

**FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION**

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January 23, 2015

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

v.

CONSOL BUCHANAN MINING  
COMPANY, LLC,  
Respondent

CIVIL PENALTY PROCEEDING

Docket No. VA 2013-190  
A.C. No. 44-04856-311430

Mine: Buchanan Mine #1

**DECISION AND ORDER**

Appearances: Ronald Gurka, Esq., Office of the Solicitor, U.S. Department of Labor,  
Arlington, VA, for the Petitioner

Billy R. Shelton, Esq., Jones, Walter, Turner & Shelton PLLC, Lexington,  
KY, for the Respondent

Before: Judge Rae

**I. INTRODUCTION**

**A. Statement of the Case**

This case comes before me upon a petition for assessment of civil penalties filed by the Secretary of Labor under section 105(d) of the Federal Mine Safety and Health Act of 1977 (the Mine Act), as amended, 30 U.S.C. § 815(d), and involves two section 104(d)(1) violations<sup>1</sup> issued to CONSOL Buchanan Mining Company, LLC (“Consol” or “the Respondent”) by the Department of Labor’s Mine Safety and Health Administration (MSHA).

A hearing was held in Abingdon, Virginia on July 15-16, 2014, at which time the parties were afforded a full opportunity to present evidence and testimony. The parties also submitted post-hearing briefs, which I have considered in rendering this decision.

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<sup>1</sup> Section 104(d)(1) of the Mine Act, 30 U.S.C. § 814(d)(1), establishes more severe sanctions for any violation that is caused by “an unwarrantable failure of [an] operator to comply with . . . mandatory health or safety standards.”

After consideration of the evidence and observation of the witnesses and assessment of their credibility, I uphold the two section 104(d)(1) violations as written and impose a total penalty of \$140,000 against Consol, for the reasons set forth below.

**B. Stipulations**

The parties have stipulated to the following facts:

1. CONSOL Buchanan Mining Company, LLC was an “operator” as defined in section 3(d) of the Mine Act, 30 U.S.C. § 803(d), at the coal or other mine at which the citation and order at issue in this proceeding were issued.
2. Operations of CONSOL Buchanan Mining Company, LLC at the coal or other mine at which the citation and order at issue in this proceeding were issued are subject to the jurisdiction of the Mine Act.
3. This proceeding is subject to the jurisdiction of the Federal Mine Safety and Health Review Commission and its designated Administrative Law Judges pursuant to sections 105 and 113 of the Mine Act.
4. The individual or individuals whose signatures appear in Block 22 of the citation and order that are at issue in this proceeding were each acting in their official capacity and as an authorized representative of the Secretary of Labor when the citation and order were issued.
5. True copies of each citation and order at issue in this proceeding were served on the Respondent or its agent as required by the Mine Act.
6. The total proposed penalty for the citation and order in this proceeding will not affect the Respondent’s ability to continue in business.
7. The citation and order contained in Exhibit A attached to the Secretary’s petition are authentic copies of the citation and order that are at issue in this proceeding with all appropriate modifications or abatements, if any.
8. CONSOL Buchanan Mining Company, LLC, is the current operator of the Buchanan Mine #1 as a result of having acquired the assets and liabilities of Consolidation Coal Company, which operated the Buchanan Mine #1 at the time the events at issue in this case occurred. CONSOL Buchanan Mining Company, LLC has thus been substituted as a party for Consolidation Coal Company in this proceeding, and CONSOL Buchanan Mining Company, LLC will be liable for any violations at issue in this proceeding found to have occurred while Consolidation Coal Company was the operator of the Buchanan Mine #1. Consistent with this substitution, any reference to Consolidation Coal Company in this proceeding shall be deemed to be a reference to CONSOL Buchanan Mining Company, LLC, and vice versa.

**C. Statement of Facts**

The violations at issue in this case arose from a fatal accident that occurred in the Buchanan Mine #1, a large underground coal mine in Buchanan County, Virginia. On Friday, January 11, 2012, miners Joe E. Saunders and W. David Green were assigned to transport a Freedom shuttle car through the mine during the evening production shift. Tr. 634; Exs. R-8 &

S-22 at 3; Ex. R-9 at 2; Ex. S-1 at 3; Ex. S-12.<sup>2</sup> They were accompanied by Greg Addington, a certified foreman with 35 years of underground coal mining experience. *See* Tr. 603; Ex. R-11. The shuttle car was to be moved along the haulage track on a rail-mounted lowboy hauler between two diesel locomotives. Exs. R-8 & S-22 at 3; Ex. R-9 at 2; Ex. S-1 at 3. The shuttle car's electrical panel board protruded 3 feet, 2 inches over the left rail of the track. Ex. S-2 at 18; Tr. 60; Ex. R-9 at 6; *see* Photograph S-7 (depicting overhang). Because it was a wide load, the shuttle car was positioned on an airbag and outfitted with come-alongs so it could be lifted or shifted from side to side in tight spots. Tr. 634-35.

Saunders, Green, and Addington were traveling inby in the #5 entry around 7:40 PM when the protruding left side of the shuttle car struck a water manifold (a pipe fitting with multiple outlets) at crosscut #61, knocking it off of the 6-inch water line that runs between the haulage track and conveyor belt in the #5 entry. Tr. 609, 636-37; Ex. S-12; Ex. R-8 & S-22 at 2, 4; *see* Ex. S-1 at 21 (diagram of accident site); Photographs S-8, R-37 to R-41, R-47 (investigators' re-creation of moment of impact). The 6-inch water line is part of the mine's fire suppression system and is required to have fire valve assemblies where a fire hose can be hooked up every 300 feet. Tr. 417, 488; *see* Ex. R-10. The manifold that was struck by the shuttle car was a fire valve assembly with four outlets: two capped fire hose outlets; an outlet that connected to the 6-inch water line in the mine floor; and another outlet that connected to a 2-inch pipe that supplied water to the fire suppression system for a rock dust distribution machine in an adjacent entry. *See* Ex. S-2 at 16; Ex. S-1 at 22; Tr. 51-58. The manifold was connected to the 6-inch water line with a bronze two-piece 1½-inch ball valve of the type demonstrated in physical exhibits J-1 and J-2 manufactured by Milwaukee Valve Company. *See* Ex. S-2 at 16.

The 1½-inch valve broke into two pieces at an internal threaded connection when the collision with the shuttle car occurred. Tr. 56; *see* Ex. J-1. The body of the valve is 3 inches long and houses the rotating ball that controls water flow through the valve, while the tailpiece of the valve is slightly more than 1 inch long and resembles a large six-sided nut. Ex. R-9 at 2; Exs. R-5, S-14; *see* Exs. J-1, J-2. During manufacturing the tailpiece is screwed into the body of the valve with a set of internal straight-cut threads and the threaded connection is then sealed with an adherent called Loctite. Tr. 119, 172-74, 322-24, 379; *see* Exs. J-1, J-2. After the collision, the tailpiece remained attached to the steel nipple protruding from the 6-inch water line in the mine floor, but the body of the valve had been sheared off. Tr. 641; Exs. R-8 & S-22 at 5; Ex. R-9 at 2. Thus, the water line was breached and the water manifold was left hanging off of the 2-inch pipe leading to the rock dust distribution machine. Water shot out to the roof, drenching the miners. Tr. 511-12, 525-26, 609, 620-21, 637; Ex. S-12.

Green, Saunders, and Addington moved the shuttle car out of the way, then Green and Saunders proceeded to shut the water off so they could assess the damage. Tr. 609-10, 637-39, 648-49. Green turned the water off inby, Tony Atwell (a miner from a motor crew that was on the haulage track directly behind Saunders, Green, and Addington) turned the water off outby, and Saunders attempted to turn the water off at a 6-inch shutoff valve on a crossover pipe at crosscut #62. Ex. S-2 at 7; Ex. R-9 at 2; Tr. 512, 609-10; Ex. S-12. The water that had been

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<sup>2</sup> In this opinion, the abbreviation "Tr." refers to the hearing transcript. The Secretary's exhibits are numbered S-1 through S-24, the Respondent's exhibits are numbered R-1 through R-48, and the joint exhibits are numbered J-1 and J-2.

shooting out of the breached line subsided to a relatively small but consistent flow that continued to discharge the entire time the miners were trying to make repairs. Tr. 526-27, 621-23, 650-51. The miners assumed this was residual water draining from the isolated section of the water line. Tr. 623, 640, 652; Ex. R-8 & S-22 at 7.

While the men were shutting the water off and beginning to make repairs, Addington walked to a nearby crosscut to dry off and called shift foreman David Lynn Semones on his walkie-talkie to tell him the move crew had struck the water line. Tr. 610-13; Ex. S-12. Semones testified he told Addington he would send another crew to fix the water line and instructed the move crew to cut the water off and continue moving the shuttle car through the area. Tr. 576-77. Addington testified he did not hear these instructions. Tr. 612-13, 654.

Meanwhile, Green and Saunders had begun repairing the fire valve assembly without waiting for the water to bleed off. Tr. 652. They first detached the manifold from the 2-inch pipe leading to the rock dust distribution machine. Tr. 640. Next, they attempted to reattach the manifold to the steel nipple on the 6-inch water line by screwing it back onto the tailpiece of the 1½-inch valve and tightening it down with a pipe wrench. Tr. 513-14, 527-28, 641, 651-54. After the manifold was back in place, Saunders attempted to reattach the 2-inch pipe. Tr. 514-15, 643. The coupling between the manifold and 2-inch pipe was a Victaulic coupling, a type of connection accomplished with a rubber gasket that folds over two abutting pipes. Tr. 151-52. As Saunders was trying to fold the rubber gasket over the abutting pipes, water was leaking out and impeding his efforts, so he turned the 1½-inch valve at the bottom of the manifold into the off position to block the flow of water. Tr. 59; Ex. S-2 at 9-10; Ex. R-8 & S-22 at 5-7; Ex. R-9 at 3. As a result, water pressure built up under the 1½-inch valve's ball plug, causing the valve to violently break apart moments later in the same place as before. Tr. 59; Exs. R-8 & S-22 at 5-6; Ex. R-9 at 3. This time, however, the manifold was not attached to the 2-inch pipe. The manifold was blown off of the 6-inch water line and into the air, struck Saunders in the face and head, struck another miner in the shoulder, hit the mine roof 13½ feet above, then came to rest on the mine floor 23 feet 4 inches away from its starting point. Ex. S-2 at 10, 14; Ex. R-9 at 5, 8. Saunders died a week later due to the very serious injuries he had incurred.

MSHA Inspectors Mark Hlywa<sup>3</sup> and Jason Hess<sup>4</sup> conducted MSHA's accident investigation. When Hlywa arrived at the scene a few minutes after the accident had occurred, water was still discharging from the point where the manifold had been blown off of the water line and a small puddle had formed. Tr. 41-46. Hlywa visited the three shutoff valves where the miners had attempted to turn the water off and discovered that the 6-inch shutoff valve at crosscut #62 was not closed all the way. To close the valve all the way, the handle needs to be

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<sup>3</sup> Hlywa has worked as a coal mine inspector for MSHA since June 2008. He has a B.S. in mine engineering. His prior mining experience includes working for Consol Energy for several years as a general underground employee, industrial engineer, and foreman and working for a mine equipment manufacturer for a year as a design engineer. Tr. 39-40.

