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

UTAH POWER & LIGHT COMPANY,
CONTESTANT

CONTEST PROCEEDING

v.

Docket No. WEST 89-160-R
Citation No. 2876485; 3/16/89

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

Cottonwood Mine
Mine ID 42-01944

DECISION

Appearances: Timothy M. Biddle, Esq., Susan E. Chetlin, Esq.
Crowell & Moring, Washington, D.C.,
for Contestant;
Robert Cohen, Esq., Office of the Solicitor
U.S. Department of Labor, Arlington, Virginia,
for Respondent.

Before: Judge Morris

This case is before me under Section 105(d) of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. 801 et seq., (the "Act"), to challenge the issuance by the Secretary of Labor of a citation charging Utah Power & Light Company ("UP&L"), with a violation of the regulatory standard published at 30 C.F.R. 75.1105.

After notice to the parties a hearing on the merits was held in Denver, Colorado on April 5, 1989. The parties relied on oral arguments, waived the filing of post-trial briefs and further requested a decision without receiving the transcript of the proceedings.

Summary of the Case

Citation No. 2876485, issued on March 16, 1989, charged contestant with violating 30 C.F.R. 75.1105, which provides as follows:

75.1105 Housing of underground transformer stations, battery-charging stations, substations, compressor stations, shops, and permanent pumps.

[Statutory Provisions]

Underground transformer stations, battery-charging stations, substations, compressor stations, shops, and permanent pumps shall be housed in fireproof structures or areas. Air currents used to ventilate structures or areas enclosing electrical installations shall be coursed directly into the return. Other underground structures installed in a coal mine as the Secretary may prescribe shall be of fireproof construction.

Citation No. 2876485 alleges the following violative condition:

The transformer being used to supply 480VAC to the 12th West belt drive located at crosscut #2 12th West was not being vented directly to the return.

When tested with chemical smoke, the smoke was observed entering the intake entry for the 12th West working section through holes in the stopping being used to isolate the transformer. A power cable was observed exiting through one of the holes. This hole measured 3 1/2 inches wide x 8 inches high.

When tested in front of (outby end), over, at the sides of the transformer, smoke was observed moving toward the intake stopping that was located 18 feet 4 inches (measured) away from the transformer.

A 12 inch vent tube was located on the left rib inby the transformer. The vent tube was 28 inches (measured) from the left corner of the transformer and back 3 feet from the end of the transformer and ran 150 feet to the return. There were no check curtains across the cross cut to enclose the transformer. The cross cut was open to the belt drive.

- 1) The transformer had been at this location since Aug. 1988.
- 2) Approximately 2 weeks ago, a major air change was done to increase the amount of air to the newly installed longwall section.
- 3) The hole was made in the stopping 1 or 2 days earlier to supply power via the cable.
- 4) Management was aware the air change and should have re-evaluated this transformer for proper ventilation. The above 4 items are contributing factors concerning this condition.

Issues

The issues are whether a violation of 30 C.F.R. 75.1105 occurred; if it occurred, should the violation be designated as S & S and if a violation occurred was it due to the unwarrantable failure of the operator to comply with the regulation.

Stipulation

At the commencement of the hearing the parties stipulated as follows:

1. The Commission and the Administrative Law Judge hearing the dispute have jurisdiction to determine this case.
2. Donald E. Gibson, an MSHA Inspector, was an authorized representative of the Secretary at the time of the inspection.
3. The Cottonwood Mine is a large coal mine.
4. Various exhibits can be admitted into evidence without further authentication. These include Exhibits C-1, C-2, C-3, as well as R-1 and R-2.

Secretary's Evidence

Donald E. Gibson is a federal coal mine inspector. He is also an electrical specialist and he has been employed by MSHA since May 26, 1987. The witness has extensive background experience in mining as well as in his specialty. He is assigned to the Orangeville, Utah office.

He is familiar with the Cottonwood Mine and on March 14, 1989, he began an electrical inspection at the mine. During his pre-inspection conference with management, he advised the operator why they were inspecting the mine. At that time he also reviewed with management previous Triple-A inspections. Those in attendance at the conference included maintenance and safety representatives as well as the superintendent, mine foreman and the miner representative. At the meeting they also discussed the national sales policy manual, that is, the inspector's manual which states the intent of certain laws and regulations relating to safety and health.

