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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-RESPONDENT

v.

SCOTIA COAL COMPANY,
RESPONDENT-APPLICANT

Civil Penalty Proceedings

Docket No. BARB 78-609-P
Docket No. BARB 78-609-P(B)
Docket No. BARB 78-610-P

Applications for Review

Docket No. BARB 78-306
Docket No. BARB 78-307
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DECISION AND ORDER

In the aftermath of the twin methane gas explosions of March 9, 11, 1976 that took the lives of 23 miners and 3 mine inspectors at the Scotia Mine in Overfork, Letcher County, Kentucky, the Secretary of the Interior cited Scotia Coal Company, a wholly owned subsidiary of Blue Diamond Coal Company, Knoxville, Tennessee for 71 violations of the Federal Coal Mine Health and Safety Act of 1969. (FOOTNOTE 1) Two years later, civil penalties were assessed in the amount of \$266,404.

The 43 less serious violations were settled in December 1980 for \$33,400, subject to approval of the trial judge. By order of February 25, 1981, the trial judge, with the

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consent of the parties, increased the settlement amount to \$36,400 and dismissed these 43 charges.

The 28 captioned review-penalty proceedings cover the 15 conditions and practices believed by the Secretary to have contributed directly to the lethal accumulation of methane gas and the ignition that caused the first explosion, (FOOTNOTE 2) plus one combustible and 12 electrical violations uncovered during the course of the departmental investigation that were believed to be indicative of a pervasive indifference to safe mining practices.

These 28 unwarrantable failure to comply violations were initially assessed at \$230,500. On Thursday, November 12, 1981, the parties entered into a settlement agreement under which Scotia offered to pay the lump sum of \$200,000, or 87% of the amount initially assessed, which sum was allocated by the Secretary in accordance with his evaluation of the "individual meaning and collective significance of the violations" for the 1976 disaster.

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The sum offered in settlement will be the largest ever paid by a mine operator for civil penalties assessed as the result of a single coal mine disaster. (FOOTNOT 3)

Except as other indicated, my evaluation and allocation of the \$200,000 accords with that recommended by the Secretary.(FOOTNOT 4)

I fully concur in the Secretary's overall evaluation of the gravity of these violations, namely, that "When viewed in the light of the underlying mine practices and the events of March 9, 1976 . . . the violations, individually and collectively are seen as extremely grave, occurring through culpable negligence, the products of reckless management attitudes and a method of operation which demonstrated indifference to federal safety standards."(FOOTNOT 5)

I.

A.

For the 15 contributory violations, which include the six violations covered by the pending criminal indictment, (FOOTNOT 6) the Secretary assessed the maximum statutory amount of \$10,000 each, finding that "The violations cannot be viewed in isolation, but must be considered within the context of mine management's attitude, which condoned and even fostered the simultaneous existence of so many serious, related violations. The deadly interaction of these violations produced the tragic results."

I concur in this finding and in the Secretary's further finding that:

The ultimate illustration of the destructive reinforcement of related violations occurred in the explosion area of 2 Southeast Main. To begin with, Scotia failed to comply with its approved Ventilation Plan when starting the 2 Left Section off 2 Southeast Main. Ventilation in the area was questionable, at best, and had not received MESA approval, although Scotia knew that such approval was required. (The proposal, had it been submitted, would not have been approved.) Production in 2 Left Section should have proceeded only after positive, permanent ventilation controls had been installed. By using a makeshift temporary curtain before it completed construction of overcasts, Scotia ignored prudent ventilation methods, as well as federal standards, for the sake of a short-term production gain -- a gain as it turned out, achieved at a terrible price.

Even assuming (as Scotia claims) a check curtain was hung at the intersection of 2 Left Section with 2 Southeast Main, the lack of permanent ventilation controls at that point created the potential for a dangerous short-circuit of intake air and a ventilation "dead end" at the inby end of 2 Southeast Main. If the check curtain was installed, it was reportedly maintained in such a haphazard manner as to provide little, if any, ventilation control, thus enhancing the potential for a short-circuit of air. Then, the night before the explosion occurred, plastic curtains were hung in the Nos. 4 and 5 entries (the intake aircourses) of 2 Southeast Main inby the 2 Left Section, thus aggravating the risk of methane accumulation in the area.

