FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

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WARRIOR COAL, LLC, Contestant, v. SECRETARY OF LABOR, UNITED STATES DEPARTMENT OF LABOR (MSHA) Respondent,	CONTEST PROCEEDINGS Docket No. KENT 2011-1084-R Order No. 8498873; 05/10/2011 Docket No. KENT 2011-1085-R Citation No. 8498874; 05/10/2011 Docket No. KENT 2011-1086-R Order No. 8498875; 05/10/2011 Docket No. KENT 2011-1088-R Citation No. 8498877; 05/10/2011
SECRETARY OF LABOR, UNITED STATES DEPARTMENT OF LABOR (MSHA) Petitioner, v. WARRIOR COAL, LLC, Respondent.	CIVIL PENALTY PROCEEDING Docket No. KENT 2012-706 A.C. No. 15-17216-280358 Mine: Cardinal

DECISION

Appearances: Eric Johnson, Esq., Office of the Solicitor, U.S. Department of Labor, Nashville, Tennessee, for Petitioner;

Gary D. McCollum, Esq., Assistant General Counsel, Alliance Coal, Lexington, Kentucky, for Respondent.

Before: Judge Andrews

This proceeding is before me on a petition for assessment of civil penalty filed by the Secretary of Labor ("Secretary" or "Petitioner"), acting through the Mine Safety and Health Administration ("MSHA"), against Warrior Coal, LLC, ("Warrior" or "Respondent"), at its

Cardinal mine, pursuant to Sections 105 and 110 of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. §§ 815, 820 ("Mine Act" or "Act"). On May 9 and May 10, 2011, MSHA Inspectors conducted inspections of the #2 Unit of Respondent's mine and issued citations and orders for alleged violations of the Mine Act. This docket involves five of the orders and citations issued pursuant to Sections 104 and 107 of the Act with a total proposed penalty of $215,200.

The case was originally assigned to Administrative Law Judge William S. Steele. On November 29, 2012, the Secretary filed an unopposed motion to amend his petition to note citations and orders Nos. 8498874, 8498875, and 8498877 were contested pursuant to Commission Rule 20. On January 31, 2013, Judge Steele granted the Secretary's request. On February 6, 2013, Judge Steele further ordered the dismissal of one contest proceeding, regarding Citation No. 8498876, which was paid in full by the Respondent. Subsequently, the above-listed dockets were reassigned to the undersigned.

The parties presented testimony and documentary evidence at the hearing held in Madisonville, Kentucky, on March 31 and April 1, 2015. After the hearing, each party submitted a post-hearing brief and a reply brief.[1] All of the evidence of record has been considered.[2]

Stipulations

The parties submitted joint stipulations, marked as Exhibit JX-1:[3]

1. During all times relevant to this matter, Warrior Coal, LLC, (hereinafter referred to as Respondent) was the operator, as defined in Section 3(d) of the Mine Act, 30 U.S.C. § 802(d), of the Cardinal mine, Mine ID No. 15-17216.

[1] Throughout this decision the Secretary's Post Hearing Brief will be cited as "SPHB" and the reply brief as "SRB". Respondent's Post Hearing Brief will be cited as "RPHB" and the reply brief as "RRB".

[2] The findings of fact in this decision are based on the record as a whole and the Administrative Law Judge's careful observation of the witnesses during their testimony. In resolving any conflicts in the testimony, the ALJ has taken into consideration the interests of the witnesses, or lack thereof, and consistencies, or inconsistencies, in each witness's testimony and between the testimonies of the witnesses. In evaluating the testimony of each witness, the ALJ has also evaluated demeanor. Any failure to provide detail as to each witness's testimony is not to be deemed a failure on the ALJ's part to have fully considered it. The fact that some evidence is not discussed does not indicate that it was not considered. *See Craig v. Apfel,* 212 F.3d 433, 436 (8th Cir. 2000) (administrative law judge is not required to discuss all evidence and failure to cite specific evidence does not mean it was not considered).

[3] The Secretary's exhibits will be marked "GX" followed by the number and Respondent's exhibits will be marked "RX" followed by the letter.

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

3. At all material times involved in this case, the products of the Cardinal mine entered commerce or the operations or products thereof affected commerce within the meaning and scope of Section 4 of the Mine Act, 30. U.S.C. § 803.

4. Respondent produced 5,841,599 tons of coal at its Cardinal mine in 2010.

5. The 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 113 of the Mine Act, 30 U.S.C. §§ 815 and 823.

6. MSHA Inspector Curtis Hardison, whose signature appears in Block 22 of Citation Number 8503299, was acting in his official capacity and as authorized representatives of the Secretary of Labor when he issued the citation.

7. MSHA Inspector David Winebarger, whose signature appears in Block 22 of Citation Numbers 8498874 and 8498877 and Order Numbers 8498873 and 8498875, was acting in his official capacity and as authorized representatives of the Secretary of Labor when he issued the citations and orders.

8. The citations and orders at issue in this proceeding were properly served by duly authorized representatives of the Secretary of Labor, Mine Safety and Health Administration, upon an agent of Respondent.

Citation No. 8503299

Summary of the Evidence

On May 9, 2011 Inspector Curtis Hardison[4] ("Inspector Hardison" or "Hardison") conducted an inspection of Warrior's Cardinal Mine. Tr. at 9.[5] He arrived at approximately 7:15 am and first inspected the pre-shift books and mine map. Tr. 28, 29. The Preshift Reports for the

[4] Inspector Hardison graduated with a bachelor's degree in Secondary Education, with a minor concentration in World History and a major concentration in Political Science and U.S. History, from the University of Southern Indiana, in 1998. Tr. 28. He began work for MSHA in 2006. Tr. 23. At time of inspection, Hardison was a full-time coal mine inspector with collateral duties as a special investigator; he also possessed accident investigation credentials. Tr. 27. As of hearing he was employed as the Field Office Supervisor in Morganfield, Kentucky. Tr. 23.

[5] Hereinafter the transcript will be cited as "Tr." followed by the page number.

#2 Unit[6] show that for three consecutive shifts beginning with the examination during the first shift on May 8, 2011 no hazards were observed other than loose pins[7] in the #4 and #5 entries. GX-8. Accompanied by Warrior Safety Tech Randy Ivey[8] ("Ivey") he traveled to the #2 Unit and began an imminent danger run across the working faces. Tr. 29. He also recorded his observations in his notes. GX-2. Hardison discovered that in the #7 entry at the last open crosscut the intersection had been mined wider than allowed by the mine's roof control plan. Tr. 31, 51; GX-1, GX-2. It appeared the mining machine operator had taken a cut[9] too far over to the right side of the entry. Tr. 51, 52. Using a tape measure, he found that the entry was wider than 20 feet. Tr. 31. The entry measured from 25 feet wide to 20 feet wide for a distance of 27 feet. Tr. 31; GX-2, p. 3. The entry was widest at the intersection, and came back into compliance at 20 feet wide as you went toward the face. Tr. 32; GX-2, p. 8. The maximum allowable width for entries under the roof control plan in effect was 20 feet. Tr. 30, 31, 35; GX-3, p. 5. In the entry that had been cut too wide there was sloughage[10] and rib rashing, a crumbling off the side of the coal rib due to the pillar[11] taking more weight from the overburden.[12] Tr. 33, 53. He saw the entry had bad top.[13] The 20-foot width limitation came from a history of roof falls nationwide, especially present in the Western Kentucky coal seam. Tr. 36. Additional support was required and was promptly installed in the entry. Tr. 34, 35.

Inspector Hardison testified he was worried about a roof fall with rock striking miners. This was made reasonably likely by the wide entry, bad top and no supplemental support. Tr. 36,

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[6] "Unit" as used throughout this decision will refer to the mining unit that was producing coal in the 2nd west panel.

[7] "Pins" is another term for bolts or roof bolts.

[8] Randy Ivey started in the mines in 1987 as an outby utility worker. He then worked loading for 4 years at Pyro, and started at Warrior in 1997. His experience includes power mover, belt mechanic, unit mechanic, greaser, and electrician. At the time of the hearing, he had been in the safety department for about 5 years. His certifications include surface and underground foreman and instructor, MET, electrician and dust sampling. Tr. 228-231.

[9] A "cut" is the part of a block of coal that is mined or cut out. "The swath of coal extracted by a continuous mining machine is called a 'lift' or 'cut.'" *Excel Mining, LLC,* 34 FMSHRC 99, 102 (ALJ) (2012).

[10] "Sloughage" was described by Hardison as where the ribs start to rash, a crumbling off of the coal rib from the weight of the overburden. Tr. 33.

[11] A "pillar" is a column of coal normally left permanently to support the overlying roof strata in a mine. Advance mining usually results in a "room and pillar" type of array. For example, see the map at RX-C.

[12] "Overburden" is the material, of any nature, that overlies the coal deposits.

[13] "Top" is the mine roof; "Bad top" as used here refers to the condition of the mine roof.

37, 39; GX-2, p. 7. He wrote the intersection had high traffic with a lot of people working and they would have a lot of exposure to this area. GX-2, p. 4. This was in a high coal seam, and large rocks falling on someone would have a major impact, which could lead to permanently disabling or crippling injuries. Tr. 37; GX-2, p. 7. Hardison determined that injury was reasonably likely due to the entry width and the amount of exposure to miners. Tr. 39. He relied on his training and experience with roof falls to make this likelihood determination, as well as recollection of a previous accident at the Cardinal Mine eight years prior that led to a fatality. Tr. 36, 38. He also testified that entry widths and pillar sizes play a huge role in roof conditions, and as a result of these major safety factors, the widths are not allowed over 20-foot. Tr. 36, 37.

Hardison testified that any possible injury would be permanently disabling, but also testified "I guess I could have gone fatal." He reached this conclusion by recollecting that miners in Western Kentucky had been killed by roof falls in the past, and that Warrior itself had seen a face boss killed in an accident involving falling rock. Tr. 38. Moreover, Hardison had met a miner recently who had been permanently crippled by falling rock in a mine in Elk Creek. Tr. 39.

Inspector Hardison made the likelihood and expected injury findings based on the following considerations: First, the roof conditions in the area; second, the entry width; and third, he noted that numerous miners traveled through the #7 entryway, both in shuttle cars and on foot. Based on these considerations, he concluded that there was an "extreme amount of exposure." Tr. 39, 40. However, judging by the traffic in the area he had personally observed, he concluded two miners were likely to be affected by the condition, because while many miners would be temporarily exposed to the potential hazard, only two would be likely to occupy the entryway at any given time. Tr. 41.

Turning to negligence, Inspector Hardison assessed the level as "high". He testified that high negligence was appropriate due to the obviousness of the condition, as there was no question that it was wide. Tr. 41, 42. He observed rib rashing and there was draw rock[14] everywhere, but the entry had not been closed off and was still being used. Tr. 42. Production continued instead of getting the area fixed to eliminate the hazard to miners. In his notes he wrote "There is bad broken up top, loose draw rock & ribs rashing badly". GX-2, p. 4. Moreover, he concluded that with all the activity occurring near the entryway, including face bosses, the mine's examiners, and foremen, management was aware of the condition or should have been aware of it. Tr. 43, 44; GX-2, p. 6. The area had been mined on the day shift or the second shift the previous day and went through the third shift. Tr. 42, 43. When Hardison made his imminent danger run the next morning, they were running coal and allowing men to use the entry. Tr. 42, 43. He stated "negligence is not only when it happens but it's how long you've allowed this to happen." Tr. 61, 62. He found there were no mitigating factors. Tr. 44. However, Hardison did testify he was unaware of wide entries in District 10 that had resulted in permanently disabling injuries. Tr. 60, 61.

[14] "Draw rock" is generally understood to refer to pieces of material in the roof or ribs that tend to fall easily when under pressure. *See, Excel Mining, LLC,* 33 FMSHRC 1421, 1423 n. 4 (2011)(ALJ). The term also refers to soft rock permeating coal seams, prone to falling after coal extraction.

Inspector Hardison testified that during his inspection the top looked bad in the #2 Unit, they were putting in a lot of roof support. Tr. 45. There was a lot of draw rock, clay veins[15] in the roof, slips[16] around the ribs, and some pretty tough roof on the whole Unit. Tr. 45, 46.

Rusty Vernon Smith[17] ("Smith") testified for Respondent. Smith was the third shift Crew Leader, responsible for getting the unit ready for the next day including extending the belt line, pre-shifting the unit, and rock dusting. Tr. 252. He was working in the #2 Unit on the nonproducing third shift, the shift just prior to the day shift during which Hardison's inspection was conducted. Tr. 255-257. Smith testified the roof conditions on the left side were better than average in his opinion. The ribs were loose with "regular typical sloughage", and they were scaled.[18] Tr. 257, 258. At that time the height was worse on the left side of the Unit and the conditions encountered did not allow for full cuts to be taken. Tr. 257, 276.

Randy Ivey, a Warrior safety tech, testified for Respondent. Tr. 228. He also recorded notes regarding the inspection on May 9, 2011. RX-B. On the inspection with Inspector Hardison, he testified the only concern in the #2 Unit was the excessive width of the #7 entry. Tr. 239. When they took the second lift, the right side became wide in the advancing entry. RX-B. He further testified that 8-foot pins were installed as additional roof support to abate the citation. The cable bolts were put in the intersection and along the right side inby rib. Tr. 241, RX-B. The roof bolts looked good, the pin spacing was correct, he did not see any cracks or slips, the limestone roof thickness was more than adequate at 32 inches, and the overall roof conditions were very good. Tr. 240, 242, 243, RX-B. Ivey also opined that the width of the #7 entry did not appear to present a hazard to miners. Tr. 243. He did not notice any sloughage there and the top was good. Tr. 244. The area would have been mined on the second shift the day before; the third shift was not a production shift. Tr. 247.

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[15] A "clay vein" is formed where the coal seam has been pulled apart and clay has been forced into the crevice. Tr. 71; AMERICAN GEOLOGICAL INSTITUTE, DICTIONARY OF MINING, MINERAL, AND RELATED TERMS 104 (2nd ed. 1996).

[16] A "slip" is a "[l]andslip, or subsiding mass of rock or clay in a quarry or pit; a minor landslide." AMERICAN GEOLOGICAL INSTITUTE, DICTIONARY OF MINING, MINERAL, AND RELATED TERMS 514 (2nd ed. 1996). *See also*, Footnote 29.

[17] Smith first worked for Warrior in 2004 as a roof bolter and putting on belts for about 18 months. He then became a third shift Crew Leader, a position he held at the time of the hearing. He was responsible for getting the Unit ready for the next day. Tr. 251, 252. In 2005 he was certified as a Mine Foreman. He began in mining in 1985, performing all work except running a continuous miner. Tr. 253, 254.

[18] "Scaling" is the taking down of loose rock or coal that remains on the roof or ribs after mining.

Inspector Hardison finished his notes on May 9th with his observations of the left side of the #2 Unit. He had seen extremely bad top, lots of slips, gob[19] falling out when the miner cuts, heads[20] everywhere in the top, draw falling, ribs starting to rash at the top of the coal seam, coal ribs rashing, and what looked like a clay vein in the top. GX-2, pp. 13-15.

Inspector Hardison testified that on his way back to his office he thought about what he had seen that day. He recalled draw rock falling, heads everywhere in the roof, clay veins in the roof, and slips around the ribs. This caused him to seek guidance from his supervisor. Tr. 45-47.

