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SOL (MSHA) V. M & J COAL
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Federal Mine Safety and Health Review Commission (F.M.S.H.R.C.)
Office of Administrative Law Judges

SECRETARY OF LABOR, MINE SAFETY AND HEALTH ADMINISTRATION (MSHA), PETITIONER	CIVIL PENALTY PROCEEDINGS Docket No. WEVA 87-199 A.C. No. 46-06225-03533
v.	Docket No. WEVA 87-200 A.C. No. 46-06225-03534
M & J COAL COMPANY, INC., RESPONDENT	Mine No. 1

DECISION

Appearances: William T. Salzer, Esq., Office of the Solicitor, U.S. Department of Labor, Philadelphia, PA, for Petitioner; W. Henry Lawrence IV, Esq., and Louis E. Enderle, Esq., Steptoe & Johnson, Clarksburg, WV, for Respondent.

Before: Judge Fauver

These are consolidated civil penalty proceedings in which the Secretary of Labor alleges violations of safety standards under the Federal Mine Safety and Health Act of 1977, 30 C.F.R. 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:

FINDINGS OF FACT

Citation 2699438 - WEVA 87Ä199

1. On November 16, 1986, at 3:20 p.m., MSHA began an investigation at Respondent's No. 1 Mine, in response to a report of a mine fire. MSHA Supervisor Raymond Ash was informed of the mine fire by John Markovich, superintendent of M & J Coal Company, by phone at 2:22 p.m., on November 16. Mr. Markovich informed Mr. Ash that the fire was located approximately 300 feet inby the opening to the mine. Mr. Ash issued a 103(k) order, closing the mine subject to an investigation of the fire by representatives of the Secretary.

2. An MSHA representative arrived at the mine site around 3:00 p.m. with methane and carbon monoxide detectors, and safety

gear. At that time, Mr. Markovich revised his statement regarding the location of the fire, placing it 1000 feet inby the pit mouth.

3. MSHA assisted Respondent on November 16 and thereafter by using carbon monoxide and methane detectors to test for the presence of explosive gases, providing technical assistance regarding the methods of building fire seals, providing self-contained oxygen equipment to individuals fighting the fire to protect them against smoke inhalation, providing expertise in testing the mine roof, which can weaken during a fire, providing a back-up team in the event of injury to the individuals fighting the fire, and by providing expertise in recommending the installation of additional phones for better communication.

4. Beginning November 11, and each day from November 11 through November 15, Mr. Markovich or C.J. Tharp, mine foreman, or both, observed smoke along the roof above the No. 1 tailpiece and No. 2 head drive. The smoke had a "sooty smell." The smoke originated from within the underground mine and was not drawn in from outside the mine. Respondent did not notify MSHA of a mine fire until November 16.

5. On November 11, Respondent's Mine No. 1 was not in production. The only persons who entered the mine on November 11 were Superintendent John Markovich and General Foreman C.J. Tharp. Mr. Markovich and Mr. Tharp entered the mine to check the operation of certain "stand pumps."

6. On November 11, Mr. Markovich and Mr. Tharp observed pockets of white or gray smoke along the mine roof near the No. 1 belt tail piece and No. 2 belt head. Mr. Markovich testified that he initially thought the smoke might be coming from a trash fire outside the mine near the mine intake fan. He investigated outside the mine but found no indication of a fire near the entrances to the mine.

7. Mr. Markovitch testified that, when he saw no evidence of a fire near the mine entrances, he began to suspect that a gob pile 100 to 200 feet from the pit mouth of the mine might be smoldering. On November 13 or 14, he ordered a DÄ6 caterpillar bulldozer brought in to doze the pile to see whether or not the gob pile was burning and producing smoke that might be pulled into the mine by the ventilation fan. He testified that they discovered that the gob pile was burning and producing smoke, and he ordered that the gob pile be dozed until the burning material was uncovered and extinguished. That operation took place on November 14, 1986.

