

**FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION**

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August 1, 2013

SECRETARY OF LABOR,	:	CIVIL PENALTY PROCEEDINGS
MINE SAFETY AND HEALTH	:	
ADMINISTRATION (MSHA),	:	Docket No. KENT 2010-956
Petitioner,	:	A.C. No. 15-19114-213966-01
	:	
	:	Docket No. KENT 2010-990
v.	:	A.C. No. 15-19114-215039
	:	
	:	Docket No. KENT 2010-1087
	:	A.C. No. 15-19114-216579
REX COAL COMPANY, INC.,	:	
Respondent.	:	Mine: C-5

**DECISION**

Appearances: Kent Hendrickson Esq., Rice & Hendrickson, Harlan, KY for Respondent  
  
Joseph B. Luckett, Esq., Office of the Solicitor, U.S. Department of Labor, Nashville, TN for the Secretary

Before: Judge Andrews

**STATEMENT OF THE CASE**

This civil penalty proceeding is conducted pursuant to the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 801 *et seq.* (2000) (the “Mine Act” or “Act”). This matter concerns Citation Nos. 8401220 and 8401221 and Order No. 8355742. Citation No. 8401221 was issued under §104(a) of the Act while Citation No. 8401220 and Order No. 8355742 were issued under §104(d)(1). The Citations and Order were served on Rex Coal Company, Inc. (“Rex Coal” or “Respondent”) following an investigation of an accident that occurred on November 26, 2009. The Secretary assessed a total penalty of \$81,142.00 in this matter. A hearing was held in Middlesboro, Kentucky on March 7, 2013.

## **STIPULATIONS**

The parties have entered into several stipulations, introduced as Government Exhibit 1.<sup>1</sup> Those stipulations include the following:

1. Respondent is subject to the Act.
2. Respondent has an affect upon interstate commerce within the meaning of the Act.
3. Respondent is subject to the jurisdiction of the Federal Mine Safety and Health Review Commission and the presiding Administrative Law Judge has the authority to hear this case and issue a decision.
4. Respondent operated the C-5 Mine, I.D. No. 15-19114, in 2009.
5. The C-5 Mine produced approximately 123,000 tons of coal in 2009.

## **CITATION NO. 8401221**

On February 11, 2010 at 10:00 a.m. Inspector Arthur Dale Jackson (“Jackson”) issued Respondent Citation No. 8401221 for an alleged violation of 30 C.F.R. §50.10. That standard states:

The operator shall immediately contact MSHA at once without delay and within 15 minutes at the toll-free number, 1-800-746-1553, once the operator knows or should know that an accident has occurred involving:

- (a) A death of an individual at the mine;
- (b) An injury of an individual at the mine which has a reasonable potential to cause death;
- (c) An entrapment of an individual at the mine which has a reasonable potential to cause death; or
- (d) Any other accident.

30 C.F.R. §50.10. In this citation, Taylor observed the following condition or practice:

The operator failed to notify MSHA immediately of a conveyor belt fire that occurred on 11-26-2009, lasting longer than 30 minutes on the No. 3 belt tailpiece as evidenced by charred conveyor belt, excessive amounts of soot on the mine roof, fire damage to the No. 3 tailpiece and testimony from mine management of times exiting the mine and re-entry into the mine when the smoke was encountered.

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<sup>1</sup> Hereinafter, Government Exhibits will be referred to as “GX” followed by the number. Respondent’s Exhibits will be referred to as “RX” followed by the number.

(GX-12).

Jackson found that this violation was highly likely to lead to an injury and that such an injury could reasonably be expected to be fatal. *Id.* He determined that the violation was Significant and Substantial (“S&S”) and affected two persons. *Id.* Jackson found Respondent’s actions exhibited high negligence. *Id.*

A subsequent Action was filed the same day at 12:52 p.m. stating:

The operator has instituted a company policy explaining procedures for “Immediately Reportable” accident and the policy, along with the 12 guidelines for reportable accidents and the MSHA National Call Center phone number, are posted on the wall in the mine office. The operator has explained the procedure to the foreman.

*Id.* at p. 2

Summary of the Testimony

**I. Arthur Dale Jackson’s Testimony:**

Jackson was familiar with a fire that occurred at the C-5 mine on November 26, 2009. (Tr. 12-13).<sup>2</sup> Jackson received a call at home from his ventilation supervisor, Scott Whittaker, at around 12:40 telling him that his wife had heard of a fire on the news. (Tr. 13). Jackson called Eddie Sparks (“Sparks”), the Mine Emergency Unit (“MEU”) team leader, who then called Sam Creasy (“Creasy”), the supervisor at MSHA’s Harlan office. (Tr. 13). Sparks called back minutes later and said that there had been a fire and requested Jackson go to the office and prepare to check on it. (Tr. 13).

Jackson arrived at the mine at 2:05 but did not go underground until later; instead Sparks told him to sample the atmosphere at the return fan. (Tr. 14, 68-69). When they arrived, two state inspectors and company officials were underground. (Tr. 14).

Jackson reviewed his notes, GX-13. (Tr. 55). On page 9, the notes indicated that he

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<sup>2</sup> He had twenty-five years in mining before joining MSHA. (Tr. 10). He operated equipment underground, had safety jobs, and worked as a foreman for six or seven years. (Tr. 11). He started in mine rescue in 1976 and has worked as a captain, a briefing officer, and a gas man. (Tr. 11). A captain leads the team into the mine in case of an emergency or disaster and makes sure that the commands are followed. (Tr. 12). He has been employed by MSHA in Harlan as a ventilation specialist for five and a half years and been with MSHA for almost thirteen years. (Tr. 10). He received twenty-six weeks of training at the Academy. (Tr. 10). He has also worked as an inspector and a member and trainer on the MSHA Mine Emergency Unit for almost six years. (Tr. 10, 12). Jackson has helped in six or seven underground mine fires and three explosions. (Tr. 12).

interviewed Anthony Coots (“Coots”). (Tr. 55). According to the notes, Coots arrived at the mine site at 4:40 a.m., traveled underground to do examinations, and then went to the surface and met Billy Joe Clem, Jr. (“Clem”).<sup>3</sup> (Tr. 55-56). They then traveled underground. (Tr. 56). In an interview, Jackson learned Coots went to burn holes into the metal tailpiece to insert bolts. (Tr. 18-19, 21). The belt was not running at the time. (Tr. 21). The only other person in the mine was Clem. (Tr. 21). Coots left Clem at the 001 MMU and traveled back to the #3 tailpiece with tanks and torches to work on the skirt. (Tr. 56). At around 8:30 a.m., a carbon monoxide (“CO”) alarm went off and he called to surface to get the security guard to silence it. (Tr. 56). This was also likely the time he turned off his Solaris detector. (Tr. 56). The alarm possibly went off after detecting CO from the smoke caused by the hole he burnt in the tailpiece. (Tr. 57-59). When the guard could not silence it, he went outside, turned it off, and at around 9:30 went back underground. (Tr. 59). When Coots got to crosscut 26 his spotter went off showing 35 ppm CO; a significant amount. (Tr. 59). Ordinarily, it is zero. (Tr. 59).

Coots then said he went to the tailpiece and found 90 ppm CO, an orange glow, and heavy smoke at around 9:30-9:45 a.m. (Tr. 59, 62). Coots got two fire extinguishers, took them to the area and discharged them, but the fire did not go out. (Tr. 60). After that, he traveled thousands of feet across all six entries looking for Clem. (Tr. 60). Eventually Coots reached the surface and called his father and then Respondent’s bookkeeper. (Tr. 60). Terry Loving (“Loving”) and Matthew Coots went underground later and put the fire out with water. (Tr. 70-71). Jackson went in later, after the state inspectors left, after the fire was out. (Tr. 71). Loving and Matthew Coots went back in later that day and put more water on the tailpiece to make sure the area did not ignite. (Tr. 71-72). Loving said he put water on the area for about one hour. (Tr. 72).

After conducting interviews, Jackson, Sparks, Superintendent Tim Johnson (“Johnson”), Loving and Coots went down.<sup>4</sup> (Tr. 14). They traveled to the site of the fire, the #3 tailpiece. (Tr. 14). Jackson never saw any flames. (Tr. 69). At the fire site, the entry was 6.5 feet tall and about 20 feet wide. (Tr. 16). The belt was 30 inches high and he approximated that it was a 42 inch belt conveyor. (Tr. 16). The area damaged was about 20 feet long and 9 feet at the widest spot. (Tr. 16-17). There was soot on the roof from smoldering belts. (Tr. 16, 89). When they arrived, the roof had started “spiderwebbing” and was hot to the touch. (Tr. 15).

Jackson reviewed a side-view illustration of the area of the #3 belt conveyor tailpiece and the #4 belt conveyor head drive, GX-2. (Tr. 14-15). It was prepared by Kevin Doan (“Doan”), a roof control specialist. (Tr. 15). The illustration accurately shows the condition of the #3 belt conveyor tailpiece and the #4 belt conveyor drive prior to the fire. (Tr.15). It shows the tailpiece, the belt threaded through the tailpiece, the #4 belt conveyor, and the belt threaded

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<sup>3</sup> Clem testified at the hearing. He works for Rex Coal Company at the D-5 mine (though he worked at C-5 on November 26, 2009). (Tr. 198-199). He has worked in the mines approximately 26.5 years. (Tr. 200).

<sup>4</sup> Coots testified at the hearing. He worked at the C-5 Mine as a foreman. (Tr. 202). He had been a foreman since 2007 and also had electrician, MET, and dust sampling certifications. (Tr. 202). Coots has been in the coal industry for ten years. (Tr. 203).

through the head roller, down through the take-up rollers, and back underneath the boom. (Tr. 15). The illustration shows damage to the roof, which was not present before the fire. (Tr. 15).

Jackson reviewed another illustration by Doan of the same area looking down from the top, GX-3. (Tr. 17, 21-22). It accurately reflects what he saw on the day of the fire. (Tr. 21-22). The area where the belt was still intact is dark and the shaded area is where it burned. (Tr. 17). It also showed where about five feet of the #4 belt roller head was burned in two. (Tr. 17). The illustration also shows coal pillars and a mandoor marked "D." (Tr. 18). There is information written above and below the #3 belt. (Tr. 18). Above, it states that Coots had been preparing to put a rubber skirt in the tailpiece to prevent spillage while the coal moves from one belt to another. (Tr. 18-19). The writing below the belt shows where the fire began. (Tr. 19). Hot slag can fall from the burning metal to coal fines that fall from the tailpiece. (Tr. 19-20). Hot material can cause smoldering or a fire. (Tr. 20).

The fire went to the back of the #3 tailpiece. Tr. 20. The #4 head drive extended over the #3 tailpiece two or three feet. (Tr. 20). The fire went to the tailpiece and burned the belt in two across the head roller. (Tr. 20). The investigation team measured forty-five to forty-eight feet of damage to the #4 conveyor. (Tr. 20-21).

Sparks took photographs of the area. (Tr. 23). Jackson reviewed a photograph of the #3 tailpiece, GX-4. (Tr. 23-24). It showed a place where the belt was missing after being burned. (Tr. 24). The belt was under the tailpiece. (Tr. 24). A bucket was on top of the tailpiece because Coots used it to put water on the holes he was drilling. (Tr. 24).

He reviewed a photograph of a hole burnt in the tailpiece to install the rubber skirt, GX-5. (Tr. 25). It also shows where the belt is missing from being burned. (Tr. 26).

He reviewed a photograph of a plug for the land line that was burned, GX-6. (Tr. 26-27).

He reviewed a photograph of the three wires used to run the heat sensor, GX-7. (Tr. 27). It shows melted insulation from the fire. (Tr. 27-28). The heat sensors were part of deluge system, which activated. (Tr. 28, 70). A deluge system squirts water over the belt when the temperature reaches 190 degrees. (Tr. 28, 70).

He reviewed a photograph of the back of the #3 tailpiece where the belt was burned in two, GX-8. (Tr. 28-29). It showed where the #4 head drive extended over the area and where it burned the #4 belt also. (Tr. 29). There were also burned pieces of belt. (Tr. 29).

After Sparks took the pictures, Loving sprayed water on the area for an hour to ensure it did not rekindle. (Tr. 29). Then, they went back to the surface. (Tr. 29-30).

