FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

OFFICE OF ADMINISTRATIVE LAW JUDGES
601 New Jersey Avenue, N.W., Suite 9500
Washington, D.C. 20001

July 19, 2004

BLUE DIAMOND COAL COMPANY,	:	CONTEST PROCEEDINGS
Contestant	:	
	:	Docket No. KENT 2002-99-R
	:	Citation No. 7476996; 12/3//2001
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	:	Docket No. KENT 2002-100-R
	:	Order No. 7476997; 12/3/2001
	:	
	:	Docket No. KENT 2002-101-R
	:	Order No. 7476998; 12/3/2001
v.	:	
	:	Docket No. KENT 2002-102-R
	:	Order No. 7476999; 12/3/2001
	:	
	:	Docket No. KENT 2002-103-R
	:	Citation No. 7477000; 12/3/2001
	:	
SECRETARY OF LABOR,	:	Docket No. KENT 2002-104-R
MINE SAFETY AND HEALTH	:	Order No. 7478001; 12/3/2001
ADMINISTRATION, (MSHA),	:	
Respondent	:	Mine No. 77

SECRETARY OF LABOR,	:	CIVIL PENALTY PROCEEDING
MINE SAFETY AND HEALTH	:	
ADMINISTRATION (MSHA),	:	Docket No. KENT 2002-255
Petitioner	:	A. C. No. 15-09636-03687
	:	
v.	:	
	:	
BLUE DIAMOND COAL COMPANY,	:	
Respondent	:	Mine No. 77

DECISION

Appearances: MaryBeth Zamer Bernui, Esq., Office of the Solicitor, U.S. Department of Labor, Nashville, Tennessee, on behalf of the Secretary of Labor;
Melanie J. Kilpatrick, Esq., Wyatt, Tarrant & Combs, LLP, Lexington, Kentucky, on behalf of Blue Diamond Coal Company.

Before: Judge Zielinski

These cases are before me on Notices of Contest filed by Blue Diamond Coal Company ("Respondent"), and a Petition for Assessment of Civil Penalties filed by the Secretary of Labor ("Secretary"), pursuant to section 105 of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 815 ("Act"). The petition alleges that Blue Diamond is liable for six violations of the Secretary's regulations applicable to underground coal mines, and proposes the imposition of civil penalties totaling $315,000.00. A hearing was held in Hazard, Kentucky, and the parties filed briefs after receipt of the transcript. For the reasons set forth below, I find that Blue Diamond committed the violations and impose civil penalties totaling $90,500.00.

Findings of Fact - Conclusions of Law

On July 20, 2001, Gary Caudill was electrocuted while working in Blue Diamond's No. 77 mine, located in Perry County, Kentucky. Caudill, who had been a certified electrician for about 14 months, was assigned to the 010 section on the third shift. He and Toy Coots, who was listed on Blue Diamond's time sheets as "shift chief electrician 3," were assigned to disconnect wiring to the 010 section's head drive, so that the equipment could be moved. They went underground about 2:00 a.m., after waiting for a fellow employee who was late.

When they arrived at the end of the track, Coots proceeded toward the area of the head drive, passed through a "man door," and surveyed the area to ascertain what had to be done. He then went back out the man door and around to the 300 kilovolt ("KV") power center that supplied electrical power to the two pieces of equipment in that area, the #9 head drive (the 010 section's head drive) and a 20 horsepower ("HP") booster pump. The power center, head drive and booster pump are depicted in exhibit P-3. While the equipment and the power center were located in close proximity, they were separated by a concrete block brattice wall, and getting from the equipment to the power center involved traversing over 1,000 feet and passing through three man doors. As Coots left the area, he passed Caudill, who was proceeding to the head drive. Coots opened a man door in the brattice that enclosed the power center and observed that the connector for the head drive's power cable, referred to as a "cat head," had been pulled and was laying on the floor. No lock had been placed on it, to prevent insertion into the power center's circuit breaker. He placed his lock on the connector, and proceeded back to the area of the head drive. The circuit breaker for the head drive's power cable was located very close to the man door. Coots did not actually enter the power center enclosure and did not check the breaker for the booster pump, which was located on the far side of the power center.

When Coots arrived at the head drive, he saw Caudill working on the head drive's starter box ("belt starter box" or "belt box"), a three-sectioned metal box housing switches that transmitted electric power from the power center to the drive's motor. Coots assisted in pulling the motor leads from the belt box after Caudill had disconnected them. He then began to remove guards from the head drive, located approximately 25 feet away, while Caudill continued to work on the belt starter box.

Coots heard Caudill say something to the effect that he thought there might be power on the belt box. He replied that there shouldn't have been power on the box because the cat head had been pulled and locked.[1] A very short time later, no more than a few seconds, Coots heard Caudill scream and saw that he had fallen to the floor. At first, Coots thought that Caudill was joking, because he had acted in such a manner about a week earlier. He shouted at Caudill, but got no response, and then proceeded over to where he was laying. It was apparent that Caudill was not faking distress. His arm was resting against the belt box, and the sleeve of his shirt was caught on the latch on one of the box's doors. Coots grabbed Caudill's suspenders and tried to pull him away, but felt electrical power. He then turned and used his foot to move Caudill away from the box. Coots attempted to revive Caudill, but was unable to do so. He then ran to the man-door to the section and called out to the 010 section crew that was working about 150 feet away.[2]

Sam Combs, the foreman, and the rest of the crew ran to where Caudill was located. Combs sent for an Emergency Medical Technician ("EMT") and a Mine Emergency Technician ("MET"). He and Tommy Rice performed CPR on Caudill for about 10 minutes. Rice mentioned that he felt power on the box. Combs then sent Gary Hubbard to check and make sure there were no power cables plugged into the power center.[3] Tr. 177, 186-87. Robert Begley was an EMT and foreman on the 010 section's second shift, which was working overtime to assist in moving the equipment.[4] He and his electrician, Jeffrey Begley, an MET, ran some 33 breaks from where they were working to the accident scene. As they arrived, Sam Combs was exiting the man door to the head drive area to look for them. Robert Begley asked him if all power was off. He reported that it was, and there were no lights in the area. Tr. 215, 254-55. Coots also said that all power was off. Tr. 218. The Begleys performed CPR on Caudill, but had great difficulty establishing and maintaining an airway. Caudill's jaw was locked and he felt cold. Tr. 259. After about 30 minutes, they abandoned their effort.

When Robert Begley learned that Combs had had difficulty notifying surface officials, he sent a man down to the end of the track line, where another phone was located. After abandoning the CPR effort, Begley went to that phone and called John Boylen, Blue Diamond's director of operations, who directed that Caudill be evacuated, and that all employees be removed

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[1] The exact wording of Coots' reply is disputed.

[2] There was a mine phone on the belt box, but the 20-volt data line to the box, including the phone line, had been cut.

[3] Combs did not mention that he had ordered that any power be disconnected during the investigation. He testified that he recalled doing so only after receiving a subpoena to testify at the hearing. Tr. 187. He did not recall whether Hubbard reported back that he had disconnected any power cables. Tr. 189.

[4] Robert Begley was called in that day because the second shift foreman had quit.

from the area. He also instructed Begley that nothing involved in the accident was to be disturbed and that the site was to be preserved for investigations. Combs testified that Rice knocked a hole in the concrete block brattice between the accident scene and the power center, in an attempt to create a shorter passage for the evacuation, but Combs told him to leave it alone. Tr. 192. The Secretary's Mine Safety and Health Administration ("MSHA") was notified of the accident and an investigation was begun immediately by MSHA and State officials.

When investigators arrived at the scene of the accident, they found no power source on the belt box that could have produced a fatal injury. Its power cable had been disconnected and locked out at the power center. The power cable to the nearby booster pump had also been pulled, but not locked out. The cut data/phone line carried only 20 volts, and there were no other wires connected to the box. Their most significant discovery was a 118-foot length of 16/3 wire that had been cut at one end.[5] A piece of identical wire, about seven inches long, was found immediately adjacent to the starter box of the booster pump. The cut ends of those wires mated-up, as depicted in exhibit P-9. The investigators eventually determined that the wire had been used as a control circuit between the booster pump and the belt starter box, so that the pump would operate whenever the head drive belts were running.[6] One end had been connected to the start/stop switch contacts in the pump's starter box, which carried 480 volts. The other end had been inserted into the belt starter box and attached to interlock contacts that closed when the head drive was energized. This substituted the contacts in the belt starter box for the manual start/stop switch in the pump's starter box.

