FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

OFFICE OF ADMINISTRATIVE LAW JUDGES
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April 12, 1995

SECRETARY OF LABOR,	:	CIVIL PENALTY PROCEEDING
MINE SAFETY AND HEALTH	:	
ADMINISTRATION (MSHA),	:	Docket No. CENT 94-97-M
Petitioner	:	A.C. No. 14-00164-05520
v.	:	
	:	Kansas Falls Quarry & Mill
WALKER STONE COMPANY, INC.,	:	
Respondent	:	

DECISION

Appearances: Ann M. Noble, Esq., Office of the Solicitor, Department of Labor, Denver, Colorado, for the Secretary;
Keith R. Henry, Esq., Weary, Davis, Henry, Struebing & Troup, Junction City, Kansas, and Katherine S. Larkin, Esq., Jackson & Kelly, Denver, Colorado, for Respondent.

Before: Judge Maurer

STATEMENT OF THE CASE

This case is before me upon the 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., charging Walker Stone Company, Inc., with two violations of the regulatory standards found in Part 56, Title 30, Code of Federal Regulations, as the result of an MSHA investigation into the cause of a fatal machinery accident at the respondent's Kansas Falls Quarry & Mill, located at Chapman, Dickinson County, Kansas. The general issues before me are whether the respondent violated the cited regulatory standards and, if so, the appropriate civil penalty to be assessed in accordance with section 110(i) of the Act.

Pursuant to notice, the case was heard at Fort Riley, Kansas, on October 26-27, 1994. At the hearing, Inspectors Roger G. Nowell and Lloyd R. Caldwell testified for the Secretary of Labor. Mr. David S. Walker, the President of Walker Stone Company, Inc., testified for respondent. The parties simultaneously filed briefs on January 9, 1995, which I have duly considered in making the following decision.

STIPULATIONS

At the hearing, the parties entered the following stipulations into the record (Tr. 16,

Joint Ex. No. 1):

1. Walker Stone, Inc. is engaged in mining and selling construction aggregates and road building materials.

2. Walker Stone, Inc. is the owner and operator of Kansas Falls Quarry and Mill, MSHA I.D. No. 14-00164.

3. Walker Stone, Inc. is subject to the jurisdiction of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. ' 801 et seq. ("the Act").

4. The administrative law judge has jurisdiction in this matter.

5. The subject citations were properly served by a duly authorized representative of the Secretary upon an agent of respondent on the date and place stated therein and may be admitted into evidence for the purpose of establishing their issuance, and not for the truthfulness or relevancy of any statements asserted therein.

6. The exhibits to be offered by respondent and the Secretary are stipulated to be authentic but no stipulation is made as to their relevance or the truth of the matters asserted therein.

7. The proposed penalties will not affect respondent's ability to continue in business.

8. The operator demonstrated good faith in abating the violations.

9. Walker Stone, Inc. had 54,977 manhours of production in 1992.

10. The certified copy of the MSHA Assessed Violations History (dated March 16, 1994) accurately reflects the history of this mine for the 2 years prior to the date of the citations.

THE ACCIDENT

The accident occurred on June 25, 1993, at the primary crushing plant of the Kansas Falls Quarry and Mill, owned and operated by the Walker Stone Company, Inc.

Dan Robert Boisclair, a general cleanup man and alternate truck driver, with one year of mining experience, was fatally crushed while helping the crusher operator and other employees unclog the primary impact crusher.[1] Because a truck driver had quit the previous day, on June 25, 1993, Boisclair's job was to haul blasted rock from the quarry to the crusher. Work progressed normally throughout the day until approximately 3:00 p.m., when the impact crusher plugged up and stalled the drive motor. As was the established procedure in this circumstance, Roy Brooner, the crusher operator, signaled the truck drivers by turning the green light at the rock bin off and turning the red light on. A red light meant for the truck drivers to stop dumping their trucks' limestone loads into the hopper and to proceed to the crusher to assist the crusher operator in unplugging the crusher. By 3:30 p.m., the men had succeeded in unplugging the crusher and went back to their regular routine.

