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GATLIFF COAL v. SOL (MSHA)
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Federal Mine Safety and Health Review Commission
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GATLIFF COAL COMPANY, INC., CONTESTANT	CONTEST PROCEEDINGS
v.	Docket No. KENT 89-242-R Citation No. 3178703; 8/3/89
SECRETARY OF LABOR, MINE SAFETY AND HEALTH ADMINISTRATION (MSHA) RESPONDENT	Docket No. KENT 89-243-R Citation No. 3178704; 8/3/89
	Docket No. KENT 89-244-R Order No. 3178706; 8/3/89
	Docket No. KENT 89-245-R Citation No. 3178707; 8/3/89
	Docket No. KENT 89-246-R Citation No. 3178708; 8/3/89
	Docket No. KENT 89-247-R Citation No. 3178709; 8/3/89
	Docket No. KENT 89-248-R Citation No. 3178710; 8/3/89
	Docket No. KENT 89-249-R Order No. 3178711; 8/3/89
	Docket No. KENT 89-250-R Citation No. 3178712; 8/3/89
	Docket No. KENT 89-251-R Citation No. 3178713; 8/3/89
	Docket No. KENT 89-252-R Order No. 3178714; 8/3/89
	Gatliff No. 1 Mine Mine ID # 15-04322

SECRETARY OF LABOR, MINE SAFETY AND HEALTH ADMINISTRATION, (MSHA), PETITIONER	CIVIL PENALTY PROCEEDINGS Docket No. KENT 90-100 A.C. No. 15-04322-30530
v.	
GATLIFF COAL COMPANY, INC., RESPONDENT	Docket No. KENT 90-215 A.C. No. 15-04322-30531 Gatliff No. 1 Mine

DECISION

Appearances: Robert I. Cusick, Esq., Wyatt, Tarrant and Combs, Louisville, Kentucky, for Gatliff Coal Company, Inc.;
Anne Knauff, Esq., U.S. Department of Labor, Office of the Solicitor, Nashville, Tennessee, for the Secretary of Labor.

Before: Judge Melick

These consolidated cases are before me under sections 105(d) and 107(e) of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. 801 et seq., the "Act," to contest citations and withdrawal orders issued by the Secretary of Labor to Gatliff Coal Company, Inc., (Gatliff) and for review of civil penalties proposed by the Secretary for those violations of mandatory standards alleged therein.

Citation No. 3178703 alleges a violation of the standard at 30 C.F.R. 50.10 and charges as follows:

> A fatal accident occurred at 3:20 a.m. and the victim was pronounced dead at local hospital at 5:00 a.m. The company never reported this accident to MSHA. An employee heard the announcement on the radio around 8:00 a.m. and contacted the subdistrict manager. The first company contact with MSHA was by Freddie Maggard at 8:30 a.m., on 8/1/89, returning a call from the MSHA subdistrict manager.

The standard at 30 C.F.R. 50.10 provides as follows:

> If an accident occurs an operator shall immediately contact the MSHA District or Subdistrict Office having jurisdiction over its mine. If an operator cannot contact the appropriate MSHA District or Subdistrict Office it shall immediately contact the MSHA Headquarters Office in Washington, D.C. by telephone, toll free at 202-783-5582.

The testimony of MSHA Inspector James P. Payne, Sr., in

regard to the instant citation, is undisputed. The accident giving rise to this citation occurred at 3:20 a.m., on August 1, 1989. According to Payne the first contact from Gatliff came from Freddie Maggard, an official of Gatliff, when he returned a call to the MSHA office in Barbourville, Kentucky around 8:30 that morning. Payne also acknowledged that the MSHA subdistrict manager had received information relating to the accident earlier that morning and indeed that information had been relayed to Inspector Payne around 8:00 that morning. Payne testified that after receiving this information he did not report to the mine site until about noon that day. It did not appear that the accident site had been altered. Indeed Payne acknowledged that he would not have done anything differently had he been informed of the accident earlier. Payne also acknowledged that had an MSHA office had been contacted by 7:00 that morning he would not have cited Gatliff for the instant violation.

