CCASE:

SOL (MSHA) V. S-S-S INC.

DDATE: 19860519 TTEXT: 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. CENT 86-35-M A.C. No. 23-00192-05502

SÄSÄS Quarry & Mill (Pike)

SÄSÄS INCORPORATED,
RESPONDENT

v.

DECISION

Appearances: Eliehue C. Brunson, Esq., Office of the

Solicitor, U.S. Department of Labor, Kansas

City, Missouri for Petitioner;

John M. McIlroy, Sr., Esq., McIlroy and Millan,

Bowling Green, Missouri for Respondent.

Before: Judge Melick

This case is before me upon the petition 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," charging one regulatory violation against SÄSÄS Incorporated (SÄSÄS), in connection with the death of miner Brad Hobbs on July 30, 1985.

The issues before me are whether SÄSÄS has committed the violation as alleged and if so whether that violation was of such a nature as could have significantly and substantially contributed to the cause and effect of a coal or other mine safety or health hazard, i.e., whether the violation was "significant and substantial." If a violation is found it will also be necessary to determine the appropriate civil penalty to be assessed in accordance with the criteria set forth in section 110(i) of the Act.

The one citation at issue, No. 2392700, alleges a "significant and substantial" violation of the standard at 30 C.F.R. 56.16009 and charges as follows:

On 7/30/85 a fatal accident occured when a laborer was struck by a falling suspended load. He was struck by the load as he had put himself in an

exposed position directly under the elevated load. The suspended load in this case was a roll of 42" conveyor belt.

The cited standard states that "persons shall stay clear of suspended loads."

The events leading to the death of employee Brad Hobbs are not in dispute. Hobbs had just been released from military service and had been working for SÄSÄS as a laborer for only 3 weeks when the accident occurred. Quarry manager and SÄSÄS president Gerald Smith told senior employee Steve Luebreicht to take Hobbs and another employee Robert Osborne and show them how to replace a worn conveyor belt. Neither Hobbs nor Osborne had done this before. Smith also told crane operator William Swarnes of the plans to change the belt and that Steve Luebreicht would tell him when he was needed with the crane. Smith did not directly supervise the belt change and was not present when the accident occurred.

Steve Luebreicht acknowledged that for purposes of changing the belt he was the "team leader." When Luebreicht arrived at the conveyor Hobbs and Osborne, along with the new belt and a pipe, were already there. They ran the pipe through the center of the rolled belt, passed a chain through the clevis attached to the crane cable and wrapped the chain around each end of the pipe. The crane operator raised the new belt into position as Luebreicht guided him with arm signals, then locked the roll in position and left the scene.

The rolled belt was binding against the chain and was difficult to unravel. Luebreicht had twice before rigged belts for replacement but those belts were smaller and the chain did not bind on the belt as it did now. The three men continued tugging at the end of the belt hanging above them to thread it into the conveyor. Hobbs was standing on the conveyor when the belt suddenly fell striking all three and killing Hobbs.

Osborne testified that in replacing the belt he was taking directions from the more experienced Luebreicht. According to Osborne it was difficult to pull the belt and they found it necessary to go beneath the roll in order to rig it properly. Suddenly Osborne felt a slack in the belt, looked up and saw the belt roll falling. Osborne acknowledged that he had never been trained and had no experience in changing conveyor belts. However he had once been told by Wayne Smith (President Gerry Smith's father) not to go beneath any load. He nevertheless went under the belt on this occasion because he thought it was necessary.

Howard Lucas an MSHA supervisory mine inspector testified that the use of a chain in the described manner and particularly a chain not fastened at either end of the pipe nor at the clevis, was contrary to accepted safe industry practice. Because the chain was not fastened at either end of the pipe nor at the clevis the roll could easily shift position, the chain slip off and the roll fall. Lucas observed that the manner in which the roll was jammed against the chain made it necessary for all three of the miners to pull on it. He also observed that in order for all three to obtain the best grip on the belt it was necessary for one of the men to stand on the conveyor beneath the suspended roll where Hobbs was standing.

Within this framework of evidence it is clear that the violation did occur as alleged and was "significant and substantial" and serious. Secretary v. Mathies Coal Company, 6 FMSHRC 1 (1984). The violation was also the result of operator negligence. Although SÄSÄS president Gerry Smith testified that he had showed Hobbs only a week before the fatal accident how to stay out from under a suspended load at another location on the mine site and two other SÄSÄS employees had on one occasion overheard Wayne Smith tell Hobbs not to stand beneath a raised loader bucket, it is clear that the fatal accident herein was the result of negligent supervision and inadequate training. Neither Hobbs nor Osborne had ever had any training or experience with the assigned task. Moreover the group leader and only experienced employee present, Steve Luebreicht, not only failed to warn these two miners about going beneath the suspended belt but indeed gave implicit acceptance to the violation by placing himself beneath the suspended belt roll in their presence. Thus while Luebreicht may not have given direct orders to Hobbs and Osborne to place themselves beneath the suspended belt roll, he was nevertheless negligent by omission. The negligent supervision by Luebreicht is also chargeable to the operator since he was the task leader and agent designated by President Smith. The inadequate training of Hobbs and Osborne to safely perform the assigned task also warrants an independent finding of operator negligence.

In assessing a penalty for the violation herein I have also considered that the operator was of moderate size and that the violation was approprately abated. There is no evidence of any history of violations at the subject mine. I have also considered that the operator has already paid a civil penalty of \$5,000 for the improper rigging of the belt roll-the proximate cause of the fatal accident. Thus although the instant citation charges a separate violation I am considering the incident as a whole for purposes of an appropriate civil penalty.

ORDER

 $\mbox{S\ddot{\mbox{A}}S\ddot{\mbox{A}}S}$ Incorporated is hereby directed to pay a civil penalty of \$1,000 within 30 days of the date of this decision.

Gary Melick Administrative Law Judge