FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION
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December 31, 2009

SECRETARY OF LABOR, MINE SAFETY AND HEALTH ADMINISTRATION (MSHA), Petitioner	:	CIVIL PENALTY PROCEEDING Docket No. SE 2008-667 A.C. No. 01-03217-146922
v.	:	
SHELBY MINING COMPANY, LLC, Respondent	:	Mine: Coke Mine No. 1

DECISION

Appearances: Tom Grooms, Office of the Solicitor, U.S. Department of Labor, Nashville Tennessee, for Petitioner;
Warren B. Lightfoot, Maynard, Cooper and Gale, PC Birmingham, Alabama, for Respondent.

Before: Judge Miller

This case is before me on a petition for assessment of civil penalty filed by the Secretary of Labor ("Secretary"), acting through the Mine Safety and Health Administration ("MSHA"), against Shelby Mining Company, LLC, pursuant to sections 105 and 110 of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. §§ 815 and 820 (the "Mine Act" or the "Act"). This case involves one citation and one order issued by MSHA under section 104(d) of the Mine Act at the Coke Mine No. 1 operated by Shelby Mining Company, LLC. The parties presented testimony and documentary evidence at a hearing held in Birmingham, Alabama.

At all pertinent times, Shelby Mining Company, LLC, operated the Coke Mine No. 1 mine in central Alabama. The Coke Mine No. 1 mine, although now closed, mined coal and/or coal byproducts which affected commerce. The mine is subject to the Mine Act.

I. FINDINGS OF FACT AND CONCLUSIONS OF LAW

Shelby Mining Company, LLC ("Shelby") operated an underground coal mine, the Coke Mine No.1 ("Coke Mine"), near Montevallo, Alabama. Like most mines in the area, it is "gassy," liberating over seven million cubic feet of methane per day. As a result, it is subject to 5-day spot inspections by MSHA, pursuant to section 103(i) of the Act. 30 U.S.C. § 813(i); (Tr.

21-22). On November 27, 2007, Randall Weekly, an MSHA inspector, conducted a spot inspection at the Coke Mine. He was accompanied on that inspection by Randy Clements, Shelby's safety supervisor at the mine. The inspection took place on the regular day shift, during which mining normally occurs. (Tr. 95-96). Weekly cited two violations that are subject to this decision: (1) a citation for failure to follow the ventilation plan, and (2) an order for failure to conduct an adequate preshift examination.

a. Citation No. 7692075

As a result of the inspection, Inspector Weekly issued Citation No. 7692075 alleging a violation of 30 C.F.R. § 75.370(a)(1), which requires that mine operators "develop and follow a ventilation plan approved by the [MSHA] district manager." The citation described the violation as follows:

> At the Coke mine on the #1 section in the #5 entry the ventilation plan was not being followed. The entry had been mined a full cut of 30 feet, the blowing curtain was 12 feet from the last row of bolts or 42 feet from the face,[sic] There is no evidence of an exhaust curtain or back drop ever being in place while this area was mined. The air was traveling through the cross cut between #4 and #5 then straight to the return never going to the face. This mine has had 6 ignitions from 3/30/2006 until 11/2/2007, one resulting in 2 employees receiving burns. The mine operator has engaged in aggravated conduct by failure to follow the ventilation plan. This violation is an unwarrantable failure to comply with a mandatory standard.
>
> Gov. Ex. 2.

The citation was later modified to clarify that it was issued for a violation of item 7 on page 2 of Shelby's ventilation plan. *Id.*

Weekly determined that it was "reasonably likely" that the violation would result in "lost workdays or restricted duty," that the violation was significant and substantial, that three employees were affected, and that the operator's negligence was high. A civil penalty in the amount of $2,473.00 has been proposed for this violation.

1. <u>The Violation</u>

Weekly is an MSHA mine inspector who has held that position since 2005. (Tr. 19). Prior to joining MSHA he worked in the mines in Alabama for twenty-five years. He held a number of positions in the mining industry where he accrued a working knowledge of ventilation systems and ventilation controls. (Tr. 20-21).

