

**FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION**

OFFICE OF ADMINISTRATIVE LAW JUDGES  
601 New Jersey Avenue, N.W., Suite 9500  
Washington, DC 20001  
202-434-9981/tele 202-434-9949/fax

May 14, 2010

SECRETARY OF LABOR,	:	CIVIL PENALTY PROCEEDING
MINE SAFETY AND HEALTH	:	
ADMINISTRATION (MSHA),	:	Docket No. KENT 2008-14
Petitioner	:	A.C. No. 15-09636-125440
	:	
v.	:	
	:	
BLUE DIAMOND COAL COMPANY,	:	Mine No. 77
Respondent	:	

**DECISION**

Appearances: Mary Sue Taylor, Esq., Office of the Solicitor, U.S. Department of Labor, Nashville, Tennessee, on behalf of the Secretary of Labor; Melanie J. Kilpatrick, Esq., Rajkovich, Williams, Kilpatrick & True, PLLC, Lexington, Kentucky, on behalf of Blue Diamond Coal Company.

Before: Judge Zielinski

This case is before me on a Petition for Assessment of Civil Penalties filed by the Secretary of Labor pursuant to section 105 of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 815. The Petition alleges that Blue Diamond Coal Company is liable for two violations of the Secretary’s Mandatory Safety Standards for Underground Coal Mines, and proposes the imposition of civil penalties in the total amount of \$21,200.00. A hearing was held in Hazard, Kentucky, and the parties filed briefs after receipt of the transcript. At the hearing, the parties advised that they had reached a settlement agreement as to one of the alleged violations. A motion seeking approval of the settlement has been filed, and will be granted. For the reasons set forth below, I find that Blue Diamond committed the remaining violation, but that it was not significant and substantial or the result of an unwarrantable failure, and impose a civil penalty in the amount of \$4,000.00.

Findings of Fact - Conclusions of Law

Robert Ashworth, an MSHA inspector, began an inspection of Blue Diamond’s No. 77 mine, located in Perry County, Kentucky, on April 4, 2007. On April 5, he and fellow inspector, Patrick Stanfield, returned to the mine to abate citations previously issued, and to conduct an inspection in response to a phoned-in safety complaint raising a number of issues, including illicit drug use by miners, non-compliance with ventilation requirements, and roof control violations. They traveled into the mine with Charles Williams, the mine superintendent. They reached the 011 Mechanized Mining Unit during the second shift, and gathered the miners so that a search could be conducted for smoking materials and other contraband. None was found. During their travel through the section, they observed conditions that they determined violated

various safety standards. Citations and orders were issued for roof control violations, and failure to comply with the approved ventilation plan.

Stanfield and Ashworth left the section shortly after midnight, in the early morning hours of April 6. They walked inby along the belt entry, intending to terminate violations issued several days earlier. The 011 section had just moved to a new panel, which was adjacent to the previously mined panel. When Stanfield and Ashworth had traveled about five breaks, they were in the area of the previously mined panel, and observed that there was no permanent stopping separating the belt entry from the return in one of the old panel's entries. Stanfield issued Order No. 7521760, alleging a violation of the applicable standard. Blue Diamond timely contested the Order and the proposed penalty.

#### Order No. 7521760

Order No. 7521760 alleges a violation of 30 C.F.R. § 75.333(b)(2), which requires that permanent stoppings or other permanent ventilation control devices be built and maintained to "separate belt conveyor haulageways from return air courses."

The violation was described in the "Condition and Practice" section of the Order as follows:

The # 11 conveyor belt (alternate escapeway off the 011/MMU) is not being separated from the return. One crosscut inby SPAD #3699, a permanent stopping has not been installed to separate the #11 conveyor belt from the return. The next stopping inby, where the old #12 belt was located, has sealant applied on the non-pressure side. The next two stoppings inby marked crosscut #13 and #14 do not have sealant applied to either side or to cover the wood products used in the construction of the stoppings. The permanent return stopping marked as the 15th has the personnel door open.

Order #4220150 is issued for failure to comply with the approved ventilation plan on the 011/MMU (failure to maintain the required 9,000 cfm at the last open crosscut). The approved roof control plan requires only two open crosscuts to be maintained. This mine is currently on a 103(i) spot inspection for methane liberation. This condition has existed for a significant amount of time. The 011/MMU was moved on or about 04/02/2007.

Ex. G-1.

