FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION
OFFICE OF ADMINISTRATIVE LAW JUDGES
601 NEW JERSEY AVENUE, N.W., SUITE 9500
WASHINGTON, D.C. 20001

September 27, 2007

SECRETARY OF LABOR,	:	CIVIL PENALTY PROCEEDING
MINE SAFETY AND HEALTH	:	
ADMINISTRATION (MSHA),	:	Docket No. CENT 2007-25-M
Petitioner	:	A.C. No. 41-01118-99184
v.	:	
	:	
LATTIMORE MATERIALS COMPANY, LP,	:	Ambrose Sand Plant
Respondent	:	

DECISION

Appearances: Amy S. Hairston, Esq., and Michael D. Schoen, Esq., Office of the Solicitor, U.S. Department of Labor, Dallas, Texas, on behalf of the Petitioner;
Charles C. High, Jr., Esq., Kemp Smith, LLP, El Paso, Texas, on behalf of the Respondent.

Before: Judge Melick

This case is before me upon a petition for civil penalty filed by the Secretary of Labor pursuant to Section 105(d) of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 801 et seq. (2000), the "Act," charging Lattimore Materials Company, LP (Lattimore) with violations of mandatory standards and proposing civil penalties of $37,450.00, for the violations. The general issue before me is whether Lattimore violated the cited standards and, if so, what is the appropriate civil penalty to be assessed in accordance with Section 110(i) of the Act. Additional specific issues are also addressed as noted.

As amended, Citation No. 6262905, issued pursuant to Section 104(d)(1) of the Act, charges a "significant and substantial" violation of the standard at 30 C.F.R. § 56.16009 and, alternatively, the standard at 30 C.F.R. § 56.9201. [1] [2] The citation alleges as follows:

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[1] Section 104 (d)(1) of the Act provides as follows:

> If, upon any inspection of a coal or other mine, an authorized representative of the Secretary finds that there has been a violation of any mandatory health or safety standard, and if he also finds that, while the conditions created by such violation do not cause imminent danger, such violation is of such nature as could significantly and substantially contribute to the cause and effect of a coal or other mine safety or health hazard, and if he finds such violation to be caused by an unwarrantable failure of such operator to comply with such mandatory health

> Three miners were seriously injured when a suspended shaker deck slipped and pinned two of the miners against a pipe and knocked the third miner down into the belly of the sand screen. Three other miners narrowly avoided serious injury by the swinging screen deck. The Plant Manager was directing the crew and was one of the miners pinned against the pipe. The crew was working directly in front of the suspended shaker deck. The plant manager engaged in aggravated conduct by allowing the crew, while under his direction, to work in the path of the suspended deck. This is an unwarrantable failure to comply with a mandatory standard.

The standard at 30 C.F.R. § 56.16009 provides that "[p]ersons shall stay clear of suspended loads." For the reasons that follow, I find that the Secretary has sustained her burden of proving a violation of the cited standard.

It is undisputed that three employees of Lattimore, Bradley Rader, Ricky Pittman, and Robert Fondren, were seriously injured around 8:20 a.m. on January 12, 2006, while helping to install a replacement deck on a shaker at the Ambrose processing plant. A crane operated by co-worker Jerry Hicks was used to maneuver the deck frame at a 20 degree angle into the shaker. The 4,200 pound replacement deck was approximately eight feet wide, 20 feet long and four feet high. When the deck had been partially inserted into the shaker screen housing, it became stuck. At that point, the four hoisting straps were slackened by the crane operator and the two front straps removed. Just before the straps were released from the crane, Rader, Pittman and Fondren, were pulling on the replacement deck with two hoists and a "come-along". The deck then suddenly slid into place striking Rader, Pittman and Fondren. Rader and Pittman were standing between the deck frame and the bottom chute in front of a cross-member pipe and both employees were struck in the pelvic area.

Crane operator Jerry Hicks witnessed the incident from the crane cab. Hicks testified that he had, on at least six prior occasions, used a crane to insert a replacement deck into a shaker and he discussed the procedures to be followed that day with his supervisor, Ricky Avery. Four hoisting straps were rigged so that the deck was at a 20 degree angle- - the angle at which the insertion was

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> or safety standards, he shall include such finding in any citation given to the operator under this Act. If, during the same inspection or any subsequent inspection of such mine within 90 days after the issuance of such citation, an authorized representative of the Secretary finds another violation of any mandatory health or safety standard and finds such violation to be also caused by an unwarrantable failure of such operator to so comply, he shall forthwith issue an order requiring the operator to cause all persons in the area affected by such violation, except those person referred to in subsection (c) to be withdrawn from, and to be prohibited from entering, such area until an authorized representative of the Secretary determines that such violation has been abated.

