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SOL (MSHA) V. AUSTIN POWER
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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. CENT 86-40 A.C. No. 41-01192-03503
v.	Big Brown Strip
AUSTIN POWER, INCORPORATED, RESPONDENT	
AUSTIN POWER, INCORPORATED, CONTESTANT	CONTEST PROCEEDINGS
v.	Docket No. CENT 86-59-R Citation No. 2339411; 8/20/85
SECRETARY OF LABOR, MINE SAFETY AND HEALTH ADMINISTRATION (MSHA), RESPONDENT	Docket No. CENT 86-60-R Citation No. 2339412; 8/20/85 Docket No. CENT 86-61-R Citation No. 2339413; 8/20/85
	Big Brown Strip

DECISIONS

Appearances: Robert Fitz, Esq., Office of the Solicitor, U.S. Department of Labor, Dallas, Texas, for the Petitioner/Respondent;
Steven R. McCown, Esq., Jenkins & Gilchrist, Dallas, Texas, for the Contestant/Respondent.

Before: Judge Koutras

Statement of the Proceedings

These proceedings concern proposals for assessment of civil penalties filed by MSHA against Austin Power, Inc., pursuant to section 110(a) of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. 820(a), seeking civil penalty assessments totalling $10,000, for three alleged violations of mandatory safety standards 77.1607(g), 77.1710(g), and 77.404(a) or 77.205(e). Docket No. CENT 86Ä40 is the civil

penalty proceeding, and Docket Nos. CENT 86Ä59ÄR, CENT 86Ä60ÄR, and CENT 86Ä61ÄR, are the contests filed by Austin Power challenging the legality of each of the section 104(a) "significant and substantial" (S & S) citations.

Austin Power filed timely answers and contests, and the cases were consolidated for a hearing which was held in Dallas, Texas. The parties filed posthearing proposed findings and conclusions, and the arguments presented therein have been considered by me in the course of these decisions.

Issues

The issues presented in these proceedings are (1) whether the cited mandatory safety standards are applicable to the alleged fact of violations; (2) whether the alleged violations were "significant and substantial;" and (3) the appropriate civil penalties which should be imposed for the violations in question. Additional issues raised by the parties are identified and disposed of in the course of these decisions.

Applicable Statutory and Regulatory Provisions

1. The Federal Mine Safety and Health Act of 1977, Pub.L. 95Ä164, 30 U.S.C. 801 et seq.

2. Section 110(i) of the 1977 Act, 30 U.S.C. 820(i).

3. Commission Rules, 20 C.F.R. 2700.1 et seq.

Stipulations

The parties stipulated to the following (Tr. 8Ä10):

1. Austin Power, Inc. was incorporated under the laws of the State of Texas on June 10, 1976.

2. Among other things, Austin Power, Inc. has been an independent contractor, engaged in construction at the Big Brown Strip, a surface coal mine owned and operated by Texas Utilities Company in Freestone County, Texas.

3. The Big Brown Strip is a "mine," within the meaning and definition of Section 3(h) of the Federal Mine Safety and Health Act of 1977, hereinafter referred to as the Act.

4. Austin Power, Inc. is an "operator" within the meaning and definition of Section 3(d) of the Act.

5. On Monday, August 19, 1985, Jeff Arent, Kevin Saulsburg, and Steve Smith were employed by Austin Power, Inc. at the Big Brown Strip and were "miners" within the meaning and definition of Section 3(g) of the Act.

6. The products of the Big Brown Strip enter or affect interstate commerce.

7. Citation Nos. 2339411, 2339412, and 2339413 and the modifications thereof, were served upon Sydney Woodson, respondent's superintendent, by authorized representatives of petitioner on the dates and at the times and places stated therein, and may be admitted into evidence for the purpose of establishing that they were so issued, but not for the purpose of establishing the violations alleged therein.

8. The miners employed by respondent worked a total of 41,012 hours in all mining activity in 1985.

9. Respondent demonstrated good faith in attempting to achieve rapid compliance after being notified of the alleged violations.

During the course of the hearing, Austin Power's counsel stipulated that the proposed civil penalties assessed by MSHA for the violations in question will not adversely affect Austin Power's ability to continue in business (Tr. 188).

Discussion

This case concerns a fatal accident which occurred at the Big Brown Strip Mine construction site on August 19, 1985. The mine is a surface coal mine owned and operated by the Texas Utilities Company. Austin Power is an independent contractor subject to the Act who at the time of the accident

was in the process of constructing and erecting a cross-pit spreader at the site for Texas Utilities. The spreader was manufactured by DeMag Company, a German concern, and Austin Power was under contract with that firm for the construction and erection of the spreader at the mine site.

At the time of the accident, three employees of Austin Power were engaged in certain work on a 20Ämeter boom, an integral part of the spreader. The employees were engaged in work connected with the placement of certain counter weights on the boom and the installation of a wire rope choker on the boom for the purpose of facilitating the movement of the boom in a lateral direction by means of a 518 link belt crane and cherry picker. While performing their work from a walkway or catwalk located on one side of the boom, the boom was subjected to a sudden and unexpected "whiplash" action caused by the failure of an eyelet located at the back end of the boom. The boom raised up and propelled the three employees off the walkway where they were standing in an upward direction into the air, and one employee, Steven Smith, fell to the ground below and suffered fatal injuries. The other two employees managed to come down on the walkway structure which they grabbed as they came down, and they subsequently walked off the boom to safety and were not injured.

MSHA Inspector Donald R. Summers conducted an accident investigation on August 20, 1985, and prepared a report (exhibit PÄ5). Based on the information received by Inspector Summers during the course of his investigation, he issued a section 107(a) imminent danger order, and three section 104(a), S & S citations. The imminent danger order is not in issue in these proceedings, but the citations are. The narrative description of the cited conditions or practices as stated in the citations issued by Inspector Summers are as follows:

Citation No. 2339411, August 20, 1985, 30 C.F.R. 77.1607(g). "The Link Belt 518 operator was not notified by signal or other means that all persons were not in the clear before starting or moving equipment in that 3 employees were on the 20Ämeter cross pit spreader boom which was being moved by the link belt."

Inspector Summers subsequently modified the citation on October 8, 1985, to include the following condition or practice: "The linkbelt 518 operator was not certain that all persons were in the clear before he put his machine into operation. Three (3) employees were on the 20 meter cross

pit spreader boom which was being moved by the linkbelt operator."

Citation No. 2339412, August 20, 1985, 30 C.F.R. 77.1710(g).

> Three (3) employees were on the 20 meter cross pit spreader boom was (sic) wearing safety belts but the lines was (sic) not tied off. Due to equipment failure the boom flip (sic) upward. The three (3) employees were thrown from the platform, one fell to his death. The two remaining employees managed to grab hand rails and climb (sic) to safety.

Citation No. 2339413, August 20, 1985, 30 C.F.R. 77.205(e) or 77.404(a).

> The elevated walkway along the left side of the 20 meter boom on the cross pit spreader was not maintained in good condition in that the hold downs for the floor plate had been removed. The boom flip (sic) upward due to equipment failure, the floor plates came loose and fell to the ground. One (1) of the three employees on the walkway fell to his death.

MSHA's Testimony and Evidence

MSHA Inspector Donald R. Summers, testified as to his background and experience, and he confirmed that he conducted an investigation of the circumstances surrounding the fatal accident. He identified copies of the citations he issued as a result of the investigation, and also identified a copy of the investigation report and certain photographs which he took during the investigation (Tr. 15Ä38). He confirmed that he began the investigation on the morning of August 20 (Tr. 17).

With regard to photographic exhibit PÄ16, of the cited walkway and the clamps which Mr. Summers claimed were not secured, he conceded that he did not know the condition of the walkway prior to the accident, nor did he know whether the walkway was secured prior to that incident (Tr. 33).

Mr. Summers stated that company representative Woodson accompanied him on a "quick walk through look" of the accident area and explained that the 518 linkbelt crane was connected to the end of the 20 meter boom in order to move

the boom from a westerly direction to an easterly direction to facilitate the loading of certain counter-weights on the machine, and that the machine could not move under its own power (Tr. 40, 44). Mr. Summers confirmed that Mr. Woodson identified the three employees who were on the boom, but he could not state whether Mr. Woodson explained what the three were doing on the boom. Someone else advised him that one of the employees was on the boom securing a choker on the end of the boom, and he pointed out the choker in question in photographic exhibit PÄ7, in the center, hooked on the right-hand lower corner of the beam on the end of the boom. He was told that the accident victim had secured this choker at the location shown in the photograph (Tr. 41Ä43).

Mr. Summers was of the opinion that none of the employees should have been on the boom while it was being moved, but he saw no reason why they could not be there prior to its being moved (Tr. 49). He saw no reason why the choker in question could not have been installed while the boom was stationary and not being moved (Tr. 50).

Mr. Summers stated that his investigation revealed that the accident victim was in the process of placing the choker over a brace on the end of the 20Ämeter boom in order for a cherry picker to receive the boom when it passed under another 70Ämeter boom. The linkbelt crane could not pass under the 70Ämeter boom, and another piece of equipment was to be used to connect onto the boom in order to pull it in a westerly direction. Mr. Summers stated further that it was his understanding that the victim was standing on the left-hand walkway at the end of the boom as shown in photographic exhibit PÄ7, and while he was inside the walkway hand rail, he was leaning over the hand rail connecting the choker. Mr. Summers stated that if the victim was leaning over the hand rail, he should have been tied off by a safety lanyard (Tr. 51Ä52). Although the investigation revealed that the victim was wearing a safety belt, it was not secured (Tr. 52).

Mr. Summers stated that his investigation revealed that while the boom walkway was secured within the hand rails, sometime during the construction phase of the cross-pit spreader, the left-hand walkway had been removed in order to allow access to the electrical cable located in a tray under the walkway and for painting purposes. The walkway had been removed and not secured back in place (Tr. 52). All of the walkway had clamps removed or either not secured back in place (Tr. 52).

On cross-examination, Mr. Summers confirmed that he has inspected the mine site at least once a month, and that aside from the citations issued in the instant proceedings, he has issued only two prior citations at the site in the past 3 years. He agreed that the company makes a good faith effort to comply with the law. He also confirmed that he had previously inspected the cross-pit spreader and linkbelt crane and never issued any citations for any violations on that equipment. He also observed the crane operators operating the equipment, and had no problem with the manner in which they did their work (Tr. 56Ä57).

Mr. Summers stated that he issued the citations to Austin Power because it was in charge of the erection site for the cross-pit spreader. He confirmed that the DeMag Company designed the manufactured the spreader and the 20Ämeter boom, and he could not state whether that company had supervisors on the site to insure that Austin Power was erecting the spreader in compliance with their specifications (Tr. 59).

Mr. Summers stated that the failure of an eyelet used to connect a hydraulic device used to lower and raise the 20Ämeter boom to the boom's structure was a contributing factor to the accident (Tr. 61). The failure of the eyelet caused the boom counter weight to take over and resulted in the sudden and unexpected raising of the end of the boom. Mr. Summers confirmed that he had previously observed the eyelet before the accident, and saw nothing which caused him any concern. He also confirmed that from his prior inspections of the equipment, including the eyelet, no one could have foreseen that the eyelet would fail (Tr. 63).

The 20Ämeter boom is one part of the entire cross-pit spreader machine. The boom was described as a conveyor which received dirt that was removed or stripped from the ground. The 70Ämeter boom also digs dirt from the ground, but from another area of the open pit mine. The excavated materials from both booms are received by the spreader and discharged in other locations. Mr. Summers described the booms as movable conveyor systems which receive the materials which are dug by the bucket wheel escalator part of the spreader. Although the digging apparatus and booms are separate pieces of equipment, they are connected together electrically (Tr. 66). The two cranes in question were simply used to reposition one portion of the 20Ämeter boom while the counter-weights were being loaded (Tr. 65).

Mr. Summers stated that the 20Ämeter boom has walkways or catwalks on both sides of the boom conveyor. The walkways

are equipped with a standard guard rail consisting of a top rail approximately 42 inches off the walkway surface, and a midrail. It also has a toeboard constructed of angle iron. Although the boom is designed to move up and down and left and right, Mr. Summers was of the opinion that employees should not be on the walkway while the boom is in operation. He believed that a chain should be across the access to the walkway, with a sign indicating that no one should be on the boom while it is in operation (Tr. 69). Mr. Summers confirmed that no one from Austin Power, DeMag, or Texas Utilities ever informed him that employees were not to be on the boom while it was in operation, and that this is simply his opinion (Tr. 71).

Mr. Summers confirmed that the cross-pit spreader moves on tracks, and that when it moves, the 20Ämeter boom also moves because it is attached to the spreader. He did not know how many employees would be on the spreader while it was in operation, and he assumed that one employee would have to operate the spreader, and two others would have to operate the bucket wheels at the end of the 20 and 70 meter booms (Tr. 72). He described the cross-pit spreader as a structure approximately a half a mile long and 500 to 600 feet high, and the super structure looks "much like a large ship out in the middle of the mine," with catwalks and walkways all over it (Tr. 74).

