

FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

OFFICE OF ADMINISTRATIVE LAW JUDGES
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January 25, 2008

MCELROY COAL COMPANY, Contestant	:	CONTEST PROCEEDING
	:	
	:	Docket No. WEVA 2005-243-R
	:	Order No. 7124782; 08/11/2005
	:	
v.	:	
	:	
SECRETARY OF LABOR, MINE SAFETY AND HEALTH ADMINISTRATION (MSHA), Respondent	:	McElroy Mine Mine ID 46-01437
	:	
SECRETARY OF LABOR, MINE SAFETY AND HEALTH ADMINISTRATION (MSHA), Petitioner	:	CIVIL PENALTY PROCEEDING
	:	
	:	Docket No. WEVA 2006-465
	:	A.C. No. 46-01437-85760
	:	
v.	:	
	:	
MCELROY COAL COMPANY, Respondent	:	McElroy Mine

DECISION

Appearances: Joanne Jarquin, Esq., Office of the Solicitor, U.S. Department of Labor, Philadelphia, Pennsylvania, on behalf of the Secretary of Labor; Rebecca J. Oblak, Esq., Bowles Rice McDavid Graff and Love, LLP, Morgantown, West Virginia, on behalf of McElroy Coal Company.

Before: Judge Zielinski

These cases are before me on a Notice of Contest, filed by McElroy Coal Company (“McElroy”), and a Petition for Assessment of Civil Penalties filed by the Secretary of Labor (“Secretary”), pursuant to section 105 of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 815 (“Act”). The petition, which includes the contested order, alleges that McElroy is liable for four significant and substantial and unwarrantable failure violations of the Secretary’s Mandatory Safety Standards for Underground Coal Mines, and for Surface Areas of Underground Coal Mines, and proposes the imposition of civil penalties totaling \$23,300.00. A hearing was held in Wheeling, West Virginia, and the parties filed briefs after receipt of the

transcript.¹ For the reasons set forth below, I find that McElroy committed the violations, but that two of them were not unwarrantable failures, and impose civil penalties totaling \$18,400.00.

Findings of Fact - Conclusions of Law

McElroy operates an underground coal mine and surface preparation plant located in Marshall County, West Virginia. The alleged violations at issue in these proceedings arose out of inspections conducted by the Secretary's Mine Safety and Health Administration ("MSHA") on December 1 and 22, 2004, February 23, 2005, and August 30, 2005.

Order No. 7123909

Order No. 7123909 was issued on December 1, 2004, by MSHA inspector James C. Preece, and alleges a violation of 30 C.F.R. § 75.360(f), or in the alternative § 75.360(a)(1),² which provide, in pertinent part:

(a)(1) [A] certified person designated by the operator must make a preshift examination within 3 hours preceding the beginning of any 8-hour interval during which any person is scheduled to work or travel underground. . . .

¹ The record consists of the transcript of the hearing testimony, the exhibits admitted into evidence at the hearing, excerpts of deposition transcripts that were submitted after the hearing, and final stipulations submitted by letter dated August 7, 2007. The Secretary's deposition excerpts, exhibits G-21 through G-28, and G-33, were submitted on June 29, 2007. McElroy's deposition excerpts, exhibits R-3 (Preece) and R-16 (Yudaz), were submitted, untimely, on July 9, 2007, and were re-submitted on July 18, 2007, along with a motion to allow late-filing. Although it was noted that the Secretary was opposed to the motion, no opposition was submitted. The motion is granted, and McElroy's deposition excerpts are admitted as part of the record. The Secretary's counter designations were submitted on July 13, 2007, and are also admitted.

² The Order, as issued, cited a violation of section 75.360(f). Prior to the hearing, the Secretary moved to amend the Order to include, in the alternative, that the conditions found by Preece constituted a violation of section 75.360(a)(1). Respondent opposed the motion, arguing that it raised potential new issues, specifically, whether a preshift examination had actually been conducted, whether the examiner had the appropriate qualifications, and whether the examination was done timely. The Secretary stipulated that no such issues were being raised, and argued that the facts stated in the Order, i.e., that "mine examiners . . . fail[ed] to identify and correct [or record] hazardous conditions," had been found to have been in violation of both regulatory provisions. On the basis of the Secretary's stipulation and argument, the motion to amend was granted. Tr. 16-21.

(f) *Recordkeeping.* A record of the results of each preshift examination, including a record of hazardous conditions and their locations found by the examiner during such examination and the results and locations of air and methane measurements, shall be made on the surface before any persons, other than certified persons conducting examinations required by this subpart, enter any underground area of the mine. . . .

Preece was conducting a regular inspection of the McElroy Mine. He found several hazardous conditions in the area of the head roller in by the take-up pulley of the No. 10 conveyor belt, and issued citations for the conditions charging that they violated various safety standards. The hazardous conditions had not been reported on the record of the results of the preshift examination that had been performed before the start of the shift. Ex. G-19. Preece believed that the conditions existed at the time the preshift examination had been conducted, and should have been identified and recorded on the report of the preshift examination.

He determined that it was reasonably likely that the violation would result in an injury involving lost work days or restricted duty, that the violation was not significant and substantial, that one employee was affected, and that the operator's negligence was high. The Order was issued pursuant to section 104(d)(2) of the Act, and alleges that the violation was the result of McElroy's unwarrantable failure to comply with the standard.³ A civil penalty in the amount of \$4,800.00 has been proposed for this violation.

The Violation

The preshift examination for the 8:00 a.m. to 4:00 p.m. shift on December 1, 2004, was conducted by Bruce M. Kinser, a certified preshift examiner, from 5:36 a.m. to 7:43 a.m., and was called to the surface at 7:45 a.m. Ex. G-19. The only hazardous conditions or violations recorded for the No. 10 belt were a rib roll at location "44-1/2 s/s" and an area that needed to be rock dusted from "16 to 26." Ex. G-19. Preece inspected the No. 10 belt drive between 10:00 and 11:00 a.m. In the area of the first three crosscuts traversed by the belt, which he referred to as "10-0 to 10-2," he found what he believed to be violations of safety standards for which he issued citations.⁴ The area is traveled by preshift examiners three times a day. A belt attendant works in the area one shift per day, and a belt examiner travels the area once per day. Tr. 616-18.

³ The parties stipulated that there was no intervening "clean inspection" between the time of the issuance of the orders at issue in this proceeding and the previous section 104(d)(1) order issued on January 9, 2004.

⁴ When it was explained that there is no section of the belt designated 10-0, Preece clarified that it was the first three crosscuts. Tr. 539. The area was considerably removed from the areas where problems had been noted on the preshift report.

The guarding on the “solid side” of the take-up unit consisted of five-by-five-foot metal frames to which metal, chain link fence-like, material had been welded. The guard panels were about six inches away from the moving belt and take-up rollers, and two feet away from the rib. Corrosion and general wear and tear had resulted in two “holes” in the guarding, one was three-by-five feet and the other was two-by-three feet. The preshift examiner had traveled that side of the belt. A card attached to the guard close to the location of the holes bore his initials and a time of 6:59 a.m. Tr. 373. The guarding material had dust on it, and it could be pushed in to touch the belt. Tr. 366. Preece issued Citation No. 7123907, alleging a significant and substantial violation of the applicable guarding standard. Ex. G-8. A civil penalty was subsequently assessed for the violation, and was paid by Respondent. Upon payment, the violation became a final order of the Commission and the “assertion of violation contained in the citation is regarded as true.” *Old Ben Coal Co.*, 7 FMSHRC 205, 209 (Feb. 1985).