Stanfield determined that it was highly likely that the violation would result in a fatal injury, that the violation was significant and substantial ("S&S"), that eight persons were affected, and that the operator's negligence was high. The Order was issued pursuant to section 104(d)(2) of the Act, and alleged that the violation was the result of the operator's unwarrantable

failure to comply with the mandatory standard.<sup>1</sup> A specially assessed civil penalty, in the amount of \$19,000.00, was proposed for this violation.

### The Violation

As noted in the Order, the 011 section had been moved about three days prior to the phone-complaint inspection. The old panel, consisted of seven entries, and was just outby the new panel. Both panels were mined at right angles to entries referred to as the “Daugherty Mains” (DM). As depicted on the mine map, when facing inby and counting from left to right, the first two entries of the DM were returns, entries #3 and #4 were neutrals, and entries #5, #6 and #7 were intakes.<sup>2</sup> The intake entries were designated as the primary escapeway, and the neutral entries were designated as the secondary escapeway. The belt was located in entry #4. Permanent stoppings were required to separate the intake entries from the neutral entries, and the neutral entries from the return entries.

The entries of the new panel, like the old one, were mined off the #1 DM return entry, at right angles to it. At the time of the inspection, six entries on the new panel had been started, and mining of the first crosscut had commenced with a right turn from entries #1 through #5. None of the crosscuts had been cut through. Therefore, the #1 DM entry was the last open crosscut (LOCC) for the new panel. When Stanfield and Ashworth arrived on the section it was not in production. A shuttle car had broken down on a cable at the feeder, and the second shuttle car had ben loaded and was awaiting access to the feeder. An electrician had traveled in with the inspection party in order to repair the shuttle car.

The continuous miner was in the #1 entry. As Ashworth approached that entry to gather miners for the search, he observed the continuous miner operator in the LOCC and a significant amount of what appeared to be dust suspended in the air in the intersection. When the miner operator saw Ashworth, he started back into the #1 entry, ostensibly to hang line curtain. Ashworth became concerned about inadequate ventilation, which was one of the allegations of the phoned-in complaint. He instructed the miner to get his jacket and lunch bucket and proceed to the area near the feeder, where the smoke/drug search and a safety meeting were to be conducted. The foreman searched the assembled miners, and Williams searched the foreman. No smoking articles or drugs were found.

Ashworth and Stanfield then conducted an imminent danger run. Stanfield went inby to the #6 entry and Ashworth started at the #4 entry and worked outby. Ashworth took an air

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<sup>1</sup> The parties stipulated that the predicate section 104(d)(1) order, Order No. 7550843, issued on June 3, 2005, was in paid status, and that there had not been an intervening “clean” inspection of the mine. Tr. 8-9.

<sup>2</sup> Air in the neutral/belt entries flowed inby. However, it could not be used to ventilate the face, and was routed to the returns, in part, through a tied-open mandoor, which was being used temporarily as a regulator.

reading in the #1 DM entry. He testified that he took the measurement between the #1 and #2 entries of the new panel. Tr. 145-47. However, his field notes report that the reading was taken between the #2 and #3 entries. Ex. G-4 at 9. He calculated that 7,611 cubic-feet-per-minute (cfm) of air was moving through the entry, less than the 9,000 cfm required in the LOCC under Blue Diamond's approved ventilation plan. Tr. 148, 165-66; Ex. G-4 at 9. As his notes reflect, he repeated the measurement at 9:45 p.m. "at the same location," and it again was inadequate. Ex. G-4 at 9. Efforts were made to improve ventilation, and the third reading, taken at 10:00 p.m., was 9,648 cfm, which was satisfactory. Ex. G-4 at 15. However, mining could not proceed because the ventilation plan's required volume of 5,500 cfm on the return side of the curtain in the #1 entry could not be obtained. A measurement taken at 11:00 p.m. yielded an air flow of only 2,066 cfm at that location. Ex. G-4 at 15. Ashworth wrote an order based upon those violations of the ventilation plan. That order is not at issue in this proceeding.

In the early morning hours of April 6, Stanfield and Ashworth traveled out of the mine by walking the belt entry, the #4 DM entry. They intended to check on progress that had been made to abate violations that had been written several days earlier during an electrical inspection, including the presence of accumulations of coal near the #10 and #11 belts. Tr. 53-55. They were accompanied by mine foreman Burley Adams, who had replaced Williams. It was during this exit trip that Stanfield observed that there was no permanent stopping separating the #3 DM neutral entry from the #2 DM return entry in the crosscut that was the extension of entry #3 of the old panel. Stanfield issued Order No. 7521760, citing the missing stopping and two adjacent stoppings that were inadequately sealed. Adams confirmed that the stopping was missing and that other stoppings were improperly "plastered," as Stanfield noted in the order.

