

CCASE:
SOL (MSHA) V. DICAMILLO MINING
DDATE:
19820421
TTEXT:

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. WEST 81-210-M MSHA CASE No. 05-02730-05002 FFG5
v.	
DICAMILLO BROTHERS MINING COMPANY, A CORPORATION, RESPONDENT	Mine: Cross Mine

Appearances:

Phyllis K. Caldwell, Esq., Office of the Solicitor
United States Department of Labor, 1585 Federal Building
1961 Stout Street, Denver, Colorado 80294,
For the Petitioner

John R. Henderson, Esq., Vranesh, Raisch and Aron
2120 13th Street, P.O. Box 871, Boulder, Colorado 80306,
For the Respondent

Before: John A. Carlson, Judge

DECISION

This civil penalty case arose out of a fatal accident at the Cross Mine near Nederland, Colorado on September 19, 1980. The Secretary of Labor, in three citations, charges that respondent violated mandatory safety standards relating to ventilation practices. He also alleges that the violations were "significant and substantial" and seeks a civil penalty of \$3,000 for each citation. Respondent resisted the Secretary's petition, and the issues were tried under the Federal Mine Safety and Health Act of 1977 (30 U.S.C. 801 et seq, the "Act") in Denver, Colorado beginning on January 27, 1982. Counsel agreed to submit no post-hearing briefs.

REVIEW AND DISCUSSION OF
THE EVIDENCE

The undisputed evidence shows that at the time of the accident and the Secretary's subsequent investigation the Cross Mine was operated by a closely-held family corporation, DiCamillo Brothers Mining Company. This company, whose principals are David, Henry, Paul, and Jay DiCamillo, worked the mine under an operating contract with Tom Hendricks, who in turn leased it from out-of-state owners.

~719

This small underground gold and silver mine was first worked in the late Nineteenth Century and was reopened by Hendricks in 1974. DiCamillo Brothers took over active operation under a series of short-term contracts beginning in 1979. At one time or another ore had been mined from four separate drift levels. The deepest of these was level four, some 200 feet below the surface. A two-compartment shaft, encompassing ladderways and a skip hoist, reached all levels.

In September, 1980, the DiCamillos and their crews were actively mining the third and fourth levels. Prior to the summer of 1980 the mine had no mechanical ventilation system. Natural surface winds moving over the raise were believed sufficient to ventilate the mine. Before regular work began in the fourth level drift, however, a fan capable of moving air at 12,000 cubic feet per minute was installed to provide adequate ventilation at all active workplaces within the mine. As a part of this new system, the DiCamillos (or Henderson) installed air doors at various strategic locations to insure the proper flows of intake and return air, and to prevent dissipation or short circuiting of flows.

On September 19, 1980, David DiCamillo removed the plywood air door which blocked off the large mined-out drift at level two. He did so to show a prospective employee where he proposed to drive a new raise to the tunnel level above. DiCamillo did not replace the door when he left.

Sometime between 7:00 and 7:30 a.m., two miners, Jerry Miller and Paul Ouellet, had descended to the fourth level to begin to pull ore shot the previous night. Eventually, David and Henry DiCamillo learned that the hoistman had brought up no muck from the fourth level, checked, and found that both Miller and Ouellet were unconscious in the skip. The rescuers were able to revive Ouellet, but Miller was dead. The parties stipulate that Miller died and Ouellet was rendered unconscious because of exposure to excessive levels of carbon monoxide. The DiCamillos closed down the mine as soon as the victims were removed.

We now consider the individual citations.

Citation No. 333981

This citation, coupled at the time of issuance with a withdrawal order, charges that DiCamillo Brothers violated the mandatory standard published at 30 CFR 57.5-5. As pertinent here, that standard provides:

Control of employee exposure to harmful airborne contaminants shall be, insofar as feasible, by prevention of contamination, removal by exhaust ventilation, or by dilution with uncontaminated air. [The remainder of the standard governs the use of respirators where engineering controls of contamination have not been developed, or in other special circumstances not present in this case.]

~720

The specific threshold limit values for contaminants are set out in 30 CFR 57.5-1, which adopts by reference the exposure limits set out in the 1973 edition of the American Conference of Governmental Industrial Hygienists publication "TLV's Threshold Limit Values for Chemical Substances in Workroom Air."

Inspector Edward Machesky, acting on behalf of the Secretary, descended to the fourth level in the early afternoon on the day of the accident and took a number of air samples in the area where the two victims had been sent to work. His immediate readings, and subsequent laboratory analyses of sealed samples, showed carbon monoxide concentrations of between 550 and 600 parts per million. The air appeared quite clear despite these potentially lethal concentrations, and tested normal for oxygen and methane.

