

FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

1331 PENNSYLVANIA AVE., N.W., SUITE 520N
WASHINGTON, DC 20004-1710

January 30, 2026

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

v.

CANYON FUEL COMPANY, LLC,
SHANE ALLRED, employed by
CANYON FUEL COMPANY, LLC, and
MICHAEL COOPER, employed by
CANYON FUEL COMPANY, LLC

Docket Nos. WEST 2021-0229
WEST 2021-0254
WEST 2021-0315
WEST 2021-0319¹

BEFORE: Rajkovich, Chair; Jordan, Baker and Marvit, Commissioners

DECISION

BY: Jordan, Baker, and Marvit, Commissioners:

These proceedings arise under the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 801 et seq. (2024) (“Mine Act”). The case concerns an August 25, 2020, rib burst which occurred at the Canyon Fuel Company, LLC’s (“Canyon Fuel”) Skyline Mine #3. The ground material struck a miner, knocking him to the ground, partially submerging him in coal, causing him to strike his head against a bolt resulting in a traumatic head injury.

The Department of Labor’s Mine Safety and Health Administration (“MSHA”) investigated the accident. They issued two orders to Canyon Fuel. The first alleged a failure to control the rib and the second a failure to immediately report the accident as required. MSHA proposed that the mine operator pay a civil penalty for these violations and additionally assessed individual penalties to employees Shane Allred and Michael Cooper. The parties filed to contest the orders and penalties before a Commission Administrative Law Judge. 45 FMSHRC 328 (May 2023) (ALJ).

¹ In its Petition for Discretionary Review, Canyon Fuel included in the caption of its filing three dockets (Docket Nos. WEST 2021-0314, WEST 2021-0317, and WEST 2021-0318) pertaining to 110(c) penalties vacated by the Judge, and one docket that had been settled (WEST 2021-0188). As the Judge’s decisions on these penalties were not appealed by either party, the Secretary filed a motion to amend the caption to remove the four aforementioned dockets from the caption. The motion is granted and the caption has been amended accordingly.

MSHA issued Order No. 8541891 to Canyon Fuel for failing to maintain the rib in violation of the requirements imposed by the mandatory safety standard at 30 C.F.R. § 75.202(a).² MSHA issued Order No. 8541892 for failing to immediately notify MSHA of an injury with a reasonable potential to cause death as required by 30 C.F.R. § 50.10(b).³ Both orders alleged that the violations of the safety standards were significant and substantial (“S&S”) and caused by an unwarrantable failure to comply with the standards.⁴

The Judge affirmed both orders. However, the Judge modified Order No. 8541891 to find that the operator was only moderately negligent and vacated the unwarrantable failure designation. In addition, the Judge affirmed that Allred and Cooper were personally liable for failing to timely report the accident. For the reasons that follow, we reverse the Judge’s modification of the negligence and unwarrantable failure designation for Order No. 8541891 and affirm the Judge’s other findings.

I.

Statement of the Facts

On August 20, 2020, a rib burst occurred near the eight-bay conveyor at Canyon Fuel’s Skyline Mine #3, an underground coal mine in Utah.⁵ The protective bolts and mesh installed by the operator to support the rib failed, allowing coal to envelop the machinery that runs the conveyor. The primary escapeway was completely blocked off and it took hours to clean the area. Tr. 45-46. No one was injured in the accident. Canyon Fuel re-installed the bolts and mesh after the ground failure.

Five days later, on August 25, 2020, Bryce Adams was working in the same section where the August 20 rib burst had occurred. While Adams was kneeling near the eight-bay starter and performing an examination, another rib burst occurred, sending material three feet

² Section 75.202(a) 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.”

³ Section 50.10(b) provides that: “[t]he operator shall immediately contact MSHA at once without delay and within 15 minutes . . . once the operator knows or should know that an accident has occurred involving. . . [a]n injury of an individual at the mine which has a reasonable potential to cause death.”

⁴ The S&S terminology is taken from section 104(d)(1) of the Act, which distinguishes as more serious any violation that “could significantly and substantially contribute to the cause and effect of a . . . mine safety or health hazard.” 30 U.S.C. § 814(d)(1).

The unwarrantable failure terminology is taken from section 104(d)(1) of the Act, 30 U.S.C. § 814(d)(1), which establishes enhanced sanctions for any violation that is caused by “an unwarrantable failure of [an] operator to comply with . . . mandatory health or safety standards.”

⁵ The eight-bay is an enclosure that houses all of the controls for the longwall. Tr. 248.

deep and five feet wide into the area, forcing Adams against the eight-bay. Adams' head struck a bolt head on the eight-bay control box, and he fell to the ground and was partially covered by coal. The coal covered him to the top of his torso, restricting movement of his extremities and toes. He began bleeding from the head and lost consciousness. Tr. 35-36.

Shane Allred, the shift foreman and designated "responsible person" for contacting MSHA in case of serious injuries, was notified of the accident at approximately 5:08 P.M. Allred was working on another section, approximately 25-30 minutes away from where the accident took place. Charlie Wilson, the production foreman, explained to Allred that Adams was "covered up with coal," and Allred immediately proceeded to the site of the accident. Tr. 262-63. Allred did not inquire into the extent of Adams' injuries. While in his truck, Allred notified the mine's communication center, Conspec, of the accident and requested that Dana Anderson, a former EMT, be sent to the accident scene.

Michael Cooper, the mine safety manager, was informed of the accident by Conspec shortly thereafter. Cooper was at his home, 65 miles from the mine site at the time of the call. Cooper inquired as to Adams' condition, but they were unable to confirm if the injuries were serious or life-threatening. Tr. 301-02.

It took approximately 30 minutes to dig Adams out from under the coal. Fellow miners had loaded Adams onto a stretcher, applied a head dressing, and stabilized Adams' neck with a cervical collar, when Anderson arrived at the scene. Tr. 91-93. Anderson was the first person with any medical training to assess Adams condition. Anderson noted that Adams was conscious and coherent but was bleeding through his head bandages from a "pretty good cut." Tr. 93. Anderson checked Adams legs to see if any of the bones were broken.

Allred arrived shortly thereafter—approximately 40 minutes after the accident occurred. Tr. 286. Allred did not recall if he saw any blood on the bandage on Adams' head but testified that there was no "excessive bleeding." Tr. 266. Allred spoke to Adams to determine the extent of his injuries. Allred described Adams as coherent and joking, but remembered Adams complaining about pain in his neck, back, and leg. Tr. 267, 269. Allred testified that he was unable to physically examine Adams because he was covered with blankets, but he confirmed that Adams was able to move his feet and arms. Allred further testified that he spoke to Anderson, and they determined that Adams did not likely have a leg fracture. Allred did not testify that he spoke to John Bonnanci, the longwall foreman, who had helped provide initial first aid to Adams. Tr. 237-38, 266-73.

Allred called Cooper to report on the extent of Adams' injuries. Allred explained to Cooper that he did not think that Adams' injuries were immediately reportable under the regulations. Tr. 274. Allred testified that he informed Cooper that there was a 1-1 ½ inch laceration on Adams' forehead but the bleeding was under control. Allred explained that Adams was complaining about pain to the back, neck, and right leg, but that he did not think Adams' leg was broken.

Anderson accompanied Adams on his trip to the surface in a vehicle referred to as the "ambulance." Once Adams was moved onto the ambulance, Anderson changed Adams' blood-

soaked bandages. Anderson again noted that Adams' head had a "pretty good cut" but also observed that his skull was exposed and dented in. Tr. 93. Anderson rode with Adams in the ambulance to the surface, administering oxygen to him. However, the oxygen ran out approximately 40 crosscuts from the surface, and Adams began to go pale, sweat, and shake—signs Anderson thought indicated that Adams was going into shock. Anderson did not report to anyone that Adams's injuries were life-threatening but testified that he would have reported the accident after reaching the surface. Tr. 101-02.

