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

HARRISON WESTERN CORPORATION,  
APPLICANT

v.

SECRETARY OF LABOR,  
MINE SAFETY AND HEALTH  
ADMINISTRATION (MSHA),  
RESPONDENT

APPLICATION FOR REVIEW

Docket No. CENT 81-249-RM  
Withdrawal Order No. 151337  
Dated June 15, 1981

Mt. Taylor Mine

SUMMARY DECISION

Before: Judge Carlson

This case comes on for decision upon cross motions for summary decision filed by both parties under Commission Rule 2700.64. (FOOTNOTE 1) All facts are submitted by joint stipulation.

The case arose out of a withdrawal order issued by the Department of Labor's Mine Safety and Health Administration

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(MSHA) on October 3, 1979. (FOOTNOTE 2) The order was issued under provisions of section 107(a) of the Federal Mine Safety and Health Act of 1977 (the "Act"). (FOOTNOTE 3) The case reaches me upon the petition for review filed by the Harrison Western Company (Harrison Western). Both parties submitted extensive briefs in support of their respective motions for summary decision.

I conclude that no material facts are in dispute and the case is ripe for summary decision.

#### ISSUE

The crucial issue to be decided is whether the issuance of the 107(a) withdrawal order challenged by Harrison Western may be sustained in light of the prior issuance of 103(k) (FOOTNOTE 4) withdrawal order covering the same area of the mine.

THE FACTS

The stipulation of facts filed by the parties clearly sets forth all material happenings surrounding the issuance of the challenged order. I therefore approve it and adopt it as a part of this decision. All exhibits mentioned in the stipulation are appended to this decision. The stipulation, omitting caption and signatures, is as follows:

I. Statement of the Case

This proceeding was commenced by Harrison Western Corporation ("Harrison"), pursuant to Section 107 of the Federal Mine Safety and Health Act of 1977 (the "Act"), for review of Section 107(a) Withdrawal Order No. 151337 dated June 15, 1981 (Exhibit "A" attached hereto), issued to it with regard to the Mt. Taylor Project ("Project") by the Secretary's authorized representative, Glenn C. Johnston. Harrison's Application for Review was timely filed on or about July 15, 1981 and the Secretary's Answer was timely filed on or about July 31, 1981.

Withdrawal Order No. 151337 replaced Section 107(a) Withdrawal Order No. 151295 (Exhibit "B") issued at 2:00 p.m. on October 3, 1979, also by Inspector Johnston. The original Order named "Gulf Mineral Resources (Harrison Western, Inc.)" as operator and was sought to be enforced by the Secretary against Gulf Mineral Resources Company ("Gulf") alone in Docket No. CENT 80-309-M. While that case was pending, the Secretary revised his policy and regulations under the Act to provide for issuance of citations and orders to production-operators and/or independent contractors. 30 CFR, Part 45; 45 F.R. 44494, July 1, 1980. As a result of this policy change and an agreement between the Secretary and Harrison, Withdrawal Order No. 151337 was issued to Harrison on June 15, 1981, on the basis that Harrison would have access to all applicable formal and informal review procedures. Thereafter, motions to vacate Withdrawal Order No. 151295 and to dismiss Docket No. CENT 80-309-M were granted by the Administrative Law Judge assigned to that proceeding.

Since Order No. 151337 replaced Order No. 151295, they are virtually identical in all material respects, except only that Harrison is named alone as the operator in Order No. 151337. The facts which underly and determine the validity of Order No. 151295 are likewise the facts which underly and determine the validity of Order No. 151337 at issue in this case.

## II. Description of the Project

### A. General.

On the day material to this proceeding, October 3, 1979, the Project was a uranium mine in the construction stage. Gulf was the owner of the Project. Harrison was the primary contractor for the shaft sinking portion of the construction. The Project was located approximately one mile north of San Mateo, Valencia County, New Mexico, and was subject to the Act.

