FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION
OFFICE OF ADMINISTRATIVE LAW JUDGES
1331 PENNSYLVANIA AVENUE, NW, SUITE 520N
WASHINGTON, DC 20004-1710
TELEPHONE: 202-434-9900 / FAX: 202-434-9954

January 17, 2019

SECRETARY OF LABOR MINE SAFETY AND HEALTH ADMINISTRATION (MSHA), Petitioner	:	CIVIL PENALTY PROCEEDING: Docket No. YORK 2018-0031-M A.C. No. 37-00156-453924
v.	:	
RICHMOND SAND & STONE, LLC, Respondent	:	Mine: Richmond Sand & Stone

SUMMARY DECISION

Before: Judge Bulluck

This case is before me upon a Petition for Assessment of Civil Penalty filed by the Secretary of Labor ("Secretary") on behalf of the Mine Safety and Health Administration ("MSHA") against Richmond Sand & Stone, LLC ("Richmond"), pursuant to section 105(d) of the Federal Mine Safety and Health Act of 1977 ("Mine Act"), 30 U.S.C. § 815(d). The Secretary seeks a civil penalty in the amount of $5,000.00 for an alleged violation of his mandatory safety standard regarding timely accident notification.

Richmond filed a Motion for Summary Decision ("Resp't Mot."); a Memorandum in Support of Respondent's Motion for Summary Decision ("Resp't Mem."), including Peter Robbins' Affidavit ("Robbins Aff."), and a Prehearing Report with a Supplemental Report ("Resp't Rep.") and attached exhibits ("Exs. A through C"). The Secretary filed an Opposition to Respondent's Motion for Summary Decision and Cross-Motion for Summary Decision ("Sec'y Mot."); a Memorandum of Points and Authority in Support of His Opposition to Respondent's Motion for Summary Decision and In Support of Secretary's Cross-Motion for Summary Decision ("Sec'y Mem."); and Parties Stipulations for Summary Judgment ("Jt. Stips.") and attached exhibits ("Exs. P–1 through P–12"), including a copy of the Citation, MSHA Inspector Everett G. Kinser's notes, Inspector Kinser's Affidavit ("Kinser Aff."), the Autopsy Report, EMS Patient Care Report, and Dr. Keith Hilliker's Report. Richmond then filed a Response to Secretary of Labor's Opposition to Respondent's Motion for Summary Decision and Cross-Motion for Summary Decision ("Resp't Reply").

The following are issues for resolution in this case: (1) whether Richmond violated 30 C.F.R. § 50.10(a); and, if so, (2) whether Richmond was moderately negligent in violating the standard; and (3) the appropriate penalty.

Pursuant to Commission Rule 67(b), "[a] motion for summary decision shall be granted only if the entire record, including the pleadings, depositions, answers to interrogatories, admissions and affidavits, shows: (1) that there is no genuine issue as to any material fact; and (2) that the moving party is entitled to summary decision as a matter of law." 29 C.F.R. § 2700.67.

It is well settled that summary decision is an extraordinary measure and the Commission has analogized it to Rule 56 of the Federal Rules of Civil Procedure, which the Supreme Court has construed to authorize summary judgment only "upon proper showings of the lack of a genuine, triable issue of material fact." *Hanson Aggregates New York, Inc.*, 29 FMSHRC 4, 9 (Jan. 2007) (citations omitted). When considering a motion for summary decision, the Commission has noted that "the Supreme Court has stated that 'we look at the record on summary judgment in the light most favorable to . . . the party opposing the motion,' and that 'the inferences to be drawn from the underlying facts contained in [the] materials [supporting the motion] must be viewed in the light most favorable to the party opposing the motion.'" *Id.* at 9 (quoting *Poller v. Columbia Broadcasting Sys., Inc.*, 368 U.S. 464, 473 (1962); *United States v. Diebold, Inc.*, 369 U.S. 654, 655 (1962)). Moreover, Commission Judges should not grant motions for summary decision "unless the entire record shows a right to judgment with such clarity as to leave no room for controversy and establishes affirmatively that the adverse party cannot prevail under any circumstances." *KenAmerican Res., Inc.*, 38 FMSHRC 1943, 1947 (Aug. 2016) (quoting *Campbell v. Hewitt, Coleman & Assocs., Inc.*, 21 F.3d 52, 55 (4th Cir. 1994)); *but see Scott v. Harris*, 550 U.S. 372, 380 (2007) (holding that there is no genuine issue for trial unless a rational trier of fact could find for the nonmoving party).

