FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

1244 SPEER BOULEVARD #280
DENVER, CO 80204-3582
303-844-3993/FAX 303-844-5268

February 20, 20002

SECRETARY OF LABOR,	:	CIVIL PENALTY PROCEEDING
MINE SAFETY AND HEALTH	:	
ADMINISTRATION (MSHA),	:	Docket No. CENT 99-20-M
Petitioner	:	A.C. No. 29-00762-05515
	:	
v.	:	
	:	SX/EW
CHINO MINES COMPANY,	:	
(previously captioned as Burro	:	
Chief Copper Company)	:	
Respondent	:	

DECISION

Appearances: Ernest A. Burford, Esq., Office of the Solicitor, U.S. Department of Labor Dallas, Texas, for Petitioner;
Katherine Shand Larkin, Esq., JACKSON & KELLY, PLLC, Denver, Colorado, for Respondent;
Lawrence J., Corte, Esq., PHELPS DODGE CORPORATION, Legal Department, Phoenix, Arizona, for Respondent.

Before: Judge Cetti

CHINO MINES COMPANY

The Chino Mines Company is owned and operated by Phelps Dodge Chino, Inc., and employs nearly 570 miners. The company's Solvent Extraction Mining Plant (SX/EW) is an open pit copper mine which employs approximately 40 miners. The location of the accident was the Motor Control Center (MCC) of the SX/EW plant tankhouse where the main 480-volt, 1200 amp current breaker exploded. (Tr. 22). There is no dispute as to the material facts of how, when, and where the accident occurred and the identity of the three employees who were injured.

I

THE ACCIDENT

On Saturday, June 7, 1997, at approximately 6:15 a.m., power was lost to the SX/EW tankhouse. The SX/EW Shift Supervisor, Larry Filkins and Solvent Extraction Operator, Bruce Shannon, requested a shift electrician to determine the cause of the power failure and to restore power. The Motor Control Center (MCC) consists of a large number of breakers and motor starters, variable frequency drives, and lights on the SX and EW plants. Upon initial inspection of the Motor Control Center, the employees noted that the auxiliary breaker for the tankhouse tripped. The main 480-volt, 1200-amp circuit breaker was manually turned off during Shannon's inspection. After several initial but unsuccessful attempts, Filkins was able to reset the main breaker but did not attempt to reset the auxiliary breaker.

The electrical supervisor, R. McSherry, and the shift electrician, Virgil Biambernandi, responded to the call for assistance and began to trouble-shoot the MCC. McSherry disengaged the main circuit breaker and Giambernandi isolated individual breakers to the SX/EW plant. McSherry then opened the outer cabinet of the main circuit breaker and began metering the main breaker to check voltage. He metered both the top and bottom of the breaker. After closing the cabinet doors, he again attempted to reset the breaker without success. McSherry followed the same procedure two more times. On the third attempt, an explosion and fire occurred at the main breaker at 6:45 a.m., seriously burning Filkins, Walter Gomez, and McSherry. Giambernandi was not injured. McSherry died early the next morning, June 8th, as a result of his burn injuries.

MSHA commenced its inspection and investigation of the June 7th accident about 3 p.m. on Monday, June 9. As a result of the inspection and investigation, Petitioner issued three 104(a) citations to Respondent. Citation No. 7859009 alleges a violation of 30 C.F.R § 56.12002; Citation No. 7850488 alleges a violation of 30 C.F.R § 50.10; and Citation No. 7850489 alleges a violation of 30 C.F.R. § 56.12.

II

STIPULATIONS.

At the hearing, the parties entered the following stipulations into the record:

1. Respondent is an operator within the meaning of the Mine Act.

2. Respondent is subject to the jurisdiction of the Federal Mine Safety and Health Administration.

3. The Administrative Law Judge has jurisdiction over this matter.

4. The contested citations were properly served by a duly authorized representative of the Secretary of Labor for the Mine Safety and Health Administration upon an agent of the respondent on the dates and places stated herein.

5. The gravity findings for Citation No. 7859009 are appropriate, based upon the alleged factual findings stated by the inspector in the citation.

