

# FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

OFFICE OF ADMINISTRATIVE LAW JUDGES  
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November 19, 2014

SECRETARY OF LABOR  
MINE SAFETY AND HEALTH  
ADMINISTRATION (MSHA),  
Petitioner,

v.

SCH TERMINAL COMPANY, INC.,  
Respondent.

CIVIL PENALTY PROCEEDING

Docket No. KENT 2013-413  
A.C. No. 15-18639-311429

Docket No. KENT 2013-378  
A.C. No. 15-18639-308629

Mine: Calvert City Terminal, LLC

## DECISION

Appearances: Willow E. Fort, U.S. Department of Labor, Office of the Solicitor  
618 Church Street, Suite 230, Nashville, TN 37219

Flem Gordon, Gordon Law Offices  
121 W. Second Street P.O. Box 1146 Owensboro, KY 42303

Before: Judge Simonton

## I. INTRODUCTION

This case is before me on a civil penalty petition filed by the Secretary of Labor, acting through the Mine Safety and Health Administration, against SCH Terminal Company, Inc. (Respondent), pursuant to the Federal Mine Safety and Health Act of 1977, 30 U.S.C. §§ 815 and 820. This case involves four 104(a) citations issued in response to a fatal drowning accident that occurred on February 26, 2012 at the Calvert City Terminal mine. The Secretary has proposed specially assessed penalties which total **\$163,003.00**. On November 20, 2013, I granted the Secretary's motion for partial summary judgment, holding that MSHA had jurisdiction over work activity on barges at the Calvert City riverside loading dock. Order Granting Partial Summary Judgment. The parties presented testimony and documentary evidence at a hearing held in London, Kentucky beginning May 14, 2014 followed by submission of post hearing briefs.

Prior to hearing, the parties agreed to a detailed list of stipulations. Tr. I, 7-8. At hearing, MSHA Inspector Richard Hardison testified for the Secretary. SCH Manager William Rager, Safety Trainer David Hicks, Consultant James Manley and retired MSHA Supervisor Roderic Breland testified for the Respondent. For the reasons that follow, Citation Nos. 7657715, 7657713, and 7657714 are **VACATED**. Citation No. 7657716 is **AFFIRMED** as originally written. For reasons explained below I am assessing a total penalty of **\$25,000.00**.

## II. BACKGROUND

The Calvert City Terminal is a coal-handling and processing facility located on the Tennessee River in Calvert City, Marshall County, Kentucky. *Jt. Stip.* 8, 12, 17. The terminal has a land based processing facility and a riverside dock that loads custom blended coal onto customer barges. *Order Granting Partial Summary Judgment*, 2.

The terminal receives shipments of coal from producers by barge, rail, and truck. Once the coal is received, it is unloaded and stored at the terminal. *Id.* Customers place orders for the amount and desired blend of coal. *Id.* The terminal uses a series of hoppers, belts, and conveyors to blend coal to the customer's specifications on the land portion of the terminal. *Id.* Once blended, the coal is sent onto a series of belts and loaded into rail cars, coal trucks, or barges that are owned by customers or independent contractors. *Id.* Respondent receives barges at the riverside dock facility. *Tr. I*, 28, 185-86. The barges vary in size and specific configuration and are provided by the customer for Respondent to load. *Tr. I*, 186, 193-94. The standard coal barge is approximately 195 feet long by 35 feet wide. *Tr. I*, 193. The outside gunnels of the barges are approximately 8-12 feet above the water prior to loading. *Tr. I*, 64. The barges lower down to approximately three feet above the water after loading. *Tr. I*, 64-65. The exterior gunnel walkway of the coal barges is approximately two to three feet wide. *Tr. I*, 131; *Tr. II*, 42-43. Some barges have rake ends with platforms 6-20 feet long. *Tr. I*, 194. Barge interior cargo holds are buffered by a combing that ranges from 36 to 40 inches tall. *Tr. I*, 195. The gunnel walkway has eighteen inch wing hatches with locking lids used to inspect and pump out the barge wing tanks. *Tr. II*, 22-24. An independent contractor, Wepfer Marine, maneuvers the barges into position under direction of Respondent's load out operator. *Tr. I*, 186; *GX 8*, 4.<sup>1</sup>

Prior to February 26, 2012, the barges next in line were tied off loosely to the fixed barge and maneuvered when needed by tugboats. *Tr. I*, 71, 198; *Tr. II*, 96; *GX 3*, p. 6. The deckhands stage, draft and pump in-line barges, and then tie the barges to a winch system in order to be loaded. *Tr. I*, 30, 100-01; *GX*, 7-8. A deckhand "drafts" a barge by walking out onto the gunnel or platform surrounding the barge's hold. *Tr. I*, 30. The deckhand then extends a long measuring stick, called a "drafting stick," down to the surface of the water below to determine the position of the barge. *Id.* The drafting stick measurements are relayed to the load-out operator in charge of the chute, which extends out over the barge to load the coal. *Tr. I*, 30-31.

Prior to February 26, 2012, the Respondent did not require deckhands to use fall protection while drafting the barges. *Tr. I*, 191-92. The Respondent did require all deckhands to wear a U.S. Coast Guard approved flotation vest. *Tr. I*, 207, 223. The life-vest in use prior to the accident did not support an unconscious person's head above water. *Tr. I*, 251. There have previously been instances where SCH personnel fell into the water while working on the barges, but all apparently swam to safety without incident. *Tr. I*, 75, 247.

Respondent's Safety Trainer David Hicks provided annual safety training and general fall protection instruction to all SCH employees, including accident victim Kevin Meyers. *Jt. Stip.* 24; *Tr. I*, 239. On February 24, 2012, MSHA completed a regularly scheduled E 01 Inspection

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<sup>1</sup> Volume 1 of the transcript will be designated as *Tr. I*, volume 2 as *Tr. II*. Consistent with the hearing record the Secretary's exhibits will be denoted as *GX* and Respondent's exhibits *RX*.

of the SCH terminal. Jt. Stip. 15. MSHA did not issue any citations regarding illumination, fall protection, or inadequate training at the SCH loading dock during the E 01 inspection. Tr. I, 192, 202; GX 13, 3.

The Calvert City terminal is located in Calvert City, Kentucky in the Central Time Zone. Tr. I, 118. The MSHA Hotline Call Center is located in Arlington, Virginia in the Eastern Time Zone. Tr. I, 117, 119.

