

FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

OFFICE OF ADMINISTRATIVE LAW JUDGES
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March 29, 1996

SECRETARY OF LABOR,	:	CIVIL PENALTY PROCEEDING
MINE SAFETY AND HEALTH	:	
ADMINISTRATION (MSHA),	:	Docket No. LAKE 94-3
Petitioner	:	A.C. No. 11-00599-03883
v.	:	
	:	Mine: Orient No. 6
FREEMAN UNITED COAL MINING,	:	
Respondent	:	
	:	
SECRETARY OF LABOR,	:	CIVIL PENALTY PROCEEDING
MINE SAFETY AND HEALTH	:	
ADMINISTRATION (MSHA),	:	Docket No. LAKE 95-262
Petitioner	:	A.C. No. 11-00599-03925-A
v.	:	
	:	Mine: Orient No. 6
JAMES YANCIK, Employed by	:	
FREEMAN UNITED COAL MINING,	:	
Respondent	:	
	:	
SECRETARY OF LABOR,	:	CIVIL PENALTY PROCEEDING
MINE SAFETY AND HEALTH	:	
ADMINISTRATION (MSHA),	:	Docket No. LAKE 95-269
Petitioner	:	A.C. No. 11-00599-03926-A
v.	:	
	:	Mine: Orient No. 6
NEAL MERRIFIELD, Employed by	:	
FREEMAN UNITED COAL MINING,	:	
Respondent	:	

DECISION

Appearances: Christine M. Kassak, Esq., Office of the Solicitor, U.S. Department of Labor, Chicago, Illinois, for Petitioner;
Richard R. Elledge, Esq., Gould & Ratner, Chicago, Illinois, for Respondent;
Timothy M. Biddle, Esq., Crowell & Moring, Washington, D.C., for Respondent.

Before: Judge Fauver

These civil penalty cases were brought under §§ 105(d) and 110(c) of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 801 et seq. The corporation and two of its supervisors, who are qualified engineers, are charged with failure to maintain an elevated walkway in good repair to prevent accidents and injuries to employees. The walkway collapsed and four men were severely injured.

Having considered the hearing evidence and the record as a whole, I find that a preponderance of the substantial, probative and reliable evidence establishes the Findings of Fact and further findings in the Discussion below:

FINDINGS OF FACT

1. Freeman owns and operates Orient No. 6 Mine in Waltonville, Illinois, where it produces bituminous coal for sales in or substantially affecting interstate commerce.
2. Freeman is a large coal mine operator, producing over 4 million tons a year. Orient No. 6 is a large mine, producing over a million tons a year.
3. In 1968 Freeman engaged Roberts and Schaefer Company, Engineers and Contractors, Chicago, Illinois, to design and build a preparation plant at Orient No. 6 Mine.
4. The plant is 105 feet high, 100 feet long and 100 feet wide. It is a frame structure with steel columns and beams that provide a basis for installing and removing floors as needed for conveyor belts and other equipment used in the plant.
5. Because of the unique properties of the coal at Orient No. 6 Mine, the atmosphere in the preparation plant is very corrosive to metal. This condition hastens the deterioration of steel columns, beams and other metal supports.

6. Because of widespread corrosion and deterioration of steel members in the preparation plant, in 1984 Freeman built a new preparation plant adjacent to the old one. The old plant was abandoned as a preparation plant but kept as a building for certain functions. Walkways and conveyor belts run through the old plant to the new plant, and the plants are connected by pumps and motor controls. In addition, there is a large electric power station in the old plant. The areas of the old plant that are most frequently used are elevated walkways, conveyor belts, the electrical power station, and a drainage system.

7. Once metal deterioration begins, it continues to worsen until rust disintegrates the metal. Steel beams, columns, and metal supports in the old plant continued to deteriorate after the new plant was built. In 1987 a conveyor belt collapsed in the old plant because of deterioration of steel members.

8. The collapse of the conveyor belt in 1987 shut down production and caused Freeman to recognize that it needed to rehabilitate or replace weakened and deteriorated steel members in the old plant. Rehabilitation work moved slowly. In 1989 Freeman engaged Roberts and Schaefer to evaluate the structural condition of the old preparation plant and to make recommendations for its rehabilitation. R & S was chosen because it had designed the old preparation plant, built it, and knew the loads the members could carry and had expertise in diagnosing defective steel members and how to repair them. It also had built the new preparation plant.

9. After inspecting the old preparation plant, R & S submitted a report to Freeman on November 30, 1989, prepared by Engineer Paul G. Meifert. The report is entitled "Report to Determine Structural Integrity of Existing Coal Preparation Plant for Freeman United Coal Company Orient No. 6 Mine." Govt. Exh. 3.