[2] In light of my findings herein that the Secretary has sustained her burden of proving a violation of the standard at 30 C.F.R. § 56.16009, there is no need to address the alternative charges. The issue is moot.

to take place. Two of the four hoisting straps were attached about six feet from the front of the deck and the other two were attached at the rear (Dol. Exh. No. 31). Hicks testified that, as he raised the deck to about 30 feet, employees grabbed the sides of the deck to feed it into the slot. The front hoisting straps were removed after the shaker deck was inserted up to the point where those straps had been attached to the deck. Hicks testified that he lowered the position of the crane to provide enough slack to enable removal of the front straps. At the same time, the rear straps were also slackened. Hicks testified that the rear straps had "quite a bit of slack" and that he was not given any signal to resume tension on the straps. He was following the hand signals of his supervisor, Randy Brazier, who was standing on a platform on the shaker. Hicks testified that he then saw the deck suddenly start sliding into the shaker without warning. The crane was not then holding the deck. There was no tension on the straps. When the deck slid in, it had been inserted about half way "more or less". Hicks noted that once the straps were slackened, he had no control over the deck. It was about five minutes later when he learned of the injuries and he assisted in hoisting the injured miners down by stretcher. He observed that all of the injured were talking but he did not know how serious they were injured.

Ambrose plant manager, Bradley Rader, also testified. Ricky Avery, Lattimore's area supervisor was his supervisor. Rader was in charge of the deck installation. He had never been trained by Lattimore on deck installations nor about safe installation procedures. He had only twice before installed such decks. On this occasion, as the deck was being installed, he was in the shaker "possum belly" with Pittman and Fondren (Dol. Exh. No. 6). Rader testified that they were using two five-ton hoists and a one-and-a-half-ton "come-along" to pull the deck inside. They were pulling the deck in only about one-quarter to one-half inch at a time and it had been pulled about half way in when it became stuck. Rader testified that he added the "come along" and was trying to rehook the hoist when the deck suddenly came sliding in pinning him. The deck was moved to free him and he was transported to a stretcher by the crane to the ground. He felt bruised, and intermittently hot and cold. He was taken to Parkland Hospital by helicopter where his spleen and one kidney were removed.

On cross examination Rader testified that he had never before seen a deck slide in as it did on this occasion. It had to be pulled in with hoists and "come-alongs" an inch at a time. Later at the hospital, Mark Clark, the Vice President of Aggregates Operations, visited him. Rader said that he did not know anything about his condition. His surgery was not completed until after 6:00 p.m. that day.

Another eyewitness, Robert Fondren, the Ambrose plant operator, testified that he was working for Brad Rader in the "possum-belly" of the shaker. He recalled that it took about one hour to move the replacement deck about half way in. It then took off, pinning him. Fondren credibly testified that he wanted to use the one-and-one-half ton "come-along" as a brake to hold the deck but he could not get it hooked up. "Brad stopped me from hooking it up". Fondren opined that the "come-along" should have been used as a brake to prevent the deck from sliding into the miners.

Eyewitness Ricky Pittman was also in the "possum-belly" helping to install the deck.

Pittman recalled that he was working a "come-along" pulling the deck into the housing as Rader was working another "come-along". The deck was half way into the shaker when it stopped. Suddenly the deck slipped and he saw that Rader was trapped. Pittman testified that "Rader didn't look good". Pittman testified that the emergency medical technicians (EMT's) never told him what was wrong with him. He arrived at the hospital around mid morning but did not go to the emergency room until 5:00 p.m. that day.