The Carbon County ambulance crew and a flight medic greeted the ambulance on the surface, examined Adams, and brought Adams to a nearby hospital. An hour after Adams arrived at the hospital, he was taken into surgery. Adams' wife texted Cooper and informed him that Adams's skull had been fractured, Adams had an injury to a vertebra, and he was in surgery. Doctors had to place a plate in Adams' head to repair a hole of about two centimeters in his skull. In addition, Adams had to wear a cervical collar for six weeks and had to have subsequent surgery to repair damage sustained to his knee. Tr. 43.

Canyon Fuel did not report the accident to MSHA. The following morning, August 26th, MSHA Inspector Rudy Madrigal arrived at the mine, after learning of the accident from miners at a different mine. The MSHA inspector observed a stretcher laying outside of Mr. Cooper's office and questioned him about the event, before proceeding underground to investigate.

II.

Disposition

On review, the Secretary argues that the Judge erred in lowering the negligence of the operator in Order No. 8541891 from "high" to "moderate" and in vacating the unwarrantable failure designation. The operator argues that the Judge should have vacated Order No. 8541891 as duplicative of Citation No. 8541894, challenges the finding of a violation in Order Nos. 8541891 and 8541892, and challenges the upholding of the S&S designation and unwarrantable designations. In addition, the operator argues that the Judge erred in finding section 110(c) liability for Allred and Cooper.

A) Order No. 8541891 (the failure to support or control the rib)

1) Judge's Decision

The Judge concluded that the operator violated section 75.202(a)'s requirements to support or control the rib. 45 FMSHRC at 341. In determining that the violation was S&S, the Judge relied on the fact that the hazard caused serious injuries to a miner. *Id.* at 342-43.

The Judge determined that the Secretary failed to demonstrate "high" negligence amounting to an aggravated lack of care or that the violation was caused by an unwarrantable failure. The Judge concluded that the operator knew that the effort to control the ribs was insufficient and that Canyon Fuel was on notice for five days of possible hazardous conditions because of the rib failure on August 20 in the same section. However, the Judge credited the

operator for attempting, albeit inadequately, to control the ribs by means of using mesh and rock props,⁶ stating that the abatement efforts were not lacking to an aggravated degree. Further, the Judge found that, although the operator had knowledge of a possible hazard of a rib failure that happened in the same section, it did not have knowledge of the condition around the area where the accident occurred. The Judge determined that the violative condition was not obvious despite having existed for the duration of mining in the area. *Id.* at 343-46.

In accordance with his negligence and unwarrantability modifications, the Judge assessed a penalty of \$25,000.00, rather than the penalty of \$74,700.00 proposed by the Secretary. *Id.* at 347.

2) Whether Order No 8541891 was duplicative of Citation No. 8541894

The operator requests that the Commission vacate the Judge's finding of a violation of section 75.202(a) (Order No 8541891). Canyon Fuel alleges that Order No. 8541891 was duplicative of a separate citation issued to Canyon Fuel by MSHA after the accident (alleging a failure to follow the approved roof control plan in violation of 30 C.F.R. § 75.220(a)(1)). That separate citation (Citation No. 8541894) was previously settled by the parties and is not at issue before the Commission in any of the captioned proceedings.⁷ Decision Approving Partial Settlement (May 19, 2022).

We have held that citations or orders are not duplicative as long as the allegedly violated standards impose separate and distinct duties. *Western Fuels-Utah, Inc.*, 19 FMSHRC 994, 1003 (June 1997); *see also Sumpter v. Sec'y of Labor*, 763 F.3d 1292, 1301 (11th Cir. 2014); *Spartan Mining Co.*, 30 FMSHRC 699, 716 (Aug. 2008); *Cyprus Tonopah Mining Corp.*, 15 FMSHRC 367, 378 (Mar. 1993) (violations are not duplicative merely because they emanate from the same events); *El Paso Rock Quarries, Inc.*, 3 FMSHRC 35, 40 (Jan. 1981) (hole in fence around electrical power transformer and leaving fence gate unlocked constituted separate offenses). However, examining the requirements of the competing standards is only a part of our inquiry. We also must look at the particularities of the case to determine if MSHA was citing the operator on the basis of more than one specific act or omission. *See Western Fuels-Utah*, 19 FMSHRC at 1004, n.12.

In cases where we have found citations to be duplicative, the contests of both relevant citations were before the Commission. *See, e.g., Western Fuels-Utah, Inc.*, 19 FMSHRC at 1003. However, in the present case, Citation No. 8541894 was settled prior to hearing and

⁶ Rock props are telescoping steel supports that can be placed in areas experiencing roof or rib issues. Tr. 278-79.

⁷ Section 75.220(a) provides that “[e]ach mine operator shall develop and follow a roof control plan, approved by the District Manager, that is suitable to the prevailing geological conditions, and the mining system to be used at the mine. Additional measures shall be taken to protect persons if unusual hazards are encountered.” 30 C.F.R. § 75.220(a)(1).

accordingly is not before the Commission.⁸ Decision Approving Partial Settlement (May 19, 2022). There was no testimony at hearing regarding the scope of the alleged violation of the roof control plan and, thus, no factual findings were made by the Judge about what conduct constituted a violation of section 75.220(a)(1).

Had the operator not settled Citation No. 8541894, it is possible that we could have found that the violations spoke to a shared act or omission. However, given the procedural posture of this matter, such an analysis would require us to attempt to glean the facts of a settled citation from the parties' meager prehearing submissions. The Commission, as a general matter, does not find facts. *Brody Mining, LLC*, 37 FMSHRC 1914, 1931 (Sep. 2015) (noting that the Commission cannot review an ALJ decision absent a factual record below). Adjudicators are not in the position to know the facts of settled violations sufficiently to make any sweeping pronouncements in the context of a decision on the merits after hearing. *See, generally, Newmont USA Limited*, 37 FMSHRC 499, 506 (Mar. 2015) (finding that the Judge improperly relied on settled citations when determining the penalty assessment).

Accordingly, we decline to vacate Order No 8541891 because it was allegedly duplicative of a separate citation.

3) Whether the Judge erred in finding a violation of 30 C.F.R. § 75.202(a)

Canyon Fuel argues that the Judge improperly applied a *per se* standard in determining that section 75.202(a) was violated because the rib failed. The operator contends that the Judge's analysis should have been controlled by *Cannon Coal Co.*, 9 FMSHRC 667 (Apr. 1987), in which the Commission recognized that alleged violations of the predecessor standard, 30 C.F.R. § 75.200, should be resolved by reference to whether a reasonably prudent person, familiar with the mining industry and the protective purpose of the standard, would have recognized the hazardous condition that the standard seeks to prevent. *See id.* at 668. Canyon Fuel argues that the Secretary did not adduce substantial evidence to show that the operator was on notice that additional supports were necessary.

Section 75.202(a) states 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. § 75.202(a). Thus, under the plain language of the standard and the strict liability approach⁹ governing Mine Act violations, the

⁸ The Judge mistakenly notes that Citation No. 8541894 was vacated and uses this fact as justification for not finding the citation duplicative. The Judge approved a settlement of Citation No. 8541894 and its associated civil penalty on May 19, 2022. This is a harmless factual error as it does not impact our conclusion. *See Chapman v. California*, 386 U.S. 18, 21-22 (1967) (defining harmless errors as “small errors or defects that have little, if any, likelihood of having changed the result of the trial.”).

