CCASE:
SOL (MSHA) V. FREEPORT KAOLIN
DDATE:
19800130
TTEXT:

Federal Mine Safety and Health Review Commission
Office of Administrative Law Judges

SECRETARY OF LABOR, MINE SAFETY AND HEALTH ADMINISTRATION (MSHA),	PETITIONER	Civil Penalty Proceedings Docket No. BARB 79-219-PM A/O No. 09-00231-05001
v.		Docket No. BARB 79-280-PM A/O No. 09-00231-05003
FREEPORT KAOLIN COMPANY,	RESPONDENT	Docket No. BARB 79-281-PM A/O No. 09-00231-05004
		Docket No. BARB 79-282-PM A/O No. 09-00231-05002
		Griffin Mill

DECISION

Appearances: Thomas P. Brown IV, Esq., W. Thomas Truett, Esq., Office of the Solicitor, U.S. Department of Labor, for Petitioner Gene B. Strouss, Personnel Manager, Freeport Kaolin Company, Gordon, Georgia; and Alexander E. Wilson III, Esq., and Thomas J. Hughes, Jr., Esq., Jones, Bird & Howell, Atlanta, Georgia, for Respondent

Before: Judge Cook

I. Procedural Background

The Mine Safety and Health Administration (MSHA) filed petitions for assessment of civil penalty against Freeport Kaolin Company (Freeport) in the above-captioned cases pursuant to section 110(a) of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. 820(a) (1978) (1977) Mine Act). The petition in Docket No. BARB 79-219-PM was filed on January 17, 1979. The petitions in the remaining cases were filed on February 9, 1979. Freeport filed its answer in Docket No. BARB 79-219-PM on February 21, 1979, and filed answers in the remaining cases on March 12, 1979.

An order was issued on June 8, 1979, consolidating the above-captioned cases for hearing and decision. Pursuant to notice of hearing issued on June 5, 1979, a hearing on the merits was conducted on June 21 and June 22, 1979, in Macon, Georgia. Representatives of both parties were present and participated. During the course of the hearing, the representatives of the parties informed the undersigned Administrative Law Judge that a settlement

had been reached as relates to three of the alleged violations in Docket No. BARB 79-281-PM and as relates to five of the alleged violations in Docket No. BARB 79-282-PM. The motion to approve settlement pertaining to those eight alleged violations was filed on October 22, 1979. A decision and order approving the proposed settlements is included herein.

A schedule for the submission of posthearing brief was agreed upon at the conclusion of the hearing. The original briefs were to be filed simultaneously by both parties on August 22, 1979, with reply briefs due on September 6, 1979. On August 21, 1979, counsel for the Respondent requested a 30-day extension of time from August 22, 1979, for the filing of its brief, which request was granted by an order dated August 22, 1979. Under the revised schedule, both parties were accorded until September 21, 1979, to file their briefs, with reply briefs due on October 5, 1979. MSHA and Freeport filed their posthearing briefs on September 24, 1979, and September 25, 1979, respectively. No reply briefs were filed. The final filing of information necessary to consider approval of settlement in Docket Nos. BARB 79-281-PM and BARB 79-282-PM occurred on December 27, 1979.

II. Violations Charged

A. Docket No. BARB 79-219-PM

Citation No.	Date	30 CFR Standard
96161	July 20, 1978	55.12-16

B. Docket No. BARB 79-280-PM

Citation No.	Date	30 CFR Standard
96162	July 20, 1978	55.14-26
96173	July 25, 1978	55.14-1
96174	July 25, 1978	55.12-30
96179	July 26, 1978	55.12-34
96181	July 26, 1978	55.14-6
96184	July 26, 1978	55.12-30(FOOTNOTE 1)

C. Docket No. BARB 79-281-PM

Citation No.	Date	30 CFR Standard
96191	July 26, 1978	55.14-1
96194	July 26, 1978	55.12-30*
96200	July 26, 1978	55.14-8(b)*
97202	July 27, 1978	55.12-34*
97205	July 27, 1978	55.4-18

D. Docket No. BARB 79-282-PM

Citation No.	Date	30 CFR Standard
96145	July 18, 1978	55.11-2*
96149	July 18, 1978	55.14-1*
96398	July 18, 1978	55.20-3*
96399	July 18, 1978	55.20-3
96156	July 19, 1978	55.14-1*
96158	July 19, 1978	55.14-1*
96159	July 20, 1978	55.17-1
96160	July 20, 1978	55.17-1

[NOTE: Citations accompanied by an asterisk are encompassed in the October 22, 1979, motion to approve settlement.]

III. Evidence Contained in the Record

A. Stipulations

At the commencement of the hearing, the parties entered into stipulations which are set forth in the findings of fact, infra.

B. Witnesses

MSHA called as its witnesses MSHA inspector Spencer Lindbeck; MSHA supervisory inspector Reino Mattson; and Bruce Dial, an MSHA employee who accompanied Inspector Lindbeck on his July 1978, inspection of Freeport as a trainee.

Freeport called as its witnesses Ronnie D. Amerson, a mechanic's helper for Freeport at the time of the hearing, and who had been the Nos. 8 and 9 dryer operator on July 20, 1978; Paul H. Bacon, vice president and general manager of Freeport at the time of the hearing, and manager of production and shipping in July 1978; William Wharton, Freeport's supervisor of safety and health; Ray Crumbley, Freeport's manager of production and shipping at the time of the hearing, and production superintendent of section No. 1 in July 1978; L. E. Scandlyn, Freeport's maintenance superintendent; and James V. Turner, Jr., the president of Welding Supply and Service Company, Inc.

C. Exhibits

1. MSHA introduced the following exhibits into evidence:

M-1 is a computer printout prepared by the Office of Assessments listing the history of previous violations for which Freeport had paid assessments beginning July 27, 1976, and ending July 27, 1978.

M-2 is a computer printout prepared by the Office of Assessments listing the history of previous violations for which Freeport had paid assessments beginning July 20, 1976, and ending July 20, 1978.(FOOTNOTE 2)

M-3, page 1, is a copy of Citation No. 96161, July 20, 1978, 30 CFR 55.12-16.

M-3, page 2, is a copy of the inspector's statement pertaining to Citation No. 96161.

M-4, page 1, is a copy of Citation No. 96173, July 25, 1978, 30 CFR 55.14-1.

M-4, page 2, is a copy of the termination of Citation No. 96173.

M-4, page 3, is a copy of the inspector's statement pertaining to Citation No. 96173.

M-5, page 1, is a copy of Citation No. 96162, July 20, 1978, 30 CFR 55.14-26.

M-5, page 2, is a copy of the termination of Citation No. 96162.

M-5, page 3, is a copy of a modification pertaining to Citation No. 96162.

M-5, page 4, is a copy of the inspector's statement pertaining to Citation No. 96162.

M-5, page 5, is a copy of a modification of M-5, page 3.

M-6, page 1, is a copy of Citation No. 96174, July 25, 1978, 30 CFR 55.12-30.

M-6, page 2, is a copy of the termination of Citation No. 96174.

M-6, page 3, is a copy of the inspector's statement pertaining to Citation No. 96174.

M-7, page 1, is a copy of Citation No. 96179, July 26, 1978, 30 CFR 55.12-34.

M-7, page 2, is a copy of the termination of Citation No. 96179.

M-7, page 3, is a copy of the inspector's statement pertaining to Citation No. 96179.

M-8, page 1, is a copy of Citation No. 96181, July 26, 1978, 30 CFR 55.14-1.

M-8, page 2, is a copy of the termination of Citation No. 96181.

M-8, page 3, is a copy of the inspector's statement pertaining to Citation No. 96181.

M-9, page 1, is a copy of Citation No. 96184, July 26, 1978, 30 CFR 55.12-30.

M-9, page 2, is a copy of the termination of Citation No. 96184.

M-9, page 3, is a copy of the inspector's statement pertaining to Citation No. 96184.

M-10, page 1, is a copy of Citation No. 96191, July 26, 1978, 30 CFR 55.14-1.

M-10, page 2, is a copy of the termination of Citation No. 96191.

M-10, page 3, is a copy of the inspector's statement pertaining to Citation No. 96191.

M-11, page 1, is a copy of Citation No. 97205, July 27, 1978, 30 CFR 55.4-18.

M-11, page 2, is a copy of the termination of Citation No. 97205.

M-11, page 3, is a copy of the inspector's statement pertaining to Citation No. 97205.

M-12, page 1, is a copy of Citation No. 96399, July 18, 1978, 30 CFR 55.20-3.

M-12, page 2, is a copy of the termination of Citation No. 96399.

M-12, page 3, is a copy of a modification of M-12, page 2.

M-12, page 4, is a modification of M-12, page 3.