The primary ground connection for equipment is supplied through its main power cables. When they are plugged into the power center, those pieces of equipment are properly grounded. Ground leads in wires connecting various elements of the equipment, e.g., disconnect switches, starter boxes, and motors, assure that all such elements are grounded through the power center. The ground conductors in the 16/3 wire had been cut off at both ends at the point that outer insulation had been stripped back to, i.e., the ground wire had not been connected to either the belt box or the pump starter box. Consequently, the control circuit had not been grounded. As wired prior to the accident, when the head drive power cable was disconnected, the belt starter box was no longer grounded – yet power was being delivered to the box by the ungrounded 480-volt control circuit connected to the pump's starter box.

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[5] The "16" refers to the size of the conductors, and the "3" refers to the number of conductors. The three conductors in the wire are separately insulated by color-coded material. The conductors that carry current are colored white and black, respectively. The third conductor is a ground wire, which appears to have had a green insulating covering. Ex. P-9.

[6] The pump increased water pressure to spray nozzles used for dust control. The water lines were somewhat fragile and tended to rupture if the pump was operated for lengthy periods. Since the high-pressure sprays were needed only when coal was actually being mined, the pump was wired so that it would operate with the head drive.

In the early morning hours of July 20, 2001, MSHA and the State of Kentucky commenced a thorough investigation of the fatal accident. Their efforts were frustrated by the changes that had been made to the accident scene, the absence of records, and a lack of candor on the part of Blue Diamond employees. The identity of the electrician who installed the pump's control circuit was never ascertained. Nor was it determined exactly how Caudill came into contact with the energy source. After eliminating other potential sources of power, including other nearby equipment, stray current from surface overhead electrical lines, and even lightning, the investigation team determined that Caudill most likely encountered at least one phase of the 480-volt control circuit, either by touching one of its leads or by touching the frame of the belt box when the lead was in contact with it.[7] The ultimate conclusion reflected in the Report of Investigation was that Caudill came "into contact with energized electrical components [as a result of work] being performed on energized electrical equipment prior to the mine operator's ensuring that all electrical power sources to the equipment were properly locked and tagged out." Ex. P-1, at 11.

Based upon the findings and conclusions of the investigative team, on December 3, 2001, MSHA issued one citation and four orders to Blue Diamond, charging violations of mandatory safety standards for underground coal mines and one citation charging a violation of a regulation mandating preservation of accident sites. The five charges based upon safety standards were issued pursuant to section 104(d) of the Act, and alleged that the violations "could significantly and substantially contribute to the cause and effect of a coal . . . mine safety . . . hazard, . . . [and were] caused by an unwarrantable failure of [the] operator to comply with [the] mandatory safety standard." 30 U.S.C. § 814(d). It was also alleged that each of the violations was a cause of the fatal accident. The Secretary proposed civil penalties of $55,000.00, then the statutory maximum, for each of those violations, and a civil penalty of $40,000.00 for the site alteration charge. Blue Diamond timely contested the issuance of the charges and the proposed penalties. Proceedings were stayed pending completion of investigations into potential criminal charges and additional civil penalty assessments against individual agents of the operator. At the conclusion of those investigations, no additional charges were brought. Additional delay was prompted by the initiation of bankruptcy proceedings by Blue Diamond's parent company, the James River Coal Company.

The alleged violations are discussed below.

Citation No. 7476996

Citation No. 7476996, alleges a violation of 30 C.F.R. § 75.509, which requires that, "All power circuits and electrical equipment shall be deenergized before work is done on such circuits and equipment, except when necessary for trouble shooting or testing." The "Condition or Practice" section of the citation reads:

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[7] The 480-volt power was supplied in two phases. The potential from one phase to ground was 277 volts. Spanning both phases yielded a potential of 480 volts.

> Work was performed on electrical circuits and equipment without all power first being deenergized, while under the direct supervision of the chief electrician.
>
> The electrical circuit (277 volts) entering the #9 belt starting box and supplying power to the 20 HP booster pump was not deenergized prior to work being preformed on the energized circuit. This resulted in a mine electrician contacting energized components and receiving fatal injuries on July 20, 2001.

Ex. Jt.-1.

The Violation

In an enforcement proceeding under the Act, the Secretary has the burden of proving an alleged violation by a preponderance of the evidence. *In re: Contests of Respirable Dust Sample Alteration Citations*, 17 FMSHRC 1819, 1838 (Nov. 1995), *aff'd, Sec'y of Labor v. Keystone Coal Mining Corp.,* 151 F.3d 1096 (D.C. Cir. 1998); *ASARCO Mining* Co., 15 FMSHRC 1303, 1307 (July 1993); *Garden Creek Pocahontas Co.*, 11 FMSHRC 2148, 2152 (Nov. 1989); *Jim Walter Resources, Inc.*, 9 FMSHRC 903, 907 (May 1987).

It is not disputed that Caudill worked on electrical circuits and equipment that had not been deenergized. The testimony of the Secretary's witnesses paralleled the findings in the Report of Investigation, exhibit P-1. All sources of power, other than the 480-volt control circuit, were eliminated as causes of Caudill's electrocution. While the belt drive's power cable connector had been pulled and locked out, the power cable connecter to the booster pump had not been pulled and the power supplied to the booster pump's control circuit caused the electrocution. It is also clear that the violation was significant and substantial.[8] The issue is whether the violation was the result of the operator's unwarrantable failure.

Unwarrantable Failure

In *Lopke Quarries, Inc.,* 23 FMSHRC 705, 711 (July 2001), the Commission reiterated the law applicable to determining whether a violation was the result of an unwarrantable failure:

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[8] A significant and substantial ("S&S") violation is described in section 104(d)(1) of the Act as a violation "of such nature as could significantly and substantially contribute to the cause and effect of a coal or other mine safety or health hazard." A violation is properly designated S&S "if, based upon 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 Div., Nat'l Gypsum Co.*, 3 FMSHRC 822, 825 (Apr. 1981); *see also U.S. Steel Mining Co., Inc.*, 7 FMSHRC 1125, 1129 (Aug. 1985); *Mathies Coal Co.*, 6 FMSHRC 1 (Jan. 1984); *Austin Power, Inc. v. Sec'y of Labor*, 861 F.2d 99, 103-04 (5th Cir. 1988), *aff'g Austin Power, Inc*., 9 FMSHRC 2015, 2021 (Dec. 1987) (approving *Mathies* criteria).

> The unwarrantable failure terminology is taken from section 104(d) of the Act, 30 U.S.C. § 814(d), and refers to more serious conduct by an operator in connection with a violation. In *Emery Mining Corp.*, 9 FMSHRC 1997 (Dec. 1987), the Commission determined that unwarrantable failure is aggravated conduct constituting more than ordinary negligence. *Id*. at 2001. Unwarrantable failure is characterized by such conduct as "reckless disregard," "intentional misconduct," "indifference," or a "serious lack of reasonable care." *Id*. at 2003-04; *Rochester & Pittsburgh Coal Co.*, 13 FMSHRC 189, 194 (Feb. 1991) ("*R&P*"); *see also Buck Creek* [*Coal, Inc. v. FMSHRC*, 52 F.3d 133, 136 (7th Cir. 1995)] (approving Commission's unwarrantable failure test).
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> Whether conduct is "aggravated" in the context of unwarrantable failure is determined by looking at all the facts and circumstances of each case to see if any aggravating factors exist, such as the length of time that the violation has existed, the extent of the violative condition, whether the operator has been placed on notice that greater efforts are necessary for compliance, the operator's efforts in abating the violative condition, whether the violation is obvious or poses a high degree of danger, and the operator's knowledge of the existence of the violation. *See Consolidation Coal Co.*, 22 FMSHRC 340, 353 (Mar. 2000) . . . ; *Cyprus Emerald Res. Corp.*, 20 FMSHRC 790, 813 (Aug. 1998), *rev'd on other grounds*, 195 F.3d 42 (D.C. Cir. 1999); *Midwest Material Co.*, 19 FMSHRC 30, 34 (Jan. 1997); *Mullins & Sons Coal Co.*, 16 FMSHRC 192, 195 (Feb. 1994); *Peabody Coal Co.*, 14 FMSHRC 1258, 1261 (Aug. 1992); *BethEnergy Mines, Inc*., 14 FMSHRC 1232, 1243-44 (Aug. 1992); *Quinland Coals, Inc.*, 10 FMSHRC 705, 709 (June 1988). All of the relevant facts and circumstances of each case must be examined to determine if an actor's conduct is aggravated, or whether mitigating circumstances exist. *Consol*, 22 FMSHRC at 353. Because supervisors are held to a high standard of care, another important factor supporting an unwarrantable failure determination is the involvement of a supervisor in the violation. *REB Entrs., Inc.*, 20 FMSHRC 203, 225 (Mar. 1998).

