FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

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SECRETARY OF LABOR MINE SAFETY AND HEALTH ADMINISTRATION (MSHA), Petitioner, v. NORTHSHORE MINING COMPANY, Respondent.	CIVIL PENALTY PROCEEDINGS Docket No. LAKE 2017-0224 A.C. No. 21-00831-434118 Docket No. LAKE 2017-0248 A.C. No. 21-00831-435608 Mine: Northshore Mining Company
SECRETARY OF LABOR MINE SAFETY AND HEALTH ADMINISTRATION (MSHA), Petitioner, v. MATTHEW ZIMMER, employed by NORTHSHORE MINING COMPANY, Respondent.	CIVIL PENALTY PROCEEDING Docket No. LAKE 2018-0141 A.C. No. 21-00831-457528 A Mine: Northshore Mining Company
SECRETARY OF LABOR MINE SAFETY AND HEALTH ADMINISTRATION (MSHA), Petitioner, v. ROGER PETERSON, employed by NORTHSHORE MINING COMPANY, Respondent.	CIVIL PENALTY PROCEEDING Docket No. LAKE 2018-0146 A.C. No. 21-00831-457527 A Mine: Northshore Mining Company

DECISION AND ORDER

Appearances: Barbara M. Villalobos, U.S. Department of Labor, Office of the Solicitor, Chicago, Illinois, for Petitioner;

R. Henry Moore, Arthur M. Wolfson, Jackson Kelly PLLC, Pittsburgh, Pennsylvania, for Respondent.

Before: Judge Miller

These cases are before me upon petitions for assessment of civil penalties 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 dockets involve a citation and an order issued to Northshore Mining Company ("Northshore") pursuant to Section 104(d) of the Act with originally proposed penalties totaling $199,600.00. The alleged violations involve a failure to maintain a walkway in good condition and a failure to barricade the walkway from access by miners. MSHA also seeks to impose personal liability under section 110(c) of the Mine Act, 30 U.S.C. § 820(c), against two section managers, Matthew Zimmer and Roger Peterson, for the failure to maintain the walkway. The parties presented testimony and evidence regarding the citations and orders at a hearing held in Duluth, Minnesota. Based upon the parties' stipulations, my review of the entire record, my observation of the demeanors of the witnesses, and consideration of the parties' legal arguments, I make the following findings and order.

I. FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Northshore Mining Company is an iron ore mine located in Lake County, Minnesota. The parties have stipulated that Northshore is an "operator" as defined in Section 3(d) of the Mine Act, 30 U.S.C. § 803(d), and is subject to the jurisdiction of the Commission. Jt. Stips. ¶¶ 2-4.

This case involves an outer east walkway of the 62/162 conveyor gallery at the mine's pellet processing plant in Silver Bay, Minnesota. The facility processes iron ore pellets for use in steel production. The conveyor gallery is a covered gallery with two conveyors, a primary walkway between the two conveyors, and an outer walkway on each side. The citations here involve the east outer walkway.

The citations at issue stem from an accident at the mine on September 7, 2016 that resulted in the failure of the elevated east outer walkway. The accident involved a contract miner, Evander King, who testified at hearing on behalf of the Secretary. King was employed in 2016 by VanHouse Construction as a contractor at the Northshore processing facility. He primarily performed clean-up work at the mine with a number of other contractors. He and the other contractors were supervised by John Gornik, a Northshore employee responsible for coordinating the day crew, and Dennis Lehtinen, a senior operations technician employed by Northshore. Tr. 47, 61, 480.

On September 6, 2016, the VanHouse contract crew checked in with Gornik at the beginning of the shift to receive work orders for the day. Gornik informed King and two other VanHouse employees that they would be doing clean-up on the 62 conveyor ramp. Gornik and the VanHouse miners then went to the office of Roger Peterson, the section manager for operations on the "hot side," which includes the conveyor gallery. Peterson informed the miners that they should use fall protection to work on the walkway because there was a danger of slipping on the pellets or getting caught in the moving conveyor. Lehtinen, the Northshore employee who frequently acted as a liaison between Gornik and the contract workers, walked with the VanHouse workers to the transfer tower at the top of the 62/162 conveyor. He demonstrated how to put on the safety harnesses and then demonstrated how to wrap a canvas wrap with D-rings onto a vertical support beam and use it to tie off with the lanyard from the harness. Lehtinen told the contractors to work their way down the walkway and keep tying off to successive beams. Tr. 50, 486. Because of the dusty and steamy conditions, along with the width of the walkway, only one of the three contractors could work on the walkway at a time.

Therefore, the contractors rotated the duty every fifteen minutes and the two not on the walkway waited in the transfer tower. King explained that the miners worked on the east walkway, hosing the pellets and mud down toward the bottom of the ramp. The walkway was covered in 6 to 12 inches of muddy pellets and the floor was not visible to the miners. They clipped onto a D-ring on the anchor strap wrapped around a beam, cleaned until there was not enough water pressure to move the pellets, then unclipped and moved the anchor strap farther down the walkway. Tr. 51. The contract miners could not see the walkway under the accumulated pellets, were not aware of any problems with the walkway, and did not see any hazard or warning signs on the walkway. Tr. 69.

King explained that while moving up and down the outer conveyor walkway, there were times between support beams when he was not tied off. Lehtinen, however, testified at hearing that he had shown the miners how to use two lanyards in alternation in order to stay tied off the entire time. Lehtinen also claimed that the miners used the process in reverse to remain tied off while walking back up the walkway to the transfer tower. Tr. 487. King disagreed and explained that the miners were not tied off the entire time because they had to unclip their harnesses to move down the walkway when they reached the end of the lanyard. He did not recall being told that he could be tied off continuously by using a lanyard borrowed from one of the other miners, and denied that Lehtinen had instructed them to be clipped on the entire time. Tr. 52, 77. Instead, King stated in an interview with an MSHA inspector that when the miners walked up the ramp to switch places, they were not tied off. Lehtinen indicated that he did not observe King or the other contractors while they were working on the walkway, and that he had told them only that they should be tied off, assuming they would understand that they needed to be tied off the entire time. Lehtinen also explained that he was not told directly why the miners needed to be tied off, but he assumed it was because of the slip hazard presented by the pellets and the slope of the walkway. Tr. 492. However, in an interview with Inspector Norman, Lehtinen observed that Gornik told him to have the workers tie off both because of the pellets and because of concerns over bad decking. Tr. 107. Norman also interviewed Gornik, who confirmed that the workers were required to tie off because of the bad floor. Tr. 125. However, at hearing, Gornik believed the fall protection was required because of the slip hazard from the pellets. Tr. 129, 479. Given the contradiction in testimony, I find that both Gornik and Lehtinen

understood that the decking was bad on the east walkway and asked the miners to tie off for that reason, along with the slip hazard. I also credit King's testimony that the three contract miners did not understand that they were to be tied off the entire time while working and while walking off the east walkway, primarily because they were told only that there was a slip hazard on the pellets. I find that there were times when they were not tied off while standing or walking on the conveyor walkway.

King and the other VanHouse workers spent the remainder of the shift on September 6 cleaning the east outer walkway and completed about half of the cleaning work. The following day, on September 7, the VanHouse employees were given other work assignments and, when those were complete, they returned to the east walkway to resume cleaning the bottom half of the walkway. On one of King's first turns at hosing the pellets down the walkway, he heard a loud bang and felt the building begin to shake. Sheets of caked mud and buildup from around the structure began to fall on him. King, who was standing on pellets, crouched down to protect himself from the falling material. When the shaking stopped, there was a hole in the floor of the walkway directly in front of him. He recalled looking down and seeing a front-end loader below. He also recalled seeing the outer walls and conveyor buckling. He believed he was about 45 or 50 feet above ground when the incident occurred and that he would have been seriously injured if he had not been tied off. King waited to be certain that the shaking had stopped, then unhooked his fall protection and ran back up the walkway to the transfer tower. Tr. 59.

King met with the other contractors in the transfer tower and they were joined by Matt Bailey, a maintenance technician employed by Northshore. Bailey told King he never should have been working on the walkway. He believed the conveyor should have been shut down, and also stated that the walkway had been in terrible condition for years and that it had been reported to management. Bailey then drove the contractors to the breakroom in the pelletizer. There, King discussed the accident with several other miners. Steven Floen, a second maintenance technician employed by Northshore, became angry and replied that he had been telling the people upstairs about this problem for a long time. Tr. 61. Floen told King he had carried heavy equipment on that ramp many times and was lucky it hadn't collapsed on him. The shaking King experienced was due to a fall or buckling of the conveyor walkway, along with a broken beam and bolts that were sheared.

King provided an incident report to the company that day describing what had happened. At first report, King did not believe he had not been injured, but later discovered that he had incurred a spinal cord contusion, which required pain medication and physical therapy. King also suffered from mild post-traumatic stress disorder and sleep disturbances after the accident. Tr. 71-73.