Weekly arrived at the Shelby Coke Mine during the day shift on November 27, 2007. At 7:00 a.m. he left the surface to travel underground with Mr. Clements and the two arrived at the

#5 entry at approximately 9:00 a.m. (Tr. 32, 57). While production was the norm on the day shift, there was no activity at the #5 entry when Weekly and Clements arrived. (Tr. 22-24).

Immediately upon arriving at the #5 entry, Weekly observed that a full cut of 30 feet had been made in that entry, but it had not yet been roof bolted. He observed that the line curtain outby the #5 entry had been pulled back 12 feet from the last row of bolts. He further observed that there was no exhaust curtain across the entry and air was short-circuiting directly to the return instead of traveling into the entry or face area. (Tr. 30). Clements confirmed Weekly's observations. (Tr. 112).

The ventilation plan and the citation issued by Inspector Weekly refer to two curtains in the area of the #5 entry that act as ventilation controls: (1) a "blowing curtain," also known as a "line curtain," and (2) an "exhaust curtain."

The Coke Mine's ventilation plan requires that a "line curtain" be maintained "no greater than 30 feet from the point of deepest penetration in all *unbolted idle working places*." Gov. Ex. 3 at 5 ¶ 7(emphasis added). (Tr. 26-28). According to Weekly, the line curtain was 12 feet from the last row of roof bolts and 42 feet from the face (i.e., more than 30 feet). Gov. Ex. 2.

I credit Weekly's testimony and find that the line curtain was more than 30 feet from the point of deepest penetration and, therefore, was in violation of the ventilation plan. Weekly explained that the position of the curtain prevented air from reaching the #5 entry, and instead of reaching the face, caused the air to short circuit into the return. (Tr. 24). Clements agreed that the curtain was inby the rib in the crosscut and was 42 feet from the face. (Tr. 111-112). Clements was unable to explain exactly why the line curtain had been pulled back or how long it had been in that position.

The mine's ventilation plan also requires that an "exhaust curtain" be maintained "within 30 feet of the face" while mining is occurring. Gov. Ex. 3 at 5 ¶ 3; (Tr. 26-28). According to Weekly, and confirmed by Clements, there was no exhaust curtain present when the inspection was conducted. (Tr. 114). Weekly determined that the area had recently been mined, most likely on the last production shift the evening prior to the inspection. Weekly testified that he looked carefully for any sign that a curtain had been hung in the area, specifically to determine if the curtain had been in place when the 30-foot cut had been made. He examined the roof and the bolts, and looked for evidence of nails or marks that would have indicated the previous presence of an exhaust curtain. (Tr. 69). He did not see the "pogo sticks" that are often used to hold the curtain in place, and he saw no material that could have been used as a curtain. (Tr. 68). Based on his observations, Weekly determined that an exhaust curtain had never been in place as required by the plan. (Tr. 38, 68-69).

Clements, referencing the company production report, testified that on November 26, 2007, coal was cut for 28 feet in the #5 entry. Resp. Ex. 9 at 3; (Tr. 121-122). However, the following morning, when the two arrived on the section, there was no activity. Shelby argues, therefore, that an exhaust curtain is only required when miners are working at the face, and, at the time of the inspection, coal was not being mined in the area; hence no one was working at the face and no violation of the ventilation plan existed.

While no one was working at the face, there is credible testimony that there was work conducted in the area without the proper ventilation. Weekly's testimony that he made a careful search for any sign of the previous existence of an exhaust curtain in the area, and none could be found, demonstrates that no curtain was ever in the area, even while the work was being done on the prior shift. When it came time to abate the violation and hang the curtain, Clements was unable to locate one in the area of the #5 entry and had to travel to another area in the mine to retrieve a curtain and return it to the #5 entry to be hung as required by the plan. (Tr. 77). While coal was not being mined at the time of the inspection, there was no sign that an exhaust curtain had ever been in place. Because an exhaust curtain was never in place, and a cut had been made which would have necessitated miners working at the face, Shelby was in violation of its ventilation plan for the second time. *See* Gov. Ex. 3 at 5 ¶ 3.