The testimony of Gatliff Safety Director John Blankenship is not inconsistent. Blankenship first learned of the accident while home in bed when he received a call around 4:00 a.m. He arrived at the mine site around 4:30 a.m. after the ambulance had already departed with victim, Boyd Fuson. Concerned about the Fuson's condition, Blankenship went immediately to the hospital where he learned that Fuson had died.

Around 5:40 that morning Blankenship first made efforts to telephone the MSHA offices but without success. He later telephoned the MSHA office around 5:45 a.m. and again around 6:00 a.m., but again without success. Blankenship testified that he was aware that a toll free telephone number appeared in the Code of Federal Regulations but that his copy of the code was in his office some 40 miles away. He then succeeded in reaching a state mine safety official, Leroy Gross, and he thought Gross would call the MSHA District Office.

The evidence shows that the accident at issue occurred about 3:20 a.m. on August 3, 1989, and that Gatliff officials did not execute direct contact with MSHA officials until about 8:30 on that morning. I therefore conclude that Gatliff failed to "immediately contact" an MSHA office as required by the cited standard. I find however, under the particular circumstances of this case, that Gatliff officials made good faith efforts to make timely contact with MSHA offices which were not open during the early hours of August 1. I also take into consideration that the accident scene was admittedly not tampered with and Gatliff officials cooperated in the MSHA investigation. Under these particular circumstances the violation was not of significant gravity nor did it involve significant negligence. Considering the criteria under section 110(i) of the Act it is apparent that a penalty of $20 would be appropriate for the instant violation.

Citation No. 3178704, issued pursuant to section 104(d)(1) of the Act, alleges a "significant and substantial" violation of the standard at 30 C.F.R. 77.1605(k) and charges as follows: (Footnote 1)

> The haulage road leading to the backfill ramp was not provided with sufficient berm, as required. The berm ranged from 0-2 feet in height and the truck axle was three feet in height. A fatal haulage accident occurred when a Euclid R-50 rock truck travelled through the berm and down a 120 foot embankment. The driver was thrown from the vehicle.

The cited standard provides that: "[b]erms or guards shall be provided on the outer bank of elevated roadways."

It is not disputed that the area cited was the outer bank of an elevated roadway. According to Inspector Payne the berm in the area cited was from 0 to 2 feet high. Payne opined that an axle-high berm, at least i.e. 3 feet high, may have been adequate although he conceded that even a 3 foot berm would not have stopped a truck such as that involved herein when fully loaded. Payne observed however that such a berm would have turned the wheels of the truck away from the embankment. Payne believed that the operator was highly negligent because any prudent person should have observed this inadequate berm. He also opined that the violation was "significant and substantial" because an

accident had in fact occurred resulting in fatal injuries. The violation was abated by the dumping of refuse along the outer bank to form a berm 3 to 3 1/2 feet high.

According to Gatliff Safety Director John Blankenship, the area of the accident had been for the most part bermed except for one turn-around area. Blankenship testified that Operator's Exhibit No. 5, a photograph, depicts the area where the truck passed over the berm. He observed, based on tests performed at the mine site, that even a 5 foot berm with the same type truck under similar circumstances would not prevent overtravel.

Based on the undisputed evidence alone however it is clear that there was no berm in place in at least some portion of the outer bank of the cited roadway. Under the circumstances the violation is proven as charged. In reaching this conclusion I have not disregarded Respondent's argument that under the cited standard a reasonably prudent mine operator could not have known what size berm was required. However in this case the evidence shows that at least some areas of the cited elevated roadway had no berm at all. Accordingly the Respondent's argument that it did not know what size berms were required is inapposite to the specific facts herein. The violation was also "significant and substantial". While the truck herein apparently passed through an area of roadway that may have had a two-foot berm, clearly in the areas of elevated roadway where no berm existed the violative condition was even more serious. Clearly fatal injuries were reasonably likely. See Mathies Coal Company 6 FMSHRC 1 (1984).

I also find that the violation herein was the result of "unwarrantable failure". The complete absence of berms over sections of the cited elevated roadway in this case may reasonably be inferred to have resulted from a lack of supervision. It is not disputed that there was no supervisor on site in this area during the shift at issue. This omission is of such an aggravated nature as to constitute gross negligence and "unwarrantable failure". See Emery Mining Company, 9 FMSHRC 1997 (1987). Considering the factors under section 110(i) of the Act I find that the proposed civil penalty of $4,000 is indeed appropriate.

