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WESTERN FUELS-UTAH V. SOL (MSHA)
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Federal Mine Safety and Health Review Commission (F.M.S.H.R.C.)
Office of Administrative Law Judges

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| WESTERN FUELSÄUTAH, INC.,<br>CONTESTANT | CONTEST PROCEEDINGS |
| v. | Docket No. WEST 87-166-R<br>Order No. 2835325; 3/21/87 |
| SECRETARY OF LABOR,<br>MINE SAFETY AND HEALTH<br>ADMINISTRATION (MSHA),<br>RESPONDENT | Docket No. WEST 87-167-R<br>Citation No. 2835326; 3/22/87 |
| | Docket No. WEST 87-168-R<br>Citation No. 2835327; 3/22/87 |
| | Docket No. WEST 87-169-R<br>Citation No. 2835328; 3/22/87<br>Mine I.D. 05Ä03505 |
| SECRETARY OF LABOR,<br>MINE SAFETY AND HEALTH<br>ADMINISTRATION (MSHA),<br>PETITIONER | CIVIL PENALTY PROCEEDING<br>Docket No. WEST 87-251<br>A.C. No. 05-03505-03540 |
| v. | Deserado Mine |
| WESTERN FUELSÄUTAH, INC.,<br>RESPONDENT | |

DECISION

Appearances: Karl F. Anuta, Esq., Boulder, Colorado, for Contestant/Respondent;
Margaret A. Miller, Esq., Office of the Solicitor, U.S. Department of Labor, Denver, Colorado, for Respondent/Petitioner.

Before: Judge Lasher

The penalty case was consolidated with the four contest proceedings at hearing---which as reflected in the caption involve a Section 103(k) withdrawal order and 3 citations. The 5 dockets arise under and the Commission has jurisdiction pursuant to the Federal Mine Safety and Health Act of 1977, 30 U.S.C. Section 801 et seq. (1982) (herein the Act).

The four enforcement papers (order and 3 citations) were issued by MSHA Inspector Dale L. Hollopeter subsequent to the occurrence of a serious accident which occurred at approximately 9:25 a.m., on March 20, 1987, near the Deserado mine, an underground coal mine operated by Contestant/Respondent (herein Western Fuels) in Rio Blanco County, Colorado.

One of the citations (No. 2835327) charged that the alleged violation described therein was "significant and substantial". The other 2 Citations (numbered 2835326 and 2835328) did not contain "S & S" designations.

A. General Findings

The Deserado Mine is an underground coal mine located near Rangely, Rio Blanco County, Colorado. Coal is taken from the mine to a preparation plant from which it is transported for several miles to a train loadout area by an overhead conveyor (T. 27, 55, 153).

The parties, in addition to stipulations as to jurisdiction, admissibility of underlying documentation and mandatory penalty assessment criteria, also submitted the following written stipulations:

> a. On Friday, March 20, 1987, at about 9:25 a.m., a non-fatal powered haulage accident occurred on the County Road 78 at the Beltline Conveyor Overpass (CNVÄ2). Dale J. Ackerman, truck/light equipment operator, and Michael G. Smith, heavy equipment operator, were seriously injured when the Euclid, RDÄ50, end dump haulage truck, with the bed raised, struck the overpass, causing the truck to overturn onto its left cab side. The accident occurred because the haul truck operator failed to lower the truck bed after dumping refuse material at Pit 2/3 (Footnote 1)
>
> b. The accident was reported by the (mine) operator to the MSHA office in Glenwood Springs at approximately 12:00 noon on March 20, 1987.
>
> c. The No. 2 Beltline conveyor overpass is above County Road No. 78 and is used as a haul road by Western Fuels with express permission of Rio Blanco County and Bureau of Land Management.
>
> d. The No. 2 Beltline Conveyor overpass was not at the time of the accident marked and did not contain warning signals.

Inspector Hollopeter, who is stationed in Denver, was advised of the accident by his supervisor sometime after "noontime" on Friday, March 20, 1987. After packing, he drove from Denver to Craig, Colorado that afternoon. That night he prepared his equipment, etc. for the ensuing investigation, and the following morning traveled from Craig to the mine where he met with company and union officials at approximately 8 a.m. (T. 28Ä32). He was advised by Mine Superintendent John Trygstad that the haulage truck-with the bed thereof in the raised position--had struck the overland conveyor structure. At the conclusion of the meeting, Inspector Hollopeter issued the Section 103(k) Order-- based on what he was told at the meeting-- to insure the safety of the miners (T. 33Ä38, 55). Following the meeting, Inspector Hollopeter, accompanied by Western Fuels' Safety Director Jerry Kowlok, went to the accident scene, and then to Pit 2Ä3, i.e. the refuse pile (T. 40, 59).