The shaft sinking operation consisted of excavating two parallel, vertical shafts, one twenty-four feet in diameter and the other fourteen feet in diameter. The two shafts were horizontally separated by a distance of about 400 feet and were connected by horizontal tunnels located at depths of approximately 700 feet, 1,600 feet, 2,600 feet, 3,100 feet and 3,200 feet. The planned, total depth of both shafts was 3,300 feet. The primary elements of the shaft sinking operation included excavation, pouring a concrete liner around the circumference of each shaft, installation of air, water and power lines, installation of hoist and other transportation systems, and construction of operating stations in the horizontal connecting tunnels with installation of associated equipment to be used in the mining process.

### B. 24-Foot Shaft.

On October 3, 1979, the 24-foot shaft had been sunk to a depth of approximately 3,240 feet. A 220-foot high headframe was located above the shaft on the surface and contained the hoist equipment and control room. A main collar was installed at the surface which completely covered the shaft when its retractable, horizontal doors were shut. The doors were opened only to allow passage of men and materials by way of the hoisting mechanisms. Two subcollars of a similar nature were located in the shaft a short distance below the main collar.

The lower deck of a three-deck Galloway was located at the 3,200-foot level near the bottom of the shaft on October 3, 1979. The Galloway was the working platform from which excavation, muck removal and concrete liner pouring was performed. It was suspended by four 1 3/8 wire ropes from the hoisting mechanism located in the headframe on the surface.

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Two 75-cubic foot capacity buckets were used in the shaft for hoisting and lowering men, material, muck and concrete. Each was suspended by a 1 7/8-inch non-rotating wire rope from the hoist mechanism in the headframe. Each was guided by a crosshead which travelled vertically along one pair of the wire ropes suspending the Galloway. In this manner, one bucket travelled along the east side of the shaft (No. 1) and the other travelled along the west side (No. 2). The wire rope suspending each bucket was attached to the bucket by a shackle assembly which was detachable.

A two-deck "chippy cage" travelled along wooden guides attached to the concrete perimeter liner on the northeast side of the shaft. This cage was similar to a small, rectangular elevator enclosed by a combination of welded steel plates and heavy wire mesh. It was suspended from the headframe on the surface by a 1-3/8 inch nonrotating wire rope, and was used for transporting men and performing repairs along the shaft perimeter.

A "basket" had been fabricated at the site for use in hoisting and lowering material and performing repair work in the shaft. It was made of 1/2-inch steel plate and was 4-feet square with sides 42 inches high. At the surface, it could be attached to the shackle assembly of either bucket hoisting cable by four 1-inch wire ropes, each 10 feet long. The other end of these four ropes would be attached to the top corners of the basket by shackles. When the basket was attached in this manner in place of one of the buckets, and with the crosshead chaired in the headframe, the basket could be swung the short distance to the perimeter of the shaft for repair work. When the basket was attached in this manner and suspended freely without being swung to the perimeter, the horizontal distance between it and the "chippy cage" was 17 feet.

An 8-inch diameter "slickline" pipe was installed vertically in the shaft at the perimeter adjacent to the "chippy cage." Directly opposite from the "slickline," a 12-inch compressed air line was installed vertically at the perimeter of the shaft. Both of these lines extended from the surface to virtually the bottom of the shaft.

### III. Events of October 3, 1979, Up To and Including the Accident

The crew assigned to work in the 24-foot shaft on October 3, 1979 was under the general supervision of Wayne Thomas, whose title was "walker." This position was equivalent to that of general foreman for the underground shaft sinking operation. Stanley Henry was the "shaft leader" of the crew, which is a position equivalent to foreman. The crew working at Henry's direction in the shaft on that day consisted of Bob Hales, Orlando Castillo, Jack Mathieu, David Stovall and Michael Borody. These five men held the designation of either shaft miner or operator, which were roughly equivalent positions with small wage differentials. All were Harrison employees.