10. The R & S report found many structural hazards. It stated that part of the floor at elevation 454 "is beginning to collapse and has been roped off above and below per [the R & S engineer's] request. Obviously this area needs attention." An abandoned coal conveyor above elevation 468 was "on the verge of collapse . . . [which would be] life threatening" (p.4). Vertical bracing was "virtually nonexistent due to deterioration and to field removal for access. Bracing should be brought back to original as much as possible" p.4. The report called for "immediate attention" to "beams and columns where holes exist or can be punched out with a hammer." p.3. It also stated that "many beams and columns were tested by hammer blows to determine the extent of rust and deterioration" and that, "although many sections were reduced due to rust scale. . . , in the majority of

cases, enough material remains to carry reduced loads." Emphasis added; p.2. To reduce the loads, heavy equipment and other materials were to be removed from a number of floors.

11. The R & S report included the following cautionary notice: "Although the structure appears to be sound in general these findings are based only upon a visual inspection. No load tests or calculations were performed to determine actual stresses. Extent of deterioration and actual safety of structure cannot be determined without extensive measuring, testing, and calculation" (p.5).

June 1993 Collapse of Elevated Walkway

12. On June 8, 1993, Mr. Steve Stanley, the surface manager of the mine, led a crew of two supervisors and two miners to work on a coal belt on the first floor (elevation 454 on the R & S drawing). To gain access to the belt, the men were standing on an elevated walkway parallel to the belt, 17 feet above a concrete floor. Mr. Stanley left to get a bolt. Shortly after he left, the walkway suddenly collapsed and the four men fell to the concrete floor amidst jagged and broken steel and concrete debris. They were severely injured.

13. MSHA began an investigation on June 9. On June 10, Engineers Terence Taylor and Dan Mazzei, from MSHA's Safety and Health Technology Center, inspected the fallen walkway as well as the general plant.

14. Mr. Taylor is a professional engineer and has both a bachelor's and a master's degree in civil engineering with specialization in structural engineering. He is a member of the American Society of Civil Engineers. Mr. Taylor's supervisor is Dan Mazzei, who has a bachelor's degree in civil engineering and a master's degree with an emphasis on water resources.

15. The Tech Support team observed widespread deterioration of steel members with some remedial work done to some of the columns in the basement. They did not inspect every steel member, but they looked at the supports for the walkway and found widespread corrosion and deterioration of structural members. At the accident site they observed that members that were still dangling or touching the ground were severely corroded. Much of the cross section was missing on some of the dangling members. The failed members were badly deteriorated and one failed beam was almost totally deteriorated.

16. The area where the collapse occurred is delineated by column lines E and F in the north-south direction and 4 and 5 in the east-west direction of the original plant drawings. These

four columns are the corners of a 5 by 20 foot bay. The slab that collapsed was supported at its north and south ends by two wide flange beams, along its east edge by a wide flange beam, and its west edge by six-inch wide channel sections. The center of the slab was supported by a wide flange beam and the quarter points by light beams. The three intermittent support beams had fallen along with the west and east edge supports. The north and south beams were still in place. The west or east edge support was the first support to fail. Most likely the beam on the east edge collapsed first, transferring the load to the west edge, shearing the channel sections and bending down the three intermittent beams. The east edge beam was almost completely deteriorated with many holes and extensive corrosion. There was extensive rust on the 20 foot long wide flange beam supporting the edge of the slab. The bottom flange and parts of the web were deteriorated, reducing the load-carrying capabilities of the section. In the collapsed bay, the connection between the east edge beam and the column was still intact on the column, indicating that the beam sheared right through its cross section.

17. Along the same column line that failed, in the bay to the south of the area of collapse, Mr. Taylor and Mr. Mazzei saw a steel member that was identical in section and dimensions to the beam that failed on June 8, 1993. This member was still in place, but deterioration holes could be seen plainly. This member is the subject of Govt. Exh. No. 6 and was the support for the walkway farther south of the point of collapse. The unsafe condition of this beam was similar to that of the beam that failed on June 8.

18. The failure on June 8 was caused by excessive corrosion reducing the section-carrying capacity at the edge supports where the shear load was the highest and where it ultimately failed.

19. Before the accident on June 8, the deteriorated steel members supporting the walkway section that collapsed were observable from the floor below, and were visibly in bad repair.

20. Some beams under the walkway in other bays were also visibly in bad repair. The walkway presented numerous hazards of steel corrosion and deterioration.

21. A number of beams had holes in them and were rusted and twisted and deteriorated. MSHA inspector Charles Conaughty observed instances where a hammer struck against a structural member traveled through the member.

