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June 12, 2014

SECRETARY OF LABOR MINE SAFETY AND HEALTH ADMINISTRATION, (MSHA), Petitioner, v. THE DOE RUN COMPANY, Respondent.	CIVIL PENALTY PROCEEDING Docket No. CENT 2013-605-M A.C. No. 23-00457-325635-01 Mine: Buick Mine/Mill

DECISION

Appearances: Carol Liang, Office of the Solicitor, U.S. Department of Labor, Denver, Colorado, for Petitioner;

R. Henry Moore, Jackson Kelly, PLLC, Pittsburg, PA, for Respondent.

Before: Judge Miller

This case is before me on a petition for assessment of civil penalty filed by the Secretary of Labor, Mine Safety and Health Administration ("MSHA") against The Doe Run Company ("Doe Run") at its Buick Mine/Mill, pursuant to sections 105 and 110 of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. §§ 815 and 820. This docket involves one citation with a penalty assessed pursuant to section 110(i) of the Mine Act. The parties presented testimony and evidence at a hearing held on April 17, 2014 in St. Louis, Missouri.

The parties agree that Doe Run is an operator as defined by the Act, and is subject to the jurisdiction and provisions of the Mine Safety and Health Act. The parties further agree that the citation was abated within the allowed time and the penalty of $2,106.00 will not inhibit the mine's ability to continue in business. Jt. Stip. 11. Buick Mine/Mill consists of an underground mine that mines lead, copper and zinc, and a surface mill. The mine is located near Rolla, Missouri.

I. FINDINGS OF FACT AND CONCLUSIONS OF LAW

On May 15, 2013, Inspector Dale Coleman with the Department of Labor's Mine Safety and Health Administration ("MSHA") issued Citation No. 8688248 under section 104(d)(1) of the Act for an alleged violation of 30 C.F.R. § 57.15005, which requires that "safety belts and lines shall be worn when persons work where there is danger of falling." The citation alleges that a miner was working while standing on top of an electrical cabinet that was seven feet tall, without wearing fall protection. Inspector Coleman designated the alleged violation as reasonably likely to result in a permanently disabling injury, significant and substantial, one

person affected, and the result of high negligence on the part of the operator. The Secretary proposed a penalty of $2,106.00 for this citation.

On May 15, 2013, two electricians, Marion Mills and Kevin Brady, were assigned to change out an electrical switch in the motor control room ("MCC") at the mine. Mills and Brady were both experienced miners. Andrew Wlaschin, an electrical engineer, was responsible for supervising and directing the work of Mills and Brady while they completed the job. Wlaschin had been at the mine for less than a year and, while he had worked on various projects, had never performed the job which had been assigned to Mills and Brady.

The assigned task required the two electricians to disconnect a cable in an electrical cabinet and pull the cable out from inside its location. The top of the cabinet, which is roughly 34 inches by 36 inches in area, is approximately 7 feet, 7 inches above the cement floor below. Two pipes extend vertically from the top of the cabinet to the ceiling above.

Prior to beginning the work, the electricians locked out power to the cabinet at a substation location. Locking out the power to the cabinet and work area also disabled the lights in the work area. As a result, the electricians worked with cap lamps and flashlights. After locking out the power, Mills removed the door on the high voltage center, and then moved to an adjacent cabinet to remove another door. Brady helped Mills with the removal and, as Mills began disconnecting the cable within the box, Wlaschin reminded Brady that he was required to wear a respirator. Brady left the area for a short time to locate the respirator and when he returned saw that Mills was inside the cabinet disconnecting the cable and Wlaschin was at his side. Brady then got a ladder, which he positioned next to the cabinet and climbed to the top of the cabinet to help pull the cable.

Wlaschin saw Brady return with his respirator, get the ladder, and climb to the top of the cabinet, but he asserts that he was distracted by watching Mills and looking at prints, and did not see Brady step off of the ladder and climb on top of the cabinet. According to Wlaschin, he only noticed that Brady was on top of the cabinet after being told by the inspector that Brady was required to come down or have fall protection. Wlaschin acknowledged that he did not see any harness or other safety device on Brady as he climbed the ladder.