M-12, page 5, is a copy of the inspector's statement pertaining to Citation No. 96399.

M-13, page 1, is a copy of Citation No. 96159, July 20, 1978, 30 CFR 55.17-1.

M-13, page 2, is a copy of the termination of Citation

No. 96159.

M-13, page 3, is a copy of the inspector's statement pertaining to Citation No. 96159.

M-14, page 1, is a copy of Citation No. 96160, July 20, 1978, 30 CFR 55.17-1.

M-14, page 2, is a copy of the termination of Citation No. 96160.

M-14, page 3, is a copy of the inspector's statement pertaining to Citation No. 96160.

2. Freeport introduced the following exhibits into evidence:

O-1 is a drawing of a drum dryer.

O-2 is a letter concerning lock-out procedures established for Freeport's production and shipping department.

O-3 is a photograph.

O-4 is a photograph.

O-5 is an engineering drawing.

O-6 is a photograph.

O-7 is a photograph.

O-8 is a photograph.

O-9 is a booklet entitled "Welding, Cutting & Heating Guide."

O-10 is a gauge.

O-11 is a photograph.

O-12 is a photograph.

O-13 is a photograph.

3. X-1 is a drawing.

IV. Issues

Two basic issues are involved in the assessment of a civil penalty: (1) did a violation of the Act occur, and (2) what amount should be assessed as a penalty if a violation is found to have occurred? In determining the amount of civil penalty that should be assessed for a violation, the law requires that six factors be considered: (1) history of previous violations; (2) appropriateness of the penalty to the size of the operator's

business; (3) whether the operator was negligent; (4) effect of the penalty on the operator's ability to continue in business; (5) gravity of the violation; and (6) the operator's good faith in attempting rapid abatement of the violation.

V. Opinion and Findings of Fact

A. Stipulations.

1. Between July 17, 1978, and July 27, 1978, the Respondent, Freeport Kaolin Company, was the operator of a kaolin mine in the State of Georgia known as the Griffin Mine, and with accompanying mills known as the Griffin Mill and the Savannah Mill. In addition, Freeport operates a research lab at the same location (Tr. 4).

2. Between July 17, 1978, and July 27, 1978, Freeport was subject to the provisions of the Federal Mine Safety and Health Act of 1977 with respect to said operations (Tr. 4).

3. Freeport is a large operator. During 1978, the size of said operation was rated at 909,699 man-hours (Tr. 4).

4. There is no evidence of a history of prior violations (Tr. 5).

5. Any penalty that may be assessed may not affect the Respondent's ability to continue in business (Tr. 6).

B. Opinion and Findings of Fact

Between July 18, 1978, and July 27, 1978, MSHA inspector Spencer Lindbeck conducted an inspection of the Freeport Kaolin Company (Tr. 9-10). The subject citations were issued during the course of the inspection (Exhs. M-3, p. 1; M-4, p. 1; M-5, p. 1; M-6, p. 1; M-7, p. 1; M-8, p. 1; M-9, p. 1; M-10, p. 1; M-11, p. 1; M-12, p. 1; M-13, p. 1; M-14, p. 1). The various citations are addressed individually, herein.

I. Docket No. BARB 79-219-PM

Citation No. 96161, July 20, 1978, 30 CFR 55.12-16

Inspector Lindbeck issued Citation No. 96161 on July 20, 1978, citing Freeport for a violation of the mandatory safety standard codified at 30 CFR 55.12-16, when he observed Mr. Ronnie D. Amerson, an employee of Freeport, cleaning the screw conveyor on the No. 8 drum dryer without having the controls locked out (Exh. M-3, p. 1; Tr. 11, 19). The inspector recorded in the body of the citation that Mr. Amerson had the door on the screw conveyor open with his arm inside cleaning clay from the screw (Exh. M-3, p. 1).

The machine in question was a double drum Buffalo Vac atmospheric drum dryer employed to process kaolin by a technique known as thermal evaporation

(Tr. 12-13, 42). Thermal evaporation was accomplished through the use of two rotating cast iron drums, each approximately 3-1/2 feet in diameter and approximately 10 feet in length, heated by steam to a temperature of approximately 300 degrees Fahrenheit (Tr. 42, 45). The sequential steps employed in processing kaolin with the drum dryers is set forth as follows: Clay slurry, or slip, consisting of approximately 55 to 60 percent solid material, is introduced into a pan located beneath the two rotating drums (Tr. 42). Two splash shafts throw clay slurry up onto the underside of the drums (Tr. 21, 42). The heated drums rotate, removing the moisture from the mixture, and eventually reach a point at which a doctor blade, or drum blade, removes the dried product from the drums (Tr. 42). The dry product falls into a trough where the screw conveyor mentioned in the citation is located (Exh. O-1; Tr. 21-22, 42). The door mentioned in the citation was a hinged door, described as a drop-out chute, covering a 12-inch by 16-inch opening in the trough (Tr. 72, 76; Exhs. O-1, O-3, O-4).

Mr. Amerson testified that he had changed the blades on the drum dryer approximately 30 minutes before Inspector Lindbeck arrived (Tr. 28-29), but admitted that he had not locked out the machine while changing the blades (Tr. 30). The machine was not locked out when the inspector arrived and observed Mr. Amerson working on the drum dryer, although the magnetic switch, located approximately 25 feet from where Mr. Amerson was working, was off (Tr. 11, 18, 29, 34, 76-77). The evidence clearly establishes that Mr. Amerson had his hand inside the screw conveyor (Tr. 11, 13, 17, 92), and Freeport's own vice president and general manager testified that under the company's lock-out procedure (Exh. O-2) the machine should have been locked out if a worker had to place his hand inside the screw conveyor (Tr. 69).

Freeport advances two theories contending that 30 CFR 55.12-16 is inapplicable to the facts presented. In its answer to the petition for assessment of civil penalty, Freeport contends that the regulation deals with working on "electrical equipment." Freeport characterizes the equipment involved in the instant proceeding as "mechanical equipment," and not "electrical equipment." Accordingly, Freeport argues, the machine operator was not performing work on any kind of electrical equipment within the meaning of the cited regulation. In its proposed findings of fact and conclusions of law, Freeport argues that 30 CFR 55.14-29 is the regulation applicable to the facts presented. According to Freeport, 30 CFR 55.14-29 permits the machinery to be in motion when such motion is necessary to make adjustments during repair and maintenance. Freeport argues that the evidence convincingly demonstrated that machinery motion was absolutely necessary during maintenance and adjustment of the drum dryer (Respondent's Proposed Findings of Fact and Conclusions of Law, p. 4).

30 CFR 55.12-16, the provision in the Code of Federal Regulations cited by the inspector, provides:

Mandatory. Electrically powered equipment shall be

deenergized before mechanical work is done on such equipment. Power switches shall be locked out or other measures taken

> which shall prevent the equipment from being energized without the knowledge of the individuals working on it. Suitable warning notices shall be posted at the power switch and signed by the individuals who are to do the work. Such locks or preventive devices shall be removed only by the persons who installed them or by authorized personnel.

30 CFR 55.14-29, the regulation upon which Freeport relies, provides: "Mandatory. Repairs or maintenance shall not be performed on machinery until the power is off and the machinery is blocked against motion, except where machinery motion is necessary to make adjustments."

I am unable to agree with either theory advanced by Freeport. The purported distinction between "electrical equipment" and "mechanical equipment," as set forth in Freeport's answer to the petition for assessment of civil penalty, does not have a bearing on the issue of whether the cited condition constitutes a violation of 30 CFR 55.12-16. The regulation, insofar as it applies to the facts presented in the instant case, requires the use of lock-out devices or other measures to prevent electrically-powered equipment from being energized without the knowledge of the individuals performing mechanical work on such equipment. The reference is to "electrically-powered equipment" and to "mechanical" work done on it, a reference that fails to support the "electrical/mechanical" distinction advanced by Freeport. The evidence in the record, and the inferences drawn therefrom, establishes that the No. 8 drum dryer was electrically-powered equipment within the meaning of the cited regulation (Tr. 11-12, 13-14, 26, 29-30, 34).

Freeport's reliance on 30 CFR 55.14-29 is misplaced.(FOOTNOTE 3) The testimony germane to this issue reveals that the drum dryer had to be in operation in order to adjust the blade subsequent to the blade's replacement (Tr. 23-24, 27, 43-45, 56), and that during this operation both the drums and the screw conveyors are in motion (Tr. 42-43). Although the inspector indicated to Mr. Amerson that the machine did not have to be locked out while adjusting the blade (Tr. 29-30, 37), the evidence in the record reveals that a lock-out procedure should have been observed at other stages of the blade-changing operation. According to Mr. Crumbley, the Respondent's manager of

production and shipping, the machine should have been locked out while the machine operator was changing the blade (Tr. 83), a safety precaution which Mr. Amerson had failed to observe (Tr. 30).

