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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. VA 81-51-M  
A.O. No. 44-03995-05007F

v.

Culpepper Plant

A. H. SMITH STONE,  
RESPONDENT

DECISION

Appearances: David T. Bush, Attorney, Office of the Solicitor, U.S.  
Department of Labor, Philadelphia, Pennsylvania, for the  
petitioner  
Wheeler Green, Safety Director, A. H. Smith Stone,  
Branchville, Maryland, for the respondent

Before: Judge Koutras

Statement of the Case

This proceeding concerns a proposal for assessment of civil penalty filed by the petitioner against the respondent pursuant to section 110(a) of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. 820(a), charging the respondent with one alleged violation pursuant to the Act and the implementing mandatory safety and health standards. Respondent filed a timely answer in the proceeding and a hearing was held on November 5, 1981, in Falls Church, Virginia, and the parties appeared and participated therein. The parties waived the filing of posthearing proposed findings and conclusions, but were afforded the opportunity to make arguments on the record and those have been considered by me in the course of this decision.

Issues

The principal issues presented in this proceeding are (1) whether respondent has violated the provisions of the Act and implementing regulations as alleged in the proposal for assessment of civil penalty filed in this proceeding, and, if so, (2) the appropriate civil penalty that should be assessed against the respondent for the alleged violation based upon the criteria set forth in section 110(i) of the Act. Additional issues raised by the parties are identified and disposed of in the course of this decision.

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In determining the amount of a civil penalty assessment, section 110(i) of the Act requires consideration of the following criteria: (1) the operator's history of previous violations, (2) the appropriateness of such penalty to the size of the business of the operator, (3) whether the operator was negligent, (4) the effect on the operator's ability to continue in business, (5) the gravity of the violation, and (6) the demonstrated good faith of the operator in attempting to achieve rapid compliance after notification of the violation.

#### Applicable Statutory and Regulatory Provisions

1. The Federal Mine Safety and Health Act of 1977, Pub. L. 95-164, 30 U.S.C. 801 et seq.
2. Section 110(i) of the 1977 Act, 30 U.S.C. 820(i).
3. Commission Rules, 29 C.F.R. 2700.1 et seq.
4. 30 C.F.R. 56.4-35 provides as follows: "Mandatory. Before any heat is applied to pipelines or containers which have contained flammable or combustible substances, they shall be drained, ventilated, thoroughly cleaned of residual substances and filled with either an inert gas or, where compatible, filled with water."

#### Stipulations

The parties stipulated to the following:

1. A. H. Smith Stone owns and operates the Culpeper Plant.
2. A. H. Smith Stone and the Culpeper Plant are subject to the Mine Safety and Health Act of 1977.
3. The Administrative Law Judge has jurisdiction over this proceeding.
4. Citation No. 309243 was properly served upon A. H. Smith Stone by Carl Liddeke and may be admitted into evidence to show its issuance and not for the relevancy or truthfulness of the statements contained therein.
5. The size of A. H. Smith Stone is as follows: 167,966 annual production tonnage; 17,462 annual production tonnage for the Culpeper Plant.
6. Prior to the issuance of the subject citation, the operator had a history of eight assessed violations.

#### Discussion

Citation No. 309243, November 26, 1980, alleged the following:

An employee was critically injured on November 24,

1980, at about 1:53 p.m. by an explosion and resulting  
fire when he

attempted to cut a fifty-five gallon oil drum with a Victor C-1400 cutting torch. The oil drum had contained Exxon XD3-30 engine lubricating oil, but was considered empty. The fill plugs had not been purged of fumes or filled with an inert gas or water.

Action to terminate: "All employees were instructed in the proper procedures to use when cutting or welding containers that have had flammable liquids."

#### Testimony and Evidence adduced by Petitioner

MSHA inspector Carl W. Liddeke testified that he issued the citation in question after he conducted an investigation on November 25, 1980, the day after the accident. He spoke with employee Henry K. Nicholson and Superintendent Lonnie Fields about the accident. He observed a 55-gallon oil drum that had the bottom blown out of it. It appeared that the drum had exploded when a cutting torch had been applied to it. Mr. Liddeke stated that Mr. Fields had told him that he was unaware of any permission given to an employee to cut the drum. Since Mr. Fields also stated that he had no knowledge that the injured employee, actually cut the drum, he determined that there was no negligence. Mr. Liddeke then testified that his opinion had changed regarding the operator's degree of negligence, since subsequent to his investigation, he received conflicting statements from the victim's wife (Rachael Morton) regarding knowledge on the part of the operator. Mr. Fields had told him that employees frequently took barrels for their own use, and Mr. Liddeke stated that the barrels are normally emptied and stored without being purged (Tr. 17-30).