⁹ As part of the Mine Act's strict liability framework, every violation of a mandatory safety standard “imposes liability upon an operator regardless of [the operator's] knowledge of unsafe conditions. What the operator knew or should have known is relevant, if at all, in

Secretary, to prevail here, need only show (1) that the rib failure occurred in an area where persons work or travel, and (2) that the ribs were not supported to protect persons from hazards related to falls. *See Cyprus Empire Corp.*, 12 FMSHRC 911, 917 (May 1990).

On the first point, there is no question the area where the rib failure occurred was a place where miners work or travel. The accident occurred near the eight-bay starter. 35 FMSHRC at 335. Adams was performing routine maintenance there, and there is no evidence demonstrating that the area was otherwise off limits to miner work or travel. On the second point, evidence that the same area experienced two rib failures, one resulting in a serious injury to Adams, is clearly indicative of inadequate rib support. We have found that where a miner is injured beneath a rock fall, the *only* conclusion that can be reached is that the ribs/roof/face was not supported to protect persons from hazards. *Jim Walter Res. Inc.*, 37 FMSHRC 493, 496 (Mar. 2015).

The operator's reliance on *Cannon Coal* is inapposite. In *Jim Walter Resources*, we clearly addressed this issue and found that the occurrence of a roof/rib/face failure is enough to demonstrate that control measures were inadequate to protect miners from hazards. *Id.* Subsequent Commission decisions have not questioned the validity of the reasoning in *Jim Walter Resources*, and we decline to revisit the decision here. *See The Doe Run Co.*, 42 FMSHRC 521 (Aug. 2020) (recognizing that 75.202(a) is a *per se* standard, but declining to apply that in the metal/nonmetal context). Accordingly, we affirm the Judge's holding that Canyon Fuel violated section 75.202(a).

4) Whether the Judge erred in finding “moderate” negligence.

The Secretary argues that the Judge erred in lowering the operator's negligence from high to moderate primarily relying upon the fact that the operator had installed mesh, bolts, and rock props in the area to help control the ribs against failure. Given the condition of the mine and the rib failure that occurred in the same section only a few days earlier, the Secretary contends that the operator's failure to provide sufficient support represented a significant breach of the duty of care and that, even if the operator's ineffective efforts mitigated their negligence, a single mitigating circumstance does not preclude a finding of “high” negligence.

determining the appropriate penalty, not in determining whether a violation of the regulation occurred.” *Peabody Coal Co.*, 1 FMSHRC 1494, 1495 (Oct. 1979); *see also Nally & Hamilton Enter. Inc.*, 33 FMSHRC 1759, 1764 (Aug. 2011); *Rock of Ages Corp. v. Sec'y of Labor*, 170 F.3d 148, 156 (2d Cir. 1999) (holding that Mine Act regulation “imposes strict liability on mine operators … regardless of whether the operator has knowledge” of hazard); *Stillwater Mining Co. v. FMSHRC*, 142 F.3d 1179, 1184 (9th Cir. 1998) (“[k]nowledge and culpability, however, are not relevant to the determination of whether there was a violation. As we have observed, the [Mine Act] imposes ‘a kind of strict liability on employers to ensure worker safety’”) (citation omitted); *Allied Products*, 666 F.2d 890, 894 (5th Cir. 1982) (“If the Act or its regulations are violated, it is irrelevant whose act precipitated the violation or whether or not the violation was found to affect safety; the operator is liable.”). Accordingly, Canyon Fuel's arguments that the Judge erred in finding it liable, and that the violation should be vacated, based upon what it knew or should have known, stand in stark conflict with the underlying precepts of the Mine Act.

The Commission reviews a Judge’s negligence findings for substantial evidence. *Leeco, Inc.*, 38 FMSHRC 1634, 1638 (July 2016). In reviewing an operator’s degree of negligence, the Commission has recognized that “[e]ach mandatory standard . . . carries with it an accompanying duty of care to avoid violations of the standard, and an operator’s failure to meet the appropriate duty can lead to a finding of negligence if a violation of the standard occurs.” *A.H. Smith Stone Co.*, 5 FMSHRC 13, 15 (Jan. 1983). In determining whether an operator met its duty of care, the Commission considers what actions would have been taken under the same circumstances by a reasonably prudent person familiar with the mining industry, the relevant facts, and the protective purpose of the regulation. *Brody Mining, LLC*, 37 FMSHRC 1687, 1702 (Aug. 2015) (citations omitted); *U.S. Steel Corp.*, 6 FMSHRC 1908, 1910 (Aug. 1984).

The “gravamen of high negligence is that it ‘suggests an aggravated lack of care.’” *Brody Mining LLC*, 37 FMSHRC at 1703. (citing *Topper Coal Co.*, 20 FMSHRC 344, 350 (Apr. 1998)). *Sec’y of Labor v. Kentucky Fuel Corp.*, 40 FMSHRC 28, 31 (Feb. 2018).

We conclude that the Judge’s finding of “moderate” negligence is not supported by substantial evidence and fails to logically flow from the Judge’s culpability findings. The Judge not only found that the Secretary established “a lack of adequate mitigation,” but also described the operator’s mitigation efforts as “a significant breach of the duty of care” and acknowledged that there was evidence that the operator *knew* the mitigation efforts were insufficient. 45 FMSHRC at 344, 345. If the operator knew that mesh and bolts were inadequate to prevent a rib failure, it stands to reason that such evidence cannot be used to support a lessened degree of negligence. *See Mach Mining, LLC v. Sec’y of Labor*, 809 F.3d 1259, 1265 (D.C. Cir. 2016) (actions that “neither prevented nor corrected the hazardous condition” did not amount to a factor mitigating high negligence). *See also Mach Mining, LLC*, 40 FMSHRC 1, 9, 12 (Jan. 2018) (affirming a finding of high negligence when the operator took inadequate measures to comply with the cited standard). Here, not only did the mitigation efforts not prevent a second rib failure, but the Judge found that the operator should have known that the mitigation efforts were inadequate.

Accordingly, we reverse the Judge’s lowering of negligence and find that the record evidence compels a finding of high negligence. *See Am. Mine Servs., Inc.*, 15 FMSHRC 1830, 1834 (Sept. 1993) (remand not necessary when record supports no other conclusion).

5) Whether the Judge erred in vacating the unwarrantable failure designation

Whether conduct is “aggravated” in the context of unwarrantable failure is determined by looking at all the facts and circumstances of each case, including (1) the extent of the violative condition, (2) the length of time that it has existed, (3) whether the violation posed a high risk of danger, (4) whether the violation was obvious, (5) the operator’s knowledge of the existence of the violation, (6) the operator’s efforts in abating the violative condition, and (7) whether the operator has been placed on notice that greater efforts are necessary for compliance. (“*IO Coal factors*”). *IO Coal Co.*, 31 FMSHRC 1346, 1350-57 (Dec. 2009); *see also Manalapan Mining Co.*, 35 FMSHRC 289, 293 (Feb. 2013); *Cyprus Emerald Res. Corp.*, 20 FMSHRC 790, 813 (Aug. 1998), *rev’d on other grounds*, 195 F.3d 42 (D.C. Cir. 1999). All of the relevant facts and circumstances of each case must be examined to determine if an operator’s conduct is aggravated

or whether mitigating circumstances exist. *Consolidation Coal Co.*, 23 FMSHRC 588, 593 (June 2001).

We consider the *IO Coal* factors in reviewing the Judge's holding that the violation was not unwarrantable and conclude that the Judge erred.

The Judge acknowledged that the violative condition posed a high degree of danger and that the operator was aware, based on the August 20 accident in the same section, that greater efforts were needed to achieve compliance. 45 FMSHRC at 346. The Judge stated that while the exact extent of the violation of the safety standard was unknown, in evaluating whether the violative condition was the result of an unwarrantable failure he would consider "the rib at issue, the *nearby* rib that burst on August 20, and any surrounding areas where [the operator] found it necessary to install additional mitigation." *Id.* (emphasis added).

