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SOL (MSHA) V. ONEIDA COAL
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Federal Mine Safety and Health Review Commission (F.M.S.H.R.C.)
Office of Administrative Law Judges

SECRETARY OF LABOR, MINE SAFETY AND HEALTH ADMINISTRATION (MSHA), PETITIONER	CIVIL PENALTY PROCEEDING Docket No. WEVA 88-204 A.C. No. 46-06846-03517
v.	Oneida Mine No. 12
ONEIDA COAL COMPANY, INC., RESPONDENT	

DECISION

Appearances: James H. Swain, Susan M. Jordan, Esqs., Office of the Solicitor, U.S. Department of Labor, Philadelphia, Pennsylvania, for the Petitioner; W. T. Weber, Jr., Esq., Weston, West Virginia, for the Respondent.

Before: Judge Koutras

Statement of the Proceeding

This proceeding concerns civil penalty proposals filed by the petitioner against the respondent pursuant to section 110(a) of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. 820(a), seeking civil penalty assessments for two alleged violations of the mandatory accident reporting requirements found in Part 50, Title 30, Code of Federal Regulations. The respondent filed a timely answer contesting the proposed civil penalties, and a hearing was held in Charleston, West Virginia. The parties filed posthearing arguments, which I have considered in the course of my adjudication of this matter.

Issues

The issues presented in this case are (1) whether the conditions or practices cited by the inspector constitute violations of the cited mandatory standards, and (2) the appropriate civil penalties to be assessed for the violations, taking into account the statutory civil penalty assessment criteria found in section 110(i) of the Act.

The crucial issue in this case is whether or not a purported "accident" which prompted the issuance of the violations, was in fact a reportable accident within the definition of the term "accident" found in 30 C.F.R. 50.2(h)(2).

Applicable Statutory and Regulatory Provisions

1. The Federal Mine Safety and Health Act of 1977, Pub. L. 95-164, 30 U.S.C. 801 et seq.

2. Section 110(i) of the 1977 Act, 30 U.S.C. 820(i).

3. Mandatory accident reporting standards 30 C.F.R. 50.10 and 50.12.

4. Commission Rules, 29 C.F.R. 2700.1 et seq.

Stipulations

The parties stipulated to the admission of certain documents, and also stipulated to the following (Tr. 5-6).

1. The respondent and its controlling company are subject to the Act, and the presiding judge has jurisdiction to hear and decide this matter.

2. The inspector who issued the contested citations was acting in his capacity as a duly authorized representative of the Secretary of Labor.

3. A true and correct copy of each of the citations was properly served on the respondent's representative.

4. Imposition of civil penalties for the alleged violations will not adversely affect the respondent's ability to continue in business.

5. The respondent's history of prior violations is reflected in an MSHA computer print-out, exhibit P-7, and it is correct.

6. The respondent is a medium-size coal mine operator who produced 1.4 million tons of

coal in 1987, and its Mine No. 12 produced 477,466 tons of coal for that same year.

7. The injured miner in question, James Mullens, was a miner employed by the respondent on December 7, 1987.

Discussion

The undisputed facts in this case establish that on Monday, December 7, 1987, continuous-mining machine operator James Mullens, who was working on the afternoon shift on the L-2 Section of the underground mine in question sustained injuries at approximately 8:30 p.m. to 9:00 p.m., when he was pinned against a coal rib by the machine cable restraining clamp. Mr. Mullens was the operator of the remote controlled machine, and after receiving first-aid underground, he was removed from the mine and taken to the Braxton County, West Virginia Hospital by ambulance where he was treated in the emergency room. He was then transported to the West Virginia University Medical Center in Morgantown, West Virginia, by helicopter. Following an accident investigation by MSHA, Inspector Richard Herndon served the respondent with two citations, and they are as follows:

Section 104(a) Non-"S&S" Citation No. 2944551, issued on December 9, 1987, cites an alleged violation of mandatory accident reporting standard 30 C.F.R. 50.10, and it states as follows:

> The operator failed to notify MSHA immediately at the occurrence of a serious accident to James Mullens at approximately 9:00 p.m. 12-7-87. MSHA was not made aware of the accident until 4:30 p.m. 12-8-87.

Section 104(a) Non-"S&S" Citation No. 2944552, issued on December 9, 1987, cites an alleged violation of 30 C.F.R. 50.12, and it states as follows:

> The operator was not granted permission by MSHA to continue operation or alter the accident site or related area on the L-2 section where a serious accident occurred 12-7-87. Due to the continuing of the mining cycle the scene of the accident and subsequent maintenance of the Joy 14CH the scene of the accident was altered.

Testimony and Evidence Adduced by the Petitioner

Dr. Jose Bordonada, testified as to his education and experience, and he confirmed that he practices medicine at the Braxton County Memorial Hospital in Gassaway, Braxton County, West Virginia. He also confirmed that his experience includes 18 years of practice in general surgery, a fellowship in abdominal surgery, and that he has extensive experience in treating traumatic injury patients in emergency situations, including emergency room treatment for vehicular chest and abdominal injuries. Dr. Bordonada was qualified and admitted as an expert medical witness (Tr. 18-22).

Dr. Bordonada confirmed that he was the hospital emergency room attending physician on December 7, 1987, and he treated the respondent's employee James Mullens on that day. Referring to a copy of the hospital emergency department outpatient record, (exhibit P-1), Dr. Bordonado explained the information appearing therein, as well as several notations which he made in the course of his examination and treatment of Mr. Mullens.

Dr. Bordonada stated that according to his notations, Mr. Mullens was pinned against a rock and miner across his upper abdomen and lower chest, and that he was complaining of severe abdominal pain, tenderness, back pain, and numbness and weakness of his lower leg. He further explained that his examination of Mr. Mullens' head, eyes, ear, nose, and throat were all negative, but that his abdomen was rigid and tender which was a sign "of something going on, especially over the left upper quadrant" (Tr. 24). He also confirmed that Mr. Mullens' lumbar dorsal spine, or abdomen, chest, and pelvis were x-rayed, and that certain blood tests were taken. Mr. Mullens was given demoral for his pain, and phenergan and peritoneal lavage medications were also administered as part of his diagnostic procedures. His diagnosis indicated "intra-abdominal bleeding, ruptured spleen compression fracture L5, with left hemiparesis, and a renal contusion" (Tr. 27).

With regard to page two of the hospital report, Dr. Bordonada confirmed that his notation reflects that he discussed Mr. Mullens' case with a Dr. Monger, West Virginia University Hospital, and that Dr. Monger agreed to accept a transfer of Mr. Mullens to that facility by helicopter (Tr. 28). Dr. Bordonada also explained the further treatment he administered to Mr. Mullens after he arrived at the emergency room, and he believed that Mr. Mullens had suffered intra-abdominal injuries, with possible nerve injuries to his lower leg. He also explained the notations he made on page

four of the hospital report, and confirmed that from the results of the blood tests administered to Mr. Mullens, he concluded that Mr. Mullens showed signs of intra-abdominal bleeding, which is a serious condition, and usually indicative of a ruptured spleen. He indicated further that a ruptured spleen is not to be taken lightly, and that a patient could "go into shock in a matter of a few minutes." If a patient were to go into shock, his blood supply to the brain and heart could be jeopardized, and the patient could develop a heart attack and die (Tr. 29-33).

Dr. Bordonada stated that a urinalysis conducted on Mr. Mullens reflected 20 to 30 red blood cells in his urine, and this would indicate a contusion of the kidney (Tr. 33). He also confirmed that the last page of the report is the x-ray report and the interpretations made by the radiologist who made the report. Although the reports were essentially negative, Dr. Bordonada stated that he still suspected an L5 fracture because such an injury is consistent with the patient's complaint of weakness and decreased sensation of the lower left extremity (Tr. 34). Dr. Bordonada confirmed that he immediately requested the assistance of a MediVac helicopter because of his "suspicion of the kind of injury that needs more work-up and treatment," and that this would be available to Mr. Mullens at another facility (Tr. 35).

