FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

OFFICE OF ADMINISTRATIVE LAW JUDGES
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July 25, 2002

SECRETARY OF LABOR,	:	CIVIL PENALTY PROCEEDINGS
MINE SAFETY AND HEALTH	:	
ADMINISTRATION (MSHA),	:	Docket No. PENN 99-213
Petitioner	:	A.C. No. 36-07328-03541
v.	:	
	:	Docket No. PENN 99-254
SUMMIT ANTHRACITE, INC.,	:	A. C. No. 36-07328-03542
Respondent	:	
	:	Docket No. PENN 2000-9
	:	A.C. No. 36-07328-03544
	:	
	:	Docket No. PENN 2000-10
	:	A.C. No. 36-07328-03545
	:	
	:	Tracy Vein Slope

DECISION

Appearances: Donald K. Neely, Esq., Natalie A. Appetta, Esq., Office of the Solicitor, U.S. Department of Labor, Philadelphia, Pennsylvania, on behalf of Petitioner; Mike Rothermel, President, Summit Anthracite, Inc., Klingerstown, Pennsylvania, on behalf of Respondent.

Before: Judge Zielinski

These cases are before me on Petitions for Assessment of Civil Penalty filed by the Secretary of Labor pursuant to section 105 of the Federal Mine Safety and Health Act of 1977 ("Act"), 30 U.S.C. § 815. The petitions allege that Summit Anthracite, Inc., is liable for 22 violations of mandatory safety and health standards applicable to underground coal mines. A hearing was held in Harrisburg, Pennsylvania. Subsequently, Respondent moved to reopen the record to allow the submission of documentary evidence related to its financial condition and ability to pay civil penalties. That motion was granted, conditionally, by Order dated March 7, 2002. The Secretary was also granted leave to submit additional evidence related to Respondent's financial condition. Respondent satisfied the condition imposed and the financial evidence was admitted as part of the record. The Secretary submitted additional evidence on April 10, 2002, which was also admitted. The Secretary submitted a brief following receipt of the transcript. By letter dated May 6, 2002, Respondent elected not to submit a brief, and offered the mine for sale at a price of $0.00, provided that existing liabilities be assumed,

including "five years back pay for the 3 stockholders." At the commencement of the hearing, the Secretary withdrew two of the alleged violations and the petitions as to those citations will be dismissed.[1] The Secretary proposes civil penalties totaling $57,039.00 for the remaining charges. For the reasons set forth below, I find that Summit committed twelve of the alleged violations and impose civil penalties totaling $16,330.00.

Findings of Fact - Conclusions of Law

Background - Anthracite Mining

Respondent operated an underground anthracite coal mine, the Tracy Vein Slope, located near Goodspring, in Schuylkill County, Pennsylvania. The coal vein varied from five to eight feet thick and sloped at an angle of 70-80 degrees, i.e., nearly vertical. The mine liberated approximately 35,503 cubic feet of methane every 24 hours. Thirteen miners normally worked at the site, nine underground and four on the surface. Coal was produced on one shift and was processed at Summit's preparation plant. Anthracite is hard coal, with a high percentage of fixed carbon and a low percentage of volatile matter. Because of its hardness and the configuration of the typical coal seam, anthracite coal is mined by drilling and blasting. Virtually none of the mechanized equipment used in the mining of bituminous coal can be used in anthracite mining, and it is highly labor intensive.

Anthracite coal is mined through pairs of entries driven into the coal seam horizontally off a haulage slope. The lower entry is called the "gangway" heading or entry. It has tracked haulage cars to transport coal to the haulage slope and serves as the main air intake and primary escapeway. The upper entry, called the "monkey" heading, is driven 50-60 feet above and parallel to the gangway heading and serves as the return air course and secondary escapeway.

Openings, called "chutes," are developed upward from the gangway to the monkey heading at approximately 50-foot intervals. Coal mined at the monkey heading level is passed down the chutes to the gangway level, where it is loaded out on the railed haulage cars. Wooden "batteries" are constructed at the bottom of the chutes to control the coal and facilitate loading it into the haulage cars. Manways are constructed in the chutes, and provide a means of travel between the gangway and monkey headings. They are separated from the coal portion of the chute by boards, or lagging. As new chutes are developed, the old ones are closed off. The last inby open chute, i.e., the chute nearest to the gangway and monkey faces, serves as the main air course from the gangway (intake) to the monkey (return) level.

Openings similar to chutes, called "breasts," are driven upward from the monkey heading at roughly the same spacing as the chutes. Breasts are driven up 60 or more feet above the monkey heading. The bottoms of the breasts open into the monkey heading, where the coal is

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[1] The Secretary also withdrew the citation and order at issue in Docket No. PENN 99-297. That case was dismissed shortly after the conclusion of the hearing.

confined by timbers and lagging boards constructed in an "L" shape. Together with the side of the monkey heading they form a three-sided box. The open side of the "box" faces inby, i.e., toward the monkey face and is adjacent to the corresponding chute opening in the floor of the monkey heading. Coal from the breast is fed down the chute to the gangway level, where it is loaded out of the mine.

Underground coal mines are inspected by MSHA four times each year. The last regular inspection of the Tracey Vein Slope was completed on June 12, 1998. The mine had an excellent safety record. Only one violation of federal mandatory safety and health regulations had been cited in the two years preceding August 14, 1998.

The Incident

On July 16, 1998, there was a major accident at the mine. An explosion, or similar event, occurred on the monkey heading. One miner was killed and another was severely injured. The nature and exact location of the "explosion" remain in dispute. Mike Rothermel, Respondent's President, was at the mine and became aware of the incident when he received a call from underground indicating that something serious had happened. He immediately entered the mine and found one miner, Gary Laudenslager, with an apparently mortal head wound, lying on the floor of the monkey heading, partially into the No. 45 chute. Sticks of explosive and detonators were scattered for about 150 feet over the floor of the monkey heading. Those in close proximity to the deceased miner were picked up and put into explosive shipping boxes, or parts of boxes that were in the vicinity. The deceased miner was removed from the mine. The injured miner was able to ambulate, with assistance, and was helped out of the mine. Immediately following the accident Rothermel observed a great deal of methane gas present in the mine. He proceeded to the monkey face and found "everything gone," i.e., the ventilation fan and tubing were no longer present and a heavy "drag boat" used to drag coal from the face to the nearest open chute was deposited some 30 feet down that chute. He located a compressed air hose and dragged it to the monkey face, tied it off on a support timber and turned it on. He then proceeded to the surface, where he encountered Jack McGann, an MSHA inspector who had arrived to participate in an inspection of the accident.

Several MSHA inspectors and other federal and state officials were on the scene that day and commenced an investigation. Temporary ventilation controls were reestablished, where necessary, and by the following Monday, July 19, 1998, the methane concentrations had been reduced to safe levels. MSHA's lead investigator was Vincent Jardina, who had served as an inspector for 22 years, including 13 years as an accident investigator. Prior to becoming an inspector, he worked as a miner for seven years and obtained certification as an assistant mine foreman. He has had considerable experience with bituminous coal mines, but very limited experience with anthracite mines.

Jardina had never inspected the Tracey Vein Slope, which was one of the factors that resulted in his being chosen as the lead investigator. It is MSHA policy to designate an accident investigator that has had no direct contact with the mine and does not know the operators or

miners. The investigative team included a total of 23 MSHA personnel, many with specialized areas of expertise, such as blasting. Five representatives of the Pennsylvania Department of Environmental Protection were also involved. Jardina was responsible for conducting the investigation and personally surveyed the mine, noting the locations of various objects and pieces of equipment, damage apparently resulting from the accident, and other conditions. He prepared a drawing of the mine, reflecting the results of his survey, Government exhibit 7, which is attached as an appendix to this decision. Other members of the investigative team interviewed and took statements from miners. Physical evidence was removed from the mine and tested in various laboratories. The on-site investigation was concluded on August 28, 1998. Testing results were not available until December 21, 1998.

MSHA was ultimately unable to determine the cause of the accident. The "conclusion" section of the report, Government exhibit 6, read:

> The direct cause of the accident was an unplanned detonation of explosives in or around the No. 46 breast of the 001-0 working section. Although testing was conducted on evidence gathered from the accident scene, the source of origin for the unplanned detonation could not be identified, due to the extent of damage from the blast. A significant factor increasing the severity of the accident was improper storage and handling of explosives and detonators. One of the following three factors were considered as a possible cause of the accident:
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> 1. Undetonated explosives in the north borehole remaining from a misfire, which could not be totally removed, may have been drilled into from the south borehole or heat generated by the drilling operation may have caused the explosives to burn in the hole which in turn caused an ignition of detonators and explosives in the No. 46 breast or on the floor of the monkey.
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> 2. Coal or rock may have fallen striking the detonators and/or explosives left in or around the No. 46 breast or on the floor of the monkey level.
>
> 3. An unintentional detonation of the wrong firing line possibly connected to an unconfined shot used to free hanging material may have detonated other explosives in or around the No. 46 breast.

MSHA's causation theories, and Respondent's objections thereto, are discussed in more detail, *infra*, in conjunction with the violations that initially were alleged to have been contributing factors to the fatal accident.

The citations are discussed below in the order that they were presented at the hearing.

Docket No. PENN 2000-10

Citation No. 7001585

Citation No. 7001585 was issued by Jardina on January 28, 1999, and alleged a violation of 30 C.F.R. § 75.1310(a), which requires that: "Only permissible explosives . . . and permissible blasting units shall be taken or used underground." The conditions noted on the citation were:

> During a fatal accident investigation conducted between July 16, 1998 and August 3, 1988, it was discovered that Prima Cord, a non-permissible explosive, was found and used underground at the 2nd Level East 001-0 active working section. On July 22, 1998, one (1) full and two (2) partial rolls of Prima Cord (detonating cord) were found buried beneath wooden liner boards located between the No. 34 and 35 chutes of the monkey (return) heading. On July 24, 1998, two (2) partial rolls were found buried beneath wooden posts and line boards between the No. 42 and No. 43 chutes of the monkey (return) heading. The mine operator admitted that Prima Cord, a non-permissible explosive, was used for blasting of long holes.

He concluded that it was highly likely that the violation would result in a permanently disabling injury, that the violation was significant and substantial, that seven persons were affected and that the violation was due to the operator's reckless disregard of the standard and the consequences of violating it. The citation was issued under section 104(d)(1) of the Act, based upon Jardina's conclusion that the violation was a result of the operator's unwarrantable failure to comply with the standard. A civil penalty of $3,000.00 is proposed.

The Violation

Permissible explosives are those that have been tested and approved by MSHA for use in underground coal and certain metal/non-metal mines. They are designed to minimize the risk that methane gas will be ignited. Prima Cord has not been tested or approved by MSHA for use in underground mines and is not a permissible explosive. Prima Cord was found at two locations in the mine. Rothermel knew that Prima Cord was not an approved permissible explosive and also knew that it was used in the mine. Tr. 93, 1730-31. He chose to use it for long hole blasting because he believed that it was the "lesser of two evils." While it burned at a high temperature, posing a risk of igniting any methane present in the blast area, it assured complete detonation. He felt that use of permissible blasting materials would result in incomplete detonation and/or a slow burning of explosive which posed a greater danger. Respondent did not apply to MSHA for an exception to allow the use of Prima Cord, because Rothermel believed that the only exceptions granted in the past involved situations where citations had been issued, i.e., that Summit would have to incur a safety citation and fine for the practice sought to be approved.

Respondent violated the regulation by using Prima Cord, a non-permissible explosive, in its underground coal mine.

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 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 1007 (Dec. 1987).

The violation was significant and substantial. Prima Cord poses a danger because of its very nature. While it is a high explosive, it looks like rope and those untrained in its use tend to underestimate how dangerous it is. An unplanned detonation of Prima Cord being mishandled by a miner would result in serious injury or death. Tr. 962-63. The Tracey Vein Slope was a

"gassy" mine. In excess of 30,000 cubic feet of methane was liberated on a typical mining day. The use of non-permissible explosives in that mine could ignite methane and seriously injure miners. There can be little question that despite Rothermel's belief that Prima Cord, as used in the Tracey Vein Slope, did not present as much of a hazard as alternative approved products, use of that non-permissible explosive in the mine posed a reasonable likelihood that an injury would occur and that the injury would be of a reasonably serious nature.

While I find that the violation was S&S, I also find that the danger was not as great as perceived by Jardina. The ignition of methane in an underground mine would obviously be an extremely serious event. However, it appears that Summit's primary use of Prima Cord was in longhole blasting, i.e., when the coal between breasts or chutes was being "slabbed" or "pillared." In order to mine the coal between breasts, holes are drilled from the monkey heading alongside the breast, approximately 50-60 feet in length. The holes are loaded with explosives and the entire side of the breast is blasted into the open breast. It is difficult to ventilate the breasts, especially since methane is lighter than air and tends to get trapped in the top of the breast. However, it is unclear exactly how miners would have been further imperiled by an ignition of methane in a breast, considering the large amounts of explosives used in the pillaring operation.

Unwarrantable Failure

In *Windsor Coal Co.*, 21 FMSHRC 997, 1000 (Sept. 1999), the Commission reiterated the law applicable to determining whether a violation was 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 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); *see also Buck Creek Coal, Inc. v. FMSHRC*, 52 F.3d 133, 136 (7th Cir. 1995) (approving Commission's unwarrantable failure test). The Commission has recognized that a number of factors are relevant in determining whether a violation is the result of an operator's unwarrantable failure, such as the extensiveness of the violative condition, the length of time that the violative condition has existed, the operator's efforts to eliminate the violative condition, and whether an operator has been placed on notice that greater efforts are necessary for compliance. *Mullins & Sons Coal Co.*, 16 FMSHRC 192, 195 (Feb. 1994); *Peabody Coal Co.*, 14 FMSHRC 1258, 1261 (Aug. 1992). The Commission also considers whether the violative condition is obvious, or poses a high degree of danger. *BethEnergy Mines, Inc*., 14 FMSHRC 1232, 1243-44 (Aug. 1992) (finding unwarrantable failure where unsaddled beams "presented a

danger" to miners entering area); *Warren Steen Constr., Inc*., 14 FMSHRC 1125, 1129 (July 1992) (finding violation aggravated and unwarrantable based on "common knowledge that power lines are hazardous, and . . . that precautions are required when working near power lines with heavy equipment"); *Quinland Coals, Inc.*, 10 FMSHRC 705, 709 (June 1988) (finding unwarrantable failure where roof conditions were "highly dangerous"); *Kitt Energy Corp*., 6 FMSHRC 1596, 1603 (July 1984) (conspicuous nature of the violative condition supports unwarrantable failure finding).