<sup>4</sup> Hess has worked for MSHA as a general coal mine inspector since 2007 and as a ventilation specialist since 2012. He is also trained as an accident inspector, and serves in that capacity as needed. Before coming to MSHA, Hess worked in the coal mining industry for eleven and a half years, including as a continuous miner operator and as a production, maintenance, and lead foreman. He is also a certified electrician. Tr. 122-28.

turned 90 degrees until it is perpendicular to the water line and contacts the handle stop embossed on the top of the valve. Tr. 346-47. Hlywa discovered the 6-inch valve was visibly open in that the handle was not fully perpendicular to the water line and audibly open in that water was hissing where it was bypassing a small opening. Ex. S-2 at 7, 13; Tr. 63-65, 78, 147-48. Hlywa asked the miners to try to turn the water all the way off, after which the puddle at the accident site subsided, but a small amount of water continued to discharge. Tr. 48, 51, 75-76, 134; Ex. S-2 at 20. Inspector Hess, who arrived at the mine around 9:45 PM to take over the accident investigation, testified that the water was not completely shut off until the 6-inch shutoff valve at crosscut #62 was replaced with a new valve after he had left the mine that night. Tr. 134-38, 149-50; *see also* Ex. S-3 at 8-9; Tr. 156; Photograph S-11 (picture of replacement valve taken the next morning).

The evening of the accident, Hlywa, Hess, and other investigators from the company and the state examined the manifold and the two pieces of the broken 1½-inch valve. They found that the 1½-inch valve's internal threaded connection was damaged. The damage was not readily apparent to the touch or to the naked eye. However, upon close examination and measurement with a feeler gauge, the investigators found that the female threads on the body of the valve were stretched such that only a few threads on the tailpiece were engaging and holding when the two pieces were screwed together. Tr. 67, 85-87, 107-08, 143-44, 297-99; Ex. S-2 at 21, 27; Ex. S-3 at 18-20; Exs. R-8 & S-22 at 11-12; Ex. R-9 at 2.

Inspector Hess later obtained the manufacturers' information on both the 1½-inch valve (Exs. S-14, R-5) and the 6-inch shutoff valve (Exs. S-15, R-6) and sent the valves to MSHA fire protection engineer Michael Hockenberry<sup>5</sup> for analysis. Tr. 165-76. Based on his correspondence with a Milwaukee Valve representative (Ex. S-20) and his review of the manufacturer's information, Hockenberry concluded the 1½-inch valve was a throwaway item that should not be reused after being taken apart. Ex. S-18; Tr. 319-29, 367-70. Hockenberry procured a brand new fully assembled 1½-inch valve (Ex. J-2) and another partly assembled exemplar valve (Ex. J-1) to compare to the accident valve. He found that the male threads on the accident valve's tailpiece were worn down or stripped, showing a 25% loss of material as compared to the exemplar valve. Ex. S-18; Tr. 310-18, 366-67. In addition, the valve's safe allowable working pressure was rated at just 600 pounds per square inch (psi), which fell below the mine's typical water pressures of 800 psi or greater. Tr. 334-39, 370-73; *see* Exs. S-14, R-5; Ex. R-7; Ex. S-5; Tr. 158-59; 465.

When Hockenberry examined the 6-inch shutoff valve, he was able to rotate the handle to within 3 millimeters of the closed position by applying less than 50 foot-pounds of torque. However, accumulated coal dust and grime in front of the handle stop prevented him from closing it the rest of the way. Ex. S-18; Tr. 349-53. According to the manufacturer's information, it should have taken 225 foot-pounds of torque to close the 6-inch valve. Exs. S-15, R-6; Tr. 355-57. The manufacturer supplies a 22.5-inch leverage bar with each 6-inch valve that can be attached to the handle with a cotter key to increase the torque exerted. Tr. 156-57, 196-

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<sup>5</sup> Michael Hockenberry has a Master's degree in mechanical engineering and has worked for MSHA as a Fire Protection Engineer since 2000. In this capacity, he provides technical assistance relating to fire prevention and fire suppression systems in mines. He also holds an assistant mine foreman certification in the state of West Virginia. Tr. 303-07; Ex. S-19.

99; Ex. S-5; *see* Photograph S-11 (new valve with leverage bar). At the Buchanan Mine, however, these leverage bars were customarily detached from the valves as soon the valves were brought into the mine. Tr. 89, 197, 223, 421-22, 581-82.

After the conclusion of the accident investigation, Inspector Hess issued two enforcement actions against Consol. Citation No. 8190902 alleged that the Respondent's act of reusing the 1½-inch valve after it had been pulled apart by the collision with the shuttle car constituted a failure to maintain equipment in safe operating condition, in contravention of 30 C.F.R. § 75.1725(a). Exs. S-16, R-1. Order No. 8190903 alleged that the Respondent's failure to maintain the 6-inch shutoff valve in usable and operative condition violated the requirement that firefighting equipment must be maintained in usable and operative condition under 30 C.F.R. § 75.1100-3. Exs. S-17, R-2.

The Respondent removed the cited valves from service immediately after the accident, abating the violations. Exs. S-16, S-17, R-1, R-2; Tr. 242-43. The Respondent later took more extensive steps, some partly in response to other non-contributory violations, to make the mine safer. These steps included replacing all the two-piece 1½-inch valves in the mine with valves that had a soldered connection and were rated to handle 1000 psi; repositioning the fire valve assemblies to move them away from the haulage track; partnering with MSHA to develop an action plan for equipment moves; changing the policies for fixing damaged water line components; and hanging heavy-duty steel leverage bars above each 6-inch shutoff valve in the mine. Tr. 212-16, 223-24, 242-43, 451-55; *see* Exs. R-8 & S-22 (containing enforcement actions issued by state of Virginia, with evidence of corrective actions taken).

## II. LEGAL PRINCIPLES

### A. Gravity/S&S

The gravity of a violation is generally expressed as the degree of seriousness of the violation. *Hubb Corp.*, 22 FMSHRC 606, 609 (May 2000); *Consolidation Coal Co.*, 18 FMSHRC 1541, 1549 (Sept. 1996). Gravity is measured in terms of the likelihood of injury, the type of injury expected, the number of persons affected, and whether the violation is significant and substantial (S&S). *See Energy West Mining Co.*, 18 FMSHRC 565, 571 (Apr. 1996) (“In considering the gravity of a violation, the Commission has generally considered the likelihood of an occurrence of the hazard against which a standard is directed and the severity of the resulting injury.”).

An S&S violation is a violation “of such nature as could significantly and substantially contribute to the cause and effect of a . . . mine safety or health hazard.” 30 U.S.C. § 814(d). A violation is properly designated S&S “if, based upon the particular facts surrounding the 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).

In *Mathies Coal Company*, the Commission set forth the following four-part test to determine whether a violation is properly designated S&S:

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.

6 FMSHRC 1, 3-4 (Jan. 1984); accord *Buck Creek Coal, Inc. v. FMSHRC*, 52 F.3d 133, 135 (7th Cir. 1995); *Austin Power, Inc. v. Sec’y of Labor*, 861 F.2d 99, 103 (5th Cir. 1988); *Consolidation Coal Co. v. FMSHRC*, 824 F.2d 1071, 1075 (D.C. Cir. 1987). The inspector’s judgment is also an important element of an S&S determination. *Wolf Run Mining Co.*, 36 FMSHRC 1951, 1959 (Aug. 2014); *Maple Creek Mining, Inc.*, 27 FMSHRC 555, 563 n.6 (Aug. 2005); *Harlan Cumberland Coal Co.*, 20 FMSHRC 1275, 1278-79 (Dec. 1998); *Mathies*, 6 FMSHRC at 5. The S&S determination must be based on the particular facts surrounding the violation at issue. *Peabody Coal Co.*, 17 FMSHRC 508, 511-12 (Apr. 1995); see, e.g., *Wolf Run*, 36 FMSHRC at 1957-59 (remanding S&S finding for further consideration of relevant circumstances).

It is the third element of the S&S criteria that is the source of most controversies regarding S&S findings. This element is established only if the Secretary proves “a *reasonable likelihood* the hazard contributed to will result in an event in which there is an injury.” *U.S. Steel Mining Co.*, 6 FMSHRC 1834, 1836 (Aug. 1984). Evaluation of the reasonable likelihood of injury should be made assuming “continued normal mining operations,” *U.S. Steel Mining Co.*, 6 FMSHRC 1573, 1574 (July 1984), i.e., the evaluation should be made “in consideration of the length of time that the violative condition existed prior to the citation and the time it would have existed if normal mining operations had continued.” *Black Beauty Coal Co.*, 34 FMSHRC 1733, 1740 (Aug. 2012); *Rushton Mining Co.*, 11 FMSHRC 1432, 1435 (Aug. 1989).

The S&S nature of a violation and the gravity of the violation are not synonymous. Gravity is an element that must be assessed for every violation, while an S&S determination is made only in the context of enhanced enforcement under section 104(d) of the Mine Act. The gravity assessment and a finding of S&S are frequently based upon the same or similar factual circumstances, *Quinland Coals, Inc.*, 9 FMSHRC 1614, 1622 n.11 (Sept. 1987), but the focus of the inquiries differs. The Commission has pointed out that the focus of the gravity inquiry “is not necessarily on the reasonable likelihood of serious injury, which is the focus of the S&S inquiry, but rather on the effect of the hazard if it occurs.” *Consolidation Coal Co.*, 18 FMSHRC at 1550; see also *Harlan Cumberland Coal Co.*, 12 FMSHRC 134, 140-41 (Jan. 1990) (ALJ) (explaining that notwithstanding likelihood of injury, some violations are serious in the context of the standard violated and the Mine Act’s deterrent purposes – for example, violations of an important safety standard; violations demonstrating recidivism or defiance on the operator’s part; or violations that can combine with other conditions to set the stage for disaster).

## B. Negligence/Unwarrantable Failure

Negligence is conduct that falls below the standard of care established under the Mine Act. Under the Mine Act, an operator is held to a high standard of care and is required to be on the alert for conditions and practices that may cause injuries and to take necessary precautions to prevent or correct them. 30 C.F.R. § 10.0(d). High negligence is defined as having occurred in connection with a violation when “[t]he operator knew or should have known of the violative condition or practice, and there were no mitigating circumstances.” *Id.* § 100.3 Table X. The Commission has stated that a finding of high negligence “suggests an aggravated lack of care that is more than ordinary negligence.” *DQ Fire & Explosion Consultants, Inc.*, 36 FMSHRC \_\_\_, slip op. at 5-6, Nos. WEVA 2011-952-R & WEVA 2011-2480 (Dec. 19, 2014) (citing *Topper Coal Co.*, 20 FMSHRC 344, 350 (Apr. 1998)).

More serious consequences can be imposed under the Mine Act for violations that result from the operator’s unwarrantable failure to comply with mandatory health or safety standards. The unwarrantable failure terminology is taken from section 104(d) of the Mine Act, 30 U.S.C. § 814(d), and refers to more serious conduct by an operator in connection with a violation. The Commission has determined that unwarrantable failure is aggravated conduct constituting more than ordinary negligence. *Emery Mining Corp.*, 9 FMSHRC 1997, 2001-04 (Dec. 1987). Unwarrantable failure is characterized by such conduct as “reckless disregard,” “intentional misconduct,” “indifference,” or a “serious lack of reasonable care.” *Id.* at 2003-04; *Rochester & Pittsburgh Coal Co.*, 13 FMSHRC 189, 193-94 (Feb. 1991); *Buck Creek Coal, Inc. v. FMSHRC*, 52 F.3d 133, 136 (7th Cir. 1995).

Whether conduct is “aggravated” in the context of unwarrantable failure is determined by looking at all the facts and circumstances of each case to see if any aggravating factors or mitigating circumstances exist. These factors often include (1) the extent of the violative condition, (2) the length of time the violative condition existed, (3) whether the violation posed a high degree of danger, (4) whether the violation was obvious, (5) the operator’s knowledge of the existence of the violation, (6) the operator’s efforts in abating the violative condition, and (7) whether the operator had been placed on notice that greater efforts were necessary for compliance. *Wolf Run Mining Co.*, 35 FMSHRC 3512, 3520 (Dec. 2013); *see Lopke Quarries, Inc.*, 23 FMSHRC 705, 711 (July 2011); *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). 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. *Lopke Quarries*, 23 FMSHRC at 711; *Capital Cement*, 21 FMSHRC 883, 892-93 (Aug. 1999); *REB Enters., Inc.*, 20 FMSHRC 203, 225 (Mar. 1998); *see Spartan Mining Co.*, 30 FMSHRC 699, 715, 720 (Aug. 2008).