Order No. 3178705, also issued pursuant to section 104(d)(1) of the Act, alleges a violation of the standard at 30 C.F.R. 77.1701 and charges as follows:

> Emergency communications were not available at the Colonel Hollow Job Number 75. Communications with the services that provide emergency medical assistance and transportation were discontinued when the company vehicle with the company radio left the mine property. On 8/1/89, following a serious accident which occurred at approximately 3:20 a.m., employees were required to

travel approximately 2 1/2 miles to a public telephone to summons an ambulance.

The cited standard, 30 C.F.R. 77.1701 provides as follows:

> (a) Each operator of a surface coal mine shall establish and maintain a communication system from the mine to the nearest point of medical assistance for use in an emergency. (b) The emergency communication system required to be maintained under paragraph (a) of this section may be established by telephone or radio transmission or by any other means of prompt communication to any facility (for example, the local sheriff, the State highway patrol, or local hospital) which has available the means of communication with the person or persons providing emergency medical assistance or transportation in accordance with the provisions of paragraph (a) of this section.

According to the undisputed testimony of Inspector Payne, the foreman's truck, which carried a radio sufficient to provide emergency communication, had departed the mine site around 5:30 or 6:00 p.m., the evening before the accident leaving only a bulldozer with a citizen band radio. Payne observed that the citizen band radio was incapable of reaching the mine office the hospital or the police station because of its limited range. He also noted there were no telephones at the job site and the nearest telephone was 2 1/2 miles away. Payne also maintained that the subject accident had occurred around 3:20 a.m., so that there purportedly had been no radio communications since 6:00 p.m. the night before. Payne acknowledged however that a citizen band radio could provide adequate means of communication under the cited regulation if it was properly monitored.

According to James Meadors, a Gatliff foreman, the men at the Colonel Hollow Job No. 75 were able to communicate by citizen band radio to the mechanics' trucks the lube truck and/or to the foreman's truck within a 3 mile range. Each of those trucks carried a radio sufficient to communicate with the mine office and thereupon police and ambulance emergency services could have been called by telephone. According to Meadors the lube truck with such radio was at the job site three miles from the Colonel Hollow Job site.

Donald Hopkins was one of two miners travelling to the nearest telephone that morning to call for an ambulance. Hopkins testified that he did not think to use the citizen band radio. Safety Director Blankenship testified that indeed emergency notification was then available by radio from the lube truck to Gatliff offices where telephones were located to further communicate as necessary for emergency services. According to Blankenship the lube truck was at the adjacent job site on the

morning of the accident only three miles from the accident.

Within this framework of evidence I cannot find that the Secretary has sustained her burden of proving the violation charged herein. While Inspector Payne testified that there was no radio at the Colonel Hollow Job site at the time of the accident sufficient to communicate with the mine office some 15 miles away, he failed to consider the citizen band radio then at that job site which was capable of communicating with the lube truck radio which could then communicate with the mine office where it is undisputed there was a telephone. Under the circumstances Order No. 3178705 must be vacated.

Citations 3178707, 3178708, 3178709 and 3178710 all charge violations of the regulatory standard at 30 C.F.R. 77.1710(i). That standard provides in relevant part as follows:

> Each employee working in a surface coal mine . . . shall be required to wear protective clothing and devices as indicated below:
>
> ***
>
> (i) Seat belts in a vehicle where there is a danger of overturning and where roll protection is provided.

In particular, Citation No. 3178707 charges as follows:

> It was evident that seat belts were not being worn on the R-50 rock truck and that the driver was thrown from the vehicle when it overturned. The belts were dirty and it did not appear that they had been worn for some time. This vehicle was travelling over hazardous terrain where there was danger of overturning. These conditions were observed on 8/1/89, during a fatal accident investigation.

Gatliff does not dispute that the cited trucks were operating in areas subject to the danger of overturning but maintains that the R-50 rock trucks do not need seat belts under that standard in any event because "roll protection" is not provided in those vehicles. Even assuming, arguendo, that haulage trucks such as the one at issue are not required by the standard at 30 C.F.R. 77.403(a) to have "roll protection" it is nevertheless apparent that the truck at issue in fact did have "roll protection".