At this meeting it was indicated that certain District 9 policy had been rescinded.

On December 30 there was another inspection at the mine and Inspector Gibson indicated to the company they would have to vent transformers directly to the return. This was discussed with representatives of the safety department including Tatton, Norton and a miner representative. In the witness' opinion "directly to the return" means the venting shall be without any deviation. The Bureau of Mines recommends a 3,000 cfm flow of air over transformers.

The company can use tubing to vent its transformers to the return. If the area is vented without being enclosed it would not be vented directly to the return.

After the pre-inspection on March 14 he started this inspection and it continued on March 16, 1989. On that date Inspector Gibson went underground at approximately 8:05 a.m. to 8:15 a.m. He was accompanied by the superintendent of maintenance, safety department representatives, and a miner representative.

During the course of the inspection they went to the 12 West Belt Area where he intended to observe the longwall where miners

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were working. After leaving the longwall face they were on their way outside. While traveling in a vehicle the inspector noticed a power center in an open crosscut.

The power center was in crosscut 6. (Crosscut 6 was marked on Exhibit R-1.) The equipment in the XC was a 480 VAC rectifier. The rectifier was neither housed nor plugged. He then followed the electrical cable of the rectifier 400 feet to a stopping in the main intake airway, which was also a primary escapeway. At crosscut 2 the inspector observed that the cable went through a hole in the stopping. Beyond the stopping was an energized transformer. A person could pass through the stopping by using a 5-foot high by 6-foot wide steel door. (See Exhibit C-2 showing equipment in CX2.)

Also located in crosscut 2 were electrical belt starters and belt drive electric motors. The belt entry also serves as a secondary escapeway.1

Inspector Gibson believed the transformer was not being vented directly to the return. To verify this he took 9 different smoke samples at various places close to the transformer. (Marked as red X on Exhibit C-2.)

The long and short of his 9 samples were that the smoke was not moving directly to the return. Some of the smoke hung in place and in the last 3 tests (closest to the stopping) the smoke moved through the 3 1/2" x 8" hole in the stopping.

It is permissible to knock a hole in the stopping but it must be resealed.

The inspector opened the door in the stopping and saw smoke in the air intake. He also repeated these tests for his supervisors who were present. In addition, the company representative agreed they saw smoke in the air intake.

He then told company representative Peacock that the company had a (d)(2) order. He issued such an order because 15 miners inby were subjected to the hazard of a fire occurring at the transformer. The belt air was not isolated and there was no isolation because of the hole in the stopping. In addition, the secondary escapeway was not separated from the primary escapeway. (The witness marked the intake air course with red arrows on Exhibit C-2.)

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In addition there was a CO center inby the transformer. If the inby crews came out the secondary return escapeway, that area would already be contaminated by any smoke.

The vent pipe would also pick up the smoke if there was a fire in the transformer area.

After Inspector Gibson orally issued his (d)(2) order, company representatives claimed the company was no longer subject to the (d) series. Inspector Gibson believed otherwise but he checked with William Ponceroff, his supervisor. Mr. Ponceroff confirmed that Inspector Jones had just completed an inspection and, in fact, the company was off the (d) series.

For this reason Inspector Gibson issued a (d)(1) citation.

A company representative indicated that the hole in the stopping had been made by a diamond drilling crew in the last day or two. But the hole was not more than three days old. The inspector did not recall the name of the person he was given but he didn't feel he was being too harsh on the operator in issuing the (d)(2) order. He felt the company met the unwarrantability feature. In fact, the inspector previously had three conversations with management about venting directly into the return.

To be in compliance, the company would have had to erect a fire wall check curtain to enclose the transformer and the air would have to be channeled into the vent tube. Without the installation of a stopping, the smoke could go into the belt entry. (See Exhibit C-2 to locate belt entry.)

When the inspector saw smoke enter the intake entry, he concluded there was a violation of 75.1105.

He then told company representative Tatton that if the Jones' inspection was completed, the company could put up a check curtain inby the transformer and plug up the hole in the stopping with cinder block and plaster.

Additional smoke tests by Inspector Gibson showed the smoke merely hanging in the area of the transformer; it was not being drawn into the vent tubing.