Within the framework of the above essentially undisputed eyewitness testimony, it is clear that the replacement deck remained at least partially suspended from the crane as it was inserted into the shaker and up to the point at which the front two harnesses, located approximately six feet from the front of the deck, were slackened and removed and when the two rear harnesses were also slackened. There is no dispute that the three man crew under the direction of plant manager Bradley Rader were working directly in the path of the replacement deck as it was suspended from the harnesses attached to the crane until that point in time. This clearly constitutes a violation of the standard at 30 C.F.R. § 56.16009. It is also clear, however, that at this point in time the deck continued to be suspended by the shaker frame itself. Indeed, the eyewitness testimony of crane operator Jerry Hicks that the deck then "was hung in the shaker frame" is undisputed (Tr. II p. 76). Shortly thereafter, demonstrating that it was capable of free movement, the deck slid into the shaker frame injuring Mssrs. Rader, Pittman and Fondren. Under these circumstances there was also a violation of the cited standard.

In reaching these conclusions I have not disregarded Lattimore's argument that the meaning of the cited standard should be controlled by the heading of the subpart of the Secretary's regulation in which it appears, i.e. "Materials Storage and Handling". Lattimore contends that the shaker deck was not a "material" and that the cited standard is therefore inapplicable hereto. When considering analogous arguments regarding the rules of statutory construction however, the dominant legal authority is that, when interpreting statutes, where the text of the section is clear, the section's heading does not limit or alter its text. See Brotherhood of Railroad Trainmen v. Baltimore & Ohio R. Co., 331 U.S. 519, 528-29 (1947); Francisco v. Stolt Achievement Mt., 293 F.3d 270, 275 (5th Cir. 2002); and Samirah v. O'Connell, 335 F. 3d 545, 548-549 (7th Cir. 2003). I find therefore that Lattimore's argument herein is not only without legal support but contrary to analogous legal authority.

I further find that the violation was "significant and substantial". A violation is properly designated as "significant and substantial" if, based on 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, 3-4 (January 1984), the Commission explained:

> In order to establish that a violation of a mandatory standard is significant and substantial under National Gypsum the Secretary 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 injury in

question will be of a reasonably serious nature.

See also 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).

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., 6 FMSHRC 1834, 1836 (August 1984), and also that the likelihood of injury be evaluated in terms of continued normal mining operations. U.S. Steel Mining Co., 6 FMSHRC 1573, 1574 (July 1984); See also Halfway, Inc., 8 FMSHRC 8, 12 (January 1986) and Southern Ohio Coal Co., 13 FMSHRC 912, 916-917 (June 1991).

In this case there was a clear danger to safety created by the violation i.e. the danger of being crushed by a deck weighing 4,200 pounds. Injuries, which of course actually occurred, were also reasonably likely. At the time of the incident there was nothing except friction to hold the deck from sliding into the shaker frame at a 20 degree angle and crushing miners working in its path. Indeed Mr. Fondren testified that he wanted to use a "come-along" to serve as a "brake" for the deck but was prevented from doing so by his Plant Manager Rader. It was also highly likely for injuries to be serious because of the weight of the deck. Indeed, as a result of the violation, Mr. Rader lost his spleen and a kidney and continues to suffer from brain trauma, Mr. Pittman suffered a broken pelvis and was unable to return to work for almost a year and Mr. Fondren suffered a fractured arm.

The violation was also clearly the result of Lattimore's "unwarrantable failure" to comply with the cited standard. Unwarrantable failure is "aggravated conduct, constituting more than ordinary negligence, by a mine operator in relation to a violation of the Act." Emery Mining Corp., 9 FMSHRC 1997, 2004 (December 1987). Unwarrantable failure is characterized by such conduct as "reckless disregard," "intentional misconduct," "indifference," or a "serious lack of reasonable care." Id. at 2002-03; Rochester & Pittsburgh Coal Co., 13 FMSHRC 189, 193-94 (February 1991); see also Rock of Ages Corp. v. Secretary of Labor, 170 F.3d 148, 157 (2d Cir. 1999); Buck Creek Coal, Inc. v. MSHA, 52 F.3d 133, 136 (7thCir. 1995) (approving Commission's unwarrantable failure test). Moreover, the Commission has examined the conduct of supervisory personnel in determining unwarrantable failure and recognized that a heightened standard of care is required of such individuals. See Youghiogheny & Ohio Coal Co., 9 FMSHRC 2007, 2011 (December 1987) (section foreman held to demanding standard of care in safety matters); S&H Mining, Inc., 17 FMSHRC 1918, 1923 (November 1995) (heightened standard of care required of section foreman and mine superintendent).

