FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION
OFFICE OF ADMINISTRATIVE LAW JUDGES
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February 9, 2011

SECRETARY OF LABOR,	:	CIVIL PENALTY PROCEEDINGS
MINE SAFETY AND HEALTH	:	
ADMINISTRATION, (MSHA),	:	Docket No. KENT 2008-312
Petitioner	:	A.C. No. 15-17110-131880
	:	
	:	Docket No. KENT 2008-697
	:	A.C. No. 15-17110-140405
v.	:	
	:	Docket No. KENT 2008-875
	:	A.C. No. 15-17110-136530
	:	
ICG KNOTT COUNTY, LLC,	:	Calvary Mine
Respondent	:	
SECRETARY OF LABOR,	:	CIVIL PENALTY PROCEEDING
MINE SAFETY AND HEALTH	:	
ADMINISTRATION, (MSHA),	:	Docket No. KENT 2009-517
Petitioner	:	A.C. No. 15-17110-159591A
v.	:	
	:	
RANDY PACK, employed by	:	
ICG KNOTT COUNTY, LLC,	:	Calvary Mine
Respondent	:	

DECISION

Appearances: Christian P. Barber, Esq., Office of the Solicitor, U.S. Department of Labor, Nashville, Tennessee, on behalf of the Secretary of Labor;
John N. Williams, Esq., Rajkovich, Williams, Kilpatrick & True, PLLC, Lexington, Kentucky, on behalf of Respondent, ICG Knott County, LLC.;
Billy R. Shelton, Esq., Jones, Walters, Turner & Shelton, Lexington, Kentucky, for Respondent, Randy Pack.

Before: Judge Zielinski

These cases are before me on Petitions for Assessment of Civil Penalties filed by the Secretary of Labor pursuant to sections 105(d) and 110(c) of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 815(d), 820(c). The petitions allege that ICG Knott County, LLC, is liable for three violations of the Secretary's Mandatory Safety Standards for Underground Coal

Mines,[1] and propose the imposition of civil penalties in the total amount of $63,867.00. The Secretary also filed a petition against Randy Pack, an agent of ICG Knott County, LLC., charging him with a violation of a mandatory standard. That petition seeks the imposition of a civil penalty in the amount of $1,500.00 against Pack, in his individual capacity. A hearing was held in Pikeville, Kentucky, and the parties filed briefs after receipt of the transcript. For the reasons set forth below, I find that ICG Knott County committed the violations, and impose civil penalties in the total amount of $36,100.00. I also find that Pack committed the violation, as alleged, and impose a civil penalty in the amount of $1,000.00 against him in his individual capacity.

Findings of Fact - Conclusions of Law

At all times relevant to this proceeding, ICG operated the Calvary mine, an underground coal mine located in Knott County, Pennsylvania.[2] The incident that prompted issuance of the violations occurred on September 13, 2007, in the 009 working section, when ICG cut into an adjacent bleeder area in order to establish a bleeder line for retreat mining. Water that had pooled in the bleeder entries flowed into the active workings. Equipment was moved to higher ground, the power center was deenergized, and the miners eventually left the mine. The following morning, ICG phoned the MSHA field office and reported the incident. MSHA's field office supervisor, Gregory Ison, and inspector, Roy Parker, traveled to the mine to conduct an investigation. In the course of the investigation, the contested citations and orders were issued. Following a special investigation, the mine superintendent, Randy Pack, was also charged with one of the violations. ICG and Pack timely contested the violations and assessed civil penalties.

The 009 section consisted of seven entries and was located at the inby end of a series of panels that had been mined alongside a pillared-out area. The worked-out area was immediately to the left of the active workings, which had been driven for a substantial distance. Once past the worked-out area, the entries made a 90 degree turn to the left, and continued alongside the worked-out area for a distance the equivalent of four to five breaks. The layout of the 009 section and part of the bleeder system are depicted on a portion of the mine map. Ex. G-3. The mine floor/coal seam in the worked-out area generally sloped down, in two planes, toward the corner around which the active entries had been driven. There was a slope from the pillared-out area downward toward the 009 section, and a slope roughly parallel to that in the 009 section entries, i.e., downward from the faces outby. The two outermost entries of the worked-out area adjacent to the 009 section were the travelable bleeder entries, and they extended into the corner. Water had accumulated in the bleeder entries, and because of the slopes, was pooled against the corner, primarily in the outermost entry.

The lay of the coal seam/mine floor in the 009 section was somewhat different than that in the worked-out area. As noted above, the slope of the entries was roughly parallel to that in

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[1] 30 C.F.R. Part 75.

[2] MSHA's data base shows the mine's status as "Abandoned" as of November 11, 2010.

the bleeder entries. They sloped downward from the faces as they proceeded outby. However, the floor in the crosscuts sloped upward from the #4 entry to the #7 entry, opposite to the slope in the worked-out area. There was a low point, or dip, approximately 10-12 breaks outby from the 009 section faces, where the #8 conveyor belt connected at a right angle with the #7 belt.

Mining in the 009 section had proceeded only a little over four breaks past the corner of the worked-out area because the entries began to "rock out," i.e., the coal seam ended. The last open line of crosscuts was the third break past the corner. One additional crosscut, the fourth break, had been completed only between the #1 and #2 entries. ICG intended to prepare the 009 section for retreat mining. To create a bleeder for the retreat mining, it planned to cut through from the #1 entry into the adjacent bleeder entries.

Pack conducted the required weekly examinations of the bleeder entries.[3] He traveled in the second outermost entry. The path traveled in the bleeder is depicted by a black line on the map. Tr. 91-92; Ex. G-3. Approximately five breaks from where that entry terminated at the aforementioned corner in the worked-out area there was a date board on which he recorded the dates of his examinations and initialed the entries. Prior to the cut-through there was standing water in the traveled bleeder entry. Pack testified that there was no more than 12-14 inches of water in the bleeders and that it had not changed in the year that he had been conducting the examinations. Tr. 222. He never got water in his transport vehicle, a three-wheeled "Johnson stinger," the seat of which was about 16 inches off the ground. Tr. 241. The pooled water extended from the corner up to the area of the date board. There was a dip down from the traveled entry to the outermost bleeder entry and, as a result, the water was deeper in that entry.

After the start of the second shift on September 13, Pack talked to Verlin Robinson, ICG's president and general manager, and a decision was made to make the cut-through from the 009 section into the bleeder system. Pack testified that he intended that the cut-through be made in the "last" crosscut, i.e., the most inby break between entries #1 and #2.[4] Tr. 226. At approximately 7:00 p.m., he called down to David Gibson, the section foreman, and instructed him to make the cut-through. Gibson understood Pack to say that the cut-through was to be made in the "last open" break, i.e., the last open line of crosscuts, which was the second break from the face in the #1 entry. Tr. 50. The difference was significant because it appears that the most inby crosscut was approximately one foot higher in elevation than the next crosscut outby.

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[3] Unsealed worked out areas must be examined at least every seven days. 30 C.F.R. § 75.364(a).

[4] Pack had read and signed a statement prepared in the course of the subsequent special investigation, in which he stated that he instructed Gibson to make the cut-through in the "last open crosscut." Tr. 236-37; Ex. G-12. He also reaffirmed that statement at his deposition. Tr. 238-39; Ex. G-13. At the hearing he testified that the statement was in error, and that he first noticed the error in the course of the hearing. Tr. 239. I find that his original statement was accurate. However, I do not find the fact of the miscommunication, or that the cut-though may have been made in the wrong place, to be of particular significance in the analysis of the various issues.

