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SOL (MSHA) v.MONTEREY 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
v.
MONTEREY COAL COMPANY,
RESPONDENT

Civil Penalty Proceeding

Docket No. WEVA 81-186
A/O No. 46-05121-03038F

Wayne Mine

DECISION APPROVING SETTLEMENT
AND
ORDERING PAYMENT OF CIVIL PENALTY

Appearances: Edward H. Fitch, Esq., Office of the Solicitor, U.S. Department of Labor, Arlington, Virginia, for the Petitioner;
Timothy M. Biddle, Esq., Crowell & Moring, Washington, D.C., for the Respondent.

Before: Judge Cook

On January 22, 1981, the Secretary of Labor (Petitioner) filed a petition for assessment of civil penalty in the above-captioned case pursuant to section 110(a) of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. 801 et seq. (Supp. III 1979) (Act). The petition charges Monterey Coal Company (Respondent) with a violation of mandatory safety standard 30 C.F.R. 75.1726(b) in that:

> It was revealed during the investigation of a fatal accident, based upon sworn testimony and evidence observed at the scene of the accident that the victim and continuous miner operator were performing the work of evaluating damage sustained to the miner under the ripper head that was not blocked in the elevated position in the No. 2 entry, on the Intake Mains Section (001), being developed in the direction of the Intake Airshaft.

An answer was filed, the case was consolidated with the associated notice of contest proceeding in Docket No. WEVA 80-322-R, a prehearing order was issued, and the matter was scheduled for hearing. Various motions seeking approval of settlement were filed on May 8, 1981,

September 1, 1981, and September 8, 1981. The settlement proposed in the September 8, 1981, filing is identified as follows:

Order No.	Date	30 C.F.R. standard	Assessment	Settlement
675312	3/19/80	75.1726(b)	$1,000	$1,000

Information as to the six statutory criteria contained in section 110 of the Act has been submitted. This information, found in Docket Nos. WEVA 80-322-R and WEVA 81-186, 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 various filings submitted by the parties are set forth below.

On May 8, 1981, the Petitioner filed a motion requesting approval of a $500 settlement which stated, in part, as follows:

> This case involves one violation of 30 CFR 75.1726(b) which was originally assessed a penalty of $1,000. The Secretary has determined, based on the attached letter filed by counsel for Monterey, that a voluntary penalty payment of $500 is an appropriate resolution of the conflict involved in this matter.
>
> As a condition of the settlement Monterey has agreed to withdraw its notice of contest involving this citation in Docket No. WEVA 80-322-R.
>
> The violation involves the fatality of a maintenance foreman who, knowing repair work was being done on the hydraulic hose, failed to block a miner ripper head before reaching under the ripper head. The victim apparently did not believe the ripper head would fall when the hose was disconnected. Blocking material was present in the immediate area, and the victim, being a foreman, should have been the individual most responsible for complying at that instant with the standard cited in the citation involved in this proceeding.
>
> While the Secretary does not adopt the contents of counsel's letter, it is clear to the Secretary that the settlement is consistent with the remedial purposes of the Federal Mine Safety and Health Act of 1977, and is in the range of a penalty the Secretary would expect to be assessed if the case proceeded to a hearing on the merits.

The attached letter from counsel for the Respondent stated, in part, as follows:

The deceased, John Groves, was a maintenance foreman at Monterey's Wayne Mine in West Virginia. On March 19, 1980, at about 10:45 p.m., Groves and a miner operator named Wilbur were changing bits on the ripper head of a continuous mining machine which was de-energized and parked in an intersection.[FOOTNOTE.1] The ripper head was elevated approximately 3-4 feet as they performed that task. At the same time, two repairmen were preparing to change an O-ring at a fitting on a hose which was part of the hydraulic system for the right support jack of the ripper head. As they changed bits, Groves and Wilbur noticed some fluid leakage under the ripper head. Groves began to peer under the ripper head to figure out where the fluid was coming from.

