CCASE:
CONSOLIDATION COAL V. SOL (MSHA)
DDATE:
19820805
TTEXT:

Federal Mine Safety and Health Review Commission
Office of Administrative Law Judges

CONSOLIDATION COAL COMPANY, CONTESTANT	Contest of Citation
v.	Docket No. PENN 82-44-R
SECRETARY OF LABOR, MINE SAFETY AND HEALTH ADMINISTRATION (MSHA), RESPONDENT	Citation No. 1143669

SECRETARY OF LABOR, MINE SAFETY AND HEALTH ADMINISTRATION (MSHA), PETITIONER	Civil Penalty Proceeding
	Docket No. PENN 82-99 A.C. 36-00807-03107 V
v.	Renton Mine
CONSOLIDATION COAL COMPANY, RESPONDENT	

DECISION

Appearances: Robert Vukas, Esq., Pittsburgh, Pennsylvania, for Consolidation Coal Company
David T. Bush, Esq., Office of the Solicitor, U.S. Department of Labor, Philadelphia, Pennsylvania, for the Secretary of Labor

Before: Judge Melick

These consolidated cases are before me pursuant to sections 105(a) and 105(d) of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. 801 et seq., the "Act", to contest a citation containing special findings under section 104(d)(1) of the Act (Citation No. 1143669) and for review of a civil penalty proposed by the Mine Safety and Health Administration (MSHA), for that citation. (FOOTNOTE 1) The issues before me are whether the Consolidation Coal Company (Consol)

violated the regulatory standard at 30 C.F.R. 75.1725(a) as alleged and, if so, whether that violation was "significant and substantial" as defined in the Act and as interpreted in Secretary of Labor v. Cement Division, National Gypsum Company, 3 FMSHRC 822 (1981), and whether the violation was the result of the "unwarrantable failure" of the operator to comply with the law. An appropriate civil penalty must also be assessed if a violation is found. Evidentiary hearings on these issues were held in Pittsburgh, Pennsylvania on June 24, 1982.

The citation at bar was issued by MSHA inspector Frank Murin on December 18, 1981, and alleges as follows:

> A 103(g)(1) request (FOOTNOTE 2) was initiated concerning a malfunction that had occurred to the man-hoist at the Renton Mine on the 4 p.m. shift on October 21, 1981. During the course of the investigation it was revealed that repairs were made to the overspeed device for the hoist, however [sic] were not completed prior to lowering workmen into the mine. A locking screw that prohibits movements of the overspeed retaining nut was not replaced into position. (The retaining nut is used to hold the overspeed assembly in place.)

The cited regulatory standard, 30 C.F.R. 75.1725(a) reads as follows: "Mobile and stationary machinery and equipment shall be maintained in safe operating condition and machinery or equipment in unsafe condition shall be removed from service immediately."

The essential facts in this case are not in serious dispute. The specific issue is whether those facts support a violation of the cited standard, i.e., whether or not the cited man-hoist had been operated in an unsafe condition. The problem arose on October 21, 1981 at the beginning of the 4 p.m. shift. As the man-hoist (cage) was being lowered for the third time that shift it suddenly stopped. According to Leonard Conti, one of the miners on the cage at the time, it stopped so suddenly that it buckled his knees and "bounced up and down." It was about 15 minutes before the cage started again and descended the remaining 50 to 75 feet to the bottom of the 520-foot shaft. Conti had previously experienced similar sudden stops of the cage as a result of blown fuses.

Maintenance foreman Richard Murphy and general plant foreman Emerick Kravic were called in to correct the problem. A round retaining nut designed to hold a brass washer and tripping mechanism on the man-hoist overspeed governor had come loose thereby causing the overspeed governor to pre-maturely trigger and stop the man-hoist. When operating correctly the governor is designed to bring the man-hoist to an emergency stop if for some reason the rate of ascent or descent exceeds a pre-set speed. After the emergency stop in this case the miners in the third cage were apparently lowered to the bottom as Murphy held the trip bar in position with a screwdriver. The MSHA inspectors did not find this procedure to have been unacceptable for the limited purpose of allowing the miners to escape.

