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SOL (MSHA) V. PEABODY COAL
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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 PROCEEDINGS Docket No. KENT 83-86 A.C. No. 15-03987-03502
v.	
PEABODY COAL COMPANY, RESPONDENT	Docket No. KENT 83-66 A.C. No. 15-03987-03501 River Queen Strip

DECISION

Appearances: Darryl A. Stewart, Esq., Office of the Solicitor, U.S. Department of Labor, Nashville, Tennessee, for Petitioner;
Michael O. McKown, Esq., Peabody Coal Company, St. Louis, Missouri, for Respondent.

Before: Judge Koutras

Statement of the Proceedings

These cases concern civil penalty proposals filed by the petitioner against the respondent pursuant to Section 110(a) of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. 820(a), seeking civil penalty assessments for three alleged violations of certain mandatory safety standards promulgated pursuant to the Act.

The respondent contested the proposed assessments, and the cases were heard in Evansville, Indiana. The parties waived the filing of written post-hearing arguments, but their oral arguments made on the record during the course of the hearing have been reviewed and considered by me in the course of these decisions.

Issues

The principal issue presented in these proceedings is (1) whether respondent has violated the provisions of the Act and implementing regulations as alleged in the proposals

for assessment of civil penalties filed, and, if so, (2) the appropriate civil penalties that should be assessed against the respondent for the alleged violations based upon the criteria set forth in section 110(i) of the Act. Additional issues raised are identified and disposed of where appropriate in the course of these decisions.

In determining the amount of a civil penalty assessment, section 110(i) of the Act requires consideration of the following criteria: (1) the operator's history of previous violations, (2) the appropriateness of such penalty to the size of the business of the operator, (3) whether the operator was negligent, (4) the effect on the operator's ability to continue in business, (5) the gravity of the violation, and (6) the demonstrated good faith of the operator in attempting to achieve rapid compliance after notification of the violations.

Discussion

The citations at issue in these proceedings are as follows:

Docket No. KENT 83-66

Following an investigation of a fatal accident which occurred at the mine, an MSHA inspector issued Section 104(a) Citation No. 1035414, on March 29, 1983, for an alleged violation of mandatory safety standard 30 CFR 77.404(a). The condition or practice described by the inspector on the face of the citation states as follows:

> The TD 25 International dozer was not maintained in a safe operative condition in that the mechanism for stopping the engine from inside the cab was inoperative.

Docket No. KENT 83-86

Following an investigation of a second fatal accident which occurred at the mine, an MSHA inspector issued Section 104(a) Citation Nos. 2075266 and 2075267, on September 9, 1983.

Citation No. 2075266 alleges a violation of mandatory safety standard 77.1000, and the condition or practice is as follows:

> The operator was not following the Ground Control Plan in that: hazardous high wall conditions had not been corrected before men were allowed to work in the area Pit No. 001-0. This citation was issued during a fatal accident investigation. This is the responsibility of Ben Rheu day shift,

> Gary Hulsey evening shift, Carol McIntosh, morning shift pit foreman.

Citation No. 2075267 describes an alleged violation of mandatory safety standard 77.1005, and the condition or practice is as follows:

> Loose hazardous material had not been removed from the face of the highwall in pit no. 001-1 for a distance of approximately 150 feet. This citation was issued during a fatal accident investigation. This is the responsibility of Ben Rheu (day shift) Gary Hulsey (evening shift), Carol McIntosh, morning shift pit foreman.

KENT 83-86--Petitioner's testimony and evidence

MSHA Inspector George W. Siria, confirmed that he conducted an investigation on September 3, 1982, into the circumstances surrounding a fatal accident which had occurred at the mine in question the previous day. As a result of that investigation, he issued two citations, and he identified copies of the citations which he issued, exhibits P-1 and P-2 (Tr. 10-11). He identified copies of the respondent's surface mine ground control plan, exhibit P-3, and he explained why he issued citations for violations of sections 77.1000 and 77.1005 (Tr. 12-15).

Mr. Siria confirmed that he is not a surface mining inspector, and while his experience is in underground mines, he stated that "I do know something about highwalls" (Tr. 16). Upon inspection of the 150 foot highwall in question, he stated that "it looked bad," and while conceding that he never worked as a surface mine inspector, he confirmed that MSHA Inspector Herald Utley and Subdistrict Manager Hudson Sorrel were with him when he conducted his investigation (Tr. 17).

Mr. Siria reviewed his Citation No. 2075266, for a violation of section 77.1000, and when asked why he did not make any negligence findings on the face of the citation which he issued, he replied "I don't really know why," and that "it looks like I made a mistake here" (Tr. 18). He stated that he intended to mark "high negligence." He confirmed that the respondent abated the citation in a timely manner (Tr. 20).

On cross-examination, Mr. Siria testified as to his background and training, and he confirmed that in the prior two-year period he had not inspected any surface mines, but only conducted one prior fatality involving a surface mine highwall (Tr. 24).

Mr. Siria described the mine highwall in question as being 70 to 80 feet high, and he described the methods used to strip the overburden. He stated that the length of the highwall was some 1000 to 1500 feet, but he had no idea how long it had been in place, nor could he recall the prevailing weather conditions prior to the accident (Tr. 26). He indicated that his main objective in conducting an inspection of the highwall would be to look for loose, overhanging rock, and to determine whether it had been removed (Tr. 27). He conceded that a rockfall could occur without any prior danger signs being noticed (Tr. 28), and he conceded that prior to the accident in question he had never previously inspected the highwall in question (Tr. 28). He also conceded that a rockfall could change the condition of a highwall, but that he did observe loose, hazardous materials on the highwall in question after the accident (Tr. 29).

Mr. Siria stated that with the exception of the cited 150 foot highwall area, the remaining portion of the highwall looked properly scaled, and when asked "Can you see any reason why that 150 area would not be properly scaled?," he replied "no" (Tr. 29). Mr. Siria confirmed that the basis for his opinion that the highwall was dangerous was that someone was killed by a rock which rolled down and struck the victim (Tr. 32). However, he indicated that he would have issued the citation even if the accident had not occurred, and this was because of his observation of the condition of the highwall. After the accident, he believed the highwall looked safer because the stripping shovel had "brushed the highwall out and knocked the loose rocks away" (Tr. 33). He confirmed that he had not observed the conditions of the highwall prior to the accident, and that he only observed it after the accident occurred. He conceded that a rockfall can change the appearance of a highwall, but that any such changes would only occur in the immediate fall area and not along the entire 150 length of the 80 foot highwall in question (Tr. 35). Mr. Siria also stated that the condition of the highwall was such that he would have issued a violation even if there were no fatality (Tr. 35).

In response to further questions, Mr. Siria stated that he had no knowledge that miners Mike Montgomery or Robert Penrod were told to work in the accident area knowing that the hazardous highwall condition existed. Mr. Siria confirmed that his belief that a hazardous highwall condition existed prior to the accident was based solely on his observations after the accident occurred (Tr. 36). Mr. Siria described the rock which struck the victim as four foot wide, and he stated that the rock "was rolling as it struck the victim" (Tr. 39).

MSHA Inspector James Utley, testified that he is a supervisory surface mining inspector. He confirmed that he was summoned to the mine approximately 15 to 20 minutes after the accident in question, and that he was at the mine on September 2 and 3, 1982. When he arrived at the pit area on September 2, he went to the accident scene and he observed the rock which struck the victim. The victim was still there, and the accident scene had not changed from the time he was called until his arrival. He identified the citation issued by Inspector Siria (Tr. 56).

Mr. Utley described the highwall as he observed it when he arrived at the scene on September 2nd as follows (Tr. 57-59):

> A. The highwall at the time we looked at it had an area near the top where a rock had turned loose and fallen into the pit. It was a little bit rough for an area of, oh, 150 feet long in the area where the accident had occurred.
> Above the highwall there was an area approximately 150 feet long where the dirt or soil had not been drug off by the bucket of the stripping shovel the way that it usually had been done.
>
> Q. If I understand you correctly, are you stating that the face had not been cleaned for 150 feet?
>
> A. I wouldn't say that it had not been cleaned. It was just a little rough.
>
> Q. Okay, and that on top of the highwall it hadn't been--
>
> A. The top of the highwall had not been drug off, to use the term that we use, with the bucket of the stripping shovel.
> * * *
> Q. Where you able to determine whether the fatal accident in this case, the rock falling, caused the rough condition of the highwall that you observed?
>
> A. No, the rock falling didn't cause the condition.

Q. And prior to your making that statement--

A. Well, the rock that turned loose and came down, came down the highwall in the area where the fatality occurred, but the area of the highwall that was a little rough was approximately 150 feet long.

Q. Okay. Did it encompass the area where the rock had fallen?

A. Yes.

Q. Did this rock fall midway that area or to one side or the other or do you remember?

A. I believe it was nearer the west end of the area.

Q. And was that an area further removed from the mining operations going--was the mining operations moving from west to east or east to west?

A. At that time the shovel was stripping from west to east.

Mr. Utley stated that if the condition of the highwall as he observed it after the accident had looked that way prior to the accident, he believed it would have been a violation as stated by Inspector Siria in the citation. Mr. Utley confirmed that he was familiar with the respondent's ground control plan, and he confirmed that no mine inspection took place prior to the accident on September 2, and his inspection and on September 3, included only the accident scene (Tr. 61).

On cross-examination, Mr. Utley stated that his prior surface mining experience was in connection with "engineering work" with a stripping contractor or as an "engineering technician" in underground mines. He confirmed that he has never served as a pit boss, operated a stripping shovel, or worked in a surface mine (Tr. 62-63). He also confirmed that Mr. Siria does not work for him in his normal inspection duties (Tr. 63). He went on the describe several conditions which change the appearance or condition of a highwall (Tr. 64-68).

Mr. Utley confirmed that he personally questioned no one about the highwall conditions during the fatality investigation, and that Mr. Siria did most of the interviewing. Mr. Utley

also confirmed that he had no personal knowledge of the condition of the highwall prior to the accident, and that he did not know whether or not loose, hazardous materials were in fact present on the highwall for a distance of 150 feet prior to the accident (Tr. 69). He did state that he inspected company records pertaining to the condition of the highwall for the dates prior to the accident, but had no copy of those records, could recall no particular notations for the pit in question, and could recall no statements to the effect that the highwall was a "rough area" (Tr. 69-70). He also could not recall being contacted by any MSHA assessment officer concerning the condition of the highwall after the citation was issued (Tr. 71). He then explained that he did recall such a contact, and he also recalled that with the exception of the 150 area, the highwall was in generally good condition (Tr. 72).

In response to further questions, Mr. Utley believed that assuming no accident occurred, the highwall was in such a state that required it to be scaled. He was also of the opinion that mine management should have known that it should have been scaled (Tr. 73). He further explained his position as follows (Tr. 74-82):

> JUDGE KOUTRAS: Now when they take that bucket and scrap the highwall, am I to assume the purpose of that is to take down any loose, unconsolidated material?
>
> THE WITNESS: Yes, sir.
>
> JUDGE KOUTRAS: Now let's assume that a mine operator takes the bucket, and let's assume that in this case the bucket had acraped the entire 150 feet across this highwall, scraped it, and then the rock fell. Would they then be susceptible to the charge that they hadn't properly scaled the highwall?
>
> THE WITNESS: No, sir.
>
> JUDGE KOUTRAS: In other words the scraping with the bucket, is that an acceptable means of scaling down and taking down loose, unconsolidated material?
>
> THE WITNESS: It is at the top of the highwalls.
>
> JUDGE KOUTRAS: So you just assume that that bucket is going to make the swipe and take everything?