It was Inspector Hollopeter's understanding, and I so find from the entire record, that Dale Ackerman, the driver of the 50Äton capacity truck on the trip in question, his second of the day (T. 132), started out from the preparation plant on March 20 with a load of refuse, proceeded down the 2Älane haul road (County Road 78) to the refuse pile (pit) where he dumped the refuse material, picked up passenger Smith, and was traveling back down the gravel-dirt haul road to the preparation plant when the accident occurred as above noted about 9:25 a.m. at a point about 1.75 miles from the pit (T. 41, 44Ä48, 132, 256Ä257). The speed limit on the haul road from the refuse pit (dump) is 30 m.p.h. (T. 256).

The accident occurred when the right side of the front of the "headache rack" (a protective part of the bed extending out over the cab to keep falling objects from striking the cab and the truck operator) struck the overpass structure (T. 60Ä61, 71, 362; Exs. MÄ11, 12 and 13).

The truck ended up on its left side following the accident; Michael G. Smith, an "authorized" passenger (T. 243, 260, 294, 295) was removed from the truck at 10:40 a.m. and Ackerman, whose lower left leg had to be amputated at the scene, was removed from the truck at 12 noon (T. 52Ä53, 116; Ex. MÄ14).

After his arrival at the accident scene (and the refuse pit), Inspector Hollopeter took various measurements and photographs of the truck, overpass structure, and accident scene (Ex. MÄ6 through MÄ13) (T. 41, 50Ä58).

The overpass structure (sometimes referred to as an overhead conveyor) extends over the haul road in an arch, the lowest point of which is 20.16 feet and highest point being 27 feet; there was a clearance of approximately 26 feet at the point where the truck struck it (T. 65, 68, 138, 141). The conveyor is in the center

of the structure itself with walkways on either side. One effect of the withdrawal order was to prohibit persons from walking on these walkways (T. 78). When the bed of the truck is raised it extends upward at a 60 degree angle and is about 28 feet 4 inches in height. The truck thus failed to clear the overpass by about 18Ä24 inches (T. 69 ). With the bed raised, there was thus no place the truck could have cleared the overpass (T. 70). In its travel position, i.e., with the bed lowered, the height of the truck is 14 feet 5 inches (T. 72).

B. Docket No. WEST 87Ä166ÄR

Validity of Withdrawal Order No. 2835325

The Order was issued pursuant to Section 103(k) of the Act which provides:

> "In the event of any accident occurring in a coal or other mine, an authorized representative of the Secretary, when present, may issue such orders as he deems appropriate to insure the safety of any person in the coal or other mine, and the operator of such mine shall obtain the approval of such representative, in consultation with appropriate State representatives, when feasible, of any plan to recover any person in such mine or to recover the coal or other mine or return affected areas of such mine to normal."

Subsequent to its issuance at 8:50 a.m. on March 21, 1987, the Order was modified four times by Inspector Hollopeter.

Western Fuels contends that the Order as modified, was improperly issued since its purpose was not to insure the safety of persons in the mine, but rather was intended to preserve evidence (T. 202). The Order itself charges no violation and MSHA seeks no penalty in connection therewith (T. 9).

The "Condition or Practice" involved in the Withdrawal Order was set forth by Inspector Hollopeter in Section 8 thereof as follows:

> The mine has experienced a nonfatal powered haulage accident on the surface haul road (County Rd. 78) at No. 2 Beltline Conveyor overpass. This order is issued to assure the safety of persons until an examination or investigation is made to determine the area is safe. An investigation party of company officials, state and county officials, safety committeemen are permitted to enter the area.

Section 15 of the Withdrawal Order, wherein the "Area or Equipment" to be withdrawn is to be described, was filled in by Inspector Hollopeter as follows:

> "The No. 2 Beltline Conveyor overpass structure 150 feet each side of the haul road and the haul road 150 feet easterly and westerly of the structure, except the southern portion of the haul road to permit traffic to pass."

Inspector Hollopeter issued the Order to ensure the safety of persons until an investigation could be conducted (T. 34Ä36, 142).

At 1:40 p.m. on March 21, 1987, the Inspector issued the following modification:

> 103(k) Order is modified to allow the operator to move the Euclid RÄ50 (Company No. 4) from the accident area to the shop area. Also, the closure of a section of this haul road is now removed from this order.

At 7:35 p.m. on March 21, 1987, this second modification (Footnote 2) was issued:

> The 103(k) Order is modified to show the area of the No. 2 Beltline Conveyor (overland conveyor) closure from the 150 feet on each of the haul road changed to just the No. 2 Beltline Conveyor Overpass structure and belt at the main supports north of the haul road to the main supports south of the haul road.

At 11:39 a.m. on March 22, 1987, this third and final modification was issued by Inspector Hollopeter:

> The 103(k) Order is modified to allow repairs to the No. 2 beltline conveyor overpass and operation of the conveyor belt this being based on the Chief Engineer opinion which was given and to allow repairs on the Euclid RÄ50 (Company No. 4) haulage truck, with stipulation that the District Office, MSHA, CMSH & H, Denver, Co., be notified of any defective item found and that we get a report of the damage and repairs done to the truck.
>
> If an independent shop is to do the repairs, we are to be notified so that we might be present during examination or testing.