While Rothermel disputes whether the use of Prima Cord increased the danger to miners, there is no question that he deliberately chose to use it, knowing that it was not a permissible explosive. Consequently, I find that the violation was the result of an unwarrantable failure by Respondent.

Citation No. 7001587

Citation No. 7001587 was issued by Jardina on January 28, 1999, and alleged a violation of 30 C.F.R. § 75.370(a)(1), which requires that operators "develop and follow a ventilation plan approved by the district manager." The conditions noted on the citation were:

> The mine ventilation plan approved on March 26, 1997 and revised on January 27, 1998, was not being followed at the 2nd Level East 001-0 active working section. An accident investigation conducted on July 17, 1998, indicates that approved face ventilation controls were not being used at the advancing No. 50 chute face developed off the gangway, the monkey (return) heading face area, the No. 46 breast area and the No. 44 breast area. There was no evidence of face ventilation controls at these areas by use of line brattice, ventilation tubing, or compressed air movers. Pages C(3), G(7), H(8) and I(9) of the Approved Ventilation Plan specif[y] these requirements. Statements, interviews and evidence in the mine indicated that compressed air lines were being used to ventilate the working faces.

He concluded that it was reasonably likely that the violation would result in a permanently disabling injury, that the violation was significant and substantial, that seven persons were affected and that the violation was due to the operator's high negligence. The citation was issued under
section 104(a) of the Act. A civil penalty of $2,000.00 is proposed.

The Violation

Summit's approved mine ventilation control plan required that ventilation devices, fans/air movers and 12-inch ventilation tubing or line brattice, be used to provide ventilation within 20 feet of working faces. Jardina based his conclusion that Respondent did not comply with that requirement on his observations, statements made to him by Rothermel and statements

made by other miners to other members of the investigative team. In his survey of the mine following the accident, Jardina did not see evidence of any ventilation tubing or line brattice at the monkey heading, the #50 chute, the #46 breast or the #44 breast. He went into the #44 breast for a short distance and looked around. There was some air flow up the #44 breast. He could not enter the #46 breast. He briefly looked up the #51 chute, but he could not look up the #50 chute because it was blocked by coal. Tr. 1444. It is clear, and Respondent does not contend otherwise, that neither ventilation tubing nor line brattice were used in the chutes or breasts.

However, the absence of ventilation controls in a chute or a breast does not, standing alone, establish a violation of the ventilation control plan, which requires that ventilation tubing or line brattice be within 20 feet of a working face. If there is no working face more than 20 feet beyond the heading, ventilation controls are not required by the plan. Tr. 153, 161. Kevin Wolfgang was a miner working on the gangway level on July 16, 1998. He had been employed only for about two months and had initially assisted in driving the gangway face. He began to drive chutes when another miner was moved up to the monkey heading. He was working in the #51 chute on the day of the accident, and stated that he frequently used a methane detector to check for methane and used a compressed air hose to keep methane levels within acceptable limits. The #51 chute had been advanced only about 15 feet, and no ventilation controls were required under the plan. There is a conflict in the evidence as to how far the #50 chute had been driven. Jardina did not measure or observe it because it was blocked with coal. He thought that Rothermel had told him that it was advanced about 45 feet. Rothermel asserts that the #50 chute was advanced only 15 feet beyond a corner where ventilation tubing was installed. Ex. G-43.

There were no ventilation devices at the monkey face when Jardina inspected it, save for a compressed air hose that Rothermel had dragged there following the accident. However, an air mover/fan and a piece of ventilation tubing were found in coal that was later loaded out of the #49 chute. Rothermel testified that there was proper ventilation at the monkey face prior to the accident, i.e., the air mover and tubing were in use at the monkey face and had been thrown down the #49 chute by the force of the blast. Tr. 1648-49; ex. G-43. Mott surmised that the air mover and tubing had been used at the monkey face. Tr. 1447-48. Jardina offered no explanation as to what the air mover and tubing had been used for and apparently made no assumption about their use. He based his conclusion that no ventilation controls were being used at the monkey heading on the absence of such controls at that location after the blast, and a report by another inspector that Pete Klinger, the miner injured in the blast, had said that he only used an air hose at the monkey face. Tr. 120-21. This, at least second-hand hearsay statement, related entirely out of context, is deserving of virtually no weight.[2] I find that when actively being worked, prior to the accident, the monkey face was ventilated by an air mover and

[2] Jardina frequently relied upon statements attributable to miners. The miners were interviewed by other members of the investigative team. Jardina acknowledged that virtually none of the statements were made to him and his knowledge of such statements was derived from other investigators' discussions of the statements. The statements were not offered into evidence and Jardina did not read them. Tr. 303-05.

ventilation tubing, in compliance with the plan.

According to Rothermel, ventilation tubing and line brattice were not used in the chutes or breasts because they would be destroyed each time coal was blasted from the advancing face. Consequently, miners were not assigned to work at the face of any chute that had been developed beyond 20 feet. To drive the chute the rest of the way up to the monkey heading, boreholes were drilled down from the monkey heading to the partially developed chute. Methane, which is lighter than air, was vented up through the holes to the monkey (return) heading. Explosives were pushed down to the last, or bottom, 4-6 feet of the holes and the coal was blasted in successive steps until the chute connected with the monkey heading. Tr. 1648-50, 1733-35. Under this approach, there never was a miner working at the face of any chute advanced beyond 20 feet.

Breast ventilation had to be handled differently because there was no heading immediately above the monkey heading. Instead, holes were drilled and/or headings were driven from the developing breast to the adjoining outby breast and air would then flow up through the developing breast over into the existing breast. In the area of the #44, #43 and #42 breasts, pillaring was being performed, i.e., the coal between breasts was being mined. The pillaring had proceeded slightly inby the #43 breast. The #44 breast had been connected to the #43 breast by a heading or holes, which provided air flow part way up the #44 breast. Tr. 1482. As explained by Mark Mott, MSHA's Assistant District Manager, ventilating the #44 breast by connecting it to the #43 breast was acceptable and in conformance with the plan. Only by driving the face of the #44 breast more than 20 feet above the connecting passage would ventilation tubing or line brattice be required to ventilate the working face. Tr. 1482-85. Neither Jardina, nor any other MSHA investigator, inspected or measured the #44 breast to determine whether there was a working face more than 20 feet beyond the connection. Jardina went only a few feet into the breast and checked the air flow. He did not further examine the breast and did not know if there were holes or a heading connecting it to the #43 breast. Tr. 216-17, 224. His determination that the ventilation plan was not being complied with at the #44 breast was based, in essence, solely on the fact that he did not observe ventilation tubing or line brattice in that area. Tr. 216-17.

Gary Laudenslager, the miner who was killed, had been working in the #46 breast two days prior to the accident. However, his last blast at the face had dislodged support timbers and rock that had blocked the breast opening. Because the breast had "crashed," noone was scheduled to work there, i.e., there was no working face in the #46 breast on July 16, 1998. Tr. 1658-59, 1664. No ventilation controls were required in the #46 breast.

In an enforcement proceeding under the Act, the Secretary has the burden of proving an alleged violation by a preponderance of the evidence. *In re: Contests of Respirable Dust Sample Alteration Citations*, 17 FMSHRC 1819, 1838 (Nov. 1995), *aff'd., Secretary 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 clear that there was no violation of the ventilation control plan at the monkey face or the #46 breast. Whether the #50 chute had been developed to 45-50 feet above the gangway heading, or less than 20 feet as Rothermel believed, there was no miner working at the face of that chute once it was advanced beyond 20 feet. The holes drilled through from the monkey heading to the chute face ventilated methane in the chute, and it does not appear that the chute development process followed by Summit violated the ventilation control plan, despite Rothermel's understanding that it wasn't consistent with it. There may have been a violation of the plan in the #44 breast. However, the absence of ventilation controls, Jardina's sole focus, does not establish a violation of the plan. The Secretary introduced no proof, and there is no other convincing evidence, that there was a working face in the #44 breast more than 20 feet beyond the heading or the connection with the #43 breast. The Secretary has failed to carry her burden of proof with respect to this alleged violation.

Order No. 7001591

Order No. 7001591 was issued by Jardina on January 28, 1999, and alleged a violation of 30 C.F.R. § 75.1322(d), which requires that: "Each borehole 4 or more feet deep shall be stemmed for at least 24 inches." The conditions noted on the order were:

> During a fatal accident investigation conducted between July 16, 1998 and August 3, 1988, it was determined that stemming was not being used during the process of loading bore holes which were 4 feet or more in depth at the gangway face, No. 50 chute face and the monkey (return) face of the 2nd Level East 001-0 active working section on July 16, 1998 and prior dates. Also, stemming materials were not found in the 001-0 section during this investigation.

He concluded that it was highly likely that the violation would result in a permanently disabling injury, that the violation was significant and substantial, that four persons were affected and that the violation was due to the operator's reckless disregard of the standard and the consequences of violating it. The order was issued pursuant to section 104(d)(1) of the Act, based upon the determination that the violation was the result of the operator's unwarrantable failure to comply with the standard. A civil penalty of $2,800.00 is proposed.

The Violation

Stemming is in inert substance, e.g., clay, that is tamped into a borehole after the explosives have been inserted. It serves to confine the blast, reducing the possibility of fly rock being "rifled" out of the borehole. It also displaces any methane that might have been in the borehole and confines the explosion flame, reducing the possibility that methane outside the borehole will be ignited. Stemming materials can be purchased, e.g., tubing that can be filled with clay, sand, water or some other inert substance, or inert materials can simply be tamped into the borehole. Neither Jardina, nor Thomas Lobb, an MSHA blasting expert, observed any evidence of stemming materials being used in the mine. Jason Dodson, a miner who performed blasting, testified that he did not use stemming for boreholes that were typically drilled six feet

deep. While there was some question about the number of boreholes that exceeded four feet in depth, it should be noted that 30 CFR § 75.1322(d) requires that boreholes less than four feet deep be stemmed for at least half of their depth.

Respondent offered little defense to the violation. It stated, in response to discovery requests, that explosive and detonator containers were formed into tubing, filled with drillings and used as stemming. Ex. G-43. However, there is no other evidence that the containers were used in this fashion, or that any other method was used to stem boreholes. I find that Respondent violated the subject regulation.

Significant and Substantial

MSHA's blasting expert, Lobb, testified that the potential for injury as a result of failure to properly stem boreholes is primarily that miners may be struck by fly rock that is "rifled" out of the open end of the borehole or that small amounts of methane in the borehole may be ignited.

Tr. 968-69. Jardina, however, based his assessment of the likelihood and severity of injury on the possibility that large accumulations of methane, outside of the borehole, would be ignited. Tr 281-82.

I find that the violation was not significant and substantial. Miners would normally position themselves out of the direct line of sight from any blast. The possibility of increased fly rock would not appear to pose any significant risk of injury. Jardina apparently did not perceive an increased risk of injury from fly rock because he did not base his assessment of the probability of injury on that mechanism. Nor did he base it on the possibility that a small amount of methane might reach explosive concentrations in the borehole itself, which might have marginally increased the force of the explosion. While there was a large amount of methane liberated in the mine, there is no evidence that a methane explosion would be likely to occur as a result of blasting. It is undisputed that Respondent could detonate unconfined explosives for certain purposes, e.g., starting a battery for a chute or creating a pocket for installation of a timber. Tr. 289, 970. Jardina could not explain his determination that the failure to use stemming created such a high potential for serious injury when unconfined blasting, which would arguably pose a greater risk, is permissible under the regulations. Tr. 295. Moreover, the regulations require testing for methane concentrations in a blast area immediately before shots are fired and that no shot be fired when concentrations are 1% or higher. 30 CFR § 75.1324. While, as noted *infra*, some of the miners performing blasting did not possess the proper certification to test for methane, they were competent to perform the relatively simple methane concentration test and were performing such tests.[3] The Secretary argues that Jardina's

[3] Methane detectors are about the size of a package of cigarettes and provide an "LED" readout of methane concentration when a button is pushed. All of the underground miners had methane detectors. Tr. 1737-38. The miners that testified stated that methane detectors were used. Tr. 759, 763, 776-79.

conclusion that Respondent was not complying with its ventilation plan provides further justification of his assessment of the possibility of a methane explosion. However, as noted above, the Secretary failed to prove that Respondent violated its ventilation plan.

Considering the evidence as a whole, and the fact that the firing of unconfined shots was permissible, for certain purposes, in Respondent's mine, I find that the Secretary has failed to carry her burden of proving that the violation was significant and substantial. I find that the violation was unlikely to result in an injury, but that any injury could be permanently disabling.

Unwarrantable Failure

Based upon the considerations discussed above, I find that the violation was not the result of the operator's unwarrantable failure. While Rothermel likely knew that stemming was not being used in the mine, his actions do not rise to the level of a reckless disregard of a serious safety risk or a serious lack of reasonable care. In light of the permissibility of firing unconfined shots, Rothermel did not perceive any significant threat posed by the non-use of stemming, a practice that had likely been followed, as the Secretary argues, for some time prior to July 16, 1998. Respondent had not previously been cited for such a violation in prior MSHA inspections. Under the circumstances, I find that the operator's negligence was no more than moderate.