Abatement was accomplished by a combination of steps. Initially, a check curtain was hung (and rehung) outby the transformer. (See blue dots on C-2 for location of curtain.) Further, the 12-inch metal corrugated vent pipe was extended 10 feet toward the transformer and an additional 5 feet to the side. (See green lines on Exhibit C-2 showing route of vent piping from the transformer some 135 to 140 feet to the return air in 3rd South entry.)

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It took an hour and fifteen minutes to abate the violation. Abatement was confirmed when smoke flowed directly into the tube.

Prior to abatement the transformer had not been vented directly to the return.

Crosscut 2, where the transformer was located, is a work area that must be pre-shifted and the hole in the stopping was obvious. Someone told the drilling crew to do this work and there had been three weekly examinations and two or three electrical examinations of the area. Some person must have observed these conditions.

The inspector observed a beltman in the belt entry downwind from the belt drive. Any smoke would come down to him. The safety and health of the beltman and the 15 miners in the longwall would be affected by the hazard.

Any fire in the transformer or belt drive would generate thick heavy smoke from the neoprene, rubber and transformer insulation cables. Such smoke could take away your breath. A W-65 self-rescuer would not filter such smoke. It would only take a small amount of it to overcome a miner.

Exhibit C-2 shows various fire-suppression devices in the crosscut. The installed heat sensors would detect any heat; however, there are times when the solenoids will stick.

The inspector wrote a three-page citation describing the conditions he observed. He also wrote four items which contributed to the citation.

These items, as testified by Inspector Gibson and as listed on the citation, were as follows:

1. The company indicated that the transformer had been at this location since August 1988.
2. Although he was told that there had been a major air change two weeks ago, such a change should have caused the air to draw better.
3. The hole had been made in the stopping 1 or 2 days earlier to supply power to the cable.
4. When a major air change is made, the company should have re-evaluated this transformer for proper violation.

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The witness is aware of the definition of unwarrantable failure. Basically, unwarrantable failure means aggravated conduct by the operator, that the operator knew and was aware of the concerns. He had talked to the operator repeatedly and if after such discussions the company goes in the direction of non-compliance then such conduct constitutes aggravated negligence.

The company had experienced a major mine fire. The company has 24 belt drives and probably a transformer for each belt drive.

None of the areas were enclosed before the citation was issued and the inspector had only looked at two other belt drives.

The inspector considered the violation to be serious because the primary and secondary escapeway could be contaminated with smoke. The 15 miners at the longwall and the beltman would be affected.

The inspector concluded that the conditions here involved unwarrantable failure on the part of the company for several reasons. Initially, the drill foreman had been told to knock a hole in the stopping. The area was pre-shifted and in fact some 18 to 27 pre-shifts had been done as well as 6 to 9 on-shift checks. But no one reported the hole in the stopping. In addition, Section 75.512 requires weekly examinations of electrical equipment and this should have been discovered.

In addition, the inspector personally discussed venting the transformer with upper management and they had 2 or 3 days to re-evaluate their position after he was on the company's property. In addition, he was astounded when he saw the ventilation tubing and he concluded that the company could not reasonably think that it could ventilate the transformer in this fashion.

Further, all pre-shifters have smoke tubes. In addition, the four items he listed on the citation indicated to him that the operator was indifferent and did not seal or enclose the transformer area so the ventilation pipe could accomplish its desired result.

The inspector believed it was an S & S violation for a number of reasons:

1. Section 75.1105 was violated.
2. A strong safety hazard was involved as miners could be overcome by smoke.

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3. It was likely that an injury could result and it would be serious; being overcome by smoke could result in disability or a fatality.

Concerning gravity, the inspector concluded it was reasonably likely that an injury could result from the violative condition. It would be possible to have smoke in the entry without being detected by a monitor. This occurred in a previous 26-minute fire where the surface did not receive a signal from the monitors.

On cross-examination the inspector admitted that the transformer was enclosed in a metal container and so there was no violation in the first sentence of the regulation. He believed the second sentence had been violated.²

The revoked District 9 policy in essence stated that an operator was in compliance if it vented a transformer into a return entry "eventually". The District 9 policy which was revoked did not address transformers as such.

On December 20, the Manager of District 9 rescinded previous District 9 policy and a memorandum to this effect went to the inspection force. Inspector Gibson did not give the company anything in writing nor did they ask for it. (Exhibit C-4 revokes prior policy.)

