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SOL (MSHA) V. S & H MINING
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FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

OFFICE OF ADMINISTRATIVE LAW JUDGES
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SECRETARY OF LABOR, MINE SAFETY AND HEALTH ADMINISTRATION (MSHA), Petitioner	:	CIVIL PENALTY PROCEEDINGS
	:	Docket No. SE 93-202
	:	A.C. No. 40-03011-03545
v.	:	
	:	Docket No. SE 92-396
S & H MINING, INCORPORATED, Respondent	:	A.C. No. 40-03011-03528
	:	
	:	S & H Mine No. 7

DECISION

Appearances: Thomas A. Grooms, Esquire, Office of the Solicitor, U.S. Department of Labor, Nashville, Tennessee, for Petitioner; Imogene A. King, Esquire, Frantz, McConnell and Seymour, Knoxville, Tennessee, for Respondent

Before: Judge Melick

These cases are before me upon the petitions 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," charging S & H Mining, Inc. (S & H) with three violations of mandatory standards and seeking civil penalties of $2,440 for those violations. The general issue is whether S & H violated the cited standards and, if so, what is the appropriate civil penalty to be assessed. Additional specific issues are addressed as noted.

The citations at bar were issued by Inspector Don McDaniel of the Mine Safety and Health Administration (MSHA) as a result of his inspection at the S & H Mine No. 7 on May 7, 1992. Citation No. 3383512 issued pursuant to Section 104(d)(1) of the Act(Footnote 1) alleges a "significant and substantial" violation of

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

"If, upon any inspection of a coal or other mine, an authorized representative of the Secretary finds that there has been a violation of any mandatory health or safety standard, and if he also finds that, while the conditions created by such violation do not cause imminent danger, such violation is of such a nature as could significantly and substantially contribute to the cause and effect of a coal or other mine safety or health hazard, and if he finds

the mine operator's roof control plan under the standard at 30 C.F.R. 75.220 and charges that "the approved roof control plan was not being complied with in the No. 7 entery [sic] on the 001 working section had been driven 22 feet and 9 inches wide for a distance of 15 feet long and additional roof support had not been installed." It is not disputed that the approved roof control plan required that the entries be driven no wider than 20 feet.

Inspector McDaniel was sent to the S & H No. 7 Mine to investigate a telephone report of an accident and injury. McDaniel was met by Mine Superintendent Charles White and they proceeded underground to check the accident area. According to McDaniel, in the area where the accident occurred and rock had fallen from the roof, the entry was excessively wide. McDaniel testified that he and White measured the entry widths at four locations along 15 feet 9 inches of entry and found the entry at three locations to be 22 feet 9 inches and at one location to be 22 feet 6 inches (Tr. 16). These areas had not been supported by added roof bolts at the time of the accident and in the area of the roof fall.

McDaniel opined that the violation was the result of "unwarrantable failure" because Steve Phillips, who was foreman on the shift preceding the accident on May 5, 1992, had also been operating the continuous miner on that shift and acknowledged that he had in fact made the cited cuts on the morning preceding the injury, i.e., the cuts that created the excess widths. Phillips also acknowledged to McDaniel that he had performed the preshift examination for his shift and that Foreman Willie Byrd performed a preshift examination for his second shift. Under the circumstances McDaniel concluded that

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fn. 1 (continued)
such violation to be caused by an unwarrantable failure of such operator to comply with such mandatory health or safety standards, he shall include such finding in any citation given to the operator under this Act. If, during the same inspection or any subsequent inspection of such mine within 90 days after the issuance of such citation, an authorized representative of the Secretary finds another violation of any mandatory health or safety standard and finds such violation to be also caused by an unwarrantable failure of such operator to so comply, he shall forthwith issue an order requiring the operator to cause all persons in the area affected by such violation, except those persons referred to in subsection (c) to be withdrawn from, and to be prohibited from entering, such area until an authorized representative of the Secretary determines that such violation has been abated."

both foremen should have discovered the excess widths and should have removed all miners and supported the roof before allowing anyone in the area.

In reaching his conclusions, McDaniel further relied upon statements by Second Shift Miner Operator Mark Moran who told McDaniel that before the roof fall he noticed that the roof bolts were located too far from the rib and that he (Moran) had asked Second Shift Foreman Willie Byrd to correct the condition.

McDaniel opined that a roof bolter could have bolted the roof in the cited area without removing the continuous miner by lifting the cable over the roof bolter or by protecting the miner's power cable with boards. McDaniel also concluded that, alternatively, they could have timbered the area without removing the continuous miner. McDaniel concluded that by allowing continuing efforts to clean up the face with the mining machine after Moran had notified Foreman Byrd of the excess widths, the violation was the result of "unwarrantable failure."

