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METTIKI COAL V. MSHA, MSHA V. METTIKI COAL
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FEDERAL MINE SAFETY & HEALTH REVIEW COMMISSION
FALLS CHURCH, VA
April 18, 1990

METTIKI COAL CORPORATION, Contestant	CONTEST PROCEEDINGS
v.	Docket No. YORK 89-31-R Order No. 2944492; 2/21/89
SECRETARY OF LABOR, MINE SAFETY AND HEALTH ADMINISTRATION (MSHA), Respondent	Docket No. YORK 89-32-R Order No. 2944493; 2/21/89
	Docket No. YORK 89-33-R Order No. 2944494; 2/21/89
	Mettiki Mine
	Mine ID 18-00621
SECRETARY OF LABOR, MINE SAFETY AND HEALTH ADMINISTRATION (MSHA), Petitioner	CIVIL PENALTY PROCEEDINGS
	Docket No. YORK 89-52 A.C. No. 18-00621-03674
v.	
METTIKI COAL CORPORATION, Respondent	Docket No. YORK 89-56 A.C. No. 18-00621-03673
	Mettiki Mine

DECISION

Appearances: Timothy M. Biddle, Esq., Crowell & Moring, Washington, D.C., for the Contestant/Respondent; James E. Culp, Esq., U.S. Department of Labor, Office of the Solicitor, Philadelphia, Pennsylvania for the Respondent/Petitioner.

Before: Judge Maurer

STATEMENT OF THE CASE

These consolidated cases are 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 validity of three 104(d)(2) orders issued to Mettiki on February 21, 1989, and for review of the civil penalties proposed by the Secretary of Labor for the related violations.

There is also an unrelated and uncontested Order No. 3115408, which the Secretary also included in Docket No. YORK 89-52. Order No. 3115408 was issued on March 1, 1989, pursuant to 104(d)(2) of the Act for a violation of 30 C.F.R. 75.313-1. A penalty of $1000 was originally assessed. However, the parties now agree that this order should be modified to delete the special finding of unwarrantability and they have proposed by separate written motion that I approve their agreed settlement which reduces the civil penalty to $150 for this particular violation.

Considering the representations submitted in the motion, I conclude that the proffered settlement is appropriate under the criteria set forth in section 110(i) of the Act. Accordingly, the motion for approval of the settlement with regard to Order No. 3115408 is granted and the respondent will be ordered herein to pay the $150 civil penalty.

Pursuant to notice, these cases were heard in Morgantown, West Virginia on August 1 and 2, 1989. Both parties nave filed post-hearing proposed findings of »act and conclusions of law, which I have considered along with the entire record herein. I make the following decision.

STIPULATIONS

The parties have agreed to the following stipulations, which I accept:

1. The Mettiki Mine is owned by contestant Mettiki Coal Corporation.

2. The Mettiki Mine is subject to the jurisdiction of the Federal Mine Safety and Health Act of 1977.

3. The undersigned Administrative Law Judge has jurisdiction over this proceeding pursuant to 105 of the Act.

4. The subject orders, their termination, and modification were properly served by duly authorized representatives of the Secretary of Labor upon an agent of Mettiki on the dates, times, and places stated therein, and may be admitted into evidence for purposes of establishing their issuance without admitting the truthfulness or relevance of any statement therein.

5. Mettiki had 720 assessed violations in the 24-month period prior to the issuance of the subject orders.

6. There has been no "clean" inspection of the Mettiki Mine between the 104(d)(2) orders at issue and the previous 104(d) (1) order, No. 2701558, dated May 30, 1986.

7. The violations alleged, if proved, were abated in good faith.

8. If the violations are proven, the imposition of civil penalties based on the facts as required by Section 110(i) of the Act will not affect Mettiki's ability to continue in business.

9. Respondent's annual coal production is 1,987,594 tons at the Mettiki Mine.

I. Docket No. YORK 89-31-R; Order No. 2944492

Order No. 2944492, issued pursuant to section 104(d)(2) of the Act, alleges a violation of the regulatory standard at 30 C.F.R. 75.202(a) 1/ and charges as follows:

> The coal ribs of an area where persons were required to work and travel were not supported or otherwise controlled to protect persons from the hazards related to falls or the rib. A fatal rib roll accident has occurred in the No. 1 Entry of the 23 Butt Section, approximately thirty feet outby station No. B3109, where belt hangers were being bolted to the roof. Carl Johnson was the section foreman.