After the citation for the plan violation was issued, Clements conducted an internal investigation to determine why the ventilation plan was not being followed in the #5 entry. (Tr. 129). He spoke to Jerry Wells, the foreman on the production shift on the evening prior to the inspection. Wells told Clements that he had observed a curtain in place; however, he could not confirm which curtain (i.e., line or exhaust) he saw during the production. (Tr. 119-120). Wells could not explain who removed the curtain after he left the area, why the curtain was removed, or when it was removed. He also could not address why or when the line curtain had been pulled back twelve feet in violation of the ventilation plan. Clements confirmed that he could learn nothing further about the position of either curtain but he recalls that someone told him that they took down the exhaust curtain to "scoop up some muck." (Tr. 123). There was no explanation about why the curtain had not simply been pulled aside or why it had not been returned when the clean up was complete.

Shelby argues that the curtain had to be in place to make the cut in order for the continuous miner to operate. Clements reasoned that a cut could not be made without the ventilation controls in place because, without the air moving to the face, methane levels would rise and automatically shut down the continuous miner. He believes that the safety device on the machine would have prevented mining if proper ventilation were not in place. Wells agreed with Clements and confirmed that so much gas is emitted while the coal is being mined that it could not be done without ventilation in place. (Tr. 15). Therefore, Clements opined, the exhaust curtain had been in place during mining but was removed to clean the area, and therefore, was not a violation. Wells on the other hand explained that cleanup is done only after the roof is bolted because it is not safe to clean in an unbolted area, such as was the case in the #5 entry. (Tr. 155). Given the discrepancy in the testimony of Shelby's witnesses, I do not credit the theory advanced by Clements, that the curtain had been removed to clean.

In an enforcement proceeding under the Act, the Secretary has the burden of proving all elements of an alleged violation by a preponderance of the evidence. *In re: Contests of Respirable Dust Sample Alteration Citations*, 17 FMSHRC 1819, 1838 (Nov. 1995), *aff'd sub nom. Sec'y of Labor v. Keystone Coal Mining Corp.*, 151 F.3d 1096 (D.C. Cir. 1998); *ASARCO Mining Co.*, 15 FMSHRC 1303, 1307 (July 1993); *Garden Creek Pocahontas Co.*, 11 FMSHRC 2148, 2152 (Nov. 1989). The Secretary has met her burden of proving that the mine was not following its ventilation plan in two specific areas on the day of the inspection.

2. Significant and Substantial Violation

A significant and substantial ("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." 30 U.S.C. § 814(d)(1). 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*, 861 F.2d 99, 103-04 (5th Cir. 1988), *aff'g Austin Power, Inc.*, 9 FMSHRC 2015, 2021 (Dec. 1987) (approving *Mathies* criteria).

As noted above, I find that there is a violation of the mandatory safety standard as alleged by the Secretary. Further, I find that the violation contributes to the danger of an explosion or ignition of methane at the #5 entry. In analyzing the hazard presented by methane, the critical question is whether there was any likelihood of explosive concentrations of methane coming into contact with an ignition source. *See Texasgulf, Inc.*, 10 FMSHRC 498, 501 (Apr. 1988). Although Weekly was unable to go to the face of the #5 entry to take a methane level reading because the roof of the entry had not yet been supported, the condition clearly pointed to a buildup of methane in the working area. The ventilation had been short circuited in two regards, both with the pulled back curtain and the absence of the exhaust curtain, resulting in no air movement at the face. It would take little time for methane to build up to a dangerous level in that entry. The mine's history of ignitions, coupled with a build up of methane, clearly creates a hazard.

The third element of the *Mathies* criteria often presents difficulties in determining whether a violation is S&S. 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 consideration of the length of time that the violative condition existed prior to the citation and the time it would have existed if normal mining operations had continued. *Elk Run Coal Co.*, 27 FMSHRC 899, 905 (Dec. 2005); *U.S. Steel Mining Co., Inc.*, 6 FMSHRC 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 length of time that the violative condition existed prior to the citation was significant. Weekly testified that, after a diligent search, he saw no evidence that an exhaust ventilation curtain had ever been in place at the #5 entry and therefore the condition had existed on the prior evening shift, through the night shift and into the day until Weekly arrived. Wells, on the other hand, testified that he observed a curtain in place about twelve hours prior to the violation. I have credited the testimony of Weekly that no exhaust curtain had ever been put in place, and that the violation existed the evening before the inspection, giving ample time for methane to build in the area.

