

FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

OFFICE OF ADMINISTRATIVE LAW JUDGES
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January 21, 2005

SECRETARY OF LABOR,	:	CIVIL PENALTY PROCEEDING
MINE SAFETY AND HEALTH	:	
ADMINISTRATION (MSHA),	:	Docket No. KENT 2004-65
Petitioner	:	A. C. No. 15-17497-07578
	:	
v.	:	
	:	
LEEEO INCORPORATED,	:	
Respondent	:	No. 68 Mine

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 Leeco Incorporated.

Before: Judge Zielinski

This case is before me on 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 Leeco Incorporated (“Leeco”) is liable for two violations of the Secretary’s regulations applicable to underground coal mines, and proposes the imposition of civil penalties totaling \$10,500.00. 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 Leeco committed the violations and impose civil penalties totaling \$7,000.00.

Findings of Fact - Conclusions of Law

Leeco operates a large underground coal mine, Mine No. 68, in Perry County, Kentucky. As depicted in Leeco’s roof control plan, coal is recovered from a 36-inch-thick seam, the “amburgy seam.” Ex. Jt-2 at 2. Immediately above the coal seam is a layer of shale, and above that is the main roof of sandstone, typically 20 feet thick. The thickness of the shale layer above the coal seam varies considerably throughout the large mine, and in some places it is non-existent. Below the coal seam is a layer of fire clay and sandy shale.

The Act requires that underground coal mines be inspected at least four times each year. 30 U.S.C. § 813(a). At issue in this case are two citations issued by mine inspectors employed by the Department of Labor’s Mine Safety and Health Administration (“MSHA”) during inspections

conducted in July and December of 2002. Each citation was issued pursuant to section 104(d)(1) of the Act, and alleges that the violation was significant and substantial, and the result of the operator's unwarrantable failure. The alleged violations are discussed below in the order that they were presented at the hearing.

Citation No. 7479106

Patrick Stanfield, who was certified as an MSHA inspector in 2000 and has 29 years of mining experience, participated in an inspection of Leeco's No. 68 mine that commenced on July 1, 2002, at which time the mine was in production. Mining operations continued until July 5, when miners started a vacation period that extended to July 15. Some maintenance operations continued during the vacation period, as did MSHA's inspection. On July 2, Stanfield had issued citations for conditions on the mine's 007 section. He returned to the 007 section on July 10, to continue the inspection and determine whether the previously cited conditions had been abated. He was accompanied by Lonnie Pennington, normally Leeco's second shift foreman on the 004 or 006 sections. Jerry Hensley, another foreman was also present at various times.

The Secretary's mandatory safety standards for underground coal mines require that mine operators "develop and follow a roof control plan, approved by the [MSHA] District Manager, that is suitable for the prevailing geological conditions, and the mining system to be used at the mine." 30 C.F.R. § 75.220(a)(1). Before commencing the inspection, Stanfield reviewed Leeco's roof control plan, the mine's inspection history, and various other documents. The roof control plan contains a number of specific requirements for mine roof support that are at issue here. Roof bolts must be installed on four-foot centers and within four feet of faces and ribs, such that there is a minimum of one bolt for each 16 square feet of exposed roof. Ex. Jt-2 at 14. Roof bolts must be installed with suitable bearing plates. Ex. Jt-2 at 10. Entries cannot be wider than 20 feet, except that the belt entry can be 22 feet wide with bolts installed within three feet of the ribs. Ex. Jt-2 at 14, 16. Test holes must be drilled into the roof at each intersection, and in crosscuts when entry centers are more than 55 feet apart. Ex. Jt-2 at 8, 13.

Stanfield observed a number of conditions in the 007 section that he determined were in violation of Leeco's roof control plan. He issued Citation No. 7479016, which alleges that Leeco violated 30 C.F.R. § 75.220(a)(1). Alleged instances of non-compliance with plan requirements were itemized in the "Condition or Practice" section of the citation, which reads:

The operator failed to comply with the approved roof control plan (Dated 06/25/2001) on the 007/MMU, in that:

- (1) #6 entry (or #5 kick-back) at the 22nd crosscut, the 48" resin bolts were not installed to within 4' of the coal rib. The installed roof bolts measured 54" and above from bolt to the coal rib.
- (2) At same location, in off-set, installed roof bolts measured over 64" from the coal rib at three locations.

- (3) At same location, installed roof bolts measured 60" between rows.
- (4) At 23rd crosscut, #5 right crosscut, 3 roof bolts had bearing plates missing, that had not been replaced. Draw rock of substantial size and weight was present in the area. Reflectors were installed to prevent travel in area.
- (5) At 24th crosscut, from five right to #6, no roof drill test hole could be found, a distance of approximately 90 feet.
- (6) #4 right adjacent to spad #12811, at four locations the installed roof bolts measured over 50" from the coal rib.
- (7) #3 right crosscut, 20 feet inby spad #12816, along the left rib installed roof bolts measured 60" from the coal rib.
- (8) #3 entry in the area of spad # 12817 the entry measured 25.5' wide. This condition extended to exceed approved plan by measured distance of 22'. This is the belt entry. The operator's plan allows for 22' belt entry, but when it is utilized, the installed roof bolts cannot exceed 3' from coal rib. Inby to face and outby for distance of four crosscuts the roof bolts have not been installed to within 3' of coal rib.
- (9) The #3 entry, from the second crosscut outby to the face, a roof drill test hole could not be found.
- (10) #2 entry, at spad # 12813, both inby and outby side of the right crosscut had corners clipped, creating an opening measuring 30' wide.
- (11) At same location, the right (outby corner clip) had not been bolted, creating an area measuring 10' x 10' that was not supported in any manner. Reflectors were hung to prevent travel in the area. This area had been scooped and rockdusted. A miner could easily advance beyond supports in this area.
- (12) The operator's approved plan allows both corners to be clipped, only in the far right and far left entries. This is in the #2 entry, and is not one of the outside entries.
- (13) #2 entry, at spad #12812, at six different locations roof bolt bearing plates were sheared off, and not replaced. Draw rock, measuring 6' x 3' x 6" was pulled in the area.
- (14) #2 left crosscut, adjacent to spad # 12812, along the left rib, installed roof bolts measured over 52" at four locations.
- (15) #1 entry, at spad #12814, three roof bolt bearing plates had been sheared off, and not replaced.
- (16) #1 push-up was not bolted to within 4 feet of the coal. From the last bolt to the face measured 10'. No obstructions prevented the area from being supported. Reflectors were installed to prevent travel in the area.
- (17) #3 entry, at the 21st crosscut, a roof drill test hole revealed a crack at 43". This area is supported with 48" resin bolts. Additional supports are need[ed] to maintain safe travel in the area. This area was dangered off until additional supports can be installed.
- (18) #3 entry from the tailroller, outby along the length of the low-low, roof bolt bearing plates were damaged, missing, and not firm against mine roof, due to

sloughing of mine roof.