Mr. Amerson and Mr. Bacon testified that rust develops on the drums during the blade-changing procedure, rust that would contaminate the product if permitted to reach the product bin (Tr. 22, 45). Since the clay produced while adjusting the blade contains contaminants, it is necessary that the door on the screw conveyor dropout chute be open while the screw conveyor is running in order to prevent the contaminated material from reaching the product bin (Tr. 22-23, 45). The testimony of Mr. Bacon indicates that the door is somewhat larger than the dropout chute opening. Accordingly, a buildup of clay on the door will prevent obtaining a tight fit when the door is closed (Tr. 45).

Mr. Amerson was not adjusting the blade when the inspector arrived at the No. 8 drum dryer. He was waiting for feed, and the blade adjustment was not completed (Tr. 30). Neither the drum nor the screw conveyor was running at the time (Tr. 30, 32-33, 76). Mr. Amerson testified that he was in the process of cleaning the door on the screw conveyor when the inspector arrived (Tr. 25, 32-33; Exhs. O-1, O-3). He indicated that the next step in the operation would have been to turn on the machine, finish adjusting the blade, and obtain a sample of the material inside the screw conveyor in order to check the moisture (Tr. 34-35). Mr. Amerson indicated that it was not necessary to place his hand inside the screw conveyor since the sample material would simply fall through the opening (Tr. 35-36). The next sequential step would have been to clean and close the door (Tr. 36).

Under the procedure instituted subsequent to the issuance of the citation, the cleaning of the door occurred with the machine locked out (Tr. 38-39). According to Mr. Amerson, this procedure did not produce a satisfactory product (Tr. 39), a statement confirmed by Mr. Bacon's assertion that the screw conveyor must be in operation in order to clean the flap and maintain a good product (Tr. 58).

Although it may be true that machine motion was necessary during certain stages of the blade adjustment process, the evidence establishes that machine motion was not required at the point in time when the inspector observed the violation. As noted above, Mr. Amerson was cleaning the flap and the machine was not in motion. Mr. Bacon confirmed that machine motion was not necessary for the performance of these activities (Tr. 64-65). At one point in his testimony, Mr. Bacon indicated that shutting down the machine in order to close the dropout chute door would permit the heated drums to expand sufficiently to ride against the blade holders (Tr. 57-58). However, he indicated that this problem would not occur with neither the drum nor the conveyor turning and no product being processed (Tr. 61).

Assuming for purposes of argument that 30 CFR 55.14-29

applies to the facts presented, the above-noted considerations reveal that the machine should have been locked out both while changing the blade and while the

machine operator was engaged in the door-cleaning activities observed by the inspector. Machine motion was not necessary for the performance of these steps.

Accordingly, I conclude that a violation of 30 CFR 55.12-16 has been established by a preponderance of the evidence in that the No. 8 drum dryer was not locked out while the operator was performing mechanical work on the machine.

Negligence of the Operator

Exhibit O-1, dated May 31, 1977, mandates a lock-out procedure for the No. 8 drum dryer. The existence of this document establishes not only that Freeport was aware of the importance of locking out electrically-operated equipment prior to performing work on the equipment, but also that Freeport was aware of this for more than 1 year prior to the issuance of the citation.

The evidence in the record indicates that the company's lock-out procedure had not been effectively communicated to the employees. Inspector Lindbeck testified that when the violation was observed, he querried Mr. Amerson as to the lock-out procedure. Not only did Mr. Amerson have no idea of what the lock-out procedures were, but Mr. Scandlyn, the maintenance superintendent, and Mr. Wharton, the supervisor of safety and health, had to show Mr. Amerson how to use the lock-out device after one had been obtained (Tr. 12). The inspector's testimony was confirmed by Mr. Amerson, who testified that he was not told that he was required to lock out the machine while changing the blades until the day the citation was issued (Tr. 30-31). In fact, Mr. Crumbley opined that it was unnecessary to use a lock-out and that Mr. Amerson was following the normal procedure for the piece of equipment involved (Tr. 77). Mr. Bacon testified that the failure to lock out the machine was a common practice, stating that no danger was involved since the workman would be accustomed to working near moving parts (Tr. 62-63).

Although Mr. Bacon stated that the lock-out procedure was posted on the bulletin boards and was covered with the section foremen and the section superintendents (Tr. 46), he could not state affirmatively that each employee received a copy (Tr. 63). He testified that the foremen were supposed to distribute them, but noted that the company did not have them signed and that no meeting was held (Tr. 63). Although Mr. Amerson had seen a copy of the letter, he testified that he was left to interpret it on his own (Tr. 104-105).

In light of these considerations, I conclude that Freeport demonstrated gross negligence.

Gravity of the Violation

As noted previously, Mr. Amerson's hand was inside the screw conveyor (Tr. 11, 13, 17, 92). Although the screw conveyor was not in operation at the time (Tr. 33, 76), the evidence

establishes that Mr. Amerson was exposed

to a danger of serious injury or death. Inspector Lindbeck testified that a man could lose his life or an arm in the screw conveyor in the event the machine was started inadvertently (Tr. 13-15). Mr. Bacon conceded that an individual would sustain an injury to the portion of his body inside the screw conveyor if the machine was turned on (Tr. 49). The evidence clearly showed that the screw conveyor would be in motion if the machine started. Even under Mr. Crumbley's definition of "dangerous," Mr. Amerson was in a hazardous situation. According to Mr. Crumbley, "dangerous" means "near moving parts" (Tr. 81). In such cases, the machine should be locked out (Tr. 81).

Accordingly, I conclude that the violation was extremely serious.

Good Faith in Attempting Rapid Abatement

Abatement was achieved by providing a lock-out device, and abatement was completed in approximately 5 minutes (Exh. M-3, p. 1; Tr. 14-15). Accordingly, In conclude that Freeport demonstrated good faith in attempting rapid abatement.

II. Docket No. BARB 79-280-PM

Citation No. 96162, July 20, 1978, 30 CFR 55.14-26

Inspector Lindbeck issued Citation No. 96162 citing the following condition as a violation of 30 CFR 55.14-26: "The glass coverings are broken on the oxygen and acetylene guages [sic] on the service truck at the selas building" (Exh. M-5, p. 1; Tr. 113).

The evidence reveals that two gauges were present on the oxygen cylinder and two gauges were present on the acetylene cylinder. One gauge on each cylinder was a high pressure gauge, monitoring the pressure inside the cylinder (Tr. 288). These high pressure gauges indicate the contents of the cylinders (Tr. 305). The remaining gauge on each cylinder was a low pressure gauge used to indicate the pressure on the hose and torch (Tr. 305).

At the time of the inspection, the glass was broken out and missing from the high and low pressure gauges on both the oxygen and acetylene cylinders (Tr. 301). Inspector Lindbeck testified that the indicator needle was bent on one of the gauges on the oxygen cylinder. He believed that the bent needle was on the low pressure gauge (Tr. 301). He did not recall the condition of the needles on the acetylene tank gauges (Tr. 301-302).

The regulation in question, 30 CFR 55.14-26, is a mandatory safety standard which provides: "Unsafe equipment or machinery shall be removed from service immediately." The question presented is whether MSHA has established a violation of the regulation by a preponderance of the evidence. 29 CFR 2700.48 (1978) (interim procedural rules). For the reasons set forth below, I answer this question in the negative.

In order to establish a violation of 30 CFR 55.14-26, MSHA must affirmatively establish that the welding equipment was unsafe and that it had not been removed from service immediately.

The threshold question is whether MSHA has established that the welding equipment was unsafe. In this regard, it is important to bear in mind that the low pressure gauges and the high pressure gauges perform different functions, as set forth above, and that each type of gauge presents separate considerations from the standpoint of safety.

Inspector Lindbeck, at one point in his testimony, indicated that the absence of the glass coverings and the presence of the bent indicator needle rendered the gauges defective in that their absence interfered with the operator's ability to obtain accurate pressure readings (Tr. 118-119, 128-130, 132-133). The testimony of Inspector Lindbeck further reveals his opinion that the inability to obtain accurate pressure readings renders the welding equipment unsafe by presenting an explosion hazard (Tr. 137). According to Inspector Lindbeck, if the welding equipment operator is obtaining a different pressure than the one indicated by the gauges, an explosion can occur when the welder lights the cutting torch (Tr. 138).

Both Inspector Lindbeck and Inspector Mattson indicated that safe welding procedure envisions the welder adjusting this oxygen/acetylene mixture with reference to the pressure gauges, a procedure that requires him to stand near the regulator (Tr. 139, 262-263, 284-290). The photograph on page 22 of Exhibit 0-9 reveals that the regulator is attached to the tank. According to Mr. Scandlyn, the regulator, not the gauge, is what controls the flow of gas from the tank (Tr. 197). According to Inspector Mattson, a welder adjusts his pressure for both oxygen and acetylene by monitoring the gauges while turning the valve controls on the respective regulators (Tr. 284-290).