Inspector Coleman testified that when he entered the room it was dark, although there was some ambient light. However, he immediately noticed movement and saw someone wearing a cap lamp while standing near the edge of the top of the cabinet. When Coleman shined his flashlight toward the top of the cabinet he saw Brady standing near the pipes, preparing to guide the cable. The top of the cabinet was flat and dry and it would have taken Brady a few minutes to pull the cable from that position. Coleman asked Wlaschin if Brady should be on the top of the cabinet without fall protection. Wlaschin testified that he responded to the question and agreed that Brady should have been wearing fall protection. Coleman remembers that Wlaschin did not agree and argued that fall protection was not necessary. Either Wlaschin or Coleman asked Brady to come down and he complied. As Brady made his way down, Wlaschin secured the ladder and Brady grabbed onto the cable tray above his head. Sec'y Ex. 2. However, Brady acknowledged that the cable tray was not strong enough to use as a place to tie off and that he saw nothing he could use as an anchor. Coleman testified that it was clear

to him that Wlaschin had to see Brady on the top of the cabinet and failed to take any action as his supervisor.

Wlaschin, the supervisor, did not indicate to the inspector that he was unaware of Brady's position. Rather, Brady and Wlaschin told the inspector that there was no hazard and fall protection was not necessary. Brady explained that, because he was working in the middle of the area on top of the cabinet, and given the presence of a wall roughly 32 inches from the edge of the cabinet, there was no risk of falling. Brady acknowledged that he had been trained in the use of fall protection, and fall protection was available nearby for his use. Further, he testified that it was the company policy to use fall protection and he realized he may face disciplinary action for failing to do so.

The mandatory standard requires that any person working in an area where there is a danger of falling must use fall protection. Brady was not wearing a safety belt and line, and was working in a small area atop a 7 foot 7 inch tall electrical cabinet, with a concrete floor below. Brady asserts that he was not in danger of falling due to working in the middle of the area on top of the cabinet and the presence of a wall approximately 32 inches from the edge of the top of the electrical box, which he could have used to catch himself had he lost his balance. I find these arguments to be entirely without merit. The area had no handrails or other protective devices which could have been used by Brady had he lost his balance. Further, working near the middle of a roughly nine square foot area, some of which was taken up by the pipes which extended up from the cabinet, still placed him perilously close to the edge of the cabinet. Furthermore, his belief that the wall 32 inches away from the edge of the electrical box would have prevented a fall is unreasonable. A miner should not, and must not, be expected to arrest themselves from falling by catching themselves against a wall 32 inches away from the surface they are standing on. Moreover, these miners were operating in an unlit room with only cap lamps and flashlights. I credit Coleman's testimony that pulling cable can cause a miner to lose their balance. While Brady had not yet begun to pull the wire, he testified that he would have done so had he not been ordered down. Pulling wire would have exposed him to the hazard to a greater degree. I find that any misstep or loss of balance would have resulted in Brady falling over seven feet to the concrete floor below. Clearly a danger of falling existed. Given the location of the cabinet, its height, and that Brady was focused on removing cable, I find that there was a danger of falling, and hence, Brady should have been wearing fall protection. Accordingly, I find that a violation of the cited standard existed.

I also find that the violation was significant and substantial. A "significant and substantial" violation is described in section 104(d)(1) of the Mine Act as a violation "of such nature as could significantly and substantially contribute to the cause and effect of a coal or other mine safety or health hazard." 30 U.S.C. § 814(d)(l). A violation is properly designated significant and substantial "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 Division, National Gypsum Co.*, 3 FMSHRC 822, 825 (Apr. 1981). In *Mathies Coal Co.*, 6 FMSHRC 1, 3-4 (Jan. 1984), the Commission explained its interpretation of the term "significant and substantial" to be:

> In order to establish that a violation of a mandatory safety standard is significant and substantial under *National Gypsum*, the Secretary of Labor must prove: (1) the underlying violation of a mandatory safety standard; (2) a discrete safety hazard--that is, a measure of danger to safety--contributed to by the violation; (3) a reasonable likelihood that the hazard contributed to will result in an injury; and (4) a reasonable likelihood that the injury in question will be of a reasonably serious nature.

I have already found a violation of the cited standard. Moreover, I find that a discrete safety hazard existed; the danger of falling from a height of more than seven feet and landing on the concrete floor below.