Mr. Nelson Blake, a mining engineer and roof control specialist employed by MSHA since 1980, issued the above order on February 21, 1989, following the investigation of a fatal rib roll accident which occurred on February 17, 1989. Delmas Martin, a Mettiki employee, was killed at approximately 8:20 that evening in the No. 1 entry of the 23 Butt Section of Mettiki's B Mine, between the No. 13 and No. 14 breaks.

The 23 Butt Section was originally developed in March of 1982 as a return air course for Mettiki's main mine. The original roof support in this section consisted of 6 foot resin roof bolts, installed 4 bolts to a row, with rows on four foot centers. This roof-bolting was supplemented by cribbing on 7-foot centers w:tn about J feet of space between the rib and the edge of the crib nearest the rib. At the time of the accident, respondent was in the process of rehabilitating the No. 1 entry

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1/ 30 C.F.R. 75.202(a) provides as follows:

The roof, face and ribs of areas where persons work or travel shall be supported or otherwise controlled to protect persons from hazards related to falls of the roof, face or ribs and coal or rock bursts.

for use as a headgate entry for a longwall panel. The immediate work being done was removing cribs as well as rib bolting while simultaneously installing belt hangers, and any necessary roof bolts. Just prior to the accident, two miners (Delmas Martin and Dave Holland) were installing belt hangers and another was using the horizontal drill on the back of the Fletcher dual head bolter to install rib bolts.

At the time of the accident, the cribs had been removed in the Nos. 1 and 2 Entries up to the No. 16 break. More specifically, the cribs between the Nos. 13 and 14 breaks, where Mr. Martin was killed, were removed two to »our days before the accident.

This mine has a history of rib roll accidents, including an earlier fatality in 1984. The ribs in the 23 Butt Section consist of soft coal beneath 2 feet of cap rock. Mr. Biddle stipulated that the ribs are soft in this mIne and that they have to be carefully watched and controlled. Due to the excessive weight of the coal (8 to 10 feet) and the softness of the coal, the cap rock setting on top of the coal tends to crush the coal out, causing the rock and the coal rib to fa!1 out into the entry. It is a known hazard in this mine. After the 1984 fatality, MSHA has required rib bolting in the mine and that has reduced the incidence of these rib rolls.

At the time of the accident, Delmas Martin was working with his section foreman, Carl Johnson and David Holland. Martin and Holland were installing belt hangers between the No. 13 and No. 14 crosscuts of the No. 1 Entry of the 23 Butt Section. They were working near the front of and on either side of the Fletcher dual head bolting machine operating the root drills. Foreman Johnson was working at the rear of the machine, using the horizontal drill to install rib bolts. Approximately 30 seconds before the accident, Johnson walked from behind the roof bolter up the left side of the machine to talk to Martin, looking at the left rib as he passed between it and the machine. He noticed nothing hazardous about the rib, and Martin expressed no concern about it. He talked to Martin less than a minute and then returned to the rear of the machine again via the left side and began installing a bolt in the right-hand rib. At that instant, the left-hand rib collapsed, and Martin was covered up by the falling debris. Neither Johnson nor Holland heard any sounds or had any other warning that the rib was about to fall.

The investigation of the accident, conducted by Mr. Blake, revealed that the rock brow and coal rib that fell measured 41 feet in length. The newly exposed roof line, created by the

fallen cap rock ranged from a feather edge to 34 inches wide and the cap rock itself measured 18 to 27 inches thick. The specific piece of laminated rock and coal that. struck Mr. Martin measured approximately 5 1/2 feet long, 2 1/2 feet wide and 1 1/2 feet thick.

Mr. Blake concluded that the accident and the resulting fatality occurred because an unsupported overhanging rock brow and coal rib was not properly evaluated and taken down or supported. He also opined that this brow would have been readily visible to a reasonable person.

Another of the Secretary's witnesses, Mr. Barry Ryan, also a mining engineer, and a field office supervisor for MSHA agreed with Blake's analysis. He participated in the investigation and also came to believe that a brow was present prior to the accident. Furthermore, he was also of the opinion that the brow should have been obvious to anyone in the area.