At approximately 5:00 p.m., barely 30 minutes before quitting time, the crusher jammed again, stalling the diesel drive motor. Brooner again turned the red stoplight on at the rock bin and the truck drivers, including Boisclair, went to assist him, as was the usual practice.

The upper part of the crusher has three access openings; the opening on each side is pinned closed while the crusher is in operation; the other is a hydraulically operated "flop gate," 52 inches wide and 38 inches high. The "flop gate," when down, provides access to the impeller or rotor, which can be gained by crouching or crawling through the "flop gate" opening onto the impeller. The cylindrical impeller or rotor inside the crusher housing contains three metal bars about 3 inches high running horizontally along the impeller drum. When the impeller rotates, it crushes the rocks and/or throws the rocks against the crusher's walls until the rocks break into pieces small enough to exit the crusher.

When the truck drivers arrived at the crusher, the "flop gate" was opened and Boisclair, along with Bill Scott, entered the interior of the crusher. They used a sledge hammer to break up one or two large boulders they found on top of the rotor. Boisclair and Scott thereupon exited the crusher and Brooner, the operator, tried to move the rotor by "jogging" it with the "flop gate" still open.[2] He did this by pressing the start button on the diesel engine with the

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[1]The primary impact crusher is designed to break larger rocks into smaller pieces which can then be processed by the milling operation into a saleable product.

[2]The crusher operator duty station is normally in a small operating house located above the crusher and the diesel engine. When the crusher gets clogged, however, the operator moves

clutch engaged. But the impeller would not rotate and thus they

knew the crusher was still clogged. At this point, Scott and Brooner agreed that Scott would go down on the conveyor belt below the impact rotor and see if a rock had gotten caught in the area of the splash pan. Meanwhile, Boisclair, unbeknownst to Brooner, reentered the interior of the crusher. Frank Esterly, another truck driver, was behind Boisclair just inside the "flop gate," but outside the crusher compartment. From this position, Esterly could see Scott as he was working below the rotor. While Scott was cleaning out the exit area of the crusher, Boisclair was on his hands and knees on top of the rotor, cleaning out some small wedged-in rocks on the top side of the crusher with his hunting knife. At some point, Esterly called down and asked Scott if he needed any help. Scott replied that he thought he had removed the problem rock and was about ready to leave. Esterly told Boisclair to hurry and get out of the crusher as Scott was about done below. While Scott was climbing out from below, Boisclair started to turn around on the rotor to exit. As Boisclair was exiting, but not yet out, Brooner, cleared by Scott, but unaware that Boisclair had reentered the crusher, "jogged" the rotor to see if it was free. This time the impeller turned. As it turned, Boisclair's foot was caught by an impeller bar, dragging him partially into the crusher and crushing him between the impeller drum and the wall of the crusher. The cause of death was "massive crushing injuries to the upper and lower torso."

The next day, June 26, 1993, MSHA began its investigation of the accident. It's report was released on August 11, 1993, and is included in this record as Petitioner's Exhibit No. 1.

The two inspectors who subsequently wrote the report, Nowell and Caldwell, concluded that the direct cause of the accident was the failure to ensure that all employees were in a safe location before initiating movement of the crusher. They also found other contributing causes, such as: (1) the failure to provide and use an audible warning device or other effective means to warn employees of impending crusher movement; (2) the failure of the victim to notify the crusher operator of his intention to reenter the crusher compartment; and (3) other unrelated factors that might have caused the employees to hurry the unplugging of the crusher, like the hot weather, the fact that the plug-up occurred just 30 minutes prior to quitting time and paychecks were to be distributed at the end of the shift.

As a result of their accident investigation, Inspector Nowell issued two section 104(a) citations to the operator which are the subject of this proceeding.

