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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

v.

A. H. SMITH STONE COMPANY,
RESPONDENT

Civil Penalty Proceeding

Docket No. VA 80-2-M
Assessment Control
No. 44-02965-05005F

Louisa Quarry and Mill

DECISION

Appearances: Barbara Krause Kaufmann, Attorney, Office of the Solicitor, U.S. Department of Labor, for Petitioner
A. H. Smith, Jr., and Wheeler B. Green III, Branchville, Maryland, for Respondent

Before: Administrative Law Judge Steffey

Pursuant to a notice of hearing issued August 28, 1980, a hearing in the above-entitled proceeding was held on October 21, 1980, in Falls Church, Virginia, under section 105(d) of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. 815(d).

After the parties had completed their presentations of evidence, I rendered the bench decision (FOOTNOTE 1) which is reproduced below (Tr. 101-114):

> This proceeding involves a Petition for Assessment of Civil Penalty filed in Docket No. VA 80-2-M on November 8, 1979, by the Secretary of Labor, seeking to have a civil penalty assessed for an alleged violation of 30 C.F.R. 56.11-1.
>
> The issues in a civil penalty case are whether a violation occurred and, if so, what civil penalty should be

assessed based on the six criteria set forth in section 110(i) of the Federal Mine Safety and Health Act of 1977.

I shall make some findings of fact on which my decision will be based. I shall set them forth in enumerated paragraphs.

1. A. H. Smith Stone Company, according to a stipulation of the parties, had 163,693 man-hours in 1979. The company operates the facility which is involved in this proceeding, namely, the Louisa Quarry and Mill which is located in Louisa County, Virginia. The man-hours worked at that particular facility in 1979 were 47,586.

The parties have stipulated that the company is subject to the provisions of the Act.

2. On January 25, 1979, Mr. James H. Whalen, the operator of the crusher at the Louisa Quarry and Mill was found head first in the primary crusher, resulting in his death before he could be extricated from the crusher.

On January 26, 1979, the day after the fatality occurred, several people made an investigation of the accident. The only person representing MSHA during that inspection who testified here today was Inspector Charles W. Quinn. He stated after he had examined the feeder at the site where Mr. Whalen was killed, that he had concluded that there was not a safe means of access to and from the feeder.

For that reason, he wrote Citation No. 301536, dated January 26, 1979, alleging a violation of section 56.11-1, which provides that a "ÕsÊafe means of access shall be provided and maintained to all working places."

3. There were a number of photographs introduced into evidence in this proceeding. They are essential for an understanding of the area where the victim was killed and also of the physical layout of the facility where Inspector Quinn felt a violation of section 56.11-1 had occurred.

Some of these exhibits were introduced by Inspector Quinn and some by the company. All the photographs have been very helpful in showing the situation which existed. Exhibit No. 4-A shows how a person who is 5þ 8" tall would have to proceed and how he would have to move his body in order to get out of the feeder in the vicinity of the control booth from which the crusher is operated.

4. Exhibit No. 4-D is a very close-up picture of the exact area where a person would have to stand if he wanted to get out of the feeder. That picture indicates that an individual leaving the feeder would have to stand on what is known as a "grizzley," which consists of 4-inch wide metal strips with an opening between them of about 6 inches. Although the witnesses, or at least Mr. Christopher, who was a witness for the respondent, indicated that the grizzley is 5 feet long, a person coming out of the control booth, or going into it from the feeder, is considerably closer to the terminal end of the grizzley on the side of the crusher than 5 feet, according to Exhibit No. 4-D.

5. Exhibit No. A-6 shows a good view of the grizzley at the site where a person would be if he wanted to go out at the control booth and it is especially obvious that a person stepping up from the feeder would be stepping up, from an insecure footing, a distance of 2 feet.

6. Exhibit No. A-10 is a close-up view of the feeder and control booth after a handrail was installed near the control booth and after a step was made toward the top of the feeder. Those improvements were made in order for the company to abate the violation alleged in Citation No. 301536.

7. Ms. Kaufmann correctly stated in her remarks that no one knows for sure what caused Mr. Whalen to fall into the crusher, but we do have the testimony of Mr. Christopher who was the person who last talked to Mr. Whalen before his death. Exhibit No. A-4 shows the end of the feeder farthest from the control booth and, according to Mr. Christopher's testimony, Mr. Whalen, the victim, was standing in the feeder about 3:50 p.m. when Mr. Christopher last talked to him. That was on January 25, 1979. At that time, Mr. Christopher told Mr. Whalen an explosive charge would be set off in the quarry and that Mr. Whalen should shut off the crusher and could leave for the day after he had finished cleaning the feeder which was almost entirely free of residue at that time.