6. The facts as alleged by the inspector in Citation No. 7859009 would, if proven, establish that the circuit breaker was not properly installed.

7. Because the Respondent cannot disprove the facts alleged in the citation, it will stipulate to the facts of the violation based upon the allegation stated in Citation No. 7859009.

8. The total proposed penalty in the amount of $60,000.00 will not affect respondent's ability to continue in business.

9. The operator took immediate abatement steps in good faith and addressed each of the three violations. (Tr. 128; lines 22-24)

III

CITATIONS

Citation No. 7859009

This citation is issued under Section 104(a) of the Act. The citation alleges a significant and substantial violation of 30 C.F.R. § 56.12002. That standard provides as follows:

> Electrical equipment and circuits shall be provided with switches or controls. Such switches or controls shall be of approved design and construction and <u>shall be properly installed</u>. (Emphasis added.)

Respondent does not contest the material facts set forth in the citation which states the following:

> On 6/7/97 an accident occurred at the Siemens Motor Control Center. The main circuit breaker in the Siemens Motor Control Center, located west of the tank house, was not properly installed. The design of the circuit breaker was altered by the covers for the bottom and top electrical terminals not being in place. The covers provide insulation between phases and grounded metal parts near the breaker. A short circuit to ground was created by the black test lead of multi-tester being used to troubleshoot the electrical problem at the motor control center, when it came in contact with

> the bottom electrical terminal and the extended metal nut used for securing the breaker to the motor control center.

Respondent did not contest the fact that the main circuit breaker was not properly installed in that the fiberglass covers for the bottom and top electrical terminals were not in place. The covers had been taken off at some unknown point in time and never replaced. The main breaker involved in the accident was installed in 1992. When last inspected by MSHA Inspector Lambert in 1993, the fiberglass covers were in place. (Tr. 73). None of the employees interviewed by Inspector Lambert could recall seeing the covers prior to the accident. (Tr. 35). These covers provide insulation between energized phases and grounded metal parts near the breaker. As stated in Petitioner's Exhibit 7, page 2,

> "The decedent Mr. McSherry may have grounded his meter lead between an energized phase connection located at the base of the breaker and a grounded mounting bracket located immediately adjacent to the energized phase. The grounding electrical spark may have triggered a phase-to-phase power reaction which would instantly create an ionized air explosion and fire."

Mr. Sherry had been employed as an electrician by Phelps Dodge Chino Mines Company since 1992. He worked on and was familiar with all aspects of the Mine and SX/EW electrical systems. He was certified to work on 480-volt high amperage systems. Prior to working for Phelps Dodge Chino Mines Company, he was an electrician for the United States Navy. (Ex. P-7).

The citation was issued as a Section 104(a) moderate negligence citation. It was nevertheless specially assessed and a penalty of $50,000.00 was proposed. The operator contends that the proposed $50,000.00 penalty is "clearly excessive in light of the factors to be considered under 30 C.F.R. § 100.5," and states that MSHA Agency completely disregarded the numerous mitigating factors. Evidence was presented that Respondent did not know and had no reason to know that the top and bottom covers for the main breaker were missing at the time of the accident. Only the middle cover was in place. The main breaker is enclosed in the mobile control center and is not open to view without opening both the outer and inner panel of the enclosure. (Tr. 48). The main panel doors have to be opened to gain access to the breaker covers which can then be unscrewed by an electrician. Both McSherry and Giambernandi were electri-cians qualified to work on 480-volt equipment. Witness statements obtained by Inspector Lambert during his investigation of the accident disclosed that unless the breaker malfunctions, there is no reason for the panel covers to be removed. Respondent thus contends that the evidence supports its position that the breaker had been functioning properly for over five years after it was installed in May 1992 by qualified hourly electricians. Witness statements obtained by Inspector Lambert during his investigation of the accident indicated that no one was aware of any malfunction of the main breaker between the time of its installation by Respondent's hourly electricians in May 1992 until the time of the accident. Witness statements obtained by Inspector Lambert also disclosed that there was no maintenance reason for any Chino Mines'

employee to have observed that circuit breaker between May of 1992 and the date of the accident. (Tr. 49).

