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SOUTHERN OHIO COAL V. SOL (MSHA)
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Federal Mine Safety and Health Review Commission
Office of Administrative Law Judges

SOUTHERN OHIO COAL COMPANY,
CONTESTANT

v.

SECRETARY OF LABOR,
MINE SAFETY AND HEALTH
ADMINISTRATION (MSHA),
RESPONDENT

CONTEST PROCEEDINGS

Docket No. WEVA 86-8-R
Citation No. 2557030; 9-10-85

Docket No. WEVA 86-9-R
Order No. 2564405; 2-10-85

Docket No. WEVA 86-11-R
Order No. 2564943; 9-17-85

Docket No. WEVA 86-35-R
Order No. 2564613; 10-10-85

Docket No. WEVA 86-36-R
Citation No. 2564615; 10-10-85

Docket No. WEVA 86-37-R
Citation No. 2564821; 10-9-85

Docket No. WEVA 86-38-R
Order No. 2705721; 10-16-85

Docket No. WEVA 86-39-R
Citation No. 2705722; 10-16-85

Docket No. WEVA 86-47-R
Citation No. 2705729; 10-21-85

Docket No. WEVA 86-48-R
Order No. 2706704; 10-22-85

Docket No. WEVA 86-49-R
Citation No. 2706709; 10-22-85

Docket No. WEVA 86-154-R
Order No. 2706772; 2-5-86

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SECRETARY OF LABOR,
MINE SAFETY AND HEALTH
ADMINISTRATION (MSHA),
PETITIONER

CIVIL PENALTY PROCEEDINGS

Docket No. WEVA 86-30
A.C. No. 46-03805-03685

v.

Docket No. WEVA 86-42
A.C. No. 46-03805-03686

SOUTHERN OHIO COAL COMPANY,
RESPONDENT

Docket No. WEVA 86-51
A.C. No. 46-03805-03688

Docket No. WEVA 86-54
A.C. No. 46-03805-03687

Docket No. WEVA 86-71
A.C. No. 46-03805-03690

Docket No. WEVA 86-75
A.C. No. 46-03805-03692

Docket No. WEVA 86-102
A.C. No. 46-03805-03700

Docket No. WEVA 86-264
A.C. No. 46-03805-03722

DECISION

Appearances: David M. Cohen, Esq., and David A. Laing, Esq.,
American Electric Power Service Corporation,
Lancaster, Ohio, for Southern Ohio Coal Company;
Susan Jordan, Esq., Office of the Solicitor, U.S.
Department of Labor, Philadelphia, Pennsylvania,
for the Secretary of Labor.

Before: Judge Fauver

Southern Ohio Coal Company seeks to have certain orders and citations vacated, and the Secretary seeks to have them affirmed and civil penalties assessed for violations charged in them, under the Federal Mine Safety and Health Act of 1977, 30 U.S.C. | 801, et seq.

Having considered the hearing evidence and the record as a whole, I find that a preponderance of the substantial, reliable, and probative evidence establishes the following:

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FINDINGS OF FACTS
WEVA 86-9-R and WEVA 86-30

1. Settlement proposed at the hearing was GRANTED. Order 2564405 will be AFFIRMED and a civil penalty of \$600 is APPROVED.

WEVA 86-37-R and WEVA 86-42

2. Settlement proposed at the hearing was GRANTED. Citation 2564821 will be AFFIRMED and a civil penalty of \$137 is APPROVED.

WEVA 86-39-R and WEVA 86-51

3. Settlement proposed at the hearing was GRANTED. Citation 2705722 is VACATED and the Petition for Civil Penalty will be DISMISSED.

WEVA 86-11-R and WEVA 86-75

4. Settlement proposed at the hearing was GRANTED. Order 2564943 will be AFFIRMED and a civil penalty of \$400 is APPROVED.

WEVA 86-38-R and WEVA 86-102

5. Settlement proposed at the hearing was GRANTED. Order 2705721 will be AFFIRMED and a civil penalty of \$550 is APPROVED.

WEVA 86-36-R and WEVA 86-54

6. Citation 2564615 was issued on October 10, 1985, by MSHA Inspector David Workman when he observed that the offtrack shuttle car roadway in 3 Butt Section had excessive mud.

7. The area affected was 180 feet inby the belt feeder including the entire four way intersection. The mud measured approximately twelve to sixteen inches in depth. The wet and muddy conditions made the steering of the shuttle cars difficult.

8. "A Notice to Provide Safeguards" had been issued on September 10, 1974, requiring that off-track haulage roadways "be maintained as free as practicable from bottom irregularities, debris, and wet or muddy conditons." It was still in effect at the time that the subject citation was issued.

9. The large accumulations of mud could affect the control of equipment driven through this area.

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10. The muddy conditions could have contributed to the cause and effect of a serious accident.

11. For abatement of the cited condition, the area was made safe by running a scoop through and removing the accumulation of mud.

