## JUNE 2012

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**ADMINISTRATIVE LAW JUDGE ORDERS**

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No case was filed where Review was granted during the month of June 2012.

No petition was filed in which review was denied during the month of June 2012.

COMMISSION DECISIONS AND ORDERS
June 6, 2012

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

v.

STILLHOUSE MINING, LLC

Docket No. KENT 2007-309

BEFORE: Jordan, Chairman; Duffy, Young, Cohen, and Nakamura, Commissioners

ORDER


On May 30, 2012, the Commission received from Stillhouse a motion to withdraw its contest and appeal in this matter. Counsel for the Secretary of Labor has indicated that the Secretary does not oppose the motion.
Upon consideration of Stillhouse’s motion, it is granted. We hereby vacate our order granting review.

/s/ Mary Lu Jordan
Mary Lu Jordan, Chairman

/s/ Michael F. Duffy
Michael F. Duffy, Commissioner

/s/ Michael G. Young
Michael G. Young, Commissioner

/s/ Robert F. Cohen, Jr.
Robert F. Cohen, Jr., Commissioner

/s/ Patrick K. Nakamura
Patrick K. Nakamura, Commissioner
This temporary reinstatement proceeding arises under the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 801 et seq. (2006) (“Mine Act” or “Act”). On June 5, 2012, the Commission received from Mammoth Coal Company (“Mammoth”) a petition for review of Administrative Law Judge Kenneth R. Andrews’ Decision and Order granting temporary economic reinstatement to miner Robert Nickoson pursuant to section 105(c)(2) of the Act, 30 U.S.C. § 815(c)(2). 33 FMSHRC___, slip op. at 16, No. WEVA 2012-1069-D (May 25, 2012) (ALJ). On June 11, 2012, the Commission received the Secretary of Labor’s opposition to Mammoth’s petition. For the reasons that follow, we grant the petition and affirm the judge’s order temporarily reinstating Mr. Nickoson.

I.

Factual and Procedural Background

The factual background of this matter is set forth in detail in the judge’s decision. Slip op. at 4-13. Briefly, Mammoth Coal Company operates the Mammoth Coal Processing Plant and River Tipple. Id. at 1. Although it has changed ownership several times, miner Robert Nickoson has worked at the plant his entire career, beginning in 1975. Slip op. at 6; Tr. 12. As relevant here, in January 2010, Nickoson was designated as a miners’ representative. Slip op. at 7; Tr. 17. As a miners’ representative, Nickoson accompanied inspectors from the Department of Labor’s Mine Safety and Health Administration (“MSHA”). Slip op. at 6. During one inspection, Nickoson, who was also accompanied by Charles Hamilton, a Mammoth representative, pointed out several pieces of equipment in disrepair, which resulted in the
issuance of citations to Mammoth. Slip op. at 7. Nickoson testified that he said to Hamilton “I hope you don’t get mad at me,” to which Hamilton replied “I hope you don’t get mad at me.” Slip op. at 7; Tr. 20-21. Nickoson believed this meant that Hamilton would report Nickoson’s conduct during the inspection to the Mine Superintendent Jon Adamson. Slip op. at 7; Tr. 21, 56.

Nickoson also testified that when the company asked for volunteers to form the “Running Right” safety committee, he volunteered but was denied. Slip op. at 7 n.4; Tr. 28-29. Mammoth allowed two other miners’ representatives, not known for making safety complaints, to join the committee. Slip op. at 7 n.4; Tr. 27-33.

In June 2011, Nickoson was denied the right as a miners’ representative to accompany an MSHA inspector during an inspection, allegedly due to deficiencies in his miners’ representative paperwork. Slip op. at 7; Tr. 22. Nickoson testified that Adamson was involved in the determination that he could not participate as a miners’ representative. Id. In order to regain his position as a miners’ representative, Nickoson was required to fill out paperwork, have it approved by MSHA, and then take the company’s “Running Right” safety class. Slip op. at 7; Tr. 23, 26. Nickoson subsequently filed a section 105(c) discrimination complaint with MSHA regarding this incident. Slip op. at 7; Humphrey Aff. at 2. Nickoson filed additional paperwork with MSHA and was recognized as a miners’ representative by the end of June 2011. Tr. 53-54.

On the morning of January 12, 2012, Nickoson became ill and went to the emergency room. Slip op. at 8. Nickoson’s wife called Mammoth to say that Nickoson was being treated for kidney stones and that he would not make it into work that day. Id. Nickoson missed two days of work. Id. When he returned to work on January 16, Nickoson and other miners attended a safety meeting conducted by his foreman, Roger Powers. Id. At the end of the meeting, Nickoson asked Powers what type of days had been turned in for Nickoson’s absences, to which Powers replied that personal days had been turned in. Slip op. at 8; Tr. 37. Nickoson cursed and made heated statements, noting in part his displeasure that personal days had been used. Slip op. at 8; Tr. 37-38, 70. The next day, Nickoson was asked to sign a piece of paper notifying him that he was being suspended for five days with an “intent to discharge.” Slip op. at 9; Tr. 43. Nickoson refused to sign it because he did not believe that he had done what was described in the paper. Id.

On January 23, 2012, Nickoson went back to work for a “return-to-work” meeting with management. Id. Nickoson brought a union representative with him, but the representative was not allowed in the meeting. Slip op. at 9; Tr. 44. Nickoson testified that during the meeting he was questioned about the absentee policy. Slip op. at 9; Tr. 45. In addition, among other things, Nickoson asked about an incident in 2011, in which a boss brought uncertified men into a locked power substation that was restricted to entry by certified electricians only. Id. Nickoson testified that he had previously reported the incident but that Mammoth had taken no action.

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1 This matter remains under investigation. Slip op. at 7; S. Br. at 3 n.1.
Slip op. at 9; Tr. 44-46. Nickoson was eventually informed during the meeting that he was being terminated. Slip op. at 9. It is Mammoth’s position that Nickoson was terminated due to his insubordinate and unprofessional conduct at the January 16 safety meeting. Pet. at 1; Slip op. at 12; Tr. 133.

Nickoson filed a section 105(c) complaint on February 3, 2012, alleging that his termination on January 23 was motivated by his protected activity while serving as a miners’ representative. Slip op. at 1. On April 30, 2012, the Secretary filed an Application for Temporary Reinstatement. On May 8, 2012, Mammoth requested a hearing on the matter, and the hearing was held on May 21. Id. at 2.

The judge determined that Nickoson’s complaint was not frivolously brought. Id. at 16. He determined that the record indicates that Nickoson engaged in protected activity when he became a miners’ representative in January 2010 and began reporting equipment defects to management, when he accompanied inspectors during their inspections and when he identified a dangerous situation concerning the power substation. Id. at 13. The judge further concluded that there was sufficient evidence to allow one to have reasonable cause to believe that Nickoson’s termination was motivated in part by that protected activity. Id. at 3, 13-16. The judge relied on evidence that could support an inference of discriminatory intent, such as Mammoth’s knowledge of the protected activity, its hostility or animus toward that activity, a coincidence in time between the protected activity and the adverse action, and disparate treatment. Id. at 13-16.

II.

Disposition

Under section 105(c)(2) of the Mine Act, “if the Secretary finds that [a discrimination] complaint was not frivolously brought, the Commission, on an expedited basis upon application of the Secretary, shall order the immediate reinstatement of the miner pending final order on the complaint.” 30 U.S.C. § 815(c)(2). The Commission has recognized that the “scope of a temporary reinstatement hearing is narrow, being limited to a determination by the judge as to whether a miner’s discrimination complaint is frivolously brought.” See Sec’y of Labor on behalf of Price v. Jim Walter Res., Inc., 9 FMSHRC 1305, 1306 (Aug. 1987), aff’d, 920 F.2d 738 (11th Cir. 1990). In reviewing a judge’s temporary reinstatement order, the Commission has applied the substantial evidence standard. Sec’y of Labor on behalf of Williamson v. CAM Mining, LLC, 31 FMSHRC 1085, 1088 (Oct. 2009).

As recognized by the judge, slip op. at 3, while an applicant for temporary reinstatement need not prove a prima facie case of discrimination, it is useful to review the elements of a discrimination claim in order to assess whether the evidence at this stage of the proceedings meets the non-frivolous test. Cam Mining, 31 FMSHRC at 1088. In order to establish a prima facie case of discrimination under section 105(c) of the Act, a complaining miner bears the burden of establishing (1) that he engaged in protected activity and (2) that the adverse action complained of was motivated in any part by that activity. Sec’y of Labor on behalf of Pasula v.
Consol. Coal Co., 2 FMSHRC 2786, 2799 (Oct. 1980), rev’d on other grounds, 663 F.2d 1211 (3rd Cir. 1981); Sec’y of Labor on behalf of Robinette v. United Castle Coal Co., 3 FMSHRC 803 (Apr. 1981). The Commission has identified the following indicia of discriminatory intent to establish a nexus between the protected activity and the alleged discrimination: (1) hostility or animus toward the protected activity; (2) knowledge of the protected activity; (3) coincidence in time between the protected activity and the adverse action; and (4) disparate treatment of the complainant. CAM Mining, 31 FMSHRC at 1089; Turner v. Nat’l Cement Co. of California, 33 FMSHRC 1059, 1066 (May 2011) (citing Sec’y of Labor on behalf of Chacon v. Phelps Dodge Corp., 3 FMSHRC 2508, 2510 (Nov. 1981)).

Mammoth does not take issue with the judge’s application of law to this matter. Pet. at 3-4. Rather, the operator argues that Nickoson’s testimony was not sufficiently credible to constitute “substantial evidence” that his discharge was motivated in part by his alleged protected activity. Id. Specifically, Mammoth points to alleged inconsistencies in Nickoson’s testimony regarding the incident in which he was refused the ability to accompany an MSHA inspector as a miners’ representative due to alleged problems in his paperwork and Adamson’s involvement in this incident, as well as the extent and timing of Nickoson’s heated comments during the January 16, 2012 safety meeting. Pet. at 4-9. Consequently, Mammoth contends that because the evidence the Secretary offered, and upon which the judge relied, consisted solely of inconsistent testimony by Nickoson, the judge’s ruling must be reversed. Pet. at 3-4, 9-10.

Mammoth incorrectly frames the issue before us. The judge’s responsibility at the temporary reinstatement phase is to determine if the Secretary has proven that a non-frivolous issue exists as to whether the adverse action was motivated in part by the miner’s protected activity. Sec’y of Labor on behalf of Albu v. Chicopee Coal Co., Inc., 21 FMSHRC 717, 718-19 (July 1999). A non-frivolous issue may be shown where there is both supporting and detracting evidence in the record. Id. Thus, the question posed in this case is whether substantial evidence supports the judge’s finding that the complaint is not frivolous.

Contrary to Mammoth’s assertion that the record consisted only of Nickoson’s testimony, with her Application for Temporary Reinstatement, the Secretary also submitted the affidavit of MSHA Special Investigator James R. Humphrey (Ex. A), Nickoson’s discrimination complaint (Ex. B), and Mammoth’s disciplinary action form submitted at the hearing (Gov. Ex. 1). See Slip op. at 4-6; Tr. 3, 131. The judge included this evidence in his consideration. Slip op. at 4-6, 12.

Moreover, it is premature to address the operator’s credibility challenge. Even if there are internal inconsistencies in Nickoson’s testimony, such conflicts need not be resolved at this stage of the proceedings. Cam Mining, 31 FMSHRC at 1089-91; see also Chicopee Coal Co., 21 FMSHRC at 719 (finding that it “is not the judge’s duty, nor is it the Commission’s, to resolve the conflict in testimony at this preliminary stage of the proceedings”); see generally Fleischut v. Nixon Detroit Diesel, Inc., 859 F.2d 26, 29 (6th Cir. 1988) (concluding that the “court need not concern itself with resolving conflicting evidence if facts exist which could support the Board’s theory of liability”).
Considering the record as a whole, we conclude that substantial evidence supports the judge’s determination that the complaint is not frivolous. Nickoson’s testimony, his discrimination complaint, and Humphrey’s affidavit support the judge’s findings that Nickoson engaged in protected activity, and that a sufficient nexus existed between the protected activity and the alleged discrimination.\(^2\) We intimate no view as to the ultimate merits of this case.

### III.

**Conclusion**

For the foregoing reasons, we affirm the judge’s determination that Nickoson’s discrimination complaint is not frivolous and that temporary reinstatement is appropriate.

/s/ Mary Lu Jordan  
Mary Lu Jordan, Chairman

/s/ Michael F. Duffy  
Michael F. Duffy, Commissioner

/s/Michael G. Young  
Michael G. Young, Commissioner

/s/ Robert F. Cohen, Jr.  
Robert F. Cohen, Jr., Commissioner

/s/ Patrick K. Nakamura  
Patrick K. Nakamura, Commissioner

---

\(^2\) Because Mammoth does not directly challenge any of these elements of the judge’s analysis, we need not elaborate further.
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ORDER

BY THE COMMISSION:

This matter arises under the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 801 et seq. (2006) ("Mine Act"). On November 21, 2011, the Commission received from Mid-Tex Minerals, Inc. ("Mid-Tex") a motion seeking to reopen a settlement agreement and relieve it from the order to pay entered against it.

On October 28, 2011, Chief Administrative Law Judge Lesnick issued a Decision Approving Settlement and an Order to Pay in response to the Conference and Litigation Representative’s ("CLR") motion to approve the proposed settlement.

Mid-Tex asserts that it did not understand that its telephone discussions with the CLR were considered a final response to the settlement agreement. Mid-Tex further states that it had contested and requested a hearing on this matter, but was never contacted by MSHA. It appears from Mid-Tex’s enclosed documents that it sent a letter, which was received by MSHA on August 17, 2011, stating that the discussion with the CLR had not been satisfactory.

The Secretary asserts that the CLR in this case drafted a settlement agreement and proposed order based on his discussion with the operator, and sent the proposed agreement and order to the operator. After waiting for five days and having received no response, the CLR submitted the settlement agreement and proposed order to the Commission. It appears that the CLR mailed the documents to Mid-Tex on August 15, 2011, and filed them with the Commission on August 19, 2011. Because there appears to be a factual dispute about what happened in this case, the Secretary requests that the Commission assign this case to the Chief Administrative Law Judge for resolution of that dispute.
Under the Mine Act and the Commission’s procedural rules, relief from a judge’s
decision may be sought by filing a petition for discretionary review within 30 days of its
issuance. 30 U.S.C. § 823(d)(2)(A)(i); 29 C.F.R. § 2700.70(a). If the Commission does not
direct review within 40 days of a decision’s issuance, it becomes a final decision of the
Commission. 30 U.S.C. § 823(d)(1). Consequently, the judge’s order here has become a final
decision of the Commission.

In evaluating requests to reopen final orders, the Commission has found guidance in Rule
60(b) of the Federal Rules of Civil Procedure under which, for example, a party could be entitled
to relief from a final order of the Commission on the basis of mistake, inadvertence, or excusable
neglect. See 29 C.F.R. § 2700.1(b) (“the Commission and its Judges shall be guided so far as
practicable by the Federal Rules of Civil Procedure”); Jim Walter Res., Inc., 15 FMSHRC 782,
786-89 (May 1993) (“JWR”). We have also observed that default is a harsh remedy and that, if
the defaulting party can make a showing of good cause for a failure to timely respond, the case
may be reopened and appropriate proceedings on the merits permitted. See Coal Prep. Servs.,
Having reviewed Mid-Tex’s request and the Secretary’s response, in the interest of justice, we hereby reopen the proceeding, vacate the decision, and remand this matter to the Chief Administrative Law Judge for further proceedings pursuant to the Mine Act and the Commission’s Procedural Rules, 29 C.F.R. Part 2700.

/s/ Mary Lu Jordan
Mary Lu Jordan, Chairman

/s/ Michael F. Duffy
Michael F. Duffy, Commissioner

/s/ Michael G. Young
Michael G. Young, Commissioner

/s/ Robert F. Cohen, Jr.
Robert F. Cohen, Jr., Commissioner

/s/ Patrick K. Nakamura
Patrick K. Nakamura, Commissioner

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Chief Administrative Law Judge Robert J. Lesnick
Federal Mine Safety & Health Review Commission
601 New Jersey Avenue, N. W., Suite 9500
Washington, D.C.  20001-2021
Pursuant to Commission Procedural Rule 12, on our own motion, we hereby consolidate docket numbers LAKE 2010-19-M and LAKE 2010-20-M, both captioned Forrest Aggregate, and involving similar procedural issues. 29 C.F.R. § 2700.12.

Pursuant to Commission Procedural Rule 12, on our own motion, we hereby consolidate docket numbers LAKE 2010-19-M and LAKE 2010-20-M, both captioned Forrest Aggregate, and involving similar procedural issues. 29 C.F.R. § 2700.12.
The Secretary does not oppose the request to reopen. However, the Secretary notes that the operator did not file an answer to the assessment petitions or the show cause orders. The Secretary has been informed by the Denver Regional Office Attorney that the case file indicates that the paralegal did not forward this case to an attorney to contact Forrest.

The judge’s jurisdiction in this matter terminated when the default occurred. 29 C.F.R. § 2700.69(b). Under the Mine Act and the Commission’s procedural rules, relief from a judge’s decision may be sought by filing a petition for discretionary review within 30 days of its issuance. 30 U.S.C. § 823(d)(2)(A)(i); 29 C.F.R. § 2700.70(a). If the Commission does not direct review within 40 days of a decision’s issuance, it becomes a final decision of the Commission. 30 U.S.C. § 823(d)(1). Consequently, the judge’s order here has become a final decision of the Commission.

In evaluating requests to reopen final orders, the Commission has found guidance in Rule 60(b) of the Federal Rules of Civil Procedure under which, for example, a party could be entitled to relief from a final order of the Commission on the basis of mistake, inadvertence, or excusable neglect. See 29 C.F.R. § 2700.1(b) (“the Commission and its Judges shall be guided so far as practicable by the Federal Rules of Civil Procedure”); Jim Walter Res., Inc., 15 FMSHRC 782, 786-89 (May 1993) (“JWR”). We have also observed that default is a harsh remedy and that, if the defaulting party can make a showing of good cause for a failure to timely respond, the case may be reopened and appropriate proceedings on the merits permitted. See Coal Prep. Servs., Inc., 17 FMSHRC 1529, 1530 (Sept. 1995).
Having reviewed Forrest’s request and the Secretary’s response, in the interest of justice, we hereby reopen the proceeding and vacate the Orders of Default. Accordingly, this case is remanded to the Chief Administrative Law Judge for further proceedings pursuant to the Mine Act and the Commission’s Procedural Rules, 29 C.F.R. Part 2700. Forrest shall file an Answer to the Show Cause Orders within 30 days of the date of this order.

/s/ Mary Lu Jordan
Mary Lu Jordan, Chairman

/s/ Michael F. Duffy
Michael F. Duffy, Commissioner

/s/ Michael G. Young
Michael G. Young, Commissioner

/s/ Robert F. Cohen, Jr.
Robert F. Cohen, Jr., Commissioner

/s/ Patrick K. Nakamura
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Chief Administrative Law Judge Robert J. Lesnick
Federal Mine Safety & Health Review Commission
601 New Jersey Avenue, N. W., Suite 9500
Washington, D.C. 20001-2021

On March 16, 2011, Chief Administrative Law Judge Lesnick issued two Orders to Show Cause which by their terms became Orders of Default if the operator did not file its answers within 30 days. These Show Cause Orders were issued in response to Bledsoe’s failure to answer the Secretary’s June 16, and July 16, 2010 Petitions for Assessment of Civil Penalty.

Bledsoe asserts that it timely answered the assessment petitions on July 1, and August 3, 2010. Bledsoe further states that upon receiving the Show Cause Orders, it believed that its prior answers were sufficient to avoid default in these cases. The Secretary does not oppose the requests to reopen, and notes that the Nashville Regional Solicitor’s office received Bledsoe’s answers on July 6, and August 4, 2010.

¹ Pursuant to Commission Procedural Rule 12, on our own motion, we hereby consolidate docket numbers KENT 2010-1016 and KENT 2010-1149, both captioned Bledsoe Coal Corporation, and involving similar procedural issues. 29 C.F.R. § 2700.12.
The judge’s jurisdiction in this matter terminated when the default occurred. 29 C.F.R. § 2700.69(b). Under the Mine Act and the Commission’s procedural rules, relief from a judge’s decision may be sought by filing a petition for discretionary review within 30 days of its issuance. 30 U.S.C. § 823(d)(2)(A)(i); 29 C.F.R. § 2700.70(a). If the Commission does not direct review within 40 days of a decision’s issuance, it becomes a final decision of the Commission. 30 U.S.C. § 823(d)(1). Consequently, the judge’s order here has become a final decision of the Commission.

In evaluating requests to reopen final orders, the Commission has found guidance in Rule 60(b) of the Federal Rules of Civil Procedure under which, for example, a party could be entitled to relief from a final order of the Commission on the basis of mistake, inadvertence, or excusable neglect. See 29 C.F.R. § 2700.1(b) (“the Commission and its Judges shall be guided so far as practicable by the Federal Rules of Civil Procedure”); Jim Walter Res., Inc., 15 FMSHRC 782, 786-89 (May 1993) (“JWR”). We have also observed that default is a harsh remedy and that, if the defaulting party can make a showing of good cause for a failure to timely respond, the case may be reopened and appropriate proceedings on the merits permitted. See Coal Prep. Servs., Inc., 17 FMSHRC 1529, 1530 (Sept. 1995).
Having reviewed Bledsoe’s requests and the Secretary’s responses, in the interest of justice, we hereby reopen the proceedings and vacate the Orders of Default. Accordingly, this case is remanded to the Chief Administrative Law Judge for further proceedings pursuant to the Mine Act and the Commission’s Procedural Rules, 29 C.F.R. Part 2700.

/s/ Mary Lu Jordan
Mary Lu Jordan, Chairman

/s/ Michael F. Duffy
Michael F. Duffy, Commissioner

/s/ Michael G. Young
Michael G. Young, Commissioner

/s/ Robert F. Cohen, Jr.
Robert F. Cohen, Jr., Commissioner

/s/ Patrick K. Nakamura
Patrick K. Nakamura, Commissioner
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Chief Administrative Law Judge Robert J. Lesnick
Federal Mine Safety & Health Review Commission
601 New Jersey Avenue, N. W., Suite 9500
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Pursuant to Commission Procedural Rule 12, on our own motion, we hereby consolidate docket numbers KENT 2010-803 and KENT 2010-804, both captioned Trivette Trucking, and involving similar procedural issues. 29 C.F.R. § 2700.12.
The Secretary does not oppose the requests to reopen for the limited purpose of allowing the submission of the Motion to Approve Settlement, filed August 5, 2011. The Pikeville, KY, Conference and Litigation Representative (“CLR”) confirms that he was unaware of the Show Cause Orders.

The judge’s jurisdiction in this matter terminated when the default occurred. 29 C.F.R. § 2700.69(b). Under the Mine Act and the Commission’s procedural rules, relief from a judge’s decision may be sought by filing a petition for discretionary review within 30 days of its issuance. 30 U.S.C. § 823(d)(2)(A)(i); 29 C.F.R. § 2700.70(a). If the Commission does not direct review within 40 days of a decision’s issuance, it becomes a final decision of the Commission. 30 U.S.C. § 823(d)(1). Consequently, the judge’s order here has become a final decision of the Commission.

In evaluating requests to reopen final orders, the Commission has found guidance in Rule 60(b) of the Federal Rules of Civil Procedure under which, for example, a party could be entitled to relief from a final order of the Commission on the basis of mistake, inadvertence, or excusable neglect. See 29 C.F.R. § 2700.1(b) (“the Commission and its Judges shall be guided so far as practicable by the Federal Rules of Civil Procedure”); Jim Walter Res., Inc., 15 FMSHRC 782, 786-89 (May 1993) (“JWR”). We have also observed that default is a harsh remedy and that, if the defaulting party can make a showing of good cause for a failure to timely respond, the case may be reopened and appropriate proceedings on the merits permitted. See Coal Prep. Servs., Inc., 17 FMSHRC 1529, 1530 (Sept. 1995).
Having reviewed Trivette’s requests and the Secretary’s response, in the interest of justice, we hereby reopen the proceedings and vacate the Orders of Default. Accordingly, this case is remanded to the Chief Administrative Law Judge for further proceedings pursuant to the Mine Act and the Commission’s Procedural Rules, 29 C.F.R. Part 2700.

/s/ Mary Lu Jordan
Mary Lu Jordan, Chairman

/s/ Michael F. Duffy
Michael F. Duffy, Commissioner

/s/ Michael G. Young
Michael G. Young, Commissioner

/s/ Robert F. Cohen, Jr.
Robert F. Cohen, Jr., Commissioner

/s/ Patrick K. Nakamura
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Chief Administrative Law Judge Robert J. Lesnick
Federal Mine Safety & Health Review Commission
601 New Jersey Avenue, N. W., Suite 9500
Washington, D.C. 20001-2021
June 25, 2012

SECRETARY OF LABOR, MINE SAFETY AND HEALTH ADMINISTRATION (MSHA) v. MEMPHIS STONE & GRAVEL COMPANY

BEFORE: Jordan, Chairman; Duffy, Young, Cohen, and Nakamura, Commissioners

ORDER

BY THE COMMISSION:


On May 10, 2011, Chief Administrative Law Judge Lesnick issued an Order to Show Cause which by its terms became an Order of Default if the operator did not file an answer within 30 days. This Order to Show Cause was issued in response to Memphis’ failure to answer the Secretary’s October 1, 2010 Petition for Assessment of Civil Penalty. The Commission did not receive Memphis’ answer within 30 days, so the order of default became effective on June 10, 2011.

Memphis asserts that it timely responded to the Show Cause Order on May 20, 2011. Memphis further states that it was in negotiations with a Conference Litigation Representative (“CLR”) in June 2011, and was unaware that a default order had been issued, until it received MSHA’s delinquency notice, dated October 5, 2011.

The Secretary does not oppose the request to reopen and notes that the CLR indicated that he received a copy of the answer. However, the answer does not indicate that it was also sent to the Commission, as instructed in the penalty petition.
The judge’s jurisdiction in this matter terminated when the default occurred. 29 C.F.R. § 2700.69(b). Under the Mine Act and the Commission’s procedural rules, relief from a judge’s decision may be sought by filing a petition for discretionary review within 30 days of its issuance. 30 U.S.C. § 823(d)(2)(A)(i); 29 C.F.R. § 2700.70(a). If the Commission does not direct review within 40 days of a decision’s issuance, it becomes a final decision of the Commission. 30 U.S.C. § 823(d)(1). Consequently, the judge’s order here has become a final decision of the Commission.

In evaluating requests to reopen final orders, the Commission has found guidance in Rule 60(b) of the Federal Rules of Civil Procedure under which, for example, a party could be entitled to relief from a final order of the Commission on the basis of mistake, inadvertence, or excusable neglect. See 29 C.F.R. § 2700.1(b) (“the Commission and its Judges shall be guided so far as practicable by the Federal Rules of Civil Procedure”); Jim Walter Res., Inc., 15 FMSHRC 782, 786-89 (May 1993) (“JWR”). We have also observed that default is a harsh remedy and that, if the defaulting party can make a showing of good cause for a failure to timely respond, the case may be reopened and appropriate proceedings on the merits permitted. See Coal Prep. Servs., Inc., 17 FMSHRC 1529, 1530 (Sept. 1995).
Having reviewed Memphis’ request and the Secretary’s response, in the interest of justice, we hereby reopen the proceeding and vacate the Order of Default. Accordingly, this case is remanded to the Chief Administrative Law Judge for further proceedings pursuant to the Mine Act and the Commission’s Procedural Rules, 29 C.F.R. Part 2700.

/s/ Mary Lu Jordan
Mary Lu Jordan, Chairman

/s/ Michael F. Duffy
Michael F. Duffy, Commissioner

/s/ Michael G. Young
Michael G. Young, Commissioner

/s/ Robert F. Cohen, Jr.
Robert F. Cohen, Jr., Commissioner

/s/ Patrick K. Nakamura
Patrick K. Nakamura, Commissioner
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Chief Administrative Law Judge Robert J. Lesnick
Federal Mine Safety & Health Review Commission
601 New Jersey Avenue, N. W., Suite 9500
Washington, D.C. 20001-2021
June 25, 2012

SECRETARY OF LABOR, MINE SAFETY AND HEALTH ADMINISTRATION (MSHA) v. BONITA GRANDE AGGREGATES

BEFORE: Jordan, Chairman; Duffy, Young, Cohen, and Nakamura, Commissioners

ORDER

BY THE COMMISSION:


On March 17, 2011, Chief Administrative Law Judge Lesnick issued an Order to Show Cause which by its terms became an Order of Default if the operator did not file an answer within 30 days. This Order to Show Cause was issued in response to Bonita’s failure to answer the Secretary’s June 2, 2010 Petition for Assessment of Civil Penalty. The Commission did not receive Bonita’s answer within 30 days, so the order of default became effective on April 18, 2011.

Bonita asserts that it became the new owner of the mine in question in April 2011, and just recently became aware of the outstanding citations. Bonita further states that the previous owner submitted a timely answer to the Secretary’s Petition for Assessment on June 29, 2010, but mailed it to the Mine Safety and Health Administration Conference Litigation Representative, as it was not aware it also had to mail a copy to the Commission. The previous owner also claims to have no record of receiving the show cause order. Moreover, the new owner notified the Commission by email that a representative of the U.S. Department of Treasury will contact the previous owner for the debt collection.
The Secretary does not oppose the request to reopen and notes that her penalty petition advised the operator to file its answer with the Commission with a copy to the Secretary.

The judge’s jurisdiction in this matter terminated when the default occurred. 29 C.F.R. § 2700.69(b). Under the Mine Act and the Commission’s procedural rules, relief from a judge’s decision may be sought by filing a petition for discretionary review within 30 days of its issuance. 30 U.S.C. § 823(d)(2)(A)(i); 29 C.F.R. § 2700.70(a). If the Commission does not direct review within 40 days of a decision’s issuance, it becomes a final decision of the Commission. 30 U.S.C. § 823(d)(1). Consequently, the judge’s order here has become a final decision of the Commission.

In evaluating requests to reopen final orders, the Commission has found guidance in Rule 60(b) of the Federal Rules of Civil Procedure under which, for example, a party could be entitled to relief from a final order of the Commission on the basis of mistake, inadvertence, or excusable neglect. See 29 C.F.R. § 2700.1(b) (“the Commission and its Judges shall be guided so far as practicable by the Federal Rules of Civil Procedure”); Jim Walter Res., Inc., 15 FMSHRC 782, 786-89 (May 1993) (“JWR”). We have also observed that default is a harsh remedy and that, if the defaulting party can make a showing of good cause for a failure to timely respond, the case may be reopened and appropriate proceedings on the merits permitted. See Coal Prep. Servs., Inc., 17 FMSHRC 1529, 1530 (Sept. 1995).
Having reviewed Bonita’s request and the Secretary’s response, in the interest of justice, we hereby reopen the proceeding and vacate the Order of Default. Accordingly, this case is remanded to the Chief Administrative Law Judge for further proceedings pursuant to the Mine Act and the Commission’s Procedural Rules, 29 C.F.R. Part 2700.

/s/ Mary Lu Jordan
Mary Lu Jordan, Chairman

/s/ Michael F. Duffy
Michael F. Duffy, Commissioner

/s/ Michael G. Young
Michael G. Young, Commissioner

/s/ Robert F. Cohen, Jr.
Robert F. Cohen, Jr., Commissioner

/s/ Patrick K. Nakamura
Patrick K. Nakamura, Commissioner
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601 New Jersey Avenue, N. W., Suite 9500  
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SECRETARY OF LABOR, :
MINE SAFETY AND HEALTH :
ADMINISTRATION (MSHA) :

v. :
ROGERS ASPHALT PAVING CO. :

Docket No. WEST 2009-1406-M
A.C. No. 35-03352-196102

BEFORE: Jordan, Chairman; Duffy, Young, Cohen, and Nakamura, Commissioners

ORDER

BY THE COMMISSION:


On March 14, 2011, Chief Administrative Law Judge Lesnick issued an Order to Show Cause which by its terms became an Order of Default if the operator did not file an answer within 30 days. This Order to Show Cause was issued in response to Rogers’ failure to answer the Secretary’s December 4, 2009 Petition for Assessment of Civil Penalty. The Commission did not receive Rogers’ answer within 30 days, so the order of default became effective on April 14, 2011.

Rogers asserts that it submitted a timely answer to the Secretary’s Petition for Assessment on December 22, 2009. Rogers provided a copy of the certified mail receipt showing the answer was sent to the Conference Litigation Representative (“CLR”) in Vacaville, CA. Rogers states it assumed the Commission knew of its contest since the CLR sent the Commission a copy of the petition. Moreover, Rogers submitted copies of its email correspondence with an MSHA attorney from October 2010 to March 2011, including an agreement to the proposed settlement. Rogers received a collection notice from the Department of Treasury on November 30, 2011.

The Secretary does not oppose the request to reopen for the limited purpose of allowing the submission of the Motion to Approve Settlement, filed June 14, 2011. The Denver Regional
Office Attorney confirms that the parties were unaware of the Show Cause Order. MSHA records show that the status of this mine was posted as “abandoned” as of March 22, 2011, and the mine information report shows its mailing address was changed to “P.O. Drawer K, La Grande, OR 97850.” The record also indicates that the Commission mailed the Show Cause Order to “10410 N. McAlister Road, La Grande, OR 97850,” and it was returned to sender, saying there was no mail receptacle and the USPS was unable to forward the Order.

Having reviewed Rogers’ request and the Secretary’s response, in the interest of justice, we conclude that the Default Order has not become a final order of the Commission because the Show Cause Order was never delivered. Accordingly, this case is remanded to the Chief Administrative Law Judge for further proceedings pursuant to the Mine Act and the Commission’s Procedural Rules, 29 C.F.R. Part 2700.

/s/ Mary Lu Jordan
Mary Lu Jordan, Chairman

/s/ Michael F. Duffy
Michael F. Duffy, Commissioner

/s/ Michael G. Young
Michael G. Young, Commissioner

/s/ Robert F. Cohen, Jr.
Robert F. Cohen, Jr., Commissioner

/s/ Patrick K. Nakamura
Patrick K. Nakamura, Commissioner
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Chief Administrative Law Judge Robert J. Lesnick
Federal Mine Safety & Health Review Commission
601 New Jersey Avenue, N. W., Suite 9500
Washington, D.C. 20001-2021
BY THE COMMISSION:


On May 3, 2011, Chief Administrative Law Judge Lesnick issued an Order to Show Cause which by its terms became an Order of Default if the operator did not file an answer within 30 days. This Order to Show Cause was issued in response to Austin’s failure to answer the Secretary’s October 26, 2010 Petition for Assessment of Civil Penalty.

Austin asserts that its counsel filed an answer to the penalty petition on November 29, 2010. Austin enclosed a copy of the fax confirmation page, indicating the answer was sent to MSHA and the Commission. Austin’s counsel states that she faxed another copy of the answer to MSHA and the Commission on May 5, 2011, in response to the Show Cause Order. Austin filed this motion to reopen after receiving MSHA’s delinquency notice, dated October 5, 2011.

The Secretary does not oppose the request to reopen and notes that the Nashville Regional Office attorney received both copies of Austin’s answer. However, those answers included an incorrect case docket number.
The judge’s jurisdiction in this matter terminated when the default occurred. 29 C.F.R. § 2700.69(b). Under the Mine Act and the Commission’s procedural rules, relief from a judge’s decision may be sought by filing a petition for discretionary review within 30 days of its issuance. 30 U.S.C. § 823(d)(2)(A)(i); 29 C.F.R. § 2700.70(a). If the Commission does not direct review within 40 days of a decision’s issuance, it becomes a final decision of the Commission. 30 U.S.C. § 823(d)(1). Consequently, the judge’s order here has become a final decision of the Commission.

In evaluating requests to reopen final orders, the Commission has found guidance in Rule 60(b) of the Federal Rules of Civil Procedure under which, for example, a party could be entitled to relief from a final order of the Commission on the basis of mistake, inadvertence, or excusable neglect. See 29 C.F.R. § 2700.1(b) (“the Commission and its Judges shall be guided so far as practicable by the Federal Rules of Civil Procedure”); Jim Walter Res., Inc., 15 FMSHRC 782, 786-89 (May 1993) (“JWR”). We have also observed that default is a harsh remedy and that, if the defaulting party can make a showing of good cause for a failure to timely respond, the case may be reopened and appropriate proceedings on the merits permitted. See Coal Prep. Servs., Inc., 17 FMSHRC 1529, 1530 (Sept. 1995).
Having reviewed Austin’s request and the Secretary’s response, in the interest of justice, we hereby reopen the proceeding and vacate the Order of Default. Accordingly, this case is remanded to the Chief Administrative Law Judge for further proceedings pursuant to the Mine Act and the Commission’s Procedural Rules, 29 C.F.R. Part 2700.

/s/ Mary Lu Jordan
Mary Lu Jordan, Chairman

/s/ Michael F. Duffy
Michael F. Duffy, Commissioner

/s/ Michael G. Young
Michael G. Young, Commissioner

/s/ Robert F. Cohen, Jr.
Robert F. Cohen, Jr., Commissioner

/s/ Patrick K. Nakamura
Patrick K. Nakamura, Commissioner
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Chief Administrative Law Judge Robert J. Lesnick
Federal Mine Safety & Health Review Commission
601 New Jersey Avenue, N. W., Suite 9500
Washington, D.C.  20001-2021

Robles asserts that it timely contested the penalties. Robles also states that it had not received any communication until it was contacted by the U.S. Department of Treasury regarding its debt. In order to ensure accurate delivery in the future, Robles modified its address on the legal identity report.

The Secretary does not oppose the request to reopen and notes that the Atlanta Regional Office attorney indicated that there is nothing in the file to verify whether or not the penalty petition was delivered to the operator.
Having reviewed Robles’ request and the Secretary’s response, in the interest of justice, we hereby reopen the proceeding and vacate the Order of Default. Accordingly, this case is remanded to the Chief Administrative Law Judge for further proceedings pursuant to the Mine Act and the Commission’s Procedural Rules, 29 C.F.R. Part 2700.

/s/ Mary Lu Jordan
Mary Lu Jordan, Chairman

/s/ Michael F. Duffy
Michael F. Duffy, Commissioner

/s/ Michael G. Young
Michael G. Young, Commissioner

/s/ Robert F. Cohen, Jr.
Robert F. Cohen, Jr., Commissioner

/s/ Patrick K. Nakamura
Patrick K. Nakamura, Commissioner
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Chief Administrative Law Judge Robert J. Lesnick
Federal Mine Safety & Health Review Commission
601 New Jersey Avenue, N. W., Suite 9500
Washington, D.C.  20001-2021
BY THE COMMISSION:


On March 18, 2011, Chief Administrative Law Judge Lesnick issued an Order to Show Cause which by its terms became an Order of Default if the operator did not file an answer within 30 days. This Order to Show Cause was issued in response to FMC’s failure to answer the Secretary’s December 24, 2009 Petition for Assessment of Civil Penalty. The Commission did not receive FMC’s answer within 30 days, so the order of default became effective on April 18, 2011.

FMC asserts that it timely responded to the Show Cause Order. The Secretary does not oppose the request to reopen and notes that the Denver Regional Solicitor’s Office indicated that it received a copy of the answer. However, the answer does not indicate that it was also sent to the Commission, as instructed in the penalty petition.

The judge’s jurisdiction in this matter terminated when the default occurred. 29 C.F.R. § 2700.69(b). Under the Mine Act and the Commission’s procedural rules, relief from a judge’s decision may be sought by filing a petition for discretionary review within 30 days of its issuance. 30 U.S.C. § 823(d)(2)(A)(i); 29 C.F.R. § 2700.70(a). If the Commission does not direct review within 40 days of a decision’s issuance, it becomes a final decision of the
Commission. 30 U.S.C. § 823(d)(1). Consequently, the judge’s order here has become a final decision of the Commission.

In evaluating requests to reopen final orders, the Commission has found guidance in Rule 60(b) of the Federal Rules of Civil Procedure under which, for example, a party could be entitled to relief from a final order of the Commission on the basis of mistake, inadvertence, or excusable neglect. See 29 C.F.R. § 2700.1(b) (“the Commission and its Judges shall be guided so far as practicable by the Federal Rules of Civil Procedure”); Jim Walter Res., Inc., 15 FMSHRC 782, 786-89 (May 1993) (“JWR”). We have also observed that default is a harsh remedy and that, if the defaulting party can make a showing of good cause for a failure to timely respond, the case may be reopened and appropriate proceedings on the merits permitted. See Coal Prep. Servs., Inc., 17 FMSHRC 1529, 1530 (Sept. 1995).

Having reviewed FMC’s request and the Secretary’s response, in the interest of justice, we hereby reopen the proceeding and vacate the Order of Default. Accordingly, this case is remanded to the Chief Administrative Law Judge for further proceedings pursuant to the Mine Act and the Commission’s Procedural Rules, 29 C.F.R. Part 2700.

/s/ Mary Lu Jordan
Mary Lu Jordan, Chairman

/s/ Michael F. Duffy
Michael F. Duffy, Commissioner

/s/ Michael G. Young
Michael G. Young, Commissioner

/s/ Robert F. Cohen, Jr.
Robert F. Cohen, Jr., Commissioner

/s/ Patrick K. Nakamura
Patrick K. Nakamura, Commissioner
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Chief Administrative Law Judge Robert J. Lesnick  
Federal Mine Safety & Health Review Commission  
601 New Jersey Avenue, N. W., Suite 9500  
Washington, D.C. 20001-2021
ADMINISTRATIVE LAW JUDGE DECISIONS
March 7, 2012

SECRETARY OF LABOR, MINE SAFETY AND HEALTH ADMINISTRATION (MSHA), Petitioner, v. PERFORMANCE COAL COMPANY, Respondent. Mine: Upper Big Branch Mine-South

SECRETARY OF LABOR, MINE SAFETY AND HEALTH ADMINISTRATION (MSHA), Petitioner, v. NUMEROUS FORMER MASSEY MINES2 And their successors. Mine:

ORDER LIFTING STAY ORDER GRANTING MOTION FOR WITHDRAWAL OF CONTESTS ORDER TO PAY

Appearances: Derek Baxter, Dana Ferguson, Office of the Solicitor, U.S. Department of Labor, for the Secretary of Labor. David Hardy, Christopher Pence, Eric Silkwood, Guthrie & Thomas, PLLC, for the Respondent.

Before: Judge Margaret A. Miller and Chief Judge Robert J. Lesnick

These cases are before the Federal Mine Safety and Health Review Commission (the “Commission”) on petitions for assessment of civil penalties filed by the Secretary of Labor, acting through the Mine Safety and Health Administration (“MSHA”), against multiple mine

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1 Numerous other Performance Coal Company dockets are addressed by this order. The affected dockets are listed in the attached exhibits and specifically exhibit 5.

2 The mines, along with the docket numbers addressed by this order, are listed in the attached exhibits. Although this order refers to Performance mines, it is intended to dispose of all the subject citations and orders contained in the exhibits.
operators, pursuant to sections 105 and 110 of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. §§ 815 and 820 (the “Mine Act”). The cases include, among other things, 48 penalty dockets, and approximately 928 citations and orders issued at the Upper Big Branch Mine (“UBB,” or the “mine”) both before and after the April 5, 2010 explosion that resulted in the deaths of 29 miners. In addition, this order addresses more than one thousand other dockets that include citations and orders issued at other former Massey Energy Company (“Massey”) controlled mines. The total proposed penalty for the relevant citations and orders is $19,855,483.00.3 The parties have reached an agreement and Respondent has filed a motion to withdraw the contests of the relevant citations and orders included in the above captioned dockets.4 A telephone hearing was held on the motion on Wednesday, February 29, 2012.5 Subsequently, the Secretary of Labor filed a response to the motion and the Respondent filed an amended motion with Exhibit 5 attached.


The explosion occurred at the longwall section, due to an ignition of methane that was propagated by coal dust. The explosion occurred at the time of a shift change and resulted in the deaths of the above-listed miners who, for the most part, were either at the working face or traveling on mantrips in the mine. Following the retrieval of all 29 victims, MSHA began an investigation of the explosion and its causes. The investigation was conducted jointly by MSHA and the State of West Virginia. At the time of the deadly explosion, Massey was the controlling

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3 This number does not include the proposed penalty amounts for the “unresolved/still contested” citations orders that are a part of the split dockets. This amount may be changed in the event errors are found in any of the attached exhibits and corrections are necessary.

4 In addition to the dockets that are completely disposed of by this order, i.e., those included in Exhibit Nos. 1, 2 and 3, Respondent has agreed to withdraw its contest of numerous citations and orders that are included in the dockets that have other “unresolved/still contested” citations and orders in the same docket. The “resolved” citations and orders in the split dockets are listed in Exhibit 4. This order grants the Respondent’s motion to withdraw its contest of the citations listed in Exhibit 4. However, the citations and orders listed in Exhibit 4 will not be formally disposed of until the “unresolved/still contested” citations and orders that make up the remainder of the split dockets have been settled and/or adjudicated, at which point the assigned judge can dispose of the entire docket in one decision/order.

5 At the hearing, the parties agreed that the language in paragraph 13 of Respondent’s motion refers only to cases outside of the Mine Act and specifically that the language “may not be considered an adjudication on the merits” is meant to be used only in matters outside the Mine Act and is not binding on the Commission.
entity of Performance Coal. However, in June, 2011, Performance, along with other Massey mines, was purchased by Alpha Natural Resources (“Alpha”).

In the wake of the explosion, MSHA issued hundreds of citations and orders at UBB, including citations and orders that cited Performance for interfering with the accident investigation. The citations that were issued as a result of the explosion in April, 2010, contributory to the accident, are not the subject of this proceeding. Performance has agreed to accept those citations and orders as issued and pay the penalties proposed by the Secretary. As a result, the Commission does not have jurisdiction over those citations and orders. However, there are roughly one thousand citations before us that were issued to Performance prior to and after the April explosion, and thousands more issued to other Massey mines.

A disproportionate number of the citations and orders that are pending in this matter are characterized by MSHA as resulting from “high negligence” and are designated as “significant and substantial,” “unwarrantable failure” and even “flagrant” violations. There were more than 43 open petitions for assessment of penalty for Performance prior to the devastating explosion, with citations dating as far back as June of 2006. A number of the Performance cases were stayed based upon a joint request by the parties and a letter, dated May 14, 2010, from the United States Attorney for the Southern District of West Virginia requesting such a stay. The stay on all of the subject cases is hereby LIFTED.

It is important to note that Massey, the parent company of Performance at the time of the explosion, is the same company that owned and operated Aracoma Coal’s Alma #1 Mine, which experienced a deadly fire in 2006. Following the Aracoma fire, Massey contested every single piece of paper issued by MSHA. The Aracoma fire eventually resulted in a settlement that included criminal charges against agents of the mine and an assurance from the mine operator that it would reduce its violations over the years to come. Aracoma Coal Co., 30 FMSHRC 1160 (Dec. 2008) (ALJ). Chief Judge Robert J. Lesnick questioned whether the agreed upon “penalty of $1.7 million was adequate in light of Aracoma’s enormous size.” Specifically, he noted the compensation of the Chairman, Chief Executive Officer, and President of Massey Energy Company, Aracoma’s parent company, who “received in 2007 a compensation package that probably exceeded $23 million.” That same CEO received a package from Massey prior to the buy-out by Alpha that included, among other things, a “$12 million golden parachute,” potential performance bonuses, and deferred compensation. Howard Berkes, Former Massey CEO Gets Golden Parachute … And A Blue Truck, NPR, Dec. 7, 2012, http://www.npr.org/blogs/thetwo-way/2010/12/08/131891377/former-massey-ceo-gets-golden-parachute-and-a-blue-pickup-truck. Since its purchase of Massey, Alpha has grown significantly larger, and is able to pay a total amount of over $200 million for fines, programs, and restitution, while at the same time continue in business.

In a subsequent Commission decision addressing the Aracoma fire, Commissioner Cohen decried Massey’s apparent strategy of contesting every citation and order issued by MSHA as an “outrageous” intentional burdening of the administrative judicial system. Aracoma Coal Co., 32 FMSHRC 1639, 1665 n. 4 (Dec. 2010) (Dissent of Commissioner Cohen). Here, Performance has continued the Massey practice with its contest of every citation and order written by MSHA at the mine after April 5, 2010, by filing a separate notice of contest for each. It would appear to
be a strategy enlisted by the mine to overwork an already overloaded system. Notably, this intentional burdening of the administrative judicial system to avoid responsibility for mine safety was a major finding in the McAteer Report, discussed infra. GOVERNOR’S INDEPENDENT INVESTIGATION PANEL, REPORT TO THE GOVERNOR, UPPER BIG BRANCH – THE APRIL 5, 2010, EXPLOSION: A FAILURE OF BASIC COAL MINE SAFETY PRACTICES 99-100, 112. (2011) (hereinafter “McAteer Report”). While Massey contested far more citations and orders after the explosion, it can be said that, given the number of citations and orders pending before the Commission prior to the explosion at the Upper Big Branch mine, the burdening of the judicial system was one of the means Massey employed to avoid responsibility for its actions. Given that the former Massey mines are now owned by Alpha, we are hopeful that such a strategy will be abandoned.

Following the explosion at Upper Big Branch, former West Virginia Governor, Joe Manchin, commissioned an independent investigation into the explosion. In May of 2011, the Investigation Panel’s report, referred to as the McAteer Report, was submitted to the current governor, Earl Ray Tomblin. Among other things, the report explored the effect of earlier settlements and consequences in relation to current mine practices and stated that the purpose of the inspections and investigations into disasters such as that which occurred at Upper Big Branch is to ensure “that such tragedies don’t happen again.” Id. at 107. The report expresses “genuine hope,” albeit with reservations, that disasters such as the one at the Upper Big Branch can be eliminated. Id. Further, the report states that “[t]he disaster at Upper Big Branch was man-made and could have been prevented had Massey Energy followed basic, well-tested and historically proven safety procedures.” Id. at 109. The purpose of the agreement reached between the Secretary and the mines formerly operated by Massey is to take the next step toward preventing future mine disasters such as the one at UBB.

Here, Alpha has filed a motion on behalf of Performance, as well as the former Massey operators and mines captioned above, to withdraw its contest of all citations and orders contained in Exhibits 2 and 4. Alpha has agreed to pay the penalties in full for each of the dockets contained in Exhibit 2, and to pay the penalties in full for the specific citations and orders included in Exhibit 4. Further, as noted above, as a part of the overall settlement, Performance has agreed to pay the penalties in full for all citations and orders related to the explosion at the Upper Big Branch Mine, more than ten million dollars, and pay a total of approximately $209 million as part of the overall settlement. Alpha will pay $46.5 million in restitution to the families of the 29 victims and another $48 million to fund mining research. According to the parties, the restitution and research fund, in conjunction with the civil penalties, serves as an additional deterrent and will encourage future compliance with the Mine Act and its mandatory standards. Furthermore, as a part of the overall settlement, the former Massey controlled mines, now under the ownership of Alpha, will make a renewed effort to go forward with an improved safety record at each mine and, to that end, they have dedicated $80 million dollars to implement new programs in conjunction with the Mine Safety and Health Administration. Finally, the agreement does not remove the possibility that criminal charges may be filed against Massey management.

6 Exhibit 5 serves as a summary of the docket numbers in which the contests are being withdrawn.
In support of the proposed agreement, and with regard to the penalty criteria set forth at 30 U.S.C. § 110(i), the Respondent acknowledges that the Secretary accurately evaluated the gravity and negligence in proposing a penalty for each docket included in the motion. The mines that are the subject of this order are of the size and have the history as designated in the file for each. Massey was not only large, but it was the parent company of many large mine operators. Many of those operators under the former Massey umbrella have an extensive history of violations. Performance is a large operator on its own, which, even prior to the explosion in April 2010, had an unusually high number of violations, including serious ventilation and roof control violations. See Ex. A attached to all penalty petitions. The history of Performance demonstrates that a number of the citations and orders at issue were not abated and the mine was issued a significant number of “failure to abate” orders prior to the citations and orders actually being abated. Respondent asserts that the Secretary considered the unprecedented number of failure to abate orders issued in assessing the penalties in each case. Finally, Respondent agrees that the payment of the proposed penalty amount will not adversely affect any of the above-captioned operators’ ability to continue in business.

Based upon a review of the facts and the Secretary’s proposed assessment procedures at 30 C.F.R. § 100, the Respondent represents that the agreed upon total civil penalty of $19,855,483.00 for the citations and orders set forth in Exhibits 2 and 4 is reasonable, and that payment of this amount will serve to affect the intent and purpose of the Act. In considering the parties’ proposal, we have looked at the penalty criteria in broad terms and considered all of the representations made by the parties, including the payments to the U.S. Attorney and the funds marked for future improvements in safety and health at the former Massey mines. The Commission currently has no jurisdiction over the citations and orders issued as contributing to the explosion of April 2010, but we do consider the penalty payment amount for those citations and orders in addressing the parties’ agreement as a whole. We also consider that, by deciding to pay the penalties for the contributory violations, Performance has accepted the violations as established and takes responsibility for those violations.

While we grant the motion proffered by the Respondent, we do so with great caution. We note that Alpha, on behalf of its former Massey mines, seeks to withdraw the notices of contest of all of the subject citations and orders, with few conditions. The Commission has noted that “[i]n determining whether to approve a proposed settlement a judge must consider, inter alia, whether the amount proposed will accomplish the underlying purpose of a civil penalty - to encourage and induce compliance with the Mine Act and its standards.” Madison Branch Management, 17 FMSHRC 859, 867 (June 1995) (citations omitted). In Wilmot Mining Co., the Commission stated that “[s]ettlement of contested issues and Commission oversight of that process are integral parts of dispute resolution under the Mine Act. 30 U.S.C. § 820(k) . . . . A judge’s oversight of the settlement process ‘is an adjudicative function that necessarily involves wide discretion.’” 9 FMSHRC 684, 686 (1987) (citations omitted). Moreover, in reviewing settlement agreements, Commission judges must “accord due consideration to the entirety of the proposed settlement package, including both its monetary and non-monetary aspects . . . [to] determine whether it is ‘fair, adequate and reasonable’ . . . [and] ‘adequately protects the public interest.’” 17 FMSHRC at 868 (citations omitted). The Commission has emphasized that a judge’s approval or rejection of a settlement agreement must “be based on principled reasons.” Id. at 864 (June 1995) (quoting Knox County Stone Co., 3 FMSHRC 2478, 2480 (Nov. 1981)).
The Commission looks to the penalty assessed in determining the appropriateness of the settlement, and the fact that the Secretary has proposed an assessment based upon the statutory penalty criteria.

The operators associated with the mines captioned above have agreed to pay all of the proposed penalties in full and to withdraw their contests of the subject citations and orders. Under Commission Rule 11 “[a] party may withdraw a pleading at any stage of a proceeding with the approval of the Judge or the Commission.” 29 C.F.R. § 2700.11. The Secretary does not object to the payment of proposed penalties and withdrawal of contests and agrees that she has considered all of the penalty criteria in determining the proposed assessment for each citation and order. Based upon all of the facts and information presented by the parties, we agree that the Respondent’s request to withdraw its contest of all penalties is appropriate for all of the subject citations and orders contained in these dockets.

The Federal Mine Safety and Health Review Commission exists to provide due process of law to the parties that practice before it. Here, the parties have reached a mutual agreement that, based on the information before us, adequately protects the public interest. Going forward, it is essential that the April 5, 2010 events at the Upper Big Branch Mine not be forgotten. We are sorely aware of the fact that no civil or criminal monetary or other penalty can come close to righting the wrong that those miners suffered, and that the families and friends of those miners continue to suffer. We are hopeful that, by agreeing to pay the proposed penalties in full and withdrawing its notices of contests of the subject citations and orders, Performance Coal Company has taken one step towards holding itself accountable for this terrible tragedy and that the former Massey mines are taking the necessary steps to assure compliance with MSHA regulations, thereby providing a safer working environment for all of their miners. Based on the information before us, the Respondents’ motion is granted.

For the foregoing reasons, the Respondents’ request for withdrawal of the subject contests is GRANTED, and Alpha Natural Resources Inc., on behalf of the former Massey mines named on the attached exhibits, is ORDERED TO PAY the Secretary of Labor the total proposed penalty for all subject citations and orders within 30 days of this order. Upon receipt of payment, the contest proceedings listed in Exhibits 1 and 3 are DISMISSED.

/s/ Robert J. Lesnick
Robert J. Lesnick
Chief Administrative Law Judge

/s/ Margaret A. Miller
Margaret A. Miller
Administrative Law Judge
ORDER GRANTING UNOPPOSED MOTION TO MODIFY THE LEGACY MASSEY COMPANIES’ AMENDED NOTICE OF WITHDRAWAL AND MOTION TO DISMISS

After careful review of the thousands of citations and/or orders that were addressed by our March 7, 2012 Order Granting Motion for Withdrawal of Contests and Order to Pay (the “Order”), the parties discovered a clerical error which resulted in the inadvertent inclusion of Road Fork, Docket No. WEVA 2008-1068-M, in the exhibits attached to the March 2, 2012 Amended Notice of Withdrawal and Motion to Dismiss (the “Motion”) filed by Alpha Natural Resources (“Alpha”), on behalf of the Legacy Massey Companies captioned above. On April 6, 2012 Alpha filed an Unopposed Motion to Modify the Legacy Massey Companies’ Amended Notice of Withdrawal and Motion to Dismiss (“Motion to Modify”). Alpha now moves to substitute a revised, and correct, set of exhibits. Accordingly, Alpha also moves to modify the

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1 Numerous other Performance Coal Company dockets are addressed by this order. The affected dockets are listed in the newly substituted exhibits and specifically exhibit 5.

2 The mines, along with the docket numbers addressed by this order, are listed in the attached exhibits.
amount that it is ordered to pay to reflect a newly calculated total of $19,854,313.00. The Secretary does not oppose the Motion to Modify. The Motion to Modify is therefore **GRANTED** and the exhibits in the master file shall be replaced with the amended exhibits filed with the Motion to Modify.

/s/ Margaret A. Miller  
Margaret A. Miller  
Administrative Law Judge

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June 1, 2012

OAK GROVE RESOURCES, LLC, : CONTEST PROCEEDINGS
Contestant
v.

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

Docket No. SE 2009-589-R
Order No. 767684; 05/21/2009

Docket No. SE 2009-591-R
Order No. 7697686; 5/21/2009

SECRETARY OF LABOR
MINE SAFETY AND HEALTH ADMINISTRATION (MSHA),
Petitioner
v. Mine: Oak Grove Mine

OAK GROVE RESOURCES, LLC,
Respondent

DECISION

Appearances: LaTasha T. Thomas, Esq., U.S. Department of Labor, Nashville, TN, on behalf of the Secretary of Labor

R Henry Moore, Esq., Jackson Kelly, PLLC, on behalf of Oak Grove Resources, LLC

Before: Judge Rae

These cases are before me on three notices of contest filed by Oak Grove Resources, LLP (“Oak Grove” or “Respondent”) against the Secretary of Labor (“Secretary”) and a petition for assessment of penalties filed by the Secretary against Oak Grove, pursuant to section 105(d) of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 75.801 et seq., the “Act”. The parties resolved two assessed orders leaving these three to be decided by me. An order for partial settlement was issued by me on March 2, 2012. A hearing was held on January 24, 2012 in Birmingham, Alabama at which evidence was presented. Post-hearing briefs were submitted by both sides and have been considered in issuing this decision.
The parties entered into the following joint stipulations of fact:

1. On May 21, 2009, Oak Grove Resources, LLC was an operator as defined in §3(d) of the Federal Mine Safety and Health Act of 1977, as amended, 30 U.S.C. §802.(d).

2. The facility is a “mine” as that term is defined in Section 3(h) of the Mine Act, 30 U.S.C. §802(h).

3. Oak Grove Mine, an underground bituminous coal mine, is subject to the jurisdiction of the Mine Act.

4. An authorized representative of the Secretary served copies of the orders at issue in this proceeding on the Respondent.

5. Respondent timely contested the orders.

6. Respondent is subject to the jurisdiction of the Federal Mine Safety and Health Review Commission, and the presiding Administrative Law Judge has the authority to hear this case and issue a decision regarding this case.

7. The proposed penalties will not affect the Respondent’s ability to remain in business.

**FINDINGS OF FACT**

Oak Grove is a large underground bituminous coal producer. Mining is done by the longwall retreat method whereby mining is done in an outby direction in the working panel. At the time these three orders were issued, mining in the Old 10 East panel had been completed in October 2005 and had begun in the New 10 East panel adjacent to the old panel. (Tr. 116; Ex. R-3.) The two panels were separated by a 60-foot barrier of coal with a series of entries and crosscuts on either side of the barrier. The purpose of the barrier was to isolate the mined out area from the new district of longwall panels. The barrier also supported the weight of the roof and reduced the pressure from building in the Old 10 East area as the New 10 East was mined. (Tr. 116-17.) As mining retreated outby in the new panel, more weight was placed on the barrier and the roof of the Old 10 East section, causing conditions in the old area to deteriorate. (Tr. 96.)

A pump is located at crosscut 45 on the Old 10 East side of the coal barrier which aids in ventilation and prevents a buildup of methane in the area. (Tr. 11.) Under the approved ventilation plan, Oak Grove was required to examine the pump every 24 hours. Examination of the entire Old 10 East entry was also required once every seven days. (Tr. 31.) It is the condition of the roof and ribs from crosscut 37 to crosscut 47 that is at issue in this case.
The Secretary’s Evidence

Rodney Williams had been an MSHA certified inspector for over two years at the time he conducted an EO1 inspection of Oak Grove in May 2009. (Tr. 19.) His prior mining experience of 30+ years began in 1974 and included positions as a driller, shot foreman, roof bolter, fireboss, mine examiner and rescue team member. (Tr. 18-21.)

On May 19, 2009, MSHA inspector Williams was accompanied by a miner on his inspection of the Old 10 East No. 1 entry and pump located at crosscut 45. The miner was one of the certified examiners who performed the pre-shift examinations of these areas on a regular basis. (Tr. 31-32.) Williams and the miner started at the East Bleeder section that ran behind longwall panel #36 and went to a cut-through in the Old 10 East isolated intake. (See mine map Ex. R-3.) The miner indicated that they were following the route that he normally took to access the pump at crosscut 45. (Tr. 74.) The miner traveled one or two crosscuts to crosscut 47 where Williams observed that the prop setters had taken weight, the ribs had rolled out and the miner was about to proceed through “very, very serious bad roof and rib conditions.” (Tr. 32, 35.) He told the miner to stop and not travel any further. The miner responded by saying “well, I’m glad to hear that.” (Tr. 32-33.) Williams asked the examiner if there was another route he could take to access the pump; the examiner responded that he thought he could do so through the outby side up through the No. 1 isolated intake area. (Tr. 33-35; mine map Ex. R-3.) Williams could not recall if he instructed the miner to put a danger flag in the area at that time but felt it unlikely that anyone else would pass through there again as the area was only accessed by the examiner. Williams was not aware at that time that people were using this route on a daily basis to check the pump. (Tr. 33.) Williams did not issue any citations or orders on the 19th but instructed the examiner to stay out of the area until the he could examine the entire No 1 isolated intake entry. (Tr. 35-36.)

On May 21, 2009, MSHA Inspector Williams, accompanied by several other MSHA inspectors as well as mine representatives, traveled up the isolated intake in the Old 10 East panel from outby in an attempt to make the entire entry. They started at crosscut 1 and traveled as far as crosscut 37 when he observed areas where roof bolt plates had popped off and bolts were broken, deep cracks in the roof were evident, areas where the bottom had heaved up from the stress of the roof pushing down on the pillars of coal, and ribs had sloughed at the corners. Oak Grove had installed additional roof support in the area in the form of pumpable cribs and prop setters but Williams determined that the supports were insufficient to support the weight of the roof and that the area inby crosscut 37 was too dangerous to be traveled. (Tr. 24-27.) He ordered the area be dangered off at that time. (Tr. 25.) Williams testified that there could have been some area between crosscut 37 and 45 where the roof was safe but based upon what he had seen on the 19th and 21st, he felt it was not possible to make that determination because the conditions were unsafe from either direction approaching that area. (Tr. 36.) He also stated that an examiner traveling to the pump from any direction would have had to travel under unsafe roof. (Tr. 85.)
When back on the surface, Williams met with members of management to discuss his findings. He was told that they were aware of the poor condition of the roof in the isolated intake and had ceased conducting their weekly examination of the area two weeks prior to this inspection and changed the firebosses’ examination route, notating it in their examination book. (Tr. 41, 43-47; Ex. R-2.)

Williams testified that the Preshift-Mine Examination Report indicates that on May 17, 18 and 21 and 22, the pump at crosscut 45 had been examined by several different individuals under the cited roof conditions before it was corrected on June 1, 2009. (Tr. 42-46, Ex. S-3.) The hazardous condition of the roof, however, was not notated in the company examination and hazards book as it should have been. (Tr. 47.)

Based upon the conditions that he found and the information provided by the Respondent that the intake entry had not been examined in two weeks, Williams issued 104(d)(2) orders for failure to protect against roof and rib falls under 30 C.F.R. §75.202(a); failure to conduct weekly examinations of an intake air course under 30 C.F.R. §75.364(b) (1); and, failure to post a danger sign in a hazardous area pursuant to 30 C.F.R. §75.363(a). (Exs. S-1 – S-3.) Each of these orders was designated as significant and substantial (S&S) and an unwarrantable failure to comply with a mandatory standard.

Section 104(d)(1) of the Mine Act provides: If, upon inspection of a coal or other mine, an authorized representative of the Secretary finds that there has been a violation of any mandatory health or safety standard, and if he also finds that, while the conditions created by such violation do not cause imminent danger, such violation is of such nature as could significantly and substantially contribute to the cause and effect of a coal or other mine safety or health hazard, and if he finds such violation to be caused by an unwarrantable failure of such operator to comply with such mandatory standards, he shall include such finding in any citation given to the operator under this act. If, during the same inspection or any subsequent inspection of such mine within 90 days after the issuance of such citation, an authorized representative of the Secretary finds another violation of any mandatory health or safety standard and finds such violation to be also caused by an unwarrantable failure of such operator to so comply, he shall forthwith issue an order requiring the operator to cause all persons in the area affected by such violation, except those persons referred to in subsection (c) to be withdrawn from, and to be prohibited from entering, such area until an authorized representative of the Secretary determines that such violation has been abated. 30 C.F.R. §814(d).

Section 104(d)(2) of the Mine Act provides: If a withdrawal order with respect to any area in a coal or other mine has been issued pursuant to paragraph (1), a withdrawal order shall promptly be issued by an authorized representative of the Secretary who finds upon any subsequent inspection the existence in such mine of violations similar to those that resulted in the issuance of the withdrawal order under paragraph (1) until such time as an inspection of such mine discloses no similar violations. Following an inspection of such mine which discloses no similar violations, the provisions of paragraph (1) shall again be applicable to that mine. 30 C.F.R. §814(d).
**Oak Grove’s Evidence**

In addition to making the argument that the violation for allowing miners to travel under unsupported roof is inconsistent with an order alleging a failure to examine the entry, Oak Grove contends that miners neither traveled nor worked under unsupported roof conditions and therefore the first order should not have been issued. They contend the cited area from crosscut 37 to 47 included the span between crosscuts 37 and 45 which was only traveled by examiners prior to May 2009 after which time they were told not to enter this area. (Tr. 69, 75.) The examination route had been changed and noted in the record books to prevent entry into the unsafe area outby the pump in the isolated entry. (Tr. 138-39; 155; Ex. R-2, p. 55.) They assert that the only area actually in controversy, therefore, is between crosscuts 45 and 47, which they allege was perfectly safe. They point out that Williams did not travel between these crosscuts on May 21st when he issued this order but had been there on May 19th and had not issued any orders or citations at that time. (Tr. 69, 75.) Oak Grove asserts that the route taken by Williams on the 19th, through the Old 10 East intake was not proven by the Secretary to be the route normally used by the examiners to access the pump. They assert, instead that the route normally taken by the examiners was a safe one through the longwall headgate above the coal barrier to the A or B cut-through into the Old 10 East entry and then to the right to the crosscut 45pump (as depicted on Ex. R-3 mine map points A and B cut-through areas). It is their position that the area from the pump to crosscut 47 was safe for travel and should not have been cited under C.F.R. §75.202(a). They admit to technical violations of the other two orders. (See Oak Grove’s post-hearing “Brief.”)

Gary Shortt, an employee of Oak Grove with 40 years of mining experience and a mine engineering degree, testified that he traveled to the pump on May 8, 2009 by the B cut-through outby route from crosscut 46 to 45 and found the roof to be safe. The roof at the pump was heavily cribbed. He then walked outby a couple more crosscuts to crosscut 43 and observed the roof was still holding but was deteriorating. (Tr. 124-25.) He stated that he could not be sure but he felt the examiners would take the same route he did. (Tr. 126.) Marion Conners, Oak Grove’s fireboss/certified examiner, told Shortton May 8, 2009 that he had walked as far as the 44 crosscut and felt uncomfortable with the conditions in 44 and 45. (Tr. 126, 129.) Thereafter, Shortt spoke with the engineering department and told them he wanted to submit a plan to MSHA requesting evaluation points from which to perform the required examination of the No. 1 entry because the firebosses were starting to feel uncomfortable traveling the intake. (Tr. 127.) He was told that the company had the authority from a previous meeting with MSHA to examine the entry from both ends rather than travel its entirety. (Id.)

Shortt had a discussion with Williams on the 21st immediately after Williams issued his imminent danger order. He told Williams that he had suspicions that the area was “going to get bad” based upon the deterioration he saw on the 8th. (Tr. 130.) Shortt accompanied the general manager, Paul Hafera, and the vice president, Doug Williams, and several others to the pump area in order to determine what was needed to terminate the order. He felt as though the conditions at the pump were the same as he had observed them on the 8th. Outby the pump, however, the area had deteriorated to the point that it was futile to attempt to support it. They
concentrated instead on the area between the pump and crosscut 47 by adding 25 additional cribs. (Tr. 131-133.) Shortt testified that this area was already so heavily cribbed, one could hardly walk through it. (Tr. 133.) It was still safe in his opinion, however, to travel through the bleeders to the cut-through and over one crosscut to the pump (from 46 to 45). (Tr. 134.)

John “Rusty” Hedrick, III, testified on behalf of Oak Grove as the former manager of safety and current superintendent of the mine. Hedrick was involved in the post-inspection discussions with Williams regarding when the Old 10 East entry had been last examined and what the roof conditions were. He recalled that at the time of the inspection the company was making the isolated entry from either end due to poor roof conditions. (Tr. 93.) He was with Williams when he made the inspection on the 21st of the area around crosscut 35 and 37 as he walked down the Old 10 East entry. As he approached 37, he saw the roof had broken up as the longwall retreated in the 11 East panel. (Tr. 96.) The area by 37 had supplemental roof support in the form of pumpable cribs, tri-timbers and pilasters which he described as significantly more than usually found in other longwall tailgates or headgates. The area was dangered off at William’s direction at that time. (Tr. 97-99.) Hedrick had not been in the area for some time prior to the inspection, but stated that he was not surprised to hear that the area around pump 45 was bad and was dangered off even with the additional support due to the retreat of the adjacent longwall mining and the geological conditions. (Tr. 93, 107-08; 110-12.) He was aware that certified examiners traveled the area in question. (Tr. 108.)

James Richardson is Oak Grove’s mining engineer who has over 30 years in the field. He testified that in May 14, 2009, he had a conversation with Rex Hartzel, Oak Grove’s general mine foreman, in which they discussed the fact “that the area in Old 10 East around 45 crosscut pump and before you get there, the examiners were not able to make that area completely through…” (Tr. 138.) They discussed changing the firebosses’ route and made the change in the “Old Works Fireboss Examinations & Hazards” book. (Tr. 138-40.) Following the issuance of the orders by Williams, Oak Grove submitted a plan to MSHA to postpone inspecting the pump for seven days. (Tr. 141-42; R-5.) Thereafter a plan was submitted proposing the Old 10 East be evaluated from vantage points at either end rather than traveling the entire No. 1 entry. (Tr. 142-42; R-6.) Richardson testified that in his opinion, Oak Grove could not have asked for permission to change the examination route earlier because MSHA requires an area to actually become hazardous before they will consider such an amendment. (Tr. 144.)

Rex Hartzel testified that he has over 37 years of mining experience to include longwall shear operator, roof bolter, and foreman and rescue team member. (Tr. 146-47.) In May 2009, a fireboss came to him to report that the roof conditions in the area of crosscuts 43 and 44 had deteriorated to the point that he no longer felt it safe to travel that area. (Tr. 148.) He discussed changing the book to note the route that was being taken to access the pump at 45 through the New 10 East to the cut-through inby the Old 10 East and around to 45 on the daily examinations and outby crosscut 37 in Old 10 East on the weekly examinations. (Tr. 149.) Hartzel was with Williams on the 21st and felt that when Williams ordered the area at 37 dangered off, it was still possible to travel further inby safely. (Tr. 150.) He also went underground after the inspection and traveled to the pump and inby from there and felt the roof was in good condition. The
middleman, or layer under the coal seam, had already fallen out leaving the main roof in good condition. Additionally, there were several extra cribs and props making the area secure. (Tr. 151-52.) Hartzel confirmed that certified persons still examined the pump even after the fireboss’ route was changed by he and Richardson. Had there been any mechanical issues, an electrician would also be sent in, he confirmed. (Tr. 155-58.)

General Manager Paul Hafera testified that he went underground after the orders were issued to examine the New 10 East and the inby end of the Old 10 East from crosscut 47 to 44 and through the No. 1 entry up to crosscut 37. (Tr. 166-67.) He described the roof as broken in many places from 47 to 44. He also noticed a distinct change at crosscut 35 where the roof was soft. (Tr. 167.) He could see in from 37 to about 41 which he felt was easily travelable with a lot of supplemental roof supports in both the inby and outby areas. (Tr. 167-68.) In fact, from 47 to 41, the area was “saturated” with timbers, pumpable cribs and pilasters to the point where it was difficult to walk in a straight line. He did not see any supplemental support failure which formed the basis of his opinion that the area was safe. (Tr. 168.) Hafera denied any knowledge of a fireboss voicing a concern over the roof conditions in the entry near the pump. (Tr. 174.)

**LEGAL PRINCIPLES**

### Significant and Substantial (S&S)

Each of the three orders issued by Williams has been designated as S&S.

An S&S violation is a violation “of such nature as could significantly and substantially contribute to the cause and effect of a . . . mine safety or health hazard.” 30 U.S.C. § 814(d). A violation is properly designated S&S, “if, based upon the particular facts surrounding the violation, there exists a reasonable likelihood that the hazard contributed to will result in an injury or illness of a reasonably serious nature.” *Cement Div., Nat’l Gypsum Co.*, 3 FMSHRC 822, 825 (Apr. 1981). As is well recognized, in order to establish the S&S nature of a violation, the Secretary must prove: (1) the underlying violation; (2) a discrete safety hazard – that is, a measure of danger to safety – contributed to by the violation; (3) a reasonable likelihood that the hazard contributed to will result in an injury; and (4) a reasonable likelihood that the injury will be of a reasonably serious nature. *Mathies Coal Co.*, 6 FMSHRC 3-4 (Jan. 1984); accord *Buck Creek Coal Co., Inc.* 52 F. 3rd 133, 135 (7th Cir. 1995); *Austin Power Co., Inc. v. Sec’y of Labor*, 861 F. 2d 99,103 (5th Cir. 1988) (approving *Mathies* criteria).

It is the third element of the S&S criteria that is the source of most controversies regarding S&S findings. The element is established only if the Secretary proves “a reasonable likelihood the hazard contributed to will result in an event in which there is an injury.” *U.S. Steel Mining Co., Inc.*, 7 FMSHRC 1125, 1129 (Aug. 1985). An S&S determination must be based on the particular facts surrounding the violation and must be made in the context of continued normal mining operations. *Texasgulf, Inc.*, 10 FMSHRC 1125 (Aug. 1985); *U.S. Steel*, 7 FMSHRC at 1130.
The S&S nature of a violation and the gravity of a violation are not synonymous. The Commission has pointed out that the “focus of the seriousness of the violation is not necessarily on the reasonable likelihood of serious injury, which is the focus of the S&S inquiry, but rather on the effect of the hazard if it occurs.” Consolidation Coal Co., 18 FMSHRC 1541, 1550 (Sept. 1996).

**Unwarrantable Failure**

Each of the orders involved herein has been designated as an unwarrantable failure.

In Lopke Quarries, Inc., 23 FMSHRC 705, 711 (July 2001), the Commission reiterated the law applicable to determining whether a violation was the result of an unwarrantable failure:

The unwarrantable failure terminology is taken from section 104(d) of the Act, 30 U.S.C. § 814(d), and refers to more serious conduct by an operator in connection with a violation. In Emery Mining Corp., 9 FMSHRC 1997 (Dec. 1987), the Commission determined that unwarrantable failure is aggravated conduct constituting more than ordinary negligence. *Id.* at 2001. Unwarrantable failure is characterized by such conduct as “reckless disregard,” “intentional misconduct,” “indifference,” or a “serious lack of reasonable care.” *Id.* at 2003-04; Rochester & Pittsburgh Coal Co., 13 FMSHRC 189, 194 (Feb. 1991) (“R&P”); see also Buck Creek Coal, Inc. v. FMSHRC, 52 F.3d 133, 136 (7th Cir. 1995) (approving Commission's unwarrantable failure test).

Whether conduct is “aggravated” in the context of unwarrantable failure is determined by looking at all the facts and circumstances of each case to see if any aggravating factors exist, such as the length of time that the violation has existed, the extent of the violative condition, whether the operator has been placed on notice that greater efforts are necessary for compliance, the operator’s efforts in abating the violative condition, whether the violation is obvious or poses a high degree of danger, and the operator’s knowledge of the existence of the violation. See Consolidation Coal Co., 22 FMSHRC 340, 353 (Mar. 2000); Cyprus Emerald Res. Corp., 20 FMSHRC 790, 813 (Aug. 1998), rev’d on other grounds, 195 F.3d 42 (D.C. Cir. 1999); Midwest Material Co., 19 FMSHRC 30, 34 (Jan. 1997); Mullins & Sons Coal Co., 16 FMSHRC 192, 195 (Feb. 1994); Peabody Coal Co., 14 FMSHRC 1258, 1261 (Aug. 1992); BethEnergy Mines, Inc., 14 FMSHRC 1232, 1243-44 (Aug. 1992); Quinland Coals, Inc., 10 FMSHRC 705, 709 (June 1988). All of the relevant facts and circumstances of each case must be examined to determine if an actor’s conduct is aggravated, or whether mitigating circumstances exist. Consol, 22 FMSHRC at 353. Because supervisors are held to a high standard of care, another important factor supporting an unwarrantable failure determination is the involvement of a supervisor in the violation. REB, 20 FMSHRC 203, 225 (Mar. 1998).
CONCLUSIONS OF FACT AND LAW

Order No. 7697684

The narrative portion of this order reads as follows:

The travelway in the No. 1 entry of the Old 10 East isolated intake is not being supported or otherwise controlled to protect persons from hazards related to falls of roof or ribs. Prop setters have been installed in this entry and additional support has been provided in the form of pumpable cribs. These measures have failed to maintain the stability of the roof in the areas from cross-cut (sic) No. 37 to crosscut No. 47, a distance of approximately 1500 feet. There are many areas of broken and falling roof, as well as broken roof bolts, throughout the cited area. Cracks and fissures are running deep into the mine roof. Based on interviews with Management, this condition has been known to exist for approximately 2 weeks.

This entry is used by supervisors and certified examiners in making the pump at cross-cut (sic) No. 45 as recorded in the daily examination book. The pump is required to be examined daily according to the mine’s approved ventilation plan. The entire entry is required to be made on a weekly basis. This violation is an unwarrantable failure to comply with a mandatory standard. This violation is subject to review as a flagrant violation.

