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CYPRUS PLATEAU MINING V. SOL (MSHA)
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FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION
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August 24, 1993

CYPRUS PLATEAU MINING CORPORATION,	:	CONTEST PROCEEDINGS
Contestant	:	Docket No. WEST 92-370-R
	:	Citation No. 3850267; 3/10/92
v.	:	
	:	Docket No. WEST 92-371-R
SECRETARY OF LABOR, MINE SAFETY AND HEALTH ADMINISTRATION (MSHA),	:	Order No. 3588140; 3/12/92
	:	Star Point No. 2
Respondent	:	
	:	Mine I.D. 42-00177
	:	
	:	
SECRETARY OF LABOR, MINE SAFETY AND HEALTH ADMINISTRATION (MSHA),	:	CIVIL PENALTY PROCEEDING
	:	Docket No. WEST 92-485
Petitioner	:	A.C. No. 42-00171-03633
	:	
v.	:	Star Point No. 2
	:	
CYPRUS PLATEAU MINING CORPORATION,	:	
Respondent	:	

DECISION

Appearances: R. Henry Moore, Esq., Pittsburgh, Pennsylvania, for Contestant/Respondent;

Margaret A. Miller, Esq., Office of the Solicitor U.S. Department of Labor, Denver, Colorado, for Respondent/Petitioner.

Before: Judge Morris

These consolidated cases are contest proceedings and a civil penalty proceeding arising under the Federal Mine Safety and Health Act of 1977, 30 U.S.C. 2801, et seq. (the "Act").

After notice of the parties, a hearing commenced in Salt Lake City, Utah, on April 13, 1993.

The parties filed post-trial briefs.

WEST 92-371-R

Ventilation Tubing

In this case Cyprus Plateau Mining Corporation ("Cyprus") con-tests MSHA Order No. 3588140. The order was issued under Section 104(d)(1) of the Act to the Star Point No. 2 Mine on March 12, 1992.

The order, under the heading captioned "Condition or Practice" alleges the following:

> As a result of a 103(g)(1) complaint it was determined that in the 3rd Right Working Section (two entry system) a mine opening had been holed into a permanently supported entry. The Section Foreman told the crew to hang the ven- tilation tubing. One member of the crew asked him if he wanted a row of roof bolts installed first, and another member of the crew asked if he wanted jacks set. The foreman said it was quitting time and that they were going to hang the tube and go home. The unsupported area in the breakthrough was approximately 15 to 20 feet long. The approved Roof Control Plan states when a mine opening holes into a permanently supported entry, no work shall be done in or inby such intersection until the new opening is either permanent supported or timbered off with at least 1 row of timbers or jacks.

The order further alleges Cyprus violated 30 C.F.R. Section 75.220(a)(1) which provides:

> 75.220 Roof Control Plan
>
> (a) (1) Each mine operator shall develop and follow a roof control plan, approved by the District Manager, that is suitable to the prevailing geological conditions, and the mining system to be used at the mine. Additional measures shall be taken to protect persons if unusual hazards are encountered.

ISSUES

The issues are whether MSHA's order described with particu-larity the nature of the violation as required by Section 104(a) of the Act. Further issues are whether Cyprus violated the regula- tions. If such violations occurred, were they S&S, unwarrantable, and what penalties, if any, should be assessed.

Section 104(a) of the Act provides as follows:

> Sec. 104.(a) If, upon inspection or investigation, the Secretary of his authorized representative believes that an operator of a coal or other mine subject to this Act has violated this Act, or any mandatory health or safety standard, rule, order, or regulation promulgated pursuant to this Act, he shall, with reasonable promptness, issue a citation to the operator. Each citation shall be in writ-ing and shall describe with particularity the nature of the violation, including a reference to the provision of the Act, standard, rule, regulation, or order alleged to have been violated. In addition, the citation shall fix a reasonable time for the abatement of the violation. The requirement for the issuance of a citation with reasonable promptness shall not be a jurisdictional prerequisite to the enforcement of any provision of this Act.

STIPULATION

At the commencement of the hearing the parties stipulated as follows:

1. Cyprus Plateau Mining Corporation is engaged in mining and selling of bituminous coal in the United States, and its mining operations affect interstate commerce.

2. Cyprus Plateau Mining Corporation is the owner and operator of Star Point No. 2 Mine, MSHA I.D. No. 42-00171.

3. Cyprus Plateau Mining Corporation is subject to the juris-diction of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. 801 et seq. ("the Act").

4. The Administrative Law Judge has jurisdiction in this matter.

5. The subject citation and order were properly served by duly authorized representatives of the Secretary upon an agent of re- spondent and may be admitted into evidence for the purpose of estab- lishing their issuance, and not for the truthfulness or relevancy of any statements asserted therein.

6. The exhibits to be offered by Respondent and the Secretary are stipulated to be authentic but no stipulation is made as to their relevance or the truth of the matters asserted therein.

7. The proposed penalties will not affect Respondent's ability to continue business.

8. The operator demonstrated good faith in abating the violations.

9. Cyprus Plateau Mining Corporation is a large mine operator with 1,574,629 tons of production in 1991.

10. The certified copy of the MSHA Assessed Violations History accurately reflects the history of this mine for the two years prior to the date of the citation and order.

EVIDENCE

WILLIAM M. TAYLOR has been a coal mine inspector since 1982. He is experienced in underground mining.

On March 12, 1992, with MSHA inspector Dale Smith he visited the Cyprus Mine in Carbon County, Utah.

The visit was undertaken because he had received a complaint filed under Section 103(g) of the Act. The complaint did not in- volve imminent danger. Mr. Taylor removed Complainant's name from the 103(g) form before giving it to the company.

It was alleged the violation mentioned in the 103(g) had oc- curred in September 1991.

Mr. Taylor and Mr. Smith separately interviewed the five men who were on the crew. Those interviewed were Eric Chiaretta, Mark Stevens, Seldon Barker, Sheldon Anderson, and Robert Powell (section foreman).