### **III. FINDINGS OF FACT AND CONCLUSIONS OF LAW**

#### **A. February 26, 2012 Accident**

During the night shift of February 25-26, 2012, SCH personnel loaded coal at the riverside dock onto a string of barges. Tr. I, 37; GX 3, 5-6. The air temperature was 26 degrees and the water temperature in the river was approximately 47 degrees. Tr. I, 116, GX, 3, 9. At approximately 1:10 AM CST, SCH load-out operator Matt Kissiar asked deckhand Kevin Meyers by radio to draft the next barge in line. Tr. I, 37; GX Ex. 3, 5. Mr. Meyers crossed over to an empty barge, which was tied off loosely to the fixed loading dock. Tr. I, 53; GX 3, 6. Meyers wore a coast guard-approved life-vest, personal radio, and carried a flashlight and drafting stick with him when he crossed over to the empty barge. Jt. Stip. 18.

At approximately 1:15 a.m., Kissiar asked where Meyers was after Meyers failed to report drafting measurements and was not visible. Tr. I, 37; GX Ex. 3, 4. SCH personnel and Wepfer Marine began searching for Meyers in both the river and within the cargo hold of the barge. Tr. I, 37-38; Sec'y Ex. 3, 7. A Wepfer Marine deckhand spotted and then retrieved Meyers' ball cap from the river at approximately 1:25 a.m. Tr. I, 129, GX 3, 8. At 1:34 a.m., Wepfer Marine requested the US Coast Guard to stop river traffic and also called 911 to request a rescue squad. Tr. I, 115; GX 8, 4. The Marshall County Rescue Squad located Meyers' body floating face down under the rake end of the fixed work barge at 2:36 a.m. Tr. I, 74, 116. Mr. Meyers was pronounced dead at 3:40 a.m. by the Marshall County Coroner. GX 3, 8-9. Meyers' body did not exhibit any signs of broken bones, bleeding or obvious physical trauma. GX 3, 11. The Coroner determined that the cause of Mr. Meyers' death was drowning. Tr. I, 8; GX 3, 13; GX 8, 6.

#### **B. Citation No. 7657715**

Inspector Hardison issued Citation No. 7657715 for an alleged violation of 30 CFR § 77.1710(g) on September 18, 2012. Hardison alleged within the citation that:

Safety belts or lines were not provided to protect miners from falling into the water while performing work on barges. The mine operator's failure to provide safety belts or lines contributed to a fatality involving a deckhand on February 26, 2012.

GX 11, 1.

Hardison designated Citation No. 7657715 as a high negligence violation that contributed to the occurrence of a fatal injury. The Secretary has proposed a specially assessed penalty of \$52,500.00 for Citation No. 7657715. GX 13, 3.

## 1. Testimony

Inspector Hardison testified on the basis of his visits to Respondent's loading dock on February 26, 2012 and October 23, 2012. Tr. I, 36. Hardison stated that his observations and interviews led him to conclude that SCH employees were particularly exposed to falling into the river while drafting the barges at night. Tr. I, 78. Hardison was concerned that deckhands had to hold the drafting rod in one hand and use their other hand to point a flashlight down the rod while leaning out over the edge of the barge. *Id.* He testified that deckhands could also fall 8-10 feet into the interior cargo hold before the barge was loaded. Tr. I, 72. Hardison stated that he did not believe it was possible for a deckhand to maintain three points of contact with the combing while carrying both a flashlight and drafting stick. Tr. I, 173-74. Hardison testified that MSHA had previously issued a Program Information Bulletin on July 8, 2010, notifying coal operators that an employee had drowned while wearing a life vest after falling from a barge into cold water. Tr. I, 80-81; GX 5 (PIB No. 10-08). Hardison stated that Respondent should have realized that drafting the barges at night involved inherently dangerous conditions that required the use of fall protection. Tr. I, 76-77. On cross-examination, Hardison conceded that he did not have any prior work or inspection experience on barges. Tr. I, 172-73. He also confirmed that after the accident, MSHA tech support visited Respondent's loading dock, but were unable to provide viable guidelines for a barge based fall protection system. Tr. I, 158.

Respondent's Chief Operating Officer William Rager testified regarding the work conditions at the SCH loading dock. Rager stated that he had worked for SCH for over 29 years and had performed many dockside tasks previously. Tr. I, 185. Rager testified that MSHA had never previously issued any citations regarding fall protection at the SCH loading dock. Tr. I, 192. Rager opined that tying off to a moveable barge was more hazardous than potential falls into the river. Tr. I, 193. He explained that employing a tie-off system on a moveable barge could cause a deckhand to be caught between barges and or the dock. Tr. 192-93. Rager testified that in visiting numerous riverside loading facilities, he had never observed a deckhand use a tie-off system to prevent falls into water. Tr. I, 191. Rager did state that deckhands would use fall protection when working on covered barges above hard surfaces. Tr. I, 217. However, he stated that the interior cargo hold of the open coal barges loaded by SCH were protected by a combing that averaged somewhere between 36 and 40 inches high. Tr. I, 195.

Rager testified that Mr. Meyers had worked with Respondent for over 5 years and spent the majority of his time working as a deckhand. Tr. I, 188. Rager stated that after the accident, Respondent consulted with several engineering companies regarding possible fall protection systems, but none of these companies offered a system designed to prevent workers from falling off the barge into water. Tr. I, 229-233. He testified that following Meyers' accident, Respondent instituted a number of new safety protocols. Tr. I, 210. These measures included drafting barges from the fixed barge side while attached to the winch system, use of a different type of lifejacket, use of personal locators, and an improvised tie off method designed by Respondent's personnel. Tr. I, 211-15, 221.

Respondent's Safety Trainer David Hicks testified regarding Respondent's fall protection training. Hicks stated that in addition to his normal electrical duties, he had previously worked as a deckhand and drafted barges. Tr. I, 236. Hicks stated that he had always interpreted 30 CFR 77.1710(g) as applying to potential falls onto hard surfaces. Tr. I, 255. Hicks acknowledged that an SCH worker had previously fallen into the river, but swam safely to shore with the use of a lifejacket. Tr. I, 247.

Marine Surveyor James Manley testified for the Respondent regarding industry practices on navigable barges. Manley had worked as marine surveyor for 37 years and owned a fleet of towboats and barges. Tr. II, 8. Manley had previously testified as an expert witness on marine practices in federal admiralty courts. Tr. II, 9. He stated that deckhands never tie off to navigable barges while maneuvering, securing, or drafting barges. Tr. II, 14, 16. Manley explained that tying off to a navigable barge increased the dangers associated with working around loading equipment and other moving barges. Tr. II, 17, 27. He opined that a fall from a barge into water did not present a fall hazard in itself and the use of a lifejacket minimized drowning hazards. Tr. II, 16-17.

