

FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

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January 23, 2020

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

v.

SUPERIOR SILICA SANDS LLC,
Respondent.

CIVIL PENALTY PROCEEDINGS

Docket No. CENT 2019-0133
A.C. No. 41-01126-482167

Docket No. CENT 2019-0171
A.C. No. 41-01126-484042

Mine: Superior Silica Sands San Antonio
Plant

DECISION AND ORDER

Appearances: Lindsay A. Wofford and Phillip Marquez, U.S. Department of Labor, Office of the Solicitor, Dallas, Texas, for Petitioner;

Joseph A. Fisher, III and Benjamin Rhem, Jackson Walker LLP, Houston, Texas and Austin, Texas, for Respondent.

Before: Judge Miller

These cases are before me upon petitions for assessment of a civil penalty filed by the Secretary of Labor pursuant to Section 105(d) of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 815(d) (“the Act”). These cases involve one citation and two orders issued pursuant to Section 104(d)(1), with a total proposed penalty of \$49,195.00. The parties presented testimony and evidence regarding the citations at a hearing held in San Antonio, TX commencing on November 6, 2019.

The Superior Silica Sands San Antonio Plant is an open pit, surface sand mine located in Bexar County, Texas. The parties have stipulated that Superior Silica is an “operator” as defined in Section 3(d) of the Mine Act, 30 U.S.C. § 803(d), and that the mine is subject to the provisions of the Mine Act and the jurisdiction of the Commission. Tr. 6–7; Sec’y Amend. Prehearing Submissions at para. 4.a–g.

I. FINDINGS OF FACT AND CONCLUSIONS OF LAW

The citation and two orders at issue in this proceeding involve railcars on the south section of the company owned rail spur at the Superior Silica Sands San Antonio Plant. On June 23, 2018, a fatal accident occurred at the mine when Rodney Fernandez, a 46-year-old electrician, was struck by two uncoupled railcars after attempting to set the manual handbrake. Fernandez had no previous mining experience and had been employed at Superior for about ten weeks. The accident occurred when Fernandez climbed on a set of moving railcars after they began to roll down the track while he was helping Plant Manager Chad Thomsen uncouple and move railcars from the south spur to the north spur. The parties agree that most of the facts in this case are not in dispute. There is, however, a dispute regarding the time on the day of the accident and what occurred between Thomsen and Fernandez leading up to the accident. At hearing, the parties agreed that the diagram taken from the MSHA accident investigation report and labeled as Joint Exhibit 1, would be used to facilitate testimony regarding the railcars and the rail spurs. The diagram labels the cars from one to six on the south spur, with a track mobile, also referred to as a Rail King, at the front of Railcar #1. The north spur shows a car labeled "spare". The cars are shown in the photographs in Secretary's Exhibit 2.

The problem with the railcars began on March 2, 2018, when railcar TILX 338713 (Railcar #4 on Joint Exhibit 1), was involved in an accident in the area of the south spur of the Superior rail line. The car derailed, and as a result, the brakes and underside of the car suffered significant damage. The mine hired a contractor to set the car back on the rail, and subsequently moved it into place on the south spur between Railcars #3 and #5, both of which had functioning brakes. The three cars were coupled together and signs were placed on Railcar #4 that read "DO NOT FILL." Sec'y Ex. 2, 9. The railcars are leased and at the time of the accident in June, no repairs had been made to Railcar #4.

Superior operated an old plant and a new plant. The mined product was moved by railcar at times from the old plant and onto a portable conveyor, which in turn was used to load material onto trucks. At times, material is loaded first onto the rail cars. The railcars operate on the rail spur, as seen on the second page of Secretary's Exhibit 2, to a load out area to be filled with sand and are then returned to the south spur until the sand is needed. When sand is needed, the portable conveyor is moved to the railcar to empty it by opening the bottom of the car, and loading material onto a conveyor that moves the sand from the railcar to a truck for transport out of the mine. There is conflicting evidence about the use of Railcar #4 from the time the brakes were damaged in March until the accident in June. The car was not filled and the mine asserts that the car had not been moved at all, but several witnesses indicated that the string of cars was moved on a weekly basis in order to take on sand for storage. Nonetheless, Railcar #4 remained in the string of cars and coupled to Railcars #3 and #5 on the rail spur from March until the accident in June.

Emilio Gonzales works as a team leader, primarily in the dryer, and sometimes loaded the railcars by opening a valve at the end of the silo's load out arm shown in Exhibit 2. Once loaded with sand, the railcars were moved back to the spur to wait unloading onto the trucks for transport out of the mine. Gonzales did not move the railcars and, in his view, that was done only by the veteran employees who knew the procedure and had moved them in the past.

After the derailment of Railcar #4 in March, but before the accident in June 2018, the mine provided railcar training to some of the miners at the old plant. Adian Amador-Doss attended the training for the full twenty hours over several days. Amador worked as a field mechanic and plant operator at Superior. Amador had been asked at one time to help move the railcars, but he refused, not only because he did not know how, but also because he believed it was not a good idea without the proper training. In May 2018, railcar training was given to Amador and five others, and included class time with videos and a number of handouts. Sec'y Ex. 21. The videos explained how the railcars operated and the hazards associated with working around them. After time in the classroom, the miners spent time around the railcars with demonstrations and hands-on training. Amador explained that at least three miners must be present when a train moves, each with a radio for communication. The training emphasized that trains can fail, and, in the case of a runaway train, miners were told "to let it go." Fernandez did not attend the railcar training.

On Saturday, June 23, 2018, Fernandez reported to work just before seven a.m. He spoke with Amador and Gonzales, and spent time with his immediate supervisor, Taft. Fernandez was the main electrician on site, but also performed general repairs. After discussing the tasks for the day, Taft and Fernandez went to the control room to inspect items that needed repair. Around 8:30 or 9:00 a.m., Taft was called away to look at a conveyor at the old plant, and he told Fernandez to stay at the control room to see if he could find the problem there.

Gonzales, who was working at the dryer that Saturday, greeted Fernandez when he arrived and then went back to work. Just before 9:00 a.m., Gonzales left the control room to change filters and saw Fernandez standing by the railcars. He did not see Thomsen. Gonzales changed the filters, collected a sample of sand, and walked back towards the new plant. As he was on the control room stairs, he looked out and saw Fernandez on the back of moving Railcar #6. At hearing, Gonzales said that one moment he said hello to Fernandez and the next thing he knew, Fernandez was on the moving rail cars. He explained that "Rodney was on the moving train, cranking on the manual brake as it was moving." He also described that Railcars #5 and #6, which were coupled to each other, began "rolling pretty good," and Gonzales could not believe that Fernandez would try to stop them. Fernandez was cranking on the wheel to set the brake as the train was headed for the spur where it would derail. Gonzales saw Fernandez attempt to jump off, and ran toward the cars while calling on the radio for help. Taft heard the radio call, called 911, and shut down the plant. A call went into the paramedics at 9:26 a.m. Sec'y Ex. 15.

