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SOL (MSHA) V. JEWELL SMOKELESS COAL
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SECRETARY OF LABOR, MINE SAFETY AND HEALTH ADMINISTRATION (MSHA), Petitioner	:	CIVIL PENALTY PROCEEDING Docket No. VA 92-82 A.C. No. 44-00649-03541
v.	:	
	:	Coronet Jewell Prep Plant
JEWELL SMOKELESS COAL CORPORATION, Respondent	:	

DECISION

Appearances: Tina Mullins, Esq., Glenn M. Loos, Esq., Office of the Solicitor, U.S. Department of Labor, Arlington, Virginia, for the Petitioner; Charlie R. Jessee, Esq., Jessee & Read, Abingdon, Virginia, for the Respondent.

Before: Judge Koutras

Statement of the Case

This is a civil penalty proceeding initiated by the petitioner against the respondent pursuant to section 110(a) of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. 820(a). Petitioner seeks a civil penalty assessment in th amount of $58, for an alleged violation of mandatory safety standard 30 C.F.R. 77.1607(v). The respondent filed a timely answer contesting the alleged violation, and a hearing was held in Grundy, Virginia. The parties filed posthearing arguments, and I have considered them in my adjudication of this matter.

Issues

The issues presented in this proceeding are (1) whether the respondent has violated the cited standard as alleged in the proposal for assessment of civil penalty; (2) whether the alleged violation was significant and substantial (S&S); and (3) the appropriate civil penalty that should be assessed for the violation based upon the civil penalty assessment criteria found in section 110(i) of the Act. Additional issues raised by the parties are identified and disposed of in the course of this decision.

Applicable Statutory and Regulatory Provisions

1. The Federal Mine Safety and Health Act of 1977; Pub. L. 95-164, 30 U.S.C. 801 et seq.

2. Section 110(i) of the 1977 Act, 30 U.S.C. 820(i).

3. 30 C.F.R. 77.1607(v).

4. Commission Rules, 29 C.F.R. 2700.1 et seq.

Stipulations and Admissions (Tr. 5-9).

1. The respondent is the owner and operator of the Coronet Jewell Preparation Plant, and its operations at that plant are subject to the jurisdiction of the Mine Act.

2. The Commission and the presiding judge have jurisdiction to hear and decide this matter.

3. The inspector who issued the contested citation was acting in his official capacity as an authorized representative of the Secretary of Labor.

4. True copies of the citation were served on the respondent or its agent.

5. Assuming a violation is established, the payment of the proposed civil penalty assessment will not adversely affect the respondent's ability to continue in business.

6. The cited condition or practice was timely and immediately abated by the respondent.

7. The preparation plant annual coal production in 1991 was two-million tons, and the plant is a medium sized operation.

8. The respondent's history of prior violations is shown in an MSHA computer print-out covering the period October 1, 1989 through September 30, 1991 (Exhibit P-5).

Discussion

Section 104(a) "S&S" Citation No. 3507478, issued on October 17, 1991, by MSHA Inspector Robert P. Davis, cites an alleged violation of mandatory safety standard 30 C.F.R. 77.1607(v), and the cited condition or practice states a follows:

Railcars were not being kept under control at the raw coal shakeout area on 10-1-91, when the car hoist cable hook slipped out of the hook eye on railcar and two

loaded and one empty car got away (Run Away), and one employee was injured while making an attempt to stop the cars. The run away cars rammed loaded cars and threw the employee against the end of the cars causing injury to the employee's ribs.

Petitioner's Testimony and Evidence

Gary R. Buckland, employed by the respondent as a utility person, testified as to his training and seventeen years of experience on the job, and he confirmed that he worked at the shake out area of the plant. He described his duties and the procedures for shaking and dropping the railroad cars from the shake out area to the load out area. He stated that the cars are dropped by hand, and one person is on the car operating the hand brake while it is dropping down to the load out area after it has been emptied at the shake out area. He confirmed that he was aware of the accident of October 1, 1991, which resulted in an injury to Mr. Benny Shook. Mr. Buckland stated that a trip of two loaded cars and an empty car became unhooked from a cable and hook apparatus which holds the cars in place during the shake out and they began rolling freely towards the load out area.

Mr. Buckland described what he was doing at the time he was positioning the cars at the shake out area, and he stated that while he was in the process of pulling one of the cars into position he observed that the cable hook was still on the car, and that "it must have rolled another foot on farther backwards when I quit looking at it". He then proceeded to attend to another car and that when he "turned around and looked, two loads and an empty, I guess,, about a car length past the shake out or farther, they came off the hook and started rolling freely themselves" (Tr. 25).

Mr. Buckland stated that he ran after the cars and climbed on one of the loaded cars and tried to tighten the brake. However, the car had no brakes and he climbed down the ladder and jumped off. The cars continued to roll as he chased after them, and they collided with three other cars at the load out area, and this slowed them down. As the cars proceeded under the tipple, he climbed on one of the cars that had escaped from the shake out area and attempted to set the brake, and Mr. Shook climbed on one of the cars that had broken free at the load out area after the initial collision. However, the two trips came together and collided with other loaded cars parked on the tracks below the tipple, and Mr. Shook was thrown off and injured his ribs, (Tr. 20-28).