The next day that King was scheduled to work, he met with Gornik to receive his work orders. King recalled that Gornik was nervous, and told King that he had been discussing the incident with other miners. Gornik explained that people at the company had known about the potential for a collapse and had been hoping that removing the weight of the pellets would allow the ramp to last longer before it had to be replaced. At hearing, Gornik denied making any such statement, claiming instead that he had no knowledge that the walkway was in danger of collapsing and would not have sent workers onto the outer walkway if he had. Tr. 475.

As a result of the accident, King filed a hazard complaint with MSHA on September 8, 2016, and Inspector Terrance Norman was assigned to investigate. His investigation resulted in the issuance of the citation and order at issue here, and was the basis for the 110(c) investigation regarding Peterson and Zimmer. Norman has been a mine inspector since 2014, and previously worked for 20 years in the mining industry. His investigation into the hazard complaint and the incident involving King lasted approximately eight weeks. He conducted interviews with Northshore employees, management, contract laborers, the contract safety director, and the owner of the contracting company. Tr. 98. He also worked with a special investigator from MSHA and an engineer from the MSHA technical support division regarding the safety of the east walkway.

Norman determined that concerns about the walkway had been ongoing for several years. Daniel Scamehorn, a structural engineer with Northshore, testified that he first learned of a problem with the 62/162 gallery in 2013. An engineer supervised by Scamehorn submitted a work order in October 2013 reporting that concrete panels on the underside of the gallery had been falling. The work order mentioned that steel plates had been installed sometime earlier under the center walkway, but that the two outer walkways had not been reinforced and thus needed repair. Sec'y Ex. 18. Scamehorn testified that around the same time, the company had to do repairs on another conveyor at the mine, the No. 2, which had a similar problem with concrete falling from the bottom of the conveyor. The company prioritized the work on the No. 2 conveyor and put the repairs for the 62/162 on a project list to be considered in the future. Tr. 339.

In November 2014, another work order concerning a walkway in the 62/162 gallery was initiated by Jason Betzler, then the hot side maintenance planner at the mine. Betzler noticed cracking in the concrete and observed that in places along the walkway, the concrete had settled up to four inches. Resp. Ex. A. Betzler testified at hearing that the work order was in reference to the center walkway and did not concern the outer walkways. Upon receiving the work order, Scamehorn reviewed the maintenance records for the 62/162 gallery, and learned that steel plates had been installed under the center walkway in 2010. Scamehorn also examined the center walkway himself, and observed that it was cracked and that the edges of the walkway were settling. Scamehorn believed that the middle of the walkway was being heaved upward by material trapped by the steel plates. He did not examine the outer walkways. Subsequently, Scamehorn contacted the engineering firm Krech Ojard and Associates, Inc. ("KOA") to contract with the firm to evaluate the condition of the 62/162 conveyor walkway. An engineer from KOA visited the mine and conducted a visual inspection of the conveyor gallery. As a result, a report was prepared and sent to Scamehorn in June 2015. Tr. 324-25; Sec'y Ex. 12.

The KOA report was introduced as Secretary's Exhibit 12. As part of their work, KOA engineers reviewed structural design documents for the gallery, and learned that the center and outer walkways were constructed of 2 5/8 inch perlite panels reinforced with wire mesh fabric and a 1 1/2 inch plain concrete topping. KOA structural engineer Patrick Leow visited the gallery to conduct the evaluation for KOA. He visually inspected the gallery from the ground level inside and outside the gallery, then walked the center and east walkways and a portion of the west walkway. He observed cracking and heaving on the outer walkways. Tr. 367.

Following the examination of the walkway, an engineer-in-training from KOA prepared the written report that was submitted to the mine. The report states that Leow observed damage over large areas of the walkway slab underside, which included spalled concrete, delaminated concrete, debonded reinforcement, and corroded reinforcement. Sec'y Ex. 12. Leow clarified at hearing that this description referred to the perlite panels forming the underside of the walkway and did not refer to the concrete topping. Tr. 366. The damage was observed on the outer walkways but it was not visible on the center walkway because of the steel plate reinforcement on that walkway's underside. The report further states that the topping slab was in poor condition with large surface cracks and heaving, and that it was in need of replacement. The engineers believed that the damage was caused by the freeze-thaw cycle and water seeping into the space between the perlite and the concrete. The report also includes an evaluation of the load rating for the center walkway. KOA found that the perlite slabs, as well as the concrete, were compromised and provided little to no structural support. Thus, the report found that the center walkway was "potentially reliant upon the structural capacity of the steel plate reinforcing alone." With respect to the outer walkways, the report found that the concrete was damaged but lacked the steel panels. The report states that without steel plate reinforcing, the outer walkways "may not contain adequate structural support for the use of these walkway areas." Sec'y Ex. 12. Therefore, the outer walkways "cannot be found to be structurally adequate for use." *Id.* The report concludes with the recommendation that Northshore "restrict access to these [outer] walkways as they are not safe for personnel to be using until a repair has been completed." *Id.* KOA also recommended that the company prohibit use of a heavy equipment cart on the center walkway, and limit the use of that walkway to personnel performing minor maintenance activities due to the tripping hazard from cracked concrete. The report recommends that Northshore replace the walkway slabs.

After receiving the report, Scamehorn discussed the findings with Leow, the structural engineer from KOA. Based upon their conversation, Scamehorn supposed that the condition of the gallery was not as severe as the report had indicated. Scamehorn believed that Leow's main concern with the gallery was the cracking on the top concrete slab of the outer walkways, which created the potential for a "very finite failure," meaning a small foot hole, if the cracks were to align a certain way. Tr. 328-29. Leow gave the impression that there was a potential for a small hole, but not a hole large enough for a person to fall through, nor did he indicate that it was necessary to completely prohibit access to the outer walkways. Scamehorn understood that access to the outer walkways should be limited to maintenance activities, with no casual traffic permitted. Tr. 330.

Scamehorn conveyed the KOA report, along with information from the conversation with Leow, to Matthew Zimmer and Roger Peterson, the section managers of hot side maintenance and operations. Scamehorn explained that the potential issue with the walkways was a finite failure in the form of a foot hole. While there was cracking visible, it was nothing that he believed formed any present concern. Based on that information, the three decided to require fall protection on the outer walkways to mitigate any risk of a person falling through to the ground. Scamehorn said that he believed it to be a conservative approach because there was no actual risk of a person falling through to the ground. The three did not discuss installing warning signs or barriers on the outer walkways.

In November 2015, the mine was idled due to economic conditions in the steel industry, and most of the workforce was laid off. Workers were rehired and the plant was restarted beginning in March 2016. Tr. 552. Around that time, Erik Ollila, a maintenance supervisor, received a report from one of the maintenance workers that material was falling from the underside of the 62/162 gallery. Ollila went to look at the gallery and observed that there were pieces of perlite on the ground that had fallen from the gallery. Ollila directed miners to install jersey barriers in the areas where material was falling from above so that miners traveling under the walkway would not be hit by falling debris. However, the roadway under a portion of the conveyor walkway was not blocked off. Around the time the jersey barriers were installed, Northshore discontinued a practice of using front-end loaders to knock icicles down from under the gallery during the winter months. Tr. 127. There is no evidence of further maintenance or safety measures taken to address the condition of the conveyor walkways.

Inspector Norman interviewed several miners at Northshore to determine how the east outer walkway was used prior to the accident in September 2016. Steve Floen, a miner employed as a maintenance mechanic at Northshore, informed Norman that he had worked in the gallery the week prior to the accident, changing idlers on the conveyor. He stated that the miners were afraid to walk down the outer walkways, and instead climbed over the conveyors to reach them. He explained that while changing the rollers there was not always a place to tie off, so sometimes they worked on the outer walkways without being tied off. Tr. 116, 196. Floen claimed that he had brought these issues to the attention of his supervisor, Erik Ollila, as well as to Roger Peterson. Inspector Norman confirmed that the central walkway rather than the outer walkways was the usual route for travel for maintenance work, but some limited access to the outer walkways was necessary.

As part of his inspection, Norman took photographs of the site where the accident occurred. The photos were introduced as the Secretary's Exhibit 7. A photograph of the exterior of the gallery taken from the mine road shows that about halfway down the length of the gallery, the roof of the gallery had settled and a piece of siding was missing. Sec'y Ex. 7, 00015. A photograph taken closer to the area where the siding is missing shows that the upper and lower beams on the gallery have settled significantly. Sec'y Ex. 7, 00019. Norman determined that the failure point of the walkway was at a height of 50 feet and was located above the roadway through the gallery. Norman also took photographs of the underside of the east outer walkway, which show that the perlite had deteriorated to the point of falling, and the internal wire mesh of the floor was exposed. Sec'y Ex. 7, 00086, 00088. Photographs of the west outer walkway also show deteriorating perlite. Sec'y Ex. 7, 00097.

