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SOL (MSHA) V. BETHLEHEM MINES
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Federal Mine Safety and Health Review Commission
Office of Administrative Law Judges

SECRETARY OF LABOR, MINE SAFETY AND HEALTH ADMINISTRATION (MSHA), PETITIONER	Civil Penalty Proceeding Docket No. PITT 77-50-P A.C. No. 36-00840-02004 F
v.	
BETHLEHEM MINES CORPORATION, RESPONDENT	Cambria Slope No. 33 Mine

DECISION

Appearances: John H. O'Donnell, Esq., Office of the Solicitor, U.S. Department of Labor, for Petitioner; T. W. Ehrke, Esq., Bethlehem Mines Corporation, Bethlehem, Pennsylvania, for Respondent.

Before: Judge Charles C. Moore, Jr.

On April 16, 1976, Denton R. Bodenschatz, a shuttle car operator for Bethlehem Mines Corporation, was killed in the No. 5 air course of the 3 Right 6 South section of the Cambria Slope No. 33 Mine in Cambria County, Pennsylvania. The decedent who was operating the No. 50 shuttle car immediately prior to the accident, was in the process of hauling coal to the conveyor belt tail when the said shuttle car lurched forward causing the decedent, who had partially moved out from under the protection of the canopy, to be squeezed between the belt tail jack and the shuttle car frame.

Immediately following the accident, the Mining Enforcement and Safety Administration of the Department of the Interior (hereinafter referred to as MESA), (FOOTNOTE 1) initiated an investigation. As a result of the investigation, MESA issued citations and on August 24, 1977, filed a petition for assessment of a civil penalty in accordance with section 109(a) of the Federal Coal Mine Health and Safety Act of 1969, 30 U.S.C. 819(a). (FOOTNOTE 2)

The Respondent filed an answer on September 15, 1977, denying the violation alleged in the petition for assessment of civil penalty. A hearing on the merits was held in Ebensburg, Pennsylvania, on January 23 and 24, 1979.

Notice of Violation No. 1 CMB, April 19, 1976

The notice of violation, which bears the closest relation to the fatality, alleges a violation of 30 CFR 75.1725(a). It states:

> The standard shuttle car, Joy 21SC Serial # ET11903, in the 3 Rt. 6 South Section (056) was not maintained in a safe operating condition, in that coal was permitted to accumulate around the tram lever and control linkage and the machine was not taken out of service to completely correct the condition. This violation was observed during an investigation of a fatality and was a contributing factor in the fatality.

Section 75.1725(a) of Title 30, Code of Federal Regulations states: "Mobile and stationary machinery and equipment shall be maintained in safe operating condition and machinery or equipment in unsafe condition shall be removed from service immediately."

Government Exhibit 2 contains the following decription:

DESCRIPTION OF ACCIDENT

> On Friday, April 16, 1976, the crew for 3 right 6 south section entered the mine at about 7:55 a.m. and arrived in the face area approximately 25 minutes later. Robert Wolfe, section foreman, made an examination of the section. Owen D. Croyle, roof-bolter helper, had been assigned to operate the standard shuttle car this shift because the regular operator was absent. He first had to clean an accumulation of loose coal 12 to 18 inches deep which had been left by the previous shift from the operator's cab of the standard shuttle car. Denton R. Bodenschatz, shuttle-car operator, began cleaning loose coal which had been left by the previous shift from around the belt tail while William Perkins, miner helper, and Andrew Orlovsky, miner operator, pulled down loose ribs. After Wolfe completed the examination of the section, production activities began as Orlovsky used the continuous miner to push spilled runway coal into the pillar split of the pillar between Nos. 6 and 7 air courses. One car of coal was loaded and dumped. When the second shuttle car of coal was hauled to the belt tail, Croyle had difficulty positioning the shuttle car to dump because of coal spillage. While maneuvering the shuttle car, it became stuck

