CCASE:
SOL (MSHA) v. PYRO MINING
DDATE:
19851025
TTEXT:

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

SECRETARY OF LABOR, MINE SAFETY AND HEALTH ADMINISTRATION (MSHA) PETITIONER v. PYRO MINING COMPANY, RESPONDENT	CIVIL PENALTY PROCEEDINGS Docket No. KENT 84-236 A.C. No. 15-13881-03534 Pyro No. 9 Slope William Station Mine Docket No. KENT 85-25 A.C. No. 15-13920-03525 Docket No. KENT 85-27 A.C. No. 15-13920-03527 Docket No. KENT 85-54 A.C. No. 15-13920-03530 Docket No. KENT 85-88 A.C. No. 15-13920-03536 Docket No. KENT 85-113 A.C. No. 15-13920-03543 Pyro No. 9 Wheatcroft Mine Docket No. KENT 85-52 A.C. No. 15-14492-03504 Palco Mine

DECISION

Appearances: Thomas A. Grooms, Esq., Office of the Solicitor, U.S. Department of Labor, Nashville, Tennessee, on behalf of Petitioner; William Craft, Safety Manager, Pryo Mining Company, Sturgis, Kentucky, for Respondent.

Before: Judge Melick

These consolidated cases are before me upon the petitions for civil penalty filed by the Secretary of Labor pursuant to section 105(d) of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. 801 et seq., the "Act," for alleged violations of regulatory standards. The general issues before me are whether the Pyro Mining Company (Pyro) has violated the cited regulatory standards and, if so, what is the appropriate civil penalty to be assessed in accordance

with section 110(i) of the Act. Additional issues are also addressed in this decison as they relate to specific citations and orders.

DOCKET NO. KENT 84-236

The one citation in this case (No. 2339124) as amended, alleges a "significant and substantial" violation of the mandatory standard at 30 C.F.R. 75.1306 and charges as follows:

> The explosives and detonator cart being used on number 4 unit (ID004) to carry explosives and detonator [sic] from one (1) working place to another is not being maintained in a permissible manner. The explosives and detonator cart is between Nos. 4 and 5 entry in the last travelled crosscut with the lids open exposing loose sticks of explosives and loose detonators. Also one (1) detonator is laying on the main [sic] floor next to the cart. An energized trailing cable is approximately 22 inches from the explosives and detonator cart laying on the mine floor. Also one shuttle car is traveling this crosscut.

The standard cited after amendment, 30 C.F.R. 75.1306, reads in relevant part as follows:

> When supplies of explosives and detonators for use in one or more working sections are stored underground, they shall be kept in section boxes or magazines of substantial construction with no metal exposed on the inside, located at least 25 feet from roadways and power wires, and in a dry well rock dusted location protected from falls of roof. . . .

Respondent alleges in his post-hearing brief that the charging language of the citation was not sufficient to state a violation of the standard cited. The citation alleged that the subject cart was used to "carry" explosives and the standard applies to the "storage" of explosives. Since a cart used to carry explosives may also be used to store explosives I find no deficiency in the charging language. It is clear, moreover, from the hearing record that Respondent was fully aware at the time of hearing of the nature of the charges and was prepared to defend against those charges. The profferred defense is accordingly rejected.

During the course of an underground inspection on July 12, 1984, Inspector James Hackney of the Federal Mine

Safety and Health Administration (MSHA) found the cited explosive cart in the number 4 unit with its lids open and "Tovex" explosives exposed. The cart also had a hole in its side some 4 inches in diameter and exposed metal inside. In addition, a power cable was located only 22 inches from the cart and a stick of the Tovex explosive and some detonator caps were lying on the ground 2 feet away. The caps had been shunted however and, according to the manufacturer, were therefore not supposed to detonate.

According to Hackney if the cable was energized and had blown-up, the caps and explosives nearby could have been detonated. In addition explosive 5.5 percent levels of methane gas were found in the No. 1 entry which, if ignited, could trigger an explosion of the Tovex. Conversely if the Tovex had exploded, the explosive levels of methane could have been drawn out of the No. 1 entry by the vacuum created thereby and have amplified the explosive forces. Finally, Hackney found shuttle car tire tracks close to the cited explosives cart, indicating that it was near a roadway and subject to collision. Since there is no dispute that the cited cart was found storing explosives within 25 feet of a power wire there was clearly a violation of the standard.

In defense, the operator suggests that Tovex is not a dangerous explosive and that, even under the circumstances cited herein, created no danger. According to William Craft, Pyro's Safety Manager, Tovex is "not near as sensitive as nitroglycerin" and does not emit toxic fumes.

