

FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

OFFICE OF ADMINISTRATIVE LAW JUDGES
601 New Jersey Avenue, N.W., Suite 9500
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December 31, 2002

SECRETARY OF LABOR,	:	CIVIL PENALTY PROCEEDING
MINE SAFETY AND HEALTH	:	
ADMINISTRATION (MSHA),	:	Docket No. LAKE 2002-61
Petitioner	:	A.C. No. 33-01159-04192
	:	
v.	:	
	:	
THE OHIO VALLEY COAL COMPANY,	:	
Respondent	:	Powhatan No. 6 Mine

DECISION

Appearances: Rafael Alvarez, Esq., Office of the Solicitor, U.S. Department of Labor, Chicago, Illinois, for Petitioner;
Michael O. McKown, Esq., General Counsel, The Ohio Valley Coal Company, Pepper Pike, Ohio, for Respondent.

Before: Judge Hodgdon

This case is before me on a Petition for Assessment of Civil Penalty brought by the Secretary of Labor, acting through her Mine Safety and Health Administration (MSHA), against The Ohio Valley Coal Company, pursuant to section 105 of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 815. The petition alleges two violations of the Secretary’s mandatory health and safety standards and seeks a penalty of \$50,000.00. A hearing was held in Wheeling, West Virginia. For the reasons set forth below, I vacate one citation, affirm the other as modified and assess a penalty of \$5,000.00.

Background

The parties stipulated to the facts in this case. (Jt. Ex. 1.) They are set out below in narrative fashion.

The Ohio Valley Coal Co. owns and operates the Powhatan No. 6 underground coal mine in Belmont County, Ohio. The Ohio Valley Resources, Inc., a subsidiary of Murray Energy Corporation, is the parent company of The Ohio Valley Coal Co.

At about 5:15 p.m. on April 19, 2001, the pre-shift examiners examining the 2nd Main North belt heard a flapping noise somewhere around the stationary take-up roller at break 62. The plastic mesh guarding the belt drive and take-up unit was in place and they were unable to

determine the cause of the flapping noise. The examiners did not report the noise in the pre-shift examiners book.

Later that evening, at about 8:30 p.m., Randy Brunner and Dennis Miller, two belt repairmen, parked their jeep at break 61 so that they could repair the 1st Main North belt wings, located near break 60. During the repairs, Brunner returned to the jeep to get some parts. While there he observed a jeep park at break 62. He could tell by the cap light that there was only one person, but was unable to identify who it was. As they were finishing the job, the repairmen could see a cap light at the 2nd Main North belt drive take-up unit, about 180 to 200 feet away. The 1st Main North belt was not shut down during the 15 minutes while the repairs were performed.

Approximately one minute after completing the job and returning to their jeep, the repairmen heard a voice calling for help. Looking toward the spur switch, they saw the unidentified miner running and staggering along the track and then falling to the mine floor. They ran to the miner and discovered that it was Thomas Ciszewski, the belt foreman. Ciszewski was missing his left arm and had facial cuts.

While Ciszewski was being tended to underground, Miller went to the accident site to try to find the arm. It was lying outside of the guarding in the walkway on the return side of the 2nd Main North belt conveyor, adjacent to the take-up cart. Miller took the arm back to where Ciszewski was. Ciszewski was carried to the surface where he was pronounced dead at 9:00 p.m.

MSHA was notified of the accident at 9:20 p.m. An initial response team arrived at the mine at 10:15 p.m. A 103(k) order,¹ 30 U.S.C. § 813(k), was issued, preliminary information was collected, an investigation was begun and photographs, measurements and drawings of the accident scene were collected. The team found that the two guard panels adjacent to the take-up unit on the return side had been removed from their top hangers at one end and were hanging down on the mine floor, creating a two inch gap at the top and a six inch gap at the bottom between the panels. In this condition, the panels could be swung inward or outward. There was approximately 26 inches of space between the guarding and the moving belt, which normally

¹ Section 103(k) provides that:

In the event of any accident occurring in a coal or other mine, an authorized representative of the Secretary, when present, may issue such orders as he deems appropriate to insure the safety of any person in the coal or other mine, and the operator of such mine shall obtain the approval of such representative, in consultation with appropriate State representatives, when feasible, of any plan to recover any person in such mine or to recover the coal or other mine or return affected areas of such mine to normal.

operates at 700 feet per minute (about 8 mph). A steel jack handle, measuring 1 x 24 inches, was found partially inside the guarded area and partially in the walkway.