Respondent, however, does not stipulate to the citation finding of negligence as "moderate" and implies the negligence was less than "moderate." (Tr. 43). I do not find any sound basis for diminishing the Inspector's finding of moderate negligence. It is self-evident that an employee or someone under Respondent's control removed the fiberglass covers enclosing the main breakers and failed to replace them at some time between Inspector Lambert's inspection of 1993 and the date of the accident. The absence of the covers appears to be a significant factor in the fatal accident. Respondent's investigation after the accident indicated that the decedent, Supervisor McSherry, may have caused the accident by working on the main breaker without the fiberglass covers for the bottom terminals in place and inadvertently permitted the grounding of his meter lead between an energized phase connection located at the base of the breaker and a grounded mounting bracket located immediately adjacent to the energized phase. (Ex. P-7). There was no need to remove the protective cover to test this breaker. Tr. 158, lines 8-15. I find no reason to modify or reduce the inspector's finding of "moderate" negligence in the citation. I agree and accept all the findings in the citation, including negligence, gravity, and S&S findings. The penalty for this citation along with the remaining two citations will be discussed below under Section IV with the heading "Penalty."

Citation No. 7850488

This citation was issued pursuant to Section 104 (a) of the Act and alleges a non-S&S violation of 30 C.F.R. § 50.10. The citation states the following:

> On June 7, 1997, at 0645 hours, two shift supervisors from Burro Chief Copper Company, SX/EW, received serious burn injuries, and an electrician supervisor from Phelps Dodge Corporation, Chino Mines Company mine, received critical burn injuries, when a 480-volt electrical circuit breaker exploded. The 480-volt circuit breaker was located in the Siemens Motor Control Center west of the tank house at the SX/EW plant. On June 8, 1997, at 0700 hours[1], the electrical supervisor died of his burn injuries.
>
> The operator did not immediately contact the MSHA District nor the Subdistrict office having jurisdiction over the SX/EW plant, or call the MSHA headquarters office in Arlington, Virginia. On June 7, 1997, at 1257
>
> hours the operator did call the MSHA Albuquerque,

---

[1] It is undisputed that death occurred June 8, 1997, at 1:10 a.m. not at 0700 hours, as alleged in the citation.

> New Mexico, field office, and left a message on the answering machine. The message stated that there had been an "unplanned explosion when a switch blew up, and it burned an electrician. The employee had been burned enough to where he had to go to the hospital."

The cited standard 30 C.F.R. § 50.10 provides as follows:

> **§ 50.10 Immediate notification.**
>
> If an accident occurs, an operator shall immediately contact the MSHA District or Subdistrict Office having jurisdiction over its mine. If an operator cannot contact the appropriate MSHA District or Subdistrict Office, it shall immediately contact the MSHA Headquarters Office in Arlington, Virginia, by telephone, at 800-746-2554.

"Accident" as used in the cited standard quoted above is defined in § 50.2(h) as

> An injury to an individual at a mine which has a reasonable potential to cause death;

Supervisor McSherry died from his burn injuries early Sunday morning, June 8th, at 1:10 a.m. Thus he died within 19 hours after the accident. Sadly, his death from the burn injuries he sustained in the June 7th accident establishes beyond any doubt or debate that the injury caused by the accident was an injury that had a reasonable potential to cause death.

Respondent contends that its agents were not aware that McSherry's injuries were so serious that the injury had a reasonable potential to cause death. Immediately after the accident, McSherry was taken by ambulance to the emergency room of the Gila Medical Center Hospital in Silver City. Accompanying McSherry in the ambulance was Respondent's Emergency Medical Team EMT, Mark Osborne. Dr. Neely was McSherry's attending physician in the emergency room at the Gila Hospital. Dr. Neely told the mine's EMT Osborne, that McSherry had second degree burns over 70 to 80 percent of his body. Dr. Neely also told Osborne that he thought McSherry "had a chance to survive." (Tr. 98). By 8 a.m. they were already making arrangements to airlift McSherry to the Burn Center in Albuquerque, New Mexico. By 9 a.m. McSherry was being transported by air to the Albuquerque Burn Center. Tr. 107.

