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SOL (MSHA) V. W.S. FREY
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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. VA 93-59-M
	:	A.C. No. 44-00044-05534
v.	:	
	:	Docket No. VA 93-80-M
W.S. FREY COMPANY, INC., Respondent	:	A.C. No. 44-00044-05537
	:	
	:	Docket No. VA 93-89-M
	:	A.C. No. 44-00044-05538
	:	
	:	Clearbrook Mine and Mill

DECISION

Appearances: Javier I. Romanach, Esq., Office of the Solicitor, U.S. Department of Labor, Arlington, Virginia, for the Petitioner;
Thomas Moore Lawson, Esq., Hazel and Thomas, P.C., Winchester, Virginia, for Respondent.

Before: Judge Barbour

STATEMENT OF THE PROCEEDINGS

These cases are before me upon petitions for assessment of civil penalties filed by the Secretary of Labor (Secretary) pursuant to Sections 105 and 110 of the Federal Mine Safety and Health Act of 1977 (Mine Act), 30 U.S.C. 815 and 820. The petitions allege six violations of mandatory safety standards for surface metal and non-metal mines found in 30 C.F.R. Part 56. In addition, the Secretary asserts that five of the alleged violations constituted significant and substantial (S&S) contributions to mine safety hazards, and that three were caused by W.S. Frey Company, Inc.'s (Frey) unwarrantable failure to comply with the cited standards.

The single violation alleged in Docket No. VA 93-89-M resulted from the Mine Safety and Health Administration's (MSHA) investigation of a fatal accident that occurred at Frey's Clearbrook Mine and Mill on December 11, 1992. The five violations alleged in Docket Nos. VA 93-59-M and VA 93-80-M resulted from the agency's investigation of a fatal accident that occurred at the Clearbrook facility on December 13, 1992.

The cases were consolidated and a hearing on the merits was conducted in Winchester, Virginia.

STIPULATIONS

The parties chose to try first Docket Nos. VA 93-59-M and VA 93-80-M, the cases pertaining to the December 13, 1992 accident. With respect to these two cases, the parties stipulated as follows:

1. The Administrative Law Judge has jurisdiction to hear and decide the case.

2. MSHA Inspector Elwood S. Frederick was acting in his official capacity when he issued Citation No. 4083442.

3. Citation No. 4083442 was properly issued to [Frey's] agent.

4. Abatement of the conditions cited in Citation No. 4083442 was timely.

5. Frederick was acting in his official capacity as a federal coal mine inspector when he issued [Order/Citation] No. 4082539 on December 14, 1992.

6. Frederick was acting in his official capacity as a federal mine inspector on December 21, 1992 when he issued Citation No. 4083441, [Order No.] 4082540 and [Order No.] 4083444.

7. Order/Citation No. 4082539, [Citation No.] 4083441, [Order No.] 4082540 and [Order No.] 4083444 were properly served to Frey's agent.

8. Abatements of the conditions cited in Order/Citation No. 4082539, [Citation No.] 4083441, [Order No.] 4082540 and [Order No.] 4083444 were timely.

9. The Clearbrook Mine and Mill is a surface lime and crushed stone operation owned and operated by [Frey].

Tr. 11-12 (nonsubstantive editorial changes made).

The parties further agreed that the witnesses be sequestered.

DOCKET NOS. VA 93-59-M AND VA 93-80-M

THE ACCIDENT OF DECEMBER 13, 1992

THE SECRETARY'S WITNESSES

Elwood S. Frederick

Frederick testified that he took part in MSHA's investigation of the fatal accident that occurred at Frey's Clearbrook Mine and Mill on December 13, 1992. As a member of the investigation team, Frederick visited the facility on December 14. Frederick was accompanied by his supervisor, Charles McNeal (Tr. 21-22). Frederick and McNeal arrived at the mine between 6:15 a.m. and 6:30 a.m. (Tr. 122).

The accident had occurred the previous night in the coal storage area of the facility. There, contractor-supplied coal used to fuel coal-fired kiln was piled under a open-sided, square "shed" (Tr. 41-42). The shed consisted of four pillars or beams supporting a roof. The roof was slightly more than 31 feet above the storage area floor. The shed's purpose was to keep rain and snow off of the coal.

Once the coal was dumped in the storage area it was pushed into a floor level hole (surge hole) by a front-end loader. It then fell through the surge hole into a hopper below the shed floor (Tr. 42-43). At the bottom of the hopper was a surge vibrator (syntron feeder) that shook the coal onto a conveyor belt through the feeder opening (the dog house opening). The belt transported the coal to a storage tank in the kiln building. The coal fired the kiln (Tr. 44, 48).

The coal occasionally stuck (or hung-up) at the surge hole, especially in the winter when the coal had lumps of snow in it. The fact that the coal was hung-up was evidenced by a lack of coal coming through the feeder and dumping onto the belt (Tr. 50.) When this happened, a Frey employee would approach the surge hole and use a 9-1/2 foot long metal bar to poke or probe at the coal (Tr. 48, 50). If the hole could not be cleared with the bar, the front-end loader would try to dig the hole free (Tr. 50). If the hang-up was at the feeder, rather then at the surge hole, the employee would use a similar bar or pole to pry the coal free from the feeder end of the hopper (Tr. 51-52).

The victim was Denny Bernaldes, the kiln burner helper on the second shift. He was found with the upper half of his body (shoulders and above) stuck in the syntron feeder and the lower half of his body on the conveyor belt. One of Bernaldes' legs was off the conveyor belt (Tr. 70). There was coal around

the upper half of his body. The coal had to be removed before the body could be extracted from the feeder (Tr. 70). Bernaldes, who was dead when he was found, died of asphyxiation.

Although Frederick stated he "he had no facts to document [it]" (Tr. 97), Frederick believed that Bernaldes fell through the surge hole and into the hopper while trying to do free a hang-up (Tr. 49, 121). The bar used to free surge hole hang-ups was found about 5 feet from the surge hole sticking straight up in the coal (Tr. 184-185). In Frederick's opinion Bernaldes died when he became stuck in the dog house opening while trying to get out of the hopper. The dog house opening measured 14 inches wide by 24 inches high (Tr. 117).

Frederick did not see Bernaldes' body. It was removed prior to Frederick's arrival at the facility by the county rescue squad. Frederick's information came from interviews with Frey personnel. Frederick did not interview the rescue squad members who freed the body (Tr. 128-130). Nor did Frederick take into consideration Bernaldes' size when he concluded how the victim had died (Tr. 132).

In response to suggestions that Bernaldes climbed onto the belt and stuck his head and shoulders into the feeder rather then fell through the surge hole, Frederick stated that Halbard Meyers, the second shift kiln operator, told him when Meyers found the body, Meyers had to shut off the feeder and the conveyor belt (Tr. 116, 128). To get onto the belt and crawl into the feeder with the belt running would have been practically impossible (Tr. 116). Frederick understood the belt ran at a speed of 400 feet per minute (Tr. 117).

When Frederick arrived at the coal storage area the temperature was cold. Some of the coal had chunks of snow on it (Tr. 57). The shed itself was roped off with police tape because of the accident (Tr. 158). He could not see where the hole was because it was covered with coal. However, someone from the company turned on the feeder and this cleaned the coal out of the surge hole and the hole became visible (Tr. 41-42).

Frederick and a Virginia state mine inspector, who was at the facility in connection with the state's investigation of Bernaldes' death, measured the surge hole opening and found it to be 24 inches long and 39 inches wide (Tr. 28-30, 124). Using a diagram of the site that he had prepared, Frederick testified that it was 7 feet from the surge hole to the syntron feeder at the bottom of the hopper (P. Exh. 11; Tr. 32). (In other words, the hopper was 7 feet tall.) The belt onto which the coal dumped was 24 inches wide (Tr. 34). There was no

barrier or device to warn a person where the surge hole was (Tr. 53). Also, there was no grisly over the hole (Tr. 174). In short, there was nothing to prevent a person from falling in.

Because of what he observed, Frederick issued Frey an imminent danger withdrawal order and associated citation (Order/Citation No. 4082539) for a violation of section 56.16002(a)(1). This mandatory safety standard requires that where loose, unconsolidated materials are stored or transferred at surge piles, the piles be equipped with mechanical devices or other means of handling the materials so that during normal operations persons are not required to work where they are exposed to entrapment by caving or sliding materials. Frederick explained, "There was an unguarded opening at ground level. And, the coal has a tendency to hang-up and some individual must come there and poke this. Therefore, where anybody can walk directly in and fall into this hole, you can work right over to the hole if you didn't know where it is at" (Tr. 60-61). Moreover, because the coal did not necessarily flow straight down into the hopper, but also could funnel down in a cone shape along its angle of repose, the size of the area of coal falling through the chute could increase as the material fell and a person could be inadvertently drawn into the hole (Tr. 62, 139).

Frederick stated if someone had to work where he or she was exposed to entrapment by caving or sliding material, the cited standard required a mechanical means of handing the material. Here, where a person trying to free a hang-up might not know where the hole was and could step on a bridge of coal temporarily covering the hole, or could be drawn into the hole as the coal funneled down, such a mechanical means was lacking (Tr. 64-65). To abate the alleged violation, Frey freed the area of coal and welded a plate over the hole. Frey then installed a new hopper that was only loaded with a front-end loader (Tr. 65-66).

Frederick considered the alleged violation to be S&S because the coal could suddenly fall and easily draw into the hopper a person trying to free a hang-up (Tr. 71). Such an accident was reasonably likely to happen because there was no protection around the surge hole and no warning of its presence (Tr. 71). Once in the hopper there was no way out and no one could hear the person if he or she yelled for help (Tr. Id., 75). The coal storage area was positioned so that a person trying to free a hang-up would be out of sight of other employees (Tr. 75). Frederick believed death would be the likely result (Tr. 73-74).

With regard to Frey's negligence, Frederick indicated that it was "high" (Tr. 77; Exh. P-1). He stated that Frey management personnel knew the hole was there yet took no precautions, such as having a safety belt or line at the job site or having a sign indicating the presence of the hole.

More important, during the investigation Frederick discovered other employees had fallen into the hopper prior to the accident. These persons included Foreman Raymond Murray's brother, who was not injured because there were other people present to help get him out (Tr. 77, 152-153). However, Frederick was not aware if any person had brought the conditions at the surge hole to management's attention (Tr. 165).

Frederick further testified that as a result of the investigation he issued other citations and orders to Frey. Pursuant to section 104(d)(1) of the Act, 30 U.S.C. 814(d)(1), he issued Citation No. 4083441, alleging a violation of section 56.15005. The mandatory safety standard requires safety belts and lines to be worn when there is a danger of falling. Frederick believed Bernaldes did not wear a safety belt and line when he was working around the surge hole (Tr. 79).

Frederick testified he also cited Frey because "they had no safety belts and lines at the job site" (Tr. 80). To put it another way, "We wrote [the violations] because ... there was no safety belt and line there where there was a hazard of falling into that bin" (Tr. 171). Frederick explained, "Where employees work where there is a hazard of falling into ... surge bins or hoppers ... they must be provided with a safety belt and they must wear a safety belt and either have it tied off or have a second person in attendance" (Tr. 80-81). An employee was in danger of falling while attempting to free a hang-up. An employee could be standing directly along side the hole, not know it, and "go down with the material" (Tr. 81). Snow made the coal slippery and there was no place to tie off a safety line, except 30 or 40 feet away on one of the columns of the shed (Tr. 83-84). In Frederick's opinion, the safety belts and lines should have been kept at the coal shed (Tr. 167-168). He stated, "They could ... store them in a box like most companies do" (Tr. 168).

Frederick maintained that employees interviewed during the investigation indicated they did not wear safety belts or lines when working in the area, although he could not recall which employees made the statement (Tr. 85).

Frederick considered the alleged violation to be S&S because of the hazard of falling into the hopper and being buried by the coal. He also believed that if business at the facility continued as usual, it was highly likely that such a fatal accident would occur (Tr. 86-87). Indeed, Frederick concluded that the alleged violation contributed to the victim's death. Frederick stated that had Bernaldes been wearing a safety belt and line, "he would have been able to get out" of the hopper (Tr. 88).

Frederick believed management's negligence was "high" and that the alleged violation was due to Frey's unwarrantable failure to comply with section 56.15005 (Tr. 88). He testified that during the investigation it was revealed that management was advised several times about having safety belts at the job site but had done nothing about it (Tr. 88-89). Nonetheless, management had assigned the victim to go to the coal storage area, an area where the location of the surge hole could not be defined and where no safety belts or lines were present (Tr. 91).

