FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

Office of the Chief Administrative Law Judge
1331 Pennsylvania Avenue, N.W., Suite 520N
Washington, D.C. 20004

July 31, 2025

SECRETARY OF LABOR,	:	CIVIL PENALTY PROCEEDINGS
MINE SAFETY AND HEALTH	:	
ADMINISTRATION (MSHA),	:	Docket No. SE 2023-0182
Petitioner,	:	A.C. No. 01-01401-571548-01
	:	
	:	Docket No. SE 2023-0183
v.	:	A.C. No. 01-01401-571548-02
	:	
WARRIOR MET COAL MINING, LLC,	:	Mine: No. 7 Mine
Respondent.	:	

DECISION

Appearances: Tyler K. L. Hurst, Esq., U.S. Department of Labor, Office of the Solicitor, Nashville, Tennessee, for Petitioner;
Guy W. Hensley, Esq., Counsel for Warrior Met Coal, LLC, Brookwood, Alabama & Brock Phillips, Esq., Maynard Nexsen, P.C., Birmingham, Alabama, for Respondent.

Before: Judge Paez

This case comes before me upon the Petitions for the Assessment of Civil Penalty filed by the Secretary of Labor ("Secretary") pursuant to section 105 of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 815(d) ("Mine Act"). In dispute are three section 104(a) citations issued to Warrior Met Coal Mining, LLC ("Warrior Met" or "Respondent") at its No. 7 Mine.

To prevail, the Secretary must prove any cited violation "by a preponderance of the credible evidence." *In re: Contests of Respirable Dust Sample Alteration Citations*, 17 FMSHRC 1819, 1838 (Nov. 1995) (citing *Garden Creek Pocahontas Co.*, 11 FMSHRC 2148, 2152 (Nov. 1989)), *aff'd sub nom.*, *Sec'y of Labor v. Keystone Coal Mining Corp.*, 151 F.3d 1096, 1106–07 (D.C. Cir. 1998). This burden of proof requires the Secretary to demonstrate that "the existence of a fact is more probable than its nonexistence." *RAG Cumberland Res. Corp.*, 22 FMSHRC 1066, 1070 (Sept. 2000) (citations and internal quotations omitted), *aff'd*, 272 F.3d 590 (D.C. Cir. 2001).

I. STATEMENT OF THE CASE

Chief Administrative Law Judge Glynn F. Voisin assigned me Docket Nos. SE 2023-0182 and SE 2023-0183, and I consolidated them for hearing. The Secretary initially issued

Warrior Met eight citations under section 104(a) of the Mine Act for alleged violations of health and safety standards. I issued my Decision Approving Partial Settlement on January 25, 2024, after the parties settled five of the eight citations. Three section 104(a) citations remain at issue.

Docket No. SE 2023-0182 involves two citations. First, Citation No. 9701033 alleges a violation of 30 C.F.R. § 75.342(a)(4) for failing to maintain a methane monitor on a continuous mining machine in proper operating condition. The Secretary designated the violation as significant and substantial ("S&S")[1] and determined Warrior Met's negligence to be "moderate." The Secretary proposes a penalty of $1,152.00 for this citation. Second, Citation No. 9706551 alleges a violation of 30 C.F.R. § 50.12 for altering an accident site before MSHA completed an investigation of the accident. The Secretary did not designate the violation as S&S but did mark Warrior Met's negligence as high. The Secretary proposes a penalty of $606.00 for this citation.

Citation No. 9706550 in Docket No. SE 2023-0183 alleges a violation of 30 C.F.R. § 50.10(b) for failing to contact MSHA within fifteen minutes once the operator knew or should have known that an accident occurred involving an "injury of an individual at the mine which has a reasonable potential to cause death." The Secretary designated the violation as S&S and determined Warrior Met's negligence to be "moderate." The Secretary proposes the statutory minimum penalty of $7,133.00 for this citation.

After proper notice to the parties, I held a hearing in Birmingham, Alabama. The Secretary presented testimony from the following witnesses: Miner Randy Nichols; MSHA Supervisor Sammy Elswick; and MSHA Inspector Miller Craig. Warrior Met presented testimony from the following witnesses: Warrior Met Director of Compliance Edward ("Ed") Boylen; the No. 7 Mine Manager Craig Dickerson; Warrior Met CO Operator Charles Dickey; Miner John Hackney; Miner Colton Hallman; Foreman Jonathan Pippin; Warrior Met Maintenance Coordinator William Michael Coleman; and Warrior Met Safety Manager Eric Barnes. The parties each filed post-hearing briefs and reply briefs.[2]

II. ISSUES

The Secretary asserts that the three citations should be affirmed as issued. (Sec'y Br. at 1; Sec'y Reply Br. at 1.) Warrior Met argues that the gravity and negligence designations for Citation No. 9701033 should be reduced, and the citation should be classified as non-S&S. (Resp't Br. at 1; Resp't Reply Br. at 1.) Warrior Met also contends Citation Nos. 9706550 and 9706551 should be vacated. (Resp't Br. at 1; Resp't Reply Br. at 1.)

[1] The S&S terminology is taken from section 104(d)(1) of the Mine Act, 30 U.S.C. § 814(d)(1), which distinguishes as more serious any violation that "could significantly and substantially contribute to the cause and effect of a . . . mine safety or health hazard."

[2] In this decision, volume one of the hearing transcript, volume two of the hearing transcript, the Secretary's exhibits, Warrior Met's exhibits, the Secretary's Post-Hearing Brief, Warrior Met's Post-Hearing Brief, the Secretary's Reply Brief, and Warrior Met's Reply Brief are abbreviated, respectively, as: "I Tr.," "II Tr.," "Ex. S–#," "Ex. R–#," "Sec'y Br.," "Resp't Br.," "Sec'y Reply Br.," and "Resp't Reply Br." The parties also agreed to a list of stipulations admitted at hearing as a joint exhibit and abbreviated as "Ex. Jt.–1."

Accordingly, I determine that the following issues are before me: (1) whether the Secretary's gravity determination was properly designated as S&S for the methane monitor violation in Citation No. 9701033; (2) whether Warrior Met's negligence is properly designated as "moderate" for Citation No. 9701033; (3) whether Warrior Met violated MSHA's 15-minute accident notification requirement under 30 C.F.R. § 50.10(b) as alleged in Citation No. 9706550; (4) whether the Secretary's gravity determination was properly designated as S&S for Citation No. 9706550; (5) whether Warrior Met's negligence is properly designated as "moderate" for Citation No. 9706550; (6) whether Warrior Met altered an accident site in violation of 30 C.F.R. § 50.12 as alleged in Citation No. 9706551; (7) whether Warrior Met's negligence is properly designated as "high" for Citation No. 9706551; and (8) whether the Secretary's proposed penalties are appropriate for each of the three alleged violations.

For the reasons set forth below, Citation Nos. 9701033, 9706550, and 9706551 are **AFFIRMED** and **MODIFIED** as discussed below.

III. PRINCIPLES OF LAW

A. Significant and Substantial

Section 104(d)(1) of the Mine Act describes the S&S designation to mean a violation "of such nature as could significantly and substantially contribute to the cause and effect of a coal or other mine safety or health hazard." 30 USC § 814(d)(1). A violation is S&S "if, based upon the particular facts surrounding that violation, there exists a reasonable likelihood that the hazard contributed to will result in an injury or illness of a reasonably serious nature." *Cement Div., Nat'l Gypsum Co.*, 3 FMSHRC 822, 825 (Apr. 1981). The Commission has held that to establish an S&S violation, the Secretary must meet the four elements of the *Mathies* test, which are:

> (1) the underlying violation of a mandatory safety standard; (2) the violation was reasonably likely to cause the occurrence of the discrete safety hazard against which the standard is directed; (3) the occurrence of that hazard would be reasonably likely to cause an injury; and (4) there would be a reasonable likelihood that the injury in question would be of a reasonably serious nature.

Peabody Midwest Mining, 42 FMSHRC 379, 383 (June 2020) (citing *Newtown Energy*, 38 FMSHRC 2033, 2037–38 (Aug. 2016); *Mathies Coal Co.*, 6 FMSHRC 1, 3–4 (Jan. 1984) (footnote omitted)); *see also Buck Creek Coal, Inc. v. Fed. Mine Safety & Health Admin.*, 52 F.3d 133, 135–36 (7th Cir. 1995) (affirming the application of the *Mathies* criteria); *Austin Power, Inc. v. Sec'y of Labor*, 861 F.2d 99, 104 (5th Cir. 1988) (approving the *Mathies* test).

The Commission has indicated that "an inspector's judgment is an important element" in an S&S determination. *Mathies*, 6 FMSHRC at 5 (citing *Nat'l Gypsum*, 3 FMSHRC at 825–26); *see also Buck Creek Coal*, 52 F.3d at 135 (stating that ALJ did not abuse discretion in crediting opinion of experienced inspector). The Commission has also specified that 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). Additionally, the presence of safety measures designed to mitigate the likelihood of a hazard's occurrence, or the likelihood of injury

from the hazard is irrelevant for the S&S inquiry. *Black Beauty Coal Co.*, 38 FMSHRC 1307, 1312–14 (June 2016); *Knox Creek Coal Corp. v. Sec'y of Labor*, 811 F.3d 148, 162 (4th Cir. 2016); *Cumberland Coal Res., LP v. FMSHRC*, 717 F.3d 1020, 1028–29 (D.C. Cir. 2013); *Buck Creek Coal, Inc. v. Fed. Mine Safety and Health Admin.*, 52 F.3d 133, 135–36 (7th Cir. 1995).

B. Negligence

The Commission evaluates the degree of negligence using "a traditional negligence analysis." *Am. Coal Co.*, 39 FMSHRC 8, 14 (Jan. 2017) (quoting *Mach Mining, LLC v. Sec'y of Labor*, 809 F.3d 1259, 1264 (D.C. Cir. 2016) (citation omitted)). Because the Commission is not bound by the Secretary's regulations addressing the proposal of civil penalties set forth in 30 C.F.R. part 100, the Commission and its Judges are not required to consider the negligence definitions in 30 C.F.R. § 100.3(d). *Am. Coal Co.*, 39 FMSHRC at 14 (citing *Mach Mining, LLC*, 809 F.3d at 1263–64). Under a traditional negligence analysis, an operator is negligent if it fails to meet the requisite standard of care. *Brody Mining, LLC*, 37 FMSHRC 1687, 1702 (Aug. 2015). In determining whether an operator met its duty of care, the Commission considers what actions a reasonably prudent person familiar with the mining industry would have taken under the same circumstances, the relevant facts, and the protective purpose of the regulation. *Id*. In making a negligence determination, a Commission Judge is not limited to an evaluation of allegedly "mitigating" circumstances but may consider the "totality of the circumstances holistically." *Id.*

C. Penalty

The Commission is not bound by the Secretary's proposed penalty but reviews penalty assessments *de novo*. *Mach Mining, LLC v. Sec'y of Labor*, 809 F.3d 1259, 1263–64 (D.C. Cir. 2016). Under section 110(i) of the Mine Act, I must consider six criteria in assessing a civil penalty: (1) the operator's history of previous violations; (2) the appropriateness of the penalty relative to the size of the operator's business; (3) the operator's negligence; (4) the penalty's effect on the operator's ability to continue in business; (5) the violation's gravity; and (6) the demonstrated good faith of the operator in attempting to achieve rapid compliance after notification of a violation. 30 U.S.C. § 820(i).

IV. FINDINGS OF FACT – PARTIES' STIPULATIONS

At the hearing the parties stipulated in a joint exhibit to the following items verbatim:

A. Respondent is subject to the Federal Mine Safety and Health Act of 1977 and to the jurisdiction of the Federal Mine Safety and Health Review Commission;
B. The presiding Administrative Law Judge has the authority to hear this case and issue a decision;
C. Respondent was the operator of the above-captioned mine at all times relevant to this matter;
D. The above-captioned mine is a "mine" as defined in the Federal Mine Safety and Health Act;

E. The products and operations of the above-captioned mine entered and/or affected commerce;
F. True and accurate copies of the Citations in these dockets may be admitted into evidence for the purpose of establishing their issuance and not for the purpose of establishing the accuracy of any statements asserted therein;
G. A true and accurate copy of the inspector's notes for the Citations identified in Paragraph F may be admitted into evidence for the purpose of establishing their existence and not for the purpose of establishing the accuracy of any statements asserted therein;
H. According to the information provided by Respondent to MSHA's Mine Data Retrieval System, Respondent mined 4,755,684 tons of bituminous coal in 2022 at No. 7 Mine;
I. The Citations in these dockets were properly served on Respondent by a duly authorized representative of the Secretary on the dates stated therein;
J. The penalties proposed in this docket by the Secretary would not affect Respondent's ability to remain in business; and
K. Respondent abated the 104(a) citations involved herein in a timely manner and in good faith.

(Ex. Jt.–1; I Tr. 10:1–15.)

V. FURTHER FINDINGS OF FACT, ANALYSIS, AND CONCLUSIONS OF LAW – CITATION NO. 9701033

A. Facts Relevant to the Methane Monitor Violation – Citation No. 9701033

1. Methane Detection at the No. 7 Mine

Warrior Met's No. 7 Mine is on a five-day spot inspection due to the large amount of methane liberated from the mine in a 24-hour period. (I Tr. 163:2–4, 174:1–6; II Tr. 190:8–15.) Specifically, the No. 7 Mine liberates approximately 13,858,143 cubic feet of methane during a 24-hour period. (II Tr. 229:14–20.) Maintenance Coordinator William Michael Coleman testified that at least one ignition has occurred at the No. 7 Mine since 2012. (II Tr. 196:4–197:10.)