Preece found deposits of coal dust, including float coal dust, around the belt drive from the head roller to the end of the take-up unit. An area extending 200 to 300 feet was black in color. There were trash bags, trash and other miscellaneous items throughout the area. Tr. 359. Two of four water sprays used by Respondent to control dust were not working.⁵ He issued Citation No. 7123905, charging a significant and substantial violation for the combustible accumulations. Ex. G-6. Respondent paid the civil penalty that was assessed for that violation.

Preece also observed that the fifth roller from the end of the top, track-side, of the take-up unit was hot and throwing off sparks. This was in the area that had accumulations of coal dust and other combustible materials. A ribbon had been tied to the guarding next to the roller. Both the ribbon and the roller were covered with coal dust. Citation No. 7123906 was issued, charging a significant and substantial violation for failure to maintain equipment, and the assessed civil penalty was paid by Respondent. Ex. G-7. The belt was shut down, and the roller was changed. It was sufficiently hot that the crew changing it couldn’t handle it. Ex. R-3 at 183.

Preece also found a violation related to firefighting equipment. Two fire extinguishers located at the drive did not have tags showing that they had been examined within the past six months. Tr. 373. He issued Citation No. 7123903, charging a non-significant and substantial violation as to the fire extinguishers.⁶ Ex. G-5. The civil penalty assessed for that violation was paid by Respondent.

The Secretary contends that these conditions existed at the time of the preshift examination, and should have been identified and recorded on the report of that examination.

⁵ Spraying water on the belt to control dust is not required by federal regulations.

⁶ Preece also issued Citation No. 7123908 for inadequate firefighting equipment. Ex. G-9. However, that equipment was located in the track haulage area, which is not in the same preshift examination area as the No. 10 belt, and the Secretary does not rely upon that condition as proof of the instant violation. Tr. 393.

McElroy contends that the conditions were not hazardous, and that any conditions observed by Preece did not exist at the time the preshift examination was conducted some three hours earlier.

The fact that the conditions, as cited by Preece, existed at the time of his inspection is not disputed, either factually or legally. Frederick T. Blizzard, a miners' representative who traveled with Preece during the inspection, confirmed the existence of the conditions. He testified that there was a "lot of coal dust," about 1 inch thick, black in color, that extended at least from the head pulley past the take-up unit of the No. 10 belt. Tr. 581-82. He also confirmed that there were holes in the guarding on the solid side near the take-up roller, that there was a sparking roller, and that two of the four dust control water sprays were working. Tr. 583-87. McElroy did not present evidence challenging the existence of the conditions. Moreover, its payment of the civil penalties assessed for the violations established their existence as a matter of law.

McElroy argues that the conditions were not hazardous, contending, e.g., that the "openings in the guarding could have been avoided with the use of reasonable care; therefore, they did not constitute a hazardous condition." Resp. Rpy. Br. at 9. The argument hardly merits a response. One of the basic tenets of enforcement of guarding and other safety standards has been the fact that miners do not always exercise caution, and that hazards must be guarded to prevent "contact stemming from inadvertent stumbling or falling, momentary inattention, or human carelessness." *Thompson Bros. Coal Co.*, 6 FMSHRC 2094, 2097 (Sept. 1984). The belt attendant on December 1, had been temporarily assigned to that job for a few days. He was a very large individual, who had to move sideways through the narrow passage between the guarding and the rib. Tr. 606-07. In addition, the citations issued for the inadequate guarding, the accumulations and the defectively maintained roller, now final orders of the Commission, were significant and substantial, i.e., reasonably likely to result in a reasonably serious injury under continued normal mining operations.

The critical question is whether the conditions existed at the time of the preshift examination, i.e., at approximately 7:00 a.m. on December 1, 2004. The "holes" in the guarding resulted from corrosion and general wear and tear. Preece believed that the worn and corroded guarding took multiple shifts to deteriorate. Tr. 384. Michael A. Conjeski, the mine foreman, testified that the guarding was probably at least eight years old, and that it does deteriorate. Tr. 637-38, 655. It is highly likely that the holes existed at the time of the preshift examination, probably considerably longer. What is not clear is how obvious they were. As noted above, Preece stated that the guarding could be pushed in to touch the belt. Tr. 366. He later testified that the condition was pretty obvious. "[I]t's pretty obvious when you hit the screen or you touch the screen it's moving. You walk by it. You can see it move." Tr. 525-26.

While the size of the "holes" was described, their appearance was not. Despite their characterization, it appears that they were not actual holes, i.e., the fence-like material was not completely missing. Rather it was hanging in place, and could be pushed in with minimal force. The guarding was woefully inadequate. However, it may not have appeared to have been defective, unless touched or moved. Conjeski opined that the preshift examiners generally

walked the other side of the belt and may have missed the guarding defects. Tr. 636. However, the examiner on the midnight shift, consistent with McElroy policy, walked the “solid side,” and would have been in a better position to observe the hazards. Tr. 645, 654. Nevertheless, unless he pushed or touched the loose screen, the condition may not have been obvious.

Preece believed that the coal dust accumulations had existed for more than one shift, because, in his experience, having performed inspections in that particular area, “it would have been difficult to get that black within two hours.”⁷ Tr. 362, 366. He opined that “if [the area] got that black in a couple hours you’ve probably got a problem.” Tr. 362. The appearance of the dust, a dull black color, also led him to believe that it had been there for some time, because fresh coal dust is shiny and sparkly. Tr. 385-86. Conjeski agreed that it would normally take days for black coal dust to accumulate. However, if the water sprays weren’t functioning, it wouldn’t take that long. Tr. 667. Chad Deloma, a McElroy safety inspector at the time the order was issued, stated at his deposition that he’d never seen a clean area go black in one shift. Normally, it wouldn’t happen in two shifts, “it would take a long time. Something would have to go very wrong for that to happen.” Ex. G-25 at 33-34.

There is no evidence that there was an unusual problem in the area, or that something had gone “very wrong,” that could have caused an unusual rapid build-up of dust. Two of the four water sprays were functioning at the time of the inspection. It is highly likely, from the nature and appearance of the condition, that there was a significant accumulation of coal dust at the time of the preshift examination.

Preece did not believe that it was possible that the roller went bad after the preshift examination had been conducted, because it had been tagged with the ribbon, and the ribbon had old damp rock dust on it. Tr. 178-82. While he did not know what the condition of the roller was at the time of the preshift examination, he believed that it “did not wear out in two hours and wear the metal away and the bearings away on this roller.” Tr. 527. However, at his deposition, Preece conceded that the roller may not have been hot at the time the preshift examination had been conducted. Ex. R-3 at 182.

Conjeski and Deloma described McElroy’s policy with respect to “hot” rollers. They were changed immediately, and anyone in the area had the authority to shut the belt down so that a hot roller could be changed. If a roller was starting to go bad, e.g., its bearings were beginning to fail causing it to squeak, it would be tagged with a ribbon and a new roller would be spotted next to it. The roller would then be replaced on the weekend, when the belt was not operating. Tr. 627-32. December 1, 2004, was a Wednesday. The roller could have been showing signs of wear, and been tagged two days earlier. Accumulations of dust on the ribbon and roller do not establish that the roller was hot and/or throwing off sparks at the time of the preshift examination.

⁷ Preece entered the area about 10:00 a.m., two hours after the shift began, and three hours after the preshift examination had been conducted.

