

JULY 2004

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JULY 2004

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

Secretary of Labor, and United Mine Workers of America, Local 1248 v. Maple Creek Mining, Inc., et al., Docket Nos. PENN 2002-116, etc. (Judge Bulluck, June 18, 2004)

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

COMMISSION ORDERS

FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

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

July 16, 2004

SECRETARY OF LABOR,	:	
MINE SAFETY AND HEALTH	:	
ADMINISTRATION (MSHA)	:	
	:	Docket No. WEST 2004-296-M
v.	:	A.C. No. 05-04476-19061
	:	
AGGREGATE INDUSTRIES	:	

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 May 5, 2004, the Commission received from Aggregate Industries (“Aggregate”) 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).

In its request, Aggregate states that MSHA conducted an inspection on October 9, 2003, issuing seven citations. Mot. The proposed assessment for these citations was divided between two cases: A.C. No. 05-04476-19061, including five of the citations, was dated February 13, 2004; A.C. No. 05-04476-21171, covering the two remaining citations, was dated March 11, 2004. *Id.* Aggregates’ safety manager did not notice the different dates on the penalty assessment. *Id.* He assumed that March 11, 2004, was the controlling date for both cases with regard to the 30 day time-limit for requesting a hearing. *Id.* The safety manager mailed his hearing request on March 29, 2004. *Id.* This request was timely with regard to the penalty assessment dated March 11, 2004 (A.C. No. 05-04476-21171), but late with regard to the assessment dated February 13, 2004 (A.C. No. 05-04476-19061.). *Id.* The Secretary states that

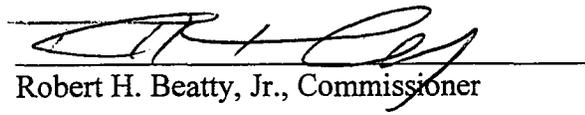
she does not oppose Aggregate's request for relief. *Id.*

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 Aggregate'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 Aggregate's failure to timely contest the penalty proposal and whether relief from the final order should be granted. If it is determined that such relief is appropriate, this case shall proceed pursuant to the Mine Act and the Commission's Procedural Rules, 29 C.F.R. Part 2700.



Michael F. Duffy, Chairman



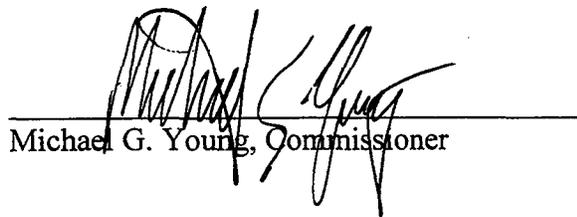
Robert H. Beatty, Jr., Commissioner



Mary Lu Jordan, Commissioner



Stanley C. Subofeski, Commissioner



Michael G. Young, Commissioner

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FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

601 NEW JERSEY AVENUE, NW
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July 29, 2004

SECRETARY OF LABOR, :
MINE SAFETY AND HEALTH :
ADMINISTRATION (MSHA), :
 : Docket No. LAKE 2004-99-M
v. : A.C. No. 11-03084-15194
 :
JOLIET SAND & GRAVEL COMPANY :

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

ORDER

BY THE COMMISSION:

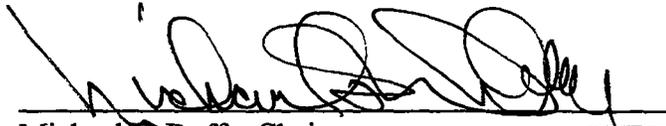
This matter arises under the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 801 et seq. (1994) (“Mine Act”). On May 12, 2004, the Commission received from Joliet Sand & Gravel Company (“Joliet”) a motion made by counsel to reopen a penalty assessment that had become a final order of the Commission 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).

A fatality occurred at Joliet’s Underground Mine No. 1 on March 24, 2003. Mot. at 2. MSHA issued a number of citations to Joliet during March and April 2003. *Id.* Joliet timely contested all of the citations. Subsequently, the Secretary issued proposed penalty assessments. *Id.* In its motion, Joliet states that it mistakenly believed that the pendency of contest proceedings obviated the need to respond to the proposed penalties and that, without consulting counsel, it failed to challenge the proposed penalties. *Id.* Joliet also states that, before the penalty proposals became final, the parties had been conducting settlement negotiations and had successfully reached a settlement as to all of the citations that were issued. *Id.* The Secretary states that she does not oppose Joliet’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. 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).

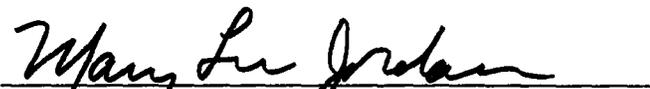
Having reviewed Joliet's motion, in the interests of justice, we remand this matter to the Chief Administrative Law Judge for a determination of whether good cause exists for Joliet's failure to timely contest the penalty proposal and whether relief from the final order should be granted. If it is determined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



Michael F. Duffy, Chairman



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Mary Lu Jordan, Commissioner



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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, D.C. 20001

July 19, 2004

BLUE DIAMOND COAL COMPANY,	:	CONTEST PROCEEDINGS
Contestant	:	
	:	Docket No. KENT 2002-99-R
	:	Citation No. 7476996; 12/3//2001
	:	
	:	Docket No. KENT 2002-100-R
	:	Order No. 7476997; 12/3/2001
	:	
	:	Docket No. KENT 2002-101-R
	:	Order No. 7476998; 12/3/2001
v.	:	
	:	Docket No. KENT 2002-102-R
	:	Order No. 7476999; 12/3/2001
	:	
	:	Docket No. KENT 2002-103-R
	:	Citation No. 7477000; 12/3/2001
	:	
SECRETARY OF LABOR,	:	Docket No. KENT 2002-104-R
MINE SAFETY AND HEALTH	:	Order No. 7478001; 12/3/2001
ADMINISTRATION, (MSHA),	:	
Respondent	:	Mine No. 77
	:	
SECRETARY OF LABOR,	:	CIVIL PENALTY PROCEEDING
MINE SAFETY AND HEALTH	:	
ADMINISTRATION (MSHA),	:	Docket No. KENT 2002-255
Petitioner	:	A. C. No. 15-09636-03687
	:	
v.	:	
	:	
BLUE DIAMOND COAL COMPANY,	:	
Respondent	:	Mine No. 77

DECISION

Appearances: MaryBeth Zamer Bernui, Esq., Office of the Solicitor, U.S. Department of Labor, Nashville, Tennessee, on behalf of the Secretary of Labor;
Melanie J. Kilpatrick, Esq., Wyatt, Tarrant & Combs, LLP, Lexington, Kentucky, on behalf of Blue Diamond Coal Company.

Before: Judge Zielinski

These cases are before me on Notices of Contest filed by Blue Diamond Coal Company (“Respondent”), and a Petition for Assessment of Civil Penalties filed by the Secretary of Labor (“Secretary”), pursuant to section 105 of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 815 (“Act”). The petition alleges that Blue Diamond is liable for six violations of the Secretary’s regulations applicable to underground coal mines, and proposes the imposition of civil penalties totaling \$315,000.00. A hearing was held in Hazard, Kentucky, and the parties filed briefs after receipt of the transcript. For the reasons set forth below, I find that Blue Diamond committed the violations and impose civil penalties totaling \$90,500.00.

Findings of Fact - Conclusions of Law

On July 20, 2001, Gary Caudill was electrocuted while working in Blue Diamond’s No. 77 mine, located in Perry County, Kentucky. Caudill, who had been a certified electrician for about 14 months, was assigned to the 010 section on the third shift. He and Toy Coots, who was listed on Blue Diamond’s time sheets as “shift chief electrician 3,” were assigned to disconnect wiring to the 010 section’s head drive, so that the equipment could be moved. They went underground about 2:00 a.m., after waiting for a fellow employee who was late.

When they arrived at the end of the track, Coots proceeded toward the area of the head drive, passed through a “man door,” and surveyed the area to ascertain what had to be done. He then went back out the man door and around to the 300 kilovolt (“KV”) power center that supplied electrical power to the two pieces of equipment in that area, the #9 head drive (the 010 section’s head drive) and a 20 horsepower (“HP”) booster pump. The power center, head drive and booster pump are depicted in exhibit P-3. While the equipment and the power center were located in close proximity, they were separated by a concrete block brattice wall, and getting from the equipment to the power center involved traversing over 1,000 feet and passing through three man doors. As Coots left the area, he passed Caudill, who was proceeding to the head drive. Coots opened a man door in the brattice that enclosed the power center and observed that the connector for the head drive’s power cable, referred to as a “cat head,” had been pulled and was laying on the floor. No lock had been placed on it, to prevent insertion into the power center’s circuit breaker. He placed his lock on the connector, and proceeded back to the area of the head drive. The circuit breaker for the head drive’s power cable was located very close to the man door. Coots did not actually enter the power center enclosure and did not check the breaker for the booster pump, which was located on the far side of the power center.

When Coots arrived at the head drive, he saw Caudill working on the head drive’s starter box (“belt starter box” or “belt box”), a three-sectioned metal box housing switches that transmitted electric power from the power center to the drive’s motor. Coots assisted in pulling the motor leads from the belt box after Caudill had disconnected them. He then began to remove guards from the head drive, located approximately 25 feet away, while Caudill continued to work on the belt starter box.

Coots heard Caudill say something to the effect that he thought there might be power on the belt box. He replied that there shouldn't have been power on the box because the cat head had been pulled and locked.¹ A very short time later, no more than a few seconds, Coots heard Caudill scream and saw that he had fallen to the floor. At first, Coots thought that Caudill was joking, because he had acted in such a manner about a week earlier. He shouted at Caudill, but got no response, and then proceeded over to where he was laying. It was apparent that Caudill was not faking distress. His arm was resting against the belt box, and the sleeve of his shirt was caught on the latch on one of the box's doors. Coots grabbed Caudill's suspenders and tried to pull him away, but felt electrical power. He then turned and used his foot to move Caudill away from the box. Coots attempted to revive Caudill, but was unable to do so. He then ran to the man-door to the section and called out to the 010 section crew that was working about 150 feet away.²

Sam Combs, the foreman, and the rest of the crew ran to where Caudill was located. Combs sent for an Emergency Medical Technician ("EMT") and a Mine Emergency Technician ("MET"). He and Tommy Rice performed CPR on Caudill for about 10 minutes. Rice mentioned that he felt power on the box. Combs then sent Gary Hubbard to check and make sure there were no power cables plugged into the power center.³ Tr. 177, 186-87. Robert Begley was an EMT and foreman on the 010 section's second shift, which was working overtime to assist in moving the equipment.⁴ He and his electrician, Jeffrey Begley, an MET, ran some 33 breaks from where they were working to the accident scene. As they arrived, Sam Combs was exiting the man door to the head drive area to look for them. Robert Begley asked him if all power was off. He reported that it was, and there were no lights in the area. Tr. 215, 254-55. Coots also said that all power was off. Tr. 218. The Begleys performed CPR on Caudill, but had great difficulty establishing and maintaining an airway. Caudill's jaw was locked and he felt cold. Tr. 259. After about 30 minutes, they abandoned their effort.

When Robert Begley learned that Combs had had difficulty notifying surface officials, he sent a man down to the end of the track line, where another phone was located. After abandoning the CPR effort, Begley went to that phone and called John Boylen, Blue Diamond's director of operations, who directed that Caudill be evacuated, and that all employees be removed

¹ The exact wording of Coots' reply is disputed.

² There was a mine phone on the belt box, but the 20-volt data line to the box, including the phone line, had been cut.

³ Combs did not mention that he had ordered that any power be disconnected during the investigation. He testified that he recalled doing so only after receiving a subpoena to testify at the hearing. Tr. 187. He did not recall whether Hubbard reported back that he had disconnected any power cables. Tr. 189.

⁴ Robert Begley was called in that day because the second shift foreman had quit.

from the area. He also instructed Begley that nothing involved in the accident was to be disturbed and that the site was to be preserved for investigations. Combs testified that Rice knocked a hole in the concrete block brattice between the accident scene and the power center, in an attempt to create a shorter passage for the evacuation, but Combs told him to leave it alone. Tr. 192. The Secretary's Mine Safety and Health Administration ("MSHA") was notified of the accident and an investigation was begun immediately by MSHA and State officials.

When investigators arrived at the scene of the accident, they found no power source on the belt box that could have produced a fatal injury. Its power cable had been disconnected and locked out at the power center. The power cable to the nearby booster pump had also been pulled, but not locked out. The cut data/phone line carried only 20 volts, and there were no other wires connected to the box. Their most significant discovery was a 118-foot length of 16/3 wire that had been cut at one end.⁵ A piece of identical wire, about seven inches long, was found immediately adjacent to the starter box of the booster pump. The cut ends of those wires mated-up, as depicted in exhibit P-9. The investigators eventually determined that the wire had been used as a control circuit between the booster pump and the belt starter box, so that the pump would operate whenever the head drive belts were running.⁶ One end had been connected to the start/stop switch contacts in the pump's starter box, which carried 480 volts. The other end had been inserted into the belt starter box and attached to interlock contacts that closed when the head drive was energized. This substituted the contacts in the belt starter box for the manual start/stop switch in the pump's starter box.

The primary ground connection for equipment is supplied through its main power cables. When they are plugged into the power center, those pieces of equipment are properly grounded. Ground leads in wires connecting various elements of the equipment, e.g., disconnect switches, starter boxes, and motors, assure that all such elements are grounded through the power center. The ground conductors in the 16/3 wire had been cut off at both ends at the point that outer insulation had been stripped back to, i.e., the ground wire had not been connected to either the belt box or the pump starter box. Consequently, the control circuit had not been grounded. As wired prior to the accident, when the head drive power cable was disconnected, the belt starter box was no longer grounded – yet power was being delivered to the box by the ungrounded 480-volt control circuit connected to the pump's starter box.

⁵ The "16" refers to the size of the conductors, and the "3" refers to the number of conductors. The three conductors in the wire are separately insulated by color-coded material. The conductors that carry current are colored white and black, respectively. The third conductor is a ground wire, which appears to have had a green insulating covering. Ex. P-9.

⁶ The pump increased water pressure to spray nozzles used for dust control. The water lines were somewhat fragile and tended to rupture if the pump was operated for lengthy periods. Since the high-pressure sprays were needed only when coal was actually being mined, the pump was wired so that it would operate with the head drive.

In the early morning hours of July 20, 2001, MSHA and the State of Kentucky commenced a thorough investigation of the fatal accident. Their efforts were frustrated by the changes that had been made to the accident scene, the absence of records, and a lack of candor on the part of Blue Diamond employees. The identity of the electrician who installed the pump's control circuit was never ascertained. Nor was it determined exactly how Caudill came into contact with the energy source. After eliminating other potential sources of power, including other nearby equipment, stray current from surface overhead electrical lines, and even lightning, the investigation team determined that Caudill most likely encountered at least one phase of the 480-volt control circuit, either by touching one of its leads or by touching the frame of the belt box when the lead was in contact with it.⁷ The ultimate conclusion reflected in the Report of Investigation was that Caudill came "into contact with energized electrical components [as a result of work] being performed on energized electrical equipment prior to the mine operator's ensuring that all electrical power sources to the equipment were properly locked and tagged out." Ex. P-1, at 11.

Based upon the findings and conclusions of the investigative team, on December 3, 2001, MSHA issued one citation and four orders to Blue Diamond, charging violations of mandatory safety standards for underground coal mines and one citation charging a violation of a regulation mandating preservation of accident sites. The five charges based upon safety standards were issued pursuant to section 104(d) of the Act, and alleged that the violations "could significantly and substantially contribute to the cause and effect of a coal . . . mine safety . . . hazard, . . . [and were] caused by an unwarrantable failure of [the] operator to comply with [the] mandatory safety standard." 30 U.S.C. § 814(d). It was also alleged that each of the violations was a cause of the fatal accident. The Secretary proposed civil penalties of \$55,000.00, then the statutory maximum, for each of those violations, and a civil penalty of \$40,000.00 for the site alteration charge. Blue Diamond timely contested the issuance of the charges and the proposed penalties. Proceedings were stayed pending completion of investigations into potential criminal charges and additional civil penalty assessments against individual agents of the operator. At the conclusion of those investigations, no additional charges were brought. Additional delay was prompted by the initiation of bankruptcy proceedings by Blue Diamond's parent company, the James River Coal Company.

The alleged violations are discussed below.

Citation No. 7476996

Citation No. 7476996, alleges a violation of 30 C.F.R. § 75.509, which requires that, "All power circuits and electrical equipment shall be deenergized before work is done on such circuits and equipment, except when necessary for trouble shooting or testing." The "Condition or Practice" section of the citation reads:

⁷ The 480-volt power was supplied in two phases. The potential from one phase to ground was 277 volts. Spanning both phases yielded a potential of 480 volts.

Work was performed on electrical circuits and equipment without all power first being deenergized, while under the direct supervision of the chief electrician.

The electrical circuit (277 volts) entering the #9 belt starting box and supplying power to the 20 HP booster pump was not deenergized prior to work being performed on the energized circuit. This resulted in a mine electrician contacting energized components and receiving fatal injuries on July 20, 2001.

