FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

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SECRETARY OF LABOR MINE SAFETY AND HEALTH ADMINISTRATION (MSHA), Petitioner	CIVIL PENALTY PROCEEDING Docket No. KENT 2012-166 A.C. No. 15-17497-269552-01
v.	
LEECO INCORPORATED, Respondent	Mine: No. 68

DECISION AND ORDER

Appearances: Latasha T. Thomas, Esq., Office of the Solicitor, U.S. Dept. of Labor, Nashville, Tennessee for Petitioner

Melanie J. Kilpatrick, Esq., Rajkovich, Williams, Kilpatrick & True, PLLC, Lexington, Kentucky for Respondent

Before: Judge McCarthy

I. Statement of the Case

This case is before me upon a petition for assessment of a civil penalty under section 105(d) of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 815(d). The parties stipulated to the following: jurisdictional issues; that Respondent Leeco violated 30 C.F.R. section 75.220 (a)(1) by failing to ensure that Bobby Smith, the continuous miner operator, followed the approved Roof Control Plan by staying out of the red zone; that the violation was significant and substantial (S&S); that a fatal injury occurred with one miner (Smith) affected; that Respondent abated the Citation in a timely manner and in good faith; and that the proposed penalty of $21,442 will not affect Respondent's ability to remain in business. Tr. 8-9; Sec'y Br. at 2, R. Br. at 1. The only issues remaining are whether the violation occurred as a result of Respondent's moderate negligence, as set forth in Citation No. 8359591, and whether the proposed penalty of $21,442 is appropriate.

An evidentiary hearing on these issues was held in Tazewell, Tennessee. The parties introduced testimony and documentary evidence and filed post-hearing briefs.[1]

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[1] Petitioner Exhibits 1-5 (P. Exs 1-5) were received into evidence. These exhibits included Citation No. 8359591, MSHA inspector and accident investigator Robert Ashworth's notes, MSHA's Preliminary Report of Accident, Respondent's MSHA-approved Roof Control

For the reasons set forth below, I affirm the Citation as written with moderate negligence and I assess a penalty of $21,442.

Based on the entire record and my observation of the demeanor of the witnesses, and after consideration of the parties' post-hearing briefs, I make the following:

II. Findings of Fact

Smith had twelve years of industry mining experience and had worked for 89 weeks as a continuous miner operator for Respondent, including about seven months under section foreman Harold Bronson's supervision. Tr. 49, 100. On one occasion, a couple of months before Smith's June 24, 2010 fatality, Respondent's superintendent Rick Campbell observed Smith operating the continuous miner "in the outer area of the red zone," when he was tramming the miner from cut to cut. Tr. 79. The red zone is a pinch point area between the continuous mining machine and the rib where serious and fatal crushing accidents have occurred while the miner is operating. Tr. 40.

The undersigned stumbled upon the above-mentioned incident during questioning of inspector Ashworth after re-cross examination. See Tr. 59-61. The Secretary apparently made a tactical decision not to raise the issue or subpoena Smith's personnel file because she did not know how this incident would cut on the supervision, training, and discipline of Smith, whose rank-and-file negligence was not imputable to Respondent Leeco. Tr. 61-62.

Thereafter, Respondent's counsel decided to address the issue through superintendent Campbell's testimony. Tr. 63, 79-80. Campbell testified that he had never observed Smith in the red zone, but had observed him in the outer area of the red zone. Tr. 79. Campbell testified that he instructed Smith to shut down the miner and then verbally admonished or counseled him about "what he did wrong" and told "him not to be in the red zone, how important it is not to be in the red zone . . . ." Tr. 79-82. Campbell then showed Smith where to be and not to be, although Campbell did not recall having a safety meeting with employees about the incident. Tr. 82.

Campbell brought the incident to foreman Bronson's attention and told him to keep an "eye out for it." Tr. 111. Bronson testified that thereafter he observed Smith operate the machine, but did not observe Smith tramming the machine very often. Tr. 112. Bronson

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Plan, and MSHA's certified Assessed Violation History Report for Respondent. Respondent's Exhibits 1-3 (R. Exs. 1-3) were also received into evidence. These exhibits included the training records for Smith, another copy of Respondent's MSHA-approved Roof Control Plan, and a poster entitled a "Red Zones are No Zones." A redacted portion of inspector Ashcroft's notes (P. Ex. 2), which revealed an MSHA informant, were reviewed in camera and placed under seal. Tr. 13-19.

testified as follows:

BY MS. THOMAS:

Q: Do you recall Mr. Campbell telling you anything about Mr. Smith being in or around the area and he disciplined Mr. Smith? He didn't discipline. Counseled Mr. Smith about approaching the red zone.

A. Yes.

THE COURT: Yes, you do recall a discussion with Mr. Campbell?