Additional supports are need[ed] in cited area to maintain safe travel and protect miners from hazards associated [with] falls of roof in the areas listed above.

The above cited condition is extensive and obvious. The operator has just recently received similar violations. The cited conditions create a high degree of risk to miners working in the area. This condition has existed for a significant amount of time - since at least 07/05/2002. This area is required to be examined on three shifts daily. The operator displayed a serious lack of reasonable care, by exposing miners to these conditions. By allowing this condition to exist, the operator displayed conduct constituting more than ordinary negligence.

Ex. Jt.-1.

Stanfield determined that it was highly likely that the violation would result in a permanently disabling injury, that the violation was significant and substantial, that five persons were affected and that the violation was due to the operator's high negligence. The citation was subsequently amended to specify that one person was affected. As noted previously, the citation was issued pursuant to section 104(d)(1) of the Act, based upon Stanfield's determination that the violation was the result of the operator's unwarrantable failure to comply with the mandatory safety standard. The Secretary has proposed a civil penalty of \$5,000.00 for this violation.

The Violation

In an enforcement proceeding under the Act, the Secretary has the burden of proving all elements of 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 largely undisputed by Leeco that the roof control plan was violated. Its arguments are directed at the extensiveness of the violation, and the alleged gravity and negligence. Leeco offered limited evidence on the specific conditions cited. To the extent that its evidence addressed deviations itemized in the citation, it largely confirmed Stanfield's descriptions. Tr. 170-72, 187. I accept Stanfield's un rebutted testimony regarding missing and damaged bearing plates, numerous instances of excessive bolt spacing, the absence of test holes,¹ the

¹ Test holes must be drilled into the roof at each intersection. They are left open to allow monitoring of roof conditions, typically by insertion of the end of a tape measure. If shale begins to separate from the main roof, the clip on the end of the tape measure will catch in the crack, and the condition can then be addressed. While there is no specific requirement as to the frequency of monitoring during normal mining operations, Pennington testified that it would

unaddressed presence of a crack or pocket in one test hole, unbolted areas and excessive entry width.

Leeco challenges some of Stanfield's assessments of excessive bolt spacing, relying upon a provision in The Coal General Inspection Procedures Handbook recognizing that reasonable tolerances in bolt spacing are permitted. The provision reads, in part:

“an occasional inadvertent deviation that slightly increases the spacing of roof bolts but does not detrimentally affect support performance may not constitute a violation. Typically, roof bolt spacings that occasionally exceed the approved spacing pattern by less than 6 inches at intermittent locations and do not create a specific hazard should not be cited.”

Ex. Jt-5, item 7.

The handbook does not include definitions of “occasional” or “intermittent,” and MSHA inspectors receive no instruction on their meaning. Tr. 101. Nevertheless, I agree with the testimony of Steven Sorke, MSHA's roof control and impoundment supervisor, that the spacing deviations noted by Stanfield went beyond occasional and intermittent. Tr. 112-13. Many of the spacings were in excess of six inches beyond the 48-inch standard.² They were often grouped together, e.g., an entire row of bolts in the #6 entry, at least four, had been installed 60 inches from the adjoining row. Tr. 27-28. While the improperly spaced bolts represented only a small percentage of the thousands of roof bolts installed in the overall area, they were not occasional deviations at intermittent locations, and they detrimentally affected roof support performance. Leeco's challenge to the roof bolt spacing deviations is unavailing.

Leeco also challenged Stanfield's determination that the clipping, or rounding off, of two corners in the same intersection violated the plan, pointing out that the notes to the sketch on page 17 of the plan state that “corners of pillars may be rounded off.” Ex. Jt-2 at 17. Pennington testified that it was his understanding that the plan permitted two corners in an intersection to be

probably be done during a preshift inspection. Tr. 162. He confirmed the existence of a crack or pocket at a depth of 43 inches in one test hole, which indicated that the 48-inch roof bolts did not have the required 18 inches of anchorage in stable strata. Tr. 187. That void may have been a pocket in the sandstone, rather than a sagging shale layer. However, the nature of the condition had not been determined, and additional roof supports should have been installed.

² Stanfield testified, consistent with the citation, that the bolt spacing deviations specified were the smallest among a particular grouping. However, the notes that he took during the inspection do not indicate that only the smallest measurement was recorded. His explanation for the inconsistency was that he didn't have time to write down all of the individual deviations. Tr. 79. I find that the deviations itemized were typical of those that existed. It is unlikely that Stanfield would have failed to record any significantly longer spacings.

clipped, emphasizing the use of the word “corners” in the note. Tr. 168-69. Similarly, Patrick Schoolcraft, Leeco’s safety supervisor, testified that he understood the plan to allow clipping two corners in an intersection, provided that limitations on the overall width of the entry were not exceeded. Tr. 191-99. He also testified that two intersection corners were frequently clipped in the belt entry, and that such conditions had not been cited by MSHA as violations unless overall width limitations were exceeded. Tr. 212-15. The mine map appears to support his testimony that two corners have been clipped in belt entry intersections. Ex. R-3.