Manley did state that fall protection was used at barges when elevated work was performed above a hard surface. Tr. II, 16. On cross-examination, Manley explained that wing hatches on a typical coal barge are 18 inches in diameter and are not large enough for it to be likely for a significant fall or injury to occur. Tr. II, 34-35. He specifically stated that the eighteen inch wing hatches did not present a fall hazard similar to the four foot by seven foot hatch on a covered barge that had been involved in a fatality at a different operator's facility. Tr. II, 32-34. Manley testified that the typical coal barge has a three foot high combing that protects deckhands from falling into the interior cargo and allows workers to maintain three points of contact while walking on the exterior gunnel. Tr. II, 42-43. Manley specifically stated that the exterior gunnel, or wing deck, of an open coal barge is three feet three inches wide. *Id.*

## **2. The Cited Standard**

30 CFR 77.1710(g) mandates that:

Safety belts and lines (shall be worn) where there is danger of falling; a second person shall tend the lifeline when bins, tanks, or other dangerous areas are entered.

Within the same section, 30 CFR 77.1710(h) provides that:

Lifejackets or belts (shall be worn) where there is danger from falling into water.

The MSHA Program Policy Manual (PPM) states that:

Paragraph (g) of this section requires that safety belts and lines shall be worn where there is a danger of falling, except when safety belts and lines may present greater hazard or are impractical.

In those cases, the standard requires that alternative precautions be taken to provide the miners with an equal or greater degree of protection. Substantial scaffolding with adequate guardrails or safety nets are acceptable alternatives. The objective of this policy is to insure that miners working where there is a danger of falling are always protected.

PPM, Vol. V, p. 208-209.

MSHA's Program policy manual does not provide any specific guidance on 30 CFR 77.1710(h). However, the July 2010 PIB testified to by Inspector Hardison states that:

MSHA *recommends* the following Best Practices when working at river load out facilities:

Where possible, install and use lifeline tie-off runs and fall protection.

Where fall protection is not feasible, always wear a life jacket when working around bodies of water.

GX 5, 2 (emphasis added).

Neither 30 CFR 77.1710(h) nor the July 2010 PIB require or recommend the use of a particular type of lifejacket when there is a danger of falling into water. 30 CFR 77.1710(h); GX 5, 2.

### 3. Statutory Interpretation

An operator is entitled to the due process protection available in the enforcement of regulations. *Energy West Mining Co.*, 17 FMSHRC 1313, 1317 (Aug. 1995). When a violation of a regulation subjects private parties to criminal or civil sanctions, a regulation cannot be construed to mean what an agency intended but did not adequately express. *Id.* Laws must give a person of ordinary intelligence a reasonable opportunity to know what is prohibited, so that he may act accordingly. *Id.* at 1318. The Commission applies a reasonably prudent person test to determine, "whether a reasonably prudent person familiar with the mining industry and the protective purposes of the standard would have recognized the specific prohibition or requirement of the standard." *Id.*

A regulation must be interpreted so as to harmonize and not to conflict with the objective of the statute it implements. *Cumberland Coal Res., L.P. v FMSHRC*, 2005 WL 3804997 (D.C. Cir. 2005). Regulatory language cannot be construed in a vacuum and the words of a statute must be read in their context and with a view to their place in the overall statutory scheme. *Northshore Mining Company v. Secretary of Labor*, 709 F.3d 706, 710 (8<sup>th</sup> Cir. 2013). An agency's interpretation of its own standards should be given deference when the interpretation is sensible and in accord with purposes of the Act. *Energy West Mining Co v. FMSHRC*, 40 F. 3d

457, 460 (D.C. Cir. 1994). However, an agency's interpretation of a regulation is not owed deference if it fails to correspond to the apparent purpose of the regulation and overall placement within the regulation. *Northshore Mining*, 709 F.3d at 711-712 (holding that standard protecting workers from electrocution did not require protection from mechanical movement); *see also Phelps Dodge Corp. v. FMSHRC*, 681 F.2d 1189 (9<sup>th</sup> Cir. 1982). MSHA publications such as a PIB and or the PPM may aid the Commission in determining the proper application of a regulation. *Connolly Pac. Co.*, 33 FMSHRC 2270, 2277 (ALJ Miller)(Sept. 2011); *TwentyMile Coal Co.*, 30 FMSHRC 736, 738(Aug. 2008)(split decision upholding Secretary's interpretation when PIB detailed mandatory requirements of regulation).

#### 4. Party Arguments

The Secretary argues that 30 CFR 77.1710(g) is not limited to falls onto a particular type of surface. Sec'y Br., 20. The Secretary contends that deckhands were exposed to falls into both interior cargo holds and the water. *Id.* at 21. The Secretary states that the use of fall protection was feasible at Respondent's loading dock and that SCH management were aware of fall protection systems in use at other loading docks. *Id.* at 22. The Secretary argues that 30 CFR § 77.1710(g) applies to all fall hazards and 30 § CFR 77.1710(h) merely supplements 30 CFR § 77.1710(g) when water presents a hazard. *Id.* at 21-22. The Secretary argues that MSHA's failure to previously issue fall protection violations at the loading dock does not present a viable defense to Citation No. 7657715. Sec'y Br., 17; *Sec'y v. Mach Mining, LLC*, 34 FMSHRC 1769, 1774 (Aug 2012).

The Respondent argues that 30 CFR § 77.1710(g) is a generic standard while 30 CFR § 77.1710(h) is a specific standard that governs work around water. Resp. Br., 7. The Respondent contends that it complied with the applicable specific standard, 30 CFR 77.1710(h), by requiring Mr. Meyers and all other deckhands to wear a U.S. Coast Guard approved life vest during work on the barges. Resp. Br., 7. The Respondent also argues that the three foot high combing adequately protects deckhands from falls into the interior cargo. Resp. Br., 7-8. It contends that the PIB issued by MSHA in 2010 only *recommends* the use of fall protection on barges and specifically states that a life jacket shall be worn where fall protection is not feasible. Resp. Br., 5. The Respondent also argues that MSHA's failure to issue previous citations or notifications deprived it adequate notice of the legal position advanced at hearing by the Secretary. Resp. Br., 8, citing *Clintwood Elkhorn Mining*, 36 FMSHRC 1282, 1287-88 (ALJ Rae)(May 2014)(vacating alleged violation of 77.1710(g) when MSHA failed to issue citations regarding obvious condition prior to fatal fall; *Lanham Coal*, 13 FMSHRC 1341, 1333-34 (1991)(remanding case when ALJ failed to determine whether the 30 CFR 77.1710(g) provided adequate notice to the operator that the use of fall protection was required under the circumstances).<sup>2</sup>

#### 5. Findings

After reviewing all evidence submitted, I conclude that the Secretary has not shown that

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<sup>2</sup> On remand, the ALJ determined that despite evident hazards, a reasonable person familiar with industry practices would not have realized that tarping a truck required the use of safety belts and lines and vacated the citation. *Lanham Coal*, 13 FMSHRC 1710, 1712 (ALJ Broderick)(October 1991).

the Respondent violated 30 CFR 77.1710(g). As an initial observation, I again note that Inspector Hardison conceded he had no previous work or inspection experience at loading docks. Tr. I, 83, 127. Although Mr. Hardison claimed that he had previously inspected unfamiliar work sites, I found his application of 30 CFR 77.1710(g) to navigable barges vague and unsupported by any published guidance or industry practice. Tr. I, 31-32, 76-77. Furthermore, during cross-examination, I found his testimony evasive and non-responsive to questions regarding the application of the cited standard. Tr. I, 163-64. Additionally, I found the testimony of Mr. Rager, Mr. Hicks, and Mr. Manley straight forward, detailed, unequivocal and credible, and based upon many years of experience at dockside loading operations.