Jackson reviewed Citation No. 8401221, issued on February 11, 2010 under §50.10, GX-12. (Tr. 53). That regulation requires operators to notify MSHA, via an 800-number, within fifteen minutes if a belt fire occurs that lasts longer than ten minutes without being extinguished.<sup>5</sup>

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<sup>5</sup> The notation to thirty minutes in the citation was an error. (Tr. 54). The regulation used to be

(Tr. 53, 77, 94). If someone calls the number, the accident is recorded and the appropriate MSHA field office will be notified to help and investigate. (Tr. 87). Respondent never reported the accident; MSHA learned about it on the news. (Tr. 54-55). The purpose of the regulation is to allow adequate personnel and equipment to arrive to fight the fire and rescue miners. (Tr. 63). If a fire is out within 10 minutes is still must be reported to MSHA, just not to the hotline. (Tr. 78).

Citation No. 8401221 was marked as high negligence because after Coots found the fire he went looking for Clem instead of contacting MSHA. (Tr. 64). MSHA did not become aware of the fire until around 12:20 when Whittaker's wife saw it on the news. (Tr. 64). On cross examination, Jackson admitted he was aware that Lewis Blevins ("Blevins") said he attempted to call MSHA.<sup>6</sup> (Tr. 69). However, when MSHA officials asked Blevins about whether Respondent had tried to contact MSHA, he said he would only tell Joe Bennett ("Bennett"), the owner. (Tr. 65). Jackson conceded that he never spoke to Blevins. (Tr. 90).

This citation was marked as highly likely because more than 10 minutes elapsed and it was not reported. (Tr. 65-66). Coots did not call out to the security guard to make sure there were proper notifications. (Tr. 90). There were two people underground and no one knew what was occurring, which could have resulted in the situation getting out of hand. (Tr. 66). Jackson has extensive experience in collecting body parts of people in just these kinds of accidents. (Tr. 66). Jackson marked the violation as fatal because both men could have been killed by CO. (Tr. 63, 66, 92). Also, only one person knew about the fire and the surface was not notified. (Tr. 91-92). Further, there was no Responsible Person.<sup>7</sup> (Tr. 66). The situation may have changed if MSHA was called.<sup>8</sup> (Tr. 92). Jackson marked two people affected because there were two people underground and no one knew where they were. (Tr. 67, 90). However, Coots was a foreman and knew the mine lay-out. (Tr. 91). Jackson marked the citation as S&S because it was a mandatory standard and a great deal of hazard was created for both miners. (Tr. 67).

## **II. Charles Douglas Ramsey's Testimony**

Charles Ramsey ("Ramsey") received a call about the fire on November 26, 2009 and was told to begin an investigation the next day.<sup>9</sup> (Tr. 143). To investigate, he reviewed the site

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thirty minutes, now it is fifteen. (Tr. 78).

<sup>6</sup> Blevins testified at the hearing. He is a superintendent at Harland Cumberland Coal (Respondent's sister company). (Tr. 185-186). He has been in the mining industry since 1981, a foreman since 1998, and has foreman's papers. (Tr. 186-187). He is familiar with pre-shift examinations. (Tr. 187).

<sup>7</sup> This issue will be explored in full during the discussion of Order No. 8401220.

<sup>8</sup> It took Jackson forty minutes to get there. (Tr. 92). Jackson does not know how long someone would last in CO, it would depend on the rescuer and if someone was barricaded. (Tr. 92).

<sup>9</sup> Ramsey began working the mining industry in 1995 and had six years of experience before starting at MSHA. (Tr. 142). He worked as a purchasing agent, an underground general laborer,

of the accident, took pictures, and reviewed records. (Tr. 143). He traveled underground on November 27. (Tr. 143).

Ramsey reviewed a photograph, marked as GX-19. (Tr. 144). The photograph depicts the tailpiece where the fire occurred and shows that the belt was burnt. (Tr. 144). The belt is lying on the mine floor. (Tr. 144). It had been burnt more in one area than up near the end. (Tr. 144).

Ramsey reviewed another photograph, marked as GX-20. (Tr. 145). The photograph depicts what was left of the top belt on the #4 head drive behind the tailpiece. (Tr. 145). The remains varied between twelve to sixteen inches in length and forty-two to forty-six inches in width. (Tr. 145).

Ramsey reviewed another photograph, marked as GX-21. (Tr. 145). The photograph depicts black soot on the mine roof adjacent to the left side of the head drive. (Tr. 145). The soot area was twenty feet wide for a distance of around forty feet. (Tr. 145).

Ramsey reviewed another photograph, marked as GX-22. (Tr. 146). The photograph depicts the top belt on the #4 head drive that had burned in two, the burnt section being in the middle. (Tr. 146). The black insulation on the fire detection line had melted. (Tr. 146).

Ramsey reviewed another photograph, marked as GX-23. (Tr. 147). The photograph depicts the torch gauges that Coots said he had used earlier in the day. (Tr. 147). The plastic covering from one of the gauges has a bubble in it from heat. (Tr. 147).

Ramsey reviewed another photograph, marked as GX-24. (Tr. 147). The photograph depicts the acetylene hose Coots had used. (Tr. 147). The hose burnt in two. (Tr. 148).

As part of his investigation, Ramsey interviewed Coots, Johnson, Blevins, Loving, (superintendent at another mine), Matthew Coots, Ray Allred (“Allred”) (safety director), and Joe Reece (“Reece”) (bookkeeper). (Tr. 148). Lewis Blevins told him that he attempted to inform MSHA of the fire starting at 11:54 a.m. (Tr. 148-149).

Coots stated that he conducted his pre-shift examination between 4:30 a.m. and 6:10 a.m.<sup>10</sup> (Tr. 150-157). He met Clem and they traveled to the scoop charger and watered the batteries between 6:10 a.m. and 8:00 a.m. (Tr. 157). Coots left Clem at the batteries and traveled to the #3 tailpiece sometime after 8:00 a.m.. (Tr. 157). Coots got equipment together to work on the tailpiece and began to cut holes so that he could put the skirting on. (Tr. 157-158).

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a repairman, and electrician. (Tr. 142). He has an underground electrician certification and a master commercial and residential electrical license in Kentucky. (Tr. 142). He had been an inspector at MSHA for six years. (Tr. 141). He received 21 weeks of training at the Academy. (Tr. 141-142).

<sup>10</sup> Ramsay’s testimony regarding Coots’ pre-shift examination will be discussed more fully during the discussion of Order No. 8355742.

While he was cutting with the torch, the security guard called and said the CO system was going off and that he did not know how to shut it down. (Tr. 158). Coots explained how, but the guard could not do it, so Coots said he would go outside. (Tr. 158). Coots said he took his torches apart, placed them in the break, and poured two buckets of water on the hose (holes) he had cut before he left. (Tr. 158). He left the area between 9:00 and 9:15 a.m. (Tr. 158). When he got to the surface he disarmed the CO system and explained it to the guard. (Tr. 159). At that point, Clem was on the surface so they loaded up the shuttle car. (Tr. 159).

Coots went back into the mine between 10:00 and 10:15 a.m. (Tr. 159). He went alone in the buggy but Clem was behind him in the scoop. (Tr. 159). At 10:40 to 10:45 at about break 26 on the #3 belt, he ran into smoke. (Tr. 160). He went over to the return and traveled to the #5 head drive and got two fire extinguishers and went back to the #4 belt. (Tr. 160). Coots could only get between 150-200 feet of the #3 tailpiece because of the smoke, but he saw a glow under the tailpiece. (Tr. 160). Coots said at that point he knew he had a fire. (Tr. 160).

After seeing the glow, Coots said he went back to where he could get into the fresh air and crossed over into the return to where he left his buggy and noticed that Clem's scoop was there, but Clem was not. (Tr. 161). He began to look for Clem; traveling through each man door across all six entries calling for him. (Tr. 161). Wall to wall, it was 400 feet across the entries. (Tr. 161). Where the map says 1823.69 there was a man door marked "D" and circled in silver on the map where he started to walk up the left side return (GX-27). (Tr. 161-162). Coots started in the return on the left side near the "D" and crossed back and forth across all six entries all the way to the surface. (Tr. 162-163). It would take 35 to 40 minutes to walk this entire route. (Tr. 163).

He arrived on the surface at around 11:20 a.m. (Tr. 164). When he got there, he called his father, a foreman at another mine, and told him the situation. (Tr. 164). His father said not to go anywhere and that he would be there in a few minutes. (Tr. 164). He then called the office and spoke to Reece. (Tr. 164). Matthew Coots then arrived at the mine followed by Loving. (Tr. 164).

They were preparing to go underground when Coots noticed a red light on the mine phone. (Tr. 165). It was Clem at the #3 head drive. (Tr. 165). Coots told Clem there was a fire and that he should go to the intake. (Tr. 165). At 12:00 p.m. they went underground, found Clem walking toward the surface from the intake end and picked him up. (Tr. 165-166). They then went to the fire and discharged at least one extinguisher and saw that the deluge system was on. (Tr. 166). The fire did not go out, so they hooked up a fire hose and Loving sprayed the fire. (Tr. 166). This was some time after 12:00 p.m., but Coots did not know the exact time. (Tr. 166).

### **III. Lewis Blevins' Testimony**

Blevins was at home on November 26, 2009. (Tr. 187). Reece called at 11:50 and Blevins told his wife to take notes, RX-4. (Tr. 188). He always takes notes when someone calls during an emergency and he usually keeps them in a file at the company office. (Tr. 187-188).



Reece said that Coots had called the main office and said they could not find Clem. (Tr. 188). Blevins gave Johnson's number to Reece. (Tr. 188). He asked Reece if anyone called MSHA and Reece did not know. (Tr. 189). While Reece called Johnson, Blevins called MSHA's hotline. (Tr. 189).

Belvins testified that he called and pressed "one" for emergency, and the system hung up on him. (Tr. 189). If he called the hotline, there would be an indication in his notes. (Tr. 195). If he tried to call back, that would also be in his notes. (Tr. 196). He then tried to call Bob Ray, an MSHA supervisor in Harlan, and he believed he tried to call the MSHA field office number too. (Tr. 189, 191, 196). He tried to call the state mining officials, but had to reach George Johnson at home. (Tr. 189-190). Eventually, Johnson called him back but by then Clem was already outside and the fire was out. (Tr. 190). He told Johnson to cancel the rescue team. (Tr. 190).

#### **IV. Anthony Coots' Testimony**

On November 26, 2009, Coots worked at the #3 tailpiece. (Tr. 206). He worked there because they were having trouble with the skirt; it had torn off earlier in the week and the belt was spilling. (Tr. 206). He was going to put new holes in the tailpiece and bolt a new piece on the skirt. (Tr. 206).

The CO system went off and the guard called. (Tr. 207). The guard did not know how to turn it off. (Tr. 207). Coots does not think his spotter was going off at that time. (Tr. 217). He does not think he turned his spotter off for any reason underground. (Tr. 217-218). Coots went outside and turned off the CO alarm. (Tr. 207). Coots does not remember when the guard called, but it was in his statements. (Tr. 220-221).

He went inside and saw smoke around the #3 Belt. (Tr. 207). It did not take long to travel 28 breaks because the buggy runs at twelve miles per hour and the bottom is good. (Tr. 218). He got off the buggy and went to the next head drive and got two fire extinguishers. (Tr. 207). He tried to get close enough to put it out, and he assumed something was smoldering. (Tr. 207). He could not approach "whatever it was" because of smoke, and because the spotter was going off. (Tr. 207, 213). This was when he started circling to look for Clem, the only other person underground, and he traveled all the way to the surface on foot. (Tr. 207, 213). He was anxious about Clem and yelled for him. (Tr. 208). He never found Clem while he was zigzagging. (Tr. 208, 215). He did not know how long the search took; he was "pretty amped up" and running as hard as he could. (Tr. 216). He did not call out to the guard while he looked for Clem. (Tr. 208). It never crossed his mind because his main goal was to find Clem. (Tr. 208, 216).