One effect of the Withdrawal Order, as previously noted was to prohibit persons from walking on the walkways alongside the conveyor. The operation of the conveyor was also "closed" by the

order (T. 85, 86). The order did not prevent traffic on the haulage road (County Road 78) from travelingunder the overpass structure, and thus would not have the effect of preventing the same kind of accident from happening had another Euclid truck proceeded under the overpass with its bed raised (T. 80Ä85). This is a moot point, however, since there was only one such truck operating at the time-- the one involved in the subject accident (T. 87). The Inspector testified he also put an order on the truck to "prevent people from being in or around" it (T. 87Ä88) although this is not specifically reflected in Section 15 (Area or Equipment) of the order itself.

At the time of his initial investigation, Inspector Hollopeter did not know the truck was being driven-- why/or what caused the truck to be driven-- with the bed in a raised position (T. 73, 77). He considered the possibility that there was a malfunction which would have caused the bed to be in a raised position (T. 77, 151).

Inspector Hollopeter issued the first modification of the Withdrawal Order because the County wanted the truck moved and so that the truck could be moved off the road to the shop area allowing traffic to move in both directions (T. 151). At the time of its issuance he had not checked out and cleared the overpass structure for safety (T. 74Ä76, 142, 189). He described his concerns relating to the overpass as follows:

> "Just underneath, looking at the conveyor, I saw where -- the side which the truck had contacted, initially, and -- at the initial contact point, I saw, on the lattice work, where there was (sic) braces broken out, bent out. And, also, the I-beams were bent, twisted underneath it."
>
> (T. 77)

The Inspector was also concerned about the cracking of paint around the bolts of the overpass which may have been caused by the accident (T. 147Ä149 ). (Footnote 3)

Following issuance of the first modification which permitted removal of the damaged truck from the accident area, the Inspector again examined the conveyor structure. He testified as to what he observed:

> "On the easterly side of the structure, which was the side, which the haulage truck had initially contacted, I saw

> the lattice work bent, braces broken out completely on one end, and bent out. The metal, which was bent. For a distance along the bottom of the conveyor, I observed some of the I-beams going across underneath this structure, bent. Also, I notice on the opposite side of the impact area, paint which appeared to be cracked, which was apparently caused by the impact.
>
> Q. But, it was on the opposite side of the conveyor?
>
> A. Yes." (T. 89)

Surface Area Foreman Jack L. Monfrada described what he saw when he arrived as follows:

> "There was some beams and lattice work that was -- one lattice work was broke and pokin' up on the air, and you could see where these beams had been bent. They were horizontal beams, across the bottom of the structure.
>
> (T. 342)

After this visual examination and conducting interviews (T. 89Ä91) Inspector Hollopeter issued the second modification at 7:35 p.m. on March 21, 1987. He explained what led to issuance of the second modification:

> "Mainly, my understanding was that the company were (sic) havin' security people stay at that area to prevent people from goin' in the accident area -- or, under the 103K Order area. And, they'd have to keep people -- they said they was going to keep people there all the time. And, at that particular time, I didn't feet the Order should be lifted, because I had concern on the structure, but I felt the Order cold be modified to bring the distances in from 150 feet just to -- just so the Order would pertain to the overland conveyor structure, that went across the road. And, that -- that way you wouldn't need to have a -- anyone secure the area, or -- as far as havin' a person there all the time."
>
> (T. 90Ä91)

XXX XXX XXX XXX

> I was concerned about the amount of metal, which was damaged -- your braces, your I-beams, which were bent; the cracking of the paint, walkway, everything.
>
> I was concerned about if the conveyor was operated, how much -- this metal was fatigued -- there could have been maybe an accident, shortly thereafter, if it was turned on. Just -- I had concern.

Q. And, concern about the safety of anyone who might walk up on that conveyor belt?

A. Yes.

(T. 92)

The third modification was issued at 11:34 a.m. on Sunday, March 22, 1987, to permit Western Fuels to repair the conveyor belt, it being the opinion of Western Fuels Chief Engineer Mike Weigand that upon completion of such the conveyor belt could be safely operated (T. 92Ä94) Inspector Hollopeter remained concerned about the safety of the structure and wanted MSHA "technical support people" to examine it. The third modification thus continued MSHA control over this aspect of the matter. By letter he requested them to examine it and subsequently received a written report back indicating the structure was safe which led to issuance of a fourth modification of the Order in May, 1987 (T. 93Ä96, 98) which removed the structure from the effect of the Order (T. 97). At this point only the truck remained under the control of the Order (T. 98). Following further investigation of the truck and the Inspector's receipt of information that the truck had no indications of defective parts, malfunction, etc., Inspector Hollopeter terminated the subject Section 103(k) withdrawal order (T. 98Ä100).

