FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

OFFICE OF ADMINISTRATIVE LAW JUDGES
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December 5, 2001

SECRETARY OF LABOR,	:	CIVIL PENALTY PROCEEDING
MINE SAFETY AND HEALTH	:	
ADMINISTRATION (MSHA),	:	Docket No. CENT 2001-30-M
Petitioner	:	A.C. No. 23-01787-05549
v.	:	
	:	West Fork Mine/Mill
THE DOE RUN COMPANY,	:	
Respondent	:	

DECISION

Appearances: Gregory Tronson, Esq. and Lydia Tzagoloff, Esq., Office of the Solicitor, U.S. Department of Labor, Denver, Colorado;
R. Henry Moore, Esq., Buchanan Ingersoll, Pittsburgh, Pennsylvania.

Before: Judge Bulluck

This case is before me upon Petition for Assessment of Penalty filed by the Secretary of Labor, through her Mine Safety and Health Administration ("MSHA"), against the Doe Run Company ("Doe Run"), pursuant to Section 105(d) of the Federal Mine Safety and Health Act of 1977 ("the Act"), 30 U.S.C. § 815(d). The petition seeks a civil penalty of $25,000.00 for an alleged violation of section 57.15005, 30 U.S.C.
§ 57.15005.

A hearing was held in St. Louis, Missouri. The parties' Post Hearing Briefs are of record. For the reasons set forth below, the citation shall be AFFIRMED, as modified.

I. Stipulations

1. Doe Run operates the West Fork Mine, MSHA ID No. 23-01787, an underground lead and zinc mine near Bunker, Missouri.

2. Doe Run and its mine are subject to the jurisdiction of the Federal Mine Safety and Health Act of 1977 ("the Act"), 30 U.S.C. § 801 et seq.

3. In the year 2000, Doe Run worked 1,719,972 hours and West Fork worked 228,525 hours. West Fork was a medium-sized mine and Doe Run is a medium-sized operator.

4. In the 24 months prior to January 24, 2000, the West Fork Mine had 28 assessed violations in 42 inspection days.

5. The presiding Administrative Law Judge has jurisdiction over these proceedings, pursuant to Section 105 of the Act, 30 U.S.C. § 815.

6. The parties stipulate to the authenticity of their exhibits, but not to the relevance or truth of the matters asserted therein.

7. Citation No. 7880464 was issued pursuant to Section 104(a) at Doe Run's West Fork Mine on January 24, 2000, alleging a violation of 30 C.F.R. § 57.15005.

8. Under the heading and caption "Condition or Practice" the citation alleges as follows:

> A shaft maintenance man was fatally injured at this operation on October 18, 1999, when his lanyard snagged a bolt on a shaft guide fish plate. The lanyard had not been attached to the hoist cable, instead it was left with both clips attached to the belt D-ring. Standing on the guard elevated the worker above the handrail, allowing a 32 inch loop to overhang the handrail and hook the bolt on the skips ascent.

9. The citation was terminated on January 12, 2000, when a newly redesigned cage was installed.

10. The subject citation was properly served by duly authorized representatives of the Department of Labor upon agents for Doe Run on the date and at the place indicated therein.

11. The subject citation may be admitted into evidence to establish the issuance, but not for the truth of any statement asserted therein.

12. Doe Run's mining operations affect interstate commerce.

13. Mining at the West Fork Mine was conducted by room and pillar mining by a process of drilling and shooting the faces and then loading the material into trucks for transport.

14. In 1998, the Doe Run Company took over the operation of West Fork from Asarco Incorporated.

15. The mine was normally operated two, ten-hour shifts per day, five days a week. Total employment was 101 employees. The mine is no longer producing ore and no longer has a separate MSHA ID number.

16. The ore body was drilled, blasted, loaded onto haul trucks, and transported to the

production shaft.

17. The ore was hoisted by skip to the surface where it was crushed and conveyed to the mill.

18. This case arose out of an accident on October 18, 1999. At about 9:30 a.m. on that day, James W. ("Billy") Vest, a shaft maintenance repairman, was fatally injured while performing a routine shaft inspection.

19. Mr. Vest was working with another employee, Willard Cooper, another maintenance repairman.

20. The accident occurred during the weekly hoist and shaft inspection that was typically performed on Monday mornings.

21. Mr. Vest and Mr. Cooper had already inspected the service hoist first that morning and were in the process of starting the inspection process of the production hoist and shaft.

