

## JUNE 2004

### COMMISSION DECISIONS

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## JUNE 2004

Review was granted in the following cases during the month of June:

Georges Colliers, Inc. v. Secretary of Labor, MSHA, EAJ 2002-2. Equal Access to Justice proceeding (Judge Barbour, April 26, 2004)

Secretary of Labor, MSHA v. Calmat Company of Arizona, WEST 2004-86-M. (Judge Melick, May 21, 2004)

No case was filed in which Review was denied during the month of June:



COMMISSION DECISIONS AND ORDERS



**FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION**

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

June 3, 2004

SECRETARY OF LABOR,	:	
MINE SAFETY AND HEALTH	:	
ADMINISTRATION (MSHA)	:	Docket No. YORK 2004-38-M
	:	A.C. No. 30-01295-03040
v.	:	
	:	
CAHILL INDUSTRIES CORPORATION	:	

BEFORE: Duffy, Chairman; Beatty, Jordan, Suboleski, and Young, Commissioners

ORDER

BY THE COMMISSION:

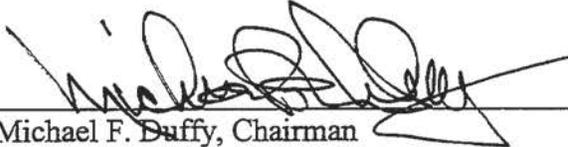
This matter arises under the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 801 et seq. (1994) (“Mine Act”). On April 2, 2004, the Commission received from Cahill Industries Corporation (“Cahill”) correspondence which we construe as a motion to reopen a penalty assessment that had become a final 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 July 11, 2003, the Department of Labor’s Mine Safety and Health Administration (“MSHA”) issued a proposed assessment (A.C. No. 30-01295-03040) to Cahill. In its motion, Cahill stated that it challenges the citations contained in the assessment and wishes to appeal them. Mot. No documentation was attached to Cahill’s motion. The Commission received a response from the Secretary of Labor stating that, because Cahill had identified no grounds for reopening the penalty assessments, she required additional information before she could express her position on the operator’s motion. Sec’y Resp. at 1-2. Cahill subsequently submitted an affidavit from its President, stating that he believed the inspection was a “safety audit” and that MSHA officials confirmed that any citations immediately abated would not result in financial penalties. Aff. of Anthony B. Cahill, Jr. at 1-2.

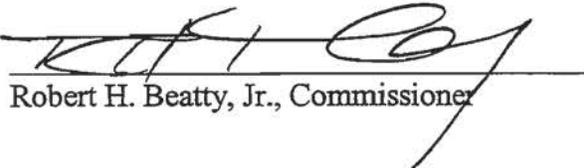
We have held that in appropriate circumstances, we possess jurisdiction to reopen uncontested assessments that have become final Commission orders under section 105(a). *Jim Walter Res., Inc.*, 15 FMSHRC 782, 786-89 (May 1993) (“*JWR*”). In evaluating requests to reopen final section 105(a) orders, the Commission has found guidance in Rule 60(b) of the Federal Rules of Civil Procedure 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).

Cahill has not adequately explained why it failed to timely contest the proposed assessment. On the basis of the present record, we are unable to evaluate the merits of Cahill's position. We hereby remand this matter to the Chief Administrative Law Judge for a determination of whether good cause exists for Cahill'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.



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Michael F. Duffy, Chairman



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Robert H. Beatty, Jr., Commissioner



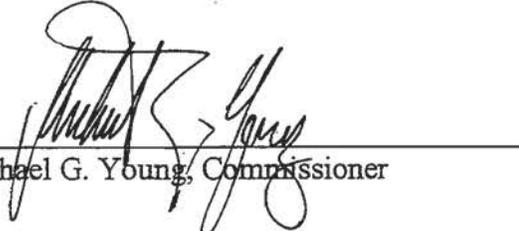
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Mary Lu Jordan, Commissioner



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Stanley C. Suboleski, Commissioner



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Michael G. Young, Commissioner

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**FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION**

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

June 8, 2004

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

v.

ENERCORP INCORPORATED

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Docket No. PENN 2003-187  
A.C. No. 36-08071-03528

BEFORE: Duffy, Chairman; Beatty, Jordan, Suboleski, 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. (1994) (“Mine Act”). On August 22, 2003, the Commission received from EnerCorp Incorporated (“EnerCorp”) correspondence which we construe as a request 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 23, 2002, the Department of Labor’s Mine Safety and Health Administration (“MSHA”) issued a proposed penalty assessment (A.C. No. 36-08071-03528) to EnerCorp’s mine in Morrisdale, Pennsylvania. In its request, EnerCorp states that its president had discussed the proposed penalties with an individual with MSHA; that, based on this conversation, the company believed that MSHA would “throw out” most, if not all, of the penalties; and that the company had been waiting for further information from MSHA. Mot. EnerCorp did not attach any supporting documentation to its request. The Secretary states that, in her opinion, EnerCorp’s request does not establish that the proposed penalty assessment should be reopened but that she does not oppose EnerCorp’s filing of a supplemental motion further addressing the

question of whether it can satisfy the requirements for reopening the assessment and obtaining relief from the final section 105(a) order.

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) of the Federal Rules of Civil Procedure 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 EnerCorp's motion, in the interests of justice, we remand this matter to the Chief Administrative Law Judge for a determination of whether good cause exists for EnerCorp'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.



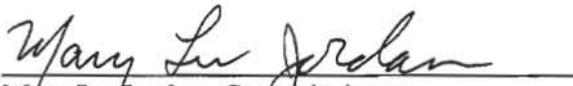
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Michael F. Duffy, Chairman



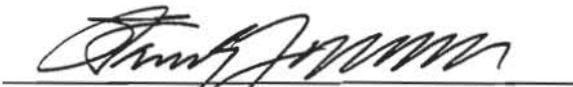
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Robert H. Beatty, Jr., Commissioner



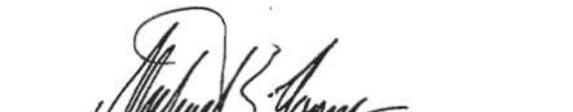
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Mary Lu Jordan, Commissioner



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Stanley C. Suboleski, Commissioner



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Michael G. Young, Commissioner

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**FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION**

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

June 9, 2004

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

v.

DACOTAH CEMENT

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Docket No. CENT 2001-218-M

BEFORE: Duffy, Chairman; Beatty, Jordan, Suboleski, and Young, Commissioners

DECISION

BY: Beatty, Jordan, and Young, Commissioners

This contest proceeding arises under the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 801 et seq. (1994) (“Mine Act”). Administrative Law Judge Irwin Schroeder vacated Citation No. 791963 charging Dacotah Cement with a significant and substantial (“S&S”)<sup>1</sup> violation of 30 C.F.R. § 46.7 (2001).<sup>2</sup> 24 FMSHRC 782, 786 (July 2002) (ALJ). We granted the

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<sup>1</sup> The S&S terminology is taken from section 104(d)(1) of the Act, 30 U.S.C. § 814(d)(1), which distinguishes as more serious any violation that “could significantly and substantially contribute to the cause and effect of a . . . mine safety or health hazard.”

<sup>2</sup> At the time of the incident giving rise to the citation at issue in this proceeding, section 46.7 provided in pertinent part:

(a) You must provide any miner who is reassigned to a new task in which he or she has no previous work experience with training in the health and safety aspects and safe work procedures specific to that new task. This training must be provided before the miner performs the new task.

(b) If a change occurs in a miner’s assigned task that affects the health and safety risks encountered by the miner, you must provide

Secretary of Labor's petition for discretionary review challenging the judge's decision. For the reasons set forth below, we vacate the judge's decision and remand this case for further proceedings.

I.

Factual and Procedural Background

Dacotah Cement operates a large portland cement production facility in Rapid City, South Dakota. 24 FMSHRC at 783. In cement production, limestone, shale, and iron ore are crushed, mixed together, and sent to a losche mill, which consists of two rolling cylinders that press down against a rotating turntable. *Id.* The ground material is mixed with water and sent through a kiln to become clinker. *Id.* In the losche mill, the downward grinding pressure of the two rolls is controlled by a hydraulic system. *Id.* When this system is energized, the oil in the system is pressurized to approximately 1000 pounds per square inch ("psi"). *Id.* The mill control panel contains valves to reduce and relieve this pressure in the event work is required on the system. *Id.*

The hydraulic pressure is transmitted from a pump to the mill through heavy duty hoses. *Id.* Several Dacotah Cement employees are responsible for servicing and maintaining the equipment, including replacement of the hoses. *Id.* at 783-84. On January 11, 2001, service and maintenance crew employee Robert Rohrbach noticed a pool of oil below one of the two-inch-

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the miner with training under paragraph (a) of this section that addresses the change.

(c) You are not required to provide new task training under paragraphs (a) and (b) of this section to miners who have received training in a similar task or who have previous work experience in the task, and who can demonstrate the necessary skills to perform the task in a safe and healthful manner. To determine whether task training under this section is required, you must observe that the miner can perform the task in a safe and healthful manner.

(d) Practice under the close observation of a competent person may be used to fulfill the requirement for task training under this section, if hazard recognition training specific to the assigned task is given before the miner performs the task.

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30 C.F.R. § 46.7 (2001) (revised 67 Fed. Reg. 42382 (June 20, 2002), effective September 23, 2002).

diameter hydraulic hoses and concluded that the hose was leaking hydraulic oil. Tr. 43. On January 12, 2001, he and fellow service and maintenance crew employee Fred Juopperi were assigned to replace one of the hydraulic hoses on the losche mill. 24 FMSHRC at 784.

As of January 12, 2001, Rohrbach had worked as a maintenance employee for Dacotah Cement for more than ten years. *Id.* at 784. Juopperi had been employed by Dacotah since June 1991 and had worked as a mechanical repair person, second class, for about one and one half years. Tr. 163. Before January 12, 2001, Juopperi had never performed significant maintenance work on the losche mill. 24 FMSHRC at 784. John Harris, Dacotah's Safety Director, testified that all miners received training in Spring 2000 covering the company's safety and health manual, which instructed miners on the lockout/tagout procedures of various systems, including bleeding off stored energy. Tr. 213, 233-34; R. Ex. D at 21-24. Both Rohrbach and Juopperi testified that they were familiar with the company's lockout/tagout policy contained in its manual. Tr. 140-41, 178-79.

Rohrbach and Juopperi worked under the direction of several supervisors. 24 FMSHRC at 784. On January 12, 2001, Melvin Wooley was the supervisor responsible for Rohrbach and Juopperi. *Id.* At the hearing, Wooley testified about Rohrbach's and Juopperi's work history and training. *Id.* He testified that neither Rohrbach nor Juopperi had received specific training in heavy hydraulic hose replacement, but that he had observed Rohrbach perform a great number of procedures on the losche mill which required use of the pressure relief valves. *Id.*

On January 12, 2001, Rohrbach began the work of replacing the hoses by assembling the necessary tools and cleaning the work area. *Id.* He turned off the pump which pressurizes the system, turned off and locked the breaker switch which supplies power, and read the pressure indicator at 1,024 psi. Tr. 33-34. He had almost completed these preparations when Juopperi joined him. 24 FMSHRC at 784. The two men removed the guards around the hose area and finished gathering the necessary tools to complete the job. Tr. 150, 153-54. They then left the losche mill for approximately 30 minutes to join the rest of the maintenance crew for the mid-morning break. 24 FMSHRC at 784. When they returned to the losche mill they resumed the process of replacing the hose. *Id.*

Working together, Rohrbach and Juopperi attempted to uncouple the hose from the hydraulic system manifold. Tr. 130, 157-58, 161-62. Using a piece of pipe or "cheater bar" over the end of his wrench to provide more leverage, Juopperi was able to loosen the coupling. Tr. 17-18, 142. After the coupling was broken loose and turning, Rohrbach noticed fluid oozing from the threaded joint. 24 FMSHRC at 784. Before he could act on his suspicions that the system was still pressurized, the coupling parted and the hose began to thrash about releasing fluid on both men. *Id.* Juopperi got fluid in his eyes and Rohrbach was struck by the metal end of the hose and doused with fluid. *Id.* at 784-85. Both men moved away from the immediate danger area and called for help. *Id.* at 785. As the fluid escaped, the system pressure rapidly decreased and the danger abated. *Id.*

Both Rohrbach and Juopperi were taken to a hospital for medical attention. *Id.* Rohrbach suffered a fractured elbow; Juopperi had less significant injuries. *Id.* Dacotah notified the local MSHA office of this accident. *Id.* MSHA Investigator Joseph Steichen went to the site to investigate. *Id.*

Steichen testified that he interviewed Juopperi and Rohrbach after their release from the hospital, asked Rohrbach if he had opened the pressure relief valves prior to disconnecting the hose, and that Rohrbach replied that he did not know where the pressure relief valves were located. *Id.* Steichen further testified that based on this response and Rohrbach's and Juopperi's actions, he concluded that Rohrbach and Juopperi had not been sufficiently trained in the task they were assigned to perform. *Id.*; Tr. 36-38.

The judge found that the Secretary failed to meet her burden of proof that both Rohrbach and Juopperi were inadequately trained in violation of 30 C.F.R. § 46.7. 24 FMSHRC at 786. In reaching this conclusion, the judge gave more weight to evidence of Rohrbach's training history and the corroborating testimony of his supervisors than to the inspector's testimony. *Id.* at 785. The judge found that the inspector made an improper presumption based on the conclusion that the accident would not have happened had the employees been properly trained. *Id.* at 785-86. He noted that the inspector took what amounted to a "*res ipsa loquitor*"<sup>3</sup> attitude toward the training requirement when he based his conclusion on his interview of Rohrbach and Juopperi, and an examination of the accident scene. *Id.* Concluding that "the record in this case does not demonstrate that the . . . accident was the result of inadequate training rather than carelessness or inattention," the judge found that the record supported the conclusion that "Rohrbac[h] had been adequately trained in the task assigned to him . . . and he was able to provide sufficient supervision to Mr. Juopperi." *Id.* at 786. The judge dismissed the Secretary's penalty petition. *Id.*

## II.

### Disposition

Section 46.7 of 30 C.F.R. implements section 115(a)(4) of the Mine Act, 30 U.S.C. § 825(a)(4),<sup>4</sup> requiring operators to provide miners with training for new tasks and to supply any new health and safety information related to assigned tasks before miners perform those tasks.

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<sup>3</sup> Literally, "the thing speaks for itself." *Black's Law Dictionary* 1173 (5th ed. 1979). "Res ipsa loquitor is [a] rule of evidence whereby negligence of alleged wrongdoer may be inferred from mere fact that accident happened. . . ." *Id.*

<sup>4</sup> Section 115(a)(4) of the Mine Act provides in pertinent part that "any miner who is reassigned to a new task in which he has had no previous work experience shall receive training in accordance with a training plan approved by the Secretary . . . in the safety and health aspects specific to that task prior to performing that task." 30 U.S.C. § 825(a)(4).

See 64 Fed. Reg. 53080, 53115 (Sept. 30, 1999). Sections 46.7(a) and (b) set forth the conditions when task training is required, specifically when a miner is reassigned to a new task with which he or she does not have prior work experience or training, 30 C.F.R. § 46.7(a), or where a change occurs in the miner's assigned task that affects the health or safety risks associated with the task, 30 C.F.R. § 46.7(b). There are various means of providing task training, two of which are specifically set forth in sections 46.7(c) and (d). 64 Fed. Reg. at 53116.

The Secretary has petitioned for review of the judge's apparent conclusion that Juopperi was adequately trained under the regulations before Dacotah assigned him to replace the hydraulic hose on the losche mill with Rohrbach. PDR at 9; S. Br. at 9. In particular, the Secretary alleges that the operator failed to satisfy any of the requirements for task training as to Juopperi under section 46.7, including subsection (d). PDR at 9, 12-14; S. Br. at 9, 13-16. Dacotah responds that it was providing task training to Juopperi pursuant to subsection (d) by having Juopperi practice under the close observation of Rohrbach, "a competent person." D. Br. at 10-11.

Section 46.7(d) permits an operator to satisfy the new task training requirements by allowing a miner to "[p]ractice [the new assigned task] under the close observation of a competent person," if the miner has received "hazard recognition training *specific to the assigned task . . . before the miner performs the task.*" 30 C.F.R. § 46.7(d) (emphasis added). Although the judge did not explicitly frame his analysis within the terms of section 46.7, it appears that he may have implicitly considered the terms of subsection (d) when he concluded that "Rohrbac[h] had been adequately trained in the task assigned to him . . . and he was able to provide sufficient supervision to Mr. Juopperi."<sup>5</sup> 24 FMSHRC at 786.

The Secretary cites record evidence which tends to support her claim that Dacotah failed to provide adequate task training to Juopperi pursuant to section 46.7(d), and which fairly detracts from the judge's conclusion. S. Br. at 10-16. There is no indication in the judge's decision that he considered this evidence. To the extent that the judge ignored record evidence, he erred. As the Commission explained in *Mid-Continent Resources, Inc.*, the judge must

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<sup>5</sup> Contrary to our concurring colleagues' concerns, the Secretary explicitly raised the argument below that the operator did not satisfy the task training requirements as to Juopperi under subsection (d). She amended her citation prior to trial to allege a violation of section 46.7 in its entirety, putting the operator on notice that the entire standard was at issue. 24 FMSHRC at 782; Tr. 4-7. Notwithstanding our colleagues' contention that she was late in raising the argument (slip op. at 15), the record is clear that she expressly addressed the issue in her response to the judge's pre-hearing order (S. Resp. to Pre-Hearing Order at 2) and raised the issue at trial (Tr. 86-87). She then explicitly argued it in her post-hearing brief to the judge (S. Post-Hearing Br. at 7-9). Even Dacotah acknowledges in its brief to the Commission that "[t]he Secretary attempted to convince the Administrative Law Judge that Dacotah Cement had violated the regulation with respect to both Mr. Rohrbach and Mr. Juopperi." D. Br. at 3.

analyze and weigh all probative record evidence, make appropriate findings, and explain the reasons for his decision. 16 FMSHRC 1218, 1222 (June 1994).

We now turn to the question of the appropriate interpretation of section 46.7(d). The “language of a regulation . . . is the starting point for its interpretation.” *Dyer v. United States*, 832 F.2d 1062, 1066 (9th Cir. 1987) (citing *Consumer Prod. Safety Comm’n v. GTE Sylvania, Inc.*, 447 U.S. 102, 108 (1980)). Where 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 *Dyer*, 832 F.2d at 1066; *Utah Power & Light Co.*, 11 FMSHRC 1926, 1930 (Oct. 1989); *Consolidation Coal Co.*, 15 FMSHRC 1555, 1557 (Aug. 1993).

While the parties disagree on the meaning of certain terms in the first portion of subsection (d), the language of the second portion pertaining to hazard recognition training is clear and unambiguous. Subsection (d) clearly requires that a miner be trained in recognizing hazards *specific* to the assigned task *before* performing the task. 30 C.F.R. § 46.7(d). The hazard recognition training must be *specific* to the assigned task – in this instance, repairing and replacing the hydraulic hose on the losche mill – and “must cover the health and safety aspects and safe work procedures specific to the task.” 64 Fed. Reg. at 53087. In the preamble to the final rule, the Secretary explained that hazard recognition training would encompass “an explanation of the potential health or safety hazards associated with the task and ways of minimizing or avoiding exposure to these hazards.” *Id.* The language of the regulation also clearly requires that such training be given *before* the miner performs the assigned task.

The Secretary contends that Dacotah did not provide hazard recognition training to Juopperi before permitting him and Rohrbach to replace the hydraulic hose. The judge made no finding regarding what training, if any, Juopperi received. The judge’s legal analysis is thus incomplete. See *Mid-Continent*, 16 FMSHRC at 1222.

Our review of the record suggests there is evidence on both sides of the issue. Dacotah points to evidence that Juopperi understood that he was to take instructions from Rohrbach as they performed the assigned tasks. Tr. 181. While the Secretary contends that there is no evidence that Juopperi received any relevant training, the record indicates that Juopperi may have received annual refresher training approximately nine months prior to the accident, which may have covered aspects of hydraulics and high-pressure hazards. Tr. 138-41, 177-79, 233-34. Dacotah also points to its safety and health manual which includes instructions to bleed off stored energy in various systems before performing maintenance and service on such systems under its lockout/tagout procedures. Tr. 233-34; R. Ex. D at 21. However, when making a finding as to whether Juopperi received hazard recognition training specific to the task of replacing a hydraulic hose, the judge must take into account whether such training was provided sufficiently close in time to the assigned task. He should also consider whether the training included not only general familiarization with hydraulic systems and principles, but also

sufficient guidance in safely releasing stored energy from the type of hydraulic system used on the losche mill.

If the judge finds that Juopperi did not receive hazard recognition training specific to the task of replacing a hydraulic hose, he must affirm the citation. If he finds Juopperi did receive such training, he must address the other requirement of subsection (d), and determine whether Juopperi “practice[d] under the close observation of a competent person,” 30 C.F.R. § 46.7(d), as he did not fully address this aspect of the regulation in his original decision.<sup>6</sup>

Although the judge did not make an explicit finding as to whether Rohrbach qualified as a “competent person,” he did find that Rohrbach was adequately trained and able to supervise Juopperi. 24 FMSHRC at 786. To the extent that the judge took into account, when making his finding, the standard’s “competent person” requirement, we conclude that substantial evidence supports the judge’s finding.<sup>7</sup>

Under the Secretary’s regulations, a “competent person” is defined in pertinent part as “a person designated by the [operator . . . who has the ability, training, knowledge, or experience to provide training to miners in his or her area of expertise [and the ability] both to effectively communicate the training subject to miners and to evaluate whether the training given to miners is effective.” 30 C.F.R. § 46.2(b).

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<sup>6</sup> Our colleagues misconstrue our reading of the regulation by claiming that we are finding a violation based on only one component of subsection (d) – the lack of adequate hazard recognition training. Slip op. at 18 n.7. First, there is no question that section 46.7 applies because the record clearly establishes that Juopperi was assigned to a new task in which he had no prior experience or training. 24 FMSHRC at 784; Tr. 163-65, 167, 170-71. See discussion *infra*, slip op. at 10-11. In addition, an operator who relies on subsection (d) when providing task training must satisfy *all* the components of the subsection. Thus, if an operator fails to fulfill one component of subsection (d), it cannot rely on subsection (d) as a means of providing task training, even if it can show that it fulfilled the other components. For example, even if an operator allows a miner requiring new task training to practice a task under the close observation of a competent person, if the operator has not given that miner hazard recognition training specific to the assigned task *before* the miner practices the task, then the operator has failed to satisfy the requirements of subsection (d). *Id.*

<sup>7</sup> When reviewing an administrative law judge’s factual determinations, the Commission is bound by the terms of the Mine Act to apply the substantial evidence test. 30 U.S.C. § 823(d)(2)(A)(ii)(I). “Substantial evidence” means “such relevant evidence as a reasonable mind might accept as adequate to support [the judge’s] conclusion.” *Rochester & Pittsburgh Coal Co.*, 11 FMSHRC 2159, 2163 (Nov. 1989) (quoting *Consolidated Edison Co. v. NLRB*, 305 U.S. 197, 229 (1938)).

The record evidence indicates that Rohrbach had extensive work experience at Dacotah, and more particularly, as a mechanical repair person, first class, he was responsible for directing mechanical repair employees in the second and third classes. Tr. 102-06; D. Ex. B. The record evidence also indicates that Rohrbach received some training specific to hydraulics and previously worked on the hydraulic spring system, which included locking down and depressurizing the system. Tr. 106-10, 198-99. Rohrbach testified that he knew how to depressurize the system and that in all past instances, he had successfully performed work on the system. Tr. 109-13. Contrary to the judge's finding that Rohrbach had never replaced a hose before the January 12 accident (24 FMSHRC at 784), the record clearly establishes that he had performed such work before the accident (Tr. 111-12). We also note that although Investigator Steichen testified that Rohrbach admitted he did not know the location of the pressure release valves (Tr. 34-35; G. Ex. 2 at 9, 11), the judge credited Rohrbach's conflicting testimony that he was familiar with the valves (24 FMSHRC at 785; Tr. 116-18).<sup>8</sup> Accordingly, we conclude that substantial evidence supports that Rohrbach was a competent person under section 46.7(d).

As to the remaining issues – whether Juopperi was “practicing” the assigned task of replacing a hose under the “close observation” of Rohrbach – the judge did not sufficiently address them. Consequently, if he reaches the issues on remand, we are leaving it to him to make the necessary findings in the first instance. See *Donovan ex rel. Chacon v. Phelps Dodge Corp.*, 709 F.2d 86, 92 (D.C. Cir. 1983).

We do note the following about section 46.7(d). The term “practice” is not defined in the regulations, the Mine Act, or in the preamble. In the absence of a statutory or regulatory definition, the Commission applies the ordinary meaning of the word. *Peabody Coal Co.*, 18 FMSHRC 686, 690 (May 1996), *aff'd*, 111 F.3d 963 (D.C. Cir. 1997) (table). The definition of the verb “practice” is “to make use of . . . to carry on or engage in . . . to do or perform often, customarily or habitually . . . to perform an act often or customarily in order to acquire proficiency or skill.” *Webster's Third New Int'l Dictionary (Unabridged)* 1780 (1993).

Consequently, we reject the Secretary's argument that under subsection (d), “practice” should be narrowly defined as only permitting a test or trial performance. Defining “practice” in the limited manner the Secretary suggests is inconsistent with the language and general framework of section 46.7, which permits an operator to satisfy task training in a number of different ways, including traditional classroom instruction as contemplated in subsection (a) or alternatively, with hands-on training as described in subsection (d). Moreover, the preamble to the final rule generally encourages hands-on training to assist miners in learning “how to avoid the hazards presented by the performance of the task in the surrounding environment.” 64 Fed. Reg. at 53117. In the preamble, the Secretary stated that the intent of the regulation is to allow

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<sup>8</sup> To the extent that the Secretary now challenges the judge's credibility determinations, we defer to the judge. A judge's credibility determinations are entitled to great weight and may not be overturned lightly. *Farmer v. Island Creek Coal Co.*, 14 FMSHRC 1537, 1541 (Sept. 1992).

“greater flexibility in the implementation of new task training to fit [an operator’s] specific mining operation and workforce.” *Id.* at 53116. Thus, we conclude that construing the word “practice” broadly, to include repeated performances of an assigned task, is consistent with both the dictionary definition of the term and the language and purpose of the regulation. By remaining under the close observation of a competent person, a miner is permitted to actually perform the task, while minimizing the risk of accident or injury, and gain hands-on experience, which is consistent with the underlying purpose of task training. *See id.* at 53116 (stating that the purpose of task training is “to reduce the likelihood of accidents resulting from a miner’s lack of knowledge about the potential hazards of a task”). If the Secretary intended a more restrictive reading of the word “practice,” she could have explicitly stated that intent in her preamble.

Likewise, the regulatory framework of section 46.7 encourages an expansive reading of the term “practice.” Under subsections (a) and (b), it appears that the Secretary clearly intended that new task training would be provided by traditional classroom instruction. *See* 30 C.F.R. § 46.7(a) and (b). Subsection (d) is an alternative training method to classroom instruction under subsections (a) and (b). *See* 30 C.F.R. § 46.7(d). In the preamble, the Secretary explained that “effective task training includes a combination of different types of training, such as classroom instruction, demonstration by the competent person, practical hands-on training, and evaluation of the miner’s ability to apply the training in the workplace.” 64 Fed. Reg. at 53116. Given the dictionary definition of the term and the regulatory framework of section 46.7, interpreting “practice” in the restrictive manner as the Secretary suggests would defeat the purpose of the alternative approaches to task training permitted under section 46.7. Of course, we also note that any “practice” contemplated by the regulation must be carried out in a safe manner.

As for the requirement that a miner practice under the “close observation” of a competent person, in the preamble to the final rule, the Secretary explained:

“Close observation” means that the competent person is in the immediate vicinity of the miner and is watching the actions of the miner being trained to make sure that the miner is performing the task in a safe and healthful manner. The nature of the task will determine the degree of attention that is needed, and the level of observation should be commensurate with the risks inherent in the task being performed. The competent person who is observing the miner should also be assessing the miner’s proficiency in performing the task, as part of the training itself as well as the competent person’s evaluation of whether the training is effective.