According to the evidence gathered by the MSHA inspectors, Fernandez had been in the control room until close to 9:00 a.m. He then left, walked out to the railcar area, and spoke with Thomsen, the plant manager. Thomsen's plan was to first move a spare car coupled to the Rail King from the south spur to the north spur. Next, he planned to move the damaged Railcar #4, from its position with the five other cars on the south spur to the north spur, where it would be coupled with the spare car. Thomsen next planned to move the remaining five cars and offload the sand from Railcars #1 and #2 onto the conveyor. Tr.269. Although Thomsen was working earlier with a partner, he was alone at the railcars when he agreed that Fernandez could help. A few witnesses explained that Fernandez may have left the control room and arrived at the railcars as early as 8:40 a.m. to start the tasks with Thomsen, but the inspector concluded that he left

around 9:00. Although not all witnesses agreed, there is evidence to show that Fernandez may have been with Thomsen for up to 45 minutes, or as little as 25 minutes prior to the fatal accident.

Fernandez had no prior mining experience and had worked as an electrician at the mine for ten weeks. He had never worked with or around railcars, so he had to be task trained prior to completing the work with Thomsen. Thomsen explained that Fernandez was intelligent and caught on quickly. Shortly after Fernandez arrived, Thomsen started up the Rail King, the engine that would pull the cars from the south spur to the north spur. The Rail King had the spare car connected and Thomsen described the process to Fernandez, and then moved the Rail King with the spare car coupled down the south track. Fernandez was responsible for throwing the switch to change the tracks once the cars were in position. Thomsen backed the Rail King onto the north spur and the spare car was uncoupled. Then, the process was reversed, with Fernandez on the ground, changing the tracks as necessary. Next, the Rail King was backed onto the south spur and coupled with Railcar #1 to begin the process of moving Railcar #4 out of the line of cars. The plan was to uncouple Railcar #4 from Railcar #5, and move Railcars #1–4 down the south spur. Then, switch tracks and deliver Railcar #4 to the north spur to couple it with the spare car, and return with Railcars #1–3 to the south spur to couple with Railcar #5. Fernandez was tasked with uncoupling Railcar #4 from #5 to initiate the process.

The mine's maintenance supervisor, Taft, explained the process for moving the railcars as contemplated by Thomsen. Tr. 99–109. The process typically involves two people: an engineer and a ground person. The two miners communicate either by radio or by hand signals. The miners first complete a walk around or a visual check of each of the cars, set the air brakes from inside the Rail King, set the manual or mechanical brake on each car if not already set, and then ascertain that all cars are coupled or uncoupled, based upon what must be moved. It is the duty of the engineer to set the air brakes from inside the Rail King, and the ground person is tasked with setting the manual or park brake on each car by climbing onto an affixed ladder and turning the wheel until it can no longer move. *See* Sec'y Ex. 2, 22.

The process contemplated by Thomsen should have followed the scheme described by Taft, and, after completing a walk around inspection of the cars, setting each mechanical brake, starting at the back of Railcar #6, moving forward, before any cars were uncoupled or moved. The air brakes should have also been set and then Railcar #4 could have been uncoupled from Railcar #5 so that only Railcars #1–4 were moved with the Rail King. According to the testimony, coupling and uncoupling of cars does not take much time. Setting the manual brake is a longer task, as the miner on the ground must climb a ladder onto the back of each car and turn the wheel until it stops.

Following the move of the spare car, Fernandez and Thomsen began the process of moving the damaged Railcar #4 to the north spur.¹ In addition to learning the operation of the

1. At hearing, Thomsen explained that he and Fernandez moved the spare car to the north spur that same day prior to the accident. Thomsen indicated that during this process, Fernandez operated the rail switch. Barrick explained that he was not told during the investigation that Thomsen and Fernandez had successfully moved the spare car prior to the accident nor was that

switch, Fernandez had to learn how to complete a walk around inspection of the cars, couple and uncouple the cars, set the mechanical brake, and communicate with Thomsen. Thomsen, who had task trained miners in the past, explained that he had confidence in Fernandez after working with him for several weeks because Fernandez was intelligent and caught on quickly. At the time the two were coupling the Rail King to Railcar #1, Thomsen explained the tasks and demonstrated how to climb on the back of the car to set the brake. There is some dispute in the testimony at this point. Thomsen agrees that he did not observe Fernandez set a brake after he demonstrated the action, but he remembers that he did tell Fernandez to set the brakes. Inspector Barrick recalls his conversation with Thomsen differently; twice he was told that Thomsen did not tell Fernandez to set the brakes, but instead assumed Fernandez knew it should be done. Thomsen believed that the brakes on Railcars #5 and #6 were set, but could not explain why the cars began to roll away once uncoupled from Railcar #4. There is no disagreement that the manual brakes on both railcars #5 and #6 were not set when Thomsen began to move the first four cars forward.

Thomsen had a conversation with Fernandez about the process of moving the cars, then walked up the spur to the Rail King and climbed in, leaving Fernandez to uncouple Railcar #5 from Railcar #4. The Rail King was approximately 250 feet away from where Fernandez was uncoupling Railcar #5. Once Fernandez had uncoupled Railcar #5 from Railcar #4, he signaled to Thomsen to begin pulling the four railcars. As Thomsen began to pull the railcars, he looked out of the side window and saw Railcars #5 and #6, which were coupled to each other, rolling down the spur. Thomsen could not see Fernandez, so he stopped the train, ran down the track, and found Railcar #6 derailed and Fernandez lying between the tracks.

As a result of the accident, one citation and two orders were issued to Superior Silica on December 6, 2018. Citation No. 8660296 was issued for failure to properly task train a miner. Order Nos. 8660297 and 8660298 were issued for failure to effectively secure parked Railcars #5 and #6 by blocks or brakes, and for failure to maintain the braking system on Railcar #4 in functional condition, respectively.

A. CENT 2019-0171

Citation No. 8860296

Ten minutes after the accident occurred, MSHA was notified and Inspectors Lance Miller and David Tijerina, along with Lead Investigator Brett Barrick, were dispatched to the mine. As a result of the investigation into the accident, Inspector Barrick issued Citation No. 8860296 to the mine.

The citation states that:

An accident occurred on this mine site on 6/23/18, at approximately 9:20 am, when a miner was fatally injured while assisting in relocating a rail

fact included in the statement Thomsen gave to the 110(c) investigator several months after the accident. *See Resp't Ex. G.*

car. The miner uncoupled the last two rail cars and they began to roll away. The miner then ran to the moving cars and attempted to set the manual handbrake. The miner fell from the moving cars and was run over. The miner had not received adequate task training nor did he have any prior experience in this task. The Federal Mine Safety and Health Act of 1977 states that an untrained miner is a hazard to himself and to others. Management engaged in aggravated conduct constituting more than ordinary negligence in that it failed to instruct or ensure that the miner set the manual handbrakes or block the two cars from movement. This is an unwarrantable failure to comply with a mandatory standard.

The citation was designated as S&S and an unwarrantable failure, and the Secretary proposed a penalty of \$18,846.00 for this violation. The Secretary alleges that the operator violated 30 C.F.R. § 46.7(a), new task training, which requires that:

You must provide any miner who is reassigned to a new task in which he or she has no previous work experience with training in the health and safety aspects of the task to be assigned, including the safe work procedures of such task ... This training must be provided before the miner performs the new task.

30 C.F.R. § 46.7(a). The Secretary argues that Fernandez, who had never worked around railcars and had been at the mine only 10 weeks, needed further and more extensive task training; more than the 25-40 minutes provided by the plant manager, Chad Thomsen.

