FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

OFFICE OF ADMINISTRATIVE LAW JUDGES
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December 2, 2010

FREEDOM ENERGY, MINING CO.,	:	CONTEST PROCEEDING
Petitioner	:	
	:	Docket No. KENT 2007-433-R
v.	:	Order No. 6643527;07/31/2007
	:	
SECRETARY OF LABOR,	:	
MINE SAFETY AND HEALTH	:	#1 Mine
ADMINISTRATION, MSHA,	:	Mine ID 15-07082
Respondent	:	
	:	
SECRETARY OF LABOR,	:	CIVIL PENALTY PROCEEDING
MINE SAFETY AND HEALTH	:	
ADMINISTRATION, (MSHA),	:	Docket No. KENT 2008-776
Petitioner	:	A.C. No. 15-07082-142973 -01
v.	:	
	:	
FREEDOM ENERGY MINING CO.,	:	#1 Mine
Respondent	:	
SECRETARY OF LABOR,	:	CIVIL PENALTY PROCEEDING
MINE SAFETY AND HEALTH	:	
ADMINISTRATION, (MSHA),	:	Docket No. KENT 2008-1503
Petitioner	:	A.C. No. 15-07082-157603A (10633A)
v.	:	
	:	
MYRON DESKINS, employed by	:	
FREEDOM ENERGY MINING CO.,	:	#1 Mine
Respondent	:	
SECRETARY OF LABOR,	:	CIVIL PENALTY PROCEEDING
MINE SAFETY AND HEALTH	:	
ADMINISTRATION, (MSHA),	:	Docket No. KENT 2008-1506
Petitioner	:	A.C. No. 15-07082-157602A (10634A)
v.	:	
	:	
JERRY VARNEY, employed by	:	
FREEDOM ENERGY MINING CO.,	:	#1 Mine
Respondent	:	

DECISION

Appearances: Joseph B. Luckett, Esq., Office of the Solicitor, U.S. Department of Labor, Nashville, Tennessee, on behalf of the Secretary of Labor;
Carol Ann Marunich, Esq., Dinsmore & Shohl, LLP, Morgantown, West Virginia, for Respondents

Before: Judge Zielinski

These cases are before me on a Notice of Contest and Petitions for Assessment of Civil Penalties filed pursuant to sections 105 and 110 of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 815, 820. The petition in Docket No. KENT 2008-776 alleges that Freedom Energy Mining Company is liable for 20 violations of the Secretary's Mandatory Safety Standards for Underground Coal Mines[1] and proposes the imposition of civil penalties in the amount of $52,116.00. The Secretary also filed petitions, pursuant to section 110(c) of the Act, alleging that two employees of Freedom Energy are liable in their individual capacities for one violation, and seeks imposition of a civil penalty in the amount of $1,000.00 against each of the individual respondents. A motion seeking approval of partial settlement of 12 violations as to Freedom Energy was filed prior to the hearing. At the hearing, which was held in Pikeville, Kentucky, an oral motion was made seeking approval of settlement of an additional four violations. The proposed settlements will be approved. Remaining at issue as to Freedom Energy are four alleged violations, for which the Secretary has proposed civil penalties in the total amount of $29,809.00. The violations alleged as to the individual Respondents also remain at issue. The parties filed briefs following receipt of the hearing transcript.[2] For the reasons set forth below, I find that Freedom Energy committed three of the violations, and impose civil penalties in the amount of $3,850.00. I also find that the Secretary failed to prove the allegations against the individual Respondents, Deskins and Varney, by a preponderance of the evidence. That citation is vacated as to all parties and the petitions against the individual Respondents are dismissed.

Findings of Fact - Conclusions of Law

Freedom Energy operates the subject underground coal mine, the #1 Mine, located in Pike County, Kentucky. Inspectors from the Secretary's Mine Safety and Health Administration ("MSHA"), inspected the mine several times from July 2007 through January 2008. The citations and orders at issue in these cases were issued in the course of those inspections. Freedom Energy and the individual Respondents timely contested the alleged violations and assessed civil penalties.

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[1] 30 C.F.R. Part 75.

[2] The transcript of the first day of the hearing is referred to as "Tr." The transcript of the second day of the hearing is referred to as "TrII."

Citation No. 6643527

Citation No. 6643527 was issued by MSHA inspector Darrell Hurley on July 31, 2007, and alleges a violation of 30 C.F.R. § 75.202(b), which provides that "No person shall work or travel under unsupported roof . . . ." The violation was described in the "Condition and Practice" section of the Citation as follows:

> Observed the rail-mounted Fletcher Roof Bolter S/N 75170 being used to install primary support in a fall area. Six rows of four-foot resin rods had been installed and the Fletcher Roof Bolter was not equipped with an ATRS nor were any safety jacks being used or present at the work site. The distance the roof bolts had been installed measured 17'6". Two foremen were engaged in aggravated conduct constituting more than ordinary negligence because one was observed operating the roof bolter and one was standing beside the machine observing this action. A clean-up plan was posted at the three sides of the fall area and item 2 and item 10 directly stated that under no circumstances will any one be allowed to travel out past roof support and the bolter will be equipped with an ATRS or safety roof jacks. This violation is an unwarrantable failure to comply with a mandatory standard.

Ex. G-2.

Hurley determined that it was reasonably likely that the violation would result in a permanently disabling injury, that the violation was significant and substantial ("S&S"), that one person was affected, and that the operator's negligence was high. The citation was issued pursuant to section 104(d)(1) of the Act. A specially assessed civil penalty in the amount of $18,700.00 was proposed for this violation.

The Violation

Freedom was considering a change to its roof control plan in its No. 1 working section, and had requested that MSHA evaluate the proposal.[3] Hurley, an MSHA roof control specialist, traveled to the mine in response to Freedom's request. He was accompanied by Arnold Fletcher, an MSHA trainee. Worley Taylor, a roof control specialist for the Kentucky Office of Mine Safety and Licensing, was also present to evaluate the roof control plan proposal, and traveled with Hurley and Fletcher. On the previous day, July 30, there had been a small roof fall on the track entry. The fall resulted from a shift in rock strata that had sheered off roof bolts ranging from several inches to two or three feet above the mine roof. It was below the anchorage zone of

[3] Operators are required to develop and follow a roof control plan approved by the MSHA district manager. 30 C.F.R. § 75.220(a).

the six-foot-long roof bolts and was not required to be reported as an accident.[4]

The inspectors arrived at the mine and went to the office where they met with Eric Coleman, the mine superintendent at the time, who told them about the fall. They advised Coleman that they wanted to see the area of the fall, and Coleman replied that they would be traveling right by it because it was on the track entry that was the route to the section. Coleman called underground to Rodney Chapman, a mine foreman, and instructed him to bring a transport vehicle to the elevator. The inspection party, including Coleman, went underground about 9:00 a.m., and traveled to the working section on tracked vehicles. When they reached the area of the fall, they had to stop and proceed on foot. Escapeways and lifelines had been re-routed around the fall, the area had been dangered off, and copies of Freedom's clean-up plan had been posted at all approaches to the area. That plan specified that, when re-bolting a fall, a bolter with an ATRS be used, or that roof jacks be employed if the ATRS was not available or would not reach the roof.[5] Ex. G-3.