In response to a question with respect to the severity of Mr. Mullens' injuries, Dr. Bordonada responded as follows (Tr. 355-36):

> Q. Doctor, do you have any opinion with respect to whether or not the injuries sustained by James Mullens on December 7, 1987, presented a reasonable potential to cause death?
>
> A. Yes, sir.
>
> Q. What is that opinion?
>
> A. I believe we are dealing here with a serious case of a case, and that is really threatening his life.
>
> JUDGE KOUTRAS. Would you repeat that again? The last part.
>
> THE WITNESS: I believe this case, that his life is threatened.

BY MR. SWAIN:

Q. Why did you think that his life was threatened?

A. Because of the nature of the injury that he received.

Q. In what respect were those injuries life threatening?

A. On the record, it was even mentioned. This gentlemen was pinned with this miner in the lower chest, one would also suspect a contusion of the heart, and there's a big thing that they also observed in Morgantown but at that time, the real prominent situation is in the abdomen, and which like I mentioned, there are signs of intra-abdominal bleeding. This is the one I worried -- I've seen a lot of patients who go into shock just right there, and the patient exterminated right before your eyes. That happened to me many times.

In response to a question as to whether or not the respondent or its safety director Edward Bauer asked him whether or not the injuries sustained by Mr. Mullens had a reasonable potential to cause his death, Dr. Bordonada replied "I don't think so" (Tr. 36). Dr. Bordonada also denied that Mr. Bauer ever mentioned that such an inquiry was related to any legal reporting requirement (Tr. 37). In the event he were asked for an opinion whether or not the injuries were life threatening, Dr. Bordonada stated that "my answer would be positive" (Tr. 37).

On cross-examination, Dr. Bordonada confirmed that he first saw Mr. Mullens at the hospital at 9:30 p.m., on the evening of December 7, 1987. He confirmed that Mr. Mullens was conscious, and that his blood pressure was within normal limits, his pulse rate was "abnormally high," and that his respiratory rate was "too high" (Tr. 40). Dr. Bordonada was of the opinion that the pulse rate is significant and indicative of the possibility of intra-abdominal bleeding, and although Mr. Mullens was bleeding from a lacerated finger, he did not believe that this was related to the high pulse rate. Dr. Bordonada stated that he confirmed that Mr. Mullens had internal abdominal bleeding when he inserted a needle and

found bloody fluid. This "tap" was done at 10:45 p.m., according to the hospital report (Tr. 42).

Dr. Bordonada confirmed that Mr. Mullens arrived at the hospital by ambulance, and that there "were some people" with him. He also confirmed that he knew Mr. Bauer and had "seen him around whenever there's a mine injury." He also knew that Mr. Bauer was "involved" with the respondent company, and that he was at the hospital asking questions (Tr. 44). When asked whether he made a statement to Mr. Bauer after 9:30 and before 10:45 p.m., that he did not believe that Mr. Mullens' injuries were life threatening, Dr. Bordonada replied "I don't believe so." He also stated that "I don't recall any conversation of such nature," but "It's most possible, because I talk to so many people when you go out of the room" (Tr. 45). When asked whether he had a second conversation with Mr. Bauer at approximately 10:00 p.m., during which Mr. Bauer asked him whether or not the injuries sustained by Mr. Mullens had a reasonable potential for death, Dr. Bordonada replied "I would say no, but it's possible that I talked to him," and that it was possible that he had that conversation (Tr. 45).

Dr. Bordonada confirmed that his great concern with respect to the life threatening aspects of the injuries sustained by Mr. Mullens was with respect to his belief that Mr. Mullens may have ruptured his spleen, and that this would have been some time after 10:45 p.m., after he had done the abdominal tap (Tr. 48). He agreed that his call for a helicopter evacuation was received by the hospital in Morgantown at 10:57 p.m., and that the helicopter arrived at the Braxton Hospital at approximately 11:55 p.m., and left for Morgantown with Mr. Mullens at 12:30 a.m., December 8 (Tr. 49-50).

Dr. Bordonada confirmed that Mr. Mullens did not in fact have a ruptured spleen or any fractured vertebrae, but that he did have a sprained leg, a cut finger, and a lumbar plexus contusion or bruise to the loose nerves that supply the leg. In his opinion, these injuries did not present a reasonable potential to cause death (Tr. 52-53).

Robert Stump, section foreman, stated that he was the section foreman on December 7, 1987, when the incident concerning Mr. Mullens occurred. He confirmed that he was summoned to the area by one of his buggy operators, and when he arrived he observed Mr. Mullens between the cable stand-off of the miner and the rib (Tr. 60). He described the "cable stand-off" as the metal compartment that holds the miner cable to the machine. Mr. Stump stated that when he first observed Mr. Mullens, he could not tell whether he was conscious. He

explained that Mr. Mullens was in a sitting position with the cable stand-off "pressing up against him," and Mr. Mullens' back was "to the coal rib." Mr. Stump confirmed that the miner pump motor was still running, and that he shut it off. He described the mining machine as approximately 30 feet long and that it weighed approximately 12 tons (Tr. 59-62).

Mr. Stump stated that he sent the buggy operator to get help, and that he (Stump) supervised the placing of Mr. Mullens on a back board and taking him out of the mine. Mr. Stump confirmed that he supplied the information which appears on the respondent's accident report form, as well as the information from which the sketch attached thereto was made, and that he also discussed the incident with Mr. Harold Hayhurst, the individual who completed the report, but that Mr. Hayhurst was not present when Mr. Mullens was extricated from the miner and taken out of the mine (Tr. 62-63; exhibit P-3).

MSHA Inspector Richard Herndon stated that he is a special investigator, and he testified as to his experience and background, and confirmed that he and three other inspectors conducted an investigation at the mine on December 7, 1987, with respect to the incident concerning Mr. Mullens. He identified a copy of MSHA's accident report, and confirmed that he issued the two contested citations in this case (Tr. 64-67; exhibit P-6).

Referring to the accident report, Mr. Herndon stated that at approximately 4:30 p.m., on Tuesday, December 8, 1987, the respondent's safety director Edward Bauer, notified MSHA's Clarksburg, West Virginia, field office, that a serious accident had occurred at the mine on the previous day on the afternoon shift sometime between 8:30 and 9:00 p.m., and that "a man was pinned between a continuous miner and the coal rib," and had been transported to the West Virginia University Medical Center. The MSHA supervisor to whom the accident was reported (James Satterfield) issued a verbal section 103(k) order over the telephone to Mr. Bauer, and the effect of that order was to "freeze the accident site" so that an investigation could be conducted (Tr. 67-68). Mr. Herndon confirmed that he was aware of the regulatory definition of an "accident" as found in section 50.2(h), and that as a result of the investigation, he determined that mine management had knowledge of the fact that there was an injury to a miner that had a reasonable potential to cause death prior to the time it was reported at 4:30 p.m., on December 8, 1987 (Tr. 72). Mr. Herndon further confirmed that he came to this conclusion in light of the fact that the miner was transferred from Braxton County to the University Medical Center, and that his

interviews with people at the mine suggested that Mr. Mullens had suffered internal injuries (Tr. 73).

Mr. Herndon identified a copy of the respondent's accident report (exhibit P-3), and he confirmed that he did not see it or review it during his investigation. However, he confirmed that during the course of the investigation he spoke with Mr. Hayhurst, the individual who prepared the report, and Mr. Hayhurst showed him a drawing of the accident scene which is similar to the one attached to the report (Tr. 74).

Mr. Herndon stated that during the investigation, he determined and "understood" that Mr. Mullens had "sprains, injury to, I believe, the L5 vertebra, possible internal injuries, plus abrasions and various contusions." On the basis of this information, he concluded that an accident had occurred, and that it was required to be reported immediately (Tr. 75). With regard to Mr. Mullens' condition at the time of the accident, Mr. Herndon stated that according to the witnesses who were interviewed, Mr. Mullens was found with the miner restraining clamp block against his chest, and that he was against the rib in an unconscious state. After the machine was moved away, Mr. Mullens was semi-conscious, and after first-aid was administered, he was taken by ambulance to the Braxton Hospital, and then transported by helicopter to the University Medical Center later that evening (Tr. 76).