He went outside and asked the guard if he saw Clem, but the guard said he had not. (Tr. 208). Then he called Reece from the mine office, but he could not remember at what time. (Tr. 209, 213). Matt Coots, Loving, and Allred arrived seven or eight minutes later. (Tr. 209). Then, Coots saw a light flashing on the man phone and it was Clem. (Tr. 209). Coots told him to get to the intake and they went and got him. (Tr. 209). Clem went to the hospital because he was asked to go, but he came back that night to get his vehicle. (Tr. 210). Then, Coots, Matt Coots,

Loving and Allred went back in and put out what was smoldering. (Tr. 209-210). It was just smoldering, it was smoky. (Tr. 210). They sprayed water on everything, mostly on the oxygen and acetylene tanks, to cool everything off. (Tr. 216). It probably took 15-20 minutes. (Tr. 210). Bennett was there by the second or third time Coots came out. (Tr. 210).

Coots never tried to contact MSHA about the fire; he called Reece, as was part of the green plan. (Tr. 215). The green plan is the procedure for immediate reportables and it was in place in 2009. (Tr. 219). The Plan was dated 2007. (Tr. 219). If someone was hurt or their life was in danger, the surface had to be notified within 15 minutes. (Tr. 219). Then, High's Plant would have to be called so the ambulance would come and others would block the road to prevent the news from getting in. (Tr. 219). High's Plant is where he called Reece. (Tr. 219).

### Contentions of the Parties

The Secretary contends that Citation No. 8401221 was validly issued, that the violation was highly likely to result in a fatal injury to two persons, that the violation was significant and substantial ("S&S"), that Respondent was highly negligent, and that the proposed civil penalty is appropriate. The Secretary argues that the citation is valid because an accident, specifically a fire, burned for more than ten minutes and was not reported. (*Secretary's Post-Hearing Brief* at 25-27). The Secretary also argues that, with respect to gravity, two men were underground during a fire and could have easily been overcome with smoke. *Id.* at 28-29. Further, Respondent's actions were exhibited high negligence when Coots did not try to contact MSHA and Blevins only attempted to call MSHA after the deadline had passed. *Id.* at 16-19. Finally, the Secretary contends that the assessed penalty is appropriate in light of established case law. *Id.* at 33-35.

Respondent contends that Citation No. 8401221 was not validly issued, the condition was not grave or S&S, and that it was not highly negligent. Respondent argues that the citation was not valid because Blevins attempted to call but there was no answer, because there was no "operator" to take the call, and there was no evidence of when the event became "reportable." (*Respondent's Post-Hearing Brief* at 6-8). Respondent also claims that it did not exhibit high negligence because of Blevins' call, Coots was looking for Clem, a phone call would have been fruitless as MSHA was not answering, and the inspectors endorsed Coots' actions. *Id.* Respondent also argues that the failure to make a phone call was not grave. (*Respondent's Reply Brief* at 6-7). Finally, Respondent argues that the violation was not S&S. *Id.* at 6.

### Discussion & Analysis

Under 30 C.F.R. §50.10, an operator is required to call the MSHA hotline in the event of an accident. An accident in underground mines is defined in relevant part as "an unplanned fire not extinguished within 10 minutes of discovery..." 30 C.F.R. §50.2(h)(6). I credit the testimony of the MSHA accident investigators, Jackson and Ramsay, who testified that Coots encountered the fire no later than 10:45 a.m.<sup>11</sup> (Tr. 62, 160). Following this discovery, Coots

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<sup>11</sup> The Secretary discusses the possibility that Respondent would argue that there was no fire. *Secretary's Post-Hearing Brief* at 26-27. However, in its brief, Respondent concedes that Coots

retrieved fire extinguishers, but after ten minutes, the fire had not gone out. (Tr. 60). Respondent had until no later than 11:10 a.m. to contact MSHA regarding the fire. There is no evidence that anyone called MSHA to notify the agency of a fire at or before 11:10 a.m. Therefore, the undersigned finds that Respondent violated 30 C.F.R. §50.10.

Respondent presented several arguments challenging the validity of Citation No. 8401221. However, Respondent's arguments are not compelling. Respondent asserts that under *Consolidation Coal Co.*, it had the right to conduct an investigation into the accident before reporting it pursuant to 30 C.F.R. §50.10. 11 FMSHRC 1935, 1938 (Oct. 1989). Respondent argues that after Coots used the extinguishers on the fire and went to look for Clem, he had no way of knowing if the fire extinguished itself until he returned at around 12:00 p.m. and found it still smoldering. *Respondent's Post-Hearing Brief* at 7. According to the Respondent, only at that time did he know there was a fire that took more than ten minutes to extinguish, making it reportable. *Id.*

However, Respondent fundamentally misunderstands the investigative time the Commission interprets 30 C.F.R. §50.10 to include. *Consolidation Coal Co.*, only allows a reasonable opportunity for investigation prior to reporting. 11 FMSHRC at 1938. Further, that investigation must be conducted "in good faith without delay, and in light of the regulation's command of prompt, vigorous action." *Id.* This means that an operator is responsible for immediately notifying MSHA about accidents that it knows about or should know about. *See* 50 C.F.R. §50.10 ("The operator shall immediately contact MSHA without delay and within 15 minutes...once the operator knows *or should know* that an accident has occurred")(*emphasis added*); *see also Pine Ridge Coal Company, LLC*, 33 FMSHRC 987, 1004-1005 (Apr. 2011) (ALJ).

Here, Coots' delay after attempting to put out the fire was not for the purpose of investigating whether a reportable accident had occurred. He had already determined that a fire existed. Further, I find that Coots did not believe that the fire was out within ten minutes. If he had, he would not have feared for Clem's safety and frantically searched each entry of the mine for his co-worker. Therefore, the need for investigation (and the additional time allowed for it) was over and Respondent was required to report the condition to MSHA. Respondent's reading of the standard would stretch the definition of "immediately" beyond a reasonable time for investigation and into willful ignorance. At its logical conclusion, Respondent's argument would allow Coots to notice the fire and then simply look away and after nine minutes, assume that the fire had "extinguished itself," and toll the reporting requirement. Such a result would undermine the purpose of the standard and must be rejected.

Respondent also argues that if it was required to report the fire before Coots' return to the fire at noon, it attempted to do so but received no answer. *Respondent's Post-Hearing Brief* at 6.

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encountered a "glow" underneath the #3 tailpiece. *Respondent's Post-Hearing Brief* at 2-3. Coots also reported seeing smoke. (Tr. 207, 213). A reportable mine fire does not need to include flames, but can instead simply be smoldering material that has the potential for flames. *The American Coal Company*, 35 FMSHRC 380, 385 (Feb. 2013). Therefore, there is no issue as to whether there was a fire.

Blevins testified that he attempted to call the MSHA hotline sometime after hearing about the accident at 11:50 a.m. (Tr. 188). Ramsey testified that Blevins told him that the call occurred at 11:54 a.m. (Tr. 148-149). There is no evidence of anyone attempting to contact MSHA earlier than approximately 11:50 a.m. However, Respondent was required to contact MSHA no later than 11:10 a.m. Leaving aside any argument about whether Respondent had actually attempted to contact MSHA, the alleged call occurred 40 minutes too late. Therefore, Respondent's assertion, even if true, does not change the validity of the citation.

Respondent argues that the standard requires the "operator" to contact MSHA, but the only person at the mine who was an agent of Respondent, and therefore could count as the operator, was Coots. *Respondent's Post-Hearing Brief* at 6. It argues that it was impossible for Coots to contact MSHA and that the Secretary's position, that the guard should have contacted MSHA, would not have complied with the Act. *Id.* While it may be true that Coots could not have contacted MSHA from the mine to inform the agency of the fire, there is no requirement that the person who witnesses the condition be the one to report it. Coots was able to contact the surface and could have told the guard to contact MSHA. Despite the fact that the guard was not an agent of Respondent, it is unlikely that MSHA would have ignored or rejected a notification of a fire simply because that notice came from a guard. In the extremely unlikely event that MSHA refused to listen to the guard's notification, the guard could have contacted one of several other agents for Respondent who could have made the call. More importantly, MSHA is not required to relax standards to accommodate Respondent's staffing choices. If Respondent did not have the adequate personnel on hand to comply with all applicable standards, it should not have had workers at the mine that day.

Negligence "is conduct, either by commission or omission, which falls below a standard of care established under the Mine Act to protect miners against the risks of harm." 30 C.F.R. § 100.3(d). "A mine operator is required to be on the alert for conditions and practices in the mine that affect the safety or health of miners and to take steps necessary to correct or prevent hazardous conditions or practices." *Id.* Low negligence exists when "[t]he operator knew or should have known of the violative condition or practice, but there are considerable mitigating circumstances." *Id.* Moderate negligence is when "[t]he operator knew or should have known of the violative condition or practice, but there are mitigating circumstances." *Id.* High negligence exists when "[t]he operator knew or should have known of the violative condition or practice, and there are no mitigating circumstances." *Id.* See also *Brody Mining, LLC*, 2011 WL 2745785 (2011)(ALJ). Finally, an operator exhibits reckless disregard where it displays "conduct which exhibits the absence of the slightest degree of care." 30 C.F.R. § 100.3(d). Mitigating circumstances may include, but are not limited to, actions taken by the operator to prevent or correct hazardous conditions or practices. *Id.*

Respondent's conduct with respect to Citation No. 8401221 constituted high negligence. For the reasons discussed above, Respondent knew, or should have known, that there was a fire in the mine that had existed for more than ten minutes and that MSHA should have been contacted. It is uncontested that, after failing to put out the fire, Coots searched through the mine alone for forty minutes rather than contacting MSHA to ensure a mine rescue team was made

ready.<sup>12</sup> Further, even when he returned to the surface, he did not call MSHA. (Tr. 64, 208, 215-216). Instead, he called his father and the bookkeeper to inform them of the conditions at the mine. (Tr. 60, 164, 209, 213).

None of Respondent's actions mitigate this negligence. Respondent argued that Blevins' unanswered calls sometime after 11:50 a.m. mitigated the negligence. However, as shown above, even if Blevins called the MSHA hotline, it was at least forty minutes too late. Therefore, the call does not mitigate Respondent's negligence. Similarly, Respondent's actions were not mitigated by MSHA's alleged failure to answer the phone. Respondent would be required to follow the law, even if MSHA were completely derelict in its duties. The alleged call was late and, therefore, Respondent did not fulfill its obligations; it does not matter for this issue if there was anyone to answer it.

Respondent also raised the argument that Coots' actions in searching for Clem rather than calling MSHA were themselves praiseworthy and therefore mitigated any violation of the act. However, Respondent cites no authority for the proposition that a foreman can substitute his own judgment about correct action for the requirements of the standard. If anything, Coots' statement that calling MSHA was the last thing on his mind and that he chose instead to search for Clem shows disregard for the standard. It is possible that Coots' actions that day were brave, but they were not the required actions under the law. As shown by the evidence, his decision to negligently avoid the requirements of the Act put himself and Clem in danger.

In its brief Respondent raises a related argument by noting that the inspectors stated they agreed with Coots' actions on the day of the accident. *Respondent's Post-Hearing Brief* at 7-8. Respondent cited to Jackson's testimony when he stated "I do not have a problem with what he did."<sup>13</sup> (Tr. 84). Respondent also cites to Ramsay's testimony that he recalled telling Coots he appreciated his efforts to take care of safety in the mine. (Tr. 182). Further, Respondent provides no authority for the proposition that an inspector's comments to a miner mitigate negligence. The undersigned finds that the inspectors' words do not denote endorsement of Coots' actions or a belief that he acted correctly. Even if they did, such an endorsement does not change the law and the requirements placed on an operator. In short, Respondent's actions were negligent without mitigation.

The undersigned finds the evidence establishes that this violation was highly likely to result in a fatal injury to two persons. Respondent argues that the failure to make a phone call was not grave because no one answered the phone for MSHA and, as a result, the failure to call did not delay the arrival of MSHA officials. (*Respondent's Reply Brief* at 6-7). However, Respondent merely asserted that this was true. Respondent presented no phone records or any other evidence to suggest that such a call actually occurred or that MSHA officials were

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<sup>12</sup> Ramsay estimated it would take 35-40 minutes to conduct the search. (Tr. 163). Coots said he did not know how long it took. (Tr. 216).