Frederick next testified about Order No. 4082540, issued pursuant to Section 104(d)(1) of the Act, alleging a violation of section 56.18020, a mandatory standard forbidding an employee to work alone where hazardous conditions exist that could endanger his or her safety, unless the person could communicate with others, could be heard or could be seen (Tr. 91; Exh. P-3). He issued the order because the victim was working alone in the coal shed in the vicinity of the surge hole (Tr. 94). To Frederick, the very nature of the job of freeing a hang-up at night meant that the person doing it had to work alone. Further, the person could be assigned to free a hang-up several times during the shift and no method of communication was provided for the person. If he or she fell into the hopper there was no way to be heard or seen, and thus no way of getting help to get out (Tr. 96-99). For example, employees sent to do the job were not provided with a radio (Tr. 98).

Raymond Murray, the foreman, should have realized the hazard and had the condition corrected (Tr. 99-102, 180). However, Frederick had no information that Murray actually knew about the problem (Tr. 180).

Frederick testified he also issued Order No. 4083444, another order of withdrawal pursuant to section 104(d)(1) of the Act. The order charged a violation of 30 C.F.R. 56.17001, a mandatory safety standard requiring an operator to furnish lighting sufficient to provide safe working conditions in and on all surface structures and work areas. According to Frederick, there was only one overhead light in the coal shed, 31 feet above the shed floor. Frederick asked Meyers, the kiln burner operator, if Meyers could see anyone at the surge hole when he was standing at the open doors of the kiln building and looking at the coal shed, which was approximately 110 feet away from the kiln building. Frederick testified that Meyers told him that he could not see anyone, that it was too dark (Tr. 102-103, 181). In Frederick's opinion, at night, if the area had sufficient light, persons in the shed could have been seen (Tr. 192-193).

The overhead light in the shed was not centered exactly over the surge hole, but was a little off center, perhaps by 2 or 3 feet (Tr. 105, 151). The light was covered with a plastic lens, and the lens was covered with coal dust (Tr. 104, 182).

Frederick agreed, however, that the front-end loader was equipped with lights and that when the loader was in the shed, it would provide illumination (Tr. 187-188). According to Frederick, the problem was that the front-end loader was not continuously in the shed (Tr. 189). Frederick further agreed that he had not been to the facility after dark and that the inspection party did not test the lighting to gauge its intensity (Tr. 122-123). The alleged violation was abated when Frey installed additional lights in the coal shed (Tr. 193).

Frederick found the alleged violation of section 56. 17001 to be S&S (Tr. 106). He believed insufficient illumination contributed to Bernaldes' death. The accident occurred at night, and coal does not reflect light. The lack of adequate light made it easy for Bernaldes to step where the hole was and fall into the hopper (Tr. 108).

He also found the alleged violation was the result of Frey's "high negligence" and unwarrantable failure because "the foreman should [have] been checking his people and [have] seen that th[ere] was not enough lighting in th[e] area" (Tr. 111). Frederick was unsure how long the condition had existed (Tr. 112).

Finally, Frederick testified that he issued Citation No. 4083442, alleging that Frey had violated 30 C.F.R. Section 56.18009, a mandatory standard requiring a competent person designated by the operator to be in attendance at the mine when persons are working in order to take charge in case of an emergency. Frederick stated he determined a foreman was not present at the time of the accident. Frederick testified that when the foreman was asked who was "in charge of the operation when he was not present," the foreman responded Meyers was in charge (Tr. 114). When asked about this, Meyers stated, "If I'm in charge, nobody ever told me" (Tr. 114).

In Frederick's opinion, Meyers had done "a very good job" when he discovered Bernaldes' body, in that he immediately ran and called 911 to alert the rescue squad (Tr. 114).

Dwayne Johnson

Dwayne Johnson was plant superintendent at the Clearbrook Mine and Mill from November 4, 1991, until the end of January 1993 (Tr. 197-198). As such, he was in charge of coal handling and kiln production and in overall charge of the area where the accident occurred (Tr. 199).

Johnson described how coal was transported to the kiln and explained that the conveyor feeding coal to the kiln storage bin was located under the coal shed dumpling area. The syntron

feeder drew the coal from the surge pile into the hopper and then fed it onto the conveyor belt (Tr. 199).

Johnson maintained that coal "constantly" was hung-up at the surge hole. While large pieces of coal tended to wedge against one another, even the finer coal, if wet, would stick together and clog the hole (Tr. 200-202).

Approximately 250 to 300 tons of coal were usually piled around the surge hole. As the feeder drew the coal down into the hopper, the loader would "take it from the sides and continue to feed the draw hole" (Tr. 201). If coal was piled over the hole, the angle of the draw could be such that the hole at the top of the pile could move off center by as much as 6 or 7 feet (Tr. 241-242). However, the draw area usually formed in the shape of a symmetrical inverted cone (Tr. 261).

When coal became hung up at the hole, an employee would take a metal bar and would poke at it in order to loosen it. The bar distanced the person trying to free the hang-up from the surge hole (Tr. 271). However, when trying to pry loose a hang-up, an employee might well be within the draw and not know it (Tr. 258, 309). Employees were not formally trained in how to free hang-ups; they taught one another (Tr. 258).

Johnson maintained that hang-ups usually occurred at the surge hole (Tr. 235). If coal hung up at the feeder, an employee would try to free the hang-up by going into the conveyor tunnel and by using a bar to poke at the hang-up through a small hole in the feeder or through the dog house opening (Tr. 221, 233-234).

Johnson testified he had discussed with management officials the practice of freeing hang-ups with the bar and that "it was the opinion that the pipe was sufficient ... that [the employee assigned to free a hang-up] could use the pipe and stay away from the hole well enough to make the coal flow without actually being on the pile" (Tr. 204, 265). According to Johnson, he and Vincent Lord, Frey's plant superintendent, decided that the bar was long enough to allow the employee to prevent himself or herself from being drawn into the hopper in that the employee could wedge the bar across the hole or could push away from the hole with it (Tr. 204-205).

Johnson believed that during the day an employee could see the location of the surge hole, but that at night an employee would have difficulty seeing it. If the hole was covered and the employee walked onto the coal pile, the employee easily could place himself over the draw point.

Johnson maintained that after Bernaldes' death he was told by other employees that they had fallen into the surge hole or had seen others fall in. For example, Calvin Light, a truck operator, told Johnson that he had fallen into the hole but was able to extricate himself by using the bar (Tr. 227). In addition, Gary Dillow, a kiln burn helper, told Johnson that he was standing on the pile when it gave way and he slid into the hole. Id.

Johnson stated that the company rejected the idea of putting a grizzle over the surge hole because it would have increased problems with the flow of the coal (Tr. 206, 253). Further, in the company's opinion, it was not economically feasible to otherwise alter the coal feeder system (Tr. 206-207).

Turning to the conditions on Sunday, December 13, 1992, Johnson stated that because of the weather, the company's coal supplier had difficulty delivering coal. Therefore, the coal inventory was "down to zero" (Tr. 207). After an urgent request from Johnson, the supplier trucked-in three or four loads of coal on the afternoon of December 13. The coal was spread in different piles in the coal storage shed. Two of the piles, one of which was over the feeder, were approximately 4 or 5 feet high and 10 or 12 feet wide (Tr. 272). It was cold and the moisture in the piles was frozen (Tr. 209, 267). According to Johnson, "you had to stay with [the coal] and constantly work on it to get it to go in [the hopper]" (Tr. 276).

Johnson was asked about the use of safety belts in the coal storage area. He stated that although the company had a policy that safety belts would be worn at bins and hoppers, employees did not wear them when freeing hang-ups (Tr. 277). A single safety belt was located in the kiln burner building (Tr. 210, 280). In Johnson's opinion, management officials knew of the work habits of Frey's employees in the coal storage area in that they frequently traveled past the area to go to the kiln and in so doing could see how the employees were working (Tr. 210-211). Johnson admitted, however, that while he was with Frey, he never indicated in his preshift inspection reports that more safety belts were needed (Tr. 283).

If a hang-up occurred at the surge hole it was the job of the assistant kiln burner to go to the hole and free it while the kiln burner stayed in the kiln burner building to run the kiln. On Sundays the only way an assistant kiln burner would have had another person on the scene to help free a hang-up would have been to go the shop and get the front-end loader operator to come to the coal shed to assist (Tr. 212). There was no system for an employee working to free a hang-up to

communicate with the rest of the plant. There had been some discussions about supervisors using two-way radios to communicate. It was never suggested that radios be provided for rank-and-file-employees, and, in any event, radios never were purchased for either supervisors or employees (Tr. 214-215, 303-304).

Johnson also was asked about the lighting in the shed and he stated that there was a single overhead light (Tr. 215-216). He was of the opinion that it would have been "very difficult" to see the surge hole at night (Tr. 216). The black coal absorbed light (Tr. 218). If the surge hole "crusted over," a person working at the hole would not be able to see any warning cracks in the crust. The cracks indicated the crust was going to give way. (Id., Tr. 219). Johnson agreed that he had probably never indicated on his pre-shift inspection reports that the lighting at the coal storage shed was insufficient (Tr. 283-284). Johnson also agreed that Bernaldes had a flashlight, but Bernaldes did not take it to the shed. He further stated that Bernaldes never complained the lighting was inadequate (Tr. 285).

Johnson described Bernaldes' position as assistant to Meyers. During the course of the shift, Bernaldes had a series of jobs requiring him to be here and there around the kiln building, the coal shed and the feeder (Tr. 246-247). Meyers had no supervisory authority. It was company policy on week-ends to have two supervisors report early in the morning. If everything was in order, they left later in the day with the understanding they could be called at home and would come back if there were any problems (Tr. 298, 316). Ray Murray, the foreman on duty on Sunday, December 13, had been at the plant and had gone home (Tr. 298-299). Johnson had also been at the plant earlier that day and had gone home. At approximately 11:30 p.m., Johnson was called by Meyers who told Johnson that he, Meyers, had found Bernaldes and that he thought Bernaldes was dead. Johnson stated he was at the plant within 15 minutes. Murray too was called and came to the plant.

Johnson testified he arrived at the plant immediately after the emergency medical technicians. He followed the technicians into the coal tunnel (Tr. 220). According to Johnson, Bernaldes was lying on the conveyor belt with his head and arms in the feeder. His body was lying on its left side and his right leg was over the top of the skirt board that ran along the side of and about 6 inches above the conveyor belt. Bernaldes' left leg was on the belt (Tr. 221, 285, 677, 288). Johnson did not believe Bernaldes entered the feeder by climbing on the belt (Tr. 680). In Johnson's opinion, because of the speed of the conveyor belt, it was "virtually impossible" for a person to get inside the dog house opening while the belt was running (Tr. 225, 286). If a person put his or her foot on the belt, it would throw the person off or, if a person did somehow get on the

belt, the vibration from the feeder would throw the person off. There were no hand rails to help climb onto the belt (Tr. 225-226). If the belt was not moving, a person could crawl up on it and into the feeder, but the person would need a flashlight to see inside. Bernaldes did not have a flashlight when his body was found. The person would need a bar to poke at the hang-up and no such bar was found immediately adjacent to Bernaldes (Tr. 286-287).

Johnson believed that around 6:30 p.m. on the evening of December 13, Bernaldes had the front-end loader operator fill the hopper to the top of the surge hole and level with the ground. He speculated that around 9:30 p.m., Bernaldes started the belt and the feeder to move the coal from the hopper to the kiln storage bins. Approximately 10 to 15 minutes later he left the kiln building and returned to the coal storage shed. By then a crust of coal had frozen over the surge hole. Bernaldes stepped on the crust and the coal gave way. Bernaldes fell into the hopper. The bar, which Bernaldes was not carrying, was of no assistance to him. The only way for Bernaldes to get out was through the dog house opening. In trying to wiggle out, Bernaldes' shoulders stuck in the opening. Later, the front-end loader operator came to the shed and dumped coal in the hopper and Bernaldes suffocated.

To remove his body the rescue squad had to use a hose to wash the coal from around his head and shoulders. Bernaldes' body was then slid out of the feeder (Tr. 230-232).

Halbard Meyers

Halbard Meyers was the kiln operator on the second shift. Second shift hours were from 3:30 p.m. to 11:30 p.m. Bernaldes was Meyers's assistant. As such, Bernaldes' duties were to make certain the belt was running, to free coal hang-ups, to maintain the pumps, and to oil and grease specified equipment.

In describing Bernaldes duties regarding coal hang-ups, Meyers stated that the first thing Bernaldes did was to enter the coal tunnel and use a bar to try to dislodge a hang-up by poking inside the syntron feeder (Tr. 321-322, 351). If coal did not begin to flow, Bernaldes went to the coal shed and used the bar located there to poke through the surge hole. If that did not free the hang-up, he called the maintenance shop and the front-end loader operator came and dug out the surge hole (Tr. 321-322, 341).

Meyers stated that all employees were instructed to follow that procedure (Tr. 323). The training was given by other employees and did not involve the use of safety belts or lines (Tr. 330).