Mr. Herndon was of the opinion that the respondent should have reported the accident immediately at the time Mr. Mullens was transported to the Braxton Hospital because he had internal injuries and the scope of those injuries were not known (Tr. 77). In this regard, he stated as follows at (Tr. 76):

> Q. Based on what information did you conclude that these injuries that Mr. Mullens had received had a reasonable potential to cause death?
>
> A. Based on, really, past experience, and the fact that I have done accident investigations in the past of this type, as well as reviewing reports from across the country, this type of an accident has, in many cases, become fatalities. As a matter of fact, I believe it was in 1983, the first fatality of the year was this type of an injury, where a person was crushed between a miner and the rib.

And, at (Tr. 112):

> JUDGE KOUTRAS: In other words, the fact that Mr. Mullens didn't die, didn't in effect, reaffirm your past experience with incidents of this kind.
>
> THE WITNESS: The fact that Mr. Mullens didn't die does not make the determination of whether or not it was an accident. When Mr. Mullens was injured, there was the potential for a fatality. * * * *

Mr. Herndon believed that Mr. Bauer accompanied Mr. Mullens to the hospital, and confirmed that no MSHA representatives were at the hospital because MSHA was not aware of the fact the accident had occurred (Tr. 77).

With regard to his gravity findings concerning the section 50.10 violation, Mr. Herndon confirmed that while the violation was not "significant and substantial" he believed the failure to immediately report the accident was a serious violation because MSHA needs to immediately investigate such incidents while the accident scene is undisturbed in order to obtain knowledge of the facts so that appropriate action is taken to prevent repeat accidents. Mr. Herndon confirmed that he based his "high negligence" finding on the fact that the respondent was aware of the seriousness of the accident on the evening of December 7, and was aware of the fact that MSHA should have been notified (Tr. 79-80). The violation was abated by explaining to the respondent the Part 50 requirement for immediately reporting accidents (Tr. 80).

Mr. Herndon confirmed that he cited a violation of section 50.12, because the respondent continued mining after the accident, and made some changes to the mining machine, and that this hampered MSHA's investigation of the accident. When the accident was reported some 20 hours later, the operator did not have permission to continue mining since a section 103(k) order was issued at that time. Mr. Herndon stated that during the 20-hour period prior to the report to MSHA, the entry where the accident had occurred had been mined to completion and the continuous-mining machine right-hand traction motor had been replaced. The machine was also moved to a different entry (Tr. 82-84). Mr. Herndon confirmed that the machine was operated by remote control, and that Mr. Mullens was the operator at the time of the accident (Tr. 85). Petitioner's counsel agreed that by the time the accident was reported by Mr. Bauer the changes to the accident scene and

the mining machine had already taken place (Tr. 86). Inspector Herndon confirmed that the old traction motor was removed from the property, and MSHA was unable to determine whether any motor malfunction caused the accident (Tr. 95).

Mr. Herndon believed the violation was serious because by changing the scene, MSHA could make no determination as to the actual cause of the accident. He based his "high negligence" finding on the fact that the respondent was aware of the seriousness of the injury sustained by Mr. Mullens, but did not report it. Abatement was achieved by explaining the requirements of section 50.12 to the respondent (Tr. 95-96).

On cross-examination, Mr. Herndon confirmed that he relied on the definition of "accident" as found in section 50.2(h), to support the violations which he issued. He conceded that the definitional language does not use the word "serious," and if an accident had not occurred, the respondent was not required to report it or to preserve the scene (Tr. 97).

Mr. Herndon explained his investigative procedure, and he confirmed that neither Dr. Bordonada or anyone else at the Braxton Hospital were interviewed, and that the hospital records at Braxton and the University of West Virginia were not reviewed (Tr. 98). Mr. Herndon described the mining machine cable restraining clamp which had pinned Mr. Mullens to the rib (Tr. 102-105). He also identified the witnesses who were interviewed during the investigation, and confirmed that the cause of the accident was never factually determined and there were no eye witnesses (Tr. 105-110).

In response to further bench questions, Mr. Herndon confirmed that at the time of the investigation, the miner motor which had been removed from the machine was disassembled and in the repair shop, but that no MSHA electrical inspector looked at it, notwithstanding the fact that there was some indication that it was "shorting out inside." In response to a question as to why the hospital records were not reviewed during the investigation, Mr. Herndon stated that "we have had problems getting these reports," and he conceded that no attempts were made to obtain the records during the investigation (Tr. 116-117). In reply to a question as to the source of the information which appears at page 2 of MSHA's accident investigative report (exhibit P-6), concerning the Braxton Hospital diagnosis of the injuries sustained by Mr. Mullens, Mr. Herndon stated that the information was supplied by Mr. Bauer (Tr. 118).

Respondent's Testimony and Evidence

Robert B. Stump, section foreman, stated that he was the section foreman on December 7, 1987, when Mr. Mullens was injured, and he confirmed that he has received specialized medical or health training, and that he is a certified Emergency Medical Technician (EMT), licensed by the State of West Virginia, and certified through the National Registry. He also confirmed that he serves on the local Hacker Valley Medical Service Ambulance and Emergency Squad, and that on a dozen or more occasions has rendered services at accident scenes involving traumatic injuries and fatalities. He explained the procedures he follows during his examination of such patients (Tr. 120-126).

Mr. Stump stated that he became aware of the incident involving Mr. Mullens when he was summoned to the scene by Mr. Sheldon Simmons, the buggy operator. Mr. Stump stated that when he arrived at the scene, he saw Mr. Mullens between the rib and the continuous miner cable stand-off, and he passed by him and shut off the machine. Mr. Mullens was in a sitting position, with his left knee into his chest, between his chest and the cable stand-off. After turning off the machine, Mr. Stump looked at Mr. Mullens, and 15 seconds later, Mr. Mullens stated "Get me out of here, I'm hurt." Mr. Stump then re-started the machine and trammed the miner away from Mr. Mullens. He then examined Mr. Mullens and determined that he was able to breathe and speak to him, and that "he did have an airway." Mr. Mullens was then placed in a reclining position, and Mr. Stump continued his examination and explained what he did. He confirmed that he found discoloration of the chest, apparent discomfort of the upper abdomen, and a bruised upper left leg. After administering further aid, Mr. Mullens was placed on a back board and transported out of the mine (Tr. 126-131).

Mr. Stump stated that on the basis of his examination of Mr. Mullens he did not believe that the injuries he had received had a reasonable potential to cause his death (Tr. 132). He confirmed that he reported the incident to his shift foreman Harold Hayhurst by telephone approximately 15 minutes after it occurred, and that Mr. Hayhurst called for an ambulance. Mr. Stump then assembled his crew at the power center to "settle them down, because everyone was excited," and he waited for Mr. Hayhurst to call him back. Mr. Hayhurst called him back and advised him that he would come to the area as quickly as possible. After Mr. Hayhurst arrived at the scene, they measured the accident area and made a sketch of

the scene which is included as part of the respondent's accident report, exhibit P-3. Mr. Hayhurst then left the area, and at approximately 10:30 to 10:45, he authorized Mr. Stump to "start running coal or go back to work" (Tr. 134).

On cross-examination, Mr. Stump stated that Mr. Hayhurst did not accompany Mr. Mullens to the hospital, and that during his conversations with Mr. Hayhurst, he expressed concern about Mr. Mullens, and asked "what shape that I thought James was in," and whether "I thought he was hurt bad." Mr. Stump confirmed that Mr. Hayhurst based his accident report on the information that he (Stump) supplied him, but that he did not observe Mr. Hayhurst filling out the report. Mr. Stump also confirmed that the information on the report form that Mr. Mullens had suffered "possible internal injuries," was based on his examination which indicated that Mr. Mullens was experiencing palpitation of the upper abdomen, some discomfort in his legs, and had trouble moving them. Mr. Stump was of the opinion that Mr. Mullens could not have been alone for more than 90 seconds before he was discovered, and that his examination of Mr. Mullens reflected a very full pulse rate which was somewhat rapid because of "fear and anxiety," but "not enough to be overly concerned about" (Tr. 139).