Upon consideration of all of the above factors, I find that at the time of the preshift examination there was an accumulation of coal dust and other combustible materials that should have been identified as a hazardous condition and recorded on the preshift report. I also find that, while the roller may not have been hot and sparking at the time of the examination, it was obviously a roller that was breaking down, and had the potential to become hot and dangerous in a short period of time, such that increased attention should have been paid to accumulations and the sufficiency of fire fighting equipment. The guarding near the take-up unit was clearly defective at the time of the examination. While it may not have been as obvious as Preece related, I credit his testimony, and find that it should have been discovered and reported during a proper preshift examination.⁸

I find that there was a violation. Because it was the examiner's failure to identify the hazardous conditions, rather than simply a failure to record them, I find that section 75.360(a)(1) was the provision violated. I also find that the failure to identify the conditions, and note them on the report of the preshift examination, resulted in at least one miner entering and working in the area before the hazardous conditions were corrected, and that it was reasonably likely that an injury would have occurred resulting in lost work days or restricted duty.

Unwarrantable Failure - Negligence

In *Lopke Quarries, Inc.*, 23 FMSHRC 705, 711 (July 2001), the Commission reiterated the law applicable to determining whether a violation is the result of an unwarrantable failure:

The unwarrantable failure terminology is taken from section 104(d) of the Act, 30 U.S.C. § 814(d), and refers to more serious conduct by an operator in connection with a violation. In *Emery Mining Corp.*, 9 FMSHRC 1997 (Dec. 1987), the Commission determined that unwarrantable failure is aggravated conduct constituting more than ordinary negligence. *Id.* at 2001. Unwarrantable failure is characterized by such conduct as "reckless disregard," "intentional misconduct," "indifference," or a "serious lack of reasonable care." *Id.* at 2003-04; *Rochester & Pittsburgh Coal Co.*, 13 FMSHRC 189, 194 (Feb. 1991) ("R&P"); *see also Buck Creek [Coal, Inc. v. FMSHRC]*, 52 F.3d 133, 136 (7th Cir. 1995)] (approving Commission's unwarrantable failure test).

Whether conduct is "aggravated" in the context of unwarrantable failure is determined by looking at all the facts and circumstances of each case to see if any aggravating factors exist, such as the length of time that the violation has existed, the extent of the violative condition, whether the operator has been placed on

⁸ The missing tag on one fire extinguisher, and the tag that failed to show that another fire extinguisher had been serviced within the past six months, were also items that should have been noted and recorded on the report of the preshift examination.

notice that greater efforts are necessary for compliance, the operator's efforts in abating the violative condition, whether the violation is obvious or poses a high degree of danger, and the operator's knowledge of the existence of the violation. See *Consolidation Coal Co.*, 22 FMSHRC 340, 353 (Mar. 2000) . . . ; *Cyprus Emerald Res. Corp.*, 20 FMSHRC 790, 813 (Aug. 1998), *rev'd on other grounds*, 195 F.3d 42 (D.C. Cir. 1999); *Midwest Material Co.*, 19 FMSHRC 30, 34 (Jan. 1997); *Mullins & Sons Coal Co.*, 16 FMSHRC 192, 195 (Feb. 1994); *Peabody Coal Co.*, 14 FMSHRC 1258, 1261 (Aug. 1992); *BethEnergy Mines, Inc.*, 14 FMSHRC 1232, 1243-44 (Aug. 1992); *Quinland Coals, Inc.*, 10 FMSHRC 705, 709 (June 1988). All of the relevant facts and circumstances of each case must be examined to determine if an actor's conduct is aggravated, or whether mitigating circumstances exist. *Consol*, 22 FMSHRC at 353. Because supervisors are held to a high standard of care, another important factor supporting an unwarrantable failure determination is the involvement of a supervisor in the violation. *REB Enters., Inc.*, 20 FMSHRC 203, 225 (Mar. 1998).

The Secretary argues that the violation was the result of an unwarrantable failure because the conditions were extensive, obvious and existed for more than one shift, that they posed a high degree of danger, and that the failure to note or record them on the preshift report evidenced an indifference to safety. Sec'y. Br. at 34. Had the evidence justified a finding that the conditions, as Preece found them, had existed at the time of the preshift examination, the Secretary's argument might be well-founded. However, there are significant mitigating factors. There is insufficient evidence to justify a finding that the roller was "hot" and sparking at the time of the preshift examination. While the accumulations of coal dust were such that they should have been reported, they would most likely have been somewhat smaller in volume and/or extensiveness three hours before Preece observed them. As to the "holes" in the guarding, it appears from Preece's description, that the fence-like material was hanging in place, and that the "holes" may not have been obvious unless the examiner made contact with the loose material.

Based upon all of the above factors, and considering the fact that the Secretary has the burden of proof on all elements of a violation, I find McElroy's negligence with respect to this violation to have been moderate, and not the result of an unwarrantable failure.⁹ Accordingly, the Order will be modified to a citation issued pursuant to section 104 of the Act.

⁹ In an enforcement proceeding under the Act, the Secretary has the burden of proving all elements of an alleged violation by a preponderance of the evidence. *In re: Contests of Respirable Dust Sample Alteration Citations*, 17 FMSHRC 1819, 1838 (Nov. 1995), *aff'd*, *Sec'y of Labor v. Keystone Coal Mining Corp.*, 151 F.3d 1096 (D.C. Cir. 1998); *ASARCO Mining Co.*, 15 FMSHRC 1303, 1307 (July 1993); *Garden Creek Pocahontas Co.*, 11 FMSHRC 2148, 2152 (Nov. 1989); *Jim Walter Resources, Inc.*, 9 FMSHRC 903, 907 (May 1987).

Order No. 7124015

Order No. 7124015 was issued by Preece on December 22, 2004, and alleges a violation of 30 C.F.R. § 75.512, which requires that:

All electric equipment shall be frequently examined, tested, and properly maintained by a qualified person to assure safe operating conditions. When a potentially dangerous condition is found on electric equipment, such equipment shall be removed from service until such condition is corrected. A record of such examinations shall be kept and made available to an authorized representative of the Secretary and to the miners in such mine.

Preece inspected a power center located in a crosscut in the 1 Left, 5 South Tailgate section of the mine. He observed several defects that he believed presented a potential for serious injury, and which appeared to have been present for at least one shift. He determined that the power center ("PC") was not being maintained in safe operating condition, and issued the Order pursuant to section 104(d)(2) of the Act, alleging that the violation was the result of McElroy's unwarrantable failure to comply with the standard. Ex. G-3. He also determined that it was highly likely that the violation would result in a fatal injury, that the violation was significant and substantial, that one employee was affected, and that the operator's negligence was high. A subsequent review resulted in a modification of the Order, specifying that it was reasonably likely, not highly likely, to result in an injury. A civil penalty in the amount of \$6,600.00 has been proposed for this violation.

The Violation

The PC in question was approximately eight feet wide, 20 feet long and four feet high. It was located in the center of a crosscut that was about 15 feet wide, leaving approximately two-to-three feet on each side. It was energized and was being used to charge a piece of mobile equipment. Tr. 307. The high voltage end of the PC, where a cable supplied 12,470 volts of power, was facing the track entry. The PC is depicted in several photographs taken at the time of the inspection. Ex. G-17A-F.

Preece found multiple defects in the PC, virtually all of which were confirmed by Charles B. Racer, McElroy's representative, who accompanied Preece on the inspection, and took photographs of the conditions. The first problem that Preece noticed was on the end of the PC facing the track entry. Located close to where the power supply cable enters the PC, there was a glass observation port, oval in shape, approximately five-to-six inches wide and 18 inches high. It was held in place by a rubber grommet. The lower end of the glass had been pushed in about two and one-half inches, and it appeared that there was an imprint of a boot or shoe on the top of a rock dust bag, located such that the toe of a boot would have been against the lower part of the glass. Tr. 298-300. The Secretary introduced pictures of the condition as first observed by Preece, and with the rock dust bag removed showing the displaced glass more clearly. Ex. G-

17C, 17F. Preece testified that a conductor associated with the 12,470-volt power cable was visible through the opening, and it was possible that high voltage could “track” to anything inserted into the opening, such as a steel-toed boot, or a piece of metal like the slate bar shown in pictures leaning against that end of the PC. Tr. 303-10; ex. G-17C and F.

