

FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION
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August 3, 2000

SECRETARY OF LABOR,	:	CIVIL PENALTY PROCEEDING
MINE SAFETY AND HEALTH	:	
ADMINISTRATION (MSHA),	:	Docket No. SE 99-244-M
Petitioner	:	A. C. No. 40-00022-05593
v.	:	
	:	
	:	
FRANKLIN INDUSTRIAL MINERALS,	:	Mine: Anderson Mine
Respondent	:	

DECISION

Appearances: Thomas A. Grooms, Esq., Office of the Solicitor, U.S. Department of Labor, Nashville, for the Petitioner,
Timothy Biddle, Esq., Crowell & Moring, Washington, DC for Respondent.

Before: Judge Barbour

This civil penalty proceeding arises under section 105 of the Federal Mine Safety and Health Act of 1977 (30 U.S.C. §815) (Mine Act or Act). The Secretary of Labor (Secretary) on behalf of her Mine Safety and Health Administration (MSHA) seeks the assessment of a civil penalty against Franklin Industrial Minerals (Franklin) for an alleged violation of 30 C.F.R. §57.9101, a mandatory safety standard for underground metal and nonmetal mines that requires operators of self-propelled mobile equipment to maintain control of the equipment while it is in motion.¹ Franklin was cited for the violation following MSHA's investigation of a fatal accident that occurred at Franklin's Anderson Mine on December 23, 1998. The accident happened when a miner was crushed between a front-end loader (FEL) and a railcar. In addition to alleging a violation, the Secretary charges the violation was a significant and substantial contribution to a mine safety hazard (S&S) and was the result of Franklin's unwarrantable failure to comply with the regulation. The Secretary proposes that Franklin be assessed a civil penalty of \$55,000.

¹ The Secretary originally charged Franklin with a violation of 30 C.F.R. §57.14205, a mandatory safety standard requiring that machinery and equipment not be used beyond the design capacity intended by the manufacturer where such use will create a hazard. A few days before the hearing the Secretary moved to amend her pleadings to allege a violation of section 57.9101. I consulted with counsels and advised them I would hear arguments and would rule on the motion at the hearing. At the start of the hearing counsel for the Secretary stood upon the motion, counsel for Franklin summarized the reasons for the company's opposition, and I granted the motion (Tr. 8-9, 36).

Franklin denies that it violated section 57.9101. Alternatively, it argues the violation was neither S&S nor unwarrantable. The matter was heard in Nashville, Tennessee, and following the hearing counsels filed helpful briefs.

THE ISSUES

The issues are whether Franklin violated section 57.9101; whether the violation was S&S and unwarrantable; and the amount of any civil penalty that must be assessed.

STIPULATIONS

The parties stipulated that Franklin demonstrated good faith in achieving rapid compliance after being cited. They also stipulated that in 1998 the company had sales of approximately \$110,000,000 and employed 620 persons (Tr. 13-14). Based on the stipulations, the Secretary took the position that the company was a large operator, while Franklin maintained that the company was medium in size when compared to other companies in the metal/nonmetal industry (Tr. 13-14). The Secretary also took the position that the proposed penalty would not adversely affect the company's ability to continue in business. The company responded that a "reasonable" penalty would not affect its ability to continue in business (Tr. 17). Finally, the company agreed to the facts stated in the first three pages of the MSHA accident investigation report. (The pages contain sections entitled, *General Information*, *Physical Factors Involved*, and *Description of Accident* (Tr. 18; Exh. P-6 at 1-3)). The company took exception to the conclusions MSHA drew from the facts.

THE FACTS

The Mine and The Equipment Involved In The Accident

The report states as follows² :

The Anderson Mine, an underground crushed stone operation, . . . [is] located about six miles south of Sherwood, Franklin Country, Tennessee. . . . The mine [is] normally operated two, ten-hour shifts a day, 5-1/2 days a week. . . .

The operation consists of an underground mine with a surface mill. . . . [Underground broken limestone [is] loaded into trucks by [FELs] and [is] transported to the surface where it [is] crushed, sized, and stored in silos [see Tr. 121, 227]. The finished

² Bracketed citations within the quoted passages reference testimony and exhibits that amplify the report.

product [is] shipped by rail and truck to . . . customers.[³]

* * * *

The accident occurred on the surface near the scales at the railcar load-out area[(an area where the railcars are loaded and weighed)]. Three parallel sets of tracks [serve] the load-out area. The first and second sets [are] joined by a switch near the scale [see Exhs. P-42, P-44, P-48]. The scale and silos [are] adjacent to the second set of tracks. Empty [rail]cars [are] parked on the first track and towed to the silos, two at a time, by a ... [FEL] so both [rail]cars [can] be filled simultaneously. Loaded [rail]cars [are] towed over the scales, down the second track[(the middle track)] then switched to the third track where they [are] parked [see Tr. 122, 230].