Meyers stated that he had freed hang-ups frequently, but never alone and at night during the winter (Tr. 324, 341). He also stated that he once had been caught in the coal as it fell into the hopper up to his right knee when he was on top of a "pretty good size coal pile" (Tr. 346). He used the bar to push himself out (Tr. 347). Another employee told Meyers that he had fallen into the surge hole but had pulled himself out (Id., 353-354). Meyers testified that he told Charlie Morrison, Frey's safety director, that Frey employees were having problems getting the coal to feed into the hole, and that he, Meyers, had raised the problem during the latter part of 1988 at a company safety meeting. Meyers stated he discussed the matter because he was afraid an employee would fall in the hole (Tr. 348-350).

Turning to the events of December 13, Meyers testified that he last saw Bernaldes alive at 9:30 p.m. At that time, Bernaldes was getting ready to go to the coal tunnel and "start picking the belt" (Tr. 326). Meyers explained that this meant to pick large pieces of rock off of the belt (Tr. 344).

Meyers stated that between that time and when he found Bernaldes' body, the conveyor belt was running (Tr 355). The control panel in the kiln building was the place where the belt could be turned on and off and Meyers frequently was in and out of the control room that night (Tr. 488-489). Meyers never saw Bernaldes during these visits (Tr. 492). Moreover, Meyers could see the indicator light during the relevant two hour period and it indicated the belt was running (Tr. 489-490).

Around 11:30 p.m. Meyers started to take his lunch box to the car, stopping first at the coal tunnel to look for Bernaldes. He did not see him so he went to his car and got his flashlight to look for Bernaldes around the plant. He walked around the coal storage area (Tr. 327). The flashlight was not that bright but he could "vaguely" see, although he could not see the surge hole (Tr. 328). Meyers then went into the conveyor tunnel to look for Bernaldes. He found Bernaldes lying on the conveyor belt. The belt and syntron feeder were running (Tr. 327).

Bernaldes' was lying on his left side at an angle. His right foot was on the belt and his left foot was on the railing alongside the belt. Part of his body, from the shoulders up, was in the feeder (Tr. 328-329). Meyers turned the feeder off and ran to the kiln building where he told some third shift employees who had arrived to call "911." A short time later Meyers called "911" to make certain the first call had been made (Tr. 338). Meyers then called Johnson and Murray. Id.

FREY'S WITNESSES

Charles Morrison

Charles Morrison, Frey's director of personnel and safety, was the company's first witness. Morrison stated that he had been employed by Frey for six years, and for the last five he had been the personnel and safety director (Tr. 368). In preparing for the hearing, Morrison measured the dog house opening of the syntron feeder. The opening was 19 inches high and 13 inches wide (Tr. 368-369). He also indicated that because of coal buildup on the bottom of the feeder, usually the height of the opening was reduced by 3 or 4 inches (Tr. 369). Morrison identified a drawing of the opening (Resp. Exh. 17).

Morrison also identified a scale drawing of the feeder unit (Resp. Exh. 18). The unit included a box into which the coal fell. The dog house opening was at the front of the box. The back of the box was 16 inches high and the box got progressively larger toward the opening (Tr. 370). From the back wall to the opening the box measured 30 inches. Id.

Regarding the coal shed, Morrison testified the light was installed directly above the surge hole in order to give direction to miners if they needed to find the hole (Tr. 371). Morrison described the light as a 500 watt, dusk-to-dawn light (Tr. 626). After the accident Morrison took a reading with a light meter in the shed. He measured 4.8 foot candles of light. Morrison testified that a General Electric Company handbook recommended 5 foot candles for a congested parking lot and 2-1/2 foot candles for a rarely traveled path. The handbook did not cover mining operations (Tr. 656).

Morrison stated that at night from the bay doors of the kiln building he could see people in the coal shed. He knew because he had stood in the opened doorway and looked at the coal shed the night of the accident. Although he could not identify who the people were, he could definitely see them (Tr. 634).

Safety belts or lines were not located in the coal shed. Morrison implied that state mine inspectors required Frey to keep such equipment "centrally located so people know where they are ... and can go get them and ... use them when they need them" (Tr. 629).

Morrison did not recall Meyers raising at the company safety meetings the problem of people slipping into the surge hole. Morrison testified that he reviewed the minutes of the meetings and found no reference to the topic. He observed that Meyers attended only two such meetings (Tr. 639-641).

However, after the accident one employee, Calvin Light, told Morrison that he had started to slide into the surge hole (Tr. 659).

Morrison identified photographs of the coal shed area taken the day after the accident. The photographs represented the conditions that existed at the time of the accident, including the position of the bar stuck in the coal pile (Resp. Exhs. 1-3; Tr. 374). A photograph of the kiln burner building taken from the shed showed the bay doors that could be opened to give a view of the shed from the kiln burner building (Resp. Exh. 4; Tr. 376).

Morrison further identified photographs of the conveyor belt. He testified that the skirt board on the left hand side of the belt (if one faced the dog house opening) was taken off to assist in the removal of Bernaldes' body. However, the board on the right hand side was clearly shown in two of the photographs (Resp. Exhs. 7 and 9). According to Morrison, in addition to keeping coal on the belt, the skirt boards could serve as hand rails (Tr. 380-381).

Morrison described how, at Frey's direction, another employee, who was somewhat taller than Bernaldes, was able to climb onto the belt frame and place his head into the dog house opening without touching the belt (Tr. 382-383, 637-638; Resp. Exhs. 11 and 12). Morrison believed this is what Bernaldes had done. He stated, "I can't see any way ... Bernaldes dropped 7 feet into that very narrow, 19 [inch] by 30 [inch], box and came out ... of that dog house opening, which is 13 by 19 inches, and ... did so without any coal in his pockets, in his socks, anywhere on his stone-washed jeans" (Tr. 386).

Morrison explained that after the accident and after things had "calmed down a little bit," company personnel started interviewing employees and taking notes (Tr. 665). The investigation extended from just after the accident to approximately 2 months prior to the hearing, when company representatives completed their last interviews with rescue squad members (Tr. 667).

Morrison identified a copy of the accident report he completed on December 16, 1992, and sub-mitted to MSHA (Gov. Exh. 12). In the report Morrison had stated that Bernaldes fell through the surge hole (Tr. 644). Morrison testified that he completed the report three days after the accident and prior to speaking with the rescue squad personnel (Tr. 389, 645). Approximately six weeks after the accident, the father of a member of the rescue squad told Morrison the rescue squad members could not believe the reports in the newspapers concerning how the accident occurred. One week later Morrison spoke to rescue squad personnel (Tr. 671-672). Once he was advised of the

cleanliness of the body, the lack of abrasions on the lower body, and Bernaldes' size, he came to the conclusion Bernaldes tried to climb into the feeder from the bottom and that it was physically impossible for him to have fallen from above and come out the dog house opening (Tr. 646-647).

Morrison speculated that the feeder might have clogged and Bernaldes might have climbed up on the belt, stuck his head and arms into the dog house opening and tried to grab something to unclog it when the coal caved in on him. Morrison stated that, although it made no sense to do such a thing, it also made no sense for Bernaldes to be walking around on top without the pry bar (Tr. 674).

Will Baker

Will Baker, an employee of the Frederick Country Sheriff's Office, was Frey's next witness. Baker stated that he went to the mine following the discovery of Bernaldes body and that he was the second or third person from the Sheriff's Department to arrive. Baker spent most of his time at the mine talking to Meyers. Baker saw Bernaldes' body before it was removed from the feeder, but was candid to state that at that time, aside from Bernaldes feet, he did not get a good look at it (Tr. 393-394). Nonetheless, Baker was of the opinion the body was bigger than the dog house opening (Tr. 395). Baker also saw the body after it was removed from the feeder and he described it as being very black above the upper chest (Tr. 396).

Ralph Freeman Robinson III

Ralph Robinson was a member of the rescue squad. Without objection, Robinson was ruled qualified to testify as an expert in confined space rescue (Tr. 410-411). He stated that upon arriving in the tunnel area, he observed Bernaldes' body sticking out of the dog house opening from mid-sternum down (Tr. 412). Bernaldes' right arm was over his head and he was lying on his left side with his left arm underneath him (Tr. 413, 419). Most of his body was resting on a metal shaker plate, not on the belt (Tr. 442). His right leg was to one side of the conveyor belt wrapped around a pole or piece of angle iron. Robinson believed Bernaldes had used his right leg as a brace to keep himself in position (Tr. 413). In his opinion, this indicated that Bernaldes was trying to go into the dog house opening, not come out (Tr. 414).

Robinson stated that the Bernaldes was "clean" from the waist down, even though it was very dirty inside the feeder (Tr. 415). Bernaldes clothes were in tact, not ripped or torn, and his body did not appear to be in anyway deformed by the accident (Tr. 421). The tape around his ankles (used to keep

coal dust out of his socks and shoes) was not smudged with coal dust (Tr. 422).

Reading from the autopsy report that indicated Bernaldes weighed 270 pounds and was six feet tall, Robinson stated that from viewing the body and the dog house opening he did not believe a person of Bernaldes' size could have come through the opening (Tr. 426-428). Bernaldes' hip size was 38 inches. Robinson believed Bernaldes would have suffered broken bones if he had fit through the 19 inch by 13 inch opening, and Bernaldes had no broken bones (Tr. 431, 445; Resp. Exh. 20). Robinson believed Bernaldes could have gotten only his feet and upper thighs through the opening before he became stuck. In Robinson's opinion, there was no way he could have twisted his body to get the rest of himself through (Tr. 432-433). The dog house opening simply was not big enough (Tr. 433).

Brenda Sue Gray

Brenda Gray, a rescue squad paramedic, was part of the team called to the mine. Her description of the position of Bernaldes' body was essentially the same as that of Robinson. In her opinion, the fact that Bernaldes' right leg was wrapped around a metal post along the side of the belt indicated he was trying to keep himself in that position, not trying to wiggle out of the feeder (Tr. 452).

Gray stated she raised the victim's shirt and tried to detect a femoral pulse, but could not. She noticed that Bernaldes' body had very little coal dust on it and that the exposed portions of his body were relatively clean. She stated this on the report she filed (Tr. 454, 455). She believed if Bernaldes had fallen through the surge hole he would have been covered with coal dust (Tr. 458). When she heard he had fallen though the surge hole, she disagreed. She thought he had climbed up on the frame of the belt, stabilized himself with his right leg, and poked his head into the opening (Tr. 458). It was, she stated, a "tight fit" (Tr. 454). Given the size of Bernaldes' hips, she did not believe his waist would have fit through the dog house opening (Tr. 459, 467).

Chester Locke

Chester Locke, the captain of the rescue squad, was in charge of the squad's activities. Unlike Robinson, Locke recalled Bernaldes' hips and legs as resting on the belt itself (Tr. 484). Because of Bernaldes' size and the relative cleanliness of his clothing outside the feeder, Locke also felt Bernaldes was trying to enter the dog house opening from the bottom (Tr. 475-476). If his hips had made it through the opening, Locke believed his shoulders and head would have come through as well (Tr. 483).

Locke believed that the conveyor belt would have had to have been off before Bernaldes climbed onto it (Tr. 480). If the belt had been running Bernaldes would have been fighting the belt as it ran opposite the way he wanted to go. Bernaldes' clothing would have been torn or he might have suffered abrasions, neither of which occurred (Tr. 481).

Thomas E. Robinson, Sr.

Thomas Robinson was the kiln foreman. Robinson was not at the mine on the day of the accident (Tr. 530).

Robinson explained that "everyone" had complained about coal hang-ups, especially when the coal was wet (Tr. 536). He agreed he had probably "hollered" at Johnson about it. Id. He too explained how coal hang-ups were cleared. The miner assigned to the job started at the bottom and tried to open the feeder by poking the bar through the hole in the feeder (Tr. 506). If that procedure was unsuccessful, the person would get the front-end loader operator to open the surge hole (Tr. 506-507). If the loader was not successful, the miner took the bar and used it to loosen the coal (Tr. 508-509). The bar was always on the surface, usually leaning against a pier of the coal shed, although sometimes it was stuck into a coal pile (Tr. 510). The purpose of the 9-1/2 foot bar was to keep the miner away from the hole (Tr. 512). Robinson was asked how far away from the hole a miner would stand in order to be safe, and he responded, "I would stand far enough away where I would know I wasn't going to slide in there. Sometimes its's 2 or 3 feet, 4 feet, whatever you think is safe" (Tr. 528). Robinson stated that he never had fallen into the surge hole, nor heard of anyone who had done so (Tr. 516).

According to Robinson, a miner would stand back away from the hole and poke at the hole (Tr. 511). The miner "bore" out the hole (Tr. 531). The miner would know where the hole was located because it was directly under the light (Tr. 518). When the syntron feeder was drawing from a large coal pile, the funnel created by the draw could be 9 feet across (Tr. 522-523, 533).