> near the inby corner of the intersection. Bodenschatz, who had been cleaning coal spillage at the belt tail with Michael Korinchak, roof bolter, attempted to free the shuttle car but was unsuccessful. It was necessary to use the continuous miner to pull it free. Bodenschatz then volunteered to haul a load since Croyle had been having trouble. When he arrived at the face, he had difficulty in positioning the shuttle car under the tail of the continuous miner because the tram control was sticking. He and Perkins cleaned the cab out and found that the helper spring on the forward tram pedal had very little tension on it. They repositioned the spring in another hole which provided more tension. Bodenschatz tried the pedal several times and commented that it was working all right. The shuttle car was loaded, and he drove it toward the belt tail to dump the load. As he approached the corner of the intersection of No. 5 entry, the operator's side of the shuttle car was too close to the rib and the top of the canopy began to wedge against the roof. Wolfe, who was behind the check curtain assisting William Clarke, mechanic, with repairs to the Kersey tractor, was then informed of the trouble in trying to position the shuttle car to unload. Wolfe evaluated the situation and instructed Bodenschatz to back out and to swing wider. Bodenschatz tried to start the car but could not do so. He told Croyle, who was standing between the shuttle car and the rib, that the shuttle car would not start. Croyle noticed that the shuttle-car light was on and he also heard the control circuit contactors close but without the pump motors starting. An instant later, the shuttle car unexpectedly lunged forward in the direction opposite to that intended until it struck the belt tail. As the shuttle car traveled the short distance, Bodenschatz's head was squeezed between the top frame of the shuttle car and the belt tail jack. Croyle ran forward and used the panic bar to deenergize the shuttle car. First-aid materials were obtained and first-aid care was administered. Bodenschatz was transported to the intensive care unit at Conemaugh Valley Memorial Hospital, Johnstown, Pennsylvania. He died at 8:25 p.m. the same day of a severe head injury.

Petitioner alleges that at the time of the accident, there were coal accumulations around the control levers which interfered with the normal operation of the machine (Tr. 199, 200) and Respondent had knowledge of these accumulations. Petitioner introduced Exhibit Nos. 16 and 17 which depicted the coal and coal dust accumulations mixed in with the blood of the victim on the floor of the cab (Tr. 22, 28). Although these pictures were taken on April 19, 1976, 3 days after the fatal accident, they allegedly are an accurate representation of the floor of the cab immediately following the

accident. Petitioner asserts that these exhibits clearly illustrate that the blood of the victim fell on the coal, which would imply that these accumulations were already present at the time of the accident (Petitioner's Brief, p. 13, Tr. 22, 23, 157, 158).

I find that these pictures (Exh. Nos. 16 and 17) cannot be accepted as a true and accurate portrayal of the cab of the shuttle car as it looked immediately following the accident. In the first place, the two exhibits show the brake pedal in different positions. Someone moved it before the second picture was taken. Also, Inspector Biesinger testified that the initial investigation revealed that the helper spring was found disconnected following the accident, whereas Exhibit Nos. 16 and 17 show the helper spring to be connected (Tr. 127). Mr. Ford, director of safety and environmental health for Bethlehem, who was one of the first persons to arrive at the scene of the accident, stated in reference to observing the helper spring in Exhibit Nos. 16 and 17, "Well, it looks like it's attached, but that's not what I saw" (Tr. 391). The preceding evidence clearly establishes that the shuttle car had been tampered with subsequent to the accident and prior to taking the photographs. Petitioner made no attempt to explain this discrepancy in its evidence.

It is also noted that Petitioner had some difficulty with determining the exact date when the pictures were taken. The evidence presented by both parties establishes that the pictures were taken on April 19, 1976, 3 days after the accident, yet, towards the end of the hearing, after one of Respondent's witnesses had testified that the pictures were not taken on April 16, Mr. O'Donnell, after consulting with one of the inspectors who had previously testified, proceeded to ask "You heard them testify they did take the pictures on the 16th?" (Tr. 403).

The evidence also indicates that the MESA inspectors may not have made their first examination of the cab until April 20, 1976 (Tr. 55). (FOOTNOTE 3)

If so, that was even after the pictures (Govt. Exh. Nos. 16 and 17) were taken and I have already rejected them as accurate depictions of the accident scene. Respondent's witness, Mr. Ford, however, had observed the cab of the shuttle car on April 16, 1976, shortly after the fatal accident. Mr. Ford and two other management personnel were the first persons to arrive at the scene of the accident during the initial investigation. Mr. Ford testified that he observed a large pool of blood, approximately 15 to 17 inches in diameter, on the deck of the shuttle car (Tr. 378). He observed that the deck did not contain one handful of dirt (Tr. 378). In response to Government Exhibit Nos. 16 and 17, Mr. Ford stated, "Without a doubt that is not the condition I observed. This definitely shows coal all around the place. Whenever I looked at it, why, hey, it was perfectly clean" (Tr. 381).