Weekly testified that he believed an injury was reasonably likely to occur. He based this conclusion on his determination that the #5 entry was an unventilated area where gas was being allowed to build up. Given his experience, and the direction of the air flow, he had no doubt that the face had no air movement and hence, methane was building in that area. (Tr. 40). The fact that this is a gassy mine with a history of ignitions, along with the fact that roof bolting would next occur in the area, made it reasonably likely that an ignition or explosion would occur in the unventilated area resulting in an injury. In the normal mining sequence, the roof bolter would have been brought in to begin bolting the area so that mining could continue. Weekly explained that he is aware of a number of methane ignitions caused by roof bolters. (Tr. 41). When the bolter drills the hole in advance of placing the roof bolt, the hot bit can hit the methane that has not been carried away or hit a bleeder and ignite. This mine has many methane bleeders, and without ventilation in place the roof bolter would, not only ignite the methane that had accumulated without ventilation, but would be more likely to ignite the stream of gas from the bleeder, resulting in an explosion or at the very least a burn injury to those working in the area. A previous ignition at the mine which caused burn injuries to two miners substantiates the Secretary's argument that the injuries could be sustained and those injuries would be serious.

Weekly indicated that three people were affected by the lack of ventilation. Gov. Ex. 2. He determined that two roof bolters and one service person who would be working the scoop would have been exposed to the condition he cited. Shelby agrees that roof bolters would have entered the area next to secure the roof, while the service man would operate the scoop to clean up.

Shelby disputes the S&S designation and presented evidence that the continuous miner would automatically stop cutting and shut down if dangerous methane levels were present.

Therefore, Shelby argues, it is impossible to operate without air flow to the face. The argument was not extended to the roof bolting machines, however, that were scheduled to enter the area next in the normal course of mining.

Shelby also argues that the previous ignitions in the mine occurred during the production shift and had nothing to do with ventilation curtains and therefore ignition is unlikely in this idle area. Clements testified that, normally, the continuous miner would hit an area with methane, causing the various ignitions that had been reported to occur. One of the ignitions was investigated by Weekly and he agreed that it was during a production shift and that the ventilation plan was being followed at the time of the ignition. (Tr. 46-48). However, without the ventilation in place, as it had been for the previous ignitions, it is even more likely that a hazard exists, as there is nothing to move the methane away from the source of ignition.

Shelby's failure to comply with its approved ventilation plan resulted in extremely hazardous conditions in locations where persons were scheduled to travel and work. Weekly said that the mine was "setting itself up to have another ignition." (Tr. 44). Any injury that might result from an ignition of methane or exposure to oxygen-deficient air would be serious, and potentially fatal. Therefore, I find it was reasonably likely that the hazard would result in an injury and that injury would be serious.

3. Unwarrantable Failure

The term "unwarrantable failure" is defined as aggravated conduct constituting more than ordinary negligence. *Emery Mining Corp.*, 9 FMSHRC 1997, 2004 (Dec. 1987). Unwarrantable failure is characterized by such conduct as "reckless disregard," "intentional misconduct," "indifference," or the "serious lack of reasonable care." *Id.* at 2003-04; *Rochester & Pittsburgh Coal Co.*, 13 FMSHRC 189, 193-194 (Feb. 1991). Aggravating factors include 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 were necessary for compliance, the operator's efforts in abating the violative condition, whether the violation was obvious or posed 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); *Mullins & Sons Coal Co.*, 16 FMSHRC 192, 195 (Feb. 1994); *Windsor Coal Co.*, 21 FMSHRC 997, 1000 (Sept. 1999); *Consolidation Coal Co.*, 23 FMSHRC 588, 593 (June 2001). 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. *Consolidation Coal Co.*, 22 FMSHRC at 353.

