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

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

CIVIL PENALTY PROCEEDING

Docket No. KENT 86-101  
A.C. No. 15-02705-03587

v.

Camp No. 2 Mine

PEABODY COAL COMPANY,  
RESPONDENT

DECISION

Appearances: Thomas A. Grooms, Esq., Office of the Solicitor,  
U.S. Department of Labor, Nashville, TN, for  
Petitioner; Michael O. McKown, Esq., Henderson, KY,  
for the Respondent.

Before: Judge Fauver

This proceeding was brought by the Secretary of Labor for  
civil penalties for alleged violations of safety standards under  
the Federal Mine Safety and Health Act of 1977, 30 U.S.C. 801,  
et seq.

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

FINDINGS OF FACT

1. Peabody Coal Company is a large operator of coal mines  
producing coal for use or sale in interstate commerce.

2. The penalties proposed by the Secretary of Labor would  
not affect the ability of the operator to continue in business.

3. Camp No. 2 Mine is opened into the Kentucky No. 9 coal  
seam by one slope and six shafts. The coal seam is about 62  
inches thick.

4. On October 10, 1985, about 7:30 p.m., a methane explosion  
occurred in Camp No. 2 Mine, in the No. 1 unit, section 013. The  
explosion was in the No. 3 entry working place where a loading  
machine and shuttle car were operating. The shuttle car had just  
entered the working place and was

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being loaded when its trailing cable arced as it came through the sheave bracket, igniting methane. The explosive fire ball expanded into the first outby intersection then traveled back into the working place and once again went out into the intersection and was self-extinguishing. The explosion caused serious burn injuries to the loading machine operator and the shuttle car operator.

5. The MSHA accident investigation team began their investigation at the mine about 11:00 p.m., October 10, 1985. They gathered a number of eyewitness accounts, which may be summarized as follows:

(a) George Wallace, the loading machine operator, stated that he was in the process of loading a three-way place, and had just completed loading the fall of coal from the crosscut right of the No. 3 entry when the methane monitor deenergized the machine. The line brattice was extended to within approximately 10 feet of the face, and the power was restored to the loader. Wallace then began to position the machine in preparation to load the fall of coal at the face of the No. 3 entry when the explosion occurred.

(b) Harry D. Cowan, the shuttle car driver, stated that he had entered the working place and was in the process of being loaded when his trailing cable arced to the frame as the cable came through the sheave bracket. The methane fire ball traveled into the intersection of the last open crosscut, then back to the face of the No. 3 entry, and once again out into the intersection and was self-extinguishing.

(c) Jim Ashby, shot fireman was in the crosscut between No. 2 and No. 3 entries, and Donald Strouse, a unit helper, had just walked up to the outby side of the intersection. They saw the cable arc and ignite the methane. Ashby stated that as the flame came into the intersection the second time, he ran to the unit power center shouting to have "someone knock the power."

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6. Wallace sustained burns to his arms, back, face, and hands; Cowan sustained burns to his hands, left arm, and face. Coworkers administered first aid and the injured miners were transported to the surface and taken by ambulance from the mine to the Valley View Medical Center, Union County, Kentucky.

7. The No. 1 unit is a conventional mining unit. After blasting, coal is loaded into shuttle cars that dump onto a series of belt conveyors. The mine is developed by the room and pillar system of mining. Pillars are not extracted.

9. In the accident investigation, MSHA Inspector Louis Stanley found that the area was not adequately rock-dusted in that rock dust had not been applied to the roof, face, and ribs of the following places: No. 1 entry from the face outby for 50 feet, No. 2 entry from the face outby 55 feet (No. 3 entry was wetted down after the explosion and was too wet to sample for rock dust), No. 4 entry from the face outby for 50 feet, No. 5 entry from the face outby for 47 feet, and throughout the last open crosscut from No. 1 to No. 6 entries. Based on this condition, he charged Respondent with a violation of 30 C.F.R. 75.402, in Order No. 2507995, and MSHA assessed a civil penalty of \$750. Respondent did not contest this charge. The gravity of this violation was serious.

10. In the accident investigation, MSHA Inspector J.M. Larmouth tested with a multimeter across a 0.1 ohm resistor between the frames of the 480 volt A.C. loading machine and the 300 volt D.C. shuttle car and found that the level of D.C. millivolts was in excess of 150. Because of this condition, he charged Respondent with a violation of 30 C.F.R. 75.524, in Citation No. 2508383, and MSHA assessed a civil penalty of \$750. Respondent did not contest this charge. This was a serious violation that presented another possible source of ignition of methane.