Mr. Buckland disagreed with the respondent's contention that no "runaway" occurred, and he did not believe that the cars that got away drifted slowly. However, he did not know how fast the cars were moving, and he stated that "they had to start out slow

to get fast" (Tr. 29). He stated that two people are used to shake each car and that one person is always on the car tightening the brakes to stop it. He confirmed that prior to the accident, the hook that attaches to the car to hold it in place "would come out sometimes three times a day, sometimes three times a week", but that since a chain has been installed on the hook, it does not slip free anymore (Tr. 29-31).

Mr. Buckland explained the safety procedures for runaway cars, including the use of warning sirens, oral instructions to try and catch and stop the cars if they get away, and the use of a safety belt while on the car (Tr. 32-33). He stated that there were occasions when the cars had no brakes, but that this was "very seldom" and that "you can run into that" (Tr. 34). He stated that if a car gets away and causes some damage it is reported to a supervisor, but if he catches up to a car and gets it under control, and no damage has occurred, it is not reported (Tr. 34).

On cross-examination, Mr. Buckland stated that during his 17 years with the company there have been no other incidents such as the one which occurred on October 1, 1991. He confirmed that Mr. Shook had his safety belt on at the time of the accident. He also believed that the respondent is a safety conscious company and he confirmed that it received the corporate president's safety award and numerous other safety commendations. Mr. Buckland further explained how he attempted to stop the cars which had moved away from the shake out area at the time of the accident, and he confirmed that when he tightened the brake down it failed. If the brake had not failed, there would have been no accident (Tr. 40). Mr. Buckland could not recall any conversations that he may have had with Inspector Davis in October, 1991 (Tr. 41). He confirmed that he has never reported a disengaged car hook to his foreman (Tr. 38).

Benny H. Shook, testified that he has been employed by the respondent for approximately 15 years, and that he has worked as a railroad car dropper for the past four years. He confirmed that he has received safety training from the respondent and that he has 36 years of preparation plant experience. He described his work in the load out area and he explained how the empty cars are dropped from the shake out area to the load out area for loading. He explained that there is always someone on one of the three-car trips that are dropped, and that this person operates the brake wheel which is tightened by hand to control the cars (Tr. 46-47).

Mr. Shook stated that the accident happened after a trip of two loaded and one empty railroad cars "got loose at the shake out", but he did not see them come loose and had no first hand

knowledge as to how they got away. He described what occurred as follows at (Tr. 48):

> A. And the three cars came down and there was a young man on them, Gary Buckland, trying to stop them. They hit the cars that we had on our load out rope. It broke that rope and they started running away. So, I got one car and set a brake. Got off of it and got on another car and set a brake. Now, by this time I...we had somewhere between three and five cars on our rope and them the three that he come with down, with, the empty and two loads. And by the time we got the brakes set on them again, they hit cars that were already parked out on the lower yard ready for shipment. When they hit, then I hit against the side of the car like against here, broke my ribs.

Mr. Shook could not estimate how fast the cars were travelling, and he confirmed that he had time to catch up to the first car and set the brake, and then step off and get on the next car and set that brake. He confirmed that he wore and used a safety harness while doing this. When asked if he believed that the cars which came down from the shake out area were "under control", he responded "No, the boy was trying to get them under control, but they weren't under control or he would have stopped them" (Tr. 50). He confirmed that those cars were stopped after the cars that he was on hit the loaded cars and threw him against the end of a car (Tr. 50).

Mr. Shook stated that he was treated at a hospital emergency room where he was x-rayed and given a complete physical examination by a doctor. He was diagnosed as having broken ribs, wore a rib cage protective device for three weeks, but returned to work the day after he was treated, and was assigned less strenuous work until he was able to resume his car dropping duties a week or so later (Tr. 51-52).

Mr. Shook was of the opinion that a "runaway" occurred and that he cars that came from the shake out area "ran away", and he explained as follows at (Tr. 53):

> A. Well, there is a restraining rope on those cars with a hook on it and the hook fell off the cars and they were below the shake out before Gary got on them to get them stopped. And he couldn't get them stopped until they hit the ones that we were on. So, I consider that to be a runaway. Yes, I do.
>
> Q. Is a person supposed to be on the cars before they are released from the cable?
>
> A. Yes.

Q. And they were not? A person was not on the cars?

A. Well, they weren't released purposely, so there wasn't anyone on it.

Q. Would you agree that the cars drifted slowly?

A. Probably when they first...when the hook first came off of them. But, then after they cleared the shake out they picked up speed.

Mr. Shook confirmed that the respondent had established procedures to be followed in the event a car gets away, and these include the use of warning devices, safety harnesses, and instructions not get on a runaway car (Tr. 54-55). He believed that chains have been installed in conjunction with the use of eye hooks to keep the hook from falling off, and he confirmed that prior to the accident, a hook had never come off a car in the loading area where he worked (Tr. 56). Mr. Shook explained the car dropping procedures, and he confirmed that the loaded cars are brought in by the N & W Railroad (Tr. 57-61).