Michael J. Weigand, Western Fuels' Chief Engineer at the Deserado Mine, testified that when he inspected the overpass structure on the day of the accident he observed that one of the diagonal braces had broken loose and there was "some damage" to the ends of some I-beams which run "roughly parallel to the road" underneath the structure (T. 363). He felt that the photographs in the record as exhibits CÄ5, 10, 16 and 17 accurately depicted the damage to the structure imediately after the accident (T. 362Ä368). Mr. Weigand indicated that his inspection disclosed a 5Äinch deflection of the structure the existence of which "was possible" before the accident (T. 371). He conceded that "there could be some effects from that accident" that could "weaken" the structure over the "longterm" (T. 373Ä374) and the relatively extensive repairs made to the structure after the accident were done because such were reimbursed by insurance, it took a shorter time to perform the repairs in that manner, and it was decided to do it "right" so that the structure would last its projected 30Äyear term (T. 374Ä376).

During the MSHA investigation in the 2Äday period following the accident, Mr. Weigand participated and gave his opinion to Inspector Hollopeter that the structure "was safe" (T. 377Ä378 ). It was also his opinion that the structure was not a "dangerous overpass" either before or after the accident (T. 386).

On cross-examination, this exchange, of some significance, between Mr. Weigand and MSHA's counsel occurred:

> Q. All right. And, you did tell Mr. Hollopeter, as I understand, that it was your opinion that there were some braces that should be replaced on this overpass?
>
> A. I felt that if immediate work was done, that that's the part that should have been done, yes. (T. 392)

Mr. Weigand also conceded the possibility that the cracked paint on the structure occurred as a result of the truck's impact with it (T. 396).

Maintenance Superintendent Anthony Lauriski described the damage to the overpass structure as follows:

> A. There was two trusses tore loose, and the hand rail was sort of bent in one spot, and there was some damage to the supports that go across and hold the walkway up (T. 410).

Western Fuels' Safety Instructor/Inspector David G. Casey, who in the beginning took charge of the rescue operation, described the damage to the structure this way:

> "We had a couple of cross-beams that were tore loose- they were vertical beams, and a few I-beams that had been bent."
>
> (T. 450)

Mr. Casey expressed the opinion that the overpass was not dangerous, perilous or risky either before or after the accident (T. 452, 461) for persons or vehicles to travel under or near (T. 461Ä462).

As to that part of the Order pertaining to the truck, Mr. Lauriski testified that he first "knew" there was no malfunction which would have caused the bed to raise (and thus cause the accident) when the valve was disassembled after the truck was taken to the repair shop (T. 419). This is supportive of the Inspector's judgment.

Although Western Fuels, in its Brief, repeats several times the charge that Inspector Hollopeter's issuance of the Section 103(K) Order was to "preserve evidence"- an allegedly unauthorized purpose, I find no direct or substantive support in the record, arguments or briefs for making such a finding. Inspector Hollopeter testified that he issued the subject order so that could "go in and look at the area to insure the safety of the miners" (T. 34). Scrutiny of the actions of the Inspector, from the time of his notification of the accident through his ensuing investigation and issuance of the Order and its three primary modifications, supports the contention of the Petitioner that "Throughout the course of the investigation, as Mr. Hollopeter learned more of the accident and investigated the

site, he was able to modify the order to keep in line with what he knew, while still ascertaining that no further injuries would occur." The nature of the possible hazards which the impact might have sustained to the structure (See Ex. CÄ2) and the possible problems with the truck which could have caused the bed to raise without operator negligence, all adequately evidenced in this record, would have made it irresponsible for the Inspector to have (1) proceeded without issuing the Order, or (2) to have terminated the Order prematurely. I find no support in the record for the proposition that the Order was issued either routinely or for the sole-or primary-purpose of preserving evidence pending a post-accident investigation. (Footnote 4)

Western Fuels' contention (Brief, p. 22) that "The inspector used a club when a simple "please' would have been sufficient," ignores the responsibility placed on the Inspector by the Mine Act to insure safety in such circumstances. (Footnote 5)

There being no admissions or substantive or probative evidence upon which to conclude otherwise, it is found that the exercise of discretion by the Inspector in issuing the Order and its modifications was appropriate in the circumstances and that such Order and its modifications should be affirmed.

C. Docket No. WEST 87Ä167ÄR

Citation No. 2835326

The "Condition or Practice" deemed a violation by Inspector Hollopeter was described in Section 8 of the Citation as follows:

> "The operator did not immediately contact the MSHA District or Subdistrict office having jurisdiction over its mine of an accident which had injuries to two miners which had reasonable potential to cause death. A non fatal powered haulage accident occurred on 3/20/87 about 9:25 a.m. in

> which an Euclid RÄ50 (Co No. 4) End dump haulage truck contacted the No. 2 Beltline Conveyor overpass and the two miners in the cab were seriously injured. MSHA Glenwood Springs, CO. field office was notified of the accident 12 p.m. on 3/20/87."

The standard alleged to have been violated was, 30 C.F.R. 50.10 (entitled "Immediate Notification") which is placed in the codification system of the regulations under Subchapter M (entitled "Accidents, Injuries, Illnesses, Employment, and Production in Mines"), under Part 50 thereof (entitled "Notification, Investigation, Reports and Records of Accidents, Injuries, Illnesses, Employment and Coal Production in Mines") and lastly under Subpart B thereunder (entitled "Notification, Investigation, Preservation of Evidence"). Section 50.10 provides:

> "If an accident occurs, an operator shall immediately contact the MSHA District or Subdistrict Office having jurisdiction over its mine. If an operator cannot contact the appropriate MSHA District or Subdistrict Office it shall immediately contact the MSHA Headquarters Office in Washington, D.C., by telephone, toll free at (202) 783Ä5582."

