# FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION 1730 K STREET N.W., 6TH FLOOR

WASHINGTON, D.C. 20006

August 1, 1996

SECRETARY OF LABOR, MINE SAFETY AND HEALTH	:	CIVIL PENALTY PROCEEDING
ADMINISTRATION (MSHA),	:	Docket No. SE 96-9-M
Petitioner	:	A. C. No. 08-01058-05528
v.	:	White Rock Quarries
VECELLIO & GROGAN	:	
INCORPORATED,	:	
Respondent	:	

#### DECISION

Appearances: Karen E Mock, Esq., Office of the Solicitor, U. S. Department Of Labor, Atlanta, Georgia, for Petitioner; Roger L. Sabo, Esq., Schottenstein, Zox & Dunn, Columbus, Ohio for Respondent.

Before: Judge Merlin

Statement of the Case

This case is a petition for the assessment of a civil penalty filed by the Secretary of Labor against Vecellio & Grogan, Incorporated, under section 110 of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 820. A hearing was held on May 8, 1996, and the parties have submitted post hearing briefs.

Section 110(a) of the Act, 30 U.S.C. § 820(a), provides that a mine operator of a facility covered under the Act where a violation of a mandatory health or safety standard occurs, shall be assessed a civil penalty. It is well settled that the Secretary has the burden of proving a violation. <u>Keystone Coal Mining Corp.</u>, 17 FMSHRC 1819, 1838 (November 1995); <u>Southern Ohio Coal</u> <u>Co.</u>, 14 FMSHRC 1781, 1785 (November 1992); <u>Garden Creek Poca-</u> <u>hontas</u>, 11 FMSHRC 2148, 2152 (November 1989); <u>Consolidation Coal</u> <u>Co.</u>, 11 FMSHRC 966, 973 (June 1989); <u>Jim Walter Resources, Inc.</u>, 9 FMSHRC 903, 907 (May 1987). Where a violation is proved, section 110(i), 30 U.S.C. § 820(i), sets forth six factors to be considered in determining the appropriate amount of a civil penalty as follows: gravity, negligence, prior history of violations, size, ability to continue in business, and good faith abatement.

The alleged violation in this case is contained in a citation issued under section 104(d)(1) of the Act, 30 U.S.C. § 814(d)(1). This section provides that where there is a violation that is both significant and substantial and due to unwarrantable failure, a citation shall be issued containing such findings. If within 90 days the Secretary finds another violation due to unwarrantable failure, a failure, a withdrawal order must be issued.

The subject citation charges a violation of section 56.12071 of the Secretary's mandatory standards, 30 C.F.R. § 56.12071, which provides as follows:

When equipment must be moved or operated near energized high-voltage powerlines (other than trolley lines) and the clearance is less than 10 feet, the lines shall be deenergized or other precautionary measures shall be taken.

Citation No. 4088141, dated April 13, 1995, charges a violation for the following condition or practice:

A fatal accident occurred at this mine at about 12:05 P.M. on April 10th 1995, when a Manitex Boom Truck, Model No. 1461, boom came in contact with, 13,200, Volt Overhead Power Line. The victim was holding onto the boom cable preparing to hook up for a lift when the extended boom was swung into the power line resulting in an electrocution.

The foreman (victim) was aware of the vicinity of the power lines and was also directing the boom operator by hand signals, this is an unwarrantable failure.

The inspector who issued the citation found the violation was significant and substantial and due to high negligence.

At the hearing the parties agreed to the following stipulations (Tr. 5-6):

1. The operator is the owner and operator of the subject mine, and for purposes of this proceeding the operator is White Rock Quarries, a division of Vecellio & Grogan, Inc.;

2. The operator and the mine are subject to the jurisdiction of the Federal Mine Safety and Health Act of 1977;

3. I have jurisdiction of this case;

4. The inspector who issued the subject citation was a duly authorized representative of the Secretary of Labor;

5. A true and correct copy of the subject citation was properly served upon the operator;

6. Payment of a penalty will not affect the operator's ability to continue in business;

7. The operator demonstrated good faith abatement;

8. The operator has a low history of prior violations for an operator its size;

9. The operator is medium in size;

10. The power lines identified in the subject citation were a three phase wire, 13,200 volts, and not de-energized at the time in question.