An engineer from MSHA Technical Support, Michael Superfesky, inspected the mine after the accident and took photographs. One of his photographs taken from a manlift shows mesh in one area of the walkway. Sec'y Ex. 7, 000921. There is no perlite in the mesh as there should be; instead, the floor is visible through the mesh. There is also a significant crack in the concrete, which Superfesky believed had been there for some time. Tr. 247-48. Another photograph shows the underside of the walkway 15 to 30 feet up the walkway from where the accident occurred. Sec'y Ex. 7, 000950. The mesh is showing through in this part of the walkway as well, and much of the perlite is missing. Sec'y Ex. 7, 000950. Superfesky noted

that the upper layer of concrete showing through the mesh was stained red from taconite pellets, indicating that it had been exposed for some time. Tr. 251. Superfesky explained that the mesh broke easily, either during or before the accident, and thus must have been corroded. Tr. 254. In Superfesky's view, the weight of the pellets as they were being moved with high compression water added to the cause of the failure of the walkway.

Following the accident, David Franseen, an engineer at KOA, visited the mine site to investigate the accident and assist with remediation. He took photographs of the gallery over the course of several weeks. Respondent's Exhibit M3 illustrates the east side of the gallery after the exterior cladding had been removed. There are two vertical support beams with a diagonal beam between them. The diagonal beam is broken and no longer connected to the left beam. Resp. Ex. M3. The photograph also shows that a horizontal board used to attach the cladding is broken, and bolts are sheared in the lower right hand corner at the connection point of two horizontal beams. Franseen believed the horizontal beam had moved significantly during the accident. Respondent's Exhibit M1 shows the piece of steel that the walkway would have been resting on, known as the "clip angle." Tr. 526-27. It is bent downward to an angle of approximately 48 degrees. Resp. Ex. M1. Franseen opined that the pellets that were being hosed down the walkway were a component of the failure of the beam and the walkway. The entire conveyor structure was compromised and could no longer be used following the failure of the beam and the walkway in September 2016.

A. Order No. 8897220

Following his inspection, Inspector Norman issued Order No. 8897220 to Northshore for failing to maintain the 62/162 outer walkways in good condition. The Secretary alleges a violation of 30 C.F.R. § 56.11002, which provides that "[c]rossovers, elevated walkways, elevated ramps, and stairways shall be of substantial construction provided with handrails, and maintained in good condition. Where necessary, toeboards shall be provided."

The parties disagree as to whether the walkways were "maintained in good condition" prior to the accident on September 7, 2016. The Secretary argues that the walkway had extensive cracking, spalling concrete, delaminated concrete, and debonded and corroded reinforcements, which diminished the carrying load strength. The walkways had been deteriorating over a long period of time and, given the conclusions of the KOA report, the walkway was not safe. The mine operator argues that the actual condition of the walkway was substantial and had been maintained. The condition of the perlite panels and concrete did not support the Secretary's view that the walkway was not maintained.

Several expert witnesses testified regarding the condition of the east outer walkway. Michael Superfesky,[1] a civil engineer with MSHA Technical Support, testified for the Secretary. Superfesky visited the Northshore mine after the accident to determine the cause of the collapse and whether the structure was safe for continued use. Superfesky discussed the accident with Inspector Norman and mine personnel, and inspected the gallery, primarily the outside from a

1. Superfesky holds a master's degree in civil engineering with an emphasis in structural engineering. Tr. 234. He is a licensed professional engineer. He has conducted around 28 accident investigations for MSHA.

manlift and from the ground. Superfesky observed that the east outer walkway was about four inches thick and was composed of two layers. The bottom layer was a 2.6-inch layer of perlite containing 10-gauge, bi-directional wire mesh. Above the perlite was a 1.6-inch layer of concrete. Superfesky observed that the mesh in the perlite layer had detached or de-bonded from the perlite. He explained that the mesh is essential to the structure because it provides tensile strength, which is lacking in concrete. That tensile strength was significantly diminished when the mesh de-bonded from the perlite. Superfesky estimated that the de-bonded mesh had reduced the load-carrying capacity of the walkway by as much as 50 percent. Superfesky also observed cracking or spalling in the top layer of concrete in isolated areas as a result of the freeze/thaw cycle. Superfesky noted that the structure was old and would have been through many freeze/thaw cycles. He explained that with the loss of the tensile strength, the concrete would be distressed and the cracking would accelerate.

Superfesky concluded that prior to the accident the walkway was structurally deficient for foot traffic. He reviewed the mine's maintenance records and found that there had been no maintenance to the walkways other than to add steel plates to the center walkway. He also reviewed the KOA report and observed that the KOA engineers had noted many of the same indicators of deterioration in 2015 that he noted in the fall of 2016. He interpreted the KOA report as recommending that no one access the outer walkways until repairs were made. The KOA report referred to a strength of 3,000 psi for the top concrete layer and Superfesky explained that such strength was insufficient to support the weight of a person along with the weight of the large amount of taconite pellets observed on the walkway.

Superfesky explained that the east walkway was in deteriorating condition, and that the walkway failed due to its condition. Contrary to the assertion of Northshore, the problem with the walkway was not caused by the beam that broke but, instead, had the walkway been maintained, it would not have failed. I find Superfesky to be a credible and knowledgeable witness. His opinion is based on sound scientific principles and sound reasoning. He demonstrated the various ways in which the walkway was compromised through the photographs in Secretary's Exhibit 17. He also testified that fall protection does not completely mitigate the fall; the use of fall protection can result in a number of serious, if not fatal, injuries.

Patrick Leow,[2] one of the engineers who prepared the 2015 KOA report, testified on behalf of Northshore about the condition of the walkway at the time of the report. Leow's testimony implied that he did not believe that the walkway was in as bad of a condition as his report had indicated in 2015. That KOA report explained that the outer walkways in the gallery "cannot be found to be structurally adequate for use." Sec'y Ex. 12. Leow explained that it is difficult to calculate the load carrying capacity of concrete, and this statement simply meant that he could not provide calculations to definitively show the load carrying capacity of the walkways. The report also recommended "that Northshore Mining restrict access to these [outer] walkways as they are not safe for personnel to be using until a repair has been completed." Sec'y Ex. 12. Leow testified that he intended that Northshore limit access to the walkways to authorized personnel only, and not that the mine completely prohibit use of the walkways. He

2. Leow holds a master's degree in civil engineering and is a licensed professional engineer. He works in structural engineering. Tr. 362. His testimony was not offered as that of an expert witness.

stated that his primary concern was that excessive cracks could lead to deformation of the walkway or that small chunks could fall out, and not that someone would fall through the walkway. While the deterioration of the walkways would continue, it would be slow, according to Leow. Nevertheless, he concluded that there was some risk with the outer walkways and that mitigation was necessary. He proposed limiting use of the walkways to reduce exposure and also suggested that the mine provide protective measures for people who did use the walkway. I do not find Leow to be a credible witness given that his testimony in 2018 departs dramatically from the written conclusions of the 2015 KOA report.

A second engineer with KOA, David Franseen,[3] provided expert opinion as to the cause of the September 7 accident. Franseen testified that due to the cleaning work being done at the time of the accident, there was a significant amount of taconite pellets on the walkway, more than the walkway was designed to carry. Resp. Exhibit O. Franseen determined that the concentrated weight of the pellets caused the diagonal beam in the gallery to fracture. The fracture of the beam then caused one of the vertical beams in the gallery to be displaced downward. *Id.* The vertical displacement of the beam created an increased vertical load on the clip angle, a piece of steel below the concrete and perlite of the walkway. These forces caused the clip angle to bend and rotate away and the bolts of the walkway support beam to shear off. With the left edge of the walkway no longer supported, the concrete and perlite portions fell. Franseen stated that the concrete portion was mainly intact with no significant holes when it was removed after the accident. He believed the walkway would have failed as a result of the beam failure even if it had been in brand new condition. He acknowledged that the perlite was deteriorating, but stated that the perlite is primarily used during the construction stage as a form to pour the concrete into and is not intended to last. Franseen explained, that in addition to the mesh in the perlite layer, there was also mesh reinforcement in the concrete layer providing additional strength to the walkway. Franseen's ultimate conclusion was that the walkway was in fact capable of supporting more weight than the primary structure of the gallery. Thus, he believed that the weight of the taconite pellets on the walkway led to the failure of the beam rather than to the failure of the walkway. Tr. 539. The Secretary suggests the opposite, that the weight of the pellets caused the walkway to fail, resulting in the failure of the beam. In any event, the failure of the beam is not definitive evidence of the condition of the walkway itself. Instead, I rely on the KOA report, along with eye witness testimony regarding the condition of the walkway.

The issue here is whether the elevated walkway, specifically the east side walkway of the conveyor, was maintained in good condition. There is ample evidence to demonstrate that it was not. Even if it had not failed during the moving of the taconite pellets, the evidence demonstrates that the walkway was not in good condition at the time of the KOA report in June 2015 and no action to correct the condition of the walkway had been taken up to the time the walkway failed in September 2016. Inspector Norman learned through interviews that the maintenance crew would not walk on the east walkway, but walked up the middle walkway and climbed over the conveyor to maintain it. Floen, one such maintenance worker, explained to Norman that they worked in that manner because the outside walkway was in bad condition.

