FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

OFFICE OF ADMINISTRATIVE LAW JUDGES
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February 11, 1999

SECRETARY OF LABOR,	:	CIVIL PENALTY PROCEEDING
MINE SAFETY AND HEALTH	:	
ADMINISTRATION (MSHA),	:	Docket No. CENT 98-128-M
Petitioner	:	A. C. No. 13-02166-05504
v.	:	
	:	
ANDERSON SAND & GRAVEL	:	
Respondent	:	Anderson Sand & Gravel Mine

DECISION

Appearances: Mark W. Nelson, Esq., Office of the Solicitor, U.S. Department of Labor, Denver, Colorado, on behalf of Petitioner;
B. Douglas Stephens, Esq., Wessels, Stojan and Stephens, P.C., Rock Island, Illinois, on behalf of Respondent.

Before: Judge Melick

This case is before me upon the Petition for Civil Penalty filed by the Secretary of Labor against the Anderson Sand & Gravel Company (Anderson), pursuant to Section 105(d) of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. ' 801, *et seq.*, the "Act," alleging five violations of mandatory standards and seeking civil penalties of $14,100.00 for those violations. The general issue before me is whether Anderson committed the violations as alleged and, if so, what is the appropriate civil penalty to be assessed considering the criteria under Section 110(i) of the Act.

Citation No. 7812338 alleges a "significant and substantial" violation of the standard at 30 C.F.R. Section 56.14130(g) and charges as follows:

> On 12-15-97, while conducting load and carry operations with a Case 821 front end loader, the operator was thrown or jumped from the cab, when the engine died while backing down from the crusher feed surge pile. The loader continued down to the pit floor where it rolled over, resulting in extensive damage to the loader. The loader operator landed in a snow drift adjacent to the pit roadway. The operator received 3 broken ribs, a punctured lung, and several head wounds requiring stitches. The seatbelt provided was not being worn by the operator.

The cited standard, 30 C.F.R. Section 56.14130(g), provides as relevant hereto that: "[s]eat belts shall be worn by the equipment operator."

The evidence supporting this violation is undisputed. Anderson employee Alan Kent admitted that he was operating the subject Case 821 front end loader on December 15, 1997, without wearing a seat belt. Kent testified that he did not feel like wearing the belt because of the discomfort with his heavy winter clothes. Kent also acknowledged that on prior occasions when he was wearing heavy winter clothes he would not wear a seat belt. He nevertheless was aware that he was supposed to wear a seat belt and had been told by his supervisor, Bruce Anderson, more than once to wear it. He did not believe that on this occasion Anderson was aware that he was not wearing his seat belt. It is undisputed in this case that Kent was thrown, or jumped, from the cab of the loader when he lost control. He had been backing-up on a steep grade from the crusher feed surge pile. He suffered three broken ribs, a punctured lung and several head wounds requiring sutures. Kent was also rendered unconscious due to his head injuries. The violation has clearly been proven as charged.

The Secretary also maintains that the instant 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 safety 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 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.
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> *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 the *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)). The likelihood of such injury must be evaluated in terms of continued normal mining operations without any assumptions as to abatement. *U.S. Steel Mining Co., Inc.*, 6 FMSHRC 1573, 1574 (July 1984); *See also Halfway, Inc.*, 8 FMSHRC 8, 12 (January 1986) and *Southern Ohio Coal Co.*, 13 FMSHRC 912, 916-17 (June 1991). On the facts of this case the violation was clearly "significant and substantial."

I also find that the violation was the result of operator negligence. It may reasonably be inferred from Kent=s testimony that he had previously and repeatedly failed to use a seat belt. His

supervisor had, on several prior occasions, also told him to wear his seat belt but he continued to disobey these instructions. It may be inferred from this evidence that there was insufficient training and discipline of employees for failure to comply with the requirement for wearing seat belts.

Citation No. 7812339 alleges a violation of the standard at 30 C.F.R. Section 50.12, and Section 103(j) of the Act and charges as follows:

> On 12-15-97 at approximately 11:30 A.M. an accident occurred in which the loader operator received serious injuries. While conducting load and carry operations with a Case 821 front end loader, the operator was thrown or jumped from the cab, when the engine died while backing down from the crusher feed surge pile. The loader continued down to the pit floor where it rolled over, resulting in extensive damage to the loader. The loader operator landed in a snow drift adjacent to the pit roadway. The operator received 3 broken ribs, a punctured lung and several head wounds requiring stitches. The company failed to preserve the accident site, and the loader involved was removed from mine property, and sent to the equipment dealer for repair prior to the arrival of M.S.H.A. personnel.