WEVA 86-35-R and WEVA 86-102

12. On October 10, 1985, Order 2564613 was issued by MSHA Inspector David Workman when he observed that two brows of a boom hole in the roof of No. 4 entry of the 3 Butt section were not supported adequately.

13. The boom hole had been cut in the entry during the midnight shift of October 9, 1985. The area was being prepared as a belt transfer or dumping point. The hole was about three feet high and nineteen and one-half feet wide.

14. After the boom hole was cut, additional roof bolts were put in the top of the cavity of the hole. No new bolts were placed on any of the four brows of the boom hole. The bolts on the brows were there before the roof was cut.

15. On two sides of the boom hole a row of bolts was very close to the edge of the brows. The bolt plates were up to the edge. These bolts provided adequate support to two sides.

16. On each of the other two sides of the boom hole in by a row of bolts was much farther from the edge of the brow. On the right side, the bolts were 1' 2", 2', 1' 8" and 2' 2" from the edge. On the left side, the measurements were 2', 2' 5" and 2' 5". Inspector Workman and David Antock, the miners' representative, took these measurements at the time the order was issued.

17. The roof control plan for this mine does not provide specifically for the support of boom holes. However, it is a well established practice in the mining industry that roof support be provided as close to the edge of a brow of a boom hole as possible.

18. The lack of roof bolts near the edge resulted in two exposed areas of roof approximately fifteen and one half feet long and two and a half feet wide.

~2002

19. At the time of the order there was no imminent danger of a roof fall. However, given the size and weight of the unsupported areas, the type and history of the slate roof in this mine, and the heavy vibrations the area was subject to, it could reasonably be expected that parts or all of the exposed roof areas would fall at some point and result in serious injuries.

20. The bolting pattern was readily observable. The section foreman did not require the roof bolters to put additional bolts on the brows and ensure that the area was supported properly after the boom hole was cut. Furthermore, this area is required to be examined during pre-shift and on-shift examinations. The section foreman did not report that the brows were not adequately supported during any subsequent examination of the area.

21. For abatement of the cited condition, the area was made safe by installing bolts on the brows closer to the edge. This took approximately one-half hour.

WEVA 86-48-R and WEVA 86-102

22. Order No. 2706704 was issued on October 22, 1985, by MSHA Inspector David Workman when he observed a large piece of loose roof on the B-6 longwall section supply track inby the pumping station 150 feet.

23. The piece of loose slate roof was about 5 feet long, 30 inches wide and 4 inches thick. There was a gap between the remaining roof and the loose rock of one half to one inch for the entire length of the loose slate. The loose piece of roof could have fallen at any time.

24. The condition of the loose roof was obvious and very dangerous. The gap between the roof and rock could be observed when approaching from either direction.

WEVA 86-49-R and WEVA 86-71

25. Citation No. 2706709 was issued on October 22, 1985, by MSHA Inspector David Workman when he observed an unguarded opening on a tail gate motor on the 3-5 Longwall which exposed moving parts of the fluid coupler.

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26. The unguarded opening was 1-3/4 inches by 1-1/2 inches and large enough that a person's fingers could fit through it. The opening was located on the side of the coupler approximately two feet from the ground.

27. The exposed moving parts of the coupler moved at 178 RPM.

28. There was a reasonable probability of tripping in the area of the coupler in that the coupler was located in the walkway along the face conveyor which contained refuse, bottom irregularities and a number of rams that had to be stepped over.

29. There was a substantial risk that someone would accidentally put a finger or fingers into the opening and suffer a serious injury. To abate the condition, the opening was guarded by fixing a piece of rubber belting over the hole.

WEVA 86-154-R and WEVA 86-264

30. On February 5, 1986, Order No. 2706772 was issued by MSHA Inspector Harry Markley based upon his finding that a safe means of access was not provided and maintained to the power center located at the Grassy Run Portal.

31. The MSHA inspector and union walkaround observed wet, muddy and rocky conditions in the pathway that was used around the power center.

32. The walkway in front of the power center consisted of approximately eight feet of flat area. In this area the mud was knee deep in places and extremely slippery.

33. The pathway around the left side of the power center to the back consisted of a two foot rocky and muddy walkway along the power center and the dangered-off power cables for a distance of approximately forty feet.

34. From the edge of the power center walkway toward the open pit there was an increasing downward slope ending in a vertical highwall. The slope was 3 degrees for about 10 feet, then there was a slope of 22 degrees for about 12 feet, followed by a slope of 27 degrees for about 16 feet, ending in a sharp highwall that dropped vertically about 11 to 15 feet.

35. At least part of the two foot wide walkway between the power center and slope would need to be used in order to access the left back side of the power center where the power

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plugs were located. If someone came around the front of the power center, he would have to walk along the two foot wide path between the power center and pit to reach the power switches on the left back side. In the event he came around the back, he would need to walk around the power cables that were staked and wired off and then up the two foot path along the power cables to the left back side of the power center where the switches for the cables were located.

36. Due to weather conditions that time of year, the walkway around the power center was extremely wet and muddy. The slope between the pathway and vertical highwall was also muddy and not safe to walk on.