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3. Franseen holds a bachelor's degree in civil engineering and has done work in concrete testing and the forensics of concrete. Tr. 512-13. He was accepted as an expert witness in the field of structural engineering.

They understood that because of its bad condition, they should use fall protection when on the east walkway but they were often not able to do so. Lehtinen explained that he learned from Gornik that workers must tie off on that outer walkway because the floor was bad. Most importantly, the KOA engineering report clearly indicates that the outer walkways were in bad condition and, at best, protective measures should be used when accessing the outer east walkway.

The KOA report, Secretary's Exhibit 12, indicates that the walkways were not safe for personnel to use until repaired. All of the evidence—the falling chunks of cement, the cracks, and the heaving, for several years—points to the fact the walkway was not maintained. Respondent argues that the fall protection requirement was a mitigating factor but fall protection is not a substitute for keeping the walkway in good condition. It may lessen an injury, but it does not prevent the walkway from being dangerous. Norman relied upon the findings in the KOA report in issuing the violation and specifically referred to the report's conclusion that "the deteriorated condition of the conveyor walkway slabs is significant . . . access to the outer walkway slabs be restricted." I find that there is substantial evidence to support the alleged violation. Further, I find that the violation was significant and substantial.

Significant and Substantial

The Secretary alleges that the violation was highly likely to result in fatal injury and was significant and substantial ("S&S"). An 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)(l). 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, 2036 n.8 (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.

Inspector Norman explained that based upon his investigation, he concluded that using the outer walkways would result in an accident. The cited standard is designed to protect persons from having to walk in an area that is not maintained in good condition. The lack of such maintenance would result in any number of hazards, including a fall on the walkway, or a fall through any holes in the walkway. Given that the walkway was covered in mud and taconite pellets, the miners could not see the condition of the floor below and all accounts indicate that the walkway floor was in poor condition. The fact that the concrete was in poor condition, and that the walkway was covered in mud and pellets, both indicate a violation of the requirement to keep the walkway maintained in good condition. Each condition created a separate hazard. First, the pellets and mud contributed to a fall hazard in an area next to a moving conveyor. Second, the condition of the walkway created a hazard of material falling to the ground below, as well as uncertain footing and walking in the area with cracks and missing portions. Finally, the condition of the walkway would cause it to give way, causing the miner to fall 50 feet to the area below. I find it likely that all of these hazards were created in this instance and find further that each of the hazards is likely to result in a serious injury.

Norman explained that if the floor gave way, a fall to the ground below would be fatal. Even if tied off, the miner would be jolted and strike his head. He could hit equipment below and injure his back or neck, or cement could fall and hit the miner. The use of fall protection, therefore, does not mitigate the seriousness of the injury. Nor is the hazard mitigated by the fact that the primary walkway was the center one, and not the east side walkway. Miners were often sent out into the area of the east walkway, and were not tied off. Certainly the crew on September 7 was only tied off a portion of the time, and King was fortunate that he was not more seriously injured. The standard is designed to keep walking areas in good condition to prevent fall hazards. Here, the hazard of falling was likely and a fall would result in a serious, if not fatal injury. The violation is properly designated as S&S.

Negligence

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 FMSHRC1687, 1702 (Aug. 2015); *U.S. Steel Corp.*, 6 FMSHRC 1908, 1910 (Aug. 1984).

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); *see also* 30 U.S.C. § 801(e). "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." *Wilmot*, 9 FMSHRC at 688.

Reckless disregard is "the closing of the eyes to or deliberate indifference toward the requirements of a mandatory safety standard, which standard the (mine) should have known and have reason to know at the time of the violation." *United States v. Jones*, 735 F.2d 785, 790 (4th Cir. 1984). The Commission has recognized that negligence is properly characterized as reckless disregard where a supervisor directs a miner into a situation knowing that the situation poses an immediate and appreciable risk to the safety of that miner. *Lehigh Anthracite Coal*, 40 FMSHRC 273, 283-84 (Aug. 2018).

The Secretary alleges that the violation involved reckless disregard for the safety of miners. The Secretary bases his argument on the fact that Scamehorn understood there could be a localized failure of the walkway and that both Peterson and Zimmer, agents of the operator, were aware of the deteriorated condition of the walkway and took no reasonable steps to correct the condition. Northshore argues that the negligence was lower because the mine made reasonable efforts to address the safety hazard by requiring miners to wear fall protection. The Secretary believes the fall protection measures were "wholly inadequate," and did not mitigate the negligence in this case.

Northshore received the engineering report from KOA in June 2015, after it had received a number of complaints about the condition of the outer walkways on the 62/162 conveyor. There was no indication that anything was done to shore up or otherwise repair the aging outer walkways. Steel reinforcement had been installed to support the center walkway, but the outer walkways did not receive such reinforcement. The center walkway was the primary access to the conveyor and was used most often. Nonetheless, miners were required to use the east outer walkway and to work on that walkway.

The mine argues that the miners were directed to use fall protection, that access to the walkway was restricted, and that employees had been trained on the use of the fall protection, thereby mitigating the negligence. However, nothing was done to directly correct the condition of the walkway or make it safer to use. Instead, it continued to deteriorate. Further, for miners who were not familiar with the area, there was no sign posted to indicate that fall protection was required. The miners were often not tied off when doing maintenance or changing the rollers, and on the day of the accident, the worker hosing down the pellets was not continually tied off.

Inspector Norman indicated that the mine was reckless in continuing to allow access to the east walkway, even if miners were tied off. In his view, fall protection may have been discussed at one time, but it was not made clear to the miners or the contractors how and when to tie off. Management was aware of the condition of the walkway, yet made no effort to correct or maintain the walkway in a safe condition.

Failure to maintain the walkway resulted in the walkway crumbling and falling away while workers were on it. On the day of the accident, the contract miners were using hoses to wash the pellets down the 300 feet of the outer walkway ramp, and in doing so, the pellets built up in some locations, causing a heavy load on the walkway. The condition of the walkway was such that it could not withstand the weight of the pellets as they washed down. Mine management knew of the condition of the area yet demonstrated indifference to the violation, thereby placing the contract miners in a hazardous position. I credit Superfesky's testimony that the condition of the walkway was the primary reason for its failure, and find that the failure of the mine to correct the condition and maintain the walkway in good condition was the result of reckless disregard.

Unwarrantable Failure

The Secretary alleges that the violation was the result of an unwarrantable failure to comply with the regulation.

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.

The Secretary submits that the violation was extensive, that both outer walkways were dangerously deteriorated, and because it was unknown when a failure would occur, miners were exposed to a hazard for the entire length of both walkways. Miners doing work over the previous year were exposed to the same hazard as those in September 2016. The amount of time that the mine knew of the hazard is significant, along with the obviousness of the condition. Northshore argues that the violation was not an unwarrantable failure to comply because the mine took what it viewed as effective remedial measures to address a known condition. The walkways were in usable condition and there was no significant hazard.

Length of time that the violation has existed. In *IO Coal Co.*, the Commission emphasized that the duration of time that the violative condition existed is a "necessary element" of the unwarrantable failure analysis. 31 FMSHRC at 1352. The condition in *IO Coal* had existed for four or five days, and the Commission remanded to the judge to consider whether such duration was an aggravating factor. 31 FMSHRC at 1352. The Commission noted that analysis of the duration factor may be affected by the operator's good-faith, reasonable belief that the condition did not exist. *Id.* at 1352-53.

The problem with the outer walkways had existed for several years, at least from the time in June 2015 when the KOA report had been completed. In all likelihood, the problem also existed prior to the report, as there is evidence that a number of miners complained about the walkways. Even after the mine was made aware of the deteriorating condition of the walkways from the 2015 KOA report, no maintenance or repair had occurred by the time of the accident in September 2016. During the time between the report and the accident, the walkway continued to crack and deteriorate. The length of time figures prominently in the evaluation of the unwarrantable failure.

Extent of the violative condition. 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). Facts relevant to the extent of the condition include the size of the affected area and the number of persons affected. *Id.* at 3079-80. In *Dawes*, the Commission found that where only one miner endangered himself by walking under a suspended load, the violation was not extensive. *Id.* at 3080.

Here, the violation included the entire 300 feet on the east outer walkway, as well as the west outer walkway. Accessing the conveyor system was most often done by using the reinforced, center walkway. Still miners explained that they used the outer walkway to perform maintenance tasks and on the day of the accident, the contract miners had been using the walkway for two days. The violation was thus extensive and workers were called to use the entire area.

