CCASE: FMC WYOMING V. SOL (MSHA) DDATE: 19880628 TTEXT:

Federal Mine Safety and Health Review Commission (F.M.S.H.R.C.) Office of the Administrative Law Judges FMC WYOMING CORPORATION, CONTEST PROCEEDINGS CONTESTANT Docket No. WEST 86-43-RM Citation No. 2647693; 11/23/85 v. SECRETARY OF LABOR, Docket No. WEST 86-44-RM Order No. 2647694; 11/23/85 MINE SAFETY AND HEALTH ADMINISTRATION (MSHA), RESPONDENT Docket No. WEST 86-45-RM Order No. 2647695; 11/23/85 FMC Trona Mine SECRETARY OF LABOR, CIVIL PENALTY PROCEEDING MINE SAFETY AND HEALTH ADMINISTRATION (MSHA), Docket No. WEST 86-110-M PETITIONER A.C. No. 48-00152-05535 v. FMC Trona Mine FMC WYOMING CORPORATION, RESPONDENT AND UNITED STEEL WORKERS OF AMERICA, INTERVENOR

DECISION

Appearances: James H. Barkley, Esq., Margaret A. Miller, Esq., Office of the Solicitor, U.S. Department of Labor, Denver, Colorado, for Respondent/Petitioner; James Holtkamp, Esq., VanCott, Bagley, Cornwall & McCarthy, Salt Lake City, Utah, for Contestant/Respondent; Stan Loader, Staff Representative, United Steelworkers of America, Rock Springs, Wyoming, Intervenor.

Before: Judge Cetti

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Statement of the Case

These consolidated contest and civil penalty proceedings arise under the Federal Mine Safety and Health Act of 1977, 30 U.S.C. 801 et seq., (1982) ("Mine Act"). The Secretary on behalf of the Mine Safety and Health Administration (MSHA) charges the FMC Wyoming Corporation ("FMC") with violating three regulatory safety standards. The three violations charged are based upon MSHA's mine inspector Robert Scheneman's November 19th inspection of FMC's Trona mine surface facility.

## Factual Background

FMC operates a trona mining and processing facility near Green River, Wyoming. The trona is found in thick underground seams. FMC extracts the trona from its natural deposits by using underground mining and in situ leaching methods. Adjacent to the mine is a large surface plant where the trona is processed into various products.

The citation and orders in these proceedings arise not from extracting or processing trona but from maintenance work done by FMC's maintence crew on the No. 3 turbine in the "Sesqui" powerhouse, located in the surface plant. The turbine is one of three turbines which are used to generate electricity for use at the surface plant. The turbines and associated boiler are enclosed in the powerhouse which has large doors on the west side for heavy equipment access.

#### STIPULATIONS

The parties stipulated as follows:

1. FMC is a large operator.

2. The violations were abated within the period proscribed.

3. Payment of the amended penalties will not impair FMC's ability to continue in business.

4. The operator's history of prior violations is average for an operator of its size.

Citation No. 2647693

This citation was issued under section 104(a) of the Mine Act on November 23rd by MSHA Inspector Robert Scheneman.

The citation alleges a violation of 30 C.F.R. 57.5002 which mandates the following:

Dust, gas, mist, and fume surveys shall be conducted as frequently as necessary to determine the adequacy of control measures.

In the citation MSHA inspector Robert Scheneman correctly states the facts as follows:

The company Industrial Hygienist was not notified when work was being started to remove the asbestos type

insulation from the No. 3 turbine in Sesqui Powerhouse. There were no surveys taken to determine if the people working were overexposed to asbestos. The Industrial Hygienist did take samples after the work was done and they were cleaning up.

This citation was modified from a 104(a) citation to a 104(d)(1) citation on December 12, 1985.

On November 4, a maintenance crew supervised by FMC foreman John Wilfong began the process of dismantling the No. 3 turbine for its scheduled 5Äyear overhaul.

The dismantling work began with the removal of the turbine covers and blanket insulation. The blanket appeared to be made of "grayish" fiberglass cloth 2 inches thick. It extended only along the flange area of the turbine cover. The blanket insulation was placed over the handrail behind the control room which is near the turbine.

Next the maintenance crew removed the flange bolts using a hydraulic wrench and separated the halves of the turbine. This process took approximately three days and entailed the chipping away of insulation around the bolts.

The insulation in the bolt area appeared to be a hardboard type mortar. As the insulation was chipped away, the pieces fell on either side of the turbine down to the first floor below. The mortar was enmeshed in chicken wire. Underneath the mortar were bricks of insulation, held in place by baling wire. The removal of the mortar insulation entailed cutting the chicken wire with pliers and chipping some of the mortar to loosen it from the bricks. The chicken wire with the mortar then fell underneath the turbine to the floor below. The brick insulation was removed by cutting the baling wire, allowing the bricks to fall to the floor beneath the turbine. The brick insulation was a soft chalky substance that would stick under a thumb nail if scratched. The mortar and brick insulation removal required approximately two to four hours of work. The total time taken to remove the insulation was about three days. The insulation debris was left scattered about the area for approximately two weeks.