Mr. Summers stated that on the day of the accident, five counter weights, approximately 24,000 pounds each, were being loaded onto the boom, and the boom did not have any independent power while this was being done because the power had not been connected (Tr. 76Ä78).

Mr. Summers confirmed that the crane in question was used to lift the boom in order to remove some cribbing from under it, as well as moving it from left to right, or from east to west. The only lifting action of the crane would be for the purpose of removing the cribbing, and once this was done the linkbelt crane was to be used to rotate the 20Ämeter boom back under the 70Ämeter boom. Since the linkbelt crane could not move the 20Ämeter boom completely under the 70Ämeter boom, a cherry picker was to be used for this task, and he saw nothing wrong with this entire procedure (Tr. 81).

Mr. Summers stated that Austin Power has a safety program, and he confirmed that it has a mandatory policy requiring employees to be tied off if they are in danger of falling. He stated that during the time he has inspected the facility he has never previously cited Austin Power for a

violation of section 77.1710(g). He confirmed that he had been on the same cited 20Ämeter boom walkway in the past while inspecting the spreader and did not wear a safety belt (Tr. 103). With regard to his application of section 77.1710(g), Mr. Summers stated as follows (Tr. 104Ä106):

> Q. Thank you. Now, let's take a hypothetical, that you were inspecting the 20Ämeter boom and you were walking out to the end of the boom, but you weren't performing construction work. Is that right?
>
> A. That is right, sir.
>
> Q. And you didn't have to be tied off in that situation, did you?
>
> A. If I was walking out there, you couldn't tie off and walk down the boom.
>
> Q. Okay, let's say you were walking out there and you were inspecting it and the eyelet failed.
>
> A. Okay.
>
> Q. And you weren't tied off. And the same thing might have happened to you that has happened to Mr. Smith, wouldn't it?
>
> A. If the floor plate and all that hadn't been secured, more than likely would have.
>
> Q. And would you have been, then, in non-compliance with 1710(g)?
>
> A. No, sir.
>
> JUDGE KOUTRAS: Why not?
>
> THE WITNESS: I was travelling from one area to the other. I wasn't performing any work that would be requiring me to be outside the hand-rail.
>
> JUDGE KOUTRAS: So that pre-supposes that this particular individual at the time of the accident was outside the hand-rail?

THE WITNESS: Yes, sir.

MR. MCCOWN: So the point of your issuance of a citation, which I assume that since these other gentlemen, Mr. Cameron and other people--your supervisors--aren't here, the whole point on the citation is that a man was outside the hand-rail, and therefore, that was the danger. Right?

THE WITNESS: And performing work at a elevated area.

MR. MCCOWN: So--

THE WITNESS: He should have been tied off.

MR. MCCOWN: So the other two employees that were up there, if they were just standing around, they didn't need to be tied off?

THE WITNESS: They wouldn't have to be tied off, sir.

MR. MCCOWN: But for the fact that they were able to grab hold of the side of the catwalk, they would have been killed just as much as Mr. Smith had, wouldn't they?

THE WITNESS: Rather fortunate.

In response to further questions, Mr. Summers stated that had it not been for the sudden jerking of the boom caused by the eyelet failing the other two employees on the boom were not in danger of falling. He conceded that he issued the citation because of his concern that the three employees were on a piece of moving equipment and his belief that they should not have been there in the first place. Mr. Summers knew of no mandatory standard that specifically prohibits work on a moving piece of equipment. Assuming he saw three employees on a catwalk 36 feet above ground on a moving piece of equipment, he would issue a section 107(a) imminent danger order because of the danger of falling even though they may be protected by a hand rail, because the walkway would be unstable (Tr. 108Ä109).

Mr. Summers stated that no employees would be required to be on the end of 20Ämeter boom while the counter weights are being loaded, and that they would be positioned at the

rear of the boom giving hand signals to the crane operator. He conceded that he has never observed counter weights loaded, and assumed that since they cannot be observed from the ground, someone had to be there (Tr. 111). He suggested that no one should be on the end of the boom while it is being moved, and that there would be less of a danger if they were at the rear of the boom because the movement would be slower (Tr. 112). He conceded that at some point in time someone had to go the end of the boom to disconnect the linkbelt crane and hook the cherry picker to the boom in order to move it under the 70Ämeter boom, and that the eyelet could have failed at that point in time before the boom was moved (Tr. 113).

With regard to the walkway grating citation, Mr. Summers stated that while it was his opinion that section 77.205(e) applies to the condition that he cited, section 77.404(a) and 77.1606 were equally applicable (Tr. 114). He confirmed that he did not issue the amended citation, and still believes that section 77.205(e), is the better standard (Tr. 114). Mr. Summers confirmed that he had nothing to do with the civil penalty assessments in this case, and that he had no communication with anyone in MSHA's office of assessments (Tr. 120). Mr. Summers believed that the conditions he cited as violations were contributing factors to the fatality which occurred in this case (Tr. 123).

With regard to the walkway grating fasteners, Mr. Summers stated that if they were properly connected to the grating, they would have prevented the grate from moving in either lateral or vertical directions. He stated that in photographic exhibits PÄ15 and PÄ16, the clamps are not extended all the way under the walkway or under the piece of angle iron, but only halfway. He pointed out that the right-hand walkway was properly secured with the clamps and none of the grating was thrown off or disrupted when the accident occurred. He assumed that the reason that all of the grating on the left side of the boom was not thrown off was the fact that the raising of the boom was less violent at that location (Tr. 124). He confirmed that the 20Ämeter boom was still under construction at the time of the accident, and that a few adjustments were still to be made before it was placed into operation (Tr. 124).

Mr. Summers confirmed that the location where the eyelet failed was the same side as the walkway on which the accident victim was standing. His investigation revealed that the grate clips or fasteners were not broken off by the force of the eyelet breaking, but were simply loose and unsecured. He had no way of knowing whether the force of the boom moving

because of the failure of the eyelet caused the fasteners to come loose, and that he was informed by Mr. Woodson and Mr. Arent that the floor grating had been removed and not secured back down (Tr. 126). Mr. Summers stated that there was a difference of opinion as to whether the accident victim fell through the openings that were left when the walkway grating flipped up, or whether he went over the top of the hand railing (Tr. 127). Had the walkways been fastened down, the victim could possibly have come down on the walkway when he was catapulted into the air rather than down between the opening (Tr. 127).

Mr. Summers stated that the information he received during his investigation through the interviews with the survivors indicated that the three employees on the 20Ämeter boom at the time of the accident were instructed to go out on the boom to tie the choker on in order to facilitate the moving of the boom under the 70Ämeter boom. The breaking of the eyelet had a "whiplash effect," and when the end of the boom flew up and settled back down, six or eight of the walkway plates came out of the channel and fell to the ground (Tr. 129).

Russell Crowell, testified that he is presently employed by Erection and Rigging Inc., White Oak, Texas, and that at the time of the accident in question he was employed by Austin Power at the Big Brown Strip as an iron worker-rigger and crane operator. He stated that he has 9 years of experience as a crane operator, and confirmed that he was operating the 518 linkbelt crane on August 15, 1985. He described what he was doing as follows (Tr. 132Ä134):

> A. About 10:00 I was instructed to bring the rig up to the 20Ämeter receiving boom, to tie onto it, and after I tied onto it, we picked it up five, six inches, enough to get the shoring out from underneath it; tracked backwards with the rig, which swung the 20Ämeter boom from the westerly to the easterly position; stayed in a dogged off position for around five and a half hours, while they loaded counter weights with another crane from the other side.
>
> Q. What time, or can you give us an approximate time that you finished, or that the shoring was removed from the 20Ämeter boom so you were able to swing it around?

A. That wasn't maybe 45 minutes. It wasn't very long.

* * * * * * * * *

A. After the fifth counter weight was loaded and into position, I was instructed to slack off, which I slacked the rig off. It was suspended by itself; they checked for movement on the boom; there wasn't any. I was instructed to pick back up enough just to get my chokers taut. The rigging was taut and I walked the rib back into position, just a reverse procedure to what we had done that morning.

And just prior to getting, oh, 30Äfoot or so from coming up to transferring the rigging from the 518 to cherry picker, the pin failed and the load went up and Steve came down.

Q. Who was giving you the instructions on what to do that day?

A. There were several people involved, among one Alvin, the German; Woody and Pat Patterson. At one time, Jim White may have even relayed signals.

Q. Now, Woody is Sydney Woodson, the job superintendent. Is that right?

A. Yes.

Q. And who is Jim White?

A. At that time was general foreman on the project.

Q. Now, I understand that you were attempting to swing the 20Ämeter boom under the 70Ämeter boom so it could be tied onto with a cherry picker. Is that correct?

A. Yes.

Q. Was anybody on the 20Ämeter boom when you were attempting to swing it around so it could be tied onto the cherry picker?

A. Yes.

Q. Who was on it?

A. Jeff Arent, Kevin Saulsburg and Steven Smith.

Q. Do you know why they were on it?

A. They had work to do out there; they had to be out there to transfer the rigging.

Mr. Crowell stated that he did not actually see the accident, but saw the accident victim Steven Smith in the air. He explained that his view was obstructed by the boom and that Mr. Smith was on the back side of the boom. He confirmed that he was not present when the three employees were told to go up on the boom (Tr. 136).

On cross-examination, Mr. Crowell stated that in addition to instructions by an employee of DeMag Company, he also received instructions from Mr. Woodson with respect to the lifting of the 20Ämeter boom with the crane for the purpose of removing the cribbing. The boom lifted just enough to remove the cribbing, and he denied that his operation of the crane had anything to do with the failure of the eyelet, or that the crane put any undue stress on the boom (Tr. 140). He experienced no difficulty in moving the 20Ämeter boom laterally and indicated that it was "free-swinging" (Tr. 141). With regard to the movement which was experienced, he stated as follows (Tr. 141Ä142):

Q. Now you testified that there was a movement between the loading of the third and the fourth counter weight. At that time, when that happened, did you feel like there was any problem with any part of the construction process that was going on?

A. No, I didn't. I couldn't see what was going on the back side, and at the time of these counter weights being loaded, when they would lower them into the framework, they would bump the counter weight framework that they set in, and I was getting bumps and shocks all day long. But that was when there was counter weights being loaded. And at this time I could tell from the position of the other rig that he wasn't coming in with a

counter weight. He was swung out the other way.

Q. So, this particular movement that you felt was unrelated to a loading of a counter weight. Is that correct?

A. Yes, it was.

Q. And that is the one that you also feel, in your opinion, Mr. Smith noticed, too?

A. Yes, he asked me if I had done anything, was I still dogged off. And I said yes, I am dogged off, I didn't--haven't touched anything.

Q. Did you report this movement that you felt between the third and fourth counter weight to anyone?

A. No, not until the 20th, in retrospect. We got to thinking about it.

Q. Do you know if Mr. Smith reported it to anyone?

A. No, he did not. He turned around and went right back to loading the counter weights.

Mr. Crowell confirmed that he considered Mr. Smith to be a good and safe worker, and that they worked together as riggers. Mr. Crowell confirmed that when he began to swing the 20Ämeter boom back into position just before the accident he knew that the three employees in question were still on the walkways, but did not consider them to be in any danger because the boom or load was not freely-suspended, but was pinned to the main frame with the eyelet which failed, as well as by big pins at the fulcrum (Tr. 144). In his view, no part of his crane posed a danger to the three employees who were on the boom. He believed that all three individuals were clear and free from any danger from the boom or the crane he was operating (Tr. 144).

Mr. Crowell stated that when the eyelet failed, and the load went up, he had eye contact with Mr. Smith as he fell to the ground below, and that he noticed Mr. Saulsburg's legs dangling out from "underneath the off side" of the boom (Tr. 145).

In response to further questions, Mr. Crowell confirmed that he had in the past worked on the walkway at the end of the boom in question adjusting chokers or tension on the belt, or doing a number of other things. He confirmed that Mr. Smith was rigging a choker at the end of the boom, and while he could not see the side of the boom where Mr. Smith was working, he assumed he was rigging one of two chokers shown in photographic exhibits PÄ10 and PÄ11, but was not certain as to which one he was working on at the time of the accident (Tr. 147). He believed that the choker located at the end of the boom was installed earlier in the day while the boom was still in its original position on the cribbing. Assuming that Mr. Smith installed that particular choker, Mr. Crowell believed that he could have done it while on his hands and knees by reaching through the walkway mid-rail. He believed the other choker could have been installed by pulling up a piece of the grating and wrapping it. He confirmed that he had installed chokers in this fashion in the past, but that he used a safety belt and was tied off. He confirmed that he always tied off "when you stand a chance of falling." He explained that if a piece of grating were removed, there is a chance of falling because "that leaves an open hole, and you are bent over into it" (Tr. 150). When asked why Mr. Smith was not tied off at the time of the accident, Mr. Crowell responded "He felt there was no danger, I am sure. The grating was--must have been in place, or something. I know Steve just wouldn't jump right out there and take a chance" (Tr. 150).

