FMSHRC 1367, 1371 (Sept. 1985). 13

The Report of the Senate Committee on Health, Education and Welfare on the MINER Act, published on December 6, 2006, indicates that the established cooperative plan development, review and approval process was intended to apply to ERPs, including the resolution of disputes through issuance of a citation for a “technical violation.” S. Rep. No. 109-365, at 4-5 (2006). 14 That process was followed by the parties here. Extended negotiations took place over the content of the ERPs, with each Respondent submitting multiple draft documents. As early as March, there was agreement on virtually all aspects of the post-accident breathable air portions of the plans. The only disputes were whether and when purchase orders would be required. Respondents committed to provide purchase orders, but the parties remained at odds over the time period. Respondents did not retreat from their “60 days following plan approval” position. The Secretary sought significant reductions, at one time proposing submission within two days after plan approval, and eventually establishing ten days as the time to abate the citations.

13 Both the Secretary and the operator are obligated to engage in good faith negotiations and an operator who fails to do so may be precluded from challenging the denial of a proposed amendment. *Id. and see C.W. Mining Co.*, 18 FMSHRC at 1746-47; *Peabody Coal Co.*, 15 FMSHRC 381, 387-88 (March 1993).

14 A copy of the report was submitted as an exhibit by Respondents following the hearing. Ex. R-48. The Secretary did not object to its admission. It is admitted as part of the hearing record.
There is no question that Congress intended to promptly secure a substantial increase in the amount of post-accident breathable air available to trapped miners. The MINER Act’s post-accident breathable air provisions are not couched with any delayed time frame language, such as the three years allowed for installation of flame-resistant directional life lines and wireless post-accident communication systems. 30 U.S.C. § 876(b)(2)(E)(iv) and (F)(ii). Provisions for post-accident breathable air were required to be included in ERPs adopted and submitted for approval by August 14, 2006. Moreover, post-accident breathable air is referred to in the “Immediate Requirements” section of the Senate Report. S. Rep. 109-365, at 6-7. The expedited plan dispute resolution process is further evidence that Congress intended that post-accident breathable air be expeditiously provided.

By the time the PIB was issued, in February 2007, MSHA had conducted a great deal of research on methods to provide post-accident breathable air, including the provision of breathable air in applications ranging from coal and metal mining to submarines and spacecraft. Tr. 152-55. It also had solicited and received information from the mining community. It was aware that there were tried and proven mechanisms to provide breathable air for extended periods of time, that were then commercially available.

Mine operators had to provide breathable air in safe havens, either barricades or refuge chambers. Barricades have been a method used by trapped miners in the past to enhance survival. All of the materials to provide a sustained supply of breathable air in a barricade-type shelter are either already maintained by operators, or are readily available. The only exception is CO₂ scrubbing materials, as to which there may be some delivery problems.

Prefabricated refuge chambers are a more recent development, but would work in much the same way as a barricade. However, there are currently no production models available, and it was clear that there were going to be delivery back-logs. Tr. 75. Significant delivery delays were expected, much more so than with CO₂ scrubbing materials. The district manager felt that filling in part of a component system would be quicker and easier than getting a whole system delivered. Tr. 142-43. Donald Foster, who was the point person for the district manager on ERP approvals, was of the opinion that under current market conditions it would “most definitely” take “significantly longer” to get delivery of a refuge chamber than components of a barricade system. Tr. 147. Purchase orders had been required for additional SCSRs, when manufacturers were overwhelmed with orders and delivery problems existed. Tr. 78, 131.

In light of these considerations, the district manager decided to require submission of purchase orders for refuge chambers as part of the ERP, in order to secure assurance that the operator was actually proceeding to implement the plan. He did not require purchase orders for components of barricade-type systems as part of an ERP. Under his approach, ERPs have been approved for 31 of the 33 underground coal mines in MSHA District 2. The only exceptions are Emerald and Cumberland. Tr. 64-65. Seventeen of the operators chose to use barricade systems. Their ERPs have been approved and they should be well on their way to actually implementing their plans. Fourteen of the operators chose rescue chambers and, by mid-May, all of them had
submitted purchase orders for the chambers they had chosen, either with their ERPs, or within ten days thereafter. Tr. 64-65, 74, 106. Those ERPs have also been approved and implementation will occur upon delivery of the chambers.