The second track, where the accident occurred, slope[s] at a maximum of 1.56 %. The first 24 feet of track [drop] 3/4-inch per each 4 feet. The next 100 feet [drop] 1/2-inch per each 4 feet. . . . [Rail]cars were parked on the third track approximately 100 feet from the scale.

The railcar involved in the accident . . . was loaded . . . and was on the second track.

* * *

The . . . [FEL] involved in the accident [see Exh. P-32] . . . [has] an enclosed cab. The . . . [FEL] weigh[s] 52,440 pounds. The [FEL's] bucket measure[s] 57 inches high by 10 feet, 3-inches wide. Eyelets [have] been welded near each end of the bucket for the purpose of attaching a cable to pull railcars on the tracks.

Two, 8-foot by 1-inch choker cables [are] used to tow [a] railcar The cables [are] double-ended and connected with cable clevises. The first cable [is] attached to the eyelets on the loader bucket with pinned clevises [see Exh. P-34]. A second cable [is] attached to the first cable by a swivel clevis so it [can] slide from one end of the bucket to the other in order to tow from either side of the railcar [Id.; see e.g. Exh. P-38]. The other end of the

³ Most of the railcars are owned by CSX. CSX picks up the railcars and moves them off of mine property after the railcars have been loaded, weighed, and stored (Tr. 229-230).

cable [has] an open hook attached with a clevis. The hook [is] connected to a ring located on the side of the railcar [see e.g. Exh. P-43] (Exh. P-6 at 1-2).

At the hearing the procedure for moving the railcars off of the scale was described by Kurt Kiser, the plant manager:

As the [railcar] was being pulled . . . off of the scale, the . . . [FEL] would apply tension to the cable and start the railcar rolling . . . and whenever sufficient movement and momentum had been picked up by the [rail]car, then slack resulted in the cable at which point the ground man [(a miner who was assigned to work with the FEL operator)] would grab the cable, grab the hook and unhook it from the [rail]car, and walk and toss the hook into the bucket of the . . . [FEL]. The railcar would proceed on its own momentum down the inclined part of the track to the storage track (Tr. 231).⁴

Kiser acknowledged that there were times when the ground man was unable to unhook the tow-cable from the railcar and as a result, “the . . . [FEL] operator was required to follow the railcar down the inclined part of the track until such time . . . [as] either the [rail]car came to rest on its own because of the rolling resistance of the [rail]car or . . . the . . . [FEL] operator [had to] apply pressure to the tow-cable along the side of the car to bring the car to a rest” (Tr. 232-233). According to Kiser when the FEL operator applied pressure to the tow-cable and increased the tension of the cable, either the railcar stopped due to the increased tension or it continued to roll past the FEL, pulled the FEL into the side of the railcar, and the resulting collision stopped the railcar (Tr. 234).

The Accident

The accident report described the events of December 23.

Weather on [that] day . . . was cold and wet with rain mixed with sleet. Ground conditions were muddy.

* * *

Brandon Privette (victim) and Gary Gardner, . . . [FEL] operator, reported for work at 5:00 a.m., their normal starting time. They went to the silos to load [railcars]. Several loaded [rail]cars had been left from the previous shift, so they moved those cars down the second track. Privette operated the . . . [FEL] loader

⁴ In tests conducted at the mine after the accident under conditions similar to those on December 23, MSHA determined the average speed of the railcar as it rolled leaving the scales was approximately 100 feet in 22.4 seconds or 3.04 mph (Exh. P 6 at 2).

while Garner rigged the tow-cable and worked the brakes on the [railcars]. After moving the loaded [rail]cars, they began moving empty [rail]cars onto the second track, filling, weighing, and then towing them down the track. At about 7:15 a.m., Thomas Guess arrived and relieved Privette on the . . . [FEL]. Privette assisted him on the ground. Shortly after, Garner left to work elsewhere.