The Judge also found that the violative condition likely existed for the duration of mining in the area. *Id.* In calculating the penalty, the Judge described the duration of the violative condition—i.e. the time between the previous accident and the one that caused Adams to be injured—as "only five days." *Id.* However, if the operator had knowledge of a dangerous condition, allowing a violative condition to exist for one day is enough to establish an unwarrantable failure. *See Southern Ohio Coal Co.*, 12 FMSHRC 1498, 1502-03 (Aug. 1990) (1 day), *Mid-Continent Res. Inc.*, 16 FMSHRC 1226, 1233 (June 1994) (accumulations that were known for two-shifts were an unwarrantable failure).

For the reasons provided in the negligence section above, the Judge's holding that the violative condition was not obvious is not supported by his factual findings. Knowledge of the August 20 rib failure in the same section as the August 25 rib failure and the high level of danger posed by a rib failure should have alerted the operator to take a closer look at the section where there were visible signs that the pillars were not properly yielding.¹⁰

Here, however, the Judge found that the operator was "on notice that its mesh and bolts in the area were inadequate to prevent a rib burst" based on the circumstances that existed at the mine, particularly after the August 20th accident. 45 FMSHRC at 345. Given this finding, Canyon Fuels' belief that additional mesh and bolts would alleviate the violative condition was not reasonable.¹¹ Accordingly, the Judge erred in concluding that the operator's violation was not the result of an unwarrantable failure.

¹⁰ Pillars are properly yielding if they are adequately taking the weight of the roof. Tr. 167-68.

¹¹ We have found that if mitigation efforts were made in a good faith but mistaken belief that the actions taken were the safest method of complying with the Mine Act and MSHA's regulations, there is no unwarrantable failure. *Wyoming Fuel Co. n/k/a/ Basin Res., Inc.*, 16 FMSHRC 1618, 1628-29 (Aug. 1994) (finding a violation did not result from an unwarrantable failure where the operator had a good faith belief that it was complying with the Secretary's regulations when it attempted to improve the safety of the mine's ventilation system); *but see*

B) Order No. 8541892 (the failure to notify MSHA of the accident)

1) Judge's Decision

The Judge held that Canyon Fuel violated section 50.10(b) as alleged by the Secretary. The Judge recognized that section 50.10(b) requires immediate reporting of any injury that has a “reasonable potential to cause death,” rather than a clinical or hyper-technical opinion of the miner’s chance of survival. *See Signal Peak Energy, LLC* 37 FMSHRC 470, 474-75 (Mar. 2015); *Cougar Coal Co.* 25 FMSHRC 513, 516 (Sept. 2003). The Judge found that the 15-minute notification window began to run as soon as Allred was notified of the accident. 35 FMSHRC at 355. During the relevant time period, the Judge found that the operator was aware that a rib had failed, and that Adams had been buried in coal, and should have been aware that Adams was bleeding from a head wound. *Id.* at 357. Based on the totality of the circumstances, the Judge determined that this was enough information to determine that an injury with the reasonable potential to cause death had occurred. *Id.* at 358. The Judge found that subsequent medical opinions that Adams’ injuries were not life-threatening were irrelevant to the reporting requirement analysis. *Id.* at 356.

The Judge affirmed the S&S designation, finding that the violation contributed to the danger of additional rib failures which were reasonably likely to result in a reasonably serious injuries to miners. *Id.* at 362-63.

The Judge also concluded that the violation was the result of a high level of negligence on the part of the operator. *Id.* at 363-65. The Judge found that management was aware of the accident and should have recognized that the accident had the reasonable potential to cause death. *Id.* The Judge expressly found that the operator’s failure to immediately report was not motivated by a concern for continued production or a desire to avoid MSHA enforcement—indicia of a reckless disregard for miners’ safety. *Id.* Rather, the Judge credited the failure to report on the Respondent’s improper understanding of what type of injuries were required to be reported. *Id.*

In upholding the unwarrantable failure designation, the Judge determined that mine management should have known that they were required to notify MSHA based on the nature of the accident and the inability to assess Adams injuries during the 15-minute timeframe. *Id.* at 366. The Judge held that the failure to report was obvious and posed a high degree of danger because miners were working in the area after the accident but before an MSHA inspection. *Id.* at 366-67. Although the Judge found that the violation was significant in scope—extending the length of the longwall—he held that the violative condition only existed for 14 hours, which he deemed to not be an aggravating factor. *Id.* at 367-68. Moreover, the Judge credited the operator’s efforts to abate the violative condition and for not having been placed on notice that greater efforts were required for compliance. *Id.* at 369.

Amax Coal Co., 19 FMSHRC 846, 851-52 (May 1997) (finding the decision to send one mine to clean up a spill was unreasonable in light of the size of the spill).

2) Whether the Judge erred in concluding that Canyon Fuel violated 30 C.F.R. § 50.10(b)

Canyon Fuel argues that the Judge erred in concluding there was an immediately reportable accident under section 50.10(b). The operator contends that the term “reasonable potential to cause death” set forth in the standard is synonymous with the more colloquial phrase “life threatening injury.” Thus, Canyon Fuel claims that the Judge erred in not focusing on Adams’ actual injuries and the assessments of Anderson, paramedics, and hospital evaluations that the injuries, while serious, were ultimately not life-threatening. Rather, Canyon Fuel argues that the Judge improperly relied on the event—i.e. the rib failure—and information outside the record to determine the seriousness of Adams’ potential injuries to find that the violation was reportable.

Canyon Fuel further contends that the 15-minute limit for reporting only begins when the operator knows the accident is reportable. It asserts that its interpretation of section 50.10(b) would allow operators the opportunity to investigate the accident in order to determine the extent of the injuries before the 15-minute time begins to run. Canyon Fuel strongly implies that the 15-minute reporting requirement would have only begun in this case if there were a medical assessment that Adams’ injuries were life-threatening. Because later evaluations revealed that Adams was not at immediate risk of death, Canyon Fuel contends that the 15-minute reporting requirement was never triggered.

Section 50.10(b) requires an operator to “immediately contact MSHA at once without delay and within 15 minutes . . . once the operator knows or should know that an accident has occurred involving . . . an injury . . . which has a reasonable potential to cause death.” 30 C.F.R. § 50.10(b).¹² In its final rule, MSHA explained that 15 minutes “provides adequate time for operators to notify MSHA with sufficient information. For example, the mine operator often knows the general character of an event, such as an explosion or inundation, and can report it under the 15-minute requirement before knowing whether a person has been injured or killed or whether the event is life threatening.” 71 Fed. Reg. 71430, 71435 (Dec. 8, 2006). We have found that prompt reporting is essential to the standard which requires a prompt determination as to whether an accident has occurred. *See Consolidation Coal Co.*, 11 FMSHRC 1935, 1938 (Oct. 1989) (finding that section 50.10 “accords operators a reasonable opportunity for investigation,” but that the investigation “must be carried out . . . in good faith without delay and in light of the regulation’s command of prompt, vigorous action”); *see also* 71 Fed. Reg.