Mr. Stump stated that Mr. Mullens was pinned against the rib by the restraining clamp of the machine, and while he could have pulled Mr. Mullens out without moving the machine, he decided to move the machine away so that he could have access to him and not cause any further injury (Tr. 142). Mr. Stump stated that his experience with past traumatic injury cases involved cases in which two-thirds of the victims were already dead at the scene, and one-third had injuries that would have a reasonable probability to cause death and the victims were not conscious. He confirmed that he had no prior experience at the mine where he made any assessment as to whether or not any injury had a reasonable probability of death. He also confirmed that he was aware of MSHA's injury reporting requirements, but had never previously made any recommendations or a report which had to be immediately reported to MSHA (Tr. 143).

Mr. Stump confirmed that he was interviewed by Inspector Herndon during the course of the investigation, but he could not recall informing the inspector about his medical training, or whether the inspector asked him about it. He also confirmed that the inspector never inquired as to the diagnosis that he made of Mr. Mullens' injuries, and he could not recall discussing the reporting requirements with the inspector (Tr. 149).

Edward Bauer, respondent's Director of Safety and Training, stated that he provides emergency medical training for the respondent's employees, including first-aid training for supervisors as required by MSHA's regulations, and mine rescue training. He confirmed that in accordance with company procedures, anytime an employee is injured and taken to a hospital both he and the company president, Robert McGregor are notified. Mr. Bauer confirmed that at approximately 8:40 p.m., on December 7, Mr. Hayhurst called him and advised him that Mr. Mullens was involved in an accident with a miner, and that he was caught between the rib and the miner, and that an ambulance had been called (Tr. 153). Mr. Bauer stated that he directed Mr. Hayhurst to speak with Mr. Stump in order to determine Mr. Mullens' vital signs and his injuries. Mr. Bauer stated that he learned from Mr. Hayhurst that Mr. Mullens was complaining of pain in his leg, but that Mr. Stump had indicated that he was stable and that his vital signs were good. Mr. Bauer then proceeded to the hospital and advised Mr. Hayhurst to inform Mr. McGregor about the accident. Mr. Bauer arrived at the hospital emergency room approximately 35 minutes ahead of Mr. Mullens, and he helped unload him from the ambulance when he arrived. At that time, Mr. Mullens stated that his leg hurt and he was trying to explain to the ambulance attendants the circumstances under which he was injured, but they had some difficulty in understanding the mining terminology used by Mr. Mullens. Mr. Bauer spoke with Mr. Mullens and explained further to the attendants (Tr. 156).

Mr. Bauer stated that Mr. Mullens arrived at the hospital at 9:35 p.m., and that shortly after his arrival Dr. Bordonada examined him in the emergency room. Mr. Bauer stated that at approximately 10:05 p.m., he asked Dr. Bordonada about the nature of the injuries sustained by Mr. Mullens, and the doctor explained that he was concerned about the pain in the abdomen, but was not sure about the back, and mentioned that Mr. Mullens had some abrasions on his hand and leg. Mr. Bauer stated that he asked the doctor whether or not there was any chance at all that the injuries sustained by Mr. Mullens would cause him to die, and that the doctor responded "no" (Tr. 158).

Mr. Bauer confirmed that after speaking with the doctor, he received a call at the hospital from Mr. McGregor inquiring about the condition of Mr. Mullens. Mr. Bauer stated that he told Mr. McGregor about his conversation with Dr. Bordonada, and Mr. McGregor inquired as to whether or not the accident needed to be reported under Part 50, and Mr. Bauer informed him about the reporting requirement in cases where an injury

has a reasonable potential to cause death. Mr. McGregor then instructed Mr. Bauer to insure that he asked the doctor that specific question, and at approximately 10:25 Mr. Bauer spoke to the doctor again and asked him whether the injuries sustained by Mr. Mullens had a reasonable potential to cause death. Mr. Bauer stated that the doctor again answered "no," and that he called Mr. McGregor back to inform him of this conversation with the doctor (Tr. 160).

Mr. Bauer stated that on the day after the accident, he was at the mine in the company of MSHA Inspector Roy Bennett, and Mr. Bennett asked him whether or not the mine had experienced any "lost time and accidents." Mr. Bauer stated that he explained the circumstances surrounding Mr. Mullens' accident, including his conversations with the doctor and the EMT treatment received by Mr. Mullens, and advised Mr. Bennett of his opinion that the accident was not reportable. Mr. Bennett informed Mr. Bauer that the accident should be called in to MSHA, and following his instructions, Mr. Bauer reported the accident by telephone at approximately 12:30 noon on December 8, to the MSHA Clarksburg Field Office. He later spoke with Mr. Satterfield of that office at 4:30 p.m. that same day, and after explaining the circumstances to him, Mr. Satterfield issued a section 103(k) order (Tr. 171). Later, on December 10, Inspector Herndon came to Mr. Bauer's office to examine the accident report and the training records of Mr. Mullens and Mr. Stump. Mr. Stump stated that at no time on December 7, or thereafter, did he have reasonable cause to believe that the injuries sustained by Mr. Mullens could have caused his death (Tr. 172).

On cross-examination, Mr. Bauer confirmed that he made no notes concerning his discussions with Dr. Bordonada, but did write down the reported injuries sustained by Mr. Mullens in order to report them to Mr. McGregor. Mr. Bauer could not recall the doctor telling him that he suspected a possible ruptured spleen or internal abdominal injuries, but did recall the doctor telling him that he was concerned about the pain in the abdominal region and the leg (Tr. 173). He denied that the doctor said anything about taking x-rays or fluid from the abdomen before he could determine whether the injuries were serious, and he re-confirmed that the doctor responded "no" to his question concerning any reasonable potential for death (Tr. 174). Mr. Bauer confirmed that he did not inquire as to why Mr. Mullens was being taken to another hospital by helicopter because it was not uncommon to transfer patients out of Braxton County by helicopter (Tr. 175). Mr. Bauer stated that the exact words he used in posing his question to Dr. Bordonada were whether there was "any chance at all that he would die

from those injuries" (Tr. 176). Mr. Bauer confirmed that he asked the doctor no further questions after the lab reports were in, and he denied any knowledge that Mr. Mullens had blood in the fluid, or that the doctor suspected a renal contusion or bruise of the kidney, or a possible spleen injury (Tr. 179).

In response to further questions, Mr. Bauer confirmed that he is a certified Emergency Medical Technician, and if the doctor had told him that Mr. Mullens had a ruptured spleen or blood in his abdomen, he would have had some doubt about the doctor's negative answer that there was no reasonable potential for death and would have immediately reported the accident. However, he relied on the doctor's negative answers to his questions in forming his opinion that there was no reasonable potential for death (Tr. 179-180).

Mr. Bauer confirmed that he participated in MSHA's accident investigation, and that he informed Inspector Herndon of his view that the accident was not reportable. However, Mr. Satterfield took the position that because of the fact that the accident involved a mining machine, the accident was immediately reportable (Tr. 182). Mr. Bauer also confirmed that when he spoke to Mr. Satterfield at 4:30 p.m., on December 8, when the 103(k) order was issued, he informed Mr. Satterfield that the section had been mined out and the machine removed, and that Mr. Satterfield stated that he did not want the scene "disturbed any more" (Tr. 182).

Mr. Bauer agreed that the accident was a "lost time accident" which needed to be reported, and that as of December 9, he had not completed the necessary paperwork. He confirmed that he was not cited for failure to file a lost time accident, and MSHA's counsel confirmed that such accidents need not be reported immediately (Tr. 185).