Mr. Crowell believed that the failure of the eyelet was a "freak design," and that he had never experienced this before. He confirmed that he saw some of the grating fly off the walkway and that it hit the ground just prior to Mr. Smith. He stated that "it all happened at once, * * * it was raining grating and one body" (Tr. 150). With regard to the grating in question, Mr. Crowell stated as follows (Tr. 151Ä152):

> THE WITNESS: It is secured grating. It is in there. The only way that it could have come out would be the way that it--to have had a pin failure and that thing have such a whiplash attitude. The grating--for it to come out of those channels--had to come straight up, turn on edge and then go through the hole, because the catwalk framework is made out of angle iron that is turned in toward each other.

The only movement of these--and especially these here are fitted pieces of grating; they are mitered in. So you don't have any clearance left or right in this angle iron frame, and as long as all pieces of grating were in, you have no forward and back movement. The only movement that you could have would be straight up. And when the pin failed, it catapulted everything. It threw the grating straight up.

JUDGE KOUTRAS: Would you have any--as a rigger, would you have any problem with walking on some grating that wasn't pinned or secured the way it was supposed to be?

THE WITNESS: No, not in that type of design.

* * * * * * * * * *

JUDGE KOUTRAS: Let me ask you this. As a rigger, let's assume--this is a hypothetical. Let's assume that a couple of pieces of walkway are removed, and you had to go up and walk on the supporting steel structure to do some work, without any walkways under it. Would that cause you any problem.

THE WITNESS: No.

JUDGE KOUTRAS: Why wouldn't it?

THE WITNESS: It is an acceptable risk. Whenever you hire in in this business and putting a rigging belt on, it is high risk. You better know what you are doing.

JUDGE KOUTRAS: Would you be tied off?

THE WITNESS: Not while I was moving, I wouldn't.

JUDGE KOUTRAS: While you were walking along that structure, you wouldn't be tied off?

THE WITNESS: Not while I was moving.

JUDGE KOUTRAS: When would you tie yourself off?

THE WITNESS: When I stopped and got to my work station.

Mr. Crowell stated that he was not familiar with the safety standards cited as violations in this case. When asked to explain his understanding of section 77.1607(g) requiring equipment operators to be certain, by signal or other means, that all persons are clear before starting or moving equipment, he replied as follows (Tr. 154Ä157):

THE WITNESS: Yes, it is your responsibility not to jump into a rig, crank it up and run over the mechanic that is changing your oil.

JUDGE KOUTRAS: Very well put. Very well put. What kind of instruction do you get with regard to that safety standard?

THE WITNESS: I was flagged to propel the rig.

JUDGE KOUTRAS: Did it ever dawn on you on this day that, with these three people being on that 20Ämeter boom, that you may have been violating some safety standard by moving that rig while these three fellows were on there?

THE WITNESS: No, it was not a freely-suspended load. Had it been a freely-suspended load, I may have had some thoughts on the matter, but it is not like riding a connector up on a ball, which happens frequently in the construction business. It wasn't that type. It was a main structural component. You know, in retrospect, sure they shouldn't have been there, but then again--

JUDGE KOUTRAS: Why do you say they shouldn't have been there?

THE WITNESS: Well, you know, the accident happened is why. But they could have just as easily have been there, had that pin not failed. It was an acceptable risk to the rigger.

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JUDGE KOUTRAS: What do you mean by a freely-suspended load?

THE WITNESS: One where the crane is in total control of it, that I am not pinned off, as I was with that. One end was pinned off. I wasn't applying any lift. I was applying lateral movement, left and right, just swinging.

JUDGE KOUTRAS: Now, what are your instructions as a crane operator to look out for that mechanic that you just mentioned when you defined the standard for me here? If you are lifting a free-load, so to speak, do you stop, look, see if anybody is on it or clear of it before you attempt to move it, or just what procedure there do you do?

THE WITNESS: Yes, you use your years of experience and common sense and judgment call on all lifts. I have shut lifts down in the middle of a lift because I knew it was going to be unsafe. And I am not afraid to. That is part of my responsibility. Had I had any--had I known my rig would have been in any bind or anything like that, somebody would have definitely known about it.

JUDGE KOUTRAS: How about blind lifts? Have you ever had occasion to lift lifts that were totally out of sight?

THE WITNESS: Yes.

JUDGE KOUTRAS: Well, what procedure did you use there to ascertain whether or not there was anyone--

THE WITNESS: Well, you can either use walkie-talkies, you can use headset with radio/telephone, or you can telegraph signals by hand signals.

JUDGE KOUTRAS: But in this case, you knew three men were up there, right?

THE WITNESS: Yes.

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JUDGE KOUTRAS: Because one had signalled to you, Mr. Smith himself?

THE WITNESS: That--prior to the accident. That was two hours before.

JUDGE KOUTRAS: Oh, I see.

THE WITNESS: It wasn't just before it happened, no. This was two hours earlier, when we were loading between three and four. And we put in four and five.

JUDGE KOUTRAS: Were they up there when you were doing the slight lifting to get the shoring out?

THE WITNESS: No.

JUDGE KOUTRAS: You indicated in response to questions by Mr. Fitz that when you were maneuvering that 20Ämeter boom, that these three men were out there, and one of your responses was, well, they had to be there because they had some work to do.

THE WITNESS: Uh-huh.

JUDGE KOUTRAS: So you were aware that they were out there doing something?

THE WITNESS: Yes.

JUDGE KOUTRAS: And they were kind of out of your line of sight?

THE WITNESS: They were in the blind on my side, yes. I knew they were up there.

JUDGE KOUTRAS: And you say it is not unusual for there to be this lateral movement with people on it doing work?

THE WITNESS: No, not unusual.

Mr. Crowell stated that he did not know how close he would bring the 20Ämeter boom to the cherry picker so as to transfer the boom from the 518 crane to the cherry picker and that this would have been a "supervisor's call shot." He

indicated that he would have manuevered his crane as close as possible, and that the choker would have been passed and installed by hand from the boom to the cherry picker. He believed that this could have been done by someone on the walkway while inside the hand rail (Tr. 158).

Jeffrey D. Arent, testified that he no longer works for Austin Power, but was so employed as a helper for approximately 6 months, including August 19, 1985, the day of the accident. He confirmed that he, Mr. Smith, and Mr. Saulsburg had been working on the boom all day installing counter weights. Mr. Smith summoned him to go to the end of the boom to see if it was stable, and they determined that it was and that it had no movement. Mr. Arent confirmed that Mr. Smith placed a choker on the end of the 20Ämeter boom. He identified photographic exhibits PÄ7 and PÄ8 as the boom walkway location where they were located at the time of the accident, and he stated that Mr. Smith was at the end of the boom and that he (Arent) was at the other end where there is a bend in the walkway as shown in exhibit PÄ8. Mr. Arent stated that he observed Mr. Smith tie the choker onto the end of the boom by bending over the hand rail "not very far out," and he observed that Mr. Smith "wrapped the choker around the beam and put the eye through the other eye." He stated that Mr. Smith "just had his head just barely out and his hands were out there" (Tr. 163).

Mr. Arent stated that he could not recall whether the boom was stationary or was being moved in a lateral direction while Mr. Smith was installing the choker. When the eyelet failed, Mr. Arent stated "all I remember is that I went up and hit my head" and that he came down in that same spot where there was an extra beam. Mr. Arent stated that he hit his head on the overhead walkway roofing, and when asked whether he was aware that the walkway grating was not fastened down before he went there with Mr. Smith, he responded "we didn't pay no attention to it" (Tr. 164). He stated that Mr. Saulsburg was between him and Mr. Smith on the walkway. When the eyelet failed, Mr. Saulsburg also went up in the air and hit his head, but came down and caught himself. He confirmed that he and Mr. Saulsburg were able to come off the boom by walking down the sides. When the eyelet failed, he did not see what happened to Mr. Smith and Mr. Saulsburg because "I was worried about myself" (Tr. 166).

On cross-examination, Mr. Arent examined photograph exhibit PÄ7, and stated that the choker at the end of the boom which is circled in blue in the photograph was not the one that Mr. Smith was installing at the time of the accident.

He stated that Mr. Smith had installed that choker prior to the accident, and that the one he was installing at the time of the accident was the choker which is shown around the walkway structure outby the end of the boom. Mr. Arent marked an "X" where he believed Mr. Smith was located installing the choker just before the accident. He then stated that the "X" mark is where he observed Mr. Smith putting on the choker that he testified to on direct examination, but then stated that he did not know whether that was the choker "that we are talking about" (Tr. 169). He stated further that he did not observe Mr. Smith install the choker which is circled in exhibit PÄ7, and explained as follows at (Tr. 167Ä168):

> A. Well, I don't know. I think he put it up there earlier. He was doing that before he did the other one that was over at--it should have been out here where he was putting it, though, because that is where he was at, unless he dropped that choker when he--that he was working on.
>
> Q. So the choker that is circled on PÄ7--did you see him put that choker on?
>
> A. No.
>
> Q. You did not? So the testimony that you gave before about him standing and leaning over the rail or doing anything, that doesn't apply to this particular choker that is circled?
>
> A. No.
>
> Q. If anything, it applies to the one that is--
>
> A. He was out over here.
>
> Q. At the end of the catwalk?
>
> A. Yes, he was out in this area.

Mr. Arent identified a smaller second choker, as shown in photographic exhibit PÄ8, and confirmed that it appeared to be wrapped around the angle iron on the catwalk. When asked whether this was the choker that Mr. Smith was working on, Mr. Arent replied "Could have been" (Tr. 170). He further explained as follows (Tr. 170Ä171):

Q. Could it have--if he was applying it at the end of the--where you have him marked as an X at PÄ7, would the fact that it goes around the back side, where you have marked on PÄ8--would that prevent it from being pulled all the way to the end of the--

A. Yes.

Q. It would? So does that mean--would you agree then, that probably is not the choker that he was putting on?

A. I don't--it don't seem like that would be the one, because he was out on the end.

Q. And was Mr. Smith kneeling down?

A. Yes.

Q. Was he on all fours?

A. On his knees, not his hands.

Q. Okay. And when you saw him where you have marked on PÄ7 with an X, was he reaching through the mid-rail, between the mid-rail and the grating, or between the mid-rail--just--and the top-rail?

A. Between the middle and the bottom.

Q. He was reaching between the mid-rail and the bottom, where the grating would be, where the toeboard is?

A. Yes.

JUDGE KOUTRAS: Mr. Arent, I thought you said on direct that he was reaching over the top, slightly not too far over it. And now it is the middle and the bottom?

THE WITNESS: Yes.

JUDGE KOUTRAS: What was it?

THE WITNESS: The bottom.

JUDGE KOUTRAS: What moved you to say the top, when asked on direct?

THE WITNESS: I don't know. Just the way the question was asked.

Mr. Arent stated that if Mr. Smith was standing on the grating and reaching over the hand rail there would be a danger of falling because he could lose his balance and go over the top of the railing. If he was reaching over, he should have been tied off, but if he was kneeling, he would be more balanced and did not need to be tied off (Tr. 174). Mr. Arent stated further that when he observed Mr. Smith on his knees reaching through the hand rail, he believed his head was outside the mid-rail, but his shoulder was not (Tr. 173).

Mr. Arent confirmed that he was wearing a safety belt at the time of the accident, but that he was not tied off because he moved around so much and was not tied off all of the time. He would tie off if he had a wrench in his hand and was using it. He also confirmed that he had his lanyard line with him and that it is part of his regular safety equipment, and that Mr. Smith also had his line with him (Tr. 175).

Mr. Arent stated that when he and Mr. Smith were on the boom, Mr. Smith was his supervisor and he would do what Mr. Smith told him. Mr. Arent did not know who Mr. Smith's supervisor was, but he confirmed that general foreman Jim White told him (Arent) where he was to work that morning (Tr. 177). Mr. Arent stated that he was not familiar with the safety standards which are in issue in this case, but confirmed that he knew he was supposed to wear a safety belt and tie off and that he learned this at weekly safety meetings conducted by Mr. White (Tr. 177).

Austin Power's Testimony and Evidence

Inspector Summers was recalled, identified several photographs of the eyelet which failed, and the scene of the accident, and described some of the damage to the eyelet (Tr. 183Ä184). He also testified as to certain statements and conclusions which appear in MSHA's "narrative assessment" concerning the supervising of the work being done on the boom at the time of the accident, and he confirmed that the statements were not obtained from him (Tr. 185Ä187).

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James C. "Pat" Patterson, testified that he is employed by Austin Power, and was the rigging foreman at the time of the accident. He stated that at the time of the accident he was not aware of any movement of the 20Ämeter boom between the third and fourth counter weight loading process, but learned about it the following day. Immediately prior to the accident, he was on the ground and approximately 35 to 40 feet from the end of the boom. Mr. Smith was kneeling on the catwalk putting a choker around the framework under the grating. The choker was to be used to lead the boom around with the cherry picker, and his feet were at the place marked with an "X" on exhibit PÄ7. Mr. Smith was reaching underneath the mid-rail, but Mr. Patterson did not see how much of his body was through the rail. Based on his experience as a rigging foreman, and 30 years of construction experience, Mr. Patterson did not believe that Mr. Smith was in danger of falling (Tr. 197).

