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SOL V. SELLERSBURG STONE
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Federal Mine Safety and Health Review Commission
Office of Administrative Law Judges

SECRETARY OF LABOR,
PETITIONER
v.
SELLERSBURG STONE COMPANY,
RESPONDENT

Civil Penalty Proceedings

Docket No. LAKE 80-363-M
AC No. 12-00109-050061

Docket No. LAKE 80-364-M
AC No. 12-00109-05007

DECISION

Appearances: Stephen P. Kramer, Esq., Office of the Solicitor
U.S. Department of Labor, for Petitioner
Edwin S. Sedwick, Esq., for Respondent

Before: Judge William Fauver

These consolidated proceedings were brought by the Secretary of Labor under section 110(a) of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. 801 et seq., for assessment of civil penalties for alleged violations of mandatory safety standards. The case was heard at Louisville, Kentucky.

Having considered the contentions of the parties and the record as a whole, I find that the preponderance of the reliable, probative, and substantial evidence establishes the following:

FINDINGS OF FACT

1. At all pertinent times, Respondent operated an open-pit, multiple-bench, crushed limestone operation in Clark County, Indiana; its products were regularly produced for sales or use in or substantially affecting interstate commerce.

2. After material was blasted from the side of the quarry ("primary blasting"), a frontend loader was used to gather boulders that were too large to go through the stone-crusher. These were moved to the floor of the quarry where they were exploded by "secondary blasting."

3. "Secondary blasting" involved: a) drilling a hole into a boulder with a jackhammer drill; the hole was about 1 inch x 18 inches; b) loading the hole with a 1-inch x 4-inch stick of dynamite; adding a primer cord; and packing the hole with fine stones; and c) detonating the dynamite, in blasts of about 20 boulders at a time. The boulders were piled or grouped in a rather close cluster for drilling and blasting.

4. In secondary blasting, at times a dynamite charge would not explode. After the blast, the standard safe practice in the industry was to inspect all boulders remaining to see whether any contained undertonated dynamite, and this inspection required turning the boulder over to drill all sides for a drill hole. However, Respondent did not follow the practice of turning boulders over, and relied upon visual inspection of the top and sides of a boulder.

5. In secondary blasting, at various times some boulders would be turned over by the blast so that if a boulder were unexploded the drill hole might be on the bottom and not detectable unless the boulder was turned over for visual inspection.

6. The boulders were about two to four feet in diameter, and usually the drill hole did not exit, so that there would be only one hole visible on a boulder.

7. On December 13, 1979, two men were assigned to do secondary blasting. Carl Sparrow, the blaster, had about four or five months experience in blasting and David Hooper, the driller, had about three months experience. Neither was carefully or well trained in the performance of his duties.

(a) That morning they inspected about 20 boulders; Hooper drilled them and Sparrow loaded them with dynamite and primer cord. At times Hooper helped pack or load a hole.

(b) They set off a blast of about 20 boulders, and went to lunch. When they returned, Sparrow worked around his truck and Hooper started inspecting and drilling boulders. The first boulder he inspected had no visible drill hole, but he could not see the bottom. The boulder was about four feet in diameter and too heavy to turn over without equipment, such as a frontend loader. Respondent had such equipment, but did not use it or make it available for turning over boulders for inspection. He started drilling a hole. When he was about halfway through the boulder it exploded. Hooper received permanent disabling injuries, including loss of the sight of one eye and a crippled leg.

(c) Respondent did not preserve the accident site; after Hooper was taken to the hospital, all evidence of the accident was removed or disturbed and normal mining was resumed.

(d) Respondent did not report the accident to MSHA by telephone or by other prompt means. Its first notice to MSHA was a Form 70001, mailed to MSHA's Vincennes, Indiana subdistrict office on January 2, 1980.

DISCUSSION WITH FURTHER FINDINGS

The Secretary has alleged three violations. The first citation charges a violation of 30 CFR 56.6106, which provides:

> Faces and muck piles shall be examined by a competent person for undetonated explosives or blasting agents and any undetonated explosives or blasting agents found shall be disposed of safely.