An MSHA Accident Investigation team, as well as investigators from Ohio, arrived at the mine on April 20, to continue the investigation and conduct interviews. The investigators determined that a grease hose, which had gotten wrapped around the shaft of the stationary take-up roller on the track side of the belt, was making the flapping noise heard by the pre-shift examiners. They concluded that the accident had occurred when Ciszewski's left arm contacted and was caught in the pinch point between the moving belt and the stationary roller of the belt take-up unit.

As a result of the investigation, two citations were issued to the company. Citation No. 7088894 alleges a violation of section 75.1722(a) of the Secretary's mandatory health and safety standards, 30 C.F.R. § 75.1722(a), because the guarding on the belt drive had been removed from the hangers, allowing access to the belt and roller.² (Jt. Ex. B.) Citation No. 7089484 charges a violation of section 75.1725(c), 30 C.F.R. § 75.1725(c), in that:

Based on evidence revealed during the accident investigation, Thomas M. Ciszewski failed to comply with the cited regulation, when he attempted to repair or perform maintenance on the belt take-up unit, while the belt and take-up unit were still in operation and not blocked against motion. Thomas M. Ciszewski, foreman, was fatally injured on April 19, 2001, while conducting assigned duties on the 2nd Main North belt conveyor. While attempting to assess or repair a noise problem on the return walkway side of the belt take-up roller, Mr. Ciszewski had displaced two guarding panels installed on hangers around the belt take-up unit so that he could position himself within the confines of the guarding. Evidence indicates that his left arm was detached from his body at the shoulder, when he became caught in the pinch point between the moving belt and the take-up stationary roller causing his death shortly thereafter.³

(Jt. Ex. C.)

² This citation originally alleged a violation of section 75.1722(c), 30 C.F.R. § 75.1722(c), but was modified on June 28, 2001, to cite section 75.1722(a) and to raise the level of negligence from "low" to "moderate."

³ This citation was originally issued as a 104(d)(1) order, 30 U.S.C. § 814(d)(1), but was modified on June 28, 2001, to a 104(a) citation, 30 U.S.C. § 814(a), as well as to substitute a new narrative description of the violation and to lower the level of negligence from "high" to "moderate."

Findings of Fact and Conclusions of Law

The company concedes that the guarding violation occurred. (Tr. 194.) With regard to the second citation, however, Ohio Valley claims that the Secretary has failed to prove that it violated the regulation. The Secretary maintains that the Respondent violated both regulations. However, the Secretary's position, with regard to the second citation, is not supported by a preponderance of the evidence.

Citation No. 7088894

This citation alleges a violation of section 75.1722(a), which requires that: "Gears; sprockets; chains; drive, head, tail, and takeup pulleys; flywheels; couplings, shafts; sawblades; fan inlets; and similar exposed moving machine parts which may be contacted by persons, and which may cause injury to persons shall be guarded." The evidence that the guards, which were in place during the pre-shift examination, were found, immediately subsequent to Ciszewski's accident, to have been removed from their hangers so they could be swung open, clearly supports the operator's concession that this regulation was violated.

Significant and Substantial

The Inspector found this violation to be "significant and substantial." A "significant and substantial" (S&S) violation is described in Section 104(d)(1) of the Act, 30 U.S.C. § 814(d)(1), 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 Division, National Gypsum Co.*, 3 FMSHRC 822, 825 (April 1981).

In *Mathies Coal Co.*, 6 FMSHRC 1 (January 1984), the Commission set out four criteria that have to be met for a violation to be S&S. *See also Buck Creek Coal, Inc. v. FMSHRC*, 52 F.3d 133, 135 (7th Cir. 1995); *Austin Power, Inc. v. Secretary*, 861 F.2d 99, 103-04 (5th Cir. 1988), *aff'g Austin Power, Inc.*, 9 FMSHRC 2015, 2021 (December 1987) (approving *Mathies* criteria). Evaluation of the criteria is made in terms of "continued normal mining operations." *U.S. Steel Mining Co., Inc.*, 6 FMSHRC 1573, 1574 (July 1984). 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 (April 1988); *Youghiogheny & Ohio Coal Co.*, 9 FMSHRC 2007 (December 1987).