The Secretary countered, through Sorke, that the plan’s sketch showed only one clipped corner in an intersection, and that use of the plural was simply to recognize that one corner can be clipped in multiple intersections. Tr. 116. He also explained that in other roof control plans, where the clipping of two corners in an intersection is allowed, the reference sketch shows two corner clips. Tr. 117. The Secretary also argues that shortly before the issuance of the citation, Leeco submitted a proposed amendment to its roof control plan that would have allowed clipping of two corners, but that the proposed amendment was denied. Tr. 132-37; ex P-7. However, Leeco introduced evidence that the proffered reason for the denial was the fact that the proposed sketch had not been scaled properly, and when it checked with MSHA, it was advised that no amendment of the plan was necessary to allow clipping of two corners in an intersection. Tr. 190-91.

If clipping of two corners in the intersection were the only alleged deviation from the plan, I would be inclined to hold that the Secretary’s interpretation could not be enforced in this instance because of lack of notice to Respondent.³ However, all of the other deviations itemized in the citations have easily been established by a preponderance of the evidence. Therefore, Leeco failed to follow its approved roof control plan, in violation of 30 C.F.R. § 75.220(a)(1).

Significant and Substantial

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).

The Commission has explained that:

In order to establish that a violation of a mandatory safety standard is significant and substantial under *National Gypsum*, the Secretary of Labor must prove: (1) the underlying violation of a mandatory safety standard; (2) a discrete

³ See *Lodestar Energy, Inc.*, 24 FMSHRC 689, 694 (July 2002); *Island Creek Coal Co.*, 20 FMSHRC 14, 24 (Jan. 1998).

safety hazard--that is, a measure of danger to safety--contributed to by the violation; (3) a reasonable likelihood that the hazard contributed to will result in an injury; and (4) a reasonable likelihood that the injury in question will be of a reasonably serious nature.

Mathies Coal Co., 6 FMSHRC 1, 3-4 (Jan. 1984) (footnote omitted); *see also*, *Buck Creek Coal, Inc. v. MSHA*, 52 F.3d 133, 135 (7th Cir. 1999); *Austin Power, Inc. v. Secretary*, 861 F.2d 99, 103-04 (5th Cir. 1988), *aff'g Austin Power, Inc.*, 9 FMSHRC 2015, 2021 (Dec. 1987) (approving *Mathies* criteria).

In *U.S. Steel Mining Co., Inc.*, 7 FMSHRC 1125, 1129 (Aug. 1985), the Commission provided additional guidance:

We have explained further that the third element of the *Mathies* formula "requires that the Secretary establish a reasonable likelihood that the hazard contributed to will result in an event in which there is an injury." *U.S. Steel Mining Co., Inc.*, 6 FMSHRC 1834, 1836 (August 1984). We have emphasized that, in accordance with the language of section 104(d)(1), it is the *contribution* of a violation to the cause and effect of a hazard that must be significant and substantial. *U.S. Steel Mining Co., Inc.*, 6 FMSHRC 1866, 1868 (August 1984); *U.S. Steel Mining Co., Inc.*, 6 FMSHRC 1573, 1574-75 (July 1984).

This evaluation is made in terms of "continued normal mining operations." *U.S. Steel Mining Co., Inc.*, 6 FMSHRC at 1574. The question of whether a particular violation is significant and substantial must be based on the particular facts surrounding the violation. *Texasgulf, Inc.*, 10 FMSHRC 498 (Apr. 1988); *Youghiogheny & Ohio Coal Co.*, 9 FMSHRC 2007 (Dec. 1987).

The fact of the violation has been established. Violation of the roof control plan contributed to a discrete safety hazard, i.e., exposure to roof falls. Any injury suffered from a roof fall would be serious. The focus of the S&S analysis for this violation is the likelihood that the hazard would result in an injury.

Stanfield testified that he determined that the violation was S&S because he believed that it was highly likely that a miner would be seriously injured by falling shale or draw rock, which he identified as a leading cause of injuries. Tr. 50-53. He also noted that there have been fatal accidents caused by draw rock falling between roof bolts and that the greater the span of roof, the greater the tendency for shale to break loose and fall. Tr. 51, 54. The absence of test holes prevented monitoring for sagging shale in some places and the unbolted areas, which had not been dangered off to prevent travel, were particularly troubling.⁴ The unbolted corner clip, item

⁴ As noted in the citation, reflectors were hung in such areas to prevent travel. However, that was done only after the condition had been identified as a violation. Tr. 29, 37, 47.

11 in the citation, was in an area that was highly likely to have been traveled by miners, and had been cleaned and rock-dusted so that persons would assume that it had been bolted. Tr. 37. Areas where bolts had been installed too far from the rib were, in his opinion, subject to roof falls and rib rolls. Tr. 55. His determination that an injury was highly likely was based upon the nature of the conditions, and the fact that they were present throughout the working section. Tr. 56. Of particular concern, were areas where bearing plates had been sheared off or damaged. Draw rock was present at those locations, and a large piece of loose, dangerous draw rock was pulled down in the #2 entry.

Sorke testified that he was familiar with roof conditions at the mine through his review of roof control plans, reports of accidents, and citations for violations of roof control plans.⁵ It was his experience that Leeco's mine # 68 experienced a "lot of roof falls and a lot of injuries from draw rock." Tr. 105. The Secretary introduced three reports of injuries to Leeco miners who had been struck by falling draw rock from April 15 to June 26, 2002. Ex. P-3, P-4, P-5. However, Sorke was unable to state where in the mine the subject incidents had occurred. Tr. 111. Sorke had never been in the 007 section of the mine, and had no personal knowledge of the roof conditions in that area. Tr. 140. His knowledge of accidents and injuries was derived solely from his review of reports. Tr. 140-41. Sorke also concurred with Stanfield's determination that the violation was S&S, based upon the number of deviations from the plan and the mine's history of roof falls and injuries. Tr. 119.