¹² It is noteworthy that the regulation emphasizes four times in succession that the reporting must occur as quickly as possible, saying that it must occur, “immediately...at once without delay and within 15 minutes.” This repetition was expressly intended to be cumulative rather than repetitive. 71 Fed. Reg. at 71436 (“The final rule retains the ETS terms ‘at once and without delay,’ which highlight that reporting must be done promptly. Though a commenter said that these terms are synonyms and should be deleted, the terms are dictionary references used by the Commission in defining and emphasizing what is intended by ‘immediately.’ [See *Consolidation Coal*, 11 FMSHRC 1935 at 1938 (October 31, 1989).] ‘Immediately’ is to be understood ‘in light of the [notification] regulation’s command of prompt, vigorous action.’” p. 71436)

12,252, 12,260 (Mar. 9, 2006) (noting that “[t]aking too much time to determine whether … an accident occurred” is a common reason for violations of section 50.10). As the Third Circuit recognized:

[I]t is plain that the notification requirement was designed to serve the Mine Act’s unyielding purpose of protecting miners by encouraging rapid notification, thereby allowing MSHA to effectively initiate an emergency response and to ensure the preservation of evidence for use in investigations. The notification requirement should be interpreted to effectuate that purpose.

Consol Pa. Coal Co., LLC v. FMSHRC, 941 F.3d 95, 106 (3d Cir. 2019). In *Consol*, the Third Circuit stated that in determining whether an injury has the reasonable possibility to cause death, a mine operator should be guided by principles that favor MSHA notification. In accordance with that principle:

First, reasonable doubts must be resolved in favor of notifying MSHA; second, liability must be assessed based on whether a reasonable person in the circumstances would view the injuries as having a reasonable potential to cause death; third, the totality of the circumstances must be considered; and fourth, the focus must be on the information available around the time of the injury, so post-hoc medical evidence is less probative.

Id. at 103. In total, the notification requirement “must be analyzed on an objective basis, asking whether a reasonable person in the circumstances would view a miner’s injury as having a reasonable potential to cause death.” *Id.* at 107.

The record demonstrates that it was immediately apparent that the rib where Adams was working had failed and that no further investigation was needed to understand what type of accident had occurred. Fellow miners on the section, including the longwall foreman, quickly came to Adams’ aid and discovered that he was packed tightly in relatively small pieces of coal. Tr. 36. It was instantly clear that Adams had sustained a serious blow to the head with a potential for internal bleeding or brain damage. Tr. 38. Not only was the head lacerated and bleeding, but there is evidence that Adam’s skull was exposed and visibly “dented in.” Tr. 93. We conclude that while the exact extent of Adams’ other injuries was unknown for at least 30 minutes, the nature of the accident and the clearly observable serious head injury was enough to alert a reasonably prudent miner that Adams’ injuries had a reasonable potential to cause death.

Canyon Fuel’s argument that the standard allows for additional time for the operator to investigate the exact nature of the accident and injury is without merit. Given that section 50.10 requires a prompt determination on whether an accident is reportable, operators must often rely on readily available information, such as the nature of the accident, in determining whether an injury is reportable. Medical or clinical opinions, while helpful, may come too late and thereby “frustrate the immediate reporting of near fatal accidents.” *Cougar Coal Co.*, 25 FMSHRC 513, 520-21 (Sept. 2003) (holding that an electric shock, 18-foot fall, and head injury had a “per se”

reasonable potential for death); *see also Mainline Rock & Ballast, Inc.*, 693 F.3d 1181, 1188-89 (10th Cir. 2012) (holding that an operator could not claim to not have known the extent of a miner’s injuries when only a cursory physical examination was performed after the miner was pulled through a roller).

Accordingly, we affirm the Judge’s conclusion that Canyon Fuel violated section 50.10(b).

3) Whether the Judge erred in finding that Order No. 8541892 was significant and substantial

A violation is S&S when a miner is exposed, or would be exposed in the normal course of mining, to a violation that could significantly and substantially contribute to a mine safety or health hazard. *Consol Pennsylvania Coal Co.*, 47 FMSHRC 793, 823 (Sept. 2025); *see also Youghiogheny & Ohio Coal Co.*, 9 FMSHRC 673, 677 (Apr. 1987) (citing *U.S. Steel Mining Co.*, 6 FMSHRC 1834, 1836 (Aug. 1984) (“[I]t is the contribution of a violation to the cause and effect of a hazard that must be significant and substantial.”)). In the instant case, Adams was buried under a significant amount of coal and had sustained serious injuries, and the operator delayed notifying the accident far past the 15-minute deadline from when they were made aware of the accident. In proposing Part 50.10(b), MSHA explained that the Sago and Aracoma Mine disasters of 2006, “led MSHA to conclude that a more integrated approach to mine emergency response and evacuation was necessary.” 71 Fed. Reg. 71430 (Dec. 8, 2006). This integrated approach required operators to “provide additional self-contained self rescue devices (SCSRs) for persons working underground; conduct improved SCSR training and more realistic evacuation drills; and install and maintain lifelines in both escapeways. *The [Emergency Temporary Standard] also required all mine operators to immediately notify MSHA of accidents within 15 minutes.*” *Id.* (emphasis added). Several comments to the proposed rule suggested that MSHA either retain the original language that had no set time requirement or that the time limit be raised to half an hour, an hour, or longer. *Id.* at 71434. They argued “that 15 minutes passes too fast, is too short, and does not allow for the gathering of sufficient information.” *Id.* MSHA rejected these suggestions, explaining:

Timely reporting can be crucial in emergency, life-threatening situations to activate effective emergency response and rescue. Not only can this be vital to the saving of lives, but it can be instrumental to having expert Agency personnel at the scene with authority to assure that the accident site remains undisturbed and preserved for investigation into causes.

Id. at 71435. MSHA further highlighted the “dynamic nature of the mining industry. The mining environment is ever-changing; there is always the threat of new hazards or dangers. The reporting of roof falls, unplanned explosions, haulage accidents, or unstable conditions at impoundments, for example, may necessitate critical, pro-active corrective actions and the need for emergency response assistance.” *Id.*

The violation of not notifying MSHA within 15 minutes of finding out about the accident exposes a miner to the hazard of not having MSHA’s expertise and resources utilized in aiding

the miner. *See Cumberland Coal Res.*, 717 F.3d 1020, 1026-27 (D.C. Cir. 2013) (Section 104(d)(1) “refers to the violation’s intrinsic capacity to contribute to the hazard, not to any specific probability that it will.”). It further exposes other miners to the hazard of not coordinating possible withdrawals or immediate investigations into the cause of the accident, potentially imperiling their safety. Failing to contact MSHA regarding the accident here exposed miners working in the section to these hazards. As a result, we find that, consistent with section 104(d) and the analysis described in *Consol*, this citation was properly designated as S&S.

4) Whether the Judge erred in finding that Order No. 8541892 was a result of an unwarrantable failure

Canyon Fuel argues that the Judge applied the *IO Coal* factors but did so contrary to evidence. *See IO Coal Co.*, 31 FMSHRC at 1350-57. The operator notes the Judge found that Canyon Fuel should have known that reporting was required because Adams’ injury was indicative of an “unknown but ‘probable’ head injury.” *Canyon Fuel* PDR at 18, *citing* 45 FMSHRC at 365. The operator asserts that this holding changes the interpretation of section 50.10(b) by requiring that the operator assume that minimal evidence of a head laceration had a reasonable potential to cause death, even when the miner was conscious and coherent.

Canyon Fuel further argues that the Judge failed to adequately consider facts relevant to whether the failure to timely report created a high degree of danger. The operator contends that the fact that Inspector Madrigal investigated the accident site the next day, observed Canyon Fuel’s remedial actions, but did not propose any corrective measures, is indicative of a low degree of danger. Canyon Fuel observes that the Judge failed to explain exactly what safety benefit would have been achieved if the operator had called MSHA within 15 minutes of the accident.

Lastly, Canyon Fuel takes issue with the Judge’s holding that the violative condition was extensive. The operator points out that the accident site was confined to the area around a single rib.