Subsection (g) of 30 CFR 77.1710 mandates that safety belts and lines must be used when there is a danger of falling. 30 CFR 77.1710(g). The Secretary failed to present any evidence that a fall of 8-10 feet into water presents a significant hazard in and of itself. On cross examination, Inspector Hardison conceded that there are distinct differences between a fall into water and a fall onto a hard surface. Tr. I, 159. Indeed, Safety Trainer Hicks testified another SCH worker had previously fallen into the river and swam to safety with the use of a lifejacket. Tr. I, 247.

The Secretary has submitted evidence of incidents at other loading docks where a worker drowned after falling into water and a separate incident in which a worker died after falling into an empty cargo hold through a large unprotected hatch. GX 5 and 7. However, these incidents reinforce this court's finding that the danger of falling into water is drowning while the danger of falling onto a hard surface is blunt trauma. Indeed, although the Secretary has argued that 30 CFR 77.1710(g) applies in situations of varying fall distances, all of the cases cited by the Secretary involve falls onto solid surfaces. GX 19; *Worley Blue Quarry, Inc.*, 25 FMSHRC 399, 401 (July 2003) (ALJ Melick); *Cannelton Indust. Inc.*, 7 FMSHRC 1077, 1078 (July 1985) (ALJ Melick); *Kaiser Steel Corp.*, 1 FMSHRC 343, 343 (May 1979).

Furthermore, the language of 30 CFR 77.1710(h) clearly mandates that,

Lifejackets or belts (shall be worn) where there is danger from falling into water.

30 CFR 77.1710(h).

Thus, the plain text of 30 CFR 77.1710 specifies that the required means of compliance for a possible fall into water is the use of a lifejacket. 30 CFR 77.1710(h).

Additionally, MSHA's July 8, 2010 PIB explicitly recognizes that the use of a lifejacket on a barge without fall protection is allowable in situations where fall protection is infeasible. GX 5, 2; *see also* PPM, Vol. V, p. 208-209 (stating that alternate means of protection may be used to comply with 30 CFR 77.1710(g) when safety lines are hazardous or impractical). In this regard it is important to note, despite the absence of fall protection, MSHA did not find that the operator had violated 30 CFR 77.1710(g), after investigating the accident upon which the July 8, 2010 PIB was based. MSHA Accident Investigation Report, CAI-2008-30 (investigating drowning that occurred on river based coal barge and issuing one citation for a violation of 30



CFR § 48.31(a)).<sup>3</sup> Indeed, MSHA had not cited *any* coal terminal operators for a violation of 30 CFR § 77.1710(g) in the five years prior to the issuance of this citation. Jt. Stip. 25.

Thus, MSHA has not previously applied the interpretation of 30 CFR 77.1710(g) advanced by the Secretary at hearing in the instant matter. CAI-2008-30; Jt. Stip. 25. It is well established that a previous inconsistent enforcement pattern by MSHA inspectors does not offer a defense to a correct application of the standard. *Mach Mining, LLC*, 34 FMSHRC 1774. However, in this case, MSHA's previous enforcement history of 30 CFR 77.1710(g) merely reinforces this court's independent finding that the Secretary's instant interpretation of 30 CFR 77.1710(g) is unreasonable and contradictory to the plain text of 30 CFR 77.1710, the PPM, and the PIB. 30 CFR 77.1710 (g)-(h); PPM, Vol. V, p. 208-209; Sec'y Ex. 5, 2.

During cross examination of Mr. Rager, the Secretary's counsel alluded to available fall protection systems but did not submit any exhibits or testimony regarding systems available at the time of the incident. Tr. I, 229-30; GX, 22. Additionally, Rager and Manley consistently and credibly testified that the use of fall protection on open coal barges was highly unusual and increased the likelihood of entrapment and crushing hazards. Tr. I, 192-93; Tr. II, 14, 27. Therefore, I find that the Respondent has credibly demonstrated that the use of fall protection on the coal barge at issue was infeasible at the time of the accident.<sup>4</sup>

I further find that the Respondent has submitted convincing rebuttal evidence that the 36-40 inch high combing adjacent to the gunnel protected workers from falls into the interior cargo hold. Tr. I, 195; Tr. II, 42-43. Finally, I conclude that the Secretary's assertion that 30 CFR 77.1710(g) imposes additional requirements upon water-side workers who are in compliance with 30 CFR 77.1710(h) is contradictory to both the plain language of 30 CFR 77.1710 and MSHA's official guidance on the two standards. 30 CFR 77.1710(g)-(h); PPM, Vol. V, p. 208-209; GX 5, 2.

Therefore, I find that the interpretation of 30 CFR 77.1710(g) advanced by the Secretary at hearing is undeserving of deference. *Northshore Mining*, 709 F.3d at 711-712. In a situation where the use of safety lines was infeasible, the Respondent provided the statutorily required means of protection for a possible fall into water by requiring all deckhands, including Mr. Meyers, to wear a U.S. Coast Guard approved lifejacket. 30 CFR 77.1710(h); Sec'y Ex. 5, 2. The Respondent also complied with the general requirements of 30 CFR 77.1710(g) by maintaining barge combings that protected workers from falls into the interior cargo hold. Tr. I, 195; PPM, Vol. V, p. 208-209 (stating that the use of guardrails to prevent falls provides an

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<sup>3</sup> <http://www.msha.gov/FATALS/2008/ft108c30.pdf>.

<sup>4</sup> Mr. Rager testified in detail regarding comprehensive abatement efforts undertaken by Respondent after the accident including the use of an improvised tie-off method during drafting. Tr. I, 211-215. This court finds that these remedial efforts, while admirable best management policies, are not mandatory measures required by the current language of the Mine Act or the Secretary's regulations. Indeed, the Respondent adopted several of these measures under duress from MSHA and has credibly asserted that the prohibition on walking the outside gunnel increases the risks of a barge sinking during loading due to undetected damage or imbalance. Tr. I, 196-97. Most critically, it would be inappropriate to rely upon the Respondent's remedial measures following the accident to establish liability under the Mine Act. *Russell Collins and Virgil Kelley v. Secretary of Labor*, 5 FMSHRC 1339, 1352; Federal Rule of Evidence 407.

alternate means of compliance for 30 CFR 77.1710(g)). Accordingly, Citation No. 7657715 is **VACATED**.

