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Federal Mine Safety and Health Review Commission (F.M.S.H.R.C.)
Office of Administrative Law Judges

GREEN RIVER COAL COMPANY,
INC.,

CONTESTANT

v.

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

CONTEST PROCEEDING

Docket No. KENT 87-167-R
Citation No. 2835650; 4/28/87

No. 9 Mine

SECRETARY OF LABOR,
MINE SAFETY AND HEALTH
ADMINISTRATION,
PETITIONER

v.

GREEN RIVER COAL COMPANY,
INC.,

RESPONDENT

CIVIL PENALTY PROCEEDING

Docket No. KENT 87-227
A.C. No. 15-13469-03612

No. 9 Mine

DECISION

Appearances: Flem Gordon, Esq., Gordon, Gordon, and Taylor, Owensboro, Kentucky for Green River Coal Company, Inc.; Mary Sue Ray, Esq., Office of the Solicitor, U.S. Department of Labor, Nashville, Tennessee for the Secretary of Labor.

Before: Judge Melick

These consolidated cases are before me under section 105(d) of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. 801 et. seq., the "Act," to challenge five citations issued by the Secretary of Labor against the Green River Coal Company, Inc. (Green River) and for review of civil penalties proposed by the Secretary for the violations alleged therein.

Citation No. 2835668 alleges a "significant and substantial" violation of the regulatory standard at 30 C.F.R. 75.302(b) and charges that "[a] violation was observed on the No. 7 unit section ID 007 in that the space between the line brattice and rib in the No. 1 entry was not large enough to permit the flow of a sufficient volume and velocity of air to keep the working face

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clear of flammable, explosive, and noxious gases, dust and explosive fumes."

The cited standard requires that "the space between the line brattice or other approved device and the rib shall be large enough to permit the flow of a sufficient volume and velocity of air to keep the working face clear of flammable, explosive, and noxious gases, dust and explosives fumes.

Citation No. 2835669 alleges a "significant and substantial" violation of the regulatory standard at 30 C.F.R. 75.301 and charges that "the air current reaching the face of the No. 1 entry on the No. 7 unit ID 007 was not sufficient to dilute, render harmless, gases and dust, and smoke and explosive fumes."

The cited standard provides in relevant part that "all active workings shall be ventilated by a current of air containing not less than 19.5 volume per centum of oxygen, not more than 0.5 volume per centum of carbon dioxide, and no harmful quantities of other noxious or poisonous gases; and the volume and velocity of the current of air shall be sufficient to dilute, render harmless, and to carry away, flammable, explosive, noxious and harmful gases and dust and smoke and explosive fumes." The standard also requires that "the minimum quantity of air in any coal mine reaching each working face shall be 3,000 cubic feet a minute."

The essential facts supporting the cited violations are not in dispute. Ronald Oglesby, an inspector for the Federal Mine Safety and Health Administration (MSHA), reported to the Green River No. 9 mine on April 7, 1987, at about 7:15 a.m. to investigate an alleged ignition and mine fire. After interviewing employees outside the mine Oglesby proceeded underground to the scene of the accident. Arriving on the No. 7 Unit at the No. 1 Entry Oglesby observed "slack coal" piled to within 18 inches of the mine roof in the space between the brattice and rib. He also found that the right tire of the cutting machine in the No. 1 Entry was pushed into the line curtain thereby further restricting the flow of air. (See Secretary's Exhibit No. 2).

Oglesby then recreated conditions as they reportedly existed at the time of the accident by removing an extension to the brattice curtain. Under these conditions Oglesby was unable to detect any movement of air upon testing with a calibrated anemometer. Even with the added curtain replaced Oglesby detected only 1,260 cubic feet of air per minute (C.F.M.) 4 feet in by the end of the line curtain. Near the right tire of the cutting machine where the curtain was pushed over he still found only 1,600 C.F.M. Once the slack coal had been removed and the

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curtain again extended Oglesby found legally sufficient air ventilating the face of the No. 1 Entry i.e. at least 3000 C.F.M. Within this framework of undisputed evidence both violations are clearly proven as charged.

