FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION
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January 26, 2001

SECRETARY OF LABOR,	:	CIVIL PENALTY PROCEEDINGS
MINE SAFETY AND HEALTH	:	
ADMINISTRATION (MSHA),	:	Docket No. WEST 99-280-M
Petitioner	:	A.C. No. 05-00344-05502 RGE
	:	
v.	:	Docket No. WEST 99-376-M
	:	A.C. No. 05-00344-05503 RGE
WATKINS ENGINEERS AND	:	
CONSTRUCTORS,	:	Lyons Cement Plant
Respondent	:	

DECISION

Appearances: Edward Falkowski, Esq., and Lydia Tzagoloff, Esq., Office of the Solicitor, U.S. Department of Labor, Denver, Colorado, for Petitioner; Carl B. Carruth, Esq., and Jason M. Bradley, Esq., McNair Law Firm, Columbia, South Carolina, for Respondent.

Before: Judge Manning

These cases are before me on petitions for assessment of civil penalty filed by the Secretary of Labor, acting through the Mine Safety and Health Administration ("MSHA"), against Watkins Engineers and Constructors ("Watkins"), pursuant to sections 105 and 110 of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. §§ 815 and 820 ("Act" or "Mine Act"). A hearing was held in Denver, Colorado. The parties presented testimony and documentary evidence and filed post-hearing and reply briefs.

I. FINDINGS OF FACT AND CONCLUSIONS OF LAW

In January 1999, Watkins was constructing a bag house at the Lyons Cement Plant (the "plant") owned by Southdown, Inc. The plant is in Boulder County, Colorado. Jefferson B. Davis, an employee of Watkins, was seriously injured when he fell 70 feet onto a concrete pad while he was attempting to enter the bag house from a Snorkel man-lift basket. Following an investigation, MSHA issued a citation under section 104(a) of the Act; and one citation and two orders under section 104(d)(1) of the Act. The Secretary proposes a total penalty of $90,500 for the alleged violations. Watkins duly contested each item and its associated civil penalty. Watkins also contends that MSHA was without jurisdiction to issue the citations and orders.

The plant produces portland cement and the bag house being constructed by Watkins is an integral part of the plant. The plant is near a quarry owned by Southdown. Limestone and shale

mined at the quarry are transported to a primary crusher which is at the quarry site. Once it is crushed, the rock is carried on a two-mile long conveyor belt to the plant where it is stockpiled. Quartz is mined at a second quarry in the area. After it is mined, the quartz is transported by truck to the same primary crusher. The crushed quartz is also transported to stockpiles at the plant via the conveyor belt. All of the material that is transported to the stockpiles at the plant is used in the production of Portland cement. (Tr. 39).

The stockpiled material is then taken into the plant where it goes through various operational steps in the production of cement. The material is crushed, ground up into a powder, preheated to 1,900 degrees Fahrenheit, and heated to 2,500 degrees in a kiln where it undergoes a chemical reaction to form chunks of crystalized cement known as "clinker." The clinker is cooled and stored for later use. The clinker is then ground into a fine powder in the finish mill. The fine powder is drawn by vacuum into the bag house. The bag house contains large bags that collect the fine powdered cement, which is then pumped to finished cement storage silos for sale.

This description of the process is a simplification of a more complex process. For example, other material, such as gypsum, is added and coarse material is recirculated back through the process at several steps. They key fact is that all of the material that enters the plant is used in the finished product. No waste material is created from cement production at the plant other than carbon dioxide that is released from the limestone in the kiln.

Prior to the construction of the bag house by Watkins, mechanical devices were used to separate the fine cement powder from coarser material. The bag house is a high-efficiency separator that can handle more material and produce better cement. (Tr. 31). The accident that gave rise to the citations and orders at issue occurred during the construction of the bag house. The plant has been operating for at least 26 years under several owners. MSHA has continuously inspected the plant for the Secretary of Labor since MSHA was created in 1978.

A. Jurisdiction

1. Summary of the Parties' Arguments

The Secretary contends that MSHA had jurisdiction to inspect the construction of the bag house at the plant under the Act. She argues that she has consistently interpreted the Act to include cement plants under the jurisdiction of MSHA. The term "coal or other mine" is defined in section 3(h)(1) to include the milling of minerals. That section also provides that, in making a determination of what constitutes mineral milling, the Secretary shall give due consideration to the convenience resulting from delegating to one Assistant Secretary all safety and health authority employed at one physical establishment. Thus, the Secretary contends that she was delegated the authority to determine where mineral milling ends and where post-milling operations that are not subject to MSHA jurisdiction begin.

In 1979, MSHA entered into an interagency agreement with the Department of Labor's Occupational Safety and Health Administration ("OSHA") to provide some guidance to the regulated community on the jurisdiction of these two agencies ("Interagency Agreement"). The Secretary relies on paragraph B(6)(a) of the Interagency Agreement which states that MSHA jurisdiction includes cement plants. She maintains that MSHA has been inspecting cement plants throughout the country since the Act was passed and that her interpretation is entitled to deference.

Watkins argues that MSHA does not have jurisdiction over this matter because no mineral milling occurs at the plant. It contends that mineral milling is the separation of valuable minerals from waste constituents. For example, mineral milling occurs when various processes, such as crushing, are used to separate a metallic mineral from the host rock. If, on the other hand, these same processes are used only to change the physical nature of the material, without any separation of waste material, mineral milling is not taking place. Watkins argues that at the Lyons Cement Plant, the various processes are used to manufacture cement. Watkins maintains that mineral milling does not take place at the plant because there is no segregation of waste material. It contends that OSHA has jurisdiction at the plant, not MSHA.

Watkins argues that MSHA's exercise of jurisdiction over the plant is an abuse of its discretion under the Act. To the extent that there is no abuse of discretion, then it maintains that the grant of power to the Secretary to construe the word "milling" is an unconstitutional delegation of legislative power.

2. <u>Discussion</u>

For the reasons explained below, I find that MSHA has jurisdiction to inspect the Lyons Cement Plant under the Mine Act. The starting point for an analysis of Mine Act jurisdiction is the definition of the term "coal or other mine," in section 3(h)(1). A coal or other mine is defined, in pertinent part, as "(A) an area of land from which minerals are extracted ..., (B) private ways and roads appurtenant to such area, and (C) lands, ... structures, facilities, equipment, machines, tools, or other property ... on the surface or underground, used in, or to be used in ... the work of extracting minerals from their natural deposits, ... or used in ...the milling of such minerals...." 30 U.S.C. § 802(h)(1). The Senate Committee that drafted this definition stated its intention that "what is considered to be a mine and to be regulated under this Act be given the broadest possible interpretation, and ... that doubts be resolved in favor of inclusion of a facility within the coverage of the Act." S. Rep. No. 181, 95th Cong., 1st Sess. 14 (1977), *reprinted in* Senate Subcommittee on Labor, Committee on Human Resources, 95th Cong., 2nd Sess., *Legislative History of the Federal Mine Safety and Health Act of 1977* at 602 (1978)("*Legis. Hist.*"); *see also Donovan v. Carolina Stalite Co.*, 734 F.2d 1547 (D. C. Cir. 1984). The final sentence of this definition states that in "making a determination of what constitutes mineral milling ..., the Secretary shall give due consideration to the convenience of administration resulting from the delegation to one Assistant Secretary of all the authority with respect to the health and safety of miners employed at one physical establishment."