11. In the accident investigation, MSHA Inspector T.W. Cullen found that the trailing cable attached to the shuttle car had exposed bare wires at one place. Because of this condition, Respondent was charged with a violation of 30 C.F.R. 75.517, in Citation No. 2508003, and MSHA assessed a civil penalty of \$750. Respondent did not contest this charge. This violation was serious. The exposed power wires apparently came into contact with the sheave bracket, causing

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an electric arc, which was the probable source of ignition of the methane. The arcing of the trailing cable could have been prevented, if the exposed wires had been properly insulated and protected from contact with other metal objects.

12. In the accident investigation, MSHA Inspector J.M. Larmouth tested the methane monitor on the loading machine and found that it did not work properly. When tested with a 2.5 percent mixture of methane, the monitor would not deenergize the power on the loading machine and the meter on the methane monitor did not register more than 1.75 percent methane when the tests were conducted. Because of the defective monitor, Respondent was charged with a violation of 30 C.F.R. 75.313Å1, in Citation No. 2508385, and MSHA assessed a civil penalty of \$2,000. Respondent at first contested this charge but settled at the hearing by withdrawing its contest and agreeing to pay the penalty of \$2,000. This was a serious violation. The methane explosion may have been prevented if the methane monitor had been operative and properly maintained.

13. In the accident investigation, MSHA Inspector Stanley found that permanent stoppings had not been installed in the third open crosscut between the intake and return entries. Because of this condition, Respondent was charged with a violation of 30 C.F.R. 75.316, in Order No. 2507994, and MSHA assessed a civil penalty of \$950. Respondent did not contest this charge. This was a serious violation. This condition could have allowed air in the intake entry to escape into the return entry, thus lessening the ventilation reaching the working face.

14. In the accident investigation, Inspector Stanley tested for ventilation at the site of the explosion and found there was no perceptible movement of air. When he attempted to take an air reading at the inby end of the line curtain, 10 feet from the working face, the vanes of his anemometer would not turn and a smoke tube test also failed to disclose any perceptible movement of air. Management had represented to the MSHA investigation team that the evidence at the accident scene had not been disturbed or changed. Based upon this representation and his findings at the scene, Inspector Stanley determined that the ventilation conditions he found were as they had existed at the time of the explosion. Accordingly, he issued Order No. 2507996, charging a

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violation of 30 C.F.R. 75.301Å1. This order was contested and is one of the two disputed charges in this proceeding.

15. In the accident investigation, Inspector Stanley found that there were no temporary stoppings (air locks) across Entries 2 and 3 immediately outby the tailpiece as required by the operator's approved ventilation plan. Because of this condition, Inspector Stanley issued Order No. 2507993 charging a violation of 30 C.F.R. 75.316. This order was contested and is the second disputed charge in this proceeding.

#### DISCUSSION WITH FURTHER FINDINGS

Order No. 2507996 (Ventilation at the Working Face)

This order charges a violation of 30 C.F.R. 75.301Å1, which provides that:

A minimum quantity of 3,000 cubic feet a minute of air shall reach each working face from which coal is being cut, mined or loaded

Inspector Louis Stanley, a Ventilation Specialist for MSHA, with many years experience, testified that during the accident investigation he could find no perceptible movement of air in the working place of No. 3 entry. He tested for air at the inby end of the line curtain with an anemometer and then with a smoke tube. He stated that the line curtain was in place, 10 feet from the face, and appeared to be tight and intact. The ventilation problem was that the curtain extended only about seven feet into the crosscut. Inspector Stanley stated that Peabody's failure to extend the curtain across the crosscut was the primary reason that there was no air movement at the inby end of the curtain in No. 3 entry. He stated that the line curtain was in very good condition showing no signs of scorching, burning, or tattering, and that neither the inby nor the outby ends were torn but were, in fact, cut smoothly.

Because the curtain looked surprisingly new, Inspector Stanley repeated his question to officialsÅincluding Mr. Douglas Rowans, the Mine Superintendent and Mr. Tom Barton, Assistant Superintendent, both of whom testified at the hearingÅwhether or not the scene of the explosion had been changed. The officials told him that the scene had not

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been changed. He relied upon their representations in determining that the ventilation conditions he found at the explosion site had existed at the time of the explosion.

