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SOL (MSHA) V. CONSOLIDATION COAL
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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. WEST 85-169 A.C. No. 42-00079-03525
v.	Emery Mine
CONSOLIDATION COAL COMPANY, RESPONDENT	

DECISION

Appearances: James H. Barkley, Esq., Office of the Solicitor, U.S. Department of Labor, Denver, Colorado, for Petitioner;
Hal Pos, Esq., Parsons, Behle & Latimer, Salt Lake City, Utah, for Respondent.

Before: Judge Morris

The Secretary of Labor, on behalf of the Mine Safety and Health Administration, charges respondent with violating a safety regulation promulgated under the Federal Mine Safety and Health Act, 30 U.S.C. 801 et seq., (the Act).

After notice to the parties a hearing on the merits took place in Salt Lake City, Utah on February 13, 1986.

The parties waived their right to file post-trial briefs and, in lieu thereof, orally argued their cases.

Issue

The issue is whether there was an unwarrantable failure on the part of the operator to comply with a ventilation regulation.

Citation

Citation 2503093 charges respondent with violating 30 C.F.R. 75.316. The cited regulation provides as follows

STATUTORY PROVISIONS

> A ventilation system and methane and dust control plan and revisions thereof suitable to the conditions and the

> mining system of the coal mine and approved by the Secretary shall be adopted by the operator and set out in printed form on or before June 28, 1970. The plan shall show the type and location of mechanical ventilation equipment installed and operated in the mine, such additional or improved equipment as the Secretary may require, the quantity and velocity of air reaching each working face, and such other information as the Secretary may require. Such plan shall be reviewed by the operator and the Secretary at least every 6 months.

Stipulation

At the commencement of the hearing the parties stipulated as follows: the air velocity at the working face was not maintained at the required 6000 cubic feet per minute (CFM). Respondent thereby violated its ventilation plan and the regulation. In addition, there had been no intervening clean inspection between a prior (d)(1) citation issued February 26, 1985 and the (d)(1) citation in the instant case. Finally, the parties agreed that the proposed penalty of $255 is appropriate if the violation was due to the unwarrantable failure of the operator to comply; if not, then the penalty should be for a lesser amount (Tr. 5Ä7).

Summary of the Case
The Secretary's Evidence

Robert Lee Heggins, an MSHA inspector experienced in mining, inspected respondent on May 13, 1985 (Tr. 8Ä11). On this occasion he was accompanied by Steve Behling, the company's safety director (Tr. 11). When the men walked into the No. 5 entry of 2 West Main the inspector observed that the curtain was partly blown in at crosscut 29 (Tr. 12, 13). As they proceeded further the inspector also saw that the mine curtain was sagging at several locations (Tr. 11, 13). Continuing on, the inspector noticed that a trailing cable had pulled the curtain against the rib causing a restriction of the air flow to the working face (Tr. 15).

When he approached the face the inspector saw dust in the air as the shuttle car in crosscut 30 was being loaded. In his position he did not feel the free flow of air that one would normally expect (Tr. 16). The absence of the air flow and the condition of the curtain convinced the inspector that there was a failure of the air flow at the face (Tr. 16).

After he observed the coal being loaded into the shuttle car the inspector attempted to take an anometer reading; the device would not turn. He also tested with smoke but it went up against the roof and did not move. He also tested at the line curtain and found 3990 CFM; it should have been 6000 CFM (Tr. 17).

In the inspector's opinion the placement of the curtain at crosscut 29 was abnormal, improper and significant because it disrupted the normal flow of air (Tr. 12, 13). Further, the curtain was sagging from the roof. This caused the air to leak. The curtain shouldn't have been hung in this fashion (Tr. 13, 14, 18). The third problem contributing to the air flow restriction was caused by the trailing cable as the equipment made a sharp right turn into the working face (Tr. 32). It would be natural to expect a trailing cable to contact a brandish curtain in these circumstances. In the inspector's view the cable had been pulling against the curtain since this shift began, for about an hour to an hour and a half (Tr. 33, 34).

The inspector watched the shuttle car being loaded for two to three minutes before issuing his order. In this period neither foreman Petty nor anyone else attempted to reestablish ventilation (Tr. 24). Supervisor Petty, who was in the middle of the dust, should have sensed a lack of air sweeping over his body. He should have realized there was a failure of the ventilation (Tr. 23).

The violative conditions were abated by straightening the curtain at crosscut 29; by fixing the sagging curtain in the entry and by placing an object to keep the curtain from contacting the rib (Tr. 33Ä35).

Consolidation Coal's Evidence

Horace Petty (section foreman), David Day (miner operator), Richard Childs (continuous miner operator) and Steve Behling (safety supervisor) testified for respondent.

The section foreman, Horace Petty, indicated that at crosscut 29 they had spadded the curtain to the floor two or three feet toward the direction of entry 6 (Joint Exhibit No. 1 illustrates the placement of the curtain). This placement was to prevent any shuttle cars from snagging it as they turned the corner. Placement of the curtain in this fashion had never caused a ventilation problem. The fire boss had a reading of 17,000 CFM before the shift started mining that morning (Tr. 38, 39, 46, 47).