MSHA engaged in substantial negotiations with Respondents over the course of two months. Respondents had opted for refuge chambers in their March 12 ERPs, and were on the verge of providing purchase orders for specific refuge chambers as of April 20. Questions regarding the bulk soda lime CO₂ scrubbing systems that were used in those chambers, and MSHA’s directive that such systems would not be approved, legitimately caused Respondents to delay moving forward. Those questions were quickly resolved, and MSHA expected a resumption of the process and prompt delivery of purchase orders. However, Respondents then began to reevaluate their choices of shelters. Because of the prevalence of methane in their mines and the likelihood of roof falls and secondary explosions, considerations known since the beginning of the process, they decided that rigid refuge chambers would be more preferable, and had actually settled on a vendor. Tr. 234-36, 292-93. As Gallick explained, the change in thinking was due to “more thought about the application” and “less corporate thought process” about getting the same shelters. Tr. 291-92. MSHA viewed Respondents’ changed approach as a substantial regression in any commitment to promptly provide enhanced supplies of post-accident breathable air.

MSHA’s district manager had no reason to doubt the effectiveness of the CO₂ scrubbing systems, which would be used in barricade or refuge chamber applications. The disapproval of the bulk soda lime systems had nothing to do with their effectiveness. His interest was in promptly securing the substantial enhancements to supplies of post-accident breathable air that were required under the MINER Act, as informed by the PIB. By May 25, all mine operators in his District had approved ERPs, with the exception of Respondents.

Respondents could have chosen barricade-type systems, had approved ERPs, and have largely implemented their plans. No concerns about CO₂ scrubbing systems should have deterred them, because if they proved less effective more material could simply have been provided, and the heat issue was not a concern for the larger barricaded areas. Tr. 281. They chose to purchase rescue chambers, and provided good reasons for doing so. The district manager did not veto that choice, even though it meant that delivery delays would push actual implementation well beyond that of a barricade-type system. Even after the delay since the March 12 ERP submission, had Respondents agreed to purchase the chambers within ten days, their ERPs would have been approved. However, Respondents refused to purchase the chambers for another 60 days. In light of the time that had already elapsed, and the fact that 14 other operators had submitted purchase orders for chambers, the district manager determined that 60 days was too long a delay for purchasing equipment with an uncertain delivery date. He insisted on a much shorter time period.

Respondents contend that the requirement to submit purchase orders is contrary to the Act’s requirement that ERPs reflect the most recent credible scientific research and be

29 FMSHRC 554
technologically feasible. 30 U.S.C. § 876(b)(2)(C). They claim that they refused to submit purchase orders until certain limited testing was completed, so that they could be assured that refuge chambers were technologically feasible and consistent with credible scientific research.\textsuperscript{15} Resp. Br. at 28, 33. This appears to represent a bit of a retraction of their disputed plan provisions, that purchase orders would be submitted within 60 days of plan approval.

Cumberland’s ERP was approved, with the exception of the disputed provision, on May 23. Had the disputed provision been approved also, its commitment would have been to provide purchase orders by July 22. It is doubtful that Respondents could have had any reasonable expectation that testing would have confirmed the technological feasibility of CO\textsubscript{2} scrubbing systems in refuge chambers within that time period. It is unclear whether they were aware, at that time, that NIOSH planned to commence testing on June 18. They certainly did not have the draft protocol, which was not circulated until June 1. They had planned to do their own testing, but that proved unavailing. While Gallick was confident that he would have preliminary test data “within 60 days,” as phrased, that was 60 days from June 12, the hearing date, well past the ERP commitment. Tr. 275. In any event, if Respondents believed that refuge chambers were not technologically feasible, they should have removed them from their ERPs, and opted for barricade-type systems.