On cross-examination, Mr. Shook confirmed that he missed no work as the result of the accident, and he believed that the respondent is safety conscious and has received safety awards at its preparation plant. In the 15 years that he has been employed by the respondent, he was not aware of any prior similar accidents with personal injury (Tr. 62). He confirmed that the plant and shake outs have been inspected on numerous occasions by state and Federal inspectors with the same steel rope cable and hook in use, and he believed that the respondent was doing what it thought was safe by using the steel rope and hook assembly (Tr. 64).

MSHA Inspector Robert D. Davis, testified that he has served as an inspector for 17 years and he confirmed that he visited the respondent's preparation plant on October 17, 1991, as a follow-up to an accident report filed by the respondent. He stated that he spoke with plant superintendent Bill Lipps and plant foreman Jessie Williams, and they basically told him what had been written up in the accident report. He was told that "the rail cars had runaway or broke loose from the shake out area and one man was injured trying to stop the cars" (Tr. 69). He was also informed that a safety or slack chain was installed in place of the cable that was previously used and that this chain served to keep the cable tight (Tr. 70).

Mr. Davis stated that based on what was reported to him by Mr. Lipps and Mr. Williams, and the company accident report, he issued the citation in question. He confirmed that the citation was not issued because of the accident, but that it was issued

because the railroad cars were not under control, and it was his opinion that this constituted a violation of section 77.1607(v) (Tr. 70-71). He confirmed that he made a finding of "moderate" negligence because "I felt that management should keep a better . . . if this had happened before, then something should have been done before" (Tr. 72). He also believed that the violation was "significant and substantial", and he explained as follows at (Tr. 71-72):

A. Well, it met the criteria of and S & S citation.

Q. What is that?

A. Condition existed, if not corrected, it reason...likely cause an accident.

Q. Now, what kind of accident would occur?

A. And if it did occur, it would cause serious injury.

Q. What kind of accident can you envision with the cars getting away?

A. Well, get caught in the cars, throw their feet under the track and get their leg cut off or crushed, fatal injuries.

Q. And those would be more serious than the accident that occurred in this case?

A. Yeah.

Q. How likely do you think it is that an injury...that injuries would occur because of rail cars getting away?

A. It would be reasonably likely that, you know, over a period of time this keep happening, maybe.

Inspector Davis agreed that his citation only makes reference to one set of cars, two loaded and one empty, when in fact the testimony of the prior witnesses that two sets of cars were out of control is correct. However, he did not believe that this made any difference and that a violation still existed. He also believed that appropriate safety procedures were not being followed because the cars would not have gotten away if the employees were more alert. He confirmed that there are no MSHA safety standards covering the use of car hooks or protective devices to prevent the hooks from coming off (Tr. 73-76).

On cross-examination, Mr. Davis stated that he based his "significant and substantial" finding on the fact that the cars were not being controlled at the time of the accident. He

confirmed that the likeliness of an occurrence is to be considered when making such a finding, and the fact that such an incident may have occurred in the past is part of the criteria for an "S&S" finding (Tr. 76-77). He conceded that at the time he made his finding he had no knowledge as to whether any accidents of the kind in question had occurred in the past, and stated that "anytime the railroad cars get away, there is a chance that someone could get hurt" (Tr. 78). He further conceded that he did not determine whether the kind of injury suffered by Mr. Shook had ever occurred in the past, and he disagreed that one incident or injury in the past 15 years would constitute an unlikely event because "you just heard those two fellows say those hooks come out often" (Tr. 81).

Mr. Davis denied that he had the citation prepared when he visited the plant on October 17, 1991, or that he had previously discussed what he would write with his supervisor before going to the mine site. He confirmed that he did not speak with Mr. Shook or Mr. Buckland prior to issuing the citation, and although he actually observed no violation taking place, he went to the area where the accident occurred and took some notes (Tr. 85-87). He further explained the basis for his "S&S" finding as follows at (Tr. 90-91).

> Q. It's not. What parameters do you use then, to determine that an injury is likely?
>
> A. If this condition would reasonably cause...if it occurred, it would cause an accident and if that..if those rail cars are not under control, it could reasonably cause an accident.
>
> Q. But what parameters did you use to determine what was reasonably likely to have occurred?
>
> A. To people at work?
>
> Q. Do you not have to...let me help you a little bit. An injury of illness has to be reasonably likely to occur, before you can write a S&S violation, does it not, sir?
>
> A. Yes, yes.

Mr. Davis confirmed that he is required to substantiate an "S&S" violation, and that he made notes and relied on the information given him by Mr. Lipps and Mr. Williams. Mr. Davis conceded that he did not bother to determine whether Mr. Buckland had applied the car brakes, where Mr. Shook was located when he was injured, or the extent of his injuries, and that he "just tried to determine if the cars were under control at the time of the accident" (Tr. 94). Mr. Davis stated that an S&S violation could be issued even if there were no injury, but that the

potential for an injury may be considered, and if an injury did in fact occur, he may consider the seriousness of the injury as part of his finding (Tr. 95).

Mr. Davis confirmed that prior to issuing the citation he made no determination as to whether or not mine management had any indication of prior problems with the car hook. He explained that he based his negligence finding on the fact that the hook did come out, and that "if somebody wasn't negligent, the hook wouldn't have come out. It would have been a better system" (Tr. 97). He agreed that there was no regulatory safety standard concerning car hooks, and he confirmed that he had inspected the shake out area on prior occasions and has observed cars being pulled by the hooks that were used at the time of the accident. He was not aware of any prior violations concerning car hooks or the shake out area (Tr. 98-99). He agreed that the use of a hook, or a chain which is presently in use, does not in and of itself constitute a violation. He also agreed that an accident would not have occurred if the car brakes had worked (Tr. 99-100).