Vincent Lord

Vincent Lord, Frey's plant superintendent, was not present at Clearbrook Mine and Mill the night of the accident. He arrived just before midnight (Tr. 580-581). He testified that, although Bernaldes held the job of alternate burner, on the night he was killed he was acting as an oiler. His duties as an oiler required him to ensure the pumps were pumping, to watch the conveyor belts and to make certain coal fed into the bin. Bernaldes' duties on the night of the accident

also included acting as Meyers' assistant (Tr. 539-540). If Bernaldes did not perform his duties correctly, it was Meyers' responsibility to report Bernaldes to the foreman.

Lord described the "experiment" conducted to determine if a person could climb onto the belt and place his head in the feeder without touching the belt. (The belt and syntron feeder were disconnected for the test (Tr. 595.)) Although Lord was not present when the test was conducted, he understood the man was able to stay free of the belt by crawling on the belt frame and skirts (Tr. 560; Resp. Exhs. 11, 12).

The Clearbrook facility is the subject of two complete inspections a year by MSHA, during which MSHA inspectors are present day and night (Tr. 568-569). Prior to the accident the conditions at the surge pile for which Frey was cited were never alleged to constitute violations of federal or state safety regulations (Tr. 569-571).

Like other of Frey's witnesses, Lord testified that company procedures in freeing hang-ups required an employee to first try to free the coal from the syntron feeder. "[I]f the bottom is not open you are not going to open the top" (Tr. 589). The next thing tried was to free it with the loader at the surge hole and, if that failed, to use the bar to open up the hole (Tr. 590). When using the bar, employees were instructed to stand back from the hole 4 to 6 feet (Tr. 591). Lord acknowledged it would not be safe to stand at the edge of the hole (Tr. 599).

Lord stated that prior to December 13, 1992, he never had been advised that anyone had slipped into the surge hole (Tr. 552). He did not recall discussing with Johnson the safety of employees using the bar to open the hole or employees using the bar to get free of the hole if they slipped in (Tr. 610). Subsequent to the accident, he heard that from two to four people had slipped in at one time or another (Tr 548).

Lord discussed the lighting of the coal shed. He noted that front-end loaders used in the shed were each equipped with four lights (Tr. 576). Bernaldes had a flashlight, although he had not used it the night of the accident (Tr. 579). In Lord's opinion, if the bay doors of the kiln burner building were opened, a person looking from the doors to the coal shed could see a man walking in the shed (Tr. 582). The distance from the kiln burner building to the shed was approximately 110 feet (Tr. 583). The shed could be seen also from a doorway to the deck of the kiln burner building, a door the kiln burner had to use when checking if the kiln bin was being filled with coal from the belt (Tr. 585-586).

With regard to oral communication at the facility, Lord stated the acquisition of radios had been discussed, but only in terms of the foremen communicating with one another (Tr. 579). He agreed that if a miner yelled for help from the coal shed, he could not be heard in the kiln burner building (Tr. 593).

On weekends, a shift foreman who worked the day shift was in charge in case of an emergency. After the afternoon shift, the kiln burner (Meyers at the time of the accident) was in charge and he was responsible for telephoning the foreman or plant superintendent (Tr. 594).

Lord was asked to give his opinion regarding how Bernaldes died. He stated that at first he believed Bernaldes had fallen through the surge hole. "But after further seeing all the evidence ... and looking at the configuration of the opening and the size of the opening and the size of his body and the position that his body was found in," Lord found it "very, very difficult to see that he could have gone down through the top" (Tr. 613). On the other hand, Lord could not think of a reason why Bernaldes would have tried to crawl into the dog house opening (Tr. 614-615).

MOTION TO STRIKE

At the close of the testimony, counsel for Frey renewed a motion to strike that he had made when the Secretary rested after presenting his case-in-chief. Counsel noted the Secretary bore the burden of proof and argued the evidence offered by the Secretary was insufficient to establish any of the alleged violations (Tr. 358-365). I reserved a ruling (Tr. 365). I herein deny the motion.

Counsel renewed the motion after all of the evidence had been submitted (Tr. 692-693). Counsel argued the only conclusion to draw from the testimony was that Bernaldes, for whatever reason, entered the feeder from the bottom and did not fall into the hopper from above. In addition, the evidence did not establish that a hazardous condition existed in the coal shed, and, without a hazardous condition to endanger workers violations could not be found (Tr. 696-697).

The Commission's rules provide that on a procedural question not regulated by the Act, the Commission's rules, or the Administrative Procedure Act, the judge be guided by the Federal Rules of Civil Procedure. 29 C.F.R. 2700.1(b). Neither the Act, the Commission's Rules, the Administrative Procedure Act, or the Federal Rules apply to the specific situation at hand. Nevertheless, the essence of Frey's motion is not unknown at law. Frey is contending that even if all evidence presented by the Secretary is regarded as true, the government has failed to establish its case and judgment must

be entered for Frey. As set forth more fully below, while I do not find favorably for the Secretary regarding all of his allegations, I cannot find that his evidence, if unrefuted, is so wholly deficient as to fail to establish three of the violations alleged. Moreover, only an analysis of the evidence of both parties allows me to reach the conclusion that the Secretary has not prevailed with regard to the other two alleged violations.

DISCUSSION FINDINGS AND CONCLUSIONS

DOCKET NO. VA 93-80-M

Order/Citation No.	Date	30 C.F.R.	Proposed Penalty
4082539	12/14/92	56.16002(a)(1)	$3,500

The order/citation, issued pursuant to sections 107(a) and 104(a) of the Act, 30 U.S.C. 817(a), 814(a), states:

> A fatal accident occurred at this operation when an employee fell into a coal chute to the syntron feeder. There was an unguarded opening on top of this chute. The coal has a tendency to bridge over or hang up in this chute. Normal operating procedures require an employee to work near this opening when hang ups occur. A method shall be provided to eliminate the need for employees to free hang ups in this unguarded opening.

Exh. P-1. The order/citation was modified subsequently as follows:

> This modification is to change the wording from coal chute to surg[e] hole and add a paragraph.
>
> The paragraph should read as: The surg[e] hole to the syntron feeder was not equipped with a mechanical device or other means to handle material so that persons are not required to work where they are exposed to entrapment by caving or sliding materials.

Id. 2.

Section 56.16002(a)(1) states:

> (a) Bins, hoppers, silos, tanks and surge piles, where loose unconsolidated materials are stored, handled or transferred shall be --
> (1) Equipped with mechanical devices or other effective means of handling materials so that during

> normal operations persons are not required to enter or work where they are exposed to entrapment by the caving or slinging of materials[.]

THE VIOLATION

The violation alleged by the Secretary is set forth in the modification of the order\citation. It states that the surge hole for the surge pile was not equipped with a mechanical device or other means to handle the coal so that employees were not required to work where they were exposed to entrapment by caving or sliding coal.

The testimony of all of the witnesses confirms the coal piled in the coal storage shed fed through the surge hole into the hopper and syntron feeder and hence to the conveyor belt that carried it to the kiln plant. The coal was piled in the shed in a loose, unconsolidated fashion -- a surge pile. Indeed, it had to be so piled in order to fall through the surge hole. Being a storage and transportation system containing both a surge pile and a hopper, the facility clearly came within subsection (a) of section 56.16002.

The principal question is whether persons were required to enter or work in an area during normal operations where they were exposed to entrapment by caving or sliding coal. If they were, the standard required the facility to be equipped with a mechanical device or another effective means of handling coal. I conclude that the testimony overwhelmingly establishes that persons were required to free hang-ups at night in the coal shed during normal operations at which time they were exposed to the danger of entrapment.

I accept Frederick's testimony that coal piled in the storage shed had a tendency to hang-up (Tr. 60). The bar used by miners to free the hang-ups in the storage shed testified to this fact as effectively as the witnesses. I further accept the testimony of Johnson that the hang-ups were more frequent when the coal was wet and when the temperature fell below freezing, as it did the night of the accident (Tr. 200-202, 276, 536). I further find that when such hang-ups occurred, the surge hole could "crust over,"and I conclude the repeated nature of the hang-ups made them normal occurrences at the facility.

I also accept as a fact of physics that the coal did not always fall straight down into the hopper. (Loose, unconsolidated materials do not always fall in that way.) Rather, and as explained by Frederick and Johnson, like any such piled material, the coal was drawn down in a funnel pattern, or, as Johnson put it, in the shape of a "inverted cone" (Tr. 60, 261). I further find that the cone was not always symmetrical. This physical attribute of the draw was what Johnson described when

he stated that the coal could be "feeding in at an angle to the [surge] hole" depending, among other things, upon the consistency of the coal (Tr. 241). In addition, I accept as a fact that the radius of the funnel varied depending upon the size of the coal pile.

As most completely described by Frederick and Johnson, but as agreed by all of the witnesses, I find that during normal operations it was a practice at the Clearbrook Mine and Mill for employees to stand at the coal pile when freeing a hang-up and poke at the coal with the 9 foot bar. I also conclude, given the inconsistency with which the coal could fall or draw, that the employees working to free hang-ups could not always determine where the coal would draw. Consequently, miners working in the coal shed to free hang-ups were in fact in danger of being pulled into the hopper by the falling coal. I base this conclusion upon the logical assumption that if a miner could not be certain exactly how the coal pile would draw, there would inevitably come a time when he or she would guess wrong and stand on coal that was a part of the draw.

This conclusion is reenforced by the testimony regarding training and practice in freeing hang-ups. I note Lord testified that employees were instructed to stand 4 to 6 feet away from the hole (Tr. 591, 599). However, Johnson testified employees were not trained by Frey in how to free hang-ups, that employees taught one another. Frey offered no evidence to establish it formally trained its employees in this task, and I accept Johnson's statement, with which Meyers agreed. I conclude, therefore, that employees were not formally instructed to stand a specific distance from the surge hole. Thomas Robinson, who had not heard Lord's testimony, stated the distance to stand away from the surge hole and be safe varied. He described a safe distance as "sometimes two or three feet, four feet, wherever you think is safe" (Tr. 528). Given the nature of the task at hand, I believe Robinson accurately described the practice. Therefore, rather than being an act of certainty, freeing a hang-up required individuals to judge that about which they could not be certain, i.e., the distance to stand to be outside the draw of falling coal.

That employees' judgements were not always accurate was confirmed by the testimony of Frederick, Johnson, Meyers, Morrison and Lord, all of whom stated they had been told post-accident that other miners had been caught by the sliding coal and had been dragged into the hopper or toward the hopper (Tr. 77, 228, 277, 353-354, 548, 552, 659).

I further agree with Johnson that employees were at times in danger of falling into the hopper when the coal was not drawing. I credit his testimony that in the winter the coal could crust over and, therefore, that the surge hole

could have a thin "bridge" of coal over it. While I believe the testimony established that the single light in the coal shed for all practical purposes was directly over the surge hole, it strikes me as entirely credible that an employee intent on determining why coal was not flowing, easily could forget the light was over the hole, step on the coal bridge and fall into the hopper. Further, I believe Johnson was right in maintaining this was likely to happen at night when light from the single lamp, approximately 31 feet above the surge hole, was absorbed by the coal on the floor so that telltale cracks in the coal bridge were not easily noticed (Tr. 216-219).

I conclude, therefore, that the cited conditions in the coal shed violated section 56.16002(a)(1).

S&S and GRAVITY

The Commission has held that a violation is "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 Division, National Gypsum Co., 3 FMSHRC 822, 825 (April 1981). Further, the Commission has offered guidance upon the interpretation of its National Gypsum definition by explaining four factors the Secretary must prove to establish that a violation is S&S.

In Mathies Coal Co., 6 FMSHRC 1, 3-4 (January 1984) the Commission stated:

> [T]o establish that a violation of a mandatory standard is significant and substantial under National Gypsum the Secretary ... must prove: (1) the violation of a mandatory safety standard; (2) the discrete safety hazard contributed top 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.

I have concluded a violation of 30 C.F.R. 56.16002(a)(1) existed. I also find the evidence establishes a discrete safety hazard in that the lack of a mechanical device or other means for handling the coal when it became hung-up subjected miners trying to free the hang-ups to the danger of being caught in the surging coal as it broke free and of being pulled into the hopper below or of falling through the crusted coal. Either the initial fall or coal falling on top of the miner once he or she was in the hopper was reasonably likely to result in serious bruises or broken bones. Moreover, if the accident occurred when no other miner was around and help was not immediately available, death from suffocation was reasonably likely, especially since the front-end loader operator might well arrive in the coal shed

after the miner had fallen and push or dump coal unknowingly on the miner.

The remaining question is whether the evidence establishes that there was a reasonable likelihood the hazard contributed to would result in an event in which there was an injury. The relevant time frame for determining whether a reasonable likelihood of injury existed includes both the time that the violative condition existed prior to the citation and the time that it would have existed if normal mining operations had continued. U.S. Steel Mining Co. Inc., 6 FMSHRC 1573, 1574 (July 1984), Halfway, Inc., 8 FMSHRC 8, 12 (January 1986).