The Tovex manufacturer's explanatory booklet (Exhibit P-7) warns however, not to allow any source of ignition within 50 feet of a magazine or vehicle containing Tovex. It also warns not to expose the Tovex to excessive impact, friction, electrical impulse or heat from any source and warns against storing Tovex in wet or damp places with flammable or other hazardous material or near sources of excessive heat. It further warns against storing detonators in the same magazine with Tovex.

Within this framework of evidence it is clear that the storage of Tovex here cited violated even the manufacturer's standard of care. It may reasonably be inferred from these circumstances that the conditions constituted a "significant and substantial" violation of the cited standard. See Secretary v. Mathies Coal Company, 6 FMSHRC 1 (1984). The violation was accordingly also of a serious nature.

Negligence may also reasonably be inferred from the circumstances. The explosives cart was being used in the

cited manner in plain view observable by supervisory personnel. Considering the large size of the operator and the subject mine and what I consider to be a significant history of seven previous violations of the same standard over the 2 year period preceding the instant citation, I find that a civil penalty of $1,000 is warranted. In reaching this assessment I have not failed to consider that the cited condition was abated in accordance with MSHA's instructions in a good faith manner.

DOCKET NO. KENT 85-25

Pursuant to his investigation on July 27, 1984, of a methane and/or dust ignition at Pyro's Number 9 Wheatcroft Mine, MSHA Inspector George Siria found what he opined could have been contributing factors. In citation Number 2339004 he found a "significant and substantial" violation of the mine operator's ventilation plan under the mandatory standard at 30 C.F.R. 75.316. The ventilation plan then in effect required at least five thousand cubic feet a minute (CFM) of air at the cited crosscut. Siria's measurement at that location of only 2250 CFM is not disputed and the violation is accordingly proven as charged.

It is further undisputed that proper ventilation will dilute and carry away coal dust and methane and other explosive or noxious gases and inadequate ventilation may very well allow coal dust and methane to build up to explosive levels. It was Siria's opinion that proper ventilation could have prevented the ignition in this case in which two miners were seriously burned. In light of the seriousness of injuries that could reasonably have been caused by inadequate ventilation it is clear that the violation was "significant and substantial". Mathies, supra, Secretary v. U.S. Steel Mining Co., Inc., 7 FMSHRC 1125 (1985). In light of the method of abatement followed in this case (extending line brattice across the last open crosscut) it is apparent that the condition had existed for a sufficient time during which the section foreman or other supervisory personnel should have known of the violation. Accordingly I find that the violation was the result of operator negligence. Secretary v. Ace Drilling Company, 2 FMSHRC 790 (1980).

Citation No. 2339005, as amended, charges a violation of the standard at 30 C.F.R. 75.313 and alleges that "the methane monitor on the continuous miner is inoperative in that it will not deenergize the miner when checked with the test button." 30 C.F.R. 75.313 requires, as applicable hereto, that continuous mining equipment must be provided with a methane monitor installed and maintained properly and

in an operative condition. It is not disputed that such a monitor must provide a warning when the methane concentration reaches a maximum level of one volume percentum and must deenergize the continuous miner when the concentration of methane reaches a maximum percentage of not more than 2 volume percentum.

It is undisputed that the cited methane monitor was in fact inoperative as alleged. I accept the undisputed conclusions of Inspector Siria that methane ignitions were reasonably likely in light of the existence of the permissibility violations and potential ignition sources found on the same continuous miner. See discussion of citation No. 2339006, infra. The violation was accordingly particularly serious and "significant and substantial". Mathies, supra.

In reaching this conclusion I have not disregarded the testimony of the injured miner, Frank Barber, who had been operating the continuous miner at the time of the earlier ignition. Barber opined that that ignition occured when the miner struck "jack rock" and set off a spark igniting dust but not methane. He observed that the face boss had found no methane only five minutes before the ignition. My findings herein are based however upon evidence of conditions existing at the time of the citation and not on conditions at the time of the prior ignition. The fact that the MSHA investigators were unable to pinpoint the source of that previous ignition is immaterial to this case.

I also find that the violation was the result of operator negligence. Barber admittedly did not check the operation of the methane monitor prior to the commencement of his shift that day and although he said that such examination was the responsiblity of the miner operator on the preceding shift, that examination presumably had not been performed because Barber had not been informed of the defect. This failure to check the operation of the methane monitor and/or of communicating the defects to Mr. Barber clearly demonstrates a lack of proper employee training and/or supervision. This evidence supports a finding of operator negligence. Secretary v. A.H. Smith Stone Company, 4 FMSHRC 13 (1983).