In order to prove that a violation is S&S, the Secretary must establish: (1) the underlying violation of a safety standard; (2) a distinct safety hazard, 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 will be of a reasonably serious nature. *Mathies*, 6 FMSHRC at 3-4.

Turning to these criteria, I make the following findings: (1) there was a violation of a safety standard, section 75.1722(a); (2) removing the guarding from the pinch points of an operating belt contributed to the danger of being caught in a pinch point; (3) there was a reasonable likelihood that a miner would be caught in a pinch point which was not guarded, while the belt was running, and suffer an injury; and (4) there was a reasonable likelihood that such an injury would be reasonably serious in nature. Manifestly, the removal of the guarding was a significant contributing cause to the fatal accident, making it “significant and substantial.” *Walker Stone Co., Inc.*, 19 FMSHRC 48, 53 (January 1997). Accordingly, I so conclude.

Citation No. 7089484

This citation charges a violation of section 75.1725(c), which provides that: “Repairs or maintenance shall not be performed on machinery until the power is off and the machinery is blocked against motion, except where machinery motion is necessary to make adjustments.” The company argues that Ciszewski was performing neither repair nor maintenance, rather he was performing an inspection, and that, therefore, section 75.1725(c) is not applicable to what happened. (Tr. 192-93.) It is the Secretary’s position that assessing what repair or maintenance is required is included within the scope of the regulation. (Jt. Ex. C, Tr. 99-105.)

No one knows exactly what Ciszewski did or why he did it. It appears unlikely, however, that he was trying to repair the flapping noise by reaching in to remove the grease hose. Corporate Safety Director Jerry Taylor testified that:

I don’t believe there’s no way that Mr. Ciszewski was reaching in to pull out that grease hose. He couldn’t even see it vibrate or going around. I was there when we started the belt back up after the fatality, before the grease hose was removed. You could hear the noise, but you couldn’t see the grease hose. That belt is running at 700 feet a minute and knowing Tom and the size of that belt, it’s 54 inches wide with like one-inch thick rubber.

There’s no way that Tom Ciszewski would reach in there to try to pull that hose out. How he got entangled in the belt, sir, I have no idea, but I cannot for the life of me believe that he is – with all the common sense and the experience that that individual has that he would reach in there to try to grab a hold of something that he couldn’t see that was making noise. It just – there’s no logic to that at all to me.

(Tr. 155-56.) MSHA Inspector Charles Thomas, who was in charge of the investigation of the accident, agreed Ciszewski was probably not trying to grab the grease hose because: “I think with a man with that much experience and worked around belts, and there’s probably been some near misses in his career, that it would be a foolish thing to do to grab that grease hose.” (Tr. 106.)

Since the evidence does not indicate that Ciszewski was trying to repair the belt, then he must have been assessing the situation to determine what repairs were needed. Consequently, whether his failure to turn off the power and block the belt against motion, when performing that function, was a violation, depends on whether merely assessing the problem is included in “repairs or maintenance.” The Commission has held that when “the language of a regulatory provision is clear, the terms of the provision must be enforced as they are written unless the regulator clearly intended the words to have a different meaning. *See, e.g. Utah Power & Light Co.*, 11 FMSHRC 1926, 1930 (October 1989) (citing *Chevron U.S.A., Inc. v. Natural Resources Defense Counsel, Inc.*, 467 U.S. 837, 842-43 (1984)).” *Walker Stone*, 19 FMSHRC at 51.

The Commission has defined the words “repair” and “maintenance,” in a similarly worded regulation,⁴ as follows:

The term “repair” means “to restore by replacing a part or putting together what is torn or broken: fix, mend . . . to restore to a sound or healthy state: renew, revivify” *Webster’s Third New International Dictionary, Unabridged* 1923 (1986). The term “maintenance” has been defined as “the labor of keeping something (as buildings or equipment) in a state of repair or efficiency: care, upkeep . . .” and “[p]roper care, repair and keeping in good order.” *Id.* at 1362; *A Dictionary of Mining, Mineral, and Related Terms* 675 (1968).