Foreman Willie Byrd was night shift foreman at the time of the accident on May 5, 1992. He proceeded underground around 2:30 p.m. on that date to perform a preshift examination. He estimated the preshift exam took about 45 minutes, including about 15 minutes at the face. Sometime during the shift, miner operator Mark Moran called him to the section. Moran was then waiting for a shuttle car to return and showed Byrd what he described as a spot that "looked a little wide." Byrd admitted that indeed you could tell it was "a little bit wide."

According to Byrd, he then told Moran to continue to clean up loose coal with the continuous miner to enable the bolting machine to position itself and then to "get out." Byrd conceded that loose coal was in front of the continuous miner at the time and that it was company procedure to clean that area before removing the continuous miner. He did not see any need to come "straight out." Byrd reiterated that after Moran showed him the wide spot he told the bolter to bolt the area. Byrd then proceeded elsewhere for about five minutes before learning of the rock fall. He admittedly had checked the same area on his preshift exam but concluded the area "wasn't that noticeable." While he believed the last row of bolts looked a little wide he did not believe it was in excess of 20 feet. Byrd further admitted that the continuous miner did not have to clean up before the bolter came in but he nevertheless told Moran to clean up the loose coal in front of the miner before backing out. Byrd also admitted that he could have placed timbers in the wide area even without removing the continuous miner.

As noted, the continuous miner operator for the second shift on May 5, 1992, was Mark Moran. Moran testified that he proceeded underground on May 5 at about 3:00 p.m. and began operating the miner at around 3:45 or 3:50 p.m. He completed a cut about 10 foot wide and 20 feet deep before the roof fall accident. He had been waiting for the shuttle car to leave and started backing up the continuous miner. In the process of backing up, the victim, Mr. Suttles, picked up the trailing cable and at that time the roof fall occurred.

Eddie Suttles testified that on May 5, 1992, he was the helper on the second shift assisting Moran with the continuous miner. He recalled that, after cleaning up, the continuous miner started backing up. Suttles first held the miner cable as the shuttle car backed up. It was at that point that the rock fell on Suttles dislocating his vertebrae and resulting in paralysis.

Steve Phillips, miner operator and foreman on the first shift on May 5, 1992, acknowledged that he made the cited cuts sometime after the dinner break at 11:00 or 11:30 on May 5. He had to make a left turn with the miner into the No. 7 entry and had to make several cuts to get around the turn. According to Phillips the area looked like the diagram in Exhibit R-3. He stated that if he thought he had been cutting wide he would have immediately stopped operating, but he did not see anything that lead him to believe it was more than 20 feet wide. He stated that he did not report any excess widths in the mine examination book because he did not see any excess width. He noted, however, that the usual cut varied from 16 feet to 18 feet wide and further acknowledged that the entry in fact was 4-l/2 feet wider than the usual 18 foot cut.

Roof Bolter Sam Ward bolted the area in the No. 7 entry after it had been cut by Phillips on that shift. Ward testified he could see "nothing wrong with the entry," only "just a little corner cut out when I saw it after the roof fall. "

Citation No. 3383512

The violation charged in this citation is not disputed, but only the "unwarrantable failure," negligence and gravity findings. "Unwarrantable failure" has been defined as conduct that is "not justifiable" or is "inexcusable." It is aggravated conduct by a mine operator constituting more than ordinary negligence. Youghegheny and Ohio Coal Company, 9 FMSHRC 2007 (1987); Emery Mining Corp., 9 FMSHRC 1997 (1987). In this case it is clear from the testimony alone of Second Shift Foreman Willie Byrd that the violation was the result of an inexcusable and aggravated omission constituting more than ordinary negligence.

It is not disputed that Byrd was apprised by Continuous Miner Operator Moran of the cited excess widths. Byrd himself admitted that "you could tell it was a little bit wide" (Tr. 88). After being apprised of this fact Byrd nevertheless directed Moran to continue to clean up loose coal in the face area in front of the miner before backing out. Byrd explained that he did not order the continuous miner operator to back out immediately because "it was just a procedure ... we always clean it up" (Tr. 89). In the process of removing this coal a shuttle car thereafter entered the No. 7 entry and, when backing up, caused Miner Helper Eddie Suttles to step into the wide, unsupported area where the roof material fell causing severe injuries and paralysis. Under the circumstances the violation was clearly the result of "unwarrantable failure" and high negligence.

The violation was also "significant and substantial" and of high gravity. A violation is properly designated as "significant and substantial" if, based on the particular facts surrounding that 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 (1981). In Mathies Coal Co., 6 FMSHRC 1, 3-4 (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 reasonably 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.
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> See also Austin Power Co. v. Secretary, 861 F.2d 99, 103-04 (5th Cir. 1988), aff'g 9 FMSHRC 2015, 2021 (1987) (approving Mathies criteria).