(Ex. S-1.)

Based upon the facts as set forth above, Williams designated this section 104(d)(2) order as highly likely to result in a fatal accident affecting one person and the result of reckless disregard for the safety of miners, S&S and an unwarrantable failure to comply with a safety standard. (Ex. G-1.) The proposed penalty is $56,900.00. The violation was abated by the installation of 25 additional pumped cribs from crosscuts 45 to 47. (Ex. S-1.)

The mandatory standard provides that “[t]he roof, face and ribs of areas where persons work or travel shall be supported or otherwise controlled to protect persons from hazards related to falls of the roof, face or ribs and coal or rock bursts.” 30 C.F.R. §75.364(b).

While Oak Grove alleges that no persons traveled between crosscut 37 and 45, there is evidence that the examiners were traveling through portions of that area under unsafe roof as discussed above. Specifically, fireboss Marion Connors reported to Shortt that he had been traveling under roof conditions he felt were unsafe in vicinity of crosscuts 44 and 45. Shortt himself testified that he observed the mine roof between crosscuts 45 and 43 had deteriorated when he was in the section in early May. He believed the examiners did not travel in that area but he admitted that he could not be sure what route the examiners used. Hedrick testified that when he accompanied Williams on the inspection, he saw broken sections of the roof at crosscut 35 and 37. He was not surprised as geological conditions and retreat mining caused additional
stress on the roof at crosscut 45 as well. Richardson stated that he knew the area around the
pump and the crosscuts just outby were not passable based upon reports made to him by the
examiners. Hartzel had been told by a fireboss in early May that the area between crosscut 43
and 44 was too dangerous to travel through. He also confirmed that the pump was still being
examined after the firebosses’ route was changed and that, had there been mechanical issues, an
electrician would have been sent into the area as well. The fireboss’ book, which Shortt testified
reflected the change in the route, indicates this change was not actually made until May 19. The
examination route on the 12th included all of the East bleeders. (Tr. 138- 140; Ex. R-2 pp. 39
and 55.) The examination book, Ex. S-4, indicates the pump at crosscut 45 was examined
several times between May 17th and May 22nd. While miners may not have been traveling the
entire entry, the evidence conclusively refutes the Respondent’s argument that no one was in the
entry between crosscut 45 and outby that area.

Oak Grove’s second argument that the area outby crosscut 45 to crosscut 47 was not
unsafe also fails. The miner who accompanied Williams on the 19th told Williams that the route
they were taking was the one he used to make the required examinations. He traveled in from the
bleeders through crosscuts 46 and 47 heading towards the pump at 45. When Williams told him
it was unsafe to continue along this route and danger it off, the miner was relieved to hear it. In
order to terminate the order, Oak Grove installed an additional 25 pumpable cribs between
crosscuts 45 and 47, a distance of some 30 feet. General Manager Hafera viewed the area
himself immediately after the order was issued and observed that the roof was broken in many
places between crosscuts 47 and 44. This was in an area that he had described as already so
“saturated” with timbers, cribs and other means of supplemental support that walking through it
in a straight line was impossible.

Had the supplemental support already in place in the Old 10 East entry been sufficient,
one would not expect to find the roof in the poor condition Williams observed. Furthermore,
installation of an additional 25 pumpable cribs in an expanse of only 30 feet would not have
been necessary if the area was as safe as the Respondent claims. Williams testified that
regardless of the route the examiner took to inspect the pump, he would have had to travel under
dangerous roof conditions.

I find Williams’s testimony to be credible that miners were traveling and working under
unsupported roof exposed to the danger of a roof fall while making examinations in areas
between crosscuts 37 and 47 of the Old 10 East No. 1 entry in violation of this mandatory
standard.

S&S

Oak Grove makes the same argument it did in contest of the violation as it does in
refuting the S&S designation. That is that persons did not travel or work between crosscuts 37
and 45 and that the area outby crosscut 45 was not unsafe. For the same reasons as discussed
above, this argument is not persuasive.
Williams testified that based upon the very dangerous roof conditions he found in the No. 1 entry on the 19th and 21st, it was his opinion that it was reasonably likely that the hazard posed by the improperly supported roof and ribs would cause a roof fall if the condition went uncorrected. Throughout the areas Williams inspected, he found places of fallen and broken roof, ribs that had rolled out, and broken bolts and plates as well as heaving from unsupported pressure on the roof. (Tr. 27-28.) Based upon his experience, once the roof is compromised in the manner he observed, pieces of coal the size of a car can fall without notice.

Obviously, the firebosses/examiners at Oak Grove also felt the conditions posed such likelihood when they reported to management that they no longer felt comfortable making the examinations just two weeks before Williams made his inspection. Also indicative of how likely a roof fall was, was Oak Grove’s own conclusion following the inspection that the entry outby crosscut 45 was not salvageable and that the area from 45 to 47 required an additional 25 pumpable cribs to provide adequate support to the roof in an area that was already congested with supplemental supports.

It is reasonably likely that a roof fall would result in a reasonably serious injury to the examiner - the one person who Williams felt would be the victim of such an event. (Tr. 30.) Roof falls are notorious in the mining industry for resulting in extremely serious injuries, often death, when they occur in a working area of the mine.

I accept Inspector Williams’ assessment of this violation as S&S and of very high gravity.

Negligence/Unwarrantable Failure

The order was assessed as reckless disregard for the safety of the miners and an unwarrantable failure to comply with the mandatory standard. Although Oak Grove knew of the conditions of the roof and had spent considerable sums installing supplemental support, their examiners were still being sent into an unsafe mine on a daily basis to make their examinations. (Tr. 122-26, 130.) Connors and Hedrick were just two certified persons who told management that they were uncomfortable traveling their examination route. Hedrick testified that they were aware of the geological conditions in that area of the mine and that with the retreat mining being done in the adjacent panel, it was no surprise that the area needed to be dangered off. Shortt, Hartzel, Hafena and Richardson were all aware of the deteriorating conditions in this entry but none had gone into the entry after May 8 to monitor the conditions. They claimed that they could not obtain an amendment to their ventilation plan from MSHA in advance of the issuance of the orders unless they could prove it was not possible to travel the entry. However, not a single one of them had even made the effort to present the more recent information at hand to MSHA in an attempt to establish the necessity for the amendment. In fact, their last contact with MSHA was seven months earlier in October 2008 when they reported that the barrier between
the two panel districts was not providing adequate roof support. (Tr. 117-20.) It was only after Williams cited them, did they submit the change which was immediately approved. Oak Grove’s assertions are self-serving and untenable and clearly demonstrate a reckless disregard for the safety of their miners.

In addressing the individual factors discussed in Consolidation Coal Co., I find the following:

The conditions at Oak Grove existed for at least two weeks before management took steps to change the examiner’s route to the pump. (Tr. 31.) However, even with the change in the route, the examiner was still exposed to hazardous roof conditions from crosscut 45 to 47 when entering from the alternate route. It was not until Williams issued this order, that the roof above the pump and outby to crosscut 47 was supplemented with additional cribs. Thus, the violation existed for a period of time that unreasonably exposed miners to serious bodily injury.

The condition was obvious and posed a high degree of danger to the miners. As previously discussed, management was well aware of the deteriorating condition of the roof and was informed by the firebosses that it had worsened. Williams found the condition of the roof to be open and obvious to a casual observer. (Tr. 39.) The timbers and prop setters were evidencing signs of failure and there were visible cracks and fissures and sloughing in the roof and ribs. (Tr. 24-27.) A roof fall in an area of a mine that is being worked or traveled would be reasonably likely to, and often does, cause fatal injuries. (Tr. 29, 50.)

Oak Grove was on notice that greater efforts at compliance were necessary. Oak Grove has received 16 citations for violation of this same mandatory standard within the past two years preceding the issuance of this order. (Ex. G-8.) Furthermore, they had been involved in discussions with MSHA in October 2008 during which they admitted they were aware that their supplemental roof support was failing and were compelled to install additional supports. They were also apprised of the continuing degradation of the roof by their own examiners at least several weeks before this inspection and failed to inspect the area themselves and take appropriate action.

Oak Grove had knowledge of the existence of the violation for at least two weeks prior to the inspection, by its own admission. (Tr. 31.) They further knew of the continued deterioration of the roof and lack of support thereof from the reports of Conners and Hedrick.

Oak Grove installed 25 pumpable cribs between the pump and the cut-through at crosscut 47. In addition, they submitted a change to the ventilation plan to MSHA, as discussed above. However, they made no attempt to do either before they were forced to with the issuance of the 104(d) order.

Based upon all of the above factors, I find this assessment of an unwarrantable failure and reckless negligence to be supported by the evidence.
The order alleges that Oak Grove had not made the required examination of the entry in its entirety for approximately two weeks. Williams characterized this 104(d)(2) violation as reasonably likely to result in a fatality affecting one person, S&S, the result of high negligence and an unwarrantable failure to comply with the standard. (Ex. G-2.) The proposed penalty is $27,900.00.

The mandatory standard requires state that:

At least every 7 days, an examination for hazardous conditions at the following locations shall be made by a certified person designated by the operator: (1) In at least one entry of each intake air course, in its entirety, so that the entire air course is traveled.

30 C.F.R. §75.364(b)(1).

This order was issued upon the admission by the Respondent that the Old 10 East No. 1 entry had not been examined in its entirety due to the poor roof conditions in the isolated intake. (Tr. 24, 48.) Oak Grove admits to this violation.

The Secretary has established that Oak Grove did violate this mandatory standard.

S&S

The isolated intake area that was to be examined on a weekly basis was part of an intake airway that did not ventilate any active area of the mine. Williams testified that the purpose of the weekly examination was to detect changing conditions which would pose a hazard such as a roof fall or an explosion from a methane buildup. (Tr. 49-50.) In his opinion, it was reasonably likely that conditions “could occur” that would be reasonably likely to result in death. (Tr. 51.)

Air readings were being taken by Oak Grove during the period in which they stopped making the examination of the entire entry, from evaluation points. These readings registered safe concentrations of gases and volumes of air. (Ex. S-4; Tr. 154.) Likewise, MSHA took readings during their inspection and did not detect any increased levels of methane or decreased airflow or levels of oxygen. (Tr. 77-78.) Moreover, in order to terminate the order Oak Grove submitted a plan to MSHA which eliminated the requirement to examine this entry between crosscuts 37 and 45 which was readily approved. All of these factors indicate to me it was not necessary to examine this entire entry for ventilation or any other purposes.

The area from crosscut 44 to 47 was being examined on a daily basis when checking the pump. Regardless of the fact that management did not sufficiently heed the examiners voiced concerns regarding the roof conditions in the area, it was being examined for both roof conditions and ventilation requirements. The failure to examine the remainder of the entry
where no one was working or traveling during the cited time period in no way posed a likelihood of injury to a miner. If anything, Oak Grove’s actions did reduce the exposure of miners to some of the risk by not traveling the entire entry.

I do not find this violation was properly designated as S&S.

**Negligence/Unwarrantable Failure**

The Secretary contends that this order is properly evaluated at high negligence and as an unwarrantable failure to comply with the standard for the same reasons she asserts it is S&S. The Secretary asserts that the hazardous conditions of the roof in this entry were extensive. Not sending miners into the area between crosscuts 37 and 47 constituted aggravated conduct. (See *Secretary’s Post-Hearing Brief at 17.*) I am in agreement with the Respondent’s position that the Secretary’s stance is antithetical to the purpose of the Act. The area surrounding the pump was already being examined daily. The decision by Oak Grove, albeit without permission from MSHA, to suspend the weekly examination of the remaining portions of the entry was by no means reckless or negligent. It was specifically intended to provide some measure of safety to the examiners; however, the effort was not sufficient with respect to the pump area as discussed above regarding Order No. 7697684.

I find this order was not properly designated as an unwarrantable failure to comply with the standard and was the result of moderate negligence.

**Order No. 7697686**

This order alleges that:

Hazardous conditions in the form of dangerous roof and ribs were found in the No. 1 entry of the Old 10 East isolated intake in the area around crosscut No. 37. These conditions had not been posted with a conspicuous danger sign to prevent entry or corrected as required. They had not been recorded in the fireboss book. This area is required to be traveled by supervisors or certified examiners on a daily basis. This violation is an unwarrantable failure to comply with a mandatory standard and is subject to review as a flagrant violation.

(Ex. S-3.)

The mandatory standard requires:

Any hazardous condition found by the mine foreman or equivalent mine official, assistant mine foreman or equivalent mine official, or other certified persons designated by the operator for the purposes of conducting examinations under this subpart D, shall be posted with a conspicuous danger sign where anyone entering the areas would pass.
Williams designated the alleged violation as reasonably likely to result in a fatal accident affecting one person, S&S, the result of high negligence and an unwarrantable failure to comply with the cited standard. (Ex. G-3.) The Secretary has proposed a penalty of $27,900.

Williams testified that while traveling inby, the area around crosscut 37 was found to be hazardous causing him to order the area be flagged off with danger warnings. The condition was known to exist for two weeks. (Tr. 56, 59.) Oak Grove concedes a technical violation of this standard.

S&S

Williams assessed the violation as S&S because he observed very dangerous roof conditions inby crosscut 37 which posed a reasonable likelihood of a reasonably serious injury to an examiner resulting from a roof fall. (Tr. 57-58.) He likewise testified that on the 19th he observed similar conditions outby crosscut 45 to 47.

Respondent contends that the S&S designation is inappropriate because the only persons who would travel the area are the certified examiners who had been directed not to travel the area and therefore there was no exposure to miners.

The analysis of this order is similar to that set forth above in the discussion of Order No. 7697684. The evidence establishes that while the area between crosscuts 37 and 47 had not been accessed once the firebosses’ route was changed, examiners were still traveling crosscuts 44 to 47 to access the pump. Members of management testified that they felt this inby area was safe for travel; however, there is ample evidence to demonstrate that this area was extremely hazardous and should have been flagged as a danger zone to prevent the examiners’ entry. For the same reasons as set forth above, I find the Secretary has established this violation was S&S and of very serious gravity.

Negligence/Unwarrantable Failure

This violation was deemed the result of high negligence and an unwarrantable failure for the same reasons as was Order No. 7697684. (Tr. 58-60.) In addition, Williams testified that Oak Grove had been previously cited for violations of this standard putting them on notice of the necessity for greater compliance. (Tr. 59.)

Based upon the same analysis of the negligence and unwarrantable failure discussed above, I find this violation is also appropriately designated as high negligence and an unwarrantable failure. Although the fireboss’ book had been changed to reflect the examiners were no longer traveling the entire entry, they were still traveling through the last four crosscuts on a daily basis. This area had been known to management as having deteriorated roof conditions for at least two weeks. They had discussed the failure of the barrier in supporting the...
roof as early as October 2008, and were aware of the firebosses informing them of further deterioration. The condition was extensive and obvious and posed a very high degree of danger to the examiners. They failed to contact MSHA with this newer information in an attempt to change the ventilation plan and failed to install the necessary number of supplemental supports to make the area safe and put up no danger signs to keep the examiners out of it.

This order was properly designated an unwarrantable failure and resulting from high negligence.

**PENALTIES**

Under Section 110(i) of the Act, the Commission and its judges must consider the following factors in assessing a civil penalty: the history of the violations, the negligence of the operator in committing the violation, the size of the operator, the gravity of the violation, whether the violation was abated in good faith and whether the penalties would affect the operator’s ability to continue in business. The parties have stipulated that the mine is a large mine and that the proposed penalties would not affect the operator’s ability to continue in business. There is no evidence that the conditions were abated in good faith or that the mine has a significant history of violations. (Ex. S-8.) The findings with regard to the gravity and negligence involved in each citation are set forth above. I find that the penalties proposed by the Secretary for Order Nos. 7697684 and 7697686 appropriate. I assess a penalty for Order No. 7697685 of $1000.00.

**ORDER**

Order Nos. 7697684 and 7697686 are affirmed as written with the penalties proposed by the Secretary. Order No. 7697685 has been modified to moderate negligence, non-significant and substantial and not an unwarrantable failure with a penalty of $1,000.00. It is hereby **ORDERED** that Respondent pay penalties on the citations adjudicated herein in the amount of $85,800.00 within 30 days of this order.²

/ s / Priscilla M. Rae  
Priscilla M. Rae  
Administrative Law Judge

² Payment is to be made to the Mine Safety and Health Administration, U.S. Department of Labor, Payment Office, P.O. Box 790390, St. Louis, MO 63179-0390.
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June 4, 2012

SECRETARY OF LABOR, MINE SAFETY AND HEALTH ADMINISTRATION, (MSHA), Petitioner v. BANNER BLUE COAL COMPANY, Respondent

Docket No. VA 2010-288
A.C. No. 44-06685-210987

Docket No. VA 2010-289
A.C. No. 44-07046-210990

PAW PAW MINE

LOCUST THICKET

DECISION

Appearances: Robert E. Motsenbocker, Esq., U.S. Department of Labor, Office of the Solicitor, Nashville, Tennessee, for the Petitioner

Robert Huston Beatty, Jr., Esq., Dinsmore and Shohl, Morgantown, West Virginia, for the Respondent

Before: Judge Koutras

STATEMENT OF THE CASE

These civil penalty proceedings pursuant to the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 802, et seq. (2000), hereinafter the “Mine Act,” concern two Section 104(a) significant and substantial (S&S) citations served on the respondent on December 8, and 9, 2009, alleging violations of mandatory health standard 30 C.F.R. § 72.630(a). A hearing was held on September 7, 2011, in Abingdon, VA, and the parties appeared and participated fully therein. The parties filed post-hearing briefs, and I have considered their arguments in the course of this decision.

The Alleged Violations

Docket No. VA 2010-288

Section 104(a) S&S Citation No. 8170287, December 9, 2009, 30 C.F.R. § 72.630(b), states as follows (Ex. P-1):

The No. 1 Fletcher Dual Head Roof Bolter (Serial No. 90114) used in the face area of the 002 MMU, the dust collection system was not maintained in permissible operating condition. The filters were...
allowing dust to get into the clean air that is returned out through the blower motor and in to the mine air. This dust contains silica and is a known cause of lung problems in mining. The dust would be spread across the left half of the working section, exposing bolter crew and miner and shuttle cars operating in the LOCC.

**Docket No. VA 2010-289**

Section 104(a) S&S Citation No. 8170285, December 8, 2009, 30 C.F.R. § 630(b), states as follows (Ex. P-3):

The dust collection system on the DBT Dual Head Roof Bolter (Serial No. 62-862R) used in the face area of the 001 MMU, was not maintained in permissible operating condition. The filter in the operators side dust box, had dust collecting behind the filter in the exhaust air for the system, thus this allows the dust to travel through the blower and in to the mine air, where personnel are exposed to the dust.

MSHA Inspector Johnny Asbury testified about his mining experience and training, and confirmed that he issued Citation No. 8170287 on December 9, 2009, and confirmed the notes that he made that day (Tr. 7-19; Exs. P-1, P-2). He explained that the cited roof bolter dust collection system was not maintained in permissible condition because he observed dust coming out through the machine mufflers when it was started and placed in operation. He opened the dust collector box that housed the dust filter and observed a “dent place on the side” of the filter that had been “bent in pretty hard” (Tr. 7-23).

Mr. Asbury stated that he observed that a rubber bushing used to seal the top of the filter with a metal wing nut was missing, allowing dust to escape (Tr. 24). He removed the filter, placed his finger in the area behind the filter, and pulled out approximately one-inch of dust out of the ridges where it by-passed the filter and accumulated. If the bolter was operating the dust that he found behind the filter would pass through the mufflers and into the air breathed by the miners (Tr. 25). He confirmed that Mine Superintendent, David Smith accompanied him and did not disagree with his observations. Mr. Asbury believed that someone “banged the filter pretty bad” while cleaning it and that it had been changed the day before (Tr. 26-27).

Mr. Asbury explained that the violation was a health violation and that an illness was reasonably likely to occur because silica dust is heavy and sticks to the lungs, and given the amount of dust blowing out of the muffler, the roof bolter and pinner would be breathing in the dust as it passed over them and would likely be permanently disabling because once it is breathed into the lungs it results in a disabling condition (Tr. 29). He agreed that while a one time exposure would not cause injury, the condition cumulatively would contribute to a lung disease. He based his S&S finding on the fact that it would be more likely than not that someone would be exposed to the dust (Tr. 32). Mr. Asbury stated that he based his moderate negligence
finding on the fact that the foreman should have found the condition when he conducted his dust parameters inspection but may not have seen the accumulated dust behind the filter and the condition was abated in fifteen minutes by replacing the filter (Tr. 35-36).

On cross examination, Mr. Asbury confirmed that his inspection field notes are used “to jog his memory” and are an important part of what he includes in a citation. After reviewing his notes, he confirmed that they do not reflect that he pulled one-inch of dust from the area behind the filter. If there was one-eighth of an inch of dust, it would not create dust through the muffler and may not have been seen by the foreman (Tr. 44). He also confirmed that his notes do not reflect that he observed visible dust in the air coming out of the muffler and commented that “there’s a lot of times you just have to put key notes where you remember those.” However, in response to a bench question, he stated that the notation on the citation, that “silica was being dumped into the fresh air”, referred to the dust coming from the exhaust (Tr. 45-48).

Mr. Asbury stated that the dust systems are washed out routinely during the pre-shift examinations and he observed that the filter was dented enough to damage the paper inside the filter. He conceded that his notes do not reflect any filter damage and that it should have been recorded (Tr. 52). He identified a photocopy of a filter that represents the type he cited (Ex. R-2). He stated that the filter is incased with a wire mesh screen that protects the inside filtering system and it was this screen that was damaged and pushed in. He made no notation that the filter inside the cardboard was damaged and although he believed that the inside and outside filter screen mesh was smashed together, he made no note of this (Tr. 54-57). He conceded that his belief that the dust was escaping through the end of the filter with the metal wing nut and missing bushing is not included in his notes and that it should have been noted (Tr. 59-61).

Mr. Asbury confirmed that the cited condition was limited to the operator’s side of the roof bolter. He checked the permissibility of the bolter, and the drill head suction, dust hoses, and door seals to make sure that they were all in compliance (Tr. 65). He confirmed that he did not sample the dust to determine whether it was harmful (Tr. 75-75). Mr. Asbury stated that his S&S finding of permanently disabling, due to silica exposure and “history of dust violations” related to all dust violations, including Section 75.400 and 72.630, were factors in that determination (Tr. 79-80).

Mr. Asbury stated that the discrete hazard in support of his S&S finding was lung disease that would reasonably likely result in a reasonably serious injury. He agreed that one dust exposure would not automatically support an “S&S” finding. However, he considered the amount of time that the bolting machine was operated constituted long term exposure (Tr. 82-83). Mr. Asbury confirmed that he was not present at the beginning of the shift when roof bolting began and that work was taking place at the second row of roof bolts in the entry. He observed the work for two or three minutes before issuing the violation and did not know how long the roof bolter had been operated prior to his arrival (Tr. 84, 87, 90-91).
Mr. Asbury explained on redirect, that the roof bolting machine was not in permissible operating condition because visible dust was reaching the fresh air through the filter wing nut with a missing bushing. Mr. Smith shut the machine down, washed the area with a hose from the miner machine, installed a new wing, put it back in operation, and the violation was terminated (Tr. 88-89).

In response to bench questions, Mr. Asbury stated that the escaping dust would pass over the top of the bolter operators who are at the front of the machine and out of the rear exhaust (Tr. 93). He confirmed that he could not visibly distinguish silica dust from other dust. He determined it was not coal dust coming out of the exhaust because he could see it was white in color. He is not required to perform any dust tests, and was taught to rely on his observations that the dust “was going to cause some kind of exposure to support a violation” (Tr. 95). He confirmed that replacing the filter wing nut with a new one that provided a proper seal rendered the machine permissible (Tr. 97).

MSHA Inspector Johnny Asbury confirmed that he issued citation number 8170285, on December 8, 2009, after he observed dust coming through the DBT roof bolting machine exhaust. Superintendent, Todd Belcher was with him and they were trying to determine the source of the dust by opening one of the machine dust boxes (Ex. P-3, Tr. 100-101). Referring to his notes, (Ex. G-4), Mr. Asbury stated that they found a hole in the wire mesh, on the side of a filter that was bent and not sealed, allowing dust to accumulate behind the filter. He stated that the filter had been replaced earlier and confirmed that management had a policy of changing filters each week (Tr. 103-107).

Mr. Asbury stated that the hole in the filter allowed dust to pass through it and posed a health hazard because the dust is returned to the fresh air through the bolter blower motor and out through the exhaust. He stated that Mr. Belcher corrected the condition by removing the filter from the box and replacing it after washing it and the condition was abated in twenty minutes. He stated that Mr. Belcher found that the accumulated dust behind the filter was caused by the hole in the filter and that they both put their fingers behind the filter area and “it was all full with dust” (Tr. 108).

Mr. Asbury stated that the cited standard, 30 C.F.R. § 72.630(b) requires the roof bolter dust collection system to be maintained in a permissible operating condition, and he determined that it was not (Tr. 109). He confirmed that he did not sample the dust and that the cited condition was likely to cause injury or illness to miners, namely pneumoconiosis, black lung, and exposure to silica dust (Tr. 110).

Mr. Asbury stated that the condition would result in lost work days or restricted duty, as opposed to permanent and disabling, because there was enough air ventilation that could “clear the dust out a little quicker” than the previous violation he issued. He believed that the section foreman who was responsible for performing the dust parameters should have observed the dust coming out of the exhaust as soon as the machine was in operation. Although he believed that the foreman had three to four hours after lunch to observe the condition, he determined that the
violation was the result of moderate negligence because of the increased amount of ventilation air and the fact that the foreman may have been occupied with a broken belt situation (Tr. 112-113).

Mr. Asbury stated that when he issues dust violations he considers problems other than silica, such as emphysema and lung and heart conditions. He noted only silica in his notes because it causes silicosis and remains in the lungs while coal dust can be coughed up while white heavy dust will not and that his father died from exposure to silica. He estimated from the amount of dust he found that the condition existed for more than one cut or at least 45 minutes to an hour. He confirmed that he has never studied or received any medical training concerning the effects of silicosis on the lungs (Tr. 150-154).

On cross-examination, Mr. Asbury confirmed that he issued both of the citations on December 8 and 9, 2009, at two different mines. He was not the regular inspector assigned to these mines and he was functioning as a roof control specialist. He did not believe this was unusual and that he regularly scheduled his own inspections and that greater emphasis had been placed by MSHA on Virginia and Kentucky mines where there was exposure to black lung and silica cases (Tr. 116-117).

Mr. Asbury stated that he observed visual dust in the air behind the roof bolter located in the number four entry behind the continuous miner, which was in the number five entry. He believed the roof bolter was approximately forty-feet (two-cuts), in by the last open cross-cut in the entry where he observed it, but there was nothing in his notes to confirm this location, nor did his notes reflect which entry it was located in (Tr. 120-121).

Mr. Asbury stated that he uses “key words” in his notes at the time he observes a condition, but admits that he misses a lot of issues. He explained that as he reads his notes “it puts me back into the mine area and puts my mind back in the same day I was there”, and that his testimony concerning dust suspended in the air is based on what he remembered after reading through his notes rather than what he recorded when he issued the citation (Tr. 125-126).

Mr. Asbury stated that he was not required to take any dust samples to support the violation because he was citing the dust that was in the system that was not maintained in permissible operating condition and not what was in the dust. He was not required to sample the dust to substantiate his S&S finding because the presence of visible dust in the air is enough to establish that finding (Tr. 129).

Mr. Asbury confirmed that the violation was terminated after the dust collection box was cleaned out and washed and his notes do not reflect that the filter was changed (Tr. 132). He further confirmed that his notes do not reflect that the filter had a hole through the mesh and through to the cardboard. He believed the hole was one-half inch, but he did not measure it, and it appears that it was hit by “a rolled steel punch, about the size of a roof pole” at the top of the filter (Tr. 134).
Mr. Asbury suggested that Mr. Belcher also saw the hole while they were trying to determine the source of the dust. He stated that he did not record that Mr. Belcher also found the hole, and that he spoke to the bolters about the hole in the filter and they informed him that the filters are changed weekly. He confirmed that the respondent changed the filters weekly irrespective of their condition (Tr. 137).

Mr. Asbury confirmed the absence of any evidence that any airborne dust was actually being ingested by the bolter operators and he had no reason to believe that the air ventilating the roof bolt entry was out of compliance because he observed air movement that was pushing any dust through the line curtain as required by the ventilation air blowing system (Tr. 137). Mr. Asbury stated that the section foreman is responsible for performing the permissibility examination before production starts and there is no distinction when there is a “hot seat” change or between shifts. He based his moderate negligence finding on the fact that the foreman probably made the examination but may not have seen the condition and he took the foreman’s word that he made the examination (Tr. 141).

Mr. Asbury was not present when the shift started and had no evidence that the cited conditions existed at that time. He confirmed that he had no way of determining whether the dust he observed in the atmosphere was silica dust, rock dust, or coal dust (Tr. 144). His determination that the condition was reasonably likely to result in a reasonably serious injury was based “on a lot of other conditions” that he did not record. He also considered several prior dust citations, but did not produce them and conceded that he only reviewed a computer list of dust citations that may have related to violations other than Section 72.630(b), and did not review those cited conditions (Tr. 145-147).

David Smith, Superintendent of Locust Thicket Mine, testified that he had 38 years of underground mining experience, and is a certified mine foreman, electrician, and holds shop foreman, dust sampling, and advanced first aid cards. He had three years of experience operating a Fletcher dual head roof bolter. He was the superintendent of the Paw Paw Mine on December 12, 2009, and traveled with Inspector Asbury during his inspection that day (Tr. 157-163). Mr. Smith stated that the roof bolter was parked in the number three entry and the back of the bolter was sticking out of the intersection in the area of the last open crosscut where roof bolting was taking place and two complete rows of bolts had been installed. The bolting machine was in operation and Mr. Asbury told him he wanted to check it. As they approached the machine, Mr. Asbury said nothing about visible dust in the air, at the rear of the bolter, and Mr. Smith observed no visible dust (Tr. 163-166).

Mr. Smith stated that he shut the bolter down so that Mr. Asbury could inspect it, denied that he shut it down because it was emitting visible dust through the muffler, and Mr. Asbury did not tell him he was shutting it down for that reason. He stated that Mr. Asbury checked the vacuum on the drill pot head, looked at the dust hoses, and stated that he wanted to check the dust boxes. The bolter operators and Mr. Smith did not notice any visible dust in the air when it was started, and confirmed that Mr. Asbury did not find any problem with the drill heads, vacuum, or hoses (Tr. 167-169).
Mr. Smith stated that Mr. Asbury checked the operator side of the bolter and after the operator took his dust filters out, Mr. Asbury placed his finger behind the filter area and “got a little film on it” and told him there was dust behind the filters that needed to be washed out. Mr. Smith stated that he did not check the area with his finger and that Mr. Asbury was not wearing gloves and had “a light film of dust” on his finger and did not measure the dust or take any sample (Tr. 171).

Mr. Smith stated that the two stacked filters were removed for inspection. He examined the outer area of the first filter where the wire mesh circles the paper inside the filter and observed no damage, dents, or crushing of any kind. He then examined the second filter and found no damage, dings, dents, or smashing (Tr. 174). He stated that the dust behind the filters was washed out with a gallon jug of water that was kept on the bolter. The dust boxes were then closed, and when the drill was started, the water was flushed through the muffler, and the entire inspection took five minutes. The filter was put back and roof bolting continued. The same two cited filters were put back and were not replaced, and he observed nothing that was done to seal the filter.

Mr. Smith stated that all purchased Donaldson brand filters include a plastic wing nut that is taped to every filter, and that he did not see any metal wing nut described by Mr. Asbury. He stated that each filter is changed out as a regular procedure on the first day of the work week without limitation (Tr. 178). He observed no dust at the rear or over the bolter, or at the face area where bolting was taking place, and he received no complaints of any airborne dust emissions from the bolter operators (Tr. 188).

Mr. Smith did not recall whether Mr. Asbury asked him if he disagreed with the violation, he confirmed that he did disagree, and commented to Mr. Asbury after the first filter was removed that “I didn’t think that was a violation for that little old bit of film and dust being behind the filter” (Tr. 182).

Mr. Smith stated that production had started before the violation was issued and that Foreman, Joe Waynick would have conducted a permissibility examination of the dust collection system prior to activating the section. Mr. Smith verified that the examination took place when he checked the board at the power center and that Mr. Asbury made no inquiry about this. Mr. Smith stated that such an examination does not include the removal of the filters from the dust boxes and he was not aware of any MSHA regulation that required that this be done (Tr. 183 - 185).

On cross-examination, Mr. Smith stated that if he observed roof bolters emitting dust as a result of a damaged filter, he would promptly take corrective action because the dust causes danger to health. He did not know whether a single exposure was dangerous, but if he observed it, he would shut the machine down because of the following contention: “I don’t want to breathe anymore then I have to because it hurts in the long run and gives you black lung” (Tr. 186-188).
Mr. Smith agreed that a roof bolter dust collection system is covered by mandatory Section 72.630(b). A filter with a hole in it is not considered to be in operational condition. If he were to find that dust was getting on the inside or clear air side of the filter, he would wash it out and replace it if it had a hole in it. He confirmed that a filter would be in properly operating condition if it was not blowing dust out of the muffler (Tr. 191-192).

Mr. Smith agreed that he had testified without the benefit of notes to the inspection which occurred two years ago, and that he filled out an accountability form for every violation, and did so in this case, and remembered what transpired without notes. He confirmed that he would only remove a filter if he believed there was a vacuum problem or he saw dust coming out of the filter, and he agreed that if he saw dust coming out of the muffler, the prudent thing for the inspector to do would be to look for the source of the dust (Tr. 193).

Mr. Smith clarified the examination by the foreman and stated it was a dust parameter examination and not a permissibility examination that does not include removing the filter. A dust parameter examination includes a proper vacuum on the pinner head, the dust collection hoses, and a machine check for any blowing dust out of the machine bottom. There is no MSHA regulation requiring the removal of the filters during a parameter check. He agreed that if a roof bolter is emitting dust, removing the filter to determine the source is acceptable (Tr. 195-196).

Mr. Smith reiterated that he saw no dust coming out of the muffler and that he only observed “a film of dust” and saw no dust behind the filter area after it was removed (Tr. 202).

Willy Todd Belcher, Paw Paw Mine maintenance foreman, testified that he had 24 years of underground mining experience as a foreman, electrician, and maintenance worker. His experience included work with dust collection systems and DBT dual head roof bolters. He confirmed that he was the Locust Thicket mine superintendent when the citation was issued and traveled with Inspector Asbury during his inspection (Tr. 204-207).

Mr. Belcher stated that the roof bolter machine was backed into the intersection of the number five entry and no bolting was taking place. He and Mr. Asbury approached the machine from the operator’s side, and after checking the drill top vacuum the machine was started. Mr. Belcher observed no airborne dust and did not recall whether Mr. Asbury told him that he observed visible dust when the machine was started. The dust boxes were then removed and Mr. Asbury did not go to the back of the machine to check the mufflers until after checking the dust boxes (Tr. 213-214).

Mr. Belcher stated that after the filters were removed he observed “a small film of dust on the back side of the dust box where the filter sits.” The dust box tray was not removed and there was no dust in the boxes. Mr. Belcher stated that after the bolter operator removed the filter wing nut to pull out the filter, he held it and that “it looked fine” (Tr. 216-217). Mr. Belcher denied that he told Mr. Asbury that he would shut the machine down to correct the condition because the section was down for an unrelated problem. He observed no hole in the filter and denied that Mr. Asbury informed him that the filter needed to be changed because of the hole and he could not recall that the filter was changed (Tr. 219).
Mr. Belcher stated that Mr. Asbury took no dust measurements or samples and that “he more or less stuck his finger back in there, like my wife would do to wipe dust, and got some on his finger” (Tr. 219). Mr. Asbury then advised him that he would issue the citation as an S&S violation because of the dust behind the filter, and Mr. Belcher voiced his objection because there was no dust in the air, the bolter was not operating and was parked in the intersection with fresh air (Tr. 220). He stated that the dust boxes were cleaned out after each cut and that mine policy required the changing of the filters on the first shift of each week, and more often if necessary (Tr. 221).

Mr. Belcher stated that he received no dust complaints from the bolter operators, and disagreed with the violation “because it just had a small film behind it, and no dust was in the air or on the muffler”. He believed there was a change in MSHA’s dust enforcement and that “years ago unless it was dusting heavily you never seen a violation like this”. He explained that during his maintenance experience he has never observed an inspector remove a filter and reach behind the area with his hand to remove dust film (232-233).

On cross-examination, Mr. Belcher confirmed that he has traveled with many inspectors and usually does not take notes but does discuss the violation with the inspector. He has traveled with Mr. Asbury 20 or 30 times, and considered him to be honest and thorough, and had no reason to believe that he lied during his testimony about what he observed. He could not recall whether Mr. Asbury told him that there was a hole in the filter, but he indicated that he would have remembered it. He also believed that Mr. Asbury would have recorded the hole and the filter changes, but only “recorded exactly what we done, cleaned it down and washed it down” (Tr. 226-229). He agreed that any prolonged exposure to dust would be a health problem (Tr. 231).

Eddie Taylor testified that he was a certified maintenance foreman and electrician and confirmed that he was familiar with citations 8170287 and 8170285 issued at the Paw Paw and Locust Thicket mines, and he was the maintenance superintendent at both mines when they were issued. He confirmed that he was familiar with the Fletcher and DBT roof bolters and he explained the differences in the two dust collection systems and explained the functions of the dust boxes, filters, and other components of the system, including the filter area of the dust box (Tr. 249-260; Exs. R-5 - R-7). He stated that the dust collection systems on both bolters are functionally the same (Tr. 249-261; Exs. R-5 - R-7).

Mr. Taylor confirmed that it is possible that a dust collection system could be operational but not permissible. He explained that permissibility encompasses the dust hoses, clamps, and associated parts from the drill pot to the blower, and if a clamp were missing the machine would not be permissible but would be operational (Tr. 261).

Mr. Taylor stated that the two contested citations were emailed to him and he reviewed them after they were issued but never discussed them with anyone at the two mines at that time. However, he subsequently visited the Paw Paw mine to speak to superintendent, David Smith
and maintenance chief, Donald Giffey about Citation No. 8170287. Mr. Smith told him there was no dust blowing in the atmosphere and the only dust found was behind the filter. He also spoke with Todd Belcher at the Locust Thicket mine who informed him that there was no dust in the air and that Inspector Asbury showed him dust on his finger which had accumulated behind the filter area (Tr. 263-264).

Mr. Taylor stated that over the prior two years MSHA has changed the way it is enforcing and issuing Section 72.630(b) citations for the dust collection systems. He explained that in the past, if a clamp was missing or the dust hose was not exactly one that was approved, it was not an issue as long as the dust system was maintained in fairly reasonable condition. Further, the dust boxes were not inspected “that carefully”, and if it passed the vacuum test and the system “Visually looked okay” it was considered a good system at that time (Tr. 266-267). Mr. Taylor did not believe that the presence of dust in the area behind the filters established that dust was being emitted into the atmosphere because dust can accumulate in that area and the system will not pick it up because it is lodged or stuck, and any dust film or residue would not be emitted into the air. He stated that there was no way to check the area beyond the filter dust box where it exited the rear of the bolter to determine the presence of any collected dust and he did not believe it was possible for the dust collection system to be 100 percent efficient because of operational filter sealing variables (Tr. 268-270).

Mr. Taylor stated that Mr. Smith and Mr. Belcher never informed him that Inspector Asbury mentioned any filter hole or damage or missing washer behind a wing nut (Tr. 276). He confirmed the standard operational procedures requiring weekly roof bolter filter changes at the beginning of the day and owl shifts, and six additional spare filters, and records are required to show the date of the filter changes. Dust boxes are required to be cleaned and dust is “tapped out” of the filters after each working place is bolted. He agreed that it was possible to strike a filter hard enough to damage the screening, but had never observed anyone doing this. He was not aware of any dust emission complaints from the roof bolter operators (Tr. 277-283).

On cross-examination, Mr. Taylor stated that if there was a half inch of very fine dust accumulation behind the machine filter area, and the machine was started, it could be emitted out through the blower, but if it was wet compacted dust, it may not move out if the half-inch dry dust moved out into the air through the exhaust manifold. It would be possible that what remained behind the filter would be a thin film of dust, and some of the dust would reach the atmosphere. If there were two-inches of dust, it would be more probable than possible, and if four inches of dust, with a remaining thin film, the rest would have been emitted (Tr. 289-290).

**Discussion, findings, and conclusions**

Both Citation Nos. 8170185 and 8170287, issued in Docket Nos. VA 2010-288 and VA 2010-289, allege violations of 30 C.F.R. § 72.630(b) and relate to virtually identical alleged
conditions on two different models of roof bolters. The cited regulatory standard states as follows:

(b) Dust collectors. Dust collectors shall be maintained in permissible and operating condition. Dust collectors approved under Part 33-Dust Collectors for Use in Connection with Rock Drilling in Coal Mines of this title or under Bureau of Mines Schedule 25B are permissible dust collectors for the purpose of this section.

The petitioner’s post-hearing brief only addresses Citation No. 8170285, and not Citation No. 8170287. However, given the similarity of the alleged conditions, I have considered the petitioner’s arguments and have applied them to both citations.

The petitioner argues that the violations are supportable because the inspector discovered a hole in a filter which allowed dust to bypass and collect behind the filter and contaminate the clean air in the work area. That alleged condition relates to Citation No. 8170285 for the DBT bolter. The two citations, on their face, do not specify or describe the alleged defective filter conditions that were described by the inspector at the hearing.

The respondent argues that both of the cited bolters were in permissible condition as required by Section 72.630(b), and that the petitioner’s allegations that the bolter dust collection systems were defective or damaged were refuted by the testimony of its employees. With regard to the cited DBT bolter dust collection system, the respondent asserts that the testimony of the inspector, that the filters were dented, was likely the result of efforts to clean the filters by tapping dust out of them. This testimony is refuted by employee, Belcher’s testimony that the filters were not damaged in any way, and employee, Taylor’s testimony that he has never seen anyone “tap” the dust out of the filters with such force as to collapse the steel filter mesh.

The respondent points out that none of the alleged filter defects or damages testified to by the inspector are recorded in his inspection notes, including his testimony that when the filter was pulled out he saw damaged and pushed in metal screening.

With regard to the inspector’s testimony that a metal wing nut on the side of the Fletcher roof bolter filter was missing its bushing (rubber washer), respondent again points out that the inspector’s notes do not mention any missing bushing wing nuts, and that employee, Smith definitively testified that the filter had the requisite wing nut.

The respondent argues that the inspector could not prove his assumption that the missing bushing was allowing dust to enter the dust collection box without passing through the filter, and that the majority of the dust located behind the filter was coming from the area of the missing wing nut, and that his conclusion was based solely upon the amount of dust he allegedly visually observed in the area.
The respondent points out that the inspector made no mention of any of the aforementioned information in his notes, admitted that he should have done so, and conceded that even if the damage existed, it would not affect the structural integrity of the seal. Under all of these circumstances, the respondent concludes that the dust collection system was permissible.

The respondent maintains that the petitioner has not proved that the cited dust collection systems on the two cited roof bolters were not in “operating” condition based on the inspector’s testimony that the presence of dust in the mine atmosphere was indicative of the inoperable condition of the dust collection system. Conceding that there is some Commission authority supporting the petitioner’s assertion that the presence of dust on the clean side of a machine is indicative of the fact that a filter was being bypassed, respondent believes the facts in the instant case are distinguishable.

The respondent points out that the inspector said nothing about dust in the air when he approached the bolter, and that his notes do not reflect the presence of visible dust in the atmosphere. Respondent further relies on the testimony of Smith and Belcher that they observed no airborne visual dust in the DBT and Fletcher area, and that they considered both bolters to be in operational condition.

The respondent maintains that even assuming the truth of the presence of dust in the atmosphere, the inspector nonetheless conceded that due to the mine blowing ventilation, as well as the downwind location of the bolter, it was possible that the bolter was generating dust while installing roof bolts creating “a little blow back”. Respondent relies on the testimony of maintenance superintendent, Eddie Taylor, who has 33 years of mining experience. Mr. Taylor testified that it was possible for a dust collection system to be operational, and yet not permissible.

Respondent further relies on Mr. Taylor’s testimony that the purpose of the dust collection system is to collect the dust emitted when drilling the roof and depositing it into the dust collection box; and, the purpose of the filters is to catch the dust before it exits into the blower system. Mr. Taylor testified that a small film of dust behind the filters does not necessarily mean that dust was emitted into the atmosphere because it can accumulate in that area and not be picked up because it is a film residue or lodged or stuck. Respondent concludes that the testimony of Mr. Belcher, Mr. Taylor, and the inspector reflects that the dust collection systems are not 100% efficient.

The respondent takes serious issue with the numerous discrepancies between the inspector’s hearing testimony and what he recorded, and what was significantly omitted from his notes, particularly in light of his acknowledgment that his notes are a very important part of what he includes in his citations. As an example of significant omissions, the respondent cites the inspector’s testimony, that he pulled one inch of dust from behind the Fletcher bolter, but did not mention this in his notes. Respondent points to the admission by the inspector that one-inch of dust should have been recorded to support his testimony of visible dust in the area, particularly in light of his testimony that 1/8 inch dust would only be blowing through the drill muffler.
Finally, the respondent cites the testimony of Mr. Belcher and Mr. Smith that MSHA had not previously used the inspection method of running a finger in the area behind the filter to detect any dust, and that the instant inspections constituted a change in enforcement. Respondent cites Mr. Belcher’s testimony that he has never previously observed an inspector wipe his finger to check a film of dust and that “years ago unless it was dusting heavily you never see a violation like this”, and Mr. Taylor’s testimony that in the past, “dust boxes were just looked at and not inspected carefully”, and “if the system vacuum was operational and usually looked okay, it was a good system at that time.”

The respondent maintains that the dust inspection “finger method” used by the inspector is a MSHA enforcement change adopted without fair due process notice to the respondent. Respondent maintains that Section 72.360 is clear and unambiguous, and while the regulatory text has not changed, MSHA has changed its interpretation without issuing any policy guidelines, or informational letters or bulletins to provide the regulated community notice of the change. Respondent concludes that a reasonably prudent person would not expect an enforcement change, particularly since it is unreasonable to test the area behind a filter and use the results as an indicator of compliance with Section 72.630(b).

I conclude and find that the collector box filters are an important and integral part of the dust collector system. The purpose of a filter is to absorb and isolate any dust before it exits into the machine blower system. Notwithstanding the disputed testimony of the inspector attributing the source of the dust behind the filter areas to damaged filters, the fact remains that dust was found in those areas.

I further conclude and find that even though a small amount of dust that has bypassed a collector box filter and accumulates behind it may not immediately result in an emission into the mine atmosphere, it poses a potential for doing so, and adversely contributes to the operational effectiveness of the dust collector system. Accordingly, I conclude and find that the bolter dust collection systems were not maintained in operational condition as required by Section 72.630(b). The violations ARE AFFIRMED.

The respondent’s arguments that the inspector’s “finger method” for detecting the dust found behind the collection box filter area constituted an enforcement change without due process notice are not well taken. The fact that Mr. Belcher and Mr. Smith never previously observed that method being used is irrelevant. In this case, Inspector Asbury met with Mr. Belcher and Mr. Smith, were attempting to locate the source of the dust, and the boxes were opened and the filters were removed as part of that process. I take note of Mr. Smith’s testimony that he would remove a filter for inspection if he observed dust coming out of a bolter muffler, and agreed that it would be a prudent thing for an inspector to look in to the filter area to determine whether it was the source of the dust (Tr. 193).
I conclude and find that the inspection process used by the inspector in an attempt to locate the dust that he believed was being emitted from the bolter exhaust systems was reasonable in the circumstances and was not the result of any enforcement changes. I cannot conclude that increased enforcement scrutiny or focus on potential health hazards constitutes an unreasonable change in MSHA’s interpretation of Section 72.360, or its application to Section 72.360(b). Accordingly, the respondent’s arguments ARE REJECTED.

**Significant and Substantial Issues**

A significant and substantial (“S&S”) violation is described in Section 104(d)(1) of the Act as 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.” A violation is properly designated S&S “if based upon the particular facts surrounding that violation, there exists a reasonable likelihood that the hazard contributed to will result in an injury or illness of a reasonably serious nature.” Cement Div., Nat’l Gypsum Co., 3 FMSHRC 822, 825 (Apr. 1981).

The Commission has explained that:

In order to establish that a violation of a mandatory safety standard is significant and substantial under National Gypsum, the Secretary of Labor must prove: (1) the underlying violation of a mandatory safety standard; (2) a discrete safety hazard—that is, a measure of danger to safety-contributed to by the violation; (3) a reasonable likelihood that the hazard contributed to will result in an injury; and (4) a reasonable likelihood that the injury in question will be of a reasonably serious nature.

*Mathies Coal Co.,* 6 FMSHRC 1, 3-4 (Jan. 1984) (footnote omitted); see also, *Buck Creek Coal, Inc. v. FMSHRC,* 52 F.3d 133,135 (7th Cir. 1995); *Austin Power, Inc. v. Sec’y,* 861 F.2d 99, 103-04 (5th Cir. 1988), aff’g *Austin Power, Inc.*, 9 FMSHRC 2015, 2021 (Dec. 1987) (approving *Mathies* criteria).

In *U.S. Steel Mining Co., Inc.*, 7 FMSHRC 1125, 1129 (Aug. 1985), the Commission provided additional guidance:

We have explained further that the third element of the *Mathies* formula “requires that the Secretary establish a reasonable likelihood that the hazard contributed to will result in an event in which there is an injury.” *U.S. Steel Mining Co., Inc.*, 6 FMSHRC 1834, 1836 (August 1984). We have emphasized that, in accordance with the language of section 104(d)(l), it is the contribution of a violation to the cause and effect of a hazard that must be significant and substantial. *U.S. Steel Mining Co., Inc.*, 6
This evaluation is made in terms of “continued normal mining operations.” *U.S. Steel Mining Co., Inc.*, 6 FMSHRC at 1574. The question of whether a particular violation is significant and substantial must be based on the particular facts surrounding the violation. *Texasgulf, Inc.*, 10 FMSHRC 498 (Apr. 1988); *Youghiogheny & Ohio Coal Co.*, 9 FMSHRC 2007 (Dec. 1987).

Inspector Asbury cited the Fletcher roof bolter after he removed a filter from the dust collection box and stuck his finger behind the filter area and pulled out what he believed to be approximately one-inch of dust. He confirmed that he did not measure the dust and that his notes do not reflect that he pulled out that amount of dust.

Mine superintendent, David Smith, who was with the inspector, confirmed that he observed the inspector reach in the area behind the filter, wipe it down, and “got a little bit of light film” of dust on his finger (Tr. 170-171). He stated that he informed the inspector that he did not believe there was a violation “for that little old bit of film and dust behind the filter” (Tr. 202). He further confirmed that the dust in the area behind the filter concerned the inspector because he believed it would get out in the atmosphere through the muffler (Tr. 196, 199-200).

Inspector Asbury cited the DBT bolter after the dust collection box was opened and the filter was removed so that he could inspect the area behind it. He placed his finger into that space behind the filter and found an accumulation of dust, but did not measure it. His notes reflect the presence of dust behind the filter. He confirmed that the bolter was operating when he initially arrived at the area and that he observed “quite a bit of dust” coming out of the rear exhaust system muffler (Tr. 114-115). His notes include a brief reference that “silica was being dumped into the fresh air” (Ex. P-2 at 11).

Maintenance foreman, Todd Belcher, who was with the inspector, confirmed the presence of dust behind the filter area after it was removed. Mr. Belcher described the dust as a small film behind it that he observed on the inspector’s finger (Tr. 219, 232). He also stated that the condition “might be a violation, but not S&S (Tr. 220).

Inspector Asbury’s determinations that the roof bolter dust collection system, which in this case is comprised of the dust collector boxes, including its component parts, and filters, were not maintained in permissible condition, or in a permissible operating condition, in violation of Section 72.630(b), is based on his asserted observations of dust being emitted from the rear of the bolter machine into the atmosphere clear air.

The respondent maintains that both bolters were in permissible condition pursuant to Section 72.630(b), and that the petitioner has not proved that the bolter dust collection systems were not in operating condition. The regulation requires dust collectors to be maintained in permissible and operating condition.
The respondent does not dispute the presence of dust found by the inspector upon his examination of the areas behind the collector box filters. Its dispute focuses on the absence of any credible testimony or evidence establishing the presence of dust being emitted into the atmosphere from the cited bolters.

I find merit in the respondent’s arguments regarding the inspector’s failure to document his observations of airborne dust and damaged filters, and the absence of any references to these alleged conditions in his notes. However, I accept as credible the inspector’s testimony regarding the presence of dust that he found behind the filter areas, and take note of the fact that respondent’s witnesses, Smith and Belcher, disputed the amount of dust, but not its existence.

With regard to the DBT bolter Citation No. 8170185, the petitioner argues that the inspector determined “quite a bit of dust” was blown out of the muffler “pretty quickly,” bypassing the filter right over the top of two men operating the roof bolter, who “were breathing every bit of it” (Tr. 114-115). The petitioner asserts that there was a reasonable likelihood the dust contained silica, which is a leading cause of lung conditions (Ex. G-4 at 9), at the time the inspector issued the citation, and he engaged in a discussion with the miners about black lung and the importance of good dust control (Ex.G-4 at 8-10).

The petitioner concludes that the Mathies test is met because a discrete safety hazard violated a mandatory health standard and made it reasonably likely that a reasonably serious injury would result. Petitioner further argues that because a single exposure of respirable silica dust can “contribute to” the illness of silicosis, it is considered significant and substantial; that is, the petitioner is not required to prove that the subject exposure alone will cause the illness, citing Genwal Resources Inc., 27 FMSHRC 580 (Aug. 2005) (ALJ Manning).

The respondent argues that the petitioner has failed to establish that the two citations were significant and substantial. With regard to the Fletcher bolter, Citation No. 8170287, the respondent asserts that although the inspector believed that the exposure to dust in the air, that he claimed he observed, will result in injury to the lungs over a long period of time, he conceded that one exposure cannot automatically support an S&S finding, and that he only observed the condition for two or three minutes, and had no knowledge with regard to the length of time that the exposure lasted.

With regard to the DBT bolter Citation No. 817085, the respondent argues that although the inspector based his S&S finding on his alleged observation of dust in the atmosphere, as well as the dust behind the filter, he took no dust sample. Further, although the inspector also based his S&S determination on previous dust citations, no evidence was provided regarding those citations. The respondent points out that Section 72.630(b) does not involve a violation of a respirable dust standard, and as such, there is no presumption of S&S, and that any determination in this regard must be made on the controlling four Mathies factors.
The respondent asserts that the petitioner has not established that the cited bolter conditions violated Section 72.630(b). With regard to the existence of any discrete safety hazard, which the inspector described as exposure to silica dust which could lead to lung disease, the respondent concludes that since there is no conclusive evidence of silica dust in the mine atmosphere, there is no clear evidence that a safety hazard existed.

Regarding the third Mathies prong, the respondent argues that there was no reasonable likelihood that the alleged hazard would result in an injury because there is no clear and undisputed evidence that dust was present in the mine atmosphere and that the S&S standard is based on what is reasonably likely to occur, not what “could” or “might” occur. The respondent further argues that there is no clear evidence regarding the content of the alleged dust and that the inspector was unable to distinguish silica dust from other dust, and did not take dust samples to determine its contents. The respondent recognizes that sampling is not required to establish a violation of Section 72.630(b), and maintains that the absence of sampling leaves open the question of the contents of the alleged dust.

The affirmance of the violations establishes the first Mathies, prong. With respect to the second prong requiring a discrete safety hazard, contributed to by the violation, the thrust of the petitioner’s case is that exposure to silica dust during the drilling process exposes miners to the illness of silicosis, a serious health condition. I agree that exposure to silica dust may present a discrete safety hazard and measure of danger to safety contributed to by the violation, pursuant to the second Mathies prong. The third Mathies prong requires proof establishing a reasonable likelihood that the hazard contributed to will result in an injury as stated in Cumberland Coal Resources LP, 33 FMSHRC 2357 (Oct. 2011).

The contested citations are based on a single dust filter that the inspector believed was the source of the dust he observed in a ridged area behind the filters. The inspector concluded that the dust contained silica, ranging in amounts of one-inch or less in one instance, and a “thin film” in the other. He believed the dust visible was airborne silica dust in the atmosphere that exposed the bolter operators to a reasonably likely risk of contracting serious lung diseases, including silicosis.

The citations were issued over 2 ½ years prior to the hearing, and I am troubled by the inspector’s failure to include any information, as part of his inspection notes, documenting the condition of the filters, or his visual observations regarding dust circulating in the air. Although I have affirmed the violations based on the existence of the dust observed by the inspector behind the filters, which is not disputed by the respondent, the failure of the inspector to include notations of his alleged visual observations of airborne silica dust over the bolting machines and the operators, which is critical evidence, raises credibility doubts and concerns that he acknowledged when he agreed that he should have included his claimed observations in his notes (Tr. 45).

The inspector testified that he based his S&S determination in support of Citation No. 8170187 (Fletcher bolter), on his belief that the amount of dust he found behind the filter area
contained silica and the respondent’s history of all dust citations, including Section 72.630, as well as Section 75.400 (Tr. 79-80). His inspection notes reflect that he made that determination at 10:14 a.m., when he issued the citation, and the reason noted is “due to amount of dust and history on violations on dust” (Ex. P-2 at 9). The inspector believed that a discrete hazard associated with his S&S determination was lung disease, but agreed that a single silica dust exposure would not cause an injury or support an S&S finding. However, he believed that cumulative exposure that “happens over a long period of time” would contribute to an injury, and that “seeing it right there, the dust was in the air, and it was a violation of law” (Tr. 30-31).

The inspector confirmed that he could not distinguish silica dust from any other dust, but believed the dust he observed was white, while coal dust is black. He agreed that rock dust is also white, but did not believe it could get into the system while drilling was taking place (Tr. 84). He further stated that he was trained to conclude that his visual observation of dust “was going to cause some kind of exposure” to support a violation (Tr. 95, 97). However, he agreed that a single dust exposure would not cause injury, and that a single dust exposure will not support an S&S finding (Tr. 32, 82-83).

The inspector believed that his S&S finding based on his visible observation of dust in the air is supportable because his citation was based on the presence of dust in the collector system that rendered it less than permissible and operational. He explained that he cited the presence of dust in the system and not the content of the dust (Tr. 128). I find this to be contradictory and incredible since the focus of his S&S determination is based on the alleged silica content of the dust.

The inspector confirmed that his notes regarding dust exiting the roof bolter do not indicate that it was suspended or circulating in the atmosphere (Tr. 45-48). He explained that he placed his finger into the muffler and found “dust caked on the inside that had been washed out through the suction system”, and he concluded that the dust stuck to the muffler. He conceded that none of these conditions are recorded in his notes (Tr. 49-50). I find the inspector’s testimony regarding dust exiting the bolter muffler to be contradictory and not credible to support his alleged visual observation or airborne dust in the atmosphere circulating over the bolter operator’s position. I note his agreement that it was possible that when the bolter was started “it would have had a little moisture in it and it may have thrown it out right at the start” (Tr. 34).

I credit the testimony of respondent’s witness David Smith that he observed no visible dust in the air as he and the inspector approached the bolter that was parked and operating and that he shut it down so that the inspector could inspect it and that the inspector did not tell him that he had observed visible dust in the air, and found no problems with the bolter drill heads, vacuum, or hoses. I also credit Mr. Smith’s testimony that the filter was washed out and bolting resumed (Tr. 167-171).
Although the inspector believed that the passage of time from the start of the shift until he arrived at the bolter location was a long term dust exposure, he admitted that he was not present at the start of the shift, had no idea how long the bolter was operated, and that he only observed it for two or three minutes (Tr. 84, 87). In spite of this, he still believed the cited dust condition had existed from the beginning of the shift when the section foreman performed his dust parameters, and he based his conclusion in this regard on his statement that he could determine how long the condition existed “due to the amount of dust in the air” (Tr. 32-33).

I reject the inspector’s reliance on the respondent’s history of prior dust violations that he relied on in part for his S&S determination. No evidence, other than the prior history, reflected in Exhibit A to the petitioner’s penalty assessment petition and copies of the asserted prior citations were produced, and no further information was advanced or introduced by the petitioner regarding the circumstances of those prior violations.

The burden of proof lies with the petitioner to present credible evidence establishing the inspector’s assertions that he observed visible airborne silica dust in the atmosphere at the time he issued the citations. Undocumented assumptions and speculations as to what may have occurred 2 ½ year ago, that I find lack credibility, are insufficient to establish the inspector’s S&S determinations with respect to the contested violation.

I find no credible evidence to support a conclusion that the small amount of dust of an inch or less observed by the inspector was in fact silica dust. Nor do I find any credible evidence that any dust that may have been expelled through the bolter muffler was airborne and circulating over the bolter and bolter operator’s position, or was likely to be expelled and circulated in the air if normal mining operations were to continue, particularly in view of the inspector’s agreement that the dust collection systems are routinely washed out during the pre-shift examinations, and his confirmation that the bolter permissibility requirements for the bolter drill head suction, dust hoses, and door seals were all functional and in compliance (Tr. 52, 65).

After careful consideration of all of the arguments and credible evidence in this case, I conclude and find that the third and fourth prongs required by the *Mathies* tests have not been established by a preponderance of the credible evidence. In the absence of any credible evidence establishing that the dust observed by the inspector was silica dust, the absence of any credible evidence to support the inspector’s asserted visual observation of silica dust in the air over the bolter or bolter operator’s position, which I find not credible, and the absence of any credible evidence that the bolter operator’s were exposed to any dust over a prolonged period of time, I cannot conclude that it was reasonably likely the dust observed by the inspector behind the filter of the Fletcher roof bolter would contribute to a serious lung disease or injury of a reasonably serious nature. Accordingly, the inspector’s S&S determination is modified to a non-S&S violation.

The inspector’s S&S determination with respect to the DBT roof bolter (Citation No. 8170285), is based on the amount of dust he found behind the filter area, and the respondent’s prior history of dust violations. This is confirmed by his notation made at the time he recorded
his observations that states “made S&S due to the amount of dust and previous issued citations”, with a reference to a discussion with the miners concerning black lung and dust controls (Tr. 144; Ex. P-4 at 8, 10).

The inspector’s notes confirm that the section was down when he checked the vacuum on both bolter heads and found that the dust box on the operator’s side “had dust behind the filter and clean air return”, and that he issued the citation “for not maintaining dust system in permissible operating condition” (Ex. 4 at 7-8). However, his notes do not include any information with respect to the “amount of dust” that he observed visible dust circulating in the atmosphere over the bolter or bolter operators.

The inspector conceded that he did not measure the dust, even though he could have readily done so. Although he was not required to measure the dust, since the “amount of dust” was part of his S&S determination made 2 1/2 years ago when he issued the citation, which he later described during the hearing as “a lot of dust”, with no further elaboration, his failure to document this condition, raises credibility doubts that do not rebut the respondent’s credible testimony that the amount of dust observed by the inspector was no more than a “thin film”.

I credit the testimony of Willy Belcher who testified that when he and the inspector approached the bolter, it was parked in an intersection in fresh air and was not bolting. He further testified credibly that after the inspector checked the bolter vacuum, the bolter was started and the box was removed, but the dust tray was not. Mr. Belcher stated he observed a small dust film in the back side of the dust box where the filter was located (Tr. 216-217). I take note of the inspector’s agreement that when the bolter starts to install a roof bolt, the drilling action creates dust that creates “a little bit of blow back” before the suction is activated, and that the resulting dust may not necessarily be blown back into the clean air system (Tr. 123).

I find Mr. Belcher’s testimony that he observed no visible air circulating in the atmosphere over the bolters to be credible. I also credit his testimony that the inspector stuck his finger behind the filter and that there was a thin film of dust on his finger and that he voiced his objection to his S&S determination because the bolter was parked and was not operating and there was no visible dust in the atmosphere (Tr. 219-220).

Although the inspector testified that the bolter operators were breathing in “every bit of the dust”, he conceded there was no evidence that the dust was being ingested by the operators (Tr. 137). In view of the fact that the section was down and the bolter was not in operation, I cannot conclude that his observations are credible. Further, I take note of his confirmation that any air pushed through the bolter exhaust under pressure would dissipate “real fast”, and that with the “right amount of ventilating air, the dust is gone and you do not see it” (Tr. 138).

The inspector further confirmed that he had no reason to believe that the ventilation, where the bolter was parked, was out of compliance. He confirmed that the required amount of air that was present is designed to move out any harmful dust, and that any dust that he may have
observed was moving out through the line curtain, and that he had no way to determine whether the dust he claimed he observed in the atmosphere was silica dust, rock dust, or coal dust (Tr. 144).

With respect to the amount of dust that may have existed behind the filter in question, which the inspector conceded was not measured, but nonetheless described by him as “a lot of dust”, I take note of the cross-examination of foreman, Eddie Taylor who responded to several hypothetical questions suggesting that any remaining dust accumulations, other than a thin film residue, ranging from one-half to four inches, would indicate that some of the dust may at some time have been expelled through the bolter exhaust as visible airborne dust.

Mr. Taylor’s responses suggested several possibilities and probabilities, including whether or not it was “very fine”, “dry”, or “wet compacted” dust, that could have previously been emitted into the atmosphere before the inspector observed the conditions that prompted the issuance of the citation (Tr. 288-291). While it may be possible that a small amount of residue of dust behind the filter may be an indication that dust was emitted in the atmosphere at some time prior than the time the inspector issued the citation, it may also be possible that it was coursed out of the area by the effective air ventilation as described by the inspector.

I take particular notice of the inspector’s testimony that he was not required to sample or test the dust to establish that it was hazardous silica dust because he did rely on the content of the dust to support his S&S determination. (Tr. 128). I find this contradicts and undermines his testimony that he based his S&S finding on his belief that the dust he observed contained silica.

The petitioner’s arguments that it is reasonably likely that the dust observed by the inspector behind the filter in the bolter dust box contained silica is based on his assumption at the time he discovered it, and his discussions with the bolter operators concerning the hazards of black lung and the importance of controlling dust. The burden of proof is on the petitioner to establish credible evidence to establish the presence of any visible airborne hazardous dust in the atmosphere to support an S&S determination at the time the inspector observed those conditions and issued the citation, and not on speculative after-the-fact assumptions that may have been present prior to that time.

With regard to the duration of dust exposure, the inspector speculated that it was possibly 45 minutes, or one cut, based on his assumption that the foreman should have observed the dust when he conducted his permissibility inspection. He conceded that he had no knowledge when this was done and that he was not present (Tr. 153). I find no credible evidence to support any conclusion that the bolter operators were exposed to any hazardous dust conditions over any prolonged or extended period of time, and I reject any credible inference that there were.

I reject the inspector’s reliance on the respondent’s history of violations as part of his S&S determination. Aside from its relevance, no information was forthcoming with respect to the facts and circumstances related to these alleged violation other than a review of a computer
generated list that may have included violations of dust standards other than Section 72.630(b). The inspector confirmed that these alleged violations are not listed in the mine file (Tr. 145-147).

With regard to my bench comments that the only “repeat violations” of Section 72.630(b), reflected by Exhibit A to the petitioner’s initial petition for assessment of civil penalties filed in this case reflect two alleged violations of Section 72.630(b), that are a matter of record before me, the parties confirmed that there are no stipulations regarding prior violations. Further, the petitioner’s post-hearing arguments do not address prior history, and it was not offered or admitted as part of the record.

Based on the foregoing findings and conclusions, including my credibility findings regarding the absence of any credible evidence to support the inspector’s asserted observations of visual hazardous silica dust circulating over the DBT roof bolters, and the absence of any credible evidence of dust exposure over a prolonged period of time, and particularly in view of the small residue of dust that I find was behind the filter, I conclude and find that the third and fourth prongs of the Mathies tests have not been established. I conclude and find that under these circumstances, it was not reasonably likely that the aforementioned conditions would contribute to a serious lung disease or injury of a reasonably serious nature. Accordingly, the inspector’s S&S determination IS MODIFIED to a non-S&S violation.

**History of Prior Violations**

The petitioner presented no additional information regarding the respondent’s history of violations other than Exhibit A attached to its petition for assessment of civil penalties which reflects no repeat violations of 30 C.F.R. § 72.630(b), in (Docket No. VA 2010-289), and 8 violations (Docket No. VA-2010-288). In the absence of any further evidence with respect to the respondent’s compliance record, I cannot conclude that additional increases in the penalty assessments for the violations are supportable.

**Good Faith Compliance**

I conclude and find that the violations were timely abated and corrected in good faith by the respondent.

**Gravity**

I conclude and find that the violations that have been modified to non-S&S, as well as the settled violations, are non-serious.
Negligence

Citation No. 8170287

The inspector based his moderate negligence finding on the amount of air he claimed he observed in the air. However, he stated that it was difficult to determine the negligence level because it was possible that when the foreman began his dust parameters check before any mining started, the bolter may have expelled some dust and the foreman may have not seen it or overlooked it (Tr. 33-34). He determined these mitigating circumstances supported his moderate, rather than high, negligence finding. I find the inspector’s moderate negligence to be reasonable and supportable, and it is AFFIRMED.

Citation No. 8170285

The inspector based his moderate negligence finding on the possibility that the condition existed for 45 minutes, and on his assumption that the foreman should have observed it when he conducted his dust parameters. He confirmed that he considered the fact that the section was down and that there was a problem with the belt that may have called the foreman away and he did not see the condition, and the increased amount of air, as mitigating circumstances that prompted him to determine that the negligence was moderate and not high (Tr. 112-113, 141). Under the circumstances, I find the inspector’s moderate negligence to be reasonable and supportable, and it is AFFIRMED.

I have considered the respondent’s arguments that its standard operating procedures and practices with respect to its dust collection system, and the maintenance and changing of filters, are mitigating circumstances that support low rather than moderate levels of negligence with respect to both citations. Although these are commendable efforts to insure compliance, I would expect nothing less from any responsible mine operator, and can conclude that they are extraordinary mitigating factors.

Size of Business and Effect of Civil Penalty Assessments on the Respondent’s Ability to Remain in Business

The parties stipulated that the Locust Thicket Mine had a year 2009 coal production of approximately 187,780 tons, and 185,016 tons in 2010. The Paw Paw Mine produced 176,834 tons in 2009, and 222,757 tons in 2010. I conclude and find that for the purposes of these proceedings, the respondent is a relatively small to medium mine operator. The parties further stipulated that the proposed penalties will not affect its ability to remain in business.
Proposed Settlement of Remaining Violation

Docket No. VA 2010-288

The parties filed a motion for approval of a proposed settlement of the following Section 104(a) S&S violation.

<table>
<thead>
<tr>
<th>Citation No.</th>
<th>30 C.F.R. Section</th>
<th>Assessment</th>
<th>Settlement</th>
</tr>
</thead>
<tbody>
<tr>
<td>8169268</td>
<td>75.1725(a)</td>
<td>$1,412.00</td>
<td>$634.00</td>
</tr>
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The contested issue, with respect to this violation, is the level of gravity determination by the inspector that a permanently disabling injury affecting one person was reasonably likely to occur as a result of an alleged scoop service brake defect.

The respondent asserts that a permanently disabling injury was not reasonably likely as a result of the cited condition, and requests a reduction of the severity of injury from permanently disabling to lost workdays or restricted duty and a reduction of the penalty.

The petitioner recognizes the existence of a legitimate factual and legal dispute in this matter and believes that a settlement compromise of the gravity of the violation is consistent with her enforcement responsibility under the Mine Act. Accordingly, the petitioner agrees to the requested gravity modification and reduction of penalty.

I have considered the representations and documentation submitted by the parties, and conclude that the proffered settlement is appropriate under the criteria in Section 110(I) of the Mine Act. Accordingly, I conclude and find that the proposed settlement is reasonable and in the public interest. The motion IS GRANTED, and the settlement IS APPROVED.

It is ORDERED that Citation No. 8169628 be modified to reduce the injury to be reasonably expected from Permanently Disabling to Lost Workdays/Restricted Duty, and that the respondent pay a penalty amount of $634 within thirty (30) days after the date of the decision (Docket No. VA 2010-288).

It is ORDERED that Citation No. 8170287 is modified to a non-S&S violation. The respondent is ORDERED to pay a civil penalty assessment of $750 for the violation within 30 days of the date of this decision (Docket No. VA 2010-288).

It is ORDERED that Citation No. 8170285, is modified to a non-S&S violation, and the respondent is ORDERED to pay a civil penalty assessment of $500 for the violation within 30 days of the date of this decision (Docket No. VA 2010-289).
The respondent is **ORDERED** to pay a total civil penalty assessment of $1,884, in satisfaction of all of the aforesaid violations issued in these matters. Payment shall be made within thirty (30) days of the date of this decision, and remitted by check made payable to U.S. Department of Labor/MSHA, P.O. Box 790390, St Louis, MO 63179-0390. Upon receipt of payment, these matters are **DISMISSED**.

/s/ George A. Koutras  
George A. Koutras  
Administrative Law Judge

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INTRODUCTION

On December 23, 2009, Signal Peak Energy miner Mike Stewart, working in a travelway adjacent to a longwall, was propelled some 50 to 80 feet from a blast of air produced by a roof cave behind longwall shields, numbers 1, 2 and 3. As will be discussed, the record shows that Mr. Stewart’s injuries from that blast were significant and serious. Respondent Signal Peak Energy never informed MSHA about the event; MSHA only learned of it through a reporter’s inquiry. MSHA then investigated the matter and cited the Respondent for failing to notify it of an injury to a miner which has a reasonable potential to cause death. The standard, 30 CFR § 50.10, entitled “Immediate notification,” in relevant part, obligates a mine operator to contact MSHA “at once and without delay” once it knows or should know that an accident has occurred involving an injury of an individual at the mine “which has a reasonable potential to cause death.” For the reasons which follow, the Court affirms the violation and an associated violation for its failure to preserve the accident site. Further, the Court assesses civil penalties totaling $83,750.00.1

1 Per the discussion infra, Citation number 8463717 is assessed at $74,250.00 and Citation number 8463718 is assessed at $9,500.00.
The Cited Standards

30 CFR § 50.10 provides, in full: “Immediate notification. The operator shall immediately contact MSHA at once 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: (a) A death of an individual at the mine; (b) An injury of an individual at the mine which has a reasonable potential to cause death; (c) An entrapment of an individual at the mine which has a reasonable potential to cause death; or (d) Any other accident.” (emphasis added).

30 CFR § 50.12 provides, in full: “Preservation of evidence. 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.”

30 C.F.R. § 50.10(d). MSHA also maintains that the mine’s actions, or more accurately, its lack thereof, also violated the immediate reporting obligations under 30 C.F.R. § 50.10(d). That subsection, as just noted, requires the same notification requirement, that is a notification “at once and without delay,” for “[a]ny other accident.” As applied here, MSHA applies the “any other accident” provision to subsection 50.2 (h)(8) which, among many aspects encompassing the term “accident,”² includes “[a]n unplanned roof fall at or above the anchorage zone in active workings where roof bolts are in use; or, an unplanned roof or rib fall in active workings that impairs ventilation or impedes passage.”

² 30 CFR § 50.2 Definitions. “As used in this part: . . . (h) Accident means (1) A death of an individual at a mine; (2) An injury to an individual at a mine which has a reasonable potential to cause death; (3) An entrapment of an individual which has a reasonable potential to cause death; (4) An unplanned inundation of a mine by a liquid or gas; (5) An unplanned ignition or explosion of a gas or dust; (6) In underground mines, an unplanned fire not extinguished within 10 minutes of discovery; in surface mines and surface areas of underground mines, an unplanned fire not extinguished within 30 minutes of discovery; (7) An unplanned ignition or explosion of a blasting agent or an explosive; (8) An unplanned roof fall at or above the anchorage zone in active workings where roof bolts are in use; or, an unplanned roof or rib fall in active workings that impairs ventilation or impedes passage; (9) A coal or rock outburst that causes withdrawal of miners or which disrupts regular mining activity for more than one hour; (10) An unstable condition at an impoundment, refuse pile, or culm bank which requires emergency action in order to prevent failure, or which causes individuals to evacuate an area; or, failure of an impoundment, refuse pile, or culm bank; (11) Damage to hoisting equipment in a shaft or slope which endangers an individual or which interferes with use of the equipment for more than thirty minutes; and (12) An event at a mine which causes death or bodily injury to an individual not at the mine at the time the event occurs.
Preliminary Matter

The Respondent’s contention that 30 C.F.R. § 50.10 is not a mandatory standard

    Respondent argues that the provisions cited in this case are merely regulations and, as distinct from mandatory health and safety standards, no significant and substantial finding may be attached to regulations. The reasoning behind the putative regulation and standard distinction is that Section 3(l) provides a definition of a mandatory health or safety standard and any rules or regulations arising under authority other than that provision are not mandatory.

    The Secretary, citing Secretary v. Wolf Run Mining Co., Dkt. No. WEVA 2008-1417 (July 2, 2010) (Judge Zielinski), and Secretary v. Pine Ridge Coal Co., 33 FMSHRC 987, 2011 WL 1924269 (April 29, 2011) (Judge McCarthy), contends that 30 C.F.R. § 50.10 “became effective on March 9, 2006 as an emergency temporary standard and was later published as a Final Rule on December 8, 2006, as part of the rulemaking process initiated pursuant to Title I, Section 101, of the Mine Act,” and accordingly, through that action, it is a mandatory standard, enforceable under Section 104 of the Mine Act. Sec. Br. at 38.

    Little needs to be said about this claim because Section 50.10 was published pursuant to section 101 and therefore it is a mandatory standard. The mandatory standard became effective on March 9, 2006, and the tried and tired claims made that somehow this was ineffective or insufficient rulemaking are reminiscent of the tax protester claims that the Sixteenth Amendment was improperly ratified. Accordingly, per the cases cited by the Secretary in her post-hearing brief and in light of the Agency’s bona fide rulemaking actions, further comment is unwarranted.

Findings of Fact

    Wayne Vincent Johnson,3 has been an MSHA coal mine Inspector for six years, working out of that Agency’s Gillette, Wyoming Field Office.4 The Inspector informed that around

3 Inspector Johnson has some 26 years of coal mining experience. This experience includes 15 years on a Mine Rescue Team and, with three of those years, Johnson was the captain of the International Mine Rescue Competition. Tr. 28. Although most of his inspections involve surface mines, as that is the nature of the mining carried out within the area covered by the Gillette office, an exception is the mine involved in this litigation, Signal Peak’s Bull Mountain No. 1. Tr. 28. Inspector Johnson is quite familiar with the mine, having partaken in MSHA inspections of it during the past five years. Tr. 30.

4 Although the Respondent noted that the Inspector’s background was primarily with surface mines, and that he never worked on a longwall, the Court finds that the lack of such experience did not hinder his ability to determine whether the cited violations occurred. The (continued...)
December 28<sup>th</sup>, MSHA received a call from a Billings, Montana newspaper reporter, inquiring about an accident that had occurred at the Respondent’s mine which is located near Roundup, Montana. Ultimately this led to MSHA making an inquiry about the matter at the mine, as initiated by Dave Hamilton, Johnson’s supervisor at that time at the Gillette office. Tr. 40. MSHA then spoke with the mine’s Tom Rice about the reported incident and Johnson was directed to go to the mine to learn more about the matter. Tr. 41. MSHA had learned that an injured miner, Mike Stewart, was at the St. Vincent’s Hospital in Billings and that hospital was the Inspector’s first stop the next morning. When Inspector Johnson arrived at the hospital, on December 29<sup>th</sup>, which was six days after the accident had occurred, he learned that Mr. Stewart “had three surgeries already.”<sup>5</sup> Tr. 42. GX 11, the injured miner’s hospital records. The injured miner’s first surgery was a “left chest tube,” on December 25<sup>th</sup>. This was followed by a right chest tube the next day, and then a third surgery, a T-9 thoracotomy, fusion for a burst thoracic vertebrae. Miner Stewart’s other injuries included fractures of the left scapula, ribs, and sternal fractures. Tr. 46.