### **C. Citation No. 7657713**

Inspector Hardison issued Citation No. 7657713 for an alleged violation of 30 CFR § 48.27(a) on September 18, 2012. He alleged within the citation that:

The mine operator failed to provide task training for employees regarding the use of safety belts or lines where there is a danger of falling. The mine operator's failure to provide adequate training in the use of safety belts or lines contributed to the fatality involving a deckhand on February 26, 2012.

GX 9, 1.

Hardison designated Citation No. 7657713 as a high negligence violation that contributed to the occurrence of a fatal injury. The Secretary has proposed a specially assessed penalty of \$52,500.00 for Citation No. 7657713. GX 13, 3.

#### **1. Testimony**

Inspector Hardison testified the Respondent's records indicated that Respondent had failed to train employees on the fall protection hazards involved in loading coal barges. Tr. I, 85. Hardison stated that he inspected the training records for Mr. Meyers specifically and did not find any record for instructions regarding fall hazards associated with loading barges. Tr. I, 87. Hardison maintained that the failure to train Meyers in the use of fall protection contributed to his fall and fatality. Tr. I, 93-94. Hardison confirmed that the Respondent employed an MSHA certified trainer to provide safety training to employees. Tr. I, 92.

Respondent's Safety Trainer David Hicks testified regarding the training he provided Mr. Meyers and other SCH employees prior to February 26, 2012. Hicks testified that he had conducted the MSHA required 8 hour annual refresher training at the Calvert City terminal for over seven years. Tr. I, 236. Hicks stated that he submitted copies of his training plans to MSHA for their approval prior to conducting the refresher class. Tr. 237. Hicks testified that all employees, including deckhands, were provided fall protection training concentrating on methods of avoiding falls onto hard surfaces. Tr. I, 239. He stated that MSHA inspectors had previously sat in on the annual refresher course. Tr. I, 238. Hicks testified that he dedicated one hour of the annual refresher course to fall protection requirements. Tr. I, 239. Hicks stated that he had provided the annual refresher course, including the fall protection section, to Kevin Meyers in 2010 and 2011. Tr. I, 247; RX 1, 2-3.

Hicks testified that new deckhands were trained before being allowed to work on the barges. Tr. I, 241. He explained that deckhands were first taken on a tour of the loading dock and shown trip hazards and pinch points. Tr. I, 241-42. Hicks stated that new employees spent their first shift observing loading operations from the facility shack. *Id.* He testified that once a

deckhand received hands on training on the dock, the trainer and the worker signed a form certifying that the training had been completed. *Id.* On cross-examination, Hicks explained that he specifically warned new deckhands to avoid stepping on man hatches, maintain good housekeeping, and keep three points of contact with the gunnel while working on the barge. Tr. I, 255. The Respondent submitted a copy of the syllabus for the annual refresher training, which included sections on slip/trip hazards and fall protection. Tr. I, 237; Resp. Ex. 1, 2-3.

## **2. The Cited Standard**

The cited standard, 30 CFR § 48.27(c), requires that:

Miners assigned a new task not covered in paragraph (a) of this section shall be instructed in the safety and health aspects and safe work procedures of the task, including information about the physical and health hazards of chemicals in the miner's work area, the protective measures a miner can take against these hazards, and the contents of the mine's HazCom program, prior to performing such task.

## **3. Findings**

The parties stipulated that Kevin Meyers participated in an 8 hour annual refresher course on July 22, 2011. Jt. Stip. 24. After reviewing Hardison's testimony it appears that Hardison located task training records for SCH deckhands, including Mr. Meyers, but based Citation No. 7657713 on a failure to instruct deckhands on the use of safety lines during barge loading operations. Tr. I, 88-89. However, I have held above that the Respondent complied with both 30 CFR § 77.1710(g) and 30 CFR § 77.1710(h) through the use of protective barge combings and life vests. Thus, the Respondent was not obligated to provide training on barge-based safety lines not required by the Secretary's regulations.

Additionally, I credit Safety Trainer Hicks detailed testimony regarding new deck hand training and annual-refresher courses provided to all SCH deck hands. Tr. I, 239, 241-42. Accordingly, I find that the Respondent provided new task training pursuant to 30 CFR 48.27(c) to all SCH deckhands, including Kevin Meyers, regarding possible hazards and appropriate safety measures during barge loading activities. Therefore, Citation No. 7657713 is **VACATED**.

### **D. Citation No. 7657714**

Inspector Hardison issued Citation No. 7657714 for an alleged violation of 30 CFR § 50.10(a) on September 18, 2012. He alleged within the citation that:

The mine operator failed to contact MSHA in a timely manner after the occurrence of a fatal accident. The operator shall immediately contact without delay and within 15 minutes at the

toll-free number, 1-800-746-1553, once the operator knows or should know that an accident has occurred.

GX 10, 1.

Hardison designated Citation No. 7657714 as a non-contributory violation but noted that a fatal injury had occurred and alleged that the failure to report the fatality was due to high negligence. GX 10, 1-2. The Secretary has proposed a regularly assessed penalty of \$5,700.00 for Citation No. 7657714. GX 13, 3.

### **1. Testimony**

Inspector Hardison testified that load-out operator Matt Kissiar first issued a radio lookout for Kevin Meyers at 1:15 a.m. Tr. I, 113. Hardison stated that a Wepfer Marine deckhand then located Mr. Meyers' baseball cap in the river at 1:25 a.m. Tr. I, 114. Hardison testified that the Marshall County Rescue Squad did not find Meyers body until 2:36 a.m.. Tr. I, 116. Hardison stated that as the river was 47 degrees, the Respondent should have contacted MSHA by 1:40 a.m. fifteen minutes after the Wepfer Marine deckhand located Meyers' ball cap in the river. Tr. I, 120. Hardison testified that the Arlington, Virginia MSHA Call Center report indicated that Respondent first reported Mr. Meyers missing at 2:41:15 a.m. Hardison stated the Arlington Call Center adjusted this time to reflect the Central Time Zone for the Calvert City Terminal. Tr. I, 118. However, Hardison acknowledged that the Arlington Call Center, which is in the eastern time zone, had previously failed to adjust call times to reflect the time zone where an incident had occurred. Tr. I, 118-119. On cross-examination, Hardison confirmed that the MSHA Accident Report on Mr. Meyers' fatality stated that Respondent contacted the Arlington Call Center at 1:40 a.m. Tr. I, 148-49.