The difficulty with finding a violation S&S normally comes with the third element of the *Mathies* formula, in which the Secretary must establish that there is a reasonable likelihood that the hazard will result in an injury. In *U.S. Steel Mining Co., Inc.*, 7 FMSHRC 1125, 1129 (Aug. 1985). The Commission has explained that the third element of the 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). 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 1573, 1574 (July 1984). In addition, the question of whether a particular violation is S&S is a circumstantial inquiry that 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). The Commission and courts have also observed that an experienced MSHA inspector's opinion that a violation is significant and substantial is entitled to substantial weight. *Harland Cumberland Coal Co.*, 20 FMSHRC, 1275, 1278-79 (Dec. 1998); *Buck Creek Coal Inc.*, 52 F.3d 133, 135 (7th Cir. 1995).

I find that there was a reasonable likelihood that the hazard would have resulted in an injury. Although Brady insists that he was only on top of the cabinet for a short time and he might be able to catch himself on the wall 32 inches away, I agree with Coleman that it is likely that he would fall from the top of the cabinet. In evaluating the level of exposure, I have considered the length of time the violation existed both before and after the inspector arrived. Brady acknowledged that he was on top of the cabinet preparing to pull wire prior to the inspector entering the room, and attests that he would have followed through had he not been ordered down. I find that, while the time of his exposure may have amounted to only minutes, there was more than enough time for Brady to fall. First, the area on the top of the cabinet was small for one person to stand on and some of that area was obstructed by the pipes which extended upward from the center of the cabinet. Given the size of the area, the obstructions present, and Brady's position of working with his back to the edge of the cabinet, it is difficult to imagine how he could safely maneuver while maintaining his balance. Second, the area was dark. While the inspector testified that there was some ambient light present, Brady asserted that there was none. Accordingly, if Brady's testimony is to be taken at face value, then the only light he had to work with was that which was provided by the cap lamp. The lack of light and

the inability to fully see his surroundings certainly contributes to the likelihood of a fall. Third, Brady's balance would have been compromised because he would have needed both hands to pull and direct the cable that was being removed from the cabinet. I credit Coleman's testimony that pulling cable can cause a miner to lose his balance. Had Brady lost his balance, it is likely he would have attempted to arrest his fall by grabbing the cable tray, which he relied upon and grabbed to steady himself when descending the ladder. Notably, Brady conceded the cable tray could not support his weight. Given the circumstance, I find it likely that he would have fallen had the inspector not addressed the situation.

The normal actions of miners must be considered in determining whether a violation is S&S. In discussing the injuries related to guarding in *Thompson Bros. Coal Co.*, 6 FMSHRC 2094, 2097 (Sept. 1984), the Commission took into account "inadvertent stumbling or falling, momentary inattention, or ordinary human carelessness" and explained that "in related contexts, we have emphasized that the constructions of mandatory safety standards involving miners 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 (Nov. 1981). Here, a simple misstep, inadvertent stumble, or moment of inattention would have resulted in Brady falling more than seven feet to the concrete floor below.

The inspector testified that he is aware of a number of falls from such heights, including a fall in which a miner was attempting to pull cable prior to losing his balance and falling. Coleman explained that there have been fatalities in the mining industry as a result of falls from this height. I credit Coleman's testimony and agree that falling from a height of more than seven and a half feet, as measured by the inspector, would result in a serious injury. It is reasonably likely that the miner would strike his head, break a bone, or receive other serious injuries due to the impact on the floor. The injuries would be permanently disabling or even fatal. Consistent with my above analysis, I find that the violation is significant and substantial.

I also find that the violation was a result of the mine operator's high negligence. The Secretary's regulations explain that "high negligence" exists when "the operator knew or should have known of the violative condition or practice, and there are no mitigating circumstances." 30 C.F.R. § 100.3(d), Table X (defining "high negligence"). The Secretary argues that Doe Run "should have known of the violation, and presented no mitigating factors." Sec'y Br. 11. I agree, and find that the operator either knew or should have known of the violation, and that there were no mitigating circumstances.