Work proceeded without incident until about 9:00 a.m. when Privette and Guess moved two loaded [rail]cars to the scale. The first car was weighed and towed past the scale. [(Guess continued to back up the FEL to keep pace with the rolling railcar.)] When the second car was weighed, it was determined that more product was needed to make the proper weight. Because the . . . [FEL] could get little traction with no-lug tires and muddy ground, Guess was unable to move both [rail]cars back to the silos. The [rail]cars were then separated and Privette attached the tow-cable to the first [rail]car to move it down the track to join the other loaded [rail]cars. Guess backed [up] the [FEL], towing the [rail]car.

When the [rail]car began to roll freely, the tow-cable became slack and Privette stepped between the slowly moving [FEL] and [the railcar] to unhook the cable. The [rail]car continued to roll approximately 100 feet while Guess tried to maintain enough slack for Privette to unhook the cable. When Guess realized he was about to back into the loaded railcars parked on the third track, he stopped the loader. The [railcar] continued to roll past the . . . [FEL]. When the slack in the cable was taken up abruptly, the side of the . . . [FEL] bucket was jerked against the rail car [see e.g. Exh. P-35, Exh. P-39] crushing Privette.

Guess summoned help and mine personnel administered CPR unsuccessfully. Emergency medical technicians transported Privette to a local hospital where he was pronounced dead on arrival. The immediate cause of death was respiratory arrest caused by [a] major chest crushing injury (Exh. P-6 at 2-3).

Additional Details

Guess's testimony added particulars to the events of December 23. He explained that he and Privette were working as a team that morning. Together they moved approximately 10 railcars off of the scales (Tr. 221). Around 9:00 a.m. two additional railcars were on the track, one had been weighed and one was waiting to be weighed. The cars were coupled. At first the men attempted to pull the weighed railcar off of the scales and to move the second car onto the

scales. However, the FEL could not get sufficient traction, and Guess, who was operating the FEL, could not move the cars. Therefore, the men decided to move one car at a time. They uncoupled the cars and Privette attached a tow-cable to the railcar on the scales. Guess backed up the FEL. It was difficult to get the railcar to move but Guess continued to pull and the railcar began to roll. The tow-cable hook was still attached to the railcar and the FEL had to continue pulling to keep the car rolling. Finally, the railcar began to move more freely. Guess turned and looked to make sure he was not going to back the FEL into the railcars on the storage track (Tr. 217-219).

Guess described what happened next, "I noticed [Privette] trying to run in to unhook . . . [the cable]. And the next thing I [knew], when I turned around, I was being jerked over to him, and I was turning the wheel to keep from hitting him, but it was too late" (Tr. 219-220, see also Tr. 223).

Guess stated that he was unable to keep the FEL from being pulled into the railcar, "Because I was tied to the car with the cable" (Tr.220). He was asked why he did not apply the brakes. He responded, "If I would have slammed on the brakes, it would have more than likely turned the FEL over . . . [b]ecause I was pretty much in an 'L' shape trying to keep [the FEL] from hitting [Privette]" (Id.).

The Towing Procedure and Loss of Control

Volvo Construction Equipment, Inc. (Volvo) manufactured the FEL. Roy Ghrist, Director of Product Integrity for Volvo, testified that he was consulted frequently about safety issues related to the use of Volvo equipment. He stated that he did not believe the procedure used by Franklin to tow and to stop railcars was safe. He objected to the fact that it required a person physically to go between the FEL and the railcar to unhook the tow-cable (Tr. 53, 56). If the railcar rolled past the FEL the force of the railcar on the tow-cable would very quickly pull the FEL and its bucket into the side of the railcar (Tr. 56). The FEL operator could not stop the FEL from hitting the railcar which, according to Ghrist, meant that the FEL operator had lost control of the FEL (Tr. 71).

Dennis Ferlich, of MSHA's technical support division and a participant in MSHA's investigation of the accident, agreed with Ghrist. He too testified that once the railcar passed the FEL and tension was placed on the tow-cable there was nothing an FEL operator could do to prevent the loader from being dragged sideways into the railcar (Tr. 127, 131-132, see also Tr. 92-93).

Not surprisingly, Franklin's witnesses had a different view. For example, Kiser did not believe the FEL's movement represented a loss of control because, as Kiser stated, the FEL operator was, "...performing what he want[ed] to perform and that [was] to position a railcar where he want[ed] to position it" (Tr. 235). Rather than losing control of the FEL, the operator, "was in the process of performing a controlled stop of the railcar" (Tr. 237).

