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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. YORK 89-6  
A. C. No. 18-00621-03645

v.

Mettiki Mine

METTIKI COAL COMPANY,  
RESPONDENT

DECISION

Appearances: Judith Horowitz, Esq., Office of the Solicitor,  
U.S. Department of Labor, Philadelphia, PA,  
for the Secretary;

Ann Klee, Esq., Crowell and Moring, Washington, DC,  
for the Respondent.

Before: Judge Fauver

The Secretary of Labor seeks civil penalties for alleged safety violations under 110(a) of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. 801 et seq.

Having considered the hearing evidence and the record as a whole, I find that a preponderance of the substantial, reliable, and probative evidence establishes the following Findings of Fact and additional findings in the Discussion below:

FINDINGS OF FACT

Mine Ventilation

1. At all relevant times, the Mettiki Mine was ventilated by an exhaust system. Mine fans on the surface pulled fresh intake air from the portals into the mine.

2. From the portals, intake air was pulled through three main entries to the bottom of the hill, as shown on Exh. R-4, and directed to the left into the K-Mains so it could be used to ventilate the L-3 and L-4 longwall panels.

3. On July 19, 1988, when Order 3115856 was issued, Mettiki was in the process of retreat mining the L-3 longwall panel, although no mining was being done that day because the mine was idle for the miners' vacation.

4. The L-3 longwall panel was ventilated by five intake entries, two on the headgate side and three on the tailgate side.

5. The intake entry on the headgate side served as the main section intake; most of the air in that entry was used to ventilate the longwall face. Once the intake air ventilated the longwall face, it became return air which was carried out of the mine through the bleeder entries and the gob and into the main return.

6. The three entries on the tailgate side of the L-3 longwall panel were also intake entries, which carried more fresh air in an inby direction up the tailgate and into the bleeders.

7. This method of ventilating the L-3 panel was approved in the mine ventilation and methane and dust control plan.

8. The main entries immediately outby the L-3 longwall panel, which are the subject of this case, were ventilated entirely with intake air.

9. The "teardown rooms," consisting of two entries and connecting crosscuts immediately inby these main entries, were also ventilated with intake air. The teardown rooms were to be used to disassemble the longwall equipment when the panel was mined out, so that the L-3 longwall equipment could be moved to the next panel.

10. Because the L-3 panel was nearly mined out, Mettiki was using the vacation period to complete a substantial amount of work in the teardown rooms (including hauling supplies, rehabilitating a roadway and operating a diesel scoop).

11. Management decided that the rehabilitation work in the teardown rooms required increased intake air, and to provide this two special ventilation measures were taken. First, a stopping was removed from the No. 12 crosscut between the Nos. 3 and 4 entries of the K-Mains so that intake air could be maintained in the L-3 teardown rooms. Second, although it was not required by the ventilation plan, a check curtain was erected in the No. 11 crosscut of the No. 2 main track entry ("A" on Exh. R-4) to direct some of the fresh air headed for the longwall face into that area.

12. Once the intake air in the K-Mains ventilated the teardown rooms, it was directed up the L-3 tailgate entries into the bleeders behind the L-3 panel and out of the mine through the main return.

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13. Intake air from an isolated K-Mains entry was also used to ventilate the seals adjacent to a mined-out area.

14. Once the fresh air swept the seals, it was directed into the bleeder entries adjacent to the mined-out L-2 longwall panel, into the main return, and out of the mine. The intake air that ventilated the seals was not used to ventilate any working areas.  
Order 3115856

15. On July 19, 1988, MSHA Inspector William Darios inspected the K-Mains entries immediately outby the L-3 longwall panel.

16. Inspector Darios had never been to the L-3 section before, but he believed that the L-3 longwall panel was ventilated in accordance with page 48b of Mettiki's ventilation plan.

17. Acting Mine Foreman Joe Peck accompanied Inspector Darios on his inspection.

18. Near the mouth of the tailgate entry, immediately adjacent to the L-3 longwall panel, Inspector Darios took an air measurement of 7,104 cubic feet per minute.

19. He believed the air at that location was moving in an outby direction and concluded it was return air.

20. In addition, Inspector Darios believed that the air used to ventilate the seals adjacent to the K-Mains entries was return air, because he thought the seals were examined only weekly, as required by 75.305 for seals ventilated with return air. Because he thought there was return air in the tailgate entry and at the seals, he assumed that all K-Mains entries at the mouth of the L-3 longwall panel carried return air.