22. Government Exhibits 4,5, and 11 show the area where the June 8 accident occurred. Exhibit 4 shows the beam that failed under the east side of the walkway. Exhibit 5 shows part of the

material that was still hanging from the collapsed walkway. Exhibit 11 shows deteriorated vertical bracing that was at the end of the row of columns in the same row in which the collapse occurred.

23. Government Exhibits 6, 7, 8, 9 and 10 show other areas of deterioration adjacent to or near the accident site. The beam shown in Exhibit 6 was in the adjacent or a nearby bay just south of the area that fell, and was in the same column line (column line 4) in which the accident occurred. The steel members that failed would have been exposed to the same corrosive elements as the beam depicted in Exhibit 6.

24. In 1989, when Freeman was removing the floor area described in the R & S report (defined by column lines A to F and 4 and 5), Freeman personnel were within close visual range of the steel members of the walkway section that failed on June 8, 1993.

25. As of the date of the collapse, a number of areas in the old plant still needed rehabilitation and repair work, including the section that collapsed.

26. At the time of the collapse, Mr. Thomas J. Austin had been the safety director of the mine since 1987. There were three employees in the safety department. Mr. Austin's immediate supervisor was Respondent Neal Merrifield. Mr. Austin is not an engineer and has never taken any engineering courses.

27. Prior to the accident, Mr. Austin never received any instructions to have his safety employees look for holes in beams and columns or perform tests with a hammer on any of the beams or columns that supported walkways. Nor did he see or discuss the R & S report before the accident. He first learned about the R & S report during the investigation following the walkway collapse.

28. In 1989, Mr. Steve Stanley was the assistant mine manager of the Orient No. 6 mine. Mr. Stanley became surface manager of the mine in 1991. He is not an engineer, but he was called upon to direct rehabilitation work and repairs in the old plant. He made decisions on a day to day basis as to where to assign employees. Prior to the accident, no one directed Mr. Stanley to put more people to work in the old plant or to give any priority to checking beams and other metal supports that held up the walkways. Nor did anyone instruct Mr. Stanley to have employees look for holes in beams and columns or perform tests with a hammer on any beams or columns that supported walkways.

29. Mr. Stanley had never seen and was not given a copy of the R & S report until after the accident. No one discussed the R & S report with Mr. Stanley until after the accident.

30. On June 8, 1993, when Mr. Stanley directed four employees to work on the conveyor belt by standing on the walkway, he had no knowledge of the R & S report or the dangers observed in the report.

Respondent James Yancik

31. At all relevant times, Respondent James Yancik was manager of quality control and plant maintenance and the preparation engineer. Mr. Yancik has a B.S. degree in mining engineering and is a member of the Society of Mining Engineering. One of his specialties is structural analysis.

32. Mr. Yancik accompanied Engineer Paul Meifert of the R & S Company during Mr. Meifert's inspection of the old preparation plant in 1989. During their inspection they used three tools: a chipping hammer, a wire brush, and a hammer. They did not take core samples. They were visually looking at steel members and in some cases they would scale and test steel members.

33. Mr. Meifert and Mr. Yancik observed a crack in a floor that was beginning to sag. Mr. Meifert identified the floor as dangerous and had it roped off.

34. When part of the floor at elevation 454 was removed, Mr. Yancik reviewed the work. During the time he was conducting inspections for Mr. Mullins, he remembered seeing several beams in a condition like that of the beam in Govt. Exh. No. 6. At the hearing he stated that some of these were possibly not repaired.

35. Before accompanying Mr. Meifert, Mr. Yancik had personally inspected the old preparation plant. In 1987, when starting the initial rehabilitation program, Mr. Yancik spent eight hours a day there, five days a week, for several weeks. Mr. Yancik did not continue that frequency of inspections after the R & S report. During the period from the issuance of the R & S report (November 30, 1989) until the walkway collapse on June 8, 1993, Mr. Yancik conducted inspections of the old plant "on a periodic basis" depending upon his "available time." His inspections were not frequent.

36. Mr. Yancik read the R & S report several times and was very familiar with its contents. He received his copy of the R & S report from Mr. Mullins, vice president of operations.

37. Before the accident, Mr. Yancik had seen holes in some beams like those that were shown on figures 7 and 9 in the R & S report but never directed anyone to repair or rehabilitate those beams. Mr. Yancik did not personally set priorities for the rehabilitation or repair of the old plant.

38. Mr. Yancik had "expertise in structural analysis." He agreed that when an engineer sees a corroded hole in a steel beam he views it as a potential hazard.