## Statement of Facts

White Rock Quarries, where the fatality occurred, is a limestone quarry that has been in operation for approximately 10 years (Tr. 56). The limestone is in a lake and respondent hires a blasting company to do the shooting which is the first step in the extraction process (Tr. 56). When blasting is completed, respondent uses draglines sitting on the lake to remove the material and then leaves it on the bank to be carried to the bag plant (Tr. 56, 169). Caterpillar or Euclid 85 ton trucks haul the material from the lake to the aggregate or processing plant where the material is broken down into various sizes and fed onto different belts depending on the size desired (Tr. 57). The trucks go up a 400 foot ramp which rises about 65 or 70 feet (Tr. 29, 59). When they reach the top of the ramp, the trucks back into the primary crusher where the truck beds are raised and the loads deposited (Tr. 59-60). The ramp is located next to the parts storage yard (Tr. 27, 30-32, 180).

In early February 1995, Florida Power and Light, at the request of respondent, installed a three phase power line with a voltage of 13,200 volts (Tr. 21-22, 25-26, Stip. 10). The power was needed to assemble an electric shovel (Tr. 22). Florida Power decided where the line would go and respondent agreed to the location (Tr. 24-25). The line ran along the toe of the slope created by the ramp and along the edge of the parts storage area (Tr. 27, 36-38). The weight of the evidence indicates that the power line passed over an area immediately adjacent to that part of the storage area where mantels were kept (Tr. 28, 35, 39-40, 139). Mantels are liners used in the crushing process (Tr. 61).

Before the power lines were installed, the operator's employees were told about their installation (Tr. 26-27, 231). Several meetings were held to discuss the lines (Tr. 26-27, 181). The employees were told to be careful around the lines (Tr. 222, 230-231). As a general matter, safety meetings were held weekly and safety materials, including the Employment and Safety Policy Handbook, were given to new employees (Tr. 51, 65, 217, Exhs. R-A, R-B). The corporate safety director furnished foremen with a list of suggested topics for the meetings (Tr. 27). Also, each new employee was placed with an experienced employee for a minimum of 40 hours and if large equipment was involved, the period could be longer. An employee would be suspended for three days for his first safety violation and terminated for his second offense (Tr. 197-198). Foremen were given the same training as regular employees, but there was an increased emphasis on overall safety supervision (Tr. 67, 179). New foremen were put with experienced foremen for two weeks and, in addition, the operations manager to whom all foreman report, spent time with foreman trainees before they were turned loose (Tr. 174-175). Foremen were told to make sure that areas were kept clean and safe and that the employees worked safely in a safe environment (Tr. 179). There were quarterly safety meetings for foremen and they were given safety materials to hand out at their meetings with the employees under their supervision (Tr. 68).

The decedent, James Knapp, was the day shift foreman in charge of production at the operator's aggregate plant (Tr. 171). He had worked at the quarry for over seven years and had been a foreman for six years (Tr. 69). Prior to becoming a foreman, decedent had been the aggregate plant operator from the time the plant was opened (Tr. 176-177). When the plant was opening and later as foreman, decedent spent time with the operations manager, learning and going over how the aggregate plant should be run (Tr. 177-178). He was very familiar with everything that occurred at the plant (Tr. 177-178). Because of his skills, abilities, and attitude decedent was promoted to foreman (Tr. 177). As foreman, his immediate supervisor was the operations manager (Tr. 171). Decedent supervised 12 to 14 people and oversaw the running of the plant, including sizing the limestone (Tr. 69, 70, 172). There were seven foremen, all of whom were working foremen and had been cross trained (Tr. 45, 70). Decedent had been cross trained in all operational matters, but his

primary responsibilities were at the aggregate end (Tr. 177). As part of his supervisory duties, decedent conducted weekly safety meetings (Tr. 94-96).