64 Fed. Reg. at 53117.

While the judge found that Rohrbach “was able to provide sufficient supervision” to Juopperi, 24 FMSHRC at 786, he made no finding whether Rohrbach indeed provided such supervision. On appeal, the parties disagree as to whether Rohrbach provided “close

observation” of Juopperi while performing the assigned task. The Secretary points to evidence in the record suggesting that Rohrbach provided little direction to and supervision of Juopperi, who was inexperienced with high pressure systems, while changing the hydraulic hose. PDR at 9-10; S. Br. at 9-11. Although Juopperi testified that he understood that he was to take instructions from Rohrbach as they performed the assigned task (Tr. 181), both Rohrbach and Juopperi testified that Rohrbach did not provide explicit instruction to Juopperi (Tr. 149-51, 183-84, 187). Dacotah contends that Rohrbach did provide “close observation” of Juopperi, arguing that the two miners worked side-by-side as they attempted to replace the hose. D. Br. at 9.

Despite Dacotah’s reliance on the close physical proximity of the two miners while performing the task, the preamble clearly indicates that the Secretary intended the term “close observation” to mean more than merely working side-by-side. The regulation imposes a duty to supervise, evaluate performance, and ensure the trainee is able to safely perform the procedure. The preamble envisions that a competent person be in the “*immediate vicinity*” and watching the miner-in-training to assure that he is performing the task safely. 64 Fed. Reg. at 53117. The record evidence suggests that at times, Rohrbach was not carefully watching Juopperi during the hose change. Rohrbach testified that while he and Juopperi were trying to loosen the nut on the hose, he “scooted around the corner still holding the wrench while [Juopperi] was loosening the nut.” Tr. 130. The judge must consider the evidence and make a finding as to whether Rohrbach in fact “closely observed” Juopperi while he performed the assigned task.

Despite the contention of our concurring colleagues (slip op. at 15-17), the facts of this case clearly support the conclusion that Juopperi was assigned to change the hose on the losche mill, and thus subject to the task training requirements of section 46.7. It is undisputed that changing hoses was within Juopperi’s assigned duties. Tr. 164. In addition, the evidence clearly indicates, and the judge found, that as a part of Juopperi’s duties as a maintenance repair person, on January 12, he was assigned with Rohrbach to replace the hydraulic hose on the losche mill. Tr. 170-71; 24 FMSHRC at 783-84. This occurred at a 7 a.m. meeting held that day. Tr. 170-71. The concurrence fails to point to evidence to the contrary. Thus, notwithstanding our colleagues’ concurring opinion, we see no need for the judge to revisit his finding on remand.<sup>9</sup>

In the regulations, a “task” is defined as “a work assignment or component of a job that requires specific job knowledge or experience.” 30 C.F.R. § 46.2(n). The Secretary explained in the preamble to the final rule that “a task may or may not be performed on a regular basis” and rejected that “instances where a miner is assigned to perform a task on a one-time basis” would preclude the requirement for task training. 64 Fed. Reg. at 53097. Clearly, changing a hydraulic

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<sup>9</sup> We acknowledge that there may be circumstances that call into question the application of section 46.7, such as where a miner coming across another miner in the midst of performing a routine task, for which general mining experience would provide sufficient grounding in the health and safety aspects of the task, provides assistance to the other miner without his or her supervisor’s explicit instruction to do so. *See infra*, slip op. at 17. However, this was not the case here.

hose on the losche mill requires specific knowledge of hydraulic systems and losche mill operations. Thus, the job Juopperi was assigned to perform is certainly a “task” within the meaning of the regulations. As explained above, that task was also clearly within the scope of Juopperi’s job duties. Tr. 164.

We also note that the preamble to the final rule requires training “if a change occurs in a miner’s task that affects the health and safety risks encountered by the miner. . . . This means that task training is required whenever any change could impact the health and safety conditions under which the miner works.” 64 Fed. Reg. at 53116. This was clearly the case when Juopperi changed the hose. In any event, because the parties have not had a chance to be heard on the issue, it would be unwise for the Commission to address in this case the application of section 46.7 to “commonplace” assignments.<sup>10</sup>

Based on the foregoing, we vacate the judge’s decision. Because the judge vacated the citation below, he did not reach the issue of whether the violation was S&S. If the judge concludes on remand that Dacotah violated the standard, he must then determine whether the violation was S&S and assess a penalty.

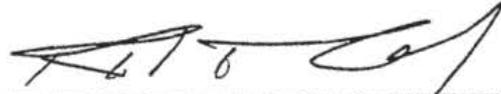
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<sup>10</sup> We also note that because the operator never raised the issue of the non-applicability of section 46.7 to Juopperi either to the judge below or before the Commission on review, and the Commission did not *sua sponte* direct review of the issue, there is some question as to whether this issue is properly before the Commission. Our decision need not focus on this question, for we conclude, in any event, that the regulation is clearly applicable to Juopperi. *See supra*, slip op. at 10 n.9. Moreover, the operator has implicitly conceded that section 46.7 applies to Juopperi by arguing in its rebuttal to the Secretary’s post-hearing brief that the regulation did not apply to Rohrbach. R. Rebuttal at 1. The operator did not repeat this contention vis-a-vis Juopperi, arguing instead that Mr. Juopperi had received the necessary training because he “was performing the task under the close observation of Mr. Rohrbach, ‘a competent person’.” *Id.* Moreover, the operator explicitly cited section 46.7(d) when it also supplied this rationale in both its pre-hearing and post-hearing submissions to the judge. *See* R. Pre-Hearing Submissions at 1 (citing section 46.7(d) in support of its contention that “Juopperi was performing the task under the close observation of Mr. Rohrbach, a ‘competent person’”), R. Post-Hearing Br. at 3, 7 (same); *see also* R. Answer to Pet. for Assessment of Penalty at 1 (stating, in the alternative, that the employees “were in the process of being trained at the time of the incident”).

III.

Conclusion

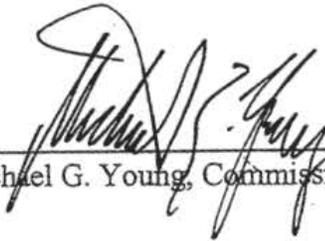
Accordingly, we vacate the judge's decision and remand for further proceedings consistent with the Commission's decision.



Robert H. Beatty, Jr., Commissioner



Mary Lu Jordan, Commissioner



Michael G. Young, Commissioner

Chairman Duffy and Commissioner Suboleski, concurring:

We concur with our colleagues' conclusion that this case should be remanded to the Administrative Law Judge so that he can make additional findings concerning whether a violation of section 46.7 occurred with regard to Fred Juopperi. While the judge's opinion contains all necessary findings with regard to the need for new task training for Robert Rohrbach, we do not believe that his opinion contains all necessary findings with regard to the need for new task training for Juopperi.

Although we concur with the need for a remand, we write separately for two principal reasons. First, unlike our colleagues, we believe that on remand the judge's findings and legal conclusions must further address the following matters: (1) the ambiguity of the evidence regarding whether on January 12 the supervisor specifically assigned Juopperi, in addition to Rohrbach, to perform the task of changing the hydraulic hose at the losche mill; and (2) what training requirements applied, if any, when Juopperi began assisting Rohrbach in changing the hose after Rohrbach, who clearly had been assigned to perform the task, had already undertaken several steps of the task. Second, we are concerned about certain aspects of the approach taken by our colleagues in their opinion. In particular, we believe that they have gone too far in retroactively supplying a rationale for the issuance of a citation when the Secretary has apparently been unable to do so.

#### The Regulatory Background

The Secretary's "new task" training regulations for sand, stone, and gravel mining operations are set forth in 30 C.F.R. § 46.7. Section 46.7(a) requires that a miner "who is reassigned to a new task in which he or she has *no* previous work experience" must be provided "training in the health and safety aspects of the task to be assigned . . . before the miner performs the new task." 30 C.F.R. § 46.7(a) (emphasis added). In lieu of the formal task training required under this subsection, section 46.7(c) provides that an operator need not provide training to miners who have received training in similar tasks or who have previous work experience in the task and can demonstrate the necessary skills to perform the task in a safe manner. 30 C.F.R. § 46.7(c). Similarly, section 46.7(d) provides an alternative to the formal training in section 46.7(a) by allowing a miner to "practice under the close observation of a competent person, . . . if hazard recognition training specific to the assigned task is given before the miner performs the task." 30 C.F.R. § 46.7(d).

#### Presentation of Evidence Before the Administrative Law Judge

In discussing the evidence before the judge and the manner in which he addressed it in his opinion, we believe that it is important to recognize that the judge's disposition of the citation in this proceeding has been complicated by the Secretary's varying and confusing bases for citing Dacotah. The Secretary's litigation strategy at trial focused on her allegation that both Rohrbach and Juopperi had not been trained in compliance with section 46.7(c). Following the accident

involving both miners, MSHA had issued a single citation alleging, in relevant part, “The two employees demonstrated that they were not properly tasked [sic] trained in safe work practices.” Citation No. 7919763. In her pretrial statement, the Secretary stated that Rohrbach and Juopperi were not properly trained under section 46.7(c). S. Resp. to Prehearing Order at 1. In addition, the Secretary alleged that Rohrbach did not know how to perform the task in a safe manner and that he was not a “competent person.” *Id.* at 2. Just prior to trial, counsel for the Secretary moved to amend the citation to allege a violation of section 46.7, in general, stating “Reading section 46.7 as a whole, it is clear that subsections (a), (b), and (c) must be construed and applied together.” S. Mot. to Amend Cit. at 2 (Jan. 10, 2001). *See also* Tr. 5 (Secretary’s counsel stating, “I don’t believe this is changing the theory or the scope of the evidence or anything. I mean, the heart of the allegation is in Subsection (c) . . .”).

The central factual underpinning of the Secretary’s case at trial was MSHA investigator Steichen’s testimony that Rohrbach had not been adequately trained to change the hydraulic hose because he did not know where the pressure relief valves were located. 24 FMSHRC at 785. This testimony was based on a post-accident interview that Steichen had with Rohrbach. *Id.* Steichen testified that this statement was the basis for his belief that Rohrbach had not been properly trained. Tr. 76. Steichen, the Secretary’s sole witness, further testified that he was not concerned with whether Rohrbach was a “competent person” under section 46.7(d). Tr. 83. Indeed, during the cross-examination of Steichen, the Secretary’s counsel objected to a question concerning whether Rohrbach was a “competent person” under section 46.7(d). Counsel noted that there were other requirements of the subsection of the regulation, even assuming it could be established that Rohrbach was “competent,” and the judge sustained the Secretary’s objection that the question was “hypothetical.” Tr. 84-87. At the conclusion of the testimony of Steichen, the Secretary’s only witness, the Secretary rested her case and did not present any further witnesses or evidence concerning section 46.7(d).

During Dacotah’s presentation of its case, Rohrbach testified that he had indeed been trained to perform the hydraulic hose repair and had successfully performed the same repair job just four days prior to the accident. Tr. 110-12, 123. The judge credited Rohrbach’s trial testimony over Steichen’s interview statement. 24 FMSHRC at 785.<sup>1</sup> Based on this and other factual findings, the judge determined that the record supported a conclusion “that Mr. Rohrbach [sic] had been adequately trained in the task assigned to him on January 12, 2001, and he was able to provide sufficient supervision to Mr. Juopperi.” 24 FMSHRC at 786.

Once the Secretary failed to prove that the operator had not complied with section 46.7(c) with regard to either Rohrbach or Juopperi, there was little left of her case in light of the citation, pre-trial statements, and the limited evidence that she presented at trial. This is because the

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<sup>1</sup> In light of Rohrbach’s unequivocal testimony as to his own training and experience in changing the hose, we conclude that the judge did not merely “[give] more weight to evidence of Rohrbach’s training and the corroborating testimony of his supervisors than to the inspector’s testimony.” Slip op. at 4.

Secretary's case as presented to the judge was premised on noncompliance with section 46.7(c). Indeed, even in her brief to the Commission, the Secretary continues to argue that Juopperi was not adequately trained under section 46.7(c). S. Br. at 9-13. In her post-hearing statement, the Secretary directly argued *for the first time* that Juopperi had not been properly trained under section 46.7(d) because he had not been trained by a "competent" person and because he had not received hazard recognition training. S. Post-Hearing Statement of Position at 8-9.

Because the Secretary tried the case as a section 46.7(c) violation, the evidence presented by the parties addressing section 46.7(d) was confused and arguably incomplete. Accordingly, it is understandable, given the state of the record, that the judge's opinion focussed on compliance with subsection (c) with regard to Rohrbach and did not address compliance with subsection (d) with regard to Juopperi. The opinion states that Rohrbach "was adequately trained in the task assigned to him on January 12, 2001, and he was able to provide sufficient supervision to Mr. Juopperi" (24 FMSHRC at 786), but it is unclear precisely how that statement applies to subsection (d) and its language allowing a miner to "practice under the close supervision of a competent person." Because the Secretary eventually did raise the issue of the operator's compliance with subsection (d) with regard to Juopperi, albeit at the eleventh hour, we believe that the judge should have made more specific findings regarding the operator's compliance with subsection (d) or explained why it was not possible to do so based on the record before him.

#### The Need for Additional Specific Findings on Remand

Because we conclude that the case should be remanded for additional findings, we believe that the judge should also reexamine the question of whether Juopperi's actions on January 12 triggered the training requirements of section 46.7(a) as a threshold matter. Subsection (a) provides that the new task training requirements apply to a miner "who is reassigned to a new task in which he or she has no previous work experience." Thus, for a violation to have occurred in this case, the operator must have actually "reassigned" Juopperi to perform a new task.<sup>2</sup> However, the record in this case is ambiguous, at best, with regard to whether the maintenance crew supervisor had assigned Juopperi the task of changing the hydraulic hose so as to trigger section 46.7(a). Rather, as discussed below, the evidence appears to indicate that the supervisor had assigned Rohrbach the task and that Juopperi was merely assisting Rohrbach with part of the task on the day of the accident.

Rohrbach's testimony indicates that he observed a leak in the hydraulic hose and reported it to his supervisor, and that the supervisor assigned Rohrbach to make the repair the next day –

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<sup>2</sup> Our colleagues state at one point that the task of changing the hose "was also clearly within the scope of Juopperi's job duties" (slip op. at 11) and imply that this is determinative in concluding whether Juopperi was assigned to perform the task. However, section 46.7(a) provides that the new task training regulations are triggered only when a miner is "reassigned" to carry out the new task in question. It is not enough to trigger the regulations that a particular task falls within the scope of the miner's general job duties.

January 12. Tr. 126. Rohrbach did not testify that the supervisor also assigned Juopperi to make the repair. After Rohrbach had already begun the repair on January 12, Juopperi happened to appear after completing his routine maintenance tasks and offered to assist Rohrbach. 24 FMSHRC at 784; Tr. 126, 170-71. Rohrbach further testified that he had failed to release the pressure from the hose, when he was doing preparatory work, before Juopperi's appearance.<sup>3</sup> 24 FMSHRC at 784; Tr. 126, 144.

Juopperi's testimony likewise seems to indicate that it was Rohrbach who was specifically assigned to change the hydraulic hose. Juopperi testified that, at the morning meeting on January 12, the supervisor "mentioned to [Rohrbach] – how I remember that there is a hose needs to be changed on the losche mill." Tr. 170-71. Juopperi's description of how he became involved with assisting Rohrbach on January 12, when the accident occurred, is nearly identical to his description of his involvement with Rohrbach on January 8, when he saw Rohrbach changing another hydraulic hose and offered to help. Tr. 165. Juopperi never stated that the supervisor assigned him – Juopperi – to change the hose.

In this regard, it is highly significant that the Secretary did not attempt to elicit testimony from any witness indicating that Juopperi had been assigned the task of changing the hose. Counsel for the Secretary's cross-examination of the maintenance crew supervisor dealt *entirely* with Rohrbach, and counsel made no attempt to establish that Juopperi had been assigned the task of changing the hose.<sup>4</sup> Instead, the Secretary focussed throughout the trial on Rohrbach's alleged lack of training and apparently assumed, without a clear basis in the record, that Juopperi had also been assigned the task of changing the hose.

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<sup>3</sup> In light of these factual circumstances, the judge was clearly correct in concluding that the accident was not "the result of inadequate training rather than carelessness or inattention." 24 FMSHRC at 786.

<sup>4</sup> Indeed, in describing Juopperi's participation in changing the hose on January 12 during cross-examination, the Secretary's counsel characterized it as follows: "... you came in and offered to help or said, do you need some help . . ." Tr. 186. Similarly, during the cross-examination of Rohrbach, the Secretary's counsel acknowledged that Juopperi was merely assisting Rohrbach in performing the task (Tr. 151):

Q. Okay. What exactly – what did you think [Juopperi's] role was in this process? Was he basically there just to assist you or what?

A. Yes.

Q. Okay. And is that the same for the January 8th incident?

A. Yes.

In light of the foregoing, the judge's statement that both Rohrbach and Juopperi "were assigned" to replace the hydraulic hose, 24 FMSHRC at 784, should be revisited on remand. Moreover, the judge should reconcile the statement with his statement that Juopperi was "occupied" with other maintenance jobs before joining Rohrbach, who was in the process of changing the hose. *Id.* On remand, the judge should determine whether Juopperi, in addition to Rohrbach, had been assigned the task of replacing the hydraulic hose.

Moreover, on remand, the judge should address the issue of how the new task training regulations should be applied under the specific circumstances of this case. The Secretary's Part 46 regulations do not address situations where, as in this case, a miner who is not assigned to perform a particular task enters the scene and provides assistance to the miner assigned to and in the process of performing a task. Such assistance could be as commonplace as steadying a ladder or (as here) loosening a nut. Moreover, neither the preamble to the final rule nor any subsequent guidance document appears to provide any relevant guidance concerning how the regulations should be applied in such a situation. Indeed, the Secretary has not explained what constitutes the "assignment of a task." Even assuming *arguendo* that a miner providing assistance to the miner assigned to perform a task should receive some hazard recognition training, it is unclear whether that training must address the entire task or only the discrete portion for which the miner is providing assistance.<sup>5</sup>

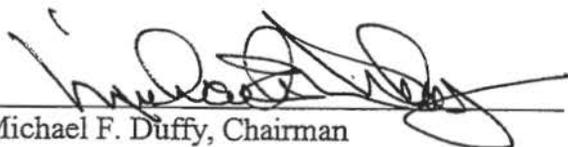
Finally, we disagree with our colleagues regarding the Commission's role in this proceeding. While Congress established the Commission to "develop a uniform and comprehensive interpretation of the law . . . [to] provide guidance to the Secretary in enforcing the [Mine Act]," *Hearing on the Nomination of Members of the Federal Mine Safety and Health Review Comm'n Before the Senate Comm. on Human Res.*, 95th Cong., 1 (1978), the Mine Act imposes on the Secretary the burden of proving the violation alleged and imposes a substantial evidence test for Commission review. *Consolidation Coal Co.*, 11 FMSHRC 966, 973 (June 1989). *See* 30 U.S.C. § 823(d)(2). It is not the role of the Commission to retroactively supply a rationale for the issuance of a citation when the Secretary has been unable to do so – particularly in a case such as this where the circumstances giving rise to the citation are not addressed under the explicit terms of the regulation, the preamble, or in other guidance to the mining community.

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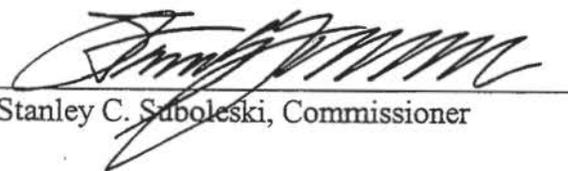
<sup>5</sup> The only example of miner training pursuant to this regulation that has been provided by the Secretary, S. Br. at 14-15 (quoting 64 Fed. Reg. at 53117-18), is the task training of a miner newly assigned the job of loader operator. That circumstance is in no way analogous to the present case involving a general repairman in a production facility who is primarily responsible for a variety of general maintenance functions and who assists with more complex repair jobs. *See* Tr. 163-64. Since the issuance of this regulation under Part 46, MSHA has provided no guidance as to its meaning and application that we have been able to find. As explained above, clarification by MSHA is particularly needed regarding the level of training needed when a miner assists with only a portion of a job, such as steadying a ladder or loosening a bolt.

The Secretary's briefs in this case have not addressed the Secretary's interpretation of key terms in any meaningful detail. For example, the Secretary's brief before the Commission argues that there was no evidence that Juopperi was "practicing" the task in question, that Rohrbach was providing "close observation" of what Juopperi was doing, or that Rohrbach was a "competent person" *without providing an interpretation of those terms, prior guidance concerning their application, or a meaningful discussion of the policy concerns and practical considerations involved.* S. Br. at 15-16.<sup>6</sup> Similarly, the Secretary's brief makes no effort to explain what constitutes a "task" or "change in task" in the context of this case.

Despite the Secretary's failure to explain her interpretation and application of key terms or to have provided adequate guidance to the mining community, our colleagues have attempted to fill the void by discussing the terms in their opinion. We believe that the better course of action would be to remand the case to the judge for further findings as explained above and let the burden of proving her case rest with the Secretary.<sup>7</sup>



Michael F. Duffy, Chairman



Stanley C. Suboleski, Commissioner

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<sup>6</sup> We note that, although Dacotah's brief challenged the legal and factual bases for these assertions in its brief (D. Br. at 8-10), the Secretary chose not to file a reply brief and therefore provided the Commission no additional assistance in addressing these issues.

<sup>7</sup> We are not inclined to engage in an extensive analysis of section 46.7(d) in responding to our colleagues for the reasons noted above. However, we note the lack of case authority or principles of regulatory interpretation that would lead to the conclusion of a violation on the basis of inadequate hazard recognition training (slip op. at 7) in the absence of showing the factual predicate for application of sections 46.7(a) (assignment of a new task) and (d) (practice under the close observation of a competent person). Simply put, a violation of section 46.7(d) cannot be established by applying the hazard training requirement in isolation.

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

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

FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

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

June 22, 2004

SECRETARY OF LABOR,	:	
MINE SAFETY AND HEALTH	:	Docket No. WEVA 2004-91
ADMINISTRATION (MSHA)	:	A.C. No. 46-05295-13102
	:	
v.	:	
	:	
EASTERN ASSOCIATED COAL	:	
CORPORATION	:	

BEFORE: Duffy, Chairman; Beatty, Jordan, Suboleski, and Young, Commissioners

ORDER

BY: Duffy, Chairman; Beatty, Suboleski, and Young, Commissioners

This matter arises under the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 801 et seq. (1994) ("Mine Act"). On March 17, 2004, the Commission received from Eastern Associated Coal Corporation ("Eastern") a motion made by counsel to reopen penalty assessments that had become final orders of the Commission pursuant to section 105(a) of the Mine Act, 30 U.S.C. § 815(a).

On November 12, 2003, the Department of Labor's Mine Safety and Health Administration ("MSHA") issued proposed penalty assessments (A.C. No. 46-05295-13102) to Eastern. In its motion, Eastern states that on September 9, 2003, a Notice of Contest of Proposed Assessments was filed with the MSHA Civil Penalty Compliance Office. Mot. at 1.<sup>1</sup> Eastern also states that on December 16, 2003, its attorney wrote a letter to the MSHA Payment Office

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<sup>1</sup> We note the discrepancy between the date of the proposed penalty assessment (November 12, 2003) and the date that Eastern alleges it filed a notice of contest of the penalties (September 9, 2003).

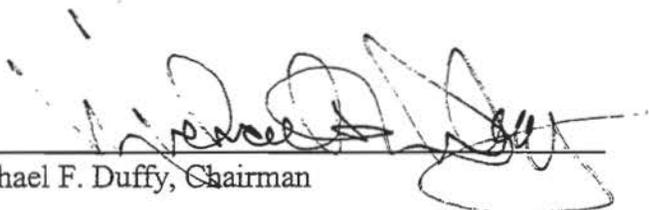
stating that the payment made for seven citations was in error.<sup>2</sup> *Id.*; Ex. A. In this letter, he requested a refund for the penalty amount that had mistakenly been paid. Mot. at 1; Ex. A. Eastern further states that the payments were mistakenly made due to a clerical error. Mot. at 2. The Secretary states that she does not oppose Eastern's request for relief.

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) of the Federal Rules of Civil Procedure 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.

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<sup>2</sup> In its motion, Eastern asks the Commission to reopen proceedings on eight referenced citations. One of them, Citation No. 4192110, does not appear on the proposed penalty assessment Eastern attached to its motion, nor is it referenced in the letter sent to MSHA by Eastern's counsel. Records indicate that this citation has been vacated. Therefore, it is not properly before us, and is not included within the scope of this order.

Having reviewed Eastern's motion, 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 inadvertent payment of the penalties 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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Michael F. Duffy, Chairman



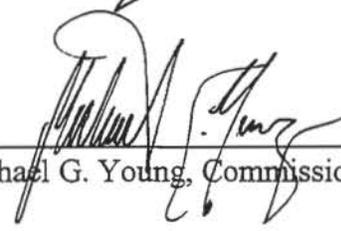
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Robert H. Beatty, Jr., Commissioner



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Stanley C. Suboleski, Commissioner

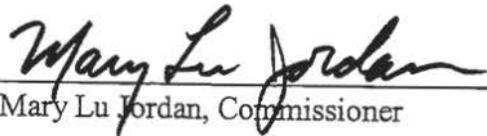


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Michael G. Young, Commissioner

Commissioner Jordan, dissenting:

I would deny the operator's request to reopen these proceedings. Although the proposed assessments in this case were not issued until November 12, 2003, the operator, through counsel, mistakenly asserts that it filed a contest of the proposed assessments with the MSHA Civil Penalty Compliance Office on September 9, 2003. Mot.at 1. Moreover, in one of the proceedings for which the operator requests relief, the underlying citation was vacated. Slip op. at 2. In light of this confusing submission, I do not believe that the assertion from the operator's attorneys that the penalties were paid in error warrants relief.

  
Mary Lu Jordan, Commissioner

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Chief Administrative Law Judge Robert J. Lesnick  
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ADMINISTRATIVE LAW JUDGE DECISIONS



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

June 3, 2004

SECRETARY OF LABOR,	:	CIVIL PENALTY PROCEEDING
MINE SAFETY AND HEALTH	:	
ADMINISTRATION (MSHA),	:	Docket No. KENT 2003-274
Petitioner	:	A.C. No. 15-18015-03527 A
	:	
v.	:	
	:	
CHARLES CLEVINGER, Employed by	:	
LODESTAR ENERGY, INC.,	:	Bent Mountain
Respondent	:	
	:	
SECRETARY OF LABOR,	:	CIVIL PENALTY PROCEEDING
MINE SAFETY AND HEALTH	:	
ADMINISTRATION (MSHA),	:	Docket No. KENT 2003-275
Petitioner	:	A.C. No. 15-18015-03528 A
	:	
v.	:	
	:	
DAVID R. COLEMAN, Employed by	:	
LODESTAR ENERGY, INC.,	:	Bent Mountain
Respondent	:	
	:	

**DECISION**

Appearances: Thomas A. Grooms, Esq., Office of the Solicitor,  
U.S. Department of Labor, Nashville, Tennessee, for the Petitioner;  
Mark E. Heath, Esq., Spilman Thomas & Battle, PLLC,  
Charleston, West Virginia, for the Respondents.

Before: Judge Feldman

These consolidated proceedings are brought by the Secretary under section 110(c) of the Federal Mine Safety and Health Act of 1977 (the Act), 30 U.S.C. § 820(c), following a fatal truck accident that occurred on October 3, 2001, at Lodestar Energy Inc.'s (Lodestar's) Bent Mountain Mine. Section 110(c) of the Act provides that a corporate agent "who knowingly authorized, ordered or carried out . . . [a] violation" committed by a corporate operator may be subject to individual liability. As a general proposition, a "knowing" violation under section 110(c) involves aggravated conduct rather than ordinary negligence. *Bethenergy Mines, Inc.*, 14 FMSHRC 1232, 1245 (August 1992).

These matters concern petitions for assessment of civil penalties filed by the Secretary against the respondents Charles Clevinger and David R. Coleman who were supervisory personnel at Lodestar's Bent Mountain facility. The Secretary alleges that Clevinger and Coleman "knowingly" violated the provisions of section 77.1605(b) of the Secretary's mandatory safety standards that require all loading and haulage mobile equipment to be equipped with adequate brakes. 30 C.F.R. § 77.1605(b).

A hearing was conducted on February 11 and February 12, 2004, in Pikeville, Kentucky. At the hearing, the Secretary moved to dismiss the case against Clevinger because the facts did not support that he "knowingly" violated the cited safety standard, and because of Clevinger's untimely death in November 2003. The Secretary's motion to dismiss was granted on the record. (Tr. I, 8-12).<sup>1</sup> Accordingly, the civil penalty proceeding against Charles Clevinger in Docket No. KENT 2003-274 was dismissed on the record. (Tr. I, 8-11).

With respect to the case against Coleman, the record was left open for the parties to submit transcripts of the MSHA accident investigation interviews of David Coleman and Elchaney Cline. Coleman filed his transcript interviews on February 23, 2004. The Secretary provided the transcripts of Cline's interviews on March 5, 2004. (Tr. II, 342, 353; Resp. Ex. 6, Joint Ex. 1).