THE WITNESS: Yes, sir.

THE COURT: What do you recall about that discussion?

THE WITNESS: Mr. Campbell was on the section one day, and, to my understanding, Mr. Smith was not in the red zone but he was borderline while moving the continuous miner from one place to another. Mr. Campbell told me he had, you know, gave, you know a discussion with Mr. Smith about that and told me to keep an eye out for it as well.

THE COURT: Did you keep an eye out for it?

THE WITNESS: Yes.

THE COURT: Did you observe Mr. Smith thereafter approaching the red zone when he was moving the machine?

THE WITNESS: No.

THE COURT: How often would you observe him?

THE WITNESS: I'd say two to three times a day.

THE COURT: What particular operations would you observe him engaging in?

THE WITNESS: Well, every cut we went to, I was there before we started the cut. Different times I have observed him moving the continuous miner. I have observed him loading coal with the

continuous miner.

THE COURT: How often would you observe him tramming the miner?

THE WITNESS: Actually, not a lot.

THE COURT: On a weekly basis, would you observe him at all or once a week or a couple of times a week or it depends on the week?

THE WITNESS: It would depend. Maybe two to ten times, you know, depending in a week.

THE COURT: In the six to seven month period that Mr. Smith operated the continuous miner under your watch, how often did you observe him tram the miner? How many times?

THE WITNESS: Just like I - - that's what I was saying; maybe two to ten times a week on the tramming, moving place to place. When he would be moving, you know, I would be getting the ventilation and things like that established.

THE COURT: Did you ever see him approach the red zone?

THE WITNESS: No.

THE COURT: Did you ever see him in the red zone?

THE WITNESS: No.

THE COURT: Do you have anything else?

BY MS. THOMAS:

Q: Did you ever observe him making a cleanup? In other words, cleaning up the area with the continuous miner.

A. Yeah.

Tr. 110-113.

On March 17, 2011, MSHA accident investigator Ashworth investigated the June 24, 2010 fatality. Ashworth found that Smith had finished cutting coal in the No. 4 entry and hung the miner against the rib during a cleanup run before roof bolting. Tr. 36, 38. Ashworth

concluded that while attempting to free the miner, Smith stepped into the red zone near the stand-off chain toward the back of the miner. When the miner broke free, Smith was pinned against the rib and killed. Tr. 39.

No witness saw the accident occur. The last shuttle car operator to load before the accident told Ashworth that he did not see Smith in the red zone at any time. Tr. 46-47. Based on his investigation, however, Ashworth concluded that Smith was in the red zone while the machine was running because he "was standing real close to the back of the machine where the tail, the conveyor tail connects to the back of the frame." Tr. 39.

Foreman Bronson was with Smith at the start of the cut, but had moved to the No. 5 entry to conduct a pre-shift examination when the accident occurred. Tr. 99, 101. Bronson recalled sitting beside Smith in annual training during which red zone issues were discussed in a group setting. Tr. 102, 104. Respondent also held weekly safety meetings at which red zone issues were discussed about once a month. Tr. 102. Bronson testified that posters about the red zone were hanging in the foreman's office, the light house, the change room(s), and the warehouse. Tr. 103-04. Bronson testified that he had never seen Smith in the red zone while operating the continuous miner accident. Bronson further testified that he had no reason to believe that Smith would stand in the red zone while operating the machine. Tr. 101.

As noted, Respondent stipulated that it violated 30 C.F.R. section 75.220 (a)(1) by failing to ensure that Smith followed the approved Roof Control Plan by staying out of the red zone. Respondent argues that Leeco neither knew nor should have known of the violation and therefore there can be no finding of any negligence. R. Br. at 7.

III. Legal Analysis

When assessing penalties, section 110(i) of the Mine Act requires the Commission to consider, *inter alia*, whether the operator was negligent. 30 U.S.C. § 820(i). Each mandatory standard carries with it an accompanying duty of care to avoid violations of the standard. If a violation of the standard occurs, an operator's failure to meet the appropriate duty of care can lead to a finding of negligence. *A.H. Smith Stone Co.*, 5 FMSHRC 13 (1983).

For purposes of assessing a proposed penalty, the Secretary, by regulation, defines conduct that constitutes negligence under the Mine Act as follows:

> Negligence is 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. Under the Mine Act, an operator is held to a high standard of care. 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. The failure to exercise a high standard of care constitutes negligence. The negligence criterion

> assigns penalty points based on the degree to which the operator failed to exercise a high standard of care. When applying this criterion, 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. This criterion accounts for a maximum of 50 penalty points, based on conduct evaluated according to Table X.