Leeco introduced evidence, through Schoolcraft, that the incidents in the accident and injury reports relied on by the Secretary had occurred in other sections of the mine. Tr. 184-85. Schoolcraft also testified that roof conditions varied in the different sections of the mine, and that there was more shale in the 004 and 006 sections in the upper end than in the 007 section, which had harder slate and sandstone with very little draw rock. Tr. 185. Dr. Kot Unrug, a professor at the University of Kentucky, testified as an expert on rock mechanics, roof strata and roof fall protection. He had visited the 007 section of the mine in September 2002, and testified that the vast majority of the mine roof was comprised of a thick layer, some 27 feet, of grey sandstone that had no laminations or stability problems. Tr. 230. With reference to a chart plotting the time that unsupported mine roof remains stable, as functions of the rock mass rating and the span of the roof, he explained that the sandstone roof of the mine was extremely stable and likely would remain so, even without roof support. Tr. 233-34, 242-43; ex. R-12. He also testified that the roof conditions varied in different sections of the mine, and that the diagram of the geological

⁵ Pursuant to 30 C.F.R. Part 50, mine operators must report all accidents and occupational injuries to MSHA. The regulatory definition of "accident" includes "An unplanned roof fall at or above the anchorage zone in active workings where roof bolts are in use; or, an unplanned roof or rib fall in active workings that impairs ventilation or impedes passage." 30 C.F.R. § 50.2(h)(8). The term "occupational injury," includes "any injury to a miner which occurs at a mine for which medical treatment is administered, or which results in death or loss of consciousness, inability to perform all job duties on any day after an injury, temporary assignment to other duties, or transfer to another job." *Id.* § 50.2(e).

strata included in the roof control plan, showing 2-12 feet of shale above the coal seam, was not indicative of the conditions in the 007 section. Tr. 236, 241-43. However, he also stated that there were pockets of shale in the mine roof. Tr. 230.

Dr. Unrug also explained the significance of notations on the mine map that indicate the amount of material that had been removed from above and below the coal seam. Ex. R-3. The notations in question are sets of three numbers enclosed in circles, approximately 1/2 inch in diameter, and are printed in blue. The top number indicates the number of inches of material above the coal seam that was removed, the middle number is the thickness of the coal seam, and the bottom number is the number of inches of material removed from below the coal seam. In the area where the roof control plan violations were noted, the map indicates that no material was removed from above the coal seam. Dr. Unrug concluded that that is an indication that there was very little shale above the coal seam, because miners would typically opt to remove it. He also stated, however, that although there was not much fire clay below the coal seam, miners would tend to remove it because it becomes mud when exposed to the mine's moist conditions. Tr. 241.

Of the numerous notations on the map, some have only two numbers, and the top number of every three-number set is zero. Ex. R-3. Under Dr. Unrug's theory, this would indicate that there was no shale present in the entire area depicted on the map, a clearly erroneous conclusion. Dr. Unrug, himself, testified that there were pockets of shale in the mine roof. Tr. 230. I conclude that the map notations at issue have virtually no probative value on the issue of the presence of shale or draw rock in the area in question.

Stanfield described the roof as "primarily sandstone, but it also had slate. And in the transition [areas] where it was changing back and forth from slate to sandstone, the slate was wanting to break away from the sandstone." Tr. 26. He specifically identified the areas where bearing plates had been sheared off or damaged as locations where draw rock was present, and noted that in the citation. Tr. 26, 44, 65-66, 94-95; ex. Jt-1. He described having to bar down a large, loose and dangerous piece of draw rock. Tr. 44, 64. Pennington confirmed that event. Tr. 171-72. As noted above, Dr. Unrug agreed that there were pockets of slate in the area. Although Pennington had little recollection of draw rock or sloughing of the roof in the subject area, he did not normally work on that section and apparently had little familiarity with the actual conditions of the roof. Tr. 156-57, 166, 170, 179.

The main mine roof, comprised of a thick layer of sandstone, was undoubtedly extremely stable, as Leeco contends. I also credit Leeco's evidence that the roof conditions in the 007 section are more stable than in other areas of the mine, where miners had been injured by roof falls. In that Sorke's opinion of the dangers presented was based, in part, upon such injury reports, I discount it to that extent. However, I accept Stanfield's description of the particular

conditions that he cited, and find that shale and draw rock was typically present in the area cited.⁶ Cumulatively, the numerous instances of non-compliance with the roof control plan subjected miners working or traveling in the area to a significant risk of serious injury, i.e., being struck by falling shale.

Leeco contends that the cited conditions existed only five days, during which all but a skeleton crew of miners were on vacation. Consequently, it argues, the conditions did not present a significant risk because of the absence of miners who might have been injured, and its failure to discover and correct the conditions is not evidence of high negligence or unwarrantable failure. However, the 007 section was a working section, in production, through July 4, typically with a crew of five miners. Tr. 56. The conditions cited by Stanfield did not all spring into existence the instant the miners left for vacation. Rather, they were created over the July 3-4 period, when the area was being mined. Even during the vacation period, some maintenance work was being performed, which required that a preshift examination be conducted at least once per day in most of the areas where deficiencies were noted. Tr. 57. On July 10, two persons were working on a continuous miner, and a scoop operator and foreman were also present. Tr. 24-25. While there may have been little reason for anyone to travel in the areas that were the subjects of items 1, 2, 3 and 15 after July 5, miners working and traveling in that area on July 3 and 4, and in other areas up to July 10, were exposed to a significantly increased risk of serious injury due to roof falls, particularly in the area of the unbolted corner clip. Tr. 37.

The judgment of MSHA's inspector is an "important element" in determining whether a violation is S&S. *Harlan Cumberland Coal Co.*, 20 FMSHRC 1275, 1278-79 (Dec. 1998); *Mathies Coal Co.*, 6 FMSHRC 1, 5 (Jan. 1984). I find that the Secretary has carried her burden of proving that the violation was S&S.⁷

Unwarrantable Failure

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

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

⁶ A proposed supplement to Leeco's roof control plan was rejected in January 2002, based upon the results of an investigation that concluded, in part, that "Draw rock is common throughout this coal seam in layers from a few inches thick to as much as two feet in thickness." Ex. P-6.

⁷ The fact that there were two corner clips in the intersection at the #2 entry, at spad 12813, was not considered in making the S&S finding.

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).

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 Enters., Inc.*, 20 FMSHRC 203, 225 (Mar. 1998).

Stanfield testified that his determination regarding unwarrantable failure was based upon his assessment that the conditions cited were obvious, extensive, and presented a high risk of danger. In addition, they had existed for several days and were similar to conditions that he had cited in the same section only a few days earlier. Tr. 64-70. Stanfield had inspected the 007 section on July 2, 2002, and found several instances of non-compliance with the roof control plan, including excessive bolt spacing, missing bearing plates, and excessive entry widths. He issued Citation No. 7479088, which was not contested by Leeco. Ex. P-2. When Stanfield returned to the section on July 10, he found that those conditions had been abated. However, he found numerous similar conditions that were the subject of the instant citation. The conditions that he cited on July 10 were new violations, in areas that had been mined on July 3 and 4, after his earlier visit. Tr. 70.

