FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

OFFICE OF ADMINISTRATIVE LAW JUDGES
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November 21, 2005

SECRETARY OF LABOR,	:	CIVIL PENALTY PROCEEDING
MINE SAFETY AND HEALTH	:	
ADMINISTRATION (MSHA)	:	Docket No. YORK 2005-22-M
Petitioner	:	A.C. No. 30-00048-44703
	:	
v.	:	
	:	
HANSON AGGREGATES	:	
NEW YORK, INC.,	:	Jordanville Plant
Respondent	:	

SUMMARY DECISION

Before: Judge Hodgdon

This case is before me on a Petition for Assessment of Civil Penalty brought by the Secretary of Labor, acting through her Mine Safety and Health Administration (MSHA), against Hanson Aggregates New York, Inc., pursuant to section 105 of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 815. The petition alleges a violation of the Secretary's mandatory health and safety standards and proposes a penalty of $9,100.00. For the reasons set forth below, I affirm the citation and assess the penalty proposed.

Procedural Background

The parties have submitted the case on cross motions for summary decision. The Commission rule governing summary decisions, Rule 67(b), 29 U.S.C. § 2700.67(b), provides that: "A motion for summary decision shall be granted only if the entire record . . . shows: (1) That there is no genuine issue as to any material fact; and (2) That the moving party is entitled to summary decision as a matter of law." The parties have stipulated to the facts, so the first requirement of the rule is met. Based on the stipulated facts, I conclude that the Secretary is entitled to summary decision as a matter of law.

Stipulated Factual Background

On the morning of March 23, 2004, an accident occurred at Hanson's Jordanville Plant in Herkimer, New York, as several Hanson employees were in the process of setting up a 75 ton P & H mobile crane on a ramp leading to the mine's primary crusher. The feeder and hopper assembly on the primary crusher were scheduled for repair, and the crew needed the crane to lift the feeder and hopper off the crusher.

When the accident occurred, the crew had extended the crane's outriggers and roped off the working radius of the crane, and the crane operator, Robert Kimball, was setting up the crane. The crane operator raised the crane's boom approximately 71°, and he extended the boom about fifty feet. The supervisor of the crew, Dean Robertson, was the designated signal or ground man. At the time of the accident, Mr. Robertson was standing to the side of the crane.

As Mr. Kimball extended the crane's hydraulic boom, he apparently failed to lower or extend the auxiliary hoist line. A hoist ball with a hook was secured to the crane's auxiliary hoist line. The extending boom eventually pulled the hoist ball tight against the tip of the boom, snapping the auxiliary hoist line. Such an occurrence is commonly known as "two-blocking."

The hoist ball and hook fell and struck Dean Robertson, killing him instantly. The forces involved in separating the ball and the hook from the auxiliary hoist line and the reactionary movement of the boom caused the assembly to be thrown out and away from the head sheave a few feet.

After the accident, MSHA issued Citation No. 6002658 to Hanson. MSHA later modified the citation to allege that Hanson violated 30 C.F.R. § 56.14211(c) in that:

> A fatal accident occurred at this operation on March 23, 2004, when a mine foreman was struck by a metal ball and lifting hook that detached from the auxiliary hoist cable of a crane. The auxiliary hoist cable's weight ball and hook contacted the end of the boom causing the cable to break (two-block condition). The crane's anti-two block device either was not activated or malfunctioned and there was no other functional means to prevent accidental lowering. The victim, who was performing the task of a signal man at the time of the accident, was exposed to the hazard of the hoist's ball and hook suddenly falling.

Section 56.14211(c) provides that "[a] raised component must be secured to prevent accidental lowering when persons are working on or around mobile equipment and are exposed to the hazard of accidental lowering of the component."

Facts and Conclusions of Law

Hanson argues that it did not violate the regulation. It maintains that the Secretary has stipulated that it used all of the load locking devices that it could have and that an anti-two-block device is not required by the regulation. Further, the Respondent asserts that a reasonably prudent person familiar with the mining industry would not have understood the requirement of the regulation as urged by the Secretary. The Secretary counters that the meaning of the regulation is plain on its face and that Hanson clearly violated the regulation. I hold that the Secretary's position is correct.