37. Access to the power center would be required at least twice a shift to energize the cables at the start of the shift and de-energize them at the end of the shift. If any problems with equipment were encountered during a shift, personnel would be required to travel to the power center more often to remove the power. Whenever a piece of equipment would break down, the power would have to be removed from the equipment to work on it.

38. The MSHA inspector and union walkaround observed two men working on the power center during the time that they were in this area. They were electricians who were repairing a problem with a ground fault system.

39. The power center had been in this location and in operation for approximately two to five days before the MSHA order was issued.

40. This area is required to be examined daily during on-shift examinations by certified personnel. The assistant shift foreman, John Vevilock, was responsible for this area and had conducted the on-shift examination that day. He was also working in the area at the time the order was issued.

41. The wet, muddy, rocky conditions in the walkway along side of the power center and trailing cables presented a slipping hazard.

42. The conditions around the power center presented a serious hazard that someone could stop or fall in the walkway and continue slipping down the incline into the pit below. A person falling down the slope and over the highwall could be seriously injured or killed.

~2005

43. All that was required to make the area safe was a guard rail or barrier to prevent a person from falling in the first place and keep him from slipping down the slope over the highwall in the event that he did slip and fall. The operator built a platform with guard rails between the power center and slope by the next day.

WEVA 86-8-R AND WEVA 86-75

44. On September 10, 1985, Citation 2557039 was issued by MSHA Electrical Inspector John Paul Phillips for a violation of 30 C.F.R. 75.503 on a five horsepower Flygt pump located in the face of the Number One heading on 1 North off 2 West Section

45. The citation stated that the pump was not maintained in permissible condition in that an input power cable to the controller was not entered through the entrance gland. In addition, the citation stated that the cable had been pulled out of the packing gland and only insulated wires were through the gland.

46. The operator does not contest that a violation of 30 C.F.R. 75.503 existed in that the input cable did not go completely through the packing gland of the controller. The operator does contest, however, the special findings of an unwarrantable, significant, and substantial violation.

47. The inspector entered the area to inspect the controller because of problems he had observed with other similar controllers in this mine. He was accompanied by Pat Grimes, union walkaround, and Kenney Moore, company representative. The inspector immediately observed that the controller was hung by its two cables which were looped on j-hooks in the roof.

48. It is recognized that the normal mining practice is to hang these control boxes from the roof by their handles which are on top of the boxes or by bolting brackets on the back.

49. The control box in question may or may not have had a handle on it, but it did have bolting brackets for mounting.

50. It is not considered good mining practice to hang the controller by its cables because strain is put on the input cables by the weight of the box. The control box itself weighs approximately thirty pounds.

~2006

51. The electrical inspector asked the union walkaround, Mr. Grimes, who is also a certified electrician, to take the controller down. As Mr. Grimes was about to do this, he noticed that one of the input cables was pulled out of the box. He specifically observed the insulated colored leads through the slot between the straining clamp and the outside of the box. He observed that the black cover of the cable did not go completely through the straining clamp into the control box. Mr. Grimes pointed out his observations to the inspector.

52. Once the controller was on the ground, the cover was removed by Mr. Grimes. The fact that the input cable did not pass completely through the wall of the controller, as is required, was confirmed. In addition, the inspector observed two other violations in the controller. These violations involved inadequate overcurrent protection and ground monitoring system. These violations were the conditions that the inspector was concerned with when entering the area because of similar findings on other controllers. The inspector issued citations for violations of 30 C.F.R. 75.518 and 75.902 for these conditions at the same time he issued the order at bar.

53. With respect to the citation at issue, the inspector and union walkaround observed that the input cable went to the straining clamp on the outside of the box but did not go through the packing gland. The packing gland consists of packing material made of asbestos between two rings. The input cable had to extend through the packing gland and into the controller in order to be permissible. It is uncontested that the input cable did not go through the packing gland.

54. The fact that the input cable itself did not extend through the packing gland and into the box was observable without the cover off since the colored leads of the cable could be observed coming out of the box in the small space between the outside of the box and the straining clamp.

55. Mr. Grimes, a certified electrician, attempted to enter the cable back into the control box. However, the cable would not fit through the inner ring of the packing gland. Mr. Grimes took the whole packing gland out of the box. It was apparent to him and the inspector that while the input cable could fit through the ring closest to the outside, it would not fit through the ring toward the inside of the box.

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56. Given the manner in which the control box was hung from its cables on j-hooks and the weight of the box itself, the pressure on the cable had caused the cable to slip farther back from the packing gland and exposed colored leads on the outside of the box. While the straining clamp was tight, it was not so tight as to prevent any movement of the cable. The straining clamp could not be too tight or it would affect the conductors inside.

57. Due to the fact that the input cable could not be entered completely through the packing gland and the existence of the other violative conditions that were cited, the operator made a decision to take the pump and its controller out of service and remove it to the outside of the mine.