Based on agreement of the parties to file cross-motions for summary decision and the facts, as represented by the parties, I find that there is no genuine issue as to any material fact. For the reasons set forth below, I conclude that the Secretary is entitled to summary decision as a matter of law, **AFFIRM** the Citation, and assess a penalty of $5,000.00 against Richmond.

I. Joint Stipulations

Stipulations of Fact:[1]

1. Richmond Sand and Stone ("the mine") is an "operator" as defined in Section 3(d) of the Mine Act, 30 U.S.C. § 802(d), at the crushed stone mining plant at which the Citation at issue in this proceeding was issued.
2. The mine at issue is located at 35 Stolsen Road in Wyoming, Rhode Island.
3. The mine at issue is subject to the jurisdiction of the Mine Act.
4. This proceeding is subject to the jurisdiction of the Federal Mine Safety and Health Review Commission and its designated Administrative Law Judges, pursuant to sections 105 and 133 of the Mine Act, 30 U.S.C. §§ 815, 823.
5. The mine is an open-pit crushed stone plant.
6. On October 2, 2017, Jose Manuel Ledo, a miner who was operating an excavator, was observed by two other miners to have slumped over the controls at 2:19 p.m.

[1] The Joint Stipulations have been numbered for clarity in this Decision.

7. The plant's leadman directed a miner to call "911," and the leadman and another miner attempted cardio-pulmonary resuscitation of Mr. Ledo.
8. The ambulance squad arrived on the scene at 2:24 p.m., attended to Mr. Ledo, removed him from the excavator, and transported Mr. Ledo to the Westerly (Rhode Island) Hospital, leaving the mine site 2:56 p.m.
9. The ambulance squad arrived at the hospital at 3:19 p.m.
10. Mr. Ledo was treated at the Westerly Hospital, but was pronounced dead at 3:35 p.m. by Dr. Hilliker.
11. The first report of Mr. Ledo's death was made to MSHA by telephone at 11:21 a.m. on October 3, 2017, the day after Mr. Ledo died, by Peter Robbins, the Respondent's Health and Safety Director.
12. Mr. Robbins was informed by telephone on October 2, 2017, at 2:34 p.m. about Mr. Ledo's situation.
13. The Citation attached to the Petition for Assessment of Penalty is a true and authentic copy of the Citation at issue.
14. Each of the Secretary's Exhibits, P–1 through P–12, are true and authentic copies of documents prepared or assembled by MSHA's personnel in the course of the investigation of this matter.
15. The deceased, Jose Ledo, died of a natural heart attack on October 2, 2017, and not as a result of any accident while pursuing his employment.
16. The deceased, Jose Ledo, was declared deceased at the Westerly Hospital at approximately 3:10 p.m. on October 2, 2017.[2]
17. The Respondent's pre-marked Exhibits, A, A–1, B, B–1 and C, are made part of the Stipulations.

II. Factual Background

On October 2, 2017, Jose Ledo suffered a fatal heart attack while operating an excavator at the Richmond Sand & Stone Mine, an open-pit crushed stone plant in Wyoming, Rhode Island. Jt. Stips. 1, 6, 15. At approximately 2:19 p.m., the plant's leadman and a front-end loader operator noticed that Ledo's excavator was idle, and when they checked on Ledo, they found him slumped over the controls of the excavator. Jt. Stip. 6; Ex. P–7. The plant's leadman directed another miner to call "911," while he and the loader operator attended to Ledo. Jt. Stip. 7. When they reached him, Ledo was not breathing and had no discernible pulse. Ex. B–1. They began performing cardio-pulmonary resuscitation ("CPR"). Jt. Stip. 7. The Hope Valley Ambulance Squad ("ambulance squad") arrived on the scene at 2:24 p.m., and Ledo was still unresponsive. Jt. Stip. 8; Ex. P–11. The ambulance squad took over CPR, and Ledo did not respond to their resuscitation efforts. Ex. P–11 at 4; Jt. Stip. 8. Between 2:30 p.m. and 3:24 p.m., he was defibrillated 12 times, six times at the mine and six times en route to the hospital. Ex. P–11 at 6-7; Jt. Stip. 8. The report generated by the defibrillator indicated that there were moments of ventricular fibrillation and pulseless electrical activity, but there was no detectible blood pressure or pulse following any of the 12 defibrillations. Ex. P–11 at 6-7.

[2] The Medical Report was amended to correct the time that Dr. Hilliker declared Ledo dead from 3:10 p.m. to 3:35 p.m. (see Jt. Stip. 10).