A methane monitor is an air quality device that detects and reports in real time the methane concentration present in the environment. (II Tr. 155:19–2.) If the methane monitor detects 1.0 percent methane in the atmosphere, it will display a flashing warning and Warrior Met will de-energize the machine and improve ventilation as required by 30 C.F.R. sections 75.342(b)(1) and 75.323(b)(1). (I Tr. 189:11–190:12; II Tr. 156:21–22, 163:11–20, 178:1–18, 191:18–22, 208:5–209:14.) If the monitor reads 1.5 percent methane, Warrior Met kills power at the power source for the affected area as required by section 75.323(b)(2)(ii). (II Tr. 163:20–22, 209:15–211:5.) If the methane monitor detects 2.0 percent methane in the environment, it automatically turns off the machine as required by section 75.342(c)(1). (II Tr. 157:4–5, 163:14–15, 178:21–179:10, 192:2–9, 209:20–210:12.)

Warrior Met calibrates its methane monitors on a weekly basis. (I Tr. 196:1–8; II Tr 164:21–22.) MSHA Inspector Miller Craig explained that Warrior Met began calibrating its methane monitors on a weekly basis, rather than monthly as required by law, because it was experiencing calibration issues. (I Tr. 195:15–196:8.) Additionally, Warrior Met "bump tests" its methane monitors, meaning it tests the monitors before every shift. (II Tr. 164:12–165:8.)

2. April 13, 2022, Inspection and Citation

On April 13, 2022, MSHA Inspector Miller Craig traveled to Warrior Met's No. 7 Mine to perform a spot, or methane liberation, inspection. (I Tr. 162:17–163:2.) Upon arrival at the No. 7 Mine, Inspector Craig met with Warrior Met Safety Supervisor Mike Carroll and inspected the exam books for the No. 12 Section of the mine. (I Tr. 163:12–21, 165:6–9; Ex. S–2.) Inspector Craig then traveled underground with Warrior Met Safety Supervisor Matt Lane. (I Tr. 165:6–22; Ex. S–2.) Maintenance Coordinator Coleman joined Craig and Lane underground. (II Tr. 173:14–16, 189:12–16.)

After coming upon continuous miner[3] CM137, Inspector Craig tested the calibration of its methane monitors. (I Tr. 167:7–12.) Two methane monitors are mounted on either side of the CM137 continuous miner, one for each sniffer head.[4] (II Tr. 158:14–161:15, 185:17–21.) Two sniffer heads are installed on the CM137 continuous miner because the levels of methane can differ on either side of the machine. (II Tr. 186:19–187:12, 198:9–13.) To test a methane monitor's calibration, a cap with a hose is placed on the sniffer head and the hose is connected to a canister tank with a known methane concentration of 2.5 percent. (I Tr. 169:6–170:9, 185:14–20, 186:19–187:6.) If the monitor is properly calibrated, it should detect an increasing amount of methane until it reaches 2.5 percent. (I Tr. 169:13–22; II Tr. 156:3–5.) According to the manufacturer of the continuous mining machine, a monitor that reads two/tenths (0.2) above or below 2.5 percent when tested with a canister of 2.5 percent methane concentration is still considered properly calibrated. (I Tr. 181:13–22, 189:4–10; II Tr. 156:6–16.)

At the time of his inspection, Inspector Craig did not detect any methane in the surrounding environment. (I Tr. 187:10–14, 188:2–6; II Tr. 181:20–22.) Inspector Craig explained that this was because no mining was occurring at the time of his inspection. (I Tr. 187:15–188:1, 188:7–15, 192:20–193:4, 195:3–5; II Tr. 186:14–18.) During this inspection, one of the methane monitors for the CM137 continuous mining machine accurately reflected 2.5 percent methane concentration when tested. (II Tr. 174:12–20.) However, the other monitor inaccurately reflected only 2.2 percent methane concentration when tested, indicating improper calibration. (I Tr. 170:12–171:2; II Tr. 174:12–175:11.) Inspector Craig explained that even though this monitor read 2.0 percent at the time it killed power, the CM137 machine was actually

[3] "A continuous miner is a remote-controlled machine that extracts the coal and rock from the working face" and is operated by a miner who stands behind the machine. (I Tr. 179:13–180:14; II Tr. 157:16–18.)

[4] The sniffer heads are the pieces of equipment that detect the level of methane in the air, which is displayed on the methane monitors. (II 158:3–10.)

exposed to 2.3 percent methane due to the faulty calibration.[5] (I Tr. 170:13–14, 171:11–172:9, 191:4–12; II Tr. 178:19–179:19.)

Accordingly, Inspector Craig issued Citation No. 9701033 to Warrior Met on April 13, 2022, in which he wrote the following:

> Methane monitors shall be maintained in proper operating condition. When tested with a known air/gas mixture of 2.5% the methane monitor on the National Mine Services methane monitor that is mounted on the Joy Continuous Miner C/N CM-137 would only read 2.2%. The methane monitor would de-energize the machine at 2.0%. The continuous miner was in service at the time of the inspection on the E-18 #12 Section. This exposes miners to not knowing the amount of methane that they are encountering due to the methane monitor only reading to 2.2%. Miners would receive injuries associated with a[n] ignition happening at the face. This mine is on a five day methane spot. The last exam was conducted on 4-6-2022.

(Ex. S–1; I Tr. 171:5–10.)

Inspector Craig assessed the likelihood of injury to be "reasonably likely" based on the large amounts of methane the No. 7 Mine liberates and the mine's history of ignitions. (Ex. S–1; I Tr. 172:19–11.) Inspector Craig determined miners could suffer smoke inhalation or burns during an ignition or mine explosion caused by the violation, which could lead to "lost workdays or restricted duty." (Ex. S–1; I Tr. 175:6–14.) He determined that two miners could be affected by the violation because both a mine operator and a coal hauler operator would likely be working at the time methane is liberated using the CM137 continuous mining machine. (Ex. S–1; I Tr. 179:13–180:14.)

Inspector Craig designated the violation as S&S based on the expected amount of coal dust in the air while the continuous miner cuts the coal, which increases the likelihood of an ignition. (Ex. S–1; I Tr. 176:13–178:16.) He determined Warrior Met to be moderately negligent because it tested the methane monitor weekly, even though the law only requires monthly methane monitor testing. (Ex. S–1; I Tr. 178:17–179:12.) Inspector Craig terminated the citation fifteen minutes after it was issued when Warrior Met recalibrated the system and retested the calibration. (II Tr. 175:10–177:12.)

[5] During the test when the methane monitor read 1.0 percent methane, the monitor's alarm went off; thus, based on the testimony of Inspector Craig as well as Warrior Met's Coleman and Barnes, I determine that the CM137 continuous mining machine was actually exposed to 1.3 percent methane when the alarm went off. (I Tr. 171:11–172:9, 191:4–12; II Tr. 178:17–18, 192:10–16, 235:9–14.)

B. Analysis and Conclusions of Law: Citation No. 9701033 – Methane Monitors

1. Violation of 30 C.F.R § 75.342(a)(4)

Warrior Met acknowledges that one of the methane monitors on the continuous mining machine was off by 0.3 percent and, therefore, was not properly calibrated as required by the standard. (Resp't Br. at 23.) Consequently, Warrior Met does not contest the fact of a violation of 30 C.F.R. § 75.342(a)(4)[6] as cited in Citation No. 9701033. (Resp't Br. at 23.) Accordingly, I conclude that Warrior Met violated 30 C.F.R. § 75.342(a)(4).

2. S&S Analysis for Violation of 30 C.F.R § 75.342(a)(4)

a. Underlying Violation of a Mandatory Safety Standard

To establish the first element of the *Mathies* test, the Secretary must prove an underlying violation of a mandatory safety standard. *Mathies Coal Co.*, 6 FMSHRC 1, 3 (Jan. 1984). Given that Warrior Met does not contest the fact of a violation of 30 C.F.R. § 75.342(a)(4), I determine that the Secretary has satisfied the first element of the *Mathies* test.

b. Likelihood of Causing the Occurrence of the Discrete Safety Hazard Against Which the Standard is Directed

For the second *Mathies* element, the Secretary must establish that "based upon the particular facts surrounding the violation, there exists a reasonable likelihood of the occurrence of the hazard against which the mandatory safety standard is directed." *Newtown Energy, Inc.*, 38 FMSHRC 2033, 2038 (Aug. 2016).[7] In assessing this element, "[t]he Commission . . . defines the 'hazard' in terms of the prospective danger the cited safety standard is intended to prevent." *Id.* Section 75.342 seeks to prevent mine explosions. *See* Safety Stands for Underground Coal Mine Ventilation 61 Fed. Reg. 9,764, 9,836 (Mar. 11, 1996) ("[m]ethane monitors are a critical link in the safety protections designed to prevent mine explosions"). Here, the specific hazard

[6] Section 75.342(a)(4) states, "[m]ethane monitors shall be maintained in permissible and proper operating condition and shall be calibrated with a known air-methane mixture at least once every 31 days. To assure that methane monitors are properly maintained and calibrated, the operator shall: (i) Use persons properly trained in the maintenance, calibration, and permissibility of methane monitors to calibrate and maintain the devices. (ii) Maintain a record of all calibration tests of methane monitors. Records shall be maintained in a secure book that is not susceptible to alteration or electronically in a computer system so as to be secure and not susceptible to alteration. (iii) Retain the record of calibration tests for 1 year from the date of the test. Records shall be retained at a surface location at the mine and made available for inspection by authorized representatives of the Secretary and the representative of miners." 30 C.F.R. § 75.342(a)(4).

[7] I reject the Secretary's argument that the Commission's analysis of step two of the *Mathies* test in *Newtown Energy* is inconsistent with the Mine Act's definition of S&S. (*See* Sec'y Br. at 5–6.) Because *Newtown Energy* is the most recent case addressing the elements of S&S decided by the Commission, I must follow its directives.

posed by a violation of section 75.342(a)(4) is a spark or ignition occurring among undetected, elevated methane levels, causing an explosion in the mine.

The Commission has held that—

> [w]hen examining whether an explosion or ignition is reasonably likely to occur, it is appropriate to consider whether a 'confluence of factors' exists to create such a likelihood . . . Some of the factors to be considered include the extent of accumulations, possible ignition sources, the presence of methane, and the type of equipment in the area.

Excel Mining, LLC, 37 FMSHRC 459, 463 (Mar. 2015) (citations omitted).

The Secretary asserts that the monitor at issue on the CM137 continuous miner liberates methane when in operation, thereby creating a hazard of methane ignition at the face where active mining occurs. (Sec'y Br. at 8.) The Secretary also alleges that the No. 7 Mine liberates a large amount of methane and has had at least one prior methane ignition since 2016. (Sec'y Br. at 8.) Specifically, the Secretary notes that the mine is on the most frequent testing schedule, five-day spot tests, due to its high level of methane liberation. (Sec'y Br. at 10.) The Secretary argues that these risk factors satisfy the confluence-of-factors test for a methane ignition hazard. (Sec'y Br. at 8.)

In contrast, Warrior Met raises several arguments to support its contention that the violation was not S&S. These arguments pertain to the second element of the *Mathies* test, which I address below.

First, Warrior Met argues that given the various methane mitigation measures in place at the time of the inspection, the violation was not reasonably likely to cause an explosion. (Resp't Reply Br. at 16.) However, "[w]hen deciding whether a violation is S&S, courts and the Commission have consistently rejected as irrelevant evidence regarding the presence of safety measures designed to mitigate the likelihood of injury resulting from the danger posed by the violation." *Brody Mining, LLC*, 37 FMSHRC 1687, 1691 (Aug. 2015). Warrior Met notes in its brief that these mitigation measures are required by other MSHA regulations. (Resp't Br. at 23–24.) Consequently, Warrior Met's compliance with these other regulations is irrelevant to any determination of whether its violation of section 75.342(a)(4) was S&S.

Second, Warrior Met asserts that because one of the two methane monitors on the CM137 continuous miner was perfectly calibrated, the likelihood of any hazard decreases considerably. (Resp't Reply Br. at 17.) In making this argument, Warrior Met cites Maintenance Coordinator Coleman's testimony explaining that the different sides of the continuous miner can experience different levels of methane while in operation. (II Tr. 158:17–159:6.) Indeed, it is precisely because of this variation in methane levels that the CM137 continuous miner has two methane detectors placed on either side of the machine. Consequently, the continuous miner operator would not have discovered that the monitor at issue was 0.3 percent out of calibration as Warrior Met argues, because there is no base-line assumption that

the dual monitors should detect the same amount of methane. Each methane monitor detects levels independent of the other, so Warrior Met's argument fails logically.