<sup>13</sup> Although, Respondent did not note that shortly thereafter Jackson also stated, "I have a problem because he did not do what he was required to do." (Tr.84).

unprepared for an emergency. In fact, as soon as MSHA officials learned about the fire (from the local news) they immediately sprang into action and went to the mine. (Tr. 13-14). Thus the evidence suggests that, more likely than not, the phone call to MSHA never occurred. Or, if it did occur, a mechanical error caused the hotline to hang up on Blevins, in which case he should have called back. In light of this finding, the undersigned finds that the failure to contact MSHA created a grave risk to the miners. The Secretary presented evidence that a mine fire occurred and produced thick, toxic smoke. Miners were in danger of succumbing to carbon monoxide poisoning and possibly even burns. These two miners could have lost consciousness and may not have been discovered for the rest of the day. The failure to notify MSHA meant that rescue personnel were unnecessarily delayed in arriving. In the event that a mine rescue team had been needed (and it should be noted that Respondent was very lucky a team was not needed), they may not have arrived until it was too late.<sup>14</sup>

Respondent's violation cited in Citation No. 8401221 was significant and substantial ("S&S"). In order to establish S&S, the Secretary must prove: (1) the underlying violation of a mandatory safety standard; (2) a discrete safety hazard contributed to by the violation; (3) a reasonable likelihood that the hazard contributed to will result in an injury; and (4) a reasonable likelihood that the injury in question will be of a reasonably serious nature. *Mathies Coal Co.*, 6 FMSHRC 1, 3-4 (Jan. 1984). As already shown, Respondent violated 30 C.F.R. §50.10. However, Respondent argues that §50.10 is not a mandatory standard, but instead a "regulation" that cannot be adjudicated S&S. (*Respondent's Reply Brief* at 1-2 citing *Cyprus Emerald Resources Corporation v. Federal Mine Safety and Health Review Commission*, 195 F.3d 42 (D.C. Cir. 1999)). On this point, the undersigned finds Judge McCarthy's reasoning in *Pine Ridge Coal Company*, persuasive. 33 FMSHRC 987, 1003-1008 (Apr. 2011). Specifically, the undersigned finds that since the decision cited by Respondent was issued, §50.10 has been codified under 30 U.S.C. §§811, 813(j) and promulgated as a new emergency standard. Therefore, it is now a mandatory standard. As a result, Respondent's failure to comply with §50.10 was a violation of a mandatory standard.

This condition meets the second element of *Mathies* since the violation of a mandatory standard contributed to the hazards of smoke inhalation or burns by prolonging exposure and preventing the arrival of rescue personnel. Respondent argues that the failure to make a phone call did not contribute to a hazard because the MSHA office was closed, so a call would have no effect. (*Respondent's Reply Brief* at 3-4). Further, it argues that there were only two miners at the location and Coots was more concerned with safety than with calls. (*Id.*). As already noted, the evidence suggests that MSHA was prepared to deal with an emergency on the day of the fire and were not called. Further, Coots is not permitted to substitute his judgment for the requirements of the standard, and he should have contacted MSHA so that it could prepare for rescue operations. Failure to do so increased the time during which the miners were exposed underground and contributed to the hazards noted above.

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<sup>14</sup> Similarly, Respondent argued that the call was unnecessary because, if there was an emergency, the miners would have died waiting for rescue, citing to Jackson's testimony. (*Respondent's Reply Brief* at 3-4). However, the undersigned credits Jackson's testimony that miners would not have died waiting. (Tr. 88).

The Commission has recently clarified the third element of *Mathies*, stating the test “is whether there is a reasonable likelihood that the hazard contributed to by the violation... will cause injury.” *Musser Engineering Inc. and PBS Coals, Inc.*, 32 FMSHRC 1257, 1281 (Oct. 2010); *see also Cumberland Coal Resources LP*, 33 FMSHRC 2357, 2365-2369 (Oct. 2011). The Commission emphasized that the Secretary need not “prove a reasonable likelihood that the violation itself will cause injury...” *Id.* There is no question that a mine fire could cause injury, either from burns or from smoke inhalation. Finally, it is reasonably likely that the injuries resulting from such an accident would be reasonably serious, even fatal. As a result, this violation was S&S.

In light of these findings, a civil penalty is appropriate. Under 30 U.S.C. §830(i), there are six penalty criteria to consider when assessing a civil penalty. Those criteria are the operator’s history of previous violations; the appropriateness of the penalty compared to the size of the Operator’s business; whether the Operator was negligent; the effect on the Operator’s ability to remain in business; the gravity of the violation; and the demonstrated good-faith of the person charged in attempting to achieve rapid compliance after notification of a violation. *Id.*

Respondent argued that the penalty was too high. (Respondent’s Reply Brief at 5-7). However, that argument was based on Respondent’s disagreement with the Secretary’s findings with respect to gravity and negligence. *Id.* Having considered the findings and the six statutory criteria listed above, the undersigned **AFFIRMS** Citation No. 8401221 as written by Jackson and find that the proposed penalty of \$18,271.00 is appropriate for this violation.

#### **CITATION NO. 8401220**

On February 11, 2010 at 9:45 a.m. Inspector Jackson issued Respondent Citation No. 8401220 for an alleged violation of 30 C.F.R. §75.1501(a). That standard states:

- (a) For each shift that miners work underground, there shall be in attendance a responsible person designated by the mine operator to take charge during mine emergencies involving a fire, explosion, or gas or water inundation.
  - (1) The responsible person shall have current knowledge of the assigned location and expected movements of miners underground, the operation of the mine ventilation system, the locations of the mine escapeways and refuge alternatives, the mine communications system, any mine monitoring system if used, locations of firefighting equipment, the mine's Emergency Response Plan, the Mine Rescue Notification Plan, and the Mine Emergency Evacuation and Firefighting Program of Instruction.
  - (2) The responsible person shall be trained annually in a course of instruction in mine emergency response, as prescribed by MSHA's Office of Educational Policy and Development...
  - (3) The operator shall certify by signature and date after each responsible person has completed the training and keep the certification at the mine for 1 year...

30 C.F.R. §75.1501(a). In this citation, Jackson observed the following condition or practice:

The operator had no responsible person in attendance for the day shift on November 26, 2009 when miners were working underground. Foreman Anthony Coots, knowing that no responsible person was in attendance, entered the mine to conduct a pre-shift examination this day. He subsequently returned to the surface and then re-entered the mine with another miner in order to perform the day's assigned tasks. A mine emergency involving a fire occurred during this shift, endangering the miners underground. This violation is an unwarrantable failure to comply with a mandatory standard.

(GX-10).

Jackson found that this violation was highly likely to lead to an injury and that such an injury could reasonably be expected to be fatal. *Id.* He determined that the violation was S&S and affected two persons. *Id.* Jackson found Respondent's actions were an unwarrantable failure and exhibited High negligence. *Id.*

A subsequent Action was filed by the same day at 1:50 p.m. stating, "Foreman Coots has been trained as a 'Responsible Person' and the operator has reviewed the requirements of a 'Responsible Person' with other foremen." *Id.* at p. 2

### Summary of Testimony

#### **I. Jackson's Testimony**

Jackson reviewed the 104(d)(1) citation he issued on February 11, 2010 under 75.1501(a), GX-10. (Tr. 33). The cited regulation requires operators to provide a "Responsible Person," someone trained for fire events, at a mine site in case of an emergency. (Tr. 33). That person must call the proper authorities and comply with the Mine Emergency Evacuation Firefighting Plan ("the Plan"). (Tr. 33). Responsible Persons are trained by a certified instructor and receive a signed 5023 form. (Tr. 33-34). The citation was issued because on the day of the fire, Coots, Clem, and a security guard were the only miners present, and they were not Responsible Persons. (Tr. 34). None of their names were posted on the list of such persons on the mine office wall. (Tr. 34, 50). Coots did not have a 5023 form. (Tr. 83). Also, the miners did not behave like Responsible Persons. (Tr. 34-35, 83). On cross examination, Jackson conceded that if Coots said he was trained there would be no grounds to disagree with him, other than his actions. (Tr. 83-84).

Jackson reviewed the Plan for the C-5 mine, GX-11. (Tr. 35). Plans are approved to prevent hazards during an emergency. (Tr. 35). The C-5 mine's Plan was approved on November 21, 2007 and was in effect on the day of the fire. (Tr. 35-36). Under paragraph one of the Plan, the primary Responsible Person can appoint a temporary Responsible Person in instances when the primary person is in inaccessible areas. (Tr. 37). On November 26, 2009, there was no Responsible Person on the surface or at the mine. (Tr. 37-38).



With respect to the Plan, Respondent did not comply with Paragraph 4. (Tr. 40). That paragraph states, “

As persons enter the mine, their designation will be recorded by an outside dispatcher. Upon arrival at the destination, the dispatcher will be notified. Any change in location will be communicated to the outside dispatcher. For persons traveling such as mine examiners, the expected route of travel will be recorded. Any deviations from the anticipated travel route will be communicated to the dispatcher. A log will be maintained on the surface as to the location of each person underground.

(Tr. 38-39). Coots did not comply with this paragraph because he did not know where Clem was located and no one was logging where people were underground. (Tr. 40, 74-75). He went underground and found fire at the #3 tailpiece. (Tr. 40). He traveled inby, got fire extinguishers, and tried to find Clem. (Tr. 40). He traveled back and forth through man doors, though all six entries and traveled back to the surface without finding Clem. (Tr. 40). This amount of activity would take 30-40 minutes. (Tr. 40, 69). This was dangerous to both Clem and Coots. (Tr. 40).

Respondent did not comply with Page 2, Item 5 of the Plan. (Tr. 40-41). It requires all miners to assemble so they can be counted by the Responsible Person and be utilized during an emergency. (Tr. 41). When the fire occurred there was no assembly of men and neither Clem nor the guard even knew there was a fire. (Tr. 42, 75). Coots should have called outside to the security guard and told him where he was and where he was going to look for Clem. (Tr. 75). Assembly would occur underground at designated locations. (Tr. 76). Jackson knew that Clem was not aware of the fire because Clem called Coots to ask what was going on. (Tr. 43). Coots told him there was a fire and told him to go to the #2 head drive to be picked up. (Tr. 43).

Respondent did not comply with Page 3, Item 14. (Tr. 43). It requires all power to be turned off on equipment in the effective area, with only power necessary for travel, evacuation or ventilation used. (Tr. 43-44). The power was on when Jackson got to the tailpiece. (Tr. 44). He knew this because the power center was on, the lights were on, and the deluge had gone off when he entered the mine at 2:05 p.m. (Tr. 76).

Respondent did not comply with Page 4, Item 5D. (Tr. 44). It requires the Responsible Person to report occurrences to MSHA if required. (Tr. 44). A fire lasting more than 10 minutes must be reported and this one lasted longer than ten minutes. (Tr. 45). This was not reported, MSHA learned about it from the news. (Tr. 44-45).

Respondent did not comply with Page 4, Item 5E. (Tr. 45). It requires the Responsible Person to disconnect power from an affected area; that did not occur here. (Tr. 45). Jackson knew this because the lights were still on at the power center and head drive. (Tr. 45). However, Jackson was not there at the time of the fire. (Tr. 79).

Respondent did not comply with Page 4, Item 5F. (Tr. 46). It requires the Responsible Person to assign a qualified person to monitor the fan or returns for methane or carbon monoxide during an emergency. (Tr. 46). This was not being done. (Tr. 46). When Jackson arrived, he

went over to the fan and checked for methane and CO, and he found 30 ppm of CO showing light smoke in the #1 return portal. (Tr. 79-80).

Respondent did not comply with Page 5, Item (1)(i). (Tr. 47). It requires the Responsible Person to conduct an immediate evacuation of a mine with an imminent danger due to fire. (Tr. 47). When Coots realized there was a fire he traveled looking for Clem for thirty or forty minutes and only reached him when Clem called outside. (Tr. 47).

On cross examination, Jackson stated that he did not testify that Coots should not have looked for Clem; rather, he testified that Coots did not do what a Responsible Person would do. (Tr. 80-81, 84). If Jackson were to look for Clem, he would first call out to the security guard, tell him there was a fire, tell him he was looking for Clem, and ask him to call for help. (Tr. 81, 88). If Coots had been overcome by smoke, the security guard may have left after his shift and the miners would have died underground without anyone knowing. (Tr. 81). He conceded that it takes a while to assemble the mine rescue team and Clem could have died waiting. (Tr. 81-82, 88). Jackson did not believe he would die waiting. (Tr. 88).