Ex. Jt.-1.

The Violation

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

It is not disputed that Caudill worked on electrical circuits and equipment that had not been deenergized. The testimony of the Secretary's witnesses paralleled the findings in the Report of Investigation, exhibit P-1. All sources of power, other than the 480-volt control circuit, were eliminated as causes of Caudill's electrocution. While the belt drive's power cable connector had been pulled and locked out, the power cable connector to the booster pump had not been pulled and the power supplied to the booster pump's control circuit caused the electrocution. It is also clear that the violation was significant and substantial.⁸ The issue is whether the violation was the result of the operator's unwarrantable failure.

Unwarrantable Failure

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

⁸ A significant and substantial ("S&S") violation is described in section 104(d)(1) of the Act as a violation "of such nature as could significantly and substantially contribute to the cause and effect of a coal or other mine safety or health hazard." A violation is properly designated S&S "if, based upon the particular facts surrounding that violation, there exists a reasonable likelihood that the hazard contributed to will result in an injury or illness of a reasonably serious nature." *Cement Div., Nat'l Gypsum Co.*, 3 FMSHRC 822, 825 (Apr. 1981); *see also U.S. Steel Mining Co., Inc.*, 7 FMSHRC 1125, 1129 (Aug. 1985); *Mathies Coal Co.*, 6 FMSHRC 1 (Jan. 1984); *Austin Power, Inc. v. Sec'y of Labor*, 861 F.2d 99, 103-04 (5th Cir. 1988), *aff'g Austin Power, Inc.*, 9 FMSHRC 2015, 2021 (Dec. 1987) (approving *Mathies* criteria).

The unwarrantable failure terminology is taken from section 104(d) of the Act, 30 U.S.C. § 814(d), and refers to more serious conduct by an operator in connection with a violation. In *Emery Mining Corp.*, 9 FMSHRC 1997 (Dec. 1987), the Commission determined that unwarrantable failure is aggravated conduct constituting more than ordinary negligence. *Id.* at 2001. Unwarrantable failure is characterized by such conduct as "reckless disregard," "intentional misconduct," "indifference," or a "serious lack of reasonable care." *Id.* at 2003-04; *Rochester & Pittsburgh Coal Co.*, 13 FMSHRC 189, 194 (Feb. 1991) ("R&P"); see also *Buck Creek [Coal, Inc. v. FMSHRC]*, 52 F.3d 133, 136 (7th Cir. 1995)] (approving Commission's unwarrantable failure test).

Whether conduct is "aggravated" in the context of unwarrantable failure is determined by looking at all the facts and circumstances of each case to see if any aggravating factors exist, such as the length of time that the violation has existed, the extent of the violative condition, whether the operator has been placed on notice that greater efforts are necessary for compliance, the operator's efforts in abating the violative condition, whether the violation is obvious or poses a high degree of danger, and the operator's knowledge of the existence of the violation. See *Consolidation Coal Co.*, 22 FMSHRC 340, 353 (Mar. 2000) . . . ; *Cyprus Emerald Res. Corp.*, 20 FMSHRC 790, 813 (Aug. 1998), *rev'd on other grounds*, 195 F.3d 42 (D.C. Cir. 1999); *Midwest Material Co.*, 19 FMSHRC 30, 34 (Jan. 1997); *Mullins & Sons Coal Co.*, 16 FMSHRC 192, 195 (Feb. 1994); *Peabody Coal Co.*, 14 FMSHRC 1258, 1261 (Aug. 1992); *BethEnergy Mines, Inc.*, 14 FMSHRC 1232, 1243-44 (Aug. 1992); *Quinland Coals, Inc.*, 10 FMSHRC 705, 709 (June 1988). All of the relevant facts and circumstances of each case must be examined to determine if an actor's conduct is aggravated, or whether mitigating circumstances exist. *Consol.*, 22 FMSHRC at 353. Because supervisors are held to a high standard of care, another important factor supporting an unwarrantable failure determination is the involvement of a supervisor in the violation. *REB Entrs., Inc.*, 20 FMSHRC 203, 225 (Mar. 1998).

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

Section 3(e) of the Act defines "agent" as "[a]ny person charged with responsibility for the operation of all or a part of a coal or other mine or the supervisor of the miners in a coal or other mine." 30 U.S.C. § 802(e). In considering whether an employee is an operator's agent, the

Commission has relied, not upon the job title or the qualifications of the miner, but upon his function, and whether it is crucial to the mine's operation and involves a level of responsibility normally delegated to management personnel. *Martin Marietta Aggregates*, 22 FMSHRC 633, 637-38 (May 2000); *REB Enterprises, Inc.*, 20 FMSHRC at 211; *Ambrosia Coal & Constr. Co.*, 18 FMSHRC 1552, 1560 (Sept. 1996); *U.S. Coal Inc.*, 17 FMSHRC 1684, 1688 (Oct. 1995).

The Commission has relied upon precedent developed under the National Labor Relations Act, 29 U.S.C. § 141, *et seq.*, to the effect that the authority to assign tasks and make schedules is not sufficient to afford an individual supervisory status. *Martin Marietta*, 22 FMSHRC at 638. In *Ambrosia* it was held that a "person in charge" was an agent because he performed functions that were crucial to the mine's operation and exercised responsibility normally delegated to management personnel. Those functions were: accompanying MSHA inspectors and attending close-out conferences as the operator's representative, conducting daily examinations and recording findings as a certified mine examiner, and issuing work orders to abate citations. There was also evidence that the agent held himself out as the employee in charge, signed documents as mine foreman and was viewed by other miners as a person with authority.

In *Whayne Supply Co.*, 19 FMSHRC 447, 451 (Mar. 1997), the Commission held that a "highly experienced repairperson who needed little supervision and helped less experienced employees [was not] a supervisor, much less a manager [because there was] no evidence that [he] exercised any of the traditional indicia of supervisory responsibility such as the power to hire, discipline, transfer, or evaluate employees [or that he] 'controlled' the mine or a portion thereof." Similarly, in *Martin Marietta*, it was held that an employee who had the authority to tell other miners how he wanted a job done and to stop them if he did not like what they were doing was not an agent or supervisor. His control was tightly circumscribed and he could not hire, fire, evaluate or discipline miners and could not take any action to abate citations, or change a miner's job or the equipment on a job, was paid at an hourly rate, and did not hold himself out as a supervisor or person in charge.

An employee's functions, and status as agent, are considered as of the time of his allegedly negligent conduct. *Martin Marietta* at 638; *REB* at 194; *Whayne Supply* at 452; *U.S. Coal* at 1688. Consequently, even a rank-and-file miner can be found to be an agent while performing critical, management-related functions such as required safety examinations. *R&P* (rank-and-file miner who was a certified mine examiner was agent of operator when assigned to perform such inspections); *compare Mettiki Coal Corp.*, 13 FMSHRC 760 (May 1991) (certified electrician acts as an agent when performing monthly electrical inspections), *with U.S. Coal*, 17 FMSHRC at 1688 (certified electrician does not act as an agent when performing routine repairs).

As stated in the citation and argued in the Secretary's brief, the unwarrantable failure allegation is principally based upon the contention that Coats was a supervisor and agent of Blue Diamond, and that his actions in responding to Caudill's concern that there might be power on

the box amounted to reckless disregard. In reaching the conclusion that Coots was Blue Diamond's agent, Conley, the lead investigator, relied solely upon Coots' job title, which was reflected on time sheets as "shift chief electrician 3."⁹ Tr. 25, 41; ex. P-4. Patrick A. Stanfield, an MSHA electrical inspector, confirmed that Coots' actions were the basis of the unwarrantable failure charge, and also related his belief that Coots had been directing the work force, although he was unable to specify the grounds for that belief. Tr. 310, 315-16, 395-97. He later conceded that the determination was based upon Coots' title, and that he worked on the electrical portion of the investigation and left the determination regarding agency to Conley. Tr. 414-15, 422-26.

Coots was assigned to maintenance, and worked under Willie Collins, Blue Diamond's chief of maintenance. He was referred to as the "floater," and was the only electrician that was assigned to maintenance for the entire third shift. There were two other certified electricians that worked on the third shift: Caudill, who was assigned to the 010 section for the first part of the shift, and Roger Cornett, who was assigned to the 09 section for the first part of the shift. Tr. 444. The working sections were supervised by a foreman, and usually produced coal for the first 3-4 hours of the shift. When coal was being produced, Caudill and Cornett performed a variety of mining tasks, reported to, and were supervised by, the section foremen. Tr. 168, 200-01. Sam Combs was the foreman for the 010 section, and Troy Combs, Jr., was the foreman for the 09 section.

The last part of the third shift was usually devoted to maintenance. During that time, the section electricians joined Coots and worked on electrical maintenance tasks. They ceased being part of the section crews and were no longer supervised by the section foremen. Coots, Caudill and Cornett, as certified electricians, were qualified to work independently, and did so. Tr. 443. They did not review or inspect each other's work. Coots had approximately 3 years more experience as an electrician and was paid a little more than Caudill.¹⁰ Coots, who had left Blue Diamond's employment in October 2001, testified that he was a floater, or troubleshooter, on the third shift. He helped the section electricians and was not Caudill's boss, but was more his helper. Tr. 78, 120-23. Collins described Coots' duties in similar terms. He was a floater, who handled the outby equipment, e.g., "rail runners, man trips and scoops." Tr. 442-43.

Collins and the second shift foremen identified maintenance tasks to be performed on the third shift. Tr. 445. Those tasks were usually transmitted from Collins in the form of work orders or a "to do" list. An electrician responsible for a certain task would perform the work required, sign-off on the work order, and turn it in at the end of the shift. Tr. 445-46. While Coots, who was typically the only electrician present at the beginning of the shift, may have

⁹ Coots was identified in the Report of Investigation as one of Blue Diamond's "principal officers." Ex. P-1, p.4. The title ascribed to Coots on the time sheet was apparently the sole basis for that determination.

¹⁰ Collins testified that Coots was given the title of chief electrician in order to justify a slightly higher rate of pay, because experienced electricians were difficult to retain. Tr. 490-91.

distributed, or facilitated the distribution of the work orders, the actual assignment of tasks appears to have been more of an informal, ad hoc, process. Collins testified that Coots did not assign jobs to other electricians. Tr. 478.

Coots was generally responsible for obtaining in-stock parts needed for electrical repairs being done on the third shift, usually by physically walking out and getting them. Tr. 84, 443-44. Collins had to approve requests for parts that had to be ordered. Tr. 444. While it is not clear that other electricians could not also obtain parts, it appears that Coots was the primary person that performed that function.

Coots performed weekly electrical inspections on a regular basis.¹¹ Tr. 81. Other electricians also performed such inspections. Tr. 83. MSHA inspectors reviewed the electrical books and saw that Coots had signed-off in several places. There was no evidence that Caudill had signed the electrical books. Coots did not recall what areas he had inspected, and specifically could not recall whether he had inspected the booster pump, which had been installed approximately six weeks prior to the accident.¹² Tr. 141. He testified that he was not aware of the 480-volt control circuit running from the booster pump to the belt starter box.¹³ Tr. 140. MSHA's witnesses did not specify the location of the equipment that Coots had certified that he had inspected on the electrical books. Nor did they state that Coots had signed-off on an inspection of the 010 section's head drive during the six weeks that it had been at that location.

On the day of the fatal accident, the 010 section second shift had been held over to help the third shift move the longwall equipment, and no production had occurred. Consequently, from the beginning of the shift, all three electricians worked on maintenance tasks associated with the move. Work orders were not issued for such tasks, in part, because it was difficult to predict exactly when the equipment move would be required. The "to do" list for that date directed that the electrical connections to the 010 section's head drive be removed. Coots and Caudill intended to jointly perform that task. According to Coots, Caudill liked to hurry and get started on any job. "He was the first one there." Tr. 154. When he and Coots arrived underground, Caudill apparently went directly to the power center and removed the power cable connector for the head drive. Coots first went to survey the work area. While he proceeded to the power center, where he placed his lock on the cable connector, Caudill began disconnecting

¹¹ Electrical equipment is required to be examined weekly by a qualified person. 30 C.F.R. §§ 75.512 - 75.512-2.

¹² The parties stipulated that the booster pump had been installed on or about June 5, 2001.

¹³ Coots knew that booster pumps were typically wired so that they would run when the belts ran. However, in his experience, that was accomplished by use of a "smoke roller," a roller with a mercury switch that closed when the moving belt caused the roller to spin. Tr. 87-88, 114-18.

the power cables and other wires at the belt starter box. Tr. 121. Caudill was not acting at the direction of Coots. He independently chose to begin disconnecting wires from the belt box.

Coots was paid on an hourly basis and did not have authority to hire, fire, or discipline other employees. These factors are of little significance, however, because foremen also were paid hourly and the power to hire and fire resided considerably farther up the chain of command. However, unlike Coots, foremen had the authority to recommend discipline and participate in disciplinary proceedings.

The Secretary argues that the testimony of two of Blue Diamond's supervisors, Sam Combs and Robert Begley, supports her allegation that Coots was a supervisor. However, while both witnesses made statements relied upon by the Secretary, other portions of their testimony substantially undercut the portions that the Secretary relies upon. There was also extremely limited foundation for their testimony on the supervisory structure for the electricians working maintenance and, at least as to Begley, an admitted lack of personal knowledge.

Sam Combs testified that floaters usually "were mostly in charge," and that "your float was usually considered one of the bosses." Tr. 164, 167. He also stated that he understood that the responsibility to make electrical examinations was Collins' and Coots'. Tr. 199-200. However, Combs specifically declined to state that Coots was in charge of telling Caudill what to do. Tr. 166. He later stated that when Caudill was working maintenance, Collins was his supervisor. Tr. 168. He added that Coots would not usually check on work being performed by Caudill. Tr. 167-68. Combs also believed that it was Collins' responsibility to assure that weekly electrical examinations were conducted and recorded in the books, although he added that the responsibility was Collins' and Coots', "I guess." Tr. 200. As to work assignments, Combs' understanding was that the electricians' maintenance tasks were "already laid out for them [on cards] before we ever arrived at the mines." Tr. 166.

Robert Begley, who was called in to be the second shift foreman on the 010 section on July 20, 2001, testified that "as far as [he] knew, [Coots] was like . . . the electrical boss on the third shift. He'd give . . . the to do list to the repairmen. Make sure, I guess, that they got . . . their stuff done." Tr. 253. However, he later testified that he did not work directly with the third shift electricians and "Collins made all the calls as far as electrical at the mine," and might have told Coots what the maintenance work assignments would be. Tr. 270.

I find that the functions performed by Coots were comparable to those of a "lead man," as described in *Wayne Supply* and *Martin Marietta*. He did not supervise Caudill's work or the work of other electricians. He did not decide what maintenance tasks would be performed. At best, he facilitated the distribution of work assignments to other third shift electricians. He was primarily responsible for physically obtaining parts needed for work on the third shift. While the Secretary makes much of this responsibility, she offers little support for the contention that this is a level of responsibility normally delegated to management personnel. Aside from conducting safety inspections, there is no evidence that Coots performed any of the functions identified in

Commission cases as those of an agent. Coots did not control a portion of the mine, and his functions were not those typically assigned to management. Consequently, when performing his routine duties, he was not Respondent's agent.¹⁴

R&P and *Mettiki* make clear that Coots acted as Blue Diamond's agent when performing weekly electrical examinations. However, the accident here, and the allegedly negligent conduct cited by the Secretary, did not occur when he was performing such an examination. Consequently, his alleged negligence cannot be imputed to Respondent.¹⁵

That does not end the inquiry, however, because the Secretary contends that, even if Coots were not Blue Diamond's agent, the company is chargeable with unwarrantable failure because of the overall dangerousness of the situation created, and its failure to assure that Caudill was aware that the booster pump's control circuit provided a source of power in the belt starter box. I find that Blue Diamond was negligent with respect to this violation, by failing to take steps to assure that an electrician working on the belt starter box would know that there was a second source of power to the box, but that the negligence was moderate.

Since Caudill and Coots were not agents of Respondent's, any negligence by them cannot be imputed to Respondent. *Wayne Supply*, 19 FMSHRC at 451-53; *Southern Ohio Coal Co.*, 4 FMSHRC 1459, 1463-64 (Aug. 1982). Blue Diamond's negligence, if any, must be ascertained by examining the supervision, training and discipline of its employees. *Id.*

Blue Diamond had a clear written policy that all electrical equipment was to be deenergized and locked out and tagged out prior to being worked on. Tr. 505-06; ex. R-7 at pp. 9-2 to 9-3. That policy was provided to its employees. Blue Diamond furnished appropriate equipment to its electricians: locks, voltmeters and voltage sensing wands. Tr. 509, 561. It provided training on proper lock/tag out procedures. In fact, it provided training on those procedures to Caudill and Coots only two days prior to the accident. Tr. 142-46; ex. R-1, R-2. It also had an enforcement program, which consisted of spot-checking electricians to assure that they complied with the deenergize, lock and tag out policy. Tr. 144, 240, 507, 510, 556-57.