The fact that Leeco had been put on notice, by issuance of the July 2 citation, that greater efforts were necessary for compliance in the 007 section with essentially the same provisions of the roof control plan, is particularly significant. *Eagle Energy, Inc.*, 23 FMSHRC 829, 838 (Aug.

2001) (prior citation, even if not designated as unwarrantable, places operator on notice that greater compliance is required); *Jim Walter Resources, Inc.*, 19 FMSHRC 480, 488-89 (March 1997), citing *Youghioghney & Ohio Coal Co.*, 9 FMSHRC 2007, 2010-11 (Dec. 1987) (unwarrantable failure premised upon the fact that inspector issued a citation for similar violation in the same area). The violations, for the most part, were obvious and extensive, and should have been apparent to Leeco's supervisors. Stanfield testified that they should have been discovered by the section foreman and corrected no later than the next mining cycle. Tr. 65. Despite the fact that the cited conditions had been created on July 3 and 4, they continued to exist on July 10.

These facts are largely uncontested. Leeco's challenge to this citation is directed more to the dangerousness of the conditions. However, I have found that the violation was S&S, i.e., that it was reasonably likely that it would result in a serious injury, and have rejected Leeco's efforts to establish the absence of draw rock and minimize the significance of the excessive bolt spacing. For all of the foregoing reasons, I find that the violation was the result of Leeco's unwarrantable failure.

Citation No. 7479336

Operators of underground coal mines are obligated to "develop and follow a ventilation plan, approved by the [MSHA] district manager." 30 C.F.R. § 75.370(a)(1). Leeco's approved ventilation plan contains a drawing of a typical layout of the 004 section of the No. 68 mine, showing 5 entries, crosscuts and the location of required ventilation controls, including check and line curtains. Ex. Jt-4 at 7B. Ventilation air actually flows in a direction opposite to that shown in the drawing, because Leeco uses an exhaust ventilation system. Air is channeled across the face of the #1 entry, and successively through the most inby crosscuts to the #2, #3, #4 and #5 entry faces. After sweeping the #5 face, the air flows out the return entries, #4 and #5. Improperly installed, or missing, check curtains, particularly on the return side, can seriously impair face ventilation because the air will "short circuit," i.e., take the shortest path, to the return entries, rather than being channeled inby across the #3, #4 and #5 entry faces. Notes to the drawing specify that "Permanent stoppings shall be maintained to and including the fourth connecting crosscut outby the working face," and that 17,000 CFM (cubic feet per minute) of ventilation must be maintained. Only 12,000 CFM is required if stoppings are maintained to and including the third crosscut.

The Secretary's regulations require that the volume of ventilation air be measured in the "last open crosscut of each set of entries or rooms on each working section The last open crosscut is the crosscut in the line of pillars containing the permanent stoppings that separate the intake air courses and the return air courses." 30 C.F.R. § 75.360(c)(1). As the 004 section was being operated at that time, that line of pillars consisted of those separating the #3 and #4 entries.

Citation No. 7479336 was issued by MSHA inspector Kevin Bruner on December 9, 2002, and alleged that Leeco had not followed its approved ventilation plan because it failed to maintain the required volume of ventilation in what he determined to be the last open crosscut of

the 004 section. Leeco contends that the cited location was not the last open crosscut because, due to incomplete roof-bolting, it was not travelable. In the alternative, Leeco contends that it did not have fair notice of the Secretary's interpretation of the regulation.

Bruner had been an MSHA inspector for four years as of the time he testified. Prior to becoming an inspector, he had worked for Leeco for 21 years, performing a variety of jobs, including that of assistant safety director. On December 9, 2002, he was conducting a dust survey in the 004 section of Leeco's No. 68 mine.⁸ He was accompanied by an inspector trainee and Ricky L. Campbell, the mine's superintendent. They traveled up the #1 and #2 entries, the intake side, collecting samples of coal/rock dust. As they approached the face area, Bruner observed that a permanent stopping had not yet been constructed in the fourth open crosscut on the intake side between the #2 and #3 entries. He issued Citation No. 7479332, which charged Leeco with failing to follow its approved ventilation plan. He determined that the violation was unlikely to result in an injury because a check curtain had been installed, which allowed ventilation to be maintained. Ex. P-11, P-8 at 6. That citation was not contested by Leeco. Ex. P-14.

When Bruner crossed over to the return side, entries 4 and 5, he discovered significant ventilation deficiencies. Check curtains were not present in the #3 and #4 entries, and no check curtain had been installed in the second crosscut outby the face between the #3 and #4 entries.⁹ At approximately 12:10 p.m., he issued Citation No. 7479335, charging that the failure to install and maintain those ventilation controls violated the approved roof control plan. Ex. P-12. That citation also was not contested by Leeco. Ex. P-14.

Because there was no check curtain in the second crosscut outby the face between the #3 and #4 entries, there were two crosscuts through which ventilation air could pass between those entries. With the absence of a curtain across the #4 entry, the vast majority of the air coming from the intake side was taking the shortest route to the #4, return entry, i.e., through that second crosscut, rather than flowing through the first crosscut which was angled 30 degrees inby toward the face of the #4 entry. Roof-bolting had not been completed in the most inby crosscut because a rock had fallen. A triangular area of the crosscut's roof, two legs of which consisted of the

⁸ Dust surveys are conducted to determine the combustibility of coal/rock dust mixtures. Samples, collected every 300 feet in the entries, are analyzed to assure that adequate amounts of rock dust are being applied to minimize the risk of unintended ignition and combustion.

