FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

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SECRETARY OF LABOR MINE SAFETY AND HEALTH ADMINISTRATION (MSHA), Petitioner, v. MACH MINING, LLC, Respondent.	CIVIL PENALTY PROCEEDINGS Docket No. LAKE 2011-518 A.C. No. 11-03141-248113 Docket No. LAKE 2012-861 A.C. No. 11-03141-296483 Mine: Mach #1 Mine

DECISION

Appearances: Daniel McIntyre, Esq., United States Department of Labor, Office of the Solicitor, Denver, Colorado, for the Secretary.

David Hardy, Esq., Hardy Pence, PLLC, Charleston, West Virginia, for the Respondent.

Before: Judge Andrews

This case is before me upon a petition for assessment of civil penalty filed by the Secretary of Labor ("Secretary"), acting through the Mine Safety and Health Administration ("MSHA"), against Mach Mining, LLC, ("Mach," or "Respondent") at its Mach #1 Mine, pursuant to Sections 105 and 110 of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. §§ 815 and 820 (the "Act"). There were originally five dockets as part of this proceeding. However, three of them, LAKE 2011-422, LAKE 2011-977, and LAKE 2012-808, have fully settled, and LAKE 2011-518 and LAKE 2012-861 have partially settled.[1] Tr. 4, 5.[2] At issue in this proceeding are the six remaining citations, and the proposed assessment of civil penalties totaling $14,706.00. A hearing was held on October 23, 2014 in Evansville, Indiana at which

[1] A Decision Approving Settlement was issued for LAKE 2011-422, LAKE 2011-977, LAKE 2012-808, Citation No. 8424247 of LAKE 2011-518 and Citation Nos. 8436394, 8445204, 8445218, 8445222, 8445228, 8445233, and 8444830 of LAKE 2012-861 on October 29, 2014.

[2] Here and hereinafter, the official transcript of the hearing from October 23, 2014 is abbreviated as "Tr."

time the parties presented testimony and documentary evidence. After the hearing, the parties submitted post-hearing briefs.[3]

I. STIPULATED FACTS

The parties have agreed to the following stipulations:

1. Mach Mining, LLC ("Mach") was at all times relevant to these proceedings engaged in mining activities at the Mach #1 Mine located in or near Johnson City, Illinois.
2. Mach's mining operations affect interstate commerce.
3. Mach is subject to the jurisdiction of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 801 *et seq.* (the "Mine Act").
4. Mach is an "operator" as that word is defined in §3(d) of the Mine Act, 30 U.S.C. §803(d), at the Mach #1 Mine (Federal Mine I.D. No. 11-03141) where the contested citations in these proceedings were issued.
5. The Administrative Law Judge has jurisdiction over these proceedings pursuant to §105 of the Act.
6. On the dates the citations in these dockets were issued, the issuing MSHA coal mine inspectors were acting as a duly authorized representatives of the United States Secretary of Labor, assigned to MSHA, and was acting in his official capacity when conducting the inspection and issuing MSHA citations.
7. The MSHA citations at issue in these proceedings were properly served upon Mach as required by the Mine Act.
8. The citations at issue in these proceedings may be admitted into evidence by stipulation for the purpose of establishing their issuance.
9. Mach demonstrated good faith in abating the violations.
10. In 2010 the Mach #1 Mine produced 5,795,493 tons of coal and its controlling entity produced 7,912,241 tons of coal.
11. In 2011 the Mach #1 Mine produced 7,226,500 tons of coal and its controlling entity produced 10,846,269 tons of coal.
12. The penalties proposed by the Secretary in this case will not affect the ability of Mach to continue in business.

JX 1.[4]

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[3] The Secretary's Post Hearing Brief is abbreviated as "SPHB." Mach Mining's Post Hearing Brief is abbreviated as "RPHB." Respondent's Response Brief is abbreviated as "RRB."

[4] The Joint Exhibit is abbreviated as "JX." The Government's exhibits are abbreviated as "GX." The Respondent's exhibits are abbreviated as "RX."

II. LAKE 2011-518: CITATION NO. 8427074

a. Summary of the Evidence

On January 28, 2011, MSHA Inspector Larry Morris[5] ("Inspector Morris" or "Morris") inspected the Mach #1 Mine. Tr. 16. He was originally called by his supervisor, Mike Rennie ("Supervisor Rennie" or "Rennie"), to investigate a fire on the mine's surface. Morris and Rennie went to the mine together. Tr. 16.

While at the mine site, Morris noticed a violation of a safeguard issued on January 2, 2009 that required all persons being transported on all mobile equipment to keep their extremities within the structural support (bed) of the vehicle. GX 4. Morris testified that the safeguard was issued in order "[t]o prevent people from getting injured by having parts of their bodies outside of the structural confines of the equipment they were being transported in." Tr. 19. Morris was aware of the safeguard when he was inspecting Mach #1 Mine in 2011. Tr. 20.

Morris saw two miners sitting on the tailgate of a truck leaving the slope of the mine with their legs hanging off the back of the tailgate. Tr. 21. Another truck exited the mine approximately 30 feet behind the first truck. Tr. 25. Supervisor Rennie also observed both miners with their feet hanging off, and Morris discussed the matter with him. Rennie sent Morris to issue the violation to the supervisor, while Rennie attended to the fire. Tr. 42, 43. Morris testified that the miners "were sitting on the tailgate and their knees were right at the end of the tailgate with their legs hanging down off the tailgate." Tr. 23, 24. He observed that the miners' legs were hanging vertically from the truck, and their thighs and buttocks were on the tailgate. Tr. 24, 26. Both miners were sitting in the back of the truck with their legs hanging out and looking directly at Morris as he approached the truck. Tr. 32-35, 38.

Morris did not interview either of the two miners whose legs he saw hanging off the bed of the pickup truck. Tr. 29, 30. But, he had a conversation with Foreman Johnny Dotson ("Foreman Dotson"), the driver of the truck, when he went to see him to issue the violation. Tr. 34. Morris walked up to a few feet from the driver's side of the truck after he saw the miners with their legs hanging off the end of the truck. Tr. 103, 115, 116. He testified that when the tailgate is down the bumper is underneath it and you cannot reach the bumper. Tr. 24, 117. Morris further testified that when the tailgate is down, he considered it to be a part of the bed of the truck. Tr. 45. He stated the photograph marked as Exhibit RX 2 was an accurate illustration of a tailgate in the down position. Tr. 46, 47. Morris did note that some trucks used to have a chain hooked across the back of the sides of the bed instead of the device shown in that photograph. Tr. 48.

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[5] Morris was a Coal Mine Inspector and accident investigator for MSHA, and has also worked as a conference and litigation representative. Tr. 12, 13. He has worked for MSHA for approximately eight years and was in the mining industry for an additional 32 years. Tr. 12, 14. He attended 26 weeks of training and also underwent on-the-job training, learning from experienced inspectors and specialists. Tr. 15.

Inspector Morris memorialized his observations in handwritten notes recorded at the time of the inspection:

> Mike Rennie (FOS/MSHA) & myself were standing approx 100 feet from the slope mouth when 2 pick up trucks/mantrips came up the slope approx 30 feet apart. Two miners in the front truck were sitting in the back of the truck bed with their legs hanging out over the rear bumper. I walked over to where the truck was being parked & told the miners that they must keep their legs inside the body of the truck. I told the foreman Johnnie Dotson, also the driver of the front truck that I was issuing a citation on the safeguard in force at this mine regarding this situation.

GX 3, pp 4, 5.[6]

Morris issued a 104(a) Citation, No. 8427074, to Foreman Dotson at 1640 hours. Section 8 of the citation read, in pertinent part:

> Two miners were observed coming out of the mine in the slope, riding in the back of a pickup truck/mantrip, sitting in the bed of the truck with their legs hanging out of the back of the truck bed. There was another pickup truck/mantrip following approximately 30 feet behind the front truck.

The Standard, 30 CFR § 75.1403, was cited 13 times in two years at the mine.

Morris determined that the violation was Significant and Substantial ("S&S"), that an injury was reasonably likely, and such injury could reasonably be expected to be permanently disabling. He marked the citation as two miners affected, and the negligence as high. Termination of the citation was at 1642 hours, when the miners were removed from the truck.

GX 2.

Morris also testified the truck, with the miners' legs dangling off the back, would have traveled over various potholes. Tr. 25, 26. Morris did not see the potholes on the day of the inspection but knew of the potholes from previous experience. Tr. 36, 37. If a miner were to fall from the truck, an injury could be permanently disabling or even fatal. Tr. 26. Morris testified that if the truck in front had stopped, the truck following only 30 feet behind would not have much stopping distance. Tr. 25. Morris marked the condition as resulting from high negligence because Foreman Dotson was driving the pickup truck. Tr. 27, 52. The initial action was listed as safeguard number 6674671 dated January 2, 2009, and Morris testified this safeguard put the mine on prior notice. Tr. 27; GX 2, 4.

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[6] Respondent objected to the admission of the notes of the Inspectors on the basis that such notes can only be used to refresh the recollection of the witness. However, an Inspector's notes written at the time of the inspection are not so limited. These recordings of observations and actions taken are relevant to the violations cited and are admissible as evidence into the official record. At the hearing, notes of the Inspectors in the Government's exhibits were admitted.

Robert Darrell Shaw[7] ("Shaw") testified for Respondent. Shaw, a shuttle car driver at the Mach mine, was one of the two people whom Morris observed with his feet hanging out of the truck. Shaw stated that a crew of 11 people was working outby. Tr. 52. At the end of their shift, he was riding in the back of a Dodge Ram truck. Tr. 53, 54. The crew rode in the back of the truck and they all had their "spots". There was no tailgate on the truck; there was a tailgate when they went to the work site, but none when they came back. Tr. 53. Shaw was sitting with his right foot on top of the bumper and his left foot folded underneath him. Tr. 59, 60. He said that he would never ride with his legs hanging out of the truck, and that he remembered his position on the day of the inspection because it is how he sat every day. Tr. 61. Shaw rode in a truck like that at least two times a day, but sometimes he would be inside the pickup. Tr. 70. He saw somebody come up and talk to Dotson but did not know who it was. Tr. 65, 66. Chris Wilson[8] ("Wilson") sat across from Shaw, and Wilson was sitting in the same position as Shaw, except that his feet were in opposite positions. Tr. 63–65. Wilson also sat like that every day. Tr. 65.

Wilson testified he was working on the same crew as Shaw on the day of the inspection. Tr. 88. Foreman Dotson was the crew's supervisor. Tr. 88. All 11 crew-members were in the truck, with six riding in the quad cab and five in the back. Tr. 88, 89, 92. Wilson was in the rear right of the truck's bed, and Shaw was sitting directly across from him. Tr. 93; RX 7. The two were facing each other. RX 7. Wilson's left foot was on the bumper and his right foot was in the bed of the truck. Tr. 99, 100. Wilson also testified there was no tailgate when they got back. Tr. 101. Wilson testified that he does not normally sit with his legs hanging over the bed of the truck because of potential harm. Tr. 100, 102. He also testified that most of the time the trucks had tailgates. Tr. 108. Wilson recalled that Shaw's back was to the Inspector and Shaw would not have been able to see the Inspector run up to the truck. Tr. 106, 107.

b. Contentions

The Secretary contended the Respondent violated the January 2, 2009 safeguard requiring people being transported in a vehicle to keep their extremities within the vehicle's structural support. Specifically, the Secretary alleged that Inspectors Morris and Rennie witnessed two miners sitting on the tailgate of a truck with their legs hanging off the tailgate's back. The miners could be injured by a fall or by the second truck being unable to avoid a fallen miner. The Secretary further contended the violation was the result of Respondent's high negligence, since it was unacceptable to permit the cited behavior after receiving the safeguard. The Secretary argued that feet on the bumper would violate the safeguard. The Secretary also argued the Respondent's witnesses were not credible, and the Court should uphold the citation as issued. For this citation, the Secretary proposed a penalty of $5,080.00.

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[7] At the time of the hearing, Shaw had worked at the Mach mine for almost 8 eight years. Tr. 50. He was an hourly worker there. Tr. 51. He was a certified miner for the State of Illinois, and is able to drive a scoop and tram a pinner. Tr. 50, 51. He was not a roof bolter. Tr. 51.