Exhibit M-2 is a diagram Mr. Taylor made after his interview with the miners. The "Xs" shown on M-2 are the permanent roof sup- ports and the area without roof bolts has been colored in yellow. About 15 to 22 feet of the entire area was unbolted. On the day of the alleged violation the Powell crew had mined through the crosscut into the No. 2 entry. Mr. Taylor identified on M-2 with an orange pen the area where the miners were hanging tubing. In Mr. Taylor's opinion five miners had undoubtedly worked in the unsupported area after they had broken through the intersection. In addition, it would not be possible to hang tubing without being under an unsup- ported roof.

The company's Roof Control Plan as it relates to unsupported openings at intersections states as follows:

> Q. UNSUPPORTED OPENINGS AT INTERSECTIONS:
>
> When a mine opening holes into a permanently supported entry, room or crosscut, or when new openings are created by starting a side cut, no work shall be done in or inby such intersection until the new opening is either perma- nently supported, timbered off with at least one (1) row of temporary support (posts or jacks) or at least one (1)

row of permanent supports are installed across the opening in the bolting pattern.

In Mr. Taylor's opinion, installation of the tubing itself can cause miners to be under unsupported roof. Further, exposure to un- supported roof and resulting roof falls cause more fatalities than any other hazard in coal mines.

The inspector further testified as to accidents involving unsupported roofs that occurred in the late 1970's in this mine.

Mr. Taylor believes that the situation was due to the opera- tor's unwarrantable failure because in his opinion it meets the criteria for such a violation. Further, it was an S&S violation.

In Mr. Taylor's opinion, the failure to use bolts or jacks supports the unwarrantable failure allegation. Mr. Taylor did not know who the individual was who stated to the foreman that bolts or jacks should have been installed. However, he believed it was stated by one of the witnesses he interviewed. According to Mr. Taylor's notes, the unsupported area was 15 to 20 feet.

Mr. Taylor agrees the time of the alleged violation of the Roof Control Plan and the filing of the 103(g) complaint was six months (September to March).

Section 75.222(e) contains criteria for a Roof Control Plan for unsupported openings at intersections. The plan itself refers only to the term "work." "Travel" is not included in the plan.

Mr. Taylor further agrees that the place of the violation, as shown from his notes, was either the 2nd Right or the 3rd Right section.

SELDON L. BARKER is employed at the Cyprus Mine as a shuttle car operator. He was involved in hanging the ventilation tubing on the day of this incident involving the Robert Powell crew. They were working in the RIGHT section and it could have been 2d Right or 3d Right. There is about a 500-foot difference. However, there is no difference in the roof.

This incident occurred toward the end of the graveyard, a production shift.

Mr. Barker identified the location of the roof bolter in No. 2 entry (marked in blue on Exhibit M-2).

The ventilation tubing itself is two feet in diameter and about 10 feet long and it takes two tubes to cross a 20-foot-wide intersection.

The area marked in yellow on Exhibit M-2 is the last cut between No. 1 and No. 2 entry.

The ventilation tubes insert one into the other, male to female. A miner holds the first tube and it takes two or three people to hang it. They were hanging it as fast as they could. Mr. Barker did not recall any conversation regarding unsupported roof nor did he hear anyone say anything about installing roof support.

Mr. Barker was not sure if he was under any unsupported roof when he was hanging the ventilation tubing but the nature of the job could possibly put him under such unsupported roof.

Mr. Barker knows you don't go out past unsupported roof and expose yourself to the hazard of having it fall on you.

The weakest part of the roof is the first few feet of the breakthrough and that portion falls regularly.

It is the supervisor's decision to decide if jacks or roof bolts should be set.

Mr. Barker was not sure if he was under unsupported roof and he didn't tell the foreman to install jacks or roof bolts. It took about five minutes to get the tubing up.

ERIC CHIARETTA was a Cyprus roof bolter in September 1991 and he was familiar with the incident involving Robert Powell as the supervisor.

They were working in the 2nd Right or 3rd Right and they were at the end of the graveyard shift, which is an eight-hour shift.

Mr. Chiaretta was a roof bolter on the Powell crew. He iden-tified the location of the roof bolting machine as being 15 feet outby the intersection.

Mr. Chiaretta was present when they discussed hanging the tubing and he agreed with the statements of witnesses Taylor and Barker.

In September 1991 at the time of the incident, the crew hung three to four pieces of ventilation tubing and there were five to six of them involved. Powell also assisted.

Gary Groom, a member of the group, asked Powell if he wanted to put in a row of bolts. Groom is no longer in the State of Utah, and he did not testify at the hearing.

Mr. Chiaretta did not remember being under unsupported roof but such a possibility exists. You could go into such an area.

If unsupported roof falls it can cause a fatality. The roof in this mine was fair to poor. The 2nd Right and/or 3rd Right area consists of a lot of mud and siltstone and it has fair top.

Prior to September 1991, normally the miners would support any unsupported area and then hang ventilation tubing. There were jacks available on the roof bolting machine.

Ventilation tubing can obscure your view of any roof hazard as it is being installed. The roof bolts were four six-inch plates.

SHELDON P. ANDERSON has been a Cyprus mechanic for 13 years and is familiar with the incident that occurred in September 1991 at the time they holed through the No. 2 entry. He had discussed this incident with Inspector Taylor. About 500 feet separates 2d Right and 3rd Right.

After they broke through into the No. 2 entry, the area was not supported. The unsupported area of the roof was 12 to 15 feet and the distance across the intersection was 19 to 20 feet.

The crew hung at least three pieces of tubing. While hanging the tubing, Mr. Anderson might have had his arm out under the un- supported roof. He recognizes that it is an unsafe practice to work under unsupported roof.

Mr. Anderson stated that the day after this incident occurred it was discussed and decided that in the future they would install jacks or roof bolts before installing ventilation. Mr. Powell was present and he said they were in a hurry. Mr. Anderson knew it wasn't right. It took about five to six minutes to hang the tubing. Mr. Anderson was nervous about testifying. Mr. Powell didn't force him to do anything that was unsafe. There was a possibility that he was under unsupported roof. The conversation they had about this matter was at a regular safety meeting. It may have been the fol- lowing week. Mr. Powell said, "We were all responsible"; but he didn't think it was unsafe.

