

6. The Mine Safety and Health Administration assessed a civil money penalty against Respondent for the violation alleged in Citation No. 6391461.

7. Payment by Respondent of the proposed penalty of \$5,000 will not affect Respondent's ability to remain in business.

8. A Premier Chemicals employee, John LaCroix (Lower Shop Mechanic, 56 years old), began work at 6:30 a.m. on July 19, 2006, and collapsed near the Lower Maintenance Shop around 6:35 a.m. in the presence of Alan Hermance, who immediately called for help and began life saving efforts, which included CPR. It was a generally known fact that Mr. LaCroix suffered from high blood pressure and had been complaining of feeling bad for a number of days prior to the incident.

9. Between 6:35 a.m. and 6:40 a.m., fellow employees Elvie Selbach, Shift Foreman, and James Loeppky, Maintenance Supervisor, arrived at the scene to assist in the first aid efforts.

10. At 6:45 a.m., fellow employee, Maintenance Leadman, Bobby Adamson informed Jennifer Williamson, Safety Coordinator, of Mr. LaCroix's collapse by cell phone. Mrs. Williamson was in her vehicle about ten minutes away from the mine at the time she received the call.

11. At 6:45 a.m., all lifesaving efforts at the scene ceased based on the statement of Scott Janis, a licensed EMT.

12. At 6:55 a.m., Jennifer Williamson arrived at main mine site office. Adam Knight, Plant Manager, accompanied Mrs. Williamson to the Lower Maintenance Shop where Mr. LaCroix was located, approximately a ten minute trip from the main office. At 7:05 a.m., Mr. Knight and Mrs. Williamson arrived at the scene. Present at the scene were fellow employees Alan Hermance, Elvie Selbach, Scott Janis, Bobby Adamson and James Loeppky. Immediate efforts were undertaken to ensure that all attempts at lifesaving had indeed been performed; as well as a safety assessment of immediate area and discussions with employees on the scene as to what had occurred, when and where. It was determined that there were no dangers to other employees and no further actions were required, other than notifying MSHA of the incident.

13. At 7:40 a.m., Jennifer Williamson returned to the main mine site office and made the call to MSHA District Office in Boulder City, Nevada. Mrs. Williamson left a message for John Melfi on that answering machine.

14. At 7:55 a.m., MSHA returned the phone message and, given that there had been a death at a mine under their jurisdiction, they indicated they would be at the mine site the following day to conduct their investigation. There was no emergency response action implemented by MSHA based on the accident.

15. On July 20, 2006, MSHA personnel, Miles Frandsen and Paul Wildrick arrived, interviewed the appropriate employees, investigated the scene and, after consultation with the MSHA district office, issued Citation No. 6391461.

I. BRIEF SUMMARY OF THE PARTIES' ARGUMENTS

A. Secretary of Labor

The Secretary argues that MSHA's Emergency Temporary Standard ("ETS") and the MINER Act required Premier to notify MSHA of LaCroix's death within 15 minutes of the time of his death. As applicable here, the ETS modified 30 C.F.R. § 50.10 to provide that when an accident occurs at a mine, the operator must immediately contact the MSHA District Office having jurisdiction over its mine "at once and without delay and within 15 minutes." The term "accident" is defined to include a "death of an individual at a mine." (30 C.F.R. § 50.2(h)(1)).

The Secretary contends that the stipulations show that Mr. LaCroix collapsed at about 6:35 a.m. and lifesaving efforts were discontinued at about 6:45 a.m. Lifesaving efforts were discontinued based on the EMT's apparent determination that Mr. LaCroix had died. The Secretary takes the position that Ms. Williamson knew that LaCroix had died immediately upon her arrival at the machine shop at 7:05 a.m. As a consequence, Premier was obligated to contact MSHA by no later than 7:20 that morning to provide notice of the accident. Because Williamson did not call MSHA until 7:40 a.m., Premier violated section 50.10. The only exception to the 15-minute reporting requirement in the ETS is for situations in which the mine has lost communications because of an emergency or some other unexpected event. This exception clearly does not apply to this case.

Section 5(b) of the MINER Act provides that the operator of a mine who "fails to provide timely notification to the Secretary as required by section 103(j) (relating to the 15 minute requirement) shall be assessed a civil penalty by the Secretary of not less than \$5,000 and not more than \$60,000." (30 U.S.C. § 820(a)(2)). The Secretary argues that there are no exceptions to this provision. As a consequence, she maintains that she has "absolutely no discretion to assess a penalty lower than \$5,000 for this violation." (S. Motion 7). MSHA assessed the lowest possible penalty based on the fact that the violation was not significant and substantial and the operator's negligence was low.