THE WITNESS: No, sir, the bucket is also used to run up the face of the highwall to remove loosened dirt.

JUDGE KOUTRAS: Was there any indication in this case that there was any overhanging material?

THE WITNESS: No, sir.

JUDGE KOUTRAS: Okay. Now let's assume that the bucket had done the required cleaning of the area that you described as rough; am I to assume that that scraping process also would have taken out the rock that subsequently fell?

THE WITNESS: It is a possibility but no guarantee.

JUDGE KOUTRAS: I assume the bucket just scrapes rather than digs.

THE WITNESS: Yes, when it is scaling a highwall.

JUDGE KOUTRAS: Am I also to assume then when we use the term "unconsolidated loose" we literally mean that. I mean it doesn't literally go in and dig out big rocks, does it, that are imbedded into--

THE WITNESS: No, sir. Usually the material has been shot and is small, loose, and unconsolidated with no large boulders in it.

* * *

MR. STEWART: I guess if the crack appeared suddenly, I would agree that management can't know about the crack appearing suddenly.

JUDGE KOUTRAS: Okay.

MR STEWART: But management certainly can know from working in the area what conditions may lead to the cause of these sudden cracks that they later claim that they had no way of knowing.

JUDGE KOUTRAS: And you say the rough condition of the highwall as it existed shortly after the incident led the inspectors to believe that they hadn't scaled it properly.

MR. STEWART: That is correct.

JUDGE KOUTRAS: And that had they scaled it properly the crack wouldn't have appeared, the rock wouldn't have fallen, and the man wouldn't have been killed.

MR. STEWART: That is our basis.

JUDGE KOUTRAS: That is right.

MR. STEWART: But we are not necessarily saying that had they scaled it properly the crack would not have appeared, in fact.

JUDGE KOUTRAS: That is right. So had they scaled it properly there wouldn't have been a citation, correct?

MR. STEWART: That is correct.

JUDGE KOUTRAS: Okay. Had they scaled it properly in the eyes of these two inspectors, in the eyes of MSHA, then the crack suddenly appeared, and the rock fell, and the man gotten killed, then they wouldn't have been cited?

MR. STEWART: That is my understanding of their testimony.

JUDGE KOUTRAS: Okay. If you look at this narrative finding, it says, "The crack in the highwall appeared suddenly after the examination had been made"--

I don't know what examination they are talking about--"therefore management was not aware of it, and allowed the man to work in the area." Now that is totally nonsensical. And not only that it is nonsense because I don't understand it--

MR. MCKOWN: Well, Your Honor--

JUDGE KOUTRAS: I understand it. That is not evidence, I am just reading from the narrative finding of the special assessment officer number code name 21, whoever he is. If you ever find out, tell him what I said about his assessment.

MR. STEWART: I certainly will, Your Honor.

JUDGE KOUTRAS: The other thing that he concluded is that if the operator had not allowed men to work in the area prior to correcting hazardous highwall conditions the accident may not have occurred.

So here in the citation is that hazardous highwall conditions had not been corrected, meaning the rough area which you claim, MSHA claims, should have been scaled and taken down and taken care of.

Robert W. Penrod, testified that he has been employed at the mine in question as a "shooter," and that his duties entail loading and blasting, but that he is now a welder. He confirmed that on September 2, 1982, he was working as a shooter at the base of the highwall pit in question. He stated that the victim was a good friend of his, and Mr. Penrod described the condition of the highwall as follows (Tr. 88-95):

Q. Mr. Penrod, did you have an occasion to look at the highwall prior to the death of your fellow employee?

A. Yes, sir, I did.

Q. In the area in which you were working in?

A. Yes, sir.

Q. Would you describe to the court what it looked like.

A. At the time when we noticed the highwall we--just a little before the accident, we had noticed a big crack in the wall, and we was watching it because you could tell that there was a little bulge there, but it was cracked. And at the time we didn't see it working--and what I mean working is that when you see a part of the highwall starting to work it usually has dust; it usually looks like a little stream of dust flowing from it, and we know then that the wall is working; and we kind of avoid the area. And at the particular area that we had been in, the highwall hadn't been scraped or scaled, what we call, you know, kind of clean and loose material; it hadn't been. It was ahead of us, but at the area that we was at at that time it was not.

Q. How do you know it hadn't been?

A. Well, from being in the pit many times or around the mines as much as we have, you can tell from looking at it. In some instances you can tell when they've scraped the highwalls, the teeth marks, and at the top, especially on a highwall like this, is rounded off like, you know where they drag the bucket back over the highwall to break loose all the loose material. You could tell by looking at the highwall.

Q. So how were you able to tell that this one hadn't been scaled at the location that you worked in?

A. In the location we had, it was obvious you could tell because of the highwall we was at there was loose material; and plus right down from it you could tell where it was, where they had been dragging the highwall and cleaning it. But at the area we was at, they hadn't done it.

Q. Okay. Were you instructed to work in that area?

A. Yes, sir, at the time. Yes, sir.

Q. Who instructed you to work there?

A. Well, our drill foreman at the time was Bob Barrett.

Q. Bob Berry?

A. Bob Barrett.

* * *

Q. Now you stated that you observed a crack in the highwall but didn't see it working.

A. No, sir, I didn't see it working.

Q. What--did you observe any other changes in the highwall?

A. No, sir, not at that time I didn't.

Q. At any time?

A. Well, right before the--I mean, if you are talking about right before I seen the rock hit him, you know, I had turned around and looked; and it all broke loose and came down.

Q. And you saw the rock actually strike the victim?

A. Yes, sir.

Q. When you saw it coming down, what did you do, if anything?

A. Well, I had just talked to Mike; and he walked away from the truck; and I had to walk to the back end--

JUDGE KOUTRAS: Who was Mike?

THE WITNESS: Mike Dulin, the man that was killed.

JUDGE KOUTRAS: Okay.

THE WITNESS: And I turned back and looked, and I looked up, and I seen this rock falling, and hollered for Mike to run, and I took one step towards him--I don't know why--but he never did hear me because of the drills that we work beside are so loud that he didn't hear me. And he looked up, and he seen them coming, and he turned around and took one step, and the rock just wiped him out.

Q. And you say the drills were operating at the time?

A. Yes, sir, at the time.

Q. Do you know what position Mr. Dulin was employed in?

A. He was a shooter, as I was.

Q. The same?

A. Yes, the same.

Q. How far away from the base of the pit were you at the time the rock broke loose?

THE WITNESS: Are you saying from the base of the highwall?

MR. STEWART: Yes.

A. (By Mr. Penrod) I was standing about twenty five to thirty feet away from the highwall.

Q. Out away from it in the pit area?

A. Yes, in the pit area.

Q. Do you recall--Withdraw that question. Do you know that distance the highwall had not been scraped, in your opinion?

A. No, sir.

Q. Do you have an approximate distance it was?

THE WITNESS: Oh, you mean the length of it?

MR. STEWART: Yes.

A. (By Mr. Penrod) Really no.

Q. Was it 10 feet, was it a long way, or a short way?

A. Well, if you are talking about the area we were in, it could be 150 to 200 feet, you know. The area we drilled in, the area we drilled in that day was all in that area, so I would say it would be 150 maybe 200 feet, that area we was in.

Q. And had the highwall been scraped in any of that area?

A. Not in the area we was at, no, sir.

Q. So that is approximately 200 feet that the highwall had not been scraped.

A. Yes, sir.

Q. Now within that 200 feet where did this rock break loose? Did it break loose in the middle or what?

A. Yeah, I could say it was in that area or maybe like closer to the part where it had scraping on it. It was close to the middle of the area that we was in. I can remember.

Q. So if I understand you, you observed the highwall before the accident.

A. Yes, sir.

Q. And you saw it after the accident.

A. Yes, sir.

Q. Were there any other changes in the highwall after the rock broke loose?

THE WITNESS: You mean--

MR. STEWART: Throughout the entire length.

A. (By Mr. Penrod) Not that I know of.

Q. Did rock break loose any place else along that highwall that you observed?

A. Not that I can remember, no, sir.

Q. Mr. Penrod, did you report the condition of that highwall to anyone?

A. Not at the time, no, sir, I did not.

Q. And why not?

A. Because from the time we noticed the crack until the accident there wasn't that much time in between it, you know.

Q. What about the overall condition of the highwall in the area you were working in? Why didn't you report that?

A. Well, it was, I mean, I'm not saying I failed in the reporting it; but it was obvious everybody could tell by looking at it. You know, it had never been scraped or anything but--

Q. Was Peabody Coal Company in a habit of failing to scrape the highwall?

A. Well, they had failed before, yes they have.

Q. But that is not, is that something they usually do?

A. Yeah, they usually scrape the highwall.

Q. They usually scrape it.

A. Yes, sir.

Q. Do they usually clean off the top?

A. Yes, sir.

Q. Do you know any reason why that hadn't been done on, September 2?

A. No, sir, I do not.

Q. Was the shovel there?

A. Yes, sir.

Q. Was it operating?

A. Yes, sir.

On cross-examination, Mr. Penrod confirmed that he is a member of the mine safety committee, and has served as chairman. However, he resigned and was not a member at the time of the highwall accident. He stated that he was aware of his right to refuse to work in an unsafe environment. He confirmed that he knew the accident victim for four years and considered him to be an experienced miner and safe worker. Mr. Penrod also considers himself to be a safe worker (Tr. 98).

Mr. Penrod confirmed that he was in the pit on the day of the accident and that he visually observed it while there. He stated that he usually "keeps an eye on it" while working in the pit, and even though it is the pit foreman's job to inspect the highwall, Mr. Penrod indicated that he personally watches it (Tr. 99). Mr. Penrod confirmed that he was aware of his safety rights on the day of the accident, and when asked why he did not report the highwall conditions to management, he responded as follows (Tr. 100-101):

Q. Now, when you noticed this area that you considered not to be properly scaled, why didn't you report it to management?

A. Because at the time I didn't pay that much attention to--

> JUDGE KOUTRAS: Hold it just a minute.
> All right. Go ahead.
>
> THE WITNESS: As I went to the pit, I noticed the highwall. But as we do a lot of things, we--on our daily routine you go ahead and work; and you just kind of watch it.
>
> It's just--a lot of things like anybody else's job, sometimes it's a daily thing that happens. You just don't pay much attention to it.

Mr. Penrod confirmed that the shovel operator scales the highwall as he "dead-heads" back after exposing the highwall, and that this is done to take down loose material on a bad wall. He also indicated that "sometimes after you strip a wall it will break loose again. It happens down there" (Tr. 102). He did not observe the shovel operator either scale or not scale the highwall in question, and he relied on what he observed after the accident. He confirmed that highwall conditions may change and may vary, and that this is due to sandrock and mud which may be encountered during the stripping operation (Tr. 102).