On the upper-left side of the high voltage end of the PC, Preece found a damaged cover for a low voltage pilot circuit. The cover, which is depicted in a photograph taken at the time, was ajar at about a 45-degree angle, and would not close. Ex. G-17C. A terminal strip, supplying power for safety devices, was located under the defective cover, and was partially exposed. Preece tested the circuit and found in excess of 50 volts. Tr. 322. He later determined, after learning that the resistance of the grounding circuit at the mine was 166 ohms, that the pilot circuit could deliver 302 milliamps at 50 volts. Tr. 489-91. At 96 volts, which was the most likely voltage of the circuit, it could deliver nearly 600 milliamps. Tr. 562.

The PC has four-to-five lids, or covers, each about four feet by eight feet, which, by design, are to be secured by bolts on each end. All of the lids’ bolts were missing.¹⁰ The lids weigh 50-to-100 pounds. A person could grasp the handles, lift one end of the lid and slide it over. Tr. 480. The lids on the high voltage end of the PC had “whisker switches,” that would deenergize the PC if the lids were lifted. However, the lids on the lower voltage end did not have such switches. Tr. 481-84. Preece has seen miners lift the lids on power centers for no particular reason, and has found drinking water and parts stored in other power centers. Tr. 316-19. Lifting a lid on the lower voltage end of the PC would expose energized electrical components and create a potential for something to fall in and create an arc or fire. Tr. 312.

The PC had several 480-volt receptacles, to which cables could be connected. The ground pins on three of the receptacles were displaced at an angle. Preece testified that the pins were broken, or would become broken if someone attempted to attach a cable to the receptacle. Tr. 325-29; ex. G-17D. He explained that, even though the pins were broken and at an angle, miners could screw a connector onto the receptacle. The PC was designed to prevent energizing of a receptacle if the ground circuit was not intact. However, Preece explained that the broken ground pin could show sufficient continuity to allow the receptacle to be energized, but that the marginal connection would not be adequate to provide an effective ground. Tr. 330-33. An electrocution hazard would then be created if there was a short circuit to the frame of a piece of equipment.

The Secretary contends that these conditions violated the standard because the PC had not been maintained to assure safe operating conditions.¹¹ McElroy disputes that the conditions

¹⁰ PC lids, handles and missing bolts are shown in a picture introduced by the Secretary. Ex. G-17A.

¹¹ Preece had included another defect in his Order, but realized during his deposition, that he had been mistaken. Item numbered 2 in the Condition or Practice section of the Order is

violated the standard. As to the displaced glass, it contends that there was no opening, and that any opening was not large enough or located such that it presented a hazard to anyone other than a person intent on committing suicide. Resp. Br. at 28, Rpy. Br. at 3-4. However, the existence of the opening cannot be seriously disputed. McElroy's safety inspector, Racer, confirmed that the conditions described by Preece existed. Tr. 692, 722, 745. One of the pictures he took clearly shows the opening created by displacement of the glass. Tr. 685; ex. G-17F.

McElroy argues that the missing lid bolts presented no hazard because all lids had safety switches on them, it would take two people to remove one of the lids, and even if bolts had been present a miner could have removed them. The fact that a miner could have removed lid bolts, if he had access to a wrench or other appropriate tool, does little to diminish the significance that unsecured lids presented ready opportunities for miners to lift and move them. The remaining arguments are based upon an overly optimistic reading of Racer's testimony. While he did state that it "takes two people, one on each side, to actually remove the lid fully," he acknowledged that he could raise one side, and did not contradict Preece's testimony that one miner could lift one end of the lid and slide it over. Tr. 701-02. In addition, while he first testified that the "lids all have switches," he promptly clarified that that was his "understanding," and later stated that he didn't know "one way or the other" whether the PC had switches on all of its lids. Tr. 701-02, 737. Preece testified that he looked at this PC, and not all of the lids had switches. Tr. 481. He also testified that PC's that he had worked on as an electrician did not have switches on the low voltage side. Tr. 482. I accept the testimony of Preece, a certified electrician, and find that not all of the lids had safety switches.

McElroy argues that Preece did not test the integrity of the grounding circuits for the receptacles. The hazard described by Preece was that the ground pins were broken, but that a cable could still be attached to the receptacle, and the grounding circuit could give a false positive test result. It is unclear whether the test referred to would have confirmed the existence of the hazard. In addition, there is no claim by McElroy that it could not have tested the grounding circuits. It apparently chose not to do so, or if it did, chose not to offer the results of such tests into evidence. The case cited by McElroy in support of its argument is inapposite. *Consolidation Coal Co.*, 10 FMSHRC 745 (June 1988) (ALJ).

McElroy's arguments as to the pilot circuit are similarly deficient. It advances a number of contentions, none of which have merit. The first argument is that the door covering the terminal strip was only bent and ajar, and that its integrity was not compromised. Resp. Br. at 10. This argument also is based upon a misreading of Racer's testimony. Tr. 706-07. As noted above, Racer confirmed the existence of the conditions found by Preece. Tr. 745. A picture that Racer took of the end of the PC shows that the door that was designed to cover the terminal strip was bent and ajar at approximately a 45-degree angle. Ex. G-17C. The "integrity" of the door to perform its intended function, preventing inadvertent contact with the terminal strip, was substantially compromised. McElroy argues, citing Racer's testimony, that there was only a

incorrect and is not relied upon in support of the alleged violation. Tr. 336-38; ex. G-3.

“very small voltage” on the strip, and that Preece did not measure the voltage. Resp. Br. at 10. However, Racer made clear that that was only his “understanding,” and that he did not know how much voltage was present. Tr. 706-07. It is true that Preece did not measure the voltage. However, he did check it with an instrument, and confirmed that there was at least 50 volts present. Tr. 322. McElroy is also critical of the fact that Preece did not know, at the time he issued the Order, how much resistance was on the grounding circuits and, consequently, the amount of amperage that could be generated. Preece obtained that information on a return visit to the mine in preparation for the hearing. Tr. 489-91. Whether Preece knew those facts when he issued the Order is immaterial.

Significant and Substantial

A significant and substantial (“S&S”) violation is described in section 104(d)(1) of the Act as a violation “of such nature as could significantly and substantially contribute to the cause and effect of a coal or other mine safety or health hazard.” A violation is properly designated S&S “if, based upon the particular facts surrounding that violation, there exists a reasonable likelihood that the hazard contributed to will result in an injury or illness of a reasonably serious nature.” *Cement Div., Nat’l Gypsum Co.*, 3 FMSHRC 822, 825 (Apr. 1981).

The Commission has explained that:

In order to establish that a violation of a mandatory safety standard is significant and substantial under *National Gypsum*, the Secretary of Labor must prove: (1) the underlying violation of a mandatory safety standard; (2) a discrete safety hazard--that is, a measure of danger to safety--contributed to by the violation; (3) a reasonable likelihood that the hazard contributed to will result in an injury; and (4) a reasonable likelihood that the injury in question will be of a reasonably serious nature.