The phrase "the milling of such minerals" and the word "mineral milling" are not further defined in the Act, but the word "milling" is defined in the Interagency Agreement. (44 *Fed. Reg.* 22827 (April 17, 1979), amended by 48 *Fed. Reg.* 7521 (February 22, 1983)). This agreement provides, in Appendix A:

> Milling is the art of treating the crude crust of the earth to produce therefrom the primary consumer derivatives. The essential operation in all such processes is separation of one or more valuable desired constituents of the crude from the undesired contaminants with which it is associated.

This definition is supported by Dr. Baki Yarar, professor of mining engineering at the Colorado School of Mines. He stated that the separation of unwanted parts of the extracted crude from the wanted parts is a critical component in the definition of mineral milling. (Tr. 329-31). To be considered mineral milling, there must be a separation of the "worthless" from the "valuable." *Id.* If any of the milling-type processes are used for other purposes, mineral milling is not taking place. Thus, if materials from the earth are being crushed, but there is no separation of the valuable from the worthless, it is not mineral milling. For that reason, Dr. Yarar believes that the Lyons Cement Plant is a cement manufacturing facility. Minerals are not being milled at the plant.

For purposes of this decision, I accept the definition of "mineral milling" in the Interagency Agreement and the testimony of Dr. Yarar on this subject. My finding in this regard does not end the matter, however, because section 3(h)(1) of the Act specifically grants the Department the Labor the authority to determine "what constitutes mineral milling." Although section 3(h)(1) does not grant the Secretary unfettered discretion, it does allow the Secretary to take into consideration "the convenience of administration" when drawing the line between MSHA and OSHA jurisdiction. Congress recognized that this line is somewhat fuzzy and it did not require the Secretary to follow precise engineering principles when drawing this line. Congress authorized the Secretary to take a practical approach and that "doubts be resolved in favor of inclusion of a facility within the coverage of the Act." (*Legis. Hist.* at 602). The line drawn by the Secretary is a legal boundary, not a scientific or technical boundary.

Paragraph B(2) of the Interagency Agreement provides that the Act gives MSHA jurisdiction over lands, structures, facilities, and equipment used in or to be used in mineral milling, including the construction of such facilities. Paragraph B(3) states that Appendix A to the Interagency Agreement provides more detailed descriptions of the kinds of operations included in milling. This paragraph further states that there will remain areas of uncertainty especially in operations near the termination of the milling cycle and the beginning of the manufacturing cycle. In Paragraph B(4), the Interagency Agreement provides that the "scope of the term milling may be expanded to apply to mineral product manufacturing processes where these processes are related, technologically or geographically, to milling." This paragraph also provides that the term milling "may be narrowed to exclude from the scope of the term processes listed in Appendix A where such processes are unrelated, technologically or geographically, to mineral milling."

Paragraph B(5) states that the following factors will be taken into consideration when determining whether MSHA or OSHA has jurisdiction: "the processes conducted at the facility, the relation of all processes at the facility to each other, the number of individuals employed in each process, and the expertise and enforcement capability of each agency with respect to the safety and health hazards associated with the processes conducted at the facility." Then, in a pivotal provision of the Interagency Agreement, Paragraph B(6) provides, in part, as follows:

> Pursuant to the authority in section 3(h)(1) to determine what constitutes mineral milling considering the convenience of administration, the following jurisdictional determinations are made:
>
> (a) MSHA jurisdiction includes salt processing facilities on mine property; electrolytic plants where the plants are an integral part of mining operations; stone cutting and stone sawing operations on mine property where such operations do not occur in a stone polishing or finishing plant; and alumina and ***cement plants***.
>
> (b) OSHA jurisdiction includes the following, whether or not located on mine property: brick, clay pipe and refractory plants, ... concrete batch, asphalt batch, and hot mix plants.... OSHA jurisdiction also includes salt and cement distribution terminals not located on mine property....

(emphasis added). Thus, the Secretary made these "jurisdictional determinations" after considering all of the relevant factors thereby eliminating the need to resolve jurisdictional issues at these facilities on a case-by-case basis. All cement plants are to be inspected by MSHA, while cement distribution terminals that are not on mine property and all concrete batch plants are to be inspected by OSHA. I conclude that, as a consequence, further analysis of the processes used within the facilities listed in Paragraph B(6) is both unnecessary and unwarranted.

Appendix A of the Interagency Agreement contains "a list with general definitions of milling processes for which MSHA has authority to regulate..." under the heading "Milling - MSHA Authority." It is noteworthy that this list is specifically made "subject to Paragraph B6 of the Agreement." I interpret that language to mean that the determinations made in Paragraph B(6) take precedence over the provisions of Appendix A.

It is also instructive to note that most facilities are made subject to MSHA jurisdiction under Paragraph B(6)(a) only under certain circumstances. Electrolytic plants, for example, are subject to MSHA jurisdiction only if they are an integral part of mining operations. There are no qualifications for cement plants, however. All cement plants are subject to MSHA jurisdiction no matter what processes are used at the facility or where they are located. Thus, the fact that the Lyons Cement Plant uses all of the materials in its stockpiles of mined rock in the final product does not defeat MSHA jurisdiction. MSHA jurisdiction at cement plants does not depend upon

whether the processes within the plant separate valuable parts of the earth's crust from the worthless parts. Under paragraph B(6)(a) of the Interagency Agreement, the Secretary defined mineral milling to include all activities at cement plants.

It is significant that Dr. Yarar testified that, at some cement plants, waste products must be separated from the valuable limestone to remove contaminants from the final product. (Tr. 336-37). He stated that mineral milling is taking place at these plants. On this basis, Watkins argues that if MSHA exercised jurisdiction over such a cement plant it would "arguably be a proper use of the Secretary's discretion because the plant might ... be viewed as either engaging in a milling process or a manufacturing process." (Watkins Br. 25). This may be one of the distinctions that the Secretary was attempting to avoid when she determined that all cement plants shall be inspected by MSHA. Under Watkins' theory, some cement plants must be inspected by OSHA while others could or should be inspected by MSHA, depending on the purity of the limestone entering the plant. The safety and health hazards at these cement plants would not be any different. I conclude that the fact that some cement plants do engage in "mineral milling," as that term is used by Dr. Yarar, supports the Secretary's position in this case. Although some cement plants do not, in an engineering sense, engage in mineral milling, the Secretary determined that she will exercise her jurisdiction through MSHA rather than OSHA at all cement plants as an administrative convenience. By making this determination in the Interagency Agreement, the Secretary avoids having to analyze each cement plant on a case-by-case basis to determine whether "mineral milling" is occurring at that particular plant at the time of the inspection.

