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

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

Civil Penalty Proceeding  
Docket No. LAKE 80-399  
A.C. No. 11-00588-03079 F

v.

No. 21 Mine

OLD BEN COAL COMPANY,  
RESPONDENT

DECISION

Appearances: Thomas Lennon, Esq., Office of the Solicitor,  
U.S. Department of Labor, Chicago, Illinois,  
for Petitioner;  
Robert J. Araujo, Esq., Old Ben Coal Company,  
Chicago, Illinois, for Respondent

Before: Judge Charles C. Moore, Jr.

The above case was tried in Evansville, Indiana, on April 8, 1981, and final briefs of the parties were submitted by May 29, 1981. The citation alleged a violation of 30 C.F.R. | 77.1700 in that:

A bulldozer operator was allowed to perform work in a hazardous area where he could not be seen or heard by others and no communication means was provided. This violation was determined during a fatal accident investigation of the bulldozer operator working atop the raw coal storage pile on 4/8/80.

Although no one will ever know exactly how this accident occurred, and although there was some difference of opinion as to whether the bulldozer backed into a hole or fell through a bridged-over area of the coal, the evidence indicates that the events could have taken place as described in the "Commentary" and "Discussion and Evaluation" sections of the accident report (Petitioner Exh. 13). Those sections are as follows:  
"Commentary

On Tuesday, April 8, 1980, at midnight, the surface preparation plant crew under the supervision of Gale Pearce, Surface

Foreman, entered their respective work areas and routine coal preparation activities commenced. At this time, Robert Mitchell, Bulldozer Operator, mounted the TD-25-C International bulldozer and began coal pushing operations on top of the unusually large raw coal pile located near the preparation plant. Mitchell's duties consisted of pushing coal away from the coal stacker and pushing coal over the four load-out holes located beneath the coal pile. Coal is loaded out from beneath the raw coal pile by feeders located on four sides of the coal stacker. The preparation plant operator, Jesse Jones, began loading out coal from the north feeder at the beginning of the shift and continued until 1:30 a.m. when he received a telephone call from Mitchell requesting that he switch over and load from the south feeder. Jones switched to the south feeder and continued loading out coal until he received another call from Mitchell at 1:45 a.m. At this time, Mitchell told Jones it was alright to load from any hole because he had come down off the raw coal pile with the bulldozer. Jones then began loading coal from the various feeders until he achieved the desired flow rate of coal to satisfy the preparation plant. To do this, Jones loaded coal approximately 10 minutes from the west feeder which would have conveyed approximately 100 tons of coal from the coal pile on the west side of the stacker. At approximately 2:30 a.m., Mitchell pulled a stuck vehicle from a mud hole in the mine yard and trammed the bulldozer onto the coal pile to resume coal pushing. However, Mitchell did not contact the plant operator, Jones, to inform him that he was returning to the coal pile.

"At approximately 6 a.m., a belt line in the head house stopped and Steve Mazur, Top Utility Man, walked up to the top of the stacker to investigate why it had stopped. At that time, Mazur looked out over the coal pile and saw a small portion of the bulldozer blade protruding from beneath coal directly over the west feeder hole location.

"It was quickly determined that Mitchell was still on the buried bulldozer because he could not be located elsewhere. Rescue operations were commenced immediately. An endloader and a backhoe were driven onto the coal pile to help, but they were ineffective in moving the large quantity of coal. Two large bulldozers brought to the accident scene from a nearby mine began digging out Mitchell and the buried bulldozer. The stacker had apparently dumped a large quantity of coal on top of Mitchell and the bulldozer after the accident occurred.

"At approximately 9 a.m., enough coal had been removed to get to the operator's cab which had filled up with coal when the front windows of the cab were pushed in under the weight

of the coal which buried the bulldozer. At 9:20 a.m., Mitchell who had apparently been suffocated by the inrush of coal into the cab was found and removed from the cab of the still partially buried bulldozer.

#### "Discussion and Evaluation

The investigation revealed the following factors relevant to the occurrence of the accident:

"1. The unusually large raw coal pile, approximately 75,000 tons, had accumulated due to poor coal sales recently.

"2. It had rained heavily several times during the shift on which the accident occurred.

"3. Illumination for the coal pile was provided by large spotlights on the top of the stacker as well as headlights on the bulldozer.

"4. It was assumed that as Mitchell operated the bulldozer in reverse it fell through crusted over coal into a void created when coal was loaded out by the west feeder.

"5. The two previous shifts had not loaded coal from the west feeder and the bulldozer operators had trammed over the west feeder hole location numerous times. This action presumably tightly compacted the loose coal on the surface of the pile in this area.

"6. The gear shift in the cab of the bulldozer was in the reverse position when the bulldozer was recovered.

"7. The bulldozer was examined after the accident and found to be mechanically sound.

"8. No means of communication was provided between the preparation plant operator and the dozer operator."