The factors listed above must be viewed in the context of the factual circumstances of a particular violation, and it is not necessary to find that all factors are relevant or deserving of equal weight in order to determine that the violation is unwarrantable. *Wolf Run*, 35 FMSHRC at 3520-21; *E. Associated Coal Corp.*, 32 FMSHRC 1189, 1193 (Oct. 2010); *IO Coal Co.*, 31



FMSHRC 1346, 1351 (Dec. 2009). However, all factors that are relevant should be considered. *San Juan Coal Co.*, 29 FMSHRC 125, 129 (Mar. 2007).

### C. Violations and the Notice Requirement

The Commission generally applies the reasonably prudent person test to determine whether a violation has occurred under the Mine Act. The reasonably prudent person test is a means of determining whether the operator has sufficient notice of the meaning of the cited regulation to be charged with violating it. See *LaFarge North America*, 35 FMSHRC 3497, 3500 (Dec. 2013). MSHA may charge an operator with a violation of a safety or health regulation only when the operator has actual notice of MSHA's interpretation of the regulation, or when "a reasonably prudent person familiar with the factual circumstances surrounding the allegedly hazardous condition, including any facts peculiar to the mining industry, would recognize a hazard warranting corrective action within the purview of the applicable regulation." *Alabama By-Products Corp.*, 4 FMSHRC 2128, 2129 (Dec. 1982); see *LaFarge*, 35 FMSHRC at 3501. Thus, even if the operator does not have explicit notice of a specific prohibition or requirement contained in a safety or health standard, the operator still can be charged with a violation if a reasonably prudent person familiar with the protective purposes of the cited safety or health standard would have ascertained the specific prohibition or requirement contained therein and realized that under the factual circumstances there was a violation. *LaFarge*, 35 FMSHRC at 3501; *Ideal Cement Co.*, 12 FMSHRC 2409, 2415-16 (Nov. 1990).

## III. FINDINGS OF FACT AND CONCLUSIONS OF LAW

### A. Citation No. 8190902

#### 1. *The Violation*

Citation No. 8190902 alleges that Consol's act of reusing the 1½-inch bronze connector valve after the shuttle car struck and separated it constituted a failure to maintain equipment in safe operating condition, in violation of the mandatory safety standard at 30 C.F.R. § 75.1725(a). Exs. S-16, R-1. This regulation mandates: "Mobile and stationary machinery and equipment shall be maintained in safe operating condition and machinery or equipment in unsafe condition shall be immediately removed from service." 30 C.F.R. § 75.1725(a).

As noted by the Secretary in his post-hearing brief, Consol does not genuinely dispute that a violation of 30 C.F.R. § 75.1725(a) occurred when the 1½-inch valve was returned to service after being struck by the shuttle car. The valve was a component of the mine's water supply and fire suppression systems and constituted "stationary equipment," bringing it within the ambit of the cited regulation. When the shuttle car struck the valve, the force of the impact broke the valve in two. The valve's tailpiece was still attached to the 6-inch water line but water was shooting out where the body of the valve should have been connected. Tr. 641. The body of the valve is normally connected to the tailpiece by a set of internal threads sealed with Loctite, but this internal threaded connection had been forcibly pulled apart by the collision. The witnesses uniformly testified they had not previously recognized that this type of valve could come apart. See Tr. 92-93, 115, 277-78, 458-59, 533, 547, 585, 633. MSHA's witnesses

testified the internal threads could not have escaped damage after being forcibly pulled apart. Tr. 68-71, 178-80, 279-81, 331-33, 398-99. Consol's witnesses seemed to agree that the valve would have incurred damage under these circumstances and should have been replaced rather than returned to service. *See, e.g.*, Tr. 427, 462-68, 555-57, 644. Indeed, the valve proved to be in unsafe condition, because it split in two again at the same threaded connection several minutes after it was returned to service and placed under pressure. Subsequent analysis of the valve revealed damage to the internal threaded connection, including stretching of the female threaded portion and loss of material on the peaks of the male threads. Tr. 67, 85-87, 107-08, 143-44, 297-99, 310-18, 366-67; Ex. S-2 at 21, 27; Ex. S-3 at 18-20; Exs. R-8 & S-22 at 11-12; Ex. R-9 at 2; Ex. S-18.

I find that the 1½-inch valve was in unsafe condition as soon as it was pulled apart by the shuttle car and should have been immediately removed from service. A reasonably prudent miner who knew the valve had been struck and forcibly pulled apart by the shuttle car would have recognized that the valve's structural integrity was compromised under the circumstances and would have immediately removed it from service. However, the Respondent placed the valve back in service instead. Under these circumstances, a violation of 30 C.F.R. § 75.1725(a) is established.

## 2. *S&S Designation and Gravity*

In assessing the gravity of this violation, Inspector Hess indicated that one fatal injury had occurred. Exs. S-16, R-1. He also designated the violation S&S. Consol does not directly dispute MSHA's gravity findings or the S&S designation.

I find that this violation meets the four elements of the *Mathies* test and therefore I uphold the Secretary's characterization of the violation as S&S. As discussed above, the Secretary has established an underlying violation of a mandatory safety standard, satisfying the first *Mathies* element. Consol's use of the 1½-inch valve while it was in unsafe condition contributed to the risk or hazard that the valve would fail again when placed under pressure during continued normal mining operations, satisfying the second *Mathies* element. The remaining *Mathies* elements are reasonable likelihood of injury and reasonable likelihood that such injury will be reasonably serious in nature.

The hazard that the valve would fail again was reasonably likely to result in injury based on the particular facts surrounding the violation. The valve was connected to a water line carrying pressurized water. The water pressure at the Buchanan Mine was known to be unusually high. Tr. 276-77, 460, 488-89, 504-05. Inspector Hess obtained water pressure measurements exceeding 800 psi, more than 200 psi greater than the 1½-inch valve's 600 psi rating. Tr. 158-59, 192-94; Ex. S-5; *see* Exs. S-14, R-5; Ex. R-7. The valve could be closed to shut off the water supply to the manifold at crosscut #61, in which case pressure would build up behind the 1½-inch valve's ball plug; failure of the valve would cause a sudden outrush of the highly pressurized water. On the night the violation occurred, the valve was closed in order to shut off the water supply to the manifold so Saunders and Green could finish repairing it. Tr. 59; Ex. S-2 at 9-10; Exs. R-8 & S-22 at 5-7; Ex. R-9 at 3. Saunders and Green were working directly above and in front of the damaged 1½-inch valve while it was under pressure, and at least seven other miners were standing nearby. *See* Tr. 525; Ex. S-13; Exs. R-8 & S-22 at 7.

The manifold was partly disassembled such that the only pipe fitting holding it in place was the damaged 1½-inch valve. Under these circumstances, it was reasonably likely that the failure of the 1½-inch valve would cause a piece or pieces of the manifold to be blown apart by escaping pressurized water, injuring one of the nearby miners. In fact, this event occurred. Considering all the foregoing facts, I find that the third *Mathies* element is satisfied.

There was also a reasonable likelihood that any injury caused by the violation would be of a reasonably serious nature. The 1½-inch valve and the other components of the manifold were heavy metal objects. *See* Exs. J-1, J-2. The water pressure at the mine was high enough to propel these objects through the air with sufficient force to cause serious injuries to anyone within striking distance, as evidenced by the fact that the fire valve assembly fatally struck Saunders and was propelled more than twenty feet across the #5 entry even after bouncing off of another miner and the mine roof. Ex. S-2 at 10, 14; Ex. R-9 at 5, 8. I find that the fourth *Mathies* element is satisfied, and I uphold the Secretary's S&S designation for this violation.

The gravity inquiry focuses on the seriousness of the violation and "the effect of the hazard if it occurs." *Consolidation Coal Co.*, 18 FMSHRC 1541, 1550 (Sept. 1996). A judge can find that the gravity of a violation is very serious based solely on the potential effect of the violation. *See, e.g., PBS Coals, Inc.*, 30 FMSHRC 1087, 1091-92 (Nov. 2008) (ALJ) (finding violations that led to nine miners being trapped in a flooded section were "of the utmost gravity" even though the miners were rescued). In this case, the actual effect of the violation was a fatality. I find that this violation was extremely serious in view of its contribution to a fatality. *See Madison Branch Mgmt.*, 17 FMSHRC 859, 873 (June 1995) (Doyle and Holen, Comm'rs, dissenting on other grounds) (noting violation was very serious in view of fatality); *Spartan Mining Co.*, 29 FMSHRC 465, 481 (June 2007) (ALJ) ("Obviously, the gravity of the violation is extreme as evidenced by the fatality in this case."), *vac'd in part on other grounds*, 30 FMSHRC 699 (Aug. 2008).

### 3. *Negligence and Unwarrantable Failure*

Hess assessed this violation as resulting from the operator's high negligence and issued the citation under section 104(d)(1) of the Mine Act, stating that the violation resulted from Consol's unwarrantable failure to comply with a mandatory standard. The narrative portion of the citation includes the following explanation for his decision to charge unwarrantable failure:

The operator and its agent displayed aggravated conduct constituting more than ordinary negligence by allowing this damaged and separated ball type closure valve to be reused. Mine management, including the foreman assigned to supervise the miners making the repairs, were aware that the water valve assemblies were frequently struck and damaged during movement of oversized equipment. This knowledge should have prompted the operator and his agent to take extra care in the repair or replacement of these water valve assemblies. This extra care would include following the ball valve manufacture[r]'s recommendations which state that this is a throw away item and should not be repaired or rethreaded if a separation within the threaded portions occur[s]. Also management, despite the numerous previous times fire valve assemblies were struck and damaged, failed to improve the design and layout of the fire valve

assemblies in this mine to prevent them from being struck during equipment moves. This is an unwarrantable failure to comply with a mandatory standard.

Exs. S-16, R-1. Inspector Hess additionally noted that a foreman, Addington, had been in plain sight and hearing distance of the violation who could and should have stepped in to take control of the situation and prevent the valve from being reused. Tr. 206-12, 248-55, 285-88. At the hearing, Hess explained that his characterization of the 1½-inch valve as a “throwaway item” was based on the manufacturer’s recommendations and the information fire protection engineer Hockenberry had provided. Tr. 204-05, 273-75. Although mine management did not see the manufacturer’s information prior to the accident, Hess felt that the other circumstances supported a finding of aggravated conduct. Tr. 268-69, 285-86. Hess’s position was that mine management as a whole displayed a high degree of negligence because management was aware fire valve assemblies had been hit during equipment moves in the past but failed to take any action to mitigate the problem until after the fatality occurred. Tr. 212, 257, 294.

The Secretary requests that Hess’s unwarrantable failure designation be upheld, citing the high degree of danger posed by the violative condition; the obviousness of the condition; the presence of a supervisor at the accident scene; the operator’s knowledge that the water pressure in the mine was unusually high and that components of the water supply system were regularly struck during equipment moves; and the operator’s failure to take any concomitant precautions to ensure the safety of miners in the face of this knowledge. Sec’y’s Br. at 11-24.