21. All these assumptions led him to the conclusion that having a check curtain (instead of a permanent stopping) in a crosscut in the No. 2 entry of the K-Mains ("A" on Exh. R-4) allowed air from the headgate side of the L-3 panel to "mix" with the return air he believed to be present in the K-Mains entries.

22. Believing this condition violated the mine's ventilation plan, Inspector Darios issued Order 3115856, alleging a violation of 30 C.F.R. 75.316.  
Order 2493077

23. On July 6, 1988, Inspector Darios issued Section 104(d)(2) Order 2943077 after observing a kink or bend in the

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cable of the C Portal Nordberg Hoist. The kink was 13 inches long and kinked 3/8 of an inch when the cable was weighted and 7/8 of an inch without weight.

24. The kink in the cable was 10 feet 2 1/2 inches from the Nordberg Hoist Barney car.

25. Grease and dirt imbedded in the cable at the point of the kink made it impossible to properly examine the damage without proper cleaning.

26. When the inspector observed the kink in the cable, the equipment had not been removed from service.

27. The condition was noted in the daily examination book by the hoist operator on July 1, 1988.

28. The damage was not repaired nor was the hoist cable removed from service between July 1, 1988 and July 6, 1988.

29. The kink was examined visually by the hoist operator but the cable was not cleaned before his examination nor was the kink measured during his examination.

30. The equipment needed to repair the cable was present on the mine property.

#### DISCUSSION WITH FURTHER FINDINGS

##### Order 3115856

The ventilation plan required that return entries be separated from intake entries by permanent stoppings within three crosscuts of any working face. Exh. J-3 at 48a. There was no requirement that intake entries be separated from other intake entries or that returns be separated by stoppings from other returns. At the time Order 3115856 was issued, the K-Mains immediately outby the L-3 longwall panel were ventilated with intake air so that work could be performed in the teardown rooms.

The check curtain cited by the inspector was placed in the middle of an intake entry, and permitted a small amount of intake air to pass through the curtain to intake entries on the other side. Placement of the curtain did not violate Mettiki's ventilation plan. Rather, as Mr. Peck testified, at the time the order was issued, the ventilation of the K-Mains and the L-3 longwall panel complied with the ventilation plan; the air pressure against the check curtain was what he expected to see, indicating that the K-Mains were ventilated with intake air.

There was no requirement for a stopping or even a check curtain at the No. 11 crosscut of the No. 2 entry cited by the inspector. Mr. Peck testified that the only reason a check

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curtain had been installed at that location was to maintain the amount of fresh air going to the longwall face; it was not intended as a permanent separation because one was not required. Moreover, there was no requirement for a stopping at the No. 12 crosscut between the Nos. 3 and 4 entries of the K-Mains. Mr. Peck testified that a stopping had been necessary at that location to maintain the separation between the primary and secondary escapeways from the L-2 longwall section during the retreat mining of that panel. However, once the L-2 panel was mined out and retreat mining switched to the L-3 longwall panel, the escapeways had to be rerouted, obviating the need for a stopping at the location cited by the inspector. Tr. 330-33.

I find that the L-3 longwall panel was being ventilated in accordance with page 48a of the ventilation plan, as Mr. Peck explained. The inspector was mistaken in his conclusion that Respondent was following page 48b of the plan.

Thus, contrary to the inspector's assumptions, there was no mixing of intake and return air in violation of the ventilation plan, because there was no return air in the places he believed it existed. Where the stopping had been removed and where the check curtain was located, intake air was mixing with intake air and that did not violate Mettiki's ventilation plan or any other mandatory standard.

Order 23943077

The Secretary has alleged a violation of 30 C.F.R. 75.1434(e), which provides in part:

Unless damage or deterioration is removed by cutoff, wire ropes shall be removed from service when any of the following conditions occurs:

\* \* \*

(e) Distortion of the rope structure \* \* \*.

On Friday, July 1, 1988, Hoistman Ellsworth Lambert noticed a kink, or bend, in the hoist cable and noted it in the hoist examination book at 4:20 p.m. On Tuesday, July 6, before 7:30 a.m., Mine Superintendent Steve Polce called Maintenance Foreman Dave Blythe to inform him that a bend in the hoist rope had been reported. He sent Maintenance Foreman Blythe to investigate the condition. Mr. Blythe examined the kink and considered it a distortion of the rope structure within the meaning of 75.1434(e). He ordered parts to replace the damaged part of the cable, but did not remove the cable from service pending repairs.