¹⁴ Coots testified that he left Blue Diamond in October of 2001, for a "better job." Tr. 78. At the time of the hearing, he was working as an electrician, apparently in a non-supervisory position. Tr. 76. Had he been a supervisor, as the Secretary contends, it would be more likely that he would have remained in supervisory positions.

¹⁵ The degree of Coots' negligence is a contested issue rendered moot by the finding that he was not acting as Blue Diamond's agent at the time. The Secretary argues that Coots was not aware of the control circuit. He knew that the power cable to the belt box had been disconnected and had reason to believe that there was no power on the box. Only a week earlier, Caudill had pretended to encounter power. Coots' reaction to Caudill's comment, under the circumstances presented here, would appear to be a tenuous foundation for her reckless disregard argument.

There is considerable evidence that Blue Diamond had a clear policy, thorough training and an effective enforcement system, to assure that electrical equipment was deenergized, and locked and tagged out, prior to being worked on. However, running a second source of power, particularly a 480-volt circuit, to another piece of equipment, and failing to clearly identify that source of power either on the equipment itself, or at the power center, created a potentially dangerous situation. Although Collins testified that such control circuits were not uncommon at the mine, he described no training program or other mechanism whereby electricians were informed of such wiring schemes. Stanfield testified that no one in mine management told MSHA that Coots or Caudill had been trained on how the box was wired. Tr. 325. Neither Caudill, nor Coots, was aware of the presence of the 480-volt control circuit in the belt box. Coots testified that there were no schematic, or other drawings of circuits for equipment such as the belt-box, that an electrician could consult to learn the presence of a second power source in the box.¹⁶ Tr. 153.

Blue Diamond argues that it was entitled to rely upon the expertise of its certified electricians, and that Caudill should have identified the control circuit as a second source of power and deenergized it. Caudill was clearly negligent in failing to deenergize the starter box. He failed to effectively use his voltmeter, and especially his power sensing wand, to make sure there was no power on the box. He also failed to ascertain the presence and/or purpose of the 16/3 wire carrying 480 volts that entered the box. Nevertheless, failing to inform electricians about a second power source to a piece of equipment they were assigned to work on, leaving them to find it on their own, created a risk that was not consistent with the high standard of care to which supervisory officials are held.

Based upon consideration of the above factors, I find that Blue Diamond's negligence with respect to this violation was moderate. There was no direct involvement by any supervisor in Caudill's failure to deenergize the equipment, and many of the other factors typically considered in the unwarrantable failure analysis do not implicate Blue Diamond. The violation was isolated and of very short duration. There was no notice that greater efforts were necessary for compliance and no supervisor or agent of Blue Diamond was aware of the violation prior to the accident. The violation was promptly abated.

Order No. 7476998

Order No. 7476998, alleges a violation of 30 C.F.R. § 75.511, which requires, *inter alia*, that, "Disconnecting devices shall be locked out and suitably tagged by the persons who perform such work, . . . [and] shall be removed only by the persons who installed them." The basis for the violation was that the power cable connector for the booster pump was not locked out and suitably tagged while electrical work was being performed. Ex. Jt.-3.

¹⁶ In fact, there was a mine wiring map that should have depicted the control circuit. However, it had not been kept up-to-date, and did not reflect the presence of the control circuit at issue, a violation for which Respondent was separately cited.

The Violation – S&S – Unwarrantable Failure

There is no dispute that the power cable connector for the booster pump, and its control circuit routed through the belt box, was not disconnected from the power center and was not locked out and suitably tagged. Blue Diamond disputes the alleged violation, contending that it is duplicative of the failure to deenergize violation charged in Citation No. 7476996. It also contends that if this order is found to be a proper separate charge, it was not a cause of Caudill's death, was not properly designated S&S, and was not due to its unwarrantable failure.

Citations and orders alleging violations of different standards arising out of the same, or related, conduct are not duplicative, as long as the standards involved impose separate and distinct legal duties on an operator. *Western Fuels-Utah, Inc.*, 19 FMSHRC 994, 1003-05 (June 1997) (citing *Cyprus Tonopah Mining Corp.*, 15 FMSHRC 367, 378 (Mar. 1993); *Southern Ohio Coal Co.*, 4 FMSHRC 1459, 1462-63 (Aug. 1982); and *El Paso Rock Quarries, Inc.*, 3 FMSHRC 35, 40 (Jan. 1981)). In *Western Fuels-Utah*, the Commission held that a charge of violating a specific standard was duplicative of a charge of violating a more general standard. However, the Commission made clear that its decision was not based solely upon the premise that every violation of the more specific standard would also be a violation of the more general one. Rather, it looked to whether the operator had been cited for more than one specific act or omission. Had there been evidence of additional deficiencies that violated the general regulation, such that that allegation would not have been based upon the identical evidence used to support the violation of the more specific standard, the charges would not have been found duplicative. *Id.* at 1004 n.12.

Here, Blue Diamond argues that every failure to deenergize will always involve a failure to lock out and suitably tag, because locking and tagging cannot be accomplished unless the device has been unplugged, i.e., deenergized. Accepting that as a correct statement, I find that the alleged violations are not duplicative because the standards impose separate and distinct duties, and the alleged violations are based upon two separate and specific omissions. The two standards are designed to address related, but different, duties. The first, section 75.509, requires that electrical power be disconnected prior to work being performed. The second, section 75.511, requires additional actions to assure that reenergizing does not occur accidentally when individuals are performing electrical testing or working on equipment. *See U.S. Coal Inc.*, 17 FMSHRC at 1684 n.1; *Badger Coal Co.*, 6 FMSHRC 874, 902 (Apr. 1984) (ALJ). The specific omission that supported the violation of section 75.509 was the failure to disconnect the booster pump's power cable. The specific omission that supported the violation of section 75.511 was the failure to lock and tag the disconnecting device. While it is true that every violation of section 75.509 will also entail a violation of section 75.511, the two standards impose separate and distinct duties and, consequently, charges that each were violated are not duplicative.

While the two charges are not legally duplicative, the unique facts of this case dramatically alter the causation and S&S analyses. There is no evidence that Caudill was killed

because the booster pump was reenergized, after having been disconnected. It was the failure to deenergize the pump that resulted in the fatality. The failure to lock and tag violation did not result in a fatality and, on the facts of this case, the failure to lock and tag *an energized circuit* did not incrementally increase the risk of injury already present. Consequently, I find that this violation was unlikely to result in an injury and was not S&S.

The violation was not the result of Blue Diamond's unwarrantable failure. Much of the analysis of unwarrantable failure with respect to Citation No. 7476996 applies fully to this violation, with the exception of the finding that Respondent was moderately negligent. Respondent's negligence with respect to the failure to deenergize citation was based upon its failure to impart knowledge of the control circuit to electricians who were assigned to work on the belt box. The lock and tag violation, at least legally, stands on its own footing, and the negligence found with respect to the citation has no application here. As noted previously, Caudill and Coots received specific training on lock and tag procedures only two days prior to the accident. Blue Diamond had a perfectly adequate written policy to lock and tag equipment and provided the equipment to facilitate that procedure. It also had an effective program of spot checking electricians to assure that they were complying with the required procedure. I find that Respondent was not negligent with respect to this violation.

Order No. 7476999

Order No. 7476999 alleges a violation of 30 C.F.R. § 75.512, which requires that, "All electric equipment shall be frequently examined, tested, and properly maintained by a qualified person to assure safe operating conditions. . . . A record of such examinations shall be kept and made available to an authorized representative of the Secretary and to the miners in such mine." The basis for the violation was described in the Conditions and Practice section of the order as:

Electric equipment (20 HP booster pump and the #9 belt drive's starting box) had not been properly examined and maintained to assure safe operating conditions: 1) a separate circuit originating from the booster pump's start box had been wired to the #9 belt box; 2) the start/stop switch located on the booster pump had been defeated (by-passed), allowing the booster pump to start when the #9 conveyor belt was started; 3) the ground wires were found to have been cut at the booster pump and the belt drive starting box; and 4) the 20 HP booster pump was not listed in the records of the examination of the electrical equipment. The failure of the mine operator to insure proper examination and maintenance of electrical equipment contributed to the death of a mine electrician on July 20, 2001.

Ex. Jt.-4.

The Violation – S&S

Inspector Stanfield reviewed Blue Diamond's electrical books from the date of the accident back to year 2000. Although the booster pump should have been listed separately, and examined weekly, there was no record of the booster pump in the books. Tr. 337. There is no evidence that the booster pump and its control circuit had been examined by a qualified individual during the approximate six weeks that the pump had been installed. Respondent does not dispute that the pump should have been listed, but was not. It alleges that this order is duplicative of a citation issued on July 25, 2001, alleging a violation of the same regulation with respect to several pumps for which examination records were deficient. Alternatively, Respondent contends that the causal relationship between this violation and the electrical grounding violation alleged in Order No. 7476997 is the same, and that the two should not both be unwarrantable failure violations assessed at \$55,000.00.

Blue Diamond's duplication argument is based upon Citation No. 7477177, issued by Stanfield on July 25, 2001. It alleged a violation of 30 C.F.R. § 75.512-2, based upon observations that the records of electrical examinations of "pumps, at the mine" did not show that they had been examined weekly, noting that the "last date of examination of the pumps was recorded on 4/19/2001." Ex. P-14. Blue Diamond contends that the booster pump on the 010 section was included in this citation, which had been paid, and that it cannot be subjected to another charge, i.e., Order No. 7476999, for the same violation. While the notes and back-up documentation prepared by Stanfield from his field notes contain references to the 010 booster pump, I accept his explanation that the booster pump was not included in the pumps for which the citation was issued. As he explained, the citation was issued for seven pumps listed on page 3 of his notes (Ex. P-14, p.3), for which there were records of examinations, but the examinations had not been done weekly. Tr. 367-70. There was no record of any examinations for the booster pumps for the 09 and 010 sections, which were the subject of separate citations for violations of 30 C.F.R. § 75.512. Tr. 368. I find that the 010 section booster pump, referred to in Order No. 7476999, was not included in Citation No. 7477177.

The absence of any record of examinations of the booster pump, and the absence of any evidence that the pump and related control circuit had been inspected establish the violation. I also find that the violation was S&S. The failure to perform required weekly safety inspections of electrical equipment, particularly for extended periods of time, can result in serious hazards going undetected, exposing miners to risk of serious injury. There was no record of the 010 section booster pump having been examined for at least several months. Hazardous conditions can occur and become exacerbated quickly in the mining environment. That is why frequent inspections are required, with appropriate testing and maintenance. The failure to perform such examinations, and to keep records of them, created a reasonable likelihood that a reasonably serious injury would result.

Unwarrantable Failure

It is not clear why the first two items listed in the body of the order were included. Nothing in the record establishes that wiring a control circuit from the pump's starter box to the belt starter box, in itself, was improper or violative of any safety standard. The only witnesses to testify on the issue stated that it was permissible. Tr. 232, 403, 479-80, 541. Nor does the fact that the start/stop switch on the pump starter box was "by-passed" appear to be of significance. Substitution of the control circuit contacts for the start/stop switch would appear to be required for such a control circuit to operate properly and, as Stanfield admitted, there was a manual disconnect switch box for the pump located virtually in the same location as its starter box. Tr. 329-30, 404. Consequently, there was a readily available on/off switch for the pump. Respondent was not cited for installation of the control circuit itself, or for by-passing the start/stop switch.

The third item listed, the unconnected ground leads in the control circuit wire, was clearly of significance. The primary ground connection for electrical equipment is provided by the power cables connected to the power center. Consequently, no ground is provided when the cable is disconnected, which was the case when Caudill began work on the belt starter box. The power cable to the booster pump was plugged into the power center, and that piece of equipment was effectively grounded. Had the ground leads in the control circuit wire leading from the pump to the belt starter box been properly connected, the belt box would also have been grounded. However, the leads for the ground wire in the 16/3 control circuit had been cut off, rather than connected, at the time the circuit was installed. Consequently, when the power cable for the belt drive starter box was disconnected, the box was no longer grounded. Yet it could, and possibly did, become "alive" through contact with the energized control circuit.

If the ground leads on the control circuit had been properly connected, Caudill may not have been killed. Ground circuits serve two purposes. They make the metal equipment frames part of the circuit, providing a path to ground for electrical energy that might come into contact with the frame. They also have devices that limit to 25 amps the amount of current that can flow through the ground default circuit. Tr. 321-22. If an energized lead of the control circuit contacted the belt box frame, the circuit breaker to the booster pump would have tripped, deenergizing the pump. Tr. 322. If Caudill had contacted an energized lead of the control circuit and the belt box frame, the current that passed through him would have been limited to 25 amps. Although he still may have been electrocuted, he may have received only a shock. Tr. 534-35.

The Secretary argues that the failure to perform weekly electrical examinations of the booster pump for the six weeks it had been installed resulted in a failure to discover and correct the absence of ground connections in the control circuit, and that the absence of any system of assuring that the examinations were being conducted amounted to an unwarrantable failure that resulted in Caudill's death. Blue Diamond counters that the Secretary did not establish that the missing ground connections would have been discovered during an examination and that it was

guilty only of “mass confusion” over the responsibility for conducting the examinations, which did not rise to the level of reckless disregard. I reject both of Respondent’s arguments.

The fact that the ground leads had been cut off rather than connected could have been observed by opening the belt starter box and/or the pump starter box and performing an examination of the connections for the various leads. A thorough and carefully performed weekly electrical examination would most likely have resulted in discovery of the improper connections. Tr. 135-36, 233, 338-43, 461, 617-18. While the focus of such examinations is to detect adverse conditions that occurred since the last inspection, such as malfunctioning breakers and abrasions to cables, boxes might well be opened to check for dust or other conditions indicating lack of permissibility, which MSHA inspectors may do when performing normal inspections.¹⁷ 135-36, 617-18. If there were signs that stress or tension may have been placed on a wire or cable, or a bushing was damaged or missing, close examination of wire connections might also be required. There was no bushing where the control cable entered the pump starter box. Tr. 342.

As noted above, the pump was not listed in the electrical books, and there is no evidence that it was examined by a qualified electrician during the six weeks that it had been installed prior to the accident. It is also apparent that Respondent did not, at the time, have an effective system of assuring that weekly electrical examinations were being conducted of all of the involved electrical equipment. Coots testified that the second shift floater had been responsible for performing the examinations, but he had been laid off at some point. Tr. 86. Collins, who was also referred to as the chief electrician, testified that he started working at the mine only four weeks prior to the accident and was not sure whether the prior chief of maintenance had designated someone as responsible for performing the examinations, but he believed that it would have been the responsibility of the face electrician, Caudill at the time. Tr. 455, 459-60. In its brief, Respondent notes this testimony, and further cites the testimony of other witnesses which it claims “revealed mass confusion as to whose responsibility examination of the booster pump was.” Resp. Br. at 30. It then argues that any violation was not the result of intentional

¹⁷ Respondent cited MSHA’s Program Policy Manual (“PPM”) to support its assertion that weekly examinations are intended to detect deterioration of equipment through neglect, abuse or normal use. Resp. Br. at 21. The Secretary moved to strike references to the PPM because it was not admitted as evidence at the hearing. I will not consider references to the PPM in this decision. However, Respondent’s witness, Kenneth P. Katen, a safety consulting expert, testified that the PPM stated that “the examination is to insure that there are no hazards that would have accrued due to abuse, neglect, or for that matter, even normal use of the equipment.” Tr. 618. That would also be a logical purpose of repeated weekly examinations.

Respondent also asserted that MSHA had performed a regular inspection in July of 2001, and had not cited the missing ground connections. However, there is no evidence that MSHA inspected the booster pump during the six weeks that it had been installed. While an inspection may have been conducted in July 2001, as Andy Fields, Blue Diamond’s safety director, indicated, due to Respondent’s large size, such inspections were “basically continuous.” Tr. 555.

misconduct, and that its negligence must be classified as no more than moderate.

There are few, if any, responsibilities of mine management more critical than assuring that required safety inspections are performed. As noted in the discussion of agency above, preshift examinations, weekly electrical examinations, and similar functions are of such importance that they are classified as management functions, regardless of who performs them. Mine managers and supervisors are also held to a high standard of care. Mass confusion that leads to important safety inspections not being performed is a gross deviation from the high standard of care that supervisors are held to. While it is, perhaps, understandable that multiple changes in personnel might result in some confusion over such responsibilities for a short time, when the result is that important safety examinations are not conducted for six weeks, or longer, that confusion rises to the level of gross negligence or reckless disregard.

Respondent argues that a finding of unwarrantable failure would amount to application of a “knew or should have known” test and that in the absence of actual knowledge by a supervisor, its negligence could be no more than moderate. I reject that contention. The cases cited by Respondent do not substitute an “actual knowledge” litmus test for the multi-factored approach to determining unwarrantable failure. In fact, the seminal case, *Emery Mining*, makes clear that an operator’s failure to abate a violation he “knew or should have known” existed can form the basis of an unwarrantable failure finding. 9 FMSHRC at 2002, 2003. Collins and Hershell Asher, the mine superintendent, may have had no actual knowledge that the ground wires in the control circuit had not been connected, or that the booster pump had not been examined. However, they are chargeable with knowledge that, over an extended period of time, they had taken no steps to ascertain whether weekly examinations were being conducted. Moreover, the violation was obvious. Even a cursory review of the readily available electrical books would have revealed the absence of any listing for the pump. Collins certainly knew about the pump and was also aware of the control circuit. The violation existed for months, including during the critical six week period that the pump had been installed in the configuration it was in on the day of the accident. The failure of mine management over an extended period of time to assure that the booster pump was being examined, as required by the standard, can only be characterized as indifference – a “total or nearly total lack of interest” – and easily rises to the level of reckless disregard. *Emery Mining*, 9 FMSHRC at 2003.