[8] Chris Wilson was employed by Mach for almost eight years. Tr. 85. He worked as a coal miner for Willow Lake before working for Mach. Tr. 86. He worked for almost 14 years in the mining industry, and held a certification from the State of Illinois. *Id.*

The Respondent contended that Citation No. 8427074 should be vacated because the Secretary bears the burden of proof but has not rebutted the operator's testimony and a violation of Safeguard No. 6674671 has not been proven. The Respondent cited *Bethenergy Mines Inc.*, 14 FMSHRC 17, 25 (Jan. 1992) in which the Commission held that a safeguard must be narrowly interpreted so that the Secretary's authority to require a safeguard and the operator's right to fair notice of what the safeguard requires is balanced. Respondent argued that the safeguard does not define "structural support" and also does not define what it means to keep extremities within the "structural support". The miners were resting their feet on the rear bumper which according to Respondent is part of the "structural support" of the vehicle. They did not face any additional danger by having their feet on the bumper, and there was an absence of clarity regarding the bumper. Respondent also argued that no person other than the inspector claimed to have seen the miners riding on the tailgate, and that the inspector did not make an effort to interview the miners. The Respondent also contended the Secretary failed to call any witnesses to corroborate Morris's version of the events in contrast to the two hourly employees that it called who consistently testified. In the Respondent's opinion, the present case is a "quintessential equipoise" case. The Respondent also contended that any negligence of the miners in having their feet on the bumper is not attributable to the operator, and the absence of notice regarding the bumper is a mitigating factor. Also, the Foreman was driving and there was no testimony he could see the miner's feet on the bumper. The negligence should be reduced from high and the significant and substantial designation should be removed.

c. Analysis

30 C.F.R. § 75.1403, "Other safeguards", provides:

> Other safeguards adequate, in the judgment of an authorized representative of the Secretary, to minimize hazards with respect to transportation of men and materials shall be provided.

Under 30 C.F.R. § 75.1403, the operator was required to follow the safeguard Inspector Bobby Jones issued on January 2, 2009. That safeguard read:

> On 1/02/2009 a Dodge pickup truck was observed heading toward the slope collar with 7 miners riding in the bed of the truck. Two of the seven miners were sitting on the tailgate with their legs hanging outside of the structural support (bed) of the Pick up [*sic*] truck. This is a notice to provide safeguards requiring all persons being transported on all mobile equipment to keep their extremities within the structural support of the vehicle.

GX 4.

While the Secretary bears the burden of proving the citation by a preponderance of the evidence, I find that Morris's testimony was credible and the Secretary presented sufficient evidence to meet his burden. Morris credibly testified that he witnessed the two miners' legs outside the bed of the truck, which was in violation of the January 2, 2009 safeguard. The

Secretary also pointed to Shaw and Wilson's testimony wherein each miner stated they placed one of their feet on the bumper of the truck, and even this constituted a violation of the safeguard, which required that all miners' extremities remain within the truck.

No strain of interpretation is required to understand the safeguard at issue. The safeguard is not at all vague, indefinite or uncertain as to its meaning. It requires that miners keep their extremities within the bed of a pickup truck. The safeguard, as written, identifies the truck bed as the structural support of that type of vehicle. It is striking that what was observed by Inspector Bobby Jones in January 2009 was identical to what was observed by Inspector Morris two years later. In each instance two miners were sitting on the tailgate with their legs hanging out. It is compellingly clear that the operator would be on notice that a repeat of this behavior would be a violation. Simply put, Respondent disregarded the safeguard that was in effect.

The Secretary also contended that the testimony of the Respondent's witnesses was not credible. Both Shaw and Wilson testified to the effect that the tailgate was on the truck at the beginning of the trip, but was off the truck for the trip out. Not established or even explained by any evidence were the circumstances, the reasons or by whose direction the tailgate was removed by or on January 28, 2011. For example, no work order for this change to the truck or even testimony by a person responsible for or conducting this work is of record. And, Wilson also testified that *most of the time* the trucks had tailgates. Just when the truck tailgates were on or off the trucks was not clearly established. Respondent failed to corroborate the testimony of the miners regarding the removal of the tailgates.

That Shaw had excellent recollections about that ride on that day out of the thousands of his rides in and out of the portal is contradicted by his conflicting testimony that the crew rode in the back of the truck and all had "spots", whereas in further testimony he said that he was not always in the back of the truck but sometimes inside the pickup. Also, Shaw's testimony was vague on whether he saw an Inspector come up to the truck and talk to Foreman Dotson. But Wilson testified that Shaw's back was to the Inspector and Shaw would not have been able to see the Inspector approach the truck.

In contrast, Inspector Morris directly observed the truck from the time it exited the slope until it parked, discussed with Supervisor Rennie what they were observing, and recorded what he saw in his notes. Approaching and arriving only a few feet from the truck, Morris was in a position to clearly see the miners and how they were riding on the tailgate with their legs-both legs-hanging down vertically. Morris also pointed out that with the tailgate down the bumper would be covered and it would not be possible for the miners to rest their feet on it. Morris considered the tailgate in the down position to be a part of the bed of the truck.

The plain language of the safeguard has the word "bed" in parentheses to define "structural support." It is clear that the purpose of the safeguard was to ensure that miners kept their extremities within the bed of the truck. Whether the lowered tailgate is viewed as a *part of* or as an *extension of* a truck bed, this is a reasonable interpretation of what constitutes the "bed" of a truck and hence "structural support" for the purposes of the safeguard. The rear bumper is not mentioned in the context of either "bed" or "structural support", and for the purposes of the safeguard there was no need to include it. Indeed, in the instant case, it is not necessary to

determine and does not matter whether the rear bumper is considered a part of the "structural support" of a pickup truck.

I place the greatest weight on the evidence presented by the Secretary. The testimony of Inspector Morris, his contemporaneously written notes, and the citation as issued are all very consistent. The probative value of this evidence outweighs the uncorroborated recollections of Respondent's witnesses. Shaw and Wilson agreed in their recollections that somehow the truck tailgate had been removed just before they rode out from their work site. While it is well established that the pickup trucks at this mine did have tailgates, just when and for what time period the tailgates were not installed is not clear. I find the testimony of Inspector Morris to be credible. I do not find the agreed upon memories of Shaw and Wilson, with no other support, to be credible. It was not necessary for the Secretary to call any other witness to corroborate Morris's testimony.

Since both Morris and Supervisor Rennie observed the violation, there was also no reason to interview any miners. That no one else *claimed* to have seen Shaw and Wilson riding on the tailgate ignores the fact that there were six miners in the cab and three other miners in addition to Shaw and Wilson present in the bed of the truck. At least one of the miners in the crew was well aware of the presence of an MSHA Inspector and the reason the Inspector approached the truck. This miner verbally made a threat to Morris, which Morris recorded in his inspection notes:

> A miner, later identified as Travis Curry, heard me talking to Mr. Dotson & told his buddy that he "can't wait to meet some of these people out in public."
>
> I told Mr. Dotson that he needed to get control of his people because that was a threat made against me & that I was a Federal representative working in the capacity of my duty.
>
> I then informed Mike Rennie and Steve Miller (FOS/MSHA) of this incident.
>
> They told me they would handle it.

GX 3, pp. 5, 6.

Whether anyone else *claimed* to see Shaw and Wilson sitting on the tailgate is not relevant.

Respondent's equipoise argument rests on the proposition that where the evidence presented by the parties is found to be "equally convincing" the doctrine of equipoise would lead to the conclusion that the Secretary had failed to carry the burden of proof. *See*, *Dana Mining Co.*, 33 FMSHRC 2295, 2300-01 (Sep. 2011) (CALJ), and *Excel Mining, LLC,* 35 FMSHRC 2604, 2622 (Aug. 2013) (ALJ). However, the Secretary's evidence is found credible whereas Respondent's attempt to dispute the observations of the inspector failed. From the analysis discussion above, it follows that I do not find the evidence in this case to be "equally convincing". Accordingly, the doctrine does not apply here.

I find the citation was validly issued.

This violation was determined to be Significant and Substantial. The S&S designation of a violation is derived from section 104(d)(1) of the Act, which describes such a violation as one "of such nature as could significantly and substantially contribute to the cause and effect of a coal or other mine safety or health hazard." 30 U.S.C. § 814(d)(1). A violation is properly designated S&S "if, based upon the particular facts surrounding that violation, there exists a reasonable likelihood that the hazard contributed to will result in an injury or illness of a reasonably serious nature." *Cement Div., Nat'l Gypsum Co.*, 3 FMSHRC 822, 825 (Apr. 1981). The Commission has explained that:

> [i]n 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.

Mathies Coal Co., 6 FMSHRC 1, 3, 4 (Jan. 1984) (footnote omitted); *see also, Buck Creek Coal, Inc. v. MSHA*, 52 F.3d 133, 135 (7th Cir. 1999); *Austin Powder, Inc. v. Secretary*, 861 F.2d 99, 103-04 (5th Cir. 1988), *aff'g Austin Powder, Inc.*, 9 FMSHRC 2015, 2021 (Dec. 1987) (approving *Mathies* criteria).

The difficulty with finding a violation S&S normally comes with the third element of the *Mathies* formula. In *U.S. Steel Mining Co., Inc.*, 7 FMSHRC 1125, 1129 (Aug. 1985), the Commission provided additional guidance:

> We have explained further that the third element of the *Mathies* formula "requires that the Secretary establish a reasonable likelihood that the hazard contributed to will result in an event in which there is an injury." *U.S. Steel Mining Co., Inc.*, 6 FMSHRC 1834, 1836 (August 1984). We have emphasized that, in accordance with the language of section 104(d)(1), it is the *contribution* of a violation to the cause and effect of a hazard that must be significant and substantial. *U.S. Steel Mining Co., Inc.*, 6 FMSHRC 1866, 1868 (August 1984); *U.S. Steel Mining Co., Inc.*, 6 FMSHRC 1573, 1574-75 (July 1984).

The Secretary "need not prove a reasonable likelihood that the violation itself will cause injury." *Cumberland Coal Resources, LP*, 33 FMSHRC 2357, 2365 (Oct. 2011) (citing *Musser Engineering, Inc. and PBS Coals, Inc.*, 32 FMSHRC 1257, 1281 (Oct. 2010). This evaluation is made in consideration of the length of time that the violative condition existed prior to the citation and the time it would have existed if normal mining operations had continued. *Elk Run Coal Co.*, 27 FMSHRC 899, 905 (Dec. 2005); *U.S. Steel Mining Co., Inc.*, 6 FMSHRC at 1574. The question of whether a particular violation is S&S must be based on the particular facts surrounding the violation. *Texasgulf, Inc.*, 10 FMSHRC 498 (Apr. 1988); *Youghiogheny & Ohio Coal Co.*, 9 FMSHRC 2007 (Dec. 1987).

In support of the determination that the violation was S&S, the Secretary argued that if the miners were to fall off of the truck, they could either be injured in the fall itself or by the second truck following closely behind. Moreover, the Secretary contended that the violation was reasonably likely to result in a permanently disabling injury since the second trucks' speed could have prevented it from being able to avoid hitting a miner if one or both were to fall.

The Respondent argued that the citation was not S&S because the miners did not face any additional danger by having their feet on the bumper than if they would have had their feet a few inches closer to the cab. I do not find this to be persuasive because I credit the inspector's testimony that the miners were seated on the tailgate and could not have had their feet on the bumper. By having their feet outside of the structural support of the truck, they were more likely to fall out of the truck and thus more likely to sustain injuries.

The first prong of the *Mathies* test was satisfied because the January 2, 2009 safeguard was violated, as discussed *supra*[9]. The second prong of the *Mathies* test was satisfied since the condition presented a discrete safety hazard, namely, that the miners did not have their feet within the bed of the truck and could have fallen or bounced out. The third prong of the *Mathies* test was satisfied because the hazard contributed to would result in an injury. If either of the miners fell out of the truck, they would be injured from the impact with the surface and/or from being hit by the second truck. The fourth prong of the *Mathies* test was satisfied in that such injury would be serious in nature. Whether as a result of the fall from the tailgate, or by coming into contact with the second truck following so close behind, the injuries could be at least permanently disabling.

I find the S&S designation was correct.

When considering the question of negligence of a mine operator, I am not bound by the Secretary's Part 100 regulations; however, those regulations may be useful as guidance. *White County Coal, LLC,* 37 FMSHRC 2568 (Nov. 17, 2015)(ALJ); *See also Brody Mining, LLC,* 37 FMSHRC 1687, at 1701-1704 (Aug. 2015). Negligence is defined by 30 C.F.R. § 100.3(d) as "conduct, either by commission or omission, which falls below a standard of care established under the Mine Act to protect miners against the risks of harm." A mine operator is held to a high standard of care. Further, "A mine operator is required to be on the alert for conditions and practices in the mine that affect the safety or health of miners and to take steps necessary to correct or prevent hazardous conditions or practices." MSHA considers mitigating circumstances which may include, but are not limited to, actions taken by the operator to prevent or correct hazardous conditions or practices. MSHA finds high negligence to exist when "[t]he operator knew or should have known of the violative condition or practice, and there are no mitigating circumstances."

The Secretary argued that the violation was the result of Respondent's high negligence, and that once Respondent received Safeguard No. 6674671, it was unacceptable for the

[9] Although Respondent did not make the argument that safeguards are not mandatory safety standards, it should be noted that they have been found to satisfy this first element of *Mathies*. *See*, e.g. *Wolf Run Mining*, 31 FMSHRC 306 (Feb. 26, 2009)(ALJ).

Respondent to permit the cited behavior. The Secretary contended this violation was the result of a deliberate choice of a miner, and that Foreman Dotson contributed to it. The Secretary further argued that Foreman Dotson was responsible for his passengers' safety during the ride, and that the hazard was obvious since Inspector Morris and Supervisor Rennie observed it from 100 feet away.