On cross-examination, Mr. Liddeke stated that the respondent was negligent because the accident happened on company property during working hours. He also testified that he knew from the conversations he had with the employees that the company had cut oil drums, but he did not know whether any instructions for cutting the barrels had been given to the employees (Tr. 30-31, 53-54).

In response to bench questioning, Mr. Liddeke stated that the employees could have the barrels by merely asking for them. Mrs. Morton had learned from Mr. Fields that her husband had asked for the barrel which later exploded. He testified that normally the barrels are not purged of liquid before they are stored, and he confirmed that the only barrel he examined and tested was the one Mr. Morton had tried to cut. He determined that an explodable liquid was present since the barrel ignited when a torch was applied to it. He felt that if the barrel had been purged of the flammable liquid, it would not have exploded. Furthermore, part of the barrel had been sent to a state laboratory which showed that a petroleum distillate-type material was present (Exh. ALJ-1; Tr. 31-37).

Mr. Liddeke testified that Mr. Morton intended to use the barrel as an oil-drain pan for his personal tractor, and that Mr.

Fields told him that

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sometimes barrels were used to transport diesel fuel to vehicles. Also, they often were cut and used as garbage cans, but Mr. Liddeke could not recall seeing these barrels used in these ways (Tr. 38-49).

Henry K. Nicholson, who was a loader operator at A. H. Smith Stone at the time of the accident, testified that he is presently employed as a correction officer by the State of Virginia. He had been an employee of A. H. Smith Stone for 3 years and on the day of the accident he was using a welder and a torch to construct a rack on which to store tools. Mr. Nicholson testified that Mr. Morton came to him in his work trailer to ask whether he could use a torch later on that day to cut a barrel so that he could drain oil at his house. Mr. Nicholson stated that Mr. Fields would let employees have these barrels if they asked for them. Mr. Morton had always asked permission to take the barrels and Mr. Nicholson remembered seeing him use a torch on them in the past. After obtaining permission, Mr. Morton returned to the trailer and took the torch. Mr. Nicholson stated that the next thing he heard was an explosion and then he saw Mr. Morton on fire. Looking at the barrel afterwards, he could tell that a torch had been applied to it (Tr. 54-58, 59-60).

On cross-examination, Mr. Nicholson testified that Mr. Fields had instructed the employees as to how barrels should be cut. Plugs were to be taken out and the barrels allowed to ventilate, after which they should be filled with water and rinsed out. After this procedure was completed, if the barrels were to be used as trash cans, they could be torched. Mr. Nicholson stated that the barrel which exploded still had a plug in it, so no air could get in. He also indicated that the normal storage area for barrels was behind the trailer. The antifreeze barrels were returnable but he was not sure whether the Exxon barrels were returnable. Sometimes empty oil drums were refilled to transport fuel. The barrel that exploded had contained Exxon motor oil for the loaders and dozers (Tr. 58-59, 60-63).

Mrs. Rachel Morton, wife of the accident victim, testified that her husband had taken company barrels before and used a torch on them. She stated that she spoke with Mr. Fields in the hospital on Thanksgiving Day and he had told her that her husband had asked specifically for the barrel and that Mr. Fields told him that he could use a torch on it as long as it would not interfere with Henry Nicholson's job. Mrs. Morton stated further that during her hospital visit she repeatedly asked her husband whether he had asked permission to take a barrel and cut it with a torch. Although he could not speak at the time, he nodded affirmatively. Her husband also indicated that he had checked to see whether anything was in the barrel (Tr. 63-67).

On cross-examination, Mrs. Morton testified that Mr. Morton brought the barrels home for various uses. She knew that he always asked Mr. Fields for them, and had observed Mr. Morton cut these barrels at home (Tr. 67-69).

Ms. Sarah C. Honenberger testified that she was retained by

Mrs. Morton to determine whether she was entitled to any insurance or workmen's compensation benefits as a result of Mr. Morton's death after the accident in



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question. She stated that Mrs. Morton has received all available benefits and has no present claims against the company. She testified that she had spoken with Mr. Fields regarding the circumstances surrounding the accident in order to know how the company would report it to the state industrial commission. Mr. Fields stated that Mr. Morton had asked for a barrel to take home as this was his usual practice. After the accident, Mr. Nicholson advised him that Mr. Morton had borrowed his welding torch (Tr. 70-73).

On cross-examination, Ms. Honenberger testified that she did not recall Mr. Fields stating that he specifically told Mr. Morton to use a cutting torch on the barrel. The only purpose of her conversation with Mr. Fields was to determine whether Mr. Morton's activities were work-related (Tr. 73-74).