Order No. 7001592

Order No. 7001592 was issued by Jardina on January 28, 1999, and alleged a violation of 30 C.F.R. § 75.360(b)(3), which requires that a qualified person conduct a preshift examination of working areas and sections where miners are scheduled to work, to assure, *inter alia,* the presence of required ventilation controls and proper air movement. The conditions noted on the order were:

> The preshift examination conducted by Michael Rothermel, President, on July 16, 1998 of the 2nd Level East 001-0 active working section was not adequate. The No. 44 and No. 46 breast work areas were not examined and approved ventilation controls were not being used in the No. 44 breast, No. 46 breast, No. 50 chute face and monkey face.

He concluded that it was reasonably likely that the violation would result in a permanently disabling injury, that the violation was significant and substantial, that seven persons were affected and that the violation was due to the operator's reckless disregard of the standard and the consequences of violating it. The citation was issued under section 104(d)(1) of the Act, based upon Jardina's conclusion that the violation was a result of the operator's unwarrantable failure to comply with the standard. A civil penalty of $2,500.00 is proposed.

The Violation

Preshift examinations were conducted by Rothermel every morning before the shift began. The order was issued because it was determined that the examination on July 16, 1998, was inadequate for several reasons: neither the #44 breast nor the #46 breast was examined and the examination in the #50 chute and the monkey face failed to note the hazardous condition of the absence of required ventilation controls at those locations.

As noted above, the Secretary failed to prove that required ventilation controls were not being used at the #50 chute and the monkey face. The failure to note hazardous conditions at those locations does not evidence a violation of the regulation, because no such hazardous conditions existed. Rothermel readily admitted that he did not conduct a preshift examination of the #46 breast or the #44 breast. Tr. 310-11, 1733-35. The # 46 breast had "crashed." The last blasting done at the face had dislodged support timbers in the breast, likely those near the blast at the top of the breast, and the breast opening was clogged with coal, rock and timbers. Because of the hazardous condition in the #46 breast, Rothermel had not scheduled anyone to work there on July 16, 1998. Tr. 1658-59, 1664. Jardina appears to have expanded Rothermel's admission that there was a hazardous condition in the #46 breast, to include part of the monkey heading in the "area" or "vicinity" of the #46 breast, and concluded that when Rothermel assigned a man to work near the #46 breast drilling test holes, he failed to assure that the miner was not exposed to a known hazardous condition. Tr. 319, 332-34. However, there is no evidence that the hazardous condition that Rothermel knew of in the #46 breast posed any danger to miners either working or traveling on the monkey level.[4] Rothermel had inspected the monkey, or return, heading and noted no hazardous conditions. I find that there was no hazardous condition on the monkey heading where Laudenslager had been assigned to work and that the failure to note such a condition on the preshift report does not evidence a violation of the regulation.

Rothermel admitted that he had not conducted a preshift examination of the #44 breast, either on July 16, 1998, or for several days prior thereto. Tr. 1735. A miner, Randy Maurer, was assigned to work in the #44 breast. This, ostensibly, would be a violation of the regulation. However, Maurer was a certified mine foreman, who was, himself, qualified to conduct a preshift examination of working places. Rothermel had been told by an MSHA official, whom he described as "Bob Elam, MSHA official in charge of policy in Arlington," that allowing a certified person to conduct the examination prior to commencing work in the area was

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[4] There was evidence that roof supports were installed near the #46 breast following the accident. However, it appears that some supports that had been dislodged during the accident were simply replaced. Tr. 341, 344-45. Jardina did not know the condition of the roof supports prior to the accident and failed to explain why he interpreted Rothermel's acknowledgment of a hazardous condition in the #46 breast as an admission that there was a hazardous condition on the monkey heading in the area of the #46 breast. Jardina, Rothermel and other investigators were working in the same "vicinity" of the #46 breast after the roof supports had been replaced and noone, including Jardina, perceived any dangerous condition. Tr. 346.

permissible as a supplemental or auxiliary examination under 30 C.F.R. § 75.361. Tr. 1733-37. Rothermel disclosed this information in discovery and in his prehearing report.[5] The Secretary made no effort to rebut Rothermel's claim of what he had been told. Rather, Jardina testified that that interpretation of the regulations was erroneous, and that such supplemental examinations were permissible only where an operator had no intention of working in a particular area when the preshift examination was conducted, and it was later determined that work needed to be performed there. Tr. 313.

I credit Rothermel's testimony regarding what he was told by an MSHA official and find that in reliance upon that information, he believed that allowing Maurer to inspect his work area before commencing work was in compliance with the regulation. Although Respondent, represented by Rothermel, a lay person, has not asserted a formal due process defense, I hold that the Secretary cannot enforce the regulation under the circumstances presented here.

In *Island Creek Coal Co.*, 20 FMSHRC 14, 24 (Jan 1998), the Commission explained that due process may prevent enforcement of an agency's interpretation of a regulation, stating:

> Where an agency imposes a fine based on its interpretation, a separate inquiry may arise concerning whether the respondent has received "fair notice" of the interpretation it was fined for violating. *Energy West Mining Co.*, 17 FMSHRC 1313, 1317-18 (August 1995). "[D]ue process . . . prevents . . . deference from validating the application of a regulation that fails to give fair warning of the conduct it prohibits or requires." *Gates & Fox Co. v. OSHRC*, 790 F.2d 154, 156 (D.C.Cir. 1986).

Assuming, *arguendo*, that the interpretation offered through Jardina represents the Secretary's authoritative position on the meaning of the regulation and that it is entitled to deference, it represents a significant change to the interpretation previously given to Respondent, invalidating the practice that had been established in reliance on MSHA's advice. I find that Respondent cannot be held liable for violating the regulation as alleged in the subject order.

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[5] Ex.G- 43, R-6.

Docket No. PENN 2000-9

Citation No. 7001401

Citation No. 7001401 was issued by Jardina on August 14, 1998, and alleged a violation of 30 C.F.R. § 50.10 which requires that: "If an accident occurs, an operator shall immediately contact the MSHA District or Subdistrict Office having jurisdiction over its mine." The conditions noted on the citation were:

> The mine operator failed to immediately contact the Mine Safety and Health Administration, District or Headquarters Office, of a reportable fatal accident which occurred on July 16, 1998 at approximately 10:30 hours. However, the Mine Safety and Health Administration was alerted about the accident from an outside source at 11:00 hours and was never contacted by the operator.

He concluded that there was no likelihood that the violation would result in an injury, that the violation was not significant and substantial, that two persons were affected and that the violation was due to the operator's high negligence. The citation was subsequently modified to reflect that the operator's negligence was moderate, because the "mine operator assumed that when his wife called 911 all appropriate parties were contacted." The citation was also modified to specify that the time of the accident was 9:15 rather than 10:30. No reason was given for that modification. A civil penalty of $55.00 is proposed.

Jardina originally concluded, as stated on the citation, that the accident occurred "at approximately 10:30 hours." He did not know why the citation was subsequently amended to reflect a time of 9:15. Tr. 394. The earlier time is also reflected in the accident investigation report, Government exhibit 6, though the source of the information is not specified. Presumably, it was a statement by one of the miners. Rothermel testified that the accident occurred sometime after 10:20 a.m., based upon records of calls made from the office phone. Tr. 1643; ex. R-9. When he finished the 10:20 a.m. call, he had a discussion with a state mine inspector. *Id*. After the mine inspector had left, he got a "panic call" from the mine indicating that help was needed. He did not know what had happened, or how bad things were. Tr. 1644. He immediately went underground to investigate. He assisted in attending to the injured miners and their removal from the scene, picked up some explosives in the immediate vicinity of the victims that had been scattered during the incident and dragged an air hose to the monkey face to provide some ventilation because the air mover and tubing were no longer present and there was an excessive amount of methane. He returned to the surface shortly after 11:00 a.m., and encountered MSHA inspector Jack McGann, who was already on the scene. Tr. 1703-04. At no time did Respondent telephone the MSHA office to report the accident. Tr. 389, 1644. Jardina concurred that MSHA personnel arrived shortly after 11:00 a.m. and that, thereafter, no call to MSHA was required. Tr. 390.

30 C.F.R. § 50.10 requires that MSHA be notified "immediately" when a reportable accident occurs. Jardina interpreted "immediately" to mean within 20 minutes, depending upon

the circumstances. Tr. 390. He felt that, while Rothermel was properly engaged in assisting at the accident scene, there were other Summit personnel, including Rothermel's wife, who were present in the office and should have notified MSHA. Tr. 396-98.

The Commission interpreted the regulatory accident reporting obligation in *Consolidation Coal Co.*, 11 FMSHRC 1935, 1938 (Oct. 1989), where it stated:

> Although the regulation requires operators to report immediately certain "accidents" as defined in section 50.2(h), it must contemplate that operators first determine whether particular events constitute reportable "accidents" within that definition. Section 50.10 therefore necessarily accords operators a reasonable opportunity for investigation into an event prior to reporting to MSHA. Such internal investigation, however, must be carried out by operators in good faith without delay, and in light of the regulation's command of prompt, vigorous action. The immediateness of an operator's notification under section 50.10 must be evaluated on a case-by-case basis, taking into account the nature of the accident and all relevant variables affecting reaction and reporting.

It could hardly be disputed that Rothermel took prompt, vigorous action to find out what had happened in the mine and render assistance as needed. He did not know what had happened when the "panic" call came in. Although he might have assumed that a reportable accident had occurred, he was entitled to investigate. I credit his testimony and find that the accident occurred at approximately 10:30 a.m. After proceeding underground and arriving at the location of the victims on the monkey heading, he knew that a reportable accident had occurred. However, there was no mine phone in that area. He soon proceeded out of the mine and encountered an MSHA inspector, shortly after 11:00 a.m.

The Secretary has failed to carry her burden with respect to the alleged violation. It is unclear exactly when Rothermel arrived at the scene of the accident and knew that it was reportable. While there may have been agents of Respondent on the surface, it is unknown when they became aware that a reportable accident had occurred. Apparently, a call was placed for emergency assistance, but there is no evidence as to when that call was made. Nor is there evidence of when, within this relatively short time frame, MSHA became aware of the accident or the length of time it took its inspector to travel to the scene. It is likely that Rothermel encountered the MSHA inspector within approximately 20 minutes of his arrival at the scene of the accident. I find that the regulation was not violated.

The "Contributing Factor" Violations

The remaining four violations in this docket were determined to be contributing factors to the fatal accident and, with one exception, the alleged gravity of the violations was premised, in part, on the fact that a fatality had occurred as a result of the violation. They were specially assessed on that basis and substantial civil penalties, ranging from $5,000 to $20,000 were proposed. In light of those allegations, Respondent took the position that one of the major issues

in the case would be to determine the actual cause of the accident. The Secretary, knowing that MSHA had been unable to determine the actual cause, or causes, of the accident, took the position that it was not necessary to litigate that issue. Tr. 23-24, 27.

When questioned as to how the Secretary could sustain the gravity allegations without establishing the cause, or causes, of the accident, the Secretary announced that the only violation alleged to have been an actual contributing factor to the fatality was Order No. 7001594, alleging that miners doing blasting did not possess the required qualifications. *Id*.; tr. 516-17. The Secretary also amended Order No. 7001595, alleging that boreholes were drilled less than 24 inches apart, to reduce the operator's negligence from "high" to "moderate," and to make it a citation issued pursuant to section 104(a) of the Act. Tr. 12. Despite these changes, the proposed civil penalties were not altered and, with one exception, the Secretary continues to urge that they be imposed.

As noted, *supra*, despite MSHA's very thorough investigation, the actual cause of the accident was not identified, and there are significant disputes between the parties regarding the conduct of the investigation and many of the conclusions reached. Under MSHA's preferred theory, as described by Lobb, the victim, Gary Laudenslager, was drilling the south borehole just inby the #46 breast. The drill encountered undetonated explosives that had been loaded into the north borehole, or existed from a previous misfire in the #46 breast, and a low-order explosion resulted, rifling fly rock down the open north borehole, striking the victim and generating a secondary explosion of one or more sticks of explosive that were located in that vicinity. Tr. 1007-18. According to Lobb, an explosion appeared to have occurred just inby the #46 breast, because that is where the most significant damage was and the forces appeared to go outward from that point.

Rothermel took issue with MSHA's theories, arguing that they are not consistent with the physical evidence, including the location of the victim, the absence of any "blast effect" on the victim, the presence of the drag bucket, fan and vent tubing in the #49 chute, and the location of the drill. MSHA's responses to Rothermel's objections fall considerably short of conclusive rebuttals.

The location of the victims following the accident was openly disputed. MSHA investigators could not explain how the victim could have been recovered near the #45 chute, a considerable distance outby where the explosion was thought to have occurred, if it occurred as he was drilling the south borehole. Tr. 629-30, 642, 1532. Rothermel was certain that Laudenslager was lying on the monkey heading floor, partially down the #45 chute, as indicated in Government exhibit 7. Tr. 1700. Jardina did not believe that Laudenslager was at that location immediately following the accident, and maintained that position as of the hearing. Tr. 174-75, 625. Mott also did not think that the victims' locations, as reflected on exhibit G-7, were the result of the explosion. Tr. 1531. Jardina obtained some luminol, a chemical substance that can indicate the presence of blood, and tested in the vicinity of #46 breast, where the injury was thought to have occurred. However, the results were inconclusive in that environment. Tr. 171-73. It was obviously with great reluctance that he indicated the position

of the victim as he did on the diagram of the accident scene, a location admittedly inconsistent with the accident theory that MSHA considered most likely. The autopsy report, exhibit G-44, noted that there was "no evidence of severe disruptive injury, severe thermal trauma, or blast effect" on the victim's body, which would also appear inconsistent with his having been in close proximity to an explosion in the relatively confined space of the monkey heading.

The drag bucket on the monkey heading was a heavy wooden sled-like device that was used to drag coal from the monkey face to the #49 chute. Following the accident, it was found about 30 feet down the #49 chute, along with a fan and ventilation tubing that had been supplying air to the monkey face. Rothermel felt that the location of these objects indicated that a powerful force must have originated near the monkey face, pushing the drag bucket outby and into the #49 chute, obviously negating the theory that the main force of the explosion occurred near the #46 breast, which would have pushed the drag bucket toward the face. MSHA's investigators had no credible explanation for the location of the drag bucket. Jardina formed no conclusion as to how the drag bucket got into the chute. He did not consider it significant and stated that it was of no concern to him. Tr. 181-82, 187. Lobb did not consider the drag bucket part of the physical evidence. Tr. 1083. Mott did not know how the drag bucket got into the chute, did not believe that it was by the force of the explosion and didn't factor it into the theories "one way or the other." Tr. 1534-35, 1575. In addition, Jardina never did identify a cause of the damage on the gangway level at the #48 chute, and did not consider it to have resulted from the accident. Tr. 89, 836.