James Jean was a boom truck operator who had worked for the operator for approximately six years when the accident occurred (Tr. 183, 214). First, he had been a grounds man who cleaned things up and helped wherever needed, and then a mechanic's helper (Tr. 215). He subsequently became a boom operator and performed that job for about three to four years before the accident (Tr. 218). He was not a supervisor (Tr. 72). He had gone through standard job and safety training for new employees (Tr. 183). Decedent had trained him in all the positions he had occupied (Tr. 216). Initially, decedent spent 40 hours with the boom operator, going with him all over the place and showing him everything until he was ready to do his own work (Tr. 216). Decedent also trained him in the safe operation of the boom truck (Tr. 218). Decedent had been the boom operator's supervisor for five or six years and they worked together three or four times a week (Tr. 102, 216, 218).

Respondent's Employment and Safety Policy Handbook requires that when a spotter is necessary, one designated person shall do all the signaling and use standard hand signals (Exh. R-B, p. 37). The handbook further directs that safe clearances from electrical lines always be maintained and that allowances be made for boom sway, rock or sag and for electrical line swaying. Finally, the handbook provides that a clearance of at least 10 feet horizontally and vertically must always be maintained between any part of the crane, loadline or load and any electrical line carrying up to 50,000 volts (Exh. R-B, pp. 38-39). According to the manual for boom truck operators, signals shall be as they are delineated in the manual's drawings. Also, under the manual the signal person must be qualified by experience with the operations, be knowledgeable of the standard signals, position himself in clear view of the operator and have a clear view of the load, crane and operating area (Exhs. P-15, R-I).

On April 10, 1995, decedent and the boom operator were moving mantels from the storage yard onto the boom truck (Tr. 43, 44). As already noted, the mantels were in an area immediately adjacent to a point directly under the 13,200 volt powerline (Tr. 28, 35, 39-40, 139). Decedent directed the operation (Tr. 44). The boom operator swung the boom to pick up the first mantel without receiving hand signals as required by the boom operator's manual and the Employment and Safety Policy Handbook (Tr. 220, Exhs. R-B and R-I). The boom operator knew he was supposed to have a signalman (Tr. 225). The foreman attached the mantel to the chain at the end of the boom, walked over to the truck, waited there until the boom operator lowered the mantel onto the bed of the truck, and then unhooked the mantel from the chain (Tr. 220-221).

After the first mantel was unhooked, decedent did not let go of the chain at end of the boom (Tr. 220). When the boom operator swung the boom to get the second mantel, decedent gave him hand signals with one hand while holding the chain with the other (Tr. 44-45, 219). The operator watched the signals and followed them (Tr. 219). The operator watched decedent and expected decedent to watch the wires (Tr. 226, 227). When lifting mantels onto the truck, decedent usually told the operator to lower the boom, but in this instance he did not. The boom was swung over in an upright position and hit the high voltage line (Tr. 46-48, 120, 220, 225). The operator saw decedent lying on the ground and then looked up to see the boom touching the high voltage wire (Tr. 226). Because decedent was holding the chain, he was electrocuted when the boom touched the wire (Tr. 110, 163).

### <u>Conclusions</u>

Section 56.12071, <u>supra</u>, requires that high voltage power lines be deenergized or other precautionary measure taken, when equipment must be moved or operated near energized high voltage power lines and clearance is less than 10 feet. There is no dispute in this case that the boom truck which was being operated in connection with moving the mantels came closer than 10 feet to the high voltage power lines. The boom truck actually touched the wire. There is also no disagreement that the wires were energized. The issue presented is, therefore, whether respondent took precautionary measures.