The Respondent argued that the absence of clarity and notice regarding the bumper mitigated the negligence. The Respondent also argued that the negligence of the miners in keeping their feet on the bumper is not attributable to the operator. The Respondent noted that the crew foreman was driving the lead vehicle and that there was no testimony indicating that he could see the miners' feet on the bumper.

I have found that the bumper is irrelevant and the responsible person was Foreman Dotson who did not testify and hence there could not be any direct testimony whether he could see his miner's feet in any position before or during the trip. More important is the unanswered question of any action taken by Foreman Dotson to insure all extremities of the crew members were inside the bed of the truck *before* the ride began.

I find that no mitigating circumstances have been established. First, the operator knew or should have known of the violative practice. As set forth above, the Safeguard was clear and provided notice that extremities must remain inside a vehicle. The truck itself was being driven by Foreman Dotson who was responsible for his crew's safety, which included insuring that the extremities of his riders were inside the bed of the truck at all times. The negligence of the foreman is attributable to the operator.

As pointed out above, I am not bound by the Secretary's definitions of negligence, and in this instance even if some mitigating circumstance were shown I would find high negligence. This is because the practice of riding seated on the tailgate of a truck over uneven terrain with lower legs hanging down outside of the tailgate is inherently very dangerous. In my opinion Respondent ignored the Safeguard, took no steps to prevent this hazardous practice, and as a result the required standard of care to protect miners simply did not exist in this case.

Accordingly, I affirm this citation as written.

d. Penalty

The penalty assessed by the Commission is based on the six criteria in section 110(i) and the deterrent purpose of the Mine Act. *Wade Sand & Gravel Company,* 37 FMSHRC 1874, at 1876, 1877, (Sep. 2015); *See also Westmoreland Coal Co.,* 8 FMSHRC 491 (Apr. 1986). While penalties are independently assessed *de novo*, MSHA's Part 100 regulations may provide useful guidance. *Orica Nelson Quarry Serv.,* 35 FMSHRC 3004, 3014 (Sept. 2013) (ALJ); *Ligget Mining, LLC,* 33 FMSHRC 1702, 1717 (July 2011) (ALJ).

I have found that the violation was serious, S&S and reasonably likely to result in permanently disabling injuries to two miners. The operator was highly negligent, since the easily understood safeguard had been in effect for two years and was ignored by the foreman in charge

of the crew. The parties have stipulated that the penalty would not affect the operator's ability to remain in business and there was demonstrated good faith in abating the violation. The penalty appears appropriate to the stipulated size of the business, and on this record the violation history is essentially the safeguard issued in 2009. Therefore, I find that the monetary penalty should be $5,080.00, as proposed.

III. LAKE 2012-861: CITATION NO. 8420533

a. Summary of the Evidence

MSHA Inspector Jeff Adams[10] ("Inspector Adams" or "Adams") conducted an E01 general inspection of the Mach #1 Mine on June 27, 2012. Tr. 277. He had previously inspected the Mach #1 Mine twice and had also been there several times for training. Tr. 277, 278. On that day, he was inspecting the areas away from the main portal; the bleeder fans, the pumps, and the area near the Gob Hill equipment. Tr. 278.

Adams was inspecting a turbine water pump approximately 18 feet above the ground. Tr. 279. During the inspection he issued the citation because he saw hand rail pipes on the ground. Tr. 279. Upon further inspection, he saw that the broken pipes were from the handrail that had surrounded the turbine pump. Tr. 279. Some additional piping remained, but was broken. Tr. 279. Six pieces of the handrail had fallen off, three of which were on the ground and, he thought, three were on the landing by the pump. Tr. 279. Two sections were broken away from the upright post and only some were still present. Tr. 281. Adams testified these would not support a miner's weight. Tr. 281; GX 6. The area was regularly accessed; it contained an oil tank that needed to be filled manually by hoisting a five-gallon bucket up to the tank with a rope. Tr. 281. Adams estimated that the five gallon bucket weighed about 35 pounds. Tr. 282. Adams stated that a person would have to hang over the edge in order to reach out and hoist one of the buckets up to the tank. Tr. 283. He said that while it would take some strength to be able to hoist the bucket up, it would probably just take one miner to do it. Tr. 283, 284.

The cited area was about five miles away from the mine, and there were no Mach employees regularly assigned to that facility. Tr. 286. Other than a county or township road right next to the location, the area was isolated. Tr. 286. One miner would be affected because one person would be required to do the routine work in the area. Tr. 285. The only time someone would be in the area would be if the person was there to check on a problem or to service the pump. Tr. 287. This would include filling the oiler. Tr. 287.

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[10] Jeff Adams was an MSHA surface specialist. Tr. 275. A surface specialist takes care of all strip mines and surface properties, which are surface mines and surface components of underground mines. Tr. 275. He holds an associate's degree and a bachelor's degree in industrial education. Tr. 275. He has worked for MSHA for seven years. Tr. 275. Before working for MSHA, he spent 26 years working at Galatia Mine, including three years underground. Tr. 276. At the time of the inspection on June 27, 2012, Adams was an underground inspector in Hillsboro, Illinois. Tr. 277. He subsequently became a surface specialist. Tr. 277.

Adams did not know how the pump was monitored and was not aware that it was monitored from a computer five miles away. Tr. 287. He also did not try to determine the last time that a Mach employee was at the site, and did not have any firsthand knowledge of when a Mach employee would have seen the condition. Tr. 288. But, he believed Respondent was required to regularly maintain the area. Tr. 289.

Because the condition could lead to an 18-foot fall, Adams determined that an injury was reasonably likely to occur. Tr. 282. He also determined that it could be a permanently disabling injury or even a fatal injury. Tr. 282. He concluded the violation as S&S because so many pieces had been broken off and because the rail could give way if someone leaned against it. Tr. 283.

Adams assessed the violation as the result of moderate negligence since someone should have been aware that many of the handrail pieces had been broken off. Tr. 284. However, he did not know how long the condition existed. Tr. 287, 288. In his opinion, the condition was the result of a vibration and that it was something that happened gradually over time. Tr. 284. Based on his experience, he estimated that it took a lot of force for the breakage to occur. Tr. 284, 85.

In his notes, Adams wrote that six sections of the handrails had broken off due to excessive vibration caused by a failing pump bearing and two sections were broken away from the upright posts. Three of the sections were on the ground adjacent to the ladder and three were on the elevated walkway next to the pump. A person has to regularly access the pump to manually fill an oil reservoir, and the two sections broken away from the upright posts would give way if leaned against. GX 7, pp. 6-10.

Adams issued a 104(a) Citation, No. 8420533, to Respondent at 110 hours. Section 8 of the citation reads:

> The handrails on the elevated walkway providing access to the turbine pump beside the bleeder fan were not being maintained in good condition. Six sections of the handrail had broken off due to vibration and two sections were broken away from the upright posts. Management locked the access gate to the elevated walkway to prevent entry.

The safety standard, 30 CFR § 77.205(e), had been cited two times in two years.

The violation was marked S&S, reasonably likely to cause a permanently disabling injury to one person, and the result of moderate negligence. The citation was terminated at 1600 hours when the handrails were repaired.

GX 5.

Norman Quertemous [11]("Quertemous"), a maintenance manager for Mach, traveled with Adams during the June 27, 2012 inspection. Tr. 290. He would normally accompany the inspector to the turbine pump as part of his job duties. Tr. 290.

Quertemous testified that no employee was assigned to the area where the turbine pump was located. Tr. 291. Barry Butler, a Mach maintenance foreman, conducted an installation check at the facility monthly. Tr. 291. According to Quertemous, Butler was a competent and meticulous examiner. Tr. 292. If Butler found anything, he would either notify management immediately or fix the problem himself if he was able to do so. Tr. 292. Quertemous believed that Butler had done a good job in identifying hazards during his monthly inspections. Tr. 294.

Quertemous concluded that the damage to the rail was caused by a "bearing down" in the pump resulting in a violent shaking. Tr. 292, 293. Based on his experience, Quertemous believed that harmonics in the steel shook the rail apart quickly, and that it took one to three days to bring it down. Tr. 293. But, he was not able to determine whether the condition was present during Butler's last examination of the area. Tr. 293. Respondent took prompt measures to repair the railing. Tr. 295.

Quertemous also testified a computer in central supply monitored this area. Tr. 294, 295. The computer monitored the current on the pump, but did not monitor vibrations. Tr. 296. If there was a problem, the superintendent could send someone to take care of it. Tr. 295. The person checking would either be the maintenance chief or the superintendent. Tr. 295.

b. Contentions

The Secretary contended that Citation No. 8420533 was issued for violating 30 C.F.R. § 77.205(e) because the Respondent did not maintain the handrails on the elevated walkway at a turbine pump in good condition. The Secretary argued the citation should be affirmed as written, because a miner who needed to fill the oil tank, and who needed to rely on the handrails for support to do his job, would be affected. The Secretary also contended the S&S designation was correct, since the cited condition presented a safety hazard, a fall, to miners who regularly accessed the elevated area during the course of mining. Further, a fall of 18 feet would cause permanently disabling or possibly a fatal injury. Respondent should have been aware of the condition since it takes a large amount of force and a long period of time for handrails to break. Therefore, Respondent was moderately negligent. The Secretary proposed a penalty of $1,530.

The Respondent contended that Citation No. 8420533 should be vacated, or, in the alternative, the S&S designation should be removed and that the moderate negligence should be reduced. Respondent also contended that a platform is not an elevated walkway and the area around the turbine pump should not be found to be a walkway, and hence not covered by the

[11] Norman Quertemous retired from Mach Mining on March 31, 2014. Tr. 257. He worked in mining for 42 years, including nine years for Mach. Tr. 257. At Mach, Quertemous worked as a maintenance manager, and in this position he helped with a variety of tasks. Tr. 258. Quertemous also worked as an instructor at Southeastern Illinois College, teaching electrical retraining, annual refresher training, and safety courses. Tr. 258.

safety standard. Respondent also argued that no employee was assigned to the location at issue and since one hourly employee only visited the site on a monthly basis, the operator did not have notice that the handrails were broken. Further, the area was remote, injury was unlikely, and the citation should not be S&S. The Respondent also argued that before the inspection, the mine pump had a bad bearing that caused the platform to violently shake and also caused damage to the rails. The Respondent further noted that Adams did not dispute that the condition could have been caused by a vibration from a bad bearing in the pump and that Quertemous said that the condition could have been caused over the course of one to three days.

c. Analysis

The safety standard cited provides:

> Crossovers, 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.

30 C.F.R. § 77.205(e).

In support of its contention that the citation was valid, the Secretary argued that the miner who needed to fill the oil tank, and who needed to rely on the guardrails to do his job, would have been affected.

In support of its contention that the citation should be vacated, the Respondent argued that 30 C.F.R. § 77.205(e) regulates "elevated walkways" and not "platforms" and that a "platform" is not an "elevated walkway." The Respondent cited *Alan Lee Good*, 23 FMSHRC 995 (Sept. 2001), in which the Commission vacated a citation where the Secretary alleged that a platform was a "walkway" after interpreting a similar metal/non-metal standard. In that decision the Commission determined:

> A "walkway" is defined in the dictionary as "a passageway used or intended for walking . . . a passageway in a place of employment . . . designed to be walked on by the employees in the performance of their duties." *Webster's Third New Int'l Dictionary Unabridged* 2572 (1993). A "passageway" is defined as "a way that allows passage to or from a place or between two points."

Alan Lee Good, at 999 (footnote omitted). Respondent acknowledged that in a different case, another ALJ found that a platform that is accessed every day for examinations was a "walkway," *Boart Longyear Co.*, 34 FMSHRC 2715, 2722, 2724 (Oct. 2012) (ALJ), but this ALJ's analysis was distinguishable from the Commission's. The Respondent pointed out that in *Oil-Dri*, 34 FMSHRC 458 (Feb. 2012) an area in question was a "travelway" since it was "used as a means for miners to go to and from one area of the mine to another." *Oil-Dri*, at 461. The Respondent argued that the present case is factually different than *Oil-Dri*, and that because of the differences the area in question at Mach should not be found to be a "walkway."

I do not find this argument to be persuasive. Even using the definition from *Alan Lee Good*, the surface area in the instant case would be considered a walkway and therefore governed by 30 C.F.R. § 77.205(e). This is because the Commission in *Alan Lee Good*, citing *Webster's Third New Int'l Dictionary*, stated that a walkway is a passageway in a place of employment designed to be walked on by the employees in the performance of their duties. That is the case here since miners use the elevated surface area as a passageway in a place of employment; it is used when miners need to climb up and walk to the pump assembly and perform maintenance including filling the oil tank.

I am also not persuaded that the specific nomenclature for the elevated area constructed to provide access to the turbine pump is important. Certainly it is an elevated area that must be accessed and walked on to perform required periodic maintenance. It is a "way" that allows passage to or from a place, the turbine pump and any associated equipment. The pertinent language of the standard is "Crossovers, elevated walkways, elevated ramps, and stairways". While the term "platforms" was not included, there is nothing to suggest the named areas were considered all inclusive. An elevated structure, however named, accessed by miners and walked on to go to or from a place to perform their duties fits neatly into the safety standard. This is because the intent of the safety standard is to require the handrails to be well maintained in such elevated areas, rather than to precisely describe the surface area to be protected.