Respondent Neal Merrifield

39. At the time of the collapse in June 1993, Mr. Merrifield was vice president of operations. He is a mining engineer. Prior to becoming vice president of operations, he had been the mine superintendent. As vice president of operations, his responsibilities included safety of the operations of the mine facilities. Mr. Yancik reported to Mr. Merrifield.

40. Mr. Merrifield read the R & S report and, as an engineer, he understood it. After 1991, when he became vice president of operations, Mr. Merrifield set priorities for the rehabilitation work in the old plant. Mr. Merrifield approved the mine's budget and had responsibility for the budget for the old plant. Although he did not have final authority on the budget, Mr. Merrifield's budget recommendations were not normally overruled by his supervisor.

41. The chief engineer of the mine reported to Mr. Merrifield. As supervisor of the engineering department, Mr. Merrifield approved the time spent on rehabilitation efforts. Along with other mine management and the corporate officers, Mr. Merrifield approved the allocation of dollars for those rehabilitation efforts.

42. Mr. Merrifield approved the engineering department's decisions regarding priorities for the rehabilitation of the old plant. The engineering department reported to him regarding its recommendations for sequencing repair work and to get authorization to contract out rehabilitation work. When the engineering department wanted items beyond the budget, it would present its request to Mr. Merrifield and he would approve or disapprove it.

43. Mr. Merrifield had input into the final report in response to Mr. Mullin's memorandum of January 1, 1990 (Govt. Exh. 26) including recommendations regarding replacement of bracing as recommended by the R & S report. Mr. Merrifield attended a February 1, 1990, meeting with Mr. Mullins regarding corrective actions to be taken.

44. Mr. Merrifield did not give Mr. Jim Hess, his successor as mine superintendent, a copy of the R & S report. Mr. Merrifield also did not give Mr. Steve Stanley, surface manager, a copy of the R & S report. Nor did he give a copy of the report to the mine safety director.

45. Mr. Mullins sent a copy of his letter regarding Mr. Yancik's job responsibilities (Govt. Exh. 18) to Mr. Merrifield. A copy of an October 26, 1988, document regarding inspection of all belt supporting structures on an annual basis, to visually assess the competency of the structural members, went to Mr. Merrifield. Mr. Yancik sent a copy of a memorandum of May 4, 1988 (Govt. Exh. 20), to Mr. Merrifield. A copy of a memorandum of December 17, 1988 (Govt. Exh. 21), regarding areas that required immediate attention and reporting that the second floor was badly deteriorated, went to Merrifield.

46. Mr. Yancik sent copies of a memorandum of January 29, 1990 (Govt. Exh. 22), regarding the R & S report, and a memorandum of August 13, 1990 (Govt. Exh. 23), regarding his inspection of the old plant, to Mr. Merrifield. Mr. Yancik also sent a memorandum of October 2, 1990 (Govt. Exh. 24), in which he informed Mr. Merrifield that "no definitive plan has been formulated to correct the deficiencies" in the old plant.

DISCUSSION WITH FURTHER FINDINGS, CONCLUSIONS

I

RESPONDENTS' CHALLENGE OF THE REGULATION

On June 8, 1993, a large section of an elevated walkway -- about 5 by 20 feet -- suddenly collapsed. The four miners standing on it fell 17 feet to a concrete floor amidst jagged and broken steel and concrete debris. They were severely injured.

The Secretary alleges that Respondents violated 30 C.F.R § 77.200, which provides:

Surface installations; general

All mine structures, enclosures, or other facilities (including custom coal preparation) shall be maintained in good repair to prevent accidents and injuries to employees.

Respondents challenge the regulation as being vague and ambiguous.

A safety standard must provide adequate notice of the conduct it prohibits or requires, so that the mine operator or other affected persons may act accordingly. Southern Ohio Coal Company, 14 FMSHRC 978,983 (1992). The "appropriate test is not whether the operator had explicit prior notice of a specific prohibition or requirement, but 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 (1990).

In U.S. Steel Mining Co., 14 FMSHRC 973, 974 (1992), the Commission affirmed a decision in a § 77.200 case, noting the judge's holding that "the primary purpose of § 77.200 was to assure the physical and structural integrity of surface coal preparation facilities . . ." I find that the regulation gives sufficient notice of the safety conduct required. The plain language of the regulation means that surface structures and facilities must be maintained in good repair relative to safety. In dictionary terms, "maintenance" means "The labor of keeping something (as buildings or equipment) in a state of repair or efficiency: care, upkeep . . . [p]roper care, repair, and keeping in good order . . . [t]he upkeep, or preserving the condition of property to be operated." See Webster's Third New International Dictionary, Unabridged 1362 (1971); A Dictionary of Mining, Mineral, and Related Terms 675 (1968); and Black's Law Dictionary 859 (5th ed. 1979).