The Inspector then traveled to Roundup Memorial Hospital, which was the first hospital that treated the injured miner. Tr. 47 and GX 23, the Hospital and ambulance records. At that hospital, the Inspector spoke with Dr. Flannery and Diane Newman, the latter being with the hospital’s records department. Dr. Flannery informed the Inspector that he had approved the miner’s “life-flight” and when specifically asked by the Inspector if he considered the miner’s injuries to be life-threatening, he advised the inspector “absolutely, yes.”<sup>6</sup> Tr. 49. To be sure that the Inspector and the doctor were, so to speak, on the same page, the Inspector related to the

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<sup>4</sup>(...continued)

standards cited do not require any special underground experience to recognize whether they were violated. Similarly, while the Inspector expressed agreement that an initial fall on a longwall is something a mine wants, and expects, and that the initial fall is “oftentimes larger than subsequent later falls in the longwall gob,” those points amount to misdirections from the very out-of-the-ordinary initial fall which happened here and which initial fall’s air blast blew miner Stewart a great distance. Tr. 92-93. Any suggestion that such occurrences are within the expected events for an initial fall cannot be taken seriously. Thus, while Inspector Johnson agreed with Respondent Counsel’s characterization that “if falls don’t occur in the longwall gob, it would create safety problems,” that does not imply that the event in which miner Stewart was injured avoided the creation of safety problems.

<sup>5</sup> Counsel for the Respondent noted that it did not have access to the injured miner’s hospital records and therefore contended it would be unfair to suggest that those records could inform the mine’s decision regarding its decision whether to notify MSHA. Tr. 44. The Court agrees and its decision is not based on those records.

<sup>6</sup> The quoted words refer to the words expressed by the Inspector, but relating the words that the doctor used when speaking to him. Tr. 49.
7 In questioning those individuals, the Inspector specifically advised that it was important to determine “whether at the time of this accident that this was to be looked at as a potential injury that could cause death.” Tr. 124. (emphasis added). Thus, he impressed upon those individuals the importance for MSHA to determine “when this accident occurred should a reasonable person know or should know that this particular accident has the potential to cause death.” Tr. 125. Accordingly, while various individuals have used shorthand expressions, such as “life-threatening,” as easier substitutions for the standard’s words, when precision in language was in focus, the correct test, the reasonable potential to cause death test, was in fact applied.

8 To make sure the Court understood the Inspector’s testimony, the Inspector affirmed that the statements he related that others made about the injured miner’s condition were derived from the hospital records from both hospitals as well as from attending physicians and nurses. Tr. 52.

9 As Johnson later reconfirmed, he did speak with Dr. Flannery prior to January 14, 2010. In fact he spoke with the doctor about six days after the accident. Tr. 190. It was then that the Doctor expressed that Mr. Stewart had the potential to lose his life because of all the information he had at the time he examined him at the Roundup Hospital. Tr. 190-192. This was the conversation with Dr. Flannery that Inspector Johnson referred to earlier in his testimony and at which time the records manager was also present. Tr. 191. GX 3. Significantly, as noted, it was in fact the same Dr. Flannery who approved Mr. Stewart’s “life flight.” Tr. 192.

10 GX 6 is the letter signed by Dr. Flannery, dated April 23, 2010, and the Respondent relies upon a statement in that letter to support its claim that the miner’s injuries were not life-threatening. Tr. 126-127. As Respondent’s Counsel suggests, the letter conflicts with the Inspector’s testimony as to the doctor’s view of the miner’s condition. Referring to Exhibit 6, which was referenced by Respondent’s Counsel, Inspector Johnson agreed that the letter from Dr. Flannery, dated some four to five months after the accident, came about following a meeting the doctor had with the president of Signal Peak and its Safety Manager, Tom Rice. Tr. 196.

(continued...)
Having visited both hospitals, the Inspector then proceeded to the mine. At that point in his investigation, the Inspector felt that he was dealing with an injury to a miner that had the potential to be life-threatening. He also believed that, given the drop behind the roof and the attendant uncontrolled release of energy, other miners were potentially put at risk. This led him to issue a section 103(k) order to stop everything for the safety of the miners, in order to understand the potential safety hazards that could still be present.\textsuperscript{11}  Tr. 54. GX 12.

Referring to GX 1 and GX 2, reflecting Citation numbers 8463717 and 8463718, Inspector Johnson acknowledged that he issued those citations on the date reflected at 1815 (i.e. 6:15 p.m.). Tr. 32. GX 3 reflects Johnson’s notes in connection with those Citations.\textsuperscript{12} Those notes included statements he took from individuals in connection with his investigation. Regarding GX 1, Citation 8463717, finding a violation of 30 C.F.R. 50.10, Johnson stated that the standard pertains to the duty of a mine to report an accident to an individual within 15 minutes if the mine knew or should have known that an accident occurred that has a reasonable potential to cause death.\textsuperscript{13} Tr. 37. Johnson noted that the term “accident” is defined further at 30 C.F.R. 50.2, which identifies 12 criteria that meet the definition of “accident.” Tr. 38.

The Inspector explained that MSHA knew the mine had begun mining their longwall and that it was the first longwall for this mine. In advancing the longwall cut, the roof behind the shields had some severe drops in the wall and this phenomenon was affecting the working area. Tr. 55. For that reason, the Inspector issued a (k) order to assess the conditions that were causing “explosive pressures” which expanded beyond the gob area, affecting miners in the working area. The rush of air that resulted in the injury to miner Stewart was greater than

\textsuperscript{10}(...continued)

Without expressly determining that something was afoot here, the Court concludes that the more reliable recounting is the one Dr. Flannery made when he spoke with the Inspector, not the subsequent letter. This conflict could not be cleared up entirely as the doctor died subsequent to the issuance of his letter.  

\textsuperscript{11} The (k) Order is not in issue in this proceeding.

\textsuperscript{12} Johnson’s notes include information from statements of those with knowledge of the events in issue. For those aspects of his notes, the individual witnesses’ handwriting appears, not the Inspector’s writing. Johnson indicated where this was the case by initialing the bottom of the page, while the witnesses signed on the top of the page. An illustrative example of this appears on the last page of GX 3. Tr. 32-33. He added that the correct date for the notes is 12/29, not 12/23. Tr. 34.

\textsuperscript{13} Johnson explained that the reference in his citation to 30 C.F.R. Part 50.2 (h)(2) and (h)(8) stems from the fact that 50.2 has the same wording as 50.10(b) and that [8] refers to an area of the roof that has come down that affects miners in the working area. Tr. 39. The transcript refers to “(h)” but it is clear that the inspector was referring to “(8)” within that provision because the question was directed to that.
anything this mine had encountered. Tr. 56. The (k) order stopped the longwall mining, as by the time the Inspector first arrived, operations had resumed.\footnote{14} Tr. 56. The fact that operations had resumed since the accident meant that there was no longer any “accident scene” for the inspector to view. As the mining had advanced some 50 or 60 feet since the time of the accident, the Inspector was “left with trying to piece together what had taken place in [the] area where [the] individual [had been] blasted down the entry.”\footnote{15} Tr. 57, 193.

To appreciate the size of the blast, apart from the harm to the injured miner himself, the Inspector learned that some 78 stoppings were damaged, affecting the mine’s ventilation.\footnote{16} Tr. 61. GX 3, at page 5. On the outby area behind the longwall, where it had been mined, almost every stopping had been damaged. Tr. 66. The Inspector noted that sufficient air was displaced by the event that it launched miner Stewart some 50 to 80 feet down the entry.\footnote{17} As the accident scene had not been protected, only an estimate could be made as to how far the injured miner was thrown by the blast. Tr. 122. However, the estimate was not the product of pure speculation or imagination. Instead, the estimated distance was derived by the Inspector based on information he was given by the mine from Tom Rice and Bob Lowery, as well as information he obtained from Roundup Hospital. Tr. 123. Making it more reliable, the 50 to 80 feet figure was a consensus figure which those individuals then relayed to the rescuers. Tr. 123. As already made clear, this huge displacement of air was created by the initial longwall roof cave. Tr. 63-64. With such a very large number of stoppings impacted, the Inspector stated the obvious: “the ventilation in the mine was disrupted in a great way.” Tr. 64. While indirect information, the government contended that this information was a telling factor informing the mine operator as to the seriousness of the injury.\footnote{18} Tr. 62. The Court agrees.

\begin{itemize}
\item \footnote{14} It was the Inspector’s understanding that the longwall mining operations had stopped for three (3) days following the incident. Tr. 56.
\item \footnote{15} The Inspector also expressed that “this type of concussion blast should have been addressed by the mine. [The mine] had not looked at the incident as far as how [does it] prevent this from going forward.  [That is, the mine did not inquire] is this going to continue to exist? [And does it] need to make a corrective action[?]” Tr. 57-58.
\item \footnote{16} The Inspector, with the assistance of the mine’s dispatcher, found a map which reflected all the areas where the ventilation stoppings had been damaged, and together they counted 78. Johnson reiterated that his determination of the number of damaged stoppings was derived with the help of the mine’s dispatch personnel and he added that no one from the mine challenged the count. In fact, he related that they were in agreement about the number. Tr. 195.
\item \footnote{17} Others would most certainly have been injured but for the fact that ear pressure changes alerted them that something was about to occur and they quickly hung on to “iron” to avoid being thrown. Tr. 63.
\item \footnote{18} The Solicitor’s Office also offered the evidence to support an additional basis for (continued...)
\end{itemize}
Speaking to the Secretary’s contention that 30 CFR § 50.2 (h)(2) was violated, Inspector Johnson expressed that it was because, “any person in the area, that reasonable person that was to see what had taken place, the mechanism of injury of blasting somebody down, that far down an entry, the conditions of the broken spine, the labored breathing, he couldn’t breathe on one side, they had to move him to the other side, you don’t know the internal injuries to this [ ] person. You would immediately think that you need to get this individual out of the mine or this person could die from these injuries.” Tr. 66-67.

As stated earlier, in reaching this conclusion, the Inspector had interviewed miners to learn how the accident took place and what happened underground on the day of the event, December 23rd. His notes reflect his summaries of those interviews. GX 3, at p. 5. Those notes reflect that Mike Stewart, the injured miner, who was located in the five foot wide travelway, was impacted by the roof cave behind longwall shields, 1, 2 and 3 and that the cave produced an air blast into the stageloader-headgate belt entry, which blast threw the miner as far as 80 feet down the belt entry. Tr. 68.

This information was derived from multiple sources, including from the mine, and from the Roundup Hospital records. In fact, the mine itself had provided the 80 feet figure, and there was a drawing of the entry where Stewart was blown. Tr. 68. The Inspector spoke with the ambulance crew as well as with the rescue team. This included Ben Harcourt, a rescuer at the mine. Tr. 70. Harcourt told the Inspector that the injured miner “was in excruciating pain, 10 plus on a pain scale, pretty critical. Most life-threatening was his breathing.” Tr. 70. The rescuer could not get the miner’s vitals and he could only breathe on his right side. The miner was in so much pain that the rescuer could not touch his left arm. Aware of the risk of paralysis, because of the mechanism of injury, the individuals involved with removing the injured miner took an hour and a half to remove him from the mine.

In continuing to become informed about the event and the miner’s injuries, Inspector Johnson’s focus was upon learning about the time frame “not after [the injured miner] arrived at the hospital, but what took place while [he] was injured.” Tr. 72 (emphasis added). Accordingly, he gathered information from the rescue people at the mine, from the ambulance crew which awaited his exit from the mine, and from the first aid which was administered. Tr. 72. The Inspector’s notes reflect the information he gathered from Mr. Harcourt and such notes include that the miner had a large dent in his helmet, that there was a deformity in his back and broken ribs, that C spine precautions were taken because of the concern of paralysis, and that the miner was experiencing pain at a 10 level on a scale of 1 to 10. Tr. 73. The same notes reflect

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18(...continued)

reportability of this incident: namely that the event was immediately reportable under section (h)(8), which pertains to an unplanned roof fall that impairs ventilation. Tr. 62. Thus, it was the Petitioner’s position that the accident was immediately reportable under both (h)(2) and (h)(8), with the latter referring to an unplanned roof fall in active workings that impairs ventilation. Tr. 66. More will be said about this later in this decision.
that Harcourt realized that the miner’s injuries could become life-threatening. Tr. 73. GX 4, at 3A. The Inspector was perplexed that Harcourt, the mine foreman, and one of the rescuers, while initially realizing that the miner’s injuries were life-threatening, then reconsidered that assessment. The Inspector also spoke with Kerry Halverson, EMT, who was part of the ambulance crew. Tr. 74, 76. His notes, reflecting his conversation with Halverson, reflect the decision to see about the availability of a life-flight, that the miner’s breathing was not good, and did not display good volume and that, upon seeing his back exposed, raised the life-threatening issue. Halverson works for the Roundup Hospital on its ambulance rescue, and he is not a mine employee. Such was the concern about the miner’s spine and the risk of paralysis, that they kept his spinal cord correct and did not move it. Tr. 75. GX 4 at 3 B.

Inspector Johnson did confirm that it was his view that one could make the determination whether an injury has the reasonable potential to cause death based on what an normal person at the scene was presented with when the incident took place and, applying the confluence of the events, and the condition of the injured individual when they found him, such person could make a primary assessment as to whether an injury could cause death. Tr. 181-182. The Court agrees with this approach. The standard is not about making such a determination based on medical certainty. As Johnson also expressed, before the individual even got out of the portal and again at the time the ambulance was called, and yet again when the injured miner left the mine property, at each juncture, the mine had a duty to report. Tr. 182.

David Hamilton, a MSHA surface specialist from the Gillette, Wyoming field office, also testified. He described his involvement in this matter, the Agency’s issuance of citations on December 29, 2009, GX 1 and 2, explaining that he was the acting field office supervisor on that date. It was then that he learned from Wayne Johnson about the accident at the mine. Hamilton later received a call from Signal Peak’s Tom Rice, a call which was in response to an inquiry about the matter by Inspector Johnson. Tr. 211. Hamilton related his conversation with Rice, who informed that the miner was going to be fine. Tr. 212. This didn’t add up at all to Hamilton, as Mr. Stewart at that point had already been in the hospital for 5 days and, of course, MSHA had not been called, even by then. Tr. 216. It was clear from Hamilton’s testimony, which the Court found to be highly credible, that Mr. Rice was anything but forthcoming. Hamilton asked, for example, if the miner needed stitches. Rice affirmed he did but offered nothing more. Hamilton then had to prompt Rice each step of the way, asking “was there anything else?” To that, Rice responded that the miner had a broken back. Hamilton waited and, as Rice offered nothing more, he again inquired if there was anything else. Rice then responded that the miner had broken ribs. Tr. 212. After another period of silence and another prompt, Rice disclosed that the miner had a broken scapula. Tr. 212. As Hamilton fairly put it, “And I just couldn’t get him to say anything.” Tr. 212. Later, Hamilton expressed that “I just had to pry every piece of information out.” Tr. 215. It was during that same tooth-pulling conversation that Rice disclosed that 78 stoppages had been damaged. Tr. 213.

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19 When Inspector Johnson referred to the description “life-threatening,” he considered it synonymous to “reasonable potential to cause death.” Tr. 76.
Hamilton took notes of the conversation with Mr. Rice. GX 9, Hamilton’s statement regarding the conversation, which was created on January 7th, pertaining to his December 29th talk with Mr. Rice. Tr. 214. Hamilton summed up his view that, in complying with the standard, one should err on the side of safety. Tr. 216. Hamilton also noted that, given so many injuries to the miner, so many broken body parts, “there could be something you’re not seeing.” Tr. 217. Given the state of affairs with the conversation with Mr. Rice, Hamilton determined that it was best for Inspector Johnson to go to the hospital “because we just weren’t getting any information [from Signal Peak].” Tr. 217-218. Hamilton then was asked about GX 24, which he identified the first three pages as his notes. It reflects that his aforementioned conversation with Mr. Rice did occur at 11:50 a.m. on December 28, 2009. Tr. 218. Those notes reflect that the injured miner had already undergone two surgeries. Tr. 220. That information came from Inspector Johnson. Tr. 220. Mr. Hamilton made it clear, and the Court finds it to be the case, that when he wrote up his notes, on January 7, 2010, those notes were his best recollection of his phone conversation with Mr. Rice and that there was no attempt to inflate or exaggerate that conversation. Tr. 236.

Brandon Mobley, an employee of Signal Peak, also testified. Mobley works on the longwall. Tr. 140. As to the time of the event in issue, December 23, 2009, Mobley advised that it was the first major cave of the longwall, but that there had been previous, smaller, cave-ins. Tr. 142. At the time of the December 23rd cave in, he was located at shield 2 or 3. Referred to GX 8, a map, Mobley advised that it shows how the longwall was set up and that it is an accurate representation of the location of individuals that were involved on the day of the major longwall cave of December 23rd. Tr. 144. At that time, he and the other miners were walking to the headgate. The area was entered through a crosscut Mobley identified as “where Mike [Stewart] was blasted to.” Tr. 144. He and the others (which he believed involved six miners plus the foreman) were traveling towards the direction of what is labeled as “shield six” on the map. As he arrived at the location of shield 2, the roof was making noises, and then he was advised to ‘hold on,’ although the record suggests that more colorful words of warning were employed to warn him to prepare for the cave in. Tr. 147. Moments later, the blast occurred. Tr. 146. Mr. Stewart was about 15 feet behind Mr. Mobley at the time of the blast. Tr. 146. Mobley grabbed ahold of part of the shield. The air force then hit him on the left side of his face and picked him right out of the mud, which he had been “stuck” in just moments before the occurrence, slamming him into the object he had been holding onto and then he was “face planted” into the mud. Tr. 148. The force was significant enough that one side of his became completely scabbed from the incident and his side was “pretty bruised” as well.20 Tr. 148. Thus, while the focus is upon Mr. Stewart’s injuries, it should not be forgotten that Mr. Mobley was injured too.

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20 Mr. Mobley marked arrows, indicating the travel direction of the blast of the air, on Gov. Exhibit 8. That marking reflects that it came from the gob and then through the areas between each shield, a gap he estimated in this instance to be about 6 inches between each shield. Tr. 149.
Bearing upon the mine operator’s claim that initial falls are much like the one that occurred here, Mr. Mobley had a different perspective. The blast, he informed, was unlike any other he had experienced. It was “hard” and, as he noted, it picked his feet right out of the mud he had been stuck in, lifting him some three feet above the ground and blowing his hard hat off. Tr. 152-153. While Mobley knew a big blast would be inevitably coming, he had no idea that it was going to be so hard. Tr. 154. Stewart, he advised, had the misfortune of being in the worst possible area one could be in for the blast, because he was located where the air was going to, and did, travel. Tr. 154.

After the blast, the miners immediately began to inquire of one another if everyone was okay. Tr. 155-156. It was at that point that they heard Mike Stewart groaning, and communicating that he was not okay. Mobley couldn’t recall the exact words Stewart used, but it was clear that he needed help. Tr. 156. Mobley’s estimate was that Stewart was about 50 feet away. Tr. 157. The miners then proceeded to get Mr. Stewart loaded onto a backboard, and Mobley saw that Stewart had something “like a hump in his back.” Tr. 157. It looked like a triangle on his back and, strikingly, the hump was visible “under his jacket and clothes . . . in the middle of his back.” Tr. 158. Mobley agreed that the miners wear thick jackets, yet the hump was still visible. Tr. 158. The hump was significant enough that Mobley told them they should not strap Stewart down on the backboard. He was worried because none of them knew just how serious the issue was with Stewart’s back. Mobley had basic first aid training but he is not an EMT. Stewart told them his back was hurt and he was having “a hard time breathing.” Tr. 162. Mobley understood that Stewart had been “really hurt” because he did not want to be moved. They also knew that he was unable to get up and walk. Tr. 163. Mobley’s foreman told him to advise dispatch that an ambulance was needed. Tr. 164. On a scale of 1 to 10, Mobley described Stewart’s pain as an 8 or 9.

As they slowly transported Stewart out of the mine, they met up with Ben Harcourt and shortly thereafter oxygen was administered to the miner, but the oxygen didn’t make his breathing any easier. Tr. 168. Mobley stated that all of the miners were concerned about Stewart’s condition. As he expressed it: “[A]ll of us were concerned, period.” Tr. 168. Though on the trip out, Stewart tried to sit up, he had to lie back down on his side. Tr. 170. Even though miner Mobley was not injured to the extent that Stewart was, management recognized that Mobley should go to the hospital too, as they were concerned that he might have suffered a concussion. Tr. 171.

Mr. Kerry Halverson, a self-employed roofing contractor who is also a certified, and current EMT, testified. He’s been an EMT for nine years. Tr. 241. He also works as a part-time volunteer on the Musselshell County Ambulance. Tr. 241. In his experience, he has been called to Signal Peak about six times, responding to injuries ranging from a miner who hurt his back, to an individual whose head got crushed, and to an instance where a miner incurred a foot amputation. Those experiences aside, Halverson did respond to the December 23, 2009 event at the mine involving Mr. Stewart. He recalled that the ambulance had arrived even before the miner had come out of the mine. When Mr. Stewart was removed, Halverson observed that he was “coated with coal dust.” Tr. 243. He noted particularly that the miner’s face “almost looked
Mr. Stewart told Halverson that “he couldn’t breathe when he was on his back . . . and [it was noted that Stewart] had a deformity in his back . . . [and so the decision was made to] put him onto the gurney and . . . [to keep his] head in an inline position so the cervical spine [would not] twist or bend at all.” Tr. 244. EMT Halverson was concerned that the miner could have a broken back, because he had a lot of pain in the spine. Tr. 246. Thus, among other worries, with the miner’s spinal injury, the EMT was concerned about a possible cervical spine injury; nor could he rule out internal bleeding or internal damage. Tr. 247. The EMT believed that there was a reasonable possibility that internal bleeding or internal injuries could be involved because of the “mechanism of injury,” as he had been advised that he had been “blown through the air 70 to 100 feet,”21 which he described as “a pretty good blast to move somebody that far . . . [a]nd then at the end of that travel, he hit a wall or ladder or both . . . so there’s . . . a pretty good chance that there’s going to be something hurt inside.” Tr. 248.

As he saw that the miner “had a lot of pain in his spine.” Halverson called his dispatcher to see if she “could call help flight and check on [its] availability.” Tr. 245. The decision to inquire about a life flight was prompted by the mechanism of injury and the deformity in the miner’s back. Also a factor, as he had noted earlier, the miner had “a lot of pain in his spine.” Tr. 249. The bottom line was Halverson’s assessment that Mr. Stewart injuries presented a reasonable potential to cause death. Tr. 249-250. As he summed it up, there were a number of things at work: the miner had taken “a good blast,” it had thrown him up against a wall, he had broken ribs, probably a broken back, and no one knew what was going on inside. That could include things like a liver laceration, a ruptured spleen, bleeding in the brain which wasn’t showing up significantly yet. Any one of those, Halverson noted, could result in death. Tr. 250, 253.

Mike Stewart, the injured miner, was called by the Respondent. Tr. 426. Stewart has been employed as a mechanic since he began working at Signal Peak Energy. Tr. 426. When the accident occurred, Stewart was at the No. 1 headgate drive motor. Tr. 428. After the event, he described his location as “on the opposite side of the crosscut, just a foot or two from the rib.” Tr. 428. Although, following the air blast, he tried to get up, he was only able to get up

21 Halverson learned this from Ben Harcourt, a mine employee, who also works for the voluntary ambulance service. Tr. 248. Further, Halverson advised that his view would remain the same if the miner had only been thrown some 50 to 80 feet, because “[i]t is still going to take a fair amount of force to pick up a human body and throw it 50 feet. And at the end of that, he’s hitting something solid. . . . [further he informed that] blast injuries themselves can cause significant internal injuries. . . . solid organs particularly can take a pretty good beating just from the blast.” Tr. 249.
22 Although Stewart discounted his breathing issues as being “panicked [ ] a little” and, upon calming down, he stated that “it wasn’t that big a deal,” the Court concluded that his description at the hearing was a manly attempt to presently discount his condition and was not reflective of his true status at the time of the event. Tr. 433-434. Stewart would not return to work until seven months later. Tr. 434.

23 In this limited experience, he had dealt with only one previous trauma, a minor car crash. Tr. 386. Harcourt also serves as a volunteer with the Roundup Ambulance service. Tr. 359. This is not work that is necessarily related to injuries at the Mine, as he may be involved for any number of non-mine calls from private homes. Tr. 359.
testimony in this regard was to suggest that the fall that occurred here was not all that unusual in his mining experience and he related stories he had heard about such other large falls.

It was also obvious to the Court that production was Harcourt’s uppermost concern.\textsuperscript{24} Thus, when he learned of the large cave, he told men to “get ready because . . . there was probably going to be some major damage . . . [and they would have to] get ready to go start re-establishing ventilation up towards the longwall.” Tr. 365. Knowing that they “lost ventilation up at the longwall, [they had planned] to get everybody up there to help re-establish ventilation so that we could get back mining longwall.” Tr. 365-366.

Harcourt then learned “that people were hurt up at the longwalls.” Tr.366. Upon arriving near the area where injuries were reported, he met miners about 700 feet out from the face, near the power centers of the longwall. Tr.366. Mr. Stewart was in the back of the truck and Harcourt got his first look at him then. Tr. 367. Harcourt, upon first viewing Stewart, noted that he had a cut on the top of his head, “a pretty good cut, . . . an inch and a half, two-inch cut” and that he was covered in mud. As he continued to see Stewart’s injuries, he then observed a “kind of hump on his back . . . [and he saw] where the ribs were broke away . . . they were broke out . . . .” He did not see any other injuries. Tr. 367-368. Harcourt assessed that Stewart was alert and conscious. Tr. 369. He added that Stewart told him that “it hurt to breathe,” which was not surprising as he realized that the miner had broken ribs. Tr. 370. While in the process of transporting him out of the mine, there were limits to the assessment he could make; he did not undress the miner, had no stethoscope, and did not take his pulse. Tr. 371-373.

Further, with the limited ability to examine the miner, Harcourt did not realize that Stewart also had a broken sternum. Tr. 382. Oxygen was administered as a first aid treatment and to address the possibility that the miner was in shock, as Stewart told him he was feeling queezy and lightheaded, both being first signs of shock. Tr. 376.

Another indication that Stewart’s injuries could be quite serious, they were careful to remove him from the mine “very slow[ly].” Tr. 376. When Stewart was in the ambulance, Harcourt did take his pulse,\textsuperscript{25} finding it “ungodly . . . [i]t was only in the 80's,” as he recalled.

\textsuperscript{24} Following Mr. Stewart’s accident, the mine resumed production on December 27\textsuperscript{th}. GX 28, Tr. 496. Mr. Thomas Rice, the mine’s safety manager, also agreed that it is a “big deal” for a coal mine to stop production.” Tr. 499. Though the Court takes no issue with production, as it is what mines do, the concern is that, despite the great initial fall, the mine did not pause to consider the ramifications of it. Instead, the focus was upon getting the damaged ventilation repaired so that production could resume. That reaction, singularly focused on production, is consistent with the mine’s similar exercise of poor judgment in deciding not to notify MSHA about Mr. Stewart’s injuries.

\textsuperscript{25} Later, Harcourt amended his answer, stating that he did take the miner’s pulse while transporting him out of the mine. Tr. 388. He reaffirmed, however, that he could not check the (continued...)
Based on shining his cap lamp in the miner Stewart’s eyes, Harcourt believed there was no brain trauma. Tr. 374. However, they were unable to take the miner’s blood pressure, even while transporting him to the hospital. Tr. 378. Relying on some of the miner’s vital signs, Stewart seemed stable and his pulse was normal. Harcourt couldn’t find signs of internal injuries such as bleeding or bruising, though this was made in the context of a very limited ability to partially open his shirt. Harcourt concluded that Stewart was not going to die. Tr. 382-383. Despite that expressed view, more indicative of the seriousness of the situation, Harcourt noted that they did not strap the injured Mr. Stewart down, but rather kept him on his side, and were careful to make sure he stayed still. After all, he knew that Stewart had incurred “real trauma” and they didn’t want him “moving around a lot.” Tr. 383-384. Harcourt also conceded that, at least during the process of removing the miner from the mine, he did not know what Stewart’s vital signs were.26 Tr. 389.

Harcourt agreed that, in his capacity as the shift foreman, his authority included the ability to call MSHA in the event of a reportable accident. Tr. 389. However, though not

25(...continued)

miner’s blood pressure, nor his percentage of oxygen. Tr. 388-389. As there was a conflict between Harcourt’s testimony at the hearing and Inspector Wayne Johnson’s account of what Harcourt stated to him, Harcourt was asked about Inspector Johnson’s honesty. Harcourt agreed that he felt Johnson was honest. Tr. 396. Though Harcourt could only remember that MSHA’s Inspector Johnson interviewed him shortly after the accident, around December 30th, he didn’t “remember what was said or anything.” Tr. 397. Harcourt’s credibility was impacted, in the Court’s view, because he could not remember if he told Johnson that Stewart’s pain was a 10 plus on a 10 scale. Tr. 397. He then allowed that Mr. Stewart’s pain “might have been” at that high level of pain. Tr. 397. Harcourt also could not recall if he learned that Stewart’s left arm was in so much pain that he couldn’t touch it. Tr. 402. Even a broken arm, he conceded, “could be a chance of somebody dying. You never know.” Tr. 400. He also admitted that the most threatening aspect was the miner’s labored breathing, but he could not remember if he described the miner’s condition to Johnson as “pretty critical.” Tr. 397.

26 By comparison when directed to GX 6, a letter addressed “to whom it may concern,” Inspector Johnson was asked whether the letter’s reference to Mr. Stewart’s vital signs as not suggesting that his injuries were “life-threatening,” is a different issue from whether the injuries had a reasonable potential to cause death. Although the Inspector used the terms interchangeably, the Court does not. Besides, the Inspector’s answer could be interpreted to mean that, at least for him, when one is faced with injuries that have a reasonable potential to cause death, that is a “life-threatening” situation. Semantics aside, more to the point concerning what he could be informative about, Johnson pointed out that Ben Harcourt could not obtain Stewart’s vital signs when the miner was underground. Tr. 189.

27 Harcourt maintained that he didn’t ask and wasn’t told, how many feet Stewart had been thrown. Instead, he was told Stewart “got thrown up at the longwall.” Tr. 389. Later, he (continued...)
amended that remark, agreeing that he told EMT Halverson that Stewart “got thrown,” but he could not recall telling Halverson the footage involved. Harcourt, then agreed that he knew that Stewart “got thrown quite a ways.” Tr. 390. While not recalling if he added the detail of the exactly how far the miner had been thrown, he conceded that knowing such information would be important in assessing the seriousness of the miner’s accident. Tr. 391. Thus, even Harcourt admitted that the “mechanism of injury” is an important assessment factor. Further, he agreed that while transporting Stewart out of the mine, he was aware that a serious mechanism of injury was involved. Tr. 391. While he stated the miner’s breathing was good, and that his eyes were reacting appropriately to light, and that he could not discern any loss of blood signs, he didn’t know his pulse, nor his blood pressure, nor his oxygen, and that all three of those factors are critical in fully assessing one’s vital signs. Tr. 391-392. Given that, Harcourt admitted that he could not have an accurate assessment of the miner’s vital signs. Tr. 392.
Referring to Respondent’s Exhibit 5 (R - 5) Harcourt stated that the document was prepared the morning after that shift in which Mr. Stewart was injured. It is the immediate accident report for injuries. Tr. 412. Harcourt agreed that it did not note that Mr. Stewart had a broken back. Tr. 413. Harcourt stated that he did not know when he prepared the report that Mr. Stewart was in the intensive care unit at Billings. Tr. 413. However, he did know that the miner had been flown to that hospital via a “life-flight.” Tr. 413. It is noted that the Government originally intended to present the same exhibit as R 5, as its GX 20, but it opted to use the Respondent’s Exhibit instead. Thus, there is no GX 20.

The Secretary contends that Mr. Harcourt’s view that Mr. Stewart’s injuries did not present a reasonable potential to cause death should be rejected as unreasonable and not supported by his testimony. Sec. Br. at 33. Beyond his limited experience as an EMT, the Secretary notes that Harcourt was the mine’s former safety director. It notes that while Harcourt relied upon Mr. Stewart’s vital signs being okay, no one had such information until 45 to 90 minutes after the injuries occurred. Further, vital signs, which can fluctuate in any event, were not sufficient reasons by themselves to make the conclusion that a reasonable potential for death did not exist. Harcourt’s assessment failed to take into account the mechanism of injury and the obvious injuries Stewart had sustained. Sec. Br. at 34.

It has been noted earlier that Mr. Thomas Rice is the safety manager at Signal Peak, and he also testified at the proceeding. However, he had only been in that position and in the employ of Signal Peak for 13 days before Mr. Stewart was injured. Tr. 441. He has basic first aid training and is qualified to instruct others in that, but he cannot certify anyone in first aid. Tr. 445.

Rice’s involvement in the Stewart injuries occurred not long after the event. The mine dispatcher contacted him but, as he was not at the mine site when it happened, and upon learning that the miner was almost at the surface, he decided to wait on the side of the road and meet the ambulance on its way to the Roundup Hospital and then follow it to the hospital. Tr. 453. Although not solely his responsibility, Rice agreed that the duty to call MSHA, that is, should the reporting requirement have arisen in this instance, was delegated to him “[i]n conjunction with others.” Tr. 472. According to Rice’s testimony, his first question was to ask Mr. Harcourt if Stewart’s injuries were “possibl[ly] life threatening.” Tr. 454. He asked this because of his awareness that it beared upon the duty to call MSHA. Tr. 454. Unfortunately, Rice viewed the terms “life-threatening” and “reasonable potential to cause death” as synonymous. Using the “life-threatening” standard, Rice determined that the 15 minute clock, within which the Mine...
was obligated to call MSHA, never started running.\textsuperscript{29} Tr. 471. The Court, as explained further \textit{infra}, does not share that view at all, because a “life-threatening” standard implies a much greater degree of certitude about the outcome of an injury than the “reasonable potential to cause death” language requires.

Applying the incorrect measure for the reporting obligation, Harcourt told him he did not view Stewart’s injuries to be “life-threatening.”\textsuperscript{30} Tr. 454. Harcourt told Rice that Stewart’s breathing was “labored to a certain degree” but he attributed that to the miner’s broken ribs. Tr. 454-455. By Rice’s testimony, that discussion did not include the miner’s broken back. Rice also stated that none of the EMT’s believed that the miner’s injuries were “life-threatening,” though he could not recall any of their names.\textsuperscript{31} He also stated that he spoke with

\textsuperscript{29} This comment is also revealing in that it reflects that the Mine was applying the wrong test, as Rice stated that in the process of determining if the injury was “life-threatening” (which, again, is the wrong test to apply), he “still had not \textit{any conclusive indication} on whether it was or it wasn’t.” Tr. 472. Therefore, not only did the Mine apply the wrong test, it also looked to the wrong threshold, as a “\textit{conclusive indication}” is \textit{not} the basis of the duty to report.

\textsuperscript{30} When Rice was asked if waiting to find out whether there is a “risk of life or death” is a very different inquiry than determining if injuries presented a “reasonable potential to cause death,” over objections from Respondent’s Counsel to the question, and after needing it repeated three times, he eventually agreed that it is a different question. Tr. 479. Rice maintained that if he had received an “absolute[ ] yes” or if he were given some indication of yes, that it was “life-threatening,” he would have called MSHA. Tr. 479. He then confirmed his acknowledgment, agreeing that a life-threatening injury at that moment is a very different thing from injuries presenting a reasonable potential to cause death, responding, “Yes, I would think so.” Tr. 480.

\textsuperscript{31} As noted by Counsel for the government, Rice’s memory improved from the time of his deposition, as at the hearing he stated that he spoke with EMTs Halverson and “Sue.” Tr. 468. As Counsel for the government also pointed out, at some point between 2003 and 2006 Mr. Rice accepted personal liability under section 110(c) of the Mine Act. Tr. 470-471. Over objection from Respondent’s Counsel, the Court ruled that the matter could bear upon Mr. Rice’s credibility. Tr. 471. Rice admitted that he did so accept such liability under section 110(c). Tr. 471. On redirect, Respondent’s Counsel delved into Mr. Rice’s 110(c) matter. It was his testimony that he paid a $100.00 civil penalty, that he was unemployed at the time the charges were made, and that he denied the charge which had been leveled. The claim was that he instructed a miner to go underground with a faulty self-rescuer device. Tr. 502. Having heard both sides of the 110(c) matter, the Court expressed at the hearing that its evaluation of Mr. Rice’s credibility would not be impacted by the section 110(c) matter. Tr. 508.
Dr. Flannery that night, and that the doctor also expressed that Stewart’s injuries were not life-threatening. Tr.456. Harcourt also asserted that the life-flight was used as a “precautionary” action.\(^{32}\)

The Court would observe that Mr. Harcourt’s opinion on that point is simply that. He is not associated with the hospital, nor part of the life flight helicopter service, nor is he a doctor.\(^{33}\) Although Harcourt used the term “precautionary,” he stated that was “to provide him with the best care possible because the Roundup hospital did not have the facility to do the appropriate tests to keep him as comfortable as he needed to be.” Tr. 457. Again, Mr. Harcourt was well unqualified to speak to claims about the Roundup Hospital’s shortcomings.

The Court also observes that Harcourt’s statement conflicts within itself, because one does not take “precautionary” steps unless there is uncertainty about an individual’s condition. Certainly “precautions” are not taken just for the sake of comfort. So too, the need to still take “appropriate tests” supports the uncertainty about the outcome of the miner’s injuries upon his life.

Rice then went to the Billings Hospital to learn from medical personnel how Stewart was doing. Tr. 457. He was advised that “they did not know. They were not sure.” Tr. 457. (italics added). Later in his testimony, Rice confirmed that there was uncertainty, as he agreed that he was unable to get a straight answer from anyone as to whether Stewart’s injuries were “life-threatening.” Tr. 474. This too, in the Court’s view was, yet again, another point in time when the “reasonable potential” to cause death was front and center before Rice and the duty to call MSHA existed anew. Yet, Rice determined that there was no duty to report the matter to MSHA. Tr. 458. Further, he disclosed that he did not discuss the matter with anyone else in management that evening. Tr. 458, 501.\(^{34}\) It was Mr. Harcourt’s evaluation that Rice was

\(^{32}\) Rice did not agree that a flight for life is used because there is a sense of urgency. Tr. 483. Further, he would only agree that an injury must be evaluated in the context of which it occurred, “to a certain degree.” Tr. 486. Because of conflicts between his deposition testimony and the testimony given at the hearing, the government moved for the introduction of his deposition transcript. The deposition testimony was admitted as GX 26. Tr. 488.

\(^{33}\) The Respondent, in an attempt to deal with the fact that it was determined that Mr. Stewart’s condition warranted a “life flight,” suggests that “there are many reasons a life flight may be used,” and then it offers pure speculation as what those other reasons may have been. Among others, it submits that the life flight “simply seems to have been a way of making up time.” R’s Reply at 4. The question which arises to that claim, is “making up time for what?” After all, the Respondent has suggested there was no reasonable potential for death and therefore there would be no need to “make up time” under those circumstances.

\(^{34}\) Rice later repeated that, in deciding on the evening of December 23\(^{rd}\) that the accident was not reportable, he made that decision without consulting with anyone with mine (continued...)
relying upon. Tr. 506. Between the 23rd and 28th of December, Rice continued to do
“investigation” of Stewart’s condition, although he could not recall the names of anyone he
spoke with at the hospital.35 He asserted that he was told that Mr. Stewart was “recovering [and]
doing fine.” Tr. 458. Though he had learned that the miner had broken ribs, a broken scapula,
broken sternum and broken back, Rice concluded there was no duty to report. Tr. 459. Rice’s
estimate of the number of feet Stewart was thrown by the blast was similarly more optimistic
than the estimates of others. He believed, it was in the “neighborhood” of 40 to 45 feet.36 Tr.
459. After speaking with people who were underground in the area of the accident, Rice and
Robert Ochsner, the mine’s chief engineer, prepared a drawing to reflect his estimate of the
distance Stewart was propelled. R’s Ex. 2.

The mine has a simple and direct procedure when contacted by news reporters regarding
matters occurring at Signal Peak Mine: “speak to no one.” Tr. 461. Ultimately, as previously
discussed, the reporter’s inquiry led to a call to the mine from MSHA. Rice, upon being asked,
told MSHA that there had been an accident and that a miner had been injured. Tr. 462. Rice
confirmed that MSHA then asked follow-up questions upon learning of the initial fact of an
injury. In relating the conversation, after MSHA first learned of the event through the reporter’s
disclosure, Inspector Johnson agreed that it was MSHA employee Mr. Hamilton who spoke with
Mr. Rice but that, as it was on a speaker phone, he also heard the conversation. Tr. 95. Mr. Rice
confirmed that he answered each question, upon each question being asked of him. Rather than
not being forthcoming in that telephone conversation with MSHA’s Hamilton, Rice’s offered
that he was simply being very careful to give accurate information.37 The Court does not view it

34(...continued)
management, except for Mr. Harcourt. Tr. 501. Rice then amended his response to add that he
also relied upon his talk with Dr. Flannery. Tr. 506.

35 Rice also conceded that the 15 minute notification requirement does not allow an
operator to first use up whatever time is needed to do a thorough investigation. Instead, he
conceded that the obligation is to “make diligent efforts to determine if whether or not this is
immediately reportable or not.” Tr. 477-478.

36 The Court would observe that, even at that, if one visualizes an empty swimming pool
some four to five times deeper than the typical ten foot depth at the pool’s deep end, one can
appreciate that 40 to 45 feet is no small distance to be tossed. In a similar approach to
precipitating event, Mr. Rice used the “friendlier” description of a “gush” of air, as opposed to a
“blast” of air when the fall injuring Mr. Stewart occurred. Tr. 464, 465. Regardless of the
descriptor, gush or blast, it sent miner Stewart some 50 to 80 feet away from where he was
standing.

37 The purpose of this line of questioning was to suggest that Mr. Rice was quite
forthcoming in telling MSHA about the nature of the miner’s injuries but that accuracy was his
uppermost concern. Having heard both recounts of the call, the Court does not buy into Mr.
(continued...)
that way. Instead, it views Rice’s approach to be of a kind to the approach taken by Signal Peak from the onset of this event, by playing it very close to the vest. Rice’s responses were in keeping with the Mine’s approach to news’ inquiries of “speak[ing] to no one.”

It is noted that the Secretary has argued that Mr. Rice’s testimony lacked credibility. The basis for this is that what Rice knew at the time of the accident and thereafter precluded any reasonable conclusion that the accident was not reportable. Further, Rice’s close to the vest approach when reached by MSHA’s Inspector Hamilton demonstrated his awareness that the accident should have been reported. In this regard, the Secretary points to the varied approach Mr. Rice took at his deposition as compared to his testimony at the hearing. At his deposition, he maintained that the delays in answering were due to the rapidity of questions being posed, whereas at the hearing he asserted that accuracy was the cause for his pauses before answers. The Court, listening and observing Mr. Rice during his testimony concludes that he took an approach of revealing as little as possible to MSHA during that initial telephone call about the matter.

Robert Ochsner, the mine’s chief engineer, also testified for the Respondent. He was the chief engineer at the time of the December 23, 2009 initial longwall cave and he spoke to the matter of “initial caves” in longwall mining. Tr. 522. The obvious purpose of the testimony was to suggest that initial caves, such as the one which occurred at Signal Peak, were not particularly out of the ordinary. Tr. 512-514. To that end, he related that at one of the mines he worked such an initial cave blew out the overcast behind them, which was 5,000 feet away from the first longwall panel. Tr. 512. As to the event in question, Ochsner asserted that the longwall retreat was 130 feet before the initial cave. By comparison, Ochsner maintained that at another mine in his prior experience the first cave did not occur until 230 feet had been mined. Tr. 512.

Despite the theme presented that the initial cave here was not atypical and of a smaller order than instances cited by Respondents’ witnesses, Ochsner agreed that, following the initial cave in this instance, MSHA added some safety precautions for the longwall mining. Tr. 515. Further, Ochsner agreed that the second longwall panel did not amount to ‘business as usual’ in comparison to the first panel. That is, changes were instituted. Tr. 516-517. He also admitted that he had never before had a miner thrown by a longwall fall blast, as occurred to Stewart here. Tr. 522. Paradoxically, he did not believe that the cave which occurred was “unusual.” Tr. 523. It was his view that “this roof behave[d] as predicted.” Tr. 523. He then retreated from his

37(...continued)

Rice’s version. Mr. Rice was presented with an email from Robert Ochsner to Rice from December 28, 2009, reflecting that the Form 7000-1 accident report was filed out on December 28, 2009 at 1:17 p.m. Tr. 494. That form was filed approximately an hour and a half after Mr. Rice had his first conversation with MSHA. Tr. 494. GX 27. Regarding that accident report form, Rice agreed that the form did not reflect that Stewart had a broken back (i.e. multiple fractures to his vertebrae), nor does that report mention that he had a broken sternum. Tr. 492-493. GX 17.
initial assertion that the event was rather unremarkable, allowing that it did make it “necessary to take a look at it” what occurred. Ultimately he conceded that it was necessary to revise the roof control plan in order to prevent similar occurrences in the future.38 Tr. 523. Ochsner apparently considered the problem to be more of one where the miner, Stewart, was in a “bad location” when the fall occurred. Tr. 525. Thus, by this unusual vantage point, the problem was with Mr. Stewart. Yet, the chief engineer conceded that the miner was in the only entry into the longwall. That is, Ochsner admitted, everyone who came into that longwall would need to travel through the same entry that Stewart was in at the time of blast. Tr. 525. The Court viewed the chief engineer’s testimony as flying in the face of Mr. Stewart’s flying experience on the day of the accident.

The post-hearing briefs

The Court closely read the parties post-hearing submissions.39 The Findings of Fact, supra, and the Court’s Further Discussion dispose of many of the arguments made in those filings.40 The Secretary cites both Consolidation Coal Co., 11 FMSHRC 1935 (Oct. 1989) and Extra Energy, Inc., 20 FMSHRC 1, 7-8, (Jan. 1998) for the proposition that, for compliance under the standard, a mine operator has a duty to promptly, vigorously, and in good faith, investigate an accident. The Secretary also cites Cougar Coal, 25 FMSHRC at 521, for the principle that “the decision to call MSHA must be made in a matter of minutes after a serious accident.” Also referenced was this Court’s decision in Mainline Rock & Ballast, Inc. 33 FMSHRC 307, 330 for the proposition that “one does not have the discretion to remain uninformed about the circumstances of the accident and then assert that the reasonable potential for the accident to cause death was unknown.” Sec. Br. at 24. The Secretary also cites Newmont USA Ltd., 32 FMSHRC 391, 396 (ALJ Manning, April 14, 2010), for the principle that when the extent of a victim’s injuries is unknown immediate reporting is required. Sec. Br. at 24.

In its brief the Secretary notes that a mine operator has a good faith duty to conduct a prompt and vigorous investigation into what occurred. The Secretary maintains that, manifestly,

38 Grudgingly, he conceded that the pre-fracking that was instituted to prevent future such enormous falls “played a role” in stopping further such falls, he also asserted there was “some geology that was different than the initial panel.” Tr. 525.

39 Various aspects of the Respondent’s post-hearing brief and its reply are noted in this decision.

40 Accordingly, the Court rejects the Respondent’s claim that the miner’s injuries were not immediately reportable. They were, as the injuries clearly presented a reasonable potential to cause death. Further, the Court rejects the characterization that the Secretary relies upon the nature of the event that causes an injury, not necessarily on the nature of the injuries, to establish the violation. Instead, the Secretary maintained that the mechanism of the injury was to be considered along with the other facts and circumstances. The Court agrees with the Secretary’s contention.
the operator failed to so act here and the Court agrees with that characterization of Signal Peak’s conduct. Further, it is the Secretary’s position that an injury must be evaluated in the context of the accident from which it resulted. The Secretary’s contention here is that the mechanism of injury matters as a critical factor in determining whether there is a reasonable potential to cause death. In this instance that means taking full account of the fact that miner Stewart was blasted some 50 to 80 feet. When coupled with the miner’s condition upon first being located after the blast, it was obvious that the standard’s reporting requirement was triggered. Sec. Br. at 27. The Secretary contends that Mr. Rice utterly failed to consider the distance Mr. Stewart was thrown in assessing his injuries.41 The Court certainly agrees with these perspectives as well. No sound, informed, assessment of an injured miner can be made without taking into account the mechanism of injury.

Further discussion

Although the findings of fact fully establish the violation of 30 CFR § 50.10 and 30 CFR § 50.12, some additional discussion is in order. As to 30 CFR § 50.10, obviously there was an injury, in fact multiple injuries, to miner Stewart. The only disputed aspects pertain to whether the miner’s injuries presented “a reasonable potential42 to cause death” and whether the mine operator knew or should have known that the injuries presented that reasonable potential. In understanding the phraseology employed by the standard, as a counterpoint, it is useful to appreciate what the standard does not require. The standard does not speak in terms of particular probabilities and accordingly there is no requirement that, for example, there be some sort of assessment that death is more likely to result than not for it to apply. Instead, using the common dictionary definition of “potential,” one realizes that it requires only that something be “capable of being,” or something which presents a “possibility,” albeit not yet in existence. The only qualifier is that the potential for death to occur from injury must be “reasonable,” not far-fetched.

Thus, as one witness noted, although even a broken bone can result in death, such an injury is not, absent additional complicating factors, something which presents a reasonable potential for death. In stark contrast, here, Stewart’s injuries, independently and collectively, presented such a reasonable potential for death and there were multiple junctures when Signal Peak knew or should have known that was the case. To begin, upon finding Stewart had been propelled so far from his position just prior to the air blast and then realizing that he was unable to move on his own from the location where he was found was sufficient to have triggered the reporting requirement. That is to say, both the mechanism of the injury, an adult male having been thrown such a great distance, at least 50 feet, coupled with his reporting to those who came

41 The transcript reveals that the Secretary’s characterization of Mr. Rice’s position on that point is accurate. See Tr. at 481.

42 Compare, the Commission has stated that a “reasonable possibility” of something occurring exists even if there is only a “minimal” possibility. Sec. Br. at 22, citing Thompson Brothers Coal Co., 6 FMSHRC at 297.
to rescue him that he was not okay and in fact could not move, were at that moment sufficient to satisfy the reasonable, not far-fetched, conclusion that the potential to cause death was presented.

Though sufficient at that point to activate the reporting requirement, when Stewart was first located by his fellow miners, his condition at the moment of reaching him was a second point, triggering the reporting obligation. After all, Stewart could not locomote, had an obvious and significant protrusion on his back, which was immediately observable, even though he was clothed. Remembering that only one instance of a “reasonable potential” for death need be presented, a third reporting obligation arose in the very process of removing him from the mine. Stewart could only tolerate being in one position, and at that, only on one side. Though he tried to sit up during his emergency removal from the mine, he quickly discovered that could not be tolerated. Further, there was no mystery entertained on the part of those rescuing him; they were fully aware of his fragile condition, moving him ever so slowly out of the mine, and keeping his spine and neck aligned, for fear of aggravating his injuries. Then, once at the surface, a fourth set of circumstances, all fully known to the mine, presented yet another reporting obligation. Stewart could only tolerate being in one position, and at that, only on one side. Though he tried to sit up during his emergency removal from the mine, he quickly discovered that could not be tolerated. Further, there was no mystery entertained on the part of those rescuing him; they were fully aware of his fragile condition, moving him ever so slowly out of the mine, and keeping his spine and neck aligned, for fear of aggravating his injuries. Then, once at the surface, a fourth set of circumstances, all fully known to the mine, presented yet another reporting obligation. The findings of fact, supra, fully support these conclusions. Once at the Roundup Hospital, a fifth instance triggering the reporting obligation was presented. While there was innuendo that Roundup Hospital was inadequate, it can be noted that, even if it were assumed for argument that the facility had shortcomings, had Stewart been in fine shape, the need for immediate transfer would not have presented itself. Instead the evaluating physician determined that a “life flight” was in order. While the Billings area does offer scenic helicopter trips, Stewart’s trip was decidedly not of that nature.

Unhappy with the “reasonable potential” words employed by the standard, the Respondent would prefer to substitute “life threatening” in its place. R’s Reply at 3. And though it notes that MSHA used that expression in the final rule, nowhere did the agency express or suggest that the terms were interchangeable. Rather, it referred to the Review Commission’s expression in *Cougar Coal*, 25 FMSHRC 513, at 521 (September 5, 2003, that a “‘reasonable potential to cause death cannot be made upon the basis of clinical or hypertechnical opinions as to a miner’s chance of survival.’ The judgment is based on what a reasonable person would discern under the circumstances, particularly when ‘[t]he decision to call MSHA must be made in a matter of minutes after a serious accident.’” 71 Fed. Reg. at 71434. (Dec. 8, 2006) (emphasis added).

It is also notable that the Respondent concedes that Mr. Stewart’s injuries “were severe but not life threatening.” R’s Reply at 5. Having conceded that the injuries were “severe,” the inquiry then should have been whether those “severe” injuries presented a “reasonable potential” to cause death. Applying the fact specific analysis expressed by the Commission in *Cougar Coal*, the Court, has made findings of fact on that issue, and concluded that such “reasonable potential” was clearly present.
The later-obtained medical records are a non-issue

The Court rejects the Respondent’s implicit argument that somehow it was disadvantaged in not being invited by MSHA to join the agency when it visited St. Vincent’s hospital. First, it was MSHA that was disadvantaged, as the mine never reported anything about the incident, and the Agency only learned about the matter after a reporter’s call of inquiry about the event. Further, while Respondent’s Counsel was unhappy that MSHA had the authority to see the medical records, Respondent did obtain them later, through discovery. Besides, the measure of the duty to report the incident first arose when the accident occurred. In fact, the government Counsel asserted that medical records are not determinative or necessary for its case to be upheld, and the Court agrees. Counsel for the government, noting the 15 minute notification requirement, stated that the Respondent had a duty to do a “prompt and reasonable” investigation of the events that took place and that, the duty arose, once the mine knew what had taken place underground, and how serious the accident was, to make the report. Tr. 132. This duty came into being apart from any Billings Hospital records which later came into Signal Peak’s possession. Tr. 132.

The point is that the company cannot describe itself as being completely in the dark as to the miner’s condition and therefore utterly unable to determine if the reporting obligation arose shortly after the event. That other information, developed after the miner was transported via ambulance to Roundup or at other points in time following that, is not determinative of the Respondent’s obligations. Thus, Respondent’s argument that it had no access to those records and therefore could not make an assessment of them to inform them about their reporting obligation is another distraction from the issues here. Accordingly, the Respondent’s claim that, because it didn’t have access to those records until much later, its compliance with the standard was hindered, is rejected.

In short, the Court agrees that the company had to rely on what it had, at and shortly after, the time of the accident, not the records that came into their possession much later. Respondent’s Counsel asserts that the company had to rely upon medical information from the EMTs and the doctors. Tr. 102. The problem with this claim is that it misstates all the information which the company had at hand and which they then should have applied, using the duty imposed by the standard, to the situation before them. As the Court pointed out to Respondent’s Counsel, the company was aware of the event almost immediately after it occurred, and one could take a “snapshot” at that moment in time, putting aside any medical

43 A window into the Mine’s seriously mistaken perspective on the standard’s reporting requirements, Respondent’s Counsel conceded that if the company later acquired information advising “we think he’s going to die, or there’s a good chance he’s going to die, that probably raises a reporting obligation then and, in fact, if he dies, that raises a reporting obligation.” Tr. 104 (emphasis added). Respondent Counsel’s take on the reporting obligation is far off the mark and runs counter to the words employed by the standard.
Johnson agreed that he also wrote the 50.10 violation as “S & S” because Mr. Stewart was injured. Tr. 180.

Special Findings: “significant and substantial” determinations

In Mathies Coal Co., 6 FMSHRC 1 (Jan. 1984), the Federal Mine Safety and Health Review Commission (“Commission”) explained: “In order to establish that a violation of a mandatory safety standard is significant and substantial under National Gypsum, the Secretary of Labor must prove: (1) the underlying violation of a mandatory safety standard; (2) a discrete safety hazard - that is, a measure of danger to safety - contributed to by the violation; (3) a reasonable likelihood that the hazard contributed to will result in an injury; and (4) a reasonable likelihood that the injury in question will be of a reasonably serious nature.” Subsequently, in U.S. Steel Mining Co., 7 FMSHRC 1125 (Aug. 1985), it held: “We have explained further that the third element of the Mathies formula “requires that the Secretary establish a reasonable likelihood that the hazard contributed to will result in an event in which there is an injury.”[…] We have emphasized that, in accordance with the language of section 104(d)(1), it is the contribution of a violation to the cause and effect of a hazard that must be significant and substantial.” Id. at 1129 (emphasis in original) (citations omitted). Thereafter, the Commission noted that the “question of whether a particular violation is significant and substantial must be based on the particular facts surrounding the violation.” See Texasgulf, Inc., 10 FMSHRC 498 (Apr. 1988); Youghiogheny & Ohio Coal Co., 9 FMSHRC 2007 (Dec. 1987).

Here, Inspector Johnson marked his citation, Number 8463717, for the section 50.10 “Immediate notification” violation as “significant and substantial.” His justification was that the accident had occurred and that the condition contributed to the hazard, in circumstances where there was a foreseeable potential that an injury or illness would occur if the problem was not corrected. The discrete hazard was the exposure to the miners.44 Although this was the first longwall panel for this mine, the Inspector viewed that similar conditions would have been presented when the next longwall panel was initiated. This was the case because the mine did not, at that time, change its roof control plan to address what had happened. Tr. 79. Changes did ensue, but these occurred only after MSHA intervened. Accordingly, the mine operator had not addressed how to prevent a recurrence. Instead, Signal Peak Energy simply fixed the ventilation damage and resumed mining three days later. As noted, it was not until six days after the event that MSHA even knew of it. Tr. 79. Thus, the mine’s lack of action in the wake of the event factored into the Inspector’s view that the problem could be repeated. Tr. 80. As with the first occurrence, impacted by such a subsequent massive fall event would be any miner within the affected ventilation controls and all those miners working along the longwall, as they would be, just like the two injured miners here, exposed to the air blast. Beyond his prognostication about a future event and its “S & S” nature, the Inspector stated that he viewed the event itself as

44 Johnson agreed that he also wrote the 50.10 violation as “S & S” because Mr. Stewart was injured. Tr. 180.
“S & S,” because there had been some prior roof falls, which falls should have alerted the mine about the potential for a “significant disruption in the ventilation system.”\textsuperscript{45} Tr. 82. Noting that the gravity/illness category had been marked as “occurred,” a conclusion stemming from the injuries received by Mr. Stewart, the Inspector also marked it “permanently disabling.”\textsuperscript{46} Tr. 83-84. Mr. Stewart was fortunate that he mended without a permanent disability.

Accordingly, the Inspector’s determinations regarding gravity were based on his considering that Signal Peak’s continuing mining operations would reflect business as usual, as no steps to prevent a reoccurrence had been taken.\textsuperscript{47} Tr. 86. Referred to GX 24, and the notes of MSHA’s David Hamilton, relating to the accident, Johnson remarked that they included references to the significant number of stoppings that had been blowing out. It was with the third such event, the event in which Mr. Stewart was injured, that the some 78 stoppings had been blown out. As noted, Johnson believed that these prior events should have heightened the mine’s awareness that there was a problem, with so many stoppings being damaged. Tr. 195.

As for the failure to report the accident making the hazard more likely to occur, the Inspector voiced that such inaction put other miners at risk. For example, it was not known if more roof, above the area that fell, could still come down. Thus, in spite of what transpired, Signal Peak continued to conduct mining even though the air blast event had not been sufficiently investigated. Tr. 84. This concern prompted Inspector Johnson to issue his k Order. He reasonably concluded that it was highly likely that, should another such air blast occur, the matter would also be of a serious nature. Tr. 85. After all, it was not as if the mine had made an inquiry about the event. The Inspector’s concern was borne out subsequently, as MSHA’s roof control specialists came to the mine and made recommendations\textsuperscript{48} to ensure that future mining would be safer, in the sense that there would be no recurrence of an air blast of that degree. Tr. 85. Similarly, the Inspector viewed that, despite Signal Peak having learned that the roof fall was

\textsuperscript{45} The Secretary’s Counsel added that the “S & S” aspect also encompassed the failure to report within 15 minutes and that, as Signal Peak simply continued mining after the event, no steps were taken to prevent a similar occurrence. Tr. 82.

\textsuperscript{46} As the Inspector noted, some six days after the event, the miner’s back had been fused and he had gone through several surgeries. Tr. 84. He had concerns that the miner would never be able to return to work and that, at a minimum, it would be a long period of time before he could do so. Tr. 84.

\textsuperscript{47} The mine failed to present anything to Inspector Johnson to show that they had made changes in their mining practices. Tr. 86. There is no dispute that the mine made no changes until MSHA came on the scene.

\textsuperscript{48} Mr. Del Duca was the MSHA roof control specialist making the recommendations for changes in the plan. Tr. 85.
far beyond the controls it had and knowing that it posed a high degree of danger, the mine showed little effort to correct the problem. Tr. 81.

In sum, three of the S & S elements are self-evident. Only the measure of danger to safety warrants a few more words. That element was twofold: the negative impact upon MSHA’s ability to carry out its statutory and regulatory responsibilities; and the inherent prospective danger to the safety of miners by not providing immediate notification to MSHA of the reportable accident. Accordingly, the Court finds, both in terms of what actually happened and in terms of future risks, and therefore on two independent grounds, that the S & S nature of this violation was clearly established.

As to the issue of negligence, and the Inspector’s initial designation that it was an “unwarrantable failure” to comply with the requirement, he explained that the designation was later removed. When he initially listed it as such, it was based on the mine’s failure to report the incident within 15 minutes but also because they then advanced the mining without informing MSHA of the life-threatening conditions. Tr. 88.

The Inspector summed up his evaluation, concluding that any reasonable person should have known, and recognized, that the accident was immediately reportable under the provision, given the blast of air, the mechanism of the injury, the reasonable potential to cause death, and the roof that was still hanging up. All those aspects would have led one to realize that the accident was serious and promptly reportable. Tr. 88. As explained, the Court wholeheartedly agrees with this perspective.

In her Post Hearing Brief, the Secretary continues to assert that the violation of 30 C.F.R. § 50.10(b) was significant and substantial but with a focus upon the future hazards. In support of that position, it urges that the same result would be likely to occur when the mine moved to the next and subsequent longwall panels. Sec. Br. at 29-30. As noted several times, that result is likely because Respondent took no steps to avert a repeat of the great initial fall. Instead, Signal Peak simply repaired the damaged ventilation and then resumed mining. Lessons were not learned. Thus, the Secretary argues that the Respondent’s failures “made it reasonably likely that an injury of a reasonably serious nature would occur during continued mining operations on [its] longwall panel[s]” and that the failure to report the accident within 15 minutes placed other miners at risk of serious injuries, as its longwall mining resumed. Sec. Br. at 30. The Court agrees and so finds.

Signal Peak contends that the violation was not “significant and substantial” and in that regard makes a two-pronged challenge to the issue. As discussed earlier, it first contends that the violation simply can’t be “S & S” because it believes the provision is merely a regulation and as such no special findings are permitted. The Court having found that the provisions are mandatory standards, has rejected the claim. The second challenge to the S & S determination from the Respondent is simply that, factually, it does not meet the requirements set forth in National Gypsum and Mathies. The Court finds otherwise. Signal Peak does acknowledge that
the determination is based upon the particular facts involved. R’s Br. at 30. As this decision makes clear, the Court’s determination that the violation is S & S is based upon the particular facts. The fact that a particular safety or health standard may not fit perfectly within the one-size-fits-all framework of National Gypsum and Mathies does not mean that the statute’s provision for the significant and substantial element is not met.

Respondent also contends that “no hazard was created by the failure to report,” but this ignores that, had MSHA not learned of the event through the news media, Signal Peak would have proceeded to the next longwall panel with no changes in its roof control plan. Accordingly, there certainly was a hazard created. Further, the “hazard created” does not look exclusively to the future, particularly when the event has occurred.

**Reckless disregard**

The Secretary also asserts that Respondent’s 30 C.F.R. § 50.10(b) violation constituted reckless disregard. She maintains that the Respondent’s failure exhibited the absence of the slightest degree of care and that there was no excuse for its failure. Sec. Br. at 31. That it knew it had a duty to report the accident is evident from the guarded approach Mr. Rice took when MSHA called about the matter. The Court has determined that the Secretary’s characterization of Mr. Rice’s approach in speaking with MSHA is accurate. Reckless disregard was also presented in the sense that, by taking no action in the wake of the massive initial fall, Respondent placed other miners at risk when a new longwall panel was started. *Id.*

The Respondent asserts that there was no reckless disregard because the mine’s “determination that the incident was not immediately reportable was a reasonable one under the circumstances.” R’s Br. at 20. The Court has rejected this claim. Not only was the

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49 Respondent points to cases supporting the argument that S & S has been rejected when based upon “the ‘potential’ that an injury ‘could’ occur.” R’s Br. at 30. There are two responses to this. First, the injury *did* occur here. Second, when MSHA finally did learn of the event, its roof control specialist was concerned enough about a reoccurrence of another massive roof fall, when a new longwall panel was initiated, that changes were required in the mine’s roof control plan.

50 Respondent mischaracterizes MSHA’s response upon its specialist analyzing the longwall and the roof control plan, by telling only half the story. True, the mine was permitted to resume mining after MSHA’s Mr. Del Duca examined the longwall, but this retelling leaves out the very important fact that MSHA’s concern was with the initial fall when the next longwall panel was initiated and that changes in the plan were required for that.

51 In attempting to refute the “reckless disregard” charge, the Respondent again raises its claim that a roof fall in a longwall gob is “planned” and that the initial fall “will be large.” This ignores what happened here. The initial fall was far beyond anything that was “planned” and...
determination not to report unreasonable, Signal Peak missed several discrete and independent opportunities at which it was clear that the reporting obligation, stemming from Mr. Stewart’s condition from his injuries, existed. See the findings of fact, supra. Accordingly, the Court finds that, in both aspects, the Respondent acted with reckless disregard.

The Violation of 30 CFR § 50.12 for failure to preserve the accident scene

The Secretary asserts that “if the Court finds a violation of 30 C.F.R. § 50.10, [as per] Citation [Number] 8463717 it will necessarily find a violation of 30 C.F.R. § 50.12 in Citation [Number] 8463718.” Sec. Br. at 20. The Court agrees and notes that the facts are uncontested regarding the latter citation. Signal Peak would be excused from liability on the failure to preserve the accident scene only if its challenge to the obligation to report violation were dismissed.

As noted earlier, 30 CFR § 50.12, entitled “Preservation of evidence,” provides that “[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.”

Referring to the related citation, pertaining to the alleged violation of 30 C.F.R. 50.12, requiring that the accident scene be protected from alteration, the Inspector noted that the mine did nothing to comply with that provision and, again, Respondent presents no claim contending otherwise. Because they had instead opted to mine past the accident scene, it was more difficult for MSHA to assess what the conditions were at the location at the time of the accident. As opposed to the Inspector’s gravity designations for the failure to report violation, the accident alteration violation was marked as “unlikely” because Johnson did not have an accident scene to investigate. Tr. 91. Thus, while he felt the standard had been clearly violated, he believed that he had no basis to conclude whether it was “S & S,” because there was no scene to assess, the mine having elected to advance its mining beyond the accident scene. Tr. 92. While MSHA felt constrained, incorrectly in the Court’s estimation, believing that it was unable to assert that the

51(...continued)

was exponentially beyond any typical, expected, larger initial fall. Taken to its logical conclusion, the Respondent is arguing that the attendant injuries would also have part of the “plan.” Further, as noted, when MSHA did become involved they determined that changes were needed for future longwall panels, and by doing so rejected the fiction that all that occurred was “planned.”

52 Though the cited provision allows for the possibility that the MSHA District Director or District Manager may grant permission to alter the accident site, there was no contention that the exception was invoked. Tr. 90.
violation was S & S, the Court believes that, from a civil penalty perspective, the mine should not be rewarded by its safety-hindering actions.

In that light, the Secretary at least views the Respondent’s failure to preserve the accident scene as constituting a blatant disregard of the standard. Signal Peak did nothing to comply with the duty associated with the standard. Instead, it simply repaired the damaged ventilation before resuming mining three days after the accident and, notably, did so without any notification to MSHA before resuming its longwall mining. By failing to notify MSHA, there was no accident site for the Agency to assess and obviously that hindered the Agency’s ability to evaluate whether the accident could be part of a trend or problem which could present an ongoing or future hazard to miners. The Secretary also asserts that the excuse presented, that MSHA’s involvement would have prevented the repair of ventilation and stoppings, which would have created a greater hazard, is “unbelievable,” and the Court would agree that it took chutzpah for the Respondent to make that claim. Sec. Br. at 35. Further, the Secretary notes that, under the Mine Act, it is for the Secretary, not the mine operator, to evaluate accident scenes in order to protect the safety and health of miners and accordingly it is not appropriate for any mine to decide to preempt MSHA’s role.53

The Secretary’s Additional, Independent, Basis for Liability; 30 C.F.R. § 50.10(d)

The Secretary maintains that, in addition to liability under 50.10(b), liability also exists independently under 30 C.F.R. §§ 50.10(d) and 50.2(h)(8). Recall that under 50.10 there is a duty for immediate notification once a mine operator knows or should know that an accident has occurred involving events such as a death and, as discussed at length above, an injury which has a reasonable potential to cause death. However, the duty to make an immediate notification under § 50.10 also extends to “Any other accident.” 30 C.F.R. § 50.10(d). When one then turns to the definitions section, found at 30 C.F.R. § 50.2, the term “Accident” includes “... an unplanned roof or rib fall in active workings that impairs ventilation or impedes passage.” 30 C.F.R. § 50.2(h)(8).

The Respondent’s defense to this additional theory of liability is that as the fall occurred in the gob and the gob is not an active working, the section does not apply. To this, the Secretary’s view is that the ordinary definition of the terms “planned” and “impair” demonstrate that the section applies because the air blast was clearly not planned and the mine’s ventilation was significantly impaired by that blast. Sec. Br. at 36. Certainly, in terms of “planning,” there

53 This claimed “concern” was clearly suggested by Respondent Counsel’s questions to MSHA’s Mr. Del Duca in that, as Counsel noted that since ventilation was impaired by the event and that it would be important to correct the damaged ventilation, MSHA’s inevitable issuance of a k order would interfere with those important repairs. Tr. 339-340. Sec. Br. at 35. Apart from the problem with usurping MSHA’s role, under a k order mining would be stopped, at least momentarily, while the Agency assessed the situation, and therefore any such risks would be diminished.
can be no serious argument that the great fall and attendant blast that occurred here was within the mine’s expectations, though some witnesses for the Respondent suggested that was the case.

As to the more fundamental aspect of the Respondent’s defense, that the unplanned roof fall was not in active workings, the Secretary answers that the blast “materially affected the active workings by impairing ventilation of the entire mine and the violent blast of air that followed affected the health and safety of the miners working on the longwall,” noting that “[d]ebris from the roof blasted into active workings as well.” Sec. Br. at 36-37. Further, as the ventilation was impaired from the event and given the importance of ventilation, “it would never be intentionally compromised for purposes of a ‘planned’ roof fall.” Sec. Br. at 37, citing Tr. 328. Accurately, the Secretary observes that “the unplanned roof fall affected the active workings of the mine as well as any roof fall would if it occurred in a main travelway.” It notes that as the unplanned fall took out “at least 78 stoppings over 14,000 feet [and thereby] affecting the entire mine’s ventilation system, and throwing a miner in the working section approximately 50 to 80 feet, the roof fall affected active workings and therefore should have been reported pursuant to 50.2(h)(8).” Sec. Br. at 37. Since a purpose behind reportable accidents is to inform MSHA about such events so that it can investigate and ascertain their causes in order to prevent recurrences, the failure to report the unplanned roof fall prevented MSHA from performing those roles.

Findings of Fact relating to the Unplanned Roof Fall

Inspector Johnson was of the view that the accident was also immediately reportable on the basis of the definition of an “accident,” per section 50.2(h)(8) which, as noted, refers to an unplanned roof fall in active workings that impairs ventilation. Tr. 77. Certainly part of this definition was met, as the event could not be described as other than an “unplanned” roof fall. Instead of a planned condition, there was instead a “violent” one, beyond the mine’s expectations “for controlling the particular roof fall behind the shields.” The event was “way beyond the controls [the mine] had in place and it affected the entire mine’s ventilation system and the violent expansion of air affected the health and safety of [the] miners.” Tr. 77. (emphasis added). Addressing the provision’s reference to “active workings,” the Inspector reasoned that the roof fall was not in control and that is why it affected the ventilation of the miners working the area. Tr. 77. While apparently no rock from the gob flew into the active workings, a lot of debris did, as the miners were covered in such material. Tr. 180. Thus, Inspector Johnson concluded that the roof fall did affect the working area of the mine. 54 Tr. 77-78.

54 The Inspector agreed that the area behind the longwall shields is the gob and that the fall in this instance occurred in the gob. Further, the Inspector agreed that the gob is not an area where miners normally work or travel, nor an active working, at least as that term is defined in the Act. Tr. 94. However, no one is disputing these points. The question is whether the standard must be slavishly read in a strictly literal fashion, or whether, consistent with remedial legislation, it may be read in the context of its aims. Under the latter approach, recognizing that (continued...)
Mr. Pete Del Duca, who is a licensed Professional Engineer in Colorado, is a supervisory mining engineer with MSHA. Del Duca’s investigative experience in dealing with coal and rock bursts and roof falls has been noteworthy and he has a bachelor of science degree from the Colorado School of Mines. Tr. 259-261. With MSHA since 2004, from 2006 through 2010, he worked in the roof control division where he reviewed roof control plans and investigated roof control related accidents. More precisely, his work pertained to ground control issues. Accordingly, he investigated such failures with the goal of determining if the ground control plans are adequate for the conditions, to ensure “that everything is being done to safely control the ground to protect miners.” Tr. 258.

Mr. Del Duca’s experience with Signal Peak precedes the time when they began their longwall mining. Tr. 261. His involvement with this matter began on December 29th. He was detailed there to evaluate the serious roof failure at the mine and to evaluate the “potential hazard [ ] for future and for current mining [at the mine].” Tr. 267. Engineer Del Duca’s notes, from his visit to the mine, are reflected in GX 14. He was accompanied by another roof control specialist during the visit, Venkatrao Thummala. Tr. 268. Referring to a map within GX 14, Del Duca traced his tour of the mine area in issue. Among other observations he noted that “[o]n the headgate side, the cave was hanging back about 45 to 50 feet behind the shields, meaning the roof remained up. Tr. 275. He noted that, before the accident, the first cave had not yet occurred. There was a “massive volume” 1250 feet wide face, 10 to 12 feet high and 220 feet long. While some blast out is to be expected from the initial cave, what occurred here was of an entirely different order. As Mr. Del Duca expressed it, “[t]o get an air blast of this magnitude is a very real problem and a real hazard.” Tr. 280. He concluded that the mine’s massive sandstone roof was the source of the roof hanging up. He considered that to be a very real hazard, requiring changes to the roof control plan. Tr. 283.

The Court inquired of Mr. Del Duca whether the roof conditions he was examining came within the definition of an “accident,” per section 50.2 (h). His response was that though the gob itself is not an active area of the mine, “it materially affected the active area by knocking out ventilation, impaired ventilation, and it fell in an uncontrolled, unplanned manner, which is not how it was designed to fail.” Tr. 285. Thus, it was Mr. Del Duca’s position that what occurred here fell within the ambit of section 50.2(h)(8). Tr. 286.

Engineer Del Duca, noting that the Agency had concerns a subsequent fall on the order that occurred here, informed that there were changes made to the roof control plan. Tr. 298. These changes, brought about through MSHA’s intercession, were successful in preventing another such massive fall. Tr. 299. There was no dispute that the roof problem originated from a massive sandstone hang-up. Significantly, as far as Del Duca knew, the mine itself did nothing in the wake of the accident to inquire into the problem. Thus there was no attempt to investigate

54(...continued)

the gob fall affected the active workings, and in a very significant way, as the injuries to miners Stewart and Mobley attest, the effect upon the active workings could be considered. Tr.179
how to avoid having a repetition of the massive fall which injured two miners. Tr. 300. Signal Peak merely cleaned up the damaged ventilation and then resumed their longwall mining. Tr. 300. The risk of a repeat massive fall, had no changes been instituted, would be when the mine started panel two if its longwall. Tr. 303. Politely calling it “disappointing,” Mr. Del Duca noted that he was unaware of anything the operator did to address the event: “You know, I’m unaware of anything that they did. My opinion was that they just continued mining and that they didn’t do anything to try to ensure that there wouldn’t be any more, to really take a good, hard look at all. If I recall right, there wasn’t anything documenting any increased precautions, anybody looking inby[] on every shift to ensure that it was following close, minimizing persons in the headgate entry so that way, no one would - - so it would only be one person in at a time or anything like that. To the best of my knowledge, there had been nothing at that point to mitigate the potential hazard there.” Tr. 303-304.

MSHA issued its (k) Order which required precautions the mine would have to follow before resuming mining. Tr. 304. Ex. 15. The mine then developed their plans to mitigate the hazard. The result was that, prior to the start of the second longwall panel, the plan was revised to address these issues. Tr. 312. From the government’s perspective, Mr. Del Duca’s testimony is probative in two respects. First to show that there was an unplanned roof fall that affected active workings and second, to show the gravity and seriousness of the fall that occurred. Tr. 317. GX 25, a document created for the mine by an outside contractor, Malecki Technologies, was admitted. Tr. 321. Its use was limited to show, as corroboration, that Mr. Del Duca had discussions with the mine about the subject of what was needed to “take place to mitigate the same hazard from existing for the second longwall panel and panels thereafter given the roof conditions and given the outcome of his investigation and findings.” Tr. 320. It was also offered to show that the fall was not a run of the mill type of event and that measures were needed to prevent a similar occurrence. Tr. 321. Malecki was hired to “determine the best course of action to prevent these air blasts from continuing to occur.” Tr. 322. Thus the Malecki report came about as a result of MSHA’s involvement with the December 23, 2009 roof fall event, which was the originating cause of this proceeding. Tr. 322.

Engineer Del Duca also made it clear that the December 23rd event was “[a]bsolutely not” a run of the mill initial cave-in, as had been suggested by some who testified for the Respondent Mine.55 Tr. 323. Although an initial cave may blow out a stopping or two, that is not

55 Safety Manager Thomas Rice was of the opinion that damage to 78 stoppings from a roof fall was “not surprising, no.” Tr. 448. He also was of the view that stoppings in the longwall setting are designed to give away when an initial fall occurs. Tr. 449. Because the fall was in the gob, and not in “active workings,” Rice also did not believe that the event was immediately reportable under the standard. Tr. 450. However, his testimony also indicated that the line of demarcation between active workings and the gob is not as stark as it might seem and that the two areas can interact. This is because as mining advances and unsupported roof is created by that activity, pressures build up. These pressures are “[a]butment pressures, face (continued...)
pressures, [and] pressures that may cause — that may shift towards any directions.” Tr. 450-451 (emphasis added). Given his perspective, it is not surprising that he also viewed the fall which occurred as “planned.” From the context of Rice’s answer, this view was based on the idea that eventually the unsupported roof will have to fall. Tr. 450. Shift foreman, Mr. Benny Harcourt, also expressed that the cave that occurred here was not all that different or unusual from other initial caves. Tr. 406. If those pressures are not relieve — alleviated, they could cause pressure to be shifted to the face area where people are working. “[At that point] [t]he roof could deteriorate . . . and fall in on the face. It could create pressure to the block of coal that’s being mined, to start bursting . . . out to where the employees are at.” Tr. 450-451. Thus, Rice’s and Harcourt’s testimony actually confirmed both the importance of a timely initial fall and the havoc that can ensue if the pressure builds up for too long, as it did here.