22. The inspection involves riding the work deck on top of the production skip.

23. The work deck on top of the skip was provided with a top handrail, midrail and 3 inch high toe board around the perimeter of the work deck on all four sides. The top handrail was 40 inches above the deck floor and the midrail was 22 inches above the work deck floor. The top guide rollers projected above the work deck floor and were guarded by expanded metal enclosures 26.5 inches high x 12 inches deep x 30 inches wide. The work deck was protected by a 54 x 53 inch bonnet installed at a height of 93.5 inches above the deck floor.

24. The railings on the entrance side to the work deck were removed immediately after the accident to provide better access to provide assistance to Mr. Vest. The photographs taken after the accident do not show the two railings on one side of the work deck but they were present at the time of the accident.

25. The shaft opening was guarded with a handrail and provided with a gate for access onto the top of the skip. Additionally, the collar level access was restricted by a fence equipped with a gate. The skip blocked the shaft when it was in position at the collar level of the shaft.

26. Mr. Vest and Mr. Cooper positioned the production skip at the shaft collar so they could step onto the work deck on top of the skip.

27. Mr. Vest and Mr. Cooper had accessed the work deck on top of the production skip.

28. Both Mr. Vest and Mr. Cooper were wearing safety belts and lanyards when they got on the work deck.

29. Mr. Vest radioed Gary Huffman, hoistman, at approximately 9:30 a.m. to raise the skip so he and Mr. Cooper could inspect the ore chutes in the head frame.

30. Mr. Vest received internal injuries from the safety belt and lanyard pulling him down against the handrail.

31. Mr. Vest had a total of 13 years and 9 months experience, all at West Fork. He had held the job of shaft maintenance repairman for 2 years and 9 months. He and Mr. Cooper had received the required training, including task training, in accordance with 30 C.F.R. Part 48. He and Mr. Cooper were experienced in the inspection of the hoist and shaft.

32. MSHA conducted an investigation with the assistance of mine management and selected employees.

33. After the accident, MSHA did a thorough inspection of the production hoist's electrical circuits and mechanical components and they were functioning properly. Tests were performed on the limit switches, speed and over travel devices, as well as the bell signal and all were functional and working properly.

II. Factual Background

On the morning of October 18, 1999, after completing a visual inspection of the service hoist that transports miners into and out of the underground levels of the mine, shaft maintenance repairmen Billy Vest and Willard Cooper began a weekly inspection of the production hoist and shaft (Tr. 24, 149-50). The production hoist moves ore from the mine to an above ground, elevated chute, and then dumps it into a bin (Tr. 64-65, 176). Inspection of the production hoist involves riding up to the top of the head frame to the ore chutes, on the work deck atop the production skip, for a maintenance check of the liners and scrolls, and a check of the shaft guide rails and fishplates during ascent and descent for build-up of calcium deposits, cracks, loose bolts and any conditions that could be hazardous in the shaft (Tr. 24, 34, 175-76, 202, 205-06). There are actually two skips, side-by-side, in the shaft; when one is up dumping ore the other is underground for loading (Tr. 63-64). After bringing the north skip to the collar, Billy Vest stepped onto one of two elevated wheel guard cages on the work deck, followed by Willard Cooper who stepped onto the other (Tr 150-151, 158-59). Both miners had on safety belts with lanyards (Stip. 28; Tr. 150, 152, 156). Cooper tied-off above the thimble on the rope, then turned his back to Vest, facing the shaft rails for the visual inspection on ascent (Tr. 156-59; Ex. P-2, p. 5). The last time Cooper saw Vest before the accident, Vest was standing on the wheel guard cage, facing the center hoist cable with his back to the guide rails and his lanyard attached to the back of his belt (Tr. 75-76, 159). As soon as Cooper tied-on, at approximately 9:30 a.m., Vest radioed to hoistman Gary "Sugarbear" Huffman to take them up to the chutes, and the skip began moving slowly (Stip. 29; Tr. 152, 159-60). At the same time, having not seen Vest tie-off, Cooper asked Vest what he was hooked onto, and as he turned around to face Vest, Vest was

already caught (Tr. 152, 160-61, 167). Vest's lanyard, hanging outside of the moving skip into the shaft, had snagged a bolt on a fishplate and pulled him down against the railing (Tr. 25). Cooper found Vest sitting on top of the wheel guard cage with his left leg underneath him and the other on the work platform floor, with his back against the top handrail (Tr. 16, 53, 152-55, 187). Cooper immediately belled the skip to a stop, then down, until he saw slack in Vest's belt (Tr. 153-54). The skip had traveled about a foot when the lanyard snagged the bolt, and an additional two feet before it stopped (Tr. 25). Cooper immediately released Vest's belt and radioed Huffman for help (Tr. 155-56). While workers were administering first aid to Vest, he commented, "I killed myself," and ultimately died as a result of internal injuries (Tr. 78, 165).