LEE H. SMITH, an MSHA field office supervisor is an individual experienced in underground mining and roof control plans.

Mr. Smith identified Exhibit M-5 which he helped draft. M-5 are the MSHA regulations relating to 30 C.F.R. Part 75 entitled "Safety Standards for Roof, Face and Rib Support." It is the final rule effective January 27, 1983.

It is MSHA's intention, according to Mr. Smith, to prevent travel under all roof and the agency feels very strongly about any miners working or traveling under such unsupported roof. M-5 requires permanent or temporary supports on five-foot centers before "any other work or travel in the intersection." On the other hand, the operator's Roof Control Plan only contains the

term "work".

According to Mr. Smith, the term "work" means any activity and the purpose of the Roof Control Plan is to prevent all exposures under unsupported roof.

CYPRUS EVIDENCE

ROBERT POWELL, section foreman is experienced in underground mining.

In September 1991 Mr. Powell was supervisor of the 2nd Right section. In that section the conditions of the roof were good. They were taking 40-foot cuts.

Mr. Powell identified the production exhibit for September 13 in the 2d Right section. (Ex. R-1). He did not know what date the ventilation tubing incident occurred.

The roof in the 3rd Right section is the same as the 2d Right section. But without knowing the exact location, Mr. Powell cannot search out a production report.

Ventilation tubing is taken down to keep the continuous miner from chewing it up; then it is restored to ventilate the face.

Mr. Powell vaguely remembers the incident being discussed. There were no miners under the unsupported roof and it took two to three minutes to put the tubing back up. The crew was not at risk.

The term "work" as is used in the Roof Control Plans means min- ing with a continuous miner or roof bolting. Preshift exams are also included as well as rock dusting, testing the roof, gas checks, etc. No one from Cyprus said that definition was wrong.

Mr. Powell agrees the roof bolter was sitting outside the entry. If Mr. Groom had come to him in September 1991 and said it was unsafe to put up ventilation tubing without putting up jacks, they would have set jacks. He does not recall any such conversation with Messrs. Groom and/or Chiaretta. Setting jacks involves a greater risk than hanging ventilation tubing.

Mr. Powell does not dispute that in September 1991 the incident as described by Chiaretta occurred. There was only one occasion in September when the holing through occurred as described by the wit-nesses. Mr. Powell indicated the crew was never under unsupported roof; it is not a safe mining practice to be under such roof.

ROBERT A. LINDSEY is a Cyprus scoop operator who he has four years underground experience. He is familiar with this incident and with the conditions at the time. He recalls that three ventilation tubing pieces were hung and they had been lying against the ribs to

keep the continuous miner from tearing them up. The only tubing was down the middle of the crosscut.

Mr. Lindsey did not go out under any unsupported roof nor did he see anyone else do so; there was no adverse roof in the area.
No one suggested that roof bolts or jacks be installed in the un-supported crosscut.

Mr. Lindsey remembers that incident happened at the end of the shift. He believed it was highly unlikely he would have stepped out; however, an arm or leg or part of his body could have been under the unsupported roof. This incident occurred in 2d Right.

It is now the policy of Cyprus not to go beyond the last open crosscut.

CARL J. DOWNARD is a miner helper. He did not remember hanging the ventilation tubing. Further, he didn't hear anyone complaining about installing bolts and jacks.

The crew was in 2d Right with Mr. Powell. At the later safety meeting, Mr. Groom expressed concern that the activities were unsafe but he didn't know if Groom or Chiaretta had said anything to Mr. Powell, who was also at the safety meeting. Mr. Powell said it wouldn't happen again in any event.

RICHARD TUCKER is the senior safety representative for Cyprus.
Mr. Tucker has hung ventilation tubing; it is not difficult to hang. The adjustments are made by the miner simply swaying with the tubing.

Mr. Tucker believed this violation was not S&S nor was it unwarrantable.

After Cyprus received the order in this case, it attempted to change its Roof Control Plan to establish a different definition of the term "work".

Mr. Tucker admitted that there was no reason to believe that this incident had not happened. He initially learned about it when MSHA's order was issued. The Roof Control Plan does not permit miners to go inby under unsupported roof at intersections.

The primary responsibility for safety rests with the superin-endent. Mr. Powell was not disciplined as a result of the incident in question.

Mr. Tucker further agreed that no part of the body of a miner, such as an arm or leg can go under unsupported roof under any cir- cumstances. Roof bolts support a six-inch by six-inch area.

Cyprus agrees that hanging tubing inby an unsupported intersection can be safe or unsafe depending on the roof conditions.

The witness introduced a citation issued by an Inspector Ganser which was neither S&S nor unwarrantable. (Ex. R-2.) Mr. Tucker was not able to make an estimate as to whether it was safe for miners to do what they did in this case because he didn't know the conditions of the roof. He determined that there was a violation of the Roof Control Plan from what he has been told and this is why he asked Cyprus to change its definition of "work."

He believed there is reason for disagreement concerning the definition of "work." He did not believe hanging tubing constituted work and it's okay to go under unsupported roof to do things that are not considered to be "work". According to the Roof Control Plan, when you go into an area it depends on whether the roof is safe. However, no miner should ever be exposed to unsupported roof.

Mr. Tucker, who has worked with other MSHA districts, indicated that miners will go inby unsupported roof for preshift, for ventila- tion and for rock dusting.

WILLIAM TAYLOR was recalled to testify concerning the "Ganser" citation. When this citation was issued, the jacks were present although they were six feet two inches apart (not five feet as required); also, it was not shown that anyone was working in the area.

He indicated the difference between the "Ganser" citation and this citation was that the Powell crew was in a hurry and was tired. Mr. Taylor believed the MSHA office had probably talked to him about the correct citation, particularly, in view of the fact that there were two "Ganser" citations.

EVALUATION OF THE EVIDENCE

As a threshold matter, Cyprus argues the Secretary failed to comply with the particularity requirements of Section 104(a) of the Act. In this case it is true that the Secretary failed to establish the exact date and place of the alleged violation. The violation may have occurred September 13, 1991, or on some other date in Sep-tember. In addition, it may have occurred on 2d Right or 3rd Right.