At the fall, the inspectors observed a track-mounted Fletcher roof bolter attached to a locomotive. The drill head was located at the end of a boom mounted on the inby end of the bolter. The controls were located on the right side of the boom, as viewed from the track-mounted base. There was a four-foot-square canopy above the controls, made of approximately one-half inch thick steel plate. As the inspectors walked forward, past the locomotive, they observed Myron Deskins, a mine foreman, at the bolter's controls in the process of installing a roof bolt. Jerry Varney, another foreman, was standing to the right of the bolter, observing Deskins. The bolter did not have an ATRS and there were no jacks in the area.

Deskins was approximately half-way through the process of installing the bolt. The inspection party watched him finish for about two minutes, by which time Hurley "figured out what was happening." Tr. 41. Six rows of bolts had been installed in the fall area, and about two more rows of bolts needed to be installed to support the roof up to the inby edge of the fall.[6] Hurley and the other inspectors believed that Deskins and Varney had installed all of the bolts in the fall area without using jacks. Tr. 51-54, 120-21; Ex. G-2, R-14, R-15. As Hurley explained, "if you see a guy bolting and you walk up and they've been there all morning, you just make that assumption." Tr. 51. They believed that Deskins was continuing to bolt in the fall and, as such,

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[4] An unplanned roof fall that is not "at or above the anchorage zone" is not an "accident" required to be reported under the Secretary's regulations. 30 C.F.R. §§ 50.2(h)(8), 50.10.

[5] An ATRS is an automated temporary roof support system, essentially, hydraulic jacks that apply pressure against the mine roof while bolts, permanent roof support, are being installed.

[6] There is conflicting evidence on the number of bolts that had been installed in the fall. Hurley testified that it was 27-29, and his notes reflect that it was 27. Tr. 32; Ex R-14. Fletcher testified that it was 20-24, and his notes reflect 24. Tr. 112; Ex. R-15. Taylor testified that it was 23. Tr. 85.

that he was under unsupported roof.[7] Tr. 24, 88. When Deskins was finished with the bolt, Hurley called Deskins and Varney over and asked where the jacks were. No one responded, except Varney, who said he did not believe that jacks were needed. Hurley stated that Deskins and Varney should "know better" than to do what they were doing. Tr. 263. Coleman told the men to stay quiet until he could figure out what was going on. Tr. 56, 167. He believed that Hurley was accusing them of bolting the fall without jacks, and was concerned, based upon prior experience, that any statements made might be taken out of context and used against the company. Tr. 167-69. Varney and Deskins followed Coleman's lead, and did not discuss the situation with the inspectors. Tr. 55, 115. Deskins explained that he was "bombarded" with accusatory questions, didn't see that he had done anything wrong, and felt that the situation "already went sour in my eyes." Tr. 263. He did not speak, in part, because he was upset with the whole situation." Tr. 264.

Once outside Coleman was informed that a citation was being issued pursuant to section 104(d)(1) of the Act for bolting the fall without jacks, which would have been a violation of Freedom's roof control plan. Tr. 170. The citation, as issued, specified a violation of a different standard, traveling under unsupported roof. Fletcher's notes indicate that Freedom was informed that a section 104(d)(1) citation would be issued for not following the roof control plan and allowing miners to work under unsupported roof. Ex. R-15.

The parties' respective versions of the facts are in irreconcilable conflict. Respondents contend that Varney and Deskins had not installed any of the bolts in the fall, that Deskins was not bolting in the fall when the inspectors arrived, and that he was not under unsupported roof. Deskins noticed a small area where material had separated from the plate on a bolt near the right rib that was adjacent to, but not in, the fall. He decided to spot a bolt in it while he and Varney waited for the inspectors, and was in the process of installing that bolt when the inspectors arrived on the scene.

Coleman testified that, on July 30, the day of the fall, he secured jacks and the Fletcher roof bolter from another facility, and assigned John Ball, a second shift foreman, to begin the process of cleaning up and securing the roof in the area. Tr. 158-59. Ball testified that he and another miner installed cable bolts in the track entry leading up to the fall, and installed resin-grouted roof bolts in the area of the fall. Tr. 135-36. When working under the now-unsupported roof, they set jacks to provide temporary roof support, and used the track-mounted roof bolter to install a row of bolts. Tr. 136. They backed the locomotive and bolter out of the area to a spur off the main track, brought in a scoop to clean the newly re-bolted area, brought the bolter back in, re-set the jacks, and repeated the process. Tr. 135-36. They worked 16 hours and installed about 27 bolts in the fall area, over the next two shifts. A small area on the left inby corner of the fall remained to be bolted. Tr. 137-38. That area of the track entry was very confined and was crowded with water lines. In order to facilitate cleaning, they removed everything they didn't

[7] Taylor's testimony was couched in terms of his assumption that the foremen had installed the other bolts and, because Deskins was bolting in the fall, "he would have to be inby the last row of permanent roof support." Tr. 92.

need from the area, including the jacks. Tr. 139-40. The jacks were placed on a mantrip, which was backed out to allow the locomotive and bolter to be removed. Coleman thought that the third shift miners took the mantrip, with the jacks on it, to the elevator on their way out of the mine, because the jacks were found near the elevator. Tr. 182.

When Varney reported for work on the morning of July 31, Coleman told him of the fall, that Ball was working on it, and asked him to see if anything needed to be done. Tr. 199. Varney and Chapman went underground about 7:00 a.m., and proceeded to the area of the fall. Ball was preparing to clean a newly bolted area so that the remainder of the fall could be bolted. Tr. 109. Varney brought the scoop in, cleaned the area, which took about an hour, and then backed the scoop out and brought the locomotive and roof bolter forward. Tr. 199, 208-10. Deskins knew of the fall and went to the area to see if Varney needed any help. Tr. 249. He arrived about the same time that Coleman called Chapman to get a ride for the inspection party. Tr. 210.