Whether the operator has been placed on notice that greater efforts were necessary for compliance. A mine operator may be put on notice that it has a recurring safety problem in need of correction where there is a history of similar violations. *Black Beauty Coal Co. v. FMSHRC,* 703 F.3d 553, 561 (D.C. Cir. 2012); *IO Coal*, 31 FMSHRC at 1353; *Peabody Coal Co.,* 14 FMSHRC 1258, 1264 (Aug. 1992). Prior violations may be relevant even though they did not involve the same regulation or occur in the same area of the mine within a continuing time frame. *IO Coal*, 31 FMSHRC at 1354; *San Juan Coal Co*., 29 FMSHRC 125, 131 (Mar. 2007); *Peabody*, 14 FMSHRC at 1263. It is not required that the past violations were the result of unwarrantable failure. *IO Coal*, 31 FMSHRC at 1354; *Consol. Coal Co*., 23 FMSHRC 588, 595 (June 2001). Past discussions with MSHA can also serve to place the operator on notice that greater efforts were necessary to assure compliance with the safety standard. *Consol. Coal Co.,* 35 FMSHRC 2326, 2342 (Aug. 2013) (citations omitted).

The Secretary did not present evidence that the mine had been told to correct the condition of the walkway or that it had been cited for similar violations prior to September 2016. However, the mine was put on notice of the defective walkway through complaints made by miners, and through the KOA engineering report in June 2015, Secretary's Exhibit 12. The report explains that the load bearing capability could not be determined and that access to the walkway should be restricted. Therefore, notice has some effect on the finding of an unwarrantable failure.

Operator's efforts in abating the violative condition. An operator's efforts in abating the violative condition are also relevant as to whether a violation is unwarrantable. *Consol.*, 35 FMSHRC at 2342; *IO Coal*, 31 FMSHRC at 1356; *San Juan,* 29 FMSHRC at 134. Abatement efforts prior to or at the time of the inspection may support a finding that the violation was not unwarrantable. *Utah Power & Light Co.*, 11 FMSHRC 1926, 1933-34 (Oct. 1989). Conversely, where the operator has notice of a condition, such as through previous violations or conversations with an inspector, a failure to remedy the problem weighs in favor of an unwarrantable failure finding. *Consol.*, 35 FMSHRC at 2343; *Enlow Fork Mining Co.*, 19 FMSHRC 5, 17 (Jan. 1997). 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.

Northshore argues that instituting a policy of using fall protection when accessing the outer walkways was an attempt to abate the condition. Peterson and Zimmer, the managers who determined that fall protection should be used, testified that they did not understand that access should be prohibited, but merely restricted. They agreed that the use of fall protection would protect against injury. Even though they are trained mine managers and supervisors, they did not consider repairing the walkway and did not see that it was maintained in a safe condition. While the use of fall protection has some mitigating purpose, it does not correct the condition. Therefore, no effort was made to address the deteriorating walkway itself.

Whether the violation posed a high degree of danger. A high degree of danger posed by a violation can be an aggravating factor that supports an unwarrantable failure finding. *IO Coal*, 31 FMSHRC at 1355-56. In some cases, the degree of danger may be "so severe that, by itself, it warrants a finding of unwarrantable failure. However, the converse of this proposition—that the absence of significant danger precludes a finding of unwarrantable failure—is not true." *Manalapan Mining Co.*, 35 FMSHRC 289, 294 (Feb. 2013). The degree of danger is greater when there is a chronic problem that is ignored. *Consol.*, 35 FMSHRC at 2343.

The hazard created by a failure to maintain the east walkway in good condition, created a high degree of danger. The KOA engineering report explained that the outer walkways were not safe for use until repairs could be made. A number of hazards had been created, including falling through the walkway, stumbling and falling on the uneven surface, and walking on the taconite pellets. All of these examples indicate that the violation created a serious safety hazard and thus a high degree of danger.

Whether the violation was obvious. The obviousness of the violative condition is an important factor in the unwarrantable failure analysis. *IO Coal*, 31 FMSHRC at 1356. However, when a condition is non-obvious because of actions of the operator, the Commission generally does not recognize lack of obviousness as a mitigating factor. *Consol.*, 35 FMSHRC at 2343 (upholding judge's unwarrantable failure finding where the operator deliberately ignored testing requirements in the mine's ventilation plan).

The hazard was obvious to many of the miners who spoke with Inspector Norman. They indicated that chunks of the walkway had fallen to the ground below and that they crawled across the conveyor to do maintenance in order to avoid the outer walkways. The violation was also obvious to the mine and particularly to the engineers who made complaints, including Scamehorn, who requested an engineering report. The managers who reviewed the report were aware of the hazard. The obviousness of the deteriorating and unsafe condition of the outer walkways is one of the primary factors in finding this violation to be unwarrantable.

Operator's knowledge of the existence of the violation. In *IO Coal,* the Commission reiterated the well-settled law that an operator's knowledge of the existence of a violation may be established not only by demonstrating actual knowledge, but also by showing that the operator "reasonably should have known of the violative condition." *IO Coal Co.,* 31 FMSHRC at 1356-1357; *see also Drummond Co*., 13 FMSHRC 1362, 1367-68 (Sept. 1991); *E. Associated Coal Corp*., 13 FMSHRC 178, 187 (Feb. 1991); *Emery Mining Corp*., 9 FMSHRC at 2002-04.

As discussed above, even if the mine denies knowledge of the violation—that is, the condition of the outer walkway based upon their observation—the engineering report made it clear that the walkway was not safe for use. The mine managers received the KOA report in June 2015 and understood that, at best, the outer walkways should be restricted. Yet no action was taken to repair or maintain the walkways. Knowledge is an important factor in determining that the violation is unwarrantable.

Based upon the factors listed here, I find that the violation was a result of the mine's unwarrantable failure to comply with the Mine Act and its standards.

Flagrant Violation

The Secretary has designated this violation as flagrant and assessed a penalty of $130,000.00 as a result.

The Act provides that

> Violations under this section that are deemed to be flagrant may be assessed a civil penalty of not more than $220,000. For purposes of the preceding sentence, the term "flagrant" with respect to a violation means a reckless or repeated failure to make reasonable efforts to eliminate a known violation of a mandatory health or safety standard that substantially and proximately caused, or

> reasonably could have been expected to cause, death or serious bodily injury.

30 U.S.C. § 820(b)(2). Thus, in order to establish that a violation was flagrant, the Secretary must prove that:

> (1) there was a condition that constituted a violation of a mandatory health or safety standard, (2) the violation was "known" by the operator; (3) the violation either (a) substantially caused death or serious bodily injury, or (b) reasonably could have been expected to cause death or serious bodily injury; (4) there was a failure on the part of the operator to make reasonable efforts to eliminate the violation; and (5) that failure was either "reckless" or "repeated."

Am. Coal Co., 38 FMSHRC 2062, 2066-67 (Aug. 2016). As discussed below, I find that the Secretary has not established the elements of a flagrant violation.

The Secretary argues that the violation was flagrant because Northshore management knew of the condition of the walkway, failed to make reasonable efforts to eliminate a known violation, and displayed reckless disregard toward miners. Scamehorn, Peterson, and Zimmer were on notice of the violation based upon the 2015 engineering report they received from KOA, but ignored the report's findings, as well as the miners' concerns about the walkways. Northshore takes the position that the violation is not flagrant because the condition of the walkway was not the cause of the accident and that there was no injury here. The mine also asserts that the condition of the walkway would not lead to a serious injury because the miners wore fall protection.

As set forth above, the Secretary has established that a violation of a mandatory standard occurred. Next, the Secretary has shown that the violation was known by the operator. The discussion regarding the unwarrantable failure established that there is substantial evidence to demonstrate that the mine knew that the outer walkways were in a dangerous and deteriorating condition, in violation of 30 C.F.R. § 56.11002. Work orders dating back to 2013 detail concerns about cracks, debonding, and spalling of concrete on the 62/162 walkways. The June 2015 KOA report warned the mine that the load bearing capacity of the outer walkways could not be determined and that access to the walkways should therefore be restricted. While the center walkway had, at some point, been reinforced with steel plates, the outer walkways had not received the same repairs. Mine managers, employees, and engineers all testified that they were aware that the east walkway was not being maintained in a safe condition. Therefore, the knowledge required for the second element of the flagrant assessment is met.

The third element of the flagrant discussion identified in *Am. Coal Co.*, 38 FMSHRC at 2066-67, requires the Secretary to show that the violation either substantially caused or reasonably could have been expected to cause death or serious bodily injury. This part of the analysis is similar to the third and fourth prongs of the *Mathies* test, which is used to evaluate whether a violation is properly designated as significant and substantial. As discussed above, the

hazards created as a result of this violation were likely to result in serious injury. These hazards include tripping or falling on the walkway or through to the ground below.