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 (1984), and also that in the likelihood of injury be evaluated in terms of continued normal mining operations (U.S. Steel Mining Co., Inc., 6 FMSHRC 1473, 1574 (1984); see also Halfway, Inc., 8 FMSHRC 8, 12 (1986) and Southern Oil Coal Co., 13 FMSHRC 912, 916-17 (1991).

Since the rock that fell upon continuous miner helper Eddie Suttles in fact fell from the wide and unsupported area cited as a violation in this case causing serious injuries and paralysis, the violation was without question "significant and substantial" and of high gravity.

Citation Nos. 3383514 and 3383515

Citation No. 3383514 alleges a violation of the standard at 30 C.F.R. 75.303 and charges as follows:

> The preshift examinations for the second shift on the 5-5-92 was not adequate. The No. 7 entery [sic] had been driven 22 feet and 9 inches wide on the 1st shift and this condition was not recorded in book.

The cited standard provides in relevant part as follows:

> (a) Within 3 hours immediately preceding the beginning of any shift, and before any miner in such shift enters the active workings of a coal mine, certified persons designated by the operator of the mine shall examine such workings and any other underground area of the mine designated by the Secretary or his authorized representative. Each such examiner shall ... examine and test the roof, face, and rib conditions in such working section; examine active roadways, travelways ... and examine for such other hazards and violations of the mandatory health or safety standards, as an authorized representative of the Secretary may from time to time require. ... If such mine examiner finds a condition which constitutes a violation of a mandatory health or safety standard or any condition which is hazardous to persons who may enter or be in such area, he shall indicate such hazardous place by posting a 'danger' sign conspicuously at all points which persons entering such hazardous place would be required to pass, and shall notify the operator of the mine. No person, other than an authorized representative of the Secretary or a State mine inspector or persons authorized by the operator to enter such place for the purpose of eliminating the hazardous condition therein, shall enter such place while such sign is so posted. Upon completing his examination, such mine examiner shall report the results of his examination to a person, designated by the operator to receive such reports at a designated station on the surface of the mine, before other persons enter the underground areas of such mine to work in such shift.

> Each such mine examiner shall also record the results of his examination with ink or indelible pencil in a book approved by the Secretary kept for such purpose in an area on the surface of the mine chosen by the operator to minimize the danger of destruction by fire or other hazard, and the record shall be open for inspection by interested persons.

Citation No. 3383515 alleges a "significant and substantial" violation of the standard at 30 C.F.R. 75.304 and reads as follows:

> The on-shift examinations for 5-5-92 were not adequate. The No. 7 entry on the 001 working section was mined 22 feet and 9 inches wide and this condition was not recorded in the approved book.

The cited standard reads, in part, as follows:

> At least once during each coal-producing shift, or more often if necessary for safety; each working section shall be examined for hazardous conditions by certified persons designated by the operator to do so. ...

According to Inspector McDaniel these citations were based upon statements that Foreman Phillips had performed a preshift examination in the cited area but failed to report the excess widths in the preshift examination book. Based upon information that Foreman Willie Byrd had also performed a preshift examination for the second shift and failed to report this condition in the preshift examination books, McDaniel also found a violation of the reporting requirements. McDaniel testified that he also based Citation No. 3383515 upon Phillips' admission that he had performed a preshift and onshift examination but failed to observe the excess widths. McDaniel noted that Foreman Phillips was the same person who in fact cut the cited wide areas.

S & H does not deny these violations of the preshift and onshift examination requirements but maintains that its negligence was "non-existent or low due to the conditions then existing which served to obscure the violation." However, based on the evidence that First Shift Foreman Steve Phillips himself created the cited wide cuts around 11:00 or 11:30 on May 5, in an admittedly unusual maneuver with the mining machine, I find that he was thereby placed on notice that an excess width problem may thereby have been created and it was therefore his duty to ensure himself that there was not an excess width at that location. Under the circumstaces I find

that S & H was indeed negligent in failing to have observed and noted the excess widths in the preshift and onshift examination books.

The violations were also "significant and substantial" since it may reasonably be inferred that the failure to have reported the condition led to the injury and paralysis of the miner helper. The citations are accordingly affirmed with the "significant and substantial" findings.

Under the circumstances, and considering all the criteria under section 110(i) of the Act, I find that a civil penalty of $220 each for the violations cited in Citation Nos. 3383514 and 3383515, and $2,000 for the violation charged in Citation No. 3383512, are appropriate.

ORDER

Citation No. 3383512 is affirmed as a citation under section 104(d)(1) of the Act and S & H Mining, Inc. is directed to pay a civil penalty of $2,000 for the violation charged in that citation within 30 days of the date of this decision. S & H Mining, Inc. is further directed to pay within 30 days of the date of this decision civil penalties of $220 each for the violations charged in Citation Nos. 3383514 and 3383515.

Gary Melick
Administrative Law Judge

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