Citation No. 8401220 was marked as high negligence and issued under 104(d)(1) of the Act. (Tr. 48). It was an unwarrantable failure because it was the responsibility of Respondent to make sure there was a Responsible Person on duty any time miners were underground and no one was. (Tr. 49). There was a large amount of danger because Coots and Clem were underground and there was smoke and soot. (Tr. 49). Coots said that at the tailpiece he could not get closer than 100 to 150 feet because the smoke was so thick. (Tr. 49). He also said there was 90 ppm of CO outby the #3 tailpiece. (Tr. 49). Despite this, Coots did not end up in the hospital. (Tr. 86-87). Jackson heard that Clem was sent to the hospital to get checked out. (Tr. 87). He did not know if Clem checked out of the hospital and returned to work on the same day. (Tr. 87).

This citation was marked as highly likely because there was a mine fire and two people underground. (Tr. 50-51). Coots created a hazard when he went to go look for Clem because he knew he had smoke and CO and did not use a Self Contained Self Rescuer (“SCSR”). (Tr. 51). Jackson knew Coots had not used it because he still had it. (Tr. 51). Once he encountered smoke and CO, he was required by law to put on his SCSR. (Tr. 85-86). Jackson did not believe that Coots would be the best judge of when to put on the SCSR. (Tr. 86). He marked this citation as fatal because they could have both been lost in the mine, in dense smoke, and been overcome by carbon monoxide. (Tr. 51, 85). Jackson marked two persons because only Coots and Clem were underground. (Tr. 51-52). Jackson marked this violation as S&S because this was a mandatory standard and the violation created a risk of injury or death. (Tr. 52).

## **II. Coots’ Testimony**

Coots is positive he had Responsible Person training conducted by Johnson and Matt Coots. (Tr. 210-211). He received the training long before this incident. (Tr. 211). They tried to find the papers; they were kept in a folder in the office. (Tr. 211). There are three copies of the 5023 Responsible Person form. (Tr. 212). Coots thought he put his copy in the company record, but he is not sure. (Tr. 212). He never found the form for the training he received before

the incident. (Tr. 212). Coots does not recall a list on the wall of Responsible Persons. (Tr. 212-213). He was trained again after the incident but he did not learn anything new. (Tr. 212).

Coots reviewed the Mine Emergency Evacuation Plan in effect at C-5 Mine, GX-11. (Tr. 213-214). The plan controls what should be done in the event of a fire. (Tr. 214). Coots does not recall if Respondent received a citation for failure to track people in the mine. (Tr. 214). Further, the electrical power on the #3 tailpiece did not need to be de-energized because the system had never been turned on. (Tr. 214). The deluge system was off when they went back in to put the fire out. (Tr. 214). There was a battery back-up hooked to the power center. (Tr. 214). Respondent assigned someone after the fire to monitor the CO coming out of the return, but not methane. (Tr. 215). It assigned someone when MSHA ordered them to do so. (Tr. 215). There was no one to monitor for methane because he was looking for Clem. (Tr. 220).

### Contentions of the Parties

The Secretary contends that Order No. 8401220 was validly issued, that the violation was highly likely to result in a fatal injury to two persons, that the violation was significant and substantial (“S&S”), that Respondent was highly negligent, that the violation was caused by an unwarrantable failure, and that the proposed civil penalty was appropriate. The Secretary argues that the citation is valid because no one at the mine was a Responsible Person. (*Secretary’s Post-Hearing Brief* at 18-21). The Secretary argues that, with respect to gravity that no one knew where Clem was located and Coots was not wearing his SCSR, meaning that someone could have died. *Id.* at 24. Further, Respondent’s actions were highly negligent and the result of an unwarrantable failure because it was supposed to make sure a Responsible Person was present and failed to do so and a serious incident occurred. *Id.* at 21-23. Finally, the Secretary contends that the assessed penalty is appropriate in light of established case law. *Id.* at 33-35.

Respondent contends that Order No. 8401220 was not validly issued, was not S&S, and not the result of high negligence nor an unwarrantable failure. Respondent argues that the citation was not valid because Coots was a Responsible Person and was present. (*Respondent’s Post-Hearing Brief* at 8-11). Respondent argues that any negligence was mitigated because this was not a normal situation as only two miners were underground. (*Respondent’s Reply Brief* at 11-12). For the same reasons, it argues that the violation was not S&S. *Id.* Finally, Respondent argues that this violation was not an unwarrantable failure because the Secretary never identified any aggravating conduct. *Id.*

### Discussion & Analysis

Under 30 C.F.R. §75.1501(a), an operator is required to have a Responsible Person on site while miners are working underground. This person is supposed to be familiar with the Emergency Response Plan, the Emergency Evacuation and Firefighting Plan, and other procedures related to mine emergencies. 30 C.F.R. §75.1501(a)(1). A Responsible Person is supposed to have annual training on mine emergency response and signed certification of that training is to be kept at the mine for a year. 30 C.F.R. §75.1501(a)(2)-(3).

With respect to Order No. 8401220, the issue is whether Coots was a Responsible Person. In its brief, Respondent could only point to the fact that Coots asserted that he received the training as evidence that he was a Responsible Person. (*Respondent's Post-Hearing Brief* at 11). However, it is uncontested in this case that Respondent failed to maintain a record of Coots' alleged certification. (Tr. 83, 212). Despite the fact that a miner trained as a Responsible Person receives three copies on the 5023 form, Respondent could not produce any documentary evidence of Coots' training. (Tr. 212). Significantly, Jackson credibly testified that Coots' name was not on a list of Responsible Persons at the mine. (Tr. 34). Respondent argues that this failure is merely a paperwork violation and one for which it was not cited. (*Respondent's Reply Brief* at 11). However, it is more than that. It is evidence that Coots was not trained as a Responsible Person at all or that his training had lapsed due to the passage of time.

In addition to the lack of documentation, the inspector credibly testified that Coots failed to act as a Responsible Person should act in the event of an Emergency. (Tr. 34-47, 80-84) Specifically, Coots failed to log the locations of people underground, he did not assemble miners and count them during the emergency, he did not (as shown in Citation No. 8401221) report the incident to MSHA, he did not turn off and disconnect the power, he did not monitor the return air, and he did not conduct an evacuation.<sup>15</sup> (Tr. 40-47, 74-75).

In light of Respondent's inability to produce a 5023 form, the absence of Coots' name from the list of Responsible Persons, and Coots' failure to behave like a Responsible person the undersigned holds that Respondent did not have Responsible Person at the mine on the day of the fire. Therefore, the undersigned finds that Respondent violated 30 C.F.R. §75.1501(a)

Respondent's conduct with respect to Citation No. 8401220 constituted high negligence and an unwarrantable failure. For the reasons discussed above, Respondent knew, or should have known, that the C-5 mine was operating without a Responsible Person. Respondent had only three employees present on the day of the fire and none of those workers had the appropriate credentials. Even if Respondent believed Coots' was a responsible person, a quick check of the pile of 5023 forms in the mine office would have shown that Coots had not received the requisite training. Respondent argues that the negligence was mitigated because this was not a normal situation as only two miners were present, making compliance with the Plan as written impossible. (*Respondent's Reply Brief* at 12). However, Respondent cannot avoid the requirements of its Plans simply by short staffing. If Respondent is required to "assemble miners" and check for carbon monoxide at the return, then it is required to have sufficient personnel present to complete those actions. Its failure to properly staff the mine does not

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<sup>15</sup> In its brief, Respondent downplays the significance of Coots' failure to conform to the requirements placed on a Responsible Person. (*Respondent's Post-Hearing Brief* at 9-10, FN 3). Specifically, Respondent notes that Coots was looking for the only other miner underground to evacuate and that the effected areas may have been de-energized. *Id.* It is uncontested that Coots did not know where Clem was, despite the requirement that Clem's location be tracked, and this meant that Coots could not assemble or evacuate Clem in the way countenanced by the plan. (Tr. 40, 74-75). Also, I credit the testimony of the Secretary's witness that the affected areas of the mine were not de-energized. (Tr. 43-44).

mitigate its negligence, nor does anything else. Therefore, the high negligence designation is appropriate.

The Commission has recognized the close relationship between a finding of unwarrantable failure and a finding of high negligence. *San Juan Coal Co.*, 29 FMSHRC 125, 139 (Mar. 2007) (remanded because a finding of high negligence without a corresponding finding of unwarrantable failure was “seemingly at odds.”). Unwarrantable failure is defined as “aggravated conduct constituting more than ordinary negligence.” *Emery Mining Corp.*, 9 FMSHRC 1997, 2002 (Dec. 1987). The Commission has formulated a six factor test to determine aggravating conduct. *IO Coal Co., Inc.*, 31 FMSHRC 1346, 1350-1351 (Dec. 2009). Those factors are the extent of the violative condition, the length of time it existed, whether it was obvious or posed a high degree of danger, whether the operator was on notice of the need for greater efforts in compliance, the operator’s actions in abatement, and whether the operator had knowledge of the violation.<sup>16</sup> *Id.*

In the instant case, Respondent’s actions clearly constituted an unwarrantable failure. With respect to extent, the failure to provide a Responsible Person affected the entire mine and everyone working underground. No one was present to ensure that proper safety procedures were followed when the emergency occurred or to responsibly ensure the safety of Coots and Clem. The violation existed the entire shift. The violation was obvious because even a brief document check would show that Coots was not a certified Responsible Person. Additionally, it posed a high degree of danger because miners were underground when an emergency occurred and no one was present to take charge and ensure safety. There is no evidence that Respondent was on a specifically communicated notice for the need to provide a Responsible Person, beyond the requirements of 30 C.F.R. §75.1501(a). Considering the mine’s emergency plans that were in effect, there was no need for any special, additional notice. Respondent abated the condition by training Coots, but it was too late, an emergency had already occurred that required a Responsible Person and no such person was present. Finally, Respondent knew that Coots was the only supervisor present and had no reason to believe that he was a Responsible Person.<sup>17</sup> In light of the above factors, the undersigned finds that an unwarrantable failure was demonstrated.

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<sup>16</sup> While an administrative law judge may determine, in his discretion, that some factors are not relevant, or may determine that some factors are much less important than other factors under the circumstances, all of the factors must be taken into consideration and at least noted by the judge. *IO Coal*, 31 FMSHRC at 1351.

<sup>17</sup> With respect to knowledge, Coots knew or should have known that he was not a Responsible Person. Well-settled Commission precedent recognizes that the negligence of an operator’s agent is imputed to the operator for penalty assessments and unwarrantable failure determinations. See *Whayne Supply Co.*, 19 FMSHRC 447, 451 (Mar. 1997); *Rochester & Pittsburgh Coal Co.*, 13 FMSHRC 189, 194-197 (Feb. 1991); and *Southern Ohio Coal Co.*, 4 FMSHRC 1459, 1463-1464 (Aug. 1982). An agent is “any person charged with responsibility for the operation of all or part of a...mine or the supervision of the miners in a...mine.” 30 U.S.C. §802(e). A supervisor’s knowledge and involvement is an important factor in an unwarrantable failure determination. See *Lopke Quarries, Inc.*, 23 FMSHRC 705, 711 (July

The undersigned finds that the evidence established that this violation was highly likely to result in a fatal injury. The Secretary presented evidence that a mine emergency, in this case a fire, occurred and filled an area of the mine with thick, toxic smoke. (Tr. 49, 51, 85). Miners were in danger of succumbing to carbon monoxide poisoning and possibly even burns. (Tr. 49, 51, 85). The failure to provide a Responsible Person to coordinate the emergency response and ensure safety meant that the two miners were underground and acting without competent direction. Either miner, or both, could have become trapped underground or rendered unconscious and not been discovered for the rest of the day. The miners were not trained to take charge in an emergency situation and, as a result, they did not take the appropriate actions to minimize the risk of death. It is fortunate that no one was seriously injured.

Respondent's violation cited in Order No. 8401220 was S&S. Once again, the *Mathies* factors must be used to assess whether the violation as S&S. First, as already shown, Respondent violated 30 C.F.R. §75.1501(a). That violation contributed to the hazards of smoke inhalation or burns by maximizing the risks posed by the fire and smoke. The failure to have a Responsible Person prolonged the exposure to the fire and smoke. There is no question that increased exposure to a mine fire could cause injury, either directly from burns or indirectly from smoke inhalation. Finally, it is reasonably likely that the injuries resulting from such an accident would be reasonably serious, even fatal. As a result, this violation was S&S.