The next issue is whether the Secretary abused her discretion when she determined that all cement plants engage in mineral milling thereby making them subject to MSHA jurisdiction. Watkins argues that the Secretary abuses her discretion when she interprets the Act to allow MSHA to inspect the cement plant in this case because her interpretation contravenes the plain language of the Act and the definitions contained within the Interagency Agreement. Watkins contends that the Secretary has arbitrarily construed the processes at the plant to be mineral milling despite her own definitions and those applied by the mine engineering community. It further states that "[t]o the extent that the [Interagency Agreement] specifically places cement manufacturing under MSHA's jurisdiction, pursuant to the Secretary's ability to define mineral milling, such a determination is unexplained and is therefore inadequate, in addition to being irrational, and not entitled to deference." (Watkins Br. 25). It argues that MSHA cannot impermissibly "bootstrap" itself into an area in which it has no jurisdiction.

I find that the Secretary did not abuse her discretion when she determined that cement plants are to be inspected by MSHA rather than OSHA. The line between the two agencies can be logically drawn in a number of places. In the cement industry, she chose to draw it between cement plants and concrete batch plants. She also chose to include all cement plants under MSHA's jurisdiction not just those that have a milling circuit that separates the constituent parts from waste materials. There has been no showing that the general processes, much less the safety and health hazards, would be any different in cement plants that must separate waste material in the milling circuit as compared to those that do not. The same operations and hazards would be

present in each instance, except that materials would be segregated at some point along the line in the former. Having a different Assistant Secretary conduct safety and health inspections at cement plants that include a circuit that separates waste material from the product stream is illogical.

It is true that there is no information as to how the Secretary came to this determination, other than the fact that cement plants are generally located near limestone quarries. I do not know if most cement plants must separate out waste material or whether the Lyons Cement Plant is more typical. The Secretary did not introduce any evidence on this issue but this is not a crucial question. Congress granted the Secretary broad power to decide what constitutes mineral milling. There is no indication that Congress wanted the Secretary to adhere to a technical engineering definition. Congress stated that "what is considered to be regulated under this Act be given the broadest possible interpretation, and ... that doubts be resolved in favor of inclusion of a facility within the coverage of the Act." (*Legis. Hist.* 602). This language and the final sentence in section 3(h)(1) "gives the Secretary discretion, within reason, to determine what constitutes mineral milling, and thus indicates that [her] determination is to be reviewed with deference both by the Commission and the courts." *Donovan v. Carolina Stalite Co.*, 734 F.2d 1547, 1552 (D.C. Cir. 1984). "In this highly technical area deference to the Secretary's expertise is especially appropriate." *Id.* at n. 9.

A recent court of appeals decision closely parallels the present case. In *In re: Kaiser Aluminum and Chemical Co.*, 214 F.3d 586 (5th Cir. 2000), *petition for cert. filed*, 69 USLW 3366 (Nov. 13, 2000)(No. 00-770), Kaiser challenged MSHA jurisdiction at its alumina plant. The employer argued that the alumina production process used at its plant was not mineral milling. As in the present case, the employer relied upon engineering concepts and Appendix A to the Interagency Agreement in making its arguments. Kaiser argued that, unlike other alumina plants, its facility did not crush or grind the bauxite. Thus, it attempted to distinguish its plant from other alumina plants based on definitions and examples set forth in Appendix A. The court concluded that "the [Interagency] Agreement could not be more clear that '[p]ursuant to the authority in section 3(h)(1) to determine what constitutes mineral milling ... MSHA jurisdiction includes ... alumina and cement plants.' " *Id.* at 592 (footnote omitted). The court concluded that "MSHA's statutory interpretation of milling" was reasonable under the concepts developed in *Chevron v. NRDC*, 467 U.S. 837, 843 (1984). *Id.* at 591. The same logic applies to the facts in this case.

It is also important to note that the Secretary's interpretation has been consistently applied for a lengthy period of time. The Interagency Agreement was first published in the Federal Register in April 1979. MSHA has inspected cement plants throughout the country since that time. Indeed, the Lyons Cement Plant has been inspected by MSHA without challenge since MSHA was created.

Finally, I conclude that Congress's grant of authority to the Secretary to construe the word "milling" is not an unconstitutional delegation of legislative power. Congress may not

delegate its legislative powers to the executive branch. Congress must lay forth an intelligible principle that will guide and direct the executive branch in its delegated tasks. (Watkins Br. 27). Watkins argues that the final sentence in section 3(h)(1) merely delegates to the Secretary the "authority to give jurisdiction to an entire plant to MSHA, even if only part of that plant is engaged in mineral milling." *Id.* at 30. Watkins makes the following argument:

> [The Secretary] interprets the phrase "convenience of administration" to allow MSHA to exercise jurisdiction over the Lyons Plant even though ... the uncontested testimony proves that nowhere in the plant is there any sort of mineral milling process as defined both by the Secretary and by the mining and metallurgical industries. Other than being patently contrary to the plain language of the Mine Act and Congress's intent in passing the Mine Act, ... such an interpretation would force the Mine Act to be read in a manner that is unconstitutional.

Id. at 31. Watkins argues that under the Secretary's interpretation, the phrase "convenience of administration" offers no objective guidance or limitation on the Secretary's power to define milling. Instead, it is "a positive grant of power to the Secretary to extend MSHA's jurisdiction without limit." *Id*. I disagree with Watkins' reasoning.

Cement plants are closely associated with the quarries from which limestone is obtained. For the reasons discussed above, the Secretary's interpretation of the language in section 3(h)(1) to allow her to include all cement plants under MSHA jurisdiction is not unreasonable. The language of that section specifically delegates to the Secretary the power to define mineral milling so as to give one Assistant Secretary "the authority with respect to the health and safety of miners employed at one physical establishment." But, as the D.C. Circuit stated, that language "gives the Secretary guidance concerning *one criterion* to be employed in exercising [her] discretion." *Donovan* at 552 (emphasis added). The Secretary may consider other factors in exercising her discretion to determine what constitutes mineral milling. Her interpretation of her authority under section 3(h)(1) with respect to cement plants is not so far afield as to approach an unconstitutional delegation of legislative powers to the executive branch.

In making this argument, Watkins relies on *Industrial Union Dep't v. American Petroleum Inst.*, 448 U.S. 607 (1980), in which the Supreme Court vacated OSHA's health standard that lowered the exposure limit for benzene. I find that this reliance is misplaced. Under the OSHA statute, a safety or health standard must be "reasonably necessary or appropriate to provide safe or healthful employment and places of employment." 29 U.S.C. § 652(8). The Supreme Court interpreted this requirement to mean that the Secretary, when promulgating a health standard, must determine that the standard is "reasonably necessary and appropriate to remedy a significant risk of material health impairment." *Id.* at 639. It is clear that Congress wanted the Secretary to establish a scientific basis for exposure limits before promulgating health standards under the OSHA statute. It is equally clear that Congress directed the Secretary to take

a practical approach when dividing jurisdiction between OSHA and MSHA. There is no indication that Congress intended that the Secretary be constrained by engineering definitions when determining what constitutes mineral milling. I find that the Secretary established that MSHA had jurisdiction over the work that Watkins was performing at the Lyons Cement Plant.