Rothermel also noted that the drill supposedly being used by Laudenslager was found under some coal near the boreholes lying on top of neatly coiled air hose, indicating that it was not being used at the time of the accident. He pointed out similar inconsistencies with respect to the second theory, including that the #46 breast was blocked and nothing could have fallen out of it or from the lagging in that area. He also questioned the third possible cause, an unintentional detonation of the wrong firing line, because there was no tamped and wired unfired shot found after the accident. Tr. 1565-67.

MSHA's theories were certainly consistent with much of the physical evidence. However, there were also significant facts that tended to negate those theories. While there is general agreement that there was no methane explosion, MSHA candidly acknowledges that, despite the thorough investigation, it never came to a definitive conclusion as to what caused the accident. Tr. 1119-20. Rothermel recently postulated a theory that there may have been an "outburst," an explosive release of highly pressurized methane, at the monkey face. Tr. 1677-97, 1719-20,
ex. R-8. Lobb considered that unlikely. However, it would explain a number of the facts that appear inconsistent with MSHA's theories. Ultimately, no cause for the accident has been identified, and, as noted, *infra*, none of the alleged violations can be said to have caused, or to have been a contributing factor to, the fatal accident. Rothermel's outburst theory is intriguing, but it remains only a possible theory.

The "contributing factor" violations are addressed individually below.

Order No. 7001588

Order No. 7001588 was issued by Jardina on January 28, 1999, and alleged a violation of 30 C.F.R. § 75.1313(a), which requires that: "The quantity of explosives outside a magazine for use in a working section . . . shall . . . [n]ot exceed 100 pounds; or . . . the amount necessary to blast one round when more than 100 pounds of explosives is required." The conditions noted on the order were:

> The quantity of explosives outside a magazine for use in the 2nd Level East 001-0 working section or other area where blasting was to be performed on July 16, 1998, exceeded 100 pounds and exceeded the amount necessary to blast one round. This violation was determined to be a contributing factor to a fatal accident."

He concluded that a fatal accident occurred as a result of the violation, that the violation was significant and substantial, that one person was affected and that the violation was due to the operator's high negligence. The order was issued pursuant to section 104(d)(1) of the Act as being attributable to the operator's unwarrantable failure. While Jardina believed that this violation was a contributing factor to the fatal accident, he was unable to articulate a causal relationship. Tr. 416. As noted above, the Secretary announced during the hearing that she no longer took the position that this violation was a contributing factor. The position taken in the Secretary's post-hearing brief is that this violation should be found to have been highly likely to contribute to a fatal accident. A civil penalty of $5,000.00 was proposed by special assessment, prior to the Secretary's change of position.

The Violation

MSHA personnel recovered 357 sticks of explosives, weighing 385 pounds, from that working section of the mine following the accident. They also determined that no more than 57 sticks, or approximately 60 pounds, of explosives would be required to blast one round, if each of the working faces was blasted at the same time. Tr. 411-16. Under the regulatory scheme, explosives at mines are to be stored in wooden magazines and only limited amounts, essentially the amount expected to be used during a shift, are to be taken into the working section. Explosives that are not used during the shift are to be returned to the magazine. 30 C.F.R. § 75.1313(c);
tr. 408-09, 417. Respondent's only magazine was on the surface. It is apparent that the prevailing practice at Summit was that boxes of explosives would periodically be taken into the mine, and that considerably more than 100 pounds of explosives, generally more than would be needed for blasting during one shift, would be stored on shelves in the gangway and monkey headings. Unused explosives were not taken back to the surface and returned to the magazine at the end of the shift. Tr. 448-49, 775.

Respondent does not dispute these essential facts. In defense, it contends that 1,400-1,500 pounds of explosives had been used in one round when pillaring was being done, and that

under the regulation it could have had up to that amount outside a magazine in a working section without violating the regulation. Ex. R-6; tr. 1730. The regulation does not specify which "one round" is to be used to measure the maximum amount of explosives permitted in a working section, i.e., whether it is a round projected to be fired during the shift, or whether it could be any round ever fired in the mine. Jardina exhibited some uncertainty on this issue. Tr. 439-40, 448, 452-57. However, the "one round" referred to in subpart (a) must be a round that is expected to be fired on the current shift, because subpart (c) of the regulation requires that explosives not used during the shift must be returned to a magazine by the end of the shift. Any other reading of the regulation would be nonsensical.

It is undisputed that no pillaring was being done on July 16, 1998. Tr. 476, 1730. Consequently, less than 100 pounds of explosives would have been required to fire one round on that shift. Respondent had 385 pounds of explosives in the working section and violated the regulation.

Significant and Substantial

Jardina's primary reason for determining that the violation was significant and substantial was that it was deemed to have been a contributing factor to the fatal accident. Tr. 416. As noted above, however, the Secretary has abandoned that position. There is also little evidence to support such a contention and Jardina's own testimony contradicts his assertion. He testified that his determination that the handling and storage of explosives was a contributing factor to the fatality was based upon the explosives that were found near the #46 breast, and the possibility that there were other explosives "up in number 46 that weren't properly being stored." It had nothing to do with the explosives found in boxes on the gangway level. Tr. 528-30. The same would appear to be true for the explosives found stored in boxes on shelves in the monkey heading.

Under the regulation, Respondent was allowed to have up to 100 pounds of explosives in the working section. Of the 385 pounds of explosives recovered, the vast majority of it was found in boxes on shelves in the gangway and monkey headings. The remainder of the explosives does not appear to have exceeded 100 pounds. The violation was based upon the large quantity of explosives in boxes on shelves. Those explosives played no role in the accident, and this violation was not a contributing factor to the fatal accident.

The mere presence of these explosives does not establish that the violation was significant and substantial. The detonation of even one stick of explosive could easily cause substantial injury or death. However, the explosives themselves are not highly sensitive. They must be detonated with a blasting cap or detonator which must be fired in very close proximity to, virtually touching, the explosive. During the investigation, both explosives and detonators were found at several places in the mine, sometimes in close proximity. This clearly was a concern of Jardina's, because the closer the proximity of detonators to explosives, the greater the risk of an unplanned detonation. However, detonators and explosives were not kept in close proximity in the mine under normal conditions. With the exception of the debris around the #48

chute, there were no explosives within five feet of detonators on the gangway heading and Jardina agreed that the same situation likely existed on the monkey heading prior to the accident. Tr. 428-29. The relatively orderly location of explosives and detonators on the gangway level contrasted sharply with that on the monkey level, but it is clear that those explosives and detonators had been scattered by the accident. Kenneth Chamberlain, an MSHA inspector, had inspected the mine prior to the accident and found no explosives "lying around" and everything in "very good shape." Tr. 1410-11. Detonators and explosives were placed in close proximity as a result of the emergency situation presented by the accident. Rothermel picked up sticks of explosives and detonators that were lying in the vicinity of the victims and placed them into the nearest available container. Tr. 1701-02. Jardina found that action reasonable. Tr. 509-10.

Respondent has also asserted a more general due process defense. It contends that it had been conducting its mining operations in the same manner for many years prior to July 16, 1998, that MSHA inspectors had been through the mine numerous times and observed those conditions and that no citations had been issued. Ex. G-43, R-6. Even Lobb conceded that he would not be surprised if Summit had stored explosives and detonators in the same manner for six years. Tr. 1058. While these precise conditions probably did not exist during other inspections, as Respondent claims, it is highly likely that explosives and detonators were being temporarily stored in the working section in the approximate same amounts. Because there is no evidence as to the exact amount of explosives present during prior inspections, or whether pillaring was being done, or had been or would be done in close proximity to any such inspections, Respondent has not established a due process defense to the violation. However, the fact that several inspectors observed and did not issue citations for similar conditions, does suggest that the presence of explosives in the mine did not present a reasonable probability of an unplanned detonation. Considering all of the factors discussed above, I find that the violation was not significant and substantial. I find that a fatal injury was unlikely to occur as a result of the violation.

Unwarrantable Failure

Rothermel was fully aware of the amount of explosives that were taken into the working section. He also knew that the quantity generally exceeded that needed for blasting on the shift and that unused explosives were not being transported back to the surface magazine at the end of the shift. However, those practices had been ongoing for many years and numerous MSHA inspectors had not cited Respondent for violating the subject regulation. I find that the operator's negligence was not "high," and that the violation was not the result of an unwarrantable failure. Respondent's negligence was no more than moderate.

Order No. 7001589

Order No. 7001589 was issued by Jardina on January 28, 1999, and alleged a violation of 30 C.F.R. § 75.1313(b), which requires that:

> Explosives and detonators outside a magazine that are not being

> transported or prepared for loading boreholes shall be kept in closed separate containers made of nonconductive material with no metal or other conductive material exposed inside and the containers shall be -- (1) At least 15 feet from any source of electric current; (2) Out of the direct line of the forces from blasting; (3) In a location to prevent damage by mobile equipment; and (4) Kept as dry as practicable.

The conditions noted on the order were:

> On July 16, 1998, explosives and detonators, which were not being transported or prepared for loading boreholes, were not kept in closed separate containers made of nonconductive material. This violation was determined to be a contributing factor to a fatal accident.

He concluded that the fatal accident occurred as a result of the violation, that the violation was significant and substantial, that one person was affected and that the violation was due to the operator's high negligence. The order was issued pursuant to section 104(d)(1) of the Act as being attributable to the operator's unwarrantable failure. As noted above, the Secretary announced during the hearing that she no longer took the position that this violation was a contributing factor to the fatal accident. A civil penalty of $10,000.00 was proposed by special assessment, prior to the Secretary's change of position.

The Violation

This alleged violation is closely related to the preceding one and many of the same considerations apply. Again, the focus of this citation was the explosives and detonators that were in boxes on shelves. Tr. 479-90.[6] As noted above, these explosives played no part in the fatal accident and this alleged violation was not a contributing factor to it, nor does the Secretary so claim. Jardina's determination that the violation had been a contributing factor to the fatal accident was based upon conjecture that there may have been improperly stored explosives near, or up in, the #46 breast. Tr. 517-18, 528. It had nothing to do with the explosives found in boxes on the gangway level. Tr. 528. The conditions on the monkey level, following the accident, were somewhat chaotic. Explosives had been scattered over a large portion of the heading and Rothermel had picked up loose explosives and detonators in the vicinity of the victims and placed them into the nearest available box. Tr. 1701-02; ex. R-6. Jardina agreed

[6] Explosives that are being transported or prepared for loading into boreholes do not need to be in containers of any kind. A miner can take explosives that he is going to use, place them aside, e.g. three feet away on the mine floor where nothing is likely to fall on them, drill a borehole and load the explosives. Tr. 525-26. There was no evidence that the loose, or scattered, explosives found at various places in the mine following the accident, were not in the process of being transported or being prepared for loading into boreholes and, as noted above, the violation was not premised on those explosives.

that under those emergency conditions, such actions were reasonable, and that the conditions in at least one area on the monkey level may have been affected by the accident. Tr. 488, 509.

On the basis of the essentially undisputed evidence that explosives, that were not being transported or prepared for loading into boreholes, were temporarily stored on the gangway level in cardboard containers, some of which did not have lids, I find that the regulation was violated. Respondent's principal defense to this violation is that this type of temporary storage of explosives in their original shipping boxes had been observed, and, at least tacitly, sanctioned by numerous MSHA inspectors over the previous six years. Ex. G-43, R-6. However, there is no evidence that the precise conditions observed by Jardina, i.e., the missing lids, had been observed by other inspectors. Jardina and Lobb also felt that the cardboard containers were inappropriate, in that they were not substantial and tended to deteriorate and become conductive with moisture that was prevalent in the mine. Tr. 493, 981. I do not base my finding of a violation on those considerations. There is nothing in the regulation that requires the containers to be "substantial." Moreover, the original shipping containers were apparently viewed as suitable by other MSHA inspectors. They did not contain any conductive material and apparently had plastic liners.
Tr. 1127-28. While cardboard might become conductive if it becomes saturated with water, the cardboard pieces depicted in Government exhibit 18 and the description by Lobb that the cardboard didn't make noise when torn indicate that the cardboard was not "wet" and there is no evidence that it was conductive. Moreover, the regulation is likely directed at obviously conductive materials, such as metal. It seems likely that a box made of wood, the preferred material, might also become conductive as it absorbs moisture.

Significant and Substantial - Unwarrantable Failure

For the same reasons discussed with respect to the previous violation, I do not find this violation to have been significant and substantial or the result of Respondent's unwarrantable failure. I find the operator's negligence to have been low, and that an injury was unlikely to result from the violation.

Order No. 7001594

Order No. 7001594 was issued by Jardina on January 28, 1999, and alleged a violation of 30 C.F.R. § 75.1325(a), which requires that: "Shots shall be fired by a qualified person or a person working in the presence of and under the direction of a qualified person." The conditions noted on the order were:

> Blasting of explosives was being performed by persons who were not qualified in accordance with Section 75-1325-(a) and who were not working under the direct supervision of a person qualified by MSHA. This violation was determined to be contributing factor to a fatal accident.
>
> He concluded that the fatal accident occurred as a result of the violation, that the

violation was significant and substantial, that one person was affected and that the violation was due to the operator's reckless disregard of the standard and consequences of violating it. This order was issued pursuant to section 104(d)(1) of the Act because the violation was determined to be a result of the Respondent's unwarrantable failure. This is the sole violation that the Secretary now alleges was a contributing factor to the fatal accident. Tr. 555. A civil penalty of $20,000.00 is proposed.

