#### FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

OFFICE OF ADMINISTRATIVE LAW JUDGES 2 SKYLINE, 10th FLOOR 5203 LEESBURG PIKE FALLS CHURCH, VIRGINIA 22041

### March 4, 1998

ROCK OF AGES CORPORATION, CONTEST PROCEEDINGS<sup>1</sup>

Contestant

Docket No. YORK 94-76-RM v.

Citation No. 4282251; 5/20/94

SECRETARY OF LABOR,

MINE SAFETY AND HEALTH Docket No. YORK 94-77-RM ADMINISTRATION (MSHA), Order No. 4282252; 5/20/94

Respondent

Docket No. YORK 94-78-RM

Order No. 4282253: 5/20/94

Docket No. YORK 94-79-RM

Order No. 4282254; 5/20/94

Docket No. YORK 94-80-RM

Order No. 4282255; 5/20/94

Docket No. YORK 94-81-RM

Order No. 4282256; 5/20/94

Docket No. YORK 94-82-RM

Order No. 4282257; 5/20/94

Docket No. YORK 94-83-RM

Order No. 4282258; 5/20/94

Rock Of Ages Lite Side Mine ID 43-00024

<sup>&</sup>lt;sup>1</sup> Order Nos. 4282252, 4282253, 4282254 and 4282258 were vacated by the Secretary prior to trial. Consequently, Rock of Ages Corporation-s motion to withdraw its contest with respect to these orders was granted at the hearing. Tr. I at 11-12.

SECRETARY OF LABOR, : CIVIL PENALTY PROCEEDING

MINE SAFETY AND HEALTH

ADMINISTRATION (MSHA), : Docket No. YORK 95-55-M
Petitioner : A.C. No. 43-00024-05518

Petitioner : A.C. No. 43-00024-055

V.

: Rock of Ages Lite Side

ROCK OF AGES QUARRIES, INC.,
A/K/A ROCK OF AGES CORP.,

Respondent :

## **REMAND DECISION**

Before: Judge Feldman

These matters concern four citations issued as a result of the Mine Safety and Health Administration=s (MSHA=s) accident investigation of the May 20, 1994, death of Michael Bassett, a channel burner operator, at Rock of Ages Corporation=s (ROA=s) Lite Side Quarry.<sup>2</sup> The citations involve 30 C.F.R. Part 56, Subpart E, which governs the use of explosives at surface metal/nonmetal mines. MSHA charged ROA with violating 30 C.F.R.

- ' 56.6311(b), for permitting work other than work necessary to remove a misfire in the blast area; 30 C.F.R. ' 56.6306(g), for permitting work to resume prior to an adequate post-blast inspection following the June 22, 1993, blast that resulted in the fatal misfires; 30 C.F.R.
- 56.6904, for permitting an open flame within 50 feet of explosive material; and 30 C.F.R.
- ¹ 56.6300(a), for inadequately training blasting personnel. MSHA alleged the violations were significant and substantial in nature and the result of ROA=s unwarrantable failure. The initial decision in this case found that ROA committed the alleged violations as charged and that the violations were attributable to ROA=s unwarrantable failure. A total civil penalty of \$180,000 was assessed. 17 FMSHRC 1925 (November 1995) (ALJ).

On February 24, 1998, the Commission affirmed the initial decision that the violations occurred, and that they were the result of ROA=s unwarrantable failure. *Slip op.*,

The Smith Quarry is a component of Rock of Ages Corporation=s Lite Side Quarry. The Smith and Lite Side Quarries have been referred to interchangeably in this matter. The Mine Safety and Health Administration designated the Lite Side Quarry as the site of the fatality. 17 FMSHRC at 1926.

20 FMSHRC. \_\_ . However, with respect to the appropriate civil penalty to be imposed, the Commission, citing *Sellersburg Stone Co.*, 5 FMSHRC 287, 292-93; *aff=d* 763 F.2d 1147 (7<sup>th</sup> Cir. 1984), vacated the initial penalty assessment and remanded this case for a detailed

analysis of each of the six penalty criteria in section 110(i) of the Federal Mine Safety and Health Act of 1977 (the Mine Act), 30 U.S.C. \* 820(i).3

In its remand, the Commission noted, in adjudicating the appropriate civil penalty, the judge must make A[f]indings of fact on each of the criteria [to] not only provide the operator with the required notice as to the basis upon which it is being assessed a particular penalty, but also provide the Commission and the courts . . . with the necessary foundation upon which to base a determination as to whether the penalties assessed by the judge are appropriate, excessive, or insufficient. Slip op. at 21, quoting Sellersburg, 5 FMSHRC at 292-93.