Involvement of an operator's agent, typically a supervisor, is particularly significant because the negligence of an agent can be imputed to the operator for purposes of unwarrantable failure and civil penalty assessment. *E.g., Capital Cement Corp.*, 21 FMSHRC 883, 893 (Aug. 1999) (citing *R&P*, 13 FMSHRC at 194-97). "Managers and supervisors in high positions must set an example for all supervisory and non-supervisory miners working under their direction. Such responsibility not only affirms management's commitment to safety but also, because of the authority of the manager, discourages other personnel from exercising less than reasonable care." *Id.* at 892-93 (quoting from *Wilmot Mining Co.*, 9 FMSHRC 684, 688 (Apr. 1987)).

Section 3(e) of the Act defines "agent" as "[a]ny person charged with responsibility for the operation of all or a part of a coal or other mine or the supervisor of the miners in a coal or other mine." 30 U.S.C. § 802(e). In considering whether an employee is an operator's agent, the

Commission has relied, not upon the job title or the qualifications of the miner, but upon his function, and whether it is crucial to the mine's operation and involves a level of responsibility normally delegated to management personnel. *Martin Marietta Aggregates*, 22 FMSHRC 633, 637-38 (May 2000); *REB Enterprises. Inc.*, 20 FMSHRC at 211; *Ambrosia Coal & Constr. Co.*, 18 FMSHRC 1552, 1560 (Sept. 1996); *U.S. Coal Inc.*, 17 FMSHRC 1684, 1688 (Oct. 1995).

The Commission has relied upon precedent developed under the National Labor Relations Act, 29 U.S.C. § 141, *et seq.*, to the effect that the authority to assign tasks and make schedules is not sufficient to afford an individual supervisory status. *Martin Marietta*, 22 FMSHRC at 638. In *Ambrosia* it was held that a "person in charge" was an agent because he performed functions that were crucial to the mine's operation and exercised responsibility normally delegated to management personnel. Those functions were: accompanying MSHA inspectors and attending close-out conferences as the operator's representative, conducting daily examinations and recording findings as a certified mine examiner, and issuing work orders to abate citations. There was also evidence that the agent held himself out as the employee in charge, signed documents as mine foreman and was viewed by other miners as a person with authority.

In *Whayne Supply Co.*, 19 FMSHRC 447, 451 (Mar. 1997), the Commission held that a "highly experienced repairperson who needed little supervision and helped less experienced employees [was not] a supervisor, much less a manger [because there was] no evidence that [he] exercised any of the traditional indicia of supervisory responsibility such as the power to hire, discipline, transfer, or evaluate employees [or that he] 'controlled' the mine or a portion thereof." Similarly, in *Martin Marietta,* it was held that an employee who had the authority to tell other miners how he wanted a job done and to stop them if he did not like what they were doing was not an agent or supervisor. His control was tightly circumscribed and he could not hire, fire, evaluate or discipline miners and could not take any action to abate citations, or change a miner's job or the equipment on a job, was paid at an hourly rate, and did not hold himself out as a supervisor or person in charge.

An employee's functions, and status as agent, are considered as of the time of his allegedly negligent conduct. *Martin Marietta* at 638; *REB* at 194; *Whayne Supply* at 452; *U.S. Coal* at 1688. Consequently, even a rank-and-file miner can be found to be an agent while performing critical, management-related functions such as required safety examinations. *R&P* (rank-and-file miner who was a certified mine examiner was agent of operator when assigned to perform such inspections); *compare Mettiki Coal Corp.*, 13 FMSHRC 760 (May 1991) (certified electrician acts as an agent when performing monthly electrical inspections), *with U.S. Coal*, 17 FMSHRC at 1688 (certified electrician does not act as an agent when performing routine repairs).

As stated in the citation and argued in the Secretary's brief, the unwarrantable failure allegation is principally based upon the contention that Coots was a supervisor and agent of Blue Diamond, and that his actions in responding to Caudill's concern that there might be power on

the box amounted to reckless disregard. In reaching the conclusion that Coots was Blue Diamond's agent, Conley, the lead investigator, relied solely upon Coots' job title, which was reflected on time sheets as "shift chief electrician 3."[9] Tr. 25, 41; ex. P-4. Patrick A. Stanfield, an MSHA electrical inspector, confirmed that Coots' actions were the basis of the unwarrantable failure charge, and also related his belief that Coots had been directing the work force, although he was unable to specify the grounds for that belief. Tr. 310, 315-16, 395-97. He later conceded that the determination was based upon Coots' title, and that he worked on the electrical portion of the investigation and left the determination regarding agency to Conley. Tr. 414-15, 422-26.

Coots was assigned to maintenance, and worked under Willie Collins, Blue Diamond's chief of maintenance. He was referred to as the "floater," and was the only electrician that was assigned to maintenance for the entire third shift. There were two other certified electricians that worked on the third shift: Caudill, who was assigned to the 010 section for the first part of the shift, and Roger Cornett, who was assigned to the 09 section for the first part of the shift. Tr. 444. The working sections were supervised by a foreman, and usually produced coal for the first 3-4 hours of the shift. When coal was being produced, Caudill and Cornett performed a variety of mining tasks, reported to, and were supervised by, the section foremen. Tr. 168, 200-01. Sam Combs was the foreman for the 010 section, and Troy Combs, Jr., was the foreman for the 09 section.

The last part of the third shift was usually devoted to maintenance. During that time, the section electricians joined Coots and worked on electrical maintenance tasks. They ceased being part of the section crews and were no longer supervised by the section foremen. Coots, Caudill and Cornett, as certified electricians, were qualified to work independently, and did so. Tr. 443. They did not review or inspect each other's work. Coots had approximately 3 years more experience as an electrician and was paid a little more than Caudill.[10] Coots, who had left Blue Diamond's employment in October 2001, testified that he was a floater, or troubleshooter, on the third shift. He helped the section electricians and was not Caudill's boss, but was more his helper. Tr. 78, 120-23. Collins described Coots' duties in similar terms. He was a floater, who handled the outby equipment, e.g., "rail runners, man trips and scoops." Tr. 442-43.

Collins and the second shift foremen identified maintenance tasks to be performed on the third shift. Tr. 445. Those tasks were usually transmitted from Collins in the form of work orders or a "to do" list. An electrician responsible for a certain task would perform the work required, sign-off on the work order, and turn it in at the end of the shift. Tr. 445-46. While Coots, who was typically the only electrician present at the beginning of the shift, may have

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[9] Coots was identified in the Report of Investigation as one of Blue Diamond's "principal officers." Ex. P-1, p.4. The title ascribed to Coots on the time sheet was apparently the sole basis for that determination.

[10] Collins testified that Coots was given the title of chief electrician in order to justify a slightly higher rate of pay, because experienced electricians were difficult to retain. Tr. 490-91.

distributed, or facilitated the distribution of the work orders, the actual assignment of tasks appears to have been more of an informal, ad hoc, process. Collins testified that Coots did not assign jobs to other electricians. Tr. 478.

Coots was generally responsible for obtaining in-stock parts needed for electrical repairs being done on the third shift, usually by physically walking out and getting them. Tr. 84, 443-44. Collins had to approve requests for parts that had to be ordered. Tr. 444. While it is not clear that other electricians could not also obtain parts, it appears that Coots was the primary person that performed that function.

Coots performed weekly electrical inspections on a regular basis.[11] Tr. 81. Other electricians also performed such inspections. Tr. 83. MSHA inspectors reviewed the electrical books and saw that Coots had signed-off in several places. There was no evidence that Caudill had signed the electrical books. Coots did not recall what areas he had inspected, and specifically could not recall whether he had inspected the booster pump, which had been installed approximately six weeks prior to the accident.[12] Tr. 141. He testified that he was not aware of the 480-volt control circuit running from the booster pump to the belt starter box.[13] Tr. 140. MSHA's witnesses did not specify the location of the equipment that Coots had certified that he had inspected on the electrical books. Nor did they state that Coots had signed-off on an inspection of the 010 section's head drive during the six weeks that it had been at that location.