Mr. Patterson stated that company policy required Mr. Smith to have his safety belt on at all times he is off the ground, and if he is outside the handrails, he is required to be tied off. The safety belt also serves as a tool belt, and it has a lanyard attached to it. Mr. Patterson did not believe that Mr. Smith was required to be tied off at the location that he was in at the time of the accident (Tr. 197).

Mr. Patterson stated that after Mr. Smith fell to the ground, he saw that he had a head injury, and when he later examined the boom, it was his opinion that Mr. Smith struck his head on a "load cell" located above where his feet had been on the catwalk. Mr. Patterson described the "load cell" as the round white object shown by an arrow on exhibit PÄ7, and he stated that he observed that the object was bent. That led him to believe that Mr. Smith's head struck it as the boom raised up (Tr. 199).

On cross-examination, Mr. Patterson stated that he did not see Mr. Smith pick up the grating to maneuver the choker under it, and that he could swing the choker under the grating and reach and catch it with his hand on the other side. The choker consists of a wire rope, and he likened it to swinging a piece of rope under the walkway grating. The choker was not in place at the time, and Mr. Smith was preparing to get it in place to attach it to the cherry picker (Tr. 200).

Mr. Patterson stated that he was not aware that the walkway grating was not bolted or clamped down at the time of the accident, but that "I know that it had been at one time." He

was not made aware of the fact that the grating had ever been removed after it was initially installed until discussions which took place after the accident occurred. He stated that the grating could have been removed for numerous reasons, and that a painter, an electrician, or some other craftsman could have done it. Although he could not specifically identify who may have taken up the grating, he stated that it was not unusual to do so (Tr. 201Ä202). He confirmed that normal procedures, specifications, or verbal directions required that the grating be clamped at each corner and fastened down (Tr. 202).

In response to a question as to whether he believe the walkway grating was in good condition, regardless of whether it was clipped down or not, Mr. Patterson responded that he considered it to be safe to walk on (Tr. 203). Mr. Patterson explained that while he was on the ground before the accident occurred, he was primarily flagging the crane operator and also supervising Mr. Smith's work on the end of the boom. He identified the choking device as the one depicted in photographic exhibits PÄ10, PÄ11, and PÄ14, and confirmed that it appeared to be tied off around the steel member of the catwalk structure in all three photographs. He stated that Mr. Smith had tied the choker on and intended to loop it under the catwalk to the other side and then catch it. He would have then placed the two eyes of the choker onto the crane lifting hook in order to maneuver the boom around. No lifting was required, and the crane would simply lead the boom with a lateral movement.

Mr. Patterson stated that he did not specifically instruct Mr. Smith or the other two men as to what they were to do, and that Mr. Smith knew that the cherry picker would be used to guide the boom around, and knew that a choker was required for this task. The other two men simply followed Mr. Smith out to the end of the boom because "they were naturally eager also." Mr. Patterson stated that Mr. Smith was a journeyman and a good worker, and that he (Patterson) felt "felt completely comfortable as far as any safety aspect" (Tr. 205).

Mr. Patterson was of the opinion that the fact that the grating was not tied down and Mr. Smith was not tied off would not have prevented the fatal accident in question. He stated that by striking his head on the overhead cell, Mr. Smith was not able to grasp the hand rail as he came down after the boom raised, and he pointed out that Mr. Arent caught himself, and Mr. Saulsburg caught himself after falling through the area where the grating was gone and pulled

himself back up. He conceded that had the grating been secured, it probably would not have popped out with the jerking of the boom.

Although he believed that it was conjecture that the walkway on the other side of the boom which did not pop out was subjected to an equal amount of movement when the eyelet failed and the boom raised up, he conceded that it was probably true (Tr. 207). Mr. Patterson could not explain why the other walkway did not pop out when subjected to the "whiplash" movement of the boom when the eyelet failed, and when asked whether anyone speculated that it did not pop out because it was secured, he responded "probably, Yes sir" (Tr. 208).

In response to further questions regarding company policy and the use of safety lines, Mr. Patterson stated as follows (Tr. 208Ä209):

> JUDGE KOUTRAS: You say that the company policy is that when any employee is required to be off ground-level that he is to have a belt on?
>
> THE WITNESS: At this jobsite, sir, that is project policy by my boss.
>
> JUDGE KOUTRAS: And then if his work has occasion to take him outside of the area of a guard-rail, he is required to be tied off?
>
> THE WITNESS: Yes, sir.
>
> JUDGE KOUTRAS: Is this policy written, or how is it communicated to the employees?
>
> THE WITNESS: Through regular gang box, tool box safety meetings.
>
> JUDGE KOUTRAS: But do you know whether or not it is a written policy of any kind? Do you all have written work rules there?
>
> THE WITNESS: Yes, sir.
>
> JUDGE KOUTRAS: Is it part of the written work rules?

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THE WITNESS: Yes, sir. We have written safety books and I don't think it is worded as such in our safety rule book.

JUDGE KOUTRAS: Why isn't it?

THE WITNESS: I don't know. It could be. I couldn't swear that it is or isn't. But at any time you are in an unsafe area, we know that we are supposed to tie off. That is in the book. But as far as wearing a belt when you are off the ground on a catwalk with hand-rails and toeplate, I don't know.

Sidney S. "Woody" Woodson confirmed that he is employed by Austin Power as a project general superintendent, and was so employed at the time of the accident. He was the superintendent of the Big Brown Strip Mine, and approximately 30 employees were employed at this job site. The mine is owned by Texas Utilities and the cross-pit spreader was designed and manufactured by the DeMag Company from Germany. DeMag had a representative on site for the purpose of overseeing Austin Power's erection of the spreader, and Austin Power had a contract with DeMag for this purpose, and not with Texas Utilities. As general superintendent, Mr. Woodson was responsible for compliance with all safety regulations at the site, and he is certified for the safety training courses given by MSHA (Tr. 210Ä213).

Mr. Woodson identified a copy of the company safety rule book given to all new employees at the job site, and copies of the minutes of 12 "tool box" safety meetings held with employees, including Mr. Smith, during the period June 3, 1985 to August 19, 1985. Mr. Woodson stated that the meetings included a discussion of the use of safety belts and lines, and that the meetings are conducted by company supervisor Jim White. Mr. Woodson stated further that he selects the topics for discussion at the meetings, and that he usually discusses them with Mr. White (Tr. 213Ä221).

Mr. Woodson reviewed several photographic exhibits, and described the location of certain electrical conduit and boxes located outside the boom walkway. He also identified a recent photograph he took depicting a chain and a sign across the boom walkways installed after the accident. The sign states "Authorized Personnel Only." Mr. Woodson confirmed that he installed the chain, and Texas Utilities installed the sign, but he could not explain who ordered them installed (Tr. 228Ä231).

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Mr. Woodson identified photographic exhibit RÄ8, as a photograph of the catwalk on which Mr. Smith was working at the time of the accident. He confirmed that he took the pictures several days prior to the hearing, and when asked whether it depicts the condition of the catwalk as it appeared at the time of the accident, he responded as follows (Tr. 232Ä235):

> Q. Is this the catwalk that Mr. Smith was working on at the time of the accident?
>
> A. Yes, it is.
>
> Q. And was the--was there any difference in your understanding as to the condition of the catwalk as you found it in your picture last Friday and how it was during the time that the accident happened?
>
> A. The grating is laying inside that framework, identically like it was.
>
> Q. So does it--
>
> A. At the time of the accident, with the exception of maybe a few of these grating clips not being clipped down. I can't honestly tell you how many of them was and how many wasn't.
>
> Q. So RÄ8 fairly and accurately depicts the way that the grating was laying into the catwalk structure at the time of the accident?
>
> A. Yes, it does.
>
> * * * * * * * *
>
> Q. Now, let me direct your attention to Respondent's Exhibit number 8, the photograph. Would you explain to the Judge what Respondent's Exhibit 8 depicts to you, insofar as the four sections of grating that are shown in that catwalk, and how they are installed and secured.
>
> A. Well, of course, being four or however many pieces it is down through there, from

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this elevation right here, this catwalk goes off, drops down 90Ädegrees, bends 90 and takes off again. There is an angle iron frame which is approximately, now, four-inch angle by four-inch angle iron. It is millimeter type, but it approximately that, which makes the framework down this side and across the front and up the other side, which this grating is laying down in there.

Q. So all of the four pieces which are depicted in Respondent's Exhibit 8 at the--coming from the photograph and looking into the distance, the last four pieces are inside what is in effect a box of angle iron?

A. Well, you could--you could say a box frame angle iron.

Q. Was the angle iron higher than the grating itself?

A. It is some higher, yes.

Q. Was there any way that that grating, if it was all in place, could move, either left or right or in any way laterally?

A. Not under normal conditions. Just as long as it is laying out there flat, no, it can't come out of there. Something has got to disturb it.

Q. Would you consider, in your opinion and years of experience that you have had in construction industry, for that walkway to be in good condition?

A. Well, in my years of construction, we had let lots of grating like this go unclipped down, because we felt like that it was safe grating. It couldn't come out of that type of framework, because you had to go back there and do work later. Now, we had clipped this grating down at one time because we had extra people that didn't have nothing to do, and we put them and got all the grating clipped down. It is a good policy to get it all clipped down.

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Q. Did you consider it unsafe to work on that grating in that particular condition, the day of the accident?

A. No, sir, I didn't.

And, at (Tr. 238):

Q. Mr. Woodson, with regard to the grating, in your opinion was it necessary to have the clips in place for the walkway, the grating, to be in good condition?

A. Not all 100Äpercent, I wouldn't say. As long as your grating was laying in the box frame and laying all down in there properly and fit down and not any of it pulled up or anything, where it accumulated a tripping hazard or some way you could kick some of it up in the air and cause it to fall. No, not if it was all 100Äpercent uniform laying in that grating.

Mr. Woodson stated that he was not aware of any movement of the boom between the loading of the third and fourth counter weights until after the accident occurred (Tr. 234).

On cross-examination, Mr. Woodson, testified as follows with regard to the walkway clips (Tr. 238Ä239):

Q. Mr. Woodson, was it Austin Power's policy to have the grating clipped down on the cross-pit spreader at the Big Brown Strip?

A. To my knowledge, there is not anything in writing that tells you that it is--needs to be clipped down. It just says grating needs to be proper secured by means of, and it goes--I think there is some stuff somewhere that tells you, you know, that it needs to be tied down by means of number 9 wire or grating clips. There is some place we tie it down with number 9 wire, sometimes we put it down with grating clips and sometimes we weld it down.

Q. Did you know prior--did you know on August 19, 1985, prior to the accident that

afternoon, that the grating on what has been referred to as the left side of the 20Äfoot boom was not clamped down?

A. No, sir. I can't honestly say 100Äpercent I didn't know that.

Q. Do you know of any reason why the grating would not have been clipped down on the left side of the 20Äfoot boom, on August 19, 1985?

A. Well, it could have been the painters took the clips up, it could have been anybody that took the clips up. I had been in that area a couple of three days before that and some of this grating was clipped down I know, because I don't recall seeing any of the clips off in that area when I went in there. Of course, I don't think I went plumb to the end of the boom that--two or three days prior to that.

Mr. Woodson confirmed that the walkway areas are required to be inspected at least daily during the work shift, and he stated that he tries to walk the area at least once a day unless he is busy doing something else (Tr. 241). He confirmed that the walkway grating was required to be secured in order to abate the citation, and in response to additional questions, he stated as follows (Tr. 242Ä243):

JUDGE KOUTRAS: * * * What I am trying to understand is--these plates, these walkway plates are put in there with items that secure it down. Isn't that true? There is a reason for having it.

THE WITNESS: Yes, sir, that is true; but the reason for having these on these particular points is because they are moving booms up and down and sideways, and clods and stuff is falling on it during operation that could knock the grating out of there--that 99Äpercent of--or 99 chances out of 1, that there ain't nothing going to fall on it and knock the grating out in that condition as you are erecting.

JUDGE KOUTRAS: Once you get it erected and completely constructed and built and ready to go, are you telling me that you are still not required to have the tie down plates on?

THE WITNESS: No, I am not saying that. I am saying that during erection--during erection.

JUDGE KOUTRAS: So my question is that once erected and constructed, if inspector Summers walks in there and find one of them not tied down, you are likely to get a citation, aren't you?

THE WITNESS: Yes, sir, that is true.

JUDGE KOUTRAS: You are not maintaining it in good condition, or in safe condition, or whatever.

THE WITNESS: Yes, sir, that is true.

Mr. Woodson agreed with MSHA's assertion that had the walkways been secured, Mr. Smith may not have suffered fatal injuries because when he was thrown in the air he may have been able to land on them and not have continued his fall (Tr. 247Ä248).

With regard to the citation for moving equipment without insuring that employees are in the clear, Mr. Woodson believed the cited regulation applied to the 518 crane and not the boom of the cross pit spreader, and that the regulation prohibited anyone from being on a load that is being picked up off the ground by the crane and lifted into the air (Tr. 249, 252).