Mr. Penrod stated that approximately 15 or 20 minutes before the accident occurred, he "noticed there was a problem with this crack." He confirmed that he and the accident victim engaged in some "joking conversation," and he explained further as follows (Tr. 104-106):

> A. No. He--like I say, he was--he was aggravated or something because I told him about getting the Red Hots. And we was making light. And he turned around and walked over to his truck.
>
> Q. So you didn't feel that this was such a dangerous condition that you needed to report it to your supervisor?
>
> A. Not at the time, no.
>
> Q. And you didn't report it to your supervisor or any concern that you had about that area that was not properly scaled?
>
> A. We hadn't did it, no, sir.

Q. How far into the shift was this accident, did it occur?

A. I don't know. It was about 2 o'clock, I recon. I'm not sure about that.

Q. And what time does your shift start?

A. It starts at 8:00.

Q. And when does it end?

A. Four o'clock.

Q. So it was near the end of your shift?

A. Pretty close to the end.

Q. Have you ever known Mr. Dulin to work in an unsafe condition?

A. Times I've been around him, no, he wouldn't work in no unsafe conditions that I could think of. No, sir.

Q. How about you? Have you ever worked in unsafe conditions?

A. I've been in them; yes, sir.

Q. Okay. Have you--did you feel that you were in unsafe conditions that day?

A. When?

Q. Prior to the accident occurring.

A. I say this is the everyday routine. When you go into the pit, sometimes you just don't pay no attention to it--because not trying to change some--but if you have to worry about it all the time, you can't stay in there. It would drive you nuts. So you just go ahead and do it and not worry about it. You just . . .

Q. But you are aware that you could have refused to work?

A. Yes, sir.

Q. And you did, in fact, fail to report to Mr. Barrett--

A. Yes. From the time that I spotted the crack until Dulin was killed, I didn't--the thought of getting the Red Hots and that part of my job that I was doing, I failed to report it.

In response to further questions, Mr. Penrod indicated that after a highwall is scaled or stripped, it can still break loose, and he could not remember whether the highwall in question had recently broken loose. He believed that his supervisor should be able to tell if a highwall had been scaled or unscaled, but this would depend on how long he was present in the pit area (Tr. 107).

Mr. Penrod stated that at the beginning of his work shift on the day of the accident, the highwall looked like it was not scaled, but he observed no crack. The crack appeared later at the end of the shift, but he detected no movement of the rock and said nothing to the accident victim about the crack. Mr. Penrod did not know whether or not the victim saw the crack (Tr. 109).

Michael R. Montgomery, confirmed that on September 2, 1982, he worked at the mine in question as a shooter, and was working in the pit with the accident victim. Mr. Montgomery indicated that he had worked as a shooter for about two months prior to the accident, and during that time worked with the victim (Tr. 112). Mr. Montgomery confirmed that he observed the highwall in question during his shift, and he stated as follows (Tr. 113).

Q. Mr. Montgomery, did you have an occasion to observe the highwall prior to this fatal accident?

A. That morning I looked at the highwall like I normally do. I checked the highwall just looking at it. The highwall in that particular area wasn't scaled really good; but, you know, there was a lot of the pit--it didn't look any worse than it had been looking coming up through the pit. I didn't observe anything hanging loose.

Q. How did the top of the highwall look? Did you have any occasion to go to the top of the highwall?

A. I wasn't up on top of the highwall that particular day. The only observation that I got was from the bottom. You know, just looking up I didn't notice anything that loose that morning.

Q. Had it been dragged?

A. Ah, I guess it had. But in that particular section it wasn't--it hadn't been done as cleanly as it had in some other areas of the wall.

Q. Now, did you observe the fall of the rock that struck Mr. Dulin?

A. Yes. I was watching Mr. Dulin--well, I was looking over towards that drill. It was getting on to 4 o'clock in the afternoon. And normally we were getting ready to put off a shot then, and so we were trying to keep our patter squared up,--I don't know whether you are familiar or not--

Q. No.

A.--with the terminology. But, anyway, I was looking over towards the drill. And I was watching Mr. Dulin. I watched him load the hole. And I was just seeing where the other drill helper was. And, yeah, I saw the rock as it was about two-thirds of the way down the wall there. I saw it. And, of course, I yelled; but I was inside the drill with the thing running and everyghint, so he--there wasn't any way with all the noise and everything. But I saw it.

Mr. Montgomery stated that at the time he saw the rock strike the victim, he was in an enclosed cab some 70 feet from the highwall and that the victim was approximately 50 feet away from him. The stripping shovel "was on up the pit a pretty good distance," and he estimated that it was 400 yards away. He confirmed that he observed no rocks fall from the highwall during the time prior to the one that struck the victim (Tr. 116).

On cross-examination, Mr. Montgomery confirmed that he is a UMWA member and that he considers himself to be an experienced surface miner. During the time he worked with

the victim, he found him to be an experienced miner and a safe worker (Tr. 118). He further described the condition of the highwall as follows (Tr. 118-120):

> Q. Now, you stated on direct examination that the highwall had been dragged but not as cleanly as the other sections of the highwalls. What do you mean by dragged exactly?
>
> A. Well, as I understand it, they take the bucket--I've watched them--they take the bucket and go up to the top of the wall. And they will drag all the loose stuff. And in that particular area, it wasn't as cleanly--I mean, there was stuff up there, but it wasn't--I didn't observe it to be hanging loose. It wasn't--some places where they clean it off, you know, it looks like a dozer has been along there. You know, they really have done a good job of it in certain area.
>
> Q. So you were saying that this was dragged but just not as well as in certain other areas?
>
> A. Right.
>
> Q. And you stated--did you see any loose material on the highwall?
>
> A. I didn't observe any loose material about to fall. You know, there was stuff sitting up there. But from where I was at my vantage point, you know,--
>
> Q. What would have happened if you would have seen loose material? What would you have done?
>
> A. I would have notified my foreman.
>
> Q. Okay. Would you have gotten out of the pit?
>
> A. Would I have gotten out of the pit?
>
> Q. Yes. Would you have gotten away from that area?

> A. I would have gotten away from the wall, yes. I probably wouldn't have gotten out of the pit. But I would have gotten what I consider a reasonable distance from the wall.
>
> Q. But you never had any occasion prior to Mr. Dulin's accident to report a hazardous condition to mine management?
>
> A. Ever or--
>
> Q. No, I mean just that day.
>
> Q. That day. No. Huh-uh.

Mr. Montgomery indicated that mine management usually took care of previous safety conditions he has reported, and he stated that he is not afraid to make complaints. He confirmed that his supervisor was present in the vicinity of his work area at least a half an hour prior to the accident, and while he had an opportunity to report any unsafe condition to his supervisor at that time, Mr. Montgomery stated "I hadn't observed anything to report" because he was in the drill (Tr. 121). Mr. Montgomery confirmed that the respondent has corrected highwall conditions in the past, that the highwall is scaled by the shovel for safety reasons, and that highwall conditions do change and he explained those changes (Tr. 121-122). He confirmed that he had no indications prior to the fatal rock fall that it was going to fall (Tr. 122). He also confirmed that the highwall was damp, that conditions were wet, and that "the highwall had been dragged to some extent." However, he stated that "I didn't see anything about to fall" (Tr. 123).

In response to further questions, Mr. Montgomery stated that since he was in a drilling machine in the middle of the pit, he would not have observed the highwall as close as a chooter, and he described what he observed as follows (Tr. 125-126):

> A. Well, that day, you know, when I looked at that that morning--you can look at a wall and tell if they've done anything to it or not, you know. They had done some work on it.
>
> Q. Was that--

A. I'm just saying that it wasn't as clean as it was in other areas of the highwall.

Q. Because the area that you were working in, you say, was not as clean as others?

A. Right. I think right up in front of us there was clean area. I don't remember real well, but it seems like there was an area that was really scaled nice right up past that, you know.

Q. Past that area, towards the direction you were going?

A. Yeah.

* * *

A. From just what I have observed, normally once they have removed the overburden as far over as they are going to remove it, they usually, as they move the machinery up, they will scale it as they go, you know.

And at Tr. 127-128:

JUDGE KOUTRAS: Did you at anytime have any conversation with Mr. Penrod or Mr. Dulin concerning the condition of the highwall?

THE WITNESS: Not concerning the condition of the highwall.

JUDGE KOUTRAS: Several times in response to questions of either Counsel McKown or Mr. McKown asked you with regard to whether or not you observed any loose, hazardous rock, your response was: Nothing that looked like it was going to fall.

THE WITNESS: I guess you want a clarification on that?
JUDGE KOUTRAS: Yes. And my follow-up question to that is do you usually wait until the rock starts falling before you consider it to put you in peril?

THE WITNESS: No. No. The only thing that I can say is that the wall had not been good for some time up to there. By that, I meant that it didn't look any worse to me that particular day that it had been looking.

JUDGE KOUTRAS: All right.

THE WITNESS: I felt that it had not been scaled as well as it should been. But, you know, we'd been living with it.

JUDGE KOUTRAS: Based on the condition of the highwall that you observed that day, what if Mr. Barrett had said to you, Mike,--if I can take the liberty of calling you Mike--Mike, instead of putting you on the drill today, we're going to make you a loader and a shooter. Would you have insisted that the highwall be scraped better than it was, or would you have any fears of going and working and doing the job of loading and shooting?

THE WITNESS: If I had been Mr. Dulin, it would be me instead of him because I would have done the job. I didn't observe anything--I'll put it this way: Once I sat on that drill, I didn't look at the top of that wall during the day because of where I was at. I didn't have any need to. Maybe I should have, to help watch for my fellow workers; but I was in the middle of the pit; I was a safe distance from it; and I didn't feel--I just didn't observe the wall. If I had been a shooter, I know that I would have watched that wall closer.

JUDGE KOUTRAS: Well, okay. But the question was: If it wasn't as clean as it usually is, would you have insisted that they make it a little cleaner before you proceeded to work as a driller or loader?

THE WITNESS: If I had seen that falling off a wall, yeah, I would have gotten out of the area.

KENT 83-86--Petitioner's testimony and evidence

MSHA Inspector George Siria confirmed that he issued Citation No. 2075267 on September 3, 1982, exhibits P-5 and P-6, citing a violation of section 77.1005 for failure by the respondent to remove loose hazardous materials from the highwall in question. He confirmed that the citation was issued at or about the same time as the previous one

and that it concerned the same highwall condition connected with the fatal accident. Mr. Siria stated that the highwall appeared "to be loose" and that "I figured if it was loose it was hazardous to anybody working underneath it." He described the highwall as being composed of dirt, topsoil, and limestone, and he indicated that "it was just loose material that had not been scaled off" (Tr. 132).

Mr. Siria stated that in his opinion, the top of the highwall had not been scaled or "cleaned off," and he confirmed that he found "high negligence" because "it was very obvious to me and I thought it should have been to the company also" (Tr. 133). He stated that the 150 foot area which he cited did not appear to be scaled at the top or face of the highwall, and that he saw loose rocks. He also stated that "If I had been working in the pit, I would have been afraid of it" (Tr. 135).