To prevail on a penalty petition, the Secretary bears the burden of proving an alleged violation by a preponderance of evidence. *RAG Cumberland Res. Corp.*, 22 FMSHRC 1066, 1070 (Sept. 2000), *aff'd*, 272 F.3d 590 (D.C. Cir. 2001); *Jim Walter Res., Inc.*, 9 FMSHRC 903, 907 (May 1987). The Secretary may establish a violation by inference in certain situations, but only if the inference is “inherently reasonable” and there is “a rational connection between the evidentiary facts and the ultimate fact inferred.” *Garden Creek Pocahontas Co.*, 11 FMSHRC 2148, 2152-53 (Nov. 1989).

Based upon information learned during the course of the investigation, MSHA Inspector Barrick determined that Fernandez had not received adequate task training. Prior to doing any work or moving any of the cars, Thomsen was required to task train Fernandez in all aspects of the job at hand that day. He was also required to—but did not— discuss safety hazards with Fernandez and specifically did not instruct him on the procedure in the event of a runaway railcar.

Barrick credibly testified that the mine had experienced a derailment several months prior to this accident and then held a training session in May, which lasted several days. Unfortunately Fernandez did not attend that training. *See* Sec’y Ex. 21 at 2. Thus, Fernandez’s only exposure to railcars was the training received just prior to the accident, from Thomsen. Thomsen explained to Barrick that he only demonstrated to Fernandez how to set the manual brake and to couple and uncouple the cars. In Barrick’s opinion, that limited training does not meet MSHA requirements. The training did not include any documents, manuals, or other

handouts, supervised demonstration of skills, or, crucially, an explanation of hazards associated with the task. Even if Fernandez had the ability to learn quickly, Barrick found it unreasonable to believe that the short amount of time was enough to adequately train Fernandez.

MSHA provides information to mine operators regarding its standards, including task training, which is published and mailed to each mine. MSHA's guidelines suggest that task training is an extensive process that should include providing handouts to miners, maintaining a task list in a training plan, using operator's manuals to determine specific hazards related to the equipment used in the task, and reviewing safety procedures. Sec'y Ex. 28. The guidelines further provide that task training should be completed in a non-production setting, which allows a competent trainer the time to discuss a skill, demonstrate it, and then observe the miner safely complete the task. Sec'y Ex. 28. Inspector Barrick explained that the training for a ground man, working around rail cars, must involve more than uncoupling the cars. The task training should include how to communicate or use hand signals, how to check and set the brakes, the hazards associated with moving rail cars, the red zone area between the cars, the ability to warn persons about moving cars, and how to safely mount cars. Miners must also be trained in safe practices and instructed not to mount a car when it is moving, and never attempt to stop or jump on a runaway rail car.

Superior Silica argues that a competent person, Plant Manager Chad Thomsen, trained Fernandez how to set the manual handbrake and how to uncouple railcars. The mine also argues that given Fernandez's intelligence and prior work performance, the short duration of task training by Thomsen was all that was needed. The mine argues that Thomsen observed Fernandez successfully assist in moving one railcar prior to the accident by operating the switch as Thomsen moved the spare car with the Rail King. Thomsen believed that because Fernandez observed and asked questions prior to moving the spare car, he understood the process. Thomsen agrees that as they began the process, they did not conduct a walkaround inspection of the cars, and did not connect the air brake to Railcar #4, stating, "I had noticed that the steps were bent in. I mean, the braking mechanisms were bent...it was a bad car." Tr. 278. Thomsen did not set the hand brakes on any of the cars prior to uncoupling the cars, nor is it certain that he told Fernandez to set the hand brakes. Resp't Ex. G. Thomsen testified that he did not recall setting or checking the brakes himself, and he did not recall instructing, supervising, or verifying that Fernandez set the brakes, stating, "I guess I assumed he did" because "he looked like he was - I mean, he was more than capable of doing it." Tr. 279; Tr. 283. Thomsen also testified that he did not instruct Fernandez about the hazards of moving a railcar and specifically how to react to runaway cars. Thomsen was approximately 200 feet away from Fernandez with the Rail King's engine running while Fernandez performed many of these tasks for the first time. Thomsen did not observe Fernandez do the tasks he was assigned, and he could not adequately supervise him from such a distance.

Superior Silica called Carl Bradley, as an expert in rail operations, to testify about the training required to demonstrate proper techniques for setting hand brakes and decoupling railcars. While somewhat familiar with MSHA regulations based on his review for this case, Bradley is most familiar with the Federal Railroad Administration regulations. See 49 C.F.R. Ch. II. Bradley's expert opinion, based upon visits to the mine location, examination of the railcars, and review of statements made by employees, is that the mine was not negligent in

providing task training to Fernandez on the day of the accident. Resp't Ex. B. After listening to testimony at hearing, Bradley believed that Thomsen instructed Fernandez to set the hand brakes, but Bradley could not say why that was not done by either Thomsen or Fernandez. Bradley described the brake wheel in Exhibit L-21, located on the B end of Railcar #5 and agreed that the brake was not set as evidenced by the slack chain. See Resp Ex. L-1, L-2.

Bradley believed Thomsen was a qualified trainer and that adequate training could have been completed in 30 minutes. Bradley compared task training to railroad training, and he opined that Fernandez received basic brakeman training. Bradley insists that task training in this instance was straightforward because he saw the task as limited to "uncoupling and setting the brakes on a car," which he considered to be "a very simple task to grasp and understand." Tr. 319. Bradley assumes as part of his opinion that Fernandez and Thomsen communicated effectively, that Thomsen was not required to impart adequate information, and that Fernandez's intelligence was sufficient to compensate for any lack of instruction provided. Bradley did not believe that training on moving equipment was required. The only hazard Bradley considered was slipping on the ladder as Fernandez climbed up to set the brake, but he believed Fernandez, as an experienced electrician, likely had experience climbing ladders. Bradley's observations and opinions do not change my view that Fernandez was not adequately task trained. Bradley's testimony regarding the rail industry is inconsistent with MSHA's requirements and practices for task training. Bradley acknowledged when new rail workers were shown how to set a brake, he took the time to have each of them demonstrate that they could competently complete the task. Finally, Bradley did not address an important part of working with railcars, a part not explained to Fernandez: never attempt to catch or stop a runaway train but instead "let it go." Tr. 42-43; 114; 152-153.

Fernandez had never worked on a railcar, and he had only been at the mine for a short time. These factors indicate that the task training needed to be much longer and in greater detail than for an experienced miner who had worked around railcars. Superior asserts that there is no requirement in the regulations that a certain amount of time be spent on task training and that the trainer can take into account the skills of the miner. Inspector Barrick agreed that the MSHA regulations do not specify an amount of time for task training, and the training can be done through supervised practice under a competent trainer. The complexity of the task may be considered along with the experience and ability of the miner being trained. Nonetheless, these are just a few of the many considerations that go into complete task training. Notably missing from the training and from Bradley's testimony are the important requirements of task training that relate to safety considerations when working around railcars, including safety considerations when setting a brake, coupling and uncoupling cars, throwing switches, using hand signals, and understanding correct safety procedures in an emergency. When asked, Bradley responded that railroad companies no longer train miners how to board moving equipment "because there was [sic] so many injuries." Tr. 359. Although Thomsen and Barrick differ on whether Thomsen told Fernandez to set the brakes on Railcars #5 and #6 prior to moving the cars, it is not disputed that Fernandez failed to do so. The fact that Fernandez did not set the brake, and Thomsen also failed to do so, indicates that the task training was inadequate. In this instance, either Thomsen did not remind Fernandez to set the two brakes, or Fernandez who is described as an intelligent and thoughtful worker, disregarded Thomsen's direction. It was the responsibility of Thomsen,

to observe Fernandez and ascertain that he not only knew how to do a task, but when and where to do it.