8. The smoke in the mine did not dissipate after the dozing of the gob pile near the pit mouth and ventilation fan. Mr. Markovitch testified that he then began to suspect that the mine smoke (that was found each day) might be caused by a fire in

a gob pile that was owned by another company and lay on the surface over the area mined by M & J Coal Company. He testified that he thought that if there were a fire in that gob pile it might be forcing smoke into the mine through cracks in the coal seam, and that on November 15, in an attempt to test this theory, he caused three bore holes to be drilled through the gob pile and into the mine in order to sample the gob pile strata. The samples of the material brought up by the drill showed no evidence of burning or hot material in the gob pile.

9. On November 15, Mr. Markovich and Mr. Tharp continued to see white or gray smoke along the mine roof, deep within the mine.

10. Mr. Markovitch testified that on November 16, for the first time, he observed flames and dense black smoke in Mine No. 1 and immediately notified MSHA.

Order 2710147 - WEVA 87Ä200

11. On January 2, 1987, MSHA Inspector Richard Herndon inspected the No. 1 coal conveyor belt tail roller and the No. 2 coal conveyor belt drive and head roller. These were aligned so that coal would move from the No. 2 belt onto the tailpiece of the No. 1 belt. The No. 2 head drive supplied power and torque to move the No. 2 conveyor belt.

12. The tailpiece of No. 1 conveyor housed a 20Äinch diameter tail roller that rotated while the conveyor was in operation and extended 8 inches out from the tail piece. There was no guard over the roller; the exposed section of the tail roller was about 30 inches long, an area of about 290 square inches. The top of the tail roller was about knee level.

13. The head roller was about shoulder height and was 20 inches in diameter. It also was unguarded. The head roller was connected to the drive rollers by a conveyor belt, which also was not guarded. The length of exposed belt between the drive rollers and head roller was about 12 feet.

14. The drive motor for the No. 2 belt was provided with a gear guard, but the two drive rollers extended about four inches above the guarded motor and were exposed. These drive rollers rotated while the belt was in operation.

15. Individuals could accidentally come into contact with the above unguarded rollers and belt when they were in operation.

16. A walkway, with a maximum width of two feet, was adjacent to the No. 1 and No. 2 belts. It was used by persons coming to clean, monitor or service the belts. Persons using the walkway would be exposed to a hazard of slipping and falling into the belt drive, tail roller, drive rollers, or other exposed

moving parts. If an individual came into contact with such moving parts he or she could become entangled or pulled into the machinery causing a serious injury or even a fatality. At the time of inspection, the walkway was wet and slippery; this condition increased the likelihood of a slipping and falling accident.

17. No guards were provided for any of the rollers on the tight side of the No. 1 and No. 2 belts. Within reasonable probability, individuals assigned to perform clean-up or service operations on the tight side of the belts could have an accident and come into contact with a roller.

18. The conveyor belts were used between November 16 and the time of the inspection (January 2, 1987) to move supplies, such as parts, concrete blocks and bags of concrete, for the construction of fire seals. Workers who traveled near the belts were exposed to the unguarded moving parts. The mine was not in production during that period.

19. Respondent paid civil penalties for 20 violations from October 25, 1985, through November 15, 1986. No citations were issued during the above period for violations of 30 C.F.R. 1722 or 30 C.F.R. Part 50. Of the 20 citations, 15 were assessed as significant and substantial violations. No violations were charged in 1984.

20. Respondent's Mine No. 1 produced 34,470 tons of coal in 1985 and 38,171 tons in 1986.

DISCUSSION WITH FURTHER FINDINGS

Citation 2699438

On November 11, 1986, Respondent discovered white or gray smoke deep within its Mine No. 1. It did not notify MSHA of a mine fire. It checked outside the mine to see whether local residents were burning trash near the intake fan entrance to the mine. There was no indication of a trash fire. Respondent still did not notify MSHA of a mine fire. Over the next several days, Respondent investigated a number of possible sources of a fire outside the mine, without contacting MSHA. On November 16 Respondent saw flames and black smoke deep within the mine and notified MSHA of a mine fire. By that time, Respondent had a major mine fire on its hands; the fire continued to burn, and it was not until January, 1987, that the fire was sealed off and controlled so that part of the mine could be re-opened for mining. After the fire was reported to MSHA, MSHA provided substantial technical and safety assistance to Respondent to investigate, seal off and control the fire.