#### Testimony and Evidence Adduced by Respondent

Lonnie Fields, superintendent at A. H. Smith Stone at the time of the accident, testified that Mr. Morton had asked permission to take the barrel in question, and he assumed Mr. Morton would take it home. Mr. Morton did not ask to use the torch although he had used it before. Mr. Fields stated that he had no knowledge that Mr. Morton was going to use the torch, but he had instructed him in the past on torching barrels, telling him to remove the plugs and to check whether anything remained inside. This was part of A. H. Smith Stone's regular safety program in which all regulations were discussed. Mr. Fields indicated that the employees knew that Exxon takes back empty drums (Tr. 75-82).

On cross-examination, Mr. Fields stated that there was no doubt Mr. Morton had used a torch on the barrel on the day in question as he had used a torch on them in the past. On this particular day, however, Mr. Fields assumed that he was taking the barrel home with him for his own use. Mr. Fields gave him no instructions to cut it for some specific purpose, and he admitted that he would probably have given Mr. Morton permission to cut the barrel on company time since Mr. Morton had always taken proper safeguards and purged the barrels. Mr. Fields indicated that all the barrels were stored outside in a trailer. He stated that the empty drums still had the plugs in because they were returnable and the company wanted the used ones (Tr. 83-90).

#### Findings and Conclusions

##### Fact of Violation

Upon examining the evidence of record and considering the testimony elicited at the hearing, I have made the following factual conclusions regarding the events leading to the accident of November 24, 1980. Mr. Morton asked Mr. Fields for one of the empty Exxon oil barrels which were stored behind the trailer waiting to be picked up by the oil company. It was Mr. Fields' practice to allow the barrels to be taken by the employees if they asked permission for them. On this particular day, Mr.

Fields assumed

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that Mr. Morton would take the barrel home for his personal use. After asking for the barrel, Mr. Morton then obtained a torch from Mr. Nicholson. Mr. Nicholson had seen Mr. Morton use a torch on the barrels before. Mr. Morton then took the torch outside, applied it to the barrel, and caused an explosion which resulted in fatal injuries. The explosion was the result of a flammable liquid which was in the barrel, and the investigation after the accident indicated that the plug in the barrel had not been removed and the barrel had not been ventilated or rinsed out.

The employees at A. H. Smith Stone were sometimes ordered to cut the barrels with a torch to make trash cans for the company's property. The employees had been instructed in the proper procedure for purging the barrels. They were supposed to take the plug out of the barrel and allow it to ventilate. After it was rinsed out with water, it could be torched.

There is no question that a violation of 30 C.F.R. 56.4-35 took place. The evidence indicates that Mr. Morton applied a torch to a container which had contained combustible or flammable oil without draining, ventilating, and cleaning the barrel. After the explosion, the barrel was examined revealing that the plug was still intact. An examination of the plug revealed a residue of the fuel oil which had been in the barrel (Exh. ALJ-1). All the parties agree that the barrel would not have exploded if it had been properly cleaned and drained. Accordingly, there was a violation of the cited mandatory safety standard and the citation is AFFIRMED.

#### Gravity

The presence of empty oil drums which contained residue of the oil, together with a practice of using cut-off drums as garbage cans, presented a hazardous situation since torches were used on the drums. As indicated here, the danger is extremely serious, since an explosion is likely to result when a torch is applied to an unclean barrel. Here, Mr. Morton suffered serious burns which eventually led to his death. Accordingly, I find this violation to be very serious.

#### Negligence

The inspector originally made a finding of no negligence because the oil drum was cut without the operator's knowledge. At the hearing, MSHA counsel stated that based on newly uncovered evidence, it was revealed that the operator was negligent and this negligence resulted in the accident and death of Mr. Morton.

The facts in this case indicate that the barrels were stored in an accessible location near the trailer on the property. Although these empty barrels were returnable and sometimes picked up by the oil company, it was not an unusual practice for the barrels to be taken by the employees or used on the property. Management was liberal in granting permission to take these empty barrels. Management had also in the past instructed employees to

cut the barrels into trash cans by using a torch. The employees had been told to

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take the plugs out of the barrels and to ventilate them before cutting them. Therefore, it was not unforeseeable that an employee who asked permission for a barrel might use a torch on it. In fact, Mr. Fields stated that he probably would have given permission to Mr. Morton to cut the drum on company time (Tr. 87). It is fair to assume then that the operator knew or should have known that there was a likelihood that Mr. Morton would use a torch on the oil drum in question.

Respondent has raised the argument that since Mr. Morton was negligent in not removing the plugs from the oil drum prior to applying the torch, the operator should not have been found negligent. This is based on the premise that since the employees had been instructed in the proper and safe way to purge a barrel before torching it, the operator had fulfilled its responsibility.