The Secretary's regulations require that a miner who is assigned to a new task for which he has no previous work experience be provided with training in the health and safety aspects of the task to be assigned, including the safe work procedures of such task. 30 C.F.R. § 46.7(a). Moreover, this training must be provided before the miner performs the new task. *Dacotah Cement*, 26 FMSHRC 461, 466 (Jun. 2004) ("Subsection (d) clearly requires that a miner be trained in recognizing hazards *specific* to the assigned task *before* performing the task.") (emphasis original); see 30 C.F.R. § 46.7(d). Although the Commission has indicated that a short period of time may suffice for task training, it must include health and safety information in addition to supervised practice or operation. See *White Oak Mining & Construct. Co.*, 20 FMSHRC 1130 (Oct. 1998). Even if I find that everything Superior Silica suggests is true, there is no dispute that supervised practice or operation was not provided and that Fernandez was given no training in the safe work procedures of that task. I find therefore that the mine did not task train Fernandez as required and uphold the violation as issued.

i. Significant and Substantial

The Secretary further alleges that the violation was significant and substantial. A "significant and substantial" ("S&S") violation is described in Section 104(d)(1) of the Mine Act as a violation "of such nature as could significantly and substantially contribute to the cause and effect of a coal or other mine safety or health hazard." 30 U.S.C. § 814(d)(1). A violation is properly designated S&S "if based upon the particular facts surrounding that violation, there exists a reasonable likelihood that the hazard contributed to will result in an injury or illness of a reasonably serious nature." *Cement Div., Nat'l Gypsum Co.*, 3 FMSHRC 822, 825 (Apr. 1981).

In *Mathies Coal Co.*, the Commission established the standard for determining whether a violation is S&S:

In order to establish that a violation of a mandatory safety standard is significant and substantial under *National Gypsum*, 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.

6 FMSHRC 1, 3-4 (Jan. 1984).

The second element of the *Mathies* test addresses the likelihood of the occurrence of the hazard the cited standard is designed to prevent. *Newtown Energy, Inc.*, 38 FMSHRC 2033, 2037-38 (Aug. 2016). The Commission has explained that "hazard" refers to the prospective danger the cited safety standard is intended to prevent. *Id.* at 2038. For example, Newtown involved a violation of a standard requiring that equipment be locked out and tagged out while electrical work is being performed. *Id.* The Commission determined that the hazard was a miner

working on energized equipment. *Id.* The likelihood of the hazard occurring must be evaluated with respect to “the particular facts surrounding the violation.” *Id.*; see also *McCoy Elkhorn Coal Corp.*, 36 FMSHRC 1987, 1991-92 (Aug. 2014); *Mathies*, 6 FMSHRC at 4. At the third step, the judge must assess whether the hazard, if it occurred, would be reasonably likely to result in injury. *Newtown*, 38 FMSHRC at 2037. The existence of the hazard is assumed at this step. *Id.*; *Knox Creek Coal Corp. v. Sec’y of Labor*, 811 F.3d 148, 161-62 (4th Cir. 2016). As with the likelihood of occurrence of the hazard, the likelihood of injury should be evaluated with respect to specific conditions in the mine. *Newtown*, 38 FMSHRC at 2038. Finally, the Commission has found that the S&S determination should be made assuming “continued normal mining operations.” *McCoy*, 36 FMSHRC at 1990-91.

I have found a violation as discussed above, and I find that the hazard that this standard is meant to prevent is that of an untrained person engaging in a task without understanding the proper procedure and safety hazards associated with the task. As Congress noted in the Mine Act, an untrained miner is a hazard to himself and others. 30 U.S.C § 814(g). Here, given the circumstances and conditions at the time, the hazard was likely to occur, in that a miner who had not been adequately trained, was forced to deal with an unsafe condition and did not know how to do that. The failure to adequately train was likely to lead to an accident that would in turn result in serious injuries or a fatality. Clearly, the violation here led to a fatal injury.

The Commission has previously agreed with an ALJ regarding the significant and substantial nature of failing to task train a miner. In *Twentymile Coal Co.*, a miner fell from a ladder while attempting to unclog a vertical rock chute. 26 FMSHRC 666 (Aug. 2004), *aff’d in part and remanded in part by Sec’y of Labor v. Twentymile Coal Co.*, 411 F.3d 256 (D.C. Cir. 2005). The Commission unanimously agreed that the operator failed to provide task training and that the violation was S&S, finding that the operator had assigned a group of miners to a job without any training “to guard against hazards inherent to the task,” such as slipping and falling around the ladder and platforms and spillage of rocks outside of the chute. The Commission also rejected the mine’s argument that the background and experience of miners must be reviewed in order to make an S&S determination once a violation has been established. 26 FMSHRC at 681.

In this case, Fernandez was inexperienced and received very little training in the new task he was performing. As a result, the hand brakes were not set on Railcars #5 and #6, and as they were uncoupled from Railcar #4, they began to roll down the track. In addition to not understanding he must set the brakes on those two cars, Fernandez was not told that he should not jump onto a moving railcar in an attempt to set the brakes after it was in motion. Applying the S&S criteria to the circumstances here, I find that the violation is significant and substantial.

ii. Negligence

The Secretary alleges that the violation was the result of high negligence. The Mine Act places primary responsibility for maintaining safe and healthful working conditions in mines on operators, and they are thus expected to set an example for miners working under their direction. *Newtown*, 38 FMSHRC at 2047; *Wilmot Mining Co.*, 9 FMSHRC 684, 688 (Apr. 1987) (“Such responsibility not only affirms management’s commitment to safety but also, because of the authority of the manager, discourages other personnel from exercising less than reasonable

care.”); *see also* 30 U.S.C. § 801(e). The Commission has recognized that “[e]ach mandatory standard ... carries with it an accompanying duty of care to avoid violations of the standard, and an operator’s failure to meet the appropriate duty can lead to a finding of negligence if a violation of the standard occurs.” *A.H. Smith Stone Co.*, 5 FMSHRC 13, 15 (Jan. 1983). In determining whether an operator met its duty of care, the judge must consider “what actions would have been taken under the same circumstances by a reasonably prudent person familiar with the mining industry, the relevant facts, and the protective purpose of the regulation.” *Newtown*, 38 FMSHRC at 2047; *Brody Mining, LLC*, 37 FMSHRC 1687, 1702 (Aug. 2015); *U.S. Steel Corp.*, 6 FMSHRC 1908, 1910 (Aug. 1984). While the Secretary’s Part 100 regulations evaluate negligence based on the presence of mitigating factors, Commission judges are not limited to that analysis. *Brody*, 37 FMSHRC at 1702-03. Rather, Commission judges consider “the totality of the circumstances holistically” and may find high negligence in spite of mitigating circumstances. *Id.* at 1702.