On cross-examination, Mr. Siria conceded that he has never observed the stripping shovel at the pit in question, and he confirmed that he never observed the shovel scale or not scale the highwall in question, and that he relied on what he observed from the top and bottom of the highwall after the accident. He indicated that his opinion that the highwall had not been scaled was based on his observations of loose rock and adjacent area which had not been scaled (Tr. 136). Based on his experience, he believed the highwall to be "obviously dangerous" (Tr. 137). He stated further that he observed overhangs and cracks in the 150 foot highwall area in question, and did not believe that the highwall was ever scaled and that he simply did not notice it (Tr. 138). He confirmed that during abatement "they really did a good job" of scaling (Tr. 140).

MSHA Inspector James H. Utley confirmed the citation issued by Inspector Siria, and he also confirmed that on September 3, 1982, he walked the top of the highwall in the area where the fatal rock fall accident occurred. He described an area approximately 150 feet long "where the loose material on top of the highwall had been partially dragged off." He stated that the stripping shovel had dragged some of the loose material off, but that in the immediate face area where the rock fell it was "a little rough" (Tr. 150). When asked to explain further, he stated that the material he observed at the top of the highwall "was there in its normal state. It was there when the Earth was formed, I guess; and it had not been removed" (Tr. 151). He then stated that no one from the company explained to him why that area looked different from other areas which had been dragged or scaled, but that he recalled no conversations with any company officials about the citation which was issued (Tr. 151).

On cross-examination, Mr. Utley stated that part of the 150 foot highwall was scaled and part was dragged, and he was of the opinion that there was a difference in these two procedures. He was of the opinion that "maybe somebody got a little behind or in a hurry, and they failed to drag the top of the highwall the way they had been doing it in the past," but he conceded that he did not interview any of the stripping shovel operators (Tr. 153). In response to further questions, Mr. Utley stated as follows (Tr. 155-156):

> Q. How do you define overhang?
>
> A. How do I define overhang?
>
> Q. Yes.
>
> A. An overhang would be an area of the highwall that protrudes out past the average face of it. And it would have an area beneath it so that it could turn loose and fall.
>
> Q. Did you see overhangs on this 150-foot area?
>
> A. Yes. There were some areas that could be defined as overhangs.
>
> Q. And how do you identify material as being loose and unconsolidated? What do you rely on to come up with that conclusion?
>
> A. Well, loose and unconsolidated material to me would be material that had been drilled and shot that was ready to be stripped by the strip shovel. Also there can be geologic deposits that are loose and unconsolidated in their normal state.
>
> Q. And, of course, you didn't see the shovel make a pass through that area of the highwall?
>
> A. No, sir.
>
> Q. And, of course, you didn't see the condition of the highwall prior to the accident occurring?
>
> A. No, sir, I didn't.

Kerry Teague testified that he was a drill foreman on the day of the accident in question, and that he observed the highwall and was looking for loose material. He stated that on September 3, 1982, when he observed the highwall, he found it to be in good condition and properly scaled. He confirmed that when he observed it on September 2, 1982, he saw no loose rocks or other material (Tr. 168). He confirmed that he has known the accident victim for "all of his life," and he considered him to be an experienced and safe worker, and did not believe that he would work in an unsafe environment (Tr. 169).

On cross-examination, Mr. Teague confirmed that the entire pit in question was under his supervision, and he stated that he traversed the pit area by truck and by walking. He confirmed that his shift starts at midnight and that it is dark, and that any lighting present would be generated by the lights on the particular pieces of equipment operating in the pit area. He explained the movement of the stripping shovel on the day of the accident, and he stated that 50 or 60 feet of overburden was stripped that day. He also indicated that at the time of the accident, the shovel had moved approximately 36 to 45 feet along the highwall. He also confirmed that he did not remain in the area after 8:00 a.m. on the day of the accident (Tr. 175). He confirmed that he next went to work at 12 midnight after the time of the accident, and that the area was still cornered off, and that he performed no work at the location of the accident (Tr. 176).

In response to further questions, Mr. Teague stated that the area where the accident occurred had been stripped for two days prior to the time of the accident (Tr. 179). He confirmed that when loose materials are encountered it is "stripped down," and that this is done "if it is hazardous," and that "we do take care of it" (Tr. 180). When asked to explain when such loose material "is not hazardous," he stated "I can't" (Tr. 181). He confirmed that he was not present when the accident occurred, and that his observations of the conditions of the highwall were based on what he saw on the previous shift and on the shift after the accident (Tr. 181).

Robert Barrett, testified that on September 2, 1982, he was the drill foreman at the pit in question, and he explained his duties (Tr. 184). He confirmed that he had six people working for him that day, including the accident victim, and he considered him to be a safe and good worker

(Tr. 186). He stated that blasting and weather conditions can change the condition of a highwall, and he confirmed that the presence of a crack would indicate that a rock may fall, and he confirmed that he has observed a rockfall occurring without any warning (Tr. 187).

Mr. Barrett confirmed that he inspected the highwall on September 2, 1983, and observed no unsafe conditions or loose, unconsolidated materials. He also confirmed that he observed no conditions which in his opinion would cause him or anyone else to fear for their safety. He believed the highwall was adequately scaled and stripped, and he explained the procedures for doing this (Tr. 188-189). He confirmed that no one raised any safety concerns about the highwall conditions on the day of the accident, and he did not feel that he was in any danger working in the highwall area on the day of the accident (Tr. 193).

On cross-examination, Mr. Barrett stated that the pit foreman makes entries in the preshift examination books, and that he too has made such entries. He confirmed that he made no entries, but that the pit foreman did and that he examined the book (Tr. 195). He explained the mining cycle and how the coal is stripped with the shovel (Tr. 196-202).

In response to further bench questions, Mr. Barrett stated as follows (Tr. 209-210):

> JUDGE KOUTRAS: Several witnesses have testified in this case, and you haven't heard their testimonies, but they described the highwall on September 2nd as being "rough," "not like I would like it to be," "not like it usually is," "not like part of it was," all kinds of descriptions were given. But there seems to be a vast difference of opinion as to whether or not there was loose, hazardous materials on the highwall. And I have some difficulty sometimes comprehending where everybody is testifying in this case, whether it be a mine management pit foreman or some guy who is rank and file down there doing the job, doing the actual working at the foot of the highwall. And I detect that everybody is not all on the same wavelength as to what loose, hazardous material is all about. And I hear testimony, for example, that: "We're all aware of it"; and "When I see the first rock coming down,

> I turn tail and run"; and you've indicated that you inspected--you said something about driving by in your truck. Now, I don't know whether that means you drive by and inspect it or you actually get up on top. But the point I'm trying to make is: Do people just accept the highwalls and try to have everybody fend for himself?
>
> THE WITNESS: No. It's a team operation. Anytime anybody--and this is encouraged--a man facing an unsafe condition should report it.
>
> JUDGE KOUTRAS: Well, what I can't understand is how do you account for the fact that two federal inspectors went out there to the top of the highwall, and they described loose, hazardous materials to me. And you went out there and looked at the same highwall, and you didn't see any loose, hazardous materials. How do you account for the people looking at the same highwall at about the same time and coming to different conclusions as to what they observed?
>
> THE WITNESS: I can't answer that. The only thing that I can answer is my personal feeling towards it. It was a safe wall.

Edward Carlisle, mine superintendent, testified as to his background and experience, and he described how the highwall is created and mined, how the conditions could change, and what steps are taken to identify dangerous conditions (Tr. 213-220). He confirmed that he was acquainted with the accident victim and that he considered him to be an experienced and safe worker (Tr. 220).

Mr. Carlisle confirmed that he was in the pit in question on the morning of the accident, and that he arrived there shortly before 7:00 a.m. and drove through the area. He stated that he saw nothing that morning which caused him any alarm for the safety of the miners working in the pit (Tr. 221). He considered the scaling and stripping of the highwall that morning to be "satisfactory" (Tr. 221), and that "we had done the best that we could with what we had to do" (Tr. 222). He also believed that the area where the accident occurred was scaled adequately (Tr. 222), and he described how the highwall scaling is done (Tr. 223-225).

Mr. Carlisle confirmed that no MSHA or state inspectors were in the pit area on the morning of the accident and that he observed no conditions that would lead him to believe that there was a violation of the ground control plan. Further, he indicated that no one reported any unsafe highwall conditions to mine management prior to the accident (Tr. 227), and he stated that apart from the accident in question, there have been no prior highwall fatalities at the mine in question (Tr. 228).

On cross-examination, Mr. Carlisle confirmed that the pit foreman had noted some problems with the highwall conditions in the area where a truck was located at another area (Tr. 235), and he testified as to his inspection duties, including the area where he would inspect the highwall conditions (Tr. 241-243). In response to further questions, he stated as follows (Tr. 244-246):

> JUDGE KOUTRAS: I've heard some testimony about the highwall location where this M 191 truck was working, and apparently someone had made some notation in the company--either preshift or on-shift inspection report--that on that very day the highwall condition by the M 191 was hazardous and that employees were told to stay away from it. Okay?
>
> THE WITNESS: Yeah, it might have been on that day. I don't know.
>
> JUDGE KOUTRAS: Well, let's assume that there was a similar notation at the precise location Mr. Dulin was working in on September the 2nd. What would you then say about the condition of the highwall?
>
> THE WITNESS: Well, we would have got the people away from it.
>
> JUDGE KOUTRAS: Well, what leads an examiner to come to a conclusion that the highwall in one location is hazardous and that it should be dangered off; but yet in another one it is not loose or is in good shape, or what? What--
>
> THE WITNESS: If it is solid and you can't see any cracks or movement in it, then you can just on your own judgment look and see if it is going to fall or not. That's about the only way.

JUDGE KOUTRAS: Okay. Now, I'm going to ask you the same question that I asked one of the other witnesses. You inspected the highwall that very same morning?

THE WITNESS: Yes, sir.

JUDGE KOUTRAS: And about 20 minutes after the accident one federal inspector appeared on the scene, and he looked at it, and he inspected it, and he climbed to the top or at least within the next day or so, and assuming no conditions changed, their testimony is that there was loose, hazardous, unconsolidated material that hadn't been taken down.
Now, how can your counsel explain that you, as the superintendents saw the same condition and said that it was in good shape, it was scaled down, and there wasn't any problem? Yet the two inspectors looked at the very same condition or the same area, and they come to an opposite conclusion?

THE WITNESS: After the rock fell out, on either side of it, yes, there was loose material then because it made it when it came out.

JUDGE KOUTRAS: For a hundred and fifty feet?

THE WITNESS: No, sir.

KENT 83-66--Petitioner's testimony and evidence

MSHA Inspector George Siria confirmed that a fatal accident occurred at the mine on March 25, 1982, and that upon investigation of that incident he issued a citation on March 29, 1982, charging a violation of section 77.404. He also confirmed that another inspector terminated the citation after abatement of the cited condition (Tr. 6). Mr. Siria confirmed that he operated the throttle of the machine in question, and that when it was "cold" it would shut off, but when "hot," it would not. He stated that he did this either the day of the accident, or the next day (Tr. 7). He also stated that his inquiry did not establish that the cited condition had actually been reported to mine management prior to the accident, but that two months earlier the cited dozer would not shut off, and that "the practice of shutting off was getting out on the track and shutting it off, putting it in neutral and shutting it off" (Tr. 8).

