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SOL (MSHA) V. GULF RESOURCES
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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 PROCEEDING Docket No. CENT 81-271-M A.C. No. 29-01375-05008F
v.	
GULF MINERAL RESOURCES COMPANY, RESPONDENT	Mt. Taylor Project Mine

DECISION

Appearances: Eloise V. Vellucci, Esq., Office of the Solicitor, U.S. Department of Labor, Dallas, Texas, for Petitioner;
John A. Bachmann, Esq., Gulf Mineral Resources Company, Denver, Colorado, for Respondent.

Before: Judge Morris

This case, heard under the provisions of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. 801, et seq., (the "Act"), arose from a March 2, 1981 inspection of respondent's Mt. Taylor Project Mine. The Secretary of Labor seeks to impose two civil penalties because respondent allegedly violated the Act and a regulation promulgated under the Act.

Respondent denies that any violations occurred.

After notice to the parties, a hearing on the merits was held in Albuquerque, New Mexico on June 1, 1983.

Respondent filed a post trial brief.

Issues

The issues are whether respondent violated the Act and the regulation.

Stipulation

The parties agreed that at the time of the inspection the size of the company was 1,120,484 production pounds per year. The size of its Mt. Taylor Project uranium mine was 872,540 production pounds per year. The parties further stipulated that the mine was no longer in production (Tr. 5).

Citation 152663

This citation alleges respondent violated Section 108(b) of the Act in that the operator delayed three MSHA inspectors in their investigation of a fatal accident at the mine.

Section 108(a)(1) provides, in part, as follows:

> The Secretary may institute a civil action for relief, including a permanent or temporary injunction, restraining order, or any other appropriate order in the district court of the United States for the district in which a coal or other mine is located or in which the operator of such mine has his principal office, whenever such operator or his agent
>
> > (B) interferes with, hinders, or delays the Secretary or his authorized representative, . . . in carrying out the provisions of this Act. . . .

Prior to the hearing the judge advised the parties that the pertinent provision of the Act was Section 103(a) and not the cited section. [Order, February 28, 1983; Waukesha Lime and Stone Company, Inc., 3 FMSHRC 1702 (1981)].

Pursuant to the Federal Rules of Civil Procedure the complaint is amended to allege a violation of Section 103(a) of the Act. Rule 15(b), F.R.C.P.

The pertinent part of Section 103(a) provides as follows:

> . . . For the purpose of making any inspection or investigation under this Act, the Secretary . . . with respect to fulfilling his responsibilities under this Act, or any authorized representative of the Secretary . . . have a right of entry to, upon, or through any coal or other mine.

Summary of the Evidence

MSHA's evidence indicates that at approximately 11:40 a.m. on March 2, 1981, Thomas Castor, the supervisory mining inspector at the MSHA Albuquerque office was advised of a fatality at respondent's mine. The supervisor dispatched a special investigator and two inspectors to the mine (Tr. 7-9, 13). The three men travelled to the mine in two vehicles. Since the mine was approximately 100 miles from Albuquerque, they had to pick up clothing at their homes in anticipation of an overnight stay (Tr. 9).

The purpose of an MSHA investigation is to determine the cause of an accident and to recommend methods of preventing similar accidents. MSHA goes to the scene of a fatality as soon as possible. MSHA investigators prefer to interview witnesses

and then take them to the scene for a detailed analysis and reconstruction of the occurrence (Tr. 9, 10, 26, 40). By law, an operator is also required to make a complete detailed accident report. But the operator does not have to give its report to MSHA unless it is requested. (Tr. 31, 32). MSHA accepts an accident report from operators on Form No. 7000-1 even though there are more than 20 miners at the reporting mine (Tr. 30, 33).

The accident at this mine occurred at 9:45 a.m. Since MSHA was not advised until 11:40 a.m., respondent was cited for a violation of 30 C.F.R. 50.10. (FOOTNOTE 1) That citation is now a final order of the commission (Tr. 10, 11).

Inspector Omer Sauvageau reached the mine at 3:30 p.m. He waited at the mine office for Inspectors Tanner and Sisk who arrived at 3:45 p.m. to 3:50 p.m. (Tr. 95, 96).

Inspector William Tanner, Jr. estimates that he arrived at the mine between 3:00 and 3:30 p.m. In the meeting room they introduced themselves to respondent's representatives John Thompson and David Wolfe. Tanner asked if they could interview the two eyewitnesses and the two location witnesses so they could continue their investigation. Company representative Dershimer said the witnesses were not available because they were being interviewed by the company attorney (Tr. 37, 38, 40, 60, 95, 96). At that point L.E. Lewis went to check. Upon returning, Lewis said it would be another 30 minutes before the MSHA inspectors could interview the witnesses. Lewis suggested the inspectors go underground to visit the scene. They did (Tr. 38, 39). The only comment, which was repeated to the inspectors, was that it was Gulf's policy for their attorneys to confer with its witnesses before MSHA inspectors could talk to them. The company did not state to the inspectors that they were conducting their own investigation (Tr. 39, 63). For their part, the inspector did not suggest they should join the company attorney (Tr. 61, 62).