The issue posed by Western Fuels in connection with this Citation is:

> "Does an operator violate the immediate reporting obligation of the regulations where he delays advising MSHA for 2 hours while devoting full attention to the rescue of injured miners, and where the delay does not exacerbate the rescue efforts or hinder the subsequent accident investigation?" (Footnote 6)

It has been stipulated, and the record also reflects, that the accident occurred at 9:25 a.m. and that Western Fuels reported it to MSHA's Glenwood Springs Office at 12 noon (T. 107, 109, 448). This coincides with the 2 1/2 hour period of the

rescue operation (T. 111). Evidence of record (Ex MÄ5) indicates that passenger Mike Smith called in the accident on his two-way radio (hand-held pack-set) at approximately 9:23 a.m.

The first individual on the scene was a CocaÄCola delivery man. When he first arrived at the scene he thought no one was in the truck but upon investigation he saw and heard Mike Smith calling on the radio for help. When he heard no response to the first call for help, he got on Mike's radio and repeated the call for help. Immediately upon receiving the call that two miners were trapped in an overturned haul truck, the Western Fuels ambulance was dispatched and the Rangely District Hospital was notified at approximately 9:27 a.m. that their ambulance was also needed. The Rangely Rural Fire Protection District was also notified at this time. A Western Fuels Security Guard was dispatched immediately to the scene and arrived at 9:26 a.m. This security guard and the preparation plant foreman arrived in a Ford pickup (security vehicle).

Western Fuels' Safety Director at the time, Jerry Kowlok (T. 406), who did not testify, reported to Inspector Hollopeter that he contacted the Glenwood Springs office at about 12 noon and that he was "the only person designated to contact MSHA on an accident" (T. 109, 110, 339, 421, 447, 466Ä467). Mr. Kowlok did not make this report until after he had left the accident scene (T. 448, 459, 460). Mr. Kowlok had a radio at the scene of the accident, was in contact with his security base which had a telephone, and thus had the means by which to immediately notify MSHA of the accident (T. 335Ä336, 406, 429Ä430, 434, 459Ä460, 468Ä469).

Some of the general purposes of immediate notification are (1) determination of the type of accident, (2) getting the nearest available MSHA inspectors to the accident site, (3) allowing MSHA the opportunity to supply expertise to the situation as well as special equipment and special rescue teams, and (4) prevention of future accidents (T. 109Ä110). According to the Inspector, however, no such rescue teams, etc. were actually available for use in rescuing the two miners trapped in the truck in the instant situation (T. 176Ä180). On the other hand, MSHA was deprived of any opportunity to immediately investigate or be present at the accident site to assist in rescue or attempt to prevent further injuries. There was no allegation or evidence that notifying MSHA would have been a futile act i.e., that based on past inept performances by MSHA in accident situations, that Western Fuels was justified in believing a 2 1/2 hour delay would make no difference.

Further, there was no evidence presented that it was impossible- or even difficult- for Western Fuels to have notified MSHA imediately (T. 335Ä340, 341, 361, 406Ä408, 420, 428Ä432, 460, 466Ä468). There clearly was available the means of

communicating with MSHA and various management and other personnel available to do it. It is thus concluded that the violation as charged in the Citation occurred and that Western Fuels was negligent in the commission of such. The regulation infracted constitutes a highly important aspect of mine safety process and enforcement in terms of both accident investigation and assistance and is eroded only at considerable cost in the perspective of future accidents and tragedies. The importance of this regulation is related to the role Congress has mandated for inspectors in the Act itself (See Sections 103(j) and (k) thereof). Although the probability that the delay did not affect rescue or investigation processes, the humanitarian interests of Western Fuels' personnel, and the emotionally traumatic aspects of the incident itself are to be inferred from the record overall and stand in some mitigation of the considerable seriousness and culpability to be attributed to the violation, (Footnote 7) the $20 penalty sought by the Secretary, being but a token sum, is not considered appropriate. A penalty of $150.00 is assessed.

D. Docket No. WEST 87Ä168ÄR

Citation No. 2835327

The "Condition or Practice" charged to be a violation by Inspector Hollopeter was described in Section 8 of the Citation as follows:

> "The equipment, Euclid RÄ50 (Co. No. 4) End dump haulage truck, being driven from the Pit 2Ä3 Refuse dump to the preparation plant was not secured in the travel position. A nonfatal powered haulage accident occurred, severely injuring the operator and passenger of the truck, when the raised truck bed struck the No. 2 Beltline Conveyor Overpass. Through interviews it was determined that it is the Company policy to have the bed of the truck lowered when traveling."