### **I. Statement of the Case**

On October 3, 2001, Gary Blackburn was driving a Mack DM600 fuel truck down an inclined haulage road in order to refuel mining equipment located in a coal producing pit. At some point along the road, Blackburn lost control and jumped from the vehicle sustaining injuries that resulted in his death the following day. Drivers normally relied on downshifting in low gear to control their trucks while descending steep grades. After the accident, examination of the service brakes revealed significant defects.

The accident investigation team initially believed that defective brakes were the primary cause of the accident based on the erroneous belief that an employee, Elchaney Cline, had complained to Coleman about the truck's brakes the night before the accident.<sup>2</sup> Although poor brakes undoubtedly were a significant contributing factor, the evidence reflects the proximate cause of the accident was a defective clutch that was adjusted only two hours before the fatal accident. The clutch failure caused the truck to "freewheel" out of control. In this regard, at

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<sup>1</sup> The transcripts for February 11 and February 12 are cited as "Tr. I" and "Tr. II," respectively.

<sup>2</sup> In fact, Cline testified he communicated brake complaints to Coleman approximately one month before the accident. (Tr. II, 227-30). There is very little evidence of brake complaints in the intervening weeks leading up to the accident.

trial, MSHA conceded that it was implausible that Blackburn jumped while the truck was in low gear and limited to a speed of ten miles per hour. (Tr. I, 250-61).

To prevail in a 110(c) personal liability case, the Secretary must show that Coleman, as a foreman in a position to protect employee safety, failed to act on the basis of information that gave him knowledge or reason to know of the existence of a hazardous violation. *Sec'y of Labor v. Richardson*, 3 FMSHRC 8, 16 (January 1981), *aff'd*, 689 F.2d 632 (6<sup>th</sup> Cir. 1982). In addition, the Secretary must demonstrate that Coleman's failure to act in response to the information known to him constitutes aggravated conduct. *Bethenergy*, 14 FMSHRC at 1245.

In evaluating the evidence, the focus is on the nature and extent of Coleman's knowledge of the brake conditions in the weeks preceding the October 3, 2001, accident. In this regard, Coleman cannot be charged with knowledge of the significant brake defects that were revealed by a detailed examination of the wreckage after the accident. As discussed herein, the Secretary has failed to demonstrate that Coleman's failure to recognize the defective brake conditions constituted aggravated conduct.<sup>3</sup> Consequently, the personal liability case brought by the Secretary against Coleman must be dismissed.

## **II. Preliminary Findings of Fact**

Lodestar's Bent Mountain Mine began production in December 1998. Lodestar is in bankruptcy and is not currently operating the mine. At the time of the accident in October 2001, the mine facility consisted of three pits where highwall drills, a hydraulic shovel, front-end loaders and rock trucks were used to produce approximately 45 tons of coal each day.<sup>4</sup> The mine operated two ten-hour production shifts, seven days a week. Personnel were divided into two crews designated as "A" and "B". The crews worked day shifts from 6:00 a.m. until 4:00 p.m. and night shifts from 6:00 p.m. until 4:00 a.m. Each crew worked four consecutive days, and then was off for five days. It was a common practice for employees to work on days that their crew was scheduled to be off. Roger Bartley was the "B" crew day foreman. David Coleman was the "B" crew night foreman. Don Holiday was the "A" crew day foreman and Doug Trimble was the "A" crew night foreman. (Tr. II, 316-17). Bartley, Coleman, Holiday and Trimble reported to Charles Clevinger who was the Mine Superintendent.

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<sup>3</sup> I note, parenthetically, Coleman has not been charged with failing to remove the truck from service because it was defective in violation of section 77.404(a). Section 77.1605(b), the standard Coleman is charged with violating, requires that mobile equipment must have adequate brakes. Thus, the issue is whether Coleman's failure to recognize the inadequacy of the truck's brakes constitutes a knowing violation of Section 77.1605(b).

<sup>4</sup> Although not specifically cited, background information and investigation findings have been taken from MSHA's accident investigation report released on December 12, 2001, and admitted as Gov. Ex. 2.

Johnny Huffman was the maintenance supervisor in charge of vehicle maintenance. He supervised eight mechanics. (Tr. II, 290, 317-18). Huffman prepared the work schedule for the vehicles, managed maintenance work and assigned work to the mechanics. (Tr. II, 318). Huffman decided when brakes were to be serviced or replaced. (Tr. II, 269). If equipment operators experienced mechanical problems, Lodestar's procedure required the operator to immediately notify either one of the mechanics directly, the mechanic's supervisor, or the shift foreman, who would contact maintenance about the problem. (Tr. I, 82, 149, 156; Tr. II, 244, 267). Adjustments were sometimes made on equipment without the foreman's knowledge. (Tr. II, 305).

Employees who experienced equipment problems were also required to indicate the defective conditions on their time sheets. (Tr. I, 84; Tr. II, 270, 306-07). The time sheets have a specific location where brake problems are to be noted. (Tr. I, 84; Gov. Exs. 45-48, 53). The shift supervisor was responsible for ensuring that any problem noted on the time sheets was brought to the attention of the maintenance department. (Tr. II, 157). If a vehicle had a mechanical problem during Coleman's shift, Coleman's practice was to record the problem and communicate the problem directly to Huffman. (Tr. II, 352). Coleman had no direct involvement with the repairs. (Tr. II, 352).

Two fuel trucks were used at the Bent Mountain facility, a red truck and a black truck. (Tr. I, 52). The black truck, designated by Lodestar as FT916, was a newer, larger Mack fuel truck. The black truck was the primary vehicle used to fuel mine equipment. It was equipped with a Jacob's Brake, also called a "jake" brake. A Jacob's Brake uses compression from the engine to slow the vehicle lessening the operator's reliance on the service brakes. (Tr. I, 54).

The red fuel truck, designated by Lodestar as FT154, was a spare truck that was used when the black truck was being serviced or repaired. The red truck was a 1975 Mack Model DM 600, ten wheel vehicle with a 3,000 gallon capacity fuel tank. The red truck was not equipped with a Jacob's Brake. The brakes on the red truck were last replaced in April 2001, approximately six months before the accident. (Tr. II, 324, 351). The red truck had five high gears and five low gears that were engaged by using two shift levers. (Tr. I, 58). The main shift lever changed the gears from one to five and the auxiliary shift lever set the gear in high, low or neutral. Operators typically drove the red truck down steep hills in second gear (low), which limited the vehicle to approximately five to ten miles per hour. (Tr. I, 96). When in second gear, drivers normally did not have to use the service brakes to control the truck. (Tr. I, 111-12, 114, 118-19, 127).

#### a. The Events of October 3, 2003

The victim, Gary Blackburn, was an experienced truck driver. (Tr. I, 115, 255). On the day of the accident on October 3, 2001, Blackburn began work at 6:00 a.m. Blackburn normally worked as a rock truck driver on the "A" crew and he was not scheduled to work on this day. However, he decided to work an off shift and he was assigned to operate the red fuel truck.

FT154 was being used because the black fuel truck was being repaired. Blackburn filled the truck with approximately 3000 gallons of diesel fuel and proceeded to a parking area for mining equipment and private vehicles known as the #3 Knob.

Blackburn drove to the parking area to meet Mark Hamilton, a day shift mechanic. Hamilton had been directed by Johnny Huffman, the maintenance supervisor, to adjust the FT154 clutch after Elchaney Cline, who had operated the truck the previous shift, reported the clutch was slipping. (Tr. II, 262-64). After the adjustment was made, Hamilton asked Blackburn to apply the park brake and put the truck in gear to determine if the clutch would hold. (Tr. II, 263, 266). At that time, the brakes were sufficient to hold the truck until the engine almost stalled. (Tr. II, 265). Hamilton testified that Blackburn did not report any brake problem to him. (Tr. II, 265, 268).

Consistent with Hamilton's testimony, Bartley testified that Hamilton and Blackburn tested the clutch on the morning of October 3, 2001, by revving the engine while engaging the brakes. Bartley stated that, after the adjustment was made, Blackburn drove the truck around the parking lot to test the truck. Blackburn gave Bartley the thumbs-up sign indicating the truck was operating properly. Bartley testified Blackburn did not report any problems with the truck's brakes. (Tr. II, 288-89).

At approximately 10:40 a.m., Blackburn began descending the haulage road leading to the Winifrede Coal Seam to fuel and service the mining equipment in the pit. The road was composed of dry, compacted soil and rock. It was approximately 27 feet wide and 1,800 feet long, with a grade varying from 8 percent to 16 percent. This haulage road is commonly known as the "hell hole." (Tr. I, 54-58; Tr. II, 224). A public highway with a 6 percent grade is considered to be a steep grade requiring trucks to use low gear. (Tr. II, 213). On the day of the accident, the sky was clear and it had not rained for several days. At some point along the road, Blackburn apparently lost control of the fuel truck and jumped from the vehicle, landing on the left side of the road near the berm. The unoccupied truck continued traveling for an additional 180 feet and struck a larger Caterpillar rock truck parked in a flat area off of the left side of the haulage road. The impact caused extensive damage to the fuel truck. (Gov. Ex. 19). The fuel truck wreckage was found with the main shift lever in fourth gear and the auxiliary shift lever in neutral. The effect was a neutralized transmission that could result in a runaway or "freewheeling" truck. (Tr. II, 182-83, 206-08, 222-23).

At 10:50 a.m., a contract coal truck driver observed Blackburn lying on the left side of the road, approximately 1600 feet from the top of the slope. Bartley was notified and he immediately requested an ambulance. Blackburn was transported up the haulage road by ambulance to an area suitable for helicopter landings. Blackburn ultimately was air-lifted to a hospital where he died the following day of head injuries. There were no eyewitnesses to the accident.

b. The Accident Investigation

The Secretary's principal witness in this proceeding is Elchaney Cline. Cline was a utility man who operated a variety of mine equipment. Cline, whose testimony will be discussed in detail below, worked on the "B" crew supervised by Coleman. Cline drove the red FT154 fuel truck during the shift immediately preceding Blackburn's shift for 7½ hours during the evening of October 2, 2001, and into the early morning hours of October 3, 2001. Although Coleman overheard Cline complain on the CB radio about the clutch slipping during the shift that ended on the morning of October 3, 2001, Cline did not complain about the service brakes.

Cline provided equivocal information to MSHA investigators shortly after the accident about the nature and timing of relevant brake complaints he communicated to Coleman prior to the accident.<sup>5</sup> Cline was interviewed by MSHA on October 4, 2001, at which time he described the condition of the brakes stating:

And I know when you get it out of gear, you couldn't stop the truck going down with a load of fuel on it. The brakes, I mean it had good brakes on level ground but with a load of fuel pushing you down in there, ain't know way you could stop it . . . . you had good brakes but you just couldn't hold them. You just had to pump them every now and then and you couldn't get it out of gear, you know . . . . I suspect that what it was doing , you know, cause I had a whole load of fuel of it. And I didn't want to get them hot, you know, I just pump, push them, go on, let off . . . .

(Joint Ex. 1, pp 25, 27).

Cline has provided varying accounts concerning his FT154 brake complaints. On October 4, 2001, Cline told MSHA he complained to Coleman about the brakes "just about every time I [got] in the truck" during the month preceding the accident. (Joint Ex. 1, p. 11). On October 18, 2001, Cline again was interviewed by MSHA investigators. This time Cline, explaining that the red truck was used infrequently, stated that he last complained about the brakes to maintenance supervisor Huffman and Coleman "a month or two before the accident." At trial, Cline testified the only time he complained to Coleman about the red fuel truck's brakes was "three weeks to a month before the accident." (Tr. I , 67-68).

MSHA examined the brakes on the wreckage on October 5, 2001. The brakes were determined to be approximately 30 percent effective as a significant portion of the brake lining surfaces were not contacting the brake drums. (Tr. II, 19-20). On October 6, 2001, MSHA examined the differential, power divider and rear axles for excessive wear or broken gears. The clutch friction plate pads were worn down to the rivets. Several of the rivets were also worn. The

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<sup>5</sup> The Secretary concedes Cline's investigation statements and testimony "often appeared inconsistent and, sometimes, contradictory." (Sec'y Br. at 35).

friction pads and the clutch plate were bluish in color, indicating overheating from clutch slippage. The accident investigation noted that the clutch had been readjusted shortly before the accident based on an operator's complaint that the clutch was slipping.

On October 22, 2001, MSHA issued 104(d)(1) Citation No. 7378492 to Lodestar citing a violation of section 77.1605(b) for inadequate brakes attributable to Lodestar's unwarrantable failure.<sup>6</sup> The cited violation in Citation No. 7378492 is the subject of this proceeding against Coleman. (Gov. Ex. 1). On October 22, 2001, Lodestar also was issued 104(a) Citation No. 7378493, not a subject of this proceeding, for its failure to maintain the red fuel truck in safe operating condition. The worn friction plate pads bluish in color and bald right drive axle tires were cited as hazardous conditions. The negligence attributed to Lodestar was moderate. (Gov. Ex. 6).

MSHA's accident investigation concluded:

The factor that can conclusively be associated with the accident is the condition of the truck's braking system. Even if the drive train became disengaged, or an effective loss of steering occurred, the braking system on the truck should have been able to stop the vehicle. The investigation revealed that all six brakes on the truck had maintenance defects that resulted in severely reduced braking capability.

(Gov. Ex. 2, p. 11).

In evaluating culpability, the investigation report's closing statement noted that "[i]nformation obtained during the investigation indicates that mine management was aware that the brakes would not effectively stop the loaded vehicle on the grade where it was required to travel." (Gov. Ex. 2, p. 12).

c. 104(d)(1) Citation No. 7378492

Coleman has been charged with "knowingly" violating the mandatory safety standard in section 77.1605(b) that requires mobile equipment to be equipped with adequate brakes. The section 77.1605(b) violation was the subject of 104(d)(1) Citation No. 7378492 issued to Lodestar on October 22, 2001. Citation No. 7378492 states:

Adequate brakes were not provided for the Mack DM600 fuel truck (Company No. FT154) used to supply fuel to mobile mining equipment at the mine. This condition contributed to a fatal haulage accident which occurred on the Winifrede

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<sup>6</sup> A mine operator's conduct is unwarrantable when it engages in aggravated conduct constituting more than ordinary negligence. *Emery Mining Corp.*, 9 FMSHRC 1997, 2001(December 1987).

Coal Seam access road on 10/03/2001. During the accident investigation, the following deficiencies in the truck's braking system were found:

- 1) Right Front Steering Axle Brake - The pushrod stroke was excessive. Both brake lining wear surfaces were coated with grease across the width of the lining. The drum was coated with a film of grease. The return spring was missing.
- 2) Left Front Steering Axle Brake - Both brake linings and the drum were coated with grease in three separate bands approximately 1.5 inches wide each.
- 3) Right Forward Drive Axle Brake - The pushrod stroke was excessive. The service brake chamber leaked at a rate of 15 psi per minute.
- 4) Right Rear Drive Axle Brake - The pushrod stroke was excessive. The S-cam roller on the forward brake shoe was missing. The rear brake lining was worn to the point that the rivets holding the lining were also worn. The upper half of the rear lining was loose. The lower portion of the forward lining was coated with grease across the width of the wear surface.
- 5) Left Forward Drive Axle Brake - The pushrod stroke was excessive. Approximately one half of the brake lining surface was coated with mud, indicating that only half of the lining was making contact with the drum. The spring applied parking brake was not functional.
- 6) Left Rear Drive Axle Brake - The pushrod stroke was excessive. Approximately one half of the brake lining and drum were coated with grease. The lock ring that holds the slack adjuster onto the S-Cam shaft was missing.

The accident investigation revealed that all six of the fuel truck's brakes had maintenance defects that significantly reduced the overall braking capability of the truck. Information obtained during the investigation indicates that mine management was aware that the brakes would not effectively stop the loaded vehicle on the grade where it was required to travel.

(Gov. Ex. 1).

The Secretary subsequently charged Clevinger and Coleman, as agents of Lodestar, with "knowingly authorizing, ordering or carrying out" the violation of section 77.1605(b) cited in Citation No 7378492.

Lodestar has filed for bankruptcy protection. Given Lodestar's bankruptcy filing, on

May 22, 2003, Judge Melick entered an Order in Docket No. KENT 2002-292 directing Lodestar to pay the proposed civil penalty for Citation No. 7378492 after Lodestar withdrew its contest and request for a hearing.

As further discussed below, at trial I declined to adopt the Secretary's assertion that collateral estoppel prevented Coleman from challenging 104(d)(1) Citation No. 7378492. However, during the hearing, Coleman, through counsel, stipulated to the fact of the section 77.1605(b) violation and its significant and substantial (S&S) designation. Coleman declined to stipulate to the unwarrantable failure. (Tr. II, 70-71).

d. Events Preceding the October 3, 2001, Accident

i. Elchaney Cline

As noted, Elchaney Cline was a utility man who operated a variety of mine equipment. Cline was a night shift "B" crew member who reported to David Coleman. He characterized Coleman as a foreman who was interested in safety. (Tr. I, 93). Cline testified that he occasionally drove the red fuel truck when the black fuel truck was out of service. In the weeks preceding the accident, Cline testified that he drove the red fuel truck on September 13, September 14, September 15 and September 21, 2001, and on October 2, 2001. Lodestar's policy required equipment operators to note equipment defects on their daily time sheets. Cline's daily time sheets reflect he operated FT154 for 8½ hours on September 13, 2001, 4½ hours on September 14, 2001, 2 hours on September 15, 2001, 3 hours on September 21, 2001, and 7½ hours on October 2, 2001. Cline operated FT154 for a total of 25½ hours on these days. However, he did not enter any brake defects on his time sheets. (Gov. Exs. 45, 46, 47, 53, 56).

Cline described the brakes as spongy. Cline described FT154 as "junk." (Tr. I, 76). With respect to the brakes, Cline testified:

The foot brakes, you'd push it and you'd have good brakes at first, and when you tried to slow down more you wouldn't have none. They was (sic) gone, just like a sponge.

(Tr. I, 63).

Cline initially testified, "I told Dave Coleman and Johnny Huffman that the brakes wasn't (sic) working right . . . three weeks to a month before the accident." (Tr. I, 67). Cline subsequently testified he told Coleman and Huffman twice about a month before the accident. (Tr. I, 69-70).

On cross-examination, Cline further clarified the only brake complaint he communicated to Coleman prior to the accident:

Q. Now let's go back to the month before. [What] I understood from what you told me in yesterday's deposition is the first person you told was Mr. Huffman?

A. Yes.

Q. That the brakes needed worked on, they were weak, or how did you refer to it, they needed looked at?

A. Yes.

Q. And [Huffman] was head of maintenance for this Lodestar job?

A. Yes.

Q. And that after you reported it to Mr. Huffman, I think you told me, what, about ten minutes or so [you] saw Mr. Coleman?

A. Yes, I got in the truck to go around the hill and met Dave coming and I told him.

Q. And what you told Mr. Coleman was, "The brakes need to be looked at. I've just told Mr. Huffman about it," correct?

A. I never told him I talked to Johnny. I said, "The brakes need to be fixed, they ain't right."

Q. (Examining deposition transcript) Do you remember yesterday that when you had your conversation with Mr. Coleman - -

A. Yes.

Q. - - He asked you what Johnny Huffman had told you?

A. Yes.

Q. So you did have a discussion with Mr. Coleman on the fact that you just talked to Mr. Huffman about brakes?

A. Yes.

Q. Right? You remember that now, right?

A. Yes.

Q. Okay. There was a discussion about a switch on [the] pedal and some other things, wasn't there?

A. Yes.

Q. So what happens here is you talk to Mr. Huffman first, the chief of maintenance, right?

A. Yes.

Q. Then you say around the corner or around the hill when you run into Mr. Coleman?

A. Yes.

Q. You tell him that you want the brakes looked at and you have been talking to Mr. Huffman, the guy that's in charge of maintenance?

A. Yes.

Q. Now, the procedure up at this job is that if you needed something fixed you just went right to a mechanic, didn't you?

A. Yes.

Q. You didn't wait for a foreman to authorize it or anything else, you could call a mechanic over to get anything that you wanted done, basically?

A. We'd have to get a hold of Dave, yes.

Q. But you also at times went right to the mechanic, didn't you?

A. Yes.

Q. Now, you also told me yesterday that you had your conversation with Mr. Huffman first and then with Mr. Coleman, but Mr. Coleman very well could have believed that this was being handled because you had addressed it with the head of maintenance of the mine?

A. Yes.

Q. And you told me yesterday you had no further conversations with Mr. Coleman about any brake issues other than that incident about a month before?

A. Yes.

(Tr. I, 80-83).

Cline testified that the FT154 would “barely crawl” down the steep decline at no more than five miles per hour if the vehicle was downshifted in first gear. (Tr. I, 95). Downshifting in second gear limited the vehicle to five to ten miles per hour. (Tr. I, 96). Operators relied on downshifting rather than the service brakes when descending the haulage road. (Tr. I, 95-96). Cline never expressed concern that the red fuel truck could not safely traverse the steep grade on the haulage road. Cline drove down the “hell hole” hill in second and low with a full load of fuel on October 2, 2001, and did not report any brake complaints. (Tr. I, 73).

Cline testified that the clutch on the red fuel truck was slipping on the evening of October 2, 2001. He informed Coleman of the clutch problem over the CB radio. Coleman advised Cline that he would take care of it. Cline ultimately learned that the clutch was adjusted the following morning shortly before Blackburn’s accident. (Tr. I, 80).

Finally, Cline characterized Coleman as a foreman who was interested in safety and one who would not hesitate to remove a defective vehicle from service. (Tr. I, 93). While not dispositive, it is noteworthy that Cline does not believe that MSHA should have filed a case against Coleman because Coleman was not the supervisory mechanic responsible for repairs. (Tr. I, 93, 97).

ii. Craig Anderson

Craig Anderson was employed at Bent Mountain as a grease truck operator. Occasionally he would work overtime operating a rock truck or a fuel truck. Anderson was driving the red fuel truck on September 15, 2001. Anderson testified that his truck rolled backwards when he attempted to stop on a hill. (Tr. I, 140). Anderson reported the incident to the mechanic, Michael Hayden (also known as “Rodriguez”) and to Coleman. (Tr. I, 141-42). Anderson drove the red truck without incident on the following day. The truck stopped on level ground. Anderson could not tell whether the brakes had been adjusted. (Tr. I, 143). Anderson testified that mechanics routinely repaired equipment upon notification by mine personnel of an equipment problem. (Tr. I, 149). Anderson stated he subsequently drove the red truck on or about September 27, 2001, without further incident. (Tr. I, 145). Anderson did not communicate any other red truck brake complaints after September 15, 2001.

iii. Roy Collins

Roy Collins was a dozer operator who operated fuel trucks between shifts to fuel mine equipment. Collins operated the red fuel truck the day before Blackburn’s accident. (Tr. I, 106, 111). Collins testified he did not experience any problems driving the red truck down the haulage

road because he kept the truck in second low gear. (Tr. I, 111-12, 114, 118-19, 127). Collins testified that it was standard operating procedure to drive fuel trucks down steep grades in low gear. Collins primarily was concerned with the clutch on the red truck. (Tr. I, 113). If the clutch failed Collins opined that he could lose control because the brakes were weak. (Tr. I, 128-29). Although Collins characterized the brakes as weak, Collins had no difficulty stopping the FT154 on level ground. (Tr. I, 118-19, 128-29). Collins did not report any brake or clutch problems on his time sheets because he believed it was a waste of time because “[t]hey wouldn’t fix nothing.” (Tr. I, 116). Collins did not tell Coleman or a mechanic that the brakes or the clutch on the red truck needed repair. (Vol I, 117, 129). While Collins’ testimony supports the credibility of Cline and Anderson, his opinions concerning the operational condition of FT154 are not material as he admittedly did not communicate his concerns to Coleman.

#### iv. Henry Hatcher

Henry Hatcher was employed as a utility man at Lodestar’s mine. Hatcher testified that he operated the red fuel truck from September 26 through September 30, 2001. During that period he drove the fuel truck down the subject haulage road on several occasions. He downshifted in first gear when the fuel truck was fully loaded. If it was not full, he used second gear. During this period he did not experience any difficulty with the brakes. (Tr. II, 273-83).

#### v. David Carl Wright

David Carl Wright was employed by Lodestar as a grader, fueler and mechanic. On the day before the accident, Wright drove the red truck for approximately 4 hours during which time he drove down the haulage road where the accident occurred. (Tr. II, 149, 154). He was able to stop the truck without any brake problems. (Tr. II, 152).

On the morning of October 3, 2001, Wright was working as a mechanic in the parking lot area. He observed Blackburn drive the red fuel truck into the parking area where he met Mark Hamilton. Wright overheard Blackburn tell Hamilton that the clutch was slipping. Wright observed Hamilton adjust the clutch. After the adjustment, Hamilton instructed Blackburn to rev the engine while engaging the brake to determine if the clutch held. He did not hear Blackburn communicate any brake related complaints. (Tr. II, 158-60).

#### vi. Mark Hamilton

On October 3, 2001, Mark Hamilton was working as a mechanic at Lodestar’s Bent Mountain mine. At approximately 8:00 a.m., Hamilton was working in the parking area loading crib blocks in preparation for working on a truck. Blackburn drove up and said Johnny Huffman wanted Hamilton to adjust the clutch on FT154 because it was slipping. Hamilton tightened the pressure on the clutch plate to improve its contact with the disc. After Hamilton adjusted the clutch, he asked Blackburn to put the truck in gear while applying the parking brake to see if the

clutch would over-pull the brakes. The cab shook and the engine almost stalled but the clutch did not slip. (Tr. II, 243). Blackburn expressed his satisfaction with the clutch and drove away. Hamilton saw Blackburn a short time later at which time Blackburn had no complaints. Hamilton testified Blackburn did not complain about the brakes on October 3, 2001. (Tr. II, 263-68).

vii. Roger Bartley

On October 3, 2001, Roger Bartley was the day shift foreman for the "B" crew that began after Coleman's evening shift. (Tr. II, 284). At approximately 5:30 a.m. on October 3, 2001, Bartley heard Cline on the CB radio complaining about clutch problems on the red fuel truck. Cline's complaint was also overheard by Coleman. Bartley testified that Cline's complaint was limited to the clutch and that it did not concern brake problems. (Tr. II, 286-87, 289, 303). As a result of Cline's complaint, Hamilton adjusted the clutch. Bartley was present when the clutch was adjusted. Consistent with Hamilton's testimony, Bartley described how Hamilton tested the clutch by ensuring that it would not override the brake on acceleration. (Tr. II, 288-89).

Bartley testified that he was not aware of any brake complaints by Cline in the month preceding the accident. Nor did Bartley know of any other operator complaints about the red fuel truck's brakes. (Tr. II, 304).

Bartley testified that Coleman routinely gave Bartley lists of repairs that were required at the conclusion of Coleman's shift. (Tr. II, 289, 324-25). If service was required, Bartley would give the information to Huffman who would schedule the work to be done. (Tr. II, 289). Bartley also reviewed the time sheets to determine what repairs were necessary. (Tr. 368).

viii. David Coleman

David Coleman has been employed in the mining industry since 1974. He began working at the Bent Mountain Mine in January 2000. (Tr. II, 310, 313). He was foreman of the "B" crew night shift and supervised approximately 20 employees. (Tr. II, 313). Coleman usually worked from approximately 4:00 p.m. until 5:00 a.m. (Tr. II, 319). Coleman testified that he was safety conscious and that he had daily safety meetings with his crew. If equipment needed repair it was immediately removed from service. (Tr. II, 314). The red truck's brakes had been replaced in April 2001. (Tr. II, 351).

Sometime during the October 2, 2001, night shift, Coleman recalled Cline complaining about the red fuel truck's clutch slipping on the CB radio. Upon Bartley's arrival at the mine at approximately 5:00 a.m. on October 3, 2001, Coleman told Bartley that the clutch required service. (Tr. II, 322). Bartley testified he also heard Cline complain about the clutch on the CB radio. (Tr. II, 286). The clutch was adjusted by Hamilton at approximately 8:00 a.m., after Coleman had left the mine site.

During September 2001 the back-up red fuel truck was used instead of the black fuel truck which was undergoing repairs. Coleman denied that Cline had told him about brake problems during this period. (Tr. II, 325, 328, 346-47, 350). Coleman claims he initially learned of Cline's brake complaint assertion during MSHA's accident investigation. (Tr. II, 326). Coleman also could not recall Anderson complaining about the red fuel truck's brakes during September 2001. (Tr. II, 345). There is no evidence of any relevant brake problems noted on time sheets during this period by Cline, Anderson or any other red fuel truck operator.