This group met in the construction trailer on the surface to receive directions for the day's work at the start of the shift (approximately 7:30 a.m.) on October 3, 1979. Thomas directed Henry to have four men work on aligning the "slickline" starting at about the 2400-foot level of the shaft, using the "chippy cage" as a work platform. Henry directed Castillo, Mathieu, Stovall and Borody to perform this work in pairs. Because of the strenuous nature of the work and the limited area on the "chippy cage" platform, each pair was to work in alternating two-hour shifts, with the off pair resting at the 2600-level station. Thomas' initial assignment for Henry and Hales was to remove muck from the bottom of the shaft.

Henry and his shaft crew commenced the work as assigned shortly after 8:00 a.m. Later that morning, Thomas came to the bottom of the shaft where Henry and Hales were working to change their assignment. He directed them to install several valves at various points along the length of the 12-inch air line. After shutting off the air supply to the line and opening a valve to bleed the pressure from it, Thomas, Henry and Hales came to the surface in the No. 2 bucket. While Thomas attended to other matters, Henry and Hales gathered together the tools and materials needed to install the valves. With the assistance of the toplanders (Harrison employees assigned to work on the surface), the No. 2 bucket was removed, its crosshead was chaired in the headframe, and the basket was attached to the No. 2 wire rope in place of the bucket. Henry and Hales loaded their tools and materials into the basket, climbed in, and began descending toward the bottom of the shaft through the

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collar doors, which were closed behind them. At about the 2400-foot level, they passed Castillo and Mathieu who were working on the top deck of the "chippy cage" aligning the "slickline." As they passed, the two groups waived [sic] their lights and shouted to each other.

Henry and Hales had their backs to each other as the basket descended through about the 2900-foot level at approximately 11:25 a.m. At that point, Hales heard a dull thump and turned to see Henry falling into the corner of the basket. Hales signalled to the hoistman on the surface to stop their descent. He then checked Henry for life signs and found none. He then signalled to the hoistman to bring them to the surface. When they reached the surface, Henry was examined by one of the toplanders who was a paramedic. No vital signs were detected. Henry was taken by ambulance to a nearby hospital in Grants, New Mexico, and pronounced dead on arrival at 12:04 p.m.

#### IV. Accident Investigation and Order at Issue in this Proceeding

The federal and state mine safety agencies were notified of the accident immediately after the basket reached the surface and Hales was able to inform surface personnel of what had happened. Notification to MSHA was received by the Albuquerque field office at 11:40 a.m. At 11:45 a.m., Inspector Johnston issued Withdrawal Order No. 151293 under Section 103(k) of the Act (Exhibit "C") "to prevent the destruction of any evidence that may be of assistance in investigating the accident and to assure safety of all persons in or near the accident area until the investigation is complete, . . . ." The area to which that Order applied was described as:

24 ft. diam. shaft, approximately on 2950 foot level in #2 bucket position . . .

This Order was not modified in any manner until 8:35 p.m. that evening.

Upon learning of the accident and the Section 103(k) Order, Harrison's safety engineer, David Wolfe, directed all concerned not to disturb any evidence related to the accident and to remove the remaining men from the 24-foot shaft. Accordingly, Castillo, Mathieu, Stovall and Borody, came to the surface by means of the "chippy cage."



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MSHA and New Mexico mine safety officials arrived at the Project thereafter from their offices in Albuquerque to commence an investigation of the accident. After examining the collar, basket and "chippy cage" on the surface, they descended into the 24-foot shaft by means of the "chippy cage." They found a 4 1/2-pound steel wedge on the top deck of the Galloway, which was about 36 feet above the bottom deck. They also found Henry's hard hat with a hole in it at the bottom of the shaft below the Galloway. It was determined that Castillo and Mathieu had been using the wedge at the 2400-foot level to hold the "slickline" away from the concrete liner of the shaft. The safety rope which was tied by a double knot through a 3/4-inch nut welded to the wedge had been broken. Castillo and Mathieu had discovered the wedge missing at about the time of the accident when they pulled on the safety rope and found only the frayed ends.