Inspector Mattson associated two safety hazards with the defective gauges. First, it was his position that too much pressure in the lines running from the oxygen tank and the acetylene tank to the torch can cause a hose to rupture since the hoses are designed to withstand pressures less than the maximum pressure that can pass through the regulator (Tr. 287-290). Second, improperly functioning gauges induce welders to take shortcuts having an adverse effect on safety. According to Inspector Mattson, a welder should "back up" the regulator by turning it counterclockwise upon completion of his welding to prevent a sudden burst of pressure from rupturing the diaphragm when the tank valve is subsequently opened (Tr. 262-263, 270-271, 290-295). The absence of properly-functioning gauges induces workers not to "back up" the regulators. The inspector stated that rupturing the diaphragm can result in an explosion occurring at the gauge (Tr. 290-291).

Mr. James V. Turner, an individual with 26 years of experience in welding (Tr. 303) and the president of the Welding Supply and Service Company, Inc., the supplier of Freeport's

welding equipment, testified on behalf of Freeport. His description of the equipment and its functioning is germane to the issue of safety raised in the instant proceeding. According to

Mr. Turner, the regulator has a safety device that opens and vents the gases should the pressure exceed permissible levels inside the regulator (Tr. 309, 339). This venting system exists to prevent explosions (Tr. 340). The type of regulators used by Freeport are 175 pounds. The hoses are 300 psi test hoses. Accordingly, the regulator will not build up sufficient pressure to burst the hose (Tr. 309, 311). The safety valve is designed to activate if a sudden burst of pressure enters the regulator (Tr. 309-310). According to Mr. Turner, the regulator will not pass enough pressure to ignite the acetylene because 175 pounds is the maximum pressure that the adjusting screw will allow to enter the oxygen hose (Tr. 326). It is recommended that acetylene not be used at a pressure exceeding 15 pounds (Tr. 326). A gauge is not needed to prevent the equipment operator from exceeding 15 pounds because the spring inside the acetylene regulator prevents exceeding this pressure (Tr. 326-327). No evidence was presented establishing that the spring was defective.

Mr. Turner conceded that if the diaphgram ruptured, the 2,200 pounds of pressure in the tank could escape through the regulator, notwithstanding the fact that the regulator is rated at 175 pounds. However, he indicated that this gas would escape through the vents, not the hoses, and further indicated that an explosion hazard was not present (Tr. 340-341).

I am unable to conclude that a preponderance of the evidence establishes that the gauges in question were unsafe. The testimony addressing the possibility of rupturing one of the hoses clearly refers to the low pressure gauge, since that type of gauge monitored the pressure in the hoses.

As relates to rupturing the diaphgram, the crucial consideration is the failure of a welder to "back up" the regulator upon completion of his welding operations, not the proper functioning of the pressure gauge per se. I am not persuaded that an accurate reading from this gauge is necessary from a safety standpoint. As noted by Inspector Mattson, the gas released from the pressure tanks into the regulator will "shoot fast" irrespective of how slowly the tank valve is opened (Tr. 294-295).

MSHA's witnesses sought to establish that a properly functioning low pressure gauge is necessary to avoid rupturing a hose at a given point in the welding operation. The Government has failed to show that the absence of the glass on both guages and the bent needle on the oxygen tank gauge rendered the low pressure gauges unsafe per se. The most persuasive testimony by the Respondent's well qualified expert totally rebutted MSHA's claim that the condition was unsafe.

His experience and knowledge was much greater than that of MSHA's witnesses. Much greater weight must be accorded his opinions as to the safety issue.

In light of these consideration, it cannot be found that a

violation of 30 CFR 55.14-26 has been established by a preponderance of the evidence.

Citation No. 96173, July 25, 1978, 30 CFR 55.14-1

This citation was issued because covers were not provided on the screw conveyor at the spray dryer bagging building (Exh. M-4, p. 1; Tr. 140). The missing cover was approximately 6 feet long and 14 inches in width (Tr. 141), and was lying on the floor beside the screw conveyor (Tr. 143). The screw conveyor was open at the time (Tr. 141). Although none of the witnesses affirmatively stated that the screw conveyor was in operation, the fact that the inspection party heard an air leak emanating from the back of the machine renders it more probable than not that it was in operation (Tr. 143).

Mr. Scandlyn agreed that the cover was, in fact, off the conveyor (Tr. 206). His testimony further reveals that the "floor" mentioned by the inspector was a maintenance walkway or maintenance platform 12 to 15 feet above the ground (Tr. 202-203; Exh. 0-5). Access to the platform was provided by a ladder located inside the building and by a stairway located outside the building (Tr. 211). Although it was not a normal operating area in the sense that an employee would not go there to perform a routine function such as bagging clay (Tr. 202), employees would be in the area in the event of a breakdown or to perform some other maintenance function (Tr. 202). A man's arm could be tangled up in the open screw conveyor (Tr. 142).

The mandatory safety standard embodied in 30 CFR 55.14-1 states that: "Gears; sprockets; chains; %y(3)5C and similar exposed moving machine parts which may be contacted by persons, and which may cause injury to persons shall be guarded."

The location of the screw conveyor, coupled with the fact that employees would be in the area to perform maintenance work on occasion, indicates that the exposed moving screw conveyor should have been covered. Accordingly, I conclude that a violation of 30 CFR 55.14-1 has been established by a preponderance of the evidence.

Negligence of the Operator

Mr. Scandlyn believed that a malfunction in the vent indicator, or bin indicator, in the bagging bin caused the clay to pile up in the screw conveyor and force the cover off (Tr. 203-204, 208). A bin indicator is a device used to measure the flow into a particular bin, cutting off a line when the bin is full (Tr. 206).

Mr. Scandlyn testified that he remembered "a report of a problem with the bin indicator at the beginning of the shift," i.e., at approximately 8 a.m. (Tr. 206-207). The citation in question was issued at approximately 10 a.m. (Tr. 203; Exh. M-4, p. 1).

According to Mr. Scandlyn, once it has been discovered that the bin indicator is not working, the normal procedure is to request the electrical foreman to check it and to discover and

correct the problem (Tr. 207). It is routine to check the entire line to determine whether the malfunction

of the bin indicator could have caused flow problems down the line, an inspection encompassing the subject screw conveyor (Tr. 207). However, Mr. Scandlyn could not state that it had been checked (Tr. 207-208).

Based on the foregoing, I conclude that if this routine practice had been followed, it is more probable than not that Freeport knew or should have known of the condition. The 2-hour time period between 8 and 10 a.m. afforded sufficient time to discover the problem.

Accordingly, I conclude that Freeport demonstrated ordinary negligence.

Gravity of the Violation

Inspector Lindbeck testified that one employee was in the area when the violation was observed (Tr. 141-142). Mr. Scandlyn indicated uncertainty as to the identity of this employee. He believed that a foreman had been summoned to the area, and thought that the foreman had been the employee (Tr. 204). A maintenance man would pass by the area. Accordingly, I conclude that one employee would be exposed to the hazard.

A man could have been injured by getting his arm tangled in the machinery or by getting his clothing caught in it (Tr. 142). Although the inspector testified that an occurrence could prove fatal (Tr. 142), I believe the statement contained in the inspector's statement (Exh. M-4, p. 3), which was made closer in time to the actual occurrence, to be more probative. It indicates that the contemplated injury could reasonably be expected to be permanently disabling, and that an occurrence was probable.

Accordingly, I conclude that the violation was serious.

Good Faith in Attempting Rapid Abatement

The violation was abated by Mr. Scandlyn. He picked up the cover lying on the floor and placed it on the screw conveyor (Tr. 142). Accordingly, I conclude that Freeport demonstrated good faith in attempting rapid abatement.

Citation No. 96174, July 25, 1978, 30 CFR 55.12-30

This citation was issued when the inspector observed that: "The conduit is broken loose at the damper valve at the No. 2 dryer" (Exh. M-6, p. 1). According to Mr. Scandlyn, the conduit is not a rigid pipe, but a spiral-wound rubber or plastic-coated conduit providing a flexible connection (Tr. 220). Inspector Lindbeck indicated that the conduit was composed of metal (Tr. 146). The break was caused by deterioration of the conduit (Tr. 220).

The inspector testified that he did not notice any break in the wiring's insulation (Tr. 150). Mr. Scandlyn testified that

the power conductor was

visible, but that it was still insulated (Tr. 220). The inspector was uncertain of the precise voltage, but testified that it was either 110 or 120 volts (Tr. 147). The power conductor was energized (Tr. 156).