Mr. Woodson stated that after the counter weights were installed he instructed the crane operator to slack off his chokers, and since he had only one foot of clearance between the boom, he had the three employees in question walk out on the boom to see if the boom would "set down anyway." When it didn't he instructed the employees to go to the other end of the boom, and he described what happened next as follows (Tr. 250Ä253):

* * * Well, we started walking the thing around and we got the thing nearly around there in place, these three people that was out there on the boom, fixing to hook this choker on that cherry picker come down the other side to go out there. They was back here at the back at one time. But they seen that the boom was getting around here close,

that some point you had to go out there and hook it on. Some point you had to go out there. There was no choice.

So they went up this side, which is the right-hand side, went around the back, come down the left-hand side to put this other choker on, to hook on the cherry picker. So they had been out there once before the load started moving and they was instructed to go back. And they went back.

JUDGE KOUTRAS: And then the load started moving again?

THE WITNESS: Then the load started to moving, which he moved the load probably 80Äpercent of the distance that he was going with it. And Mr. Smith had already been told to put a choker on there, prior to us even start moving the boom back into position. He was told to put the choker on the front of the boom, here, but it ended up around the catwalk there.

JUDGE KOUTRAS: Now, the gentlemen in the back there that operated this particular crane that day saw nothing wrong with people being out there when it was moved. They had some work to do out there.

THE WITNESS: Well, I can't either, because there is conditions you get in where you have no choice. You have to be on it. Now, you don't want to put a man out there where you can see a hazard, but I could not see a hazard at the time that they went out there, because I didn't know that something was going to go wrong. If I had of, I sure wouldn't have sent them boys up on there.

* * * * * * * * *

JUDGE KOUTRAS: And in this particular case, that 20Ämeter boom, in your eyes, wasn't being moved?

THE WITNESS: Yes, sir, only on one end. It was rigid on--I mean, it was fixed on the other end.

JUDGE KOUTRAS: And which end was it being moved on?

THE WITNESS: It was moved out on the live end of it.

JUDGE KOUTRAS: Where the three men were at. Is that true?

THE WITNESS: Part of the time, yes, sir. They was out there part of the time. But at the biggest move of the period, they was not out there. They was out there nearly right at the end of the move.

JUDGE KOUTRAS: Mr. Patterson is sitting there watching these fellows going back and forth?

THE WITNESS: Well, Mr. Patterson seen them walk down this catwalk on one side, yes, sir.

MSHA Arguments

Citation No. 2339411

MSHA argues that as the danger increases, the equipment operator's duty to assure clearance of persons also increases, and the operator must be certain that no one will be endangered by starting or moving equipment. Texas Industries, Inc., v. FMSHRC, 694 F.2d 770 (5th Cir.1982), 2 MSHC 1915 (1982). MSHA submits that section 77.1607(g) requires that the equipment operator must be certain that all persons both are clear of the equipment and are not on the load before starting the equipment and moving the load. MSHA notes that section 77.1607(k) prohibits persons from working or passing under the buckets or booms of loaders in operation. In the instant case, MSHA concludes that the crane operator knew that three employees were on the far side of the 20Ämeter boom when he began to swing it under the 70Ämeter boom.

Citation No. 2399412

MSHA asserts that the facts in this particular case are similar to the facts in BCNR Mining Corporation, 3 MSHC 2015 (1985), where a violation of section 77.1710(g) occurred when a worker, without wearing a safety belt and line, placed his body between the top rail and middle rail on the fourth floor, lost his balance, and fell through the railings to his

death. MSHA submits that a reasonable employer should know there is a danger of falling when an employee is assigned a task which requires him to lean over or between the guard rails on an elevated walkway, Great Western Electric Company, 2 MSHC 2121 (1983); Southwestern Illinois Coal Corporation, 3 MSHC 1066 (1983).

Citation No. 2339413

MSHA submits that the cited elevated walkway was not maintained in good condition since its expanded metal floor plates were not fastened to its frame to prevent them from becoming dislodged if the elevated walkway moved or jumped because of some unexpected external force.

Austin Power's Arguments

Citation No. 2339411

Austin Power contends that mandatory safety standard 30 C.F.R. 77.1607(g), does not apply to the circumstances which existed at the time of the accident. In support of this argument, Austin Power states that the accident was caused by an unexpected failure of an eyelet on the cross pit spreader which resulted in a quick, unforeseeable movement of the 20Ämeter boom, and that at the time of the accident, the crane operator was pulling the 20Ämeter boom because the electricity was not connected to allow the boom to move on its own power. The crane operator was well aware of the fact that the three employees were working on the boom as he was swinging it around. When in operation, the boom is designed to slowly move vertically and horizontally, and it is designed to allow employees to work on the walkways. Austin Power maintains that the inspector's contention that the three employees should not have been on the boom during its operation goes against the design and purpose of the machine.

Austin Power maintains that the crane operator was in fact receiving signals throughout the day, and that the situation presented is not one in which the crane operator backed over an individual because he failed to receive signals that all individuals were in the clear. Austin Power points out that the crane itself posed no danger to the three employees on the 20Ämeter boom because the crane did not and could not come into contact with the employees. Austin Power argues that MSHA's position that the 20Ämeter boom was the load of the crane and as such was an extension of the crane is refuted by the evidence and any logical interpretation of section

77.1607(g). The 20Ämeter boom was a separate piece of equipment which was being "walked around" by the crane, and the crane operator was putting no stress on the boom and his actions had nothing to do with the eyelet failure. Austin Power concludes that the three employees were not "riding the load" at the time of the accident and were clear of the crane, and even if they were, the inspector admitted that there is no prohibition against working on moving equipment or on the boom of machinery.

In response to MSHA's contention that the three employees should not have been working on the boom while it was moving, Austin Power asserts that the equipment was designed to allow employee access at all times, and that the inspector admitted that the failure of the equipment was just as likely to have occurred while the boom was stationary. Austin Power concludes that the fact that the crane operator was moving the boom at the time of the accident is totally irrelevant.

Austin Power argues that the only relevant factor is whether the crane operator failed to receive notification that all persons were in the clear before moving the crane. Austin Power maintains that the evidence specifically shows that the operator knew where the employees were standing and that they were in the clear, the operator was given operating signals from various individuals, and the operator did not put the employees in any danger through the operation and movement of the LinkÄBelt crane. Therefore, Austin Power concludes that MSHA has failed to establish a violation of 30 C.F.R. 77.1607(g).

Citation No. 2339412

Citing Southwestern Illinois Coal Corporation, 3 MSHC 1066 (1983), Austin Power states that the phrase "shall be required to wear" found in 30 C.F.R. 77.1710(g), has been interpreted to require miners to wear safety belts under appropriate conditions, but does not make operators guarantors that safety belts and lines will be worn by its miners. Austin Power also cites Peabody Coal Co., 1 MSHC 2076 (1979), in support of the proposition that mine operators have a duty to establish a clear and understandable safety system designed to assure that employees wear safety belts and lines on appropriate occasions and to enforce the established system with due diligence.

Austin Power argues that the fact that the three employees in question did not secure their lanyards when they were working on the 20Ämeter boom did not create a hazardous

situation. Austin Power points out that while the citation stated that all three employees were in violation of section 77.1710(g), MSHA acknowledged at the hearing that the two employees who were not applying the choker when the accident occurred did not need to be tied off, and that the inspector in his deposition stated that he based his citation upon his belief that the employees were riding on moving equipment (20Ämeter boom) and therefore needed to be tied off. However, the inspector acknowledged that there is no standard which prohibits employees from working on a piece of moving equipment.

Austin Power states that MSHA based its case upon the belief that the deceased employee was leaning over a handrail on the walkway of the 20Ämeter boom while connecting a choker. Austin Power maintains that the evidence clearly established that the deceased employee was not leaning over the rail and was in no danger of falling due to his actions. In support of this conclusion, Austin Power asserts that MSHA's own witness, employee Jeffrey Arent, testified that Mr. Smith was not leaning over the top rail but was kneeling on his knees reaching between the middle and bottom rails while applying the choker, and that he was in no danger of falling.

Austin Power states that the three employees were standing on the 20Ämeter boom at the time of the accident; the boom was equipped with a standard guard rail which included a top rail, a mid-rail and a toeboard made of angle iron; and the boom was covered by a metal housing. Austin Power points out that in the Southwestern Illinois Coal Corporation case, a violation of section 77.1710(g), was found because no guard rails or protective devices surrounded the employees work area and a danger of falling existed. However, in the instant case, the employees in question were in a protected area and were in no danger of falling. Under the circumstances, Austin Power concludes that section 77.1710(g) is inapplicable to the facts in this case.

Citing Great Western Electric Co., 2 MSHC 2121 (1983), Austin Power points out that in reviewing an analogous standard (30 C.F.R. 57.15005), the trial judge supplied a test to interpret the phrase "danger of falling." In that case, the Commission applied a "reasonably prudent person" test previously applied in Alabama ByÄProducts Corp., 2 MSHC 1918 (1982), which is as follows:

> [W]e conclude that the alleged violation is appropriately measured against the standard of whether a reasonably prudent person familiar

> with the factual circumstances surrounding the allegedly hazardous condition, including any facts peculiar to the mining industry, would recognize a hazard warranting corrective action within the purview of the applicable regulation. Id. at 2122.

Applying this test to the safety belt standard, the Commission defined the test in terms of whether an informed, reasonably prudent person would recognize a danger of falling warranting the wearing of safety belts and lines. Austin Power suggests that an informed, reasonably prudent person would not have recognized a danger of falling on the protected walkway of the 20Ämeter boom. Austin Power quotes the crane operator's description of the situation: "They were in a catwalk grating area that was covered with a shed. It would be like sitting in this chair tied off." Austin Power also points to the admission by the inspector that he does not wear a safety belt while inspecting the 20Ämeter boom, and the fact that these inspections took place in the same area where the same inspector now contends that safety belts are required.

Austin Power argues that the evidence in this case clearly establishes that Mr. Smith was not leaning over the rail while applying the choker, but was crouched on his knees within the handrail. However, Austin Power asserts that at most, Mr. Smith's head was outside the rail, but not his shoulder, and that he was as protected and balanced as the other two employees which MSHA acknowledged did not need to be tied off. Austin Power concludes that since all three employees were in situations in which there was no danger of falling, they did not need to be tied off, and the fact that a "freak accident" occurred does not change the fact that the employees were in a protected area. In further support of its conclusion, Austin Power cites the belief by rigging foreman Patterson that Mr. Smith's injury was caused by a blow to the head from a load cell gauge, and that being the case, a tied-off safety belt would have provided no additional protection from the unexpected equipment failure.

Austin Power argues that in the Southwestern Illinois Coal Corp. case, a danger of falling existed, and the mine operator was found to have violated section 77.1710(g), when it left the decision to wear safety belts largely to the discretion of the miners and failed to offer or cite any specific guidelines and supervision on the presence of actual fall dangers. Austin Power suggests that if no danger of falling is present, then the issue of safety instructions and enforcement is irrelevant. On the facts presented in the instant case,

Austin Power argues that it has proved that it has a clear safety system which insures that its employees are aware of the necessity of safety belts under appropriate circumstances and that it enforces the established system with due diligence. Austin Power concludes that its testimony established that it has a stated and enforced policy that employees are to wear safety belts if they are off the ground and are to tie off with their lanyard if they are outside of the guardrails or in danger of falling.

Austin Power maintains that the determination as to when to wear a safety belt and tie off is not left to the employee's discretion but is specifically set out in its written safety manual and in tool box safety meetings. In this case, Austin Power points out that the minutes of the tool box safety meetings in which safety belts and lines were discussed show that they were signed by Mr. Smith, and that his coworker Crowell, who worked with him on a regular basis, testified that Mr. Smith was an extremely safe and good worker who wore a safety belt and tied off when the situation called for it.

Austin Power asserts that Mr. Smith was killed due to a highly unexpected equipment failure, and that a tied-off lanyard may or may not have protected him under these circumstances. Austin Power concludes that at the time of the accident, there was absolutely no foreseeable danger of falling and that this is the standard by which its actions and policies should be judged.

Citation No. 2339413

Citing Sunbeam Coal Corp., 1 MSHC 2314 (1980), and Peabody Coal Co., 1 MSHC 2422 (1980), Austin Power argues that in order to establish a violation of 30 C.F.R. 77.205(e) or 77.404(a), MSHA must prove that elevated walkways and stairways are unsafe. A lack of reliable and substantial evidence that an actual equipment defect affecting safety and resulting in an accident justified dismissal of a section 77.404(a) citation, B.S.K. Mining Co., 1 MSHC 2447 (1980).

Austin Power asserts that MSHA failed to establish by a preponderance of the evidence that clips were actually missing from the walkway grates. Assuming the clips were in fact missing, Austin Power maintains that MSHA has not established that the walkway was in an unsafe condition. In support of its arguments, Austin Power states that the evidence merely proved that grating clips were lying on the ground following

the accident, and that the witnesses, including the inspector, admitted that they did not know whether the walkway on the 20Ämeter boom was clamped prior to the accident. Although rigger foreman Patterson testified that he knew the grating had been clamped at one time, MSHA based its case on an assumption that the walkway was unsecured, and that this belief is based upon speculation rather than fact because no one acknowledged seeing the grating unsecured at any time.