In October 2006, the mine began to experience a number of ignitions at the face. Steps were taken by MSHA and Shelby to modify the ventilation plan as needed to prevent such ignitions. *See* Gov. Ex. 16. MSHA personnel were present at the mine for many days, and, with each new ignition, worked with Shelby to modify the ventilation system as needed. The ignitions were dangerous and, most importantly, occurred while ventilation was in place. With the history of ignitions, the presence of MSHA, the investigations and the ventilation changes, it is safe to say that everyone at the mine was aware of the methane problems. The ignitions were ongoing with at least four occurring between October and the time of the citation near the end of

November. Proper ventilation should have been a high priority for everyone at the mine, yet it appears that it was not. Government exhibits six through sixteen describe the ignitions that were occurring regularly, and explain that in at least one case miners were seriously injured during an ignition. Gov. Exs. 6-16.

The Secretary established that Shelby was on notice that it needed to do more to ensure that the faces were adequately ventilated at all times. However, the problem with ignitions persisted. Based on the evidence presented at the hearing, I conclude that the ventilation was restored to the cited #5 entry only after Weekly pointed out that there was no air movement. Had he not arrived at the entry at that time, the ventilation would not have been immediately restored. As the inspector explained "[t]hey knew their past history of the gas in [the] mine[] and that they needed to keep their ventilation up, and to just have no ventilation anywhere in the area and no evidence that ventilation had ever been there[,] to me[,] was aggravated conduct." (Tr. 67). The violation was exceedingly obvious and Shelby demonstrated aggravated conduct constituting more than ordinary negligence.

Shelby argues that the violation was not unwarrantable because the curtain had been in place during the mining cycle the day before and it had been taken down to clean up around the area. I have addressed the differences of opinion regarding whether the curtain was in place or why or when it was removed. The operator's argument as to why the curtain was removed is difficult to understand. The cleaning up of muck generally occurs after the roof is bolted and supported so as to be safe. Further, even if mucking were occurring, the curtains would only be moved aside so that the air would continue to be moved to the face. (Tr. 75). After the mucking occurs, the curtain must be returned to its original location. There is no evidence that any effort was made to restore the ventilation, and it seems likely that none would have been made had Weekly not arrived on the scene.

Shelby also argues that the previous methane ignitions occurred while coal was being mined, and consequently no higher degree of negligence can be imputed for ignoring ventilation in idle areas. Shelby further contends that the history of ignitions is not important for determination of gravity and negligence because the earlier ignitions occurred in working areas, as opposed to idle areas, as is the issue in this case. Given that the Coke Mine is a gassy mine subject to ignitions, Shelby has a duty to see that the ventilation plan is strictly adhered to. While ignitions during the mining process certainly require Shelby to be extra vigilant during the operation of the continuous miner, they also put Shelby on notice that there are unknown bleeders in the mine which have the known potential for ignitions. Additionally, the fact that ignitions occurred in spite of the presence of the automatic shutoff safety feature on the continuous miner is further evidence that Shelby was aware of the high potential for ignitions and the necessity of taking extra precautions to prevent such from happening.

I find that the mine was more than careless, and exhibited more than ordinary negligence in having two key ventilation controls moved or missing in an area where methane can build and work will shortly occur. The mine was clearly on notice that ignitions are a problem, that the mine was gassy, and that leaving the entry without any ventilation at the face is a formula for disaster.

b. Order No. 7692076

Inspector Weekly issued Order No. 7692076 on November 27, 2007 for an unwarrantable violation of 30 C.F.R. § 75.360(b)(3). The order describes the violation as follows:

> An inadequate pre-shift examination was performed on the #1 section at the Coke mine on 11/27/07 on the owl shift. The pre-shift examiner did not correct the ventilation in the #5 face, the blowing curtain was 12 feet from the last row of bolts, 42 feet from the face and there was no back drop or exhaust curtain in place allowing the air to short circuit directly to the return and not ventilate the #5 face. This mine has had 6 ignitions from 3/3/0/2006 until 11/2/2007, one resulting in 2 employees receiving burns. If this condition is allowed to exist methane will build in this entry and would cause a ignition or explosion.
>
> Gov. Ex. 4

Weekly determined that it was "reasonably likely" that the violation would result in an injury involving "lost work days or restricted duty," that the violation was S&S, that three employees were affected, and that the operator's negligence was high. The Order was issued pursuant to section 104(d)(1) of the Act, and alleges that the violation was the result of Shelby's unwarrantable failure to comply with the standard. A civil penalty in the amount of $5,211.00 has been proposed for this violation.