Respondent did not properly examine the muck pile after secondary blasting, because after such blasting it drilled boulders without turning them over to examine each boulder for a dynamite drill hole on the bottom of the boulder. This failure was contrary to standard safe practice in the industry, and violated 30 CFR 56.6106. Respondent's practice constituted gross negligence and a grave risk of drilling into a dynamite charge because the driller would not know whether a boulder had a dynamite charge that had failed to fire. I reject Respondent's evidence to the effect that the blast of a boulder could not move nearby boulders or turn them over. I also reject Sparrow's testimony that he had found a drill hole in the boulder that exploded and injured Hooper, and that he had ordered Hooper not to drill into that boulder. I credit Hooper's account of the facts and accident, including the fact that he had inspected the boulder before drilling and found no drill hole, that he drilled nearly halfway through the boulder when it exploded, that often boulders were piled on one another and a secondary blast moved boulders around and over.

This was a most serious violation resulting from gross negligence.

The second citation alleges a violation of 30 CFR 50.12, which provides:

> Unless granted permission by an MSHA District Manager or Subdistrict Manager, no operator may alter an accident site or an accident related area until completion of all investigations pertaining to the accident except to the extent necessary to rescue or recover an individual, prevent or eliminate an imminent danger, or prevent destruction of mining equipment.

This regulation implements 103(j) of the Act, which states in applicable part:

> In the event of any accident occurring in any coal or other mine, the operator shall notify the Secretary thereof and shall take appropriate measures to prevent the destruction of any evidence which would assist in investigating the cause or causes thereof.

No effort was made to preserve the accident site. The jackhammer and air compressor were removed and normal blasting operations were resumed. Nothing was left to indicate that an accident had happened. The investigators could not tell where the accident occurred, the actual number of rocks involved, the location of the accidental blast in relationship to the planned blast, the location of the jackhammer and air compressor, etc. MSHA's permission was not obtained to alter the accident site, nor was there a need to alter the site to recover Mr. Hooper or to avoid destruction of mining equipment. No imminent danger existed after the explosion. Respondent's conduct violated 30 CFR 50.12, and by the exercise of reasonable care this violation could have been avoided. Respondent was therefore negligent.

This was a serious violation. Failure to preserve the accident site hindered MSHA's function of investigating the cause of the accident and of identitying and recommending steps to prevent or avoid a similar accident.

The third citation charges a violation of 30 CFR 50.10, which provides:

> If an accident occurs, an operator shall immediately contact the MSHA District or Subdistrict Office having jurisdiction over its mine. If an operator cannot contact the appropriate MSHA District or Subdistrict Office it shall immediately contact the MSHA Headquarters Office in Washington, D.C., by telephone, collect at (202) 783-5582.

This provision reasonably implies that an operator is required immediately to telephone or use other prompt means, e.g., a telegram, to notify the MSHA District or Subdistrict Office.

Notice by mail involves a substantial delay in contacting MSHA. MSHA Form 7000-1 is a separate and independent reporting requirement. The information on that form is used for different purposes than the notification required under 50.10. Respondent violated 50.10 by failing to telephone or at least telegraph the proper MSHA office on the day of the accident. A violation of this kind has a serious effect on MSHA's ability to conduct an effective investigation. The accounts of witnesses in this case involved a number of contradictions, which the inspectors were impeded in resolving primarily because they were unable to investigate the incident in a timely fashion. This violation resulted from management's negligence.

CONCLUSIONS OF LAW

1. The Commission has jurisdiction over the parties and subject matter of this proceeding.

2. On December 13, 1979, Respondent violated 30 CFR 56.6-106 as alleged in Citation No. 36811. Based upon the statutory criteria for assessing a civil penalty, Respondent is assessed a penalty of $7,500 for this violation.

3. On December 13, 1979, Respondent violated 30 CFR 50.12 as alleged in Citation No. 367185 as modified. Based upon the statutory criteria for assessing a civil penalty, Respondent is assessed a penalty of $1,000 for this violation.

4. On December 13, 1979, Respondent violated 30 CFR 50.10 as alleged in Citation No. 366810 as modified. Based upon the statutory criteria for assessing a civil penalty, Respondent is assessed a penalty of $1,000 for this violation.

ORDER

WHEREFORE IT IS ORDERED that Respondent shall pay the Secretary of Labor the above-assessed civil penalties, in the total amount of $9,500.00, within 30 days from the date of this decision.

WILLIAM FAUVER
JUDGE