The continuous miner made a cut, extending the line of open crosscuts 40-45 feet past the #1 entry toward the bleeder entries. That cut was bolted, scooped, and dusted. Some water was infiltrating through the coal into the area. Tr. 25, 66. The miner then started the second cut, and had loaded one shuttle car. On the next pass, between 8:00 p.m. and 8:30 p.m., the miner broke through into the outermost bleeder entry, and water that was pooled in that entry began flowing into the section. While it had been anticipated that some water would be encountered, more water came in than was expected. Tr. 60.

There were differing assessments of the magnitude of the influx of water. A shuttle car operator, Carl Duty, who was retired at the time of the hearing, testified that miners were concerned when water was infiltrating into the extended crosscut, prior to the actual cut-through, because "it didn't look good." Tr. 25. He related that, by the time the first cut had been bolted, the water was about one foot deep. Tr. 25. However, he did not explain how he came to that assessment. It apparently was not by actually standing in the water, because during the entire incident he did not get "the soles of [his] feet wet." Tr. 30-31, 38. He also did not think that the continuous miner got much water in it. Tr. 31. Duty testified that after the cut-through it was "scary" for a minute, that he had never seen as much water in his 34-35 years of mining experience, that it "kicked the miner around," and that the water "run us out of there." Tr. 27, 28, 32. However, he also confirmed that he and the other miners did not hurry out of the area. Tr. 39-40. Rather they followed Gibson's instructions and moved the equipment outby, and then boarded a mantrip and rode out of the section. Duty was on his way away from the water in "less than five minutes" after the cut-through was made. Tr. 38.

Gibson testified that the amount of water infiltrating into the crosscut was not unusual. Tr. 66. He was in the immediate area when the cut-through was made, and instructed the men to move the equipment out of the way. He assisted the miner operator in backing the miner up the crosscut line to the #5 entry, an area that remained dry. While handling the miner's cable, he was standing in the extended crosscut. The water was approximately ankle deep. Tr. 62. As noted in the discussion, *infra*, I find Gibson's description of the flow of water from the cut-through to be accurate.

Gibson then went to the power center and deenergized it, because he did not know if the water level would reach it. There was no water in the power center while the men were underground. Tr. 62-63. The water flowed outby down the entries, primarily the belt entry, toward the low spot where the #8 belt head drive was located. Gibson then rode outby with the crew to the area of the #8 belt head drive, where he got off. It took less than ten minutes to move the equipment and begin leaving the section. Tr. 69. The crew continued outby, parked, and waited for further instructions.[5] Gibson called outside and reported what happened. He then

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[5] While waiting on the mantrip, the continuous miner operator, who was apparently drenched with water, related a "story" about having to hold his head up near the roof of the mine to breathe. Tr. 30-31. That story was fabricated. Gibson assisted him in backing the miner out of the cut-through, and the water was only ankle deep. The miner operator, and Gibson, got wet because the miner operator dropped the pan of the miner on a water line, causing them to be sprayed with water. Tr.

returned to the section to monitor the inflow of water. Tr. 60-61. Twenty to thirty minutes had elapsed following the cut-through by the time he returned to the section. Tr. 68-70.

When Gibson made his call, he told the outside man to call Pack and tell him that water was coming into the mine. Tr. 63. When Pack received the call at about 9:00 p.m., he was entering the parking lot of the mine, intent on helping the midnight shift move the 009 section to a new location.[6] Tr. 242. He immediately concluded that the cut-through had been made in the wrong location, i.e., not in the most inby "last" break between entries #1 and #2, because if it had been made there, he believed that very little water would have been encountered. Tr. 231-32. He called Robinson and told him they had hit water. Robinson said he would call Stewart Bailey, the safety manager. Pack went underground and met the crew around the head drive for the #5 belt, about 2,000 feet from the section. Tr. 243-44. They were sitting on the mantrip, talking and laughing. Tr. 244. He inquired where Gibson was, and was told that he was up at the section. Pack told the men to stay where they were, and went to find Gibson. He parked his ride and walked up the belt line and across the section and looked at the cut-through. Water was running down the #1 entry, crossing over to the #4 entry, then down by the power center and to the area of the #8 belt head drive, which was located in the low spot. Tr. 246-47. He then called out on the mine phone and talked to Bailey, who had arrived at the mine. Tr. 245. He told the men to leave because there was nothing they could do at the time. Tr. 245. Pack and Gibson followed the crew out of the mine. They reached the surface around 10:30 p.m., and the men were sent home. Pack returned underground with a few of the third shift miners to set up pumps and deal with the water. Tr. 248.

The following morning, Pack, Bailey and Robinson conferred and it was decided that Bailey should call MSHA and report what happened. Bailey talked to Ison, who remarked that it sounded like something that should have been called in immediately, but that he would get back to him. Ison called Bailey back, and told him that MSHA was going to investigate. Ison and Parker met at the mine, examined the preshift books, met Bailey and went underground. They traveled to the low spot in the area of the #8 belt drive and the tailpiece of the #7 belt. There was a sharp dip near the tailpiece. The bottom belt was under water, the top belt was dry. Tr. 87-88. The water was well up on the sides of the #8 head drive. Water in the #5 and #6 intake entries in that low area was over 18 inches deep, too deep to permit use as the primary escapeway where a

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61-62.

[6] Pack testified that he received the call about 9:30 p.m. However, I find that it was closer to 9:00 p.m. Stewart Bailey, ICG's safety manager, who was called by Robinson after talking with Pack, thought that he received the call about 9:00 p.m. Tr. 266. After Pack received his call, he called Robinson, entered the surface buildings, got dressed to go underground, traveled underground, checked on the men as he rode in, found Gibson, walked the belt line and around the section, came back to the area of the #8 head drive and called Bailey, proceeded with Gibson back to where the men were and followed them out of the mine. They had exited the mine around 10:30 p.m. It would have been extremely difficult for Pack to have accomplished what he did if he had received the call at 9:30 p.m.

miner might have to be carried on a stretcher. Tr. 88-89. Ison used a yellow highlighter and marked on a portion of the mine map indicating where the water was pooled in the #4, #5 and #6 entries. Tr. 86; Ex. G-3. Pack confirmed that the water was where Ison indicated. Tr. 247. There was no water in the return entries, which were "basically dry." Tr. 90.

Parker went to the section faces, and Ison went into the bleeder system and traveled to the area where the cut-through had been made. He observed the date board near a measuring point about five breaks outby where the travelable bleeder entry terminated at the corner. Ison indicated the location of the date board by drawing a red circle on the mine map. Tr. 94-96; Ex. G-3. The most recent date entered on the board was September 7, indicating that the bleeder system had last been examined six days before the cut-through. Tr. 95. He observed water pooled in the outermost bleeder entry, extending about four breaks from the corner, and about half way up to the traveled bleeder entry. He indicated the area of pooled water by highlighting it in yellow on the map. Tr. 96; Ex. G-3. He observed what appeared to be a high water mark, like a "bathtub ring," at the date board. Tr. 96. While there was no water at the date board, he estimated that it had receded about 18 inches as a result of the cut-through. Tr. 98. He did not attempt to measure the amount of the drop, but characterized it as "18 as opposed to 24," or 18 "as opposed to 12." Tr. 98, 133, 158-59. However, he also stated that at the furthest stopping over, the water level had "dropped 12 inches."[7] Tr. 98.