Mathies Coal Co., 6 FMSHRC 1, 3-4 (Jan. 1984) (footnote omitted); *see also*, *Buck Creek Coal, Inc. v. MSHA*, 52 F.3d 133, 135 (7th Cir. 1999); *Austin Power, Inc. v. Secretary*, 861 F.2d 99, 103-04 (5th Cir. 1988), *aff’g Austin Power, Inc.*, 9 FMSHRC 2015, 2021 (Dec. 1987) (approving *Mathies* criteria).

In *U.S. Steel Mining Co., Inc.*, 7 FMSHRC 1125, 1129 (Aug. 1985), the Commission provided additional guidance:

We have explained further that the third element of the *Mathies* formula “requires that the Secretary establish a reasonable likelihood that the hazard contributed to will result in an event in which there is an injury.” *U.S. Steel Mining Co., Inc.*, 6 FMSHRC 1834, 1836 (August 1984). We have emphasized that, in accordance with the language of section 104(d)(1), it is the *contribution* of a violation to the cause and effect of a hazard that must be significant and substantial. *U.S. Steel*

Mining Co., Inc., 6 FMSHRC 1866, 1868 (August 1984); *U.S. Steel Mining Co., Inc.*, 6 FMSHRC 1573, 1574-75 (July 1984).

This evaluation is made in terms of "continued normal mining operations." *U.S. Steel Mining Co., Inc.*, 6 FMSHRC at 1574. The question of whether a particular violation is significant and substantial must be based on the particular facts surrounding the violation. *Texasgulf, Inc.*, 10 FMSHRC 498 (Apr. 1988); *Youghiogeny & Ohio Coal Co.*, 9 FMSHRC 2007 (Dec. 1987).

As is frequently the case, whether this violation was S&S depends upon whether it was reasonably likely that an injury producing event would occur under continued normal mining operations. The fact of the violation, and the existence of several hazardous conditions contributed to by the violation have been established. It is also not disputed that any injury resulting from contact with the 12,470-volt circuit, an improperly grounded 480-volt circuit, or even the low voltage on the terminal strip could be expected to result in a reasonably serious injury. Preece testified that the 302-to-600 millivolts that would be delivered by contact with the terminal strip could result in a serious injury or a fatality. Tr. 552.

McElroy advances several arguments against the S&S designation. It's chief contention is that miners who are in proximity to the PC know that it is a piece of electrical equipment associated with high voltage and are unlikely to come into contact with any of the hazards. Racer testified that he believed that miners are aware of the hazards presented by such electrical equipment, they work with it every day, and use caution around it. Tr. 698. He did not believe that anyone would place something in the opening created by the displaced safety glass, and it "would take a suicide attempt" for a miner to be injured by that condition. Tr. 714. McElroy reiterates its argument that the unsecured lids posed no hazard because all of them had safety switches that would deenergize the PC if the lid was lifted, and that the broken ground pins on the receptacles did not present a hazard because there was a secondary system that would prevent the receptacle from being energized if the ground circuit was not intact. McElroy also claims that it established, through Racer's testimony, that the voltage on the terminal strip was too low to be a hazard. Resp. Br. at 29.

Some of McElroy's arguments are based upon erroneous factual premises, and they otherwise do little to rebut the Secretary's evidence. The gap created by the displaced safety glass was at the bottom of the oval-shaped opening, where the approximately five-to-six-inch-wide glass was pushed in two and one-half inches. McElroy misperceives the nature of the hazard. It was not necessary to insert a body part or conductive rod through the opening such that it came into physical contact with a component bearing 12,470 volts in order to cause an injury. As described by Preece, an experienced and certified electrician, high voltage can "track" to something close by, possibly to a steel toed boot inadvertently placed against the pushed-in glass. Certainly, an inadvertent placement of something like the slate bar into the opening would have produced a disastrous result. There were numerous possibilities for inadvertent contact. There were miners in the area, traveling past the PC, and using it to supply power to other

equipment. Clothing, lunch pails, and numerous other items were stored on top of the PC, all of which were accessed by miners. Someone placed a steel slate bar against the PC. Under continued mining operations, it is reasonably likely that someone or something would get in close enough proximity to the high voltage components that a serious injury could result.

As to the terminal strip, Racer's testimony fell far short of establishing that the voltage was too low to create a hazard. As noted above, Racer conceded that he did not know how much voltage was present, and that he didn't know what effect whatever voltage was on the terminal strip could have on the human body. Tr. 706, 743. In contrast, Preece testified that 50 volts could produce 302 milliamps of current, and 96 volts could produce nearly 600 milliamps of current, which could produce a fatality.

The hazard presented by the bent/broken ground pins on the receptacles was more insidious. The broken pins could falsely indicate a ground circuit competent enough to satisfy the safety system, but not sufficient to provide an adequate ground. The potential electrocution hazard identified by Preece would not be precluded by the safety circuit under the circumstances he described.

As noted above, a miner could lift the lids, not all of which were equipped with safety switches. Consequently, there was a possibility that something could fall into the PC and create a short circuit resulting in an injury. Preece had seen miners at McElroy lift lids on PCs and store items in PCs. Racer also had seen miners lift lids on PCs at the mine. Tr. 302, 736.

Considering the number of hazards presented by the deficient maintenance of the PC, I find that it was reasonably likely that an injury producing event would have occurred under continued normal mining operations, and that the violation was S&S.

Unwarrantable Failure

The hazardous conditions were, with the exception of the displaced safety glass, obvious and in plain view. Tr. 504-05, 721. Preece felt that the nature of the conditions, including the condition of the rock dust bag near the safety glass, indicated that they had existed for some time. Tr. 308, 350. As he stated, the PC "didn't get this way overnight . . . [it] took a lot more than a shift." Tr. 501. The PC had been at that location since at least the day before. Tr. 502, 708. McElroy was required to inspect the PC weekly for permissibility, and three times a day during preshift examinations of the area. Tr. 340, 731-32. Preece reviewed the preshift examination records and found that no hazardous conditions had been noted with respect to the PC. Tr. 341. He attempted to review the records of weekly examinations at McElroy's electrical department, but none were provided. Tr. 340, 731-32; ex. G-31. He felt that the PC had been examined by agents of McElroy several times, and that none of the obvious hazardous conditions had been corrected, i.e., that "some agents of the operator did look at the power center and left it this way." Tr. 347-50, 504-05.

McElroy contends that the conditions were “barely detectable,” were not extensive or hazardous, and may have occurred during a recent power move. Resp. Br. at 30. Its principal arguments have been rejected above. Whether or not the condition occurred during a power move is not relevant. Racer was unable to specify when such a move may have occurred, and had not seen a power center damaged during a move. Tr. 687-90. McElroy also attempts to make much of the fact that another MSHA inspector had conducted an inspection of the area the previous day. Tr. 708. Citations had been issued for conditions in the area, including the presence of trash and combustible materials throughout the section, but not for the PC. Tr. 709. Perhaps Preece, being a certified electrician, paid more attention to the PC. In any event, any suggestion that the conditions were not open and obvious for at least one day, is effectively rebutted by the pictures and other evidence of record. I find that the conditions, as depicted in the photographs, existed for at least one day, and that they were open and obvious.

For the reasons identified by Preece, I find that the violation was the result of an unwarrantable failure to comply with the standard. The hazardous conditions were, with one exception, open and obvious. They had existed for at least one day, most likely considerably longer than that. They were not identified and corrected as a result of preshift examinations conducted by agents of the operator, and there were no records of weekly permissibility examinations which might also have resulted in elimination of one or more of the conditions. The combination of hazardous conditions presented a serious risk of injury to miners working in the area.