Third, Warrior Met argues that because the methane monitor was off by 0.3 percent, which is only 0.1 percent outside the permissible range for the methane monitor, the violation was not S&S. (Resp't Br. at 23.) But the relevant time frame for determining whether a violation is S&S "includes both the time that a violative condition existed prior to the citation and the time that it would have existed if normal mining operations had continued." *Rushton Mining Co.*, 11 FMSHRC 1432, 1435 (Aug. 1989); *see also Halfway, Inc.*, 8 FMSHRC 8, 12 (Jan. 1986) (holding that "[t]he fact that a miner may not be directly exposed to a safety hazard at the precise moment that an inspector issues a citation is not determinative of whether a reasonable likelihood for injury existed"); *Knox Creek Coal Corp.*, 36 FMSHRC 1128, 1132 (May 2014) (holding that "[t]he Judge erred by limiting his consideration of the violative conditions as they existed at the time of the inspection, taking a 'snapshot' approach to the issue"). Even though the methane monitor was 0.3 percent out of calibration at the time of the violation, nothing guarantees that the monitor would remain at this interval under continued normal mining conditions. In fact, Maintenance Coordinator Coleman explained that Warrior Met "bump tests" the continuous mining machines every shift precisely because the methane monitors can go further out of calibration over time, meaning methane monitors could go higher out of calibration. (II Tr. 198:16–199:3.)

Fourth, Warrior Met contends that the violation did not pose a hazard because the CM137 continuous miner was not used during the shift the inspection took place and Inspector Craig did not detect any methane in the No. 12 section of the mine at the time of the violation. (Resp't Reply Br. at 17.) However, in making this point Warrior Met cites Inspector Craig's testimony explaining that the continuous miner cannot operate during his inspection of the methane monitors, because he "wouldn't be able to test it with it actually extracting material at the time." (I Tr. 183:16–19.) Inspector Craig also pointed out that "[i]t is not usual[] that you encounter large [amounts] of methane being liberated in idle faces." (I Tr. 188:2–12.) Furthermore, the Commission previously rejected another operator's similar "contention that because mining was not taking place at the precise moment the citation was issued, the violation posed no hazard." *U.S. Steel Mining Co., Inc.*, 6 FMSHRC 1866, 1869 (Aug. 1984). Rather, "[t]he Commission has clearly held that . . . Judges must consider the violative conditions as they existed both prior to and at the time of the violation and as they would have existed had normal mining operations continued." *Knox Creek Coal Corp.*, 36 FMSHRC 1128, 1132 (May 2014) (citations omitted). Indeed, section 75.342(a)(4) does not, as it might, require methane monitors to be functioning only when the equipment they are attached to is in use. While Inspector Craig detected no methane in the No. 12 section of the mine at the time he issued the citation, logic dictates that the concentration of methane would increase once Warrior Met resumed cutting into the coal face with the CM137 continuous miner. Thus, "had normal mining operations continued," Warrior Met's violation of section 75.342(a)(4) would have posed a hazard. *U.S. Steel Mining Co., Inc.*, 6 FMSHRC at 1869.

In evaluating the second *Mathies* element and the confluence-of-factors test, the amount of methane a mine emits is a decisive factor in determining whether a violation of section 75.342(a)(4) is S&S. Here, Warrior Met's No. 7 Mine liberates approximately 13,858,143 cubic

feet of methane in a 24-hour period, and the mine is subject to five-day methane spot inspections. (I Tr. 163:2–4, 174:1–6; II Tr. 190:8–15, 229:14–20.) *Cf. Mach Mining, Inc.*, 38 FMSHRC 1379, 1410 (June 2016) (ALJ) (holding that a violation of 75.342(a)(4) was S&S after finding that the mine was "on a five-day spot inspection schedule" and "liberate[d] over two million cfm methane in a 24-hour period"); *Ohio Cty. Coal Co.*, 32 FMSHRC 220, 224 (Feb. 2010) (ALJ) (holding that "[w]hile the cutting head of a continuous miner would present an ignition source, there would have had to have been a significant quantity of methane present to result in an explosion or fire" and only "12,000 to 13,000 cubic feet of methane was liberated at the . . . mine in a 24-hour period"). Additionally, the CM137 continuous mining machine is designed to cut into the coal face, which liberates methane and creates possible ignition sources. Given those facts and considering the discussion above, I determine that Warrior Met's failure to maintain the methane monitor on the CM137 continuous miner in permissible and proper operation was reasonably likely to result in an explosion under the confluence-of-factors test. (I Tr. 174:1–175:5; II Tr. 229:14–20.) Accordingly, I conclude that the Secretary has satisfied the second element of the *Mathies* test.

c. Likelihood the Occurrence of the Hazard Would Cause Injury

Regarding the third *Mathies* element, the Secretary must demonstrate a reasonable likelihood that the occurrence of the hazard would result in an injury. *Mathies Coal Co.*, 6 FMSHRC 1, 3–4 (Jan. 1984). Thus, the Secretary must establish that based upon the particular facts surrounding this violation, the occurrence of an explosion would be reasonably likely to result in an injury. The Secretary argues that "'federal . . . appellate law and Commission precedent have sufficiently established that a methane explosion is reasonably likely to result in injuries.'" (Sec'y Br. at 8 (citing *Mach Mining, Inc.*, 38 FMSHRC 1168,1199 (May 2016) (ALJ)).)

Warrior Met does not dispute that a methane explosion is reasonably likely to result in injuries but rather continues to assert that the Secretary has not shown that a methane explosion as a result of the violation was reasonably likely in the first place. (Resp't Reply Br. at 18.) Yet, as the Commission noted in *Newtown Energy, Inc.*, "'[e]very federal appellate court to have applied *Mathies* has also assumed the existence of the relevant hazard when analyzing the test's third [step].'" *Newtown Energy, Inc.*, 38 FMSHRC 2033, 2037 (Aug. 2016) (citations omitted). In light of the case law, I agree with the Secretary that a methane explosion is reasonably likely to result in injuries such as burns and smoke inhalation. Accordingly, I conclude that the Secretary has satisfied the third element of the *Mathies* test.

d. Likelihood Resulting Injury Would Be of a Reasonably Serious Nature

Lastly, under the fourth *Mathies* element, the Secretary must prove a reasonable likelihood that the resulting injury would be of a reasonably serious nature. *Mathies Coal Co.*, 6 FMSHRC 1, 4 (Jan. 1984). An injury of a "reasonably serious nature" does not require a specific type of injury, and a mere muscle strain, sprained ligament, or fractured bone may be "reasonably serious." *S&S Dredging Co.*, 35 FMSHRC 1979, 1981–82 (July 2013) (holding the ALJ erred in requiring the Secretary to demonstrate an injury would result in hospitalization,

surgery, or a long period of recuperation to satisfy the fourth *Mathies* element); *see also Buffalo Crushed Stone, Inc.*, 19 FMSHRC 231, 238 n.9 (Feb. 1997) (reversing the ALJ's finding of non-S&S and concluding that a finger or a wrist fracture are "reasonably serious injuries").

The Secretary argues that Inspector Craig and Maintenance Coordinator Coleman's testimony demonstrate that the injuries from an ignition would be serious. (Sec'y Br. at 8.) Specifically, the Secretary highlights Inspector Craig's testimony that if a mine explosion or ignition occurred, miners could suffer "smoke inhalations or burns." (Sec'y Br. at 8.) The Secretary also emphasizes Coleman's testimony in which he agreed that ignition of methane can kill a miner and cause burns. (Sec'y Br. at 9.) I determine that smoke inhalation and burns due to a mine explosion are certainly reasonably serious injuries under the Commission's standard in *S&S Dredging Co.* and could be fatal. Thus, I determine that the Secretary has satisfied the fourth *Mathies* element.

Accordingly, because the Secretary has satisfied all four elements of the *Mathies* test, I conclude that the violation in Citation No. 9701033 is appropriately designated as S&S.

3. Negligence Determination for Violation of 30 C.F.R § 75.342(a)(4)

Inspector Craig designated Warrior Met's negligence as "moderate." (I Tr. 178:17–179:12; Ex. S–1.) The Secretary asserts that "Warrior Met knew or should have known that the methane monitor was out of calibration." (Sec'y Br. at 9–10.) The Secretary argues that Warrior Met's mitigation efforts, including testing the methane monitors every shift and calibrating the monitors weekly, were taken into consideration by Inspector Craig in his assessment of "moderate" negligence. (Sec'y Br. at 10.)

Warrior Met disputes the "moderate" negligence designation and in support notes that it calibrates its methane monitors on a weekly basis, four times as frequently as the law requires. (Resp't Br. at 24; Resp't Reply Br. at 19.) Warrior Met highlights that it engages in "bump testing," meaning that if any methane monitor does not function properly at the beginning of a shift, it recalibrates the methane monitor on the spot. (Resp't Reply Br. at 19.) Warrior Met also argues that the Secretary fails to explain how Warrior Met knew or should have known that the methane monitor at issue was out of calibration. (Resp't Reply Br. at 20.)

I agree with Warrior Met that the Secretary provides no support for her assertion that Warrior Met knew or should have known that the methane monitor at issue was out of calibration. During the week of April 9, 2022, one of the methane monitors on the CM137 continuous miner detected 2.2 percent methane instead of 2.5 percent methane during a test. (II Tr. 171:21–172:7; Ex. R–4.) Warrior Met recalibrated the methane monitor and afterwards had no reason to believe the monitor was not working properly. (II Tr. 172:7–20.) Additionally, I determine that the Secretary did not give enough weight to the fact that Warrior Met tested its methane monitors at the start of every shift (II Tr. 164:12–165:8) and recalibrated its methane monitors on a weekly, rather than monthly, basis (II Tr. 164:21–22). Therefore, I conclude that Warrior Met exhibited a low level of negligence.

C. Penalty: Citation No. 9701033 – Methane Monitors

The Secretary proposes a penalty of $1,152.00 for Citation No. 9701033. (Sec'y Br. at 10.) In the fifteen-month period preceding Citation No. 9701033, Warrior Met was cited nine times for a violation of section 75.342(a)(4). (Sec'y Br. at 11.) Warrior Met is a large operator, mining 4,755,684 tons of coal at the No. 7 Mine in 2022. (Ex. Jt.–1.) The parties stipulated that the penalties proposed by the Secretary in this case would not affect Warrior Met's ability to remain in business. (Ex. Jt.–1.) Warrior Met timely abated Citation No. 9701033 by immediately recalibrating the monitor. (II Tr. 175:10–177:12.) Regarding gravity, I agree with the Secretary that the violation is reasonably likely to result in injury that could cause lost workdays or restricted duty for two miners. I also determined that Warrior Met's violation was S&S. *See* discussion *supra* Part V.B.2. However, I determined that Warrior Met exhibited a low level of negligence. *See* discussion *supra* Part V.B.3. Thus, in considering the criteria set forth in section 110(i) of the Mine Act and all the relevant facts, I hereby assess a penalty of $600.00.

VI. FURTHER FINDINGS OF FACT, ANALYSIS, AND CONCLUSIONS OF LAW – CITATION NOS. 9706550 & 9706551

A. Facts Relevant to the Elevator Accident – Citation Nos. 9706550 & 9706551

1. Falling Ice Hits Elevator at the North Portal

On December 25, 2022, the No. 7 Mine did not run its regular shifts as it was Christmas Day. (I Tr. 25:16–17, 249:1–2.) Instead, Warrior Met offered miners the opportunity to come in and work if they wished. (I Tr. 25:16–17.) Having no family close by, miner Randy Nichols decided to work. (I Tr. 25:17–26:1.) Nichols was assigned to assist Electrician John Hackney and Belt Foreman Colton Hallman underground. (I Tr. 27:15–20.) The No. 7 Mine has three portals – North Portal, East Portal, and West Portal. (Ex. R–1.)

Shortly after their shift began at 6:00 p.m., Nichols, Hackney, and Hallman descended 1,500 feet down the elevator hoist into the mine's North Portal. (I Tr. 27:16–28:16, 35:7–15; II Tr. 72:8–9.) During their decent, the miners observed large blocks of ice on the sides of the elevator shaft. (I Tr. 28:17–29:1, 105:6–110:17; II Tr. 73:5–74:11; Exs. S–13, S–14.) As the elevator cage neared the bottom of the shaft, a large piece of ice broke off[8] and fell down the 1,500-foot shaft, striking the top of the elevator cage, some time between 6:10 p.m. and 6:16 p.m. (I Tr. 29:20–30:1, 95:17–96:9, 113:19–115:10; II Tr. 9:11–12, 72:12–15, 86:12–14.) The force of the ice's impact caused the elevator's metal roof, which is composed of two panels, to hinge open and partially cave in, striking all three miners. (I Tr. 29:22–30:1, 246:22–247:5; II Tr. 9:11–13, 39:15–40:11, 72:12–15, 102:8–16.) The force of the elevator's roof collapsing knocked Nichols and Hackney's hard hats off their heads and knocked the light off Hallman's hard hat. (I Tr. 42:5–19; II Tr. 19:13–19, 41:1–8, 87:2–4, 92:13–16.)

[8] MSHA Supervisor Elswick later determined that the piece of ice that broke off the elevator shaft was roughly 50 feet below the surface of the North Portal elevator shaft, or 1,450 feet above the bottom of the elevator shaft. (I Tr 109:17–20, 110:13–16.)

Nichols briefly lost consciousness after the metal elevator roof collapsed from the force of the falling ice and hit him. (I Tr. 29:20–30:2, 33:16–22, 35:3–6.) Nichols also suffered a deep laceration inside his mouth after biting down on his cheek during the accident and was spitting up blood afterwards. (I Tr. 32:13–14, 33:12–15, 36:13–37:7, 72:22–73:19; II Tr. 10:16–17, 11:7–8, 19:3–6, 46:9, 75:10–12, 88:6–10, 93:5–6, 94:1–6, 119:7–8, 233:21–234:8.) Additionally, the elevator's roof cut Nichol's left arm when it fell. (I Tr. 36:13–14.)