Another violation of Scotia's Ventilation Plan, together with another ventilation dead end was found at the inby end of Northeast Main. The Secretary assessed maximum penalties for these violations as well as for a violation which charged that on March 1, 1976, Scotia knowingly submitted to MESA a

mine map which concealed those conditions and compounded the hazards created by the violations of Scotia's Ventilation Plan. When considered in the context of Scotia's pattern of violations, I find this action fully warranted.

B.

To its hazardous ventilation practices, the Secretary found Scotia added a reckless indifference to its obligation to inspect and examine idle or dead end areas for explosive accumulations of methane gas. Another violation maximally assessed charged that on the morning of March 9, 1976, the dead end area of 2 Southeast Main, an area which had been idle since February 9, 1976, was not examined for a deadly methane accumulation prior to the time two miners were ordered to haul a load of steel rails into the area using two locomotives with electrical connections capable of causing an incendive spark. (FOOTNOT 7) The Secretary's evaluation, in which I concur, states:

Scotia's failure to examine 2 Southeast Main inby 2 Left Section on March 9, 1976, is particularly glaring since management knew that the entire 2 Southeast Main, including 2 Left Section, was being ventilated in violation of Scotia's approved Ventilation Plan, and the potential existed for a dangerous short-circuit of intake air and a ventilation "dead end".

* * * * *

. . . the management foreman who ordered the workmen to enter the area had a duty to verify that the area had been examined before the miners

were to enter, or that the workmen were qualified and equipped to make such examinations. The failure to so verify or to have the examinations done constituted an unwarrantable failure on the part of mine management to comply with the standards, especially in view of the specific knowledge of management that the ventilation system in the 2 Southeast Main area posed a potential for methane accumulation inby 2 Left Section. When the violation of Order No. 4 LDP is viewed in context with other major violations also present, this management failure to grasp the last chance to avoid culmination of the hazards it had created, starkly illustrates Scotia's reckless indifference to federal safety standards.

Violations of the preshift examination (methane checks) requirement were found in three of the five working sections of the Scotia Mine. The Secretary's view, in which I concur, was that:

Taken together, and along with other examination violations, these violations reflect clear indifference to safety. Buttressing this disturbing conclusion is the evidence that Scotia employed only one regular fireboss to make the preshift examinations required to be performed in the widely-dispersed working sections within three hours before beginning the 7:00 a.m., day shift. This employee's normal work shift ended at 5:00 a.m., allowing only one hour of regular work time (between 4:00 a.m. and 5:00 a.m.) to perform all the examinations required before the day shift began.

C.

The constraints on the time and availability of a Fireboss resulted in a charge that it was allegedly the practice of the Fireboss to certify to preshift examinations that were not made or certainly not made by him. It was, of course, the alleged failure to make preshift or onshift methane

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checks in the idled section (the dead end) of 2 Southeast Main that set the stage for the explosion that occurred when the two locomotives came to a stop at the 31st crosscut at 11:45 a.m., Tuesday, March 9, 1976.

The final ingredient of the lethal mix that resulted in the disaster of March 9 was introduced when the Scotia mine's underground construction foreman arranged to have a motor crew pick up a load of rails with the Nos. 6 and 8 battery-powered locomotives for delivery to the dead end of 2 Southeast Main. This was the area in which ventilation had been totally blocked for six or seven hours on the evening shift the day before by the installation of check curtains across the Nos. 4 and 5 (intake air) entries.(FOOTNOT 8)

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Although ventilation of some sort was restored around midnight on March 8, it was inby this ventilation stoppage that an explosive concentration of methane occurred before 11:45 a.m., March 9. To my mind the intentional interruption of the air flow into an area known to liberate explosive concentrations of methane gas was an act of reckless endangerment that finds no excuse in the claimed negligence of MESA in failing to detect the action. For these reasons, I fully concur in the assessment of maximum penalties for these violations.