Mr. Davis reiterated that he issued the citation because the cars were out of control, and not because an accident occurred. He stated that the cars were out of control because "the hook had come out of the eye", and that "the brake did have a bearing on it. I don't know if he could get there in time to apply the brake or not" (Tr. 100). Mr. Davis believed that a "reasonably serious accident" is "one that could cause an accident if not corrected" (Tr. 101). He did not personally know that Mr. Shook had a broken rib at the time he wrote the citation on October 17, 1991, and he agreed that the accident would not have occurred if Mr. Buckland, the car dropper, had been paying attention (Tr. 105). Since the cars were not under control, a violation had to exist, and it was the result of moderate negligence on the part of the respondent (Tr. 105-106).

Mr. Davis agreed that the respondent has a good safety record, and in response to a question as to whether the respondent "was really negligent", Mr. Davis responded "I think they could have through training, they could have been more alert on what's going on over there, the employees, I think". He explained that the employees on the job should have been more alert, and if they had been watching the eye hook, they could have prevented it from coming out (Tr. 108). He confirmed that a car dropper has a duty to keep an eye on the hook (Tr. 112).

Respondent's Testimony and Evidence

Jessie Ray Williams stated that he has served as plant foreman for the past 11 years, that the shake out area has existed for 14 years, and that the cable hook configuration at

the car spotter hoist has been in use during this entire time. He confirmed that there have been no prior incidents, accidents, or injuries involving cars drifting down to the plant because of a car hook coming loose. He stated that the car hooks in use at the time of the accident were especially designed to be handled safely, and no one ever informed him that there was a hook problem prior to that incident. He believed that the hook that was being used at that time was "state of the art" and standard for the industry (Tr. 117).

Mr. Williams stated that Mr. Buckland admitted that the accident would not have happened if he had been paying attention, and also informed him that the cars would not have collided if the brakes had worked. Mr. Williams confirmed that Mr. Shook missed no work because of the accident, and that he and Mr. Buckland were wearing safety belts. He confirmed that the respondent is a safety conscious company, and that the plant has recently received safety awards, including the company president's award and an honorable mention from the State of Virginia. He confirmed that the shake out area and hook arrangement have been inspected may times by MSHA, that no violations have ever been previously issued because of that arrangement, and that no inspectors have ever suggested any better method of hooking cars (Tr. 119).

Mr. Williams described the yard grade from the shake out area to the preparation plant 575 feet away as one percent, and less in places, and he did not believe that this was a very steep grade. He confirmed that the cars will roll freely from the shake out area to the plant, starting at a gradual speed, and building up speed if they are let go, and depending on whether they are empty or loaded. He stated that some impact is desirable in order to facilitate the closing of the car couplings (Tr. 121).

On cross-examination, Mr. Williams stated that he has never observed the car hook come out of the eye, and that none of his employees have ever informed him of such an occurrence. Although Mr. Shook and Mr. Buckland were wearing safety belts at the time of the accident, he did not know if they were using them, and he did not ask them about it when he spoke with them during his accident investigation. He confirmed that it was not uncommon for railroad car brakes to fail as the cars travel from the shake out area to the load out area. He stated that "you get quite a few railroad cars with bad brakes on it", and that the Norfolk Southern Railroad, and not the respondent, owns the cars and maintains the brakes (Tr. 123).

In response to further questions, Mr. Williams stated that he was familiar with an accident and a violation at the Bedrock Pocahontas Company, similar to the one in this case, and that no violation was issued by MSHA (Tr. 124). He stated that the

respondent cannot maintain the railroad cars which it does not own, and it cannot determine whether a car brake is defective before it comes on mine property (Tr. 126). He explained the operation of the car hook, and confirmed that three cars are coupled together when they are at the shake out area, and that the hook is attached to a cable that is attached to a car hoist. The chain which was attached after the accident has slack in it to keep the hook in place and to prevent it from being pushed out of the eye hole when a car is pulled back (Tr. 131-135).

Findings and Conclusions

Fact of Violation

The respondent is charged with a violation of mandatory safety standard 30 C.F.R. 77.1607(v), for failure to keep certain railcars under control at the raw coal shake out area of the preparation plant. A trip of three cars got away after the car hoist cable hook slipped out of the hook eye on one of the railcars, and the cars collided with another trip of cars resulting in injuries to an employee who was attempting to stop the cars. The cited standard section 77.1607(v), states as follows:

> Railroad cars shall be kept under control at all times by the car dropper. Cars shall be dropped at a safe rate and in a manner that will insure that the car dropper maintains a safe position while working and traveling around the cars.

In support of the violation, the petitioner argues that Car Dropper Buckland's testimony clearly establishes that the railroad cars were out of control, and that the respondent's own accident report states that "two loaded and one empty railroad cars had gotten away from shakeout", and that mine superintendent Lipps and Foreman Williams acknowledged to Inspector Davis that the railroad cars had gotten away. Further, another eyewitness, car dropper Shook, corroborated the fact that the railroad cars coming from the shake out area were not under control. Under all of these circumstances, the petitioner concludes that the failure of the car dropper to keep the railroad cars under control constitutes a violation of section 77.1607(v), and that the cause or reasons for the cars being out of control, and the car dropper's inability to stop the cars, are irrelevant to the issue of whether a violation occurred.

The respondent argues that the cited regulatory section 77.1607(v), does not define "under control" or "safe rate", and is therefore void for vagueness. Respondent also maintains that the regulation does not provide a remedy to the mine operator should the car dropper by reason of his own

negligence, fail to maintain proper control of the equipment to which he is assigned.

The respondent argues that but for the negligence of Car Dropper Buckland, who was admittedly inattentive, the incident in question would not have occurred. The respondent asserts that the fact that an accident occurred does not give rise to an inference of a violation, and it cites the testimony of foreman Williams that in the 14 years that he worked at the plant a similar incident had never occurred; that no railroad cars had ever gotten loose because of the hook coming undone; that the shakeout area had been inspected many times by MSHA and no violations had ever been issued because of the hook arrangement; that no inspector had ever suggested a better method for attaching the hook; that he had never observed the hook come out of the cable eye; that no employee had ever told him that the hook had come out of the eye; and that the hook arrangement as it existed at the time of the incident was the standard of the industry.

The respondent also relies on the testimony of plant employees Buckland and Shook who testified that no similar incidents had ever occurred at the plant in the past 17 to 36 years; that Mr. Shook missed no work because of his injury; that the respondent is a safety-conscious company; and that Mr. Shook and Mr. Buckland were wearing safety belts at the time of the incident.

In Harman Mining Corporation v. Secretary of Labor (MSHA), 3 FMSHRC 45, 62 (January 1981), a railroad employee suffered fatal injuries after he was struck by a runaway trip of loaded coal cars. The facts established that after a trip of two cars was loaded at the preparation plant, a car dropper employed by Harman Mining proceeded to drop the cars into position to be coupled with another trip of parked loaded cars and hauled away by a locomotive. The car dropper started the two cars down the track, and after picking up speed, he applied pressure to the car brakes. However, the brakes would not hold, and when the car dropper was unable to control the cars, he jumped to the ground and the cars continued on and collided with the parked cars, one of which ran over and fatally injured the employee who was engaged in coupling two of the cars. I affirmed a violation of section 77.1607(v), after concluding that the failure of the car dropper to maintain control of the cars constituted a violation.

My decision in the Harman Mining case, supra, was affirmed by the U.S. Fourth Circuit Court of Appeals on December 24, 1981 2 MSHC 1551. The Court rejected Harman Mining's argument that it would have been more appropriate for MSHA to cite the railroad company, as an independent contractor, since it supplied the railroad cars with faulty brakes and therefore caused Harman's car dropper to lose control of the cars. The Court held that

even if the railroad has some degree of culpability, MSHA had discretionary authority to cite Harman for the violation. Citing its decision in Bituminous Coal Operators' Ass'n v. Secretary of the Interior, 547 F.2d 240 (4th Cir. 1977), the Court ruled that mine operators are absolutely liable for violations regardless of who violated the Act or created the danger. Subsequent court decisions have ruled that the Mine Act is a strict liability statute, and the courts have upheld the mine operator's liability for violations which resulted from unpreventable and unforeseeable employee conduct. Western Fuels-Utah, Inc. v. FMSHRC, 870 F.2d 711 (D.C. Cir. 1989), aff'g 10 FMSHRC 256 (March 25, 1988); Asarco, Inc.-Northwestern Mining Department v. FMSHRC, 868 F.2d 1195 (10th Cir. 1989), aff'g 8 FMSHRC 1632 (November 10, 1986).

The Commission has consistently rejected arguments advanced by mine operators that they should escape liability for a violation because of unauthorized or careless actions by a miner. See: A.H. Smith Stone Company, 5 FMSHRC 13 (January 1983); Southern Ohio Coal Company, 4 FMSHRC 1459, 1462-64 (August 1982); Sewell Coal Co. v. FMSHRC, 686 F.2D 1066, 1071 (4th Cir. 1982); Allied Products Co. v. FMSHRC, 666 F.2d 890, 893-94 (5th Cir. 1982).

The respondent's "void for vagueness" defense IS REJECTED. The first sentence of section 77.1607(v), requires a car dropper to keep control of railroad cars at all times. I find nothing vague about this requirement. I agree with the petitioner's position with respect to the fact of violation, and I take note of the fact that the respondent conceded that the car dropper "allowed three (3) railroad cars to drift free from the shakeout and roll down the grade (approximately 1%) to the preparation plant, striking cars located at the preparation plant and causing the same to drift away from him because of his inattentiveness" (pags. 2,6, posthearing brief).

On the facts and evidence presented in this case, it seems clear to me that the railroad cars in question were out of control and that the car dropper could not maintain control of the cars as they drifted and travelled from the shake out area immediately before they collided with the other cars at the load out area, causing those cars to drift free and out of control. I reject the respondent's arguments that it should not be held liable for the violation because of the negligence of the car dropper, the absence of similar incidents in the past, or the lack of prior violations for the same cited condition. These are matters that may be considered in mitigating the respondent's negligence, but they may not serve as a basis for absolving the respondent of liability for the violation. I conclude and find that the petitioner has established a violation by a preponderance of the credible testimony and evidence adduced in

this case. The failure by the car dropper to maintain control of the loaded cars in question constituted a violation of section 77.1607(v), and the citation IS AFFIRMED.

Significant and Substantial Violations

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 1866, 1868 (August 1984); 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). Further, any determination of the significant and substantial nature of a violation must be made in the context of continued normal mining operations. National Gypsum, supra, 3 FMSHRC at 825; U.S. Steel Mining Company, 6 FMSHRC 1573, 1574 (July 1984); U.S. Steel Mining Co., Inc., 7 FMSHRC 327, 329 (March 1985). Halfway, Incorporated, 8 FMSHRC 8, (January 1986).

Citing the applicable case law concerning significant and substantial violations, the petitioner argues that the evidence in this case clearly establishes the four-prong test enunciated by the Commission in Secretary of Labor (MSHA) v. Mathies Coal Company, supra, for determining whether a violation is significant and substantial.

With respect to the underlying violation, the petitioner asserts that the uncontradicted evidence in this case establishes that the car dropper failed to keep the railroad cars under control on October 1, 1991, and that this establishes a violation of section 77.1607(v). Petitioner argues that the hazard presented by the violation is the railroad cars being out of control and subjecting workers to serious injuries, and it cites the inspector's testimony that he considered the violation to be significant and substantial because it was reasonably likely that the railroad cars would become out of control and cause a reasonably serious injury. Petitioner also cites the testimony of car droppers Buckland and Shook that the restraining hooks often came out of the eye of the railroad cars allowing the cars to come out of control. Petitioner concludes that the frequency with which the hook slipped out of the eye increased the likelihood that the cars would come out of control and cause a serious injury, and it points out that a serious injury actually occurred in this case as a result of the railroad cars being out of control. Conceding that the inspector believed that the cars may not have gotten away if the employees had been more alert, the petitioner points out that the inspector did not state that such human error could be avoided, and citing Secretary of Labor (MSHA) v. Eagle Nest, Inc., 7 FMSHRC 1119 (July 1992), petitioner concludes that the likelihood of an injury continues to exist regardless of whether the miners exercise caution.

Finally, petitioner concludes that it was reasonably likely that a reasonably serious injury would occur if the railroad cars were not kept under control by the car dropper. In support of this conclusion, petitioner cites the testimony of the inspector that railroad cars which are not kept under control can cause serious injuries such as being caught between cars, crushing or cutting off a foot or leg, and fatalities. Petitioner also relies on the inspector's testimony that in issuing the citation, he considered the seriousness of any potential injury rather than

only the injury that actually occurred, and the inspector's belief that fractured ribs, which is the injury sustained by Mr. Shook, was a reasonably serious injury.

The respondent maintains that the inspector issued the citation without consulting the MSHA Program Policy Manual guidelines for determining significant and substantial violations (Exhibit R-7). Citing the applicable manual guidelines, the respondent asserts that the inspector did not evaluate the actual circumstances surrounding the purported violation; did not evaluate the nature of the injury; did not include in his notes all of the factors he relied upon to make a judgment that the violation was significant and substantial or that the respondent's negligence was moderate; and did not interview the injured employee (Shook) or the shake out operator Buckland. Further, the respondent asserts that the inspector did not know whether Mr. Shook and Mr. Buckland were wearing safety belts at the time of the incident in question, and he did not know whether any other violations were ever written pursuant to section 77.1607(v) in Southwest Virginia within the last 10 years. Respondent maintains that such determinations are mandatory in considering whether or not to label a violation "significant and substantial", and it concludes that in light of the admitted failure by the inspector to follow the manual guidelines, his "S&S" finding cannot stand and should be vacated.

Although it is true that Inspector Davis admitted that he did not read the MSHA policy manual "just before" he wrote the citation (Tr. 110), I cannot conclude that his failure to do so is grounds for vacating his "S&S" finding. The Commission has held that the MSHA Manual guidelines and instructions are not officially promulgated regulatory rules binding on the Commission or its Judges. Old Ben Coal Company, 2 FMSHRC 2806, 2809 (October 1980); King Knob Coal Company, Inc., 3 FMSHRC 1417, 1420 (June 1981); United States Steel Corp., 5 FMSHRC 3, 6 (January 1983).

The respondent's suggestions that the absence of prior accidents involving a car hook slipping out and causing a car to get out of control, the lack of any evidence that the respondent and other mine operators in Southwest Virginia have ever been previously cited for violations of section 77.1607(v), and the fact that Mr. Shook and Mr. Buckland were wearing their safety belts, support a finding of a non-"S&S" citation ARE REJECTED. These are matters that may or may not mitigate the respondent's negligence and its history of prior compliance.

The term "significant and substantial", in the context of a violation within the meaning of section 104(d)(1) of the Act, has been interpreted by the Commission in the principal cases enumerated earlier in this decision. In the instant case, the critical question presented is whether or not the evidence

presented by MSHA in support of the inspector's "S&S" finding, which is essentially the same information that he had at his disposal and considered at the time he issued the citation and made that finding on October 17, 1991, meets the "S&S" criteria enunciated by the Commission.