According to the inspector, vibration could cause the insulation to rub against the conduit and wear through, thus posing an electrocution hazard (Tr. 147, 154-155).

The question presented is whether this condition constitutes a violation of 30 CFR 55.12-30, which provides: "Mandatory. When a potentially dangerous condition is found it shall be corrected before equipment or wiring is energized." (Emphasis added.) Although the condition was potentially dangerous, this fact, standing alone, is insufficient to establish a violation of the mandatory safety standard. I interpret the regulation as requiring MSHA to prove knowledge of the condition before a violation can be found to have occurred, as demonstrated by the regulation's use of the word "found." In essence, the regulation proscribes the knowing use of electrical equipment or wiring once a potentially dangerous condition is discovered. There is no indication in the record that Freeport had knowledge of this condition prior to the issuance of the citation.

Accordingly, I conclude that a violation has not been established by a preponderance of the evidence.

Citation No. 96179, July 26, 1978, 30 CFR 55.12-34

This citation was issued when Inspector Lindbeck observed that: "There are several lights along the upper walkway that are not provided with guards" (Exh. M-7, p. 1). The inspector did not recall the number of unguarded lights (Tr. 157). The walkway in question, located at the Savannah Plant (Exh. M-7, p. 1), was above the bin storage area (Tr. 157) and served as an accessway for maintenance personnel and operators (Tr. 222). The inspector did not recall the dimensions of the walkway in terms of width and height, but opined that the height was less than 6 feet in some places because he and Mr. Scandlyn "had to bend over to walk through it." Mr. Bacon testified that all of the lights are probably within striking distance of a person wearing a hardhat (Tr. 157; Exh. O-7; Tr. 227). The testimony of Inspector Lindbeck and Mr. Bacon establish the existence of a shock or burn hazard (Tr. 158, 229).

30 CFR 55.12-34, the cited mandatory safety standard, provides that: "Portable extension lights, and other lights that by their location present a shock or burn hazard, shall be guarded." It is clear that the bulbs in the walkway area were located in such a manner as to present a shock or burn hazard. They should have been guarded in order to comply with the regulation's requirements. The fact that the evidence failed to establish the precise number of unguarded bulbs does not prevent finding a violation. One unguarded bulb would have been sufficient for this purpose.

Accordingly, I conclude that a violation of 30 CFR 55.12-34 has been established by a preponderance of the evidence.

Negligence of the Operator

Mr. Bacon testified that company practice, in recent years, had been to provide guards for lights located in "normal walkways" (Tr. 224). The fact that Mr. Bacon did not deem the cited area a "normal walkway" (Tr. 223) is not controlling. He stated that it is used by maintenance personnel and operators of equipment (Tr. 222). The fact that the company practice of providing guards existed indicates that the company was aware of the need to provide guards in areas open to access by its employees. Accordingly, I conclude that Freeport demonstrated a high degree of ordinary negligence.

Gravity of the Violation

One employee was observed in the area, and he was wearing a hardhat (Tr. 158, 160). The inspector testified that an employee could sustain an electric shock causing a fall and could be exposed to an electrocution hazard as a result of breaking a bulb (Tr. 158). The fact that the walkway was less than 6 feet in some places would aggravate the hazard (Tr. 157). The area was dry (Tr. 161). Additionally, the testimony of Mr. Bacon indicates that a burn hazard was present and that employees carried metal parts for screw conveyors through the area (Tr. 229-230).

Although the inspector's testimony implies that an occurrence could prove fatal, the entry contained in the inspector's statement indicates that the contemplated injury could reasonably be expected to be lost workdays or restricted duty (Exh. M-7, p. 3). I am inclined to accord greater probative value to the entry in the inspector's statement since it was made at a point in time closer to the observation of the condition than was his testimony.

An occurrence was classified as "probable" (Tr. 158; Exh. M-7, p. 3).

Based on the foregoing, I conclude that the violation was moderately serious.

Good Faith in Attempting Rapid Abatement

The inspector's testimony implies that the violation was abated expeditiously (Tr. 159). Accordingly, I conclude that Freeport demonstrated good faith in attempting rapid abatement.

Citation No. 96181, July 26, 1978, 30 CFR 55.14-64

This citation was issued when Inspector Lindbeck observed a loose guard over the metal saw's drive belts (Exh. M-8, p. 1; Tr. 161). The saw

in question was located in the auto repair shop (Tr. 161-162). The best available evidence indicates that the piece of equipment in question was a continuous motorized hacksaw used for cutting steel pipes and steel bars (Exh. 0-8; Tr. 232, 235-236). Mr. Scandlyn's testimony confirms the presence of the loose guard (Tr. 249). Although the equipment was not in operation when the inspector observed the loose guard (Tr. 347), his testimony reveals that it is more probable than not that an employee was using the equipment immediately prior to the issuance of the citation (Tr. 162, 166, 352).

30 CFR 55.14-6, the applicable mandatory safety standard, provides that: "[e]xcept when testing the machinery, guards shall be securely in place while machinery is being operated." No evidence was presented by Freeport rebutting the inspector's testimony that the equipment was in operation immediately prior to the issuance of the citation, and no evidence was presented by Freeport indicating that the employee in question was merely testing the equipment.

Accordingly, in view of the foregoing, I conclude that a violation of 30 CFR 55.14-6 has been established by a preponderance of the evidence.

Negligence of the Operator

The maintenance supervisor was present in the shop when the inspector arrived on the scene (Tr. 162), but the inspector admitted that he did not know whether the supervisor knew of the condition (Tr. 166). The record contains no evidence indicating how long the condition had existed (see, e.g., Tr. 162).

The fact that a supervisory employee was present in the shop indicates that Freeport should have known of the violation. Freeport demonstrated ordinary negligence in connection with the violation.

Gravity of the Violation

The area was a normal work area (Tr. 163). The hazard posed by the violation was that the guard could make contact with the drive belts causing them to break and strike an employee (Exh. M-8, p. 3). The inspector classified the probability of occurrence as "slightly remote" (Tr. 163). One employee was exposed to the hazard (Exh. M-8, p. 3).

Accordingly, I conclude that moderate gravity was associated with the violation.

Good Faith in Attemtping Rapid Abatement

The condition was corrected immediately (Tr. 236). In fact, the condition was corrected while the inspector was present (Tr. 166). Accordingly, I conclude that Freeport demonstrated good faith in attempting rapid abatement.

III. Docket No. BARB 79-281-PM

Citation No. 96191, July 26, 1978, 30 CFR 55.14-1

This citation was issued when the inspector observed a guard missing from the end shaft on the No. 4 calciner (Tr. 358; Exh. M-10, p. 1). The testimony of Mr. Scandlyn reveals that the cited piece of equipment was located on a bin discharge drive located under a bin which supplies the feed for the No. 4 calciner. He testified that the drive shaft connection was approximately 3 inches in diameter. The variable speed drive shaft rotated at 10 to 20 revolutions per minute (Tr. 400). The unguarded portion of the shaft was approximately 3 to 4 inches in length (Tr. 400). A keyway was present on the end of the shaft. A keyway is a slot in the shaft for the placement of a key (Tr. 402). The inspector testified that the end of the shaft was burred, and that the shaft was in operation when he observed the condition (Tr. 362).

According to Mr. Scandlyn, maintenance employees could perform maintenance work near the shaft (Tr. 407-408). The testimony of both Inspector Lindbeck and Mr. Scandlyn establishes that the condition presented a possibility of injury to employees (Tr. 359, 361, 402-403).

30 CFR 55.14-1 provides: "Mandatory. Gears; sprockets; chains; drive, head, tail, and takeup pulleys; flywheels; couplings; shafts; sawblades; fan inlets; and similar exposed moving machine parts which may be contacted by persons, and which may cause injury to persons shall be guarded."

Based on the foregoing testimony of Inspector Lindbeck and Mr. Scandlyn, I conclude that a violation of 30 CFR 55.14-1 has been established by a preponderance of the evidence.

Negligence of the Operator

The inspector testified that the operator should have known of the condition because it was in a frequently-traveled area (Tr. 359). The inspector's assertion that supervisors travel in the area daily (Tr. 361) was never rebutted by Freeport's witnesses. However, there is no evidence in the record indicating how long the condition had existed. Without such evidence, it is impossible to determine that the condition had existed long enough for one of Freeport's supervisory personnel to have observed it.

Accordingly, I conclude that operator negligence has not been established by a preponderance of the evidence.

Gravity of the Violation

A cleanup or maintenance man working in the area could be near the exposed shaft (Tr. 361, 407-408). According to the inspector, burrs or a keyway on the end of the shaft could get a man's clothing entangled in the shaft (Tr. 359). As noted

previously in this decision, the shaft possessed both characteristics. I therefore conclude that an occurrence was probable.