Later that day, around 9:45 a.m., MSHA Inspector Joseph W. Darios inspected the hoist. After carefully inspecting the kink

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in the cable, he issued Order 23943077 alleging a "substantial and significant" (S & S) violation of 30 C.F.R. 1434(e), and an unwarrantable failure to comply with the regulation.

I find that the kink in the cable was a "distortion of the rope structure" within the meaning of 75.1434(e), as recognized in the testimony of both Inspector Davis and Maintenance Foreman Blythe. Respondent's argument that the kink was not a distortion of the cable structure is not persuasive, and is far afield of the facts in this case.

Inspector Darios found the violation was S & S because of the risk of serious injuries in the event the cable broke. The hoist cable supported mantrips and heavy equipment up and down a steep slope (about a 15% grade). If the cable broke, there was a reasonable likelihood of serious injuries.

The Secretary has proven a significant and substantial hazard under the criteria set forth in the Act and by the Commission. An S & S violation is one "that could significantly and substantially contribute to the cause and effect of a mine safety or health hazard" ( 104(d)(1) of the Act). If, "based upon the particular facts surrounding [the] violation, there exists a reasonable likelihood that the hazard contributed to will result in an injury or illness of a reasonably serious nature" the violation meets the statutory definition. Cement Division, National Gypsum Co., 3 FMSHRC 822, 825 (1981).

In Mathies Coal Company, 6 FMSHRC 1 (1984), the Commission further discussed the element of an S & S violation. The Secretary must prove: (1) there is a violation, (2) the violation contributed to a discrete safety hazard, (3) the hazard would be reasonably likely to lead to an injury and (4) the injury would be reasonably serious. 6 FMSHRC at 3-4.

In this case, the violation contributed to a discrete safety hazard of the hoist's wire rope breaking. Inspector Darios noticed the kink in the cable. Seeing that dirt and grease were coating the cable, he asked to have the area cleaned so he could examine it. He then measured the distortion with weight on the cable and with weight removed from the cable. He observed that the spacing between the lays of the cable in the internal portion of the kink was wider than usual. He concluded, based upon his expert training, experience and careful observations, that the cable was distorted, that there could be internal damage to the wire rope and that the total condition created an S & S hazard of the rope breaking.

The evidence clearly supports the conclusion that the violation contributed to the cause and effect of a discrete safety hazard and that continued normal mining operations would endanger miners. There was sufficient visible evidence of a

distortion of the cable structure to justify the inspector's concerns about possible internal damage.

The evidence further establishes that the hazard contributed to by the violation was reasonably likely to result in serious injuries. Breakage of the cable was reasonably likely to result in a number of different events that could cause serious injury. Derailment of the hoist could result in a collision between the hoist and equipment parked on side tracks. Such a derailment and the subsequent collision could result in miners becoming caught between equipment. Also, heavy equipment could travel down the track and strike people at the bottom of the slope. In the event the cable broke, even if emergency equipment operated successfully to prevent a collision or derailment (and this is not always a reasonable assumption), lurching of a mantrip could cause serious injuries to riders.

The operator introduced the results of a destructive test in which the cable broke at 217,000 pounds. This evidence also showed that the cable broke at the point of the kink. Therefore, the weakest point, the point of failure, was the site of the distortion. The evidence demonstrates that the kink threatened the integrity of the cable. Furthermore, the test itself did not reflect the conditions under which the rope was used. In the test, constant pressure was increased until the cable broke; this was not intermittent pressure that would reflect the daily strain put on the cable. Nor did the test take into account the fact that, with continued use of the cable, strands in the distorted section would undergo greater friction, and more water would infiltrate the core of the cable with greater risk of corrosion.

The Commission stated in National Gypsum that the inspector's independent judgment and expertise are an important element in making significant and substantial findings. Inspector Darios carefully examined the distortion in the cable, including measurements with weight tests, and reasonably concluded there was an S & S hazard if the condition were allowed to continue unabated.

The inspector also found an unwarrantable violation. A violation is unwarrantable if it results from "aggravated conduct" constituting more than ordinary negligence. Emery Mining Company, 9 FMSHRC 1997 (1987). I find that Respondent displayed indifference or a serious lack of reasonable care in failing to address the problem in the hoist cable that existed for six days. Such conduct met the Emery Mining definition of an unwarrantable violation.