Blue Diamond concedes that there was no permanent stopping at the required location and that the standard was violated. It challenges the S&S and unwarrantable failure designations.

### 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 install a permanent stopping.<sup>3</sup> The Secretary contends that the missing stopping could have resulted in a methane explosion, failure to detect a fire, and exposure to respirable dust. There is little question that a fire, explosion or serious dust exposure could reasonably have been expected to result in fatalities or serious injuries. 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, i.e., an explosion, failure to detect a fire, or significant exposure to respirable dust.

The Secretary advances two arguments on the gravity of the violation. She maintains that the missing stopping created a shortage of air at the working faces, creating a possibility of an ignition or explosion and subjecting miners to respirable dust. Recognizing that there are questions about the accuracy of Ashworth's air flow measurements, she asserts that "it is clear that the air was cut off from the working section by this condition [the missing stopping]."

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<sup>3</sup> The effect of the conditions identified in the Order was to allow air to "short circuit" from the neutral entries to the return entries, which is the primary thrust of the Secretary's arguments on gravity and negligence. By far, the most significant contributor to that effect was the missing stopping. While the inadequate sealing of the two adjoining stoppings contributed some small component to that effect, the discussion herein is framed in terms of the missing stopping.

Sec'y. Br. at 7. She also argues that, since belt air was allowed to short circuit to the return, the flow of air to the carbon monoxide ("CO") monitor at the tailpiece of the belt was reduced to an extent that detection of a fire in that entry would have been delayed, resulting in serious injuries. I find neither argument persuasive.

While a serious shortage of air flow at the working faces of the section could have lead to accumulations of methane or other noxious gases and dust, the missing stopping did not have a significant adverse effect on face ventilation.<sup>4</sup> Face ventilation for the 011 section was supplied by intake air coursing inby in the #5, #6 and #7 DM entries. Fresh air also flowed inby in the neutral entries, the #3 and #4 DM entries. However, it could not be used to ventilate the faces, and was channeled directly into the return air courses, partially through the open mandoor that was temporarily being used as a regulator. Although, the missing stopping allowed some of the neutral air to short circuit into the returns, it did not reduce the flow of intake air to the faces.<sup>5</sup> Stanfield and Ashworth testified that the missing stopping would tend to lessen the pressure differential between the intake and the return entries, reducing air flow to the faces. Tr. 112-14, 160-61. However, they made no attempt to quantify the supposed impact and, because of the overall air flow pattern, it is highly unlikely that there was any significant reduction in face ventilation attributable to the missing stopping.

The lack of adverse impact is evident from face air flow measurements taken while the stopping was missing. When the old panel was being mined, several of its entries had to be open to allow for ventilation and belt haulage. When the old panel was abandoned, permanent stoppings had to be built in the old panel entries between the #2 and #3 DM entries in order to separate the neutral entries of the new panel from the return entries. Blue Diamond failed to construct a permanent stopping separating the neutral DM entries from the return DM entries in

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<sup>4</sup> While the #77 mine was subject to 15-day spot inspections, pursuant to section 103(i) of the Act, because it had liberated over 250,000 cubic feet of methane in a 24-hour period, methane was not prevalent in the mine around the time of the inspection. The 103(i) designation had been made by the MSHA district manager on the basis of the results of testing that had been done months earlier. Tr. 225. Williams testified that the mine had not liberated that quantity of methane in the past 8-10 months, and that requests to remove the spot inspection designation had been denied. Bottle samples taken by Ashworth on April 4 had contained 0.06% methane in the #11 MMU and 0.0% in the #12 MMU. Tr. 162-64; Ex. R-5. The only methane found on April 5, was 0.5% in the #1 entry of the new panel. Tr. 175. Methane is explosive at concentrations between 5% and 15%. Other than that reading, preshift reports reflect that no methane was found in any of the headings for examinations conducted on April 4 and 5. Ex. R-8.