Inspector Tanner told Wolfe the company would be cited and he issued Citation 152663 for a violation of Section 108(b) of the Act. The citation was given to the company three days later. It was issued because the witnesses were not available. The MSHA investigation was delayed and hindered at the scene because the inspectors could not get the comments of the witnesses firsthand (Tr. 41-43, 71, 72). The witnesses were interviewed at 6:00 p.m. that day (Tr. 43).

Respondent's evidence indicates the company called MSHA and the state inspectors at approximately 11:20 a.m. on the day of the accident. The state inspectors, enroute on another matter, arrived ten minutes after being called. They went underground to investigate and they also interviewed three or four witnesses (Tr. 101, 102).

Company representatives Jerry Omer (safety) and Terry Cullen (attorney) arrived from Denver the same day at approximately 3:30 p.m. They began interviewing the witnesses 15 to 30 minutes before the MSHA inspectors arrived (Tr. 102, 103, 113, 114).

After the MSHA inspectors arrived, Cullen requested an additional 20 to 30 minutes to complete his interviews. (FOOTNOTE 2)

Respondent's manager F.K. Dershimer requested that the inspectors make the trip underground while Cullen continued his interviews. The inspectors voiced no objection, nor did they give an indication that they felt they were being delayed, hindered or inconvenienced (Tr. 104-106, 114, 115). The MSHA inspectors, as suggested, went underground (Tr. 106). The first notice of any dissatisfaction with this arrangement was when Dershimer received the citation (Tr. 107, 116, 117).

If the inspectors had requested a joint interview of the witnesses Dershimer would have checked with Cullen to see if it was "okey" (Tr. 115, 116). Respondent has never prohibited inspectors from talking to company witnesses. Further, there is no such company policy (Tr. 105, 115, 116).

Discussion

Section 103(a) of the Act authorizes the Secretary to enter any mine. On the essentially uncontroverted facts in this case there was no refusal or delay of the Secretary's right of entry. On the contrary, respondent facilitated the entry of the inspectors to the site. The only delay, if there was one, occurred when the company attorney requested additional time to interview the witnesses. This scenario, at best, establishes that respondent minimally interfered with the sequence in which MSHA prefers to conduct its investigation. But, construed in a light most favorable to MSHA, these facts would not constitute a denial of the Secretary's right to enter the mine.

Section 50.11(a) of Title 30 of the Code of Federal Regulations provides for accident investigations to be performed at the discretion of MSHA district or subdistrict managers. Once the decision to conduct an investigation has been made, Section 103(a) of the Act provides MSHA inspectors with broad powers in the exercise of such an investigation. An inspector has the right of entry into any mine. While 30 C.F.R. 50.11(a) requires that notice be given prior to the investigation of accidents, the Supreme Court has held that no warrant is required to conduct such an inspection. Donovan v. Dewey, 452 U.S. 594, 101 S.Ct. 2534 (1981). However, neither the Act nor any implementing regulations mandate the interviewing of witnesses as the initial step in an investigation.

Accordingly, on the facts I conclude that no violation of Section 103(a) occurred. Citation 152663 and all penalties should be vacated.

Citation 152667

This citation charges respondent with violating Title 30, Code of Federal Regulations, Section 57.8-2, which provides:

> Mandatory. (a) A competent person designated by the operator shall examine each working place at least once each shift for conditions which may adversely affect safety or health. The operator shall promptly initiate appropriate action to correct such conditions.

Summary of the Evidence

MSHA Inspector William Tanner, Jr. issued Citation 152667 because two men with authority at this particular work place failed to insist on the crew following the proper procedure for replacing the post (Tr. 44, 45).

Superintendent Sullivan had been present a few minutes before miner Maldonado was killed. In addition, leadman Baca was present and on one occasion the victim himself was considered to be a "competent person" within the terms of the MSHA regulation (Tr. 46, 47).

MSHA construes a "competent person" in Section 57.8-2 to be one qualified by ability and experience, who makes safety checks, prevents unsafe acts, and who works in this particular area of the mine (Tr. 45, 53, 88). There was nothing to indicate to the inspecto that a safety check had been made or that a competent person had looked over the area before everyone "got into place" (Tr. 46, 53).

Sullivan, the level superintendent, came in about 9:30 a.m. and talked to leadman Baca about changing out the steel posts (Tr. 47).

At the intersection of 3N and 3E, the place of the accident, a cap goes directly across the back. It is supported by two posts. These posts are steel I-beams 8 inches by 8 inches and 10 feet long (Tr. 47). The cap is bolted by four bolts on each end (Tr. 47). A collar brace, a knee brace, and a toe brace tie all of this steel together to keep it from falling (Tr. 47).