We consider the Judge’s application of the *IO Coal* factors. First, we conclude that the Judge erred in finding the length of time to be a mitigating factor in his unwarrantable failure analysis. The Judge determined that the duration of the reporting violation was abated upon Inspector Madrigal’s inspection on the morning of August 26. 45 FMSHRC at 368. By the Judge’s calculation, the violative condition existed for 14 hours. The Judge cites to *The American Coal Company*, 39 FMSHRC 8, 22 (Jan. 2017), for the proposition that a violative condition must exist for two shifts in order for the duration to be considered an aggravating factor. The *American Coal* decision makes no such finding. In *American Coal*, the Commission reversed a Judge’s holding that duration was not an aggravating factor because a violative coal accumulation had only existed for two shifts. The decision did not set two shifts as the minimum for finding an aggravating duration with respect to any violation.

Moreover, the Judge’s reliance on *American Coal* is misplaced because the Commission has recognized a higher degree of scrutiny on the length of time that is required in the context of alleged violations of section 50.10. In *Wolf Run Mining Co.*, the Commission determined that

the imperative to notify immediately clearly plays a role in determining whether the duration was aggravating conduct in terms of an unwarrantable failure analysis. 35 FMSHRC 3512, 3521 (Dec. 2013) (Commissioner Young dissenting). In that case, the Commission found that a 90-minute delay before contacting mine safety teams after mine management first knew of an accident was aggravated conduct supporting an unwarrantable failure determination.

Second, we conclude that substantial evidence supports the Judge's determination that notice that greater efforts for compliance were necessary is not an aggravating factor.¹³ As the Judge noted, the operator had six injuries in the last two years on the longwall face. 45 FMSHRC at 369, *citing* Gov. Ex. 1. There was no evidence that Canyon Fuel did not properly report these injuries. *Id.* at 369.

In considering the operator's efforts in abating as a mitigating factor in his unwarrantable failure analysis, the Judge credited Cooper's testimony that he intended to file a 7000-1 form to notify MSHA of the accident and that he did so after speaking with Inspector Madrigal. *Id.* at 368-69. Cooper also emailed other MSHA personnel to let them know about the accident.

The Judge, however, failed to acknowledge that Inspector Madrigal was sent to the mine because Inspector Lyons had heard about the accident from miners at a different mine. *Id.* at 338, *citing* Tr. 114.¹⁴ Second, Cooper did not volunteer information to Inspector Madrigal when he arrived. Cooper only mentioned the accident after Madrigal noticed the stretcher sitting by the safety office and started asking questions. Tr. 118. Third, although the Judge credited Cooper's testimony that he intended to file the 7000-1 form, the Judge failed to square this testimony with evidence that Canyon Fuel never reported the August 20 accident. *See* Pet. for Assessment of Civil Penalty at 8 (Citation No. 8541897). Accordingly, substantial evidence does not support the Judge's conclusion that the operator's abatement efforts amounted to a mitigating factor.

As to knowledge of the violation, it is significant that the longwall foreman, John Bonnanci was one of the miners who helped remove Adams from the coal and administered first aid. As a member of management, Bonnanci's knowledge can be imputed to the operator. *See, e.g., Cougar Coal Co.*, 25 FMSHRC at 520 (knowledge of a foreman is imputable to the operator). Thus, the operator had knowledge that Adams had suffered a head injury and was buried in coal, shortly after the accident occurred. Moreover, it is uncontested that Allred had knowledge of the accident at approximately 5:08 p.m. and could have inquired into Adams' condition while speaking on the phone to miners on the section.

¹³ MSHA issued a citation to Canyon Fuel for failure to report the August 20 rib failure within 10 days, but this citation was issued on September 10, 2020, after MSHA had investigated the August 25th accident.

¹⁴ It is not clear from the record if hearing about the accident from the other mine triggered Madrigal's visit or if his visit was coincidental. Lyons testifies that he found out about the accident from talking to miners at the Rhino Mine (Tr. 114) but also testified that MSHA found out about the accident after Madrigal questioned Cooper. Tr. 118. The Judge appears to have inferred that Lyons found out first by talking to miners at the Rhino Mine and instructed his subordinate inspector, Madrigal, to visit the Skyline Mine.

Substantial evidence supports the Judge's determination that the danger caused by the violation was obvious. 45 FMSHRC at 366. The severity of Adams' head injury was immediately observable. Because Adams was buried to the upper torso, miners arriving to dig him out would have been able to observe Adams' head injury. In addition to the laceration cited by the operator, there is testimony credited by the Judge that Adams' skull was visibly "dented in." Tr. 93. Furthermore, the fact that Adams was conscious and alert does not, as the operator alleges, undermine the Judge's findings. In *Cougar Coal*, 25 FMSHRC at 520, the Commission held that "[w]e are not persuaded by [the operator's] assertions . . . that because [the injured miner] was conscious and alert . . . [the operator] could reasonably surmise that [the miner's] injuries lacked the potential to cause death." In *Consol*, 40 FMSHRC at 1006, the Commission emphasized the importance of internal injuries, holding that a limited assessment at the mine which relied on the miner being conscious and alert would not be sufficient to determine the extent of internal injuries to a miner.

Furthermore, the duty to report should have been obvious because there were other indications known to Bonnanci, Allred, and Cooper that Adams' injuries had the potential to cause death: a serious injury to the spinal column requiring a neck brace; Adams had to be removed by a stretcher; Adams needed oxygen to stabilize his condition; and Adams' bandages had to be changed within approximately 30 minutes because his head was continuously bleeding. Tr. 39, 40, 59.

In sum, the Judge erred in concluding that the length of time that the violative condition existed and the operator's abatement efforts were mitigating factors in his unwarrantable failure analysis. We conclude that substantial evidence supports the Judge's findings with respect to the remaining *IO Coal* factors. Accordingly, we affirm the unwarrantable failure finding for Order No. 8541892.

C) Section 110(c) Liability for Allred and Cooper

1) Judge's Decision

The Judge found that Allred and Cooper were agents of Canyon Fuel, that they were in positions to notify MSHA of the accident, that they knew or should have known that the accident compelled them to notify MSHA, and that they failed to do so. 45 FMSHRC at 371-74. The Judge held that Allred, as the person primarily responsible for gathering information on accidents and hazardous conditions, should have known that a high degree of danger was posed to Adams based on the apparent nature of the accident. *Id.* at 375-76. To the extent that Allred did not have all the facts about Adams' condition during the 15-minute window, the Judge observed that Allred was in phone contact with people on site but remained remarkably non-inquisitive, only conducting the most minimal of fact-finding regarding the nature of the accident or Adams' injuries. The Judge found that to the extent that Allred had a good faith belief that he did not have a duty to report an accident when the condition of the miner was unknown, that belief was unreasonable. *Id.* Moreover, even if that belief were reasonable, Allred would have had a duty to immediately report once arriving on scene and seeing the extent of Adams' injuries. *Id.* The

Judge assessed a reduced penalty of \$1,000.00 rather than the penalty of \$4,000.00 proposed by the Secretary, in recognition of Allred's forthrightness at the hearing.

The Judge found Cooper to be particularly liable as an individual and agent of the operator due to his role as a safety professional. *Id.* at 376-77. Although Cooper was on leave during the August 20 rib burst, the Judge believed it likely that he would have reviewed the information about the accident upon his return to the office. *Id.* Moreover, the Judge found Cooper to be similarly uninquisitive in terms of finding out the nature of Adams' injuries. *Id.* The Judge found that Cooper had been poorly trained on when injuries should be reported and acknowledged that this fact mitigated his culpability. *Id.* Accordingly, the Judge assessed a penalty against Cooper of \$1,500.00 rather than the penalty of \$4,300.00 proposed by the Secretary. *Id.*

2) Whether the Judge erred in finding Section 110(c) liability

Canyon Fuel argues that the Judge ignored evidence that Allred and Cooper were acting in good faith within the confines of their understanding of what types of injuries were reportable. The operator states that these men had no reason to believe they were applying the standard incorrectly or that the 15-minute reporting requirement would start before Allred was fully able to investigate the extent of Adams' injury.