In light of the above findings and the six statutory criteria in 30 U.S.C. §830(i), I **AFFIRM** Order No. 8401220 as written by Jackson and find that the proposed penalty of \$18,271.00 is appropriate for this violation.

### **ORDER NO. 8355742**

On February 11, 2010 at 10:30 a.m. Inspector Charles Ramsey issued Respondent Order No. 8355742 for an alleged violation of 30 C.F.R. §75.360(b). That standard states in pertinent part:

(b) The person conducting the preshift examination shall examine for hazardous conditions, test for methane and oxygen deficiency, and determine if the air is moving in its proper direction...

30 C.F.R. §75.360(b). In this order, Taylor observed the following condition or practice:

The foreman failed to conduct an adequate pre-shift exam on 11-26-2009. The person performing the pre-shift exam is required to test for methane and oxygen deficiency. In a statement by foreman Coots, he said his first D.T.I.'s of his pre-shift exam were 4:45 a.m. at the #2 head drive. (See attached picture). A data memory check of the foreman's spotter, MSA Solaris s/n A5-80274, indicated

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2001) citing (*REB Enterprises, Inc.*, 20 FMSHRC 203, 224 (Mar. 1998) and *Secretary of Labor v. Roy Glenn*, 6 FMSHRC 1583, 1587 (July 1984).

that the spotter was not turned on until 5:10 a.m. One of the last times recorded on the outby pre-shift exam was 5:13 a.m. at #4 head drive. Foreman Coots engaged in more than ordinary negligence in that the proper checks for methane and oxygen were not conducted as required by 30 C.F.R. and exposed Bill Clem, scoop operator, to exposure of possible unknown gases that could have been present and only detected with an approved gas detector. This mine liberates approximately 31,253 cubic feet of methane in a 24 hour period and has a blowing fan which moves the air towards the surface from the face. This violation is an unwarrantable failure to comply with a mandatory standard.

(GX-30).

Jackson found that this violation was reasonably likely to lead to an injury and that such an injury could reasonably be expected to be fatal. *Id.* He determined that the violation was S&S and affected two persons. *Id.* Jackson found Respondent's actions were an unwarrantable failure and exhibited high negligence. *Id.*

A subsequent action was filed by the same day at 1:36 p.m. stating, "A pre-shift exam with the recorded levels for CH<sub>4</sub>, O<sub>2</sub>, and CO are being recorded in the pre-shift exam record book." *Id.* at p. 2

### Summary of the Testimony

#### **I. Jackson's Testimony**

On November 26, 2009, Sam Creasy took into custody the three Solaris multi-gas detectors used by Clem, Coots, and Johnson.<sup>18</sup> (Tr. 30, 72). They then filled out the chain of custody forms, GX-9. (Tr. 30-31). Jackson reviewed those forms. (Tr. 31). There are three forms, one for each detector. (Tr. 31). Kevin Doan received the detectors on November 30, 2009 and signed for them.<sup>19</sup> (Tr. 32-33). They were then passed to Charles J.C. Maggard ("Maggard"), an electrical supervisor. (Tr. 32). Maggard passed them on to Carla Marcum ("Marcum"), a specialist who downloads Solaris information.<sup>20</sup> (Tr. 32). The documents are kept in the ordinary course of business. (Tr. 32).

#### **II. Carla Bard Marcum's Testimony**

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<sup>18</sup> Sam Creasy is the supervisor at MSHA's Harlan office. (Tr. 13).

<sup>19</sup> Kevin Doan is a MSHA roof control specialist. (Tr. 15).

<sup>20</sup> Marcum is employed by MSHA as a geologist in the roof control division. (Tr. 95-96). She has been in the roof control division for two years and at MSHA for twenty years. (Tr. 96). She worked as an inspector for six years, a ventilation specialist for six years, and a health specialist for six years. (Tr. 96). She has a bachelor's degree from Berea College with an independent major emphasis on geology, soil sciences, and planning. (Tr. 96). She can certify mine maps, facilitate the design and lay-out of a mine, and coordinate drilling. (Tr. 96-97).

Marcum has experience with multi-gas detectors, which are devices that analyze the atmosphere using more than one sensor. (Tr. 97). Marcum first gained experience with multi-gas detectors in 1996 as a health specialist. (Tr. 97). She used them to obtain emissions readings from diesel equipment and to determine how much ventilation was needed at the face to neutralize methane. (Tr. 97-98). A Solaris detector is a hand-held multi-gas detector with three modes: usage, calibration, and download.<sup>21</sup> (Tr. 98, 105-106). A download takes data stored in the detector and puts it on a computer where it can be printed. (Tr. 98, 102). Marcum has downloaded hundreds, maybe thousands, of reports, both from her detectors and ones used by miners during a survey. (Tr. 102). She has also downloaded detectors when events take place; fires, methane ignitions, explosions, or where there were questions about whether miners were using them. (Tr. 102-103).

Marcum was not part of the investigation team for the fire at issue here. (Tr. 103). She became involved on November 30, 2009 when she was contacted by the electrical supervisor, Maggard. (Tr. 103-104). Maggard brought her three bagged Solaris detectors with the chain-of-custody form attached and asked that she download each. (Tr. 104).

Marcum reviewed the chain-of-custody forms she received from Maggard, GX-9. (Tr. 104). According to those documents, the Solaris detector, serial number A5-80274 was taken from Coots, serial number A5-65867 was taken from Clem, and A5-61509 was taken from Johnson. (Tr. 104). The forms reflect that Marcum downloaded the reports. (Tr. 105). Clem's did not download properly. (Tr. 105).

Marcum reviewed an information sheet regarding Coots' Solaris detector, serial number A5-80274, GX-16. (Tr. 107-108). She wrote notes on top of the first page of GX-16 because it was the only way to include the serial number and name. (Tr. 116-117). She did not write the second line. (Tr. 117). The sheet shows three sensors, the date it was downloaded, the ID, the calibration date, and things of that nature. (Tr. 108). The second page shows the session download. (Tr. 108). Every time the sensor is turned on, whether for usage, calibration, or download, this is called a session. (Tr. 108-109). Every time the sensor is turned on and then off, a session is logged showing the duration of the session and what the sensors show. (Tr. 109). This session shows three sensors: methane, oxygen, and CO. (Tr. 109). It will also list any events like an alarm or calibration. (Tr. 109). The gas readings will show peaks, minimums, and time-weighted averages. (Tr. 110). Time can be set manually with a computer. (Tr. 110). A calibrator can also be used to calibrate, set the time, and do a bump test. (Tr. 110).

With respect to time, Solaris detectors are not always correct because they are no different than any other timing device and synchronizing can be difficult. (Tr. 111-112). A large

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<sup>21</sup> Marcum reviewed a front-view photograph of a Solaris multi-gas detector, GX-14. (Tr. 99). There are four sensor points, a viewing screen, and an infrared reader (the red dot behind the screen, circled in blue). (Tr. 99-100). The infrared reader is designed to be the contact point between the reader and the sensor. (Tr. 100-101). Marcum also reviewed a back-view of a Solaris multi-gas detector, GX-15. (Tr. 101). There is a serial number, and a clip so that it can be worn. (Tr. 101). The photograph was magnified to make the serial number larger. (Tr. 102).



percentage, perhaps fifty percent, of the detectors Marcum has downloaded have had incorrect times. (Tr. 112). She often has to conduct a time correlation between real time and whatever time the instrument believes the time to be. (Tr. 112). To do this, she compares the time on the Solaris to the time on her computer. (Tr. 135). She subtracts the difference between the instrument time and the actual time. (Tr. 135-136). The difference is specific for each instrument. (Tr. 136). Marcum was trained in adjusting time differentials on the Solaris at her first training on multi-gas detectors by an MSA employee at a ventilation specialists' conference. (Tr. 126-127).

With respect to the download of Coot's spotter, page 2 states that the download took place on November 30, 2009 at 11:27 a.m. (Tr. 112). The Solaris download notes say that the session occurred at 1:45 p.m.-1:35. p.m. (Tr. 113). Therefore, there was a two hour and eighteen minute difference between the actual time and the instrument time. (Tr. 113). Page 13 shows when the unit was used on November 26, 2009. (Tr. 113). It was turned on at 7:34 a.m. and stayed on until 10:56 a.m. (Tr. 113-114). Marcum adjusted the time two hours and eighteen minutes to around 5:14-5:15 a.m. (Tr. 114).

This sort of discrepancy can occur because, when the instrument is calibrated or downloaded, it can mark a certain minute in the day. (Tr. 114-115). However, it does not know the exact second, so it can be off. (Tr. 114-115). The instrument was last calibrated November 4, 2009. (Tr. 115). Nothing else could have changed the time of the instrument between the fire and Marcum's download. (Tr. 115). The print-out on pages 13 and 14 show that after the instrument was activated on November 26, 2009, it was not turned on again until Marcum's download. (Tr. 115-116). She does not know if the Solaris is bad at keeping time and is not acquainted with the phrase "time drift" with respect to the Solaris.<sup>22</sup> (Tr. 127-128).

Marcum reviewed an illustration depicting the download of Coots' Solaris, GX-18. (Tr. 120-121). Marcum prepared this document to explain her time correlations. (Tr. 121). The top portion of the sketch shows the real time computer at 11:25 a.m. on 11/30/2009. (Tr. 121). The center portion shows a Solaris with four sensors and a screen with information. (Tr. 121). There were several red "AC" marks and a red "A" on Coots' Solaris (Tr. 122). Miners often mark a Solaris so they know which one they typically use. (Tr. 122-123). The lower third of the picture shows the date and time of 11-26-2009 at 7:35 a.m. and then shows how the time correlation set the actual time to 5:14 a.m. (Tr. 123). These were not exact times; they could be a minute or two off in either direction. (Tr. 123-124). The notes also state a time of 5:10 a.m., and that was Marcum's estimate of the earliest time the instrument could have been turned on. (Tr. 124-125).

Marcum reviewed an information sheet regarding Johnson's Solaris, serial number A5-61509, GX-17. (Tr. 117-118). It shows there were sensors embedded in the equipment and shows the calibration dates for each. (Tr. 118). The serial number and "Tim J." was handwritten by Marcum for the same reasons as the other spotter. (Tr. 118). The rest of the pages show the same type of information as in GX-16. (Tr. 118-119). On page one it shows that Marcum used the Solaris on November 30, 2009 at 10:14 a.m. (Tr. 119). The discrepancy between the actual

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<sup>22</sup> Respondent offered RX-1, a printout from an MSHA website regarding the reliability of the Solaris at keeping time. (Tr. 128-135).

time and Solaris' time was the same for Johnson's Solaris as it had been for Coots', two hours and 18 minutes. (Tr. 119). This was because they used the same calibrator. (Tr. 119-120).

During download, the infrared sensor communicates with the infrared reader and after a few minutes, if it does not go through, the download will stop. (Tr. 106). This occurred with Billy Clem's Solaris. (Tr. 105, 136). She cleaned off the sensor to make sure it did not have soot, she tried to download again but was unsuccessful. (Tr. 106-107). Something was wrong with Clem's spotter. (Tr. 107). However, Marcum conceded on cross examination that on the second attempt it downloaded all the way through. (Tr. 136). Marcum reviewed an information sheet regarding the Clem's Solaris sensor serial number A5-65865, RX-2. (Tr. 137). On the final page of that document it shows that on 11-26-2009 it was turned on at 7:40 a.m. and turned off at 1:18 p.m. (Tr. 137). There is no reason to believe those times are inaccurate. (Tr. 138). Marcum stated she would have to look at her notes to see the differential. (Tr. 138). Marcum reviewed her notes dated November 13, 2009, RX-3, and they showed that she marked that Clem's Solaris was turned on at 5:15 a.m. (Tr. 139-140).

### **III. Ramsey's Testimony**

Ramsey interviewed Coots on November 27 and December 9. (Tr. 149). He reviewed a timeline he prepared based on the interviews, GX-25. (Tr. 149-150). He created the timeline to show where Coots was during the fire. (Tr. 150). The timeline begins at 4:30 a.m. when he arrived at the mine. (Tr. 150). Coots related that he got his equipment and began his pre-shift examination. (Tr. 150).