Mr. Siria stated that his investigation indicated that the accident victim had previously shut the machine off by climbing out on the track, and when he first observed the machine, the gear was between second and third, rather than the neutral or "lock-out" position. He concluded that the victim had pushed the lever from outside opening the throttle, and that instead of shutting the machine off, the machine went forward throwing the victim off (Tr. 8-9).

On cross-examination, Mr. Siria stated that he has never operated any surface mine heavy equipment, including an International TD 25 Dozer, and that he did not examine the cited machine in question in any detail. He did examine the throttle and linkage, and while he did sit in the cab, he did not test the brakes or transmission, nor did he start the machine up (Tr. 9). He did not use the throttle when the machine was running, and he relied on statements given to him during his investigation to support his conclusion that the throttle did not work. He confirmed that he had no personal knowledge as to whether the throttle worked or not, nor did he have any idea as to why "hot" and "cold" made any difference to shift linkage (Tr. 10).

Mr. Siria stated that the dozer transmission lock-out device was operative, and he stated that he sat in the machine cab and he described the operating positions of the transmission shift lever (Tr. 11-12). He stated that not all equipment defects necessarily render a machine "unsafe" and in violation of the cited safety standard, and he defined "safe" as "where it would not be likely to harm someone that was operating it" (Tr. 13). He believed that the failure or inability to throttle down the machine was unsafe because this was the only means for shutting it off, but he conceded that the machine could be stopped from inside the cab by dropping the blades to turn it off, and that this alternative method would be safe (Tr. 13).

Mr. Siria conceded that there were no eye witnesses to the accident and that MSHA did not know how it occurred. He stated that the accident victim was 62 years old, had 31 years of mining experience, six of which were as a dozer operator. He did not investigate the victim's health, and he found it surprising that anyone would fail to lock out the dozer transmission. He explained further as follows (Tr. 16):

> Q. And you feel that that throttle was the cause of his death?
>
> A. Yes.

Q. Please explain.

A. The throttle in addition to him not locking it up. If the throttle had worked and he had shut the dozer off like it was designed to do, then he wouldn't have been out on the--If that was what he was doing, and we presume this was what he was doing from the statements of other people. And other people have shut it off the same way.

Q. But he also had the alternative of using the hydraulic, you admit that?

A. Yes.

In response to further questions, Mr. Siria confirmed that MSHA's accident investigation indicated that when the accident was first discovered the machine motor was still running (Tr. 16). He confirmed that during the accident investigation it was determined that several other miners had operated the dozer in question approximately a month or so before the accident and that they had problems shutting the engine down from inside the cab of the machine.

Mr. Siria confirmed that MSHA's accident investigation report concludes that "the machine was not kept in a safe operating condition in that the mechanism for stopping the engine from inside the cab was inoperative" (Tr. 23). In response to further questions concerning this conclusion, he stated as follows (Tr. 23-27):

JUDGE KOUTRAS: Did anybody ever determine that the mechanism for stopping the engine from inside the cab was inoperative?

THE WITNESS: Yes, your Honor. It--

JUDGE KOUTRAS: I'm asking you a question. Did anybody ever determine that the mechanism for stopping the engine from inside the cab was inoperative?

THE WITNESS: Who do you mean by anybody?

JUDGE KOUTRAS: Well, let's say during the course of these investigations. I take it that once the machine was found that someone did something with the machine. Right?

THE WITNESS: The machine was idle and the citation was abated about a month and a half later.

JUDGE KOUTRAS: No. During the course of the investigation of the fatality did someone make a determination that this machine that the engine could not be stopped from inside the cab?

THE WITNESS: From the statements. I don't know. They were there before I got there. I don't know really if anyone checked it out. I don't know if another inspector checked it out or not to see what the problem was there. Personally, I didn't crank it up and try to shut it off.

* * *

JUDGE KOUTRAS: Thank you. Here is a bulldozer that is found operating with a closed throttle and it had just run over somebody and is against the embankment. And based on the investigative report, two eye witnesses, two persons that were summoned to the scene or went to the scene and found the victim got up there and did something to the machine. They shut the engine off, or they put it--I'm talking about during the course of the investigation of the fatality, did anybody ever tear the machine apart or make any determination that the mechanism for stopping the engine from inside the cab was, in fact, inoperative as of the time of the fatality? Did anybody ever make that determination?

THE WITNESS: Not in my presence.

JUDGE KOUTRAS: Did anybody ever do it? In your presence or out of your presence.

THE WITNESS: No.

JUDGE KOUTRAS: Would that be a logical investigative step to take to find out what's wrong with the machine. It's for somebody to tear it down and find out what was wrong with it. In your opinion, would that be a logical thing to do? Or would it be illogical?

THE WITNESS: The logical part of it would be to fix it so it would shut the machine off like it should be.

JUDGE KOUTRAS: Before you can fix anything you've got to find out what's wrong with it, don't you?

THE WITNESS: Mainly what was wrong with it.

JUDGE KOUTRAS: Did--

THE WITNESS: When they investigated it the linkage was out of adjustment and some dirt and stuff would cause it not to let the lever go down far enough, and worn parts in the linkage would cause it too.

JUDGE KOUTRAS: I note from Exhibit P-1 that the citation was terminated on May 4th, and Inspector Sparks says that the TD 25 International dozer appears to be in safe operating condition. This is a month or so after the fatality, the citation is terminated. Do you know what they did to terminate the--

THE WITNESS: I don't know. But that was my--When this was printed I got back to my regular duties and I don't go back to this anymore unless I got assigned to it. I was on another accident.

* * *

JUDGE KOUTRAS: But no one tore the machine down during the time that the accident happened and the time that you issued the citation--

THE WITNESS: No.

JUDGE KOUTRAS:--to specifically find out if the mechanism did not, in fact, stop it from inside.

THE WITNESS: That's true.

During a bench colloquy as to why the throttle mechanism was not examined, MSHA's counsel stated as follows (Tr. 29-31):

JUDGE KOUTRAS: Well, I don't--how about the other particular ones. The TD 25 International, all are designed to be cut off from inside the cab?

MR. STEWART: That's correct.

JUDGE KOUTRAS: And the reason this one wasn't was what?

MR. STEWART: Our contention is that the throttle mechanism did not work properly. That is the piece of machine that cuts it off from inside the cab.

JUDGE KOUTRAS: At the time of the investigation did someone dismantle that throttle and take a look at it and come to the conclusion that you just stated?

MR. STEWART: No. Apparently, Peabody did.

JUDGE KOUTRAS: He says, no. Nobody ever did.

THE WITNESS: No. during the investigation, no. Not while I was there.

JUDGE KOUTRAS: Has anybody to this day ever come to the conclusion that that's what caused this piece of equipment not to be shut off from inside the cab?

MR. STEWART: I don't. I'm not aware of any finding that that was what stopped it.

JUDGE KOUTRAS: Doesn't that seem like a very logical step in the investigative process?

MR. STEWART: Well, your Honor, I believe that this situation--

JUDGE KOUTRAS: If someone were to say to you that there was an accident caused by defective brakes, wouldn't the first step be to pull the brakes off and see if they're defective?

THE WITNESS: This happened. They did.

JUDGE KOUTRAS: They did what?

THE WITNESS: They--

JUDGE KOUTRAS: They pulled the throttle off and they found that it was defective?

> THE WITNESS: Well, they put a new one on and it worked. Evidently that was all because the citation was abated by the Service Inspector about a month and a half later. That was an extra dozer anyhow they didn't use it all of the time.

William Jarvis stated that in 1982 he worked as a tractor operator at the mine in question. He testified that approximately two months before the accident he operated the TD 25 dozer and found that one cutting clutch was inoperative and that one of the brakes was bad. At the conclusion of one of his work shifts he advised his foreman that he would not operate the dozer because of these conditions, and that he had to shut the engine off by manipulating the throttle linkage on the fuel pump from outside the cab of the machine. At that time, he placed the machine in neutral gear but it did not lock it out (Tr. 31-33).

Mr. Jarvis stated that the throttle linkage inside the cab of the dozer was designed to shut off the engine, but at the time he used it he had to step out on the machine crawler in order to press the fuel pump throttle linkage down further in order to shut the engine down (Tr. 34). He also stated that he had never experienced this problem in the past while operating many tractors (Tr. 35).

On cross-examination, Mr. Jarvis confirmed that he had no knowledge as to whether the bulldozer in question was in the maintenance shop for repairs after his experience with it, and he had no knowledge as to whether any repairs were made on the machine. He again confirmed that he shut the engine off at the end of his shift by means of the throttle linkage from outside the cab of the machine.

Mr. Jarvis stated that he could not recall reporting the throttle linkage problem to his foreman, and he did not believe that the machine at that time was unsafe for him since he could have used the hydraulic blade to stop the engine (Tr. 37). Mr. Jarvis indicated that one had to back out of the cab of the machine, and he described the locations of the heater and the lock-out lever (Tr. 38). He also indicated that it was cool during March, and that he would usually stay in the cab of the machine to eat lunch because it was warm and that he would have no reason to shut down the engine until the end of the shift (Tr. 40).

In response to further questions, Mr. Jarvis testified as follows (Tr. 43-44):

JUDGE KOUTRAS: Mr. Jarvis, let me ask you this. As a bulldozer operator, do you consider having to get out of that cab and fooling with the linkage on the fuel pump an ideal way of shutting off that machine?

THE WITNESS: No.

JUDGE KOUTRAS: What is the acceptable way of shutting off that machine?

THE WITNESS: From inside the cab with a hand throttle.

JUDGE KOUTRAS: And have you shut off such machines from inside the cab with hand throttles in the past?

THE WITNESS: Yes.

JUDGE KOUTRAS: Ruling out getting out on the crawler with the--

THE WITNESS: Yes.

JUDGE KOUTRAS: How many times have you stopped the machine by dropping the front blade and raising up the engine and choking it out, assuming that's what it does, doesn't it?

THE WITNESS: Well, if you can get it raised up enough you can.

JUDGE KOUTRAS: How--What's the proper--What's the best way? What's the most acceptable was as a dozer operator to stop that machine by dropping the blade or doing it from the inside?

THE WITNESS: Shutting it off with the hand throttle.

James Jones testified that he has worked for the respondent at the mine in question for approximately 5 1/2 years and that for the past 4 years he has operated bulldozers. He confirmed that in March 1982, he operated the TD 25 International bulldozer which was cited in this case. He stated that he operated it during the 4:00 p.m. to midnight shift on March 24, 1982, just prior to the accident, and that the machine was brought to him by a mechanic and that the engine was running.

His regular bulldozer was down for repairs and the TD 25 in question was a substitute. He operated it for the rest of the shift with no problem, but at the end of the shift he could not shut the engine off by means of the throttle and had to raise the blade, thereby "choking" the engine out in order to shut it off. This was done from inside the machine and he considered this a safe procedure as long as he was in the machine. He confirmed that he had not previously operated the dozer in question, and that he always used the hand throttle from inside the cab to shut the engine down on other bulldozers he had operated (Tr. 44-50).