Citation No. 2339006 alleges a violation of the standard at 30 C.F.R. 75.503 and specifically charges that the same "continuous miner was not maintained in a permissible condition in that 3 of its lights were not fastened to the miner and the conduit was pulled from the junction box at the point the trailing cable enters the box." It is not disputed that the continuous miner was in violation of the cited standard in the manner described. According to

Inspector Siria, the lights were in the "on" position when cited, indicating that they were energized. Siria opined without contradiction that the lights or the excessive gap in the junction box could provide an ignition source for methane and/or coal dust explosions. In light of the actual ignition that had already occurred and the other violative conditions cited on the same date, it is clear that this violation, too, was serious and "significant and substantial". Mathies supra.

I also find that this violation was the result of operator negligence. It may reasonably be inferred that these obvious conditions had existed for some period of time during which the section foreman or other supervisory personnel should have seen the violations. The failure of non-supervisory personnel to have corrected these obvious defects also demonstrates negligent training and/or supervision. A.H. Smith, supra.

DOCKET NO. KENT 85-27

At hearing Petitioner filed a motion to approve a settlement agreement and to dismiss this case. A reduction in penalties from $471 to $371 was proposed. I have considered the representations and documentation submitted, and I conclude that the proffered settlement is appropriate under the criteria set forth in Section 110(i) of the Act.

DOCKET NO. KENT 85-52

Citation No. 2505981 alleges a "significant and substantial" violation of the regulatory standard at 30 C.F.R. 75.1103 and alleges as follows:

> "the automatic fire sensor installed on the 001-0 unit belt was inoperable. The component on the end of the line that completes the circuit was not in place. The system would not give warning should a fire occur."

The cited standard requires as relevant hereto that devices must be installed on underground belt conveyors which will give a warning automatically when a fire occurs on or near a belt. The testimony of MSHA Inspector George Newlin is not disputed that the fire sensor was in fact inoperable as alleged. According to Newlin if a fire did occur along the affected area there would be no warning. Such a fire, out of control, would emit smoke and gases including carbon monoxide and could result in fatalities to the underground miners. It is further undisputed that such fires could

result from a jammed roller developing friction heat. The violation was extremely serious and "significant and substantial" even though Inspector Newlin did not in fact find any "jammed" rollers. I do not find operator negligence without either direct or circumstantial evidence to support such a finding.

Citation No. 2505983 alleges a "significant and substantial" violation of the standard at 30 C.F.R. 75.400. The citation alleges as follows:

> Coal dust and float coal dust had accumulated along the full length of the No. 2 belt. Dust had settled on the mine floor and all rock dusted areas. Several bottom roller [sic] was running in water and gob.

The cited standard requires that "coal dust, including float coal dust deposited on rock-dusted surfaces, loose coal, and other combustible materials, shall be cleaned up and not be permitted to accumulate in active workings, or on electric equipment therein."

The conditions cited by Inspector Newlin on October 4, 1984, are not disputed. Newlin found coal dust accumulations along the No. 2 belt up to 3 inches deep along the 1500 to 2000 foot-long belt. Any ignitions within the vicinity of the belt would be amplified by the coal dust and expose the maintenance workers in the area to serious injuries or death. The seriousness of the hazard was somewhat mitigated by the fact that the belt was located away from the face and 20% of the area was damp. I find that a "significant and substantial" and serious hazard nevertheless existed. Serious injuries were reasonably likely under the circumstances. See Secretary v. Black Diamond Coal Mining Co., 7 FMSHRC 1117 (1985).

I also find that the violation was a result of operator negligence. It may reasonably be inferred from the amount of accumulations and the large area over which they existed, that the violative conditions had existed for a sufficient period during which they should have been discovered by managerial personnel. In addition it may reasonably be inferred from the failure of other personnel working in the area to have cleaned up the accumulations that they were not properly supervised and/or trained.

Citation No. 2505987 alleges a "significant and substantial" violation of the standard at 30 C.F.R. 75.503 and charges that "the Joy miner serial no. JN3119 used to mine

coal on the 001-0 unit was not maintained in permissible condition in that the panel cover on the control box was not tight when check [sic] with a 5/1000 feeler gage [sic]."

