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SOL (MSHA) v. BCNR MINING
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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. PENN 85-131 A.C. No. 36-00808-03527
v.	Russellton Mine
BCNR MINING CORPORATION, RESPONDENT	

DECISION

Appearances: John S. Chinian, Esq., Office of the Solicitor, U.S. Department of Labor, Philadelphia, Pennsylvania, for Petitioner;
Bronius K. Taoras, Esq., BCNR Mining Corporation, Meadowlands, Pennsylvania, for Respondent.

Before: Judge Merlin

This case is a petition for the assessment of a civil penalty filed by the Secretary under section 110 of the Act against BCNR Mining Corporation for a violation of 30 C.F.R. 77.1710(g) involving a fatality. A hearing on the merits was held on June 11, 1985, and the parties now have filed post-hearing briefs.

The subject citation describes the violative condition or practice as follows:

> During the course of a fatal fall of person [sic] accident investigation it was revealed that the victim was not wearing a safety belt and line when he placed his body between the top and middle guard rails around an opening on the fourth floor of the preparation plant. The victim was attempting to free a ladder wedged between beams inside the opening and when the ladder became free, he lost his balance and fell to the concrete ground floor, a distance of about 49 feet.

* * * *

30 C.F.R. 77.1710(g) provides as follows:

> Each employee working in a surface coal mine or in

> the surface work areas of an underground coal mine shall be required to wear protective clothing and devices as indicated below:
>
> * * *
>
> (g) Safety belts and lines where there is danger of falling; * * *

The subject fatality occurred under the following circumstances: About 9:10 p.m. on June 8, 1984, the afternoon shift foreman at respondent's preparation plant instructed Mr. Kerleski, a repairman, to fix a leaking flange in the chance cone separator of the plant (Tr. 12-13). The foreman sent the decedent, also a repairman, to help Kerleski (Tr. 15, 102). In connection with the repair job, the two men tried to raise a 20 foot ladder to the fourth floor level of the plant, first using an electric hoist and then a rope (Tr. 13-14). The ladder became wedged between an angle brace on the fifth floor and a floor support beam on the fourth (Tr. 14). In order to free the ladder the decedent first started to go over the railing on the fifth floor but Kerleski told him not to (Tr. 14, 36). Kerleski unsuccessfully pushed against the ladder from the fourth floor (Tr. 36). Then the decedent tried pushing against the ladder (Tr. 15-16). According to the first MSHA inspector who testified, the accident investigation disclosed that the decedent was kneeling on one knee, holding a tow board with one hand, placing his body above the waist out between the middle and top railings and pushing with his other hand against the stuck ladder (Tr. 16-18). The inspector testified that when the ladder broke free, the decedent lost his support and fell through the railings for a distance of 49 feet (Tr. 19). The decedent was taken to the hospital where he died a few hours later from injuries suffered in the fall (MSHA Exhibit No. 23, p. 5). The operator's plant foreman expressed the view that the decedent was down on both knees not just one, and was bending through the handrails (Tr. 76-85). I find the foreman's testimony unclear and confused. The inspector's description of what happened and how the decedent was positioned was clear and straightforward and I accept it.

The first issue to be decided is whether the cited standard applies, i.e., was there a danger of falling. The Commission has held that the test is whether an informed, reasonably prudent person would recognize a danger of falling warranting the wearing of safety belts. Great Western Electric Company, 5 FMSHRC 840 (1983). I conclude that an informed, reasonably prudent person would have recognized the danger of falling in this instance. The risk of falling from putting one's body out so far and pushing against a ladder should have been clear to any reasonably prudent person. Indeed, in Great Western Electric Company a risk of falling was held to be present in circumstances somewhat analogous, but less compelling than the instant matter. In that case the miner was on the ladder leaning over to change light bulbs. The Commission noted that the situation involved a shift in the

miner's physical center of gravity, which is what was present here, except in this case the shift in balance was far more extreme because the decedent deliberately pushed against the ladder to free it and when he did so, the freed ladder no longer supported him and he fell.

It next must be determined whether the operator's actions satisfy the mandate of section 77.1710(g) that it require employees to wear safety belts in these situations. Here again, Commission decisions are determinative. In Southwestern Illinois Coal Corporation, 5 FMSHRC 1672 (1983) the Commission held that although the operator does not have to guarantee that safety belts are actually worn, its duty is one of requirement diligently enforced. According to the Commission, a violation exists where there are no signs at the mine reminding employees to wear belts, no safety analyses or directives are issued to identify specific situations where belts could be worn, no specific guidelines are given to identify specific working situations where belts should be worn, and the wearing of belts is delegated to the discretion of each employee, with only general guidance at best. More recently, in Southwestern Illinois Coal Corporation, 7 FMSHRC 610 (1985), the Commission reiterated that an operator violates this mandatory standard by not engaging in sufficiently specific and diligent enforcement of the safety belt requirement and where the decision to wear a safety belt is left largely to the miner because of an absence of any site-specific guidelines and supervision on the subject of actual fall dangers. In addition, in Southwestern II, the Commission held that although the operator has a safety program requiring the wearing of belts and miners violating the requirement are disciplined, a violation still exists where evidence is lacking of the operator's specific enforcement actions and of its diligence in site-oriented enforcement. The Commission concluded by again referring to a too broad delegation to the miner of the ultimate decision whether the wearing of a belt is necessary and too little hazard-specific guidance and supervision by the operator.