Mr. Scandlyn described the potential harm as ranging from a torn pair of pants to a small scratch or cut, but not a deep laceration (Tr. 402-403). Based on the fact that the shaft rotated at a low rate of speed, I find his testimony on this point credible.

Based on the foregoing, I conclude that the violation was accompanied by moderate gravity.

Good Faith in Attempting Rapid Abatement

Mr. Scandlyn testified that the guard was replaced immediately (Tr. 402). Although the inspector believed that the condition was abated on July 27, 1978, the day after the issuance of the citation, he nevertheless testified that the operator attempted rapid compliance after notification of the condition (Tr. 360). Accordingly, I conclude that Freeport demonstrated good faith in attempting rapid compliance.

Citation No. 97205, July 27, 1978, 30 CFR 55.4-18

The citation alleges, in pertinent part, that oxygen was being stored in an area where grease, paint and oils were stored (Exh. M-11, p. 1). The testimony reveals that the "oxygen" in question consisted of a fully-charged oxygen cylinder on an oxyten-acetylene welding set located in part of the pilot plant (Tr. 363-364, 409).

According to Mr. Scandlyn, the pilot plant building was probably 60 feet in width, 100 to 150 feet in length and approximately 25 to 30 feet in height (Tr. 408). According to the inspector, the building was basically a large open room which he described as an operating area (Tr. 367).

Two areas screened off by wire mesh, and each measuring approximately 10 feet by approximately 15 to 20 feet, were located inside the building (Tr. 409). According to Mr. Scandlyn, the first wire cage area was a workshop area. He testified that it "has power tools, drill presses, I believe a band saw, and tools of various nature, a work table, a sorting iron, this type of thing, what we call a lazy susan for part storage approximately four feet in diameter with several rotating shelves on it" (Tr. 409). Mr. Scandlyn confirmed that an oxygen-acetylene tank set mounted on a hand truck was in the area on July 27, 1978 (Tr. 409). Mr. Scandlyn classified the area as a "normal work place," and would not classify the area as a storeroom (Tr. 410).

The inspector, however, classified the area as a storage area containing tools, paint, grease, oil, and solvent, in addition to the oxygen cylinder (Tr. 363). The inspector testified that at least a dozen cans of paint and oil were present (Tr. 363-364).

Mandatory safety standard 30 CFR 55.4-18 states that "[o]xygen cylinders shall not be stored in rooms or areas used or

designated for oil or grease storage." The question presented is whether the evidence establishes

"storage" within the meaning of the regulation. At the outset, it cannot be found that the paint observed by the inspector was "oil" within the meaning of the regulation. Such a finding would have to be based on probative evidence establishing the presence of oil-based paint in the subject area of the pilot plant building. The record contains no evidence establishing this fact. Accordingly, only the grease and oil observed by the inspector are germane to a resolution of the issues presented.

I am inclined to accept the inspector's characterization that the oxygen was at the time in question being "stored" with the oil and grease cans due to the dimensions of the wire mesh area, and the volume and types of materials observed there and the fact that it was locked. This conclusion is bolstered by inferences drawn from the testimony of Mr. Scandlyn, which indicate that the time the oxygen would be in the cage area between uses could be days; and therefore the area was used as a "short-term" storage area (Tr. 414-415).

Accordingly, I conclude that a violation of 30 CFR 55.4-18 has been established by a preponderance of the evidence.

Negligence of the Operator

Regular supervision was attached to this area of the plant and the condition was in plain view (Tr. 364). Inferences drawn from the testimony of Mr. Scandlyn (Tr. 411-412) indicate that it is more probable than not that the condition had existed for an appreciable period of time prior to July 27, 1978. However, considering the fact that the area was used periodically as a workshop, and the other surrounding circumstances, it cannot be found that Freeport demonstrated gross negligence.

Accordingly, I conclude that Freeport demonstrated ordinary negligence.

Gravity of the Violation

An occurrence was probable (Exh. M-11, p. 3; Tr. 364). The resulting injury could reasonably be expected to produce lost workdays or restricted duty (Exh. M-11, p. 3). The record contains no evidence relating to the number of employees exposed to the hazard.

Accordingly, I conclude that moderate gravity was associated with the violation.

Good Faith in Attempting Rapid Abatement

Abatement was accomplished by expeditiously moving the combustibles to another area (Tr. 365; Exh. M-11, p. 2). Accordingly, I conclude that Freeport demonstrated good faith in attempting rapid compliance.

IV. Docket No. BARB 79-282-PM

Citation No. 96399, July 18, 1978, 30 CFR 55.20-3

This citation was issued when Inspector Lindbeck observed "several holes in [the] walkway on top of storage tank I-T-17 that need to be covered" (Exh. M-12, p. 1). The subject walkway was constructed of expanded metal (Tr. 371). The cited holes were three or four in number (Tr. 372). Estimates as to the size of the holes varied. Inspector Lindbeck estimated that the holes were approximately 6 inches by 8 inches or 8 inches by 8 inches (Tr. 372), while Mr. Scandlyn's estimate was "4 to 6 inches %y(3)5C to about 6 to 8 inches" (Tr. 421, 426). However, it is significant to note that Mr. Scandlyn believed, as a general proposition, that holes over 4 inches "probably should be covered" (Tr. 422).

Mr. Scandlyn testified that the walkway in question was located above a holding tank (Tr. 419). The platform was reached by a spiral stairway (Tr. 424). The tank was approximately 32 feet in height and 37 feet in diameter and was used to hold a mixture consisting of clay and water (Tr. 419, 426). He further testified that an agitator gearbox and grind motor was located atop the tank which operated a large shaft extending toward the bottom of the tank. A rake arm on the shaft prevents mixed material from "settling out and becoming semi-solid in the bottom of the tank" (Tr. 419-420).

Mr. Scandlyn testified that the holes had been cut in the walkway around the "periphery of the base of the agitator gear box" to provide access to a support chain used to stabilize the agitator shaft (Tr. 420, 429). The testimony of Mr. Wharton indicates that the walkway was 3 to 4 feet wide (Tr. 430-431).

Mandatory safety standard 30 CFR 55.20-3 provides, in part, as follows: "Mandatory. At all mining operations: %y(3)5C (c) Every floor, working place, and passageway shall be kept free from protruding nails, splinters, holes, or loose boards, as practicable." It is undisputed that the holes existed in the subject walkway. Furthermore, the evidence establishes that it was practicable to keep the walkway free of holes. There is no indication that the holes performed any function essential to the daily operation of the agitator mechanism, outside of providing periodic access to the support chain. This conclusion is confirmed by the testimony of Mr. Scandlyn, wherein he expressed his belief that the employees had permitted the platform to remain in the condition observed by the inspector "because they knew they would be back there someday to do that same job over, and they would need that same access" (Tr. 424-425). Furthermore, the steps taken to abate the condition, infra, reinforce the view that it was practicable to keep the walkway free of holes.

Accordingly, it is found that a violation of 30 CFR 55.20-3 has been established by a preponderance of the evidence.

Negligence of the Operator

Two employees were observed performing maintenance functions on the walkway, but the inspector's testimony reveals that those employees were not engaged in alleviating the violation (Tr. 371-372, 374). The inspector did not know how long the holes had been present in the walkway (Tr. 373, 376). He testified, however, that Mr. Scandlyn and a foreman indicated that either a motor or its base had been replaced and that the resulting hole had not been covered (Tr. 379), a statement which differs radically from Mr. Scandlyn's previously-mentioned testimony wherein he indicated that the holes had been made to provide access to the agitator shaft stabilizing chain. Having been afforded the opportunity to assess the credibility of the witness, I conclude that Mr. Scandlyn's testimony accurately reflects the circumstances surrounding the cutting of the subject holes.

It can be inferred from Mr. Scandlyn's testimony that the condition not only existed for a long period of time but also would have been permitted to exist for a period of several months or several years into the future (Tr. 425). Furthermore, Mr. Scandlyn stated that holes greater than 4 inches should be covered and even acknowledged the presence of a tripping hazard (Tr. 422).

In view of these considerations, I conclude that Freeport demonstrated gross negligence.

Gravity of the Violation

Two maintenance employees were present on the walkway when the inspector arrived (Tr. 371). Additionally, an employee visited the area daily to check the tank level (Tr. 423-424).

The inspector indicated that a man's foot could enter one of the holes and he could either suffer a broken leg or stumble and fall into a storage tank (Tr. 373; Exh. M-12, p. 5). However, I conclude that the presence of the handrail around the outside of the walkway (Exhs. O-13, X-1) would render improbable falling into the storage tank. Considering the size of the holes, the dimensions of the walkway, and the extent of employee exposure, I conclude that a broken leg hazard existed. An occurrence was probable. An occurrence could reasonably be expected to result in lost workdays or restricted duty (Exh. M-12, p. 5).