Based on the foregoing, I find that MSHA had jurisdiction to inspect the Lyons Cement Plant, including Watkins' bag house construction project. All of the other arguments made by Watkins concerning jurisdiction in its brief and reply brief are rejected.

B. Citations and Orders

1. Citation No. 7923622

Citation No. 7923622 alleges a violation of 30 C.F.R. § 56.11012, as follows:

> Contract employees were exposed to a fall hazard at the bag house level, on both ends of the dust collector. The openings were approximately five feet wide and 70 feet from the ground level. The openings were located approximately five feet from the access doors for the east and west bag houses. The openings were also being used by contract employees as a means of accessing the bag house level from a man lift.

MSHA Inspector Richard Laufenberg determined that the violation was of a significant and substantial nature ("S&S") and was a result of Watkins' high negligence. The citation was issued under section 104(d)(1) of the Act. Section 56.11012 provides, in part, that "[o]penings above, below, or near travelways through which persons or materials may fall shall be protected by railings, barriers, or covers." The Secretary proposes a penalty of $2,000 for this alleged violation.

There is no dispute that the cited openings were not protected by railings, barriers, or covers. The issue is whether such protection was required by the standard in this instance. Watkins was constructing a bag house for the plant, which was a separate building within the plant. The building was comprised of two large compartments, which were to contain the collecting bags called "socks." There were openings at each end of this building that were about 70 feet above the ground. The openings were four- to five-feet wide and were used to gain access to the large compartments during construction of the bag house via a man-lift. There were no barriers at these openings. The two openings were connected by what Watkins refers to as a "breezeway" that ran between the two compartments. To enter the compartments, Watkins' employees stepped onto the man-lift at ground level, were lifted to the opening at the north end of the building, exited the man-lift into the breezeway through the opening, traveled a few feet down the breezeway, and entered the compartments via doors along the sides of the breezeway. The floor of this breezeway was the top of a heating duct. This configuration existed only during

construction of the bag house. When completed, metal stairs were attached to the outside of the bag house to provide access to the opening, which was equipped with doors. Flooring was also installed in the breezeway.[1]

The Secretary contends that this breezeway was a travelway that was included within the protections of the standard. Watkins argues that the Secretary failed to establish a violation. First, it argues that the breezeway was still under construction and was not used on a regular basis. In addition, it states that its employees were not walking "on a 'travelway,' but were instead walking on top of a heating duct." (W. Br. 36). Further, Watkins contends that the evidence establishes that workers were required to be tied off at all times while working in the bag house.

Watkins maintains that there was no danger of falling through the opening because it had work procedures in place to protect its employees. The long side of the man-lift basket was required to be placed flat against the wall of the bag house. The employee would then lift the center bar on the basket, crawl under the top bar, and enter the breezeway. The basket more than covered the opening on the bag house. In addition, the employee was required to be tied off at all times. It contends that there was no danger of falling if the proper procedures were used because whenever anyone was in the breezeway the basket of the man-lift acted as a barrier. The fact that the employee was tied off at all times provided additional protection.

As discussed in more detail below, these procedures were not all being used when Jefferson Blaine Davis fell from the opening. The short end of the man-lift basket was positioned adjacent to the opening, leaving a gap to one side. In this instance, Mr. Davis disconnected his safety line from the support structure on the basket before he climbed over the top rail into the breezeway. He lost his footing and fell about 70 feet to the ground.

The issue is whether this opening was required to be protected by railings or barriers. I find that the breezeway was a travelway as that term is used in the safety standard. During the several days that the "socks" were installed in the two compartments of the bag house, workers had to travel through the breezeway to get to their place of work. The fact that the area was under construction or that the floor of the breezeway was the top of a heating duct is irrelevant. I also reject Watkins' argument that the breezeway was not a travelway because workers were traveling through the area for only a few days. I find that while Watkins' employees were installing the socks, the breezeway was a travelway. The Secretary defines "travelway" as "a passage, walk, or way regularly used and designated for persons to go from one place to another." 30 C.F.R. § 56.2. The breezeway fits within this definition. The cited opening was immediately adjacent to this travelway.

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[1] The witnesses at the hearing used different terms for the breezeway. For consistency, I use the term "breezeway" throughout this decision .

The next issue is whether "persons or materials" could reasonably be expected to fall through the opening. The Commission and the courts have uniformly held that mine operators are strictly liable for violations of safety and health standards. *See, e.g. Asarco v. FMSHRC,* 868 F.2d 1195 (10th Cir. 1989). "[W]hen a violation of a mandatory safety standard occurs in a mine, the operator is automatically assessed a civil penalty." *Id.* at 1197. In addition, the Secretary is not required to prove that a violation creates a safety hazard, unless the safety standard so provides.

> The [Mine Act] imposes no general requirement that a violation of MSHA regulations be found to create a safety hazard in order for a valid citation to issue. If conditions existed which violated the regulations, citations [are] proper.

Allied Products, Inc., 666 F.2d 890, 892-93 (5th Cir. 1982)(footnote omitted). The negligence of the operator and the degree of the hazard created by the violation are taken into consideration in assessing a civil penalty under section 110(i). 30 U.S.C. § 820(i). I believe, however, that this safety standard requires the Secretary to establish that the cited condition created a safety hazard.

I find that a safety hazard was created by the cited condition. First, even if the proper procedures for entering and exiting the bag house were followed, there is a chance that a person or materials could fall. For example, if a worker were trying to get down from the area, he might get too close to the edge of the breezeway before the lift basket was in place. Even if he were hooked up to a safety line, he could be injured by the short fall. More importantly, a worker could make errors of judgment when entering and exiting the breezeway. This safety standard is, in large measure, designed to protect against such errors of judgment. As the Commission stated, "[e]ven a skilled employee may suffer a lapse of attentiveness, either from fatigue or environmental distractions...." *Great Western Electric Co.*, 5 FMSHRC 840, 842 (May 1983).

The condition was abated by attaching angle iron to the edges of the opening to provide a partial barrier and then attaching chains across the remaining opening. (Ex. P-6). Although no method of abatement would be foolproof, this barrier provided significant protection against falls. The fact that the chains would have to be removed when workers were entering and exiting the breezeway is not a defense.

Inspector Laufenberg determined that the violation was very serious and S&S. An S&S violation is described in section 104(d)(1) of the Mine Act as a violation "of such nature as could significantly and substantially contribute to the cause and effect of a ... 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." *National Gypsum Co.*, 3 FMSHRC 822, 825 (April 1981). In *Mathies Coal Co.*, 6 FMSHRC 1, 3-4 (January 1984), the Commission set out a four-part test for analyzing S&S issues. Evaluation of the criteria is made assuming "continued normal mining operations." *U.S. Steel Mining Co.*, 6 FMSHRC 1573, 1574 (July 1984). The

question of whether a particular violation is S&S must be based on the particular facts surrounding the violation. *Texasgulf, Inc*., 10 FMSHRC 498 (April 1988).