The standard allegedly violated was subsection (s) of 30 C.F.R. 77.1607 pertaining to "Loading and Haulage Equipment; Operation", which provides:

> "When moving between work areas, the equipment shall be secured in the travel position." (Footnote 8)

Inspector Hollopeter designated this to be a "significant and substantial" violation on the face of the Citation, giving rise to what appears to be the contention raised by Western Fuels: "Should an operator be charged with a significant and substantial violation where a driver, contrary to common sense, company policy, and specific operational instruction, operates a dump truck without lowering the bed" (Western Fuels Brief, p. 33). It is noted parenthetically at this juncture that the phraseology of this contention appears directed more to the mine safety concepts of "liability without fault" and mitigation of the penalty assessment criterion of negligence than to the "significant and substantial" formula.

I first find that it is a violation, whether or not a "significant and substantial" one. Thus, in reaffirming the strict liability or "liability without fault" doctrine's application in mine safety matters in Western FuelsÄUtah, Inc., 10 FMSHRC 256 (March 25, 1988), the Commission pointed out that the principle of liability without fault requires a finding of liability even in instances where the violation results from unpreventable employee conduct. It thus rejected the notion of an exception to the rule even for unforeseeable employee misconduct. (Footnote 9) The parties have stipulated, and the record is clear, that the accident occurred because the truck operator failed to lower and secure the truck bed. The bed was raised when the accident occurred (T. 408, 418Ä419). The truck thus was not in "travel position" as the standard requires and Ackerman was driving the truck between work areas when the accident occurred. This constitutes a violation of the pertinent standard. For purposes of liability- as distinguished from penalty assessment purposes-- a miner's negligence or misconduct is properly imputed to the mine operator. Secretary v. A.H. Smith Stone Company, 5 MSHRC 13 (1983). The question of negligence imputation for penalty purposes will be taken up subsequently herein.

In a recent decision Secretary v. Texasgulf, Inc., 10 FMSHRC _____ (April, 1988) the Commission reaffirmed its position as to proof of significant and substantial violations:

"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 further 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). We have 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 1574 (July 1984)."

In the circumstances of this case, the infraction of the safety standard was clearly established, as well as the fact that the violation contributed to the creation of a discrete safety hazard. Not only was there a reasonable likelihood that the hazard contributed to would result in an injury, but the hazard actually occurred, that is, it came to fruition when the raised truck bed struck the overpass structure, the direct result of which were the serious injuries to Ackerman and Smith (T. 115Ä118, 408; Ex. MÄ5). This is found to be a "significant and substantial" violation.

We turn now to the questions of negligence and mitigation. Mr. Ackerman was a full-time employee whose primary job was to

drive the Euclid RÄ50 haul truck and another haul truck whose dumping mechanism was similar to that of the Euclid. Ackerman would normally (at least since December, 1986) make 8Ä13 trips a day from the preparation plant to the refuse dump (T. 220Ä222, 286). Ackerman was familiar with the road-and by inference-the presence of and characteristics of the overpass he was to travel under (T. 283Ä286; See also "General Findings", supra).

Western Fuels established that in December, 1986, Mr. Ackerman had been trained in the operation of the Euclid RÄ50 truck by its Surface Area Foreman, Daniel J. Rideout (T. 216Ä218).

This training covered proper dumping procedures which Rideout described as follows:

> "The proper dumping procedures would be to make sure your area -- where you're backing on up to --- that there's no obstructions or anything in the way, like that. Try to be on as level ground as possible, and set your dump bed; put your truck in neutral, sound the horn, dump your load; lower your bed; sound your horn, again; release your dump brake; put it in gear, and that's basically it; you're done."
>
> (T. 220) (emphasis added)

Rideout described the Euclid RÄ50 as an "easy-to-drive", stable truck which had no tendency to tip over, and said there was no occasion on which it should be driven with the bed raised (T. 225Ä226). Ridout reiterated the company "policy" of not driving the truck with the bed raised and pointed out that such is set forth also in the "Operator Handbook" for the truck, Ex. CÄ7, at p. 33Ä35, (T. 227, 253, 293). Truck drivers were directed to keep a copy of the Handbook in the truck and to read it in their idle time (T. 228, 289). Rideout had never seen Ackerman driving with the bed up and would have disciplined him had he done so (T. 232Ä233). Rideout was certain that in meetings with his drivers, which I conclude would have included Mr. Ackerman, that the need for lowering the truck bed before traveling was discussed (T. 248, 258, See also T. 288). The drivers, however, were not specifically advised that the haul truck with the bed up would not clear the overpass, nor were they specifically advised what the height of the truck was with the bed raised (T. 258). Nor were they specifically advised what the clearance of the overpass was (T. 259). This was the only overpass the truck drivers would have occasion to drive under (Tr. 259).

The overpass was constructed in 1982 and would have been in existence throughout Mr. Ackerman's tenure as truck driver (T. 251).

At the time of the accident there was no sign or notice in the cab of the truck to remind the driver to lower the bed (T. 270) although such notice was apparently installed thereafter (T. 270, 323). There was an "indicator" (depicted in Exhibit CÄ11) which comes down in front of the truck's windshield from which the truck driver can determine if the bed was raised or lowered (T. 255Ä256, 262Ä263, 296).