Robert McGregor, respondent's President and Chief Executive Operations Officer, stated that he was thoroughly familiar with MSHA's Part 50 reporting requirements, and that during his past experience in the mining industry has had occasion to make such reports. He confirmed that he first learned of the incident concerning Mr. Mullens when he received a telephone call from Mr. Hayhurst on December 7, at approximately 9:00 p.m. Mr. McGregor informed Mr. Hayhurst to "stop everything on the section" and to contact Mr. Stump for a full investigation and "a drawing of the circumstances." Mr. McGregor stated that the thought of immediately reporting the accident crossed his mind after Mr. Hayhurst told him of the circumstances concerning Mr. Mullens being pinned against the rib by a miner, but he waited until Mr. Mullens was at the

hospital so that he would have a preliminary diagnosis of the problem. Mr. McGregor then called the hospital and spoke with Mr. Bauer who informed him that the doctor was concerned about Mr. Mullens' back but said that his life was not in danger. Mr. McGregor discussed the reporting requirements of Part 50 with Mr. Bauer and instructed him to ask the doctor about the potential for death, using the exact language of the standard, because he did not want any misunderstanding. Mr. Bauer called him back and stated that the doctor had informed him that Mr. Mullens' injuries had no reasonable potential to cause death (Tr. 194-197).

Mr. McGregor stated that after speaking with Mr. Bauer, he called Mr. Hayhurst and instructed him to "go ahead and release the section," and that they would confer the next day to investigate the accident. When he later spoke with Mr. Bauer, he was informed that Inspector Bennett was of the opinion that the accident should have been immediately reported, and Mr. Bauer advised him that Mr. Satterfield had placed a "K order" on the section and was going to come to the mine to investigate the accident (Tr. 199). Mr. McGregor stated that he personally called Mr. Satterfield and tried to explain why the accident was not immediately reported, but that Mr. Satterfield took the position that it should have, and gave him the following reasons for his position (Tr. 199):

> A. * * * [I] tried to explain to him why we hadn't called in at the time. Basically, that the doctor had told us at that time, and our people said they didn't feel his life was threatened as a result of his injuries. At that time, we got into a lengthy discussion. He basically told me that didn't matter. He said the nature of the injury could have been fatal. The event itself could have been fatal, and that's what he was basing his decision. I said, "Jim, that's not the way I read the law." He said, "Well, that's the way I see it." I said, "Are you telling me that if somebody gets a brush burn, but if they had been six inches over, that it could have killed them, that's still a" -- he said, "That's exactly what I'm telling you."
>
> As a result of that, as a matter of that, Ed Bauer and I got together and drew up a new set of guidelines, and quite frankly, the reason we're here today is because, for our

> purpose, we want to comply with the law and we wanted the position clarified.

On cross-examination, Mr. McGregor confirmed that he first learned of the accident from Mr. Hayhurst, and that Mr. Hayhurst informed him that Mr. Mullens had a leg injury and a pain in his stomach, but that his vital signs were good. Mr. McGregor stated that he informed Mr. Hayhurst that he wanted nothing further done on the section until he could investigate to learn exactly how serious Mr. Mullens was injured. Mr. McGregor stated that he then called Mr. Bauer at the hospital approximately an hour after he spoke with Mr. Hayhurst, but that he (McGregor) never spoke to the doctor (Tr. 200-204).

Mr. McGregor confirmed that he was concerned about the accident, and in order to make a record, he wanted to investigate the incident and take measurements and detail all of the particulars. He confirmed that Mr. Hayhurst said nothing to him about any possible internal injuries suffered by Mr. Mullens, other than that "his stomach was hurting" (Tr. 205). Mr. McGregor also confirmed that he received a report concerning the prevailing conditions on the section after the accident from Mr. Hayhurst before releasing the section to continue working, and he explained why he did not initially report to MSHA after receiving this information (Tr. 206-209). When asked about the factors he relied on when he made his decision to release the section after the accident, Mr. McGregor stated as follows (Tr. 217-218):

> THE WITNESS: Of course, the one factor, was the information I got from the hospital, and the other factor was that we had -- I was told that the miner was in good operating condition, that it worked fine, that we had made a drawing of the area, and that I felt there was no reason not to proceed. That there would be nothing to gain one way or the other, once we had the dimensions, a picture of the scene and the fact that the machinery, at least, was reported to me that it was operating properly with the exception that the remote control box was damaged, where as it turned out later, was the cause of the accident.
>
> Where the cable had caught his hand, it set his control box on the ground. He had two tram leaders that worked the cats. When he was tramming them back, he wasn't watching the

> cable and the clamp caught his -- came over his hand and forced his hand down on the control levers. Brought the machine back to him. Therefore, he got his abrasion on the hand. When he got his hand free, it bent the little guard down that we had on the side of the control box.
>
> So at that point, I felt that there was no reason not to put the section back in service, and we would continue the investigation the next day.

Inspector Herndon was recalled by the court, and he denied any knowledge of any MSHA requirement for the immediate reporting of accidents involving miners being pinned against the rib. However, he confirmed that in most cases he has been involved in when a miner is pinned against a rib there is a reasonable potential for death (Tr. 220-221). He confirmed that he issued the citation because of the information related to him during the investigation from mine personnel who were with Mr. Mullens at the time of the accident, namely, that Mr. Mullens was conscious or semi-conscious, and suffered a compression fracture of the fifth lumbar vertebra, contusions to the lung, abrasions on the left hand, and a possible strained knee. He concluded from all of this that the injuries presented a reasonable potential for death and should have been immediately reported (Tr. 222-223).

Findings and Conclusions

Fact of Violation - 30 C.F.R. 50.10

The respondent is charged with an alleged violation of mandatory reporting standard 30 C.F.R. 50.10, for failing to immediately notify MSHA of the occurrence of the accident involving Mr. Mullens. The statutory requirement for reporting mine accidents is found in section 103(j) of the 1977 Mine Act, which states in pertinent part as follows: "[I]n the event of an accident occurring in any coal or other mine, the operator shall notify the Secretary thereof and shall take appropriate measures to prevent the destruction of any evidence which would assist in investigating the cause or causes thereof." While it is clear that an accident must be reported, the requirement that it be done immediately is not found in the statute. The requirement for an immediate report is found in the regulation at 30 C.F.R. 50.10, which provides as follows:

50.10 Immediate notification.

> If an accident occurs, an operator shall immediately contact the MSHA District or Subdistrict Office having jurisdiction over its mine. If an operator cannot contact the appropriate MSHA District or Subdistrict Office it shall immediately contact the MSHA Headquarters Office in Washington, D.C., by telephone, toll free at (202) 783-5582.

The definition of the type of "accident" which must be immediately reported to MSHA pursuant to section 50.10, is found at 30 C.F.R. 50.2(h)(2), which defines such an accident as "An injury to an individual at a mine which has a reasonable potential to cause death."

The evidence in this case establishes that the respondent reported the accident to MSHA by telephone at 12:30 p.m. and 4:30 p.m., on December 8, 1987. Petitioner takes the position that the injuries sustained by Mr. Mullens in the accident presented a reasonable potential for causing his death, and that the respondent should have immediately reported the accident when it occurred on December 7, 1987. The respondent takes the position that the injuries sustained by Mr. Mullens did not present a reasonable potential for causing his death, and that the incident of December 7, 1987, was therefore not an "accident" within the definition found in section 50.2(h)(2), or an "accident" which was required to be reported immediately to MSHA.

In MSHA v. Climax Molybdenum, 2 FMSHRC 1967, a miner suffered fractures to the left femur, the pelvis, and the right hip, when a 7,000 pound tire fell on him. An initial examination which took place at the mine infirmary by an attending doctor and nurse showed that the victim's vital signs were stable and he was cooperative, and the attending medical personnel advised the mine safety director that while the injuries suffered by the miner were serious, they were not life threatening. The victim was transferred from the infirmary to a local hospital for treatment, and was subsequently transferred again to another hospital in Denver where he developed a fat embolism associated with a bone fracture, but this condition was not considered to be life-threatening.

in the Climax case, Judge Morris found no merit in MSHA's contention that immediate notification is required whenever there exists any question as to whether an injury is life

threatening. He also rejected MSHA's contentions that immediate reporting was required due to a combination of circumstances, namely, the injuries were serious, a fat embolism developed, intensive case was required, and the miner was moved to three different treatment facilities. In short, Judge Morris found that the injuries sustained by the miner were not required to be immediately reported pursuant to section 50.10, because MSHA offered no credible evidence to support a conclusion that the injuries had a reasonable potential to cause the death of the miner. I reached the same conclusion in Hecla Mining Company, 1 FMSHRC 1872 (November 1979).