The statement above that there was no means of communication between the bulldozer operator and the preparation plant operator means that there was no means of constant communication. There were telephones that the bulldozer operator could use to phone the preparation plant operator. But in order to do so, he would have to drive his dozer off of the top of the raw coal storage pile to telephone the preparation plant operator. There were three locations from which he could make such telephone calls.

Mr. Jesse Jones and Mr. Hosea Thomas are both bulldozer operators who work on top of the raw coal storage pile at the present time. At the time of the accident, however, Mr. Jones was the preparation plant operator. The

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testimony of these two miners resulted in a detailed description of the operations of the raw coal storage pile and the preparation plant insofar as this accident is concerned. The pile itself is created by the stacker which is a tube approximately 60 feet high containing rectangular holes at various levels. The coal is brought to the top of the stacker by means of a conveyor tube and is dropped into the top of the stacker. The coal comes out of the stacker through the aforementioned rectangular holes and forms a cone of coal around the stacker. The bulldozer operator's job is to create a plateau out of the lower portions of this cone in such a manner that he can keep coal feeding into four coal feeders which are openings 6 feet on a side with grates at the bottom or ground level of the stack of coal. The coal feeders are in all four cardinal directions from the stacker and 40 feet away from it. The bulldozer driver has to guess where these coal feeders are because on the surface of the coal, which at the time of the accident was approximately 40 feet above the coal feeders, he has no way of knowing where they are located except, as aforesaid, that they are 40 feet from the stacker and either north, east, south, or west. When a feeder is taking coal and the coal is feeding properly an indentation or a "bird's nest" appears above the feeder at the surface of coal and the dozer operator can continually push coal in such a manner as to make sure there is an adequate supply over the feeder. At the time of the accident, the plateau area had become unusually large and about 40 feet in height. When coal gets wet, it is possible for the bulldozer running over the surface to compact it in such a way that when a feeder starts to load coal from beneath the pile a cavity or a void is created in that the looser coal near the feeder goes into the feeder and onto a conveyor belt to be taken into the preparation plant, whereas the surface of the coal bridges over creating a situation similar to that of a snow bridge over a crevasse in a glacier. A bulldozer may be able to run over the bridged-over area for a time, but it is not uncommon for one to collapse the bridge and fall into the void. There appears to be no problem when the bulldozer goes forward into a void, because both of the bulldozer operators said when they suspected a void they deliberately put their blade down into the area and drove forward. The blade itself apparently protects the bulldozer from going too deep into the void.

MSHA's theory of this case is that if there had been two-way radio communications, the preparation plant operator would have informed the victim that he had been feeding out of the east feeder and that the victim upon seeing no "bird's nest" would have known that a void existed and would have avoided the area or collapsed the bridge with his blade. It is the theory that he did not know this, that he was running over the bridged-over area and that on one of his trips backing over the bridged area, it collapsed and that he fell backwards into the void and that coal fell in behind him, crushed the front window of the cab and that he suffocated under the coal.

When the bulldozer was found, only one tip of the blade was not covered with coal because the coal stacker had continued to

run after the accident and had buried the bulldozer. There is no evidence as to the extent of its burial immediately after the accident. There was no autopsy report. There was no testimony as to what would happen if a bulldozer either backed into

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a hole or fell through a bridge and the engine continued to run with the treads in reverse. According to the accident report, the bulldozer was found with the front portion elevated 60 degrees from the horizontal. The pictures look more like 80 degrees but there was apparently no attempt to determine what caused the bulldozer engine to stop or whether the continued action of the treads would cause the elevation angle to become steeper. The victim was found with his arms stretched out in front of him but the significance of that finding was not explored. It is puzzling to me that if the accident happened as MSHA supposes in that the bulldozer suddenly fell into a collapsed void in an almost vertical position and that the inrush of coal following the collapse covered the cab and crushed the front windshield so that coal could come in and smother the driver, that he should have had his arms stretched out in front of him. The inrush of coal it would seem would have brushed his arms aside.

Certainly if the victim had been alive and in control of himself within seconds after the collapse through the bridge, he would not have left the operating controls in a reverse position. There are thus a lot of questions that the investigation leaves unanswered.

There is nothing in the accident report, for example, that would negate the possibility that the victim had a heart attack or some other seizure, backed into or caved into the hole and died while the engine was still turning the treads in reverse with the stacker continuing to pile up sufficient coal to cave in the windshield and eventually almost cover the bulldozer.

I think it possible that the accident happened as envisioned by MSHA in its accident report but I think it matters little whether the victim backed into a hole that had collapsed behind him, or actually broke through the bridged-over area. In either event, there is no contention by MSHA that a two-way radio would have enabled the victim to call for help and thus be rescued. The contention is that if a two-way radio had been present in the cab, the operator would have found out from the plant operator which feeders had been in use and thus would be aware of the location of possible voids.