Order No. 7476997

Order No. 7476997 alleges a violation of 30 C.F.R. § 75.701, which requires that, “Metallic frames, casings, and other enclosures of electric equipment that can become “alive” through failure of insulation or by contact with energized parts shall be grounded by methods approved by an authorized representative of the Secretary.” The basis for the violation was that the ground leads in the 16/3 control circuit wire had been cut off, rather than connected. As a consequence, when the power cable to the belt starter box was disconnected, the box was no longer grounded, even though the 480 volt power source remained in the box. Ex. Jt.-2.

The Violation – S&S

As noted in the discussion of Order No. 7476999, the leads for the ground wire in the 16/3 control circuit had been cut off, rather than connected, at the time the circuit was installed. The result was that when the power cable for the belt drive starter box was disconnected, the box was no longer grounded. Yet it could, and possibly did, become “alive” through contact with the energized control circuit. The failure to establish and maintain a ground for the starter box, which could become “alive” because of the presence of an energized circuit, created a substantial possibility that a serious injury would result, and was a causative factor in Caudill’s death. Respondent does not dispute those elements of the charge. Its challenge is to the unwarrantable failure designation.

Unwarrantable Failure

The Secretary’s primary argument is that the improperly installed control circuit had existed for nearly six weeks and that it should have been discovered during weekly electrical examinations, but that Respondent had no system of assuring that the examinations were being conducted and, in fact, the booster pump and control circuit had not been inspected.¹⁸ Blue Diamond counters that the improperly wired circuit presented a danger only when the head drive power source was disconnected, that the defect was not obvious and may not have been discovered during a weekly electrical examination, and that it was not unreasonable for Blue Diamond to have relied upon its certified electricians to have properly installed the cable.¹⁹

Respondent correctly points out that it was only when the belt drive’s power cable was disconnected, shortly before the accident, that the belt starter box ceased to be grounded. Technically, therefore, the failure to ground violation existed only for a few minutes prior to the accident, even though the control circuit wire had been improperly installed for six weeks. However, on the facts of this case, it is the length of time that the wiring defect existed that should be considered in evaluating Respondent’s negligence. The fact that the defect did not result in an actual grounding violation until later should not be considered a mitigating factor, especially since the defect could have been corrected at any time during the six weeks preceding the accident. As noted above, I have found that the unconnected ground leads would most likely

¹⁸ The Secretary initially argues that Blue Diamond acted in a highly negligent manner when it allowed an employee to install the control circuit without a ground. However, the identity of the electrician who installed the control circuit was never determined, and the negligence of an employee, as opposed to an agent, cannot be imputed to Respondent.

¹⁹ Blue Diamond also attacks certain wording in the body of the order to the effect that the booster pump was not grounded and its on/off switch had been bypassed. Both points have merit. However, the order makes clear that the violation is based upon a failure to ground the belt starter box while the 480 volt control circuit supplied power to it. There was no confusion on the bases for the violation at the hearing.

have been discovered during a reasonably thorough weekly examination. That is true even though Respondent may have been entitled to rely upon its certified electricians to have properly installed the control circuit. Respondent was not obligated to double-check the installation to assure that it had been done properly. Tr. 626. Certified electricians are not trainees. They are expected to work independently. Tr. 578-79. However, reasonable reliance on an electrician's expertise does not justify or excuse Respondent's indifference to the conduct of weekly electrical examinations.

Respondent's argument that the conduct that the Secretary seeks to sanction through this violation is, in essence, the same as that cited in Order No. 7476999, bears more weight. It was the grounding defect that was a major factor in elevating the seriousness of that violation and establishing the causal connection between it and the fatality. Premising an unwarrantable failure finding for this violation on the very same failure to inspect, discover and correct the grounding violation, would, in essence, penalize Respondent twice for exactly the same conduct. While the violations are not legally duplicative, they are largely duplicative in practical terms, and I decline to find an unwarrantable failure with respect to this violation. Rather, I hold that Respondent's negligence was moderate.²⁰

Order No. 7478001

Order No. 7478001 alleges a violation of 30 C.F.R. § 75.904, which requires that, "Circuit breakers shall be marked for identification." The basis for the violation was that the circuit breaker on the power center controlling the booster pump, where the pump's power cable was connected, specified only that it controlled the pump, and did not reflect the fact that it also supplied power to a set of contacts in the belt starter box. Ex. Jt.-4.

The Violation – S&S

It is undisputed that the pump's circuit breaker was labeled "pump." Tr. 346, ex. R-5. The cable connector for the belt drive, the #9 head drive, was plugged into a circuit breaker labeled "#9 head drive," which Stanfield agreed was proper. Tr. 430. He explained that the violation was issued because the pump's circuit breaker should have been labeled "pump and #9 head drive" to disclose that it supplied power to both pieces of equipment. Tr. 346-49. The violation was determined to have been a causative factor in the fatality because it was determined that proper labeling of the pump's circuit breaker would have "alerted" electricians performing weekly exams or working on the equipment that there was a second power source to the belt starter box. Tr. 349. It was classified as an unwarrantable failure because Collins knew about the control circuit and should have assured that the pump circuit breaker was properly labeled.

²⁰ If this violation could properly be categorized as an unwarrantable failure, then a substantial reduction in the proposed penalty would be in order, for the same reason.

Blue Diamond contends that the circuit was properly labeled and that there was no violation. Alternatively, it contends that it did not have fair notice of the Secretary's interpretation of the regulation. It also challenges the assertion that the violation was a causative factor of the fatality and the unwarrantable failure designation. Respondent relies upon the testimony of James W. Oakley, Sr., MSHA's electrical supervisor for District 7, who described the use of pump control circuits wired to a "smoke roller" or similar device that would close a switch energizing the pump when a belt started.²¹ He testified that such arrangements were quite common, and that in such instances the pump circuit breaker was simply labeled "pump" or "pump circuit," and it was not necessary to add "and smoke roller" to the label. Tr. 580-83. In those situations, however, the control circuit was not wired into another piece of equipment with its own power source. It was simply a start/stop switch that was located a distance from the equipment. Tr. 588-89. He had never seen a situation where the control circuit was wired to contacts in a belt starter box, a piece of equipment that had its own power source. Tr. 580. It was his opinion that, because the control circuit supplied 480 volts of power to both the booster pump and the belt starter box, it should have been labeled as supplying both pieces of equipment. Tr. 585. He also testified that he had encountered situations where a circuit was supplying power in the range of 480 volts to two different locations, and that he had required both pieces of equipment to be identified on the circuit breaker, as well as on the cable connector and the female receptacle. Tr. 584.

On balance, I find that the Secretary has carried her burden of proof with respect to this violation. The plain wording of the regulation requires that circuits be marked for identification, i.e., that the piece or pieces of equipment to which they deliver power must be identified. There is no dispute that the booster pump circuit supplied power to both the pump and to the #9 head drive's starter box. I can conceive of no reasonable interpretation of the regulation that would allow an operator to omit either piece of equipment from the label. I also find that the plain wording of the regulation provides adequate notice that labels for circuits that supply power to two pieces of equipment, as opposed to a remotely located switch, should identify both pieces of equipment. "[A] reasonably prudent person familiar with the mining industry and the protective purposes of the standard would have recognized the specific prohibition or requirement of the standard." *Ideal Cement Co.*, 12 FMSHRC 2409, 2416 (Nov. 1990). While the Secretary does not rely upon any published interpretations of the standard addressing similar situations, it appears that the standard has been consistently enforced, at least from the limited evidence in the record.²²

²¹ Collins testified about a situation where kill switches on a continuous miner and a carrier were interlocked, but not so-labeled. Tr. 478. However, that wiring arrangement was not explained in any detail, and that testimony has virtually no probative value with respect to this violation.

²² In Oakley's experience, situations where one circuit supplies power to two pieces of equipment are uncommon, but, when encountered, he has required double labeling. Collins testified that the wiring of the booster pump's control circuit to the belt starter box was common

Respondent does not argue that the violation, if proven, was not S&S. In a general sense, failure to properly label a circuit would create a reasonable possibility that a serious injury would result. Here, however, the deficient label was located on the side of the power center opposite the man door through which its enclosure was accessed. Moreover, while the power center was relatively close to the booster pump and head drive, it was separated from that area by a concrete block brattice wall. Ex. P-3. To view the pump's circuit breaker, someone in the area of the equipment would have had to travel through a man door, down about 10 breaks (approximately 900 feet), pass through another man door, travel back to the power center, through a man door into its enclosure, and walk around to the opposite side of the power center. Tr. 65-67, 573. Stanfield accurately described it as a "remote location." Tr. 430-32.

The hazard, to which the violation contributed, was described by the Secretary as a miner working on the belt starter box while it was still energized by the control circuit, just as Caudill did. She further asserts that had "the circuit breaker been correctly marked, Caudill would have known that the two pieces of equipment were interconnected." Sec'y Br. at 52. The latter assertion must be rejected. There is no evidence that Caudill had performed any electrical examinations or worked on the pump prior to July 20, 2001. While it appears that he entered the power center's man door and removed the head drive's power cable from its properly labeled circuit, it is highly unlikely that he would have walked around to the opposite side of the power center to look at the pump's circuit breaker. He was unaware of the connection between the two pieces of equipment and there would have been no reason for him to have done so. Moreover, in light of the haste with which he approached the job, it is a virtual certainty that he did not take the extra step of looking at the pump's circuit breaker. Had weekly electrical examinations been performed as required, that electrician would have seen a proper label, and might have mentioned it to Caudill, or others that may have passed it on to him. However, that is an extremely remote possibility.

On the facts of this case, I find that the violation was S&S, but that it was not a cause of the fatality. Rather, it was reasonably likely to result in a fatality.

Unwarrantable Failure

The Secretary's argument that the violation was a result of Blue Diamond's unwarrantable failure is based upon the involvement of Collins, Blue Diamond's agent, who failed to assure that the circuit breaker was properly labeled, and the fact that it had existed for six weeks prior to the accident. I find that Collins was negligent in not taking steps to assure that the pump's circuit breaker was properly labeled. However, while I have found that adding

at Blue Diamond, and had been employed at other mines. Tr. 449. However, Coots testified that control circuits for booster pumps at Blue Diamond were usually wired through a smoke roller or other device. Tr. 114. Jeffrey Begley testified that he knew about the control circuit and that he had seen pumps wired that way in other mines. Tr. 220, 232. I find that the wiring of pump control circuits to belt starter boxes was not a common practice, as Collins claimed.

the belt starter box to the pump's circuit breaker was required by the plain language of the regulation, that conclusion is not so strongly compelled that his failure to do so can be equated to reckless disregard. The use of control circuits employing smoke rollers, which is admittedly treated differently under the regulation, is somewhat similar to the control circuit used here. While the violation existed for some six weeks, it was not in an obvious location, and there was nothing that should have prompted Collins to reconsider whether the circuit's label should have been changed after the control circuit had been installed. I find that Respondent's negligence was moderate.

Citation No. 7477000

Citation No. 7477000 alleges a violation of 30 C.F.R. § 50.12, which requires that, "no operator may alter an accident site or an accident related area until completion of all investigations pertaining to the accident except to the extent necessary to rescue or recover an individual, prevent or eliminate an imminent danger, or prevent destruction of mining equipment." The basis for the violation was described in the Condition or Practice section of the citation as:

The site of an accident that resulted in the death of a mine electrician on July 20, 2001, was found to have been altered prior to the completion of all investigations and without MSHA approval. It was determined that the site was altered due to the following: 1) the disconnect device (cat-head) which supplied power to the 20 HP booster pump had been disconnected at the 300 KVA power center and was lying on the mine floor, 2) the 16/3 cable extending from the booster pump to the #9 belt drive starting box had been cut at the pump start box location, 3) the 16/3 cable extending from the booster pump to the #9 belt drive starting box had been disconnected from the interlock on the vacuum breaker and had been pulled completely out of the belt box. None of these conditions could have existed at the time of the fatal accident. Mine management failed to preserve and secure the accident site.

Ex. Jt.-6.

The violation was determined to be "Unlikely" to result in an injury, was not S&S, and was the result of the operator's "Reckless Disregard" of the standard. The Secretary proposes a civil penalty of \$40,000.00 for this violation.

The Violation

The accident scene was certainly altered after Caudill was electrocuted. As configured at the time of the investigation, there was no source of power to the belt starter box that could have caused the accident. The cable connector for the booster pump had been pulled from the power center, apparently after a hole had been knocked in the brattice. More significantly, the 16/3

control wire had been pulled from the belt starter box, and its end at the pump starter box had been cut. The cut end had then been removed from the pump's box and the start/stop switch wires had been twisted together so that the pump would run whenever its power cable was plugged in and its disconnect switch was in the "on" position.

Respondent does not dispute that these changes were made to the accident scene. However, it argues that disconnecting the pump's power cable, which appears to have been accomplished at Sam Combs' direction, was justified as a safety measure to eliminate an imminent danger. Similarly, it argues that pulling the 16/3 cable from the belt starter box could have been justified as eliminating an imminent danger. It does not attempt to account for the fact that the cable was cut near its connection with the booster pump starter box, and argues that the re-wiring of the pump switch is not included in the narrative of the citation. It also points to testimony that the mine's manager of production, John Boylen, ordered that the scene be preserved when he was advised of the accident.

I find that the Secretary has carried her burden of proof with respect to this violation. While the booster pump's power cable may have been disconnected in a reasonable effort to make the scene safe, the elimination of the pump control circuit was done in such a manner that it must have been a deliberate attempt to conceal the existence of the circuit. There is no direct evidence in the record as to the identity of the person who pulled the 16/3 cable from the belt starter box, cut the other end and re-wired the pump switch. Conley understood from statements made during the investigation, that Coots pulled the 16/3 cable from the box, thereby deenergizing it. Tr. 59. However, at the hearing, Coots testified that the cable he was talking about was the data/phone cable, not the 16/3 control cable. Tr. 104. There is no evidence that the 16/3 cable was pulled from the box in an attempt to eliminate an imminent danger, and there is no evidence or plausible explanation that the other alterations were justifiable under the regulation.

Negligence

The Secretary's argument that the violation was the result of Blue Diamond's reckless disregard is based upon her contention that both Coots and Sam Combs were supervisors, i.e., Respondent's agents, and that they altered the scene, directed that the scene be altered, or permitted the scene to be altered. However, as explained in the discussion of Order No. 7476996, Coots was not a supervisor or agent of Respondent. Consequently, any actions that he took in altering the scene cannot be imputed to Blue Diamond. I agree with the Secretary's argument that whoever pulled and cut the 16/3 cable and re-wired the pump switch most likely was comfortable working with electrical equipment and clearly understood the wiring of the control circuit. There may also have been some time that passed after the accident happened before others were summoned to the scene. These factors tend to implicate Coots more than Combs. Coots was alone at the scene until he summoned Combs. He was an electrician, who would have been comfortable working with electrical equipment and, possibly, may have been familiar with the control circuit. There is no evidence that Combs had any electrical expertise.

Combs, a foreman, was Respondent's supervisor/agent. However, aside from his presence at the scene at various times, the evidence establishes only that he directed that any power cables in the power center be disconnected. Tr. 177, 186-87. His intention was to assure that all power sources in the area be eliminated, which Stanfield agreed would have been legitimate under the regulation. Tr. 434. It is not clear whether his instruction resulted in the booster pump's cable connector being pulled from the power center. Tr. 186-89.

While I appreciate the Secretary's frustration in her inability to identify who altered the scene, I cannot find that Respondent acted with reckless disregard. When advised of the accident, Blue Diamond's higher level managers appropriately directed on-site personnel to preserve the scene. While Combs might have exercised more control over the scene, the significant alterations may already have been made by the time he arrived. In the highly charged atmosphere that he was thrust into, Combs' focus was appropriately on Caudill and the attempts to revive him. Respondent cannot be charged with reckless disregard for Combs' failing to prevent alterations that he justifiably did not observe being made, even if they had been made while he was on the scene. I find that Respondent's negligence was low.

The Appropriate Civil Penalties

The parties stipulated that Blue Diamond is a large operator. Its controlling entity, James River Coal Company, is very large. Exhibit P-16 is a printout from an MSHA computer database showing that Blue Diamond had paid 983 violations, five of which were specially assessed, over the period December 3, 1999, to December 2, 2001. Blue Diamond presented some evidence of limitations on its ability to make payments to vendors. Tr. 559-60. However, it makes no argument in its brief that imposition of the proposed penalties would affect its ability to remain in business. The gravity and negligence associated with the alleged violations are discussed above.

