

CCASE:

SOL (MSHA) V. VALLEY CAMP COAL

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DDATE:

19850118

TTEXT:

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

SECRETARY OF LABOR,
MINE SAFETY AND HEALTH
ADMINISTRATION (MSHA),
PETITIONER
v.

CIVIL PENALTY PROCEEDING

Docket No. WEVA 84-373
A.C. No. 46-03307-03567

No. 15-A Mine

VALLEY CAMP COAL COMPANY,
RESPONDENT

DONALDSON MINE CORPORATION,
CONTESTANT
v.

CONTEST PROCEEDING

Docket No. WEVA 84-147-R
Order No. 2127006; 2/28/84

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

No. 15-A Mine

DECISION

Appearances: Mary K. Spencer, Esq., Office of the
Solicitor, U.S. Department of Labor,
Arlington, Virginia, for the Secretary of
Labor;
Laura E. Beverage, Esq., Jackson, Kelly,
Holt & O'Farrell, Charleston, West Virginia,
for Valley Camp Coal Company and Donaldson
Mine Corporation.

Before: Judge Melick

These consolidated cases are before me pursuant to section 105(d) of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. 801 et seq., "the Act", to contest a citation and withdrawal order issued to Valley Camp Coal Company (Valley Camp) and its wholly owned subsidiary, Donaldson Mine Corporation, and for review of civil penalties proposed by the Mine Safety and Health Administration (MSHA), for the violations charged therein.

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Withdrawal Order No. 2127006 issued under section 104(d)(2) of the Act (Footnote 1) reads as follows:

Overhanging rock was present at the junction of the roof and rib along the left side of No. 5 room right off 6 left section (NNU002-0). The overhang was present 30 feet in by survey station No. 3739 and extended in by towards the face for a distance of 12 feet. The overhanging rock extended from the vertical rib line a distance of 48 inches out over the active work place.

The cited standard, 30 C.F.R. 75.202, requires in relevant part that "loose roof and overhanging or loose faces and ribs shall be taken down or supported."

MSHA Investigator Homer Grose, arrived at the scene of a fatal rock fall in the No. 5 room right off 6 left section of the No. 15 Mine at around 6:30 p.m., on February 27, 1984. At the accident scene, he observed that a portion of overhanging brow some 12 feet long still remained along the left rib of the No. 5 room. Grose described the brow as ranging from 24 inches to 48 inches in width and extending into the work area. According to Grose, the brow was readily observable because of its size and within the brow, fractures could be seen. It is not disputed that photographs taken at the time of the investigation (Exhibit G-6, Photographs 1 through 6) accurately depict the cited brow.

Valley Camp does not deny the existence of the cited brow but alleges that it was not as large as described by Inspector Grose and was not a hazard. While the responsible section foreman, Paul Williams, was not sure he saw any

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brow, Keith Grounds, the continuous miner operator who had been working in the No. 5 room just before the fatal accident, thought there was indeed a brow about 2 feet thick. Another Valley Camp witness, Jack Campbell, the Manager of Safety and Training, estimated that the brow was not more than 10 inches thick.

The thickness of the brow as demonstrated in Photographs 4, 5 and 6 of Exhibits G-6 is not disputed. Moreover, since Inspector Grose used a tape measure to determine the dimensions of the brow, (see for example Exh. G-6 photographs 4, 5 and 6) I give dominant weight to his testimony in this regard. Since even a 10 inch overhanging rib constitutes a violation of the cited standard, the size of the overhanging area is, in any event, significant only insofar as it relates to a greater hazard and increased negligence. It is of course also relevant to the "significant and substantial" and "unwarrantable failure" findings associated with the order at bar.

In determining whether there was an unwarrantable failure to comply with the cited standard, additional evidence must also be considered. An unwarrantable failure to comply may be proved by showing that the violative condition or practice was not corrected or remedied prior to the issuance of the order because of indifference, willful intent, or a serious lack of reasonable care. *United States Steel Corporation v. Secretary*, 6 FMSHRC 1423 at 1437 (1984).