Their shared opinion is based largely, if not exclusively, on three factors. First, portions of two painted red lines were still visible on the coal rib near the accident site after the rock and rib fell. Before the accident, the ribs had vertical red lines painted approximately every five feet, marking locations where rib bolts would be installed. Those two remaining paint marks indicated to Blake and Ryan that that was where the original rib line was located. Prior to the fall or rib roll, the paint marks had extended ali the way to the cap rock on the rib and after the fall the top if the paint marks were approximately one foot below the cap rock. Secondly, they also felt that there was insufficient coal present on the floor after the accident compared with the amount of fallen rock for the coal rib to have extended far enough into the entry to have obscured the vast majority of the rock brow. Thirdly, the large size of the fallen rock material was another factor which led them to conclude that an obvious overhanging brow had to have existed before the accident.

Mr. Blake also opined in his accident investigation report that "[m]atching the old roof line to the coal pillar indicates that an overhanging coal rib and/or brow was present."

There really is no dispute that a rib or brow fell on and killed Delmas Martin. Nor is it disputed that any reasonable person, knowledgeable about roof and rib control would recognized an overhanging brow as a hazardous condition and not work under it or permit work under it until it was removed, control!ed or supported.

The issue squarely presented for decision then is whether or not an overhanging brow was present and observable prior to the accident.

The issue of liability for violations of the roof and rib control standards, more particularly, the standard's requirement that the roof and ribs be supported or controlled, is resolved by reference to whether a reasonably prudent person, familiar with the mining industry and the protective purpose of the standard, would have recognized that the roof or ribs were not adequately supported or otherwise controlled. Canon Coal Co., 9 FMSHRC 667,668 (April 1987); Quinland Coals, Inc., 9 FMSHRC 1614, 1617-18 (September 1987). Cf. Ozark-Mahoney Co., 8 FMSHRC 190, 191-92 (February 1986); Great Western Electric Co., 5 FMSHRC 840, 841-42 (May 1983). Put another way, were there any objective signs existent prior to the accident that would have or should have alerted a reasonably prudent person to the danger or even the existence of an overhanging brow? If there were, then that brow should have been taken down or supported and the failure to do so would constitute a violation of the cited standard.

The Secretary submits that there was an overhanging brow present before the accident which was readily observable. As support for this allegation, she offered the factual and ultimately the opinion testimony of Mr. Blake and Mr. Ryan. Blake and Ryan are both mining engineers and have extensive experience in underground coal mines. The Secretary urges that they be accepted as experts and I do acknowledge their expertise. Their theory, based on the factors I enumerated earlier in this opinion, is certainly a plausible one. However, the weakness in the Secretary's case besides the fact that she has the burden of proof lies in the fact that the acceptance of the Blake/Ryan theory requires the rejection of all the eyewitness, on-site testimony in the record.

Most significantly it would require me to outright reject as incredible the two most important percipient witnesses' testimony about the accident; the two men who were working with Delmas Martin at the time he was killed. David Holland, a miner with 10 years experience at Mettiki was a co-worker of Martin's. He was working on the other side of the roof bolter with Martin at the time of the accident. Concerning the condition of the accident site the day before the accident Mr. Holland testified at Tr. 286:

> Q. Do you recall whether there was a brow present along the left-hand side of the rib between 13 and 14 crosscut?
>
> A. No.

Q. You do not recall or there was no brow?

A. No brow.

As to the day of the accident he testified at Tr. 290-92:

Q. Did you examine the ribs between 13 and 14 crosscut before you started working beside them?

A. Yes.

Q. What method did you use?

A. Visual.

Q. Why did you examine the rib?

A. To make sure they was safe.

Q. Did you discover any hazard in the area where you were working?

A. No.

Q. Do you know if Mr. Martin examined the ribs beside him?

A. Yes.

Q. How do you know?

A. I seen him looking at it.

Q. How long before the accident occurred did you see that?

A. Five, ten minutes.

Q. Was there a brow on Mr. Martin's side?

A. No.

* * * * * * *

Q. Are you aware that after the accident there was a paint mark left on the rib on the left-hand side near the accident area?

A. Yes.

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Q. And you say there was no brow; is that correct?

A. That is correct.

Q. If there was no brow, how can you explain the paint mark that was left on the rib after the rib fell?

A. Well, on those ribs the ribs is curved, and your top might -- well, the coal in the middle is real soft and it will kind of work out a little bit. All your rib lines go like this (indicating) to the bottom, and there was a good bit of coal underneath the rock. There wasn't no brow.