The fact that the conditions, as cited by Weekly and discussed above, existed at the time of the inspection is not disputed. Clements, who traveled with Weekly during the inspection, confirmed the existence of the conditions. He testified that there was not an exhaust ventilation curtain and that the blowing curtain was more than 30 feet back from the face. In addition to the ventilation violation, Weekly also found a number of roof control violations which he included in his determination that a preshift examination was not adequately conducted.

1. <u>The Violation</u>

Order No. 7692076 alleges a violation of 30 C.F.R. § 75.360(b), which requires that preshift examinations be conducted in areas where miners are scheduled to work or travel, and that the certified person conducting the examination "examine for hazardous conditions, test for methane and oxygen deficiency, and determine if the air is moving in its proper direction."

Joel Stevens, a certified preshift examiner, conducted the preshift examination for the 7:00 a.m. to 3:00 p.m. day shift on November 27, 2009. (Tr. 130-131, 139). The examination began around 3:00 a.m. and was completed around 5:00 or 6:00 a.m. (Tr. 127). The examination report did not list any hazardous conditions or violations. However, a few hours later, Weekly, while conducting a spot inspection, found what he believed to be violations of safety standards and issued the ventilation citation discussed herein, as well as roof control citations. (Tr. 34-35). The preshift examiner's report does not mention any ventilation problems, nor does it mention the roof areas that were cited by the inspector. (Tr. 131).

The Secretary's position is that the miner charged with the duty of conducting the preshift examination conducted an inadequate preshift examination because he did not report the ventilation and roof control problems, nor did he correct the ventilation problems as required. (Tr. 78, 81, 33-35). The roof control citations referred to unsupported roof in the #1, #4 and #5 entries. (Tr. 34). Respondent, on the other hand, contends that the preshift examination was timely completed and accurately reflected that no hazardous conditions existed when the examination was made (i.e., that the conditions did not exist until after the preshift). Specifically, the Respondent avers that the ventilation curtains were in place and, therefore, were not required to be noted on the preshift examination report. The Respondent did not address why the areas of the roof that were cited by Weekly were not included in the preshift examination.

The critical question is whether the conditions existed at the time of the preshift examination. The hazardous conditions most likely developed, as Weekly believed, during the production shift, more than twelve hours before the preshift was conducted. (Tr. 72-75). Weekly cited the condition as having been present for five hours, based on the time when the preshift examination was to have occurred. I have already credited Inspector Weekly's testimony that the ventilation violations existed at the time the coal was cut from the #5 entry on the second shift on November 26th. It follows that the ventilation controls were missing, and violation apparent, when Stevens conducted his preshift examination in the early hours of November 27th.

During his testimony Clements identified Joel Stevens, a foreman at the Coke Mine, as the preshift examiner. Clements testified that he did not follow up with Stevens to determine whether or not the conditions, as cited by Weekly, existed at the time Stevens conducted the preshift examination. (Tr. 131-132). Moreover, Clements did not provide any justification for the bad roof area or raise any defense that the roof violation occurred during the period after the preshift examination but prior to the inspection.

Upon consideration of the above factors, I find that, at the time of the preshift examination, hazardous roof and ventilation conditions existed. Further, I find that, the conditions should have been discovered, corrected and reported during a proper preshift examination and, hence, a violation is proven.

2. Significant and Substantial

A significant and substantial ("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." 30 U.S.C. § 814(d)(1). 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).

I find that there was a violation of an underlying mandatory safety standard. The preshift examiner not only failed to record the presence of hazardous conditions, but also, and more

importantly, failed to even identify those hazards. In doing so, Shelby violated both section 75.360(a)(1), requiring the preshift examination, and section 75.360(b), requiring the examiner to look for "hazardous conditions, test for methane and oxygen deficiency, and determine if the air is moving in its proper direction." 30 C.F.R. §§ 75.360(a)(1), 75.360(b). Second, I find that the failure to identify the conditions and note them on the preshift examination report would have resulted in at least three miners entering and working in a dangerous area that was both unbolted and unventilated.