Having found that the area falls under the regulation, it is apparent from the evidence that the handrails were not kept in good condition. Several parts of the handrail had fallen to the ground and what remained could not support a miner. A total of six pieces had fallen off and two sections had broken away from their supporting upright post. With these conditions present a miner would be 18 feet off the ground while working on the pump or filling the oiler without the protection of solid, well maintained handrails. The three photos taken by Adams show a ladder type access to the walkway around the vertical turbine, visibly broken and missing rails, and pieces on the ground, just as he described in his testimony and notes. GX 6, 7. The Respondent violated 30 C.F.R. § 77.205(e) because the rails should have been securely in place to protect miners from falling.

I find the citation was validly issued.

Regarding the S&S designation, the Secretary argued that the cited condition presented a discrete safety hazard to miners in that they could fall 18 feet from the platform. The Secretary also argued that this fall would cause a permanently disabling or possibly fatal injury, and that it could affect many different people, including non-employees, because it was next to a township road and accessible by anyone passing through. Further, the Secretary stated that a miner regularly accessed the platform during the course of mining. Furthermore, in order to properly fill an oil tank used for the turbine pump, a miner was required to lean over the handrail and the edge of the platform, which would require support.

The Respondent argued that the parties agreed that the area was remote and that the platform was rarely visited. The Respondent also argued that there were handrails around most of the platform and that the area was only accessed during the day. The Respondent cited *Rivco Dredging Corp.*, 10 FMSHRC 1195, 1199 (Sept. 1988) (ALJ) and argued that violations in remote areas are less likely to be S&S. Similarly, the Respondent cited *Arcata Readimix*, 17

FMSHRC 816, 820 (May 1995) (ALJ) and *Carmeuse Lime, Inc.*, 29 FMSHRC 266, 271 (Mar. 2007) (ALJ). The Respondent also contended the Secretary did not offer any evidence that trespassers had entered the area and that Adams acknowledged that the area was remote, even though it was near a road. The Respondent also argued that the Secretary did not present evidence that miners would haul buckets of oil onto the platform and specifically did not present evidence that this had occurred in the area with the broken railing. Ultimately, the Respondent argued that the various factors made an injury unlikely and thus the citation should not be S&S.

The four elements of *Mathies* and the controlling case law have been set forth above in the analysis of the first citation. This will not be repeated, except as needed for clarity, in this decision.

I find that the violation was properly designated S&S. First, as discussed *supra*, there was an underlying violation of a mandatory safety standard. Second, there was a discrete safety hazard in that a miner could fall while working 18 feet off the ground to fill the oiler or work on the pump without adequate handrails in place; this would be the case regardless of how oil is brought up to the tank. Third, there was a reasonable likelihood that the hazard contributed to will result in an injury. It is reasonably likely that a miner's fall from the elevated walkway would cause an injury. Finally, it is reasonably likely that the injury in question would be of a reasonably serious nature, because a fall from that height would be at least permanently disabling if not fatal. The *Mathies* criteria have been met.

That the area was remote does not affect this gravity determination, because the area was regularly accessed by a miner. While the parties address whether outside people could also access the area because it was near a public road, a determination on this is not necessary. A miner, given his duties, was likely to be in an elevated area without well maintained protective handrails. This by itself, as discussed, allows me to find the citation was properly designated S&S.

I have discussed negligence and the duty of care required of an operator in the first citation, above. Here, the Respondent's position was that the damage to the handrails occurred quickly, as a result of a bad bearing in the pump that caused violent shaking, and the operator was not on notice of the condition of the handrails. The Secretary's position was that the damage occurred over a longer period of time, and the operator should have been aware of it considering the monthly maintenance visits.

The flaw in Respondent's argument was that at the time the bad bearing was repaired, the damage would already have occurred and should have been readily visible to and reported by the foreman or the miner making the repairs. Respondent also argued the monthly access to the pump was by an hourly employee, not an agent of the operator. However, Respondent's witness retired Maintenance Manager Quertemous testified that the person performing the monthly checks was a Maintenance *Foreman.* This would suggest a supervisory position, rather than a rank and file employee. Respondent's argument on notice appears incorrect.

The flaw in the Secretary's argument was that Inspector Adams in his testimony could not clearly articulate that it was more likely than not the handrail damage had been present long

enough for the next monthly check to have discovered it. He was only able to opine that the breakage happened gradually, over time, since a lot of force would be required. His opinion is simply too vague to be accorded controlling weight.

Notwithstanding that the time of breakage cannot, on this record, be accurately determined, the operator is held to a high standard of care, and is responsible for the safety of miners. The standard of care in this case is somewhat mitigated by the infrequent access to the area, which is in a remote location. There is remote monitoring of the turbine pump, but apparently not for vibration and shaking, and the length of time the bad bearing could have existed is unknown. The record does not contain the dates on which the monthly checks were made nor is there evidence of the date a bad bearing was discovered and repaired. Weighing these factors, I find the negligence should be reduced to low.

d. Penalty

The penalty is assessed *de novo* pursuant to section 110(i) of the Mine Act. The parties stipulated to the size of the mine, that the proposed penalties would not affect the ability of Mach to remain in business, and that Mach demonstrated good faith in abating the violation. The violation was S&S, and the working environment around the elevated pump assembly without protective handrails was a serious safety concern. However, the history of previous violations was not an important factor, and the negligence was reduced to low. Considering all of the relevant factors and the change to the citation, I find the monetary penalty should be reduced to $700.

IV. LAKE 2012-861: CITATION NO. 8442233

Respondent did not contest the fact of a violation of the approved ventilation plan. Tr. 303. The issues remaining are whether the violation was S&S and whether the negligence was moderate. RRB 14-16.

a. Summary of the Evidence

On June 11, 2012, MSHA ventilation specialist Michael A. Pritchard[12] ("Inspector Prichard" or "Prichard") conducted an E02 inspection[13] at the Mach #1 mine. Tr. 299, 323, GX

[12] Michael Pritchard worked as a health specialist for approximately two-and-a-half years, and has been with MSHA for over five years. Tr. 298. He possessed a bachelor's degree in general engineering and a master's degree in mining engineering. Tr. 298, 299. He had worked as a mining engineer in the coal industry for 25-30 years. Tr. 299.

[13] An E02 inspection is a five-day spot inspection of a mine's ventilation. Tr. 300. A mine is placed on a spot inspection schedule based on the amount of methane it liberates in a 24-hour period. Tr. 300.

8. He was accompanied by a company representative, Johnny Robertson,[14] ("Superintendent Robertson" or "Robertson") Tr. 300, 301, 312. Pritchard had previously inspected the Mach #1 mine a couple dozen times. Tr. 300.

During the inspection, Inspector Pritchard issued a citation in the MMU-002 section of the mine because there was only 5,490 cfm of air at the end of a line curtain that was supplying air to the continuous mining machine. Prichard testified this was approximately 78% of the requirement of 7,000 cfm, or 1,510 cfm less than required. Tr. 301, 302, 314, 315, 325, GX 16, p. 13. At the time this condition was discovered, Respondent was in the process of extracting coal with the mining machine in the #2 right, #195 crosscut. Tr. 302, 303, GX 8. This condition was likely caused by a disruption in the line curtain. Tr. 318. Periodically, shuttle car operators will knock a line curtain out of place with their equipment, but Pritchard did now know whether it happened frequently. Tr. 317. Other problems could have occurred with the curtain that would require it to be re-hung, moved, or have a "skirt" added to get it closer to the floor. Tr. 318. Pritchard had seen line curtains disrupted in a matter of seconds. Tr. 318, 319. He could not say exactly what had happened to disrupt the curtain in the cited area. Tr. 318. However, he knew it was ultimately corrected by adjusting the curtain. Tr. 316, 318.

Inspector Prichard testified that under the mine's ventilation plan 7,000 cubic feet per minute (cfm) of air was required to be delivered to continuous miners when they were extracting coal. Tr. 301, 302, GX 16. This air requirement was placed in the ventilation plan because of the volume of air discharged from miners' scrubbers; ideally the same amount of air should be delivered by the ventilation system as was discharged from the scrubbers. Tr. 303. A scrubber is a device that gathers dust-laden air from the face while the miner is cutting coal and traps it in a flooded bed screen. Tr. 304, 307, 328. The relatively clean air is then discharged from the scrubber. Tr. 304. The scrubber requires at least 7,000 cfm of air and if it does not receive sufficient fresh air, it will re-use air that has already been scrubbed. Tr. 304, 307, 308, 324. The scrubbers cannot remove 100% of the dust in the air and, as a result, the recirculated air also contains dust. Tr. 304, 305, 308, 324, 325.

Inspector Pritchard did not know how efficient the scrubber was and never looked up the technical specifications, but he knew it was not 100% effective because no machine can be. Tr. 324-325. Even if the scrubber was 99% effective, there would still be a build-up of dust over time to a dangerous level. Tr. 329. Constant recirculation would result in a build-up of dust in the air which miners then breathe, resulting in pneumoconiosis, or black lung. Tr. 304, 305, 308, 310. Prichard further testified that the amount of time necessary for a miner to develop black lung varies by individual. For some miners it can take many years and for susceptible individuals it might take a few months; he was aware of cases of miners in West Virginia suffering from black lung in their early 20s. Over a long enough period of time, any miner exposed to coal dust will develop black lung, a debilitating and even fatal disease. Tr. 310, 311.

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[14] Johnny Robertson was the superintendent of the Mach #1 Mine. Tr. 330. All personnel reported to him. Tr. 330. He was retired at the time of the hearing. Tr. 331. He had 32 years of underground mining experience. Tr. 331. He held various MSHA certifications and was a certified instructor. Tr. 333.

Inspector Pritchard took the reading showing insufficient air volume while the continuous miner machine and its scrubber were turned off. Tr. 321, 328, 329. He conceded at hearing that if the scrubber was on, it would increase the air volume. Tr. 321. He also conceded that the anemometer had a margin of error of plus or minus 10%, or 700 cfm of air for a required finding of 7,000 cfm. Tr. 321, 322, 326, 327. If the reading had been 6,300 cfm, Pritchard would have been reluctant to write a citation because it would be in the margin of error. Tr. 328. But here, the margin of error might be as low as 549 because of the actual, measured reading of 5,490 cfm of air. Tr. 327, 328. Prichard was told by the mine foreman that the minimum amount of air was present when the shift started in the morning. He saw nothing to refute the foreman's statement. Tr. 315, 316.

Inspector Pritchard testified that he designated the citation as "Reasonably Likely" to result in "Permanently Disabling" injury or illness because of the risk of black lung from dust exposure. He determined three miners would be exposed to this condition, including the miner operator and the two shuttle car operators in the area. Tr. 308–310. Prichard pointed out that when the airflow dropped below 7,000 cfm, the shuttle operators were exposed to air with a higher dust concentration than what would normally occur. Tr. 309. With continued mining and continuous exposure the consequence is black lung, a debilitating disease. Tr. 310. The miner operator, as a best practice, should stand on the intake side and away from the discharge on the scrubber but he sometimes had to move to avoid shuttle cars. Tr. 319, 320. Pritchard did not know where the miner operator was located while the machine was operating in the instant matter. Tr. 320, 321. He also conceded he was not a health specialist or black lung expert. Tr. 324, 326.

While in the mine, Pritchard conducted an imminent danger run and checked the air at the last open crosscut and found no methane and no imminent danger. Tr. 312, 313, 322, 323. He also checked the continuous miner, air velocity (even in the belt air), methane monitors, and other equipment and found no violations. Tr. 313, 314. The only condition he found was the condition he cited. Tr. 314, 323.

Inspector Prichard's notes confirm that multiple checks were made and were good, with no violations observed except for the line curtain air reading at #2 right, crosscut #195. GX 9. There, the air velocity was 5490 cfm when the #3A miner was loading coal. *Id,* pp. 8, 9. There was dust visible in the air, and with continued mining activities there would be elevated levels of respirable dust caused by insufficient fresh air to the scrubber. *Id,* pp. 10, 11. He also wrote that the negligence was moderate since the foreman said he measured 8150 cfm at the start of the cut. *Id,* p. 11.

On June 11, 2012, at 1250 hours Inspector Pritchard issued a 104(a) Citation, No. 8442233, to Respondent. Section 8 of the citation reads as follows:

> The approved ventilation plan is not being followed on the Headgate #6 unit (MMU-002). When measured, the quantity of air at the end of the line curtain supplying ventilation to the company number 3A continuous mining machine was found to be 5,490 cfm; the approved ventilation plan requires a minimum of 7,000 cfm (page 8, ventilation). The affected

mining machine was extracting coal in the #2 right (crosscut #195) at the time of the inspection.

Standard 75.370(a)(1) was cited 23 times in two years at the mine.

Pritchard determined the violation was S&S, injury or illness was reasonably likely to be permanently disabling to two persons, and the negligence was moderate. The violation was terminated at 1305 hours after the line curtain was adjusted raising the quantity of air to 7,350 cfm.

GX 8.