The Commission ruled that the primary reasons for the specifi- city requirements are "for the purpose of enabling the operator to be properly advised so that corrections can be made to insure safety and to allow adequate preparations for any potential hearing on the matter. Jim Walters Resources, Inc., 1 FMSHRC 1827, 1829 (November 1979). See also Cyprus Tonopah Mining Corporation, 15 FMSHRC 367 (March 1993) wherein the Commission repeated its view that the re-

quirement serves the purpose of allowing the operator to discern what conditions require abatement and to adequately prepare for a hearing.

The record shows the witnesses who testified for the Secretary and Cyprus knew what event was being discussed and what actions were taken. Some witnesses testified the incident took place in 2d Right and some testified it was 3rd Right. The sections are in the same area of the mine, about 500 feet apart. (Tr. 97, 105, 152). Every- one agreed it occurred in September 1991. (Tr. 105, 152).

Section foreman Powell acknowledged there was only one "hole-through incident." While he only "vaguely" recalled it, he testi- fied at length concerning the facts.

In this case abatement of the violative condition was not involved.

Cyprus failed to show any prejudice and the specificity section does not warrant a dismissal of this case.

In this case there is no direct evidence that any miners were under unsupported roof when installing the ventilation tubing. However, it is clear that the work (hanging the tubing) was being done "inby" (Footnote 1) the intersection without the new opening being supported in any manner. Such work constitutes a violation of the roof control plan.

The credible evidence establishes such "inby" work and on the record I enter the following:

FINDINGS OF FACT

1. Sheldon L. Barker, a shuttle car operator, was involved in hanging the vent tube. (Tr. 103, 104).

2. Mr. Barker agreed with Mr. Taylor as to the location of the roof bolting machine. (Tr. 106).

3. The crew was hanging at least two vent tubes across the 20-foot intersection. (Tr. 108).

4. The area marked in yellow on M-2 is the last cut between No. 1 entry and No. 2 entry. (Tr. 108, 109).

_____

1 "Inby" has been defined as "toward the working face, or interior of the mine." A Dictionary of Mining, Mineral and Related Terms, at 572.

5. They hung the tubing at the end of the shift and they were in a hurry to get out of there. (Tr. 110).

6. Mr. Barker "can't really be sure" if he was out under unsupported roof when hanging the tubing. (Tr. 112-113).

7. There is a "good possibility" that from the nature of the hanging the vent he might be out under the unsupported roof. (Tr. 113).

8. Eric Chiaretta stated five or six miners were hanging three or four lines of tubing. Mr. Charietta couldn't recall if he "was actually out in the intersection or not," but "the possibility was there to step out." (Tr 136). While hanging the tubing you are not standing still. (Tr. 136). There was 15 to 20 feet of unsupported roof. (Tr. 137).

9. Sheldon Anderson hung the tubing. To hang the tubing "you may have an arm sticking out" or you "may move with the tube." (Tr. 151, 154).

Section foreman Powell asserts it was not "work" within the meaning of the roof control plan to hang the tubing. In addition, they were never under unsupported roof. [Mr. Powell's views of the roof control plan are erroneous. Hanging tubing is "work" inby any unsupported intersection.]

Mr. Tucker seeks to persuade the Judge that the hanging of vent tubing is relatively "very easy." (Tr 303). I am not persuaded since it is overhead work, an effort is being made to insert one sleeve into another, vision is limited, and miners must move and sway with the tubing. Those factors cause me to conclude that there is a reasonable likelihood these miners would be under the unsup- ported roof. It may well be that witnesses Powell and Lindsay did not go under unsupported roof when hanging the tubes. However, the likelihood still exists and therein lies the violation.

SIGNIFICANT AND SUBSTANTIAL

A violation is properly designated as being S&S "if, based on 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 Divi- sion, National Gypsum Co., 3 FMSHRC 822, 825 (April 1981). In Mathies Coal Co., 6 FMSHRC 1, 3-4 (January 1984), the Commission explained:

> In order to establish that a violation of a mandatory standard is significant and substantial under National Gypsum the Secretary 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 like- lihood that the hazard contributed to will result in an injury; and (4) a reasonable likelihood that the injury in question will be a reasonably serious nature.

See also Austin Power Co. V. Secretary, 861 F.2d 99, 103-04 (5th Cir. 1988), affg. 9 FMSHRC 2015, 2021 (December 1987) (approving Mathies criteria). The question of whether any specific violation is S&S must be based on the particular facts surrounding the violation. Texasgulf Inc., 10 FMSHRC 498, 500-501 (April 1988); Youghiogheny and Ohio Coal Co., 9 FMSHRC 2007, 2011-2012 (December 1987).

The evidence establishes factors (1), (2) and (4) of the Mathies formulation. In connection with paragraph (3) of Mathies, Cyprus asserts the S&S allegations fail because the evidence did not consider the specific roof conditions in the entry and other factors related to the likelihood of a roof fall. (Tr. 62-63, 92-93, 95). I agree. Chiaretta described the roof as "fair to poor." However, the inspector did not discuss the roof conditions with the miners. Although additional roof support was used, the inspectors were not present at the time of the hole-through. As a result there was no evidence of paragraph (3) of Mathies.

A credibility issue arises concerning the two citations issued by Inspector "Ganser." These two citations were not S&S. However, I give the Ganser citations zero weight. Basically, the facts in the Ganser citations were not the same as involved here.

The S&S allegations should be stricken.

UNWARRANTABLE FAILURE

The special finding of unwarrantable failure, as set forth in section 104(d) of the Mine Act, 30 U.S.C. 814(d), may be made by authorized Secretarial representatives in issuing citations and withdrawal orders pursuant to Section 104. In Emery Mining Corp., 9 FMSHRC 1997, 2004 (December 1987), and Youghiogheny and Ohio Coal Company, 9 FMSHRC 2007, 2010 (December 1987), the Commission defined unwarrantable failure as "aggravated conduct constituting more than ordinary negligence by a mine operator in relation to a violation of the Act." Emery examined the meaning of unwarrantable failure and referred to it in such terms as "indifference," "willful intent," "serious lack of reasonable care," and "knowing violation." 9 FMSHRC at 2003.