Ison walked down to the outermost bleeder entry, and traveled to his right, against the rib of the pillar, to a point across from the cut-through. The water got progressively deeper as he moved, and he had to steady himself by holding onto the rib of the pillar. Mining height was approximately 50-52 inches. When he was across from the cut-through, he talked to Parker and could see his through the opening. Tr. 96, 130. He did not attempt to cross that outermost entry to reach the actual cut-through because the floor dipped down toward the section, and he was not sure how deep the water was. Tr. 97. There was standing water in the bleeder at that point, because the cut-through did not extend down to the floor of the bleeder entry. Tr. 98. As he was facing the cut-through, the mine floor dipped down toward the 009 section and sloped down to his right toward the corner. Tr. 156-57. The water had finished draining into the section at the time, which was about noon on September 14. Tr. 138.

Ison and Parker returned to the surface. Parker wrote and issued the citations and orders. The section 103(k) order that had been issued when they arrived was modified to allow pumping

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[7] The surface of the water pooled in that corner of the bleeder could not have dropped 18 inches in one area and 12 inches in another. I give more credit to Ison's estimate of a 12-inch drop at the furthest stopping. It would have been very difficult to accurately estimate the vertical drop from a high-water mark at the date board to the water's surface which was, according to his depiction on the mine map, over 120 feet away down one break and over one break. Ex. G-3. In contrast, judging from where Ison indicated that the water remained pooled in the bleeder, the surface of the water would have been a little more than one entry-width away from the furthest stopping. Ex. G-3. I find that the surface of the water pooled in the bleeder entries dropped approximately 12-14 inches as a result of the cut-through.

of water. Moving of the section equipment had to await pumping of water from the low area in the #5 and #6 entries because that primary escapeway had to be re-opened before miners were allowed inby. Tr. 99-100. They then left the mine site.

Citation No. 6648616

Citation No. 6648616, was issued by Parker on September 14, 2007. As modified by him on September 18,[8] it alleges a violation of 30 C.F.R. § 75.388(a)(1), which requires that: "Boreholes shall be drilled in each advancing working place when the working place approaches – to within 50 feet of any area located in the mine as shown by surveys that are certified by a registered engineer or registered surveyor unless the area has been preshift examined." The violation was described in the "Condition and Practice" section of the Citation as follows:

> A room was driven off the no. 1 entry on the 009 section which was cut through into a bleeder which resulted in the active 009 section being inundated by water. Boreholes were not being drilled when the working places approached to within 50 ft. of the location of the cut through as required by this section. Also, the area had not been preshifted prior to the cut through. This determination was made when the area was examined and the Dates, Times and Initials of the examiner could not be found. The last examination date observed in this area was 09-07-2007 which was the date of the last weekly examination. If the boreholes had been drilled prior to the cut through, the section would not have been inundated. The inrush of water entering flooded the 009 section, caused the main power to be de-energized due to the water entering the high voltage power center, caused the equipment to be moved outby the faces as far as conditions would allow before a determination was made to evacuate the area due to rising water. Management engaged in aggravated conduct constituting more than ordinary negligence in that had the boreholes been drilled prior to the cut through the inundation would not have occurred. This violation is an unwarrantable failure to comply with a mandatory standard.

Ex. G-7.

Parker determined that it was reasonably likely that the violation would result in a fatal injury, that the violation was significant and substantial ("S&S"), that eight persons were affected, and that the operator's negligence was high. The citation was issued pursuant to section 104(d)(1) of the Act, and alleged that the violation was the result of the operator's unwarrantable failure to comply with the mandatory standard. A specially assessed civil penalty, in the amount of $45,000.00, was proposed for this violation.

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[8] The citation originally alleged a violation of 30 C.F.R. § 75.361(a), which requires supplemental workplace examinations in certain circumstances. It was modified to allege a violation of § 75.388(a)(1), and the Condition and Practice section was amended to address the new standard.

The Violation

The standard requires that when mining approaches to within 50 feet of other areas of the mine, that boreholes be drilled into the area being approached, unless that area has been the subject of a preshift examination to identify any hazardous conditions that might be present. When ICG initiated the cut-through toward the bleeder entries, it mined to within 50 feet of another area of the mine as shown on certified surveys. Tr. 103. There was no drill on the section, and there is no dispute that boreholes were not drilled. There is also no dispute that a preshift examination had not been conducted in the bleeder area prior to the second shift beginning work. The Secretary argues that ICG violated the plain language of the regulatory standard. ICG contends that the intent of the standard is to ensure that boreholes be drilled into areas that are inaccessible and, since the bleeder was accessible and had been examined regularly, that boreholes were not required.

ICG's argument is premised upon two Commission decisions, wherein the general intent of the standard was described as preventing exposure to hazards in inaccessible areas, *Kellys Creek Resources, Inc.*, 19 FMSHRC 457, 461 (Mar. 1997) and *Williams Bros. Coal Co., Inc.*, 17 FMSHRC 1274, 1275 (July 1995) (ALJ).[9] Both cases dealt with mining into old works that had been sealed, and the discussion of the standard was, understandably, couched in terms of the hazards posed by mining into such areas. The Secretary argues that the standard is clear on its face and plainly requires the drilling of boreholes unless the area about to be encountered has been the subject of a preshift examination. I agree. Language quoted by ICG from *Kellys Creek* confirms the point.

> The text of section 75.388(a) makes plain that the borehole drilling requirements apply in lieu of the preshift examination required by 30 C.F.R. § 75.360 . . . .

19 FMSHRC at 461. While the Commission went on to observe that preshift examinations cannot take place in inaccessible areas of a mine, that fact and the discussion that followed do not alter the conclusion that the standard plainly requires the drilling of boreholes or a preshift examination when mining approaches another area of the mine.

ICG did not conduct a preshift examination of bleeder area for the second shift on September 13. It did not drill boreholes into the bleeder area to test for hazardous conditions prior to mining into it. The standard was clearly violated.

Significant and Substantial

An S&S violation is described in section 104(d)(1) of the Act as a violation "of such

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[9] The *Williams Bros.* case was not identified in ICG's brief as a non-binding Administrative Law Judge decision, in contravention of Commission Procedural Rule 5(h), 29 C.F.R. § 2700.5(h).

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 of Labor*, 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*, 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); *Youghiogheny & Ohio Coal Co.*, 9 FMSHRC 2007 (Dec. 1987).

The fact of the violation has been established. A measure of danger to safety was contributed to by the failure to drill boreholes or preshift the bleeder area. An injury resulting from mining into an area containing an unexpected hazardous condition could be expected to be reasonably serious. As is often the case, the primary issue in the S&S analysis is whether the violation was reasonably likely to result in an injury causing event.