Inspector Hardison issued Citation No. 8503299 to Warrior. The citation alleges a violation of 30 C.F.R. § 75.220(a)(1), "Roof control plan". The condition was described as follows:

> There is an entry that has excessive width on #2 Unit. The #7 Entry is from 20 to 25 feet wide for a distance of 27 feet. The long diagonal distance from #7 right outby rib corner to #7 left inby rib corner is 45 feet 5 inches. This is a violation of the Company's Approved Roof Control Plan.

The safety standard provides:

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

Inspector Hardison designated the violation as Significant and Substantial ("S&S"). He determined that injury was reasonably likely and could be reasonably expected to be permanently disabling to 2 persons. Hardison rated the negligence as high.

GX-1.

The Warrior Cardinal Mine Roof Control Plan in effect on May 9, 2011 was approved on March 9, 2011. In paragraph two of the cover letter of approval the minimum requirements were addressed. As pertinent here, the District Manager pointed out that:

> Roof bolt spacing and widths of entries, rooms, and cross-cuts...are the maximum, and if during an inspection or investigation by MSHA, conditions warrant, the spacing and widths are subject to reduction.

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[19] "Gob" is "[c]oal refuse left on the mine floor" AMERICAN GEOLOGICAL INSTITUTE, DICTIONARY OF MINING, MINERAL, AND RELATED TERMS 239 (2nd ed. 1996).

[20] "Heads" have been described as smooth round rocks, Tr. 72, and "big pieces of rock that hang from the roof". *Pyro Mining Co.*, 6 FMSHRC 1789, 1794 (1984) (ALJ). *See also*, footnote 30.

In the plan, supplementary roof support materials were specified. Also, under the heading of "Entry, Rooms, and Crosscuts Widths & Centers":

> No mining width, other than turnouts described in other areas of this plan, will exceed 20'.

Under the heading of "Safety Precautions for Roof Control Plan":

> 1. This is the minimum Roof Control Plan and was formulated for normal roof conditions and the mining system described. Additional measures will be taken in accordance with 75.220 (a) (1) to protect persons if unusual hazards are encountered.
>
> 13. Unless using eight (8) fully grouted bolts, when the corners of pillars are cut off, (notches to the right or left), at least three bolts, a minimum of 12 inches longer than the bolt being used in the bolting cycle, will be installed midway of the notch area.

GX-3, pp. 5, 7, 8.

Inspector Hardison told Warrior representatives when issuing the citation that it involved a "Rule To Live By",[21] and as a result, he would be recommending a specially assessed penalty. Tr. 56. He made no other recommendations concerning the #2 Unit. Tr. 56. Hardison issued no further citations on May 9th. Tr. 55-57.

After returning to the local MSHA district office, Hardison spoke with his supervisor, Mike Whitfield. Tr. 57. Hardison told Whitfield that he had some concerns regarding roof and rib conditions in the #2 Unit. Tr. 46. Whitfield in turn recommended that Hardison speak to another MSHA inspector, David Winebarger, a roof control specialist. Tr. 47. Hardison informed Winebarger about the roof and rib conditions that prompted him to speak to Whitfield. Tr. 47. Winebarger would travel to the Cardinal Mine to conduct an inspection the following day, May 10, 2011. Tr. 57, 67.

Burden of Proof

In an enforcement action before the Commission, the Secretary bears the burden of proving any alleged violation. *Jim Walter Resources, Inc.*, 9 FMSHRC 903, 907 (May 1987). The burden imposed on the Secretary by the Mine Act is to prove alleged violations and related allegations such as gravity and negligence by a preponderance of the evidence. *Garden Creek Pocahontas Company,* 11 FMSHRC 2148, 2152 (Nov. 1989), citing *Consolidation Coal Co.,* 11 FMSHRC 966, 973 (June 1989); *Jim Walter Resources, Inc.,* 30 FMSHRC 872, 878 (Aug. 2008) (ALJ). Quoting the Supreme Court in *Concrete Pipe*, 508 U.S. 602, 622 (1993), the Commission observed that "[t]he burden of showing something by a 'preponderance of the evidence,' the

[21] The complete list of "Rules to Live By", in three parts, is available to the public online at MSHA's website: http://www.msha.gov/focuson/RulestoLiveBy/RulestoLiveByI.asp.

most common standard in the civil law, simply requires the trier of fact 'to believe that the existence of a fact is more probable than its nonexistence.'" *RAG Cumberland Res. Corp.*, 22 FMSHRC 1066, 1070 (Sept. 2000), *aff'd*, 272 F.3d 590 (D.C. Cir 2001); *In re: Contests of Respirable Dust Sample Alteration Citations: Keystone Mining Corp.*, 17 FMSHRC 1819, 1838 (Nov. 1995), *aff'd sub nom. Secretary of Labor v. Keystone Coal Mining Corp.*, 151 F.3d 1096 (D.C. Cir. 1998).

Significant and Substantial

A significant and substantial ("S&S") violation is described in section 104(d) (1) of the Mine Act as a violation "of such nature as *could* significantly and substantially contribute to the cause and effect of a coal or other mine safety or health hazard." 30 U.S.C. § 814(d) (1) (emphasis added). The four-part test long applied to establish the S&S nature of a violation examines: "(1) the underlying violation of a mandatory safety standard; (2) a discrete safety hazard – that is, a measure of danger to safety – contributed to by the violation; (3) a reasonable likelihood that the hazard contributed to will result in an injury; and (4) a reasonable likelihood that the injury will be of a reasonably serious nature." *Mathies Coal Co.*, 6 FMSHRC 1, 3-4 (Jan. 1984); *accord Buck Creek Coal Co., Inc.*, 52 F. 3rd. 133, 135 (7th Cir. 1995); *Austin Power Co., Inc. v, Sec'y of Labor*, 861 F. 2d 99, 103 (5th Cir. 1988) (approving *Mathies* criteria).

In addition to the *Mathies* criteria, the Commission has established that the S&S determination must be based on the particular facts surrounding the violation, *Texasgulf, Inc.*, 10 FMSHRC 498, 500 (Apr. 1988), and should be made assuming "continued normal mining operations." *McCoy Elkhorn Coal Corp.*, 36 FMSHRC 1987, 1990-91 (Aug. 2014) (citing *U.S. Steel Mining Co.*, 7 FMSHRC 1125, 1130 (Aug. 1985)). The Commission has emphasized that it is the contribution of a violation to the cause and effect of a hazard that must be significant and substantial. *U.S. Steel Mining Co., Inc.*, 6 FMSHRC 1866, 1868 (August 1984); *U.S. Steel Mining Co., Inc.*, 6 FMSHRC 1573, 1574-75 (July 1984). The Commission has also established that the operator may not rely on redundant safety measures to mitigate the likelihood of injury for S&S purposes. *Buck Creek Coal, Inc., v. FMSHRC* 52 F.3d 133 (7th Cir. 1995); *Brody Mining, LLC*, 37 FMSHRC 1687, 1691 (Aug. 2015).

The Commission has clarified that "The Secretary need not prove a reasonable likelihood that the violation itself will cause injury." and "the absence of an injury-producing event when a cited practice has occurred does not preclude a determination of S&S" *Cumberland Coal Resources, LP*, 33 FMSHRC 2351 (October 5, 2011), (citing *Musser Engineering, Inc. and PBS Coals, Inc.*, 32 FMSHRC 1257, 1280-81 (Oct. 2010); *Elk Run Coal Co.*, 27 FMSHRC 899, 906 (Dec. 2005); and *Blue Bayou Sand & Gravel, Inc.*, 18 FMSHRC 853, 857 (June 1996)).

In 2014 the Seventh Circuit held that "A violation is significant and substantial if it *could* lead to some discrete hazard, the hazard was reasonably likely to result in injury, and the injury was reasonably likely to be reasonably serious." *Peabody Midwest Mining, LLC v. FMSHRC* 762 F.3d 611, 616 (7th Cir. 2014) (emphasis added). The Circuit Court's use of the term "could" is the same term embodied in section 104(d) (1) of the Act, set forth above. In *Knox Creek Coal Corp., v. Secretary of Labor*, 811 F.3d 148, 160 (4th Cir. 2016), the Circuit Court recognized that the *Mathies* test had been consistently applied by the Commission and ALJs for decades and adopted

by Federal Appellate Courts. However, in analyzing the second *Mathies* element which primarily accounted for the concern with the *likelihood* that a given violation may cause harm, the Court found "for a violation to contribute to a discrete safety hazard, it must be *at least somewhat likely* to result in harm." *Id.*, at 162 (emphasis added). The Court reasoned that "the *second* prong of *Mathies* requires proof that the violation in question contributes to a 'discrete safety hazard,' which implicitly requires a showing that the violation is at least somewhat likely to result in harm." *Id.*, at 613.

Recently, a majority of three Commissioners revisited the "reasonable likelihood" standard finding that "the second step requires a determination of whether, based upon the particular facts surrounding the violation, there exists a reasonable likelihood of the occurrence of the hazard against which the mandatory safety standard is directed". *Sec'y of Labor v. Newtown Energy, Inc.*, 38 FMSHRC 2033, 2038 (Aug. 2016).[22] To establish this element, a clear description of the hazard at issue is required in order to determine whether the violation sufficiently contributed to that hazard. *Id.*

The roof control plan in effect specified the type and use of supplemental roof support materials, the maximum width of an entry, and as noted by the District Manager entry widths could be subject to reduction where warranted by conditions. It was contemplated that if the unusual hazard of a wide entry were encountered supplemental support would be required. Respondent has conceded the fact of the violation; therefore, the first element is established.

Respondent does not deny that the hazard contributed to and caused by the violation of its roof control plan was a potential roof fall or rib sloughage, but argues that this hazard was ultimately benign in nature. RRB p. 11. The abnormal conditions on the left side of the #2 Unit had been recognized and production was reduced to ten foot cut lengths with immediate roof bolting to ensure safe mining. Relying on the testimony and notes of Warrior employee Ivey, Respondent contends that the #7 entry roof conditions were very good, the roof bolts were tight and firm against the roof, there were no cracks or slips, the limestone roof thickness was more than adequate, and the overall roof in the entry was competent. RRB pp. 11, 12.

The Secretary contends the citation was properly designated S&S, since the excessive entry width created an area with inadequate roof support, contributing to the discrete safety hazard of a roof fall, and that roof falls pose one of the most serious hazards to miners. SPHB pp. 8, 11. The Secretary argues that Inspector Hardison's credible testimony is entitled to substantial weight. *Id.* at 7. The entry was a working section traveled by miners on foot and in shuttle cars, and due to the weakened intersection there was a reasonable likelihood of injury. Further, with roof falls a leading cause of death in underground mines, such injury would be reasonably serious in nature. *Id.* at 10.

The discrete safety hazard contributed to by the violation of the roof control plan was a fall of roof. The particular facts established on this record are that in the #2 Unit the #7 entry had

[22] The Chairman and one Commissioner dissented from this interpretation on the basis that the Fourth Circuit Court in *Knox Creek* required at the second *Mathies* step only that the violation be shown to be "at least somewhat likely to result in harm". *Newtown,* at 2052.

been mined 25 feet wide at an intersection, and proceeding inby came into compliance at 20 feet wide after a distance of about 27 feet. Under the mine's roof control plan this condition required the installation of additional roof support. At the time of the inspection, this additional roof support had not been installed. The measurements made at the time of the inspection clearly established that the entry was impermissibly wide and also defined the area affected by the measured distance the condition extended into the entryway.

This violation of the roof control plan did contribute to a measure of danger to safety in the active mining section. Inspector Hardison credibly testified that entry width and pillar size play a huge role in roof conditions; a wide entry increases the weight on the pillars from the overburden creating the potential for roof falls. In the notes he wrote that day, he memorialized his observations in the wide entry area of sloughage and rib rashing with crumbling off the side of the coal rib indicating the increased weight on the pillar, and broken up top with draw rock. Because of these major safety factors, mining widths are not allowed over 20-foot, with one exception not relevant here, under Warrior's roof control plan. The #7 entry was widest at the intersection, where numerous miners traveled on foot and in shuttle cars.

Commission Administrative Law Judges ("ALJs") have considered entry widths mined in excess of a mine's roof control plan. In *Mountain Edge Mining, Inc.*, 33FMSHRC 1290, 1295 (May 2011), Judge Moran found there was a discrete safety hazard, a measure of danger to safety, because exceeding the maximum mining width increased the likelihood of a roof fall and to conclude otherwise would mean that the roof control plan requirement was meaningless. Similarly, Judge Steele found that an entryway impermissibly wide by eight feet contributed to the potential of a roof fall. *Elk Run Coal Co.*, 36 FMSHRC 900, 915-16 (Apr. 2014). Recently, Judge Gill observed that roof control plans are tailored to the specific conditions that exist in each mine. He found that excessive cut widths contributed to the hazard of a roof fall. *Tri County Coal, LLC*, 37 FMSHRC 268, 288-89 (Feb. 2015). I agree with the reasoning of the judges in these cases.

The discrete safety hazard here is that miners would be exposed to the potential of a roof fall due to an inadequately supported, impermissibly wide roof during continued mining operations. The area had probably been mined on one or both shifts the day before and the condition had lasted through the third shift, which was a nonproducing maintenance shift. Therefore, the condition had lasted from the time the wide cut had been taken, through the remainder of that shift, throughout the following maintenance shift, and until the Inspector found it during the day shift on May 9th. That the area had otherwise been bolted according to the requirements for an entry of the correct width with bolts used in the bolting cycle does not change this determination. At the time of the citation, the safety precautions for additional measures in the form of added roof support had not been installed. Therefore, the failure to comply with the mine's roof control plan in an entry with excessive cut width did pose a discrete safety hazard to miners, that of a fall of roof. This was more than a mere technical violation of a mandatory safety standard.

The discrete safety hazard found here, a fall of roof, was reasonably likely to occur. Inspector Hardison credibly testified that the wide entry created the potential for roof falls. A wide entry roof fall had not occurred in that District, but Hardison relied on his experience with

roof falls, his training, and the history of other roof falls at Warrior and in Western Kentucky in making the likelihood determination.

In 1982 the Commission, referring to the Senate and House bills that ultimately became the 1969 Coal Act, noted that:

> A prime motive in the enactment of the 1969 Coal Act was to "[i]mprove health and safety conditions and practices at underground coal mines" in order to prevent death and serious physical harm....One of the problems that greatly concerned Congress was the high fatality and injury rate due to roof falls. The legislative history is replete with references to roof falls as the prime cause of fatalities in underground mines. *Eastover Mining Co.,* 4 FMSHRC 1207, 1211 & n. 8 (Jul. 1982) (citations omitted).

The Commission has also noted:

> Mine roofs are inherently dangerous and even good roof can fall without warning. *Consolidation Coal Company,* 6 FMSHRC 34, 37 (Jan. 1984).

And in a case where rib sloughage had increased the overall width of an entry weakening the roof and requiring installation of additional roof support, the Commission affirmed an ALJ's finding that the violative roof conditions posed a high degree of danger to miners based on the present danger the miners faced in the area.[23] *Eastern Associated Coal Corp.,* 32 FMSHRC 1189, 1191-92, 1201 (Oct. 2010).