II

RULING ON RESPONDENTS' MOTION TO DISMISS

At the end of the Secretary's case, the individual Respondents moved to dismiss the § 110(c) charges. The judge took the motion under advisement to be ruled upon in the final decision. Respondents then presented evidence on all matters.

The Commission's Rules of Procedure, the Administrative Procedure Act and the Mine Act are silent as to the standards that apply to motions to dismiss at the close of an opposing party's case-in-chief. Accordingly, it is appropriate to consult the Federal Rules of Civil Procedure for guidance. Basic Refractories, 13 FMSHRC 2554, 2558 (1981).

When a party moves for dismissal at the close of the opponent's case, the judge has discretion to take the motion under advisement. Fed. R. Civ. P. 52(c), "Judgment on Partial Findings," provides, in pertinent part:

If during a trial without a jury a party has been fully heard with respect to an issue . . . , the court may enter judgment as a matter of law against that party on any claim . . . or the court may decline to render any judgment until the close of all the evidence.

The notes of the Advisory Committee on Rules to Fed. R. Civ. P. 52(c) specify that a court has discretion to enter no judgment prior to the close of all the evidence. Clifford Meek v. ESSROC Corporation, 15 FMSHRC 606, 615 (1993). Here, as there, the judge exercised that discretion. In making that determination, a court is within its prerogative to weigh all the evidence, resolve any conflicts in it, and decide for itself where the preponderance lies. Local Union 103 v. Indiana Construction Corp., 13 F.2d 253, 257 (7th Cir. 1994).

In his dissent on other grounds in Mathies Coal Company, 5 FMSHRC 300, 307 (1983), Commissioner Lawson stated that "a trial court's reservation of ruling on a motion for involuntary dismissal [under 41(b) Fed. R. Civ. P., the predecessor to 52(c)] is, in effect, a denial of the motion." The Commissioner concluded that: "Respondent had the choice of proceeding or standing on its motion. By presenting evidence, Respondent waived its right to appeal from the judge's 'denial' of its motion."

Here, Respondents presented evidence following the judge's reservation of a ruling. The motion is denied and the case will be decided upon all the evidence.

III

DECISION ON THE MERITS

The first question is whether the walkway was "maintained in good repair to prevent accidents and injuries" as required by 30 C.F.R. § 77.200.

Freeman contends that the old preparation plant had undergone an extensive rehabilitation program to repair or replace deteriorating steel columns and beams and that the particular walkway section had not been observed as requiring repairs.

This argument fails because the steel supports that collapsed were visibly badly deteriorated due to corrosion. Also, a number of other steel members supporting the walkway were visibly deteriorated due to corrosion. Under the R & S report, "immediate attention" was required for "beams and columns where holes exist or can be punched out with a hammer." Without rehabilitation or replacement of the deteriorated members, the walkway clearly was not being "maintained in good repair to prevent accidents and injuries to employees." Freeman was therefore in violation of 30 C.F.R. § 77.200.

The next question is whether Freeman was negligent in failing to maintain the walkway in good repair. I find that it was.

Freeman contends that it had started the rehabilitation program in 1987 and in 1989 engaged the engineering firm (R & S) that built the plant to return to inspect the structural condition of the plant and make recommendations. It states that before the walkway collapsed it had taken corrective action on the specific recommendations in the engineering firm's report and was carrying out an ongoing inspection and repair program on columns and beams in accordance with the engineering report.

However, the walkway collapse occurred more than three and a half years after the R & S report, which had warned Freeman that "immediate attention" must be given to "beams and columns where holes exist or can be punched out with a hammer" and that "for beams, holes near connecting and concentrated loads are critical." Exh. G-3, p.3. The steel supports that collapsed under the walkway were badly deteriorated and were plainly visible before the accident.

In Alabama By-Products, 4 FMSHRC 2128, 2129 (1982), the Commission held:

[I]n deciding whether equipment or machinery is in safe or unsafe operating condition, . . . the alleged violative condition is appropriately measured against the standard of whether a reasonably prudent person familiar with the factual circumstances surrounding the allegedly hazardous condition, including any facts peculiar to the mining industry, would recognize a hazard warranting corrective action.

The "reasonably prudent person" test applies to engineers as well as to laymen. This case focuses upon the responsibility of engineer-supervisors to protect the safety of miners using an elevated walkway. Miners and supervisors who are not engineers are not expected to know the structural integrity of steel beams and columns. To a layman, including a supervisor who is not an engineer, deteriorated or corroded steel beams 14 feet above the floor may not seem dangerous if the company engineers indicate that they have carefully checked the structural condition and that the beams are safe. However, the walkway suddenly collapsed because of deteriorated steel beams. The question raised is whether a reasonably prudent engineer would have inspected and repaired or replaced the beams before they collapsed.