30 C.F.R. | 77.1700 provides:

No employee shall be assigned, or allowed, or be required to perform work alone in any area where hazardous conditions exist that would endanger his safety unless he can communicate with others, can be heard, or can be seen.

This standard has been interpreted by other Commission judges. In *Secretary of Labor v. B.S.K. Company, Inc.*, Docket No. BARB 79-190-P, 2 FMSHRC 998, 1006, Judge Cook said:

All surface mines present certain common dangers, yet the wording of the regulation is such that its mandate

applies only when conditions outside the norm are present.



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The regulation is designed to assure that an individual working in an area where hazardous conditions exist that would endanger his safety is within sight or hailing distance of others who can render or summon assistance when necessary.

Judge Broderick reached a similar conclusion in a bench decision issued on February 11, 1981, in *Monterey Coal Company v. Secretary of Labor*, Docket No. WEVA 81-203-R, 3 FMSHRC 439, 442, Judge Broderick said:

I do not accept the interpretation that apparently MSHA follows, that any work at a mine site is in an area where hazardous conditions exist that would endanger an employee's safety. Such an interpretation would render the words meaningless. And I am bound to give all words in a mandatory standard meaning, and can only conclude that the standard applies to areas where conditions exist that are hazardous, which would endanger an employee's safety, over and above the conditions that exist throughout the mining industry, or indeed in any industry.

I agree with these decisions.

In hindsight, since a miner was killed on the raw storage stockpile, it is easy to say that it was an area that was more hazardous than other areas. At the time of the accident, however, falling into a void was a frightening and uncomfortable experience that the miners did not like, but there is no evidence that they feared for their lives when they fell into one of these voids. If the bulldozers had been equipped with two-way radios prior to the accident, there is no reason to assume that all of the operators, including the victim, would have inquired as to which feeders had been in use. In fact, the victim could have stopped to telephone the plant operator on his way back to the storage pile if he had been inclined to do so. The situation after the accident is, of course, different. The bulldozer operators are informed as to which feeders have been in use and if there is no "bird's nest" present they proceed to collapse the bridge.

The safety standard involved in this case appears to be more concerned with rescuing a miner after an accident than it is in preventing the accident in the first place. If someone had kept the bulldozer constantly in sight, it would not have prevented the accident. Nor would the accident have been prevented by having another miner sit in the cab with the victim or having a miner close enough so that he could have heard the victim call out. Rescue operations could have begun earlier but whether that would have saved the miner's life is a matter of conjecture. Yet, by the wording of the regulation itself, if there had been another miner in the cab with the victim or within hailing distance or if the victim and his bulldozer had been constantly observed by someone, there would be no violation. Old Ben attempted to prove that the victim's bulldozer was visible but the evidence, at most, amounted to the fact that the bulldozer

was visible when operating in certain parts of

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the raw storage coal pile area if someone had been looking. While I reject the Government's argument that I should disregard the words of the regulation and interpret it as though it were a panacea to prevent accidents of the type involved here, I also reject Old Ben's defense that the victim was under observation or in sufficient communication with others to avoid a violation of the regulation.

I find that this was in fact a hazardous area, this raw coal storage pile that was 40 feet high, but I also find that it was not so considered by MSHA or the operator prior to the accident. MSHA was specifically requested at the hearing to indicate whether it considered other companies' storage piles as hazardous areas where communication would be required and while the Government's brief mentioned the problem, it did not supply an answer. I do not know whether any other company has been cited for failure to provide two-way communication with the bulldozer operators on top of a raw storage coal pile. Nor do I know whether MSHA would have issued the citation in this case had the coal pile been only 30 feet high or if it had not been raining or if there had been no accident. I find that there was a violation and that the current system of two-way radio communication is a much safer way to operate the raw coal storage pile than is required by the regulations. Under the present system, the accident that occurred in this case would not happen, if the cause actually was a bridging over of a void. At the time, however, it is very doubtful that two-way communication would have prevented the accident. The fact that the victim told the plant operator by phone that he could feed out of any of the feeders he wanted because the operator was leaving the top of the storage pile for another chore and the fact that when he returned to the pile he did not stop to phone the preparation plant operator to find out which feeders had been used indicates that he did not consider it a matter of great concern. There is no reason to think he would have used a two-way radio to ask the appropriate questions.

While I find a violation of the regulation, I find that MSHA has failed to carry the burden of proof that the violation caused the fatal accident or that compliance with the regulation would have prevented the accident. Old Ben is a large company with a substantial history of violations, although I am not aware of a history of violating this particular section. The negligence was of a very low order, there was good faith abatement and the degree of hazard is questionable. A penalty of \$900 is assessed.

#### ORDER

It is therefore ORDERED that Old Ben Coal Company pay to MSHA, within 30 days, a civil penalty in the amount of \$900. It is FURTHER ORDERED that all arguments not specifically adopted in the above opinion are REJECTED.

Charles C. Moore, Jr.  
Administrative Law Judge