D.

When high enough concentrations of methane gas, 5 to 15 percent, in an underground coal mine are associated with inadequate ventilation and an ignition source, a violent coal mine explosion is very likely to occur.(FOOTNOT 9)

According to the Secretary the "evidence is conclusive" that the ignition source in the case of the first explosion was on one of the battery-operated locomotives, and most likely the No. 6, (Goodman) locomotive. As the Secretary points out, "The evidence, which includes positive laboratory tests demonstrates that, on or within each locomotive, there were several potential ignition sources for an explosive methane-air mixture."

In the case of the No. 6 (Goodman), locomotive, the Secretary claims a "copper wire 'bridge' was deliberately inserted in order to reactivate the circuit after the fuse element had broken." In the case of the No. 8, (Westinghouse) locomotive the Secretary's representatives claimed they "observed that electrical connections to the terminals of the locomotive batteries and between the batteries themselves, were neither mechanically nor electrically efficient, a condition chiefly due to the absence of suitable connectors."

Neither of these violations, however, is believed by MSHA's experts to have been "the actual cause of the spark which ignited the methane gas of March 9." What the experts hypothesize is "that the accumulated methane gas was ignited by the arcing created by the open-type controller on the No. 6 Goodman locomotive when the controller was turned to the 'off' position by the locomotive operator after reaching his destination at the inby end of 2 Southeast Main."

The controller, of course, is the device on electrically-powered locomotives that regulates speed and direction. Counsel for the Secretary suggests that the absence of a permissible, explosion proof controller on the No. 6 locomotive was not a violation because it was not taken inby the last open crosscut of 2 Southeast Main on March 9. Recent decisions by the Commission indicate that if the locomotives were manufactured as permissible equipment, as apparently they were, they may be deemed intended for use inby the last open crosscut and should, therefore, have been maintained in a permissible, i.e., explosion proof condition. 30 C.F.R. 75.503, Peabody Coal Co., 1 MSHC 1700 (1978); Solar Fuel Company, 3 FMSHRC 1384; 2 MSHC 1359 (1981).

I concur in the maximum assessments for the two electrical violations on the locomotives because their presence (1) was indicative of a knowing disregard for voluntary compliance and (2) they or similar conditions completed the triad of circumstances that contributed directly to the explosion of March 9.

II

A

The Secretary allocated \$42,500 of the proffered settlement sum among 12 electrical violations. These, while not believed to have contributed to the conditions which caused the explosion of March 9, 1976, created severe electrical shock hazards and potential sources for explosive ignitions. In his prehearing submission, the Secretary found these violations were "part of a pervasive failure" to comply and stated he believed,

these violations were caused not only by a systemic failure in electrical maintenance, but also by the systemic failure to carry out examinations required by the Coal Act and its standards. A close look at these violations demonstrates they did not result from mere happenstance. Most were clear, unmistakable breaches of the electrical protections of the standards, and ironic evidence of Scotia's "production at all costs" attitude; ironic because the investigation revealed that the mine electrical system, as originally purchased and installed, was high-grade.

While the \$42,500 allocated amounted to a 42% reduction in the amount initially assessed for these 12 violations, I find that when viewed in the context of the total settlement (FOOTNOT 10) the allocation made was reasonable.

B

The last violation covered by the proffered settlement involves an alleged excessive accumulation of float coal dust. Investigators found excessive float coal dust, which

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is highly explosive, deposited on rock-dusted surfaces for a distance of approximately 2,500 feet in the 1 West Main, running from the mouth of the main inby along the conveyor belt entry. The accumulation covered the layer of white rock dust to such an extent that the area appeared black in color. The belt roller, of course, provided a potential source of heat and ignition that could have caused a fire or explosion. The existence of this violation is another example of the operator's reckless disregard for voluntary compliance. The Secretary allocated \$7,500 to the settlement of this violation which was the amount initially assessed by MESA. I concur in this action.