The Secretary must establish: (1) the underlying violation of the safety standard; (2) a discrete safety hazard, 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. The Secretary is not required to show that it is more probable than not that an injury will result from the violation. *U.S. Steel Mining Co.*, 18 FMSHRC 862, 865 (June 1996).

Inspector Laufenberg based his S&S determination on the fact that, unless the long side of the basket of the lift were present, there was nothing to prevent a worker from falling from the opening. He believed that the metal braces across the top of the air duct presented a tripping hazard to employees walking between the doors to the bag house compartments and the cited breezeway openings. (Tr. 195). It had been snowing and raining during January 1999 and light snow had accumulated in the breezeway. (Tr. 195; Ex. P-6). He was also concerned about the number of times employees entered and exited the area, as well as the sheer 70-foot drop to the concrete below.

I find that the Secretary established that this violation was S&S. A discrete safety hazard was contributed to by the violation. There was also a reasonable likelihood that the hazard contributed to would result in an injury. The cited openings were the only means of access to the bag house compartments. Watkins' employees were installing the socks in the bag house compartments. The testimony establishes that workers were entering and exiting the bag house via the man-lift about eight times a day. They would enter the bag house at the beginning of the day, exit during breaks, and exit for lunch. Two or more employees were working in the bag house during this period. Except during those brief periods that the basket for the lift was present, there was no protection whatsoever. The presence of snow and the braces on top of the air duct increased the tripping and slipping hazard.

I also find that it was reasonably likely that an injury would be of a reasonably serious nature. The fact that employees were required to wear safety lines when entering and exiting the opening lessened the risk of a fatal injury, but the risk of a serious injury remained. If a worker were to fall out of the opening while wearing a safety line, he could sustain serious injuries.

Inspector Laufenberg also determined that the violation was caused by Watkins' unwarrantable failure to comply with the safety standard. He believed that Watkins exhibited high negligence because the violation was obvious; the condition existed for a period of time; the opening was 70 feet above the ground; and employees had to enter and exit the breezeway frequently each day. (Tr. 196).

Unwarrantable failure is aggravated conduct constituting more than ordinary negligence. *Emery Mining Corp.*, 9 FMSHRC 1997, 2004 (December 1987). 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, 193-94 (February 1991). The Commission stated 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 violation, 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 and Sons Coal Co., Inc.*, 16 FMSHRC 192, 195 (February 1994)(citation omitted).

I find that Watkins' failure to protect the openings at the bag house with railings or barriers constituted an unwarrantable failure to comply with the safety standard. I agree with the inspector that the violation was obvious. Employees walked along the breezeway to get to their place of work in the bag house and, in doing so, they traveled close to and through this opening. Anyone working at or around the bag house could see the openings, including Watkins' management. The condition had existed for a number of days. Prior to using the man-lift, employees were entering the breezeway via a ladder on the south side of the bag house. This practice was halted by Watkins management because of the hazards presented by snow and wind. Throughout this period, workers traveled in proximity to the two openings. The height of the openings above the ground and the fact that employees had to travel through the area more than a few times a day also demonstrate Watkins' high negligence.

For the reasons set forth above, this citation is **AFFIRMED**. Taking into consideration the penalty criteria in section 110(i) of the Act, I assess a penalty of $2,000 for this violation.

2. Order No. 7923623

Order No. 7923623 alleges a violation of 30 C.F.R. § 56.14205. After briefs were filed, the Secretary moved to vacate this order because she "concluded that the evidence is insufficient to support a violation of the standard." Watkins does not oppose the motion. For good cause shown, the motion is granted and this order is **VACATED**.

3. Order No. 7923625

Order No. 7923625 alleges a violation of 30 C.F.R. § 56.11001, as follows:

> A non-fatal, serious accident occurred at the mine site on 01/21/99 at approximately 3:30 pm when a contract laborer fell while climbing out of a man lift basket he had been riding in. The laborer fell approximately 70 feet, landing on a concrete pad. He unhooked his lanyard, used the railings of the basket to climb out, slipped, lost his grip and fell. The contract operator's failure to ensure that a safe means of access was provided and being used by their employees is an unwarrantable failure to comply with a mandatory standard.

MSHA Inspector Laufenberg determined that the violation was S&S and was a result of Watkins' high negligence. The order was issued under section 104(d)(1) of the Act. Section 56.11001 provides that "[s]afe means of access shall be provided and maintained to all working places." The Secretary proposes a penalty of $50,000 for this alleged violation.

Ordinarily, employees would enter and exit the breezeway via a staircase from the ground. At the time of the accident, this staircase had been partially constructed but it had not been installed on the south side of the building. (Tr. 244). Until about three days before the accident, Watkins' employees entered and exited the breezeway via a ladder at the south end of the bag house. The opening to the breezeway at the south end was also very high off the ground. Because of the snowy conditions and wind, Watkins' management determined that using a ladder to access the bag house breezeway presented safety hazards. Insulation panels were being installed on the outside of the bag house building at this time by a subcontractor, Mountain States Engineering ("Mountain States"). Mountain States had leased the Snorkel man-lift in question for use in installing the insulation panels. Watson made arrangement with Mountain States to use this man-lift to transport Watkins' employees to the opening in the bag house building.

During the accident investigation, Inspector Laufenberg testified that Walter J. Brannan, foreman for Mountain States, advised him that Anthony Perez, a sheet-metal worker for Mountain States, was the individual who operated the man-lift for Mountain States. (Tr. 185; Ex. P-8, p. 23-24). Laufenberg also testified that Brannon told him that it was his understanding that Perez would operate the lift whenever a Watkins employee needed to be taken up to the breezeway. *Id.* Perez was advised to place the long end of the man-lift basket against the building whenever anyone was transported to or from the breezeway. *Id.*

Mr. Perez told Inspector Laufenberg that he was instructed by Mr. Brannon to take only one Watkins employee up at a time and to always place the long end of the man-lift basket against the bag house. (Ex. P-8, p. 24). Perez also told Laufenberg that he was instructed to make sure that the Watkins employee was tied off in the basket and that the employee exited the basket by lifting the middle railing rather than climbing over the railing. *Id.* Perez told Laufenberg that he always followed this procedure.

During his investigation, Inspector Laufenberg also interviewed Jeffery Bochette, the general foreman for Watkins. Bochette told him that he never discussed with Watkins' employees the proper procedure for getting to and from the breezeway via the man-lift. (Tr. 185; Ex. P-8, p. 26). He also told the inspector that he was not aware that Jeremy Boyette, an hourly employee for Watkins, was operating the lift to get employees in and out of the bag house. (Ex. P-8, p. 25).