According to the testimony given during the MSHA accident investigation, one of the repairmen, Robert Burress, walked around to the front of the miner prior to disconnecting a hydraulic hose to replace the O-ring and told Groves that he was going to have to take the hose off. He recalls specifically telling Groves that he was afraid the jack would let the ripper head down when he disconnected the hose. According to Burress, Groves told him to go ahead and disconnect the hose because a safety valve would hold the ripper head in an elevated position. Burress returned to the side of the machine and disconnected the hose. When he disconnected it, the ripper head fell on Groves who had inexplicably crawled part way under the ripper head, apparently to get a closer look at the fluid leak. It was clear from the testimony of the witnesses that Groves did not believe the ripper head would fall when Burress disconnected the hose. Unfortunately, Groves was wrong and paid for the mistake with his life.

Several factors suggest a lower penalty would be more appropriate than the $1,000 assessed. First, Groves was a maintenance foreman who had an impeccable safety record and who was characterized by the witnesses as being "safety conscious." Monterey has records to show that Groves was trained specifically in the requirement for blocking raised equipment. Groves signed a statement of company policy to that effect. Moreover, Groves himself had instructed miners in blocking procedures. Witnesses confirmed that Groves knew how to block equipment; in fact he had demonstrated this by using blocking procedures only three days prior to the accident. On the day of the accident, there was no impediment to blocking the elevated ripper head. Wooden blocks provided for that purpose were located near the scene of the accident.

The inspector who issued the Order following the investigation stated on MSHA Form 7000-4 (his "worksheet"):

> "It is relevant to note that the victim was a supervisor of equipment maintenance and was trained in hydraulics, block [sic] of equipment, etc. and has instructed miners in the aforementioned at this mine. Also, it was revealed during the investigation that the victim assisted other mechanics in blocking up the ripper head of the miner a few shifts prior to the accident, which indicated that he was knowledgeable of the related hazards. * * * The fatal act committed by the victim was strictly contrary to the company policy in effect, the instructions he had been given and instructions and/or training he had given the miners. * * * The management personnel and miners demonstrated an outstanding attitude and was [sic] very cooperative in helping to obtain all the surrounding facts of this fatal accident."

> The circumstances of this tragic fatality indicate truly idiosyncratic conduct on the part of the foreman who was killed. I cannot discern anything Monterey could have done differently to prevent the accident. The accident occurred because of the inexplicable conduct of an experienced and safety conscious maintenance foreman who was trying to do his job and apparently believed he was doing it safely. While we recognize the Act mandates strict liability, under the peculiar circumstances of this accident no legitimate purpose would be served by penalizing the company with a penalty assessment of $1,000.

On July 23, 1981, an order was issued denying the Petitioner's May 8, 1981, motion for approval of settlement. The order stated, in part, that:

> [T]he information contained in the official case files in Docket No. WEVA 81-186 and Docket No. WEVA 80-322-R, the associated notice of contest case, presently indicates that the continuous miner operator was under the raised ripper head of the machine, and thereby exposed to danger, while under the direct supervision and control of the maintenance foreman shortly prior to the occurrence of the accident which claimed the maintenance foreman's life.

On September 1, 1981, the Respondent filed a motion for reconsideration of settlement denial stating, in part, as follows:

Respondent Monterey Coal Company respectfully submits this Motion to provide the presiding Judge with additional information about the actions of the continuous miner operator immediately prior to the accident.

As explained in the Solicitor's Motion to Approve Settlement, Monterey was cited for a violation of 30 C.F.R. 75.1726(b) after the occurrence of an accident at Monterey's Wayne Mine which killed a maintenance foreman. The information provided herewith supplements the information provided in the Solicitor's Motion to Approve Settlement.