MSHA Inspector Michael Davis arrived on-site on October 19th and, along with MSHA Inspectors Robert Seelke and Vern Miller, conducted an accident investigation. On January 12, 2000, prior to issuance of Citation No. 7880464 by Inspector Davis on January 24th , Doe Run abated the hazardous condition by redesigning the cage, and the citation was terminated the same day it was issued (Tr. 45, 77). The work platform floor surrounding the rope attachment and thimble was raised above the wheel guard cages to increase the standing and work surface, and screening was installed to prevent objects from extending beyond the cage (Tr. 191-92). Citation No. 7880464 alleges that Doe Run's violation of section 57.15005 was "significant and substantial" and the result of the operator's moderate negligence.

III. Findings of Fact and Conclusions of Law

A. Fact of Violation

30 C.F.R. § 57.15005 provides, in pertinent part, that "[s]afety belts and lines shall be worn when persons work where there is danger of falling. . . ." Like the surface companion to the underground standard at issue herein, the mandate that safety belts and lines be worn under section 57.1005 necessitates that they be worn properly. *Mar-Land Industrial Contractor, Inc.*, 14 FMSHRC 754, 757 (May 1992), *citing Austin Power, Inc.*, 9 FMSHRC 2015 (December 1987), *aff'd* 861 F.2d 99 (5th Cir. 1988). Furthermore, the Commission has held that "[t]he fact that belts are not worn properly is a violation under this standard for which the operator is liable irrespective of employee misconduct." *Id.* (citations omitted).

The parties have stipulated that safety belts and lanyards were worn by Billy Vest and Willard Cooper when the accident occurred (Stip. 28). Doe Run has conceded that there was a danger of falling from the wheel guard cages on the skip (Tr. 224-25, 239-40). However, the company challenges that there was a danger of falling from the work platform floor, where it contends that Vest had been standing, because of the two-tiered handrails surrounding the skip. Moreover, Doe Run argues that there was no violation because Vest did not actually fall. Since it is undisputed that there was a danger of falling from the wheel guard cage, the issue, then, is whether that danger existed from the work platform floor, if I find that Vest had been standing there. An actual fall need not have occurred for a violation to be established. Under applicable precedent, a determination must be made as to whether a reasonably prudent person familiar with the mining industry and the protective purposes of the standard would have recognized a danger

of falling under the circumstances in this case. *Ideal Cement Co.,* 12 FMSHRC 2409, 2416 (November 1990); *Lanham Coal Co.,* 13 FMSHRC 1341, 1343 (September 1991).

Inspector Davis testified that he interviewed witnesses, took measurements, photographs and made sketches of the accident scene, compiled field notes, and concluded that Billy Vest's death was caused by his failure to properly wear his fall protection while riding the skip (Tr. 14-15, 18-19; Ex. P-1, P-2, P-3). Davis's conclusion was based, in part, on his findings that the size of the skip's work platform floor restricted work activity, and that Vest had been standing on one of the wheel guard cages when his lanyard snagged the bolt (Tr. 22-23, 29, 31-32). Davis testified that, in positioning Vest on the wheel guard cage, he considered the length of Vest's lanyard, the location of the bolt, the amount of travel of the skip, Vest's location after the accident, interview statements, and particularly Willard Cooper's statement that Vest had been standing on the cage (Tr. 25-26). That position, he explained, would have put the top handrail approximately 13 to 14 inches above Vest's foot (midcalf) (Tr. 27, 71; Ex. P-2, p.6). Finally, Davis testified that, because the hoist is a moving conveyance, the potential for falls always exists, irrespective of whether workers stand on the floor or elevated above the handrails on the wheel guard cages, due to unforseen jerks, sudden stops and falling objects, as well as the leaning and moving required of the workers in performance of their maintenance duties (Tr. 32-34, 85). In the instant case, he opined, had Vest's back not slammed into the shaft guide rail, he would have been pulled from the cage (Tr. 85-86). Therefore, he concluded, fall protection is always required "[a]ny time that they step on top of that conveyance" (Tr. 33-34).