Mr. Boyette told Laufenberg that he operated the man-lift about 10 to 15 times. (Ex. P-8, p. 14-15). He also told Inspector Laufenberg that he never saw anyone place the long end of the lift basket against the bag house when transporting employees to the breezeway. *Id.* Boyette had operated man-lifts at other job sites, but he was not given any specific instructions on how to transport employees up to the breezeway. (Ex. P-8, p. 4-5).

The basket on the man-lift is about 7.5 feet long and 2 feet 2 inches wide. The basket is equipped with a 5- to 6-inch kick plate, a middle rail and a top rail. (Tr. 162-63; Ex. P-5, p. 5). The top rail is about 3.5 feet above the floor of the basket. (Ex. P-8, p. 3). The controls for the lift are at the back of the basket adjacent to where the basket is connected to the boom. The rails along the front of the basket, opposite the controls, are supported by four posts, one at each corner and two in the middle. Thus, the front railing is divided into thirds. The middle third of the middle rail slides up to the top rail. Apparently, both Mountain States and Watkins agreed, prior to the use of the lift to transport employees to the breezeway, that the proper way to enter and exit the basket at the breezeway is to lift the middle rail and crouch under the top rail. In order to enter and exit the basket in that manner, the long end of the basket must be positioned against the bag house building.

On January 21, 1999, Mr. Davis was assigned to work inside the bag house compartments. Mr. Davis testified that he had been working in the bag house installing the socks in the days prior to the accident. He said that he entered the breezeway eight to ten times a day during that period. (Tr. 100). Davis said that a Hispanic gentleman with the insulation contractor operated the lift most of the time and that Jeremy Boyette operated it other times. (Tr. 101-02). Davis testified that at the time of the accident, Boyette was operating the lift and that there was a third person on the lift as well. In addition, he testified that there were about four panels of insulation on the lift. (Tr. 110). During his investigation, Inspector Laufenberg measured these insulation panels. Each panel was about 22 inches wide, 48 inches high, and 4 inches thick, and weighed between 19 and 20 pounds. (Tr. 163; Ex. P-8, p. 5).[2]

Davis testified that every time he was taken up to the breezeway in the lift, the lift basket was positioned so that the short end was up against the opening to the breezeway. (Tr. 103). The operator of the lift would attempt to place the floor of the lift basket even with the bottom of the breezeway. To exit the basket, he climbed over the top rail on the short end of the basket and stepped into the breezeway. (Tr. 106). The middle rail does not lift on the short ends of the basket. He also stated that he was always protected by his safety belt and line when he followed this procedure. He did not unhook his lanyard from the railing of the basket until he was in the breezeway. The opening to the breezeway was about five feet wide and the short end of the basket was about two feet two inches wide. Consequently, the opening for the breezeway was almost three feet wider than the end of the basket.

Davis testified that at the time of the accident the basket was on the right (west) side of the opening so that the three foot "gap" was on the left (east) side of the basket. (Tr. 112-13). Davis testified that when Boyette took him up to the breezeway at the time of the accident, there were four insulation panels on the end of the basket that he had to climb out of. Davis further testified that he did not attempt to move the insulation panels, but used his arms to pull himself up on top of the insulation panels using the top rails for support. He sat on top of the panels with his

[2] The photographs at Exhibits P-5 and P-6 generally depict the configuration of the breezeway, the man-lift basket, and the insulation panels.

feet facing the building. He then began pushing himself across the top of the insulation panels towards the building. At this point, he was above the height of the top rail on the basket. (Ex. P-5, p. 5). When he reached the top rail of the end of the basket next to the building, he placed one foot on the middle rail. (Tr. 112) He testified that he had to unhook his safety line from the railing of the basket at this point because that was "as far as I can go." (Tr. 112). He implied that the safety line was not long enough for him to enter the breezeway while it was still connected to the railing of the basket. (Tr. 112, 139). He did not attempt to retie the lanyard to the rail that he was sitting on. He testified that he did not do so because he was going to tie off on the "structure," meaning the bag house building. (Tr. 139). There were several metal components on the bag house at the entrance of the breezeway that can be used. (Ex. P-6, p. 1).

As Davis was sitting on the top rail with one foot on the middle rail, he placed the other foot on the entrance to the breezeway. Davis testified that his forward foot slipped, he fell backwards, hit the left corner of the basket, and fell through the three-foot gap between the left corner of the basket and the left side of the opening to the breezeway. (Tr. 112). He fell approximately 70 feet to a concrete pad below.

Inspector Laufenberg testified that he issued this order because he believed that Watkins had not provided a safe means of access for its employees to enter the bag house compartments. (Tr. 186). He stated that he issued the order because the short end of the man-lift basket was being positioned against the opening to the breezeway and Watkins' employees were climbing over the top rail of the basket to enter the breezeway. (Tr. 186-87). He believed that this means of access was unsafe, even if employees were tied off at all times. A safety belt and line do not provide fall protection, they just keep a worker from falling all the way to the ground. *Id.* An employee falling from the breezeway while tied off would still be likely to sustain injuries as a result of the fall. (Tr. 187-88).

Inspector Laufenberg also testified that it was highly likely that someone would be seriously injured as a result of this condition. (Tr. 189). Finally, he testified that he determined that Watkins was highly negligent for allowing its employees to enter and exit the short end of the basket over the top rail and that the violation was caused by its unwarrantable failure to comply with the safety standard. (Tr. 189-90, 217-18).

Watkins maintains that it did not violate the safety standard because it established a safe means of access. Whenever an employee needed to go up to the bag house compartments, he was to get into the lift basket with Mr. Perez, who would operate the lift. Mr. Perez would position the basket so that the long side was against the building. The Watkins employee would remain tied off at all times. At the top, the employee would raise the center bar of the middle handrail of the basket and crawl under the top handrail. Once the employee was out of the basket, Mr. Perez would unhook the employee's lanyard and the employee would attach it to a structure within the building. Because the lift basket would remain in place until the employee entered the door to one of the bag house compartments, there was no danger of anyone falling. The opening to the

breezeway would remain completely protected at all times. Watkins argues that the Secretary presented no evidence that this means of entering and exiting the breezeway was unsafe.

In addition, Watkins contends that Mr. Davis's testimony as to the events of the day of the accident should not be credited. It notes that he has a civil action pending against Watkins in California over this accident. It also notes that Davis is a convicted felon. Watkins raises several factual discrepancies in Mr. Davis's testimony. For example, Davis testified that it would have not been possible to move the insulation panels to the other side of the basket. Boyette, the basket operator, told Inspector Laufenberg that he was starting to move the panels when, without warning, Davis climbed on top of them. In addition, Mr. Bartholomew testified that the safety line on the safety belt that the company provided Davis is six feet long. Watkins maintains that Davis's testimony that he was restrained by his safety line and was forced to unhook it to exit the basket is contrary to the facts.