Deskins testified that he noticed a small defect next to an existing bolt near the right rib that was not in the area that fell. He decided to put a bolt in it to make it safer while he and Varney waited for the inspectors. Tr. 211, 255-56. Varney did not object. Deskins went to the controls under the canopy on the right side of the roof bolter's boom and began to install the bolt. There was permanently supported roof to his rear, on both sides and in front of him. Tr. 211-13, 258. He drilled the hole, but had trouble getting the drill steels out. Tr. 258. About that time the inspectors arrived. Tr. 258. Deskins put the resin grout into the hole, and installed the bolt. Tr. 259. Hurley called Deskins and Varney over after Deskins finished, and the other previously-described events occurred.

It is unfortunate, although perhaps understandable, that Coleman instructed Varney and Deskins to keep quiet when Hurley began to question them. Had there been an open discussion at that point, major conflicts in the evidence might have been eliminated. The precise location of the bolt that Deskins installed could have been fixed and the exact boundaries of the fall could have been diagramed. If there was disagreement, more probative evidence, e.g., pictures and drawings, could have been developed on those critical issues.[8] As it is, when Hurley made a sketch of the area, he approximated the area of the fall, and he made no attempt to indicate the locations of the bolts that had been installed in the fall or the bolt that Deskins installed. Tr. 60; Ex. G-4, R-14.[9] His later-prepared diagram shows Deskins, who was at the controls of the bolter,

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[8] Freedom apparently conducted some sort of investigation after the citation was issued. Tr. 187-89. However, no pictures diagrams or other materials were presented at the hearing. Varney testified that, in 2007, he didn't think they would need much evidence to refute the violation, and that if it happened today, he would gather information to support a defense. Tr. 243-44. He also stated that if he had to do it over again he would have explained what had happened to the inspectors - but that "hindsight was 20/20." Tr. 228.

[9] It appears that Hurley initially made a rough sketch of the scene in his notes. Ex. R-14. Later that day, he prepared a more detailed diagram. Tr. 30; Ex. G-4.

on the wrong (left) side of the boom, which would have placed him closer to the unsupported inby area of the fall.[10] Ex. G-4.

It is understandable that Hurley was not particularly concerned about the location of the bolt that Deskins installed. He, and the other inspectors, thought that Varney and Deskins had installed all of the bolts that had thus far been installed in the fall, and were simply installing one more. Since they were "obviously" bolting the fall without an ATRS or jacks, they were in clear violation of Freedom's roof control plan, and Deskins would have had to have been under unsupported roof to install the next row of bolts, both to get to and while under the canopy. Tr. 70. The assumption that Varney and Deskins were in the process of bolting the fall, undoubtedly resulted in a lack of focus on the location of the bolt, and the possibility that it was adjacent to, not in, the fall.

Despite the conflicts noted above, there are a few issues upon which the parties' evidence is not diametrically opposed. The diagram made by Hurley and the drawing submitted by Respondents show the bolter in virtually the same position in the entry, with the boom extended toward the right rib. Ex. G-4, R-16. Respondents' exhibit also depicts the location of the bolt that Deskins was installing when the inspectors arrived. It is consistent with the location and orientation of the bolter, as shown in both depictions, and I find that it accurately shows the location of the bolt along the right rib of the entry.

Witnesses agreed that a substantial portion of the fall had been bolted, and that only a small area on the inby end remained to be supported.[11] There is also general agreement that the fall was somewhat irregularly shaped, and the area remaining to be bolted extended further inby on the left side of the entry than on the right.[12] Again, there are similarities in Hurley's sketch

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[10] Hurley's diagram shows Deskins on the left side of the boom. Ex. G-4. Witnesses established that the controls are on the right. Tr. 91, 122, 163, 214-15, 254.

[11] Approximately 11 feet of the 30-foot fall remained to be bolted. (Hurley) Tr. 32, 38. Seven to 11 feet of fall was unbolted. (Fletcher) Tr. 113. Unbolted area was 11 feet on left side, 6-7 feet on right. (Taylor) Tr. 85, 101-04. Unbolted area was 6-8 feet, and two rows of bolts were needed. (Coleman) Tr. 179. Small portion on left needed to be bolted, three to four bolts. (Varney) Tr. 179, 201-04, 230-32; Ex. R-16. Fall was 98% bolted. (Deskins) Tr. 253. Inby corner on the left side of the entry was the only thing left to bolt, three to four bolts to finish. (Ball) Tr. 137-38, 142-43.

[12] Fall was oblong, like a football, and the area remaining to be bolted was about 11 feet on the left and 6-7 feet on the right. (Taylor) Tr. 101-04. Fall was shaped like a "u" from the left side, area to be bolted was on left side of the bolter. (Coleman) Tr. 155, 163. Area to be supported was small and pie-shaped, fall was wider outby and tapered in inby. (Varney) Tr. 230-32. Fall remaining to be bolted was to the left of the bolter. (Deskins) Tr. 261.

and Respondents' depiction of the area on those issues.[13] On Respondents' drawing, the area of the fall was outlined in blue pen by Varney. Tr. 200-04; Ex. R-16. It generally corresponds with the shape of the fall described in the testimony. The area that had been bolted, highlighted in pink, also generally corresponds with the testimony, and shows a small, unbolted area on the left inby portion of the fall. Neither Hurley's original sketch, nor his diagram, purport to show the bolted and unbolted areas of the fall. However, at the hearing he drew a line on his diagram to indicate the area of unsupported roof inby, and marked "x"s and dots to indicate where bolts had been installed.[14] Tr. 66-68; Ex. G-4. The line that he drew to identify the unsupported area in the entry shows the supported area extending inby past the depicted location of the bolter drill head. He later testified that the line should have been further outby closer to the bolter, where he depicted the bolts. Tr. 72-73. However, the line, as drawn, corresponds with the testimony that the fall had largely been bolted. If it were moved back outby to where he depicted the bolts, there would have been substantially more of the fall, at least half, that had yet to be bolted.

I find that the roof in the entry had been supported to a point inby where the bolter drill head was located, and that there was supported roof inby and outby where Deskins was located on the right side of the bolter's boom, as Deskins and Varney testified.[15] The irregular shape of the fall, and the fact that it extended further on the left side of the entry than the right, also supports Respondents' contention that the right rib, where Deskins installed the bolt, was not in the area of the fall. Ex. R-16. I so find.