In this case, Mr. Powell interpreted the roof control plan to mean that certain activities including pre-shift examinations estab- lishing ventilation or preparing the mine by rockdusting, scaling

bad rib, sound testing the roof, or gas checks were permitted inby an unsupported opening. (Tr. 246, 262).

Mr. Powell's interpretation is somewhat supported by the criteria in 30 C.F.R. 75.222(e). While the criteria refer to "work or travel," the Cyprus roof control plan refers only to "work." (Tr. 90). The absence of "travel" on Cyprus's work plan suggests that some activity could be permitted inby an unsupported roof.

As previously stated, Mr. Powell's view is erroneous. In view of the hazards involved by roof falls I agree with Mr. Smith's opinion that all exposures to unsupported roof are prohibited. (Ex. M-5).

However, a good faith belief (although mistaken) that no vio- lation existed excludes the imposition of an unwarrantable failure finding, Florence Mining Co., 11 FMSHRC 747, 753 (May 1989); Southern Ohio Coal Co., 11 FMSHRC 138, 143 (February 1988); Utah Power and Light Co., 12 FMSHRC 965, 972 (May 1990).

For these reasons the unwarrantable failure allegations are stricken.

A credibility issue arose as to whether some crew members may have suggested to Mr. Powell, the crew foreman, that roof bolts or jacks be installed before rehanging the tubing. While these facts were alleged in Order No. 3588140, Inspector Taylor could not recall if anyone made such statements during his interviews. In addition, Mr. Taylor's notes did not reflect such statements. Messrs. Barker, Anderson, Kindsey, and Downard were not aware of any such conver- sation. (Tr. 112, 124, 155, 280-182, 295). In sum, I credit Mr. Powell's testimony that he did not recall anyone in general or specifically Mr. Chiaretta or Mr. Groom, questioning him about set- ting jacks or bolting the area before installing the tubing. (Tr. 244, 249, 252, 261). Mr. Powell has been an underground miner for 20 years. If anyone had requested him to install temporary or permanent support, he would have done so. (Tr. 251, 261-262).

CIVIL PENALTIES

Section 110(i) of the Act mandates consideration of six criteria in assessing appropriate civil penalties.

Cyprus is a large operator with 1,574,629 tons of production in 1991.

The penalty set forth in this order is appropriate and will not affect the operator's ability to continue in business.

The prior history is favorable to Cyprus as the company had only 13 violations assessed for the two-year period ending March 9, 1992.

The operator was negligent in that its section foreman should have known of the requirements of the roof control plan.

Since miners could have been exposed to the unsupported roof, the gravity should be considered as high.

In view of the circumstances, abatement was not involved on this record.

For the above reasons, Order No. 3588140 is MODIFIED to a 104(a) citation, which citation is AFFIRMED.

WEST 92-370-R

Shuttle Car Brakes

In this case, Cyprus contests Citation No. 3850267 issued under the provisions contained in Section 104(d)(1) of the Act.

The citation under the heading captioned "Condition or Practice" alleges the following:

> As a result of a 103(g)(1) complaint it was determined that the #8 off standard Joy shuttle car was operated on the 3rd South Active Working Section in an unsafe condition. The foot brakes on the shuttle car were inoperative. An agent of the operator knew the condition existed and permitted the shuttle car to be operated in an unsafe condition for the purpose of producing coal.

The citation further alleged that the above condition or prac- tice constituted a violation of 30 C.F.R. Section 75.1725(a), a mandatory safety standard. It is further alleged that the violation was of such a nature that it significantly and substantially con- tributed to the cause and effect of a mine safety and health hazard. The regulation allegedly violated provides as follows:

> 75.1725 Machinery and equipment; operation and maintenance.
>
> (a) Mobile and stationary machinery and equipment shall be maintained in safe operating condition and machinery or equipment in unsafe condition shall be removed from serv- ice immediately.

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The principal actors in the shuttle car/brake incident were Seldon Barker (car operator), Paul Downard (spell boss), and Bill Burton (shift foreman).

EVIDENCE

WILLIAM TAYLOR received a 103(g) complaint. It alleged a shut- tle car had been operated without brakes. Mr. Taylor traveled to the mine on March 10 and gave the company a copy of the complaint. It indicated that on February 12, 1992, this incident occurred in 3rd south.

Mr. Taylor met with company representatives Hansen, Gunderson, and Salerno and they helped him interview company workers in the foreman's office.

Mr. Taylor interviewed Seldon Barker, Bill Burton and Paul Downard. Barker told Mr. Taylor that the brakes on the shuttle car kept getting worse and within two hours before the end of the shift the operator could push the brakes all the way down and they did not respond.

The shuttle car operates from the face to the feeder breaker. In this distance it travels one crosscut and goes around pillars; the maximum distance travelled would be 400- to 700 feet. There were two shuttle cars in use in this section that traveled to the feeder breaker. [A shuttle car normally carries 8 to 10 tons.]

Mr. Barker told Inspector Taylor he almost ran over a man com- ing out of a crosscut. However, he was able to stop. Mr. Barker complained that there were "no brakes" but he agreed to run the equipment for the last two hours if Mr. Downard informed those on the shift that the brakes were not operating. Mr. Downard agreed to this arrangement. Mr. Barker also told Supervisor Burton that he had "brake problems."

Mr. Taylor believed this was a violation of 30 C.F.R. 75.1725(a) because the service brakes were not operational The regulation requires an operator to remove equipment from service that is in an unsafe condition.

The operator of the shuttle car normally sits in the direction of travel and to tram the equipment he would move it in a reverse direction.

There are panic bars or emergency brakes provided on the shut- tle car. Mr. Barker indicated the emergency brakes worked. In a normal mining cycle the shuttle car operator used the service brakes to stop the shuttle car.

On February 12 the area where the shuttle car was operating was sloped; driving the shuttle car around the corner would present a hazard. In Mr. Taylor's opinion, if this equipment continued to operate, it was reasonably likely that an accident would occur. Supervisors Downard or Burton could have taken this equipment out of service.

Mr. Taylor issued this citation as an unwarrantable failure since he felt it was an aggravated situation for the foreman to allow this equipment to operate. The same reason applied to the second level supervisor.