In an effort to provide the presiding Judge with complete information with respect to the activities of the miner operator, who was helping the deceased maintenance foreman determine the location of a fluid leak under the continuous mining machine, counsel for Monterey has reviewed Monterey's transcripts of the accident investigation interviews conducted by MSHA shortly after the accident, reviewed MSHA and State of West Virginia accident reports, studied Monterey's reports of the accident and, on August 28, 1981, interviewed the miner operator who witnessed the accident, Mr. David Wilbur.

Both the Order of Withdrawal and the MSHA Form 7000-4 (Inspectors Statement) reflect the issuing inspector's belief that Mr. Wilbur was under the ripper head (the ripper head was elevated approximately 40" off the mine floor before it fell) with the maintenance foreman immediately prior to the accident. The Order of Withdrawal reads, in part:

> It was revealed during the investigation of a fatal accident, based upon sworn testimony and evidence observed at the scene of the accident that the victim and continuous miner operator were performing the work of evaluating damage sustained to the miner under the ripper head that was not blocked in an elevated position....

The inspector's statement reads, in part:

> It is worthy to note the miner operator was under the miner ripper head with the victim prior to the occurrence of the accident, in that the helper stepped out from under the head immediately prior to the accident.

Monterey believes the inspector who issued the order and who made the statement on Form 7000-4 concluded that the miner operator was under the ripper head based on the interviews

conducted of the miner operator shortly after the accident. Prior to interviewing Mr. Wilbur, the MSHA accident investigation team interviewed several other crew members who were present when the accident occurred. None of those crew members were located in a position to see what the deceased maintenance foreman and Mr. Wilbur were doing immediately prior to the accident. For instance, the repairman who disconnected a hose coupling which caused the head of the mining machine to fall testified as follows:

> DAVIS [MSHA]: Q. Did you see [Mr. Groves, the maintenance foreman] at any time prior to the accident looking in that area where the hose coupling was to be disconnected?
>
> BURRESS: A. No, sir. He was in front of the miner all the time that I was up there at the miner performing that work.
>
> * * *
>
> DAVIS: Q. Immediately prior to this accident did you verbally inform Mr. Groves and Mr. Wilbur who was working with him in front of the miner of what you intended to do in removing the hose coupling?
>
> BURRESS: A. Yes, sir. I didn't speak directly to David Wilbur, I spoke directly to John Groves, but I spoke loud enough so David Wilbur should have heard it because he was standing close to John Groves and Lemasters heard what I said to him and he was back at the jack which is probably 12'... from it.
>
> DAVIS: Q. What did you tell them exactly, do you remember?
>
> BURRESS: A. Yes, sir, I said, "John, I tightened that fitting and the leak won't stop, the oil ring's broke, I'm going to have to take the hose off to replace the oil ring and I'm afraid the head might come down because we don't trust

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> those safety valves or anything in those heads." And John says, "O.K., it'll stay there." That's exactly what he said, "O.K., it'll stay there."

A few questions later, Burress made the following statement:

> DAVIS: Q. You did not observe their location or work or whatever they were observing and so forth after you had looked up and seen Mr. Groves shining his light over top of the ripper head?
>
> BURRESS: A. No, sir, I didn't. The only way I could have seen what, you know, they might have been doing was to have quit what I was doing and walked around the edge of the head there. As far as I knew they were through because they had set all the bits, they were through setting the bits and I guessed they observed that cut place in there and wanted to get a closer look at it. That's the only thing I could figure out, it was something that wasn't planned to do, you know, they just went ahead and done it, went ahead and looked at it.

When David Wilbur was interviewed, Investigator Davis read into the investigation record a written statement prepared by Mr. Wilbur following the accident. After reading into the record part of Mr. Wilbur's account of the events leading up to the accident, the following exchange took place:

> DAVIS: [reading statement of David Wilbur]
>
> * * * "I trammed the continuous miner down the number 2 entry to its present location, which is the accident scene. Me and John Groves started removing a broken bit holder and removed a broken bit.'
>
> WILBUR: The holder wasn't broken, just had a broke bit in it. We took it out.
>
> DAVIS: Thank you. We observe that it was a bit. Now let me stop just a minute.