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down to a location which is right next to the diesel engine so that he can "jog" the engine to determine whether the crusher's impeller is free.

DISCUSSION, FINDINGS, AND CONCLUSIONS

Citation No. 4337450

Citation No. 4337450, issued on June 28, 1993, alleges a "significant and substantial" ("S&S") violation of the standard at 30 C.F.R. ' 56.14105[3] and charges as follows:

> All employees were not effectively protected from hazardous motion of the Impact rotor of the Pettibone universal 5165 primary impact crusher. An employee was fatally crushed at approximately 5:20 p.m., on June 25, 1993, when the crusher operator jogged the drive engine starter switch. Five employees had been working to free the rotor from a rock jam and all had exited the crusher interior. The victim reentered the crusher interior without the crusher operators knowledge and was caught between the rotor and stripper bar when the starter was jogged. Procedures for accurate accounting of all employees present during hazardous unplugging operations of the crusher and/or a positive mechanical device to prevent movement of the rotor were not provided.

Respondent's first line of defense against this citation is that no "repair" or "maintenance" work was being performed on the crusher, and therefore this standard is inapplicable to the facts of this case. I agree. The standard speaks to "repairs" to or "maintenance" of the machinery or equipment in question. In this case, the crusher. The respondent's employees were not performing any mechanical, maintenance or repair work on the

[3] 30 C.F.R. ' 56.14105 provides:

> Repairs or maintenance on machinery or equipment shall be performed only after the power is off, and the machinery or equipment blocked against hazardous motion. Machinery or equipment motion or activation is permitted to the extent that adjustments or testing cannot be performed without motion or activation, provided that persons are effectively protected from hazardous motion.

crusher or making any structural modification to the crusher. The only thing they were actually working on were the rocks, breaking them up with a sledgehammer, and/or otherwise dislodging them from the crusher.

Accordingly, Citation No. 4337450 will be vacated herein. The mandatory standard cited simply does not apply to the facts of this case. In my opinion, that standard was written to apply to repair or maintenance evolutions, as those terms are commonly used and not relatively minor annoyances that arise during the on-line production usage of the machinery or equipment, that do not involve any adjustments, maintenance or repairs to the equipment itself.

Citation No. 4337451

Citation No. 4337451, also issued on June 28, 1993, alleges a "significant and substantial" ("S&S") violation of the standard found at 30 C.F.R. ' 56.14200[4] and charges as follows:

> An audible warning or other effective means was not being used to warn all employees working on or around the Pettibone universal 5165 primary impact crusher of impending movement. On June 25, 1993, at approximately 5:20 p.m., the crusher rotor was moved by jogging the diesel engine starting switch. The rotor movement fatally crushed an employee, who had reentered the crusher interior without the crusher operator's knowledge. The victim and four other employees had been working to remove large rocks which had jammed or plugged the impact rotor.

Respondent's argument with regard to this citation is that there was no violation of the cited standard because the crusher was being "jogged", not "started", but even if "jogging" is construed to be the same as "starting" in this instance, other effective means were used to warn persons potentially exposed to any hazard.

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[4]30 C.F.R. ' 56.14200 provides:

> Before starting crushers or moving self-propelled mobile equipment, equipment operators shall sound a warning that is audible above the surrounding noise level or use other effective means to warn all persons who could be exposed to a hazard from the equipment.

I disagree on both counts. First of all, the potentially dangerous movement of the crusher is in fact movement of the impeller itself. When the crusher was "jogged", the impeller moved, Danny Boisclair was caught by that impeller and crushed to death. He was without a doubt a person exposed to a hazard from the equipment.

Secondly, once the cited standard is deemed applicable to the factual situation, the inquiry turns to whether that standard was satisfied by either of the two allowable methods. I find it was not. It is undisputed that there was no audible warning sounded before the crusher was "jogged." That leaves us with the issue of whether other effective means were used to warn persons potentially exposed to any hazard from the equipment. Again, I find that there were not.