Inspector Coleman testified that, based on Wlaschin's reaction to the inspector's initial identification of the hazard, it was his belief that the supervisor, Wlaschin, knew or at the very least should have known, that Brady had climbed the ladder and was standing on top of the cabinet without fall protection. Specifically, Coleman noted Wlaschin's lack of surprise that Brady did not have fall protection on, Wlaschin's denial that fall protection was needed, and the absence of any argument presented by Wlaschin at the time of the incident that he did not know Brady was on top of the cabinet. While Wlaschin acknowledged that he was aware that Brady had begun to ascend the ladder, he claims that he did not know Brady was on top of the cabinet. Moreover, Wlaschin claims that, contrary to Coleman's testimony, he did tell the inspector that he did not know that Brady had climbed on top of the cabinet.

I credit the inspector's testimony and find that Wlaschin had knowledge that Brady was on top of the cabinet without fall protection. While the area was dark, it is undisputed that Wlaschin saw Brady move the ladder into place and climb up without fall protection. I find it curious, at best, that, immediately upon seeing Brady begin to ascend the ladder, Wlaschin became distracted by Mills' work and the blueprints he was holding on to.[1] Moreover, I find it unlikely that he couldn't hear Brady moving on top of the large metal cabinet or see the light of Brady's cap lamp as he moved above. Tr. 62. I find that Wlaschin's testimony amounts to revisionist history of the events and, accordingly, credit the inspector's testimony and find that Wlaschin had knowledge of the violative condition. Moreover, I credit Coleman's testimony and agree that no mitigating circumstances existed. Accordingly, I find that Wlaschin, exhibited high negligence.

Doe Run, in arguing that the high negligence finding is not supported, states that Brady's conduct "was an isolated incident involving one miner who disregarded the company's policy, his training, and the availability of fall protection equipment" and that his negligence cannot be imputed to the operator. Resp. Br. 11. However, this argument, along with other arguments in its post hearing brief, ignores my above findings regarding Wlaschin's high negligence. Undoubtedly, Brady acted with extreme negligence and has admitted as much. However, Brady was a rank-and file miner, whose negligence generally cannot be imputed to the operator. *Whayne Supply Co.*, 19 FMSHRC 447, 451, 453 (Mar. 1997); *Fort Scott Fertilizer-Cullor, Inc.*, 17 FMSHRC 1112, 1116 (July 1995); *Southern Ohio Coal Co.*, 4 FMSHRC 1459, 1463-64 (Aug. 1982)("SOCCO"); *Reading Anthracite Co.*, 32 FMSHRC 399, 411 (Apr. 2010) (ALJ). Wlaschin, on the other hand, was a supervisor, whose negligence can be imputed. *See generally Capitol Cement Corp.*, 21 FMSHRC 883, 894 (Aug. 1999). Wlaschin offered testimony that he was relatively new to the mine, had far less experience than the two electricians he was observing, and hinted that he wasn't really a supervisor because he was learning from the electricians and had never completed this specific task in the past. However, he was the one who noticed that Brady was not wearing his required respirator before starting the job, and signed the reprimand for Brady as his supervisor. Therefore, I find that Wlaschin was the supervisor in charge of the job. This finding is further supported by Brady's testimony that Wlaschin was his supervisor. While Wlaschin is young and was only at the mine for about a year prior to the incident, he is well educated and agreed that he had training on the mine's fall protection policy. I find that the totality of the evidence requires a finding that the violation was due to a combination of Brady's and Wlaschin's high negligence, and that Wlaschin's negligence may properly be imputed to the operator.

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[1] Wlaschin testified that he "saw Brady up on a ladder. Then he went back in the cabinet when Brady wasn't standing there anymore." Tr. 59. I find this testimony puzzling. If Wlaschin saw Brady standing on the ladder, and then saw that Brady was no longer on the ladder, and could not be seen on the ground, it stands to reason that Brady had climbed up, gotten off of the ladder, and was on top of the cabinet. Yet somehow, if Wlaschin's testimony is to be believed, he failed to make this connection. At the very least, based on his own testimony, I find that Wlaschin *should have known* where Brady was and, given that he knew Brady did not have fall protection on, *should have known* of the violative condition.