Several factors stand out in this regard. I find that indeed the violative condition was obvious and posed a high degree of danger. The evidence establishes that a deck weighing 4,200 pounds, was pointed at a downward angle of about 20 degrees, was restrained only by friction and that three employees working in a confined area were in its direct path. At least one of these employees, Robert Fondren, also clearly recognized the obvious danger of the situation when he requested to use a "come-along" to serve as a "brake" and indeed had used a "come-along" in this manner during a

previous installation of a deck into the same shaker. The operator's agent, Plant Manager Bradley Rader vetoed Fondren's request with the tragic consequences that followed. Thus, the hazard was not only obvious but was also pointed out to the operator's agent who vetoed remedial action. The serious injuries suffered by Rader, Pittman, and Fondren further confirm the high degree of danger presented by the violative condition. These factors also establish that the operator was highly negligent in committing the violation.

Citation Nos. 6262903 and 6262904

Citation No. 6262903 alleges a violation of the mandatory standard at 30 C.F.R. § 50.10 and charges as follows:

> The mine operator failed to notify MSHA of a serious accident when three miners were injured on 1/12/06 while attempting to install a shaker screen deck. After losing control of the suspended deck two of them were pinned inside the belly of the sand screen. The deck knocked down the third miner as it swung into the belly. The accident occurred on 1/12/06 around 8:00 a.m. MSHA was notified of the accident on 1/13/06 around 10:00 a.m. by a "courtesy call" from Scott Horner, Manager of ES&H.
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> The cited standard, 30 C.F.R. § 50.10, provides as follows:
>
> If an accident occurs, an operator shall immediately contact the MSHA District Office having jurisdiction over its mine. If an operator cannot contact the appropriate MSHA District Office, it shall immediately contact the MSHA Headquarters Office in Arlington, Virginia by telephone, at (800) 746-1553.

Citation No. 6262904 alleges a violation of the standard at 30 C.F.R. § 50.12 and charges as follows:

> The mine operator altered the site of an accident prior to notifying MSHA that a serious accident had occurred and after the recovery of injured miners. The mine operator took pictures of the accident scene and talked to miners at the site. The mine operator failed to preserve the accident scene and resumed work on the sand screen on 1/13/06 prior to notifying MSHA of the accident.
>
> The cited standard, 30 C.F.R. § 50.12, provides as follows:
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> Unless granted permission by a MSHA District Manager, no operator may alter an accident site or an accident related area until completion of all investigations pertaining to the accident except to the extent necessary to rescue or recover an individual, prevent or eliminate an imminent danger, or prevent destruction of mining equipment.

As noted, the cited regulatory provisions are triggered only by the occurrence of an "accident" within the meaning of the Secretary's regulations. The term "accident" is defined in 30 C.F.R. § 50.2(h)(2) to include "[a]n injury to an individual at a mine which has a reasonable potential to cause death...." The issue to be decided then, is whether any of the injuries to the three miners in this case had a "reasonable potential to cause death".

I find that, indeed, even before the injured miners were transported by ambulance and helicopter to area hospitals, there was evidence available to agents of Lattimore that the injuries had a reasonable potential to cause death. It was clear, or should have been clear, to Lattimore's agents who where present at, and immediately after, the accident that three miners had suffered crushing injuries from the shifting movement of a 4,200 pound replacement deck for the shaker screen. At least one of the victims, Plant Manager Brad Rader, told paramedic Deborah Sarrao, in the presence of other Lattimore employees, that he was in severe pain. Both Rader and Pittman were placed on backboards to protect them from spinal cord injuries. Rader was, according to Ms. Sarrao, also showing signs of shock. His skin was pale, he was sweating profusely and was disoriented. Rader and Pittman were also sent by helicopter to the Parkland Hospital, the nearest "level one trauma center"- - the highest level trauma center.[3]