Austin Power asserts that the testimony established that the side of the eyelet which broke was on the left side of the 20Ämeter boom, the side on which the employers were standing, and that the inspector admitted that he did not know the amount of force involved in the eyelet failure, nor did he know whether the force was evenly distributed on the left and right sides. Further, MSHA offered no evidence to discount the possibility that the failure of the eyelet distributed greater force to the left side of the boom, causing the clips on the left to be knocked loose. It is entirely possible given the facts and circumstances that the force of the accident went down the left side of the boom. The clips are not substantial pieces of equipment and are not designed to withstand the type of force which they were subjected to in this accident.

Alternatively, Austin Power maintains that MSHA has failed to prove that a walkway without clips is unsafe. A finding that the walkway was unsafe is required in order to establish a violation of section 77.205(e) or section 404(a), Sunbeam Coal Corporation and Peabody Coal Co., supra.

Austin Power argues that the standards in issue do not state, and no case has held, that walkways must be clipped; they merely refer to maintaining walkways and machinery in a good, safe condition. In the case at hand, Austin Power points out that there appears to be a dispute between MSHA and the inspector as to the proper standard to apply. Although MSHA amended the citation to allege a violation of section 77.404(a), the inspector believed that section 77.205(e) is the more accurate standard. Austin Power suggests that this confusion and disagreement underscores the inapplicability of the citation to the conduct at hand. As an example, Austin Power states that most cases referring to section 77.404(a) relate to bulldozers and heavy equipment, Peabody Coal Co., 3 MSHC 1404 (1984).

Austin Power asserts that the design of the walkway secured the grating from lateral movement due to the angle iron device which was cut to hold the grates in a tightly

secured position, and that the walkway was of a substantial steel construction, as opposed to cases such as The Hoke Co., 1 MSHC 2455 (1980), in which the walkway was found to violate section 77.205(a) because the guardrail was merely a rope. Further, Austin Power maintains that the testimony established that the only way for the gratings to come out of the channels was from the unforeseeable whiplash effect which occurred from the eyelet failure, and that its employees testified to their belief that the walkway was maintained in a good condition and that no safety concerns existed with walking on unclipped grating given the design characteristics. Additionally, the 20Ämeter boom was still under construction at the time of the accident, and a highly unlikely effect from a "freak" accident should not be the measure of whether a walkway is maintained in a good condition. Austin Power concludes that the walkway on the 20Ämeter boom, with or without clips, was maintained in a good, safe condition, thereby meeting the requirements of sections 77.205(e) and 77.404(a).

Austin Power maintains that even if the grates had been clipped down, the evidence suggests that the fatality may still have occurred. First, if clips were affixed to the grates, the clips quite possibly would have come loose upon such a severe impact. Second, MSHA admits that no one knows whether Mr. Smith was flipped over the guardrail or fell through an area where the floor grates were missing. In response to MSHA's assertion that "it is reasonble to assume that he was flipped up and came back down, as did the other two employees," Austin Power points out that no one saw Mr. Smith fall through the handrail. The inspector stated that one witness told him that Mr. Smith went over the top rail. Additionally, Mr. Smith was closer to the end of the boom than the other employees and could easily have been catapulted over the edge. Third, foreman Patterson testified to his belief that Mr. Smith suffered his injury when his head hit the load cell gauge on the 20Ämeter boom; the gauge was bent upon review after the accident. Under this scenario, Austin Power concludes that secured grating may not have prevented the fatality, and that MSHA has failed to prove that a hazard existed due to the condition of the walkway.

Proposed Civil Penalty Assessments

With regard to MSHA's proposed civil penalty assessments for the alleged violations in question, Austin Power argues that the accident which resulted in the death of Mr. Smith was an unforeseeable failure of an eyelet on the cross pit spreader, and that this totally unexpected failure was so unusual that it goes beyond what is anticipated even by

MSHA's system of liability without fault. Austin Power maintains that it and its employees did not and could not recognize a hazard when trained individuals were working on a well-maintained, guarded walkway outside of the zone of danger from the 518 LinkÄBelt crane, and that the standards cited are not applicable to the facts and circumstances which existed at the time of the accident. Austin Power concludes that the accident was due to a situation beyond Austin Power's control, and that the facts presented should not have led to the three citations and the accompanying penalties.

Austin Power states that whether it knew or should have known of any unsafe conditions is relevant in determining the appropriate penalty. Peabody Coal Co., 1 MSHC 2215 (1979). It believes that it is apparent that Austin Power had absolutely no notice that the equipment was defective, and that the alleged violations did not contribute to the accident, nor would further actions by Austin Power employees have prevented the accident. Austin Power believes that its lack of negligence is relevant criteria in the assessment of penalties. Peabody Coal Co., 1 MSHC 2422 (1980).

Austin Power takes issue with MSHA's Narrative Findings for a Special Assessment which led to the proposed civil penalty assessments for each of the alleged violations. Austin Power points to the inspector's acknowledgement that he had nothing to do with the narrative findings made by MSHA's Office of Assessments, and that he was not given an opportunity to review those findings prior to the proposed penalty assessments.

Austin Power maintains that the narrative findings do not correlate with the evidence presented at trial in terms of the citations and proposed penalties. Although the narrative findings state that the three citations contributed to the severity of the fatal accident, Austin Power maintains that the evidence has shown to the contrary. In addition, the narrative findings state that the violations resulted from "operator negligence," which has not been established. The findings state that management knew that employees were not in the clear while the 20Ämeter boom was being moved. Austin Power asserts that the evidence shows that the employees were actually in the clear and the crane operator and supervisors were aware of this fact.

In addition, the findings state that the operator was negligent in allowing the employees to work on the boom without tying off. Austin Power asserts that the evidence shows no negligence on its part, as the employees were working in

an area with standard guardrails which presented no danger of falling. The findings further state that the operator was negligent because it knew or should have known that the walkway floor plates were not secure. Austin Power points out that there was no definitive testimony that the walkway was unclipped. In addition, the evidence established that the walkway with or without clips was of substantial construction and maintained in a good, safe condition. Austin Power concludes that the sole cause of the accident was the defective machinery; any theory to the contrary is unsupported by the evidence.

Finally, Austin Power states that the record is replete with evidence of its extensive safety program and commendable safety history. Additionally, MSHA stipulated to Austin Power's good faith effort toward compliance in relation to the accident and imminent danger order, and the inspector testified to the cooperation he received from Austin Power and the good working relationship he maintains with them. Austin Power points to the fact that it has received only two prior citations at the Big Brown strip mine, neither of which related to a violation of a standard in issue in this case. Austin Power also cites its safety training for employees on a regular basis, including weekly toolbox safety meetings, and concludes that its safety history, good faith effort toward compliance, and cooperation are relevant to the assessment of penalties. It concludes that the proposed penalties are grossly excessive and not supported by the totality of the evidence.

Findings and Conclusions

Fact of Violation--Citation No. 2339411

Austin Power is charged with a violation of mandatory safety standard 30 C.F.R. 77.1607(g), because the crane operator was not signalled, notified, or certain that the three employees on the 20Ämeter boom were in the clear before using the crane to move the 20Ämeter boom in a lateral direction. Section 77.1607(g) provides as follows: "Equipment operators shall be certain, by signal or other means, that all persons are clear before starting or moving equipment."

Although Inspector Summers stated that there was no regulatory standard specifically prohibiting employees working on moving equipment, he also stated that if he ever observed employees on a walkway 36 feet above the ground while a piece of equipment was moving, he would issue a section 107(a) imminent danger order, even though the employees were protected

by a handrail, because there would be a danger of falling from the unstable walkway while the equipment was moving. Further, the fact that the boom design was such as to permit free access to employees while performing work on or from the walkway cannot serve as a defense for failure by the employees to adhere to any applicable mandatory safety standards while at their work stations. By analogy, simply because a conveyor belt drive mechanism is designed to permit free access to an employee while servicing the belt does not absolve an operator from insuring that the drive mechanism is guarded pursuant to the applicable guarding standards.

Superintendent Woodson believed that section 77.1607(g) applied to the crane but not to the boom, and his interpretation of the standard is that it prohibited anyone from being on a load that is lifted off the ground by a crane and into the air. The crane operator was of the same opinion, and stated that at the time of the accident, the boom was being moved laterally left and right, and he was attempting to position it close to the cherry picker.

The crane operator testified that the boom was lifted by the crane some 5 to 6 inches to facilitate the removal of shoring, and that after "tracking it" in a westerly direction, the boom remained "dogged off" for approximately 5 hours while the counter-weights were being lowered in place by another crane. After the loading of the fifth counter-weight, he slacked the crane off and then picked it up again to get his chokers taut.

In referring to the boom, foreman Patterson stated that "I try to keep people off of anything like that, you know, as much as possible" (Tr. 249). Mr. Patterson also indicated that when the boom was lowered after the counter-weights were installed, he instructed the three employees to walk down the walkway on the opposite side of the boom where the accident occurred to check the clearance, and then ordered them back to the end of the boom. The boom was then "walked around" with the crane, and while it was moving, the three men proceeded down the walkway where the accident occurred following their previous instructions to hook the choker to the cherry picker. Mr. Patterson indicated that the three employees "had no choice" but to be there to install the choker.

Austin Power suggests that the crane operator was constantly monitoring the movement of the employees while on the moving 20Ämeter boom and that he was receiving signals throughout the day. While it is true that the crane operator was receiving instructions, and some hand signals were given

during the course of the day, the crane operator testified that the last signal he received from Mr. Smith was some 2Ähours before the accident occurred (Tr. 156). Further, although the crane operator confirmed that he knew the three employees were on the moving boom while he was attempting to swing it around to the cherry picker, he confirmed that his view was obstructed by the boom, and that the employees were on the back side of the boom and out of his line of sight while he was moving the boom with the crane. The crane operator also admitted that he was unfamiliar with any of the safety standards cited in these proceedings, and while conceding in retrospect that the three employees should not have been on the moving boom, he believed that their presence there was an "acceptable risk."

Austin Power's arguments that section 77.1607(g), does not apply to the facts of this case are rejected. I conclude that the standard must be construed to insure the safety of the men while on the moving boom which was being lifted and maneuvered about during the course of the work shift in question. Based on the evidence presented in this case, it seems clear to me that the operator of the crane had the boom under load and under his control while it was being lifted, lowered, and maneuvered about laterally during the performance of the work. Under the circumstances, I conclude and find that the crane operator had a duty under the standard to be certain that the men were clear of the boom which was attached to the crane before he moved it, particularly in this case where the men were out of his line of sight. I also conclude and find that foreman Patterson had a duty to instruct the men to leave the end of the boom before the crane operator proceeded to move it. Mr. Patterson admitted that the men "had been out there once before the load started moving and they were instructed to go back (Tr. 250). Under the circumstances, I believe that Mr. Patterson recognized the hazard presented while the men were on the moving boom, and while it is true that someone had to be there to install the choker, I believe that Mr. Patterson should have instructed the men to remain clear of the boom until it stopped its movement, and then allowed them to walk out to install the choker.

In view of the foregoing, I conclude that MSHA has established a violation by a preponderance of the credible evidence adduced in support of its case, and the citation IS AFFIRMED.

Fact of Violation--Citation No. 2339412

Austin Power is charged with a violation of mandatory safety standard 30 C.F.R. 77.1710(g), because three

employees who were working on the elevated 20Ämeter boom walkway some 36 feet off the ground were not tied off with safety lines. Although the evidence establishes that the three employees had safety belts and lines with them, none of them were tied off or secured. Section 77.1710(g), provides as follows:

> 77.1710 Protective clothing; requirements.
>
> 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; a second person shall tend the lifeline when bins, tanks, or other dangerous areas are entered.

During the course of the hearing, the inspector and MSHA's counsel conceded that the two employees who were not engaged in installing the choker at the time of the accident were not required to be tied off pursuant to sections 77.1710(g). Accordingly, I will confine my findings and conclusions to the circumstances surrounding the positioning of the accident victim on the walkway and whether or not he was in any danger of falling requiring him to be tied off.

Two precedential cases involving the interpretation and application of an identical safety belt standard as that presented in this case (30 C.F.R. 57.15Ä5), are relevant in these proceedings. In KerrÄMcGee Corp., 3 FMSHRC 2496, 2497 (November 1981), the Commission held that the purpose of the standard is the prevention of dangerous falls. In Secretary of Labor v. Great Western Electric Company, 5 FMSHRC 840 (May 1983), the Commission followed a previously enunciated "reasonably prudent person" test applied in Alabama ByÄProducts Corp., 4 FMSHRC 2128 (December 1982), and U.S. Steel Corporation, 5 FMSHRC 3 (January 1983). In the Great Western Electric Company case, at 5 FMSHRC 841Ä842, citing Alabama ByÄProducts Corp., at 4 FMSHRC 2129, the Commission stated as follows:

> [W]e conclude that the alleged violation is appropriately measured against the standard of whether a reasonably prudent person familiar

with the factual circumstances surrounding the allegedly hazardous condition, including any facts peculiar to the mining industry, would recognize a hazard warranting corrective action within the purview of the applicable regulation.