Among other employees of the Respondent who were at the Gila Medical Center before McSherry's flight to Albuquerque commenced was Mr. Steve Holmes, who at that time was manager for Chino Mines. Holmes was the coordinator of the company's investigation of the accident. (Tr. 158, lines 10-11). Upon hearing of the accident about 7 a.m. on June 7, Holmes immediately traveled to the Gila Regional. Medical Center. He testified his first priority was to determine the condition of the employee, Rob McSherry. At this hospital, just outside the

emergency room, Holmes met Respondent's EMT, Mark Osborne. Holmes testified that Osborne told him that McSherry had first and second degree burns over 60 to 70 percent of his body and that McSherry was talking coherently when he was being transported by ambulance to the Gila Medical Center. Holmes testified that Osborne told him that he thought McSherry was going to be okay. Holmes did not try to talk to McSherry as McSherry's family members came to the hospital and were talking to McSherry while he was being prepared for air transport to Albuquerque. Unfortunately, Holmes as coordinator of the investigation whose first priority was to determine the condition of McSherry, did not talk to Dr. Neely to ascertain McSherry's condition or to determine whether the injury had a reasonable potential to cause death.

Later the same day, about 11 p.m. at the Albuquerque Burn Center, McSherry's condition took a decided turn for the worst and in spite of all efforts to save him, he died two hours later at approximately 1:10 a.m.

David Hays, Respondent's safety director, was kept advised of McSherry's condition by the EMT Osborne during the period of time McSherry was at the Gila Medical Center. Hays had basic first aid training and testified he knew second degree burns could cause shock that could cause death. He testified that Lillian Medina, an employee, was dispatched to the Albuquerque Burn Center to be in contact with McSherry and to see how McSherry was progressing. About 11 p.m. Hays received a disturbing call from Medina that McSherry's condition changed for the worst, and a second call at 1:30 a.m. notified Hays that McSherry was dead. Hays waited until 7 a.m. that same Sunday morning, June 8th, to phone Mr. McLloyd at his residence to report that McSherry died. Hays testified that in the 7 a.m. phone call, McLloyd acknowledged that he was already aware of the recorded message concerning the June 7th accident that Respondent put on MSHA's Field Office telephone recorder on Saturday, June 7th, about 1 p.m.

Dr. Neely was McSherry's attending physician in the emergency room at the Gila Medical Center. Both parties point to Dr. Neely's statement that McSherry "had a chance to survive," in support of their respective positions. That statement by the attending emergency room doctor clearly demonstrates that the injury had the potential to cause death. I find that a reasonable person with basic first aid training on receiving the information from Dr. Neely or Osborne should have known that the injury was one that had a reasonable potential to cause death. Respondent should also have known from the extensive burns on such a large area of McSherry's body, that the injury had the potential to cause death. That, along with the statement of Dr. Neely indicating only a chance to survive should have made Respondent aware by 9 a.m., June 7th, that the injury had a reasonable potential to cause death. Respondent should have called the Arlington office at the 800 number set forth in the cited standard.

The evidence presented clearly established that the injury McSherry sustained in the accident had a reasonable potential to cause death and, in fact, the potential became a reality with death occurring at the Burn Center within 19 hours of the time of the accident. I find that Respondent's general manager, Holmes, the EMT man Osborne, and Respondent's safety director Hays knew or should have known the injury had a reasonable potential to cause death and should have made the immediate notification to MSHA, required by the cited standard

by 9:30 a.m. on June 7th, the day of the accident. There are mitigating circumstances which will be discussed below under Section IV with the heading "Penalty".