In the ALJ decisions cited *supra*, the judges found that impermissibly wide entries could lead to roof falls, leading in turn to permanently disabling or fatal injuries. *Mountain Edge Mining,* at 1295; *Elk Run Coal,* at 915-16; and *Tri County Coal*, at 288. Considering the critical role pillars play in supporting areas that have been mined, where an entry is too wide there would be less pillar mass where needed - along the ribs. Inspector Hardison's testimony regarding the weight on the pillars along the ribs and the symptoms of rib sloughage and rashing is well taken. If these conditions were not dangerous, there would be little reason to establish maximum mining widths in roof control plans.

Therefore, considering the length of time the violative condition existed, and the credible evidence of rib rashing, sloughage, bad roof conditions, increased weight on the remaining pillar mass and the failure to install the required additional support until after the hazard was discovered, a roof fall was reasonably likely to occur.

Contrasting the third and fourth *Mathies* elements, which are primarily concerned with *gravity*, the seriousness of the expected harm, the Circuit Court in *Knox Creek* reasoned that at this stage of the analysis the existence of the hazard should be assumed; however, "evidence is still necessary to establish that the hazard is reasonably likely to result in serious injury." *Knox*

[23] There was also "potting", or material falling away from around existing roof bolts.

Creek, at 162, 164. At step three, the focus shifts to whether occurrence of the hazard would be reasonably likely to result in injury. *Newtown,* at 2037.

The Commission has determined that "The Secretary need not prove a reasonable likelihood that the violation itself will cause injury" and "the absence of an injury-producing event when a cited practice has occurred does not preclude a determination of S&S". *Cumberland Coal Resources, LP*, 33 FMSHRC 2351 (October 5, 2011), (citing *Musser Engineering, Inc. and PBS Coals, Inc.,* 32 FMSHRC 1257, 1280-81 (Oct. 2010); *Elk Run Coal Co.,* 27 FMSHRC 899, 906 (Dec. 2005); and *Blue Bayou Sand & Gravel, Inc.*, 18 FMSHRC 853, 857 (June 1996)).

The hazard established is that of a fall of roof and rock. As already set forth in this decision, roof falls are inherently dangerous and a serious risk to the health and safety of miners. Respondent argues that a roof fall was unlikely, relying on the testimony and notes of Safety Tech Ivey. Ivey stated he did not see any slips, sloughage or cracks in or adjacent to the #7 entry, the roof bolts looked good, the limestone roof thickness was more than adequate at 32 inches, the overall roof conditions were very good, and the entry did not appear to present a hazard to miners. However, this is not the correct standard to be applied to an impermissibly wide entry. Ivey's opinion regarding the *appearance* of the roof conditions evades the *reasons* for the provisions in the mine's roof control plan requiring additional support when an entry is mined too wide. The additional support is important to maintain the integrity of the roof in the overly wide entry in the absence of properly situated pillar mass that would provide the needed support.

Weighing the testimony of Ivey against that of Inspector Hardison, I am unable to assign any significant probative value to Ivey's opinion. Instead, I credit Hardison's more detailed and informed testimony. He credibly testified that entry widths and pillar sizes play a huge role in roof conditions, and a wide entry increases the potential for roof falls. He observed and recorded that there was bad, broken up top, loose draw rock everywhere, and ribs rashing badly. Impermissibly wide entrys are a hazard to miners. Hardison recalled that miners in Western Kentucky had been permanently disabled and killed by falling rock and roof.

Ivey focused on the roof bolts already installed, the limestone thickness, and that he did not see cracks, slips or sloughage. To Ivey, the overall roof conditions were very good. But Hardison's more detailed observations included loose draw rock, ribs rashing, and broken up top. To the conflicting evidence on sloughage, I credit Hardison's observation of crumbling off of the side of the coal rib, rib rashing. These observations are more consistent with the testimony of Smith, that there was typical sloughage present on the shift just prior to the day shift. As to the roof conditions in the wide entry, Hardison specifically noted the broken up top and loose draw rock, whereas Ivey reported on the existing roof bolts and limestone thickness.

It is the greater risk of a fall of roof and rock presented by the failure to follow the mine's own roof control plan that is at issue here. I find that injury was reasonably likely and could reasonably be expected to be at least permanently disabling. The Secretary has carried his burden by proving the seriousness of the hazard and the serious degree of harm that can be reasonably expected to occur. Therefore, the third and fourth elements are satisfied.

The above analysis, it should be noted, is also consistent with *Peabody,* wherein the Circuit Court found:

> "...the question is not whether it is likely that the hazard...would have occurred; instead, the ALJ had to determine only whether, if the hazard occurred (regardless of likelihood), it was reasonably likely that a reasonably serious injury would result."

Peabody, at 620.

In summary, I conclude that under either current Commission precedent or the Circuit Court decisions, the preponderance of the evidence found credible establishes it was likely that the roof fall hazard contributed to by the impermissibly wide entry was reasonably likely to result in injury causing events, and the injuries would be reasonably serious in nature. I find the violation of mandatory safety standard 30 C.F.R. § 75.220(a)(1) was S&S.

Gravity

The term "gravity" is contained in Section 110(i) of the Mine Act in the context of factors to be considered by the Commission in assessing civil monetary penalties. Among those factors is "the gravity of the violation". This is generally expressed as the degree of seriousness of the violation and is measured in terms of the likelihood of injury, the severity of such injury should it occur, the number of persons affected, and whether the violation is S&S. I have affirmed that the violation was S&S. The remainder of the gravity factors must be determined for every violation. The focus is on the *effect* of the safety hazard if it occurs.

Respondent argues that the gravity determinations should be reduced. The citation was a technical violation and not reasonably likely to result in injury. There would be little to no travel in the area as mining advanced in entry #7. RPHB pp. 23, 24; RRB pp. 10, 12.

The Secretary contends that the wide area was large enough to cover two miners and the hazard was likely to cause injury that would be reasonably serious in nature. Inspector Hardison's designation of permanently disabling injury was not overstated. SPHB pp. 8, 10, 11.

Inspector Hardison determined that there was exposure of miners to the condition in the working section to the hazard. He determined that numerous miners travelled through the #7 entry, but based on the traffic he personally observed, he concluded that only two miners were likely to be affected by the hazard at any given time. That traffic in the future would be reduced as mining advanced does not change the conclusion that at a particular time two miners could be under the noncompliant roof.

The effect of a roof fall, should it occur, can be catastrophic. Hardison marked injury as reasonably likely. In his testimony, Hardison suggested he could have marked "fatal". Of course, not all roof falls happen where miners are working; but miners under falling roof or large rock could suffer fatal injuries, as history tragically teaches. It follows that I agree with the seriousness of expected injury. Miners in that intersection at the wrong time would be exposed

to the risk of fall of extremely heavy material. Accordingly, I affirm the gravity determinations of the Inspector.

Negligence

Section 110(i) of the Mine Act includes "negligence" as one of the six criteria the Commission is required to consider in assessing a penalty. The term is not defined in the Act, but over 30 years ago the Commission recognized that:

> [e]ach mandatory standard...carries with it an accompanying duty of care to avoid violations of the standard, and an operator's failure to meet the appropriate duty can lead to a finding of negligence if a violation of the standard occurred.

A. H. Smith Stone Company, 5 FMSHRC 13, 15 (Jan. 1983).

The Commission has also determined that to evaluate an operator's negligence, consideration should be given to "what actions would have been taken under the same circumstances by a reasonably prudent person familiar with the mining industry, the relevant facts, and the protective purpose of the regulation." *Jim Walter Resources*, 36 FMSHRC 1972, 1975 (Aug. 2014).

Under the divided penalty assessment authority mandated by Congress in the Act, it is MSHA that begins the process by *proposing* a monetary civil penalty based on the procedures contained in Part 100 of the Secretary's regulations. Therein, the criterion of negligence is defined as:

> 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. Under the Mine Act, an operator is held to a high standard of care. 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. The failure to exercise a high standard of care constitutes negligence.

30 C.F.R. § 100.3 (d).

Negligence is further categorized into levels, including "no," "low", "moderate", and "high" negligence, with the highest level being, "reckless disregard". These levels are based on the degree of the operator's knowledge of the violative condition or practice along with the existence or multiples of mitigating circumstances found to be present. The Secretary's procedures are essentially formulaic and mechanical, reducing the level of negligence determined to a number of "points," *Id.,* Table X, which are then added to other point evaluations to arrive at the calculated *proposed* penalty amount. 30 C.F.R. § 100.3, Tables I-XIV.

It is well settled that the Commission is not bound by the Secretary's *proposed* penalties.

> Judges may evaluate negligence from the starting point of a traditional negligence analysis rather than based upon the Part 100 definitions. Under such an analysis, an operator is negligent if it fails to meet the requisite standard of care-a standard of care that is high under the Mine Act...In making a negligence determination, a Judge is not limited to an evaluation of allegedly "mitigating" circumstances. Instead, the Judge may consider the totality of the circumstances holistically.
>
> "[T]herefore a Commission Judge may find 'high negligence' in spite of mitigating circumstances or may find 'moderate' negligence without identifying mitigating circumstances." *Brody Mining, LLC,* 37 FMSHRC 1687, 1701-02 (Aug. 2015). High negligence is considered an aggravated lack of care that is more than ordinary negligence.

Id., at 1703, citing *Topper Coal Co.*, 20 FMSHRC 344, 350 (Apr. 1998).

Respondent contends the excessive width of entry #7 resulted from the mining machine operator simply taking a cut too far over on the right side of the entry. Respondent argues that the entry had properly installed roof bolts, and that the Secretary cannot show that mine management had knowledge of the condition. Respondent's position is that the citation should be modified to low negligence based on significant evidence of mitigation of any risk due to the condition. RPHB at 29, 30.

The Secretary contends the wide entry had been mined on or before the second shift the day before, had existed through that shift, the third shift, and for hours during the shift on which it was found. Face bosses and the mine's examiners would have been through the affected area and should have observed the condition, which was exceptionally obvious since it looked like a slice of pie. The wide entry should have been easily seen, but no steps were taken to correct the condition prior to the issuance of the citation. The Secretary also argues that no mitigating circumstances existed. SPHB pp. 12, 13.

Inspector Hardison determined the Respondent's negligence in this citation to be "High." Tr. 41, 42; GX-1. I agree.

The impermissibly wide entry was obvious. On his imminent danger run Inspector Hardison discovered the wide area; he credibly testified that there was no question it was wide. Warrior's Safety Tech Ivey did not disagree. The measurements they took revealed a width of 25 feet at the intersection, and the entry continued to be too wide for 27 feet inby along the entryway. The condition had existed since at least the second shift the day before, long enough for numerous mine personnel to have travelled through the working area, including the mine's own examiners, face bosses and foremen, and in particular the third shift Crew Leader. Other signs Hardison observed were broken up top, loose draw rock, and ribs rashing.

Respondent essentially argues that it did not have knowledge of the condition. The argument mischaracterizes the Secretary's burden. Due to the obvious nature of the condition, the time it was in existence and the fact that mine personnel were in the area during the preceding third, nonproducing shift performing preparation work, the operator *should have*

known of the wide entry. Smith's testimony reveals there was significant activity in the area to extend belts, rock dust, and preshift the Unit. At the very least, the preshift examination should have found the hazard, recorded it, and had it corrected before the day shift accessed the area. Had the Inspector not discovered the violation, it is most likely the wide entry would have continued to exist uncorrected under continued normal mining operations. This failure to observe and correct a wide entry as prohibited in the mine's roof control plan falls well below the standard of care established to protect miners from harm. Under these facts and circumstances, a reasonably prudent person familiar with the mining industry, the relevant facts, and the protective purpose of the safety standard would have acted differently; closing off the area to install the required additional roof support and make the intersection and entryway safe for miners. I would also observe that the crew present at the time of the wide cut by the mining machine operator should have reported the error to their supervisor.

The duty of care to miners not addressed in the instant case was the installation of the required additional roof support called for in the mine's own roof control plan. Respondent argues for low negligence, but considerable mitigating circumstances were not present at the time of the citation. Indeed, I am unable to find any mitigating circumstance. I understand Respondent's position that good faith efforts were made to control the roof conditions in the #7 entry. And, Inspector Hardison cited no other violative condition that day. But this is not enough. Even if I found a mitigating circumstance, a reduction in the imputed negligence is not warranted. This is because all requirements for roof support must be followed to insure, to the extent possible, the safety of miners. The potential consequences are too dire to permit the operator to behave otherwise.

Respondent is probably correct when it offers that the violation resulted from the continuous mining machine operator simply taking a cut too far over to the right side of this particular entry. Because a mistake is unintentional does not mean it is benign. Roof falls are a highly dangerous risk to run in any context, and the "cut too far" in this case ran without additional support for about 27 feet. I affirm the designation of high negligence.

Specially Assessed Penalty

The Secretary's regulation, as currently constituted states:

Determination of penalty amount; special assessment.

(a) MSHA may elect to waive the regular assessment under § 100.3 if it determines that conditions warrant a special assessment.

(b) When MSHA determines that a special assessment is appropriate, the proposed penalty will be based on the six criteria set forth in § 100.3(a). All findings shall be in narrative form.

30 C.F.R. § 100.5.

In the Mine Act of 1977 the Secretary was authorized to issue regulations deemed appropriate to carry out any provision of the Act. 30 U.S.C. § 957. The Act provided for the

assessment of a civil penalty by the Secretary for violation of a mandatory health or safety standard. 30 U.S.C. § 820. On review of the special assessment regulation that had been established in 1978 and modified in 1982 the D. C. Circuit Court of Appeals found that the special assessment regulatory criteria were designed for "particularly serious or egregious violations." *Coal Employment Project, et. al., v. Dole*, 889 F.2d 1127, 1129-30 (D.C. Cir. 1989). Although the regulation was revised in 2007 to remove reference to particular circumstances to be considered in special assessment reviews, the Circuit Court's holding remains controlling precedent. At the time of the revision of the regulation in 2007, it was made clear that MSHA would have the discretion to determine which types of violations would be reviewed for special assessment. *See,* 71 FR 53054, 53063; 72 FR 13542, 13620-22.

If MSHA elects to waive regular assessment, the regulation specifically requires that all special assessment findings be in narrative form. 30 C.F.R. § 100.5(b). Therefore, the burden is on the Secretary to justify a proposed enhanced penalty under the standard announced by the D.C. Circuit Court that special assessments are reserved for "particularly serious or egregious violations." *See, Oak Grove Resources, LLC,* 35 FMSHRC 3039, 3074 (Sep. 2013)(ALJ); *American Coal Company*, 35 FMSHRC 1774, 1824 (Jun. 2013)(ALJ); *American Coal Company*, 37 FMSHRC 1267, 1278-79 (Jun. 2015)(ALJ); *Traylor Mining, LLC,* 37 FMSHRC 1373, 1375 (Jun. 2015)(ALJ). This burden includes basing the proposed special assessment on the six penalty criteria in 30 C.F.R. § 100.3(a).

The Petition for the Assessment of the Civil Penalty in this case included the "Narrative Findings for a Special Assessment". In the petition, this document was said to identify the reasons for a special assessment. However, it only set forth that MSHA had carefully evaluated the conditions cited and the Inspector's information and evaluation, and that based on the six criteria of 30 C.F.R. § 100.3(a) Warrior would be assessed the enhanced penalty. The point calculations for either a regular or specially assessed penalty were not disclosed by the Secretary. The reasons supporting the decision to propose the enhanced penalty considering the facts and circumstances surrounding the violation, other than the boilerplate, were not provided in the Petition.