The collapsing roof cut Hackney's forehead, drawing blood. (I Tr. 35:20–21, 19:10–11, 19:20–22, 41:9–10, 54:11–17, 66:11–12, 75:9–10, 87:5, 118:19–119:4, 126:14–15; Ex. S–17.) The falling roof also hit Hackney's left arm and right leg, causing bruises later. (II Tr. 8:9–10, 19:11–12, 20:1–6, 54:18–21, 75:9–10; Ex. S–17.) Hackney later testified that the roof hitting him felt "like somebody opened the door on you real hard." (II Tr. 20:1–3.) Lastly, the roof hit Hallman's arm, scraping it and causing bruises later. (II Tr. 8:14–16, 12:9–12, 75:2–3, 77:22–78:1, 118:18–19.)

2. Injured Miners and Warrior Met's Initial Response to the Accident

a. Injured Miners' Exit Elevator

After the impact, the miners rode the remaining short distance to the bottom of the elevator shaft. (I Tr. 30:10; II Tr. 74:17–18, 87:6–8.) Then the miners exited the elevator cage to avoid being struck by further ice debris. (I Tr. 31:3–14; II Tr. 9:16–18, 43:9–13.) To exit the elevator cage, the miners had to climb over some ice, as well as the cargo net attached to the elevator cage because they could not open the gate at the bottom of the elevator shaft. (II Tr. 9:19–22, 15:4–6, 42:12–18, 66:5–67:13, 72:16–21, 89:22–90:3.) The miners then walked approximately thirty feet towards a phone and a cache of first aid materials. (II Tr. 12:21–13:12, 43:16–17, 44:13–14, 90:22–91:2.)

Nichols testified that once he exited the elevator and sat down his adrenaline wore off and he started to feel immense pain, particularly in his knee, neck, and head. (I Tr. 30:13–31:2, 32:4–5, 32:11–17, 37:8–17, 69:2–20.) Hackney testified that Nichols was "screaming and squalling" and complaining about his knee. (II Tr 10:14–15, 11:5–8, 12:5–20, 15:8–16, 20:17–21:1, 44:2, 49:6–10, 64:20–65:2, 93:9–12.) Similarly, Hallman testified that Nichols said his knee was bothering him and he was emitting sounds of pain. (II Tr. 75:10–19, 76:16–22, 93:20–94:15.)

b. Hackney Notifies Warrior Met Management of the Accident

Between approximately 6:11 p.m. and 6:15 p.m., Hackney called North Portal Shift Foreman Tim Jenkins who was on the surface of the North Portal, to notify him that ice had hit the elevator cage, that he and the other miners sustained some injuries, and they needed help. (I Tr. 32:11–12, 79:1–13; II Tr. 17:22–18:8, 22:11–24:8, 43:1–8, 44:16–45:15, 63:15–20, 80:4–15, 91:6–16.) Jenkins responded that some miners at the West Portal could come help them. (II Tr. 18:2–5, 22:21–23:3.) Jenkins also stated he needed to go call "Carbon Monoxide" or "CO" Operator Charles Dickey, a member of Warrior Met management at the East Portal, to alert Dickey of the accident as well as call an ambulance. (II Tr. 18:7–8, 23:2–5.)

While Hackney was talking on the phone with Shift Foreman Jenkins, Hallman testified that the North Portal elevator cage was pulled up to the surface, but personnel on the surface reported that the cage could not be used to exit the mine due to its condition. (II Tr. 74:19–21, 76:4–6, 78:21–79:15, 95:9–11.) Nichols similarly testified that during Hackney's phone call, Jenkins initially suggested that the injured miners get back on the North Portal elevator to exit the mine, but Hackney refused to get on the elevator again. (I Tr. 44:22–45:7, 45:15–46:9, 74:11–17.)

After receiving Hackney's call, Shift Foreman Jenkins[9] called Foreman Jonathan Pippin at the West Portal at approximately 6:10 p.m. shortly after Pippin's shift began. (II Tr. 114:3–22, 131:3–6.) Jenkins informed Pippin that an incident occurred involving the North Portal elevator cage with injured miners who needed help. (II Tr. 114:12–115:16.) After the call, Pippin and other miners at the West Portal prepared to go underground and meet the injured miners. (II Tr. 114:12–115:19.) Upon arriving underground, Pippin and the other miners gathered a stokes basket, used to carry injured miners, and a first-responder kit containing first aid materials and took two man buses to travel towards the North Portal. (II Tr. 115:20–116:17, 139:19–22.)

After speaking with Shift Foreman Jenkins, Hackney checked on the other miners; Hallman told him he was fine, aside from his arm hurting, while Nichols was still complaining about his knee. (II Tr 12:5–20, 15:8–16, 20:17–21:1, 21:12–16, 22:8, 46:6–13, 49:6–10, 64:20–65:2, 93:9–12.) Hackney offered to put an air splint on Nichols's leg but warned that it could cause more pain, so Nichols rejected the splint. (II Tr. 11:9–12:2, 15:17–16:5, 19:7–9.) Hackney gave Nichols some paper towels to absorb the blood coming from his mouth. (II Tr. 19:3–6.) Hallman also offered Nichols an instant cold pack from the first aid kit, but Nichols did not use it. (II Tr. 95:4–6, 103:21–104:9.)

c. CO Operator Dickey's Response to the Accident

At approximately 6:16 p.m., CO Operator Dickey sitting in his office on the surface of the East Portal, called Hackney, and asked what had happened. (I Tr. 242:14–19, 275:3–276:4; II Tr. 23:6–7, 80:14–18.) Hackney told Dickey that ice fell down the elevator shaft of the North Portal and dislodged part of the elevator's roof, hitting Hackney and two other miners. (I Tr. 246:22–248:2, 263:4–12, 266:8–18; II Tr. 23:6–17.) Hackney specified that the roof hit his forehead and the right side of his body, Hallman's arm, and Nichols' face. (I Tr. 248:6–12, 266:19–267:5; II 46:14–47:17.) Hackney reported that the other miners were alert, walking, and talking. (I Tr. 248:3–12, 250:7–8.) Yet Dickey noticed that Hackney was speaking in an excited demeanor during the call. (I Tr. 268:4–22, 273:20–21; II Tr 52:1–15.) Indeed, Hackney testified that he experienced a burst of adrenaline after the accident occurred. (II Tr. 9:1–7.)

[9] Pippin testified that Tim "King" called him. (II 114:19–22.) However, Pippin also noted that Tim was the Shift Foreman for the North Portal, therefore I infer that he was referring to Tim Jenkins, the Shift Foreman for the North Portal the night of the accident. (II Tr. 114:10–14.)

Hackney and CO Operator Dickey ultimately agreed the miners would exit the mine by driving an electric-powered vehicle called a "man bus" towards the West Portal of the mine rather than take the North Portal elevator hoist again or wait for the miners from the West Portal to arrive at the North Portal. (I Tr. 32:18–33:5, 44:11–20, 74:15–75:6, 249:5–16, 267:14–16, 269:1–3; II Tr 25:7–15, 47:18–48:20.) The path between the North and West Portals is approximately 28,000 feet or 5.3 miles. (I Tr. 222:22–223:2; Ex. R–1.)

After talking with Hackney about the accident, CO Operator Dickey testified that he called the staff at the surface of the North Portal to report that ice had fallen on the elevator cage, and therefore they did not need to pull the elevator cage up until it was checked. (I Tr. 250:21–251:4, 251:12–18, 269:10–13.) Next, Dickey testified that he called the West Portal and asked that someone who had first-responder training go towards the North Portal to meet the injured miners on their way towards the West Portal. (I Tr. 251:5–252:9, 269:14–19.) The miner in charge of the West Portal responded that they were sending Foreman Pippin and other miners to meet the injured miners. (I Tr. 252:11–13.)

After calling the West Portal, CO Operator Dickey called Mine Manager Craig Dickerson, who was at home having Christmas dinner. (I Tr. 216:4–6, 253:12–13.) Dickey informed Dickerson that ice had fallen down the North Portal elevator shaft, knocking down part of the elevator's roof which struck three miners inside the elevator cage. (I Tr. 216:10–12, 227:8–11, 254:4–8.) Dickey shared that the three miners were injured, and they were on a man bus heading towards the West Portal. (I Tr. 227:10–11, 254:8–11.) In response, Dickerson directed Dickey to go to the West Portal and help organize the response there. (I Tr. 216:15–17.) Dickerson testified that he also told Dickey they should prepare the North Portal as a backup option for the injured miners to exit the mine, in case there were issues exiting the mine via the West Portal. (I Tr. 216:13–18, 223:17–224:8, 225:7–13, 230:7–10.) Dickerson testified that as Mine Manager, he instructed the miners at the North Portal to "get [the North Portal elevator] out, [and] get [the North Portal elevator] ready" at an unspecified time. (I Tr. 224:8.) Immediately after speaking with Dickey, Dickerson drove to the West Portal at the No. 7 Mine. (II Tr. 217:6–8, 227:12–22.)

Then after speaking with Mine Manager Dickerson, some time between approximately 6:40 p.m. and 7:00 p.m., CO Operator Dickey called Ed Boylen, the Director of Compliance, who was at home, but on-call during the holiday weekend. (I Tr. 200:12–16, 205:20–21, 254:22–255:2.) Dickey informed Boylen that ice fell down the North Portal elevator shaft, dislodging the elevator's roof which struck three miners and injured them. (I Tr. 201:8–9, 255:3–5, 259:18–260:1.) Dickey shared that the three miners were currently traveling towards the West Portal and someone from the West Portal was coming to meet them. (I Tr. 255:6, 260:1–3.) Dickey also told Boylen that he still had to call the "ambulance company." (I Tr. 273:1–8.) Upon learning the North Portal elevator cage was damaged, Boylen asked Dickey whether anyone had called MSHA since the law[10] requires operators to report damaged elevators

[10] Section 50.10 provides that an "operator shall immediately contact MSHA at once without delay and within 15 minutes . . . once the operator knows or should know that an accident has occurred involving: . . . [a]ny other accident." 30 C.F.R. § 50.10(d). Section 50.2 provides several definitions of "accident" including: "[d]amage to hoisting equipment in a shaft

that are inoperable for more than thirty minutes. (I Tr. 201:12–18, 208:16–18, 211:16–212:2, 260:3–12.) Dickey responded that no one had called MSHA. (I Tr. 201:19–21.) Boylen replied that they were obligated to call MSHA because it had been over thirty minutes. (I Tr. 201:21–202:2, 260:3–6.)

At approximately 7:00 p.m., CO Operator Dickey called the MSHA hotline to report the accident. (I Tr. 278:17–19; Ex. S–8.) The MSHA operator who answered Dickey's call recorded the following notes in the escalation report:[11]

> [t]he caller, who is the Field Supervisor, is reporting the injuries of three miners. There was ice that fell down to the bottom of the service shaft, and the three men on the elevator at the time sustained injuries from the falling ice. The incident occurred at the bottom of the #7 North Service Elevator. An ambulance has been called and is en route. The miners will be staying at either Druid City Hospital in Tuscaloosa, Alabama, or at The University of Alabama, Birmingham-West, located in Bessemer, Alabama.

(Ex. S–8.) The escalation report generated by the MSHA hotline at 7:28 p.m. does not mention that the North Portal elevator was inoperable for more than thirty minutes. (Ex. S–8.) Under the section, "Information Provided to Caller," the report states "Solution: MSHA – EMERGENCY – COAL MINE – LIFE THREATENING INJURY." (Ex. S–8.)

d. Night Shift Foreman Burdette calls 911

CO Operator Dickey testified that he had Jeremy Burdette, the Night Shift Foreman for the East Portal, come to assist him with addressing the accident. (I Tr. 288:1–6, 290:11–291:3.) At an unknown time, Burdette[12] called 911 and requested that two ambulances go to the West Portal. (Ex. S–16; I Tr. 205:8–10, 286:7–287:18.)[13] During the call, Burdette reported that they had three injured miners with a head injury, an arm injury, and a leg injury. (Ex. S–16; I Tr. 284:5–8.) Burdette also requested the ambulances use lights and sirens to get there as quickly as possible. (Ex. S–16.)

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or slope which endangers an individual or which interferes with use of the equipment for more than thirty minutes." 30 C.F.R. § 50.2(h).

[11] If an accident is reported to the MSHA hotline it is recorded in an escalation report which is emailed to MSHA staff. (I Tr. 84:12–21.)

[12] Before counsel for the Secretary played the audio recording of the 911 call at the hearing, Dickey mistakenly believed he himself had called 911. (I Tr. 256:1–258:7, 273:1–5, 274:17–22, 281:3–16.)

[13] In the recording, Burdette did not request a helicopter. (Ex. S–16.) However, the 911 operator ordered a helicopter which arrived on the scene and transported Nichols to UAB hospital. (Ex. S–16; I Tr. 39:21–40:3, 58:19–22,62:3–4, 112:17 –20, 143:7–14; II Tr. 99:18–100:5, 220:19–21, 230:22–231:4.)