The parties disagree over whether a fall due to the failure of the walkway floor would reasonably have been expected to cause death or serious bodily injury. The mine argues that the potential for such a fall from the elevated walkway must be evaluated in the context of a miner using fall protection. The mine's argument assumes that miners were always correctly and appropriately tied off when using the outer walkways. The testimony in this case has shown otherwise. King was clear that he and the other contractors were not tied off for the entire time and gave two examples. First, they were not tied off when they walked up the ramp in order to take turns cleaning the walkway. Second, they could not tie off for the entire time while using a high pressure hose to move the pellets down the walkway because they had to unclip in order to move down the walkway. Furthermore, the contract miners did not appear to understand that they needed to be tied off for the entire time that they used the east walkway. Thus, based on the facts surrounding the violation, I find that the violation reasonably could have been expected to cause death or serious bodily injury.

Finally, a flagrant violation involves a "reckless or repeated" failure to make reasonable efforts to eliminate the violation. 30 U.S.C. § 820(b)(2). This component of the flagrant violation relates to the degree of negligence with which the operator acted. The unwarrantable failure analysis above also relates to negligence. However, the Commission in *Am. Coal* found that based on the heightened penalties available under the flagrant provision, the violations should be distinguishable from those addressed under the S&S and unwarrantable failure provisions of the Act. 38 FMSHRC at 2069-70. Thus, the "reckless failure" component of a flagrant violation requires a higher negligence showing than that required under the unwarrantable failure analysis.

The mine's conduct amounts to reckless disregard when analyzed in the context of the negligence and unwarrantable failure frameworks, but the same conduct does not rise to the heightened recklessness contemplated by a flagrant designation. In *Stillhouse Mining,* Judge Paez noted that a reckless failure to make reasonable efforts to eliminate a violation occurs when "in light of all the facts and circumstances surrounding the violation, the operator does not take the steps a reasonably prudent operator would have taken to eliminate the known violation of a mandatory health or safety standard and consciously or deliberately disregards an unjustifiable, reasonably likely risk of death or serious bodily injury." *Stillhouse Mining, LLC*, 33 FMSHRC 778, 804 (Mar. 2011) (ALJ). The analysis is in line with the Commission's discussion in *Am. Coal*, 38 FMSHRC 2062.

While it is true that Northshore failed to take steps that a reasonably prudent operator familiar with the mining industry would have taken to protect miners from the risks related to using the walkways in their deteriorated condition, they made some effort to address their concerns. Respondent could have repaired the walkway but the mine chose to use fall protection as a solution. Given that decision, there is no evidence to suggest a conscious or deliberate indifference to the risks on the part of the mine. Instead, the evidence indicates that the mine was limited at best in its evaluation of the risks. In other words, rather than ignoring the problem, the mine did not fully consider the appropriate steps to take to mitigate the risk

posed by the condition of the walkways. Respondent believed, albeit wrongly, that requiring miners to wear safety harnesses would solve the problem with the walkways until repairs were completed. This type of conduct, while careless and indicative of reckless disregard, does not meet the heightened negligence showing required under *Am. Coal*, 38 FMSHRC 2062. Therefore, I find that the violation of section 56.11002 cited in Order No. 8897220 is not flagrant within the meaning of section 110(b)(2) of the Act.

B. Citation No. 8897219

Based upon his observations and the interviews conducted at the mine following the accident in September 2016, Inspector Norman issued Citation No. 8897219 for a failure to barricade the east outer walkway. The Secretary alleges a violation of 30 C.F.R. § 56.20011, which provides that "[a]reas where health or safety hazards exist that are not immediately obvious to employees shall be barricaded, or warning signs shall be posted at all approaches. Warning signs shall be readily visible, legible, and display the nature of the hazard and any protective action required." There is no dispute that there were no warning signs or barricades at the east walkway. The only barricades related to the walkway had been placed below the walkway when chunks of cement were observed falling from the walkway onto the area below where miners traveled. Those barriers had been removed at the time of the incident and had no effect, in any event, on the walkway above.

The Secretary alleges that the violation is proven because there were no barricades or warnings to alert miners to the hazards of the walkway. The condition of the walkway, while perhaps known to some workers, was not obvious to contractors and miners who did not routinely work in the area. The condition was not immediately obvious because the walkway was covered in mud and 6 to 12 inches of pellets. The mine defends that the Secretary did not prove that the condition of the walkway was not obvious. Further, the walkway was in good condition and it was not often used.

I find that the Secretary has shown that the walkway created a safety hazard to miners that was not immediately obvious due to the mud and pellets on the surface. The area should, therefore, have had barricades or warning signs and none were present. The discussion regarding the first violation cited by Norman relates to the safety hazard of the walkway and is incorporated here, along with the S&S discussion related to the hazards. A number of miners told Norman that the walkway was a safety hazard and they avoided it. Floen advised the inspector that it was necessary to access the outer walkways at least every four to six weeks to change the conveyor rollers or idlers. Other maintenance was done from the walkway as necessary, including hosing down the pellets to clear the walkway.

The walkway created a safety hazard, as evidenced by the cracks, the chunks of cement that had fallen to the ground below, and the lack of reinforcement similar to that on the center walkway. In addition, the KOA report specifically said that the load bearing capacity could not be determined, and the area should be restricted. The cracks in the concrete, coupled with the spalling and uneven surface, created a hazard on the walkway. In addition, the walkway was in such poor condition that holes could develop leading to a miner putting a foot through the floor

or falling through the floor onto the roadway 50 feet below. Hence, the Secretary has demonstrated that the area was a safety hazard.

Next the Secretary has demonstrated that the hazard was not obvious to all miners and particularly the contractors working at the mine. The contractors were not told about the condition of the walkway, except to say that fall protection was needed to avoid the fall hazard of walking on the pellets. King explained that the condition of the walkway was not obvious because it was covered in mud and pellets and he could not see the surface. The contractors and miners who did not routinely use the walkway would not be aware of the hazardous condition of the walkway because it could not be seen. Even miners who worked in the area claimed that they did not know that the walkway was in bad condition. For example, Lehtinen explained that he learned from Gornik that the floor of the walkway was bad when they were discussing the use of fall protection by the contractors in September 2016. Therefore, it was not obvious to him that the cement floor beneath the pellets was a hazard. For miners or contractors who did not routinely work in the area, there was no indication of a hazard or of a requirement to use fall protection. Given that the walkway created a safety hazard, and that hazard was not obvious, barricades or warning signs were required at either end of both outer walkways. I find that the violation, as alleged, has been shown.

Significant and Substantial

The Secretary alleges that Citation No. 8897219 was highly likely to cause a fatal injury and was significant and substantial. I have found that there is a violation and I find further that the standard violated is meant to protect miners from entering unsafe areas where the hazard is not obvious so that miners can avoid the area or take other precautions. The KOA report, Secretary's Exhibit 12, includes a statement that the outer walkways of the conveyor area are not safe for personnel to use until repaired. The conclusion of the report includes "the deteriorated condition of the conveyor walkway slabs is significant... access to the outer walkway slabs be restricted." Thus, the outer walkways were compromised and the condition created a hazard to anyone who entered the area. The lack of warnings and barriers created a hazard by not warning workers to stay out of the area. The mandatory standard is intended to prevent access, or at least provide caution, when miners must access an area where a hazard exists, yet is not obvious. The evidence here demonstrates that there is a strong likelihood that a miner, who is not familiar with the area, would enter into an unsafe walkway and likely be injured.

Inspector Norman suggests that unknowingly using the floor of the walkway would result in an accident if the floor gave way. In addition, the condition of the concrete under the mud and pellets added to the slip and fall hazard. Without notice, miners will not avoid the area or take precautions if they do decide to access the area. The miners also explained to Inspector Norman that tying off to use the walkway was difficult at best and, often times, miners were without fall protection. The decision to require fall protection was not effective in this case, and did not mitigate the hazard created by the lack of barriers or warning signs.

Norman also testified that a hazard is likely to lead to an accident which would in turn result in a serious injury. A miner who wanted to use the walkway, would not be aware of the floor under the pellets, and could trip on the uplifted cement floor, or stumble on one of the

cracks, resulting in a fall. But most importantly, when the walkway heaves or gives way, as it did for King, there is a real danger of falling through the walkway to the ground below. Falling through a hole from 50 feet to a concrete surface below would lead to a fatal injury. In the event a miner only put a leg through the hole, a serious injury would still likely occur. Similarly, if a miner is tied off when the floor gives way, a hole opens up, or he trips, a serious injury can occur. A safety line may stop the miner from falling 50 feet, but it can lead to other hazards, such as being jostled or yanked by the lanyard resulting in back and neck injuries. A miner who is tied off could also strike his head, hit equipment below, or be hit by falling cement. The presence of the fall protection may lessen the injury in some circumstances, but does not remove the likelihood of a serious injury. Further, the miners agreed that even if they used fall protection, there were not always tied off. Therefore, I find that it is reasonably likely that an accident would occur, and result in a serious, if not fatal, injury. The violation is therefore, significant and substantial.