On September 22, 1980, James Atwood, a supervisory mine inspector for the Secretary, used a smoke tube to test for air flow at the fourth level. With the second level air door down, and the fan running, he found no perceptible air movement in the fourth level. During this inspector's visit David DiCamillo nailed the door back in place. Inspector Atwood concluded that removal of the door had "short circuited" the ventilation flow, depriving the fourth level of moving air.

This conclusion was ratified by William Bruce, Chief of the Ventilation Division at the Denver Safety and Health Technology Center of the Mine Safety and Health Administration, who made a ventilation study at the mine on September 24, 1980. Mr. Bruce, a graduate mining engineer with ten years of specialization in ventilation, measured the fourth level air flow at 1,400 cubic feet per minute with the second level door in place. Such a flow, he testified, was "minimal" for miner safety.

Respondent did not seriously dispute any of these findings. It also agreed with the Secretary's witnesses that carbon monoxide is one of the gases released by blasting; and that the muck pile created by the blast the night before the accident was the only possible source for the carbon monoxide which caused the death of Jerry Miller.

Uncontested evidence adduced by respondent's witnesses shows that Miller and Ouellet had loaded charges in both sides of the fourth level drift on the day before the accident. This "slab" round was not detonated at the end of their shift, however, because Paul DiCamillo, the brother in charge of the entire Cross Mine operation, was working a crew on the third level and wished no blasting below until his shift ended at 11:00 p.m. At that time he discharged the round so that the gases would have cleared and Miller and Ouellet could begin mucking at 7:00 the next morning.

In their defense, the DiCamillos first contend that at the time of the accident they were wholly without knowledge of any factors which could account for the excess buildup of carbon monoxide. Thus, they argue, they cannot reasonably be held

responsible under the Act for violation of the mandatory airborne
contaminant control standard.

~721

Before examining the particulars of this defense, I should observe that an absence of operator negligence is not a defense to a charge of violation of a mandatory safety standard unless the standard itself declares it so. United States Steel Corp., 1 FMSHRC 1306 (1979); El Paso Rock Quarries, Inc., 3 FMSHRC 35 (1981).

The full sense of 57.5-5 is gained by reading it with its sister standards, particularly 57.5-1 and 57.5-2. In 57.5-1 the Secretary requires absolute adherence to the limits of exposure set out in the 1973 tables of the American Conference of Governmental Industrial Hygienists. The only exception is under 57.5-5 itself where removal by ventilation or dilution by uncontaminated air is not feasible from an engineering standpoint. In that instance respirators may be used. In this case, of course, no one suggests that that exception came into play. The pertinent Hygienists' publication establishes the threshold limit value for carbon monoxide at 50 parts per million. Because of the extremely high concentrations measured by Inspector Machesky, however, the more relevant figure in this case is the 15 minute "excursion limit" of 400 parts per million. (FOOTNOTE 1) The readings obtained on the afternoon of September 19, 1980, coupled with the fate of Miller and Ouellet, demonstrate conclusively that this excursion value was exceeded. The absolute obligation of the mine operator to insure that contamination limits are not exceeded is underscored in 57.5-2, which provides:

Dust, gas, mist and fume surveys shall be conducted as frequently as necessary to determine the adequacy of control measures. (Emphasis added.)

I therefore hold that respondent violated the cited standard.

Operator negligence is relevant, though, on the issue of appropriate penalty. Respondent's argument of lack of fault has many facets. Central however, is a claim that the principal means of removing contaminants from the fourth level was compressed air, not the mechanical ventilating system. Undisputed evidence does show that after every blast the resulting muck pile was flushed with compressed air supplied through a central system. On the fourth level the air hose was attached to the mucking machine. Paul DiCamillo testified that after shooting the fourth level round on the night of September 18, he turned on the fourth level compressed air and that it remained on throughout the night. Respondent maintains that even with the

~722

central ventilation short circuited on the morning of the 19th, the combination of compressed air and the large flows of fan-driven air during the night should have cleared any accumulations of carbon monoxide many times over. According to respondent's witnesses, universal practice in such mines is to wait no longer than 45 minutes after a blast before re-entering the area.

Respondent's witnesses also emphasized their belief that the compressed air flushing process should have adequately cleared the air of contaminants whether or not the fan system was working at all. Frequent references were made to the fact that until a year before the accident the entire mine had operated successfully with no fan system (Tr. 180, 205, 232).