If there had been any gaps in the curtain Petty would have noticed them. The top is not perfectly level and there may have been an inch or two spacing at the top. Such openings do not cause much loss of air (Tr. 51, 52, 64).

The curtain had not been pushed against the rib when Petty went up the entry that morning at about 7:20. The curtain was spadded to the top, as well as the floor, along all entry No. 5 (Tr. 39). He went up the entry an additional three or four times before the violation occurred.

At about 10:00 or 10:30 a.m. Petty walked to the working face from behind the line curtain. He frequently took this approach. As he proceeded toward the face he found the curtain had pulled loose from the spads; it was against the rib. There wasn't much ventilation coming through and Petty knew he had a problem. He immediately came through the curtain. The miners were loading the shuttle car and Petty signaled them to stop (Tr. 41, 42, 80). Since the shuttle car was loaded he directed them to back it away from the face. It took the operator about ten seconds to stop (Tr. 41, 42). As the miner was backed out MSHA inspector Heggins stopped them (Tr. 42). About 10 to 15 seconds had elapsed (Tr. 43). Petty had stopped the mining operation before he knew the MSHA inspector was present (Tr. 63).

In order to reestablish ventilation after the miner was shut down, the employees pulled the curtain out and spadded it back to the floor (Tr. 52, 53). They started from the face and walked the whole curtain line, tightening all gaps, checking all spads and cracks (Tr. 55). After the gaps were fixed, after the restriction was removed at the corner and after the curtain was moved at crosscut 29 there was sufficient ventilation (Tr. 57).

According to witness Petty the curtain, as it hung from the ceiling, was properly installed in the first place. They retightened it after the citation was issued in order to get the maximum amount of air to the face (Tr. 58).

In Petty's opinion, changing the position of the brandish curtain at crosscut 29 did not contribute to an increase in the air flow (Tr. 61).

Closing the gaps along the curtain from the working face to crosscut 29 contributed an additional two or three thousand cubic feet of air flow (Tr. 61). The trailing cable pinching the curtain was the main problem. Petty had stopped to take care of it (Tr. 62). This particular condition was abated by moving the curtain back from the rib and spadding it to the floor (Tr. 62).

David Day, a miner operator, described his activities on this day as well as the inspections made by the section foreman (Tr. 65Ä67).

Shortly prior to the inspection the water line had to be repaired. After the line was repaired it took about 15 or 20 seconds to finish loading the car (Tr. 68, 70). As they finished loading Petty came through the curtain and signaled them with his light to stop mining. They stopped and backed the shuttle car away from the continuous miner. As they were backing up Behling and inspector Heggins told them to stop (Tr. 68, 71). In Day's opinion, before the water line was fixed, the three-inch trailing

cable had not been pressing against the rib. He believed that after the line was fixed and as he started around the corner the cable snapped tight and pulled out the bottom of the curtain (Tr. 69). At the time the citation was issued the miner was 50 to 60 feet into crosscut 30 from entry 5 (Tr. 76Ä79).

This portion of the mine is a very dry and dusty section. The ventilation seemed okay (Tr. 71, 76). There was no gas at this face (Tr. 78). Day estimates 50 to 70 trips were made that day by the shuttle car (Tr. 74).

At the time of the incident witness Richard Childs had been absent from 2 Main West for approximately 30 minutes. Upon returning he found the water line had been repaired and the shuttle car was 1/2 to 3/4 full. He then replaced Day as the operator and moved the miner back into the face and started cutting. They had already mined about 60 feet into crosscut 30. Childs completed filling the car in 20 to 30 seconds (Tr. 84Ä87, 94).

Day motioned to Childs that the car was filled. Childs then saw Horace Petty shaking his light directing them to stop mining. He then started to back away from the face. At that point the MSHA inspector appeared and directed him to shut down the miner, which he did. There was no dust because the miner hadn't been operating (Tr. 87Ä89, 93). Childs did not notice the lack of air flow across his body nor did he notice any air problem (Tr. 92, 96).

Other than spadding the curtain, no other precaution had been taken to keep the trailing cable from collapsing on the curtain. Spadding is usually sufficient but a temporary post or jack had not been used to block the curtain from moving against the rib (Tr. 94, 95). Childs estimated that the trailing cable was 1 1/2 inches thick (Tr. 99).

Steve Behling, Consolidated's safety supervisor, accompanied MSHA inspector Heggins during the inspection. Behling took the inspector to 2 Main West because that section was probably one of the best in the mine (Tr. 100, 101).

When the two men approached entry 5 no comment was made concerning the curtain at crosscut 29. The men saw the cable against the curtain and Behling knew there was a problem. Coming around the corner, Behling saw Petty waving his light to shut down the miner operator (Tr. 101Ä106). Inspector Heggins continued on and got out his anometer. It wouldn't turn and Heggins said the company was under an order situation (Tr. 103).

After the mining activity was discontinued the curtain was picked up and pulled out. Behling rechecked and found they still had no air (Tr. 105). They then started pushing the curtain out. At that point Heggins got an air reading of about 6100 (Tr. 105).