The Violation

As defined in the regulations, a "qualified person," is one who has been certified to use permissible explosives by the State in which the mine is located, or who has demonstrated to an authorized representative of the Secretary the ability to use permissible explosives safely. 30 C.F.R. § 75-1301. The only miner working underground on July 16, 1998, who possessed the requisite qualification was Randy Maurer, who was working alone at the #44 breast. Tr. 548-53.

In general, new miners at Summit began working with experienced miners and rather quickly progressed to essentially independent mining activities, including blasting. With the exception of Maurer, all of the miners working in that section of the mine were performing blasting activities without the proper certification. Maurer was working alone in the #44 breast and was not in the presence of, or directing the activities of, the other miners. The regulation was violated.

Significant and Substantial

Allowing unqualified persons to independently perform blasting presents a reasonable possibility of a serious injury occurring. This is not a situation like the methane testing qualifications violation, where the miners were entirely capable of performing, and did perform, the required testing, but merely lacked a credential. The unqualified persons conducting blasting in Respondent's mine lacked training in the proper blasting methods, failed to use stemming, as required by the regulations, and failed to test blasting circuits with a galvanometer, as discussed, *infra*. Misuse of explosives in a mine poses a grave threat to all miners underground and any miners who would be involved in a rescue in the event of an unplanned explosion. As Lobb explained, untrained blasters tend to believe that explosives are considerably safer than they are and may fail to exercise appropriate care. Tr. 1004. He also opined that the various theoretical causes of the accident could have been avoided if the miners had been properly trained and qualified. Tr. 1003-05. While I do not fully accept that aspect of his testimony, I find that the violation was significant and substantial.

Unwarrantable Failure

Rothermel was fully aware that the miners doing blasting in that section of the mine, with the exception of Maurer, were not qualified within the meaning of the regulation. While there is evidence that he made efforts to provide training to new miners, it appears that most of the training on blasting procedures was provided by the more experienced miners, most of whom

were also not properly qualified. It is not surprising that deficiencies existed in their blasting techniques, including failure to test blasting circuits with galvanometers and failure to use stemming. Whether Rothermel was fully aware of these deficiencies or was ignorant of them, it was his responsibility to assure that the miners performing blasting were properly trained and qualified, and that proper blasting procedures were being followed. His failure to do so amounts to an unwarrantable failure to comply with the regulation.

I cannot find, however, that this violation was a contributing factor, or cause, of the fatal accident. It is possible that it was. But, the actual cause of the accident was never determined and, it is also possible that some unexpected event that had nothing to do with a deficient or unsafe blasting procedure caused the accident, e.g., a rock falling on explosives that were being transported or prepared for loading into boreholes. Consequently, while I find that the violation was significant and substantial, I do not accept the gravity assigned by the Secretary. I find that the violation was highly likely to result in a permanently disabling injury.

Order No. 7001595

Order No. 7001595 was issued by Jardina on January 28, 1999, and alleged a violation of 30 C.F.R. § 75.1315(b), which requires that: "Each borehole in coal for explosives shall be at least 24 inches from any other borehole and from any free face, unless prohibited by the thickness of the coal seam." The conditions noted on the order were:

> During a fatal accident investigation it was determined that two (2) boreholes, one of which contained explosives, were not drilled at least 24 inches apart. The two holes were drilled in the high side coal rib approximately 6 feet inby the No. 46 breast of the monkey (return) heading area of the 2nd Level East 001-0 working section on July 16, 1998. These boreholes were approximately 6 inches apart. This violation was determined to be a contributing factor to a fatal accident.

Despite the above notation, he concluded that it was reasonably likely that a fatal accident would occur as a result of the violation, that the violation was significant and substantial, that one person was affected and that the violation was due to the operator's high negligence. The Order was modified on January 10, 2002, to change the operator's negligence to "moderate" and to reflect that it was a citation issued pursuant to section 104(a) of the Act. There was no change made to the proposed penalty of $10,000.00, although the Secretary suggests, in her brief, that a penalty "slightly less" than that proposed may be appropriate in light of the amendments.

The Violation

There is no dispute that two boreholes were drilled, approximately six inches apart, 38-40 feet up into the high rib, or roof, of the monkey heading about six feet inby the #46 breast. The north hole was approximately 38 feet deep and the south hole was 40 feet deep. The question is whether or not these boreholes were intended to be loaded with explosives. Tr. 662.

If they were test holes, as contended by Respondent, there would be no violation. I find that there was no intention that the holes be loaded with explosives and that the regulation was not violated.

Rothermel consistently stated that the holes were not intended to be used for explosives. They were drilled to try and ascertain the location of a fault. The fault had been encountered in a different set of headings 300 feet higher in the coal seam, and Rothermel expected to encounter it in the neighborhood of the #40 chute, but hadn't done so. Randy Maurer, the miner who normally drilled long holes for pillaring, had encountered problems near the #43 and #44 breasts. Gary Laudenslager had been driving the #46 breast, but encountered rock on the last shot fired that had taken out the timber supports, precluding further work in the breast. Rothermel assigned him to drill test holes inby the #46 breast to locate the fault and try and project where it would intersect the monkey heading. Tr. 662, 1659-66, 1678; ex. G-43, R-6.

Jardina concluded that the holes were intended to be used for explosives based upon a number of considerations. Traces of undetonated ammonium nitrate explosives were found in scrapings from the holes and in material blown out of the south hole by the induction of compressed air into the north hole. A piece of detonator wire, shaped like it had been attached to a stick of explosive, had been removed from the opening of the north hole. Tr. 662-66. Drill steels and a bit were recovered from the south hole. The wire and the drill bit also bore traces of undetonated ammonium nitrate explosive. Jardina felt that test holes would be drilled at least 5-10 feet apart because drilling them that close together would provide little useful information. Tr. 663-64.

Lobb also believed that the holes were not test holes and that blasting operations were being performed. Tr. 929, 941. He relied upon essentially the same factors as Jardina. Faults, like that ostensibly being explored by Laudenslager, change elevation gradually, such that he expected that test holes would be drilled 50-100 feet inby the #46 breast in the monkey heading, not within six feet of the breast and definitely not within six inches of one another. Tr. 946-48. It was his opinion that the location of the holes was more indicative that a miner was engaged in slabbing the pillar, in part, because drilling two parallel holes was consistent with Respondent's slabbing practice. Tr. 948-50. He placed considerable significance on the piece of detonator wire and the lab tests that showed the presence of ammonium nitrate based explosives in the samples, with the highest concentrations on the drill bit, the detonator wire and the scrapings from the north hole.

Respondent raised several issues that cast some doubt on the theory that the boreholes were intended for explosives, including the possibility that the samples were contaminated in a number of ways. The holes were not drilled directly into solid coal. Rather, the drill had been inserted through openings in the lagging boards on the top of the monkey heading. Immediately above the lagging is rock fill, and/or fractured coal, ranging from a few inches to several feet thick. Such material is placed there to fill the space between the lagging and the coal left undisturbed when the face is blasted. Additional material is thrown into that space when the face of the monkey heading is next blasted. Tr. 702-04. Respondent argues that the scrapings and

material purportedly obtained from the "holes" were actually recovered from the openings in the lagging and could have included materials from the fill. Respondent also argues that the detonator wire could have been in the fill material and points out that it was recovered from the collar of the hole, the space immediately above the lagging. Tr. 675, 928. Another source of contamination suggested by Respondent was the surface of the plastic compressed air pipe that was used to probe the holes.[7]

Lobb conceded that there was a possibility of contamination, and that the presence of the detonator wire could be attributed to other factors. However, he felt that it was highly unlikely that there was any significant contamination and noted that the results of the testing were consistent with the conclusion that there was ammonium nitrate based explosive in the north hole that underwent a low-order detonation when the south hole was drilled into it. Higher concentrations of undetonated explosive were found on the drill bit and the scrapings from the north hole. Relatively low concentrations were found in the scrapings from the south hole, which would have been largely blocked by the drill steels at the time of the detonation.

The Secretary's theory necessarily requires that a number of unlikely events occurred. First, Gary Laudenslager, the decedent, would have had to have decided, on his own, that rather than drill test holes to locate the fault, he would attempt to blast more coal into the "crashed" #46 breast. He was not the miner who performed such tasks, and it would apparently have been inconsistent with Summit's mining sequence to pillar the #46 breast when the long hole pillaring work being done by Randy Maurer had proceeded inby only to the #44 breast. Laudenslager would also have had to drill the north hole first, load it with explosives, and then drill the south

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[7] There were two types of permissible explosives used in, and recovered from, the mine -- Atlas 7D and Coalite 8S. Respondent made much of Lobb's testimony that the explosive found in the scrapings and on the drill and wire was Atlas 7D, a pliable substance considerably less suitable for use in long holes than the more rigid Coalite 8S. However, after careful review of Lobb's testimony and the forensic report appended to the "Executive Abstract Summary of the Laboratory Technical Investigation on the Summit Anthracite, Tracey Mine Explosives Accident," Government exhibit 32, I have concluded that Lobb was mistaken in that aspect of his testimony. Lobb stated that the test results showed the presence of undetonated ammonium nitrate based explosives, which he identified as the 7D and *not* 8S, which he stated was a nitroglycerine based high explosive, contradicting the conclusion in the abstract summary of the technical report. Tr. 954-55, 1028-32. However, the report is internally consistent and was not erroneous. The report on testing of the explosives done by the National Institute for Occupational Safety and Health, pages 5 and 6, shows that the 7D and 8S explosives are *both* ammonium nitrate based explosives, with similar concentrations of that compound (66.77% and 68.06% for the two samples of 7D and 63.72% and 64.33% for the two samples of 8S). Ex. G-32. Consequently, the undetonated explosives found in the long holes could have been the more suitable Coalite 8S, and were not necessarily the Atlas 7D. Lobb was likely confusing the Coalite 8S explosive with the illegal Prima Cord, which is a more powerful explosive.

hole in very close proximity to it, a sequence that Lobb believed would have been highly unusual. Tr. 1098-99.

It is highly unlikely that this sequence of events occurred. I conclude that the Secretary has not carried her burden with respect to this alleged violation. The possibility of these events occurring is slightly more probable because of the fact that Laudenslager was not properly qualified as a blaster, and also lacked training. However, there was general agreement that Rothermel provided excellent instruction to his miners. Tr. 1162, 1167, 1204-06, 1361. Also of significance is the fact that, while this sequence of events was found to be more likely than other potential scenarios to have caused the accident, MSHA was ultimately unable to identify the cause. I am also troubled by the pristine condition of the detonator wire, which was described as very clean and intact. Tr. 723-24. There were sharp protrusions, especially in the north hole, evidenced by the fact that shavings were scraped off the plastic air line used to probe them. Tr. 924-25. It would seem that a detonator wire, also with a plastic coating, that was wrapped around a stick of explosive only slightly smaller than the diameter of the borehole and tamped up to the top of the 38 foot hole, and subjected to a low-order detonation, would have shown some signs of this relatively violent treatment. Tr. 723-24. Lobb did concede that there was no forensic evidence that established that a detonator had exploded in the boreholes. Tr. 1075. It is possible, if there was a detonation of explosives, that it was explosives from a previous misfire in the #46 breast, itself. Tr. 727-28, 1025-26, 1103-04. If so, there was never any explosive loaded into either of the two holes. I agree with Jardina and Lobb that the location of the holes was difficult to reconcile with the concept that they were intended to locate the fault. However, their proximity would also have been unusual if they were boreholes intended to be loaded with explosives, especially if the second hole was drilled after explosives had been placed into the north hole.

DOCKET NO. PENN 99-254

Citation No. 7001590

Citation No. 7001590 was issued by Jardina on January 28, 1999, and alleged a violation of 30 C.F.R. § 75.1323(j), which requires that: "Immediately prior to firing, all blasting circuits shall be tested for continuity and resistance using a blasting galvanometer or other instrument specifically designed for testing blasting circuits." The conditions noted on the citation were:

> During a fatal accident investigation conducted between July 16, 1998 and August 3, 1988, it was determined that immediately prior to firing the gangway working face and the monkey (return) face, blasting circuits were not tested for continuity and resistance using a blasting galvanometer or other instrument specifically designed for testing blasting circuits. This testing was not conducted on July 16, 1998 and prior dates. These areas are located at the 2nd Level East 001-0 active working section.

He concluded that it was highly likely that the violation would result in a permanently

disabling injury, that the violation was significant and substantial, that seven persons were affected and that the violation was due to the operator's high negligence. A civil penalty of $1,000.00 is proposed.

The Violation

A galvanometer is an instrument that will show both the continuity and resistence of a blasting circuit. Each of the electric detonators has two plastic coated wires extending from it out of the borehole. They have about three inches of bare wire at their ends. The detonators are connected together in series by twisting the bare ends of the wires together to form part of the blasting circuit. As many as 20 detonators may be fired in one round. Each of the detonators has a known electrical resistance, e.g., 1.5 ohms. Use of a galvanometer will inform a miner that the blasting circuit has continuity and, by indicating the overall resistence of the circuit, that the proper number of detonators are wired in series. That would confirm that none of the bare portions of the detonator wires have unintentionally touched, possibly short circuiting, or eliminating, some of the detonators from the blasting circuit, which could result in a misfire. Misfires of explosives are the second or third leading cause of blasting accidents. Tr. 879-82, 885-86, 991-96, 1001-02.

Galvanometers were generally not used at Respondent's mine, except when there was a misfire of explosives. Two miners testified to that effect and other miners had so stated in their statements to MSHA. Tr. 760, 778-79, 787, 883-84. Rothermel asserts that there were galvanometers in the gangway and monkey headings and that the miners used a blasting battery that checked the continuity of the circuit. Tr. 1738; ex. R-6, G-43. Whether galvanometers were present, as Rothermel claims, it is clear that they were not being used, as required by the regulation, and that the miners who were doing blasting had not been instructed to use them. Use of a firing battery that checked for continuity, but not for resistence of the circuit, would not comply with the regulation. The regulation was violated.