### **III. Further Findings and Conclusions**

#### **a. Collateral Estoppel**

The Secretary contends that collateral estoppel applies to Judge Melick's May 22, 2003, Decision and Order Directing Payment for 104(d)(1) Citation No. 7378492 in the civil penalty case involving Lodestar in Docket No. KENT 2002-292. The question of collateral estoppel is moot with respect to the fact of the violation of section 77.1605(b) and the significant and substantial designation as Coleman has stipulated to these elements of the citation.

With respect to the issue of unwarrantable failure, it is clear that collateral estoppel does not apply. Identity of issue is a fundamental element that must be satisfied before collateral estoppel may be applied. Thus, "a judgement on the merits in a prior suit may preclude relitigation in a subsequent suit of any issues actually litigated and determined in the prior suit. . . ." *Bethenergy Mines, Inc.*, 14 FMSHRC 17, 26 (Jan. 1992) (citations omitted).

As an initial matter, Judge Melick's Order Directing Payment is not a judgement on the merits. Moreover, identity of issue is not present as the question of a mine operator's unwarrantable failure is markedly different from the question of whether an agent committed a "knowing" violation. An unwarrantable failure finding is based on aggravated conduct attributable to the mine operator. A knowing violation requires a showing of aggravated conduct on the part of an individual corporate agent. Surely, an unwarrantable failure finding against a company is not a determination that all agents of the mine operator are subject to personal liability.

Although Lodestar's unwarrantability has not been a subject of this litigation, the Secretary need not demonstrate unwarrantability to prevail in a 110(c) proceeding. She need only demonstrate that an underlying violation of a safety standard was committed by a mine operator, and that an agent of the operator "knowingly authorized, ordered or carried out" the violation. The cited standard requires mobile equipment to be equipped with adequate brakes. Faced with the self-evident nature of the red fuel truck's brake defects, Coleman has stipulated to the fact of the occurrence of the violation. The focus shifts to whether the violation was "knowingly" committed by Coleman.

b. Application of Statutory Provisions and Pertinent Case Law

Section 110(c) of the Mine Act provides:

Whenever a corporate operator violates a mandatory health or safety standard . . . any . . . agent of such corporation who knowingly authorized, ordered or carried out such violation . . . shall be subject to the same civil penalties [as the corporate operator] . . . .

Simply put, a “knowing” violation under section 110(c) involves aggravated conduct, not ordinary negligence. *Bethenergy*, 14 FMSHRC at 1245. Unfortunately, the indicia necessary to support a finding that a corporate agent acted “knowingly” is difficult to articulate. What is clear is that individuals charged with 110(c) liability should be judged based on their individual knowledge and actions not on the collective actions or inferred knowledge of the company.

The operative term “knowingly” has been extensively discussed by the Commission and the courts. The Commission discussed the criteria for determining if there is personal liability under section 110(c) of the Mine Act in *Lefarge Construction Materials*, 20 FMSHRC 1140 (October 1998). The Commission stated:

The proper 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 (6<sup>th</sup> 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 only that an individual knowingly acted, 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 (1971)). An individual acts knowingly where he is “in a position to protect employee safety and health [and] 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.

20 FMSHRC at 1148 (emphasis added).

Similarly, in *Roy Glen*, 6 FMSHRC 1583 (July 1984), the Commission stated:

We hold that a corporate agent in a position to protect employee safety and health has acted “knowingly” in violation of section 110(c) when, **based upon facts available to him**, he either knew or had reason to know that a violative condition or conduct would occur, but failed to take appropriate preventative steps.

6 FMSHRC at 1586 (emphasis added).

In *Freeman United Coal Mining Co. v. FMSHRC*, 108 F.3d. (D.C. Cir. 1997), the Court addressed the issue of individual knowledge:

. . . the meaning of “knowledge” depends upon context and that a continuum of meaning stretches from “constructive knowledge” to “actual knowledge” with various gradations between . . . under the Commodity Exchange Act, [an] individual “knowingly” induced a violation if he had “**actual or constructive knowledge of the core activities that constitute the violation** at issue and allowed them to continue.”

108 F.3d at 363 (emphasis added) *citing JCC v. CFTC*, 63 F.3d 1557, 1567-68 (11<sup>th</sup> Cir. 1995).

c. The Nature and Extent of Coleman’s Knowledge

As a threshold matter, given Blackburn’s fatality, and MSHA’s responsibility in determining the cause of the accident, it is not surprising that Coleman, a focus of the investigation, asserts that he cannot recall the reported brake complaints by Cline and Anderson. Without question, examination of the wreckage revealed significant defects in the condition of the service brakes that rendered them ineffective. Thus, the reported brake complaints by Cline and Anderson are corroborated by the post-accident analysis of the brake condition. Consequently, the testimony of Cline and Anderson is credible.

Resolving whether Coleman’s failure to recognize the hazardous condition of the service brakes constitutes aggravated conduct requires viewing Coleman’s conduct in context. In other words, Coleman must be judged based on whether he knew or should have known of the **core elements** (the nature and extent) of the violation **based on the facts available to him**.

Obviously, no one had actual knowledge of the specific brake defects that were disclosed by examination of the wreckage. However, a lack of actual knowledge is not a defense to 110(c) liability. *Kenny Richardson*, 3 FMSHRC at 16. As the Commission has stated, “[t]o knowingly ignore that work will be performed in violation of an applicable standard would be to reward a see-no-evil approach to mine safety . . .” *Roy Glenn*, 6 FMSHRC at 1586. Thus, the analysis shifts to whether Coleman had reason to know of the serious brake defects and whether he ignored the need for service to be performed.

Turning to the nature of Coleman’s knowledge, approximately one month prior to Blackburn’s accident, Cline told Coleman the brakes were “spongy.” Cline admits that when he complained to Coleman, he told Coleman that he had already informed Johnny Huffman, who was the vehicle maintenance supervisor, that the brakes needed service. (Tr. I, 80-83). Company policy permitted equipment operators to communicate directly with the mechanics if equipment needed service. Under such circumstances service would be performed.

Cline's testimony reflects he communicated no further brake complaints during the intervening three to four weeks prior to the accident. In fact, although he complained about the clutch the night before the accident, Cline did not express any brake concerns. Although Cline continued to operate the red fuel truck after his only brake complaint to Coleman, Cline did not report any subsequent brake complaints on his time sheets. In the absence of subsequent verbal or recorded complaints by Cline, it was not unreasonable for Coleman to conclude that the brakes had been adjusted by Huffman and that Cline's concerns had been alleviated.

Given the grades on which the vehicle traveled, Coleman's failure to confirm that the brakes had been serviced in response to Cline's complaint may constitute ordinary negligence. When viewed in context, however, Coleman's conduct was not so egregious, unjustifiable or inexcusable to warrant the conclusion that he ignored the potential hazard by adopting a see-no-evil approach. Consequently, Coleman's failure to take further action following Cline's complaint does not constitute aggravated conduct.

On or about September 15, 2001, Anderson attempted to stop on a hill and rolled backwards. Like Cline, consistent with company policy, Anderson reported the incident directly to mechanic Michael Hayden as well as to Coleman. Anderson drove the red truck without incident on the following day. Anderson did not know whether the brakes had been adjusted. Anderson subsequently drove the red truck on or about September 27, 2001, without further incident. Whether, the brakes were adjusted after Anderson's complaint is unclear. What is known is that Anderson did not communicate any additional relevant brake complaints after September 15, 2001. Moreover, time sheets reflect the red FT154 fuel truck was operated by Anderson for ten hours and Cline for two hours on September 15, 2001. Neither Anderson nor Cline noted any brake complaints on their time sheet. (Gov. Ex. 47). In the absence of subsequent complaints by Anderson or Cline evidencing continuing brake concerns, Coleman's failure to contact Hayden following Anderson's complaint to determine if the brakes were serviced does not constitute a reckless disregard of the potential hazard and does not otherwise evidence aggravated conduct.

Thus, without Coleman having the benefit of hindsight, the Secretary has failed to demonstrate that Coleman's failure to act was based on "self-induced ignorance" or a "blind acquiescence" in the face of apparent unsafe working conditions. *Roy Glenn*, 6 FMSHRC at 1587. Consequently, on balance, the Secretary has not shown that Coleman "knowingly authorized, ordered or carried out" a violation of section 77.1605(b) because the red fuel truck was not equipped with adequate brakes. Thus, the 110(c) case against David Coleman shall be dismissed.

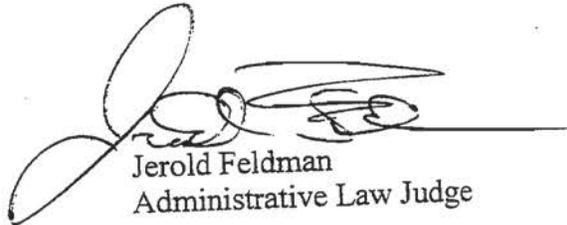
As a final matter, as previously noted, 110(c) liability should be judged based on an individual's knowledge and actions not on the collective actions of the mine operator. While the issue of unwarrantable failure goes beyond the scope of this proceeding, the Secretary fails to recognize the distinction between a mine operator's unwarrantable failure and the aggravated conduct necessary to impose personal liability. Surely, an unwarrantable failure determination is

not a finding that all agents of the mine operator are subject to 110(c) personal liability. Coleman was a foreman not a supervisory mechanic. Yet the Secretary submits that both “Lodestar and Coleman had a duty to perform periodic and regular inspections on the red fuel truck . . .” (Sec’y Br. at 35). The evidence fails to support the Secretary’s claim that Coleman was responsible for implementing or carrying out Lodestar’s service maintenance program. Nor has Coleman been charged with a failure to maintain mobile equipment. Rather, the case against Coleman concerns a lack of adequate brakes. As noted, Coleman’s failure to recognize the inadequacy of the brakes does not constitute a “knowing” violation of section 77.1605(b).

**ORDER**

The Secretary’s motion to dismiss the case brought pursuant to section 110(c) of the Mine Act against Charles Clevinger **IS GRANTED**. Accordingly, **IT IS ORDERED** that Docket No. KENT 2003-274 **IS DISMISSED**.

Consistent with the above discussion, the Secretary has failed to demonstrate that David Coleman knowingly authorized, ordered or carried out a violation of section 77.1605(b). Consequently, **IT IS FURTHER ORDERED** that Docket No. KENT 2003-275 **IS DISMISSED**.

  
Jerold Feldman  
Administrative Law Judge

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**FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION**

601 New Jersey Avenue, N.W., Suite 9500

Washington, D.C. 20001-2021

Fax No.: (202) 434-9949

June 4, 2004

SECRETARY OF LABOR,	:	CIVIL PENALTY PROCEEDING
MINE SAFETY AND HEALTH	:	
ADMINISTRATION (MSHA),	:	Docket No. WEST 2003-392-M
Petitioner	:	A. C. No. 45-03338-04297
v.	:	
	:	
PALMER COKING COAL COMPANY,	:	Mine: Morgan Kame Terrace
Respondent	:	

**DECISION**

Appearances: John D. Pereza, Conference and Litigation Representative, Office of the Solicitor, MSHA, U S. Department of Labor, Vacaville, California  
Bruce L. Brown, Esq., Office of the Solicitor, U. S. Department of Labor, Seattle, Washington  
William Kombol, Manager, Palmer Coking Coal Company, Black Diamond, Washington, for Respondent

Before: Judge Barbour

This case is before me on a petition for assessment of civil penalty filed by the Secretary of Labor (Secretary) on behalf of her Mine Safety and Health Administration (MSHA) against Palmer Coking Coal Company (Palmer), pursuant to sections 105 and 110 of the Federal Mine Safety and Health Act of 1977 (30 U.S.C. §§ 815, 820) (Mine Act or Act). The Secretary seeks the assessment for an alleged violation of 30 C.F.R. § 56.11027, a mandatory safety standard for surface metal and nonmetal mines, that requires, inter alia, that working platforms be provided with handrails.<sup>1</sup> The violation allegedly occurred at the Morgan Kame facility of Palmer Coking

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<sup>1</sup> Section 57.11027 states:

Scaffolds and working platforms shall be of substantial construction and provided with handrails and maintained in good condition. Floorboards shall be laid properly and the scaffolds and working platform shall not be overloaded. Working platforms shall be provided with toeboards when necessary.

Coal Co. (Palmer), a facility where sand and rock are processed. A hearing was held in Tacoma, Washington.

### **THE EVIDENCE AND FACTS**

Ronald Jacobsen, who testified on behalf of the Secretary, is an MSHA inspector who has been employed by the agency for approximately three years. Prior to joining MSHA, Jacobsen worked for 12 years in the mining industry, primarily in sand and gravel operations (Tr. 11-12). Jacobsen identified a legal identity report Palmer filed on December 7, 2000 (Gov. Exh. P-1). In the report, Palmer described itself as a partnership. William Kombol, who represented Palmer at the hearing and who testified on the company's behalf, was listed as the company's manager (Gov. Exh. P-1). Jacobsen also identified Palmer's Employment and Incident Rate Information Report (Gov. Exh. P-2). The report was generated from Palmer's quarterly reports (Tr. 13). The report showed that in 2003, Palmer had an average of eight employees, who worked a total of 3,678 hours. Further, Jacobsen identified a printed copy of Palmer's web page (Gov. Exh. P-4). The page stated in part:

“Palmer is a producer, supplier, and retailer of a wide selection of sand, gravel, topsoil, . . . red cinder, lava rock and other construction and landscaping products. All . . . products are sold either picked up or delivered. Palmer serves both commercial dump trucks and trailers and the small pick-up trade.”

(Gov. Exh. 4a).

Jacobsen believed the Morgan Kame facility was subject to the Mine Act. He noted that Palmer “dig[s] minerals [i.e., sand and rock] from the ground and . . . [sizes] them with a screening and crushing operation” and, therefore, is “considered a mining operation” (Tr. 14, see also Tr. 45). He also stated that some aggregate produced at the operation is used as a base for private and state roads (Id.). Further, at Morgan Kame, front end loaders fill trucks with processed material, and Jacobsen believed some of the equipment was manufactured by Caterpillar (Tr. 17, 45; see also Tr. 50).

On May 20, 2003, Jacobsen inspected the facility. The inspection included an examination of the facility's rock crusher. There was a metal work platform around the cone of the crusher. A ladder lead from the ground to the platform. Employees accessed the platform by climbing the ladder, grabbing the handrails and stepping onto the platform's metal deck (Tr. 24). Jacobsen observed that all of the platform was surrounded by a railing, except the area where the ladder met the platform. At that point, there was a gap (Tr. 18, 32).<sup>2</sup> Jacobsen explained that most other such platforms have a gate at the top of the ladder. An employee can swing open the

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<sup>2</sup> The railing around the platform was between 36 and 48 feet long. The gap was 3 feet long (Tr. 32, 19).

gate to access the platform and swing it shut after stepping onto the work area (Tr. 25). When the gate is swung shut, it “totally encloses” the platform (Id.)

Through discussions with a company employee, Jacobsen determined that a miner must use the platform at least twice a week to tighten the cone on the crusher and to grease the conveyors that dump into the crusher. The cone requires tightening because, as crushing continues, wear loosens it. Tightening allows the crusher to produce material of a uniform size (Tr. 19-20).

The cone was about three feet from the opening (Tr. 21). When an employee tightened it, the employee would use a large tool – a four-foot pipe wrench. The procedure required the employee to come close to the opening (Tr. 18-19; Gov. Exh. 7). If the employee were to fall through the opening, he or she would drop between 2 feet and 6 feet, depending on the direction of the fall (Id.; Tr. 23). Jacobsen testified that at the time of the inspection, there were loose rocks on the platform, making a slip or a fall more likely (Id., 43; Gov. Exh. 8). Jacobsen also noted that it frequently rained in the area and that a wet deck enhanced the likelihood of a slip and fall (Tr. 22).<sup>3</sup> Based on what he saw and was told, Jacobsen concluded that a handrail was required around the entire platform and that the gap violated section 56.11027 (Tr. 18-19).

Kombol, on the other hand, testified that the employee who designed the platform for Palmer did not believe a railing was required at the top of the ladder because employees would have to have climb over or under it to get to work (Tr. 55, 57). He stated, “[T]he person who constructed . . . [the platform] . . . didn’t realize . . . you have to have a handrail on a passageway” (Tr. 55).

Jacobsen believed as mining activities continued, it was reasonably likely a serious accident would occur. He reiterated that miners regularly used the platform as a work station, that some of their tools were large and that their use brought the miners near the opening. The miners could slip and fall, and if the platform was wet and there was mud on the miners’ shoes, the likelihood of a slip or fall was even greater (Tr. 26-27). In addition, during major repair work, discarded crusher parts, e.g., nuts and bolts and other parts, might be lying on the platform and these, too, could cause a slip or a fall (Tr. 28). If a miner were to fall two feet, a sprain or broken bones was likely. If a miner were to fall six feet, the fall could be fatal (Tr. 27, 37).

For Kombol, it was a “stretch” to think a fall of six feet was likely (Tr. 54). Rather, if a miner were to fall through the gap, he or she would fall two feet at most (Id.; see Resp. Exh. 7).

In Jacobsen’s view, the company was moderately negligent (Tr. 29). The condition was not brought to the attention of management by the crusher operator who conducted the workplace

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<sup>3</sup> Jacobsen stated that the leading causes of injury in metal and nonmetal surface mines are slips and falls. In fiscal 2003, there were 18 such injuries in the State of Washington (Tr. 22).

examination, and the platform was newly installed (Id., Tr. 31).

Kombol stated he had not seen the gap prior to Jacobsen's inspection, but, if he had, he "would not have thought the first thing about it" (Tr. 66). It seemed logical to leave open the passageway to the platform (see Tr. 67).

The condition was corrected when mine management installed a chain across the opening (Tr. 30). According to Jacobsen, a chain was used because, when hooked, it could prevent a fall and because it could be unhooked easily to provide access to the platform (Tr. 47-48). Jacobsen viewed the chain as equivalent to a handrail (Tr. 48).

### **STIPULATIONS**

The parties jointly stipulated as follows:

1. Ron Jacobsen was acting in his official capacity as an authorized representative of the Secretary . . . when he issued [C]itation [N]umber 6350614 . . . and the citation was properly served upon an agent of [Palmer].

2. The violation was promptly abated.

3. Payment of the proposed penalty will not affect . . . [Palmer's] ability to continue in business.

4. [Palmer's] mine size is small, and . . . the employment hours documented in Exhibit A of the Petition . . . are correct.

5. [Palmer's] history of violations as documented in Exhibit A of the Petition . . . is correct.<sup>4</sup>

Joint Exh. 1; Tr. 7.

### **JURISDICTION**

After the Secretary's witness testified, Kombol moved to dismiss on the basis the Secretary had not proven Palmer engaged in interstate commerce. I denied the motion, primarily on the basis of Jacobsen's unrefuted testimony that the material produced at the facility was used to build state roads. Such roads facilitate the transportation of interstate goods and services, and being engaged in the building of state roads by producing materials for their construction qualifies as interstate commerce (Tr. 51-52). I also note that Kombol confirmed Palmer's

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<sup>4</sup> Exhibit A indicates 12 violations in the two years preceding the alleged violation, a history the Secretary's representative termed, "not . . . excessive" (Tr. 63).

ownership and use of Caterpillar equipment and I take judicial notice of the fact that Caterpillar equipment is manufactured in Illinois.

### **THE VIOLATION**

Section 57.11027 states that “working platforms shall be . . . provided with handrails.” Jacobsen and Kombol agreed the crusher platform was used by miners working at the crusher and by miners servicing it and the conveyor belts. Thus, the crusher platform was a “working platform” within the meaning of the standard.

In addition, Jacobsen and Kombol agreed that the handrail surrounding the platform contained a gap of approximately 36 inches where the ladder accessed the platform. Therefore, all of the platform was not provided with a handrail as required by the standard, and the violation existed as charged.

### **S&S AND GRAVITY**

Although Jacobsen found the violation was a significant and substantial contribution to a mine safety hazard (S&S), I do not agree. The only way one could have fallen from the platform was through the 36-inch gap. The total perimeter of the platform measured between 36 and 48 feet (Tr. 32). The gap represented only about 7% or 8% of the area that required protection. The limited nature of the opening reduced the chance a miner would fall through it to the point where it was not reasonably likely.

Despite the fact the violation was not S&S, it was serious. I credit Jacobsen’s testimony that the leading causes of injury in metal and nonmetal surface mines are slips and falls (Tr. 22). I also credit his testimony that at the time he observed the violation, the work platform was littered with rock, making it easier for a miner to slip and fall. If a miner in fact were to fall through the opening, he or she would fall between two feet and six feet, and, no matter which distance the miner fell, contusions, sprains, or broken bones could result.

### **NEGLIGENCE**

The violation was due to the operator’s moderate negligence. Kombol testified he did not know of the gap (Tr. 66), and Jacobsen testified he was told that the miner who performed the on-shift examination of the platform did not report the gap to mine management (Tr. 66, 29). While these factors are to some extent exculpatory, the fact remains that the gap was visually obvious. A reasonably prudent operator should have been aware that the entire perimeter of the platform had to be protected, even the space through which access was provided. In other words, the condition should have been known to management and should have been corrected.

### OTHER CIVIL PENALTY CRITERIA

The parties stipulated the violation was promptly abated, that payment of the proposed penalty would not affect the company's ability to continue in business and that Palmer is a small operator (Joint Exh.1; Tr. 7). Further, in the two years preceding the subject violation, Palmer was cited for 12 violations, a relatively small history (Tr. 63).

### ASSESSMENT OF PENALTY AND ORDER

Based on the foregoing findings and conclusions, and taking into account the statutory civil penalty criteria as required by section 110(i) of the Act (30 U.S.C. §820(i)), I assess a civil penalty of \$60 for the violation of section 57.11027. Palmer **SHALL PAY** the civil penalty within 30 days of the date of this decision. Within the same 30 days the Secretary **SHALL MODIFY** Citation No. 6350614 by deleting the S&S finding. Upon payment of the penalty and modification of the citation, this proceeding is **DISMISSED**.



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

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**FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION**  
601 New Jersey Avenue, N.W., Suite 9500  
Washington, D.C. 20001-2021  
Fax No.: (202) 434-9949

June 4, 2004

MICHAEL MILLER,	:	DISCRIMINATION PROCEEDING
Complainant	:	
	:	Docket No. CENT 2003-307-D
v.	:	DENV CD 2003-9
	:	
TXU MINING CO., LP,	:	Mine ID 41-02632
Respondent	:	Beckville Strip

**DECISION**

Appearances: Alan J. Marcuis, Esq., Hunton & Williams, LLP, Dallas, Texas, for Respondent  
Michael E. Miller, Beckville, Texas, Complainant

Before: Judge Barbour

This case is before me on a complaint of discrimination filed by Michael Miller pursuant to section 105(c)(3) of the Federal Mine Safety and Health Act of 1977 ("the Act"), 30 U.S.C. § 815(c) (3).<sup>1</sup> Miller alleges that TXU Mining Co., LP., ("TXU") discriminated against him by terminating him for disciplinary reasons on December 5, 2002, as a result of his complaints about safety. A hearing was held in Carthage, Texas. For the reasons set forth below, I find that the Respondent did not discriminate against Miller, and dismiss the complaint.

**FINDINGS OF FACT**

Miller was employed as a mechanic by TXU at its Tatum Mine, a coal mine located in Tatum, Texas. He had worked for TXU for several years, and during that time had allegedly been harassed by management. Specifically, in 1997, while working at TXU's Beckville Mine, Miller was allegedly harassed by Don Johnson, a supervisor, and Dennis Watkins, a Human Resources representative. After this incident, Miller was transferred to the Tatum Mine. He attempted to file a complaint reporting the incident, but TXU refused to accept this complaint. Miller then began to compile a report to file with MSHA on the harassment issue believing the Agency had

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<sup>1</sup> Pursuant to section 105(c)(2) of the Act, a miner may submit a complaint of discrimination to the Secretary of Labor, who must conduct an investigation and file a complaint with the Commission if she determines that the Act has been violated. Section 105(c)(3) provides that, if the Secretary determines that the Act has not been violated, the miner may file an action before the Commission on his own behalf. 30 U.S.C. § 815(c)(2) and (3).

jurisdiction. He was fired before he lodged the report. Tr. 18.

On November 6, 2002, Miller made a presentation on the alleged mistreatment that occurred at the Beckville Mine during a Career Development Meeting. Tr. 33. During this presentation he discussed the impact harassment by managers had on employees. Tr. 35. He spoke specifically about his experience at the Beckville Mine, and gave his suggestions on how to handle these situations. Tr. 35. Miller also named three supervisors, all of whom were present, he believed had a problem with harassing employees. The supervisors were Jerry Poland, Gibson, and Cooper.

On December 4, 2002, a monthly safety meeting was held at the Tatum mine. Tr. 59. During this meeting, Miller and the members of his crew were shown a safety video, which included scenes of violence in the workplace. Once the video ended, the foreman invited comments. At this time Miller stood to address those present. Miller believed that TXU mishandled employees with anger management problems and had not taken the proper actions in situations where employees had been harassed. It was Miller's opinion that both of these issues would lead to workplace violence, and thus cause an unsafe working condition. Specifically, Miller used his own situation as an example. He described how he believed managers had mistreated and belittled him. In discussing what he believed was a potential safety issue, Miller used abusive language and profanities to describe the two managers about which he had complained and directed other profanities at fellow employees.<sup>2</sup> That afternoon, Miller met with his direct supervisor Stanley Berry to discuss what he said during the safety meeting. Berry stated he would have to notify his direct supervisor Jerry Poland because Miller had used inappropriate language. Tr. 179. Upon finishing his shift, Miller met with Berry and Poland. At this time, Poland informed Miller that there would be an investigation of the incident, which could possibly lead to disciplinary action.

On December 5, 2002, Berry and Poland questioned members of Miller's crew who were present at the meeting the previous day. Tr. 184-85. The employees confirmed that Miller had used abusive language and profanities directed towards management and co-workers. Tr. 185. Also, they voiced their concerns about working with Miller. Some were unsure how to act around Miller, and believed he needed professional help. The group were most worried about what would set-off his next outburst. Next, Berry and Poland met with other members of management to discuss the issue further. The company discipline policy provided for a four-step process: an oral warning, a written warning, a final warning and termination. Tr. 188. However, under certain circumstances, if the violation is severe enough, the company can by-pass steps and terminate employment immediately. The group decided to terminate Miller because he violated both the

---

<sup>2</sup> Miller referred to Johnson and Watkins as "stupid son of a b\*\*\*\*"; "g\*\* d\*\* stupid b\*\*\*\*\*"; sorry mother f\*\*\*." Tr. 172.

Company's code of conduct and employee handbook, and had a prior history of similar acts.<sup>3</sup> Tr. 185.

On May 13, 2003, Miller filed a complaint of discrimination with the Secretary's Mine Safety and Health Administration ("MSHA"), alleging that he had been discriminated against when he was terminated on December 5, 2002. He stated in his complaint that his termination was in retaliation for trying to complain about a safety concern. Miller believed that TXU mishandled employees with anger management problems and situations where employees had been harassed. It was his opinion that both of these issues could lead to workplace violence causing an unsafe working condition. MSHA concluded, on behalf of the Secretary, that no discrimination had occurred, and declined to file a complaint on Miller's behalf. On August 13, 2003, Miller then filed the instant complaint with the Commission.<sup>4</sup>

### THE LAW

A complainant alleging discrimination under the Act typically establishes a *prima facie* case by presenting evidence sufficient to support a conclusion that he engaged in protected activity and suffered adverse action motivated in any part by that activity. See *Driessen v. Nevada Goldfields, Inc.*, 20 FMSHRC 324, 328 (Apr. 1998); *Sec'y of Labor on behalf of Pasula v. Consolidation Coal Co.*, 2 FMSHRC 2786, 2799 (Oct. 1980), *rev'd on other grounds sub nom. Consolidation Coal Co. v. Marshall*, 663 F.2d 1211 (3d Cir. 1981); *Sec'y of Labor on behalf of Robinette v. United Castle Coal Co.*, 3 FMSHRC 803, 817-18 (Apr. 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 way motivated by protected activity. See *Robinette*, 3 FMSHRC at 818; n. 20. 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 817-18; *Pasula*, 2 FMSHRC at 2799-800; see also *Eastern Assoc. Coal Corp. v. FMSHRC*, 813 F.2d 639, 642-43 (4th Cir. 1987) (applying *Pasula-Robinette* test).

While the operator must bear the burden of persuasion on its affirmative defense, the ultimate burden of persuasion remains with the complainant. *Pasula*, 2 FMSHRC at 2800; *Schulte v. Lizza*, 6 FMSHRC 8, 16 (Jan. 1984).