Ramsey reviewed a map of a portion of the mine, GX-27. (Tr. 151-152). At the bottom left of the map, where it says "portals," is where Coots entered the mine. (Tr. 152). At 4:45, Coots recorded his date, time, and initials ("DTI's") at the #2 head drive. (Tr. 150-151). The #2 head drive is shown on GX-27 where it states #2 belt conveyor drive with an arrow. (Tr. 152). The #2 belt drive was 2,365 feet from the surface. (Tr. 153-154). Ramsey reviewed a photograph, GX-26. (Tr. 151). It depicts the date board on the #2 head drive and shows that Coots was there at 4:45 a.m. (Tr. 151). Ramsey noted that Coots would have turned on his Solaris at around 4:30 a.m., as it takes a few minutes to start it up and then a few more to conduct a bump test. (Tr. 152). Before placing his DTI's anywhere, law required Coots to check for hazardous conditions, methane, and oxygen. (Tr. 153, 156). He would use a detector to check for methane about 12 inches from the top and lower for oxygen. (Tr. 153).

After checking the #2 belt conveyor he checked the #2 power center at 4:55 a.m. (Tr. 154). Ramsey saw Coots' DTI's at that location. (Tr. 154). Then Coots traveled to the #3 power center and recorded his DTI's at 5:02 a.m. (Tr. 154-155). This was around 3,000 feet from the surface. (Tr. 155). Then he traveled to the #3 head drive and did his pre-shift at 5:08 a.m. (Tr. 155). Ramsey saw Coots DTI's at that location. (Tr. 155). That location is shown on the map with the #3 conveyor and an arrow. (Tr. 155).

Coots then traveled to the #4 belt drive, the accident area. (Tr. 155). That location is marked as the #4 conveyor tailpiece and fire location on the map. (Tr. 155). Ramsey reviewed another photograph, GX-28. (Tr. 155). It depicts the date board on the #4 head drive and shows

that Coots was there on November 26 at 5:13 a.m. (Tr. 155-156).

Coots then traveled to the section scoop charger or section power center, between 5:42 and 5:45 a.m. (Tr. 156). Ramsey did not actually observe Coots' DTI's there. (Tr. 156-157). Ramsey observed all the DTI's himself except for the last pre-shift examination at 5:42 to 5:45 a.m. (Tr. 182-183). Coots arrived back at the surface following his pre-shift examination at between 6:00 and 6:10 a.m. (Tr. 157).

Ramsey reviewed a manual on the tracking system required by the Plan, GX-29. (Tr. 166). It requires Respondent to track anyone underground. (Tr. 166). It shows that Coots and Clem went underground at 5:45 a.m. and that they arrived at the section at 6:00 a.m. (Tr. 167). Ramsey learned this from the mine site and the guard, Melvin Noland, who thought he had done the tracking. (Tr. 167-168). The mine does not have to maintain a book with these records, but keeps them in a folder. (Tr. 167-168).

Ramsey reviewed the 104(d)(1) order issued to Respondent under 75.360(b) for failure to conduct a pre-shift examination, GX-30. (Tr. 169). Ramsey issued the order because Coot's first DTI's, which should have included a check for methane, was at 4:45 a.m., but according to Marcum's download he did not turn his Solaris on until 5:10 a.m. (Tr. 169-170). Ramsey reviewed the download of Coots' Solaris, GX-16. (Tr. 170). He wrote on the form that there was a time difference of two hours and eighteen minutes. (Tr. 170-171). He also reviewed a copy of the download of Johnson's Solaris, GX-17 and noted the same time difference. (Tr. 171).

Air quality is one of the biggest dangers facing miners. (Tr. 170). Ramsey stated that this violation was based on the calculation to determine real-time. (Tr. 177-178).

Ramsey marked this citation for high negligence because Coots recorded his DTI's and knew that he had to test for oxygen and methane but also knew that his spotter was turned off. (Tr. 171, 173). To comply he would have to look at the Solaris twice. (Tr. 171-172). The Solaris has a red light and a green light and they will go off, but it was not illuminated. (Tr. 178). In order to read the readout on the Solaris, Coots would have to shine his cap lamp on it. (Tr. 183). Miners depend on the examination to check for any hazards. (Tr. 173). Ramsey found this was high negligence solely because Coots knew the Solaris was not on. (Tr. 178).

Ramsey marked the gravity of this Order as reasonably likely because the ventilation is important and failure to turn on the Solaris meant that there was no way to detect differences in air quality. (Tr. 173). There could have been a build up of methane or a depletion of oxygen. (Tr. 173-174, 178). On cross examination, he conceded that there was no reason to believe that the ventilation was down in the mine. (Tr. 179). The only evidence of methane was the liberation rate.<sup>23</sup> (Tr. 179). The gravity was marked because those things could have happened.

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<sup>23</sup> Methane is measured using samples of the atmosphere, air readings, and a formula. (Tr. 180). Samples are taken anywhere air exits the mine and also on the active section. (Tr. 180). Ramsey will often take them near seals. (Tr. 180). Ramsey does not know how many sample bottles were taken in 24-hours, but the amount is based on a calculation. (Tr. 180-181).

(Tr. 179). Ramsey marked this Order as fatal because miners in the past had died from low oxygen. (Tr. 174). This mine liberated 31,253 cubic feet of methane in a 24-hour period. (Tr. 175). He marked this as affecting the two people in the mine that day. (Tr. 174-175).

Ramsey marked this Order as S&S because all of the factors involved would lead to an increased likelihood of injury. (Tr. 175). The Order affected the areas of the mine pre-shifted between 4:45 a.m. and 5:10 a.m. (Tr. 175).

Ramsey reviewed a 104(a) citation issued to Rex Coal Company, GX-31. (Tr. 176). It was issued for a violation of 75.360(g) which requires a pre-shift examination record on the surface before miners go underground. (Tr. 176). There was no record in the examination book on the day of the accident before Coots and Clem went underground the second time. (Tr. 176). The extent of the violation was that there was no report. (Tr. 177).

#### **IV. Coots' Testimony**

On November 26, 2009, Coots and Clem were at the mine to do "dead work" on the off-shift. (Tr. 203). At 4:40 a.m., Coots arrived at the mine. (Tr. 203). At 4:45-4:50 he got a spotter off the wall. (Tr. 203-204). Coots turns his spotter on when he gets it off the wall. (Tr. 204). He has never failed to turn on his spotter. (Tr. 205). When it turns on it rings and goes through the full system. (Tr. 204). It would be surprising if it were silent. (Tr. 204). He turned on his spotter that day and it was on the whole time he was in the mine and at every electrical installation he saw. (Tr. 204-205). There is no doubt in his mind that he turned it on.<sup>24</sup> (Tr. 206). Coots can see the readout on the spotter because it flashes green every few seconds. (Tr. 205-206). It did so that morning. (Tr. 206).

At 4:45-4:50 he went inside to do a pre-shift. (Tr. 203-204). Coots conducts pre-shifts all the time and has made them with every inspector at the Harlan office. (Tr. 205). Coots used his wrist-watch for his DTI's. (Tr. 216-217). He had no motive not to do a pre-shift examination. (Tr. 219-220).

#### **V. Billy Joe Clem, Jr.'s Testimony**

On November 26, 2009, Clem arrived at the mine between 5:40 and 5:55. (Tr. 199). That is the regular start time. (Tr. 199). He was the first to arrive and saw Coots when he came out of the changing room. (Tr. 199). A few minutes before he went into the mine he turned on the spotter. (Tr. 200). Clem went into the mine with Coots between 5:45 and 6:00 a.m., probably at 5:45. (Tr. 200-201). That was the normal time. (Tr. 200-201).

#### **VI. Blevins' Testimony**

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<sup>24</sup> Coots reviewed the chain of custody form, GX-9 and the signature on that does not look like Coots', because he writes in cursive and that was in print. (Tr. 218). However, Coots provided MSHA with the Solaris that was at his side when he came out the second or third time. (Tr. 220).

Blevins brought three new methane spotters to the hearing from the company. (Tr. 191-192). They make a loud whistle when turned on. (Tr. 192). It takes a few minutes after a Solaris is turned on for it to be ready go, it has to count down through the system. (Tr. 196). When there is a situation, it lights red and beeps loudly. (Tr. 192). The time on one of the spotters was 15:18, another was 15:27, and the final one was 15:21. (Tr. 193-194). Respondent's counsel noted that the actual time was about 2:00 p.m. (Tr. 193). Blevins never uses the spotters to tell time, he uses his watch. (Tr. 194). No one, not even federal inspectors, use the time from the spotters. (Tr. 195).

Blevins' personal Solaris has "LB" written on it. (Tr. 197). Miners often put their initials on them so they can get them back after they are sent off. (Tr. 197). There are fifteen to eighteen spotters at C-5. (Tr. 197). There are 14 people per shift who use spotters. (Tr. 198).

### Contentions of the Parties

The Secretary contends that Order No. 8355742 was validly issued, that the violation was highly likely to result in a fatal injury to two persons, that the violation was S&S, that Respondent was highly negligent, that the violation was caused by an unwarrantable failure, and that the proposed civil penalty was appropriate. The Secretary argues that the citation is valid because the DTI's entered on the pre-shift boards were entered before Coots' spotter was turned on, meaning he could not have done the required gas checks. (*Secretary's Post-Hearing Brief* at 29-30). The Secretary argues that, with respect to gravity that miners rely on the air quality tests and there could have been a number of dangerous conditions. *Id.* at 32. Further, Respondent's actions were highly negligent and the result of an unwarrantable failure because it knew it was supposed to test for gases and did not. Coots' knew the spotter was not on, and a supervisor was involved. *Id.* at 31-32. Finally, the Secretary contends that the assessed penalty is appropriate in light of established case law. *Id.* at 33-35.

Respondent contends that Citation No. 8355742 was not validly issued. Respondent argues that the citation was not valid because Marcum's method for determining the time of the pre-shift examination was flawed and Coots said that he conducted the pre-shift examination. (*Respondent's Post-Hearing Brief* at 12-16).

### Discussion & Analysis

Under 30 C.F.R. §75.360(b), an operator is required to conduct pre-shift examinations, including checks for methane and oxygen levels, in working sections of the mine. With respect to Order No. 8355742, the issue is whether Coots actually took the required methane and oxygen readings at the times he listed on the DTI boards. I find that the Secretary provided credible evidence to support a finding that Respondent did not test for methane and oxygen at the times listed. According to the Secretary, the underground records show that Coots recorded his first DTI's at the #2 head drive at 4:45 a.m. (Tr. 150-151) (GX-26). At 4:55 a.m. Coots recorded his DTI's at the #2 power center. (Tr. 154). At 5:02 Coots recorded his DTI's at the #3 power center. (Tr. 154-155). At 5:08 Coots recorded his DTI's at the #3 head drive. (Tr. 155) (GX-X). No earlier than 5:10 a.m., according to Marcum's testimony, Coots turned on his spotter. (Tr.

123-125). That would mean that the four DTI's that Coots signed before 5:10 occurred without the use of the spotter. Coots could not have known the methane and oxygen levels at those locations. The first location where Coots' spotter was on was the #4 head drive at 5:13 a.m. (Tr. 155-156)(GX-28). Therefore, the pre-shift examination did not meet the requirements of 30 C.F.R. §75.360(b).

Respondent proffered several arguments to undermine the validity of this citation. However, I do not find any of those arguments to be compelling. First, Respondent presented evidence in the form of Coots' testimony, which included a timeline different from the Secretary's. Specifically, Coots testified he arrived at the mine at 4:40 a.m. (Tr. 203). At 4:45-4:50 Coots retrieved his spotter and turned it on. (Tr. 203-204). At 4:45-4:50 Coots went underground to do his pre-shift examination. (Tr. 203-204). Therefore, he would have turned his spotter on before beginning the pre-shift examination and could have checked for methane and oxygen. After that, Coots no longer testified to specific times. However, I find that the evidence best supports the Secretary's timeline. First, as has already been shown with respect to Citation No. 8401220, Coots was not a credible witness. Beyond his lack of credibility with respect to Responsible Person training, Coots' testimony regarding the timeline is not credible. He claims he arrived at the mine at 4:40, turned on his spotter between 4:45-4:50 a.m. and then went underground. However, the photographic evidence shows that his first DTI's were also recorded at 4:45 a.m. at the #2 head drive. The mine map and Ramsay's testimony show that the #2 head drive was 2,365 feet underground, nearly half a mile from the surface. (Tr. 153-154). Coots could not have been entered the mine at the same time he was taking methane and oxygen readings at the #2 head drive. As Coots' testimony is the only evidence supporting the Respondent's timeline, it is not credible. Instead, the undersigned finds that the Secretary's timeline best conforms to the evidence.