Id. In addition to these definitions, “perform” is defined as “to carry out or bring about: accomplish, execute” *Webster’s Third New International Dictionary* 1678 (1993).

Reading these definitions together, it is evident that the regulation means that fixing, mending or keeping machinery in a state of repair shall not be carried out until the power is off and the machinery blocked against motion. Plainly, it connotes action and deals with the physical acts of fixing, mending or keeping in a state of repair. It follows that it does not include assessing what repair or maintenance is needed. Accordingly, I find that the regulation is plain and unambiguous on its face and that it does not apply to this situation.

This is not to say that Inspector Thomas was incorrect in saying that the proper way for Ciszewski to have investigated the flapping noise was to first shut down the belt line, only that Ciszewski’s failure to do so was not a violation of this regulation. Therefore, the citation will be vacated.

⁴ Section 56.14105, 30 C.F.R. § 56.14105, states: “Repairs or maintenance of machinery or equipment shall be performed only after the power is off, and the machinery or equipment blocked against hazardous motion.”

Civil Penalty Assessment

The Secretary has proposed a penalty of \$15,000.00 for the violation in Citation No. 7088894. However, it is the judge's independent responsibility to determine the appropriate amount of penalty in accordance with the six penalty criteria set out in section 110(i) of the Act, 30 U.S.C. § 820(i). *Sellersburg Stone Co. v. FMSHRC*, 736 F.2d 1147, 1151 (7th Cir. 1984); *Wallace Brothers, Inc.*, 18 FMSHRC 481, 483-84 (April 1996).

In connection with these criteria, the parties have stipulated that the Powhatan No. 6 mine extracted 4,619,247 tons of coal from February 1, 2001, to February 1, 2002, which makes it a large mine, and that Murray Energy extracted 17,647, 608 tons of coal during the same period, which makes it a large operator. They have also stipulated that payment of the proposed penalty will not affect the Respondent's ability to remain in business. In addition, I find that the company demonstrated good faith in abating the violation in a timely manner.

The parties have also stipulated that the company had 848 violations in the two years preceding the violation. Inspector Thomas testified that the operator had a higher than average history of violations. (Tr. 84.) Based on his testimony and the Assessed Violation History Report, (Govt. Ex.1), I find that Ohio Valley has a worse than average history of violations.

I find the gravity of this violation to be very serious. No more need be said than that a death occurred.

Inspector Thomas determined that this violation was a result of "moderate" negligence on the part of the company. The company argues that Ciszewski's negligence should not be imputed to it based on the so-called *Nacco* defense. The Commission has summarized the imputation of negligence and the *Nacco* defense as follows:

It is well established that the negligent actions of an operator's foremen, supervisors, and managers may be imputed to the operator in determining the amount of a civil penalty. *See, e.g., Southern Ohio Coal Co.*, 4 FMSHRC 1459, 1463-64 (August 1982). In *Nacco Mining Co.*, 3 FMSHRC 848 (April 1981), the Commission recognized a narrow and limited exception to this principle. The Commission held that the negligent misconduct of a supervisor will not be imputed to an operator if: (1) the operator has taken reasonable steps to avoid the particular class of accident involved in the violation; and (2) the supervisor's erring conduct was unforeseeable and exposed only himself to risk. 3 FMSHRC at 850. The Commission emphasized, however, that even a supervisory agent's unexpected, unpredictable misconduct may result in a negligence finding where his lack of care exposed others to risk or harm or the operator was otherwise blameworthy in hire,

training, general safety procedures, or the accident or dangerous condition in question. 3 FMSHRC at 851.

Wilmot Mining Co., 9 FMSHRC 684, 687 (April 1987).

Here the second part of the test is clearly met. Ciszewski's conduct was unforeseeable and he exposed only himself to risk.

Attempting to show that the operator had not taken reasonable steps to avoid this particular class of accident, the Secretary offered the testimony of Randy Brunner, a rank-and-file miner. He claimed that other than his fellow belt repairman, Dennis Miller, no one trained him to do belt repair. (Tr. 27-28.) When asked if he had ever done belt repair work without shutting the belt down, he replied: "Yeah, we've dropped hot rollers out. I have. And other minor stuff on it. We just shut the switches off to cut flappers off and drop rollers to the remote switches. We never tagged them out and locked them out, I never have." (Tr. 29.) He also testified that he had removed a guard from a belt to "look at splices" while the belt was running. (Tr. 30.)