On the day of the fatal accident, the 010 section second shift had been held over to help the third shift move the longwall equipment, and no production had occurred. Consequently, from the beginning of the shift, all three electricians worked on maintenance tasks associated with the move. Work orders were not issued for such tasks, in part, because it was difficult to predict exactly when the equipment move would be required. The "to do" list for that date directed that the electrical connections to the 010 section's head drive be removed. Coots and Caudill intended to jointly perform that task. According to Coots, Caudill liked to hurry and get started on any job. "He was the first one there." Tr. 154. When he and Coots arrived underground, Caudill apparently went directly to the power center and removed the power cable connector for the head drive. Coots first went to survey the work area. While he proceeded to the power center, where he placed his lock on the cable connector, Caudill began disconnecting

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[11] Electrical equipment is required to be examined weekly by a qualified person. 30 C.F.R. §§ 75.512 - 75.512-2.

[12] The parties stipulated that the booster pump had been installed on or about June 5, 2001.

[13] Coots knew that booster pumps were typically wired so that they would run when the belts ran. However, in his experience, that was accomplished by use of a "smoke roller," a roller with a mercury switch that closed when the moving belt caused the roller to spin. Tr. 87-88, 114-18.

the power cables and other wires at the belt starter box. Tr. 121. Caudill was not acting at the direction of Coots. He independently chose to begin disconnecting wires from the belt box.

Coots was paid on an hourly basis and did not have authority to hire, fire, or discipline other employees. These factors are of little significance, however, because foremen also were paid hourly and the power to hire and fire resided considerably farther up the chain of command. However, unlike Coots, foremen had the authority to recommend discipline and participate in disciplinary proceedings.

The Secretary argues that the testimony of two of Blue Diamond's supervisors, Sam Combs and Robert Begley, supports her allegation that Coots was a supervisor. However, while both witnesses made statements relied upon by the Secretary, other portions of their testimony substantially undercut the portions that the Secretary relies upon. There was also extremely limited foundation for their testimony on the supervisory structure for the electricians working maintenance and, at least as to Begley, an admitted lack of personal knowledge.

Sam Combs testified that floaters usually "were mostly in charge," and that "your float was usually considered one of the bosses." Tr. 164, 167. He also stated that he understood that the responsibility to make electrical examinations was Collins' and Coots'. Tr. 199-200. However, Combs specifically declined to state that Coots was in charge of telling Caudill what to do. Tr. 166. He later stated that when Caudill was working maintenance, Collins was his supervisor. Tr. 168. He added that Coots would not usually check on work being performed by Caudill. Tr. 167-68. Combs also believed that it was Collins' responsibility to assure that weekly electrical examinations were conducted and recorded in the books, although he added that the responsibility was Collins' and Coots', "I guess." Tr. 200. As to work assignments, Combs' understanding was that the electricians' maintenance tasks were "already laid out for them [on cards] before we ever arrived at the mines." Tr. 166.

Robert Begley, who was called in to be the second shift foreman on the 010 section on July 20, 2001, testified that "as far as [he] knew, [Coots] was like . . . the electrical boss on the third shift. He'd give . . . the to do list to the repairmen. Make sure, I guess, that they got . . . their stuff done." Tr. 253. However, he later testified that he did not work directly with the third shift electricians and "Collins made all the calls as far as electrical at the mine," and might have told Coots what the maintenance work assignments would be. Tr. 270.

I find that the functions performed by Coots were comparable to those of a "lead man," as described in *Whayne Supply* and *Martin Marietta*. He did not supervise Caudill's work or the work of other electricians. He did not decide what maintenance tasks would be performed. At best, he facilitated the distribution of work assignments to other third shift electricians. He was primarily responsible for physically obtaining parts needed for work on the third shift. While the Secretary makes much of this responsibility, she offers little support for the contention that this is a level of responsibility normally delegated to management personnel. Aside from conducting safety inspections, there is no evidence that Coots performed any of the functions identified in

Commission cases as those of an agent. Coots did not control a portion of the mine, and his functions were not those typically assigned to management. Consequently, when performing his routine duties, he was not Respondent's agent.[14]

R&P and *Mettiki* make clear that Coots acted as Blue Diamond's agent when performing weekly electrical examinations. However, the accident here, and the allegedly negligent conduct cited by the Secretary, did not occur when he was performing such an examination. Consequently, his alleged negligence cannot be imputed to Respondent.[15]

That does not end the inquiry, however, because the Secretary contends that, even if Coots were not Blue Diamond's agent, the company is chargeable with unwarrantable failure because of the overall dangerousness of the situation created, and its failure to assure that Caudill was aware that the booster pump's control circuit provided a source of power in the belt starter box. I find that Blue Diamond was negligent with respect to this violation, by failing to take steps to assure that an electrician working on the belt starter box would know that there was a second source of power to the box, but that the negligence was moderate.

Since Caudill and Coots were not agents of Respondent's, any negligence by them cannot be imputed to Respondent. *Whayne Supply*, 19 FMSHRC at 451-53; *Southern Ohio Coal Co.*, 4 FMSHRC 1459, 1463-64 (Aug. 1982). Blue Diamond's negligence, if any, must be ascertained by examining the supervision, training and discipline of its employees. *Id.*

Blue Diamond had a clear written policy that all electrical equipment was to be deenergized and locked out and tagged out prior to being worked on. Tr. 505-06; ex. R-7 at pp. 9-2 to 9-3. That policy was provided to its employees. Blue Diamond furnished appropriate equipment to its electricians: locks, voltmeters and voltage sensing wands. Tr. 509, 561. It provided training on proper lock/tag out procedures. In fact, it provided training on those procedures to Caudill and Coots only two days prior to the accident. Tr. 142-46; ex. R-1, R-2. It also had an enforcement program, which consisted of spot-checking electricians to assure that they complied with the deenergize, lock and tag out policy. Tr. 144, 240, 507, 510, 556-57.

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[14] Coots testified that he left Blue Diamond in October of 2001, for a "better job." Tr. 78. At the time of the hearing, he was working as an electrician, apparently in a non-supervisory position. Tr. 76. Had he been a supervisor, as the Secretary contends, it would be more likely that he would have remained in supervisory positions.

[15] The degree of Coots' negligence is a contested issue rendered moot by the finding that he was not acting as Blue Diamond's agent at the time. The Secretary argues that Coots was not aware of the control circuit. He knew that the power cable to the belt box had been disconnected and had reason to believe that there was no power on the box. Only a week earlier, Caudill had pretended to encounter power. Coots' reaction to Caudill's comment, under the circumstances presented here, would appear to be a tenuous foundation for her reckless disregard argument.

There is considerable evidence that Blue Diamond had a clear policy, thorough training and an effective enforcement system, to assure that electrical equipment was deenergized, and locked and tagged out, prior to being worked on. However, running a second source of power, particularly a 480-volt circuit, to another piece of equipment, and failing to clearly identify that source of power either on the equipment itself, or at the power center, created a potentially dangerous situation. Although Collins testified that such control circuits were not uncommon at the mine, he described no training program or other mechanism whereby electricians were informed of such wiring schemes. Stanfield testified that no one in mine management told MSHA that Coots or Caudill had been trained on how the box was wired. Tr. 325. Neither Caudill, nor Coots, was aware of the presence of the 480-volt control circuit in the belt box. Coots testified that there were no schematic, or other drawings of circuits for equipment such as the belt-box, that an electrician could consult to learn the presence of a second power source in the box.[16] Tr. 153.

Blue Diamond argues that it was entitled to rely upon the expertise of its certified electricians, and that Caudill should have identified the control circuit as a second source of power and deenergized it. Caudill was clearly negligent in failing to deenergize the starter box. He failed to effectively use his voltmeter, and especially his power sensing wand, to make sure there was no power on the box. He also failed to ascertain the presence and/or purpose of the 16/3 wire carrying 480 volts that entered the box. Nevertheless, failing to inform electricians about a second power source to a piece of equipment they were assigned to work on, leaving them to find it on their own, created a risk that was not consistent with the high standard of care to which supervisory officials are held.

Based upon consideration of the above factors, I find that Blue Diamond's negligence with respect to this violation was moderate. There was no direct involvement by any supervisor in Caudill's failure to deenergize the equipment, and many of the other factors typically considered in the unwarrantable failure analysis do not implicate Blue Diamond. The violation was isolated and of very short duration. There was no notice that greater efforts were necessary for compliance and no supervisor or agent of Blue Diamond was aware of the violation prior to the accident. The violation was promptly abated.