Inspector Johnson’s noted that there were several stoppings damaged on the longwall panel in connection with the incident and, with the help of the mine’s dispatcher, he used the map, which is GX 4, to count that 78 stoppings were affected. Tr. 111. He acknowledged that the degree of damage to those stoppings varied. Tr. 111-112. Although the Inspector referenced that the total number of damaged stoppings may not be exact, because of the map that was available for him to use, Johnson clarified that simply meant his count could be off by up to ten stoppings, meaning that it could be up to 10 more or 10 less damaged stoppings from the event. Accordingly, working from the most conservative estimate, the Inspector was stating that at least 68 stoppings were damaged by the event. Tr. 113. In any event, the Inspector advised that the majority of the stoppings that were damaged were inby the longwall face and that this comprised a distance of roughly 3 and ½ football fields in length. Tr. 118.
Mr. Del Duca expressed that a roof fall comes within the 50.10(d) provision on the basis that, while the fall occurred in the gob area, material from it was expelled out and because the fall knocked out ventilations that were in the active workings. Thus, the fall very much affected the active workings of the mine. Thus, its effect was indistinguishable from a fall occurring in a main travelway.\footnote{Del Duca later explained that by that he was referring to the air pressure, not physical material. Tr. 331.}

As alluded to earlier, the Respondent simply maintains that as the roof fall was not in active workings but rather occurred in the gob and as the gob is not a place where miners normally are required to work or travel, there was no duty to report the fall.\footnote{As the Court stated at the hearing, it recognized that Respondent’s Counsel’s point was that MSHA did not require any roof control revisions until after the miner was injured following the tremendous air blast. However, that is not the issue. The issue is the duty to report, or not, under the Secretary’s second theory of liability.}

Respondent argues that the language of the provision, section 50.10, controls and, as such a roof fall which does not occur in active workings, even though it has significant effects upon the active workings, be that impairing mine ventilation or injuring miners, is still outside the provision. R’s Br. at 19. Thus, for the Respondent the inquiry over the reach of the standard abruptly ends once it is acknowledged that the roof fall occurred in the gob and any effects on the mine beyond the gob are simply to be ignored. Because that perspective runs against the precepts of construing remedial legislation and its progeny, safety and health standards, the Court rejects this defense.

As noted at the outset, MSHA maintains that the mine’s actions, or more accurately, its lack thereof, also violated the immediate reporting obligations under 30 C.F.R. § 50.10(d), requiring notification “at once and without delay,” for “[a]ny other accident,” with the term “accident” including “[a]n unplanned roof fall at or above the anchorage zone in active workings where roof bolts are in use; or, an unplanned roof or rib fall in active workings that impairs ventilation or impedes passage.” 30 C.F.R. § 50.2(h)(8).

As the Tenth Circuit has noted, the Commission’s interpretation of standards is to be consistent with the safety promoting purposes of the Mine Act. This is in keeping with the concept that the Mine Act should be liberally construed to accomplish its remedial purposes. \textit{Walker Stone Co., Inc. v. Secretary of Labor}, 156 F.3d 1076, (10th Cir. 1998), citing \textit{Joy Techs., Inc. v. Secretary of Labor}, 99 F.3d 991, 996-97 (10th Cir.1996) (interpreting regulation to further safety promoting purposes of), cert. denied, 520 U.S. 1209, 117 S. Ct. 1691, 137 L.Ed.2d 818 (1997) and \textit{RNS Servs., Inc. v. Secretary of Labor}, 115 F.3d 182, 187 (3d Cir.1997). In RNS Servs., Inc. v. Secretary of Labor, the Court rejected the Respondent’s argument that the provision was not violated because the fall occurred in the gob and any effects on the mine beyond the gob were simply to be ignored.

\footnote{The Respondent also maintains that the fall was not “unplanned.” R’s Br. at 18. The credible evidence resoundingly shows otherwise. Clearly this enormous and injury producing fall was not “planned.”}
The Third Circuit noted it was mindful that "[t]he canons of statutory construction teach us to construe such remedial legislation broadly, so as to effectuate its purposes," citing *Stroh*, 810 F.2d at 63.

Accordingly, for the reasons articulated above in this decision, the Court agrees that this additional source of liability was established.

**PENALTY ASSESSMENT**


In *Secretary v. Ember Contracting*, 33 FMSHRC 2742, 2011 WL 5826782 November 4, 2011 (Judge Paez), it was noted "[t]he determination of the proper civil penalty is committed to the Administrative Law Judge's discretion, which is bounded by the statutory criteria of section 110(i) of the Mine Act as well as the deterrent purpose of the Mine Act's penalty assessment scheme. *Sellersburg Stone Co.*, 5 FMSHRC 287, 294 (Mar. 1983) (citation omitted), aff'd sub nom. *Sellersburg Stone Co. v. FMSHRC*, 736 F.2d 1147 (7th Cir. 1984).

Speaking to the subject of effective civil penalties, the Commission, looking to the legislative history of the Act, observed in *Secretary of Labor v Double Bonus Coal Co. et al*, 31 FMSHRC 886, 2009 WL 2915303, (Aug. 2009), that “Senator Williams, the sponsor of the Mine Act, emphasized that the civil penalty was ‘the mechanism for encouraging operator compliance with safety and health standards.’” and that “[i]n reviewing the relevant legislative history, the D.C. Circuit concluded that “Congress was intent on assuring that the civil penalties provide an effective deterrent against all offenders, and particularly against offenders with records of past violations.” Id. at *893, citing S. Rep. No. 95-181, at 41, 43 (1977), reprinted in Senate Subcomm. on Labor, Comm. on Human Res., Legislative History of the Federal Mine Safety and Health Act of 1977, at 629, 631 (1978) Legis. Hist. at 85, and *Coal Employment Project v. Dole*, 889 F.2d 1127, 1133 (D.C. Cir. 1989). The same legislative history stated that “[t]o be successful in the objective of inducing effective and meaningful compliance, “a penalty should be of an amount which is sufficient to make it more economical for an operator to comply with the Act's requirements than it is to pay the penalties assessed and continue to operate while not in compliance.” S.Rep. No. 181, 95th Cong., 1st Sess. 40–41 (1977), reprinted in Senate Subcommittee on Labor, Committee on Human Resources, 95th Cong. 2d Sess., Legislative History of the Federal Mine Safety and Health Act of 1977, at 628–29 (1978).

The Secretary seeks a minimum penalty of $51,400.00 for the two violations. By any measure Signal Peak is a large mine, presently employing about 240 people and with a goal of shipping a million tons of coal per year. Tr. 30. Sec. Br. at 7. In terms of the mine’s history of
violations, the Court has taken into account GX 21, the certified Assessed Violations and History Report. There is no evidence that the penalty imposed would have an effect on the mine’s ability to continue in business. Nor was there any good faith on the Respondent’s part, in the sense that term is employed under 30 U.S.C. 820(i), because there could be no rapid compliance in either instance after notification of the violation.

In addition to the findings already discussed, the Court makes the following additional comments in support of its penalty determinations. The Court considers both violations to be egregious failures on Signal Peak’s part. The decision not to call MSHA, in violation of the immediate notification requirement of 30 C.F.R. § 50.10, was in no way a borderline call for which reasonable minds could differ. Signal Peak’s negligence in both these violations matters. The penalties assessed are fully appropriate upon consideration of the gravity and negligence involved.

As noted in numerous cases, including Secretary v. Newtown Energy, Inc., 2012 WL 1564583, April 19, 2012, ("Newtown Energy") (Judge Gill), “[t]he gravity penalty criterion under section 110(i) of the Mine Act, 30 U.S.C. § 820(i), is most often viewed in terms of the seriousness of the violation. Sellersburg Stone Co., 5 FMSHRC 287, 294-95 (March 1983), aff'd, 736 F.2d 1147 (7th Cir. 1984); Youghiogheny & Ohio Coal Co., 9 FMSHRC 673, 681 (Apr. 1987). The seriousness of a violation can be examined by looking at the importance of the standard which was violated and the operator's conduct with respect to that standard in the context of the Mine Act's purpose of limiting violations and protecting the safety and health of miners. See Harlan Cumberland Coal Co., 12 FMSHRC 134, 140 (Jan. 1990) (ALJ). Judge Gill went on in Newtown Energy to note that “the gravity of a violation and its S&S nature are not the same. The Commission has pointed out that the “focus of the seriousness of the violation is not necessarily on the reasonable likelihood of serious injury, which is the focus of the S&S inquiry, but rather on the effect of the hazard if it occurs.” Consolidation Coal Co., 18 FMSHRC 1541, 1550 (Sept. 1996). The gravity analysis can include the likelihood of an injury, but should focus more on the potential severity of an injury, and the number of miners potentially injured. The analysis should not equate gravity, which is an element that must be assessed in every citation or order, with “significant and substantial,” which is only relevant in the context of enhanced enforcement under Section 104(d),” citing Quinland Coals Inc., 9 FMSHRC 1614, 1622 n.1 (Sept. 1987) Id. at *6.

Here, in examining the effect of the hazard if it occurs, the first observation is that, for both citations, the hazard did occur. MSHA cannot perform its role if not notified and, by keeping the agency in the dark, miners potentially may suffer. For the preservation of evidence violation, the mine literally covered up the accident by continuing its longwall mining. Accordingly, the gravity for both violations was serious. Finally, regarding the violation of 30 CFR § 50.12, the failure of Signal Peak to preserve the evidence, that can be viewed as more
As noted, at the hearing the Secretary urged that the proposed total amount be viewed as the “minimum” assessment. Accordingly the gravity and negligence attendant with that failure warrant the five-fold increase from the modest penalty proposed by MSHA. 60

Civil Penalty Assessment

Based on the findings above, the Court assesses a civil penalty in the total amount of $83,750.00.

ORDER

Within 40 days of the date of this decision, Signal Peak Energy LLC, Respondent, is ORDERED to pay a total civil penalty of $83,750.00 for its violations of 30 C.F.R. 50.10 and 30 CFR § 50.12, as set forth in Citation numbers 8463717 and 8463718, respectively. 61

/s/ William B. Moran
William B. Moran
Administrative Law Judge

60 As noted, at the hearing the Secretary urged that the proposed total amount be viewed as the “minimum” assessment.

61 Though on an entirely separate and independent basis, as noted supra, the Court found that Signal Peak also violated the same immediate reporting obligation on the basis of 30 C.F.R. § 50.10(d), as the accident involved here was also included within subsection 50.2 (h)(8) and its provision regarding an unplanned roof or rib fall in active workings that impairs ventilation or impedes passage.
Distribution: (E-Mail and Certified Mail)


Ralph Henry Moore, Esq., Jackson Kelly PLLC, Three Gateway Center, Suite 1340, 401 Liberty Avenue, Pittsburgh, PA 15222-1000.
June 14, 2012

JIM WALTER RESOURCES, INC., : CONTEST PROCEEDINGS
Contestant


SECRETARY OF LABOR, : Docket No. SE 2007-203-R
MINE SAFETY AND HEALTH : Citation No. 7689677; 02/15/2007
ADMINISTRATION, (MSHA), : Citation No. 7689678; 02/15/2007
Respondent : Docket No.; SE 2007-204-R

SECRETARY OF LABOR, : Mine: No. 7
MINE SAFETY AND HEALTH : Mine ID: 01-01401
ADMINISTRATION, (MSHA), : CIVIL PENALTY PROCEEDINGS
Petitioner : Docket No. SE 2007-263

v. : A.C. No. 01-01401-114900-01

JIM WALTER RESOURCES, INC., : A.C. No. 01-01401-118868-01
Respondent : Docket No. SE 2007-294

: A.C. No. 01-01401-118868

: Mine: No. 7

DECISION

Appearance: Neil A. Morholt, Esq., Office of the Solicitor, U.S. Department of Labor,
Nashville, Tennessee, for the Secretary of Labor;
John Holmes, Esq., Allen Bennett, Esq., Maynard, Cooper & Gale, P.C.
Birmingham, Alabama, for Jim Walters

Before: Judge Weisberger

These cases are before me based upon petitions for assessment of civil penalty filed by
the Secretary of Labor (“Secretary”) alleging that Jim Walter Resources, Inc. (“Jim Walter”)
violated various mandatory safety standards set forth in Title 30 of the Code of Federal
1 The history of the cases are set forth at the commencement of the hearing on March 6, 2012 (Tr. 6-12), and are incorporated herein by reference.


I. Citation No. 7690417 (Violation of 30 C.F.R. § 77.400(d)) (Docket No. SE 2007-263)

At the conclusion of the Secretary’s case, the Respondent made a motion for summary decision arguing that the Secretary failed to establish a prima facie case that it violated Section 77.400(d), supra. After listening to oral arguments, the motion was granted in an oral decision which is set forth below, with the exception of corrections of matters not of substance.

Section 77.400(d) supra requires that “[e]xcept when testing the machinery, guards shall be securely in place while machinery is being operated.” On September 29, 2006, MSHA inspector Russell Alan Weeks inspected the No. 7 Mine and observed a structure used as a truck shop. Located outside the truck shop was a pressure washer (“washer”) that was mounted on a flat concrete pad and was used to wash heavy equipment parked nearby. Weeks observed that there was not any guard in place on the washer. As a consequence, moving parts consisting of a flywheel and a rubber V-belt were exposed. According to Weeks, these parts were “within arm’s reach.” Tr. 34. He issued a citation alleging a violation of Section 77.400(d) supra, which provides that, “[e]xcept when testing the machinery, guards shall be securely in place while machinery is being operated.”

There is not any evidence in the record that the exposed machinery was being tested. Accordingly the exception to Section 77.400(d), supra does not apply. Weeks testified that he observed that the cover that was used as a guard, “was on top of the [steam cleaning unit] basically between the control box and the top of the unit.” (Tr. 33). Therefore the focus is on the clear operative language of Section 77.400(d) supra that “guards shall be securely in place while machinery is being operated.” That phrase has two components. Thus, in order to prevail, the Secretary must establish two elements set out in Section 77.400(d) supra, i.e., (1) that a guard was not securely in place and (2) that the machinery was being operated. The Secretary adduced evidence that a guard was raised; thus it established the first element. However the second element concerning whether the machinery was being operated, is a concern. It is the Secretary’s position that the machinery was neither tagged, nor otherwise removed from power, and therefore was not locked out, and was thus available for use.
I am unaware of any cases that interpret Section 75.400(d), *supra* in the manner in which the Secretary has argued; more importantly, the language of the standard is clear that guards shall be securely in place while machinery *is being operated*. The Secretary’s witness testified that when he observed the machinery, the flywheel and the belt were not in operation. Therefore, the machinery was not being operated. Since the Secretary has not established a prima facie case, Jim Walter’s motion for summary decision is granted and Citation 7690417 is dismissed.

II. Citations No. 7690107 (Violation of 30 C.F.R. § 75.400) (Docket No. SE 2007-263)

At the conclusion of the Secretary’s case, the Respondent made a motion to dismiss. After listening to oral arguments for both parties, the motion was granted. After both parties rested, the parties presented closing arguments, and an oral decision was made which is set forth below with the exception of corrections of matters not of substance.

A. Introduction and Discussion

Citation No. 7690107 concerns an alleged violation of 30 C.F.R. § 75.400, involving float coal dust within a power center located in the underground section of Jim Walter’s No. 7 Mine. On November 29, when MSHA Inspector Edward Nicholson inspected the power center, the section was not producing coal, but the power center was energized.

The inspector indicated that his view of the power center was through a window on one side of the power center, which was approximately four-to-six inches in height and ten-to-twelve inches long. Jim Walter’s safety director testified to those measurements, which were not rebutted or impeached by the Secretary.

Within the power center were various pieces of electrical equipment – insulators, circuit breakers, cables and transformers. There was not any physical barrier or separation between the area referred to as the disconnect compartment, and the rest of the interior of the power center. According to the inspector, a switch was located outside the power center; that in operating the switch, it is possible to eliminate power to the equipment inside the power center. However, the operation of the switch does not cause arcing on the various electrical components. The inspector indicated that he observed black float coal dust that was paper thin on the various surfaces. He opined that the float coal dust could be ignited, or even could propagate an explosion. He stated that float coal dust is highly combustible, and indicated that as a consequence of a possible fire or explosion, significant injuries could result to persons in the area such as burns or smoke inhalation. He indicated that such injuries were reasonably likely to occur if the accumulations were not cleaned. Accordingly, he issued the subject citation.

On the other hand, Richard Parker, Jim Walter’s safety director who accompanied the inspector, indicated that he looked through the same window and the dust that he saw was not black. Parker indicated that he told two individuals within two hours of the next shift, which commenced at 3:00 p.m., to vacuum the inside of the power center, to collect the dust, and then
to put a sample of the collection of dust that was vacuumed in a sealed bag, and place it in an office where he would pick it up. Parker stated that he received an e-mail from these individuals indicating essentially what he testified to, and he confirmed the information in a subsequent conversation with them.

The following day Parker took the sample items to a laboratory for testing. Subsequently, the test results were sent to Jim Walter, and a proffer was made of that exhibit. The exhibit was not admitted because there were significant defects in the proof of the chain of custody of the dust.

Since there is no evidence to indicate that there was not any change in the composition of the material inside the power center, there is not any assurance that what was vacuumed was exactly the same as what was observed, and which formed the basis for the citation. Next, there also is no evidence as to the fashion of the vacuuming, leaving serious questions as to the reliability of what was scooped up and sent to the laboratory.

It is unknown whether each and every particle of dust that was collected or only a certain portion was turned in to the office; whether only certain areas were vacuumed; and whether there were any alterations to the sample when it was not under anyone’s control. Due to all these uncertainties and others that are presented on the record, the laboratory results were not admitted.

B. Further Discussion

The subject citation involves a violation of 30 C.F.R. § 75.400 which provides, in essence, that the coal dust, loose coal, “and other combustible materials” shall be cleaned up. Based upon the clear language, it is manifest that the qualifying phrase “and other combustible material” modifies all nouns set out in Section 75.400 supra. The Secretary has the burden of establishing that what was observed within the power center was considered “combustible.” The inspector did provide his opinion based upon a visual examination. But he did not touch or measure the subject materials. It is not clear what, aside from his observation, provides a basis for his conclusions.

Consequently, there are significant defects in both the Secretary’s case and Jim Walter’s case. At best, the evidence is in conflict. In finally resolving the matter, the focus is on the critical fundamental principle of burden of proof. The Secretary has the burden of establishing a violation by a preponderance of evidence that is clear and convincing. In regard to the quality of the evidence, it is a concern that the inspector’s testimony does contain many uncertainties that tend to detract from his testimony. He did not recall the location of the vents in the power center. He was not sure of the amount of voltage that came into the power center, he did not recall if the window had dust on it, and he was not sure if the transformers were connected to one another.
I also reviewed his notes which are admitted in evidence as Government Exhibit 3. According to his testimony, these are contemporaneous notes. His notes pertaining to his observations of the conditions at issue are set forth on page four of five. There are three columns, and each column has a page number at the lower right-hand corner (“Nicholson’s page”). On Nicholson’s pages eleven and twelve, he set forth his contemporaneous notes of his observations; and, again, there are not any specific facts to substantiate his opinion found in the third line that he issued the citation for combustible material in the form of float coal dust. Given all of the above concerns regarding the evidence before me, I find that the Secretary has failed to meet its burden of establishing a violation by a preponderance of clear and convincing evidence. Therefore Citation No. 7690107 is dismissed.

III. Citation No. 7689677 (Violation of 30 C.F.R. § 75.202(a) (Docket No. SE 2007-294))

A. Introduction

On October 12, 2006, a rockfall occurred in the No. 2 entry adjacent to a previous rockfall in a crosscut at survey station (“spad”) 3575, North Mains Section, in the underground portion of Respondent’s No. 7 coal mine. At approximately 8:00 a.m. that day, Special Project’s Manager, Jerry McKinney’s body was found pinned under a piece of rock, in the immediate area of the fall. There were not any eyewitnesses to the accident. Within a few hours after the discovery of McKinney’s body, MSHA Inspector Harry Wilcox, who was serving as an investigator, inspected the site along with John Church, an MSHA Electrical Specialist, and MSHA Supervisor, Jerry Langley. In addition, Dale Johnson and Sam Mullen represented the state of Alabama. In the course of a subsequent investigation of the accident, these investigators interviewed 13 persons. On February 15, 2007, MSHA issued a Report of Investigation, (“Report”), and on the same date issued a citation to Jim Walter alleging a violation of 30 C.F.R. § 75.202(a).

B. The Secretary’s witnesses

Wilcox testified that he was advised by a supervisor at the Bessemer field office at approximately 9:00 a.m. on October 12, 2006, to go to the mine and start an investigation of a fatal accident.

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2 In October 2006, entries in the area ran north-south, parallel to the main track entry. The entries were approximately 100 feet apart, and were separated by crosscuts that extended inby from main entry, and were perpendicular to the entries. The site of the rockfall at issue in the No. 2 entry, was just north of a crosscut approximately 700 feet inby the main track entry.
Wilcox indicated that he and the rest of the investigation team traveled the green route\(^3\) from main track entry towards the site of the victim and observed three rockfalls\(^4\), but their progress was not hindered. According to Wilcox, as he approached the survey spad 3575 where McKinney’s body had been located, he observed a “large” previous\(^5\) rockfall (Tr. 293). He indicated that in order to make the area safe for the investigators, he “had” the operator install posts. (Tr. 293).

According to Wilcox, the body of the victim was located under a rock 83 inches long by 43 inches wide by 7 inches thick that had fallen from a brow from a previous rockfall. A roof bolt and metal strap were attached to the rock that had fallen on McKinney. Wilcox indicated that he could not tell for sure how long the fall had existed before McKinney had arrived there on the date of the accident.\(^6\)

In addition, Wilcox opined that the cited conditions resulted in a hazard of a roof fall because there had been a previous roof fall at the accident site, and there were two other roof falls to the east of the site. He said that the history of previous falls indicated that the roof had deteriorated, and was unsafe.

Wilcox further indicated that the roof in the area where McKinney was found was supported by bolts, straps and timber. He opined that since it was close to a previous roof fall, it could have been compromised due to the potential of weakened anchorage points, especially for conventional “bail type roof bolts” which had been used in the area at issue.\(^7\) (Tr. 407-408)

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\(^3\) The various possible paths to the areas at issue from the main track entry, via various crosscuts are indicated by different colored lines in the Report of Investigation (Government Exhibit 10, p. 12) (“Gx”) and referred to in the text as green, red, or blue route, path or pathway, respectively.

\(^4\) Labeled “1,” “2,” and “3” on page 12, Gov. Ex. 10. Also, Wilcox testified that in addition there was another previous roof fall in a crosscut just east of the evaluation point No. 5. He indicated that he could not travel in that crosscut because the roof was unsupported.

\(^5\) Thatched area on Gx 10, p. 4.

\(^6\) According to Wilcox, based on McKinney’s notes (Gov. Ex. 9), he concluded that McKinney’s route the day of the rockfall was as follows: he started at “A”, went to “B,” went West to “C”, then south to “D” and returned to the fall area at “3.” (Tr. 326-332; Gov. Ex. 10, p. 12).

\(^7\) He indicated this opinion is based on his observation of the accident site; that bolts had been pulled away in the area immediately around where the rock was “and the roof bolts that have pulled out of the roof” (Tr. 408).
In essence, Wilcox testified that he found a violation of Section 77.202(a) based on the following facts: Jim Walter had been aware of deteriorating roof conditions outby the site where McKinney was found,\(^8\) and that the roof conditions at the site were a continuation of the hazards alleged in a previously filed petition for modification which covered the areas south of the evaluation points in north mains, and are indicated by the entries and crosscuts within pink circle in Appendix “B” to the Report (Gov. Ex. 10, p. 12). Wilcox described the violation as being significant and substantial because a fatality occurred.

Wilcox found the negligence to be moderate because the company knew or should have known of adverse roof conditions at the accident site. In this connection, Wilcox asserted that McKinney, a Senior Projects Manager, had seen “the conditions . . and then the company knowing the deteriorating conditions, bad conditions from the previous resupport times in 2003 and 2006.” (sic) (Tr. 378). Additionally, Wilcox testified that he saw an area that had been resupported in 2003 that extended along the green path east from the five seals\(^9\) until two entries west of the track entry. He opined that accordingly the company should have been aware that the conditions in the roof were deteriorating, and that it needed to be resupported.

C. Discussion

The ultimate issue in this case is whether the Secretary has established, by a preponderance of evidence, that Jim Walter violated Section 77.202(a) \textit{supra} which provides as follows:

The roof, face and ribs of areas where persons work or travel shall be supported or otherwise controlled to protect persons from hazards related to falls of the roof, face or ribs and coal or rock bursts.

In \textit{Harlan Cumberland Coal Company} 20 FMSHRC 1275, 1277, the Commission held as follows regarding the test to be utilized in determining whether a violation exist under Section 75.202(a) \textit{supra}:

The Secretary’s roof control standard is broadly worded. \textit{See} 30 C.F.R. § 75.202(a). Accordingly, we have held that “the adequacy of particular roof support or other control must be measured

\(^8\) McKinney’s notes for the day of the accident indicate “fall[s]” in three successive locations inby “3825 ” (Gov. Ex. 9, p. 3). In addition, Wilcox opined that the fact the additional posts had been installed in the green walkway path indicates that Jim Walter had been aware of unsafe roof conditions in the cited area.

\(^9\) The Report, \textit{supra} Gx 10, p. 12, contains a map of the area at issue. The seals are marked on the left side of the map as five dark colored rectangles.
against the test of whether the support or control is what a
reasonably prudent person, familiar with the mining industry and
protective purpose of the standard, would have provided in order
to meet the protection intended by the standard.”

Canon Coal Co., 9 FMSHRC 667, 668 (Apr. 1987) (citing Helen Mining Co., 10 FMSHRC
1672, 1675 (Dec. 1988)) 20 FMSHRC 1277

In Cannon Coal Company, 9 FMSHRC 667 (April 1987), the Commission emphasized as
follows regarding the application of its reasonable person test as follows:

We emphasize that the reasonably prudent person test
contemplates an objective – not subjective – analysis of all the
surrounding

circumstances, factors, and considerations bearing on the inquiry
in issue. See, e.g., Great Western, supra, 5 FMSHRC at 842-43;
U.S. Steel, supra, 5 FMSHRC at 5-6.

9 FMSHRC at 668

The Commission, in Canon, supra, in affirming the judge’s decision that the test had not
been met by the Secretary set forth its rationale as follows:

The judge [examined] objective circumstances surrounding the
roof fall. 8 FMSHRC at 700-10. He concluded, in essence, that
the Secretary had failed to produce evidence that objective signs
existed prior to the roof fall that would have alerted a reasonably
prudent person to install additional roof support beyond the
support that actually had been provided by the operator. 8
FMSHRC at 710 (Emphasis added).

Canon, supra, at 668

Thus, under Canon, supra, in order to establish a violation of Section 75.202 (a), supra,
the Secretary has the burden of establishing the existence of “objective signs [that] existed prior
to the roof fall,” (emphasis added), and that these objective signs would have alerted a
reasonably prudent person to install additional roof support beyond that which had been actually
provided at the time. (Canon supra at 668). For the reasons that follow, I find that the Secretary
has failed to meet this burden.

It is most significant to note that the Secretary did not adduce the testimony of any
witnesses who had observed conditions of the roof prior to the fall at issue. Nor does the record
indicate that they were any persons who had observed the roof in the areas at issue prior to the
accident. The Secretary relies on McKinney’s notes taken on the date in question prior to the roof fall. These indicate “rockfall[s]” which appear to be noted by him inby spad 3825 (Gov. Ex. 9, p. 3). However, it is most significant to note that he did not set forth any observations of specific roof conditions which would have been indicative of need for further support.

Wilcox testified that when he traveled the green path on the morning at issue on the way to the location of McKinney’s body, he noted evidence of roof falls, the existence of a brow, and cracks. In addition, he said that he saw that the top was “ragged” (Tr. 409). Wilcox did not explicitly opine that these latter conditions had existed prior to the roof fall. To the contrary, he admitted on cross-examination that he could tell what the roof looked like before it fell on McKinney. He also conceded that timbers had already been set when he was in the area in question, that bolts, T-boards, posts, and straps were contained in the roof just north of the site where McKinney’s body was found, and that the bolts in the roof there looked secure. Critically, there is not any evidence of any indicia of inadequately supported roof such as: loose draw rock present on and above straps (See, Harlan Cumberland Coal Co., 20 FMSHRC 1275, 1277 (Dec. 1998), unsupported roof (See, Eastern Associated Coal Corp., 32 FMSHRC 1189, 1196 (Oct. 2010); a brow suspended four feet from the floor (See, Jim Walter Resources, 30 FMSHRC 69, 79 (Jan. 2008) (ALJ); ribs flaking and emitting a cracking sound, and roof bolts hanging down (See, Consolidation Coal Company, 19 FMSHRC 1897, 1905-6, 1908 (Dec. 1997); or areas of roof that had “potted out,” between bolts which resulted in some bolts becoming loose, or bearing plates that were not up against the roof, (See, Eastern Associated Coal Co. 31 FMSHRC 174, 179-180 (Jan. 27, 2009) (ALJ). Nor is there any evidence that prior to the accident the roof control plan had not been fully complied with.

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10 It is significant that there is not any evidence based on personal observations or forensics to indicate that these conditions were in existence prior to the roof fall at issue. Also, it is significant to note that under Section 75.202(a) supra, the requirement of providing roof support is limited to “areas where person work or travel.” There is not any indication in the record that persons work or travel along the green path. In this connection, I take cognizance of a statement by Jim Walter’s foreman Paul Arthur Phillips (Gov. Ex. 6, p. 20), that the green path represents the travelway used by miners. Not much weight was given to this statement as it was not signed by Phillips nor was it notarized. It is also significant to note that Phillips was not called to testify and there is not any showing that he was no longer available to testify. More weight is accorded the in-court testimony of John Aldrich, Safety Manager at the mine at issue, who testified that the “green path” was not utilized due to the presence of multiple area of rocks on the floor resulting from previous falls; instead, miners heading west to the evaluation point from the main track entry traveled the “red path” as illustrated on Gov. Ex. 10, p. 12.

11 He also conceded that it probably is correct to assume that the area through which McKinney passed contained been strapped and had at least two bolts.
Thus, for all the above reasons, I conclude that the Secretary has failed to establish by a preponderance of clear and convincing evidence that prior to the roof fall at issue, the roof conditions were such that a reasonable and prudent person would have recognized the need for additional support. Accordingly, I conclude that it has not been established that Jim Walter violated Section 75.202(a) supra.

ORDER

It is ordered that Citation Nos. 7689677, 7690107, and 7690417 be dismissed, and that the above captioned proceedings be DISMISSED.

/s/ Avram Weisberger
Avram Weisberger
Administration Law Judge

Distribution

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/cmj
June 15, 2012

SECRETARY OF LABOR, o/b/o  : DISCRIMINATION PROCEEDING
CHARLES SCOTT HOWARD,  : Docket No. KENT 2011-1379-D
   Complainant,  : Mine: Band Mill No. 2
   Respondent.  : Mine ID 15-18705

DECISION

Appearances:  Mary Sue Taylor, Office of the Solicitor, Nashville, Tennessee, on behalf of the Secretary of Labor;
   Tony Oppegard, Wes Addington, on behalf of Complainant;
   Willa Perlmutter, Glen Grant, Crowell & Moring, Washington D.C., on behalf of Respondent.

Before:  Judge Miller

This case is before me on a Complaint of Discrimination brought by the Secretary of Labor, on behalf of Charles Scott Howard against Cumberland River Coal Company, pursuant to section 105(c) of the Federal Mine Safety and Health Act of 1977, as amended, 30 U.S.C. § 815(c) (the “Mine Act” or “Act”). The parties presented testimony and evidence at a hearing in Pikeville, Kentucky commencing on March 14, 2012.

I. BACKGROUND

Cumberland River Coal Company (“CRCC”), Respondent, operates the Band Mill No 2 mine (the “mine”) near Eolia, Letcher County, Kentucky. (Tr. 167-168). CRCC hired Complainant, Charles Scott Howard (“Howard”), on March 21, 2005. Howard has held various positions at the mine and his most recent position was as a face worker in the belt corridor. 1 (Tr. 82). Howard worked in that position until July, 2010, when he was injured on the job. CRCC discharged Howard from his employment on May 16, 2011 after receiving a note from Dr. Robert Granacher, amending his first report, and explaining that Howard could not return to work as a coal miner due to the nature of his injury. However, Howard had seen a number of physicians, including two neurosurgeons, and all agreed that Howard could return to work without restriction.

1 Howard was classified as face worker, but he did not work at the face or in an area producing coal. At the time of his injury, Howard’s job duties primarily involved working on a track-load, picking up coal and dumping it on the belt.
Howard filed a complaint of discrimination with MSHA shortly after being terminated from his employment on May 16, 2011. Howard alleged that he was terminated for engaging in activity protected under section 105(c)(2) of the Mine Act, 30 U.S.C. § 815(c)(2), on numerous occasions from April 2007 until shortly before his termination. The Secretary of Labor (“Secretary”) seeks a $20,000.00 civil penalty for CRCC’s violation of the Act.

The parties entered into a number of stipulations, including that Howard engaged in a number of protected activities beginning in April, 2007 and continuing until May, 2011. (Tr. 8). The parties further agree that Howard was the subject of an adverse action by CRCC when he was terminated in May, 2011. The parties stipulated that CRCC is a mine operator subject to the provisions of the Mine Act and that the Commission has jurisdiction to hear this case. Additional stipulations include that CRCC is a large operator, that Howard is a miner as defined by the Act, and that the payment of the penalty will not affect CRCC’s ability to continue in business. (Tr.10).

II. STATEMENT OF LAW

Section 105(c)(1) of the Act, 30 U.S.C. § 815(c)(1), provides that a miner cannot be discharged, discriminated against, or interfered with in the exercise of his statutory rights because: (1) he “has filed or made a complaint under or related to this Act, including a complaint . . . of an alleged danger or safety or health violation;” (2) he “is the subject of medical evaluations and potential transfer under a standard published pursuant to section 101;” (3) he “has instituted or caused to be instituted any proceeding under or related to this Act or has testified or is about to testify in any such proceeding;” or (4) he has exercised “on behalf of himself or others . . . any statutory right afforded by this Act.”

In order to establish a prima facie case of discrimination under section 105(c)(1), a complaining miner must show: (1) that he engaged in protected activity; and (2) that the adverse action he complains of was motivated at least partially by that activity. Driessen v. Nevada Goldfields, Inc., 20 FMSHRC 324, 328 (Apr. 1998); Secretary on behalf of Robinette v. United Castle Coal Co., 3 FMSHRC 803 (Apr. 1981); Secretary on behalf of Pasula v. Consolidation Coal Co., 2 FMSHRC 2786 (Oct. 1980), rev’d on other grounds sub nom. Consolidation Coal Co. v. Marshall, 663 F.2d 1211 (3rd Cir. 1981). Factors to be considered in assessing whether a prima facie case exists include the operator’s knowledge of the protected activity, hostility or “animus” towards the protected activity, timing of the adverse action in relation to the protected activity, and disparate treatment. Secretary on behalf of Chacon v. Phelps Dodge Corp., 3 FMSHRC 2508 (Nov. 1981).

The operator may rebut the prima facie case by showing either that no protected activity occurred or that the adverse action was in no part motivated by the protected activity. Pasula, 2 FMSHRC at 2799-800. If the operator cannot rebut the prima facie case in this manner, it, nevertheless, may defend affirmatively by proving that it was also motivated by the miner's unprotected activity and would have taken the adverse action for the unprotected activity alone. Id. at 2800; Robinette, 3 FMSHRC at 817-18; see also Eastern Assoc. Coal Corp. v. FMSHRC, 813 F.2d 639, 642 (4th Cir. 1987).
The findings of fact that follow are based on the record as a whole and my careful observation of the witnesses during their testimony. In resolving any conflicts in testimony, I have taken into consideration the interests of the witnesses, corroboration or lack thereof, and consistencies or inconsistencies in each witness’ testimony and between the testimonies of witnesses. In evaluating the testimony of each witness, I have relied on his or her demeanor. Any failure to provide detail on each witness’s testimony is not to be deemed a failure on my part to have fully considered it. The fact that some evidence is not discussed does not indicate that it was not considered. See Craig v. Apfel, 212 F.3d 433,436 (8th Cir. 2000) (administrative law judge is not required to discuss all evidence and failure to cite specific evidence does not mean it was not considered).

III. FINDING OF FACT AND ANALYSIS

a. Protected Activities

In order to sustain his discrimination complaint, Howard must first demonstrate that he engaged in an activity or activities that are protected by Section 105(c) of the Mine Act. The record before me clearly establishes that Howard engaged in protected activities and the parties have agreed and stipulated that Howard engaged in a number of protected activities. As an initial matter, Howard engaged in protected activity when he filed 105(c) complaints with MSHA over the course of four years. See Secretary on behalf of Strattis v. ICG Beckley, LLC, 32 FMSHRC 614, 616 (June 2010) (ALJ) (holding that filing a 105(c) discrimination complaint is a protected activity for which operators are barred from retaliating against).

In the months, and even years, before CRCC terminated the employment of Howard, he engaged in numerous protected activities. As early as March, 2007, Howard testified before a Congressional committee about safety issues. In April, 2007 he made a video tape of leaking mine seals. The video was the subject of an email from Valerie Lee to a number of CCRC and Arch Coal management personnel, and an email from Mike Kafoury, counsel for Arch, to a number of others with a link to the video. Sec’y Ex. 120; (Tr. 140). After being reprimanded, Howard filed his first discrimination case with MSHA. Howard eventually filed four separate discrimination complaints with MSHA, raised safety issues with his supervisors on many, many occasions, filed civil lawsuits based upon discriminatory actions, called MSHA to make safety complaints, asked MSHA to conduct certain safety inspections, filed grievances naming specific managers for failing to protect miners, and engaged in other safety-related activity from 2007 until May, 2011 when the present case was filed. Sec’y Exs. 84 and 110; Howard Ex. 3. In May, 2011, just before he was terminated, Howard filed a civil lawsuit against CRCC as a result of alleged safety issues. All of these actions clearly qualify as activities protected under Section 105(c)(1) as exercising a statutory right afforded by the Act. There is no doubt that every person involved in this case and, indeed, every person at the CRCC mines was aware of all, or some, of Howard’s protected activity, either through the media or through discussions at work and in the community.

2 Arch Coal is the parent company of CRCC.
b. **Adverse Action**

While it appears that the mine has taken a number of adverse actions against Howard over the years of his employment, the action at issue here is the mine’s refusal to allow Howard to return to his job after being released to return to work by his treating physician. Instead, CRCC sought the supplemental opinion of a doctor who, after changing his mind from his earlier diagnosis, determined that Howard could not return to work. I find that the failure of the mine to allow Howard to return to work was an adverse action and, again, the parties agree that the actions taken by the mine satisfy the criteria for an adverse action. (Tr. 7-8).

c. **Discriminatory Motive**

Having found that Howard engaged in protected activity, it is then necessary to determine whether CRCC was motivated, at least in part, by those protected activities when it refused to allow Howard to return to work after being released to return by his treating physicians. The Commission has determined that direct evidence of actual discriminatory motive is rare. Short of such evidence, illegal motive may be established if the facts support a reasonable inference of discriminatory intent. *Secretary on behalf of Chacon v. Phelps Dodge Corp.*, 3 FMSHRC 2508, 2510–11 (Nov. 1981), rev’d on other grounds sub nom. *Donovan v. Phelps Dodge Corp.*, 709 F.2d 86 (D.C.Cir.1983); *Sammons v. Mine Services Co.*, 6 FMSHRC 1391, 1398–99 (June 1984). As the Eighth Circuit analogously stated with regard to discrimination cases arising under the National Labor Relations Act in *NLRB v. Melrose Processing Co.*, 351 F.2d 693, 698 (8th Cir.1965):

> It would indeed be the unusual case in which the link between the discharge and the . . . [protected] activity could be supplied exclusively by direct evidence. Intent is subjective and in many cases the discrimination can be proven only by the use of circumstantial evidence. Furthermore, in analyzing the evidence, circumstantial or direct, the [NLRB] is free to draw any reasonable inferences.

Circumstantial indicia of discriminatory intent by a mine operator against a complaining miner or miners includes hostility towards the miner because of his protected activity and disparate treatment of the complaining miner by the operator. *Chacon* at 2510.

I find that Howard has shown, by substantial evidence that there is a causal connection between the adverse action and the protected activities. First, the protected activity was extensive and known to each person who was involved with Howard’s work-related injury and subsequent termination. (Tr.55, 99). Second, Howard was known as a hard worker, and no complaints about his ability to perform his job were made. (Tr. 55-56). Hence there is no suggestion that Howard was terminated due to poor work performance and there was no incident that would have justified his termination. The only difficulty that CRCC had with Howard was the fact that he continued to make safety complaints and continued to contact MSHA. Finally, not only was there open hostility against Howard, he was treated differently than other miners who had suffered a work-related injury. Specifically, Denise Hartling, a member of Arch management,
authored an email to Underwriters, the workers compensation insurer (owned by Arch), and their employee, Penny Carter stating, from the beginning, that CRCC did not want Howard to return to work. This occurred in spite of the fact that the standard goal of an employer is to see that injured miners return to work as soon as practicable, thereby negating the need for workers compensation and medical payments. In her deposition, Hartling indicates that she was told by Arch that the mine did not want Howard back, but instead was looking to have him resign his position and not return to CRCC. Howard Ex. 1 p. 106. On December 17, 2010 Hartling sent an email to Denise Davidson, a worker’s compensation attorney, and Underwriters, with copies to Valarie Lee and a number of CRCC Human Resources personnel, in which she stated the following:

In any event, Dr. Granacher’s report from that 2002 injury is not favorable to the claimant so I am wondering whether we stand a chance of getting Granacher to give him an impairment rating. I still cannot get over the similarities of these two incidents that are 8 years apart…..

The hope is that we will get restrictions as we need to settle with a resignation. I think that both Sherry and Howard feel that they won’t get any restrictions and he will be back in the driver’s seat (not what we want).

Sec’y Exs. 42, 66. Hartling, also in December 2010, emailed Sue McReynolds of Underwriters to see if McReynolds had sent the file to the Arch Workers Compensation attorney and stated, “this will be her biggest challenge yet.” Sec’y Ex 32. The attitude demonstrated by Hartling is evidenced throughout the entire case. There can be no doubt that the mine sought to prevent Howard’s return to work under any circumstance, and the evidence demonstrates that the only reason for such action was his protected activity.

Howard was injured while working alone in June, 2010 and, as a result, was treated by a number of physicians, including Dr. Krishnaswamy, M.D., a neurologist, Sec’y Ex 10, Dr. Knox, Ph.D, a therapist who saw Howard several times, Sec’y Exs. 19 and 36, Dr. Reddy, M.D., an ophthalmologist, Sec’y Ex. 31, Dr. Burt, M.D., a neurosurgeon, Sec’y Exs. 28 and 54, Dr. Breeding, M.D., a board certified neurosurgeon and Howard’s primary care physician, Sec’y Ex. 88, Dr. Hartman, M.D., a board certified neurosurgeon, Sec’y Ex. 88; (Tr. 15 and 339), and Dr. Kedar, M.D., a neuro-ophthalmologist, Sec’y Exs. 29 and 118. Howard also, at the request of CCRC, saw Dr. Granacher, a neuropsychiatrist. Each doctor, in turn, saw no reason why Howard could not return to work. Granacher was the first to release Howard to return to work in March, 2010. Dr. Breeding and Dr. Hartman released Howard to return to “full duty at work.” Sec’y Exs 89 and 99. Dr. Kedar, who was given a letter by Penny Carter, Underwriter’s nurse, along with a copy of Howard’s job description and Granacher’s report, released Howard to return to

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3 Hartling was not able to attend the hearing. The parties agreed that her deposition would be entered into evidence.
work on April 12, 2011. Sec’y Exs. 29, 70, 72 and 118. By mid-April, 2011, each physician, including Granacher, agreed that Howard had reached his maximum medical improvement and that he could return to work.

Granacher initially restricted Howard from working at heights, but no other doctor who had seen Howard recommended any work restriction. In fact, Dr. Burt, a neurosurgeon, believed that Howard had no injury whatsoever. When Granacher’s first report was received by CRCC, the mine manager at CRCC, Gaither Frazier, explained to Valerie Lee of Human Resources that the mine could accommodate the height restriction and put Howard back to work. (Tr. 64). Instead, Lee, who was Frazier’s subordinate, decided that she would further clarify what the height restriction required. From this point forward, CRCC and Arch worked to keep Howard from returning to work. Lee testified that she explained to Sue McReynolds, at Underwriters, the need for clarification regarding Granacher’s restriction, but at no time did Lee inform any other person involved in Howard’s case that her superior, Frazier, had agreed that Howard could be accommodated and return to work. Moreover, at no time did anyone from CRCC, Arch, or Underwriters ask Granacher what he intended when he advised that Howard could not work at heights. Instead, at a meeting in March, it was decided that further information from Granacher was needed and that a job analysis would be provided. (Tr.356).

In an email from Penny Carter two days after she first met with Granacher in March, sent to Hartling (Arch), Lee (CCRC HR), McReynolds (Underwriters) and Davidson (workers comp attorney) she writes that “if the height restriction alone does not exclude [Howard] from returning to work, we may need to clarify further with the job analysis . . . This is certainly not one of the ‘usual’ cases.” Sec’y Ex. 62; (Tr. 348). After Howard saw Dr. Kedar for the last time and was released to return to work on April 12, 2011, Penny Carter asked Hartling if she should next provide Granacher with the same job analysis given to Kedar, or simply clarify the height restriction. Sec’y Exs. 70, 72, and 118. It was determined that a job analysis would be provided to Granacher.

When Howard asked to return to work in May, 2011, after receiving the releases from his various physicians, but before Granacher’s modified report, Frazier spoke to Mike Kafoury, counsel for Arch, along with Lee’s subordinate in HR, and confirmed that Howard could return and, if necessary, accommodations could be made. Kafoury had already learned that Howard’s physicians had released him to return to work and, after receiving a call on May 11, 2011, said that “[w]e should discuss how to handle Howard’s call today.” Sec’y Ex. 90. Frazier was not included in the email. Howard returned to work, for part of one day, to begin his training, but was told by McReynolds, and a few minutes later by Lee, that he could not return to work based upon a new determination made by Granacher. Sec’y Ex. 12; (Tr. 269).

Ample evidence of the disparate treatment of Howard can be found in the many conversations discussing Howard’s work-related injury and subsequent treatment. The record is replete with emails detailing every step that Howard took, every doctor, every diagnosis, every word said. The emails include Kafoury, the Arch attorney, Underwriters, Valerie Lee from

4 In an earlier discrimination case involving Howard, Lee was found to have been involved in the discriminatory actions taken against Howard.
CCRC Human Resources, and the contracted nurses. Most do not include Frazier, the only person who suggested Howard could be accommodated. Both in a conversation with Lee and with Kafoury, Frazier expressed his opinion that Howard could be accommodated. Frazier agreed that it was unusual to speak with Kafoury, the Arch attorney, before allowing a worker to return and that it often happened that an injured worker returned to work with some restriction. As Frazier and Lee explained, the general goal was to get miners back to work as quickly as possible after an injury. (Tr.57, 61). Lee further explained that, prior to Howard’s injury; she had not heard Hartling express the desire to see a miner be restricted from returning to work. In fact, witnesses for both sides agreed that the case of Howard was different in many ways from the normal worker injury case. (Tr.100). Penny Carter, the nurse who was employed by Underwriters to follow Howard’s case, did not normally deal with Denise Hartling or Mike Kafoury, both from Arch, when she was assigned a case, yet the record contains a plethora of emails going back and forth that include both of these high level Arch managers. Carter admits that this is the only case in which she sent emails to Hartling and faxed reports to her. Carter says she also spoke with both Hartling and Kafoury by telephone a number of times. Carter further testified that she only meets with worker’s doctors in the event she has questions but, in this case, Carter asked to meet with Granacher before he even conducted his evaluation of Howard. In addition, while Valerie Lee did not believe it unusual for Kafoury to be involved if a miner is returned to work with restrictions, when she was asked how many times that occurred in the past, Lee said “I don’t think he has... I don’t remember any.” (Tr. 178).

Arch Coal held quarterly meetings to discuss the status of employees off of work due to work related injuries. (Tr. 72-73). Although Arch personnel do not discuss every worker, a summary is prepared that contains each worker who is currently off of work due to a work-related injury. (Tr. 164). The meetings, beginning primarily in December, 2010, included discussions about Howard and were attended by personnel from Arch and CRCC, and included Valerie Lee from HR for CRCC, Denise Hartling of Arch management, Sue McReynolds from Underwriters, the insurer for Arch, Penny Carter, the nurse engaged by Underwriters to work on Howard’s case, Denise Davidson, a workers compensation attorney, Mike Kafoury, Arch attorney, and others. (Tr.73). The purpose of the meeting was to plan expenditures for workers compensation cases, and to discuss what treatments workers were receiving and what could be done to get the employee back to work. At the December, 2010 quarterly meeting, it was decided that Howard should see Dr. Granacher, who was not a member of the normal panel of doctors who see CRCC patients. Shortly after that meeting, on December 17, 2010, Hartling sent an email to Penny Carter, Valerie Lee and Sue McReynolds, see supra, in which she discussed Howard’s claim and explained that her “hope is that we will get restrictions, as we need to settle with a resignation.” Sec’y Ex. 66. Granacher eventually issued a report setting Howard’s impairment rating at 7%, and recommended a return to work with the restriction of not working “at height.” Sec’y Ex. 55. Granacher’s initial report contains a photo of Howard and specifies that it took ten and one-half hours, over two days, to complete the examination. The examination included a consultation with Dr. Joseph, a neurologist. The report is dated March 7, 2011 and is 27 pages in length with an additional three-page attachment that includes a summary of test results. Granacher’s lengthy initial report is full of information, some of it “canned” but, certainly, the report gives the appearance of being thorough. I note that Dr. Burt examined Howard after Granacher, conducted even more tests, and found that Howard did not suffer from any impairment.
Carter, the Underwriters nurse assigned to Howard’s case, notes that on March 7, 2011 she had a meeting with Granacher. He explained that Howard had a very mild brain injury and he had diagnosed a cognitive disorder with a 7% impairment rating. Granacher explained in his testimony that the impairment rating means that the brain impairment affects seven percent of the whole body. (Tr. 216). In his initial report, Granacher explained that the use of Zoloft should be enough to control Howard’s disorder and that his prognosis was reasonably good. Sec’y Ex. 55 p. 26. “In regards to work, advised that with any brain injury, it is recommended that no work is done at heights.” Sec’y Ex. 117. However, Granacher also testified that it is not his job to say whether someone can return to work, but rather to simply supply the employer and insurer with an impairment rating. (Tr. 241-242).

Shortly after Granacher’s initial report, Carter noted that, in a meeting on March 15, 2011, she received a job analysis from Valerie Lee that related to Howard. Carter subsequently provided a copy to Dr. Kedar and on April 11, 2011, after a final examination and review of the job analysis, Kedar released Howard to return to work. On April 15th Carter was advised to send the job description to Granacher for further evaluation. Carter, along with Arch management and CRCC, anxiously awaited Granacher’s further report leading Carter to contact his office almost daily, and eventually provide a second letter that was hand delivered to Granacher just days before the report was signed on May 16, 2011. Sec’y Ex. 117. Granacher did not ask to see Howard a second time or conduct further examination prior to rendering a supplemental report. Instead, he relied on the information and questions provided to him by Penny Carter.

Although both McReynolds and Lee insist that a supplemental report was sought from Granacher for the purpose of explaining the meaning of his restriction, Granacher was not asked that question. In the second report, issued in May, Granacher said instead, that Howard could not return to work as a coal miner. Sec’y Ex. 79. When questioned about his change of heart, Granacher had no real explanation, except to say that, even though he is intimately familiar with the work of a coal miner, he excluded Howard from work after reviewing the job analysis that was provided when the supplemental opinion was sought. (Tr. 227, 234). The job analysis was prepared by Lee, with some input from a supervisor in the area where Howard worked and, although CRCC argues that the job description was appropriate and accurate, I find, relying on Howard’s testimony, that it did not describe Howard’s actual duties. Instead it described the general duties of that classification of worker. Sec’y Ex. 79; (Tr.112). Lee testified that Gilliam, Howard’s supervisor, did not tell her that Howard works at heights. However, she included working at heights in the analysis as Gilliam told her it was a requirement for a face worker in general. (Tr.148 and 163). Lee put together the job analysis based upon a general underground face worker, even though Howard works on the belt line, which is not underground and not at a face. (Tr.171). Lee did not contact Howard to inquire about his specific job duties. (Tr. 255).

I note that, while the parties discussed the possibility of preparing a job description after reviewing Granacher’s first report, they held off seeking any further information from Granacher until all doctors had submitted their final reports. None of those reports contained work restrictions for Howard if he chose to return to his job at CRCC. It was only at this point that Penny Carter, at the direction of the mine operator, eagerly sought a second opinion from Granacher.
CRCC suggests that the various doctors who released Howard to return to work did not directly address his head injury. For example, according to CRCC, Burt released Howard to go to work but only for purposes of his back and neck injury. It argues that each doctor addressed a discrete part of the injury, and each release related only to that part of the overall injury. While I understand that some doctors may not have addressed the injury that Granacher addressed, that does not explain why CRCC needed a further evaluation from Granacher and not from any other doctor or specifically from one of the neurosurgeons who would have addressed the specific head injury.

At hearing, the parties generally relied upon the testimony of the same witnesses. Gaither Frazier, the mine manager, credibly testified that the mine could accommodate the restriction of working at height originally recommended by Granacher. (Tr. 64). Valerie Lee was not as credible and did not pass on the information about the possibility of an accommodation to others involved in the case. (Tr. 115). Penny Carter, while credible, could not adequately explain her actions in dealing with Arch and Granacher. Sue McReynolds did not recall much, but it is obvious that she knew that her employer, Arch, and, in turn, CRCC, did not want Howard to return to work. Finally, Denise Hartling, who appeared through her deposition, unsuccessfully attempted to explain her emails that directly and clearly demonstrate that Respondent would settle only for a resignation from Howard and the mine would do whatever necessary to achieve that end. There is ample testimony and much detail that I have considered in reaching my conclusions. I find that there is a significant amount of both direct and circumstantial evidence that demonstrates CRCC terminated Howard because of his protected activities. Howard was not only terminated the same day that CRCC received the one paragraph supplemental report from Granacher indicating that Howard could not return to work, but within hours. (Tr. 272).

Therefore, I find that the Secretary and Howard have met the burden of demonstrating a prima facie case of discrimination. I find no credible evidence to rebut the prima facie case.

d. Affirmative Defense of Operator

Having found that Howard has established a prima facie case of discrimination, I must still consider evidence that may indicate that CRCC terminated Howard based upon a legitimate business purpose and “would have taken the adverse action for the unprotected activity alone.” Secretary of Labor on behalf of Robinette v. United Castle Coal Co., 3 FMSHRC 803, 817-818 (1981). Secretary on behalf of Pasula v. Consolidation Coal Co., 2 FMSHRC 2786 (Oct. 1980).

The Commission has enunciated several indicia of legitimate non-discriminatory reasons for an employer's adverse action. These include evidence of the miner's unsatisfactory past work record, prior warnings to the miner, past discipline, and personnel rules or practices forbidding the conduct in question. Id. The Commission has explained that an affirmative defense should not be “examined superficially or be approved automatically once offered.” Haro v. Magma Copper Co., 4 FMSHRC 1935, 1938 (Nov. 1982). In reviewing affirmative defenses, the judge must “determine whether they are credible and, if so, whether they would have motivated the particular operator as claimed.” Bradley v. Belva Coal Co., 4 FMSHRC 982, 993 (June 1982). The Commission has held that “pretext may be found . . . where the asserted justification is weak, implausible, or out of line with the operator's normal business practices.” Sec'y of Labor on behalf of Price v. Jim Walter Res., Inc., 12 FMSHRC 1521, 1534 (Aug. 1990).
Here, CRCC asserts that it would have taken the action against Howard based upon the fact that it received information from a reliable doctor that Howard could not return to work as a coal miner. According to CRCC, based upon that information, it could not take the risk of endangering the safety of Howard or other miners. While any number of doctors released Howard to return to work, CRCC takes the position that the finding by Granacher that Howard could not return to work is a legitimate, non-discriminatory reason for it to terminate his employment. I agree that CRCC has a reasonable concern about the safety of returning any injured miner to work, but the circumstances in this case do not lead to the conclusion that terminating Howard was justified.

It is obvious that CRCC worked diligently to end Howard’s employment. The mine waited until every doctor, including two neurosurgeons, two eye doctors, a psychiatrist and others found no impairment and agreed Howard could return to work. Then it asked Granacher to further review his first finding of a 7% impairment and a restriction against working at height. It is interesting to note that Granacher did not see Howard prior to making his second determination, did not change his impairment rating the second time, and did little more than answer a paragraph submitted to his office by Penny Carter. (Tr. 225). Yet Granacher in his testimony recalled that his supplemental view that Howard could never work in coal mining was based upon “this catwalk issue, working in heights of five to twenty feet.” (Tr. 227). As discussed above, CRCC did not seek to clarify the earlier restriction of working at heights, but instead submitted a job analysis that, while applicable to the general pay rate of Howard, did not accurately reflect Howard’s duties.

Frazier testified after receiving the Granacher report in March that the mine could accommodate Howard. If the height meant not climbing ladders or working in high or confined space, Howard could still be accommodated by the mine. Willie Gilliam, Howard’s supervisor, agreed that he would assign work to Howard according to any restrictions he may have. The mine fired Howard with little consideration once Granacher’s amended report was received. No one thought to discuss possible accommodation, to question Granacher further, or to seek another opinion given the disparity of the many reports received about Howard’s injury and his ability to return to work.

I find that the mine sought out and received the opinion they were seeking and immediately upon receipt of that single opinion, terminated Howard’s employment. The mine attempted to achieve its goal first by providing the job analysis to Kedar to have a restriction imposed and, when that failed, they went to Granacher for a further opinion. At hearing, Granacher made it clear that he works for “lawyers representing virtually every major coal company in Kentucky[.]” (Tr. 208). Granacher’s actions are questionable and while he angrily defended his decision, Granacher did not explain why the conclusions were so drastically different, but the impairment rating had not changed. (Tr. 234-235). Finally, if Howard’s injury was so severe, as Granacher indicated in his testimony, why wasn’t that discovered prior to the issuance of the first 27-page report. No further tests or examination of Howard were conducted in reaching the second conclusion.
CRCC argues that they chose to rely on Granacher’s second opinion because his specialty is different from that of the other doctors. Specifically, the mine argues that, since Howard had complaints about vision, his eye doctors signed off on only a part of the injury, as did the examining neurosurgeons. Moreover, the mine avers that Granacher dealt in a different way with the head injury and, therefore, a different opinion would not be out of the ordinary. I do not find these arguments persuasive. Given the many physicians who examined Howard, including several neurosurgeons whose specialties are integrally related to Granacher’s, something should have come up to demonstrate that Howard’s injury had resulted in some type of impairment. If the other doctors had given any kind of impairment rating, it may have been different, but they found none at all. In this circumstance, it certainly required more review and consideration before relying on the changed opinion of Granacher. See Sec’y Ex. 108.

I find that CRCC did little if anything to reconcile the many differences of medical opinion before quickly terminating Howard without any substantive basis for the termination. After carefully considering the credibility of all witness, I find that CRCC did not have a legitimate business reason to terminate Howard and that the affirmative defense is without merit.

e. 

Penalty

The Secretary has proposed a penalty of $20,000 in this case. There is some evidence in the record as to the penalty criteria but more importantly, there is ample evidence of blatant discrimination against Howard to support a high penalty. The discrimination against Howard ran through CRCC and its parent, Arch, at the highest management levels. The evidence supports a finding that Respondent acted willfully and used any means available to terminate Howard. CRCC, together with its parent company, is a large operator. CRCC has been found guilty of discrimination against Howard in the past and in that case a penalty of $10,000 was assessed. Therefore, I find it appropriate to assess a penalty of $30,000 against CRCC in this instance.
IV. ORDER

Cumberland River Coal Company is ORDERED to immediately reinstate Charles Scott Howard to his previous position as a permanent full time employee with an equal or greater rate of pay, along with all benefits that relate to that position. CRCC shall, within ten days of this order, post this decision along with a visible notice on a bulletin board that is accessible to each and every employee, explaining that the company has been found to have discriminated against an employee, that such discrimination will be remedied and that it will not occur in the future. The notice shall inform all employees of their rights in the event they believe they have been discriminated against. All reference to the termination of Howard, and the reasons therefore, shall be removed from his personnel file. Since Howard has been temporarily reinstated to his former position, he seeks no back wages or other monetary relief.

Within 30 days of the date of this order, CRCC is ORDERED TO PAY a penalty in the amount of $30,000 for the violation of section 105(c) of the Mine Act.

/s/ Margaret A. Miller
Margaret A. Miller
Administrative Law Judge

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I. Statement of the Case

This case is before me upon a petition for assessment of a civil penalty under section 105(d) of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 815(d).

This case is before me upon a petition for civil penalty filed by the Secretary of Labor pursuant to section 105 of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. §§ 815 (the “Mine Act”). The parties stipulated to the following facts: that Respondent Cemex is an operator, whose Inglis Quarry is subject to jurisdiction under the Act; that Gary Navarro was a miner employed by Respondent’s maintenance contractor, Tampa Armature Works (TAW), at the time that he suffered an injury on August 10, 2009, while performing maintenance on Respondent’s dragline; that no employee of Respondent was present to witness the incident; and that the proposed penalty of $5,000 does not affect Respondent’s ability to remain in business.1

1 Five thousand dollars is the minimum penalty the Secretary may assess under §

(continued...)
At issue is Citation No. 8553410 issued by the Department of Labor’s Mine Safety and Health Administration (“MSHA”) under Section 104(a) of the Act alleging a violation of 30 C.F.R. § 50.10(b), which provides:

30 C.F.R. § 50.10: The operator shall immediately contact MSHA at once 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) An injury of an individual at the mine which has a reasonable potential to cause death.

Citation No. 8553410 was issued to Respondent Cemex on August 9, 2010, some thirteen months after the incident, during MSHA’s investigation of an anonymous Code-A-Phone complaint. That complaint alleged that an MSHA 7000-1 form completed on August 10, 2009 understated the seriousness of the injury that Navarro incurred. P. Ex. 1; R. Ex. 1, p. 3; Tr. 37-39. The MSHA 7000-1 report, which is referenced in the written summary of the anonymous Code-A-Phone complaint allegation and triggered MSHA’s September 2010 investigation, is not in evidence. See R. Ex. 15, p. 3.

Citation No. 8553410 alleged the following condition or practice:

An accident occurred at this mine on August 10, 2009. A contractor employee received an electrical shock that could have resulted in a fatal injury. The employee was unconscious for approximately one minute and had a serious injury to his left shoulder. The mine operator was aware that the employee was shocked and injured but failed to immediately notify MSHA of the accident.

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1(...continued)

110(a)(2) of the Mine Act, 30 C.F.R. § 820(a)(2), for failure to timely report . . . an injury at a mine that has a reasonable potential to cause death.

2 As a result of his investigation, MSHA inspector, John D. Reed, issued three section 104(a) citations: Citation No. 8553409 issued to TAW for violation of 30 C.F. R. § 50.20(a) requiring, inter alia, each operator to report each accident, occupational injury, or occupational illness at the mine; and Citation Nos. 8553410 and 8553411, issued to Cemex and TAW respectively, for violations of 30 C.F.R. § 50.10(b). See R. Ex. 15, p. 3; Tr. 123-24. Only Citation No. 8553410, which was issued to Cemex, is at issue here.

3 In this Decision and Order, the Petitioner’s or Government’s exhibits are designated P. Ex. #, Respondent’s exhibits are designated R. Ex. #, and citations to the transcript are designated as Tr. followed by page number(s). P. Exs. 1-5 were received in evidence. R. Exs. 1-7, 9, 10, and 13-15 were received in evidence. There is no R. Ex. 8 or 12. R. Ex. 11 was withdrawn. Tr. 12-13, 294, and 383.
Negligence was alleged to be high and gravity was alleged to be no likelihood of injury, no lost work days, and not significant and substantial (non-S&S).

An evidentiary hearing was held in Tampa, Florida on January 12, 2012. The parties introduced testimony and documentary evidence. Witnesses were sequestered.

For the reasons set forth below, I find that no immediately reportable accident occurred on August 10, 2009 because Navarro’s injuries from electric shock did not have a reasonable potential to cause death under the totality of facts and circumstances present in this case. Rather, I agree with the Respondent that the objective, contemporaneous and credible evidence surrounding the incident supports the conclusion that Navarro did not sustain an injury that was immediate reportable because it had a reasonable potential to cause death. Accordingly, I vacate Citation No. 8553410.

On the entire record, including my observation of the demeanor of the witnesses, and after considering the post-hearing and reply briefs of the parties, I make the following:

II. Summary of the Testimony

A. The August 10, 2009 Injury and Subsequent Events

1. Navarro’s testimony

On August 10, 2009 at 8 a.m., TAW lead mechanic Michael Watson and mechanic Gary Navarro, signed into Respondent’s Inglis Quarry to perform preventative maintenance services on Respondent’s dragline. That work included inspection of heaters, which kept moisture out of the motors. R. Ex. 7; R. Ex. 14; Tr. 161-62, 241–42, 218-19, and 295. Respondent’s dragline operator, Michael Millen, discussed the scope of work with Watson and Navarro and followed them to the dragline, before embarking on his own work of moving dragline equipment. Tr. 241-42.

Watson and Navarro initially removed panels from the dragline motors to check the brushes and heaters. Tr. 162-63. Navarro was wearing regular, cotton work gloves issued by TAW. Tr. 192-93. Navarro testified that as he was lying on his stomach on the metal surface of the dragline platform, he reached under a motor and pushed some wires with his hand to

4 Watson and Navarro are good friends, who have known each other for five or six years and socialize off the job. Tr. 218. Both received site-specific hazard training, including training on Respondent’s lockout/tagout policy. Tr. 117, 225; R. Exs. 3 and 4.
This account is inconsistent with the report that Watson prepared for TAW concerning the incident. See R. Ex. 13, discussed infra.

As he did so, Navarro testified that he received a “very painful” electric shock that caused his muscles to “tense up really hard to where [he] couldn’t move.” He remembers thinking, “I needed to get off of them . . . that’s all I remember.” Tr. 164. Navarro does not remember crying out, but Watson told Navarro that he did so. Tr. 165, 202.

When asked what happened next, Navarro testified as follows:

A Well, I remember -- I would say waking up and seeing Michael Watson standing there laughing at me, which I was totally in shock. And I was telling him that I was having a heart attack because I felt like I was having a heart attack.

Q When you say you felt like you were having a heart attack, what did that feel like to you?

A My chest is pounding, and my -- just pounding really hard, like I couldn’t catch my breath, and my heart was just beating very hard. And I was just, you know, totally in shock of the whole experience.

And I kept yelling out to him that I was having a heart attack, and he just kept laughing at me until he figured out that I wasn’t joking because I was passing -- passing out. I kept passing in and out. And so he had to grab ahold of me, and he hung on to me, and then he looked at me --

Am I going too far?

Q No.

A Okay. And he looked at me, and he said to me, “What’s wrong with your arm?” Which he was talking about my left shoulder was way out of socket. My arm was sticking up in the air.

And he -- and I looked at it, and I was like, “I don't know.”

And so he grabbed my arm, and he pulled up on it and it popped in joint, so it was obviously popped out of joint.

Q Do you remember if you hit that arm on anything?

A There was nothing there that I could see that I would have hit my arm on, but no, I don't remember anything like that. I do not remember hitting my arm.

Q Okay.

THE COURT: Do you remember hitting your shoulder?

THE WITNESS: No. I -- I had no inclination about hitting my shoulder. There was nothing there that I probably would have been able to hit my shoulder on.
I note that electrocution is death caused by electric shock. Electrocution is frequently used to refer to any electric shock received, but that reference technically is incorrect. Inspector Reed confirmed the difference between electric shock and electrocution or death by shock. Tr. 65-66. Navarro certainly did not die, but did suffer injuries (a burn on his left hand and a shoulder sublaxation) from electric shock.

On cross, Navarro could not recall getting in the vehicle that Watson drove to the hospital, could not recall stopping at the shop on Cemex property on the way out, and did not recall talking to dragline operator Mike Millen that day, although Navarro subsequently acknowledged that he was present when Millen spoke to Watson at the dragline prior to the incident. Tr. 180-81. On redirect, Navarro recalled speaking with Millen about the brushes before arriving at the dragline, but did not remember seeing or speaking with Millen or anyone from Cemex after he sustained the electric shock.

Navarro then testified that Watson used his cell phone to call someone and Navarro heard Watson tell this person that Navarro had been “electrocuted.”6 Navarro further testified, without additional explanation, that he could hear the person talking on the phone tell Watson, “Take him to the hospital.” Tr. 167. According to Navarro, as they were leaving the dragline, Navarro’s shoulder again popped out of joint and he began “screaming at [Watson] again” until Watson lifted Navarro’s arm up in the air and popped his shoulder back into joint. Tr. 167-68, 179. After that, Navarro did not recall “too much. . . I don’t even know how I got off the dragline, to be honest with you.”7 Tr. 168.

Navarro recalls being at the hospital, but does not “particularly remember going to the hospital.” Tr. 168. At the hospital, Navarro recalls observing wires stuck to his chest and a discussion with the doctor. Navarro recalls the doctor stating that he had been “electrocuted” and that “. . . normally when somebody’s laying. . . flat on an iron plate that usually the electricity just runs straight through you without leaving any wounds.” Tr. 168-69. Navarro testified that after that, he did not remember much, and was “in and out.” Tr. 169.8

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8 On redirect, Navarro testified that he does not remember losing consciousness, but does remember waking up. Tr. 189. When asked on further redirect whether Navarro believed that the incident could have caused his death, Navarro testified, “Oh, yes. Oh, yes, I do. I -- I mean, I (continued...)
I generally discredit this testimony from Navarro. Navarro did not impress me as a very reliable witness while testifying on the stand, and I find his testimony to be rehearsed and exaggerated in an effort to establish a loss of consciousness and augment the intensity and severity of the injury that he actually sustained from a momentary, startling electric shock of moderate severity. In addition, Navarro’s testimony that he passed in and out and does not remember hitting his shoulder is undercut by his own testimony that Watson was laughing at him, and by contemporaneous medical records in which Navarro informed examining personnel that he did not sustain loss of consciousness and he jumped up and hit his left shoulder on a bar and dislocated it. See R. Ex. 1, pp. 1-2 discussed infra. I find the contemporaneous medical records about what happened to be the best and most reliable evidence. I further find, as explained herein, that the Secretary failed to establish that Navarro lost consciousness.

Page one of the contemporaneous medical records indicates, inter alia, that Navarro presented at the hospital at 11:43 a.m., and was triaged at about 11:50 a.m., with “Chief Complaint - BURNS - ELECTRICAL.” Navarro was examined at 11:52 and a history was taken from the patient. The initial exam states, inter alia, “Current source was AC. Patient did not sustain loss of consciousness. Patient states symptoms are of moderate intensity. SHOCKED BY ELECTRICAL ENGINE -240-VOLTS-LOW AMPS-WHEN HIT, THROWN BACK AND HIT L SHOULDER AND FELT LIKE IT WAS DISLOCATED.”

Page two of the contemporaneous medical records is an initial assessment form that was signed by a hospital nurse and contains, inter alia, the following: “Brief Assessment: per pt states electrical shock to left hand. States went up to shoulder, jumped up and hit left shoulder on bar and dislocated it. States was able to [replace] it by himself but keep coming dislocated. Pt noted to have no burn injuries at this time.” Pain intensity was assessed at seven on a scale of ten at the shoulder location.

Page three of the contemporaneous medical records indicates that Navarro received a primary assessment about 12:05 p.m., after he was moved to a hospital room for several types of assessments. The psychosocial assessment states, inter alia, “Patient demonstrates normal behavior . . . . is able to ambulate independently, and can perform all activities of daily living without assistance.” The brief assessment states, “Patient is alert and oriented x 3. Respirations are unlabored. Skin is warm and dry, vascular status intact.” The pain assessment states “Patient rates pain as 7 on a one-to-ten scale with ten as the worst pain ever. Pain is located in the left shoulder. Onset of pain was sudden, within the past 3 hours, Patient describes the pain as constant, aching. Pain is exacerbated by movement activity.” The cardiovascular assessment

8(...continued)

honestly felt like I was having a heart attack, and I honestly felt like I wasn't going to make it out of that place.” Tr. 191.

9 On questioning from the undersigned, Navarro confirmed a clear recollection of Watson laughing because his laugh is kind of silly. Tr. 199.
states, that “EKG was performed at 08/10/2009 12:06 by tech.” The musculoskeletal assessment states, “Patient rates pain as 8 on a one-to-ten scale . . . . Reports a minor injury that is to the shoulder left, skin temperature at injury site is warm to touch, capillary refill is less than 2 second distal to the injury site, decreased range of motion above and below the injury site, swelling at the site is minimal.” The integumentary assessment states, “Skin temperature is warm and dry. The burn is caused by electricity. The burn appears to be red. Pain or injury is located in the left hand.”

Thereafter, Navarro was treated with 5 mg of Percocet and a sling and swathe for left shoulder, which Navarro tolerated well upon final reassessment at 1:20 p.m. At that time, splint was intact with good vascular status, as evidenced by strong distal pulses and capillary refill in less than two seconds, with skin pink and warm. See R. Ex. 1, pp. 1-3.

On questioning from the Court about statements made to hospital personnel as captured in contemporaneous medical records (R. Ex. 1, pp. 1-3), Navarro attempted to distance himself from those records, which undercut his previous testimony. He testified as follows:

Q   Do you recall making that complaint to anyone at the medical center, “burns - electrical”?  
A   I'm sure I did.  
Q   What about the brief assessment below that? It says “Per patient, states electrical shock to left hand. States went up to shoulder. Jumped up and hit left shoulder on bar and dislocated it. States was able to” – is that retrace or – can anybody help me out? – “replace it by himself but keep coming dislocated. Patient noted to have no burn injuries at this time.”  
A   I don't recall, really, making any type of statement like that.  
Q   Let me direct your attention to page 1 of that document .  
A   Okay.  
Q   And under – do you see where it says “Chief Complaint” again?  
A   Uh-huh.  
Q   It says "Burns - electrical" there in the second paragraph or so. Do you see that?  
A   Can I look at it for a second? My eyes ain't all that great. Okay. Must be the top phrase, right? I'm not 100 percent sure what I'm looking at.  
Q   I'll direct your attention to this area here. It says “Chief Complaint: Burns - electrical,” and then the material underneath there, can you see that clearly?  
A   Yes, I can see it.  
Q   Okay. It indicates “Patient states symptoms are moderate intensity.” And above that, it says, “Patient did not sustain loss of consciousness.” Do you recall – do you recall telling anybody at the hospital that?  
A   Not at all, no.  
Q   Below that, it says “Shocked by electrical engine - 240 volts - low amps - when hit, thrown back and hit left shoulder and felt like it was dislocated.”
Do you recall making any statements to that effect?

A  I would never have made that kind of a statement, no, because there were – I couldn’t move anywhere. So being thrown back, you would have to be on your feet to be thrown back. I was not on my feet. I was laying on my stomach.

Q  Was – where was Mr. Watson when you were being evaluated by personnel at the medical center?

A  I think – I think he was out in the waiting room.

Q  Do you know whether Mr. Watson spoke to medical personnel at the –

A  I don’t. I don’t know if he spoke to them or not.

Q  Did he accompany you when you spoke to medical personnel? I mean, was he –

A  He checked me in. He checked me in. He was the one that checked me into the hospital.

Q  Describe the check-in process that you recall.

A  Going up – walking up to the front desk and signing my name and them asking him what was wrong with me and what happened to me. And then them proceed to take me to the back. I mean –

Q  Did you tell them what was wrong with you at that point in time?

A  Honestly, sir, I cannot – I don’t recall me telling them what happened or anything like that.

Q  Do you recall Mr. Watson telling them what happened?

A  I recall him checking me in, but I don’t – when they took me back there, I didn't see him for a while. So whether they talked to him or not, I don’t know.

Q  When they took you back there, where did they take you?

A  Back to a room that just had a curtain that would wrap around it.

Q  Was Mr. –

A  Sitting on the table.

Q  – Watson left in the waiting area at that time?

A  Yes, I believe so.

Q  Okay.

A  But I do recall him coming out to the waiting – I mean to the back room after they were talking to me or after they had the things on my chest and everything. He came out there. I mean, that's – that's what I think happened.

Tr. 193-97.

When asked on direct what happened after leaving the hospital, Navarro testified that Watson told me that he “needed to go pick up his tools off the dragline and take the locks off the dragline. . . . ” Navarro testified that he returned to Cemex’s Inglis Quarry with Watson because Watson was his “only ride home.” Navarro emphatically denied seeing or talking to anyone from Cemex when they returned because it was “after hours. . . so there was absolutely nobody
No one from Cemex ever called Navarro to ask how he was doing or request a copy of his medical records. Tr. 169.

On cross-examination, Navarro did not recall where he was on the dragline when he was shocked, but denied that he was under a shaft or anything like that, as depicted in Respondent’s Exhibit 9. Navarro denied having to climb down into any confined area to access the site where the incident occurred. Rather, he testified that he ascended steps and stepped up on a platform, where two motors laid side-by-side, and then laid down beside the two motors and looked under one. Tr. 173. Once again, I note that this account is inconsistent with Watson’s report of the incident to TAW, as set forth in Respondent’s Exhibit 13, page 2, which indicates that while climbing out of the pit, Navarro’s right arm brushed against live heater lead wires, which caused him to sustain an electric shock, with no burns, but shoulder sublaxation.

The record indicates that Navarro revisited the Cemex site in May 2010 (some nine months later) with an attorney to consider filing a lawsuit against Cemex. At that time, he could not recall where he was injured. Tr. 174, 177, 179. No suit had been filed at the time of the hearing, although since the site visit Navarro had retained another law firm. Tr. 184, 186, 353. 11 Navarro retained separate counsel to file a workers’ compensation claim against TAW, which paid for shoulder surgery at some unspecified date after the incident and prior to the hearing. Tr. 178. At the time of the hearing, Navarro was still receiving treatment for his shoulder injury and had been on workers’ compensation for about six months as a result of the incident. Tr. 178-79, 198. Navarro denied injuring his shoulder prior to the August 10, 2009 incident. Tr. 179.

On re-cross, when asked why 911 was not called, Navarro testified, “I was in shock . . . I just did not think about something like that. Why anybody else didn’t do it, I have no idea . . . .” Tr. 190. On further re-cross, Respondent’s counsel established that an EKG was taken at the hospital. No abnormalities were noted. See R. Ex. 1, p. 3; Tr. 191.

10 Navarro was discharged from the hospital sometime shortly after 1:20 p.m. See R. Ex. 1, p. 3. Watson testified that he drove Navarro immediately back to the quarry, about a ten to fifteen minute ride. Watson further testified that although the quarry was not closed, they did not check in because there was nobody to check in with. Rather, they drove straight to the dragline so Watson could collect his tools and determine the voltage that had shocked Navarro. Tr. 224. As further explained below, I discredit this testimony from Navarro and Watson that they did not speak with anyone upon their return from the hospital. I credit Millen’s clear recollection that he again spoke with Watson and Navarro at the shop area upon their return from the hospital. Tr. 253-254, 273-274.

11 When assessing Navarro’s credibility, Respondent asks the Court to take judicial notice of the fact that the statute of limitations for a personal injury claim in Florida is four years (see F.S.A. § 95.11 (3)(a)), which has not yet expired. R. Br. at p. 5, n.3.
2. Watson’s testimony

Watson testified that at the time of the incident, he was standing on the other side of the motor above the platform where Navarro was located and heard Navarro yell out. Watson then “jumped around” and saw Navarro “kind of dazed and kind of limp.” Tr. 202-03, 215. Watson does not remember whether Navarro was sitting down or standing up, but there was a shaft there and Navarro was located by that shaft. Tr. 203. On cross, Watson confirmed that he laughed at Navarro because he thought Navarro was joking around at first, and it was funny before Watson realized what happened. Tr. 208-09.