There are only three ways to stop a shuttle car: using a foot pedal, emergency brake, or the service brakes. The ability to use an emergency brake did not affect Mr. Taylor's S&S evaluation.

Mr. Barker told Mr. Downard he would continue to operate the shuttle car for the two hours left in the eight-hour shift. Mr. Downard was filling in as the crew boss but normally he is a member of the crew.

SELDON BARKER has been a shuttle car operator for 19 years. On February 12, 1992, he was working in the 3rd South section developing a main panel for a longwall. There were seven members in the crew plus a supervisor. Mr. Downard was acting supervisor and Billy Burton was his supervisor.

Mr. Barker was operating an off-standard shuttle car. Off-standard means he would be driving on the opposite side that is normal for driving an automobile.

Mr. Barker was hauling coal from the continuous miner to dump it behind the feeder breaker, a distance of about 600- to 700 feet. The shuttle car weighs 33,000 pounds. There were holes in the road. It takes about a minute to load the shuttle car and a minute to go from the continuous miner to the feeder breaker, which is uphill. When the shuttle car is empty, you drive downhill. It takes about a minute to dump at the feeder breaker and a round trip takes about five minutes. When operating the shuttle car to the feeder breaker you do not travel in a straight line but you drive around corners.

On February 12, the brakes on the shuttle car became inoperable as there were no brakes at all with two hours remaining in the shift. Mr. Burton advised Mr. Downard that he had no foot brakes.

Mr. Downard suggested bleeding the brakes. This took from 15 to 20 minutes to do, but it did not restore braking power. They discussed the possibility that the master cylinder was not functioning.

In an eight-hour shift, they move about 100 shuttle cars. If they shut down this equipment, their goal could not be achieved. Messrs. Downard and Barker agreed to keep the shuttle car running. Mr. Barker couldn't tell Mr. Downard to take the shuttle car out of production. They made their 100 shuttle car quota for that day.

When operating the shuttle car without brakes and when unload- ing at the feeder breaker, the operator is going uphill. In this position, the shuttle car is held in position by taking your foot off of the pedal and changing seats. When Mr. Barker saw Mr. An- derson behind him, he back-trammed the shuttle car. Back-tramming or feather-tramming is when you put a toe under the tram pedal lo- cated on the reverse side. Mr. Barker was not in the proper seat to operate the tram pedal.

On February 12, Supervisor Burton was on the section for an hour and Mr. Barker believed Mr. Burton talked to Mr. Downard who said there was a problem with the brakes. It was Mr. Barker who first suggested that he could operate the shuttle car in a reason- ably safe manner.

Mr. Barker did not use the emergency brakes except when he stopped on a hill. He has more shuttle car experience than anyone else at the mine. He did not refuse to operate the shuttle car with the bad brakes. He thought he had a choice in this matter, (i.e., to refuse to operate the shuttle car), but he didn't know how far he could go with it.

SHELDON ANDERSON was the mechanic on February 12 in the 3rd South section. The 3rd South floor bottom has a grade going down- hill. The floor was slick and contained loose coal. In addition, the surface was uneven.

On February 12, Mr. Barker was on the feeder dumping a load of coal and Mr. Anderson was going through the crosscut behind him. Mr. Anderson flashed his light and as he stepped around the shuttle car it came back on him. If he hadn't jumped he would have been struck and either killed or hurt.

Mr. Anderson yelled at Mr. Barker. Mr. Barker did not say anything. Mr. Anderson did not know the brakes on the shuttle car were inoperative. The next day, Mr. Downard stated he had made a mistake and he should have told everyone the shuttle car had no brakes. In Mr. Anderson's opinion, it was not a safe practice to use emergency brakes.

GEORGE W. MANSON has been a Cyprus mechanic for 12 years and is experienced in mining. On February 12, he was involved with the brakes on the No. 8 shuttle car. Generally he serviced and main- tained equipment in the section and on February 12 he repaired the brakes on shuttle car No. 8 in accordance with a maintenance request.

The brakes were slow in stopping the equipment so the disks were cleaned and the brakes bled. Thereafter, the equipment was tested for stopping ability. They found that the reservoir brake fluid might have been three-eighths of an inch to one-half inch below normal. [The shuttle car was equipped with a dry braking system.]

On the second day the maintenance department received the same complaint and the brakes were bled. They were also tested and Mr. Manson felt they were operable.

A third time they were instructed to recheck the equipment because something was causing the brakes not to function. In removing the master cylinder they discovered that there was no fluid coming out of the line. They then went to the upper reservoir and removed the line. At this point they found a small rock which stopped the flow of the brake fluid into the master cylinder.

In Mr. Manson's opinion, the problem that they found would not make the equipment unsafe to operate. The brakes would still stop the equipment but it would take longer to stop it.

ART C. GORE is an MSHA coal mine inspector and experienced in mining. He identified Exhibit M-8 and discussed the technical as- pects of the braking system. He further indicated that MSHA records show 87 fatalities have occurred from bad brakes and 16 fatalities have been the result of shuttle car accidents.

PAUL DOWNARD is a person experienced in underground mining. He has been a member of the Robert Powell crew as an hourly employee and he occasionally fills in as spell boss. On February 12, 1992, he was spell boss on the afternoon 10-hour shift. Mr. Barker talked to him about the brakes on the shuttle car and he further indicated he was having problems with the brakes. Mr. Downard told him they should find some brake fluid. Mr. Downard was experienced with Joy shuttle cars and he felt he could handle the mechanics involved. Mr. Barker added the brake fluid and Mr. Downard was outside looking at the brake calipers. He did not touch the brakes. They found there was some air in the system and you could see air bubbles in the leaking fluid. Mr. Downard also looked in the brake fluid res-ervoir but couldn't see anything. The brake pedal felt spongy. There may have been some air but there was some braking power. The frame was wet from where the fluid was leaking. Mr. Downard told Mr. Barker that they would order a master cylinder. Mr. Barker said there was no way to get it changed before quitting time. Mr. Barker said he could run the shuttle car safely. Mr. Barker has 15 years experience running shuttle cars.