Q. Would you tell us what a brow is in your understanding of it?

A. Overhanging rock or coal.

Q. Was there any requirement that you know of from anyone dealing with brows? What do you do when there is a brow?

A. We pull it down; or if it is too big, we get a scoop and knock it down.

Q. Why?

A. So to be safe.

At the end of his direct testimony, I again questioned him regarding this important issue and he responded at Tr. 295:

JUDGE MAURER: Mr. Holland, in the five or ten minutes before this accident did you have an occasion to look at that left-hand side rib, the rib that feel in on Mr. Martin?

THE WITNESS: Yes, I did.

JUDGE MAURER: You didn't see anything untoward there whatsoever?

THE WITNESS: No, nothing. There was nothing.

Even more dramatic was the testimony of foreman Carl (Randy) Johnson. He has nineteen years of underground coal mining experience, eleven of those years with Mettiki. On the day of the accident, he was the section foreman of the crew of men, including Delmas Martin, who were doing rehabilitation work in the 23 Butt Section to establish a belt line for a longwall panel.

Johnson performed pre-shift and onshift examinations of the affected area on each of the two days immediately preceding the accident as well as the accident date itself and observed no hazardous rib conditions and detected no overhanging coal rib and/or brow.

Immediately before the fall, he himself was standing next to Delmas Martin. He described the incident in his testimony at Tr. 244-246:

Q. When was the last time you were along that rib before it fell, if you can recall?

A. The last time I was [along] that rib was approximately 30 seconds before it fell.

* * * * * * *

I was rib bolting, and I had walked up to the side to talk to Delmas.

* * * * * * *

Q. When you walked up to talk to Mr. Martin which way did you go?

A. I come from behind the roof bolter to the left side and come up to ta!k to him.

* * * * * * *

Q. At that time did he express any concern about the rib that you had just passed beside?

A. No, he did not.

Q. Did you notice anything about that rib that caused you any concern?

A. No, I did not.

Q. Did you look at that rib as you walked up there?

A. Yes, I did.

Q. Why did you look at the rib?

A. It is common practice to look at the ribs when you go in past the machines. You always look at the ribs.

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Q. How long did you talk to Mr. Martin?

A. It was less than a minute.

Q. Then what happened?

A. I come back to the back end of the bolter.

* * * * * * *

[A]nd started installing the bolt on the right-hand rib.

* * * * * * *

I was drilling the hole when the roof come in.

As section foreman of this area, as well as the mine examiner, Randy Johnson would have been primarily responsible for detecting any overhanging brow that was there. I have heard his testimony, observed him at the trial and re-read the transcript of his testimony. I find it hard to believe that he would work and walk alongside that rib under an observable brow. He was standing right next to Martin talking to him less then a minute before the fall. I doubt very much he would have been doing so had he known there was an unsupported overhanging rock brow over his head.

He certainly had inspected this area many times in the days and hours, even minutes before the accident. Just as certainly, he knows what an overhanging rock brow looks like as well as the danger involved in working under or near such a thing. He also knows the only acceptable practice in such an instance is to either support the brow or take it down. I would say that his presence alongside Martin in the minute or minutes before the accident speaks louder than words. It says to me that he didn't know he was standing under a 41-foot long overhanging rock brow. If we give him the fact that he knows a brow when he sees one, it is a reasonable inference that if there was a brow there, it was not observable by visual means.

In support of the testimony of the two eyewitnesses, there is also the testimony of several other Mettiki employees who were in the accident area prior to the fall.

The mine foreman, Allen Rohrbaugh, testified that he spent an average of four hours per day in the No. 1 Entry of the 23 Butt Section during the week the accident occurred. He observed the rib conditions between the Nos. 13 and 14 crosscuts on the

day of the accident and saw no brow present or any other problem with the rib that fell.

Mr. Thomas, who was the foreman on the night shift in the 23 Butt Section on the day of the accident also testified. He had performed two onshift examinations and a preshift examination the night prior to the accident. These examinations included visual examination of the ribs between Nos. 13 and 14 crosscuts. He likewise observed no brow.