The Commission and its Judges are not bound by the Secretary's Part 100 proposed penalty regulations. *Sellersburg Stone Company,* 5 FMSHRC 287, 291 (Mar. 1983), *aff'd* 736 F.2d 1147, 1151-52 (7th Cir. 1984); *Jim Walter Resources, Inc.*, 36 FMSHRC 1972, 1975 n. 4 (Aug. 2014); 29 C.F.R. § 2700.30(b). Those regulations apply only to the proposal of penalties by the Secretary and do not extend to the independent Commission. *Mach Mining, LLC, v. SOL*, 809 F.3d 1259 (D.C. Cir. 2016), citing *Brody Mining, LLC,* 37 FMSHRC 1687, 1701 (Aug. 2015). Commission Judges are accorded broad discretion in assessing civil penalties under the Mine Act, but this discretion is not unbounded and must reflect proper consideration of the six statutory penalty criteria set forth in section 110(i) and the deterrent purpose of the Act. *Hubb Corporation,* 22 FMSHRC 606, 611 (May 2000), citing *Westmoreland Coal Co.,* 8 FMSHRC 491, 492 (Apr. 1986) and 29 C.F.R. § 2700.30(a).

In determining penalty amounts the Commission must consider (1) the operator's history of previous violations, (2) the appropriateness of such penalty to the size of the business of the operator charged, (3) whether the operator was negligent, (4) the effect on the operator's ability

to continue in business, (5) the gravity of the violation, and (6) the demonstrated good faith of the person charged in attempting to achieve rapid compliance after notification of a violation. 30 U.S.C. § 820(i).

When considering the six statutory penalty criteria the Commission Judge must make findings and conclusions sufficient to give the operator and the regulated community appropriate notice of the bases for the assessed penalty and to provide a factual basis adequate to set forth a discernible path allowing for Commission or Court review. Where there is a substantial divergence from the Secretary's original penalty proposal, an explanation of the assessment is essential. *Douglas R. Rushford Trucking*, 22 FMSHRC 598, 600-01 (May 2000), citing *Sellersburg Stone Company* at 292-93; *Martin County Coal Corp.*, 28 FMSHRC 247, 261 (May 2000); *See also*, 29 C.F.R. § 2700.30(a).

Beyond the six statutory penalty criteria, the Commission Judge considers the potential deterrent effect of the penalty amounts assessed. In the Mine Act's legislative history, and numerous Commission and federal cases, deterrence is identified as a central tenet underlying the entire statutory scheme of imposing civil penalties. *Black Beauty Coal Co.,* 34 FMSHRC 1856, 1864-69 (Aug. 2012). On review of the legislative history of the Mine Act, the D.C. Circuit Court of Appeals determined:

> From this history, we conclude that Congress was intent on assuring that the civil penalties provide an effective deterrent against all offenders and particularly against offenders with records of past violations.

Coal Employment Project, at 1133.

The penalty assessment findings and explanations of the Commission Judge need not be exhaustive, but must be adequate to show compliance with the requirement to consider and make findings on the statutory penalty criteria. *Cantera Green*, 22 FMSHRC 616, 621 (May 2000). All six of the criteria must be considered, but there is no requirement that equal weight be assigned to each one. *Thunder Basin Coal Company,* 19 FMSHRC 1495, 1503 (Sep. 1997). According to the circumstances of the case, there is discretion to assign different weights to the factors, and negligence and gravity may be weighed more heavily than the other four criteria. *Lopke Quarries, Inc.,* 23 FMSHRC 705, 713 (Jul. 2001); *Spartan Mining Company, Inc.,* 30 FMSHRC 699, 724-25 (Aug. 2008); *Musser Engineering, Inc.,* 32 FMSHRC 1257, 1289 (Oct. 2010).

Respondent argues the Secretary did not justify his deviation from the section 100.3 civil penalty tables in proposing a specially assessed penalty.

The Secretary contends the special assessment of $30,200 is consistent with Congressional intent that penalties be an effective deterrent against future violations. Respondent has an extensive history of violations that includes violations of the same safety standard. Respondent is a large producer of coal, and there is no evidence that the penalty would adversely affect its ability to stay in business. In effect, the Secretary also contends that the gravity and negligence determinations of the Inspector were proper. SPHB, pp. 13-16.

The testimony of Inspector Hardison included his notice to mine management that he would recommend a specially assessed penalty because the violation involved a "rule to live by", referring to the MSHA publication available to the industry and the public on the Administration's website. The publication is an initiative by MSHA focused on 24 safety standards that were frequently cited in fatal accident investigations and were included as a result of MSHA's analysis of conditions and practices that had contributed to 589 deaths. Among those fatalities were those that resulted from falling roof rock or rib in coal mines. The roof support safety standard cited in the instant case is one of the 24, and one of the listed conditions leading to fatalities is "Failure to install supplemental support...when adverse roof conditions are encountered." Through outreach and education coal mine operators would be encouraged to identify and correct the hazardous conditions with the goal of reducing or preventing fatalities and serious accidents. MSHA enforcement would be directed toward confirming that violations related to these standards are not present in mines.

This non-regulatory issue, as important as it is for the information and guidance offered to mine operators, does not contain any notice to the mining community that a violation of one of the listed safety standards would result in a recommendation for or implementation of a specially assessed proposed penalty. I note, in particular, that while the Inspector testified to his recommendation for a special assessment, which may have been accepted by MSHA management, there was no information provided as to what actually lead to the amount proposed. The facts and circumstances relied upon and the reasons for proposing the enhanced amount are completely opaque to review by the undersigned. Clearly, non-regulatory issues of the Administration intended to improve safety, which by their nature primarily represent general guidance, cannot provide a *basis* for a proposed special assessment in the context of specific facts and circumstances in a particular case. While I agree that the Secretary did not justify his deviation from the section 100.3 penalty tables, this does not matter when independently considering the evidence to finally assess the penalty under the statutory criteria. Further, even if the reasons for the proposed assessment were available for review, which would at least provide some due process at the initial level of adjudication, I am not required to take such reasons into consideration in making a decision on the amount of the penalty to be charged.

The operator's history of previous violations.

In the fifteen months prior to the issuance of Citation No. 8503299, Respondent was issued 629 citations at its Cardinal mine, 24 of which were violations of 30 C.F.R. § 75.220(a)(1). SPHB p. 14; GX-10. This is a significant history of violations. However, Warrior may have 240 production days each calendar year, about 300 in a 15-month period. Tr. 167. Therefore, when viewed against the very large size of this mine, the overall number and average rate of citations for either roof control plan violations or all violations during the 15-month period, an *egregious* violation history is not suggested. I conclude this is not an aggravating factor.

The appropriateness of such penalty to the size of the business of the operator charged.

At the time of the issuance of the citation, Respondent's Cardinal mine operated five (5) production units and ranked second among all non-longwall underground coal mines in terms of

total coal production in the United States. Tr. 138; RPHB p. 3. In the year prior to this citation, 2010, the mine produced 5,831,599 tons of coal. JX-1. The very large size of this business weighs against any reduction in the penalty to be assessed. *See, Thunder Basin Coal Company*, 19 FMSHRC 1495, 1502 (Sep. 1997).

Whether the operator was negligent.

I have found the operator's negligence was "high". This is because there was shown an aggravated lack of care beyond "ordinary" negligence. However, there was no more than high negligence; the facts and circumstances do not establish, and the Inspector did not determine, a reckless disregard for the safety of miners. While mine management should have known of the wide cut, because it was obvious, actual knowledge is not shown on this record. The wide entry without supplemental support existed for about the time of two shifts, not an extensive period of time. In this case, there was not an extreme disregard of the duty of care owed to miners. While I do find high negligence, the degree was not *very* high or *particularly egregious.*

The effect on the operator's ability to continue in business.

As the Secretary notes in his brief, the Respondent provided no evidence at hearing that the penalty proposed would adversely affect its ability to continue in business. SPHB p. 15. The production of this mine, as noted above, would support a finding that the Secretary's proposed penalty would not impair the viability of the business. The lack of effect on Respondent's ability to continue in business also weighs against reduction in the penalty to be assessed.

The gravity of the violation.

I have found the violation to be S&S. The failure to install the required supplemental roof support when the wide entry was cut was serious. This was no mere technical violation, the wide roof area lacking properly positioned pillar support with evidence of rib rashing, sloughage, broken up top, and loose draw rock presented a dangerous situation. This represents an aggravating factor, weighing in favor of an enhanced penalty. However, while serious, the evidence found credible does not support a finding that the gravity was *particularly* serious.

The demonstrated good faith of the person charged in attempting to achieve rapid compliance after notification of a violation.

The Respondent's good faith is not disputed by the Secretary. SPHB p. 16. I find the Respondent moved quickly to support the roof along the rib where the wide cut was taken to abate the violation. This criterion is found to weigh in favor of the Respondent.

Because this case involves roof control, of great importance to the safety of miners, I weigh the factors of gravity and negligence more heavily than the other factors. *Lopke Quarries, Inc.,* at 713. Also, the combined factors of operator size and the ability to remain in business would support an enhanced penalty. The remaining two factors are either not aggravating or weigh in favor of Respondent. As to gravity and negligence, I find that neither meets the requirement of "particularly serious or egregious". *Coal Employment Project,* at 1129.

The discretion of a Commission ALJ to assess the penalty *de novo* is bounded by the statutory criteria and the deterrent purpose of the Mine Act. *Sellersburg* at 292. The weighted analysis above supports an enhanced penalty, and I do consider the deterrent effect of the penalty. Considering the size and production of this mine, it is important to provide an incentive to the operator to place a higher priority on adherence to its roof control plan. I find that an enhanced penalty of $20,750 is consistent with the facts and circumstances established on this record, and would adequately serve as a deterrent.

May 10, 2011

On May 10, 2011 Inspector David William Winebarger[24] ("Inspector Winebarger" or "Winebarger") traveled to the Cardinal Mine to conduct an inspection. During the inspection and at the close-out meeting Winebarger was accompanied by MSHA Inspector Tony Sims ("Sims"). GX-5, p. 2; Tr. 155, 156, 183, 184, 189-191, 293. He had been asked to go to the mine the afternoon before, when he was briefed on the conditions in the #2 Unit by Inspector Hardison. Tr. 47, 67. Hardison wanted Winebarger, on behalf of the roof control department, to take a look at the conditions the mine was experiencing. Tr. 110. Winebarger wrote extensive notes that day, beginning with his arrival at the mine at 0730, the time of the day shift. GX-5, pp. 1, 2. In his testimony, he frequently referred to his notes; the hearing was held almost 4 years after the inspection.[25] He first examined the #2 Unit pre-shift and on-shift records and maps above ground. He talked to Bruce Morris[26] ("Morris") and Tommy Kessinger[27] ("Kessinger") about conditions on the #2 Unit. Tr. 67, 111. Morris and Kessinger reported they had been in this panel for three production days, and that the left side was not as good as the right side. GX-5, pp. 1-3. Morris and Kessinger said they would travel with Winebarger to the #2 Unit. Tr. 111.

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[24] David Winebarger began work for MSHA in February of 2007. Tr. 64. Prior to joining MSHA Winebarger began work in the coal mine industry in 1971. Tr. 65. He became a mine foreman in 1975, and worked as a fire boss and foreman until 1978. Tr. 65. He also worked as a drill operator, mechanic, mine foreman and mining coordinator until 2003. Tr. 66. At the time of his inspection of the Cardinal Mine on May 10, 2011, Inspector Winebarger was a roof control specialist. Tr. 65.

[25] Due to the passage of this much time, and to provide clarity regarding events of this day, the testimony and notes of the witnesses, where available, will be considered together.

[26] Bruce Morris has been Warrior Coal's Safety Director for the Cardinal Mine since 2009. Tr. 165. Morris's mining career began in 1981, and his experience has "run the gamut of jobs within the mining industry." Tr. 165-6. Morris is certified as a mine foreman, MET and MET Instructor, and also certified to run respirable dust. Tr. 166-7.

[27] Tommy Kessinger was Cardinal's General Mine Superintendent. Tr. 142.

The Imminent Danger Run

The #2 Unit consisted of entries #1 through #5 on the left and entries #6 through #9 on the right.[28] Tr. 68, 111, 114; GX-5, p. 3. To begin the imminent danger run Winebarger, Morris and Kessinger came in on the supply road, and then walked straight ahead down the #4 entry to the face. Tr. 68, 69, 111; GX-5, pp. 3, 4. When the group arrived, they were not mining coal. Tr. 89, 112.

In the #4 entry inby the spad 3+10 crosscut there were cavities with a roof height of 10 to 11 feet. GX-5, p. 4. There was a slip[29] running across the entry causing the rib and rock above it to be loose. Tr. 69; GX-5, pp. 4, 11. The loose rib had caused approximately 4 feet of chunky rock to fall out from above the coal during mining. Tr. 69; GX-5, pp. 4, 11, 14. There were also 2 unsupported heads[30] that were broken and cracked and appeared to be loose by the gaps around them. Tr. 72, 73; GX-5, pp. 4, 11. Although the mining height was typically 7 feet, with the rock falling out above the coal the entry and crosscut heights were 10 to 11 feet. Tr. 69, 70. Looking at the map, Winebarger testified that a slip went almost all the way across the section. Tr. 70, 71; GX-5, p. 42. In the #4 entry the slips in the roof were supported, but in the ribs they were not. Tr. 71. Winebarger observed clay veins in the entry; since the roof or coal was not consolidated, the areas around the clay vein were loose and not sturdy. He stated if a clay vein goes into a pillar, the pillar support would be weakened. Tr. 71, 72. At this location a citation[31] was issued to Morris. Kessinger scaled some of the corner of the loose rib down. GX-5, p. 5.

From the #4 entry the imminent danger run continued to the left side through the last open crosscut between the #4 and #3 entries. Tr. 74. There Winebarger found a lot of loose stack rock[32] in the center of the crosscut that had been bolted up. There was a cavity in the crosscut that had been created by mining. Tr. 75, 76; GX-5, pp. 6, 11. Stack rock had been supported in the roof but not in the ribs. There were loose heads in the ribs, but they were not broken. Tr. 76.

The imminent danger run moved on to the left to the #3 entry. There Inspector Winebarger saw 2 roof bolter operators placing a bolt at the left inby corner where there was an overhanging rock rib right next to the operator on the return side. Tr. 76, GX-5, p. 6. Winebarger

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[28] Entries #1 through #9 of this section of the mine are shown by the marked up map in Winebarger's notes. GX-5, p. 42.

[29] A "slip" was described by Winebarger as a polished rock to which the limestone surrounding it does not adhere and falls off from around it. He testified unsupported slips could fall at any time. Tr. 70.

[30] Winebarger described "heads" as heavy, round, smooth, hard rocks of any size that are hard to support and can fall at any time. Tr. 72.

[31] This citation is not at issue in the instant case.

[32] "Stack rock" was described by Winebarger as thinly laminated shale that is not solid and flakes off, looking like slices of bread or the side of a deck of cards. Tr. 75, 76.

immediately withdrew the operators outby and an imminent danger order was issued to Morris and Kessinger. Tr. 77, GX-5, p. 6. Winebarger did not speak to the bolter operators about any previous efforts they had made on the condition. Tr. 116. At page 13 of his notes, Winebarger's drawing shows where the bolter was and the site of the imminent danger order. Tr. 85, GX-5, p. 13.