In this case the credible evidence shows that the apron of the truck dump bed overhung the cab of the truck in a manner which provided some roll protection when in the lowered position. While the apron may not have provided the best possible protection it provided sufficient protection to even meet the definition set forth in 30 C.F.R. 77.2(w). Since the apron did provide "roll protection" seat belts were required to be worn in

accordance with the cited standard.

It may also reasonably be inferred from the evidence in this case that the victim was not wearing a seat belt at the time the cited truck overturned. He was thrown from the truck and the undisputed testimony was that the steering wheel was bent upwards as his body exited. The seat belt was also found unclasped behind the driver's seat. Under the circumstances it may reasonably be inferred that the victim was not wearing his seat belt at the time his truck overturned. Accordingly I find that the violation is proven as charged. I also find that the violation was "significant and substantial". See Mathies Coal Company, supra. The fatal accident in this case provides ample support for this conclusion.

I do not however find that the Secretary has proven her claims of high negligence. There is insufficient evidence that this driver's failure to wear a seat belt was the result of inadequate training, discipline or supervision. According to Mr. Blankenship he had restated to his employees in the annual refresher training the previous June the necessity to wear seat belts. The victim was present at this training. Blankenship also testified that he had never seen the victim not wear his seat belt.

Under the circumstances and considering the criteria under section 110(i) of the Act I find that a civil penalty of $400 is appropriate for this violation.

Citation No. 3178708 charges as follows:

> It is evident that the seat belt is not being used in the Euclid R-50 rock truck, company No. 3027. The belt is dirty and was coupled behind the driver's seat and air hoses were stacked on top of the belt. This vehicle was travelling over hazardous terrain where there is danger of overturning. These conditions were observed 8/1/89, during a fatal accident investigation.

According to Inspector Payne the cited truck had been operating earlier on the shift during which the fatal accident occurred, had been parked some two to three hours before the accident and was not then being used. Payne surmised however from the evidence that the belt was dirty, that it was coupled behind the driver's seat, and that air hoses were stacked on top of the belt, that the seat belts had not been used when the truck was in operation earlier on that shift.

According to John Blankenship however, it was common practice to buckle the belts behind the seats to keep the belts from the mud on the truck floors. He noted that the cited truck had been out of service for some time when the inspector examined

it and that it was therefore implicitly not surprising that the belts were in a dirty condition. Blankenship also noted that the fact that air hoses may have been stacked on top of the belts in a truck that had been taken out of service hours before the inspection does not necessarily lead to the inference that the seat belts had not been used when the truck was last operated.

The fact that the seat belts were dirty, that the belts were buckled behind the driver's seat, and that air hoses were stacked on top of the seat belts is not sufficient from which to infer that seat belts were not used 12 hours earlier while the truck was operating. The truck had been taken out of service 2 or 3 hours before the accident at issue and Inspector Payne admittedly did not arrive at the accident site for nearly 12 hours after the truck had been withdrawn from service. The Secretary's suggested inference is therefore not reasonable under the circumstances and the required nexus between the evidentiary facts and the ultimate fact to be inferred does not exist. See Mid-Continent Resources, 6 FMSHRC 1132 (1984), Garden Creek Pocahontas, 11 FMSHRC 2148 (1989). Under the circumstances I find that the Secretary has failed to sustain her burden of proving the alleged violation and the citation must be vacated.

Citation No. 3178709 charges as follows:

> It is evident that the seat belt is not being used in the Michigan 475 end loader company No. 2035. The seat belt is dirty and was placed behind the operator's seat. This vehicle was travelling over hazardous terrain where there was a danger of overturning. These conditions were observed on 8/1/89, during a fatal accident investigation.

Again, according to Inspector Payne the citation at issue was based upon his conclusion that the seat belts on the cited equipment were dirty and that they were "placed behind the operator's seat". Payne did not observe any of the equipment in operation without seat belts and never asked the equipment operator's whether they indeed used seat belts. Again, under the circumstances I do not find a sufficient nexus between the evidentiary facts and the ultimate facts the Secretary seeks to have inferred. Under the circumstances there is insufficient evidence to support the alleged violation and this citation must also be vacated.

Citation No. 3178710 charges as follows:

> It is evident that the seat belt is not being used in the bull dozer. The seat belt is dirty and was placed behind the operator's seat. This vehicle was travelling over hazardous terrain where there was danger of overturning. These conditions were observed

on 8/1/89, during a fatal accident investigation.