In MSHA v. Allied Chemical Corp., 7 FMSHRC 2053 (December 1985), Judge Morris affirmed a violation of section 50.10, after concluding that the injuries sustained by a miner who received an electrical shock posed a reasonable potential to cause death. The shock victim was hospitalized and his heart beat was monitored for 12 to 18 hours. The attending hospital physician advised the inspector that the injured miner was being monitored because there was still a potential for death, and Judge Morris was not persuaded by the testimony of another doctor who was experienced in the hazards of electrical shock, and who testified for the operator that in his opinion, the injuries would not have caused the miner's death.

MSHA's position in this case is that any determination of whether there are injuries with a reasonable potential to cause death and, thus, an immediately reportable accident, is subject to a "reasonable person test." MSHA asserts that a reasonable determination must be made at the scene of the accident or the earliest point or as near in time to the accident as possible based on the particular facts of the case. MSHA concludes that as soon as a reasonable person would conclude that there is a reasonable probability of death from the injuries involved, the accident should be reported. MSHA further concludes that the determination does not necessarily require a medical opinion because such a requirement would defeat the purpose of the regulation since valuable time would be lost. Of course, once there is a medical opinion to the effect that the injury poses a reasonable potential for death, MSHA believes that it must be immediately reported.

MSHA maintains that in view of Mr. Mullens' condition at the time of the accident, mine management should have made a determination that his injuries had a reasonable potential to cause death and, therefore, should have immediately reported the accident. In support of this conclusion, MSHA relies on

the fact that Mr. Mullens was knocked unconscious, mine management suspected internal injuries, Mr. Mullens was rushed to the hospital by ambulance, and the "general knowledge" that the type of accident (a miner being pinned against a rib by a continuous-mining machine) is very serious and sometimes fatal.

MSHA's conclusions that the respondent should have made a reasonable determination at the time of the accident that Mr. Mullens' injuries posed a reasonable potential for causing his death are based on the testimony of MSHA Inspector Herndon, the individual who participated in the accident investigation and wrote the accident report of December 18, 1987 (Exhibit P-6). Mr. Herndon testified that his interviews with mine personnel "suggested" that Mr. Mullens had suffered internal injuries, and that it was his "understanding" that Mr. Mullens had sustained "possible" internal injuries.

Mr. Herndon conceded that at the time of MSHA's accident investigation, no interviews were conducted with the attending emergency room doctor, and no hospital records concerning Mr. Mullens' condition were reviewed. He also conceded that he did not review the accident report prepared by Mr. Hayhurst which contains a notation that Mr. Mullens had sustained "possible internal injuries" (exhibit P-3). Mr. Herndon's accident investigation report reflects that he issued the citation because of the respondent's failure to immediately notify MSHA "of this serious accident" (exhibit P-6, pg. 3).

Mr. Herndon testified on direct examination that it was his understanding that in addition to possible internal injuries, Mr. Mullens had sustained sprains, an injury to the L5 vertebra, abrasions and various contusions, and that he was in an "unconscious state" when first observed, but was semi-conscious when the machine was moved away from him. When recalled to testify later in the hearing, Mr. Herndon stated that Mr. Mullens had suffered a compression fracture of the fifth lumbar vertebra, contusions to the lung, abrasions to the left hand, and a possible strained knee. This information also appears at page 2 of his accident report, and Mr. Herndon asserted that he received the information from Mr. Bauer after Mr. Mullens was taken to the Braxton Hospital emergency room.

Mr. Herndon testified that he believed the respondent should have immediately reported the accident at the time Mr. Mullens was transported to the hospital by ambulance because he had suffered internal injuries, the scope of which were unknown. When asked the basis for his conclusion that Mr. Mullens' injuries had a reasonable potential to cause

death, Mr. Herndon responded "past experience, and the fact that I have done accident investigations in the past of this type, as well as reviewing reports from across the country, this type of an accident has, in many cases, become fatalities" (Tr. 76). Mr. Herndon later confirmed that in most cases he has investigated, when a miner is pinned against the rib, there is a reasonable potential for death (Tr. 220-221).

In my view, Inspector Herndon's belief that the respondent should have immediately reported the accident at the time that Mr. Mullens was taken out of the mine and transported to the hospital emergency room was based on several factors. Mr. Herndon was of the opinion that since the accident was serious, it was required to be immediately reported. I find no such requirement in the cited regulation. The definition of a reportable accident relied on by MSHA does not include any language with respect to the degree of injury, and Mr. Herndon's characterization of the accident as "serious" cannot support a violation for failure to immediately report the matter.

Inspector Herndon's reliance on his past experience concerning miners being pinned against a rib by a mining machine cannot ipso facto support any reasonable conclusion that the injuries sustained by Mr. Mullens posed a reasonable potential for death. The fact that MSHA generally believes that accidents of this type generally have been known to result in the demise of past accident victims is irrelevant. MSHA is bound by its own regulatory definition of an accident which is required to be immediately reported, and given that definition, any such determination must necessarily be made on the facts of each incident on a case-by-case basis. Further, if MSHA believes that such incidents in general need to be reported immediately, regardless of the extent of any injury, it is free to amend its regulations.

In my view, the question of whether the respondent met its duty to immediately report the accident in question depends on when it possessed reasonably reliable information which would have reasonably led it to conclude that the accident was immediately reportable. On the facts of this case, it seems clear to me that Inspector Herndon had no personal first-hand knowledge of the injuries sustained by Mr. Mullens at the time of the accident. He issued the citation on the basis of certain information given to him during the course of his investigation. The issue is not whether Mr. Herndon, after the fact believed that Mr. Mullens' injuries were such as to pose a reasonable potential for death, but whether or not those management representatives who had first-hand knowledge of the

injuries sustained by Mr. Mullens acted reasonably or unreasonably in concluding that there was no reasonable potential for death, and whether they acted reasonably or unreasonably in concluding that they were not required to immediately report the accident to MSHA during the critical time period beginning with the occurrence of the accident and the removal and transportation of Mr. Mullens from the mine to the hospital.

After careful examination of all of the testimony and evidence presented in this case, I find no credible or probative evidence to support MSHA's assertions that when Mr. Mullens was removed from the mine and transported to the hospital, his condition presented a reasonable potential for death, and that the respondent knew, or should have known that this was the case, and should have immediately reported it to MSHA. MSHA's reliance on the fact that Mr. Mullens was knocked unconscious, that management suspected internal injuries, that he was transported to the hospital, and that incidents of this type have generally be known to result in serious, and sometimes fatal injuries, to support its conclusions that the accident was reportable at the time of its occurrence is rejected.

The credible testimony of Robert Stump, a trained and experienced certified Emergency Medical Technician who first observed and examined and administered first aid to Mr. Mullens, and who assisted in removing him from the scene and placing him in the ambulance, reflects that when he first observed Mr. Mullens he could not tell whether or not he was conscious, and that Mr. Mullens was looking at him while bent over in a sitting position (Tr. 60, 128). Mr. Stump testified that within 15 seconds after reaching Mr. Mullens and turning off the machine, Mr. Mullens spoke to him. After tramming the machine away from Mr. Mullens, Mr. Stump placed him in a reclining position and examined him further and found that he had a very full pulse rate which was somewhat rapid because of "fear and anxiety," but not rapid enough to cause Mr. Stump to be concerned. Mr. Stump explained the details of his examination of Mr. Mullens, and confirmed that he followed his standard EMT examination procedures, and established spontaneous eye and verbal contact with Mr. Mullens, and Mr. Mullens confirmed and showed him that he could move his hands. Shortly before placing Mr. Mullens on a "back board," Mr. Stump stated that Mr. Mullens "was responding to us, talking with us. We could ask him what was hurting and everything, and he would respond whatever his problems were, what he was thinking or anything else" (Tr. 130-131).