I conclude that respondent knew or should have known of the possibility of an employee using a torch on a barrel before purging it. See *Secretary of Labor v. Heldenfels Brothers, Inc.*, 2 FMSHRC 851 (1980). I find that the events of November 24, 1980, were highly foreseeable because employees often took barrels, and using torches on them was not an uncommon practice. Knowing this, respondent should have taken extra precautions to insure that all barrels were purged. Since the consequences of an employee putting a torch to a barrel containing oil residue could predictably result in an explosion resulting in serious or fatal injuries to one or more people, the duty of the operator is much greater. While Respondent did attempt to instruct the employees as to the proper procedure for purging barrels, management could have been more diligent in its attempts to insure that all barrels were properly ventilated and cleaned. It could have required that every barrel be ventilated and cleaned as soon as they were empty and before they were stored behind the trailer. By not doing so, the operator took the risk that someone might torch a barrel before taking all the necessary steps to clean it. Mr. Morton's conduct was "not aberrational or unforeseeable, but ordinary human error that stemmed from a lack of safety consciousness." See *Secretary of Labor v. Warner Company*, 2 FMSHRC 972, 973 (1980). Accordingly, I conclude and find that the respondent was negligent for not foreseeing Mr. Morton's conduct and taking action to prevent a possible accident.

This situation is not analogous to the facts of *Secretary of Labor v. Nacco Mining Company*, 3 FMSHRC 848. There the Commission found the operator not negligent for the acts of the foreman where the foreman proceeded alone past the last row of permanent supports under loose, unsupported roof where a large rock fell on him causing the injuries from which he later died. The Commission ruled that "where an operator has taken reasonable steps to avoid a particular class of accident and the erring supervisor unforeseeably exposes only himself to risk, it makes little enforcement sense to penalize the operator for "negligence." 3 FMSHRC at 850. But here the employee's conduct and subsequent accident were foreseeable and I have found that the operator did not take all reasonable steps to insure that the

barrels were properly drained and cleaned. Therefore, the operator was negligent.

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In considering the degree of negligence to be imposed for this violation, I have taken into account the fact that the operator had instructed the employees in the proper cleaning procedures. While these efforts were inadequate to fulfill the operator's duty of care for avoiding an accident, I cannot conclude that the record in this case supports a finding that the operator was grossly negligent. I find that the operator did not exercise reckless disregard of mandatory health and safety standards or recklessly or deliberately fail to correct an unsafe condition or practice which was known to exist.

#### Good Faith Compliance

On the facts of this case it is clear that abatement took place by means of the post-accident instructions to all employees concerning the proper procedures and safeguards when cutting or welding containers that have contained flammable or combustible materials. Inspector Liddeke found that the violation was abated within a reasonable time and the respondent complied with the instructional requirements of the abatement. Thus, it is clear that the respondent exhibited good faith in the abatement requirements imposed by the inspector. However, some comment is in order with regard to the language of section 56.4-35, and these follow below.

In my view, the inspector should have considered requiring the respondent to purge all empty oil drums which remained in storage on respondent's property after the accident in question so as to preclude another unfortunate accident. Hopefully, as a result of this incident, the respondent will insure that steps are taken to purge all such oil drums so as to render them safe while in storage or awaiting shipment to the supplier. Further, I suggest that MSHA consider the possibility of amending the standard to specifically require that all such flammable containers be purged and rendered safe. The regulatory language "[B]efore any heat is applied" leaves much to the imagination and whim of any employee who may put a torch to an oil drum which may or may not have been purged of flammable or combustible residue. By requiring this to be done as soon as the drum is empty and stored on company property where it is readily available to anyone would eliminate any uncertainty.

#### History of Prior Violations

The parties stipulated that prior to the issuance of the subject citation, the operator had a history of eight violations. This indicates that respondent has a good record with respect to safety and I have considered this in assessing a civil penalty.

#### Size of Business and Effect of Penalty on the Respondent's Ability to Remain in Business

The parties stipulated that A. H. Smith Stone produces 167,966 annual tons and 17,462 tons is produced at the Culpepper Plant. I find that this is a small operation and that fact is reflected in the penalty assessed. The penalty will not

adversely affect its ability to remain in business.



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Penalty Assessment and Order

On the basis of the foregoing findings and conclusions, and taking into account the requirements of section 110(i) of the Act, I conclude and find that a penalty assessment in the amount of \$1,000 is reasonable and appropriate for the citation which I have affirmed, and the respondent IS ORDERED to pay the assessed penalty within thirty (30) days of the date of this decision and order.

George A. Koutras  
Administrative Law Judge