Another factual inconsistency relates to the statement of an eyewitness to the accident. Donald Busbee, a Watkins hourly employee, saw the accident from the ground. He told Inspector Laufenberg that Davis was standing, not sitting, on the top rail of the basket when he fell. Busbee told Laufenberg that Davis's hands were holding a flange above the breezeway opening at the time of the accident. (Ex. P-8, p. 8 & 17). There was also conflicting evidence as to the number of people in the basket. Finally, Watkins objects to the Secretary's attempt to establish that the base of the lift was located in a position where it would have been impossible to place the long end of the basket against the bag house building at the breezeway. It contends it would have been easy for Mr. Boyette to move the base of the lift in any event.

Watkins argues that the Secretary bases her case, not on any failure by Watkins to *provide* a safe means of access, but because an alleged unsafe method was *used* at the time of the accident. It contends that every possible means of access need not be made safe, only those that are reasonably possible. *Hanna Mining Co.*, 3 FMSHRC 2045, 2046-47 (September 1981). The Secretary failed to show that Mr. Davis's means of entering the bag house was reasonably foreseeable by Watkins. Mr. Bartholomew testified that he had never seen anyone access the bag house by positioning the short end of the basket against the building (Tr. 246, 286-87). It also argues that Mr. Davis knew the correct way to use the man-lift to access the bag house building and that he knew he was required to be tied off at all times. In addition, even if it was foreseeable that an employee might climb over the top rail, there is no persuasive evidence that he would be injured if he were using his safety line.

I find that the Secretary established a violation. The evidence establishes that Watkins' employees regularly entered the breezeway by climbing over the top rail at the short end of the basket. The testimony of Mr. Davis and the statements of several Watkins' employees support this finding. Both Mr. Boyette and Mr. Busbee told Inspector Laufenberg that they had never seen anyone place the long side of the lift basket against the building. Busbee said that he rode in the lift about 10 times and Boyette said he operated the lift 10 to 15 times.

Two individuals stated that the long end of the basket was placed against the building on a regular basis. Mr. Perez told Inspector Laufenberg that every time he took a Watkins employee up to the breezeway, he followed the proper procedure. (Ex. P-8, p. 24-25). He also said that he took Mr. Bartholomew up several times on the days preceding the accident by placing the long end of the basket against the bag house building. He told Laufenberg that he did not take Bartholomew up on the day of the accident. He also stated that he was not present when anyone else operated the man-lift. *Id.*

Mr. Bartholomew testified that he had never observed anyone enter or exit the breezeway via the short end of the basket of the lift. (Tr. 246, 288). He stated that if he had seen anyone doing that, he would have counseled them about the proper procedure. Bartholomew also testified that he was rarely at the north end of the bag house building, but he did observe the basket being positioned correctly several times. (Tr. 238-39, 247, 287-88). He also stated that Mr. Perez took him up to the breezeway prior to the accident on that same day. (Tr. 274, 285-86). When Mr. Bartholomew heard about the accident, he left his office trailer at the south end of the bag house building and walked to the north end. (Tr. 245). He observed that the short end of the man-lift basket was adjacent to the building. (Tr. 290).

The Secretary established that Watkins' employees were regularly transported to the breezeway in the manner described by Mr. Davis. The short end of the basket was placed against the building at the breezeway and employees climbed over the top rail into the breezeway. The hearsay evidence presented through Inspector Laufenberg shows that Boyette used this procedure on a regular basis and that he had not been trained or advised to follow any other procedure. Hearsay evidence is admissible in Commission proceedings as long as it is relevant. 29 C.F.R. § 2700.63. The testimony and notes of Inspector Laufenberg with respect to this issue corroborate the testimony of Mr. Davis. I credit Inspector Laufenberg's testimony.

Mr. Bartholomew was not in a position to know how Watkins' employees were getting out of the basket at the breezeway. His office trailer was at the opposite (south) end of the bag house building and he rarely was at the north end. Thus, his testimony does not rebut the testimony of Mr. Davis and Inspector Laufenberg that employees were required, on a frequent basis, to exit the basket by climbing over the top rail at the short end. Although there was a safe means of access to the breezeway, as set forth by Mr. Bartholomew, it is clear that the cited, unsafe method was used on a regular basis.

The Commission's decision in *Hanna Mining Co.* does not support Watkins' position in this case. In that case, the Commission reasoned:

> We agree with the Secretary and the judge that the standard requires that each "means of access" to a working place be safe. This does not mean necessarily that an operator must assure that every conceivable route to the working place, no matter how circuitous or improbable, be safe. For example, an operator could

> show that a cited area is not a "means of access" within the meaning of the standard, by proving that there is no reasonable possibility that a miner would use the route as a means of reaching or leaving a workplace.

3 FMSHRC at 2046. In the present case, the evidence shows that Boyette, a Watkins employee, was regularly taking employees to the breezeway via the unsafe route. Boyette's conduct was neither unforeseeable nor improbable. Mr. Bochette, Watkins' general foreman, told Inspector Laufenberg that he had not been in the bag house since the ladder was taken away and that he never saw anyone operate the man-lift. (Ex. P-8, p. 25). Bochette and Mr. Brannan of Mountain States established a safe procedure to be used when using the man-lift, but Bochette told Laufenberg that he never discussed these procedures with Watkins' employees. *Id.* at 23 & 26. Bochette apparently assumed that only Mr. Perez would be operating the lift because he told Laufenberg that he did not even know that Boyette was operating the lift. The standard requires employers to provide and maintain a safe means of access to all working places. This responsibility is not met by establishing a safe procedure and then failing to advise the affected employees of the procedure and failing to take any steps to see that the safe procedure is being implemented.

One of Mr. Davis's legs was amputated as a result of this accident and he has a civil suit against Watkins pending in California, his home state. (Tr. 121-22, 129). Mr. Davis admitted that, when he was younger, he was convicted of stealing "a car and stuff like that." (Tr. 122). His testimony about the issues before me is consistent with the statements that other employees gave to Inspector Laufenberg. Most of the inconsistencies referred to by Watkins are not relevant in this proceeding and I make no attempt to resolve them. Such inconsistencies include whether Davis was standing or sitting when he fell, the number of people in the basket at the time of the accident, and whether there were physical impediments to placing the long side of the basket against the building.

I also find that the violation was serious and S&S. It was very hazardous for Mr. Davis and other Watkins employees to climb over the top rail of the short end of the basket to enter the breezeway. An employee could slip and fall as Mr. Davis did and, because there was a three-foot opening that was not covered by the basket, it was reasonably likely that he would be seriously injured. (Tr. 187-89). The fact that employees used safety lines when entering the breezeway does not alter this finding. A serious injury was reasonably likely to employees using safety lines.