Significant and Substantial

Failure to use a galvanometer, or other such instrument, to check the continuity and resistence of blasting circuits significantly increased the risk of misfires, making it reasonably likely that a reasonably serious injury would occur. A misfire could result in the presence of undetonated explosives and blasting caps in coal being loaded out of the mine, creating a possibility of an unplanned detonation and a high risk of serious or fatal injury to miners. The violation was significant and substantial.

Despite his efforts to provide training to his anthracite miners, Rothermel should have been aware of their failure to properly use galvanometers and the surprising ignorance of some of the newer miners regarding what a galvanometer was or what it was used for. I concur with the assessment that the violation was attributable to the operator's high negligence.

Citation No. 7001453

Citation No. 7001453 was issued by MSHA Inspector Kenneth Chamberlain on March 17, 1999, and alleged a violation of 30 C.F.R. § 75.370(a)(2), which requires that operators submit proposed revisions to a mine's ventilation plan to MSHA's district manager in writing. The conditions noted on the citation were:

> The operator did not comply with the current approved Ventilation Plan in that the middle fan located between the 002-0 and 001-0 sections has been discontinued and is not operating. A proposed revision to the plan was not submitted to MSHA for review and approval prior to implementation.

He concluded that it was unlikely that an injury would result from the violation, that the violation was not significant and substantial, that four persons were affected and that the violation was due to the operator's moderate negligence. A civil penalty of $55.00 is proposed.

On a regular inspection, conducted in March of 1999, Chamberlain observed that the middle mine fan, operation of which is envisioned in Respondent's approved ventilation plan, had been shut off and the power disconnected. He ascertained that no revision to the plan, embodying that change, had been submitted to or approved by MSHA. Tr. 1406-08. The air samples he took in the mine revealed no methane or bad air, and he agreed that the shutting down of the fan had no effect on the major mine air ventilation currents. Tr. 1409-11. The fan at issue was not a main mine fan and the mine was engaged in pillaring at the time. The fan was shut down because the entryway to the middle mine fan had collapsed and no additional ventilation of the mine would have been provided whether or not the fan was operating. Ex. R-6, G-43. Chamberlain did not travel the entryway to the fan and acknowledged that it could have been closed. Tr. 1410-11.

The regulation requires that proposed ventilation plans and any revisions thereto be submitted in writing to the district manager. 30 C.F.R. § 75.370(a)(2). A corresponding provision, § 75.370(d), provides that:

> Any intentional change to the ventilation system that alters the main air current or any split of the main air current in a manner that could materially affect the safety and health of miners, or any change to the information required in § 75.371 shall be submitted to and approved by the district manager before implementation.

The Secretary argues, citing *Harlan Cumberland Coal Co.*, 17 FMSHRC 1342 (Aug. 1995) (ALJ), that "the shutting down of an auxiliary fan is a major ventilation change requiring the prior approval of MSHA." Gov. Br. at p. 95. Here, she continues, Respondent "removed its middle fan from service . . . without seeking approval of MSHA before doing so, as a result, the Operator failed to comply with its ventilation plan." *Id*. It appears that the subject violation could more properly have been charged as a violation of § 75.370(d), i.e., the implementation of a "major ventilation change" prior to securing MSHA's approval. The issue is whether or not the regulation obligated Respondent to submit, in writing, a proposed change to its ventilation plan and secure MSHA's approval prior to shutting down the fan.

The essence of the regulation, as stated in section 75.370(d), is that intentional significant changes to a mine's ventilation system must be approved prior to implementation. Normally, the shutting down of a mine fan would be such a change. However, here, the entryway to the fan had collapsed and the shutting down of the fan had no effect on the mine's ventilation system, which remained highly effective. There is no suggestion that the collapse of the entryway was due to an intentional act by Respondent. The shutting down of the fan and disconnection of the power cables was an intentional act but, under the circumstances, had no effect on mine ventilation. I find that the Secretary has not carried her burden of proving that Respondent violated the regulation.

DOCKET NO. PENN 99-213

Citation No. 7001403

Citation No. 7001403 was issued by Jardina on August 14, 1998, and, as amended, alleged a violation of 30 C.F.R. § 75.312(h), which requires that: "Records, including records of [main] mine fan pressure . . . shall be retained at a surface location at the mine for at least 1 year and be made available for inspection by authorized representatives of the Secretary and the representative of miners." The conditions noted on the citation, as amended, were:

> During a fatal accident investigation, it was determined on July 17, 1998 that records of the mine's East and West main mine fans, pressure recording gauges, were not being retained. Only 16 weekly interval fan charts could be provided by the mine operator. The oldest dated fan chart was for the week of October 9-15, 1997.

He concluded that it was unlikely that the violation would result in an injury, that the violation was not significant and substantial, that nine persons were affected and that the violation was due to the operator's high negligence. The negligence assessment was later amended to moderate because the operator had reported vandalism in the past, which resulted in destruction of records. A civil penalty of $55.00 is proposed.

Under the regulation Respondent was obligated to maintain twelve months of weekly fan pressure reading records. On July 17, 1998, it was unable to produce records for the period October 16, 1997 through July 17, 1998. The asserted reason for the apparent violation was recurrent vandalism at the mine, some of which had been previously reported. Due to the repetitive nature of the vandalism, Respondent had stopped reporting it. Ex. G-43.

I accept Respondent's assertion that at least some of the fan pressure records were either taken or destroyed by vandals. However, there is no credible evidence that vandalism accounted for all of the missing records. Absent evidence that there was vandalism at the mine on or shortly prior to July 17, 1998, and that the records had been maintained, as required, only to be lost or destroyed by vandals, I find that the regulation was violated. I also concur with the assessment of low gravity and moderate operator negligence.

Citation No. 7001405

Citation No. 7001405 was issued by Charles Moore, supervisor of MSHA's Wilkes-Barre, District One office, and an education and training specialist, on August 14, 1998, and alleged a violation of 30 C.F.R. § 48.5(a), which requires that: "Each new miner shall receive no less than 40 hours of training as prescribed in this section before such miner is assigned to work duties." The conditions noted on the citation were:

> During a fatal accident investigation conducted between July 16, 1998 and August 3, 1998, it was determined that Adam Laudenslager, who was performing work in the gangway area of the 2nd level East 001-0 working section on July 16, 1998, had not received the required 40 hours of new miner training as specified in CFR, Title 30, Section 48.5 (a) - (c). Mr. Laudenslager was hired by this company on or about July 3, 1998 and only completed part of the required training. This miner is no longer employed at this mine.

He concluded that it was reasonably likely that the violation would result in a fatal injury, that the violation was significant and substantial, that one person was affected and that the violation was due to the operator's moderate negligence. A civil penalty of $113.00 is proposed.

The Violation

Moore issued the citation on the basis of information provided to him by an MSHA field office supervisor who had interviewed the subject miner, Adam Laudenslager. Moore did not speak to the miner himself, nor does it appear that he read any written statement by the miner. According to the field office supervisor, the miner had spent a day at the mine, had watched two instructional video tapes and had been shown how to use a methane detector. That was the extent of the training provided. Moore was also informed that the miner had no prior experience as an underground miner. Tr. 1158-60.

Adam Laudenslager is Rothermel's nephew and, while he apparently had not previously worked as an underground miner, he had considerable exposure to the anthracite mining industry. Ex. R-6, G-43. He had spent one full day at the mine and watched video tapes that had been assembled by Rothermel based upon their subject matter and relevance to anthracite mining. Rothermel has been instrumental in developing training materials for anthracite mining, which is somewhat of a blend of underground bituminous coal and metal/non-metal mining. Tr. 1750-51.

The regulation was violated. While there is some question about the length of the video tapes, the clear weight of the evidence is that Adam Laudenslager was not provided with 40 hours of new miner training and that not all of the required subject matters were addressed in the training that was provided.

Significant and Substantial

Moore concluded that the violation was significant and substantial because a new miner, somebody off the street, with no previous mining experience, finds himself in a "completely alien environment" and can be a danger to himself and other miners, especially in anthracite mining because of the use of explosives and labor intensive nature of the work. Tr. 1164-66. He did not feel that the fact that a person was raised in a mining community was a proper substitute for the required training, because he has found that such individuals are sometimes exposed to erroneous or unsafe methods and it is important to correct the "misinformation" that a person may have.
Tr. 1172-74.

Putting a person with no prior mining exposure or experience to work as a miner without providing the required new miner training would be a prototypical example of a significant and substantial violation. However, Adam Laudenslager was not such a person and he had been provided with a significant amount of training – in the words of Rothermel, some of the "best training" available for anthracite miners. Ex. R-6, G-43. Moore, like other MSHA personnel, had a very high regard for Rothermel's capability and competency as a trainer. Tr. 1162, 1167. Rothermel helped to assemble training materials for his miners, because he felt that much of the material used in the typical new miner training had very little to do with anthracite mining. As he explained: "The majority of the training that made a difference between life and death to those guys was given at the mine." Tr. 1750-51. Adam Laudenslager did receive a full day of training at the mine and had watched training videos that had been carefully selected as being highly pertinent to anthracite mining.

Moore was handicapped in his assessment of whether the violation was significant and substantial because he was dependent upon hearsay for information regarding what training experiences had been provided. His assessment appears to be based more on the hypothetical putting to work of a completely inexperienced miner without any training. He had virtually no knowledge as to what training areas had been covered during the day Laudenslager spent at the mine, what subjects were covered in the videos, or how they were covered. It is the Secretary's burden to prove that this particular violation was significant and substantial, not that it could have been in a hypothetical sense. I credit Rothermel's assertion that some of the best training available was given to Laudenslager. While there were, no doubt, essential areas of new miner training that were not covered, e.g., statutory rights of miners, without some qualitative evidence of the shortcomings of the training that was provided, I find that the Secretary has failed to carry her burden of proving that the violation was significant and substantial. I find that the violation was reasonably likely to result in a lost time accident. I agree that the violation was the result of the operator's moderate negligence.

Citation No. 7001406

Citation No. 7001406 was issued by Moore on August 14, 1998, and alleged a violation of 30 C.F.R. § 75.1324(b), which requires that: "Immediately before shots are fired, the methane concentration in a working place or any other area where blasting is to be performed, shall be determined by a person qualified to test for methane." The conditions noted on the

citation were:

> During a fatal accident investigation conducted between July 16, 1998 and August 3, 1998, it was determined that 4 miners conducted tests for methane and oxygen deficiency immediately before blasting. These miners were not qualified to make these tests as required by CFR 30, Part 75.151. Their daily work practices included the above tests and the charging and detonation of explosives.

He concluded that it was reasonably likely that the violation would result in an injury requiring lost work days or restricted duty, that the violation was significant and substantial, that seven persons were affected and that the violation was due to the operator's moderate negligence. The citation was later amended to reflect that the violation was unlikely to result in an injury and that it was not significant and substantial. A civil penalty of $55.00 is proposed.

As defined in 30 C.F.R. § 75.151, a person qualified to test for methane is a person who "demonstrates to the satisfaction of an authorized representative of the Secretary that he is qualified to test for methane with a portable methane detector." Respondent does not dispute that the subject miners did not have the requisite qualification. Tr. 1199-1200. On the other hand, MSHA does not dispute that the miners had been trained to use a methane detector or that they competently tested for methane prior to blasting. Tr. 1190, 1205-06. It was the lack of the paper certification that resulted in the violation.

I find that the regulation was violated and that the gravity, as amended, and operator negligence were properly assessed.

Citation No. 7000327

Citation No. 7000327 was issued by MSHA Inspector Ronald Pinchorski on August 20, 1998, and alleged a violation of 30 C.F.R. § 75.904, which requires that: "Circuit breakers shall be marked for identification." The conditions noted on the citation were:

> The circuit breakers and disconnecting devices installed and operational in the 2nd level west gangway (001-0) did not have any type of identification to describe their function. This electrical equipment was used for the control of the pumps which were rated at 440 volts.

He concluded that it was unlikely that the violation would result in an injury requiring lost work days or restricted duty, that the violation was not significant and substantial, that one person was affected and that the violation was due to the operator's moderate negligence. A civil penalty of $55.00 is proposed.

Pinchorski was performing a regular AAA inspection of the mine at the time the citation was written. However, he had been told of the condition by other inspectors who had been involved in the accident investigation. The inspection was performed over a period of many

weeks and Pinchorski observed the conditions recorded on the citation sometime around August 4 or 5. Tr. 1366. He also observed the switch boxes on August 20, the day the citation was issued and, on the basis of that observation, terminated the citation. Tr. 1366, 1368.

Respondent's exhibits 4 and 5 are pictures depicting two switch boxes at the subject location. Each bore a tag from the motor being controlled that identified specific characteristics of the motor, e.g., its horsepower. Also depicted are pink plastic stickers stating, respectively, "MAIN" and "50 HP PUMP." The pictures were taken on August 20, and the presence of the stickers was sufficient to justify termination of the citation. Tr. 1367-68. Rothermel testified that the pink stickers had been placed on the boxes over two years prior to the inspection. Tr. 1610. Pinchorski was fairly certain that the pink stickers were not on the switch boxes he observed on August 4 or 5, because he did not believe that he would have issued the citation if they had been present. Tr. 1370, 1375, 1379. The tags from the motors were present at that time, but they were not sufficient to satisfy the regulation because they did not identify the device, i.e., which pump or a fan, the switch controlled. Tr. 1357-60.

I credit the testimony of Pinchorski and find that he observed switch boxes on August 4 or 5, 1998, that had no pink stickers identifying the particular device that the switch controlled. It is not clear exactly how many switch boxes were observed by Pinchorski that day. Consequently, it is not clear that the two boxes depicted in Respondent's exhibits 4 and 5 were the only boxes that were the subject of the citation. The precise basis of Rothermel's testimony is also less than clear. I have no doubt that there were pink stickers identifying electrical devices on many switch boxes in the mine and that they had been affixed well prior to the inspection. However, I find that there were some switch boxes without proper identification. The stickers shown in Respondent's exhibit may have been supplied by someone other than Rothermel after Pinchorski first observed the switches and questioned compliance with the regulation. I credit Pinchorski's testimony because I found him to be a credible witness and it is highly unlikely that he issued a citation for the same conditions that he found satisfied the regulation some two weeks later, when it was terminated.