The Respondent engineer-supervisors were fully aware of the history of deterioration of steel members in the old plant,

including a major collapse of a conveyor belt in 1987 because of deteriorated steel members, and the 1989 R & S report that warned of the need to give "immediate attention" to "beams and columns where holes exists or can be punched out with a hammer." I find that a reasonably prudent engineer having such knowledge and being familiar with the mining industry would have performed or required careful and frequent inspections of the steel beams of the elevated walkways including hammer tests of suspicious looking beams. By the exercise of reasonable care, the failed beams and steel supports could have been detected and corrected to prevent the collapse that occurred on June 8, 1993. I also find that, before the walkway collapse, a reasonably prudent engineer who observed the other deteriorated steel members later found by the MSHA engineers would have repaired or replaced them.

I now turn to the issue of whether the individual Respondents are liable as corporate agents under § 110(c) of the Act. This section provides:

Whenever a corporate operator violates a mandatory health or safety standard or knowingly violates or fails or refuses to comply with any order issued under this Act or any order incorporated in a final decision issued under this Act, except an order incorporated in a decision issued under subsection 105(c), any director, officer, or agent of such corporation, who knowingly authorized, ordered, or carried out such violation, failure, or refusal shall be subject to the same civil penalties, fines, and imprisonment that may be imposed upon a person under subsections (a) and (d).

The individual Respondents were agents of the corporate Respondent within the meaning of § 110(c). Respondent Neal Merrifield was vice president of operations at the time of the collapse of the walkway. He is a mining engineer. Before becoming vice president of operations he had been mine superintendent. As vice president of operations, his responsibilities included safety of the operations of the mine facilities. The safety and engineering departments reported to him. Respondent James Yancik reported to Mr. Merrifield. Mr. Yancik was manager of quality control and plant maintenance and the preparation engineer at the subject mine. He is a mining engineer with a specialty in structural analysis.

In Warren Steen Construction, Inc. and Warren Steen, 14 FMSHRC 1125, 1131 (1992), the Commission held that, "In order to establish § 110(c) liability, the Secretary must prove only that an individual knowingly acted, not that the individual knowingly violated the law." In Kenny Richardson v. Secretary of Labor, 3 FMSHRC 8, 16 (1981), aff'd, 689 F.2d 632 (6th Cir 1982),

cert. denied, 461 U.S. 928 (1983), the Commission defined the term "knowingly" as follows:

"Knowingly," as used in the Act, does not have any meaning of bad faith or evil purpose or criminal intent. Its meaning is rather that used in contract law, where it means knowing or having reason to know. A person has reason to know when he has such information as would lead a person exercising reasonable care to acquire knowledge of the fact in question or to infer its existence.

A "knowing" violation does not require a showing that the corporate agent "willfully" violated the Mine Act or safety regulations. Rather, the Commission held that:

If a person in a position to protect employee safety and health fails to act on the basis of information that gives him knowledge or reason to know of the existence of a violative condition, he has acted knowingly and in a manner contrary to the remedial nature of the statute. [Id.]

The individual Respondents knew as early as 1984 that the steel members in the old preparation plant were deteriorating. After the new plant was built in 1984, the steel members in the old plant continued to deteriorate. In 1987, a conveyor belt collapsed because of deteriorated steel members. The collapse shut down production and caused Freeman to recognize that the old plant must be rehabilitated. However, progress toward rehabilitation was slow. In 1989, Freeman engaged the engineering firm (R & S) that built both plants to return to evaluate the structural condition of the old plant and make recommendations. After Freeman received the R & S report (November 30, 1989), rehabilitation efforts still moved slowly. More than three and a half years after the report, the cited walkway was still in bad repair, as evidenced by the collapse of the walkway on June 8, 1993, and the deterioration of other steel members disclosed by the MSHA investigation after the walkway collapsed. The three and a half years from the R & S report to the walkway collapse represents about 1,600 workshifts during which miners were exposed to the hazards of the elevated walkway.

Respondents had a legal duty to ensure that the elevated walkway was "maintained in good repair to prevent accidents and injuries to employees." 30 C.F.R. § 77.200. The R & S report put them on notice that "immediate attention" was needed to repair or replace all "beams and columns where holes exist or can be punched out with a hammer. For beams, holes near connections and concentrated loads are critical."