When Behling and Heggins got to the surface the inspector said he was issuing a 104(d)(1) Order. He stated that Petty should have known about the ventilation problem (Tr. 106, 107).

Behling conducted his own investigation by interviewing the miners as well as the foreman. Behling concluded that the water line breakdown, the movement of the shuttle car into the crosscut, the almost full shuttle car, the fact that equipment is always backed away from the face and the actions of Petty, caused him to believe that there were two ways of viewing the situation (Tr. 109Ä113). He also believed that Heggins and Petty were on opposite sides of the curtain as they approached the face (Tr. 111).

As soon as Petty recognized the problem he properly shut down the mining operation (Tr. 111, 122).

Even though the shuttle car cable and the obstruction had been removed the air was insufficient; the curtain doesn't fall all the way back into position (Tr. 116, 117). After the cable was pulled out it wasn't immediately spadded to the floor.

To reestablish the ventilation the miners started at the face and went out from there. As they progressed they pushed, spadded down and laid chunks of coal on the curtain. Activity of that type would cause a lower air reading (Tr. 118, 119).

In Behling's opinion when the shuttle car started up the cable moved against the curtain and pulled the spad out. The time interval was about 15 seconds (Tr. 121, 122).

Discussion

The Commission has defined the statutory term of "unwarrantable failure" to mean a violation resulting from indifference, willful intent or serious lack of reasonable care, Section 104(d)(1); Westmoreland Coal Company, 7 FMSHRC 1338 (September 1985); U.S. Steel Corp., 6 FMSHRC 1423, 1437 (June 1984).

In this case I find that the respondent's evidence is credible. In short, the MSHA inspector and the company's section foreman arrived at the ventilation problem from different sides of the brandish curtain at approximately the same time. While the presence of a section foreman is not necessary to establish an unwarrantable failure I find the violative events occurred in the short period of approximately 20 seconds as claimed by the operator.

The Secretary argues extensively (Tr. 124Ä131) that his evidence is credible and the operator's is fatally flawed.

I am not persuaded. The Secretary's evidence relies on three factors to establish an unwarrantable failure. These factors consist of the placement of the curtain at crosscut 29, the gaps and sagging curtain from crosscut 29 to the working face, and, finally, the restriction of the air flow caused by the cable pushing the curtain against the rib.

Concerning crosscut 29: Joint Exhibit No. 1 illustrates the placement of the curtain. I am unable to see how the position of the curtain as shown on the exhibit could interfere with the air flow. The witnesses referred extensively to the exhibit throughout the hearing. I agree with section foreman Petty that the curtain placement at crosscut 29 did not affect the air flow. The operator had moved the curtain to that position to prevent the shuttle cars from snagging it as they turned at the crosscut.

The second facet concerns the gaps or sags in the curtain. MSHA's evidence is not precise on this point. I credit the operator's evidence that the minimal spacing at the top caused the loss of no more than 3000 to 4000 CFM from the measured air flow of 17,000 CFM.

The final asserted defect is that the curtain had been pushed against the rib by the trailing cable. Everyone recognized that this condition effectively restricted the air flow. I do not find it credible that this restriction could have existed for an hour to an hour and a half as the inspector asserts. I credit witness Day's contrary opinion that the cable snapped tight and pulled out the bottom of the curtain as the miner went around the corner after the water line had been fixed. The time involved was less than 30 seconds.

A credibility issue also arises as to whether the inspector watched the mining of the coal for two or three minutes or whether the shuttle car was filled in 10 to 15 seconds. Petty, Day and Childs all confirmed the short period of time involved. Inasmuch as Day and Childs loaded the car they would be in the best position to know the extent to which it had been filled and, conversely, the amount of time necessary to finish loading it.

For the foregoing reasons, I conclude that the conduct of the operator did not constitute an unwarrantable failure to comply with the ventilation regulation. Accordingly, the allegations of unwarrantable failure should be stricken.

The facts and the stipulation of the parties confirm that the operator violated 30 C.F.R. 75.316. Accordingly, the citation should be affirmed.

Further, based on the stipulation, the evidence and the statutory criteria pertaining to the assessment of civil penalties, 30 U.S.C. 820(i), I deem that a penalty of $100 is appropriate.

Conclusions of Law

Based on the entire record and the factual findings made in the narrative portion of this decision, the following conclusions of law are entered:

1. The Commission has jurisdiction to decide this case.

2. Respondent violated 30 C.F.R. 75.316.

3. The conduct of respondent did not constitute an unwarrantable failure to comply with the above regulation.

4. Citation 2503093 should be affirmed and a civil penalty assessed therefor.

ORDER

Based on the foregoing facts and conclusions of law, I enter the following order:

1. The allegation that respondent's conduct constituted an unwarrantable failure to comply with the regulation is stricken.

2. Citation 2503093 is affirmed.

3. A civil penalty of $100 is assessed.

4. Respondent is ordered to pay to the Secretary the sum of $100 within 40 days of the date of this decision.

John J. Morris
Administrative Law Judge