---

<sup>3</sup> In 1994, Miller was placed in step one of the disciplinary process. In 1997, he was placed in step two. Both incidents involved threats, abusive language, and disrupting meetings. Tr. 189.

<sup>4</sup> The Act mandates that such claims must be filed within 60 days of termination. Miller's complaint was filed well after the lapse of this deadline. In view of the fact that he was representing himself and the lack of demonstrative prejudice to the Respondent, I was reluctant to strictly apply the time-limit and allowed the complaint to be heard. Tr. 12.

### PRIMA FACIE CASE

There is no dispute that Miller suffered an adverse action. Therefore, the principle issue is whether the activity resulting in the action was protected. For the reasons that follow, I find that it was not.

Section 105(c)(1) of the Act prohibits discrimination against any miner who complains to an operator or its agent about "an alleged danger or safety or health violation." 30 U.S.C. § 815(c)(1). Miller testified that he was terminated for reporting a safety violation. Tr. 15. He believed that when an employee is harassed by management or co-workers, hostility is created leading to a potentially violent situation. This possible violence is the unsafe working condition about which Miller was concerned. Miller was speaking from his own experience which, in his view, exemplified "how not to handle an employee." Tr. 39. Miller attempted to notify management of this potential problem during his November 6, 2002, presentation. He was also in the process of compiling a report to document the harassment he allegedly was subject to at the Beckville mine. Miller's final attempt to bring attention to this issue was at the safety meeting held on December 4, 2002.

The supervisors who terminated Miller testified that at no time during these attempts did he mention conventional safety concerns. Tr. 227-28. Both Poland and Berry stated that Miller never brought up traditional unsafe working conditions during the safety meeting or in their meetings with Miller just prior to his termination. Tr. 173, 181, 210. Rather, it was their believe that Miller was complaining about the way he was treated by Johnson and Watkins. Tr. 173.

From the record it is clear that the essence of Miller's discrimination complaint is that the company's failure to properly handle his and others employee harassment issues could cause anger induced violence in the workplace, and violence is a safety hazard. While the complaint is novel, it is not grounded on an alleged violation of a health or safety standard or on a hazardous mining-related condition or practice existing in the mine environment. Rather, it relates to what best is described as an unacceptable, unreasonable and idiosyncratic reaction to a personnel complaint. As such, it falls outside the penumbra of the Act, which is primarily concerned with conditions present in a mine that pose a threat to miners' physical health and well-being. Miller's attempt to equate irrational work place violence triggered by a personnel matter with protected activity is too attenuated to come within the statute. For this reason alone, Miller's complaint must be dismissed.

### AFFIRMATIVE DEFENSE

Even if Miller were found to have engaged in protected activity, and thus to have established a prima facie case, I find the TXU defended affirmatively by proving that it was motivated by Miller's unprotected activity and would have dismissed Miller for the unprotected activity alone. The supervisors who terminated Miller - Berry, Johnson and Ralph Dick - credibly testified that their decision was based solely on the events of December 4, 2002, Tr. 227-28, and that Miller was terminated because he used "very abusive and profane language" toward

managers and co-workers during the comment portion of the monthly safety meeting. Tr. 172. Stanley Berry testified that TXU has a four-step discipline policy which culminated in termination, but under special circumstances termination can be used immediately. Tr. 188. The group concluded it would use immediate termination because Miller not only violated both the TXU's code of conduct and employee handbook, but also had a prior history of similar acts. Tr. 185.

It is clear from the evidence and the testimony that the company regarded Miller's profane and irrational outburst of December 4 as not only violative of the company's profanity and abusive language policy but also as a harbinger of other possible irrational behavior. The latter concern was not unreasonable, for it is also clear that some of Miller's co-workers were wary of him. Tr. 185-188. TXU thus had lawful business justifications for terminating Miller's employment and did not formulate a mere pretext to mask an unlawful motive.

### ORDER

For the reasons stated above, I find that Miller did not engage in protected activity and therefore did not establish a prima facie case. I further find that even if Miller engaged in protected activity, T.X.U.'s decision to terminate him was based solely upon legitimate business considerations and did not violate the Act. Accordingly, the Discrimination Complaint is DISMISSED.



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

Distribution: (Certified)

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FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION  
OFFICE OF ADMINISTRATIVE LAW JUDGES  
601 New Jersey Avenue, N.W. Suite 9500  
Washington, DC 20001-2021

June 8, 2004

SECRETARY OF LABOR, : CIVIL PENALTY PROCEEDING  
MINE SAFETY AND HEALTH :  
ADMINISTRATION (MSHA), : Docket No. KENT 2004-34  
Petitioner : A.C. No. 15-07201-10885  
v. :  
: :  
: :  
HARLAN CUMBERLAND COAL CO, :  
Respondent. : Mine: C-2

**DECISION**

Appearances: Michael Finney, CLR, U.S. Department of Labor, MSHA, Madisonville, KY, and  
Ronnie Brock, CLR, U.S. Department of Labor, MSHA, Barbourville, KY, and  
Marybeth Bernui, Esq., U.S. Department of Labor, Office of the Solicitor,  
Nashville, TN, for the Secretary;  
H. Kent Hendrickson, Esq., Rice & Hendrickson, Harlan, KY, for the Respondent.

Before: Judge Avram Weisberger

**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") seeking the imposition of a civil penalty against Harlan Cumberland Coal Company, ("Harlan Cumberland"), based on the latter's alleged violation of certain mandatory safety standards, set forth in Title 30, Code of Federal Regulations. A hearing was held in Knoxville, Tennessee, on May 5, 2004. At the close of the hearing, after the parties presented oral arguments, a bench decision was issued, which, aside from correction of matters not of substance is set forth below:

1. Citation No. 7538234

Citation No. 7538234 alleges a violation of 30 C.F.R. §75.400, which provides that '[c]oal dust, including float coal dust deposited on rock-dusted surfaces, loose coal, and other combustible materials, shall be cleaned up and not be permitted to accumulate in active workings or on diesel-powered and electric equipment therein.'

The inspector testified that he observed a spillage 'pretty much' along the entire 4,000 length of the belt; and that the accumulation was black in color, which indicated the presence of float coal dust. He also observed that loose coal was six inches deep, and extended the entire length of the belt, from the head to

the tail, with the exception of approximately 100 feet that had been cleaned. This testimony was not contradicted by Respondent's witness, nor was it impeached.

Respondent argues that inasmuch as 30 C.F.R. §75.400-1(a) and (b), define coal dust and float coal dust as particles of coal that can pass through a 20 sieve and 200 sieve, respectively, since the inspector conceded that he did not pass the accumulations through a sieve he thus did not establish the presence of float or coal dust.

I do not find the inspector's failure to pass the items through a sieve as being fatal to establishing a violation. In *Old Ben*, 1 FMSHRC, 1954, 1956, December 12, 1979, the Commission analyzed the purpose of Section 304(a) of the 1969 Act, whose language is repeated in Section 75.400, supra. The Commission held, that the legislative history and purposes of the Act "... point to a holding that the standard is violated when an accumulation of combustible materials exists." Thus, I find that Section 75.400 near does not require that the accumulated materials be passed through a sieve to establish a violation of that Section.

Respondent further argues that the inspector did not conduct any study with regard to the amount of combustible material present. Section 75.400, supra, does not require, to establish a violation, that the presence of a specific percentage of combustible material be set forth in order to establish a violation. It merely provides that any combustible material, including loose coal dust, shall be cleaned up.

Based upon the inspector's testimony regarding the accumulations of coal and their extent, I find that Section 75.400 supra, was violated.

I take cognizance of the holding of the Commission *Mathies Coal Co.*, 6 FMSHRC 1, January 1984, that for a violation to be considered significant and substantial, the Secretary must establish the following elements: an underlying violation of a safety standard, a discreet safety hazard contributed to by the violation, a reasonable likelihood that the hazard contributed to would result in an injury, and a reasonable likelihood that the injury in question would be of a reasonably serious nature. I have already found that there was a violation of a mandatory safety hazard. The inspector testified, with regard to the second element, that should the belt catch on fire, the accumulations would lead to production of a smoke, which he said was extremely hazardous. This testimony was not contradicted, and it was not specifically impeached. I find that the second element has been met.

With regard to the third element, the Secretary must establish that it was

reasonably likely for a fire to have occurred. In this connection, the inspector testified that there was oxygen present, that there was loose coal present which was combustible, that the belt runs 8 to 12 hours a day, and that because sixty rollers were stuck in coal, movement of the belt across these rollers would lead to friction, which could cause bearings to heat up leading to a fire. However, I find it significant that there wasn't any evidence adduced that any of the rollers were hot or warm to the touch. Nor was any testimony that any of them appeared to be red, which would indicate they were hot.

The inspector indicated that he had been told by other inspectors that stuck rollers have caused fires. Not much weight is accorded this hearsay testimony. There were no specifics referred to in this testimony. There is an absence of evidence that the specific conditions herein, that the inspector testified to, have led to mine fires at other mines.

Therefore, I find that the Secretary has not established the third element of *Mathies*, supra, i.e., that there was a reasonable likelihood that the accumulations present would have contributed to an injury-producing event, in this case, a fire.

Regarding a penalty, I find that Respondent's negligence was of a moderate degree, as the record indicated that Respondent had started to clean the accumulations and had, in fact, cleaned 100 feet. The gravity of the violation was moderately high, as it could have caused injuries due to smoke inhalation. Taking into account the remaining factors set forth in Section 110(i) of the Act as stipulated to, I find a penalty of \$100.00 is appropriate.

2. Citation No. 7538233

Citation No. 7538233 alleges a violation of 30 C.F.R. § 1722(b), which provides that guards at conveyor head pulleys "... shall extend a distance sufficient to prevent a person from reaching behind the guard and becoming caught between the belt and the pulley."

The inspector testified that, regarding the Number 3 belt, there was a section of guarding missing at the head roller exposing an eight-foot section along the walk-side of the belt. He opined that without the guard a miner in the area could get caught in the roller. He said that anybody cleaning would be within an arm's length of the roller. This testimony, in essence, was not contradicted or impeached. Based on this testimony, I find that Respondent did violate Section 1722, supra.

With regard to the significant and substantial aspect of the violation, the inspector testified that because the belt examiner who had been cleaning the area

was wearing loose clothing, it was reasonably likely that he would have gotten caught in the unguarded pulley. However, the belt was not in operation at the time, and was not in operation when it was cited. There was not any evidence adduced setting forth the spatial relationship between a miner cleaning in the area, and the location of any hazardous parts that were unguarded. Under these conditions, I find that the third element set forth in *Mathies, supra*, has not been established. Thus, I find that the violation was not significant and substantial.

With regard to a penalty, the inspector testified that should an injury have occurred as a result of the violation, in all likelihood it would have been in the nature of broken limbs or possibly a fatality. Based upon this testimony, which was not contradicted or impeached, I find that the level of gravity was moderately high. Respondent's witness, Ray Alred, testified, regarding negligence, that it is necessary to remove the guard in order to shovel coal dust, and that the belt was off when this was done. This testimony was not contradicted. Indeed, the inspector testified that the belt examiner told him that he had removed the guard in order to clean, and had forgotten to put in back. Within this context, I find Respondent's negligence moderately high. Considering the remaining factors set forth in Section 110(i) of the Act, as stipulated to by the parties, I find that a penalty of \$100.00 is appropriate.

3. Citation No. 7538235

At the conclusion of the hearing, the Secretary made a motion to approve a settlement agreement entered into by the parties regarding Citation No. 7538235. A reduction in penalty from \$153.00 to \$60.00 is proposed. I have considered the representations, testimony, and documentation submitted regarding this citation, and I conclude that the proffered settlement is appropriate under the criteria set forth in Section 110(i) of the Act.

Order

It is **Ordered** that Respondent pay a total civil penalty of **\$260.00** within 30 days of this Decision.

  
Avram Weisberger  
Administrative Law Judge

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FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

601 New Jersey Avenue, N.W., Suite 9500

Washington, D.C. 20001-2021

Fax No.: (202) 434-9949

June 15, 2004

SECRETARY OF LABOR	:	CIVIL PENALTY PROCEEDINGS
MINE SAFETY AND HEALTH	:	
ADMINISTRATION, (MSHA)	:	Docket No. WEVA 2002-138
Petitioner	:	A.C. No. 46-08603-03527
	:	
v.	:	Docket No. WEVA 2002-144
	:	A.C. No. 46-08603-03528
INDEPENDENCE COAL CO., INC.,	:	
Respondent	:	Cedar Grove Mine
	:	
SECRETARY OF LABOR	:	CIVIL PENALTY PROCEEDING
MINE SAFETY AND HEALTH	:	
ADMINISTRATION, (MSHA)	:	Docket No. WEVA 2003-188
Petitioner	:	A.C. No. 46-08603-03529 A
	:	
v.	:	
	:	
FREDDY TERRAL, employed by	:	
INDEPENDENCE COAL CO., INC.,	:	Cedar Grove Mine
Respondent	:	
	:	
SECRETARY OF LABOR	:	CIVIL PENALTY PROCEEDING
MINE SAFETY AND HEALTH	:	
ADMINISTRATION, (MSHA)	:	Docket No. WEVA 2003-189
Petitioner	:	A.C. No. 46-08603-03530 A
	:	
v.	:	
	:	
BRUCE GILMOUR, employed by	:	
INDEPENDENCE COAL CO., INC.,	:	Cedar Grove Mine
Respondent	:	
	:	
INDEPENDENCE COAL CO., INC.,	:	CONTEST PROCEEDINGS
Contestant	:	
	:	Docket No. WEVA 2002-27-R
	:	Citation No. 7205804; 8/27/2001
	:	
v.	:	Docket No. WEVA 2002-28-R
	:	Order No. 7205805; 8/2715/2001

SECRETARY OF LABOR,	:	
MINE SAFETY AND HEALTH	:	Docket No. WEVA 2002-29-R
ADMINISTRATION (MSHA),	:	Order No. 7205806; 8/27/2001
Respondent	:	
	:	Docket No. WEVA 2002-30-R
	:	Order No. 7205807; 8/27/2001
	:	
	:	Docket No. WEVA 2002-31-R
	:	Order No. 7205808; 8/27/2001
	:	
	:	Docket No. WEVA 2002-5-R
	:	Order No. 7205802; 8/28/2001
	:	
	:	Docket No. WEVA 2002-6-R
	:	Citation No. 7205803; 8/28/2001
	:	
	:	Cedar Grove Mine No. 1
	:	Mine ID 46-08603

**DECISION**

Appearances: Robert S. Wilson, Esq., and Francine A. Serafin, Esq., Office of the Solicitor, U.S. Department of Labor, Arlington, Virginia, for the Secretary of Labor; David J. Hardy, Esq., Spilman Thomas & Battle, PLLC, Charleston, West Virginia, for Independence Coal Co., Inc.; Robert B. Allen, Esq., Allen Guthrie McHugh & Thomas, PLLC, Charleston, West Virginia, for Freddy Terral and Bruce Gilmour.

Before: Judge Hodgdon

These consolidated cases are before me on Notices of Contest and Petitions for Assessment of Civil Penalty brought by Independence Coal Co., Inc., against the Secretary of Labor, and by the Secretary of Labor, acting through her Mine Safety and Health Administration (MSHA), against Independence Coal and Freddy Terral and Bruce Gilmour, both employees of Independence, pursuant to sections 105 and 110(c) of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. §§ 815 and 820(c). The company contests the issuance of Order No. 7205802, an “imminent danger” order under section 107(a) of the Act, 30 U.S.C. § 817(a), and two citations and four orders alleging violations of the Secretary’s mandatory health and safety standards. The petitions allege six violations of the Secretary’s mandatory health and safety standards by Independence Coal and three violations each by Terral and Gilmour. The Secretary seeks penalties of \$284,500.00 against Independence Coal and \$1,500.00 each against Terral and Gilmour. A hearing was held in Charleston, West Virginia. For the reasons set forth below, I dismiss Docket Nos. WEVA 2003-188 and WEVA 2003-189, dismiss three of the contest

dockets, modify four citations and assess a penalty of \$34,750.00.

### Settled and Dismissed Matters

At the beginning of the hearing, the parties announced that they had settled Citation No. 7205803 in Docket No. WEVA 2002-144. The agreement, which I approved, provides that the negligence alleged will be reduced from “high” to “moderate” and that Independence Coal will pay a penalty of \$4,750.00. (Tr. I. 8-9.)<sup>1</sup> The terms of the agreement will be carried out in the order at the end of this decision.

Also, at the start of the hearing, counsel for the Secretary moved to dismiss the 110(c) charge with respect to Order No. 7205807 against Freddy Terral and the 110(c) charge with respect to Order No. 7205808 against Bruce Gilmour. The motions were granted without objection, (Tr. I. 13-14), and will be carried out in the order at the end of this decision.

On May 21, 2004, counsel for Independence Coal moved to withdraw its Notice of Contest in Docket No. WEVA 2002-5-R contesting the issuance of Order No. 7205802, the “imminent danger” order. Noting that that order was included in the citation modified and settled in Docket No. WEVA 2002-144, the company moved to withdraw the contest because it considered the imminent danger order moot.

Commission Rule 11, 29 C.F.R. § 2700.11, provides that: “A party may withdraw a pleading at any stage of a proceeding with approval of the Judge or the Commission.” Accordingly, the request to withdraw the Notice of Contest in Docket No. WEVA 2002-5-R is **GRANTED** and the docket will be dismissed in the order at the end of this decision.

### Background

Independence Coal Company operates the Cedar Grove underground coal mine in Raleigh County, West Virginia. Independence Coal is a subsidiary of Massey Energy.

On August 27, 2001, Bruce Gilmour, a section foreman on the first shift, told continuous miner operator George Bailey to shear the right hand rib in the No. 5 entry, because the entry was too narrow. This occurred at about 2:20 p.m. as Gilmour was beginning to perform the preshift examination for the oncoming second shift. As directed, Bailey sheared the right rib and took a partial cut out of the face. By the time he did that, the shift ended and Bailey backed the miner out of the face and proceeded to the surface to go home.

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<sup>1</sup> A separate transcript was printed for each of the three hearing days. Accordingly, transcript citations will be “Tr. I.,” “Tr. II.,” or “Tr. III.” depending on the transcript volume being cited.

When Gilmour completed his preshift examination, he called it out to Freddy Terral, the second shift section foreman, to be recorded in the preshift book. Then, he also proceeded to the surface. He did not return to the No. 5 entry after he examined it and told Bailey what to do.

Terral performed an on-shift examination of the No. 5 entry at 3:52 p.m. Shortly after that time, Gregory Barron, a continuous miner operator, began mining in the entry. The shuttle car operator taking the coal from Barron's miner to the dumping point at the belt was Brandon Davis. When he returned from his thirteenth trip, at about 4:45 p.m., Davis found Barron under a large rock that had fallen on him. Barron was in a sitting position and the rock was lying on his back and shoulders. Davis was unable to move the rock by himself and called for help. When help arrived, the rock was lifted and Barron was removed from under it. He was not breathing and Terral began administering CPR. Barron was then moved out of the mine and taken to a hospital where he was pronounced dead.

Accident investigators from MSHA and West Virginia arrived at the mine around 9:00 p.m. Roger Richmond was the lead investigator for MSHA and was in charge of the investigation. He was accompanied by Jon Braenovich, a Supervisory Roof Control Specialist in the Mt. Hope, West Virginia, District Office, and by Joseph Cybulski, a Supervisory Mining Engineer in the Roof Control Division of MSHA's Pittsburgh Safety and Health Technology Center.

The MSHA investigators, along with state investigators and representatives of the company, went underground to the No. 5 entry about 9:30 p.m. Once there, the investigators made observations, took notes and made measurements. Photographs were also taken of the accident scene. The next day, the investigators interviewed witnesses and took more measurements. Among other things, the investigators observed the rock which had fallen on Barron. It measured 83 inches long, was 27 inches wide and was 8 inches thick. (Jt. Ex. 1, stip. 24.) They also saw that the head had been cut off of a roof bolt in the second row of bolts from the face and that there were no reflectors hanging anywhere in the entry.

As a result of the investigation, one citation and four orders were issued to Independence Coal. A subsequent 110(c) investigation resulted in Terral and Gilmour being individually charged with three of the violations.

### **Findings of Fact and Conclusions of Law**

It is the Secretary's theory that the fatal accident occurred as follows: (1) Bailey sheared the right rib in the No. 5 entry, leaving an obvious and hazardous brow where the rib and the roof come together; (2) Bailey also sheared the head off of a roof bolt and knocked down reflectors, which were hanging from the second row of roof bolts from the face, and did not replace them; (3) Gilmour failed to conduct an adequate preshift examination because he did not return to the No. 5 entry even though he should have known that Bailey's shearing of the rib would result in a hazardous condition; and, if he had done so, he would have seen the hazardous brow, the sheared

bolt and the missing reflectors; (4) Terral did not conduct an adequate on-shift examination because he did not observe the hazardous brow, the sheared bolt or the missing reflectors; and (5) Barron mined in the No. 5 entry for almost an hour, without observing the hazardous brow, the sheared bolt or the missing reflectors, until the brow fell on him.

As always, the Secretary has the burden of proof. In this case, the Secretary's theory requires that it be concluded that all of the Independence employees who testified at the hearing, including two who were called by the Secretary, were untruthful. However, even if that conclusion is reached, the Secretary still presented no evidence, other than the fact that the accident occurred, to prove her case. Neither Cybulski nor Braenovich, the only other witnesses who testified, saw what the No. 5 entry looked like after Bailey finished shearing the rib, or when Terral conducted his on-shift examination, or when Barron began mining or when the accident happened. Thus, while some of the violations must be affirmed, because they existed after the accident, the Secretary has failed to prove that anything occurred as she theorizes.

The individual violations will be discussed in the order that they were issued.

Citation No. 7205804

This citation alleges a violation of section 75.202(a) of the Secretary's rules, 30 C.F.R. § 75.202(a), because:

The roof and/or ribs were not supported or otherwise controlled to protect persons from hazards related to falls. A large rock brow measuring approximately 81 inches in length, 9 ½ inches to 25 inches wide and 7 inches to 15 inches thick fell and hit the continuous mining machine operator who was working under the unsupported brow. A fatal roof fall accident occurred on 8/27/01. The cited condition or practice resulted from evidence and information obtained during the fatal accident investigation that followed.

(Govt. Ex. 1.) Section 75.202(a) requires that: "The roof, face and ribs of areas where persons work or travel shall be supported or otherwise controlled to protect persons from hazards related to falls of the roof, face or ribs and coal or rock bursts."

Independence Coal does not assert, in its brief, that a violation of section 75.202(a) did not occur. Instead with regard to this citation, it argues only that the violation was neither "significant and substantial" nor an "unwarrantable failure." (Resp. Br. at 20-23.) Nonetheless, the facts support this apparent concession.

It is undisputed that the rock brow fell from the roof and struck Barron, who was working in the area. The Commission, noting that section 75.202(a) is broadly worded, has stated:

Accordingly, we have held that “the adequacy of particular roof support or other control must be measured against the test of whether the support or control is what a reasonably prudent person, familiar with the mining industry and protective purpose of the standard, would have provided in order to meet the protection intended by the standard.” *Canon Coal Co.*, 9 FMSHRC 667, 668 (Apr. 1987) (cited in *Helen Mining Co.*, 10 FMSHRC 1672, 1675 (Dec. 1988)).

*Harlan Cumberland Coal Co.*, 20 FMSHRC 1275, 1277 (Dec. 1998).

As to whether the brow was adequately supported, Cybulski and Braenovitch testified that “[a]ny brow poses a hazard” and that normally a rock brow is “either supported or taken down.” (Tr. I. 157, 287.) The company witnesses, Norman “Red” Hill, Jr., Gilmour, Terral and John Adkins, would not admit that every brow was hazardous, but at least agreed that a brow could be hazardous, needed to be examined carefully and either taken down or supported.<sup>2</sup> (Tr. II. 229-30, 291, Tr. III. 79.)

In this case, the brow obviously had not been taken down. Nor had it been supported. (Tr. I. 288.) I find that, although no one saw the brow before it fell, except possibly Barron, based on the size of the brow and because such brows are usually hazardous, a reasonably prudent person would have concluded that the brow had to be supported or taken down. Consequently, I conclude that the brow was not adequately supported or otherwise controlled in violation of the regulation.

While there is no evidence in this case that anyone in authority was aware of the existence of the rock brow, “the Mine Act clearly contemplates that a violation may be found where the wrongful act is performed by someone other than the operator.” *Western Fuels-Utah, Inc. v. FMSHRC*, 870 F.2d 711, 716 (D.C. Cir. 1989). Thus, “the Act’s scheme of liability provides that an operator, although faultless itself, may be held liable for the violative acts of its employees . . . .” *Bulk Transportation Services, Inc.*, 13 FMSHRC 1354, 1359-60 (Sept. 1991); accord *Fort Scott Fertilizer-Cullor, Inc.*, 17 FMSHRC 1112, 1115 (Jul. 1995). Consequently, it makes no difference whether Bailey or Barron caused the brow; under the Act’s scheme of strict

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<sup>2</sup> In her brief, the Secretary requested that I find that the company was judicially estopped from arguing “that rock brows are not inherently dangerous” because in another case involving Independence Coal, the company attorney stated that a brow “is a very dangerous condition in any mine, you don’t want a rock brow hanging without support underneath it, it could fall.” (Sec. Br. at 13-14.) In the first place, the company, as noted, has made no argument concerning the fact of violation. In the second place, the statement quoted does not claim that rock brows are *always* dangerous. Accordingly, I decline the Secretary’s invitation to hold that Independence Coal is forever estopped from arguing that a particular brow might not be a hazardous condition.

liability, the fact that the brow existed makes Independence Coal liable for the violation.

Significant and Substantial

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

In *Mathies Coal Co.*, 6 FMSHRC 1 (Jan. 1984), the Commission set out four criteria that have to be met for a violation to be S&S. *See also Buck Creek Coal, Inc. v. FMSHRC*, 52 F.3d 133, 135 (7th Cir. 1995); *Austin Power, Inc. v. Secretary*, 861 F.2d 99, 103-04 (5th Cir. 1988), *aff’g Austin Power, Inc.*, 9 FMSHRC 2015, 2021 (Dec. 1987) (approving *Mathies* criteria). Evaluation of the criteria is made in terms of “continued normal mining operations.” *U.S. Steel Mining Co., Inc.*, 6 FMSHRC 1573, 1574 (Jul. 1984). 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); *Youghiogeny & Ohio Coal Co.*, 9 FMSHRC 2007 (Dec. 1987).

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

The operator argues that “there is no evidence the brow was in such a condition that would present a hazard,” and, therefore, the violation was not S&S. (Resp. Br. at 23.) This conclusory statement does not consider the *Mathies* criteria. Applying those criteria, I have already found the violation of a safety standard, section 75.202(a). I further find that the violation of that standard contributed to the danger of a roof fall—which in fact occurred. In addition, I find that there was a reasonable likelihood that the hazard contributed to, a roof fall, would result in an injury. What the Commission said twenty years ago, that “[r]oof falls have been recognized by Congress, the Secretary of Labor, the industry, and this Commission, as one of the most serious hazards in mining” and “remain the leading cause of death in underground mines,” is just as true today. *Consolidation Coal Co.*, 6 FMSHRC 34, 37 n.4 (Jan. 1984). Finally, since the fall resulted in a death, I find that there was a reasonable likelihood that the injury would be of a reasonably serious nature.

Clearly, the failure to support or otherwise control the brow “was a significant contributing cause to the fatal accident.” *Walker Stone Co., Inc.*, 19 FMSHRC 48, 53 (Jan.

1997). Accordingly, I find that the violation was “significant and substantial.”

### Unwarrantable Failure

This violation was also alleged to be an “unwarrantable failure.”<sup>3</sup> The Commission has held that unwarrantable failure is aggravated conduct constituting more than ordinary negligence by a mine operator in relation to a violation of the Act. *Emery Mining Corp.*, 9 FMSHRC 1997, 2004 (Dec. 1987); *Youghiogheny & Ohio Coal Co.*, 9 FMSHRC at 2010. “Unwarrantable failure is characterized by such conduct as ‘reckless disregard,’ ‘intentional misconduct,’ ‘indifference’ or a ‘serious lack of reasonable care.’ [Emery] at 2003-04; *Rochester & Pittsburgh Coal Corp.* 13 FMSHRC 189, 193-94 (February 1991).” *Wyoming Fuel Co.*, 16 FMSHRC 1618, 1627 (Aug. 1994); see also *Buck Creek Coal, Inc. v. FMSHRC*, 52 F.3d 133, 136 (7th Cir. 1995) (approving Commission’s unwarrantable failure test).

The Secretary asserts that the failure of Gilmour and Terral “to detect and correct this hazardous condition constitutes inexcusable, neglectful conduct which meets the . . . definitions of unwarrantable failure and reckless disregard.” (Sec. Br. at 18.) Unfortunately, there is no evidence to support this assertion.