THE VIOLATION

Citation No. 4875742 as amended states:

A fatal accident occurred at this operation . . . when a miner working in the railcar load-out area was crushed between a . . . [FEL] and a loaded railcar. The miner was killed when he stepped between the FEL and the railcar to detach a tow-cable and hook-assembly which was attached to the FEL and hooked to the railcar. The FEL had been modified by the attachment of this tow-cable and hook-assembly to be used to control the movement of loaded railcars along the load-out tracks. This modification and use periodically caused the FEL to be pulled into the railcar when it traveled past the FEL which was still attached to it by the tow-cable and hook-assembly. The FEL operator could not control the FEL when the tow-cable and hook-assembly pulled it into the railcar. The operator knew the practice of moving railcars with the FEL and tow-cable and hook-assembly periodically caused the FEL to be pulled into the railcar. The FEL operator had limited experience and training in the use of the FEL to move railcars (Exh. P 4).

As the Secretary correctly notes, section 57.9101 requires: 1) that the equipment involved is “self-propelled mobile equipment”; 2) that control of the equipment is not maintained by the equipment operator; and 3) that the equipment is in motion when control is not maintained (Sec. Br. 24).

Section 57.9101 is found in Subpart H of Part 57. The term “mobile equipment” used in Subpart H is defined as “Wheeled . . . equipment capable of being moved” (30 C.F.R. §57.9000). The FEL moved on wheels and under its own power. It was both mobile and self-propelled.

The fact that the FEL operator was unable to maintain control of the moving equipment and therefore was in violation of the standard was compellingly described by Guess, “[T]he next thing I [knew] . . . I was being jerked over to . . . [Privette], and I was turning the wheel to keep from hitting him, but it was too late” (Tr. 219-220). Given the situation, there was nothing Guess could do to avoid a violation. As he testified, if he had slammed on the brakes the resulting movement of the FEL could have caused the equipment to overturned. This result also would have represented a loss of control (Tr. 220).

Other Franklin employees agreed that Guess essentially was powerless to control the FEL’s movement. Jon Hannah, an FEL operator who trained Guess, stated that because the FEL operator could not keep going backward indefinitely, at some point the operator had to slow down or apply the brakes. At that time, the railcar could roll past the FEL; could jerk the FEL into the side of the railcar; and the FEL operator could do nothing to prevent it (Tr. 195-196). Franklin’s superintendent of production agreed (Tr. 253).

The focus of the violation is on the movement of the FEL not, as Kiser argued, on an attempted “controlled stop” of the railcar (Tr. 237). The salient points are that as the FEL was pulled toward the railcar the FEL was in motion and its operator could not control the motion. It is true that as a result of the violation Privette was hit and killed, but even if Privette had not gotten between the FEL and the railcar, even if the FEL had only hit the railcar, the FEL’s uncontrolled and uncontrollable movement into the side of the railcar would have violated section 57.9101.

The company argues that sections 57.9101 does not apply to a situation in which an FEL tows a loaded railcar because section 57.9101 and its associated sections are titled, *Traffic Safety* and “A plain language reading of . . . [section 57.9101] and a reading of the accompanying traffic safety regulations, make clear that the regulation does not prohibit Franklin’s method of stopping railcars” (Franklin Br. 10). It adds, “use of a cable by an FEL to pull a railcar can hardly be considered ‘traffic’ ”(*Id.*). However, and as the Commission has stated, “The headings used in . . . Part [57] are designed for organizational convenience to supply short-hand characterizations of the general subject matter involved in the standards (*Allied Chemical Corp.*, 6FMSHRC 1854, 1856-57 (August 1984)). Therefore, the headings, “do not control over the plain words of the text” (*Id.*). Here, the words of the standard are unambiguous and easy to understand. They were violated when the FEL was jerked into the side of the railcar in a movement Guess was unable to control.

S&S and GRAVITY

A violation is significant and substantial when, based on particular facts surrounding the violation, there exists a reasonable likelihood that the hazard contributed to will result in an injury or illness of a reasonably serious nature (*Arch of Kentucky*, 20 FMSHRC 1321, 1329 (December, 1998); *Cyprus Emerald Resources, Inc.*, 20 FMSHRC 790, 816 (August 1998); *National Gypsum Co.*, 3 FMSHRC 822, 825 (April 1981)). In *Mathies Coal Co.*, 6 FMSHRC 1 (January 1984), the Commission held that in order to establish an S&S violation of a mandatory standard the Secretary must prove: (1) the existence of an underlying violation; (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 the injury in question will be of a reasonably serious nature. Evaluation of these elements is made in terms of “continued normal mining operations” (*U.S. Steel Mining Co., Inc.*, 6 FMSHRC 1573, 1574 (July 1984)).