Peabody's other witness, Carol Browning, the Section Foreman, testified to a different fact situation concerning the line curtain. He stated that he arrived at the scene a few minutes after the explosion, more than four hours before all the other hearing witnesses, who arrived as a group about midnight. Browning stated that he found the curtain pushed back into the crosscut and that it must have been blown back there by the explosion. He stated that he pulled the curtain along with him as he walked up to the working place of No. 3 entry, and rehung the curtain as he went along. He stated that he rehung the curtain in order to have oxygen as he checked and watered down the working place. He stated that he did not reanchor the curtain on the anchor provided, 10 feet from the working face, but merely looped the end of the curtain over a nail about 15 to 20 feet from the working face. He said that he did not tighten the overhead cable that the curtain hung on, and that the curtain sagged down from the roof in several places. He also said the curtain was scorched for two or three feet on one end, but did not have any holes (other than the eyelets provided for hanging the curtain).

Barton testified that the curtain was scorched in places, that it had some holes, and sagged in several places.

Rowans testified that the curtain was loose and sagged in places. He did not look at it closely to notice whether or not there were holes or scorching.

Browning did not tell anyone he had moved and rehung the curtain, until one or two weeks after the accident investigation. I find there was a strict obligation on the part of Respondent not to disturb or change the evidence at the explosion scene and, if any changes were made, to notify the MSHA accident investigation team of such changes immediately. Respondent may not be heard now to come in with a new version of the facts after the MSHA accident investigation with respect to changes in the evidence that were made by Respondent's own supervisor but not revealed to the MSHA investigation team. Moreover, the key to Inspector Stanley's finding of no air movement at the accident scene was the location of the curtain only seven feet into the crosscut, indicating that the air escaped into the crosscut

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and did not reach the working face. I credit Stanley's testimony as to the distance of the curtain's extension into the crosscut over Browning's estimate of the distance, and also over the estimates given by Peabody's other witnesses. The location of the curtain end only seven feet into the crosscut substantially shows that at the time of the explosion the curtain was inadequate to direct the required ventilation to the working face.

The evidence shows that Browning was in a nervous, emotional state after the explosion. His unit had just had a serious explosion, with severe burns to two miners, due to a number of negligent violations that could have been prevented by the exercise of reasonable care and that would point to his supervision. I do not find that Browning was in a state of mind to register matters very accurately or objectively in his memory, right after the explosion. Also, he did not make notes or diagrams and measurements of the conditions he observed. On balance, his recollections are not accepted as sufficient to rebut Inspector Stanley's recollection, notes and diagrams of what he observed in the working place and crosscut. The other witnesses, Barton and Rowans, also did not make contemporaneous notes or diagrams of the location of the curtain. No company representative objected when Inspector Stanley stated he was going to cite the company for a ventilation violation at the working face.

Respondent argues that Inspector Stanley's observations of the ventilation conditions at the face were not made while coal was being mined or loaded and therefore cannot sustain a charge of a violation of 75.301Å1, which requires 3,000 cfm of air at "each working face from which coal is being cut, mined or loaded" I find that mine management's representations to MSHA that the conditions of the accident scene had not been changed and Inspector Stanley's observation of the curtain extending only seven feet into the crosscut and his finding that there was no perceptible air movement at the face at the time of investigation justify a finding that this ventilation condition existed at the time of the explosion, when coal was being loaded. I credit Inspector Stanley's expert opinion, as a Ventilation Specialist, that the failure to extend the curtain across the last open crosscut in No. 3 entry was the primary cause of the lack of perceptible air movement at the face. I also find that this dangerous ventilation condition existed at the time of the explosion and was a major contributing factor in allowing the buildup of methane to reach an explosive degree.



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It is commonly known in underground coal mining that a mixture of 5% to 15% methane in a mine environment is explosive and will remain explosive without adequate ventilation. The purpose of the 3,000 cfm ventilation standard is "to dilute, render harmless, and to carry away, flammable, explosive, noxious, and harmful gases" (see section 303(b) of the Act). The evidence preponderates to show that Respondent violated the ventilation standard as charged in Order No. 2507996.

Peabody's compliance history shows that, in the 24-month period preceding the explosion, Camp #2 Mine was cited for approximately 50 paid violations of ventilation standards (75.300, 301, 301A1, 302, 302A1, and 316) many of which were significant and substantial violations, i.e., reasonably likely to result in serious injury to miners. The violation of the ventilation standard involved here contributed to a methane explosion that seriously burned two miners. It was a very serious violation that was due to a high degree of negligence.