Although all of the statutory penalty criteria must be considered in assessing the appropriate penalty, it is not uncommon, due to aggravating or mitigating circumstances, for one criterion to outweigh another when determining the ultimate penalty. For example, the appropriateness of the penalty to the size of the operator may warrant a lower civil penalty despite aggravating circumstances that ordinarily would justify a higher penalty. In this case, as noted by the Commission in its remand, I based the imposed \$180,000 civil penalty primarily upon the Aextremely high negligence and serious gravity associated with each of the violations. *Id.* at 21. Consistent with the Commission=s remand directive, a discussion of all of the penalty criteria follows.

### 1. History of Violations

The record reflects that ROA had a history of 32 violations during the two year period preceding the fatal accident. The vast majority of these violations were designated as non S&S. I

<sup>&</sup>lt;sup>3</sup>Section 110(i) sets forth six forth six criteria to be considered in the assessment of penalties under the Act:

<sup>[1]</sup> the operator=s history of previous violations, [2] the appropriateness of such penalty to the size of the business of the operator charged, [3] whether the operator was negligent, [4] the effect on the operator=s ability to continue in business, [5] the gravity of the violation, and [6] the demonstrated good faith of the person charged in attempting to achieve rapid compliance after notification of a violation.

view this as a good history of compliance, particularly in view of the fact that ROA is a large operator with numerous employees. However, as discussed below, I do not view this as a significant mitigating circumstance in view of the magnitude of negligence and the serious gravity involved in this case.

#### 2. Appropriateness of Penalty to Size of the Operator

ROA is a large operator with approximately 500 employees. It has gross sales of more than \$25,000,000 annually. It has neither been contended nor shown that the civil penalty liability imposed in this case is disproportionately excessive with respect to ROA=s size.

## 3. <u>Degree of Negligence</u><sup>4</sup>

The ROA quarry process is set forth in the Commission=s remand and need not be repeated in detail. *See Id.* at 1-4. However, in order to appreciate the exceptionally high degree of negligence in this case, it is important to briefly revisit ROA=s experimental use of pyrodex in its quarry process.

As a threshold matter, it is this experimental nature of the sequential ignition of its pyrodex blasts that should have alerted ROA to the importance of exercising a high degree of care. Unlike its usual practice of using seismic cord (a continuous charge) as a blasting agent, bags of pyrodex were placed at the front, in the middle, and in the rear of lift holes, without any connecting detonating or ignition cord. The heat generated from the front bag, ignited by a squib at the mouth of the lift hole, was supposed to travel through the lift hole and ignite the middle bag. Similarly, it was anticipated the heat from ignition of the middle bag would travel to the rear of the lift hole igniting the rear bags.

As discussed in the Commission-s decision, the blasting process routinely occurs 35 days into quarrying the bench. *Id.* at 2. The entire bench is ordinarily removed, in pieces, approximately 47 days from the initial channel burning that starts the quarrying process. *Id.* at 3. Consequently, it takes approximately 12 days to remove a bench after it is blasted.

<sup>&</sup>lt;sup>4</sup> Although the Commission has affirmed the unwarrantable failure findings for each of the four violations in issue, it is essential to summarize the specific findings to provide the required notice regarding the basis for the imposed civil penalties. *Sellersburg*, 5 FMSHRC at 292-93.

<sup>&</sup>lt;sup>5</sup> As a consequence of its unfamiliarity with pyrodex, ROA kept blasting reports for each pyrodex shot. There are less than ten documented production uses of pyrodex by ROA in its 90 year history. *See* Gov. Ex. R-7; 17 FMSHRC at n.7.

On June 22, 1993, a granite bench, measuring approximately 42 feet wide, 16 feet high and 37 feet deep, was separated from the quarry floor using a pyrodex blast. This was accomplished by loading four bags of pyrodex in every fourth of 80 lift holes, measuring 1f inches in diameter, drilled at six-inch intervals, 37 feet deep across the bottom of the face. The loading pattern in every fourth hole was one pyrodex bag in front, one in the middle, and two in the back placed approximately 32 to 37 feet from the mouth of the hole. *Id.* at 4.