Respondents argue that “MSHA doesn’t actually know if any of the systems will work in a mine environment.” Resp. Br. at 34. However, there is little reason to question whether long-recognized effective methods to scrub CO\textsubscript{2} from the air will work as effectively in the mining environment as they have elsewhere. There is no real evidence to suggest that they will not, and the available evidence tends to confirm the effectiveness of the systems. A Canadian study involving 25 men in a shelter in an underground mine for 24 hours yielded results that “exceeded expectations.” Tr. 283-84. A vendor of lithium hydroxide CO\textsubscript{2} scrubbing curtains has also performed testing of a chamber. While the results have not been made public, Gallick had been told they were “good.” Tr. 242. Moreover, the refuge chamber used in that test appears to have been a rigid chamber which Respondents are interested in purchasing. Tr. 292-93. The CO\textsubscript{2} scrubbing technology is not new. It has been tried and proven effective in multiple applications. Tr. 168-70. Respondents recognize that there is no question that the “physics of scrubbing works.” Tr. 297. MSHA’s expert believeci that the technology should be tested in the mining environment, but, he did not anticipate any substantial differences in performance. Tr. 197-98.

I find that the Secretary has carried her burden of proving that the refusals to approve the disputed ERP provisions, and to require submission of purchase orders within ten days, were not

\textsuperscript{15} At the hearing, Respondents also raised concerns about committing funds, significant non-refundable deposits, for the purchase of chambers that might not have proven to be effective. Tr. 247. However, they conceded that chamber vendors provided warranties that their products would meet all applicable requirements or guidelines in effect at the time of order confirmation, and would repair, replace or provide a refund if testing revealed that the chambers did not meet the breathable air requirements. Tr. 278-79. Respondents do not make an economic argument in their brief.
arbitrary and capricious. The district manager’s decisions were reasonable, and the fact that most other district managers decided not to require purchase orders as part of ERPs doesn’t alter that conclusion.

ORDER

Citation Nos. 7020004 and 7020005 are AFFIRMED. Respondents are directed to include in their Emergency Response Plans a commitment that purchase order(s) for refuge chambers shall be submitted to the Secretary’s Mine Safety and Health Administration (MSHA) on or before July 9, 2007.16

Michael E. Zielinski
Administrative Law Judge

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/mh

16 The tenth day from the date of this decision, July 7, 2007, falls on a Saturday. Accordingly, the revisions to the ERPs are due on Monday, July 9, 2007. Section 316(b)(2)(F)(iii) of the Act provides that any decision requiring the inclusion of a disputed plan provision will not be limited by any appeal unless such relief is requested by the operator and permitted by the Administrative Law Judge. Any stay sought by Respondents will be denied. The date by which purchase orders must be submitted under this decision is only a few days earlier than when Respondents committed to provide them. Had Cumberland’s provision been approved along with the rest of the ERP on May 23, purchase orders would have been required by July 22. Moreover, it is apparent that Respondents have made decisions about what products they intend to purchase, and have been in a position since late April to make purchase commitments. In addition, if the NIOSH testing commenced on June 18, Respondents should have access to some of the preliminary data they sought. In any event, the ten days allowed in the decision will provide ample time to seek relief from the Commission in the event of an appeal.

29 FMSHRC 556
June 28, 2007

SECRETARY OF LABOR,
MINES SAFETY AND HEALTH
ADMINISTRATION (MSHA),
Petitioner

v.

LONE MOUNTAIN PROCESSING, INC.,
Respondent

CIVIL PENALTY PROCEEDINGS

Docket No. KENT 2006-237
A.C. No. 15-18647-82666

Docket No. KENT 2006-238
A.C. No. 15-17234-82541

Huff Creek No. 1

DEcision

Appearances: Joseph B. Luckett, Esq., Office of the Solicitor, U.S. Department of Labor, Nashville, Tennessee, Alex R. Sorke, Jr., Conference and Litigation Representative, Office of Mine Safety and Health Administration, Barbourville, Kentucky, for the Petitioner; Marco M. Rajkovich, Esq., Noelle Holladay True, Esq., Rajkovich, Williams, Kilpatrick & True, PLLC, Lexington, Kentucky, for the Respondent.