Order No. 7476998

Order No. 7476998, alleges a violation of 30 C.F.R. § 75.511, which requires, *inter alia*, that, "Disconnecting devices shall be locked out and suitably tagged by the persons who perform such work, . . . [and] shall be removed only by the persons who installed them." The basis for the violation was that the power cable connector for the booster pump was not locked out and suitably tagged while electrical work was being performed. Ex. Jt.-3.

[16] In fact, there was a mine wiring map that should have depicted the control circuit. However, it had not been kept up-to-date, and did not reflect the presence of the control circuit at issue, a violation for which Respondent was separately cited.

The Violation – S&S – Unwarrantable Failure

There is no dispute that the power cable connector for the booster pump, and its control circuit routed through the belt box, was not disconnected from the power center and was not locked out and suitably tagged. Blue Diamond disputes the alleged violation, contending that it is duplicative of the failure to deenergize violation charged in Citation No. 7476996. It also contends that if this order is found to be a proper separate charge, it was not a cause of Caudill's death, was not properly designated S&S, and was not due to its unwarrantable failure.

Citations and orders alleging violations of different standards arising out of the same, or related, conduct are not duplicative, as long as the standards involved impose separate and distinct legal duties on an operator. *Western Fuels-Utah, Inc.*, 19 FMSHRC 994, 1003-05 (June 1997) (citing *Cyprus Tonopah Mining Corp.*, 15 FMSHRC 367, 378 (Mar. 1993); *Southern Ohio Coal Co.*, 4 FMSHRC 1459, 1462-63 (Aug. 1982); and *El Paso Rock Quarries, Inc.*, 3 FMSHRC 35, 40 (Jan. 1981)). In *Western Fuels-Utah*, the Commission held that a charge of violating a specific standard was duplicative of a charge of violating a more general standard. However, the Commission made clear that its decision was not based solely upon the premise that every violation of the more specific standard would also be a violation of the more general one. Rather, it looked to whether the operator had been cited for more than one specific act or omission. Had there been evidence of additional deficiencies that violated the general regulation, such that that allegation would not have been based upon the identical evidence used to support the violation of the more specific standard, the charges would not have been found duplicative. *Id.* at 1004 n.12.

Here, Blue Diamond argues that every failure to deenergize will always involve a failure to lock out and suitably tag, because locking and tagging cannot be accomplished unless the device has been unplugged, i.e., deenergized. Accepting that as a correct statement, I find that the alleged violations are not duplicative because the standards impose separate and distinct duties, and the alleged violations are based upon two separate and specific omissions. The two standards are designed to address related, but different, duties. The first, section 75.509, requires that electrical power be disconnected prior to work being performed. The second, section 75.511, requires additional actions to assure that reenergizing does not occur accidentally when individuals are performing electrical testing or working on equipment. *See U.S. Coal Inc.*, 17 FMSHRC at 1684 n.1; *Badger Coal Co.*, 6 FMSHRC 874, 902 (Apr. 1984) (ALJ). The specific omission that supported the violation of section 75.509 was the failure to disconnect the booster pump's power cable. The specific omission that supported the violation of section 75.511 was the failure to lock and tag the disconnecting device. While it is true that every violation of section 75.509 will also entail a violation of section 75.511, the two standards impose separate and distinct duties and, consequently, charges that each were violated are not duplicative.

While the two charges are not legally duplicative, the unique facts of this case dramatically alter the causation and S&S analyses. There is no evidence that Caudill was killed

because the booster pump was reenergized, after having been disconnected. It was the failure to deenergize the pump that resulted in the fatality. The failure to lock and tag violation did not result in a fatality and, on the facts of this case, the failure to lock and tag *an energized circuit* did not incrementally increase the risk of injury already present. Consequently, I find that this violation was unlikely to result in an injury and was not S&S.

The violation was not the result of Blue Diamond's unwarrantable failure. Much of the analysis of unwarrantable failure with respect to Citation No. 7476996 applies fully to this violation, with the exception of the finding that Respondent was moderately negligent. Respondent's negligence with respect to the failure to deenergize citation was based upon its failure to impart knowledge of the control circuit to electricians who were assigned to work on the belt box. The lock and tag violation, at least legally, stands on its own footing, and the negligence found with respect to the citation has no application here. As noted previously, Caudill and Coots received specific training on lock and tag procedures only two days prior to the accident. Blue Diamond had a perfectly adequate written policy to lock and tag equipment and provided the equipment to facilitate that procedure. It also had an effective program of spot checking electricians to assure that they were complying with the required procedure. I find that Respondent was not negligent with respect to this violation.

Order No. 7476999

Order No. 7476999 alleges a violation of 30 C.F.R. § 75.512, which requires that, "All electric equipment shall be frequently examined, tested, and properly maintained by a qualified person to assure safe operating conditions. . . . A record of such examinations shall be kept and made available to an authorized representative of the Secretary and to the miners in such mine." The basis for the violation was described in the Conditions and Practice section of the order as:

> Electric equipment (20 HP booster pump and the #9 belt drive's starting box) had not been properly examined and maintained to assure safe operating conditions: 1) a separate circuit originating from the booster pump's start box had been wired to the #9 belt box; 2) the start/stop switch located on the booster pump had been defeated (by-passed), allowing the booster pump to start when the #9 conveyor belt was started; 3) the ground wires were found to have been cut at the booster pump and the belt drive starting box; and 4) the 20 HP booster pump was not listed in the records of the examination of the electrical equipment. The failure of the mine operator to insure proper examination and maintenance of electrical equipment contributed to the death of a mine electrician on July 20, 2001.

Ex. Jt.-4.

The Violation – S&S

Inspector Stanfield reviewed Blue Diamond's electrical books from the date of the accident back to year 2000. Although the booster pump should have been listed separately, and examined weekly, there was no record of the booster pump in the books. Tr. 337. There is no evidence that the booster pump and its control circuit had been examined by a qualified individual during the approximate six weeks that the pump had been installed. Respondent does not dispute that the pump should have been listed, but was not. It alleges that this order is duplicative of a citation issued on July 25, 2001, alleging a violation of the same regulation with respect to several pumps for which examination records were deficient. Alternatively, Respondent contends that the causal relationship between this violation and the electrical grounding violation alleged in Order No. 7476997 is the same, and that the two should not both be unwarrantable failure violations assessed at $55,000.00.

Blue Diamond's duplication argument is based upon Citation No. 7477177, issued by Stanfield on July 25, 2001. It alleged a violation of 30 C.F.R. § 75.512-2, based upon observations that the records of electrical examinations of "pumps, at the mine" did not show that they had been examined weekly, noting that the "last date of examination of the pumps was recorded on 4/19/2001." Ex. P-14. Blue Diamond contends that the booster pump on the 010 section was included in this citation, which had been paid, and that it cannot be subjected to another charge, i.e., Order No. 7476999, for the same violation. While the notes and back-up documentation prepared by Stanfield from his field notes contain references to the 010 booster pump, I accept his explanation that the booster pump was not included in the pumps for which the citation was issued. As he explained, the citation was issued for seven pumps listed on page 3 of his notes (Ex. P-14, p.3), for which there were records of examinations, but the examinations had not been done weekly. Tr. 367-70. There was no record of any examinations for the booster pumps for the 09 and 010 sections, which were the subject of separate citations for violations of 30 C.F.R. § 75.512. Tr. 368. I find that the 010 section booster pump, referred to in Order No. 7476999, was not included in Citation No. 7477177.

The absence of any record of examinations of the booster pump, and the absence of any evidence that the pump and related control circuit had been inspected establish the violation. I also find that the violation was S&S. The failure to perform required weekly safety inspections of electrical equipment, particularly for extended periods of time, can result in serious hazards going undetected, exposing miners to risk of serious injury. There was no record of the 010 section booster pump having been examined for at least several months. Hazardous conditions can occur and become exacerbated quickly in the mining environment. That is why frequent inspections are required, with appropriate testing and maintenance. The failure to perform such examinations, and to keep records of them, created a reasonable likelihood that a reasonably serious injury would result.

Unwarrantable Failure

It is not clear why the first two items listed in the body of the order were included. Nothing in the record establishes that wiring a control circuit from the pump's starter box to the belt starter box, in itself, was improper or violative of any safety standard. The only witnesses to testify on the issue stated that it was permissible. Tr. 232, 403, 479-80, 541. Nor does the fact that the start/stop switch on the pump starter box was "by-passed" appear to be of significance. Substitution of the control circuit contacts for the start/stop switch would appear to be required for such a control circuit to operate properly and, as Stanfield admitted, there was a manual disconnect switch box for the pump located virtually in the same location as its starter box. Tr. 329-30, 404. Consequently, there was a readily available on/off switch for the pump. Respondent was not cited for installation of the control circuit itself, or for by-passing the start/stop switch.