Section 103(j) of the Act provides as follows:

> In the event of any accident occurring in any coal or other mine, the operator shall notify the Secretary thereof and shall take appropriate measures to prevent the destruction of any evidence which would assist in investigating the cause or causes thereof. In the event of any accident occurring in a coal or other mine, where rescue and recovery work is necessary, the Secretary or an authorized representative of the Secretary shall take whatever action he deems appropriate to protect the life of any person, and he may, if he deems it appropriate, supervise and direct the rescue and recovery activities in such mine.

The standard at 30 C.F.R. Section 50.12 provides that "unless granted permission by a MSHA district manager or subdistrict 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."

It is undisputed that the accident at issue occurred on December 15, 1997. According to Inspector William Owens of the Department of Labor=s Mine Safety and Health Administration (MSHA), MSHA learned of the accident only through an anonymous telephone call on December 19, 1997, apparently from a business competitor. Owens confirmed with Bruce Anderson that the accident had in fact occurred. Owens was then informed that the subject front end loader, which had gone out of control and rolled over, had been removed for repairs. Owens thereafter

inspected the damaged loader at a repair shop. During the course of his investigation at the mine site on December 22, Owen also observed, and was told by Bruce Anderson, that one of the berms along the roadway, through which the front end loader had passed, had been rebuilt. I agree with the Secretary=s determination that the violation was of low gravity.

In her post hearing brief the Secretary argues that Respondent was highly negligent because it had been in business since 1989 and, implicitly, should therefore have known of its obligations to timely report accidents and preserve accident scenes. The Secretary also claims that Respondent had received the MSHA manual explaining the operator=s obligations in this regard but offered no proof of this. In any event I agree that it may reasonably be inferred that Respondent should have known of its obligations in this regard and that it was therefore negligent. Respondent argues only that it was not motivated by an intent to conceal the accident or alter evidence.

Citation No. 7812340 alleges a violation of Section 103(j) of the Act and the regulatory standard at 30 C.F.R. Section 50.10 and charges as follows:

> On 12-15-97 at approximately 11:30 A.M. an accident occurred in which the loader operator received serious injuries. While conducting load and carry operations with a Case 821 front end loader, the operator was thrown or jumped from the cab, when the engine died while backing down from the crusher feed surge pile. The loader continued down to the pit floor where it rolled over, resulting in extensive damage to the loader. The loader operator landed in a snow drift adjacent to the pit roadway. The operator received 3 broken ribs, a punctured lung, and several head wounds requiring stitches. The company failed to immediately report to M.S.H.A. the occurrence of this accident. M.S.H.A. became aware of this accident 12-19-97 at approximately 03:30 P.M. by an anonymous phone call to the Fort Dodge Field Office. A phone call to the mine operator confirmed the occurrence and an investigation was initiated at that time.

The standard at 30 C.F.R. Section 50.10, provides as follows:

> If an accident occurs, an operator shall immediately contact the MSHA district or subdistrict office having jurisdiction over its mine. If an operator can not contact the appropriate MSHA district or subdistrict office, it shall immediately contact the MSHA headquarters office in Arlington, Virginia, by telephone, at (800) 746-1553.

This violation is unchallenged. As previously noted, MSHA did not learn of the accident on December 15, 1997, until it received an anonymous phone call, apparently from one of Anderson=s competitors, on December 19, 1997. For the reasons set forth regarding the previous violation I also find that the operator was negligent. The violation was not "significant and substantial" and was of low gravity.

Citation No. 7812341, alleges a "significant and substantial" violation of the standard at 30

C.F.R. Section 56.14100(a), and charges as follows:

> On 12-15-97 the operator of the Case 821 front end loader failed to conduct a proper pre-operational inspection of this loader. While conducting load and carry operations with this loader the engine died, while the machine was backing down the crusher feed surge pile. The loader operator was thrown or jumped from the cab at the top of the pit ramp. The loader continued down this ramp to the bottom where the loader came to rest on its side. Inspection of this loader indicates this machine rolled end over end and sideways before coming to rest. Inspection of the service brakes found them operational. Inspection of the emergency/parking brake found it not operational. The actuator cable was broken at the cab lever. Dirt in the cable track indicated this was not a new break. The operator stated he had not checked this brake prior to operating this day.

The cited standard 30 C.F.R. Section 56.14100(a), provides that "[s]elf-propelled mobile equipment to be used during a shift shall be inspected by the equipment operator before being placed in operation on that shift."