Respondent also argues that Marcum's calculation regarding the time Coots turned on his spotter was inaccurate. If the Secretary cannot prove that the spotter was not turned on until 5:10 a.m., then he cannot prove that Coots filled in his DTI's without checking for methane and oxygen. Marcum testified that she determined that Coots could not have checked for methane and oxygen before 5:10 a.m. by conducting a time correlation with Coots' spotter. Apparently, the calibration process will often cause the spotters to have the wrong time. When downloading the information on the spotter, a technician can determine the correct time by correlating the actual time with the time the spotter believes it to be. For example, in this case Marcum downloaded Coots' spotter at the actual time of 11:27 a.m. (Tr. 112). However, the spotter stated that the time was 1:45 p.m., a discrepancy of two hours and 18 minutes. (Tr. 113). Marcum then looked at the time the spotter was turned on the day of the fire. The spotter believed it was turned on at roughly 7:35 a.m. (Tr. 113-114). Adjusting for the fact that the spotter was off by two hours and 18 minutes, Marcum determined that the spotter had been turned on no earlier than 5:10 a.m.

Respondent questions the accuracy of the time correlation conducted by Marcum. First, it introduced a memo issued during the Upper Big Branch investigation. (RX-1). That document showed that several multi-gas detectors used at UBB experienced "time drift." With respect to spotters, time drift means the "internal clocks can deviate from the length of the same time period measured by more precise means: one second measured by a gas detector can differ

from one second measured by the National Institute of Standards and Technology (NIST).” *Id.* at 8. If Coots’ spotter had a time drift, his spotter may be two hours and 18 minutes off one day and, for example, three hours off another. This would make Marcum’s calculation of the time Coots turned on his spotter inaccurate. However, Respondent reads this memo too broadly. It simply states that spotters can experience time drifts and that, after investigation in laboratory conditions, the spotters at UBB proved to have them. These findings do not show that the spotters at C-5 experienced time-drift or that Marcum’s calculations were flawed. If Respondent wished to undermine Marcum’s calculations in this way, it needed to show that the spotters *at C-5 Mine* experienced time drift. As no evidence on that point was raised, the undersigned sees no reason to hold that Coots’ spotter experienced a time drift or that Marcum’s simple mathematical calculation could not be used to determine the actual time. The fact that Johnson’s spotter was calibrated at the same time and had the same deviation confirms the accuracy.

Respondent also showed that the download of Coots’ spotter had 32 start-times recorded between 5/16/09 to 11/26/09 that varied greatly despite the fact that Coots works the same shift everyday. (*Respondent’s Reply Brief* at 8-9 citing GX-17). Respondent argued that this means that the simple subtraction conducted by Marcum could not accurately determine the time as the spotter time oscillated erratically and would not remain static from November 26, 2009 to November 30, 2009. However, Marcum noted in her testimony that the time a spotter’s time is set is affected by calibration. (Tr. 114-115). In essence, each calibration “re-sets” the clock in the spotter to a new time. According to Marcum, the last calibration date was 11-4-2009. (Tr. 115). That means that any times before November 4, 2009 would not deviate from the actual time by the same amount as after that calibration because the spotter’s time had been re-set. Only four of the 32 start times listed by Respondent in its *Response Brief* occurred on or after November 4, 2009. The other 28 times are not relevant as the start times were not set relative to the same calibration.

Furthermore, one of the four remaining start-ups actually occurred on November 4, 2009 and therefore it is possible the calibration occurred before the start-up on that date. However, even if that start-up occurred after the calibration, there is no evidence to suggest that the calculation of time conducted by Marcum would therefore be inaccurate. On November 26, 2009 the startup time according to the spotter was 7:28 a.m. Marcum determined that it was actually on at around 5:10 a.m. On November 13, 2009, for example, the spotter was turned on at 8:08 a.m., meaning that if the deviation was constant that it would actually be turned on at 5:50 a.m. Respondent presented no evidence to show that Coots turned his spotter on before or after 5:50 a.m. on that date and Coots’ arrival time on those dates were not verified. It is entirely possible that the discrepancy between the actual time and the time the spotter stated on both of those days was two hours and 18 minutes. The same is true of the other dates after the last calibration.<sup>25</sup> Therefore, the undersigned does not believe that this evidence undermines Marcum’s calculations.

Along a similar vein, Respondent notes that, using the time correlation, the Clem’s

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<sup>25</sup> Further, there is no evidence to suggest that Coots was using this spotter on those dates. It is possible it was used by another miner on that day while Coots used a different one.

spotter showed it was turned on at 5:15 a.m., about 25 minutes before he arrived at the mine. (*Respondent's Post-Hearing Brief* at 12-13). It argues that, given the impossibility of the spotter being turned on before Clem's arrival, the method of calculating times is not as precise as the Secretary claims and raises doubt about when the spotter was turned on. *Id.* However, Respondent's argument ignores the fact that Marcum testified that there was something wrong with Clem's spotter and that she could not glean useful information from it. (Tr. 106-107). The two spotters that she was able to download showed a consistent two hour and 18 minute discrepancy. (Tr. 119-120). Further, Marcum has downloaded hundreds, perhaps thousands, of spotters and was trained on conducting time correlations by a representative of the manufacturer. (Tr. 102). There is no reason to doubt her testimony regarding the efficacy of the time correlation, the time Coots' spotter was turned on, or the lack of usable information provided by Clem's spotter.

Respondent also notes that Coots was using his watch to determine the time, not the time provided by the spotter. Since the Secretary's calculation of 5:10 a.m. is based on the spotter, Respondent argues that the discrepancy is not based on Coots' failure to turn on the spotter, but the difference between the time on his watch and the actual time as calculated with the spotter. However, for this to be true Coots' watch would have had to be running 25 minutes slow. It is not reasonable to believe that he used a watch that was so far off from the actual time without noticing. Perhaps more importantly, regardless of the time his watch stated, Coots' credibility with respect to the time he acted has already been called into question.<sup>26</sup>

In light of the evidence showing that Coots conducted pre-shift examinations in four locations without the use of his spotter, the undersigned finds that Respondent violated 30 C.F.R. §75.360(b).

Respondent's conduct with respect to Citation No. 8355742 constituted high negligence. For the reasons discussed above, Respondent, through its agent Coots, knew, or should have known, that the pre-shift examination was being conducted inadequately. Specifically, Coots knew he was not checking for methane and oxygen because he did not turn on his spotter. As noted in the hearing and even in Respondent's brief, it would be impossible for Coots to mistakenly believe his spotter was on given the fact that it emits an ear-splitting screech when turned on and has several lights that blink while in use. As a result, there are no mitigating factors with respect to Coots' failure to turn on his spotter until 5:10 a.m. Therefore, the high negligence designation is appropriate.

Respondent's actions also clearly constituted an unwarrantable failure. With respect to extent, the failure to provide a Responsible Person affected every area pre-shifted before the spotter was turned on and everyone working underground. The violation was obvious because Coots knew that he had not checked for methane and oxygen. Additionally, it posed a high degree of danger because the mine liberates methane and there actually was a fire that day. If

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<sup>26</sup> Coots' lack of credibility, as discussed above, stems from the discrepancy between his testimony about the time and the photographic evidence of his DTIs and also from his testimony regarding Responsible Person training. None of this relies on the time provided by the spotter and therefore could not have been caused by an inaccurate watch.



there had been methane present that day, there may have been a deadly explosion in addition to the fire. There is no evidence that Respondent was on specific notice with respect to 30 C.F.R. §75.360(b).<sup>27</sup> Respondent abated the condition by conducting a new pre-shift examination, but it was too late. Miners had already worked underground without a proper pre-shift examination and Respondent was extremely fortunate there was no explosion. Finally, Coots was a supervisor and knew he was not properly conducting the pre-shift examination. In light of the above factors, the undersigned finds that an unwarrantable failure has been established.

The undersigned finds that the evidence established that this violation was reasonably likely to result in a fatal injury to two persons. The Commission has recognized preshift examinations as “of fundamental importance in assuring a safe working environment underground.” *Buck Creek Coal*, 17 FMSHRC 8, 15 (Jan. 1995); see also *Jim Walter Resources, Inc.*, 28 FMSHRC 579, 598 (Aug. 2006). Chairman Jordan and Commissioner Marks have referred to the preshift inspection requirement as “the linchpin of Mine Act safety protections.” *Manalapan Mining Co., Inc.*, 18 FMSHRC 1375, 1391 (Aug. 1996) (Jordan and Marks, concurring and dissenting in part). MSHA requires several layers of examinations, including on-shift, preshift, and weekly examinations, in order to ensure miner safety. “These examinations are designed to create a multi-layer, prophylactic approach to the identification and correction of hazardous or unsafe conditions in the mine.” *Coal River Mining, LLC*, 34 FMSHRC 1087, 1095 (May 2012) (ALJ). The Commission has clarified that the term “hazardous conditions” in §75.360(b) does not require that the condition be S&S or reasonably likely to result in injury; rather, the term “hazard” denotes a measure of danger to safety or health. *Enlow Fork Mining Co.*, 1997 WL 14346, \*7 (Jan. 1997). “The Commission has approved the definition of “hazard” as “a possible source of peril, danger, duress, or difficulty,” or “a condition that tends to create or increase the possibility of loss.” *Id.* The documented failure in this case to conduct an adequate pre-shift examination meant that miners were working in an environment with unknown atmosphere. This mine liberates methane. Respondent is fortunate that there was no explosion in this mine. Considering the high level of danger presented by a required examination that did not adequately check for hazards where miners were about to work, I find that the special assessment was fully justified.

Respondent’s violation cited in Order No. 8355742 was S&S. Once again, the *Mathies* factors must be used to assess whether the violation as S&S. First, as already shown, Respondent violated 30 C.F.R. §75.360(b). That violation contributed to the hazards of asphyxiation from lack of oxygen or explosion from the presence of methane in an area where fire was present. There is no question that lack of oxygen or explosion could lead to injury. Finally, it is reasonably likely that the injuries resulting from such an accident would be reasonably serious, even fatal. As a result, this violation was S&S.

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<sup>27</sup> Respondent undoubtedly received notifications regarding the importance of pre-shift examinations following the Sago disaster and UBB disaster, as the other mines in the country did. However, that issue was not raised at hearing. Furthermore, it is possible that C-5 mine may have some history of violations with respect to 30 C.F.R. §75.360(b). However, the Secretary submitted the violation history of Webster County Coal LLC’s Dotiki Mine, rather than Rex Coal Company, Inc.’s C-5 mine. (GX-32).

In light of the above findings and the six statutory criteria in 30 U.S.C. §830(i), I **AFFIRM** Order No. 8355742 as written by Jackson and find that the specially assessed penalty of \$44,600.00 is appropriate for this violation.

**SUMMARY**

Citation No. 8401220, Citation No. 8401221, and Order No. 8355742 were **VALIDLY ISSUED**. The Citations and Order are **AFFIRMED** as issued. The assessed penalties have been considered using the six statutory criteria set fort above and found to be appropriate, including the special assessment for No. 8355742

The total amount of \$81,142.00 is **AFFIRMED**.

**ORDER**

Respondent is **ORDERED** to pay civil penalties in the total amount of \$81,142.00 within 30 days of the date of this decision.<sup>28</sup>

/s/ Kenneth R. Andrews  
Kenneth R. Andrews  
Administrative Law Judge

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<sup>28</sup> Payment should be sent to: MINE SAFETY AND HEALTH ADMINISTRATION, U.S. DEPARTMENT OF LABOR, PAYMENT OFFICE, P. O. BOX 790390, ST. LOUIS, MO 63179-0390