I am persuaded that the lack of a mechanical device or other means to prevent miners from being drawn into the surge hole meant that sooner or later, in the context of continued mining operations, such an accident was bound to happen. In this regard, I find especially compelling the testimony of the various witnesses, both those called by the Secretary and those called by Frey, who learned post-accident about other miners who had been caught in the draw. Moreover, as I have noted, I am persuaded also that the fact that miners were required to free hang-ups at night and in freezing weather, meant that it was only a matter of time before a miner would inadvertently step on the crusted over surge hole and fall into the hopper. An injury or fatality was reasonably likely once either of these things happened. Therefore, I conclude that the violation was properly found to be S&S.

In determining the gravity of the violation, I must consider both the potential hazard to the safety of the miners and the likelihood of the hazard occurring. As I have noted, the violation subjected miners to serious injury or death. Given the fact that miners were continually sent to the coal shed to free hang-ups, it was highly likely that an accident of this kind would happen. Therefore, I conclude the violation was extremely serious.

The Secretary tried to establish that Bernaldes' death was the result of such an accident. In my opinion, the Secretary did not succeed. A review of the testimony offered by the Secretary illustrates its deficiencies. Frederick testified that he had "no facts to document" his belief Bernaldes fell through the surge hole and into the hopper (Tr. 97, 121). Frederick neither saw the body nor interviewed those members of the rescue squad who did (Tr. 128-130, 132). Further, Frederick agreed that if, as he believed, Bernaldes had fallen into the hopper and gotten stuck at his shoulders in the dog house opening, it was "very possible" Bernaldes would have had coal dust on and inside his clothing, and the testimony of the rescue squad members establishes Bernaldes' clothing and body were relatively clean below the point where he became stuck (Tr. 138).

When Meyers last saw Bernaldes alive, Bernaldes was headed toward the tunnel to pick coal from the belt (Tr. 326). Meyers did not know what Bernaldes did after that. While neither Frederick or Johnson believed Bernaldes would have climbed up on the belt frame and stuck his head into the feeder, Johnson agreed that it was possible for a person to get up on the frame of the conveyer without touching the belt (Tr. 685).

I cannot infer from this testimony that Bernaldes fell into the hopper from above, especially considering the unrefuted testimony of Frey's witnesses that Bernaldes clothing and body were relatively free of coal dust below the point where he had become stuck and that his body was free of broken bones, and largely free of scrapes and bruises. It is true that Morrison originally believed Bernaldes had fallen from above and, indeed, reported such to MSHA, but he changed his mind -- as well he might -- after discussing the situation with rescue squad personnel (Gov. Exh. 12, Tr. 644). They uniformly believed that a person of Bernaldes' size would not have gotten all of the way through the feeder, and, given Bernaldes weight and hip size, their belief is convincing.

I, therefore, find that the relatively clean state of Bernaldes' clothing and of his body below the shoulders, Bernaldes' lack of broken bones and significant abrasions, as well as Bernaldes' size and the size of the feeder box and dog house opening -- together with the deficiencies in the Secretary's evidence -- preclude a conclusion that Bernaldes fell though the surge hole.

I am also persuaded that it made absolutely no sense for Bernaldes to climb onto the frame of the conveyor and stick his head and upper body into the feeder. Lord, the plant superintendent, could think of no reason why Bernaldes would have done so, and neither can I (Tr. 614-615). It seems extremely unlikely he was trying to look up into the dark feeder. He did not have a flashlight (Tr. 285-286). Moreover, if the coal were hung-up in lower part of the hopper or feeder, freeing it would not have required Bernaldes to assume the position in which his body was found. He could have poked at the hang-up with the bar kept near the feeder for that purpose. Obviously, the lack of a reason for Bernaldes to put himself in such an extremely dangerous position strongly militates against finding he did.

In the end, the evidence does not permit a finding regarding how Bernaldes met his death. Nevertheless, even without such a finding, the extreme seriousness of the violation has been established. If Bernaldes did not fall through the surge hole, I am convinced, as I have already found, that sooner or later a Frey employee would have done so. In other words, the lack of a mechanical device or other means to handle material so that

persons were not exposed to possible entrapment from caving or sliding coal created conditions in which serious injury or death was virtually inevitable given time.

NEGLIGENCE

I again note the testimony of Johnson, Morrison and Lord that following Bernaldes' death they became aware of employees who had been caught in the surging coal. In and of itself, this bespeaks a failure of communication at the facility and, in my opinion, is indicative of a fundamental failure of Frey management personnel to meet the standard of care required of them. Also indicative of Frey's fundamental failure is Frey's practice of having employees instruct one another on how to free hang-ups. In my opinion, the lack of operator-initiated training typifies Frey's noncholance to the hazard involved.

The testimony establishes that the task of freeing hang-ups was inherently dangerous. As Lord's testimony indicates, Frey management personnel realized it was hazardous for employees to stand too close to the surge hole (Tr. 599). Management also should have realized, given the nature of task and the manner in which coal fell, that inevitably an employee would be too near the surge hole or would walk over the crusted surge hole, especially since hang-ups were not unusual occurrences. (Thomas Robinson credibly testified that "everyone" complained about them (Tr. 536).)

The surge hole had been in existence since 1967 and Frey had never been cited for violations relating to conditions at the surge pile (Tr. 552, 569-571). If these facts stood alone, they might indicate conditions at the surge pile were not such as to require a heightened standard of care on Frey's part. However, they do not stand alone. Rather, the overwhelming impression gathered from the record is that the employees assigned to free hang-ups at the surge pile were sent to do a very dangerous job and that Frey was simply lucky a serious injury or fatality had not occurred prior to Bernaldes' death. Thus, Frey's failure to provide a mechanical device or other means to handle the coal so that its employees were not exposed to entrapment or caving from the sliding material represented a major and fundamental departure from the care the circumstances required. Frey was highly negligent.

ORDER NO.	DATE	30 C.F.R.	PROPOSED PENALTY
4082540	12/21/92	56.18020	$6,000

The order states in part:

> A fatal accident occurred at this operation on December 13, 1992 when an employee fell into a surg[e] hole in the coal storage shed. The shed

was poorly illuminated and the floor was slippery around the top of the open hole. The victim was working alone and was required to free hangups in the surg[e] hole. He could not be seen or heard and there was no method provided for him to communicate with others. The accident occurred on the afternoon shift between 9:50 P.M. and 10:45 P.M. The victim was not found until 11:30 P.M. ... (This is an unwarrantable failure violation.)

Exh. P-3. Section 56.18020 states:

> No employee shall be assigned, or allowed, or be required to perform work alone in any area where hazardous conditions exist that would endanger his safety unless he can communicate with others, can be heard, or can be seen.

THE VIOLATION

To establish a violation of section 56.18020, the Secretary must prove that an employee was required to work in an area where hazardous conditions existed that endangered his or her safety. I have found that the conditions under which Frey's employees (including Bernaldes) worked when they were sent to the surge pile area to free hang-ups were extremely hazardous. Indeed, they constituted an accident waiting to happen. While I have also found that the Secretary has not proven how Bernaldes met his death, the testimony of Bernaldes' immediate superior, Meyers, makes clear that one of Bernaldes' duties was to ensure there were no hang-ups and this required him to visit the coal shed and to free those that occurred (Tr. 321-322, 341). The testimony also makes clear that hang-ups were not infrequent. Therefore, I find the nature of Bernaldes' job required him to encounter the conditions alleged in the order.

The Secretary also must prove the employee was required to work alone. In this regard, the testimony establishes that when Bernaldes went to the shed on the weekend, he usually was working by himself. No one else was in the shed. If the front-end loader operator was needed, Bernaldes would call for the front-end loader operator to come to the shed (Tr. 212). In this regard, I accept Meyers' specific description of how Bernaldes freed hang-ups (Tr. 321-322, 341). Bernaldes was working under Meyers' direction.

The Secretary must also establish that when Bernaldes worked to free a hang-up Bernaldes' contact with others was insufficient to satisfy the protective purposes of the standard. Cotter Corp., 8 FMSHRC 1135, 1137 (August 1986) (interpreting then identical mandatory safety standard 30 C.F.R. 57.18-25 (1984)). The Commission has stated that to be sufficient under

the standard, the communication or contact must be "of a regular and dependable nature commensurate with the risk presented in a particular situation" and that "as the hazard increases, the required level of communication or contact increases." Old Ben Coal Co., 4 FMSHRC 1800, 1803 (October 1982) (interpreting identical mandatory standard 30 C.F.R. 77.1700).

Here, I accept Frederick's opinion that if Bernaldes had fallen into the hopper, no person would have heard his cries for help (Tr. 98). The kiln building where Meyers was working was too far away for oral communication and the front-end loader operator was not always present in the shed. While I credit the testimony of Morrison that at night a person in the coal shed could be seen from the bay doors of the kiln building and of Lord that a person could be seen from the kiln building's deck (Tr. 634, 585-586), I note that there was no testimony regarding how frequently the bay doors were opened and no testimony regarding how frequently anyone would have looked from the doors when they were opened. Although Lord testified the kiln burner went onto the deck, the kiln burner's purpose, according to Lord, was to determine whether the kiln bin was filled with coal, not to check for the presence of a worker in the coal shed (Tr. 585-586). Any sightings of Bernaldes by the kiln burner would have been inadvertent to the task at hand. Even if Bernaldes had been seen, the person seeing him might not have been certain it was Bernaldes. As Morrison testified, people could be seen from the open doors, but "you might not be able to identify exactly who they were" (Tr. 634).

Finally, no testimony was offered from which to find that a miner was assigned to check regularly on the status of a person freeing hang-ups and certainly no testimony was offered that anyone checked specifically on Bernaldes.

I conclude, therefore, that when Bernaldes went to the coal shed to free hang-ups there was no oral communication with him and visual communication was inadvertent and imprecise. I have found that freeing hang-ups at night in the coal shed was extremely hazardous. I further find that when Bernaldes was required to do the job, the level of communication or contact between Bernaldes and any other miners was inadvertent and haphazard. In other words, there was no communication or contact of a regular or dependable nature commensurate with the risk involved. Consequently, I find that the violation occurred.

S&S and GRAVITY

As Frederick noted, if Bernaldes was caught in the surging coal and was pulled into the hopper, or otherwise fell into the hopper, there was no way to let another person know where he was (Tr. 99, 593). The danger was that injuries associated with the

fall would be aggravated for lack of timely rescue or, worse yet, would be compounded by the loader operator dumping or pushing coal through the surge hole and unknowingly covering Bernaldes. Thus, a discrete safety hazard existed.

The question is whether sending Bernaldes to free hang-ups at night when others had only occasional and inadequate visual contact with him was reasonably likely to result in an injury. I have found it was reasonably likely Bernaldes would, sooner or later, have fallen into the hopper. I further find that given the lack of adequate communication, the accident would not have been timely detected. Thus, it was reasonably likely that injuries suffered from the fall into the hopper would have been made worse -- perhaps fatally worse -- by the violation. This is especially so because in the context of continued mining operations, the front-end loader operator, who would have come to fill the hopper eventually, would not have been able visually to detect the accident.

Injuries resulting from an inability to assure timely assistance would have been of a reasonably serious nature. For these reasons I conclude the violation properly was designated S&S.

I also conclude the violation was extremely serious. Regular and dependable communication and contact, while it would not have excluded the possibility of injury, would have gone a long way to eliminate the potential of an existing injury being aggravated or compounded and would have reduced the chances of a fatality.

UNWARRANTABLE FAILURE and NEGLIGENCE

The Commission has held that within the context of the Mine Act, "unwarrantable failure" is aggravated conduct constituting more than ordinary negligence by a mine operator in relation to a violation of the Act. Emery Mining Corp., 9 FMSHRC 1997, 2004 (December 1987); Youghiogheny and Ohio Coal Co., 9 FMSHRC 2007, 2010 (December 1987) (Y&O). The Commission also has stated the fact an operator "knew or should have known" of conditions constituting a violation is not sufficient, in and of itself, to establish unwarrantable failure, for that would make such failure indistinguishable from ordinary negligence. The thrust of Emery/Y&O is that unwarrantable failure represents more than an operator's actual or constructive knowledge of violative conditions. Virginia Crews Coal Co., 15 FMSHRC 2103, 2107 (October 1993).

The Commission has specified factors that may be indicative of such aggravated conduct. They include: (1) the extent of the hazard created by the violative condition, (2) the length of time the condition has been left uncorrected, and (3) whether

the violation was the result of deliberate activity on the part of the operator. Emery, 9 FMSHRC at 2004-2005; Y&O, 9 FMSHRC at 2011; Quinland Coals, Inc., 10 FMSHRC 705, 708-709 (June 1988).

The testimony regarding unwarrantable failure was sparse. Frederick noted that the foreman should have known about the lack of communication and contact. Lord emphasized that no previous violations for conditions at the coal shed had been issued to Frey (Tr. 180, 569-571).