Superior Silica argues that a competent person, Chad Thomsen, observed Fernandez successfully move one railcar prior to attempting to move Railcar#4 to the other track. Therefore, the mine argues some training was provided and so the negligence was not high. The Secretary alleges that because Thomsen did not take the time required to adequately train Fernandez, and made assumptions about his abilities, the violation was the result of high negligence. I agree. Thomsen knew that Fernandez had no experience or prior training on rail work and as Inspector Barrick explained Thomsen should have either refused the help offered by Fernandez or taken the time necessary to include all aspects of the training needed by Fernandez to do the job safely. Thomsen was a manager with experience who should understand the risks of failing to adequately train miners. In particular, Thomsen should have understood the risks of an untrained miner uncoupling and moving large and heavy railcars on a grade.

In *Ky. Fuel Corp.*, the Commission approved a judge’s decision that similarly concluded that high negligence was appropriate due largely to the operator’s failure to provide adequate training and materials that resulted in an improper wheel blocking violation. 40 FMSHRC 28 (Feb. 2018). In this case, the supervisor made little to no effort to task train the miner. The Secretary believes the task training was inadequate for three reasons: (1) the mine failed to ensure that Fernandez set the manual handbrakes or blocked the two cars prior to Thomsen attempting to decouple the cars; (2) Thomsen should have either set the manual handbrakes on or blocked the two railcars himself, or directly observed Fernandez set the manual handbrakes on or block Railcars #5 and #6; and (3) the mine should have instructed the miner that in the event of a runaway train, the miner should allow the railcars to proceed to derailment. In failing to do any of these three items, Thomsen was highly negligent.

iii. Unwarrantable failure

Citation No. 8860296 was designated as an unwarrantable failure to comply with a mandatory standard. The unwarrantable failure terminology is taken from Section 104(d) of the Act, 30 U.S.C. § 814(d). The Commission has explained that unwarrantable failure is “aggravated conduct constituting more than ordinary negligence. [It] is characterized by conduct described as ‘reckless disregard,’ ‘intentional misconduct,’ ‘indifference,’ or a ‘serious lack of reasonable care.’” *Consol. Coal Co.*, 22 FMSHRC 340, 353 (Mar. 2007) (citing *Emery Mining*

Corp., 9 FMSHRC 1997, 2001-04 (Dec. 1987)) (citations omitted). In determining whether a violation is an unwarrantable failure, the Commission has instructed its judges to consider all of the relevant facts and circumstances in the case and determine whether there are any aggravating or mitigating factors. *Id.* Aggravating factors to be considered include:

the length of time that the violation has existed, the extent of the violative condition, whether the operator has been placed on notice that greater efforts were necessary for compliance, the operator's efforts in abating the violative condition, whether the violation was obvious or posed a high degree of danger, and the operator's knowledge of the existence of the violation.

IO Coal Co., 31 FMSHRC 1346, 1352 (Dec. 2009); *see also Consol.*, 22 FMSHRC at 353.

A number of the factors outlined in *IO Coal*, are a basis for the unwarrantable finding in this case, particularly that the violation was obvious, posed a high degree of danger and the operator knew of the violation. First, there is no testimony regarding how long the mine has failed to adequately task train its miners, and there is also nothing to demonstrate that the mine had been placed on notice that greater training efforts were necessary. However, the record reflects that the violation was extensive in terms of the total failure to task train prior to attempting to move the railcars. The extent factor is intended to "account for the *magnitude* or scope of the violation" in the unwarrantable failure analysis. *Dawes Rigging & Crane Rental*, 36 FMSHRC 3075, 3079 (Dec. 2014) (emphasis added). To safely work in this sort of situation, a miner must have a breadth of understanding about the very large equipment and the safety hazards associated with it. Yet, the mine failed to train Fernandez on the important safety factors related to the task, and therefore the violation was extensive in those terms.

Thomsen and Fernandez were working on enormous pieces of machinery. The railcars at issue are nearly 50 feet long and 15 feet high. The railcars weigh approximately 53,000 pounds when empty and are estimated to contain 200,000 pounds of sand when full, on a track that has a grade of 2-3%. Resp Ex. F at 4, Tr. 173-177 217, 281. Work on this equipment posed a considerable risk to miners, regardless of their level of training or experience. The degree of danger was exacerbated by the fact that Thomsen left Fernandez alone to perform a task that he clearly did not have enough experience or training to do. Moreover, the fact that Thomsen did not include any explanation regarding the safety hazards associated with the tasks, including what to do in the event of a runaway train, made this already dangerous activity all the more hazardous. Fernandez's death resulted from a reckless disregard for his safety when working under conditions that posed an extremely high degree of danger. I find these to be aggravating circumstances that support a finding of unwarrantable failure to comply with a mandatory standard.

Knowledge is also a factor in determining that the violation is an unwarrantable failure. Thomsen was the plant manager, a supervisor with experience who had conducted task training in the past. Thomsen knew, or at best, should have known, that given the lack of experience in both mining and in the use of railcars, the training he gave Fernandez was inadequate. Despite the fact that Fernandez had performed well during his short time at the mine, Thomsen should

not have assumed that Fernandez knew what to do safely. The need for explicit and careful training was obvious, and the operator was aware of that fact.

Abatement efforts relevant to the unwarrantable failure analysis are those made prior to the issuance of the citation or order. *Consol*, 35 FMSHRC at 2342; *IO Coal*, 31 FMSHRC at 1356. In this case, Thomsen provided inadequate instruction before leaving Fernandez to work on his own and no abatement efforts were made. Given that the task was inherently dangerous, that the lack of task training was obvious, and that Thomsen should have known that more training was needed, yet failed to do so, I find the Secretary has demonstrated that the violation occurred as the result of the operator's unwarrantable failure to comply with a mandatory health or safety standard.

Order No. 8860297

On December 6, 2018, Inspector Barrick issued a second citation as a result of the accident. The citation states:

An accident occurred on this mine site on 6/23/18, at approximately 9:20 am, when a miner was fatally injured while assisting in relocating rail cars. The miner uncoupled the last two rail cars and they began to roll away. The miner ran to the moving cars and attempted to set the manual handbrake. The miner fell from the moving cars and was run over. The two loaded cars at the end of the train were not effectively secured by either of the raking systems. Management engaged in aggravated conduct constituting more than ordinary negligence in that it did not ensure or instruct the miner to set the manual handbrakes or block the two cars from movement prior to uncoupling. This is an unwarrantable failure to comply with a mandatory standard.

The inspector designated the order as S&S and as an unwarrantable failure, and the Secretary proposed a penalty of \$20,940.00. The Mine Act and its standards "are to be interpreted to ensure, insofar as possible, safe and healthful working conditions for miners." *Pittsburg & Midway Coal Mining Co.*, 8 FMSHRC 4, 6 (1986). The mandatory standard at issue here, 30 C.F.R. § 56.14217, securing parked rail cars, is part of the safety standards for equipment and is intended to ensure miner's safety when working around equipment such as railcars. The standard requires that "[p]arked railcars shall be blocked securely unless held effectively by brakes," which is meant to "provide [p]rotection for miners against unintended movement of railcars." 30 C.F.R. § 56.14217; 53 Fed. Reg. 32,496 (Aug. 25, 1988).