Former Superintendent Johnny Robertson testified he traveled with Pritchard during the spot inspection at issue. Tr. 333, 340. The mining faces were at crosscut 195 on a three-entry longwall development panel when Pritchard wrote the instant citation. Tr. 334-336, 342. Robertson testified he saw Pritchard take the air reading leading to the citation. The miners were operating and taking the coal to the tailpiece of the feeder for transport outside. Tr. 337. Robertson asked the miner operator to shut off his machine so Pritchard could work. Pritchard then went behind the curtain area and took his reading. Pritchard found that the area was a bit low, around 5,490 cfm of air. Tr. 342. The scrubber ran at 8,000 cfm of air, so the plan required between 7,000 and 9,000 cfm. Tr. 352. Ensuring at least 7,000 cfm of air in the entry allowed the intake air to satisfy the demands of the scrubber and prevent air coming from the return side. Tr. 352, 353. Robertson testified this presented a low hazard to the miners. Tr. 353.

Robertson also testified that problems usually occur at the intake area where shuttle cars run through the curtain. Tr. 346. He believed the cited condition was caused by a shuttle car hitting the line curtain, which was pulled loose when a loaded shuttle car went through the curtain. Tr. 347, 348. He stated a shuttle car may also pull a curtain out at the bottom, because it was hung with nails. Tr. 355. Shuttle car operators were warned about the danger of knocking down a curtain. Tr. 348. Robertson also testified that a drooping curtain would look different than a tight curtain and would be obvious. Tr. 354, 355.

Robertson told the miner not to load, and then he and the section boss went to tighten the wing curtain coming through crosscut 194 to get more air. Tr. 343, 346. When a curtain is not tight, it will droop and allow air to pass it, rather than forcing the air to the face. Tr. 346. Once the curtain was tightened, the air increased to over 7,000 cfm. Tr. 346, 347. This was the only action needed to terminate the condition and it only took around 15 minutes. Tr. 347.

Robertson testified the section boss said the air reading was 8,000 cfm when he started the cut. Tr. 348, 349. Robertson could not tell how long before the citation that the boss had started the cut. Tr. 349. However, he believed that the danger posed by this violation was very low because the miner operator would keep himself in fresh air and keep the continuous miner turned off until the shuttle cars were ready to load coal. Tr. 350, 351, 353. Robertson also testified that the continuous miner operator would move around in the area where the cuts were made while working, but he would know that the intake air was the proper place to start. Tr. 357.

Robertson also testified that there were three shuttle cars on the section that day and stressed that each had an enclosed cab with air conditioners installed. Tr. 337, 338, 345, 360. While three cars were present, only two were actually operating. Tr. 345, 346. The air conditioners had air filtering systems on them. Tr. 338, 360. Robertson believed these air conditioners offered protection to the miners and made the hazard they faced by the cited condition low. Tr. 339, 353. However, he did not know if the filters were certified to remove respirable dust. Tr. 360, 361.

b. Contentions

The Secretary contended that the violation was S&S, since the violation must be considered in the context of continued normal mining operations. Based on the particular facts surrounding this violation, the test under the third element is met, since there was a reasonable likelihood that the hazard contributed to would cause injury. The Secretary also contended that the violation was the result of Respondent's moderate negligence, because Respondent should have exercised heightened diligence and been aware of the condition since curtains hit by shuttle cars is a regular occurrence happening periodically during a shift and obvious to anyone in the area.

Respondent argued that the violation of the cited standard was not S&S because the Secretary has failed to prove the third element of *Mathies*. Respondent contended there was not a reasonable likelihood that the hazard contributed to will result in injury. Respondent also contended that the Inspector did not conduct airborne dust sampling, and no evidence was presented that 78% of the required ventilation was unable to remove harmful dust and gas when the scrubber fan was off. Respondent argued that the shuttle car operators were protected by air conditioned cabs, and the miner operator was protected because he was standing in clean intake air. Respondent also contended it should not be found to be negligent since the condition was caused by an hourly shuttle car operator. Further, there were mitigating circumstances; all of the ventilation controls and dust sprays were working, there were no other violations on the section, and the problem occurred quickly with no notice to the operator.

c. Analysis

The cited standard, 30 C.F.R. § 75.370(a)(1) "Mine ventilation plan; submission and approval", provides the following:

> The operator shall develop and follow a ventilation plan approved by the district manager. The plan shall be designed to control methane and respirable dust and shall be suitable to the conditions and mining system at the mine.

30 C.F.R. § 75.370(a)(1).

Regarding the first element of S&S, the Respondent did not contest the fact of the violation of the safety standard.

The second element of a discrete safety hazard – that is a measure of danger to safety – contributed to by the violation was met. Inspector Pritchard credibly testified that the low air volume would cause the scrubber to recirculate discharged air in order to meet its capacity. Tr. 304, 307, 308, 324. Pritchard testified that this dust in the air would contribute to the miners' exposure to the danger of occupational lung disease. Tr. 304-305, 308, 310. I do not find credible the testimony of Robertson that the danger presented by the violation was very low. The reason is that the facts and circumstances surrounding the violation must be viewed in the context of continued mining operations.

Respondent cited *Peabody Coal Co.*, 17 FMSHRC 26 (Jan. 1995) to support its contentions that the hazard contributed to would not result in injury and hence the Secretary failed to prove the third element of S&S. However, in *Peabody*, the testimony of the Inspector was equivocal on the hazard of dust recirculation from inadequate airflow. In the instant case Inspector Prichard credibly testified that the low air volume would cause the scrubber to recirculate discharge air, that this recirculated air would contain dust, and with sufficient time exposure to dust would lead to occupational lung disease. Prichard's testimony was not equivocal, and hence not the same as the testimony the Commission found unsupportive in *Peabody*. Further, the Commission did not set a binding rule that dust exposure from air recirculation or inadequate ventilation cannot result in an S&S citation. Instead, the Commission held that the facts presented and the Inspector's testimony, as evaluated by the judge, are the determining factors.

Respondent also noted that in *Peabody* the Commission considered that air measurements were not made while the continuous miner and scrubber were operational, which could increase the ventilation through the line curtain. However, the ventilation plan in effect at the Mach #1 Mine specified the minimum cfm behind the line curtain must be 7,000 without the scrubber operating. GX 16, p. 13. Therefore, there was no need to measure with the scrubber operating. If such a measure is important, it should have been included in the mine's ventilation plan.

Neither the safety standard nor any authority cited by Respondent requires airborne dust sampling to be conducted by an Inspector when a violation of 30 C.F.R. 75.370(a)(1) is discovered. Inspector Prichard observed dust visible in the air, measured the quantity of air as 5,490 cfm at the line curtain, and determined that the inadequate air was reasonably likely to result in permanently disabling injury or illness affecting two people. In his notes, Prichard recorded that injury was reasonably likely with the continuation of mining activity and exposure to elevated levels of respirable dust caused by insufficient air being supplied to the scrubbers. GX 9, pp. 9-11. Further, there was no need for the Secretary to present evidence that the ventilation present was unable to remove dust and gas. The 7,000 cfm air requirement was not met and a hazard was created that was reasonably likely to result in injury or illness.

Other arguments of Respondent, that the shuttles had air conditioned cabs - that all other ventilation and dust controls were functioning at the time, and that the miner operator would stand in clean intake air - are not compelling. Even if so, these measures would be irrelevant. The fact that additional safety measures are in place does not mean dust poses no risk to miners; there are additional precautions that are required *because of* the significant danger of respirable dust. *See, Buck Creek Coal, Inc., v. Federal Mine Safety and Health Admin.*, 52 F.3d 133, 136

(7th Cir. 1995). Even if other safety measures are in place, insufficient air volume still contributed to the hazard of visible dust in the air and exposure to respirable dust would still be a hazard to miners. Therefore, the arguments do not undermine the S&S designation.

It is important also to recognize the effect of *Musser Engineering, Inc., and PBS Coal Inc.*, 32 FMSHRC 1257, 1280-81 (Oct. 2010) on the third prong of *Mathies*. In that case, the Commission held that the "test under the third element is whether there is a reasonable likelihood that the hazard contributed to by the violation...will cause injury." *Id.* at 1281. Importantly, it stated that the "Secretary need not prove a reasonable likelihood that the violation itself will cause injury." *Id.* The Commission also emphasized the well-established precedent that "the absence of an injury-producing event when a cited practice has occurred does not preclude a determination of S&S." *Id, (citing Elk Run Coal Co.*, 27 FMSHRC 899, 906 (Dec. 2005); *Blue Bayou Sand & Gravel, Inc.*, 18 FMSHRC 853, 857 (June 1996). Two cases cited by Respondent were issued well before the Commission's decision in *Musser*, and need not be discussed.

In short, the question is not whether the particular violation here would result in miners suffering black lung disease, but instead that the hazard contributed to by the violation would result in black lung disease. As discussed, the cited condition contributed to the hazard of coal dust exposure. Inspector Pritchard credibly testified that this hazard, given sufficient time, will result in black lung disease. Tr. 304-305, 308, 310. I find the Secretary has carried his burden, and the third prong of *Mathies* was met.

The fourth and final element that the Secretary must establish is that there was a "reasonable likelihood that the injury in question will be of a reasonably serious nature." Pritchard credibly testified that black lung can be a debilitating, even fatal disease. Tr. 310-311. Therefore, the fourth prong of *Mathies* is also met, and the cited condition was properly designated S&S.

The Secretary argued that Respondent's actions constituted "moderate" negligence. Specifically, the Secretary argued that a miner striking a line curtain was a regular occurrence and therefore Respondent should have exercised heightened diligence and checked periodically during the shift. Further, the Secretary argued that the condition would be obvious because a loose curtain would look different than a tight curtain.

Respondent contended the condition occurred quickly, caused by an hourly shuttle car employee, and hence there was no notice to the operator. Further, all other ventilation controls were working, and there were no other violations on the section.

The Secretary's arguments have more merit. There was a Section Foreman in that area of active mining. Shuttle cars hitting line curtains are a regular occurrence and certainly could happen periodically during a shift. The visible dust in the air should have prompted the Section Foreman to make a quick check to determine the reason. The loose curtain would have been obvious, and a simple air measurement would have quickly shown that the air was not at the required velocity. Superintendent Robertson's testimony was consistent with that of Inspector Pritchard that loaded shuttle cars did hit and pull loose line curtains and a drooping curtain would be obvious. The Section Foreman had both the opportunity and the means to discover and

correct the problem, since adjusting the curtain took only a few minutes. Therefore, Respondent should have known the air supply to the continuous miner was not sufficient and did not meet the requirement of its own ventilation plan.

Inspector Prichard was told by the Foreman, and he recorded in his notes, that the measurement was 8,150 cfm at the beginning of the cut. This was the mitigating circumstance he found, and he marked the negligence as moderate. I find no other mitigating circumstance. While hitting and displacing a line curtain can happen quickly, this does not relieve the Section Foreman of making sure the ventilation remains adequate during the extraction of coal. That other ventilation controls were working and there were no violations in other areas of the section is not relevant to the duty of care to the miners working in the affected section where the ventilation was not at the required minimum and there was a violation. The obvious condition of the curtain and the ease with which it was repaired underscores the conclusion that it should have been found and corrected by management through its Section Foreman. I find the negligence was moderate.

d. Penalty

The discovery of visible dust in the context of insufficient air movement through the mining section during coal extraction does not meet the requirement of the mine's own approved ventilation plan and under continued mining operations is a serious safety concern. I have found that the violation was S&S and reasonably likely to result in permanently disabling injuries to two miners. The operator was moderately negligent, since the only credible mitigating circumstance was the single pre-shift air check by the Section Foreman. The parties have stipulated that the penalty would not affect the operator's ability to remain in business and there was demonstrated good faith in quickly abating the violation. The penalty appears appropriate to the stipulated size of the business, and the violation history is not so egregious as to warrant an increased penalty. Therefore, I find the monetary penalty should remain $2,678.00 as proposed.

V. LAKE 2012-861: CITATION NO. 8445042 & CITATION NO. 8445043

a. Summary of the Evidence

On June 21, 2012, MSHA Inspector Eddie Kane[15] ("Inspector Kane" or "Kane") inspected the Mach #1 Mine. He had inspected the mine several times in the past. Tr. 198. Kane inspected two Fletcher dual boom roof bolter machines, Nos. 2 and 4, both in the same section of the mine. Tr. 199, 206, 207. Roof bolter machines drill through shale and slate, which contain a high amount of silica. Tr. 201. The amount of silica would vary depending on the type of rock, but in Respondent's mine there would be at least 5% silica.[16] Tr. 219. Silica is a fine, dusty

[15] Eddie Kane had been a special investigator for one year and previously worked as a regular inspector for five years. Tr. 196,97. Before MSHA, Kane spent six and a half years in the mining industry. Tr. 197. He had a BS degree in business administration, and also had extensive training Tr. 197. He was certified to "run dust" but he was not a health specialist and there was no such thing as a dust specialist. Tr. 221, 222.

[16] Rock dust used in the mine must be below 1% silica. Tr. 219.

powder, like little shards of glass. Tr. 201. The roof bolter machines each had two dust collection systems to remove this dust from the air and store it in a collection box. Tr. 200-203, 207. Referring to GX-18, a picture of a similar roof bolter machine, Kane explained that the systems suction dust from the drills and bring it back to the collection box to eliminate it from the mine atmosphere. Tr. 200, 201.