When asked if there were safety procedures the belt repairmen were supposed to follow, Brunner said: "If it was splices and stuff like that, they're supposed to lock them out. You're supposed to have your own lock. They always had one boss or somebody go lock them out, you know." (Tr. 32-33.) He later stated that he guessed there were safety procedures, but he was not aware of them. (Tr. 39) When asked if anyone had ever discussed safety procedures with him, he stated: "No, not to me. Not that I know of. I mean, I'm not saying they didn't because I'm not 100 percent sure." (Tr. 39.) Finally, he admitted that he had received new miner training and annual refresher training. (Tr. 40.)

To rebut this evidence, the company offered the testimony of Jerry Taylor and Roy Heidelberg, mine superintendent. Taylor described the training offered at the mine as follows:

In their initial training when they're brought on board, they're explained all the hazards of working around conveyor belts, around the drives and so on, and about maintaining the guards in place and that the guards have to be – the belt has to be de-energized before the guards can be removed. They're explained all the things, the remote switches, how they can turn the belts off and on temporarily. And that they're not to rely on remote switches as a means, excuse me, to de-energize the belt. We want them to go to the breaker and de-energize it.

They're explained the procedures for removing structures on the longwall, if they work on the lo[n]gwall tailpiece. It has a different set of guidelines than the other ones do. And also not only on belts, they're also given the procedures on de-energizing

any type of equipment before they work on it doing repairs and maintenance to the equipment.

(Tr. 134-35.) He also testified that safety meetings were held “biweekly, sometimes more often” by the mine safety director or a foreman. (Tr. 136.) Finally, he testified that “awareness meetings” were periodically held for the entire workforce on a shift and that safety was covered at those meetings. (Tr. 137.)

Heidelbach testified concerning training that:

Well, there’s a wide variety of subjects that are covered. There are several different types of training. There’s annual retraining, which all employees have eight hours annually. There’s also task training, which involves any time an employee is working on a new task, the supervisor or an experienced employee in that task may train him as to the hazards and the things to look for on the job. And we also have regular safety meetings that also discuss hazards and the proper work procedures.

(Tr. 165.) He also testified that miners had been disciplined for failing to follow safety procedures. (Tr. 166-67.)

I find that the operator was neither blameworthy in its hiring, training, and general safety procedures, nor was it answerable with regards to the accident or dangerous condition in question. Ciszewski had close to 20 years experience in underground coal mines and was a very experienced belt foreman. (Tr. 161.) There was no reason for the company to expect him to remove the guarding while the belt was running and place himself in a position where he could fall into the pinch point.⁵ Further, the testimony of Taylor and Heidelbach is entitled to more weight concerning the general safety procedures at the mine, than the inconsistent testimony of a single rank-and-file miner, who was not “100 percent sure.”⁶ Finally, while the company has a worse than average history of violations, it does not appear that they had an inordinate amount of guarding violations.

Consequently, I find that Ciszewski’s conduct in removing the guarding was unforeseeable and only he was exposed to risk and that the operator had taken reasonable steps to avoid the type of accident involved in the violation. The citation will be modified to show that the operator was not negligent in the commission of this violation.

⁵ I find from the evidence that this is the most likely explanation of what happened.

⁶ The Secretary subpoenaed another miner, Dennis Miller, who was present at the hearing, but elected not to call him.

Taking all of the penalty criteria into consideration, I conclude that a \$5,000.00 penalty is appropriate for Citation No. 7088894.

Order

Accordingly, Citation No. 7089484 is **VACATED** and Citation No. 7088894 is **MODIFIED** by reducing the level of negligence from “moderate” to “none” and is **AFFIRMED** as modified. The Ohio Valley Coal Company is **ORDERED TO PAY** a civil penalty of **\$5,000.00** within 30 days of the date of this decision.

T. Todd Hodgdon
Administrative Law Judge

Distribution: (Certified Mail)

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/hs