On questioning from the Court during cross, Watson testified “. . . I don’t recall exactly if he was standing next to the shaft or if he was kind of leaning down here on the thing, but he was – just kind of limp, and, you know, his eyes were closed. I grabbed him up and drug him the best I could to a good spot, and he was still limp. And, you know, I – I got him to where I could get him on his feet completely, you know, then he started coming around. And I was asking him, ‘are you all right?’” Tr. 216-17. On further questioning from the Court, however, Watson could not recall whether Navarro’s eyes were open or closed when he was laughing at him. Tr. 217. Thereafter, Watson told the Court that Navarro was kind of crouched down leaning against the shaft and did not make eye contact with him, but once Watson got Navarro up and moving, they made conversation. Tr. 231-32.

Watson identified the wires that shocked Navarro as a thermistor lead and a heater lead, which were untaped as depicted in the Secretary’s Ex. 3. Tr. 209-10. After identifying Respondent’s Exhibit 9 as an accurate photograph of the area where the leads were located, Watson testified that in order to touch the leads, one had to be underneath the shaft and either climb down into the area or lay on the platform. Tr. 211-12, 214. When Watson first observed Navarro after the incident, Navarro was below the shaft on the little platform marked with an X on Respondent’s Exhibit 9. Tr. 213-14.

Watson testified that Navarro needed help to leave the shaft area and was not walking on his own. Rather, Watson carried his weight for a minute or so until Navarro started “coming to” and was able to function a little bit and help Watson out. Tr. 203-04. Watson further testified that he helped Navarro up by grabbing his arms and heaving him around his belly or chest area. Tr. 232. When asked whether Navarro lost consciousness at that time, Watson testified. “Yeah. He was out of it when I was holding him. He was unconscious when I . . . grabbed him . . . ” for “a minute or less.” Tr. 204. I discredit this testimony as an effort to embellish a friend’s case two years after the fact, given the equivocal recollection about loss of consciousness at the time of inspector Reed’s investigation a year later, and contemporaneous medical records at the time of the 2009 incident, which show no loss of consciousness.
Watson testified that Navarro was responsive once they reached the walkway above the platform area where the incident occurred. When Watson asked if he was okay, Navarro said no, his shoulder was hurting. Tr. 205-06, 215. Watson noticed “bone sticking up,” but Navarro was able to hold a semi-comfortable position. Tr. 206. Watson helped Navarro relocate his shoulder. Tr. 222.

Watson testified that he called TAW supervisor, Dennis Palowski, and told him that Navarro “got hurt. Just told him what happened and we were going to the hospital.” Tr. 206-07. Watson testified that he then called Millen and told him “[t]hat Gary got hurt and we were going to the hospital.” Tr. 207. Watson testified that he did not call 911 because Navarro “was conscious once we got settled.” Tr. 219. On cross, Watson had no recollection of talking to Millen at the shop area before leaving for the hospital. “No. I mean, I can’t remember. I don’t think we did, but I don’t know.” Tr. 226.

On direct, Watson testified in cursory fashion that he took Navarro to the hospital and then came back to Inglis Quarry to get his tools. He testified that he did not see or speak with anyone from Cemex about the incident thereafter. Tr. 207-08.

On cross, Watson testified that Navarro spoke with him on the way to the hospital and complained of pain in his shoulder. Tr. 221. Watson further testified that on the way to the hospital, Navarro “wasn’t regular Gary” and only made sense part of the time. Watson could not specify, however, how Navarro’s small talk (“jibber-jabber”) made no sense. Tr. 227-28. Watson did not recall whether he gave any information to hospital personnel, and then testified “I don’t think I said anything.” Tr. 221. On further questioning from the Court, Watson testified that he drove Navarro to the emergency room entrance, took him inside, but did not check in with him, and then parked his vehicle. Tr. 229-30. Thereafter, Watson sat with Navarro in the lobby until Navarro was called back for his examination. Contrary to Navarro, Watson testified that he never went back to the examination area. Tr. 231. Having observed Watson and Navarro testify, I credit Watson in this regard, particularly since on questioning from the bench, Navarro appeared to be searching for a way to justify his testimony with inconsistent medical records. See Tr. 193-97, quoted above.

Watson testified that after returning from the hospital, he tested the leads with his Fluke meter by lying on the platform, while Navarro remained in the truck. Watson determined the voltage to be about 200. Tr. 210, 228.

Watson further testified that TAW supervisory project manager, Jim Stoutamire, asked Watson to complete a report about the incident. Tr. 219-20. The only report in evidence is an OSHA 301 form, which indicates that it was completed by Stoutamire and Watson some time before review by a TAW plant manager on August 12, 2010. R. Ex. 13. That report indicates that the incident occurred at 10:45 a.m. on August 10, 2009. It further indicates that as Navarro was climbing out of the pit on the dragline next to hoist motor # 1, “[h]is right arm brushed against the live lead wires which caused him to get electrically shocked. He sustained no burns but did have shoulder sublaxation.” Id.
3. Testimony from Respondent’s witnesses

a. Millen’s testimony

Dragline operator, Michael Millen, testified that during the late morning right before lunch, he spoke with Watson and Navarro in front of the shop area before they left for the hospital. Tr. 243. Millen credibly testified that he was around the shop area with the loader, when he saw Watson’s truck parked in front of the shop, and stopped to see how Watson and Navarro were doing. Tr. 243. According to Millen, Watson was leaning against the truck, drinking a soda, when Millen asked, “What’s going on?” Tr. 244, 274. Watson told Millen that Navarro got shocked. Tr. 245.

As Millen was speaking with Watson, Navarro came walking out of the bathroom, apparently after cleaning up a bit. According to Millen, Navarro told him that he got shocked, and when he jumped up, he dislocated his shoulder on a crossover shaft. Watson then helped Navarro get out of there and pop his shoulder back into joint. When Millen asked how they got Navarro’s shoulder back in place, Navarro told Millen that “it had happened to him before so it was easy to get back in.” Tr. 244-45, 251-52, 272. Millen further asked Navarro how he was feeling and whether he needed an ambulance or anything. Tr. 245, 273. Navarro said his shoulder was hurting. Tr. 246. Watson then told Millen that he was going to take Navarro to the hospital to get checked out. Tr. 245, 274. Millen told Navarro to give him a call to keep him posted. Tr. 246. The encounter lasted about ten or fifteen minutes. Tr. 258, 273.

Millen found Navarro to be coherent and embarrassed by the incident. Millen did not consider Navarro’s injury to be life threatening, although he conceded on cross examination that he had no medical background. Tr. 246, 259. Millen testified that he did not believe that the injury was immediately reportable because Navarro was walking around and talking and his shoulder had been relocated. Tr. 250. Contrary to Watson’s testimony, Millen does not recall Watson calling him from the dragline on his cell phone. Tr. 247.

On cross, Millen admitted that on or about September 27, 2010, he had written a short statement at the request of Todd Sumlin concerning MSHA’s investigation about what happened on August 10, 2009. Millen’s written statement did not mention Navarro coming out of the shop restroom, or stating that his shoulder had popped out before. Tr. 257-58, 270-71. That statement was used for impeachment purposes, but was not offered into evidence.

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12 As noted, Navarro denied that he had ever dislocated his shoulder prior to the August 10, 2009 incident at Cemex. Tr. 179. I credit Millen. I find it implausible that Millen would make this up. I further note that Navarro was contemplating legal action against Cemex.

13 Millen further testified that there is a company radio on the dragline, in the office, at the scale house, and on every piece of equipment. Tr. 247.
After speaking with Watson and Navarro, Millen testified that he called plant manager, Todd Sumlin, who was returning from an off-site lunch. Tr. 249. Millen told Sumlin that Navarro had been shocked, and when Navarro jumped up, he hit and dislocated his shoulder on a shaft, and Watson was taking him to the hospital. Tr. 250, 253, 262. According to Millen, Sumlin asked what kind of shape Navarro was in, whether he was conscious, and whether he was all right. Millen told Sumlin, “he seemed okay to me.” Tr. 253.

Millen testified that he briefly spoke with Watson and Navarro again when they pulled up in their truck after returning from the hospital about 3 p.m. on August 10, 2009. Tr. 257-58. Millen asked what happened at the hospital and how Navarro was doing. Tr. 273. Navarro told Millen that he had been given some pain medication, and Millen noticed that Navarro’s shoulder was in a blue and white sling. Tr. 254, 273. Later that day, Millen informed Sumlin that he had seen Navarro, who appeared to be all right. Tr. 254. As noted in footnote 10 above, I credit this testimony from Millen based on his clear and accurate recollection of events that are consistent with Navarro’s contemporaneous medical records.

Millen further testified that Respondent conducts annual training about immediately reportable accidents and injuries, that he had been trained on such policies, and that an MSHA flyer concerning the need to immediately report such injuries to the MSHA 1-800 hotline is posted at the time clock. Tr. 247-48, 261; see R. Ex. 2. On cross, however, Millen conceded that he had not been trained on identifying electrical injuries, although he had seen some electrical injuries in Cemex’s first responder class, which covered CPR. Tr. 262, 266. Millen testified that Cemex reports every accident, but it is not Millen’s job to report to MSHA. Rather, Millen reports to his immediate superior, Todd Sumlin, who determines whether to call MSHA. Tr. 260-261.

On direct, when asked how Millen would determine whether an injury has a reasonable potential to cause death, Millen testified: “If they’re unconscious, if they’re bleeding, if they’re not making sense. You know, they’re like delirious; they don’t know what they’re talking about. They’re bleeding, broken bones.” Tr. 248. When asked by the Court what the words “reasonable potential to cause death” meant to him, Millen responded, “If somebody’s unconscious or bleeding or something obviously is broken like an arm or a leg, swelling, if they’re talking unintelligibly where you can’t understand, like they’re talking about stuff that doesn't make any sense.” Tr. 272.

On cross, when asked if loss of consciousness could potentially be a factor in making an incident immediately reportable, Millen testified that if somebody wasn’t talking to him or was unconscious or bleeding, he would have called the ambulance and then called his boss. Tr. 262-63. Millen further testified that even had he known that Navarro had lost consciousness, he would not likely have acted differently because Navarro was walking, talking and responsive. Millen further testified that he would have told Sumlin that Navarro had lost consciousness, and let Sumlin determine whether to immediately report to MSHA. Tr. 263-65. Eventually, on cross, Millen reluctantly acknowledged that Navarro’s loss of consciousness would have made his injury immediately reportable. See Tr. 264-65. Millen did not ask Watson or Navarro
whether Navarro had lost consciousness. Nor did Watson or Navarro mention to Millen that Navarro had been unconscious. Tr. 263, 266, 271-72. In fact, “[n]obody said anything about [Navarro] being unconscious. It never came up.” Tr. 264-65.

When asked on redirect whether loss of consciousness for a minute or less rendered an injury immediately reportable, Millen opined that it all depends on the circumstances. Tr. 267. Millen conceded that Navarro was working on powerful machines with voltages at 120, 240, 480 and 4160, and that Navarro was exposed to about 240 volts of electricity. Tr. 268-69. Millen testified that 110 volts “will grab you, and 220 will throw you away.” Tr. 268.14

b. Sumlin’s testimony

Quarry manager, Todd Sumlin, testified that Millen called him as he was leaving a restaurant after an early lunch about 12:20-12:30 p.m. on August 10, 2009. Millen told Sumlin that Millen had spoken with Watson and Navarro around the shop area and that Navarro had been shocked and hurt his arm, and Watson was taking Navarro to the hospital to get him checked out. Tr. 281. Sumlin asked Millen if Navarro was okay. Millen said that Navarro was coherent, appeared to be in some pain, but had his faculties about him. Tr. 281.15

Sumlin testified that the information that he received from Millen – that Navarro had been shocked, hurt his shoulder, and was going to the hospital, but was walking, talking and had control of his faculties – was sufficient to make the determination that the incident did not involve an injury with a reasonable potential to cause death and was not immediately reportable to MSHA within fifteen minutes. Tr. 308-10, 321, 327. Sumlin confirmed that after Millen called, Sumlin made the judgment that the injury was not immediately reportable: “Not after he described the man standing there and in the shape he was – that he was standing, had his faculties about him, wasn’t cold and clammy, wasn’t hot and sweaty, didn’t seem to be bleeding profusely anywhere. He had a pain in his shoulder.” Tr. 327. When asked whether Sumlin felt like he had a duty to investigate what happened before making that determination, Sumlin testified, “The man was going to the hospital. That’s the best place he could have been, not coming to me. . . . I wouldn’t want him to stop on the side of the road and me chase him down to say, ‘Are you okay?’ He was going to the hospital, and it’s very close.” Tr. 309.

On cross, Sumlin conceded that the highest voltage attributable to incoming power on the dragline was 4160 volts, that Cemex relied on TAW to check the voltage of the wires that shocked Navarro on Cemex’s dragline, and that Sumlin did not know the equipment or voltage

14 As noted, Watson testified that he tested the voltage at about 200 with a Fluke meter.

15 Sumlin did not know that Navarro had been shocked by heater wires at that time. Tr. 316.
that shocked Navarro, nor did he investigate beyond Millen’s phone call, prior to deciding that MSHA need not be called. Tr. 310-12, 321.16

Sumlin testified that after speaking with Millen, he immediately called Dave Thompson, regional safety manager, and relayed the information conveyed by Millen. Sumlin asked Thompson if Cemex needed to immediately call MSHA under the fifteen minute rule. Tr. 282, 320-21. Although Sumlin had determined that the incident was not immediately reportable, he sought out and obtained Thompson’s confirmation. Tr. 282.

Sumlin then called TAW sales representative, Al Jackson, to ensure that Jackson was aware of the “accident” and to share with Jackson what Sumlin knew about it. Tr. 284. Jackson told Sumlin that he was aware of the accident. Sumlin asked Jackson to do an investigation of the accident and provide Sumlin with a copy, but there was no discussion about who was going to report the occupational injury to MSHA. Tr. 284, 297, 322. When asked by the Court whether Cemex reported to MSHA – as opposed to immediately reported to MSHA – the occupational injury that contractor Navarro suffered on Cemex’s mine site, Sumlin testified that he did not know. See Tr. 329-330. Sumlin acknowledged that he received a copy of Respondent’s Exhibit 13, namely, the OSHA 301 form, which was completed by Stoutamire and Watson at TAW. Tr. 284-85.

Sumlin testified that he eventually returned to the mine after riding past the dragline. He performed some office duties while waiting for Watson and Navarro to return to the office and check out, but they never did. Tr. 283. Sumlin also testified that he called Jackson later that afternoon to inquire about the health of Navarro. Sumlin learned from Jackson that Navarro had been released from the hospital and was going to be okay.17 Tr. 285. After the date of the incident, Cemex did not follow up with Watson or Navarro. Tr. 320.

At no point did Sumlin consider Navarro’s injury to have a reasonable potential to cause death because no CPR, emergency vehicle, or loss of consciousness was involved. Tr. 285. Sumlin opined that a dislocated shoulder is not an injury with a reasonable potential to cause death, and that all electrical shocks are not reportable immediately, nor do they all result in death or reasonable potential to cause death. Tr. 303, 305. Sumlin testified that the requisite  

16 On redirect, Sumlin testified that he knew at the time of the instant hearing in January 2012 that Navarro had been shocked by about 240 volts, but that fact did not change his initial view that the injury was not immediately reportable because Navarro was walking, talking and coherent at the time that Millen spoke with him at the shop. Tr. 322.

17 Jackson did not testify, but was present during inspector Reed’s investigation, as explained below.
determination of whether an injury has a reasonable potential to cause death must be made on a case-by-case basis, and Sumlin was responsible for making the contrary judgment in this case.\textsuperscript{18} Tr. 305-06.

Sumlin testified that he and Millen visited and inspected the “accident” site (see P. Ex. 3 and R. Exhs. 9 and 10) shortly after the August 10, 2009 injury occurred to make sure that the wires were no longer bare. They found that the wires had been taped up to eliminate the hazard. Tr. 286-87, 289. Sumlin postulated that Watson or Navarro taped up the wires when they returned to the quarry after the hospital run.\textsuperscript{19} Tr. 288, 317.

Sumlin further testified that one would have to climb down into the area, but it would be a “pretty good reach,” about 30 inches, to lie on one’s belly from the platform and reach the wires. Tr. 289-90, 293. Sumlin testified that from everything he had read and from the telephone conversation with Watson, Navarro climbed down in the hole. Tr. 293; cf. R. Ex. 13, p. 2 (referring to Navarro “climbing out of the pit”).

Sumlin also testified about MSHA inspector Reed’s investigation that occurred a year after the incident, which is further explained below when discussing Reed’s testimony. Sumlin and Thompson from Cemex and Don Chrosniak and Al Jackson from TAW were present when Reed conducted his investigation on September 9, 2010 at the Inglis Quarry. Tr. 300. Sumlin recalled that Reed called Watson twice (about an hour and 45 minutes apart) to ask him some questions on speaker phone. Tr. 297, 299, 301.

Sumlin stated that during the first call, Reed asked Watson what work he had been tasked to perform on August 10, 2009. Tr. 301. Sumlin remembered inspector Reed asking Watson whether he was qualified to perform that type of work and Watson said that he was qualified. Tr. 302. Sumlin testified that during the second call, Reed asked Watson to describe what happened during that day. Tr. 302. According to Sumlin, Watson said that he had been down in the hole and saw two bare wires. He came back out of the hole and asked Navarro to go down there and Navarro must have contacted those wires. Watson “heard like a pop” and “Navarro went limp” and [Watson] thinks he lost consciousness for less than a minute. Watson then “helped him out of the pit, the hole.” Tr. 302, 324.

\textsuperscript{18} Thompson confirmed that Sumlin made the judgment call, although Thompson could have directed Sumlin to notify MSHA immediately, or could have called MSHA himself. Tr. 355-56.

\textsuperscript{19} Sumlin opined that Navarro did not follow the lockout/tagout policy on August 10, 2009, but no foundation was established for this testimony. Moreover, other record evidence indicates that the dragline was down at the time of the incident. Tr. 241, 243, 291.
According to Sumlin, TAW and Cemex representatives informed Reed that this was the first time that they had heard that Navarro had potentially lost consciousness back on August 10, 2009. Tr. 324-25. Sumlin confirmed that the first time that he found out that Navarro may have been unconscious for a minute or so was during Reed’s call to Watson on speaker phone in September 2010. Tr. 304, 318-19. September 10, 2010 was also the first time that Sumlin or Thompson had seen Navarro’s medical records from the date of the incident. TAW had supplied them to inspector Reed at that time, and Sumlin asked for a copy. Tr. 325-26, 365. Sumlin testified that those contemporaneous documents did not indicate that Navarro lost consciousness. Tr. 304. In fact, as noted above, they indicated the opposite. “Patient did not sustain loss of consciousness.” R. Ex. 1, p.1.

Sumlin further testified that even as of September 2010, when inspector Reed conducted his investigation, Sumlin had no reason to believe that the incident, which had occurred over a year earlier, was immediately reportable. Tr. 303. Sumlin acknowledged that the citation indicated that Navarro was unconscious for approximately one minute, but opined that any such fact did not render the incident immediately reportable. Tr. 304, 305. Even assuming an electric shock, loss of consciousness for a minute or less, and a dislocated shoulder, Sumlin did not view such incident as immediately reportable. Tr. 305. Moreover, Sumlin was aware of no guidance from MSHA to the mining community as to whether an electrical shock injury has a reasonable potential to cause death. Tr. 306.

Sumlin did not speak to Watson about the incident prior to Reed’s investigation, and Sumlin did not ask Navarro any questions about the incident when he escorted Navarro and his attorney around the incident site in May 2010. Tr. 319-20. According to Sumlin, Navarro could not recall where the incident occurred during the May 2010 site visit. Tr. 322.20

c. Thompson’s testimony

Regional safety manager, Dave Thompson, was Respondent’s observer-representative at the hearing. He is responsible for fourteen operations throughout the Southeast and acts as liaison between Cemex and MSHA concerning inspections.

Before addressing the incident at issue, Thompson testified about the 10-day reporting responsibility for any occupational injury that requires medical treatment, and about immediate reporting requirements within the fifteen minute rule instituted under the Miner Act following the 2006 Sago mine disaster. Tr. 331-36. Thompson testified that MSHA’s flyer regarding immediately reportable accidents and injuries (Respondent’s Exhibit 2) was posted in conspicuous places throughout Respondent’s mines, and discussed during weekly safety meetings and annual refresher training, including training given at the Inglis Quarry prior to 2009. Tr. 337-38. Thompson testified that TAW, a Cemex contractor with an MSHA ID

20 Thompson testified that he was also present during this site visit and Navarro could not recall where he had been injured. Tr. 352-53.
number, is responsible for reporting an occupational injury incurred by a TAW contractor employee at a Cemex mine site. Thompson was unaware of any requirement that Cemex report an injury to a contractor employee at its mine site. When led by counsel, Thompson testified that if there is one injury, there is one report. Tr. 339. Thompson further testified that he expected TAW to report Navarro’s occupational injury to MSHA. Tr. 346.

On cross, Thompson was asked to read 30 C.F.R. § 50.11(b), which provides: “Each operator of a mine shall investigate each accident and each occupational injury at a mine. Each operator of a mine shall develop a report of each investigation.” Thompson maintained that Cemex investigated the accident by asking questions about the injury and going to the dragline a day or so after the incident to investigate the area where the injury occurred. (Tr. 361-62). He conceded, however, that Cemex never filed any report regarding the injury. Moreover, Thompson continued to maintain that Cemex had no obligation to report an occupational injury that was incurred by a contractor employee (Navarro) on Cemex’s mine site. Tr. 363. MSHA did not cite Cemex for a violation of 30 C.F.R. § 50.11(b) concerning an obligation to investigate and develop a report of such investigation.

With respect to immediate reporting requirements, Thompson testified that Cemex personnel are instructed to determine whether an “incident has a reasonable potential to cause death” on a case-by-case basis, and once supervision is made aware of an injury, a judgment will be made as to whether Cemex supervision will call MSHA. Thompson opined that a shock, coupled with a dislocated shoulder and a loss of consciousness for a minute or less, was not an injury with a reasonable potential to cause death. Tr. 343. In fact, Thompson testified that nothing he has learned since the incident would lead him to change his opinion that the event was not immediately reportable. Tr. 370. Thompson emphasized that Respondent does not employ medical doctors to assist at the mine in making a fifteen minute judgment call about whether a particular injury has a reasonable potential to cause death. He opined that Millen acted as a reasonably prudent person when evaluating Navarro’s condition, and that the information available to Cemex was sufficient to determine whether the injury was immediately reportable. Tr. 371, 375.

Thompson further testified that he had not read any documents [from MSHA] that gave notice that shocks with burns are immediately reportable, as inspector Reed suggested in his testimony. Tr. 339-40; cf. Tr. 133-35 (Reed testimony and professional opinion). Thompson further testified, contrary to inspector Reed, that a burn did not indicate that an injury had a reasonable potential to cause death. Tr. 375. Rather, Thompson opined that shocks with burns are not immediately reportable in all instances, that he is aware of shocks with burns where there was no immediate reporting, and that he is aware of shocks with burns where there was no
reasonable potential to cause death. Tr. 340.  
Thompson also opined that not all shocks from 240 volts of electricity lead to a reasonable potential to cause death, although on cross, he conceded that he did not know the voltage that shocked Navarro when Cemex chose not to report. Tr. 342, 354.

With regard to that incident, Thompson confirmed that Sumlin called him “directly after the accident,” around noon. Tr. 344. According to Thompson, Sumlin said that he had a couple of TAW people on site performing maintenance on the dragline, and one of them came in contact with some live wires and apparently jumped up or fell back and hurt his shoulder. Tr. 344-45.  
Thompson asked Sumlin, “Well, how is he doing? Is he okay?” Sumlin informed Thompson of Millen’s report that Navarro’s shoulder hurts him, but he seems like he is doing okay, and he is going to the emergency room to get checked out. Thompson asked Sumlin to let him know the outcome of the hospital visit and how the TAW employee was doing. Tr. 345, 356-57, 364-65.

Sumlin also told Thompson that he had called sales representative, Al Jackson, at TAW. Tr. 345-46. Thompson testified that Sumlin followed up with TAW after the hospital visit and reported to Thompson what Sumlin had learned from Jackson, i.e., that Navarro’s shoulder was hurt, but everything else was okay. Tr. 348-49, 369.

With regard to inspector Reed’s investigation, Thompson testified that on September 8, 2010, Reed called him to schedule an investigation at the Inglis Quarry the next day. Tr. 346-47. Thereafter, Thompson called Jackson and arranged for TAW representatives to be present. Tr. 347.

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21 When asked in what situations he had encountered such, however, Thompson testified that he has never had a reporting situation where a person has been shocked on Cemex properties Tr. 341-42.

22 On cross, Thomspon testified that Cemex relied on TAW’s report to Cemex that the wires had been taped up. Tr. 366. When shown pictures of the bare wires to which Navarro was exposed (P. Exs. 2-4), Thompson speculated that the photographs were taken by TAW on the date of the incident because they were presented during Reed’s investigation. Tr. 367-68. I note that such photos do not show the bare wires to be taped up. Tr. 369; P. Exs. 2-4. On redirect, Thompson testified that Sumlin verified that the bare wires had been taped up by TAW after the incident. Tr. 368, 370.

23 Thompson further testified that the medicals records uncovered during Reed’s September 2010 investigation actually confirmed what Sumlin had relayed to Thompson from Jackson after Navarro’s hospital visit on August 10, 2009. Tr. 370, 372. Thompson testified that he also learned that Millen had a brief conversation with Watson and Navarro about 3 p.m. when they returned to the site from the hospital, and that Navarro was okay, but his arm was in a sling. Tr. 352.
On September 9, 2010, Reed met with Thompson and Sumlin from Cemex and Chrosniak and Jackson from TAW. Reed questioned them about the August 10, 2009 injury that he was investigating. Tr. 348, 351. Reed informed them that the investigation was prompted by an anonymous complaint that the accident was more serious than had been reported. Tr. 297. Reed presented Respondent with a copy of the September 7, 2010 complaint allegation (R. Ex. 15, p. 3). Tr. 298. As noted, the complaint allegation states that the MSHA 7000-1 form completed on August 10, 2009, understated the seriousness of the injury that Navarro incurred, but no MSHA form 7000-1 was offered into evidence by the Secretary.24 R. Ex. 15, p. 3; Tr. 121.

Reed testified that Chrosniak from TAW had filed a 7000-1 report concerning an occupational shoulder injury, but that report had been filed late. Tr. 121-23, 125. Reed further testified that TAW supplied Reed with a copy of the report from its investigation. Then Reed called Watson on speaker phone. Tr. 299, 349.

Unlike Sumlin, Thompson recalls only one conversation between Reed and Watson, not two, as Sumlin recalls. Tr. 351.25 According to Thompson, Reed asked Watson about site specific training for the TAW employees (Tr. 351), and about what happened at the dragline when Navarro was hurt. Tr. 349. Thompson heard Watson tell Reed the following: that Watson heard Navarro make a noise; that Watson went over to investigate and saw Navarro sort of squatting and stooped over; that Watson helped Navarro out and away from the shaft area; that Watson found out that Navarro had been shocked and hurt his shoulder; and that Watson and Navarro left the dragline, went to the shop where they had a conversation with Millen about the incident, and then went to the hospital to get Navarro checked out. Tr. 349.

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24 If an accident, injury or illness occurs at or in conjunction with activity at a mine, mine operators are required to report the circumstances of the incident to MSHA using Form 7000-1. MSHA’s online instructions for completing Form 7000-1 state, inter alia: Section 50.20 of Part 50, Title 30, Code of Federal Regulations, requires a report to be prepared and filed with MSHA of each accident, occupational injury, or occupational illness occurring at your operation. The requirement includes all accidents, injuries, and illnesses as defined in Part 50 whether your employees or a contractor's employees are involved. A Form 7000-1 shall be completed and mailed within ten working days after an accident or occupational injury occurs, or an occupational illness is diagnosed.” See MINE SAFETY & HEALTH ADMINISTRATION, DEPT. OF LABOR, MINE ACCIDENT, INJURY AND ILLNESS REPORT, www.msha.gov/forms/form7000-1.pdf.

25 I find this discrepancy immaterial to the ultimate disposition of this matter. Nevertheless, I find it more likely than not that there was only one phone call from Reed to Watson because Reed did not reference more than one phone call in his testimony, as set forth below.
When asked by the Court whether Watson mentioned to Reed that Navarro had lost consciousness at that time, Thompson testified:

A I don't know what his exact words were, but he said it looked like he had passed out, is what I got. He was – he was – he wasn’t – he wasn’t 100 percent there during that – according to what Mr. Watson said. I believe Mr. Watson said it looked like he passed out a little bit where he was squatting. His eyes were closed, and he wasn’t right.

BY MS. BEVERAGE:

Q Did Mr. Watson say for how long this lasted?
A I remember less than a minute.
Q Did Mr. Watson say how Mr. Navarro had hurt his shoulder?
A He bumped the shaft that was above him.

THE COURT: Mr. Watson said that, told Mr. Reed that?

THE WITNESS: To the best of my recollection, yes; he had bumped the shoulder.

Tr. 350.

Like Sumlin, Thompson testified that the first time that Thompson had ever heard that Navarro had passed out for less than a minute was during the conversation between Reed and Watson that the Cemex and TAW representatives overheard on the speaker phone. Tr. 351, 355. Thompson testified, however, that this information would not have affected his determination that the incident was not immediately reportable on August 10, 2009 because Millen had observed Navarro outside the shop, walking under his own power, and engaged him in lucid conversation. Thompson further speculated erroneously that Navarro “was able to climb out of the area where he was and make his way off of the dragline on his own power, get in the car and drive up to the shop and have a conversation.” Tr. 351-52. Rather, I credit Watson that Navarro needed assistance when leaving the dragline.

On cross, Thompson confirmed that Millen had reported to Sumlin that Navarro was coherent, but Thompson conceded that he had no information about the duration of that coherency, what the voltage exposure had been, whether there were exit wounds, whether Navarro had chest pains or felt like he was having a heart attack during the incident, or whether Navarro felt like he may not leave the dragline alive. In fact, Thompson admitted that he considered such facts to be irrelevant to his determination of whether the injury was immediately reportable. Tr. 355, 357-58. On further re-cross, Thompson admitted that he was unaware that Navarro suffered a burn on his left hand, as set forth in Navarro’s medicals records at Respondent’s Exhibit 1, page 3, and that Thompson never requested to see the medical records. Tr. 374.
4. Inspector Reed’s Testimony

John Reed has been an MSHA inspector, specializing in electrical issues, since 1989. Tr. 32. Before that, Reed was employed with the West Virginia Department of Mines as an underground electrical inspector for about seven years. Tr. 37-38. Reed has two associate degrees from the West Virginia Institute of Technology; one in electrical engineering and technology and another in mechanical engineering technology. Moreover, Reed has taught courses in mine electricity for vocational, technical schools and for MSHA. Tr. 33-34. Reed testified he is considered a technical expert for electrical matters within MSHA’s southeast district, but Reed was not proffered, nor qualified, as an expert witness by the Secretary. Tr. 37.

Reed testified that on or about September 7, 2010, MSHA’s national hotline received an anonymous Code-a-Phone complaint that eventually was referred to him for assignment. Tr. 37-38. Reed followed the verbal hazard complaint manual and reviewed the Cemex Inglis Quarry mine file, but saw no accident report or 7000-1 report filed by Cemex regarding this injury. Tr. 38-40, 42. Reed testified that MSHA does not keep files on subcontractors, but he did see an initial report that was brought to the mine by Don Chrosniak from TAW, and such report “didn’t indicate anything to the degree of what I found when I investigated the incident.” Tr. 40-42.

Reed investigated the complaint at the Inglis Quarry on September 9, 2010. He met with Sumlin and Thompson from Cemex and Chrosniak and Jackson from TAW. He presented them with a copy of the redacted complaint. Tr. 42, 44-45, 49, 129.26 When all were assembled, Reed asked them what they recalled about the incident a year earlier when Navarro was injured. Then Reed called Watson on speaker phone and asked him to recount what had occurred. Tr. 46-49, see also Tr. 61. I note that Reed did not reference two phone calls.

Sumlin told Reed that sometime before 11:30 a.m. on August 10, 2009, he received a call from dragline operator Millen informing Sumlin that Watson had phoned Millen to report that Navarro received an electrical shock while working on the dragline, “smashed” his shoulder, and was leaving the site. Tr. 50, 148-49.27 Sumlin also told Reed that Sumlin immediately called Thompson and Jackson to inform them about the incident and then Sumlin returned to the job site about 11:30 a.m. Tr. 50, 53. Reed testified that he asked Sumlin or Thompson whether they had verified whether there had been any logout/tagout and was told that nobody had done so. Tr. 146.

Jackson told Reed that Sumlin had called him about the incident and that Jackson had called Watson after he left for the hospital. Tr. 55. Reed testified that he was particularly

26 Reed did not bring a copy of the late-filed 7000-1 report from TAW with him to the mine site. Tr. 127-28. Nor was one offered by the Secretary at trial.

27 Reed never asked Watson if he also spoke to Millen in person at the shop that day, nor did Watson tell Reed that he had done so. Tr. 149-50.
interested in written documentation, i.e., hospital records and an internal accident report that he had asked TAW to provide concerning the incident. Tr. 55-57.

Reed then called Watson and spoke to him on speaker phone. Tr. 46, 57. Reed confirmed that Watson and Navarro had signed in and received site-specific training and then asked Watson to describe the nature of their work and what happened when Navarro was injured during such work. Tr. 57-58, 64. Watson told Reed that they were working on a 240-volt circuit that was fed from a 480-volt transformer and that Watson entered some confined space, saw bare wires, and asked Navarro to verify what Watson had seen. Then, Navarro “got down in there and started to do something, and then he received an electrical shock.” Tr. 58-59. Watson further told Reed, and those listening on speaker phone, that Watson thought Navarro lost consciousness for about a minute, but then Watson told Reed that he was not sure that Navarro had lost consciousness. Tr. 59. On cross examination, Reed reiterated that Watson told him that Navarro may or may not have lost consciousness. Tr. 132. As noted, Reed never asked Watson whether Watson and Navarro had spoken with Millen on site before leaving for the hospital. Tr. 150.

After listening to Watson’s account over the speaker phone, Cemex and TAW representatives told Reed that this was the first time they had heard that Navarro may have lost consciousness after the electrical shock. See Tr. 61-63. On cross, Reed could not recall whether Watson told him how Navarro hurt his shoulder, and then testified that Watson stated that he did not see Navarro hit his shoulder on anything. Tr. 132, 136.

Reed opined that Navarro’s exposure to 240 volts of electricity when shocked could cause death. Tr. 64. Reed testified that he has presented fatality reports involving individuals exposed to less than 240 volts, who have died, and he was aware of four electrocutions since 2000 that involved less than 120 volts, including a welder, who died after exposure to 90 volts of electricity. Tr. 65, 66-67. Reed testified that fatal electrocutions typically occur because of a confluence of factors, including confined space and incidental contact with electric current in a wet, metal environment. Tr. 66, 92. Reed expressed his belief that such factors were present in this case because the dragline was a metal structure and Navarro had climbed down into a confined space with low lighting, i.e., a pit to access heater wiring in a cable tray about four or five feet below floor level. Tr. 67-68, 91-92, 105-06; see also R. Ex. 13, p. 2 (TAW’s report noting that Navarro was climbing out of pit when shocked).

28 On cross, Reed testified that he never would have contacted those wires without using a voltmeter to determine whether they were energized. Tr. 116.

29 As noted, Reed wrote in the instant citation that Navarro “was unconscious for approximately one minute and had a serious injury to his left shoulder.” P. Ex. 1. I further note that Navarro’s hospital records, which Reed reviewed prior to issuance of the citation, describe the left shoulder injury as “minor.”
During his investigation, Reed was presented with photographs of the bare wires or electrical leads to which Navarro was exposed, and Reed took photographs of the photographs and identified the former during his direct testimony. Tr. 69-70, 100-108; P. Ex. 2-4. Reed also testified about P. Ex. 5, which was a fatalgram concerning the twelve metal/nonmetal fatalities in 2008. In that fatalgram accident, the victim was electrocuted while contacting an energized steel water line, where one conductor in a 480-volt electrical circuit passed through a common conduit box, and the heater tape, which was attached to the water line, overheated and energized the water line to 277 volts of electricity. Tr. 108-09; P. Ex. 5. In an effort to highlight any similarities between the fatalgram and the Navarro incident, Reed noted that the voltage was about the same, there was accidental contact with an energized wire or water pipe, and both scenarios involved metal grounded structures. Tr. 110-12. On cross, however, Reed acknowledged that the fatalgram victim was found electrocuted, without a pulse. Tr. 114-15.

When asked why he wrote the instant citation for Cemex’s failure to immediately call MSHA to report an injury that had the reasonable potential to cause death, Reed testified that the facts were all there. Specifically, Watson told Reed that Navarro hurt his shoulder; Watson told Reed that Navarro did not hit his shoulder on any structure; Reed could never establish any reason other than violent muscle contractions for the dislocated shoulder; and page three of Navarro’s medical records indicated a burn on left hand, which in Reed’s opinion meant that Navarro had received a shock above the magnitude of current that could cause death. See Tr. 72-79. In Reed’s view, “there was no question this should have been called in.” Tr. 80. “...You know, I mean the facts from the hospital said the man got burned, and he had a bad shoulder injury. That is an electrical injury that does that and has the reasonable potential to cause death.” Tr. 152. Reed further testified that the issue of consciousness or unconsciousness made no difference to him, despite language about loss of consciousness that he had written in the citation, and that the shock appeared severe, given the burn and dislocated shoulder. Tr. 80-81.

On cross, Reed testified that in his professional opinion, if an individual sustains an electrical burn from an electric shock, then it is an immediately reportable accident with a reasonable potential to cause death, even if the individual was lucid, coherent and had no loss of consciousness. Tr. 133-35, 151. Reed, however, was aware of no notice from MSHA to this effect. Tr. 133-134. On re-cross, Reed conceded that not all shocks that cause a burn result in a

30 Reed later clarified that Watson told Reed that Watson did not see Navarro hit his shoulder on anything. Tr. 79.

31 When confronted on cross with Navarro’s medical records, Reed still opined that violent muscular contractions from the electrical shock could have caused Navarro’s dislocated shoulder. Reed discounted how Navarro thought he hurt his shoulder, as set forth in Navarro’s medical records, particularly since Watson told Reed that he did not see Navarro hit his shoulder, which Reed described as a “conflicting account.” Tr. 136-139. Rather defensively, Reed testified that he did not talk to Navarro because he did not have a phone number for him, he had the “doctor’s statement,” and he had the witnesses that “saw” the incident. Tr. 139-40.
Reed testified that he asked a Cemex representative (either Thompson or Sumlin) why Cemex did not report the incident on form 7000-1. Reed was informed that it was the contractor’s responsibility and that the Cemex representative thought the contractor had reported it. Tr. 81-82. Reed further testified that Chrosniak (TAW) told him that Cemex had the reporting obligation. Tr. 82. Reed opined that both Cemex and TAW had a reporting obligation and he gave them both citations, although Cemex was never cited for failure to report the contractor injury at its mine site, just the failure to immediately report the alleged accident. Tr. 82; see also n. 2, above.

Reed designated Cemex’s negligence as high for the following reasons: MSHA had listed and emphasized immediately reportable accidents and injuries in its “One Call Does it All” outreach and enforcement campaign targeting the industry (see R. Ex. 2; Tr. 85-86, 140-41); Cemex was aware of the campaign and had posted MSHA’s flyers at its mine sites and thus knew that it had to report an injury to an individual at its mine, which had a reasonable potential to cause death; Cemex knew that Navarro had been shocked and had a severe shoulder injury; and Cemex offered no mitigating circumstances for failure to report, other than ascribing reporting responsibility to TAW. Tr. 85-86.

Reed testified that the purpose of the immediate notification requirements set forth in 30 C.F.R. § 50.10, including § 50.10(b), is to protect the health and safety of miners and to enable MSHA to assist in a thorough and objective investigation of all facts surrounding an accident, and in any rescue or recovery effort that is required. Tr. 88-89.

Reed did not visit the dragline during his investigation. Tr. 130, 153.32 Nor did he speak to Millen, Navarro or anyone from the hospital or medical group, who treated Navarro. Tr. 53, 63, 131, 137-38, 140. Like Cemex’s investigation, I find that Reed’s investigation was not very thorough.

III. Discussion and Analysis with Further Findings of Fact and Conclusions of Law

At the outset, I find that Cemex had no intention of immediately reporting this incident. This is because Thompson testified that Cemex had no reporting obligation at all, only TAW had such. Contrary to Thompson’s testimony, the plain meaning of 30 C.F.R. § 50.10 expressly

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32 On questioning from the Court, he testified, rather incredulously, that he issued a citation to Cemex for the exposed bare wires without visiting the dragline, and then told the Court, “I don’t know. Never mind.” Tr. 144. This was the second time that Reed told the Court “[n]ever mind,” when the Court asked a question about his testimony. See Tr. 126.
places the responsibility to immediately report on the shoulders of the operator. Furthermore, the Commission and ALJs have consistently affirmed the plain meaning of section 50.10 in finding that when an reportable accident occurs involving contractor employees at a site owned and supervised by the operator, the operator is responsible for immediately reporting the accident to MSHA. See Phelps Dodge Tyrone, Inc., 30 FMSHRC 646 (2008); Extra Energy, Inc., 20 FMSHRC 1 (1998); Nichols Construction, Inc., 31 FMSHRC 1172 (2009) (ALJ); Prairie State Generating Co., 33 FMSHRC 2549 (2011) (ALJ).

Nevertheless, Thompson’s erroneous understanding of the law is not dispositive here. Reed did not cite Cemex for failure to investigate or for an inadequate investigation or for failure to report an occupational injury. And even though Cemex had no intention of immediately reporting Navarro’s injury, I find that no immediate reporting obligation of an accident ever attached to Cemex under the surrounding facts and circumstances at issue here. Rather, for the reasons set forth below, I find that the Secretary failed to establish that Cemex violated 30 C.F.R. § 50.10(b) by a preponderance of the credible evidence.

As noted, 30 C.F.R. § 50.10(b) provides that an operator shall immediately contact MSHA at once 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) an injury of an individual at the mine which has a reasonable potential to cause death. As MSHA noted in the preamble to the final rule:

In using the “reasonable potential to cause death” basis for injuries and entrapments, the MINER Act and the final rule retain an element of judgment. This “reasonable potential” language also appeared under the ETS and the prior standard in relation to injuries. According to the Federal Mine Safety and Health Review Commission (Commission), the operator’s decision as to what constitutes a “reasonable potential to cause death” “cannot be made upon the basis of clinical or hypertechnical opinions as to a miner’s chance of survival.” The judgment is based on what a reasonable person would discern under the circumstances, particularly when “[t]he decision to call MSHA must be made in a matter of minutes after a serious accident.” [See Cougar Coal, 25 FMSHRC 513 at 521 (September 5, 2003)]. Based on MSHA experience and common medical knowledge, some types of “injuries which have a reasonable potential to cause death” include concussions, cases requiring cardio-pulmonary resuscitation (CPR), limb amputations, major upper body blunt force trauma, and cases of intermittent or extended unconsciousness. These injuries can result from various

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33 30 C.F.R. § 50.2(c) defines an operator as “(1) Any owner, lessee, or other person who operates, controls, or supervises a coal mine; or, (2) The person, partnership, association, or corporation, or subsidiary of a corporation operating a metal or nonmetal mine, and owning the right to do so, and includes any agent thereof charged with responsibility for the operation of such mine.”
indicative events, including an irrespirable atmosphere or ignitable gas, compromised ventilation controls, and roof instability.


In assessing this standard, I have declined to credit the testimony from the Secretary’s witnesses that Navarro lost consciousness when suffering the electric shock. I have specifically discredited Navarro’s testimony in this regard at section II, A, 1, above. Reed’s reliance on Watson’s testimony to this effect is based on Watson’s equivocal recollection more than a year after the event. Watson’s testimony at the time of the hearing, which is even further removed from the date of the event, is undercut by the equivocal nature of the statement given to Reed a year earlier. More importantly, Watson’s testimony concerning Navarro’s loss of consciousness and Navarro’s testimony that he passed in and out is undercut by Navarro and Watson’s mutually corroborative testimony that Watson was laughing at Navarro initially, and by contemporaneous hospital records in which Navarro informed examining personnel that he did not sustain loss of consciousness. I find the contemporaneous medical records to be the most reliable evidence in this case. Accordingly, I find that the Secretary failed to establish that Navarro lost consciousness.

Furthermore, I credit dragline operator Millen that he observed and spoke with Navarro at the shop area before Watson drove him to the hospital. Millen testified about this encounter with specific detail. Sumlin and Thompson essentially corroborated Millen. Although the Secretary attempted to impeach Millen based on a prior inconsistent statement, the Secretary failed to establish the circumstances surrounding the rendition of that statement, including whether it was intended to be cryptic or comprehensive. Nor did she offer it into evidence. Although Respondent did not attempt to rehabilitate Millen on this effort at impeachment, I find Millen’s testimony about his in-person encounter with Watson and Navarro to be sufficiently detailed and corroborated as to warrant credence.

Based on Millen’s credited testimony, Navarro told Millen during a face-to-face encounter shortly after the incident that he got shocked, jumped up, and dislocated his shoulder on a crossover shaft, and that Watson helped him pop it back into joint. Such testimony establishes that Navarro was lucid, coherent, and ambulatory, and did not require CPR or emergency transport to the hospital for treatment of his shoulder injury or burn. Moreover, Millen did not consider Navarro’s injuries to be life threatening. Millen then called plant manager Sumlin and told Sumlin that Navarro had suffered an electrical shock and jumped up and dislocated his shoulder on a shaft, and that Watson was taking him to the hospital. Sumlin asked what kind of shape Navarro was in, whether he was conscious, and whether he was all right. Millen told Sumlin, “he seemed okay to me.” Tr. 253. Sumlin immediately informed Thompson of these facts.
It was at this point that any immediate reporting obligation was triggered. As Judge Manning noted in *Newmont USA Limited*, 32 FMSHRC 391 (April 14, 2010):

The language of the Secretary’s regulation is clear. An operator is required to notify MSHA within 15 minutes “once the operator knows or should know that an accident has occurred.” 30 C.F.R. § 50.10. The regulation does not require reporting within 15 minutes after a miner sustains an injury. The operator must know that an accident occurred before the obligation to immediately report arises or the operator must have been in a position such that it should have known that an accident occurred.

In this case, as in *Newmont USA Limited*, supra, it became clear to Sumlin and Thompson, at or about the time of Millen’s report shortly after Navarro was injured, that an immediately reportable accident, as defined by the Secretary, had not occurred. Because there was not an immediately reportable accident that Cemex knew about or should have known about, no obligation to immediately report Navarro’s injury arose. Rather, based on the totality of facts and circumstances presented in this record, I find that a reasonable person would discern, as Millen, Sumlin and Thompson did at the time, that Navarro’s injuries from electric shock did not have a reasonable potential to cause death. 34 I note that an electric shock is not one of the events listed in the preamble or in any other MSHA document designed to provide guidance on immediate reporting obligations. Moreover, the regulation does not require mine operators to immediately report every injury that requires off-site emergency care at a hospital or clinic. Here, it was clear within a few minutes after the incident that Navarro had been shocked and suffered a dislocated shoulder and a burn to his left hand. As noted above, I find that these injuries would not cause a reasonable person to believe that there was a reasonable potential that Navarro was going to die. I further note that Navarro did not express such concerns to Millen shortly after the incident, despite his subsequent discredited testimony at trial.

In *Cougar Coal*, the Commission held that the “decision to call MSHA cannot be made on clinical or hyper-technical opinions as to a miner’s chance of survival.” 25 FMSHRC at 521. The facts in *Cougar Coal* are readily distinguishable. There, a miner received a shock of 7,200 volts of electricity, hit his head on the edge of the power center, and fell 18 feet to the ground, where he was found unconscious and without any pulse. 25 FMSHRC at 515. The miner suffered head lacerations, serious burns, and a fractured neck vertebra. A foreman administered CPR and the miner was revived before transport to the hospital by ambulance, and subsequent helicopter transport to another hospital burn unit. 25 FMSHRC at 515-516, 520. The Commission held that the near electrocution, combined with the 18-foot fall and head collision with the power center, had a reasonable potential to cause death *per se*. 25 FMSHRC at 520.

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34 As emphasized above, Cemex was not cited for failing to report the injury itself. It was only cited for failure to immediately report the alleged accident.
More recently, in *Mainline Rock and Ballast, Inc. v. Secretary of Labor*, slip op. 2012 WL 1111258 (10th Cir. 2012), the Tenth Circuit quoted Commission precedent explaining the degree of latitude afforded by § 50.10, balanced against its directive that mine operators quickly act to assess the severity of an accident that may require reporting.

Section 50.10 . . . necessarily accords operators a reasonable opportunity for investigation into an event prior to reporting to MSHA. Such internal investigation, however, must be carried out by operators in good faith without delay and in light of the regulation's command of prompt, vigorous action. The immediateness of an operator's notification under section 50.10 must be evaluated on a case-by-case basis, taking into account the nature of the accident and all relevant variables affecting reaction and reporting.


In *Mainline Rock*, the Tenth Circuit affirmed the ALJ’s unreviewed final administrative order, which found, inter alia, that Mainline Rock failed to report an accident to MSHA within fifteen minutes, as required by 30 C.F.R. § 50.10, and exhibited high negligence because a reasonable person would have called MSHA upon seeing the injured miner (Avitia) at the scene, but Mainline’s mine load-out superintendent Olsen remained “remarkably non-inquisitive about Avitia’s condition and injuries.” *Id.* at 6, 15.

In that case, Avitia was pulled into the Grizzly Conveyor by one of the return rollers. *Id.* at 2. He was instantly caught between the belt and roller and when contact was made he blacked out. When he regained consciousness, he found himself pinned in the air between the return roller and the belt, with the roller below his stomach and the belt still running along his back. His head and torso had passed through a seven-inch space, but after twenty minutes of attempting to signal for help, he miraculously was able to retrieve his radio and tell fellow miners to stop the conveyor, yelling out, “Stop everything . . . I’m dying. I’m stuck in the belt. *Id.* at 3. The conveyor was stopped, 911 was called, and Avitia was eventually freed after a torch was used to cut the roller from the conveyor. When mine superintendent Harris arrived on the scene he began administering oxygen, and when Harris told Avitia he would be all right, Avitia replied, “No, I’m in very bad shape.” *Id.* at 4. Indeed, Avitia spent two-and-a-half months recovering in the hospital. He sustained severe internal injuries requiring a tracheotomy and surgery to his pelvis, pancreas, hip, and spleen. He also suffered permanent damage to his kidneys and also broke his arm, his collarbone, and all of his ribs. *Id.* at 4-5.

During the ordeal, mine load-out superintendent Olsen, who had been working some 1500 feet away, arrived on the scene and found Avitia was laying on the ground with his head in another miner's lap. Olsen took a ‘quick glance’ at Avitia and noticed that he looked pale. Olsen described Avitia's face as “kind of swollen” and his head as “misshaped.” Olsen spoke to no one and asked no questions. After staying at the scene for “[s]econds,” Olsen went to his office to call corporate counsel, the company's compliance officer, and 911. At no point did Olsen make any inquiries of Avitia's condition. Nor did he report the accident to MSHA until after Avitia
was airlifted to a hospital. The total time from when Olsen first learned of the accident until he reported it to MSHA was approximately one hour and thirty-eight minutes. Id. at 4.

The Tenth Circuit concluded that substantial evidence supported the ALJ’s decision that § 50.10 affords an operator a degree of discretion, but Olsen did not “have the discretion to remain uninformed about the circumstances of the accident and then assert that the reasonable potential for the accident to cause death was unknown.” Id. at 15. The court emphasized that after arriving on scene, Olsen merely glanced at Avitia and left seconds later without asking a single question. Moreover, despite calling 911 and noting that Avitia's head was misshaped, Olsen never sought an update on Avitia's condition from Harris or anyone else. Id. at 15. The court further emphasized that Olsen had a reasonable opportunity for investigation but failed to seize it. He easily could have asked what happened and immediately learned that Avitia had been pulled through the roller. That knowledge alone would have alerted him to the severity of the accident and the potential for death. In fact, another miner at the scene actually thought Olsen left to get more help while he continued “working on trying to save [Avitia’s] life.” Id. at 16. The court concluded, as the ALJ recognized, that the obvious circumstances of the accident would have triggered some minimal degree of inquiry in a reasonable person, thus prompting a call to MSHA. But the court found that Olsen chose to remain blind to the circumstances. The court concluded that Olsen's ignorance of the severity of Avitia's condition did not excuse Mainline Rock's failure to timely report the accident. Id.

Here, by contrast, it became clear at the time of Millen’s initial face-to-face encounter with Navarro and well-nigh immediate notification to Sumlin that the most serious injury sustained by Navarro as a result of the electric shock was a dislocated shoulder that had been popped back into place. No CPR or oxygen was administered. No pulse was lost. No EMT or ambulance was called to the scene. Navarro did not receive treatment for a burn. No credible evidence was presented that Navarro lost consciousness.

In these circumstances, the record establishes that Sumlin’s decision that the electric shock injury was not immediately reportable was made after some minimal degree of inquiry and was not based on clinical or hyper-technical opinions as to a miner’s chance of survival. Rather, it was based on Millen’s ten-minute face-to-face assessment of Navarro’s condition, a few minutes after he was injured, and Sumlin’s at least marginal inquiries after being informed of that assessment, about what happened and whether Navarro was going to be all right. There is no evidence that Navarro’s condition worsened at any time after that. In fact, Millen credibly testified that he spoke to Navarro again upon his return to the job site and Jackson kept Millen apprised of Navarro’s status upon release from the hospital less than three hours after the incident. Furthermore, Sumlin credibly testified that he called Jackson later that afternoon to inquire about the health of Navarro. Sumlin learned from Jackson that Navarro had been released from the hospital and was going to be okay. Tr. 285. Moreover, the medical records uncovered during Reed’s September 2010 investigation confirmed what Sumlin had relayed to Thompson from Jackson after Navarro’s hospital visit on August 10, 2009. Tr. 370, 372. Thompson testified that he also learned that Millen had a brief conversation with Watson and
Navarro about 3 p.m. when they returned to the site from the hospital, and that Navarro was okay, but his arm was in a sling. Tr. 352.

By contrast, I find that inspector Reed’s testimony is based on a hyper-technical opinion years after the fact that any electric shock which causes a burn is per se an immediately reportable injury. Although the testimony of an experienced MSHA inspector is ordinarily entitled to considerable weight, no persuasive authority was proffered to support this opinion. There is no MSHA regulation or other guidance to support this view. The facts in Cougar Coal differ starkly. I reject such a per se assessment in the circumstances of this case. Nor has Cemex been given notice of this enforcement position. If the Secretary would like all electric shock injuries to be immediately reported, she should consider modifying her regulations to say so. As Judge Manning noted in Newmont USA Limited:

It appears that the Secretary believes that a mine operator should immediately report any serious injury, at least if off-site medical care or hospitalization is required. As stated by the Commission in Cougar Coal, “it would benefit the mining community if the Secretary would clarify when it is urgent to notify MSHA, when it is not, and what reports are required.”

25 FMSHRC at 52.

As the record in this case makes clear, until the Secretary does so, cases like this one will continue to be litigated before the Commission. Tr. 370.

In sum, I find that the Secretary failed to establish by a preponderance of the credible evidence that Cemex violated 30 C.F.R. § 50.10(b) by failing to immediately report an injury of an individual at its mine which has a reasonable potential to cause death.

IV. ORDER

For the reasons set forth above, Citation No. 8553410 is VACATED, and this proceeding is DISMISSED.

/s/ Thomas P. McCarthy

Thomas P. McCarthy
Administrative Law Judge
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June 20, 2012

SECRETARY OF LABOR, : CIVIL PENALTY PROCEEDING
MINE SAFETY AND HEALTH : MINE SAFETY AND HEALTH ADMINISTRATION (MSHA), :
Petitioner, : Docket No. WEST 2009-766-M

v. : A.C. No. 10-01836-181178
MAGIC VALLEY SAND & GRAVEL, INC., : Dollar Dredge
Respondent.

DECISION GRANTING RESPONDENT’S MOTION FOR SUMMARY DECISION

This case is before me upon a petition for assessment of civil penalty under section 105(d) of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 801 et seq. (the “Mine Act”). It involves a single citation issued to Magic Valley Sand & Gravel, Inc. (“Magic Valley”) at its Dollar Dredge for an alleged violation of 30 C.F.R. § 56.15002. Citation No. 6436668 was issued under section 104(d)(1) of the Mine Act. Each party filed a motion for summary decision and filed an opposition to the other party’s motion. The only issue to be resolved is the amount of the civil penalty to be assessed. The parties disagree as to what effect Magic Valley’s size and financial condition should have on the amount of the penalty assessed. The Secretary asks that I affirm her proposed penalty while Magic Valley contends that the penalty should be significantly reduced.

I. JOINT STIPULATIONS OF FACT

The parties entered into detailed stipulations of fact for the purpose of summary decision. The relevant stipulations are set forth below.

1. This case involves a sand and gravel surface mine known as Dollar Dredge (“the Mine”), which is owned and operated by Magic Valley Sand & Gravel.

2. The Mine, MSHA ID No. 10-01836, is subject to the Federal Mine Safety and Health Act of 1977 (the “Mine Act”), as amended.

3. The Administrative Law Judge has jurisdiction over these proceedings, pursuant to Section 105 of the Mine Act.

4. Magic Valley Sand & Gravel is an “operator” as defined in Section 3(d) of the Mine Act.

5. Magic Valley Sand & Gravel’s operations affect interstate commerce.
6. Randall Adamson ("Adamson") whose signature appears in Block 22 of the citation at issue in this proceeding was acting in his official capacity as an authorized representative of the Secretary of Labor during the time of the inspection and when the citation was issued.

7. Magic Valley Sand & Gravel demonstrated good faith in abating the cited condition.

8. Government Exhibit 1 reflects the history of the mine for the fifteen months prior to the date of the citation.

9. This case involves a Section 104(d)(1) citation issued November 24, 2008, after an accident occurred at the Mine on November 21, 2008. Two citations were issued; one involved working under a suspended load (alleging a violation of C.F.R. § 56.16009) and the other, involved in this matter, alleged a violation of 30 C.F.R. § 56.15002. The suspended load violation was paid and is not part of any proceeding before the Federal Mine Safety and Health Review Commission.


11. The day before, on Friday, November 21, 2008 at approximately 5:15 PM, miner Steven Heins ("Heins") was struck in the head by a loose cross member during the construction of a new screen tower. For most of the workday, the mine’s employees had been working on setting up the new screen tower. The four 20-foot posts for the approximately 12-foot square new screen tower had been set on a cement pad and the miners were hooking up the 14 foot long, 3 inches by 3 inches by ¼ inch cross braces at the time of the accident. A manlift basket was used to lower the steel cross braces. While trying to align the bottom bolt of the top cross brace on the southwest corner of the screen tower the miners had moved to the northwest corner to loosen the chain fall, so that the tower uprights (the posts) would spread some to align the bolt hole. The unbolted top cross brace at the southwest corner fell off the bolt place ("dog") and struck miner Heins in the head. Heins was not wearing a hard hat and was working under the top two suspended cross braces. As a result of the accident, Heins suffered a concussion and a skull fracture, and his left ear was practically severed. He was released from the hospital on November 22 and cleared to return to work on November 28, 2008.

12. McGill, the company president, was working on site with Heins and miner Nick Roberts ("Roberts") loosening mount bolts on the southwest upright so that Heins and Roberts could spread the angle irons to align the bolt hold with the upright post.

13. McGill knew Heins was not wearing his hard hat but nevertheless allowed Heins to work under suspended loads because it was a cold day and Heins was wearing a sock hat.

14. McGill was the supervisor on the date of the accident.
15. Roberts was standing next to Heins when the brace came loose and fell, striking Heins in the head.

16. After Heins was struck in the head by the cross member, McGill called 911 and followed the ambulance to the hospital.

17. McGill then called the MSHA accident hotline to report the accident.

18. The Mine removed equipment from the accident site before MSHA arrived to perform its accident investigation. No 103(j) or (k) order had been issued when the equipment was removed. No special investigation is pending.

19. Heins had worked for Magic Valley Sand & Gravel for approximately ten years at the time of the accident.

20. Roberts had worked for Magic Valley Sand & Gravel for approximately four years at the time of the accident.

21. Adamson issued the citation as significant and substantial. Magic Valley Sand & Gravel agrees with this finding.

22. Adamson issued the citation to reflect the chance of injury or illness as reasonable likely. Magic Valley Sand & Gravel agrees with this finding.

23. Adamson issued the citation to reflect the chance of injury or illness as reasonably expected to be fatal. Magic Valley Sand & Gravel agrees with this finding.

24. Adamson issued the Citation as high negligence. Magic Valley Sand & Gravel agrees with this finding.

25. Adamson issued the citation as 1 person affected. Magic Valley Sand & Gravel agrees with this finding.

26. The penalty assessed to the citation was $60,000. Magic Valley Sand & Gravel disagrees with this finding and states that the penalty is too high, given its small size. Furthermore, although it does not claim an inability to pay, it states that based on its tax returns and other financial information, the $60,000 is excessive.

27. The Mine has been in operation since August 1988. A copy of the Mine Quarterly Production Information from 2001 through 2011 is Government Exhibit 2.

28. The penalty computation sheet and the Narrative Finding for a Special Assessment is Government Exhibit 3. The computation sheet used “0” for the “Controller Size Points” and the “Mine Size Points” because the mine is small. See Government Ex. 2 and 3. In addition the Mine received “0” points for history and repeated violations due to its safety record prior to the accident.
29. Respondent’s Exhibit 1 consists of tax returns and other financial data (unaudited) for the company.

30. The parties do not object to the receipt into evidence of Government Exhibits 1-3 and Respondent’s Exhibit 1.

II. BRIEF SUMMARY OF THE PARTIES’ ARGUMENTS

A. Secretary of Labor

The Secretary argues that a violation of 30 C.F.R. § 56.15002 occurred and the court should affirm the citation as written. The Secretary argues that the penalty of $60,000.00 is appropriate considering the six penalty review criteria set forth in Section 110(i) and the deterrent purposes of the Mine Act. The operator had no history of repeat violation history. The operator acted in good faith in abating the cited condition. The operator agrees it was highly negligent. The Secretary argues that the negligence criteria should be given more weight than the others because the president and co-owner knew the miner was not wearing a hard hat, disregarded basic safety principles, and the miner suffered severe injuries. The Respondent does not claim an inability to pay. The gravity of the situation was high because an injury was likely to occur, likely to be fatal, one person was affected, and the violation was significant and substantial. The Secretary argues that the court should give significant weight to the gravity of the situation. The Secretary argues that the Respondent has failed to provide adequate information regarding the size of its business and that the information provided shows the mine making a profit and paying significant wages.

B. Magic Valley Sand & Gravel

Magic Valley argues that the proposed $60,000.00 penalty should be disregarded. First it argues that the penalty would adversely affect its ability to stay in business. Second, it argues the penalty is inappropriate given the small size of the operator.

Magic Valley argues that the $60,000.00 penalty would adversely affect its ability to stay in business because it has consistently lost money between 2008 and 2010 and has not turned a profit since 2007. Respondent pays salaries to two employees and two shareholders and argues that the salaries are not excessive in terms of the amount of work they do to keep the business running. It argues that the financial information provided shows that the Respondent would have to employ fewer miners if it is required to pay the proposed penalty, which is a great threat to the continuation of the business as a whole. It argues that Congress did not intend or expect miners to suffer financial harm from the civil penalties paid by mine operators.

Magic Valley further argues that the proposed penalty is inappropriate and excessive given the small size of the company. The Dollar Dredge mine was only worked for 145 hours in 2008, 122 hours in 2009, 68 hours in 2010, and 92 hours in 2011, with between one and three
employees. The mine is one of three operated intermittently by Magic Valley. Further, Magic Valley points out that proposed penalties for many other companies in the mining industry are almost miniscule considering the relative profitability of their businesses.

III. FINDINGS OF FACT AND CONCLUSIONS OF LAW

Section 110(i) of the Mine Act states:

The Commission shall have authority to assess all civil penalties provided in this Act. In assessing civil monetary penalties, the Commission shall consider the operator’s history of previous violations, the appropriateness of such penalty to the size of the business of the operator charged, whether the operator was negligent, the effect on the operator’s ability to continue in business, the gravity of the violation, and the demonstrated good faith of the person charged in attempting to achieve rapid compliance after notification of a violation.


I find that the gravity of the violation was very serious. A very serious injury occurred as a result of this violation and the violation could have resulted in a fatality. The violation was properly determined to be of a significant and substantial nature. In this instance, failure to wear a hard hat led to one miner sustaining the serious injuries of concussion, skull fracture, and damaged ear. I also find that Magic Valley’s negligence was high. Magic Valley’s President, James McGill, was aware that the miner was not wearing his hard hat but allowed him to continue constructing a screen tower.

Respondent abated the condition in good faith. Excluding the two citations issued in response to this accident, the mine has a very low history of previous violations. The mine was only issued three citations prior to November 2008: two in 2001 and one in 2007. None of these violations were significant or substantial. I also find that the mine is extremely small. The mine worked for 143 employee-hours in 2007, 145 employee-hours in 2008, 122 employee-hours in 2009, 68 employee-hours in 2010, and 92 employee-hours in 2011. (See Government’s Exhibit 2). In addition, these hours were intermittent, with the mine unworked for periods up to half a year. Id. Total employment ranged between two and three employees during this period.

I also believe that the Secretary’s proposed penalty of $60,000.00 is likely to affect the mine’s ability to continue in business. As evidence of its ability to continue in business, Magic Valley has produced tax returns for the company for years 2007, 2008, 2009, and 2012, partial tax returns of the shareholders for 2008 through 2010, and sales summaries for 2007 to 2011. (Respondent’s Exhibit 1). Magic Valley’s tax returns show that the company last turned a profit in 2007. (See Respondent’s Exhibit 1 at 1). In 2008 Magic Valley lost $184,974.00 Id. at 14. In 2009 it lost $108,727.00 Id. at 26. In 2010, the last tax year for which Magic Valley has
provided a return, the company lost $14,417.00. While Magic Valley does not dispute its ability to pay the proposed penalty, the financial losses of 2008 to 2010 indicate that paying the full $60,000.00 penalty would likely affect the company’s ability to continue in business.

In consideration of Magic Valley’s small size and the adverse effect of the penalty on the mine’s ability to continue in business, I find that a penalty of $10,000.00 is appropriate. The Secretary specially assessed the penalty in accordance with 30 C.F.R. § 100.5. The regular assessment penalty amount for this Section 104(d)(1) citation would have been $2,000.00. (Government Exhibit 3; Sec. 110(a)(3)(A) of the Mine Act, 30 U.S.C. § 820(i)). In reducing the penalty, I have primarily relied on Magic Valley’s extremely small size. The Secretary’s penalty point system simply does not produce a fair result for very small sand and gravel operations. The Secretary’s proposed penalties for large multinational mining companies are proportionally smaller than the penalties it often proposes for small, intermittent sand and gravel operations. The operator’s small size warrants a reduction in the penalty in this case.

IV. ORDER

For the reasons set forth above, Magic Valley’s motion for summary decision is GRANTED to the extent that it is consistent with this decision. The Secretary’s motion for summary decision is DENIED to the extent it is inconsistent with this decision. Based on the criteria in section 110(i) of the Mine Act, 30 U.S.C. § 820(i), I assess a penalty of $10,000.00. For the reasons set forth above, Citation No. 6436668 is AFFIRMED and Magic Valley Sand & Gravel, Inc., is ORDERED TO PAY the Secretary of Labor the sum of $10,000.00 within 40 days of the date of this decision.¹

/s/ Richard W. Manning
Richard W. Manning
Administrative Law Judge

¹ Payment should be sent to the Mine Safety and Health Administration, U.S. Department of Labor, Payment Office, P.O. Box 790390, St. Louis, MO 63179-0390.
Distribution:

Jessica Allen, Esq., Office of the Solicitor, U.S. Department of Labor, 1999 Broadway, Suite 800, Denver, CO 80202-5708


RWM
June 20, 2012

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

Petitioner,

v.

7/11 MATERIALS, INC.,

Respondent.

DEcision ApprovIng settlement

Before: Judge Manning

This case is before me upon a petition for assessment of a civil penalty under section 105(d) of the Federal Mine Safety and Health Act of 1977, as amended (the “Mine Act”). The Secretary has filed an amended motion to approve settlement of Citation No. 8609256. The originally assessed amount was $5,000.00. The Secretary agrees to modify the citation to low negligence and Respondent agrees to a reduced penalty of $750.00.

As amended, the citation alleges a violation of 30 C.F.R. § 50.10(b). That regulation requires a mine operator to notify MSHA within 15 minutes “once the operator knows or should know that an accident has occurred involving . . . [a]n injury of an individual at the mine which has a reasonable potential to cause death.” In the present case a miner fell and hit his head, which resulted in a concussion and bleeding. In its answer, Respondent stated that it does not believe that the injury was life threatening but it did report the injury to MSHA within 15 minutes after it learned from the hospital that the injury was serious.

Section 110(a)(2) of the Mine Act provides that “[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 103(j) requires mine operators to notify MSHA within 15 minutes “of the time at which the operator realizes that . . . an injury . . . of an individual at the mine which has a reasonable potential to cause death, has occurred.” 30 U.S.C. § 813(j). In settling this case, Respondent agrees to withdraw its contest of the citation and the Secretary agrees to reduce the negligence to low. The reduction in the negligence is based on Respondent’s representation that it called 911 immediately after the miner suffered the injury and reported the injury to MSHA within 15 minutes of learning from medical personnel that the injury was potentially serious.
I find that the provisions of section 110(a)(2) of the Mine Act apply in this case. When the Mine Act was amended to include the language of section 110(a)(2), the Secretary amended section 50.10 to comply with that statutory language. In this case, the Secretary proposed a civil penalty of $5,000.00 for the alleged violation in compliance with the statutory language. During settlement negotiations, the Secretary recognized that Respondent would present evidence at a hearing that it contacted MSHA within 15 minutes of learning from medical personnel that the injury was potentially serious. Respondent contends that, although the injury was serious, it was not life threatening and it notified MSHA in an abundance of caution. Recognizing that there are genuine issues of material fact as to whether there was a violation of the regulation, the parties agreed to reduce the level of negligence attributable to Respondent to settle the case.

Under section 110(i) of the Mine Act, the Commission has the authority to assess all civil penalties and, although the Secretary proposes penalties, it is the Commission that is responsible for assessing penalties. Sellersburg Stone Co., 5 FMSHRC 287, 290-91 (Mar. 1983), aff’d. 736 F. 2d 1147 (7th Cir. 1984). The Commission’s assessment of penalties is a de novo determination based on the six statutory criteria set forth in section 110(i) of the Mine Act. I find that section 110(a)(2) of the Mine Act is directed only to the Secretary and not to the Commission or its administrative law judges. On that basis, I conclude that I have the authority to assess a penalty for a violation of section 50.10 that is less than $5,000.00 in appropriate circumstances. At least one other administrative law judge has reached the same conclusion. E.S. Stone & Structure, Inc. 33 FMSHRC 515, 520 (Jan. 2011) (ALJ).

After considering the facts and circumstances in this case and all six of the statutory criteria, I find that a penalty of $750.00 is reasonable and appropriate. The parties stipulated to the following. The issuing MSHA inspector determined that the violation was neither serious nor significant and substantial. The operator had a history of 17 paid violations over the 15 months prior to May 2, 2011, the date of the present citation. The mine worked about 9,000 hours in 2011 and employed about four miners. The violation was abated in good faith and the penalty will not affect the operator’s ability to continue in business. Respondent’s negligence was low.

I have considered the representations and documentation submitted and I conclude that the proposed settlement is appropriate under the criteria set forth in section 110(i) of the Act. The amended motion to approve settlement is GRANTED, the citation is MODIFIED as set forth above, and 7/11 Materials, Inc., is ORDERED TO PAY the Secretary of Labor the sum of $750.00 within 30 days of the date of this decision.1

/s/ Richard W. Manning
Richard W. Manning
Administrative Law Judge

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1 Payment should be sent to the Mine Safety and Health Administration, U.S. Department of Labor, Payment Office, P.O. Box 790390, St. Louis, MO 63179-0390.
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Michael Machado, Safety Manager, 7/11 Materials, Inc., PO Box 4770, Modesto, CA 95352

/atc
This case is before me on a petition for assessment of civil penalty filed by the Secretary of Labor ("Secretary"), acting through the Mine Safety and Health Administration ("MSHA"), against Puna Rock, Ltd. ("Puna") at the Keaau Quarry mine ("the mine"), pursuant to section 104(a) of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 814 (the "Mine Act" or "Act"). The parties presented testimony and documentary evidence at a hearing held on May 29, 2012 in Hilo, Hawaii.

I. BACKGROUND

The Keaau Quarry is a basalt crushed stone operation owned and operated by Puna Rock Company, Ltd. The quarry is located near Hilo, Hawaii and employs six workers. (Tr. 8). The mine crushes, sizes, and loads rock. The parties stipulated that Puna is a small operator, that it is subject to the jurisdiction of Mine Act, and the Commission has jurisdiction to hear the case. (Tr.5-8). During a regular inspection on April 13, 2010, Inspector Scott Amos issued the two citations that are at issue in this case. Citation Nos. 8558520 and 8558521 have been assessed a total proposed penalty of $16,000.00.
II. STATEMENT OF FACTS AND LAW

This case involves two related citations, arising from a single activity; one for failure to provide safe access, and one for failure to wear fall protection. MSHA inspector Scott Amos issued both citations, which were accompanied by an imminent danger order. Amos designated both violations as S&S with high negligence.

Inspector Scott Amos is employed in the Boise MSHA field office and has been with MSHA for 5 years. Prior to his employment with MSHA he spent eight to ten years in the mining industry and, at two different times, was the manager of a crusher operation.

On April 13, 2010, Amos arrived at the scale house at the Keaau quarry, and then drove to the crusher with Delbert Cambra, the mine’s supervisor, who accompanied Amos during his inspection. Amos immediately noticed two miners replacing a burned out motor while standing on a wet, muddy area above the crusher. He issued an imminent danger order, and instructed the miners to come down. Subsequently, he issued two citations in conjunction with the 107(a) order. The imminent danger order has not been contested by Respondent.

After speaking with the miners and their supervisor, Amos learned that a small motor on the conveyor belt was not operating that morning. The two miners were either assigned, or decided on their own, to repair the motor. The manlift that would normally have been used to lift the miners to the motor location was not available as it was in the shop for repairs. Therefore, the miners, after discussing whether the use of fall protection was warranted, climbed up at a designated location, walked along a metal walkway, and then ducked under the rail and stepped onto the narrow metal area directly above the conveyor belt. The area they stepped on to access the motor was described as the 36-inch wide filter rock belt. The belt was 74 inches above ground level and was slick from mud and rain. After the miners accessed the area, they spread their tools on the narrow area where they were standing. One worker was standing on a narrow metal strip, just above the other, with the tools at his feet. When Amos arrived, that miner was bending over to repair the motor. The exhibits presented by the Secretary, Sec’y Exs., 4 and 7, are clear photos of the area, the route used to access the area, and the small space upon which each miner stood to repair the motor. The conveyor belt was not in operation.

According to Amos, a safe way to repair the motor would have been from either a manlift or from a ladder with the proper safety precautions in place. If the miners choose, instead, to stand near the motor, MSHA would require the mine to construct a platform with a rail, similar to the walkway with the rail that was adjacent to the area cited. Sec’y Ex. 4.

As a result of the miners climbing over the guard rail and onto the narrow metal area six feet above the ground, Amos issued two citations. Citation No. 8558520 was issued for a violation of Section 56.15005, a mandatory safety standard for metal and non-metal mines that requires, “[s]afety belts and lines shall be worn when persons work where there is danger of falling; a second person shall tend the lifeline when bins, tanks, or other dangerous areas are entered.” 30 C.F.R. § 56.15005. There is no dispute that the miners were working in an area where there was a danger of falling. In fact, Amos believed that the fall was imminent given the
conditions that he observed. While there is no dispute that lifelines and fall protection were available, there is evidence to support that they were not being worn. The standard for determining whether fall protection is required was articulated by the Commission in *Great Western Electric Co.*, 5 FMSHRC 840, 842 (May 1983), finding that the standard is “whether an informed, reasonably prudent person would recognize a danger of falling warranting the wearing of safety belts and lines.” Given the height of the work, the small area where the miners were standing, and the conditions at the time of the citation, the danger of falling was undeniable. The operator raised no defense to the fact of the violation, and I find, based upon the credible testimony of Amos, that a violation has been shown.

Amos also issued Citation No. 8558521 as a result of the miners working in the narrow area above the conveyor belt. Amos cited a violation of Section 56.11001, a mandatory safety standard for travelways that requires that “[s]afe means of access shall be provided and maintained to all working places.” 30 C.F.R. § 56.11001. Amos explained that, because the miners walked along the elevated platform with a guardrail, then ducked under the guardrail and stepped on to the narrow metal area next to the motor, no safe access was provided. Amos would expect to see either a ladder up to a constructed platform with railings or a manlift, from which the miners could work. The miners were repairing a motor while standing on the narrow metal platform, thereby establishing it as a working area. Again, there is no dispute that the violation occurred as described by Amos. The miners stepped over the guard rail and onto a slippery metal surface where they began to repair the motor. They were walking on the belts and clearly they had no means of safe access to the motor without the availability of a manlift or a ladder and protected platform. The mine manager explained that, while the mine did have a manlift for such work, it was in the shop for repairs. I find that the Secretary has presented substantial evidence to support the violation.

Each of the violations was designated by the inspector as significant and substantial (“S&S”). A S&S violation is described in section 104(d)(1) of the Act as 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 U.S.C. § 814(d)(1). A violation is properly designated S&S “if, based upon the particular facts surrounding that violation, there exists a reasonable likelihood that the hazard contributed to will result in an injury or illness of a reasonably serious nature.” *Cement Div., Nat’l Gypsum Co.*, 3 FMSHRC 822, 825 (Apr. 1981). The Commission has explained that:

[i]n order to establish that a violation of a mandatory safety standard is significant and substantial under *National Gypsum*, the Secretary of Labor must prove: (1) the underlying violation of a mandatory safety standard; (2) a discrete safety hazard--that is, a measure of danger to safety--contributed to by the violation; (3) a reasonable likelihood that the hazard contributed to will result in an injury; and (4) a reasonable likelihood that the injury in question will be of a reasonably serious nature.
Mathies Coal Co., 6 FMSHRC 1, 3-4 (Jan. 1984) (footnote omitted); see also, Buck Creek Coal, Inc. v. MSHA, 52 F.3d 133, 135 (7th Cir. 1999); Austin Power, Inc. v. Secretary, 861 F.2d 99, 103-04 (5th Cir. 1988), aff’d Austin Power, Inc., 9 FMSHRC 2015, 2021 (Dec. 1987) (approving Mathies criteria). The question of whether a particular violation is S&S must be based on the particular facts surrounding the violation. Texasgulf, Inc., 10 FMSHRC 498 (Apr. 1988); Youghiogheny & Ohio Coal Co., 9 FMSHRC 2007 (Dec. 1987).