Inspector Winebarger did not remain in the #3 entry because he heard the top working, taking weight, over towards the #2 and #1 entries. He testified you could hear the fall of roof with rocks dropping, dribbling out and there was flaking and popping. Tr. 77; GX-5, p.7. In the #2 to #1 crosscut he found a pile of rocks that had fallen out where the top was working. One rock measured 3'x4'x18" thick and had been rock dusted; there were small rocks also. Tr. 78; GX-5, p. 7. There was also a slip running across the crosscut. GX-5, p. 12. While in this crosscut Winebarger was concerned because the top was still dribbling out over towards the #3 entry where he had issued the imminent danger order and the operators had been removed. Tr. 78, 79; GX-5, p. 7. After again looking at the roof there he went back toward the #2 entry. Tr. 79.

In the #3 to #2 crosscut there were 3 loose ribs with the corners broken up and rashed off. The roof was loose and working and there was a head in the middle of the crosscut. Tr. 79, GX-5, p. 12. In the #2 entry there was a loose and cracked rib on the left, inby the last open crosscut towards the face. Tr. 79. The rock above the coal was busted up, looking like slices of bread laying down flat. The right rib corner was also loose; there was no support in the ribs. Tr. 80; GX-5, pp. 7, 8, 12.

The imminent danger run continued to the #1 entry through the #2 to #1 crosscut Winebarger had already inspected. He found a rib on the left that was loose and busted up through to the outby crosscut. The rock above the coal was chunky looking and the top was starting to work a little and fall out. Tr. 80; GX-5, pp. 8, 12. There was a slip present that was partially unbolted; this appeared to be the same slip that crossed the Unit. Tr. 81, GX-5, pp. 8, 12, 42. The roof was supported, but the ribs were not. Tr. 81.

From the #1 entry Winebarger went back towards the #3 entry, and noted that the #2 to #1 crosscut was still dribbling some at the slip. GX-5, pp. 8, 9. It was here that Kessinger told Winebarger of the decision to move the left side of the Unit out. Kessinger had the entire left side flagged and barricaded off from the #1 through the #5 entries. GX-5, p. 9. Winebarger testified that the left side was shut down because it was getting progressively worse and could not be fixed; they did not have equipment such as an angle bolter to support the ribs. Tr. 83-85. Kessenger asked Winebarger if they could mine the right side until the 3rd shift. *Id.*

Winebarger returned to the #3 entry where an outby rib corner was loose and when pulled measured 12 feet long. Tr. 82, GX-5, pp. 10, 13. The rock where he had issued the imminent danger order was scaled down and measured 5' long, 3' thick and 2' wide. Tr. 82; GX-5, p. 29.

The imminent danger run then started towards the right side of the Unit, and when traveling through entry #5 Winebarger found the whole outby right-hand rib had flaked off. Tr. 82, 83. A worker was scaling the #5 to #6 crosscut, and at least 2 scoop buckets of rock and coal

had been scaled off in that one crosscut. Tr. 83. In the #7 entry a half cut was unbolted at spad 4+10 indicating this unit had been running before he got there. GX-5, p. 15. In this entry a couple of ribs were pulled off and there were loose corners. Tr. 83, GX-5, p. 42. In entry #8 loose corners had been pulled, and one rock measured 3'x4'x8". Tr. 83, GX-5, p. 16. In entries #7, #8, and #9 he found the slip that was running across the Unit. Tr. 83, 84; GX-5, p. 42. Winebarger testified that the right side was not as bad as the left side. Tr. 83, 84. Kessinger asked if he could run the right side, and Winebarger determined it would be safe. GX-5, p. 17.

Inspector Winebarger testified that the conditions he found had existed from day one when they moved into the panel. He testified that according to Kessinger, the crosscuts between entries #1 and #2 and between #2 and #3 had been holed through 16 hours earlier. Tr. 84. He further testified that while he was there, the conditions continued to get worse. Tr. 132.

Inspector Winebarger's notes continued after the imminent danger run across the Unit through entry #9. For each citation and order he wrote down the determinations he had made. GX-5, pp. 18-36. He told Morris and Kessinger again what was issued. GX-5, p. 37. His notes also continued after traveling to the surface to do the paperwork for the citations that were issued. There a discussion took place with a number of mine employees including Morris, Kessinger and Anderson. Anderson objected to Winebarger that they had already made the decision to move the Unit before Winebarger went in, but Kessinger said that was the reason he had traveled with the Inspector, to make that decision. GX-5, pp. 37, 38. The conference became confrontational to the point that Winebarger could not do his work. Sims stated it was time to leave. GX-5, p. 40. Winebarger had to go to his office to write out the citations and hand deliver them later that day to Morris at the mine. GX-5, pp. 40, 41.

Order No. 8498873

Summary of the Evidence

After observing the conditions in the #4 entry and the #4 to #3 crosscut, the imminent danger run went to the #3 entry where at spad 3+10 Inspector Winebarger saw 2 roof bolter operators replacing a loose bolt. Tr. 76, 90. In the left inby corner there was an overhanging rock rib right next to the operator on the return side. GX-5, p. 6. Winebarger testified the two roof bolter operators were working alongside, adjacent to a loose overhanging rock rib around 11 foot high that would fall and crush them. Tr. 91. In his notes he made a sketch of the #3 entry, showing the location of the imminent danger rock. GX-5, p. 13.[33] They were replacing a loose bolt in the roof; they were not trying to support the loose rock and did not have the machinery to accomplish support. Tr. 91, 92. The roof in the area was 10 to 11 foot high; the rock was 3 feet above the coal seam. Tr. 92, 93. Winebarger thought it was loose because it had a crack in it. Tr. 93. Winebarger, Morris, and Kessinger removed the two bolters from the area and Winebarger verbally issued the imminent danger order to Morris and Kessinger. Tr. 77, 78, 91-93; GX-5, pp. 29, 30; GX-6.

[33] Respondent also submitted a sketch, see Exhibit RX-K.

He did not remain in the #3 entry because he heard the top working[34] over towards the #1 entry and the miners had been removed and were no longer in imminent danger. Tr. 77, 93. The imminent danger run went on to the #2 and #1 entries, including the crosscuts. When he returned to the #3 entry the rock he had observed was down. He measured it as 5' long, 3' thick and 2' wide. Tr. 93. He did not know how the rock was removed. Tr. 93, 117.

Bruce Morris testified for the Respondent. May 9, 2011 was the second day of mining in the 2nd west panel. The Unit had moved from the first west panel where there were similar roof and rib conditions. Tr. 169, 170, 224. The left side of the working unit consisted of entries 1 through 5, and the right side 6 through 9. Tr. 171, 172. Morris testified the next day, May 10, 2011, that he arrived at the mine at around 5:30 am and joined Eric Anderson and Tommy Kessinger in the Foreman's office. They were talking about the #2 Unit. Tr. 181, 182. The third shift Foreman had called out some concerns about the #2 Unit; there had been problems cutting coal with the top coming out and some rib sloughage. Tr. 182, 183. At about 6:00 to 6:30 Anderson said to Kessinger he was going down to evaluate the need to move the unit and Morris said he would go along. Tr. 182. When MSHA Inspectors Winebarger and Sims arrived they talked with Morris, Kessinger, and Anderson about the #2 Unit and said they were going there. Tr. 183, 184. Morris said he and Kessinger were going there, so all of them would go together. Tr. 184. They travelled underground with the Inspectors at around 8:30 and got on the Unit at about 9:20. Tr. 184. Morris also created notes regarding the inspection on May 10th .[35] Tr. 180, 181; RX-A.

Morris testified no coal was being produced because Jesse Campbell, the day shift Foreman had shut the Unit down at about 8:50 to assess and deal with the conditions. Tr. 184, 185. He traveled first to entry #4, and Winebarger was also there. Sims went to the left side. Tr. 185. After Morris and Kessinger scaled an outby right rib in the #3 entry, Kessinger left to observe the right side of the Unit. RX-A, p. 1, # 6-8. In the last opening of entry #3 the roof bolter was in the intersection partially inby toward the face. Tr. 187-189; RX-E. They were spotting a pin in the roof next to the left inby rib. Tr. 186, RX-A, p. 1, # 9. When one of the operators started to install a pin, Morris noticed a piece of rock roof move. The rock was in the corner of the rib in the roof and had a visible crack in it that he thought needed to be addressed; he was concerned because he thought it was loose. Tr. 187, 219, 220; RX-E. He told the operator to move away from the area and scale the loose material down. Tr. 187; RX-A, p. 1, # 10. The miners told him they had tried to pull on it but could not get it down. Tr. 187. He recalled that neither Inspector was with him. Tr. 186, 187. They tried again, according to Morris, but were unsuccessful. Tr. 189. Morris then went on towards entries #2 and #1, and met with the Inspectors. Tr. 189. Up to this point no imminent danger order had been issued. The Inspectors had already passed through the #3 entry to get to where they met and talked. Tr. 189, 190. Morris also testified that Sims saw the rock and had the pinners stop and move, and Winebarger issued the imminent danger order. Tr. 189-191.

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[34] "Top working" refers to the roof taking weight. Tr. 77.

[35] The notes are typewritten, unsigned, and bear the date of May 10, 2011.

Morris was asked to get Kessinger who was on the right side of the Unit. Tr. 190, 191. He found Kessinger and they discussed whether to continue or to move out of the Unit. Tr. 191, 192. They decided to move the left side of the Unit. Tr. 192, 193. When they got back to the Inspectors, they were issuing an imminent danger order. Tr. 194. Morris and Kessinger told the Inspectors they wanted to move the Unit, and started flagging out and dangering off that side of the Unit to keep people from going there. Tr. 194. Morris testified that the overhanging rock had been knocked down with a mining machine. Tr. 195. Since the machine had been needed to cut it down, Morris stated he had probably been incorrect in his evaluation of the rock. Tr. 195, 196. He also testified that the roof height in the left side was 10 to 11 feet in spots, and that abnormal mine heights are not a hazard if the roof is good and the ribs are fine. Tr. 172.

Eric Keith Anderson[36] ("Anderson") testified for Respondent and also wrote notes[37] regarding the #2 Unit on May 10, 2011. At 9:04 am Jesse Campbell called and informed him that he was shutting the #2 Unit down due to rib pins[38] being too far from the ribs in several places. Tr. 150; RX-G. He recalled that abatement for the imminent danger order was to scale down the particular rib. Tr. 156. He did not speak to the Inspectors prior to the close-out of the inspection. Tr. 144.

Jesse Wilburn Campbell[39] ("Campbell") testified for Respondent. On May 10, 2011 he was working as an assistant mine foreman and was on the #2 Unit. Tr. 281, 283-84. He was on the Unit at about 7:50 am and had two cribs built at the #7 wide entry from the day before. He traversed all of the entries, and evaluated the left side. Tr. 286-289. There were some loose ribs, pinning that needed attention and some rib rash. He shut the Unit down at about 8:50. Tr. 288, 290, RX-F. Prior to MSHA's arrival, they were correcting things that needed to be done. Tr. 300. He had two miners pulling ribs down with pry bars, one miner use a scoop for rib sloughage, and other miners spotting pins and watching the pinners. Tr. 291. The MSHA Inspectors arrived at 9:20. Tr. 290, 291. He had men spotting pins in the #3 entry. Tr. 291. He recalled he told the Inspectors he had shut the Unit down. He was involved in abatement of the imminent danger order. Tr. 293. Since they could not get the rock with a bar, he called the miner man to get it down. Tr. 293, 294.

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[36] Anderson holds a B.S. Degree in Engineering and Mines. At the time of the hearing he was General Manager of Operations at a sister operation of Warrior Coal. He had held the same position at Warrior beginning in January 2005. Tr. 136. After graduating in 1996 he served in various roles, mostly in management for 15 of his 20 years of mining experience. Tr. 139, 140.

[37] The notes at RX-G are handwritten, dated and signed.

[38] Rib pins are bolts located in the roof closest to the rib. Tr. 160.

[39] Campbell has been a Warrior Coal employee since 1996. His experience there includes work as a lead man, face boss/section foreman, assistant mine foreman, and outby mine foreman. Tr. 278, 279. His career in mining began in 1972 as a laborer, and after he got foreman papers he worked as a section foreman. Tr. 281. Of his 44 years in mining, at least 39 have been in management. Tr. 281, 282.

The Mine Act

Section 107(a) provides that:

> If, upon any inspection or investigation of a coal or other mine which is subject to this Act, an authorized representative of the Secretary finds that an imminent danger exists, such representative shall determine the extent of the area of such mine throughout which the danger exists, and issue an order requiring the operator of such mine to cause all persons, except those referred to in section 104(c), to be withdrawn from, and to be prohibited from entering, such area until an authorized representative of the Secretary determines that such imminent danger and the conditions or practices which caused such imminent danger no longer exist. The issuance of an order under this subsection shall not preclude the issuance of a citation under section 104 or the proposing of a penalty under section 110.

30 U.S.C. § 817(a).

Section 104(c) provides that:

> The following persons shall not be required to be withdrawn from, or prohibited from entering, any area of the coal or other mine subject to an order issued under this section:
>
> (1) any person whose presence in such area is necessary, in the judgment of the operator or an authorized representative of the Secretary, to eliminate the condition described in the order;
>
> (2) any public official whose official duties require him to enter such area;
>
> (3) any representative of the miners in such mine who is, in the judgment of the operator or an authorized representative of the Secretary, qualified to make such mine examinations or who is accompanied by such a person and whose presence in such area is necessary for the investigation of the conditions described in the order; and
>
> (4) any consultant to any of the foregoing.

30 U.S.C. § 814(c).

The 107(a) Order

The Condition or Practice described in Order Number 8498873, in pertinent part, was:

> Two roof bolter operators were observed installing a roof bolt in the roof in the # 3 entry on MMU-002, 2nd west panel. A loose rib was observed on the inby left

corner right adjacent to the roof bolter operator on the return side of the bolter. The 2 miners were removed from the area and the loose rib scaled down. The loose rock that was pulled down measures up to 5 ft. in length up to 3 ft. thick and 2 ft. in width. The cavity height in this entry measures 11ft. 4 inches where the roof bolter operators were observed.

GX-6.

Contentions

Respondent contends that Bruce Morris directed the roof bolter operators to remove the rock before the order was issued, and the presence of those miners in the area was necessary to eliminate the hazard. Further, the rock did not constitute an imminent danger since it was not loose but firmly affixed to the coal rib and pillar requiring a continuous mining machine to rip it down. The Inspector did not speak to the bolter operators about the rock or any efforts to remove it. In addition, MSHA lacked the authority to remove the bolter operators from the area, the Inspector abused his discretion, and the 107(a) order should be vacated. RPHB, pp. 56-59.

The Secretary contends that when in the #3 entry on the imminent danger run Inspector Winebarger observed an overhanging rock 11 feet above the floor next to roof bolter operators who were replacing a rib bolt. Further, the bolter operators were not attempting to either support or remove the rock. Winebarger reasonably believed the rock was loose and likely to fall because it was visibly cracked and had no support beneath it. In addition, when Morris saw the rock he also thought the rock was loose. The Secretary argues that it was Winebarger who withdrew the miners to safety, and the 107(a) order was not an abuse of discretion. SPHB, pp. 17, 20, 21. Also, the Inspector was not required to interview the bolter operators prior to issuing the order. SRB, p. 5

Findings and Conclusions

Inspector Winebarger along with Morris and Kessinger traveled to the #2 Unit and arrived on the left side at the #4 entry, where the imminent danger run began. They were not mining coal, because Assistant Mine Foreman Campbell had just stopped the mining due to rib rash, loose ribs, and some pinning that needed to be done. From the #4 entry the imminent danger run proceeded to the #3 entry.