This case falls squarely within the Southwestern decisions. The operator's Job Safety Analysis merely says under the heading of Repairing Machinery, "Use Safety Belts" (Operator's Exhibit No. 1, p. 3). This bare directive is not explained or related to specific job situations. Similarly, the operator's safety rule book says that safety belts shall be worn at all times when working in and around shafts, railroad cars or on high structures of any type where a fall could cause serious injury. However, the only job identified as requiring a safety belt is that of car dropper (Operator's Exhibit No. 4, p. 45; Tr. 115). Specific job situations where a fall could cause serious injury are not given. The plant foreman testified that he read the job safety analysis to miners as part of their refresher training course and that as part of the training he also walked through the preparation plant discussing hazards (Tr. 89-90). The decedent had this training four months before the fatal accident (Tr. 37-38). However, insofar as the record indicates, the miners were told nothing

about specific situations where they should wear safety belts. Since hoisting of equipment in the preparation plant was an everyday occurrence and since a ladder had to be raised to the fourth floor once a month, the falling hazard in performing these tasks should have been pointed out by the operator (Tr. 46, 97). Here, as in the Southwestern cases, the operator's actions are too general and vague to satisfy the requirements of the mandatory standard.

The operator's safety supervisor testified that an unsafe practice slip was given to any miner who violated one of the company's safety rules (Tr. 115). Unsafe practice slips for failing to wear safety belts had only been given to car droppers and never in this type of situation (Tr. 116-117). Indeed, it is hard to see how the operator could give a miner an unsafe practice slip in a case like this, since it never indicated that belts should be worn under these circumstances. In Southwestern II, the fact that the operator disciplined miners who violated the safety belt requirement was held insufficient in the absence of too little hazard-specific guidance by the operator. The same conclusion must obtain here as well.

That the operator in this case failed to diligently enforce the wearing of safety-belts is further demonstrated by the fact that at the time of the accident the only available safety belt was in the foreman's office (Tr. 44-45). Only after the accident were safety belts placed on every other floor of the preparation plant (Tr. 41, 58). Also, there were no signs reminding the miners to wear belts (Tr. 21, 67). These circumstances further demonstrate the lack of any follow-up by the operator.

In establishing the "reasonably prudent" test in Great Western, the Commission referred to "the inherent vagaries of human behavior", 5 FMSHRC at 842. The Southwestern decisions require due diligence by the operator in enforcement of the safety belt requirement, and they proscribe the too broad delegation to the miner of the decision whether or not to wear a safety belt. What happened here is exactly what the Commission decisions forbid. The decision about safety belts was left entirely up to the men. And the dangers created by this approach stand in stark relief, because evidence of record which I accept, demonstrates that neither Kerleski nor the decedent had any prior experience in raising such a ladder to the fourth floor (Tr. 48, 66-67).

In light of the foregoing I conclude the operator violated 30 C.F.R. 77.1710(g).

As stipulated by the parties the violation was extremely serious because it caused a fatality (Tr. 4). All the requirements for significant and substantial are met. Mathies Coal Co., 6 FMSHRC 1 (1984); Consolidation Coal Company, 6 FMSHRC 189 (1984); U.S. Steel Mining Co., 6 FMSHRC 1866 (1984).

The operator was negligent in doing so little to enforce the safety belt requirement. Its negligence is magnified because, as already pointed out, the decedent and his co-worker were inexperienced in performing the task assigned to them by the afternoon shift foreman and there was a lack of actual supervision. I recognize the foreman cannot be everywhere at the same time, but when he assigns a job which includes raising a 20 foot ladder to the fourth floor to two men who have never done this before, he must supervise them. Undoubtedly, the decedent himself was extremely careless. But this cannot exculpate the operator from being held responsible for failing to oversee inexperienced men in the performance of a hazardous job. I conclude the operator was highly negligent.

The other statutory criteria under section 110(i) are the subject of stipulations which, as set forth above, I have accepted.

The post-hearing briefs of the parties have been reviewed. Both were extremely helpful. To the extent they are inconsistent with this decision they are rejected.

A penalty of $5,000 is assessed which the operator is ORDERED TO PAY within 30 days from the date of this decision.

Paul Merlin
Chief Administrative Law Judge