The third item listed, the unconnected ground leads in the control circuit wire, was clearly of significance. The primary ground connection for electrical equipment is provided by the power cables connected to the power center. Consequently, no ground is provided when the cable is disconnected, which was the case when Caudill began work on the belt starter box. The power cable to the booster pump was plugged into the power center, and that piece of equipment was effectively grounded. Had the ground leads in the control circuit wire leading from the pump to the belt starter box been properly connected, the belt box would also have been grounded. However, the leads for the ground wire in the 16/3 control circuit had been cut off, rather than connected, at the time the circuit was installed. Consequently, when the power cable for the belt drive starter box was disconnected, the box was no longer grounded. Yet it could, and possibly did, become "alive" through contact with the energized control circuit.

If the ground leads on the control circuit had been properly connected, Caudill may not have been killed. Ground circuits serve two purposes. They make the metal equipment frames part of the circuit, providing a path to ground for electrical energy that might come into contact with the frame. They also have devices that limit to 25 amps the amount of current that can flow through the ground default circuit. Tr. 321-22. If an energized lead of the control circuit contacted the belt box frame, the circuit breaker to the booster pump would have tripped, deenergizing the pump. Tr. 322. If Caudill had contacted an energized lead of the control circuit and the belt box frame, the current that passed through him would have been limited to 25 amps. Although he still may have been electrocuted, he may have received only a shock. Tr. 534-35.

The Secretary argues that the failure to perform weekly electrical examinations of the booster pump for the six weeks it had been installed resulted in a failure to discover and correct the absence of ground connections in the control circuit, and that the absence of any system of assuring that the examinations were being conducted amounted to an unwarrantable failure that resulted in Caudill's death. Blue Diamond counters that the Secretary did not establish that the missing ground connections would have been discovered during an examination and that it was

guilty only of "mass confusion" over the responsibility for conducting the examinations, which did not rise to the level of reckless disregard. I reject both of Respondent's arguments.

The fact that the ground leads had been cut off rather than connected could have been observed by opening the belt starter box and/or the pump starter box and performing an examination of the connections for the various leads. A thorough and carefully performed weekly electrical examination would most likely have resulted in discovery of the improper connections. Tr. 135-36, 233, 338-43, 461, 617-18. While the focus of such examinations is to detect adverse conditions that occurred since the last inspection, such as malfunctioning breakers and abrasions to cables, boxes might well be opened to check for dust or other conditions indicating lack of permissibility, which MSHA inspectors may do when performing normal inspections.[17] 135-36, 617-18. If there were signs that stress or tension may have been placed on a wire or cable, or a bushing was damaged or missing, close examination of wire connections might also be required. There was no bushing where the control cable entered the pump starter box. Tr. 342.

As noted above, the pump was not listed in the electrical books, and there is no evidence that it was examined by a qualified electrician during the six weeks that it had been installed prior to the accident. It is also apparent that Respondent did not, at the time, have an effective system of assuring that weekly electrical examinations were being conducted of all of the involved electrical equipment. Coots testified that the second shift floater had been responsible for performing the examinations, but he had been laid off at some point. Tr. 86. Collins, who was also referred to as the chief electrician, testified that he started working at the mine only four weeks prior to the accident and was not sure whether the prior chief of maintenance had designated someone as responsible for performing the examinations, but he believed that it would have been the responsibility of the face electrician, Caudill at the time. Tr. 455, 459-60. In its brief, Respondent notes this testimony, and further cites the testimony of other witnesses which it claims "revealed mass confusion as to whose responsibility examination of the booster pump was." Resp. Br. at 30. It then argues that any violation was not the result of intentional

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[17] Respondent cited MSHA's Program Policy Manual ("PPM") to support its assertion that weekly examinations are intended to detect deterioration of equipment through neglect, abuse or normal use. Resp. Br. at 21. The Secretary moved to strike references to the PPM because it was not admitted as evidence at the hearing. I will not consider references to the PPM in this decision. However, Respondent's witness, Kenneth P. Katen, a safey consulting expert, testified that the PPM stated that "the examination is to insure that there are no hazards that would have accrued due to abuse, neglect, or for that matter, even normal use of the equipment." Tr. 618. That would also be a logical purpose of repeated weekly examinations.

Respondent also asserted that MSHA had performed a regular inspection in July of 2001, and had not cited the missing ground connections. However, there is no evidence that MSHA inspected the booster pump during the six weeks that it had been installed. While an inspection may have been conducted in July 2001, as Andy Fields, Blue Diamond's safety director, indicated, due to Respondent's large size, such inspections were "basically continuous." Tr. 555.

misconduct, and that its negligence must be classified as no more than moderate.

There are few, if any, responsibilities of mine management more critical than assuring that required safety inspections are performed. As noted in the discussion of agency above, preshift examinations, weekly electrical examinations, and similar functions are of such importance that they are classified as management functions, regardless of who performs them. Mine managers and supervisors are also held to a high standard of care. Mass confusion that leads to important safety inspections not being performed is a gross deviation from the high standard of care that supervisors are held to. While it is, perhaps, understandable that multiple changes in personnel might result in some confusion over such responsibilities for a short time, when the result is that important safety examinations are not conducted for six weeks, or longer, that confusion rises to the level of gross negligence or reckless disregard.

Respondent argues that a finding of unwarrantable failure would amount to application of a "knew or should have known" test and that in the absence of actual knowledge by a supervisor, its negligence could be no more than moderate. I reject that contention. The cases cited by Respondent do not substitute an "actual knowledge" litmus test for the multi-factored approach to determining unwarrantable failure. In fact, the seminal case, *Emery Mining,* makes clear that an operator's failure to abate a violation he "knew or should have known" existed can form the basis of an unwarrantable failure finding. 9 FMSHRC at 2002, 2003. Collins and Hershell Asher, the mine superintendent, may have had no actual knowledge that the ground wires in the control circuit had not been connected, or that the booster pump had not been examined. However, they are chargeable with knowledge that, over an extended period of time, they had taken no steps to ascertain whether weekly examinations were being conducted. Moreover, the violation was obvious. Even a cursory review of the readily available electrical books would have revealed the absence of any listing for the pump. Collins certainly knew about the pump and was also aware of the control circuit. The violation existed for months, including during the critical six week period that the pump had been installed in the configuration it was in on the day of the accident. The failure of mine management over an extended period of time to assure that the booster pump was being examined, as required by the standard, can only be characterized as indifference – a "total or nearly total lack of interest" – and easily rises to the level of reckless disregard. *Emery Mining*, 9 FMSHRC at 2003.

Order No. 7476997

Order No. 7476997 alleges a violation of 30 C.F.R. § 75.701, which requires that, "Metallic frames, casings, and other enclosures of electric equipment that can become "alive" through failure of insulation or by contact with energized parts shall be grounded by methods approved by an authorized representative of the Secretary." The basis for the violation was that the ground leads in the 16/3 control circuit wire had been cut off, rather than connected. As a consequence, when the power cable to the belt starter box was disconnected, the box was no longer grounded, even though the 480 volt power source remained in the box. Ex. Jt.-2.

The Violation – S&S

As noted in the discussion of Order No. 7476999, the leads for the ground wire in the 16/3 control circuit had been cut off, rather than connected, at the time the circuit was installed. The result was that when the power cable for the belt drive starter box was disconnected, the box was no longer grounded. Yet it could, and possibly did, become "alive" through contact with the energized control circuit. The failure to establish and maintain a ground for the starter box, which could become "alive" because of the presence of an energized circuit, created a substantial possibility that a serious injury would result, and was a causative factor in Caudill's death. Respondent does not dispute those elements of the charge. Its challenge is to the unwarrantable failure designation.

Unwarrantable Failure

The Secretary's primary argument is that the improperly installed control circuit had existed for nearly six weeks and that it should have been discovered during weekly electrical examinations, but that Respondent had no system of assuring that the examinations were being conducted and, in fact, the booster pump and control circuit had not been inspected.[18] Blue Diamond counters that the improperly wired circuit presented a danger only when the head drive power source was disconnected, that the defect was not obvious and may not have been discovered during a weekly electrical examination, and that it was not unreasonable for Blue Diamond to have relied upon its certified electricians to have properly installed the cable.[19]

Respondent correctly points out that it was only when the belt drive's power cable was disconnected, shortly before the accident, that the belt starter box ceased to be grounded. Technically, therefore, the failure to ground violation existed only for a few minutes prior to the accident, even though the control circuit wire had been improperly installed for six weeks. However, on the facts of this case, it is the length of time that the wiring defect existed that should be considered in evaluating Respondent's negligence. The fact that the defect did not result in an actual grounding violation until later should not be considered a mitigating factor, especially since the defect could have been corrected at any time during the six weeks preceding the accident. As noted above, I have found that the unconnected ground leads would most likely

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[18] The Secretary initially argues that Blue Diamond acted in a highly negligent manner when it allowed an employee to install the control circuit without a ground. However, the identity of the electrician who installed the control circuit was never determined, and the negligence of an employee, as opposed to an agent, cannot be imputed to Respondent.