Here, the Secretary met her burden. The violation existed as charged. The hazard contributed to was that the FEL operator could not avoid hitting anyone or anything that came between the FEL and the railcar because the FEL operator had no control over the equipment once it was pulled toward the railcar. Given the weight of the FEL (52,440 pounds) (Exh. P-6 at 1) and the substantial force the railcar exerted on the tow-cable serious injury or death was virtually certain to result.

I recognize that Franklin presented testimony from its then safety director (Tommy

Stevens), its mine manager (Kiser), and its superintendent of production and maintenance (Kenneth Clark) that miners were not supposed to go between a moving FEL and a railcar (Tr. 161-162, 237, 270). Stevens testified, "If a loader is hooked to a railcar and they are in a continuous motion, . . . [a miner] shouldn't approach that situation" (Tr. 161-162). He stated this was a "rule" at the mine (Id.). In other words, if the ground man failed to unhook the tow-cable and the FEL continued to back up as the railcar rolled down the track the ground man was to get out of the way. However, the initial attempt to unhook the tow-cable was made while the railcar was beginning to roll. This required the ground man to go between the FEL and the railcar while the railcar was moving. Long time FEL operator, J. C. Wilkinson testified, "You tug on the car, get it to move and then flip the hook out" (Tr. 205).

The fact that a ground man was required to unhook the cable while the railcar was moving (however slowly) meant that if the ground man failed to unhook the cable the railcar could pass the FEL and could jerk the FEL into the railcar and into the ground man if he, for some reason, did not get out of the way. Further, the fact that the practice of towing railcars with FELs had been on-going for some time and without anyone being injured, easily could have lead a ground man to believe that he could approach a railcar even if it had moved away from the scales and down the tracks toward the storage area.

Wilkinson agreed that FELs "occasionally" were pulled into railcars (Tr. 206-207). Given the fact that the towing of railcars made getting between FELs and railcars a familiar and routine procedure to the mine's ground men, I conclude that as mining operations continued it was only a matter of time before a miner would miscalculate and would place himself or herself between an FEL and railcar immediately before or as the FEL was jerked toward the railcar.⁵ To put it another way, I conclude there was a reasonable likelihood miners would be injured or killed unless the towing procedure (and hence the violation) was stopped. Therefore, I find that the violation was S&S.

The Commission recently emphasized that the focus of the gravity criterion is on, "the effect of the hazard if it occurs" (Hubb Corp., 22 FMSHRC 606, 609 (May 2000) (quoting Consolidation Coal Co., 18 FMSHRC 1541, 1550 (September 1996)). In this case the hazard occurred and the death of a miner resulted. If the practice had continued other deaths or serious injuries reasonably could have been expected. This was a very serious violation.

UNWARRANTABLE FAILURE and NEGLIGENCE

The Commission has defined unwarrantable failure as aggravated conduct constituting more than ordinary negligence (Emery Mining Corp., 9 FMSHRC 1997, 2001 (December

⁵ The procedures for towing railcars were not set forth in writing. They were given orally. Privette did not follow the instructions (Tr. 171), and I find no reason apparent in the record why other miners would not have placed themselves in similar danger if the citation had not halted the practice.

1987)). The Commission also has stated that unwarrantable failure is conduct that is characterized by reckless disregard, intentional misconduct, indifference or a serious lack of reasonable care (Emery, 9 FMSHRC at 2003-04; Rochester & Pittsburgh Coal Co., 13 FMSHRC 189, 194 (February 1991)).

Several factors must be considered in analyzing whether a violation results from unwarrantable failure. Among these are: "the extensiveness of the violation, the length of time that the violative condition has existed, the operator's efforts to eliminate the . . . condition, and whether [the] operator has been placed on notice that greater efforts are necessary for compliance" (Mullins and Sons Coal Co., 16 FMSHRC 192, 195 (February 1994)). The culpability determination required for a finding of unwarrantable failure is similar to gross negligence or recklessness. It is more than a "knew or should have known" test (Virginia Crews Coal Co., 15 FMSHRC 2103, 2107 October 1993)).