⁹ Bruner testified that there was no check curtain in the third crosscut outby the face between the #3 and #4 entries, and indicated that fact on a drawing of the section. Ex. P-9. He drew ventilation controls that were in place in black, and used a purple marker to depict controls that were installed later to abate violations. Pennington testified that there was a check curtain in the third crosscut, labeled with the number "1" in a circle, drawn in red. Ex. P-9. I credit Pennington's testimony on that issue, because Bruner did not cite the absence of a check curtain in that crosscut when he issued Citation No. 7479335.

extension of the rib of the #4 entry and the first 11 feet of the inby crosscut rib from its intersection with the #4 entry, remained to be bolted. The approximately 35 feet of the crosscut closest to the #3 entry had been bolted. A scoop had been brought up to remove the fallen rock, but it had broken down and was located in the #4 entry near the face, its rear portion extending almost to the outby rib of the crosscut.

Bruner entered the roof-bolted side of the most inby crosscut between the #3 and #4 entries and was unable to discern any air movement. He determined that that crosscut was the “last open crosscut,” and that it did not have the required 17,000 CFM of ventilation. At approximately 12:15 p.m., he issued Citation No. 7479336, charging Leeco with failing to follow its approved ventilation plan. The “Condition or Practice” section of the citation described the alleged violation as follows:

The operator was not following his ventilation plan, approved July 12, 2002. There was no perceptible air movement in the last open crosscut between the No. 3 and 4 entries on the 004 MMU. The miner was cutting in the No. 2 entry and there was methane detected in the No. 3, 4, and 5 entries. There was approximately 0.5 percent methane in the No. 3 and 4 entries and 0.3 percent methane in the No. 5 entry. The section foreman was present at the time and after adjustments were made to the ventilation control an air reading of 3,641 CFM was obtained at 12:40 PM by use of a smoke tube and 0.2 percent methane was detected in the last open crosscut. The mine foreman stopped mining until ventilation could be restored. Any reasonable person would have known that there was not sufficient ventilation on the section at the time. This shows a serious lack of reasonable care on the part of the operator to maintain the required ventilation to protect persons from hazards related to methane accumulations on the 004 MMU. Ventilation could not be restored in a reasonable amount of time and it took extensive effort to get the required amount of ventilation. There were numerous air readings taken in the last open crosscut to evaluate the efforts to get the required amount of ventilation, which is 17,000 CFM with 3 open crosscuts. It took the operator 2 hours and 15 minutes to obtain the minimum required amount of ventilation. The citation is being issued in conjunction with 2 additional citations for ventilation control on the 004 MMU.

Ex. Jt.- 3.

Bruner determined that it was highly likely that the violation would result in a permanently disabling injury, that the violation was significant and substantial, that ten persons were affected, and that the violation was due to the operator’s high negligence. As noted previously, the citation was issued pursuant to section 104(d)(1) of the Act, based upon Bruner’s determination that the violation was the result of the operator’s unwarrantable failure to comply with the mandatory safety standard. The Secretary has proposed a civil penalty of \$5,500.00 for this violation.

The Violation

Thomas Pennington, the 004 section foreman, and Campbell did not consider the first crosscut in the #3 - #4 entry pillar line to be the “last open crosscut” for purposes of ventilation measurement, because it had not been completely bolted and was not completely travelable by miners.¹⁰ Tr. 339-42, 356, 385-86. They testified that, in their collective 35 years of experience, they had never seen an MSHA inspector take an air reading in a crosscut that had not been completely bolted. Tr. 344, 385. Based upon their testimony, Leeco contends that the “last open crosscut” for ventilation measurement purposes was the first completely bolted crosscut, the second one outby the face. Pennington believed that he had the required amount of ventilation air flow in that crosscut.¹¹ No air flow measurements were taken in that crosscut. Tr. 297.

Bruner testified that whether or not a crosscut is travelable has no bearing on whether it is the last open crosscut for purposes of measuring ventilation air currents, i.e., if a crosscut has been cut through and is being used for ventilation, it is an open crosscut for purposes of taking ventilation measurements. Tr. 288, 296. Bruner agreed that if the crosscut had been completely unbolted he could not have entered it to take an air measurement, and may have taken the measurement in the entry, even though it would not have been the proper location. Tr. 290, 292. He also indicated that he might have taken the ventilation measurement in the second crosscut. Tr. 290. However, his testimony on that point was premised upon an assumption that the operator had chosen to use the second crosscut as the primary ventilation air path, i.e., had “curtained off” the unbolted first crosscut such that it was not being used for ventilation purposes. Tr. 292-94.¹²

On December 9, 2002, normal mining operations were interrupted by the rock fall, which prevented completion of the first crosscut’s roof bolting. They were further interrupted because of the break-down of the scoop. Both crosscuts were left open for an extended period of time. Under those circumstances, it appears from the testimony of Bruner and Stanfield that whether

¹⁰ References to “Pennington” in the discussion of this citation are to Thomas Pennington, the section foreman. Lonnie Pennington, another foreman who was involved in the roof control violation, played no role in this alleged violation.

¹¹ If the first crosscut is not counted, permanent stoppings would have been maintained through the third crosscut, and the ventilation plan would have required only 12,000 CFM of air. Tr. 386. Pennington believed that there could well have been 12,000 CFM of air passing through that crosscut, because there had been over 14,000 CFM of air on the intake side and there was very little air passing through the first crosscut. Tr. 344, 360.

¹² The transcript is somewhat unclear on this area of testimony because Bruner was referring to locations on exhibit P-9 that are not described accurately in the record. The above description is, in the opinion of the undersigned, the most accurate interpretation of his testimony.

the first crosscut was considered the “last open crosscut” for purposes of measuring ventilation air flow depended upon whether Leeco chose to use it for ventilation or to isolate, or close it off, with line curtains. Tr. 288-94, 407. Since it was left open, and was being used for ventilation purposes, Bruner determined that it was the location specified in the regulation where ventilation air flow was to be measured.