B. Premier

Premier argues that after Ms. Williamson arrived at 7:05 a.m., "immediate efforts were undertaken to ensure that all attempts at lifesaving had indeed been performed; as well as a safety assessment of the immediate area and discussions with employees on the scene as to what occurred, when and where." (P. Motion 2). After this assessment was completed, it "was determined that there were no dangers to other employees and no further actions were required, other than notifying MSHA of the incident." *Id.* Premier also states that it is a "ten minute walk

from the scene to the main office where a phone call to MSHA could be made.” *Id.* Premier further states that “due to the remote location of the mine site in Gabbs, Nevada, cell phones are not a reliable communication source to make a call to MSHA or any other third party that is not in the immediate vicinity of the mine site.” *Id.* Premier states that Ms. Williamson immediately called MSHA as soon as she arrived at the mine office.

Premier contends that it did immediately call MSHA as soon as it determined that an accident occurred. Premier relies on the language in the preamble to the ETS which states:

The ETS does not change the basic interpretation of § 50.10. By the terms of the provision, an operator is required to notify MSHA only after determining whether an “accident” as defined in existing paragraph 50.2(h) has occurred. This affords operators a reasonable opportunity to investigate an event prior to notifying MSHA.

(71 Fed. Reg. 12252, 12260 (March 9, 2006)). Premier contends that it notified MSHA within the 15-minute time period “based on its determination that an accident had occurred, life saving measures had concluded and the site was declared secure and of no danger to other employees at 7:25 a.m. . . .” (P. Motion 2-3).

Premier also argues, in the alternative, that any determination that it “exceeded the 15 minute time frame is mitigated by the time spent rendering life assistance, inspecting the premises, and perhaps most importantly, verifying that Mr. LaCroix presumably died of natural causes and not of any conditions that existed at the accident site that could pose a subsequent danger to other employees.” (P. Motion 3-4). Premier also argues that the LaCroix accident, although tragic, did not involve a mine emergency or require a mine evacuation. MSHA did not activate any emergency response and did not arrive at the facility until the next day. As a consequence, it argues that the penalty should be significantly reduced.

II. DISCUSSION WITH FINDINGS OF FACT AND CONCLUSIONS OF LAW

The parties maintain that there are no issues to be resolved at a hearing because they stipulated to the essential facts. They filed cross-motions for summary decision. The Commission’s Procedural Rules provide that a “motion for summary decision shall be granted only if the entire record, including pleadings, depositions, answers to interrogatories, admissions, and affidavits shows: (1) that there is no genuine issue as to any material facts; and (2) that the moving party is entitled to summary decision as a matter of law.” 29 C.F.R. § 2700.67(b). I find that the facts stipulated to by the parties are sufficiently comprehensive for me to render a decision on the legal issues raised in the parties’ cross motions.

Premier operates a surface mine and plant in Nye County, Nevada. Material containing magnesite is mined, crushed, milled, and then processed at this facility. The end product has various applications including uses in animal feed and water treatment facilities. (26 FMSHRC 414). Citation No. 6391461 states that the “mine operator did not notify MSHA within the required 15 minute time frame, after becoming aware of an accident in the lower shop.” Inspector Miles Frandsen determined that there was no likelihood of an injury or illness as a result of this violation and that it was not significant and substantial. He also determined that Premier’s negligence was low.

There can be little question that, before the MINER Act was enacted and the ETS was promulgated, this citation would not have been issued under these facts. The MINER Act imposed a new 15-minute time limit for reporting accidents. As relevant here, the language of section 813(j) of the Mine Act, as amended by the MINER Act, provides that notification to MSHA “shall be provided by the operator within 15 minutes of the time at which the operator realizes that the death of an individual at a mine . . . has occurred.” Based on that mandate in the MINER Act, the Secretary revised her regulation at section 50.10 to insert a requirement that the operator contact MSHA “at once without delay and within 15 minutes.”

The preamble to this rule provides some explanation of MSHA’s interpretation of the amended regulation at issue here. As stated above, an operator is afforded a “reasonable opportunity to investigate an event prior to notifying MSHA” to determine whether an accident occurred. (71 Fed. Reg. 12260). The MINER Act’s notification provision was enacted because, in part, “MSHA was not notified of the Sago Mine Accident until approximately two hours after the occurrence of the accident.” (71 Fed. Reg. 12256). The Secretary explained why immediate notification of accidents is so important, as follows:

Operator notification to MSHA in the event of a mine accident is vital to enable the Agency to effectively respond in emergency and potentially life threatening situations. Notification alerts the Agency so that accident investigations and assistance to trapped or injured miners can be initiated. MSHA is particularly concerned that failure to immediately notify the Agency of mine emergencies can cost lives by delaying rescue services.

(71 Fed. Reg. 12257).

The stipulations establish that Mr. LaCroix arrived at the mine at 6:30 a.m. and collapsed a few minutes later. Mr. Hermance, who was in the area, immediately called for help and began life saving efforts, which included CPR. Although Mr. LaCroix suffered from high blood pressure and had been complaining of feeling bad for a number of days prior to the incident, the cause of his collapse was not immediately known. Safety Director Williamson was notified of the events at about 6:45 a.m. as she was on her way to the mine. According to Scott Janis, a licensed EMT, all lifesaving efforts were stopped at about 6:45 a.m. When Ms. Williamson

arrived at the scene at about 7:05, she immediately made sure that all attempts at life saving had indeed been performed, that a safety assessment of the immediate area had been performed, and that she understood what had occurred. Once she determined that conditions did not pose a hazard to other employees and no further remedial actions were required, Ms. Williamson went to the mine office and called MSHA. The issue is whether this call was made “at once without delay and within 15 minutes.”