III

Had the result in these proceedings been achieved within two years after the Scotia disaster, it might have been cited as a triumph of effective enforcement. Coming as it does at this late date, in the context of new, multiple mine disasters, it may be further proof of the adage that laggardly enforcement and justice delayed is tragedy invited.(FOOTNOT 11)

The enormity of the social and economic cost of these mine disasters compels I take note of the great and continuing hazards that both operators and miners face twelve years after enactment of the mandatory safety standards and almost six years after the Scotia Mine disaster. The latest news bulletins disclose that during the five-day period between December 3 and 8, 1981, 27 miners were killed in coal mine accidents and explosions and that deaths among underground coal miners in 1981 were the highest in seven years. Even as this is written a mine explosion at the R.F.H. Coal Company in Craynor, Kentucky is reported to have killed seven more miners for a total of 33 miners killed in less than two months.

Meanwhile, MSHA has indicated that it intends to comply with the administration's budget-cutting plans by projecting the elimination of up to 150 underground coal mine inspectors, reducing the number of enforcement personnel from 1,629 to 1,479. (FOOTNOT 12) At least 153 miners were killed on the job in U.S. coal mines during 1981, compared with 133 in all of 1980. To reduce the enforcement effort by 10% when fatal accidents are up 15% represents the kind of callous illogic that few intimately engaged in coal mine health and safety can endorse.

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I also take cognizance of the fact that for no discernable reason the 1982 budget for the Federal Mine Safety and Health Review Commission was slashed by 28%, from \$4.3 million to \$3.1 million, and that the Commission, which is a vital link in the enforcement effort, suffered a 28% reduction in its support staff and administrative law judges. This crippling blow to the prompt adjudication of enforcement cases will seriously disrupt the Commission's already limited ability to protect miners and to afford operators a forum for expedited determination of their challenges to erroneous closure orders and other enforcement actions.

In the face of the rising rate of institutional manslaughter, the calls for further deregulation and relaxation of the enforcement effort seem unreal, if not morally irresponsible. (FOOTNOT 13) Several statistical studies have found that safety improves with the frequency of federal inspections. (FOOTNOT 14) A study of 539 bituminous underground coal mines producing more than 100,000 tons annually indicated a

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50% increase in federal inspection rates would result in 11 fewer fatalities, 2,400 fewer disabling injuries, and 3,800 fewer non disabling injuries per year. (FOOTNOT 15)

The staggering fact is that over 2,000 miners have been killed since Congress passed the Mine Safety Law in 1969. The statistics show this is the worst occupational safety record of any major industry and that laxity in the enforcement effort has resulted in a sharp reversal of the improvements of the last few years. It is time we stopped regarding the rising tide of deaths and disabling injuries with complacency. Something must be done and done quickly to correct the low level of morale at both the inspectorate and adjudicatory levels.

IV

Notwithstanding my misgivings and the absence of any assurance that corporate management's attitude toward mine safety has changed,(FOOTNOTE16) an independent evaluation and de novo review of the entire administrative record including

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the MESA "Report of the Scotia Mine Disaster,"(FOOTNOT 17) the Secretary of Labor's Verified Statement to Judge Hermansdorfer concerning the same and the mine operators' comments thereon, leads me reluctantly to conclude the settlement proposed is in accord with the purposes and policy of the Act.

Accordingly, it is ORDERED that the motions to approve settlement and to withdraw the challenges to the validity of the orders be, and hereby are, GRANTED. It is FURTHER ORDERED that the operator pay the amount of the settlement agreed upon, \$200,000, on or before Monday, March 1, 1982, and that subject to payment the captioned matters be DISMISSED.

Joseph B. Kennedy
Administrative Law Judge

AA

~FOOTNOTE_ONE

1 In March 1978, responsibility for enforcement was shifted from the Secretary of the Interior to the Secretary of Labor and from the Mining Enforcement and Safety Administration (MESA) to the Mine Safety and Health Administration (MSHA). 30 U.S.C. | 801, et seq., (Supp. I 1977).