It is at this point the testimony of Inspector Winebarger and that of Respondent's Morris is not in agreement. Winebarger testified that Morris and Kessinger were with him when he saw the 2 roof bolter operators replacing a loose roof bolt next to the rib where there was an overhanging rock about 11 feet off the floor that could fall and crush the operator working adjacent to that rib. But Morris testified that when he went into the #3 entry, Winebarger was not there, the Inspector having already moved through the entry and on to the entries #2 and #1 area. Morris testified that it was he who saw the roof bolter operators spotting a pin next to the left inby rib and also saw the rock in the corner of the rib that needed to be addressed. Further, it was he who told the operators to move away from the area, and he also told them to scale the loose material down.

I find Inspector Winebarger's version of the sequence of events to be credible. This is because it is more consistent with the discovery of an apparently dangerous condition during an imminent danger run. The order of the events was also recorded in his notes, supporting his recollections in testimony. GX-5, pp. 3-17. Winebarger testified that he, Morris and Kessinger together removed the miners from the area and he verbally issued the imminent danger order to Morris and Kessinger.

The testimony of Morris would have one believe the Inspector had been through the #3 entry, but this is contradicted by his testimony that he saw the same thing Winebarger saw: roof bolter operators installing a roof bolt next to a rib where there was an overhanging and apparently loose large rock above them. Obviously, if Winebarger had been there and removed the miners from the area, Morris could not have been the person who first discovered the apparently dangerous situation. I find Inspector Winebarger's testimony that both he and Morris were in the #3 entry at the same time to be credible; they saw the same activity occurring at the same place with the same apparently loose, unsupported rock overhanging the working bolter operator. They both decided the miners must be removed from the area. This is when the imminent danger order and withdrawal occurred and was in effect, rather than at some time later and in a different area.

It is credible that Morris subsequently ordered the rock scaled down. Inspector Winebarger continued the imminent danger run to the area of the #2 and #1 entries, and he testified he did not know how the rock was scaled down. This provided the opportunity for Respondent to present uncontroverted testimony that the rock turned out to be affixed to the rib requiring the miner machine to scale it down. However, this after the fact circumstance is not controlling.

The imminent danger order was properly issued, and the section 104(c) argument is not supported by the evidence found credible. The testimony of both Inspector Winebarger and Morris was that the bolter operators were not addressing the overhanging rock, but were installing a roof bolt next to the left inby rib. Therefore, the miners were not engaged in abating the apparent hazard. I find credible that only after the miners had been withdrawn from the area-subject to the order-would they then be ordered to go and scale the rock down. Not until they were working to get the rock down was their presence in the area necessary to eliminate the condition.

The argument that the rock turned out to not be dangerous and hence the order should be vacated is misplaced. The Commission has established that an Inspector "must act quickly to remove miners from a situation he believes is hazardous". *Blue Bayou Sand and Gravel, Inc.,* 18 FMSHRC 853, 859 (Jun. 1996), citing *Island Creek Coal Co.,* 15 FMSHRC 339, 346-47 (Mar. 1993). Clearly, both Winebarger and Morris thought, on observation, that the unsupported overhanging rock with a visible crack was hazardous. Under the circumstances presented to the Inspector, it would have been unreasonable to engage in any kind of investigation of the rock before withdrawing the miners from the area. Indeed, Inspector Winebarger reasonably concluded based on the information available to him when he saw the rock that an imminent danger existed. *Island Creek* at 346. This is because the rock had a visible crack and was unsupported, indications that it could be loose and fall on the miners working below. This

presented to both Winebarger and Morris the type of impending hazard that required the immediate withdrawal of miners. *Utah Power & Light Co.,* 13 FMSHRC 1617, 1621 (Oct. 1991); *Island Creek,* at 345. Considering the scene presented to the Inspector, allowing the bolter operators to continue to place the roof bolt next to the rib under the rock could reasonably be expected to cause death or serious physical harm unless the rock was first removed. *Knife River Construction*, 38 FMSHRC 1289, 1291 (Jun. 2016), citing 30 U.S.C. § 802 (j).

Inspector Winebarger's perception was reasonable that the fall of the overhanging rock several feet above the coal seam and the working bolter operator was imminent. Quick action to remove the miner from under the apparent hazard and threat to his safety was consistent with the definition of an imminent danger, a condition "which could reasonably be expected to cause death or serious physical harm before such condition or practice can be abated" 30 U.S.C. § 802 (j). I find the preponderance of the evidence found credible supports the Inspector's decision to issue the imminent danger order. The order was objectively reasonable at the time issued, and I further conclude the Inspector did not abuse his discretion and authority in issuing the 107(a) order. *Connolly-Pacific Company*, 36 FMSHRC 1549, 1555 (Jun. 2014).

Citation No. 8498874

Summary of the Evidence

Like his notes regarding the imminent danger run, Inspector Winebarger's notes regarding 104(a) citation # 8498874 are extensive, covering 9 handwritten pages. GX-5, pp. 18-26. The Condition or Practice recorded on the citation itself is very detailed, both as to the location and the description of the multiple adverse conditions he found across the #2 mining Unit:

> The ribs where persons work and travel were not being supported or otherwise controlled on the #2 unit in the 2nd west panel. Loose ribs and corners were observed from the # 1 entry to the # 5 entry in the last open xcut spad #3+10 and entries inby to the face. The roof and ribs between #1-2 entries in the locc are still working and a large rock measuring 3 ft x4 ft x18 inches was found on the mine floor in this area. In addition, there were loose heads and stack rock present in the locc between #3-4 entries. There are slicken sided slips, clay veins, stack rock, heads and loose draw rock present in the entire area. The last open xcut in the # 8 entry at spad 4+00 on the outby side has 2 loose corners. When scaled the chunk rock measures 1 ft. x 3ft x18 inches on the right side and 3ft x4 ft. x 8 inches on the left side. Several small pieces of rock were pulled from these outby ribs as well. There is a face boss and mine foreman present on the unit.
>
> Standard 75.202(a) was cited 25 times in two years at mine 1517216 (25 to the operator, 0 to a contractor).

Winebarger determined that injury was highly likely and could be expected to be fatal to 1 person; he evaluated the violation as S&S. He found the operator's negligence to be high, and although he did not record on the citation that the violation was considered an unwarrantable

failure, the Secretary argued this at the hearing and in his post hearing brief. GX-4; SPHB, pp. 28-34.

The safety standard cited provides:

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

30 C.F.R. § 75.202(a).

Inspector Winebarger testified he issued this citation because the rib conditions were about as severe as anywhere he had ever worked, and were so widespread they were difficult to map. Tr. 85. There was no rib support anywhere on the section, the ribs were not controlled. It was not possible to remove all of these hazards because they did not have the needed equipment. Tr. 76, 86. Winebarger described a loose rib as busted up or flaking off and a hazard since the rib can fall. Tr. 73, 74. The hazard was falling slabs of rock, mostly from above the coal seam, that would result in a fatality. Tr. 86. He wrote that slabs of rock falling from up to 11 feet would crush a miner. GX-5, p. 25. He testified that MSHA tech support had recommended installation of rib support for areas with a height of 7 feet or more. Tr. 87. Winebarger also testified the area was a working section, traveled every shift every day. Tr. 87, 88. In his notes he recorded his finding that there was no rib protection across the entire section. GX-5, p. 24.

Inspector Winebarger further testified these hazards were widespread across the whole left side of the Unit, and part of the right side. Tr. 88. He wrote that the injury was highly likely because clay veins, slips, heads and stack rock were so widespread that if mining continued some miner would be struck and killed. GX-5, pp. 25, 26. He stated that just being present on the Unit even without regular mining, with the continuing working and falling out, injury would have occurred sooner rather than later. Tr. 87. Although there were 15 miners working on the section that day only 1 person would be exposed, referring in his notes to the roof bolter operator he saw in imminent danger. GX-5, p. 24.

High Negligence was attributed to the operator by Inspector Winebarger because the conditions were extensive and obvious, and had existed for up to 3 days. Tr. 88, 89. He testified the conditions on the Unit were obvious, all you had to do is look, and you did not have to look very hard. Tr. 88. Winebarger determined that no attempt had been made to correct the hazards, to control the ribs. Tr. 88; GX-5, p. 26. Management, especially the face boss and mine foreman present, the preshift examiners, and anyone who walked on the Unit should have known of the conditions. Tr. 89. He wrote the slips, clay veins, heads, stack rock and roof rock up to 11 feet high above the coal seam were obvious and apparently ignored. GX-5, p. 24.

No mitigating circumstances were found by Inspector Winebarger. Although they were not mining coal during his imminent danger run this was not a factor since they had been mining prior to his arrival. Tr. 90. The only abatement steps taken were that Morris and Kessinger would scale what he pointed out but he observed no other scaling on the left side. Tr. 90, 131, 132. The shorter cuts did not fix the conditions, since there were still bad ribs. Tr. 133. Winebarger also testified that the slips in the ribs were not supported. Tr. 134.

Inspector Winebarger testified he evaluated the violation as an unwarrantable failure because the conditions were obvious, extensive and there were people working with supervisors present. Tr. 90, 91. He wrote the conditions existed for at least 16 hours, but the overall conditions most likely existed 24 to 48 hours. GX-5, p. 25. He stated that typically he did not issue an unwarrantable failure only after he put the mine on notice, but rather where a problem is ignored and there was no attempt whatsoever to mitigate. Tr. 133.

Third shift Crew Leader Smith testified about the conditions on the third, nonproducing shift that ended just before the inspection was conducted during the day shift on May 10, 2011. He testified there was no excessive weight or sloughing off on the left side of the Unit. Tr. 265. He also testified hazardous rib conditions were not observable. Tr. 268. Further, multiple slicken sided slips were not observed in entries #1 through #5, nor were stacked rock, clay veins, unsupported heads, or loose draw rock. Tr. 268-270. Smith believed the mine was adequately supporting the roof and ribs at the end of the shift. Tr. 275. However, he also testified they had advanced very little at that time, taking shorter cuts and pinning well. Tr. 258, 259.

Assistant Mine Foreman Campbell testified he was at the mine early on May 10, 2011. He wanted to go to the #2 Unit to follow up on the citation written the day before. Tr. 284-286. He dropped down at about 7:15 am arriving at the Unit about 30-35 minutes later. He went directly to the #7 entry where he had 2 cribs installed at the entry offset. He went on to the #9 entry, and then went from right to left across the Unit. Tr. 286, 287. Campbell further testified that across the Unit he found some loose ribs and corner pins that needed to be spotted, but the area from entry #4 through entry #1 needed more attention. He talked to Section Foreman Nathan Boone suggesting shutting the Unit down to get the conditions fixed. Tr. 288. This included the right side also because he was concerned about rib rash there. The Unit was shut down at 8:45 am and he called to notify Anderson. Tr. 289. He then instructed to men to spot pins, pull ribs down, and watch the roof bolters. Tr. 291, 295. In his opinion, the mine was not failing to support the ribs; they were not required to bolt the ribs and did not have a truss bolter at that time. Tr. 294, 295. Miners were not withdrawn from the left side; they were correcting the things that needed to be done. Tr. 300.

General Mine Manager Anderson was part of the morning discussion with Kessinger and Morris. Anderson testified he was informed of the deteriorating conditions on the #2 Unit requiring shorter cuts and additional bolting to better control the roof. Tr. 141-145, 148. It was decided Kessinger and Morris would evaluate the conditions that morning and a determination would be made whether to move the Unit to a new location later that day. Tr. 144, 153. He further testified that Campbell called out at 9:04 am to report mining activity was shut down on the #2 Unit after 8:50 am due to rib pins being too far from the ribs and the need to spot corner and rib pins. Tr. 149, 150; RX-G. He also testified this could mean there was sloughage off the ribs, damaged pins, installation of the pins too far from the ribs, or entry cut too wide. Tr. 150, 151. It was Kessinger and Morris that went to evaluate a potential move out of the area; he was not actually down there. Tr. 157, 163. Prior to their evaluation, miners were not removed from the #2 Unit. Tr. 161.

Anderson testified and wrote down his opinion on the mitigating circumstances that existed that day. They had only been in that area for 3 days, barely enough time to determine if

the conditions would persist. They were taking short cuts on the left side to control the roof, they shut down mining on the Unit due to the conditions they found, and the hazards were being corrected when MSHA was there. Tr. 147, 148, 156; RX-G, RX-F. Further, they decided to move the Unit, MSHA did not make them move. RX-G.

Morris testified for Respondent regarding this citation, and there are some notes at Exhibit RX-A. He opined the roof conditions on May 10, 2011 were pretty good, and his impression was they needed to continue scaling the ribs to clean off the sloughage. Tr. 198. The coal seam was about 7 feet high on average; on that day the left side had some high places, up to 10 or 11 feet. Tr. 169, 172. Morris said abnormal roof height is not a hazard if the roof is good and the ribs are fine. Tr. 172. At the morning meeting with Kessinger and Anderson he understood there were problems on the #2 Unit with the top coming out and some rib sloughage, but at that time it was his understanding the mine was providing adequate support to the roof and ribs. Tr. 181-183. When the Inspectors arrived, they all traveled to the #2 Unit together. Tr. 184. When they got to the Unit a couple of miners were scaling and there were other miners on the right side. There were also 2 pin men and 2 car drivers watching the pin men put up a pin. Tr. 185. He and Kessinger did not think the rib conditions were great; they did have the Unit move out. Tr. 198.

Morris testified there was a lot of scaling going on, there was rock on the floor, and a scoop was also used to clean the ribs. Tr. 199, 226. Referring to Exhibit RX-F, Morris pointed out there had been two 10-foot cuts taken on the left side with immediate bolting to keep rock from falling on their miners. Tr. 200, 201. Exhibit RX-F shows that two 10-foot cuts were taken in the #2 entry on the left. When he was told of the rib citation, the mitigating circumstances he offered were that they were working on the conditions, they were scaling on the Unit, and he and Kessinger were down there to investigate the Unit. Tr. 155, 156, 202-204. In the notes are the arguments that Morris and Kessinger made to the Inspectors: The Unit was shut down at 8:45 am; Scaling and roof bolting was in progress before the group arrived on the Unit; Management had already talked about moving the Unit that morning if necessary to get away from the bad conditions; and Kessinger was going to the Unit to assess the conditions and make a decision to move or not. RX-A, #18. In the comment section of these notes, it was reported several miners stated they had been scaling ribs before the Inspectors arrived on the Unit. *Id.*

Contentions

Respondent contends that the Secretary failed to prove the fact of the violation, since Warrior acted as a reasonably prudent mine operator would under the circumstances. RPHB, pp. 30-33. It was further argued that, even if the fact of the violation were proved, the Secretary's gravity and negligence determinations should be reduced because the violation was not highly likely to cause an injury nor did the Respondent act with high negligence. RPHB, pp. 33-35. In addition, the unwarrantable failure designation was not properly justified by the Secretary. RPHB, pp. 35-39; RRB, pp. 13, 14. Also, the Secretary failed to justify the proposed massive special assessment. RRB, pp. 6, 7.

