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Federal Mine Safety and Health Review Commission (F.M.S.H.R.C.)
Office of Administrative Law Judges

SECRETARY OF LABOR,
MINE SAFETY AND HEALTH
ADMINISTRATION (MSHA),
PETITIONER

CIVIL PENALTY PROCEEDING

Docket No. CENT 88-112-M
A.C. No. 14-00111-05511

v.

Lone Star Quarry and Mill

LONE STAR INDUSTRIES, INC.,
RESPONDENT

DECISION

Appearances: Charles A. Mangum, Office of the Solicitor,
U.S. Department of Labor, Kansas City, Missouri,
for the Petitioner;
Michael T. Heenan, Esq., Smith, Heenan & Althen,
Washington, D.C.,
for the Respondent.

Before: Judge Morris

The Secretary of Labor, on behalf of the Mine Safety and Health Administration (MSHA), charges respondent with violating two safety regulations promulgated under the Federal Mine Safety and Health Act, 30 U.S.C. 801 et seq., (the Act).

After notice to the parties a hearing was held in Kansas City, Missouri.

The parties filed post-trial briefs.

Summary of the Case

Citation No. 2870909 charges respondent with violating 30 C.F.R. 56.11001, which provides as follows:

56.11001 Safe access.

Safe means of access shall be provided and maintained to all working places.

The citation reads as follows:

A safe means of access was not provided into the #3 clinker cooler dust chamber. An employee was entering the shut down #3 clinker cooler dust chamber that was undergoing repairs to take some measurements. A permanently disabling injury occurred on 12-4-87 at about 1440 hours, when an employee's right leg became entangled in the #2 and #3 clinker cooler dust screw conveyor and was severed about mid-thigh.

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Citation No. 2870908 charges respondent with violating 30 C.F.R. 56.12016, which provides as follows

56.12016 Work on electrically-powered equipment.

Electrically powered equipment shall be de-energized before mechanical work is done on such equipment. Power switches shall be locked out or other measures taken which shall prevent the equipment from being energized without the knowledge of the individuals working on it. Suitable warning notices shall be posted at the power switch and signed by the individuals who are to do the work. Such locks or preventive devices shall be removed only by the persons who installed them or by authorized personnel.

The citation reads as follows:

The electrical power for the #2 and #3 clinker cooler dust screw conveyor was not turned off, locked and tagged out. A permanently disabling injury occurred on 12-4-87 at about 1440 hours when an employee's right leg became entangled in the screw conveyor and was severed at about mid-thigh.

Issues

The issues are whether respondent violated the regulations.

Stipulation

At the commencement of the hearing the parties stipulated as follows:

1. The quarry mill involved in these citations is a moderate to large operation. On an annual basis there are 200,000 to 300,000 man hours at the mill.

2. The operator's prior history is contained in a computer printout for the 24 months prior to the accident in question. The computer printout may be received in evidence as Exhibit P-1.

3. The company abated the alleged violations within a reasonable time.

4. The imposition of the proposed civil penalties will not affect the company's ability to continue in business.

(Tr. 13, 14)

The Evidence

ELDON E. RAMAGE, an MSHA inspector for 11 years, has extensive training in mining. He has been a certified electrician and safety coordinator in the metal and nonmetal industry. He has experience in hazard recognition. In addition, he has conducted some 3000 MSHA inspections.

The witness has inspected Lone Star many times at the Bonner Springs plant where the company operates an open pit quarry; cement is produced.

In December 1987 he learned of an accident at the plant and he conducted a subsequent investigation. The investigation report was received in evidence as Exhibit P-2.

During the inspection of the scene Mr. Ramage was accompanied by management representatives Green, Metzker and Krause.

Lone Star's cement producing process is illustrated by Exhibit R-1. A limestone slurry initially enters a kiln. The chamber, which rotates, in turn discharges its clinkers into a cooler. The clinkers flow from the kiln to the cooler through a clinker dust chamber. Clinker dust accumulates in the dust chamber and a slide, or chute, permits the dust to fall into a screw conveyor located at ground level.

This 16-inch screw conveyor, 49.83 feet in length, is driven by a 25 hp electric motor. It rotates at 60 r.p.m.

On the day of this accident temporary scaffolding had been erected to perform maintenance work in the clinker dust chamber. Exhibit P-3(a) shows the position of the scaffolding in the dust chamber. Repair and maintenance occurs about once a year when the kiln is shut down.

On this repair and maintenance day four workers were using impact tools to install grates in the dust chamber. These workmen had entered the dust chamber from the top via a ladder.

At the bottom of the dust chamber there are four inspection doors located just above the auger (Exhibit P-3(a)). The above described doors are not posted with any directions that they should not be used for access to the chamber.

In the above situation Lone Star's engineer Ronald E. Roebuck entered the dust chamber through the second inspection door from the left. Light and extension cords, as well as air lines, had been taken into the dust chamber through one of the

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inspection doors. The repairmen working in the dust chamber had gained access through the top of the chamber. Due to the closeness of the shroud to the side of the dust chamber, Roebuck (who was a big man) apparently decided to enter through the inspection door of the dust chamber.1 By entering the chamber through the inspection door he could ascend to the temporary scaffolding where the repairmen were working. He could then go into the air duct area to obtain some measurements.

When he entered Roebuck did not deenergize and lock out the screw conveyor. As he was attempting to climb up the metal slide or chute to the scaffolding something caught on the chute. He lost his footing and slid back down through the feed opening below the inspection door he had just entered. This permitted his right foot to pass through the opening into the rotating screw conveyor. His right foot became entangled in the rotating screw which pulled his foot and leg into the conveyor. His right leg was severed about mid-thigh.

