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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. WEVA 81-24 A/O No. 46-05769-03011F
v.	Deep Ford No. 1 Mine
LOGAN-MOHAWK COAL COMPANY, INC., RESPONDENT	
AND	
H.M.N. & S. COAL COMPANY, INC., PARTY RESPONDENT	

DECISION APPROVING SETTLEMENT

ORDER TO PAY

The Solicitor has filed a motion to approve a settlement in the above-captioned proceeding. The original assessment for the alleged violation of 30 CFR 75.200 was $10,000. The proposed settlement is $500.

The citation in question provides as follows:

> The roof control plan was not being followed in the No. 2 entry working place on the No. 1 unit (001-0), in that the plan stipulates that a minimum of six temporary roof supports shall be installed prior to roof bolting. Evidence indicated and statements received by the eyewitnesses to the accident revealed that Lewis M. Craddock, Foreman, was installing roof bolts in an area known to contain loose roof without the use of temporary roof supports, which resulted in a fatal injury to Craddock. Also, reflectors were not being used to indicate that places had not been bolted.
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> It was further revealed that a practice of using only three to four temporary roof supports during roof bolting operations prevailed at this mine on the No. 1 unit (001-0), second shift. Also, the investigation revealed that personnel required to install roof supports were not adequately trained to insure that such persons are familiar with the functions of the support being used and proper installation procedures.

The circumstances surrounding the violation are summarized in the "Commentary" portion of MSHA's investigation report as follows:

> At 3:15 p.m., Monday, December 31, 1979 the No. 1 section crew, under the supervision of Lewis M. Craddock, Foreman (victim), entered the mine and walked to the active working areas of the section. According to Mark L. Taylor, electrician, after an examination of the working areas was made by Craddock (victim), normal operations began and continued until the accident occurred. Taylor explained that Craddock assisted him in repairing the No. 4 shuttle car trailing cable. Shortly thereafter, Taylor stated that the No. 2 shuttle car became inoperative and while making repairs to the car, he (Taylor) noticed Craddock walking towards the working faces. Taylor stated that shortly thereafter he heard the roof bolting machine being operated. According to Taylor, after completing the repairs to the shuttle car, he proceeded to the No. 2 entry face where Craddock was operating the roof bolting machine. Taylor stated that Craddock (victim) was in the process of installing the second row of roof bolts when he (Taylor) noticed that there were no temporary roof supports installed in the place. Taylor continued to state that Craddock instructed him to assemble some additional roof bolts for the completion of the bolting cycle. According to Taylor, he went to the back of the roof bolting machine to assemble the bolts when the roof fall occurred.
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> Taylor stated that he ran around the machine and attempted to lift the rock from Craddock. Being unsuccessful, Taylor explained that he summoned assistance from the other miners in the section. Craddock was removed from under the rock, placed on a stretcher, and transported to the surface where he was taken to the Man Appalachian Regional Hospital. Craddock expired at 8:10 p.m.

After setting forth the foregoing, the Solicitor's motion explains that the operator should not be found negligent for the following reasons:

> The victim's behavior could not have been anticipated by the Respondents for three reasons. First, as was revealed in MSHA's investigation, Foreman Craddock's actions on the day of his death were an aberrational departure from his normal behavior. Craddock had a reputation as a very safety conscious miner. As is reflected in the inspector's statement prepared by MSHA's accident investigator, Craddock would not permit crew members to bolt roof without the use of temporary supports. He had the necessary temporary supports available to perform the job; however, he failed to use them. Second, Craddock's behavior could not have been anticipated because at the beginning of the shift on which the fatality occurred, the mine superintendent told Craddock to limit the activity of his shift to loading coal in four entries. He told Craddock to leave all roof bolting work for the midnight shift. Third, as was normally the case on the afternoon shift, there were no supervisory employees other than Craddock who were at the mine when the accident occurred.

The Solicitor further explains that other conditions set forth in the order in addition to the failure to set temporary roof supports are not especially significant, stating in this respect:

> The cause of the accident was Craddock's failure to have temporary roof supports in place while he was roof bolting. As the citation indicates, other apparent violations of the roof control plan were discovered during the investigation. The first is that reflectors were not being used to identify places in the mine where roof bolts had not been installed. In the context of Respondent's operations, this infraction was technical in nature because there was only one mining crew and it was advised at the beginning of the shift as to areas which were not bolted. MSHA also charged that a "practice" of using three to four temporary roof supports "prevailed" at the mine on the second shift. The investigation simply revealed that one individual, a roof bolter helper, had on some occasions prior

> to the accident set only four, or as few as three jacks. This individual knew that six jacks were required by the roof control plan, and would only set fewer jacks when he was concerned about prolonged exposure to unbolted roof. On those occasions when he did set four jacks, he set them in a manner which he felt was safer than the six jack pattern. Finally, MSHA alleged that this employee was not adequately trained in the requirements of the roof control plan. In fact, two days prior to the accident the safety director for the mine had presented a full day of roof control training, which included a film on the need for the use of temporary roof supports. According to the mine superintendent, this employee was extremely nervous during his interviewing session. All of the employees interviewed were aware of the roof conditions at the mine and stated that management constantly made them aware of the roof conditions.

The Solicitor cites Nacco Mining Company 2 FMSHRC 1272 (April 29, 1981) affirming VINC 76X-99 (December 17, 1976) as a basis for his position that in this case the operator was not negligent. In Nacco a section foreman, while supervising two miners who were cutting the roof belt trench, 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. There were no temporary supports in that location and the foreman was not installing temporary supports or inspecting the roof prior to such installation. In that case, I found that the gravity of the violation was very serious but that the operator was not negligent under the circumstances because it had not been remiss in selecting and training the foreman who previously had exercised good judgment. I further found the operator should not be held responsible for negligence which was part of the unexpected and inexplicable behavior of its foreman whose actions created the potential of harm only to himself but not to any of the miners working under him. In affirming, the Commission stated:

> Where as here, 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." Such an approach might well

> discourage pursuit of a high standard of care because regardless of what the operator did to insure safety, a negligence finding would automatically result. We therefore approve the judge's finding of no negligence.

The facts in the instant case support the Solicitor's assertion that this case involves a well-trained foreman with a reputation as a very safety conscious miner who unexpectedly endangered himself without jeopardizing any member of his mining crew. As the Solicitor points out, reference to the photograph in the investigation report reveals that the electrician who came onto the scene just prior to the fatal accident was well back from the danger zone in his position behind the roof bolting machine. According to the Solicitor, the electrician was in that location because the foreman told him to stay back there because the roof was bad.

In light of the foregoing, I accept the Solicitor's position that this case is governed by Nacco. In Nacco I assessed a $500 penalty which was approved by the Commission. That penalty amount which is the recommended settlement here, also comports with the other statutory criteria. The recommended settlement is therefore, approved.

ORDER

The operator is ORDERED to pay $500 within 30 days from the date of this decision.

Paul Merlin
Chief Administrative Law Judge