I also find that the violation was a result of the operator's unwarrantable failure to comply with the mandatory standard. The unwarrantable failure terminology is taken from section 104(d) of the Act, 30 U.S.C. § 814(d), and refers to more serious conduct by an operator in connection with a violation. In *Emery Mining Corp.*, 9 FMSHRC 1997 (Dec. 1987), the Commission determined that unwarrantable failure is aggravated conduct constituting more than ordinary negligence. *Id.* at 2001. Unwarrantable failure is characterized by such conduct as "reckless disregard," "intentional misconduct," "indifference," or a "serious lack of reasonable care." *Id.* at 2003-04; *Rochester & Pittsburgh Coal Co.*, 13 FMSHRC 189, 194 (Feb. 1991) ("*R&P*"); *see also Buck Creek Coal, Inc.*, 52 F.3d at 136 (approving Commission's unwarrantable failure test). The Commission has explained that whether a citation is an "unwarrantable failure" is a question that should be evaluated based on the facts and circumstances in each case, and in light of each of the following factors: 1) the length of time that the violation has existed; 2) the extent of the violative condition; 3) whether the operator has been placed on notice that greater efforts were necessary for compliance; 4) the operator's efforts in abating the violative condition; 5) whether the violation was obvious or posed a high degree of danger; and 6) the operator's knowledge of the existence of the violation. *See Consolidation Coal Co.*, 22 FMSHRC 340 (Mar. 2000); *IO Coal Co.*, 31 FMSHRC 1346 (Dec. 2009). All of the relevant facts and circumstances of each case must be examined to determine if an actor's conduct is aggravated, or whether mitigating circumstances exist. *Consol*, 22 FMSHRC at 353. Because supervisors are held to a high standard of care, another important factor supporting an unwarrantable failure determination is the involvement of a supervisor in the violation. *REB Enters., Inc.*, 20 FMSHRC 203, 225 (Mar. 1998) (Commissioner Marks, concurring in part and dissenting in part).

The condition did not exist for an extended period of time, nor was it particularly extensive, and the operator was prompt in abating the condition. It is undisputed that Brady was only on top of the cabinet for a few minutes. However, while only a few minutes would have been needed to complete the task at hand, only a moment of inattention was needed for a misstep, or loss of balance, to result in a fall. Coleman assumed, and Brady confirmed, that Brady would have worked without fall protection if Coleman had not entered onto the scene. Nonetheless, when told to come down, Brady did so immediately and did not complete the job until toggle bolts were installed so that he could safely tie off. The violative condition was confined to a small area, on one job, and one electrician who decided he could quickly pull the cable without having to locate and put on fall protection. While these three factors arguably weigh in the favor of the operator, the same cannot be said for the other factors.

The condition was obvious. Coleman testified that almost immediately upon entering the room he noticed movement on top of the cabinet. While the room was dark, Brady's cap lamp was plainly visible and clearly revealed his location on top of the cabinet. There is no dispute that Brady was not wearing fall protection and that he was working at a height of over seven feet above the concrete floor. Given my above findings regarding Wlaschin's knowledge of Brady's location and lack of fall protection, and his proximity to violative condition, I find that the condition was obvious and easily seen by Wlaschin despite his testimony to the contrary.

The degree of danger and level of exposure presented by the condition are discussed in detail above in the context of my S&S analysis. Similarly, the operator's knowledge of existence

of the violation is discussed in detail above in my negligence analysis. Nevertheless, it is worth reiterating that, given the surrounding circumstances, Brady's blatant disregard of law and Wlaschin's failure to uphold the "high standard of care" required of mine operators made it reasonably likely that Brady would fall and suffer a serious injury. *See* 30 C.F.R. § 100.3(d). The Commission has long held that the negligence of a "rank-and-file" miner cannot be imputed to the operator for civil penalty purposes. *Fort Scott*, 17 FMSHRC at 1116; *Western Fuels-Utah, Inc.*, 10 FMSHRC 256, 260-61 (Mar. 1988); *SOCCO*, 4 FMSHRC at 1464. The Commission has further determined that "where a rank-and-file employee has violated the Act, *the operator's* supervision, training and disciplining of its employees must be examined to determine if *the operator* has taken reasonable steps necessary to prevent the rank-and-file miner's violative conduct." *SOCCO* at 1464 (emphasis in original). Finally, while this standard is normally applied in determining the operator's negligence for penalty purposes, the Commission has confirmed that it also applies in determining whether an operator can be held responsible for a miner's aggravated conduct and, thus, be found to have unwarrantably failed to comply with a regulation. *Whayne Supply Co.*, 19 FMSHRC 447, 452-53 (Mar. 1997). In this case, I am particularly concerned that Brady, who agreed he had been trained, blatantly ignored the requirement to tie off. Brady is not a supervisor, but his training and any discipline at the mine obviously were not sufficient to cause him to follow the rules.