Inspector Oglesby also considered the violations to be quite serious and "significant and substantial". Based on his interviews with Dwayne Oldham, the unit cutter operator, and Kathy Lambert, the shot fireman, Oglesby opined that the mine fire on the No. 7 unit earlier that day had been caused by a methane ignition further igniting hydraulic oil leaking from the cutting machine. Oldham reportedly told Oglesby that a sudden flash came over the cutting machine as he was beginning to cut. Kathy Lambert had also seen an orange flame on the back side of the curtain. The fire was located below the cutter bar at a location Oldham could not see from the operator's compartment. The fire had been extinguished with no injuries or property damage.

Green River Safety Director Grover Fischbeck was "hesitant to believe" that there had been a methane ignition, favoring the view that the hydraulic oil had been ignited directly by sparks from the cutting bar striking rock. However, regardless of the source of the fire it would be reasonably likely to expect, in the absence of adequate ventilation in a working section of a mine having an undisputed history of methane ignitions and recent overall methane liberation of 1.9 million cubic feet in 24 hours, that methane ignitions would occur. Indeed it is undisputed that the cutter machine had earlier on the shift twice "gassed-out" because of excess methane i.e. the methane detector on the equipment automatically shut the machine down because of high levels of methane. Under the circumstances it is reasonably likely that a methane ignition would occur with resulting serious burn injuries and fatalities. The violations were accordingly serious and "significant and substantial". Secretary v. Mathies Coal Company, 6 FMSHRC 1 (1984).

I also find that the violations were the result of operator negligence. There is no dispute that face boss Robert Sandidge was on the unit at the time of the accident. Sandidge also testified that there was adequate ventilation at the No. 1 Face at the time of his preshift examination (which commenced at 5:50 a.m. on April 7) and that he found only .4 percent methane 30 minutes before the cutting machine entered the No. 1 Entry. However the fact that the cutting machine had twice before the accident "gassed-out" because of excess methane should have placed Sandidge on notice of a methane problem requiring extraordinary care in maintaining adequate ventilation. Moreover the mine operator was already under a higher duty of care because of the history of methane ignitions at this mine and because of

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the overall high liberation of methane. The recent history of similar violations in this mine for inadequate ventilation and the failure to maintain adequate brattice curtains constitute patterns that may also be considered in finding operator negligence in this case.

Citation No. 2837677 alleges a "significant and substantial" violation of the operator's ventilation system, methane and dust control plan under the standard at 30 C.F.R. 75.316. More particularly Green River is charged with failing to have "the back-up curtain between No. 6 and 7 entry ... in place." It is not disputed that there was indeed no back-up curtain in position between the No. 6 and 7 entries as alleged and that such a curtain was required by the operator's ventilation plan (Secretary's Exhibit No. 6 page 4). The violation is accordingly proven as charged. It is also undisputed that the absence of this back-up curtain would have reduced the ventilation on the working sections. Considering the history of methane liberation, ignitions, and recent violations of ventilation requirements it is apparent that this violation also was serious and "significant and substantial". Mathies Coal Company, *Supra*.

In evaluating operator negligence I have given considerable weight to the credible testimony of Face Boss Robert Sandidge that the backup curtain was in position at the time of his preshift examination at 5:50 that morning. In addition I accept the testimony of Safety Director David Harper that a check curtain of the proper size was lying on the ground in an open position below where it should have been hung. I nevertheless find that the operator was negligent because a high degree of care was required in this section. There was a history of high methane concentrations and the methane detector on the cutter machine had already "gassed-out" the machine twice before on same shift. Under the circumstances management was on notice that methane levels were approaching dangerous concentrations and it therefore should have been on particular notice to maintain its check curtains to maintain adequate ventilation.

Citation No. 2837678 also charges a violation of the ventilation plan under the standard at 30 C.F.R. 75.316 in that "a permanent stopping had not been constructed in the third open crosscut from the face in the stopping line."