The ambulance squad left the mine site at 2:56 p.m., and arrived at Westerly Hospital at 3:19 p.m. Jt. Stips. 8, 9. Dr. Keith Hilliker noted that Ledo had been unresponsive for almost an hour upon his arrival at the hospital. Ex. P–11 at 11-12. Hilliker did not check Ledo's vital signs, and pronounced him dead at 3:35 p.m. Ex. P–11 at 11-12; Jt. Stip. 10. The Autopsy Report indicates that Ledo died of a naturally caused heart attack on October 2, 2017. Ex. P–10 at 4.

Peter Robbins, Richmond's Health and Safety Director, first learned of Ledo's condition at 2:34 p.m., while the ambulance squad was still working on Ledo at the mine. Jt. Stip. 12. Robbins called MSHA to report Ledo's death at 11:21 a.m. on October 3, the day after the accident. Jt. Stip. 11. MSHA Inspector Everett Kinser was assigned to investigate the death on October 4, 2017. Ex. P–3. After inspecting the scene and interviewing witnesses, Kinser issued the Citation in question to Richmond for its failure to report Ledo's death to MSHA within 15 minutes of the accident.

III. Findings of Fact and Conclusions of Law

Inspector Kinser issued 104(a) Citation No. 9367109 on October 11, 2017, alleging a violation of section 50.10(a) that had "no likelihood" of causing an injury, and was due to Richmond's "moderate" negligence.[3] The "Condition or Practice" is described as follows:

> The operator failed to notify MSHA of a fatal accident involving an excavator operator that occurred at Richmond Sand & Stone. At approximately 2:19 p.m. on 10/02/2017, the 58 year old excavator operator suffered a heart attack while working in the quarry at the mine site. MSHA was alerted of the accident from Peter Robbins (Director of Safety for Richmond Sand & Stone) on 10/03/2017 at 11:21 a.m. and MSHA responded to the site on 10/04/2017. Contact was made with Peter Robbins, who stated that he was notified of the accident at 2:34 p.m. (verified on his cell phone) on 10/02/2017.

Ex. P–3. Kinsler terminated the Citation on October 11, 2017, after reviewing MSHA's accident reporting requirements with the mine operator. Ex. P–3.

A. Fact of Violation

Richmond contends that it is entitled to summary decision because Ledo's fatal heart attack was the result of a non-occupational illness from natural causes rather than any work-related "accident" within the meaning of sections 50.10(a) and 50.2(h)(1) and, therefore, no immediate reporting was required. Resp't Rep. at 2-4; Resp't Reply at 1-2. On the other hand,

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[3] 30 C.F.R. § 50.10(a) states that: "[t]he operator shall immediately contact MSHA at once without delay and within 15 minutes . . . once the operator knows or should know that an accident has occurred involving: (a) A *death* of an individual *at the mine*." (emphasis added).

the Secretary takes the position that he is entitled to summary decision because any death occurring at a mine is a reportable accident under section 50.10(a). Sec'y Mem. at 1.

Section 103(j) of the Mine Act provides, in relevant part that, "[i]n the event of any accident occurring in any coal or other mine, the operator shall notify the Secretary thereof. . . . For purposes of the preceding sentence, the notification required shall be provided by the operator within 15 minutes of the time at which the operator realizes that the death of an individual at the mine . . . has occurred." 30 U.S.C. § 813(j). Section 3(k) of the Mine Act defines "accident" to include "a mine explosion, mine ignition, mine fire, or mine inundation, or injury to, or *death of, any person.*" 30 U.S.C. § 802(k) (emphasis added).

Section 50.10(a) of the Secretary's regulations largely mirrors the text of the Mine Act, requiring that the operator report a death at a mine once it is known or should have been known within 15 minutes. One of the definitions of "accident" in section 50.2 is "[a] death of an individual at a mine." 30 C.F.R. § 50.2(h)(1). Moreover, the Commission has emphasized that questions of whether an operator should report an accident to MSHA "must be resolved in favor of notification." *Signal Peak Energy, LLC*, 37 FMSHRC 470, 476-77 (Mar. 2015).

When the language of a provision is plain, the plain language is the meaning of the provision, and the sole function of the courts is to enforce the language, as written. *Hartford Underwriters Ins. Co. v. Union Planters Bank, N.A.*, 530 U.S. 1, 6 (2000). Here, the plain language of the Mine Act and the Secretary's Part 50 regulations requires any death at a mine to be reported to MSHA within 15 minutes of discovery, regardless of the cause of death. Compare, for example, section 50.2(h)(2), which distinguishes "*an injury* to an individual at a mine which has a *reasonable potential to cause death,*" with section 50.10(a)'s broader category of death at a mine due to any cause. 30 C.F.R. § 50.2(h)(2) (emphasis added).