Section 110(c) of the Act provides that “[w]henever a corporate operator violates a mandatory health or safety standard,” any agent of the operator “who knowingly authorized, ordered or carried out such violation” shall be subject to penalties. 30 U.S.C. § 820(c). An individual acts knowingly where he is “in a position to protect employee safety and health [and] fails to act on the basis of information that gives him knowledge or reason to know of the existence of a violative condition.” *LaFarge Constr. Materials*, 20 FMSHRC 1140, 1148 (Oct. 1998); *Kenny Richardson*, 3 FMSHRC 8, 16 (Jan. 1981). The Commission has adopted a three-part test for ascertaining personal liability where an agent: (1) knew of or had reason to know of a violative condition, (2) was in a position to remedy the violative condition, and (3) failed to act to correct a violative action. *Peabody Midwest Mining, LLC*, 44 FMSHRC 515, 526 (Aug. 2022). Further, with respect to this standard, we note (as the Third Circuit did) that operators should resolve doubts in favor of notifying MSHA. *Consol Pa. Coal Co., LLC*, 941 F.3d at 103.

In the case of both Allred and Cooper, the record is clear that both men were in positions to remedy the violative condition. Both had access to a phone, capable of reaching MSHA directly, or reaching someone on the surface who could make the call on their behalf. Tr. 283, 288, 324. Both Allred and Cooper collectively made the decision not to call MSHA. Tr. 288. Allred was specifically designated as the person on the shift responsible for making such notifications. Tr. 258-59, 306. Cooper, as the mine safety manager, would have also been familiar with the process of contacting MSHA and was authorized to do so. Tr. 324.

It is also undisputed that Allred and Cooper failed to act to correct the violation. Allred insisted on personally observing Adams' injuries before deciding not to call MSHA. Tr. 288. Cooper did not formally file a notification until the next day, after speaking with Inspector Madrigal. Tr. 315.

As to the remaining question of whether Allred and Cooper knew or had reason to know of a violative condition, substantial evidence supports the Judge's determination that Allred and Cooper should have known that they had a duty to report the accident. In a short conversation at 5:08 p.m., Allred was informed that there was an accident that had resulted in Adams being covered with coal along the 8-bay of the longwall. Tr. 262-63. Based on the nature of the accident, Allred "assumed the worst" and decided to send for an ambulance. Tr. 288. Moreover, Allred and Cooper would have known that Adams had sustained a serious head injury if they had made the proper inquiries. Miners on the scene of the accident, including members of mine management, knew that Adams was injured. Tr. 233-34. Adams was complaining of pain in his leg and back and he had a visible wound to the head—a laceration and a denting of the skull. *Id.* at 234.

Both Allred and Cooper had more than enough information to be aware that a reportable accident had occurred. The 15-minute reporting timeframe began once Allred became aware that Adams was injured from a rib burst and was buried in coal. It was unreasonable for Allred and Cooper to believe that the decision on whether the injury was reportable required Allred to travel to Adams and personally inspect his injuries. The standard governing reporting of serious accidents demands a prompt assessment of the facts and clearly does not contemplate a single member of mine management having to travel 40 minutes to the site of the accident before a decision to call MSHA is made. Accordingly, we affirm the section 110(c) penalties against Allred and Cooper.

III.

Conclusion

For the foregoing reasons, we: (1) reverse the Judge's determinations on negligence and unwarrantable failure for Order No. 8541891; (2) affirm the holdings of violations in Order Nos. 8541891 and 8541892; (3) affirm the Judge's section 110(c) penalties against Allred and Cooper; and (4) vacate and remand the civil penalty for Order No. 8541891 for reassessment consistent with the negligence and gravity findings in this decision and the statutory minimum penalty for section 104(d)(1) citations and orders. *See* 30 U.S.C. § 820(a)(3)(A).



Mary L. Jordan, Commissioner



Timothy J. Baker, Commissioner



Moshe Z. Marvit, Commissioner

Chair Rajkovich, concurring in part and dissenting in part:

I concur with the majority in affirming the holdings of violations for Order Nos. 8541891 and 8541892 and the section 110(c) penalty against Allred. I also concur, in result only, with the majority’s decision to affirm the significant and substantial (“S&S”) designation for Order No. 8541892. Specifically, I reject the S&S test applied by the majority but agree that substantial evidence supports the Judge’s S&S designation under the Commission’s traditional S&S test. Finally, I dissent from the majority’s reversal of the Judge’s negligence and unwarrantable findings for Order No. 8541891 and the majority’s affirmance of the section 110(c) penalty against Cooper.

A) Order No. 8541891

I agree with the majority’s finding that Order No. 8541891 is not duplicative of Citation No. 8541894 in light of the settlement of the latter citation.

Additionally, I agree with the majority in affirming the Judge’s finding of a violation. The majority properly rejected Canyon Fuel’s argument that the Judge should have applied the “reasonably prudent person” test, as the Commission has already determined that this test is not appropriate for alleged violations of 30 C.F.R. § 75.202(a). *Jim Walter Res.*, 37 FMSHRC 493, 495 (Mar. 2015). However, I disagree insofar as the majority implies the reasonably prudent person test is *never* appropriate in light of the Mine Act’s strict liability framework. Slip op. at 6-7 n.9. The Commission has consistently applied the reasonably prudent person test to broadly worded standards.¹⁵ *E.g.*, *Ideal Cement Co.*, 12 FMSHRC 2409, 2415 (Nov. 1990); *U.S. Steel Mining Co.*, 27 FMSHRC 435, 439 (May 2005).

While I also agree that the Judge’s negligence findings are not supported by substantial evidence, unlike the majority, I would not find that the record compels a finding of high negligence and unwarrantable failure. In reducing the degree of negligence and removing the unwarrantable failure designation, the Judge found that the violative condition posed a high degree of danger, that the operator made efforts to mitigate the hazard but knew these efforts were insufficient, that the operator was only on notice for five days, and that the hazard was not necessarily obvious. Taking these together, he concluded that the degree of negligence was not aggravated, but then he also described the operator’s actions as a “significant breach of the duty of care.” 45 FMSHRC 328, 345-46 (May 2023) (ALJ).

The majority emphasizes the Judge’s culpability findings—the operator knew its efforts were insufficient and breached its duty of care—and reasonably states that these are inconsistent with reduced negligence. Slip op. at 8. However, I note that the *culpability findings themselves* are not supported by the record. There is no direct testimony that the operator knew its efforts to mitigate the hazard were insufficient. The Judge appears to rely solely on the occurrence of a rib roll at a different location in the same section, five days earlier, to suggest that the operator

¹⁵ With respect to Order No. 8541892, the majority acknowledges that the cited standard asks “whether a reasonable person in the circumstances would view [a miner’s injury] as having a reasonable potential to cause death.” Slip op. at 12.

should have known its efforts were insufficient. However, the record does not provide sufficient detail regarding the method of securing the rib, the cause of the rib roll, or other relevant conditions in each location of the multi-entry mine section to determine if the first incident would have put a reasonably prudent operator on notice that *different* rib control was needed in the second location. Absent sufficient contextual evidence, I do not find the simple fact of a prior rib roll sufficient to establish aggravated culpability. Since the Judge's culpability findings are unsupported by the record, they do not justify reversing the Judge and establishing high negligence and an unwarrantable failure.