Citation No. 7476996 was affirmed as a S&S violation and a cause of the fatal accident. However, it was not the result of the operator's unwarrantable failure. Blue Diamond's negligence was moderate. A civil penalty of \$55,000.00 was proposed by the Secretary. I impose a penalty in the amount of \$10,000.00, upon consideration of the above and the factors enumerated in section 110(i) of the Act.

Order No. 7476998 was affirmed. However, the violation was found not to be S&S, or to have caused the fatality. It was also not the result of Blue Diamond's unwarrantable failure. It was not negligent with respect to this violation. A civil penalty of \$55,000.00 was proposed by the Secretary. I impose a penalty in the amount of \$500.00, upon consideration of the above and the factors enumerated in section 110(i) of the Act.

Order No. 7476999 was affirmed as an S&S violation that was the result of Blue Diamond's unwarrantable failure. The Secretary proposed a civil penalty of \$55,000.00 for this violation. I impose a penalty in the amount of \$55,000.00, upon consideration of the above and the factors enumerated in section 110(i) of the Act.

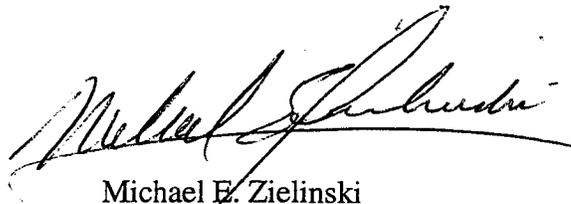
Order No. 7476997 was affirmed as a S&S violation and a cause of the fatal accident. However, it was not the result of the operator's unwarrantable failure. Blue Diamond's negligence was moderate. A civil penalty of \$55,000.00 was proposed by the Secretary. I impose a penalty in the amount of \$10,000.00, upon consideration of the above and the factors enumerated in section 110(i) of the Act.

Order No. 7478001 was affirmed as an S&S violation. However, it was not found to have caused the fatality, and was not the result of Blue Diamond's unwarrantable failure. Its negligence was moderate. A civil penalty of \$55,000.00 was proposed by the Secretary. I impose a penalty in the amount of \$5,000.00, upon consideration of the above and the factors enumerated in section 110(i) of the Act.

Citation No. 7477000 was affirmed. However, the operator's negligence was found to be low, rather than reckless disregard. A civil penalty of \$40,000.00 was proposed by the Secretary. I impose a penalty in the amount of \$10,000.00, upon consideration of the above and the factors enumerated in section 110(i) of the Act.

ORDER

Order No. 7476999 is **AFFIRMED** in all respects. Order Nos. 7476998, 7476997 and 7478001, and Citation Nos. 7476996 and 7477000 are **AFFIRMED**, as modified, and Respondent is directed to pay a civil penalty of \$90,500.00 within 45 days.



Michael E. Zielinski
Administrative Law Judge

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FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION
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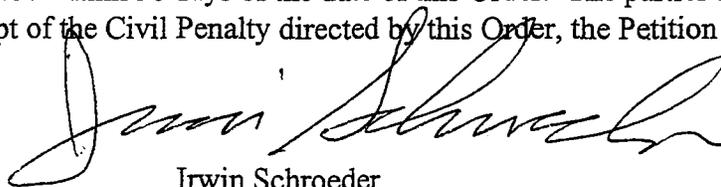
July 27, 2004

SECRETARY OF LABOR, MINE SAFETY	:	CIVIL PENALTY PROCEEDING
AND HEALTH ADMINISTRATION	:	
(MSHA),	:	DOCKET No. CENT 2001-218-M
Petitioner,	:	A.C. NO. 39-00022-05547
	:	
v.	:	
	:	Mine: Dacotah Cement
DACOTAH CEMENT,	:	
Respondent	:	

ORDER APPROVING SETTLEMENT

This case is before me on Remand from a Decision by the Commission dated June 9, 2004, in which the Commission affirmed in part and vacated in part a Decision I made on July 31, 2002. At my request, the parties have reevaluated the factual record involved in my decision. The parties have reached a settlement agreement that they have jointly submitted for my approval. Under the proposed agreement, the Secretary concludes that the violation that was the subject of the Petition was of a lower gravity than originally alleged. The lower gravity requires modification of the citation to substitute "No Lost Workdays" for "Permanently Disabling" and to eliminate the classification of the violation as "Significant and Substantial." The Secretary also agreed to delete "Robert Rohrbach" from Line 15. The parties have agreed that the proposed Civil Penalty for the violation as amended should be \$2,500.00. I have reviewed the proposed Settlement and I find it is consistent with the Mine Safety Act and it is in the public interest. Therefore, it is

ORDERED that the joint motion to approve settlement is granted. The Secretary is directed to amend the citation as agreed to by the parties. The Respondent is directed to pay a Civil Penalty of \$2,500.00 within 30 days of the date of this Order. The parties are to bear their own costs. Upon receipt of the Civil Penalty directed by this Order, the Petition is **DISMISSED**.



Irwin Schroeder
Administrative Law Judge

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

July 28, 2004

SECRETARY OF LABOR,	:	CIVIL PENALTY PROCEEDING
MINE SAFETY AND HEALTH	:	
ADMINISTRATION (MSHA),	:	Docket No. KENT 2002-218
Petitioner	:	A.C. No. 15-17651-03597
	:	
v.	:	
	:	
ROCKHOUSE ENERGY MINING CO.,	:	Mine No. 1
Respondent	:	
	:	
ROCKHOUSE ENERGY MINING CO.,	:	CONTEST PROCEEDINGS
Contestant	:	
	:	
v.	:	Docket No. KENT 2001-2-R
	:	Citation No. 7368962; 9/7/00
	:	
SECRETARY OF LABOR,	:	
MINE SAFETY AND HEALTH	:	Docket No. KENT 2001-7-R
ADMINISTRATION (MSHA),	:	Order No. 7373434; 9/20/00
Respondent	:	
	:	
	:	Docket No. KENT 2001-8-R
	:	Order No. 7373435; 9/20/00
	:	
	:	Docket No. KENT 2001-9-R
	:	Order No. 7373436; 9/20/00
	:	
	:	Docket No. KENT 2001-10-R
	:	Order No. 7373437; 9/20/00

DECISION

Appearances: Anne T. Knauff, Esq., Office of the Solicitor, U.S. Department of Labor, Nashville, Tennessee, for the Secretary of Labor;
Mark E. Heath, Esq., (Dennise Smith-Kastick, Esq., on brief), Spilman Thomas & Battle, Charleston, West Virginia, for Rockhouse Energy Mining Company.

Before: Judge Hodgdon

These consolidated cases are before me on Notices of Contest and a Petition for Assessment of Civil Penalty brought by Rockhouse Energy Mining Company and by the Secretary of Labor, acting through her Mine Safety and Health Administration (MSHA),

pursuant to section 105 of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 815. The company contests the issuance of one citation and four orders alleging violations of the Secretary's mandatory health and safety standards. The petition alleges the five violations by the company and seeks a penalty of \$230,000.00. A hearing was held in Pikeville, Kentucky. For the reasons set forth below, I vacate two orders, dismiss two contest dockets, affirm the citation, modify two orders and assess a penalty of \$65,000.00.

Background

Rockhouse Energy Mining Company operates Mine No. 1, an underground coal mine in Pike County, Kentucky. Rockhouse is a subsidiary of A. T. Massey Coal Company in Richmond, Virginia. The mine employs 148 miners on two production shifts and one maintenance shift, six days a week, and produced 3,000 tons of coal a day in 2000.

On September 6, 2000, between 6:30 p.m. and 6:50 p.m., the main, or master, breaker on a continuous mining machine tripped while the machine was approximately 14 feet in by the last row of permanent roof support in the No. 5 entry. Gary Cochran, an electrician, came to the scene to assist in recovering the machine. Cochran, Raymond Fletcher, the section foreman, and another miner began building a crib as temporary roof support to work their way out to the miner. Before the crib was half finished, a rock measuring approximately 132 inches by 84 inches by 9 inches fell from the roof, striking Cochran and killing him.

Rockhouse reported the accident that night and MSHA Inspector Kenneth Murray went to the mine to begin a preliminary investigation. On his arrival, he issued a 103(k) Order, 30 U.S.C. § 813(k), closing the section.

MSHA Inspectors William C. Cole and Robert Newberry arrived at the mine on the morning on September 7. When they learned that a Rockhouse survey crew was in the No. 5 entry, they ordered it out and issued a citation for violating the closure order. At the conclusion of their investigation, they issued four more orders.

Findings of Fact and Conclusions of Law

This case consists of one 104(a) citation, 30 U.S.C. § 814(a), and four 104(d)(1) orders, 30 U.S.C. § 814(d)(1). It is the Secretary's position that the survey crew was in the No. 5 entry in violation of the 103(k) order, that Cochran was impermissibly working under unsupported roof, that the miners failed to follow Rockhouse's roof control plan in attempting to retrieve the mining machine, that the section foreman failed to perform sound and vibrations tests prior to attempting to retrieve the mining machine and that Rockhouse did not have a supply of supplementary roof support materials available at a readily accessible location on the working section. I find that the Secretary has proved the 103(k), the sound and vibrations testing and the supplementary roof support violations, but has not proved the unsupported roof or roof control plan violations.

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

Citation No. 7368962

This citation alleges a violation of section 103(k) of the Act, because: “The operator was performing work on the 001-0 MMU after a 103(k) order had been issued after a fatal roof fall. A survey crew was mapping the area on the section before an investigation had been conducted by MSHA. The affected area was the 001-0 MMU.” (Jt. Ex. 3.) Section 103(k) provides that:

In the event of any accident occurring in a coal or other mine, an authorized representative of the Secretary, when present, may issue such orders as he deems appropriate to insure the safety of any person in the . . . mine, and the operator of such mine shall obtain the approval of such representative . . . of any plan to recover any person in such mine or to recover the . . . mine or return affected areas of such mine to normal.

Inspector Murray issued Order No. 7373621 to Ken Deskins, the mine Superintendent, at 9:15 p.m. on September 6. The order stated that:

The mine has experience[d] a fatal roof fall accident on the MMU 001 Section. This Order is issued to assure the safety of any person in the coal mine until an investigation is made to determine that the MMU 001 Section is safe. Only those persons selected from Company Officials, State Officials, the Miners’ Representative, and other persons who are deemed by MSHA to have information relative to the investigation may enter or remain in the affected area.

(Jt. Ex. 2.)

According to his notes, when Inspector Murray gave the order to Deskins, he told Deskins that the MMU 001 section was “closed.” (Govt. Ex. 1 at 5.) The notes reflect that Deskins then asked if supplies could be delivered to the section to recover the continuous miner and that Murray told him “that they could be delivered to the end of the MMU 001 section’s tail track,” but “no persons or no work could be done in affected area (MMU 001).” (*Id.*) The notes go on to state that “Mr. Deskins repeated these instructions (restricted areas) and fully understood” and that “Mr. Deskins stated he had no problems with the 103(k) order or instructions.” (*Id.*)

The company argues that it did not violate the order because it had a duty to conduct its own investigation of the accident and that “Rockhouse was not put on notice that MSHA was construing its order in such restrictive fashion.” (Resp. Br. at 20.) These arguments are without merit.

Section 103(k) provides that it is MSHA, not the operator, who is in charge of the investigation. While the Secretary's regulations require that the operator conduct its own investigation of the accident, it does not give the operator authority to do so in violation of a 103(k) order. The Respondent does not dispute that Murray's notes accurately reflect what Superintendent Deskins was told when the order was given to him. Thus, it is clear that Rockhouse was put on notice through Deskins what the order prohibited. Deskins apparently failed to disseminate the information to the appropriate Rockhouse employees. However, it was the company's duty to insure that this was done, not MSHA's.

Rockhouse goes on to argue that: "If Inspector Murray found it necessary that no one, including Rockhouse's investigative team, be in the area for any reason, he should have stated so in his Order." (Resp. Br. at 20.) In hindsight, this would have been a good idea. Nevertheless, if the order was ambiguous, Murray clarified it with his instructions to Deskins. Accordingly, I conclude that the survey crew violated the order as alleged.

Negligence

Inspector Cole testified that he alleged "high" negligence on the part of the operator in connection with this violation because there were no mitigating circumstances. (Tr. 55.) I find, however, that there are mitigating circumstances. The company did have a duty to investigate the accident, and the evidence indicates that they had not been charged with violating 103(k) orders when they had done so in the past. Further, the company did not attempt to hide the survey team from the inspectors; the inspectors learned that it was in the mine from the Mine Manager. (Tr. 46.) Finally, there is no evidence that they were using the survey as a pretext for altering the accident scene. Taking these factors into consideration, I find that the company was "moderately" negligent with regard to this violation.

Order No. 7373434

This order alleges a violation of section 75.202(a) of the Secretary's regulations, 30 C.F.R. § 75.202(a) in that:

A fatal roof fall accident occurred on September 6, 2000, when the electrician, Gary Cochran, travelled [*sic*] inby permanent roof support. The victim was building a crib to access the continuous miner which was immobilized by an electrical problem. The accident occurred near the face of the No. 5 entry on the 001-0 MMU. The victim had gone inby the last row of permanent roof support approximately 3 feet when a rock measuring approximately 132" X 84" X 9" fell because of a lack of temporary roof support causing fatal injuries. Evidence obtained during the accident investigation indicated that cribs were routinely installed while accessing immobilized equipment inby permanent roof

support without installing temporary support such as posts or jacks. Support materials such as jacks, posts, cap boards, or wedges were not available on or near the working section. Other miners were also endangered as a result of this practice. The supervisor, Raymond Fletcher, was in the working place supervising this unsafe work practice.

(Jt. Ex. 4.) 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 roof, face or ribs and coal or rock bursts.”

It is not clear why the inspector alleged a violation of section 75.202(a). The crux of the charge is that Cochran traveled inby permanent roof support. It would appear that this would be more properly charged under section 75.202(b), 30 C.F.R. § 75.202(b), which states that: “No person shall work or travel under unsupported roof unless in accordance with this subpart.” However, “this subpart,” Subpart C—Roof Support, permits persons installing temporary roof supports to proceed beyond permanent support. 30 C.F.R. § 75.210(a). And installing temporary roof support is a means of supporting or otherwise controlling the roof.

The Secretary’s problem is that she does not think that cribs, which are built by stacking six inch square by 30 inch long pieces of wood, two by two on top of each other, until they reach the roof, should be used as temporary support. It appears from the evidence at the hearing that she is probably right. Cribs take longer to install than either jacks or posts and, therefore, increase a miner’s exposure to unsupported roof. (Tr. 122.) Nor does it appear that the greater support provided by cribs over jacks or posts offsets the increased exposure while they are being constructed. This is particularly true in a situation such as this one where the temporary support is to be used only to allow someone to access the miner to reset the breaker and the support will be knocked down by the miner as it is backed out of the entry. However, as the Secretary admits in her brief, “[i]t is not illegal to use cribs as temporary support” (Sec. Br. at 12.)

Since the Secretary has not prohibited the use of cribs as temporary support, she cannot sustain this violation. Furthermore, the fact that the company did not have a complete supply of supplementary supports, which is the subject of Order No. 7373437, does not change matters. The roof fall occurred when the first crib had barely been started. Thus, a complete supply of supplementary supports would not have prevented the accident.

I conclude that the Secretary has failed to prove that Rockhouse violated section 75.202(a). Accordingly, I will vacate the order.

Order No. 7373435

This order charges a violation of Section 75.220(a)(1), 30 C.F.R. § 75.220(a)(1), because:

The roof control plan, approved August 25, 1999, was not followed on the 001-0 MMU. The plan states on page 11, item 5, that, in the event of a breakdown of face equipment inby permanent roof support, permanent roof support shall be installed as close to the work area as practical. Item 5, further states that temporary roof support, if necessary, will then be installed for a minimum of 2 rows inby the work area.

A fatal roof fall accident occurred when the electrician, Gary Cochran, travelled [*sic*] inby permanent roof support to construct a crib in the No. 5 entry of the 001 MMU. Permanent supports had not been installed as close as practical to the work area. The supervisor, Raymond Fletcher, was in the working place supervising this unsafe work practice.

(Jt. Ex. 5.) 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."

As stated in the order, item five on page 11 of the Respondent's roof control plan says that: "In the event of a breakdown of face equipment inby permanent roof support, permanent roof support shall be installed as close to the work area as practical." (Jt. Ex. 8 at 11.) The parties are in agreement that the continuous miner was face equipment which had broken down and that this provision applied. They do not agree, however, on what the "work area" was and whether installing additional roof bolts was "practical."

The company asserts that the "work area" was the area on the right side of the mining machine, because that was the side on which the breaker was. The company further asserts that roof bolts had already been installed as close to the work area as practical and no further roof bolts were needed. The Secretary does not address "work area" or "practical," instead making the conclusory statement that: "Additional roof bolts *could* have been installed inby the roof bolts on the left side of the [continuous miner's] boom and in the area where the crib was being constructed." (Sec. Br. at 15, emphasis added.)

While the term "work area" is not defined in the roof control plan, Inspector Newberry agreed with the Respondent, that the work area was on the right side of the mining machine. (Tr. 174.) The term "practical" is also not defined in the plan. Indeed, in looking the word up in the dictionary, it appears that the word is used in place of the word "practicable" which means:

1 : possible to practice or perform : FEASIBLE 2 : capable of being used : USABLE

syn PRACTICABLE, PRACTICAL means capable of being put in use or put into practice. PRACTICABLE applies to what has been proposed and seems feasible but has not actually been tested in use; PRACTICAL applies to things and to persons and implies proven success in meeting the demand made by actual living or use.