<sup>5</sup> There was a relatively small leak in one of the stoppings separating the intake entries from the neutral entries. A block was missing from a stopping, and a plastic bag had been placed over the hole. Tr. 68-69, 112-14. A separate citation was written for that violation. The Secretary does not argue that that condition adversely affected face ventilation with respect to this violation.

what had been the #3 entry of the old panel. Because the stopping was never built, all air measurements on the new panel on April 4 and 5, were taken while the stopping was missing. The preshift reports for that period show that air flow in the LOCC was measured at 14,375 cfm to 15,400 cfm, well above the required 9,000 cfm. Ex. R-8. It was not until the suspect measurements taken by Ashworth late on the second shift on April 5 that the flow dropped below 9,000 cfm. Tellingly, Ashworth, himself, had measured the air flow in the LOCC of the new panel on April 4, and found it to be 14,706 cfm. Tr. 139, 162-64. The stopping was missing at that time. Yet the ventilation volume substantially exceeded the required 9,000 cfm, as it had for several other measurements. If there was restricted ventilation at the face late on April 5, it was not due to the missing stopping.

Blue Diamond contends that Ashworth's air readings are unreliable because he took them in the wrong location, i.e., between the #2 and #3 entries on the new panel. They point out that placement of ventilation controls allowed return air to flow through both the #1 and #2 DM return entries at that point. Consequently, measurements of air flow in the #1 DM entry would reflect only a portion of the return air flow. It points to the fact that Ashworth's notes report that his measurements were taken between the #2 and #3 entries, and that a contrary indication was not placed on his notes until his deposition was taken in December of 2008. Tr. 170-71. Ashworth was adamant that he took the measurements between the #1 and #2 entries, and that his notes are erroneous. Tr. 166-69. There is also conflicting testimony on whether the error was called to his attention. Williams testified that he told Ashworth he was taking his measurement in the wrong location. Tr. 245-46. Ashworth testified that no one told him he was measuring in the wrong place. Tr. 152.

Ashworth is an experienced inspector and had 18 years of mining experience prior to joining MSHA. Tr. 132. He should have known the correct location to take the air reading, and it is unlikely that he would have taken it in the wrong location, although the fact that the section was in the initial stages of development created the potential for confusion. Tr. 148-49. However, his notes, made contemporaneously with the inspection some three years ago, clearly state that the measurements were taken between the #2 and #3 entries, which would have yielded inaccurately low measurements. The marked difference between Ashworth's April 5 readings and the numerous readings in the range of 14,000-15,000 cfm on April 4 and 5, including Ashworth's own reading of April 4, cannot be explained by the fact that the stopping was missing. On this record, the only explanation for the discrepancy is that the readings were not taken in the correct location.

The Secretary also makes more than can reasonably be made of the evidence regarding air flow at the CO monitor at the end of the belt. She argues that the missing stopping allowed belt air to short circuit and not pass by the CO monitor at the belt tailpiece, thereby significantly impairing the monitor's ability to detect a fire. Sec'y. Br. at 8. The missing stopping certainly allowed some amount of air from the neutral entries to short circuit into the return. However, there is no evidence that it resulted in an inadequate flow of air at the CO monitor. Stanfield took no air readings at that location, and did not know if the required 50 feet-per-minute of flow was provided, or if air was short circuiting at the CO monitor. Tr. 102. Ashworth could not recall observing any problems with the CO monitoring system. Tr. 175-76. If there were a

serious question about the volume of air flow at the CO monitor, it is reasonable to expect that measurements or some enforcement action would have been taken, as with other perceived violations. The Secretary also argues that the open mandoor, being used as a regulator, was “similar” to a condition that existed during a belt fire at the mine around 2006. Sec’y. Br. at 8. However, that is not the case. In the 2006 fire, which apparently did not result in any injuries, a mandoor had been left open near a head drive, allowing air to bypass a CO monitor. Tr. 74-77. Here, the mandoor/regulator was on the section at the tailpiece of the belt, in or near a location where a regulator was supposed to be located, to allow neutral air to flow into the return without going to the face. Tr. 102-03. While a mandoor is not supposed to be used as a regulator, there is no evidence that it did not effectively function as such.

The Secretary’s CO monitor argument on gravity is predicated on a fire occurring in the belt entry. She points to the fact that the mine had experienced belt fires in 2001 and 2006, and that citations had been issued for accumulations along the belt and at the feeder, and for a defective cable near the feeder, creating the potential for a fire. However, she fails to address the fact that the inspectors determined that those violations were unlikely to result in injuries, and that there is no evidence that the potential ignition source was in proximity to the accumulations. Tr. 58-59, 92-94. In addition, Stanfield testified that, while an uninsulated cable may arc if it is grounded, it is not “real common.” Tr. 58-59. Assuming the fact of a belt fire, itself an unlikely event, there is no evidence that the ability of the CO monitoring system to detect a fire was impaired to any appreciable degree, or that an injury was reasonably likely to result.