Inspector Amos explained that both violations were S&S for substantially the same reasons. The miners were standing on a narrow metal portion of the belt that was at an angle, with mud and rock creating a slip and fall hazard. The miners had no safety line, and there was no guard or railing to hold onto while maneuvering on the strip of metal that did not exceed 36 inches wide. It was raining at the time of Amos’ inspection and, as he observed the miners, he realized that their attention was focused on the repair at hand, and not the ability to remain on the slippery metal surface. Amos further explained that he is aware of a history of miners falling from such locations and being seriously injured or even killed. The potential for falling was great and the distance to the ground was more than six feet. The ground below was rock. The miners stood so close together on a narrow area that, if one fell, the other was bound to go with him. Amos asserts that the miners would have continued the repair in this unsafe manner had he not intervened. I find that there is a discrete safety hazard, that the hazard, which is a fall from greater than six feet, was reasonably likely to occur and that when it occurred it would have resulted in a reasonably serious injury. The mine argues that the fall from this height would not be fatal, but I credit the testimony and experience of Amos and agree that it is reasonably likely to be fatal.

A finding of S&S when such a fall hazard exists is in accord with prior ALJ decisions addressing this issue. For example in Moltan Co., LP, 31 FMSHRC 427 (Mar. 2009) (ALJ) the judge, crediting an inspector’s testimony that fatal falls have occurred from heights of ten feet or less, found an S&S violation where a miner was working without fall protection at a height of approximately seven feet. Here the miners were six feet above the ground, but Amos testified that fatalities have occurred from as low as three feet off of the ground. Hence, I find both violations to be significant and substantial.

Finally, Amos designated both violations as being the result of high negligence, although initially he marked both of them as moderate. He changed his view based upon what he learned from the mine manager, Cambra, and based upon his belief that Cambra knew that the motor was being repaired and that as a supervisor, he should have ascertained that it was being done safely. Amos also took into account the fact that Cambra was aware that the manlift was not working, but allowed the miners to work at a six foot height without a safe, viable alternative. Amos was under the impression that the supervisor assigned the two to complete the repairs, not that they undertook it on their own. He also learned from the workers that they considered using fall protection but determined that the height was not great enough to require the use of lifelines. Again, the supervisor did nothing to assure that they used the protection that was readily
available. Instead, the miners, left to their own judgment, determined that under OSHA regulations, the area was not above 72 inches and therefore protection was not required. They further reasoned that, even if they used the six foot safety line available, it would not prevent a fall into the conveyor given the configuration of the conveyor structure and, instead, may be more dangerous.

The mine operator testified that he questioned the manager and the miners and was given identical information regarding the life-lines. The workers did not believe they were required to wear the life lines given the location and height of the area in which they were working. However, the mine operator disagreed that the supervisor knew that the men were working on the motor. Instead, he explained, when a motor or minor repair must be made, the miners automatically do the repair and do not necessarily inform the supervisor. The supervisor is a mechanic, and if the miners have difficulty or can’t complete the repair, then they call on him. Otherwise, repairs are made daily as a matter of course without alerting the supervisor at the time. The operator further explained that the mine has not received citations of this nature in the past.

I find both the inspector and the mine operator to be credible witnesses. Given their testimony, I agree with Amos that Citation No. 8558521 is the result of high negligence. A manlift, although in need of repair, could have been available and the miners clearly should have known that it was not a safe practice to duck under a guard rail and access a cramped area that was wet and muddy to conduct repairs. The unsafe action was evident and the men should have known that such a practice could have deadly consequences. Further, even though the manlift was not working, it was quickly repaired so that the citation was terminated and the work completed from the manlift the same day.

I find that the violation for not wearing fall protection, described in Citation No. 8558520, was the result of moderate negligence. The miners explained that they considered the fall protection and believed that it was not necessary and that they would not be protected if they were to fall. If the supervisor was aware of the actions of the miners, he had a responsibility to ascertain that the work was done safely and in compliance with MSHA regulation. However, I find that there is not substantial evidence to support that he did know that the miners were doing the repair and were not wearing fall protection.

III. PENALTY

The principles governing the authority of Commission administrative law judges to assess civil penalties de novo for violations of the Mine Act are well established. Section 110(i) of the Mine Act delegates to the Commission and its judges “authority to assess all civil penalties provided in [the] Act.” 30 U.S.C. § 820(i). The Act delegates the duty of proposing penalties to the Secretary. 30 U.S.C. §§ 815(a) and 820(a). The Act requires that, “in assessing civil monetary penalties, the Commission [ALJ] shall consider” six statutory penalty criteria:

In keeping with this statutory requirement, the Commission has held that “findings of fact on the statutory penalty criteria must be made” by its judges. Sellersburg Stone Co., 5 FMSHRC 287, 292 (Mar. 1983), aff’d, 736 F.2d 1147 (7th Cir. 1984).

I accept the stipulation of the parties that the penalties as proposed will not affect the operator’s ability to continue in business. The violation was abated in good faith. This is a small mine operator with a very limited violation history. Sec’y Ex.1. I find that the Secretary has established the gravity of both violations at the levels cited. The Secretary issued a special assessment in this case. Having changed the negligence of Citation No. 8558520 from high to moderate, and based upon a review of all of the penalty criteria, a lower penalty is warranted. I assess a penalty of $2,000.00 for Citation No. 8558520 and a penalty of $4,000.00 for Citation No. 8558521.

IV. ORDER

Based on the criteria in section 110(i) of the Mine Act, 30 U.S.C. § 820(i), I assess the penalties listed above for a total penalty of $6,000.00. Puna Rock Company Ltd. is hereby ORDERED to pay the Secretary of Labor the sum of $6,000.00 within 30 days of the date of this decision.

/s/ Margaret A. Miller
Margaret A. Miller
Administrative Law Judge

Distribution: (U.S. First Class Mail)

Timothy J. Turner, Office of the Solicitor 1999 Broadway, Suite 800, Denver, CO 80202-5708
Russell Y. Kuwaye, President, Puna Rock Company Ltd., P.O. Box 566, Keaau, HI 96749
ORDER GRANTING THE SECRETARY’S MOTION FOR SUMMARY DECISION

Before: Judge Barbour

This case is before me upon a Petition for Assessment of a Civil Penalty under Section 105(d) of the Federal Mine Safety and Health Act of 1977 (the “Act”). On August 5, 2008, the Commission received the Secretary of Labor’s Petition for the Assessment of Civil Penalty in which she seeks $6,986.00 for two citations issued pursuant to section 104(a) of the Act, 30 U.S.C. § 814(a). Citation No. 6059501 alleges a violation of 30 C.F.R. § 56.3200 and Citation No. 6059507 alleges a violation of 30 C.F.R. § 56.14132(b)(2). This case was assigned to me by Chief Judge Robert J. Lesnick.

The citations arise out of an inspection conducted on April 15, 2008 by MSHA Inspector William E. Lane at the Raymond Sand & Gravel mine in Rockingham, New Hampshire. Citation No. 6059501 states:

Quarry high wall conditions that create a fall of material hazard to persons are not being corrected at this operation. The West side

1 Section 56.3200, 30 C.F.R. § 56.3200, states:

Ground conditions that create a hazard to persons shall be taken down or supported before other work or travel is permitted in the affected area. Until corrective work is completed, the area shall be posted with a warning against entry and, when left unattended, a barrier shall be installed to impede unauthorized entry.

Section 56.14132(b)(2), 30 C.F.R. § 56.14132(b)(2), states, “[a]larm[s] shall be audible above the surrounding noise level.”
face of the #1 bench contains a large area of unsupported, overhanging material. The high wall in this area is approximately 100 ft. in height, with the start of material overhang at approximately 40 ft. The unsupported material above this point, displays numerous cracks and secondary breakage, with some spalls and unconsolidated material also observed. Tracks indicate that the loader travels along this high wall to reach the muck pile at the North face of this bench. Oversized ledge that has been stacked along the East face narrows the opening and forces the loader closer to the overhanging material. The mine operator has barricaded access to the #1 bench until the unsupported material can be taken down.

Citation No. 6059501.

The inspector found that the alleged violation was reasonably likely to cause a fatal injury to one person, was a significant and substantial contribution to the cause and effect of a mine safety or health hazard and that the violation reflected high negligence by the operator. A penalty of $6,624.00 was proposed. The Respondent was given 55 minutes to abate the violation. Citation No. 6059501. When the violation was not timely abated the inspector issued a section 104(b) withdrawal order, Order No. 6059504. The order was terminated on April 16, 2008 when the overhanging material on the #1 bench was removed by the Respondent.

During the same inspection the inspector also issued Citation No. 6059507. The citation states:

The reverse activated back-up alarm provided on the Cat 988B quarry loader is not audible over the surrounding noise. A sound level meter was used to measure the noise of the loader’s engine: at an idle the reading was 84.0 dB. The engine was shut off and the sound of the back-up alarm was measured: the reading was 67.7 dB. This loader is used to excavate shot rock in the quarry and feed the crushing plant. The inaudible alarm exposes plant personnel or other equipment to being struck by or run over by the loader.

Citation No. 6059507.

The inspector found that the violation was unlikely to cause fatal injury to one person and reflected moderate negligence by the operator. Citation No. 6059507. A penalty of $362.00 was proposed.

On April 06, 2012 the Commission received the Secretary’s Motion for Summary Decision and Determination of Penalty. On the same day the court contacted the parties via electronic mail to confirm receipt of the Secretary’s motion, to remind the company that it had eight days to file a response and to advise the company that its failure to timely respond to the motion could result in a default judgment against it. The Respondent did not respond to the Secretary’s motion.

The Secretary’s Motion for Summary Decision states that the Respondent has failed to respond to her First Set of Requests for Admission which were served upon the Respondent on March 06, 2012. Sec’y Mot. for Summ. Dec. 2. The Secretary contends that because the
Respondent has failed to respond to her requests; the facts underlying the citations; the fact of violation; the effect of the penalties on the company’s ability to continue in business; and the inspector’s findings regarding gravity, negligence and the number of persons affected by the violations are deemed admitted under Commission Rule 58(b), 29 C.F.R. § 2700.58(b). See id. at 1-4. (Rule 58(b) requires a party served with a request for admissions to respond within 25 days.)

In her request for admissions the Secretary asked that the Respondent:

1. **Admit or Deny:**
   
   Respondent was an “operator[,]” as defined in §3(d) of the Federal Mine Safety and Health Act of 1977, as amended (hereinafter “the Mine Act”), 30 U.S.C. §802(d), of the Mine at the time Citation 6059501 and Citation 6059507 were issued.

2. **Admit or Deny:**

   The operations of the Respondent at the Mine, at the times Citation [No.] 6059501 and Citation [No.] 6059507 were issued, are subject to the jurisdiction of the Mine Act.

3. **Admit or Deny:**

   The above-captioned proceeding is subject to the jurisdiction of the Federal Mine Safety and Health Commission and its assigned Administrative Law Judges pursuant to Sections 104 and 113 of the Mine Act.

4. **Admit or Deny:**

   Inspector William E. Lane was acting in his official capacity and as an authorized representative of the Secretary of Labor when Citation [No.] 6059501 and Citation [No.] 6059507 were issued.
5. **Admit or Deny:**

   True copies of Citation [No.] 6059501 and Citation [No.] 6059507 were served on the Respondent and/or its agent, as is required by the Mine Act.

6. **Admit or Deny:**

   The citations contained in “Exhibit A,” attached to the Secretary’s petition in the case docketed YORK 2008-204M, are authentic copies of Citation [No.] 6059501 and Citation [No.] 6059507 with all the appropriate modifications or abatements, if any.

7. **Admit or Deny:**

   Payment of the total proposed penalty for all citations at issue ($6,986.00), will not affect Respondent’s ability to continue in business.

**Citation [No.] 6059501**

8. **Admit or Deny:**

   At the time Citation [No.] 6059501 was issued, there existed overhanging rock, featuring numerous cracks, approximately 40 feet up a 100 foot highwall, in violation of 30 C.F.R. § 56.3200.

9. **Admit or Deny:**

   With regards to the unsupported, overhanging material identified in Citation [No.] 6059501, the violative condition was reasonably likely to cause fatal injury; which was significant and substantial in nature; the result of the Operator’s high negligence; and would have affected one miner.
10. Admit or Deny:

The Operator’s failure to remove the highly dangerous unsupported material that was identified in Citation [No.] 6059501, was the result of the Operator’s unwarrantable failure to comply with the Mine Act, as that term is defined in § 104(d)(1) of the Mine Act.²

11. Admit or Deny:

The narrative provided in box 8 of Citation [No.] 6059501 is a true and accurate statement.

Citation [No.] 6059507

12. Admit or Deny:

At the time Citation [No.] 6059507 was issued, the backup alarm on the CAT 988B quarry loader could not be heard over the surrounding noise in violation of 30 C.F.R. § 56.14132(b)(2).

13. Admit or Deny:

With regards to the inadequate backup alarm identified in Citation [No.] 6059507, the violative condition was unlikely to cause a fatal injury; was the result of the Operator’s moderate negligence; and would have affected one miner.

² Citation No. 6059501 was issued pursuant to Section 104(a) of the Act, 30 U.S.C. § 814(a). The Act does not provide for findings of unwarrantable failure under this section, and the citation contains no finding of unwarrantable failure. No motion has been filed to modify the citation from an enforcement action under section 104(a) to an enforcement action under 104(d); I infer that the Secretary’s request for admission on the issue of unwarrantable failure was an error and that no ruling is required regarding this request.
14. **Admit or Deny:**

The narrative provided in box 8 of Citation [No.] 6059507

is a true and accurate statement.

Sec’y Mot. for Summ. Dec., Exhibit A.

**A. Citation No. 6059501**

Commission Rule 67(b), 29 C.F.R. § 2700.67(b), states:

A motion for summary decision shall be granted only if the entire record, including the pleadings, depositions, answers to interrogatories, admissions, and affidavits, shows:

(1) That there is no genuine issue as to any material fact; and

(2) That the moving party is entitled to summary decision as a matter of law.

Commission Rule 58(b), 29 C.F.R. § 2700.58(b), states:

Any party, without leave of the Judge, may serve on another party a written request for admissions. A party served with a request for admissions shall respond to each request separately and fully in writing within 25 days of service, unless the party making the request agrees to a longer time. The Judge may order a shorter or longer time period for responding. A party objecting to a request for admissions shall state the basis for the objection in its response. Any matter admitted under this rule is conclusively established for the purpose of the pending proceeding unless the Judge, on motion, permits withdrawal or amendment of the admission.

Rule 58(b), which governs the use of requests for admissions in Commission proceedings, does not state the effect of a party’s failure to respond to such requests. Commission Rule 1(b), 29 C.F.R. § 1(b) provides that, “[o]n any procedural question not regulated by the Act, these Procedural Rules, or the Administrative Procedure Act (particularly 5 U.S.C. 554 and 556), the Commission and its Judges shall be guided so far as practicable by the Federal Rules of Civil Procedure and the Federal Rules of Appellate Procedure.” Federal Rule of Civil Procedure 36 provides guidance regarding unanswered requests for admissions and states in pertinent part:

(a)(3) **Time to Respond; Effect of Not Responding.** A matter is admitted unless . . . the party to whom the request is directed serves on the requesting party a written answer or objection addressed to the matter and signed by the party or its attorney.
(b) **Effect of an Admission; Withdrawing or Amending It.**

A matter admitted under this rule is conclusively established unless the court, on motion, permits the admission to be withdrawn or amended.

Contrary to the Secretary’s claim, Commission Rule 58(b) does not itself deem an unanswered request for admissions admitted. The rule is silent regarding the consequences of a party’s failure to respond. Rather, it is Federal Rule of Civil Procedure 36 which provides guidance on this issue and ultimately supports the Secretary’s request that her request for admissions be deemed admitted. I find that because the Respondent failed to deny the facts as alleged in the Secretary’s Request for Admissions the facts are deemed admitted. As a result, I find that the Secretary has established that the Respondent is an operator subject to the jurisdiction of the Mine Act and that the penalties proposed in this docket will not affect the Respondent’s ability to continue in business. I also find that the Secretary has established that Raymond violated 30 C.F.R. § 56.3200, that the violation was reasonably likely to cause fatal injury was significant and substantial in nature and was the result of the company’s high negligence.

Since both the facts underlying the citation and the related legal issues have been admitted by virtue of the company’s failure to respond to the Secretary’s Request for Admissions, I find that there are no genuine issues of material fact with regard to Citation No. 6059501, and I find that the Secretary is entitled to summary decision as a matter of law.

**B. Citation No. 6059507**

For the reasons provided supra, I find the Secretary has established that a violation of the cited standard occurred, that the violation was unlikely to cause fatal injury to one miner and that the violation was the result of the company’s moderate negligence. I find that no genuine issues of material fact exist and that the Secretary is entitled to summary decision as a matter of law.

While the court is cognizant that summary decision, if used improperly, may deprive a litigant of its right to be heard, no such danger exists here. The Respondent has been given ample time to familiarize itself with the Commission’s rules and to present its case. This docket has been before the court since June 18, 2009. On December 20, 2011 the Secretary informed the court through an e-mail communication that the operator had been unresponsive and requested that the court enter a default order in this case. The court contacted the Respondent to reiterate its responsibility to actively engage with the Secretary regarding this case. As noted earlier, when the Secretary filed her motion for Summary Decision the court again reminded the company of its obligation to actively engage in the litigation process and warned the company of the consequences of failure to do so. While some latitude is granted to parties appearing before the court without the benefit of counsel, it is ultimately the responsibility of the litigants to abide by the Commission’s rules and actively litigate their rights.

I have considered the representations and documentation submitted in this case and have determined that the proposed penalty is appropriate under the criteria set forth in section 110(i) of the Act.
WHEREFORE, the Secretary’s Motion for Summary Decision and Determination of Penalty is **GRANTED**.

It is **ORDERED** that the Respondent pay a penalty $6,986.00 within 30 days of this order.\(^3\) Upon receipt of payment this case is **DISMISSED**.

\[\text{\(\text{s}/\) David F. Barbour}\]
David F. Barbour  
Administrative Law Judge

Distribution:

Kevin Cole and Linda Cole, Raymond Sand and Gravel, 321 Route 27, Raymond, NH 03077
\(\text{\textsc{ca}}\)

\(^3\) Payment should be sent to: MINE SAFETY AND HEALTH ADMINISTRATION, U.S. DEPARTMENT OF LABOR, PAYMENT OFFICE, P. O. BOX 790390, ST. LOUIS, MO 63179-0390.
June 21, 2012

SECRETARY OF LABOR, : TEMPORARY REINSTATEMENT
MINE SAFETY AND HEALTH : PROCEEDING
ADMINISTRATION (MSHA) : 

on behalf of REUBEN SHEMWELL, : Docket No. KENT 2012-655-D
Complainant : MADI CD 2012-08

v.

ARMSTRONG COAL COMPANY, INC., : Parkway Mine Surface Facilities
Mine ID: 15-19356

and

ARMSTRONG FABRICATORS, INC., : 

Respondents :

DECISION ON REMAND
AND
ORDER OF TEMPORARY REINSTATEMENT


Before: Judge Feldman

This proceeding seeking the temporary reinstatement of Reuben Shemwell has been brought pursuant to section 105(c)(2) of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 815(c)(2) (“Act” or “Mine Act”). Under section 105(c)(2), “if the Secretary finds that [a discrimination] complaint was not frivolously brought, the Commission, on an expedited basis upon application of the Secretary, shall order the reinstatement of the miner pending final order on the complaint.” 30 U.S.C. § 815(c)(2). The Commission has noted that the parameters of a temporary reinstatement hearing are narrow, being limited to a determination with respect to whether a miner’s discrimination complaint has been frivolously brought. See Sec’y of Labor o/b/o Price v. Jim Walter Res., Inc., 9 FMSHRC 1305, 1306 (Aug. 1987), aff’d, 920 F.2d 738 (11th Cir. 1990).
I. Procedural History

For the purposes of this proceeding, Shemwell’s relevant employment period as a welder was from April 19, 2010, until his termination on September 14, 2011. Shemwell’s welding duties concerned maintaining and repairing draglines at Armstrong Coal Company, Inc.’s (“Armstrong Coal Company’s” or “Armstrong Coal”) Midway and Equality surface mines. Tr. 218-19. The Midway mine is located in Ohio County, Kentucky. Tr. 119-20, 218-19. The Equality mine, located in Muhlenberg County, Kentucky, is approximately ten miles from the Midway mine. Tr. 119-20.

In addition to repairing draglines, Shemwell was assigned to work at the Armstrong Fabricators, Inc. (“Armstrong Fabricators”) shop also located in Muhlenberg County. The shop is situated off mine property, adjacent to Armstrong Coal Company’s Parkway preparation plant (Mine ID: 15-19356). The preparation plant is co-located with Armstrong Coal Company’s Parkway underground coal mine. Tr. 218-19. Armstrong Coal Company’s mobile equipment was maintained at the Armstrong Fabricators shop. Tr. 116-17, 250.

Armstrong Coal Company, Inc. and Armstrong Fabricators, Inc. are distinct corporate entities incorporated in the state of Delaware. Resp. Opp. to Sec’y Sum. Dec. Mot., Exs. A, B. Although they are distinct business entities, Armstrong Coal Company and Armstrong Fabricators are affiliated companies that are both related to Armstrong Energy, Inc.1 Tr. 120-21.

The Secretary alleges that Shemwell’s dismissal was motivated by his April 2011 complaints concerning the need for improved respirator protection from fumes that were generated during the welding process. Following Shemwell’s complaint, upgraded respirators were ordered by Armstrong Coal in August 2011 for distribution to welding personnel. The Secretary’s application initially sought an order reinstating Shemwell to a position at Armstrong Coal Company through a motion for summary decision filed on March 21, 2012.

Armstrong Coal opposed Shemwell’s reinstatement. Armstrong Coal argued that although Shemwell had worked as a welder at its surface mine facilities, Shemwell was employed by Armstrong Fabricators. Prior to Armstrong Fabricators’ inclusion as a party, Armstrong Coal Company contended that Armstrong Fabricators did not have the ability to reinstate Shemwell because it had ceased operations at its shop. Although Armstrong Coal asserted it was not a responsible party, it nevertheless asserted that Shemwell was discharged for excessive personal cell phone use during working hours.

1 MSHA’s data retrieval system records reflect that Armstrong Coal Company, Inc., is the preparation plant operator of the Parkway Mine Surface Facilities, Mine ID: 15-19356. The records further reflect that the controller of the Parkway Mine Surface Facilities is Armstrong Energy Corporation LLC.
In response to Armstrong Coal’s opposition, on April 2, 2012, the Secretary filed a motion to amend her initial application for temporary reinstatement to add Armstrong Fabricators as a party. On April 20, 2012, I issued a decision that granted both the Secretary’s amended application for temporary reinstatement, and the Secretary’s motion for summary decision that sought the reinstatement of Shemwell. 33 FMSHRC __ (Apr. 2012) (ALJ). Armstrong Coal and Armstrong Fabricators filed a joint petition for review of the April 20, 2012, decision.

The Commission remanded this matter on May 10, 2012. 33 FMSHRC __, slip op. (May 2012). The Commission did not disturb the grant of the Secretary’s motion to amend the application for temporary reinstatement to include Armstrong Fabricators. Id. at 5, fn. 4. However, the Commission accepted review, vacated the grant of the Secretary’s motion for summary decision, and remanded this matter for further proceedings. Id. at 6. In addition to receiving other evidence relevant to a temporary reinstatement proceeding, the Commission specifically directed that I determine whether there was a layoff at Armstrong Fabricators that would toll its obligation to reinstate Shemwell.2 Id. at 5. Because the vacated April 20, 2012, decision ordered Shemwell’s reinstatement no later than April 25, 2012, the Commission’s remand directed that the pay and benefits associated with any reinstatement should be retroactive to April 25, 2012. Id.

A hearing was conducted in Owensboro, Kentucky on May 23, 2012. Post-hearing briefs were simultaneously filed on June 12, 2012. The Respondents presented testimony that Armstrong Fabricators laid off its personnel at its shop where it maintained mobile equipment.3 However, welders assigned to Armstrong Fabricators continue to maintain draglines and buckets at Armstrong Coal Company’s surface mine facilities. Tr. 206-07.

David Lander, Armstrong Coal’s manager of draglines, repeatedly disciplined Shemwell for using his cell phone during the workday. The disciplinary actions occurred on three occasions beginning on June 8, 2011, shortly after Shemwell complained to Lander in April 2011 about the need for more effective respirator protection.4 Resp. Exs. 2-4. Lander’s discipline served as a significant basis for Shemwell’s ultimate September 14, 2011, termination. Given the relatively short intervening period between the protected activity and the disciplinary

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2 Shemwell’s complaint has also been challenged on the basis of timeliness. The Commission noted that this issue should be resolved in any subsequent discrimination proceeding on the merits. Comm’n Rem., slip op. at 5.

3 Armstrong Coal Company, Inc., and Armstrong Fabricators, Inc., who are jointly represented in this matter by Adam K. Spease, Esq., are collectively referred to herein as “Respondents.”

4 Counsel for Armstrong Coal and Armstrong Fabricators stipulated, for the purposes of this proceeding, that Shemwell’s respirator complaints culminated in the August 2011 purchase of upgraded respirators. Tr. 27-28.
action that led to Shemwell’s discharge, it is clear that Shemwell’s discrimination complaint has not been frivolously brought.

II. Findings of Fact

a. Protected Activity

On March 15, 2010, Shemwell filed an application for employment for the position of welder/laborer with Armstrong Coal Company. Gov. Ex. 5 at p. 1. Shemwell was hired by Armstrong Coal Company on April 19, 2010. Id. at p. 2. At that time, Shemwell enrolled in Armstrong Coal Company’s 401(k) plan. Id. at pp. 3, 6. Upon being hired, Shemwell signed statements related to Armstrong Coal Company’s policies and procedures. Namely, Shemwell certified that he had received and read Armstrong Coal Company’s anti-harassment policy. He also signed statements that he had “received a copy of the Armstrong Coal Company, Inc. Employee Handbook,” and, that he understood and agreed to abide by Armstrong Coal Company’s clothing policy. Finally Shemwell authorized Armstrong Coal Company to make direct deposits of his salary into his bank account. Id. at pp. 4, 5, 7, 8.

Shemwell’s job duties included maintaining mobile equipment at Armstrong Fabricators’ shop, as well as welding and repairing draglines at Armstrong Coal’s surface facilities. Shemwell was not aware that mining operations and welding maintenance activities were performed by separate business entities. Although Shemwell’s pay stub was annotated “Armstrong Fabricators, Inc.,” Shemwell testified that “[he] always thought [he] was employed by Armstrong Coal Company.” Resp. Opp. to Sec’y. Sum. Dec. Mot., Ex. C; Tr. 59.

While it is apparent that Shemwell reasonably believed that he was an Armstrong Coal Company employee, Shemwell’s belief, alone, is not dispositive of the issue of Armstrong Coal Company’s liability. Rather, as discussed herein, it is the objective evidence that amply demonstrates that it is appropriate to include Armstrong Coal Company as a party from which reinstatement relief can be sought.

In mid-April 2011, Shemwell was assigned by Lander, Armstrong Coal’s dragline manager, to repair the center pin of a dragline at an Armstrong Coal Company surface mine. Tr. 56, 62, 81, 206-07. To access the pin, Shemwell had to enter the tub of the dragline, an enclosed area that is not well ventilated in that it is not directly exposed to outside air. Shemwell was wearing a respirator that protected against particle inhalation. However it was ineffective with respect to minimizing or preventing the inhalation of smoke and fumes.

Before performing the welding repair, it was necessary for Shemwell to gouge out the material around the center pin by torching the material, which produced smoke that adversely affected him. Tr. 66. After completing the necessary gouging, Shemwell welded the center pin area for approximately 45 minutes, at which time he exited the tub without completing the welding because he was overcome by fumes and smoke. Tr. 72-73.
While recovering on the deck of the dragline, Shemwell encountered Lander. Shemwell’s eyes were watery and red and it was obvious that he had been adversely affected by his welding activities. Lander instructed Shemwell to get some air before returning to his welding in the tub. Shemwell responded that he would not return to weld in the tub. Shemwell testified that Lander did not respond and simply walked away. Tr. 75, 80.

Approximately one week after the welding incident in the tub, Shemwell met Lander in the bucket house where he informed Lander that Armstrong Coal “needed to do something about the respirators.” Tr. 81. Shemwell showed Lander a welding magazine that was lying on a table in the bucket house that depicted fresh air respirators. Shemwell testified that Lander responded that fresh air respirators were “pricey,” although Shemwell conceded that Lander stated “he would see what could be done about it.” Tr. 84.

Lander testified that Shemwell, as well as several other employees, expressed concerns regarding the need for better respirator protection. Tr. 169. Lander testified that he welcomed complaints about safety and that he did not view Shemwell’s complaints as a problem. In response to the respirator complaints, Lander testified that both negative and positive air pressure system respirators were purchased from a company named Airgas to afford additional protection to the welders. Tr. 172-73. The respirators were ordered in August 2011.

b. Alleged Adverse Action

Shemwell testified that shortly after he communicated his respirator complaints to Lander, his relationship with Lander deteriorated. Shemwell testified that Lander became “arrogant” and that he started to constantly complain about Shemwell’s work. Tr. 134. On June 8 and June 28, 2011, Lander verbally warned Shemwell about eating breakfast at work, using his cell phone at work, and coming to work late. Gov. Ex. 2-3. Shemwell testified that on July 22, 2011, Lander called him off the dragline and advised him that two people had complained about Shemwell arriving late to work, eating breakfast on the job, and using his cell phone. Tr. 134. Shemwell testified that these accusations were false. Tr. 134. As a result of his discussion with Shemwell, Lander issued a written warning on July 22, 2011, concerning Shemwell’s lateness and cell phone use. Lander’s written warning noted, “[i]f this happens again before 12-31-11 you will be dismissed – terminated.” Resp. Ex. 4.

Lander testified that he knew that Shemwell “was going through a difficult period of time in the month of June . . . [because] he was going through a divorce.” Tr. 181. Lander told Shemwell that he himself had “been through [a divorce] in 1980, it’s very difficult, they’re hard, they can distract you.” Tr. 181. Despite Lander’s recognition that Shemwell had personal problems, Lander found Shemwell’s cell phone use to be excessive, issuing two verbal warnings in June 2011 that culminated in a July 22, 2011, written warning admonishing Shemwell that he would be terminated before December 2011, if his cell phone use continued. Resp. Exs. 2-4.
With regard to Lander’s authority to discipline Shemwell who is purported to be an employee of Armstrong Fabricators, Lander testified:

Court: Who did Mr. Shemwell work for?

Lander: Mr. Shemwell? Fabricators, yes, sir.

Court: Okay. Look at his employment application. Is that who he applied for employment with?

Lander: I see where you’re going, but I don’t know, because may I tell you how they came to me?

Court: No. I didn’t ask you that question. Just answer my question. Did Mr. Shemwell apply for employment with Armstrong Fabricators or Armstrong Coal Company, based on that application?

Lander: Based on this application, I guess you would say [Armstrong] Coal Company

Court: And you work for who?

Lander: The Coal Company.

Court: And you disciplined him, right?

Lander: As well as I do any contract people that would come in, yes.

Court: Well, would you discipline non – [fabricator contractors] – let’s say it was Otis Elevator [that] was building an elevator down into your pit. Would you discipline Otis Elevator employees?

Lander: No, sir.

Tr. 208-09.

Following the written warning, Lander recommended the reassignment of Shemwell to the Armstrong Fabricators shop, where Oscar Ramsey, the manager of the shop, could observe Shemwell under closer supervision. Tr. 194-95, 244. Ramsey testified that, after Shemwell’s reassignment, he observed Shemwell using his cell phone several times a day as Ramsey traveled around the shop. After consulting with Armstrong Coal Company’s Human Resources Director Gary Phillips, in view of Lander’s prior disciplinary warnings, Ramsey testified that he decided to terminate Shemwell for excessive cell phone use. Tr. 241-45. Phillips testified that although he was Human Resources Director for Armstrong Coal Company, he also handled human
resource issues for Armstrong Fabricators, “an affiliated company.” Tr. 271, 290. Shemwell’s termination letter, issued by Phillips, states “[t]his letter is to inform you that your employment with Armstrong Coal Company has been terminated effective 9/14/11.” Gov. Ex. 4. (Emphasis added).

Shemwell filed for unemployment benefits as a former employee of Armstrong Coal Company. Gov. Ex. 8. However, Kentucky Unemployment Office records reflect Shemwell’s unemployment benefits were charged to the account of Armstrong Fabricators, Inc. Resp. Ex. 6.

c. Armstrong Fabricators’ Business Activities

Shortly after Shemwell filed the subject discrimination complaint, MSHA attempted to inspect the fabricator shop facility. Kenny Allen is the Executive Vice President of Operations for Armstrong Coal Company. Tr. 214. Allen told Ramsey that he believed that subjecting Armstrong Fabricators to MSHA oversight would not be economically feasible. Tr. 252. Consequently, Ramsey testified that Allen decided to cease operations at the fabricator shop. Tr. 252. As a result, approximately ten welders who worked at the shop were laid off on February 28, 2012, and the shop was closed shortly thereafter in March 2012. Tr. 220-21, 246-47, 251. However, Ramsey continues to occupy an office in the shop building from where he oversees unaffiliated contractors who now maintain Armstrong Coal Company mobile equipment. Tr. 247.

At the time of the layoff, there were approximately eight other Armstrong Fabricator welders who were assigned to maintain draglines at surface facilities. Tr. 204, 206-207. Lander testified that he currently supervises a total of “eleven Armstrong Fabricator welders” who maintain draglines at Armstrong Coal Company’s facilities.5 Tr. 203-06. These welders apparently perform the same functions Shemwell was performing when he was supervised by Lander, prior to Lander’s recommendation that Shemwell be reassigned to the fabricator shop.

III. Further Findings and Conclusions

a. Not Frivolously Brought Standard

As noted in the initial April 20, 2012, decision, while the Secretary is not required to present a prima facie case in a temporary reinstatement proceeding, it is helpful to review the proof that is necessary to ultimately support a discrimination claim to determine whether the nonfrivolous test in this matter has been met. In order to demonstrate a prima facie case of

5 The Secretary should determine whether Armstrong Fabricators, Inc., is required to file a Legal Identity Report Form as required by section 41.10 in view of the dragline maintenance services that are reportedly being performed at Armstrong Coal Company’s mine facilities. 30 C.F.R. § 41.10.
discrimination under section 105(c) of the Act, the Secretary must establish that Shemwell: (1) engaged in protected activity and (2) that the adverse action complained of, in this case Shemwell’s termination, was motivated in any part by that activity. *Sec’y of Labor o/b/o Pasula v. Consolidation Coal Co.,* 2 FMSHRC 2786 (Oct. 1980), *rev’d on other grounds,* 663 F.2d 1211 (3rd Cir. 1981); *Sec’y of Labor o/b/o Robinette v. United Castle Coal Co.,* 3 FMSHRC 803 (Apr. 1981).

Shemwell’s April 2011, protected health and safety complaints concerning respirators is not in dispute. The Secretary contends that Shemwell’s termination was motivated by his requests for respirator protection. The Respondents assert that Shemwell was terminated for his unauthorized cell phone use, and, that his discharge was not motivated by his protected activity.

As the scope of a temporary reinstatement hearing is narrow, it is premature to resolve credibility issues regarding the underlying motivation for Shemwell’s termination at this preliminary stage of the proceeding. *Sec’y o/b/o Albu v. Chicopee Coal,* 21 FMSHRC 717, 719 (July 1999). It is only necessary to determine whether Shemwell’s claim appears to have merit. *See S. Rep. 95-181,* at 36 (1977), *reprinted in* Senate Subcomm. on Labor, Comm. on Human Resources, 95th Cong., *Legislative History of the Federal Mine Safety and Health Act of 1977,* at 624.

In considering whether Shemwell’s complaint is frivolous, it is important to keep in mind that direct evidence of a discriminatory motive is rarely encountered. *Sec’y of Labor o/b/o Chacon v. Phelps Dodge Corp.,* 3 FMSHRC 2508, 2510 (Nov. 1981), *rev’d on other grounds,* 709 F.2d 86 (D.C. Cir. 1983). Rather the Commission has identified several circumstantial indicia of discriminatory intent, namely: (i) hostility or animus toward the protected activity; (ii) knowledge of the protected activity; and (iii) coincidence in time between the protected activity and adverse action. *Id.*

The Respondents concede knowledge of Shemwell’s protected activity. It is noteworthy at this preliminary stage that the initial adverse action complained of occurred shortly after Shemwell’s health and safety complaints were made. Shemwell communicated his safety complaints to Lander in April 2011. Shortly thereafter, in June 2011, Lander issued a series of disciplinary warnings culminating in the July 22, 2011, final written warning that provided a foundation for Shemwell’s September 2011 termination. The fact that Shemwell was disciplined by Lander, the recipient of Shemwell’s protected complaints, is a significant factor that supports the Secretary’s assertion that Shemwell’s complaint is not frivolous. Finally, the apparent disinclination of the Respondents to subject themselves to Mine Act jurisdiction, as demonstrated by Allen’s decision to close the Armstrong Fabricators shop, is an additional relevant factor with respect to motivation. Accordingly, the Secretary has demonstrated that the claim that Shemwell’s termination was motivated, at least in part, by his protected activity is not frivolous.
b. Party Status

i. Armstrong Fabricators

As a threshold matter, I construe the Commission’s remand that affirmed the grant of the Secretary’s motion to amend to be the law of the case with respect to the inclusion of Armstrong Coal Company and Armstrong Fabricators as proper parties. Nevertheless, during opening statements, Respondents’ counsel argued that “[i]t is our position that Armstrong Coal [Company] is not liable.” Tr. 28. Therefore, I will address the parties’ status in the event the Commission has not, in fact, disposed of the joint liability issue.

Armstrong Fabricators has conceded that it is a proper party to this proceeding. However, it asserted during a March 28, 2012, telephone conference that it has no suitable position available because the fabricator shop where Shemwell worked has been idled and the staff has been laid off. Consequently, the Commission directed that I determine the effect, if any, of the reported layoff on the liability for reinstatement in this proceeding. Comm’n Rem., slip op. at 5. At trial, Respondents’ counsel repeated the impossibility of performance claim:

We also intend to show that Armstrong Fabricators, the shop where [Shemwell] was employed, has ceased operations and, therefore, that he cannot be returned to any position there, and we also intend to show that Armstrong Coal also has no position[s] to which he can be returned that were similar to that he had previously occupied.

Tr. 27-28.

While the welders at the fabricator shop may have been laid off on February 28, 2012, Lander testified that he currently has 11 Armstrong Fabricators welders “working for [him].” Tr. 206-07. These welders are assigned to bucket houses located at Armstrong Coal’s surface mines where they rebuild dragline buckets. Tr. 179. When they are not repairing buckets, the welders perform on-site maintenance on the draglines at the surface facilities. Tr. 205-07.

As noted above, counsel has proffered the surprising assertion that Armstrong Fabricators, Inc., is unable to reinstate Shemwell to a welding maintenance position because all of the welding positions at the bucket houses at Armstrong Coal’s Equality and Midway mines are currently filled. Tr. 221-22. To accept such an assertion as a defense in a discrimination proceeding

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6 The Commission noted in its remand that it was “not suggest[ing] that the Judge erred in his determination that ‘Armstrong Coal Company, Inc., and/or Armstrong Fabricators, Inc.,’ may be ordered to temporarily reinstate Shemwell.” Comm’n Rem., slip op. at 5, fn. 6.
would eviscerate the anti-discrimination provisions of the Act. 30 U.S.C. 815(c). See Sec’y of Labor v. Akzo Nobel Salt, 19 FMSHRC 1254, 1259 (July 1997) (holding that displacement of a third party is not controlling by rejecting an operator’s claimed inability to reinstate a miner due to layoff protections afforded to existing personnel under a collective bargaining agreement).

The Respondents’ reliance on an Administrative Law Judge decision tolling back pay awarded in a discrimination proceeding based on a seniority based layoff necessitated solely by “a bona fide economic retrenchment,” rather than by an attempt to avoid MSHA jurisdiction, is inapposite to the facts in this case. Resp. Br. at 18 citing Casebolt v. Falcon Coal Co., 6 FMSHRC 485, 499-500 (Feb. 1984) (ALJ).

As the job duties of the welders performing on-site maintenance of draglines and bucket repair are similar to the duties performed by Shemwell prior to his discharge, there is a suitable welding position to which Shemwell can be reinstated. Thus, it is unnecessary to address whether the reported layoff of Armstrong Fabricator welders at its shop tolls the Respondents’ reinstatement obligation. See Comm’n Rem., slip op. at 5, citing KenAmerican Res., 31 FMSHRC 1050, 1054 (Oct. 2009).

ii. Armstrong Coal Company

The record reflects that Armstrong Fabricators currently has approximately 12 employees, including Ramsey. By way of contrast, Armstrong Coal has 830 employees. Tr. 290. Although Armstrong Fabricators has admitted that it is a proper party, and it is clear that Armstrong Fabricators has the ability to provide the relief sought, it is important to address the question of the joint liability of Armstrong Coal Company for temporary reinstatement.

The layoff of shop employees occurred after the filing of Shemwell’s complaint in an admitted effort to avoid Mine Act jurisdiction over shop operations. In the event the remaining welders performing dragline maintenance and bucket repair for Armstrong Coal Company’s benefit at its surface mines are laid off in a further effort by Armstrong Fabricators to avoid the reinstatement provisions of the Mine Act, Armstrong Coal Company must not be permitted to escape liability. Under the “alter ego” theory of corporation law, a business entity cannot seek to escape liability arising out of the operation of one business entity that was conducted for the benefit of the affiliated enterprise. Berwind, 21 FMSHRC 1284, 1314-15 (Dec. 1999).

Notwithstanding the application of the concept of “alter ego”, as indicated below, the evidence reflects that Armstrong Fabricators is, in essence, a subdivision of Armstrong Coal Company, regardless of its incorporation as a separate entity. In this regard, Armstrong Coal Company attendance records reflect “Fab” as a location, and Armstrong Coal Company disciplinary notices completed by Lander describe “Fabricators” as a “department.” (Gov Ex. 6; Resp. Ex. 2-4).
Although Armstrong Coal Company is jointly liable, significant evidence reflects that it may be considered as the primary business entity responsible for the reinstatement of Shemwell. As previously discussed: Shemwell applied for employment with, and was hired by, Armstrong Coal Company (Gov. Ex. 5 at pp. 1, 3); when hired, Shemwell was required to acknowledge Armstrong Coal Company’s policies in its employee handbook (Gov. Ex. 5 at p. 5); Armstrong Coal Company was authorized to make direct deposits of Shemwell’s salary into his bank account (Gov. Ex. 5 at p. 7); Shemwell was a participant in Armstrong Coal Company’s 401(k) plan (Gov. Ex. 5 at p. 3; Tr. 291); Shemwell’s attendance was kept on Armstrong Coal Company records that reflect Shemwell was assigned to “Loc: Fab” (Gov. Ex. 6); Shemwell’s Emergency Contact Sheet reflects he was a welder employed by Armstrong Coal Company at the “Bucket House” location (Gov. Ex. 7); Shemwell was supervised by Lander, Armstrong Coal Company’s manager (Tr. 168-69, 206-07); Shemwell was disciplined by Lander on Armstrong Coal Company’s “Employee Counseling Form” that reflected Shemwell was a welder working in the “Department: Fabricators” (Resp. Ex. 4); decisions to transfer and terminate Shemwell were made by Armstrong Coal Company management, including its Human Resources Director (Gov. Ex. 4, Tr. 194-95, 244); Shemwell’s “employment with Armstrong Coal Company [was] terminated effective 9/14/11” in a termination letter containing Armstrong Coal Company’s letterhead (Gov. Ex. 4); and Phillips acknowledged the application for unemployment benefits that Shemwell filed as an employee of Armstrong Coal Company (Gov. Ex. 8). Thus, the objective evidence amply demonstrates that it is also appropriate to hold Armstrong Coal Company as a party from which reinstatement relief can be sought.

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7 At the hearing the record was left open for the submission of Kentucky State unemployment forms to determine whether Armstrong Coal Company and Armstrong Fabricators, Inc. had separate Kentucky Division of Unemployment Insurance Employer Numbers. The requested documentation was furnished in the Respondents’ joint post-hearing brief filed on June 12, 2012, reflecting that Armstrong Coal Company’s Employer No. is 779840 and Armstrong Fabricators, Inc.’s is 793632. Shemwell’s unemployment benefits were charged against Armstrong Fabricators, Inc. under Employer No. 793632. Resp. Br. p. 16 fn. 2. Given the facts in this case, the business entity taxed by the State of Kentucky for Shemwell’s unemployment benefits is not dispositive of the reinstatement obligation in issue.
I note, parenthetically, that the April 20, 2012, initial decision in this matter based the joint liability of Armstrong Coal Company and Armstrong Fabricators on the Commission’s “unitary operator” analysis that subjects affiliated corporations to liability under the Mine Act. See Berwind, 21 FMSHRC at 1316-17. In Berwind, the Commission stated:

Accordingly, we will consider the following factors in determining whether entities will be treated as a unitary operator for purposes of the Mine Act: (1) interrelation of operations, (2) common management, (3) centralized control over mine health and safety, and (4) common ownership. To demonstrate unitary operator status, not every factor need be present, and no particular factor is controlling. Instead, we will weigh the totality of the circumstances to determine whether one corporate entity exercised such pervasive control over the other that the two entities should be treated as one.

21 FMSHRC at 1317.

Although the facts in this case demonstrate the above indicia for “unitary operator” status, Berwind relies on the establishment of collateral facts to infer the propriety of extending unitary liability to affiliated business entities. In this case, there is adequate direct evidence to demonstrate that Armstrong Coal Company is a proper party from which reinstatement relief can be sought irrespective of its relationship with Armstrong Fabricators, Inc.

ORDER

To prevail in this preliminary matter, the Secretary must only demonstrate that the application for temporary reinstatement is not frivolous. As discussed above, Lander’s disciplinary actions that served as a significant basis for Shemwell’s discharge were taken shortly after Shemwell’s health and safety complaints were communicated to Lander. As such, the record adequately reflects knowledge of the protected activity as well as a coincidence in time between the protected activity and the subject adverse actions. Consequently, the Secretary has demonstrated that Shemwell’s discrimination complaint has not been frivolously brought.

As noted, Armstrong Fabricators, Inc. and Armstrong Coal Company are proper parties that are jointly liable in this proceeding. Consequently, IT IS ORDERED that Armstrong Coal Company, Inc., and/or Armstrong Fabricators, Inc., immediately reinstate Shemwell, no later than Wednesday, June 27, 2012, to the welder position he held immediately prior to his September 14, 2011, termination, or, to a similar position as a laborer at the same rate of pay and benefits, and with the same or equivalent duties assigned to him.
IT IS FURTHER ORDERED that Armstrong Coal Company and/or Armstrong Fabricators, Inc., provide back pay and relevant benefits, less deductions for taxes and any other appropriate payroll deductions, to Shemwell effective April 25, 2012, until the date preceding Shemwell’s reinstatement. Shemwell’s payment should be reduced by any previous payments Shemwell has received for back pay during this retroactive period.

/s/ Jerold Feldman
Jerold Feldman
Administrative Law Judge

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8 In its joint post-hearing brief, the Respondents indicated that Shemwell has received one week’s pay under the previously issued reinstatement order that was vacated by the Commission on May 10, 2012.
This case is before me on a petition for assessment of civil penalty filed by the Secretary of Labor ("Secretary"), acting through the Mine Safety and Health Administration ("MSHA"), against Michels Corporation ("Michels") pursuant to sections 105 and 110 of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 801 et seq. (the "Mine Act"). The parties introduced testimony and documentary evidence at a hearing held in Milwaukee, Wisconsin. In lieu of filing post-hearing briefs, the parties presented oral argument at the hearing. This case involves Citation No. 6502898 issued under section 104(a) of the Mine Act at Michels’ Plant #6. Michels operates a limestone quarry and portable crusher in Dodge County, Wisconsin. The mine blasts limestone from benches in the pit and then crushes the limestone.
I. DISCUSSION WITH FINDINGS OF FACT AND CONCLUSIONS OF LAW

On December 7, 2010, MSHA Inspector Daniel Hongisto issued Citation No. 6502898 under section 104(a) of the Mine Act for an alleged violation of 30 C.F.R. § 56.3200. The citation alleges the following:

Loose, fractured rock had not been taken down from the face of the vertical limestone highwall prior to blasting personnel entering the area to load a pattern on the bench below it. This highwall was estimated to be about 60’ in height. Boosters and delays were...out on the ground at the base of the highwall and an employee of the contractor was observed standing within a few feet of the highwall. Another contractor was observed standing within a few feet of the highwall. Another contractor employee was standing a safe distance away serving as a “spotter” should loose rock fall from the wall. This condition exposes persons to serious injury from falling rock.

(Sec’y Ex. 2). Inspector Hongisto determined that an injury resulting in lost workdays or restricted duty was reasonably likely to occur, that the violation was of a significant and substantial (“S&S”) nature, that one person would be affected, and that the violation was the result of moderate negligence on the part of the operator. The Secretary has proposed a penalty of $100.00 for this alleged violation.

A. Summary of Testimony

Inspector Daniel Hongisto has worked for MSHA for approximately 15 years. (Tr. 16). He has participated in highwall training and approximately one third to one half of the mines he inspects have highwalls. (Tr. 22-23). Prior to his time with MSHA, Inspector Hongisto worked in the mining industry off and on from 1978 to 1990. (Tr. 16-24). While working in the mining industry, Inspector Hongisto was tasked with work as, among other things, a laborer, equipment operator, bull gang member, driller, scaler, blaster, roof bolter, ground support installer, and shift supervisor. (Tr. 16-20). While most of his formal mining industry experience was in underground mines, he did work in quarries at one point. (Tr. 59-60). His only experience working with limestone has been with MSHA. (Tr. 60). Inspector Hongisto received entry level highwall safety training at the agency’s mine safety academy, including training on how to identify loose or fractured rock. (Tr. 61-62).

On December 7, 2010, Inspector Hongisto traveled to Michels’ Plant #6 to conduct a regular inspection. (Tr. 24). Inspector Hongisto testified that, when he arrived, the crushing plant was in operation. (Tr. 26). He observed a miner working on a bench at the toe of a 60-foot highwall and two other miners on the same bench. (Tr. 27, 44, 58). Inspector Hongisto later learned that the three miners were all employees of the blasting contractor, Orica USA. (Tr. 58).
When Inspector Hongisto looked at the highwall he “could see that there was a lot of loose, fractured rock on it and that there had been a pattern of holes drilled underneath [it] . . . and that the blasting crew was preparing to load these holes to blast [the] bench out.”¹ (Tr. 27). Boosters and delays were lying on the ground at the base of the highwall. (Tr. 27, 30). Inspector Hongisto testified that he was not concerned about one particular rock on the highwall² but was concerned with “everything” about the highwall, including “the area of the highwall, the height of it and the area underneath it being about 40 feet long, that the [blasters] were going to be loading these holes, which is an extensive area, with cracked rock on the whole face.” (Tr. 28, 38-39, 67-68). He believed that the rock on the face was cracked, fractured, and not entirely tied into the wall. (Tr. 62). On cross-examination, Inspector Hongisto conceded that fractured rock is different from loose rock. (Tr. 63). However, in this instance he was sure that the rock was loose “based on the fact that this highwall had been blasted” and subsequent blasts would have occurred “that could loosen it.” (Tr. 63). He also noted that the wall was “exposed to weather conditions, rain and snow, freeze/thaw.” (Tr. 63, 66). He defined loose rock as rock that has the “potential to fall,” move, or dislodge. (Tr. 66). Nevertheless, on cross-examination, Inspector Hongisto acknowledged that he did not see any loose rock fall during the entire time that he was at the mine. (Tr. 66). Moreover, he made no attempt to dislodge, poke, or disturb a rock. (Tr. 66-67). Inspector Hongisto testified that the area was not barricaded and there were no signs to warn people of the danger presented by the unscaled highwall that the blasters had been working under. (Tr. 44, 45). He was not concerned that the whole wall would fail. (Tr. 43). Inspector Hongisto testified that he had not inspected any highwalls at this quarry prior to the subject inspection and admitted that he was not a geologist or engineer. (Tr. 58-59).

Inspector Hongisto testified that he took a number of pictures of the cited condition. (Tr. 31). He explained that Sec’y Ex. 3 depicts the upper portion of the highwall, which had a large rock that was of concern, as well as loose crumbling rock and cracks in the highwall face directly above the area where the miners had been working below. (Tr. 31-32, 64-65). Sec’y Exs. 4 and 5 show the blasting materials that were laid out on the ground and drill cuttings from the holes that were to be used for blasting. (Tr. 32-38). Sec’y Exs. 4, 6, and 7 each show the fractures on the face of the wall. (Tr. 33, 38-40). Sec’y Ex. 6 shows the upper portion of the highwall that was above the bench area where the drillers and blasters had worked, were working, and would continue to be working. (Tr. 38). Based on his experience and judgment, Inspector Hongisto testified that he could tell that the rock on the face shown in Sec’y Ex. 6 was loose. (Tr. 67). He explained that, from where he took the pictures and conducted the inspection, he could not tell whether the boulder at the top of the wall to the left in Sec’y Ex. 6 was on solid ground or if it

¹ Inspector Hongisto testified that miners would have been allowed to work under the highwall in order to take down the loose material but, in this case, the miners who were under the highwall were not in the area for that purpose. (Tr. 45). Rather, he observed an individual who was in the area to blast and, based on the holes and drill cuttings on the bench below the wall, there had been others miners in the area.

² While Hongisto stated that he was not concerned about one single rock, he did testify as to being concerned about the large rock visible in Sec’y Ex. 6 on the right hand side of the top of the highwall. (Tr. 68-69)
was part of a berm that was set back. (Tr. 68). The rock at the top of the wall on the right in Sec’y Ex. 6 was a concern, but he did not feel the need to go to the top of the wall to inspect it and, instead, only viewed it from 60 feet below. (Tr. 68-69).  

Inspector Hongisto concluded that Michels, as the mine operator, was responsible for the safety of all people, including contractors, involved in the mining process. (Tr. 44). Based on his observations and experience, he issued Citation No. 6502898. (Tr. 29).

Inspector Hongisto allowed the contractors to resume blasting preparation roughly 35 feet from the highwall. (Tr. 52). Inspector Hongisto terminated the citation the following day once he was comfortable that no one would work in the subject area. (Tr. 53). At the hearing, when told that a Michels employee had broken a backhoe while removing the large rock at the top of the highwall on the right hand side, Inspector Hongisto stated that he did not believe it and, if true, the operator must not have been a very good backhoe operator. (Tr. 69). Inspector Hongisto admitted that he was not present when the rock was removed. (Tr. 70).

Inspector Hongisto did not travel to the top of the highwall because, according to him, there was no reason to. (Tr. 41, 68). He was adamant that his findings were not based on any specific rock, but he did take note of the large rock that was at the top of the highwall. (Tr. 41). After the citation was issued, Michels sent MSHA a photograph that was taken at the top of the highwall. (Tr. 41; Sec’y Ex. 8). At the hearing, Inspector Hongisto testified that the picture showed loose rock and a backbreak at the top of the highwall. (Tr. 42). According to Inspector Hongisto, a backbreak occurs when back pressure is applied to the face of the highwall during blasting. (Tr. 42-43). The back pressure results in fracturing of the face. (Tr. 43). Inspector Hongisto did not believe that the boulders represented in Sec’y Ex. 8 were the same as those that he identified in Sec’y Ex. 6, but he could not be certain. (Tr. 71).

Inspector Hongisto determined that an injury was reasonably likely to occur based on the extent of the area affected, the amount of loose rock on the highwall, and the contractor’s use of a spotter which, according to Inspector Hongisto, indicated that the miners were not entirely comfortable working under the highwall. (Tr. 46, 47). The miners had been in the area for some time, but the blast was not near completion. (Tr. 46). While some drilling had been completed, the blasting materials had not been loaded. (Tr. 46). Inspector Hongisto determined that any injury suffered was likely to result in lost workdays or restricted duty. (Tr. 47). He based this determination on his observation that the loose material on the wall was small and he “didn’t have a single concern about one large rock or he would have marked it ‘Fatal.’ ” (Tr. 47). Inspector Hongisto was not concerned about a total failure of the highwall or a large section of

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3 The Inspector also expressed concern with the blasting contractor’s use of a “spotter” to watch the highwall and notify miners working below the wall if dangerous conditions, i.e., falling rock, were present. (Tr. 28-31, 51). He did not believe that a spotter could timely notify a miner below the wall if a rock were to fall, although he later acknowledged that a spotter could provide some additional measure of safety. (Tr. 30-31, 72). Bruce Konkle, an employee of Orica USA, testified that spotters are present to watch over blasting operations to make sure that everything is safe. (Tr. 125-26, 130). The use of spotters was a normal practice for this blasting company. (Tr. 126).
the wall. (Tr. 48). Rather, he was worried that one person would get struck by falling rock. (Tr. 48). Accordingly, he determined that only one miner would be affected. (Tr. 48). In light of his findings on the likelihood and type of injury, and based on his observations and experience, Inspector Hongisto designated the violation as S&S. (Tr. 48-49).

Inspector Hongisto determined that Michels had acted with moderate negligence. (Tr. 49). According to Inspector Hongisto, the condition was obvious and extensive and should have been seen. (Tr. 49). The entire 60-foot height and 40-foot width of the wall had not been scraped and loose material had not been taken down before people were permitted to travel under it. (Tr. 50). Inspector Hongisto cited Orica, the blasting contractor who was working in the area, for a violation of the same standard. (Tr. 50-51). Joe Schmitt, the crusher foreman for Michels, was nearby and the condition would have been in full view for him to see. (Tr. 50). There were some mitigating factors. (Tr. 49). Jason Schmidt, Michels safety coordinator, told Inspector Hongisto that he was not aware that the contractor’s employees were going to be working right at the toe of the highwall. (Tr. 49, 53). Moreover, Schmidt told Inspector Hongisto that Michels had hired Orica based on its expertise in this field and he expected its employees to work in a safe manner. (Tr. 49).

Jason Schmidt testified on behalf of Michels. Schmidt has been with Michels for 15 years and is the project and safety coordinator for the company’s materials division. (Tr. 78). Prior to holding his current position, Schmidt worked with the company as a truck driver, equipment operator, and foreman. (Tr. 78). In his current role as safety coordinator he does site inspections, oversees the foremen, and is in charge of safety for the division. (Tr. 79-81). During his inspections he checks the sites, including the highwalls, to make sure there are no hazards. (Tr. 81). He trusts the drilling and blasting contractors, who have 20 to 30 years of experience, to do their jobs safely and notify Michels if something is unsafe. (Tr. 81-82). Schmidt testified that if he or anyone else at the mine sees a hazard, they correct it right away. (Tr. 94). If an area is unsafe, the mine will correct the unsafe condition before allowing anyone into the area. (Tr. 94, 95). Schmidt acknowledged that he is not a geologist or engineer. (Tr. 97-98).

Schmidt testified that the materials division employees participate in an eight-hour annual safety refresher course that addresses highwall safety. (Tr. 83-84). The course emphasizes that, if anything is unsafe, looks like a problem, or if loose rock is present, then the miners should erect berms to keep traffic out of the dangerous area. (Tr. 85). In addition to the annual training, the mine also holds weekly “tailgate meetings” during which highwall safety is always discussed and daily or weekly task-specific training depending on what type of work will be conducted. (Tr. 85-86). Schmidt explained that the mine monitors the highwall daily and that special attention is given when there are weather changes, such as freezing and thawing that could impact the wall. (Tr. 86). According to Schmidt, in all of the time he has spent in the area of this mine, he has never seen a rock fall where people were working. (Tr. 86-87). While the highwall is constantly changing, the miners are trained to watch for hazards. (Tr. 87). He explained that this particular highwall does not have a lot of pockets or soft spots and there are no natural seams where the wall could collapse or pull apart. (Tr. 87).
Schmidt testified that, on the day the citation was issued, he received a call that MSHA was at the site to do an inspection, so he traveled to the mine. (Tr. 98-99). When he arrived, he had no concerns about the highwall. (Tr. 98). He acknowledged that he did not actually see the contractor’s employees in the area of alleged exposure. (Tr. 99). He did not believe that there was loose rock that created a hazard to the men working below the highwall. (Tr. 98). If there had been loose rock, or if the contractor’s employees felt that the area was unsafe, then work would not have been performed until the area was made safe. (Tr. 98).

Schmidt traveled to the top of the highwall to observe it both before and after the citation was issued. (Tr. 89). The top was stripped and bermed off to prevent travel to the edge. (Tr. 88-89). While Schmidt was at the top, he took a photograph of the highwall from that position. (Tr. 88; Sec’y Ex. 8). He was not aware of any changes made to the highwall between the time the citation was issued and when he took the photographs. (Tr. 97). At the hearing, Schmidt was able to identify the two large rocks in the photograph that the inspector had identified as concerns in Sec’y Ex. 6. (Tr. 90). He explained that the rock on the left was part of the berm and was set back from the edge of the top of the highwall “a couple feet.” (Tr. 89-90; Sec’y Exs. 6 and 8). With regard to the rock on the right, Schmidt testified that there were no cracks or fissures, and the rock was not loose from what he could tell. (Tr. 90; Sec’y Exs. 6 and 8). Schmidt testified that he did not see loose rock on the highwall and thought that the rock on the wall was sound and was not going to be moving. (Tr. 95, 100). The subject area had been blasted approximately six months prior, and the operator would have taken down any hazards. (Tr. 100). The highwall had never been scraped before this citation was issued. (Tr. 100).

Joe Schmitt testified on behalf of Michels. Schmitt has been at Michels for approximately 20 years and is a foreman responsible for operation and maintenance of a portable crushing plant, as well as being in charge of the pit. (Tr. 104). He is also responsible for the safety of the site. (Tr. 105, 111). As a foreman, he is part of Michels’ management. (Tr. 110).

Schmitt explained that as soon as he drives into the pit each day he looks for any conditions that may have changed from the day before. (Tr. 150). He testified that there had been 15 to 20 blasts in the subject area over the course of its existence. (Tr. 106). The area consists of two benches, both roughly 32 feet in height. (Tr. 109). Other than during blasting operations, Schmitt has not observed rock falling from a highwall in the pit. (Tr. 106). To his knowledge, the wall had never been scraped or scaled prior to the issuance of the subject citation. (Tr. 111). Schmitt testified that he was aware that, on the day the citation was issued, the contractor was working at the toe of the highwall. (Tr. 108). However, there were no ground conditions that created a hazard and he had no concerns about the contractor working in the area. (Tr. 108, 110, 116). Jason Schmidt was Schmitt’s immediate supervisor on the day the citation was issued. (Tr. 110).

Schmitt testified that the highwall, and in particular the large rock at the top right of the picture labeled Sec’y Ex. 7, had been in the same state for six months. (Tr. 106-107). Schmitt testified that he traveled to the top of the highwall and found that there were no backbreaks or fissures along the rock. (Tr. 107). He was present when the rock was later removed with a backhoe that was moved to the top of the highwall. (Tr. 107, 112). After trying to knock the rock loose by pounding on it with the backhoe, Dean Groth, the backhoe operator, was finally
able to dislodge it by reaching underneath the rock with the bucket and picking it up. (Tr. 107, 111-112). According to Schmitt, the backhoe can reach its bucket out approximately 25 to 30 feet and, at the time it was removing the subject rock, it was approximately 10 to 15 feet away from the edge of the top of the highwall and was able to reach 8 to 10 feet down from the top of the highwall. (Tr. 110, 113-114). The rock was not loose before the backhoe started working on it. (Tr. 107).

Dean Groth testified on behalf of Michels. Groth has been at Michels for six years and is an equipment operator. (Tr. 117). He received safety training at Michels, including equipment operation and highwall safety training. (Tr. 117). Groth was responsible for operating the backhoe and was charged with the task of knocking down the large rock circled in Sec’y Ex. 7 after the inspector issued the citation. (Tr. 117-119). Groth testified that the rock “wasn’t loose [and] . . . [i]t took some effort to get it out.” (Tr. 118). He initially tried to bang on the rock with the backhoe, but ended up having to use the bucket, which can reach 10 to 15 feet down the wall, to reach underneath the rock and peel it up in order to knock it down. (Tr. 118). Groth testified that as he was trying to remove this rock, he “ripped the bucket apart . . . [t]ore the metal plate that holds it all together.” (Tr. 118). According to Groth, the rock was solid. (Tr. 118-119). Moreover, he saw no conditions that concerned him, and saw no hazard on the highwall. (Tr. 119). Groth testified that he tried to scrape the wall with the backhoe after the citation was issued, but was unable to find any loose rock. (Tr. 120). He had to really “work at it” to bring any rock down. Id. Groth acknowledged that he is not an engineer or geologist. (Tr. 121).

Bruce Konkle testified on behalf of Michels. Konkle is an employee of Orica USA, the blasting contractor that was working at the mine at the time the citation was issued. (Tr. 124-125). He has been with Orica for 25 years and has worked next to numerous highwalls. (Tr. 130). In order to evaluate the stability of the highwall Orica conducts a visual examination of the wall, looks for rocks that could fall, and takes into consideration any weather of note (e.g., freezing, thawing, and rain). (Tr. 127). Konkle believed that the temperature was below zero at the mine the day the citation was issued. (Tr. 132). Konkle explained that Orica does not conduct blasting if there are safety concerns but, after surveying the blasting area at this mine and having a safety meeting, he had no concerns about the highwall that day. (Tr. 125, 127, 130). Had he noticed anything dangerous, he would have told Jason Schmidt or the quarry foreman. (Tr. 131). He did not observe loose rock on the highwall. (Tr. 125, 134). Konkle had blasted at the mine previously and noticed no change in the highwall since that time. (Tr. 128). He acknowledged that he is not an engineer or geologist. (Tr. 129).

B. Summary of the Parties’ Arguments

1. Secretary of Labor

The Secretary argues that Citation No. 6502898 should be affirmed as issued. (Tr. 136). The issuing inspector, who has a combined 30 years of experience as a miner and MSHA employee, credibly testified that he observed miners standing at the toe of a 60-foot highwall that had cracked and fractured rock on its face. (Tr. 136). The highwall had not been scaled and presented a hazard that was reasonably likely to contribute to a serious injury. (Tr. 137). “An
experienced [mine inspector’s] opinion that a hazard exists is entitled to substantial weight.” (Tr. 137 citing Twentymile Coal Co., 33 FMSHRC 1885 (Aug. 2011) (ALJ)).

Commission judges, including this court, have affirmed S&S violations of Section 56.3200 where the presence of loose, overhanging and cracked material, and other dangerous conditions were present on a highwall above an area where miners worked. (Tr. 139-140 citing Lakeview Rock Products, 34 FMSHRC 244 (Jan. 2012) (ALJ), Connolly- Pacific Co., 33 FMSHRC 2270 (Sept. 2011) (ALJ), Richard E. Seiffert Resources, 23 FMSHRC 426 (Apr. 2001) (ALJ), and Summit Inc., 19 FMSHRC 1326 (July 1997) (ALJ)). Further, this court has affirmed a violation of section 56.3200 where loose rock and unconsolidated material were found near the top of a highwall. (Tr. 141-142 citing Lehigh Southwest Cement Co., 33 FMSHRC 340 (Feb. 2011) (ALJ)). In Lehigh the court determined that an injury was not reasonably likely to occur because workers were not likely to enter the hazardous area prior to the completion of scaling of the highwall, which had already begun. Id. In the case at hand, scaling was not being utilized and workers were exposed to the hazard. Id.

2. Michels Corporation

Michels argues that loose and/or falling rock was never observed by Respondent, Respondent’s contractor, or the inspector. (Tr. 143). Michels does not dispute that, had loose material been present, it would have presented a hazard. (Tr. 143). Nevertheless, no such material was present on the highwall. (Tr. 143). The horizontal lines and fractures in the rock on the highwall do not, by themselves, create a hazard. (Tr. 143). The inspector never traveled to the top to evaluate the condition of the highwall, and the Secretary failed to present any specific evidence regarding the “dimensions of the fractures or anything along those lines” that could potentially satisfy her burden of proof. (Tr. 143-144). Moreover, the stability of the highwall was evident when the Respondent’s backhoe bucket broke during the equipment operator’s labored attempt to knock down one of the rocks observed by the inspector. (Tr. 143-144).

Michels does not dispute the strict liability nature of the Mine Act. (Tr. 143-144). It agrees that, as the mine operator, it is responsible for the safety of all persons at the mine site. (Tr. 143-144). However, in this particular case, MSHA has failed to prove that a hazard existed, as required by the cited standard, and, as such, the citation should be vacated. (Tr. 144).

C. Analysis of the Issues

The Secretary alleges a violation of Section 56.3200, which requires the following:

Ground conditions that create a hazard to persons shall be taken down or supported before other work or travel is permitted in the affected area. Until corrective work is completed, the area shall be posted with a warning against entry and, when left unattended, a barrier shall be installed to impede unauthorized entry.
30 C.F.R. § 56.3200. “The Mine Act imposes on the Secretary the burden of proving each alleged violation by a preponderance of the credible evidence.” In re: Contest of Respirable Dust Sample Alteration Citations, 17 FMSHRC 1819, 1878 (Nov. 1995), aff'd sub nom. Sec'y of Labor v. Keystone Coal Mining Corp., 151 F.3d 1096 (D.C. Cir. 1998) (quoting Garden Creek Pocahontas Co., 11 FMSHRC 2148, 2152 (Nov. 1989). In order for the Secretary to satisfy her burden, she must first establish by a preponderance of the credible evidence that the ground conditions present on the highwall created a hazard. For the reasons set forth below, I find that the Secretary did not establish this fundamental element of the cited standard and, accordingly, I vacate the citation.

It is undisputed that the face of the highwall contained fractured rock and that miners were working at the toe of the wall. However, the testimony of the parties conflicts regarding whether the condition of the highwall presented a hazard to those miners working below it. The Secretary asserts that fractured rock was loose and had the potential to fall, thereby creating a hazard for the miners working below. Respondent asserts that the face of the highwall, despite being fractured, was stable, contained no loose rock and, consequently, did not present a hazard.

I find that the preponderance of the evidence demonstrates that the highwall did not present a hazard to the miners working below. Neither the inspector, who was at the mine for two days, nor any of Michels’ witnesses, who had been at the mine for far longer than two days, observed rock fall from the highwall. Inspector Hongisto testified that his determination that the rock was loose and presented a hazard was based, at least in part, on his experience and the wall’s exposure to changing weather conditions. While Inspector Hongisto may have been familiar with the operator, he had never inspected this or any other highwall at the subject quarry prior to this inspection. Highwall stability is a localized condition. Schmidt explained that the geologic makeup of this particular highwall did not lend itself to falling material, collapse, or the pulling apart of the rock. There were not a lot of pockets, soft spots, or large natural seams along the highwall. It is significant that Groth testified that when he tried to scale down the highwall with the backhoe after the citation was issued, he had a difficult time bringing down any loose rock. Moreover, Konkle testified that the temperature at the mine had been below freezing for some time, which would seem to indicate that the wall was not subject to a freeze/thaw cycle, or other changing weather conditions, at that time. I credit the testimony of both Schmidt and Konkle that, had the wall been subject to changing weather conditions at the time, the mine and blasting contractor would have paid additional attention to the condition of the wall and would not have worked under it if a hazard were present.

I find that this particular mine operator, as well as the blasting contractor, were in a far better position to understand the local geology and its effect on the stability of the highwall. Michels’ witnesses, unlike Inspector Hongisto, were each familiar with the highwall and credibly testified that the wall was stable at the time the citation was issued and had been stable for some time. This was the first time that Inspector Hongisto had inspected the walls of this quarry and, at least based on his testimony, he did nothing more than a visual inspection of 60 foot highwall from the base of the wall. He did not travel to the top of the wall, yet he determined that rocks on the face at the top of the wall, and in particular a large rock at the top of the wall on the right hand side of the area, presented a hazard. Inspector Hongisto was not present when the rock large rock was removed. I credit the testimony of Michels’ witnesses that the rock at the top of
the highwall on the right-hand side was not loose and required a great deal of effort on the part of
the backhoe operator to bring down. Inspector Hongisto also noted a large rock at the top of the
highwall on the left-hand side. He testified that, from below the highwall, he could not be sure
whether the large rock on the left was part of the berm atop the wall. Inspector Hongisto did not
travel to the top of the wall to investigate further. I credit Schmidt’s testimony that the large
rock on the left was set back from the edge of the highwall and was part of a berm. Schmidt did
travel to the top of the wall, both before and after the citation was issued, and credibly testified
that the rock was part of the berm that was set back from the edge of the wall. Given the rock’s
location, it did not present a hazard.

Highwall stability cannot be evaluated in a “one-size-fits-all” manner. Conditions may,
and often do, vary from quarry to quarry, bench to bench, and wall to wall. The localized nature
of the conditions of each wall must be taken into consideration when determining whether the
ground conditions present a hazard. I am not holding that the Secretary must present expert
testimony about the condition of a highwall in order to establish a violation. See e.g., Richard E.
Sieffert Resources, 23 FMSHRC 426 (Apr. 2001) (ALJ) and Summit Inc., 19 FMSHRC 1326
(July 1997) (ALJ). Rather, in this particular instance, I find that, based on the testimony and
documentary evidence before me, the inspector did not conduct a thorough enough investigation
to support his determination that there was loose rock on the highwall that presented a hazard.
Other Commission judges have reached similar conclusions. See e.g. Cargill Deicing, 32

I recognize that the opinions of MSHA inspectors regarding the presence of hazards are
entitled to weight by the Commission’s judges. In Hanson Aggregates, 28 FMSHRC 1049 (Nov.
2006), Judge Zielinski held that an operator’s credible testimony that a highwall was stable and
that no rock had fallen from the highwall for some time, outweighed the Secretary’s evidence
that “tended to establish only that, in theory, detached rocks had the potential to move and might
eventually fall at some point in time.” Id. at 1055. While I am not bound by the decisions of
other Commission Judges, I find Judge Zielinski’s statement instructive. Here, there is no
dispute that there were fractures on the face of the highwall. However, given the credible
testimony of Michel’s witnesses regarding the stability of the highwall, I find that a
preponderance of the credible evidence does not support Inspector Hongisto’s assertion that the
rock was loose and created a hazard.

II. ORDER

For the reasons set forth above, Citation No. 6502898 is hereby VACATED and this
proceeding is DISMISSED.

/s/ Richard W. Manning
Richard W. Manning
Administrative Law Judge

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RWM
June 22, 2012

SECRETARY OF LABOR, MINE SAFETY AND HEALTH ADMINISTRATION, (MSHA), Petitioner v. LEECO, INC., Respondent

DECISION


Before: Judge Weisberger

Statement of the Case

This case is before me based upon a petition for assessment of civil penalty filed by the Secretary of Labor (“Secretary”), alleging that Leeco, Inc. (“Leeco”) violated 30 C.F.R. § 75.220 (a)(1), which requires, in essence, that an operator comply with its approved roof control plan.

Subsequent to notice, the case was heard in Richmond, Kentucky on February 28 and 29, 2012. On April 27, 2012, the Secretary filed Proposed Findings of Fact, Brief and Argument, and Leeco filed a Post-Hearing Brief. On May 9, 2012, Leeco filed a Response Brief.

Introduction

On September 4, 2007, a roof fall occurred in the transition zone between a crosscut and the adjacent No. 5 entry in the 001 section of Leeco’s underground coal mine (Mine No. 68). MSHA was notified of the fall, and sent Randall Lewis, an MSHA inspector, to the site. He arrived at the mine at approximately 8:00 a.m. He conducted an investigation that day, and interviewed miner witnesses. Based on the investigation, he determined that sometime during the third shift, Kenneth Bryant, a roof bolter operator, was struck by a roof fall while operating a continuous miner down a crosscut between entry No. 4 and entry No. 5, in order to turn the corner from the crosscut to head inby down entry No. 5. Bryant was injured by the fall.

Based on the investigation, Lewis issued a citation alleging a significant and substantial violation of Section 75.220(a)(1), supra.
I. Violation of Section 75.220(a)(1), supra

On September 4, the applicable roof control plan ("the Plan") allowed for the cutting of a "corner clip" 5 feet by 5 feet in the corner of a pillar between a crosscut and the adjoining entry.1 The parties stipulated that Leeco violated its roof control plan, when a corner clip was taken which was larger than 5 feet by 5 feet. (Government Exhibit 2 ("Gov. Ex."), page 19). Based on this stipulation and the record before me, I find that on September 4, 2007, Leeco violated p. 19 of the plan, and hence was not in compliance with Section 75.220(a)(1) supra. Accordingly, I conclude that it has been established that Leeco violated Section 75.220(a)(1) supra, as alleged in the citation at issue.

II. Significant and substantial

A. The Secretary’s witnesses

Lewis indicated that he observed the area of the roof fall. He measured the adjacent crosscut, which ran between entries No. 4 and No. 5, as 18 feet 5 inches wide. Lewis also measured the corner clip at issue as 11 feet 10 inches, by 7 feet 9 inches. According to Lewis, if a corner clip is too large, it exposes additional unsupported roof, and thus creates a hazard of a roof fall.

Lewis indicated the corner clip that had been taken left a brow.2 According to Lewis, the brow extended throughout the entire area of the corner clip. Lewis testified that he measured the brow which had fallen on Bryant. He indicated that it was 21 feet in length; its maximum width was 66 inches; and its maximum thickness was 12 inches.3 Lewis opined that the violation was significant and substantial.

James Vadnal a registered professional engineer, who has served as a roof control specialist in the MSHA office in Arlington, Virginia, was proffered as the Secretary’s expert. He testified that a “corner clip” is a cut taken from a coal pillar to allow passage of equipment around the corner. He confirmed that too large a corner clip “exposes a larger area of unsupported roof.” (Tr. 101). Vadnal indicated that the roof control plan provides for 20 foot wide entries, and a corner clip 5 feet by 5 feet, which creates an intersection of 570 square feet.

1 The “corner clip” (see Exhibit R-3) allows a continuous miner, 32 feet long attached to a bridge 45 feet long, to negotiate a turn from a crosscut into the next entry to be mined. The “corner clip” at issue was taken during the third shift on September 4, by cutting the inby rib of the 4-R crosscut and then turning inby into the No. 5 entry in order to mine that entry.

2 A brow is an “offset” which protrudes from the mine roof. (Tr. 39).

3 The Secretary’s Expert, James Vadnal, estimated the weight of roof that fell as approximately 2.4 tons.
In contrast, utilizing measurements taken by Leeco of the actual clip cut taken on September 4, the area of the intersection created was approximately 580 square feet. He opined that the respective areas of the intersections created were “comparable” in size (Tr. 113).

According to Vadnal, a corner clip, 5 feet by 5 feet, as provided in the plan, creates an unsupported area of roof of 10.82 square feet. In contrast, the corner clip actually taken, 11 feet 10 inches by 7 feet 9 inches created an unsupported area of roof of 39.69 square feet, which was approximately 366% larger than the permitted corner clip in the plan. (Gov. Exs. 9, 9A).

Vadnal opined that the roof fell because the operator made a corner clip with “... an exceptionally large area...” and as a result, that area fell and injured the miner.” (Tr. 125). According to Vadnal, had Leeco followed the plan and taken only a 5 foot by 5 foot cut, the area of the clip would have been “much smaller” (Tr. 125), and the roof would not have fallen.

B. Case Law

A “significant and substantial” violation is described in section 104(d)(1) of the Federal Mine Safety and Health Act of 1977 (“Mine Act”) as 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 U.S.C. § 814(d)(l). A violation is properly designated significant and substantial “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.)

In Mathies Coal Co., the Commission explained its interpretation of the term “significant and substantial” as follows:

In order to establish that a violation of a mandatory safety standard is significant and substantial under National Gypsum, the Secretary of Labor must prove: (1) the underlying violation of a mandatory safety standard; (2) a discrete safety hazard – that is, a measure of danger to safety – contributed to by the violation; (3) a reasonable likelihood that the hazard contributed to will result in an injury; and (4) a reasonable likelihood that the injury in question will be of a reasonably serious nature.