Accordingly, I conclude that the violation was moderately serious.

Good Faith in Attempting Rapid Abatement

The condition was abated immediately by covering the holes with steel plates (Tr. 373). Accordingly, I conclude that Freeport demonstrated good faith in attempting rapid compliance.

Citation No. 96159, July 20, 1978, 30 CFR 55.17-1

On July 20, 1978, Inspector Lindbeck conducted a night inspection at Freeport's Griffin Mill facility (Exh. M-13, p. 1; Tr. 380). The subject citation was issued, citing Freeport for a violation of 30 CFR 55.17-1 as follows: "The lighting in the warehouse area does not illuminate all areas - 6 large overhead lights are not working" (Exh. M-13, p. 1).

The condition was observed in the warehouse storage area (Tr. 380). The building was approximately 100 feet in length and approximately 50 feet in width (Tr. 380). The lights were approximately 20 to 25 feet above the floor (Tr. 436). According to Mr. Scandlyn, they were basically 300-Watt incandescent lamps with reflectors (Tr. 436).

Six lights were unlit out of a total of approximately 20 lights (Tr. 380-381, 435-436). Four were in the vicinity of the inspection party and two were toward the other end of the building (Tr. 436). Approximately five or six employees were working in the area. At least one forklift was operating in the area (Tr. 380).

Mandatory safety standard 30 CFR 55.17-1 provides that: "[i]llumination sufficient to provide safe working conditions shall be provided in and on all surface structures, paths, walkways, stairways, switch panels, loading and dumping sites, and work areas." The question presented is whether a preponderance of the evidence establishes that the illumination in the cited area was inadequate to provide safe working conditions. The record clearly reflects that the inspector's opinion as to inadequate lighting was based solely on his visual observation (Tr. 385-386). The inspector testified that he cited the condition because he was unable to see all employees working in the work area, and indicated that he was unable to see individuals approximately 30 to 40 feet away (Tr. 388-389). He further testified that shadows in the area prevented forklift operators from seeing the men (Tr. 381). This testimony is contradicted by the tenor of Mr. Scandlyn's testimony wherein he indicated that he was fairly certain that he was able to see a good 50 feet and distinguish color (Tr. 433).

Freeport argues that the regulation in question "is unduly and unenforceably vague in that there are no objective criteria or parameters of illumination by which an operator can reasonably be expected to measure its levels of illumination for purposes of compliance" (Respondent's Proposed Findings of Fact, Conclusions of Law, p. 21; see also Respondent's Brief in Support of Proposed Findings of Fact and Conclusions of Law, p. 3). I am unable to agree with Freeport's contention. It may be desirable as a matter of policy to promulgate a regulation specifying with particularity the level of illumination necessary to provide safe working conditions. But simply because such action is desirable from a policy standpoint does not mean that the existing regulation is unenforceably vague as a matter of law. Whether a given level of illumination is sufficient to provide safe working

conditions presents a question of fact, and there is no indication in the record that such factual issue cannot be resolved by presentation of evidence of

some recognized scientific test with an objective standard as to adequate lighting in the work place. An objective standard is necessary to prevent enforcement actions initiated solely on the basis of an inspector's subjective evaluation. It should be pointed out that certain occasions will arise where the evidence will establish inadequate lighting even absent reference to an objective standard. But this will be limited to cases where reasonable minds cannot be expected to differ as to the adequacy of the lighting, such as cases involving a complete absence of lighting or cases where other evidence clearly establishes an inadequacy of illumination.

In the instant case MSHA has failed to present enough objective evidence to sustain its burden of proof as to the warehouse area in general. The inspector's testimony that he was unable to see individuals at a distance of approximately 30 to 40 feet was rebutted by Mr. Scandlyn's assertion that he could distinguish color at approximately 50 feet. In addition, the fact that approximately 14 lights with 300-Watt incandescent bulbs and reflectors were present and alight in and of itself implies adequate illumination.

However, MSHA has sustained its burden of proof as to one specific area of the warehouse. The inspector, at one point in his testimony, indicated that Mr. Bruce Dial, the MSHA trainee who accompanied the inspector, stepped onto the edge of a large hole in the floor due to the inadequate lighting (Tr. 389-392). Since it was established that the inspector could not see the hole and the circumstances almost lead to an accident, it is considered that this is the kind of evidence which clearly establishes inadequate illumination at that one location.

Accordingly, I concluded that a violation of 30 CFR 55.17-1 has been established by a preponderance of the evidence.

Negligence of the Operator

The fact that six lights were not operating in the warehouse and the lack of sufficient lighting near a refuse hole in the warehouse should have been known to the supervisors for the Respondent.

Accordingly, the Respondent has demonstrated ordinary negligence.

Gravity of the Violation

The potential hazard in the specific situation is a fall leading to a possible broken leg or lesser injury. Accordingly, I conclude that the violation was moderately serious.

Rapid Abatement

The violation was abated the next day. Therefore, I conclude that Freeport demonstrated good faith in attempting rapid abatement.

Citation No. 96160, July 20, 1978, 30 CFR 55.17-1

This citation was issued by Inspector Lindbeck during his July 20, 1978, night inspection at the Griffin Mill (Tr. 393; Exh. M-14, p.1). The citation states that "there is not sufficient illumination at rail load out area (tank car). Lights were not in working order at time of inspection." The condition allegedly constitutes a violation of 30 CFR 55.17-1.

As noted previously in this decision, 30 CFR 55.17-1 mandates that illumination sufficient to provide safe working conditions be provided on all surface structures, paths, walkways, stairways, switch panels, loading and dumping sites, and work areas. Although the citation, as incorporated into the petition for assessment of civil penalty, appears to be confined to an allegation that the illumination was insufficient only in a loading area, the testimony of the inspector sought to characterize the area not only as a loading area but also as a walkway (Tr. 394). However, certain statements contained in the inspector's statement (Exh. M-14, p. 3) reveal that Inspector Lindbeck cited the area solely on the basis of its use as a load-out area. Under the heading of "Gravity," the inspector wrote that "poor lighting in the area could cause a slip or fall from either cars or loading platform." Accordingly, I conclude that the allegation in the petition is confined to the use of the area as a rail load-out area.

The testimony of both Inspector Lindbeck and Mr. Scandlyn reveals that no employees were working in the cited area at the time of the inspection (Tr. 393, 437-438). According to the inspector, bulk loading of the railroad cars occurs in the area at night (Tr. 393-394). However, he admitted that he did not see either tank car movement nor switching activities that night (Tr. 396). Additionally, Mr. Scandlyn testified that no cars were being loaded in the area on the night in question (Tr. 437).

Since the record reveals that work was not being performed in the rail load-out area at the time, I conclude that a violation of 30 CFR 55.17-1 has not been established by a preponderance of the evidence.

Even assuming for purposes of argument that the petition can be construed to allege a violation of 30 CFR 55.17-1 based on insufficient illumination in a walkway, or that this issue has been tried with the implied consent of the parties, I conclude that the evidence fails to establish a violation. First, the deficiencies in evidence of some scientific test with an objective standard, noted previously in this decision, presents a substantial obstacle to the finding of a violation. Logically, the objective standards should be set forth in the regulation. Second, the evidence reveals that residual lighting from surrounding buildings provided enough illumination to permit a man to walk through the area without the use of a flashlight (Tr. 397, 438, 440, 443-444). Accordingly, I am unable to conclude that a preponderance of the evidence establishes that the illumination in the cited area was insufficient to permit its

safe use as a walkway.

VI. History of Previous Violations

The parties stipulated that no evidence exists to establish a history of prior violations (Tr. 5).

VII. Size of the Operator's Business

The parties stipulated that Freeport is a large operator. During 1978, the size of the operator was rated at 909,699 man-hours (Tr. 4).

VIII. Effect on the Operator's Ability to Continue in Business

The parties stipulated that any penalty that may be assessed may not affect Freeport's ability to continue in business (Tr. 6).

Furthermore, the Interior Board of Mine Operations Appeals has held that evidence relating to whether a civil penalty will affect the operator's ability to remain in business is within the operator's control, resulting in a rebuttable presumption that the operator's ability to continue in business will not be affected by the assessment of a civil penalty. Hall Coal Company, 1 IBMA 175, 79 I.D. 668, 1971-1973 OSHD par. 15,380 (1972). Therefore, I find that penalties otherwise properly assessed in these proceedings will not impair the operator's ability to continue in business.

IX. Conclusions of Law

A. Freeport Kaolin Company and its Griffin and Savannah Mills have been subject to the provisions of the 1977 Mine Act at all times pertinent to this proceeding.