The Section 104(d)(1) order alleges that the two cars at the end of the train were not effectively secured by either of the braking systems. The Secretary argues that the mine failed to set the manual handbrakes or block the two cars prior to attempting to decouple and then move the cars. Since the miner had never performed this task, the supervisor should have either set the handbrakes or directly observed the miner set the handbrakes. And if there was any indication that the brakes would not hold, the Supervisor should have blocked the cars from movement. When the miner uncoupled Railcar #5 from #4, and Thomsen pulled Railcars #1-4 away,

Railcars #5 and #6 began rolling down the track in the opposite direction and therefore were not secured against movement.

This citation was issued because Railcars #5 and #6 did not have the mechanical brakes set or blocked prior to uncoupling and moving the front cars. *See* Jt. Ex. 1. There is no dispute that the brakes were not set, as Fernandez tried to jump on Car #6 as it was moving and was observed turning the wheel to set the brakes. When the cars came to a stop, and Railcar #6 derailed, the brake was set on that car, but was not set on Railcar #5. Inspector Barrick testified that if the brakes had been set and were functioning, that might have stopped the train. The mechanical brakes on both cars were required to be set, and if they were not, or did not hold, they were required to be blocked from movement.

Superior Silica argues that the two railcars were effectively secured because they had remained in the same position since March 2018 and until June 23, 2018, the date of the accident. I disagree, the mandatory standard requires that the mechanical brakes be set and therefore, relying on the brakes of attached equipment does not satisfy the requirements of the standard. Thomsen and Fernandez failed to set the brakes on Railcars #5 and #6 or block the cars from movement. As neither action was taken, I find that there is a violation of the mandatory standard.

i. Significant and Substantial

The Secretary alleges that the violation occurred and was fatal and marked the citation as significant and substantial. The standard is designed to protect against unintended movement of the rail cars. In the circumstances found here, uncoupling the cars resulted in an unintended movement, which in turn resulted in the hazard the standard is designed to avoid. The unintended movement of these two railcars resulted in two, very heavy, 50 foot long cars moving down the track without warning, and resulted in an injury to a miner. The additional hazard that the standard is intended to prevent is that of a miner trying to set the brake once the cars started to move, in order to avoid a derailment. Both conditions and hazards would result in an injury to a miner and the injury would be serious or fatal.

Superior argues that the railcars had been in the same location for months, and therefore it was unlikely that they would move. However, the cars had been coupled to others while on the tracks and it was the uncoupling that most likely caused the unintended movement. The Secretary argues that even if coupled, the brakes are required to be set, if the cars are not blocked from movement and the failure to do so creates a hazard that likely will lead to a serious injury. I agree and find that the violation was significant and substantial.

ii. Negligence

The Secretary alleges that the violation was the result of high negligence. Superior Silica argues that the railcars were effectively secured because they had remained in the same position from March 2018 up until the accident on June 23, 2018. The mine also argues that the miner was specifically instructed to set the manual handbrakes on the two cars to prevent movement prior to uncoupling.

The Secretary argues that the mine failed to ensure that Fernandez had set the manual handbrakes or block the two railcars before either of the men attempted to decouple the cars and before Thomsen began to move the four front cars forward. Thomsen, as the supervisor and trainer, knew that the brakes should be set prior to any movement, or even while just idle on the tracks. He should have ascertained that all of the brakes were set and would hold the two end rail cars before attempting to move the front cars. Given Thomsen's position, the Secretary contends that Thomsen should have set the manual handbrakes or blocked the railcars himself, or that he should have directly observed Fernandez perform the task. Thomsen did neither. Thomsen was the plant manager and the supervisor; he should have ascertained that the brakes were set or blocked and therefore his actions constituted more than ordinary negligence, and I find that high negligence is appropriate.

iii. Unwarrantable failure

The inspector issued the violation as an unwarrantable failure to comply with a mandatory standard. The Secretary argues that management engaged in aggravated conduct constituting more than ordinary negligence because working in and around railcars poses a high degree of danger, the supervisor made no effort to see that the brakes were set or that the cars blocked from movement prior to uncoupling, and the supervisor was aware of the dangers posed by railcars that were not held in place.

Superior Silica argues that there was no willful intent to avoid setting the brakes and that Thomsen specifically instructed Fernandez to set the manual handbrakes prior to uncoupling Railcars #5 and #6. The testimony is disputed in this regard. Barrick asserts that Thomsen did not instruct Fernandez to set the brake, nor did Thomsen in his statement to Barrick believe that the brakes had already been set. Thomsen, on the other hand, asserts that he believed the brakes had been previously set, but later asserts that he told Fernandez to set the brakes.

Nevertheless, as the plant manager and supervisor, it was Thomsen's responsibility to ensure the brakes were set prior to moving the cars. This was crucial. The brakes were not set at the time the cars were uncoupled, resulting in a critically high degree of danger and resulting in the death of Fernandez. Moreover, as long as the cars were parked, the mechanical brake should have been set, and the violation therefore was obvious and known to the mine, yet nothing was done to abate the condition prior to the date of the accident. Since the railcars were not used frequently, the brakes likely had not been set for some time. Therefore, the length of time the condition existed contributes to the finding of unwarrantability. Although the Secretary argues that the mine was put on notice by the derailment some months earlier, I cannot agree that the earlier derailment would alert the mine to the type of violation cited here. I also do not rely on how extensive the violation was in making a determination about unwarrantable failure. However, I find the other factors compelling and as a result find the violation was the result of an unwarrantable failure to comply with a mandatory health or safety standard.

B. CENT 2019-0133

Order No. 8860298

The final order issued by Inspector Barrick on December 6, 2018 cited a railcar, designated as Railcar #4 on Joint Exhibit 1, for not having functional brakes. The citation alleges:

The mine operator failed to maintain the braking system on rail car TILX 338713. The rail car was located on the South section of the mines rail spur coupled to 6 other cars situated in the 4 position. The rail cars brake linkage had been sheared off on March 2, 2018 when it was released down the spur and derailed it onto its side. The car was recovered and placed back onto the spur without repairing the braking system. Chad Thomsen, Plant Manager engaged in aggravated conduct constituting more than ordinary negligence in that he failed to ensure that the braking system on the TILX 338713 was maintained. This is an unwarrantable failure to comply with a mandatory standard.

The citation is designated as S&S and unwarrantable and the Secretary has proposed a penalty of \$9,409.00.² The standard cited at 30 C.F.R. § 56.14102, titled, “Brakes for rail equipment,” states that “[b]raking systems on railroad cars and locomotives shall be maintained in functional condition.” The standard is analogous in language to a standard dealing with back up alarms, which are also required to be maintained in functional condition. In *Wake Stone Corp.*, 36 FMSHRC 825, 827 (Apr. 2014), the Commission reviewed the standard for back up alarms and decided that the plain meaning of § 56.14132(a) requires that back up alarms and horns *always* be maintained in functional condition. Evidence showed that the service horns were defective at the time of inspection and the equipment had not been removed from service. *Id.* Therefore, the horns were not being “maintained in functional condition” as required by the regulation. *Id.* Applying a similar interpretation to the regulation at issue here, the plain language of 30 C.F.R. § 56.14102 requires that braking systems on railroad cars must always be maintained in functional condition and, if not, the car must be removed from service.