William D. Baumann conducted two onshift examinations and a preshift examination of the area between Nos. 13 and 14 crosscuts on the date of the accident. He testified there was no visible brow present.

Mr. Joseph E. Peck is and was at all times pertinent, Mettiki's Safety Coordinator. At the hearing, he produced and testified from his work notes that he accompanied MSHA Inspector Calvert through the No. 1 Entry of the 23 Butt Section on February 1, 7, 8, 9 and 15, of 1989, including the area between the Nos. 13 and 14 crosscuts. Like everyone else, Peck observed no overhanging brow or any other indication that the rib in that area may have been loose. Neither, apparently, did Inspector Calvert see any such conditions or presumably, he would have pointed it out. However, the Secretary correctly points out that any such observations or lack of observation must be evaluated from the standpoint that relatively large cribs were present in the area until either February 15th or 16th. The inspector, and for that matter, Mr. Peck, never saw the area between the time the cribs were removed and the accident occurred.

The Secretary has offered no direct evidence, such as eyewitness testimony, for example, that a visible brow existed prior to the accident. Instead, the Secretary relies entirely on the Blake/Ryan theory that an overhanging rock brow must have existed and most assuredly was visible prior to the accident. This theory and its supporting factors were discussed earlier in this decision and as I have said it is quite plausible but certainly not a scientific fact. Possibly it existed, was visible, and should have been observed and removed or supported, just as they theorize. However, there was a defense presented based on eyewitness testimony that contradicts the ultimate finding they made. Six Mettiki employees who repeatedly observed and examined the ribs in the accident area in the days and hours before the accident testified unequivocably that there was no brow or any other hazardous condition that would have put them on notice that there was a rock brow existent that needed to be supported or taken down. I can find no reason to discredit their testimony and therefore I conclude that the Secretary has failed to satisfy her burden of demonstrating that Mettiki should have

recognized the existence of a hazardous roof or rib condition and corrected it. Specifically, I find that Mettiki cannot be successfully charged with the knowledge that a hazardous condition existed prior to the accident. The Secretary's theory that a pre-accident visible brow existed is contradicted and outweighed by the unrebutted eyewitness testimony of the Mettiki witnesses, all of them experienced miners, who saw no such brow despite conducting numerous visual examinations of the ribs and roof in this Section.

I therefore conclude that the Secretary has failed to prove a violation of 30 C.F.R. 75.202(a). Order No. 2944492 will accordingly be vacated.

II. Docket No. YORK 89-32-R; Order No. 2944493

Order No. 2944493, issued pursuant to section 104(d)(2) of the Act, alleges a violation of the regulatory standard at 30 C.F.R. 75.211(a) 2/ and charges as follows:

> A proper examination of the coal ribs was not made before work was started on the 23 Butt Section. A fatal rib roll accident has occurred in the No. 1 Entry of the 23 Butt Section, approximately 30 feet outby station No. B3109 where belt hangers were being bolted to the roof. Carl Johnson was the section foreman.

The parties agree that a proper examination of the rib area would entail a visual evaluation of the rib over an extended area, looking for any hazardous conditions such as gapped or loose material or overhanging brows. They also agree that it is possible to make a proper examination and still have the rib fall out.

However, having said that, it appears to me that the only basis upon which this particular order was issued was the fact that there was a fall and a man was killed. That is plainly an insufficient basis upon which to prove the charged violation.

On the other side, Mettiki has demonstrated to my satisfaction that regular preshift and onshift visual examinations of the ribs in the accident area were conducted by certified and qualified personnel as more fully set out earlier in this decision.

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2/ 30 C.F.R. 75.211(a) provides as follows:

A visual examination of the roof, face and ribs shall be made immediately before any work is started in an area and thereafter as conditions warrant.

As I found in the earlier docket, the preponderance of the available evidence just does not support the Secretary's necessary premise that an obvious overhanging brow was present in the area.

Accordingly, Order No. 2944493 will likewise be vacated.

III. Docket No. YORK 89-33-R; Order No. 2944494

Order No. 2944494, issued pursuant to section 104(d)(2) of the Act, alleges a violation of the regulatory standard at 30 C.F.R. 75.220 (the roof control plan standard) and charges as follows:

> The approved roof control plan is not being complied with on the 23 Butt Section. At numerous locations throughout the No. 1 Entry, rib bolts have been installed without the end of the board as close to the roof as possible as required by pages 15 and 16 of the approved roof control plan. The ends of the boards measured 20 inches to 30 inches from the roof line at several locations. At the accident site, the distance between the last two rib bolts measured 9.4 feet. The approved plan requires a six foot maximum spacing on rib bolts.