Jack L. Munfrada, a Surface Area Foreman, described the bed indicator in the following examination sequence:

> "Q. Is there any other way, when you're sitting in the driver's seat, or in the passenger's seat, that you can see that the bed is in the air?
>
> A. Yes. There's a bed indicator on the bed of the truck. If the bed is lowered, it is in the right-hand corner, visually through the eight-inch window, and it is a round -- in diameter, approximately five inches, with a decal -- a red and white decal, with a black figure, pointing back towards the dump box. Also, you can see it through the driver's mirror, very plainly.
>
> Q. You can see the bed through the driver's --
>
> A. Yes. You could see it out the passenger door window -- you could see the headache rack. And, also, if the bed was up in the daytime, you'd notice the change in light." (T. 296Ä297). (Footnote 10)

Based on its maintenance records and "Pre-shift Operator's Check Lists", Western Fuels had no indication to believe that the subject truck was not functioning properly in proximity to the accident (T. 402Ä406, 410Ä413) and in the absence of any other evidence to the contrary, and in light of the evidence indicating operator failure as the cause of the bed not being lowered to travel position, it is inferred and found that the truck was in proper operating condition at the time of the accident.

The record in this proceeding indicates that the cause of the accident was the operator's failure to lower the bed before proceeding on to the haul road and moving the vehicle to its point of impact with the overpass structure.

David G. Casey, Western Fuels' Safety Instructor, testified that he visited Mr. Ackerman in the hospital on the day of the accident and recounted this conversation concerning what had happened:

> Q. And, did he explain to you what happened?
>
> A. Yes. And -- and he said that he spaced it -- he couldn't believe that he'd spaced it out.
>
> XXX XXX XXX
>
> "The Witness: He couldn't believe that he'd spaced it out -- referring to the dump bed being up."
> (T. 455Ä456)

When pressed to develop his understanding of Ackerman's use of the phrase "spaced out", Mr. Casey stated:

> "The Witness: -- and he said "spaced out", and then we -- he said "I can't believe I f----- up", and he repeated it again, "I can't believe I did that", you know."
> (T. 471)

From this and other evidence of record indicating Ackerman was a "good" employee who had received safety training (T. 439Ä445) it is concluded that the accident resulted from Mr. Ackerman's negligent oversight in not lowering the bed of the truck, and that such negligent conduct was not foreseeable by Western Fuels' responsible management personnel. Southern Ohio Coal Co., 4 FMSHRC 1459, at 1463Ä1464 (1982). In this connection, it is further noted that there is no evidence of prior accidents having occurred at the overpass (T. 465).

While a mine operator is not necessarily shielded from imputations of negligence even where non-supervisory employees such as Mr. Ackerman are concerned, A.H. Smith Stone Co., 5 FMSHRC 13 (1983), for the negligence of the miner to be attributed to the operator, consideration must be given the foreseeability of the miner's conduct, the risks involved, and the operator's supervision, training and discipline of its employees. Here, the record indicates that the mine operator fulfilled its obligations as to training and in the establishment of its policy as to not operating the truck with the bed raised. MSHA, in its brief does not contend (or discuss) imputation. Mr. Ackerman's negligence in the commission of the violation will not be imputed to Western Fuels, Southern Ohio Coal Co., supra, at 1465.

In view of the seriousness of this violation, and upon evaluation of the other general mandatory penalty assessment

factors previously discussed in connection with Citation No. 2835326, a penalty of $300.00 is determined to be appropriate and assessed.

E. Docket No. WEST 87Ä169ÄR

Citation No. 2835328

The "Condition or Practice" deemed a violation by Inspector Hollopeter was described in Section 8 of the Citation as follows:

> "The No. 2 Beltline Conveyor Overpass above the haul road (County Rd. No. 78) was not conspicuously marked or warning devices installed when necessary to insure the safety of the workers. A nonfatal powered haulage accident occurred when an Euclid RÄ50 End dump (Co. No. 4) raised bed contacted the overpass while traveling on the haulage road. The operator of the truck and passenger were severely injured. At the time of the investigation the overhead clearance was not marked.

The standard allegedly violated was Subsection (c) of 30 C.F.R. 77.1600 (entitled "Loading and haulage; General") which states:

> "Where side or overhead clearances on any haulage road or at any loading or dumping location at the mine are hazardous to mine workers, such areas shall be conspicuously marked and warning devices shall be installed when necessary to insure the safety of the workers."

Although the Inspector originally charged that this was a "significant and substantial" violation, the Citation was subsequently modified to delete such designation upon further investigation (T. 158Ä160).

Western Fuels contends that the Conveyor (CNVÄ2) overpass was not "hazardous to mine workers" and thus warning signs (or devices) were not required.