It was, therefore, concluded from the investigation that Henry had been struck by the wedge at approximately the 2950-foot level when it became detached in an unknown manner and fell from the 2400-foot level. It was further determined that neither the "chippy cage" nor the basket was provided with a bonnet or other overhead protection at the time of the accident.

In the early stages of the on-site accident investigation, Inspector Johnston issued Section 107(a) Withdrawal Order No. 151295 at 2:00 p.m. on October 3, 1979 (Exhibit "B") on the basis of his determination that an imminent danger under the Act existed. Inspector Johnston described the area to which the Order was applicable as "24 ft. shaft, #2 bucket position approx. 2950 feet below collar of shaft." The "condition or practice" recited in the Order was as follows:

At approximately 1125 hours on 10-3-79, a fatal accident occurred in the 24-foot diameter shaft. The victim and his partner were being lowered in a conveyance that did not have a protective bonnet installed. An object from above struck the victim on the head at a point 2950 ft. (approx.) below the collar of shaft. A two-man crew was working approximately 500 ft. (about the 2400-foot level) above the unprotected conveyance of the victim and his partner, mentioned above.

Safe shaft work practices shall be implemented, published to employees, and followed.

DISCUSSION

Harrison Western insists that the Secretary's 107(a) withdrawal order is invalid because the essential element of an "imminent danger" was absent at the time the order was issued. This was so, according to the applicant, because all miners who possibly would have been harmed had already been removed from the hazardous area. Also, the basket and the "chippy cage," which were inherent parts of the hazard, had been moved to the surface. Consequently, the argument proceeds, no imminent danger "existed" within the meaning of section 107(a). Moreover, the miners were already afforded protection by virtue of a previously issued 103(k) order.

Before going further we must examine the concept of an "imminent danger." Section 3(j) of the Act defines the term as

. . . the existence of any condition or practice in a coal or other mine which could reasonably be expected to cause death or serious physical harm before such condition or practice can be abated.

Cases dealing directly with the notion of "imminence" are in general agreement that the danger must be one which can cause serious physical harm at any time, but not necessarily immediately. (FOOTNOTE 5)

In its opening brief Harrison Western urges that since its men, the basket and the cage were all on the surface when the inspector arrived, we are presented with ". . . a typical case in which the inspector issued a withdrawal order based on prior circumstances which he claimed had constituted an imminent danger, but which no longer existed." (FOOTNOTE 6) It is true that imminent danger withdrawals may not be issued for past dangers. Neither the Commission nor its predecessor, the Interior Board of Mine Operations Appeals, however, has ever suggested that an imminent danger vanishes simply because miners are moved elsewhere or mobile equipment is moved. The danger remains a proper subject of an order until the underlying condition giving rise to the danger is corrected. In *Eastern Associated Coal Corp. v. Interior Board of Mine Operations Appeals*, 491 F.2d 277 (4th Cir.1974), where miners were voluntarily withdrawn from a dangerous area before a withdrawal order was issued under section

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104(a) of the 1969 Coal Act, (FOOTNOTE 7) the Court held that an imminent danger nevertheless exists where a condition could reasonably be expected to cause death or serious physical harm to a miner "if normal mining operations were permitted to proceed in the area before the dangerous condition is eliminated." The reasoning behind such a principle is clear. Where miners are voluntarily withdrawn by an operator they may just as easily be ordered back before abatement is complete. An order by an authorized representative of the Secretary of Labor, on the other hand, has a legal force which forbids return of a workforce before the underlying hazard is eliminated.