3. Injured Miners Exit Mine

Approximately twenty to thirty minutes after the ice struck the elevator cage, or between 6:30 p.m. and 6:40 p.m., Nichols, Hackney, and Hallman boarded a man bus and headed towards the West Portal, with Hallman driving and Nichols propping his injured leg in Hackney's lap. (I Tr. 33:2–3, 38:7–14, 44:11–14, 67:6–19; 70:8–13; II Tr. 25:13–19, 26:14–21, 50:8–17, 76:6–8, 95:12–20, 96:16–97:10, 117:17–18.) When the three injured miners neared the East Portal, between Crosscuts 100 and 115, they made contact with Foreman Pippin and the other miners from the West Portal. (II Tr. 25:21–26:1, 27:16–28:7, 30:7–15, 48:21–49:5, 99:2–6, 116:21–117:6.) At approximately 6:50 p.m., Pippin radioed CO Operator Dickey to inform him they found the injured miners. (II 122:20–123:8, 131:3–132:17.)

Upon encountering the injured miners, Foreman Pippin noticed they were all alert and could talk. (II Tr. 117:14–118:8, 119:12.) Hallman informed Pippin that his arm was hurting but, overall, he was okay. (II Tr. 118:18–19, 141:22–142:5.) Pippin checked out Hackney after observing blood on his face but concluded he only had a small laceration, which had stopped bleeding. (II Tr. 118:19–119:4, 126:22–127:2, 142:6–11.) Nichols told Pippin that his knee and leg were hurting, and he had a deep cut inside his mouth. (II Tr. 119:5–8, 142:12–143:1.) Nichols testified that he struggled to remember their exit out of the mine, because he was in such intense pain during their journey. (I Tr. 66:16–67:6, 68:18–69:20; II Tr. 104:15–20.)

Foreman Pippin asked Hallman if he was okay to continue driving to the West Portal, and Hallman responded that he was fine to do so. (II Tr. 98:22–99:1, 119:21–120:2.) Pippin joined the injured miners on their man bus, and they headed towards the West Portal. (II Tr. 28:17–29:9, 98:16–21, 123:9.) During his journey with the injured miners, Pippin radioed CO Operator Dickey and told him the miners were alert; Hallman's arm was hurting; Hackney had a laceration on his face and was experiencing other general pain; and Nichols had an injured knee and mouth. (II Tr. 123:2–124:4.)

When the miners arrived at the West Portal, they splinted Nichols' leg and put him in the stokes basket to easily transport him into the elevator cage. (I Tr. 38:15–39:5, 68:2–11, 75:18–20; II Tr. 26:7–9, 33:1–5, 121:14–17, 121:22–122:14.) Afterwards, Hallman and Hackney walked into the elevator cage, and they rode up the West Portal elevator hoist along with Foreman Pippin and the other miners. (II Tr. 121:18–21, 127:11–14.)

4. Injured Miners Transported to Hospitals and Subsequent Release

Upon the miners' arrival at the surface of the West Portal, first-responders, ambulances, and a helicopter were ready at the scene. (II Tr. 33:6–8, 51:10–15, 82:10–14, 99:15–22, 127:15–19.) Hallman did not feel he was hurt enough such that he needed to go to the hospital, but Mine Manager Dickerson requested that he go to the hospital anyway. (II Tr. 82:14–83:1, 100:6–10.) Hallman refused pain medicine during the ambulance ride. (II Tr. 101:3–7.) Hallman was released from the hospital the same night and was later cleared to work by Warrior Met's company doctor. (II Tr. 83:6–16, 100:11–19.) Hallman ultimately missed only one day of work due to the accident. (II Tr. 83:17–19.)

Hackney told the first-responders that he felt fine, but Warrior Met management also told him that he needed to go the hospital. (II Tr. 33:18–34:2.) At the hospital, Hackney was diagnosed with a closed head injury, abrasion of face, abrasion of right leg, and traumatic hematoma of upper left arm. (Ex. S–17; II Tr. 57:14–17.) Hackney was released from the hospital the same night and returned to work the next evening. (II Tr. 34:6–35:21.)

Nichols was transported to the hospital via helicopter. (I Tr. 39:21–40:3, 58:15–59:3, 62:3–4, 100:1–5.) Nichols bent the IV first-responders put in his arm due to the tight fist he made in response to his severe pain. (I Tr. 43:2–14.) Nichols testified that it was "the worst pain I ever felt." (I Tr. 43:13–14.) At the hospital, Nichols received stitches inside his mouth and got crutches for his injured knee. (I Tr. 40:4–9, 47:1.) Nichols was released from the hospital later that night. (I Tr. 40:10–14.) However, Nichols returned to the hospital two days later because he was experiencing headaches, and he was diagnosed with a concussion. (I Tr. 40:19–41:21; 57:22–58:4.) Nichols also later received an MRI which showed that the patella in his knee was injured. (I Tr. 36:12, 47:13–17.) Nichols did not return to work at the No. 7 Mine until a month and a half after the accident due to his knee injury. (I Tr. 46:14–48:21, 73:20–74:3.) Nichols testified that he still occasionally feels sharp pain in his neck and his knee hurts when it is cold outside. (I Tr. 36:9–11, 49:16–50:2, 52:10–16.)

5. MSHA Investigates Accident and Issues Two Citations

At some time between approximately 7:00 p.m. and 7:20 p.m., Warrior Met Vice President Rick Marlowe called MSHA Supervisor Thomas Chatham to inform him about the accident. (I Tr. 83:10–12.) Chatham then called MSHA Supervisor Sammy Elswick and shared the news about the accident. (I Tr. 83:12–14.) Shortly after the call from Chatham, at 7:28 p.m., Elswick received the escalation report for the incident generated by the MSHA hotline. (I Tr. 83:14–16; Ex. S–8.) Elswick then called Marlowe and asked about the accident. (I Tr. 94:8–16, 95:8–13.) Elswick told Marlowe that he would issue a section 103(k) order as soon as he arrived on site, so the scene needed to be preserved. (I Tr. 94:17–22, 112:21–113:8.) Elswick also called MSHA Supervisor Mark Schilke, who met him at the MSHA office, and they then went to the No. 7 Mine together. (I Tr. 84:2–6, 89:3–11.)

At approximately 9:45 p.m., MSHA Supervisors Elswick and Schilke arrived at the No. 7 Mine. (I Tr. 90:18–91:4; Ex. S–6.) Upon their arrival, Elswick noticed the elevator cage for the North Portal was on the surface and the lights were on, but the roof was disconnected. (I Tr. 92:8–13.) Elswick and Schilke then met with members of Warrior Met's management and learned that the accident occurred sometime between 6:10 p.m. and 6:16 p.m. (I Tr. 95:17–96:9, 113:19–115:10.) Warrior Met management also shared that a water line had frozen and busted open, causing water to leak and then freeze, which was likely the source of the ice that hit the North Portal elevator cage. (I Tr. 102:12–19, 130:12–17, 224:22–225:6, 232:10–14.)

After talking with management, MSHA Supervisors Elswick and Schilke inspected the elevator hoist operations for the North Portal. (I Tr. 96:10–97:13, 114:13–15.) Then Elswick and Schilke went to the North Portal elevator cage that had been brought to the surface. (I Tr. 100:8–11, 111:2–3.) Elswick and Schilke observed that the collapsed roof had already been removed from the elevator cage and was sitting about one-hundred feet away from the elevator

shaft. (I Tr. 97:14–102:7, 110:22–111:2; Exs. S–9, S–10, S–11.) The area around the North Portal elevator hoist had also been cleaned and swept. (I Tr. 92:14–15, 97:20–22, 111:3–5, 125:17–20.) Elswick also noticed that the heaters for the elevator shaft were running, causing the remaining ice in the North Portal elevator shaft to quickly melt. (I Tr. 103:11–19, 106:7–9, 126:10–12, 129:3–7, 130:7–11; Ex. S–6.) However, when Elswick touched the side of the heaters, he felt that they were cool, leading him to believe that the heaters had only recently been turned on. (I Tr. 102:22–103:10, 104:16–22, 128:4–6; Ex. S–6.)

a. Citation No. 9706550

Three days later, MSHA Supervisor Elswick issued two section 104(a) citations to Warrior Met. In Citation No. 9706550, Elswick wrote the following:

> The operator shall immediately contact MSHA at once without delay and within 15 minutes at the toll-free number, 1800-746-1553, once the operator knows or should know that an accident has occurred involving: An injury of a miner at the mine which has a reasonable potential to cause death. On December 25, 2022 at 6:16 pm the operator was notified of an accident that involved 3 miners that was entering the mine by traveling down the 7 North Mine hoist/elevator. This accident was caused by Ice that had broken loose and fell for a distance of approximately 1500 feet striking the top of the cage the miners were riding to access the mine. The ice broke the cage top and caused it to collapse on top of the 3 miners this causing injury to all 3 miners. The operator reported 1 head injury, 1 arm injury and 1 leg injury, 1 miner was transported by air and 2 by ambulance to nearby hospitals. The operator also failed to notify MSHA within the required time frame of the hoist being down and out of service. The operator was made aware of the accident at 6:16 pm and did not notify MSHA until 7:00 pm this is 44 minutes.

(Ex. S–4.)

MSHA Supervisor Elswick assessed the likelihood of injury or illness to be "reasonably likely," because there was still ice in the North Portal elevator shaft which could have fallen on miners and injured them if they used the elevator hoist. (Ex. S–4; I Tr. 116:15–117:6.) Elswick determined the violation could cause injury or illness resulting in "lost workdays or restricted duty" because "the miners were injured" and one was "airlifted out to the hospital." (Ex. S–4; I Tr. 117:10–118:2.) Elswick concluded three people could be affected by the violation since three miners were injured. (Ex. S–4; I Tr. 117:7–9.) Elswick designated the violation as S&S since miners were injured, and other miners could have continued to use the North Portal elevator hoist and been injured before MSHA inspected it. (Ex. S–4; I Tr. 118:3–119:5.) Lastly, Elswick assigned Warrior Met a "moderate" degree negligence "because they did call it in." (Ex. S–4; I Tr. 119:6–21.)

b. Citation No. 9706551

MSHA Supervisor Elswick then issued Citation No. 9706551, in which he wrote the following:

> Unless granted permission by a MSHA District Manager, no operator may alter an accident site or an accident related area until completion of all investigations pertaining to the accident except to the extent necessary to rescue or recover an individual, prevent or eliminate an imminent danger, or prevent destruction of mining equipment. On December 25, 2022 at 6:16 pm the operator was notified of an accident that involved 3 miners that was entering the mine by traveling down the 7 North Mine hoist/elevator. This accident was caused by Ice that had broken loose and fell for a distance of approximately 1500 feet striking the top of the cage the miners were riding to access the mine. The ice broke the cage top and caused it to collapse on top of the 3 miners, causing injury to all 3 miners. The operator reported 1 head injury, 1 arm injury and 1 leg injury, 1 miner was transported by air and 2 by ambulance to nearby hospitals. When MSHA arrived on site it was discovered that the accident site had been altered, the hoist/elevator had been moved to the surface from the bottom where the accident occurred, the cage top had been completely removed from the cage and was laying on the surface of the mine, all ice had been swept and removed from the cage. The operator had been working on a busted water line that was located directly beside the shaft that could have been a contributing factor to the ice build up in this shaft. The cage platform and surrounding areas had been cleaned and swept. There was no way MSHA could do an adequate accident investigation due to the altered accident scene.

(Ex. S–5.)

MSHA Supervisor Elswick determined the likelihood of injury or illness as a result of the violation to be "unlikely" and not result in any lost workdays because "this is more of . . . a paperwork" violation. (Ex. S–5; I Tr. 121:15–22.) Elswick concluded three people could be affected by the violation. (Ex. S–5.) Elswick assigned Warrior Met a "high" degree of negligence because all mine management personnel are trained to preserve an accident scene, and Warrior Met was told to preserve the scene. (Ex. S–5; I Tr. 122:4–11.)

B. Analysis and Conclusions of Law: Citation No. 9706550 – Immediate Notification Under § 50.10(b)

1. Statutory and Regulatory History of 30 C.F.R. § 50.10(b)

Section 50.10(b) provides:

> The operator shall immediately contact MSHA at once and without delay and within 15 minutes at the toll–free number, 1-800-746-1553, once the operator

> knows or should know that an accident has occurred involving: . . . (b) [a]n injury of an individual at the mine which has a reasonable potential to cause death.

30 C.F.R. § 50.10(b). Standard 50.10 was derived from section 103(j) of the Mine Act which states in relevant part that—

> [i]n the event of any accident occurring in any coal or other mine, the operator shall notify the Secretary thereof and shall take appropriate measures to prevent the destruction of any evidence which would assist in investigating the cause or causes thereof. For purposes of the preceding sentence, the notification required shall be provided by the operator within 15 minutes of the time at which the operator realizes that the death of an individual at the mine, or an injury or entrapment of an individual at the mine which has reasonable potential to cause death, has occurred.

30 U.S.C. § 813(j).

The fifteen-minute notification requirement in section 103(j) of the Mine Act was added by the Mine Improvement and New Emergency Response Act of 2006 (the "MINER Act"). MINER Act, Pub. L. No. 106-236, 120 Stat. 493 (2006). This amendment codified an MSHA emergency regulation that first imposed the fifteen-minute notification rule. S. REP. NO. 109-365, at 13 (2006); Emergency Mine Evacuation, 71 Fed. Reg. 12,252-01, 12,260 (Mar. 9, 2006) (to be codified at 30 C.F.R. pt. 50). Shortly after the MINER Act was enacted, MSHA promulgated a final regulatory version of the same notification requirement, codified at 30 C.F.R. § 50.10. Emergency Mine Evacuation, 71 Fed. Reg. 71,430-01, 71,434 (Dec. 8, 2006) (to be codified at 30 C.F.R. pt. 50). Lastly, on December 29, 2009, MSHA amended the regulation "to separately reflect the three categories of accidents in section 5 of the MINER Act, which require specific penalties for failure to report." Criteria and Procedures for Proposed Assessment of Civil Penalties/Reporting and Recordkeeping: Immediate Notification of Accidents, 74 Fed. Reg. 68,918-01 (Dec. 29, 2009) (to be codified at 30 C.F.R. pt. 50).