Pinchorski assessed the gravity of the violation as unlikely to result in an injury and the operator's negligence as moderate. He believed that Rothermel trained his miners well and that they knew which devices were controlled by the switches. I agree with his determinations on gravity and negligence.

Citation No. 7001027

Citation No. 7001027 was issued by MSHA inspector Harold Glandon on August 20, 1998, and alleged a violation of 30 C.F.R. § 75.370(d), which requires that: "Any intentional change to the ventilation system that alters the main air current or any split in the main air current in a manner that could materially affect the safety and health of miners . . . shall be submitted to and approved by the district manager before implementation." The conditions noted on the citation were:

> The mine operator intentionally implemented a change to the mine ventilation system for the 002-0 working section. This change materially altered the main air currents prior to the submission for approval by the District Manager. The changes made by the operator included the construction of an overcast, rerouting of the intake and return air currents, including the alternate escapeway, development of the intake haulage slope to a deeper level and the initiation of the 4th level gangway development. Completion of the final pillar recovery in the 4th level east gangway workings also occurred.

He concluded that it was reasonably likely that the violation would result in an injury requiring lost work days or restricted duty, that the violation was significant and substantial, that two persons were affected and that the violation was due to the operator's moderate negligence. The citation was later amended to reflect that the violation was unlikely to result in an injury and that it was not significant and substantial. A civil penalty of $55.00 is proposed.

Respondent had ceased mining on the east side of the slope and began to develop a gangway heading on the west side. In order to properly ventilate the new development, both intake and return air were routed through the same area and it was necessary to construct a channel so that the air currents could cross without mixing. The channel, called an "overcast," was constructed so that the return air could cross over the intake air and exit the west fan. Tr. 1253. Respondent did not submit a proposed change to its ventilation plan before constructing the overcast. Tr. 1256. Respondent's defense to the alleged violation is that initiating a new gangway heading was normal mine development and rerouting of air to the new work area was not a change that needed to be reflected in the mine ventilation plan. Ex. R-6. During cross-examination, Rothermel attempted to compare the change to that which occurs when a new chute is opened as gangway and monkey headings are developed. The intake air induced into the gangway heading is routed up the new chute to the monkey heading, a change that is part of normal mine development that does not need to be reflected in an amendment to the mine's ventilation plan.

The change that occurred here was not simple routine mine development, where air is routed through different headings and chutes of specified size. Rather it required construction of a special channel to allow return air to course over intake air. Nothing in the ventilation plan addressed the construction of overcasts. If the overcast was not properly constructed, ventilation to the new working places could be restricted, materially affecting the health and safety of miners. Tr. 1262. I find that the construction of the overcast was an action that was required to be approved as an amendment to the mine's ventilation plan before it was implemented, and that Respondent violated the regulation.

Glandon inspected the overcast and found it to be well-constructed and of adequate size to assure proper ventilation. The design of the overcast, as constructed, was approved as an amendment to the ventilation plan. For those reasons, it was concluded that the probability of injury was unlikely and that the violation was not significant and substantial. I agree with those conclusions. I also agree that the violation was the result of the operator's moderate negligence.

Rothermel was an experienced operator who understood the regulation and had previously submitted amendments to the ventilation plan. He should have realized that an amendment was required for construction of the overcast.

Citation No. 7001029

Citation No. 7001029 was issued by Inspector Glandon on August 20, 1998, and alleged a violation of 30 C.F.R. § 75.220(a)(1), which requires that operators "develop and follow a roof control plan, approved by the District Manager, that is suitable to the prevailing geological conditions, and the mining system to be used at the mine." The conditions noted on the citation were:

> Manways with steps spaced at no greater than 30 inches were not provided in the open chutes of Nos. 47, 48 and 49 in the 2nd level east gangway, 001-0 working section. The approved roof control plan dated 5/13/94 states that when the pitch of the coal vein exceeds 20 degrees, manways will be provided in open chutes and breasts and steps in the manway will not be spaced greater than 30 inches. The last travelable manway was at the No. 32 chute, a distance of approximately 860 feet from the gangway face. The pitch of the vein in the vicinity of chutes 47, 48 and 49 ranged from 70-80 degrees.

He concluded that it was unlikely that the violation would result in an injury, that the violation was not significant and substantial, that three persons were affected and that the violation was due to the operator's moderate negligence. A civil penalty of $55.00 is proposed.

As stated in the citation, Respondent's approved roof control plan required that manways, with steps spaced not greater than 30 inches, be provided in open chutes where the pitch of the coal vein exceeded 20 degrees. The pitch of the coal vein in Respondent's mine was 70-80 degrees and chutes numbered 47, 48 and 49 were open. Manways, with the required step spacing were, therefore, required in those chutes. Glandon looked up each of the chutes from the gangway level to the monkey level and did not see any ladders or steps. Tr. 1300-02.

Respondent contends that there were manways in the chutes, with plank steps on less than 30 inch centers. Respondent's exhibit 3a-d purports to show the steps in the #48 chute. They appear to be at least partially covered with coal, or were so covered shortly before the pictures were taken. Although not directly stated, Respondent also appears to contend that similar steps were present in the #47 and #49 chutes. Ex. G-43, R-6. Respondent also contends that the violation was written because MSHA interprets the standard to require a ladder, rather than steps on less than 30 inch centers, and that Glandon wrote the citation because there were no ladders. Tr. 1294-95, 1300. However, there was some confusion during cross-examination over the use of the term "ladder," which may well have been interpreted by Glandon to include plank steps.

I find that there were plank steps on less than 30 inch centers in the #48 chute. They may

have been obscured by coal when Glandon looked up the chute. I also find that there were steps in the #49 chute. However, there was no evidence introduced by Respondent to establish that the required steps were also in the #47 chute. On the basis of Glandon's testimony, I find that there were no such steps in the #47 chute, and that the regulation was violated. Allowing plank steps in a manway to be covered with coal, making them virtually unusable, would also be a violation of the standard. I agree that the violation was unlikely to result in an injury and that it was due to the operator's moderate negligence.

Citation No. 7001448

Citation No. 7001448 was issued by MSHA Inspector Kenneth Chamberlain on December 10, 1998, and alleged a violation of 30 C.F.R. § 75.381(c)(3), which requires that each escapeway be maintained in a safe condition, specifically, that they be "[p]rovided with ladders, stairways, ramps or similar facilities where [they] cross over obstructions." The conditions noted on the citation were:

> The alternate escapeway from the 002-0 section was not maintained in a safe condition in that ladders were not provided from the 4th level monkey heading to the 3rd level gangway.

He concluded that it was unlikely that the violation would result in an injury, that the violation was not significant and substantial, that three persons were affected and that the violation was due to the operator's moderate negligence. A civil penalty of $55.00 is proposed.

There was no ladder provided in the alternate escapeway from the 3rd level gangway to the 4th level monkey heading. However, there were plank steps, on less-than 30 inch centers, in that chute. Tr. 1396-98. The prevailing practice in anthracite mines is, apparently, to provide ladders in chutes and other portions of escapeways in steeply pitched mines. Tr. 1395-96. MSHA also appears to interpret the standard as requiring a ladder, because Chamberlain was looking only for a ladder to determine whether the standard was complied with. Tr. 1397-98. While I reject Respondent's argument that the 70-80 degree pitch of the coal vein through which the chute was driven is not an obstruction requiring a ladder, stairway, ramp or similar facility, I find that the Secretary has failed to carry her burden of proving the alleged violation, and has failed to justify MSHA's restrictive application of the standard so as to recognize only ladders as a means of compliance.

The standard provides that portions of escapeways that traverse obstructions, including steep slopes, be provided with ladders, stairways, ramps or similar facilities. The manway portion of the escapeway chute had the typical, and required, steps on less-than-30 inch centers. That is the means by which miners routinely travel the manways between different levels of the mine. MSHA has advanced no explanation or justification for its position that such steps do not satisfy the requirement that ladders, *stairways, ramps or similar facilities* be provided. Although Chamberlain testified that, in his opinion, such steps did not satisfy the standard, he did not explain the rationale of his position and it is not apparent from other portions of his testimony.

Tr. 1398-99.

Citation No. 7001586

Citation No. 7001586 was issued by Jardina on January 28, 1999, and alleged a violation of 30 C.F.R. § 75.325(e)(1), which requires that: "At least 1,500 cubic feet [of air] per minute [reach] each working face where coal is being mined." The conditions noted on the citation were:

> A quantity of at least 1,500 cubic feet a minute of air was not providing ventilation to the gangway face of the 2nd Level East 001-0 active working section. On
> July 16, 1998, it was determined by an authorized representative of the Secretary that a quantity of only 754 cubic feet per minute of air was being maintained at the inby end of the 12 inch diameter flexible tubing. It was further determined that the flexible tubing was damaged prior to the accident. An approved calibrated anemometer was used to determine the air velocity. Coal was in the process of being loaded.

He concluded that it was reasonably likely that the violation would result in a permanently disabling injury, that the violation was significant and substantial, that four persons were affected and that the violation was due to the operator's moderate negligence. A civil penalty of $131.00 is proposed for this violation.

The Violation

Although Jardina issued the citation, he did not take the measurements referred to. Rather, he relied upon discussions with Jack McGann, another inspector, and notes that he took. Tr. 844-45. The citation was written based upon the post-accident measurement of 754 cubic feet per minute made by McGann. Jardina did not know where that measurement was taken in relation to the gangway face or the end of the ventilation tubing. Tr. 844. He acknowledged that the ventilation tubing may have been damaged during the accident. Tr. 837. He concluded, however, that it was likely that less than 1,500 cubic feet per minute of air was being supplied to the gangway face because some repairs had been made to the damaged ventilation tubing and Rothermel admitted that there was some damage to the tubing prior to the accident. Tr. 821-23, 848-49.

Rothermel was closely involved in the rescue and recovery operation. After the victims had been administered to, a comment was made about damage to the ventilation tubing in the gangway heading. He went to investigate, accompanied by McGann, and found considerable damage at the #48 chute. The chute battery had been blown down by the explosion, and there was a pile of coal and several sticks of explosives on the gangway floor. The ventilation tubing had been disconnected and there were many holes in the tubing, some of them big enough to put a hand through. Tr. 1704-07. Rothermel, who had done the preshift examination that morning,

and assured that there was at least 1,500 cubic feet per minute of air at the gangway face, knew that the holes and damage to the ventilation tubing near the #48 chute had occurred during the explosion. Tr. 1707. He knew that there was excessive methane in the mine and that it was critical to reestablish damaged ventilation controls. However, he was concerned about altering the accident scene, which would violate MSHA regulations.[8] With McGann's at least tacit permission, he "sewed" the larger holes with 10d nails and replaced a piece of ventilation tubing at the gangway face, extending it to the last set of timbers and cutting off the end at that point. Tr. 1711. Closing the holes by overlapping the edges and piercing them with nails reduced the diameter of the tubing and severely restricted the air flow. Ex. G-43, R-6. He explained that the end of the ventilation tubing closest to the face is usually damaged by blasting, but that the required air flow was always maintained within 20 feet of the face. *Id.*; tr. 1710.

Neither Jardina, nor McGann, had measured the air flow at the gangway face prior to the accident. Jardina's "opinion" that it had been less than 1,500 cubic feet per minute is based upon McGann's later measurement, a determination that the accident had caused virtually no damage to the ventilation tubing, the fact that repairs had been made, and Rothermel's admission that there was some damage to the tubing prior to the accident. There are two significant problems with Jardina's analysis. His determination that the accident caused virtually no damage to the tubing is unsupported by the evidence, and his belief that the prior damage included holes near the #48 chute was erroneous.

Jardina's conclusion that the damage to the tubing near the #48 chute was not caused by the accident,[9] was based largely upon his conclusion that coal striking a chute battery, like the battery at chute #45 depicted in Government exhibit 28, would not bounce and strike the ventilation tubing that was attached to the rib near the roof supports. However, he acknowledged that, depending upon the severity of the accident's impact at the #48 chute, damage to the ventilation tubing was possible.[10] The accident produced a violent impact at the

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[8] 30 C.F.R. § 50.12 makes it unlawful for an operator to "alter an accident site or an accident related area until completion of all investigations . . . except to the extent necessary to rescue or recover an individual, prevent or eliminate an imminent danger, or prevent destruction of mining equipment."

[9] Mott was also of the opinion that it was unlikely that the ventilation tubing near the #48 chute was damaged by the accident. Tr. 1431-33. His opinion, like Jardina's, was based upon his assessment that coal coming down a chute and striking a battery, like the battery at #45 chute depicted in Government exhibit 28, would not bounce up and hit the tubing attached to the left side of the heading near the roof supports. As noted above, I find his and Jardina's conclusions essentially speculative and that they fail to take into account the violent thrust of coal and debris down the chute that damaged the chute battery.

[10] Jardina was somewhat defensive on this point, refusing to acknowledge that the coal and explosives found at that location had come down the chute as a result of the accident. Tr. 836. He also did not consider that the damage at the #48 chute resulted from the accident. Tr. 89.

#48 chute battery on the gangway level, sufficient to damage it and deposit a pile of coal and several sticks of explosive. Ex. G-7. I accept Rothermel's testimony regarding the condition of the tubing during the preshift examination and that the damage in the area of the #48 chute, including the large holes in the ventilation tubing, was a result of the accident.

Jardina was also somewhat uncertain in his recollection of what McGann had told him about Rothermel's statement that some damage to the tubing was present prior to the accident. Tr. 823. He indicated at one point that his recollection of McGann's reports of Rothermel's statements regarding pre-existing damage to the tubing included "various locations down to and including 48 chute." Tr. 855-57. However, he had previously related that McGann had been referring to statements made by Rothermel about damage to the tubing at the gangway face. Tr. 822-23. There was no damage inby the #48 chute or in the vicinity of the #45 chute. Tr. 824, 836. I find that Rothermel's statements regarding pre-existing damage to the ventilation tubing were far less incriminating. He was referring to the end of the tubing closest to the face that would typically be damaged when the face was blasted. The regulation and ventilation plan require that ventilation be supplied within 20 feet of the face. Tr. 834-35. Damage to tubing within 20 feet of the face is irrelevant to compliance because the measurement should be taken 20 feet from the face. Jardina did not know where the measurement had been taken, but seemed to recall that it may have been taken near the end to the ventilation tubing, and he did not know where that had been.