The Secretary argues that in order to be effective, the rule should be to the effect that the operator will make certain that all persons are clear before "jogging" the crusher. I agree that would be an ideal means to comply with this standard, but I am aware of the decision in the case of Secretary v. Morgan Corp., 12 FMSHRC 40 (January 1990) (ALJ),[5] wherein Judge Koutras compared the mandatory standard at bar with its predecessor, 30 C.F.R. ' 56.9005, and I understand that the standard cited herein, section 56.14200, does not contain language requiring an equipment operator to be certain that all persons are in the clear before starting his equipment. Although the old section 56.9005 did require an equipment operator to determine with some degree of certainty that all persons were in the clear before moving the equipment, I am fully cognizant that this requirement has been deleted from the revised standard and it now only requires that either audible warning be given or other effective means be used to warn persons potentially exposed to a hazard from the equipment.

Respondent urges that the company had policies in effect that employees were not to work in the crusher by themselves and that they were not to work "above" other employees. Respondent maintains that all employees, including Boisclair, were aware of these policies even through these rules were not written down anywhere and there is no direct evidence that Dan Boisclair had ever received these instructions. I find that even if it were so, this is plainly not a sufficiently effective means to warn employees who would be unclogging the crusher that at least some degree of coordination between the crusher operator and the "uncloggers" was required in order to address the hazards attendant to such an operation.

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[5]The Commission granted Morgan's petition for discretionary review of Judge Koutras' decision in this matter, but while pending on their docket, subsequently approved the parties' settlement of the case and dismissed the proceeding. Secretary v. Morgan Corp., 12 FMSHRC 394 (March 1990).

It is clear to me that the violation of the cited standard is proven as charged. Clearly, the violation was also "significant and substantial" and serious. It was a significant contributing cause to a fatal accident.

Respondent also argues that it should not be charged with significant negligence in this instance because the most direct and proximate cause of the accident and Dan Boisclair's death was his own unpredictable conduct in returning to the interior of the crusher unbeknownst to the crusher operator. I agree that Mr. Boisclair was certainly negligent and played a major role in causing his own death. I would also assess a portion of negligence to the crusher operator, who moved the impeller without knowing where Boisclair was even though he knew he was in the area. These two men (Boisclair and Brooner) were rank-and-file employees of the respondent and I am not assigning their negligence to the respondent for purposes of assessing a penalty in this case. Southern Ohio Coal Co., 4 FMSHRC 1459, 1463-65 (August 1982). However, there is plenty of negligence left to go around in this instance. More particularly, I find the respondent was negligent by not having an effective safety policy in place that specifically concerned unplugging the crusher, an operation that reoccurred on a relatively frequent basis and obviously could be hazardous duty for the "unpluggers" who actually enter the interior of the machine. Once inside, they are clearly dependent on the crusher operator to know where they are at all times and to ascertain that they are clear before he moves the crusher's impeller. It is unreasonable for the respondent to have believed that some general knowledge about the crusher and a couple of general rules about working "above" others and working by oneself would be sufficient to avoid the type of accident which in fact occurred.

In summary, the evidence in this record persuades me to conclude that the respondent had no effective means to warn all persons who could be exposed to the hazards of unplugging the crusher. Accordingly, I find the respondent is chargeable with "moderate," or ordinary negligence in this case.

In assessing a civil penalty in this instance, I have also considered the respondent's size, history of violations, and good faith abatement of the violation. Under the circumstances, I find that a civil penalty of $7500 is appropriate, reasonable, and will satisfy the public interest in this matter.

ORDER

Citation No. 4337450 **IS VACATED** and Citation No. 4337451 **IS AFFIRMED**.

The Walker Stone Company, Inc., is **ORDERED** to pay the Secretary of Labor a civil penalty of $7500 within 30 days of the date of this decision.

Roy J. Maurer
Administrative Law Judge

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