On February 1, 1989, prior to starting the rehabilitation work in the 23 Butt Section, Mettiki filed a Rehabilitation Plan with MSHA. MSHA approved the plan on February 3, 1989, and included it in Mettiki's previously-approved Roof Control Plan. The Rehabilitation Plan itself speaks to rib-bolting only in a perfunctory manner. It does not in and of itself explain with any particularity how this rib-bolting is to be done other than to articulate what the maximum spacing shall be in two different height areas. However, the Roof Control Plan, of which I find the Rehabilitation Plan is a part, requires rib bolts to be installed on six-foot maximum centers "as close to the roof as possible".

Mettiki argues that the Roof Control Plan clearly states that it applies only to areas developed after May 31, 1984; whereas the 23 Butt Section was developed between October 1981 and March 1982.

Nevertheless, I agree with the Secretary's argument that when a clear definition of exactly what work is required by a sub-part of a document is not included in that piece of the plan, the next logical step is to look to the entire document for direction. Therefore, I conclude that the rib bolts in the 23 Butt Section had to be installed on 6-foot maximum centers with rib boards placed "as close as possible to the roof".

Actually Mettiki came pretty close to doing that. They were in the process of installing rib bolts and boards in the No. 1 Entry of 23 Butt Section when the accident occurred. The rib bolts and boards outby the area of the accident were installed on five-foot centers. I think it is clear that their intention was to install all the bolts on five-foot centers. On the day of the accident, Martin and Holland had painted marks at 5-foot intervals along the ribs of the No. 1 Entry to mark the horizontal spacing for the rib bolts that were being installed as the rehabilitation work progressed up the entry. It was their practice, however, to simultaneously install belt hangers and rib bolts on ten-foot centers as the hanger installation progressed. Then, when the crew reached the next crosscut, they would come back and install an additional rib bolt between every two, resulting in a five-foot space between each bolt and board.

At the time the accident occurred, the last two rib bolts that had been installed along the left rib were spaced 9.4 feet apart. I believe the crew had intended to come back and install the missing bolt and board but the accident intervened. The subsequent accident investigation found them in that configuration and I find that to be a violation of the Roof Control Plan and the cited standard.

With regard to the placement of the rib boards, I also find that aspect of the installation to be a violation of the Roof Control Plan and the cited standard. I find credible the Mettiki testimony to the effect that the rib bolts themselves were installed as high as possible using a normally configured bolting machine with its rib drill at the maximum "up" angle, but they could simply have used longer boards.

There is no evidence that the location of the rib boards in the No. 1 Entry or the interval between the last two bolts caused the accident or in any way contributed to it. Nonetheless, for the reasons that follow, I find this to be a significant and substantial violation.

A "significant and substantial" violation is described in section 104(d)(1) of the Mine Act as a violation "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 C.F.R. 814(d)(1). A violation is properly designated significant and substantial "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." Cement Division, National Gypsum Co., 3 FMSHRC 822, 825 (April 1981).

In Mathies Coal Co., 6 FMSHRC 1, 3-4 (January 1984), the Commission explained its interpretation of the term "significant and substantial" as follows:

> In order to establish that a violation of a mandatory safety standard is significant and substantial under National Gypsum the Secretary of Labor 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.

In United States Steel Mining Company, Inc., 7 FMSHRC 1125, 1129 (August 1985), the Commission stated further as follows:

> We have explained further that the third element of the Mathies formula "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). We have emphasized that, in accordance with the language of section 104(d)(1), it is the contribution of a violation to the cause and effect of a hazard that must be significant and substantial. U.S. Steel Mining Company, Inc., 6 FMSHRC 1573, 1574-75 (July 1984).

The question of whether any particular violation is significant and substantial must be based on the particular facts surrounding the violation, including the nature of the mine involved, Secretary of Labor v. Texasgulf, Inc., 10 FMSHRC 498 (April 1988); Youghiogheny & Ohio Coal Company, 9 FMSHRC 2007 (December 1987).