B. The Administrative Law Judge has jurisdiction over the subject matter of, and the parties to, these proceedings.

C. MSHA inspector Spencer Lindbeck was a duly authorized representative of the Secretary of Labor at all times relevant to the issuance of the citations which are the subject matter of these proceedings.

D. The ruling in Docket No. BARB 79-280-PM granting MSHA's motion to amend the petition for assessment of civil penalty as relates to Citation No. 96181 to allege a violation of 30 CFR 55.14-6 instead of 30 CFR 55.14-1 is affirmed.

E. The ruling in Docket No. BARB 79-280-PM granting MSHA's motion to withdraw the petition for assessment of civil penalty as relates to Citation No. 96184, July 26, 1978, 30 CFR 55.12-30 is affirmed.

F. The violations described in the following citations are found to have occurred as alleged:

(1) Docket No. BARB 79-219-PM (Citation No. 96161, July 20,

1978, 30 CFR 55.12-16);

(2) Docket No. BARB 79-280-PM (Citation Nos. 96173, July 25, 1978, 30 CFR 55.14-1; 96179; July 26, 1978, 30 CFR 55.12-34; 96181, July 26, 1978, 30 CFR 55.14-6);

(3) Docket No. BARB 79-281-PM (Citation Nos. 96191, July 26, 1978, 30 CFR 55.14-1; 97204; July 27, 1978, 30 CFR 55.4-18);

(4) Docket No. BARB 79-282-PM (Citation No. 96399, July 18, 1978, 30 CFR 55.20-3; No. 96159, July 20, 1978, 30 CFR 55.17-1).

G. MSHA has failed to prove the violations charged as relates to the following citations:

(1) Docket No. BARB 79-280-PM (Citation Nos. 96162, July 20, 1978, 30 CFR 55.14-26; 96174, July 25, 1978, 30 CFR 55.12-30);

(2) Docket No. BARB 79-282-PM (Citation No. 96160, July 20, 1978, 30 CFR 55.17-1)

H. All of the conclusions of law set forth in Part V, supra, are reaffirmed and incorporated herein.

X. Proposed Findings of Fact and Conclusions of Law

Freeport and MSHA submitted posthearing briefs. Neither party submitted reply briefs. Such briefs, insofar as they can be considered to have contained proposed findings and conclusions, have been considered fully, and except to the extent that such findings and conclusions have been expressly or impliedly affirmed in this decision, they are rejected on the ground that they are, in whole or in part, contrary to the facts and law or because they are immaterial to the decision in these cases.

XI. Penalties Assessed

Upon consideration of the entire record in these cases and the foregoing findings of fact and conclusions of law, I find that the assessment of penalties is warranted as follows:

Docket No. BARB 79-219-PM

Citation No.	Date	30 CFR Standard	Penalty
96161	July 20, 1978	55.12-16	$255

Docket No. BARB 79-280-PM

Citation No.	Date	30 CFR Standard	Penalty
96173	July 25, 1978	55.14-1	$ 60
96179	July 26, 1978	55.12-34	50
96181	July 26, 1978	55.14-6	40

Docket No. BARB 79-281-PM

Citation No.	Date	30 CFR Standard	Penalty
96191	July 26, 1978	55.14-1	$ 40
97205	July 27, 1978	55.4-18	75

Docket No. BARB 79-282-PM

Citation No.	Date	30 CFR Standard	Penalty
96399	July 18, 1978	55.20-3	$ 75
96159	July 20, 1978	55.17-1	40
		Total	$635

XII. Approval of Settlement

During the hearing on June 22, 1979, the representatives of the parties informed the undersigned Administrative Law Judge that a settlement had been negotiated as relates to eight of the 13 citations at issue in Docket Nos. BARB 79-281-PM and BARB 79-282-PM. It was further stated that a motion requesting approval of settlement would be filed at a later date (Tr. 344-346). On October 22, 1979, the parties filed a joint motion to approve settlement and dismiss addressing the eight above-noted citations.

Information as to the six statutory criteria contained in section 110 of the 1977 Mine Act has been submitted. This information has provided a full disclosure of the nature of the settlement and the basis for the original determination. Thus, the parties have complied with the intent of the law that settlement be a matter of public record.

The alleged violations and the settlements are identified as follows:

Docket No. BARB 79-281-PM

Citation No.	Date	30 CFR Standard	Assessment	Settlement
96194	July 26, 1978	55.12-30	$ 38	$ 38
96200	July 26, 1978	55.14-8(b)	60	60
97202	July 27, 1978	55.12-34	48	48

Totals	$146	$146

Docket No. BARB 79-282-PM

Citation No.	Date	30 CFR Standard	Assessment	Settlement
96145	July 18, 1978	55.11-2	$ 24	$ 24
96149	July 18, 1978	55.14-1	48	48
96398	July 18, 1978	55.20-3	34	34
96156	July 19, 1978	55.14-1	66	66
96158	July 19, 1978	55.14-1	48	48
		Totals	$220	$220

The parties set forth the following reasons in support of the proposed settlements:

After a review of all available evidence, the parties hereby agree that the settlement set out in this motion would be proper because:

1. There is no reduction in the proposed assessment.

2. The respondent has paid the $366.00, which is the proposed assessment and such payment will have no effect on its ability to remain in business.

3. Respondent is a large operator.

4. The violations were moderately serious.

5. Respondent demonstrated good faith by attempting to achieve required compliance after notification of the alleged violation. Respondent represents that the conditions cited were immediately abated.

6. Respondent has no history of previous violations at this mine.

7. Respondent withdraws its request for a hearing.

It is the parties belief and conviction that approval of this settlement is in the public interest and will further the intent and purpose of the Federal Mine Safety and Health Act of 1977.

The reasons given above by the representatives of the parties for the proposed settlement have been reviewed in conjunction with the information submitted as to the six statutory criteria contained in section 110 of the Act. After according this information due consideration, it has been found to support the proposed settlement. It therefore appears that a disposition approving the settlement will adequately protect the public interest.

~264
XIII. Order

A. The ruling in Docket No. BARB 79-280-PM granting MSHA's motion to amend the petition for assessment of civil penalty as relates to Citation No. 96181 to allege a violation of 30 CFR 55.14-6 instead of 30 CFR 55.14-1 is AFFIRMED.

B. The ruling in Docket No. BARB 79-280-PM granting MSHA's motion to withdraw the petition for assessment of civil penalty as relates to Citation No. 96184, July 26, 1978, 30 CFR 55.12-30 is AFFIRMED.

C. The settlement outlined in Part XII of this decision is herewith APPROVED. Since Freeport has paid the agreed-upon settlement figure of $336, IT IS ORDERED that the petitions for assessment of civil penalty be, and hereby are, DISMISSED as they relate to the citations encompassed by the settlement.

D. IT IS FURTHER ORDERED that the citations set forth in Part IX(G) of this decision be, and hereby are, VACATED and the various petitions for assessment of civil penalty be, and hereby are, DISMISSED as they relate to those citations.

E. IT IS FURTHER ORDERED that Freeport pay civil penalties in the amount of $635 within 30 days of the date of this decision.

John F. Cook
Administrative Law Judge

~FOOTNOTE 1
During the hearing, the Judge granted MSHA's motion to withdraw the petition for assessment of civil penalty as relates to Citation No. 96184, July 26, 1978, 30 CFR 55.12-30 (Tr. 258).

~FOOTNOTE 2
All entries on Exhibit M-2 also appear on Exhibit M-1. All of the violations recorded thereon occurred in July of 1978. Accordingly, the exhibits confirm the parties' stipulation that no evidence exists establishing a history of prior violations.

~FOOTNOTE 3
As relates to the reference to 30 CFR 55.14-29 it should also be pointed out that the Respondent in its own safety lock-out procedure (Exh. O-2) makes reference to 30 CFR 57.12-16 which regulation relates to electrical equipment as does 30 CFR 55.12-16, which is the regulation involved herein. It should also be pointed out that 30 CFR 55.12-16 and 30 CFR 57.12-16 were changed such that the first sentence thereof, on the date of the violation herein, read: "Electrically powered equipment shall be deenergized before mechanical work is done on such equipment" (emphasis added); whereas prior thereto the first sentence read: "Electrical equipment shall be deenergized before work is done on such equipment." The changes were reported in the October 31, 1977, issue of the Federal Register. 42 Fed. Reg. 57040, 57043

(October 31, 1977).

~FOOTNOTE 4
The citation was written alleging a violation of 30 CFR 55.14-1. However, during the course of the hearing, the Judge granted MSHA's motion to amend the petition for assessment of civil penalty as relates to Citation No. 96181 to charge a violation of 30 CFR 55.14-6 instead of 30 CFR 55.14-1.