Mr. Ford explained that immediately after he had observed the shuttle car, all investigative personnel were ordered out of the accident area so that additional roof support could be installed (Tr. 400) He estimated that a MESA inspector could not have examined the cab for at least 1-1/2 hours while the roof support was being installed (Tr. 401). He speculated that coal may have been spilled into the cab during the installation of roof supports.

Petitioner does not refute the fact that Mr. Ford examined the shuttle car at least 1-1/2 hours before the MESA investigation team. I use the phrase "at least" because of the sworn testimony that the inspectors first examined the cab 4 days after the accident on April 20. Petitioner's only explanation as to why Mr. Ford observed a clean cab was that the witness was upset and therefore he imagined the cab was clean (Petitioner's Brief, p. 13).

I accept Mr. Ford's testimony and find that the shuttle car was, in fact, clean immediately after the accident. It should also be noted that the cab of the shuttle car was cleaned immediately before it was loaded at the face and during the same run in which the fatal accident occurred (Govt. Exh. No. 2, p. 5, Tr. 52). If the tram pedal was struck at the time of the accident, it was not because of accumulations of coal and coal dust in the cab of the shuttle car.

The Petitioner alleges that the operator should have known that the helper spring was malfunctioning. (See Continuation Sheet No. 3 of Govt. Exh. No. 7.) The helper spring is not the principal means of returning the tram pedal to the neutral position. The pedal is otherwise spring-loaded to return to the neutral position and the helper spring is attached so as to assist the other spring in returning the tram to neutral. The operator's foot works against both the main spring and the helper spring when he trams the shuttle car. The Petitioner argues that Bethlehem personnel had knowledge of the defective helper spring because "the time of the accident was not the first time this spring had detached so Bethlehem personnel had been warned before the accident and knew that the helper spring was stretched."

(See Petitioner's Brief, p. 10.).

The evidence does not establish that the operator had any knowledge concerning the defective helper spring. On the contrary, the evidence establishes that only the decedent, Denton R. Bodenschatz, and the miner helper, William Perkins, were aware of the difficulty with the helper spring (Govt. Exh. No. 2, p. 5, Tr. 29, 30, 86, 87). (FOOTNOTE 4) When Inspector Biesinger was asked whether Mr. Perkins had informed either the mechanic or the section foreman that the spring had been repositioned, he responded, "I don't recall" (Tr. 134). Mr. Perkins was not called as a witness. Furthermore, Robert Wolfe, who was the section foreman at the time of the accident, testified that at no time during his shift, up to the time of the accident, was he advised of any problems with the shuttle car (Tr. 352).

As to the tram pedal, Petitioner asserts that Respondent knew or should have known that it was sticking. At the time the shuttle car was examined, whether on the 16th or 20th, the tram lever was found in the forward position, the opposite direction the decedent intended to travel (Govt. Exh. No. 2, p. 6). It was thus concluded by MESA investigators that the tram lever was stuck in this position at the time of the accident.

Petitioner had two inspectors testify about the alleged sticking tram pedal. Their testimony concerning the location of the tram pedal on the machine and the operation of the machine was inconsistent. Inspector Biesinger repeatedly testified that the left foot pedal operates the brake and the right foot pedal operates the tram pedal (Tr. 27, 125, 159). He also testified that there was a switch on the control panel that had to be turned to the forward or reverse position before one could go backwards or forwards in the shuttle car (Tr. 27, 34, 69, 150). Conversely, Inspector Koba indicated that the tram lever is always on the left side and the brake lever is on the right (Tr. 169, 170, 191-193). He also testified that the directional control switch is connected to the tram pedal and the switch is automatically activated upon depressing the tram pedal (Tr. 168-172, 192, 194). Inspector Koba destroys his own credibility, however, when he states in reference to the brake and tram pedals, "Whether it was the right or left foot, I don't--I could be wrong on that. But the tramming lever was the one that was connected to the control switch" (Tr. 194).

The testimony of the two inspectors that they found the tram control was stuck in the forward position is rendered somewhat less than convincing by the fact that neither was sure which pedal was the tram control. But assuming that the tram lever was, in fact, stuck at the time of the accident investigation, the evidence does not establish conclusively that it was stuck at the time of the accident.