The Respondent argues this citation should be modified to a section 104(a) citation, contending that the violation did not result from aggravated conduct and that the factors necessary for an unwarrantable failure finding are not present. Counsel for the Respondent asserts that Addington did not observe the 1½-inch valve before it was screwed back together, did not watch Saunders and Green put it back together, and was unaware of the danger posed by reattaching the two pieces of the valve. Resp.’s Br. at 16. Counsel contends that the testimony does not establish that damaging fire valve assemblies was a common occurrence during equipment moves. *Id.* at 17. Counsel further contends that MSHA did not place the Respondent on notice that greater efforts at compliance were necessary prior to the accident, nor did the Respondent have a copy of the 1½-inch valve manufacturer’s recommendations such as would have provided notice that valve repairs should not be attempted. *Id.* Counsel argues that the mine’s high water pressure was a “non-issue” that posed no hazard despite exceeding the 1½-inch valve’s 600 psi rating because the valve had a safety factor of 2.5; no other valve in the mine had ever failed; and everyone (including MSHA) was aware of the high water pressure prior to the accident. *Id.* at 18.

As noted above, factors that should be considered in assessing an unwarrantable failure determination include the length of time that the violation existed, the extensiveness of the violation, whether the operator was placed on notice that greater efforts were necessary for compliance, the operator’s efforts in abating the violative condition, whether the violation was obvious or posed a high degree of danger, the operator’s knowledge of the existence of the violation, and the involvement of a supervisor.

(a) Duration of Violative Condition

The Commission has emphasized that the duration of the violative condition is a necessary element of the unwarrantable failure analysis. *E. Associated Coal Corp.*, 32 FMSHRC 1189, 1198 (Oct. 2010); *Coal River Mining, LLC*, 32 FMSHRC 82, 92 (Feb. 2010); *IO Coal Co., Inc.*, 31 FMSHRC 1346, 1352 (Dec. 2009); *Windsor Coal Co.*, 21 FMSHRC 997, 1001-04 (Sept. 1999). Even imperfect evidence of duration should be taken into account by the judge. *Coal River*, 32 FMSHRC at 93.

The violation at issue here is the Respondent's act of reusing the 1½-inch valve after it was struck by the shuttle car. This violation began when the 1½-inch valve was placed into service in unsafe condition. Eyewitness B.J. Davis testified that less than five minutes elapsed before the valve blew apart again, causing the water manifold to fly off of the water line and fatally strike Saunders. Tr. 515-16. Similarly, Addington estimated that five to ten minutes had elapsed. Ex. S-12. Thus, the violation lasted only a few minutes, but long enough to cause a fatal accident.

(b) Extensiveness of Violation

The purpose of analyzing the extent of a violation is to give consideration to the scope or magnitude of the violation. *E. Assoc'd Coal Corp.*, 32 FMSHRC at 1195. Sometimes extensiveness can be assessed in terms of quantity or with regard to the physical dimensions of the area affected. *Dawes Rigging & Crane Rental*, 36 FMSHRC \_\_, slip op. at 6, No. LAKE 2011-206-M (Dec. 10, 2014) (noting that extensiveness "has traditionally been determined by examining the extent of the affected area as it existed at the time the citation was issued"); *see, e.g., Twentymile Coal Co.*, 36 FMSHRC 1533, 1539 (June 2014) (noting "geographic extent" of coal accumulations supports unwarrantable failure finding); *IO Coal*, 31 FMSHRC at 1352 (instructing ALJ to consider number and distribution of unsupported kettle bottoms in assessing extent of violation); *Jim Walter Res., Inc.*, 19 FMSHRC 480, 485 (Mar. 1997) (noting judge's finding of 200 defective rollers bears on extent of belt maintenance violations); *id.* at 486-88 (analyzing extent of accumulations in terms of their depth, length, and width); *Peabody Coal Co.*, 14 FMSHRC 1258, 1259, 1261 (Aug. 1992) (describing physical dimensions of five "large" accumulations and finding them extensive). Other factors that may be relevant to extensiveness include the number of persons affected by the violation and the measures required to abate it. *See, e.g., Dawes Rigging*, slip op. at 6 (finding violation was not extensive because it endangered only one person); *E. Assoc'd Coal Corp.*, 32 FMSHRC at 1196 (instructing ALJ to consider extensiveness of abatement measures needed to terminate the citation); *Watkins Eng'rs & Constructors*, 24 FMSHRC 669, 681 (July 2002) (upholding extensiveness finding based on extent of employees' exposure to the hazard); *Jim Walter Res.*, 19 FMSHRC at 486 (finding that accumulation was extensive when it took 11 man-hours to clean it up).

The Commission has stated that the extensiveness inquiry "ultimately is a fact question concerning the material increase in the degree of risk to miners posed by the violation," and should account for the broad scope of the circumstances surrounding the violation. *E. Assoc'd Coal Corp.*, 32 FMSHRC at 1196. For example, in one recent case, the Commission relied on numerous factors to conclude that the coal accumulations in question were extensive, including

the depth and dryness of the accumulations, the number of men and hours required to clean them up, the number of entries affected, and a miner's testimony that the spillage was more extensive than normal. *McCoy Elkhorn Coal Company*, 36 FMSHRC 1987, 1993-94 (Aug. 2014).

In this case, the violation involved just one valve. However, the unsafe condition of the valve endangered numerous people. At least nine miners were located at the intersection of the #5 entry and the #61 crosscut in the vicinity of the valve while it was in unsafe condition. *See* Tr. 525; Ex. S-13; Exs. R-8 & S-22 at 7. The valve's failure allowed the water manifold it was supposed to be anchoring to fly a total distance of 23 feet 4 inches out into the intersection, striking two miners and the mine roof in the process. Ex. S-2 at 10, 14; Ex. R-9 at 5, 8. Thus, the violative condition was extensive in that it endangered all of the miners in the intersection.

The violative condition was also extensive in that it involved an extensive degree of damage to the 1½-inch valve. The valve had been struck by a massive piece of machinery and torn into two pieces at a threaded, sealed connection where it was never ordinarily taken apart.

To terminate the citation, the valve was immediately removed from service. This was not an extensive abatement effort, but the Respondent subsequently undertook more extensive efforts (some partly in response to other enforcement actions not at issue here) to eliminate the underlying conditions that led to the violation. State and MSHA investigators had discovered the mine had a history of water line components being struck during equipment moves because the 6-inch water line was positioned too close to the haulage track. Tr. 184-89; Ex. S-1 at 13; Exs. R-8 & S-22 at 7. Of the many witnesses with work experience at the Buchanan Mine, all but one indicated they had previously participated in equipment moves where a fire valve assembly was struck, or were aware of this occurring, or had disassembled valves during equipment moves to avoid hitting them. Tr. 102, 432-33, 466-67, 530, 547-49, 570-72, 624, 632-33. However, the mine did not have instructions or a policy in place specifically addressing what to do when water line components were struck and damaged or instructing miners not to reuse damaged components. *See* Tr. 441-45, 466-67. After the accident, the Respondent rerouted the entire water line to move it farther away from the perils of the haulage track and implemented new policies for safely repairing damaged water line components. Exs. S-16, R-1. Thus, extensive efforts were required to abate the underlying problems at the mine that had permitted the occurrence of the violation.

### (c) Operator's Notice that Greater Compliance Efforts Were Necessary

An operator's history of prior similar violations or other forms of specific warnings may be relevant to the unwarrantable failure analysis. The prior violations and warnings are relevant to the extent they engendered in the operator a heightened awareness of a safety problem requiring corrective action, and to the extent they placed the operator on notice that greater efforts were necessary for compliance with the standard that was violated. *See Dawes Rigging*, slip op. at 7; *San Juan Coal Co.*, 29 FMSHRC 125, 131 (Mar. 2007) (citing *Mid-Continent Res., Inc.*, 16 FMSHRC 1226, 1232 (June 1994)); *IO Coal*, 31 FMSHRC at 1353; *Consolidation Coal Co.*, 23 FMSHRC 588, 595 (June 2001); *Amax Coal Co.*, 19 FMSHRC 846, 851 (May 1997).

Recently, the Commission has clarified that a significant difference exists between the forms of notice that inform an operator of the Secretary's interpretation of a safety standard (i.e., the forms of notice that are considered in determining whether the operator may properly be charged with a violation) and the forms of notice that inform an operator that greater efforts at compliance are needed for purposes of an unwarrantable failure analysis. *Dawes Rigging*, slip op. at 7 n.5. Constructive notice suffices in the former context. By contrast, in determining whether an operator is on notice that greater efforts at compliance are needed, the judge must look to the operator's history of violations, discussions with inspectors, and other forms of specific warnings from MSHA to determine if the operator has been placed on notice of a persistent unsafe condition or practice at its mine. *Id.* (citing *Consolidation Coal Co.*, 23 FMSHRC at 595; *Lion Mining Co.*, 18 FMSHRC 695, 700 (May 1996); and *Peabody Coal Co.*, 14 FMSHRC 1258, 1262 (Aug. 1992)); *but see Windsor Coal Co.*, 21 FMSHRC 997, 1004 (Sept. 1999) (directing ALJ to consider all relevant record evidence not limited to specific warnings from MSHA, including shift book reports, to determine whether operator was on notice of recurring safety problem in need of correction); *Jim Walter Res., Inc.*, 19 FMSHRC 480, 485 (Mar. 1997) (noting management's prior receipt of complaints about recurring problem bears on notice).

As discussed above, it was common knowledge at the Buchanan Mine and mine management was aware that components of the 6-inch water line alongside the haulage track were at risk of being struck and damaged during equipment moves. *See, e.g.*, Tr. 432-33 (safety supervisor's testimony showing he had previously discussed such incidents with miners); 571 (shift foreman's testimony stating fire valves would be struck once every eight or ten moves and it was "always something you were aware of"). In fact, the shuttle car that Green, Saunders, and Addington were transporting on January 11, 2012 had struck a fire valve assembly earlier that very day as it was being moved through the mine during the previous shift. Tr. 176-78, 255; Exs. R-8 & S-22 at 3.

The Secretary argues that a 2008 injury at the mine had placed mine management on notice that working on water manifolds was hazardous. Sec'y's Br. at 21. A manifold had been propelled into a miner's face by pressurized water in 2008, giving the miner a broken nose and lacerations that required sutures. Ex. S-21. The Secretary contends that because mine management was aware of this accident and was also aware that fire valves were frequently struck during equipment moves, it was on notice of a hazard that needed to be addressed. Sec'y's Br. at 21. I agree that the evidence shows mine management was aware of a recurring problem bearing on the safety of equipment at its mine.

However, MSHA was not aware of this problem. MSHA did not issue any violations or warnings to the Respondent or engage in any discussions with mine management that would have placed the Respondent on notice that greater efforts were required to comply with 30 C.F.R. § 75.1725(a) in terms of ensuring water line components were being maintained in safe operating condition. Mine management's awareness of the general problem with water line components being struck does not constitute specific notice that the Respondent was required to take greater efforts in order to comply with § 75.1725(a). *Cf. E. Assoc'd Coal Corp.*, 32 FMSHRC at 1199 (rejecting Secretary's argument that operator's experience maintaining roof put it on notice that greater efforts at compliance with roof safety standard were necessary).

#### (d) Obviousness of Violation

The obvious nature of a violation can constitute a factor supporting an unwarrantable failure finding. *E.g., Wolf Run Mining Co.*, 35 FMSHRC 3512, 3521 (Dec. 2013); *Jim Walter Res., Inc.*, 19 FMSHRC 1761, 1770 (Nov. 1997).

This violation was very obvious. The internal threaded connection between the 1½-inch valve's two pieces had multiple, very fine threads. Tr. 96, 144-47, 395, 563. Any person familiar with valves or threaded connections of any sort would know that the valve required multiple turns and proper alignment to put back together. Here, the testimony was that the threads were not carefully checked for damage and Saunders reattached the two pieces of the valve forcibly with a wrench. Tr. 514, 527-28, 641, 652-54. This should have been an indication that the connection was not properly resealed. MSHA's witnesses testified it would be "intuitive to believe" (Tr. 331) the valve's internal threaded connection sustained damage when it was forcibly pulled apart by the shuttle car without being unthreaded. Tr. 68-71, 178-80, 279-81, 331-33, 398-99. I agree. Any person familiar with such a valve would readily understand that if it is shorn apart by blunt force, the threads would be damaged. Whether the damage was visible or not, it would be evident to any reasonable person familiar with the mining industry that this valve was damaged beyond use.