The evidence shows that Murphy then tried to re-thread the retaining nut onto the rotating shaft of the governor as the man-hoist was raised. Initially there was some difficulty in re-threading the nut and it apparently slipped off the shaft several times during the ascent. There was only a small opening in which to work and the nut was rounded with no machining (see Operator's Exhibits 16, 17, 19 and 22). According to Murphy, he was nevertheless able to re-thread the nut aided by the rotation of the shaft as the cage ascended. No one was in the cage during this ascent and MSHA does not question these efforts by the operator to correct the problem.

However mine superintendent Andrew Hathaway then directed that the cage again be lowered with additional miners without an intervening "dry run." Maintenance foreman Murphy went down with the miners in this cage even though he was aware that the retaining nut could again unthread as the hoist descended and the shaft rotated in the opposite direction. Murphy testified that he was nevertheless satisfied that necessary repairs had been completed.

Harley Pyles, director of engineering services for Consol and a graduate mechanical engineer, conceded that it would be "common knowledge" that a setscrew or similar locking device would be necessary to prevent a retaining nut, such as the one here at issue, from loosening on a rotating shaft. Maintenance foreman Denny Myers also told inspector Murin that a tapered locknut or cotter pin should have been used to prevent the retaining nut from unthreading. Myers was nevertheless confident the nut would stay in position on the fourth cage because "he watched it all the way down."

The fourth cage was lowered without incident and the governor was then dismantled. It was at this point discovered that the retaining nut contained a recessed setscrew which, if tightened, would prevent the nut from unthreading on the rotating shaft. The setscrew was apparently not previously discovered because it was obscured by grease and dirt. Because of the relatively old age of the hoist there was, moreover, no operating manual available that might have shown the existence of the setscrew.

In deciding whether there was a violation of the cited standard in this case it is essential to determine whether the man-hoist was, during its fourth descent, being "maintained in [a] safe operating condition" or alternatively whether that man-hoist should have been removed from service because it was in an "unsafe condition." As might be expected there is great divergence of opinion in this regard. On the one hand, MSHA inspector Murin testified that it was unsafe to have operated the fourth cage without the setscrew to lock the retaining nut on the governor. According to Murin, without that setscrew or other means to prevent the retaining nut from unthreading, that nut could indeed have again come loose, engaged the governor and brought the man-hoist to a sudden stop. Murin thought that such abrupt stopping would in itself be hazardous. He thought that resulting injuries from possibly falling to the floor or

against the walls of the man-hoist could be serious and involve broken limbs and sprained muscles. Murin also opined that the sudden stopping of the man-hoist could place undue strain on the wire rope causing it to stretch or "pop a cord." He thought the rope might also jump from the drum and become entangled. Murin admitted however that in spite of these alleged hazards he knew of no requirement or suggestion by MSHA, by the rope manufacturer, or by anyone else for an examination of the rope and/or drum after such sudden stops. Moreover, MSHA inspector Gerald Davis, who has specialized training and experience inspecting elevators and man-hoists, conceded that he has in the past tested man-hoists, including the man-hoist in this case, in an overspeed condition to determine whether the overspeed governor was properly functioning. Although Davis performs these tests during the ascent phase of the man-hoist operation it would appear nevertheless to place a similar strain upon the wire ropes.

On the other hand it appears to be undisputed that the fourth cage was lowered manually at a controlled slow rate of speed and that at least one person kept watch on the suspect retaining nut to make sure it did not unthread during the descent. In addition, mechanical engineer Harley Pyles testified that even assuming that the cage would have been stopped by the overspeed governor that would have been unlikely to have lead to any rope or drum damage. He pointed out that the braking effect was not that extreme and that the ropes are in any event designed with a safety factor of from 5 to 10. At worst, according to Pyles, the riders would experience some buckling of the knees.

The evidence in this case also shows that over the course of a year the man-hoist at issue will come to an emergency or sudden stop about six times. There is no evidence that anyone has ever been injured or that any damage has ever occurred as a result. I also note that the hoist rope is examined by x-ray every six months and is visually inspected every 24 hours.

