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SOL (MSHA) V. CONSOLIDATION COAL CO.
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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 PROCEEDING Docket No. WEVA 88-176 A.C. No. 46-01453-03803
v.	Humphrey No. 7 Mine
CONSOLIDATION COAL COMPANY, RESPONDENT	

DECISION

Appearances: Joseph T. Crawford, Esq., Office of the Solicitor, U.S. Department of Labor, Philadelphia, Pennsylvania, for Petitioner
Michael R. Peelish, Esq., Consolidation Coal Company, Pittsburgh, Pennsylvania, for Respondent.

Before: Judge Merlin

Statement of the Case

This case is a petition for the assessment of a civil penalty filed by the Secretary of Labor against Consolidation Coal Company for an alleged violation of 30 C.F.R. 50.10. A hearing was held on October 18, 1988.

The subject citation reads as follows:

> A roof fall accident - unintentional fall of roof above the anchorage zone of roof bolts which interfered with passage of persons - occurred at the face of the 2 southwest longwall section, 043Ä0 MMU, at approximately 2:00 PM on 11Ä13Ä87. This accident was not reported to MSHA until 3:58 PM 11Ä13Ä87.

30 C.F.R. 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.

30 C.F.R. 50.2(h) states in pertinent part:

(h) "Accident" means.

* * * *

(8) An unplanned roof fall at or above the anchorage zone in active workings where roof bolts are in use; or, an unplanned roof or rib fall in active workings that impairs ventilation or impedes passage;

At the hearing the parties agreed to the following stipulations:

(1) the operator is the owner and operator of the subject mine;

(2) the operator of the mine is subject to the Federal Mine Safety & Health Act of 1977;

(3) the administrative law judge has jurisdiction in this case;

(4) the inspector who issued the subject citation was a duly authorized representative of the Secretary;

(5) a true and correct copy of the subject citation was properly served;

(6) copies of the subject citation and termination of the violation in this proceeding are authentic and may be admitted into evidence for purposes of establishing their issuance, but not for the purpose of establishing the truthfulness or relevancy of any statements asserted therein;

(7) imposition of a penalty will not affect the operator's ability to continue in business;

(8) the alleged violation was abated in good faith;

(9) the operator's history of prior violations, as shown on the printout which was subsequently admitted as a government exhibit, is correct;

(10) the operator's size is large; and

(11) the roof fall which occurred in this case was an unplanned roof fall within the purview of 30 C.F.R., Section 50.2(h)(8).

Discussion and Analysis

The inspector testified that during his investigation on November 16, 1987, the Monday following the accident, the mine superintendent told him that at the time of the roof fall in the belt entry at the headgate, production was ceased and that the miners in the area were evacuated through the tailgate (Tr. 18). The inspector further stated that the superintendent told him the normal route of travel through the headgate was blocked (Tr. 18Ä19). The operator's safety supervisor, the company official responsible for notifying MSHA, acknowledged that at 2:00 p.m. he was informed of the roof fall and was told that the men were retreating through the tailgate (Tr. 32, 35, 53, 55).

After being so advised, the safety supervisor went underground to investigate (Tr. 35). The safety supervisor explained that the roof had fallen in on the crusher which was located in the entry at the headgate (Tr. 44, 48). Immediately behind the crusher was the stage loader (Op.Exh. No. 1). There was a 3þ to 3%p1/2%p foot clearance on each side of the crusher, but debris 2þ to 2%p1/2%p feet deep had fallen on each side (Tr. 49, 50). The supervisor said that it would have been hard to get through on the left side because the roof had fallen down there (Tr. 43). The supervisor expressed the opinion that if necessary men could crawl over the top of the crusher or over the debris (Tr. 49, 53). He further testified that as soon as he arrived on the scene he and all others present immediately began timbering the area to make it safe (Tr. 40, 42Ä43).

The longwall coordinator who had called the accident out to the mine superintendent on the surface, testified that he did not specifically report passage was impeded, but that he did say the men were coming out through the tailgate, that he needed someone to give them a ride and that he needed help in timbering the headgate side of the fall (Tr. 67).

The first question to be resolved is whether this roof fall constituted an "accident" within the purview of 30 C.F.R. 50.2(h), quoted supra. I conclude it did. The evidence clearly shows that passage was impeded. There is no dispute that instead of using the headgate which was the normal route of travel, miners in the area exited through the tailgate. The roof had fallen in on the crusher and there was debris 2Ä2%p1/2%p feet high on both sides of it. Moreover, after the fall, the remaining roof was unsecured and dangerous which was why everyone on the scene immediately started timbering. Under these circumstances I reject the opinions of the operator's witnesses that men could climb over the crusher or the debris. Even assuming this were physically possible, such action would have been a violation of

the mandatory standards and extremely dangerous because the men would have had to go under unsupported roof. The operator's safety supervisor himself stated he would not want the men to go under unsupported roof and that for all practical purposes the headgate was impassable until the roof was supported (Tr. 54). Based upon the foregoing, I find passage was impeded.