Citation No. 7850489

This citation is issued pursuant to Section 104(a). It alleges a non-S&S violation of: 30 C.F.R. § 50.12 and charges as follows:

> On June 7, 1997, at 0645 hours, two shift supervisors from the Burro Chief Copper Company, SX/EW plant, received serious burn injuries, and an electrical supervisor from the Phelps Dodge Corporation, Chino Mines Company mine, received critical burn injuries, when a 450 volt electrical circuit breaker exploded. The 480-volt circuit breaker was located in the Siemen Motor Control Center west of the tank house at the SX/EW plant.
>
> The operator did not preserve the accident site. On June 7, the circuit breaker that had exploded was removed and was replaced by another circuit breaker. On June 8, 1997, the Operator called the MSHA, Albuquerque, New Mexico, field office supervisor and informed him that the electrical supervisor had died. The operator was told not to change anything at the accident site. On June 9, 1997, when the accident investigation began by MSHA, the operator had already removed the replacement circuit breaker.

The cited standard, 30 C.F.R. § 50.12, provides as follows:

> 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.

The accident involving the explosion of the 480-volt electric circuit breaker occurred at 6:45 a.m. Saturday morning, June 7, 1997. No attempt was made to call the District Manager whose office is in Dallas, Texas. However, testimony was presented that the Albuquerque field office had jurisdiction over the mine in question since there are no subdistrict offices in the South Central District.

At 12:57 p.m. Respondent dialed the Albuquerque Field Office phone number. There was no response. That office is not open on Saturdays or Sundays so a message was left on the field office telephone recorder. The second phone call to MSHA was on June 8 at 7 a.m. This

was a courtesy call by Hays to Tom Lloyd, Supervisor of the field office. The call informed Lloyd that McSherry died at 1:10 a.m. that morning. In the conversation Lloyd told Hays not to change anything at the accident site. However, the respondent, by the time of that call, had already replaced the defective circuit breaker by 10:30 a.m. on June 7th. The MSHA investigation commenced about 3 p.m. on Monday, June 9. Clearly there was a violation of the cited standard. There are mitigating circumstances, however, that will be discussed below under the Penalty heading.

IV.

PENALTY ASSESSMENT

Section 110(i) set forth six criteria to be considered in the assessment of penalties under the Act:

> [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 on 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 a rapid compliance after notification of a violation.

In addition, Commission Procedural Rule 29 C.F.R. § 2700.30a emphasizes the need for a finding on each of the statutory criteria contained in section 110(i).

30 C.F.R. § 100.5(a) under the heading of "Determination of Penalty special assessment provides as follows:

> (a) MSHA may elect to waive the regular assessment formula (§ 100.3) or the single assessment provision (§ 100.4) if the Agency determines that conditions surrounding the violation warrant a special assessment. Although an effective penalty can generally be derived by using the regular assessment formula and the single assessment provision, some types of Violations may be of such a nature or seriousness that it is not possible to determine an appropriate penalty under these provisions. Accordingly, the following categories will be individually reviewed to determine whether a special assessment is appropriate.

Citation No. 7859009 Penalty Assessment

The violation charged in Citation No. 7859009 involves a fatality. Consequently, MSHA under 30 C.F.R. § 100.5(a)(1) is on solid ground for special assessment of the penalty for that

violation. MSHA has less solid ground or reason for special assessment of the penalty for the violations charged in Citation No. 7850488 concerning notification of the accident and Citation 7550488 involving alteration of the accident site prior to the completion of the MSHA investigation.

With respect to Citation No. 78559009, I have discussed above why I found no reason to modify any of the findings in the citation. There is no reason to diminish the Inspector's finding of "moderate" negligence in view of the hazard created when the covers for the main breaker were not replaced after they had already been removed at some time after Inspector Lambert's inspection in 1963, and the fact that Respondent's electrical supervisor on the morning of June 7 went ahead and worked on the main breaker without the required covers for the electric terminals. Because of the violation, it took only a second of inadvertent lack of careful attention on the part of McSherry to cause a serious accident that resulted in the tragic death of McSherry and serious injury to three employees. The gravity of the violation was very high.

The parties stipulated that Respondent demonstrated good faith in taking immediate abatement steps addressing each of the violations. (Stip. No.9). The size of the Respondent's business if large. The annual number of hours worked by its mine's controlling entity is approximately six million and the annual hours worked at the mine were 1,647,574. I do find as a mitigating factor the fact that Respondent had a very good history of previous violations. Tr. 52; Tr. 212, line 1-12, Resp's Ex. 7. Respondent, in the two years preceding the issuance of the citations, paid penalties on ten violations. (Pet. Ex. 1).