2. Violation of 30 C.F.R. § 50.10(b)

a. Time to Report Accident

The Secretary asserts that Hackney notified CO Operator Dickey about the accident at 6:16 p.m., at which point Warrior Met had fifteen minutes to report the accident to MSHA, or until 6:31 p.m. (Sec'y Br. at 19.) Since Warrior Met did not report the accident to MSHA until 7:00 p.m., forty-four minutes after it learned of the accident, the Secretary argues Warrior Met violated section 50.10(b). (Sec'y Br. at 19.) In contrast, Warrior Met argues that the fifteen-minute period to contact MSHA should not have begun to run until Foreman Pippin arrived on the scene to assess the three injured miners' conditions. (Resp't Br. at 15–16.) Specifically, Warrior Met asserts that it was not in a position to conduct an analysis of the miners' injuries and conditions until it had a first-responder on the scene. (Resp't Br. at 16; Resp't Reply Br. at 7.)

The preamble to section 50.10 states that "MSHA recognizes that an operator may not know instantly when an accident occurs, but emphasizes that the operator must make that determination promptly, consistent with the underlying purpose of the standard." 71 Fed. Reg. 71,430-01, 71,435–36 (Dec. 8, 2006). Similarly, the Commission has held that "[o]nce a person with sufficient authority to call learns of an event injuring a miner, the clock begins to run on the period for evaluation of whether the injury presents a reasonable potential to cause death and a determination of whether a call is required." *Signal Peak Energy, LLC*, 37 FMSHRC 470, 476 (Mar. 2015). The Commission has also held that permitting operators to wait for a medical or clinical opinion before determining whether they need to call MSHA "would 'frustrate the immediate reporting of near fatal accidents.'" *Signal Peak Energy, LLC*, 37 FMSHRC 470, 476 (Mar. 2015) (citing *Cougar Coal Co.*, 25 FMSHRC 513, 520-21 (Sept. 2003)); *see also Consol Pa. Coal Co.*, 40 FMSHRC 998, 1003 (Aug. 2018), *aff'd*, 941 F.3d 95 (3d Cir. 2019) (holding that section 50.10(b) "does not look to an opinion of a medically qualified expert"). Therefore, I agree with the Secretary that once CO Operator Dickey, a member of Warrior Met management, learned of the accident at 6:16 p.m. the clock began to run on the fifteen-minute period for Warrior Met to determine whether it needed to notify MSHA. (I Tr. 275:15–21.)

b. Whether Miners Suffered Injuries Which Had a Reasonable Potential to Cause Death

i. Regulatory Background and Case Law on Injuries with a Reasonable Potential to Cause Death

In the preamble to section 50.10, the Secretary notes that "[i]n using the 'reasonable potential to cause death' basis for injuries and entrapments, the MINER Act and the final rule retain an element of judgment." 71 Fed. Reg. 71,430-01, 71,433 (Dec. 8, 2006). Similarly, the Commission has not provided a firm definition of "reasonable potential to cause death," but has held that "[a] person with sufficient authority to call must make the decision to call based upon whether a reasonable person with the information known by him/her would have considered the injuries as creating a reasonable potential for death." *Consol Pa. Coal Co.*, 40 FMSHRC 998, 1004 (Aug. 2018), *aff'd*, 941 F.3d 95 (3d Cir. 2019).

However, given the need for prompt reporting, the Commission has held that "readily available information such as the nature of the accident and any observable indicators of trauma are relevant and proper for consideration in assessing whether an injury is reportable." *Consol Pa. Coal Co.*, 40 FMSHRC at 1003 (citing *Signal Peak Energy, LLC*, 37 FMSHRC 470, 476 (Mar. 2015)). The Commission has also endorsed consideration of the "totality of the circumstances" when assessing whether a 50.10(b) violation has occurred. *Id*.

Additionally, the Commission has held "that an operator, in determining whether it is required to notify MSHA under 30 C.F.R. § 50.10, must resolve any reasonable doubt in favor of notification." *Signal Peak Energy, LLC*, 37 FMSHRC at 477. Therefore, if an operator is unable to conclusively determine, within 15 minutes, that an accident does not involve any injury that has a reasonable potential to cause death, it must notify MSHA.

Indeed, the Commission has repeatedly rejected the assertion that because a miner is conscious and alert following an accident, an operator can reasonably conclude that there was no potential for death. *See Cougar Coal Co.*, 25 FMSHRC 513, 520 (Sept. 2003); *Signal Peak Energy, LLC*, 37 FMSHRC at 476; *Consol Pa. Coal Co.*, 40 FMSHRC at 1006.

ii. Parties' Arguments Regarding whether Miners' Injuries had a Reasonable Potential to Cause Death

The Secretary alleges that "Nichols sustained a concussion, a laceration to the inside of his jaw, a neck injury, and a patella tendon injury." (Sec'y Br. at 21.) Additionally, the Secretary asserts that "Hackney sustained a closed head injury, abrasion to the face, abrasions of the right leg, and a traumatic hematoma of upper left arm." (Sec'y Br. at 21.) The Secretary argues that Nichols and Hackney's head injuries had a reasonable potential to cause death. (Sec'y Br. at 19.) The Secretary contends that Hackney's phone call with CO Operator Dickey put Dickey on notice that a large piece of ice had fallen almost 1,500 feet, or the length of five football fields, striking the elevator cage's roof which hit the miners inside, and causing head injuries to two of the miners. (Sec'y Reply Br. at 3.) The Secretary argues that the nature of the miners' injuries, the nature of the event, and the totality of the circumstances would lead a reasonable person to conclude that there was a reasonable potential for death. (Sec'y Reply Br. at 3.)

In contrast, Warrior Met argues—after the fact and well after more than 15 minutes had passed—that it was evident neither Hackney, Hallman, nor Nichols suffered any injury posing a reasonable potential to cause death. (Resp't Br. at 14.) While Warrior Met acknowledges that Hackney and Nichols sustained head injuries, it asserts that they were not life-threatening injuries. (Resp't Br. at 17.) Warrior Met also highlights that all three miners were wearing helmets at the time of the impact, and they were alert and talking with each other after the impact. (Resp't Br. at 14.) Moreover, Warrior Met notes that CO Operator Dickey learned that all three miners were alert, walking, and communicating after the accident from his phone call with Hackney at approximately 6:16 p.m. (Resp't Reply Br. at 6; I Tr. 275:15–276:4.)

iii. Head Trauma

It is undisputed that both Nichols and Hackney sustained head trauma as result of the accident. (Sec'y Br. at 21; Resp't Br. at 17.) Specifically, Nichols sustained a head injury, a neck injury, and a deep laceration inside his mouth causing him to spit up blood after the crash. (I Tr. 30:14–15, 32:13–15, 33:12–15, 34:14, 36:9–37:7, 72:22–73:19; II Tr. 10:16–17, 11:7–8, 19:3–6, 46:9, 75:10–12, 88:6–10, 93:5–6, 94:1–6, 119:7–8, 233:21–234:8.) Nichols also briefly lost consciousness after the roof hit him. (I Tr. 29:20–30:2, 33:16–22.) Moreover, Nichols returned to the hospital two days after he was initially released because he was experiencing headaches, and he was diagnosed with a concussion. (I Tr. 40:19–41:21; 57:22–58:4.) Hackney sustained a laceration to his forehead as a result of the roof hitting him and he was diagnosed with a closed head injury at the hospital later that night. (I Tr. 35:20–21; II Tr. 19:10–12, 19:20–20:3, 41:9–10, 54:4–17, 57:3–17, 60:5–15, 75:9–10, 118:19–119:4, 126:14–15; Ex. S–17.) Additionally, while both Hackney and Nichols were wearing hard hats inside the elevator, the

force of the roof collapsing knocked both of their hard hats off their heads. (I Tr. 42:5–19; II Tr. 19:13–19, 41:1–8.)

The preamble to section 50.10 states that "[b]ased on MSHA experience and common medical knowledge, some types of 'injuries which have a reasonable potential to cause death' include concussions." 71 Fed. Reg. 71,430-01, 71,434 (Dec. 8, 2006). Indeed, blunt force trauma to the head can have serious, delayed consequences that are not immediately visible. Specifically, swelling or bleeding in the cranial cavity pose a significant risk of death. Even in circumstances where a miner demonstrates stable vital signs and minimal blood loss immediately after a head injury, there is still a risk of death. Here, Nichols returned to the hospital after his initial release because he was experiencing headaches. (I Tr. 40:19–41:21; 57:22–58:4.) This fact demonstrates that the extent of injuries following head trauma will generally not be known within the required fifteen-minute reporting time. Thus, given the potential for latent fatal outcomes, operators generally should assume severe trauma to the head to be serious and report it immediately, even if the injured miner shows no obvious signs of distress in the immediate aftermath.

I therefore determine that a reasonable operator would recognize that a significant blow to the head, like those sustained by Nichols and Hackney, has a reasonable potential to cause death.

c. Whether Warrior Met Knew or Should Have Known the Miners Suffered Injuries Which Had a Reasonable Potential to Cause Death

i. 15-minute Window to Report

Section 50.10(b) requires operators to make a prompt determination of whether an accident has occurred, often under stressful and chaotic circumstances. *Consolidation Coal Co.*, 11 FMSHRC 1935, 1938 (Oct. 1989). Indeed, the repeated language of urgency in the standard leaves no doubt that operators must quickly decide whether to report an accident to MSHA as it states: "operator[s] shall immediately contact MSHA at once without delay and within 15 minutes." 30 C.FR. § 50.10. In the preamble to section 50.10, the Secretary explains that this language highlights "that reporting must be done promptly." 71 Fed. Reg. 71,430-01, 71,436 (Dec. 8, 2006).

Given the time constraint, operators often must decide whether to call MSHA before they can conduct a comprehensive investigation into the extent of miners' injuries. Thus, the decision whether to call MSHA must be based on a very limited knowledge of the facts surrounding the injuries and the nature of the accident. In the preamble to section 50.10, the Secretary explains that an operator often will not know "whether a person has been injured or killed or whether the event is life threatening" within the fifteen-minute window, but will know "the general character of an event" which is sufficient to determine whether it needs to report the incident to MSHA. 71 Fed. Reg. 71,430-01, 71,435 (Dec. 8, 2006).

Here, no member of Warrior Met management was able to visually or physically assess the injured miners during the fifteen-minute reporting window. Warrior Met had to determine

whether to call MSHA based solely on the information that Hackney reported to CO Operator Dickey. Dickey testified that Hackney told him that—

> ice had fallen down the shaft, and it hit the surface elevator, dislodging half of the elevator roof. It had not completely fallen, but it had dislodged it and had hit three employees at the bottom . . . [Hackney] said he had been hit in the forehead right there and – I think in his side right there . . . And the other two guys there – one guy had been hit in the arm right there, and the other guy looks like he had been hit in the face. And they were walking, and they were able to talk.

(I Tr. 246:22–248:12.) Similarly, Hackney testified that he told Dickey that "some ice came in on the cage. We're hurt and need some help." (II Tr. 23:8–10.)

Thus, CO Operator Dickey – based off his phone call with Hackney – learned that ice falling down a 1500-foot shaft struck the North Portal elevator cage's heavy, steel roof collapsing on three miners inside, specifically hitting two of the miners on their heads. Dickey may not have known other details, such as the fact that Nichols briefly lost consciousness, suffered a severe laceration inside his mouth, and injured his knee. (I Tr. 274:10–16.) However, under section 50.10, operators have a duty to adequately assess accidents to determine whether notification is required. *See Mainline Rock & Ballast, Inc. v. Sec'y of Labor*, 693 F.3d 1181, 1189 (10th Cir. 2012) (holding that operator's ignorance of the severity of injured miner's condition did not excuse its failure to timely report the accident). Additionally, in the preamble to section 50.10, the Secretary states that injuries which have a reasonable potential to cause death can result from various indicative events, including roof instability. 71 Fed. Reg. 71,430-01, 71,434 (Dec. 8, 2006). Therefore, the circumstances of this accident should have alerted Dickey to the need for further inquiry into the gravity of the miners' injuries.

Warrior Met argues that the mere fact of a head injury, without more, does not trigger the immediate notification requirement of section 50.10(b). (Resp't Reply Br. at 6–7.) I agree that the mere fact of a head injury alone may not trigger the immediate notification requirement of section 50.10(b). However, the knowledge that a piece of ice fell nearly 1,500 feet and struck a large, heavy steel roof with such intensity that it partially caved in and crashed into the miners' heads, causing injuries, would lead a reasonable operator to conclude that the trauma to the miners' heads had a reasonable potential to cause death. Additionally, while Hackney told CO Operator Dickey that he and the other miners were alert, walking, and talking after the accident, Dickey also noticed that Hackney was speaking in an excited manner during their call, which can be a possible indicator of shock. (I Tr. 248:3–12, 250:7–8, 268:4–22, 273:20–21, 275:15–276:4; II Tr 52:1–15.)