The next issue is whether there was immediate notification. The fall occurred at 2:00 p.m. The inspector testified that the mine foreman became aware of the fall at 2:30 p.m. (Tr. 15, 16). However, the safety supervisor who, as already noted, is the company official responsible for notifying MSHA testified that he first had knowledge of the fall around 2:00 p.m. close to immediately after it happened when he was told by the safety escort. He further testified that the safety escort learned of the fall from the mine foreman and that he was informed of the fall within zero to five minutes (Tr. 32, 33). (Footnote 1) As already set forth, the safety supervisor was told men were retreating through the tailgate (Tr. 35, 53, 55). He then went underground to investigate (Tr. 35). He stated that it is the operator's policy to investigate falls before reporting them to MSHA unless there happens to be definite information that passage is impeded (Tr. 37). Under the circumstances of this case I find the procedures followed by the safety supervisor and other management officials failed to satisfy the requirements of the regulations. The longwall coordinator advised the mine superintendent that men were exiting through the tailgate which was not the normal route of travel (Tr. 67). He also asked for help in timbering (Tr. 67). This information was sufficient to alert mine management to inquire and seek more specifics about the fall. Indeed, no company official above ground in the long chain of communication from the mine superintendent, who received the longwall coordinator's call, to the safety supervisor, who made the decision when to call MSHA, asked those questions which would have enabled them to decide whether or not immediate notification of MSHA was required. Although the safety supervisor asked about injuries and whether

people were stuck at the face (Tr. 35), he otherwise relied upon what he was told him and did not attempt to ascertain the facts upon which he could have made an informed decision on immediate notification. If the safety supervisor or others had taken the moment or two necessary to ask the obvious questions, they would have known immediate notification was required and so would have called MSHA before going underground.

I recognize that the fall created a stressful situation for all concerned. But the requirements of the regulations are clear and mine management must remain sensitive to them even while it copes with other aspects of the situation. The time lapse from 2:00 p.m. (or even 2:30 p.m. under the inspector's version), when the supervisor found out about the fall, until 3:58 p.m., when the fall was reported, was much too long to constitute immediate notification. See Western FuelsÄUtah, 10 FMSHRC 832, 842Ä844 (June 1988). The argument in the operator's brief (p. 7) that the operator must have an opportunity to conduct a "reasonable" investigation before notification cannot be accepted as a justification for its conduct in this case. Here with minimum effort, the facts necessary to determine the propriety of immediate notification would have been readily available to management officials. Adoption of the operator's position in this case would mean that instead of being "immediate", notification would be virtually the last thing to be done and accorded little, if any, priority.

In this connection it also must be noted that even after his investigation, the operator's safety supervisor waited until he was above ground to notify MSHA although he could have telephoned MSHA from below ground 20 or 25 minutes earlier (Tr. 52, 56). On this basis as well, the regulation was violated.

The inspector testified that the violation was not serious (Tr. 19). The Solicitor expressed the same view (Tr. 23). The position that this reporting violation is not serious is wholly at odds with the views the Secretary expressed in other reporting cases involving this operator. In Consolidation Coal Company, 9 FMSHRC 727, 733Ä734 (April 1987), I accepted the Secretary's view that Part 50 violations are serious, stating:

> " * * *, it is clear that the settlement motion is on strong ground in asserting the violations involved a high degree of seriousness and negligence. Gravity cannot be doubted in view of the fact that Part 50 is the cornerstone of enforcement under the Act. Since Part 50 statistics provide the basis for planning, training and inspection

> activities, accurate reporting is essential. Moreover, failure accurately to report could have extremely dangerous consequences by concealing problem areas in a mine which should be investigated by MSHA inspectors. In short, without proper compliance by the operator under Part 50, the Secretary could not know what is going on in the mines and, deprived of such information, he would be unable to decide how best to meet his enforcement responsibilities. * * * "

The violation in this case was serious. The inspector explained that the purpose of this reporting requirement is to afford MSHA the opportunity to send an inspector to the scene as quickly as possible to determine the cause of the roof fall and prevent future occurrences (Tr. 20, 21, 25). Failure to immediately notify MSHA frustrates this important policy. Accordingly, the Secretary's position in this case that the violation was not serious, is wrong and negates effective enforcement of the reporting regulations.

I find the operator was guilty of ordinary negligence and reject the inspector's finding of high negligence as contrary to the evidence. There is nothing in the record indicating recklessness, willfulness or any other such conduct which would justify a higher degree of fault.

I have reviewed the briefs filed by counsel. To the extent that the briefs are inconsistent with this decision, they are rejected.

As already noted, the stipulations regarding the remaining criteria under section 110(i) of the Act, have been accepted.

In light of the foregoing it is ORDERED that a penalty of $500 be assessed for this violation.

It is further ORDERED that the Operator Pay $500 within 30 days from the date of this decision.

Paul Merlin
Chief Administrative Law Judge

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1 The safety supervisor's statement that he learned of the fall almost immediately after it happened is supported by his chronology of subsequent events. He stated that it took him approximately 30 minutes to reach the section (2:30 p.m.) and an additional three to five minutes to reach the fall area (2:35 p.m.) (Tr. 38, 39). He then spent 45 minutes conducting an investigation of the area (3.20 p.m.) and an additional 20 to 25 minutes to return to the surface (3:45 p.m.) from where he called MSHA (3:58 p.m.) (Tr. 50, 52). Based upon, these time frames it

appears that the safety supervisor knew of the roof fall at approximately 2:00 p.m. rather than 2:30 p.m. as the inspector testified. I so find.