The Commission also stated as follows in the Great Western Electric Company case, at 5 FMSHRC 842 and 843:

> Great Western argues that the skill of a miner is a relevant factor in determining whether there is a danger of falling because the miner's skill defines the scope of the hazard presented. We find that such a subjective approach ignores the inherent vagaries of human behavior. Even a skilled employee may suffer a lapse of attentiveness, either from fatigue or environmental distractions, which could result in a fall. The specific purpose of 30 C.F.R. 57.15Ä5 is the prevention of dangerous falls. KerrÄMcGee Corp., 3 FMSHRC 2496, 2497 (November 1981). By adopting an objective interpretation of the standard and requiring a positive means of protection whenever a danger of falling exists, even a skilled miner is protected from injury. We believe that this approach reflects the proper interpretation and application of this safety standard.
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> * * * * * * * * *
>
> We conclude that, under the reasonable person test appropriately applied to the standard, substantial evidence supports the judge's finding of a danger of falling and a violation. The miner was standing on a ladder, his physical center of gravity was shifted to one side and both of his hands were preoccupied with installing a large light fixture. A slight shift in balance or lapse of attention might have resulted in a fall. In that event, the miner would not have been protected. His position twelve feet above the ground presented a substantial height from which to fall.

Although crane operator Crowell believed that the choker located at the end of the boom was installed by Mr. Smith

earlier in the day while the boom was resting on the cribbing, he was not sure which one Mr. Smith was installing when the accident occurred. Assuming Mr. Smith installed the choker at the end, Mr. Crowell believed he could have done it while on his knees reaching through the walkway mid-railing. Assuming Mr. Smith installed the other choker, Mr. Crowell indicated that it could be installed by lifting out the walkway grating and wrapping the choker around the walkway framing. However, if it were done in this fashion, Mr. Crowell believed that there was a chance of falling through the walkway opening left by the removal of the grating, and the person would be bent over into the opening. He confirmed that he had installed chokers in this manner in the past, but used a safety belt which was tied off.

Austin Power cited Mr. Crowell's testimony indicating that the employees on the walkway were protected by a "shed," and that they "would be like sitting in this chair tied off." While it is true tht the walkway had an overhead roof, the fact remains that the employes were not in a "shed" as that term is familiar to me, but were on a walkway 36 feet off the ground protected by a hand-rail which had openings between the railings. With regard to Mr. Crowell's characterization of the positioning of the employees as somewhat akin to sitting in a chair, he also indicated that they would be tied off. He suggested that if one were tied to the hypothetical chair and the leg broke, the fall would not be great because "I would still be tied to it." In the case at hand, the evidence establishes that while the employees were wearing safety belts, none of them were tied off to prevent them from falling off the walkway. As a matter of fact, Mr. Crowell conceded that while he would not tie himself off while simply walking along the boom walkway in question, he would do so once he stopped and reached his work station.

With regard to Austin Power's comments regarding the inspector's admission that he never wore a safety belt while inspecting the boom, the inspector believed that such a belt was only required while one was in danger of falling while performing a particular job task placing himself outside the protective handrails and not while merely walking down the walkway. Under the circumstances, the inspector's admission is not particularly relevant. The issue here is whether the accident victim Smith placed himself in a precarious position, and whether he was in danger of falling while performing work without being tied off or secured with a safety line. Since MSHA has conceded that the other two employees on the walkway were not required to be tied off, my findings and

conclusions here will be limited to the facts and circumstances regarding Mr. Smith.

Foreman Patterson testified that immediately prior to the accident he observed Mr. Smith kneeling on the walkway installing a choker around the walkway framing and under the grating. Mr. Patterson stated that he did not observe Mr. Smith actually lift the walkway grating, but saw him reaching under the mid-railing. He could not state how much of his body was actually through the railing, and he confirmed that company policy requires an employee to be tied off if he is outside the handrails. In these circumstances, and based on his 30 years of experience, Mr. Patterson did not believe that Mr. Smith was in any danger of falling, nor did he believe that he was required to be tied off.

Mr. Arent, one of the employees on the boom with Mr. Smith at the time of the accident, testified for MSHA on direct-examination that he observed Mr. Smith bending over the top of the handrail, with his hands beyond the railing and his head "just barely out," as he was installing the choker on to the end of the boom. On cross-examination, he changed his testimony and indicated that Mr. Smith was on his knees reaching between the middle and bottom handrail while tying another choker around the framing of the walkway inby the end of the boom. Mr. Arent believed that Mr. Smith's head was outside the handrail, but that his head and shoulders were not (Tr. 173). Mr. Arent was of the opinion that Mr. Smith would have been in danger of falling and needed to be tied off if he were leaning over the rail, but if he were on his knees reaching between the handrails he would be better balanced and would not need to be tied off because he would not be in any danger of falling.

A review of Mr. Arent's testimony reflects a degree of uncertainty as to precisely where Mr. Smith was positioned immediately prior to the accident, and his direct testimony that Mr. Smith was at the end of the boom leaning over the railing while installing a choker, is contradicted by his statement on cross-examination by Austin Power that Mr. Smith was at another location on his knees while installing a second choker. Austin Power's counsel attributed Mr. Arent's contradictory testimony to the fact that he was a subpoenaed MSHA witness, that he had never testified in cases of this kind, and that he was nervious. When asked to explain his contradictions, Mr. Arent responded "I don't know. Just the way the question was asked" (Tr. 171). I have reviewed the trial transcript and find that Mr. Arent's initial response

was in answer to a straightforward question asking him to describe what he observed (Tr. 163).

Mr. Arent is a young man who impressed me as a credible witness, and I find nothing in his demeanor to suggest that he lied as to where Mr. Smith was positioned at the time of the accident. Since he no longer works for Austin Power, and only worked there for 6 months, he had nothing to gain by lying. Mr. Arent was extremely nervous during his testimony, and considering the fact that the accident occurred a year or so earlier, I find his uncertainty and confusion understandable. Further, Mr. Patterson's testimony that he observed Mr. Smith on his knees near the choker which was tied to the walkway frame outby the end of the boom corroborates and lends credence to Mr. Arent's belief that Mr. Smith was not at the end of the boom, but at the location further inby where the second choker was tied to the walkway framing. Under the circumstances, I conclude and find that the evidence adduced in this case establishes that at the time of the accident, Mr. Smith was not at the end of the boom leaning over the railing, but was on his knees inby the end of the boom at the location where the choker had been tied to the walkway frame as described by Mr. Arent and Mr. Patterson.

Mr. Patterson testified that Mr. Smith was on his knees installing the choker around the walkway framing and under the grating, but he did not see Mr. Smith actually pick up the grating. Mr. Patterson also observed Mr. Smith reaching under the mid-railing, but could not state whether his body was actually through the railing. Mr. Arent testified that he observed Mr. Smith on his knees and believed that his head was through the railing, but that his shoulders were not. He also confirmed that Mr. Smith had his safety line with him but was not tied off. Crane operator Crowell testified that he often installed chokers in the manner attributed to Mr. Smith, and he indicated that one method of installing the choker would be to lift out the walkway grating. However, if this were done, Mr. Crowell confirmed there would be a danger of falling through the walkway opening and he would be tied off.

In describing the method for installing the kind of choker that Mr. Smith was installing while not tied off on the walkway, Mr. Patterson likened it to the swinging of a piece of rope under the walkway. He stated that Mr. Smith had tied the choker on and intended to loop it under the walkway to the other side and then catch it. He admitted that he was supervising Mr. Smith's work on the boom from ground level, and while he did not give Mr. Smith step-by-step

instructions as to how to go about the task of rigging the choker to the cherry picker, he conceded that Mr. Smith knew that the choker was required to facilitate the movement of the boom.

After careful examination of the photographic exhibits and the testimony in this case, I conclude that Mr. Smith's position on the walkway while in the process of installing the choker in question placed him in danger of falling. While on his knees, Mr. Smith's hands were obviously occupied in attempting to swing or loop the choker cable under the walkway to the other side. Mr. Patterson indicated that Mr. Smith intended to catch the cable on the other side. Mr. Smith would have had to act swiftly to swing the cable over the edge of the walkway and then move quickly to the other side to catch it. The testimony establishes that Mr. Smith was reaching under the middle railing of the walkway and that his head was beyond the railing. Mr. Smith was some 36 feet off the ground while performing the choker task, and I believe one can reasonably conclude that in the course of the work being performed as testified to by Mr. Arent and Mr. Patterson, Mr. Smith's body was partially outside of the railing. Since Mr. Smith was on his knees reaching under the middle railing, I find that the railing afforded him little protection and that he could have lost his balance while attempting to swing the choker under the walkway and fallen to the ground.

Under the circumstances here presented, I believe it should have been clear to a reasonably prudent person that a danger of falling existed and that Mr. Smith should have been tied off. This is particularly true here, where the evidence establishes that Mr. Smith was under the direct observation and supervision of rigging foreman Patterson. I conclude that a reasonable and prudent person in Mr. Patterson's position would have instructed Mr. Smith to tie off while performing the work of installing the choker in question.

Employees Arent and Crowell expressed ignorance of the MSHA safety standards cited in these proceedings. Mr. Arent stated that he knew he had to wear a safety belt and tie off and he learned this from weekly safety meetings conducted by Mr. White. Although Mr. Crowell indicated that he would tie off while at his work station, he further indicted that if he were up on a steel structure walking around without any walkway under him he would not tie off while moving about on the structure (Tr. 152). When asked why, he responded that "it is an acceptable risk." When asked his opinion as to why Mr. Smith was not tied off, Mr. Crowell responded that he was

sure that Mr. Smith did not believe he was in any danger (Tr. 150).

Foreman Patterson testified that company policy dictates that all employees who are required to perform work off ground level must have their safety belts on. However, he was not certain as to whether the policy requires the wearing of such belts while on a catwalk with handrails and toeboards. With regard to any policy requiring an employee to be tied off when his work takes him outside the guardrail, Mr. Patterson stated that this policy is communicated to employees through regular tool box safety meetings. However, he did not know whether this tie-off policy is in writing as part of the company safety rules, but that the policy requires anyone in an "unsafe area" to be tied off.

Superintendent Woodson confirmed that he is responsible for safety compliance at Austin Power's job site, and he identified copies of the tool box safety meetings conducted by company supervisor Jim White, and a copy of Austin Power's safety rules. However, Mr. Woodson confirmed that he does not personally conduct the meetings, and Mr. White did not testify. Although Mr. Woodson generally alluded to the fact that the use of safety belts and lines are discussed at the safety meetings, he offered nothing specific as to what detailed discussions may have taken place, particularly with respect to the circumstances under which employees are instructed to be tied off when working off the ground. A review of the records of the safety tool box meetings conducted by Mr. White simply reflects that safety lines, lanyards, and lifelines were included as topics of discussion.

With regard to the company safety rules (exhibit RÄ6), references to the use of safety belts and lines are found at the following places indicated:

III A. 3 (pg. 2)--PERSONAL SAFETY EQUIPMENT--
Wear safety belt and tie off in elevated areas not protected by guard rails.

VII B. 1 (pg. 14)--SAFETY BELTS are required to be worn and tied off when working on: (g) Generally any elevated work area that is without protection to prevent you from falling.

VII D. 2 (pg. 16)--SCAFFOLDING--Personnel must wear safety belts, properly tied off, on any scaffold platform not equipped with standard handrails or not completely decked.

X E. 1 (pg. 28)--STABILITY CONTROLÄPERSONNEL, MATERIALS, and EQUIPMENT. You must insure that your person, your material and your equipment are safe from unexpected movement--falling, slipping, rolling, tipping, blowing or any other uncontrolled motion. 1. Use Safety belts as required.

I find nothing in the company written safety rules that specifically requires employees to be tied off when they are working outside of handrails on an elevated walkway. As a matter of fact, the rules which require the wearing of safety belts and lines are only applicable in cases where an employee is working in an area not protected by handrails, and while Rule X E. 1 requires an employee to insure that he is safe from falling, it only requires that he use a safety belt as required. No mention is made of being tied off or secured by a lanyard. Further, while Rule E 7 requires the securing of tools, equipment and wrenches against falling when working at heights, the securing of the individual person against falling is not included. When viewed as a whole, I conclude and find that an employee working on an elevated walkway protected by handrails 36 feet off the ground can reasonably conclude that under the company safety rules as published he is not required to be tied off while performing work on the walkway. Since the rules provide no specific requirements that he tie off when his work requires him to lean over the railing or reach through the railing, the decision to tie off in those situations appears to be left to the discretion of the employee.

In view of the foregoing, and on the facts of this case, I find an absence of any specific guidelines or supervision on the part of Austin Power with respect to the subject of actual fall dangers confronting an employee while performing work outside of the confines of the protective railing of the walkway in question. Under the circumstances, I conclude that Austin Power may not avail itself of the defenses noted

in North American Coal Corp., 3 IBMA 93, 107, 1 MSHC 1130, 1134 (1974), and Southwestern Illinois Coal Corporation, 5 FMSHRC 1672 (1983), and its defense in this regard IS REJECTED.