~FOOTNOTE_TWO

2 Responsibility for the second explosion, at a time when the government was in control of the mine, is the subject of separate litigation between Blue Diamond and the Department of Justice. Claims brought by the survivors of the miners killed in the first explosion were settled for approximately 6 million dollars in 1980 and by survivors of the victims of the second explosion for approximately 2 million dollars in 1981. Boggs v. Blue Diamond Coal Company, 590 F. 2d 655 (6th Cir. 1979). In the pending criminal case, the United States seeks the imposition of \$240,000 in criminal penalties against the corporate mine operators. United States v. Blue Diamond Coal Company, --- F. 2d ---, No. 80-5084, 6th Circuit, decided December 17, 1981.

~FOOTNOTE_THREE

3 When the present settlement proposal, \$200,000, is added to the sum already paid, \$36,400, the mine operators will have paid a total of \$236,400 in civil penalties which is 89% of MESA's initial assessment for the 71 violations charged.

~FOOTNOTE_FOUR

4 The Secretary's evaluation appears in counsel's motion to approve settlement which incorporated by reference counsel's earlier response to the trial judge's pretrial order of May 1, 1980. Counsel for the Secretary is to be commended for the clarity of expression and organization of these pleadings and for the diligence demonstrated in their preparation.

~FOOTNOTE_FIVE

5 It is the Secretary's position that both Blue Diamond Coal Company and Scotia Coal Company were responsible for the safety violations at the Scotia Mine.

~FOOTNOTE_SIX

6 On June 25, 1979, a Federal Grand Jury in Pikeville,

Kentucky handed down an indictment charging Blue Diamond and Scotia Coal Companies with six criminal violations of the Mine Safety Law. Four counts charge a willful failure to comply with the ventilation plan for the Scotia Mine and to make required inspections and examinations for potentially explosive concentrations of methane gas. The mine operators are also charged with two counts of making knowingly false statements in records required to be maintained with respect to its ventilation and examination practices.

On February 19, 1980, Judge Hermansdorfer of the United States District Court for the Eastern District of Kentucky granted the mine operators motion to suppress evidentiary records on the ground that their seizure violated the mine operators' rights under the Search and Seizure Clause of the Fourth Amendment. The United States appealed the suppression order and on December 17, 1981, the Court of Appeals for the Sixth Circuit reversed the decision of the District Court finding that the warrantless seizure of statutorily required records from the office of a coal operator is not violative of the Fourth Amendment. *United States v. Blue Diamond Coal Company, supra*. The mine operators will reportedly petition the court for a rehearing and may seek a review of the matter by the Supreme Court. Past and prospective delays in the criminal proceeding vindicate the Commission's decision to deny the mine operators a stay of the civil penalty proceedings pending final resolution of the criminal proceedings. *Scotia Coal Mining Company, 2 FMSHRC 622; 1 MSHC 2327 (1980)*.

~FOOTNOTE_SEVEN

7 An incendive spark is an electrical spark of sufficient intensity to ignite a gas or other flammable material.

~FOOTNOTE_EIGHT

8 This was done to achieve temporary compliance with a notice of violation issued by a MESA inspector between 3:30 and 4:00 o'clock that afternoon. This citation issued when the inspector found less than 9,000 cubic feet of air per minute was sweeping the last open crosscut of the 2 Left Section. The notice was terminated about two hours later when the inspector remeasured the air flow and found it to be 10,472 feet per minute. The inspector, who was on the section for approximately seven hours, never attempted to determine how the additional 2,360 feet of air flow was achieved. MESA and the Secretary claim he was not authorized to inspect any area of the mine other than the 2 Left Section and therefore did not concern himself with the adequacy of the ventilation controls or with the short-circuit of the ventilation into the dead end area of 2 Southeast Main. Had he done so he might have discovered that in order to achieve compliance with his citation the operator had robbed air from 2 Southeast Main and that the entire section was being operated in violation of the approved Ventilation Plan. This arbitrary and somewhat incredible limitation on inspection activity deprived the miners of a last clear chance for the federal regulatory presence to intervene and to avert the disaster.