The inspector testified that precautions were not taken because there should have been three people engaged in moving the mantels, one to operate the crane, a second to signal, and a third to attach the mantel (Tr. 120). However, the inspector admitted that using three people is not standard procedure in this type of task and he agreed that there was nothing wrong with a two person team (Tr. 125, 144). In light of the inspector's admissions, I conclude that the use of two persons to move the mantels was permissible and did not constitute a failure to take precautionary measures.

The inspector further stated that the failure to wear protective gloves and boots constituted a failure to take precautions (Tr. 120). At one point he expressed the belief that if the decedent had worn gloves, he would not have been electrocuted (Tr. 124). But he also stated that wearing boots and gloves was not standard procedure and that he did not know if gloves would have protected decedent from 13,200 volts (Tr. 124-125, 141-142). In view of the contradictions in the inspector's testimony, I conclude that the absence of protective boots and gloves was not a failure to take precautionary measures.

Finally, the inspector said that different equipment should have been used and that a boom truck smaller than the one in this case is ordinarily used (Tr. 125-126). However, he also stated that trucks of this size are used and there is no prohibition against them (Tr. 126). The use of the boom truck was therefore, not improper and cannot serve as the basis for finding that precautionary measures were not taken.

The inspector's reasons for finding a violation are however, not determinative in this proceeding. A hearing has now been held at which documentary evidence was received and testimony given. The matter is before me for a <u>de novo</u> decision based on all evidence presently of record.

Respondent has submitted evidence showing that weekly safety meetings were held and that new employees, including new supervisors, had a period of training during which they were accompanied and trained by an experienced person. I accept this evidence. I further accept evidence that safety meetings were held before placement of the power lines to advise company employees of the installation. As already set forth, the boom operator described his training including the instructions he received from decedent who was his foreman. Finally, I accept the statements of respondent's operations manager that decedent was trained as an aggregate plant operator and as a foreman.

Turning to the events of the day the fatality occurred, the conduct of the individuals involved must be examined to determine whether there was a violation of the mandatory standard. The boom operator was watching decedent's signals, as he had been taught and trained to do (Tr. 77-78, 99-100, 105, 182, 188, 223). The boom operator looked to the rear of the truck so that he was facing the signaler and watching his signals (Tr. 77). The signaler is the boom operator's eyes (Tr. 182). No blame attaches to the boom operator with respect to the cited condition or practice and I conclude that there was no failure on his part to take precautionary measures.

With respect to decedent's conduct, the evidence demonstrates that because he held the chain at the end of the boom, he signaled the boom operator with only one hand (Tr. 85, 219-220, 221). Holding the chain with one hand while signaling with the other was improper (Tr. 81, 250-251). And holding the chain was the reason decedent was electrocuted when the boom hit the wire (Tr. 110, 163). Testimony shows that although one man could signal and hook the mantels, the two tasks were not intended to be performed at the same time, but rather in sequence (Tr. 75, There was no reason for decedent to have held the chain 81-82). while he was signaling and no one knew why he did so (Tr. 79, 81, 151, 225). Under normal operating procedures signaling requires two hands (Tr. 85). Drawings of standard hand signals in the boom operator's manual show that either two hands are required or that one hand is used to signal while the other is at the signaler's side (Exh. R-I). No drawing shows a signaler performing another task while he is signaling. The Employment and Safety Policy Handbook which respondent gives its employees, requires that safe distances be maintained between power lines and equipment and that there be at least a 10 foot clearance horizontally and vertically between any part of a crane and any electrical line (Exh. R-B, pp. 38-39). Decedent failed to give signals that would have maintained the requisite clearance. Based upon the foregoing, I conclude that decedent violated the mandatory standard by failing to take precautionary measures as required by the standard. On the contrary, he engaged in extremely dangerous behavior which resulted in the fatal accident.