Bailey, the continuous miner operator, testified that he did not observe anything that he considered to be a hazardous condition after he finished shearing the rib and that when he left the area there was no brow. (Tr. I. 72-73, 93.) Terral testified that: “There was no rock brow there when I did my examination.” (Tr. II. 293.) Davis, the scoop operator who had only been a miner about eight months, was less positive, but stated: “I don’t—I don’t recall seeing anything loose or anything like that, that I thought, you know, might have been bad. Of course I might not have been paying as much attention as I should have.” (Tr. I. 118.) He later said: “I know I don’t recall seeing anything loose. . . . Nothing like that.” (Tr. I. 127.) Gilmour, of course, left the area before the rib was sheared to complete his preshift examination and did not see it again.

Terral also testified that the company had a “scaler” and that “the scaler’s the one—the man that’s designated every week—he goes in and he runs the whole mine, face area, feeder in, and if there’s any loose top or ribs he’ll scale them, pull them down. . . . His job is to make the area safe. . . . at the beginning of the shift” (Tr. II. 258.) With regard to the scaler, he further testified as follows:

Q Had he [the scaler] run into a condition that he felt was hazardous that he couldn’t correct on his own, he would have been back to see you, wouldn’t he?

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<sup>3</sup> The term “unwarrantable failure” is taken from section 104(d)(1) of the Act, which assigns more severe sanctions for any violation that is caused by “an unwarrantable failure of [an] operator to comply with . . . mandatory health or safety standards.”

A He would have came [sic] and got me. Right.

Q Did he come and get you with regard to any conditions in that mine on August 27th?

A No, sir.

(Tr. II. 304.)

Against this direct evidence, the Secretary's case rests on the assumption that the brow was present after Bailey finished shearing the rib. As support for this assumption, the Secretary argues that since Bailey said he thought the entry was wide enough after he sheared the rib and Terral thought the entry looked wide enough when he did his on-shift examination, there was no reason for Barron to have sheared the rib. (Sec. Br. at 19.) But, there is no evidence that the entry was as wide when Bailey finished shearing the rib as it was after the accident, because neither Bailey nor Terral measured the width of the entry or estimated how wide it was. The Secretary also argues that Davis did not see Barron shearing the rib. (*Id.*) However, the fact that Davis did not see Barron shearing the rib does not prove that he did not shear it, because as Davis said: "If, you know, he did, maybe it was while I was at the feeder dumping." (Tr. I. 106.) Thus, I find that, based on the available evidence, the inference that Bailey left the brow is not as strong as the inference that Barron did.

Despite the fact that the Secretary's case is based solely on supposition and that the direct evidence is all contrary to that supposition, with the exception of Bailey, the Secretary does not discuss anywhere in her brief the credibility of the witnesses or attempt to impeach their testimony. With regard to Bailey, the Secretary suggests that: "Given the traumatic nature of what occurred, Mr. Bailey may actually believe, albeit incorrectly, that he did not leave a brow; however, this part of his testimony is not credible." (Sec. Br. at 21.) The Secretary goes on to argue that: "Given his description of the mining conditions, and being unable to see because of the dust, this description is simply not believable." (*Id.*) The Secretary has taken Bailey's testimony about mining conditions out of context.

Bailey's testimony concerning dust obscuring his vision was given as an explanation as to why the entry was originally cut too narrowly. (Tr. I. 52-53.) In other words, he said that because of the dust caused by the operation of the continuous mining machine he was unable to see that he was cutting the entry too narrowly. However, with regard to the brow, he was asked if *after* he had finished shearing the rib he *specifically* looked at the roof and made a *conscious decision* that no additional roof bolts were needed and he answered in the affirmative. (Tr. I. 73-74.) Thus, it is clear that he examined the roof after he had stopped mining and the miner was no longer creating dust. Moreover, as already noted, Bailey's testimony is corroborated by Terral and, to some extent, Davis.

Consequently, I find that the Secretary has not proven that the brow existed before Barron began mining in the entry. Nor has she foreclosed the possibility that Barron made the cut which left the brow. In this connection, I find it somewhat significant that Barron had been mining for about 45 minutes, Davis had made thirteen scoop runs, yet, according to the diagram of the scene after the accident, the mining machine is not shown as having advanced very far into the entry. Hence, a preponderance of the evidence does not indicate that either Terral or Gilmour was negligent, let alone acted with reckless disregard.

If Barron left the brow, he was clearly negligent. However, the Commission has long held that the negligence of a “rank-and-file” miner cannot be imputed to the operator for civil penalty purposes. *Fort Scott*, 17 FMSHRC at 1116; *Western Fuels-Utah, Inc.*, 10 FMSHRC 256, 260-61 (Mar. 1988); *Southern Ohio Coal Co.*, 4 FMSHRC 1459, 1464 (Aug. 1982) (*SOCCO*). The Commission has further held that: “[W]here a rank-and-file employee has violated the Act, *the operator’s* supervision, training and disciplining of its employees must be examined to determine if *the operator* has taken reasonable steps necessary to prevent the rank-and-file miner’s violative conduct.” *SOCCO* at 1464. Finally, while this standard is normally applied in determining the operator’s negligence for penalty purposes, the Commission has confirmed that it also applies in determining whether an operator can be held responsible for a miner’s aggravated conduct and, thus, be found to have unwarrantably failed to comply with a regulation. *Whyne Supply Co.*, 19 FMSHRC 447, 452-53 (Mar. 1997).

Not surprisingly, in view of the Secretary’s theory of the case, there is no evidence concerning Independence Coal’s supervision, training and disciplining of its employees. Inasmuch as the Secretary has not shown that the company’s supervision, training and disciplining of its employees was deficient, it must be concluded that the company had taken reasonable steps to prevent the violative conduct.

In conclusion, the Secretary has not established that either Terral, Gilmour or Independence Coal was negligent with respect to this violation. Further, the Secretary has not shown that Barron’s negligence, whatever it was, is imputable to the company. Accordingly, I conclude that the violation of section 75.202(a) was not the result of aggravated conduct on the part of Independence Coal and, therefore, that the violation was not the result of an “unwarrantable failure.” The citation will be modified to a 104(a) citation, 30 U.S.C. § 814(a).

### 110(c) Violations

The Secretary has charged Terral and Gilmour with being personally liable for this violation under section 110(c) of the Act.<sup>4</sup> The parties stipulated that both Terral and Gilmour

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<sup>4</sup> Section 110(c) provides, in pertinent part, that: “Whenever a corporate operator violates a mandatory health or safety standard . . . any director, officer or agent of such corporation who knowingly authorized, ordered, or carried out such violation . . . shall be subject to the same civil penalties . . . .”

were “agents” of Independence Coal. (Jt. Ex. 1, stip. 21 & 22.) The Commission set out the test for determining whether a corporate agent has acted “knowingly” in *Kenny Richardson*, 3 FMSHRC 8, 16 (Jan. 1981), *aff’d*, 689 F.2d 623 (6th Cir. 1982), *cert. denied*, 461 U.S. 928 (1983), when it stated: “If a person in a position to protect safety and health fails to act on the basis of information that gives him knowledge or reason to know of the existence of a violative condition, he has acted knowingly and in a manner contrary to the remedial nature of the statute.” The Commission has further held, however, that to violate section 110(c) the corporate agent’s conduct must be “aggravated,” *i.e.* it must involve more than ordinary negligence. *Wyoming Fuel*, 16 FMSHRC at 1630; *Beth Energy Mines, Inc.*, 14 FMSHRC 1232, 1245 (Aug. 1992); *Emery*, 9 FMSHRC at 2003-04.

As has already been discussed in the section on “unwarrantable failure,” I do not find that either Terral’s or Gilmour’s conduct was negligent, much less aggravated. The Secretary has not proved that the brow existed when Terral conducted his on-shift examination, nor has the Secretary shown that Gilmour had a duty to return to the No. 5 entry after completing his preshift examination.<sup>5</sup> Therefore, I cannot conclude that they acted knowingly and will dismiss the citations against them.

Citation No. 7205805

This citation alleges a violation of section 75.220(a)(1) of the regulations, 30 C.F.R. § 75.220(a)(1), because:

The approved roof control plan was not being followed in that reflectors were not placed on the fourth row of bolts outby the face to aid the continuous mining machine operator to determine his position for maximum safety during mining operations. The integrity of the first two rows was destroyed when a bolt was sheared off in the second row outby the face. A fatal roof fall accident occurred on 8/27/01. The cited condition or practice resulted from evidence and information obtained during the fatal accident investigation that followed.

(Govt. Ex. 2.)<sup>6</sup> Section 75.220(a)(1) requires that: “Each mine operator shall develop and follow a roof control plan, approved by the District Manager, that is suitable to the prevailing geological conditions, and the mining system to be used at the mine.”

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<sup>5</sup> Terral’s and Gilmour’s conduct will be discussed more fully in the discussion of Orders No. 7205807 and 7205808.

<sup>6</sup> This citation was modified at the beginning of the hearing from a 104(d)(1) order to a 104(a) citation and the negligence was modified from “reckless disregard” to “high.” (Tr. I. 10-11.)

The company's approved roof control plan provides that: "Two reflectors shall be placed on the second row of bolts outby the face, on each side of the crosscut, to aid the shuttle car operators and continuous mining operators in determining their positions for maximum safety during mining operations." (Jt. Ex. 2, p. 10, no. 16.) It is undisputed that when the investigators arrived at the accident scene, there were no reflectors hanging in the No. 5 entry. It is also undisputed that the head and plate of a roof bolt in the second row of bolts had been sheared off, thus rendering that row of bolts ineffective and making the maximum safety position for the continuous miner operator outby the fourth row of bolts. Accordingly, based on strict liability, the operator violated its roof control plan and, thus, section 75.220(a)(1).

*Significant and Substantial*

The inspector found this violation to be "significant and substantial." I agree for the following reasons. Applying the *Mathies* criteria, I have already found that the lack of reflectors was a violation of the roof control plan. The second criterion is met because without the reflectors a miner could think it was safe to proceed under what was unsupported roof, exposing him to the hazard of a roof fall.

The Secretary argues that the third factor is met because: "Had reflectors been properly placed in the No. 5 entry, it is most likely that Mr. Barron would have been positioned further outby than where he was struck by the fallen rock brow." (Sec. Br. at 27.) Obviously, this depends on Barron having been inby the fourth row of bolts when he was struck. The evidence, however, indicates that he was outby the fourth row of bolts. Davis, who found him, testified Barron was somewhere between the fourth and fifth row of bolts. (Tr. I. 115.) Terral, who came in response to Davis' calls for help, said he was outby the fourth row of bolts, with the outby end of the rock leaning against him. (Tr. II. 274-75.) Finally, the diagram of the scene shows the rock extending almost halfway between the fourth and fifth row of bolts. (Jt. Ex. 6.) While the rock may have been moved some in rescuing Barron, it could not have been very far since it weighed almost 2,000 pounds. (Tr. II. 14, 86.)

Consequently, I do not find that this accident proves that the third factor has been met. On the other hand, I agree with the Secretary that, "the absence of the reflectors made it more likely that the victim, or anyone else whom might have been in the entry, would be located inby the fourth row of bolts and more likely to have been exposed to hazards related to falls of the roof and ribs." (Sec. Br. at 27.) Hence, combining the fourth and fifth criteria, I find that the lack of reflectors was reasonably likely to result in reasonably serious injury. Therefore, I find that the violation was "significant and substantial."

Citation No. 7205806

This citation also charges a violation of section 75.220(a)(1) in that:

The approved roof control plan was not being followed. The approved roof control plan requires cross-wise spacing of bolts not to exceed 5 feet and stipulates that under no condition shall any person proceed inby the next to last row of permanent roof supports. A bolt in the second row of bolts outby the face in the number 5 entry was sheared off. This resulted in two of the remaining bolts in this row being 8 ft. apart. This rendered the last two rows of bolts ineffective. The fourth row of bolts then became the next to last row of permanent supports. The continuous mining machine operator positioned himself inby the fourth row of bolts in violation of the plan. A fatal roof fall accident occurred on 8/27/01. The cited condition or practice resulted from evidence and information obtained during the fatal accident investigation that followed.

(Govt. Ex. 3.)<sup>7</sup>

The company's roof control plan provides that: "Crosswise spacing of bolts may be 5 feet provided four rows are maintained and bolts do not exceed 4 feet from the ribs." (Jt. Ex. 2, p. 8, no. 4.) It also states: "Under no conditions shall any person proceed beyond the next to last row of permanent roof supports." (Jt. Ex. 2, p. 9, no. 5.) As noted above, it is undisputed that a bolt in the second row outby the face was sheared leaving the second row with an eight foot space between bolts. Accordingly, while I do not find that the continuous miner operator was inby the fourth row of bolts, based on strict liability, I find that the company violated its roof control plan and, in doing so, section 75.220(a)(1).

*Significant and Substantial*

The inspector found this violation to be "significant and substantial." For the reasons set out in discussing S&S for Citation No. 7205805, above, I find that this violation was "significant and substantial."

Order No. 7205807

This order alleges a violation of section 75.360(b)(3), 30 C.F.R. § 75.360(b)(3), because:

An inadequate pre-shift examination was conducted by the day shift section foreman on the number 1 section on 8/27/2001. Obvious hazards were not reported or corrected in the number 5 face of the number 1 section. A large rock brow was created by

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<sup>7</sup> This citation was modified at the beginning of the hearing from a 104(d)(1) order to a 104(a) citation and the negligence was modified from "reckless disregard" to "high." (Tr. I. 11.)

shearing of the right rib of the number 5 face of the number 1 section on the day shift. This condition was not reported in the preshift examiner's log prior to the evening shift starting to work. This was a contributing factor to a fatal accident.<sup>8</sup>

(Govt. Ex. 4.) Section 75.360, 30 C.F.R. § 75.360, sets out the requirements for preshift examinations. Section 75.360(b)(3) requires that:

(b) The person conducting the preshift examination shall examine for hazardous conditions . . . at the following locations:

....

(3) Working sections and areas where mechanized mining equipment is being installed or removed, if anyone is scheduled to work on the section or in the area during the oncoming shift. The scope of the examination shall include the working places . . . and the examination shall include tests of the roof, face and rib conditions on these sections and in these areas.

The parties stipulated that “[a] preshift examination of the No. 5 entry on the No. 1 section had been conducted by Bruce Gilmour on August 27, 2001.” (Jt. Ex. 1, stip. 25.) It is undisputed that prior to performing his preshift examination of the No. 5 entry, Gilmour directed Bailey to “shear the rib, to widen the entry out. And I told him to be real careful. Watch the bolt spacing. And be sure everything’s okay.” (Tr. II. 206.) Then, Gilmour proceeded through the rest of the section, completed his preshift examination, called the results out to the surface and then left the mine. He did not return to the No. 5 entry.

It is the Secretary’s theory that the preshift regulation was violated because, “if the preshift examiner has reason to know of a hazardous condition in an area that was previously examined, the examiner has an obligation to ensure that such hazardous condition is addressed, corrected, or adequately recorded.” (Sec. Br. at 35.) Significantly, the Secretary does not cite any regulation or case law to support this assertion. Such a requirement is clearly not set out or implied in section 75.360(b)(3). Nor does it appear anywhere else in section 75.360. Indeed, in response to the question, “isn’t it true that Mr. Gilmour was not required by the preshift examination regulation to go back to the No. 5 entry,” Braenovich answered: “Correct.” (Tr. II. 64.)

Preshift examinations are required to be performed within three hours preceding an oncoming shift. 30 C.F.R. § 75.360(a)(1). It follows then that a preshift examination can be

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<sup>8</sup> This order was modified at the hearing to insert this language in place of the language in the original order. (Tr. I. 11-12.)

started within three hours before the ongoing shift ends. This plainly contemplates that mining will proceed after a preshift examination has begun and, depending on how long the examination takes, after it has been completed. Any number of hazardous conditions could result from the continued mining, yet the regulation says nothing about rechecking areas where further mining is performed.

Moreover, the Secretary has not shown that shearing the rib was a particularly hazardous procedure. Braenovich admitted that when an entry is too narrow or off-center, it is part of the normal mining cycle to shear the rib to widen the entry and get it back on center. (Tr. II. 85.) Terral testified that if the miner operator determines that an entry is off-center, he has the authority on his own to shear the rib to straighten the entry. (Tr. II. 265.) Hill, who at the time of the accident was superintendent of the Justice Mine, but who two months before had been superintendent at Cedar Grove, agreed. (Tr. II. 141.) Bailey testified that he was aware that shearing the rib might require some spot bolting and he had roof bolters standing by in case he needed them. (Tr. I. 72-73.) Similarly, when a miner operator mines an entry he also has roof bolters standing by. In short, shearing the rib in this situation was not anything out of the ordinary. Thus, even assuming *arguendo* that the Secretary's theory is correct, there was no reason for Gilmour to expect that anything *unusually* hazardous was being done.

To sum up, there is no requirement in section 75.360 that a preshift examiner revisit areas he has already examined. Furthermore, even if the Secretary's implied addition to the regulation were reasonable, there was nothing in this situation to put the examiner on notice that anything other than normal mining was being performed.<sup>9</sup> Accordingly, I find that the operator did not violate the regulation and will vacate the order.

#### 110(c) Violation

The Secretary seeks to hold Gilmour personally liable for this violation. During the hearing, at the close of the Secretary's case, I granted Gilmour's motion to dismiss this charge. (Tr. II. 114.) With her brief, the Secretary has filed a motion requesting that I reconsider that decision. In effect, my discussion of this violation has done that.

I find no violation of this regulation. Therefore, there is nothing for which Gilmour can be held personally liable. I affirm my original ruling and dismiss this allegation.

#### Order No. 7205808

This order alleges a violation of section 75.362(a)(1), 30 C.F.R. § 75.362(a)(1), because:

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<sup>9</sup> The Secretary has also not established that there were any hazardous conditions to observe, even if Gilmour had returned to the No. 5 entry.

An inadequate on-shift examination was conducted in the number 5 entry of the number 1 section by the evening shift section foreman. Date: 8/27/01, time: 3:52 PM, and initials: F. T. of the examiner were present at the accident scene. Obvious hazards were not corrected prior to the continuous mining machine operator commencing mining in the number 5 face. A large unsupported rock brow was created by the day shift shearing of the right rib in the number 5 entry. This condition should have been observed and corrected by the section foreman prior to mining the number 5 face. A fatal roof fall accident occurred on 8/27/01. The cited condition or practice resulted from evidence and information obtained during the fatal accident investigation that followed.

(Govt. Ex. 5.) Section 75.362(a)(1) provides that: "At least once during each shift, or more often if necessary for safety, a certified person . . . shall conduct an on-shift examination of each section where anyone is assigned to work during the shift . . . . The certified person shall check for hazardous conditions . . . ."

As should be evident by now, the Secretary has not proven that the rock brow was in existence when Terral was performing his on-shift examination. To reiterate, Bailey testified that after he sheared the right rib in the No. 5 entry there was no rock brow, there was no sheared roof bolt and the reflectors were hanging from the second row of roof bolts. (Tr. I. 72-74, 83, 93.) Terral testified that when he examined the No. 5 entry during his on-shift examination there was no rock brow, there was no sheared bolt, the reflectors were hanging from the second row of roof bolts and the designated scaler did not report any problems to him. (Tr. II. 252-56, 293, 304.) Finally, Davis testified that he did not recall noticing whether there was a brow, a sheared bolt or reflectors. (Tr. I. 118,127.) The Secretary has offered nothing except theory and inferences on top of inferences to rebut this testimony.

I conclude that the Secretary has not proven that Terral conducted an inadequate on-shift examination. Consequently, I conclude that the operator did not violate section 75.362(a)(1) as alleged and will vacate the order.

#### 110(c) Violation

The Secretary has attempted to hold Terral personally liable for this violation. However, since the Secretary has failed to prove the violation, it follows that 110(c) liability cannot attach. Therefore, I will dismiss this charge.

#### Conclusion

Because they existed at the time of the accident investigation, and because of strict liability, the Secretary has proved three violations against the operator. However, jumping from

the known, the Secretary has surmised that the violative conditions existed when Bailey finished working in the No. 5 entry and when Terral performed his on-shift examination. Based on this conjecture, she has then concluded that the operator and Gilmour and Terral were either “highly” negligent or acted with “reckless disregard” in connection with this accident.

Distressingly, the Secretary has presented little or no evidence to support this speculation, relying instead on “bootstrapping” inferences. Against this, the company has presented the testimony of four miners, two were actually called by the Secretary, who clearly refute the Secretary’s case. Nonetheless, faced with this strong refutation, the Secretary has not even challenged the witnesses credibility, with the exception of the half-hearted attempt concerning Bailey. Indeed, their credibility is not even discussed in the Secretary’s brief.

Aware that Gilmour and Terral, and to a lesser extent Bailey, have a pronounced interest in the outcome of this case, I, nevertheless, find them to be credible. Their testimony was not inherently incredible. It was consistent with the factual evidence. Their manner and demeanor while testifying did not indicate any evasiveness, dissembling or equivocation. Once their testimony is accepted, the Secretary’s theory of high negligence and reckless disregard must fail.

Accordingly, I conclude that the operator committed a violation of section 75.202(a) and two violations of its roof control plan under section 75.220(a)(1), but did not violate sections 75.360(b)(3) or 75.362(a)(1). I further conclude that the violation of section 75.202(a) was not the result of an “unwarrantable failure” on the part of the operator. Finally, I conclude that neither Gilmour nor Terral are personally liable for any of the violations with which they have been charged.

### **Civil Penalty Assessment**

The Secretary has proposed a penalty of \$55,000.00 for each of the three violations that I have found the company to have committed.<sup>10</sup> However, it is the judge’s independent responsibility to determine the appropriate amount of penalty in accordance with the six penalty criteria set out in section 110(i) of the Act, 30 U.S.C. § 820(i). *Sellersburg Stone Co. v. FMSHRC*, 736 F.2d 1147, 1151 (7th Cir. 1984); *Wallace Brothers, Inc.*, 18 FMSHRC 481, 483-84 (Apr. 1996).

In connection with the penalty criteria, the parties have stipulated that the maximum penalty in this case will not affect the ability of Independence Coal to remain in business. (Jt. Ex. 1, stip. 4.) Based on the Proposed Assessment Data Sheet, I find that Cedar Grove is a medium size mine and that Massey Energy is a very large company. (Govt. Ex. 6.) Based on the Proposed Assessment Data Sheet and the Assessed Violation History Report, I find that

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<sup>10</sup> As counsel for the Secretary recognized, the proposed penalties for Citation Nos. 7205805 and 7205806 are no longer valid in view of the citations’ modification at the hearing. (Tr. I. 25.) Nonetheless, the Secretary has not proposed any new penalties for these violations.

Independence Coal's history of previous violations is slightly better than average. (Govt. Exs. 6 & 7.) Based on the citation forms, I find that the company demonstrated good faith in attempting to achieve rapid compliance after notification of the violations. (Govt. Exs. 1-3.)

A death occurred as a result of these violations. Therefore, I find that the gravity of the violations was very serious.

Finally, turning to negligence, I find that the company was not negligent in connection with any of the three violations. I make this finding based on the Secretary's failure to prove that either Gilmour or Terral performed inadequate examinations, or were otherwise aware of the violations, or that anyone else in a supervisory capacity with the company was aware of the violations. That being the case, since, as discussed above, the negligence of a rank-and-file miner cannot be imputed to the operator, I find that Independence Coal was not negligent.

Taking all of these factors into consideration, I assess a penalty of \$10,000.00 for each violation. In addition, in accordance with the settlement agreement, I assess a penalty of \$4,750.00 for Citation No. 7205803 in Docket No. WEVA 2002-144.

### Order

In view of the above, with regard to Docket No. WEVA 2002-138 and contest Docket Nos. WEVA 2002-27-R, WEVA 2002-28-R, WEVA 2002-29-R, WEVA 2002-30-R and WEVA 2002-31-R, Citation No. 7205804 is **MODIFIED** from a 104(d)(1) citation to a 104(a) citation, by deleting the "unwarrantable failure" designation, and is further **MODIFIED** by reducing the level of negligence from "reckless disregard" to "none" and is **AFFIRMED** as modified; Citation No. 7205805 is **MODIFIED** by reducing the level of negligence from "high" to "none" and is **AFFIRMED** as modified; Citation No. 7205806 is **MODIFIED** by reducing the level of negligence from "high" to "none" and is **AFFIRMED** as modified; Citation Nos. 7205807 and 7205808 are **VACATED** and Docket Nos. WEVA 2002-30-R and WEVA 2002-31-R are **DISMISSED**. With regard to Docket No. WEVA 2002-144 and contest Docket Nos. WEVA 2002-5-R and WEVA 2002-6-R, Citation No. 7205803 is **MODIFIED**, in accordance with the agreement, by reducing the level of negligence from "high" to "moderate" and is **AFFIRMED** as modified and Docket No. WEVA 2002-5-R, in accordance with the Respondent's motion, is **DISMISSED**. Finally, Docket Nos. WEVA 2003-188 and WEVA 2003-189 are **DISMISSED**.

Independence Coal Company, Inc., is **ORDERED TO PAY** civil penalties of **\$34,750.00** within 30 days of the date of this order.

  
T. Todd Hodgdon  
Administrative Law Judge

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**FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION**  
OFFICE OF ADMINISTRATIVE LAW JUDGES  
601 NEW JERSEY AVENUE, N.W., SUITE 9500  
WASHINGTON, D.C. 20001

June 18, 2004

SECRETARY OF LABOR,	:	CIVIL PENALTY PROCEEDINGS
MINE SAFETY AND HEALTH	:	
ADMINISTRATION (MSHA),	:	Docket No. PENN 2002-116
Petitioner	:	A.C. No. 36-00970-04252
	:	
UNITED MINE WORKERS OF	:	
AMERICA, LOCAL 1248, DISTRICT 2,	:	
SUB-DISTRICT 5,	:	
Intervenor	:	
	:	
v.	:	
	:	
MAPLE CREEK MINING, INC.,	:	
Respondent	:	
	:	
STEVE BROWN, Employed by Maple	:	Docket No. PENN 2003-54
Creek Mining, Inc.,	:	A.C. No. 36-00970-04285 A
Respondent	:	
	:	
ALVY WALKER, Employed by Maple	:	Docket No. PENN 2003-55
Creek Mining, Inc.,	:	A.C. No. 36-00970-04286 A
Respondent	:	
	:	
GREG MILLER, Employed by Maple	:	Docket No. PENN 2003-56
Creek Mining, Inc.,	:	A.C. No. 36-00970-04287 A
Respondent	:	
	:	Maple Creek Mine

**DECISION**

Appearances: Maureen A. Russo, Esq., Mark V. Swirsky, Esq., Office of the Solicitor, U. S. Department of Labor, Philadelphia, Pennsylvania, for Petitioner;  
Leon J. Moscalink, Jr., Chairman, Mine Safety & Health Committee, Local Union 1248, United Mine Workers of America, Greensburg, Pennsylvania, for Intervenor;  
Marco M. Rajkovich, Jr., Esq., Noelle M. Holladay, Esq., Wyatt, Tarrant & Combs, LLP, Lexington, Kentucky, for Respondents.

Before: Judge Bulluck

These cases are before me upon Petitions for Assessment of Penalty filed by the Secretary of Labor (“the Secretary”), through her Mine Safety and Health Administration (“MSHA”), against Maple Creek Mining, Incorporated (“Maple Creek”), and its employees Steve Brown, Alvy Walker<sup>1</sup> and Greg Miller, pursuant to sections 105(d), 110(a) and 110(c) of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. §§ 815(d), 820(a) and 820(c). The petition respecting Maple Creek seeks to impose a civil penalty of \$9,500.00 for an alleged violation of the Secretary’s mandatory safety standards governing underground coal mines.<sup>2</sup> The petitions respecting Maple Creek’s employees seek imposition of individual penalties of \$1,000.00 against Brown, \$500.00 against Walker, and \$500.00 against Miller for allegedly authorizing, ordering or carrying out the violation for which Maple Creek is charged.

The United Mine Workers of America (“the UMWA”), Local 1248, District 2, Sub-District 5, was joined as an intervening party to the proceedings. A hearing was held in Pittsburgh, Pennsylvania. The parties Post-hearing Briefs and Respondent’s Reply Brief are of record. The UMWA waived its right to file a brief. For the reasons set forth below, I **AFFIRM** Order No. 7082507, and assess penalties against all Respondents.