Order No. 7124560

Order No. 7124560 was issued by Preece on February 23, 2005, during a regular inspection of the mine, and alleges a violation of 30 C.F.R. § 77.502, which requires that:

Electric equipment shall be frequently examined, tested, and properly maintained by a qualified person to assure safe operating conditions. When a potentially dangerous condition is found on electric equipment, such equipment shall be removed from service until such condition is corrected. A record of such examinations shall be kept.

Preece inspected the Run of the Mine Master Control Station (“MCS”), a small, 20 foot by 30 foot, rectangular building housing electrical equipment located approximately 100 yards from McElroy’s preparation plant. Two rows of electrical cabinets run lengthwise in the building, creating an aisle approximately five feet wide. The cabinets house starter panels for conveyor belts in that area of the property. A blower motor, which drove cooling fans for the No. 10 belt starter panel, had ceased functioning. In order to cool the equipment, the cabinet doors had been opened, and a 20-to-24-inch diameter fan, mounted on a floor pedestal, had been placed between them. The cabinet doors were about seven feet high and 20-to-24 inches wide. They were hinged at the outer edges of the cabinet and latched at the center, where a three-to-four-inch wide post ran from the bottom to the top of the cabinet. Energized components,

carrying 600 volts, are located inside the panel. Preece believed that a person walking down the aisle could fall and come into contact with the energized components, either directly, or indirectly by knocking the fan into them. He determined that the starter panel was not being maintained in a safe operating condition in violation of the regulation. The violation was abated promptly by removal of the fan and closing the panel doors. The condition had been in existence for about three weeks, and a replacement blower motor had been ordered. The replacement motor arrived and was installed “fairly quickly” after the order was issued, possibly “within the day.” Tr. 548.

Preece determined that it was reasonably likely that the violation would result in a fatal injury, that the violation was significant and substantial, that one employee was affected, and that the operator’s negligence was high. The Order was issued pursuant to section 104(d)(2) of the Act, and alleges that the violation was the result of McElroy’s unwarrantable failure. A civil penalty in the amount of \$6,600.00 has been proposed for this violation.

The Violation

The layout of the building, showing the aisle, fan and open panel doors, is depicted on a sketch drawn by Preece. Ex. G-16. The panel doors, shown in a closed position, are depicted in photographs taken at a later point in time. Ex. R-10, R-10A. There are two entrances to the building. A single door on the East end, opens into the aisle, approximately five feet from the subject panel. The aisle extends to the West end of the building, where there is a set of double doors and an access to a room on the North side of the building, where a bench is located. Neither the doors to the building, nor the electrical cabinets, are locked. The MCS, and others like it on the property, need to be open because persons have to have access to the electrical controls, and to a monitor/screen that displayed the status of the belts. According to Jeffrey A. Seckman, the general plant foreman, and the electrical foreman at the time of the violation, the double doors are the main access to the building. Tr. 838. He also testified that, at some point, caution tape had been strung across the open cabinet, but was unable to recall how it was placed. Tr. 779, 831. Preece did not recall seeing any warning signs or caution tape around the panel doors or fan. Tr. 244-45.

Seckman agreed that any contact with the 600-volt conductors in the panel would likely be fatal. Tr. 804. However, he did not feel that the condition presented a hazard, because people entering the building were aware of the electrical equipment, caution tape had been strung, and the fan had been placed outside the cabinet doors, so that if it was moved toward the cabinet, it would push the doors closed. Tr. 763-64, 782-85. However, he conceded that the MCS could be, and had been, accessed by rank and file miners, who had limited familiarity with electrical equipment. Tr. 811-15, 817. In addition, the evidence does not support his claims that caution tape had been strung, at least as of the time of the inspection, or that the fan would have pushed the cabinet doors closed.

The cabinets needed to be accessed when work was performed on the conveyor belt. It is highly likely that any caution tape placed initially would have been removed when subsequent access was needed, and Preece did not see any caution tape. I find that there was no caution tape present at the time the Order was entered. I also find that the cabinet doors were adjacent to, not in front of the fan. If the doors had been in front of the fan, the fan would have tended to blow them shut. Seckman testified that the doors are heavy. However, they appear to be made of sheet metal and, even if they are relatively heavy, they most likely would have been blown shut by a 24-inch diameter fan.

The fan, and its pedestal extended about two feet into the aisle, significantly reducing its width. It is certainly possible that a miner passing the fan, which was located only a few feet inside the East door, could have inadvertently contacted the doors and/or fan and fallen, and that he could have come into contact with the energized electrical components, either directly or through contact with the metal fan. I find that the regulation was violated.

S&S

Whether the violation was S&S depends upon whether it was reasonably likely that the hazard contributed to by the violation would result in an injury producing event. The Secretary argues that an injury producing event was reasonably likely because “mining personnel were present in the MCS throughout the work day and walk in the hallway directly in front of the No. 10 belt starter panel.” Sec’y. Br. at 10-11. The evidence does not support so broad a statement. Preece conceded that, despite his familiarity with the McElroy mine, having done general inspections, he had no idea how many people traveled in the MCS, and did not ask anyone about that. Tr. 419, 448. He did not see anyone in the MCS the day he issued the order, until he called McElroy personnel because of the violation. Tr. 416, 447. There is no one assigned to work in the building. Tr. 763. It is accessed by qualified electrical personnel to control the starter panels, e.g., to deenergize and lock out power to conveyor motors so that repair or maintenance work can be performed. Tr. 765, 770-71, 816. Miners also access the building to look at the monitor/screen displaying the status of the belts. An electrician is required to inspect the building once per month, and also handles cleaning chores.

Seckman was quite candid about the presence of miners. He stated that, at least on one occasion, he had seen more than one miner in the MCS, and had seen miners go into the MCS for breaks. Tr. 770, 813-14. He agreed that, because access to the building was not restricted, virtually anyone could enter the building. However, it is not in a highly traveled area and is about 100 yards away from the preparation plant. Tr. 769-70.

Preece was not concerned about the presence of qualified electrical personnel. He testified that he would not have issued the order if access to the building had been restricted to authorized persons. Tr. 278, 409. It is the miner who had no official business in the MCS, and who would not be as aware of the potential electrical hazards, that would pose the most significant risk of injury. While such miners apparently have entered the MCS on occasion, there

is very little evidence as to the frequency of such visits. Nor is there evidence that such persons would be likely to walk down the hallway in question, i.e., that they would enter or exit the MCS by the single East door. Similarly, there is very little evidence of the frequency that miners entered the MCS to check the status of the belts. The double doors on the West were the main entrance to the MCS. The monitor/screen and access to the North side of the building, the area most likely to be used for breaks, were at the West end of the building. There is no direct evidence of the frequency of travel down the subject hallway by persons who would not have been authorized to be in the building. In addition, the condition was eliminated immediately and was permanently corrected within a day after the Order was issued.

Based upon all of the factors discussed above, I find that the Secretary has failed to carry her burden of proving that it was reasonably likely that an injury producing event would have occurred under continued normal mining operations. The violation was not S&S.