8. When Mr. Christopher had returned to the area of the feeder after obtaining the detonating equipment for setting off the blast, he realized that Mr. Whalen was not in sight at any of the places where he normally saw him at that time of day. Consequently, he made a search for Mr. Whalen and eventually found his body in the crusher with his head foremost into the crusher and his legs sticking out the top. At that time, Mr. Whalen was already dead.

9. When Mr. Christopher talked to Mr. Whalen at 3:50 feeder was not operating but the crusher was. At 3:50 p.m., the feeder still had rock in it which needed to be transported by the feeder into the crusher. When Mr. Christopher returned around 4:00 or 4:05 p.m. to the vicinity of the feeder, the material in the feeder had been discharged into the crusher, but the crusher was still running.

10. The inspection report written by MSHA's investigators was received into evidence as Exhibit F. That report indicates on page three that Mr. Whalen was an epileptic and that he was normally taking phenobarbitol to counteract his illness and an analysis of his blood showed a rather high concentration of aprobarbital.

Despite the fact that Mr. Whalen had been under a doctor's treatment for his problem, Mr. Christopher worked with him for approximately 8 years without noticing that Mr. Whalen had any problems in the form of dizziness or slurred speech or any indication he had an abnormal condition of any kind. Mr. Christopher did not observe any unusual physical attributes about Mr. Whalen at 3:50 p.m. on January 25, 1979, when Mr. Christopher last talked to Mr. Whalen before his death. I believe that generally summarizes the facts in this case.

As I have indicated in the findings, the feeder was not equipped with any type of step or handrailing to assist a person who had been working in the feeder to get out of the feeder once he had finished that work. The testimony indicates that it was the practice, especially in the wintertime, to clean out the feeder during every shift because the materials in the wintertime had a tendency to cling around the top of the feeder.

While there is no doubt in my mind that a person with secure footing could step up a distance of 2 feet, or 2-1/2 feet if you include the angle into the control booth that was discussed by Inspector Quinn, the fact remains that anyone getting out of the feeder has to do so by standing on top of the grizzley and, as I have indicated in my findings, his footing would not be very stable.

It is undoubtedly true that Mr. Whalen had been down in that feeder and had cleaned in it for many years because he worked for the company from February 4, 1970, until his death

on January 25, 1979. Nevertheless, the evidence shows that without any handhold or anything to assist a person who was stepping up out of the feeder, there was certainly a hazard involved in not having any facilities whatever to assist a person coming out of the feeder. Therefore, I find that a violation of section 56.11-1 occurred because a safe means of access into and out of the feeder had not been provided.

Having found that a violation occurred, it is necessary for me to assess a penalty based on the six criteria. The first criterion is the size of respondent's business. As to that matter, I have indicated in paragraph one of my findings that the company had total man-hours of operation of 163,693. That places the company in a moderate range of size. Therefore, any civil penalty to be assessed in this case will be or should be in a moderate range of magnitude, insofar as the size of respondent's business is considered as one of the criteria.

There was introduced with respect to the criterion of history of previous violations Exhibit No. 5. That exhibit shows that there have been two previous violations of section 56.11-1 by the company. It has always been my practice to increase a penalty otherwise assessable under the other five criteria by a specific amount if I find existence of an unfavorable history of previous violations. Exhibit No. 5 shows that two previous violations occurred sometime between January 27, 1977, and January 26, 1979. I find that two violations in that length of time should be considered as somewhat unfavorable and therefore whatever penalty is assessed in this case will be increased by $50 under the criterion of history of previous violations.
As to the criterion of the operator's ability to continue in business, there was no testimony given on that subject. The former Board of Mine Operations Appeals held in Buffalo Mining Company, 2 IBMA 226 (1973), and in Associated Drilling, Inc., 3 IBMA 164 (1974), that if a company puts on no evidence showing its financial condition, that a judge may presume payment of penalties would not cause it to discontinue in business. Therefore, I find that payment of penalties will not cause A. H. Smith Stone Company to discontinue in business.

The next criterion to be considered is the question of whether the operator demonstrated a good faith effort to achieve rapid compliance after the citation was written. The inspector terminated the citation on January 30, 1979.

The citation was written on January 26, 1979. He has indicated that he felt the company showed a normal good faith effort to achieve rapid compliance. I find that the evidence supports that conclusion. When I find that a company has made a normal good faith effort to achieve compliance, I neither increase nor decrease a penalty otherwise assessable under the other criteria.