6 FMSHRC 1, 3-4 (Jan. 1984).

In United States Steel Mining Company, Inc., the Commission stated further as follows:

We have explained further that the third element of the Mathies formula “requires that the Secretary establish a reasonable
likelihood that the hazard contributed to will result in an event in which there is an injury.”

U.S. Steel Mining Co., 6 FMSHRC 1834, 1836 (August 1984).

Applying the factors set forth in Mathies, supra and U.S. Steel, supra, I find it has been established that Leeco did violate a mandatory standard i.e., Section 75.220(a)(1) supra. Also, as explained by Vadnal, the area of the corner clip actually taken by Leeco was approximately 366% larger than the area that would have been exposed had the cut been limited to the dimensions provided for in the plan, i.e., 5 feet by 5 feet. As such, I find, that due to the larger size of clip cut actually taken, the violative condition, to some degree, contributed to the hazard of a roof fall. Further, it is clear, based on the record, that should a roof fall have occurred, it could have resulted in serious injuries. Hence the sole issue for resolution relating to significant and substantial, is the third element of Mathies. In this connection, the Secretary has the burden of establishing that as a consequence of the violative condition there was a reasonable likelihood of an injury producing event, i.e. a rockfall. (U.S. Steel, supra). For the reasons that follow, I find that the record fails to establish this critical element.

C. The Secretary’s Position

The Secretary’s initial argument is that since the plan was violated and the roof did fall, there is a presumption that the fall was due to the violation of the plan.4

The Secretary next argues that even without the benefit of this presumption, the evidence establishes that the violation of the plan caused the rockfall at issue. In this connection, the Secretary cites the following: (1) the clip actually taken contributed to a roof fall, (2) the area of the clip as it was taken was approximately 366% larger than that permitted by the plan, and (3) the resulting unsupported area was three times more than what was permitted under the plan.

4 Not much weight was accorded to this argument inasmuch as the Secretary has not cited any Commission case law or other binding case law which recognizes such a presumption. In the absence of such authority, I find that there is not any legal basis to support the Secretary’s position.
D. Discussion

1. The opinion of the inspector

I take cognizance of the opinion of Lewis, which the Secretary relies upon, that the violation was significant and substantial, because “[t]he roof fell." The Plan was violated and there was an injury.” (Tr. 51).

I do not accord much weight to his opinion, as it was not rendered within the framework of Mathies, supra, i.e., which requires the Secretary, in order to prevail, to establish the third element in Mathies, supra i.e., whether there was a reasonable likelihood of an injury producing event. In this connection, it is significant to note that Lewis failed to address this critical issue. (See, U.S. Steel, supra.)

2. Whether the excessive clip cut contributed to a reasonable likelihood of a rockfall.

   a. Vadnal’s testimony

   According to Vadnal, the area of the clip that was actually taken was 366% larger than the 5 by 5 cut allowed in the plan and that “a larger area is more susceptible to fall when it is not supported.” (Tr. 120). Vadnal explained the basis for his calculations as follows:

   Q. Mr. Vadnal, you have in front of you what has been marked as Government Exhibit 9 for Identification. Could you tell us what that is, please.

   A. This is a comparison of the corner clip of the plan on the left to the actual size of the corner clip and the actual way the corner clip was cut on the right, and it’s comparing the size of the two triangles. The first one being 5' x 5' on each leg of the triangle and 120 degree angle, which would have been the angle of the intersection between the crosscut and the entry gives you results in an area of 10.82 square fee.

   On the right the 11.83 number is 11 feet 10 inches turned into a digital format. The 7.9 feet is 7 foot 9 inches turned into a digital format.

5 In this connection, I note that Lewis opined that the violative cut left a brow that fell on Bryant. However the record does not establish a clear nexus between the excessive cut and the creation of the brow.
The Court: Wait, I don’t see 7.9.
The Witness: Excuse me 7.75 feet is 7 feet 9 inches.
The Court: Okay.
The Witness: And we turn it into a digital format to accommodate calculators and computers. The area of that triangle with a 120 degree angle is 39.69 square feet, which is 366 percent larger than what was allowed in the plan.
The Court: Okay. What is 366 percent?
The Witness: The actual triangle is 366 percent larger than what is prescribed by the plan.
The Court: You mean area of the triangle?
The Witness: Correct, the square footage.
The Court: Of the area of the triangle?
The Witness: Correct

By Mr. Luckett:
Q. And what would the triangle that you are referring to be?
A. That is the triangle formed by cutting the corner clip the way it actually was cut.

Q. And what was the square footage of the actual cut?
A. The actual cut was 39.69 square feet.

I find Vadnal’s explanation, as quoted above, to be lacking in clarity and sufficient specificity as to be relied upon.

In subsequent testimony, Vadnal compared the likelihood of a rockfall as a result of the 5 foot by 5 foot clip cut allowed for in the plan versus the larger clip actually taken as follows:

Q. And what was the square footage of the actual cut?
A. The actual cut was 39.69 square feet.
Q. And does that create a problem?
A. It is a violation of the plan, and it is a larger area.
Q. And is there any hazard created by the larger area?
A. A larger area is more susceptible to fall when it is not supported.

* * *

Q. If the plan had been followed in the size of the corner clip, do you believe that the roof would have fallen?
A. No.
Q. Why?
A. Because it is much smaller.
The Court: By it you mean . . .
The Witness: The area of the corner clip is much smaller.
Q. And why would that make it less likely to fall?
A. There’s less of a distance between roof support fixtures is the best
explanation. It’s a wider span.

The Court: A wider span in the cut as taken?
The Witness: Yes.

(Tr. 120, 125–126)

In this connection, it is significant to note the following testimony of Vadnal on cross-examination regarding his knowledge of the specific area of unsupported roof that he took into account in comparing the relative hazard of the cut actually taken compared to the 5 by 5 foot cut required by the plan:

Q. On the right under the actual representation, most of that area was bolted at the time that the transition zone was cut, do you agree?
A. I don’t know.
Q. Okay. Wouldn’t that information be important in determining the amount of unsupported roof in this area?
A. Yes, it would be important. What I know is from Mr. Lewis’ earlier testimony that the entry up into the intersection and the crosscut up into the intersection had been bolted. The corner clip and some additional area toward the face had not been bolted.
Q. Okay. So you did not factor in what actual roof support was present in any of your analyses?
A. Yes, I did.
Q. Okay. Well, can you show then in the actual picture that you have made what portion of that was supported by roof bolts?
The Court: Don’t write anything yet, sir.
Q. So in other words, if I wanted you to show on my copy of Government Exhibit 8 what of this orange area was supported at the time that the transition zone was cut, could you show me that?
A. That went into my calculations or that was earlier testified to.
Q. I thought you just told me that you did take into account in your calculations that there was some roof support in the intersection?
A. Excuse me.
Q. I know this is hard.
A. No, no, no. What the purpose of this illustration is, is not to the show the area that was not supported. (sic.)

(Tr. 138-139)

I find that the cross-examination of Vadnal highlights the lack of clarity in his testimony regarding the specific dimensions and location of the unsupported roof that he took into account in concluding that the larger cut taken made it more susceptible to falls. I thus find that the cross-examination has diluted the effectiveness of Vadnal’s direct testimony. It is significant to note that his testimony in these regards was not rehabilitated as there was not any redirect examination. Hence I do not accord much weight to his direct testimony.

Moreover, according to Vadnal, the corner clip actually cut created an intersection of 580 square feet, whereas a cut taken pursuant to the plan would have created an intersection of 570
square feet. Significantly, he noted that these two areas are “comparable” (Tr. 103). This recognition by Vandal of the lack of a significant increase in the area of the intersection created by the actual clip taken, tends to minimize, to some degree, the likelihood of a rockfall as a consequence of the violative cut.

b. Lewis’ testimony

Lewis, indicated that on September 4, 2007, after the accident, the area where the brow fell “has [not] been supported” (Tr. 47).

He placed diagonal markings in blue on Gov. Ex. 4 to indicate the area that was bolted according to the plan. However, he agreed, on cross-examination that when Leeco mined the 4-5 break (crosscut) into the No 5 entry, it was already bolted all the way to the inby end of the intersection. He also agreed that when Leeco mined the “transition zone the 4 right break that cut into the No. 5 entry was already bolted all the way through to the intersection of the No. 5 entry” (Tr. 57).

I find that his testimony does not establish the exact dimensions of unsupported versus supported roof in the area in question.

c. Respondent’s witnesses

1. Jacob Lumpkins

According to Lumpkins, the section foreman for the third shift, when he arrived at the area on September 4, before the clip cut was taken, a portion of both entry No. 5, and the 4 right crosscut had already been and cut bolted. He also indicated that the bolter (Bryant) had installed two new bolts 4 feet from the new inby rib of the crosscut resulting from the clip cut. Considerable weight was given to his testimony inasmuch as he was the only witness who had personal knowledge of the extent of bolted roof prior to the cut at issue.

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6 However, this testimony appears to be in conflict with his prior testimony as follows:

Q. And the cut had been taken from the crosscut into the No. 5 entry; is that correct?
A. Yes, sir.
Q. What area was supported?
A. The crosscut would have been supported there from the No. 4 to the No. 5 entry that had been cut prior.
Q. How was it supported?
A. With roof bolts.

(Tr. 36)

7 Area marked in green on Ex. R-5.
2. **David Newman**

Newman, who has a Ph.D. in Mining Engineering, testified as Respondent’s expert witness. His testimony regarding the relationship between the area of excessive cut actually taken and the amount of unsupported roof allowed in the Roof Control Plan (“the Plan”) can be summarized as follows: (1) The Plan allowed a cut of 20' wide and 44' long (Tr. 266); (2) The area of this cut was 880 square feet, which is permitted by the Plan to be mined and then bolted (Tr. 266); (3) The area of the excessive cut actually taken was 35 square feet when it was being bolted (Tr. 269); (4) The 35 square foot area is 4% of the 880 square feet permitted by the Plan (Tr. 270); and (5) . . .

So the roof bolt operator was bolting a relatively small portion of that cut and was bolting from a previously bolted area surrounding that cut on the side from which he was approaching it, was operating in that situation where the pillar was larger, and therefore more stable than that provided by the roof control plan, was operating in an entry and then crosscut narrower than provided by the roof control plan, hence, more stable. And so at the time he was in that area bolting the clip, the conditions provided by Leeco were better than those that they would be required to have under the roof control plan.

The Court: Just generally, just getting to the bottom line, and that’s based upon a number of things that you’ve indicated, I assume, the actual width being narrower than committed in the entry and the crosscut, the fact that some number of bolts were installed at a point where they weren’t required to be installed resulting in a larger pillar and less roof exposed because it had already been bolted, is that your main point?

The Witness: That is correct, yes.

(Tr. 270, 271)

It is significant to note that the above assertions were not impeached or contradicted by the Secretary. Accordingly, they are accorded considerable weight. Thus, I find that the facts referred to by Newman and his conclusion based on those facts, tend, to some degree, to minimize the likelihood of a rockfall when considering the area of the excessive cut.

Thus, within the above context, I find that the Secretary has failed to establish, by a preponderance of clear and convincing evidence, that there was a reasonable likelihood of a roof fall. Accordingly, I find that the third element in Mathies supra has not been met. Thus, I conclude that the Secretary has not established that the violation was significant and substantial.
III. Penalty

The amount of penalty to be assessed by a Commission Judge for the violation found herein, is based upon the factors set forth in Section 110(i) of the Federal Mine Safety and Health Act of 1977 (“the Act”).

A. Gravity

In contrast to an evaluation of significant and substantial, the evaluation of the gravity of the violation is not dependent upon the likelihood of the occurrence of an injury producing event. Rather, gravity is based solely upon an analysis of the severity of particular hazard involved. The identified hazard herein is a rockfall. It is clear that in the event of a rockfall serious injuries could result. As a consequence, even though I previously found that a rockfall was not reasonably likely to have occurred, I conclude that the gravity of the violation was relatively high should a rockfall occur.

B. Negligence

The Secretary argues, based on the testimony of Lewis, that the clip taken, which exceeded the requirements of the roof control plan, was obvious in that Lumpkins should have seen that the violation occurred. On the other hand, I note Lumpkins’ testimony that he was not present when the continuous miner took the cut at issue; that he was in the No. 2 entry at the time. I observed Lumpkins’ demeanor, and found him a credible witness. Furthermore, this testimony was not impeached on cross-examination, nor was it rebutted. Accordingly, I assign it considerable weight.

Moreover, there is not any evidence that Jim Walter was negligent in the taking of the excessive cut which is the gravamen of the Plan’s requirement to take only a 5 foot by 5 foot cut. There is no indication that any other management official had knowledge, prior to the rockfall that a cut in violation of the roof control plan had taken place. Nor is there evidence of prior excessive clip cuts. There is not any evidence that MSHA had placed Jim Walter under notice that stricter attention to the requirements of the Plan was required. I thus find the negligence to be less than moderate.

8 Further, although the brow that fell on Bryant had not been bolted by him, there is not any evidence that he was either improperly trained, not trained at all, or improperly supervised.
C. **History of previous violations**

There is not anything in the record to indicate that the history of violations is other than average for an operation the size of the operation at issue. Thus, I find that the history of violations does not have any impact either positive or negative on the level of the penalty.

D. **The size of the operator’s business**

The parties stipulated that the mine produced 790,000 tons of coal in 2007, and approximately 715,000 in 2010. The record does not establish whether, as a consequence of this level of production, the mine should be classified as small, medium, or large. Accordingly, this factor does not have an impact on the level of penalty either positive or negative.

E. **The effect of the penalty on the operator’s ability to continue in the business**

There was not any evidence adduced by Leeco that the penalty would have a significant impact on its ability to continue in business. Hence, there is no basis to conclude that the penalty to be assessed should be mitigated by this factor.

F. **Good faith to achieve rapid compliance after notification of the violation**

The parties stipulated that the Respondent demonstrated good faith in terminating the citation.

G. **Conclusion**

Taking into account all the factors set forth in Section 110(i) of the Act, as discussed above, I find that although the level of gravity was relatively high, the level of negligence was less than that initially found by the Secretary in proposing a penalty. Considering the good faith of the operator, the neutral effect of the remaining factors set forth in Section 110(i) of the Act, and placing significant weight on the lower level of Leeco’s negligence as contrasted with that initially found by the Secretary, I find that a penalty of $10,000.00 is appropriate.

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9 At the hearing, the Secretary proffered “a computer-print-out” of documents containing Leeco’s history of violations. (Tr. 143). *(History of Violations, Gx. 11).* Respondent objected to the admissibility on the ground that it shows a two-year history, whereas under 30 C.F. R. § 100.3 only the preceding 15 months is relevant. This objection was overruled. The Respondent next objected on the ground that the history shows violations that occurred more than 2 years prior to September 4, 2007. A ruling was reserved to allow the Secretary to amend the exhibit. The Secretary in its brief renewed its proffer, and Respondent filed an objection on May 8, 2012. This objection, in essence, relates to the weight to be accorded Gx. 11, and not its admissibility. Accordingly, it is overruled, and Gx 11 is admitted.
ORDER

It is ordered that Leeco, within thirty (30) days of this decision, shall pay a civil penalty of $10,000.00 for the violation found herein.

/s/ Avram Weisberger
Avram Weisberger
Administrative Law Judge

Distribution: (Certified Mail)

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/cmj
This case is before me on a Petition for Assessment of Civil Penalty filed by the Secretary of Labor (“Secretary”) acting through the Mine Safety and Health Administration (“MSHA”) against Stansley Mineral Resources, Inc. (“Stansley”) pursuant to sections 105 and 110, 30 U.S.C. §§ 815, 820, of the Federal Mine Safety and Health Act of 1977 (the “Mine Act”). 30 U.S.C. § 801, et seq. The Secretary seeks the assessment of a civil penalty in the amount of $2,000 for one violation of the Secretary’s mandatory safety standards for surface metal and nonmetal mines at Stansley’s Plant 311 (“Tecumseh” site), a sand and gravel processing facility located in Tecumseh, Michigan. The violation is alleged in Citation No. 6504341, which was issued pursuant to section 104(d)(1) of the Mine Act, 30 U.S.C. § 814(d)(1). The Secretary asserts that the operator violated 30 C.F.R. § 56.14107(a), that the violation was a significant and substantial contribution to a mine safety hazard (“S&S” violation) and was caused by Stansley’s unwarrantable failure to comply with the standard. Section
56.14107(a) requires that all moving machine parts be guarded against contact by a person. ¹ In answering the petition, the company argued that the violation was not due to its unwarrantable failure and its high negligence. The case was heard in Toledo, Ohio.

**STIPULATIONS**

The parties stipulated as follows:

1. [Stansley] owns and operates Mine ID No. 20-03312, which is a surface sand and gravel mine located in Michigan.

2. Stansley’s mining operations at Mine ID No. 20-03312 affect interstate commerce.

3. Stansley’s operations at Mine ID No. 20-03312 are subject to the jurisdiction of the Mine Act.

4. The Administrative Law Judge has jurisdiction in this matter pursuant to section 105 of the Mine Act.

5. The individual whose signature appears in Block 22 of the citation at issue in this proceeding was acting in his official capacity as an authorized representative of the Secretary of Labor when the citation was issued.

6. A true copy of the citation at issue in this proceeding was served on Stansley as required by the Mine Act.

7. The total proposed penalty for the citation in this proceeding will not affect Stansley’s ability to continue in business.

8. The R-17 Assessed Violation History Report which the Secretary has designated as an exhibit is an authentic copy and may be admitted as a business record of the Mine Safety and Health Administration.

9. The Secretary stipulates that Stansley exercised good faith in terminating the citation issued in a timely manner.

¹ Section 56.14107(a) states: “Moving machine parts shall be guarded to protect persons from contacting gears, sprockets, chains, drive, head, tail, and takeup pulleys, flywheels, couplings, shafts, fan blades, and similar moving parts that can cause injury.”
THE TESTIMONY

SECRETARY’S WITNESS

Christopher Veenstra is an MSHA inspector who works in the agency’s Lansing, Michigan office. Tr. 26. He began working for MSHA on June 17, 2009. Tr. 26. He received six months of classroom training and nine months of on-the-job training, during which time he traveled with journeyman inspectors. Tr. 27. He became an authorized representative of the Secretary in April 2010. Tr. 27. Before working for MSHA, Veenstra was a shipper and then an electrician for a sand and gravel company. Tr. 28. For three-and-a-half years as a shipper he loaded railcars and customer trucks using conveyor belts and mobile equipment. Tr. 30. He then worked as an electrician for 16 years, repairing and maintaining mechanical equipment and electrical circuits. Tr. 29.

On November 8, 2010, at approximately 2:30 p.m., Veenstra arrived at Stansley’s Tecumseh site to conduct a regular inspection. Tr. 32. He reported to the scale house when he arrived and spoke with Donna Madigan, the scale clerk. He introduced himself, told her that he was at the site to conduct an inspection, and asked for Todd Crane, the site superintendent. Tr. 32. Crane was at the Clinton site, another sand and gravel mine that is owned and operated by Stansley, and where he is also the superintendent.2 Tr. 33.

Veenstra told Donna Madigan that he would begin the inspection and that Crane was welcome to join him. Tr. 38. As soon as Veenstra walked out of the scale house and around a deposit of material, he encountered the McCloskey plant (“McCloskey plant” or “the plant”), which is the machinery at issue in this case. Tr. 40. He saw a miner, whom he later learned was Lyle “Rick” Reddick, a plant operator, shoveling close to the self-cleaning tail pulley of the plant’s oversized conveyor. Tr. 40. The tail pulley was not guarded, and Veenstra asked Reddick to back away carefully from the pulley. Tr. 41. Veenstra then questioned Reddick. Reddick told Veenstra that he had to shovel around the tail pulley every one to two hours. Tr. 41. Reddick also said that Crane knew about the lack of a guard on the tail pulley. Tr. 41-42. Crane arrived shortly thereafter. Tr. 57. Veenstra testified that when he pointed out the hazard

2 Veenstra had conducted an inspection at the Clinton site with Crane in attendance on November 1, 2010. Tr. 33. During the November 1 inspection Veenstra issued several citations, three of which were for guarding violations, including two citations for violating section 56.14107(a). Tr. 34. On November 1, Veenstra and Crane discussed the need for better guarding. Tr. 58-59.
to Crane, Crane “kind of dropped his head and said ‘I know, we were going to put a guard on that tomorrow.’” Tr. 58. Veenstra interpreted Crane’s response to mean that Crane already had knowledge of the fact that the tail pulley needed a guard. Tr. 74, 82; Gov’t Ex. 6.

Veenstra described the tail pulley as completely unguarded and stated that it was very accessible to those working around it. Tr. 70. Veenstra estimated that from the bottom of the pulley to the ground measured about six inches and that from the center of the pulley to the ground measured about ten inches. Tr. 59. Reddick, while he was shoveling, was standing approximately three feet from the tail pulley. He was using a four-foot-long shovel. Tr. 44-46. The ground around the tail pulley is uneven, creating a trip hazard. Tr. 69. Veenstra explained that the material Reddick was cleaning was debris that fell from the oversized conveyor. Tr. 47. To prevent the pulley from being overwhelmed by the spillage, Reddick had to clean under, behind, and to the side of the tail pulley, bringing the shovel within inches of the pulley in-take area. Tr. 46-47. According to Veenstra, it is common for tail pulleys to spill and for miners to clean around tail pulleys. Tr. 49. The pulley was a fluted, rather than a smooth, pulley, so it had ridges that acted as points upon which tools or limbs could be caught. Tr. 69. In Veenstra’s experience, if a miner’s shovel contacted a tail pulley while the miner was cleaning, the miner could be pulled up into the pulley before he could let go of the shovel. Tr. 65-66.

Veenstra testified that not only did miners clean around the unguarded tail pulley, but they had to get close to the tail pulley every 40 hours to manually grease the pulley’s bearings. There were no extended grease fittings to allow remote greasing of the bearings.3 Tr. 67. While Veenstra did not witness a miner greasing the bearings, he worried one would try to grease them while the plant was running. Tr. 67.

Veenstra cited his experience, training, and MSHA-documented accident history when discussing the potential seriousness of the injury that could result from entanglement with the unguarded tail pulley. Tr. 60-66. Veenstra stated that such an injury was likely to be permanently disabling or fatal. An arm could be pulled into the pulley resulting in the loss of the limb, leaving the miner permanently disabled. Tr. 61. Likewise, a miner’s shovel could be caught in the pulley, pulling the miner up into the pulley, resulting in the miner’s death. Tr. 63-66; Gov’t Ex. 13.

When issuing the citation, Veenstra found that it was reasonably likely a miner would become entangled in the pulley. Veenstra was concerned because the miner was shoveling very near the unguarded tail pulley. Tr. 66. Further, there were no extended grease fittings and a miner needed to regrease the tail pulley bearings every 40 hours. Tr. 66-67. He noted that the ground was uneven in the area, increasing the likelihood a miner would trip and fall onto the unguarded pulley. Tr. 68. In addition, and as previously mentioned, the pulley had catch points that made it even more dangerous than a smooth pulley. Tr. 69. The inspector maintained that

3 A sign next to the tail pulley stated that the bearings had to be greased every 40 hours. Gov’t Ex. 2.
the condition had existed for a week. Tr. 70. Reddick had to clean around the tail pulley every one to two hours. Tr. 70-71. Finally, the tail pulley was easily accessible in that there were no barriers blocking access to it. Tr. 71. Veenstra found that the violation was S&S because he believed an injury was reasonably likely to occur that would at least result in lost workdays. Tr. 71. Veenstra also identified the violation as being caused by Stansley’s high negligence and unwarrantable failure to comply with the standard. He believed that management knew or should have known of the condition (the condition was open and obvious) and that there were no circumstances mitigating Stansley’s negligence. 30 C.F.R. § 100.3(d); Tr. 72, 76.

**COMPANY’S WITNESSES**

The company disagrees that the violation was S&S and was caused by its unwarrantable failure to comply with section 56.14107(a). It argues that the condition was not open and obvious and that the company was not on notice that having a guard on the tail pulley was required by the cited standard.

Todd Crane has worked for Stansley for five years, the first year as a mechanic and the last four as a superintendent. Tr. 175. As the superintendent of the Clinton and Tecumseh sites, he is “in charge of the manpower, for safety, scheduling, production, maintenance.” Tr. 175. Also, he accompanies all inspectors on their visits. Tr. 176. Crane spends three to four days a week at the Tecumseh site. The rest of the time he is at the Clinton site. Tr. 175. As a result of the citation issued by Veenstra for the unguarded pulley, MSHA opened an inquiry to determine if mine officials should be charged with individual liability. During the inquiry an MSHA investigator interviewed Crane, who said that Reddick did the daily workplace examinations on the McClosey plant and that when Crane went to the Tecumseh site, he always reviewed the workplace examination reports.4 Gov’t Ex. 10 at p. 3.

Crane testified that on May 1, 2008, before putting the Tecumseh site into operation, Stansley requested a courtesy inspection (also known as a “compliance assistance visit”) from MSHA. Tr. 148, 177. Crane accompanied the inspector, David Barr, on the visit, which included the McClosey plant. The inspector made no recommendations for enhancing compliance at the plant. Tr. 153, 177. It is unclear, however, whether the plant was operating during the inspection. Tr. 166. Two weeks after the courtesy visit, on May 13, 2008, the plant was in full production and another MSHA inspector came to the Tecumseh site to conduct a regular inspection. This inspection also included the McClosey plant. Tr. 178. As with all inspections, Crane accompanied the inspector. Tr. 177. During the May 13 inspection the plant was processing top soil. Tr. 178. No citations resulted. Tr. 178. The plant was set up in the same location and in the same configuration during the May 13, 2008, and November 8, 2010,

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4 Copies of the examination reports entered into evidence by the Secretary show that in the week prior to the inspection, a mine examiner conducted a daily workplace examination on the McClosey plant five times. Gov’t Ex. 9 at p. 14-18 (SMR007-SMR011). The lack of a guard on the plant tail pulley was not noted on any of the reports. Gov’t Ex. 10 at p. 3.
Counter to Veenstra’s assertion that Crane knew about the tail pulley needing a guard, Crane testified that he had no such knowledge. He maintained that when Veenstra brought up the need for a guard on the tail pulley, he told Veenstra that the McCloskey plant did not come with a tail pulley guard, but that he would put one on it the next day. Tr. 180, 183. He further stated that none of his employees had ever told him that the tail pulley needed a guard. Tr. 183-84. In support of this statement, Reddick testified that when he was interviewed during MSHA’s individual liability investigation, he did not think that he told MSHA’s investigators that the tail pulley needed a guard. Gov’t Ex. 14 at p. 2; Tr. 146. Further, Chip Tokar, a Stansley official, agreed with Crane that the tail pulley on the plant did not need a guard. Tr. 184.

When Veenstra asked how long the tail pulley had been in operation at this location without a guard, Crane stated one week or so. Tr. 58. Crane turned off the machine immediately when Veenstra pointed out the hazard. Tr. 180. He had a guard installed, thereby eliminating the hazard. See Gov’t Ex. 6.

**THE ISSUES**

The operator admits that it violated section 56.14107(a). Tr. 23. It contests that the violation rose to the level of a 104(d)(1) citation under the Mine Act. 30 U.S.C. § 814(d)(1); Tr. 23, 232. Thus, the issues are (1) whether the violation was S&S and (2) whether the violation was an unwarrantable failure to comply with a mandatory safety standard. In view of the admitted violation of section 54.14107(a), also at issue is the amount of the civil penalty that must be assessed for the violation, taking into consideration the civil penalty criteria set forth in section 110(I) of the Act.

**S&S AND GRAVITY**

An S&S violation is a violation “of such nature as could significantly and substantially contribute to the cause and effect of a . . . mine safety or health hazard.” 30 U.S.C. § 814(d). A violation is properly designated S&S “if, based upon the particular facts surrounding 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). As is well recognized, in order to establish the S&S nature of a violation, the Secretary must prove: (1) the underlying violation; (2) a discrete safety hazard – that is, a

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5 The May 1 compliance assistance visit and May 13 regular inspection were the only inspections done at Tecumseh that involved the McCloskey plant. Two regular inspections conducted between May 13, 2008 and November 8, 2010, one on August 19, 2009, and the other on August 3, 2010, did not include the plant because on those dates the plant was operating outside of MSHA’s jurisdiction. Tr. 202-216.
measure of danger to safety – contributed to by the violation; (3) a reasonable likelihood that the hazard contributed to will result in an injury; and (4) a reasonable likelihood that the injury will be of a reasonably serious nature. *Mathies Coal Co.*, 6 FMSHRC 3-4 (Jan. 1984) accord *Buck Creek Coal Co., Inc.*, 52 F.3d 133, 135 (7th Cir. 1995); *Austin Power Co., Inc. v. Sec’y of Labor*, 861 F.2d 99, 103 (5th Cir. 1988) (approving *Mathies* criteria).

It is the third element of the S&S criteria that is the source of most controversies regarding S&S findings. The element is established only if the Secretary proves “a reasonable likelihood the hazard contributed to will result in an event in which there is an injury.” *U.S. Steel Mining Co., Inc.*, 7 FMSHRC 1125, 1129 (Aug. 1985). An S&S determination must be based on the particular facts surrounding the violation and must be made in the context of continued normal mining operations. *Texasgulf, Inc.*, 19 FMSHRC 1125 (Aug. 1985); *U.S. Steel*, 7 FMSHRC at 1130.

Furthermore, the S&S nature of a violation and the gravity of a violation are not synonymous. The Commission has pointed out that the “focus of the seriousness of the violation is not necessarily on the reasonable likelihood of serious injury, which is the focus of the S&S inquiry, but rather on the effect of the hazard if it occurs.” *Consolidation Coal Co.*, 18 FMSHRC 1541, 1550 (Sept. 1996).

For the reasons that follow, I conclude that Stansley committed an S&S violation. The company does not dispute that it violated section 56.14107(a), a mandatory safety standard requiring guarding to prevent contact with moving parts. This violation created a discrete safety hazard in that Reddick, or any other employee working around the tail pulley, could become entangled. The facts reveal that a miner working around the tail pulley to remove spillage uses a four-foot-long shovel and stands about three feet away from the tail pulley on uneven surfaces while he bends over, putting both the shovel and his hands close to the pulley to scrape the debris away from the tail pulley. I credit Veenstra’s testimony that if the shovel contacts the tail pulley while the miner is cleaning, the miner likely will be pulled into the pulley before he can react and let go of the shovel. Tr. 65-66. Veenstra’s experience and training added weight to his common sense testimony of the hazards involved. Moreover, I credit his testimony that a miner greasing the pulley bearings works dangerously close to the pulley due to the lack of extended grease fittings. Tr. 66-67. Veenstra’s belief that a miner could slip and fall into the unguarded pulley was reasonable given the uneven ground upon which the miner had to stand. Tr. 68.

I further find that there was a reasonable likelihood that as mining continued the unguarded tail pulley would result in entanglement and serious injury. The testimony established that a miner’s shovel comes within inches of the pulley in-take area when the miner is cleaning and a miner has to shovel around the tail pulley every one to two hours. Tr. 41, 46, 70-71. Further, and as previously noted, the ground is uneven around the tail pulley, creating a trip hazard. Tr. 69. Adding to the likelihood of an injury is the fact that the tail pulley is a self-cleaning fluted pulley, rather than a smooth pulley. It has catch points that can readily snag an errant shovel or limb. Tr. 69. The tail pulley is easily accessible. Tr. 70. Moreover, the pulley has to be greased every 40 hours. Given the fact that a miner was cleaning around the pulley...
while it was operating, it is reasonable to assume a miner also would grease the bearings while the pulley is in motion. See Tr. 67. Finally, history and experience have documented that unguarded head or tail pulleys have resulted in serious or fatal injuries when miners work around them, and I credit the inspector’s and the Secretary’s assertions that entanglement with the tail pulley is likely to result in a miner’s permanent disability or death. Tr. 60-66. I find that the violation was S&S.

I also find that given the likely effects of the injury resulting from the violation, the violation was very serious.

UNWARRANTABLE FAILURE AND NEGLIGENCE

As noted previously, the citation was issued pursuant to section 104(d)(1) of the Mine Act. Such a citation is issued if a violation is both S&S and caused by the unwarrantable failure of the operator. I have found that the violation of section 56.14107(a) was S&S. I also find the violation was the result of the company’s unwarrantable failure.

The term “unwarrantable failure” is defined as aggravated conduct constituting more than ordinary negligence. Emery Mining Corp., 9 FMSHRC 1997, 2004 (Dec. 1987). Unwarrantable failure is characterized by such conduct as “reckless disregard,” “intentional misconduct,” “indifference,” or the “serious lack of reasonable care.” Emery, 9 FMSHRC at 2203-04. Whether conduct is “aggravated” is determined by analyzing the facts and circumstances of the case and identifying whether any aggravating factors exist. Such factors include the length of time the violation existed, the extent of the violative condition, whether the operator was placed on notice that greater efforts were necessary for compliance, the operator’s efforts in abating the violative condition, whether the violation was obvious and posed a high degree of danger, and the operator’s knowledge of the existence of the violation. Jim Walter Resources, Inc., 28 FMSHRC 579 (Aug. 2006). In practice, these factors are evaluated and weighed against factors mitigating an operator’s lack of care. See e.g. Excel Mining, LLC, 34 FMSHRC 99 (Jan. 2012) (ALJ Gill).

I find first that the lack of a guard was open and obvious and posed a high degree of danger. The Commission has held that in analyzing whether a condition is obvious, it is necessary to look not only at what is visibly obvious, but also to consider what assumptions the operator should be making given the type, use, and location of the machinery. Coal River Mining, LLC, 32 FMSHRC 82, 94 (Jan. 2010). The tail pulley was completely unguarded. It was a fluted self-cleaning tail pulley, which as previously explained is a type of pulley known to be more dangerous than a smooth pulley. Tr. 69. Given the amount of spillage, an employee needed to regularly tend to the plant every one to two hours, removing debris so that the conveyors continued to work properly. Tr. 47-49, 66. The pulley was six to ten inches off the ground, Tr. 59, putting it in a prime position to come into contact with the shovel a miner would use to remove the debris. There also was a sign by the pulley indicated that its bearings needed to be greased every 40 hours. Tr. 67. To do the job, a miner had to place himself right by the unguarded tail pulley and apply the grease manually. Tr. 67. While there was no evidence
presented that the miners at the Tecumseh site manually regreased the pulley while the plant was operating, the unguarded pulley was easily accessible, there were no extended fittings for non-manual regreasing, and there was no warning sign to turn off the plant before regreasing. See Gov’t Ex. 2. These factors convince me that it was reasonable for Stansley’s officials to assume miners would regularly work dangerously close to the pulley while the plant was operating. The company should have realized a guard was needed. The unguarded condition of the tail pulley was obviously a hazard given the amount and type of activity that the company could reasonably expect to go on around it.

The testimony established that the plant had been in the same condition and production mode for at least a week, which, given the level of danger the hazard presented and the number of times a miner or miners worked around the hazard, was an extended period of time to allow the pulley to go unguarded. I therefore find that one week was ample time to notice and fix the hazard, especially since during that week Reddick conducted an inspection that included the plant at least once per shift, as required by 30 C.F.R. § 56.18002(a).6

Finally, and as noted, the violation was very dangerous. The fact that a miner was reasonably likely to be dismembered or killed as mining continued raised the level of care Stansley should have exhibited. Not guarding the pulley represented a very serious lack of care.

I conclude that together these factors indicate that Stansley exhibited aggravated conduct constituting much more than ordinary negligence. In reaching this conclusion I recognize that Stansley abated the violation as soon as the inspector brought the condition to the attention of its superintendent. Crane immediately shut down the plant and quickly installed a guard over the tail pulley. Tr. 180. While this will be considered when a civil penalty is assessed, it does not mitigate Stansley’s aggravated lack of care. The fact remains that prior to being cited Stansley did nothing to decrease the danger of the hazard.

Stansley contends that it was not on notice about the condition or that it needed to make efforts to comply with the standard. It points out that the lack of a guard was not cited before November 8, 2010. Tr. 152-53. The plant was operating in the same configuration on November 8, 2010 as it was during MSHA’s compliance assistance visit on May 1, 2008, and during MSHA’s first regular inspection on May 13, 2008. Tr. 149. Stansley notes that during the visit and inspection MSHA’s inspectors did not make any recommendations or issue any citations pertaining to the plant. Tr. 177, 178. Stansley asserts that it reasonably understood the McCloskey plant to be in compliance with all MSHA health and safety standards and that it had no reason to believe that it needed to make any adjustments to the operation of the plant. Tr. 229-31. Stansley emphasizes that it brought to Veenstra’s attention during the inspection, Tr.

6 Section 56.18002(a) regulates the examination of working places: “A competent person designated by the operator shall examine each working place at least once each shift for conditions which may adversely affect safety or health. The operator shall promptly initiate appropriate action to correct such conditions.” 30 C.F.R. § 56.18002.
81-82, 180, and to the Court’s attention during the hearing, that the plant did not come with a guard on the tail pulley when Stansley bought the plant from the factory. Tr. 145. However, it did come with guards covering other moving parts of the plant. For all of these reasons, Stansley argues that it could not have known that the tail pulley, unguarded, presented a hazard to those working around the equipment. Tr. 228.

Assuming all arguments that Stansley asserts are true, Stansley still cannot prevail. The inquiry employed by the Commission is “whether a reasonably prudent person familiar with the mining industry and the protective purposes of the standard would have recognized the specific prohibition or requirement of the standard.” Ideal Cement Co., 12 FMSHRC 2403, 2416 (Nov. 1990). The record more than confirms that Stansley should have installed a guard. Not only was the need for one glaringly obvious, but Stansley was on notice as to the importance of compliance. The week before November 10, 2010, Veenstra inspected the Clinton site. The inspection resulted in two citations issued for violations of section 56.14107(a). It also resulted in Veenstra discussing with Crane “the need to improve guarding.” Tr. 59. Crane should have drawn the logical conclusion that the company needed to intensify its efforts to comply with the standard. Despite this warning, Stansley did nothing.

Similarly, Stansley’s argument that it should not be expected to add any guards to those supplied by the manufacturer is untenable. A manufacturer cannot be expected to anticipate all of the conditions under which its equipment will be used. Obviously, depending on the location and use of the McCloskey plant, different safety devices other than those installed by the manufacturer may be necessary. See Alan Lee Good, 23 FMSHRC 995, 1010 n. 1 (Sept. 2001). In any event, the responsibility for maintaining a safe and healthy environment is the operator’s, not the manufacturer’s. And, because a piece of machinery is not cited for violations during an inspection does not mean that the operator escapes responsibility for compliance. Mainline Rock & Ballast, Inc., 34 FMSHRC ___ (Apr. 2012); 2012 WL 1111258 at *5 (Apr. 2012). See also, Mainline Rock & Ballast, Inc., 33 FMSHRC 307, 326 (Jan. 2011) (ALJ Moran) (holding that because MSHA identified moving parts that needed guarding does not mean that other moving parts do not need guarding, and that “[i]t is the operator’s, not MSHA’s, responsibility to identify such moving machine parts.”); D. Holcomb & Co., 33 FMSHRC 1435, 1440 (Jun. 2011) (ALJ Manning).

For these reasons I find that evidence that the violation was due to aggravated conduct constituting more than ordinary negligence easily prevails over any evidence of mitigation, and that Veenstra was correct when he found that the violation was due to an unwarrantable failure.

Further, given the visually obvious nature of the violation and the length of time the violation existed, I conclude that Veenstra was correct when he found that the violation was due to Stansley’s high negligence.
REMAINING CIVIL PENALTY CRITERIA

HISTORY OF PREVIOUS VIOLATIONS

The Tecumseh site’s history of previous violations is reflected in a computer printout that shows that in the fifteen months prior to November 8, 2010, the company paid civil penalties for four violations. Gov’t Ex. 12 at 2. Three of the violations were assessed at $100 and the fourth violation was assessed at $392. I conclude from this that the company’s violation history is small.

SIZE

The parties did not stipulate to the size of the mine, nor did any witness testify as to the size of the mine. Under 30 C.F.R. § 100.3(b), the size of a metal/non-metal mine and its controlling entity is measured by the annual number of hours worked. The annual number of hours worked at the Tecumseh mine is 7,208 and by the controlling entity 29,695. Ex. A. This is a small mine.

ABILITY TO CONTINUE IN BUSINESS

The parties stipulated that the proposed penalty will not adversely affect the company’s ability to continue in business. Jt. Ex. 1.

GOOD FAITH ABATEMENT

The parties agree that the alleged violation was abated in good faith and in a timely manner. Jt. Ex. 1.

CIVIL PENALTY ASSESSMENT

<table>
<thead>
<tr>
<th>CITATION NO.</th>
<th>DATE</th>
<th>30 C.F.R. §</th>
<th>PROPOSED ASSESSMENT</th>
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<tbody>
<tr>
<td>6504341</td>
<td>11/8/10</td>
<td>56.14107(a)</td>
<td>$2,000</td>
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I have found that the violation existed, that it was very serious, and that the negligence of the company was high. Stansley is a small operator. Its small history of previous violations and its timely abatement speak to a positive attitude toward compliance. From all that appears in the record, the violation cited on November 10, 2010, was an aberration. The proposed penalty is almost five times more than any previously assessed penalty. I view the proposal as excessive and assess a penalty of $1,000.
ORDER

Within 40 days of the date of this decision, Stansley Mineral Resources, Inc. IS ORDERED to pay civil penalties totaling $1,000 for the violation of section 56.14107(a) set forth in Citation No. 6504341. Upon payment of the penalty, this proceeding IS DISMISSED.

/s/ David F. Barbour
David F. Barbour
Administrative Law Judge

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Karl Kloepfer, pro se, Paul, Idaho, for the Respondent

Before: Judge Moran

Involved in this proceeding under the Mine Act are six citations/orders. Four involve the guarding standard found at 30 C.F.R. § 56.14107(a), which deals with moving machine parts that can cause injury and requires that such parts be guarded to protect persons from contacting such parts. The fifth citation, invoking 30 C.F.R. § 56.11002, pertains to handrails, and requires that crossovers, elevated walkways, elevated ramps, and stairways be provided with handrails and maintained in good condition. The last matter involves 30 C.F.R. § 56.18002(a), a provision requiring operators to examine each working place at least once each shift for conditions which may adversely affect safety or health. It is related to the other five citations/orders because, if any of those are upheld, that can support the contention that there must have been an inadequate examination of the mine's working places. An overarching issue for all these matters pertains to whether the mine cited should have had its own mine ID, a consideration which impacted the proposed penalty calculation.

For the reasons which follow, the Court finds that Kloepfer’s original mine ID was properly applied to the Respondent's cited portable operation. Further, while it upholds each of the violations, but not the special findings associated with them, the Court reduces significantly the proposed penalties because the facts do not warrant the amounts proposed.
The mine ID issue

At the time in issue Respondent Kloepfer had two plants. Its significantly larger facility, Plant 1, is some 35 miles from Plant 4. It was at its smaller Plant 4 that Kloepfer was cited for the alleged violations in this litigation. In Mr. Kloepfer's opening statement he described Plant 4 as a completely new startup operation which had only been in operation for 1 and ½ days before the MSHA inspection which produced the citations in issue here.

Inspector Ron Jacobsen, supervisory mine inspector since 2001, testified on the mine ID issue. Jacobsen stated that MSHA issues a new ID "if there's actually a mine. They have to be taking material and sizing it or crushing it or be an actual mine before a mine ID is assigned." Tr. 167. The Inspector did recall his conversation with Mr. Kloepfer in February 2009 concerning whether Plant 4 needed a separate legal ID. Tr. 167. According to Inspector Jacobsen, Kloepfer was going to take a portion of his existing plant and move it approximately 20 to 30 miles away to the Plant 4 location. Tr. 168. The Inspector noted that there is a form for operators to fill out when they move a portable plant and that this is in place of getting a new mine ID. Tr. 168. Referred to GX P 15, the Program Policy Manual, Volume III, pertaining to portable operations, Jacobsen pointed out that it provides only that the operation send in a notification every time they move, and that a new mine ID is not issued each time. Tr. 169. Jacobsen asserted that there was no need for a new ID to be issued because Kloepfer "took part of the load - - or the conveyors and the equipment from [what] was part of the original plant. And it was [on] a trial basis. And he was not running the other plant." Tr. 169. Jacobsen confirmed that if both plants are operating at the same time, then two mine IDs are needed. Tr. 171. A statement from Mr. Kloepfer during recross-examination of Mr. Jacobsen tended to confirm that if the smaller plant worked out, there would be a situation where both plants would be operating at the same time. Tr. 173. Consistent with that, Mr. Kloepfer stated that prior to the fall of 2011 the two plants did not operate simultaneously. Tr. 188. Thus, simultaneous running of the two plants did not occur before the fall of 2011. Tr. 189, 199. Accordingly, consistent with the facts adduced at the hearing, and MSHA's policy, Plants 1 and 4 were properly treated as a single mine and therefore the violation history of Plant 1 was appropriately considered when evaluating the violations found at Plant 4.

The alleged guarding violations

1. Citation No. 6475309, pertaining to 30 C.F.R. 56. 14107(a). The government proposed a penalty of $4,329.00 for this alleged violation. 30 C.F.R. 56. 14107(a) provides: (a) Moving machine parts shall be guarded to protect persons from contacting gears, sprockets, chains, drive, head, tail, and takeup pulleys, flywheels, couplings, shafts, fan blades, and similar moving parts that can cause injury. (b) Guards shall not be required where the exposed moving parts are at least seven feet away from walking or working surfaces. An exception to the guarding requirement is set forth at 30 CFR § 56.14112(b), entitled, "Construction and maintenance of guards." That subsection provides that "Guards shall be securely in place while machinery is being operated, except when testing or making adjustments which cannot be performed without removal of the guard."
The aforementioned Supervisory Mine Inspector Ron Jacobsen testified about each of the alleged violations. Part of his duties includes reviewing the work of the inspectors who work for him. Tr. 34. Jacobsen is the supervisor of Inspector Denis Karst and it was Inspector Karst who inspected Kloepfer's Prep Plant 4 on February 11, 2009. Karst would have testified but a recent medical problem precluded his testimony at the hearing and for an indefinite period of time in the future. As with each of the disputed matters in this case, it was Karst who cited the Respondent for the guarding violation, Citation No. 6475309, pertaining to 56.14107(a). As noted, the standard requires that moving machine parts be guarded. Tr. 36. The citation states that moving machine parts, including a V-belt drive and a head pulley, were not guarded. Tr. 36. GX P 1. Injuries from coming into contact with such unguarded parts include dismemberment type accidents, such as tearing off a finger. GX P 3 is a photograph of the V belt in issue for that citation and it reflects the V belt in its unguarded state. Tr. 38-39. Jacobsen marked on GX 3, circling the unguarded pinch points he had referred to earlier in his testimony and designating that marking with the symbol "PP" (with "PP" standing for "pinch point"). Tr. 41.

Upon the government's completion of its evidence pertaining to the four guarding violations alleged, Mr. Kloepfer cross-examined Inspector Jacobsen about those, making the point that Jacobsen has never actually visited the Kloepfer plant in issue. Tr. 69.

The Court also inquired about the abatement of this guarding violation, learning that a door, which was present, was simply closed to abate the citation. Tr. 72.

Upon consideration of all the evidence, the violation was established but, in context, it was barely more than a technical violation, as someone merely forgot to close a door.

2. Citation number 6475300 pertaining to 30 C.F.R. 56.14107(a). The government proposed a penalty of $31,988 for this alleged violation. Tr. 47. This was later changed to section 104(d)(1) notice.

Inspector Jacobsen was asked about GX P 5, which exhibit refers to Citation number 6475300 and it too involves an alleged violation of 56.14107(a). The Inspector stated that the self-cleaning tail pulley, return roller and the head pulley were not guarded on the 605 cone conveyor. Tr. 43. Jacobsen stated that the hazard was entanglement. One greasing or cleaning those may do so while it is in operation and that is how the harm could come about. Tr. 43 and GX P 6. As before, Jacobsen marked the pinch points on that photograph. Tr. 44. Jacobsen considered the risk of getting caught to be "very likely" and that the result would likely be fatal. Tr. 44-45. To demonstrate the potential harm, GX P 4, a fatality report involving a conveyor at another mine (i.e. not the Respondent’s) in which a miner got caught with fatal results, was introduced. Tr. 45. As noted, the Citation, reflected in GX P 5, also reveals that it was modified from a 104(a) citation to a 104(d)(1) citation. Tr.46. Jacobsen, reading from the citation, stated that the basis for the change was the issuing inspector’s recording that Kloepfer's foreman, Steven Hill, told him that he was aware of the guard being missing. Jacobsen added that MSHA considers anything more than one shift to be "an extended period of time." Tr. 46.
A guard was installed to abate the violation. The Court noted that the record does not reveal one way or the other whether there was a guard, but that it had been temporarily removed, as opposed to no guard ever being present. Tr. 74. Jacobsen also agreed that the time of abatement is based on when the inspector next returned to the site and then observed the condition corrected. Accordingly, it is possible that the guards were installed well before the inspector returned. During cross-examination, Inspector Jacobsen could not recall if the decision to change some of the citations to (d) orders occurred after consultation with him. Tr. 78.

Upon consideration of all the evidence, the violation was established.

3. Citation number 6475301, pertaining to 30 C.F.R. 56.14107(a). The government proposed a penalty of $35,543.00 for this alleged violation. This too was later changed to a section 104(d)(1) order.

Directed to GX P 7, Inspector Jacobsen testified about citation number 6475301 and he identified it as another violation of the same guarding standard as the previous two. As with the others, Inspector Jacobsen circled the pinch points involved, which were on the self-cleaning pulley and the return roller for the 625 conveyor. Tr. 56. He added that, at the pinch point, the design is such that one's sleeve could easily get caught in it. Serious injuries can result. Tr. 57. The tail pulley here was about 2 feet above ground level and the return pulley was about 4 feet above ground. This height means that exposure to the pinch point can easily occur. Tr. 58. Jacobsen believed that an injury would be very likely to occur because of those factors and because there would be clean up work done around the tail pulley with a shovel and one could be inspecting the tail pulley for noises or other problems too. Tr. 58. The accessibility to the pinch points would also be greater if the surrounding ground were uneven or slick due to weather conditions, such as with snow or rain. This citation too was modified to a section 104(d)(1) order on the same basis as the other modification; that is, that the inspector, after speaking with Kloepfer foreman Mr. Steve Hill, learned that the mine knew that the guard was off. Tr. 59.

Upon consideration of all the evidence, the violation was established.

4. Citation number 6475305, pertaining to 30 C.F.R. 56.14107(a). The government proposed a penalty of $35,543.00 for this alleged violation. This was later changed to a section 104(d)(1) order as well, and on the same basis as the others; that the mine knew of the absent guard. Tr. 67.

Jacobsen was asked about Citation Number 6475305, GX P 9. It too is a guarding violation. In this instance a self-cleaning tail and head pulley were not guarded on the under-screen conveyor. Tr. 60. Exhibit P 10 has two photographs of the condition. The second photo shows a ladder and an entryway into the screen deck. Tr. 61. Although Inspector Jacobsen marked two pinch points, he admitted that he was not certain if the second pinch point was part of the cited condition in the citation because he did not know about accessibility to it. Tr. 62. This is understandable, as Jacobsen has never been to the Respondent’s Plant 4.

The witness then marked on the exhibit both pinch points, including the upper pinch point for
which accessibility was uncertain. In sum, regarding this alleged violation, Jacobsen stated that there was a tail pulley, a head pulley and a drive that were not guarded. Tr. 65. Like the others, he considered the hazard of entanglement with the attendant injuries, to be "highly likely." Tr. 65. Given MSHA's view about the obviousness of the condition and that it existed for more than a shift, it was changed to show the (d)(1) designation. Tr. 68. The inspector's notes indicate that "access has been moved away from the head pulley which is over 7 feet." Tr. 75. Jacobsen advised that under MSHA policy anything that is over 7 feet is guarded by location. Tr. 76.

For this citation it was Jacobsen's understanding that the tail pulley was guarded but that access was removed for the head pulley, thereby guarding that by location. Tr. 76.

Upon consideration of all the evidence, the violation was established.

The remaining violations

Order number 6475306, pertaining to 30 C.F.R. 56.11002. The government proposed a penalty of $7,176.00 for this alleged violation. This was later changed to a 104(d)(1) order.

This alleged violation pertains to a requirement for substantial handrails for elevated walkways. The standard provides: "Handrails and toeboards. Crossovers, elevated walkways, elevated ramps, and stairways shall be of substantial construction provided with handrails, and maintained in good condition. Where necessary, toeboards shall be provided."

Here, the handrail for the walkway around the screen deck was not maintained in "good condition," as a 10 foot long section of the top rail had been removed. Tr. 81. GX P-12. Inspector Jacobsen drew on the photo where the railing should have been. Tr. 83. P 12, page 2 of 4. Reading from the Inspector's notes, Jacobsen stated that there was a 7 foot fall from the deck to the ground. Ice and snow would make the likelihood of a slip and fall incident greater. As with the other matters, Jacobsen considered the risk of an injury to be very likely. Tr. 84. He expressed that a fatality was within the realm of possibilities from such a fall. In support of this the government presented GX P 13, a fatal accident report involving an individual (again at a mine other than the Respondent’s) who fell from an elevated walkway which was 7 feet 4 inches above the ground. Tr. 85. As with the other modifications in this case, here too an interview with the foreman revealed that, as the handrail had been removed so that the screen repair could be done, but not replaced thereafter, the mine knew of the condition. Tr. 86. The amount of the penalty proposed was less than the other modifications because there had not been as many incidents of this type of violation as there had been for the guarding violations. Tr. 87. However, the notes associated with this violation also state that the supervisor was not present due to illness with his child and that the citation occurred on the first day the plant had resumed operations after being down for the previous three weeks. Tr. 88-89. Given its recent resumption, Inspector Jacobsen allowed that he would have eliminated the "reckless disregard" finding. Tr. 90.

Upon consideration of all the evidence, the violation was established.
The alleged violation for failure to conduct a workplace examination.

**Order number 6475313, pertaining to 30 C.F.R. 56.18002(a).** The government proposed a penalty of $6,458.00 for this alleged violation.

Inspector Jacobsen testified about GX P 14, Citation Number 6475313, a section 104(a) citation. The condition cited was for failing to conduct a workplace examination, per section 56.18002(a). Tr. 91. The standard provides: Examination of working places. A competent person designated by the operator shall examine each working place at least once each shift for conditions which may adversely affect safety or health. The operator shall promptly initiate appropriate action to correct such conditions.

This citation is related, of course, to the other violations cited by the government for the mine's failure to address those violations and ergo its conclusion that finding such violations demonstrates that the workplace examination was inadequate. However, the standard requires that such an exam be done each shift. Tr. 92. Jacobsen agreed that to comply with the standard that exam can be done *at any time* during a shift. Yet, Jacobsen had no idea if the standard was cited before the shift had ended. If that were the case, it would have been premature to issue it. Tr. 93. Though Jacobsen stated that it was possible the failure to do the workplace exam could have occurred the day before and that there is an obligation to do such an exam even if the plant is not operating, he agreed that this was in the realm of pure speculation on his part. Tr. 93-94. On cross-examination, Jacobsen also agreed that one could tie off with a harness if up where the handrail was removed. In fact, if that were the case, Jacobsen agreed there would not be any violation of the cited handrail. Tr. 96.

Upon consideration of all the evidence, with no evidence as to whether the shift had been completed, nor evidence as to the particular shift involved, the violation was not established and the Order is DISMISSED.

**DETERMINATION OF APPROPRIATE PENALTIES**

There is no dispute that the Part 100 penalty regulations apply only up to the point that the matter is heard by an administrative law judge for the Commission. Thus, 30 CFR § 100.2, "Applicability," provides that the "criteria and procedures in this part are applicable to all proposed assessments of civil penalties for violations of the Mine Act and the standards and regulations promulgated pursuant to the Mine Act, as amended." As noted in *Secretary of Labor v. Laramie County Road & Bridge*, 17 FMSHRC 902, 1995 WL 348172, (June 5, 1995) (Judge Manning), "Section 110(i) of the Mine Act, 30 U.S.C. § 820(i), sets out six criteria to be considered in determining the appropriate civil penalty . . . Because the penalty [the judge] assessed in this proceeding is based on the evidence developed at the hearing, the Secretary's penalty regulations at 30 C.F.R. § Part 100 are not relevant. *Sellersburg Stone Co.*, 5 FMSHRC 287 (March 1983), aff'd, 736 F.2d 1147, 1151-1152 (7th Cir. 1984). [And accordingly, the judge did] not consider[ ] those regulations in assessing a penalty in th[e] case."
The Commission, as noted by Judge Manning, has spoken to the issue in Secretary of Labor v. Sellersburg Stone Company, 5 FMSHRC 287, 1983-1984 O.S.H.D. (CCH) P 26456, 1983 WL 165153 (March 11, 1983). There, it observed "[i]n the Mine Act, Congress divided enforcement responsibility between two separate and independent agencies. The Secretary of Labor is granted authority to promulgate mandatory safety and health standards, to enforce such standards through inspections, and to issue citations and withdrawal orders for violations of the Act and mandatory standards. This Commission was established as an agency independent of the Department of Labor and is authorized to adjudicate contested cases arising under the Mine Act. 30 U.S.C. § 823. Consistent with this bifurcated enforcement structure, the Act's penalty assessment scheme divides penalty assessment authority between the two agencies. Section 105(a) of the Act provides that if the Secretary of Labor issues a citation or order, "he shall ... notify the operator ... of the civil penalty proposed to be assessed ... for the violation cited and that the operator has 30 days within which to contest the ... proposed assessment of penalty." 30 U.S.C. § 815(a) (emphasis added). If an operator does not contest the Secretary's proposed penalty assessment, by operation of law the proposed assessment becomes a final order not subject to review by any court or agency. Id.

If an operator contests the Secretary's proposed assessment of penalty, however, Commission jurisdiction over the matter attaches. 30 U.S.C. § 815(d). When a proposed penalty is contested, the Commission affords an opportunity for a hearing, "and thereafter ... issue[s] an order, based on findings of fact, affirming, modifying, or vacating the Secretary's citation, order, or proposed penalty, or directing other appropriate relief." Id. (Emphasis added). See also 30 U.S.C. § 810(i)("The Commission shall have authority to assess all civil penalties provided in this Act"). Thus, it is clear that under the Act the Secretary of Labor's and the Commission's roles regarding the assessment of penalties are separate and independent. The Secretary proposes penalties before a hearing based on information then available to him and, if the proposed penalty is contested, the Commission affords the opportunity for a hearing and assesses a penalty based on record information developed in the course of an adjudicative proceeding. See Senate Subcommittee on Labor, Committee on Human Resources, 95th Cong., 2d Sess., Legislative History of the Federal Mine Safety and Health Act of 1977, at 89, 632-635, 656-657, 666-662, 906-907, 910-911, 1107, 1316, 1328-29, 1336, 1348, 1360.

The respective governing regulations adopted by the Commission and the Secretary regarding penalty assessments clearly reflect the Act's bifurcated penalty assessment procedure. Commission Rule of Procedure 29(b) provides: In determining the amount of the penalty neither the judge nor the Commission shall be bound by a penalty recommended by the Secretary.... 29 C.F.R. § 2700.29(b). The Secretary's regulations in 30 C.F.R. Part 100 expressly apply only to the Secretary's proposed assessment of penalties. See also 47 Fed. Reg. 22287 (May 1982) ("If the proposed penalty is contested, the [Federal] Mine Safety and Health Review Commission exercises independent review and applies the six statutory criteria without consideration of these [MSHA penalty assessment] regulations.") **4 Thus, in a contested case the Commission and its judges are not bound by the penalty assessment regulations adopted by the Secretary. Rather, in a proceeding before the Commission the amount of the penalty to be assessed is a de novo determination based on the six statutory criteria specified in section 110(i) of the Act (*292 30
U.S.C. § 820(i) and the information relevant thereto developed in the course of the adjudicative proceeding. Shamrock Coal Co., 1 FMSHRC 469 (June 1979), aff'd, 652 F.2d 59 (6th Cir. 1981).

The Secretary takes note that penalties must be "of an amount which is sufficient to make it more economical for an operator to comply with the Act's requirements than it is to pay the penalties assessed." See Br. at 9, quoting S.Rep. No. 95-181 at 90 (1977). The Court agrees with that principle in penalty assessments. However, that point must not be at the expense of ignoring the six specified statutory penalty criteria that are to be considered in assessing a civil penalty. 30 U.S.C. 820.

Accordingly, the Court's role is to apply the statutory criteria to the facts and arrive at an appropriate penalty.

THE SIGNIFICANT AND SUBSTANTIAL and UNWARRANTABLE FAILURE DESIGNATIONS

The government contends that each of the four guarding violations, as well as the handrail violation, was "S & S." The workplace examination violation, also marked as “S & S,” has been dismissed.

A significant and substantial violation is described in section 104(d)(1) of the Act as 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 U.S.C. § 814(d)(1). A violation is properly designated S&S "if, based upon the particular facts surrounding that violation, there exists a reasonable likelihood that the hazard contributed to will result in an injury or illness of a reasonably serious nature." Cement Div., Nat'l Gypsum Co., 3 FMSHRC 822, 825 (Apr. 1981). The Commission has explained that: [i]n order to establish that a violation of a mandatory safety standard is significant and substantial under National Gypsum, the Secretary of Labor must prove: (1) the underlying violation of a mandatory safety standard; (2) a discrete safety hazard--that is, a measure of danger to safety--contributed to by the violation; (3) a reasonable likelihood that the hazard contributed to will result in an injury; and (4) a reasonable likelihood that the injury in question will be of a reasonably serious nature. Mathies Coal Co., 6 FMSHRC 1, 3-4 (Jan. 1984) (footnote omitted); see also, Buck Creek Coal, Inc. v. MSHA, 52 F.3d 133, 135 (7th Cir. 1999); Austin Power, Inc. v. Secretary, 861 F.2d 99, 103-04 (5th Cir. 1988), aff'g Austin Power, Inc., 9 FMSHRC 2015, 2021 (Dec. 1987) (approving Mathies criteria). The question of whether a particular violation is S&S must be based on the particular facts surrounding the violation. Texagulf, Inc., 10 FMSHRC 498 (Apr. 1988); Youghiogheny & Ohio Coal Co., 9 FMSHRC 2007 (Dec. 1987).

The government's also contends that three of the four guarding violations (numbers 6475300, 6475301, and 6475305) were unwarrantable failures on the Respondent's part and that number 6475306, the handrail violation, was also an unwarrantable failure.
The term "unwarrantable failure" is defined as aggravated conduct constituting more than ordinary negligence. *Emery Mining Corp.*, 9 FMSHRC 1997, 2004 (Dec. 1987). Unwarrantable failure is characterized by such conduct as "reckless disregard," "intentional misconduct," "indifference," or the "serious lack of reasonable care." Id. at 2004-04; *Rochester & Pittsburgh Coal Co.*, 13 FMSHRC at 193-94. Aggravating factors include the length of time that the violation has existed, the extent of the violative condition, whether the operator has been placed on notice that greater efforts were necessary for compliance, the operator's efforts in abating the violative condition, whether the violation was obvious or posed a high degree of danger and the operator's knowledge of the existence of the violation. See *Consolidation Coal Co.*, 22 FMSHRC 340, 353 (Mar. 2000); *Mullins & Sons Coal Co.*, 16 FMSHRC 192, 195 (Feb. 1994); *Windsor Coal Co.*, 21 FMSHRC 997, 1000 (Sept. 1999); *Consolidation Coal Co.*, 23 FMSHRC 588, 593 (June 2001). Moreover, the Commission has examined the conduct of supervisory personnel in determining unwarrantable failure and recognized that a heightened standard of care is required of such individuals. See *Youghiogheny & Ohio Coal Co.*, 9 FMSHRC 2007, 2011 (Dec. 1987) (section foreman held to demanding standard of care in safety matters); *S&H Mining, Inc.*, 17 FMSHRC 1918, 1923 (November 1995) (heightened standard of care required of section foreman and mine superintendent). All of the relevant facts and circumstances of each case must be examined to determine if an actor's conduct is aggravated, or whether mitigating circumstances exist. *Consol*, 22 FMSHRC at 353.

For the following reasons, upon consideration of all the record evidence, the Court concludes that none of the violations were significant and substantial and that none of them warrant an unwarrantable failure designation.

The Respondent called James Spencer Kunzler. Mr. Kunzler was filling in for Mr. Hill on the day in issue, as the latter had his family medical issue that day, February 11, 2009. Tr. 100-101. The witness stated that at the time of the citations in issue, the plant had just reopened that day. At any rate, Mr. Kunzler had not been at the plant until the day of the inspection. He stated that on that day he was not aware of the V belt being unguarded. Tr. 103. On the day of the inspection, Mr. Kunzler had not yet done his morning inspection. Tr. 103. Thus, he stated that he had not seen the unguarded area depicted in P 3 at photograph 1. Tr. 104. This was also the first day he had ever worked at this location. Tr. 104. He stated that at that time he was aware that the workers were still "putting the plant - - some things together and that they were making guards for things." Tr. 104. He added that it had been the mine's policy that if there were any "plug-up or breakdown or anything, [they would] shut the machinery down, and then take care of it, and - - not to be around anything while the machinery is running." Tr. 105. He added that he follows that same procedure when he is running his own power screener at the plant. Mr. Kunzler did not know however, if they were making a guard or simply reattaching a guard that was already made. Tr. 105.

Mr. Kunzler, when asked about photograph P 6, and upon noting that there appeared to be some buildup under the belt and probably the crusher, again stated that he was unaware of that condition, as he was filling in for Mr. Joe Sanchez and he had not done his inspection at the time of the citation's issuance. Tr. 105. As his job entails running a loader and feeding a belt, he
had not been down to the cited area before the inspector arrived. Tr. 106. It was Mr. Sanchez who was getting the crusher and generator started. Tr. 106. Mr. Kunzler stated that his responses would be the same about all the guarding citations; he had not yet seen their condition at the time the inspector arrived. Tr. 107. Explaining further his work on the day in issue, Mr. Kunzler stated that he checked both loaders and got them warming up while Joe started the generator and the crusher. At that point, Mr. Kunzler started feeding the plant and Joe began removing the product. If a problem were to have developed, it would have been Mr. Sanchez who would have shut everything down.

On cross-exam, Mr. Kunzler stated he did not know "for a fact" that this was the first day the plant was running. Tr. 110. On the morning in issue he had not done any walk-around, nor reviewed any exams from the prior day to determine if there were pre-existing hazards. Tr. 110. He added that there were just himself and one other employee, Joe Sanchez, at the site that day and that they stayed on their loaders. Thus, he did not see it possible that anyone could travel into the cited area. Tr. 112. Mr. Kunzler then reiterated that on the day in issue there were only two employees at the plant; himself and Mr. Sanchez. Tr. 113. Kunzler also reaffirmed that he had no responsibilities that day which would have brought him into contact with the unguarded machinery. Tr. 114. Joe Sanchez's job at the plant was to remove the product after it was crushed, using a loader tractor. Based on what he saw, Kunzler stated that Mr. Sanchez was never exposed to any of the unguarded machine parts. Tr. 115. Both employees were operating loaders. Tr. 115. Kunzler concluded that there was no reason why either of them would have come into contact with the unguarded parts. Tr. 115. On further cross-exam, Kunzler stated that if any reason arose for either to get off their loaders, they "would definitely shut the plant down." This was company policy. Tr. 116. Neither man got out of their loaders that day until the inspector arrived. Tr. 117. As Mr. Kunzler works alone, he would never think of doing anything but shutting things down if there was an issue, as there would be no one there to help him if he needed it. Tr. 118.

Steven Hill testified. He stated that he is the "Supervisor/laborer" for the crusher and a laborer there too, as needed. Tr. 119. Normally he is the supervisor at Plant 1. Tr. 119. He stated that, during the plant set-up phase, the plant was not operating. This start-up process was in the first part of January after the holidays. Tr. 121. There were problems to be solved concerning bad bearings on the screen unit. Tr. 121. The repair to the screening unit had to be made off site. Tr. 122. In order to remove the unit and take it some 15 to 20 miles away for the needed repairs, they had to cut the top hand rails off. Tr. 123. The whole repair process for the seized bearing issue took almost a month to accomplish. Tr. 124. Hill testified that "we no more than got the plant back together and then MSHA was there for their inspection." Tr. 124. The MSHA inspection occurred on February 11th and Hill was not there on that day, as he was dealing with the aforementioned medical issue regarding his son. Tr. 125. Nor was Hill at the plant the day prior to the inspection. Tr. 125. Hill believed he was at the plant last a week before the inspection. As to when the plant operations actually started up, Hill distinguished trial start-ups from "full-blown" operations. On the day of the inspection Hill stated that he was uncertain if everything was in specification to run. He did not know if they were running product on the day of the inspection, and as he noted, he was not at the plant the day prior to the
inspection. Tr. 127. As to the day prior to the inspection, Hill believed that they only ran product to see if everything was ready or whether more adjustments were needed. Tr. 128. Hill did not know for a fact if they "ran product" either on the 11th or the 12th. Tr. 128. Further, they do not keep records of product during the "set-up" phase.

Shown Exhibit P 3, Hill identified it as a gear box and pulley. He agreed that the V belt is not guarded in that photo. This he explained is because there is a door to that area and that it is normally closed, so that there is not access to it. Tr. 130. The door had been there; it was not created to abate the citation. Asked about P 6, Hill identified it as "605, our roller cone." Tr. 131. He was aware that it was not guarded. Tr. 131. He informed the workers that if the plant was running they were not to be around any of the moving machinery. Tr. 132. When a plant first starts up there are inevitable adjustments that need to be made. Tail rolls, conveyors and other items need adjustments to be made on them. Hill stated that it was impractical to have guards in place until after they are sure everything is running properly. Tr. 133.

However, without more specificity from the Respondent, the Court does not view such impracticability to excuse compliance but it is a mitigating consideration. Hill maintained that guards would be installed after the adjustments have been made. Tr. 134. Still, he did not know if further adjustments were needed to be done on the 11th. Tr. 134. Hill expressed that the policy that workers were to stay away from all moving machinery existed during the set up phase as well as when operations would begin. Tr. 134. When asked by the Court about the plant’s operational status, the best Hill could offer was that they were still making adjustments on February 11, 2009. Tr. 135.

Referred to P 8, Hill stated that the conveyor there had not been up long and that they had to take it down and change its belting. There were adjustment issues they were dealing with and at that point they were unsure if additional adjustments would need to be made. Tr. 135-136. To solve one problem, they installed a "chevron" cleated belt to deal with material sliding back down the prior, smooth textured, belt. Tr. 136. They had installed the cleated belt just before he had to leave to deal with his child's medical issue. Tr. 137. Thus, there was credible testimony that adjustments were still being made at the plant.

Capsulizing his testimony, Hill asserted that for all the instances in which the absence of a guard was cited, they "were in the startup mode, and [they] were still trying to make adjustments that needed to be done to the plant to where [they] can run and make material." Tr. 137-138. Hill added that the feeder, generator, electrical trailer and the screen were being operated for the first time in several years. Tr. 138. He maintained that the head roll did not need to be guarded at the big operation because it was seven feet above ground level. Even after the plant was set up, they did not have the right screens in place. Several different screens were tried before they arrived at the right ones. When operations were to start, the plan was that it would be operated by two men, working as the weather permitted. Temperatures at 23 or less or a snow forecast for the day would preclude operations. Tr. 141. Hill reiterated that on the day of the inspection, the 11th, he wasn't aware of the plant being ready for operation. Tr. 142. When running, one loader feeds the plant out of the big rock pile and the other loader operator...
On recross-examination, Hill stated that he did not recall telling the inspector that the guard had been reported as "on" on a January 5, 2009 workplace exam. Tr. 157. To the contrary, Hill maintained that they never did a workplace examination on the plant until the day the inspector arrived. Tr. 158. Mr. Kloepfer did speak with Hill on the day of the inspection. Tr. 158. Thus, Hill concluded by maintaining that they "actually started producing material [ ] the day after the inspection, after the closing of all the citations." Tr. 160.

On cross-examination Hill was asked about GX P 2, notes of a conversation between Inspector Karst and him. Those notes reference that workers were told to stay away from the plant while it was running and guards were off. Hill stated that this remark was made in the context of the plant being in a start-up mode. Tr. 148. At any rate, Hill admitted that he told Inspector Karst that he knew the guards were not in place. Tr. 151. He added that the requirement only exists when the machinery is being operated but that testing or adjustments are an exception when those tasks cannot be performed with guards in place. Tr. 152. Hill, on redirect, stated that his awareness of the plant being operated was that it occurred on the 12th. Tr. 153. When he left town to deal with his son's medical issue, he knew there were still some adjustments that needed to be made. Tr. 153. His plan was to install the guards as soon as he returned from the medical issue. Thus, Mr. Hill maintained that the "final guarding' would be done after the plant was up and ready to go. Tr. 154. Accordingly, the bottom line of Mr. Hill's testimony was that the plant was still in its set-up and start-up stages and that guarding must await such final adjustments. Tr. 155. Thus, the record is unclear about the plant’s true operational status a the time of the cited violations. Based on all the evidence, at best, the plant had just resumed operations either on the day of the inspection or the day before. As noted, its recent resumption does not excuse the cited violations, but it does impact penalty considerations.

Accordingly, based upon the evidence of record, as recounted above, the Court finds that, as to the significant and substantial designations, there was not a reasonable likelihood, under these particular circumstances, that the hazard contributed to would result in an injury. This is because the mine had only recently started its operation, and because it was only a two person operation, with the two individuals restricted to the operation of their respective loaders. The company policy, that equipment had to be shut down before working on it, while not excusing the violations, did impact on the Court’s evaluation of the reasonable likelihood of an injury occurring. Further, the mine was still finalizing its operation, working out problems with their various machinery conveyors. While it was not definitively established that those steps precluded the installation of guards, there was at least some credible testimony that the guards would make the final adjustments more difficult. All of this was complicated by the fact that at the time that the plant had just begun operations its supervisor, Mr. Hill, had been called away

1 On recross-examination, Hill stated that he did not recall telling the inspector that the guard had been reported as "on" on a January 5, 2009 workplace exam. Tr. 157. To the contrary, Hill maintained that they never did a workplace examination on the plant until the day the inspector arrived. Tr. 158. Mr. Kloepfer did speak with Hill on the day of the inspection. Tr. 158. Thus, Hill concluded by maintaining that they "actually started producing material [ ] the day after the inspection, after the closing of all the citations." Tr. 160.
from the mine site to attend to a family medical issue. Thus, the Court concludes that, finding Mr. Hill to have been credible, once he returned to the mine site, the guarding issues would have been attended to, irrespective of any MSHA inspection. The same reasoning applies to the unwarrantable failure designations and the "high negligence" label applied to the workplace examination.

Although the Secretary notes, at page two of its post-hearing brief, that the inspector's determinations should be given deference so long as those determinations are reasonable, the Court has found that the Respondent's witnesses were credible and that their testimony impacted favorably on the special findings issues.

On the issue of the mine's history of violations, the Secretary has admitted that the unusually high proposed penalties for the six violations are in large measure attributable to the combination of Plant 1's guarding violations history and the impact of those past violations in tallying the Secretary's proposed penalties for the violations found at Plant 4. As noted, the Part 100 penalty regulations do not impact the penalty assessments here. The penalties imposed here are based upon the statutory criteria. Nor has the Court ignored the mine's history of prior violations, as it is imposing an additional $1,000.00 for each of three of the four guarding violations. The exception relates to citation number 6475309, for which there was an acceptable guard present, in the form of a door which blocked access to the exposed moving parts. However, the door was open. The condition was abated by simply closing the door. For that violation, the Court imposes a penalty of $100.00 (one hundred dollars). For the handrail violation, as noted, there were mitigating circumstances involved, which required the temporary removal of the handrails. Given that the operation had just started and the government's admission that there would not be any violation if a worker were tied off when on the walkway around the screen deck, a penalty of $1,000.00 is appropriate. Finally, as to the workplace examination violation, there was uncertainty in the record as to whether the citation was prematurely written, as the shift had not ended at the time that it was issued. The citation itself

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2 Kenneth Poulson, MSHA mine inspector, testified on the subject of prior warnings that had been "given to the plant." Poulson had made prior inspections of the Respondent's mine, but not Plant Number 4, likely on two occasions, but he could recall no inspections since 2008. He stated that at the end of the last few inspections he conducted at Kloepfer's plants, he advised that the numbers of citations were "extremely high," that many were guarding issues, and that, in the inspector's view, he "could see a pattern." Tr. 51. Poulson asserted that he spent considerable time explaining these issues to Mr. Kloepfer. Tr. 52. Poulson admitted that the prior citations he referred to in his testimony related to Kloepfer's larger plant and he agreed that the plant is a "good-size plant." Tr. 53. He agreed that he was not familiar with the Respondent's plant number 4. Also, he could not recall if the guarding issues at the large plant involved completely missing guards. Tr. 54. Inspector Poulson's testimony did not impact the Court’s assessment of the mine’s history of previous violations beyond what the record already established on the issue.
records that the person in charge advised that he normally did his exam at the end of his shift and that it was his first day at Plant 4. Although the citation declared that some of the absent guards were easily observable while starting the plant that day, the standard only requires that the exam be done at some point during the shift. Accordingly, on this record, the citation was prematurely issued and must be vacated.

SUMMARY OF PENALTY DETERMINATIONS

As described above, the mine's history of violations has been taken into account. In terms of the size of the business, per Exhibit A for both docket, the Respondent is a small mine. The negligence and gravity of the violations have been previously discussed. Respondent has stipulated that, even as to the penalties proposed by the government, such penalties would not have an effect on its ability to continue in business. Tr. 29. Finally, there is no dispute that the Respondent demonstrated good faith in achieving rapid compliance after the violations were noticed.

Citation Number 6475309, pertaining to 30 C.F.R. 56. 14107(a). A $100.00 penalty is imposed.

Citation number 6475300 pertaining to 30 C.F.R. 56. 14107(a). $300.00 plus $1,000.00 given the violation history for this standard, for a total penalty of $1,300.00.

Citation number 6475301, pertaining to 30 C.F.R. 56. 14107(a). $300.00 plus $1,000.00 given the violation history for this standard, for a total penalty of $1,300.00.

Citation number 6475305, pertaining to 30 C.F.R. 56. 14107(a). $300.00 plus $1,000.00 given the violation history for this standard, for a total penalty of $1,300.00.

Order number 6475306, pertaining to 30 C.F.R. 56.11002. A total penalty of $1,000.00 is imposed for this violation.

Citation number 6475313, pertaining to 30 C.F.R. 56.18002(a). This Order is DISMISSED on the basis of insufficiency of proof by the government.

ORDER

A total civil penalty of $5,000.00 (five thousand dollars) is hereby imposed upon KLOEPFER INC. and it is ORDERED to pay that sum for the violations listed above. Payment is to be made to the Mine Safety and Health Administration with 40 days of the date of this Decision. Upon timely receipt of payment, the captioned civil penalty matters ARE DISMISSED.
Finally, Mr. Kloepfer would be well advised to make all of its operations highly vigilant from this time forward with regard to compliance with all MSHA safety and health standards and in particular, but not exclusively, with regard to guarding requirements. It is very likely that future violations could come with dramatically increased civil penalties. This would be unfortunate as such expensive civil penalties are entirely avoidable.

/s/ William B. Moran
William B. Moran
Administrative Law Judge

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Karl Kloepfer, 505 East Ellis, P.O. Box 875, Paul, Idaho, 83347
ADMINISTRATIVE LAW JUDGE ORDERS
June 7, 2012

BUDDY ROOKS, Complainant, Docket No. SE 2012-167-DM
v.
LAFARGE BUILDING MATERIALS, INC., Respondent Mine ID 09-00024

ORDER DENYING RESPONDENT’S MOTION TO DISMISS WITHOUT PREJUDICE

This case is before me on a complaint of discrimination filed by Buddy Rooks pursuant to section 105(c)(3) of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 815(c)(3). Respondent filed a Motion to Dismiss the complaint on grounds that it was not timely filed with the Commission and because it failed to state a claim upon which relief could be granted. Complainant has responded to two Orders to Show Cause, supplying information responsive to the orders and addressing arguments raised by Respondent. Respondent has filed a reply to Complainant’s submissions renewing its arguments. For the reasons that follow, the motion is denied without prejudice.