30 C.F.R. § 100.3(d). High negligence occurs when "[t]he operator knew or should have known of the violative condition or practice, and there are no mitigating circumstances." *Id.* Moderate negligence occurs when "[t]he operator knew of should have known of the violative condition or practice, but there are mitigating circumstances." *Id.* Low negligence occurs when "[t]he operator knew or should have known of the violative condition or practice, but there are considerable mitigating circumstances." *Id.* No negligence occurs when "[t]he operator exercised diligence and could not have known of the violative condition or practice." *Id.*

In this case, the negligence of Smith, a rank-and-file miner, cannot be attributed to Respondent Leeco for civil penalty purposes. *See Fort Scott Fertilizer-Cullor, Inc.*, 17 FMSHRC 1112, 1116 (July 1995); *Western Fuels-Utah, Inc.*, 10 FMSHRC 256, 260-61 (Mar. 1988); *Southern Ohio Coal Co.*, 4 FMSHRC 1459, 1464 (Aug. 1982) (*SOCCO*)). The fact that a violation was committed by a rank-and-file miner, however, does not necessarily shield Respondent from being deemed negligent. Rather, the Commission must look to the operator's actual or constructive knowledge of the violative condition or practice and its supervision, training, and disciplining of its employees. Thus, "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*, 4 FMSHRC at 1464.

Just a couple of months prior to Smith's June 24, 2010 fatality, Respondent's superintendent Campbell observed Smith operating the continuous miner "in the outer area of the red zone," when he was tramming the miner from cut to cut and verbally admonished or counseled Smith about "what he did wrong" and told "him not to be in the red zone, how important it is not to be in the red zone . . . ." Tr. 79-82. Campbell informed Bronson to keep an eye out for Smith. Tr. 111. Given Campbell's instruction to Bronson to keep an eye out for Smith in or near the red zone, I find that Bronson should have known that Smith may visit the red zone area again. Accordingly, I discount Bronson's testimony that he had no reason to believe that Smith would stand in (or approach) the red zone while operating the machine. Rather, I find that it was reasonably foreseeable that Smith may do so again, and Respondent should have known about, and been on the lookout for, the violative conduct, which eventually killed Smith.

Some circumstances mitigate Respondent's negligence. Respondent trained production crew and management generally about staying out of the red zone and hung posters around the shop. Also it appears that Respondent reviewed, retrained and discussed, in general fashion,

avoiding red zone areas when operating or working near a remote-controlled continuous mining machine.

After Smith's "borderline" incident, however, Respondent did not meet the standard of care that a reasonably prudent operator, with knowledge of the goals of the Mine Act, would have undertaken in the same or similar circumstances to ensure against any recidivism by Smith. Respondent provided no evidence that it developed any specific or concrete programs, policies or procedures for starting and tramming remote-controlled continuous mining machines. Respondent failed to take specific or concrete steps to ensure that mining machine operators, including Smith, were outside the machine's turning radius before starting or moving the equipment, or to ensure that they were in a safe location while tramming the continuous miner from place to place, or repositioning the miner in the entry during cutting and loading. Although Campbell counseled Smith after the "borderline" incident about what he was doing wrong, and instructed foreman Bronson to keep an eye out for Smith, there is no evidence that Campbell followed up with Smith or Bronson about how Bronson was keeping an "eye out for it." Tr. 111. Further, although Bronson thereafter observed Smith operate the machine, he conceded that he did not observe Smith tramming the machine very often. Tr. 112. Nor did Campbell or any other member of management recall having any safety meeting about the serious incident and "how important it is not to be in the red zone, and how dangerous it would be." Tr. 81-82.

In short, Respondent failed to take sufficient steps to ensure that mining machine operators, including Smith, were outside the machine's turning radius before starting or moving the equipment, or to ensure that they were in a safe location while tramming the continuous miner from place to place, or repositioning the miner in the entry during cutting and loading. Although Respondent generally trained production crews and management to understand the hazards associated with avoiding red zones, there is no evidence that Respondent established any specific programs, policies, and procedures for avoiding red zone areas. There is also no evidence that Respondent routinely monitored work habits to ensure that operators were avoiding red zones. No engineering controls were in place to prevent this type of fatality. Nor did Respondent assign another miner or buddy to assist Smith or other continuous miner operators when the miner was being moved or repositioned. In these circumstances, Respondent failed to follow many of the best practices promulgated by MSHA. Accordingly, the citation was appropriately written with moderate negligence.

Guided by the regular assessment criteria set forth in § 100.3 and applying the penalty criteria set forth in section 110(i) to my findings above, I assess a penalty of $21,442.

IV. ORDER

It is ORDERED that Citation No. No. 8359591 is affirmed as written with moderate negligence. It is further ORDERED that Respondent pay penalty of $21,442 within thirty days of this Order.

Thomas P. McCarthy
Administrative Law Judge

Distribution:

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