The evidence supporting this violation is unchallenged. Loader operator Alan Kent admitted that he had not checked the condition of the parking brake on the subject Case 821 loader before operating it on December 15, 1997. In addition, Inspector Owens concluded, based upon the amount of dirt and rust in the cable track for the broken cable on the emergency parking brake, that the cable had been broken for a period in excess of one month.

Based on the accident that actually occurred and the serious injuries suffered by loader operator Kent, it is clear that the violation was also "significant and substantial" and of high gravity. The violation was clearly also the result of high operator negligence based on the unchallenged evidence that the cable to the emergency parking brake had been broken for a month. It may reasonably be inferred from this evidence that the operator had failed to perform inspections required by the cited standard for that period of time.

Citation No. 7812342, alleges a "significant and substantial" violation of the standard at 30 C.F.R. Section 56.14101(a)(2) and charges as follows:

> The emergency/parking brake on the Case 821 front end loader was not maintained in functional condition. On 12-15-97 at approximately 11:30 A.M. this loader was involved in an accident. While conducting load and carry operations with this loader the engine died, while the machine was backing down the crusher feed surge pile. The loader operator was thrown or jumped from the cab at the top of the pit ramp. The loader continued down this ramp to the bottom where the loader came to rest on its side. Inspection of this loader indicated this machine rolled end over end and sideways before coming to rest. Inspection of the service brakes found them operational. Inspection of the emergency/parking brake found it not operational. The actuator cable was broken at the cab lever. Dirt in the

cable track indicated this was not a new break. The operator stated he had not checked this brake prior to operating this day.

The cited standard provides that "if equipped on self-propelled mobile equipment, parking brakes shall be capable of holding the equipment with its typical load on the maximum grade it travels."

It is undisputed that with the emergency parking brake cable broken the parking brake was indeed inoperable and accordingly could not have been capable of holding the cited front end loader with its typical load on the maximum grade it traveled. The violation is accordingly proven as charged. Indeed, the undisputed evidence is that even with the parking brake cable intact, the subject brake was incapable of meeting the requirements of the cited standard. It is the operator=s duty to determine the capabilities of the braking systems of equipment it intends to use at its mine and its failure to do so in this case constitutes significant negligence. More significantly, however, the evidence is undisputed that the parking brake cable had been broken for a month prior to the accident in this case and that the loader had been used in that condition. This evidence clearly supports a finding of high operator negligence.

The violation was also "significant and substantial" and of high gravity. There is no dispute that operating the subject loader on the steep grades prevalent at the subject mine, including grades of 19.3 degrees and 22 degrees, the parking brake would be unable to hold the loader sufficient to enable the operator to safely escape in an emergency. Thus, even assuming that the service brakes were operational, should an emergency arise, the operator would have been unable to hold and secure the loader at such steep grades, thereby enabling him to escape. Accordingly, the violation herein was without a doubt "significant and substantial" and of high gravity.

Civil Penalty Assessments

In assessing a Civil Penalty under Section 110(i) of the Act, consideration is to be given to the operator=s history of previous violations, the appropriateness of the penalty to the size of its business, the effect on the operator=s ability to continue in business, good faith abatement, negligence and gravity. Anderson is a small operator. There is no evidence that Anderson=s ability to continue in business would be affected by penalties as high as those proposed by the Secretary and there is no evidence that the citations were not satisfactorily abated. The gravity and negligence relating to these violations have previously been discussed. In regard to the operator=s history, the Secretary has submitted a printout indicating that Anderson had no violations in the two years preceding December 22, 1997. The printout indicates that Anderson had seven violations for the period preceding December 23, 1995, but, with the exception of one violation, the dates are unknown (See Gov. Exh. No. 11). The Secretary has also presented a copy of Citation No. 4104178, dated August 19, 1993, indicating a prior violation of the standard at 30 C.F.R. Section 56.14101(a). Because that violation was over four years old and because of the unestablished age of the other prior violations I give this history but little weight. Consideration is particularly given in this case to the small size of this operator and to the absence

of any violations in the two-year period preceding the instant violations. Under all the circumstances, the penalties set forth in the order below are deemed appropriate.

ORDER

Citations No. 7812339 and 7812340, are affirmed and the Anderson Sand & Gravel Company is directed to pay the civil penalties of $50.00, proposed by the Secretary, for each of the violations charged therein within 40 days of the date of the decision. Citations No. 7812338, 7812341 and 7812342, are affirmed as "significant and substantial" citations and Anderson Sand & Gravel Company is directed to pay civil penalties of $2,000.00, $3,000.00 and $3,000.00, respectively for the violations charged therein within 40 days of the date of this decision

Gary Melick
Administrative Law Judge

Distribution:

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