In view of the foregoing findings and conclusions, I conclude and find that section 77.1710(g) is applicable in this case and that MSHA has established a violation. The citation IS AFFIRMED.

Fact of Violation--Citation No. 2339413

In this instance, Austin Power is charged with a violation of mandatory standards 30 C.F.R. 77.205(e) or 77.404(a), for allegedly removing the 20Ämeter boom walkway floor plates or grating clips or "hold-downs," thus rendering the walkways in less than good condition. The cited standards provides as follows:

> 77.404(a) Mobile and stationary machinery and equipment shall be maintained in safe operating condition and machinery or equipment in unsafe condition shall be removed from service immediately. (Emphasis added.)
>
> 77.205(e) Crossovers, elevated walkways, elevated ramps, and stairways shall be of substantial construction, provided with handrails, and maintained in good condition. Where necessary toeboards shall be provided. (Emphasis added.)

Superintendent Woodson suggested that during the construction of the spreader in question, the boom walkway grates need not be fastened or secured, but that once construction is completed, they do. In my view, the evidence here has established that the grating clips are necessary to preclude the walkway from popping up or moving out of its track. Mr. Woodson indicated that the grates are normally clipped, wired down, or welded in place to insure against any movement. Under the circumstances, I conclude that any failure to clip or secure the walkway grating may indicate that the walkway is not being maintained in good condition as required by section 77.205(e), notwithstanding the fact that the grates are positioned in a track and held in place laterally by angle iron. By the same token, failure to maintain the walkway grates in a clipped or tied down position could also result in the walkway being maintained in less than a safe operating condition as required by section 77.404(a).

Austin Power's suggestion that the walkway is not "a piece of equipment" within the meaning of section 77.404(a), is not well taken. The 20Ämeter boom is an integral part of the spreader, and both the spreader and boom fall within the category of "mobile and stationary machinery and equipment." The boom walkways are an integral part of the boom, and they also fall within this broad category as encompassed by the standard.

Austin Power maintains that the walkway grates were inherently safe simply by resting in place within the steel walkway framing protected from movement by angle irons which are an integral part of the framework, and that the lack of hold-down clips did not render the walkways unsafe or in less than good condition. In support of this conclusion, Austin Power cites the collective testimony of all of its witnesses who were of the opinion that even if the walkway grates were not clipped or secured in place, they were nonetheless safe.

Austin Power maintains that MSHA has advanced no credible evidence to support the charge that the clips had been removed, and argues that it was just as likely that the clips were dislodged along with the grates after being subjected to the violent whiplash force of the boom when it suddenly raised up and propelled the men into the air after the eyelet cable failed.

Before reaching any conclusions as to whether or not the lack of grating clips rendered the walkways unsafe or in less than good condition, a determination must first be made as to whether or not MSHA has advanced any probative or credible evidence to support the charge that Austin Power removed the grating clips, and that they were in fact removed and not in place at the time of the accident.

In support of its allegation that the clips were removed by Austin Power, MSHA relies on the testimony of Inspector Summers and the investigation report which he authored. However, the report is not evidence. The inspector's testimony regarding the alleged removal of the walkways and clips, and the alleged failure to resecure them, is based on his recitation of the results of his investigation as found under the "Discussion and Evaluation" portion of his report. Mr. Summers confirmed that he took no written statements from any of the individuals he interviewed during his accident investigation, and simply took notes (Tr. 137Ä138).

In his deposition of April 25, 1986, Inspector Summers stated that prior to the accident, it was his understanding

that "the walkway grating and the rest of the material that forms the catwalk, angle iron and everything, were in place" (Dep. Tr. 68). He also confirmed that during his investigation after the accident he found walkway clips on the ground. When asked how he knew that the grates which fell were not clipped prior to the accident, he responded "from looking at the other grating along the left-hand walkway" (Dep. Tr. 75). Referring to deposition exhibit SÄ7, he then explained that the "other grating" which was not clipped down was the grating located from "the end of the picture back to the pivot point of the machine." He stated that this grating was not totally secured by clips, and while it did not fall to the ground when the accident occurred "some kind of moved out of place" (Dep. Tr. 76).

Referring to his notes, deposition exhibit SÄ2, Mr. Summers identified the 14 sections of walkway grating after the accident and away from the scene of the accident which either had clips, no clips, or clips which were not secured (Dep. Tr. 105Ä107). Since the walkway grating on the right side of the boom was clipped and not thrown to the ground, Inspector Summers simply concluded that the walkway grates on the left side of the boom which fell to the ground were not secured by clips (Dep. Tr. 77).

Mr. Summers testified that during his investigation, Mr. Woodson, Mr. Arent, and the third person on the boom, Kevin Saulsburg, told him that the walkway grates at the location where the accident occurred had been removed and not resecured (Tr. 126Ä127). I have reviewed Mr. Summer's deposition and find no mention of any of these individuals. I have also reviewed the notes incorporated as part of the deposition, and find no mention of any of these individuals. Nor do I find any references as to who may have told Mr. Summers that the walkways and clips had been removed and not resecured, or that they were removed for painting. The only specific reference in the deposition on this question is a statement by Mr. Summers that he was told that the electrical people had removed the walkway or the clips in order to have access to certain electrial equipment under the walkway (Dep. Tr. 76).

Mr. Summers apparently made no effort to identify or contact the individuals who may have done any electrical work or painting, and MSHA's counsel apparently made no effort to call any of these individuals to testify. I find it rather amazing that the best evidence available during the investigation or hearing with respect to the removal of the walkway

grating and the failure to resecure it was not even pursued or developed.

Inspector Summers confirmed that representatives of the designer and manufacturer of the cross pit spreader were available at the site during his investigation, but that he did not interview or discuss the matter with them (Dep. Tr. 47). I assume that these representatives were available for depositions or subpoenas, and their testimony would be relevant to the issues concerning the effectiveness of the grating clips, whether they in fact secured the walkway to the steel framework of the boom or simply tied one piece of walkway grating to the other, and whether or not the force of the accident would have propelled the grating out of its channel, regardless of any clipping. However, none of these representatives were contacted by Mr. Summers during his investigation, and none were called to testify at the hearing.

Neither Mr. Arent or Mr. Woodson testified that they told Inspector Summers that the walkway grates were taken up by electricians or painters and not resecured. Mr. Arent testified that while on the walkway, he paid no attention to the grates and he could not state whether they were tied down or not (Tr. 164, 178). Mr. Patterson alluded to past instances in which the walkway grates may have taken up by electricians or painters, but in the case at hand, he stated that he was not aware that any electricians had any work to do in the accident area, and was not aware that the grates had been taken up (Tr. 201Ä202). Although he conceded that the grates "probably" would not have popped out if they were secured, and that someone "speculated" that the plates on the other walkway did not pop up because they were secured, he described the breaking of the eyelet cable as a "gigantic whiplash effect, or like a fishing pole" (Tr. 207Ä208).

Mr. Woodson admitted that during the course of construction, the grates are not always clipped down because ready access is required to complete the construction and the grates are inherently safe while snuggled into the iron framework channels. He also stated that all of the grating in question was clipped down "at one time" by putting extra people on this work and he indicated that "it is good policy to get it all clipped down" (Tr. 235). Mr. Woodson also stated that he was on the walkway 2 or 3 days before the accident and could not recall seeing any of the clips removed. However, he did not walk to the end of the boom at that time (Tr. 239). He indicated that when the grating is lying within its framework "it is just like one of those manholes in the street that you drive across every day" (Tr. 248).

Austin Power's counsel maintained that the grating clips are not designed to withstand major forces such as occurred in this case when the eyelet cable broke. He stated that the clips are not substantial pieces of equipment, and that they "are just to keep the things from moving one way or the other" (Tr. 246Ä247). He also indicated that no one knows what was clipped and what was not.

Inspector Summers characterized the sudden raising of the boom after the eyelet failed as a "sling shot" which tossed the three men and the walkway plates into the air (Dep. notes, exhibit SÄ2). He confirmed that he had no idea as to whether the force exerted by the boom was evenly distributed on both sides, and no such determination was apparently made during the investigation of the accident (Tr. 125). When asked why the remaining grating on the left walkway further back from the accident location did not fall to the ground (even though some were clipped down and others were not), he stated that this back area was subjected to a less violent action of the boom when the eyelet failed, and that is why they did not fall out (Tr. 124). This lends credence to Austin Power's argument that the violent action of the boom at the end of the walkway where the accident occurred may have caused the clips to be knocked loose.

After careful review and consideration of all of the testimony and evidence with respect to this citation, I conclude and find that MSHA has failed to produce any credible probative evidence to support the charge that Austin Power removed the walkway clips in question or that the walkways where the accident occurred were not secured by clips immediately before that accident. Under the circumstances the citation IS VACATED.

History of Prior Violations

Exhibit PÄ4, is a computer print-out listing Austin Power's civil penalty assessment record for the period August 19, 1983 through August 18, 1985. That record reflects that Austin Power paid civil penalty assessments in the amount of $450 for two citations, none of which are for violations of any of the standards cited in these proceedings. I conclude that Austin Power has a good safety compliance record, and I have taken this into account in assessing the civil penalties for the citations which have been affirmed.

Size of Business and Effect of Civil Penalty on Austin Power's Ability to Continue in Business

Superintendent Woodson stated that 30 employees were employed at the mine site in question (Tr. 210), and the parties stipulated that 41,012 man-hours were devoted to Austin Power's mining activities in 1985. Although Austin Power's counsel indicated that 700 employees work for the company, he explained that Austin Power's principal business is the construction of power plants, which is not normally considered "mining activities" under the Act (Tr. 13). Under the circumstances, for purposes of these proceedings, I conclude that Austin Power is a small mine operator, and this is reflected in the civil penalties assessed for the violation in question. Austin Power stipulated that the penalties proposed by MSHA will not adversely affect its ability to continue in business (Tr. 188). I conclude that the penalties assessed by me for the citations which have been affirmed will likewise not adversely affect Austin Power's ability to continue in business.

Good Faith Compliance

The parties stipulated that Austin Power demonstrated good faith in achieving rapid compliance after notification of the violations in question. I adopt this as my finding and conclusion on this issue, and it is reflected in the civil penalty assessments which I have made.

Negligence

I conclude that the violations which have been affirmed resulted from Austin Power's failure to take reasonable care to insure compliance with mandatory safety standard section 77.1607(g) and 77.1710(g), and that this failure on its part constitutes ordinary negligence. With regard to the safety line violation, since Mr. Patterson was supervising Mr. Smith's work on the boom and had him in view while in a position which placed him in danger of falling, Mr. Patterson had a duty to either order Mr. Smith away from his work location or instruct him to tie off.

With regard to the crane operator's failure to insure that the employees were clear of the boom, since the crane operator did not have the employees in view but knew they were on a moving boom performing work, he had a duty to insure that they were clear of the area before attempting to maneuver the boom with his crane. Had Mr. Smith been ordered away from the end of the boom or instructed to tie off his

safety line, he may not have fallen 36 feet and been killed when the eyelet failed.

I am not unmindful of the fact that the accident victim Smith had a safety lanyard with him, but failed to tie off. I am also cognizant of the fact that the accident which resulted in the death of Mr. Smith resulted from an unpredicted and unexpected failure of the eyelet. I have considered all of these factors in mitigating the civil penalties that I have assessed for the violations which have been affirmed.

Gravity

I conclude and find that the failure by Austin Power to insure that Mr. Smith and the other employees were clear of the boom while it was being moved, and to insure that Mr. Smith was tied off before proceeding with his work tasks constitute serious violations of the cited safety standards.

Significant and Substantial Violations

Inspector Summers found that the violations of sections 77.1607(g) and 77.1710(g) were significant and substantial violations. I agree with these findings, and conclude that the violations were significant and substantial. I believe the violations were contributing factors to the fatal injuries suffered by Mr. Smith. Even if the unexpected accident had not occurred, I would still find that the failure to insure that the employees were clear of the boom while it was being moved and the failure of Mr. Smith to tie off while in danger of falling presented a hazard and a reasonable likelihood of serious injuries.

Penalty Assessments

On the basis of the foregoing findings and conclusions, and taking into account the requirements of section 110(i) of the Act, I conclude that the following civil penalty assessments are appropriate and reasonable in these proceedings:

Citation No.	Date	30 C.F.R. Section	Assessment
2339411	8/20/85	77.1607(g)	$ 2,000
2339412	8/20/85	77.1710(g)	$ 2,500

ORDER

Austin Power IS ORDERED to pay civil penalties in the amounts shown above, and payment is to be made to MSHA within thirty (30) days of the date of this decision. Upon receipt of payment, the civil penalty proceeding is dismissed.

Citation No. 2339413, August 20, 1985, for an alleged violation of 30 C.F.R. 77.205(e) or 77.404(a), IS VACATED, and MSHA's proposed civil penalty assessment IS DISMISSED. Austin Power's Contest of this citation, Docket No. CENT 86Ä61ÄR, IS GRANTED.

Austin Power's Contests of Citation Nos. 2339411 and 2339412, Docket Nos. CENT 86Ä59ÄR and CENT 86Ä60ÄR, ARE DENIED and DISMISSED.

George A. Koutras
Administrative Law Judge