The “timeliness” issue arose because Complainant allegedly did not file his discrimination complaint (what he referred to as his “appeal” of MSHA’s denial of his complaint) with the Commission within 30 days of his receipt of MSHA’s October 18, 2011, letter advising that it had determined that no discrimination had occurred. The complaint was

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1 Despite specific instructions in the orders that copies of documents filed with the Commission must be served on the opposing party’s representative, and a certification to that effect must be included with the filed documents, Complainant has failed to include such certifications, and the extent to which he has complied with the service requirement is unknown. Copies of his response to the Second Order to Show Cause and a subsequent submission were forwarded to counsel for Respondent by this Office.

2 Section 105(c)(3) of the Act provides, in pertinent part:

If the Secretary, upon investigation, determines that the provisions of this subsection have not been violated, the complainant shall have the right, within 30 days of notice of the Secretary’s determination, to file an action in his own behalf before the Commission, charging discrimination or interference in violation (continued...
Respondent argued in its motion that: “Mr. Rooks’ right to file a discrimination action on his own behalf before the Commission expired 30 days after the Secretary issued her letter notifying Mr. Rooks of the Secretary’s determination that no discrimination occurred.” Resp. Mot. at 3.
attempts to side step the absence of critical factual information by arguing that Complainant was responsible for duly notifying MSHA, the Commission, and all parties to this action of any change in address. The source of this obligation was not identified. Commission rules certainly require that the Commission and parties be promptly notified of any “change in contact information” of a party’s representative. However, the critical time frame at issue here preceded the initiation of Complainant’s action before the Commission. Absent critical facts, Respondent argues that the available materials “suggest” that Complainant should have received the MSHA letter “in the normal course at his [former] address without any unusual delay.” Resp. Reply at 2-3.

I decline Respondent’s invitation to dismiss the complaint based upon a suggestion, particularly one as speculative as posed here. The materials submitted thus far, including Complainant’s responses to the show cause orders, leave a host of possibly relevant questions unanswered. However, Complainant squarely asserted that he complied with the 30-day time limit. That assertion cannot be rejected based upon the suggestion urged by Respondent. Absent establishment that there was, in fact, non-compliance with the 30-day filing requirement and the period during which delay occurred, it is impossible to determine whether there was adequate cause for any delay, or whether Respondent suffered any legally cognizable prejudice as a result.

**ORDER**

Based upon the foregoing, Respondent’s Motion to Dismiss is **DENIED, without prejudice**.

It is **FURTHER ORDERED** that the parties shall confer and attempt to agree on a schedule for further litigation of this case, including any contemplated discovery, further motions, and proposed hearing date(s) and location. If agreement is reached on a proposed schedule it shall be filed **on or before June 25, 2012**. If agreement is not reached, the parties shall submit their proposed schedules **on or before June 27, 2012**.

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4 Commission procedural rule 2700.5(c), 29 C.F.R. § 2700.5(c).

5 Respondent asserts that it would suffer prejudice because of the time and expense associated with delayed prosecution of the complaint. Time and expense associated with litigation, however “prejudicial” in fact, do not amount to material legal prejudice to Respondent’s ability to defend against the Complainant’s claim.

6 As noted above, the materials submitted thus far in this case, considering the liberal construction accorded pleadings prepared by pro se litigants, are sufficient to defeat Respondent’s failure to state a claim argument. See Ribble v. T&M Development Co., 22 FMSHRC 593 (May 2000) (dismissal for failure to state claim not favored; pleadings by pro se litigants held to less stringent standards than pleadings drafted by attorneys) citing Perry v. Phelps Dodge Morenci, Inc., 18 FMSHRC 1918, 1920 (Nov. 1996).
NOTICE TO COMPLAINANT ROOKS

Complainant is strongly urged to seek counsel to represent him in this matter. Civil litigation in general, and discrimination proceedings in particular, are complex legal matters. While, as a party to this action, you may represent yourself, be advised that non-attorney representatives are obligated to comply with all applicable rules of the Commission, other regulations, and laws applicable to these proceedings.

The Federal Mine Safety and Health Review Commission, which is an independent agency completely separate from the Department of Labor, maintains a website (www.fmshrc.gov) where essential and helpful information can be found including the Commission’s Procedural Rules, Decisions by the Commission and its Administrative Law Judges, and links to other useful sites.

If you continue to represent yourself, you must familiarize yourself with your basic obligations as a litigant before the Commission, e.g., all submissions to the Commission must be dated; bear the docket number of this case and the name of the assigned judge; be signed by the party or party’s representative and state the filing party’s name, address, phone number(s), fax number (if applicable) and e-mail address (if available); and a certification that a copy of the submission was served (by first class mail, fax, or other permissible means) on the representative of the other party. These obligations can be found in the Commission’s procedural rules, which are available on the Commission’s web site, and can be found at 29 Code of Federal Regulations, Part 2700.

You have failed to comply with many of these basic requirements in your responses to the show cause orders, despite clear instructions to do so. **Henceforth any submissions that fail to comply with Commission requirements in any material way will not be accepted, and will be returned.**

/s/ Michael E. Zielinski
Michael E. Zielinski
Senior Administrative Law Judge
202-434-9981
Mzielinski@fmshrc.gov
Distribution:

Buddy Rooks, 105 E. Chandler St., Carrollton, GA 30117

June 13, 2012

BLEDSOE COAL CORPORATION, : CONTEST PROCEEDING

Contestant : DOCKET NO. KENT 2011-972-R
: ORDER NO. 8353820; 04/18/2011

: DOCKET NO. KENT 2011-973-R
: ORDER NO. 8353821; 04/18/2011

v. :

HILDA L. SOLIS, Secretary,
of Labor, United States Department of Labor : DOCKET NO. KENT 2011-975-R
: ORDER NO. 8353825; 04/21/2011

: DOCKET NO. KENT 2011-976-R
: ORDER NO. 8353838; 05/03/2011

: DOCKET NO. KENT 2011-977-R
: ORDER NO. 8353839; 05/03/2011

: DOCKET NO. KENT 2011-978-R
: ORDER NO. 8353855; 05/10/2011

: DOCKET NO. KENT 2011-979-R
: ORDER NO. 8353858; 05/12/2011

: DOCKET NO. KENT 2011-980-R
: ORDER NO. 8406696; 05/10/2011

: DOCKET NO. KENT 2011-981-R
: ORDER NO. 8406699; 05/10/2011

: DOCKET NO. KENT 2011-982-R
: ORDER NO. 8406809; 05/11/2011

: MINE I D: NO. 15-19132
: MINE: Abner Branch Rider
ORDER DENYING RESPONDENT’S MOTION FOR INTERLOCUTORY REVIEW

Before: Judge Moran

Respondent Bledsoe Coal Corporation, pursuant to Commission Procedural Rule 76, 29 C.F.R. § 2700.76, has filed a Motion for Certification for Interlocutory Review. Pursuant to that provision, interlocutory review is appropriate where the ruling sought to be appealed “involves a controlling question of law and [in the judge’s opinion] immediate review will materially advance the final disposition of the proceedings.” (emphasis added). Finding that immediate review will not materially advance the final disposition of the proceedings, the Court DENIES Bledsoe’s Motion.¹

In light of the fact that this Court has already issued two Orders on the issues, expressing in some 25 pages its views on the issues raised, little more needs to be said about Bledsoe’s Motion. Initially, the Court issued its Order on Contestant’s Motion for Partial Summary Decision, and following that, it later issued its Order on the Secretary’s Motion for Partial Summary Decision. For the convenience of the Commission, the Court has attached both its Orders as Appendixes to this Order.

Nearly twenty-two years ago, MSHA promulgated its Final Rule addressing “Pattern of Violations.” Essentially, to be plain about it, Respondent is attempting to bring MSHA back to 1990, hoping that it can have the Part 104, Pattern of Violations, provisions revoked and thereby have the rulemaking begin anew. It seems a little late for that kind of challenge. The Court has found that the Agency faithfully followed its Part 104 rules in finding that the Respondent has a pattern of violations. Still, there is at least theoretical hope for Bledsoe, as noted in the Court’s Order on the Secretary’s Motion for Partial Summary Decision, because should it be able to establish that some number of 18 contested S & S violations do not, in fact, have that attribute, it is possible that Bledsoe could meet the target rate, which in turn would cause it to avoid, retroactively, its pattern designation. Yet, for some reason, Bledsoe is not so anxious to test the validity of those special findings. The hearing on those contested S & S findings is not very far off, as it is currently scheduled to commence on September 5, 2012 and the Court advised that it is willing to announce its findings on the issue for those 18 citations at the close of the evidence.

¹ See, for example, Pattison Sand Co. v. Secretary of Labor, 33 FMSHRC 2937, * 2946, 2011 WL 6740379 November 30, 2011 (Judge McCarthy), finding that the Respondent’s motion, not only would not materially advance the final disposition of the matter but that it may actually hinder it and Secretary of Labor v. Jim Walter Resources, Inc., 26 FMSHRC 734, *738, 2004 WL 2544985 (F.M.S.H.R.C.) (Judge Barbour) August 17, 2004, noting that continuing forward with the hearing “will not deprive [the Respondent] of review of the issue [and that if the Court] ultimately concluded the standard was violated, the company may appeal to the Commission, which will have the opportunity to review the matter in the context of a complete and, hope[fully], enlightening record.”
Accordingly, the Commission would be better served to have the full evidentiary record before it, should review be accepted at all, once a decision is issued.

As a review of the Court’s previous two Orders in this matter reveals, Bledsoe has a penchant for exaggeration in its submissions, and it is with bemusement that the Court observes that Bledsoe’s Motion for Interlocutory Review is no exception. To begin, Bledsoe maintains that “all agree that these issues will ultimately have to be decided by [the Commission].” Motion at 3. However, as all should know, review by the Commission is within its “sound discretion,” and therefore it may decide, after the hearing and decision, that the Court’s determinations, both as to its Orders, and however it ultimately decides the S & S issues for the disputed citations, that nothing more needs to be said about the matter. Avoiding the finality that a hearing would offer as to the presence or absence of particular S & S claims, Bledsoe instead views that proceeding as “tedious and extremely time consuming regardless of whenever it occurs during this litigation.” Motion at 3 (emphasis added).

Further, while Bledsoe states that the Secretary has no objection to its approach (i.e. interlocutory review) that is a bit less than accurate too. The Secretary did state in an email to the Court on June 12, 2012 that “the Secretary does not intend to file a response” but that is not the equivalent of not objecting to such review. Rather, it has remained silent. A review of the Court’s earlier Orders will also make it plain that Bledsoe continues to, at a minimum, not understand those Orders. For example, it states that “MSHA cannot determine an operator has a pattern of violations without proof of the requisite violations. Any interpretation that bases a POV determination on anything other than a pattern of proven violations is not reasonable, and is not entitled to Chevron deference.” Motion at 6 (emphasis in Motion). That sounds great until it is realized that the basis for Bledsoe traveling down the road to being placed in potential pattern status was based entirely on admitted violations. Upon first reading this Court’s two prior Orders, the other inadequacies in Bledsoe’s present motion, seeking interlocutory review, will be apparent. Accordingly, Respondent’s Motion for Interlocutory Review is DENIED.

/s/ William B. Moran
William B. Moran
Administrative Law Judge

2 As the Commission has stated: “Interlocutory review is a matter of [its] sound discretion . . . [and that it] will grant interlocutory review upon a majority vote that a judge's interlocutory ruling involves a controlling question of law and immediate review will materially advance the final disposition of the proceeding. 29 C.F.R. § 2700.76(a)(2).” Secretary v. Mach Mining, LLC, (August 2009) 31 FMSHRC 918, at * 920, 2009 WL 2915298.
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May 12, 2012

BLEDSOE COAL CORPORATION, Contestant

v.

HILDA L. SOLIS, Secretary, of Labor, United States Department of Labor

CONTEST PROCEEDING

DOCKET NO. KENT 2011-972-R
WRITTEN NOTICE NO. 8333606;
04/18/2011

DOCKET NO. KENT 2011-973-R
ORDER NO. 8353820; 04/18/2011

DOCKET NO. KENT 2011-974-R
ORDER NO. 8353821; 04/18/2011

DOCKET NO. KENT 2011-975-R
ORDER NO. 8353825; 04/21/2011

DOCKET NO. KENT 2011-976-R
ORDER NO. 8353838; 05/03/2011

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ORDER NO. 8353839; 05/03/2011

DOCKET NO. KENT 2011-978-R
ORDER NO. 8353855; 05/10/2011

DOCKET NO. KENT 2011-979-R
ORDER NO. 8353858; 05/12/2011

DOCKET NO. KENT 2011-980-R
ORDER NO. 8406696; 05/10/2011

DOCKET NO. KENT 2011-981-R
ORDER NO. 8406699; 05/10/2011

DOCKET NO. KENT 2011-981-R
ORDER NO. 8406809; 05/11/2011
ORDER ON THE SECRETARY’S MOTION FOR PARTIAL SUMMARY DECISION

Before: Judge Moran

Introduction

Pursuant to 30 C.F.R. § 2700.67, on March 6, 2012, the Secretary of Labor filed a motion for partial summary decision, seeking a ruling upholding the issuance of the Notice of Pattern of Violations, No. 8333606, which Notice was issued to the Respondent, Bledsoe Coal Corporation, regarding its Abner Branch Rider Mine, (“mine”), on April 12, 2011. Motion at 1-2. The Secretary notes that it issued Respondent a notice, alleging a potential pattern of violations on November 18, 2010, as well as a withdrawal order under section 104(e)(1), alleging a significant and substantial violation of a mandatory standard, and eight (8) withdrawal orders pursuant to section 104(e)(2). The Secretary contends that, as it followed the requirements for issuance of a Notice of Pattern of Violations, pursuant to 30 C.F.R. Part 104, the Notice should be upheld. For the reasons which follow, the GRANTS the Secretary’s Motion and DIRECTS that the outstanding, identified, non-final S&S citations/orders associated with this litigation be set for prompt hearing.

Findings of Fact and Conclusions of Law

The actions described above were the culmination of several preceding events. The Secretary completed its pattern of violations screening for the mine, which screening encompassed the twelve month period beginning on September 1, 2009 and ending August 31, 2010. As noted above, that screening resulted in the Respondent being notified,3 on November 18, 2010, pursuant to 30 C.F.R. § 104.4(a), that its mine was identified as having a potential pattern of violations. Nine citations or orders were identified, each pertained to violations of 30 C.F.R. § 75.400, and each of those had become final orders during the twelve month review period.4 Bledsoe opted to implement a corrective action plan, which was dated January 5, 2011.

3 The Notice informed Bledsoe that nine citations or orders, each of which, pursuant to 30 C.F.R. § 104.2(c), were issued after October 1, 1990, were considered in the initial screening.

4 The November 18, 2010 Notice advised the mine that it had been issued “10.98 S&S violations per 100 inspection hours during the 12-month review period . . . [and that] the mine must maintain an S&S rate of 5.49 or lower during the evaluation period [which would constitute] a 50 percent reduction from the . . . review period.” A greater reduction, to 3.68 or lower would be required if the mine did not opt to implement a corrective action program.

(continued...)
However, about two months later, on March 18, 2011, in compliance with 30 C.F.R. § 104.4(b), MSHA advised Bledsoe that a potential pattern of violations continued to exist, noting that the mine’s S&S violations were double the target violation rate. Ex. 6. The same report, again following section 104.4(b), informed the mine that it had 10 days to submit comments about it to the Administrator for Coal Mine Safety and Health, but comments would not forestall submission of the report to the Administrator.

The Secretary concludes that, as MSHA fully complied with the Part 104 Pattern of Violations provisions at every step of that process, and as the Mine’s “history of nine final S&S violations of 30 C.F.R. § 75.400 during the one-year pattern review period establishes a pattern of violations [pursuant to 30 C.F.R. § 104.3(a)(1)],” the pattern of violations notice, No. 8333606, should be upheld. Sec. Motion at 4-5. In support of that conclusion, the Secretary notes that this Court, in its November 10, 2011 Order on the Contestant’s Motion for Summary Decision, observed that Congress left it to the Secretary’s expertise to determine when more was needed to be done for enforcement than simply identifying each violation and then acting to have each violation corrected. Instead, when an operator has a pattern of S&S violations of mandatory standards, the provisions of section 104(e) of the Mine Act are to be applied. In enforcing those provisions, the Secretary was directed by Congress to make such rules as the Secretary deemed necessary to establish criteria for determining when a pattern of violations of mandatory standards exists and making the determination for the enhanced enforcement provision addressing a pattern of violations. The Secretary took these steps both through the Pattern of Violations provisions at 30 C.F.R. Part 104 and implementing policy. Accordingly, it is the Secretary’s position that, as it fully complied with both the statutory provision and with the Part 104 Pattern of Violations provisions in all respects, and as there is no issue of any material fact, the issuance of the Notice of Pattern of Violations No. 833606 should be upheld. Sec. Motion at 4-5.

In its response to the Secretary’s Motion, Bledsoe decided to renew its cross-motion for partial summary decision. However, that latter matter was fully addressed in the Court’s prior Order. For the reader’s convenience, it appears again as an appendix to this Order.

Bledsoe notes that the Secretary has argued that POV Notice No. 8333606 should be upheld as a matter of law as she has “followed all of the procedural requirements set forth in 30 C.F.R. Part 104.” Bledsoe Response at 2. Bledsoe contends that “[a]ll that is said by the Secretary to support a substantive finding of a POV in this case is . . . ‘the Abner Branch Rider

\[...continued\]

Bledsoe did opt for a corrective action plan.

\[5\] That provision, 30 C.F.R. § 104.3(a)(1), identifies “[a] history of repeated significant and substantial violations of a particular standard” as one of three listed, independent, criterion for identifying a pattern. To state the obvious, MSHA was identifying repeated violations of 30 C.F.R. § 75.400, which pertains to the grave matter of accumulation of combustible materials.
Bledsoe, noting that the Court observed that the dictionary definition of a “pattern” involves “a reliable sample of traits, acts, or other observable features characterizing an individual [ ] behavior [pattern] . . .,” redescribes the issue as “[w]ether there is a ‘reliable pattern, . . .’” asserting that is “a question for which there is no legal answer.” Respondent’s Response at 3-4 (emphasis added). A reliable sample is not synonymous with a reliable pattern.

Divorced from the reality of what occurred here, Bledsoe then lifts off into a nightmarish scenario, starting with the idea that the Secretary could call “any pattern of more than one S & S accusation a POV . . .[and] once a mine has more than one final S&S violation, the Secretary could call this a PPOV.” The subsequent issuance of S&S violations “could be factually deficient, contrary to law or even arbitrary, and [yet] the [mine] operator would be subject to a pattern finding.” Bledsoe Response at 5. While Bledsoe acknowledges that the Secretary would be required to follow her own internal guidelines, it asserts these could change at any time and without notice. Id.

Bledsoe then transitions to its overriding issue of dissatisfaction, a matter already addressed in the Court’s prior Order, asserting that “[i]t is incumbent upon the Secretary to establish criteria to guide Bledsoe – and other operators – on what the law requires.” Bledsoe asserts that, per the Court’s Order, the Secretary has both unfettered and unreviewable discretion to call “any pattern of more than one S&S accusation a POV.” Id. at 4-5. Resurrecting its due process claim, it suggests that, as there is no definition of a POV, it would be impossible to determine if a POV is present for Bledsoe. On this basis, Bledsoe renews, with no new grounds, its prior motion for partial summary decision. The Court again directs attention to the Appendix to this Order, which provides its prior decision addressing these contentions.

Short of its wish to have the Secretary’s POV provisions cast aside, Bledsoe alternatively maintains that “[a]t the very least, [it] must be allowed to adjudicate whether the violations which placed it on POV status were properly designated S&S.” Id. at 6. In support of this, departing from the facts here, Bledsoe points to Rockhouse Energy Co. v. Secretary, 30 FMSHRC 1125 (December 2008) (ALJ)(“Rockhouse”), wherein another ALJ “accelerat[ed] his

6 Bledsoe, noting that the Court observed that the dictionary definition of a “pattern” involves “a reliable sample of traits, acts, or other observable features characterizing an individual [ ] behavior [pattern] . . .,” redescribes the issue as “[w]ether there is a ‘reliable pattern, . . .’” asserting that is “a question for which there is no legal answer.” Respondent’s Response at 3-4 (emphasis added). A reliable sample is not synonymous with a reliable pattern.

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As Bledsoe stretches the applicability of *Rockhouse*, using a case that the Court considers to be very distinguishable, it also took the opportunity to bemoan that in this Court’s earlier Order of November 10, 2011, it “was needlessly castigated for not quoting a portion of [the] language contained in 30 U.S.C. Section 814(e), although it repeatedly cited to the statute, the full text of which is readily available.” Response at 6-7. Bledsoe claims it was “needlessly castigated” because, after all, it made *reference to the cite for* the full statutory provision. By the full provision being cited, Bledsoe means it gave a full listing to the cited provision and one would not have to guess, for example, the chapter or section involved and therefore anyone could look up the provision and there they would discover *all* of its words. While that much is true, as Bledsoe has elected to recast its approach as innocent, it is necessary to revisit what occurred in Bledsoe’s argument and its renewed protestation over the Court’s dim view of it. The provision at issue provides, *in full*, “(4) The Secretary shall make such rules as he deems necessary to establish criteria for determining when a pattern of violations of mandatory health or safety standards exists.” 30 U.S.C. § 814 (e)(4). In contrast, Bledsoe, citing to the same provision advised that “Congress mandated the Secretary, under Section 104(e)(4) of the Mine Act, to “make such rules” to establish the criteria for determining when a pattern of violations exists.” Bledsoe Motion at 3-4. (emphasis in Bledsoe’s motion). Apparently to save toner ink, Bledsoe omitted the *four* unhelpful words “as he deems necessary” from the 27 word provision. Four pages later in its argument, Bledsoe reasserted this claim, asserting that “Section 104(e)(4) of the Mine Act directed the Secretary to make rules for determining when a pattern of violations exists,” again omitting the “as he deems necessary” language. That omission is no small matter though, as Bledsoe takes the implication of its selective reading further by advising that in directing the Secretary “to make rules” “Congress, in unambiguous language directed the Secretary to use notice and comment rulemaking.

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The Court found it unclear why Citation number 8333031, issued 4/15/2008, Citation number 7528749, issued 7/30/2009 and Citation number 7528752, issued 8/3/2009 were included among the 9 citations identified by MSHA when they seemed to be before the commencement of the September 1, 2009 review period. The answer was that the test for inclusion considers citations that became final during the September 1, 2009 through August 31, 2010 time frame. The Court had overlooked that the “Pattern Criteria” provision, at 30 C.F.R. § 104.3, in fact provides that in identifying mines with a potential pattern of violations, two prerequisites must be present: only citations and orders issued after October 1, 1990 are considered and they must have become final. The nine citations identified in the Final Order Criteria meet both those requirements: each was issued after October 1, 1990 and each became final during the review period. There is no dispute about these facts.

The Court also noted that, within the Secretary’s Exhibit 1, attached to the Secretary’s Motion, five (5) pages were included, listing some 159 citations. Thirty-one (31) of those listed citations cited section 75.400 and Citation numbers 8356674, 8356676, 8362103, 8362416, 8362419 and 8362424 were among the thirty-one citations citing that section. The Secretary explained the inclusion of these documents stemmed from the fact that they were included in MSHA’s November 18, 2010 letter to the Respondent. The five page list of 159 citations represents all of the violations issued to the mine during the review period and, of those, 79 were S&S. The five page list of 159 citations supports the Secretary’s determination that...
the mine met the initial screening criteria, per 30 C.F.R. § 104.2. As shown by the “Screening Criteria Results for Pattern of Violations,” (“SCR for POV”), which was included in November 18, 2010 letter from MSHA to the Bledsoe Mine, Initial Criteria 1 at item 1 requires that a mine have at least 50 citations/orders that were “S&S” and Bledsoe had 79. In each of the three other categories for Initial Criteria 1, Bledsoe’s Abner Branch Mine met those requirements.12

11(...)continued)

The Court also inquired as to the particular pattern criteria MSHA relied upon when it informed Bledsoe on November 18, 2010 that a Potential Pattern of Violations existed at its Abner Branch Mine. A related question, the Court asked whether, when MSHA informed the mine on March 18, 2011 that a PPOV continued to exist, that determination was based upon all S&S violations or only S&S violations involving 30 C.F.R. § 75.400. The Secretary advised that the November 18, 2010 letter relied upon Section 104.2 in toto, as that Section identifies the factors to be considered in the Initial Screening review period. Once, as happened here, that Initial Screening did not eliminate the mine, MSHA advanced to the Pattern Criteria provision, as set forth at Section 104.3. In turning to Section 104.3, MSHA examined the three criteria identified at that provision, which includes “[a] history of repeated significant and substantial violations of a particular standard.” 30 C.F.R. § 104.3(a)(1). That “particular standard” here was 30 C.F.R. § 75.400. That determination was then reflected in MSHA’s November 18, 2010 letter to the mine which letter included the Agency’s “Screening Criteria Results for Pattern of Violations” (i.e. the “SCR for POV,” referred to above). Accordingly, the Court finds that MSHA followed its rules completely; first finding that the mine was captured within the Initial Screening, per 30 C.F.R. Section 104.2, then identifying the applicable Pattern Criteria, per 30 C.F.R. Section 104.3, and then issuing the notice, per 30 C.F.R. Section 104.4, on March 18, 2011, that the mine failed to meet its target rate. Again, completely complying with its 30 C.F.R. Pattern of Violations provisions, the MSHA District Manager, finding that Bledsoe did not meet its target rate,13 and that no mitigating circumstances existed to explain that failure,14 submitted

12 For example, in category 2, it exceeded the rate of eight or more S&S citations/orders issued per 100 inspection hours by having a rate of 10.98.

13 MSHA’s November 18, 2010 letter to the mine advised that it had to meet an S&S target rate of 5.49, or lower, per 100 inspection hours. As noted in MSHA’s March 18, 2011 letter to the mine, Bledsoe did not come even close to this rate. Instead, its rate was more than double the maximum rate allowed, at 11.54 S&S violations per 100 inspection hours. In noting that the mine failed to achieve the target rate, MSHA’s review took into account all S&S violations issued per 100 inspection hours.

14 It should be noted that Bledsoe’s Counsel has not argued that there were any such

(continued...)
his report to the Administrator for Coal Mine Safety and Health and noted that the mine had 10
days to submit comments to the Administrator about MSHA’s finding that a Potential Pattern of
Violations continued to exist.\textsuperscript{15}

MSHA has noted in its Supplement to Motion for Partial Summary Decision (Sec’s
Supplement) that for the 18 alleged violations, each of which is also alleged to be S&S, none are
final. That is, each of the 18 alleged violations, referenced in its March 18, 2011 letter to
Bledsoe, are contested and pending litigation. Supplement at 6 and Exhibit 6. The Secretary
takes the position that none of those 18 would need to be upheld for the Respondent to continue
to be under a pattern. As expressed in the Sec’s Supplement, the mine met the pattern criteria
per the District Manager’s November 18, 2010 letter to Bledsoe. However, the Secretary goes
on to state that “[t]o avoid the consequences that may result from establishing such a pattern,
under 30 C.F.R. § 104.4(a)(4) the mine was provided with an opportunity to institute a program
to avoid repeated significant and substantial violations. The District Manager allowed a nine-
week period, from January 11, 2011 to March 12, 2011, for determining whether the program
effectively reduced the occurrence of significant and substantial violations at the mine. . . . that
program was aimed at reducing the occurrence of significant and substantial violations at the
mine without limitation to specific mandatory standards. The program failed.” Sec’s
Supplement at 7. Thus, by the Secretary’s vantage point, because the mine “failed to effectively
reduce the occurrence of significant and substantial violations during the period provided under
30 C.F.R. § 104.4(a)(4), the Secretary issued 104(e) Notice No. 8333606.” \textit{Id.}

Although the Secretary notes, and the Court agrees, that “[t]here is no regulatory
requirement that significant and substantial violations issued during the corrective-action-
program period must be final before the Secretary may determine whether the program
effectively reduced the occurrence significant and substantial violations at the mine,” that can
only carry the Secretary’s position until the alleged violations with the disputed significant and
substantial findings have been adjudicated. Any other position would make no sense at all. For
example, if none of the 18 S&S violations were found, upon being litigated, to be, in fact,
“S&S,” the Secretary could hardly assert that the mine failed to meet its target rate. While the
Secretary adds that the pattern provision under the Mine Act does not even require “that the mine
be provided with an opportunity to institute a program to avoid repeated significant and
substantial violations before the Secretary may issue a 104(e) pattern notice,” the fact of the

\textsuperscript{14}(...continued)
mitigating circumstances that should have been considered to explain its failure to meet the
target rate of S&S violations.

\textsuperscript{15} The 18 S&S violations identified in MSHA’s March 18, 2011 letter to Bledsoe have
not become final orders. Each of them are being litigated. Accordingly, it is possible that,
should a certain number of those S&S violations ultimately be found, either through litigation or
otherwise, that they were not, in fact, S&S, the S&S violation rate could be redetermined to be at
a lower rate than the presently assumed rate of 11.54 such violations per 100 inspection hours.
manner is that MSHA does provide such an opportunity. Sec’s Supplement at 7. That opportunity would be meaningless if, under the example just given, a mine, despite showing that it in fact had met or exceeded its target rate, would remain under the pattern, regardless.

Finally, the Court inquired as to the impact on the other ten (10) dockets16 if it were to rule in favor of the Secretary’s Motion for Partial Summary Decision. The Secretary advises that a hearing would be needed for each of dockets.

Bledsoe too responded to questions posed by the Court and it renewed its cross-motion for summary judgment in the same document. (“Bledsoe Response”) In its Response, Bledsoe contends that the Secretary “argues that following the procedures set forth in 30 C.F.R. Part 104 is all that is needed for an adjudication of a POV.” Bledsoe Response at 2 (emphasis in Response). Of course, the Secretary does not merely claim that procedural fealty alone can carry the day. Among other things, there have to be violations, which have become final and which became final during a particular review period. Bledsoe continues its argument, asserting that “the statute and the regulations remain silent as to what constitutes a POV,” but that too is an exaggeration, as the regulations do explain the pattern criteria and the steps which follow on the road to the issuance of a notice of a pattern of violations from the Administrator. Continuing its usage of hyperbole, Bledsoe claims that the Secretary “has determined that more than one final S&S violation is sufficient.” Id. at 3. The Secretary made no such claim. Instead, the Secretary gathered the facts pertaining to violations which became final during the review period and applied those final determinations to the regulations, noting along the way the Agency’s meticulous adherence to the procedural steps under the Pattern of Violations regulations at Part 104.

So too, Bledsoe takes references to Congress’ statements about a pattern, wherein that body expressed that “a pattern would be ‘more than an isolated violation’ but not necessarily ‘a prescribed number of violations,” and the Court’s statement from that Congressional remark about patterns that “Congress identified one end of the spectrum, that a pattern is more than an isolated violation, but left it to the Secretary’s expertise to determine when more was needed to be done for enforcement than simply the routine process of identifying each violation, one by one, and then having each violation abated,” and transforms them into “the ALJ’s ruling” claiming that it is a “more than one” standard. In its subsequently submitted “SUPPLMENTAL [sic] MEMORANDUM”, Bledsoe repeats this claim: “Bledsoe is fully aware that the ALJ has ruled that more than one S&S violation may be sufficient to establish a pattern” and that this judge-created standard “subjects every mine in the country to a POV finding . . . [by] hold[ing]

16 These are Docket Numbers KENT 2011-1345, KENT 2011-1220, KENT 2012-284 and KENT 2012-381.
that any mine which receives more than one S&S violation over a two year period may be subject to a POV finding based on whatever criteria the Secretary chooses to apply at a given time.” SUPPLEMENTAL MEMORANDUM at 3. The Bledsoe-created “more than one” standard, blossoms into a claim that it allows the Secretary to “call any pattern of more than one accusation a POV.” BLED SOE RESPONSE TO SECRETARY’S MOTION at 4-5.17

In Bledsoe’s “SUPPLEMENTAL MEMORANDUM IN RESPONSE TO THE SECRETARY’S MOTION FOR PARTIAL SUMMARY DECISION,” it responded to two questions posed by the Court in reaction to the Motion and Bledsoe’s initial response thereto.18 The Court asked if Bledsoe believed it should be entitled to relitigate all S&S violations, including those which have become final orders. As to final orders, Bledsoe concedes that it cannot relitigate S&S violations which have become final. However, Bledsoe, notes that, of the 79 citations designated as “S&S” in the period from November 2, 2009 through August 25, 2010, it challenged 53 of them, with the 26 others becoming final orders. Bledsoe Supplemental Memorandum at 2-3. Bledsoe notes that “[a]ll 79 were the basis for the PPOV notice issued by the Secretary.” Id. at 3.

In one aspect the Court does agree with Bledsoe. This relates to any S&S citations/orders which it has contested and have not since become final orders. As noted in a more detailed fashion below, any such non-final citations/orders which were a part of the basis for MSHA’s determination to issue its Section 104(e) Notice, No. 8333606, because they were part of the Agency’s determination that Bledsoe failed to meet its target rate, must be tried promptly because there is the possibility that some number of those violations could be found by the Court as non-S&S violations. A sufficient number of such non-S&S findings raises the possibility that Bledsoe’s S&S rate could be at or below 5.49 per 100 inspection hours. Only a hearing and a decision on those non-final matters can resolve that. In the meantime, just as with a section 104(d)(1) citation or order, that is subsequently found, after a hearing, to lack the special findings of being S&S and unwarrantable, or simply unwarrantable, as the case may be, the

17 Though it started with the “more than one” seed, then nurtured it into a flower, Bledsoe then cultivates an entire garden, claiming that “[o]nce a mine has more than one final S&S violation, the Secretary could call this a PPOV [and following that] “could issue as many S&S violations as her inspectors could write.” Moving to the hysterical, in both senses of the word, Bledsoe asserts “[i]n no time, every underground coal mine in the country will be on a POV.” Id. at 5. Really.

18 The Court’s second question to Bledsoe requires little time to address. The Court asked Bledsoe whether, given its position that there is no definition of what constitutes a POV, does it maintain that MSHA must embark on rulemaking again. Bledsoe answered in the affirmative, asserting that the Secretary must engage in rulemaking to define a pattern of violations. Bledsoe Supplemental Memorandum at 4. The Court, based on its prior Order on Contestant’s Motion for Partial Summary Decision and this Order, finds that the Secretary’s Rulemaking for Part 104, Pattern of Violations passes scrutiny.
section 104(e) Notice, No. 8333606 remains intact. Should the requisite number of violations found to be “non-S&S,” and therefore establish that Bledsoe did achieve at least its target rate, the section 104(e) would be unwound, just as in the case of (d)(1) citations and orders found to be lacking. 19

CONCLUSION

For the reasons set forth above, the Secretary’s Motion for Partial Summary Decision is GRANTED. However, as noted at footnote 13, “The 18 S&S violations identified in MSHA’s March 18, 2011 letter to Bledsoe have not become final orders. Each of them are being litigated. At the hearing, these will be tried first. Accordingly, as discussed earlier, it is possible that, should a certain number of those S&S violations ultimately be found, either through litigation or otherwise, that they were not, in fact, S&S, the S&S violation rate could be redetermined to be at a lower rate than the presently assumed rate of 11.54 such violations per 100 inspection hours.” This is potentially important for Bledsoe, as a finding that some, yet to be calculated, number of violations, either were not violations or at least were not “significant and substantial” violations, could reduce its S&S violation rate to at or below 5.49 per 100 inspection hours. Therefore these alleged violations need to be set for hearing immediately. The parties are directed to email the Court immediately to establish a date and time for a conference call so that the prompt hearing for these matters can be finalized.

/s/ William B. Moran
William B. Moran
Administrative Law Judge

19 The analogy to the “chain” created under section 104(d) of the Mine Act is well understood and apt here. Placing a mine operator under the “increasingly severe sanctions” through that provision does not have to await a final determination before such sanctions become effective. See, e.g., Secretary v. Weirich Brothers, 27 FMSHRC 379, 2005 WL 1198587 (April 2005), and Secretary v. Lodestar Energy, 25 FMSHRC 343, 2003 WL 21665294 (July 2003), noting that, where S&S and unwarrantable findings are not sustained, the citations or orders issued under section 104(d) are to appropriately modified.
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November 10, 2011

BLEDSOE COAL CORPORATION, Contestant

v. 

HILDA L. SOLIS, Secretary, United States Department of Labor

CONTEST PROCEEDING

DOCKET NO. KENT 2011-972-R
WRITTEN NOTICE NO. 8333606; 04/18/2011

DOCKET NO. KENT 2011-973-R
ORDER NO. 8353820; 04/18/2011

DOCKET NO. KENT 2011-974-R
ORDER NO. 8353821; 04/18/2011

DOCKET NO. KENT 2011-975-R
ORDER NO. 8353825; 04/21/2011

DOCKET NO. KENT 2011-976-R
ORDER NO. 8353838; 05/03/2011

DOCKET NO. KENT 2011-977-R
ORDER NO. 8353839; 05/03/2011

DOCKET NO. KENT 2011-978-R
ORDER NO. 8353855; 05/10/2011

DOCKET NO. KENT 2011-979-R
ORDER NO. 8353858; 05/12/2011

DOCKET NO. KENT 2011-980-R
ORDER NO. 8406696; 05/10/2011

DOCKET NO. KENT 2011-981-R
ORDER NO. 8406699; 05/10/2011

MINE I.D. NO. 15-19132
MINE: Abner Branch Rider
ORDER ON CONTESTANT’S MOTION FOR PARTIAL SUMMARY DECISION

On August 17, 2011, Contestant Bledsoe Coal Corporation (“Bledsoe”) filed its Motion for partial summary decision (“Motion”) seeking the vacation of each order issued by the Mine Safety and Health Administration (“MSHA” or “Agency”) associated with the Agency’s issuance of a notice of a pattern of violations (“POV”) on April 12, 2011. Bledsoe assails the Agency’s decision on the grounds that it was never subjected to notice and comment rulemaking, that it lacked fair notice and that the criteria it used were an unreasonable interpretation of the Mine Act and regulations. For the reasons which follow, each of Bledsoe’s claims are rejected.20

In an unfortunate practice of selectively quoting, and by that process, being misleading as to the Mine Act’s requirements regarding a pattern of violations of mandatory health or safety standards, Bledsoe asserts “Congress mandated the Secretary, under Section 104(e)(4) of the Mine Act, to “make such rules” to establish the criteria for determining when a pattern of violations exists.” Motion at 3-4 (emphasis in motion). The Mine Act states no such thing. Instead, the provision provides, in full, that “The Secretary shall make such rules as he deems necessary to establish criteria for determining when a pattern of violations of mandatory health or safety standards exists.”21

Although once would be too often, Bledsoe repeats its mischaracterization, which mischaracterization is not about some ancillary matter, but involves a fundamental aspect of the issue. Bledsoe’s own words put this on full display, as it asserts: “Section 104(e)(4) of the Mine Act directed the Secretary to make rules for determining when a pattern exists, but in so doing, Congress, in unambiguous language, directed the Secretary to use notice and comment rulemaking in accordance with the Administrative Procedure Act.” Bledsoe Motion at 8. And yet again, not much later in its Motion: “Congress required the Secretary to use notice-and-comment rulemaking to establish POV criteria.” Id. at 11. To borrow, and slightly alter, an expression, “a mischaracterization, stated often enough, does not become an accurate characterization. That is, proof by repeated assertion does not make something so.

Simultaneously being issued today is the Court’s ruling on the Secretary’s Motion to Dismiss for Lack of Jurisdiction in which the Court DENIES the Secretary’s Motion. For ease of reference and because the two orders need to be considered together, a copy of that Order appears as an Appendix to this Order.

It is a curious thing, the practice of advocates to parse out words and apparently assume that no one will notice that only part of the story has been told. In the Court’s view, it is better, and ethically superior, to acknowledge the troublesome language and deal with it forthrightly, either by arguing that it means something other than the words suggest or by demonstrating, if possible, that notwithstanding the nettlesome words, the Secretary must make rules even though the statute suggests that discretion is involved.
Accordingly, to keep the facts straight, it bears repeating, with emphasis upon the critical phrase omitted by the Contestant, to bring attention to the words of the statutory provision:

The Secretary shall make such rules as he deems necessary to establish criteria for determining when a pattern of violations of mandatory health or safety standards exists.

Thus, as evident by the italicized language, any rules are only as the Secretary deems necessary. With that power and discretion, one obvious option for the Secretary was that it could have been decided that no such rules were necessary.

The parameters which may constitute a Pattern of Violations

As the Secretary has observed, the dictionary defines a “pattern” in a manner which is consistent with the common understanding of the word, by describing it as “a reliable sample of traits, acts, or other observable features characterizing an individual [] behavior [pattern] . . . .” In line with that sense, the Senate Committee spoke to that provision of the Mine Act, expressing that it would be shown where a mine has “an inspection history of recurrent violations’ or ‘continuing violations,’ and that a pattern would be ‘more than an isolated violation’ but not necessarily ‘a prescribed number of violations.’” Response at n. 2, citing S. Rep. No. 95-151, pp. 32-33. Thus, Congress identified one end of the spectrum, that a pattern is more than an isolated violation, but left it to the Secretary’s expertise to determine when more was needed to be done for enforcement than simply the routine process of identifying each violation, one by one, and then having each violation abated.

That Congress decided to leave it to the Secretary to develop the parameters for a pattern is not simply surmise. Both the statutory provision itself and the legislative history make this clear. Regarding the latter, the same Senate Report expresses an intent for the Secretary to be afforded “broad discretion in establishing criteria for determining when a pattern of violations exists.” Response at 6, citing the same S. Rep. at 33. The Senate, rather than setting a number of conditions and requirements for the pattern tool to be employed, did the opposite. It noted that the criteria for identifying a pattern would “necessarily have to be broad enough to encompass the varied mining activities within the Act’s coverage.” Id. The Senate went further in explaining its design, stating that a pattern can be composed of violations of different standards and was certainly not limited to violations of particular standards. Although it acknowledged the obvious, that a pattern, by definition must be more than a single, isolated, violation, that did not mean that “a prescribed number of violations” had to occur, nor that the violations had to come from “predetermined” that is, previously identified, standards. Last, the Senate noted that, while a “pattern” represents something more than an isolated violation, it does not require some intent or state of mind on the part of the mine where a pattern is found to exist. Id. Thus, if the pattern is present, that is sufficient, even if no intentional disregard of safety or health concerns is evident. In short, with intent not a prerequisite, a number, as long as it is a number greater than one, potentially can be enough, dependent upon the circumstances, to establish a pattern.
As the Secretary notes, from the Mine Act’s legislative history, the provision was intended to “provide an effective enforcement tool” in situations where the mine operator has demonstrated disregard for miners’ safety and health by having a pattern of violations. Its use was contemplated where a mine has permitted continued safety and health standard violations, and it has been concluded that simply abating violations as they occur is not doing the job, and that a next step is necessary to “restore the mine to effective safe and health conditions.” Response at 5, citing S. Rep. No. 95-181, pp. 32-33. (1977).

Apart from whether the Secretary was obligated to promulgate a pattern regulation, the fact is that it did so, utilizing the notice and comment rulemaking procedures under the Administrative Procedure Act. This result of this process, appearing at 30 C.F.R. Part 104, begins by examining the compliance records of mines annually. Other factors, such as whether a mine has demonstrated a lack of good faith in correcting significant and substantial violations, the non 104(e) enforcement measures that have been applied, and whether the mine’s accident, injury or illness record reflects a serious problem with managing safety or health matters, are examined, together with any mitigating considerations. Where a mine is not ruled out after the initial screening, then a mine with recurring significant and substantial violations is evaluated by application of the pattern criteria. These are set forth at 30 C.F.R. § 104.3(a)(1)- (3). Again, the review works by determining, at that second stage, if the mine under review may be eliminated from a pattern designation. If a mine remains a subject of concern, the third phase is applied. In that posture, the mine is notified of MSHA’s concern and that it has been identified as having a potential pattern of violations issue. Even then, in what can only be described as an

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22 § 104.3 Pattern criteria. (a) The criteria of this section shall be used to identify those mines with a potential pattern of violations. These criteria shall be applied only after initial screening conducted in accordance with § 104.2 of this part reveals that the operator may habitually allow the recurrence of violations of mandatory safety standards or health standards which significantly and substantially contribute to the cause and effect of mine safety or health hazards. These criteria are (1) A history of repeated significant and substantial violations of a particular standard; (2) A history of repeated significant and substantial violations of standards related to the same hazard; or (3) A history of repeated significant and substantial violations caused by unwarrantable failure to comply. (b) Only citations and orders issued after October 1, 1990, and that have become final shall be used to identify mines with a potential pattern of violations under this section. 55 FR 31136, July 31, 1990.

23 The Proposed Rule noted that the intention behind section 104(e) is plain; it is intended to address “mines with a record of repeated S & S violations” upon the Secretary’s determination that the Act’s other enforcement mechanisms have not been effective in achieving compliance with the safety and health standards. The Rule noted that, in accomplishing that next step, “[t]he Secretary has broad discretion in determining [the] criteria [for determining when a pattern exists].” 54 FR 23156-01 at * 23156.

Truly, the Rule’s operation allows, effectively, an individualized notice and comment (continued...)
overabundance of due process, the mine is not faced with a section 104(e) enforcement action. Instead the mine has the opportunity: to examine the documents MSHA has relied upon to arrive at that stage of review; to provide additional information to the Agency; to request a conference with MSHA; and to launch a program to avoid such repeated significant and substantial violations. As the Secretary appropriately observes, Section 104(e)(1) does not require that these extraordinary lengths be taken before a notice under that provision can be issued. Thus, it is a great understatement on the Secretary’s part to describe the rulemaking as providing “ample notice” before issuance of the section 104(e)(1) notice. A mine operator is provided notice “writ large” under the rule and this occurs in the context of requiring the Secretary to provide only a notice that a pattern of violations exists. Again, that determination by the Secretary, that a

23(...continued)

procedure, upon the Agency’s notification to a particular mine that the mine is under review for a possible pattern of violation issuance. This process ensures that a given mine will have had the opportunity for full input into the Agency’s review of the appropriateness for that specific mine to be issued a notice of a pattern under section 104(e).

Certainly the Agency’s final rule reflected full consideration of all comments made to the proposal, together with the Agency’s rationale for its responses to those comments. In short, the rule does not operate in any automatic function; input from the mine involved is considered before the Administrator makes the final determination. Further, while the “Initial screening” considers non-final citations and orders, the “pattern criteria” used to identify mines with a potential pattern takes into account only those that have become final citations or orders. 55 FR 31128-01 at * 31136.

24 Section 104.4, Issuance of notice, provides: (a) When a potential pattern of violations is identified, the District Manager shall notify the mine operator in writing. A copy of the notification shall be provided to the representative of miners at the mine. The notification shall specify the basis for identifying the mine as having a potential pattern of violations and give the mine operator a reasonable opportunity, not to exceed 20 days from the date of notification, to take the following steps: (1) Review all documents upon which the pattern of violations evaluation is based. (2) Provide additional information. (3) Submit a written request for a conference with the District Manager. The District Manager shall hold any such conference within 10 days of a request. The representative of miners at the mine shall be provided an opportunity to participate in the conference. (4) Institute a program to avoid repeated significant and substantial violations at the mine. The District Manager may allow an additional period, not to exceed 90 days, for determining whether the program effectively reduces the occurrence of significant and substantial violations at the mine. The representative of miners shall be provided an opportunity to discuss the program with the District Manager. 30 C.F.R. § 104.4.

25 Accordingly, Bledsoe’s claim that the Secretary did not give “fair notice” of the criteria to determine a POV is hollow. When challenging those citations/orders which have not been settled, Bledsoe could, in theory, challenge whether it received “fair notice” of the particular (continued...)
mine has “a pattern of violations of mandatory health or safety standards,” requires making rules for establishing the criteria for determining when a pattern exists, only as the Secretary *deems necessary*. Section 104(e)(4).

Even after the completion of all that process, more is provided, as the District Manager, upon concluding at the end of the day that a potential pattern exists, then sends a report concerning the evaluation to the applicable MSHA Administrator at which point the mine has yet another opportunity for comment. It is not until all that has transpired that the Administrator makes the decision whether the mine is to be issued a notice of a pattern of violations. 30 C.F.R. § 104.4(c). If there is a problem to be identified with the procedure developed by MSHA, it is that it is far too generous and prolonged. It is hard to imagine, given the Senate Report statements about this enhanced enforcement tool and the design for its use, that Congress intended such a protracted process.

Moving from the established framework for determining whether to proceed with a pattern of violations to applying that procedure in the present case, the Secretary notes that it conducted such a screening for Bledsoe’s Abner Branch Rider Mine, examining a 12 month period which ended on August 31, 2010, and then, following the final rule’s procedure, informed Bledsoe there was a potential pattern. Bledsoe was advised at that time that 9 citations or orders pertaining to violations of 30 C.F.R. § 75.400, which had all become final orders were part of this matter. Meetings followed and Bledsoe, utilizing the Rule’s procedures, submitted a corrective action plan. That plan, again pursuant to the Rule, was evaluated by the District Manager, who advised the Respondent that he would be required to make a report to the Administrator and that occurred on March 18, 2011. Nearly four weeks later, on April 12, 2011, the Administrator for Coal Mine Safety and Health notified Bledsoe that he had determined the existence of a pattern of violations at the mine. The District Manager then issued, that same day, a Section 104(e)(1) notice, Number 8333606, which is the subject of this litigation.

In arguing that Bledsoe’s arguments should be rejected, the Secretary first addresses the claims about inadequacy of the screening process, and its objections that the regulation does not “specify the time period of a mine’s compliance history that will be examined during the initial screening” and that it is not limited to considering only final orders in that initial screening process. The Secretary’s response is convincing, as it notes that Section 104(e) has no such

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25(...continued)

standard therein cited, as distinct from the rejected claim that it had no notice of the criteria used to determine a POV. In the same vein, claims that “rulemaking by program policy manual and website” and by “press release” do not deserve further comment.

26 While one might think that the final rule would be the final word on the subject, MSHA has further addressed the subject in its Program Policy Manual. Suffice it to say that while the PPM provides helpful explanatory guidance about the final rule for Agency personnel, it does not amend, alter, or otherwise change that Rule.
requirement for a particular time period to be examined. The implicit suggestion, that MSHA
should have selected a fixed time period, would have been arbitrary. The Secretary properly
notes that the legislative history recognized that a one-size-fits-all approach would be jejune. Further, as this reasoned choice by the Secretary is not unreasonable, nor arbitrary or capricious, the

In the same vein, the Secretary observes that the statutory provision is also silent on the
issue of whether non-final citations and orders may be considered. The Secretary makes two
key points on this issue:

Limiting pattern consideration to final orders would undermine
Section 104(e)'s effectiveness by eliminating consideration of current
or recent mine conditions and practices – precisely the matters that
are most relevant in determining whether the mine currently should be
considered for enhanced enforcement measures – and focusing
consideration instead on mine conditions and practices that are more
remote in time.

Sec. Response at 24-25.

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27 As the Secretary states: “In promulgating § 104.2 - the initial screening regulation - the
Secretary expressly declined to impose a particular period to be examined in every case,
recognizing that ‘interruptions in mining operations, changes in mine management or ownership,
or other factors could indicate that this period should be longer or shorter.’ 55 Fed. Reg. 31,130
(July 31, 1990). And in promulgating the pattern criteria in § 104.3, the Secretary expressly
rejected the suggestion that ‘only citations and orders issued within certain time periods . . . be
considered in applying the pattern criteria’ because such a rule ‘would unduly restrict the
Agency's ability to enforce section 104(e) . . .’ Id. at 31,132-3.” Sec. Response at 23. Further,
the Secretary observes that “Congress expressly delegated to the Secretary the authority to make
rules to implement Section 104(e) [and that the same Section] is silent with respect to the
compliance-history period to be considered when determining whether the mine has a pattern of
violations. Id.

28 The Secretary looks to the legislative history, urging that it “suggests that Congress did
not intend to require the Secretary to limit her consideration to final orders. Section 104(e) was
enacted in response to the Scotia mine disaster and the ensuing investigation which revealed that
the mine had an ‘inspection history of recurrent violations.’ S. Rep. No. 95 181, p. 32. Congress
thus focused Section 104(e) on a mine's ‘inspection history’ rather than on a mine's final order
history.” Sec. Response at 24. In the Court’s view, this is certainly a rational interpretation of
the legislative history and therefore it supports the Secretary’s approach here, per *Chevron*. 
The Contestant’s position would severely hamper the enforcement tool that Section 104(e) surely is, as “citations and orders frequently do not become final until months or years after they are issued.”

Second, the Secretary aptly compares the pattern of violation application with the unwarrantable failure sequence of Section 104(d). This is not a stretch by any means, as the Senate Report itself made such a comparison, observing that the POV “sequence parallels the current unwarrantable failure sequence.” S. Rep. No. 95-181, p. 33. Borrowing from that Senate Report, the Secretary notes that the comparison was expressly stated. Particularly pertinent here in that comparison is the point that “[i]t is beyond debate that a closure order under Section 104(d)(1) may be based upon a Section 104(d)(1) citation that is not final, and a closure order under Section 104(d)(2) may be based upon a Section 104(d)(1) order that is not final.” Id. at 25.

Thus, the Court agrees with the Secretary’s point that, by Congress making such a comparison, it is reflective that POV determinations also need not be based upon final orders. Further, clearly, under a Chevron analysis, the Secretary’s decision to include non-final citations and orders, does not run counter to the statute, nor can it be characterized as arbitrary, unreasonable or capricious.

Turning to Contestant’s claim that the POV Procedures Summary and Screening Criteria are “rule making through website” in violation of Section 104(e) of the Mine Act and the notice-and-comment provisions of the APA, the Secretary makes the same point that the Court noted earlier, namely that, “Section 104(e)(4) of the Mine Act does not require the Secretary to

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29 One could fairly expect that if mine operators had their way and only final orders could be considered before a pattern could be invoked, the defense would then be raised by some that such information was now stale and useless in assessing the mine’s current operational procedures, given the passage of years since the conditions were initially cited. Thus, if it were to prevail that such pre-final orders were “too soon” to be considered, and MSHA were left to consider only final orders, those would then be characterized as “too late.” Often, the approach is really about delay. For example, back in 1980, when the task of identifying mines with a pattern of violations was first raised as a proposed rule, the “concerns” raised caused the Agency to withdraw its proposal with the result that it was not until nearly nine (9) years later before it was proposed again.

30 Contestant’s Motion at 12.
use notice-and-comment rulemaking to establish POV criteria’ . . . . Section 104(e)(4) provides only that the Secretary ‘shall make such rules as he deems necessary’; it does not require any particular rule making procedure.” Id. at 26, referencing Contestant’s Motion at 11.

The Secretary also makes note that, under the Administrative Procedure Act, rules may be valid even though not promulgated after notice under 5 U.S.C. § 553(b), and that, as “rules,” they are exempt from the APA’s notice-and-comment provisions because such provisions “do not apply to ‘interpretative rules, general statements of policy, or rules of agency organization, procedure, or practice [ ].’” Id. at 26-27.

These two observations also make sense when placed in the context of the use for the “POV Procedures Summary and Screening Criteria.” That critical context is that the POV Procedures “describe the internal procedures MSHA personnel – and only those who answer to the Administrator – follow in reviewing mine violation histories under Section 104(e) of the Mine Act and Part 104; they pertain to the procedural aspects of the review of mine violation histories. They are not law; they do not bind the public.” Id. at 27. (emphasis added).

Further, as the Secretary also notes, although the POV Procedures “may bind MSHA personnel to the extent personnel must follow supervisory direction, they do not bind the Administrator in any case. They address MSHA’s conduct in reviewing mine violation histories in preparation for the Administrator’s exercise of discretion regarding possible enforcement action; they do not address operator conduct. [Accordingly,] [t]hey help ‘direct the analysis [of whether the mine has a pattern of violations] but not necessarily the answer.’” Id. at 27. (emphasis added). The Secretary observes that this is consistent with “MSHA's Procedure Instruction Letter [which was] held exempt from notice-and-comment rule making in National

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32 5 U.S.C. § 553(b)(3)(A)

33 Citing Ryder Truck Lines, Inc. v. United States, 716 F.2d 1369, 1377 (11th Cir. 1983). As the 11th Circuit observed in that case, “[a]s long as the agency remains free to consider the individual facts in the various cases that arise, then the agency action in question has not established a binding norm.” Citing American Trucking Associations, Inc. v. ICC, 659 F.2d at 463, among other cases. In Ryder, the Court recognized that various criteria had been enumerated but that any presumptions remained rebuttable and that the review will involve scrutinizing the actual operation. That is exactly what occurs here. Also as in Ryder, the process of issuance of a section 104 (e) notice follows “an intensely factual determination informed by [the] relevant criteria.”
As the 11th Circuit emphasized, *National Mining Ass'n v. Secretary of Labor*, 589 F.3d 1368, 1372 (11th Cir. 2009). Similarly, the Secretary points out that “the POV Procedures Summary and Screening Criteria address ‘the general procedures District Managers are to consider’ in evaluating a mine's violation history under Section 104(e) of the Mine Act and Part 104; but the agency – the District Managers and ultimately the Administrator – is ‘free to consider individual facts' when evaluating each specific mine.” (quoting *Ryder Truck Lines*, 716 F.2d at 1377). Sec. Response at 27-28.

The Secretary cites a host of cases presenting similar situations: the Occupational Safety and Health Administration's per-instance-penalty policy held exempt from notice-and-comment rule making in *Kaspar Wire Works, Inc. v. Secretary of Labor*, 268 F.3d 1123, 1132-33 (D.C. Cir. 2001), the POV Procedures Summary and Screening Criteria do not "'encode[] a substantive value judgment or put[] a stamp of approval or disapproval on a given type of behavior.'" (quoting *American Hosp. Ass'n v. Bowen*, 834 F.2d 1037, 1047 (D.C. Cir. 1987)); the Department of Health and Human Services ("HHS") Provider Reimbursement Manual provision held exempt from notice-and-comment rule making in *Sentara-Hampton Gen. Hosp. v. Sullivan*, 980 F.2d 749, 759 (D.C. Cir. 1992), the POV Procedures Summary and Screening Criteria are "not intended to substantively change existing rights and duties." In *Sentara-Hampton Gen. Hosp.*, the Court explained that explaining ambiguous language or reminding parties of existing duties, that is not creating new law. *Id.* Thus, the POV procedures only address the exercise of enforcement discretion under 30 C.F.R. Part 104 and not "enforcement of new obligations." Accordingly, they do not bring about substantive change. See also *JEM Broadcasting Co. v. FCC*, 22 F.3d 320, 326-27 (D.C. Cir. 1994) (holding exempt FCC's "hard look" rules that guided agency's review of license applications and resulted in elimination of some applications); the HHS Manual IM85-3 policy held exempt from notice-and-comment rule making in *American Hosp. Ass'n v. Bowen*, 834 F.2d 1037, 1051-52 (D.C. Cir. 1987), the POV Procedures Summary and Screening Criteria "target" the "focus" of MSHA's "enforcement efforts," do not impose new burdens on operators, and are well within MSHA's "discretionary enforcement authority;" and the Federal Savings and Loan Insurance Corporation's directives held exempt from notice-and-comment rule making in *Guardian Fed. Sav. and Loan Ass'n v. FSLIC*, 589 F.2d 658, 666-67 (D.C. Cir. 1978), the POV Procedures Summary and Screening Criteria preserve the enforcement discretion of the Administrator.”
Thus, the Court agrees with the Secretary that Part 104 informs the mining community of the pattern criteria used to identify a potential pattern of violations at a given mine and the procedures MSHA will follow upon making such identification, culminating in the Administrator’s decision as to whether a notice of a pattern of violations will be issued.36

Drummond is not instructive

Bledsoe points to Secretary v. Drummond Company, Inc., 14 FMSHRC 661, 682 (May 1992) for authority in support of its inaccurate claim that “Section 104(e)(4) of the Mine Act directed the Secretary to make rules for determining when a pattern of violations exists . . . .” Motion at 8.

Drummond challenged the Secretary's interim excessive-history civil penalty program and the Commission found that the program was inconsistent with and therefore modified the existing 30 C.F.R. Part 100 penalty regulations. However, as the Secretary correctly observes, “nothing in the POV Procedures Summary or Screening Criteria is inconsistent with or modifies 30 C.F.R. Part 104 or any other regulation.” Id. at 30.

The Court would add that the circumstances were very different in that case as Drummond focused exclusively on the penalty computation regulations which were in existence and formulated through the notice and comment process.37 Placed in context, in that litigation, the complaint was that penalties were being computed, not in accordance with Part 100 but rather upon the Secretary of Labor’s Program Policy Letter, which was a program established outside the notice and comment process of the Administrative Procedure Act. As the Commission expressed it, the challenge from the mine operators in Drummond was that the Secretary was failing to act within the framework of its own Part 100 regulations. Id. at *672.

36 Having concluded that the Secretary was not required to do as much as it did, the Court agrees that more was not needed beyond the issuance of Part 104. As the Secretary notes, the Administrative Procedure Act “does not require that all the specific applications of a rule evolve by further, more precise rules.” Sec. Response at 30, citing Shays v. Federal Election Comm’n., 528 F.3d 914, 930 (D.C. Cir. 2008) (quoting Shalala v. Guernsey Mem’l. Hosp., 514 U.S. 87, 96 (1995)).

37 Based on the Court’s other comments in this Order, Bledsoe’s claim that MSHA has engaged in “rule-making through website postings” needs no further comment. Bledsoe Motion at 12-13.
The Secretary’s action here would seem to fit within the APA definition of a “Rule,” but the present question is whether there is any deficiency in its application. There was, following the proposed rule, the opportunity for comment from the affected public. It is also true that the notice and comment process is not applicable where interpretive rules, general statements of policy, or rules of agency organization, procedure or practice are involved. 5 U.S.C. § 553(b)(3)(A). While notice and comment is intended to accomplish public participation and fairness, here Congress’ expressed intent was to leave it to the Secretary’s discretion as to whether such rules were needed. In short, it was left to the Secretary, not the public, to ultimately decide the parameters of a pattern. Further, consistent with the conclusion that the pattern rule is a statement of policy, it clearly leaves the Agency, through the Administrator, with discretion in its decision making. In fact, it is the ultimate in that regard, as the Administrator, not the final rule, makes the final decision whether to proceed with a pattern notice.

Regarding Bledsoe’s claim that there was retroactive rulemaking, the Secretary responds that the Pattern provision was promulgated decades before the notice of pattern issued here. The Court agrees that, by that rulemaking, Sections 104.2(a)(1) and 104.3(a) gave Bledsoe notice of the parameters upon which a pattern could be formulated. Therefore, Bledsoe’s protestation that it was caught unaware of the effect of not challenging 26 of the citations which make up the 79 citations during the period from September 1, 2009 through August 31, 2010, rings hollow. There are two reasons for this: first, “Bledsoe was not entitled to know and the Secretary was not obligated to supply information about the internal procedures adopted to guide the agency’s exercise of Section 104(e) enforcement discretion.” Second, and of significance, as

38 5 U.S.C. § 551(4) defines “Rule” as “the whole or part of an agency statement of general or particular applicability and future effect designed to implement, interpret, or prescribe law or policy or describing the organization, procedure, or practice requirements of an agency and includes the approval or prescription for the future of rates, wages, corporate or financial structures or reorganizations thereof, prices, facilities, appliances, services or allowances therefor or of valuations, costs, or accounting, or practices bearing on any of the foregoing.”

39 It must again be noted that once the Administrator makes that determination, it is hardly the end of the story. A mine operator then has the opportunity to challenge the violations constituting the pattern.
a “pattern does not necessarily mean a prescribed number of violations... Bledsoe had no reason to expect that it would ever know that a certain number of S&S violations would subject it to review for a potential pattern or pattern of violations.”

In sum, the Secretary reiterates that the POV Procedures Summary and Screening Criteria were not required to undergo notice and comment rulemaking. Instead, they serve as guidance for MSHA in the exercise of its discretionary enforcement authority and as such they are not binding on the public or the Administrator. Thus, the Secretary emphasizes that it sufficiently “informed the public through § 104.3(a) that a history of repeated S&S violations: (1) of a particular standard; (2) of standards related to the same hazard; or (3) caused by unwarrantable failure to comply, would identify it as a mine with a potential pattern of violations.”

There is one aspect of Bledsoe’s argument with which the Court agrees, at least in theory. That is Bledsoe’s assertion that the “practical effect of a POV notice is that a mine is subject to closure every time an S & S citation is issued. [It notes that] these citations may be challenged by the operator; however there will still be a closure upon issuance. This allows the Secretary, based on nothing more than allegations, to repeatedly close a mine in perpetuity. In fact, even if all such citations are later vacated, the operator has no remedy to prevent such closures.” Bledsoe Motion at 8. In the Court’s view, this observation is really an argument in support of Bledsoe’s Response to the Secretary’s Motion to Dismiss for Lack of Jurisdiction. As noted at the outset of this Order, the Court has DENIED the Secretary’s Motion. See n.1, supra.

40 Though referenced earlier in this Order, the Senate spoke to this subject at S. Rep. No. 95-181, p. 33.

41 In the same vein, the Secretary points out that Bowen v. Georgetown Univ. Hosp., 488 U.S. 204 (1988), involving as it did, the retro-active application of a substantive, legislative rule that was intended to have the force and effect of law, is inapposite, as the POV Procedures Summary and Screening Criteria are procedural.

42 The Court further agrees that the cases cited by Bledsoe, cases – Akzo Nobel Salt, Inc. v. FMSHRC, 212 F.3d 1301 (D.C. Cir. 2000), and Phelps Dodge Corp. v. FMSHRC, 681 F.2d 1189 (9th Cir. 1982) – involved challenges to the Secretary's interpretation of mandatory standards that required or prohibited certain conduct by the mine operator and that Trinity Broadcasting of Florida, Inc. v. FCC, 211 F.3d 618 (D.C. Cir. 2000) – involved the FCC's interpretation of a regulation that required certain conduct by a regulated party. It is a key distinction that the POV Procedures Summary and Screening Criteria “merely instruct agency personnel in screening and reviewing mines for potential patterns of violations” as opposed to requiring or prohibiting certain conduct by operators. Sec. Response at 33.
For the foregoing reasons, Contestant Bledsoe’s Motion for Partial Summary Decision is DENIED. The parties are directed to contact the Court via its email address for the purpose of arranging a hearing date so that this matter can proceed forward.

SO ORDERED.

/s/ William B. Moran  
William B. Moran  
Administrative Law Judge
This civil penalty proceeding arises under section 105 of the Mine Act. 30 U.S.C. §815. The case is scheduled to be heard in Morgantown, West Virginia beginning on Tuesday, August 7, 2012 at 8:30 a.m. At issue are one section 104(d)(2) (30 U.S.C. §814(d)(2)) order of withdrawal and four section 104(a) citations. 30 U.S.C. §814(a). The order and one of the citations allege that Consolidation Coal Company (“Consol”) violated mandatory safety standard 30 C.F.R. §75.202(a) at its Blacksville No. 2 Mine [1], while three of the citations allege that Consol violated §75.220(a)(1) at the mine. In addition to alleging a violation of section 75.202(a), the order and one of the citations charge that the alleged violations were a significant and substantial contribution to a mine safety hazard (“S&S”). The order also charges that the violation was caused by Consol’s unwarrantable failure to comply with the standard. In addition to alleging a violation of section 75.220(a)(1), one of the other citations alleges that the violation was S&S. The Secretary seeks a total civil penalty of $67,200.00 for the alleged violations.

Pending before the Court are several matters relating to the proposed penalties and to discovery disputes.

1 Section 75.202(a) requires an operator to support or otherwise control the roof, face and ribs of areas where persons work or travel so as to protect the persons from falls of the roof face or ribs and from coal and rock bursts.

2 Section 75.220(a)(1) requires an operator to adopt and to follow a roof control plan approved by MSHA.
I. THE PROPOSED PENALTIES

It is not clear to the Court how the Secretary arrived at the proposed penalties. Although paragraph 5 of her petition purports to explain the Secretary’s calculations, the Court finds it difficult, if not impossible, to comprehend what the Secretary has done. For example, although the petition asks its reader to “See MSHA Form 1000-179 in Exhibit A for a detailed summary of point computations,” there is no form that is identified as Form 1000-179 in the copy of Exhibit A the Secretary filed with the Commission. Further, although paragraph 5 refers to “[C]itations/orders assessed pursuant to 30 C.F.R. §100.5, which are indicated as ‘Special Assessment’ in Exhibit A,” there is no indication in the exhibit that any assessment is a “special assessment.”

Before the case can be tried the Court needs to understand how the Secretary determined the penalties she proposed. Accordingly, within 15 days of the date of this order, the Court requests the Secretary file a narrative explanation of how each proposed penalty was calculated, including the part each of the statutory civil penalty criteria played in the calculation. The Court is especially interested to know why the Secretary determined the alleged violation of section 75.202(a) set forth in the order warrants a proposed penalty of $50,700. In short, the Court needs to be “walked through” the Secretary’s proposed assessment process.

II. DISCOVERY MATTERS

The Court is in receipt of Consol’s Motion to Compel Discovery. In the motion Consol states that although the Secretary requests that “specially assessed penalties be levied against Consol with respect to each alleged violation” – something that as noted is not apparent to the Court from the present record – the Secretary’s petition “offers no substantive basis for its decision to propose a specially assessed penalty with respect to each citation in the docket.” Consol Mot. at 2, 3. The motion goes on to state that on April 20, 2012 Consol through a discovery request sought certain information related to the specially assessed penalties, including but not limited to the Special Assessment Review Forms (“SAR Forms” or MSHA Forms 7000-32) and that the Secretary responded by withholding the information because she claims it is protected by the deliberative process privilege.

Consol also states that while the Secretary produced some documents regarding her special assessment procedures, these documents “offered no substantive basis with respect to each specially assessed penalty.” Id. Consol Mot. at 4. Consol further states that the Secretary “declined to identify and provide data regarding how many citations and orders alleging violations of Sections 75.202 and 75.202(a)(1) have been specially assessed, both nationwide and
In pertinent part the Initiative states:

“Rules to Live By” is an initiative to improve the prevention of fatalities in mining. Through a first phase of industry outreach and education followed by enhanced enforcement, the focus will be on 24 frequently cited standards (11 in coal mining and 13 in metal/nonmetal mining) that cause or contribute to fatal accidents in the mining industry in 9 accident categories.

In 2009, mining fatalities fell to an all-time low for the second straight year. While the mining community achieved a record-setting low of 34 mining deaths in the United States and has seen a significant decline in fatal mining accidents during the past 10 years, too many miners still lose their lives in preventable accidents. The loss of even one miner causes devastation and pain to the victim's family and friends. From CY 2000 - 2008, 589 miners lost their lives, mostly in single and double fatality accidents. MSHA analyzed these fatal accidents to identify conditions and practices that contributed to the 589 deaths, safety standards violated, root causes, and abatement practices. MSHA's analysis identified 24 standards - 13 in metal and nonmetal mining and 11 in coal mining - frequently cited in fatal accident investigations. These violations fell into 9 different categories:

*   *   *

PRIORITY STANDARDS: COAL

§75.202* Roof, face, and ribs shall be supported and no person shall work or travel under unsupported roof
Consol argues that documents related to the specially assessed penalties are relevant in that the Secretary has requested the court to impose such penalties. Because the SAR Forms contain facts that MSHA relied upon to support its specially assessed penalties, Consol asserts it is entitled to the forms. Consol Mot. at 5. Moreover, according to Consol, even if the forms were once protected by the deliberative process privilege, they lost the protection once the recommendations they contain were adopted by the Secretary as the agency’s position. Consol Mot. at 6-7.

Consol also argues that it is entitled to data concerning all of the citations and orders alleging violations of sections 75.202 and 75.220(a)(1) that have been specially assessed in order to determine whether the Initiative is a binding norm and therefore a substantive rule requiring notice-and-comment rulemaking to be valid. Although the Secretary objects that this request is irrelevant and burdensome, Consol maintains that it is correctly attempting to prove that the Initiative is a substantive rule and therefore was improperly implemented. Consol Mot. at 9-10.

The Secretary responded to Consol’s motion by filing her own motion to compel. She wants Consol to answer supplemental interrogatories and to supply documents requested by her on May 11, 2012. She asserts that Consol’s responses were due on June 8, but that Consol’s counsel stated that he “[w]as not inclined to answer any supplemental discovery responses until [Consol’s] Motion to Compel has been ruled on.” Sec’s Mot. at 2. The Secretary asserts that there is no relation between the two motions and seeks a ruling that Consol be compelled to answer as required by the Commission’s rules. Id.

The Court has little patience with this kind of tit for tat. It agrees with the Secretary that the matters are not related and orders Consol to respond to the Secretary’s Supplemental Interrogatories/Documents Requests within 15 days of the date of this Order.

3(...continued)
§75.220(a)(1) Develop and follow approved roof control plan

*  *  *

*Includes All Supbarts


4 As Commission Administrative Law Judge Michael Zielinski explained, “Under the [Rules To Live By Initiative] all violations of [the specified] standards are forwarded for consideration of special assessment. [A SAR] form typically consists of an initial recommendation by the issuing inspector, with a short, typically factual, narrative, and concurrences or oppositions of supervisors indicated by a check in a box, which may be accompanied by comments.” Big Ridge Inc., (Order Granting In Part and Denying In Part Respondent’s Motion to Compel), slip op. at 1, Docket No. LAKE 2011-716 (March 16, 2012).
As for the SAR forms, if the alleged violations are proven, the Court must assess civil penalties *de novo* based on its consideration of the six penalty criteria set forth in section 110(l) of the Act. *Sellersburg Stone Co.*, 5 FMSHRC 287, 292 (March 1982). Therefore, the Court would view the SAR forms as irrelevant to the issues at hand except for the fact that if the Court assesses a penalty that “substantially diverges” from that which is proposed by the Secretary, the Commission requires the Court to explain the variance. *Hubb Corporation*, 22 FMSHRC 606, 612 (May 2000) (quoting *Sellersburg*, 5 FMSRHC at 293). The Court can hardly do so if it does not understand the basis for the Secretary’s proposal. Likewise, Consol can hardly show a variance is warranted without knowing the basis. The Court recognizes, however, that there may indeed be valid deliberative process concerns that arise when viewing the forms. For example, they may contain comments by MSHA personnel concerning the pros and cons of issuing a special assessment. Like other judges who have considered the matter (see e.g., *Big Ridge Inc.* at 2), the Court orders the Secretary to submit the SAR forms sought by Consol to the Court for its *in camera* review. The forms must be submitted within 15 days of the date of this order. The Court will rule as to those parts of the forms which are protected by privilege. The Secretary will then be directed to redact such parts and to send the redacted copies to Consol.

The Court is not disposed to entertain any issues pertaining to whether the Initiative is a substantive rule requiring notice and comment rulemaking. The Court views such questions as far outside the bounds of what is essentially a garden variety civil penalty proceeding, albeit with at least one unusually high proposed penalty. Therefore, the Court denies Consol’s motion to compel production by the Secretary of data respecting the number of alleged violations of section 75.202 and 75.202(a)(1) that were specially assessed both nationally and in MSHA District 3 since implementation of the Initiative.

/s/ David F. Barbour
David Barbour
Administrative Law Judge

Distribution: (1st Class U.S. Mail)


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/sa
This case is before me upon two petitions for assessment of civil penalties under section 105(d) of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 815(d). After initiating an investigation into alleged section 110(c) violations, the Secretary proposed civil penalties against Willie Rowe as a result of the violations alleged in Order Nos. 611840, 6118442, and 6118444 and a civil penalty against Christian Miller as a result of the violation alleged in Order No. 6118444. The Respondents have submitted identical Motions for Judgment on the Pleadings alleging that the Secretary’s petitions were insufficient to state a claim for relief under Commission Procedural Rule 28 and Federal Rules of Civil Procedure Rule 8(a)(2). Respondents contend that the petitions do not identify any facts supporting the rationale for imposing the civil penalties or tending to show that South Carolina Minerals’ alleged agents knowingly authorized, ordered, or carried out any violations. Respondents move to dismiss the above-captioned claims with prejudice on the basis of the insufficiency of the pleadings.

According to Commission Rule 28, a penalty petition must contain a list of the alleged violations and a short and plain statement of supporting reasons based on the criteria for penalty assessment set forth in section 110(i) of the Act. In addition, a copy of the citations or orders at issue must be attached to the penalty petition. In most cases, the citation, assessment sheet, and
When the penalty is specially assessed, the assessment sheet will direct the reader to the Special Assessment Narrative Form for explanation of the penalty on the basis of the six criteria set forth in § 100.3(a). 30 CFR § 100.5.

Between the citations, the Special Assessment Narrative Form, and the petition itself, the Secretary has met the minimal pleading requirements. The Special Assessment Narrative Form sets forth information regarding how the Secretary assessed each penalty factor and how each factor affected the proposed penalty assessment. The citations or orders explain the conditions and practices that lead to each citation and the conclusions the inspector made as to gravity and negligence. They also attribute the alleged knowing conduct to the named agent of the Respondent operator.

In these cases, however, the Respondents claim that they have not received copies of the citations associated with the section 110(c) allegations. The Secretary states that the orders were physically served on Rowe and that both Respondents were given copies of the citations at the beginning of the section 110(c) investigation. The Secretary also states that the citations were attached to the petitions for civil penalty as required by Rule 28. In reviewing the record, it appears that the Secretary did not send the citations with the petitions filed with the Commission, and thus it is likely that the Secretary also failed to include the orders with the copy of the petitions sent to the Respondents.

ALJs have shown considerable leniency when the Secretary fails to include copies of the citations with the petition for civil penalty by allowing the Secretary to amend the pleadings to perfect the petition. See, e.g., Quapaw Company, 19 FMSHRC 1927 (1997) (ALJ Merlin); Georges Colliers, Inc., 20 FMSHRC 95 (1998) (ALJ Merlin). The Commission has no specific rule regarding amendment of pleadings. Commission Rule 29 C.F.R § 2700.1(b), however, states that “[o]n any procedural question not regulated by the Act, these Procedural Rules, or the Administrative Procedures Act . . . the Commission and its judges shall be guided so far as practicable by the Federal Rules of Civil Procedure.”

Federal Rule of Civil Procedure 15(a) governs amendment of pleadings. Rule 15(a)(2) states that “a party may amend its pleading only with the opposing party's written consent or the court's leave. The court should freely give leave when justice so requires.” The Commission has applied a liberal application of Rule 15(a), explaining that “amendments are to be liberally granted unless the moving party has been guilty of bad faith, has acted for the purpose of delay, or where the trial of the issue will be unduly delayed.” See Wyoming Fuel, 14 FMSHRC 1282, 1290 (Aug. 1992), citing Cyprus Empire Corp., 12 FMSHRC 911, 916 (May 1990).

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1 When the penalty is specially assessed, the assessment sheet will direct the reader to the Special Assessment Narrative Form for explanation of the penalty on the basis of the six criteria set forth in § 100.3(a). 30 CFR § 100.5.
Dismissal without a finding on the merits is a harsh outcome, and one that must be judiciously applied. *Long Branch Energy*, 33 FMSHRC 1960, 1977 n.18 (2011) (ALJ McCarthy). While the Secretary’s oversight is regrettable, there is no evidence of bad faith or intent to delay on the part of the Secretary. In response to the Respondent’s request, the Secretary amended her petition by providing an electronic copy of the orders and Special Assessment Narrative Forms on May 22, 2012, well in advance of the hearing. Absent any show of prejudice to the Respondents, the Motions for Judgement on the Pleadings are **DENIED**.

/s/ Thomas P. McCarthy
Thomas P. McCarthy
Administrative Law Judge

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