Finally, Henry DiCamillo asserted at one point that Miller himself was responsible for the accident because he failed to turn on the compressed air valve on the morning of the accident (Tr. 173).

For these reasons the DiCamillos suggest, in essence, that the hazard on the fourth level was unforeseen and unforeseeable. I agree that it was in fact unforeseen, but not that it was unforeseeable. On the contrary, respondent's evidence showed a clear recognition that mechanical ventilation was necessary before mining was begun on the fourth level (Tr. 190). It follows that any known interruptions of fan-induced air flows through the fourth level drift should have alerted the operator to possible danger. David DiCamillo, who removed the air door, granted that he knew removal of the door would "slow down" the flow (Tr. 35). Paul DiCamillo conceded that "any prudent operator" would have known that removing the door would have short circuited the fourth level air (Tr. 182).

There is a patent inconsistency, of course, in admitting the necessity for a fan to insure safety at the fourth level, while maintaining that fan ventilation was superfluous because of the availability of compressed air. The compressed air argument is further weakened by the testimony of William Bruce, the Secretary's ventilation expert, who denied that compressed air alone should have been relied upon for adequate ventilation under the circumstances present in respondent's mine. Compressed air, he asserted, was not "meant to provide the primary source of ventilation" (Tr. 120). According to Bruce, when a muck pile is present it provides a continuing source for carbon monoxide; disturbing the pile through mucking can stimulate the release of the contaminants; and compressed air can free carbon monoxide from a muck pile but will not necessarily vent it from the drift as would a steady flow of intake and return air from a fan (Tr. 113, 119-129). I find this testimony credible.

Nor can the operator's neglect be shifted to the dead and injured miners on the theory that they ignored established procedures by failure to turn on the compressed air valve. There is some confusion as to whether the valve was on or off when Miller and Ouellet were brought to the surface (Tr. 240-241).

That the valve may have been off, however, shows no departure from accepted practice in the mine. Toward the end of the

~723

hearing Henry DiCamillo acknowledged that had Miller and Ouellet found the air on when they arrived in the drift (after it was presumably on all night) they would have been following policy to turn it off before proceeding into the drift.

Upon the entire record, then, I conclude that there was significant operator neglect. I also conclude that the character and consequences of the violation show it to be "significant and substantial" as that term is used in Section 104(d) and 104(e) of the Act. Cement Division, National Gypsum Co., 3 FMSHRC 822 (1981).

Aside from the elements of neglect and the gravity of the violation, evidence as to the remainder of the statutory penalty criteria (FOOTNOTE 2) tends to favor respondent. The gravity, of course, was high, as illustrated by the fatal results. It is undisputed, however, that the DiCamillos showed good faith in rapid abatement (Tr. 10). The mine was small, having never employed more than 18 miners. Of particular significance is the fiscal condition of the DiCamillo corporation. The four brothers formed it with the expectation of working several mines on a contract basis. It has few physical assets (Tr. 224), and at the time of hearing held approximately \$900 in its corporate account (Tr. 224). David DiCamillo was "off the payroll" and working for another employer because of the corporation's lack of funds (Tr. 243-244). The Cross Mine, where the violation occurred, was closed on December 21, 1981 (Tr. 192), and the DiCamillo corporation has no other current contracts (Tr. 227).

Owing to the virtual collapse of the corporation, I cannot in good conscience assess the \$3,000 penalty which the Secretary seeks. On the other hand, I cannot pass off this essentially grave violation with a token penalty. To do so would be to signal all financially distressed operators that safety short-cuts may be undertaken without fear of hurtful sanctions under the Act. (One must also recognize that an operating company which owns no minerals in place and few physical assets may be formed with minimum capital and may operate successfully over long periods without accumulating any substantial net worth. Choice of this mechanism for conducting business cannot serve as an absolute shield against penalty under the Act.)

~724

Giving due consideration to all the penalty criteria, I conclude that a civil penalty of \$1,500 is warranted to deter future violations. That sum is therefore assessed.

Citation No. 333581

The Secretary bases this citation upon the same facts as those in citation no. 333981, but alleges violation of a different mandatory standard. As modified before the hearing, the citation claims respondent violated 30 CFR 57.5-28, which reads:

Unventilated areas shall be sealed, or barricaded and posted against entry.

The Secretary argues that the standard applies because the DiCamillos did not immediately evacuate miners from the fourth level (FOOTNOTE 3) and seal it off when David DiCamillo interrupted the ventilation by removing the second level door. (FOOTNOTE 4)

Counsel for respondent protests that this citing of a second standard for the very acts or omissions which serve as the foundation for another charge is unfair. He brands it an attempt to multiply civil penalties by citing the same underlying facts twice.