This citation is also purportedly based upon Inspector Payne's inference (from dirty seat belts and that the seat belts were found behind the operator's seat) that the seat belts were not being used. For the reasons already stated I find this evidence insufficient. Citation No. 3178710 must therefore also be dismissed. In reaching this conclusion I have not disregarded the admission of bulldozer operator Donald Hopkins that he did not wear his seat belt all the time. The citation alleges a violation on August 1, 1989, however and there is no evidence to connect this admission of Hopkins to the alleged failure to wear his seat belt on August 1, 1989. The Secretary has therefore failed to meet her burden and Citation No. 3178710 must therefore also be vacated.

Withdrawal Order No. 3178706 was issued pursuant to section 107(a) of the Act. That section provides in part as follows:

> If, upon any inspection or investigation of a coal or other mine which is subject to this Act, an authorized representative of the Secretary finds that an imminent danger exists, such representative shall determine the extent of the area of such mine throughout where the danger exists, and issue an order requiring the operator of such mine to cause all persons except those referred to in section 104(c), to be withdrawn from, and to be prohibited from entering, such area until an authorized representative of the Secretary determines that such imminent danger and the conditions or practices which caused such imminent danger no longer exist.

Section 3(j) of the Act defines "imminent danger" as the existence of any condition or practice in a coal or other mine which could reasonably be expected to cause death or serious physical harm before such condition or practice can be abated. In this case it is charged that a "practice" rather than a "condition" existed i.e. "a common practice at this operation to not wear the seat belt provided in the mobile equipment."

In Rochester and Pittsburgh Coal Company v. Secretary of Labor, 11 FMSHRC 2159 (1989), the Commission set forth the analytical framework for determining the validity of imminent danger withdrawal orders issued under section 107(a) of the Act. The Commission indicated that it is first appropriate for the judge to determine whether the Secretary has met her burden of proving that an "imminent danger" existed at the time the order was issued. The Commission also observed however that even if an imminent danger had not then existed, the findings and decision of the inspector in issuing a section 107(a) order should nevertheless be upheld "unless there is evidence that he has

abused his discretion or authority". Rochester and Pittsburgh, supra. at p.2164 quoting Old Ben Coal Corp. v. Interior Board of Mine Operations Appeals, 523 F.2d 25 at p.31 (7th Cir. 1975).

There is no evidence that the issuing MSHA inspector ever observed any of the cited mobile equipment operators without seat belts. However the credible evidence is that the victim of the accident involving the Euclid haulage truck was not wearing a seat belt. In addition it is undisputed that bulldozer operator Donald Hopkins admitted that he did not wear his seat belt while operating equipment "all the time". This evidence I find sufficient to conclude that the failure to wear seat belts was a sufficiently established "practice" within the meaning of section 3(j) of the Act which could "reasonably" be expected to cause death or serious physical harm before such practice could be abated. That "practice" therefore constituted an imminent danger and the order at bar must be affirmed.

Order No. 3178711 issued pursuant to section 104(d)(1) of the Act, fn.1 supra, alleges a "signficant and substantial" violation of the standard at 30 C.F.R. 77.1001 and charges as follows:

> Loose overhanging material, (i.e. dirt, trees, loose rock) was observed on and above the highwall on the drill bench (Jellico Seam) and above the spoil pit (Blue Gem Seam). A highwall drill, endloader, bulldozer, and 2 rock trucks were working in these areas. These conditions were observed on 8/1/89, during a fatal accident investigation.

The cited standard, provides that "[l]oose hazardous material shall be stripped for a safe distance from the top of pit or highwalls, and the loose unconsolidated material shall be sloped to the angle of repose, or barriers, baffle boards, screens, or other devices be provided that afford equivalent protection."

According to Inspector Payne, at the time of his inspection at the Colonel Hollow Job No. 75, on August 1, 1989, there was a tree overhanging the high wall from the Jellico Seam level and loose material had not been cleaned off. He also observed fractured and loose rock on the Blue Gem Seam level. He noted that equipment was working next to the highwall at the Blue Gem level and that the highwall was from 60 to 70 feet high. The tree was lying flat ready to slide down. He concluded that the material was loose because he observed cracks in it. There was also activity around the highwall evidenced by drill holes and, on the lower level, coal had been loaded at the Blue Gem Seam level.