The Commission has held that operators must resolve any reasonable doubt in favor of notification when determining whether they need to notify MSHA of an accident. *Signal Peak Energy, LLC*, 37 FMSHRC at 477. Under this presumption, I determine that the information CO Operator Dickey learned was sufficient for him to reasonably conclude the miners may have suffered injuries, like head trauma, which had a reasonable potential to cause death. Therefore, Dickey was obligated to follow the requirements of section 50.10(b) and notify MSHA of the accident.

ii. Warrior Met's Response to the Accident

The Secretary argues that CO Operator Dickey's response to the accident proves Warrior Met's awareness that the miners' injuries had a reasonable potential to result in death. (Sec'y Br. at 23.) In support, the Secretary notes that Dickey testified that the severity of the injury dictates his response and for severe injuries he ensures that first aid is readily available. (Sec'y Br. at 21–22.) The Secretary also highlights that Warrior Met ultimately reported the accident to MSHA. (Sec'y Br. at 23.)

Warrior Met disputes that it reported the accident to MSHA because it believed the miners suffered injuries with a reasonable potential to cause death. (Resp't Br. at 19.) Rather, Warrior Met asserts that it only reported the accident because the elevator hoist was down for more than thirty minutes, and thus it was a reportable accident to MSHA under 30 C.F.R. § 50.2(h)(11). (Resp't Br. at 19.) However, CO Operator Dickey's call to MSHA belies Warrior Met's assertion that it only reported the accident to MSHA due to the damaged elevator hoist not being operable for more than thirty minutes. The escalation report indicates Dickey focused on reporting the injuries that occurred because of the accident and makes no mention that the elevator hoist was down for more than thirty minutes, as Warrior Met claims. (Ex. S–8.) From the escalation report one could reasonably infer that Warrior Met knew it needed to report the accident under section 50.10(b) but failed to do so within the fifteen-minute window; the lack of any mention of the elevator hoist being down for more than thirty minutes looks to be a post-hoc justification for its section 50.10(b) violation under the guise of 30 C.F.R. § 50.2(h)(11).

Warrior Met also argues that it only brought the North Portal elevator cage to the surface to prepare it as an alternative exit. (Resp't Br. at 21–22.) Indeed, Mine Manager Dickerson testified that after speaking with CO Operator Dickey on the phone, at some time between approximately 6:45 p.m. and 7:00 p.m., he ordered the North Portal elevator to be brought to the surface and prepared as a backup option for the miners to exit the mine, in case any issues arose exiting via the West Portal. (I Tr. 216:13–18, 223:17–224:8, 225:7–13, 230:7–10.) However, Hallman testified that while he and the other injured miners were still at the bottom of the North Portal, at some time between approximately 6:11 p.m. and 6:35 p.m., "Hackney called on the phone outside and told them what happened. They pulled the cage up and said the cage was down . . . it couldn't be rode, that we would have to go to the West side." (II Tr. 78:21–79:10.) Similarly, Nichols testified that Shift Foreman Jenkins suggested in his call with Hackney that the miners exit the mine via the North Portal elevator, but Hackney refused to ride the elevator since it did not have a roof. (I Tr. 44:22–45:7, 45:15–46:9, 74:11–17.)

I credit Hallman and Nichols' testimony as they were present at the scene of the accident and observed the elevator cage being moved to the surface of the mine. (I Tr. 44:22–45:7, 45:15–46:9, 74:11–17; II Tr. 74:19–21, 76:4–6, 78:21–79:10.) Accordingly, I find that upon first learning of the accident around 6:15 p.m., Warrior Met believed the miners' injuries could be dire enough that the miners should exit the mine through the quickest method—the North Portal elevator—and therefore it brought the North Portal elevator cage to the surface to assess its functionality. However, after inspecting the North Portal elevator cage on the surface and deliberating with Hackney, Warrior Met directed the injured miners to exit the mine via the West Portal. Given this longer journey, Warrior Met also ordered miners with first-responder training

to meet the injured miners along the way, further indicating its concern for the injured miners. (I Tr. 251:5–252:9, 269:14–19.) Accordingly, I determine that Warrior Met's handling of the damaged elevator cage demonstrates that it believed the injured miners could be in grave danger.

For the reasons discussed above, I conclude that based on the totality of the circumstances, a reasonable mine operator would have at the very least resolved any doubts regarding the severity of the injuries caused by the accident in favor of notification, as required by Commission case law. Accordingly, I conclude that Warrior Met violated section 50.10(b) by failing to report the accident to MSHA within 15 minutes after learning about it at 6:16 p.m.

3. S&S Analysis for Violation of 30 C.F.R. § 50.10(b)

a. Underlying Violation of a Mandatory Safety Standard

To establish the first element of the *Mathies* test, the Secretary must prove an underlying violation of a mandatory safety standard. *Mathies Coal Co.*, 6 FMSHRC 1, 3 (Jan. 1984). I concluded that Warrior Met violated section 50.10(b). *See* discussion *supra* Part VI.B.2. Thus, I determine that the Secretary has satisfied the first element of the *Mathies* test.

b. Likelihood of Causing the Occurrence of the Discrete Safety Hazard Against Which the Standard Is Directed

For the second *Mathies* element, the Secretary must establish that "based upon the particular facts surrounding the violation, there exists a reasonable likelihood of the occurrence of the hazard against which the mandatory safety standard is directed." *Newtown Energy, Inc.*, 38 FMSHRC 2033, 2038 (Aug. 2016). In assessing this element, "[t]he Commission . . . defines the 'hazard' in terms of the prospective danger the cited safety standard is intended to prevent." *Id.*

In the preamble to section 50.10, the Secretary states that "[t]imely reporting can be crucial in emergency, life-threatening situations to activate effective emergency response and rescue." 71 Fed. Reg. 71,430-01, 71,435 (Dec. 8, 2006). The Secretary adds that "[e]ven where MSHA does not activate an emergency response, the Agency conducts an investigation. Prompt notification enables MSHA to secure an accident site, preserving vital evidence that can otherwise be easily lost. In addition, prompt notification provides MSHA with data to accurately determine trends and means of prevention." *Id.* Thus, the Commission has held that "[w]hile immediate rescue efforts are a significant concern, section 50.10 is also intended to facilitate MSHA's ability to investigate and remedy the cause of an accident." *Signal Peak*, 37 FMSHRC at 480; *see also Consol Pa. Coal Co. v. FMSHRC*, 941 F.3d 95, 105 (3d Cir. 2019) (holding that the purpose of the notification requirement in 50.10(b) is "to encourage rapid notification so that MSHA can respond effectively in an emergency and preserve evidence to facilitate later investigation").

Two ambulances and a helicopter along with first-responders arrived on site by the time Nichols, Hackney, and Hallman were evacuated to the surface, so Warrior Met's failure to timely

notify MSHA did not impair otherwise mobilized MSHA rescue efforts. (II Tr. 33:6–8, 51:10–15, 82:10–14, 99:15–22, 127:15–19.)

However, the Secretary argues that Warrior Met's failure to timely report the accident could have resulted in injuries to additional miners who may have continued to use the North Portal elevator after the accident. (Sec'y Br. at 23; I Tr. 118:8–19.) Indeed, as I previously found, after the accident Warrior Met moved the North Portal elevator cage to the surface to determine whether the injured miners could use it to exit the mine. *See* discussion *supra* Part VI.B.2.c.ii. Nichols testified that Warrior Met suggested that the injured miners use the North Portal elevator to exit the mine, but Hackney refused to get on the elevator again since it did not have a roof. (I Tr. 44:22–45:7, 45:15–46:9, 74:11–17.) Yet, had the injured miners agreed to use the damaged North Portal elevator hoist to exit the mine as Warrior Met initially suggested, they would have faced the potential hazard of more ice[14] hitting them without a proper roof to protect them this time. Thus, due to MSHA's impeded ability to secure and assess the accident scene, I determine that a reasonable likelihood existed that the miners could have used the North Portal elevator to exit the mine and been severely injured by additional ice snapping off and hitting them.

Additionally, Warrior Met moved the North Portal elevator cage to the surface and removed the elevator's damaged roof as well as the ice that hit the elevator before MSHA personnel arrived at the scene. (I Tr. 224:8–12; II Tr. 74:19–21, 76:4–6, 78:21–79:10.) During his inspection, MSHA Supervisor Elswick noticed that the area around the North Portal elevator hoist had also been cleaned and swept. (I Tr. 92:14–15, 97:20–22, 111:3–5, 125:17–20.) Consequently, Elswick testified that he "was not able to perform an investigation because the scene had been changed." (I Tr. 138:19–20.) Furthermore, because Elswick did not learn of the accident until approximately 7:20 p.m.—over one hour after it occurred—he was not able to conclusively determine whether the heaters for the North Portal elevator shaft were on at the time of accident by seeing if heat was still radiating from the heaters during his inspection later that night. (I Tr. 83:10–12, 103:6–19, 104:9–22, 128:4–6, 226:7–10, 233:4–10.)

Thus, Warrior Met's delayed reporting and subsequent actions prevented MSHA from promptly and fully investigating the cause of the ice accumulating in the North Portal elevator shaft and, in turn, MSHA was unable to identify and remedy similar hazards that may require correction, thereby resulting in the possibility of similar accidents occurring during continued normal mining operations. Specifically, MSHA was not able to conclusively determine whether a frozen pipe, broken heaters, failure to properly use the heaters, or a combination of factors caused the ice to accumulate in the North Portal elevator shaft. Due to MSHA's impeded investigation, I determine that there exists a reasonable likelihood that another similar ice accident could occur during continued normal mining operations. Accordingly, I determine that the Secretary has satisfied the second element of the *Mathies* test.

[14] MSHA Supervisor Elswick observed and photographed the remaining ice in the North Portal elevator shaft during his inspection after the accident. (I Tr. 105:12–106:19, 126:6–7; Exs. S–13, S–14.)

c. Likelihood the Occurrence of the Hazard Would Cause Injury

Regarding the third *Mathies* element, the Secretary must demonstrate a reasonable likelihood that the occurrence of the hazard would result in an injury. *Mathies Coal Co.*, 6 FMSHRC 1, 3–4 (Jan. 1984). Thus, the Secretary must establish that based upon the particular facts surrounding this violation, the occurrence of another ice accident would be reasonably likely to cause injury. The Secretary argues that further injury could have occurred as a result of the cited hazard. (Sec'y Br. at 23.)

I determine that there exists a reasonable likelihood that the hazard of another ice accident would result in miners sustaining injuries such as lacerations, broken bones, concussions, and internal bleeding. Thus, I determine that the Secretary has satisfied the third element of the *Mathies* test.

d. Likelihood Resulting Injury Would be of a Reasonably Serious Nature

Lastly, under the fourth *Mathies* element, the Secretary must prove a reasonable likelihood that the resulting injury would be of a reasonably serious nature. *Mathies Coal Co.*, 6 FMSHRC 1, 4 (Jan. 1984). The Secretary argues that "evidence proves that serious injury could occur as a result of the cited hazard." (Sec'y Br. at 23.) In support, the Secretary asserts that "[t]wo miners sustained potentially fatal injuries during the accident." (Sec'y Br. at 23.)

As evidenced by the injuries Nichols and Hackney sustained, ice falling and striking a miner or nearby equipment has the potential to result in an extremely serious injury. *See* discussion *supra* Part VI.B.2.b.iii. Additionally, had the miners used the damaged North Portal elevator cage without a functioning roof to protect them and additional ice hit them, it is reasonably likely their injuries would be severe. Accordingly, I determine that injuries from ice falling down a 1500-foot elevator shaft are reasonably likely to result in a reasonably serious injury or fatality. Thus, I determine that the Secretary has satisfied the fourth element of the *Mathies* test.

I therefore conclude that the Secretary has satisfied all four elements of the *Mathies* test and the violation in Citation No. 9706550 is appropriately designated as S&S.

4. Negligence Determination for Violation of 30 C.F.R. § 50.10(b)

The Secretary argues that Warrior Met exhibited a "moderate" level of negligence in violating section 50.10(b). (Sec'y Br. at 24.) Specifically, the Secretary argues that Warrior Met knew or should have known it needed to report the accident to MSHA within fifteen minutes of learning about it. (Sec'y Br. at 24.) The Secretary asserts that MSHA Supervisor Elswick considered the fact that Warrior Met reported the accident to MSHA approximately forty-five minutes after learning about it in making his negligence determination. (Sec'y Br. at 24.)

Warrior Met disputes the Secretary's designation of "moderate" negligence, arguing that, at most, it exhibited a low level of negligence under the circumstances. (Resp't Reply Br. at 9.) In support, Warrior Met notes that immediately after learning of the incident, CO Operator

Dickey called miners at the North Portal and West Portal to prompt recovery efforts. (Resp't Reply Br. at 10.) Dickey also reported the situation to Mine Manager Dickerson who provided further directives for recovering the three miners. (Resp't Reply Br. at 10.) Warrior Met also highlights that Dickey reported the accident to MSHA at 7:00 p.m. after speaking with Director of Compliance Boylen, who advised doing so. (Resp't Reply Br. at 10.) Warrior Met argues that it acted in good faith and was singularly focused on ensuring the safety of the injured miners. (Resp't Reply Br. at 10.)