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[13] Hurley's original sketch, reflected in his notes, shows the fall as angled from right to left and extending further inby on the left side. Ex. R-14. His diagram shows the fall essentially across the width of the entry on the inby side. Ex. G-4. This relatively small inconsistency is quite significant, since Respondents claim that the area on the right rib toward the inby area of the fall, where Deskins installed the bolt, was not in the fall and was supported roof.

[14] The events in question occurred some three years prior to the hearing and recollections of events were not fresh in witnesses minds. When Hurley drew the line of unsupported roof on the exhibit, it is highly unlikely that he was doing so from recollection. Rather, he was most likely indicating an area consistent with his testimony that all but about 11 feet of the fall had been bolted. Likewise, when he placed "x"s and dots indicating the bolts, he was most likely showing where bolts would have been if Deskins was in the process of continuing to install another row of bolts in the fall area, which is what he assumed to be the case. But the last row of bolts in the fall could not have been that far outby, and been consistent with the testimony on the amount of the fall remaining to be bolted.

[15] Hurley also believed that there was unsupported roof behind Deskins, possibly in the crosscut intersecting the track entry on the right. There was considerable dispute about whether the fall extended into the crosscut, and whether the roof in the crosscut was permanently supported. I see no need to resolve those conflicts, because, even if there was some unsupported roof in the crosscut, neither Deskins nor Varney would have been under it. They were in much the same relative position with respect to the crosscut, and there is no contention that Varney was under unsupported roof. Tr. 69.

Respondents also argue that they would not have committed an overt violation, or exposed Deskins to a hazardous condition, in the presence of federal and State mine inspectors.[16] Varney and Deskins were very experienced foreman at Freedom, had cleaned up previous falls, and were well aware of the requirements of the clean-up plan. Tr. 198, 248. They knew that Freedom had requested an evaluation of proposed changes to the roof control plan for the No. 1 section, and expected that inspectors would be coming into the mine that day. Tr. 207, 251, 257. More significantly, Chapman was with them when Coleman summoned him to bring a transport for the inspectors. Tr. 210. Consequently, they knew that inspectors were actually in the mine and would soon be coming up the track entry to the area of the fall, where they would have to disembark from the transport vehicle and proceed on foot. Tr. 211, 245, 257. Varney testified that he could hear the approach of the diesel-powered mantrip that the inspectors were on, and could see them walking up to the bolter. Tr. 245. Taylor was confident that Varney and Deskins knew he was in the mine. Tr. 96-97.

Resolving the parties' competing versions of the facts has been difficult. The inspectors all had considerable mining experience, and were not likely to mistakenly conclude that Deskins was bolting in the fall. However, the similarities in the parties' evidence regarding the location of the bolter and the bolt, the shape of the fall and area of unsupported roof, are more consistent with Respondents' contentions, and lead me to conclude that it is more likely that Deskins was under supported roof. I am also persuaded that Deskins and Varney would not have committed an obvious serious violation knowing they were in, or would soon be in, the presence of mine inspectors.

Considering all of the above, I find that the Secretary has failed to carry her burden of proof that the violation was committed, as alleged. Accordingly, the citation will be vacated.

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[16] Deskins testified that he knew the inspectors were on the way because Chapman had gone to get them. He had no reason to hurry, because he didn't feel he was doing anything wrong. Tr. 257-58. Coleman testified that Varney and Deskins had 40 years of experience between them and deal with inspectors every day. They knew he was bringing two roof control inspectors to the section and would have to drive straight to them. If they would do something like they were accused of, they would have been fired years ago. Tr. 171-72. As previously noted, Varney testified that he heard and saw the inspectors approach and they were "absolutely not" putting a bolt in the fall. He would not have participated in an open violation of the roof control plan and would not have let his friend and co-worker engage in hazardous conduct. Tr. 224.

Individual Liability

The Act provides that a director, officer, or agent of a corporate operator may be subject to civil penalties in his individual capacity for knowingly authorizing, ordering or carrying out a violation of the Act. 30 U.S.C. § 820(c). The legal standards governing individual liability have often been stated by the Commission. *See, e.g., Maple Creek Mining, Inc.* 27 FMSHRC 555, 566-67(Aug. 2005). Having found that the Secretary failed to carry her burden of proof of establishing the violation of the cited provision, the cases against Varney and Deskins must also fail.

Order No. 6645336

Order No. 6645336 was issued by MSHA inspector Roger Workman on October 11, 2007, and alleges a violation of 30 C.F.R. § 75.360(b), which requires that certified persons conduct preshift examinations of various areas, including working sections, and specifies that "the examination shall include tests of the roof, face and rib conditions on these sections and in these areas." The violation was described in the "Condition and Practice" section of the Order as follows:

> An adequate preshift was not conducted for the 001-0 MMU section, dated 10-11-07, from 5:35 a.m. to 6:20 a.m. The preshift examiner failed to recognize the #4 right crosscut was not permanently supported and no warning devices were in place to warn miners of the unsupported mine roof. There was a line curtain hung on the last row of permanent supports going by the unsupported crosscut. The operator is required to have a safety talk with foremen before this order is terminated. Two other violations were issued in conjunction with this order. Citation # 6645334. Citation 6645335.

Ex. G-6.

Workman determined that it was reasonably likely that the violation would result in an injury requiring lost work days or restricted duty, that the violation was S&S, that one person was affected, and that the operator's negligence was high. The order was issued pursuant to section 104(d)(1) of the Act, and alleged that the violation was the result of the operator's unwarrantable failure to comply with the mandatory standard. A specially assessed civil penalty in the amount of $9,800.00 was proposed for this violation.

The Violation

Workman was at the mine to conduct a regular quarterly inspection.[17] He was accompanied by Lester Preece, an inspector trainee, and Varney, who represented Freedom. They traveled the No. 4 entry of the 001 MMU, and observed notations made by Jonathan Hunt, the foreman on the midnight shift, who had conducted the preshift examination for the oncoming day shift between 5:30 a.m. and 6:28 a.m. that morning. Preshift examiners mark the date and time of their examination and initial the entries at various locations during their examinations, including on the roof and ribs, and at the faces. The entry was clean, had been rock dusted, and a line curtain had been hung on the last row of roof bolts on the right side of the entry to within eight feet of the face. From all appearances, there were no hazards in the area, and none had been reported by Hunt in the preshift record book. Tr. 293.