The Section 104(d)(1) order alleges that the mine operator failed to maintain the braking system on Railcar #4. The Secretary argues that the car’s brakes were severely damaged in the March 2018 derailment, that the mine was aware the brakes were damaged, and the mine did nothing to repair them. *See* Sec’y Ex. 2, 25; *see also* Sec’y Ex. 16, 8–15. Instead of repairing the brakes, the mine put Railcar #4 in a string of railcars that the mine used in normal operations. The Secretary argues that while the mine placed a “DO NOT FILL” sign on Railcar #4, that action is not sufficient to comply with the clear terms of the standard. As Barrick explained, if the mine was not going to repair the brakes, the car should have been completely removed from service. The “DO NOT FILL” sign did not effectively remove the car from service. Tr. 226.

2. Order No. 8860298 was originally issued as a Section 104(d)(2) order. At hearing, the Secretary represented that the order had been modified to a Section 104(d)(1) order.

Even though Rail Car #4 was coupled to Railcars #5 and #3, it could not hold in place on its own and remained defective.

Superior Silica takes the position that the mine should not have been cited for the damaged brakes. Instead, the facts and circumstances surrounding the violation should be considered, including that the mine contacted the owner of Railcar #4 to discuss repairs, coupled the car to other cars to prevent use, did not load it with sand, and did not move the car for nearly three months. The law, however, does not support the mine's position. Once the brakes were discovered to be non-functional and inoperative, and the car remained in a location where it could be used, the mine was in violation of the standard. Railcar #4 was coupled to a line of other cars, which were on the south spur and available for use at the mine. *See Wake Stone*, 36 FMSHRC at 828 (citing *Ideal Basic Indus., Cement Div.*, 3 FMSHRC 843, 845 (Apr. 1981) (if defective equipment affecting safety is located in a normal work area and is fully capable of being operated, that constitutes use)). Following its March 2018 derailment, Railcar #4 should not have been placed in the string of cars but instead isolated in a separate area where it could not be used, as Thomsen was attempting on the day of the accident. Thus, Railcar #4 was not out of service as the mine alleges and I find that the Secretary has proven the violation.

The mine has also suggested that MSHA failed to cite the correct mandatory standard in Order No. 8860298. Superior Silica asserts that the mine should have been cited for a violation of 30 C.F.R. § 56.14100, which requires in part, that self-propelled mobile equipment with hazardous defects be tagged and removed from service. The mine's argument fails to consider the Commission's case law that requires the standard that is the most specific to be cited over a more general standard. As the Commission has consistently explained, when two regulations apply to the same condition, the more specific regulation is the appropriate standard to cite. *Western Fuels-Utah, Inc.*, 19 FMSHRC 994 (June 1997). Here, the standard cited by the inspector, 30 C.F.R. § 56.14102, deals specifically with braking systems on railroad cars and is clearly titled "Brakes for rail equipment." In a dispute over which standard should apply, it is clear that 30 C.F.R. § 56.14102 is more appropriate than the general regulation found at 30 C.F.R. § 56.14100.

i. Significant and Substantial

The citation was marked S&S and the Secretary alleges the violation was highly likely to result in a permanently disabling injury. The Secretary asserts that although the defective brakes did not contribute to the June 23 accident, it was likely that the condition of the brakes would result in an accident. Superior Silica disagrees. The operator argues that the injury was not highly likely to occur because the mine did not use Railcar #4, and instead placed a sign on each side of the car instructing miners not to fill it.

Barrick believed that the condition of Railcar #4 was bad enough that any movement would cause it to derail. He explained that any number of things could go wrong moving Railcar #4 given its severe damage. Tr. 228–29. The car had been sitting on the tracks for months and even though it was connected to Railcars #3 and #5, the brakes were not set on Railcar #5, thereby rendering the connection less effective. The failure to isolate Railcar #4 from the functional railcars and remove it from the south spur resulted in a hazard. Railcar #4 was in a

position and location where it was available for use and could be moved up and down the tracks, even if not filled.

I have found a violation of the mandatory standard and I find further that the standard is designed to prohibit railcars from use when the brakes are not functioning. Using a railcar with bad brakes would likely result in an accident, including derailment or unexpected movement, which in turn would result in a serious injury. In this case, Railcar #4 was coupled within a line of cars and between two that had functioning brakes. However, the evidence shows that Railcar #5, at a minimum, did not have its air or mechanical brakes set at the time of the accident. It is not known if the mechanical brakes were set on Railcar #3, or if they were set at any time during the several months that Railcar #4 was on the south spur and coupled with it.

Given that Railcar #4 had no functioning brakes, was coupled between cars in which at least one did not have the brakes set, and was available for use, a hazard existed. Miners using the car and anyone working or traveling in the area would be subject to the hazard of derailment or unintended movement of a very large, 50 foot long, railcar. If left on its own, Railcar #4 would not be controlled and would likely derail. A railcar without functioning brakes, and most importantly the resulting runaway car, would result in injuries to anyone working in or around the car, and those injuries would be serious and likely fatal. Therefore the violation is S&S.

ii. Negligence

The Secretary alleges that the violation was the result of high negligence. The Secretary argues that placing signs that say “DO NOT FILL” on a railcar with defective brakes is not sufficient to comply with the standard. The operator does not contest that the brakes were damaged, but argues that it took steps to make exposed miners aware of the hazard. The mine put signs on Railcar #4 to indicate that it should not be used, coupled the railcar to other cars with functioning brakes, and did not fill it with sand.

As a reasonably prudent mine operator, Superior Silica should have known its failure to repair the brakes was a violation of a mandatory standard and that the violation posed a significant danger to the miners. The mine’s placement of signs on Railcar #4 warning miners not to fill the car was an ineffective effort to comply with the standard. In *Newtown Energy*, 38 FMSHRC 2033 (Aug. 2016), the Commission overturned a judge’s finding that the use of a defective lock on a cathead should be considered as an element of mitigation for negligence purposes. “Negligence is not diminished by a miner’s clearly ineffective effort to comply with the safety standard.” *Id.* at 2048 n.21. Here, mine management was aware the brakes on the car were defective and, given its discussion with the railcar’s owner, knew it would be some time before repairs were made. Therefore, Railcar #4 should have been removed from service immediately by disconnecting it from other cars and disabling its ability to be moved. The car should have been moved to the north spur immediately following the March 2018 derailment and blocked against any movement. The mine’s failure to do so was the result of high negligence.

iii. Unwarrantable failure

The order was issued as an unwarrantable failure to comply with a mandatory standard. The Secretary argues a number of factors support a finding of unwarrantable failure, including that the operator knew the brakes were damaged on Railcar #4, yet coupled it to an active string of railcars and left it in its defective condition for several months. Since the car lacked functional brakes, the Secretary asserts that the violation was extensive, obvious, and involved a high degree of danger. The Secretary argues further that because the car derailed and was damaged, the mine was on notice that greater efforts were necessary to correct the condition. Coupling Railcar #4 with other cars available for use shows that the mine understood the seriousness of the condition.

Superior Silica argues that the violation does not amount to unwarrantable failure because the mine did not ignore Railcar #4's damaged brakes. The mine contends it could not repair the damaged brakes due to an ownership dispute. Instead, Superior Silica took reasonable steps to limit potential harm, including not filling the railcar, trying to isolate the railcar, and providing warning signs. The mine also states that the railcars were used infrequently. Although I agree that the violation was the result of high negligence, I cannot find sufficient evidence to support a finding of unwarrantable failure.