The Secretary contends that a reasonably prudent person familiar with the industry would have supported the ribs, and no testimony or evidence that the ribs were supported was provided

by Respondent. SPHB, pp. 25, 26. The Secretary argues the violation was highly likely to produce a fatality and was S&S. SPHB, pp. 26-28. The operator's negligence was high and there were no mitigating circumstances. SPHB, p. 30. It is further argued the violation is one of unwarrantable failure. SPHB, pp. 28, 30-34. Even mine management realized that scaling was not sufficient to eliminate the conditions; they gave up attempting to scale the area and flagged off the left side of the #2 unit. SPHB, p. 26. A penalty of $70,000.00 was specially assessed. SPHB, p. 34, 35.

Findings and Conclusions

There was a violation of safety standard 75.202(a). This safety standard requires, in pertinent part, that the ribs where persons work or travel must be supported or controlled to protect them from falls or bursts of coal or rock from the ribs. Respondent argues that the mine acted in a reasonably prudent manner under the circumstances, mining shorter cuts to adequately support the roof. However, the shorter cuts did not change the conditions found in the ribs. Just before the Inspectors with Morris and Kessinger arrived on the Unit that morning Campbell had halted mining, in part, to scale the ribs. But when the inspection party was on the left side of the Unit, the only scaling was by Morris and Kessinger on ribs pointed out by Inspector Winebarger. In the face of the adverse, hazardous rib conditions identified across the entire left side of the Unit, this effort was inadequate. In addition to loose and crumbling ribs, there were slips and clay veins weakening pillars that would need to be supported. There was stack rock in the ribs not supported. Campbell testified the mine was not required to support the ribs. However, there was no truss bolter available to accomplish rib support. Sloughage with scaling alone, especially in the entries and crosscuts with abnormal mine height, could increase the width of the mined area potentially calling for additional rib bolts or other measures for roof stability. I find Winebarger's testimony that there was no rib *support* anywhere on the section to be credible. The existence of compromised but unsupported ribs gives rise to operator liability. *Asarco, Inc.*, 8 FMSHRC 1632, 1634-36 (Nov. 1986), aff'd, 868 F.2d 1195 (10th Cir. 1989). Respondent's belief there was no violation is not reasonable.

There are three elements required in the evaluation of this safety standard. First, it must be determined if the cited area is one where persons work or travel; second, the area must be supported or otherwise controlled; and third, such support must be adequate to protect persons from falls or bursts of rib. *Oxbow Mining, LLC,* 35 FMSHRC 932, 944 (Apr. 2013) (ALJ).

The #2 Unit was a working section. Although mining had been halted at the time of the imminent danger run, there had been mining at the beginning of the shift, and the left side was not barricaded off until after entries #4 through #1 had been inspected. On the right side, considered safe at the time, mining continued until the third maintenance shift.

On May 10, 2011 across the #2 Unit there were ribs with adverse, hazardous conditions in many areas that were not supported or otherwise controlled. The rib conditions were such that scaling alone could not meet the protections intended by the safety standard; miners were not protected from rib falls or bursts. It was not until Morris and Kessinger traveled with the Inspectors and observed the full extent of the adverse conditions that the decision was made to move out of the left side and barricade off that part of the Unit.

A reasonably prudent person familiar with mining and the protective purposes of the safety standard would have provided support and control of the ribs on the left side of the #2 Unit during the two production shifts and the maintenance shift before mining was started on the next day shift. Campbell was on the Unit at about 7:45 am, and it did not take him long to move across the entire Unit and decide to halt mining. But there was no truss bolter available and where needed, the ribs could not be supported. Such action as was taken to try to improve the ribs by scaling did not meet the reasonably prudent person test. Persons were not protected from falls or bursts of rib.

Significant and Substantial

I have found that there was a violation of the safety standard, thereby satisfying the first element of the S&S analysis.

The hazard contributed to by violation of the safety standard was the fall of coal and rock from the ribs. The record establishes the average mining height was about 7 feet, but in a number of areas on this Unit the height was up to 10 or 11 feet due to roof fall and cavities created during the mining cycle. Respondent's Morris testified that abnormal roof height is not a hazard as long as the roof is good and the ribs are fine. But the ribs were anything but "fine". The number of adverse geologic conditions found, recorded and credibly testified to by Inspector Winebarger as set forth above during his imminent danger run and specific to this citation in both the roof and ribs clearly establishes the danger to safety contributed to by the lack of support and control of the ribs. Winebarger described the hazard of slabs of rock falling, mostly from above the coal seam that could crush a miner. He found no rib protection across the entire Unit. Although Winebarger determined roof support was generally adequate despite the cavities, he also found slips, heads, stack rock, and clay veins, and that rib support was lacking. The attempt to control the loose rib conditions by scaling alone was not possible; the adverse conditions required additional support but equipment such as a truss bolter was not available. Scaling resulted in large amounts of rib coal and rock, removed in a couple of areas by scoops. The large amount of scaling of the ribs and corners would contribute to the width of the mined areas and call for additional roof bolting to place rib pins, and this activity was observed by Winebarger. Scaling at best removed already loose rib coal and rock but did not serve to support or otherwise control the ribs. This is because hazards such as slips, clay veins, stack rock, and heads remained unsupported in the ribs in a number of areas across the Unit.

The safety standard cited, as relevant here, requires the ribs to be supported or otherwise controlled to protect miners from the hazards of falls or bursts of coal or rock from the ribs. Conditions such as slips and clay veins in a rib weaken support of the roof normally provided by the pillar and require stabilization of the rib in that area. That this Unit was in an unstable area, particularly on the left side, is well illustrated by what was happening in the area of entries #1 through #3 where the top was working and some roof rock was audibly dropping out. In this same area there were loose, busted up and cracked ribs; corners loose, broken up and rashed off; the rock above the coal was busted up and chunky looking; and there was no support in the ribs. Evidence was not presented to show that in rib areas where there were adverse and hazardous geologic conditions miners were protected by scaling alone. Instead, the evidence shows that there was a danger to miners from rolls and bursts due to unsupported, uncontrolled ribs.

Winebarger testified the left side could not be fixed due to the lack of equipment. This testimony is consistent with the decision of Kessinger and Morris to move the Unit out when they observed the conditions during the imminent danger run. There was a discrete safety hazard contributed to by the violation.

I find the violative condition existed for about 24 hours. Inspector Winebarger was told by Kessinger the area from entry #1 through #3 had been holed through 16 hours prior to the inspection. Winebarger testified the conditions had existed from the first day, May 8, 2011, when the Unit had moved into the panel. Tr. 84. Based on the evidence of record, the most likely time the conditions became evident was during the day shift on May 9, 2011, the day before this inspection. This was when Inspector Hardison observed, but did not cite, conditions including coal ribs rashing badly, slips around the ribs, and ribs starting to rash at the top of the coal seam.

Due to the widespread nature of the adverse conditions, particularly on the left side, the Inspector's estimate could be accurate. My finding is limited to about 24 hours based on the direct observations of Inspector Hardison and the evidence shorter cuts were taken on May 9th, a recognition of adverse conditions limiting advancement in the coal seam. RX-F. I do not find credible the testimony of third shift Crew Leader Smith that at the end of the shift just prior to the imminent danger run the ribs were adequately supported. Not only does the weight of the evidence establish this was not correct, the testimony is also contradicted by that of Assistant Mine Foreman Campbell who was on the Unit less than an hour after the end of that shift and found there was a need to halt mining to fix conditions including the loose ribs.

Under continued normal mining operations the adverse conditions in the ribs would have remained; the ribs could not be adequately supported because there was no equipment, such as a truss bolter, available on the Unit. There is no evidence the various adverse geologic conditions would improve if mining continued to advance in the panel even if the existing rib conditions could be supported. To the contrary, conditions were deteriorating even during the imminent danger run. It was Kessinger and Morris who decided to move the Unit, an acknowledgement that the conditions could not be fixed. It follows the area could not be made safe for miners.

The hazard was reasonably likely to occur because without rib *support* anywhere on the section, the ribs were not *controlled*. As discussed above scaling alone, even as extensive as reported by Winebarger, Morris and Campbell in their testimony could not adequately control the ribs to insure the safety of miners. Many coal ribs were loose, as were some rock ribs above the coal seam. They are a hazard since coal and rock can fall off of the rib and strike miners. Winebarger testified the rib conditions were about as severe as anywhere he had ever worked and were so widespread they were difficult to map. He was concerned about slabs of rock falling from a height of 10 to 11 feet, capable of crushing a miner. He testified that the conditions were so widespread that with continued mining some miner would be struck and killed. Just being present on the Unit with the roof working and the fall of coal and rock injury would have occurred sooner rather than later. It is clear there were many areas, particularly on the left side, where the ribs and corners were loose. An outby rib corner in the #3 entry was loose and when pulled measured 12 feet long. A whole outby right-hand rib had flaked off in the #5 entry. The

Secretary has shown a fall or burst of rib was reasonably likely to occur, and the second element is established.

The hazard of a fall of coal and rock from the ribs in the mining Unit would be reasonably likely to result in injury. Any such fall, burst or roll from a rib is a serious threat to the safety of miners. There was evidence of rock and coal that had fallen and ribs that were loose in the panel mined by the #2 Unit. On the imminent danger run Inspector Winebarger found a slip that caused a rib to be loose and about 4 feet of chunky rock had fallen out from above the coal. The slips in the ribs were not supported, and where a clay vein went into a pillar the pillar support was weakened. Loose ribs had corners broken up and rashed off. One rock from a loose corner measured 3 feet by 4 feet by 8 inches. Being struck by coal or rock from a rib can have lethal consequences. Here, the Secretary has shown that the resulting injury or injuries would be reasonably likely to be very serious, including fatal. Therefore, the 3rd and 4th elements are also satisfied.

The hazard of a coal and/or rock fall from a loose, unsupported rib contributed to by the violation of safety standard 75.202(a) was reasonably likely to result in an injury causing event, and such injury would be reasonably serious in nature. I find the Secretary has established by a preponderance of the credible evidence the violation was S&S.

Gravity

Inspector Winebarger determined and the Secretary argued that injury was highly likely and could be expected to be fatal to 1 person. Respondent argued the violation was not highly likely to cause an injury and the gravity determinations should be reduced. Since the rib conditions could not be supported or otherwise controlled by scaling alone, and the rib conditions were extensive across the Unit where mining had taken place and there were miners working on "correcting" the conditions at the time of the imminent danger run, injury was highly likely. The fall of very heavy slabs of rock and coal from the ribs striking a miner would cause a fatality. Winebarger determined only 1 miner would be at the place of a fall, and this determination was reasonable. I affirm the gravity findings of Inspector Winebarger.

Negligence

The operator failed to exercise a high standard of care to protect miners from the risks of harm from falls or bursts of the ribs. From at least the day before the inspection, the operator and its agents knew or should have known of the serious conditions in the ribs across the #2 Unit. The conditions were obvious; Inspector Winebarger's notes and the map document the easily seen hazards. Despite these adverse rib conditions mining did take place during the two shifts on May 9th, and mining started on the day shift on May 10th until halted just before the imminent danger run. The Secretary argued there were no mitigating circumstances, and Winebarger testified he found none. However, his testimony was variously to the effect that either no attempt was made, or that the abatement steps taken of scaling and shorter cuts were not adequate to control the ribs. What is established on this record is that the rib conditions could not be supported or otherwise controlled with the equipment available. The miners were attempting to correct the ribs but could not. Since *some* work was done on the ribs, albeit

unsuccessful, the negligence is somewhat mitigated. Therefore, I find moderate negligence on the part of the operator and its agents.

Unwarrantable Failure (UWF)

The unwarrantable failure terminology is taken from section 104(d)(1) of the Act, which establishes more severe sanctions for any violation that is caused by "an unwarrantable failure of [an] operator to comply with...mandatory health or safety standards." The term is not defined by the Act, but the Commission has established that "unwarrantable Failure" is "aggravated conduct constituting more than ordinary negligence, by a mine operator in relation to a violation of the Act". *Emery Mining Corp.*, 9 FMSHRC 1997, 2004 (Dec. 1987). And further, that unwarrantable failure is characterized by such conduct as "reckless disregard," "intentional misconduct," "indifference," or the "serious lack of reasonable care." *Id.* at 2003-04; *Rochester & Pittsburgh Coal Co.*, 13 FMSHRC 189, 193-94 (Feb. 1991); *see also Buck Creek Coal,* 52 F3d 133, 136 (7th Cir 1995).

The Commission has also established that the aggravating factors to be examined are the extent of the violative condition, the length of time that it has existed, whether the violation is obvious or poses a high degree of danger, whether the operator has been placed on notice that greater efforts are necessary for compliance, the operator's efforts in abating the violative condition, and the operator's knowledge of the existence of the violation. *Consolidation Coal Co.,* 22 FMSHRC 340, 353 (Mar. 2000). Although all seven of the factors must be considered, some factors may be irrelevant to a particular factual scenario. *Id*, at 353; *Wolf Run Mining Co.*, 35 FMSHRC 3512, 3520-21 (Dec. 2013). Further, some factors may be less important than other factors under the factual circumstances. *IO Coal Company, Inc.*, 31 FMSHRC 1346, 1351 (Dec. 2009). All of the relevant facts and circumstances of each case must be examined to determine if an actor's conduct is aggravated, or whether mitigating circumstances exist. *Id,* at 1351; *Eastern Associated Coal Corp.,* 32 FMSHRC 1189, 1193 (Oct. 2010). Therefore, it is not necessary to find that all factors are relevant or deserving of equal weight.

Extent of the violative condition.

The purpose of considering the extensiveness of a violation is to factor in the scope or magnitude of the violation. *Eastern Associated Coal Corp.*, 32 FMSHRC 1189, 1195 (Oct. 2010) (emphasis added). Traditionally, extensiveness has been determined by examining the extent of the affected area as it existed at the time the citation was issued. *Id.*; *Dawes Rigging & Crane Rental*, 36 FMSHRC 3075, 3079 (Dec. 2014). This can include the number of persons affected by the violation. *Dawes*, at 3079-80.

At the time of this citation there were 15 day shift miners on the Unit and the scope of the violation embraced the entire panel where the #2 Unit was active. Most of the entries and crosscuts, particularly on the left side, had adverse geologic conditions not only in the roof but also in the ribs. At least half if not more of the area had ribs that could not be supported or controlled with the equipment and methods available to the miners. Although the right side, entries #6 through #9, was considered safer, there were slips, loose ribs and corners, and scoop

bucket loads of rock and coal had been scaled off the ribs. Clearly, the violative conditions were extensive.

Length of time the violative condition existed.

The Commission has long considered analysis of the duration of a violation to be required, *Windsor Coal Company*, 21 FMSHRC 997, 1001-1004 (Sep. 1999), and therefore a necessary element of the unwarrantable failure analysis. *IO Coal Company, Inc.*, 31 FMSHRC 1346, 1352 (Dec. 2009). The Commission has permitted duration to be established through the use of circumstantial evidence. *See, Enlow Fork Mining Co.*, 19 FMSHRC 5, 16 (Jan. 1997). The duration element may be affected by a determination of whether an operator's good faith belief of the non-existence of the violation was reasonable. *IO Coal*, at 1352-53.