On December 30, he discussed the new policy with UP&L and told the company they would have to ventilate directly into the return, use an air lock,³ further, all enforcement would be guided by Part 75. The reason for ventilating is to keep the heat down on the equipment by keeping the transformer cool.

The inspector was aware that 75.1105 is part of a series of fire regulations and is not a ventilation regulation.

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The rectifier in crosscut 6 was not energized nor housed, nor was it vented directly to the return.

Walking down the intake air, the flow of it was in the inspector's face at about 62,000 - 63,000 cfm.

The CO sensor was a block away from the transformer. The sensor will activate at 15 parts per million. He did not test the sensor and he supposed it was operable.

He was tracing cable that went to the crosscut 2 area. The hole in the stopping was at the upper left side. The stopping was 18 to 20 feet wide, the hole in it was 3 1/2" x 8" It is not unusual for cable to go through a stopping. The rectifier cable is 1 1/2 inches in diameter and it took up that much of the 3 1/2" x 8" hole in the stopping. Sufficient room remained for a person to reach his hand through the opening.

There were other problems and other potential violations in the area but the inspector did not issue citations from these other conditions because he wanted to be fair with the operator. It seemed to him that issuing additional citations would be unfair.

It was 18 feet from the transformer to the stopping. The transformer was in a metal box and it was free standing.

The mine roof was above the transformer. It rested on gravel. The vent was corrugated metal and located by the left corner. It was two feet back from the transformer and located to the side.

The cable from the rectifier was connected to the transformer.

He was not sure if the belt entry at this location was a secondary escapeway. The witness agrees that the belt entry was not a secondary escapeway because the secondary escapeway makes a bend and it goes into the main return before it reaches this area.

The inspector knew the vent tube was not venting as a result of smoke tests. Vent tubing attempts to ventilate an area and to go into the main return.

The transformer must be close to the belt drive and the company attempted to comply with the regulation by putting in ventilation tubing.

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A transformer fire could affect workers. The belt was not isolated and the secondary escapeway was not separated from the primary but this is based on the inspector's misapprehension that this area was a secondary escapeway. The power pack is also protected by sprinklers. It is the Secretary's scenario that there could be a failure of the water system or the CO system or that the belt attendant would not react to a fire. In his scenario some things could go wrong.

A two-man diamond driller team made a hole in the stopping as the inspector was told by company representative Tatton.

Inspector Gibson did not talk to the diamond drillers. He also asked the company but they could not identify the drillers.

Inspector Gibson discussed venting directly into the return with the company officials. He thought they were ignoring his earlier warning but he didn't think the vent tube could vent the transformer directly into the return. They said the tube had been there for a month. It would be reasonable for the company to check to see how the tube was drawing. The hole in the stopping served to accommodate the cable and was not for ventilation purposes.

The witness issued the citation because the air was not being pushed over the transformer. The violation existed before the hole was put in the stopping. In sum, the hole in the stopping only contributed to the violation.

The violation would still have been a unwarrantable failure even if there had been no hole in the stopping.

On December 20, 1988, venting directly to the return became a requirement by virtue of a national MSHA directive.

The inspector assumed that the major air change undertaken by the operator was an increase of 40,000 cfm. Such an increase would permit the air to draw better.

Concerning unwarrantability, the inspector was told that the foreman received a directive to put the 3 1/2" x 8" hole in the stopping. The hole was a catalyst and a contributing factor in the unwarrantable failure designation.

The inspector was "astounded" when he saw an open area where the transformer was located was not enclosed as by a check curtain or omega wall.

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In his citation the inspector stated that 15 miners could be impacted by a transformer fire but this does not include the belt attendant. He did not know if the beltman was always in the area of the transformer. However, the beltman would be one to recognize the smoke conditions.

When the inspector advised the operator of the change in policy, he recognized that UP&L needed time to comply, and he personally afforded them such an opportunity. They could comply in 15 to 30 days. They could comply by evaluating the transformer and they might relocate it, and they could re-evaluate the system. The company should have re-evaluated its transformer.

Section 75.1105 has never been changed nor has there been a change since the 1969 Coal Act regarding venting directly into the return.

The 3 1/2" x 8" hole in the stopping was obvious.

Sufficient smoke could get through the 3 1/2" x 8" hole to contaminate the adjoining airway.

The inspector took no air readings as he did not think it was necessary. He didn't see any company personnel taking air readings and the air was going directly to the return.