Despite the paucity of direct testimony on the issue, I am of the opinion that the totality of facts surrounding the violation requires a finding that it was due to Frey's unwarrantable failure to comply. First, the condition under which Bernaldes was assigned to work was extremely hazardous. The failure of Frey to recognize this in any meaningful way, and the long period of time Frey allowed the condition to exist (the surge hole had been in use since 1967 and the coal shed was completed a few years before the accident) justify a conclusion that not only were Frey management personnel myopic to the hazard involved, they were inexcusably so. For me, Frey's inexcusable lack of diligence is reflected by testimony that only after the accident did Frey learn that some of Frey's employees working on the coal surge actually had been caught in the surging coal.

It is true, as Lord pointed out, that Frey had not been cited previously with respect to the conditions at the surge pile. However, I do not infer from this that the violation was minor or hard to detect, or that Frey's failure to correct it was in some respect excusable or the result of inadvertent inattention. There is nothing in the record to establish that government inspectors ever were at the mine when Frey's employees were freeing hang-ups, and inspectors are no more clairvoyant than the rest of us. Nor is this a situation where Frey has demonstrated a good faith, albeit mistaken belief that its actions were in compliance with the standard, for there is no evidence at all of hazard recognition on Frey's part (see generally, Utah Power and Light Co., 12 FMSHRC 965, 972 (May 1990). Rather, the evidence supports finding a glaring and total failure of such recognition.

I conclude that the violation resulted from Frey's negligence in assigning Bernaldes the task of freeing hang-ups at night without any adequate communication or contact, and more than that, it resulted from Frey's inexcusable and unwarrantable failure to comply.

Citation No.	Date	30 C.F.R.	Proposed Penalty
4083441	12/21/92	56.15005	$6,000

The citation states:

> A fatal accident occurred at this operation on December 13, 1992 when an employee fell into the surg[e] hole in the coal storage shed. The victim was not wearing a safety belt and line and none were available at the accident site. The area around the hole was slippery and sloped toward the opening. Company operating procedures required employees to work on this incline to free hangups in the hole. The mine operator was aware of this condition. This was an unwarrantable failure violation.

Exh. P-2. Section 56.15005 states, in part, that "safety belts and lines shall be worn when persons work where there is danger of falling... ."

THE VIOLATION

The requirements of the standard are straightforward -- that persons wear safety belts and lines where there is a danger of falling. The citation primarily is written in terms of Bernaldes' accident -- that Bernaldes was not wearing a safety belt and line when he fell into the surge hole. It is true that when Bernaldes' body was found, he was not wearing a safety belt or line. However, I have concluded that the Secretary has not established how Bernaldes met his death on December 13 and therefore cannot find a violation of the standard based solely upon what happened to Bernaldes.

The citation further alleges that a violation of section 56.15005 existed because safety belts and lines were not stored in the coal shed (Tr. 79, 170-71). This allegation goes beyond the wording of the standard, which mandates when safety belts and lines are to be worn, and which does not specify where they shall be kept or provided. Compare 30 C.F.R. 56.150001, 56.15031.

This does not, however, end the matter. The citation also is written in terms of the company's operating procedures, that is, of Frey's requirement that employees work on the surge pile to free hang-ups. I interpret this to mean that, in addition to the other allegations, the Secretary is alleging that there was a practice for those working to free hang-ups not to wear safety belts and lines. In this regard, I note the statement of proposed assessment makes this same allegation ("The operator was cited for a violation of ... [section] 56.15005 because employees were not using safety belts and lines where there existed the danger of falling while performing the task of freeing up material that had accumulated in the surge hole" (Narrative Findings for a Special Assessment 2.)) Frey

did not object to testimony that was offered to support this allegation and Frey did not claim surprise or prejudice at its receipt.

I find the Secretary has proven this part of the alleged violation. I accept Frederick's testimony that when investigating the accident, he heard one or more of Frey's employees state that safety belts and lines were not worn in the coal shed (Tr. 85-86). While Johnson testified that Frey had a safety policy of requiring safety belts to be worn at bins and hoppers, there was no testimony to establish how this policy was enforced and no testimony that it ever was applied at the surge pile (Tr. 210). I believe that what Frederick heard was true. Meyers credibly testified that when employees instructed one another regarding how to free hang-ups, the instruction did not involve the use of safety belts or lines, and his testimony was unrefuted (Tr. 330). Further, Meyers credibly testified that, although he observed employees working on the surge pile, he never saw them wearing safety belts. Id. I, therefore, find it was a practice for employees freeing hang-ups at the surge pile not to wear safety belts of lines.

As I have previously found, the danger of being drawn into the hopper by the surging coal was present when employees were sent to the coal shed to free hang-ups, as was the danger of inadvertently stepping on crusted-over coal and of falling through. Therefore, it should have been the practice at the coal shed to require the wearing of safety belts and lines. It was not, and I therefore find that a violation of section 56.15005 occurred.

S&S and GRAVITY

The violation was both S&S and extremely serious. For reasons previously stated, in the context of continued mining operations, it was reasonably likely that an employee trying to free a hang-up would be drawn into the hopper or would inadvertently fall into it. The wearing of a safety belt and line would either have prevented the accident or have significantly lessened the chance of serious injury or death by allowing the employee an immediate and safe way to get out of the hopper (Tr. 88).

UNWARRANTABLE FAILURE and NEGLIGENCE

There was little specific testimony with respect to unwarrantable failure and negligence. Frederick stated that he regarded Frey's negligence as "high" because, in essence, management knew the surge hole was there and did not require belts and lines be worn" (Tr. 77).

Despite the fact that Frederick's testimony was restricted to his assumptions about what management knew, I conclude, as with the violation of section 56.18020, that the totality of the evidence requires a finding that the violation was due to Frey's unwarrantable failure, as well as its high negligence.

I again note that the conditions under which Bernaldes and others worked to free hang-ups were extremely hazardous. The record is devoid of testimony that Frey, in any meaningful way, recognized the hazards. This is particularly emphasized by the fact that, as Johnson and Meyers observed, there was no formal training regarding how to free hang-ups, that employees trained one another, and that, as Meyers emphasized, the wearing of safety belts and lines was not a part of the training (Tr. 258, 330).

As I have also noted, the surge hole and shed had been in use at the Clearbrook facility for some time, yet during this period, Frey conspicuously and totally failed to recognize the hazards to which it subjected its employees when assigning them to free hang-ups.

ORDER NO.	DATE	30 C.F.R.	PROPOSED PENALTY
4083444	12/21/92	56.17001	$3,000

The order states:

> A fatal accident occurred at this operation on December 13, 1992, when an employee fell into a surg[e] hole in the coal storage shed. Company operating procedures required employees to work around this hole on afternoon shift. Illumination consisted of a single dust to dawn light about 31 feet overhead which did not provide sufficient illumination to readily see the surg[e] hole. The mine operator was aware of this condition. This was an unwarrantable failure.

Section 56. 17001 states, in part, "Illumination sufficient to provide safe working conditions shall be provided in and on all ... loading and dumping sites, and working areas."

THE VIOLATION

The question is what constitutes "[i]llumination sufficient to provide safe working conditions?" As the Commission has pointed out, the "[r]esolution requires a factual determination based on the working conditions in a cited area and the nature of illumination provided." Capitol Aggregates, Inc., 3 FMSHRC

1338 (June 1981). Given the evidence, I conclude such a factual determination cannot be made and, therefore, that the Secretary has failed to prove the violation alleged.

The essence of the allegation is that the lighting in the coal shed was insufficient for workers at night. There was a single light in the shed, 31 feet above the shed floor and over the surge hole. Frederick testified that its lens was covered with coal dust (Tr. 102, 182). Frederick appears to have issued the violation based upon what he believed Meyers could see when standing in the kiln building looking toward the shed (Tr. 181-182). However, the question is not what someone in the kiln building could see, but rather what a person working in and around the surge pile at night could see, and the Secretary offered no testimony in this regard.

Frederick was never in the coal shed at night, nor did the Secretary offer evidence with regard to the actual amount of light the single lamp provided. (For example, no evidence of light meter tests was presented.) Further, no Frey employees who had worked around the coal shed on the afternoon shift were called to testify. Although Johnson believed that it would have been "very difficult" to see the surge hole at night, there was no indication Johnson spoke from personal experience. Johnson admitted that when he worked for Frey and completed preshift reports for the company, he never indicated the lighting in the shed was insufficient (Tr. 216, 283-284).

Because the testimony offered by the Secretary is inadequate to support a finding regarding the nature of the illumination provided in the coal shed at night for those working around the surge hole, I conclude the alleged violation of section 56.17001 has not been established.

My conclusion in this regard is buttressed by the fact Frey presented testimony from Morrison to the effect that after the accident, the company measured the amount of light given off by the single lamp and found that it measured 4.8 foot candles. According to Morrison, a General Electric Company handbook recommended 5 foot candles for a parking lot and 2 1/2 foot candles for a rarely traveled path (Tr. 656). While not determinative of the adequacy of light in the coal shed, the company's evidence underscores the deficiencies of the Secretary's case.

DOCKET NO. VA 93-59-M

CITATION NO.	DATE	30 C.F.R.	PROPOSED PENALTY
4083442	12/21/92	56.18009	$50

The citation states "A competent person designated by the operator to take charge in case of an emergency was not in attendance on the afternoon shift. The foreman was absent

but on call during weekends which is normal practice at this operation."

Section 56.18009 states, "When person are working at the mine, a competent person designated by the mine operator shall be in attendance to take charge in case of emergency."

THE VIOLATION

The term "competent person" is defined in the regulations as "a person having abilities and experience that fully qualify him to perform the duty to which he is assigned." 30 C.F.R. 56.2. The Commission has provided guidance for the interpre tation and application of standards, such as section 56.18009, which incorporate definitions set forth in section 56.2. In analyzing another standard requiring the designation of a competent person to perform generally specified duties, the Commission noted that the standard was drafted in general terms to be adaptable to varying circumstances at the mine. FMC Wyoming Corp., 11 FMSHRC 1622, 1629 (Sept. 1989) (interpreting 30 C.F.R. 57.18002(a)). The Commission found that within the context of a such an adaptable standard, the term "competent person" means "a person capable of recognizing hazards that are known by the operator to be present in a work area or the presence of which is predictable in the view of a reasonably prudent person familiar with the mining industry." 11 FMSHRC at 1622 (interpreting 30 C.F.R. 57.18002).

The citation alleges that on the afternoon shift during the weekend, it was a practice at the Clearbrook facility not to have a competent person designated as required by the standard. According to Johnson, it was company policy during these times to have supervisors report in the morning and leave later in the day with the understanding that they could be called at home if any problems occurred (Tr. 298, 316). Lord confirmed that a foreman was in charge during the day shift on weekends, but that once the afternoon started, the kiln burner, who was Meyers at the time of the accident, was in charge and that the kiln burner was responsible for telephoning the foreman or plant superin- tendent in case of an emergency (Tr. 594). Lord's testimony was not refuted.

The Secretary failed to establish that the kiln burners left in charge, including Meyers, were not competent persons. At the time of the accident Meyers had worked at the Clearbrook Mine and Mill for more than nine years. He had trained as a greaser and oiler before being placed in charge of the kiln (Tr. 332-333). Contrary to what Frederick appeared to think, the standard does not require the person designated to be a foreman. Rather, as noted, the person must be capable of recognizing known hazards. The Secretary did not develop the record with respect to the hazards that should have been know by

any designated person, nor did he establish Meyers' knowledge, or lack of it, with respect to such hazards. If anything, the record suggests that Meyers was fully competent to take charge in emergencies. Certainly, the Secretary had no quarrel with the manner in which he responded to the December 13 accident. Frederick stated he had done a "very good job" (Tr. 114).

To the extent the Secretary relies upon Frederick's recollection of what Meyers stated ("If I'm in charge, nobody ever told me" (Tr. 114)) to establish Frey's normal practice was to fail to designate a person to be in charge, I find it unpersuasive. Meyers was called by the Secretary as a witness, but was not asked about his purported statement to Frederick. Hearsay statements, such as that reported by Frederick, are admissible in administrative proceedings. However, there are limits to the weight they may be given. When a person who is purported to have made the statement is called as a witness by the party relying upon the statement and is not asked about it, in my view, the statement is entitled to little or no weight. This is especially true here where the manner in which Meyers responded in the face of Bernaldes accident implied he fully understood he was supposed to "take charge," and when his conduct was consistent with what Robinson and Lord testified was company policy (Tr. 516-517, 594).

Therefore, I conclude the Secretary has not proven the alleged violation.