The mine had been placed on notice that greater efforts were necessary for compliance. The inspector testified that he addressed the issue twice with the operator during inspections over the previous two years. In one instance, Coleman issued a citation where a miner was not tied off correctly while working at height. During a second inspection he had a conversation with the operator regarding its failure to have tie off points in an elevated area that was accessed by miners. In the course of those conversations he discussed with the mine the need to "improve [tie off] . . . points and focus on fall protection better." Tr. 32. While I agree with the operator that, on its face, the limited history of violations does not provide an especially strong case that notice was provided, I credit Coleman's testimony that he did have conversations with the mine regarding the need to focus on fall protection after he identified a place in the mine where miners worked in an elevated area without tie off points. Similarly, here, tie off points were also not available in the area where a miner was working. While Doe Run argues that these two events were not part of Coleman's calculus of the unwarrantable failure designation, I find that the facts bear out that the mine was on notice. Accordingly, I find that Coleman did place the mine on notice that greater efforts were necessary for compliance.

I have already found that both Brady and Wlaschin exhibited high negligence. They both knew that Brady should not be working at a height of over seven feet without fall protection, yet, Brady chose to do so and Wlaschin chose to keep his attention elsewhere. In doing so, Brady engaged in intentional misconduct and his supervisor exhibited a serious lack of reasonable care, both of which are indicative of "more than ordinary negligence." Wlaschin's conduct cannot be excused because he is relatively new or has less experience than the electricians he worked with at the time of the violation. He is well-educated and as a supervisor should know the rules about working safely. While the condition may have been short-lived, it was a serious hazard that was ignored, and could have quickly led to a fall, which would have resulted in a serious, and potentially fatal injury. Therefore, I agree that the violation was an unwarrantable failure.

II. PENALTY

The principles governing the authority of Commission administrative law judges to assess civil penalties de novo for violations of the Mine Act are well established. Section 110(i) of the Mine act delegates to the Commission and its judges "authority to assess all civil penalties provided in [the] Act." 30 U.S.C. § 820(i). The Act delegates the duty of proposing penalties to the Secretary. 30 U.S.C. §§ 815(a), 820(a). Thus when an operator notifies the Secretary that it intends to challenge a penalty, the Secretary petitions the Commission to assess the penalty. 29 C.F.R. § 2700.28. The Act requires, that "in assessing civil monetary penalties, the Commission [ALJ] shall consider" six statutory penalty criteria which include the history of violations, the size of the operator, the negligence, gravity, the ability to continue in business and good faith abatement. 30 U.S.C. § 820(i). In keeping with this statutory requirement, the Commission has held that "findings of fact on the statutory penalty criteria must be made" by its judges. *Sellersburg Stone Co.*, 5 FMSHRC 287, 292 (Mar. 1983), aff'd, 736 F.2d 1147 (7th Cir. 1984). Once findings on the statutory criteria have been made, a judge's penalty assessment for a particular violation is an exercise of discretion, which is "bounded by proper consideration of the statutory criteria and the deterrent purpose[s] . . . [of] the Act. *Id.* at 294; *Cantera Green*, 22 FMSHRC 616, 620 (May 2000).

In the instant case, the operator is large, has no unusual history of these types of violations, and abated the condition in good faith. The inspector indicated that the negligence was high and, given the facts as discussed above, I agree. I have discussed the gravity and S&S nature above and find that a penalty of $2,106.00 as proposed by the Secretary is appropriate.

III. ORDER

The citation is affirmed as issued and Doe Run is hereby **ORDERED** to pay the Secretary of Labor the sum of $2,106.00 within 30 days of the date of this decision.

Margaret A. Miller
Administrative Law Judge

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