It is undisputed that FMC did not take dust surveys during the three day period the maintenance crew removed the insulation nor during the following two weeks. It it also undisputed that MSHA never took any air samples at any relevant time.

During the bolt removal process, some dust was kicked up into the air. Before the bolt could be removed the crew had to use hammers to remove the second layer of insulation. This plaster like insulation was held together with chicken wire. It

was soft and would crumble when hit. As the material was broken up it was dropped or thrown to the floor below. As the insulation was dropped to the floor it created dust. One maintenance employee described the dust as a heavy flour type dust that would fly up when hit.

The maintenance foreman in charge of the crew was John Wilfong. He had been assigned the task of overhauling the No. 3 turbine by his immediate supervisor, Mike Hruska. Foreman Wilfong was asked by three members of his crew whether insulation they were handling contained asbestos, and whether it was safe to handle it. The foreman gave them vague assurances that it was safe. Hruska as well as Wilfong saw the insulation being removed from the turbine.

On November 18, 1985, FMC's industrial hygienist Carl Watson came to the Sesqui powerhouse to check on the work of an independent outside contractor who had a crew that specialized in removal of material containing asbestos. This crew wore protive clothing and equipment. This crew was engaged in removing insulation containing asbestos from the 61 foot high upstairs ceiling of the facility. The building was properly posted with warning signs. This ceiling insulation removal is unrelated to the citation and orders in this case except to show FMC awareness and attention to airborne hazards. During his November 18th check of the Sesqui powerhouse, FMC's industrial hygienist first became aware that insulation had been removed from turbine No. 3. He indicated to the foreman Mr. Wilfong that the insulation blankets could contain asbestos and asked that they be properly bagged. He also directed that the insulation on the floor below the turbine be cleaned up by wetting the insulation and putting it into plastic bags. Two employees cleaned up the insulation after it had been wetted down. Those engaged in the cleanup wore protective clothing with canister masks.

On the following day, November 19, 1985, MSHA Inspector Robert Scheneman was making a regular inspection at the FMC facility. The inspector came to the powerhouse to check on FMC personnel cleaning up insulation material taken off the turbine. When the inspector arrived at the No. 3 turbine he saw Carl Watson, FMC's industrial hygienist taking samples and observed the cleanup crew wearing protective clothes and masks cleaning up the insulation.

The mine inspector took a "grab" sample out of one of the bags of insulation, which he sent to Denver MSHA Tech Support for analysis. The report, petitioner's exhibit 1, indicates that the sample contained 4.4 percent amosite and .3 percent crysotile by weight.

FMC presented evidence that it had in place at the time of the issuance of the citation a policy regarding asbestos identification and cleanup (Ex. PÄ2, PÄ6). I am satisfied from the evidence presented that if the foreman Wilfong had been aware that the insulation contained asbestos or that had Mr. Watson the industrial hygienist had been aware that the insulation was being removed, that the appropriate policy guidelines would have been implemented.

Approximately 17 months before the issuance of the current citation and orders FMC's Industrial Hygienist, Mr. Watson, had distributed a memorandum dated July 1, 1985 to senior managers at the FMC plant. (Ex. PÄ3). This memorandum showed the results of sampling and analysis for asbestos in various materials located throughout the facilities. Included in the memo was the analysis of the No. 3 turbine insulation which showed that it contained asbestos. Mr. Hruska, the general maintenance foreman, an immediate supervisor of Wilfong, testified that he does not recall seeing the July 1, 1985, memorandum before the turbine overhaul began and consequently did not advise Mr. Wilfong that the No. 3 turbine insulation contained asbestos.

The cited safety standard, 57.5002, mandates that dust surveys be conducted as frequently as necessary to determine the adequacy of control measures. It is a broad general standard. Such a standard should be evaluated by reference to an objective standard of what actions a reasonably prudent person familiar with all the facts, including those peculiar to the mining industry, and the protective purpose of the standard, would have taken to provide the protection intended by the standard. Section 57.5002 is broadly written so as to be adaptable to myriad circumstances. This safety standard is of central importance in the crucial regulatory area of avoiding overexposure to airborne hazards.

Upon review of the entire record I'm satisfied and find that a reasonably prudent person familiar with the facts including those peculiar to the mining industry and the protective purposes of the standard would have conducted dust surveys to determine what control measures would be adequate to prevent the possible overexposure of the employees working with the insulation. Dust surveys should have been conducted during the three days the maintenance crew removed the insulation from turbine No. 3. Since respondent took no dust surveys during that period of time respondent violated and thwarted the protective purposes of the standard.