[19] Blue Diamond also attacks certain wording in the body of the order to the effect that the booster pump was not grounded and its on/off switch had been bypassed. Both points have merit. However, the order makes clear that the violation is based upon a failure to ground the belt starter box while the 480 volt control circuit supplied power to it. There was no confusion on the bases for the violation at the hearing.

have been discovered during a reasonably thorough weekly examination. That is true even though Respondent may have been entitled to rely upon its certified electricians to have properly installed the control circuit. Respondent was not obligated to double-check the installation to assure that it had been done properly. Tr. 626. Certified electricians are not trainees. They are expected to work independently. Tr. 578-79. However, reasonable reliance on an electrician's expertise does not justify or excuse Respondent's indifference to the conduct of weekly electrical examinations.

Respondent's argument that the conduct that the Secretary seeks to sanction through this violation is, in essence, the same as that cited in Order No. 7476999, bears more weight. It was the grounding defect that was a major factor in elevating the seriousness of that violation and establishing the causal connection between it and the fatality. Premising an unwarrantable failure finding for this violation on the very same failure to inspect, discover and correct the grounding violation, would, in essence, penalize Respondent twice for exactly the same conduct. While the violations are not legally duplicative, they are largely duplicative in practical terms, and I decline to find an unwarrantable failure with respect to this violation. Rather, I hold that Respondent's negligence was moderate.[20]

Order No. 7478001

Order No. 7478001 alleges a violation of 30 C.F.R. § 75.904, which requires that, "Circuit breakers shall be marked for identification." The basis for the violation was that the circuit breaker on the power center controlling the booster pump, where the pump's power cable was connected, specified only that it controlled the pump, and did not reflect the fact that it also supplied power to a set of contacts in the belt starter box. Ex. Jt.-4.

The Violation – S&S

It is undisputed that the pump's circuit breaker was labeled "pump." Tr. 346, ex. R-5. The cable connector for the belt drive, the #9 head drive, was plugged into a circuit breaker labeled "#9 head drive," which Stanfield agreed was proper. Tr. 430. He explained that the violation was issued because the pump's circuit breaker should have been labeled "pump and #9 head drive" to disclose that it supplied power to both pieces of equipment. Tr. 346-49. The violation was determined to have been a causative factor in the fatality because it was determined that proper labeling of the pump's circuit breaker would have "alerted" electricians performing weekly exams or working on the equipment that there was a second power source to the belt starter box. Tr. 349. It was classified as an unwarrantable failure because Collins knew about the control circuit and should have assured that the pump circuit breaker was properly labeled.

[20] If this violation could properly be categorized as an unwarrantable failure, then a substantial reduction in the proposed penalty would be in order, for the same reason.

Blue Diamond contends that the circuit was properly labeled and that there was no violation. Alternatively, it contends that it did not have fair notice of the Secretary's interpretation of the regulation. It also challenges the assertion that the violation was a causative factor of the fatality and the unwarrantable failure designation. Respondent relies upon the testimony of James W. Oakley, Sr., MSHA's electrical supervisor for District 7, who described the use of pump control circuits wired to a "smoke roller" or similar device that would close a switch energizing the pump when a belt started.[21] He testified that such arrangements were quite common, and that in such instances the pump circuit breaker was simply labeled "pump" or "pump circuit," and it was not necessary to add "and smoke roller" to the label. Tr. 580-83. In those situations, however, the control circuit was not wired into another piece of equipment with its own power source. It was simply a start/stop switch that was located a distance from the equipment. Tr. 588-89. He had never seen a situation where the control circuit was wired to contacts in a belt starter box, a piece of equipment that had its own power source. Tr. 580. It was his opinion that, because the control circuit supplied 480 volts of power to both the booster pump and the belt starter box, it should have been labeled as supplying both pieces of equipment. Tr. 585. He also testified that he had encountered situations where a circuit was supplying power in the range of 480 volts to two different locations, and that he had required both pieces of equipment to be identified on the circuit breaker, as well as on the cable connector and the female receptacle. Tr. 584.

On balance, I find that the Secretary has carried her burden of proof with respect to this violation. The plain wording of the regulation requires that circuits be marked for identification, i.e., that the piece or pieces of equipment to which they deliver power must be identified. There is no dispute that the booster pump circuit supplied power to both the pump and to the #9 head drive's starter box. I can conceive of no reasonable interpretation of the regulation that would allow an operator to omit either piece of equipment from the label. I also find that the plain wording of the regulation provides adequate notice that labels for circuits that supply power to two pieces of equipment, as opposed to a remotely located switch, should identify both pieces of equipment. "[A] reasonably prudent person familiar with the mining industry and the protective purposes of the standard would have recognized the specific prohibition or requirement of the standard." *Ideal Cement Co.*, 12 FMSHRC 2409, 2416 (Nov. 1990). While the Secretary does not rely upon any published interpretations of the standard addressing similar situations, it appears that the standard has been consistently enforced, at least from the limited evidence in the record.[22]

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[21] Collins testified about a situation where kill switches on a continuous miner and a carrier were interlocked, but not so-labeled. Tr. 478. However, that wiring arrangement was not explained in any detail, and that testimony has virtually no probative value with respect to this violation.

[22] In Oakley's experience, situations where one circuit supplies power to two pieces of equipment are uncommon, but, when encountered, he has required double labeling. Collins testified that the wiring of the booster pump's control circuit to the belt starter box was common

Respondent does not argue that the violation, if proven, was not S&S. In a general sense, failure to properly label a circuit would create a reasonable possibility that a serious injury would result. Here, however, the deficient label was located on the side of the power center opposite the man door through which its enclosure was accessed. Moreover, while the power center was relatively close to the booster pump and head drive, it was separated from that area by a concrete block brattice wall. Ex. P-3. To view the pump's circuit breaker, someone in the area of the equipment would have had to travel through a man door, down about 10 breaks (approximately 900 feet), pass through another man door, travel back to the power center, through a man door into its enclosure, and walk around to the opposite side of the power center. Tr. 65-67, 573. Stanfield accurately described it as a "remote location." Tr. 430-32.

The hazard, to which the violation contributed, was described by the Secretary as a miner working on the belt starter box while it was still energized by the control circuit, just as Caudill did. She further asserts that had "the circuit breaker been correctly marked, Caudill would have known that the two pieces of equipment were interconnected." Sec'y Br. at 52. The latter assertion must be rejected. There is no evidence that Caudill had performed any electrical examinations or worked on the pump prior to July 20, 2001. While it appears that he entered the power center's man door and removed the head drive's power cable from its properly labeled circuit, it is highly unlikely that he would have walked around to the opposite side of the power center to look at the pump's circuit breaker. He was unaware of the connection between the two pieces of equipment and there would have been no reason for him to have done so. Moreover, in light of the haste with which he approached the job, it is a virtual certainty that he did not take the extra step of looking at the pump's circuit breaker. Had weekly electrical examinations been performed as required, that electrician would have seen a proper label, and might have mentioned it to Caudill, or others that may have passed it on to him. However, that is an extremely remote possibility.

On the facts of this case, I find that the violation was S&S, but that it was not a cause of the fatality. Rather, it was reasonably likely to result in a fatality.

Unwarrantable Failure

The Secretary's argument that the violation was a result of Blue Diamond's unwarrantable failure is based upon the involvement of Collins, Blue Diamond's agent, who failed to assure that the circuit breaker was properly labeled, and the fact that it had existed for six weeks prior to the accident. I find that Collins was negligent in not taking steps to assure that the pump's circuit breaker was properly labeled. However, while I have found that adding

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at Blue Diamond, and had been employed at other mines. Tr. 449. However, Coots testified that control circuits for booster pumps at Blue Diamond were usually wired through a smoke roller or other device. Tr. 114. Jeffrey Begley testified that he knew about the control circuit and that he had seen pumps wired that way in other mines. Tr. 220, 232. I find that the wiring of pump control circuits to belt starter boxes was not a common practice, as Collins claimed.

the belt starter box to the pump's circuit breaker was required by the plain language of the regulation, that conclusion is not so strongly compelled that his failure to do so can be equated to reckless disregard. The use of control circuits employing smoke rollers, which is admittedly treated differently under the regulation, is somewhat similar to the control circuit used here. While the violation existed for some six weeks, it was not in an obvious location, and there was nothing that should have prompted Collins to reconsider whether the circuit's label should have been changed after the control circuit had been installed. I find that Respondent's negligence was moderate.