There is no way of actually knowing whether the tram lever was stuck in the forward position at the time of the accident (Tr. 134). It must be remembered that the decedent had difficulty in starting the shuttle car, and although it is obvious that his head must have been out from under the canopy in order for him to have been injured as he was, there is no evidence as to the position of the rest of his body at the time of the accident. This is understandable because the only light available was from a miner's cap lamp and unless one of the witnesses was shining his lamp directly at the decedent, he would have no way of knowing his position. But there is the possibility that the decedent's foot was on the forward tram lever and that the lever did not become stuck in that position until the shuttle car crashed into the tailpiece. I am accepting as a fact, despite the discrepancies in the evidence, that after the accident the tram lever was found stuck in the forward position. While I think it is unlikely that Mr. Bodenschatz kept his foot on the tram lever until the collision with the tailpiece, I cannot find as a fact that the accident did not happen that way. I think it is more likely that the tram pedal was stuck in the forward position immediately prior to the accident and that the decedent somehow managed to start the shuttle car while the tram pedal was stuck in that position. But again, the evidence is not sufficiently convincing for me to find as a fact that that was the way the accident happened. Assuming it did happen that way, however, in order to prevail, the Government must show that Respondent knew or should have known of the malfunctioning equipment.

Hearsay evidence does indicate that the tram pedal had been stuck on several prior occasions (Tr. 60, 61). Inspector Biesinger testified that management, upon being notified of the problem with the tram lever, did not exercise reasonable care in alleviating the problem (Tr. 112-114). Inspector Koba testified that the condition (the sticking tram lever) existed for quite a length of time, and when it was reported, the foreman did not act expeditiously (Tr. 201). Inspector Bernazzoli was of the opinion that the machine should have been taken out of service the first time the tram lever had been reported sticking (Tr. 225).

Nowhere does Petitioner establish one concrete example where management, upon being informed of the tram lever problem, did not take corrective action. In fact, the evidence points to the opposite conclusion. Joe Stauski, section foreman of the shift preceding the accident, testified that he observed the shuttle car being greased and cleaned quite a few times during his shift (Tr. 305). Lynn Baum, section foreman on a different shift testified that upon being informed of a problem with the tram pedal, he had the mechanic and the shuttle car operator clean and grease around the pedals (Tr. 372). Robert Wolfe, the section foreman of the shift on which the fatal accident occurred, testified that he was not aware of any problems with the operation of the shuttle car during the shift (Tr. 343, 352, 353).

The testimony of the MESA investigators indicates that the operator had inadequately repaired the tram lever. Yet, there is no evidence presented by Petitioner revealing what action should have been taken by the operator, other than cleaning and greasing the pedals, to adequately repair the sticking pedal (Tr. 231). In fact, in the abatement notice, MESA condoned the greasing of the tram control levers as the appropriate method of repair. (See Govt. Exh. No. 8, Continuation Sheet No. 3.) I find no violation of 30 CFR 1725(a).

Section 104(b) Notice of Violation No. 3 CMB, April 19, 1976

The 104(b) notice of violation which alleges a violation of 30 CFR 75.400 states:

> Loose coal and coal dust was permitted to accumulate from 3 to 8 inches thick for a distance of approximately 30 feet from tailpiece inby, on the shuttle car travelway where the accident occurred in the No. 5 entry of the 3 Rt. off the 6 South Section (056). This was a contributing factor to the fatality.

Section 75.400 of the Code of Federal Regulations states:

> Coal dust, including float coal dust deposited on rock-dusted surfaces, loose coal, and other combustible materials shall be cleaned up and not be permitted to accumulate in active workings, or on electric equipment therein.

In accordance with the holding of Old Ben Coal Company, 8 IBMA 98 (1977), it is necessary for the Petitioner not only to prove that an accumulation existed, but also to submit evidence as to the inspector's determination, prior to issuing the citation, as to how long the accumulation had been present and what cleanup actions were taken, if any, upon discovery of the accumulation by the operator.

The evidence does establish that accumulations existed as described in 104(b) Notice of Violation No. 3 CMB, Government Exhibit No. 9 (hereinafter referred to as accumulation No. 1) (Tr. 76, 152, 234-235); Modification Sheet No. 2 CMB, Government Exhibit No. 10 (hereinafter referred to as accumulation No. 2) (Tr. 236-237); and Continuation Sheet No. 2 attached to Notice of Violation No. 3 CMB. (This sheet describes two separate accumulations. They shall hereinafter be described as accumulation No. 3 and accumulation No. 4) (Tr. 241, 242). Yet, only for accumulation Nos. 1, 3 and 4 does the evidence establish that the inspector, prior to issuing his citation, made a determination as to how long the accumulations had been present (Tr. 243, 245). Furthermore, the evidence reveals that only for accumulation No. 1 was there a determination by the inspector, prior to issuing his notice, as to what actions the operator took upon discovery of the accumulation. The evidence indicates that the decedent

had begun cleaning loose coal from around the belt tail (Tr. 75, Govt. Exh. No. 2, p. 5). In light of the preceding, I find that Petitioner has established a prima facie case for a violation of section 75.400 only for accumulation No. 1.