## **I. Stipulations**

The parties stipulated as follows:

1. The Maple Creek Mine is owned and operated by Respondent in this case, namely Maple Creek Mines, Inc.
2. The Maple Creek Mine is subject to the jurisdiction of the Federal Mine Safety and Health Act of 1977.
3. A duly authorized representative of the Secretary served the order and termination of the order upon the agent of the Respondent at the date and place stated therein, and the order and termination may be admitted into evidence to establish their issuance.
4. The presiding Administrative Law Judge has jurisdiction over these proceedings pursuant to sections 105 and 110(c) of the Act.

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<sup>1</sup> Respondent Walker’s name is incorrectly spelled in the Petition for Assessment of Civil Penalty as “Alvie.” Documents in evidence signed by Walker indicate that the correct spelling is “Alvy.”

<sup>2</sup> Docket PENN 2002-116 originally contained 12 citations/orders. By Decision Approving Settlement of August 11, 2003, settlement of 11 was approved. Consequently, only Order No. 7082507 is the subject of this hearing.

5. The parties stipulate to the authenticity of their exhibits, but not to the truth or the relevance of the matters asserted therein.

6. The imposition of the proposed civil penalty against Maple Creek Mining, Inc. will not affect Maple Creek's ability to remain in business.

7. Respondent Steve Brown has the financial ability to pay the proposed penalty of \$1,000.00.

8. Respondent Greg Miller has the financial ability to pay the proposed penalty of \$500.00.

9. Respondent Alvy Walker has the financial ability to pay the proposed penalty of \$500.00.

10. On August 9, 2001, water was present in the intake escapeway of the 4 West section in varied depths and extended for approximately 420 feet.

11. The water in the intake escapeway on the 4 West section had been present in varied amounts for approximately two weeks prior to August 9, 2001.

12. Respondent was aware that water in the intake escapeway in the 4 West section had been present in varied amounts for approximately two weeks prior to August 9, 2001.

13. In accordance with Respondent's assessed violation history, Respondent received 18 citations for violation of 30 C.F.R. § 75.380(d)(1) from August 1, 1999, through August 9, 2001.

## **II. Factual Background**

Maple Creek owns and operates the Maple Creek Mine, an underground bituminous coal mine in Washington County, Pennsylvania. The mine is wet, with depressions that fill up with water percolating from underground, and seeping through the coal seam and the mine roof. Tr. 508, 632, 664-65. Between 1.2 and 2 million gallons of water are pumped from the mine daily. Tr. 742-43. On the 4 West section, the track entry, ventilated with intake air, is the primary escapeway. The adjacent travelway, ventilated with return air, is the secondary escapeway. During the time period relevant to this case, the track in the primary escapeway ended around crosscut 15 or 16. Scoops routinely traveled up and down the primary escapeway transporting supplies from the end of the track to the working face at about crosscut 30, creating holes or "ruts" in the travelway. Tr. 115, 124. Running along the right rib was a "cow path" no wider than about 12 inches, where the work crews walked from the end of the track to their work stations at the face. Tr. 119.

On July 30, 2001, Pennsylvania Mine Inspector Dennis Walker conducted a regular quarterly inspection of the Maple Creek Mine, accompanied by Steve Brown, section coordinator on 4 West. Tr. 31-32, 40. At 12:30 that afternoon, Inspector Walker issued a Compliance Order for water accumulation in the 4 West section between crosscuts 24 and 25, rib to rib, 12 inches in depth spanning 40 to 50 feet, that created slippery walking conditions. Ex. G-1; tr. 33-34. The Compliance Order required Maple Creek to remove the water or pump it to a reasonable depth by 8:00 the next morning. Walker did not actually make a physical inspection of the area for compliance, but was told by Brown and Greg Miller that the water had been removed by pumping. Tr. 37, 57-58. Accordingly, he terminated the Compliance Order on August 14, 2001. Ex. G-1 at 2.

On August 9, 2001, ten days after the Compliance Order had been issued, Mine Safety and Health Administration ("MSHA") Inspector James Dickey conducted a regular Triple-A inspection at Maple Creek. While still on the surface, Dickey encountered MSHA Inspector George Rantovich in a discussion with UMWA safety committeemen Thomas Sutton and Jim Constable. Ex. G-3. The topic was the oxygen content in the bleeder entries and water in the mine. Sutton told the inspectors that the water problem had existed for some time, that it was not being recorded consistently in the preshift examination book, and that nobody was doing anything about it. Dickey agreed to take a look at the 4 West section. Tr. 67-68, 231-35. Dickey then reviewed the preshift and onshift record books for 4 West dating back, at least, to July 31, 2001. Tr. 235-39; ex. G-8. Dickey and the miners accompanying him, Paul Henry and Robert Maust, went down into the mine and traveled to 4 West. Tr. 105, 239-40. Upon entering the section through the air-locked doors on the track and proceeding inby, the men began to encounter water. Tr. 240-41. Initially using his walking stick, Dickey determined that the accumulation was extensive, deep, mucky, and very difficult to walk in. Tr. 240-41, 243. He took measurements across the entry as he continued out to the track, and determined the muck to be the consistency of pig slop, varying in depth up to 17 inches. Tr. 240-43. Consequently, he put the mine on notice that he would be issuing a withdrawal order. Tr. 243-44. Dickey and Henry, traveling the entry together between crosscuts 24 and 27, then out to the track, took extensive measurements and drew maps that were essentially identical. Tr. 249-50, 109-10. As a result of his observations, Dickey issued 104(d)(2) Order 7082507 at 1:15 that afternoon, withdrawing miners from the face and charging a violation of 30 C.F.R. § 75.380(d)(1), describing the violation as follows:

The intake escapeway on the 4 West section is not being maintained in safe condition to always assure passage of anyone, including disabled persons in that, there was an accumulation of black water and mucky water which measured 17 inches deep and extended for a distance of approximately 420 feet in length from just outby No. 24 crosscut to just outby No. 27 crosscut. This escapeway could not be traveled safely by miners on this section due to this water. There were also numerous large holes under this water at unknown locations which created hazards. These conditions would make travel with an injured miner on a stretcher impossible.

These conditions have existed for approximately 2 weeks and have been listed in the preshift examination record book for at least 1 week without being corrected. Management was aware of this condition and made very little effort if any to correct this condition. There was no visible work being done to correct this condition upon my arrival and discussions with various miners and officials on this section did not reveal any attempts to correct this condition”

Ex. G-9.<sup>3</sup>

It took Maple Creek approximately 16 hours to abate the condition, by building a six-foot wide bridge over the water, the entire length of the accumulation. Tr. 251-53. Dickey terminated the Order at 5:45 a.m. on August 10, 2001. Ex. G-9 at 3.

### **III. Findings of Fact and Conclusions of Law**

#### **A. Fact of Violation**

30 C.F.R. § 75.380(d)(1) requires that “[e]ach escapeway shall be maintained to always assure passage of anyone, including disabled persons.”

The Commission, in looking to the legislative history of the Act for guidance in ascertaining the requirements for safe passage of miners, has relied upon Congressional recognition of the importance of maintaining separate and distinct travelable escapeways that are maintained in safe condition. *Consolidation Coal Co.*, 15 FMSHRC 1555, 1557 (August 1993). Consistent with Congressional intent, section 75.380(d)(1) requires that each escapeway be safely maintained to always allow for passage of anyone. The Commission has also determined that the language of section 75.380(d)(1) is “plain and unambiguous” and imposes on operators a duty to maintain escapeways that satisfy a general functional test of “passability.” *Utah Power & Light Company*, 11 FMSHRC 1926, 1930 (October 1989). In determining the ultimate question of whether the standard has been violated, each case must be examined on its own facts. *Harlan Cumberland Coal Co.*, 19 FMSHRC 911, 916 (May 1997); *Jim Walter Resources, Inc.*, 16 FMSHRC 1264, 1268 (June 1994).

The parties have stipulated that the water accumulation in the primary escapeway on August 9, 2001, varied in depth, extended approximately 420 feet, and had existed for approximately two weeks. Stips.10, 11. There is disagreement, however, as to whether the condition of the escapeway, between crosscuts 24 and 27, permitted safe travel for all miners. Maple Creek takes the position that the cited area was passable, since miners on every shift

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<sup>3</sup> Maple Creek’s “D chain,” not challenged by Respondent, began with 104(d)(1) Citation No. 7082131, issued on June 28, 2001, and 104(d)(1) Order No. 3670250, issued on June 29, 2001. Ex. G-12; tr. 801.

passed along the cow path, traveling to and from the face, and that a stretcher could have been carried through the escapeway. Resp. Br. at 4-5. It argues that it is in a constant battle with water in the mine and that, in its judgment, the cited accumulation did not pose a hazard. Furthermore, the company maintains that an injured miner could have been transported through the primary escapeway on a scoop rather than a stretcher, and that the return entry and beltline were accessible alternative routes.

The Secretary presented the testimony of several witnesses to establish the obstructed condition of the primary escapeway.

Inspector Dickey testified that the consistency of the accumulation was a mucky, sloppy mix that was difficult to walk in. Tr. 242-43; ex. G-10. He justified his reason for concluding that the water created a likelihood of a disabling injury by explaining that it was impossible to see the bottom of the entry through the thickness and depth of the muck, and that a miner could “twist an ankle, a leg, a hip, break a bone, tear a tendon, injure their back . . . a number of things that can happen to them just from walking through an area like this that contains this type of holes and other obstructions on the mine floor.” Tr. 257-58. Dickey characterized the condition that he encountered on 4 West as “one of the wors[t] conditions I had ever seen an escapeway in . . . any coal mine since I’ve been inspecting. I mean this was awful. There was absolutely no excuse for it . . .” Tr. 259.

Robert Maust was a continuous miner operator on the 4 West section during the period in controversy. Tr. 99. Maust testified that the water on the section had existed for close to a week prior to Dickey’s inspection, that he had no recollection of the water level receding during that time, and that the miners on the day shift had complained to section foreman Alvy Walker, to no avail. Tr. 104, 111, 134-35; ex. G-4. In fact, Maust stated, he had complained about the water to his safety committeeman. Tr. 131. Maust described the water on the section as mucky, and estimated it to have spanned 400 feet between crosscuts 21 to 24, from rib to rib for half that distance. Tr. 99-100, 117. Where the water reached the ribs, he stated, it was about 6 inches deep, except for where there were holes in the bottom. Tr. 119. He testified that his crew, including the foreman, would get to the working face each morning by traveling by car to crosscut 15 or 16 where the track ended, then walking 12 blocks or so inby to crosscut 30. Tr. 100-02. According to him, “there was only one way to get by there was just a little patch up along the rib. And you had to watch because your foot would slide down into one of the holes or into the water. And it wouldn’t be very pleasant. Some places it would be over your boots . . .” Tr. 103. Maust traveled with Dickey and Brown on August 9. He testified that when the inspection team came upon the water, he, Maust, walked along the rib, while Dickey walked through the center of the escapeway and stepped in several holes where the water level was over the top of his 15-inch boots. Tr. 107-08, 114-17. It was after Dickey took measurements of the water with a folding ruler, Maust stated, that he issued the withdrawal order. Tr. 108-09. Maust maintained that he had slipped in the mud a few times. He opined that it would not have been possible to carry a stretcher along the rib, and it would have been very difficult to have carried it through the middle of the escapeway because of the slippery conditions. Tr. 121-23.

Roof bolter operator John Gargala worked the midnight shift under foreman Greg Miller between July 30 and August 9. Gargala testified that miners had been dealing with water accumulation in the 4 West track entry for better than a week, and that it appeared to stay at the same level. Tr. 148-51; ex G-5. By his estimation, at the end of the shift on the morning of August 9, the water was roughly 17 inches deep, from rib to rib, causing the miners to walk along the rib in order to avoid water higher than the top of their boots. Tr. 137-38, 146. Gargala related that he sustained injuries to his wrist and back when he slipped and fell at the end of his shift. Tr. 138-39; ex. 16.

Trackman Gerald Kosco was a day shift roof bolter on 4 West during the relevant period. He testified that, for a week or more, the water at the end of the track was a slippery slurry that prevented viewing the bottom and stretched two or three blocks, rib to rib. To get to and from the face, he stated, the crew would walk along the cow path in order to avoid slipping and falling in the deep part of the water. Tr. 153-56; ex. G-6. He estimated the water to have varied in depth from 6 to 14 inches. Tr. 176-77. According to Kosco, miners complained daily to Alvy Walker, who responded that Maple Creek was working on it. Tr. 157. Kosco testified that he did not see the water go down during the time the miners were required to walk through it. Tr. 157-58. He described the uneven bottom as littered with coal that had sloughed off the ribs, posing a tripping hazard. Tr. 158-59. In his opinion, a stretcher could not have been carried along the cow path, and it was improbable that it could have been carried through the primary escapeway, because of the deep water and its slippery condition. Tr. 151-52.

Miner operator John Baluh worked on the midnight shift on 4 West between July 30 and August 9. He testified that, for at least a week, his crew was required to walk through water accumulation on the section that was "black and dirty, muddy," extended about three blocks, and varied in depth from 6 to 8 inches along the cow path to as high as his 25-inch boots. Tr. 197-201, 207, 209; ex. G-7. He stated that the water level stayed the same during that period, and described the bottom as having ruts made by equipment running through the area. Tr. 200, 203-04, 206, 208. The uneven bottom, he concluded, invisible through the muddy water, made for slippery walking conditions. Tr. 202. According to Baluh, he and other miners complained about the condition. Tr. 202-03. Finally, Baluh opined that the cow path was too narrow to accommodate men wielding a stretcher. Tr. 213.

Richard Cline, also testifying for the Secretary, expressed a contrary opinion of the conditions in the track entry. He testified that, as shift foreman, he was in charge of the entire mine and responsible for visiting every working section each day. Tr. 586. He stated that he was called to 4 West on August 9, because of Dickey's Withdrawal Order, but was unable to recall what the conditions looked like on that day. Tr. 582-83, 587, 590; ex. G-15. According to Cline, if the water level was not over the top of his 16-inch boots, he would not consider the accumulation to be hazardous. Tr. 598. In his opinion, a stretcher could have been carried safely through the primary escapeway under the cited conditions and, if a miner were severely injured, he would have hauled him on a scoop. Tr. 599-602.

Maple Creek's description of the water accumulation between crosscuts 24 and 27 did not vary substantially from the Secretary's, but the company's witnesses presented their view that the area was passable and not hazardous.

Steve Brown was fill-in section coordinator on August 9. He testified that he had traveled along the rib on 4 West to the face, where he learned from Inspector Dickey and face boss Alvy Walker that the section had been shut down. Tr. 491, 499-500, 508-09. Brown opined that he could have carried a stretcher through the cited area, but added that he would have used the alternate escapeway before traveling through the deep water on the track entry. Tr. 497-98. When asked whether he could have carried a disabled miner through the primary escapeway, Brown asserted that he would have transported the miner on a scoop. Tr. 506-07. Finally, Brown opined that, as long as the secondary escapeway is open, water, even slurry, is not a concern in the primary escapeway; it would have to be waist deep – two to three feet high – in his judgment, before he would consider it hazardous. Tr. 550-54.

Day shift section foreman on 4 West, Alvy Walker, explained that water constantly percolates from the bottom into the mine, and settles in the cited area because of a gradual elevation drop. Tr. 632-33, 664-65. In its best condition, he testified, there are two to three inches of water in the area; it is never dry. Tr. 665. Walker stated that he and his crew traveled along the right rib to the working face on the morning of August 9. He acknowledged that the bottom could not be seen along the affected area because it was "slurried up," and that there were holes in the mine floor. Tr. 659-60. He personally observed water seeping from the return back into the track entry, and sent two members of his face crew to repair one of the broken pumps in the return. Tr. 649-52. He stated that he learned of the Order when Inspector Dickey informed him at the face. Tr. 621-22. According to Walker, the cited area was "walkable," he had traveled through it numerous times and, because the entry was 9 ½ feet high, the water did not pose a hazard. Tr. 629-30. Walker opined that he would have put a miner injured at the face on a scoop, although a stretcher could have been safely carried through the muddy area with no problem. Tr. 630-31, 645, 660-61. He also acknowledged that he had received complaints from miners about the water. Tr. 645.

Production coordinator Greg Miller was the midnight shift section foreman on 4 West during the pertinent period. He testified that Maple Creek had been managing water on 4 West since mining had begun on the section. Tr. 678-79. He would not give his opinion as to the depth of water that would constitute a hazard since, he asserted, it is a judgment call that depends on the variable conditions surrounding the accumulation and the availability of the secondary escapeway. Tr. 689-94. He was adamant that the regulation does not specify to what degree water constitutes a hazard. Tr. 686, 692, 694, 711, 728-29. He testified that on August 9, he and his crew traveled together to and from the working face. Tr. 670, 674-75. In his opinion, carrying a stretcher or running a scoop through the accumulation from crosscuts 24 to 27 would not have been a problem. Tr. 671.

As Maple Creek's assistant mine foreman on August 9, Paul Henry accompanied Inspector Dickey during his inspection of the mine. He testified that he did not consider the water accumulation on 4 West between crosscuts 24 and 27 to be hazardous, because the miners were able to travel along the right rib. Tr. 734-35, 794; ex. G-17. He did state, however, that he was not pleased with the condition, which he described as a very thick, dark slop, from rib to rib in some areas, caused by equipment tramping through the travelway mixing fire clay and coal with the water. Tr. 741-42, 747, 770-71, 776. When asked whether a disabled miner could have been transported through the area, he responded that miners would have made it through, because they are pretty resourceful. Tr. 735. On cross-examination, Henry estimated that it takes two hours to walk through the primary escapeway from the face to the mouth of the mine, and conceded that the cited condition would have slowed a person down. Tr. 786-88.

A review of the record indicates that the primary escapeway on the 4 West section was not maintained in a safe condition that would permit passage of all persons. From the time of Walker's Compliance Order to Dickey's Withdrawal Order, despite pumping efforts alleged by Maple Creek, work crews were routinely forced to use the narrow cow path along the right rib, in order to avoid the 6-17 inch deep muck accumulated between crosscuts 24 and 27. It is not arguable that the primary escapeway was the fastest and safest way to evacuate the mine in an emergency, and the muck created a slip and fall hazard that precluded swift passage. It is obvious that the cow path was too narrow to accommodate a team with a stretcher. Moreover, negotiating a stretcher through the slippery, rutted bottom in the center of the escapeway would have endangered the safety of the carriers and delayed medical attention to an injured miner. Therefore, it is clear that the primary escapeway did not satisfy the passability test in *Utah Power*. I have taken into account earnest testimony from Maple Creek that its miners would make their way through any condition in order to get an injured coworker out of the mine. This level of brotherhood makes it all the more important that miners not be confronted with risking life and limb to come to the aid of each other. I reject Maple Creek's argument that a scoop could have been used to transport a disabled miner through the cited area, as no evidence has been presented that this is a safe means of transporting persons with injuries. In fact, Inspector Dickey suggested otherwise. Tr. 302-04. Because accessibility of the return entry and the beltline does not excuse Maple Creek's duty to maintain each escapeway in the safe, passable condition contemplated by the standard, I reject the company's reliance on those alternatives to the primary escapeway and find that section 75.380(d)(1) was violated, as alleged.

### **B. Significant and Substantial**

Inspector Dickey determined that the violation was "significant and substantial" ("S&S"). Section 104(d) of the Act designates a violation S&S when it is "of such nature as could significantly and substantially contribute to the cause and effect of a coal or other mine or safety hazard." A violation is properly designated S&S "if, based upon the particular facts surrounding the violation, there exists a reasonable likelihood that the hazard contributed to will result in an injury or illness of a reasonably serious nature." *Cement Division, National Gypsum Co.*,

3 FMSHRC 822, 825 (April 1981).

In *Mathies Coal Co.*, 6 FMSHRC 1, 3-4 (January 1984), the Commission set forth four criteria that the Secretary must establish in order to prove that a violation is S&S under *National Gypsum*: 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. See also *Buck Creek Coal, Inc. v. FMSHRC*, 52 F.3d 133, 135 (7th Cir. 1995); *Austin Power, Inc. v. Secretary*, 861 F.2d 99, 103-04 (5th Cir. 1988), *aff'd* 9 FMSHRC 2015, 2021 (December 1987) (approving *Mathies* criteria). Evaluation of the third criterion, the reasonable likelihood of injury, should be made in the context of “continued mining operations.” *U.S. Steel Mining Co.*, 6 FMSHRC 1573, 1574 (July 1984). Moreover, resolution of whether a violation is S&S must be based “on the particular facts surrounding the violation.” *Texasgulf, Inc.*, 10 FMSHRC 498, 501 (April 1998); *Youghiogeny & Ohio Coal Co.*, 9 FMSHRC 2007 (December 1987).

Applying the *Mathies* criteria to this case, I have found a violation and that Maple Creek’s failure to maintain the primary escapeway in passable condition deprived miners of the most effective means of evacuation and created a slip and fall hazard. Considering that fire or explosion is a constant danger in continued normal mining operations, it is apparent that there was a reasonable likelihood that the hazard contributed to – impeding swift evacuation – would result in injuries of a reasonably serious nature, ranging from sprains and strains to death. The record indicates that Maple Creek had been experiencing methane and ventilation problems in the mine when Dickey issued the Withdrawal Order. Tr. 370-73,789-90; ex. G-17. Furthermore, at the end of the midnight shift before the Order was issued, John Gargala had slipped and fallen in the cited area, sustaining a sprained wrist and strained back. Tr. 138-42. It is clear, then, that the availability of alternative escapeways does not moderate the S&S nature of the violation, especially since the primary escapeway is the fastest route out of the mine and is ventilated with intake air. Tr. 186. Accordingly, I find that the violation was S&S.

### **C. Unwarrantable Failure**

“Unwarrantable failure” is aggravated conduct constituting more than ordinary negligence. *Emery Mining Corp.*, 9 FMSHRC 1997, 2001 (December 1987). Unwarrantable failure is characterized by such conduct as “reckless disregard,” “intentional misconduct,” “indifference,” or a “serious lack of reasonable care.” *Id.* at 2001-04; *Rochester & Pittsburgh Coal Co.*, 13 FMSHRC 189, 194 (February 1991); see also *Buck Creek Coal*, 52 F.3d at 136 (approving the Commission’s unwarrantable failure test). The Commission has recognized the relevance of several factors in determining whether conduct is “aggravated” in the context of unwarrantable failure, such as the extensiveness of the violation, the length of time that the violation has existed, the operator’s efforts in eliminating the violative condition and, whether the operator has been put on notice that greater efforts are necessary for compliance. See

*Consolidation Coal Co.*, 22 FMSHRC 328, 331 (March 2000); *Mullins & Sons Coal Co.*, 16 FMSHRC 192, 195 (February 1994). The Commission has also considered whether the violative condition is obvious, or poses a high degree of danger. *Windsor Coal Co.*, 21 FMSHRC 997, 1000 (September 1999) (citing *BethEnergy Mines, Inc.*, 14 FMSHRC 1232, 1243-44) (August 1992); *Warren Steen Constr., Inc.*, 14 FMSHRC 1125, 1129 (July 1992); *Quinland Coals, Inc.*, 10 FMSHRC 705, 709 (June 1988); *Kitt Energy Corp.*, 6 FMSHRC 1596, 1603 (July 1984)). Each case must be examined on its own facts to determine whether an actor's conduct is aggravated, or whether mitigating circumstances exist. *Eagle Energy, Inc.*, 23 FMSHRC 829, 834 (August 2001) (citing *Consol*, 22 FMSHRC at 353).

Pennsylvania Mine Inspector Walker testified that on July 30, he encountered water accumulation on the 4 West section in the intake escapeway between crosscuts 24 and 25, rib to rib for approximately 40 to 50 feet, varying in depth up to 12 inches. Tr. 34-36. Ten days later, on July 9, MSHA Inspector Dickey encountered water in the same location, extending from crosscut 24 and 27, for approximately 420 feet. Stip. 10. The parties have stipulated that the water accumulation had existed in varying amounts for approximately two weeks prior to Dickey's inspection. Stip. 11. It is clear, therefore, that over the ten-day period between the state and federal inspections, the water accumulation had advanced two crosscuts and, when cited by Dickey, was extensive.

Maple Creek contends that it had been actively maintaining its escapeways by use of a pumping system that utilized air pumps and a series of knee high sump pumps.<sup>4</sup> Tr. 466-68. According to Steve Brown, four air pumps had been installed on 4 West, sometime in July 2001 after Walker's Compliance Order, to draw water off different areas of the section. He testified that one pump was situated at crosscut 26 on the beltline, another was at crosscut 26 in the return, and two pumps were situated at crosscut 27 in the return. See Tr. 386-410. On August 9, knee high sump pumps had been built at crosscuts 5, 12 and 19. Tr. 399-400. Brown testified that each shift has an outby boss and two-man crew whose sole duty is to "de-water" the section. Tr. 466-68. He stated that pumping and pump maintenance was a constant in the mine, and that each shift had been battling the water on the section from its inception. Tr. 421-68; ex. R-3. Brown maintained that, the morning following Walker's Compliance Order, he observed that the water had been pumped off the section. Tr. 504-05. So, too, had water been pumped off the section during the midnight shift preceding Dickey's inspection, according to Brown, but two air pumps had gone down during that shift, causing the water to run back onto the track entry; outby crews on the midnight and day shifts had been working on the pumps in the return. Tr. 411-19; 488-92. For the reasons that follow, I reject these assertions and conclude that, from the time of the Compliance Order to the Withdrawal Order, the water in the cited area remained at a level that continuously prevented safe travel by all persons through the primary escapeway.

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<sup>4</sup> Brown explained that knee high sump pumps consist of walls built knee high, projecting 8 to 18 feet from concrete stoppings, and extending across entire widths of crosscuts. They are designed to collect water pumped off the section. Electric pumps relay stored water from knee high to knee high in sequence, then to the outside main discharge line. Tr. 395-97.

Maple Creek relies on its construction and preshift books to demonstrate its diligence in addressing the water accumulation on 4 West. An examination of the preshift records, from July 30 to August 9, reveals scattered notations of water accumulations in the track entry which, presumptively, were significant enough to merit attention in the judgment of the examiners. Maple Creek argues that intermittent recording of water in the preshift book indicates periods when the water had been removed from the section or pumped down significantly. Had it not, it contends, the accumulation that Dickey encountered would have been much higher. Tr. 486-87. I reject this argument for two major reasons, and conclude that the water consistently remained at a high level. First and foremost, the collective testimony of management officials that the water, at its peak, constituted a mere “condition” rather than a hazard, causes me to be skeptical that the chronic water problem in the section was approached with the seriousness that it deserved. In fact, Brown testified that the accumulation would have to have been waist high before he would have considered it hazardous and, if the secondary escapeway were open in that situation, he would not worry about it. Tr. 550-53. The second reason is that I fully credit the testimony of the miners who traveled daily to and from the working face through the cited area, that the “muck” had consistently remained at a high level that prevented them from walking through it, for at least a week, possibly two. Indeed, preshift records indicate high water on the track entry at crosscuts 24 to 26 at approximately 1:00 p.m. on July 31, only a few hours after Maple Creek had been directed to abate the Compliance Order, and claims to have done so. Tr. 526-30. Even Alvy Walker testified that, on August 9 at 9:00 a.m., the conditions encountered by his crew were the same as they had been throughout the week. Tr. 642-43.

In reaching this conclusion, I have considered the evidence that running and maintaining the pumps on the section was a component of outby work performed on every shift. As Dickey pointed out, however, with Brown’s concurrence, air pumps do not have the capacity to pump slurry. Tr. 325-26, 402, 481. This may explain why Dickey did not observe any pumping during his inspection, and Maple Creek did not call his attention to any activity, even when he issued the Withdrawal Order shutting down the section. For Maple Creek to have operated its air pumps without clogging them up, clear water would have had to have been pumped from somewhere other than the track entry, where scoops constantly churned up the bottom. The evidence as a whole compels me to conclude that the pumping system employed by Maple Creek, at least from the time of Walker’s inspection to Dickey’s Withdrawal Order, was woefully ineffective. Furthermore, Maple Creek knew that its equipment could not handle the muck on the section. Simply stated, Maple Creek failed to control the water condition in the primary escapeway, especially in light of the 12-inch accumulation that it was duty bound to abate after the Compliance Order had been issued.

As has already been noted, Maple Creek constantly battles water in the mine. While the frequency of preshift notations of water in the track entry, and construction book entries of pump repairs should have put Maple Creek on notice that greater effort to eliminate the hazard was necessary, it was made abundantly clear by Walker’s Compliance Order. Ten days later, however, despite complaints from its employees, Maple Creek allowed the condition to expand two crosscuts.