Richmond relies on *Vulcan Construction Materials* and *Hanson Aggregates Midwest* to support its contention that there was no reportable accident. In these cases, ALJs found that *nonfatal* heart attacks were not *injuries* for purposes of mandatory MSHA reporting under section 50.10(b).[4] Resp't Rep. at 3-4 (citing *Vulcan Constr. Materials*, 35 FMSHRC 2868, 2874-75, 78 (Aug. 2013); *Hanson Aggregates Midwest*, 35 FMSHRC 2412, 2416 (Aug. 2013)). Further, Health and Safety Director Robbins claims that he did not know that he was required to report the death to MSHA because he believed that only work-related accidents were reportable. Robbins Aff. at 1. In fact, he claims that the report made to MSHA was merely informational rather than the result of any perceived duty. Robbins Aff. at 1. Richmond also argues that sections 50.10 and 50.2(h)(1) do not provide a usable definition of "accident" because the sections presuppose a predicate accident, which is not defined by the regulations. Resp't Reply at 1-2. Therefore, according to Richmond, the word "accident" should be construed according to

[4] 30 C.F.R. § 50.10(b) requires the operator to immediately contact MSHA within 15 minutes of "[a]n *injury* of an individual at the mine which has a *reasonable potential to cause death.*" (emphasis added).

its ordinary meaning.[5] Resp't Reply at 1. Finally, Richmond argues that the regulations' inclusion of "natural death" in the definition of "accident" is overly broad. Resp't Reply at 2.

Richmond cites to my decision in *Nyrstar Gordonsville, LLC*, arguing that it was wrongly decided, and the Secretary expresses the contrary view. Resp't Rep. at 5; Sec'y Mem. at 3-4. *Nyrstar* involved an apparent suicide at the mine site, and turned on *when* the mandatory reporting period was triggered after the operator had conducted a cursory investigation upon notice of the accident. 38 FMSHRC 1819, 1821-22, 24 (July 2016). Richmond's argument that the apparent suicide was not the result of a work-related accident and, therefore, not reportable, is consistent with its challenge to the instant Citation, and is contrary to the clear mandate of the Mine Act and regulations.

Likewise, Richmond's reliance on *Vulcan* and *Hanson* is misplaced because these cases involve violations of section 50.10(b), requiring reporting of injuries occurring at a mine that have a reasonable potential of death, not deaths occurring from natural causes at a mine. Therefore, these cases are not helpful. Moreover, Richmond's claim that Robbins had no notice that he was required to report to MSHA is belied by the clarity of the standard, itself, and the regulatory definition of "accident," as well as Robbins' own admission that he knew of the standard.[6]

While neither party has addressed whether Ledo actually died at the mine or later in the hospital, it is undisputed that Ledo had been unresponsive and without a pulse for 37 minutes at the mine before being taken to the hospital and, ultimately, declared dead. The report generated by the defibrillator indicated that there was no circulation during the 12 defibrillations, six of which had occurred at the mine. Further, the fact that Dr. Hilliker did not take Ledo's vital signs upon his arrival at Westerly Hospital is another indication that Ledo was already dead. Based on these facts, I find that Richmond knew or should have known of Ledo's apparent death by 2:56 p.m. at the very latest, the time at which the ambulance squad left the mine to transport him to the hospital; at that time, the 15-minute reporting interval began to run.

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[5] Richmond's reliance on a dictionary definition of "accident" as "an undesirable or unfortunate happening that occurs unintentionally and usually results in harm, injury, damage, or loss; casualty; mishap" is of no supportive value because that definition is in conflict with the plain language of the Mine Act's and regulations' definition of "accident," insofar as it excludes a meaning that the Act and regulations expressly intend. See Resp't Reply at 1 (quoting Dictionary.com, *accident*, https://www.dictionary.com/browse/accident (last visited Oct. 27, 2018)).

[6] There is a contradiction between Kinser's Affidavit, which states that Robbins was aware of the reporting requirement but believed that he had 24 hours to make a report, and Robbins' Affidavit, which indicates that he knew of the reporting requirement but believed that the 15-minute rule did not apply to the situation. See Kinser Aff. at 1-2; compare with Robbins Aff. at 1. This inconsistency is largely immaterial to the fact of the violation, but, taking Robbins at his word, his knowledge of the reporting requirement and failure to comply are considered in assessing Richmond's negligence.