Citation No. 7477000

Citation No. 7477000 alleges a violation of 30 C.F.R. § 50.12, which requires that, "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 basis for the violation was described in the Condition or Practice section of the citation as:

> The site of an accident that resulted in the death of a mine electrician on July 20, 2001, was found to have been altered prior to the completion of all investigations and without MSHA approval. It was determined that the site was altered due to the following: 1) the disconnect device (cat-head) which supplied power to the 20 HP booster pump had been disconnected at the 300 KVA power center and was lying on the mine floor, 2) the 16/3 cable extending from the booster pump to the #9 belt drive starting box had been cut at the pump start box location, 3) the 16/3 cable extending from the booster pump to the #9 belt drive starting box had been disconnected from the interlock on the vacuum breaker and had been pulled completely out of the belt box. None of these conditions could have existed at the time of the fatal accident. Mine management failed to preserve and secure the accident site.

Ex. Jt.-6.

The violation was determined to be "Unlikely" to result in an injury, was not S&S, and was the result of the operator's "Reckless Disregard" of the standard. The Secretary proposes a civil penalty of $40,000.00 for this violation.

The Violation

The accident scene was certainly altered after Caudill was electrocuted. As configured at the time of the investigation, there was no source of power to the belt starter box that could have caused the accident. The cable connector for the booster pump had been pulled from the power center, apparently after a hole had been knocked in the brattice. More significantly, the 16/3

control wire had been pulled from the belt starter box, and its end at the pump starter box had been cut. The cut end had then been removed from the pump's box and the start/stop switch wires had been twisted together so that the pump would run whenever its power cable was plugged in and its disconnect switch was in the "on" position.

Respondent does not dispute that these changes were made to the accident scene. However, it argues that disconnecting the pump's power cable, which appears to have been accomplished at Sam Combs' direction, was justified as a safety measure to eliminate an imminent danger. Similarly, it argues that pulling the 16/3 cable from the belt starter box could have been justified as eliminating an imminent danger. It does not attempt to account for the fact that the cable was cut near its connection with the booster pump starter box, and argues that the re-wiring of the pump switch is not included in the narrative of the citation. It also points to testimony that the mine's manager of production, John Boylen, ordered that the scene be preserved when he was advised of the accident.

I find that the Secretary has carried her burden of proof with respect to this violation. While the booster pump's power cable may have been disconnected in a reasonable effort to make the scene safe, the elimination of the pump control circuit was done in such a manner that it must have been a deliberate attempt to conceal the existence of the circuit. There is no direct evidence in the record as to the identity of the person who pulled the 16/3 cable from the belt starter box, cut the other end and re-wired the pump switch. Conley understood from statements made during the investigation, that Coots pulled the 16/3 cable from the box, thereby deenergizing it. Tr. 59. However, at the hearing, Coots testified that the cable he was talking about was the data/phone cable, not the 16/3 control cable. Tr. 104. There is no evidence that the 16/3 cable was pulled from the box in an attempt to eliminate an imminent danger, and there is no evidence or plausible explanation that the other alterations were justifiable under the regulation.

Negligence

The Secretary's argument that the violation was the result of Blue Diamond's reckless disregard is based upon her contention that both Coots and Sam Combs were supervisors, i.e., Respondent's agents, and that they altered the scene, directed that the scene be altered, or permitted the scene to be altered. However, as explained in the discussion of Order No. 7476996, Coots was not a supervisor or agent of Respondent. Consequently, any actions that he took in altering the scene cannot be imputed to Blue Diamond. I agree with the Secretary's argument that whoever pulled and cut the 16/3 cable and re-wired the pump switch most likely was comfortable working with electrical equipment and clearly understood the wiring of the control circuit. There may also have been some time that passed after the accident happened before others were summoned to the scene. These factors tend to implicate Coots more than Combs. Coots was alone at the scene until he summoned Combs. He was an electrician, who would have been comfortable working with electrical equipment and, possibly, may have been familiar with the control circuit. There is no evidence that Combs had any electrical expertise.

Combs, a foreman, was Respondent's supervisor/agent. However, aside from his presence at the scene at various times, the evidence establishes only that he directed that any power cables in the power center be disconnected. Tr. 177, 186-87. His intention was to assure that all power sources in the area be eliminated, which Stanfield agreed would have been legitimate under the regulation. Tr. 434. It is not clear whether his instruction resulted in the booster pump's cable connector being pulled from the power center. Tr. 186-89.

While I appreciate the Secretary's frustration in her inability to identify who altered the scene, I cannot find that Respondent acted with reckless disregard. When advised of the accident, Blue Diamond's higher level managers appropriately directed on-site personnel to preserve the scene. While Combs might have exercised more control over the scene, the significant alterations may already have been made by the time he arrived. In the highly charged atmosphere that he was thrust into, Combs' focus was appropriately on Caudill and the attempts to revive him. Respondent cannot be charged with reckless disregard for Combs' failing to prevent alterations that he justifiably did not observe being made, even if they had been made while he was on the scene. I find that Respondent's negligence was low.

The Appropriate Civil Penalties

The parties stipulated that Blue Diamond is a large operator. Its controlling entity, James River Coal Company, is very large. Exhibit P-16 is a printout from an MSHA computer database showing that Blue Diamond had paid 983 violations, five of which were specially assessed, over the period December 3, 1999, to December 2, 2001. Blue Diamond presented some evidence of limitations on its ability to make payments to vendors. Tr. 559-60. However, it makes no argument in its brief that imposition of the proposed penalties would affect its ability to remain in business. The gravity and negligence associated with the alleged violations are discussed above.

Citation No. 7476996 was affirmed as a S&S violation and a cause of the fatal accident. However, it was not the result of the operator's unwarrantable failure. Blue Diamond's negligence was moderate. A civil penalty of $55,000.00 was proposed by the Secretary. I impose a penalty in the amount of $10,000.00, upon consideration of the above and the factors enumerated in section 110(i) of the Act.

Order No. 7476998 was affirmed. However, the violation was found not to be S&S, or to have caused the fatality. It was also not the result of Blue Diamond's unwarrantable failure. It was not negligent with respect to this violation. A civil penalty of $55,000.00 was proposed by the Secretary. I impose a penalty in the amount of $500.00, upon consideration of the above and the factors enumerated in section 110(i) of the Act.

Order No. 7476999 was affirmed as an S&S violation that was the result of Blue Diamond's unwarrantable failure. The Secretary proposed a civil penalty of $55,000.00 for this violation. I impose a penalty in the amount of $55,000.00, upon consideration of the above and the factors enumerated in section 110(i) of the Act.

Order No. 7476997 was affirmed as a S&S violation and a cause of the fatal accident. However, it was not the result of the operator's unwarrantable failure. Blue Diamond's negligence was moderate. A civil penalty of $55,000.00 was proposed by the Secretary. I impose a penalty in the amount of $10,000.00, upon consideration of the above and the factors enumerated in section 110(i) of the Act.

Order No. 7478001 was affirmed as an S&S violation. However, it was not found to have caused the fatality, and was not the result of Blue Diamond's unwarrantable failure. Its negligence was moderate. A civil penalty of $55,000.00 was proposed by the Secretary. I impose a penalty in the amount of $5,000.00, upon consideration of the above and the factors enumerated in section 110(i) of the Act.

Citation No. 7477000 was affirmed. However, the operator's negligence was found to be low, rather than reckless disregard. A civil penalty of $40,000.00 was proposed by the Secretary. I impose a penalty in the amount of $10,000.00, upon consideration of the above and the factors enumerated in section 110(i) of the Act.

ORDER

Order No. 7476999 is **AFFIRMED** in all respects. Order Nos. 7476998, 7476997 and 7478001, and Citation Nos. 7476996 and 7477000 are **AFFIRMED,** as modified, and Respondent is directed to pay a civil penalty of $90,500.00 within 45 days.

Michael E. Zielinski
Administrative Law Judge

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