Without air samples there is no way to determine whether any employee in the maintenance crew was overexposed.

Respondent's contention that the application of 57.5002 is conditioned on a finding of exposure to airborne contaminants in

excess of the permissible limit defined in 57.5001 is rejected. The rationale of the Commission's decision in Tammsco, Inc., and Schmarje, 7 FMSHRC 2006 [3 MSHC 2026] (December, 1985) is not applicable to the facts and the safety standard charged in this case.

Section 104(d)(1) of the Mine Act provides that a violation is significant and substantial if it is of "such nature as could significantly and substantially contribute to the cause and effect of a coal or other mine safety or health hazard." 30 U.S.C. 814(d)(1). A violation is properly designated significant and substantial "if, based on the particular facts surrounding that violation, there exists a reasonable likelihood that the hazard contributed to will result in an injury or illness of a reasonably serious nature." Cement Division, National Gypsum, 3 FMSHRC 822, 825 (April 1981). In Mathies Coal Co., 6 FMSHRC 1, 3Ä4 (January 1984) the Commission explained:

> In order to establish that a violation of a mandatory safety standard is significant and substantial under National Gypsum, the Secretary ... must prove: (1) the underlying violation of a mandatory safety standard; (2) a discrete safety hazard -- that is, a measure of danger to safety -- contributed to by the violation; (3) a reasonable likelihood that the hazard contributed to will result in an injury; and (4) a reasonable likelihood that the injury in question will be of a reasonably serious nature.

The Commission has explained that the third element of the Mathies formulation "requires that the Secretary establish a reasonable likelihood that the hazard contributed to will result in an event in which there is an injury." U.S. Steel Mining Co., 6 FMSHRC 1834, 1836 (August 1984) (emphasis deleted). They emphasized that, in accordance with the language of section 104(d)(1), 30 U.S.C. 814(d)(1), it is the contribution of a violation to the cause and effect of a hazard that must be significant and substantial. Id. In addition, the evaluation of reasonable likelihood should be made in terms of "continued normal mining operations." U.S. Steel Mining Co., Inc., 6 FMSHRC 1573, 1574 (July 1984). Applying these principles to the instant case. It is concluded that the cited violation is not of a significant and substantial nature.

The Review Commission has ruled that "unwarrantable failure means aggravated conduct, constituting more than ordinary negligence, by a mine operator in relation to a violation of the Act." It based this conclusion on the ordinary term "unwarrantable failure". The purpose of unwarrantable failure sanctions with in the Mine Act, the Act's legislative history and judicial precedence. The Commission stated that whereas negligence is conduct that is "inadvertent," "thoughtless," "or

inattentive," conduct constituting unwarrantable failure is conduct that is "not justifiable" or "inexcusable". The Commission pointed out that by construing unwarrantable failure by a mine operator to mean aggravated conduct constituting more than ordinary negligence, can unwarrantable failure sanctions assume their intended distinct place in the Act's enforcement scheme. See Emery Mining Corp., 9 FMSHRC 1997, 2001, 2004 (December 1987) and Youghiogheny and Ohio Coal Co., 9 FMSHRC 2007, 2010 (December 1987). Applying these principles to the facts of this case I find that the violation of Section 56.5002 was not the result of FMC's unwarrantable failure to comply. The violation was caused by ordinary negligence. For purposes of determining the appropriate penalty, I would evaluate the degree of negligence at the upper range of ordinary negligence.

The evidence shows that FMC was not indifferent to the hazard of airborne asbestos. It had shown an awareness and attention to this hazard. As previously stated FMC had in place at the time of the issuance of the citations a policy regarding asbestos identification and cleanup (Exs. PÅ2 and PÅ6). FMC's industrial hygienist Mr. Watson distributed a memorandum dated July 1, 1985, to senior managers at the FMC plant regarding the results of various sampling and analysis for asbestos, including an analysis of the No. 3 turbine insulation (Ex. PÅ3). There is no evidence indicating that had the maintenance foreman been aware that the insulation contained asbestos or that had the industrial hygienist been aware that the insulation in the No. 3 turbine was being removed, that FMC's asbestos policy guidelines would not have been implemented.

The record also shows FMC was not indifferent to the hazards of airborne asbestos dust. At the time of the current inspection FMC had an independent contractor with a crew wearing protective clothes and equipment removing insulation containing asbestos from the ceiling of the building that housed the turbine. While ceiling insulation removal was unrelated to the citation and orders in this case it indicates FMC's awareness and attention to the hazard of airborne asbestos dust. These efforts to eliminate the hazard of airborne asbestos dust tend to support the conclusion that FMC's failure to comply with the safety standard in question was due to ordinary negligence rather than to aggravated conduct exceeding ordinary negligence.