The individual Respondents were agents of the corporate mine operator and were qualified engineers in positions to protect the safety of miners who used the elevated walkway. Mr. Merrifield prioritized the rehabilitation sequences to carry out the recommendations in the R & S report and Mr. Yancik had the responsibility to inspect the steel members for compliance with the criteria in the R & S report. They knew that the steel members supporting the elevated walkway needed to be inspected carefully and frequently in order to give "immediate attention" to "beams and columns where holes exist or can be punched out with a hammer," as warned by the R & S report. This required hammer testing of any suspicious beams. It is clear that the beams that failed on June 8, 1993, were more than suspicious, but had not been properly tested and remedied before the collapse.

Mr. Yancik testified that he never received any written report that told him or caused him to believe that the plant was not being maintained in a safe condition or that the walkway that collapsed was dangerous. However, Mr. Yancik was the individual charged with making inspections of the plant to create those kinds of reports. In addition, he was aware of the 1987 collapse of the conveyor belt and of the clear warnings in the R & S report.

Mr. Yancik acknowledged that it would have been reasonable to inspect the walkway beams after Freeman removed the floor at elevation 454. When asked why Freeman did not replace any of the steel members under the walkway, Mr. Yancik concluded that the structural condition was not bad enough to require remedial attention. Yet the walkway failed because of advanced deterioration and badly corroded steel beams.

Mr. Merrifield was a decisionmaker responsible for safety of operations of the old preparation plant from the time he was mine superintendent and later vice president of operations. He had a thorough knowledge of the history of deterioration of the steel members, including the 1987 collapse of the conveyor belt and the 1989 R & S report. He made monetary decisions regarding rehabilitative efforts in the old plant. With his knowledge of the R & S report, and his qualifications as an engineer, he had a duty to heed the warnings of the R & S report and see to it that beams, columns, and metal supports for the elevated walkway were carefully and frequently inspected so that "immediate attention" would be given to any beams or columns "where holes exist or can be punched out with a hammer." He had the authority to provide copies of the R & S report to the safety director and surface manager (who both reported to him) and to discuss it with them. However, he failed to do so.

When the surface manager, Mr. Stanley, led a crew of four men onto the walkway on June 8, 1993, he had no knowledge of the R & S report and its warning that "immediate attention" must be given to "beams and columns where holes exist or can be punched out with a hammer." Since he was not an engineer, and had no training in structural analysis, he had to rely upon the individual Respondents to see that the walkway was kept in a safe condition. Respondent Merrifield prioritized the rehabilitation sequences to carry out the recommendations of the R & S report, and Respondent had the responsibility to inspect the steel members for compliance with the criteria spelled out in the R & S report. Both were qualified engineers who knew the significance of the dangers found in the report, but they did not convey them to Mr. Stanley or the mine safety director.

Had they informed Mr. Stanley, the surface manager, of the need to look out for "beams and columns where holes exist or can be punched out with a hammer," Mr. Stanley would have had crucial safety information when he assigned four men to work with him on the walkway that collapsed. This would have alerted him to immediately report any beams "where holes exist or can be punched out with a hammer," and may have alerted him to look at the beams below before placing a concentrated live load on the walkway. Had he looked at the beams, he would have seen the deterioration and corrosion that the MSHA engineers saw after the collapse of the walkway. This probably would have alerted him to call the individual Respondents for an evaluation of the safety of the walkway.

Respondents argue that a number of MSHA inspectors had inspected the old plant before the collapse in June 1993, but did not cite the walkway as being unsafe. However, MSHA inspectors are not engineers, and the dangers of the walkway were such that only specially qualified persons, such as engineers, could fully understand the hazards involved in the context of the R & S report. Moreover, in Raymer v. United States, 660 F.2d 1136, 1143 (6th Cir. 1981), cert. denied, 456 U.S. 944, 102 S. Ct. 2009 (1982), the court held that MSHA inspectors do not undertake to perform a duty owed by the mine operator to its employees. The court rejected the idea that responsibility for mine safety is shifted to the federal government.

In Joseph B. Necessary, 6 FMSHRC 2567 (1984), Commission Judge Koutras found that an agent with 45 years of experience in the construction business who was supervising the repair of a mine refuse storage bin that collapsed, killing three miners, violated 30 C.F.R. § 77.200. Judge Koutras found that the collapse was caused by a misalignment in the support columns and that the supervisor was aware of the misalignment. In affirming the citation, Judge Koutras found that, in light of the

supervisor's experience, "he knew or should have known that the misalignment posed a serious potential safety hazard requiring immediate correction."