I agree with the Secretary that Franklin unwarrantably failed to comply with section 57.9101. The violation was the result of the deliberate decision of Franklin to tow railcars off the scale by using an FEL and a tow-cable. In making this decision, Franklin knew and counted on the fact that if tension applied to the tow-cable did not stop the railcar, the uncontrolled movement of the FEL into the side of the railcar would. The practice of towing railcars had been used at the mine for some time (Tr.191-192, 204, 210-211, 247, 262). The uncontrolled movement of an FEL into a railcar was a common component of the practice (Tr. 206-207). Therefore, over time the practice involved repeated deliberate violations of section 57.9101.

Franklin maintains it was unaware that the uncontrolled movement of the FEL into the side of the railcar was a violation. Stevens believed that when MSHA inspectors came to the mine and inspected surface areas they must have seen the towing procedure in use, yet they never issued a citation based on the procedure (Tr. 260-261). However, neither Stevens nor other Franklin witnesses testified that they knew for a fact that an MSHA inspector actually observed a railcar towed by an FEL (see Tr.261, 268). MSHA supervisor Craig credibly testified that he was not aware of the procedure (Tr. 100). Therefore, I cannot find that MSHA knew about the procedure but failed to recognize that it constituted a violation.

To prevent an accident while the procedure was being undertaken, the company relied on the fact that its miners were trained in the procedure. However, training alone did not meet the company's duty of care. The oral and on-the-job training that Franklin provided may have lessened chances for a mistake, but it did not eliminate the hazard. Indeed, and as I have found, the procedure left open the possibility that a ground man like Privette would miscalculate and go between the FEL and the railcar. Therefore, the company had a duty either to provide a way to protect an erring miner from a mistake or, if that were not possible, to adopt another procedure that did not require the uncontrolled movement of equipment.

The company did not meet this duty. Rather, Franklin allowed the possibility that the FEL operator, the ground man, or both would make errors of timing or judgement and be unable to take corrective action. In purposefully adopting a procedure that over time involved repeated violations of section 57.9101 and in failing to fully meet its duty of care to its miners, Franklin

was more than ordinarily negligent.

CIVIL PENALTY CRITERIA

I have found that the violation was serious and that the company's failure to comply with section 57.9101 was due to more than ordinary negligence. In assessing a civil penalty, the Act mandates that I also consider Franklin's history of previous violations, the size of its business, the effect of the penalty on the company's ability to continue in business, and its good faith in attempting to comply rapidly after being charged (30 U.S.C. §820(i)).

To establish the company's history of previous violations the Secretary offered a computer print-out which shows the history of previously assessed and paid violations at the mine within two years prior to the accident. The report indicates that during this period 32 violations were assessed and paid. It also indicates that there were no previous violations of section 57.9101 (Exh. P-1 at 1). I find this to be a moderate to small previous history.

As I noted previously, the parties stipulated that in 1998 the company had sales of approximately \$110,000,000 and employed 620 persons (Tr. 13-14). I also observe that when she assessed the proposed penalty the Secretary listed the hours worked by the company employees as 866,738 and the hours worked at the mine as 98,740 (Petition for Assessment of Civil Penalty, Exhibit A). Considering these factors and reviewing the way in which the Secretary evaluates the size criterion (see 30 C.F.R. §100.2(b)), I conclude that Franklin is a medium size operator. Further, with annual sales of \$110,000,000, I find that the amount of the penalty that must be assessed for the violation will not affect the company's ability to continue in business. Finally, and as the Secretary stipulated, Franklin abated the violation in good faith (see Tr. 13-14).⁶

The penalty proposed by the Secretary is the maximum allowed by the Act. The civil penalty criteria augur for less. First, Franklin has a small to moderate history of previous violations. Second, Franklin is medium in size. Third, although the violation was very serious and was due to Franklin's more than ordinary lack of care, the fatal results of the violation were contributed to by Privette's own lack of care. The record supports finding that he placed himself where he should not have been. Although this in no way excuses the violation, its purposeful implementation by Franklin, nor its very serious nature, it recognizes that Privette shared in the blame for the violation's tragic consequences.

Considering all of these factors, I conclude Franklin should be assessed a civil penalty of \$15,000.

ORDER

⁶ Abatement involved adopting another method of moving railcars off the scale.

Within 30 days of the date of this Decision, Franklin is **ORDERED** to pay a civil penalty of \$15,000. Upon payment of the penalty, this proceeding is **DISMISSED**.

David F. Barbour
Chief Administrative Law Judge

Distribution: (Certified)

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