Webster's Ninth New Collegiate Dictionary 923 (1986). Thus, it appears that the plan calls for permanent support to be installed as close as seems feasible. This clearly is a judgment call.

Inasmuch as Fletcher did not testify, it can only be assumed that he did not think that installing additional roof bolts was feasible. James Pinson, who was the Mine Foreman at the time of the accident and is now the Mine Superintendent, and Johnny Robertson, who was the Safety Coordinator for Massey Coal Services at the time of the accident and is now the Mine Manager at the Justice Mine, both testified that they had observed the accident scene on the night of September 6 and that they would not have installed any additional roof bolts prior to trying to retrieve the miner. (Tr. 298, 349, 377.) Not surprisingly, Inspector Newberry testified that additional roof bolts could have been installed, particularly on the left side of the miner. (Tr. 156.)

Obviously, reasonable persons can differ on the feasibility of installing additional bolts in this case. However, when it came to exactly how the bolts would be installed, the inspector was less positive as to whether they could actually be installed. (Tr. 171-73.) Furthermore, I find it significant that when the miner was recovered the next day, the recovery plan approved by MSHA did not call for additional roof bolts, Inspector Newberry did not suggest to Pinson, who did the work, that additional roof bolts should be installed, and, in fact, no additional bolts were installed. (Tr. 170, 300.) Consequently, I conclude that the Secretary has not shown that Fletcher's judgment in not installing additional roof bolts was patently incorrect and will vacate the order.

Order No. 7373436

This order alleges a violation of section 75.211(b)(2), 30 C.F.R. § 75.211(b)(2), because:

Sound and vibration roof tests, or other equivalent tests, were not made prior to installation of roof supports on the 001-0 MMU. Evidence obtained during an accident investigation indicates that no such tests were made prior to installing a crib to access equipment immobilized in by permanent roof supports. An electrician was fatally injured while constructing a crib. The

supervisor, Raymond Fletcher, was in the working place supervising this unsafe work practice.

(Jt. Ex. 6.) Section 75.211(b)(2) provides that:

(b) Where the mining height permits and the visual examination does not disclose a hazardous condition, sound and vibration roof tests, or other equivalent tests, shall be made where supports are to be installed. When sound and vibration tests are made, they shall be conducted—

....

(2) Prior to manually installing a roof support. This test shall begin under supported roof and progress no further than the location where the next support is to be installed.

Rockhouse does not dispute that Fletcher failed to perform sound and vibration testing prior to beginning to install temporary roof support. Inspector Newberry testified that Fletcher told him that “he didn’t do one.” (Tr. 212.) Consequently, I conclude that the Respondent violated the regulation as alleged.

Significant and Substantial

The Inspector found this violation to be “significant and substantial.” A “significant and substantial” (S&S) violation is described in Section 104(d)(1) of the Act 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 (July 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.

Considering the *Mathies* criteria, I have already found the underlying violation of section 75.211(b)(2). The company argues that there was no measure of danger to safety contributed to by the violation because sound and vibration testing “[is] not useful for indicating problems where the mine has a drummy roof.” (Resp. Br. at 31.) While all parties agreed that the roof in Mine No. 1 generally had a “drummy” sound, none of the witnesses agreed that because of that sound and vibration tests were not useful in determining the status of the roof.

Inspector Cole testified that even in mines with drummy roofs, the miners “at a particular mine of these conditions, would become accustomed to telling the degree of – [t]he thickness of the rock. They can get pretty close to what they’ve got by the sound and vibration measuring.” (Tr. 81-82.) Inspector Newberry testified that sound and vibration testing was useful in a mine with a drummy roof because, “[w]hen you sound the roof in different areas and you can tell the change in roof conditions.” (Tr. 198.) Pinson agreed that in a drummy mine “there would be different sounds” when a fall is imminent as opposed to more stable places. (Tr. 317.) Finally, Robertson, when asked if he were aware that in a mine with a drummy roof one could listen for differences in the drummy nature of the roof, that there are degrees of drumminess, responded: “Absolutely.” (Tr. 386.)

Therefore, I find that performing a sound and vibration test could have indicated a possible roof fall and that failure to perform it created a distinct safety hazard of a roof fall.¹ I further find that the third and fourth criteria are met because it is reasonably likely that a roof fall will result in a reasonably serious injury. As the Commission stated 20 years ago, “[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.” *Consolidation Coal Co.*, 6 FMSHRC 34, 37-38 n.4 (Jan. 1984).

Negligence

The inspector found the level of negligence in connection with this violation to involve a “reckless disregard” on the part of the operator. The Secretary’s regulations define “reckless disregard” as “conduct which exhibits the absence of the slightest degree of care.” 30 C.F.R. § 100.3(d). While I find that Fletcher was highly negligent in not knowing about section 75.211(b)(2) and in not performing the tests, I cannot agree that he exhibited an absence of the slightest degree of care. He did, in fact, perform a visual examination of the area. And since he did not know of the regulation, it cannot be said that he deliberately ignored it. Accordingly, the

¹ The Respondent’s additional assertion that because of his height, Fletcher would not have been able to reach out far enough to perform the test does not merit comment.

level of negligence for this violation will be reduced from “reckless disregard” to “high.”

Unwarrantable Failure

This violation was also charged as resulting from the “unwarrantable failure” of the company to comply with the regulation.² 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); *Youghioghery*, 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 Co.*, 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).

In this case, Fletcher told Inspector Newberry that he did not perform a sound and vibration test because he thought he only needed to do a visual exam. (Tr. 211.) Contrary to Rockhouse’s assertion that since Fletcher was unaware of the regulation the severity of the violation is not aggravated, I agree with Inspector Newberry that as a certified foreman Fletcher should have known to perform sound and vibration tests.

In *Warren Steen Construction, Inc.*, 14 FMSHRC 1125, 1130 (July 1992), the Commission held: “Although the operator knew of the dangers involved in operating large metal machinery near energized power lines, it directly exposed its miners to such hazards without regard for their safety and without taking precautions. Such conduct is aggravated, and constitutes more than ordinary negligence.” In this case, Fletcher knew, or should have known, that the mine had an unstable, shale roof, and knew, or should have known, that that made the danger of going under unsupported roof even greater than normal, yet he exposed his miners to such a hazard without taking the precaution of performing sound and vibration tests. Such conduct is aggravated and constitutes more than ordinary negligence.

In *Rochester & Pittsburgh Coal Co.*, 13 FMSHRC at 194, the Commission held that “an agent’s conduct may be imputed to the operator for unwarrantable failure purposes.” As foreman, Fletcher was clearly an agent of Rockhouse. Accordingly, I conclude that the company’s violation of section 75.211(b)(2) was an unwarrantable failure to comply with the regulation.

² 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.”

Order No. 7373437

This order charges a violation of section 75.214(a), 30 C.F.R. § 75.214(a), because:

A supply of supplementary roof support materials such as posts or jacks, cap boards and wedges, and the tools and equipment necessary to install the materials were not available at a readily accessible location on the 001-MMU [*sic*] working section or within four crosscuts of the working section. An electrician was fatally injured while installing a crib to provide access to equipment immobilized inby permanent supports. The supervisor, Raymond Fletcher, was in the working place supervising this unsafe work practice.

(Jt. Ex. 7.) Section 75.214(a) requires that: “A supply of supplementary roof support materials and the tools and equipment necessary to install the materials shall be available at a readily accessible location on each working section or within four crosscuts of each working section.”

Inspector Newberry testified that he found 21 crib blocks at the site of the accident and another 70 blocks more than four crosscuts outby the working section. (Tr. 108, 137, 218, 228.) He further testified that nowhere did he find any wedges or caps, which are necessary to complete installation of a crib. (Tr. 108, 110.) Finally, the inspector stated that the 21 crib blocks found at the scene were not enough to complete one crib. (Tr. 240.) The company does not dispute this evidence.

Rockhouse argues that: “The regulation does not require that [an] operator have enough material to build one crib, six cribs or any other number of cribs – only that a supply be maintained.” (Resp. Br. at 33.) This argument disregards section 75.214(b), 30 C.F.R. § 75.214(b), which states that: “The quantity of support materials and tools and equipment maintained available in accordance with this section shall be sufficient to support the roof if adverse roof conditions are encountered, or in the event of an accident involving a fall.” Having only 21 crib blocks on site, not enough to build even one crib, and having no wedges or caps anywhere, plainly does not meet the requirements of section 75.214(a). Therefore, I conclude that Rockhouse violated the regulation.

Significant and Substantial

The inspector found this violation to be significant and substantial. He said that because of the bad roof on the section, Fletcher should have had a heightened awareness of the possibility of unsafe conditions and better monitored his roof support materials. (Tr. 222.)

Applying the *Mathies* criteria, I find: (1) A violation of a safety standard, section 75.214(a); (2) A distinct safety hazard, a measure of danger to safety, contributed to by the

violation, namely the roof going unsupported longer than necessary because the materials were not available, thereby increasing the danger of a roof fall; (3) A reasonable likelihood that a roof fall would result in an injury; and (4) A reasonable likelihood that the injury would be of a reasonably serious nature, most likely fatal, but at a minimum broken bones. Consequently, I conclude that the violation was “significant and substantial.”

Negligence

The inspector found that the negligence attributable to this violation was “high” because Fletcher was supervising the recovery and should have had a heightened awareness of the need to have supplementary roof support on hand. On the other hand, there has been no showing that it was Fletcher’s responsibility to stock the supplementary roof support materials or that he was aware, when he began the recovery process, that no such materials were within four crosscuts of the section. Further, even if a full supply of supplementary roof support materials had been easily accessible it would not have prevented this accident, since the roof fall occurred when the miners had barely begun building the first crib, before they had used up the materials on the site.

While Fletcher, and through him the operator, were clearly negligent with respect to the supply of supplementary roof support, there are mitigating circumstances. Accordingly, I conclude that the Respondent was “moderately” negligent with regard to this violation and will modify the citation accordingly.

Unwarrantable Failure

For the same reasons that he found “high” negligence, the inspector charged this violation as involving an “unwarrantable failure.” For the same reasons that I find the violation to involve “moderate” negligence, I find that it did not involve an unwarrantable failure. The conduct in connection with this violation was clearly not “intentional,” nor does it evidence “reckless disregard,” “indifference” or a “serious lack of reasonable care.” In short, it was not aggravated conduct constituting more than ordinary negligence. Therefore, I will modify this order to a 104(a) citation, 30 U.S.C. § 814(a), by deleting the “unwarrantable failure” designation.

Civil Penalty Assessment

The Secretary has proposed penalties of \$20,000.00 for Citation No. 7368962 and \$55,000.00, each, for Order No. 7373436 and Citation No. 7373437, the three violations that are being affirmed. 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 (April 1996).

In connection with those criteria the parties have stipulated that at the time of the accident Mine No. 1 produced 3,000 tons of coal a day and that payment of the proposed penalties will not

adversely affect Rockhouse's ability to remain in business. (Tr. 7-9.) From this I find that Rockhouse is a large company and that payment of the penalty I assess will not affect its ability to remain in business. Based on the Assessed Violation History Report ³, (Jt. Ex. 9), and the Proposed Assessment Data Sheet in the file, I find that Rockhouse has an average history of previous violations.

Based on the citation forms and evidence Rockhouse presented at the hearing that it is taking significant steps in attempting to prevent the reoccurrence of this type of accident, I find that the company demonstrated good faith in attempting to achieve rapid compliance after notification of the violations. (Jt. Exs. 3-7.) In direct response to this accident, Rockhouse has expended a considerable sum of money in developing an isolator switch to reset the main power breaker, a traction breaker reset system, an emergency stop override system and a methane monitor malfunction override system which will give miner operators the ability to restore power to a continuous miner and move it to a safe area for servicing without having to build temporary supports to go under unsupported roof. (Tr. 270, 274, 276, 280; Resp. Exs. E, F and G.) Additionally, the company has conducted presentations and seminars on these systems to share this technology with others in the industry. (Tr. 281-82.)

With regard to Citation No. 7368962, I find the gravity of the violation to be only moderately serious. While violations of inspectors orders are serious and not to be condoned, this does not appear to have been an intentional violation and resulted in no harm to the investigation. As previously discussed, I find the Rockhouse was moderately negligent in committing this violation.

The gravity of the violation in Order No. 7373436 is very serious. A death occurred and it is possible that it would not have occurred if all required precautions were taken prior to commencing the recovery of the continuous miner. The company exhibited a high degree of negligence in connection with this violation.

Finally, the gravity of the violation in Citation No. 7373437 is serious. While the violation did not cause the fatality, it shows a lack of preparedness on the part of the company in being able to immediately deal with poor roof conditions. The company was moderately negligent in committing this violation.

Taking all of these factors into consideration, I assess a penalty of \$5,000.00 for Citation No. 7368962, a penalty of \$40,000.00 for Order No. 7373436 and a penalty of \$20,000.00 for Citation No. 7373437.

³ The Assessed Violation History Report was submitted post-hearing. (Tr. 7.)

Order

In view of the above, Citation No. 7368962 and Docket No. KENT 2001-2-R are **AFFIRMED**; Order No. 7373434 is **VACATED** and Docket No. KENT 2001-7-R is **DISMISSED**; Order No. 7373435 is **VACATED** and Docket No. KENT 2001-8-R is **DISMISSED**; Order No. 7373436 is **MODIFIED** by reducing the level of negligence from “reckless disregard” to “high” and it and Docket No. KENT 2001-9-R are **AFFIRMED** as modified; and Order No. 7373437 is **MODIFIED** from a 104(d)(1) order to a 104(a) citation by deleting the “unwarrantable failure” designation, and is further **MODIFIED** by reducing the level of negligence from “high” to “moderate” and it and Docket No. KENT 2001-10-R are **AFFIRMED** as modified.

Rockhouse Energy Mining Company is **ORDERED TO PAY** a civil penalty of **\$65,000.00** within 30 days of the date of this order.


T. Todd Hodgdon
Administrative Law Judge

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/hs

FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

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

July 30, 2004

RAYMOND GEORGE, : DISCRIMINATION PROCEEDING
Complainant :
v. : Docket No. CENT 2004-98-D
24/7 SERVICE AND SUPPLY, INC., : DENV CD 2003-17
Respondent : Lee Ranch Coal Mine
Mine ID No. 29-01879 5GB

DECISION

Appearances: Raymond George, Gallup, New Mexico, pro se;
Kenneth Chaffin, Grants, New Mexico, on behalf of the Respondent.

Before: Judge Melick

This case is before me upon the complaint of discrimination filed by Raymond George pursuant to Section 105(c)(3) of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 801 et seq., (1994) the "Act." Mr. George alleges in his complaint that 24/7 Service and Supply, Inc. (24/7), violated Section 105(c)(1) of the Act when he was subjected to a lay-off on August 9, 2003.1 More particularly, Mr. George states in his complaint filed with the Department of Labor's Mine Safety and Health Administration (MSHA) on August 26, 2003, as follows:

1 Section 105(c)(1) of the Act provides as follows:

No person shall discharge or in any manner discriminate against or cause to be discharged or cause discrimination against or otherwise interfere with the exercise of the statutory rights of any miner, representative of miners or applicant for employment in any coal or other mine subject to this Act because such miner, representative of miners or applicant for employment has filed or made a complaint under or related to this Act, including a complaint notifying the operator or the operator's agent, or the representative of the miners at the coal or other mine of an alleged danger or safety or health violation in a coal or other mine, or because such miner, representative of miners or applicant for employment is the subject of medical evaluations and potential transfer under a standard published pursuant to section 101 or because such miner, representative of miners or applicant for employment has instituted or caused to be instituted any proceeding under or related to this Act or has testified or is about to testify in any such proceeding, or because of the exercise by such miner, representative of miners or applicant for employment on behalf of himself or others of any statutory right afforded by the Act.

On or about August 09, 2003, I was given a lay-off notice by Virginia Chaffin, President and Wife of Ken Chaffin. Mr. Ken Chaffin was the one who hired me on July 14, 2003, as a Welder for the 24/7 Service and Supply, Grants, NM. The lay-off letter is attached as Exhibit A. Per the lay-off letter, it is indicated that I was being laid off "due to lack of work"; however, I feel the real reason for the layoff was not due to lack of work. It is my belief the lay off letter was because I asked a question about safety in confined areas, oxygen level checks, etc. on August 7, 2003. On August 8, 2003, there were messages on our home telephone to contact the office. I returned the calls on August 9, 2003 and was informed that I would no longer be employed and for me to pick up my tools. Anyhow, the question was asked out of concern for safety reason. When I asked the question, Mrs. Chaffin immediately asked me if I wanted to work there. She also asked if it was safe for me to work there. My response to her question was that I did want to work there and that I did not want to get cited and be in trouble with MSHA. Mrs. Chaffin then said that was just work for Lee Ranch Mine and Lee Mine takes care of their citations. Mrs. Chaffin went on to say that "We don't want to start trouble with the Mine Company"

The other reason I had a concern was that I had an eye injury that I reported after the work shift at the Mine shop office on or about July 18, 2003. I went to the clinic on July 22, 2003 for this eye problem. There is doctor statement attached for this clinic visit. It is doubtful to me if this report of eye injury was ever documented.