It is not disputed that the cited conditions constituted a violation of the standard. It is further undisputed that dirt prevented the cover from fitting tightly over the control box. Upon this evidence it may reasonably be inferred that the condition had existed for a sufficient period of time during which management should have detected the violation. The violation is accordingly the result of operator negligence. It is also undisputed that an arc from the control box could ignite any methane present in the environment thereby causing serious or fatal injuries from an ignition or explosion of methane or dust. The continuous miner was in fact being used at the time of the citation to cut coal and was therefore being used at the face. I determine from this evidence that the violation was "significant and substantial" and serious.

Citation No. 2505988 alleges another "significant and substantial" violation of the standard at 30 C.F.R. 75.400. The citation alleges as follows:

> "The numbers 3, 4 and 5 heading had loose coal and coal dust in the entries and crosscut for three crosscuts outby the face. The coal ranged in depth from 0 inches to 12 inches on the 001-0 unit."

The conditions underlying the citation are not disputed. Coal dust and loose coal up to 12 inches deep extending from rib to rib across the 20 foot-wide entries were found by Inspector Newlin. The cited area was traveled by vehicles and, according to Newlin, the accumulations represented 4 or 5 days production. I find that a "significant and substantial" and serious fire and explosion hazard existed as a result of this violation. Black Diamond Co., supra. Since the accumulations represented at least several shifts of production it is clear that management should have discovered and remedied the condition well before it was cited. Accordingly the violation was the result of operator negligence.

DOCKET NO. KENT 85-54

Citation No. 2507010 alleges a "significant and substantial" violation of the standard at 30 C.F.R. 75.400 and charges as follows:

> "Accumulations of loose coal and coal dust were present on the ribs, in faces of entries (unit now in rooms) and in last room set up on ribs and in piles. Coal ranged in depth from 0 to 4 feet in depth. Areas of last room setup needs rock-dusting to within 40 feet of faces. No. 2 unit ID001."

The cited standard provides that "coal dust, including float coal dust deposited on rock-dusted surfaces, loose coal, and other combustible materials, shall be cleaned up and not be permitted to accumulate in active workings, or on electric equipment therein." MSHA Inspector Jerrold Pyles testified at hearing that the cited accumulations were not found in "active workings". Accordingly, there was no violation of the cited standard and the citation must be vacated.

Citation No. 2507013 alleges a "significant and substantial" violation of the operator's roof control plan under the standard at 30 C.F.R. 75.200. The citation alleges as follows:

> "the room necks driven on the intake side [of the No. 2 unit ID001] that are to be driven at a later date were driven more than 30 feet from center line of last entry. One was 39 feet, one 54 feet, and one 49 feet. Three of the six were driven this way."

The applicable roof control plan (Exhibit P-23 page 3) provides that "room necks driven during development that are to be driven at a later date shall not be driven more than 30 feet from the center line of the outside entry and not more than 20 feet wide until the first crosscut is turned."

According to the uncontradicted testimony of Inspector Pyles, the roofs in the cited room necks would be expected to deteriorate in the estimated 2 to 3 weeks before the operator would return to continue mining the necks. The hazard was further increased because of the proximity of the necks to cross-cuts where larger roof areas were exposed. In addition, there had been a history of roof falls at this mine and the strata above the coal seam was admittedly unstable. Indeed in two of the locations cited there were visible cracks in the roof strata. While roof bolts inserted in the neck areas did reduce the severity of the hazard, I nevertheless find that the violation and its "significant and substantial" findings are proven as charged. I find the violation was the result of operator negligence because the location chosen to conduct mining activity is within the affirmative control of management.

Citation No. 2507014 alleges another violation of the standard at 30 C.F.R. 75.400 and charges as follows:

> Loose coal and coal dust mixed with gob had been left in old room necks driven on the intake side. These rooms were driven approximately 7 to 14 days ago. Coal were [sic] in piles of approximately 4 1/2 feet high and from 10 to 15 feet in length. 4 of the 6 room necks were like this."

Pyles testimony in support of the citation is undisputed. He found loose coal and coal dust in the cited room necks in piles 4 1/2 feet high and 10 to 15 feet in length. With an ignition source the coal and coal dust presented a serious fire and explosive hazard. The violation and its "significant and substantial" findings is accordingly proven as charged. Mathies, supra; Black Diamond Coal Co., supra. It may be reasonably be inferred that the violation was the result of operator negligence because of the large quantity of loose coal and coal dust found and because the piles had been created by an affirmative act. According to Pyles the rooms had also been driven 7 to 14 days before the conditions were cited.