The Secretary contends that the subject standard is equivalent to the preshift examination

requirement, which is of fundamental importance in assuring a safe working environment underground, and that allowing miners to work or travel where no preshift examination has been conducted can be found to be an S&S violation even if it is eventually established that no actual hazardous condition existed. *Kellys Creek* 19 FMSHRC at 461 (citing *Buck Creek Coal Co.*, 17 FMSHRC 8, 13-15 (Jan. 1995)). ICG and Pack counter that a preshift examination of the drilling of boreholes would only have confirmed the existence of conditions that ICG and Pack already knew existed. They further argue that no miners were injured, miners were not exposed to risk of drowning, electrocution or suffocation, and, even with the mistake of making the cut-through in the wrong crosscut, no one was ever at any risk of injury. ICG's Br. at 23.

In *Kellys Creek* the Commission noted that:

> [S]ection 75.388 is similar in function to the preshift examination requirement; both standards seek to prevent exposure of miners to undetermined hazards. In *Buck Creek Coal Co.*, 17 FMSHRC 8, 13-15 (January 1995), the Commission, describing the preshift examination requirement as one "of fundamental importance in assuring a safe working environment underground, held that a preshift violation was S&S irrespective of the absence of a specific hazardous condition disclosed upon the inspector's examination of the mine.

19 FMSHRC at 461.

ICG's arguments that boreholes or a preshift examination would have merely confirmed what it already knew existed and that no miners were injured are misplaced in that they are focused on what actually occurred, as opposed to what reasonably might have occurred. ICG clearly did not *know* what the conditions in the bleeder were. It may have had reason to believe that it was unlikely that hazardous conditions were present, but having failed to drill boreholes or conduct a preshift examination of the area, it did not know that the miners performing the cut-through would not encounter hazardous conditions. While conditions in the bleeder appeared to have been relatively stable, conditions in mines can change without warning; that is why preshift examinations are of "fundamental importance" in assuring a safe working environment.

In ordering the cut-through into the bleeder system, ICG caused miners to work in an area that had not been examined for six days. Ison noted that additional water may have accumulated in the area since the last examination, thereby posing a more substantial threat. Tr. 113-14. It is possible that other adverse changes may have occurred. In *Buck Creek*, the Commission reversed an ALJ's finding that failure to conduct a complete preshift examination and record the results before allowing miners to enter the mine was not S&S. The facts upon which that decision was based were much more favorable to the operator than those in the present case, with the exception that the Buck Creek mine had an unspecified history of methane accumulations and roof falls, thereby increasing the probability that adverse conditions might

have developed following the last preshift examination.[10] The Commission held that the violation was S&S, even though no hazardous conditions were found upon completion of the examination. *Id*. at 13-14. Consequently, neither the absence of hazardous conditions, nor the fact that no injuries occurred, bar a finding that a violation was S&S.

Here, of course, there was a considerable quantity of water in the un-preshifted area. While the water may not have posed a hazard for a weekly examiner in the bleeder system, it could have posed a hazard for miners cutting into the bleeder. The water levels had been relatively stable. However, it is possible, as Ison noted, that additional water could have accumulated in the area. Because examinations of areas where miners are scheduled to work or travel are of fundamental importance to assuring a safe working environment underground, I find that ICG's failure to drill boreholes or to conduct a preshift examination of the bleeder area prior to mining into it was reasonably likely to result in a reasonably serious injury and was S&S.[11]

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,"

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[10] In *Buck Creek*, three miners, two of whom were certified mine examiners, entered the mine before the preshift examination had been completed and recorded. The last preshift examination had been conducted two days earlier. The area they traveled to was at the end of the slope and had been examined and found free of hazards shortly before they arrived. However, the examination had not yet been completed, and the Commission noted that a hazard in another area of the mine could have affected the miners.

[11] I do not find, however, that it was reasonably likely that the violation would result in a fatality. The Secretary argues that Pack's knowledge of the accumulation of water in the bleeder is an aggravating factor. However, I find it to have been more of a mitigating factor. Pack knew that there was a finite amount of water pooled in the corner of the bleeder entries. It was about one foot deep in the entry he traveled, somewhat deeper in the outermost entry, and had remained stable for at least a year. The Secretary did not introduce evidence on the likelihood of hazardous conditions developing in the bleeder, other than Ison's testimony regarding the possibility that additional water may have accumulated. For example, there is no evidence that the mine had a history of roof falls or methane accumulations, as there was in *Buck Creek*. On the facts of this case, I find that the violation was reasonably likely to result in a lost work days injury.

"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 an unwarrantable failure analysis 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 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).

Several factors generally considered in the unwarrantable failure analysis have no application to the facts of this case. The length of time that the violation existed, the extensiveness of the violation and efforts to abate the violation are not applicable. There is no evidence that ICG was put on notice that greater efforts to comply with the standard were necessary. The key factors are the operator's knowledge of the violation, which here is the equivalent of obviousness, and the degree of danger posed by the violation. Also relevant is the fact that the violation was the direct result of the actions or inactions of Pack, a senior management official and, secondarily, of Gibson, a section foreman.

Pack, ICG's superintendent, routinely conducted the weekly examinations of the bleeder area. Tr. 222. Initials on the date board in the area of the cut-through indicated that it had last been examined on September 7. Tr. 95; Ex. G-3, G-12. There is no evidence that anyone performed such an examination between September 7 and the date of the cut-through, September 13.[12] While ICG had been planning to cut through into the bleeder for some time to provide

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[12] ICG's examination book for the week ending September 8, 2007, did not reflect an examination as having been made on September 7. Rather, it purported to record an examination of the intake on September 4 and an examination of the return on September 5. Ex. G-6. The next report shows an examination of the intake on September 11, and an examination

ventilation for retreat mining in the section, as of the beginning of the second shift on September 13, it had not been decided that the cut-through would be made that day. After the shift started, Pack talked with Robinson, the decision was made, and Pack called down and instructed Gibson to make the cut-through.

Pack made no effort to comply with the standard because he candidly admitted that he was unaware of the standard's requirements. Tr. 240, 255; Ex. G-12. He knew that no boreholes had been drilled, that he had not examined the area, and that he had no information that anyone else had examined it. Tr. 233, 235, 240; Ex. G-12. Nevertheless, he directed that the cut-through be made. When he called Gibson to order the cut-through, he did not discuss with him the need for an examination. Tr. 235. ICG must be charged with knowledge of the standard, and its failure to make any attempt at compliance amounts to direct knowledge of the violation. I also have found that the violation was S&S, and posed a relatively high degree of danger to miners, because it caused miners to work in an area that had not been examined for six days. The area contained an accumulation of water that had not been observed in six days and posed a potential hazard to those mining into it. The fact that it was later confirmed that the amount of water was not sufficient to pose a serious threat of trapping miners or resulting in a fatality, does little to mitigate the dangers posed by causing miners to work in an area of the mine that had not been examined for several days. Pack's familiarity with the conditions in the bleeder, and his knowledge that they had not changed since his last examination, mitigates the gravity of the violation to some extent. However, it does not override the obviousness of the violation by a senior management official.

Gibson, also an agent of ICG, bears some culpability for the violation.[13] He, like Pack, thought that as long as the bleeder area was being examined weekly, bore holes or a preshift examination were not required. Tr. 66-67. When Pack called to tell him to make the cut-through, he also related that he had checked the bleeder and there was some water in it. Pack did not explicitly state that he had examined the bleeder that day. However, Gibson knew that Pack was underground when he arrived, and had been at the mine for four hours by the time the call was made. He assumed that Pack had examined the bleeder that day. Tr. 50, 59. However reasonable Gibson's assumption may have been, it fell short of confirming that the bleeder had been examined prior to the second shift commencing work. He knew, or should have known, from reviewing the preshift report for his shift that the bleeder had not been included in the preshift examination. Ex. G-5.