Workman lifted the curtain to check the condition of the right rib and found the #4 right crosscut had been cut to a depth of about 20 feet, but had been left unbolted. There were no warning devices alerting persons to the condition, which posed a serious hazard. The opening of the crosscut began about 16 feet from the face, eight feet from the end of the curtain, and extended outby for approximately 20 feet. The condition is depicted in a diagram prepared by Preece. Tr. 329; Ex. G-7. Under Freedom's roof control plan, no one is permitted to proceed inby a newly mined crosscut until at least three rows of roof bolts have been installed. Unsupported mine roof may fall, and if it falls, it would typically take out the first row of bolts it encounters. Tr. 297, 332. Consequently a fall of the roof in the crosscut would most likely have extended out into the entry, a few feet past the row of bolts that the line curtain had been hung on. Clearly, this posed a threat of serious injury to any person working or traveling in that part of the entry. And just as clearly, Hunt had failed to sufficiently examine the right rib of the entry, as required by the standard.

Respondent concedes that it was improper to hang the curtain without first having bolted the crosscut, but contends that improperly hanging the line curtain does not definitively establish a violation of section 75.360(b). Respondent argues that the preshift examiner "could have been following MSHA's regulations and conducting a thorough preshift examination and still have missed this condition." Resp. Br. at 17. Respondent's argument is based, in part, on a consideration that has nothing to do with the violation. It points to the fact that an examiner should not stand behind the line curtain to measure the volume of air flow, because his body would interfere with the flow. Tr. 345. However, a proper examination of the rib would have been entirely independent of an air flow measurement. Freedom also argues, relying on Varney's testimony, that an examiner could have examined the rib by looking behind the end of the curtain, and failed to see the crosscut. Tr. 347. However, since Varney never looked behind the curtain, the accuracy of that statement is highly questionable. Tr. 358-59. Varney also conceded that a preshift examiner should check behind the curtain for hazards, and would have to look behind the curtain to check for loose ribs. Tr. 346, 357. Any examination of the right rib

[17] The Act requires that underground coal mines be inspected four times annually. 30 U.S.C. § 813(a).

that failed to disclose the presence of the crosscut would have been *per se* inadequate. I find that Freedom violated the standard by failing to conduct a proper preshift examination.

Significant and Substantial

An S&S violation is described in section 104(d)(1) of the 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." 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:

> 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.

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 Power, Inc. v. Secretary of Labor*, 861 F.2d 99, 103-04 (5th Cir. 1988), *aff'g Austin Power, Inc.*, 9 FMSHRC 2015, 2021 (Dec. 1987) (approving *Mathies* criteria).

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).

This evaluation is made in terms of "continued normal mining operations." *U.S. Steel*, 6 FMSHRC at 1574. The question of whether a particular violation is significant and substantial 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 fact of the violation has been established. A measure of danger to safety was

contributed to by the failure to conduct an adequate preshift examination, a hazardous condition was not discovered and corrected or dangered off. There is little question that any injury resulting from a roof fall would have been reasonably serious and could easily have been fatal. As is often the case, the primary issue in the S&S analysis is whether the violation was reasonably likely to result in an injury causing event.

The injury causing event in this instance would be a roof fall in the unbolted crosscut that would extend past the first row of bolts and strike a person in the entry. That would require a confluence of two events, a roof fall in the crosscut and a person being present in the area of the entry affected by the fall. The roof in the mine was composed of sandstone and shale, which tends to separate at the seams of the layers, creating loose draw rock. Tr. 296. Workman explained that one cannot tell if a roof is about to fall by looking at it. Tr. 311. Draw rock was not uncommon on the section, but the roof in and around the crosscut appeared to be in good condition, and there was no apparent draw rock. Tr. 296, 311, 334. Judging from the appearance of the roof, a fall was not imminent.

While the entry was not a main travelway, persons had been in the entry, and were expected to be in the entry prior to the abatement of the hazardous condition. The hazardous condition most likely was created during the evening shift the day before. While it had existed for some 10 hours, it had existed only for about four hours after the preshift examination at issue, and may have existed for the rest of the shift. Tr. 299. The entry had been cleaned and dusted, and the line curtain had been hung. Tr. 307. Hunt had conducted the preshift examination, and a miner operator may have traveled to the face to conduct safety checks. However, the cleaning and dusting, as well as the hanging of the curtain, would have occurred prior to the conduct of the preshift examination. Consequently, any exposure to those persons should not be considered in evaluating the likelihood of an injury occurring because of the inadequate preshift examination. Travel in the entry after the inadequate preshift examination would have been very limited. A miner operator conducting safety checks was the only possibility noted, except for the unlikely prospect of a person simply deciding to walk up the entry. A day shift foreman may also have conducted an on-shift examination, but would likely have discovered the condition and avoided it.

A roof fall in the crosscut could extend to the second row of bolts, about eight feet into the entry, and four feet past the line curtain. Tr. 297. It was generally recognized that miners would most likely travel near the center of the entry, i.e., approximately 10 feet from either rib. Tr. 337, 342. To be struck by a fall in the crosscut, a person would have had to be within four feet of the line curtain, i.e., on the extreme right side of the 16 foot-wide opening between the left rib and the curtain.

While I agree with Workman, that people that make a habit of traveling under unsupported roof will eventually suffer a fatal injury, I am not convinced that the violation, an inadequate preshift examination, was reasonably likely to result in an injury causing event. Tr. 306. The presence of persons in the entry was and would have been quite limited, and it is likely that any persons who did travel the entry would have remained far enough away from the right rib and line curtain, such that they would not have been injured even in the unlikely event

that they happened to be adjacent to the crosscut when its roof fell.

Given all of these factors, I find that, while it is possible that a serious injury could have occurred as a result of the violation, the Secretary failed to carry her burden of establishing that it was reasonably likely that a serious injury would occur in the normal course of continued normal mining operations. I find that the violation was unlikely to result in a permanently disabling injury and that it was not S&S.