Considering the six criteria for civil penalties in section 110(i) of the Act, I find that a penalty of \$5,000 is appropriate for this violation.

Order No. 2507993 (Air Locks Outby the Working Face)

This order alleges that "Temporary stoppings (air locks) were not erected across the Nos. 2 and 3 entry (neutrals) at a point just outby the belt tailpiece on the working section as required by the approved ventilation and methane and dust control plan" (Exh. 2A).

There is no dispute, as shown by Exhibits 4A and 3A, that the four temporary stoppings shown by horizontal lines were not in a straight line across Entries 2, 3, 4, and 5, as required by the approved ventilation plan (Exh. 3A). However, Peabody contends that a fifth temporary stopping, the vertical line stopping in Exh. 3A, was in place to prevent air leakage. If Exhibit 3A is accepted as fact, there was a technical violation of the ventilation plan, but it was not serious because the air was still locked in by the fifth temporary stopping. If Exhibit 4A is accepted as fact, there was a serious violation because the gap, shown in that exhibit, would have allowed the air to escape and reduce the ventilation at the working face where the explosion occurred.

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Inspector Stanley testified that he took an air reading at the last permanent stopping in the intake side of the unit and found 13,824 cfm (Tr. 41). He took an air reading on the return air side and found 11,742 cfm (see Exh. GÄ4AÄP, upper left side).

Rowans testified that he observed the area after the explosion and found five temporary stoppings as shown in Exhibit RÄ3ÄP, and that he made notes and a diagram of his observation when he exited the mine after he inspected the area. He also testified that, in his opinion, Inspector Stanley could not have measured 11,742 cfm in the return if there were a gap in the air locks because the air leakage would have caused a much lower reading.

Barton testified that he knew the fifth temporary stopping was in place because he look a group of teachers through the area that morning and he observed that all of the temporary stoppings (shown in Exhibit RÄ3ÄP) were in place (Tr. 135).

The MSHA inspectors entered the mine with management representatives Rowans and Barton (and others) and talked to them at different times while they made their accident investigation. However, the inspectors did not tell the management representatives what citations or orders would be issued until they all left the unit where the explosion had occurred.

Rowans testified that, when Inspector Stanley told Rowans and Barton that he would be issuing an order for a violation concerning the air locks, Barton immediately objected, stating that the air locks were there, but Rowans interrupted him, saying, "I know what he's talking about. \* \* \* They're not in a straight line." and with that, Inspector Stanley went on to the next charge (Tr. 191).

I find that there was not a clear communication to management representatives when Inspector Stanley told them what the mine would be charged with concerning the air locks. They did not understand that he was contending that there was a gap in the air locks, and even the written charge did not make that clear. Had Inspector Stanley made it clear to Rowans and Barton that he was contending that there was gap in the air locks that would let air escape, they would have had an opportunity to ask him to go back to the area with

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them to see the air locks that Rowans, Barton, and Browning say they observed and Rowans put in a diagram when he left the mine.

In light of this lack of clear communication, the failure of Inspector Stanley to give Rowans and Barton adequate notice of the nature of the charge so they could show him different evidence, and in light of the direct conflict of testimony and diagrams concerning the air locks, I find that the evidence does not preponderate in showing the number of air locks present at the time of the explosion. The evidence does show that four air locks were not in a straight line, and thus a violation of the ventilation plan, but the Secretary has not shown by a preponderance of the evidence that there was a gap in the air locks, i.e., that there was not a fifth air lock as shown in Exhibit RÄ3ÄP. I therefore find that the evidence establishes a technical violation of 30 C.F.R. 75.316. Considering the six criteria for civil penalties in section 110(i) of the Act, I find that a penalty of \$50 is appropriate for this violation.

#### CONCLUSIONS OF LAW

1. The Commission has jurisdiction in this proceeding.
2. Respondent violated 30 C.F.R. 75.301Ä1, as alleged in Order No. 2507996.
3. Respondent violated 30 C.F.R. 75.316 as alleged in section 12 ("Condition or Practice") of Order No. 2507993, but the Secretary did not prove by a preponderance of the evidence the allegations in sections 11, 20, 21ÄA, 21ÄB and 21ÄC of such order.

#### ORDER

##### WHEREFORE IT IS ORDERED:

1. The motion to approve settlement of Citation No. 2508385 for a civil penalty of \$2,000 is GRANTED.

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2. Respondent shall pay the above three civil penalties in the total amount of \$7,050.00 within 30 days of this Decision.

William Fauver  
Administrative Law Judge