CCASE:
SOL (MSHA) V. U.S. STEEL MINING
DDATE:
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TTEXT:

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

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

v.

U. S. STEEL CORPORATION,
RESPONDENT

Civil Penalty Proceedings

Docket No. PENN 79-123
A.O. No. 36-05018-03022F

Cumberland Mine

DECISION AND ORDER

After intensive prehearing preparation, this matter came on for a prehearing conference in the U.S. Courthouse, Washington, D.C. on May 16, 1980. The first order of business was a consideration of the operator's motion to dismiss the charge that the operator failed to mark and identify shuttle car trailing cable plugs as required by 30 CFR 75.601. On the basis of a statement for the record by Inspector Davis, the Presiding Judge found this was a marginal, nonserious, no fault violation and suggested that in the interest of expedition the matter be settled with the payment of a $100 penalty. The parties agreed and so moved.

The next order of business was a lengthy discussion and consideration of the charge that a qualified electrician's failure to lock out a trailing cable plug as required by 30 CFR 75.511 was the effective cause of the electrocution of another miner. On the basis of an indepedent evaluation and de novo review of (1) the parties' investigative reports, (2) the statements of experts for both parties, (3) an examination of the relevant physical evidence, and (4) a review of the time-line analysis of pertinent events (copy attached as Appendix), the Presiding Judge found this was an extremely serious violation that resulted from the gross negligence of Kenneth R. Blystone, a qualified electrician employed by the operator in the 3 Butt Section of the Cumberland Mine on January 2, 1979.

It appeared that under the stress of knowing the shift was about to end with no production and two shuttle cars down, Mr. Blystone lost his composure and ability to think clearly. This led to a hasty decision to bypass the Femco ground sentinel monitor without disconnecting the trailing cable plug for the number 105 shuttle car. As a consequence, when the circuit breaker closed and energized the cable another electrician, Mr. Feather, who was splicing the cable, received a fatal shock.

On the basis of the facts appearing in the record and upon a consideration of the applicable law, the Presiding Judge further found the employee's negligence was imputable to the operator. See, National Realty and Construction Co. v. OSHRC, 480 F.2d 1257, 1266 (D.C. Cir. 1973); Pocohantas Fuel Co. v. Andrus, 8 IBMA 136 (1977), aff'd 590 F.2d 95 (4th Cir. 1979); Secretary v. Ace Drilling Co., 2 FMSHRC _____, PITT 75-1-P, decided April 24, 1980; Secretary v. Warner Co., 2 FMSHRC _____, PENN 79-161-M, decided April 28, 1980; Prosser, Law of Torts, 31, 32, pp. 145, 158 (4th ed. 1971). More specifically, the Presiding Judge concluded the Assistant Maintenance Foreman's failure to exercise the high degree of care imposed by the Act in supervising the conduct by his subordinates of hazardous work under conditions of stress that were or should have been known to him warrants imputation of the subordinate employee's negligence to the operator without diminution.

After taking into account (1) MSHA's statement that the facts did not warrant action against the individual involved under section 110(c) or (d) of the Act, (2) the operator's extensive efforts to insure against any repetition of the circumstances giving rise to this violation, (3) the operator's overall safety record, and (4) the absence of any request or showing of need for an evidentiary hearing, the Presiding Judge recommended the matter be settled with the payment of a penalty of $7,000. The parties agreed and so moved.

Whereupon each of the motions to approve settlement was granted by a decision from the bench and the operator directed to pay the penalties agreed upon within ten days.

The premises considered, it is ORDERED that the bench decision be, and hereby is, ADOPTED and CONFIRMED. It is FURTHER ORDERED that the operator pay the penalty agreed upon, $7,100 on or before Tuesday, May 27, 1980 and that subject to payment the captioned proposal for penalty be DISMISSED.

Joseph B. Kennedy
Administrative Law Judge

Attachment: Appendix

APPENDIX

TIME LINE ANALYSIS

Location: 3 Butt, 006 Section, Cumberland Mine
Room 11, Nos. 2 and 3 Entries
Day Shift, Tuesday, January 2, 1979
Fatal Accident Occurred at 3:25 p.m.

1:00 p.m. to 2:00 p.m. - Shuttle Car (S/C) 105 located in No. 3 entry developed trouble with its trailing cable.
Kenneth R. Blystone, age 58, a qualified electrician with 18-1/2 years experience removed the S/C 105 trailing cable plug from the Load Center (LC) receptacle in the #3 entry of the 006 Section and locked it out with his padlock.

Blystone and George Cook, Jr., an electrician trainee (Grade 4), with 3 years' experience made a splice in the S/C 105 trailing cable.

Blystone then gave Cook the key to unlock the padlock on the S/C 105 trailing cable plug.

Cook unlocked the lock from the S/C 105 trailing cable plug and placed the lock along with the key on top of the LC.

Cook then inserted the S/C 105 trailing cable plug into the LC receptacle, and tried to energize the circuit breaker in the LC several times without success.