The Respondent did not offer direct testimony on Citation No. 7657714. Tr. I, 207.

### **2. The Cited Standard**

The cited standard, 30 CFR § 50.10(a), requires that:

The operator shall immediately contact MSHA at once without delay and within 15 minutes at the toll-free number, 1-800-746-1553, once the operator knows or should know that an accident has occurred involving:

(a) A death of an individual at the mine.

30 CFR 50.10 also requires operators to contact the MSHA hotline within 15 minutes for:

(b) An injury of an individual at the mine which has a reasonable potential to cause death;

(c) An entrapment of an individual at the mine which has a reasonable potential to cause death; or

(d) Any other accident.

### 3. Findings

I first find that Respondent did not have reason to know of a death until 2:36 a.m. Central Time when Mr. Meyers' body was recovered unresponsive at the rake of the fixed barge.<sup>5</sup> Tr. I, 116. As such, Inspector Hardison's claim that Respondent failed to contact the MSHA call center until 2:41 a.m. Central Time does not support a violation of 30 CFR 50.10(a). Tr. I, 119.

However, I do find that the Respondent's management was nonetheless obligated by 30 CFR 50.10(b) to contact MSHA within 15 minutes of learning that Mr. Meyers had likely fallen into the river and was exposed to potential serious injuries. 30 CFR 50.10(b); *Faith Coal Co.*, 19 FMSHRC 1357, 1361-62 (Aug. 1997) (holding that an ALJ may adjudicate issues presented at hearing in reference to an alternate standard when the Respondent has appropriate notice). As the Respondent's counsel cross-examined Inspector Hardison regarding the requirements of both 30 CFR 50.10(a) and 30 CFR 50.10(b), I find that the Respondent had adequate notice of the duties imposed upon the operator by 30 CFR 50.10(b). Tr. I, 154-55.

The evidence submitted to this court indicates that a Wepfer Marine deckhand retrieved Mr. Meyers' baseball hat from the river at approximately 1:25 a.m. central time and SCH personnel contacted Respondent's management to report Meyers' disappearance within minutes.<sup>6</sup> Tr. I, 129; Sec'y Ex. 3, 8. As such, I find that Respondent's management officials learned of Meyers' disappearance at approximately 1:30 a.m..<sup>7</sup>

The MSHA escalation report indicates that SCH personnel first contacted the Arlington call center at "2:41:15 a.m.," was disconnected due to technical difficulties, and then immediately called back to report a missing worker and possible drowning. Tr. I, 118; GX 2, 1. The escalation report indicates that the caller reported the time of the incident as "1:45" a.m. *Id.* The MSHA escalation report does not specify a time zone for any of the times listed on the

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<sup>5</sup> Both parties' testimony indicates that SCH workers had previously fallen into the river and swam to safety without injury. Tr. I, 76, 247. As such, this court declines to find that the Respondent had reason to know of a fatality when Mr. Myers ball cap was spotted in the river by a Wepfer Marine deckhand at 1:25 a.m..

<sup>6</sup> Prior to hearing, the Secretary submitted deposition transcripts from SCH personnel involved in rescue efforts on February 26, 2012 for this court's consideration. During deposition, SCH personnel consistently stated that load out operator Matt Kissiar radioed supervisor Matt Foley shortly after a Wepfer Marine employee located Myer's ball cap. According to their depositions, Foley in turn notified assistant terminal manager Jerry Jones who first called the MSHA call center and then notified Dan Bailey of Myer's disappearance. Sec'y Motion for Summary Judgment: Matt Foley Dep. 27-28; Matt Kissiar Dep. 21-22; Jerry Jones Dep., 6,-10.

<sup>7</sup> All testimony and evidence submitted to this court regarding search efforts at the loading dock, including Inspector Hardison's notes, are indicated as approximate times provided by the Respondent's personnel after the occurrence of the accident. From this evidence, I have determined that Respondent's management was notified that an employee was missing and had possibly fallen into the river at approximately 1:30 a.m. Central Time.

report, including the incident time provided by the caller. *Id.*

The MSHA accident investigation report issued on September 17, 2012 states that, “On Sunday February 26, 2012 at 1:40 a.m., the mine operator notified the Mine Safety and Health Administration of the accident.” GX 8, 5. The accident report lists the other citations contained in this decision but does not list Citation No. 7657714 as one of the enforcement actions taken in response to the fatality. Thus, Inspector Hardison’s claim that the Respondent failed to contact the Arlington Call Center until 2:41 a.m. Central Time is contradicted by the MSHA accident report submitted to this court by the Secretary. Tr. I, 119; GX 8, 5, 9.

At hearing, Inspector Hardison asserted that the Arlington Call Center adjusted the recorded time of the call to reflect Central Time. Tr. I, 119. However, Hardison did not provide any support for that belief and acknowledged that the call center had failed to adjust call times to the appropriate time zone in the past. *Id.* Indeed, as the escalation report recorded the call-time down to the second, it appears that the call-time was recorded automatically. Tr. I, 118, GX 2, 1. As the Arlington Call Center is located in the Eastern time zone, I find that this automatic time record indicates that the initial call was received at 2:41:15 Eastern Time.<sup>8</sup> Thus, I find that Respondent’s management contacted MSHA at 2:41 a.m. Eastern Time, or 1:41 a.m. Central Time.

As Respondent’s management learned of Mr. Meyers’ disappearance at approximately 1:30 a.m. Central Time and contacted the MSHA call center at 1:41 a.m. Central Time, I find that the Respondent contacted the MSHA call center within 15 minutes of a reportable injury per 30 CFR 50.10(b). Thus, the evidence presented at hearing fails to support a violation of either 30 CFR 50.10(a) or (b). Accordingly, Citation No. 7657714 is **VACATED**.

#### **E. Citation No. 7657716**

Inspector Hardison issued Citation No. 7657716 for an alleged violation of 30 CFR § 77.207 on September 18, 2012. He alleged within the citation that:

Illumination was not adequate to provide a safe walkway in work areas along the perimeter of the barges that were being measured for draft. The barges being measured were away from the main lighting system that was focused on the area where coal was being loaded into the barges. The lack of walkway illumination contributed to a fatality involving a deckhand on February 26, 2012.

Hardison designated Citation No. 7657716 as a high negligence violation that contributed to the occurrence of a fatal injury. GX 12, 1. The Secretary has proposed a specially assessed penalty of \$52,500.00 for Citation No. 8436107. GX 13, 3.

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<sup>8</sup> This court finds that confusion regarding the time zone of the accident location on the part of the Arlington Call Center is not surprising, given that the state of Kentucky occupies both the Central and Eastern time zones.