Richmond failed to report Ledo's death to MSHA even after he had been declared dead at Westerly Hospital at 3:35 p.m. Although there is no basis upon which to conclude that the operator had a reasonable doubt as to whether Ledo had died on-site, the reasonable and prudent response, with or without doubt, would have been to report the accident to MSHA when Ledo *appeared* dead. As the Commission has emphasized, reporting is critical because the subsequent MSHA investigation ensures prospective safety at the mine. In the moment, a miner or the operator may not be able to readily ascertain the cause of death and, therefore, failure to report could expose more miners to unknown or unidentified hazards. *See Signal Peak*, 37 FMSHRC at 477 (citing *Emergency Mine Evacuation*, 71 Fed. Reg. 71430, 71431 (Dec. 8, 2006)).

Under these circumstances, having found that Richmond knew or should have known that it had experienced a reportable accident at the mine by 2:56 p.m., it had a duty to notify MSHA by 3:11 p.m. Richmond failed to contact MSHA until the next day, and well into the morning at 11:21 a.m. Accordingly, I conclude that Richmond violated the reporting requirement in section 50.10(a).

B. Gravity and Negligence

Given the clarity of the standard and regulatory definition of "accident," and the importance of timely notice to MSHA, Richmond's failure to report Ledo's death for 21 hours was an egregious breach of duty. The record establishes, however, that Ledo's death did not arise from an ongoing hazard affecting miners' safety, and that the delay in reporting the accident to MSHA had no likelihood of putting other miners in peril. The Secretary argues that moderate negligence is appropriate because Richmond mitigated the violation by immediately calling "911" and employing life-saving measures to resuscitate Ledo, and I credit Richmond's timely attention to Ledo's condition. See Sec'y Mem. at 5. Therefore, although this was a very serious violation, considering the mitigating factors, I find that Richmond was moderately negligent.

IV. Penalty

While the Secretary has proposed a civil penalty of $5,000.00, the judge must independently determine the appropriate assessment by proper consideration of the six penalty criteria set forth in section 110(i) of the Act, 30 U.S.C. § 820(i). *See Sellersburg Co.*, 5 FMSHRC 287, 291-92 (Mar. 1983), *aff'd* 736 F.2d 1147 (7th Cir. 1984). Notwithstanding application of *Sellersburg* criteria, however, the Mine Act imposes a minimum penalty of $5,000.00 for section 50.10 violations. 30 C.F.R. § 110(a)(2).[7] The Commission has found that

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[7] Section 110(a)(2) of the Mine Act states that an operator "who fails to provide timely notification to the Secretary as required under 103(j) of [the Mine Act] (relating to the 15-minute requirement) shall be assessed a civil penalty by the Secretary of not less than $5,000 and not more than $60,000." 30 U.S.C. § 820(a)(2). Similarly, section 100.4(c) of the Secretary's penalty regulations states that the penalty for failure to provide timely notification to MSHA "will not be less than $5,000 and not more than $65,000 for the following accidents: (1) the death of an individual at the mine." 30 C.F.R. § 100.4(c). In January 2018, the minimum penalty was increased to $5,903 and the maximum penalty was increased to $70,834 to account for inflation. 30 C.F.R. § 100.4(c); see also *Department of Labor Federal Penalties Inflation*

Commission ALJs are bound by the statutory minimums imposed by the Mine Act. *Consol Pennsylvania Coal Co., LLC*, 40 FMSHRC 998, 1008 (Aug. 2018).

Applying the penalty criteria, and based upon a review of MSHA's online records, I find that Richmond is a small operator, with no prior violations of section 50.10(a), and an overall violation history that is not an aggravating factor in assessing an appropriate penalty. There was no evidence proffered that the civil penalty proposed by the Secretary will affect Richmond's ability to continue in business. I also find that Richmond demonstrated good faith in achieving rapid compliance after notification of the violation. The remaining criteria involve consideration of the gravity of the violation and Richmond's negligence in committing it. I have found that this was a very serious violation, and that Richmond was moderately negligent in committing it. Therefore, I find that a penalty of $5,000.00, the statutory minimum proposed by Secretary, is appropriate.

ORDER

ACCORDINGLY, the Secretary's Cross-Motion for Summary Decision is **GRANTED**, Respondent's Motion for Summary Decision is **DENIED**, and it is **ORDERED** that Richmond Sand & Stone, LLC, **PAY** a civil penalty of $5,000.00 within 30 days of the date of this Decision.[8]

Jacqueline R. Bulluck
Administrative Law Judge

Distribution:

James Polianites, Office of the Regional Solicitor, U.S. Department of Labor, Government Center, JFK Federal Building, Room E-375, Boston, MA 02203

Girard R. Visconti, Shechtman Halperin Savage, LLP, 1080 Main Street, Pawtucket, RI 02860

/adh

Adjustment Act Annual Adjustments for 2018, 83 Fed. Reg. 7, 15 (Jan. 2018). The instant violation predated these adjustments.

[8] 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. Please include docket number and AC number.