If the inspector had found fire suppressor devices in that area not functioning he would have issued a 107 imminent danger order.

He has recently seen a movie where all fire suppression devices failed during a mine fire.

Fifteen to thirty days is a reasonable time to comply. The vent tube had been there for one month before March 16, 1989.

The smoke through the 3 1/2" x 8" inch hole went into the intake. There was 60,000 cfm in the intake.

In the event of a raging fire the stopping would quickly burn.

JEFFREY A. RACHETTI is a miner mechanic at the Cottonwood mine as the Safety and Health Representative for the UMWA.

He accompanied Inspector Gibson on walk-arounds and he was with him when this citation was issued.

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Mr. Rachetti agrees the (d)(1) order stated a violation of the regulation. He also agrees that it was a unwarrantable failure violation because every day people travel that area and they should have noticed it in their travels.

Mr. Rachetti was with Inspector Gibson during the smoke tube test and he believed Gibson's testing was adequate.

Concerning seriousness, he observed a real hazard in the smoke leaving the area via the hole in the stopping and going into the airway.

There was a possibility of a fire and the company has had a few fires. One of them killed 27 people, and this could happen again.

The witness was familiar with the CO monitoring intakes and there was no problem with the monitoring systems within a week of the order. However, during that previous week there had been electrical problems. The operator has a back-up electrical system.

There is a beltman assigned to the 12 West Belt Drive. He walks to the tailpiece, which would be 150 to 200 feet from the working face. The area where the transformer is located would be 2,000 to 3,000 feet away from the face.

In the witness' opinion Gibson is a very consistent inspector, that is, he does his job and explains things to the miner representatives. Mr. Rachetti has a high opinion of Mr. Gibson's skill.

The witness travels with other federal inspectors. Section 75.1105 is a violation and the transformer was not properly vented.

The tube was not over the transformer and it would not draw smoke. The company should have noticed the hole.

The vent tubing was in place 30 days before the citation and he learned this from someone in the safety department.

The CO system is activated at 30 PPM (parts per million).

The vent was physically in view when he was in the area with Inspector Gibson.

UP&L's Evidence

GLENN JOHNSON has been UP&L's general belt supervisor for a year; prior thereto he was the belt maintenance foreman. Previously he was a coal miner and also a hard rock miner.

He works the day shift supervising maintenance and all conveyor belt lines in the mine.

The witness is familiar with the 12 West Section. (Witness shows the 12 West Belt Drive on Exhibit C-1)

A belt drive is a mechanism that moves the belt and transports coal.

In 12 West there is one belt drive which is 3200 feet long.

Coal is dumped at crosscut 32, the headgate of the longwall. From that point it is transported by belt to the outside.

Electricity comes to the belt via a high voltage cable through a transformer to a starter box in a belt drive. There is a step-down unit for the transformer and the electricity is stepped down to 480 volts. The starter box itself is 15 feet from the transformer. (The witness marks starter box as "SB" on Exhibit C-2.)

SB is metally enclosed; 6 foot long, 3 foot high and sits on legs.

The witness also identified the power pack (PP) which is a metal tank 3 foot square. This is all in the No. 2 crosscut in 12 West Section. The height of the area is 9 feet.

The block stopping in crosscut 2 consists of 1 inch by 16 inch cinder blocks. The company mortars the joints on the cinder blocks.

The stopping contains a 6 foot by 5 foot steel door and the stopping is coated on the intake side to retard air movement.

The beltman inspects and maintains the area.

Water sprinklers are installed over the belt drive and over the power pack.

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A fire hydrant is located at the side of the drive and heat and sensors are connected to the fire detection systems located at 50 foot intervals. There is also 500 feet of hose stored within 50 feet of the fire hydrant.

A foam adductor mechanism attaches to the end of the fire hose and this creates suction which introduces foam into the water. The foam is a fire-fighting device that removes oxygen from the atmosphere.

On March 16, the foamer was 15 feet from the south end of the transformer.

In addition, there were 40 to 50 pound sacks of rock dust on the east side of the transformer and within 10 feet of it on the intake side of No. 2 stopping. This was approximately 250 pounds of rock dust, which covers coal on the floor and is used for fire fighting purposes.

There are 3 No. 10 fire extinguishers in the area. Two are on the south side of the transformer and one is adjacent to the starter box.