## 1. Testimony

The parties have stipulated that Kevin Meyers was carrying a handheld flash light along with a drafting stick prior to the accident. Jt. Stip. 18. At hearing, Inspector Hardison stated that he issued this citation after interviews with workers who had observed lighting conditions at the loading dock prior to the accident. Tr. I, 96-97. Hardison stated that he determined from these interviews that permanent lighting was focused on the fixed loading dock itself but barges in line for loading were not adequately illuminated. Tr. I, 99. Hardison testified that after Mr. Meyers went missing, Respondent used tugboat lights to search the area around the barges. Tr. I, 106. Hardison stated that after the accident occurred, Respondent installed additional lighting and provided workers with cap lights. Tr. I, 102. Inspector Hardison confirmed at hearing that he did not observe the Respondent's loading dock at night prior to the installation of additional lighting. Tr. I, 104.

Respondent's Chief Operating Officer Rager testified that prior to the accident, the entire loading dock area was lit by both walkway lighting on the fixed barge and dolphin mounted stadium type lighting. Tr. I, 203. Rager also stated that Respondent's loading dock was located next to an industrial park that was extremely well lit. Tr. I, 205. Rager explained that Mr. Meyers and other deckhands used their flashlights primarily to check wing tanks and cargo boxes for water. Tr. I, 204. Rager stated that he maintained an open door policy regarding safety concerns and had never received any employee complaints regarding lighting at the loading dock Tr. I, 203. Rager explained that at the time of the accident, light weight MSHA approved cap lights had only recently become available. Tr. I, 209-10.

Safety Trainer Hicks confirmed that after the accident, Respondent installed additional lighting at the fixed loading dock that pointed upstream and downstream from the fixed work barge. Tr. I, 244. Hicks referenced an inspection photo and marked which lights were added after the accident.<sup>9</sup> Tr. I, 244-45; GX 4, 63. Hicks maintained that the lighting in place prior to the accident was sufficient for loading operations. *Id.* However, on cross-examination, Hicks conceded that prior to the accident it was necessary to use a flashlight to see when drafting on the outside edge of the barge. Tr. I, 252-53.

## 2. The Cited Standard

30 CFR § 77.207 mandates that:

Illumination sufficient to provide safe working conditions shall be provided in and on all surface structures, paths, walkways, stairways, switch panels, loading and dumping sites, and working areas.

30 CFR § 77.207.

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<sup>9</sup> I have not relied upon the addition of new lighting standards after the accident as evidence of a violation. See FRE 407. Instead, I have relied upon Safety Trainer Hicks testimony regarding Inspector Hardison's inspection photo to determine which lights were in place on February 26, 2012. Tr. 244-45; GX 4, 63.

### 3. Findings

As SCH deckhands regularly walked the perimeter of upstream barges while drafting, I find that the Respondent was obligated to provide adequate lighting for in-line barges worked on by its employees. Tr. I, 198. As mentioned above, Kevin Meyers was carrying a handheld flash light along with a drafting stick the night of the accident. Jt. Stip., 18. The Commission has previously held that portable handheld lighting may satisfy 30 CFR § 77.207 when such lighting is adequate and safe to use for that situation. *Capitol Aggregates*, 3 FMSHRC 1388, 1390 (June 1981). However, the Commission also clearly stated that reliance on handheld lighting is inappropriate where use would make work unsafe or fail to provide adequate light. *Id.* The Respondent has argued that SCH deckhands could safely walk and work on the barges with a flashlight in one hand and the drafting stick in another, or alternately lay the flashlight down while drafting. Tr. I, 227-28, 252-53. However, the upstream barges were several hundred feet long, loosely tied off to the fixed barge and subject to movement. Tr. I, 193,198, 252-53. As such, I find that the handheld flashlight did not provide sufficient illumination for the deckhands and increased the hazards of working on the barge. Tr. I, 198, 252-53. Accordingly, I find that Respondent was obligated to provide permanent lighting sufficient to illuminate the working surfaces of the upstream barges in addition to the areas of the fixed loading dock.

Inspector Hardison has maintained that interviews with workers immediately after the accident indicated that in-line barges upstream from the fixed loading dock were not sufficiently illuminated by permanent lighting. Tr. I, 96-97. The Respondent has objected to Hardison's testimony as hearsay evidence not corroborated by his inspection notes. Resp. Br., 10. However, after reviewing Hardison's inspection notes, it is apparent that Hardison did record general concerns regarding the need for additional lighting of barges immediately after the accident within his February 26, 2012 inspection notes. GX 3, 17. As hearsay evidence is generally admissible at Commission proceedings, I have considered Hardison's summary of his interviews with workers as support for the Secretary's allegations. *REB Enterprises, Inc.*, 20 FMSHRC 203, 206 (Mar. 1998). Additionally, Hardison's summary and inspection notes are corroborated by Safety Trainer Hick's admission that the outside edges of the barges were not lit and required the use of a flashlight to see properly. Tr. I, 252-253.

Finally, upon this court's review, the photos taken by Inspector Hardison on February 26, 2012 and October 23, 2012 indicate that the lighting in place at the time of the accident was focused on the fixed loading dock and barges immediately alongside the fixed loading dock.<sup>10</sup> GX 4, 26-27, 62-63; Tr. I, 244. Accordingly, I find that the evidence submitted supports Inspector Hardison's reasonable inference that the upstream barge Mr. Meyers was working on at the time of his accident was not sufficiently illuminated. *Mid-Continet Res. Inc.*, 6 FMSHRC 1132, 1138 (May 1984). Thus, Citation No. 7657716 is **AFFIRMED**.

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<sup>10</sup> The Respondent objected to separate photos contained in GX 4, 28-34 and stated that these photos were of a different facility. Tr. I, 217-28. However, Safety Trainer Hicks confirmed that GX 4, 62-63 were photos of Respondent's fixed loading dock and explained which lights had been added after the accident. Tr. I, 244-45.



### **a. Significant and Substantial**

A violation is Significant & Substantial (S&S), “if based upon the particular facts surrounding the violation there exists a reasonable likelihood that the hazard contributed to will result in an injury or illness of a reasonably serious nature.” *Cement Division, National Gypsum Co.*, 3 FMSHRC 822, 825 (Apr. 1981).

In order to uphold a citation as S&S, the Commission has held that the Secretary of Labor must prove: 1) the underlying violation of a mandatory safety standard; (2) a discrete safety hazard—that is, a measure of danger to safety—contributed to by the violation; (3) a reasonable likelihood that the hazard contributed to will result in an injury; and (4) a reasonable likelihood that the injury in question will be of a reasonably serious nature. *Mathies Coal Co.*, 6 FMSHRC 1, 3-4 (Jan. 1984).