Unwarrantable Failure - Negligence

In *Lopke Quarries, Inc.,* 23 FMSHRC 705, 711 (July 2001), the Commission reiterated the law applicable to determining whether a violation is the result of an unwarrantable failure:

> 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. v. FMSHRC*, 52 F.3d 133, 136 (7th Cir. 1995)] (approving Commission's unwarrantable failure test).
>
> Whether conduct is "aggravated" in the context of an unwarrantable failure analysis is determined by looking at all the facts and circumstances of each case to see if any aggravating factors exist, such as the length of time that the violation has existed, the extent of the violative condition, whether the operator has been placed on notice that greater efforts are necessary for compliance, the operator's efforts in abating the violative condition, whether the violation is obvious or poses a high degree of danger, and the operator's knowledge of the existence of the violation. *See Consolidation Coal Co.*, 22 FMSHRC 340, 353 (Mar. 2000) . . . ; *Cyprus Emerald Res. Corp.*, 20 FMSHRC 790, 813 (Aug. 1998), *rev'd on other grounds*, 195 F.3d 42 (D.C. Cir. 1999); *Midwest Material Co.*, 19 FMSHRC 30, 34 (Jan. 1997); *Mullins & Sons Coal Co.*, 16 FMSHRC 192, 195 (Feb. 1994); *Peabody Coal Co.*, 14 FMSHRC 1258, 1261 (Aug. 1992); *BethEnergy Mines, Inc*., 14 FMSHRC 1232, 1243-44 (Aug. 1992); *Quinland Coals, Inc.*, 10 FMSHRC 705, 709 (June 1988). 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).

The Order was issued pursuant to section 104(d)(1) of the Act.[18] The predicate section 104(d)(1) citation was Citation No. 6633527. That citation was invalidated above, which dictates that, in order to be properly issued pursuant to section 104(d), the Order would have to be considered a citation, and the violation would have to be both S&S and the result of an unwarrantable failure. 30 U.S.C. § 814(d)(1). Having found that the violation was not S&S, it is technically unnecessary to decide whether it resulted from an unwarrantable failure. However, it is necessary to address the issue of negligence, which is alleged to have been high. Because the S&S findings herein may, or may not, become final, the issue of unwarrantable failure will be addressed for the sake of judicial economy.

The Secretary contends that the violation was an unwarrantable failure because the preshift examiner, an agent of the operator, failed to examine the right rib of the entry, a clear violation of the standard. She notes that the condition was extremely dangerous, and that the unbolted crosscut would have been an obvious hazard to anyone who looked at it.

The unbolted crosscut presented the potential for a roof fall that would extend into the entry, possibly four feet past the line curtain. The hazardous nature of that condition was exacerbated by the hanging of line curtain that hid the condition, so that persons traveling in the entry could not see it. The hanging of the line curtain and the failure to danger off the area were egregious actions, and Workman issued two S&S citations related to the creation of the hazard. Ex. G-8, G-9. Those citations were issued pursuant to section 104(a) of the Act, because Workman had no evidence linking the obviously high negligence of the responsible hourly employees to mine management. Tr. 323.

The instant violation stands on a slightly different footing. The violation at issue did not involve the creation of the hazard, but, rather the failure to discover it, about eight hours after it had been created. Workman noted that the condition had existed for at least 10 hours when he issued the order. However, the violation at issue had occurred approximately four hours earlier.

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[18] Section 104(b) of the Act provides:

> If, upon any follow-up inspection of a coal or other mine, an authorized representative of the Secretary finds (1) that a violation described in a citation issued pursuant to subsection (a) has not been totally abated within the period of time as originally fixed therein or as subsequently extended, and (2) that the period of time for the abatement should not be further extended, he shall determine the extent of the area affected by the violation and shall promptly issue an order requiring the operator of such mine or his agent to immediately cause all persons, except those persons referred to in subsection (c), to be withdrawn from, and to be prohibited from entering, such area until an authorized representative of the Secretary determines that such violation has been abated.

30 U.S.C. § 814(b).

The condition could not be observed by anyone in the entry, but it would have been obvious to anyone who looked behind the line curtain in the area of the crosscut. Was the violation, the inadequate preshift examination, obvious or extensive? These concepts are not easily applied to this "failure to look" violation.

Freedom contends that there are several mitigating factors that preclude a finding of high negligence or reckless disregard. The curtain had been hung to the face, giving every appearance that the crosscut had not been cut. There is no dispute that this was a highly unusual situation that had not been encountered at the mine. Workman agreed that the preshift examiner was "put in a bad position" by those who created the hazard. Tr. 315-16. Varney postulated that, under the circumstances, with the entry cleaned and dusted and the roof and left rib appearing in good condition, that he might not have looked behind the curtain to check the right rib, because it too would be fine "90% of the time." Tr. 359-60, 362.

Whether Hunt's actions rose to the level of unwarrantable failure is a close question. On the one hand, he was an agent of the operator, and he clearly did not effectively examine the right rib of the entry, as required by the standard. As a result, a condition hazardous to persons traveling in the entry was not discovered and would have continued to exist for approximately one more shift. On the other hand, the hazard affected a relatively small area of the entry. Very few miners would have had reason to travel in the entry, and probably would not have traveled in the affected area. He apparently assumed, given that the roof and left rib were in good condition, that the right rib also posed no hazard.

As the Secretary points out in her brief, the Act's preshift examination requirements are "of fundamental importance in assuring a safe working environment underground." *Buck Creek Coal Co.*, 17 FMSHRC 8, 15 (Jan. 1995). An effective examination by a certified person provides assurance that no hazardous conditions will be encountered by miners assigned to work or travel in the area. Freedom's agent's failure to effectively examine the right rib was clearly a violation of the standard that allowed a hazardous condition that could have resulted in a fatal accident to continue. I find that the violation was the result of Freedom's high negligence, and its unwarrantable failure to comply with the standard.

<u>Citation No. 6655438</u>

Citation No. 6655438 was issued by MSHA inspector Craig Plumley on January 7, 2008, and alleges a violation of 30 C.F.R. § 75.512, which requires that "electric equipment shall be . . . properly maintained by a qualified person to assure safe operating conditions." The violation was described in the "Condition and Practice" section of the Citation as follows:

> In the underground shop area at the bottom of the elevator shaft, the operator has failed to maintain electrical equipment in safe operating condition. Two electrical heating elements were operating and were red-hot with no protective guarding to prevent persons from being exposed and coming into contact with this open heat source. The two heating elements are located 24 inches above the ground, 12 inches from a 2-man bench seat, 24 inches from personnel lockers and within 48 inches of the walkway where personnel enter and exit the mantrip. Persons coming into contact with this exposed heat source would receive severe burn injuries.

Ex. G-12.

Plumley determined that it was reasonably likely that the violation would result in a permanently disabling injury, that the violation was S&S, that one person was affected, and that the operator's negligence was moderate. A civil penalty in the amount of $1,304.00 was proposed for this violation.