Referring to the two citations he issued, he observed dust behind the filters of the system, and the seals on the outer doors were not glued down and were separated from the metal doors. Tr. 199, 200. On bolter No. 2 there was high silica dust behind both filters and both door seals were worn out and leaking. On bolter No. 4, there was high silica dust behind one filter, and both door seals were worn out and leaking. Tr. 220, 237-239.

The unglued, worn and leaking door seal rings did not properly seal the collection boxes allowing normal mine air to be drawn into the system and this can cause the drill pods to lose suction. Tr. 207, 208, 231, 232. As soon as he opened a door, the seal ring just flopped over. Tr. 218. He also noticed a little bit of buildup of dust where the door was supposed to be sealed. Tr. 215. One bolter operator told Kane that the condition had existed for two or three days and that he had spoken to the mechanic about it. Tr. 216, 230, 244, 245, 251-253. He was told the parts were not available for a fix right on the spot. Tr. 217. Kane testified the condition of the door seals should have been caught during the weekly permissibility checks. Tr. 252. The dust collection systems were required to be checked daily as part of the dust parameter checks to make sure the system was functioning. Tr. 214, 215, 241, 242, 251. However, Kane conceded that if the parameter checks were done indicating adequate suction, the condition of the doors did not affect the integrity of the system. Tr. 227-30, 250, 254, 255.

Kane was worried that when the machine was turned off, back pressure in the collection box would blow dust out through the areas where the door seals were inadequate and put dust in the air. Tr. 208, 224, 225, 232. Kane had seen this "burp" of dust back into the air when a bolter was shut down. Tr. 218, 224, 225. Kane did not ask the bolter operator to start the machine and turn it off to test if the back pressure blow out would occur. He did not want to expose miners to the hazard. Tr. 225.

Each dust collection box contained a filter. Tr. 202, 203. Referring to GX 19, Kane explained the black rim on the filter[17] will not seal if drill dust is not cleaned out of the box Tr. 203, 204. The filters should screw down to a good, snug fit against the back metal wall of the box so that nothing can get past the gasket. Tr. 204. Behind or after the filters is the exhaust or clean area of the collection boxes. Tr. 203, 205, 206. Dust comes into the box, is collected, and clean air is then pushed out of the exhaust area to the muffler at the back of the machine. Tr. 202, 205, 206. Respondent was required to keep dust out of the exhaust area, which should be clean with only air that had passed through the filter. Tr. 208, 232, 233.

Kane found dust in the exhaust or clean area of three of the four collection boxes. The dust itself was located in a small trench just behind the filter. Tr. 233. Dust in the exhaust area could be caused when a filter is installed without first cleaning out the collection box. Tr. 204,

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[17] This is the gasket on the filter. Tr. 233.

234, 239, 243. The dust in the collection box would be pushed back into the trench and get between the filter gasket and the structure of the equipment. Tr. 234, 235, 239, 243. When the dust is not cleaned out of this trench the filter gasket will not seal and will allow dust to leak into the exhaust and be continuously expended into the mine atmosphere when the machine is operating. Tr. 204, 233, 235, 243, 250.

Kane testified miners would be working in the area of the expelled exhaust. Tr. 209. These miners would be exposed to the danger of silicosis, or pulmonary fibrosis. Tr. 209. It is the non-visible dust that is much smaller than a pinhead that is the most dangerous and causes silicosis, which is why the system is required to be maintained clean and free of dust. Tr. 209, 210, 211. Contracting these diseases would depend on the exposure time, but it can take as little as five to ten years. Tr. 209, 210, 223. Eventually, exposure would definitely lead to silicosis. Tr. 213, 214. He believed the condition would be permanently disabling because it would block the lungs and was related to renal failure and cancer. Tr. 214. A miner could live several years with silicosis, but eventually it would cause death. Tr. 214.

Kane testified the issues with dust in the exhaust areas and the inadequate door seals were unrelated; one did not cause the other. Tr. 212, 213, 230, 231, 237, 242. There would be two distinct ways the dust would enter the atmosphere. Tr. 213. The only common causes between the two conditions were poor maintenance of the equipment and sloppiness in changing the filters. Tr. 212.

Kane marked the citations as reasonably likely to result in permanently disabling injury. Tr. 213, 214. He made this determination based on NIOSH and CDC information regarding silicosis. Tr. 213, 218, 219. He marked the citations as affecting two miners because there were roof bolters and utility men in the area. Tr. 218.

Kane believed that Respondent's behavior exhibited moderate negligence with respect to the two citations at issue. Tr. 217. It would take time for the door seals to deteriorate to the condition he found. Tr. 216. However, Kane recognized that the bolter operators were a bit younger and may not have understood the problem.

Inspector Kane's notes show he was conducting an E01 inspection of the day active production equipment on MMU 002. When he came to roof bolter No. 2 he found leaking and worn out seals on both doors and dust behind the filters. He wrote that the condition was obvious when the boxes were opened. The bolter operator stated he had asked for new gaskets. Based on the amount of dust behind the filters and the deterioration of the gaskets he determined the condition had lasted 2 to 3 days. Kane also wrote that the condition would allow high silica dust to become airborne, and this would be reasonably likely to cause permanently disabling injuries from silicosis. GX-12, pp. 10-13.

Kane then wrote about the same conditions on roof bolter No. 4, except there was dust behind the left side filter only. The condition was obvious and should have been found by the mechanics and bolter operators. He again determined that the conditions appeared to have existed for 2 to 3 days, and that high silica dust would become suspended and reasonably likely to cause permanently disabling injuries from silicosis. GX-12, pp. 14-16.

At 1130 hours Inspector Kane issued a 104(a) Citation, No. 8445042, to Respondent. Section 8 of the citation reads as follows:

> The dust collection system of the Fletcher roof bolter #2 is not being maintained. Both dust box seals are worn out and leaking and there is high silica dust behind the filters. This condition will cause high silica dust to become suspended in the air when the system is ran [*sic*].

At 1155 hours Kane issued citation No. 8445043, for a substantially similar condition on another bolter. Section 8 of that Order, Condition or Practice, reads as follows:

> The dust collection system of the Fletcher roof bolter #4, located on MMU 002, is not being maintained. Both dust box seals are worn out and leaking and there is high silica dust behind one filter. This condition will cause the high silica dust to become suspended in the air when the system is ran [sic].

Kane marked both of the violations as S&S, reasonably likely to be permanently disabling to two persons, and moderate negligence. On both he recorded that Standard 72.630(b) was cited 12 times in two years at the mine. Both citations were terminated the next morning after new door gaskets were installed and the dust was removed from behind the filters.

GX 10, 11.

Former Maintenance Manager Norman Quertemous ("Quertemous") was travelling with Kane when the two citations were issued. Tr. 260. Quertemous had worked with Fletcher roof bolters for 30 years and had worked with the two roof bolter machines at issue here since the time they were manufactured. Tr. 261, 262. He explained the suction system works by pulling air near the drill pod and sending it through a hose down to the dust tank's cyclone. There, the bigger material settles out to the bottom of the tank while the finer material goes into the filter before the air is exhausted out to the muffler. Tr. 265. Hourly employees on every shift examined the dust boxes when they do dust parameter checks and clean their boxes. Tr. 268, 269.

Quertemous agreed that the door seals had deteriorated and that glued portions had detached in places. He also agreed that the seals were attached all the way around the doors when the machine first came from the factory. Tr. 271, 272. He believed the condition of the seals, along with the vacuum inside the box, would allow outside air into the dust box. Tr. 262. This condition would be obvious during a parameter check because there would be a short circuit back to the blower, with less sucking at the drill head. Tr. 262, 263. If the machine was not pulling enough air, then the bolter operator was at risk. Tr. 264. In that case, the vacuum gauge would not be in the green and the bolter operator would report the condition to management. Tr. 263, 264. If there was some leakage through the dust box doors but the gauge remained green, then that leakage would be insignificant. Tr. 264. The leakage through the doors would be clean air that would go to the exhaust. Tr. 264, 265. Quertemous could not say how long the dust box

door seals had been compromised. Tr. 268, 269. He did not recall anyone telling him the condition had been reported to management. Tr. 268.

Quertemous disagreed with the assertion that back pressure would cause air to burp back out through the doors when the machine was turned off; he had never in his career seen it happen. He testified that a 50 horsepower motor created the vacuum, and when the power is cut off the weight of the rotor would make the motor coast down and the vacuum in the tank collapse slowly. Tr. 260, 261.

Quertemous testified there could be several reasons for dust settling behind the filter; a hole in the filter, a torn filter gasket, and dust contamination caused when changing the filter. Tr. 266, 267. He believed the most likely reason was when they changed the filters. Tr. 268. Quertemous explained the change process as follows: You take the wing nut off, pull the filter out, get a new filter, and shove the new filter in. He further explained if you are not "really, really, really," careful when you shove it in to screw the nut back down you could push dust back up in there. Tr. 267, *see also* GX-19. He had seen this before, and the bolter men were trained to be cautious.

Quertemous testified a compromise of the filter gasket allows dust to get through to the clean side of the system, and the dust would exhaust into the atmosphere. Tr. 269, 270. He also testified that filter gasket damage could be a hazard. Tr. 270. He had been told exposure to that dust causes silicosis, and did "absolutely" understand the filter systems were important. Tr. 270, 271.

b. Contentions

With respect to Citation Nos. 8445042 and 8445043, the Secretary argued that Respondent violated 30 C.F.R. § 72.630(b) since the roof bolter dust collectors were not maintained in permissible and operating (functional) condition. Further, section 72.630 incorporates Part 33 of the regulations which require an operator to maintain the machines as they were approved by MSHA. All four dust box door seals were worn out and leaking. Of the four boxes on the two roof bolting machines, three had dust behind the filters. The secretary contended the violations were S&S because there was a reasonable likelihood that the exposure to dust created by the condition of the collectors will eventually result in injury, silicosis, and this would be at least permanently disabling. The Secretary further argued the operator was moderately negligent because the door seals had been damaged for two to three days and a mechanic had been notified but the condition had not been corrected. In addition, the dust that was found behind the filter gaskets can also compromise the purpose of the filters by allowing dust to get past the filter gasket to the clean side. Dust on the clean side will be blown out and suspended in the mine atmosphere when the machine is in operation. The Secretary proposed a penalty of $1,944.00 for each citation.

Respondent argues that it did not violate the cited standard, and that both citations should be vacated because the Secretary did not prove the dust collection systems were not permissible and inoperable allowing respirable dust to enter the atmosphere. Further, Respondent argues the S&S designation should be deleted since the "burp" of dust out of the doors was not proven, no

dust samples were collected, the filter gaskets were not damaged, and the ventilation system was operating properly. Respondent also contends there was no negligence, since the miners are taught to carefully install filters and clean out boxes to avoid allowing dust to get behind the filter, there was no notice of dust behind the filters or the worn door seals, and proper examinations had been performed on the roof bolter machines.

c. Analysis

The cited standard, "Drill dust control at underground areas of underground mines", provides the following:

> Dust collectors. Dust collectors shall be maintained in permissible and operating condition. Dust collectors approved under Part 33—Dust Collectors for Use in Connection with Rock Drilling in Coal Mines of this title or under Bureau of Mines Schedule 25B are permissible dust collectors for the purpose of this section.

30 C.F.R. § 72.630(b)

This safety standard contains two requirements. The first is that dust collection systems must be maintained in "permissible" condition. The second is that the systems must be maintained in "operating" condition.

Permissibility under Part 33 requires that dust collection systems be maintained as MSHA approved them, based on testing and the issue of a certificate of approval. *Tri County Coal, LLC,* 34 FMSHRC 3255, 3274-3275 (Dec. 2012) (ALJ). In Tri County, dust was found behind the filters in the clean sides of the collection boxes, and there was also a hole in a hose that did not render the system inoperable. The judge found that the systems were not being maintained in permissible condition because the conditions found could not have conformed to the drawings and specifications upon which the approval certificate was based. *Id.* The systems were also not in operating condition because there should not have been any dust on the clean side of the filters. *Id.* In the instant case, the unglued and leaking door seals did not render the systems inoperable. But the door seals could not be found to be permissible, since they were not maintained in the same condition as existed when the equipment was approved by MSHA.

As to "operating" condition, in *Liggett Mining, LLC,* 33FMSHRC 1702 (July 2011) (ALJ), Judge Paez analyzed the language in section 72.630(b) and concluded that the plain use of the word "operating" was synonymous with "functional", a word defined as "performing or able to perform its regular function". *Id.*, at 1714, citing *Webster's New Int'l Dictionary (Unabridged)* 921, 1581 (2002). In *Liggett Mining*, there was dust on the clean side of the machine indicating the filter was being bypassed and this evidence established the dust collection system was not performing its regular function. This was because the regular function of the system is to filter and contain dust before it reaches the clean side of the system. *Id.*, at 1714. In the instant case, three of the four filters were not performing their regular function since there was drill dust in the clean area behind the filters.