Before: Judge Weisberger

Statement of the Case

These cases are before me based on Petition for Assessment of Civil Penalty filed by the Secretary of Labor, alleging that Lone Mountain Processing, Inc., (“Lone Mountain”) violated various mandatory safety standards set forth in Title 30 of the Code of Federal Regulations (C.F.R.). Pursuant to notice, these cases were scheduled to be heard on May 30, 2007, in Johnson City, Tennessee.

I. Docket No. KENT 2006-238

At the hearing, the Secretary made a motion to approve a settlement agreement. It was asserted that the operator agreed to pay the full proposed penalty of $228. The operator did not object to the motion. I have considered the representations and documentation submitted in this case, and I conclude that the proffered settlement is appropriate under the criteria set forth in Section 110(i) of the Federal Mine Safety and Health Act of 1977.

ACCORDINGLY, the motion for approval of settlement is GRANTED.

29 FMSHRC 557
II. Docket No. KENT 2006-237

a. Citation No's 7552560, 7552564, and 7552565

At the hearing, the Secretary made a motion to approve a settlement regarding these citations. A reduction in total penalties from $1,175 to $554 was proposed. Also, the Secretary asserted it agreed to vacate Citation No. 7552565. The operator did not object to the motion. I have considered the representations and documentation submitted in this case, and I conclude that the proffered settlement is appropriate under the criteria set forth in Section 110(i) of the Act.

ACCORDINGLY, the motion for approval of settlement is GRANTED.

b. Citation No. 7552563

At the conclusion of the evidentiary hearing in this matter, a bench decision was rendered which, with the exception of corrections of non-substantive matters, is set forth as follows:

Lone Mountain operates the Clover Fork No. 1 Mine. On November 30, 2005, MSHA inspector Stanley Dale Sturgill, inspected the subject site. He picked up the cable supplying power to a Fletcher bolter on the 002-MMU Section. Sturgill observed a one-quarter inch vertical gap between the splice on the cable and the inner leads. In addition, the insulated leads within the cable were exposed for approximately four inches on either side of the splice. Normally these wires are covered by insulating tape between the end of the splice and the intact portion of the cable.

According to Sturgill, the area where the cable was located was wet, and the cable was lying in mud. He issued a citation alleging a violation of 30 CFR § 75.604(b), which provides that when permanent splices in trailing cables are made, they shall be "[e]ffectively insulated and sealed so as to exclude moisture[.]"

The operator has conceded that a violation has been established. Based on the uncontradicted testimony of the inspector relating to the existence of exposed leads, I find that the Secretary has established a violation of Section 75.604(b), supra.

The Secretary also alleges that the violation was significant and substantial. In Mathies Coal Company, 6 FMSHRC 1, 3-4 (January 1984) the Commission set forth four elements that the Secretary must prove to establish a violation as being significant and substantial. These are the underlying violation
of a mandatory safety standard, a discreet safety hazard contributed to by the violation, a reasonable likelihood that the hazard contributed to will result in an injury, and a reasonable likelihood that the injury in question will be of a reasonably serious nature.

The Secretary has established the existence of a violation. Also the record indicates that the violation contributed to the hazard of an electrical shock should a miner touch an exposed portion of the cable which contains energized wires.

The issue presented herein is the third element in the Mathies case, i.e., the existence of a reasonable likelihood that the hazard contributed to will result in an injury.

Subsequent to Mathies, supra, the Commission explained this element by articulating, in essence, that it requires the existence of a reasonable likelihood of an injury-producing event. U.S. Steel Mining Co., 6 FMSHRC 1834, 1836 (1984).

Sturgill indicated that two of the leads within the cable were energized with 480 volts, and he had to wipe the damaged cable with a rag, as it was wet and muddy. Further, according to Sturgill, the ends of the splice were open, which allows water to seep in; the cable was in water; the area was wet; and he could see moisture on the exposed leads for about one-quarter of an inch inside the splice.

However, the key issue is whether there was a reasonable likelihood of an injury-producing event. (See, U.S. Steel, supra.) The inspector indicated that in his experience he has observed pinholes in cables, wires sticking out of cable, and leads within a splice that have been pulled apart. He opined that a person coming in contact with a pinhole, exposed wires, or wires sticking out of a cable, would be exposed to at least 240 volts, resulting in a serious burn or electric shock.