The regulations provide that a mine operator "shall immediately contact...MSHA" if an "accident occurs" (30 C.F.R.

50.10) and define reportable accidents to include "an unplanne mine fire not extinguished within 30 minutes of discovery" (50.2(h)(6)).

I conclude that smoke, with a sooty smell, found deep within an underground coal mine is a reportable mine fire within the meaning of the regulations if its source is not discovered and extinguished within 30 minutes. After Respondent saw smoke in the mine, and checked outside the fan entrance to the mine, but saw no evidence of an external fire, it was clear that it would not be able to discover the source of the smoke and extinguish it within 30 minutes of discovery. Therefore, Respondent had a clear duty to notify MSHA of a mine fire on November 11 and on each of the following days through November 16.

I do not agree with MSHA's allegations of low gravity and low negligence as to this violation. I find that Respondent showed gross negligence on November 11 by failing to report smoke found deep within its mine.

This was a serious violation, because it jeopardized the safety of persons who might enter the mine after the smoke was first discovered. This could include Federal or state inspectors or other persons in addition to the two men who in fact entered the mine at various times from November 11 through November 16. By failing to notify MSHA immediately, Respondent attempted to arrogate to itself the authority to exclude MSHA from investigating a mine fire, providing technical and safety assistance and, if needed, giving directions to protect the safety of persons attempting to discover the source of the fire and to extinguish or control it.

Considering Respondent's size, compliance history, and the other criteria in 110(i) of the Act, I find that a civil penalty of $400 is appropriate for this violation.

Order 2710147

Respondent contends that the regulation cited in this order (30 C.F.R. 75.1722) does not apply to unguarded machine parts that are not moving or energized at the time of the inspection. I reject this narrow interpretation of the standard. A preponderance of the credible evidence shows that from November 16, 1986, until the time of the inspection, in January, 1987, Respondent operated the conveyor belts without the required guards to transport parts and equipment to seal or control the mine fire. Personnel were exposed to serious hazards of accidental contact with moving, exposed machinery parts, as shown in the Findings of Fact. The risk of injury was accentuated by the existence of a narrow walkway, with a maximum width of two feet, alongside the head and tail rollers and the fact that the walkway was also slippery and wet, creating a reasonably high risk of slipping and falling into or against the exposed moving

machine parts. I uphold the allegation of a "significant and substantial" violation.

I also uphold the allegation of an "unwarrantable" violation. The guards were not provided for a substantial period, from at least November 16 until the time of the inspection, January 2, 1987. The violative conditions were visible throughout that time and should have been corrected by Respondent before the January 2 inspection.

Considering all of the criteria for civil penalties in 110(i) of the Act, I find that a civil penalty of $450 is appropriate for this violation.

CONCLUSIONS OF LAW

1. The undersigned judge has jursdiction in these proceedings.

2. Respondent violated 30 C.F.R. 50.10 as alleged in Citation 2699438.

3. Respondent violated 30 C.F.R. 1722 as alleged in Order 2710147.

ORDER

WHEREFORE IT IS ORDERED that:

1. Citation 2699438 and Order 2710147 are AFFIRMED.

2. Respondent shall pay the above civil penalties in the total amount of $850 within 30 days of this Decision.

3. The parties' motion at the hearing to approve a settlement concerning Citations 2710148 (civil penalty of $85), 2710149 (civil penalty of $85), and 2710151 (civil penalty of $58) is GRANTED, and Respondent shall pay those additional penalties (a total of $228) within 30 days of this Decision.

William Fauver
Administrative Law Judge