In *Mach Mining, LLC,* 37 FMSHRC 614 (Mar. 2015)(ALJ), Judge Paez again considered safety standard 72.630(b) and concluded the Secretary may demonstrate a violation of section 72.630(b) by proving *either* (1) that the dust collection system was not maintained as it had been approved *or* (2) that the dust collection system was not in operating condition. The judge also found that in the context of section 72.630(b) the meaning of "permissible" is defined in accordance with Part 33 of the regulations. *Id.,* Fn 5. Recently, in *GMS Mine Repair*, 37 FMSHRC 2568, (Dec. 30, 2015) Judge Paez applied the same reasoning in determining that drill dust in the clean side of the systems revealed the dust collectors were not performing their regular function and proved the roof bolter machine was not being maintained in permissible *and* operating condition. *Id.*, at pp.7, 8.

I find the reasoning in these Commission ALJ decisions to be persuasive. As applied to the instant case the unglued, worn and leaking door seals could not be considered to be permissible since the equipment would not have been approved in that condition. Considering the integrity of the dust compartment, Inspector Kane credibly testified that the seals on the doors were worn out, no longer glued in place, not properly sealed against outside air and leaking. Respondent's witness Quertemous also testified that the door seals had deteriorated and that glued portions had detached in places. He was present at the time the machines came from the factory and recalled the seals were properly attached all the way around the door. He further stated that the deteriorated condition of the seals would allow outside air into the collection boxes. The testimony of both witnesses well establishes that the door seals of all four collection boxes were not being maintained in permissible condition.

The clean areas of three of the four dust collection systems would not have been approved either. The presence of drill dust behind the filters in those clean areas could not have conformed to the specifications for the systems and would not have been present when the equipment was tested for approval. Kane credibly testified he found drill dust in trenches just behind the filters which could get between the filter gaskets and the metal of the boxes. This would allow drill dust to bypass the filters and be exhausted into the mine atmosphere. On this record there is no dispute that there was drill dust behind three of the four collection box filters. Roof bolter machine No. 2 had impermissible clean areas in both collection boxes, and roof bolter machine No. 4 had one impermissible clean area.

The three impermissible dust collection systems were also not being maintained in operating condition because the dust in the clean area would be exhausted into the mine atmosphere when the roof bolter machine was in use. It is not necessary to determine that the condition actually did cause drill dust to be exhausted into the area of active mining, but only that this would happen. The system was not performing its regular function because dust had reached the clean side of the filter system. Kane testified if the dust is not cleaned out of the trench the filter will not seal and will allow dust to leak into the exhaust and be continuously expended into the mine atmosphere when the machine was operating. Quertemous agreed any dust present on the clean side of the filter would go into the mine atmosphere. As a result, the drill dust found in the clean area behind the filters was sufficient to find Respondent failed to maintain three of the four dust collection systems in operating condition on the two roof bolter machines.

It follows, then, that I do not agree with Respondent's contentions for vacating the citations. The arguments center on operating condition, citing an unrelated proceeding involving Respondent, *Mach Mining, LLC,* 35 FMSHRC 2827 (Aug. 2013) (ALJ). In that case, unlike the instant proceeding, the citations alleging violations of section 72.630(b) *only* stated that the dust collection systems were not being maintained in *permissible* condition and the Secretary had made no attempt to prove the systems were not in permissible condition. *Id.,* at 2832. In *dicta,* considered wholly unnecessary to the holding, the judge suggested that proof the systems were not in *operating* condition required air readings, compliance with the Mine's Ventilation Plan, and visible dust in the air. *Id.,* at 2833, 2834. I do not agree with these suggestions in the context of the safety standard at issue, and in any event consider it inappropriate to rely on *dicta.*

Section 72.630 sets forth alternative methods of dust control: dust collectors, or water, or ventilation, or other approved method or device. Since dust collectors are used on Respondent's roof bolters, controlled by subsection (b), the use of water or compliance with the ventilation plan is not required and irrelevant to this decision. The enforcement of the safety standard does not require dust sampling. *Jim Walter Resources, Inc.,* 17 FMSHRC 1423, 1444-45 (Aug. 1995) (ALJ); *aff'd Jim Walter Resources, Inc., v. Sec'y of Labor,* 103 F.3d 1020, 1024 (D.C.Cir.1997). *See also* the regulation history, Air Quality Standards for Abrasive Blasting and Drill Dust Control, 59 Fed. Reg. 8318, 8322 (February 18, 1994). The argument that dust must be seen ignores the fact that silica dust can be measured in microns in size, invisible and dangerous as testified by Inspector Kane. Respondent also argued that the machines met the vacuum parameter checks and therefore were in operational condition. However, that the suction at the drill pods was most likely maintained despite the unglued, worn and leaking door seals is also irrelevant since the systems were otherwise violatively defective.

Respondent argued that the deteriorated door seals would not cause dust to blow out of the collection boxes when the roof bolter was shut off. Quertemous testified that in his 30-year career he had never seen this happen. He gave his opinion why this would not occur, essentially that the vacuum motor would shut down slowly. Inspector Kane testified he had seen this occur, but he did not elaborate on the circumstances surrounding any past incident. The Secretary did not offer any authority, such as MSHA or manufacturer testing or instructions, to support the purported back pressure "burp back" condition. However, it is not necessary to resolve this conflict in the evidence; I have determined that the dust collection systems were neither in "permissible" condition nor in "operating" condition.

After careful consideration of the evidence presented and Respondent's arguments, I find that the Secretary has met the burden of proof. Respondent violated 30 C.F.R. § 72.630(b) with respect to both Citation Nos. 8445042 and 8445043.

Inspector Kane found the gravity in Citation Nos. 8445042 and 8445043 as being "Reasonably Likely" to result in a "Permanently Disabling" injury to two persons and that the violations were S&S. In the event that silica dust was emitted from the dust collection system, it would result in silicosis and/or pulmonary fibrosis. Respondent's witness Quertemous also testified to his understanding that exposure to the dust causes silicosis. This condition can cause permanently disabling injuries to miners and eventually lead to death. Further, there were at least two miners working in the area of each roof bolter. Therefore, I agree and find that the

gravity was properly marked as reasonably likely to cause permanently disabling injuries to two miners.

Regarding the first element of S&S - the underlying violation of a mandatory safety standard - it has already been established that Respondent violated 30 C.F.R. § 72.630(b).

The second element of *Mathies*, a discrete safety hazard – that is a measure of danger to safety – contributed to by the violation – has also been met. The safety hazard of silica dust in the active mining section atmosphere from the roof bolter drills has been clearly identified. Inspector Kane credibly testified that the invisible, microscopic silica dust would be contained in the drill dust generated by roof bolting. While the amount was disputed, the fact of silica in the drill dust was not disputed. The hazard that contributed to the danger to safety was the drill dust found in the clean area of three of the collection boxes of the two machines. On operation of the machines, this would be expelled from the machine and become suspended in the air where miners were working.

Inspector Kane credibly testified that exposure to silica dust, over time, would result in injury and even, ultimately in death. Respondent's witness Quertemous evaded directly addressing the danger, but he did testify he had been told exposure to dust causes silicosis, and he understood the importance of the filter systems. The condition of the collection boxes had existed uncorrected for two to three days at the time of the inspection. It is not necessary for the Secretary to prove that the violations, the impermissible and non-functional dust collection systems, will result in injury. Rather, it is the contribution of these violative conditions to the exposure to silica dust and the injury due to silicosis and/or pulmonary fibrosis that is important. In the context of continued normal mining operations such exposure is very serious and reasonably likely to result in a disabling respiratory disease. The third element of the *Mathies* formula is met.

Due to the seriousness of silicosis, the fourth element is also met. I specifically find that both violations were S&S.

In its brief, Respondent argued that management did not know and should not have known about the cited conditions because the filters were installed by hourly employees. RPHB 11 and RRB 21 *citing Martin Marietta Aggregates*, 22 FMSHRC 633 (May 2000). It is generally true that the actions of a rank-and-file employee are not imputable to an operator. However, a person's actions are imputable to the operator when that person is charged with the responsibility for the operation of part of the mine. 30 U.S.C. 802(e). The Commission has previously found that rank-and-file miners are charged with the responsibility for the operation of part of the mine when assigned statutorily mandated responsibilities of the operator, like conducting examinations. *Rochester & Pittsburgh Coal Co.*, 13 FMSHRC 189, 194-195 (Feb. 1991); *see also Mettiki Coal Corp.*, 13 FMSHRC 760, 772 (May 1991). In the instant matter, Respondent's bolter operators, while rank-and-file employees, were charged with conducting pre-operational examinations of the roof bolter machines and their dust collection systems. As a result, those operators were acting as Respondent's agents, and their negligence is imputable to Respondent.

With respect to knowledge, Inspector Kane credibly testified that one of the bolter operators was aware of the broken door seals and had reported the condition to a mechanic. The problem was obvious as soon as someone looked inside the compartments, the seals would just flop over. Similarly, the dust behind the three filters was most likely pushed into place by a miner when installing the filters. That miner should have been aware and cautious, based on the training provided. Quertemous testified the condition was most likely caused by changing the filters, and the bolter men were trained to be cautious. In addition, the dust behind the filters should have been caught on the weekly permissibility examination. Therefore Respondent knew, or should have known, that the dust collection system was not in either permissible or operable condition.

In its brief, the Secretary argued that Respondent's actions constituted "moderate" negligence. Specifically, the Secretary contended that the condition was obvious to anyone looking into the machine. Further, while the door seal condition was reported to a mechanic, it had not been corrected. In fact, it had existed for several days and for several cuts. The Secretary contended Respondent should have realized the dust collection systems were compromised and taken actions to correct the conditions. However, in the post hearing brief the Secretary did not suggest a mitigating circumstance to support the "moderate" determination. Considering the arguments advanced, this omission could be construed as a request for modification of both citations to high negligence.

In testimony, Inspector Kane observed that the bolter operators were a bit younger, which I take to mean inexperienced. Considering the testimony of Respondent's witness Quertemous that there was an awareness of the danger of pushing dust behind the filters and the bolter operators were trained to be cautious in changing the filters, their relative inexperience is not a mitigating circumstance. Notwithstanding, and despite the delay in correcting the door seals, at least one bolter operator did report the condition to a mechanic; essentially a request for repairs to be made. Therefore, I will not disturb the determination of the Inspector that the negligence was moderate.

I am aware that in the Sixth Circuit Court of Appeals decision in *Rex Coal Company, Inc., v. Secretary of Labor,* Case No. 14-4123 (October 29, 2015) (Unpublished) the Court noted that three citations were issued and three fines imposed where the same negligence resulted in the violation of three separate regulations. The Court commented that this appeared to be "piling on" and urged caution in the issuance of multiplicitous citations for the identical negligence. In *Rex Coal*, a single truck with inadequate brakes was involved, whereas in the instant case two separate roof bolter machines were each violatively defective and each was issued a single citation. Therefore, the concern for "piling on" is not applicable here.

d. Penalty

As in the discussion of the previous citation regarding dust in an active mining section, here the failure to properly maintain the two roof bolter dust collection systems raises serious safety concerns. Both of these violations were S&S and reasonably likely to result in permanently disabling injuries to two miners. I was able to find a mitigating circumstance and affirm the determination of moderate negligence. The violation history, while significant in the

context of dust control, does not support an increased assessment. The remaining factors have been stipulated by the parties. The Secretary proposed a penalty of $1,944 for each citation, and my independent assessment is that these amounts are appropriate.

VI. LAKE 2012-861: CITATION NO. 8445234

At the hearing, the Respondent did not contest the fact of the violation or, based on discussions at hearing regarding mitigation, the designation of moderate negligence. Tr. 190, 191. The Respondent argued only the designation of the violation as S&S. Tr. 191. *See also,* RPHB, RRB.

a. Summary of the Evidence

On June 27, 2012, Inspector Chad Meacham Lampley[18] ("Inspector Lampley" or "Lampley") inspected the Mach #1 Mine. Tr. 122. He had been to the mine numerous times in the past. Tr. 122-123. During the inspection, he found an inadequate guard at the drive of an 84-inch conveyor belt. Tr. 123. Referring to GX-17, he testified that a chain had been run through steel grating[19] and draped across and hooked to a motor lift eyelet on the other side. Tr. 124, 125, 149. He explained the chain was not sufficient as a guard because it could easily be disconnected and dropped, or ducked under, and did not prevent any miner from going into the drive area during cleanup. Tr. 125, 127, 128, 145, 146. This area had rotating components; two drive roller assemblies with tension where the belts come around the rollers. Tr. 124, 125. Referring also to GX-14, a wider view of the area, Lampley further explained that the rotating assemblies are required to be guarded to prevent any miner from coming into contact with those moving parts. Tr. 126, 127. The guard is supposed to extend a sufficient distance from the parts to prevent contact, and be secure in place so that it could not easily fall off or be removed. Tr. 127. The belt area would be routinely accessed by miners for cleaning, Tr. 130, 135, and by the mine's examiners each shift. Tr. 135. The area could also be accessed by general inside laborers, or if there was a problem by somebody going to see the belt running. Tr. 138.