It should be noted that Mr. Carpinello, Bethlehem's general mine foreman, did not refute the fact that accumulation No. 1 had not been cleaned up (Tr. 281). He indicated that he felt the determination of an accumulation was a judgment call (Tr. 282). He and one of the section foremen were of the opinion, however, that the accumulation could not have been present for six shifts because the area had been shoveled the day before and it was cleaned every shift (Tr. 316, 317, 355). He also testified that the belt tail area had taken only 20 to 30 minutes to clean up (Tr. 325). There was a cleanup program in effect at the time of the accident (Respondent's Exh. C, Tr. 270).

Petitioner also alleged that the loose coal on the mine floor in the area of the belt tail (accumulation No. 1) was a contributing factor to the accident in that it made it difficult to maneuver the shuttle car properly. There is no convincing evidence which substantiates this allegation. In fact, the description of the accident in the accident report does not make any reference to the decedent having any difficulty maneuvering the shuttle car as a result of coal accumulations (Govt. Exh. No. 2, p. 5). I do not find a connection between the accumulation and the accident, but I do find a violation.

I find that the operator is large in size, abated the violation promptly and in good faith, the penalty assessed herein will not affect its ability to continue in business, and the operator has a significant history of violations.

I find there is negligence in that the operator, who had knowledge of the accumulation, failed to clean it up (Tr. 281).

I find this to be a serious violation in that the potential for an explosion was increased because of the excessive amounts of methane liberated in the mine (Tr. 291). The relevant section of the mine was dry (Tr. 247) and the cables in the area could have provided an ignition source (Tr. 80, 81, 153). A penalty of $1,000 will be assessed.

Section 104(b) Notice of Violation No. 1 CMB, May 26, 1976

The 104(b) notice of violation which alleges a violation of 30 CFR 75.304 states:

> Evidence observed and revealed during an investigation of a fatal accident that occurred in the 3 Right 6 South section (056) on 4/16/76 was substantial to support that a proper on shift examination of the working section was not made for at least 6 shifts preceding the

> accident in that the following conditions were cited and observed; the roof was inadequately supported and accumulations of loose coal and coal dust were present in the active shuttle-car roadway, also, the tail of the belt (shuttle car dumping point) was installed in a hazardous location and in a hazardous manner.

Section 75.304 of the Code of Federal Regulations states:

> At least once during each coal-producing shift, or more often if necessary for safety, each working section shall be examined for hazardous conditions by certified persons designated by the operator to do so. Any such conditions shall be corrected immediately. If such condition creates an imminent danger, the operator shall withdraw all persons from the area affected by such conditions to a safe area, except those persons referred to in section 104(d) of the Act, until the danger is abated. Such examination shall include tests for methane with a means approved by the Secretary for detecting methane and for oxygen deficiency with a permissible flame safety lamp or other means approved by the Secretary.

This 104(b) notice of violation was issued on May 26, 1976, and was precipitated by a fatal accident which occurred on April 16, 1976. The accident investigation was completed on April 21, 1976. (See Government Exhibit No. 2.) This means that the notice of violation was issued 40 days after the occurrence of the fatal accident and 35 days after the completion of the accident investigation. I am of the opinion that the issuance of a citation 35 days after the completion of the accident investigation, without good cause, is an unreasonable delay in informing Respondent of the allegations lodged against it. On its face, the notice of violation indicates that it was issued because of the presence of improperly supported roof, accumulations of loose coal and coal dust, and because the tail belt was installed in a haphazard location and manner. From reading the notice, it would appear that the existence of the three conditions proved that a proper onshift examination had not been made. But the testimony of Inspector Bernazzoli makes it clear that he issued the notice because the conditions had not been properly recorded in the onshift examination book (Tr. 55, line 8, Tr. 52, lines 5-11). It should also be noted that with respect to two of the items that the inspector thought should have been noted in the book, no citations were issued (no citation was issued with respect to the unsupported roof or the so-called haphazardly-installed tailpiece). But the essential flaw with respect to this notice is that the section cited does not require the keeping of any records. (FOOTNOTE 5) The notice is VACATED.