However, it is significant that Sturgill did not observe any of these defects, nor was he able to see inside the splice to establish the existence of these defects.

Sturgill opined that these defects could occur, but he did not indicate the presence of any condition that would lead to an inference of the existence of any of these defects. Nor did he indicate any condition or practice that would have resulted in a reasonable likelihood of the creation of these defects, as a result of the continuation of normal mining operations. Sturgill indicated that the cable is regularly moved and hung up, but he did not indicate that these activities would increase the likelihood of a defect occurring.
Moreover, the exposed wires were fully insulated, Sturgill conceded on cross-examination that, in essence, insulation keeps water from contacting the leads in the cable. Also he indicated on cross-examination that if the leads are insulated, there is not any hazard of shock in the absence of a pinhole in the cable or a wire protruding from the cable, and that there is not any hazard of arcing unless the wires within a splice or a cable have been separated or have lost their insulation. There is not any evidence in the record of any of these conditions.

I conclude that there is not sufficient evidence to support the inspector's assumption of the presence of a pinhole, protruding wires, or damage to leads within the cable or splice. For all these reasons, I conclude that it has not been established that there was a reasonable likelihood of an injury-producing event, i.e., contact with a damaged wire or arcing.

I thus find that the third element set forth in Mathies has not been established, and, therefore, I find that the violation was not significant and substantial.

The parties stipulated that a reasonable penalty would not affect the operator's ability to remain in business; that the violation was timely abated in good faith; that Lone Mountain has an average violation history for an operator of that size, and that it is a large operator.

Because water was present in the area, and the cited cable might be moved in water, a serious injury could have resulted should a pinhole appear or a wire protrude in the exposed area of the cable, or if the leads would separate within the cable or water and enter the splice through a gap. I find the gravity of the violation to be relatively serious.

Sturgill indicated that before he picked up the cable, he observed that it had a splice, and that some portion of the wires were exposed. Also, he opined that, based on his observation of the cable's condition, it had not been examined weekly. However, he indicated that he checked the relevant company books, which indicated that a weekly examination had been done. Lone Mountain did not adduce any evidence of any significant mitigating factors. Within the context of all the above, I find that Lone Mountain's negligence was to moderate.

Considering and weighing all the above factors set forth in Section 110(i) of the Act, I find that a penalty of $100 is appropriate for this violation. Tr. 103-109.

29 FMSHRC 560
ORDER

It is Ordered that, within 30 days of this decision, Lone Mountain pay a total civil penalty of $882.

Avram Weisberger
Administrative Law Judge

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29 FMSHRC 561
CIVIL PENALTY PROCEEDING

Docket No. WEST 2006-577-M
A. C. No. 02-02135-95017

DECISION

Appearances: Isabella Del Santo, Esq., Office of the Solicitor, U.S. Department of Labor, San Francisco, California and Ronald D. Pennington, Conference and Litigation Representative, U.S. Department of Labor, Denver, Colorado, on behalf of the Petitioner;
Jack Kolberg, Safety Director, Asphalt Paving & Supply, Inc., Prescott Valley, Arizona, on behalf of the Respondent.

Before: Judge Melick

This case is before me upon a petition for civil penalty filed by the Secretary of Labor pursuant to section 105(d) of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 801 et seq., the "Act," charging (as amended) Asphalt Paving & Supply Inc. (Asphalt Paving) with one violation of the mandatory standard at 30 C.F.R. § 56.12008. The general issue before me is whether Asphalt Paving violated the cited standard and, if so, what is the appropriate civil penalty to be assessed in accordance with section 110(i) of the Act.

Citation No. 6306160, as amended, charges as follows:

The 110 volt power cable feeding power to the pond pump condensation heater, located at the upper pond, was not insulated and/or did not have adequate protection for the power conductors. The conductors were exposed for approximately one-half inch where the outer protective jacket had been pulled from the bushing of the junction box. Employees were exposed to the possibility of injury from shock, flash or burn hazard if the conductors were to become damaged. No bare copper wire was observed. The operator was unaware of the electrical defect and the workplace exam was incomplete for this shift.