Evidence in the record establishes that other than speed limit signs (T. 448) there were no signs, warnings, "clearance" signs or flashing lights on the overpass structure or conveyor (T. 118Ä121, 189Ä192, 245Ä246, 259, 463), or on the road on either side of the structure (T. 189, 448). Specifically, there was no sign on the overpass which said what the clearance was (T. 259). Inspector Hollopeter was of the opinion a hazard existed because there was no sign warning of the clearance of the overpass structure either on the structure itself or back along the haul road (T. 121Ä125).

~988

There are no regulations applicable in mine safety matters which establish height requirements for structures such as the subject overpass (T. 382).

The U.S. Department of Transportation's Manual on Uniform Traffic Control Devices (Ex. CÄ14) requires signs when less than 12 inches clearance is provided over the highest vehicle being used on the roadway (T. 380Ä381).

Chief Engineer Weigand expressed the opinion that prior to the accident the overpass structure was not "dangerous" "perilous" or "risky" (T. 386). As noted previously, there had been no prior accidents at the overpass, and in view of (1) the significant clearance height of the overpass (ranging from 20Ä27 feet approximately), (2) the general compliance of the structure with requirements other governmental agencies (T. 380Ä384)), (3) the general opinions of Western Fuels witnesses that the overpass was not "perilous" or dangerous, (4) the vagueness of MSHA's evidence and theory that the overpass was hazardous, and (5) the fact that the accident under scrutiny herewas caused by the forgetfulness of a truck driver who broke the rule against driving with the bed raised and who had been passing under the overpass some 20 times a day for months, it is concluded that the overpass clearance was not "hazardous" within the meaning of the regulation cited and that no violation occurred.

ORDER

(1) Withdrawal Order No. 2835325 and its modifications are affirmed.

(2) Citations numbered 2835326 and 2835327 (including its "Significant and Substantial" designation) are affirmed.

(3) Citation No. 2835328 is vacated.

Contestant/Respondent Western Fuels shall pay the Secretary of Labor the total sum of $450.00 as and for the civil penalties hereinabove assessed on or before 30 days from the date of this decision.

Michael A. Lasher, Jr.
Administrative Law Judge

ÄÄÄÄÄÄÄÄÄÄÄÄÄÄÄÄÄÄÄÄÄÄÄÄÄÄ
Footnote starts here:-

~Footnote_one

1 The evidence of record also overwhelmingly established that the driver of the truck, Ackerman, for whatever reason, failed to lower the truck bed and then drove the truck approximately 2 miles from the pit to where the bed struck the overpass as the truck attempted to proceed underneath.

~Footnote_two

2 Upon the issuance of this second modification, the coverage of the Order would have remained on the "curved arched portion of the overpass structure", the truck, and the conveyor belt (T. 153).

~Footnote_three

3 Although not well articulated by the witness, I infer that this concern was directed toward the possible traumatic effect the impact of the collision had on the structure.

~Footnote_four

4 The Inspector, under Section 103(j) of the Act, certainly does have an independent obligation and responsibility to take appropriate measures "to prevent the destruction of any evidence which would assist in investigating the cause or causes" of an accident.

~Footnote_five

5 The responsibility for determining structural damage to the overpass and conveyor, any truck malfunction, and any patent or latent safety hazards stemming therefrom, is recognized as a considerable one. Any question in the mind of the sole person bearing this burden in mine safety enforcement would necessarily be resolved on the side of safety.

~Footnote_six

6 It is initially noted that the questions whether the delay (1) exacerbated rescue efforts, or (2) hindered MSHA's investigation, would relate more directly to the penalty assessment factor of seriousness, rather than to the occurrence of an infraction of the standard cited. Obviously, at the time of delay in notification, the ultimate effects thereof may not be recognizable and the elements of proof inherent in the phraseology of the regulation contain no such exception for situations where there is no prejudicial effect. A roof-control requirement, for example, is not self-abnegating where the violation of such does not cause an injury - causing fall.

~Footnote_seven

7 The parties, as part of their written stipulation (Court Ex. 1) concurred that Western Fuels is a large bituminous coal mine operator and that it proceeded in good faith in attempting to achieve rapid compliance after notification of all the alleged violations. As part of the same stipulation, the parties submitted into evidence a computerized history of prior violations (Ex. MÄ1) indicating that Western Fuels had 129 previous violations in the 2Äyear period preceding the issuance of the subject Citations.

~Footnote_eight

8 "Travel position for the truck in question required the bed to be secured in its lowered position (T. 113, 242, 253Ä254). As noted in the Citation itself and established at the hearing, Western Fuels' policy required the truck, when moving, to have the bed in the lowered "travel" position (T. 112Ä115, 226Ä227, 310).

~Footnote_nine

9 I conclude elsewhere herein that the accident in question occurred as a result of Mr. Ackerman's unforeseeable negligence.

~Footnote_ten

10 From this dialogue as well as other evidence (T. 255Ä259) indicating other reasons why a truck driver would normally know or be aware of the raised bed, I find and infer that for a driver of the truck in question to proceed along the haul road with the truck bed raised and not have such fact enter the stream of his consciousness would be an unusual occurrence and one which would not be foreseeable by his foreman or other management (T. 471).