Inspector Lampley testified that injury was reasonably likely because people would be coming through the area, a place where accumulations occur directly underneath or in close vicinity to the belt itself. Tr. 135, 150. A miner would have to get close and reach with a shovel underneath the belt and drive to clean that area. Tr. 149, 150. Depending on where one measured from the chain, the distance to the rotating parts was 4 to 6 feet. Tr. 143, 144. Lampley considered the hazard to be the ease of access by just unhooking the chain and going into the area to clean and coming in contact with the rollers. Tr. 124, 145, 146. Lampley further testified he marked injury as permanently disabling because a miner or his clothing could contact a pinch point, get caught in a roller, or be pulled into the rotating components and have a

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[18] Inspector Lampley earned a BS degree from Southern Illinois University and had been with MSHA for about seven and a half years. Also, he had previously worked for about a year and a half for a coal company as a laborer and mechanic. Tr. 120, 121.

[19] Exhibits GX 17 and GX 14 show the chain passed through a small piece of grating attached perpendicular to the structure.

crushing injury or dismemberment. Tr. 124-126. Lampley also testified that many accidents, injuries and fatalities were caused by belt conveyors, rotating assemblies, and related equipment. Tr. 126, 136.

Inspector Lampley marked the violation as "S&S" because of the frequency with which miners were exposed to the hazard and the history of injuries in the mining industry from pulleys and rotating parts. Tr. 137.

In his notes Inspector Lampley wrote that when walking the 84 inch conveyor belt toward the head with Jimmy Henderson he observed the drive was not adequately guarded to prevent miners from contacting the moving rollers. He saw that the guards there did not extend a sufficient distance to prevent miners from traveling into the hazardous area of the drive. A chain was installed at the two foot opening of the walkpath from the end of a guard to the motor; the location of the opening would allow miners performing cleaning easy access to where the hazards of the rotating drive existed and could cause permanently disabling injuries. GX-15, pp. 29-33.

At 1517 hours Inspector Lampley issued a 104(a) Citation, No. 8445234, to Respondent. Section 8 of the citation reads as follows:

> The 84 inch belt conveyor drive is not adequately guarded to prevent miners from contacting the moving drive rollers. Guards do not extend a sufficient distance to prevent miners from traveling into the hazardous area. A two foot walkpath at the inby drive motor has a single chain installed from the end of the guard to the motor.

The safety standard 30 CFR § 75.1722(a) was cited two times in two years at the mine.

Lampley marked the violation as S&S, reasonably likely to be permanently disabling to one person, and moderate negligence. The citation was terminated at 1555 hours when metal guarding was extended to the drive motor.

GX 13.

Mine Manager Jimmy Henderson[20] ("Manager Henderson" or "Henderson") testified for the Respondent. Tr. 152. He also observed the chain at the 84-inch belt drive area that had been put up to prevent a miner from accidentally getting in the hazard of a pinch point where the belts run around the drive pulley.[21] Tr. 155-157, 160. Henderson had not seen that chain before and

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[20] Jimmy Henderson was responsible for everything at the mine, including safety and production during his shift and maintenance of guards. Tr. 152–53, 170. He had extensive experience. Tr. 154, 187. He had traveled with inspectors when they expected guards in the past. Tr. 186.

[21] The drive was located at the end of a 400-foot beltline that dumped onto the slope belt that takes the coal outside. Tr. 156. The drive operates a series of pulleys that move the belt. Tr. 156, 157.

did not believe it was adequate guarding. Tr. 160, 178. He also testified the purpose of a guard was to prevent accidental contact. Tr. 164-165. A miner contacting the drive could get a piece of clothing caught and his arm pulled into a pulley. Tr. 165. Miners were occasionally injured and killed by inadvertent contact with pulleys. Tr. 180. However, Henderson did not believe that miners would typically enter a chained off area because a chain could be used as a warning sign. Tr. 166, 179. He conceded that miners would sometimes cut corners. Tr. 180.

Manager Henderson testified that the belt drives are examined every shift, and there is a chance for cleaning to go on every shift. Tr. 160. Henderson had assigned miners to clean in the area around running belts in the past and had observed miners doing so. Tr. 175-176. Miners would clean the area with a 10 to 12 foot pancake shovel standing on the right side of the motor. They would not have to go under the chain. Tr. 176, 177. Henderson testified for someone to be hurt by the missing guard, they would have to walk up, take the chain off or go under or over the chain, walk four or five feet, and intentionally stick their arm out in between the belt and the pulley. Tr. 167. In his opinion, you could not be accidentally hurt by the chain being there and the guard missing. Tr. 168. The condition was abated promptly by removing the chain and welding a guard onto the drive perpendicular to the belt. Tr. 161, 164, 167.

b. Contentions

The Secretary contended that the violation was S&S since a miner behind the chain would be exposed to getting clothing or a body part in contact with the drive rollers causing crushing injuries or dismemberment. The area is regularly accessed for cleaning when the belt is running. One miner, examiner or cleaner, would be affected. The hazard created was reasonably likely to result in a permanently disabling injury that would be reasonably serious. The Secretary proposed a penalty of $1,530.

The Respondent contended that the S&S designation should be deleted. The chain was a protective barrier making access to the belt drive difficult. A miner would have to remove or cross over or under the chain to approach the conveyor drive, and miners would not regularly be in the area protected by the chain. The Respondent argued the distance from the chain to the drive was 4 to 6 feet, the floor was not wet, and there was no need for miners to pass the chain to clean the area; therefore, injury would be highly unlikely.

c. Analysis

The safety standard, "Mechanical equipment guards" provides the following:

> a. Gears; sprockets; chains; drive, head, tail, and takeup pulleys; flywheels; couplings, shafts; sawblades; fan inlets; and similar exposed moving machine parts which may be contacted by persons, and which may cause injury to persons shall be guarded.
> b. Guards at conveyor-drive, conveyor-head, and conveyor-tail pulleys shall extend a distance sufficient to prevent a person from reaching behind the guard and becoming caught between the belt and the pulley.

c. Except when testing the machinery, guards shall be securely in place while machinery is being operated.

30 C.F.R. § 75.1722.

I understand, of course, that Respondent here concedes the guarding was inadequate, and contests only the determination of S&S. However, to fully consider this issue, an understanding of the requirements for a "guard" is needed. The safety standard lists a number of types of moving machine parts that must be guarded, that the guard must be extended a sufficient distance from the pulleys to prevent a person reaching behind the guard becoming caught between the belt and pulley, and that the guard must be securely in place while machinery is operated. However, the term "guard" is not further defined in the regulation. The MSHA Program Policy Manual[22] contains relevant details:

> Guards installed to prevent contact with moving parts of machinery shall:
> 1. Be of substantial construction;
> 2. Be of such construction that openings in the guard are too small to admit a person's hand;
> 3. Be firmly bolted or otherwise installed in a stationary position; and
> 4. Be of sufficient size to enclose the moving parts and exclude the possibility of any part of a person's body from contacting the moving parts while such equipment is in motion.

Program Policy Manual, Volume V, Subpart R, Pages 155, 156.

Over thirty years ago the Commission provided guidance on an identically worded safety standard for guarding:

> We find that the most logical construction of the standard is that it imports the concepts of reasonable possibility of contact and injury, including contact stemming from inadvertent stumbling or falling, momentary inattention, or ordinary human carelessness. In related contexts, we have emphasized that the constructions of mandatory safety standards involving miner's behavior cannot ignore the vagaries of human conduct. See, e.g., Great Western Electric, 5 FMSHRC 840, 842 (May 1983); Lone Star Industries, Inc., 3 FMSHRC 2526, 2531 (November 1981). Applying this test requires taking into consideration all relevant exposure and injury variables, e.g., accessibility of the machine parts, work areas, ingress and egress, work duties, and as noted, the vagaries of human conduct. *Secretary of Labor v. Thompson Brothers Coal Company, Inc.*, 5 FMSHRC 2094, 2097 (Sep. 1984).

The test is "reasonable possibility" of contact and injury. *Id.*

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[22] The Program Policy Manual is an agency issue available to the public on the MSHA website. Although counsel for the Secretary referred to the Manual at the hearing, there was no need to offer it as an exhibit. All or any part of the Manual may be downloaded and/or printed.

In the instant case, as clearly shown by the photograph GX 14 and the closer view GX 17, and by descriptions in testimony, the easily removed or circumvented chain did not in any meaningful way prevent access to moving machine parts via a two foot wide pathway from the work area. Cleaners, examiners, maintenance workers or others in this pathway would be in close proximity to the open, exposed and *unguarded* pulley and belt readily visible adjacent to the end of the pathway. Respondent's exhibit RE 8 was marked to point to the pulley in question; when compared to GX 17 and GX 14 the same assembly is indicated. Considering the vagaries of human conduct, including inadvertent or accidental contact with this moving pulley and belt due to carelessness, inattention, stumbling or falling, the test of "reasonable possibility" of contact and injury is met.

Respondent contended the chain was a "protective barrier" or an "area guard" that would prevent miners from accessing a pinch point. I find the chain was neither. The ALJ decisions cited by Respondent do not support the argument, and in any event are not persuasive.[23] The entrance to the pathway between the structure and the motor was not completely screened off and the chain was not welded and padlocked and had no warning sign attached. Other decisions cited regarding distances between installed guards and moving parts do not apply here, since there was *no* guard between the end of the pathway and the exposed pulley and belt.

I credit the testimony of Inspector Lampley that miners would enter the area to clean up. He observed that miners often take expedient actions, even when such actions are not safe, and they would ignore the chain and not avoid the area behind the chain. He also testified that examiners are trained to find problem areas; therefore it was reasonably likely that an examiner or maintenance person would need to closely view the drive assembly if there was a problem. Respondent's witness Henderson testified that miners did enter the area to clean coal spillage, and he conceded that miners would cut corners. In this context, whether the cleaners were provided 12-foot long shovels does not matter; it is how and where shovels of any type would be used that makes a difference. In this case, there was no effective "barrier" or "area guard" to *prevent* access to moving machine parts by any miner.

Inspector Lampley found the gravity of the violation to be "Reasonably Likely" to result in a "Permanently Disabling" injury to one miner. I agree with these determinations and find each is supported by a preponderance of the evidence.

Regarding the first element of S&S - the underlying violation of a mandatory safety standard - it has already been established that Respondent violated 30 C.F.R. § 75.1722(a). We begin the S&S analysis here with the second element of *Mathies*, whether there was a discrete safety hazard – that is a measure of danger to safety – contributed to by the violation. As discussed *supra*, the drive assembly, specifically the unguarded pulley and belt easily accessed from the pathway, could cause injuries if contacted. These exposed moving parts contributed to the danger of clothes or limbs coming into contact with the pulley and belt and the miner being pulled into the pinch point. Miners did enter the area on a regular basis to perform various assigned tasks, including the mine's examiners and those sent to clean the area around and under

[23] Respondent cited *Secretary v. Consolidation Coal,* 15 FMSHRC 1264, 1286-1287 (June 20, 1993) and *Secretary v. Overland Sand & Gravel,* 14 FMSHRC 1337, 1342 (August 3, 1992).

the belt. The violation contributed to the safety hazard of a miner in the area contacting the moving parts of the drive. Therefore, the second prong of *Mathies* was met.

The third element of *Mathies* – a reasonable likelihood that the hazard contributed to will result in an injury – was also met. Lampley and Henderson testified that a miner contacting moving equipment could be pulled into the machine and suffer crushing injuries or dismemberment. Both acknowledged that these injuries, and fatalities, did occur in the mining industry. With continued normal mining operations there was a reasonable likelihood that the hazard contributed to by the violation, being pulled into exposed and dangerous moving equipment would result in injury. The third prong of *Mathies* was also met.

The fourth element of the *Mathies* test – a reasonable likelihood that the injury in question will be of a reasonably serious nature - was also met. It is essentially uncontested that miners pulled into these moving assemblies would be crushed or suffer dismemberment. This would be, at least, permanently disabling and therefore of a reasonably serious nature. All four prongs of *Mathies* were met, and I find the determination of S&S to be correct.

d. Penalty

I affirmed the gravity and S&S findings, and again considering the six criteria as required by Section 110(i) including the lack of a significant history of this type of violation and the matters stipulated by the parties, I also affirm the penalty of $1,530.00.

ORDER

It is **ORDERED** that Citations numbered 8427074, 8442233, 8445042, 8445043, and 8445234 are **AFFIRMED** as issued with civil penalties totaling **$13,176**.

It is further **ORDERED** that Citation Number 8420533 is **MODIFIED** to reduce the negligence to **LOW** and the civil penalty to **$700**.

It is further **ORDERED** that Mach Mining, LLC, **PAY** the Secretary of Labor the sum of **$13,876.00** within 30 days of the date of this Decision.[24]

Upon receipt of payment, this case is hereby **DISMISSED**.

Kenneth R. Andrews
Administrative Law Judge

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[24] Payment should be sent to: MINE SAFETY AND HEALTH ADMINISTRATION, U.S. DEPARTMENT OF LABOR, PAYMENT OFFICE, P.O. BOX 790390, ST. LOUIS, MO 63179-0390.