58. When the control box was taken outside, it was not in the same condition as when it was first observed by the inspector, because attempts had been made to enter the cable through the packing gland into the box. Specifically, the colored leads could no longer be seen on the outside of the box.

59. The purpose of the pump was to dewater the face area in the section. It was energized at the time the inspector entered the area.

60. The pump and its controller are required to be examined during weekly permissibility inspections. The pump had been examined during a permissibility inspection by a certified electrician on September 8, 1985, two days before the citation was written.

61. In addition, this equipment is subject to daily examination during pre-shift examinations by the section foreman. The violative condition was not observed during any permissibility or pre-shift examinations.

62. The manner in which the controller was hung by its cables was easily observable. It is not a normal mining practice because of the strain put on the cables. The way the controller was hung should have resulted in closer examinations during pre-shift and particularly in permissibility inspections to make sure the cables were not pulled out of the explosion proof box. Closer examination would have resulted in observation of the exposed colored leads on the outside of the box

63. Permissibility standards require that the input cable extend completely through the packing gland into the control

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box so that no spark, fire, or explosion can escape the explosion-proof box. Given that the cable did not go through the packing gland and that there were other violations found in the control box, it could reasonably be expected that a fire, explosion or even spark would not be contained and could result in a mine fire or explosion. Serious injuries or even fatalities would be likely to result from burns or smoke inhalation.

DISCUSSION WITH FURTHER FINDINGS

WEVA 86-36-R AND WEVA 86-54

Citation 2564615 was issued by the inspector when he observed excessive mud in an off-track shuttle car roadway. The area cited was 180 feet in by the belt feeder and included a four way intersection.

The standard cited, 30 CFR 75.1403, provides the authority to issue and enforce special safeguards regarding transportation in coal mines when an MSHA official determines that they are needed. It reads:

Other safeguards adequate, in the judgment of an authorized representative of the Secretary, to minimize hazards with respect to transportation of men and materials shall be provided.

Safeguards written and approved under this section have the force and effect of a mandatory safety regulation. Following this section are general criteria to be used in promulgating special safeguards. Section 75.1403-10(i) contains criteria regarding off-track haulage roadways. It specifically provides:

Off-track haulage roadways should be maintained as free as practicable from bottom irregularities, debris, and wet or muddy conditions that affect the control of the equipment.

A "Notice to Provide Safeguard" was issued at this mine on September 10, 1974, by MSHA Inspector Raymond Strand. The Safeguard contains language identical to 75.1403-10(i). This safeguard was in effect at the time that the citation was issued.

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I find that the off-track roadway was not maintained as free as practicable from wet and muddy conditions that could affect the control of the equipment. Inspector Workman issued the citation after observing what he believed were excessive amounts of mud in a four way intersection. He stated that he did not specifically measure the depth of the mud or the size of the area affected, but that he walked around the area and walked out into the mud until it reached the top of his boots. He estimated that the mud was 12 to 16 inches deep and possibly up to 20 inches in places. He also testified that the entire intersection was affected and measured approximately 16 x 16 feet.

David Antock, the union representative who accompanied Inspector Workman during his inspection, corroborated his observations. He testified that the mud would have been over his boots if he walked out into it.

Respondent contends that the muddy conditions were not as bad as described by Inspector Workman and Mr. Antock. However, none of Respondent's witnesses actually measured the accumulations. Also, Inspector Workman was the only person who actually walked out toward the middle of the roadway. Mr. Antock observed him do this and saw him back out when the mud reached the top of his boots.

Both Inspector Workman and Mr. Antock testified that the muddy conditions would affect the control of a shuttle car. Both men have had significant experience operating shuttle cars and Mr. Antock worked as a shuttle car operator in this mine and had driven a shuttle car in this particular section as recently as a few days before the citation was written.

Inspector Workman and Mr. Antock observed a shuttle car operator in the area trying to clean out his car. The mud had come over the deck and into the car itself. Mud was observed around the tram handles and brakes. The mud would have to be at least six inches deep to come over the deck. Both felt that it would be extremely difficult to operate a shuttle car through the area without sliding. Accumulation of mud to this extent gets underneath and inside the car and affects the control and braking of the vehicle.

The violation was abated by scooping the mud out of the roadway. Mr. Antock, who was working on this section at the time of the hearing, indicated that cleaning up one to two times per shift is sufficient to keep the area clean and safe. He testified that recently the area was being scooped once at

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the beginning of the shift and once at the end and that the shuttle cars were not having problems through there. It takes about fifteen minutes to scoop the area when done on a regular basis.

The violation was significant and substantial. It was reasonably likely or reasonably foreseeable that a shuttle car traveling through the muddy conditions would slip and result in serious injuries to the operator or others in the area.

Considering the criteria of section 110(i) for civil penalties, the proposed penalty of \$157 is found appropriate for this violation.