DOCKET NO. VA 93-89-M

THE ACCIDENT OF DECEMBER 11, 1992

STIPULATIONS

Prior to taking evidence on this portion of the case, counsel additionally stipulated as follows:

1. The Administrative Law Judge has the jurisdiction to hear and decide this case.

2. Inspector Elwood Frederick was acting in his official capacity as a federal metal/non-metal mine inspector on December 21, 1992 when he issued Citation No. 4083445.

3. Citation No. 4083445 was properly issued to [Frey's] agent.

4. Abatement of the conditions cited in Citation No. 4083445 was timely.

5. The Clearbrook Mine and Mill is a surface mine and crushed stone operation owned and operated by [Frey].

Tr. 706-707 (nonsubstantive editorial changes made).

THE SECRETARY'S WITNESSES

Charles W. McNeal

Charles W. McNeal is a MSHA supervisory metal/non-metal mine inspector. In the company of Frederick, McNeal participated in MSHA's investigation of a fatal accident that occurred at Frey's Clearbrook facility on December 11, 1992.

McNeal and Frederick arrived at the mine on December 12 and proceeded to the accident site. McNeal described the site as located along the main road into and out of the facility, approximately 200 feet from the mine entrance. The site was on the left hand side of the road and under 7,200 volt power lines (Tr. 724).

Upon arriving at the site, McNeal and Frederick observed a semi-dump truck. The truck belonged to one of Frey's customers. The truck's tires were burned (Tr. 725). The truck had been involved in an accident the previous day.

McNeal described how he believed the accident occurred. A water spray bar was located at the entrance to the facility (on the right hand side of the road as trucks leave the facility) (Tr. 760-761). The bar was positioned above the trucks. On leaving the facility, loaded trucks were driven under the bar, the spray was activated and the truck's loads were wet down (Tr. 753). McNeal believed the truck involved in the accident entered the property and the driver crossed to the left hand side of the road and used the water spray bar to wet the bed of the empty truck. (A front-end loader operator told McNeal that he, the loader operator, had seen the truck at the spray bar (Tr. 755)). The truck left the water spray bar, moved back to the right side of the road and proceeded along the road for about 200 feet. The driver again pulled over to the left hand side of the road (Tr. 727). Although no one saw what happened next, McNeal surmised that the truck driver then raised the truck bed to clean it and the bed hit one of the 7200 volt power lines (Tr. 727, 759). The power line was not deenergized or guarded (Tr. 727, 759). The truck caught fire. In trying to leave the truck's cab, the driver contacted the truck's energized frame and was electrocuted. Approximately 1-1/2 hours passed before the power company cut off electricity to the line and the truck bed was lowered (Tr. 727).

The distance from the ground to the bare power wires was 28 feet. When fully raised, the truck bed extended 30 feet above the ground. The truck bed was made of aluminum (Tr. 741-742).

McNeal testified further that he was told by Bob Morgan, a Virginia state mine inspector, that another accident occurred in 1988 at nearly the same site when the bed of a truck was raised into a power line (Tr. 728). According to McNeal, Morgan told him the previous accident occurred within 15 feet of the December 11 accident and that it involved the same power line (Tr. 733). (MSHA did not investigate the 1988 accident. McNeal did not know why (Tr. 776)).

McNeal and Frederick returned to the MSHA office and reviewed their findings. They agreed that a violation of section 56.12066 had occurred. Therefore, Frederick issued to Frey Citation No. 4083445.

Section 56.12066 requires bare power lines to be guarded or deenergized when metallic equipment can come in contact with them. McNeal explained the citation was issued to Frey, rather then the owner of the truck, because "the mining company is responsible for the safety of customers who visit [its] property (Tr. 750).

McNeal believed it highly likely a truck that pulled over at the site would raise its bed into the unguarded wires. Frey had many customers who required the materials they purchased to be clean and dry. Therefore, the truck drivers frequently cleaned the beds of the trucks before loading. McNeal explained that a truck driver "goes [to] th[e] water spray bar, deposits water in the [truck] bed, pulls up from there a little ways, pulls off the road and dumps his bed... . [W]e've been told they do it often" (Tr. 747-748). As he further explained:

> you've got this particular spot that is 200 feet down from this water spray bar which, on occasion -- not every truck that comes in here does that -- a truck will pull under to deposit water in his bed when he had to have this dry, clean material that he has to deliver and he has to have a clean bed in the truck and wash the bed of the truck out. And there's a real nice spot there to pull off that road and raise that bed of that truck under that power line. It happened twice.

Tr. 765-766.

McNeal maintained that the accident site was level with the road. It also was an area where the power lines, which here ran parallel with the road, were closest to the road (Tr. 767,

768-769). There were no signs warning of the presence of the power lines (Tr. 772).

McNeal agreed that there were several other places along the road where a trucker could stop, could raise the bed of the truck and not come in contact with power lines (Tr. 765). McNeal stated that to his knowledge there was no designated area on the facility where incoming trucks could dump their residual contents before picking up their loads (Tr. 760).

Injuries resulting from raising a truck bed into a power line could be fatal or nonexistent. If the driver stayed inside the truck's cab, nothing would happen. If the driver left the cab and touched the truck frame or the surrounding ground while the truck frame was energized, current would flow through the driver's body and the driver could be electrocuted (Tr. 748-749).

McNeal believed the company's negligence was high because a similar accident had occurred within 15 feet of the site, yet the company, in NcNeal's words, had done "nothing, absolutely nothing" (Tr. 750).

Elwood S. Frederick

Frederick testified when he first saw the truck, it was sitting at the accident site with its bed in the "down" position (Tr. 787). The overhead 7,00 volt power line was spliced where the truck bed had hit the line. In addition, Frederick maintained that 15 feet from the splice sleeve were other splices in the line. These indicated where the previous accident had occurred (Tr. 787-788, 791, 802).

With regard to the previous accident, Frederick did not remember who told the MSHA investigators it had occurred, but he believed both company personnel and the Virginia state mine inspectors mentioned it (Tr. 789). As he recalled, he and McNeal were accompanied during the investigation by Dwayne Johnson, then plant superintendent, by Charles Morrison, Frey's director of personnel and safety, and by Vincent Lord, who subsequent to the accident replaced Johnson as plant superintendent (Tr. 788). As Frederick understood it, when the 1988 accident occurred, there was a stockpile in the area, but it was removed following the accident (Tr. 789, 804). There were no signs or barricades to indicate the presence of power lines, and Frederick was of the opinion that as a result of the 1988 accident, Frey was on notice that warning signs should have been posted or other corrective measures taken (Tr. 790). As of December 11, 1992, the power lines were neither guarded nor deenergized and these conditions constituted a violation of section 56.12066 (Tr. 796).

Regarding the S&S finding, Frederick was asked how likely it was that the truck bed would have been raised into the power line and he responded "well, this occurred" (Tr. 792). He added that the area of the accident must have been a very popular spot for truckers to pull over because two accidents had happened there (Tr. 807). In his opinion, an accident was reasonably likely because controlling independent truckers was extremely difficult and, if a driver had something to dump, the driver would pull into the area, and raise the truck bed (Tr. 794, 795). As he put it, truck drivers "do a lot of dumb things" (Tr. 808). Frederick could not recall what the side of the road across from the accident site looked like (Tr. 812).

The finding of "high" negligence was based upon the previous accident and the fact that, in the intervening four years, the company had done nothing to change conditions in the accident area, except move the stockpile (Tr. 796-797). Frederick added that Frey did not own the power lines. Frey had contacted the power company about taking remedial actions following the 1988 accident, but nothing had happened (Tr. 798-801).

Dwayne Johnson

On December 11, 1992 Dwayne Johnson was plant superintendent. He stated that around 10:00 a.m. that day he was in the office when he was informed that a truck was on fire. Johnson grabbed a fire extinguisher, got in his truck and drove to the site of the fire. It was snowing hard. The truck's bed was raised. The truck was emitting a lot of smoke and sparks were coming from its wheels. Another Frey employee was at the accident scene. He and Johnson could not see the truck driver. The smoke cleared and they saw the driver lying on his back beside the truck. Johnson ran with the fire extinguisher toward the truck. About 25 feet from the truck Johnson could feel electricity. He backed away and looked up. Despite the snow, he could see that the truck bed was in contact with one of the overhead power lines (Tr. 815-816, 827-828).

Lord arrived and Johnson told Lord to call the power company and have them shut off the power. The fire department also was called. When they arrived, the firemen used a non-conductive pole to pull the driver away from the truck. The firemen tried to revive the driver, but had no success. The body was removed by ambulance.

The power company subsequently turned off the power and the fire was extinguished. The truck's bed was lowered and the power company put sleeves on the line where the bed had contacted it (Tr. 816-817). (The sleeves are what Frederick referred to as splices.)

Prior to the accident, the power lines were not guarded. The road was used by all traffic going in and out of the facility (Tr. 817). According to Johnson, the area where the accident occurred was the first open area after entering the facility. At this area, a truck driver could pull over to the left or right of the road (Tr. 829). In the case of the victim, "He just happened to pull to the left." Id. It was common to pull either way. Id., 830. There are no markings on the road indicating the right or left side of the road.

Prior to the accident, Johnson had never seen a semi-dump truck raise its bed in the accident area. However, he had seen smaller trucks do it (Tr. 818). It was common for smaller trucks to raise their beds in the area (Tr. 821). Johnson has seen it done dozens of times in a year (Tr. 828). When the beds of the smaller trucks were raised, they were not within 10 feet of the power lines (Tr. 826). Trucks generally raised their beds to remove contaminants or snow (Tr. 819). If Frey personnel observed a truck with contaminants in its bed, the driver would be told not to clean the bed on Frey property (Tr. 820, 824-825, 834).

Although Johnson was not with the company when the previous accident occurred, the story of how a driver had raised his truck's bed and hit power lines was commonly told at the facility. After the accident of December 11, Johnson became aware that the previous accident had occurred in the same area, because he could see the sleeves on the power lines from the previous accident (Tr. 822).

Vincent Lord

Vincent Lord, who became the plant superintendent after Johnson left, stated that there were approximately 150 to 200 truck trips per day into and out of the facility, involving approximately 100 trucks (Tr. 839, 859). The trucks came onto the property empty and were weighed. If the drivers were unfamiliar with the site, they were directed where to go and how to load. The trucks were supposed to enter the property with clean beds. If their beds were not clean and, if Frey officials knew, the trucks were sent to a designated area to clean the beds (Tr. 836-837).

The water spray line was installed to wet down particular material that was shipped to the State of West Virginia and that was required to arrive wet (Tr. 837). Although the line was used for other purposes, such as rinsing off cars, to flush dust off of loads or to clean beds, Frey tried to discourage such use (Tr. 838). The only way to control the use of the spray was for Frey personnel to reprimand truck drivers if the personnel saw the drivers using the water for other than its intended purpose (Tr. 839).

It had long been a policy at the facility for trucks not to raise their beds on the company's property. Lord could not recall any truck ever raising its bed in the area where the accident occurred, except the truck involved in the 1988 accident (Tr. 840, 861). He did recall seeing trucks raise their beds in areas near the accident area. While most of those trucks were smaller than the semi-dump truck involved in the accident, some were as large as the semi-dump truck (Tr. 860-861).

On the day of the accident, Lord had no trouble seeing the power lines through the snow (Tr. 841). Lord identified a photograph of the burning truck with its bed raised into one of the high voltage wires (P. Exh. 13). The photograph was taken the morning of the accident. The truck had pulled up next to a stockpile of material on its left (Id., Tr. 842). The truck had crossed over onto the left hand side of the road against the traffic (Tr. 834). Lord also identified a photograph of the truck taken from the rear (P. Exh. 14). Lord stated that the area on the right side of the road, across from the area where the accident occurred, was a low, flat area similar to the accident site on the left, but with no overhead power lines (Tr. 844). There was also a small stockpile on the right (Tr. 845). In Lord's view, in addition to the area on the right, other flat, level areas were present where a truck could pull over along the road.

Lord testified he understood that the deceased driver had completed a safety course within the past month and that the course had included, among other topics, the danger of raising a truck bed into power wires (Tr. 847-849). Lord also stated that he understood OSHA regulations required that stickers warning of the danger of raising the truck bed into wires be placed inside the truck cab (Tr. 849).

Lord acknowledged the 1988 accident involved the bed of a truck hitting a power line in the vicinity of the December 11 accident (Tr. 856). Lord believed that at the time the 1988 accident occurred, Frey had notified MSHA of the accident and the agency had done nothing (Tr. 851). The company was not cited for any violations by the state following the state's investigation of the accident. Id. As best Lord could recall, the state suggested the company work with the power company to get the company to move the power lines, raise them, or put warning signs or devices on them (Tr. 859). After the 1988 accident, the company tried to get the power company to do one of these things (Tr. 852, 856). Frey made multiple requests of the power company, but got no results (Tr. 852, 860). As Lord explained, "They ... claimed ... that the line is ours. We claim[ed] that they build the line and the line is theirs" (Tr. 853).