There are also 3 SCSRs in the adjacent area, one CO sensor in the belt entry and one in the adjacent entry.

The equipment the witness described was in place on March 16 and witness Johnson is in the 12 West Belt area four times a shift.

Seventy-five percent of the operator's coal comes from this section.

On March 16 he saw Inspector Gibson at 10:00 a.m. when he walked into the area. Inspector Gibson was looking at the equipment and he observed him use a smoke tube.

Inspector Gibson proceeded to inspect the stopping. He was looking at the cables that went through the stopping.

The inspector told the company representative Peacock that there was a problem with a hole in the stopping and he then proceeded to test with smoke between the transformer and the stopping.

The smoke tube is a chemical and when it is released into the air it produces smoke. The purpose is to detect air flow. Johnson observed three tests at the transformer and two tests at the stopping.

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On one of the tests he could see no smoke movement. The equipment entering the 3 1/2" x 8" hole in the stopping was 1-inch cable and a smaller telephone cable.

The third smoke test that Johnson observed was in the transformer area and the fourth test was in the center of the transformer and then at the north end of the transformer.

The witness saw most of the smoke go into the vent tube. The vent tube had been there for about a month and that was the only airflow through the entry.

The belt attendant checks the transformer and he is required to check with the power center of the transformer. He keeps a record of this check. He physically goes into the area.

The beltman marks his cards to show checks made on one hour intervals.

On the 16th Witness Johnson did not make any notes.

He had seen the citation issued by Inspector Gibson concerning conditions and practices.

He agrees some smoke went through the hole in the stopping and ventilation was going through the tube when he put his hand up to it. It is possible that all the air was not going into the tube.

The witness saw no smoke from the test on the transformer and didn't know if there was a violation.

Part of the smoke hung suspended on the north side but most of it went into the tube. On the test on the south side of the transformer the smoke simply hung there. He saw smoke from two tests going toward the tube.

He did not attempt to show Inspector Gibson if the fire suppressant equipment was working in the area.

Mr. Johnson did not know who made the hole in the stopping and did not know the name of the foreman. The holes were not sealed and it appeared that the workers had knocked out an entire cinder block.

No protection was provided for the trailing cables or through the stopping and he did not know if the cable was ever energized.

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Mr. Johnson concedes he is not an expert in ventilation nor in ventilating transformers. However, he was satisfied that the tube was ventilating the transformer.

The stopping hole should have been observed by mine management and the hole existed for one or two days. The hole put there was to get the cable to the power supply.

Mr. Johnson was involved in abating the citation. They plugged the hole and hung curtain on the north end of the transformer. Gibson rechecked and it was still inadequate. The tube was changed in length and direction.

During the test the inspector said the effort was still inadequate; they were not getting airflow at the south end of the transformer.

The witness agreed that you could see smoke drifting into the belt entry.

Gibson asked Peacock and another individual to go to the intake side of the stopping. In this test, within 16 feet of the stopping, smoke went through the hole in the stopping.

The airflow would go over the belt drive and course to No. 4 crosscut and vent directly into the return. (On R-1 the witness marked directional flow of the smoke with red arrows.)

Smoke will activate the CO monitors.

Discussion

The initial issue to be considered is whether or not the violation of Section 75.1105 occurred.

On this issue the credibility determination must be made between the testimony of Inspector Gibson and UP&L's witness Johnson.

I credit the testimony of the inspector for several reasons. The inspector is clearly a knowledgeable expert concerning ventilation. In comparison, Witness Johnson readily admitted that he was not a ventilation expert. I further credit the inspector's testimony because it was forthright and positive as compared with Mr. Johnson's testimony which at times hedged as to whether or not the vent pipe was in fact ventilating the transformer.

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On Inspector Gibson's testimony it is clear that the transformer was not in fact vented directly into the return and a violation of the regulation occurred.

A further issue presented is whether the occurrence should be designated as significant and substantial within the meaning of the Act.

Section 75.1105 embodies the statutory provisions and it was originally enacted by the Federal Coal Mine Health and Safety Act of 1969. It has essentially remained intact until this time.

The Secretary, relying on the legislative history of the 1969 Coal Act, argues that any violations of 75.1105 are per se significant and substantial. The legislative history of the 1969 Act⁴ expresses the Congressional view as follows:

Section 212(c)

This section provides for certain underground equipment that could cause fires if not functioning properly to be placed in fireproof structures. Air that is used to ventilate the structure and which might contain noxious fumes must be passed directly to the return air.