On cross-examination, Mr. Jones confirmed that he is a UMWA member, and he stated that he did not report the fact he could not shut the engine down on the TD 25 dozer with the bad throttle to mine management, and he confirmed that the victim had operated the same machine several months prior to the accident (Tr. 52-54). Mr. Jones confirmed that when the machine was brought to him it had recently been out of the shop, and except for the throttle, everything was in working order. He did not discover the throttle condition until the end of the shift, and he did not believe that he was in any danger by not being able to shut the engine down by means of the throttle (Tr. 55).

Gary Bowles testified that he has been employed by the respondent for 17 1/2 years, and that for the past five years he has been a mechanic. He confirmed that he was familiar with the TD 25 bulldozer in question, and that he has performed maintenance work on it. He stated that the throttle linkage from inside the cab of the machine is the primary way to shut the engine down and in those instances when the engine would not shut down the throttle linkage was the problem (Tr. 58-60).

Mr. Bowles testified that he was summoned to the scene of the accident on March 25, 1982, and was at that time serving as a mine safety committeeman. When he arrived at the scene of the accident the bulldozer in question had been trammed back from the embankment where it had come to rest and the engine was idling. He climbed into the cab of the machine and tried to shut the engine off with the throttle but could not do so. He dropped the blade of the machine to the ground and "killed" the engine. He confirmed that the throttle linkage on the bulldozer in question was a common problem (Tr. 60-63).

Mr. Bowles confirmed that a complete new throttle linkage system was installed on the machine in question

after the accident, and that while he did not perform the work, the day shift mechanic showed him the old linkage which had been taken off the machine (Tr. 63). When asked whether he believed the machine with a defective throttle linkage was a safe piece of equipment, he replied (Tr. 63-64):

> A. It wasn't safe as--Well, it wasn't unsafe as far as operating it, but it was a part of that equipment design to, for the purpose of shutting it off, it made it unsafe in the sense of the word that when to sometimes kill that engine you had to get out on the tracks to kill it.
>
> Q. Or lowering the blade.
>
> A. Or lowering the blade.

On cross-examination, Mr. Bowles stated that he knew the victim, and while he had no personal knowledge that he was aware of the throttle linkage problem, he had heard that the victim had been told about the problem. Mr. Bowles stated that he had no reason to know why the victim may have left the machine in gear (Tr. 64-66).

When asked his opinion as to how the accident may have happened, Mr. Bowles stated (Tr. 67-68):

> * * * he was going to get out of his dozer and eat dinner. And he got out of the--When the engine wouldn't shut off with the throttle, when he got out of the tractor he either locked the engine or transmission in gear or didn't take it out. And when he pulled on the throttle to throttle the engine down and kill it he pulled it the wrong way. And being a man 62 years old he couldn't--he couldn't get out of the way fast enough and he couldn't jump back fast enough to get off the dozer.

Respondent's testimony and evidence--KENT 83-66

Donald Holt, respondent's Eastern Division Safety Director, testified that while he was not present during the actual accident investigation in this case, he conducted his own investigation by interviewing personnel, reviewing MSHA and State reports, and listening to tapes of the accident investigation interviews (Tr. 72).

Mr. Holt stated that he examined the TD 25 dozer in question, and that he was familiar with mandatory standard section 77.404(a). In his opinion, a machine can have a defect and still be considered safe. He indicated that simply because a machine mechanical part is out of adjustment, or has a "slight defect," this would not render it unsafe (Tr. 73). Mr. Holt considered the accident victim to be an experienced and safe worker, and he had a reputation for being conscientious (Tr. 75).

Mr. Holt stated that the inability to shut down an engine by use of a throttle was not a safety hazard or a violation of section 77.404(a), because there was an alternative way of checking out the engine and the victim knew this (Tr. 75).

Mr. Holt offered two "theories" of his own as to how the accident could have happened. He indicated that the victim's age, lack of agility, and poor eyesight all contributed to the accident. Mr. Holt stated that the victim may have been caught up in the crawler of the machine when he attempted to stop it from creeping after leaving it to go to his pick-up truck which was nearby, or he may have accidentally accelerated the machine by inadvertently striking the throttle when he slipped while getting out of the cab during the lunch break (Tr. 76-85).

Mr. Holt was of the opinion that a defective throttle would not render the machine in question unsafe, and he conceded that the throttle in question was determined to be defective and that it was replaced (Tr. 85).

On cross-examination, Mr. Holt could not state whether or not a properly operating throttle could have prevented the accident (Tr. 87). He confirmed that his theories as to how the accident occurred were premised on the fact that the machine engine was running. When asked whether his opinions would have been different if there was a way to shut the engine down, Mr. Holt could not answer, but he considered that his opinions as to how the accident may have happened do not assume that the throttle was bad (Tr. 88).

Stipulations

The parties stipulated as to jurisdiction, and they agreed that the respondent is a large mine operator, and that the proposed civil penalties, if affirmed, will not adversely affect the respondent's ability to continue in business (Tr. 3).

Findings and Conclusions

KENT 83-66

In this case, the respondent is charged with a violation of mandatory safety standard 30 CFR 77.404(a), which provides as follows:

> (a) 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.

Petitioner's counsel argued that the testimony and evidence adduced here establishes that there was a problem with the bulldozer throttle linkage, that two months prior to the accident the operators of that equipment noted a problem with the throttle linkage, and that a mechanic had worked on it several times prior to the accident. Further, counsel asserted that the mechanic had been instructed by his supervisor to work on the linkage, that the supervisor knew there was a problem concerning the failure of the throttle linkage to cut off the machine, and that this is established by the fact that alternative means were sought to shut the machine off. Counsel concludes that the respondent has presented no evidence that there was nothing wrong with the throttle linkage (Tr. 96-97).

Respondent's counsel asserted that "this throttle linkage is sort of a mysterious piece of equipment because sometimes it works and sometimes it doesn't." Counsel suggests that there is no indication that the throttle linkage failed to work on the day of the accident, and his view of this case is that it is one of interpretation of section 77.404(a) (Tr. 98).

Respondent's counsel argues that for a machine to be in violation of section 77.404(a), it must be established that it has a defect which is likely to result in an injury. Counsel submits that given the fact that the throttle linkage in question did not work properly, this condition could not reasonably result in an injury. Citing the testimony of Mr. Holt and Mr. Siria that not all equipment defects necessarily render the equipment unsafe, counsel points to the fact that in this case there was an alternative method of shutting off the machine from inside the cab by means of the hydraulic system, and that the experienced accident victim was more than likely aware of this alternative method (Tr. 98). Even assuming a violation, counsel asserts that a very low penalty should be assessed because of the fact that mine management was not advised of any defects, and had no knowledge of any defective throttle (Tr. 99).

As I noted during the course of the hearings, I find it rather lamentable that with all of the investigative resources available to both the Federal and State agencies and "committees" who participated in the post-accident investigation in this case, no one actually dismantled the throttle linkage device and subjected it to any "shop-tests" to determine whether it was in fact defective. The accident report prepared by the Kentucky Department of Mines and Minerals, exhibit R-1, contains a list of 33 individuals, including five MSHA representatives, and a form entitled "Complete Story of Accident," contains a narrative by the two state inspectors who prepared it, as to how the accident may have occurred. The "Conclusion of State Investigating Committee" is stated in pertinent part, at page seven of the report as follows:

> It is the conclusion of the investigating team, the victim was run over by a TD-25 International Dozer that he was operating.
>
> * * *
>
> Apparently the victim positioned himself on the left crawler and was trying to shut off the engine by moving the linkage to the throttle. In this attempt, he evidently moved the rod in the wrong direction reving up the engine. The dozer being in gear started moving, rolling the victim from off the track forward between the blade and the left crawler. The lower portion of his body was crushed by the weight of the machine. There had been prior reports of the linkage throttle being out of adjustment and the engine could not shut off by using the throttle. On the day of the accident the engine could not be shut off by means of the throttle. The dozer was checked the day following the accident and it could be shut off but this may have been due to the engine being cool. (Emphasis added.)

The thrust of MSHA's case is that the cause of the accident was a defective throttle mechanism, and that by failing to take the bulldozer out of service, the violation occurred. Yet, no one ever determined that the throttle was in fact defective. Since the investigation produced information that the throttle may have been out of adjustment, or that it reacts differently when the machine is hot or cold, it seems to me that someone should have impounded the throttle, taken it apart, and determined precisely what the problem was. In this case, abatement was achieved by replacing the throttle

with a new one, and I suppose the old one was either discarded or "traded in" on the new one. As an analogy, if someone were to tell me that an accident was caused by defective brakes, the first question I would ask is whether or not the brakes were tested to determine whether they were in fact defective. Why the throttle was not subjected to any tests by mechanical experts still remains a mystery.

Notwithstanding my comments above, I conclude and find that there is ample evidence in this case to support the citation in question. Although there were no eyewitnesses to the accident, Mechanic Bowles testified that when he arrived at the accident scene, the machine had been trammed back from an embankment where it had come to rest after running over the victim, and that the engine was still running. He stated that he climbed into the cab and was unable to shut the engine off by means of the throttle. He then dropped the blade of the machine, thereby "killing the engine." He confirmed that the throttle linkage on such machines was a common problem, and that in those instances where the engine could not be shut down, the throttle linkage was the problem. Although the mechanic who installed the new throttle mechanism to achieve abatement showed him the old one which was taken off, MSHA did not produce the mechanic to testify at the hearing, and no further information was forthcoming as to the actual condition of the old one. Mr. Bowles was of the opinion that "killing the engine" from outside the machine because the throttle linkage would not do the job for which it was designed while one was seated inside the cab was unsafe.

James Jones testified that he operated the bulldozer in question on the shift immediately before the accident, and he confirmed that the machine had recently been in the shop for repairs and was a substitute machine being used while the regular one was down for maintenance. He stated that the machine was brought to him by a mechanic and that the engine was running. He operated it for the rest of the shift, and when his work was completed, he could not shut the machine down by using the throttle inside the cab and had to "kill the engine" by raising the blade, thereby "choking the motor." He never experienced similar problems with other bulldozers, and was always able to shut the engine off by means of the throttle from inside the cab of those machines. Mr. Jones confirmed that he did not report the throttle condition to anyone at the end of his shift, and he did not believe he was in any danger because he could not shut the engine down by means of the throttle.

William Jarvis testified that two months prior to the accident, he operated the same bulldozer which was involved in the accident, and at the conclusion of one of his work shifts he advised his supervisor that he would not operate the machine again because of an inoperative cutting clutch, and a bad brake. Mr. Jarvis also stated that he could not shut the engine off from inside the cab by means of the throttle, and that he had to step out of the cab and onto the machine crawler to manipulate the fuel pump throttle linkage before the engine would shut off. Mr. Jarvis could not recall informing his supervisor about the throttle condition, and he too confirmed that he had not previously experienced a throttle problem with other machines.

Respondent's sole rebuttal to the violation is the testimony of Mr. Holt, and he advanced several "theories" as to how the accident may have occurred. However, he candidly conceded on cross-examination that his theories "leaves the throttle linkage out of it completely" (Tr. 86). The issue here is whether or not there was a violation of the cited standard, and the cause of the accident is not the critical issue. Since there were no eyewitnesses, and since none of the witnesses who testified in this proceeding had any first-hand knowledge as to the chain of events or circumstances which caused the fatality, Mr. Holt's "theories," do not rebut the credible testimony by three witnesses which clearly establishes that the throttle mechanism on the machine in question did not do the job for which it was intended.