29 FMSHRC 562
The Secretary alleges that the third sentence of the cited standard was violated. That sentence provides that “[w]hen insulated wires, other than cables, pass through metal frames, the holes shall be substantially bushed with insulated bushings.”

The testimony of Bartholomew Wrobel, an inspector for the Department of Labor’s Mine Safety and Health Administration (MSHA), is undisputed that June 14, 2006, the 110 volt power cable feeding the pond pump condensation heater did not have adequate protection for the power conductors. The undisputed evidence shows that the conductors were exposed about one-half inch where the outer protective jacket had been pulled from the bushing of the junction box. Inspector Wrobel issued the citation at around 7:00 a.m. on that date. He took photographs of the cited condition and those photographs were admitted into evidence (Gov’t. Exh. Nos. 3 and 3-1). These photographs corroborate Wrobel’s testimony as they depict the power conductor pulled out of its bushing with the individual conductors exposed. Wrobel opined that injuries were unlikely because the conducting copper wires were not exposed. He also opined, however, that should an injury occur it would reasonably be expected to be fatal. He noted that with 110 volts alternating current, a person contacting the exposed wires would be unable to release their hold and fatal injuries would reasonably be expected.

Inspector Wrobel opined that the violation was caused by “moderate” operator negligence in light of his finding that the condition was obvious from 10 to 15 feet away. He conceded, however, that the mine operator was not aware of the condition and that it could have developed only minutes before it was discovered. Wrobel further acknowledged that the operator’s representative accompanying him on the inspection told him that they had not yet completed their workplace examination at the time the violation was discovered and argued that they would have discovered and corrected the condition if they only had been given more time. The representative also told Wrobel that “free-range” cattle water at the pond adjacent to the cited condition and that the condition may have resulted from cattle pulling the power cable from its bushing. In this regard Wrobel identified a cow hoof print in one of the operator’s photographic exhibits (Operator’s Exh. No. 3).

Chris Mathern, a safety assistant for Asphalt Paving, testified that another problem had been discovered during the operator’s pre-shift inspection that morning, before the violative condition was cited, and that other condition needed to be repaired. As a result, their inspection had not yet been conducted in the area where the violative condition was found.

Robert Smith, Asphalt Paving’s wash plant operator, testified that he performed the pre-shift inspection on the day before the citation was issued and, in particular, inspected the cited area and found nothing wrong with the wiring at that time. On the date the citation was issued he interrupted his inspection to repair some screens and by the time he arrived at the scene of the violative condition, it had already been repaired. Smith surmised that the damage to the wiring had occurred the night before the citation was issued based on his observation of cattle hoof tracks in close proximity to the condition. According to Mr. Mathern, the photograph depicting the cow hoof print was taken on the 15th of June, the day after the citation had been issued.
I find the testimony of Mathern and Smith to be credible and conclude that indeed the condition cited by the inspector on June 14th had occurred only the night before and prior to the completion of the mine operator’s inspection that day. Under the circumstances, I do not find the operator chargeable with negligence.

While not denying that the violative condition existed, the Respondent has presented arguments that, in effect, it is unfair for the Secretary to issue a citation for a violative condition before the mine operator has the opportunity to complete its examination of the workplace and to correct conditions found during that examination. Section 104(a) of the Act mandates the issuance of a citation, however, when an inspector finds that a mine operator has violated any mandatory safety standard.¹

Civil Penalties

Under section 110(i) of the Act the Commission and its judges must consider the following factors in assessing a civil penalty: the history of violations, the negligence of the operator in committing the violation, the size of the operator, the gravity of the violation, whether the violation was abated in good faith and whether the penalties would affect the operator’s ability to continue in business. It may be inferred from the record that Asphalt Paving is a small size mine. Its history of violations is not insignificant though most were assessed at the minimum level. Inspector Wrobel also testified that the mine had shown recent improvement in the number of violations. The gravity and negligence findings have previously been discussed. The record indicates that the violative condition was abated in a timely manner. There is no evidence that the penalty would affect the operator’s ability to continue in business. Under the circumstances, and, in particular, considering the findings of low gravity and lack of negligence, I find that a civil penalty of $25.00 for the violation charged herein is appropriate.