The Commission has long held that operators are liable without regard to fault for violations of the Mine Act. Fort Scott Fertilizer Inc., 17 FMSHRC 1112, 1115 (July 1995). The Commission's decisions on this point have been upheld by the Asarco, Inc., 8 FMSHRC 1632, 1634-36 (November 1986), courts. aff'd, 868 F.2d 1195 (10th Cir. 1989); Sewell Coal Co. v. FMSHRC, 686 F.2d 1066, 1071 (4th Cir. 1982); Allied Products Co. v. FMSHRC, 666 F.2d 890, 893-894 (5th Cir. 1982). It is therefore, established that an individual miner's misconduct in causing a violation is not a defense against operator liability. Particularly instructive for present purposes is the Commission's determination that under the liability scheme of the Act, an operator is liable for the violative conduct of its employees, regardless of whether the operator itself was without fault and notwithstanding the existence of significant employee misconduct. Ideal Cement Co., 13 FMSHRC 1346, 1351 (September 1991). So too, the Court of Appeals for the Fifth Circuit has held that an operator is liable for a violation even where significant employee misconduct caused the violation and it is irrelevant whose act precipitated the violation. Allied Products, supra at 894. The existence or degree of fault may be taken into account in determining the amount of penalty when negligence is evaluated. Asarco, supra at 1636. In light of the foregoing, I conclude the operator is responsible and liable for the violation.

The Act mandates that where there is a violation, a penalty must be assessed. Old Ben Coal Company, 7 FMSHRC 205, 208 (February 1985); <u>Tazco, Inc.</u>, 3 FMSHRC 1895, 1897 (August 1981); Van Mulverhill Coal Company, Inc., 2 FMSHRC 283, 284 (February 1980); Island Creek Coal Company, 2 FMSHRC 279, 280 (February 1980). As set forth above, section 110(i) of the Act specifies six factors to be considered in setting the amount of penalty. Gravity is one of the factors. Since the violation in this case resulted in a fatality, I conclude that it represents the ultimate in gravity. Moreover, the evidence establishes the four elements necessary to sustain a significant and substantial finding. Peabody Coal Company, 17 FMSHRC 508, 510-511 (April 1995); Mathies Coal Company, 6 FMSHRC 1, 3-4 (January 1984); National Gypsum Company, 3 FMSHRC 822, 825-826 (April 1981). Α violation existed which presented the discrete safety hazard of electrocution. In addition, there was a reasonable likelihood the hazard would result in a reasonably serious injury. The fatality was not a fluke, but a reasonably likely consequence of the foreman's hazardous conduct.

The next factor to be considered is negligence. As set forth supra, decedent acted in a reckless and irresponsible

manner by engaging in conduct which, in light of his training and experience, he must have known was very risky and dangerous. Ι conclude therefore, that decedent was guilty of the highest degree of negligence and that his conduct constituted unwarrantable failure as that term has been defined by the Commission. Emery Mining Corporation, 9 FMSHRC 1997, 2004 (December 1987); Youghiogheny and Ohio Coal Company, 9 FMSHRC 2007, 2010 (December The issue is whether decedent's negligence is imputable 1987). to the operator for purposes of fixing an appropriate penalty amount. Under Commission precedent negligence of a rank and file miner cannot be imputed unless the operator fails to discharge its responsibilities with respect to training, supervision or discipline. U.S. Coal, Inc., 17 FMSHRC 1684, 1686 (October 1995); Rochester & Pittsburgh Coal Company, 13 FMSHRC 189, 197 (February 1991); A. H. Smith Stone Company, 5 FMSHRC 13, 15 (January 1983); Southern Ohio Coal Company, 4 FMSHRC 1459, 1464 (August 1982). However, negligence of a supervisor is imputable to the operator unless the operator can demonstrate that no other miners were put at risk by the supervisor's conduct and that the operator took reasonable steps to avoid the particular class of accident. Nacco Mining Co., 3 FMSHRC 848, 849-850 (April 1981). This has been referred to as the Nacco defense. The Commission has emphasized that an agent's unexpected misconduct may result in a negligence finding where his lack of care exposed others to risk or harm. Id. at 851. Even wilful and intentional misconduct of employees may be imputed. Rochester & Pittsburgh, supra at 197.