I find that the Secretary did not establish a violation of section 50.10 under the particular facts presented by this case. When Ms. Williamson arrived at the shop, she first had to determine whether an accident occurred. She did this by making sure that all life saving measures had been taken. When a person collapses for no obvious reason, the operator must be certain that his collapse was not the result of an occupational hazard, such as an electric shock. As a consequence, the operator must immediately take measures to ensure that all hazards are eliminated so that no other miners are injured or killed. In order to determine whether any hazards were present, Premier had to investigate the accident site. Ms. Williamson completed this investigation by about 7:25 a.m. and reported the death the MSHA at 7:40 a.m. As a result of her initial investigation of the accident, Ms. Williamson was able to describe the events to MSHA with enough detail so that MSHA saw no need to immediately dispatch inspectors to the remote accident site, thereby conserving MSHA’s resources.

In reaching my conclusion that Premier did not violate section 50.10, I relied on a number of facts. Many of these facts are unique to the circumstances of this case. First, the accident was not caused by occupational factors. Mr. LaCroix died shortly after he arrived at the plant of natural causes. There was no “potentially life threatening situation” presented by this accident that required MSHA action. (71 Fed. Reg. 12257). The amendment to section 813(j) of the Mine Act, as well as the Secretary’s ETS, were enacted to enable MSHA to quickly respond to situations that could endanger miners. Because Ms. Williamson determined that Mr. LaCroix’s death did not pose a hazard to other miners, no rescue or response action by MSHA was necessary. Indeed, MSHA inspectors did not travel to the mine until the following day.

Second, as interpreted by the Secretary in the ETS, a violation does not necessarily automatically occur 15 minutes after the moment of death of a miner. The operator may not even know exactly when a miner died. Rather, a mine operator is given a “reasonable opportunity to investigate an event prior to notifying MSHA.” This “reasonable opportunity” is not a fixed concept. In the event of a mine explosion or an entrapment of miners, for example, a mine must quickly notify MSHA even before it begins its own investigation or its own recovery efforts. Such an explosion or entrapment presents a major hazard to miners, with the result that any delay by a mine operator in providing MSHA with notification would be unreasonable. MSHA would need to be involved in rescue and recovery operations. Such rescue and recovery operations take time to coordinate and assemble. When a man collapses for no readily apparent reason, on the other hand, it is reasonable for the mine operator to conduct a brief investigation to see if a hazard was present that could endanger other miners. I find that it was reasonable for Premier to take a few steps to investigate the situation before it notified MSHA of the death. At the

conclusion of Ms. Williamson's brief investigation, she determined that the accident needed to be immediately reported to MSHA and she was able to describe what had happened.

Third, and most importantly, Premier's notification was prompt. Based on the time line presented in the stipulations, it is clear that Ms. Williamson completed her investigation by approximately 7:25 a.m., about 20 minutes after she arrived at the lower shop. She immediately went to the mine office to make the call. Gabbs, Nevada, is in as remote a location as one can find. Her need to use a land line to make the call is understandable given the location of the mine. Premier should set up a procedure so that, in the event of an accident, Ms. Williamson or another management official can call the office on the mine radio and instruct office personnel to make the initial call to MSHA. A ten-minute delay to travel to the office would not be acceptable in most instances. Ms. Williamson can always call MSHA back a few minutes later with more details about the accident.

It is important to understand that this case presents a novel situation that will only arise occasionally. My holding is limited to the facts of this case. At the conclusion of her investigation, Ms. Williamson determined that Mr. LaCroix's death was not related to his work activities and that an occupational hazard was not present in the lower shop. As a consequence, she was able to impart this information to MSHA when she made the call. In vacating the citation I rely on the language of the MINER Act, the amended language of section 50.10, and the Secretary's interpretation of the regulation as set forth in the preamble to the ETS. Although this "opportunity to investigate" to determine whether an accident occurred should be construed narrowly, the facts presented in this case demonstrate the wisdom of the Secretary's interpretation. Given her enforcement position in this case, it can reasonably be presumed that the Secretary will strictly enforce the 15-minute time limit set forth in the MINER Act and her ETS. It is also clear that she will narrowly construe the language in the preamble giving a mine operator time to investigate the events to determine whether there has been an accident.

III. ORDER

For the reasons set forth above, Premier's motion for summary decision is **GRANTED**, the Secretary's motion for summary decision is **DENIED**, Citation No. 6391461 is **VACATED**, and this proceeding is **DISMISSED**.

Richard W. Manning
Administrative Law Judge

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