Despite the parties’ varying interpretations of the phrase “last open crosscut,” I find no ambiguity in the wording of the regulation, as applied to the facts presented. The crosscut, as Bruner found it, was completely open for ventilation purposes. It could be traveled almost in its entirety, and air quality and quantity measurements could be taken in it. I find that the first partially bolted crosscut was the “last open crosscut” within the meaning of 30 C.F.R. § 75.360(c)(1), and was the appropriate place to measure the volume of ventilation air flow.¹³

Leeco contends that it did not have fair notice of the Secretary’s interpretation of the regulation, and that it “should not be penalized with a 104(d) citation.” Resp. Br. at 24. When “a violation of a regulation subjects private parties to criminal or civil sanctions, a regulation cannot be construed to mean what an agency intended but did not adequately express.” *Phelps Dodge Corp. v. FMSHRC*, 681 F.2d 1189, 1193 (9th Cir. 1982), quoting *Diamond Roofing Co. v. OSHRC*, 528 F.2d 645, 649 (5th Cir. 1976). To determine whether an operator received fair notice of the agency’s interpretation, the Commission applies an objective, “reasonably prudent person” test, i.e., “whether 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); *BHP Minerals Int’l Inc.*, 18 FMSHRC 1342, 1345 (Aug. 1996). In applying this standard, a wide variety of factors are considered, including the text of the regulation, its placement in the overall regulatory scheme, its regulatory history, the consistency of the agency’s enforcement, whether MSHA has published notices informing the regulated community with “ascertainable certainty” of its interpretation of the standard in question, and whether the practice at issue affected safety. See *Island Creek Coal Co.*, 20 FMSHRC 14, 24-25 (Jan. 1998); *Ideal Cement Co.*, 12 FMSHRC at 2416.

The issue of whether a partially bolted crosscut can be a “last open crosscut” within the meaning of the regulation appears to be one of first impression, at least as far as Leeco is concerned. Pennington and Campbell testified that they had never seen an MSHA inspector take air readings in a partially bolted crosscut. However, they did not claim to have encountered the situation where an inspection was being conducted when a partially bolted crosscut was present in the specified line of pillars, and there is no viable claim that MSHA has enforced its interpretation inconsistently. MSHA has not published any notices addressing the issue, and neither party points to anything in the regulatory history bearing on it. In response to hypothetical questions, it appears that Bruner and Stanfield may have encountered similar

¹³ Neither Campbell nor Pennington protested to Bruner that he was taking the ventilation measurement in the wrong crosscut. Tr. 272, 359.

situations in the past, but that is not clear, and there is no claim that Leeco was aware of any such encounters.

Inspector Bruner testified that there was essentially no ventilation on the return side of the section, which created a significant safety concern, i.e., the accumulation of methane in the #3, #4 and #5 faces ranging from 0.3% - 0.5%. Tr. 257, 277-78. He knew that the mine was subject to ten-day spot inspections, pursuant to section 103(i) of the Act, because it liberated more than 500,000 cubic feet of methane per day. Tr. 278. These considerations led him to conclude that it was highly likely that methane would continue to build up and that an explosion would result. Tr. 279. He originally allowed only 15 minutes for abatement of the condition, but extended that period because Leeco had ceased mining and devoted all efforts to the abatement action. Tr. 286; ex. Jt-3. While Leeco challenged the accuracy of Bruner's methane readings, it offered no evidence to dispute either that methane was present or that there was a virtual lack of ventilation at the return entry faces. Consequently, the practice at issue affected safety.

I hold that Leeco received adequate notice of the Secretary's interpretation of the regulation, because its plain wording would include any crosscut that is left open and being used for ventilation purposes. It is important to recognize that the situation encountered by Bruner did not entail a brief disruption in ventilation air flow in the normal course of mining activities.¹⁴ The citation was issued at a time when two crosscuts had been left open for an extended period of time because of the rock fall and the breakdown of the scoop. When it became evident that roof bolting of the crosscut was going to be significantly delayed, it was incumbent upon Leeco to take some action. If it did not want to use the crosscut for ventilation, it should have placed line curtains to isolate it. If it wanted it to be used for ventilation, a check curtain should have been installed in the second crosscut, which would have substantially increased the flow of air through the first crosscut. In addition, although not required by the ventilation plan, a more effective permanent stopping could have been constructed in the third crosscut, reducing the required volume to 12,000 CFM. Leeco took no action to address the inadequate ventilation flow in the first crosscut, except to pursue the relatively lengthy course of repairing the scoop, so that the rock could be removed and roof bolting and placement of the check curtain could eventually be completed.

¹⁴ It appears that during normal mining operations, there may be relatively short time periods during which it may not be feasible to maintain ventilation precisely in compliance with the approved ventilation plan. As a new crosscut is cut through from the #3 to the #4 entry, air will start to pass through it. However, there will be minimal air flow until a check curtain is installed in the second crosscut, which will not normally be done until roof bolting has been completed in the new crosscut, a process which takes about an hour. Tr. 355-57. It is likely that, with both crosscuts open, neither one will have the required flow. Tr. 405. Moreover, it is doubtful that valid ventilation measurements can or would be taken in the first crosscut during this transition period. Bruner testified that, if a roof bolter is being used in the first crosscut, he would not attempt to take an air reading until it is removed, because the equipment would interfere with his measurements. Tr. 296.

Because Leeco clearly did not have 17,000 CFM or even 12,000 CFM of ventilation air passing through the last open crosscut, it was not in compliance with its approved ventilation plan, and violated the regulation.¹⁵

S&S

Bruner determined that the violation was S&S primarily because he believed that it was highly likely that methane concentrations would “continue to build up,” resulting in an explosion. Tr. 279-81.¹⁶ Bruner measured concentrations of methane, ranging from 0.3% to 0.5% at the faces of the #3, #4 and #5 entries, apparently shortly after arriving at that area. He did not take subsequent measurements at those faces. Tr. 298. A bottle sample taken at 1:00 p.m., when Bruner recorded a concentration of 0.2% methane in the last open crosscut, was later analyzed at a lab and found to have a methane concentration of 0.11%. Ex. P-10. Campbell testified that he measured methane near the broken-down scoop and found 0.1%. Tr. 382. Pennington recalled that he had taken one methane reading where Bruner was measuring 0.3%, and his meter gave him a lower reading. Tr. 342. It appears that Bruner’s meter was reporting methane concentrations slightly higher than those that actually existed.