By his misconduct decedent not only put himself in peril. He also placed the boom operator at risk. Testimony from the operator's corporate safety manager and the MSHA inspector indicates that confronted with a situation where his supervisor was electrocuted before his eyes, the boom operator in the stress of the movement could have left the truck and stepped onto the ground, thereby running the risk of becoming an electrical ground (Tr. 107, 165). I find that the boom operator was put at risk because under the circumstances there was a distinct possibility he could have stepped from the truck, making himself a ground. I recognize that in this instance the boom operator did not leave the truck, but I do not believe the risk has to mature for it to have been present. Accordingly, on this basis I conclude that the <u>Nacco</u> defense is not available to the operator in this case.

In addition, the corporate safety manager believed that despite outriggers which served as grounds, the boom operator would have been in danger even on the truck because electricity might not always go to ground (Tr. 107-109). The inspector also believed the boom operator was at risk because high power jumps (Tr. 163). In light of this evidence, I again find that the boom truck operator was put at risk by decedent's actions, precluding a <u>Nacco</u> defense.

The Nacco defense also is not applicable where the operator does not take reasonable steps to avert the particular type of accident that occurred. Evidence regarding the operator's orientation and training of new employees as well as its subsequent safety meetings has been set forth and accepted. However, the evidence also shows that in the area of the aggregate plant respondent was not conducting a safe operation. Decedent's unsafe behavior was not an aberration or isolated instance. The boom truck operator testified that decedent often held the chain while signaling (Tr. 221). Sometimes decedent held the chain and sometimes he did not (Tr. 225). Other signalers also held the chain while directing the boom operator (Tr. 228-229). The corporate safety director was not aware that signalers held the chain while signaling (Tr. 249). He was not sure whether the operator's policy regarding holding the chain was spelled out, but he believed that the general practice was not to hold the chain (Tr. 249). The operations manager, who was decedent's supervisor and who was on site, did not know how decedent and other foreman performed their duties (Tr. 249, 252). Thus, the record demonstrates that those in management above the foremen I conhad no idea what was actually happening on the ground. clude that the operator did not take reasonable steps to prevent the type of accident that occurred because holding the chain while signaling was an ongoing practice. The operator is obliged not only to train new employees and hold safety meetings, but also to monitor the activities of miners and foremen to insure that the safety procedures they have been told about are followed. I conclude that on this basis also the Nacco defense is not available to respondent. In light of the foregoing, decedent's extremely negligent conduct which constituted unwarrantable failure is imputable to the operator for purposes of determining an appropriate penalty amount.

Even more importantly, I conclude that apart from imputation of negligence, the operator itself was highly negligent because it failed to keep itself apprised of how its quarry was actually being run. As set forth above, the operator did not provide on the ground oversight of the actions of its miners and first level supervisors. It is not sufficient for the operator to initially train its foremen and have them conduct safety meetings, but then leave them to their own devices on site when the work is being performed. The operator's deficient and aggravated conduct constituted a very high degree of negligence and unwarrantable failure.

The stipulations of the parties which I have accepted, address the other criteria specified in section 110(i), <u>supra</u>. I particularly note the operator's low history of prior violations. After considering all the 110(i) factors, I determine that a penalty of \$6,000 is appropriate.

The excellent post-hearing briefs filed by the parties have been reviewed and were most helpful. To the extent the briefs are inconsistent with this decision, they are rejected.

#### ORDER

It is ORDERED that the finding of a violation for Citation No. 4088141 be AFFIRMED.

It is further ORDERED that the significant and substantial finding for Citation No. 4088141 be AFFIRMED.

It is further ORDERED that the high negligence finding for Citation No. 4088141 be AFFIRMED.

It is further ORDERED that the unwarrantable failure finding for Citation No. 4088141 be AFFIRMED.

It is further ORDERED that a penalty of \$6,000 be ASSESSED and that the operator PAY \$6,000 within 30 days of the date of this decision.

> Paul Merlin Chief Administrative Law Judge

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