Moreover, even if it had not been obvious that the 1½-inch valve's internal threaded connection was damaged, the valve itself plainly was in no condition to be safely placed back in service after being torn apart by the shuttle car. The valve manufacturer's Installation, Operation, and Maintenance Manual (Exs. S-14 and R-5), which is freely available online, (Tr. 380), states: "Repair or replacement of two piece ball valves internal parts is not recommended. Damage can occur to the body and tailpiece during disassembly that would make the valve inoperable." Consol's supplier testified that the manufacturer will not sell individual parts for these valves and he has never heard of anyone disassembling or attempting to repair them. Tr. 538-40. The valve was commonly regarded by miners as a single unit and most witnesses said they were unaware before the accident that it could come apart. *See* Tr. 92-93, 115, 277-78, 458-59, 533, 539, 547, 585, 633. However, after being struck by the shuttle car, it had broken into two pieces. Tr. 641. The Loctite that ordinarily seals the seam between the body and tailpiece, creating the impression that the valve is one piece, would have been noticeably disrupted and the seal destroyed. The inner chrome ball plug and the very guts of the valve would have been exposed. It would have been very obvious that the valve was no longer in safe operating condition and should not have been placed back in service.

#### (e) Degree of Danger Posed by Violation

The Commission has relied upon the high degree of danger posed by a violation to support an unwarrantable failure finding. *Wolf Run Mining Co.*, 35 FMSHRC 3512, 3522 (Dec. 2013); *Coal River Mining*, 32 FMSHRC at 94; *IO Coal*, 31 FMSHRC at 1355; *see, e.g., Midwest Material Co.*, 19 FMSHRC 30, 34-35 (Jan. 1997); *BethEnergy Mines, Inc.*, 14 FMSHRC 1232, 1243-44 (Aug. 1992); *Warren Steen Constr., Inc.*, 14 FMSHRC 1125, 1129 (July 1992); *Quinland Coals, Inc.*, 10 FMSHRC 705, 709 (June 1988).



The violation at issue here was highly dangerous. While this violation was occurring, water was discharging from the breached location on the water line in a constant stream, even though the miners had tried to turn the water off before making repairs to the breached manifold. Tr. 526-27, 621-23, 643, 650-52. The miners had not tried to bleed off residual water before performing the repairs and had not checked to make sure the shutoff valves were closed all the way. Tr. 647, 652. In fact, the 6-inch shutoff valve at crosscut #62 was not completely closed. This allowed water to flow into the damaged 1½-inch valve while it was in unsafe condition. In light of the unsafe condition of the valve, the proximity of the miners who were making repairs to the manifold, the known high water pressure<sup>6</sup> at the mine (see Tr. 276-77, 459-61, 488-89, 504-05), and the fact that water continued to flow into the valve and the partly disassembled manifold, it should have been obvious that the violative condition posed a very high degree of danger, a danger that was unfortunately realized when the 1½-inch valve failed a second time while the victim was working directly in front of it.

(f) Operator's Knowledge of Existence of Violation

An operator's actual or constructive knowledge of the existence of a violation is relevant to the unwarrantable failure analysis. Constructive knowledge may be established where the operator reasonably should have known of the violative conduct. *Coal River Mining, LLC*, 32 FMSHRC 82, 90-92 (Feb. 2010) (finding that knowledge may be established where operator's awareness of predicate circumstances meant it reasonably should have known of violation); see also *E. Assoc'd Coal Corp.*, 32 FMSHRC at 1199; *IO Coal*, 31 FMSHRC at 1357; *San Juan Coal Co.*, 29 FMSHRC at 133-34; *Drummond Co., Inc.*, 13 FMSHRC 1362, 1367-68 (Sept. 1991); *Emery Mining Corp.*, 9 FMSHRC 1997, 2002-04 (Dec. 1987).

As discussed above, this violation was very obvious. Addington, a foreman and agent of the operator, was present at the scene of the violation. Addington should have recognized the obvious violation that was occurring in front of him.

The Respondent contends Addington did not observe any damage to the 1½-inch valve and was unaware it had separated in two because Green and Saunders had already put the manifold back on the fire tee when Addington returned to the scene of the accident after calling a supervisor. Resp.'s Br. at 16. However, Addington reasonably should have known of the violation in his capacity as the miners' supervisor, even though he did not participate in the attempt to put the manifold back together. He knew that an oversized piece of equipment had just struck and breached this component of the water line, necessitating repairs. As the person with supervisory authority, he should have assessed the condition of the water line components that had been struck by the shuttle car and supervised the efforts to repair them. At the very least he should have inspected the valve and ensured the water was cut off. If he had done so, he would have realized that Green and Saunders were reusing a valve that had been torn apart by blunt force. Instead, however, Addington apparently spent several minutes drying off in a

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<sup>6</sup> Although I agree with Inspector Hess's suggestion that the valve could have failed at a lower pressure (Tr. 277), I reject the Respondent's argument that the high water pressure at the mine was a "non-issue" (Resp.'s Br. at 18). The valve's 600 psi pressure rating and safety factor of 2.5 became irrelevant once the valve was damaged. Under the particular circumstances of this case, the mine's high water pressure contributed to the dangerousness of the situation.

nearby crosscut before returning to stand some distance behind Green and Saunders as they were working without providing any instructions or supervision. *See* Tr. 528-34, 610-16, 622, 642, 657. As the supervisor at the scene, Addington was also the point of contact with shift foreman Semones. Addington should have heeded Semones' order to continue moving through the mine and let another crew come to check and repair the valve. In short, Addington was in a position to know of the violative condition and of the need to address it. Addington's knowledge is imputed to the Respondent.

(g) Operator's Efforts in Abating Violative Condition

An operator's prior efforts to abate a violative condition are relevant to the unwarrantable failure analysis, as is the level of priority the operator places on abating conditions for which it has received notice that greater compliance efforts are required. *See IO Coal*, 31 FMSHRC at 1356. However, abatement efforts undertaken after the issuance of the citation are not relevant. *Id.* ("The focus on the operator's abatement efforts is on those made prior to the citation or order.") (citing *New Warwick Mining Co.*, 18 FMSHRC 1568, 1574 (Sept. 1996)); *Enlow Fork Mining Co.*, 19 FMSHRC 5, 17 (Jan. 1997); *cf. Consolidation Coal Co.*, 22 FMSHRC 328, 332 (Mar. 2000) (finding that intention to abate in future is irrelevant).

Despite the obviousness and dangerousness of this violation and the presence of a foreman, the Respondent did not remove the 1½-inch valve from service or otherwise abate the violative condition. There is no indication the Respondent would have abated the violation if a fatal accident had not occurred. The mine had no standard method for handling a situation when a component of the water line was struck during an equipment move, *see, e.g.*, Tr. 433, 441-45, 466-67, even though members of mine management such as the mine's safety director and training coordinator were aware that this was a problem, *see* Tr. 432-33, 463. Thus, although shift foreman Semones had directed a different crew to come repair the water line instead of Addington's move crew, Tr. 576-77, there is no indication the different crew would have replaced the defective valve either. Addington also testified that if he had heard Semones direct a different crew to repair the water manifold, he would have ignored the instruction and allowed Green and Saunders to finish their ill-fated repair attempts. Tr. 616-17.

Additionally, even before the events of January 11, 2012, the Respondent had the knowledge and opportunity to take action that could have prevented the 1½-inch valve from being struck by the shuttle car or ensured that miners were better prepared to make repairs in the event of a collision. As discussed above, mine management was aware that components of the water line along the haulage track were sometimes struck and damaged during equipment moves. Addington even testified that he looked for replacement valves before they started the equipment move but none were on hand. Tr. 624, 627; *see* Ex. S-12. Yet it was not until after a fatality occurred that the Respondent moved the water line away from the haulage track, developed an action plan for equipment moves, and overhauled its training policies for repairing water line components. Thus, despite mine management's awareness that damage resulted from equipment moves, management apparently was not sufficiently prepared to respond to such an occurrence. I consider this a failure to abate the violative condition as well. Although MSHA did not specifically warn or instruct Consol to undertake these efforts beforehand, this does not relieve

Consol of responsibility for taking appropriate measures to address known problems potentially bearing on safety in its mine.

Consol's valve supplier testified that it costs \$42 to replace a 1½-inch valve. Tr. 538. Thus, the cost of replacing this throwaway valve would have been low. The cost of implementing a policy of replacing instead of reusing torn up parts would also have been low, while the probability of injury and the seriousness of the injury that actually resulted from the failure to implement such a policy or replace the valve were very high. In this context, the Respondent's failure to abate the violative condition was egregious.

#### (h) Involvement of a Supervisor

Because supervisors are held to a higher standard of care and entrusted with heightened safety responsibilities, the Commission takes into account the extent of supervisors' involvement in the violation in determining whether the operator's conduct was unwarrantable. *See Coal River Mining*, 32 FMSHRC at 90-92 (remanding for ALJ to consider supervisors' involvement in assessing whether operator had knowledge of violation); *Lopke Quarries, Inc.*, 23 FMSHRC 705, 711 (July 2001); *REB Enters., Inc.*, 20 FMSHRC 203, 225 (Mar. 1998). Their violative conduct can be imputed to the operator. *Capital Cement*, 21 FMSHRC 883, 892-93 (Aug. 1999).

The Secretary argues that foreman Addington's involvement in the violation is a significant aggravating factor in this case. Sec'y's Br. at 13-19. The Respondent has sought to minimize Addington's involvement in the accident.

At the time of the accident, Addington had 35 years of underground coal mining experience and had typically served as a section foreman in the past, but for the past six months to a year he had regularly worked as an outby foreman as well. Tr. 603-06. He had never worked an equipment move before. Tr. 607. Semones testified that he assigned Addington to the equipment move because Addington was an "extra" foreman that night and he wanted him to gain experience by observing Green and Saunders, who had performed equipment moves before. Tr. 567-68, 597. Addington testified his understanding was that he was to serve as "an extra person to help watch." Tr. 607.

Despite these suggestions that Addington was not acting as a supervisor, the evidence unequivocally shows he was a foreman and was in charge of the move crew on the evening of the accident. Semones acknowledged that he expected Addington to act as a foreman. Tr. 597-99. The rank-and-file miners who testified at the hearing referred to Addington as the "boss" and agreed he was in charge. Tr. 525, 534, 650, 654, 658, 661. Saunders and Green may have had more experience than Addington at equipment moves, but assigning experienced miners to a task does not relieve the operator of the responsibility of providing adequate supervision. To the extent the Respondent is arguing it should be relieved of liability because Addington did not have the requisite experience and training to fulfill his duties as a foreman, I reject this argument. If Addington's ability to fulfill his duties was a concern, the Respondent should have assigned a different foreman or ensured that Addington received the appropriate training before he was put in charge of a move crew. Otherwise, an operator could always limit its liability by assigning foremen to tasks with which they are not familiar or for which they are not fully trained. In

addition, if Addington was unsure what to do when the shuttle car struck the water line, this should have spurred him to stop his men from doing anything until after he had called Semones and received instructions on how to handle the situation properly.