Mr. Stump confirmed that Mr. Mullens was pinned against the rib by the machine cable restraining clamp, and that while it was not necessary to remove the machine in order to extricate Mr. Mullens, he moved the machine so that he could have better access to Mr. Mullens and to preclude any possible further injury if he had simply "jerked him out" (Tr. 141-142).

Although Mr. Stump confirmed that he suspected that Mr. Mullens may have sustained possible internal injuries because of discoloration and palpitation of his upper abdomen, had trouble moving his legs, and was experiencing discomfort in his legs, and had an abnormal respiratory rate which was "not too bad" (Tr. 136-137), he concluded that on the basis of his examination of Mr. Mullens at the scene of the accident the injuries sustained by Mr. Mullens did not have a reasonable potential for causing his death (Tr. 132). Mr. Stump confirmed that upon Mr. Hayhurst's arrival at the scene, Mr. Hayhurst asked him about Mr. Mullens' condition (Tr. 138). Mr. Bauer testified that Mr. Hayhurst informed him that Mr. Stump advised him that Mr. Mullens was complaining of pain in his leg, but that he was stable and that his vital signs were good (Tr. 154). Mr. Bauer testified further that he assisted in removing Mr. Mullens from the ambulance upon his arrival at the hospital, and that while he was complaining about his leg hurting, he was speaking distinctly, and was talking to all of the hospital and ambulance personnel about what had happened (Tr. 155-156).

In view of the foregoing, I cannot conclude that Mr. Stump, a trained medical technician who had prior experience with traumatic injuries, and who after examining and treating Mr. Mullens at the scene of the accident, concluded that his injuries were not life threatening and did not present any reasonable potential for death, acted unreasonably in reaching that conclusion at that point in time. Nor can I conclude that Mr. Hayhurst or Mr. Bauer acted unreasonably in not immediately reporting the accident to MSHA at the time of its occurrence. Although Mr. Hayhurst did not testify in this case, based on the testimony of Mr. Stump and Mr. Bauer, there is a strong inference that Mr. Hayhurst relied on the information given to him by Mr. Stump. The fact that Mr. Stump may have told Mr. Hayhurst that Mr. Mullens may have sustained "possible internal injuries," does not in my view support any reasonable conclusion that such undiagnosed injuries, the extent of which were not known, presented a reasonable potential for death. Insofar as Mr. Bauer is concerned, he first learned of Mr. Mullens' injuries through Mr. Hayhurst who informed him of Mr. Stump's assessment that Mr. Mullens was stable and that his life signs were good. Mr. Bauer also

personally observed Mr. Mullens when he helped remove from the ambulance, and Mr. Mullens was conscious and speaking freely with him and the medical personnel who were present while explaining what had occurred to him. Under the circumstances, I cannot conclude that Mr. Bauer had any reasonable basis for concluding that Mr. Mullens' injuries had a reasonable potential for causing death, nor can I conclude that Mr. Bauer acted unreasonably in not immediately reporting the accident to MSHA at that point in time.

MSHA asserts that following Mr. Mullens' transport to the hospital and examination by Dr. Bordonada, the respondent's duty to immediately report the accident became even clearer, because the doctor diagnosed some very serious and possibly life threatening injuries to Mr. Mullens and ordered him transferred by helicopter to another hospital. In addition to Dr. Bordonada's diagnosis and treatment of Mr. Mullens upon his arrival at the hospital, the evidentiary underpinning for MSHA's conclusion that Mr. Mullens' injuries posed a reasonable potential for death, and thus were required to be immediately be reported to MSHA at the time Mr. Mullens was admitted to the hospital, is the doctor's opinion that the injuries sustained by Mr. Mullens presented a reasonable potential for death, the doctor's denials that Mr. Bauer or any other management representative ever asked him whether the injuries were life threatening or posed a reasonable potential for death, and the doctor's assertion that if he had been asked whether or not Mr. Mullens' injuries had a reasonable potential for death he would have answered in the affirmative.

Dr. Bordonada confirmed that he was initially informed by radio by the paramedics who brought Mr. Mullens to the emergency room that he had been "crushed" by a continuous-mining machine and was unconscious, and that the paramedics may have called for a helicopter. In light of this initial call, the doctor further confirmed that he had "great concern" because "when you have injury like this, you thing right away of helicopter" (Tr. 55). He believed that he asked for the assistance of a helicopter because of "my suspicion of the kind of injury that needs more work-up and treatment and he should be taken to another facility where they can provide these kind of diagnostic instruments" (Tr. 35). The doctor also confirmed that he called for the helicopter to transfer Mr. Mullens to the West Virginia University Hospital and spoke with a doctor at that hospital who agreed to the transfer (Tr. 28, 35, 49). He also confirmed that the call for the helicopter was placed at approximately 11:00 p.m., and it arrived at the Braxton Hospital at approximately 12:00 midnight, and left with Mr. Mullens at 12:30 a.m. (Tr. 49-50).

Dr. Bordonada confirmed that when he first observed Mr. Mullens, he was conscious, his blood pressure was within normal limits, and his pulse and respiratory rates were high. He also indicated that Mr. Mullens was scared, and he agreed that it was possible that this would cause elevated pulse and respiratory rates (Tr. 40). The doctor also confirmed that his concern with respect to the life threatening aspects of Mr. Mullens' injuries focused on his belief that Mr. Mullens may have sustained a ruptured spleen, and that his conclusion in this regard was reached sometime after he had done an abdominal tap sometime after 10:45 p.m. (Tr. 48). He also confirmed that a ruptured spleen presents a problem in that a patient may go into shock (Tr. 32, 49). He agreed that the records from the West Virginia University Hospital ultimately confirmed that Mr. Mullens did not have a ruptured spleen or a fractured vertebrae, but that he did sustain a sprained leg, a cut on his finger, and a bruise or contusion to the lumbar plexus, or nerves supplying the leg (Tr. 52-53). When asked whether these injuries posed a reasonably potential to cause death, he responded "One Hundred percent no" (Tr. 53). The doctor confirmed that none of the hospital records contain any "form questions" as to whether or not a patient's condition may be "life threatening," and no such conclusions are included in any of the reports (Tr. 38).

Although Dr. Bordonada denied that Mr. Bauer ever asked him whether or not he believed that Mr. Mullens' injuries were life threatening or had a reasonable potential for causing death (Tr. 35, 44), I conclude and find that his negative answers were equivocal. For example, when he was first asked the question, Dr. Bordonada responded "I don't believe so" and "I do not think so" (Tr. 36). When asked the same question on cross-examination, he responded "I don't believe so" and "I don't recall any conversation of such nature" (Tr. 44). When asked whether he could have had such a conversation, Dr. Bordonada replied "it's most possible, because I talk to so many people when you get out of the room" (Tr. 45). When asked about a second conversation with Mr. Bauer with regard to the same question, the doctor conceded that it was possible that he had such a conversation with Mr. Bauer (Tr. 45).

Dr. Bordonada stated that since establishing his medical practice in West Virginia in 1981, his hospital practice since his residency has been confined to diagnosis and treatment in the hospital emergency room, and that at the time of the accident on December 7, 1987, he was the attending emergency room doctor (Tr. 21-22). He also stated that he had seen Mr. Bauer at the emergency room, knew who he was, and knew that he

worked for the respondent, and that whenever there was an injury involving a miner, Mr. Bauer would be there. The doctor also confirmed that he knew that Mr. Bauer was at the emergency room asking questions (Tr. 44). He also confirmed that he was the only doctor in the emergency room and that he spoke to many people after he left the roof (Tr. 45, 56).