Both the lack of procedures that would assure prompt discovery and correction of the violation and management's conduct in failing to address and correct the condition once it was discovered support a finding of unwarrantable failure. The hoist operator, Elwood Lambert, first noticed that there was a



kink in the cable around 4:20 p.m. on Friday, July 1, 1988, during his daily examination of the equipment. The condition was reported in the examination book on July 1 and was noted every day until July 6, 1988, when Inspector Darios came to the mine to conduct a regular inspection. Although the condition was noted for six days, management did not take any action to examine the cable until July 6, 1988, when Maintenance Foreman Dave Blythe examined the cable in response to a call from the Mine Superintendent. At that time, he looked at the cable and decided that the problem was not serious. He decided to perform the repairs when convenient. No other management official examined the cable before the order was issued by Inspector Darios.

Respondent's decision to allow the cable to remain in service demonstrates a serious lack of reasonable care. Because he was the only member of management to examine the cable before the order was issued, Foreman Blythe's actions must be closely examined. First, he decided to allow the cable to remain in service in spite of his belief at the time that the kink constituted a distortion of the structure of the cable within the meaning of 30 C.F.R. 75.1434(e). Tr. 602. He explained his decision to allow the violation to continue by saying that the cable had been allowed to remain in service in the past when broken wires had been found. Tr. 610. This explanation is unsatisfactory. It must be noted that he failed in this case to make measurements with a micrometer as he had been required to do when broken wires were found. Tr. 610-611. Furthermore, whereas distortions require retirement of a cable (75.1434(e)) broken wires may not (see 75.1434(a)). Moreover, although he felt the condition posed no hazard, he was aware that a visual examination of an unbroken cable does not reveal internal damage. Finally, he did not mention that he placed any reliance on previously issued citations. He only said that the mine has always repaired distortions when convenient.

Management's failure to discover and correct the violation for almost a week further supports a finding that its conduct constitutes an unwarrantable violation. The daily examination books are countersigned by a management official. However, no management official was available to perform this duty from Friday, July 1, until the following Tuesday, July 5. Even at that time, no action was taken and the condition was allowed to exist another day without attention. When Foreman Blythe was finally notified of the condition, his examination was only cursory.

Respondent argues that its conduct was not unwarrantable because its personnel relied on citations issued by another inspector, Wayne Fetty, for distortions in wire ropes in which the rope was not required to be removed from service immediately. However, the actions taken by Mettiki's management at the time of the instant violation reveal that management was not even aware of the condition for five days after it was first reported in the

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examination books. Tr. 688-689. Further, the management official who examined the cable did not indicate that he relied upon Mr. Fetty's citations. In fact, he testified that he never discussed with Mr. Fetty what constitutes sufficient damage for application of the retirement criteria. Tr. 601.

An examination of the operator's conduct at the time the distortion was discovered reveals a failure of management to address safety problems identified by the miners. The duty of assessment of the severity of the distortion of the cable was left to the judgment of an hourly employee. Tr. 691. Under management's policy, it was the rank and file's responsibility to determine if a problem already identified in the examination books is serious enough to alert management to take immediate action. Tr. 690-691. If a problem happened to occur on a Friday as it did in this case, there was no management official responsible for locating and assessing violations that occurred to the hoist. Tr. 690-691.

On balance, I find that Respondent's conduct rose to a level above ordinary negligence.

Considering all the criteria for a civil penalty in 110(i) of the Act, I assess a civil penalty of \$1100 for this violation. Orders 3115846 and 3115848

At the hearing, the parties stipulated that the only issue remaining on liability as to these orders is whether Mettiki's roof control plan required Mettiki to replace posts that were removed in order to install longwall equipment. Tr. 472. If this issue is answered in the affirmative, the parties stipulated that the above 104(d) orders should be modified to 104(a) citations with reduced findings of negligence and gravity.

Order 3115846 alleges that roof support posts had been removed in a number of places in the L-4 entry and Nos. 5 and 6 crosscuts allowing the width of the entry and crosscuts to exceed 18 feet, in violation of Mettiki's roof control plan and 30 C.F.R. 75.220. Order 3115848 alleges a violation of 30 C.F.R. 75.303 for a failure to conduct an adequate preshift examination of the cited area.