Citation No. 20507016 alleges a "significant and substantial" violation of the standard at 30 C.F.R. 75.503 and specifically charges as follows:

> A violation was observed on No. 2 unit (ID001) on the Joy Loader in that an opening in excess of .004 of an inch (measured with .005 guage) was found in the main control panel. Loader was in No. 4 entry preparing to load coal. Two-tenth percent of gas was found. Mine is on a 5 day spot due to an ignition which occured at this mine in Fiscal Year 84.

It is not disputed that the cited facts did exist and that they constituted a violation of the cited permissiblity standard. Inspector Pyles testified that the opening in the control panel of the loader would permit an ignition of methane or dust if arcing would occur inside. A resulting explosion could cause serious injuries to the loader operator and others working nearby. The violation is accordingly proven as charged and under the circumstances was "significant and substantial". It may reasonably be inferred that the cited equipment was not being properly inspected from the very existence of the violation and therefore some measure of negligence may also be inferred.

Citation No. 2507017 alleges a violation of the standard at 30 C.F.R. 75.517 and charges as follows:

> The cutting machine trailing cable, located on No. 2 unit ID001, had damage to the outer jacket in 4 to 5 places. The outer jacket was cut down to the other insulation on phase wires, therefore it was not insulated adequately and fully protected. Also cutter was dirty.

The cited standard requires inter alia that power cables "shall be insulated adequately and fully protected". Inspector Pyles testified that the defective condition of the cable would weaken the cable and allow it to separate and cut the phase wires. He opined that the cable could then reel up into the machine and cause it to become energized. Persons contacting the cable or the energized equipment could thereby be electrocuted. The violation is accordingly "significant and substantial" and serious. It may reasonably be inferred from the obviously defective condition of the trailing cable that the violative condition should have been known to management and have been remedied. The failure of other employees to have corrected the condition also indicates negligent training and/or supervision.

Citation No. 2507019 alleges a "significant and substantial" violation of the operators roof control plan under 30 C.F.R. 75.200 and charges as follows:

> "A violation of the roof control plan, dated June 22, 1984, was observed along the No. 2 unit supply road, from the 2nd main west header up to No. 2 unit, in that several crosscuts along the supply road were not timbered, some only had 1 or 2 timbers and some not at all."

The allegations are not denied by the operator. According to the roof control plan (Exhibit P-23 page 14) timbers must be installed within 240 feet of the tail piece in the crosscuts. 5 of the crosscuts had no timbers and 6 of them had only 1 or 2 timbers. The roof control plan required at least 6 timbers. Additional roof support is required in these areas because of the greater stress presented by larger areas of exposed roof. I accept the evidence that roof falls were reasonably likely under the circumstances and the violation was accordingly "significant and substantial" and serious. Operator negligence may be inferred from the obvious absence of timbers in the required quantities.

DOCKET NO. KENT 85-88

Order No. 2507020 alleges a "significant and substantial" violation of the standard at 30 C.F.R. 75.1704 and charges as follows:

> "An intake (designated primary) escapeway was not maintained to insure passage at all times of any persons, including disabled persons, from No. 2 unit (ID001). There were 2 aircourses one of which had a roof fall in it, halfway loaded, but not supported with permanent roof supports, nor marked; therefore no exit through this area was available; the other aircourse was full of rock and not passable."

The cited standard requires in relevant part that "at least 2 separate and distinct travelable passageways which are maintained to insure passage at all times of any person, including disabled persons and which are to be designated as escapeways, at least one of which is ventilated with intake air, shall be provided from each working section continuous to the surface escape drift opening, or continuous to the escape shaft or slope facilities to the surface, as appropriate, and shall be maintained in safe condition and properly marked."

According to Inspector Pyles, he and David Sutton, the company safety director, came upon a roof fall in the No. 4 entry. Upon further examination they discovered that the No. 1 entry, the primary escapeway, was also obstructed. The roof fall in the No. 4 entry extended from rib to rib and prevented passage. Some of the rock from that fall had been removed into the No. 1 entry thereby also making that escapeway impassable. Tire tracks on the floor of the No. 1 entry indicated to Pyles that the rock and gob material had been dumped there. It is not disputed that the violation was serious in that both the primary and alternate escapeways were blocked thereby preventing miners from escaping in the event of fire or other similar hazard. The violation was accordingly serious and "significant and substantial".

It is clear that the violation was also the result of negligence. Even the company safety director, David Sutton, conceded that someone in the company must have been aware of the blocked escapeways. In spite of this knowledge the escapeways were not being cleared at this time but rather the men were working at the face extracting coal.