The Violation

Plumley was a ventilation specialist who had returned to the mine to terminate a citation that had been issued related to seals. He was accompanied by Keith Preece, who was in training to become a certified MSHA inspector. As they entered the shop area where the mine elevator terminated, Plumley noticed a "burning" smell and traced it to two electrical heating elements that were located behind a small bench. The heating elements were inside stainless steel cylinders that were 10 inches in diameter and 12 inches tall. They were about 12 inches apart, and had several electrical heating elements, similar to burners on an electric stove top, arranged two to three inches below each other starting about three inches from the tops of the open cylinders. The cylinders had been used to clean filters of diesel locomotives, but were no longer used for that purpose because the engines of the locomotives had been changed, and the filters were no longer required. The heating elements were controlled by timers, which cycled on and off over a period of about 45 minutes. They were energized during cold periods to provide heat for persons in that part of the shop area.

There are no significant factual disputes as to the cited condition. The heating elements were extremely hot, and the steel cylinders were also very hot. There was no guard or other barrier to prevent access to the heating elements, or the cylinders themselves, which were located in an area traveled by miners entering and exiting the mine. The violation was abated by the installation of expanded metal guards preventing contact with the cylinders.

Respondent argues that the devices were not defective and that they presented no hazard because in order to suffer a burn injury a person would have to intentionally stick his hand down through the curing filter to the heating element. The arguments are unavailing. The key consideration in the standard is that electric equipment be maintained in a safe condition. The fact that the cylinders were not defective, in an operational sense, does not alter the fact that they

were extremely hot when in operation, and could cause injury to anyone coming into contact with them. It would not have been necessary to contact the heating elements to suffer a burn injury. The hot steel cylinders themselves could also have caused an injury. There is some suggestion that the devices were still in use to clean filters at the time of the alleged violation. I find that they were no longer used for that purpose. In any event, it is clear that they were not being used to clean filters at the time of the violation. Smith explained that the filters were also 10 inches in diameter and fit on top of the cylinders. There clearly were no filters on the devices at the time. They were being used to provide heat in the shop area, not to clean filters. With no filter on top, the heating elements were readily accessible to inadvertent contact.

I find that the cylinders and heating elements presented a hazard. Persons coming into contact with either object could suffer burns. Because the electrical equipment was not maintained in safe operating condition, the standard was violated.

S&S

Plumley believed that the hazard was reasonably likely to result in a permanent injury, either from personal contact with the hot surfaces, or a fire resulting from clothing or objects coming into contact with the heating elements. Crews worked on two sections in the mine, three shifts per day, six days per week. Consequently, two groups of 18-20 men, one exiting and one entering the mine, traveled through the shop area three times per day. If a mantrip was not immediately available, the group entering might spend 5 to 10 minutes in the area. In cold weather, men waiting in the area would gather near the cylinders for warmth. The area was clean, generally dry, and there were no slipping or tripping hazards noted. Plumley thought that there were personnel lockers in the area, but, they were actually metal tool boxes that resembled lockers and were not routinely accessed by the miners in transit. TrII. 14, 45.

Respondent counters that miners also have access to mantrips through an adjacent entry, and do not necessarily travel through the shop area when entering and exiting the mine. There are also numerous fire extinguishers in the shop area. The cylinders have been in operation for many years and have caused no injuries. Miners and other personnel, including mine inspectors, have warmed themselves by the heaters, which have never been cited as being in violation of a standard. Respondent also argues that the chance of inadvertent contact was minimized by the presence of the timing devices on a shelf located above the devices. TrII. 112.

Considering the number and frequency of miners that came into relatively close proximity to the unprotected cylinders, I find that it was reasonably likely that a miner would have suffered a burn injury as a result of the violation. However, I find it unlikely that any such injury would have been reasonably serious. Rather, a miner, typically wearing protective clothing, would suffer no more than a minor burn injury, resulting in no lost work days.[19] Consequently, the

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[19] Plumley also determined that injuries might result from a fire originating from the heating elements contacting clothing or personal items worn by miners sitting on the bench, or by

violation was not S&S. I agree with Plumley's assessment of the degree of operator negligence as moderate, for the reasons stated in his testimony. TrII. at 16-17.

Citation No. 6656994

Citation No. 6656994 was issued by MSHA inspector Kip Bell, on January 10, 2008, and alleges a violation of 30 C.F.R. § 75.202(a), which requires that the "roof, face and ribs of areas where persons work or travel shall be supported or otherwise controlled to protect persons from hazards related to falls of the roof, face or ribs and coal or rock bursts." The violation was described in the "Condition and Practice" section of the Citation as follows:

> The roof where persons work or travel, is not being supported to prevent falls of the mine roof, located at the elevator bottom at the man trip storage area (track spur). There are two cribs on the left rib that have not been constructed firmly against the mine roof. The area between the top of the cribs and the mine roof measures approximately 1 inch to 10 inches. Loose and broken draw rock is present in the affected area.

Ex. G-16.

Bell determined that it was reasonably likely that the violation would result in a permanently disabling injury, that the violation was S&S, that one person was affected, and that the operator's negligence was moderate. A civil penalty in the amount of $1,304.00 was proposed for this violation.

The Violation

Bell was conducting a regular quarterly inspection of the Freedom mine. He was accompanied by Phillip Carter, an MSHA inspector in training. The area in question was located at the bottom of the mine elevator, where crews entering the mine boarded man trips to travel to the working sections, and crews exiting the mine exited man trips to get on the elevator. Man trips, used to transport miners to and from the working sections, traveled on tracks that ran in an entry adjacent to the elevator access. Another entry intersected the main track entry in the area of the elevator. A short section of track, or spur, ran up that entry and was used to store man trips that were inactive or in need of repair. TrII. 73, 78. A switch controlled tracked vehicles' access to the spur. Generally, entering miners boarded the vehicles parked on the main track that had been used by the exiting miners to travel to the elevator. TrII. 78, 84. Occasionally, a man trip was not immediately available on the main track, and one that was stored on the spur was used.

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items being tossed into the cylinders on the mistaken belief that they were trash cans. His description of how such a fire might result in an injury was vague. He opined only that smoke could be generated and that there was flammable material used in the shop. TrII. at 30. I find it highly unlikely that the violation would have resulted in a fire-caused injury.

There had been a rib roll on the left side of the entry in which the spur was located, and 12 sets of cribs had been erected along the rib to provide roof support and protection from rib rolls.[20] Nine jacks had also been installed on the right side of the entry, to provide supplemental roof support. The spur entry was approximately 20 feet wide, rib-to-rib. The cribs and jacks effectively shortened the width to 15-16 feet. TrII. 73. The mine roof in the area of the cribs was broken, and loose draw rock was present. TrII. 56, 79. The two cribs that were nearest to the main track had been dislodged, possibly by a piece of mobile equipment, such that they were no longer in contact with the mine roof. Varney traveled with Bell and confirmed the conditions observed by Bell and Carter. TrII. 75, 79. When the inspection party traveled to the working sections, the shop personnel "tightened up" the cribs, and the citation was terminated by Bell when he returned to exit the mine.