The Commission considered a similar argument in El Paso Rock Quarries, Inc., 3 FMSHRC 35, 40 (1981), and held that the Act "imposes a duty on operators to comply with all mandatory safety and health standards", and permits no escape from liability "simply because the operator violated a different, but related mandatory standard."

I have difficulty with the cited standard, however, simply because I believe it is misapplied under the circumstances of this case. All standards must be construed in the light of the drafter's intent. Here, the cited standard must be read in association with the other standards in 30 CFR 20, all of which deal with requirements for a comprehensive ventilation plan and system. Those standards recognize that in most mines, the plan will provide no ventilation for certain areas which are mined out or not frequented for other reasons. Thus, for example, 57.5-20(b)(2) provides that maps shall show "[l]ocation of seals used to isolate abandoned workings." I read the standard cited in this instance, when requiring "unventilated areas to be sealed barricaded or posted against entry," to contemplate those areas which were intended under the operator's plan to be unventilated. I do not read it to embrace those areas which are

~725

ventilated, but where ventilation is somehow interrupted on an unplanned basis due either to mechanical failure or human error. Most particularly, I do not read it to require that the barricading, sealing, or posting be done before the operator has actual knowledge of the failure, whatever its cause. Where an unplanned failure of ventilation occurs, one would expect that the operator, upon learning of it, would withdraw miners until air flows were restored. That is what occurred here. The DiCamillos closed the entire mine upon discovery of the accident, and that action was formalized by the inspector later in the day by issuance of what appears to be a mine-wide withdrawal order. In summary, I do not understand the Secretary to contend that respondent was obliged to comply with 57.5-28 after the mine was closed; and I do not understand the standard to require posting, sealing or barricading before respondent had actual knowledge of a ventilation failure. Consequently, no violation is found. The petition proposing penalty is vacated.

Citation No. 567048

This citation relates specifically to the air ventilation door which David DiCamillo removed at the second level. It charges that the door "was not substantially constructed, nor was it maintained in good condition as required in 30 CFR 5-31." The pertinent portion of the standard provides:

Ventilation doors shall be:

- (a) Substantially constructed.
- (b) Covered of fire retardant material if constructed of wood.
- (c) Maintained in good condition.
- (d) Self-closing, if manually operated.

The undisputed evidence shows that the operators had made the door of plywood with no attempt to apply any fire retardant. Hence, a violation of the cited standard is clear. Witnesses for the Secretary also maintained without contradiction that the door, which did not conform well to the irregular shape of the bulkhead, was haphazardly held in place by a few common nails. I agree that this condition, too, violated the standard. (FOOTNOTE 5)

Counsel for the respondent notes that door construction defects were not the proximate cause of the accident. This is so, but no causal connection to an accident is necessary to establish violation of a mandatory standard. I do agree that the door defects were considerably less grave than the removal of the door. Also, on the record presented, I am unable to conclude that the "violation is of such a nature as could significantly and substantially contribute to the cause and effect of a coal or other mine safety and health hazard" under sections 104(d) and 104(e) of the Act. In Cement Division, National Gypsum Co. (supra) the Commission held that such a conclusion must be based upon a "reasonable likelihood that the hazard contributed to will result in an injury or illness of a reasonably serious nature." The cited door violations were not shown to have contributed to the ventilation failure on the fourth level; ventilation ceased because of the complete removal of the door. One may infer that the insubstantial construction, haphazard mounting, and lack of fireproofing of the door would be dangerous in the event of a fire or explosion in the mine. No evidence was given, however, as to the likelihood, reasonable or otherwise, of such events in this particular metals mine. Without such evidence, a finding of "significant and substantial" cannot be made.

Giving consideration to all the penalty factors discussed in connection with citation 333981, I conclude that \$100 is an appropriate penalty for the defects.

CONCLUSIONS OF LAW

Based upon the findings incorporated in the narrative portion of this decision, the following conclusions of law are made:

- (1) Respondent violated the mandatory standard published at 30 CFR 57.5-5 as alleged in citation 333981.
- (2) The violation was "significant and substantial" within the meaning of the Act.
- (3) The appropriate penalty for the violation is \$1,500.
- (4) Respondent did not violate the mandatory standard published at 30 CFR 57.5-28 as charged in citation 333581.
- (5) Respondent violated the mandatory standard published at 30 CFR 5-31 as charged in citation 567048.
- (6) The violation was not proved "significant and substantial" within the meaning of the Act.
- (7) The appropriate penalty for the violation is \$100.