However, I also find that the Judge's *mitigating* factors are unsupported by the record. I agree with the majority that substantial evidence does not support the Judge's finding that the hazardous condition was nonobvious. Slip op. at 9. Additionally, the record does not support the Judge's finding that the operator took specific efforts to mitigate the hazard. While additional rib controls were installed after the first rib roll, nothing in the record indicates this was *because of* the first rib roll. Instead, it appears to have simply been coincidental timing resulting from the operator's routine rib control efforts. Tr. 440; *see also* Tr. 358, 363-66, 373, 418. As the Judge's negligence and unwarrantable failure findings turned on considerations unsupported by the record, I would reverse and remand for reanalysis.

B) Order No. 8541892

I agree with the majority that the Judge did not err in finding that a violation occurred, or in finding that the violation was the result of an unwarrantable failure.

With respect to the S&S analysis, I find that the Judge did not err in affirming the S&S designation for Order No. 8541892 *or* in applying the Commission's traditional S&S test. The Act defines an S&S violation as one "of such nature as could significantly and substantially contribute to the cause and effect" of a hazard. 30 U.S.C. § 814(d)(1). The Commission has traditionally found that a violation is properly designated as 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." *Mathies Coal Co.*, 6 FMSHRC 1, 3-4 (Jan. 1984). As subsequently refined, this S&S test requires:

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

Peabody Midwest Mining, LLC, 42 FMSHRC 379, 383 (June 2020).

In *Consol Pennsylvania Coal Company*, a two-Commissioner majority rejected this traditional test and held that pursuant to the plain language of the Act, the Secretary need only "demonstrate that the violation to which miners are exposed *could* make an S&S contribution to a mine safety or health hazard." 47 FMSHRC 793, 823 (Sept. 2025) (emphasis in original).

The majority explained that forty years of “tinkering” in an attempt to “clarify the meaning of the phrase ‘significantly and substantially’” had resulted in a “problematic” test that was divorced from the statutory language and determined that a return to the plain language of section 104(d) would address this issue. *Id.* at 806, 811. Here, the majority applies the *Consol* framework and concludes that Order No. 8541892 was properly designated as S&S.

I reject the S&S test put forward by the two-Commission majority in *Consol*. I acknowledge that the traditional S&S test has become rather convoluted. However, returning to the “plain language” of section 104(d) will not resolve the issue, because the language is not plain. The Commission has spent forty years tinkering precisely because the meaning of “significantly and substantially contribute” is unclear. By stripping away all existing guidance and simply asking Judges to determine whether a violation could significantly and substantially contribute to a hazard, *Consol* may be setting up the Commission for another forty years of tinkering.

The complications in our existing test arise from the complicated nature of section 104(d), and I do not find that *Consol* adequately addresses those complications. Additionally, depending on how the words “could” and “significantly and substantially contribute” are ultimately defined under a refined *Consol* framework, virtually all non-technical violations could be designated as S&S, which is definitely contrary to the Mine Act’s graduated enforcement scheme. *See* 30 U.S.C. § 814. While the existing framework may not be perfect, I would not overturn it simply to replace it with a test that is already problematic. Unless and until a new test is developed that simplifies and improves upon the existing test, I would continue to apply the *Mathies / Peabody* test.

Here, substantial evidence supports the Judge’s finding that the violation was properly designated as S&S under the traditional *Mathies / Peabody* framework. In the context of reporting violations, the hazard against which the standard is directed may be interference with immediate rescue efforts or the recurrence of a similar accident due to interference with MSHA’s ability to investigate. *See Signal Peak Energy, LLC*, 37 FMSHRC 470 (Mar. 2015). The latter is relevant here. The Judge concluded that (1) a violation had been established; (2) the violation was reasonably likely to result in another similar occurrence arising from MSHA’s inability to promptly investigate; (3) the similar occurrence that was reasonably likely to result was also reasonably likely to result in a similar injury from falling rib material; and (4) it is reasonably likely that any such injury would be serious. 45 FMSHRC at 361-63. The record establishes that the accident site had been cleared by the time the inspector arrived to inspect it (Tr. 481), thereby frustrating MSHA’s investigation efforts. Additionally, the accident at issue resulted in serious injury, and another rib failure had occurred in the same section five days prior. The record substantially supports the Judge’s findings that the failure to report hindered MSHA’s ability to investigate the cause of the accident, that hindering MSHA’s investigation into the cause of the accident was reasonably likely to result in a similar rib fall, and that any resulting injury would likely be serious.

I reject the test applied by the majority and would instead find that substantial evidence supports the Judge’s S&S finding under the traditional *Mathies / Peabody* framework. Accordingly, I concur in result only with respect to the S&S designation for Order No. 8541892.

C) Personal Liability Assessments

I concur with respect to the personal liability assessed against Allred, but dissent with respect to the personal liability assessed against Cooper. The record does not substantially support a finding that Cooper knew or had reason to know of the violative condition. *E.g., LaFarge Constr. Materials*, 20 FMSHRC 1140, 1148 (Oct. 1998).

As the majority notes, Allred had opportunities to make on-scene inquiries and examine the injured miner, which would have provided him with information clearly indicating that the injury was reportable, but failed to do so. Additionally, he “assumed the worst” and sent for an ambulance but still failed to report the injury. Slip op. at 18.

Conversely, the record indicates that Cooper made efforts to gather information, and the information he was able to gather did not necessarily indicate a reportable accident. Cooper was off-site when the accident occurred. When he was first informed of the accident he asked if there was a serious or life-threatening injury, but the mine monitor did not know. Tr. 300-02, 323. After alerting other members of mine management, Cooper called the mine monitor again, asked if there was new information, and was told there was not. Tr. 303. Once Cooper arrived at the mine, he asked Allred if the miner had any life-threatening injuries. Allred informed him that the miner was complaining of back, neck and leg pain, but that the injuries were not life threatening. Allred and Cooper disagree as to whether Allred mentioned a laceration on the miner’s forehead. Tr. 274, 289, 303-04, 325. There is no testimony that Allred mentioned the need for a cervical collar, stretcher, or oxygen. In essence, Cooper made multiple inquiries into the status of the miner’s injuries, and the information provided by the mine safety manager did not include any indications of a serious injury, such as potential damage to the head or spine. The record does not support a finding that Cooper knew or had reason to know of a reportable injury.

D) Conclusion

For the reasons above, I would therefore: (1) affirm the holding of a violation in Order No. 8541891, the holding of a violation and significant and substantial designation in Order No. 8541892, and the section 110(c) penalty assessed against Allred; (2) reverse and remand the Judge’s determinations on negligence and unwarrantable failure for Order No. 8541891; (3) and reverse the section 110(c) penalty assessed against Cooper.



Marco M. Rajkovich, Chair

Distribution:

R. Henry Moore, Esq.
Arthur M. Wolfson, Esq.
Patrick W. Dennison, Esq.
Fisher & Phillips LLP
Six PPG Place, Suite 830
Pittsburgh, PA 15222
hmoore@fisherphillips.com
awolfson@fisherphillips.com
pdennison@fisherphillips.com

Thomas A. Paige, Esq.
Office of the Solicitor
U.S. Department of Labor
Division of Mine Safety and Health
200 Constitution Avenue NW, Suite N4428
Washington, DC 20210
Paige.Thomas.a@dol.gov

Melanie Garris
US Department of Labor/MSHA
Office of Assessments, Room N3454
200 Constitution Ave NW
Washington, DC 20210
Garris.Melanie@dol.gov

Acting Chief Administrative Law Judge Michael Young
Federal Mine Safety & Health Review Commission
Office of the Chief Administrative Law Judge
1331 Pennsylvania Avenue, NW, Suite 520N
Washington, DC 20004-1710
myoung@fmshrc.gov