IO Coal requires Commission Judges to consider a number of factors in addressing an unwarrantable failure designation. First, is length of time that the violation has existed. Following the March 2018 derailment, Railcar #4 was placed in the string of active railcars and remained between Railcars #3 and #5 until the June 23 accident. According to the mine, Railcar #4 was not used and the string of cars was moved infrequently during that time. As the Commission explained in *Coal River Mining, LLC*, 32 FMSHRC 82, 93 (Feb. 2010), even where the record does not permit the judge to make a conclusive finding as to the duration of the condition, "imperfect evidence of duration in the record should be taken into account." Here, the inspector believed that Railcar #4 was in the string of active railcars for the several months following its derailment and the mine has not presented any evidence to refute that suggestion but instead suggests that the car was not moved during that time period. Thomsen explained that he was in the process of removing Railcar #4 so that he could empty material from the railcars, but there is no evidence to suggest when the other railcars had been filled. Therefore, the violation did exist for the several months Railcar #4 remained on the active track, but it may not have been used. So while the violation existed for several months, it cannot be said to be extensive. Railcar #4 was on the track with two cars coupled behind it and three in front, each 50 feet in length. I credit Barrick's testimony that the entire railcar and the attached railcars were affected by the damaged brakes but I cannot say that the condition was extensive, given that one car in the string was damaged and was coupled with other cars that were not damaged.

Next, I must consider whether the operator has been placed on notice that greater efforts were necessary for compliance. In this case, the Secretary did not present evidence that the mine had been told to correct the condition of the brakes or that it had been previously cited for similar violations. Therefore, I do not agree that the mine was on notice that greater efforts were required for compliance. I also cannot rely on the lack of abatement efforts to support a finding of unwarrantable failure. A lack of abatement efforts may be excusable if the operator had a

reasonable, good faith belief that the condition did not exist. *See IO Coal*, 31 FMSHRC at 1356. Here, the mine did not believe the condition continued to exist because they had moved the car to a location that they believed would prohibit its use.

The Secretary argues that the condition posed a high degree of danger because Railcar #4 lacked functional brakes to hold itself in place and could have derailed following any movement. Tr. 228. Thomsen explained that coupling Railcar #4 in the string of railcars on the south spur was a safe place to keep it since the car was between two cars with operative brakes and the railcars did not move for some length of time. However, the evidence shows that the brakes were not set on Railcar #5 and the string of railcars was available for use, increasing the degree of danger posed by Railcar #4. Although there was a high degree of danger associated with a railcar that had no functioning brakes, it is not sufficient, based upon the facts here, to alone support a finding of unwarrantable failure.

In this case, the condition was obvious to the miners and mine management. Taft, the maintenance manager at the time, testified that he could see Railcar #4 was damaged because the springs were out, the brake shoes were off, the axle was not sitting down on the pin, and there was body damage to the car. Tr. 117–18. In addition, Secretary’s Exhibit 16 contains various photographs showing the brakes sheared off of Railcar #4. Sec’y Ex. 16, 9–10, 12, 15. While the condition of the car was obvious, the violation—that is, leaving the damaged car on the tracks without repair— was not as obvious to the mine, since they believed they had abated the violation by placing Railcar #4 in a location that would not require the brakes to be used. The same can be said for the knowledge of the violation. Here, both Taft and Thomsen, supervisors at the mine, explained that they were aware of the defective condition of the railcar. Tr. 116, 258. Thomsen testified that he knew the brakes were not functional because “[t]he levers were bent up on it . . . [the] brake mechanism was bent.” Tr. 260–61. While the mine should have known of the existence of the violation, the fact that they believed they had remedied the condition is a factor in determining the knowledge.

Even though the mine was negligent in not repairing or removing the car from service as required by the standard, there is not sufficient evidence in the record to conclude that the violation was the result of an unwarrantable failure to comply.

II. PENALTY

The principles governing the authority of Commission Administrative Law Judges to assess civil penalties de novo for violations of the Mine Act are well established. Section 110(i) of the Mine Act delegates to the Commission and its judges “authority to assess all civil penalties provided in [the] Act.” 30 U.S.C. § 820(i). Commission Judges are not bound by the Secretary’s penalty regulations. *Am. Coal Co.*, 38 FMSHRC 1987, 1990 (Aug. 2016). Rather, the Act requires that in assessing civil monetary penalties, the judge must consider six statutory penalty criteria: the operator’s history of violations, its size, whether the operator was negligent, the effect on the operator’s ability to continue in business, the gravity of the violation, and whether the violation was abated in good faith. 30 U.S.C. § 820(i).

The Secretary has proposed a penalty of \$18,846.00 for the violation cited in Citation No. 8860296, which alleges a failure to provide new task training to Fernandez. I have considered and applied the six penalty criteria found in Section 110(i) of the Act. The history of assessed violations has been admitted into evidence and shows 20 violations by this operator in the 15-month period prior to the issuance of the citation, two of which involve a similar standard. Sec’y Ex. 24. I have addressed negligence and gravity in the discussion above and have found that the violation was S&S, and the result of high negligence and an unwarrantable failure to comply. The mine is medium-sized and the parties agree that the citation was abated in good faith. The mine has raised no defense of ability to pay, but the mine has filed for bankruptcy. Therefore, I find that the proposed penalty of \$18,846.00 is appropriate.

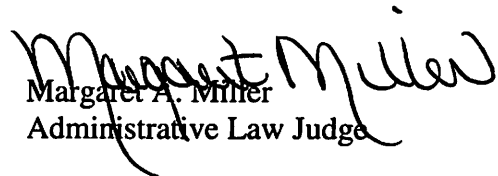
Next, the Secretary has proposed a penalty of \$20,940.00 for the violation cited in Order No. 8860297, which alleges that Railcars #5 and #6 were not effectively secured by either of their braking systems. In assessing a penalty, I have considered and applied the statutory penalty criteria. According to the history of assessed violations, there are no similar violations for this standard in the preceding 15-month period. Sec’y Ex. 24. Negligence and gravity are addressed above, with findings of high negligence, unwarrantable failure, and S&S. I have considered the operator’s good faith abatement, size, and ability to pay, and I find that the penalty of \$20,940.00 is appropriate.

Finally, the Secretary has proposed a penalty of \$9,409.00 for the violation cited in Order No. 8860298, which alleges that Railcar #4 did not have functional brakes. In determining a penalty, I have considered and applied the six statutory penalty criteria. The history of assessed violations shows no similar violations for this standard in the preceding 15-month period. Sec’y Ex. 24. Negligence and gravity have been addressed in the discussion above, and I have found that the violation was S&S and the result of high negligence. The designation of unwarrantable failure has been removed. The mine’s history, size, ability to pay, and good faith abatement have been considered. Based on these findings, I assess a penalty of \$5,000.00.

Citation No.	Originally Proposed Penalty	Penalty Assessed
Docket No. CENT 2019-0171		
8860296	\$18,846.00	\$18,846.00
8860297	\$20,940.00	\$20,940.00
Docket No. CENT 2019-0133		
8860298	\$9,409.00	\$5,000.00
TOTAL	\$49,195.00	\$44,786.00

III. ORDER

Respondent is hereby **ORDERED** to pay the Secretary of Labor the sum of \$44,786.00 within 30 days of the date of this decision.


Margaret A. Miller
Administrative Law Judge

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