Experience has shown that such a requirement will reduce the possible mine fire hazards with accompanying inherent dangers to human life and property. In the event a fire should occur in one of these installations the type of equipment enclosed is of such a nature that considerable smoke and fumes are emitted and therefore should be coursed directly into the return aircourse before endangering human life.

In Birchfield Mining Company, 11 FMSHRC 31 (1989) the Commission rejected a per se argument as it related to the violation of a different regulation. I likewise reject the per se argument. However, the credible evidence as recited in the summary of the evidence establishes the violation was S & S as outlined by Commission doctrine expressed in Mathies Coal Company, 6 FMSHRC 1 (1984) and U.S. Steel Mining Co., 6 FMSHRC 1573-74 (1984).

For the foregoing reasons the circumstances here constitute an S & S violation of the regulation as contained in Section 104(d)(1), 30 U.S.C. 814(d)(1) of the Act.

The final issue concerned is whether the circumstances involved here are due to the unwarrantable failure of the operator to comply with the regulation.

The Commission has clearly delineated its views of the meaning of unwarrantable failure. It means "aggravated conduct, constituting more than ordinary negligence, by a mine operator in relation to a violation of the Act." Emery Mining Corporation, 9 FMSHRC 1997-2004 (1987). See also, Quinland Coals, Inc., 10 FMSHRC 705 (1988), and Helen Mining Company, 10 FMSHRC 1672 (1988).

It is uncontroverted in this case that the policy in MSHA District 9 for many years was to the effect that transformers did not have to be ventilated directly to a return air course. On December 30, 1988, there was a meeting where the company was advised that previous District 9 policy had been rescinded. Thereafter, the company would have to vent transformers and similar installations directly to the return. It is further uncontroverted in the record that the company did, in fact, install a 12" corrugated metal vent pipe, one end of which was in close proximity to the end of the transformer. It extended from that point toward the belt drive entry, a distance of 25 feet, and then extended down the belt entry to the 3rd South air return, a distance of approximately 90 feet (See directions and scale in Exhibit C-2). The record is further uncontroverted that the installation was completed by the operator about 30 days before this citation was issued; namely, about mid-February 1989. Such an installation contradicts any view that the operator's actions constituted "aggravated conduct". To the writer it establishes that there was an attempt to comply with the regulation on the basis of the advice the operator had received from the inspector on December 30, 1988.

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For the foregoing reasons I conclude that the operator's conduct was not aggravated within the meaning of the Emery Mining Company, et al case precedent.

I would rule differently if I concluded the metal corrugated vent tubing was merely a charade to comply with the regulation, but I find it was not. The inspector testified he was "astounded" to observe this venting. Further, he could not believe that the company would think that this would ventilate the transformer. I concede the inspector may well have been astounded because what he saw conflicted with his expertise. However, the uncontroverted facts again are that when abatement was accomplished the transformer was vented by using the tubing. The tubing itself was extended about 10 feet toward the end of the transformer and about 5 feet to the side, and a curtain was hung to enclose the area in the crosscut. I accordingly conclude that the operator did not ignore the inspector's advice, nor did they ignore the new MSHA policy, but they acted in a responsible manner. The fact that its effort did not accomplish the desired result cannot work to its detriment. In sum, the operator's conduct was not aggravated within the meaning of the Commission decisions and the factual circumstances cannot be described as a result of the company's unwarrantable failure to comply. The designation of unwarrantable failure in the citation should be stricken.

Consolidation Coal Company, 9 FMSHRC 782 (1987) (Melick, J), relied on by the Secretary, is not inapposite the views expressed here. In Consolidation the operator did nothing and, in fact, relied on the previous interpretation that no violation occurred so long as the power center was "eventually" ventilated to the return. 9 FMSHRC at 785. But this was the prior policy that had been revoked in December, 1988.

Summary

To summarize the action to be taken: I conclude the 104(d)(1) Citation No. 2876485 should be affirmed under Section 104(a) of the Act and not under Section 104(d)(1) of the Act.

For the reasons previously stated the citation should be designated as significant and substantial; further, the designation of unwarrantable failure should be stricken.

For the foregoing reasons I enter the following:

