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SOL (MSHA) V. PEABODY COAL
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FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

OFFICE OF ADMINISTRATIVE LAW JUDGES
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FALLS CHURCH, VIRGINIA 22041

SECRETARY OF LABOR, : CIVIL PENALTY PROCEEDING
MINE SAFETY AND HEALTH :
ADMINISTRATION (MSHA), : Docket No. KENT 92-651
Petitioner : A.C. No. 15-08357-03702
v. :
 : Camp No. 11
PEABODY COAL COMPANY, :
Respondent :

DECISION

Appearances: William F. Taylor, Esq., U.S. Department of Labor,
Office of the Solicitor, Nashville, Tennessee,
for the Petitioner;
David R. Joest, Esq., Peabody Coal Company,
Henderson, Kentucky, for the Respondent.

Before: Judge Feldman

The captioned proceeding is before me as a result of a petition for civil penalty filed by the Secretary of Labor pursuant to section 105(d) of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. 801. et seq., (the Act). This case was scheduled for hearing in Owensboro, Kentucky on March 3, 1993. This matter concerns a 104(g)(1) and a 107(a) order and four 104(a) citations that were issued as a result of an investigation of a fatal accident that occurred in the respondent's Camp 11 Mine on February 26, 1991. The total assessed penalty proposed by the Secretary was \$57,000.

At the commencement of the hearing, the parties moved to settle the orders and citations in issue for a total penalty of \$28,500. The motion was supported by the testimony of Mine Safety and Health Administration (MSHA) Conference Officer Robert Phillips and Sam Spears, an electrician employed by the respondent. These individuals described the accident and provided information concerning the results of MSHA's subsequent investigation. As noted below, the parties' settlement motion was granted on the record.

BACKGROUND

This case involves fatal injuries sustained by Raymond Brown during the course of his remote control operation of a Simmons-Rand scoop. This scoop is used to remove loose coal that has fallen between the ribs after continuous miner operations. (Tr. 42). The scoop can be operated manually from the control deck. In the alternative, the scoop can be operated remotely by means of a hand held joystick. (Tr. 16,39). The advantage of operating in the remote control mode is that it allows the scoop to operate under unsupported roof before roof bolting occurs, without exposing the scoop operator to danger. (Tr. 43-44). Remote control of a scoop is a relatively new technological development in the mining industry. (Tr. 23).

The mechanical operation of the scoop's braking system is dependent upon whether it is being operated in the manual or remote control mode. If the scoop is operated in the manual mode, the operator controls the scoop from the operator's deck. To stop the scoop, the operator uses a foot pedal that is located on the floor of the deck. Operation of the foot pedal applies pressure to the service brakes. (Tr. 37-38).

Remote operation of the scoop is accomplished by the operator holding a remote station joystick while positioned behind the scoop. Movement of the scoop is achieved by holding down the plunger on the joystick. To apply the service brakes in the remote mode of operation, the operator must release the joystick. This activates the hydraulic function of the service brake system by sending oil through a flow control valve. The oil is then transported through a pressure intensifier which creates the hydraulic pressure that activates the service brakes and stops the scoop. (Tr. 37-39).

On February 26, 1991, Raymond Brown, an individual with approximately 15 years of mining experience, was operating a scoop by remote control in the crosscut between the No. 3 and No. 4 entries to provide a clean working area for the roof bolting machine operator. At approximately, 1:30 p.m., the continuous miner had completed a 34 four foot cut in the No. 3 entry and had moved to the No. 2 entry. Roof bolting was completed in the crosscut between the No. 3 and No. 4 entries. Brown was in the process of cleaning the No. 3 working face by remotely controlling the scoop. The roof bolter was parked in a crosscut adjacent from the area where Brown was cleaning the face. As the scoop retreated from the face, the service brake failed to engage pinning Brown between the rear of the scoop and the front of the roof bolter. A roof bolter operator who witnessed the accident de-energized the scoop with the panic bar located in the deck of the scoop. Brown sustained fatal chest injuries and expired shortly after being brought to the surface.

An MSHA investigation conducted at the scene cited an inoperative service brake as a result of a closed hydraulic flow valve as the proximate cause of this fatal accident. However, the investigation revealed that it was not until after the accident that Simmons-Rand, the manufacturer of the scoop, informed the respondent of the function of the flow valve and the importance of it being kept in the open position. In this regard, Sam Sears, the chief electrician at the respondent's Camp 11 Mine, testified that the existence or maintenance of a flow control valve is not noted in the Simmons-Rand scoop service manual. (Tr. 40). As a result of this accident, MSHA Conference Officer Robert Phillips testified that a nationwide alert was issued to all mine operators warning of the potential flow valve problem and requiring appropriate training for operators of such scoops in the remote control mode. (Tr. 30-32, GOV. Ex.7).

As noted above, as a result of this accident and the subsequent investigation, three citations and an imminent danger order were issued for alleged violations concerning the scoop's braking system. In addition, the respondent received a 104(g) order and a citation for allegedly failing to provide adequate task training for remote scoop operators.

Citation No. 3550636 and imminent danger Order No. 3550634 were issued for violation of the mandatory safety standard contained in section 75.1725(a)(Footnote 1) as a result of the closed flow control valve which disabled the remote operation of the service brake system.(Footnote 2) At the hearing, the parties moved to settle this citation and order indicating that the respondent has agreed to pay the \$15,000 proposed assessed penalty.

Citation Nos. 3550635 and 3550637 were issued for defects in the scoop's emergency parking brake and for worn disc brake pads on the scoop's service brakes. The proposed assessment for each of these citations was \$9,000. At the hearing, the parties agreed to settle each citation for \$6,550. The reduction in the

1 This mandatory safety standard requires that mobile equipment must be maintained in a safe operating condition or be removed from service immediately.

2 The subject scoop was repaired on February 6 and again on the day prior to the accident on February 25, 1991, for brake problems associated with manual operation. At those times, the brakes were checked and determined to be operating properly in the manual mode. The brakes were not checked in the remote operational mode. The flow control valve is located under a panel and is not easily accessible. The investigation failed to establish when or why the control valve was closed. (Tr. 49-53). The flow control valve was ultimately removed to prevent a reoccurrence of brake failure. (Tr. 41).

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proposed assessments was supported by the fact that the investigation ultimately determined that the condition of the scoop's parking brake and service brake did not contribute to Mr. Brown's death. (Tr.66-67,69).

Citation No. 3550565 and Order No. 3550566 were issued as a result of the respondent's failure to provide adequate task training as required by Section 48.7(a)(3). The citation was issued with respect to the training provided to Raymond Brown and the 104(g)(1) order was issued in connection with the training provided to Gary Woods. (Footnote 3) The penalty initially proposed for each of these alleged violations was \$12,000. At trial, the parties moved to reduce the proposed assessment to \$200 for each violation. This substantial reduction in penalties was supported by the testimony of Mr. Phillips indicating that the operator had no advance knowledge of the existence or significance of the flow control valve. Therefore, Phillips opined that even extensive training could not have prevented Mr. Brown's death. (Tr. 23-24). Although the investigation revealed that additional emphasis should have been placed on remote control training, counsel for the Secretary characterized the training provided as "substantially adequate" quantifying the training as a 9 on a scale of 1 to 10. (Tr. 16).

In view of the above, I accepted the parties' settlement agreement as proffered on the record because it is consistent with the criteria set forth in section 110(i) of the Act. By way of summary, the respondent has agreed to pay an assessed penalty of \$15,000 for Citation No. 3550636 and Imminent Danger Order No. 3550634; \$6,550 for Citation No. 3550635; \$6,550 for Citation No. 3550637; \$200 for Citation No. 3550565; and \$200 for Order No. 3550566. The settlement incorporates the gravity and negligence findings charged in these citations and orders.

ORDER

Accordingly, the citations and orders noted above ARE HEREBY AFFIRMED. Consequently, the respondent IS ORDERED TO PAY a total civil penalty in the amount of \$28,500 in satisfaction of the violations in issue. Payment is to be made within 30 days of the date of this decision, and, upon receipt of payment, this matter IS DISMISSED.

Jerold Feldman
Administrative Law Judge
703-756-5233

3 This order also cited Michael Grigg as not receiving adequate training. However, reference to Grigg was deleted when it was determined that Grigg was not a scoop operator. (Tr. 16).
Distribution:

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