Approximately eight days after the blast, around July 1, 1993, ROA=s derrick operator was loading blocks of granite to be lifted out of the quarry from the June 22, 1993, blast site when he saw four misfired bags of pyrodex that had shaken loose and were hanging from a block. There were no squibs attached to the bags. *Id.* As these bags were discovered in the midst of the 12 day post-blast quarry removal process, it is reasonable to conclude they were bags placed in the middle of the lift holes. This conclusion is supported by the accident investigation that revealed the June 22, 1993, blast resulted in nine pairs of rear bag misfires (18 total bags) in nine different lift holes. Even, if the four discoverd bags were rear bags, multiple rear misfires should have alerted ROA to a potential systematic failure of rear bag ignition, as well as a potential for additional middle bag ignition failure. 17 FMSHRC at 1947-48.

The derrick operator reported the misfires to the blasting foreman who noted the misfires on the June 22, 1993, blasting report. Gov. Ex. R-7. The uncontroverted testimony is that the blasting foreman, who was not called to testify by ROA, stated he Aforgot@to search for more misfires. *Slip op.* at 4-5.

The four misfires without attached squibs discovered during the granite removal process on July 1, 1993, should have alerted ROA that there was a substantial probability, if not a certainty, that at least eight rear bags in four different lift holes could not have ignited as planned. Misfired rear bags are the most dangerous because the channel burner will torch this rear area where the lift holes, previously drilled in the lower face of the quarried bench, become the surface of the bench to be channel burned as the level of the quarry descends.

Misfires are an unavoidable consequence of blasting and do not, alone, establish negligence. Although there is ample evidence reflecting ROA was highly negligent in its use of pyrodex, particularly in view of the 26 percent misfire rate resulting in 22 misfired bags located at

<sup>&</sup>lt;sup>6</sup> Bassett=s torch passed within two feet at the rear of a lift hole covered by caprock that contained two bags of misfired pyrodex moments before his torch ignited two other misfires located three lift holes away. After the accident, 14 additional bags were found under caprock at the rear of seven different lift holes. *Slip op.* at 5. ACaprock@is a layer of rock covering a lift hole that remains in place, sometimes with misfires inside, if the post-blast lift and separation from the quarry floor were not clean. *Id.* at 3. All of the misfired bags recovered during the accident investigation were found at the rear of lift holes. *See* Gov. Ex. R-10. Counting the four misfires found by the derrick operator, there was a total of 22 misfires at the accident bench.

the immediate scene of the fatality, the overwhelming justification for high penalties in this case is ROA=s failure to take any meaningful action to probe caprock in an effort to remove additional misfires after the four misfires were found. In this regard, the Commission concurred with the initial decision that the foreman=s Afailure to order any meaningful search for unexploded pyrodex, such as probing caprock at the blast site, \*evidenced a callous disregard for the hazards associated with misfires.= \*\mathbb{Id}\$. at 10, quoting 17 FMSHRC at 1948.

In analyzing the degree of negligence, I note ROAs argument that the perceived hazard in this case is only clear in hindsight. Contrary to ROAs assertion, it does not require hindsight to recognize that known misfires recovered during the bench removal process could not generate the heat required to ignite the rear bags placed in the lift holes behind the recovered bags. Similarly, hindsight is not essential to appreciate the potential exposure of a channel burner operator who was certain to torch the rear of the bench below the June 22, 1993, blast.

As previously noted, the Commission has affirmed the unwarrantable failure findings in this case. A finding of unwarrantable failure requires evidence of unjustifiable or aggravated conduct constituting more than ordinary negligence. *Emery Mining Corp.*, 9 FMSHRC 1997, 2001 (December 1987). Unwarrantable failure is characterized by conduct evidencing Areckless disregard,@Aintentional misconduct,@Aindifference,@or a Aserious lack of reasonable care.@ *Id.* at 2003-04; *Rochester & Pittsburgh Coal Co.*, 13 FMSHRC 189, 194 (February 1991); *see also Buck Creek Coal, Inc. v. FMSHRC*, 52 F.3d 133, 136 (7<sup>th</sup> Cir. 1995) (approving Commission=s unwarrantable failure test). Thus, the issue of unwarrantability must be based on what was known, or what should have been known, at the time of the alleged unwarrantable act.