There is limited evidence of a time line of methane readings indicating that methane was accumulating at the return entry faces. Preshift examinations had produced readings of 0.0% methane at various points on the section. Ex. R-9, R-10. Methane is liberated in the greatest quantities by the mining process. Tr. 323. Up to the time of Bruner’s arrival, mining was occurring in the #2 face on the intake side. Tr. 305. The ventilation air flow would carry any methane from that area toward the #3, #4 and #5 faces and the return entries. It appears that the inadequate flow of ventilation air through the last open crosscut, combined with the absence of ventilation controls that resulted in the issuance of Citation No. 7479335, resulted in very limited ventilation at the return entry faces, and the accumulation of methane in concentrations of less than 0.5%.

¹⁵ Leeco contends that Bruner took his measurement in a location where there was limited air flow, “dead air,” and that the disabled scoop restricted air flow in the crosscut. Both of these points have some merit. However, even in the best of circumstances, the majority of the air flow would have proceeded through the second crosscut. As long as that crosscut was allowed to remain open, the limited volume flowing through the first crosscut would not have been more than a fraction of that required.

¹⁶ Bruner was also concerned about dust in the mine’s atmosphere. However, while low ventilation air flow may have resulted in more airborne dust in certain areas on the return side of the section, that factor cannot be considered in the S&S analysis. Bruner’s concerns were based only upon his visual observations. Tr. 298-99. There is no reliable evidence of the presence or concentrations of harmful, respirable dust, the length of exposure of any miner, or correlation of dust concentrations and length of exposure to harmful physical effects.

Leeco argues that the violation cannot be S&S because none of the methane concentrations approached dangerous levels, i.e., the level of 5% when methane becomes explosive. However, whether a violation is S&S must be evaluated in terms of “continued normal mining operations.” *U.S. Steel Mining Co., Inc.*, 6 FMSHRC at 1574. Leeco was actively mining on the intake side of the section, and there is no evidence that repair of the scoop was actively underway, or that the ventilation deficiencies on the return side were actively being addressed. Had Leeco’s normal mining operations continued, it is entirely possible that methane would have continued to accumulate in the return faces in sufficient quantities to reach explosive levels.

The violation contributed to a discrete hazard, a build-up of methane in the return entry faces. There was a reasonable likelihood that the hazard would result in an injury. Any injury would be serious. Accordingly, I find that the violation was significant and substantial.

Unwarrantable Failure

The Secretary argues that Leeco’s negligence was high because Pennington, a supervisor, was present and was, or should have been, aware of the violation. The 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., Capitol 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)). Bruner determined that the violation was the result of Leeco’s unwarrantable failure because the inadequate ventilation was severe, extensive and obvious. Tr. 281-86.

Leeco contends that the condition was not extensive or severe, and that Pennington was working on the intake side of the section, where there were no ventilation air flow deficiencies, and reasonably believed that all required ventilation controls were in place on the return side.

As Bruner conducted the dust survey, traveling inby on the intake side of the section, mining was being conducted at the intake entry faces. A roof bolter was in the #1 entry and a continuous miner was backing out of the #2 entry, as Bruner arrived. Tr. 305, 333, 345. Pennington was working on the intake side, where mining was occurring. Tr. 345, 358. The preshift report, showing proper ventilation air flow, had been called out to him before the start of his shift. Tr. 317-18, 328. He checked and made sure that he had all required ventilation air volume on the intake side and in the working faces. Tr. 327, 360. Bruner had not noted any problems with ventilation air volume on the intake side, and Pennington testified that he had no reason to believe that there was a problem with ventilation until Bruner took his air reading in the first crosscut on the return side. Tr. 331.

While the inadequate ventilation flow in the last open crosscut, combined with the missing ventilation check curtains that resulted in the related citation, had allowed the accumulation of some methane in the return entry faces, the condition was limited to those locations, where no mining was being done. The condition was not so extensive that Pennington, who was on the intake side, should have been aware of it. Moreover, the condition was not as severe as Bruner believed, because actual methane concentrations did not reach 0.5%, well short of a level that would have dictated that mining be interrupted, and less than one-tenth of the concentration that would have made it explosive.

It appears that the condition had existed for, at most, a few hours. The subject crosscut was not cut through until after the shift started. Tr. 322, 365. There is no evidence of when the ventilation controls cited in the companion citation had been removed.¹⁷ It is possible that the missing check curtain in the #4 entry, which allowed air to short circuit out that entry rather than be forced up to the #5 face, was removed to allow the scoop to come up and remove the rock.

As soon as Pennington was notified that Bruner had determined that the flow of ventilation was inadequate, he devoted the crew's efforts to abating the violation – placing, tightening and finally doubling check curtains and constructing a permanent stopping in the fourth crosscut outby on the intake side. The entire process consumed over 2 hours, primarily because of the time required to obtain material for the stopping.

Considering all of these factors, I find that the negligence of Pennington, which is imputable to Leeco, and of Leeco itself, was no more than moderate.

The Appropriate Civil Penalties

Leeco is a large operator. The parties have stipulated that it produced over 1.4 million tons of coal in 2002. Its controlling entity, James River Coal Company, is very large. MSHA's computer database shows that Leeco had paid 850 violations, five of which were specially assessed, over the period December 10, 2000, to December 31, 2002. Ex. P-13. Leeco does not contend that imposition of the proposed penalties would affect its ability to remain in business. The gravity and negligence associated with the alleged violations have been discussed above.

Citation No. 7479106 was affirmed as an S&S violation, and the result of the operator's unwarrantable failure. A civil penalty of \$5,000.00 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.

¹⁷ In fact, only one of the ventilation controls had been removed. The check curtains across the #3 entry and the second crosscut had not been installed because Pennington believed that the second crosscut was the last open crosscut and it was being used for ventilation purposes.

Citation No. 7479336 was affirmed as an S&S violation. However, it was not the result of Leeco's unwarrantable failure. Rather, Leeco was moderately negligent with respect to this violation. A civil penalty of \$5,500.00 was proposed by the Secretary. I impose a penalty in the amount of \$2,000.00, upon consideration of the above and the factors enumerated in section 110(i) of the Act.

ORDER

Citation No. 7479106 is **AFFIRMED** in all respects. Citation No. 7479336 is **AFFIRMED**, as modified, and Respondent is directed to pay a civil penalty of \$7,000.00 within 45 days.

Michael E. Zielinski
Administrative Law Judge

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