WEVA 86-35-R and WEVA 86-102

Inspector David Workman issued Order 2564613 on October 10, 1985, pursuant to 104(d)(2) of the Act. He was conducting a regular inspection of the Martinka No. 1 Mine when, while proceeding through the No. 4 entry of the 3 Butt Section, he observed two brows of a boom hole that, in his opinion, were not supported adequately.

The standard cited is a broad safety regulation regarding roof control programs and plans. The part cited by the inspector and at issue here reads:

Each operator shall undertake to carry out on a continuing basis a program to improve the roof control system of each coal mine and the means and measures to accomplish such system. The roof and ribs of all active underground roadways, travelways, and working places shall be supported or otherwise controlled adequately to protect persons from falls of the roof or ribs.

The Secretary maintains that the operator violated 30 CFR 75.200 in that the brows of the boom hole were not supported adequately to protect against a roof fall.

I find that the inspector was correct in his conclusion that a violation existed based upon his observations. Inspector Workman observed the recently cut boom hole as he was traveling through the crosscut. He learned that it had been cut out with a continuous mining machine the day before and that this area was to be a belt transfer or dumping point. The

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cavity that was cut out to make the boom hole measured approximately three feet high by nineteen and a half feet wide. The boom hole was cut up into the roof and out to existing bolts. The hole was cut far enough out so that two sides had a row of bolts within several inches of the edge. However, the other two sides inby had bolts much farther from the edge. The bolts on the right side of the boom hole were 1' 2", 2', 1' 8" and 2' 2" from the edge and the bolts on the left side were 2', 2' 5" and 2' 5" away from the edge of the brow. The only new bolts installed were put in the top of the cavity.

Based on his observations, as well as his knowledge of this mine and his own experience, Inspector Workman found that the area had not been rebolted properly after the boom hole was cut. David Antock, the union representative who accompanied the inspector, agreed that the roof area had not been supported adequately.

Inspector Workman has been an MSHA inspector for fifteen years with a total of twenty three years of mining experience. He has had special training in roof control as an MSHA inspector. He has been conducting MSHA inspections at Martinka No. 1 Mine since 1977. Mr. Antock, the miners' representative, has worked at this mine for six years and for the last four years he has been a roof bolter in the section involved. Their opinions are accorded substantial weight based on their testimony, demeanor on the stand and their background. It is a recognized and well accepted practice in the underground coal mining industry that when a boom hole is cut out of the roof, the brows are supported by bolting as close to the edge as reasonably possible. Mr. Antock stated several times during his testimony that he has been told to bolt as close to the edge of the brow as possible by every foreman he has worked for as a roof bolter. He stated that he "would have bolted at the end of the brow...[f]or the reason that it keeps falling out, and that's where we've always been told..."

In the opinions of Inspector Workman and Mr. Antock, the distances between the bolts and the edge of the brow were too great to provide adequate support to the immediate area. The result was two exposed areas of unsupported roof measuring 15 1/2' x 1-1/2' on the right and 15-1/2' x 2-1/2' on the left side. Both men agreed that all of the bolts on the brow should have been within two feet to provide adequate support and the closer the better.

Respondent's witnesses recognized that bolting closer to the brow provides better roof support. Mr. Jon Merrified, the

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Respondent's Safety Director, stated that the bolts should be near the edge of the brow and "'near'" is not ten feet. 'Near' is not five feet. 'Near' could be somewhere in the vicinity of two feet, in my best judgment. And that's the way I would want to see it done, also." (June 19, 1986, Tr. 14.) He went on to comment that on average, boom hole bolts are placed "around one foot, four inches" from the edge of the brow and that "I would not have been satisfied if they weren't in the two to one and a half foot range." (June 19, 1986, Tr. 30.)

In addition to his knowledge of standard mining practice, Inspector Workman based his opinion on observations of the area and history of the roof of the mine. Although he did not observe any excessive breakage or cracks that would have signified an imminent danger, he did see several small loose pieces that he pulled down himself. Also, he was aware that the slate roof in this mine had a history of instability given its weight and lack of "interlocking" effect. He felt that given the weight of the slate rock on the unsupported brows, the roof would become loose, crack and fall. Mr. Antock stated that the roof has "never been stable there" and that a fall would have occurred if the roof were left in that condition without added bolts.

It should be noted that all that was required to make the area safe was several additional bolts on each of the two sides. It took approximately one half hour for a roof bolter to put in the new bolts.

The regulation, 30 CFR 75.200, requires adequate roof support. The order was issued because the inspector observed roof conditions which required additional roof support in his view. He believed that if additional bolts were not installed, the roof would have fallen in. His testimony and documentation are fully supported by the miners' representative and are sufficient to establish a violation in this case.

The Commission has recently restated its test for determining whether a violation constitutes an "unwarrantable failure to comply." In affirming Ziegler Coal Company, 7 IBMA 280, FMSHRC 1518 (1977), it held:

...an unwarrantable failure to comply may be proved by a showing that the violative condition or practice was not corrected or

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remedied, prior to the issuance of a citation or order, because of indifference, willful intent, or a serious lack of reasonable care.