Testimony was elicited suggesting Green and Saunders were top notch employees who took it upon themselves to fix the manifold without Addington's instructions or involvement. *E.g.*, Tr. 434, 514, 544-45, 578. This does not relieve Addington of his supervisory duties. Similarly, apparently in an attempt to explain why a foreman might not seem to be in charge during an emergency or when a problem arises, Semones testified "our people are empowered at the mines." Tr. 595-96. But this is not an excuse for a foreman's inaction in the face of an emergency or problem. An operator should not permit an atmosphere where it is left to rank-and-file miners to determine what to do in a hazardous or unusual situation.

The Respondent argues in its closing brief that Addington was unaware of the danger posed by this violation because he did not know the 1½-inch valve had broken apart. Resp.'s Br. at 16. However, as discussed above, this violation was very obvious and Addington should have been aware of what was going on under his watch. He knew the shuttle car had struck and sheared off a component of the water line and he observed water continuing to discharge from the breached manifold even after the miners had tried to isolate the line. He certainly should have investigated these extraordinary circumstances. Instead, he simply stood by. The Respondent adduced testimony that Green and Saunders did not detect any damage to the threads of the 1½-inch valve and tightened it down with a wrench, Tr. 512-14, 527-28, 641, 651-54, but the Secretary contends that this is irrelevant because Addington should have been supervising them and should have known better than to re-thread the valve. Sec'y's Br. at 19. I agree. As a foreman entrusted with responsibility for the safety of his men, he should have known that when a valve, particularly one that is commonly regarded as a single unit, is torn in two by blunt force, the threads must be damaged and a new valve should be installed. In fact, he apparently did have some inkling that valves struck during equipment moves should be replaced because he looked for replacement valves before he went underground. Tr. 624, 627; Ex. S-12. But Addington's inaction prevented him from learning the 1½-inch valve had broken apart and instructing his men to replace it.

In sum, I find that Addington's conduct demonstrated an inattention to safety that supports a finding of unwarrantable failure in connection with this violation.

(i) Analysis and Weighing of Unwarrantable Failure Factors

I find that the obviousness of this violation and the high degree of danger it posed are significant aggravating factors in this case. *See Manalapan Mining Co.*, 35 FMSHRC 289, 294 (Feb. 2013) (stating that dangerousness, alone, can be enough to justify an unwarrantable failure finding); *Windsor Coal Co.*, 21 FMSHRC 997, 1006 (Sept. 1999) (noting that Commission has relied upon obviousness and dangerousness to support an unwarrantable failure finding). In addition, the involvement of a foreman is a significant aggravating factor. Addington was in plain sight of the violation and should have known it was occurring. As the Respondent's agent, Addington was in a position to step forward and take action to avert the accident that resulted

from the violation. Yet he failed to do so, despite the obviousness of the violation and the clear dangerousness of the situation.

The Respondent argues that the fact that MSHA did not provide notice that greater efforts at compliance were necessary is a significant mitigating circumstance in this case. Resp.'s Br. at 17. However, I find that lack of notice by MSHA is not a significant mitigating factor in light of mine management's general awareness of an ongoing problem with striking and damaging water line components, and in light of the obviousness and dangerousness of the violation, which should have signaled to mine management that the situation that arose on January 11, 2012 required special care. *See Mach Mining, LLC*, 35 FMSHRC 2937 (Sept. 2013) (finding lack of notice by MSHA not a mitigating factor where even without such notice, reasonably prudent person would have recognized frustration of purpose of cited regulation in light of obviousness and extent of violative condition). Lack of notice by MSHA need not be the deciding factor in an unwarrantable failure determination. *See San Juan Coal Co.*, 29 FMSHRC 125, 129 (Mar. 2007) (remanding with reminder to consider all relevant factors when ALJ relied almost exclusively on notice factor to conclude unwarrantable failure was not present). I find that the notice factor is less relevant to this case than the Respondent's failure to take any action to abate the violation or avoid the injury that resulted despite the obviousness, dangerousness, and involvement of a supervisor.

Although this violation involved just one valve, the violation was extensive in the sense that it placed nine miners in danger and involved extensive damage to the valve. Although the violation lasted for only a few minutes, a violation that exists for a relatively short period of time can properly be deemed an unwarrantable failure when other factors so warrant. *Coal River Mining, LLC*, 32 FMSHRC 82, 93 (Feb. 2010); *see, e.g., Midwest Material Co.*, 19 FMSHRC 30, 34-36 (Jan. 1997) (upholding unwarrantable failure finding when violative condition lasted only a few minutes but posed a high degree of danger, involved a foreman, and may have continued but for occurrence of accident); *LaFarge Constr. Materials*, 20 FMSHRC 1140, 1145-48 (Oct. 1998) (same). I find that the aggravating factors discussed above – particularly obviousness, dangerousness, and involvement of a supervisor – justify a finding of unwarrantable failure in this case and I uphold the Secretary's unwarrantable failure designation.

For all the reasons discussed above, I find that the Respondent displayed an aggravated lack of care that constituted more than ordinary negligence in connection with this violation. Accordingly, I uphold the Secretary's finding of high negligence. *See DQ Fire & Explosion Consultants, Inc.*, 36 FMSHRC \_\_, slip op. at 5-6, Nos. WEVA 2011-952-R & WEVA 2011-2480 (Dec. 19, 2014) (stating that high negligence "suggests an aggravated lack of care that is more than ordinary negligence").

## B. Order No. 8190903

### 1. *The Violation*

Order No. 8190903 alleges a violation of 30 C.F.R. § 75.1100-3, which mandates: "All firefighting equipment shall be maintained in a usable and operative condition." Specifically, the

order alleges that the 6-inch shutoff valve<sup>7</sup> at the #62 crosscut was not maintained in usable and operative condition in that (1) dirt and grime had built up on the outside of the valve and obstructed the path of the handle, and (2) there was no leverage bar nearby that could be used to turn the handle. Exs. S-17, R-2. The Secretary argues that the 6-inch valve could not effectively shut off the water supply due to those two contributing factors. Sec'y's Br. at 25.

The Respondent argues that Order No. 8190903 should be vacated because MSHA did not provide reasonable notice that it considered lack of leverage bars to constitute a violation of the cited safety regulation. The Respondent contends that the sole reason Inspector Hess issued Order No. 8190903 was because of the mine's failure to keep the manufacturer-issued leverage bar attached to the 6-inch valve, but the sole reason the valve did not close all the way was the accumulation of material around the handle stop that allowed a 3-millimeter opening where water could pass through. Resp.'s Br. at 13. The Respondent further contends that MSHA was well aware that leverage bars have always been removed from shutoff valves in the mine for safety reasons, but has never previously had a problem with this practice. *Id.* at 11-13. Therefore, the Respondent argues it did not have fair notice that MSHA interpreted the broad safety regulation at 30 C.F.R. § 75.1100-3 to prohibit the practice. *Id.* The Respondent further asserts that a safeguard requires all mobile equipment at the mine to be provided with a jack and jack bar that could be used to close the 6-inch shutoff valves. *Id.* at 12.

The Respondent's argument ignores the fact that Order No. 8190903 does not charge a violation solely because the Respondent failed to keep the manufacturer's leverage bar on hand. Rather, the order charges that the valve was inoperable in that it could not be closed all the way due to both the missing leverage bar and the Respondent's failure to maintain the valve in clean condition.

The Respondent has essentially conceded a violation of 30 C.F.R. § 75.1100-3 by conceding that the 6-inch valve could not effectively perform its intended function of shutting off the water supply. The valve could not be closed completely. Before the fatal accident, Saunders attempted to close the valve in order to isolate a section of water line so the manifold could be repaired, but water continued discharging. Tr. 526-27, 621-23, 652. After the fatal accident, investigators discovered that the cited 6-inch valve was partially open and was the source of the discharging water. Ex. S-2 at 7, 13; Tr. 63-65, 78, 147-48. The flow lessened somewhat after Inspector Hlywa asked the miners to try to shut the valve all the way off, but water continued to ooze out and the flow was not completely blocked until the valve was replaced. Tr. 48, 51, 75-76, 134-38, 149-50, 589; Ex. S-2 at 20. Michael Hockenberry, MSHA's fire protection engineer, later determined that the 6-inch valve could not be closed all the way even when 50 foot-pounds of force were applied with a torque wrench; the handle was arrested 3 millimeters from the stop by the built up material in front of the stop. Tr. 349-53; Ex. S-18. Thus, as conceded by the Respondent, the shutoff valve was inoperable in that it could not be closed all the way.

The Respondent argues it did not have fair notice of the Secretary's interpretation of § 75.1100-3 in that it was not on notice that MSHA considered removal of the manufacturer's

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<sup>7</sup> The valve is a necessary component of the mine's water delivery system and is identified on the mine's fire protection map. Thus, it constitutes firefighting equipment within the meaning of 30 C.F.R. § 75.1100-3. See Tr. 363-64; Ex. R-10.

leverage bars to be a violation. The Respondent's customary practice at its mine was to detach the bars from the valves because they stuck out and could be struck by passing equipment. Tr. 89, 197, 421-22, 581-82. Also, the bars did not always provide sufficient leverage to open and close the valves due to the high water pressure at the mine. Tr. 195, 223, 428-29, 435-36. MSHA had not previously issued any citations or other warnings to the mine regarding its practice of detaching the leverage bars.

Notwithstanding the Respondent's lack of explicit notice from MSHA with respect to the leverage bars, a reasonably prudent miner would have recognized under the circumstances that a violation was occurring when the 6-inch shutoff valve failed to perform its intended function of shutting off the water. The miners assumed the water flowing out of the breached pipe was residual water draining from the isolated section of the water line, Tr. 623, 640, 652, but this was not a reasonably prudent assumption. First of all, a reasonably prudent miner would have allowed the residual water to bleed off before attempting repairs to the water manifold. Moreover, a reasonably prudent miner would have recognized the water was a problem because the flow was consistent and did not decrease in volume.

At the hearing, counsel for the Respondent questioned whether MSHA had performed any calculations to determine how long it would have taken for residual water to drain from the isolated section. Tr. 229-38. But by the testimony of Consol's own witness, water was still coming out of the breach point approximately 90 minutes after the accident. Tr. 589. No calculations are needed to establish this was more than residual drainage. A foreman, Addington, was within plain sight of the manifold while repairs were underway and admittedly noticed that water was discharging at a consistent rate, but took no action to address this obvious problem. Tr. 623. A reasonably prudent supervisor would have checked the shutoff valves or at least instructed the miners to cease repair efforts until the water bled off, which would have led to the realization that the shutoff valve was not in operable condition. Under the circumstances, explicit notice of the Secretary's interpretation of § 75.1100-3 was not necessary. *See LaFarge North America*, 35 FMSHRC 3497, 3500-01 (Dec. 2013); *Ideal Cement Co.*, 12 FMSHRC 2409, 2415-16 (Nov. 1990); *Alabama By-Products Corp.*, 4 FMSHRC 2128, 2129 (Dec. 1982).

As for the Respondent's argument that a safeguard at the mine requires all mobile equipment to contain a jack and jack bar, the Respondent has not provided a copy of the referenced safeguard. Inspector Hess testified that if such a safeguard exists, it may be satisfied without providing a jack and jack bar on some equipment. Tr. 295-96. More importantly, there is no evidence a jack bar was available at the scene of the accident. *See* Tr. 148, 421. I reject the Respondent's suggestion that a safeguard requiring jack bars somehow mitigates or refutes the fact of the violation. I find that this violation occurred.