With regard to the third element of the *Mathies* factors, the Commission has held that judges should ordinarily not rely on presumptions. *Manalapan Mining Co.*, 18 FMSHRC 1375, (Aug. 1996). Shelby argues that the violation is not S&S because it is unlikely that there would have been any activity in the area prior to the ventilation being restored. Hence, failure on the part of the examiner to notice this violation cannot result in an injury. I must analyze whether there was a reasonable likelihood that the hazards contributed to by the violation would result in an injury in the event that the hazards that went unnoticed by the preshift examiner were not corrected prior to normal mining operations. While Shelby argues otherwise, the fact that the cited area was idle at the time of the citation has little bearing on the S&S finding. Weekly confirmed that while the #5 entry was idle during his inspection, other areas were not. The men had already entered the mine for the day shift when Weekly observed the violations of the roof and the ventilation plans and, therefore, the miners were already placed in a dangerous situation; one intended to be corrected by the requirement of the preshift examination.

The Commission has recognized that the preshift examination requirements are "of fundamental importance in assuring a safe working environment underground." *Buck Creek Coal Co.*, 17 FMSHRC 8, 15 (Jan. 1995); *see also* 61 Fed. Reg. 9764, 9790 (Mar. 11, 1996) ("The preshift examination is a critically important and fundamental safety practice in the industry. It is a primary means of determining the effectiveness of the mine's ventilation system and of detecting developing hazards, such as methane accumulations, water accumulations, and bad roof."). In *Buck Creek*, the Commission concluded that the third *Mathies* element had been proven when miners were allowed to work in a preshifted area even though another area of the mine that should have been examined was not. 17 FMSHRC 8 (Jan. 1995). There, the Commission found that "hazards in an unexamined portion of the mine could affect" the area in which miners were working. *Id*. at 14; *Jim Walter Resources Inc*. 28 FMSHRC 1068 (Dec 19, 2006). The failure of the preshift examiner to recognize the dangers presented by the unbolted and unventilated area of the #5 entry could result in an ignition, explosion, or potentially a roof fall in the areas cited. The occurrence of any of these events is reasonably likely to result in injuries to the roof bolters or the service man that would be running the scoop. Finally, as I have indicated above, the injuries associated with methane ignitions and explosions are serious in nature.

Preshift examinations play a crucial role in ensuring that miners work in a safe environment. I credit the testimony of Weekly that conditions which presented an explosion hazard were present in the area and were not noted by the examiner. The hazards created by lack of ventilation and unsupported roof in several locations, and the failure of the preshift examiner to warn miners, or correct the conditions, exposed miners to a reasonable likelihood of serious injury.

3. Unwarrantable Failure

The term "unwarrantable failure" is defined as aggravated conduct constituting more than ordinary negligence. *Emery Mining Corp.*, 9 FMSHRC 1997, 2004 (Dec. 1987). Unwarrantable failure is characterized by such conduct as "reckless disregard," "intentional misconduct," "indifference," or the "serious lack of reasonable care." *Id.* at 2003-04; *Rochester & Pittsburgh Coal Co.*, 13 FMSHRC 189, 193-194 (Feb. 1991). Aggravating factors include 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 were necessary for compliance, the operator's efforts in abating the violative condition, whether the violation was obvious or posed 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); *Mullins & Sons Coal Co.*, 16 FMSHRC 192, 195 (Feb. 1994); *Windsor Coal Co.*, 21 FMSHRC 997, 1000 (Sept. 1999); *Consolidation Coal Co.*, 23 FMSHRC 588, 593 (June 2001). 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. *Consolidation Coal Co.*, 22 FMSHRC at 353.

The Secretary argues that the violation was the result of an unwarrantable failure because the conditions were extensive, obvious and existed for more than one shift, that they posed a high degree of danger, and that the failure to note or record them on the preshift report evidenced an indifference to safety. The evidence justified a finding that the conditions, as Weekly found them, had existed at the time of the preshift examination and hence, the Secretary's argument is well founded.

Shelby offered little evidence to contradict the Secretary's allegation of unwarrantable failure to comply with the requirement of a thorough and meaningful preshift examination. Clements testified that he looked into the ventilation violation, but offered little information about the violation for the preshift examination beyond providing the name of the individual who was responsible for conducting it. Clements did not investigate the allegations of an inadequate preshift, as he alleged he had done regarding the ventilation citation, and offered no explanation as to why the examiner failed to notice the violative conditions.