~FOOTNOTE_NINE

9 The legislative History of the Mine Safety Law reflects congressional concern for the danger of explosions resulting from ignition of undetected accumulations of methane in coal mines:

The most hazardous condition that can exist in a coal mine, and lead to disaster-type accidents, is the accumulation of methane gas in explosive amounts. Methane can be ignited with relatively little energy and there are, even under the best mining conditions, numerous potential sources always present . . . Men working in the face areas where coal is mined and where fresh methane can be emitted in large volumes due to the disturbance of the coal bed, are required to take numerous safety precautions to insure that methane is not present in explosive amounts. All equipment inby the last open crosscut must be of a permissible type, and frequent examinations, both preshift and onshift, are made to determine methane concentrations. The present bill requires examinations for methane onshift at least once each coal producing shift, at the start of each coal producing shift before electrical equipment is energized, at least every 20 minutes during a shift when electrically operated equipment is energized, before intentional roof falls are made, before explosives are fired, and before welding is done. When, on examination, methane concentrations exceed 1 volume percentum, changes must be made in the ventilation to reduce the methane content. When the methane concentration exceeds 1.5 volume percentum, the electricity must be shut off in the section affected, and men withdrawn from the section until the methane content is reduced. H.R. Rep. No. 91-563, 91st Cong., 1st Sess. 21.

~FOOTNOTE_TEN

10 The average per violation for the 28 violations is \$7,142.85 which is the highest average ever paid for a comparable number of violations.

~FOOTNOTE_ELEVEN

11 Existing and prospective budgetary restrictions raise the specter of a de facto, if not a de jure, repeal of the Act. Despite conventional political wisdom to the contrary, experience teaches that in the mining industry, and especially underground coal mining, voluntarism is no substitute for compulsory enforcement. The history of mine safety shows a federal regulatory presence is required to reduce disasterous accidents and achieve even a modicum of safety.

~FOOTNOTE_TWELVE

12 Due to action of the Congress, another 210 metal and nonmetal mine inspectors have been furloughed.

~FOOTNOTE_THIRTEEN

13 The importance of the federal enforcement effort is well recognized by the miners, especially the nonunion miners. As one West Virginia miner put it, "The only thing keeping the rock off your back when you're two miles underground is Government regulations." See "Miners, Mr. President, Are Not Slag", Op. Ed. Page, N.Y. Times, Sunday, January 24, 1982.

~FOOTNOTE_FOURTEEN

14 Low Productivity in American Coal Mining: Causes and Cures, GAO Rpt. EMD 81-17, March 3, 1981, at 55-56.

~FOOTNOTE_FIFTEEN

15 The Direct Use of Coal, Office of Technology Assessment, Congress of the United States, (1979), at 283.

~FOOTNOTE_SIXTEEN

16 Counsel for Scotia have always stoutly maintained that because MESA was in pari delicto, the operator culpability, if any, was extremely low. Counsel have made clear that the settlement is proffered solely in the interest of conserving their clients financial resources and not out of any sense of social remorse or responsibility.

~FOOTNOTE_SEVENTEEN

17 This report was received in camera and has never been publicly released because of an outstanding suppression order issued by Judge Hermansdorfer in January 1978. Since the report is not admissible in the criminal case and most of the civil litigation has been settled, I strongly recommend the Department of Justice seek vacation of the suppression order. My independent review of the matter leads me to conclude that while the report, as supplemented, is not perfect, it is trustworthy. Furthermore, the conclusions reached at p. 57 are supported by a preponderance of the reliable, probative and substantial evidence in the administrative record considered as a whole. This is not to say that ventilation problems were not either undetected or ignored by MESA or could not have been, by the exercise of greater diligence or suspicion, discovered. Nevertheless, two wrongs do not make a right, nor is the public interest served by suppressing the report because a court arguably believed MESA tried to coverup its own wrongdoing at the expense of the mine operators. The law places primary responsibility for compliance on the mine operators. With all due deference to Judge Hermansdorfer, my independent review of the administrative record leads me to conclude that actors other than God and MESA were primarily responsible for the concentration of methane gas that exploded at the 31st crosscut of the 2 Southeast Main Section of the Scotia Mine at 11:45 a.m., Tuesday, March 9, 1976.