The testimony by Doctor Bordonada in this case was based on his recollection of the accident which had occurred a year prior to the hearing. His testimony was based on his review of the Braxton Hospital emergency room outpatient records, which included his notations concerning his diagnosis, observations, and certain test results incident to Mr. Mullens' treatment. Given the fact that Dr. Bordonada was obviously preoccupied with attending to Mr. Mullens, the fact that he was the only doctor on duty at the time, and had spoken to many people in and around the emergency room, I find it difficult to believe or expect that he would specifically and unequivocally remember that he did not have the conversations in question with Mr. Bauer. Contrary to MSHA's assertion at page 15 of its posthearing brief that the doctor specifically denied the conversation, Dr. Bordonada, on several occasions during his testimony, conceded that while he had no recollection of the conversation, it was possible that such conversations took place. The doctor also conceded that he knew Mr. Bauer as an individual who appeared at the emergency room whenever a miner was injured, and knew that he was at the emergency room asking questions.

Respondent's safety director Edward Bauer confirmed that he went to the hospital pursuant to company policy that required both he and Mr. McGregor to be notified anytime a miner is injured and taken to the hospital. Mr. Bauer unequivocally testified that on two occasions during the course of the evening of December 7, 1987, while at the emergency room, he asked Dr. Bordonada whether or not Mr. Mullens' injuries were life threatening. Mr. Bauer stated that he first asked the doctor whether or not the injuries would cause Mr. Mullens to die, and later, upon the instructions of the company president, Robert McGregor, he asked the doctor whether Mr. Mullens' injuries had a reasonable potential for causing death. Mr. Bauer confirmed that the doctor gave negative answers to both questions. Mr. Bauer recalled the specific form of the first question, and stated that he asked the doctor whether there was "any chance at all that he (Mullens) would die from those injuries" (Tr. 176).

Mr. Bauer, who is also a trained Emergency Medical Technician (EMT), and who had knowledge of MSHA's accident

reporting requirements, confirmed that the doctor advised him that he was concerned about the pain in Mr. Mullens' abdomen, was not sure about his back, and that Mr. Mullens had some abrasions on his hand and leg. Mr. Bauer stated that he made notes concerning these reported injuries so that he could report them to Mr. McGregor, but he could not recall the doctor telling him that he suspected a possible ruptured spleen or internal abdominal injuries. In view of his EMT training, Mr. Bauer asserted that if the doctor had told him that Mr. Mullens had a ruptured spleen or blood in his abdomen, he would have doubted the doctor's negative responses to his inquiries as to whether Mr. Mullens' injuries were life threatening, and immediately reported the matter to MSHA. Mr. Bauer maintained that he relied on the doctor's negative responses in forming his opinion that Mr. Mullens' injuries did not pose a reasonable potential for death.

Respondent's President, Robert McGregor, confirmed that he was thoroughly familiar with MSHA's Part 50 reporting requirements, including the requirement for reporting accidents involving injuries which present a reasonable potential for causing death, and that he has often prepared and made such reports during the years he has been in the mining business. Mr. McGregor corroborated Mr. Bauer's testimony concerning his telephone communications with Mr. Bauer on the evening of the accident, including Mr. Bauer's assertions that he communicated to him the doctor's negative responses with respect to whether or not Mr. Mullens' injuries were potentially life threatening. Mr. McGregor confirmed that he first learned of the accident from Mr. Hayhurst who informed him that Mr. Mullens had a leg injury and pain in his stomach, but that his vital signs were good. Mr. Hayhurst did not mention any internal injuries, and Mr. McGregor confirmed that he pursued the matter further by calling the hospital to speak to Mr. Bauer about Mr. Mullens' condition.

MSHA's assertion that the evacuation of Mr. Mullens to another hospital by helicopter should have alerted mine management that his injuries posed a reasonable potential for death is rejected. I find that Dr. Bordonada's call for a helicopter was prompted by the initial information he received before his examination of Mr. Mullens which indicated that Mr. Mullens had been "crushed" by a heavy piece of equipment and was unconscious. I believe the doctor acted out of an abundance of caution, and he agreed that helicopter assistance was necessary to expedite Mr. Mullens' transfer to a hospital which had the capability for further treatment and diagnosis of Mr. Mullens' injuries. Mr. Bauer testified that he made no inquiry as to

why Mr. Mullens was being taken to another hospital by helicopter because it was not uncommon to transfer patients out of Braxton County by helicopter, and I find his testimony in this regard to be credible and plausible. Further, I find no credible evidence to establish that Mr. Bauer was aware of the doctor's concern that Mr. Mullens may have sustained internal injuries or a ruptured spleen, nor do I find any credible evidence to support any conclusion that Mr. Bauer was aware of the details concerning the doctor's diagnosis of Mr. Mullens' suspected injuries. MSHA's assertions and transcript references at page 11 of its brief that the respondent's witnesses "recognized that the existence of internal injuries is life threatening" are taken out of context. Although Mr. Bauer admitted as much at (Tr. 180), he specifically qualified his answer by stating that he had no factual knowledge that Mr. Mullens had sustained internal injuries at the time he was at the hospital.

On the facts of this case, and notwithstanding Inspector Herndon's denials to the contrary, I believe that he formed an initial opinion that the accident posed a reasonable potential for death, and was thus required to be reported immediately, because he considered the accident to be "serious" in that it involved an incident where a miner was pinned against the rib by a continuous-mining machine. I also believe that Mr. Herndon relied on his past experience in which incidents of this kind have resulted in the deaths of the accident victims.

Although Mr. Herndon asserted that he issued the citation on the basis of certain medical information given to him by the witnesses who were interviewed during the investigation, the report is devoid of any statements or conclusions that Mr. Mullens' injuries were life threatening, or posed a reasonable potential for death, and at page 3 of the report, (exhibit P-6), Mr. Herndon states "Because the operator failed to notify MSHA immediately of this serious accident, a citation was issued for a violation of 30 C.F.R. 50.10." Mr. Herndon conceded that no attempts were made to interview the hospital doctors, or to review the hospital records with respect to Mr. Mullens' injuries, and in my view the report is not particularly reliable. For example, at page 2, the report states that Mr. Mullens was transferred to the West Virginia University Hospital by ambulance, when in fact he was transported there by helicopter.

Having viewed Mr. Bauer and Mr. McCormack during their testimony, they impressed me as credible and straightforward

witnesses, and I give credence to Mr. Bauer's consistent testimony, as corroborated by Mr. McCormack, that Dr. Bordonada informed him that Mr. Mullens' injuries were not life threatening. I find Mr. Bauer's testimony regarding his two conversations with Dr. Bordonada to be believable and plausible, and while I have no reason to believe that the doctor was not telling the truth, I simply find his testimony to be too equivocal to support any conclusion that the conversations did not take place. Although Dr. Bordonada's medical opinion, expressed at the hearing after his review of his prior notations and the hospital records, that Mr. Mullens' injuries had a reasonable potential to cause death at the time the doctor treated him, is unrebutted, I find no credible or probative evidence to support any finding that this opinion was communicated to Mr. Bauer, Mr. McCormack, or anyone else in mine management, after Mr. Mullens was taken to the hospital. Nor do I find any credible or probative evidence to establish that anyone in mine management had any reasonable basis for believing that Mr. Mullens' injuries posed a reasonable potential for death. Lacking any such knowledge, I further find no basis for concluding that the respondent had a duty to immediately report the accident while Mr. Mullens was at the Braxton Hospital emergency room awaiting transportation to another hospital, or that its failure to do so was imprudent or unreasonable in the circumstances. Accordingly, I conclude and find that a violation has not been established, and the citation IS VACATED.

Fact of Violation - 30 C.F.R. 50.12

Citation No. 2944552, charges the respondent with altering the accident scene by continuing mining operations after Mr. Mullens' was removed from the mine and taken to the hospital. The cited mandatory standard section 50.12 provides as follows:

> Unless granted permission by a MSHA District Manager or Subdistrict 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.

In view of my findings and conclusions that the respondent had no duty to immediately report the accident in question, I find no basis for concluding that it had a duty to maintain the

status quo at the accident scene. Accordingly, I find no basis for concluding that the respondent violated the cited standard, and the citation IS VACATED.

ORDER

In view of the aforesaid findings and conclusions, the contested section 104(a) Citation Nos. 2944551 and 2944552, ARE VACATED, and the petitioner's proposals for assessment of civil penalties for the alleged violations in question are DENIED AND DISMISSED.

George A. Koutras
Administrative Law Judge