In this case, the evidence shows that normal mining progressed on the morning of February 27, 1984, until the second cut by the continuous-mining machine in the No. 5 room. At that time, a section of roof (ranging from 10 to 16 inches thick, 16 feet wide and 16 feet long) fell onto the continuous-mining machine, but caused no injury or damage.

Section foreman Paul Williams heard the roof fall at what he thought was around 11:30 that morning and 10 or 15 minutes later he was at the scene of the fall. He remembers talking to the deceased, Don Jones, and to Keith Grounds the continuous miner operator, but does not recall "what all was said." Williams testified that he did not see the brow, but later said he "could have" seen it. In any event, Williams gave no specific instructions to the crew, relying on their experience and the "general practice" at the mine to take down or support "loose brows." Williams opined that rock falls of this magnitude were not unusual at

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the No. 15-A Mine and occurred about once a shift. He also acknowledged, however, that loose rock and overhanging brows are potential hazards remaining after roof falls.

Keith Grounds, the continuous miner operator, testified on behalf of Valley Camp that he cleaned up after the roof fall and then inspected the area with the deceased. They agreed that the room "looked alright." Grounds concedes, however, that he had been unable to remove the cited brow in the No. 5 room because of an obstructing ledge that remained after the roof fall. Grounds testified that in any event it was then the accepted practice at the mine not to cut down brows less than 2 feet thick. He estimated that the remaining brow was in fact about 2 feet thick.

It is not disputed that the roof-bolting machine operated by the deceased was then trammed to the No. 5 room. After installation of the third row of roof supports, John Wright, acting as roof bolter helper, retracted the ATRS (Automated Temporary Roof Support System) and trammed the machine into position for the last row of roof supports. Jones stood aside near the left rib when a section of overhanging rock fell from the junction of the roof and rib pinning Jones to the floor.

According to the undisputed testimony of MSHA Investigator Grose, it is the standard industry practice for the section foreman to examine and inspect the affected roof area following a roof fall such as the one in this case. The section foreman then has the responsibility to determine what action should be taken to remove hazards and to verify that no hazards remain before allowing production to resume.

Section foreman Williams in this case admittedly left such decisions to the individual judgment of his work crew. That practice was clearly deficient under prevailing industry standards and directly contributed to the death of a miner in his charge. Williams had knowledge of the first roof fall and was present in the room in which the fall occurred, but did not even take time to thoroughly evaluate the residual roof conditions for himself. Moreover, he allowed production to resume without first examining the work place to determine whether any hazards remained. The violation was accordingly the result of gross negligence.

I also observe that it had been management policy at the subject mine to allow overhanging brows to remain in work areas so long as such brows were no more than 2 feet

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thick. Thus the miners herein allowed a substantial brow to remain along the left rib of the No. 5 room, which was deemed to be no greater than 2 feet thick. This policy also directly contributed to the death of Mr. Jones and also warrants an independent finding of gross negligence. The same evidence establishing gross negligence also supports a finding that the violation was caused by the "unwarrantable failure" of the mine operator to comply with the standard. United States Steel Corporation, *supra*, at 1437.

Since it is undisputed that an overhanging rib or brow at least 2 feet thick existed in an active working place where a roof fall had recently occurred and in an area where roof falls were common, there was clearly a "significant and substantial" violation of the cited standard. It was indeed reasonably likely that death or serious injuries would result in that active work place. *Secretary v. Mathies Coal Company*, 6 FMSHRC 1 (1984). Since it is undisputed that there had been no intervening clean inspections of the subject mine between the date of the precedential section 104(d)(1) order (Order No. 1064308) and the date of the issuance of the section 104(d)(2) order at bar, (Order No. 2127006), the latter order is affirmed.

In determining the appropriate penalty to be assessed in this proceeding, I have also considered that the mine operator is large in size and has a fairly substantial history of violations. Under the circumstances, I find that a penalty of \$5,000 is appropriate.

A motion for approval of a settlement agreement was submitted at hearing with respect to Citation No. 2127005. The citation alleges a "significant and substantial" violation of the standard at 30 C.F.R. 75.200, because work was being performed by the deceased under unsupported roof. Valley Camp has agreed to pay the proposed penalty of \$3,000 and considering the facts in this case in light of the criteria under section 110(i) of the Act, I find the proposed settlement to be appropriate.