The evidence in this case reflects that the citation was issued more than two weeks after the October 1, 1991, accident. The inspector went to the mine on October 17, 1991, as a follow-up to the accident report that was filed by the respondent. The inspector's credible and unrebutted testimony reflects that he spoke with the plant superintendent and plant foreman (Williams and Lipps), who corroborated the information supplied by the respondent in the accident reports (Secretary's Exhibits 2 and 3), did not contradict that information. In fact, they confirmed and agreed that the cars in question had gotten away. Mr. Williams did not dispute the inspector's testimony, and Mr. Lipps did not testify in this matter. Under these circumstances, it seems clear to me that the inspector relied on the information supplied by the respondent's accident reports, made some notes, and considered the information from the superintendent and foreman to support his finding that a violation had occurred and that it was significant and substantial.

On the facts and evidence adduced in this case, it seems clear to me that the failure of the car dropper to keep the cars under control, a condition which I have found constituted a violation of section 77.1607(v), contributed to the cause and effect of a discreet safety hazard, namely the real potential of a car drifting or travelling out of control and striking other cars or miners working the area. Once a car is out of control, particularly in a situation where the car has bad brakes that are subject to failure, I believe that one can reasonably conclude that miners working in the area would be exposed to the hazard. In this case, not only was there a reasonable likelihood that the hazard contributed to would result in an injury, the hazard came to fruition when the cars got away and caused or contributed to the accident that resulted in an injury to Mr. Shook's ribs. The fact that Mr. Shook did not suffer more serious injuries and lost no time from work is not determinative, Secretary v. Ozark-Mahoning Company, 8 FMSHRC 190 (February 1986). I take note of the fact that Mr. Shook's unrebutted testimony reflects that he was assigned to less strenuous duties, had to wear a rib cage protective device for three weeks, and did not resume his normal car dropper's duties until a week or so after returning to work a day after the accident.

After careful review and consideration of all of the evidence in this case, including the arguments advanced by the parties in support of their respective positions, I conclude and find that the petitioner has the better part of the argument and

that it has established by a preponderance of the evidence that the cited violative conditions in question constituted a significant and substantial violation of mandatory safety section 77.1607(v). Accordingly, the inspector's "S&S" finding IS AFFIRMED.

Negligence

Inspector Davis testified that he based his moderate negligence finding on what he was told by Mr. Lipps and Mr. Williams with respect to how the accident occurred. Mr. Davis conceded that prior to issuing the citation he made no determination as to whether or not mine management had any indication that the car hook had been a problem, and he stated that "if somebody wasn't negligent, the hook wouldn't have come out. I would have a better system" (Tr. 96-96).

In support of the inspector's moderate negligence finding, the petitioner relies on the testimony of car dropper Buckland who estimated that prior to the accident, the hook came out of the railroad cars between three times a day and three times a week, that co-workers had reported this problem to their supervisor, and that since the respondent installed a slack chain, the hook no longer slips out of the car. Conceding the fact that there is no statutory or regulatory requirement regarding the type of cable system used, the petitioner concludes that the cable system in use at the time of the accident left room for improvement, and that the installation of the slack chain was not a difficult or time-consuming procedure. Under all of these circumstances, the petitioner further concludes that the respondent was moderately negligent by failing to ensure that the railroad cars did not become out of control.

In reply to the respondent's assertion that it was not negligent because MSHA had inspected the shake out area may times before but had never issued a citation for using the cable hoist system without a slack chain, the petitioner points out that the inspector explained that the hoist system itself did not constitute a violation, and the violation occurred when the hook slopped out of the eye of the railroad car allowing the cars to become out of control. Since MSHA had never observed the cars out of control, and had not otherwise been informed that they had become out of control, petitioner maintains that no basis existed for issuing prior citations for such an occurrence.

Regarding the respondent's contention that the cable hoist system in use at the time of the accident was "state of the art", and the "industry standard", petitioner suggests that even if this were true, the industry standard is unsafe and subject to failure, and the fact that the respondent quickly and easily installed a slack chain shortly after the accident to prevent the hook from slipping out of the eye of the cars shows that the

system in use allowed room for improvement. Further, since the cars often got away, petitioner concludes that the respondent should have taken corrective action sooner to prevent an accident from occurring. The petitioner further concludes that the fact that no prior accidents had occurred due to the hook slipping out of the eye does not excuse the respondent's failure to take corrective action sooner, particularly in light of the evidence that the hook often slipped out of the eye and caused the cars to get away, and that this condition previously had been reported to the supervisor. Petitioner believes that the fact that the respondent has been lucky and has avoided prior accidents by stopping the cars quickly does not support a reduction in the degree of negligence.

In reply to the respondent's suggestion that the accident would not have occurred if the railroad car brakes had worked, petitioner concedes that the inspector acknowledged that properly functioning brakes may have prevented the accident, but it cites the inspector's testimony that the cars were out of control before the car dropper ever applied the brakes. Consequently, regardless of whether the brakes functioned properly, and in light of foreman Williams' testimony that the respondent was aware of the bad brake problem and received quite a few railroad cars with bad brakes, petitioner concludes that the respondent's knowledge of the brake problem also supports a finding of moderate negligence.