For purposes of determining the appropriate penalty FMC's degree of negligence in violating the safety standard is evaluated as reaching the upper range of plain ordinary negligence. Considering FMC's large size, that the payment of appriate penalties will not impair FMC's ability to continue in business, that FMC's history of prior violations is average for an operation of its size, and the potential seriousness of the violation it is found that the appropriate penalty for FMC's violation of 57.5002 is \$600.00.

# ~829 Order No. 2647694

This Order was vacated at the hearing upon motion by the Secretary of Labor. The Secretary's counsel stated he had reviewed the applicability of the standard and the sufficiency of the evidence and determined not to proceed with Order No. 2647694 (failure to provide special protective equipment and clothing). The Secretary's motion to withdraw the proposal for penalty and vacate the citation was granted over the objection of the Intervenor.

## Order No. 2647695

This Order was originally issued by the mine inspector as a citation under section 104(d)(1) of the Act. The order alleges a violation of 30 C.F.R 57.18002(a)(b) which provides:

(a) A competent person designated by the operator shall examine each working place at least once each shift for conditions which may adversely affect safety or health. The operator shall promptly initiate appropriate action to correct such conditions.

(b) A record that such examinations were conducted shall be kept by the operator for a period of one year, and shall be made available for review by the Secretary or his authorized representative.

The MSHA inspector, in the citation alleges:

The people responsible for setting up this maintenance [sic] job failed to notified [sic] the people doing the work that they would be working with asbestos. Their company memo section 3Å(B) states that when they do work of this type, removing asbestos insulation while making repairs. The Industrial hygiest [sic] will be notified when this type of work is being done so he can observe the job and recommend protective equipment. They have a list of all places that have asbestos present. The place were [sic] the violation occurred was document [sic] on the list. They did not clean up after every shift. And placed in the proper container for disposal. This is a failure of the operator to take appropriate safety measure [sic] to insure that the employees were adequately protected. While working in this area. There were eight (8) people doing the work plus the foreman, and supervisor in this area. This job took from Nov. 4 to Nov. 18, 1985 with no protection provided. For the employees involved. There is no records [sic] showing off [sic] examinations of this area.

On December 12, 1985, Inspector Scheneman modified this citation to a 104(d)(1) order.

To establish a violation of 30 C.F.R. 56.18002 the Secretary must prove by a preponderance of the evidence that a competent person failed to make an examination of the working place or that no record of the examination was made. Upon careful review of the record I find that the Secretary failed to prove that there was no examination of the working place by a competent persons or that no record of the examinations were made.

The log of the examination of the Sesqui powerhouse during the period of the No. 3 turbine overhaul shows the date and shift on which the examinations were conducted and the name of the person conducting the examinations and the work places examined. This log was introduced into evidence by FMC as its Exhibit DÄ27.

FMC also introduced into evidence an MSHA program directive, dated November 20, 1979, in which MSHA clarified the record keeping requirements of the safety standards (Ex. DÄ26). The program directive specifies that the items that must be recorded in order to comply with record keeping requirements are:

- (a) the date and shift;
- (b) the person(s) conducting the examination; and
- (c) the working places examined.

The MSHA's program directives also specifies that:

Citations for violations of this standard are to be issued only where there has been a failure to conduct an examination of a working place or a failure to record that an examination has been done. The standard is not to be used to cite an operator for a hazard that is not specifically covered by another standard, or for a hazard that is already covered by another mandatory standard, or for imminent danger.

I'm satisfied that the program directive as it relates to this case correctly interprets the safety standard in the manner intended by its promulgator. On careful review of the record I find that the evidence presented at the hearing does not establish a violation of 30 C.F.R. 57.18002.

Conclusions of Law

1. The Commission has jurisdiction to decide this case.

2. Respondent violated the mandatory safety standard 30 C.F.R. 57.5002 as alleged in Citation No. 2647693. The appropriate civil penalty for this violation is \$600.00.

3. FMC's violation of 57.5002 was not significant and substantial and was not caused by FMC's unwarrantable failure to comply.

4. FMC did not violate 30 C.F.R. 57.18002(a)(b). Order No. 2647695 is vacated and the proposed penalty set aside.

5. Order No. 2647694 and its related proposed civil penalty, upon motion by the Secretary of Labor, are each vacated.

ORDER

Docket No. WEST 86Ä43ÄRM Docket No. WEST 86Ä110ÄM

Citation No. 2647693 as modified to a citation issued pursuant to Section 104(a) is affirmed and the respondent is ordered to pay a civil penalty of \$600.00 to the Secretary within within 30 days of the date of this decision.

Docket No. WEST 86Ä44ÄRM Docket No. WEST 86Ä45ÄRM Docket No. WEST 86Ä110ÄM

Order Nos. 2647694 and 267695 and their related proposed penalties are each vacated.

August F. Cetti Administrative Law Judge