DOCKET NO. KENT 85-113

Citation No. 2507219 alleges a "significant and substantial" violation of the operator's roof control plan and specifically charges that "the timbers in the return in the No. 4 unit (004) was [sic] 950 feet outby the feeder."

The roof control plan (Exhibit P-31, page 14) requires that timbers be placed in the entries within 240 feet of the tailpiece. A history of roof falls in the cited area highlights the extent of the hazard and the need for the additional roof support. The violation was accordingly "significant and substantial" and serious. The violation was also the result of operator negligence. The cited areas were inspected at least weekly by the fire bosses and the violative conditions which existed for more than a week should accordingly have been discovered and remedied.

Citation No. 2507220 charges a violation of the standard at 30 C.F.R. 75.400 for the presence of loose coal and coal dust accumulations. The citation charges in particular that the loose coal and coal dust were allowed to accumulate on the floor and connecting crosscut around the unit 4 headers. According to the undisputed testimony of MSHA Inspector Newlin, the header is the main drive unit for the conveyor belt and where coal is dumped onto another belt. The accumulations were 1 to 6 inches deep and extended 40 to 50 feet in four directions at the crosscut. It is undisputed that the existence of accumulations of this nature in close proximity to belt rollers and bearings provided a serious fire hazard. It is reasonably likely that heat from a jammed roller would provide the source of ignition. Inspector Newlin conceded however that none of the rollers were in fact jammed at the time nor were any of the rollers beneath any of the cited accumulations. In addition, some water was found in the vicinity providing some measure of fire limitation. I nevertheless find the undisputed evidence sufficient to support a finding of a "significant and substantial" and serious violation. Negligence may be inferred from the size of the accumulations.

Citation No. 2507401 alleges a "significant and substantial" violation of the standard at 30 C.F.R. 75.1103 and charges as follows:

> "The automatic fire sensor installed on the 3A belt was not operable. The system would not give warning should a fire occur."

The cited standard requires in essence that belts such as that cited herein be provided with automatic fire warning devices It is not disputed that the fire sensor herein was inoperable. According to the undisputed testimony of Inspector Newlin a fire along the 3A belt or inby that location would not be signaled by the sensors because the line had been severed. About 2000 or 3000 feet of the mine was affected and therefore without a functioning fire detection system. It was reasonably likely therefore that a fire commencing in that area would burn undetected for a sufficiently long period that carbon monoxide and smoke could overcome miners in the area. The violation was accordingly "significant and substantial" and serious.

I find that the violation was the result of low operator negligence. The credible evidence shows that the line had been cut earlier on the same shift as the inspection so that the violative condition had existed only briefly.

Citation No. 2507255 alleges a "significant and substantial" violation of the standard at 30 C.F.R. 75.1106 and charges as follows:

> "A diligent search for fire after a cutting operation was not made, which in turn caused a fire in the main return. This area was located near the old No. 1 belt entry."

The cited standard requires in relevant part that "welding, cutting, or soldering with arc or flame in other than a fire proof enclosure shall be done under the supervision of a qualified person who shall make a diligent search for fire during and after such operations".

MSHA Inspector George Siria concluded that since a fire did in fact occur, the cited employee did not in fact conduct a "diligent search" for fire. I do not agree. The undisputed testimony of the cited employee, Keith McDowell, was that he in fact searched the immediate work area after his cutting operations and found no fire. Under the circumstances the violation cannot be sustained. The citation is accordingly dismissed.

The penalties I am assessing in these cases are also based upon a consideration that the mine operator is large in size and has a moderate history of violations. I am also assuming, based upon representations at hearing, that all of the violations were abated in a timely and good faith manner. Accordingly I am assessing the penalty amounts noted below.

ORDER

Pyro Mining Company is hereby ordered to pay the following civil penalties within 30 days of the date of this decision:

Docket No.	Citation No.	Amount
KENT 84-236	2339124	$1,000
KENT 85-25	2339004	1,000
	2339005	1,000
	2339006	1,000

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KENT 85-27	2505881		107
	2505884		107
	2505885		157
KENT 85-52	2505981		100
	2505983		300
	2505987		300
	2505988		300
KENT 85-54	2507010		(Vacated)
	2507013		100
	2507014		100
	2507016		300
	2507017		300
	2507019		100
KENT 85-88	2507020	(Order)	1,000
KENT 85-113	2507219		100
	2507220		200
	2507401		100
	2507255		(Vacated)

Total $7,371

Gary Melick
Administrative Law Judge