United States Steel Corp., 3 FMSRHC 1424, 1434 (1984).

The Secretary argues that the inspector correctly issued the order in this case because indifference or a serious lack of due diligence or reasonable care was demonstrated by a number of actions attributable to the operator.

The boom hole was cut the day before, at the end of the midnight shift. After the boom hole was cut, only the top of the cavity was rebolted. There is evidence that the reason that additional bolts were not provided on the brows was the fact that the roof bolters could not get the roof bolting machine around the corners of the boom hole and under the two exposed brows. There was debris left in the area from the cutting of the boom hole. The belts were down at the time and the materials could not be cleared out until the next shift. In the meantime, the bolters came in to support the roof and could only get to the center of the boom hole. Inspector Workman stated that statements to this effect were made to him by Henry Paul at the time the violation was cited and by Mike Layman at a later date. These men were section foremen at the time. Mr. Layman stated that his crew would not have been able to get the roof bolting machine around the corners because of material left from the boom hole and that he may have told Inspector Workman that.

The foremen and roof bolters knew or should have known that additional bolts were needed closer to the edge of the brow. As discussed earlier, the fact that this is an established mining practice was clearly shown by the evidence. The action of the roof bolters who came to the area to abate the violation demonstrated that they knew that the bolts should be as close to the edge as possible. They placed additional bolts within one foot of the edge. When asked by Inspector Workman why they put the additional bolts there, they stated that is where they should have been. The foreman in charge of the crew at the time that the boom hole was cut should have observed the work and made sure the roof was rebolted and supported adequately. The fact that debris hampered additional bolting did not justify leaving the job incomplete. The failure to take further action demonstrated a serious lack of reasonable care.

In addition, the violative condition should have been observed during any one of the required examinations of the

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area after the boom hole was cut. This area is required to be examined during pre-shift and on-shift examinations. The examiners should have seen the inadequate bolting pattern and exposed areas of roof. Roof falls are the primary cause of fatalities and injuries and examiners should be trained to look for roof conditions that are unsafe or potentially unsafe. The failure to observe and take action in this case amounts to a serious lack of reasonable care.

These facts amply support the Secretary's claim that this violation existed due to a lack of due diligence or reasonable care on the part of the company.

For these reasons, I find that the allegation of an unwarrantable violation is supported by the evidence.

In order to establish a "significant and substantial" finding, it must be shown that:

...based upon the particular facts surrounding the violation, there exists a reasonable likelihood that the hazard contributed to will result in an injury or illness of a reasonably serious nature.

National Gypsum, 3 FMSHRC 822 at 825, 2 FMSHRC at 1203 (1981).

The safety hazard contributed to by this violation was a roof fall. Two of the brows had unsupported areas of approximately 15-1/2' x 2-1/2'. Both of these areas presented a danger of roof fall in the opinions of the inspector and Mr. Antock.

The inspector testified that it was his opinion that these unsupported areas could reasonably be expected to move and fall given the slate roof's weight and history of instability. Mr. Antock agreed. Both of these men, as well as the company's witnesses, were aware of roof falls and injuries at this mine Mr. Merrified confirmed that there were at least six injuries from roof fall accidents between July 1985 and the time of the hearing. In addition, this particular area was travelway and was being prepared to become a belt transfer point. This area would have become highly traveled while it was being set up, making the likelihood of injury greater.

In the event of a roof fall in this area, it was reasonably likely that there would be serious injuries. Inspector Workman testified that if either of the unsupported brows fell, there could be fatalities and other serious injuries.

~2015

As a general matter, roof support is of foremost concern inasmuch as roof falls frequently result in serious injuries to miners. In *Secretary of Labor v. Consolidation Coal Company*, 3 FMSHC 1187, 1190 (1984), the Commission acknowledged Congressional concern with the serious and frequent injuries which result from roof falls:

A prime motive in enactment of the 1969 Coal Act was to '[i]mprove health and safety conditions and practices at underground coal mines' in order to prevent death and serious physical harm. One of the problems that greatly concerned Congress was the high fatality and injury rate due to roof falls. The legislative history is replete with references to roof falls as the prime cause of the fatalities in underground mines. [Citations and footnotes omitted.]

Fatality statistics reveal that during the first three months of 1986, there have been eleven roof fall fatalities in underground coal mines in the United States. Four of those deaths have been in West Virginia. Current Report, BNA MSHR p. 457 (April 16, 1986). In 1982 through 1985, there were 37, 23, 34 and 18 fatalities, respectively, due to roof and rib falls. Roof falls are the leading cause of coal mine deaths. Current Report, BNA MSHR p. 141 (January 25, 1984); p. 316 (January 9, 1985), p. 305 (January 8, 1986). In 1981, roof falls in underground coal mines resulted in 37 fatalities, 778 nonfatal injuries involving lost workdays and 116 nonfatal injuries involving no lost workdays. Current Report, BNA MSHR p. 111-112 (July 28, 1982). These statistics establish that more miners die or are injured as a result of roof falls than any other type of accident including ignitions and explosions. Thus, Inspector Workman's concern that miners could be injured in a roof fall was well-founded. The Review Commission emphasized in *National Gypsum* that the inspector's "independent judgment is an important element in making 'significant and substantial' findings which should not be circumvented." 3 FMSHRC at 825-826. The inspector's conclusions in this case were based on his observations of the roof itself, the surrounding area, his knowledge of the mine and the number of employees who would have occasion to be in the area.