Mettiki's roof control plan provided that, "As the longwall pan, shields, and shearer are installed, posts will be removed as necessary." Jt. Ex. 4, p.31.

The Secretary contends that this provision is only a conditional exception to the requirement for an 18 foot width in the longwall setup entry and crosscut. She contends that in context, the word "as" is synonymous with "while" or "when" so that the roof control provision means that after the longwall equipment is moved through the entry and crosscut, the removed

posts must be put back in place to keep a maximum width of 18 feet.

Respondent contends that the roof control plan does not expressly require posts to be reinstalled after they have been removed according to the plan, and such a requirement is not reasonably implied by the plan.

The roof control plan requires the setup entry and crosscuts to be mined 18 feet wide initially and supported with roof bolts. The operator is then required to set a double row of posts on five foot centers along the length of the setup entry and crosscuts. The plan then and only then allows the operator to shear off an additional five feet in width along the rib opposite the posts to allow the entry or crosscut to be a maximum width of 23 feet. The stated purpose of requiring the double row of posts to be set is to maintain an 18 foot width before the entry and crosscut is widened to 23 feet. At no time in the process is the setup entry and crosscut allowed to become more than 18 feet wide without additional support of the double row of posts.

The plan then provides that, "As the longwall pan, shields, and shearer are installed, posts will be removed as necessary." (Emphasis added.) The word "as" is reasonably interpreted to mean "during the time that," or "while" in this context. Thus, the plan allows for removal of the posts only during installation of the panline, shields and shearer. The limitation that the posts be removed only as necessary further emphasizes that such removal be minimized.

The roof support plan specifies the order in which the steps are to be performed so that the set-up entry and crosscuts may be sheared to a maximum width of 23 feet. The plan requires that the steps be taken in a specific order so that at each step the entry and crosscut are always narrowed by, and supported by posts. Further, the plan for supporting the roof of the longwall setup entry and crosscut specifically states that the "entry and crosscut will be sheared to 23 feet wide and supported to plan." (Emphasis added.) The plan requires the double row of posts to be set. That requirement read in conjunction with the provision allowing removal of such posts only when installation of the panline, shields or shear is occurring, supports the conclusion that the posts must be reinstalled after removal.

To interpret the roof plan to allow posts to remain absent would render the specific cutting and roof support procedures superfluous. The plan must not be interpreted to render its requirements illogical. If the roof support plan for the longwall setup entry and crosscuts were interpreted as urged by the operator, the effect would be quite dangerous. If posts were not required to be replaced, one section of panline might be installed and posts could be removed. Then if work did not continue, under Respondent's interpretation the entry or crosscut

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could remain unsupported with excessive widths indefinitely. The plan is written and must be interpreted to avoid this result.

The parties' stipulation is granted to modify these orders to 104(a) citations with reduced findings of negligence and gravity. The original allegation of negligence in Order 3115846 is changed to moderate negligence and gravity is changed by deleting S & S. In Order 3115848, the original allegation of negligence is changed to moderate negligence and gravity is changed by deleting S & S.

Independent of the question whether the instant violation is "significant and substantial" within the meaning of 104(d)(1) of the Act, I find that it is a serious violation within the meaning of "gravity" in 110(i) of the Act. It is serious because the safety standard is an important protection for miners and Respondent's conduct created a reasonable possibility of serious injury that could result from excessive widths of entries and crosscuts. It is also a serious violation because of the need to deter future violations of this type.

Considering all the criteria for civil penalties in 110(i) of the Act, I assess a civil penalty of \$100 for each of the two violations cited in revised Citations 3115846 and 3115848.

#### CONCLUSIONS OF LAW

1. The judge has jurisdiction over this proceeding.
2. The Secretary failed to prove a violation of 30 C.F.R. 75.316 as alleged in Order 3115856.
3. Respondent violated 30 C.F.R. 75.1434(e) as alleged in Order 23943077.
4. Respondent violated 30 C.F.R. 75.220 as alleged in revised Citation 3115846.
5. Respondent violated 30 C.F.R. 75.303 as alleged in revised Citation 3115848.

#### Order

WHEREFORE IT IS ORDERED that:

1. Order 3115856 is VACATED; Order 23943077 is AFFIRMED; revised Citations 3115846 and 3115848 are AFFIRMED.