During this time of employment, I noticed a safety issue involving an oxygen/acetylene hose on site that just had a hose clamp. I don't know if this was corrected at any time.

Nevertheless, all the time that I was on the job, I did not see, talk to, meet with anyone that may have been a Safety Officer. The Safety Orientation was via a 15-minutes video tape.

Overall, I feel I was discriminated against because I raised a safety questions to the people that hired me, who also in the beginning indicated to me that if I had any questions, to go to them and ask them. Instead of responding to the safety question appropriately and professionally, Chaffin's responses were inappropriately negative, defensive, and discriminate.²

² At hearing Mr. George acknowledged that he did not in fact report any eye injury to the mine shop office as he alleged in his complaint and alleges now that he only mentioned it to his supervisor. Because of Mr. George's credibility problems also described, *infra.*, and in light of the evidence that MSHA special investigator Dan Velter found that George made no such complaints either to the mine office or to his foreman, I do not find that Mr. George has met his

This Commission has long held that a miner seeking to establish a *prima facie* case of discrimination under Section 105(c) of the Act bears the burden of persuasion that he engaged in protected activity and that the adverse action complained of was motivated in any part by that activity. *Secretary on behalf of Pasula v. Consolidation Coal Co.*, 2 FMSHRC 2786, 2797-2800 (October 1980), rev'd on grounds, *sub nom. Consolidation Coal Co. v. Marshall*, 663 F.2d 1211 (3rd Cir. 1981); and *Secretary on behalf of Robinette v. United Castle Coal Co.*, 3 FMSHRC 803, 817-18 (April 1981). The operator may rebut the *prima facie* case by showing either that no protected activity occurred or that the adverse action was in no part motivated by the protected activity. If an operator cannot rebut the *prima facie* case in this manner, it may nevertheless defend affirmatively by proving that it would have taken the adverse action in any event on the basis of the miner's unprotected activity alone. *Pasula, supra; Robinette, supra*. See also *Eastern Assoc., Coal Corp. v. FMSHRC*, 813 F.2d 639, 642 (4th Cir. 1987); *Donovan v. Stafford Construction Co.*, 732 F.2d 194, 195-196 (6th Cir. 1983) (specifically approving the Commission's *Pasula-Robinette* test). Cf. *NLRB v. Transportation Management Corp.*, 462 U.S. 393, 397-413 (1983) (approving nearly identical test under National Labor Relations Act.)

Mr. George has about 25 years experience in the mining industry as a welder and maintenance worker. He began working for 24/7 on July 14, 2003, as a welder at the Lee Ranch Coal Mine (Lee Ranch) located near Grants, New Mexico. 24/7 was a contractor for Lee Ranch furnishing labor as needed. The undisputed evidence shows that on July 16, 2003, George was working inside the dragline along with a Lee Ranch welder, cutting and re-welding cracked areas of steel flooring. According to George, they were working inside a box-like area about 6 feet wide, 6 feet long and at least 8 feet high. Because of the smoke created by their cutting and welding they requested, and were provided, fans to ventilate the area. They were also provided respirators.

The next relevant event occurred on August 7, 2003, when George went to the office to pick up his paycheck from 24/7 president Virginia Chaffin. George described the conversation with Mrs. Chaffin in the following colloquy at hearing:

JUDGE MELICK: All right. Now, you say, on August 7th, when you picked up your check, you had a discussion with Mrs. Chaffin with respect to the situation working in the dragline and that area where you say there was smoke.

Can you tell me exactly what you told her and what she said?

MR. GEORGE: Well, when I asked her why - - if the mine safety people, do they ever check - -

burden of proof that any such complaint was in fact made (Tr. 59-60). In addition, Mr. George does not allege nor did he testify that he reported the alleged clamp on an oxygen/acetylene hose to anyone or that he complained to anyone about not meeting a "safety officer" or about inadequate safety training. Under the circumstances I find insufficient evidence that these latter three alleged activities constituted complaints of any kind.

JUDGE MELICK: What exactly were the words that you spoke to her?
You said - -

MR. GEORGE: I asked her if the mine people or the safety people check the air supply.

JUDGE MELICK: You asked her if the mine safety people checked the air supply?

MR. GEORGE: The air supply or the oxygen, see, in the confined areas.

JUDGE MELICK: Are you talking about specifically the area where you were working?

MR. GEORGE: Well, anywhere.

JUDGE MELICK: You asked her, in general, do the mine safety people check the air?

MR. GEORGE: That's why I asked her, see, any - -

JUDGE MELICK: I'm trying to understand what words you spoke. You're saying that you asked her if the mine safety people checked air quality or - -

MR. GEORGE: Air supply - - air supply or oxygen level.

JUDGE MELICK: Air supply and oxygen levels?

MR. GEORGE: Uh-huh.

JUDGE MELICK: And what did she say to that?

MR. GEORGE: She responded to me that if it was safety - - or if it was unsafe for me. I just told her I just - - I don't want to - -

JUDGE MELICK: She asked you if it was unsafe for you?

MR. GEORGE: Yeah.

JUDGE MELICK: She asked you if - - what were you talking about? Were you talking specifically about working in the dragline?

MR. GEORGE: Yes, working in the dragline and in the confined area.

JUDGE MELICK: So she asked you if it was unsafe for you to work in that confined area?

MR. GEORGE: Yes.

JUDGE MELICK: Well, you had already finished working there; correct?

MR. GEORGE: I already did, yeah.

JUDGE MELICK: Okay.

MR. GEORGE: But I told her - - I mean, I'm just asking her.

JUDGE MELICK: And what did you say to her?

MR. GEORGE: I was just asking the question if they ever do check the confined areas.

JUDGE MELICK: And she said - - she didn't answer your question, then? She didn't answer your question whether mine safety checked air supply and oxygen levels?

MR. GEORGE: No.

JUDGE MELICK: She didn't answer it, but then she came back with a question and asked you if you felt it was unsafe for you to work in that area in the

dragline?

MR. GEORGE: Yes.

JUDGE MELICK: All right. And what did you say?

MR. GEORGE: Well, at that time I just told her that, yes.

JUDGE MELICK: Yes?

MR. GEORGE: Yes.

JUDGE MELICK: And what further conversation occurred? Did she say anything?

MR. GEORGE: No, I just told her that I don't want to get in trouble with the MSHA, working in the confined area, and get fined or something like that. I know the rules with the safety - - the MSHA people. That's all I asked her, and then I don't want to go any further, I just left from there. I just left it at that.

JUDGE MELICK: So that was the end of the conversation?

MR. GEORGE: Yes.

JUDGE MELICK: You just said you didn't want to get in trouble with MSHA?

MR. GEORGE: Yes.

JUDGE MELICK: So you were concerned with yourself causing a violation?

MR. GEORGE: With my - - with an MSHA violation, see.

JUDGE MELICK: Well, how would you be violating MSHA regulations?

MR. GEORGE: Well, if you don't have a - - I work in the mine, and then when - - you had to have a safety line if you're working in the confined area, in case of something - - if something happens to you - - see, that's how they used to do it over at Kerr-McGee, they have somebody right there to make sure that everybody is all right when they are working in an area - -

JUDGE MELICK: You mean, if you're working in an area where oxygen may be deficient - -

MR. GEORGE: Yes.

JUDGE MELICK: - - somebody can pull you out if you pass out?

MR. GEORGE: Yes.

JUDGE MELICK: And that's what you were talking about - -

MR. GEORGE: Yes.

JUDGE MELICK: - - having a line on you so somebody - -

MR. GEORGE: A safety line, or if they check the air supply, see, before you start working in there, too.

JUDGE MELICK: I see.

Now, did you mention to her - - to Mrs. Chaffin that no one was checking the oxygen levels or nobody had a safety line on you?

MR. GEORGE: I didn't say - - I didn't mention that, though.

JUDGE MELICK: I see.

MR. GEORGE: I just asked her about if they ever to the - - check the air supply before they start working in the confined area.

JUDGE MELICK: All right. And that was the end of the conversation, though?

You told her, yes, that you felt it was unsafe, and that you didn't want to get in trouble with MSHA?

MR. GEORGE: Yes.

JUDGE MELICK: And did she say anything in response to that?

MR. GEORGE: No.

(Tr. 31-36).

In the following colloquy on rebuttal Mr. George provided additional testimony regarding this conversation. It is noted that he here contradicts his prior testimony that he told Mrs. Chaffin that he believed the work at issue was unsafe:

JUDGE MELICK: And you told Mrs. Chaffin on August 7th that it was not unsafe working - - you felt it was not unsafe working in that dragline?

MR. GEORGE: I didn't say that.

JUDGE MELICK: What did you say?

MR. GEORGE: I said it - - I just asked her if the - - if they ever checked the oxygen level in the confined areas - - anywhere in the confined areas, and she asked me it was unsafe for me, but I just said, "No, I just wanted to see if they - - if the safety people around from the Lee Mine checked there." That's what I'm really saying, if they ever check the safety oxygen level in the confined areas and all of that.

JUDGE MELICK: So you told her that you did not feel it was personally unsafe, but you wanted MSHA to look at it? You thought MSHA should look at it?

MR. GEORGE: Well, the safety people, anyway - - the safety people at the mine - -

JUDGE MELICK: Yes.

MR. GEORGE: - - or the environmentalists, whoever does that.

JUDGE MELICK: But you agree that you told her that it was not unsafe?

MR. GEORGE: That's what I said, yeah.

JUDGE MELICK: Okay.

MR. GEORGE: See, when I used to work with Kerr-McGee, any - - any - - any confined area, even with big holes, the environmentalists or the safety people check the oxygen level before you can enter those areas.

JUDGE MELICK: Right. Okay.

(Tr. 98-99).

Mrs. Chaffin also described the August 7 conversation with George in the following colloquy at hearing:

JUDGE MELICK: So what happened, then, on Thursday the 7th?

MRS. CHAFFIN: Okay. Raymond came in, and he asked me if there is supposed to be air in the dragline. And I said - he said, "Is there supposed to be air in the dragline?"

I said, "Yes, there was."

And he said something - - I can't remember exactly what he said.

I said, "Well, was there?"

And he said, "Yes, there was."

And I said, "Well, did you feel like it was unsafe?"

And he said, no, that he did not feel it was unsafe. So I don't - - I didn't understand what he was even talking about. You know, why bring it up if it wasn't unsafe, and that was - - that was the whole end of the conversation, and I - - and then he told me he didn't want to have a violation with MSHA, and I said, "Well, if MSHA - - if the mine was doing something wrong, you wouldn't have been violated for it, the mine would be."

JUDGE MELICK: That's what you told him?

MRS. CHAFFIN: Yes.

JUDGE MELICK: And anything further on that discussion?

MRS. CHAFFIN: That was the whole conversation. That was the whole thing. And then he left.

JUDGE MELICK: Well, did you say anything to the effect of, "We don't want to start trouble with the mine company"?

MRS. CHAFFIN: I don't know what - - I never said that. I don't know what kind of trouble that would have been. I don't - -

JUDGE MELICK: Well, you never made a statement like that?

MRS. CHAFFIN: No.

JUDGE MELICK: And did you say something about that the Lee Mine takes care of their citations?

MRS. CHAFFIN: I told him that. When he said he didn't want to get a citation, I told him, "Well, if Lee Ranch was in the - - if you felt it was safe, and if Lee Ranch was doing something wrong, then" - - "you know, I never did understand what it was he was asking, but he kept on - - he wanted to know about the citation, and I said, "Well, if Lee Ranch was doing something wrong, Lee Ranch would have been cited for it, not - - not you. You were" - - and I never did really understand what it was he was - -

JUDGE MELICK: So that was the extent of the conversation?

MRS. CHAFFIN: That was the whole conversation. I never did really understand what it was he was - - what - - if there was air in the dragline and he didn't feel like it was unsafe, what was the - - and he said he did not feel it was unsafe, so I don't know.

JUDGE MELICK: So that was the extent of the conversation?

MRS. CHAFFIN: That was the whole conversation. I never did really understand what it was he was - - what - - if there was air in the dragline and he

didn't feel like it was unsafe, what was the - - and he said he did not feel it was unsafe, so I don't know.

JUDGE MELICK: And he didn't ask you to do anything with respect to making the condition safe?

MRS. CHAFFIN: No, no. He said he thought it was safe.

JUDGE MELICK: And did you know when he had worked on the dragline?

MRS. CHAFFIN: Yes, because I do all the time sheets. He had worked on the dragline in July. This was in August.

JUDGE MELICK: I see.

Did he make any other prior complaints to you about that condition?

MRS. CHAFFIN: No.

(Tr. 84-86).

It is noted that Mrs. Chaffin testified that she did not make the statement attributed to her in George's Complaint to the effect that "we don't want to start trouble with the Mine Company" (Exhibit C-1) and that Mr. George did not in his testimony dispute Mrs. Chaffin's denial in this regard.

In evaluating the record evidence I find that Mr. George's testimony is not only internally contradictory in several respects but that it is also contradictory in several respects to the allegations in his own complaint. His testimony is also inconsistent in significant respects with that of other witnesses testifying under oath. I find therefore that I can give George's testimony in significant parts, but little weight.

Under the circumstances I give the greater weight to Mrs. Chaffin's description of the critical conversation on August 7. As best synthesized it appears that Mr. George asked Mrs. Chaffin whether there was supposed to be air in the dragline and she responded "Yes, there was." She then asked him "Well, did you feel like it was unsafe?" and he responded, "No, that he did not feel it was unsafe." Mr. George then said that "he didn't want to have a violation with MSHA" and Chaffin responded "if the mine was doing something wrong, you wouldn't have been violated for it, the mine would be" (Tr. 84). Finally Chaffin explained that since George told her that he did not feel it was unsafe she did not understand what he was even talking about. In this regard she testified "You know, why bring it up if it wasn't unsafe" (Tr. 84).

Due to the ambiguous and innocuous nature of this conversation, I do not find that it constituted a protected safety complaint. However, even assuming, *arguendo*, that this conversation could possibly have been interpreted as an implied threat to report George's concerns (about whether the air inside the dragline was checked) to the Lee Ranch Mine or to the "MSHA people" and, therefore, constituted a protected activity, I do not find that his layoff was motivated in any part by this conversation.

The second element of a *prima facie* case of discrimination is a showing that the adverse action was motivated in any part by the protected activity. As this Commission noted in *Chacon v. Phelps Dodge Corp.*, 3 FMSHRC 2508 (1981), *rev'd* on other grounds *sub nom. Donovan v. Phelps Dodge Corp.*, 709 F.2d 86 (D.C. Cir. 1983), “direct evidence of motivation is rarely encountered; more typically the only available evidence is indirect.” The Commission considered in that case the following circumstantial indicia of discriminatory intent: knowledge of protected activity; hostility towards protected activity; coincidence of time between the protected activity and the adverse action; and disparate treatment. In examining these indicia the Commission noted the operator’s knowledge of the miner’s protected activity is “probably the single most important aspect of the circumstantial case.”

The ambiguous and innocuous nature of the conversation at issue, the fact that George’s statements were more in the form of an inquiry rather than a complaint and the fact that George finally acknowledged at hearings that he told Mrs. Chaffin that he did not feel unsafe regarding the matter, all suggest that the operator would not have been motivated to retaliate against Mr. George for such statements. I also find credible the testimony of the co-owner of the closely held corporation, Kenneth Chaffin, that when he met with Mr. George, about a week before George started working, he told him that he had only a temporary welding job for him that would last only two or three weeks. Chaffin explained that 24/7 is in the business of providing temporary help for the Lee Ranch Mine. He meets biweekly with the Lee Ranch foreman to determine their employment needs and provides from six to thirty or forty workers depending on those needs.

According to Chaffin’s credible testimony, on this occasion the Lee Ranch Mine had only a temporary need for a welder for two to three weeks to weld some bumpers and canopies. Chaffin testified credibly that George was hired with that understanding.³ In addition, according to the undisputed testimony of Chaffin, the welding job on the bumpers and canopies was completed by August 6th. Thus a credible reason or motive for George’s layoff was established when he was hired, *i.e.*, that he was hired only for a temporary job lasting two or three weeks and this was confirmed when the designated tasks were completed on August 6. This evidence further negates the suggestion that George’s layoff would have been motivated by his ambiguous and innocuous statements about conditions that he, in any event, did not feel were unsafe.