Muck so thick that it is difficult to walk through, 12 to 17 inches deep in places, existing for two weeks in the primary escapeway is, of course, obvious. It is dangerous as well. Inspector Walker observed a miner slip and fall, and John Gargala injured his wrist and back when he also slipped and fell in the area. Obstructed evacuation of a disabled miner on a stretcher could delay critical medical treatment, subject the injured party to further injury if the stretcher were to fall into the muck, and cause sprains, broken bones or even worse to the carriers. In the case of fire or explosion, impeded evacuation through the fastest route out of the mine could result in death. I conclude, therefore, that Maple Creek's actions to abate the Compliance Order and control the water on the track entry reflect a level of indifference and serious lack of reasonable care that constitutes an unwarrantable failure to comply with the standard.

#### **D. Section 110(c) Liability**

Section 110(c) of the Act provides that, whenever a corporate operator violates a mandatory health or safety standard, an agent of the operator who knowingly authorized, ordered, or carried out such violation shall be subject to an individual civil penalty. 30 U.S.C. § 820(c). In determining liability under section 110(c), the inquiry is whether the corporate agent knew or had reason to know of the existence of the violative condition. *Lafarge Constr. Materials*, 20 FMSHRC 1140, 1148 (citing *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)). In order to establish liability under section 110(c), the Secretary need only prove that an individual acted knowingly, not that the individual knowingly violated the law. *Id.* (citing *Warren Steen Constr., Inc.*, 14 FMSHRC 1125, 1131 (July 1992) (citing *Unites States v. Int'l Minerals & Chem. Corp.*, 402 U.S. 558, 563 (1971))). An individual acts knowingly where he is "in a position to protect employee safety and health [and] fails to act on the basis of information that gives him knowledge or reason to know of the existence of a violative condition." *Id.* (quoting *Kenny Richardson*, 3 FMSHRC at 16). Section 110(c) liability is based on aggravated conduct that constitutes more than ordinary negligence. *Id.* (citing *BethEnergy Mines, Inc.*, 14 FMSHRC 1232, 1245 (August 1992)).

##### **1. Steve Brown**

I have made a finding that Maple Creek violated section 75.380(d)(1), and there is no dispute that Steve Brown was Maple Creek's agent when the violation occurred. As section coordinator, Steve Brown oversaw operations on 4 West, and was responsible for pumping activity and pump maintenance on the section. He testified that, from a production standpoint, he made walking examinations of the section at least once, sometimes twice daily. Tr. 482-84. He reviewed preshift and construction logs and, on occasion between July 30 and August 9, conducted preshift examinations of 4 West. Brown traveled with Inspector Walker during the July 30 state inspection, and was responsible for abating the Compliance Order issued that day. Tr. 535-36. Whatever active pumping took place by midday on July 31 was insufficient to abate

the condition and, by August 9, it had worsened. Brown used the cow path to travel through the cited area that day. Tr. 553-34. By his own testimony, he was aware that the air pumps set up to address the problem were incapable of pumping the muck churned up by the scoops operating in the escapeway. Despite the Compliance Order, Brown did not consider the area hazardous because the muck was below 2 ½ feet deep and the secondary escapeway was available. Had he known that John Gargala had injured his wrist and back, he would not have acted differently because, he testified, "I fall four times a day on average." Tr. 564-65. Clearly, the Compliance Order put Brown on notice of the violative condition ten days prior to the Withdrawal Order. His failure to take expeditious, effective remedial action to protect the safety of miners who traveled daily through the primary escapeway, as well those miners who would have to evacuate the mine in an emergency, amounted to an aggravated lack of care that was more than ordinary negligence. Therefore, Brown is individually liable under section 110(c) of the Act.

## **2. Alvy Walker**

Alvy Walker was day shift section foreman in charge of an 11-man production crew on 4 West and, therefore, Maple Creek's agent. He typically traveled with his crew to and from the working face, which necessitated walking along the cow path in the cited area, in order to avoid the high accumulation of muck. There were occasions between July 30 and August 9 that Walker conducted the preshift examination of the area. He conducted the preshift examination on August 8, for example, recording water in the 25 to 27 crosscut on the track. Tr. 643; ex. G-8. Walker did not consider the condition of the primary escapeway to be hazardous, however. Tr. 639. He testified that, in order to preclude passage, the water would have to be 20 inches deep, rib to rib. Muck is a hazard, in his opinion, when you cannot move your legs through it. Tr. 635. Walker also stated that he had evacuated injured miners in worse conditions in other mines, and that the alternate escapeway was available on 4 West. Tr. 660-62. He, too, expressed his belief that slips and falls are a normal consequence of working in a wet mine. Tr. 637. He did acknowledge, however, that he had received complaints about the muddy conditions. Tr. 645-46. Clearly, Walker had actual knowledge of the violative condition and failed to effectively remedy the chronic water accumulation problem in the primary escapeway to ensure safe passage of all miners. Therefore, Walker demonstrated aggravated conduct that is more than ordinary negligence, and he is individually liable under section 110(c) of the Act.

## **3. Greg Miller**

Greg Miller was the section foreman on the midnight shift on 4 West, and an agent of Maple Creek. He and his crew traveled as a team through the primary escapeway to and from the working face on a daily basis. Tr. 674-75, 696. He was well versed on the relay pumping system used on the section, and conducted some of the preshift examinations of the primary escapeway between July 30 and August 9. Tr. 695-96. In terminating the Compliance Order, Inspector Walker lists Brown and Miller as having reported that the water had been pumped off the section, although Miller did not recall making such report. Ex. G-1; tr. 722-23. He testified that he did not recall whether miners had complained to him about the wet

conditions, but did not deny that they could have done so. Tr. 675-77. He also did not deny that he reported to the safety office John Gargala's slip and fall injury that had occurred on August 9. Tr. 703-07; ex. G-16. He acknowledged that he was "under obligation in [his] area to keep everything under compliance, whether it be water, roof, ribs, whatever." Tr. 714. He was adamant, however, that the muck accumulated between crosscuts 24 and 27 was not a hazard. He emphasized that, since the regulation is non-specific, what depth of water constitutes a hazard is a judgment call. According to him, Dickey made a bad one on August 9. Tr. 685-86, 689. In fact, Miller stated, if he had to, he could get through water that is roof high. Tr. 690. It is obvious that Miller knew of the violative condition and his failure to take expeditious, effective action to maintain the primary escapeway in safe, passable condition constituted aggravated conduct. Therefore, Miller is individually liable under section 110(c) of the Act.

#### **IV. Penalty**

##### **A. Maple Creek**

While the Secretary has proposed a civil penalty of \$9,500.00, the judge must independently determine the appropriate assessment by proper consideration of the six penalty criteria set forth in section 110(i) of the Act, 30 U.S.C. § 820(j). *See Sellersburg Co.*, 5 FMSHRC 287, 291-92 (March 1993), *aff'd*, 763 F.2d 1147 (7th Cir. 1984).

Applying the penalty criteria, I find that Maple Creek is a large operator, with a two-year history of 18 violations for the standard at issue, which I find to be significant. Stip.13; ex. G-13. As stipulated by the parties, the proposed penalty will not affect Maple Creek's ability to remain in business. Stip 6. It is also my finding that Maple Creek demonstrated good faith in achieving rapid compliance, after notification of the violation.

The remaining criteria involve consideration of the gravity of the violation and Maple Creek's negligence in causing it. Respecting gravity, I find that failure to maintain the primary escapeway in condition that permits safe, unobstructed, swift passage of all persons, especially in emergencies where lives may be at stake, is a very serious breach of duty. I also find that Maple Creek's section coordinator and foremen, despite pumping efforts, were highly negligent in failing to effectively remedy and control the water accumulation in a timely manner, especially because the Compliance Order had put them on notice of the violative condition ten days before the instant Order was issued. Furthermore, because the pumping conducted by the company between July 30 and August 9 was grossly inadequate, I do not consider those efforts to be a mitigating factor.

Accordingly, having considered Maple Creek's large size, significant history of violations, seriousness of the violation, high degree of negligence, good faith abatement and lack of any mitigating factors, I find that a penalty of \$7,500.00 is appropriate.

### **B. Steve Brown**

Applying the *Sellersburg* penalty criteria, by analogy, to individuals, the factors considered are an individual's income and family support obligations, the appropriateness of a penalty in light of the individual's job responsibilities, the individual's ability to pay, the individual's history of violations, and negligence. Findings on gravity of the violation and good faith abatement rest on the same record evidence used to assess the operator's penalty for the violation underlying the section 110(c) liability. See *Sunny Ridge Mining Co.*, 19 FMSHRC 254, 272 (February 1997).

The parties have stipulated that Steve Brown has the ability to pay the \$1,000.00 penalty proposed by the Secretary. Stip. 7. No evidence has been presented that Brown has a history of previously violating the standard. As section coordinator on 4 West and responsible for outby maintenance, Brown knew of the violative condition and was highly negligent in failing to expeditiously remove and control the water accumulation in the primary escapeway. As has previously been discussed, the violation was serious and Maple Creek abated it in good faith. Therefore, I find that a penalty of \$700.00 is appropriate.

### **C. Alvy Walker**

The parties have stipulated that Alvy Walker has the ability to pay the \$500.00 penalty proposed by the Secretary. Stip. 8. No evidence has been presented that Walker has previously violated the standard. As day shift section foreman on 4 West, Walker knew of the water accumulation, traveled with his crew through it, and failed to expeditiously remedy the hazardous condition. Given the seriousness of the violation and Walker's indifference that amounted to aggravated conduct, I find that he was highly negligent. Therefore, I find that a penalty \$350.00 is appropriate.

### **D. Greg Miller**

The parties have also stipulated to Greg Miller's ability to pay the \$500.00 penalty proposed by the Secretary. Likewise, there is no record evidence of a history of previous violations. As 4 West section foreman on the midnight shift, Miller also knew of the water accumulation, traveled with his crew through it, and failed to expeditiously remedy the condition, as did Brown and Walker. Miller also demonstrated aggravated conduct, in light of the seriousness of the violation, and I find that he, too, was highly negligent. Therefore, I find that a penalty of \$350.00 is appropriate.

**ORDER**

Accordingly, it is **ORDERED** that Order No. 7082507 is **AFFIRMED**, as issued, and that Respondent Maple Creek Mining, Incorporated **PAY** a civil penalty of \$7,500.00, within 30 days of this Decision.

Further, it is **ORDERED** that Respondent Steve Brown **PAY** a civil penalty of \$700.00, that Respondent Alvy Walker **PAY** a civil penalty of \$350.00, and that Respondent Greg Miller **PAY** a civil penalty of \$350.00, within 30 days of this Decision. Upon receipt of payment, these cases are **DISMISSED**.

  
Jacqueline R. Bulluck  
Administrative Law Judge  
(202) 434-9987

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**FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION**

OFFICE OF ADMINISTRATIVE LAW JUDGES

601 New Jersey Avenue, N.W., Suite 9500

Washington, D.C. 20001

June 30, 2004

JIM WALTER RESOURCES, INC.,	:	CONTEST PROCEEDINGS
Contestant	:	
v.	:	Docket No. SE 2003-97-R
	:	Order No. 7670621; 03/03/03
SECRETARY OF LABOR,	:	
MINE SAFETY AND HEALTH	:	Docket No. SE 2003-98-R
ADMINISTRATION (MSHA),	:	Order No. 7670622; 03/03/03
Respondent	:	
	:	No. 7 Mine
	:	Mine ID No. 01-01401

**DECISION**

Appearances: Warren B. Lightfoot, Jr., Esq., Maynard, Cooper & Gale, P.C., Birmingham, Alabama, and Guy W. Hensley, Esq., Jim Walter Resources Inc., Brookwood, Alabama, on behalf of the Contestant;  
Ann G. Paschall, Esq., Office of the Solicitor, U.S. Department of Labor, Atlanta, Georgia, and Terry Gaither, Conference and Litigation Representative, U.S. Department of Labor, Mine Safety and Health Administration, on behalf of the Respondent.

Before: Judge Melick

These cases are before me upon notices of contests filed by Jim Walter Resources, Inc. (JWR) pursuant to Section 105(d) of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 801 *et seq.*, (1994), the "Act," to challenge two withdrawal orders issued by the Secretary of Labor pursuant to Section 104(d)(1) of the Act.<sup>1</sup>

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<sup>1</sup> Section 104(d)(1) provides as follows:

"If, upon any inspection of a coal or other mine, an authorized representative of the Secretary finds that there has been a violation of any mandatory health or safety standard, and if he also finds that, while the conditions created by such violation do not cause imminent danger, such violation is of such nature as could significantly and substantially contribute to the cause and effect of a coal or other mine safety or health hazard, and if he finds such violation to be caused by an unwarrantable failure of such operator to comply with such mandatory health or safety standards, he shall include such finding in any citation given to the operator under this Act. If, during the same inspection or any subsequent inspection of such mine within 90 days after the issuance of such citation, an authorized representative of the Secretary finds another violation of any mandatory health or safety standard and finds such violation to be also

Order No. 7670621

Order No. 7670621 alleges a "significant and substantial" violation of the mandatory standard at 30 C.F.R. § 75.400 and charges as follows:

Float coal dust, (dry and black in color and easily suspended in the air by placing the float coal dust between the hands and patting the hands together (A) was allowed to accumulate along the Main North belt line from #1 to #40 cross cut, a distance of approximately 4875 feet, and (B) from #54 cross cut to #77 ½ cross cut, a distance of approximately 2000 feet. In the area from #54 to #77 ½, there were bottom brackets where the bottom belt was rubbing the brackets. 1 at 110 feet inby #74 cross cut was so hot one could not leave the hand in contact with the bracket. This is an ignition source that could cause a fire with the float coal dust present. The belt was rubbing 2 bottom brackets at 20 feet and 30 feet inby #69 cross cut. The belt was rubbing a bottom bracket at #60 cross cut. 2 bottom rollers were running in coal fines, float coal dust, and rock dust 50 feet and 60 feet inby #66 cross cut. A bottom roller at #56 cross cut was broken and hanging down on one side with the belt rubbing on the other side. In the area from #1 cross cut to #40 cross cut, one bottom roller was running in accumulations of rock dust and coal fines, 3 bottom rollers running in accumulations of rock dust and coal fines at #38 cross cut, 1 bottom roller at #22 cross cut running in accumulations of rock dust and coal fines, 1 bottom roller running in accumulations of rock dust and coal fines 20 feet outby #20 cross cut, 2 bottom rollers running in accumulations of rock dust and coal fines 10 feet and 20 feet inby #19 cross cut, 2 bottom rollers at #10 cross cut running in coal fines, 2 bottom rollers 10 feet and 20 feet outby #7 cross cut turning in coal and coal fines, 1 bottom roller 50 feet outby #7 cross cut running in coal. Coal and coal fines were under the belt drive to the extent the drive rollers were turning in coal. 2 rollers on top of the East track overcast were turning in coal fines. The bottom belt had been rubbing the following belt stands to the point the stands were cut half way through and were shinny [*sic*] from being rubbed, 2 stands at #36 cross cut, 7 stands at #31 cross cut, 2 stands at #29 cross cut, 2 stands at #26 cross cut, 7 stands at #24 cross cut, 1 stand at #22 cross cut, 2 belt stands at #16 cross cut, 1 at #14 cross cut, 3 stands at #9 1cross cut , 2 stands at #8 cross cut, 1 stand at #7

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caused by an unwarrantable failure of such operator to so comply, he shall forthwith issue an order requiring the operator to cause all persons in the area affected by such violation, except those persons referred to in subsection (c) to be withdrawn from, and to be prohibited from entering, such area until an authorized representative of the Secretary determines that such violation has been abated."

cross cut. 1 broken top roller 30 feet inby #28 cross cut. The energized hydraulic belt winch unit was covered with black float coal dust.

The company has been cited 26 times since 01/02/2003 for 75.400 violations. MSHA has discussed this with management several times to no avail.

The cited standard, 30 C.F.R. § 75.400, provides that “coal dust, including float coal dust deposited on rock-dusted surfaces, loose coal, and other combustible materials, shall be cleaned up and not be permitted to accumulate in active workings, or on diesel-powered or electrical equipment therein.”

John Smoot, a coal mine inspector for the Department of Labor’s Mine Safety and Health Administration (MSHA), has been employed by MSHA since the year 2000. He has extensive underground coal mining experience of more than 20 years. He arrived at the JWR No. 7 Mine on March 3, 2003, around 2:30 p.m. At this time he reviewed the preshift examination books for the mine belts for the period March 1, 2003 through the day shift on March 3, 2003. (Government Exhibit No. 1). After examining the books, Smoot, along with union walkaround representative, Dwight Cagle and company representative, Jerry Mullins, began an underground inspection. Traveling along the main north belt line beginning at crosscut 77 ½, Smoot observed what he believed to be coal dust accumulations. He found the coal dust to be dry and black in color and easily suspended in the air. According to Smoot, the coal dust existed along the main north belt line from the No. 1 to the No. 40 crosscut, a distance of approximately 4,875 feet and from the No. 54 crosscut to the No. 77 ½ crosscut, a distance of approximately 2,000 feet. At hearing, Inspector Smoot identified on a mine map (Joint Exhibit No. 1) where he also found what he considered to be potential ignition sources within the same area, including an area where the bottom belt was rubbing the brackets. More particularly, he found a bracket so hot that he could not leave his hand in contact with it. In addition, there were several areas where bottom rollers were running in accumulations of coal fines and coal. Smoot also found several belt stands cut half way through by the belt.

Smoot opined that, due to the amount of float coal dust and the presence of ignition sources, it was reasonably likely for reasonably serious injuries to occur. Fire and smoke would likely result from an ignition and, since the ventilating air proceeded inby the belt and there were 30 miners working inby, Smoot opined that those miners would be exposed to the hazard. Smoot’s testimony in this regard is credible in essential respects. The testimony clearly supports a violation of the cited standard and a finding that the violation was of high gravity and “significant and substantial.”

A violation is properly designated as "significant and substantial" if, based on the particular facts surrounding that violation, there exists a reasonable likelihood that the hazard contributed to will result in an injury or illness of a reasonably serious nature. *Cement Division, National Gypsum Co.*, 3 FMSHRC 822, 825 (April 1981). In *Mathies Coal Co.*, 6 FMSHRC 1,3-4 (January 1984), the Commission explained:

In order to establish that a violation of a mandatory safety standard is significant and substantial under *National Gypsum* the Secretary 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.

See also *Austin Power Inc. v. Secretary*, 861 F.2d 99, 103-04 (5th Cir. 1988), *aff'g* 9 FMSHRC 2015, 2021 (December 1987) (approving *Mathies* criteria).

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.*, 6 FMSHRC 1834, 1836 (August 1984)). The likelihood of such injury must be evaluated in terms of continued normal mining operations without any assumptions as to abatement. *U.S. Steel Mining Co., Inc.*, 6 FMSHRC 1573, 1574 (July 1984); See also *Halfway, Inc.*, 8 FMSHRC 8, 12 (January 1986) and *Southern Ohio Coal Co.*, 13 FMSHRC 912, 916-17 (June 1991).

Smoot also concluded that the violation was the result of high negligence and "unwarrantable failure." In *Emery Mining Corp.*, 9 FMSHRC 1997, 2004 (December 1987), the Commission held that unwarrantable failure is aggravated conduct constituting more than ordinary negligence. This determination was derived, in part, from the plain meaning of "unwarrantable" ("not justifiable" or "inexcusable"), "failure" ("neglect of an assigned, expected or appropriate action"), and "negligence" (the failure to use such care as a reasonably prudent and careful person would use, and is characterized by "inadvertence," "thoughtlessness," and "inattention"). 9 FMSHRC at 2001. Unwarrantable failure is characterized by such conduct as "reckless disregard," "intentional misconduct," "indifference" or a "serious lack of reasonable care." 9 FMSHRC at 2003-04; *Rochester & Pittsburgh Coal Co.*, 13 FMSHRC at 189, 193-94 (February 1991). The Commission has also stated that use of a "knew or should have known" test by itself would make unwarrantable failure indistinguishable from ordinary negligence, and accordingly, the Commission rejected such an interpretation. A breach of a duty to know is not necessarily an unwarrantable failure. The thrust of *Emery* was that unwarrantable failure results from aggravated conduct, constituting more than ordinary negligence. *Secretary v. Virginia Crews Coal Co.*, 15 FMSHRC 2103, 2107 (October 1993).

Smoot based his findings of unwarrantability and high negligence on a number of factors. First, Smoot observed that notations in the preshift reports showed that accumulations had existed in the areas he cited and had not been reported in the preshift books as having been corrected. He noted, in particular, on the preshift examiner's report (Government Exhibit No. 1): (1) at page 1 at the fourth listed location: "40-header North B" "needs spot cleaning back of take up to #17"; on page 2 at the third listed location: "North A" "need swept 60-40, 88-90, 91, 92 ½"; (3) at the bottom of page 2: "North Main need additional dust 77-72, 77-65 need swept

northeast side”; (4) page 4, at the fourth listed location: “North B” “Acc of float coal dust 56-68, b-need swep [sic] need spot cleaning take up [illegible]”; (5) at page 5 the third listed location: “North A” “need swept 89, 92, 62½, 40 3 - 1.”<sup>2</sup> (6) it was reported at the bottom of page 5, under “Remarks-North A” “need additional 13-5.” (7) on page 6 the third listed location: at “Main North A” “additional dust 72-83½”; (8) at page 7 “Remarks-North A,” “needs rock dust added from #24 - #33 brattice.” Smoot observed that the above conditions were reported as “hazardous” in the preshift examiner’s book but there was no indication as of the date of his inspection on March 3, 2003, that any corrective action had been taken. With the exceptions previously noted in footnote 2, this observation appears to be correct.

As Inspector Smoot described in his testimony, the areas he observed in the preshift examiner’s books as needing corrective action were within the same areas in which he found violative “coal dust accumulations.” Even considering the exceptions noted in footnote 2, this evidence clearly supports a finding of high negligence, reckless disregard and a serious lack of reasonable care. While Contestant argues that the No. 7 Mine Belt Crew Report (Operator’s Exhibit No. 2) shows that some corrective action was reported to have been taken, such report is not required to be maintained by Federal law and is not therefore subject to the same certifications of accuracy and criminal sanctions for falsification under Federal law as the preshift and onshift examination reports. I therefore can give entries in the Belt Crew Report but little weight. The credibility of such a report is particularly suspect where entries do not have equivalent notations in the Federally mandated preshift examiner’s report.

Inspector Smoot also relied, for his findings of high negligence and unwarrantability, on his observation that insufficient efforts were being made to clean up the massive accumulations he found. While Smoot apparently found no one working on the belt, I am satisfied from the testimony of others, including union walkaround Dwight Cagle, that two miners were indeed sweeping the belt. Cagle observed two “belt cleaners” during the course of the inspection. One had a broom and was sweeping the ribs in a crosscut and the other, who had just come through a man door, was sweeping the timbers. However, Cagle opined that those two belt cleaners could, at most, clean a maximum of ten crosscuts in an 8-hour shift. He also noted that they would need to shovel under the belt line. According to Cagle, only two persons were available for belt cleaning at that time. The extra belt cleaners were working the longwall and all other miners available that day had been assigned to other work.

One of the belt cleaners, Pearl Longhorn, also testified that they were able to sweep 15 crosscuts over during the entire shift but performed no shoveling. The other belt cleaner, Margaret Martin, testified that she thought they had swept 20 crosscuts during the shift. In her opinion, however, the area also needed rock dusting.

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<sup>2</sup> It is noted, however, with respect to this latter notation that it was reported under the column “action taken” that 62-40 was “corrected.” In addition, it was reported on the March 3 “owl shift” report that “2 people swept 40-62 Br.” (Government Exhibit No. 1 p. 7).

I conclude, based on the credible evidence, that the assignment of only two belt cleaners to clean the massive accumulations was grossly inadequate. The belt cleaners themselves testified that, at best, they were able to sweep only 15 to 20 crosscuts during their shift and that the area still needed rock dusting. The failure of JWR to assign adequate manpower to the cleanup effort is also evidence of gross negligence, indifference, and a serious lack of reasonable care. This evidence therefore independently establishes that the violation was the result of the operator's high negligence and "unwarrantable failure" to comply.

As further corroboration of the grossly inadequate cleanup efforts, I also note that the abatement of the violative condition required significant rock dusting. 34 man-shifts were utilized with 28 pods of rock dust - - the equivalent of 56 tons of rock dust (Tr. 64). In addition, in order to abate the violative condition, 13 man-shifts were needed to clean the accumulations from the belt drive and 54 man-shifts to clean around the bottom rollers where they had been running in accumulations. Moreover, 43 bottom rollers and 66 bottom roller brackets were replaced. Such massive abatement efforts clearly demonstrate the inadequate efforts to have previously corrected the violative conditions. (See Government Exhibit No. 3, p.3).

The Secretary also cites, as evidence of high negligence and unwarrantability, the existence of 23 prior charging documents for violations at the No. 7 Mine of the same standard at issue herein, *i.e.*, 30 C.F.R. § 75.400, over the preceding three months. Those documents were admitted into evidence by order dated February 12, 2004. *See* 26 FMSHRC 133 (February 2004). This Commission has held that prior notification by inspectors to mine operators about potentially unsafe conditions can be used to demonstrate negligence and unwarrantability. *See Enlow Fork Mining Co.*, 19 FMSHRC 5, 11-12 (January 1997). In this case the recent issuance of 23 charging documents for violations of the same standard at issue herein, singly and in combination, indeed, provided notice to JWR that it needed to increase its efforts to comply with the requirements of that standard.<sup>3</sup> This evidence, I therefore find, provides an independent basis for the findings of high negligence and unwarrantability.

#### Order No. 7670622

Order No. 7670622 alleges a "significant and substantial" violation of the standard at 30 C.F.R. § 75.1725(a) and charges as follows:

The Main North belt was not being maintained in safe operating condition or immediately removed from service. 36 belt stands were cut over half way through from being rubbed by the bottom belt. The stands were shinny [*sic*] where they had been rubbed showing this rubbing was recent. This causes heat

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<sup>3</sup> While JWR correctly suggests in its posthearing brief that some of these charging documents are less probative to this case than others, *e.g.*, violations for trash accumulations rather than coal dust accumulations, all are sufficiently probative to be relevant to this issue.

from friction. 21 bottom rollers were running in accumulations of coal fines, and rock dust causing heat from friction. 5 broken bottom rollers were hanging down on one side with the bottom belt rubbing the other side causing heat from friction. There was 1 broken top roller. The bottom belt was rubbing 4 bottom roller brackets. One of these brackets located 110 feet in by cross cut #74 was very hot to the touch. This is an ignition source to cause a fire. 2 areas of float coal dust, (black in color, dry, and easily suspended in the air by placing the float coal dust between the hands and patting the hands together), were located in this area of the belt. An area from #1 cross cut to #40 cross cut, approximately 4875 feet, and an area from #54 cross cut to #77 ½ cross cut, approximately 2000 feet. In the area from #1 to #40 cross cut is the energized belt power center, electrical belt starter box, and the energized hydraulic take-up unit for the belt. Float coal dust (black in color) was present on all of these energized electrical units. Coal and coal fines were under the belt drive to the point the drive rollers were running in coal. In the area from #54 cross cut to #77 ½ cross cut, there was 1 broken bottom roller, 2 rollers turning in accumulations of rock dust and coal fines, 4 bottom roller brackets being rubbed by the bottom belt including the bracket at #74 cross cut.

The cited standard provides that “mobile and stationery machinery and equipment shall be maintained in safe operating condition and machinery or equipment in unsafe condition shall be removed from service immediately.” Many of the conditions cited by Inspector Smoot on the main North belt, for example most of the 36 belt stands cut more than half-way through by the bottom belt, broken rollers on the belt, etc., were cited in the prior order. These conditions were clearly violative of the cited standard and I conclude, based on the same evidence, that they constituted a “significant and substantial” violation of high gravity.

I also find that the violative conditions were the result of high negligence and unwarrantable failure based on the sheer number of violative conditions alone. It may also reasonably be inferred that conditions, such as 36 damaged belt stands cut half way through, were obvious. It may also reasonably be inferred that such conditions were observed by the preshift examiner but not corrected. This evidence establishes that the violation was the result of reckless disregard and a serious lack of reasonable care.

In reaching this conclusion I have not disregarded JWR’s argument that the defective top roller, the seven defective bottom rollers and the 36 damaged stands constituted only “1% or less of the equipment” in the 6800-foot distance traveled by Inspector Smoot and that this should be considered in mitigation of unwarrantability findings. I find, however, that the failure to identify and correct that large number of defects rather suggests that JWR has not been implementing an adequate inspection regimen. A larger area to inspect and maintain may require more inspectors and maintenance workers, but it cannot be an excuse for failure to observe and correct such a large number of defects.

Under the circumstances I find that the orders must be affirmed as written.

ORDER

Orders No. 7670621 and 7670622 are hereby affirmed and these Contests dismissed.

A handwritten signature in black ink, appearing to read "Gary Melick". The signature is fluid and cursive, with a large initial "G" and "M".

Gary Melick  
Administration Law Judge

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