I find that the violation was the result of ICG's unwarrantable failure.

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of the return, and all of the measuring points, on September 14. Ex. R-3. Pack confirmed in his statement to the special investigator that he had last been in the bleeder entries on September 7, the date noted on the date board. Ex. G-12.

[13] Gibson apparently was also charged with the violation in his individual capacity, and he did not contest the violation or the assessed penalty. Tr. 57.

Individual Liability

The Act provides that a director, officer or agent of a corporate operator may be subject to civil penalties in his individual capacity for knowingly authorizing, ordering or carrying out a violation of the Act. 30 U.S.C. § 820(c). The legal standards governing individual liability were summarized in *Target Industries, Inc.* 23 FMSHRC 945, 963 (Sept. 2001) (Commissioner Beatty):

> Section 110(c) provides that, whenever a corporate operator violates a mandatory health or safety standard, a director, officer, or agent of such corporate operator who knowingly authorized, ordered, or carried out the violation shall be subject to an individual civil penalty. 30 U.S.C. § 820(c). The proper legal inquiry for determining liability under section 110(c) is whether the corporate agent knew or had reason to know of a violative condition. *Kenny Richardson*, 3 FMSHRC 8, 16 (Jan. 1981), *aff'd on other grounds*, 689 F.2d 632 (6th Cir. 1982), *cert. denied*, 461 U.S. 928 (1983); *accord Freeman United Coal Mining Co. v. FMSHRC*, 108 F.3d 358, 362-64 (D.C.Cir. 1997). To establish section 110(c) liability, the Secretary must prove only that an individual knew or had reason to know of the violative conditions, not that the individual knowingly violated the law. *Warren Steen Constr., Inc.*, 14 FMSHRC 1125, 1131 (July 1992) (citing *United States v. Int'l Minerals & Chem. Corp.*, 402 U.S. 558, 563 (1971)). A knowing violation occurs when an individual "in a position to protect employee safety and health fails to act on the basis of information that gives him knowledge or reason to know of the existence of a violative condition." *Kenny Richardson*, 3 FMSHRC at 16. Section 110(c) liability is predicated on aggravated conduct constituting more than ordinary negligence. *BethEnergy Mines, Inc.*, 14 FMSHRC 1232, 1245 (Aug. 1992). * * *

Here, Pack had reason to know of the violative condition that he directly authorized. He, like ICG, is charged with knowledge of the standard's requirements, and he knew when he ordered that the cut-through be made that they had not been complied with. Counsel for Pack argues that Pack assumed that Gibson would examine the bleeder prior to making the cut-through, and that he had no direct knowledge that the bleeder had not been examined. Resp. Pack Br. at 3. Pack also testified that if a cut-through was to be made, he would assume that the section foreman would conduct the required examination. Tr. 234. However, I reject those factual assertions. Pack stated to MSHA's special investigator shortly after the incident, "I didn't examine [the bleeder] nor did anyone else because I wasn't aware that I had to examine it." Tr. 240; Ex. G-12. He did not discuss the examination requirement with Gibson, and did not make any assumptions about Gibson's examination of the area because he was unaware of the standard's requirements. Pack directly authorized the actions that he had reason to know constituted a violation of the standard.

Counsel for Pack also makes much of the argument that the incident was the result of miscommunication between Pack and Gibson, which resulted in Gibson's making the cut in the wrong location. If the cut had been made in the location that Pack intended, then it is likely that

less water would have entered the working section, a fact that Ison confirmed. The potential mitigation of the effects of the violation does not alter the fact that the standard was violated, on the instructions of Pack, who had reason to know of the violation.

While Pack may not have knowingly violated the standard, his conduct exhibited a degree of indifference, and a serious lack of reasonable care, that constituted more than ordinary negligence. As with ICG, Pack's knowledge of conditions in the bleeder days before the cut-through, and his observations that conditions had not changed markedly over time, mitigate the danger posed by the violation to some extent. However, I find that Pack had reason to know of the violative condition that he ordered, and is subject to liability under section 110(c) of the Act.

Order No. 6648619

Order No. 6648619 was issued by Parker on September 14, 2007, and alleges a violation of 30 C.F.R. § 75.364(h) which requires that records be kept of weekly examinations of bleeder systems. The violation was described in the "Condition and Practice" section of the order as follows:

> The record book for the weekly examination for hazardous conditions did not show that the bleeders or measuring points in the bleeders were being examined, nor were any hazards noted that may affect this area. The record book did not show that the last weekly examination for hazardous conditions for this area was conducted on 09-07-2007 and made no mention of an excessive accumulation of water in the area of the bleeder. Dates, Times and Initials of the mine examiner were present in the area of the bleeder along with the large accumulation of water, the water extended across 6 entries and appeared to have dropped approximately 18 inches since the room cut through into the bleeder inundating the active 009 section, causing the main power to be deenergized, and the miners to be evacuated from the section. The last date of examination was 09-07-2007. Management engaged in aggravated conduct constituting more than ordinary negligence by failure to record the examination of the bleeder or the hazards associated with it (large accumulations of water). This violation is an unwarrantable failure to comply with a mandatory standard.

Ex. G-8.

Parker determined that the violation posed no likelihood of injury, that the violation was not S&S, that eight persons were affected, and that the operator's negligence was high. The order was issued pursuant to section 104(d)(1) of the Act, and alleged that the violation was the result of the operator's unwarrantable failure to comply with the mandatory standard. A civil penalty, in the amount of $2,000.00, was proposed for this violation.

The Violation - Unwarrantable failure - Negligence

Section 75.364(a) requires that bleeder systems be inspected at least every seven days,

that hazards be noted and that methane and oxygen concentrations and air flow volume and direction be determined at various locations, including measuring points specified in the mine's ventilation plan. Section 75.364(h) requires that a record be kept of the results of each weekly examination. ICG's weekly examination records did not reflect the September 7 examination that was noted on the date board in the area of the cut-through. Tr. 95, 106-07; Exh. R-3. The record for the exams done during the week ending September 8 did not show air quantities at the measuring points, or the presence of water in the bleeder. Tr. 106-07, 168-70; Ex. G-6, R-3.

ICG does not contest the fact that the regulation was violated. It does contest the unwarrantable failure and high negligence designations, and argues that this was a simple record keeping violation that should have been issued pursuant to section 104(a), and assessed as such. The Secretary relies, virtually exclusively, on Pack's status as a management official, ICG's agent, in arguing that ICG exhibited indifference and a serious lack of reasonable care amounting to unwarrantable failure. Sec'y. Br. at 27-28.

Ison confirmed that the citation was for a record keeping violation. It is not contended that the examinations and measurements were not done, only that they were not recorded in the weekly exam book. Tr. 115-18, 168-70. Because of the nature of the violation most of the factors typically considered in the unwarrantable failure analysis are not pertinent here. Those most relevant are the direct involvement of a management official and the degree of danger posed by the violation. There is no dispute that Pack, the mine superintendent, was directly responsible for the deficient entries in the weekly exam book, which he signed as reflecting the results of his examinations. Ex. G-6, R-3. However, the degree of danger posed by the violation appears to have been relatively low, which most likely accounts for the Secretary's decision not to rely on that factor in her argument. Sec'y. Br. at 27-28.