According to the miners, on this particular day they cut all the collar braces off one side with a torch. The other side had only one collar brace. The inspector did not know why it was not supported (Tr. 48). At approximately 9:30 a.m., Sullivan and Baca discussed changing the post. Sullivan left without looking to see if the area was safe. At that time victim Maldonado was driving up with the replacement, a slightly larger post (Tr. 48).

When Sullivan was at the intersection there was one collar brace on one side and none on the other (Tr. 49). Normal procedure to remove and replace a post is to stick a direction boom under the cap and hold it up while a worker removes the bolts. After the bolts are removed the post is withdrawn and replaced with the new post while the boom holds up the 2,000 pound cap. The cap itself measures 21 feet by 21 1/2 feet (Tr. 49, 50).

The normal way to unscrew the bolts would be to climb up a ladder and remove them after the cap has been secured. On this particular day Maldonado climbed on top of the erection boom and was jockeyed into position. Barela handed him a one-inch impact wrench and Maldonado spun off the bolts without making sure the area was secured in any way.

After the bolts were spun off the cap leaned over. As it did, Maldonado climbed off of the erection boom pedestal (which was to be used only for lifting the cap). He then crawled down the boom into the bucket (Tr. 51-52). That's when the cap came down striking him in the back and killing him (Tr. 51, 52).

Baca, the lead miner, had not attempted to stop Maldonado. In addition, he did not see that the cap and post were secure (Tr. 51). Elliott, a co-worker, had to go after a ladder. He could have held the post to keep it from falling over. The cause of the accident was that nothing was secure (Tr. 51). This accident would not have happened had the cap been secured, pinned, or supported by the pedestal (Tr. 52).

The company said Baca and Sullivan were designated "competent persons." Sullivan told the inspector he did not investigate but he instructed the leadman in his duties (Tr. 53, 81-82). John Thompson and David Wolfe told the inspector they were "competent persons" and so designated by the company (Tr. 80-81).

The inspector did not check the log books from previous shifts to see who had signed the logs as the designated person (Tr. 82, 83).

This crew had changed out the post on the opposite side of the drift the previous day (Tr. 88). On that occasion, Maldonado, who was then the leadman, performed the same task (Tr. 91-92).

Respondent's evidence: F.K. Dershimer, the acting general manager, testified that the mine captain designates the level supervisor as the "competent person," for the purpose of the regulation. If the level supervisor is not present, then the mine captain does the walk-through for safety checks or he designates another person. Compliance with the walk-through is recorded on the shift report under the portion marked as "Supervisor". The time of the safety check, followed by the supervisor's initials, are also entered on the shift report (Tr. 118, 119, Exhibit R 1). If the supervisor saw something that needed to be fixed he would so direct (Tr. 123).

James Sullivan was in the employ of respondent between January 30, 1978 to May 14, 1982. He has 12 years of mining experience. He was hired as a long-hole driller and later was promoted to level supervisor, then to level foreman (Tr. 129-131, 152). Sullivan's experience in replacing posts has come about by watching Harrison & Western crews, in inspecting, and as a helper in installing steel (Tr. 162). Sullivan considered himself competent because he has used good judgment in putting up steel (Tr. 162).

Lead miner Baca had the responsibility for watching this crew and seeing they work safely (Tr. 158, 159). But only Sullivan, and not Baca, had the responsibility to check the entire level (Tr. 159).

On the day before this accident the same crew had changed out the post on the opposite side of the drift. Maldonado described the correct procedure to Sullivan. When he was on the scene, Sullivan discussed the situation with Cruz and Francisco. He told them to follow the same directions as before. On the day he was killed, Maldonado was doing the work improperly and he was

not following his stated procedure (Tr. 165-168).

According to Sullivan, the post to be changed out was not collar braced when he passed through the area. He didn't recall if it was pinned at the bottom. In addition, he didn't know how the post holding the I-beam was braced (Tr. 164).

Changing posts is not hazardous. The proper way is to position the boom under the cap to hold it fast. Two workers then put a ladder at the post being changed. One worker removes the bolts. The boom is then raised slightly to release the downward pressure on the post. A worker then lays down the post and installs the replacement post (Tr. 166). Normally the crew would automatically install a collar brace (Tr. 169).

The MSHA regulation requires one safety inspection by a "competent person". Respondent requires two. On the day of the fatality, inspections were performed by Ray Willis during the day shift. If Sullivan had not been required to leave the level, he would have done the inspections and signed the logs (Tr. 167, 169, Exhibit R 1).

Discussion

MSHA's regulation, Section 57.18-2, imposes two broad requirements on an operator.

The first: The operator shall designate a person who is competent to examine each working place each shift for conditions which may adversely affect safety or health.