Each time Cook threw in the circuit breaker the Femco ground sentinel system kicked it back out. This meant the short in the S/C 105 trailing cable was not corrected.

Cook, at the direction of Blystone, then removed the S/C 105 trailing cable plug from the LC and Blystone ran additional tests in an effort to locate the trouble.

2:00 p.m. to 2:15 p.m. - 106 S/C trailing cable shorted out. Blystone removed the S/C 106 trailing cable plug from the LC receptacle and locked it out using the lock that Cook had removed from the S/C 105 trailing cable plug and placed on top of the LC. This padlock was Ken Blystone's lock that he had on his belt at the time he locked out the S/C 105 trailing cable. Blystone failed to lock out the S/C 105 trailing cable plug that Cook had removed from the LC receptacle. Instead Blystone placed a danger tag in the S/C 105 trailing cable plug. Blystone could have locked out the S/C 105 trailing cable plug with a lock from his tool box.

2:15 p.m. to 2:30 p.m. - Blystone notified William Jiblits, Assistant Maintenance Foreman of the breakdown of the two S/C's. Jiblits directed Ted Chapman, a Grade 4 electrician trainee with 3 years' experience, and Joe Julian, another Grade 4 electrician trainee with 3 years' experience, to leave the 2 Butt section and

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go to the 3 Butt section to assist Blystone. In the meantime, Blystone and Cook gave first priority to working on the S/C 106 trailing cable splice, because the brakes were bad on S/C 105 and had to be repaired before it could be used.

2:30 p.m. - to 3:00 p.m. Julian and Chapman arrived on the 3 Butt section and Blystone directed them to help him troubleshoot the problem on the S/C trailing cable while Cook continued to work on the S/C 106 trailing cable problem. At 2:50 p.m., Jiblits directed William Feather, a qualified electrician with 1 year 3 months' experience in this classification, to leave the 2 Butt section and proceed to the 3 Butt section to help Blystone. At the time Feather arrived at the No. 2 entry of the 3 Butt section, Blystone, Julian and Chapman had cut a 10-foot section out of the S/C 105 trailing cable. When Feather took over from Blystone, at approximately 3:00 p.m., the S/C 105 trailing cable had been cut apart and one end had the cable insulation peeled back. Blystone then left to return to #3 entry to work with Cook on the S/C 106 trailing cable problem.

3:00 p.m. - to 3:30 p.m. Blystone proceeded to help Cook put a splice in the S/C 106 trailing cable in the #3 entry. A short time later, Chapman came over from the #2 entry and told Blystone he thought Feather had found an opening in the S/C 105 trailing cable. Blystone told Chapman to stay with Cook, while he went over to assist Feather and Julian. Blystone determined there was

an opening in the S/C 105 trailing cable and then returned to the #3 entry to help Cook and Chapman splice the S/C 106 trailing cable. At approximately 3:25 p.m., the splice in the S/C 106 trailing cable was completed. Leaving Cook at the splice, Blystone and Chapman proceeded to the load center in the #3 entry. There the plug for the S/C 106 trailing cable was lying locked out. Beside it was the plug for the S/C 105 trailing cable with the danger tag on it that had been placed there by Blystone earlier. Ignoring the danger tag, Blystone picked up the S/C 105 trailing cable plug and plugged it into the No. 1 receptacle thinking it was the S/C 106 trailing cable plug. The Femco ground check monitor circuit light indicated an open circuit. The plug was then removed by Blystone and inserted in LC receptacle No. 2 with the same result. At this point Blystone became agitated, and thinking the problem might be in the LC, told Chapman to depress the ground check monitor test switch to the unit check position and activate the circuit breaker while he observed the lights on S/C 106. (Safe practice requires that all plugs be removed from the LC before bypassing the Femco Ground Sentinel II ground monitor). When the test switch is depressed, the ground sentinel system is bypassed, and the circuit breaker and trailing cable become energized. As instructed by Blystone, Chapman depressed the test switch and activated the circuit breaker. As soon as Chapman saw the circuit

breaker close, he released the test switch and energized the trailing cable. At this point, Julian and Feather were both holding the exposed S/C 105 trailing cable. Feather was holding the cable on both sides of the splice, while Julian was taping a phase lead connection they had completed. Three of the five remaining conductors were folded back along the cable. When Chapman depressed the Femco test switch and activated the circuit breaker the trailing cable became energized. When Julian felt the surge of power he screamed, and when the power hit Feather it knocked him unconscious. Cardio-pulmonary resuscitation was started immediately and continued until arrival at the Waynesburg Hospital, where Feather was pronounced dead on arrival.

The floor of the no. 2 entry, 11 crosscut, varied from damp to wet and muddy. Feather was wearing leather boots and was not wearing gloves. A padlock in the closed position was found on Feather's belt. Feather never knew whether or not anyone had locked out and tagged the S/C 105 trailing cable. No faults were found in the LC when subsequently tested by Inspector Davis.