Unwarrantable Failure

The condition had existed for about three weeks. Seckman, the electrical foreman at the time, an agent of McElroy's, had known about the condition, and had ordered a replacement part. Seckman honestly believed that the condition did not present a hazard, primarily because only qualified electricians would have any reason to access the electrical control panels arrayed along the subject hallway. While he knew that access to the building was unrestricted, and had seen miners in the building in the past, he also knew that the area was not highly traveled. The main entrance to the building was at the West end, where the double doors were located. Access to the area on the north side of the building, which would most likely be used for breaks, was also at that end of the building, as, it appears, was the monitor/screen. As noted above, there is very little evidence of the frequency with which miners entered the MCS, and virtually no evidence that any miner actually traveled the hallway, much less did so with some frequency. While there was no caution tape at the time of the inspection, there may well have been caution tape strung around the open doors during a portion of the three-week period. The hazardous condition was corrected immediately, and permanent repairs were made within a day. At the hearing, Preece related his belief that the unwarrantable failure designation was enhanced by the fact that the replacement blower motor had been delivered the day before the inspection, but had not been installed. Tr. 455-57. His belief was based on examination of a printout of a purchase order that indicated a February 22, 2005, delivery date for the replacement motor. Ex. R-21. However, Seckman explained that the delivery date stated on the form was only an estimate, not an actual delivery date, and that if the motor had arrived on February 22, it would have been installed that day. Tr. 790-95.

Considering all of these factors, I find that the violation was not the result of McElroy's unwarrantable failure, but that its negligence was high.

Order No. 7124782

Order No. 7124782 was issued on August 30, 2005, by MSHA inspector, Joseph R. Yudaz, and alleges a violation of 30 C.F.R. § 75.321(a)(2), which requires that "air in areas of bleeder entries and worked-out areas where persons work or travel shall contain at least 19.5% oxygen." Yudaz had inspected the "5 South-Left side bleeder travelway, from the South approach at the bottom of the 5 South 1 Left Bleeder fan shaft to the MP-1," an area required to be examined every seven days, and discovered that the air had an oxygen content below the required 19.5%. Ex. G-1. Yudaz determined that it was reasonably likely that the violation would result in an injury involving lost work days or restricted duty, that the violation was significant and substantial, that one employee was affected, and that the operator's negligence was high. The Order was issued pursuant to section 104(d)(2) of the Act, and alleges that the violation was the result of McElroy's unwarrantable failure to comply with the standard. A civil penalty in the amount of \$5,300.00 has been proposed for this violation.

The Violation

Inspector Yudaz was conducting a regular quarterly inspection of the mine. He reviewed McElroy's weekly examination book, in which the results of required seven-day examinations of bleeder travelways were recorded, and noticed that the most recent report, dated August 25, 2005, showed that only 17.9% oxygen was present at the "1 Left 5 South Bleeders MP-1 [Measuring Point #1]." Ex. G-11. He noticed that several other entries also reported less than 19.5% oxygen at that location. He proceeded underground and entered the bleeder travelway near the bleeder fan shaft. He soon encountered oxygen below the required level. His hand-held atmospheric monitor alarmed, and showed oxygen at a concentration of 18.5%. Located in close proximity was an air measuring station, where examiners recorded the results of their measurements. That record showed that the quantity of air in the bleeder entry had been steadily falling since February 2005. Concentrations of oxygen had also been falling, and had been below the required 19.5% since April 28, 2005. Tr. 71-79; ex. G-12. Rather than proceed the remainder of the 1,200-to-1,300 feet to MP-1, he retreated, and issued the Order.

McElroy does not dispute the fact of the violation. Its examiners had recorded low oxygen readings for numerous past examinations dating back to April 28, 2005. Jack Price, a McElroy management representative, traveled with Yudaz during the inspection and confirmed the oxygen reading of 18.5% that Yudaz measured in the bleeder travelway. Tr. 69. McElroy argues that the violation was not S&S, because the oxygen concentrations were not low enough to pose a reasonable possibility of injury.

S&S

The fact of violation has been conceded, and it contributed to an obvious hazard, an atmosphere with low oxygen concentration.¹² Any injury resulting from the hazard would most likely be serious, possibly fatal. Whether the violation was S&S depends upon whether the Secretary established a reasonable likelihood that the hazard would result in an injury if normal mining operations continued. Her theory of injury, as explained by Yudaz, is that oxygen levels below 19.5% can cause a person to breath deeper and faster. Tr. 121, 128. They can also lead to dizziness and impaired judgment, which could result in a slip and fall incident and resulting injury.

Yudaz testified that he had voluntarily entered locations with oxygen concentrations as low as 17.9%, and did not feel any noticeable effects. Tr. 129-33. He was “cautious” when he entered such conditions, and did not stay in them long or travel any significant distance. Tr. 129-33; ex. R-16 at 112. He would not travel as far as 1,300 feet in 18.0% oxygen and, on the day of the inspection, when the oxygen concentration was 18.5%, he did not travel to MP-1. Tr. 139; ex. R-16 at 127-30. William F. Newman, a McElroy ventilation foreman at the time, was a certified weekly examiner who generally traveled the bleeder in question, and recorded a majority of the sub-standard oxygen readings reflected on McElroy’s records. He testified at the hearing and at deposition that he had no concerns traveling in oxygen concentrations as low as 17.0%, because he had been in such conditions and they didn’t seem to have any effect on him. Tr. 935; ex. G-28 at 21, 30. Although he testified at his deposition that he would be concerned if the oxygen concentration dropped to 17.9%, at the hearing he stated that he later reviewed an MSHA publication on the effects of low oxygen and learned that that level “shouldn’t be a problem.” Tr. 945.

None of the witnesses that testified at the hearing had any expertise on the effects on human beings of particular levels of oxygen concentrations. Yudaz’s assessments were based upon “general knowledge.” Ex. R-16 at 131-32. McElroy’s examiners were not trained on the effects of low oxygen levels. Tr. 877. The most authoritative evidence on that issue is an MSHA publication, Program Information Bulletin No. P07-05 (“PIB”), issued on March 27, 2007. Ex. G-14. That document notes generally that “oxygen concentrations below 19.5 percent can have adverse physiological effects, and atmospheres with less than 16 percent oxygen can become life threatening.” Ex. G-14 at 1. It also contains the following table:

¹² McElroy contends that there was no hazardous condition. Resp. Br. at 36. However, the sub-standard oxygen concentrations, under conditions that were highly susceptible to adverse changes, clearly constituted a hazardous condition.

<u>Percent Oxygen in Air</u>	<u>Effect</u>
17	Faster, deep breathing
15	Dizziness, buzzing in ears, rapid heartbeat
13	May lose consciousness with prolonged exposure
9	Fainting, unconsciousness
7	Life endangered
6	Convulsive movements, death

Ex. G-14 at 3.

The PIB appears to validate the opinion of the mine foreman, Michael Conjeski, that the oxygen concentrations that were being experienced in the travelable bleeder entry were not low enough to produce an injury causing event, considering that the only persons entering the area were experienced examiners who carried two atmospheric monitors and were well-aware of the ongoing problem. Tr. 877-99. However, witnesses for both parties agreed that there could be unexpected drops in oxygen concentrations caused by roof falls, a stopping crushing out, or a drop in barometric pressure. Tr. 106, 178-80 (Yudaz); 945-47 (Newman). The Secretary's argument is that the examiners travel the bleeder alone, and must traverse approximately 1,300 feet to the MP-1 location. An unexpected drop in oxygen concentrations from the 17.9% level, could have resulted in conditions that would have produced dizziness, making a slip and fall or other injury causing event reasonably likely. These were more than theoretical possibilities, because there is evidence that roof falls affecting airflow in the bleeder travelway were common and could be expected. Yudaz was aware that McElroy was having airflow problems in the bleeder travelway. Tr. 173-74; ex. R-16 at 30-33, 145-46. Conjeski conceded that McElroy had not supported the roof in the tailgate side "mixing chamber" entry very well, and that roof falls were making it "tight" for air flow in the bleeder. Tr. 861, 864-74.