Section 104(b) Notice of Violation No. 2 CMB, May 26, 1976

The 104(b) notice of violation which alleges a violation of 30 CFR 75.303(a) states:

> Evidence observed and revealed during an investigation of a fatal accident that occurred in the 3 Right 6 South section (056) on 04/16/76 was substantial to support that a proper pre-shift examination of the working section was not made for at least 6 shifts preceding the accident in that the following conditions were observed and cited; the roof was inadequately suported and accumulations of loose coal and coal dust were present in the active shuttle car roadway, also, the tail of the belt (shuttle car dumping point) was installed in a hazardous location and in a hazardous manner. The pre-shift examiner recorded in the book that the section was safe for the men to enter.

Section 75.303(a) of Title 30, Code of Federal Regulations, states, in part:

> Within 3 hours immediately preceding the beginning of any shift, and before any miner in such shift enters the active workings of a coal mine, certified persons designated by the operator of the mine shall examine such workings and any other underground area of the mine designated by the Secretary or his authorized representative. * * * Each such mine examiner shall also record the results of his examination with ink or indelible pencil in a book approved by the Secretary kept for such purpose in an area on the surface of the mine chosen by the operator to minimize the danger of destruction by fire or other hazard, and the record shall be open for inspection by interested persons.

This 104(b) notice of violation, like the prior notice, was issued 35 days after the completion of the accident investigation. Again, I am of the opinion that this time period amounts to an unreasonable delay in informing Respondent of the allegations lodged against it. Unlike the section involved in the previous violation, however, 30 CFR 75.303(a) does require that the results of the examination be recorded in an approved book. In order to find a violation, I would have to decide that the three items listed in the notice were hazardous conditions. Inasmuch as there was no citation issued in connection with the installation of the tail belt, I do not see how I could agree that it was a hazardous situation that should have been included in the preshift examiner's report. As to the unsupported roof, while it apparently existed after the accident, I think it safe to assume that if the inspectors had thought that it had existed for any significant time, they would have issued a citation in connection

with that condition. I therefore cannot agree that the preshift examiner ignored the unsupported roof for six shifts.

Respondent was cited for accumulations of loose coal and coal dust and I have previously found that accumulations of coal and coal dust in this mine are serious. Since, however, it is not the practice in Respondent's mine to include coal and coal dust accumulations on a preshift report, and inasmuch as there is a program wherein one shift is supposed to clean up whatever coal and coal dust was left by the prior shift, I cannot find that there was a significant degree of negligence on the part of the preshift examiner in failing to include the condition on the preshift examation report. A penalty of $100 will be assessed.

ORDER

It is therefore ORDERED that Respondent pay to MSHA, within 30 days of the entry of this decision, a civil penalty in the amount of $1,100.

Charles C. Moore, Jr.
Administrative Law Judge

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~FOOTNOTE_ONE
1 As of March 9, 1978, by operation of law the Mining Enforcement and Safety Administration was transferred to the Department of Labor where it became the Mine Safety and Health Administration.

~FOOTNOTE_TW0
2 The corresponding section under the Federal Mine Safety and Health Act of 1977, P.L. 95-164, 91 Stat. 1290, is section 110(a).

~FOOTNOTE_THREE
3 At page 55 of the transcript, Inspector Biesinger states: "Let me make a correction there. I believe it was on April 20 that we removed the shuttle car and made the first examination of the cab and control levers." At page 134 of the transcript, he states: "[W]e found it stuck in the forward position upon examining it on the day of the accident." At page 175 of the transcript, Inspector Koba states: "When he did find the shuttle car immediately after the accident, the tram lever was jammed in the forward position which would make it tram towards the tailpiece." The only definite conclusion I can make from this testimony is that at some time between April 16, the day of the accident, and April 20, the inspectors found the tram lever jammed in the forward position, although according to Inspector Biesinger, that tram lever was merely in a full throttle position because he was of the opinion that the forward and reverse tram switch was in another part of the cab.

~FOOTNOTE_FOUR
4 Andrew Orlovsky may have also been aware of it (Tr. 36),

but he was not called as a witness.

~FOOTNOTE_FIVE
5 See my decision in MESA v. Hobbs Brothers Coal Company, Inc., NORT 74-815-P, p. 6 (March 31, 1975); also see 30 CFR 75.1802.