Fellow employees heard Roebuck's screams for help and they went to his assistance. To reach Roebuck they descended from the scaffold to the bottom of the dust chamber and exited via an inspection door. Roebuck was then sitting outside the chamber and a fellow employee immediately went to the burner floor and shut off the conveyor.

Discussion

In The Hanna Mining Company, 3 FMSHRC 2045 (1981) the Commission considered the "safe access" regulation and ruled that "the standard requires that each 'means of access' to a working place be safe." In addition, the Commission observed that "(t)his does not mean necessarily that an operator must assure that every conceivable route to a working place no matter how circuitous or improbable, be safe." 3 FMSHRC at 2046.

The regulation in contest here is generally listed under the category of "Travelways." Accordingly, it is appropriate to consider whether a travelway was involved here. Section 56.1 defines a travelway as "a passage, walk or way regularly used and designated for persons to go from one place to another."

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As a threshold matter the record here fails to disclose that a route via the inspection door was regularly used by employees. I recognize that this incident occurred during a repair and maintenance mode. (In fact, due to excessive heat generated by the process, workers cannot enter the clinker cooler when it is operational.)

After extensive testimony on the issue of whether employees regularly went through the inspection doors, respondent moved to strike portions of the testimony of the inspector (Tr. 81-82). The judge reserved his ruling until the conclusion of the case and at that point he ruled that no credible evidence supported the view that workmen used the inspection door to enter the dust chamber (Tr. 110-111).

It is further apparent that the inspection door was not designated as an entry door. The ordinary definitions of "designate" are "to point out the location," or to "indicate."² The testimony, scale drawings and photographs do not show that the inspection doors were designated as entry doors. (Exhibits P-4, P-5, P-6 and P-7 are photographs of the inspection doors.)

With the Commission's mandate in Hanna it is necessary to further review the evidence to determine whether an inspection door presented a reasonable means of access.

As a threshold matter it is apparent these four inspection doors were to be opened to inspect the flow of material entering the screw conveyor (Tr. 75). No evidence indicates they are access doors to be used by workers to enter the dust chamber.

At the hearing there was no testimony as to the size of the opening. The only evidence is contained in the scale drawing (Exhibit P-3(a)). This exhibit indicates a door was 3 feet high by 2 feet 8 inches wide. Entry from the bottom of the chamber would be, at best, difficult for any person.

When Roebuck entered the dust chamber he had to physically pass over the enclosed screw conveyor. He would then be entering the chamber onto a sharply inclined dusty or gritty chute. The testimony does not disclose the angle of the chute. However, Exhibit P-3(a) shows the scaffolding and the chute.

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The point where Roebuck's leg slipped into the screw conveyor was normally guarded by a grizzly. It was apparently not guarded on this occasion. However, the failure to guard the conveyor does not convert this route to a travelway. It is uncontroverted that the grizzly was not a man guard nor was it designed to prevent a person from being caught in the screw auger (Tr. 94-95).

It is true that air lines and hoses had been passed through the door opening to the workmen on the scaffolding but that fact, in and of itself, would not convert this inspection door and route into a passageway.

It is further true that Roebuck's fellow workers came down from the scaffold and reached him through the inspection door. However, this was in response to his calls for help and after he had been injured.

The Secretary argues that a violation of 56.11001 was established by the very absence of a safe travelway into the dust chamber (Brief at 5). Indeed, she argues the accident would not have occurred if respondent had designated a safe passage for employees to regularly use.

The evidence does not support the Secretary's argument. Entry through the top of the dust chamber was not shown to be unsafe. In fact, the four workmen entered through the top and performed their maintenance work from the scaffold (Tr. 74). The testimony is unclear but access through the top involved a three foot by four foot opening (Tr. 89).

The regulation requires an operator to furnish safe access. It does not require an operator to assure that every conceivable route to a working place be safe.

The Secretary further argues that the accident itself establishes that the means of access used by Roebuck was unsafe.

The Secretary's arguments are rejected. It is well established that an accident, in and of itself, does not prove a violation of a regulation. Texas Industries, Incorporated, 4 FMSHRC 352 (1982).

In sum, on the evidence presented here I conclude the entry through the inspection door was not a means of access within the meaning of the standard. Further, there was no reasonable possibility that a miner would use this route as a means of reaching a work place.

Citation No. 2870909 should be vacated.

This citation charges respondent with violating 30 C.F.R. 56.12016, cited, *supra*.

During the hearing the Secretary was granted leave to allege, in the alternative, that the operator violated 30 C.F.R. 56.14029.

The uncontroverted facts indicate that Roebuck entered the dust chamber without turning off and locking out the screw auger. The uncontroverted facts further establish that no repairs or maintenance was being performed on the screw auger at the time.

Both of the regulations cited here forbid repairs or maintenance on moving machinery except where motion is necessary to make adjustments. In the instant case the screw auger was moving but no repairs or maintenance were being performed on it. The cited regulations are not applicable in this factual situation.

For a case illustrating this principle, see the well-reasoned decision of Judge James A. Broderick in *United States Steel Corporation*, 4 FMSHRC 906 (1982).

The matter of taking measurements (as Roebuck intended to do) and the workmen installing grates cannot be stretched to include a repair or maintenance of the screw auger.

Various other cases demonstrate the proper application of the standards: Cf. *Greenville Quarries, Inc.*, 9 FMSHRC 1390 (1987) (Koutras, J); *North American Sand & Gravel Co.*, 2 FMSHRC 2017 (1980), (Moore, J); *Brown Brothers Sand Co.*, 3 FMSHRC 734 (1981) (Cook, J).

The Secretary argues that the cited standards are designed, in part, to prevent the hazard of human entanglement in moving