In addition to testifying that Billy Vest had stepped onto the wheel guard cage just before the skip began its ascent, Willard Cooper also maintained that, because the work platform floor's standing room allowance of 8 ½ inches was "just too tight to turn around," and because the floor was generally wet, the maintenance crew always rode the skip standing on the cages (Tr. 164, 166, 168, 172-73; see also Tr. 22-23, 32). Myron "Rat" Halbert, whom Vest had been training to perform shaft inspections, similarly testified that he and Vest had always ridden on the wheel guard cages during entire inspections (Tr. 174, 178).

Gharib Ibrahim, a civil engineer at MSHA's Bruceton Research Center in Pittsburgh, Pennsylvania, assisted in determining Billy Vest's position at the time of the accident, and testified as an expert witness for the Secretary. Ibrahim testified that he had spoken with one of the investigators, reviewed the investigative notes, sketches and photographs, and run a computer analysis of the accident data (Tr. 94-95, 110). The two possible scenarios of where Vest had been standing, he explained, result in different horizontal and vertical forces exerted by his body on the top handrail: if he had been standing on the work platform floor the force would be downward with at least 1/3 of that force pushing outward, whereas standing on the guard cage would exert downward force with outward force almost diminished to zero (Tr. 96, 98-99, 101-02, 103-06, 144). Based on the downward deflection of 10 ½ inches and negligible outward deflection of the top handrail, Ibrahim opined that Vest had been standing on the wheel guard cage when the accident occurred (Tr. 97, 99-103, 120; Ex. 2, p.4; see Ex. 15). Vest had not been pulled out of the skip, he testified, because the shaft guide rail provided a barrier (Tr. 119-

20, 125).

Doe Run's witnesses disagreed with Garhib Ibrahim's conclusion as to Vest's placement on the skip. Safety specialist Owen Erickson opined, based on his own common sense, that no matter where Vest had been standing, because he was not a fixture, only vertical force would have been exerted on the handrail by his body (Tr. 217-20). Therefore, he reasoned, no conclusion as to Vest's position could be drawn from the defection of the top handrail (Tr. 220). Safety manager David Brown testified that, in his opinion, more time had elapsed than Cooper realized between Cooper's last view of Vest and when he found him injured, and that Vest had probably stepped down from the guard cage; otherwise, if he had been elevated on the cage, he would have fallen down the shaft (Tr. 252-55, 266-67, 271, 279). Neither Erickson nor Brown have any background or training in engineering, and for that reason I give their opinions little weight (Tr. 222, 266).

I have considered the evidence in its entirety respecting where Vest was situated when the accident occurred, including the MSHA video simulating a similar type of accident (Ex. R-1). Based on credible evidence that Vest had last been seen standing on the wheel guard cage, that he and other shaft maintenance workers had routinely conducted shaft inspections riding the cages, and Ibrahim's placement of Vest on the cage from an engineering analysis, I find that Vest had been standing on the cage when his lanyard snagged the fishplate bolt. It is also my finding that fall protection was required from all locations on the skip, and that a reasonably prudent person would have recognized the danger of falling for the reasons that Inspector Davis enumerated--it is a moving conveyance that can become unstable at any time, and the full range of maintenance duties requires movement on the part of the workers. As the Commission noted, finding a violation of section 56.1005 applicable to surface mines, where an employee had been standing on an 18 foot ladder installing a light fixture without benefit of a safety belt, "[e]ven a skilled employee may suffer a lapse of attentiveness, either from fatigue or environmental distractions, which could result in a fall." *Great Western Electric Co.*, 5 FMSHRC 840, 842 (May 1983). Indeed, Doe Run recognizes the danger of falling from moving hoists and provides safety belts at no cost to its employees. The company's Safety Rule Book, its Handbook of Safe Practices, and its Preventive Maintenance Work Order require use of safety belts and ropes during performance of shaft inspection or work (Tr. 34-39, 212-15; Ex. P-5, p. 25, P-6, p. 7). Moreover, Doe Run's Part 48 annual training of its employees and its weekly safety meetings address fall protection (Tr. 188, 196, 227-33; Ex. R-4, R-5, R-6). In this case, it is clear that Vest's failure to wear his safety belt and lanyard properly, as required, violated the standard. As a consequence, Doe Run is strictly liable.