It is not disputed that a permanent stopping had not been constructed in the third open crosscut from the face in the stopping line. Green River maintains however that a permanent stopping was not required and that in any event the back-up curtain being used was adequate. Whether there was a violation in this instance depends on the applicable definition of "open crosscut". According to Inspector Newlin the definition of "open

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crosscut" that had been uniformly applied to Green River on prior occasions included a crosscut where air could pass through or a crosscut that was clean and travelable (i.e. supported). According to Safety Director David Harper the cited area was not an "open crosscut" because it had not been completely bolted and cleaned.

I find that the definition adopted by Green River is the more persuasive. It meets the "reasonably prudent person" standard. Alabama By-Products, 4 FMSHRC 2128 (1982); United States Steel Corp., 5 FMSHRC3 (1983). Inspector Newlin acknowledged that his definition was not accepted by some other inspectors and it is undisputed that MSHA approved a modification to the ventilation plan shortly after this citation which allowed a check curtain to be used in the cited crosscut instead of a permanent stopping. MSHA thus, in effect, acknowledged that there was no hazard in Green River's prior practice of utilizing a check curtain instead of a permanent stopping in the third open crosscut from the face. Under these circumstances it cannot be said that a reasonably prudent person, familiar with the facts, would have recognized a hazard in the practice here followed by Green River. Accordingly there was no violation and the citation must be vacated.

Citation No. 2835650, issued under section 104(d)(1) of the Act, alleges a violation of the standard at 30 C.F.R. 75.301 and charges as follows: (Footnote 1)

The quantity of air reaching the end of the line curtain in the No. 2 Entry on 7 Unit was 1,320 cfm CH 4.7. The loader was loading coal in this entry.

As previously noted, the standard at 30 C.F.R. 75.301 provides that "the minimum quantity of air in any coal mine reaching each working face shall be 3,000 cubic feet a minute." It is undisputed that there was only 1,320 C.F.M. of air at the end of the line curtain in the No. 2 Entry on the No. 7 Unit. Indeed, Green River now admits the violation, does not deny that it was "significant and substantial" and challenges only the "unwarrantable failure" findings.

The Secretary maintains that the violation was due to the "unwarrantable failure" of the operator to comply with the standard because "of the history of ventilation problems at this mine, and the apparent lack of concern by the operator while [Inspector Newlin] was on the unit". Newlin had found several other violations for inadequate ventilation shortly before discovering the instant violation (see Secretary's Exhibits Nos. 9 and 10). Indeed Newlin observed that 15 to 20 minutes had elapsed while the operator abated a prior citation (No. 2835649) and before he had moved on to discover the instant violation. During this time miners were continuing to load coal. Newlin also observed that it took only six minutes to improve the ventilation and to abate the instant violation.

It was apparently Newlin's position that Green River should have, upon the issuance of Citation No. 2835649 for deficient ventilation in the No. 1 Entry, not only abated that violation but also stopped all mining activity on the unit and checked the No. 2 Entry for sufficient ventilation. Newlin acknowledges however that after observing the abatement of the violation in the No. 1 Entry and as he proceeded to the No. 2 Entry he in fact did see two or three miners working to improve the ventilation affecting the No. 2 Entry even before he cited inadequate ventilation in the No. 2 Entry. In light of this evidence that Green River had commenced abatement even before the violation was cited I cannot find that the violation was the result of inexcusable aggravated conduct constituting more than ordinary negligence. *Emery Mining Company v. Secretary* 9 FMSHRC 1997, (1987). The violation was therefore not the result of "unwarrantable failure" and the 104(d)(1) citation must be modified to a citation under Section 104(a) of the Act. In light of the recent history of ventilation violations on this unit and the presence of high levels of methane I do find however that Green River was negligent. Under these circumstances it was under a heightened duty of care to maintain proper ventilation.

In determining appropriate civil penalties in this case I have also considered that the operator is of moderate size, has a moderate history of violations and abated the violative conditions cited herein as prescribed by the Secretary.