Aside from the respondent's liability for the violation, the conduct of an employee may mitigate the degree of negligence, if any, of the mine operator for the violation. A.H. Smith Stone Company, 5 FMSHRC 13, 15 (January 1983). In cases of this kind, the judge may consider the foreseeability of the miner's conduct, the risks involved, and the operator's supervising, training, and disciplining of its employees to prevent a violation. Southern Ohio Coal Co., 4 FMSHRC 1459, 1463-64 (August 1982); Nacco Mining Co., 3 FMSHRC 848, 850-51 (April 1981), Western Fuels-Utah, Inc., 10 FMSHRC 256, 259-60 (March 1988).

Mr. Shook testified that prior to the accident, he was not aware of a hook ever coming off a car in the area where he worked, and there is no evidence that the ever reported such an incident to mine management. Although Mr. Buckland testified that the hook came out rather often, he admitted that he had never reported this to management, and while he also testified that "other men" had reported it to their supervisor, none of these unidentified individuals were called to testify, and I have given Mr. Buckland's hearsay testimony in this regard no weight. Plant Foreman Williams' testimony that no one had ever previously reported a hook slipping out of the car stands unrebutted, and I find no credible evidence to support any conclusion that the respondent was previously aware of the problem.

Mr. Buckland and Mr. Shook confirmed that the respondent had safety procedures in effect to deal with runaway cars, that they were wearing safety belts at the time of the incident, and there is no evidence that they were not adequately trained by the respondent to perform their respective job tasks. However, I take note of Mr. Shook's testimony that the respondent's safety procedures include instructions prohibiting anyone from getting on a runaway car, and Mr. Buckland's contradictory testimony concerning "oral instructions" that he is to attempt to "catch and stop the cars if they get away", and that "get away" cars are not reported to management unless some damage has occurred (Tr. 34, 54-55). The respondent may wish to reexamine its safety procedures in light of this testimony.

I find no evidence to support any reasonable conclusion that the respondent could have foreseen the lack of attention on the part of Mr. Buckland which initially resulted in the first trip of cars drifting away from the shake out area and rolling freely towards the load out area. However, on the facts of this case, one of the contributing factors to the accident was the failure of the brakes on the trip of railroad cars that got away from Mr. Buckland. If the brakes had not failed, I believe that it is reasonable to conclude that Mr. Buckland could have brought the cars under control and the initial collision with the other cars may have been avoided. However, the brakes did fail, and foreman Williams candidly admitted that the respondent accepted railroad cars with bad brakes for use at the plant, and that it was not uncommon for car brakes to fail as the cars travelled from the shake out area to the load out area. Under the circumstances, and notwithstanding the lack of knowledge by the respondent that car hooks have come loose in the past, I conclude and find that the respondent should have foreseen that the acceptance and use of railroad cars with faulty brakes at its preparation plant property posed a potential accident hazard. Under the circumstances, the moderate negligence finding by the inspector IS AFFIRMED.

Size of Business and Effect of Civil Penalty Assessment on the Respondent's Ability to Continue in Business

The parties have stipulated that the Coronet Jewell Preparation Plant is a medium-sized operation, and the unrebutted information found in an MSHA computerized "Proposed Assessment Data Sheet" (Exhibit P-6), reflects that the respondent's overall corporate mine production was in excess of twenty-three (23) million tons in 1990. This same production information is also reflected in the Proposed Assessment (Exhibit A), which is part of the initial civil penalty assessment pleading served by the Secretary on the respondent. I conclude and find that the respondent is a large mine operator, and the parties have stipulated that the payment of the proposed civil penalty

assessment for the violation in question will not adversely affect the respondent's ability to continue in business.

History of Prior Violations

An MSHA computer print-out (Exhibit P-5), reflects that for the period October 1, 1989, to September 30, 1991, the respondent paid civil penalty assessments for twenty-two (22) violations issued at the plant. None of these prior violations involved the same safety standard in issue in this case, and the petitioner believes that the respondent has a low history of violations. I agree with the petitioner in this regard, and for an operation of its size, I conclude and find tht the respondent has a good compliance record, and I have taken this into consideration in assessing the civil penalty for the violation which has been affirmed.

Good Faith Compliance

The parties stipulated that the respondent timely and immediately abated the violation, and I adopt this as my finding on this issue and have taken it into consideration in this case.

Gravity

Based on all of the evidence adduced in this case, including my "S&S" findings, I believe that Mr. Shook was fortunate in avoiding more serious injuries, and I conclude and find that the violation was serious.

Civil Penalty Assessment

Taking into consideration all of the civil penalty assessment criteria found in section 110(i) of the Act, I conclude and find that the petitioner's proposed civil penalty assessment of $58, for the violation in question is reasonable, and IT IS AFFIRMED.

ORDER

The respondent IS ORDERED to pay a civil penalty assessment of $58, for the section 104(a) "S&S" Citation No. 3507478, October 17, 1991, 30 C.F.R. 77.1607(v). Payment is to be made to MSHA within thirty (30) days of this decision and Order, and upon receipt of payment, this matter is dismissed.

George A. Koutras
Administrative Law Judge

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