I have already held that the Respondent violated 30 CFR § 77.207 by failing to provide adequate illumination for the inline barges. Additionally, this violation contributed to the discrete safety hazard of deckhands not having enough light to recognize and avoid trip, fall, and caught between hazards. Furthermore, as the large barges varied in configuration and were subject to movement, the lack of lighting was reasonably likely to cause a trip, fall, or caught between injury. Tr. I, 193. The failure to light the in-line barges also increased the difficulty of treating and or rescuing injured persons. Tr. I, 106-07. For all of these reasons, I find that the lack of illumination was reasonably likely to contribute to a fatal injury.

### **b. Negligence**

The Mine Act defines reckless disregard as conduct which exhibits the absence of the slightest degree of care, high negligence as actual or constructive knowledge of the violative condition without mitigating circumstances; moderate negligence as actual or constructive knowledge of the violative condition with mitigating circumstances; and low negligence as actual or constructive knowledge of the violative condition with considerable mitigating circumstances. 30 CFR § 100.3: Table X.

Prior to the accident, Respondent’s deckhands regularly drafted in-line barges upstream from the fixed loading dock. Tr. I, 198. The Respondent has contended the lights on the fixed loading dock, dolphin mounted lighting, and ambient lighting from a nearby industrial plant all made the area very well lit. Tr. I, 203, 205. The Respondent has also emphasized that MSHA had never issued any citations regarding illumination at the loading dock and had just finished an annual inspection of the SCH terminal two days before the accident. Resp. Br., 10. However, it is clear that the Respondent’s own safety trainer was aware that it was necessary to use a flashlight to see properly at the outside edges of the barges while drafting. Tr. I, 252-253. As such, the Respondent had actual knowledge that the inline barges were not sufficiently lit by permanent lighting. Given the inherent dangers of working on a movable barge, I find that the Respondent has not submitted credible evidence of mitigating circumstances for failing to provide permanent lighting for workers on upstream barges. Therefore, I find that the violation was the result of the Respondent’s high negligence.

#### 4. Penalty

It is well established that Commission administrative law judges have the authority to assess civil penalties de novo for violations of the Mine Act. *Sellersburg Stone Company*, 5 FMSHRC 287, 291 (March 1983). The Act requires that in assessing civil monetary penalties, the Commission ALJ shall consider the following six statutory penalty criteria:

[1] the operator's history of previous violations, [2] the appropriateness of such penalty to the size of the business of the operator charged, [3] whether the operator was negligent, [4] the effect on the operator's ability to continue in business, [5] the gravity of the violation, and [6] the demonstrated good faith of the person charged in attempting to achieve rapid compliance after notification of a violation.

30 U.S.C. 820(I).

For all penalty assessments, the Secretary bears the burden of establishing the proposed penalty is appropriate based upon the statutory criteria of Section 110(i) of the Act. *In re: Contest of Respirable Dust Sample Alteration Citations*, 14 FMSHRC 239, 241 (ALJ Broderick) (January 1992) (Order). Similarly, for specially assessed penalties in excess of the standard penalty calculation, the Secretary has the burden of establishing the existence of aggravating factors to justify such an increase. *S&M Construction, Inc.*, 18 FMSHRC 108, 1052-53 (ALJ Koutras) (June 1996); *Freeport McMoran Morenci, Inc.*, 35 FMSHRC 172, 181 (ALJ Miller) (January 2013)

A regular assessment of Citation No. 7657716 would have resulted in 110 penalty points and a penalty of approximately \$6,115.00. GX 12, 1; 30 CFR § 100.3 Table XIV. The Secretary has asserted that all citations related to fatalities receive consideration for Special Assessment. Sec'y Br., 32-33. However, the Special Assessment Narrative Form submitted by the Secretary merely restates negligence and gravity findings that are already accounted for in a regular assessment, including the occurrence of a fatality. GX 12, 1. As the Secretary has not submitted specific evidence of aggravating factors necessary to support the specially assessed penalty, I have performed the following review of the evidence presented based upon the statutory criteria of Section 110(i).

The Respondent has a low overall violation rate and MSHA had not previously issued any illumination citations at the SCH terminal loading dock. GX 13, 3; 30 CFR § 100.3 Table VI. Exhibit A of the Secretary's Petition indicates that the Calvert City terminal is a small mine and that the Respondent is a small operator with zero tons of coal produced. *Id.* However, the Respondent has testified that it operates at least five different coal handling facilities and it appears that the Calvert City terminal alone processes approximately twelve million tons of coal annually.<sup>11</sup> Tr. 184-85. As such, the Respondent appears to be more appropriately considered a large operator. I have found that Respondent was highly negligent in failing to provide adequate lighting on the in-line barges. In particular, I have noted that SCH safety personnel had actual

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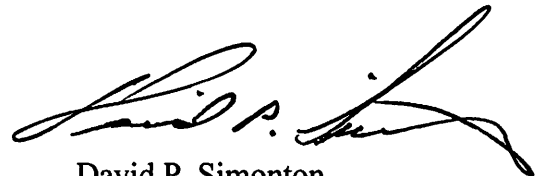
<sup>11</sup> <http://www.sch-ces.com/cct.html>

knowledge of the inadequate lighting conditions on in-line barges. Tr. I, 252-53. The parties have stipulated that the proposed penalty will not affect the Respondent's ability to continue in business. Jt. Stip., 4. The failure to adequately illuminate the in-line barges was a significant and substantial violation that reasonably could have, and apparently did, contribute to a fatal accident. Tr. I, 106-07. Subsequent to Mr. Meyers' accident and the issuance of this citation, the Respondent has provided deckhands with new LED cap lights and installed upstream and downstream lighting standards. Tr. I, 209-10, 244.

After considering all of these factors, I find that a civil penalty of \$25,000.00 is an appropriate civil penalty for Citation No. 7657716.

#### IV. ORDER

Based on the findings above Citation Nos. 7657715, 7657713, and 7657714 are **VACATED** and Citation No. 7657716 is **AFFIRMED**. SCH Terminal Company, Inc, is hereby **ORDERED** to pay the Secretary of Labor the total sum of **\$25,000.00** within 30 days of this order.<sup>12</sup>



David P. Simonton  
Administrative Law Judge

Distribution: (First Class U.S. Mail)

Willow E. Fort, U.S. Department of Labor, Office of the Solicitor, 618 Church Street, Suite 230, Nashville, TN 37219

Flem Gordon, Gordon Law Office, 121 W. Second Street P.O. Box 1146 Owensboro, KY 42303

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<sup>12</sup> Payment should be sent to: MINE SAFETY AND HEALTH ADMINISTRATION, U.S. DEPARTMENT OF LABOR, PAYMENT OFFICE, P. O. BOX 790390, ST. LOUIS, MO 63179-0390