After careful consideration of all of the credible testimony and evidence adduced in this case, I conclude and find that the petitioner has established the fact of violation by a preponderance of the evidence. It seems clear to me that the throttle linkage mechanism in question was defective and malfunctioning, and that the bulldozer engine could not be shut down by the usual and normal method of activating the throttle from inside the operator's cab. As a matter of fact, on the very day of the accident, a mechanic could not shut the engine down by means of the throttle and had to use the "alternative" method of dropping the blade to choke the engine.

While I have taken note of the fact that no one actually tested the old throttle mechanism to determine what actually caused it to malfunction, on the record here presented there is more than ample evidence to support the conclusion that the throttle was defective. Aside from the mechanic who arrived at the scene shortly after the accident, operator James Jones testified that he operated the very same bulldozer on the shift immediately preceding the accident and could not

shut the engine down by means of the throttle. Further, since the use of the "alternative" method of choking the engine appears to be a known and acceptable practice, it logically follows that the respondent had prior knowledge of a problem with the throttle mechanism in question. If this were not the case, there would be no need to use the alternative method.

I further conclude and find that a defectiave throttle which requires an operator to stand on the machine crawler to manipulate the throttle linkage by hand places him in an unsafe position, particularly when the engine is running and he is attempting to shut the engine down from this position. Any sudden forward or backward movement of the machine caused by over-manipulation of the linkage would probably cause the man to lose his balance. On the facts of this case, while it may not be absolutely clear as to what may have caused the accident, it does seem clear the victim was run over by the machine. Had the throttle been fixed when the operators were experiencing prior problems in shutting down the engine, any temptation by the operators to stand on the crawler to manipulate the throttle by hand would have been removed. Thus, I conclude and find that the throttle in question was not maintained in a safe operating condition, and that this in fact resulted in the bulldozer in question being operated in an unsafe condition. Since it was not taken out of service as required by the cited regulation, the violation is established. The citation IS AFFIRMED.

Gravity

I conclude and find that the violation here was very serious. Failure of the throttle mechanism to do the job that it was supposed to do, namely, facilitate the shutting down of the machine engine from inside the operator's cab without resort to outside manipulation or the use of the "alternative" blade-dropping procedure, contributed to the severity of the violation. As indicated above, while there is no direct evidence that the victim was standing on the crawler and was thrown off when he attempted to manipulate the throttle mechanism, this conclusion is more reasonable than any of the theories offered by the respondent.

Inspector Siria marked the "S & S" block on the face of the citation which he issued. While his testimony in support of this finding may be rather skimpy, on the facts of this case the defective throttle mechanism in question did prevent the machine from being shut down from inside the operator's compartment. Given this fact, I conclude that it was reasonably likely that this condition contributed to, or was the proximate cause of the accident in question. Accordingly, the inspector's "S & S" finding IS AFFIRMED.

Negligence

I conclude and find that the violation here resulted from the failure by the respondent to exercise diligence in seeing to it that the throttle mechanism was operating properly. Since the testimony in this case indicates prior problems with the throttle in question, and that other operators had to use an alternative means of shutting down the engine by either standing on the crawler or dropping the blade of the machine, it seems clear to me that the respondent knew or should have known about the violative condition. I conclude that the violation resulted from a high degree of negligence on the respondent's part.

Good Faith Compliance

The cited machine was taken out of service and the repairs were made. Although the citation was actually terminated and abated on May 4, 1982, by another MSHA inspector, there is no suggestion that any delay was attributable to respondent's lack of good faith in achieving compliance once the violation issued, and that is my finding on this issue.

Findings and Conclusions

CENT 83-86--Fact of violations

Citation No. 2075266, charges the respondent with a violation of 30 CFR 77.1000, for failure to follow its ground control plan by allegedly failing to correct certain hazardous highwall conditions before men were allowed to work in the cited area. Section 77.1000 provides as follows:

> Each operator shall establish and follow a ground control plan for the safe control of all highwalls, pits and spoil banks to be developed after June 30, 1971, which shall be consistent with prudent engineering design and will insure safe working conditions. The mining methods employed by the operator shall be selected to insure highwall and spoil bank stability.

Inspector Siria confirmed that the particular ground control plan provision purportedly violated by the respondent was the one found on page three, under 77.1004(b), (exhibit P-3). I take note of the fact that the ground control plan provisions are identical to MSHA's mandatory standards, and the particular one relied on by Inspector Siria states as follows:

> 77.1004(b). Overhanging highwalls and banks shall be taken down and other unsafe ground conditions shall be corrected promptly, or the area shall be posted.

I take note of the fact that the respondent's ground control plan provision simply parrots the language of the identical mandatory section 77.1004(b). Although the inspector stated that he reviewed the plan before deciding which portion to cite, he conceded that he could have cited a violation of 30 CFR 77.1001, but decided to cite section 77.1000 because of the failure to follow the plan provision.

Citation No. 2075267, charges the respondent with a violation of 30 CFR 77.1005, for an asserted failure to remove loose hazardous material from the face of the highwall in question for a distance of approximately 150 feet. Section 77.1005, provides as follows:

> (a) Hazardous areas shall be scaled before any other work is performed in the hazardous area. When scaling of highwalls is necessary to correct conditions that are hazardous to persons in the area, a safe means shall be provided for performing such work.
> (b) Whenever it becomes necessary for safety to remove hazardous material from highwalls by hand, the hazardous material shall be approached from a safe direction and the material removed from a safe location.

In support of the citations, petitioner's counsel argued that even though Inspector Siria may not have known about the condition of the highwall prior to the accident, the testimony of the two miners in this case establishes that the highwall condition "did not look good." Conceding that one of the miners was of the opinion that the highwall had not been scaled, while the other one stated that it appeared that it had been scaled "but not very good," counsel nonetheless asserted that a violation may still be established on the basis of the second miner's testimony alone. Counsel suggests that, at best, the differences in the testimony only goes to the degree of the violation, and may not serve to eliminate the presence of the violation (Tr. 249). Counsel also maintains that the respondent has presented little rebuttal

or contradictory testimony concerning the condition of the highwall as described by the petitioner's witnesses. Counsel asserts that respondent's management witnesses testified as to general mine problems, and what the highwall looked like on the shift prior to the accident, but had no knowledge as to what it looked like at the time the accident occurred, nor did they rebut the evidence presented by the petitioner as to how the highwall looked before and after the accident (Tr. 250). Counsel maintains that MSHA has established both violations.

Respondent's position with respect to the citations is that the highwall in question was in fact inspected prior to the fatal accident by the drill foreman on the prior shift and by the mine superintendent, and that they found the highwall to be free of any hazardous conditions, including any readily observable or detectable hazards. Further, respondent's position is that the highwall was properly scaled and stripped, and that prior to the accident in question it was safe and comported with all of the requirements found in Part 77 of MSHA's safety standards dealing with highwalls (Tr. 163). Counsel pointed out that the pit foreman who actually supervised the work of the accident victim died of a heart attack (Tr. 162). However, based on the testimony of its experienced witnesses, respondent is of the view that the highwall conditions did not give rise to the issuance of any violations in this case.

In further support of its case, respondent's counsel argued that the crux of the matter concerns the condition of the cited highwall prior to the accident, and that any knowledge of this condition on the part of Inspectors Siria and Utley came after the incident during their investigation. Further, counsel asserted that, as testified to by the witnesses, events such as weather and nearby blasting operations would result in changes to the highwall. Counsel also argues that the testimony of Inspectors Siria and Utley, and Mr. Penrod, that no scaling was done, was contradicted by the testimony of Mr. Montgomery, as well as Mr. Carlisle, Mr. Barrett, and Mr. Teague. Since Mr. Siria and Mr. Utley had limited or no practical surface mining experience, as compared with the many years of daily practical surface pit experience by the respondent's witnesses, counsel suggests that their testimony outweighs that presented by the petitioner in support of the violations. Finally, counsel cites a prior decision of mine in which I concluded that a violation had not occurred in circumstances similar to the instant case, MSHA v. S.A.M. Coal Co., Inc., Docket No. SE 81-21, June 3, 1982, 4 FMSHRC 1051 (June 1982).

In this case, it is clear that the citations were issued after a fatality occurred at the respondent's mine. The citations issued after MSHA had completed an investigation into what may have caused the rock fall. Typically, fatal accident investigations invariably result in the issuance of citations and recriminations which all too often are after-the-fact attempts by the parties to exonerate each other from responsibility. Invariably, MSHA takes the view that since someone was killed, the respondent mine operator was obviously at fault and should be held accountable. The respondent mine operator reacts by taking a defensive posture that "accidents happen," and that simply because an accident happens, it should not be assumed that the operator has violated the law and should pay the price. Once the case comes on for hearing before the Judge, the parties attempt to litigate the matter on the basis of speculative theories and hypothesis.

Citation No. 2075266 was issued after the accident occurred. Based on certain information obtained during the course of the investigation, Inspector Siria issued the citation and charged the respondent with failing to follow its ground control plan. The particular plan provision relied on by Inspector Siria was a provision that requires the respondent to "take down overhanging highwalls and banks" and to otherwise insure that "unsafe ground conditions are corrected." I am convinced that had the rock which killed the miner in this case not fallen, there would have been no citation. Once the rock fell and struck the miner, MSHA felt compelled to hold someone accountable.

The cited ground control plan requires that overhanging highwalls and banks be taken down. Here, the citation was issued by an inspector with little or no experience in the inspection of surface mines or highwalls. As a matter of fact, when he issued the citation, he made no negligence findings, and did not mark the appropriate block on the face of the citation. At the hearing, after having an opportunity to ponder on it, he conceded that he didn't know why he failed to make any negligence findings, and he conceded that he made a mistake. Recognizing the fact that an inspector's job is difficult enough without a Judge second-guessing him, here the citation issued after an investigation. I would think that MSHA would assign an inspector who is experienced in surface mining inspections to conduct the investigation and issue any citations which may be warranted. I am not particularly impressed by after-the-fact excuses, and it places the Judge in the untenable position of making credibility findings based on speculative testimony.

On the facts and circumstances surrounding this particular citation, the inspector conceded that he had never inspected the highwall prior to the rock fall in question, and he admitted that such a fall can change the appearance of the highwall. Even though the inspector charged that men were allowed to work in the pit area in question before any hazardous conditions had been corrected, he admitted that he had no evidence or knowledge that any miners were assigned any such duties by mine management personnel who knew that any hazardous conditions existed. The inspector's sole basis for this allegation was the fact that a rock fell and struck a miner.

There is no testimony by the inspector who issued the citation that any overhanging highwalls or banks ever existed prior to the accident. As a matter of fact, Supervisory MSHA Inspector Utley, who accompanied Inspector Siria during his post-accident investigation, testified that he saw no indication of any overhanging highwall materials. MSHA's counsel conceded during the course of the hearing that if the crack which appeared suddenly and without warning caused the rock fall which resulted in the fatality, mine management would have no way of knowing in advance about the crack. Counsel also candidly conceded that even if the highwall had been properly scaled, there was no way to assure that a sudden crack would not unexpectedly appeared.