The inspector concluded that the violations were the result of aggravated conduct, high negligence and "unwarrantable failure" on the grounds that he believed the foreman should have observed these conditions during his preshift examination. He also concluded that the violation was "significant and substantial" because the material could likely fall off the highwall injuring drillers and other workers below. He noted that the large rocks and the tree (approximately 18 to 20 inches in diameter) could cause such injuries. It was "highly likely" for an accident to occur because of its position on the highwall. Moreover persons loading holes and drill operators were unprotected without cabs or other devices. It is noted however that Inspector Payne apparently did not inquire and did not determine whether work was actually being performed in the pit area.

James Meadors, the day shift foreman, maintains that he told the night shift workers not to work in the pit area because of the apparently dangerous highwall conditions and told them that the conditions would be corrected on the following day shift. There is no evidence however that Meadors "dangered off" the area.

Within this framework of essentially undisputed evidence it is clear that the violation is proven as charged. Since there was no effective barricade of the endangered area I also find that the violation was "significant and substantial". While the day shift foreman may very well have warned some of the workers present at the time he left the mine site not to work in the endangered pit area, that warning was clearly not sufficient in itself. Without barricades, other persons later entering the mine site could easily wander beneath the dangerous highwall with a reasonable likelihood that they would suffer serious injuries. The violation was therefore "significant and substantial". Mathies Coal Company, supra. The failure of Meadors or other supervisory personnel to have "dangered off" or physically barricaded the acknowledged dangerous area also constitutes negligence of such an aggravated nature as to constitute "unwarrantable failure". Emery Mining Company, supra. Within this framework and considering the criteria under section 110(i) of the Act it is clear that the proposed civil penalty of $800 is warranted.

Citation No. 3178712 alleges a "significant and substantial" violation of the standard at 30 C.F.R. 77.207 and charges as follows:

> Sufficient illumination was not provided in the pit for a bulldozer pushing down spoil and an endloader loading rock trucks. The only illumination available was the headlights and backup lights of the equipment. These vehicles were working in close

proximity to a 70-60 foot highwall. These conditions were observed 8/1/89, during a fatal accident investigation.

The cited standard, 30 C.F.R. 77.207, reads as follows:

> Illumination sufficient to provide safe working conditions shall be provided in and on all surface structures, paths, walkways, stairways, switch panels, loading and dumping sites, and working areas.

While the issuing inspector acknowledged that he did not observe the cited conditions under night conditions he nevertheless inferred from prior night experience that the existing illumination from vehicle lights alone would not be sufficient. He noted that while the trucks had four lights and the endloader had lights on both ends there would nevertheless be unlighted blind spots during night operations. He noted that the bulldozer was pushing spoil into the pit at the Blue Gem Level and that vehicles below including the trucks and loader, were working within 20 to 30 feet of the highwall. Without adequate illumination of the highwall these operators would be unable to see material falling off the highwall.

Safety Director John Blankenship disagreed with this assessment and noted that another MSHA Inspector had previously examined this site during night operations and had never issued citations for insufficient lighting. Within the above framework of evidence however it may reasonably inferred that indeed there was insufficient illumination of the highwall during night operations. Clearly the face of the highwall could not be sufficiently illuminated merely by vehicle lighting as the vehicles moved about. In light of the equivocal testimony of the inspector however I am unable to conclude that the violation was "signficant and substantial".

Moreover in light of the undisputed evidence that MSHA inspectors had previously observed this site during evening hours and had never previously cited this condition I cannot find that the operator is chargeable with significant negligence. Within the above framework and considering the criteria under section 110(i) of the Act I find that a civil penalty of $50 for the violation is appropriate.

Citation No. 3178713 similarly alleges a "significant and substantial" violation of 30 C.F.R. 77.207 and charges as follows:

> Sufficient illumination was not provided at the backfill dumping ramp for the rock trucks to dump. The only illumination provided was the headlights and backup lights of the rock trucks. These conditions

> were observed on 1/1/89, during a fatal accident investigation.

There does not appear to be any direct evidence in the record concerning this alleged violation. I am, moreover, unable to infer from testimony that any such violation occurred. The citation must accordingly be vacated.