The history of the mine demonstrates an institutional lack of interest in demanding that the preshift examinations be done adequately at this mine. *See* Gov. Ex. 1. In February 2007, the mine received an unwarrantable failure order for failure to conduct an adequate preshift examination. Two months later a citation was issued for failing to meet the requirements of the preshift. During the nine months prior to this violation the mine was warned about the inadequacy of its preshift examinations. Everyone at the mine, including the preshift examiner, knew that the ventilation system presented a challenge because the mine had at least six ignitions from March 2006 until just a few weeks before Weekly issued his citation. The actions of the preshift examiner constitute high negligence. The examiner failed to do his job even in a cursory fashion. It was obvious that the ventilation controls were not in place, one curtain was missing and another was pulled back 12 feet. Yet, the preshift examiner did not mention the problem and subsequently didn't correct the problem prior to the workers entering the mine.

I find that the evidence establishes that the failure to conduct an adequate preshift examination constituted more than ordinary negligence on the part of Shelby. Shelby's behavior and lack of interest in the importance of the preshift examination can be accurately characterized as "intentional misconduct," which the Commission has concluded "is a form of unwarrantable failure for purposes of the Mine Act." *Rochester & Pittsburgh Coal Co.*, 13 FMSHRC 189, 194 (Feb. 1991).

II. PENALTY

The principles governing the authority of Commission Administrative Law Judges to assess civil penalties de novo for violations of the Mine Act are well established. Section 110(i) of the Mine Act delegates to the Commission and its judges "authority to assess all civil penalties provided in [the] Act." 30 U.S.C. § 820(i). The Act delegates the duty of proposing penalties to the Secretary. 30 U.S.C. §§ 815(a), 820(a). Thus, when an operator notifies the Secretary that it intends to challenge a penalty, the Secretary petitions the Commission to assess the penalty. 29 C.F.R. § 2700.28. The Act requires that, "in assessing civil monetary penalties, the Commission [ALJ] shall consider" six statutory penalty criteria:

> [1] the operator's history of previous violations, [2] the appropriateness of such penalty to the size of the business of the operator charged, [3] whether the operator was negligent, [4] the effect of the operator's ability to continue in business, [5] the gravity of the violation, and [6] the demonstrated good faith of the person charged in attempting to achieve rapid compliance after notification of a violation.
>
> 30 U.S.C. § 820(i).

In keeping with this statutory requirement, the Commission has held that "findings of fact on the statutory penalty criteria must be made" by its judges. *Sellersburg Stone Co.*, 5 FMSHRC at 292. Once findings on the statutory criteria have been made, a judge's penalty assessment for a particular violation is an exercise of discretion, which is bounded by proper consideration of the statutory criteria and the deterrent purposes of the Act. *Id.* at 294; *Cantera Green*, 22 FMSHRC 616, 620 (May 2000).

I accept the stipulation of the parties that the penalties proposed are appropriate to this operator's size and ability to continue in business, and that the violations were abated in good faith. The history is normal for this size operator, with the exception of the violations discussed above. I find that the Secretary has established high negligence on the part of Shelby for both violations. Further, I find that the Secretary has established the gravity as listed in each citation.

Both violations in this case are extremely serious, given this mine's history of ignitions and the possibility for a major accident. Not only was the ventilation violation obvious to any person who approached the #5 entry, it was not recorded by the person charged with ascertaining that the mine was safe for miners who were, or would be, working in the area. The mine had at least six ignitions prior to this incident and each had been investigated. It is fair to say that the

mine paid little attention to the safety of its miners in ignoring its history and the potential for disaster.

III. ORDER

Based on the criteria in section 110(i) of the Mine Act, 30 U.S.C. § 820(i), I assess a penalty of $5,000.00 for each violation. Shelby Mining Company, LLC is hereby **ORDERED** to pay the Secretary of Labor the sum of $10,000.00 within 30 days of the date of this decision.[1]

Margaret A. Miller
Administrative Law Judge

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/atc

[1] Payment should be sent to Mine Safety and Health Administration, U.S. Department of Labor, Payment Office, P.O. Box 790390, St. Louis, MO 63179-0390.