B. Significant and Substantial

Section 104(d) of the Act designates a violation "significant and substantial"

("S&S") when it is "of such a nature as could significantly and substantially contribute to the cause and effect of a coal or other mine or safety hazard." A violation is properly designated S&S "if, based upon the particular facts surrounding the 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, 3-4 (January 1984), the Commission set forth the four criteria that the Secretary must establish in order to prove that a violation is S&S under *National Gypsum*: 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. *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* 9 FMSHRC 2015, 2021 (December 1987) (approving *Mathies* criteria). Evaluation of the third criterion, the reasonable likelihood of injury, should be made in the context of "continued mining operations." *U.S. Steel Mining Co.,* 6 FMSHRC 1573, 1574 (July 1984). Moreover, resolution of whether a violation is S&S must be based "on the particular facts surrounding the violation." *Texasgulf, Inc.,* 10 FMSHRC 498, 501 (April 1998).

Inspector Davis testified that he determined the violation to be S&S because of the resultant fatality (Tr. 40). The violation involved in this case created the discrete hazard of falling. Tragically, Billy Vest suffered the ultimate consequence of his failure to use fall protection properly and, furthermore, there is convincing evidence that, had the shaft guide rail not acted as a barrier, he would have fallen down the shaft. Because his injuries were fatal, I find that the violation was S&S and very serious.

C. Penalty

While the Secretary has proposed a penalty of $25,000.00, the judge must independently determine the appropriate assessment by proper consideration of the six penalty criteria set forth in Section 110(i) of the Act, 30 U.S.C. § 820(j). *See Sellersburg Co.,* 5 FMSHRC 287, 291-92 (March 1993), *aff'd*, 763 F.2d 1147 (7th Cir. 1984).

Doe Run is a medium-sized operator, with no violations of the same standard at issue in its two year history (Stips. 3, 4; Ex. 12). The proposed penalty will not affect Doe Run's ability to remain in business (Resp. Br. at 8).

The remaining criteria involve consideration of the gravity of the violation and Doe Run's negligence in causing it. As stated previously, I find the violation to be very serious. My assessment of Doe Run's negligence, however, differs substantially from that of the Secretary. Inspector Davis testified that he found Doe Run moderately negligent because there was no supervisory oversight of shaft inspections to ensure use of fall protection, by spot-check

observation or accompaniment, despite the heightened potential for falls in this line of work, and also because the lanyard was overly long (Tr. 40- 43, 44-45, 83). Respecting the lanyard, other than the bare allegation, no evidence has been presented to support this conclusion. On the other hand, the record is replete with evidence that Doe Run is a safety conscious operation, and that use of fall protection had been "pounded" into the shaft maintenance crew not only by management, but also by Billy Vest as trainer of many junior workers, and that fall protection had been properly and uniformly used at the mine (Tr. 55-56, 59-61, 77-78, 160-62, 166, 168-69, 175-80, 185-86, 188-90, 193-99; Ex P-1). Additionally, there is some evidence that management had periodically observed its maintenance crew riding the hoists (Tr. 184-85, 192-98). This level of observation, combined with Part 48 annual training and weekly safety meetings, leads me to conclude that Doe Run satisfied the level of care necessary to ensure the safety of its shaft maintenance crew and that the company was not negligent. The record in its entirety is simply lacking in evidence that Doe Run should have anticipated Vest's failure to tie-off, nor is there any indication that spot-checks would have prevented Vest's deviation from his routine, compliant behavior. Doe Run bears no duty, by law or regulation, to have supervisors present each time employees tie-off. *See Mar-Land,* 14 FMSHRC at 759. Therefore, having considered Doe Run's medium size, insignificant history of prior violations, seriousness of the violation, lack of negligence, and good faith abatement, I find that a civil penalty of $5,000.00 is appropriate.

ORDER

Accordingly, it is **ORDERED** that Citation No. 7880464 is **AFFIRMED**, as modified to reduce the level of negligence to "none," and the Doe Run Company is ordered to **PAY** a penalty of $5,000.00 within 30 days of the date of this decision. Upon receipt of payment, this case is **DISMISSED**.

Jacqueline R. Bulluck
Administrative Law Judge

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