The post-accident inspection turned up approximately thirty rib boards placed 20 to 30 inches below the roof and not touching the cap rock in a 1200 foot area in the No. 1 Entry. The purpose of installing these boards is to assist in controlling both the coal rib and the cap rock above it. The installation of the boards below the cap rock could allow the cap rock to roll out and possibly strike persons working or walking near the rib line. I am convinced that this would be a reasonably likely occurrence. If it occurred, and anyone was there, a serious injury or fatality would be very likely.

In Halfway, Incorporated, 8 FMSHRC 8, 13 (January 1986), the Commission upheld a significant and substantial finding

concerning a roof area which had not been supported with supplemental support, and ruled that a reasonable likelihood of injury existed despite the fact that miners were not directly exposed to the hazard at the precise moment of the inspection. In that case, the Commission stated as follows at 8 FMSHRC 12:

> [T]he fact that a miner may not be directly exposed to a safety hazard at the precise moment that an inspector issues a citation is not determinative of whether a reasonable likelihood for injury existed. The operative time frame for making that determination must take into account not only the pendency of the violative condition prior to the citation, but also continued normal mining operations. National Gypsum, supra, 3 FMSHRC at 825; U.S. Steel Mining Co., Inc., 6 FMSHRC 1573, 1574 (July 1984).

In view of the foregoing findings and conclusions, I conclude and find that the violation was significant and substantial, and the inspector's finding in this regard will therefore be affirmed.

The Secretary also submits that the violation was the result of an unwarrantable failure.

In several relatively recent decisions concerning the interpretation and application of the term "unwarrantable failure," the Commission has further refined and explained this term, and concluded that 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 (December 1987); Youghiogheny & Ohio Coal Company, 9 FMSHRC 2007 (December 1987); Secretary of Labor v. Rushton Mining Company, 10 FMSHRC 249 (March 1988). Referring to its prior holding in the Emery Mining case, the Commission stated as follows in Youghiogheny & Ohio, at 9 FMSHRC 2010:

> We stated that whereas negligence is conduct that is "inadvertent," "thoughtless" or "inattentive," unwarrantable conduct is conduct that is described as "not justifiable" or "inexcusable." Only by construing unwarrantable failure by a mine operator as aggravated conduct constituting more than ordinary negligence, do unwarrantable failure sanctions assume their intended distinct place in the Act's enforcement scheme.

The major reason the Secretary gives for the "unwarrantability" of this violation is that the cited condition had existed

for a two-week period and covered a substantial area that was regularly inspected. I don't think there is any doubt that Mettiki management saw the violative condition concerning the rib boards and knew of the practice of initially installing the rib bolts on 10-foot centers and then going back and filling in. The real problem is that they didn't recognize these situations as violations. The next question is should they have, and I conclude that they should have. But this is ordinary negligence, not aggravated conduct in my opinion. Reasonable persons I think could differ as to what exactly the Roof Control Plan requires with regard to rib-bolting. I found the Roof Control Plan requires Mettiki to install rib bolts and boards "as close to the roof as possible", but there is no explanation in the plan as to what exactly that means vis-a-vis the cap rock, which seems to be the sine qua non of the Secretary's complaint. Nor is there any specific requirement for installing the rib bolts in any particular order as long as they finally get installed on 6-foot maximum centers. The violation in the case at bar is that they didn't.

Accordingly, the inspector's unwarrantable failure finding will be vacated and the contested section 104(d)(2) order modified to a section 104(a) citation, with special significant and substantial findings.

For the reasons stated above, I conclude and find that the violation was serious and resulted from Mettiki's failure to exercise reasonable care to make sure it was complying with its Roof Control Plan. This amounts to ordinary negligence.

On the basis of the foregoing findings and conclusions, and taking into account the requirements of section 110(i) of the Act, I conclude and find that a civil penalty of $400 is reasonable and appropriate to the violation found.

ORDER

1. Section 104(d)(2) Order Nos. 2944492 and 2944493 are vacated and MSHA's related civil penalty proposals are rejected.

2. Section 104(d)(2) Order Nos. 2944494 and 3115408 are hereby modified to "S&S" section 104(a) citations and affirmed as such.

3. Mettiki Coal Corporation is ordered to pay the sum of $550 within 30 days of the date of this decision as a civil penalty for the violations found herein.

Roy J. Maurer
Administrative Law Judge

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