Finally, I find that the violation was the result of Watkins' unwarrantable failure to comply with the safety standard. Management did very little to make sure that employees were accessing the breezeway in a safe manner. Management knew that to provide safe access, the long end of the basket had to be positioned against the building at the breezeway. Yet, this fact was not communicated to the employees. The safe procedure was frequently not followed. Thus, there was no follow-through by management to make sure that safe access was being provided. I do not believe that Watkins exhibited "reckless disregard"or "indifference" with respect to the

requirement of safety standard or that the violation was the result of its "intentional misconduct." Rather, the violation was the result of its "serious lack of reasonable care." Watkins removed the ladder from the south end of the bag house building because management believed that it did not provide safe access, but it failed to take steps to make sure that the man-lift, as used by its employees, provided safe access.

For the reasons set forth above this order is **AFFIRMED**. Taking into consideration the penalty criteria in section 110(i) of the Act, I assess a penalty of $40,000 for this violation.

4. Citation No. 7923626

Citation No. 7923626 alleges a violation of 30 C.F.R. § 56.15005, as follows:

> A non-fatal, serious accident occurred at the mine site on 01/21/99 at approximately 3:30 pm when a contract laborer fell while climbing out of the basket of a man lift he had been riding in. The laborer fell approximately 70 feet, landing on a concrete pad. Safety belts and lines shall be worn when persons work where there is a danger of falling. The laborer was wearing a safety harness and line at the time of the accident. The line was not tied off during the transfer from the man lift to the work site landing.

MSHA Inspector Laufenberg determined that the violation was S&S and was a result of Watkins' moderate negligence. The citation was issued under section 104(a) of the Act. Section 56.15005 provides, in part, that "[s]afety belts and lines shall be worn when persons work where there is a danger of falling...." The Secretary proposes a penalty of $35,000 for this alleged violation.

There is no dispute that Mr. Davis was wearing a safety belt and line when he fell from the man-lift. It is also undisputed that he unhooked his safety line before he attempted to get out of the basket. It is clear under Commission precedent that this safety standard is violated if the employee is wearing a safety belt and line but the line is not properly attached. *See Mar-Land Contractor, Inc.*, 14 FMSHRC 754, 756-58 (May 1992). As stated above, employers subject to the Act are strictly liable for violations of safety standards. Accordingly, a violation was established.

I also find that the violation was S&S. Climbing out of the short end of the man-lift basket 70 feet above the ground without a secured safety line created a reasonable likelihood that the hazard contributed to by the violation would result in an injury of a reasonably serious nature. The three-foot gap resulting from the fact that the breezeway was wider than the basket created a serious falling hazard.

I find, however, that Watkins was not negligent with respect to this violation. The hazard was created because Mr. Davis, on his own initiative, disconnected his safety line before he attempted to get off the basket. Mr. Davis testified that he had no choice but to disconnect his line because he became stuck on the top bar at the end of the basket. (Tr. 110). He stated that his safety line "kept him from going any further." (Tr. 111-12). Mr. Bartholomew testified that the safety lines in use at the plant were about six feet long. I credit Mr. Bartholomew's testimony in this regard. Mr. Davis stated that he tied off on an upright support near the middle of the basket. (Tr. 127). The basket was about 7.5 feet long, so he would have been less than four feet from the position of his tie-off as he was sitting on top of the insulation. Moreover, Mr. Davis gave no reason for not retying his safety line to a railing or upright closer to the end of the basket before he attempted to climb up on the panels. (Tr. 139). He could have done so. (Tr. 241-42). I credit the testimony of Mr. Bartholomew over that of Mr. Davis on these issues.

More importantly, I find that Mr. Davis's method of dismounting from the basket was idiosyncratic and unforeseeable to his employer. As stated above, Davis climbed up on top of the insulation panels, placing himself above the plain of the upper rails of the basket, unhooked his safety line, and attempted to step into the opening of the breezeway. Mr. Boyette, the man-lift operator, told Inspector Laufenberg that he was in the process of moving the insulation panels when Davis climbed up on top of them. (Tr. 214; Ex. P-8, p. 15). Mr. Davis claimed that there was no room in the basket to move the panels. Even if I credit this testimony, he could have insisted that they be moved before he entered the basket, or he could have asked that the basket be taken back down to move them. Davis was well aware of Watkins' safety rule requiring that each employee be tied off whenever anyone was six feet or more off the ground. (Tr. 138). I credit the testimony of Mr. Bartholomew concerning Watkins' training program on that rule. Watkins regularly trained employees to follow this rule at all times. Davis was reminded of this rule when he started working in Colorado and he also knew of this requirement from his previous experience and training with Watkins on other projects in California. (Tr. 235-37).

I reject the Secretary's arguments on this issue. She contends that the evidence establishes that Watkins was lax on the enforcement of this standard, relying upon the fact that it was cited for violating this standard on two previous occasions. (Ex. P-1). She also relies upon the fact that Davis did not attend the safety meeting that was held on January 4, 1999, at which the 100% tie-off rule was discussed. Davis apparently missed the safety meeting because it was his first day on the job at the plant. These facts do not establish that the company was lax in enforcing its tie off rule, at least on this job.

I find that Watkins could not have anticipated that an employee would climb up on the insulation panels, unhook his safety line, and then step or jump into the breezeway without any fall protection. I credit the testimony of Bartholomew that, up until the time of the accident, Davis had a good record of tying off and following job rules. (Tr. 238). Davis testified that in all previous trips up to the breezeway in the basket he had remained tied off the entire time. (Tr. 109-10). Based on the foregoing and the fact that Davis's conduct was quite idiosyncratic and unforeseeable, I find that Watkins was not negligent with respect to this violation. Consequently,

I vacate Inspector Laufenberg's moderate negligence determination. For the reasons set forth above, this citation is **AFFIRMED**, as modified. Taking into consideration the penalty criteria in section 110(i) of the Act, I assess a penalty of $500 for this violation.

II. APPROPRIATE CIVIL PENALTIES

Section 110(i) of the Act sets out six criteria to be considered in assessing appropriate penalties. Watkins performs construction work nationwide and it was issued 32 MSHA citations during the two years prior to this accident. (Ex. P-1). Watkins has about 2,800 employees nationwide and, in 1998, its employees worked about 6.8 million hours. (Tr. 4-5). Watkins demonstrated good faith in abating the citations and orders. *Id.* The penalties assessed in this decision will not have an adverse effect on Watkins' ability to continue in business. My findings with regard to gravity and negligence are set forth above. Based on the penalty criteria, I find that the penalties set forth below are appropriate.

III. ORDER

Based on the criteria in section 110(i) of the Mine Act, 30 U.S.C. § 820(i), I assess the following civil penalties:

Citation/ Order No.	30 C.F.R. §	Penalty
7923622	56.11012	$2,000.00
7923623	56.14205	Vacated
7923625	56.11001	40,000.00
7923626	56.15005	500.00

Accordingly, the citations and orders at issue in these cases are **VACATED**, **AFFIRMED**, or **MODIFIED** as set forth above, and Watkins Engineers and Constructors is **ORDERED TO PAY** the Secretary of Labor the sum of $42,500.00 within 40 days of the date of this decision. Upon payment of the penalty, these proceedings are **DISMISSED**.

Richard W. Manning
Administrative Law Judge

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