I agree with the Secretary that Warrior Met should have known based on the description of the event and the miners' injuries that it needed to call MSHA within fifteen minutes of learning about the accident. While I acknowledge that Warrior Met was busy trying to address the accident, that does not account for the twenty-nine-minute delay in reporting the accident to MSHA. CO Operator Dickey made several non-essential calls before he ultimately reported the accident to MSHA. However, Warrior Met called MSHA within forty-four minutes of learning about the accident, which is significantly shorter than other cases, *see, e.g.*, *M-Class Mining, LLC*, 39 FMSHRC 1013, 1016 (May 2017) (ALJ) (finding that operator did not notify MSHA of accident until the following morning), and less egregious than cases in which the operator did not report the accident at all, *see Webster Cty. Coal, LLC*, 39 FMSHRC 1131, 1134 (May 2017) (ALJ) (finding that operator did not inform MSHA of the accident); *Red River Coal Co.*, 39 FMSHRC 368, 391 (Feb. 2017) (ALJ) (finding that operator failed to report accident to MSHA); *Clintwood Elkhorn Mining Co.*, 36 FMSHRC 1282, 1301 (May 2014)(ALJ) (finding that operator never reported accident to MSHA). In weighing all the evidence, I conclude that on a continuum of negligence Warrior Met's actions fall on the higher degree of "low" negligence.

5. Penalty: Citation No. 9706550 – Immediate Notification Under § 50.10(b)

The Secretary proposes a penalty of $7,133.00 for Citation No. 9706550. (Sec'y Br. at 24.) Under section 110(a)(2) of the Mine Act, "[t]he operator of a coal or other mine who fails to provide timely notification to the Secretary as required under section 103(j) (relating to the 15 minute requirement) shall be assessed a civil penalty by the Secretary of not less than $5,000 and not more than $60,000." 30 U.S.C. § 820(a)(2). Section 4 of the Federal Civil Penalties Inflation Adjustment Act (1990 Pub. L. 101–410, 104 Stat. 890; 28 U.S.C. 2461 note), as amended by the Debt Collection Improvement Act of 1996 (Pub. L. 104–134, 110 Stat. 1321–373) and the Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015 (Pub. L. 114–74, 129 Stat. 599, 28 U.S.C. 2461 note) (collectively, the FCPIA Act), requires each federal agency with statutory authority to assess civil monetary penalties to adjust its civil monetary penalties annually for inflation according to a formula described in section 5 of the FCPIA Act.

At the time the Secretary assessed a proposed penalty for Citation No. 9706550, the minimum penalty for a violation of section 103(j) of the Mine Act and thus a violation of standard 50.10(b) was $7,133.00. Federal Civil Penalties Inflation Adjustment Act Annual Adjustments for 2023, 88 Fed. Reg. 2,210, 2,218 (Jan. 13, 2023). Therefore, the penalty assessed in Citation No. 9706550 is the statutory minimum for this violation. In considering the criteria set forth in section 110(i) of the Mine Act and all the relevant facts, as well as being constrained by the statutory minimum penalty, I hereby assess a penalty of $7,133.00.

C. Analysis and Conclusions of Law: Citation No. 9706551 – Preservation of Evidence

1. Violation of 30 C.F.R. § 50.12

Section 50.12 states, "[u]nless granted permission by a MSHA District Manager, no operator may alter an accident site or an accident related area until completion of all investigations pertaining to the accident except to the extent necessary to rescue or recover an individual, prevent or eliminate an imminent danger, or prevent destruction of mining equipment." 30 C.F.R. § 50.12.

a. Whether Warrior Met Altered the Accident Site

The Secretary argues it is uncontroverted that Warrior Met altered the accident site because Mine Manager Dickerson testified that he ordered the damaged elevator cage to be brought to the surface. (Sec'y Br. at 15–16.) The Secretary contends that this prevented MSHA's investigators from being able to examine the cage as it existed after the ice hit it at the bottom of the elevator shaft. (Sec'y Br. at 16.) Additionally, the Secretary alleges that Warrior Met not only removed the elevator cage's damaged roof, but it also removed the ice that hit the elevator cage and cleaned the area around the elevator hoist. (Sec'y Br. at 16.) In response, Warrior Met asserts that none of its actions hindered MSHA's investigation and the scene was not altered. (Resp't Br. at 22.) The Secretary disputes this claim, noting that MSHA Supervisor Elswick testified that he was not able to perform a complete investigation because the scene had been changed. (Sec'y Reply Br. at 5; I Tr. 138:19–20.)

Hallman testified that the North Portal elevator cage was pulled up to the surface while Hackney was making calls at the bottom of the North Portal. (II Tr. 74:19–21, 76:4–6, 78:21–79:10.) Mine Manager Dickerson also acknowledged that miners pulled the North Portal elevator cage up to the surface and set the elevator's roof to the side, as well as the ice that hit the elevator. (I Tr. 224:8–12.) Thus, when MSHA Supervisors Elswick and Schilke arrived at the scene, they noticed the North Portal elevator cage had already been brought to the surface and the roof of the cage had been removed and was sitting about one-hundred feet away from the elevator shaft. (I Tr. 97:14–102:7, 110:22–111:5; Exs. S–9, S–10, S–11.) Elswick also noticed that the area around the North Portal elevator hoist had been cleaned and swept. (I Tr. 92:14–15, 97:20–22, 111:3–5, 125:17–20.) Due to Warrior Met's alteration of the scene, Elswick said he and Schilke "really couldn't investigate anything. There was nothing we could really do because everything had been changed . . . I have no idea what was gone . . . everything was cleaned up and removed and done. I had no idea what I was supposed to do there." (I Tr. 111:8–10, 125:17–20.) Accordingly, I determine that Warrior Met altered the accident scene.

b. Whether Warrior Met's Alteration of Accident Scene is Exempted

Warrior Met argues that its alteration of the accident scene is exempted under section 50.12 which allows operators to alter accident scenes "to rescue or recover an individual." (Resp't Br. at 20; Resp't Reply Br. at 10); 30 C.F.R. § 50.12. Specifically, Warrior Met alleges that given the potential for issues traveling to the West Portal, Mine Manager Dickerson found it necessary to investigate whether the North Portal was an alternative option to bring the injured

miners to the surface. (Resp't Br. at 21–22; Resp't Reply Br. at 11.) Therefore, Warrior Met contends that Dickerson instructed employees at the North Portal to bring the elevator cage to the surface. (Resp't Br. at 21; Resp't Reply Br. at 10.)

Despite Warrior Met's arguments to the contrary, I previously found that upon learning of the accident, Warrior Met believed the miners' injuries could be dire enough that the miners should exit the mine through the quickest method – the North Portal elevator, and it therefore moved the North Portal elevator cage to the surface to assess its functionality. *See* discussion *supra* Part VI.B.2.c.ii. Thus, Warrior Met may have believed it necessary to bring the elevator cage to the surface to rescue or recover an individual. However, Hallman testified that Warrior Met staff on the surface of the North Portal told Hackney that the elevator "cage was down [and] it couldn't be rode." (II Tr. 78:21–79:10.) Yet, Warrior Met removed the elevator cage's damaged roof and the ice that hit the elevator cage, both of which were extra steps unnecessary to the assessment of the hoist as operational and were significant alterations to the accident scene. (I Tr. 97:14–102:7, 110:22–111:5, 224:8–2; Exs. S–9, S–10, S–11.)

Additionally, when MSHA Supervisor Elswick inspected the North Portal elevator shaft he touched the side of the heaters and felt that they were cool, leading him to believe that the heaters had only recently been turned on and likely were not on at the time of the accident. (I Tr. 102:22–103:10, 104:16–22, 128:4–6; Ex. S–6.) Nichols also testified that the heaters for the North Portal elevator shaft were not running at the time of the accident. (I Tr. 50:20–51:2.) Furthermore, Mine Manager Dickerson was not able to confirm whether the heaters for the North Portal elevator shaft were running at the time of the accident. (I Tr. 226:7–10, 233:4–9.) Dickerson also testified that the heaters produce a great deal of heat when they are running. (I Tr. 233:19–234:7.) Indeed, Elswick testified that the fact the water from the busted pipe near the elevator shaft froze demonstrates that the heaters likely were not running at the time of the accident. (I Tr. 130:16–20.) However, during Elswick's inspection following the accident the heaters were running, causing the remaining ice in the North Portal elevator shaft to quickly melt, which further inhibited his investigation of the accident. (I Tr. 103:11–19, 106:7–9, 126:10–12, 129:3–7, 130:7–11; Ex. S–6.) I determine that it was not necessary to turn the heaters on "to rescue or recover an individual" and by turning them on, Warrior Met altered the accident site.

Accordingly, I conclude that Warrior Met violated section 50.12.

2. Negligence Determination for Violation of 30 C.F.R. § 50.12

The Secretary argues that the violation of section 50.12 meets the standard for "high" negligence. (Sec'y Br. at 17.) In support of this designation, the Secretary asserts that MSHA Supervisor Elswick specifically instructed Warrior Met management to preserve the accident scene before his arrival. (Sec'y Br. at 17.) Warrior Met disputes the Secretary's designation of "high" negligence, arguing that Mine Manager Dickerson found it necessary to bring the North Portal elevator cage to the surface to determine the feasibility of utilizing the cage as an alternative means of egress from the mine. (Resp't Br. at 22; Resp't Reply Br. at 14.) Because these actions were taken to assist the injured miners by removing them from the mine as quickly as possible, and not to hinder MSHA's investigation, Warrior Met argues that any violation of

section 50.12 should reflect nothing more than "low" negligence. (Resp't Br. at 22; Resp't Reply Br. at 14.)

Warrior Met concedes that MSHA Supervisor Elswick told Vice President Rick Marlowe that he would issue a section 103(k) order once he arrived on-site, requiring the scene to be preserved. (Resp't Reply Br. at 13.) However, Warrior Met argues that there is no evidence that this conversation took place prior to CO Operator Dickey's call with Mine Manager Dickerson or that Marlowe spoke with Dickerson. (Resp't Reply Br. at 13.) Alternatively, Warrior Met argues that even if Dickerson had knowledge of the section 103(k) order, his instructions were reasonable in light of the ongoing circumstances. (Resp't Reply Br. at 14.)

MSHA Supervisor Elswick testified that he called Vice President Marlowe shortly after he received the escalation report for the incident generated by the MSHA hotline at 7:28 p.m. (I Tr. 83:14–16, 94:8–9; Ex. S–8.) Hallman testified that the North Portal elevator cage was pulled to the surface while he and the other injured miners were still waiting at the bottom of the North Portal. (II Tr. 74:19–21, 76:4–6, 78:21–79:10, 95:9–11.) Hackney and Hallman testified that they were at the bottom of the North Portal for approximately twenty to thirty minutes after the accident before they got into a man bus to go to the West Portal. (II Tr. 26:14–21, 95:12–20.) Therefore, the North Portal elevator cage was likely brought to the surface sometime between 6:11 and 6:35 p.m., and thus before Elswick called Marlowe at approximately 7:30 p.m. and told him about the pending section 103(k) order.

Nevertheless, MSHA Supervisor Elswick testified that all mine management personnel are trained to preserve accident scenes and are therefore clearly on notice of this requirement. (I Tr. 122:6–11.) Thus, as soon as Warrior Met management learned of the accident, mine management should have known they needed to preserve the accident scene. Additionally, Warrior Met's removal of the elevator cage's roof, setting aside the ice that hit the elevator cage, and turning on the heaters causing the remaining ice in the elevator shaft to melt, leads me to infer Warrior Met may have tried to rectify the cause of the accident before MSHA staff arrived to inspect the accident scene at 9:45 p.m., over two hours after MSHA's Elswick told Warrior Met he would be issuing a section 103(k) order. I therefore do not find any mitigating circumstances for Warrior Met's violation of section 50.12. Accordingly, I conclude that Warrior Met exhibited a high level of negligence.

3. Penalty: Citation No. 9706551 – Preservation of Evidence

The Secretary proposes a penalty of $606.00 for Citation No. 9706550. (Sec'y Br. at 18.) Warrior Met was not cited for a violation of section 50.12 in the fifteen-month period preceding Citation No. 9706551. (Sec'y Br. at 18.) Warrior Met is a large operator, mining 4,755,684 tons of coal at the No. 7 Mine in 2022. (Ex. Jt.–1.) I determined that Warrior Met exhibited a high level of negligence. *See* discussion *supra* Part VI.C.2. The parties stipulated that the penalties proposed by the Secretary in this case would not affect Warrior Met's ability to remain in business. (Ex. Jt.–1.) Regarding gravity, I agree with the Secretary that the violation is unlikely to result in injury or illness and therefore the gravity level is low. The parties stipulated that Warrior Met abated the citation in a timely manner and in good faith. (Ex. Jt.–1.) Thus, in

considering the criteria set forth in section 110(i) of the Mine Act and all the relevant facts, I hereby assess a penalty of $606.00.

VII. ORDER

In light of the foregoing, it is hereby **ORDERED** that Citation Nos. 9701033 and 9706550 both be **MODIFIED** to reduce the negligence findings from "moderate" to "low" and are otherwise **AFFIRMED** as written.

Respondent Warrior Met is **ORDERED** to pay a combined civil penalty of $8,339.00 for Citation Nos. 9701033, 9706550, and 9706551, within 40 days of this decision.[15]

Alan G. Paez
Administrative Law Judge

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/MEK

[15] Please pay penalties electronically at Pay.Gov, a service of the U.S. Department of the Treasury, at https://www.pay.gov/public/form/start/67564508. Alternatively, send payment (check or money order) to: U.S. Department of Treasury, Mine Safety and Health Administration P.O. Box 790390, St. Louis, MO 63179-0390. Please include Docket and A.C. Numbers.