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I find that Inspector Workman made a careful assessment of the conditions he observed and reasonably concluded that the violation cited was "significant and substantial."

WEVA 86-48-R and WEVA 86-102

At the hearing and in prehearing exchanges, the parties stipulated that the violation of 30 CFR 75.200 charged in Order 2706704 occurred, that it was of such a nature as could significantly and substantially contribute to the cause and effect of a mine safety hazard, and that it was based on an underlying citation properly issued under 104(d)(1) of the Act. The only remaining issue is whether the violation was caused by an "unwarrantable failure" to comply.

The violation was obvious and very dangerous. A large piece of slate roof was loose, gapping down and could have fallen at any time. The loose piece of slate roof was approximately five feet long, thirty inches wide and four inches thick. A gap of one-half to one inch existed between the roof and loose rock. The condition was visible when approaching from either direction on the supply track. In light of the size, weight and looseness of the piece of slate, there could have been a roof fall at any time resulting in serious or fatal injuries.

This specific area along the supply track was required to be examined by a certified person during pre-shift and on-shift examinations.

The Secretary contends that the violative condition was allowed to develop into a very dangerous situation without being reported during examinations of the area. The Secretary submits that the fact that this obvious condition in a regularly used travelway went unreported and uncorrected amounts to a lack of due diligence, indifference or serious lack of reasonable care and is sufficient grounds for a finding of unwarrantability. The company contends that the condition occurred suddenly sometime between the time of the last examination and Inspector Workman's arrival in the area.

Both Inspector Workman and Mr. Antock testified that it was very unlikely that the roof could have gotten into this condition in the three to four hours since the last preshift examination. Based on their mining experience and familiarity with the-top in this mine, it was their opinion that movement of such a large and heavy piece of rock in a short period of time would have meant a major fall throughout the area. It was

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their opinion, based on their observations of the area that day, that the rock had moved gradually over a period of time and did not develop suddenly since the pre-shift examination of this area at 2:20 p.m.

In addition, both Inspector Workman and Mr. Antock stated that this area of the supply track is frequently traveled by crew members on their way to and from the supply truck during each shift.

Therefore, the Secretary argues that the facts amply support the allegation that this violation existed due to a lack of due diligence or reasonable care on the part of the operator.

Inspector Workman testified that:

Well, as I started to say a little bit ago, our guidelines say that if there are foremen who are in the area, then we are required if we find a violation like this to charge unwarrantable failure, and reasonably believe that the foreman should have known this condition existed or a condition and practice that exists throughout the area, conditions left unabated. [June 19 Tr., p. 2511.]

Because Section Foreman Jim Chiater and Longwall Foreman Fitzhugh were on the section, Inspector Workman believed they "should have known" of the cited condition. However, they testified that they checked the preshift report, which did not indicate a roof hazard, and did not see this area until after the order was issued.

The crew on the shift on which the order was issued did not walk through the cited roof area, but traveled in another entry to get to the dinner hole and later to get to the face. No one on the crew saw the cited area before the order was issued.

The gap in the loose slate, about one-half to one inch wide, contained no rock dust, indicating that the slate did not loosen over a substantial period of time.

I find that there is no direct or objective evidence supporting the allegation of an unwarrantable failure by

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Respondent. The Secretary has not met his burden of proving the allegation of an "unwarrantable" violation by a preponderance of the evidence.

Considering all the criteria for assessing a penalty, I find that penalty of \$25 is appropriate for this violation.

WEVA 86-49-R and WEVA 86-71

Citation 2706709 alleges a violation of 30 CFR 1722(a) for the failure to guard exposed moving machine parts of a fluid coupler.

The regulation provides:

Gears; sprockets; chains; drive, head, tail, and takeup pulleys, flywheels; couplings; shafts; sawblades; fan inlets; and similar exposed moving machine parts which may be contacted by persons, and which may cause injury to persons shall be guarded.

The fluid coupler has moving parts and is subject to the requirements of 1722(a). There was guarding around most of the fluid coupler, but a small opening exposed moving parts.

The size of the unguarded opening, its location and the speed of the moving parts, combined with the potential for tripping in this area, substantiate the inspector's finding that it was reasonably likely that someone would fall and lose fingers. I conclude that there was a violation, and that it was significant and substantial. Considering all the criteria for assessing a penalty, I find that a penalty of \$157 is appropriate for this violation.