I find that Respondents Merrifield and Yancik "knowingly authorized, ordered, or carried out" a violation of 30 C.F.R. § 77.200, within the meaning of § 110(c) of the Act, by failing to take necessary steps within their competence and authority to see that the cited walkway was "maintained in good repair to prevent accidents and injuries to employees." Miners and supervisors who are not engineers cannot be expected to judge the structural integrity of steel beams and columns. However, when a mine operator engages the engineering firm that constructed a building to return to evaluate its structural condition after years of corrosion of steel members, it is incumbent upon the operator's own engineers to exercise due diligence and reasonable care in implementing the builder's repair and rehabilitation recommendations. The individual Respondents patently failed to do so with respect to the walkway that collapsed on June 8, 1993.

The collapse was not an unforeseen accident. There had already been a major collapse in 1987. As rehabilitation work progressed in the old plant, beams that were repaired or replaced were painted yellow. As of the date of the collapse, yellow horizontal beams were in areas where weight had been removed from the floor and where holes had been covered to prevent falls through the floor. Apparently there were no yellow beams supporting the elevated walkway. The MSHA engineers found a number of beams and supports that were deteriorated, similar to the beams that collapsed on June 8, 1993. This indicates that the walkway was in overall bad repair, that the collapse on June 8 could readily have occurred in many dangerous places in the walkway, and that a concentrated live load (several miners) was critical, as predicted by the R & S report.

This was not a situation in which a claim of "unforeseen accident" could be reasonably asserted. Rather, it was a collapse ready to happen.

I find that the violations of § 77.200 by the individual Respondents were due to high negligence and their negligence is imputed to the corporation. In reaching this conclusion, I have considered a number of factors. These include: their expert knowledge as engineers of the history of deterioration of steel members in the old plant, the 1987 collapse of the conveyor belt, and the clear notice in the 1989 R & S report of the steps necessary to maintain the elevated walkway in good repair; their failure to heed the R & S report by taking necessary action to inspect and repair the walkway that collapsed; their failure to advise the safety director and the surface manager of the need to

look out for holes and weak spots in the beams under the walkway; and the great risk to the miners who regularly used the elevated walkway, including the four miners who were injured.

IV

CIVIL PENALTIES

The key to the Mine Act is prevention of mining hazards by compliance with safety and health standards. This requires diligence in monitoring changing mine conditions to see that the mine is in compliance.

As found in the Discussion, Freeman and the two individual Respondents were highly negligent in failing to maintain the walkway in good repair to prevent accidents and injuries to employees. Their violations of § 77.200 are aggravated by the fact that they had a supervisory and professional responsibility to protect laymen who were dependent upon their expert knowledge.

In Roy Glenn, 6 FMSHRC 1583, 1587 (1984), the Commission repeated its holding in Kenny Richardson, supra, that "a supervisor's blind acquiescence in unsafe workings would not be tolerated," and that "supervisors . . . could not close their eyes to violations, and then assert lack of responsibility for those violations because of self-induced ignorance." Similarly, in passing the 1977 Mine Act, Congress was particularly concerned over the high number of mining injuries and fatalities that resulted from inadequate supervision and hazardous "conditions reasonably within the power of management to prevent." H.R. Rep. No. 312, 95th Cong., 1st Sess. 4 (1977), reprinted in Legislative History of the Federal Mine Safety and Health Act of 1977, at 360 (1977).

Section 110(i) of the Act provides six criteria for assessing civil penalties. Considering each of the criteria, I find that Freeman is a large operator, the civil penalties in this Decision will not affect its ability to continue in business, Freeman has an average compliance history for its size, and after the citation was issued the three Respondents made a good faith effort to achieve compliance with 30 C.F.R. § 77.200. The three Respondents violated that section, as found above. The gravity of the violations was high and the violations were due to high negligence on the part of each Respondent.

Considering all of the criteria for civil penalties in § 110(i) of the Act, I find that the following civil penalties are appropriate for Respondents' violations of § 77.200:

Respondent Freeman United Coal Mining Company, a civil penalty of \$10,000.

Respondent Neal Merrifield, a civil penalty of \$5,000.

Respondent James Yancik, a civil penalty of \$4,000.

The penalties are higher than the penalties proposed by the Secretary because of Respondents' aggravated conduct in ignoring the clear steps needed to protect the safety of the miners. Through their high negligence in failing to replace defective beams, the walkway was allowed to deteriorate to the point of a sudden collapse causing severe injuries.

CONCLUSIONS OF LAW

1. The judge has jurisdiction.
2. Respondents violated 30 C.F.R. § 77.200 as found above.

ORDER

1. Citation No. 3537447 is AFFIRMED.
2. Within 30 days of the date of this Decision: Respondent Freeman United Coal Mining Company shall pay a civil penalty of **\$10,000**; Respondent Neal Merrifield shall pay a civil penalty of **\$5,000**; and Respondent James Yancik shall pay a civil penalty of **\$4,000**.

William Fauver
Administrative Law Judge

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