As previously noted, Pack routinely performed the weekly examinations and had observed the presence of water in the bleeder entry in the area of the cut-through. The amount of water had remained constant for a long period of time. Ison believed that the presence and depth of water should have been recorded in the exam book, so that there would have been a record of the rate that the water had accumulated, and so that its presence would have been noted and possibly considered in conjunction with the cut-through. Tr. 116-17, 134-35. However, aside from his belief that the water must have built up over time, there is no evidence to rebut Pack's testimony that the water level had not changed during the time he performed the examinations. Ison testified that he had no reason to doubt that the water levels had remained constant. Tr. 152. Ison also conceded that as far as he knew the water had not compromised air flow or travel in the bleeder, and that it was not required to be recorded as a hazard, at least until a decision was made to cut into the bleeder from the working section. Tr. 117, 136-37, 168-70. Ison agreed with Pack that MSHA inspectors would have traveled the bleeder with him during any inspections, and would have addressed any failure to record the water as a hazard, which was not done. Tr. 123, 167.

The deficiencies in the entries on the weekly examination records did not include the failure to record hazards. While it may have been helpful to have noted the presence of water in that area of the bleeder system, it was not required by the regulation, and the failure to do so

could have had only a tangential impact on the eventual release of water into the working section. ICG could not have relied on weekly examination records to assure that it was safe to cut through into the bleeder. It was required, under section 75.388, to either drill boreholes or conduct a preshift examination of the area.[14] The consequences of its failure to do so have been addressed above.

While Pack's responsibility for the violation, as an agent of ICG, justifies a finding of high negligence, the fact that the violation did not pose a high degree of danger and that ICG had not been put on notice that greater compliance efforts were required, lead me to conclude that the violation was not the result of ICG's unwarrantable failure to comply with the standard. The order will be modified to a citation issued pursuant to section 104(a) of the Act, with high negligence and the other special findings as cited.

Citation No. 6648617

Citation No. 6648617 was issued by Parker on September 14, 2007, and alleges a violation of 30 C.F.R. § 50.10 which requires that operators notify MSHA within 15 minutes of the occurrence of an accident. Included in the definition of the term "accident" is "an unplanned inundation of a mine by liquid or gas." 30 C.F.R. § 50.2(h)(4). The violation was described in the "Condition and Practice" section of the citation as follows:

> An inundation of water occurred on the 009 section on 09-13-2007 at approximately 20:00 hrs. after a room was driven left off the no. 1 entry, cutting through into the bleeder releasing a large volume of water causing the section to be flooded, the main power to be deenergized and the men to be evacuated from the section. The operator did not immediately contact the MSHA District Office having jurisdiction [over] its mine, nor did they contact MSHA Headquarters in Arlington, Va. The operator waited until the next morning on 09-14-2007 and contacted the local MSHA Field Office at approximately 08:15 a.m.

Ex. G-9.

The citation alleged that the violation posed no likelihood of an injury, that it was not S&S, that eight persons were affected, and that the operator's negligence was high.

On October 23, 2007, the citation was modified by Danny Deel, then acting in his capacity as an MSHA conference and litigation representative for the Secretary. Following a conference requested by ICG to challenge the citation, the gravity of the violation and the operator's negligence were substantially enhanced. The wording of the Condition and Practice section was amended by adding the following:

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[14] Failure to record the presence of the water accumulations on the report of a section 75.388 preshift examination would have been a different matter.

> Timely reporting can be crucial in emergency, life-threatening situations to activate effective emergency response and rescue. As the chance for encountering older underground works increases, so does the potential for water inundation. In this case, the operator's lack of concern for miner safety is apparent in the almost 12 hours it delayed until MSHA was notified.

Ex. G-9.

As amended, the citation alleged that it was reasonably likely that the violation would result in an injury necessitating lost work days, that the violation was S&S, that eight persons were affected, and that the operator's failure to comply rose to the level of reckless disregard. A civil penalty, in the amount of $16,867.00, was proposed for this violation.

The Violation - Inundation

The term "inundation" is not defined in the regulations. In *Island Creek Coal Co.*, 20 FMSHRC 14 (Jan. 1998), the Commission interpreted the accident notification standard in the context of an inundation:

> In the absence of an express definition or an indication that the drafters intended a technical usage, the Commission has relied on the ordinary meaning of the word to be construed. *Peabody Coal Co.*, 18 FMSHRC 686, 690 (May 1996), *aff'd*, 111 F.3d 963 (D.C.Cir. 1997) (table). "Inundate" and "Inundation" are defined as "a rising and spreading of water over land not usu[ally] submerged: FLOOD . . . DELUGE" and "SUBMERGE . . . to overwhelm by great numbers or a superfluity of something: SWAMP[.]" *Webster's Third New Int'l Dictionary (Unabridged)* 1188 (1986). "Flood" is in turn defined, in relevant part, as "an outpouring of considerable extent . . . a great stream of something . . . that flows in a steady course . . . a large quantity widely diffused: superabundance[.]" *Id.* at 873. "Deluge" is defined as "an irresistible rush of something (as in overwhelming numbers, quantity, or volume) . . . a forceful jet of water (as from a fire hose)[.]" *Id.* at 598.

20 FMSHRC at 19.

The Secretary's witnesses offered differing definitions of the term "inundation" and also differed on when the alleged inundation occurred. Ison testified that, in this context, an inundation was an inflow of water that caused ICG to lose its ability to produce coal and prompted the withdrawal of miners. Tr. 120-21. In describing the inundation further, he stated: "They lost their ability to run coal. Their belts were covered with water. Their head drive was standing in water. Water was up around the head drive. They thought water was going to get in the power centers. I don't know if it did or didn't, but they did kill the power and their ability to produce coal was through for the day." Tr. at 120. Later he added, "They had to kill the power. They left the mine and mining could not continue. That's an inundation." Tr. 141-42.

Ison didn't know precisely when the inundation occurred. He explained that the men were sent home before the shift was over. "This happened at 8:00, between 8:00 and 9:00 on Thursday evening, and their shift was probably over by 11:00, I guess. . . . So, it happened pretty quickly. It certainly happened by the time they sent the men home." Tr. 121. Later, he explained further that the inundation occurred when all the elements of his definition "come together that stop them from running coal. You know, the inundation may not have occurred until 9:30 that night." Tr. 143.

Deel offered several definitions of the term. Initially, he stated that: "My definition [of an inundation] is an accidental inrush of water or liquid or gas that stops production." Tr. 195. At his deposition, three months earlier, he offered the following definition: "it's an inrush of water or gas that would cause injury to persons in the mine." Tr. 196. At the hearing he adopted both definitions. Tr. 196. Later, he testified that there would be an inundation even if no one was in the mine, and that any water coming into the mine, no matter how quickly or slowly it comes in, is an inundation. Tr. 197, 212. He was of the opinion that the inundation occurred, and the 15-minute reporting period began, at the time the cut-through was made. Tr. 177-78. His opinion was based on his understanding that the miners were scared and panicked, and that they hurried and left the section as fast as they could by riding on equipment, walking or running. Tr. 176, 185, 189, 203-04.