The testimony by the miners who were in the pit at the time of the accident, including an eyewitness and member of the safety committee, establishes that once the crack became visible and known, those miners working under it, including the victim, were not necessarily concerned because "it was not working" and they observed no visible changes in the highwall conditions. In short, the testimony of miners who worked in the pit, and directly under the area where the rock fell, indicates that they were not particularly concerned with the conditions of the highwall and they had no reason to believe that they were in any danger. Of course, once the rock fell and struck the victim, and once MSHA embarked on an official inquiry, it is a natural tendency for the very same people who had no concern for the conditions prior to the incident in question, and who failed to give any warning to the victim in advance or withdrawing from the zone of danger, to now infer or imply that the highwall was not scaled or that the conditions which prompted the rock fall were obviously ignored.

After careful consideration of all of the evidence and testimony in this case, I conclude and find that MSHA has

failed to establish by any credible evidence that the respondent failed to follow its ground control plan by failing to correct any hazardous highwall conditions, particularly the taking down of overhanging materials, before men were allowed to work in the pit. Accordingly, Citation No. 2075266 IS VACATED.

Citation No. 2075267 was issued approximately five minutes after the previous one, and it charges the respondent with failing to remove "loose hazardous material" from the face of the highwall for a distance of approximately 150 feet. The cited standard, section 77.1005, requires in pertinent part that "hazardous areas shall be scaled before any other work is performed in the hazardous area." This language is similar to the language used by Inspector Siria in the previous citation where he charged the respondent with failing to correct hazardous highwall conditions before men were allowed to work in the area.

Mr. Siria testified that the highwall "appeared to be loose," that the top had not been scaled, and that overhangs were present. This testimony is contrary to that given by Mr. Siria in support of the previous citation he issued. There, he said absolutely nothing about any overhanging conditions, and Inspector Utley, who was with him, testified that he saw no indications of any overhanging materials. Further, MSHA's counsel conceded that there are no allegations that overhangs were present on the highwall, or that the top of the highwall was not cleaned off or scaled (Tr. 158, 159).

When asked whether he was contending that the face of the highwall had not been cleaned for a distance of 150 feet, Inspector Utley replied that "I wouldn't say that it had not been cleaned. It was just a little rough." Although he indicated that he believed that someone had "got a little behind or in a hurry" and that "they failed to drag the top of the highwall the way they had been doing in the past," Inspector Utley admitted that he did not interview any of the shovel or stripper shovel operators (Tr. 153). Mr. Siria interviewed none of the shovel operators, and the petitioner did not summon them for testimony. It occurs to me that if there is a question as to whether a highwall had ever been scaled or cleaned at some time prior to an accident, one critical item of evidence would be some testimony from shovel or scraper operators who do that type of work. I find it lamentable that the inspectors here did not contact the shovel operators to determine whether they did in fact scrape or clean the highwalls. A possible answer as to why this was not done may lie in Mr. Siria's statement that "it was a proven fact that it was bad because it had killed a person, and so I thought that would be proof enough really" (Tr. 13).

When asked whether he had spoken to anyone who may have observed the highwall prior to the accident, Mr. Siria identified Mr. Penrod and Mr. Montgomery. Both of these individuals were "hole loaders," and their testimony concerning the highwall consists of their observations immediately prior to the rock fall.

Mr. Penrod testified that the highwall area ahead of where he was working had been scaled, dragged, and cleaned, but that his immediate work area was not. While he could not state the distance that the highwall had not been scraped, he did indicate that in his immediate work area, the distance was approximately 150 to 200 feet. Although he did indicate that the respondent had failed in the past to scrape the highwall, he also indicated that the respondent usually scraped and cleaned the wall and the top. He also confirmed that the shovel operator scales the highwall to take down loose material. However, he could not state whether he did or did not observe the shovel operator scale the wall. His observations of the highwall conditions were only what he saw after the accident, and he conceded that highwall conditions do change.

Mr. Montgomery's testimony is that when he observed the highwall during his shift it did not appear that it had been scaled "really good," that it looked "no worse" than other pit areas, and that he observed no loose hanging material. He also indicated that the area where the rock fell "hadn't been done as cleanly as it had in some other areas of the wall."

Respondent's defense is based on the testimony of a drill foreman who said that he observed the highwall the day after the accident and found it to be in good condition and properly scaled, a drill foreman who stated that he inspected the highwall on the day of the accident and observed no unsafe conditions or loose, unconsolidated materials on the highwall, and the mine superintendent who testified that he drove through the pit area on the morning of the accident and found nothing to alarm him because in his opinion the highwall area where the accident occurred had been adequately scaled.

Respondent's witnesses, for the most part, testified as to how scaling and stripping of the highwall is normally done. MSHA's eye witnesses who were in the vicinity of the rock fall and who saw the accident, testified that while they observed a crack which apparently appeared unexpectedly after the work shift had begun, they did not believe it was hazardous because they detected no movement, and opted not to withdraw from the area, not to say anything to their foremen, and not to caution the victim that he should be alert to any possible danger. Of course, once the rock came loose and began rolling towards the victim, it was too late, and he could not hear the warnings from his fellow miners.

On the basis of all of the testimony and evidence adduced in this case, and after viewing all of the witnesses during the course of the hearing, I am convinced that the accident resulted from an unforeseeable and unexpected event, namely the sudden appearance of a crack in the highwall which caused a large rock to roll down and strike the victim. I am further convinced that there was nothing anyone could do to prevent the accident. Even if it could be established without any doubt that scaling and stripping had taken place immediately before the crack appeared, the accident would probably have still happened.

I take note of the fact that the respondent's ground control provision, 77.1005, only provides for corrective action "where hazardous highwall conditions exist that would endanger persons in the area." The comparable MSHA mandatory standard section 77.1005, requires scaling in "hazardous areas," and the regulatory language requires that this scaling work be done in a safe manner when scaling of highwalls is necessary to correct conditions that are hazardous to persons in the area. As I have often observed, such regulatory language leaves much to the imagination. Rather than simply requiring the removal of loose, unconsolidated materials from highwalls, the language contains a condition precedent that requires that someone make a judgment call that a hazard is initially present. Typically, that judgment is made after the highwall collapses and someone is hurt. This case is a classic example of this. Three miners, including the victim, worked in an area where a crack appeared, but no one was concerned until a rock began to roll down the highwall towards the victim. None of the miners saw fit to alert the pit foreman about the crack, and they opted not to withdraw from the work area. For its part, mine management was satisfied that a prior cursory inspection of the highwall detected no unusual conditions. Once the accident occurred, MSHA arrives on the scene, and after an investigation by two nonsurface mine inspectors who failed to establish first-hand whether any scaling work had actually been done, citations were issued based on observations which lend themselves to differences of opinion and sheer conjecture as to whether or not the required scaling had taken place.

It is not unusual in cases of this kind where there had been a fatality, for the parties to speculate as to what may have happened. However, in the context of a specific citation charging a violation of a specific mandatory standard, I am compelled to decide the case on the basis of credible evidence. On the facts of this case, the critical question is whether or not the highwall had been scaled and loose

material taken down for a distance of 150 feet as charged in the citation. While I am not convinced that MSHA has established through any credible testimony that the immediate highwall area where the crack appeared and the rock fell were not properly scaled, neither has the respondent established that it was. MSHA's case as to what the highwall looked like after the accident occurred supports a finding that loose, unconsolidated materials were present along the highwall perimeters adjacent to the rock fall area.

I conclude and find that the testimony of Mr. Penrod, Mr. Montgomery, and Inspectors Siria and Utley, establish that the highwall areas adjacent to, and in the proximity of the actual rock fall area were not scaled so as to remove all loose and unconsolidated materials. I am not convinced that these adjacent areas were changed in any marked degree by the rock which fell, nor am I convinced that the respondent has established that it inspected the highwall and that actually scaling of the entire cited area had taken place. Accordingly, while I conclude and find that MSHA has not established that the immediate area above the actual rock fall had not been scaled, I do find that it has presented enough credible testimony to support a finding that some of the adjacent areas did contain loose hazardous materials which had not been scaled or stripped. Accordingly, to that extent the citation IS AFFIRMED.

Gravity

I conclude and find that violation no. 2075267 was serious. Failure to adequately scale the loose hazardous materials which were present in the areas adjacent to the rock fall area presented a hazard to miners who had to travel and work under the highwall area in question.

Inspector Siria marked the "S & S" block on the face of the citation which he issued. The failure by the respondent to adequately scale the highwall area in question would reasonably likely result in injuries in the event that the unscaled materials fell. Accordingly, the inspector's finding IS AFFIRMED.

Negligence

I conclude and find that the violation here resulted from the failure by the respondent to exercise reasonable care to insure that the cited highwall area was adequately scaled. Accordingly, I conclude that the violation resulted from ordinary negligence.

I take note of the fact that in exhibit R-2, MSHA's assessment officer notes that in a telephone interview with Inspector Utley on November 23, 1982, Mr. Utley stated that mine management could not have known about the crack which appeared in the highwall, and that management "makes a diligent effort to promote a good safety program."

The issue here is whether or not the areas adjacent to the rock fall and crack area were adequately scaled. Under the circumstances, the fact that the sudden appearance of the crack could not have been predicted, does not absolve the respondent from its responsibility to insure that the cited areas were otherwise adequately scaled of loose hazardous materials.

Good Faith Compliance

The record reflects that the loose materials in question were timely removed from the highwall area in question a day after the citation issued, and three days earlier than the time fixed by the inspector. Accordingly, I conclude that the respondent exhibited more than adequate good faith abatement efforts in achieving compliance.

Size of Business and Effect of Civil Penalties on the Respondent's to Remain in Business.

The parties have stipulated that the respondent is a large mine operator and that any penalty assessments for the violations in question will not adversely affect its ability to remain in business. I adopt these stipulations as my findings and conclusions in both of these docketed cases.

History of Prior Violations

Respondent's history of prior violations for the mine in question is reflected in MSHA's computer print-out, exhibit P-4. This information reflects that for the period March 29, 1980 through March 28, 1982, the respondent paid civil penalty assessments for a total of 45 violations. None of these were for prior violations of section 77.1000, but two were for prior violations of section 77.404(a). However, no further information was forthcoming as to what these two were all about.

For an operation of its size and scope, I cannot conclude that respondent's history of prior violations is such as to warrant any additional increases in the civil penalties assessed by me in these cases.

Penalty Assessments

On the basis of the foregoing findings and conclusions, and consideriang the statutory criteria found in section 110(i) of the Act, I conclude that the following civil penalties are reasonable and appropriate for the two violations which have been affirmed:

KENT 83-66

Citation No.	Date	30 CFR Section	Assessment
1035414	3/29/83	77.404(a)	$2,500

KENT 83-86

Citation No.	Date	30 CFR Section	Assessment
2075267	9/9/83	77.1005	$ 850

ORDER

Respondent IS ORDERED to pay civil penalties in the amounts shown above within thirty (30) days of the date of these decisions, and upon receipt of payment by MSHA, these proceedings are dismissed.

George A. Koutras
Administrative Law Judge