Mr. Downard has the authority to take the equipment out of service if it is unsafe. If Mr. Barker had not made the suggestion about safe running, Mr. Downard would have taken the equipment out of service.

Mr. Downard told some of the men on the crew that Mr. Barker was having problems with the brakes but he did not tell all of them. Mr. Downward was hoping to get the master cylinder installed within 15 to 20 minutes.

Mr. Downard observed Messrs. Burton and Barker talking and Mr. Burton said to shut it down if there was any problems. Mr. Downward did not have any discussion with Mr. Burton concerning the brakes.

During the rest of the shift, Mr. Downard saw Mr. Burton at the shuttle car. He did not see Barker almost run over Mr. Anderson but he felt that he had a fail-safe brake system and the emergency brake; in addition, back-tramming was also available. Back tramming or feathering a tram pedal will slow down the equipment.

Mr. Downard indicated his relationship with shuttle car opera- tor Barker was not good. Mr. Barker does not like to take orders and he was previously suspended one day when Mr. Downard was the spell boss.

The company budgets 100 shuttle carloads per shift. Mr. Barker did not say to him that he wanted to help him make his quota.

The following shift, Mr. Downard and the crew discussed the Anderson incident. Mr. Downard was concerned that he had not made it around to everyone to tell them about the brakes on the shuttle car. Mr. Downard indicated to the crew that if it happened again, he'd shut it down and fix it. Mr. Downard should have done it dif- ferently and he doesn't feel he should have relied on Mr. Barker. But as spell boss, Mr. Downard thinks he is entitled to rely on statements by his equipment operator.

Mr. Downard felt that Mr. Barker's desire was for safety and he felt confident that Barker could safely operate the equipment.

Mr. Barker was confident in this regard but he wanted the crew to know about it. He agreed that operating a shuttle car without service brakes would be unsafe. However, there are times when it depends upon how bad the brakes are. Mr. Downard assumed there were some brakes because Barker could still operate the equipment. Mr. Barker said he had other brakes, however the condition was un- safe if there were no brakes and the equipment was being operated by tramming and emergency brakes. [The purpose of the reverse tram is not to stop the shuttle car.]

After Mr. Downard agreed to let Mr. Barker operate the shuttle car he did not tell Anderson about the brakes. Mr. Downard's re- sponsibility was greater than Mr. Barker's under the circumstances.

ROBERT A. LINDSEY has been employed by Cyprus for 11 years and has operated diesels, shuttle cars, and roof bolters.

It is company policy to remove any unsafe equipment from serv- ice. That authority is set forth on the task training sheet.

Messrs. Barker and Downard did not have a good relationship. It was, in fact, a "bad" relationship and there was animosity between the two men but Mr. Lindsey did not know why. It has been going on for a long time. Additional miners having a bad relation- ship are Mr. Barker, Ben Brady, and Benny Avhil.

Mr. Lindsey agrees he is not saying someone engineered accidents to make Mr. Downard look bad. He considers Mr. Downard to be a good supervisor but other individuals do not agree. In Mr. Lind- sey's opinion, Mr. Barker is fairly vocal about safety issues and he wouldn't be shy in this respect with Mr. Downard.

JERRY DOLINSKI is the maintenance foreman for Cyprus. He has been employed by the company for 15 years and is experienced in maintenance and underground coal mining. In February 1992, he was superintendent for George Manson and on February 13, 1992, they worked on the No. 8 shuttle car. The complaint was that there were no brakes. The pedal went to the floor.

Messrs. Dolinski and Manson bled the brakes but they would not build up. This indicated to Mr. Dolinski that there was no brake fluid in the master cylinder.

Exhibit R-13 shows that there was no reference to work on the shuttle car on February 11 nor on February 12. On February 13 it was indicated the line was plugged and the brake fluid could have been going through and later plugged. On February 14 no work was done on the brakes. Even if the master cylinder is one-half or one-third full the brakes will still continue to operate.

Mr. Dolinski found no brakes at all on shuttle car 8. He explained in detail the nature of the dry (as distinguished from wet) brakes. He further explained the cause of the problem was a small rock that blocked the flow of the brake fluid.

WILLIAM B. BURTON is a shift foreman with 21 years experience. He has held various positions in the mine. On February 12, 1992, he was a shift foreman and was making his rounds. He came to Mr. Bark- er and talked to him while he was in the shuttle car. Mr. Barker stated the brakes were bad or screwed up but he was running it fine and the crew had been notified. He said he had no brakes.

Mr. Burton indicated that any operator can shut down equipment if it is unsafe and he is expected to notify the foreman when he does that. On February 12 Mr. Burton said the shuttle car should be taken out of service. He also checked with Sheldon Anderson and asked him if he had been almost run over by a shuttle car. He replied, "No, it wasn't a big deal."

On this particular day there were two or three shuttle cars on 3rd South. If Barker went out of service they could still continue to run coal. The shuttle car should be taken out of service if it is unsafe to operate and Mr. Burton believed they were all partly responsible.

Mr. Barker received a disciplinary for the matters between him and Downard; this occurred a couple of weeks ago. This event was because Mr. Barker was "harassing" Mr. Downard.

DISCUSSION, EVALUATION AND FURTHER FINDINGS

Credibility issues involve the condition of the shuttle car brakes and the operator's knowledge as to these unsafe conditions on February 12, 1992. On these issues I essentially credit the testi- mony of Sheldon Barker. As the shuttle car operator, he would be the most knowledgeable person concerning the condition of the shut- tle car. The credible evidence established the following:

FINDINGS OF FACT

1. Sheldon Barker was the shuttle car operator on February 12, 1992. (Tr. 432).

2. On that day, the brakes slowly deteriorated until there were about two hours left in the shift. At that point the foot brakes would not stop the shuttle car. (Tr. 442, 443).

3. Mr. Barker advised Supervisor Paul Downard that he had no brakes. (Tr. 443). Downard said, "We'll bleed them." After bleeding them Mr. Downard could not get any brakes. (Tr. 443, 453).