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As I am going through this [Wilbur's written statement], anything that should happen to come to your mind that you've forgotten or is different, you interrupt me would you?

[continuing to read Wilbur's statement] We observed that a bit had damaged the transmission gear case. Lemasters and Burress were working on the right side of the miner, that's the operator's side, replacing and [sic] "O" ring to the right head jack ("O" ring to the staplelok fitting".) John and I were up under the ripper head about one minute prior to the accident. I called out and then the head fell.'

WILBUR: No, I don't think we were all the way up under it. We were just... we were more or less leaning under. I don't know exactly how far we was up under, but we wasn't crawled up under. We more or less leaning there and kind of leaned down under it looking at it.

DAVIS: Q. But you were, were you positioned under the confines of the head itself, your body?

WILBUR: A. I guess we was, yeah, I guess we was, not all the way but we was under it.

DAVIS: Q. Partially?

[no response]

DAVIS: [continuing to read Wilbur's statement] "I called out and then the head fell (at 10:50 p.m.).'

WILBUR: I don't know if I called out then or if I was behind it, I just ain't real clear about where, I don't know if I was exact behind him or maybe to the side of him, I don't know exactly what I seen, I remember turning and calling at him, reaching for him.

DAVIS: O.K., we will proceed. [continuing to read Wilbur's statement] "John Groves

> told me as he was leaning down under the head that it was going to have to be welded up. When I seen it fall I was located to the rear of him and about three feet from him.'

Later in the Wilbur interview, the following exchange took place:

> DAVIS: Q. And, Mr. Wilbur, at the time that you were seated under the ripper head -- that was the ripper head?
>
> WILBUR: A. I didn't crawl up under it all the way, I just more or less leaned up under it, I raised up and kind of looked up under it to see what needed to be fixed.
>
> DAVIS: Q. Would that have been from the operator's side that you maybe have leaned under the ripper head?
>
> WILBUR: A. Yes.
>
> DAVIS: Q. How much did your body did you project under the head?
>
> WILBUR: A. I don't know, I don't know exactly, I just more or less looked up under it to see if it was broke, the arm was broke or just needed a bolt or, you know, something like that.
>
> DAVIS: Q. Did you position, do you recall [whether] you positioned your head or shoulder or any portion thereof up under it or just maybe your arm?
>
> WILBUR: A. I don't know, I could have had my head under it or something, I don't know.
>
> DAVIS: Q. You're not for sure though, are you?
>
> WILBUR: A. No, I'm not.

Mr. Wilbur's oral statement given to undersigned counsel on August 28, 1981, and which presumably would reflect his testimony if this matter must go to trial, confirmed his statements during the accident investigation interview.

Mr. Wilbur said that shortly before the accident occurred, he and the maintenance foreman were bending down side by side trying to locate the source of a leak under the ripper head near the chassis of the machine. He described their position as "leaning up under" the ripper head. When asked to describe his exact position when they were "leaning up under" the ripper head, Mr. Wilbur said that he believed that his head might have moved slightly under the foremost part of the ripper head, but not his body. He said that at no time was his body under the ripper head. When asked whether he would have been killed or injured if the ripper head had fallen when he was in that position, Mr. Wilbur said that he wasn't sure but that it was possible that his head would have been grazed. Immediately prior to the accident, Mr. Wilbur moved back a short distance from the ripper head; Mr. Groves, the deceased, apparently decided to crawl up and get a closer look at the leaking transmission case when the head fell on him.

From the series of events which occurred immediately prior to the accident, it is clear that the maintenance foreman believed that the ripper head had a check valve which would prevent it from falling. No "work" in the usual sense of the word was being performed under the ripper head by the maintenance foreman or by Mr. Wilbur. Instead, the two of them were simply trying to figure out where a leak was coming from. The maintenance foreman apparently wanted a closer look, so he crawled under the ripper head to see better, Mr. Wilbur was standing close by awaiting his report. At that moment several feet away, Mr. Burress disconnected a hose on the mining machine which released enough hydraulic pressure to cause the ripper head to fall on Mr. Groves. Mr. Wilbur was not injured.