Upon consideration of all of the above, I find that the Secretary has not met her burden of proving that the violation was S&S. I find that the violation was unlikely to result in lost work days or restricted duty injuries.

#### 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 Secretary argues that the violation was the result of Blue Diamond's unwarrantable failure because it was obvious, had existed for several shifts, should have been discovered by several mine examiners, and posed a high degree of danger. Blue Diamond counters that the condition was not obvious, it had no actual knowledge of it, it existed only for one full shift and portions of two others, and it did not pose a danger to miners.

Production commenced on the second shift on April 4, and the stopping was required to be in place at that time. Production also occurred on the first and second shifts on April 5. Blue Diamond argues that the violation existed only for one shift, and portions of two others. While correct, that is a significant period of time.

The move to the new panel started on April 2, and production resumed on the second shift on April 4. Mine foreman Adams supervised the second shift on April 3, during which some of the required stoppings were built, and material for other stoppings was distributed. He instructed the oncoming midnight shift that the remaining stoppings needed to be built. Adams substituted as section foreman on the second shift on April 4. He did not personally verify that the stoppings had been built, and no one told him that they had been built. Tr. 214-15. He believed that the required permanent stoppings had been constructed because he had advised the previous midnight shift to do so, and the first shift had run production. He measured air flow of approximately 15,000 cfm in the LOCC, and he did not observe any other problems. Tr. 206. He later conducted the preshift examination for the oncoming third shift between the hours of 8:30 and 9:30 p.m., and measured 15,310 cfm of air flow in the #1 DM entry, just outby the #1 entry of the new panel. Tr. 201-04; Ex. R-8. He also found no methane in any of the new panel headings. Ex. R-8.

Stanfield believed that "numerous" examiners had failed to discover the condition.

Tr. 81. The belt was required to be examined on every production shift, and an examination of the return was required weekly. Consequently, the condition was not discovered by the belt examiner on the second shift on April 4, or the belt examiners on the first and second shifts on April 5. Stanfield believed that the outby examiner, inspecting the return, should have made sure to check the stoppings because of the recent move. Tr. 81. He believed that he had seen a notation in the outby exam book that the exam had been conducted on April 5. Tr. 95. However, he could not recall when he had seen the book, and he had not listed the outby exam book among the records that he reviewed in conjunction with the inspection. Tr. 95-97. He conceded that he could not be sure that an outby examination had been conducted in the area of the violative condition while it existed. Tr. 96.

The belt line had to be examined on every production shift, i.e., on the first and second shifts. Examinations were performed on the second shift on April 4 and the first shift on April 5. It is unclear whether the belt exam for the second shift on April 5 had been conducted prior to the inspection. Charles Hensley was the belt foreman on the day shift. Hensley's first post-panel-move examination of the #11 belt occurred on April 5. The brattice line, the line of permanent stoppings, was between the #2 and #3 DM entries. The belt was in the #4 DM entry. Consequently, the location where the stopping was supposed to have been constructed was about 100 feet away from where Hensley traveled. Tr. 183-84. It was dark where the stoppings were supposed to be located, and there was gob piled up to within about one foot of the mine roof in some of the entries of the old panel, between the #4 and #3 DM entries. Tr. 184-86. Hensley could not see all of the stoppings and did not notice any missing stoppings or any of the other defects noted in the order. He believed that it was the section foremen's responsibility to make sure that the required stoppings were in place before starting to mine. Tr. 190.

George Abner, who no longer worked for Blue Diamond when he testified, was the mine examiner during the pertinent period, and performed weekly inspections of all outby areas. He typically would travel long distances in a "buggy" and, in the area of the violation, would have traveled in the #1 DM entry, next to the "wall," because he had to inspect seals at various points. He did not recall when he performed the weekly inspection in the area of the missing stopping. The outby book, where the inspections would have been recorded, was unavailable at the hearing.<sup>6</sup> He believed that if he had failed to note a missing stopping during an examination and a citation or order was issued, Williams would have reprimanded or disciplined him, and he did not recall any such incident. Tr. 122-23. Abner also believed that it was the section foreman's responsibility to install required stoppings and to assure that that was done. Tr. 126. Williams testified that, other than weekly examinations by the outby foreman, no one traveled the return. He recalled looking at the outby book with Abner shortly after the Order had been issued, and