Negligence

The Secretary alleges that Citation No. 8897219 involved reckless disregard on the part of the operator and cites to the same arguments as those for the negligence in the violation cited above in Order No. 8897220. The arguments include the miners' complaints about the condition of the walkway and the subsequent engineering report that indicated that the walkway was not safe for use. The Secretary argues that both Gornik and Lehtinen say they did not know about the condition of the walkway, but were the persons assigned to direct the contractors. They were told by Zimmer to have the contractors use fall protection, but only for purposes of protecting against a fall on the pellets. Both Zimmer and Peterson failed to consider the serious consequences of their actions. Northshore, too, makes the same arguments as to the negligence of the order discussed above. That is, that the mine required fall protection and therefore made some effort to protect the safety of miners. In addition, the mine argues that the managers understood from Leow that the condition may not have been as bad as the report suggested and were not negligent in relying on those representations.

A reasonably prudent miner would have understood that telling miners to wear fall protection was not enough. Instead signs should have been posted advising miners about the condition of the walkway and, if the fall protection was required, to have a sign advising of the requirement. The primary support for a finding of reckless disregard is the fact that the mine commissioned the 2015 KOA engineering report to address concerns about the condition of the conveyor walkway. The resulting report from KOA found that the walkway was not safe for personnel to use and access should be restricted. The mine, through its engineers and two of its managers, knew of the poor and dangerous condition of the walkway, yet failed to put up any warning or barricade to at least limit access to the area until repairs could be completed. The area was open and available to anyone who was in the conveyor area, and it could have been accessed without any warning. The mine knew of the problem with the east walkway but took no steps to limit access and those actions demonstrate an indifference to a known violation. The managers put the miners in a situation that posed a significant risk to safety. Therefore, I agree that the violation is the result of reckless disregard on the part of the mine.

Unwarrantable Failure

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 at 353 (citing *Emery*, 9 FMSHRC at 2001-04) (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. *IO Coal Co.*, 31 FMSHRC at 1352; *see also Consol.*, 22 FMSHRC at 353. Both the Secretary and Northshore refer to the arguments made when discussing the unwarrantable nature of the violation in Order No. 8897720. Many of those arguments apply here.

Length of time that the violation has existed. The problem with the outer walkways had existed for several years, at least from the time in June 2015 when the KOA report had been completed. As a result of the report, the mine was made aware of the deteriorating condition of the walkway in 2015 and nothing was done to correct the condition. The walkway continued to crack and deteriorate up until the accident on September 7, 2016. For more than a year, the mine failed to put any barriers in place to prohibit access, or post any warning signs to prevent access, to warn of the dangerous condition, or to provide notice of a requirement to wear fall protection. The length of time figures prominently in the evaluation of the unwarrantable failure designation.

Extent of the violative condition. The extent of the violative condition included the entire walkway, on both the east and west side of the conveyor, each extending about 300 feet. No barriers or warnings were used at either of the two walkways, leaving it accessible to anyone. The entire area was open to use by any person at the mine. Therefore, the violative condition was extensive.

Whether the operator has been placed on notice that greater efforts were necessary for compliance. In this case, the mine was put on notice of the defective walkway, first by complaints by miners and then by the KOA engineering report in June 2015, Secretary's Exhibit 12. The report indicated that the load bearing capability of the outer walkway could not be determined. The KOA report indicated that the mine should restrict access to the outer walkways, and yet no barriers or warnings were put in place following that notice. The mine did determine that fall protection should be used on the outer walkways, but again did not post a warning or notice in that regard.

Operator's efforts in abating the violative condition. The only effort made to address the deteriorating walkway and its unsafe condition was to tell miners to use a safety harness when accessing the outer walkways. Although mine management may have told workers at the location to use safety harnesses, they did not post a notice explaining the requirement. Nor did mine management place any barriers to restrict access to the walkways as suggested by the report. Therefore, I find that no efforts were made to abate the condition.

Whether the violation posed a high degree of danger. This violation, the failure to warn miners of the unsafe condition of the walkway, posed a high degree of danger. A contractor or a miner who did not usually work in or around the conveyor walkways would not understand that access to the area was restricted, or that there was a safety hazard to be considered. Anyone using the walkway would be subjected to a number of hazards, including the cracks, uneven concrete, and the possibility of falling through a hole in the walkway floor.

Whether the violation was obvious. The hazard regarding the walkway was obvious to many of the miners who spoke with Inspector Norman, but the unsafe condition of the walkway was not obvious to each miner or contractor who may have been required to use the walkway. Although the condition of the walkway was not obvious to all miners or contractors due to the mud and pellets, the condition, and hence the violation, was obvious to mine management.

Operator's knowledge of the existence of the violation. The mine had knowledge of the existence of the violation and failed to take any action. The mine received a number of complaints from miners and engineers about the condition of the outer walkways, including complaints about falling cement and debris. The mine managers received the KOA report in June 2015 and understood that, at best, the outer walkways should be restricted from use. Yet no action was taken to barricade or otherwise provide a warning about the condition of the walkways. A reasonable prudent miner, and manager, familiar with the requirements of the Act, would understand that to limit access or require the use of fall protection, requires a barricade or some kind of notice at each end of each walkway.

Based upon the factors discussed, I find that the violation was a result of an unwarrantable failure to comply with the standard.

C. Liability of the Agents

The Secretary also seeks to impose personal liability under Section 110(c) against two employees of the mine: Matthew Zimmer, Section Manager for Hot Side Asset Management, and Roger Peterson, Section Manager for Hot Side Operations and Maintenance. The Secretary alleges that both Zimmer and Peterson, acting as agents of the mine, knew of the violative condition addressed by Order No. 8897220, the failure to maintain the walkway, and failed to act on the basis of that information to protect worker safety and health.

The negligence of an operator's agent is imputable to the operator for penalty assessment and unwarrantable failure purposes. *Nelson Quarries, Inc.*, 31 FMSHRC 318, 328 (Mar. 2009); *Whayne Supply Co.*, 19 FMSHRC 447, 450 (Mar. 1997); *Rochester & Pittsburgh Coal Co.*, 13 FMSHRC 189, 194 (Feb. 1991). The Mine Act defines an "agent" as "any person charged with responsibility for the operation of all or a part of a coal or other mine or the supervision of the miners in a coal or other mine." 30 U.S.C. § 802(e). In analyzing whether an employee is an agent of an operator, the Commission has considered factors including "the ability of the employee to direct the workforce, whether the employee holds himself out as a person with supervisory responsibilities and is so regarded by other miners, and whether the actions of the

employee in directing the workforce have an impact on health and safety at the mine." *Nelson Quarries*, 31 FMSHRC at 328.

Section 110(c) provides that when a corporate operator violates a mandatory health or safety standard . . . any director, officer, or agent of such corporation who knowingly authorized, ordered, or carried out such violation . . . shall be subject to the same civil penalties, fines, and imprisonment that may be imposed upon a person under subsections (a) and (d) [providing for assessment of civil and criminal penalties against mine operators]. 30 U.S.C. § 820(c). The Commission has explained that an agent is liable under Section 110(c) when the agent, "knew or had reason to know of a violative condition." *McCoy*, 36 FMSHRC at 1996. The relevant question is whether the agent knowingly acted; the Secretary need not prove that the individual knowingly violated the law. *Id.*; *Warren Steen Const. Inc.*, 14 FMSHRC 1125, 1131 (July 1992).

The Commission has determined that "[a]n individual acts knowingly where he is, 'in a position to protect employee safety and health [and] fails to act on the basis of information that gives him knowledge or reason to know of the existence of a violative condition.'" *McCoy*, 36 FMSHRC at 1996 (quoting *LaFarge Constr. Materials*, 20 FMSHRC 1140, 1148 (Oct. 1998)) (alteration in original). Liability under Section 110(c) "is generally predicated on aggravated conduct constituting more than ordinary negligence" but, "does not hinge on whether an agent engaged in 'willful' conduct." *Matney, employed by Knox Creek Coal Co.*, 34 FMSHRC 777, 783 (Apr. 2012). For the purposes of Section 110(c), "knowing" conduct includes deliberate ignorance and reckless disregard as well as actual knowledge. *Freeman United Coal Mining Co. v. FMSHRC*, 108 F.3d 358, 363 (D.C. Cir. 1997).

Zimmer and Peterson have worked at the mine for 13 and 25 years, respectively, and both have shared an office and worked in managerial roles since at least 2015. As part of their responsibilities, they both assigned and directed the work of other miners. Zimmer's team was normally comprised of seven miners, while Peterson directed three operating supervisors and four maintenance supervisors. Zimmer testified that it was part of his job to plan and coordinate the maintenance and repair work that would take place in the 62/162 gallery, and ensure that his group worked safely. Peterson was largely responsible for reviewing work orders, prioritizing and directing maintenance work, and, when necessary, informing miners of any changes in safety policies or procedures. Both Zimmer and Peterson became aware of the KOA report and its conclusions with respect to the outer walkways shortly after the mine received the report in June 2015.