Section 56.14211(c) can be broken down into four elements. It requires that: (1) raised components; (2) be secured to prevent accidental lowering; (3) when persons are working on or around mobile equipment; and (4) exposed to the accidental lowering of the component. The parties have stipulated that the raised component was the hook and ball originally secured to the auxiliary hoist line. (Stipulated Material Fact (SMF)16.) They further agree, as set out in the stipulated narrative, that Robertson was working around the crane and that he was exposed to the accidental lowering of the hook and ball. Thus, the issue in this case is whether the hook and ball were secured to prevent accidental lowering.

Section 56.14211(d), 30 C.F.R. § 56.14211(d), sets out the method for securing raised components against accidental lowering. It states that: "Under this section, a raised component of mobile equipment is considered to be blocked or mechanically secured if provided with a functional load-locking device or a device which prevents free and uncontrolled descent."

In this connection, the parties have agreed that the crane was equipped with an anti-two-block device, that the load braking system on the crane's auxiliary hoist was working properly when the accident occurred, and that the ball and hook were properly rigged or secured to the auxiliary hoist line. (SMF 5, 7 and 12.) In addition, they have agreed that the load brake on the auxiliary hoist line constitutes a "load locking device" or a device that "prevents free and uncontrolled descent." (SMF 14.) They have further agreed that load brakes, anti-two-block devices and proper rigging are the only load locking devices that Hanson could have used to prevent the free and uncontrolled descent of the hook and ball. (SMF 15.) Finally, they have stipulated that based on tests conducted by MSHA following the accident, MSHA could not determine whether the anti-two-block device was working properly and consistently on the day of the accident. (SMF 6.)

Because MSHA was unable to determine whether the anti-two-block device was working properly on the day of the accident, the company argues that the Secretary has failed to prove the violation. It asserts that it had two load locking devices in working condition, when it was only required to have one, and, therefore, it complied with the regulation. This contention, however, ignores the failure of the anti-two-blocking device.

Respondent's arguments might be pertinent if the crane had only been equipped with a load brake and proper rigging. Then, if the Secretary were contending that the crane should have been equipped with an anti-two-block device, it would be relevant that the regulation does not specifically require an anti-two-block device, or that MSHA's *Program Policy Manual* discussion of the rule mentions such a device only in connection with using a crane to hoist personnel. But here, the crane *was already equipped with an anti-two-block device*. Thus, these arguments are beside the point.

The crane was equipped with a Microguard 424 Rated Capacity Indicator (Microguard system), a computerized system with anti-two-block elements. Those elements included two anti-two-block switches or devices, one for the main hoist line and one for the auxiliary hoist

line. (SMF 22.) The Microguard system has two modes: the "rigging/travel mode" and the "work mode." (SMF 23.)

If the crane approached a two-block condition while in "rigging/travel mode," the anti-two-block switch for the hoist approaching the two-block condition should trip or open, and the Microguard would display a red warning light. (SMF 24.) If the crane approached a two-block condition while in "work mode," one or both of the anti-two-block switches should trip or open, and the Microguard would activate hydraulic cut valves, depending upon whether one or both hoists are approaching a two-block condition, sound an audible alarm and display a red warning light. When activated, the hydraulic cut valves would essentially shut the crane down, hydraulically preventing a two-block condition from occurring. (SMF 25.)

MSHA was unable to determine whether the Microguard system was in "rigging/travel mode" or "work mode" when the accident occurred. (SMF 3.) And if anyone from the company knows, that information has not been volunteered. Further, there is no evidence that a red warning light was displayed, that an audible alarm sounded, or that the crane was shut down. Nevertheless, it seems a logical inference that if the crane had shut down, this case would not be before me.

It is possible, however, to arrive at the following conclusions: (1) The crane was in the "rigging/travel mode," the anti-two-block switch for the hoist did not trip or open and/or the red warning light was not displayed; (2) The crane was in the "work mode," the anti-two-block switches did not trip or open and/or the hydraulic cut valves were not activated, the audible alarm was not sounded and the red warning light was not displayed; or, (3) The crane was in either the "rigging/travel mode" or the "work mode," the hydraulic cut valves were activated, the audible alarm was sounded and/or the red warning light was displayed and the crane operator ignored them.