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<sup>6</sup> The book was apparently destroyed in the normal course of business. Because the book was not maintained by Blue Diamond, the Secretary urges that an adverse inference be drawn on the issue of whether the outby examination was conducted while the section was in production and the stopping was missing. For the reasons advanced by Blue Diamond, I decline to draw such an inference. Resp. Br. at 7 n.4; Resp. Rply. Br. at 2-3.

believed that Abner's examination had been conducted earlier in the week, before the move had been completed. He confirmed that he would have disciplined or "consulted" Abner, had he failed to notice that a required stopping was not in place, and he did not do so. Tr. 222-23.

The Secretary contends that the violation was obvious, which it would have been to anyone standing at that location. However, it was not obvious to the section foremen, who were not in a position to have seen it, and who did not suspect a problem because there was ample ventilation at the faces. The belt examiners, at least two of whom made examinations on production shifts while the violation existed, did not see the missing stopping. It was not obvious from the belt examiners' route of travel. The Secretary argues that the violation was obvious because Stanfield observed it while walking along the belt while his mind was on other things. Sec'y. Br. at 12-13. However, Stanfield testified that he may well have been specifically looking for the stoppings because he was aware of the recent panel move and the inadequate air flow readings, and questioned whether a missing stopping could have caused the problem. Tr. 61.

As evidenced by the S&S discussion, the violation did not pose a high degree of danger to miners. It did not significantly affect ventilation on the working section. Blue Diamond had no direct knowledge of the violation, and had not been put on notice that greater efforts were needed for compliance. The violation was promptly abated.

Considering all of these factors, I find that the violation was not the result of Blue Diamond's unwarrantable failure to comply with the mandatory safety standard. While Blue Diamond did not have direct knowledge of the violation, it should have known of it. Placement of critical ventilation controls in conjunction with a move of a section is an important task, the completion of which should have been verified. Because placement of such controls is required prior to commencing production, the section foreman initiating production on the new panel should have personally made sure that the stopping was in place, as several witnesses opined. It is not apparent that Blue Diamond had assigned that responsibility directly, or whether the assigned person failed to discharge the responsibility. In either case, Blue Diamond's negligence was high.

#### The Appropriate Civil Penalties

Blue Diamond is a medium-sized operator, with a large controlling entity. The assessment data reflects that it averaged 2.0-2.1 violations per inspection day during the relevant period, a relatively high incidence of violations. Blue Diamond does not contend that payment of the proposed penalty will affect its ability to continue in business. The violation was promptly abated.

Order No. 7521760 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 violation was not the result of Respondent's unwarrantable failure. Rather, its negligence was high. A specially assessed civil penalty of \$19,000.00 was proposed by the Secretary. The lowering of the levels

of negligence and gravity justify a reduction in the proposed penalty. I impose a penalty in the amount of \$4,000.00, upon consideration of the above and the factors enumerated in section 110(i) of the Act.

#### The Settlement

The parties have moved for approval of a settlement agreement as to Citation No. 7553882. It is proposed that the penalty be reduced from \$2,200.00 to \$1,540.00. I have considered the representations and evidence submitted and conclude that the proffered settlement is appropriate under the criteria set forth in section 110(i) of the Act.

### **ORDER**

**WHEREFORE**, the motion for approval of settlement is **GRANTED**, and it is **ORDERED** that Respondent pay a penalty of \$1,540.00 for Citation No. 7553882.

Order No. 7521760 is **modified to a citation issued pursuant to section 104(a) of the Act, and is AFFIRMED, as so modified**, and Respondent is **ORDERED** to pay a civil penalty in the amount of \$4,000.00 for that violation.

Respondent's payment of civil penalties in the total amount of \$5,540.00 for the settled and contested violations shall be made within 30 days.

Michael E. Zielinski  
Senior Administrative Law Judge

Distribution (Certified Mail):

Mary Sue Taylor, Esq., Office of the Solicitor, U.S. Department of Labor, 618 Church Street,  
Suite 230, Nashville, TN 37219-2440

Melanie J. Kilpatrick, Esq., Rajkovich, Williams, Kilpatrick & True, PLLC, 2333 Alumini Park  
Plaza, Suite 310, Lexington, KY 40517