Jardina and the Secretary make much of the fact that, prior to the new piece of ventilation tubing being replaced at the gangway face and the holes being "sewed" up, the flow would have been less than the 754 cubic feet per minute measured by McGann. This point is relevant only if the repairs had been made to damage that existed prior to the accident. I have found, however, that the damage near the #48 chute, repair of which severely restricted the air flow, occurred as a result of the accident. I also find that, while the end of the tubing nearest the face was damaged prior to the accident, that whatever damage existed further than 20 feet from the face, was not sufficient to reduce the air flow below the required level. I find that the regulation was not violated.

Citation No. 7001593

Citation No. 7001593 was issued by Jardina on January 28, 1999, and alleged a violation of 30 C.F.R. § 75.1715, which requires that:

> Each operator of a coal mine shall establish a check-in and check-out system which will provide positive identification of every person underground, and will provide an accurate record of the persons in the mine kept on the surface . . . [and] shall bear a number identical to an identification check that is securely fastened to the lamp belt worn by the person underground. The identification check shall be made of rust resistant metal of not less than 16 gauge.

The conditions noted on the citation were:

> The check in - check out system established by the operator, which will provide positive identification of every person underground was not being followed. During a fatal accident investigation it was determined that a lamp belt worn by Gary Laudenslager (victim) did not have any identification (check) number securely fastened to the belt. This condition was observed on July 17, 1998, at approximately 0822 hours.

He concluded that it was unlikely that the violation would result in an injury, that the violation was not significant and substantial, that one person was affected and that the violation was due to the operator's moderate negligence. The citation was amended at the hearing to specify that the operator's negligence was low. A civil penalty of $55 was proposed for this violation, prior to the amendment.

Respondent contends, and asserted in discovery, that its check in - check out system consisted of the miner's name being placed on his mine light and on the charger located on the surface. Mine lights absent from the charger indicated who was underground. The mine light bearing the miner's name, was securely fastened to his belt before going underground. Ex. G-43. Respondent additionally contends that this system was followed for nine years prior to, and two years following, the accident and no citations were issued during any other inspection. Ex. R-6.

Jardina testified that Gary Laudenslager's mine belt was found in the mine, that no identification marking was on the belt itself, and there was no evidence of any marking having been permanently affixed to the belt. Tr. 872, 875. He did not look at any other miner's belt and had no recollection of whether or not Laudenslager's mine lamp was affixed to his belt or whether the lamp bore Laudenslager's name. Tr. 876-78. He testified that use of a name system on a mine light would not satisfy the regulation because a miner might borrow someone else's light and that, if the names were painted or stenciled on, they might wear off or become obscured.

I find that Respondent had, for many years, operated with a check in - check out system as described in its discovery response. Gary Laudenslager had worn his mine belt into the mine on July 16, 1998, with his mine lamp securely affixed to it and bearing his name. I find Jardina's testimony somewhat defensive on those points. He was careful to specify that there was no identification marking "on the belt." I interpret that testimony to mean only that there was no permanent identification marking separately affixed directly to the belt – not that no identification marking was on something else, like a mine lamp, that was affixed to the belt. His concerns about the borrowing of lights and shortcomings of painted or stenciled names appear valid. If those situations occurred, they might well be violations of the regulation. There is no indication in the evidence, however, that any miner had borrowed any other miner's lamp or that the marking on Laudenslager's mine lamp, which was affixed securely to his belt, was not legible and fully sufficient to identify him.

The Secretary has failed to carry her burden of proving that the regulation was violated. In addition, I credit Respondent's assertion that its identification system had been in use for many years and had never been found to be in violation of the regulation by a multitude of other MSHA inspectors. While it is conceivable that one or two inspectors might not have specifically examined the system, it is highly unlikely that all of them failed to notice or inspect the system for compliance with the regulation. Having had its system at least tacitly approved by many prior inspectors, Respondent was not provided fair notice that its system was deficient, and the regulation cannot be enforced in this situation, consistent with due process.

The Appropriate Civil Penalties

The parties stipulated that Summit Anthracite had only one, non-S&S, assessed violation in the two year period preceding August 14, 1998, that Summit Anthracite, and the Tracey Vein Slope, had produced 11,721 tons of coal in the year preceding that date, and that the operator demonstrated good faith in achieving compliance with the regulations. The violations, gravity and negligence assessments with respect to each alleged violation are discussed above.

Summit maintains that the imposition of civil penalties in the approximate amount of $57,000.00 proposed by the Secretary would threaten its ability to remain in business. It relies on financial statements and tax returns for three years, 1998-2001, that were submitted following the hearing. The Secretary, in response, submitted an analysis by a certified public accountant, Steven Dearien, who concluded that the documents are insufficient to establish that payment of

civil penalties in the proposed amounts would impair Summit's ability to continue in business. The Secretary points out that the financial statements submitted were unaudited and bore a disclaimer stating that they were based upon unverified information supplied by management. Dearien's conclusion was based upon a number of factors, including the fact that Summit's cash balance, inventory and sales for 2001 were the highest they had been in five years, and that no information was supplied regarding a related and interdependent company, S & R Coal Company, whose partners are the same as the stockholders of Summit Anthracite.

On the basis of the evidence and arguments advanced by the Secretary and considering that the civil penalties imposed below are significantly lower than the proposed amounts, I find that the operator has failed to demonstrate that the civil penalties imposed below would threaten its ability to remain in business.

Docket No. PENN 2000-10

Citation No. 7110585 was affirmed as a significant and substantial violation and the result of Respondent's unwarrantable failure. However, the danger posed by the violation was found to be not as great as determined by the inspector. A civil penalty of $3,000.00 was proposed by the Secretary. I impose a penalty in the amount of $2,500.00, upon consideration of the above and the factors enumerated in section 110(i) of the Act.

Order No. 7001591 was affirmed. However, the violation was found not to be significant and substantial or the result of the operator's unwarrantable failure. Rather, the violation was found to be unlikely to result in a serious injury and the operator's negligence was found to be moderate. A civil penalty of $2,800.00 was proposed by the Secretary. I impose a penalty in the amount of $1,000.00, upon consideration of the above and the factors enumerated in section 110(i) of the Act.

Docket No. PENN 2000-9

Order No. 7001588 was affirmed. However, the violation was found not to have been significant and substantial or the result of the operator's unwarrantable failure. The operator's negligence was moderate and the possibility of injury was unlikely. The proposed penalty for this violation was $5,000.00, which was based, in part, upon a determination that the violation was a contributing factor to the fatal accident, a position now abandoned by the Secretary. Considering the gravity and negligence factors, as found, and that a civil penalty of $90.00 would appear to be the result of application of the formula specified in 30 C.F.R. § 100.3, Respondent is directed to pay a civil penalty of $1,000.00 within 45 days.

Order No. 7001589 was affirmed. However, the violation was found not to have been significant and substantial or the result of the operator's unwarrantable failure. The operator's negligence was moderate and the possibility of injury unlikely. The proposed penalty for this violation was $10,000.00. However, that special assessment was based upon a determination that the violation was a contributing factor to the fatal accident, a position now abandoned by the

Secretary. Considering the gravity and negligence factors, as found, and that a civil penalty of $55.00 would likely have been imposed in a normal assessment, Respondent is directed to pay a civil penalty of $500.00 within 45 days.

Order No. 7001594 was affirmed as a significant and substantial violation that was the result of the operator's unwarrantable failure. The proposed penalty for this violation was $20,000.00. However, the gravity of the violation was not as high as alleged because it was not found to have been a contributing factor to the fatal accident. Considering the gravity, as found, and the other factors specified in section 110(i) of the Act, Respondent is directed to pay a civil penalty of $10,000.00 within 45 days.

Docket No. PENN 99-254

Citation No. 7001590 was affirmed in all respects. A civil penalty of $1,000.00 was proposed by the Secretary. Considering the factors specified in section 110(i) of the Act, Respondent is directed to pay a civil penalty of $1,000.00 within 45 days.

Docket No. PENN 99-213

Citations Nos. 7001403, 7001406, 7001327, 7001027 and 7001029 were affirmed in all respects. A civil penalty of $55.00 was proposed for each violation. Considering the factors specified in section 110(i) of the Act, a civil penalty of $55.00 is imposed for each violation and Respondent is directed to pay a civil penalty of $275.00 within 45 days.

Citation No. 7001405 was affirmed. However, the violation was found not to have been significant and substantial. A civil penalty of $113.00 was proposed by the Secretary. Considering, the above and the factors specified in section 110(i) of the Act, Respondent is directed to pay a civil penalty of $55.00 within 45 days.

ORDER

Docket No. PENN 2000-10

Citation No. 7001587 and Order No. 7001592, are hereby **VACATED**, and the petition as to them is hereby **DISMISSED**.

Citation No. 7110585 is **AFFIRMED** and Order No. 7001592 is **AFFIRMED** as modified, and Respondent is directed to pay a civil penalty of $3,500.00 within 45 days.

Docket No. PENN 2000-9

Citation Nos. 7001401 and 7001595, are hereby **VACATED**, and the petition as to them is hereby **DISMISSED**.

Orders numbered 7001588, 7001589 and 7001594 are **AFFIRMED** as modified, and Respondent is directed to pay a civil penalty of $11,500.00 within 45 days.

Docket No. PENN 99-254

Citation No. 7001453 is hereby **VACATED**, and the petition as to it is hereby **DISMISSED**.

Citation No. 7001590 is **AFFIRMED** and Respondent is directed to pay a civil penalty of $1,000.00 within 45 days.

Docket No. PENN 99-213

As to the citations vacated by the Secretary, Citation Nos. 7001403 and 7001028, the petition is **DISMISSED**.

Citation Nos. 7001448, 7001586 and 7001593 are hereby **VACATED** and the petition as to them is **DISMISSED**.

Citations Nos. 7001403, 7001406, 7001327, 7001027 and 7001029 are **AFFIRMED**, and Citation No. 7001405 is **AFFIRMED**, as modified, and Respondent is directed to pay a civil penalty of $330.00 within 45 days.

Michael E. Zielinski
Administrative Law Judge

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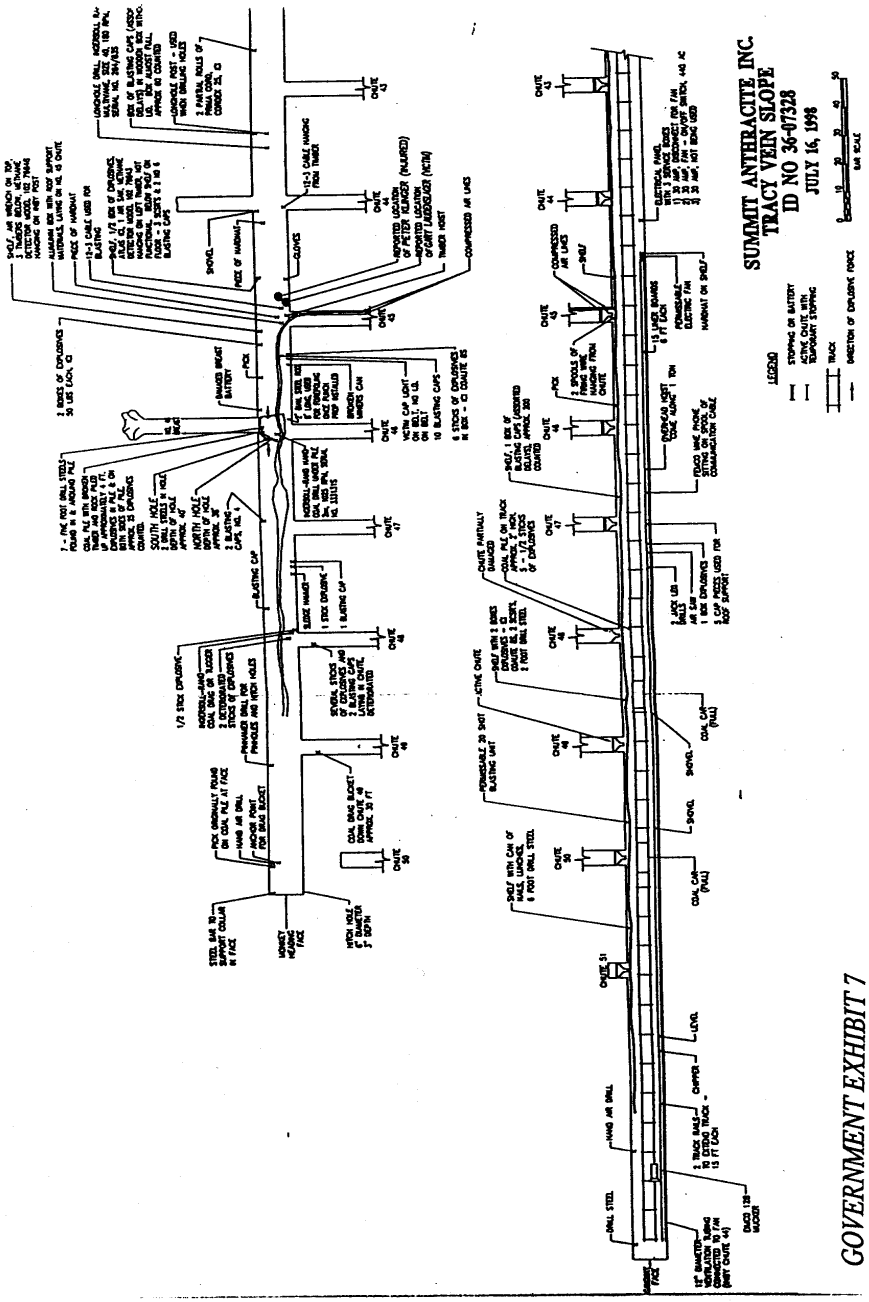

GOVERNMENT EXHIBIT 7