It seems unlikely that condition No. 3 occurred without there being any evidence of it.[1] As noted above, if the hydraulic cut valves had been activated, the crane would have shut down whether the operator ignored the situation or not, and the accident would presumably have been prevented. Further, bystanders would have noticed the shut down. Similarly, if an audible alarm had sounded, bystanders would have heard it. Moreover, when MSHA tested the anti-two-block device after the accident, it worked when crane's boom was at 50° and below, but it did not work consistently when tested above 50°. (SMF 6.) When the accident occurred, the crane's boom was at approximately 71° according to the stipulated narrative. Thus, I find that a preponderance of the evidence, and the logical inferences to be drawn therefrom, supports a conclusion that the anti-two-block device did not function properly.

It is not enough that the crane was equipped with an anti-two-block device, if it did not

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[1] The parties have stipulated that operator error was a root cause of the accident. (SMF 17.) However, no information beyond that enigmatic statement is provided.

function properly. In *Mettiki Coal Corp.*, 13 FMSHRC 760 (May 1991), a case involving an improperly functioning lockout device on a circuit breaker, the Respondent argued that "since the Secretary's regulations do not require that a breaker be equipped with a lockout device and the failure to have such a device would not violate section 77.507, then having a modified lockout device cannot be deemed to violate the safety standard." *Id.* at 768. Like Hanson, Mettiki also argued that MSHA's interpretation of the regulation did not meet the "reasonably prudent person" test. *Id.* The Commission rejected these arguments and held that:

> A reasonably prudent person would have recognized that the standard required that the No. 34 breaker, a switch used by Mettiki to lock out the belt motor circuit, be equipped with a *functioning* lockout device and that the improperly installed lockout device on the switch was in violation of section 77.507.

Id. at 769 (emphasis added); *accord Western Fuels-Utah. Inc.*, 19 FMSHRC 994, 999 (June 1997).

Hanson makes the same arguments in this case. They must be rejected for the same reasons. I find that a reasonably prudent person would recognize that section 56.14211(c) requires that if the crane is equipped with an anti-two-block device as a means of preventing accidental lowering, it be equipped with a functioning anti-two-block device and that the failure of the device to function is in violation of the regulation. This is particularly apparent in this case where the device is designed, as its name indicates, to prevent "two-blocking."

Accordingly, I conclude that the Respondent violated the regulation as alleged.

Civil Penalty Assessment

The Secretary has proposed a penalty of $9,100.00 for this violation. However, it is the judge's independent responsibility to determine the appropriate amount of penalty in accordance with the six penalty criteria set out in section 110(i) of the Act, 30 U.S.C. § 820(i). *Sellersburg Stone Co. v. FMSHRC*, 736 F.2d 1147, 1151 (7th Cir. 1984); *Wallace Brothers, Inc.*,18 FMSHRC 481, 483-84 (Apr. 1996).

In connection with penalty criteria, the parties have stipulated that the violation was abated in good faith, that the penalty proposed for the violation will not affect Hanson's ability to continue in business and that the Jordanville Plant is a small mine. (SMF 1, 20, 32.) Furthermore, the Assessed Violation History Report shows that Hanson's Jordanville Plant has a very good history of prior violations. (SMF 27, App. A.) In addition, the negligence involved in this violation was "low." Finally, the gravity of the violation was very serious in that it resulted in the death of a miner.

Taking all of these factors into consideration, I conclude that the $9,100.00 penalty proposed by the Secretary is appropriate. Accordingly, that is the penalty that will be assessed.

Order

In view of the above, the Secretary's Motion for Summary Decision is **GRANTED** and the Respondent's motion is **DENIED**. Citation No. 6002658 is **AFFIRMED**. Hanson Aggregates New York, Incorporated, is **ORDERED TO PAY** a civil penalty of **$9,100.00** within 30 days of the date of this decision.

T. Todd Hodgdon
Administrative Law Judge

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