ORDER

Citation No. 6306160 is affirmed and Asphalt Paving Supply Inc., is directed to pay a civil penalty of $25.00 for the violation charged therein within 40 days of the date of this decision.

Judge Melick
Administrative Law Judge
(202) 434-9977

¹ Section 104(a) provides in relevant part as follows:

If, upon inspection or investigation, the Secretary or his authorized representative believes that an operator of a coal or other mine subject to this Act has violated this Act, or any mandatory health or safety standard, rule, order, or regulation promulgated pursuant to this Act, he shall, with reasonable promptness issue a citation to the operator.
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/lh
SECRETARY OF LABOR,
MINE SAFETY AND HEALTH
ADMINISTRATION (MSHA),
On behalf of Frederick Martin,
Applicant

v.

DICKENSON-RUSSELL COAL CO.,
Respondent

TEMPORARY REINSTATEMENT PROCEEDING
Docket No. VA 2007-40-D
NORT CD 2007-01
Mine ID 44-07146
Roaring Fork No. 4

STAY ORDER

This case is before me based on an application for temporary reinstatement brought by the Secretary of Labor (the Secretary) on behalf of Frederick Martin against Dickenson-Russell Coal Company (Dickenson) under section 105(c)(2) of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 815(c)(2) (the Act). This case was scheduled for hearing on May 23, 2007. During a May 18, 2007, telephone conference, the parties agreed to stay this matter for a period not to exceed 60 days from the date of this Order during which time Dickenson agreed to economically reinstate Martin. Specifically, the Secretary and Dickenson have agreed that, in lieu of Dickenson reinstating Martin to a job at the Roaring Fork No. 4 Mine, Dickenson shall pay Martin, on a bi-weekly basis consistent with Dickenson's regular payroll practices, a sum of money, net of taxes and other required withholdings, that is equal to the amount of wages that Martin would have earned, net of taxes and other required withholdings, if he had been reinstated to his former position, hereinafter referred to as "temporary economic reinstatement." Dickenson shall be entitled to a credit or refund for any wages earned by Martin from other employers during the period of temporary economic reinstatement.

The parties will initiate a telephone conference within this 60 day period to discuss the status of the Secretary's discrimination investigation. If the Secretary, during this 60 day period, elects to file a discrimination action on Martin's behalf, the parties will agree on a mutually satisfactory discovery schedule and hearing date for the underlying discrimination matter.

Therefore, by agreement of the parties, it is hereby ORDERED that:

1. Dickenson-Russell shall provide temporary economic reinstatement to Martin effective upon entry of this Order.
2. Temporary economic reinstatement shall continue for a period of 60 days from entry of this Order. During this 60-day period, the temporary reinstatement proceedings in this case shall be stayed. If during the 60-day period the Secretary files a complaint on the merits of Martin's allegations of discrimination, temporary economic reinstatement shall continue pending a final order by the Administrative Law Judge on the complaint. If during the 60-day period the Secretary determines not to file a complaint, the parties shall address whether temporary economic reinstatement shall terminate. If at the end of the 60-day period, the Secretary has not determined whether to file a complaint, the Secretary may seek a hearing on the application for temporary reinstatement.

3. The parties agree that any future proceedings on temporary reinstatement or on a discrimination complaint shall be conducted expeditiously.

4. This Order is entered without prejudice to Dickenson-Russell's right to contest the allegations made in the Secretary's application for temporary reinstatement and in any discrimination complaint. This Order is also entered without prejudice to the right of either party to move to enlarge, dissolve, or modify this Order, and I retain jurisdiction to hear and determine any such motions.

5. If Martin is employed in another comparable position in the mining industry, the temporary economic reinstatement shall terminate.

Accordingly, **IT IS FURTHER ORDERED** that the captioned temporary reinstatement matter **IS STAYED** for a period not to exceed 60 days from the date of this Order.

Jerold Feldman
Administrative Law Judge
(202) 434-9967

Distribution: (Facsimile and Certified Mail)

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