The remaining two criteria, that is, gravity and negligence, are the ones that affect the penalty the most severely. The first consideration is the degree of negligence involved in this particular violation. I think in connection with that criterion, it is worthwhile to note that the inspector had made a previous examination of the crusher at the Louisa Mill and had not noticed this particular hazard. I can understand why an inspector would not see everything that might be hazardous around the crusher on his first inspection. The inspector did indicate that he had been in this part of the facility and it did not occur to him at that time that this was a particularly hazardous area and he did not write a citation for a violation of section 56.11-1 at that time.

Nevertheless, when one does examine the area of the feeder from the standpoint of the photographs which I have discussed in my findings, one reaches the inescapable conclusion that the operator was at least guilty of a normal amount of negligence in not having put any kind of provisions here for a person to grab when he is trying to get in or out of the feeder, particularly since Mr. Christopher has indicated the feeder has to be cleaned out rather constantly during cold weather. Therefore, I find that there is a moderate amount of negligence involved in this case. The final criterion I have to consider is the question of gravity. Gravity gets back to the question of whether the failure to provide a safe means of egress, specifically a step and a handhold for getting up out of the feeder, was the direct cause of the person's death in this instance. In a general situation, the question would be how serious a fall from the side of this feeder would normally be. The difficulty with making that finding in this case is associated with the fact that there was no eyewitness who saw Mr. Whalen fall, if he did fall, and there is no one who can say for certain that the medication he was taking had no bearing upon the fact that he was found in the crusher. The inspector and Mr. Christopher have been unable to explain satisfactorily why a person, assuming he did slip in trying to get out of the feeder, would not only have fallen

backwards but also would have further slid into the opening to the crusher. There was a distance of at least a couple of feet from the place where he would have fallen to the point where he would have started down into the crusher.

Another part of the problem in assessing gravity in this instance gets to the fact that when Mr. Christopher was talking to Mr. Whalen at 3:50 p.m., the feeder was not running. When Mr. Christopher next came back to the feeder, it still was not running but all the material that had been thrown down by Mr. Whalen onto the feeder had been transported by the feeder into the crusher and the feeder was empty of any material. The foregoing facts support a conclusion to the effect that Mr. Whalen at least successfully got out of the feeder and turned it on in order to eliminate the materials that were in it. Inspector Quinn's belief that Mr. Whalen slipped while trying to get out of the feeder and fell backwards and rolled into the crusher, is really not supported by the facts because, once Mr. Whalen got out of the feeder and turned it on, there is no reason that we know of, based on the facts in this case, that he would have gotten back down into the feeder. We simply do not have any evidence to show for certain that failure to have a step and a handhold for a person to come out of the feeder was the direct cause of Mr. Whalen's death in this case.

Since we do not have any way to show the exact cause of death, and the inspector's accident report, Exhibit F, so indicates on page three, I can only find on the evidence in this case that the violation was moderately serious and would not normally be expected to result in a person's death.

There is one aspect of the evidence which does make this feeder and its lack of facilities to help a person get out of it serious, and that is, up until this accident occurred, Mr. Whalen was cleaning out the edges of the feeder while keeping the crusher in operation. That practice meant if anyone should fall into the crusher while cleaning out the feeder, his death was more likely than if the crusher had not been operating.

According to Mr. Christopher, after the accident, the company has discontinued that practice and now turns off both the feeder and the crusher at the time that a person is down in the feeder cleaning it out.
At the time this particular accident occurred, the company was engaging in a kind of operation which was less safety-oriented than it is now.

The lack of a means of egress, a safe means of egress on January 25, 1979, was more serious than it would be today when neither the crusher nor the feeder is operating, but on January 25, 1979, the crusher was operating even though the feeder was not.

For that reason, I find that the evidence supports a conclusion that the violation was moderately serious. In summary, since we have a company which operates a medium-sized business, and since we have a good faith effort to achieve compliance and a moderate amount of negligence and a moderate amount of gravity, I believe a penalty of $400 should be assessed, to which there should be added $50 under the criterion of history of previous violations, so that the total penalty in this case should be $450.

WHEREFORE, it is ordered:

Within 30 days from the date of this decision, A. H. Smith Stone Company shall pay a penalty of $450.00 for the violation of section 56.11-1 charged in Citation No. 301536 dated January 26, 1979.

Richard C. Steffey
Administrative Law Judge
(Phone: 703-756-6225)
(Phone: 703-756-6225)

~FOOTNOTE_ONE

1 A petition seeking review of my bench decision was filed with the Commission by respondent on November 21, 1980. Since I had not yet issued my decision in final form, the official file was still in my office. Therefore, the petition was routed to me so that it could be placed in the official file.