4. The two men believed it could be a master cylinder problem. (Tr. 444).

5. If Barker could operate the shuttle car, they could reach their goal of 100 car production quota. (Tr. 445).

6. Barker had never operated a shuttle car with complete loss of service (foot) brakes. (Tr. 447). He wasn't too sure he had the option to shut down the shuttle car. (Tr. 446).

7. He held the shuttle car (while unloading it) by feathering the tram pedal. Feathering means you engage the pedal and then let off. (Tr. 447, 448).

8. While he was dumping one load, Mr. Anderson walked in front of the shuttle car but jumped out of the way. (Tr. 448, 449).

9. On February 12, Supervisor Barker was in the section. Mr. Barker heard Mr. Downard tell Mr. Burton there was trouble with the brakes. (Tr. 450).

10. Mr. Barker suggested to Mr. Downard that he could operate the shuttle car rather than wait for the master cylinder. (Tr. 456).

11. It was agreed by Barker that Downard would advise all persons in the section that the buggy was in an unsafe condition. (Tr. 458). Barker did not tell Burton that the shuttle car was unsafe. (Tr. 458).

12. Mr. Barker was operating the shuttle car more cautiously than usual. (Tr. 462).

13. Mr. Barker was assured everyone in the section knew the brakes were not operating. (Tr. 466).

14. There was no refusal to operate the equipment. Barker felt he was doing a service to Downard to keep the buggy operating. (Tr. 466).

15. William Burton, shift foreman, encountered Barker late in the shift. He stated he was having problems with the brakes. They were "bad" or "screwed up." However, he (Barker) was running it fine and the crew had been notified. (Tr. 721-722).

16. Mr. Burton didn't hear about the Barker/Anderson near collision until about a month later. (Tr. 728).

FURTHER FINDINGS

It may well be that Mr. Barker could run this equipment by using reverse tramming. However, the use of a shuttle car without service brakes is "unsafe" within 75.1725(a) and the equipment must be removed from service immediately.

Mr. Dolinski confirmed Mr. Barker's view that there were no brakes, which was the condition Mr. Dolinski found when he examined the equipment. Mr. Manson's contrary testimony is rejected.
Mr. Dolinski, Manson's supervisor, would be more knowledgeable than Manson.

The statements by Superintendent Burton, the shift foreman, further confirm the lack of brakes on the equipment. Mr. Burton stated the shuttle car should have been taken out of service because it was unsafe to operate.

As a defense, Cyprus asserts that the animosity between shuttle car operator Barker and spell foreman Downard, as noted in the rec- ord, establish a situation where Barker was interested in "getting" the foreman.

Mr. Lindsey testified along these lines. In addition, Superin- tendent Burton indicated that Messrs. Downard and Barker did not like each other. He cites the incident where Barker was suspended by Downard as a possible motive for their feelings (i.e., Downard and Barker).

I am not persuaded by Mr. Lindsey's testimony. The two men may not have gotten along, but the testimony about a "bad" relationship is somewhat ambiguous and vague. Further, the Downard/ Barker in- cident where Barker was suspended and lost five hours' pay only happened two weeks before the hearing. In point of time, this would not be too relevant here. Mr. Barker was suspended by Mr. Downard for heckling him; Burton did not recall any other incidents involv- ing the two men.

From having observed the witnesses, it is apparent that Mr. Barker would not hesitate to complain about safety matters and he made such a complaint here; however, the equipment was not re- moved from service.

SIGNIFICANT AND SUBSTANTIAL

The case law as to S&S citations are set forth in connection with the previous citation.

The record establishes criteria as to paragraphs (1), (2) and (4) of the Mathies formulation.

Paragraph (3) is also established since Barker almost collided with Anderson.

Cyprus argues S&S was not established because the Secretary failed to prove there was a reasonable likelihood that an injury would occur.

I conclude a reasonable likelihood existed. In connection with the "near miss" between the shuttle car and Anderson, if the miner helper had not jumped, he would have been struck by the shuttle car.

Inspector Taylor further confirmed that it was reasonably likely that a serious injury or a fatality could occur. His opinion was based in part on the shuttle car operator's limited visibility, the area in which it was operating, the size of the equipment, the slope and undulating floor. (Tr. 382-385).

UNWARRANTABLE FAILURE

I consider Paul Downard, the spell boss, to have been negligent. Mr. Downard had an opportunity to more thoroughly investigate the shuttle car problem. Further, an upper level supervisor also failed to follow up on the problem. I consider such conduct consti- tutes high negligence which establishes a statutory unwarrantable failure.

Cyprus argues unwarrantable failure does not apply here because there are no specific guidelines or tests that can be performed under the cited standard to determine the adequacy of the brakes. Compare 30 C.F.R. 56.14101 and 75.523-3.

I am not persuaded. "No brakes" as matter of law are "unsafe" within the meaning of 75.1725(a). The unwarrantable failure arises here in the continued use of the shuttle car without brakes and the failure of two supervisors to investigate and remedy the situation.

Cyprus argues Mr. Barker found some braking power because he bled the brakes and observed pressure on the brake calipers. Mr. Downard also found some braking power.

I am not persuaded. Mr. Barker said he had "no brakes." His testimony was confirmed by the maintenance foreman Mr. Dolinski. On February 13, he "pushed on the brake pedal and the pedal went all the way to the floor" (Tr. 665) and in his investigation he "didn't have any brakes at all." (Tr. 685).

For the above reasons, Citation No. 3850267 should be affirmed.

CIVIL PENALTIES

The size of the operator, the appropriateness of the penalty and the company's prior history have been previously discussed.

The operator was negligent in that it failed to thoroughly investigate and remedy this situation.

Gravity is high since miners could have been struck by the shuttle car.

Abatement was not involved in this situation.

For the foregoing reasons, I enter the following:

ORDER

1. In Docket No. WEST 92-485, Order No. 3588140, is modified to a 104(a) citation and the citation, as modified, is AFFIRMED and a penalty of $200.00 is ASSESSED.

2. In Docket No. WEST 92-485, Citation No. 3850267 is AFFIRMED and a penalty of $600.00 is ASSESSED.

3. The contest cases in WEST 92-370-R and WEST 92-371-R, pending herein, are DISMISSED.

John J. Morris
Administrative Law Judge

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