While hindsight may be a relevant mitigating consideration in cases of ordinary negligence, hindsight is not material in cases of unwarrantable failure, as the operative consideration is the nature and extent of the information available at the time of the alleged unwarrantable conduct, *i.e.*, the occurrence of misfires and the likelihood of additional misfires. Consequently, I am not persuaded by ROA=s attempt to use the issue of hindsight as a justification for its failure to exercise common sense.

In short, ROAs conduct manifested a reckless disregard which, absent any significant mitigating circumstances, warrants the imposition of the highest civil penalties contemplated by the Mine Act. This exceptionally high degree of negligence, which caused ROA to ignore the probability of misfires in close proximity to torch flames, is applicable to all four of the cited violations under consideration.

# 4. The Effect of the Civil Penalty on ROA=s Business

<sup>&</sup>lt;sup>7</sup> The dimensions of benches essentially were unchanged as they were quarried in a vertical direction down into the rock formation. The Commission noted Aunexploded bags of pyrodex would not lie harmlessly under piles of rock but would eventually be exposed as benches were removed and pose a hazard as channel burning resumed. Slip op. at 10.

It has neither been contended nor shown that ROA=s ability to continue in business, given its multi-million dollar revenue, would be effected by the imposition of a \$180,000 civil penalty in this case.

### 5. Gravity

This case concerns a fatality that was caused by four violations of mandatory safety standards that resulted in the foreseeable presence of torch flames in the vicinity of potential misfires. One cannot imagine a scenario constituting more serious gravity.

### 6. Good Faith Abatement and Compliance

ROA cooperated with MSHA during its accident investigation, during which time operations were halted and a total of 40 pyrodex misfires were found. As noted above, given the degree of negligence and serious gravity, and, the exigent nature of the circumstances that required an immediate cessation of operations, I do not view ROA=s cooperation as a significant mitigating factor.

Citation No. 4282251 and Order No. 4282257 concern ROAs failure to act prudently immediately after the June 22, 1993, blast that resulted in the fatal misfires. Accordingly, the maximum \$50,000 penalties are imposed for the failure of ROA to take any meaningful action to search for additional misfires immediately after four misfires were discovered on July 1, 1993. The two remaining orders concern violations that occurred in May 1994, approximately one year later, when the victim began channel burning the bench below. The reduced \$40,000 civil penalties are imposed for these orders because of the slight mitigation associated with the time period that elapsed between the initial June 22, 1993, blast that caused the misfires and the May 20, 1994, fatal ignition of those misfires.

In view of the above I am reinstating the total \$180,000 civil penalty imposed in the initial decision. This civil penalty is comprised of: \$50,000 for Citation No. 4282251/violation of 30 C.F.R. ' 56.6311(b); \$40,000 for Order No. 4282255/violation of C.F.R. ' 56.6306(g); \$40,000 for Order No. 4282256/30 C.F. R. ' 56.6904; and \$50,000 for Order No. 4282257/violation of C.F.R. ' 56.6300(a).

#### **ORDER**

Accordingly, consistent with the penalty criteria in section 110(i) of the Mine Act, the \$180,000 civil penalty in this matter **IS REINSTATED**. Consequently, **IT IS ORDERED** that Rock of Ages Corporation pay a civil penalty of \$180,000 in satisfaction of the citation and orders in issue within 30 days of this order, and, upon receipt of timely payment, these docketed proceedings **ARE DISMISSED**.

Jerold Feldman
Administrative Law Judge

Distribution:

Robin A. Rosenbluth, Esq., Office of the Solicitor, U.S. Department of Labor, 4015 Wilson Blvd., Suite 400, Arlington, VA 22203 (Certified Mail)

Henry Chajet, Esq., Patton Boggs, LLP, 2550 M Street, N.W., Washington, D.C. 20037 (Certified Mail)

Harry Tuggle, Esq., United Steelworkers of America, Health & Safety Department, Five Gateway Center, Pittsburgh, PA 15222 (Certified Mail)

David Gomo, c/o United Steelworkers of America, Amalgamated Local #4, P.O. Box 584, Barre, VT 05641 (Certified Mail)

David Gomo, Union Stewart & Safety Committeeman, United Steelworkers of America, P.O. Box 482, Barre, VT 05641 (Certified Mail)

/mh