Charles W. Morrison

Charles Morrison testified that he called MSHA following the 1988 accident. After describing the accident to an MSHA official, the official told him MSHA did not need to investigate it (Tr. 863). In contrast, the state investigated the accident and state officials recommended that the area be barricaded, or that warning markers be placed on the lines (Tr. 875-876, 882). The state mine inspector recommended that Frey try to work with the power company, which Frey repeatedly tried to do (Tr. 863-864, 876, 879).

Morrison also identified the OSHA regulation requiring the outside of equipment with hoists (such as the semi-dump truck) to be posted with signs warning that it is unlawful to operate the truck within 10 feet of overhead high voltage lines. One such sign also was required inside the equipment's cab (Tr. 865-865).

Truckers were supposed enter Frey's property with clean beds. When they did not, and, when Morrison saw truck drivers raise their beds on Frey's property, he would tell them not to do it (Tr. 871-872).

MOTION TO STRIKE

At the close of the Secretary's case, counsel for Frey moved to strike the testimony of the Secretary's witnesses. Counsel was particularly concerned with the testimony of Johnson regarding the likelihood of injury. Counsel stated that, even if his testimony were credited in the light most favorable to the Secretary, it would not establish that an injury was reasonably likely in that he testified truck beds were raised "all over the place," and not in one particular spot (Tr. 835). I reserved a ruling.

The Motion is DENIED. As with the initial motion to strike, I conclude if I were to totally credit Johnson's testimony, there are portions of it that certainly are relevant to the question of whether, in the context of continued operations at the mine, the cited conditions were reasonably likely to result in an injury.

CITATION NO.	DATE	30 C.F.R.	PROPOSED PENALTY
4083445	0 12/21/92	56.18009	$9,500

The citation states:

A fatal accident occurred at this operation on December 11, 1992 when a customer truck driver raised the bed of his truck into an overhead 7,200 volt bare power line 28 feet above. A similar incident occurred

at this location on May 18, 1988 when another customer truck driver raised the bed of his truck into the same power line.

Section 56.12066 states, "Where metallic tools or equipment can come in contact with trolley wires or bare powerlines, the lines shall be guarded or deenergized."

THE VIOLATION

McNeal and Frederick agreed that in the area where the accident occurred, the high voltage lines were 28 feet above the ground. They also stated that the facility was at times visited by semi-dump trucks whose beds, if raised, extended 30 feet above the ground (Tr. 741-742, 787-788). The height of the power lines and the raised beds of semi-dump trucks was not disputed by Frey's witnesses. Lord agreed with McNeal and Frederick that the facility was at times visited by semi-dump trucks of that, or a similar, size and he recalled seeing trucks of that size raise their beds on mine property (Tr. 860-861). McNeal, Frederick and Johnson testified that the powerlines were not guarded or deenergized, and Frey does not argue otherwise (Tr. 727, 787-788, 790, 817).

It is clear, therefore, that the beds of semi-dump size trucks if raised in the area where the December 11, 1992 accident occurred, could contact the powerlines that were bare and were not guarded or deenergized. Not only could it happen in theory, it happened in fact, and I find the violation existed as charged.

S&S and GRAVITY

I conclude that the Mathies test for determining the S&S nature of a violation has been easily met.

A violation of mandatory safety standard 56.12066 existed. The evidence establishes a discrete safety hazard in that by failing to guard or deenergize the power wires, Frey subjected the drivers of semi-dump sized trucks in general, and the deceased driver in particular, to the possibility of death or serious injury. As Frederick noted, once the bed touched a wire, the driver could avoid injury only if he or she remained in the cab of the truck. If the driver left the cab -- and if the truck caught fire, as happened in the case of the deceased driver, a driver almost surely would have attempted to flee -- serious shock injury or electrocution was virtually certain (Tr. 748-749).

As is frequently the case, when the alleged S&S nature of a violation is challenged, the essential question is whether the Secretary has also established a reasonable

likelihood that the hazard contributed to will result in an injury. The testimony establishes that the raising of truck beds was an ongoing problem at the facility. McNeal was the first witness to explain that many customers of Frey's products required materials purchased from Frey to be clean and dry and, therefore, that trucks that entered the facility often raised their beds to clean them prior to being loaded (Tr. 747-748). Frederick's and Johnson's testimony corroborated McNeal's (Tr. 794-795). Lord did not deny the practice occurred. Indeed, he remembered seeing trucks raise their beds on Frey property, even near power lines (Tr. 860-861).

This is not to say that the practice was condoned by Frey. I credit the testimony of Johnson and Morrison that drivers were not supposed to clean their beds on Frey property (Tr. 820, 834. 871-872). I further credit Johnson's testimony that if Frey personnel saw drivers dumping contaminants, they told the drivers not to do it, and that Johnson had seen Lord so instruct drivers (Tr. 825). I note, as well, Morrison's similar testimony regarding Lord (Tr. 871-872). This said, the testimony amply documents that Frey's objections did not prevent the practice and that the raising of beds remained an ongoing problem. I believe that Frederick was correct when he observed that it was difficult for Frey to control the actions of the truckers (Tr. 793-794).

I also conclude that the area where the accident occurred was one that invited such conduct. McNeal and Johnson credibly described the area as level and with room enough for a semi-dump truck to pull over (Tr. 765-766, 829, 830). I recognize that the area across from the accident site (the area on the right side of the road when headed into the facility) was an even more inviting site at which to clean truck beds in that it was equally level, afforded ample room and had no overhead power lines (Tr. 766-767). I believe it is just common sense that an incoming truck would have been more likely to pull to the right hand side of the road than to left. Nonetheless, this does not exclude finding that it was reasonable likely trucker drivers would pull to the left side and, having done that, would raise their beds.

I believe it important to remember, as did Johnson, that the road was not divided with a median line, something that might have made a trucker think twice before crossing to the left side of the road (Tr. 831). Indeed, the road itself appears not to have been well defined at all. Johnson described it as not as a road per se, but more like "a big, open level area" (Tr. 830). All of which, in my opinion, made crossing to the left, while perhaps less likely than crossing to the right, an easy thing to do.

The power wires ran above the area and parallel to the road (Tr. 767, 768-769). Obviously, a truck driver with a bed long enough to hit the wires would have been out of his or her mind to purposefully raise the bed under the wires. The hazard presented by the violation was from an inadvertent accident, not from a suicide. Even though warned by notices inside and outside the cab of the truck and, even though trained in the hazards posed by overhead wires, truck drivers intent on cleaning their beds would not always have noticed the wires without visual signs or warning devices present and external to the truck to remind the drivers of the wires' presence.

Given the many daily truck trips into and out of the facility, given the continuing practice on Frey's property of cleaning truck beds by raising them, and given the conducive nature of the area where the accident occurred to the performance of the practice, I conclude it was reasonably likely that sooner or later, in the context of continued normal operations at the facility, a truck the size of a semi-dump would have pulled to the left, raised its bed into the overhead unguarded and energized power wires. I also conclude that this would have lead to the serious, if not fatal, injury of the driver.

As all of the witnesses recognized, the very accident that triggered the citation occurred before, and in virtually the same spot. From all that appears on the face of the record, the interval between the accidents was simply fortuitous, as was the fact the first accident appears not to have resulted in a fatality. Having happened twice, had the conditions continued unabated, the accident could have happened again at any time and with a result as disastrous as that of December 11. The violation was S&S.

The violation also was extremely serious. Traumatic shock injury or death were the potential hazards, and the likelihood of an accident causing such injuries was very great indeed.

NEGLIGENCE

Negligence is the failure to meet the standard of care required by the circumstances and it is difficult to imagine a situation in which an operator could have been less responsive to meeting its required standard of care than was Frey. In fact, more than simply failing to meet the required standard of care, the record compels the conclusion, and I find, that Frey hardly even tried.

The Mine Act requires that Frey comply with the mandatory standards, not only to protect its own employees, but also to protect all individuals working at its facility. This is an extensive responsibility, but it is one that Frey assumed in choosing to operate, control and supervise its Clearbrook

facility. If Frey were not on notice before the 1988 accident that in the accident area, truck beds could and would be raised into the energized power wires, it subsequently was. As Johnson testified, the story of the 1988 accident was known throughout the facility (Tr. 822). McNeal described Frey's response as "nothing, absolutely nothing," and McNeal was hardly exaggerating (Tr. 750).

It is clear that after the 1988 accident the practice of raising truck beds on Frey's property continued. It is equally clear that after the 1988 accident Frey knew full well what should have been done to guard against the practice in the accident area. I credit the testimony of Lord and Morrison that Virginia mine officials who investigated the first accident recommended that either the power lines be moved, raised, or that warning devices be installed on the lines (Tr. 852, 875 876). Had any of these recommendations been instituted, Frey would have gone a long way toward eliminating the hazard. In addition, Frey might well have been in compliance with section 56.18009, and, most important, the deceased driver might yet be alive.

Unfortunately these speculations must remain just that because Frey's efforts to alleviate the danger posed by the situation in the accident area were limited essentially to disputing with the power company who was responsible for taking remedial measures. Frey could not get the power company to do the work (Tr. 852, 860, 882). Therefore, Frey did virtually nothing to change the conditions in the area that allowed the accident to occur. (Frey did remove a stockpile from the area, but that did little to make it a less attractive place to pull over.)

The result was another accident. This time one that resulted in death. The fact that the deceased driver contributed to the accident with a negligent action of his own does not diminish Frey's lack of care. Many of the mandatory safety standards are designed to protect miners from themselves. Frey was required to take remedial measures precisely because a truck driver might act in the negligent manner of the victim.

The failure of MSHA to cite the violation in the four years that passed between the first accident and the second does not indicate that Frey was any less irresponsible. Whatever the deficiencies of MSHA's investigation process and the inadequacies of its inspections, they are not exculpatory of Frey's glaring, irresponsible and totally inexcusable failure to meet the standard of care required.

OTHER CIVIL PENALTY CRITERIA

In the 24 months prior to the issuance of the subject citations and orders, 32 violations of the mandatory safety standards were cited at the Clearbrook Mine and Mill (Exh. P-6). This number falls between a small and medium history of previous violations and is not such as should increase civil penalties otherwise assessed. Further, the Clearbrook Mine and Mill is a medium sized facility and Frey is a small operator. See Sec. Br. 47. Frey offered no evidence to indicate the size of any penalties assessed would have an effect on its ability to continue in business, and I so find. Finally, Frey exhibited good faith in achieving rapid compliance after being cited for all of the violations found herein. I also note the parties' stipulation that the violation of section 56.12066, cited in Citation No. 4083445 (Docket No. VA 93-89-M), was timely abated.

CIVIL PENALTIES

The Secretary has proposed a civil penalty of $3,500 for the violation of section 56.16002(a)(1) set forth in Order/Citation No. 4082539. The violation was extremely serious. Frey repeatedly sent its employees into harm's way and its failure to correct conditions that were inordinately hazardous represented heightened negligence on the company's part. Given these factors, I find the Secretary's proposal inadequate. Rather, I conclude a civil penalty of $10,000 is appropriate for the violation.

For the violation of section 56.18020, set forth in Order No. 4082540, the Secretary has proposed a civil penalty of $6,000. Again, I find the proposal inadequate given the extreme seriousness of the violation and the inexcusable failure of Frey to recognize the hazard to which the violation subjected its miners. I, therefore, conclude a civil penalty of $10,000 is appropriate for the violation.

For the same reasons, I also find inadequate the Secretary's proposal for a civil penalty of $6,000 for the violation of section 56.15005, set forth in Citation No. 4083441. Again, I conclude a penalty of $10,000 is warranted.

Finally, the extreme seriousness of the violation of section 56.18009, set forth in Citation No. 4083445, and Frey's inexcusable negligence in allowing the violation to exist, coupled with the fact that the violation unquestionably contributed to the death of a customer truck driver, in my view calls for a civil penalty far in excess of the $9,500 penalty proposed by the Secretary. (The Commission has recently stated the "potential for death .. posed by the violation is appropriate in applying the gravity criterion." Dolese Brothers Co., 16 FMSHRC _____, Docket No. CENT 92-110-M

(4/11/94), Slip op. at 7). I conclude a penalty of $35,000 is appropriate. But for the company's small size and the fact that the truck driver negligently helped to occasion his own death, an even larger penalty would have been justified.

ORDER

Order/Citation No. 4082539, Order No. 4082540, and Citation No. 4083441 are AFFIRMED and Frey is ORDERED to pay civil penalties of $10,000 each for the violations set forth in each. Citation No. 4083442 is AFFIRMED and Frey is ORDERED to pay a civil penalty of $35,000 for the violation set forth therein. Order No. 4083222 and Citation No. 4083442 are VACATED.

Frey is ORDERED to pay the civil penalties within 30 days of the date of this decision and upon receipt of payment these matters are DISMISSED.

David F. Barbour
Administrative Law Judge

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