On the particular facts of this case, I conclude that the violation was S&S. The ongoing problems with the poorly supported tailgate bleeder entries, made it reasonably likely that a roof fall or similar event would occur under continued mining operations, and that the already sub-standard level of oxygen concentration would be reduced to the point that an examiner would experience dizziness and impaired judgement. The examiners carried two atmospheric monitors with them. However, the monitors would have begun to sound an alarm upon entry into the bleeder travelway, and would have continuously alarmed while the examiner traversed the 1,300 feet to MP-1 and back. Consequently, he would have had to visually monitor the oxygen concentration readings to detect any changes, and he was also obligated to examine the roof and other conditions in the entry, as well as navigate around or through puddles of water that were present. An examiner concentrating on other conditions could easily fail to perceive a reduction in oxygen concentration caused by an unexpected event until it had a significant impact upon him. I find that the low oxygen concentrations, and the likelihood of unpredictable events that could drive them lower, rendered an injury producing event reasonably likely, and that the violation was S&S.

Unwarrantable Failure

There is ample evidence to sustain the allegation that the violation was the result of McElroy's unwarrantable failure. The violation was known to and tolerated by high levels of management. Conjeski, the mine foreman, talked to the examiners, signed most of the examination reports, and was well-aware that examiners were traveling in oxygen deficient atmosphere for several months. Tr. 849, 860; ex. G-11. While Conjeski did not feel that McElroy had done anything wrong, no corrective action was taken as of June 2, even though examiners had been traveling in sub-standard oxygen concentrations for over one month. Tr. 900; ex. G-12, G-26 at 67. Conjeski claimed that McElroy had been working "religiously" on the problem, and had been trying to get more air into the bleeder travelway, putting air in slowly and monitoring it. Tr. 900, 907-08. None of the claimed corrective actions were documented, even though documentation of corrective action is required by regulation. 30 C.F.R. § 75.364(h). Conjeski explained that the attempts to address the problem were unsuccessful, and that there was no need to document that ongoing process. Tr. 904-05. While he claimed, at his deposition that he didn't want his examiners going into atmospheres with oxygen concentrations less than 19%, and acknowledged that such conditions were not safe even though he did not know the effects on the human body, he continued to tolerate examiners traveling in oxygen concentrations below 19%, and even as low as 17.9%. Ex. G-26 at 70-72.

It may be that McElroy was taking steps in an effort to increase the air flow and oxygen concentrations in the bleeder travelway, and that Yudaz was told about them. However, it is obvious that any such attempts had proven ineffective, and that, as of the August 30 inspection, the condition had not improved significantly. Yet examiners were still traveling the bleeder in deteriorating conditions, and there is no indication that anything would have changed if Yudaz had not issued the Order.¹³ The condition was substantially improved within two days by

¹³ There are two written records of oxygen concentrations in the bleeder entry. Examiners first recorded conditions at the air measuring station at the end of the entry close to the bleeder fan. Ex. G-11. Conditions were also measured and recorded at MP-1, some 1,300 feet up the entry. Ex. G-12. Yudaz and Newman agreed that the oxygen content at the two measuring points should not have varied by more than one or two tenths of one percent. Tr. 88, 951. A comparison of the records confirms the consistency of the measurements, with one notable exception. On June 23, 2005, Newman recorded oxygen concentrations of 18.7% at the measuring station and 19.8% at MP-1. A relatively high reading of 19.7% was also recorded at MP-1 on June 30, but there is no corresponding record for that date at the measuring station. The entries of acceptable oxygen concentrations are suspect. The June 23 entry is substantially at variance with that recorded at the other measuring point. Moreover, Conjeski did not describe any actions being taken that would have had a substantial effect on the quality of air flow. Rather, he stated that air was being added to the system "slowly." Tr. 908. Conjeski signed the weekly examination record maintained at the surface, which showed the higher readings. However, he also talked to the examiners, and should have been aware that, even though an acceptable level of oxygen had been recorded for the MP-1 measuring point on June 23, that at

removal of a stopping, which resulted in measurements of 19.2-to-19.3% oxygen on September 1, 2005. Tr. 116-17, 881-82; ex. G-1. When Yudaz returned on October 5, oxygen levels had been increased to 19.5-to-19.6%, and the order was terminated. Ex. G-1. McElroy claimed that the stopping could not have been removed in June, because the longwall face had not advanced far enough. Tr. 881-82. However, assuming that was true, there is no explanation as to why that, or some comparable corrective action, could not have been taken in July or August, prior to issuance of the Order, and Conjeski indicated that it possibly could have been. Ex. G-26 at 124-26.

The involvement of an operator's agent, typically a supervisor, is particularly significant because the negligence of an agent can be imputed to the operator for purposes of unwarrantable failure and civil penalty assessment. *E.g., Capitol Cement Corp.*, 21 FMSHRC 883, 893 (Aug. 1999) (citing *R&P*, 13 FMSHRC at 194-97). "Managers and supervisors in high positions must set an example for all supervisory and non-supervisory miners working under their direction. Such responsibility not only affirms management's commitment to safety but also, because of the authority of the manager, discourages other personnel from exercising less than reasonable care." *Id.* at 892-93 (quoting from *Wilmot Mining Co.*, 9 FMSHRC 684, 688 (Apr. 1987)).

Here, the reaction of McElroy's high level managers to the long-standing violation exhibited the type of indifference that easily satisfies the test for unwarrantable failure.

The Appropriate Civil Penalties

The parties stipulated to many of the factors that are to be considered in establishing the amount of any civil penalty.¹⁴ McElroy is a large mine operator that produced 8,357,061 tons of coal in 2004. It is controlled by a very large entity, Consol Energy, Incorporated, which produced 64,516,367 tons of coal in 2004. For the period September 1, 2003 to August 31, 2005, McElroy was assessed approximately 1,426 violations in the course of 1,090 inspection days, a moderate history of violations record. McElroy demonstrated good faith in abating the violations, and the imposition of the proposed penalties would not affect McElroy's ability to remain in business. The gravity and negligence associated with the violations have been discussed above.

Order No. 7123909 is modified to a citation issued pursuant to section 104(a) of the Act, with moderate negligence. A civil penalty of \$4,800.00 was proposed by the Secretary. The reduction of the negligence factor, from high and unwarrantable failure to moderate, justifies a significant reduction in the proposed penalty. I impose a penalty in the amount of \$2,000.00, upon consideration of the above and the factors enumerated in section 110(i) of the Act.

least part of the entry remained out of compliance with the standard.

¹⁴ Final stipulations were submitted by letter dated August 7, 2007.

Order No. 7124015 is affirmed as a significant and substantial and unwarrantable failure violation. A civil penalty of \$6,600.00 was proposed by the Secretary. I impose a penalty in the amount of \$6,600.00, upon consideration of the above and the factors enumerated in section 110(i) of the Act.

Order No. 7124560 is modified to a citation issued pursuant to section 104(a) of the Act, The operator's negligence was high. However, the violation was not significant and substantial. A civil penalty of \$6,600.00 was proposed by the Secretary. I impose a penalty in the amount of \$4,500.00, upon consideration of the above and the factors enumerated in section 110(i) of the Act.

Order No. 7124782 is affirmed as a significant and substantial and unwarrantable failure violation. A civil penalty of \$5,300.00 was proposed by the Secretary. I impose a penalty in the amount of \$5,300.00, upon consideration of the above and the factors enumerated in section 110(i) of the Act.

ORDER

Order Nos. 7124015 and 7124782 are **AFFIRMED**, and Order Nos. 7123909 and 7124560 are **AFFIRMED, as modified**, and Respondent is directed to pay a civil penalty of \$18,400.00 within 45 days.

Michael E. Zielinski
Administrative Law Judge

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