Chaffin also testified that he planned on advising George on August 7th that he would be laid off but that he was unable to meet with George because he (Chaffin) was working in the mine at the time. According to Chaffin it was his practice to meet personally with workers he was laying off. Virginia Chaffin testified that after Kenneth Chaffin, her husband, met with Lee Ranch superintendent Ralph Ortega on August 5, he told her to have a layoff letter and last paycheck ready for George. He also told her that he wanted to talk to George before announcing his layoff. According to Mrs. Chaffin their office help was unavailable at the time so she had to prepare the layoff letter and Mr. George’s final paycheck herself. She did not get around to this

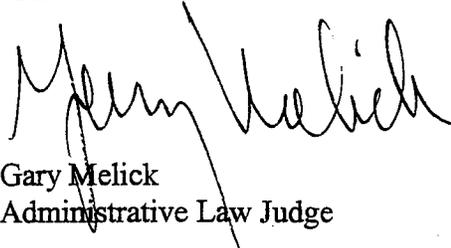
³ George was equivocal in his testimony whether he could recall whether Chaffin told him that it would be a short term job (Tr. 96-97).

until August 9th. On that date Mr. George returned Mrs. Chaffin's telephone call of August 8th and was told he would be laid-off and that he was to come to the office to pick up his tools and final paycheck. He was told that his lay-off was due to a lack of work and that some other workers would also be laid-off. Mr. Chaffin was present when Mr. George came to the office. Chaffin told him he would be one of the first to be rehired. According to Mrs. Chaffin, additional layoffs were avoided when, shortly thereafter, two workers quit.

Under all the circumstances I do not find that Mr. George's statements to Mrs. Chaffin on August 7th constituted either a protected safety complaint or a motivating factor in his layoff. Accordingly, I do not find that he has met his burden of proving that his layoff on August 9, 2003 was in violation of Section 105(c)(1) of the Act.

ORDER

Discrimination Proceeding Docket No. CENT 2004-98-D is dismissed.



Gary Melick
Administrative Law Judge

Distribution: (Certified Mail)

Mr. Raymond George, 329 ½ East Jefferson, Gallup, NM 87301

Kenneth Chaffin, 24/7 Service & Supply, Inc., P.O. Box 183, Grants, NM 87020

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ADMINISTRATIVE LAW JUDGE ORDERS

FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

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

July 2, 2004

SECRETARY OF LABOR,	:	CIVIL PENALTY PROCEEDINGS
MINE SAFETY AND HEALTH	:	
ADMINISTRATION (MSHA),	:	Docket No. SE 2003-160
Petitioner	:	A.C. No. 01-01322-00004
v.	:	
	:	Docket No. SE 2003-161
JIM WALTER RESOURCES, INC.,	:	A.C. No. 01-01322-00005
Respondent	:	
	:	No. 5 Mine

**ORDER DENYING JIM WALTER RESOURCES' MOTION
FOR SUMMARY DECISION**

In these cases, the Secretary of Labor (“Secretary”) on behalf of her Mine Safety and Health Administration (“MSHA”), alleges that Jim Walter Resources, Inc. (“JWR”) violated twenty-six mandatory safety standards promulgated pursuant to the Federal Mine Safety and Health Act of 1977. 30 U.S.C. § 801, et seq (“The Act”). The alleged violations are contained in citations and orders of withdrawal issued pursuant to sections 104(a) and 104(d) of The Act. 30 U.S.C. §§ 814(a), 814(d). Jim Walter Resources objects to the issuance of one of the orders – Order No. 7328082 – and moves for summary decision, pursuant to Commission Procedural Rule 67, 29 C.F.R. § 2700.67. JWR argues the undisputed material facts establish that the underlying standard cited in the order does not apply. For the reasons set forth below, Jim Walter’s motion is denied.

FACTS¹

JWR’s No. 5 Mine is located in Tuscaloosa County, Alabama. Approximately 250 miners are employed at the mine. At the time of the events at issue, the mine operated 3 shifts a day. On Friday September 21, 2001, while the No. 4 Section of the mine was idle for maintenance, a crack in the roof was observed. In addition, a noise was heard and water was seen dripping from some of the roof bolt holes in the No. 2 Entry of the section, near the scoop battery charging station. (Resp’t’s Bf. Ex. 2 at 1). The section coordinator directed Tony Key, section foreman, to have supplemental roof support installed throughout the area. About 16, 10 foot long cable bolts were installed during the day shift on September 21. Methane, water,

¹ The facts are derived from factual statements in the parties’ briefs.

broken coal and broken shale were encountered above the anchorage zone of the primary roof supports. Because of the poor roof conditions, the cable bolts proved ineffective to support the roof, and on Sunday, September 23, a roof fall occurred near the scoop battery charging station. (Resp't's Br. Ex. 2 at 1).

When the roof fell, methane was liberated from the roof strata into the section's entries. This occurred at approximately 5:17 p.m., minutes before an initial explosion. The arching of a scoop battery that was damaged by the roof fall is believed to have ignited the methane. The explosion damaged critical ventilation controls and disrupted the airflow in the section. It also injured four miners.

Three of the injured miners left the No. 4 Section. The fourth was too badly hurt to be moved. Twelve other miners came into the area in an attempt to rescue the fourth miner and respond to the emergency situation. Other miners not responding to the explosion were not evacuated from the mine, even though the explosion damaged critical ventilation controls. At approximately 6:15 p.m. a second explosion occurred, leaving thirteen miners dead.

After the incidents, the Secretary conducted an extensive investigation. The investigation resulted in MSHA charging JWR with numerous violations, including that set forth in Order No. 7328082. The order states:

On September 21, 2001, two separate explosions occurred in 4 Section, resulting in fatal injuries to thirteen miners. The accident investigation revealed a proper evacuation procedure was not followed after the first explosion on 4 Section. Miners were not evacuated from the mine after an explosion damaged critical ventilation controls. These conditions were known by, and communicated to, management personnel including the CO Room Supervisor. The section foreman believed there was a possibility of explosion and did not effectively communicate this information to other miners. Miners from other areas of the mine responded to the emergency on 4 Section believing either an ignition or a fire had occurred. These miners were unaware an explosion had occurred and a second explosion was possible. Miners underground were not alerted to the problem through the mine wide telephone paging system. Also, management directed 7 additional miners to join the 13 miners already in 4 Section.

The order cites a violation of Section 75.1101-23(a)², which at the time the order was issued read as follows:

Each operator of an underground coal mine shall adopt a program for the instruction of all miners in the location and use of fire fighting equipment, location of escapeways, exits, and routes of travel to the surface, and proper evacuation procedures to be followed in the

² As discussed more fully below, this regulation was later amended and republished as 30 C.F.R. §75.1502 (2003).

event of an emergency. Such program shall be submitted for approval to the District Manager of the Coal Mine Health and Safety District in which the mine is located no later than June 30, 1974.³

STANDARD FOR SUMMARY JUDGMENT

Commission Rule 67 provides: “A motion for summary decision shall be granted only if the entire record including the pleadings, depositions, answers to interrogatories, admissions, and affidavits shows: (1) That there is no genuine issue as to any material fact; and (2) That the moving party is entitled to summary decision as a matter of law.”

JWR’S ARGUMENTS

JWR argues that Section 75.1101-23(a) did not govern its actions on September 23, 2001, after the first explosion. It is JWR’s belief that the standard expressly applied “only to emergencies involving underground fires.” (Resp’t’s Br. at 9). JWR notes that the standard was located in Subpart L of the mandatory safety standards for underground coal mines. This subpart was titled “Fire Protection.” JWR contends that the “purpose of the program of instruction for ‘evacuation procedures’ referenced in § 75.1101-23(a) must be to address fire emergencies, not other emergencies that could occur in an underground mine.” (Resp’t’s Br. at 10).

Second, JWR argues that its MSHA approved Fire Fighting and Evacuation Plan (the “Plan”) only applies to fire emergencies. JWR cites the language of the Plan to illustrate “its exclusive focus on preparing for and responding to *fire* emergencies.” (Resp’t’s Br. at 15) (emphasis in original).

Third, JWR argues that “MSHA’s post-accident issuance of an emergency temporary standard (‘ETS’) and final rule broadening the scope of the program of instruction under § 75.1101-23(a) further confirms that, when the JWR explosion occurred, the requirements of [the standard] were limited to fire emergencies.”⁴ (Resp’t’s Br. at 16). JWR believes that this

³ On September 21, 2001 a plan approved by MSHA was in effect at the No. 5 Mine.

⁴ The ETS addressed a deficiency in the relevant MSHA policy. MSHA stated it recognized that Section 75.1101-23(a) “did not adequately address responsibilities of the responsible person on the surface and the responsible person under ground” in the event an emergency evacuation was necessary. (Resp’t’s Br. Ex. 4 at 57). Therefore, the ETS required mine operators to designate a responsible person at the mine to take charge during mine fire, explosion, and gas or water inundation emergencies. This person was responsible for not only making the decision to evacuate, but also coordinating evacuations. MSHA further stated that “[t]he ETS . . . provide[d] that only properly trained and equipped persons essential to respond to the mine emergency may remain underground.” (Resp’t’s Br. Ex. 4 at 57). The ETS “also broaden[ed] the existing requirements for a program of instruction for firefighting and evacuation

“broadening” of Section 75.1101-23(a) indicates the standard was not inclusive enough to cover the events that occurred on September 21, 2001.

Moreover, JWR argues that even if Section 75.1101-23(a) “could somehow be construed to apply to events that were not fire emergencies,” the company was in compliance with the standard. JWR states that by having a Fire Fighting and Evacuation Plan (“Plan”) that was approved by MSHA, it satisfied the requirements of Section 75.1101-23(a). JWR also states that it “did follow the Plan and the miners’ actions in response to the explosion were consistent with [the] training and instruction” they received under the Plan’s “program of instruction.” (Resp’t’s Br. at 20).⁵

SECRETARY’S ARGUMENTS

The Secretary submits that Section 75.1101-23(a) “is plainly worded and was intended to protect miners against hazards by requiring, without limitation, evacuations in mine emergencies.” (Pet’r’s Br. at 9). Accordingly, the Secretary states that “[i]f the meaning of a regulation’s language is plain, the plain meaning of the language is controlling and the regulation cannot be interpreted to mean something else.” (Pet’r’s Br. at 10). Thus, the word “emergency” in the standard is not limited to “fire emergency.”

Alternatively, the Secretary argues that even if the meaning of the standard is ambiguous, there are “two additional rules of regulatory construction [that] compel the court to find the standard applies to explosion related emergencies.” (Pet’r’s Br. at 11). First, on May 8, 1995, MSHA published an abstract stating that Section 75.1101-23(a) “requires each operator of an underground coal mine to adopt a program for mine evacuation in the event of an emergency, such as a fire or explosion” (Pet’r’s Br. at 13) (quoting 60 Fed. Reg. 23567 (1995)). This interpretation of Section 75.1101-23(a) was reasonable and entitled to deference. Second, “safety legislation and regulations must be constructed broadly to effectuate their purposes,” and “[s]ince the purpose of the evacuation provisions [was] to prevent loss of life during emergencies,” the Secretary’s broader interpretation should be accepted.” (Pet’r’s Br. at 14).

ANALYSIS

Applicability of Section 75.1101-23(a)

Based on the facts as presently revealed in the record, I conclude it was not improper for MSHA to cite JWR for a violation of Section 75.1101-23(a). I am not swayed by JWR’s

to address fire, explosion, and gas or water inundation emergencies.” (Resp’t’s Br. Ex. 4 at 57).

⁵ JWR also argues that the “Secretary’s interpretation of the regulation and Plan, even if permissible, is unenforceably vague” and fails to provide the notice required to support imposition of a civil penalty. (Resp’t’s Br. at 27). Given my conclusions on the proper interpretation of the standard, I need not address this issue. (*See infra* pp. 6-8).

argument that the standard only applies to fire emergencies, and I am persuaded by the Secretary's argument that the meaning of the standard is plain, and so must be enforced as written.

As has been observed by the Commission, the language of many standards is "simple and brief in order to be broadly adaptable to myriad circumstances." *Kerr-McGee Corp.*, 3 FMSHRC 2496, 2497 (November 1981); *Alabama By-Products Corp.*, 4 FMSHRC 2128, 2130 (December 1992). "Such broadly written standards must afford reasonable notice of what is required or proscribed." *Palmer Coking Coal Co.*, 22 FMSHRC 887 (citing *U.S. Steel Corp.*, 5 FMSHRC 3, 4 (January 1983)). In order "to pass constitutional muster, a statute or standard adopted thereunder cannot be 'so incomplete, vague, indefinite or uncertain that men of common intelligence must necessarily guess at its meaning and differ as to its application.'" *Ideal Cement Co.*, 12 FMSHRC 2409, 2416 (quoting *Alabama By-Products Corp.*, 4 FMSHRC 2128, 2129 (December 1982) (citations omitted)). A standard must "give a person of ordinary intelligence a reasonable opportunity to know what is prohibited, so that he may act accordingly." *Lanham Coal Co.*, 13 FMSHRC 1341, 1343 (September 1991).

When faced with a challenge that a safety standard failed to provide adequate notice of prohibited or required conduct, the Commission has applied an objective standard, i.e., the reasonably prudent person test. *BHP Minerals Int. Inc.*, 18 FMSHRC 1342, 1345 (August 1996). The Commission summarized this test as "whether a reasonably prudent person familiar with the mining industry and the protective purposes of the standard would have recognized the specific prohibition or requirement of the standard." *Ideal Cement Co.*, 12 FMSHRC at 2416.

"In evaluating whether a reasonably prudent person familiar with the mining industry and the protective purposes of the standard at issue would have recognized the applicability of the standard to the cited facts at issue, the Commission has analyzed a number of factors including the ordinary definition of the terms of the text of the regulation at issue, the consistency of the Secretary's enforcement, and whether MSHA has published notices regarding its interpretation [sic] the standard in question." *Western Industrial, Inc.*, 24 FMSHRC 269 (March 2002). (citations omitted).

Here, application of the test requires determining whether a reasonable operator would have concluded that an explosion was the kind of emergency event referenced in Section 75.1101-23(a), and I conclude that it would.

I find JWR's attempt to differentiate between a fire and an explosion to be a distinction without difference. I concur with the Secretary's statement that "explosions and fires are similar in nature and present similar hazards to miners underground." (Pet'r's Br. at 15). I agree with the Secretary that "it is reasonable to anticipate that a fire could create an explosion risk and an explosion could create a fire risk." (Pet'r's Br. at 15). This is because fires and explosions are fundamentally interrelated. According to the *Dictionary of Mining, Mineral and Related Terms*, an explosion is "a rapid oxidation, accompanied by heat and flame, of firedamp, coal dust, or

other strongly flammable material, resulting in a great and sudden development of gases and pressure.”; while a fire is “ the manifestation of rapid combustion or combination of materials with oxygen.” U.S. Dept. Of Interior, Bureau of Mines 402, 429 (1968).⁶ These two events are so intertwined, I conclude it is eminently reasonable to view the “emergency” referred to in the standard as inclusive of an explosion. In other words, it is reasonable to apply the standard to both occurrences.

Given this interpretation of the standard, I find its placement in Subpart L logical, and I reject JWR’s suggestion that the placement of the standard and its regulatory context restricts it to fires only and excludes explosions. (Resp’t’s Br. at 13) (citing *Phelps Dodge Corp. v. FMSHRC*, 681 F.2d 1189, 1192 (9th Cir. 1982)).

Lack of Undisputed Material Facts

Since Section 75.1101-23(a) applies to explosion-related emergencies, the question is whether JWR followed its MSHA approved Fire Fighting and Evacuation Plan on September 23, 2001. However, the question can not be answered at this time because there are material facts in dispute that are essential in making this determination.

It is established law that once a plan is approved and adopted, its provisions are enforceable at the mine as mandatory safety standards. *See Cf. VP-5 Mining Co.*, 14 FMSHRC 1033, 1036-37 (June 1992) (citations omitted). As noted earlier, Order No. 7328082 charges JWR with allegedly failing to comply with its Plan. Specifically, the Secretary cites the following as alleged violations of the Plan: failure to evacuate No. 4 Section when the CO monitors started sending signals, failure to properly investigate the emergency as provided in the Plan, and sending poorly informed miners into No. 4 Section before the second explosion. (Pet’r’s Br. 33-34). JWR contests these allegations and argues that it did follow the Plan. Given the disputes over the applicable provisions of the Plan and whether they were violated, the Secretary will have to prove the alleged violations of the Plan at trial, either through documentary evidence or testimony, or both. JWR can rebut the Secretary’s case by showing the particular events of September 21 that the Secretary contends contravened the Plan either did not occur or were not contrary to the provisions of the Plan. Therefore, a trial is necessary to determine the outcome of this issue.

ORDER

For the reasons stated above, I find that Section 75.1101-23(a) was correctly cited. I further find that there are material facts in dispute, and a determination of the facts must be made

⁶ The similarity between a fire and an explosion is noted in the Report created by JWR’s expert Malcolm J. McPherson. He states that “[i]t is probable that [the] second ignition of methane resulted in the propagation of flaming” and “[t]he flame would then accelerate into a gas explosion.”(Pet’r’s Br. Ex. J at 46).

to determine if the standard was violated. Accordingly, the Motion for Summary Decision by JWR is DENIED.⁷



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⁷ JWR has directed my attention to a recent decision by the Court of Appeals for the District of Columbia Circuit regarding regulatory interpretation. *Association of Civilian Technicians, Wichita Air Capital Chapter v. FLAR*, 360 F.3d 195 (D.C. Cir 2004). Given my conclusions on the plain meaning of Section 75.1101-23(a), I find the case, which concerns among other things a discussion of broad versus strict construction of a standard, inapposite.