Harrison Western, in its excellent briefs, speaks repeatedly to the fact that the fatality in the present case took place at about 11:25 a.m. but the inspector did not issue his imminent danger withdrawal order until 2:00 p.m., a time after the miners were out of the shaft and the cage and basket were at the surface. To the extent that applicant thus appears to suggest that this alone vitiated the 107(a) order because the imminent danger no longer "existed," the suggestion is wholly without merit. If "normal mining" (in this case shaft construction) were to resume it must be inferred that miners would continue to work atop the hoist conveyances which were not equipped with protective bonnets overhead. (FOOTNOTE 8)

In sum, Harrison Western has simply taken too parochial a view of the concept of a hazard or "danger" as embodied in 107(a). The applicant stresses the inspector's highly literal description of the circumstances leading to the accident and then suggests that since none of those circumstances existed at 2:00 p.m., the hazard had been "eliminated." On the contrary, the danger lay in the very nature of the work to be done and the fact that miners were doing that work without protection from falling objects. Such a danger does not cease within the contemplation of section 107(a) merely because miners come to the surface or go home for the night.

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By far the most effective argument advanced by Harrison Western concerns the effect of the previous 103(k) order. Where an inspector has withdrawn miners for an accident investigation under 103(k), may he legitimately superimpose a 107(a) imminent danger withdrawal order? Put another way, can there be an "imminent danger" where miners already have been ordered out, not voluntarily by a mine operator, but by a representative of the Secretary of Labor acting under the authority of the Act?

In such a case it cannot be said, as with a wholly voluntary withdrawal, that exposure of the miners could reoccur at the whim of the employing operator or contractor. Thus, one can construct an argument that a subsequent 107(a) order issued while a 103(k) order remains in effect is invalid because the prior 103(k) order nullifies any realistic possibility of injury to miners and thus, any "imminent danger."

This argument, too, must be rejected. To understand why, one merely need look to how 103(k) and 107(a) fit into the statutory enforcement scheme. Their purposes differ. Section 103(k) confers broad emergency powers upon the Secretary to take charge of an accident scene and, in the words of the statute, to ". . . issue such orders as he deems appropriate to insure the safety of any person. . . ." See *Roscoe Page v. Valley Camp Coal Co.*, 6 IBMA 1 (1976).

A 107(a) order, on the other hand, is more limited and more closely focused. It may issue only upon a specific determination of an "imminent danger" and, once issued, remains in effect to protect miners until the conditions constituting the danger are corrected. When a 103(k) order is issued the cause of the accident is often unknown until the Secretary's investigation discovers it. Moreover, investigation may not disclose an imminent danger at every accident scene. It is wholly proper, however, for inspectors to proceed to issue a 107(a) order when an imminently dangerous condition is found, even though a 103(k) order may already be in effect. *Itmann Coal Company*, 1 FMSHRC 1573 (1979). This is so, if for no other reason, because the accident investigation may be completed and all rescue and other accident exigencies dealt with long before the conditions constituting an imminent danger are corrected. In that event, a 103(k) order would likely be ripe for termination while a 107(a) order should remain effective to accomplish its narrower and more specific aims. Thus, once the Secretary properly determines that

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the elements of an imminent danger persist after an accident, a 107(a) order is appropriate and valid. That is so whether a 103(k) order is in effect or not.

In the present case I conclude that the facts disclose the existence of an imminent danger. The issuance of the 107(a) withdrawal order was therefore proper. Consequently, the respondent Secretary's motion for summary decision will be granted, and Harrison Western's motion for the same relief will be denied.

ORDER

In accordance with the foregoing, the applicant's motion for summary decision is DENIED, respondent's motion for summary decision is GRANTED and the withdrawal order issued by the respondent under section 107(a) of the Act is ORDERED AFFIRMED.

John A. Carlson  
Administrative Law Judge

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EXHIBIT "A"  
TABLE

~2113  
EXHIBIT "B"  
TABLE





~FOOTNOTE\_FIVE

5 See, e.g. Old Ben Coal Corporation v. Interior Board of Mine Operation's Appeals, 523 F.2d 25 (7th Cir.1975).

~FOOTNOTE\_SIX

6 Applicant's opening brief at 9.

~FOOTNOTE\_SEVEN

7 Section 104(a) of the 1969 Act is in all significant respects identical to section 107(a) of the 1977 Act.

~FOOTNOTE\_EIGHT

8 The record shows that a protective bonnet was installed on the day following the accident. (See stipulated exhibits).