For the reasons that follow I conclude that although the operation of the fourth cage in the cited manner was indeed not free from danger it did not constitute a "significant and substantial" violation. At the very minimum there was the admitted danger according to Consol engineer Harley Pyles to the mechanics who were manually rethreading the retaining nut while the shaft was in motion. A similar

potential danger existed during the fourth descent of the cage as the mechanics watched the nut and inferentially were prepared to intervene should that nut begin to unthread.

Whether a violation is "significant and substantial" depends on whether, based on the particular facts surrounding the violation, there existed a reasonable likelihood that the hazard contributed to would have resulted in an injury of a reasonably serious nature. Secretary of Labor v. Cement Division, National Gypsum Company, 3 FMSHRC 822 at page 825. The test essentially involves two considerations, (1) the probability of resulting injury, and (2) the seriousness of the resulting injury.

On the precise facts of this case I find a very low probability of injury. The retaining nut that had caused the initial problem had been completely rethreaded before the cited fourth descent, the descent was monitored and manually controlled at a low rate of speed and an individual continuously monitored the position of the retaining nut during the descent to make sure that it did not become unthreaded. I therefore find it highly unlikely that the cage could not have been brought to a gradual and complete stop before any loss of the retaining nut. Moreover, even with the unlikely loss of that retaining nut it is not disputed that the descent of the man-hoist would have been halted by the intervention of the overspeed governor. Since the cage was also descending at a slow rate of speed the alleged dangers attributed to sudden stopping would have also been greatly diminished. In addition the evidence shows that over the course of a year the man-hoist had almost routinely come to abrupt stops for various reasons without any history of resulting injuries or damage. Finally, I observe that MSHA's own man-hoist "expert" admitted performing tests of the cited overspeed governor by triggering an emergency stop of the man-hoist. Although the test was apparently performed during an ascent phase I do not find significant variance between this acceptable "test" and the alleged hazardous operation cited. It would appear that if MSHA's "test" does not place unacceptable stress on the wire ropes then Consol's operation of the man-hoist in the manner here cited posed no significantly greater hazard in this regard.

Under all the circumstances I cannot find that the violation was "significant and substantial." It is not therefore necessary to decide whether the violation was the result of "unwarrantable failure," Note1 supra. Since I

have found that the hazards alleged by MSHA were in fact quite improbable I attribute relatively low gravity to the violation. To the extent that there was some hazard, however remote, in operating the fourth cage without a setscrew, locking nut or other locking device on the retaining nut and in light of the concessions by Consol's own witnesses that the use of such a device would be generally accepted "common practice" I find that the operator was negligent. It is observed that after the fourth cage was lowered the entire overspeed mechanism was dismantled and, upon discovery of the setscrew in the retaining nut, was reassembled with the setscrew tightened to prevent the unthreading of the retaining nut. The condition was accordingly abated in a timely fashion and indeed even before the condition had been cited by MSHA. It is undisputed that the operator is large in size. I note that the Renton Mine has a rather substantial history of paid violations, however, there is no evidence that any violation of a similar nature has ever been cited. Under all the circumstances and considering the evidence in light of the criteria under Section 110(i) of the Act I conclude that a civil penalty of $100 is appropriate.

ORDER

Citation No. 1143669 is affirmed, however the special "significant and substantial" findings made therein are hereby stricken. Consolidation Coal Company is ORDERED to pay a civil penalty of $100 for the violation in Citation No. 1143669 within 30 days of the date of this decision.

Gary Melick
Assistant Chief Administrative Law Judge

ÄÄÄ
~FOOTNOTE_ONE

1 Section 104(d)(1) provides in part as follows:

"If, upon any inspection of a coal or other mine, an authorized representative of the Secretary finds that there has been a violation of any mandatory health or safety standard, and if he also finds that, while the conditions created by such violation do not cause imminent danger, such violation is of such nature as could significantly and substantially contribute to the cause and effect of a coal or other mine safety or health hazard, and if he finds such violation to be caused by an unwarrantable failure of such operator to comply with such mandatory health or safety standards, he shall include such finding in any citation given to the operator under this Act."

~FOOTNOTE_TWO

2 A request for an inspection by the Secretary under Section 103(g)(1) of the Act, is one initiated by a miner or representative of miners.