## 2. Gravity and S&S Designation

Inspector Hess characterized this as an S&S violation. In assessing gravity, he noted that one fatal injury had occurred. Exs. S-17, R-2. The Respondent disputes the S&S finding, arguing that the violation was not S&S because the lack of a leverage bar played no role in the fatality. Resp.'s Br. at 15. In support of this argument, the Respondent asserts that it took only 50 foot-pounds of torque to close the 6-inch shutoff valve to the position where the handle would have been stopped by the material buildup, and therefore a leverage bar would not have

prevented the accident from occurring because the sole reason the valve would not close was the built-up material on it. *Id.*

First, I reject the Respondent's argument that the lack of a leverage bar played no role in this accident. Although it took only 50 torque-pounds for Hockenberry to squeeze through the built-up material in the path of the handle in order to close the valve as far as it could go, the evidence shows the valve was not closed that far at the time the accident occurred, whereas a leverage bar obviously would have helped move the valve handle closer to that position. Several facts support this conclusion. Before the accident, the water discharging from the valve was described not as a trickle but as a constant flow that was large enough to disrupt the miners' efforts to repair the manifold and to build up rapidly under the damaged 1½-inch valve, causing it to blow apart in just a few minutes. *See* Tr. 58-61; Ex. S-2 at 9-10; Exs. R-8 & S-22 at 5-6. Afterward, when the 6-inch valve had been closed as far as possible (i.e., to 3 millimeters), the flow of water was reduced and was described as an ooze. Tr. 76, 134, 589. The defective 6-inch shutoff valve must have been open substantially more than 3 millimeters before the accident based on these differing amounts of bypassing water. A leverage bar would have helped the miners close this substantial gap, reducing the amount of pressurized water escaping and thereby reducing the hazard, even though the valve still would not be completely closed. Yet the evidence does not show that a leverage bar was available to push through the built up material before the accident. Green did testify that Saunders used a bar to attempt to close the valve at crosscut #62. Tr. 639-40, 646-47. However, Inspector Hess testified that during the witness interviews he had conducted to prepare MSHA's accident report, Green had said Saunders closed the valve with his hand as best he could then tapped the handle a few times with a hammer. Tr. 261. Hess had included this finding in the accident report prepared before the hearing. Ex. S-1 at 4. Having observed the witnesses' demeanors, I find that Hess is a more credible witness than Green, whose inconsistent subsequent account is not corroborated by any other evidence that a bar was available near the shutoff valves the night of the accident. The Respondent's failure to provide a leverage bar contributed to the miners' inability to close the valve and therefore contributed to the fatality.

Turning to the S&S inquiry, I uphold the Secretary's S&S finding for this violation. The Respondent violated a mandatory safety standard, satisfying the first *Mathies* element. The violation was the Respondent's failure to maintain the 6-inch valve in usable and operative condition in that the valve was incapable of being fully closed. This contributed to the hazard that water would bypass the valve when it was supposed to be closed, satisfying the second *Mathies* element.

The hazard that water would bypass the valve was reasonably likely to result in an event that would cause an injury, considering the particular facts surrounding this violation. The water pressure at the mine was unusually high. Tr. 276-77, 460, 488, 504-05; *see* Ex. S-5. The miners tried to close the 6-inch valve to prevent the mine's highly pressurized water from flowing into the area where they were working on the damaged manifold at crosscut #61. Nine miners were in the vicinity of the damaged manifold. Ex. S-13; Exs. R-8 & S-22 at 7; Tr. 525. The manifold was partly disassembled and not all of its components were anchored securely to the water line. Under these circumstances, it was reasonably likely that allowing pressurized water to bypass the 6-inch shutoff valve and flow toward the damaged manifold would cause a piece or pieces of the



manifold to be blown apart by the pressurized water, injuring a nearby miner. Thus, the third *Mathies* element is satisfied.

There was also a reasonable likelihood that any injury caused by the violation would be of a reasonably serious nature. The water pressure at the mine was high enough to propel heavy pipe fittings through the air with sufficient force to cause serious injuries to anyone within striking distance, as evidenced by the fact that the manifold fatally struck Saunders and was propelled more than twenty feet across the #5 entry even after bouncing off of another miner and the mine roof. Ex. S-2 at 10, 14; Ex. R-9 at 5, 8. Therefore, I find that the fourth *Mathies* element is satisfied. Because the four *Mathies* elements are met, I uphold the Secretary's S&S designation for this violation.

Because the 6-inch shutoff valve was incapable of being fully closed, pressurized water bypassed the valve and accumulated in an area that should have been dry and isolated during repair work. After a few minutes, the built up water blew the top of the 1½-inch valve off of its tailpiece, resulting in a fatal injury. In view of this violation's direct contribution to a fatality, I find that its gravity was extremely serious.

### 3. *Negligence and Unwarrantable Failure*

Inspector Hess characterized this violation as resulting from the operator's high negligence and issued the order under section 104(d)(1) of the Mine Act, stating in the narrative portion of the order that the violation resulted from unwarrantable failure to comply with a mandatory safety standard:

The operator and its agent displayed aggravated conduct constituting more than ordinary negligence through two failures which resulted in the occurrence of this accident. First the operator failed to ensure that the 6-inch ball valve in use at this mine was provided with the necessary leverage handle to be used when closing and opening the valve. These valves are provided with these leverage handles when purchased from the manufacturer to provide the necessary leverage when opening and closing the valve. It is the responsibility of the consumer to maintain them for use. The second display of aggravated conduct was on the part of the foreman assigned to supervise the miners making the repairs. The negligence [sic] on the part of this foreman was his failure to provide adequate supervision of the miners making the repairs. This foreman was aware that it was a common practice for the fire valve assemblies in this mine to be struck and damaged during the movement of oversized loads. This foreman was also aware of the extremely high water pressures at this mine. These factors should have prompted this foreman to take extra care and provide guidance and instruction to the miners including to ensure that the water line was properly isolated to prevent an inadvertent pressure build up. The foreman was in the immediate area and in plain sight and sound during the repair and took no actions to ensure that the repairs were being conducted properly and safely. This is an unwarrantable failure to comply with a mandatory standard.

Exs. S-17, R-2. At the hearing, Hess reiterated that the 6-inch shutoff valve was not provided with any readily available tool to close it despite the fact that the manufacturer provided a leverage bar for each valve, leaving it up to the miners to figure out what they would use to close the valve and whether it would be sufficient. Tr. 222-27. Although he conceded that MSHA had not cited this condition in the past, he disagreed that MSHA had “allowed” Consol to remove the leverage bars, noting that Consol was the one that had installed the valves and MSHA had not been aware that the leverage bars were insufficient. Tr. 239-42. Hess also emphasized that a foreman had been present and had noticed water discharging continuously even though only a relatively small section of the water line had been isolated, so the foreman should have realized this was not just residual water draining and checked the shutoff valves. Tr. 224, 227.

The Secretary contends Hess’s unwarrantable failure designation should be upheld, particularly arguing that the Respondent’s failure to provide any sort of leverage bar for the 6-inch valve constituted aggravated conduct. The Secretary contends this condition was extensive, existed for years, and posed a high degree of danger in light of the high water pressure at the mine. Sec’y’s Br. at 28-29. The Secretary further asserts that the Respondent knew of the violative condition and was on notice that greater efforts at compliance were necessary, yet took no action to abate the condition. *Id.* at 29-32.

The Respondent argues that the violation did not result from aggravated conduct. The Respondent asserts that Addington, the foreman who was present, played no role in the attempts to shut off the 6-inch valve and there was nothing he could have done to assist the miners closing the valve. Resp.’s Br. at 14. The Respondent also notes that the miners who attempted to close the valve thought that it was fully shut and would not have been able to hear water bypassing the valve because the belts were running. *Id.* Finally, the Respondent argues that MSHA’s failure to take prior enforcement action against the mine for not maintaining the leverage bars on the valve is a major factor weighing against a finding of aggravated conduct. *Id.*

After considering the following factors, I uphold the unwarrantable failure designation.

(a) Duration of Violative Condition

Although definitive evidence of duration is not available, I find that the 6-inch shutoff valve was in violative condition long enough for the condition to have been noted by shift examiners. Grime and coal dust had accumulated on the valve such that the path of the handle was obstructed. This would not have happened in one shift.

As for the Respondent’s failure to provide a leverage bar, the leverage bar would have been detached from the valve when it was brought into the mine. Tr. 89, 197, 421-22, 581-82. Shift foreman Semones testified leverage bars were usually propped against a timber or placed at a sign nearby. Tr. 581-82. Hess, on the other hand, almost never saw leverage bars in the mine and was of the impression that once detached the bars would usually disappear into the dust. Tr. 197, 223-24. I find that the Respondent effectively discarded the leverage bars as soon as they were brought into the mine.

(b) Extensiveness of Violation

This violation was not extensive in that a single valve was inoperable. However, this violation endangered nine miners. All of the miners were at risk who were in the vicinity of the damaged water line components that were blown apart when pressurized water bypassed the 6-inch valve. *See* Ex. S-13; Exs. R-8 & S-22 at 7; Tr. 525.

Additionally, this violation stems from extensive underlying violative conduct on the Respondent's part. Specifically, even though only one valve was at issue here, the Respondent failed to maintain leverage bars for all of the 6-inch valves throughout the mine. Similarly, although the violation could be terminated simply by removing the cited valve from service, the Respondent later took the more extensive step of providing leverage bars for all the 6-inch valves throughout the mine. Tr. 223-24. This extensive abatement step, while laudable, shows that the underlying conduct leading to the violative condition was extensive because it involved many valves.

(c) Operator's Notice that Greater Compliance Efforts Were Necessary

There is no evidence MSHA issued any prior citations or otherwise warned the Respondent that greater compliance efforts were needed in order to maintain shutoff valves in safe condition in the mine. Members of mine management knew that miners sometimes had trouble closing the 6-inch valves, *see, e.g.*, Tr. 428-29, 434-36, and that the manufacturer's leverage bars were customarily detached from the valves due to clearance issues, Tr. 581-82. However, MSHA had not specifically notified the Respondent that these problems took the valves out of compliance with 30 C.F.R. § 75.1100-3.

(d) Obviousness of Violation

This violation was very obvious.

First, the two underlying conditions that caused the violation (accumulation of grime and coal dust on the valve handle's track and failure to maintain a leverage bar nearby) could have been easily recognized during an on-shift examination.

It also should have been obvious that the 6-inch valve was not functioning properly and therefore was not in safe, operable condition on the night of the accident. After the miners had tried to close the valve, they saw that water continued to flow at a consistent rate into the section of the water line that was supposed to be isolated while the manifold was repaired. Tr. 526-27, 621-23, 643, 650-52. The flow of water was especially noticeable because it impeded Green's and Saunders' efforts to reattach the manifold to the 2-inch pipe to the rock dust distribution machine, to the point that they closed the 1½-inch valve at the bottom of the manifold to stem the flow. Tr. 59; Ex. S-2 at 9-10; Ex. R-8 & S-22 at 5-7; Ex. R-9 at 3. A foreman, Addington, was standing in plain view of the repair work after returning from his phone call with Semones and observed pressurized water flowing continuously from the relatively small section of the water line that was supposed to be isolated. Tr. 621-23. The water line had just been struck with a large piece of equipment, an aberrant occurrence necessitating examinations and supervision to

abate. Addington should have been focused on finding the damage and on the lookout for potential hazards in this situation. The escaping water should have alerted the miners, particularly Addington, that something was obviously very wrong.

Additionally, the 6-inch valve was found to be visibly and audibly open when checked after the accident. Ex. S-2 at 7-8, 13; Tr. 63-65, 78, 147-48, 275-76. The Respondent argues that the hiss of the bypassing water may not have been audible while the belt was running. Resp.'s Br. at 14. However, had Addington acted as a foreman should have and investigated the cause of the flowing water, it would have been obvious as soon as he looked at the 6-inch shutoff valve that the handle was not perpendicular to the water line.