Respondent has a good Preventive Maintenance Program that was effective and resulted in the good prior history. The main breaker, however, was enclosed and needed no maintenance. It was a breaker that either worked or did not work. It functioned without any problem during the five years preceding the accident. The parties stipulated the proposed penalties would not affect Respondent's ability to continue in business. (Stip. No. 8)

Everything considered, I find the appropriate penalty for this serious S&S violation of the cited standard, 30 C.F.R. § 56.1200 is $27,000.00.

Citation No. 7850488 Penalty Assessment

The evidence presented established that Respondent did not immediately contact any MSHA personnel at the Albuquerque Field Office, the District Office in Dallas, Texas, nor the MSHA headquarters in Arlington, Virginia. Apparently, Respondent were under the impression that as long as they believed McSherry would not die, they did not have to make immediate notification of the accident to MSHA. That is not the proper interpretation of the cited standard. The standard requires immediate notification of an accident that causes an injury which has a reasonable potential to cause death.

Respondent made a feeble attempt to contact MSHA by a telephone call to the Albuquerque Field Office. They did not contact any MSHA personnel until Sunday, June 8, after McSherry died. The MSHA investigation commenced about 3 p.m. Monday, June 9. In

many cases the violation of the regulation could be much more serious than it is under the facts in this case. Under the facts of this case there is no showing of any potential harm by the failure to notify MSHA immediately. Under the facts and circumstances in this case the violation in some respects is more akin to a paper violation. Respondent showed good faith but misjudged the requirements of the standard and misjudged the severity of McSherry's injury caused by the accident. On evaluating of all the facts, I find that negligence was "moderate" rather than high. I would affirm every other factor in the Inspector's evaluation as set forth in Section II of the citation. In view of all the above, including Respondent's very good history of prior citations, I assess a penalty of $800 for this violation of 30 C.F.R. § 50.10.

Citation 7850489 Penalty Assessment

Within two hours of the accident, Respondent commenced his investigation of the accident. Respondent took photographs of the entire accident scene to preserve all the associated evidence and made it available to the inspectors. Respondent removed and replaced the main breaker that exploded. Respondent preserved the main breaker and all the equipment and paraphernalia associated with the accident. MSHA began the investigation on Monday, June 9.

Before writing the citation, the Inspector never questioned the reason why the breaker that exploded was replaced within a few hours after the accident. One important reason was that Respondent was concerned with a potential environmental hazard. When the main breaker is inoperable, the entire SX-EW plant is down and the plant's holding dam (Dam 8) is at risk of overflowing its acidic bleaching fluid. (Tr. 125-126, 131, 190). There is no downstream protection for the pool at Dam 8 to prevent the acidic bleaching overflow to move into the environment and damage plant life and possible animal life. If the bleaching solution in the deep ponds were to overflow, the acidic solution, in addition to harming the environment, would constitute a violation of Respondent's water discharge permit issued by the state of New Mexico.

Respondent fully cooperated with MSHA in the investigation. It appears from the record that Respondent did not intend to hinder or delay MSHA's investigation in any way.

Everything considered, including Respondent's very good prior history, Respondent's cooperation with MSHA in its investigation, and the need to protect against the potential harm to the environment, I assess a penalty of $600.00 for the violation of the cited safety standard 30 C.F.R. § 5012.

ORDER

Citation No. 7859009 with its S&S finding is **AFFIRMED**. Citation Nos. 7850488 and 70850489 are **MODIFIED** by changing the negligence factor form "high" to "moderate" and, as so modified, are **AFFIRMED.**

Respondent, Chino Mines Company is **ORDERED TO PAY** a civil penalty of $28,400.00 within 30 days of the date of this decision.

August F. Cetti
Administrative Law Judge

Distribution:

Ernest Burford, Esq., Office of the Solicitor, U.S. Department of Labor, 525 South Griffin Street Suite 501, Dallas, TX 75202

Katherine Shand Larkin, Esq., JACKSON & KELLY, 1660 Lincoln Street, Suite 2710, Denver, CO 80264

/ek