The Facts

The opening between the bleeder and the 009 section was approximately four feet wide and four feet high. Tr. 260. When Ison observed it from the bleeder on September 14, water had ceased flowing through the hole. Tr. 138. Standing water remained at the cut-through because it did not extend down to the floor of the bleeder entry. As noted above, I have found that the level of the water pooled in the bleeder entries dropped a little over one foot as a result of the cut-through. Consequently, when the cut-through was made, it extended approximately one foot below the surface of the water. Water would have started flowing into the section through the lowest foot of the four-foot wide cut-through (assuming that the low edge was horizontal). The water was not "forced" into the section under pressure. Rather it flowed, as water would flow out of a swimming pool, if a four foot wide section of the pool's wall was suddenly removed to one foot below the water level. The flow was initially at a depth of one foot, but receded down to zero depth as the pool level subsided to the low point of the cut-through.

When the water entered the roughly 20-foot-wide main part of the cut-through and the #1 entry, it spread out, with a corresponding reduction in depth. Gibson, who was standing in the water handling the continuous miner cable, testified that the water was a little over ankle deep. Tr. 62. I accept that testimony as accurate, because it is likely that the one-by-four foot flow would have spread out to a depth of roughly three-to-four inches as it flowed down the wider entry. It would have spread out further, with a corresponding reduction in depth, as it flowed through more entries outby toward the low spot near the #8 belt head drive, where Ison found it pooled in the #4, #5 and #6 entries.

The miners had been told to expect some water. While Duty expressed some initial

concern, there was no general panic among the miners, and no one hurried to leave. They followed Gibson's instructions and moved the equipment across the section, and then boarded a mantrip and rode outby away from any flowing water. Within five to ten minutes, the miners were on their way out of the section.[15] Gibson deenergized the power center because he was uncertain about where the water would eventually pool. There was no water in the power center, or up on the head drive while the miners were underground. Tr. 63. Duty did not see any water in the power center or at the head drive. Tr. 40. Gibson rode with the men to the area of the #8 head drive where a phone was located. He disembarked, called outside and instructed that Pack be called and told that they had hit water. Pack received a call about 9:00 p.m., when he was entering the mine's parking lot. He then called Robinson, who said that he would call Bailey. Pack entered the mine, spoke briefly to the miners, who were waiting on the mantrip, 1,000-2,000 feet from the section, talking and joking. After Pack checked the conditions in the section and talked with Gibson, he determined that there was nothing more they could do, and he told the men to go home. Everyone had left the mine by 10:30 p.m. or 10:45 p.m.

The Parties' Positions - Analysis

The Secretary argues that the inrush of water at the time of the cut-through was an unplanned inundation, relying almost exclusively on selected portions of Duty's testimony in characterizing the inflow of water in the nature of a deluge as described in *Island Creek*. Sec'y. Br. at 24. She argues that the water was "released with such force that it 'kicked the [continuous] miner around'" that it came in "pretty fast," that the event was "scary" and it was more water than Duty had seen in his 34 or 35 years as a miner. *Id. quoting* Duty.

ICG argues that there was no "accident" as defined in the regulations, because at least some of the influx of water was planned, and that the amount of water that entered the working section did not amount to an inundation.[16] While ICG contends that there was no inundation, it appears to concede that once the section was flooded, as it was when Ison and Parker saw it, an inundation had occurred. It cites the definition in *Island Creek* and argues that: "Simply put, an inundation is a flood. . . . Only several hours later did it become apparent that the section was flooded." Resp. ICG Br. at 9.

Considering the various definitions of the term "inundation" offered by the Secretary's witnesses, as in *Island Creek*, I find some ambiguity in the term, and must assess the

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[15] Duty testified that he was on his way away from the water less than five minutes after the cut through. Tr. 38. Gibson testified that, in less than ten minutes, the equipment had been moved and the men were on their way out. Tr. 69.

[16] While ICG expected that it might encounter some water, the amount of water that actually flowed into the section, and the resultant disruption of operations, was definitely not planned. ICG also argues that it did not have fair notice of the Secretary's interpretation of the term inundation; that section 50.10 is not a mandatory standard and, as such, it cannot be S&S; and that any violation was not S&S or the result of its reckless disregard.

reasonableness of the Secretary's interpretation.[17] 20 FMSHRC at 19. I do not find the Secretary's interpretation to be reasonable. Her argument that there was an inundation at the time of the cut-through is not convincing. Water was not forced into the mine under pressure, nor was it released with force. Rather it flowed in, and drained down toward the low spot near the #8 head drive; a flow that was no more than a few inches deep. She did not address portions of Duty's testimony that paint a significantly different picture and, consequently, mischaracterized the facts.[18] Duty thought it was scary "for a minute." Tr. 32. Neither he nor any other miner panicked or rushed to leave the area. Tr. 39-40. Duty erroneously thought that there was one foot of water in the mine *before* the cut-through, when there was no more than a few inches of water after the cut-through.[19] He was never in any water, did not get the soles of his feet wet, and did not get any water in his shuttle car. Tr. 38-39. The initial flow was not a forceful, irresistible overwhelming rush of water. It clearly was not in the nature of a deluge or, as yet, a flood, as described in *Island Creek*.

While I find the Secretary's position too expansive, I find ICG's too restrictive. By 9:00 p.m., the miners had left the section at Gibson's instruction. The flow had been deemed by Gibson to pose a threat to the power center, which he deenergized as a precaution. Water had been draining into the section for almost an hour and was beginning to pool in the area of the #8 belt drive and the #4, #5 and #6 entries, which were part of the primary escapeway. Pack had been advised of the situation and had called the president and general manager, who called the safety director. While the water pooling in the section had most likely not yet risen to a significant depth, it should have been apparent that it soon would. I find that, at that point, the inflow of water constituted an inundation within the meaning of the regulation. This is consistent with Ison's opinion of when the inundation occurred, which I find to be reasonable, and consistent with *Island Creek*.[20]

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[17] There is no evidence that the Secretary has made any effort to further define the term inundation. The definitions espoused by Ison and Deel were never conveyed to a mine operator, except in the course of this litigation. Tr. 142, 197.

[18] Deel, who also was of the opinion that an inundation occurred at the initial cut-through, based his decision on an understanding that bore little relationship to the facts. His third-hand knowledge of the facts was woefully deficient in several major respects, and he steadfastly held to his opinion under considerably less-favorable factual scenarios, eventually stating that any water coming into the mine, no matter how quickly or slowly it comes in, would be an inundation. Tr. 182, 205, 211.

[19] Duty testified that the water "kicked the miner around." Tr. 27. However, he didn't explain what he meant. Gibson had instructed the continuous miner operator to push the miner's head into the opening if water came out. Tr. 54. Duty may have misinterpreted such a movement. He also did not describe other experiences he had had with water entering a mine.

[20] There are similarities between the facts in this case and those in *Island Creek*. There, the Commission traced the time line of events, and held that by the time more than six hours had elapsed following when the miner cut through the core drill hole, the general foreman and

I find that an inundation occurred at approximately 9:00 p.m. on September 13. ICG did not notify MSHA until the next morning, well beyond the 15 minute deadline. The standard was violated.