#### (e) Degree of Danger Posed by Violation

The Respondent's failure to maintain the 6-inch valve in operable condition posed a high degree of danger under the circumstances. The water pressure at the mine was unusually high. Tr. 276-77, 460, 488, 504-05. The violation allowed highly pressurized water to flow into a section of pipe that was intended to be dry and isolated while repair work was performed. This section of pipe had just been struck by a large piece of equipment with enough force to breach the line, meaning water pressure was flowing into an area of piping that had just sustained severe damage. The two miners making the repairs were working directly in front of the damaged area, and at least seven other miners were gathered in the vicinity. *See* Ex. R-13. The violative condition caused a fatality, further demonstrating the high degree of danger it posed.

#### (f) Operator's Knowledge of Existence of Violation

This violation was very obvious, as discussed above. Numerous miners, including foreman Addington, saw the water continuing to flow out of a section of the water line that was supposed to be isolated. Tr. 621-23. Under these circumstances, the Respondent should have known a shutoff valve was not functioning properly.

The Respondent also had reason to know that leverage bars were not customarily maintained with the 6-inch valves in the mine and that the 6-inch valves were generally coated in grime and coal dust. It was apparently common knowledge in the mine that leverage bars were not maintained with the valves, *see* Tr. 195-97, 223, and the many photographs submitted to the record show that the 6-inch water line was essentially buried in dust. *E.g.*, Photograph R-32; *see also* Tr. 523-24 (miner's testimony that all the valves were dirty because they had been in the mine a long time). As noted above, these underlying conditions that caused the violation were obvious and could have been easily discovered during a pre-shift exam.

#### (g) Operator's Efforts in Abating Violative Condition

Despite the obviousness of this violation, especially the water continuing to flow after the water line was supposed to be isolated; the high degree of danger the violation posed; and the presence of a foreman, the Respondent did not abate this violation and remove the 6-inch shutoff valve from service until after a fatality had occurred.

Additionally, as was the case with the 1½-inch valve, the Respondent had the knowledge and opportunity long before the fatality occurred to undertake measures that could have prevented the violation from occurring or from being as severe. Specifically, the Respondent could have made sure that leverage bars were provided at every 6-inch valve so that miners would be able to close them. As seen in the many photographs submitted to the record, the 6-inch water line at the Buchanan Mine #1 was essentially buried. *See* Tr. 46. One of Consol's foremen referenced the corrosive effects of high acidity and salt in the mine atmosphere, which caused components of the water supply system to rust together, potentially making it more difficult to turn the valve handles once they were in the mine. Tr. 575, 587. In addition, the mine was known to have abnormally high water pressure. Tr. 276-77, 460, 488, 504-05. Mine management was aware that under these conditions, the leverage bars supplied by the valve manufacturer did not always provide sufficient force to open or close these valves. *See* Tr. 195, 428-29, 435-36, 592-93. The mine's safety supervisor, Darrell Johnson, had heard miners mention the manufacturer's leverage bars were not strong enough and were too short to provide adequate leverage, especially after the valves were taken underground and "the dampness and rust and things set in." Tr. 428-29, 435-36. Nonetheless, the Respondent did not make available any tools that could provide sufficient leverage to operate the valves and did not even ensure that the manufacturer's leverage bars were always available. In short, the Respondent made no effort to address a known, widespread problem, even though the solution could have been as simple as training miners to use a specific available tool to operate the valves. It was left to the miners to find a tool to use and judge its efficacy.

#### (h) Involvement of a Supervisor

A foreman, Addington, was present while the 6-inch valve was allowing water to bypass and had every reason to recognize an unsafe condition, yet failed to take action to abate the dangerous condition. He did not provide any instructions to the miners, who shut off the water on their own without his help or direction. He did not remind the miners to wait until the residual water drained from the isolated section, nor did he investigate to make sure the water was completely shut off. He saw water flowing from the manifold, Tr. 621, 623-24, yet still he failed even to ask the miners if they had checked the shutoff valves to confirm they were in the "off" position. Green testified he did not remember doing so. Tr. 647. In short, Addington's behavior did not conform to the high standard of care expected of supervisors.

The Respondent asserts that failure to adequately supervise is not an aggravating factor in connection with this violation because Addington had nothing to do with Green's and Saunders' attempts to turn off the 6-inch shutoff valves. Resp.'s Br. at 14. But the Secretary contends that as a supervisor, Addington should have known to check to be sure that the shutoff valves were completely closed in light of the steady stream of discharging water, the amount of time it continued to flow, the very small area of pipe that should have been isolated, and the fact that the slight change in elevation would not have created what was described as a "fountain" of water flowing from the pipe. Sec'y's Br. at 28. I agree that under these circumstances, Addington displayed a disregard for the safety of his men in failing to investigate the situation. Further, his complete lack of involvement in shutting off the valves does not mitigate his conduct because as the person with supervisory authority, he should have in fact provided supervision.

(i) Weighing the Factors

This violation involved just one valve, but was extensive in that it endangered nine miners and stemmed from extensive underlying negligence in the Respondent's failure to maintain leverage bars for the 6-inch valves throughout the mine despite the knowledge that closing the valves presented problems. The underlying conditions that contributed to the violation, missing leverage bars and failure to maintain the 6-inch valve in clean condition, had lasted for a lengthy indeterminate period before the violation was abated. I find that these are aggravating factors. However, the most important aggravating factors for this violation are the obviousness of this violation, the high degree of danger it posed, the involvement of a supervisor who should have known this obvious violation was occurring, and the Respondent's concomitant failure to take any abatement action before a fatality occurred. I find that these factors support a finding of reckless disregard for safety and higher than average negligence.

The Respondent argues that MSHA's failure to take prior enforcement action against the mine for missing leverage bars is a "major factor" showing this violation did not result from aggravated conduct. Resp.'s Br. at 14. However, I find that lack of notice by MSHA is not a significant mitigating factor in light of mine management's general awareness of the conditions that caused the violation, and in light of the obviousness and dangerousness of the violation, which should have alerted the Respondent that heightened care was needed. *See Mach Mining, LLC*, 35 FMSHRC 2937 (Sept. 2013). As noted above, lack of notice by MSHA need not be the deciding factor in an unwarrantable failure determination. *San Juan Coal Co.*, 29 FMSHRC 125, 129 (Mar. 2007). The Commission has emphasized that while all relevant factors must be considered, a judge may properly accord unequal weight to the factors or determine that some factors are not relevant. *Wolf Run Mining Co.*, 35 FMSHRC 3512, 3520-21 (Dec. 2013); *E. Associated Coal Corp.*, 32 FMSHRC 1189 (Oct. 2010); *IO Coal Co.*, 31 FMSHRC 1346, 1351 (Dec. 2009). In this case, the lack of notice by MSHA that greater compliance efforts were needed is outweighed by the very significant aggravating factors discussed above. For the reasons discussed above, I uphold the Secretary's unwarrantable failure finding.

For all the reasons discussed above, the Respondent displayed an aggravated lack of care that constituted more than ordinary negligence in connection with this violation. Accordingly, I also uphold the Secretary's finding of high negligence.

#### IV. CIVIL PENALTIES

##### A. Legal Principles

Section 110(i) of the Mine Act grants the Commission the authority to assess all civil penalties under the Mine Act. 30 U.S.C. § 820(i). It further directs that the Commission, in determining penalty amounts, shall consider (1) the operator's history of previous violations, (2) the appropriateness of the penalty to the size of the business of the operator charged, (3) whether the operator was negligent, (4) the effect of the penalty on the operator's ability to continue in business, (5) the gravity of the violation, and (6) the demonstrated good faith of the person charged in attempting to achieve rapid compliance after notification of a violation. *Id.*; *Mize Granite Quarries, Inc.*, 34 FMSHC 1760, 1763-64 (Aug. 2012).

A penalty assessment is an exercise of discretion bounded by proper consideration of the statutory penalty criteria and the deterrent purposes underlying the statutory penalty scheme. *Douglas R. Rushford Trucking*, 22 FMSHRC 598, 601 (May 2000); *Sellersburg Stone Co.*, 5 FMSHRC 287, 294 (Mar. 1983), *aff'd*, 736 F.2d 1147 (7th Cir. 1984); *see also Black Beauty Coal Co.*, 34 FMSHRC 1856, 1864-69 (Aug. 2012) (explaining deterrence is “central tenet” of penalty scheme and permitting ALJ to consider potential deterrent effect beyond the six penalty criteria); *Cantera Green*, 22 FMSHRC 616, 620 (May 2000) (noting “broad discretion” accorded to ALJs). The Commission and its ALJs are not bound by the penalties proposed by the Secretary, nor are they governed by MSHA’s Part 100 regulations, although substantial deviations from the proposed penalties must be explained using the section 110(i) criteria. *See Cantera Green*, 22 FMSHRC at 621; *Sellersburg Stone*, 5 FMSHRC at 293; 29 C.F.R. § 2700.30(b). However, in considering the six penalty criteria and assessing a penalty, the ALJ must make findings of fact sufficient to give the operator notice of the basis for the penalty and to provide a factual basis upon which the Commission can perform its review function. *Martin Co. Coal Corp.*, 28 FMSHRC 247 (May 2006); *Cantera Green*, 22 FMSHRC at 620-21; *Rushford Trucking*, 22 FMSHRC at 600-01; *Sellersburg Stone*, 5 FMSHRC at 292-93; *see also* 29 C.F.R. § 2700.30(a).

#### B. Penalty

For each of the two violations the Secretary seeks a \$70,000 civil penalty, which is the maximum penalty allowed under section 110(a) of the Mine Act. The Secretary asserts the proposed penalties are appropriate under the circumstance, noting in particular that both of the violations directly contributed to a fatality, that both resulted from the Respondent’s high negligence, and that the Respondent is an extremely large mine operator. Sec’y’s Br. at 34. The Respondent, on the other hand, contends that the civil penalty for the two violations should not exceed \$20,000. The Respondent offers no supporting arguments for this position beyond the arguments already rejected above with respect to the gravity of the violations and the negligence associated with the violations.

The Secretary concedes that the Respondent has a low history of previous violations. Sec’y’s Br. at 32-33; *see* Exs. S-23, S-24. Consol is a very large operator. The parties have stipulated that the proposed penalties will not affect the Respondent’s ability to continue in business. *See* Stipulation 6. I have taken into account the appropriateness of the penalty to the size of the operator’s business as well as the desired deterrent effect of civil penalties in comparison to the size of the operator and its overall resources. *See Black Beauty*, 34 FMSHRC at 1864-69; *Thunder Basin Coal Co.*, 19 FMSHRC 1495, 1505 (Sept. 1997). I have also taken into account the Respondent’s demonstrated good faith in its attempts to achieve rapid compliance with the Mine Act after the fatal accident.

As discussed in detail above, the gravity of these violations is extremely serious and the operator demonstrated high negligence in connection with both violations. I find that gravity and negligence are the most important penalty criteria in this case and warrant the imposition of a high penalty. *See Musser Engineering, Inc.*, 32 FMSHRC 1257, 1289 (Oct. 2010) (permitting gravity and negligence to be weighed more heavily than other penalty factors); *Spartan Mining*

*Co.*, 30 FMSHRC 699, 724-25 (Aug. 2008) (same); *Lopke Quarries, Inc.*, 23 FMSHRC 705, 713 (July 2001) (same).

After consideration of all the evidence and the six statutory penalty criteria, I assess a penalty of \$70,000 for each violation.

**ORDER**

It is hereby ORDERED that CONSOL Buchanan Mining Company, LLC pay a total penalty of \$140,000 within thirty (30) days of the date of this order.<sup>8</sup>

A handwritten signature in black ink, appearing to read "Priscilla M. Rae". The signature is fluid and cursive, with the first name being the most prominent.

Priscilla M. Rae  
Administrative Law Judge

**Distribution:**

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<sup>8</sup> Payment should be sent to: Mine Safety and Health Administration, U.S. Department of Labor, Payment Office, P.O. Box 790390, St. Louis, MO 63179-0390.