Michael Bose, then a Lattimore vice president, was at the plant at the time of the accident but was not at the immediate scene. He heard commotion and was able to talk to the victims as they laid on stretchers. Rader told Bose that he was in pain and Bose observed that Rader was disoriented. Pittman also told Bose that he was in severe pain. Bose acknowledged that he knew that disorientation was a sign of shock. He was also aware that helicopters picked up the victims and took them to Parkland Hospital. Bose, who acknowledged having had first aid training for about the previous 15 years and that he kept his training current, therefore had almost immediate knowledge that the three victims had suffered crushing injuries, that at least one was in severe pain, that they had been placed on backboards, (a practice he should have known is used to protect against spinal injuries), that one miner was showing signs of disorientation which were known to Bose as evidence of shock (a condition he knew or should have known may in itself cause death), and that the two injured miners were being sent by helicopter to what he should have known was a "level one" trauma center. Having had first aid training, Bose should also have known that crushing injuries often cause unseen internal injuries. Indeed, he should have been aware, as was Scott Horner, Lattimores' manager of environmental safety and health and Mark Clark, vice president of aggregate operations, that a year and a half earlier at another Lattimore facility, a miner had also suffered crushing injuries and died as a result (See Exh. Dol. 14).

Under the circumstances, I conclude that indeed Lattimore's agents should have known almost immediately after the incident that the injuries sustained by at least two of the injured miners had a reasonable potential to cause death and that, accordingly, the incident qualified as a "accident"

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[3] While there is no evidence that paramedic Sarrao conveyed her medical opinion to any agent of Lattimore, her observations of the victims corroborate what was observable to those agents.

within the meaning of 30 C.F.R. § 50.2(h)(2). Since MSHA was not contacted for more than 24 hours after the accident i.e. not until January 13th, at approximately 10:00 a.m., I do not find that such notification was "immediate" within the meaning of 30 C.F.R. § 50.10. Accordingly, the violation charged in Citation No. 6262903 is affirmed. The Secretary has found that gravity was low and I have no reason to disagree with that assessment. The Secretary has also found, however, that negligence was the result of the operator's "reckless disregard". I find the operator chargeable, however, with only moderate negligence in light of the ambiguities in the definition of "accident" in the cited standard, the fact that there was no evidence of any intentional cover-up or concealment after the accident, that there was no evidence that the delay impeded the investigation, that notice was actually provided to MSHA within 26 hours and that the violation was admittedly of low gravity and, in effect, presented no danger. See Secretary v. Cougar Coal Company, et. al., 25 FMSHRC 513, 521-522 (September 2003), wherein the Commission stated that "it would benefit the mining community if the Secretary would clarify when it is urgent to notify MSHA, and when it is not".

Trenton Scott Homer, Lattimore's manager of environmental safety and health, testified that he authorized work to be resumed at the accident site around 4:30 or 5:00 pm. on the date of the accident. Homer acknowledged that thereafter the work crew moved the crane, removed rigging that was used for the deck installation and reinstalled guardrails that had been removed during the installation process. Walter DeLoach an inspector for the Department of Labor's Mine Safety and Health Administration (MSHA) arrived at the mine around 1:30 p.m. on January 13, 2006. DeLoach testified that the rigging used to lift the deck was rolled up in the bed of the crane and miners were observed adding parts to the shaker screen. The shaker deck had also been mounted. Under the circumstances, I find that the accident site was indeed also altered following the "accident". The Secretary has again alleged low gravity and I have no reason to dispute that finding. The Secretary has also found the operator chargeable with "reckless disregard". I find no evidence of any attempt to cover-up or conceal the accident, there is no evidence that the altered scene was relevant to or impeded MSHA's accident investigation and the violation was admittedly of low gravity and, in effect, presented no danger. For these and for the additional reasons stated above, I find the operator chargeable with but moderate negligence.

Civil Penalties

Under section 110(i) of the Act, the Commission and its judges must consider the following factors in assessing a civil penalty: the history of violations, the negligence of the operator in committing the violation, the size of the operator, the gravity of the violation, whether the violation was abated in good faith and whether the penalties would affect the operator's ability to continue in business. The record shows that Lattimore is a relatively small mine and has a modest history of violations (four violations for 19 inspection days). The gravity and negligence findings have previously been discussed. There is no dispute that the violations were abated in a timely and good faith manner and there is no evidence that the penalties would affect the operator's ability to continue in business. Under the circumstances, I find that penalties of $75.00, $75.00, and $36,800.00 for Citations No. 6262903, 6262904 and 6262905 respectively, are appropriate.

ORDER

Citations No. 6262903, 6262904 and 6262905 are affirmed and Lattimore Materials Company, LP, is directed to pay civil penalties of $36,950.00 for the violations charged therein within 40 days of the date of this decision.

Gary Melick
Administrative Law Judge
(202) 434-9977

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