Monterey believes the facts set forth above are accurate. Monterey also believes that it would serve little purpose to assess a high civil penalty to deter it from future violations of this nature. As recognized by the MSHA investigation team (and stated specifically on the Inspector's statement), Monterey had a specific company rule which prohibited work on raised equipment unless it was blocked and had repeatedly instructed its maintenance personnel to that effect both orally and in writing. Material to block the ripper head was located nearby the scene of the accident. The deceased maintenance foreman was described by both crew members and the company as being highly skilled and safety conscious. He obviously believed that the ripper head had a check-valve which would not permit the ripper head to fall, and said so specifically to Mr. Burress, who was preparing to disconnect the hydraulic hose.

> Given all these circumstances, Monterey believes there would be nothing gained by going to trial to explore the uncontested facts associated with this accident. In its view, the only issue in such a proceeding would be the amount of civil penalty that should be assessed based on the six statutory factors under 110(i) of the Act. The two most important factors in this case are gravity and negligence. The gravity of the violation is clear: a fatality occurred. Negligence is the remaining factor and Monterey believes it is the sole factor for consideration in this case. The Congressionial purpose for requiring assessment of civil penalties on a strict liability basis is to deter future violations and to remind operators of the high degree of care owed the miners. Monterey is well aware of its obligation to the miners and the requirement of complying with the mandatory standards under the Act. No violation of this nature had occurred at the mine before, according to MSHA's computer records. Monterey had a specific and communicated rule prohibiting the activity which killed the maintenance foreman. The deceased foreman was experienced and had been thoroughly trained. He made a mistake and paid for it with his life.
>
> Under these circumstances, Monterey believes that the amount agreed to by MSHA and by Monterey is appropriate and consistent with the public interest. It is the presiding Judge's duty to assure that a settlement was not reached for improper reasons violative of the Mine Safety Act's objectives. Davis Coal Co., 2 FMSHRC 619 (1980). Monterey believes the facts presented justify approval of the settlement as consistent with the objectives of the Act.

The foregoing statements did not materially change the foundation upon which the determination was made that the proposed $500 settlement could not be approved. Therefore, an order was issued on September 2, 1981, denying the Respondent's motion for reconsideration of settlement denial.

On September 8, 1981, the Petitioner filed a motion requesting approval of a $1,000 settlement. The motion states, in part, as follows:

> Following the Administrative Law Judge's Order Denying Respondent's Motion for Reconsideration of Settlement Denial, issued on September 2, 1981, counsel for the parties discussed this matter anew on September 3, 1981.
>
> The Respondent has now proposed that these matters be resolved by the full payment of the original assessment in this matter, and the voluntary withdrawal of their notice of contest proceeding (WEVA 80-322-R) upon approval of the resolution of the civil penalty proceeding.

As the terms of the proposed settlement have been changed, the Secretary now submits this new proposal for settlement.

The reasons given above by counsel for the parties 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 $1,000 settlement. It therefore appears that a disposition approving the settlement will adequately protect the public interest.

ORDER

Accordingly, IT IS ORDERED that the proposed $1,000 settlement, as outlined above, be, and hereby is, APPROVED.

IT IS FURTHER ORDERED that the March 2, 1981, order consolidating the proceedings in Docket Nos. WEVA 80-322-R and WEVA 81-186 for hearing and decision be, and hereby is, DISSOLVED.

IT IS FURTHER ORDERED that the Respondent, within 30 days of the date of this decision, pay the agreed-upon penalty of $1,000 assessed in this proceeding.

John F. Cook
Administrative Law Judge

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~FOOTNOTE_ONE

The fatal accident investigation report prepared by the Mine Safety and Health Administration states that the accident occurred on March 17, 1980.