Rib rolls change the location of the rib/roof intersection, lengthening the distance from existing roof bolts to the rib, and necessitating the installation of supplemental roof support. TrII. 83. Properly installed cribs supplied that support, and provided protection from further deterioration of the rib and the adjacent mine roof. The two cribs that were not installed firmly against the roof did not provide the required support and created the possibility of further deterioration of the roof and rib. TrII. 55-56. They also presented an additional hazard, because they could be toppled by a rib roll and strike a nearby miner. TrII. 56-57.

Respondent argues that the standard was not violated because there was adequate roof support in the area, and the "loosened cribs were still present and provided adequate protection." Resp. Br. at 26. I reject the argument. The critical area was located in the immediate vicinity of the left rib of the spur entry, where the rib roll had occurred, and the cribs had been erected. The presence of permanent roof support in the entry, and the jacks on the opposite side, did not provide support in that area. TrII. 88. Nor did the loosened cribs provide support for the roof in that area, which had loose and broken draw rock.

I find that the standard was violated, as alleged in the citation.

S&S

An injury caused by falling draw rock, or crib timbers toppling into or onto a miner, would have been reasonably serious. TrII. 58. The critical question in the S&S analysis is whether an injury causing event was reasonably likely to have resulted from the violation. There was loose draw rock in the area that could have fallen at any time. However, the evidence establishes that it was confined to the immediate area of the cribs, where the rib roll had occurred. The cribs themselves, including the two that were not firmly against the roof, provided a reasonably effective barrier to travel under the loose draw rock. Bell did not require that any draw rock be taken down before departing the area, and did not require that the area be dangered off before departing to inspect the working sections. TrII. 64, 79. It is unlikely that a miner

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[20] Cribs are constructed of 6-by-6-by-30-inch pieces of hardwood, stacked in alternating pairs. Wooden wedges are driven between the mine roof and the last layer of structural timber.

would have been injured by falling draw rock. A rib roll might have toppled the loose cribs, and they might have fallen on or into a miner in the immediate area. However, the probability of such a rib roll occurring is unknown. That section of the mine had been developed many years before, and the rib roll had occurred years before. TrII. 71. Miners were only occasionally in the area. Man trips on the spur were not routinely accessed. TrII. 78. If an additional vehicle was needed, an operator would conduct a pre-operational inspection of the vehicle, and then move it onto the main track. TrII. 53. If it was to be used to transport a crew to a working section, the miners would generally enter the spur entry to board the covered man trip. However, there is no evidence that that was a frequent occurrence.

In light of the uncertainty of a potentially injury-causing event and limited presence of miners in the subject area, I find that the Secretary has failed to prove by a preponderance of the evidence that the violation was S&S.

Negligence.

Bell determined that Respondent's negligence was moderate because examiners checked the area three times per day, and there were numerous foremen passing by the condition daily. While the condition should have been observed by foremen passing through the area, there is no evidence as to how long the condition had existed. The cribs could have been dislodged by a piece of mobile equipment shortly before the inspectors arrived. Varney had noted a similar condition and corrected it about a month earlier. TrII. 61, 86. I find that Respondent's negligence was low.

The Appropriate Civil Penalties

The Freedom Energy Mining Company's #1 mine is a very large mine which produced over 1,000,000 tons of coal in 2007. Its controlling entity is also extremely large. The assessment data reflects that it averaged slightly over 0.5 violations per inspection day during the relevant period, a moderate incidence of violations. Freedom does not contend that payment of the proposed penalties will affect its ability to continue in business. The violations were promptly abated.

Order No. 6645336 is modified to a citation issued pursuant to section 104(a) of the Act, and the violation is affirmed. However, the gravity of the violation was found to be less serious than alleged, including that it was not S&S. Respondent's negligence was found to be high. A specially assessed civil penalty of $9,800.00 was proposed by the Secretary. The reduction in gravity justifies a significant reduction in the proposed penalty. I impose a penalty in the amount of $3,000.00 upon consideration of the above and the factors enumerated in section 110(i) of the Act.

Citation No. 6655438 is affirmed. However, the gravity of the violation was found to be less serious than alleged, including that it was not S&S. A civil penalty in the amount of $1,304.00 was proposed by the Secretary. The lowering of the level of gravity justifies a reduction in the proposed penalty. I impose a penalty in the amount of $500.00 upon

consideration of the above and the factors enumerated in section 110(i) of the Act.

Citation No. 6656994 is affirmed. However, the gravity of the violation was found to be less serious than alleged, including that it was not S&S. In addition, the operator's negligence was found to be low. A civil penalty in the amount of $1,304.00 was proposed by the Secretary. The lowering of the levels of negligence and gravity justify a significant reduction in the proposed penalty. I impose a penalty in the amount of $350.00 upon consideration of the above and the factors enumerated in section 110(i) of the Act.

The Settlement

On May 19, 2010, the Secretary filed a Joint Motion to Approve Partial Settlement, which presented a proposed disposition of 12 of the citations at issue. At the commencement of the hearing, the parties jointly moved for approval of a proposed settlement of four additional citations. As to the settlement of the 16 citations which are the subjects of the motions, the Secretary has agreed to modify six citations and it is proposed that the total penalty for the settled violations be reduced from $21,058.00 to $14,102.00. I have considered the representations and evidence submitted and conclude that the proffered settlements are appropriate under the criteria set forth in section 110(i) of the Act.

ORDER

WHEREFORE, the motions for approval of settlement are **GRANTED**, and it is **ORDERED** that the citations are hereby amended as proposed in the motions and that Respondent pay a penalty of $14,102.00 for the settled violations.

Citation No. 6643527 is **VACATED**, and the petitions in Docket Nos. KENT 2008-1503 and KENT 2008-1506 are **DISMISSED**. Order No. 6645336 is **MODIFIED** to a citation issued pursuant to section 104(a) of the Act and, as so modified, is **AFFIRMED**. Citation Nos. 6655438 and 6656994 are **AFFIRMED, as modified**, and Respondent is **ORDERED** to pay civil penalties in the amount of $3,850.00, for the litigated violations.

Michael E. Zielinski
Senior Administrative Law Judge

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