The second: If there are defective conditions, the operator, through his "competent person," shall initiate appropriate action.

We will review these requirements in the light of the evidence in the case. First of all, did respondent designate a person to examine each working place?

Yes, I find that witness James Sullivan was so designated by the company. He so testified. Further, the company records (Exhibit R 1) establish that Sullivan, as supervisor, initiated and indicated the times of the safety checks on March 3 and 4, 1981. He would have performed the safety checks on March 2 but, due to the accident, he went to the surface.

The inspector testified there was nothing to indicate that a "competent person" had looked over the area. But I am not persuaded by the inspector's testimony. He admits he did not check the company logs on this point.

Was Sullivan competent as a safety inspector?

Yes, I find that Sullivan's broad experience includes 12 years as a miner. He was hired as a long-hole driller, promoted to level supervisor and then level foreman. He has helped install steel,

watched other crews working with it, and he has inspected in connection with this activity.

The Secretary waived closing argument and a post trial brief; hence, it is somewhat difficult to perceive his position. But the citation and the evidence suggest several facets. The citation alleges that the person designated by the company as competent did not examine the work place "before work commenced." If the Secretary had intended a pre-shift inspection he could have done so as he did in 30 C.F.R. 57.3-22 and 57.19-129.

An additional element filtering through the evidence is that Baca, the lead miner, or for that matter anyone in charge of the crew, was the "competent person" under the regulation. Therefore, such a "competent person" would have prevented the unsafe acts.

I reject such a view of the regulation. On the facts, neither Baca nor anyone in the crew were so designated by the company as the "competent person" at the time of the accident.

A secondary factor appearing in MSHA's evidence is that the "competent person" should have been present when all of the workers were "in place." If so, he could have stopped Maldonado's unsafe acts.

The regulation does not require the "competent person" to anticipate unsafe acts by an employee. This record establishes that the changing of the post was not inherently dangerous. In addition, the crew was experienced. Maldonado had himself removed the post on the opposite side of the drift on the previous shift. Further, he recited the proper procedure to Sullivan. The crew was told to proceed as before. For the foregoing reasons, I conclude that respondent complied with the initial portion of the regulation; namely, the company designated a competent person to examine the work places.

The second broad requirement of the regulation mandates that the competent person initiate appropriate action if there is a defective condition. Simply put, was there a defective condition when Sullivan was present?

No, at the time Sullivan was present the most unfavorable scenario was that the post being changed out was not collar braced. But no evidence establishes that this in and of itself is a defective condition. Even without the collar brace the steel was also tied together with a knee brace, a toe brace and secured by four bolts. Sullivan was at the intersection of Drift 3N-3E at approximately 9:35 a.m. to 9:40 a.m. on March 2, 1981. At that time Maldonado was driving the loader in with the replacement post (Exhibit R 2). There was nothing to indicate to Sullivan that a defective condition existed. Further, there was nothing to indicate that the post could not be changed without incident. Under these facts he was entitled to proceed with his safety check survey at the other work places on the 3100 level.

Along with other contentions in its post trial brief respondent argues that the inspection performed by Sullivan at the beginning of the shift was not an "official inspection". Therefore, it is contended that his walk-through could not in any event constitute a faulty inspection.

I reject that position. If the facts had established that a defective condition existed at any time when Sullivan was present and he failed to take corrective action, I would affirm the citation.

For the reasons stated herein Citation 152667 should be vacated.

Brief

Respondent's counsel has filed a detailed brief which has been most helpful in analyzing the record and defining the issues. I have reviewed and considered this excellent brief. However, to the extent that it is inconsistent with this decision it is rejected.

ORDER

Based on the facts found to be true in the narrative portion of this decision, and based on the conclusions of law as stated herein, I enter the following order:

1. Citation 152663 and all proposed penalties therefor are vacated.

2. Citation 152667 and all proposed penalties therefor are vacated.

John J. Morris
Administrative Law Judge

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~FOOTNOTE_ONE

1 30 C.F.R. 50.10 Immediate Notification.

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

~FOOTNOTE_TWO

2 The record does not reflect the purpose of these interviews. But in view of the fact that the safety officer and company attorney were present on the day of the accident, I infer the operator was conducting its investigation pursuant to 30 C.F.R. 50.11(b). The cited regulation provides, in part,:

(b) Each operator of a mine shall investigate each accident and each occupational injury at the mine. Each operator of a mine shall develop a report of each investigation. No operator may use Form 7000-1 as a report, except that an operator of a mine at which fewer than twenty miners are employed may, with respect to that mine, use Form 7000-1 as an investigation report respecting an occupational injury not not related to an accident. No operator may use an investigation or an investigation report conducted or prepared by MSHA to comply with this paragraph. An operator shall submit a copy of any investigation report to MSHA at its request.