Notice

On the facts of this case, an inundation, as described above, occurred at approximately 9:00 p.m. ICG contends that it did not have fair notice of an interpretation of the standard that would lead to a finding of a violation. As the Commission explained in *Island Creek*, it is not required that an operator receive actual notice of an adverse interpretation. "Instead, the Commission uses an objective test, i.e., 'whether a reasonably prudent person familiar with the mining industry and the protective purposes of the standard would have recognized the specific prohibition or requirement of the standard.' *Ideal Cement Co.*, 12 FMSHRC 2409, 2416 (November 1990)." 20 FMSHRC at 24. I find that, as interpreted above, a reasonably prudent person familiar with the mining industry and the protective purposes of the standard would have recognized the specific prohibition or requirement of the standard.[21] Consequently, I reject ICG's notice argument. The report of water entering the section at the cut-through prompted Pack to call Robinson, who called Bailey. With the section's power cut, the miners moved a good distance away from the section, and water draining into the section and pooling in the low spot, it should have been apparent that an inundation had occurred which needed to be reported to MSHA.

S&S

This is a reporting violation. The inundation should have been reported by about 9:15 p.m. At that time, the miners were approximately 2,000 feet from the section awaiting further instruction.[22] No miners were in danger of being trapped. Parker originally determined, when he wrote the citation, that there was no likelihood that a miner would have been injured as a result of the reporting violation. Ison had conferred with Parker on the citation, and obviously remained of the opinion that the violation posed no likelihood of injury, because by the time the

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superintendent had been notified, and "methane had continued to flow with great force for over 6 hours, and that methane readings were elevated, on one occasion in the explosive range, albeit in a limited area" that the "conditions presented a safety hazard that should have alerted [the operator] to the necessity of immediately reporting the incident as an accident to MSHA." 20 FMSHRC at 24.

[21] On the facts of this case, I would find that a reasonably prudent person familiar with the mining industry and the protective purpose of the standard would not have recognized that an inundation had occurred when the cut-through was made, i.e., ICG would not have had fair notice of such an interpretation of the standard.

[22] Gibson returned to the section to monitor the flow. He was in no danger of suffering an injury at that point, and didn't see any reason to worry about the situation. Tr. 69.

violation occurred, the miners were well away from any water and were on their way out of the mine. He did not express any opinion about the likelihood of injury from this violation during his testimony.

I reject Deel's analysis of the likelihood of injuries occurring as a result of the violation for the same reasons that I rejected his opinion on what constituted an inundation. His third-hand knowledge of the facts was woefully inadequate in several respects, and he steadfastly maintained his opinion virtually regardless of the facts, stating that his assessment of whether an injury was reasonably likely would not be affected by how quickly the water was coming in, even if it was a little as one inch per day. Tr. 211-12. His initial explanation of the likely mechanics of an injury was focused on the period immediately after the cut-through, before this violation occurred. Tr. 200. He did not know where the men had gathered up, or where the water was draining to, information that he should have obtained from Ison, Parker, MSHA's records, or ICG itself.[23] Tr. 206. He appeared to be of the opinion that any inundation was reasonably likely to result in serious injury because he knew that fatal injuries had been suffered in the past when abandoned works had been cut into. Tr. 78-79, 207-08.

I find the assessment of gravity originally made by Parker and Ison, who were far more familiar with the facts than Deel, to have been accurate. The violation posed no likelihood of injury and was not S&S.

Negligence

The amended citation charges that the violation was the result of ICG's reckless disregard, a level most often associated with a section 104(d) unwarrantable failure violation. While the citation was issued pursuant to section 104(a), the unwarrantable failure analysis is useful in determining whether the violation was the result of ICG's reckless disregard. Most of the factors that would be taken into account in the unwarrantable failure analysis are inapplicable to this violation. ICG's management officials were responsible for providing the notice. Consequently, the involvement of a management official is presumed. The violation did not pose a danger to miners, and there is no indication that ICG was put on notice that greater efforts were necessary for compliance. In light of the ambiguity in the definition of the term inundation and the differing views of when the violation occurred, the violation was not obvious. The violation was not the result of ICG's reckless disregard. Its negligence was no more than moderate.

The Appropriate Civil Penalties

The parties stipulated that the Calvary mine was a medium-sized mine and that the International Coal Group, Inc., its controlling entity, was large. ICG's history of violations, a

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[23] ICG was obligated to maintain a periodically updated certified mine map, showing a number of things, including elevations. Its map was available to the MSHA upon request, and it is likely that the MSHA had a copy of ICG's map. *See* 30 C.F.R. §§ 75.1200, 1203.

printout from MSHA's computerized database, was introduced into evidence. Ex. G-1. As summarized in the assessment documents, it reflects that ICG averaged 0.68 violations per inspection day during the relevant period. It had no repeat violations, and the two section 104(d) violations at issue in these cases were the only section 104(d) violations noted in the pertinent time period. ICG's relatively good history of violations is a mitigating factor in the determination of appropriate penalties. The parties stipulated that the proposed penalties would not affect ICG's ability to continue in business. The violations were promptly abated.

Citation No. 6648616 is affirmed as an S&S and unwarrantable failure violation. However, a fatal injury was not found to be reasonably likely, and Pack's knowledge of the conditions in the bleeder mitigated ICG's culpability slightly. A specially assessed civil penalty of $45,000.00 was proposed by the Secretary. I impose a penalty in the amount of $35,000.00, upon consideration of the above and the factors enumerated in section 110(i) of the Act.

Citation No. 6648616 is also affirmed as to Pack in his individual capacity. A specially assessed civil penalty in the amount of $1,500.00 was proposed by the Secretary. Pack has no history of violations, and there was virtually no evidence introduced as to his financial condition. He does not contend that payment of the proposed penalty would pose an undue financial hardship. I impose a penalty in the amount of $1,000.00 against Pack in his individual capacity, upon consideration of the above and the factors enumerated in section 110(i) of the Act.

Order No. 6648619 is modified to a citation issued pursuant to section 104(a) of the Act and, as modified, is affirmed. The violation was not the result of ICG's unwarrantable failure. Its negligence was high and the other special findings were affirmed. A civil penalty of $2,000.00 was proposed by the Secretary. I impose a penalty in the amount of $1,000.00, upon consideration of the above and the factors enumerated in section 110(i) of the Act.

Citation No. 6648617 is affirmed as a violation that posed no likelihood of injury and was not S&S. It was also not the result of ICG's reckless disregard. Rather its negligence was moderate. A civil penalty of $16,867.00 was proposed by the Secretary. Upon consideration of the above and the factors enumerated in section 110(i) of the Act, and guided by the Secretary's penalty calculation regulations,[24] I impose a penalty in the amount of $100.00.

ORDER

Citation No. 6648616 is **AFFIRMED**. Citation No. 6648617 and Order No. 6648619, which is **modified to a citation issued pursuant to section 104(a) of the Act, are AFFIRMED, as modified**. Respondent, ICG, is **ORDERED** to pay civil penalties in the total amount of $36,100.00 for the violations, within 45 days.

Citation No. 6648616 is **AFFIRMED** as to Respondent Randy Pack, and he is **ORDERED** to pay a civil penalty in the amount of $1,000.00 within 45 days.

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[24] 30 C.F.R. Subchapter P, Part 100.

Michael E. Zielinski
Senior Administrative Law Judge

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