Order No. 31788714, issued pursuant to section 104(d)(1) of the Act, (See, fn. 1 supra.) alleges a violation of the standard at 30 C.F.R. 77.1713 and charges as follows:

> Adequate and sufficient examinations for hazardous conditions to eliminate such conditions were not being conducted on the second shift by a certified person. Numerous violations were observed during a fatal accident investigation which occurred at 3:20 a.m., on 8/1/89. It was a practice for the day shift foreman to make an on-shift examination just prior to leaving work each day. This one examination was usually conducted around 5:30 p.m. to 6:00 p.m. The second shift crew then worked from 5:30 p.m. until 4:00 a.m., without any further examinations. Violation Nos. 3178704 through 3178713 were issued. These conditions were observed on 8/1/89 and 8/2/89 during a fatal accident investigation.

The cited standard, 30 C.F.R. 77.1713, provides in relevant part as follows:

> At least once during each working shift, or more often if necessary for safety, each active working area and each active surface installation shall be examined by a certified person designated by the operator to conduct such examinations for hazardous conditions and any hazardous conditions noted during such examinations shall be reported to the operator and shall be corrected by the operator.

The issuing inspector based this order upon his observation of the existence of the violations charged in the citations and orders previously discussed. He concluded that this violation was also "significant and substantial" because of those violations. He also concluded that this alleged violation was the result of "unwarrantable failure" on the grounds that the evening shift foreman, who was the only person certified to perform the required examinations, had left the mine site at 6:00 p.m. the evening before and there was no foreman remaining on the job at a time when the violative conditions should have been discovered by proper inspection. While it is apparent from the previous discussion in this decision that I do not agree that all of the violations cited by the issuing inspector were valid, I

nevertheless have found sufficient violations from which I can conclude that the Secretary has proven there was an insufficient examination performed at this job site. Indeed the existence of admittedly dangerous highwall conditions without "dangering off" or barricading the area to prevent entry is sufficient alone to warrant the conclusion that an insufficient examination was performed and that the failure to perform such an examination was the result of an aggravated omission constituting gross negligence and "unwarrantable failure" Failure to properly conduct examinations and therefore allowing such dangerous conditions to remain also warrants the conclusion that this violation was "significant and substantial".

Inasmuch as there is redundancy between the underlying substantive violations subject to separate civil penalties and the violation herein I conclude that a reduced civil penalty of $500 is warranted considering the criteria under section 110(i) of the Act.

At hearing the parties presented a settlement agreement with respect to Citation No. 2996585 in which it was agreed that full payment of the proposed penalty of $20 would be paid. I have considered the representations and documentation submitted in support of the motion and conclude that the proffered settlement is appropriate under the Act.

ORDER

Citation/Order Nos. 3178705, 3178708, 3178709, 3178710 and 3178713 are vacated. Citation/Order Nos. 3178703, 3178704, 3178707, 3178711, 3178712, 3178714 and 2996585 are affirmed. Imminent Danger Order No. 3178706 is affirmed. Gatliff Coal Company Inc., is accordingly directed to pay civil penalties totalling $5,790 within 30 days of the date of this decision.

Gary Melick
Administrative Law Judge

Footnote start here:

1. Section 104(d)(1) provides as follows:

> If, upon any inspection of a coal or other mine, an authorized representative of the Secretary finds that there has been a violation of any mandatory health or safety standard, and if he also finds that, while the conditions created by such violation do not cause imminent danger, such violation is of such nature as could significant and substantially contribute to the cause and effect of a coal or other mine safety or health hazard, and if he finds such violation to be caused by an unwarrantable failure of such operator to comply with such mandatory health or safety standards, he shall include such finding in any citation given to the operator under this Act. If, during the same inspection or any subsequent inspection of such mine within 90 days after the issuance of such citation, an authorized

representative of the Secretary finds another violation of any mandatory health or safety standard and finds such violation to be also caused by an unwarrantable failure of such operator to so comply, he shall forthwith issue an order requiring the operator to cause all persons in the area affected by such violation, except those persons referred to in subsection (c) to be withdrawn from, and to be prohibited from entering, such area until an authorized representative of the Secretary determines that such violation memory accordingly has been abated.