WEVA 86-154 and WEVA 86-264

The operator contends that the degree of slope between the edge of the power center and high wall was no greater than an acceptable slope for refuse piles, and was actually purposely constructed to meet the guidelines for the construction of refuse piles in 30 C.F.R. 77.215(h). However, refuse piles that miners are permitted to walk on do not end in a sharp highwall dropping vertically into an open pit. The slope in this case was muddy, slippery and not safe to walk on. The danger of slipping and continuing to slide to and over the highwall required a guard rail or barrier under 30 C.F.R. 77.205

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The violation constituted an unwarrantable failure to comply with the requirements of 30 C.F.R. 77.205 in that the failure to provide a safe walkway around the power center at the time it was set up demonstrates a serious lack of care. In addition, the fact that this area had been examined during each shift every day that the power center had been in this location and that the foreman was working in this immediate area amounts to indifference or a serious lack of reasonable care. United States Steel Corp., 3 MSHA 1424, 1434 (1984).

The violation was of such a nature as could significantly and substantially contribute to the cause and effect of a slipping accident.

WEVA 86-8-R and WEVA 86-75

The operator violated 30 C.F.R. 75.503 by its failure to maintain the five horsepower Flygt pump in permissible condition. The operator concedes that the power input cable did not extend completely through the packing gland into the control box and therefore the pump was not in permissible condition.

The violation constituted an unwarrantable failure to comply with the requirements of 30 C.F.R. 75.503 in that the failure to install and hang the box properly demonstrates indifference or a serious lack of care. The manner in which the box was hung was unusual and put strain on the cable which caused it to pull farther out of the packing gland.

Furthemore, the failure to observe that the cable was pulled out of the box during at least the weekly permissibility examination demonstrates a serious lack of care. The manner in which the box was hung and the exposed colored leads should have been observed during examinations of the area.

The violation was of such a nature as could significantly and substantially contribute to the cause and effect of a mine fire or explosion.

Considering all the criteria for assessing a penalty, I find that a penalty of \$500 is appropriate for this violation.

GENERAL FACTORS

Southern Ohio Coal Company is a large operator with a history of a substantial number of violations within the

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24-month period before the first inspection involved in these proceedings. It made a timely and good faith effort to abate each violation found herein, after the violation was cited by the inspector.

CONCLUSIONS OF LAW

1. The Commission has jurisdiction in these proceedings.
2. Respondent violated the safety standard as alleged in each of the following citations and orders: Citation 2564615; Citation 2706709; Citation 2705729; Citation 2557039; Order 2564943; Order 2705721; Order 2564613; and Order 2706772.
3. With the exception of the allegation of "unwarrantable," Respondent violated the safety standard as alleged in Order 2706704.

ORDER

WHEREFORE IT IS ORDERED that:

1. In WEVA 86-30, Respondent shall pay the approved civil penalty of \$600 (settlement).
2. In WEVA 86-42, Respondent shall pay the approved civil penalty of \$157 (settlement).
3. Based upon the approved settlement to vacate the citation in WEVA 86-51, that proceeding is DISMISSED.
4. In WEVA 86-11-R and WEVA 86-75, Respondent shall pay the approved civil penalty of \$400 (settlement).
5. In WEVA 86-38-R and WEVA 86-102, Respondent shall pay the approved civil penalty of \$550 (settlement).
6. In WEVA 86-36-R and its related penalty case, WEVA 86-54, Citation 2564615 is AFFIRMED and Respondent shall pay the ASSESSED penalty of \$157.
7. In WEVA 86-49-R and the related penalty case, WEVA 86-71, Citation 2706709 is AFFIRMED and the Respondent shall pay the ASSESSED penalty of \$157.

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8. In WEVA 86-47-R and the related penalty case, WEVA 86-71, based upon the bench decision at the hearing, Citation 2705729 is VACATED and the Petition for Civil Penalty is DISMISSED.

9. In WEVA 86-49-R and WEVA 86-11-R and their related penalty case, WEVA 86-75, Order 2557039 is AFFIRMED and Respondent shall pay the ASSESSED civil penalty of \$500; Order 2564943 is AFFIRMED and Respondent shall pay the ASSESSED civil penalty of \$400.

10. In WEVA 86-38-R and WEVA 86-48-R and their related penalty case, WEVA 86-102, Order 2705721 is AFFIRMED and Respondent shall pay the ASSESSED penalty of \$550; Order 2706704 is MODIFIED to delete "unwarrantable" and as modified is AFFIRMED and Respondent shall pay the ASSESSED civil penalty of \$25; Order 2564613 is AFFIRMED and Respondent shall pay the ASSESSED civil penalty of \$1,000.

12. In WEVA 86-8-R and its related penalty case, WEVA 86-75, Citation 2557039 is AFFIRMED, and Respondent shall pay the assessed civil penalty of \$500.

13. In WEVA 154-R and its related civil penalty case, WEVA 86-264, Order 2706772 is AFFIRMED and Respondent shall pay the ASSESSED civil penalty of \$500.

12. All payments of the civil penalties ordered above shall be made within 30 days of this Order.

William Fauver
Administrative Law Judge

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