The KOA report included the recommendation that access to the outer walkways be restricted, "as they are not safe for personnel to be using until a repair has been completed." Sec'y Ex. 12. Following a conversation with Scamehorn, the mine engineer who initially received the KOA report, both Zimmer and Peterson believed that the report's recommendation to restrict access was not an outright prohibition, but rather a limitation on use of the outer walkways. Instead of repairing or prohibiting use of the walkways, together they decided to implement a fall protection policy. Shortly after receiving the report, Zimmer and Peterson informed their crews of the fall protection requirement. When the

mine used contractors more than a year later, they were told to use fall protection to avoid tripping on the pellets, but were not warned about the condition of the walkway. There is no indication that the policy was reduced to writing, or that any signs or notices were posted indicating that fall protection was essential. Zimmer and Peterson did not take any steps to repair or maintain the outer walkways after learning of the condition, both from miner complaints and from the written KOA reports. Peterson maintained that he did not believe anyone would fall through the floor of the walkway and was not aware that miners could not be tied off the entire way while accessing the outer walkways. Nonetheless, as a manager, Peterson is trained in safety and in the requirements of the Mine Act.

The Secretary alleges that both Peterson and Zimmer were agents of the operator based upon their supervisory roles and their authority to hire, fire, discipline miners, assign job duties, shut down operators and direct the workforce. Northshore does not dispute that they are agents as defined by the Act.

The Secretary argues that both Peterson and Zimmer failed to act based upon the KOA report findings and recommendations that detailed the unsafe condition of the walkways. Both participated in conversations with Scamehorn concerning the deteriorating condition of the outer walkways, and agreed to require the use of fall protection rather than repairing or maintaining the walkway as required by the MSHA standard. They were aware that the walkways were used for maintenance and other travel, but subjected miners to an unsafe and unsound work area.

Northshore argues that Peterson should not be charged as an agent because he did not directly interact with Leow regarding the KOA report, but instead acted based upon what he learned from Scamehorn. Further, following the June 2015 KOA report, Peterson was involved in implementing the fall protection requirement and communicated the need for fall protection to the supervisors. The mine makes the same argument on behalf of Zimmer, but adds that on June 1, 2015, Zimmer no longer had responsibility for employees who worked along the outer walkway. I do not find merit in the mine's argument that Zimmer was no longer in charge of employees in that area as of June 1, since it is undisputed that he was involved in making the decisions after receiving the KOA report.

During the accident investigation, Zimmer and Peterson were interviewed by James Hautamaki, a special investigator with MSHA. Based on his interviews with Zimmer and Peterson, Hautamaki concluded that both men had knowledge of the violative condition and failed to act to protect worker safety. Hautamaki testified that he learned that both Zimmer and Peterson knew about the structural concerns with the floor of the outer walkways before KOA was called in to perform the evaluation. Once they received the KOA report, Zimmer, Peterson, and Scamehorn came to the conclusion that fall protection would be sufficient. According to Hautamaki, neither Zimmer nor Peterson personally inspected the area before deciding to implement fall protection, and neither manager thought to put up barricades or warning signs to warn miners about the condition of the walkway or of the need to wear fall protection. Hautamaki also learned that while both managers informed their respective crews about the condition of the walkways and that access was to be restricted, a similar warning was not given to the contractor crew in charge of cleaning the outer walkways.

There is sufficient evidence to demonstrate that both Zimmer and Peterson, acting as agents of the mine, knew that the walkways of the 62/162 gallery were not of substantial construction or maintained in good condition. Many of the actions that resulted in a finding of reckless disregard, for Order No. 8897220, can be attributed to the action or inaction of Zimmer and Peterson as agents of the mine. For example, Zimmer authorized a work order for the 62/162 gallery in September 2015, which stated, in part, "[v]erify the floor is safe on the east side of the conveyor. Roger [Peterson] says that fall protection is required." Resp. Ex. F. The contractors testified that they were not told of the condition of the floor, only that they needed fall protection to avoid falling on the pellets. Moreover, as managers, Zimmer and Peterson received copies of the KOA report, along with an email from Scamehorn alerting them to the structural issues with the walkways and suggesting that they restrict access.

Similarly, there is sufficient evidence to support the conclusion that Zimmer and Peterson failed to act on the basis of the walkway information to protect worker safety and health. Following receipt of the KOA report, Zimmer and Peterson spoke with Scamehorn. Together, they decided that they would take no corrective action, but instead put the walkways on a list for later repair. More than a year later, when King and the contract crew were assigned to clean the outer walkway, nothing had been done to repair or maintain the walkways. Zimmer and Peterson did agree to require fall protection and instructed the supervisors regarding the need for fall protection on the outer walkways. However, they failed to repair or maintain the walkway. Fall protection was an inadequate solution to address the violative condition here; miners could not be tied off the entire time on the outer walkways and had to unclip their harnesses to move when performing maintenance on the conveyor belts and when hosing down the pellets. Both Zimmer and Peterson did not fully consider the importance of repairing the walkways or warning the miners of the deteriorated state of the walkways, and instead tried to work around the issue by implementing, rather badly, a policy of fall protection. Mine managers who are trained on the requirements of the regulations, and on the importance of safety and health, should have known that the conveyor walkways must be maintained in good condition or, alternatively, restricted from access appropriately. Therefore, I find both Zimmer and Peterson, individually, liable under section 110(c) of the Act.

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). The duty of proposing penalties is delegated to the Secretary. 30 U.S.C. §§ 815(a), 820(a). The Secretary calculates penalties using the penalty regulations set forth in 30 C.F.R. § 100.3, or following the guidelines for special assessments in 30 C.F.R. § 100.5. When an operator notifies the Secretary that it intends to challenge a penalty, the Secretary then petitions the Commission to assess the penalty. 29 C.F.R. § 2700.28. Commission judges are not bound by the Secretary's penalty regulations or his special assessments. *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). In keeping with this statutory requirement, the Commission has held that judges must make findings of fact on the statutory penalty criteria. *Sellersburg Stone Co.*, 5 FMSHRC 287, 292 (Mar. 1983), *aff'd*, 736 F.2d 1147, 1152 (7th Cir. 1984). Once these findings have been made, a judge's penalty assessment for a particular violation is an exercise of discretion, "bounded by proper consideration of the statutory criteria and the deterrent purposes underlying the Act's penalty scheme." *Id.* at 294; *see also Cantera Green*, 22 FMSHRC 616, 620 (May 2000). The Commission requires that its judges explain any substantial divergence from the penalty proposed by the Secretary. *Am. Coal*, 38 FMSHRC at 1990.

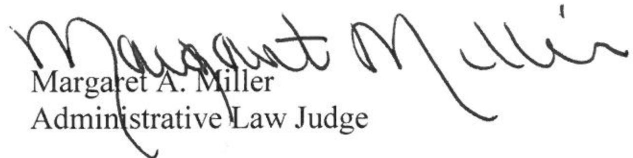
The Secretary has proposed a penalty of $130,000 for the violation cited in Order No 8897220, which alleges a failure to maintain the outer walkways. The proposed penalty is based upon a finding that the violation was flagrant, and assessed pursuant to 30 U.S.C. § 820(b)(2). The flagrant aspect is discussed above and I have found that the Secretary has not met his burden of proof with regard to the flagrant finding. However, there is a violation of the mandatory standard, the violation is S&S and unwarrantable. In addressing those issues, I addressed the negligence of the operator and agree that the mine engaged in a reckless disregard of the mandatory standard. I have also addressed the gravity of the violation and found it to be a serious violation that would result in death or serious bodily injury. I have also considered the history of assessed violations. Sec'y Ex. 1. The violation was abated in good faith. The mine has not raised the ability to pay. Northshore is considered a large mine operator. Based upon my findings, I assess a penalty of $60,000 for this violation.

The Secretary has proposed a penalty of $69,400 for the violation cited in Citation No. 8872219, which alleges a failure to provide barricades and/or warning signs at either end of the outer walkways. The proposed penalty was assessed as a special assessment, but in determining the penalty, I have considered and applied the six penalty criteria. Northshore is a large operator and did not raise the ability to pay the penalty as proposed. The history of assessed violations shows three citations for violations of this standard in the 12 months prior to this citation. Sec'y Ex. 1. The good faith abatement has been considered. I have addressed the negligence and gravity in the discussion above and have found the negligence to be reckless disregard and the gravity to be extremely serious. Therefore, I assess a penalty of $60,000.

The two agents named in this matter, Zimmer and Peterson, have been assessed a proposed penalty of $4,300 and $4,500 respectively. I have addressed the negligence of each of the agents above, along with the gravity of the violation. Neither of the agents has raised the issue of the ability to pay, and neither have a history of a violation as an agent of the operator. Based upon all of the findings, I assess a penalty of $4,000 for each.

III. ORDER

Respondent, Northshore Mining, is hereby **ORDERED** to pay the Secretary of Labor the sum of $120,000.00 within 30 days of the date of this decision. Matthew Zimmer is ordered to pay $4,000.00, and Roger Peterson is ordered to pay $4,000.00 as an agent of the operator within 30 days of the date of this decision.



Margaret A. Miller
Administrative Law Judge

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