Respondent argues the roof and rib conditions existed for-at most-*less than* 24 hours. RPHB, p. 37. This argument is not persuasive. The third shift Crew Leader Smith testified the conditions looked good between 4 am and 5 am, the time of his preshift examination on May 10th. Smith's testimony that slips, stack rock, clay veins, unsupported heads and loose draw rock were not observable on the left side of the Unit during the nonproducing shift before the arrival of the day shift on May 10th is not credible. It is more probable than not that essentially the same adverse conditions existed from the time of the day shift on May 9th. Inspector Hardison had already seen and documented the conditions in his notes. Before Smith's shift Hardison had already discussed the conditions with his supervisor and Inspector Winebarger. The production report for the first shift on May 9th shows the left side of the Unit advanced only 8 to 15 feet. During the next shift only 10 foot cuts were taken on the left. On the May 10th day shift, before mining was halted, only two 10-foot cuts were taken. RX-F. Smith's testimony is not credible; the weight of the evidence reveals there were conditions limiting advancement beginning, at least, on the morning of May 9th.

However, I also do not find Inspector Winebarger's opinion that the conditions existed from day one, May 8th, when the #2 mining Unit turned into the panel to be persuasive. I understand the opinion of an Inspector, here one with experience and the expertise of a roof control specialist, is entitled to considerable weight. And there is evidence that the mine had encountered adverse conditions before and pulled out of other sections of the mine. *See*, RPHB, p. 6; Tr. 191, 223, 224. But I focus here on the credible evidence of what Inspector Hardison saw on the Unit the day before; extremely bad top, lots of slips, draw rock falling, heads everywhere in the roof, clay veins and coal ribs rashing with ribs starting to rash at the top of the coal seam. These discoveries show the rib conditions were becoming obvious by or during the time of that day shift. Although Hardison did not issue a citation, he did see the conditions, and decided to seek the guidance of his supervisor, after which he met with Roof Control Specialist Winebarger. I conclude that the violative conditions existed from the time of the day shift on May 9th until the Unit moved out of the area on May 10th.

Whether the violation was obvious.

Respondent acknowledges the conditions were obvious in nature. RPHB, at 38.

Whether the violation posed a high degree of danger.

Although the level of danger is but one relevant factor to be considered in evaluating whether a violation is unwarrantable, the factor of dangerousness may be so severe that, by itself, it warrants a finding of unwarrantable failure. *Manalapan Mining Company, Inc.,* 35 FMSHRC 289, 294 (Feb. 2013). The Commission has relied upon the high degree of danger posed by a violation to support an unwarrantable failure finding. *See, IO Coal Company, Inc.,* 31 FMSHRC 1346, 1355 (Dec. 2009); *Midwest Material Company,* 19 FMSHRC 30, 34 (Jan. 1997) (citations omitted).

The circumstances presented to the miners on the #2 Unit did pose a high level of danger. But the factor of dangerousness was not so severe as to warrant, by itself, a finding of UWF. The conditions existed about 24 hours. The rib conditions during that time were not completely ignored; there were attempts by scaling to remove loose material. This proved ineffective and management decided to move the Unit out of the area. I find that during the 24-hour existence of the hazardous rib conditions, the violation did pose a high degree of danger.

Whether the operator was placed on notice that greater efforts were necessary for compliance.

A mine operator may be put on notice that it has a recurring safety problem in need of correction where there is a history of similar violations. *Black Beauty Coal Company,* 703 F.3d 553, 566 (D.C. Cir. 2012); *Peabody Coal Company,* 14 FMSHRC 1258, 1264 (Aug. 1992). An operator with such a history should have a heightened awareness of a continuing serious safety problem. *Black Beauty*, at 567; *IO Coal Company*, 31 FMSHRC 1346, 1353 (Dec. 2009); *San Juan Coal Company*, 29 FMSHRC 125, 131 (Mar. 2007) (citing cases). The history of violations as well as any past discussions with MSHA can serve to place the operator on notice that greater efforts were necessary to assure compliance with the safety standard. *Consolidation Coal Company*, 35 FMSHRC 2326, 2342 (Aug. 2013) (citing cases).

Consideration of prior violations is not limited to the same regulation or those occurring in the same area within a continuing time frame. *IO Coal,* at 1354; *San Juan Coal*, at 131; *Peabody* at 1263. It is not required that the past violations were also caused by unwarrantable failure. *Consolidation Coal Company*, 23 FMSHRC 588, 595 (Jun. 2001); *see also, Eagle Energy, Inc.,* 23 FMSHRC 829, 838 (Aug.2001).

There was a history of 18 violations of the same safety standard in the 15 months prior to the issuance of the instant citation. During the same period, there were a total of 629 citations. The question, not answered on this record, is whether any of the prior violations involved failure to support or otherwise control ribs. It is not shown that the operator had such a history of rib control violations that there should have been a heightened awareness of this type of serious safety problem. The safety standard speaks to both roof and ribs, but the citation here was issued specifically for dangerous, unsupported ribs. The total number of citations was certainly significant; but this was a very large mine subject to very frequent and sometimes even multiple inspections in a single day. *See*, Tr. 178, 231, 232. Further, there is no evidence of past discussions with MSHA regarding adverse rib conditions that would place the operator on notice

that greater efforts were required to comply with the safety standard. The Secretary offered no such evidence, instead relying on other factors such as obvious and extensive. SPHB, pp. 32-34.

The operator's effort in abating the violative condition.

An operator's efforts in abating the violative condition is also a factor established by the Commission as determinative of whether a violation is unwarrantable. *San Juan Coal Company,* 29 FMSHRC 125, 134 (Mar. 2007); *IO Coal Company,* 31 FMSHRC 1346, 1356 (Dec. 2009); *Consolidation Coal Company*, 35 FMSHRC 2326, 2342 (Aug. 2013). Abatement efforts prior to or at the time of the inspection may support a finding that the violation was not unwarrantable. *New Warwick Mining Company*, 18 FMSHRC 1568, 1574 (Sep. 1996), citing *Utah Power & Light Company*, 11 FMSHRC 1926, 1933-34 (Oct. 1989). Conversely, efforts to abate post-citation, efforts found to be insufficient, or subordination of efforts to other work may be found to be irrelevant or support a finding that the violation was unwarrantable. *Enlow Fork Mining Company*, 19 FMSHRC 5, 17 (Jan. 1997); *Peabody Coal Company*, 14 FMSHRC 1258, 1263 (Aug. 1992); *San Juan Coal* at 134-35.

That scaling was done prior to the inspection can be accepted as credible because there was coal and rock on the floor during the imminent danger run, and scoops were in use removing large amounts of the material that had been scaled down. Some scaling during the inspection was done by Kessinger and Morris, and Inspector Winebarger observed some scaling by miners on the Unit. However, these efforts have been found to be insufficient to support or control the hazardous rib conditions, and therefore the scaling that was done is not relevant to this determination. *See, U.S. Steel Mining Co.*, 6 FMSHRC 1573, 1574 (Jul. 1984); *McCoy Elkhorn Coal Corp.,* 36 FMSHRC 1987, 1991 (Aug. 2014). The left side was shut down and barricaded off during the imminent danger run, but the violative conditions had already been documented in entries #4 through #1, and thereafter some of the same conditions were found on the right side where mining continued through the second shift. However, mine management did evaluate the conditions on the Unit and did ultimately decide to move out of the area.

The operator's knowledge of the existence of the violation.

Findings regarding the knowledge of an operator of the existence of violation are critical to the evaluation of the operator's efforts, or lack thereof, in abating the condition. *San Juan Coal Company*, 29 FMSHRC 125, 134 (Mar. 2007). The operator's knowledge may be established where the operator had reason to know or should have known of the violative condition. *IO Coal Company, Inc.,* 31 FMSHRC 1346, 1356-57 (Dec. 2009); *Emery Mining Corp.*, 9 FMSHRC 1997, 2002-04 (Dec. 1987); *Drummond Company, Inc.,* 13 FMSHRC 1362, 1367-68 (Sep. 1991), quoting *Eastern Associated Coal Corp.*, 13 FMSHRC 178, 187 (Feb. 1991).

At the time of the day shift on May 9, 2011 the adverse geologic conditions in the ribs and roof of the Unit were visible. Inspector Hardison became concerned about the slips, clay veins and rib rashing he had seen when he was on the Unit. That he did not issue a citation at that time does not mean the conditions did not exist or that the ribs were adequately supported. Rather, if an Inspector can spot problems in an active mining area, certainly the mine's own foremen, face bosses, and examiners should also see those problems. I find the operator should

have known of the violative rib conditions at least by the day shift on May 9th. The meeting of mine managers Kessinger, Morris and Anderson in the early morning hours of May 10th to discuss what they had heard about the conditions on the #2 Unit does not suggest the conditions were not known by mine personnel before that time. Instead, this suggests prior knowledge by those on the Unit reported in some manner to management before the meeting.

Respondent acknowledged the conditions were obvious, and the Secretary relies on this and the extent and danger of the unsupported ribs in arguing the UWF assessment should be affirmed. Under the facts and circumstances presented in this case, I find the most important factor is whether the operator had notice that greater efforts were needed to insure the support or control of ribs that contained adverse and potentially dangerous geologic conditions. As set forth above, acceptable evidence of such notice is lacking. In addition to a lack of discussions with MSHA and a compelling history of violations, there are other reasons to place the greatest weight on this factor. The roof control plan[40] in effect at the time of the inspection did not contain provisions for supporting or otherwise controlling the ribs, except that loose material would be taken down under certain circumstances not relevant here. GX-3, p. 18. Respondent's Assistant Mine Foreman Campbell testified that the mine was not required to bolt the ribs and did not have a truss bolter at the time. The mine was not prepared to address rib support. The lack of requirements to be followed when encountering adverse rib conditions also suggests that the operator was not on notice that such conditions must be addressed with adequate support methods. Further, the behavior of mine management reveals a preference for abandoning areas with these types of rib conditions rather than attempting support measures. I understand the rib conditions on the #2 Unit were extensive and presented a high level of danger; however, as Inspector Winebarger observed the mine was working to control the roof. I conclude the mine was not on notice that more than taking down loose rib material was required. Examining the totality of these factors, I find the UWF determination was not supported.

Specially Assessed Penalty

The Secretary proposed a specially assessed penalty of $70,000. However, it is the role of the judge to independently determine the penalty to be assessed for this violation under the six criteria set forth in § 110(i) of the Mine Act.

In the 15 months preceding the issuance of this citation there were only 18 violations of the same safety standard. There were 629 total violations. SPHB p. 34; GX-10. As noted above for citation # 8503299, there would be about 300 production days in a 15-month period. Although the total of 629 is significant, since one or more inspections are essentially on a daily basis at Warrior's Cardinal mine the rate of violations is not great. Although not controlling, how many of the 18 roof control violations also involved the ribs is not known. The Cardinal mine is very large and very productive; the history of previous violations is not an aggravating factor.

The proposed penalty is not inappropriate to the very large size of the business of this operator. The Cardinal mine produced 5,841,599 tons of coal in 2010. Controller tonnage

[40] The roof control plan will be discussed in greater detail below.

totaled 32,831,873. The penalty as proposed would not affect this large operator's ability to remain in business. This violation was serious, the S&S determination was affirmed and there was the potential for a fatal injury. While serious, the gravity factor was not "particularly serious or egregious". *Coal Employment Project,* at 1129.

I have reduced the negligence determination from high to moderate after fully considering all of the evidence found credible surrounding the violation. I have also found the UWF determination not supported. The Secretary accepted that Respondent did demonstrate good faith in abating the violation after notification.

The greatest weight is placed on the factor of gravity because this violation involved the safety standard governing roof, face and rib support and control. Such support is crucial to the safety of miners. Here, the focus was on the lack of adequate rib support in the area of mining that had many adverse and dangerous geologic conditions in both the ribs and roof. The potential for a fatal fall, roll or burst of rib existed in many entries and crosscuts of the #2 Unit. The serious nature of this violation supports an enhanced penalty.

Also supporting an enhanced penalty is the large size of the operator and its ability pay the proposed penalty charged and remain in business. However, the history of violations is not an aggravating factor; the negligence of the operator is reduced from high to moderate and the violation was not the result of an unwarrantable failure of the operator. Mine management did ultimately shut down the Unit and move out of that section of the mine.

The special assessment is not supported but the weighted analysis, particularly the gravity, supports an enhanced penalty. The deterrent effect of the penalty to be charged is considered. Where there are unsupported ribs that could result in a fatality, the operator must be encouraged to place a higher priority on controlling those conditions to ensure the safety of its miners. I find that an enhanced penalty of $30,500 is consistent with the facts and circumstances established, and would adequately serve as a deterrent.

Order No. 8498875

Summary of the Evidence

The initial action for this order was citation # 8498874, discussed above, and issued the same day for the ribs on the left side of the Unit not supported or otherwise controlled. That citation included the entire Unit in the area affected, since there was a loose corner in entry #8 on the right side. This order focused on the left side, entries #1 through #5. The Condition or Practice was described as:

> An inadequate pre shift was conducted on the #2 unit MMU-002 in that hazardous ribs were observed in entries #1 thru # 5 entries. Multiple slicken sided slips, stack rock, clay veins, heads and loose draw rock was widespread across these entries. The existence of these abnormal mining conditions have caused excessive mining heights up to 11 ft 4 inches. These hazards were not noted in

the preshift exam record book on the surface and were not corrected before the start of the shift.

Standard 75.360 (a)(1) was cited 2 times in two years at mine 1517216 (2 to the operator, 0 to a contractor).

Inspector Winebarger determined injury was highly likely, could reasonably be expected to be fatal to 1 person, and was significant and substantial. He found the negligence to be high, and although not explained in the order, the Secretary argued the violation constituted an unwarrantable failure.

GX-8, SPHB at 41-43.

Inspector Winebarger testified he issued this order because of an inadequate preshift examination. The hazards he found underground were not identified or recorded with corrective action, if any, in the record book before he went to the Unit. Tr. 94. In his notes he wrote the hazards were not entered into the record book on the surface; only loose bolts were recorded as hazards in entries #1, #2, #4, #7 and #8. GX-5, p. 31. The hazards he had found and discussed previously, such as the unsupported loose ribs, were not identified in the preshift examination. Tr. 95. Winebarger was of the opinion the loose ribs, broken heads, slips, stack rock and excessive mining heights would have been present prior to his inspection because these conditions did not happen all at once. He believed some hazards existed for up to 3 days, from day one, and some were probably from the shift before his inspection for a period of at least 16 hours. GX-5, p. 32. The latter was based on Kessinger's statement that the two crosscuts from entry #1 to entry #3 had been holed through16 hours before. The slips were evident, you could see them. Winebarger further testified that 4-foot of rock above a 7-foot coal seam is not mined intentionally. Tr. 95-97.

During his testimony, Inspector Winebarger reviewed the preshift examiner's reports. The two records for May 8, 2011 contained only loose pins observed on the second shift. The three reports for May 9, 2011 also had only loose pins observed on the first shift, and otherwise no hazards were reported. For May 10, 2011, the morning he was there, a number of loose pins and a damaged pin were reported and corrected. But none of the hazards he had found were listed. Tr. 98, 99; GX-8.

Inspector Winebarger testified the safety standard cited required a certified person to preshift the area before people work or travel. Tr. 94. All hazards the examiner comes across are required to be put into the examination report. The preshift examinations are important because the next shift needs to know what they are walking into. Tr. 99. If hazards are entered into the book foremen, supervisors or whoever is in charge will have a better opportunity to get those hazards corrected. Not knowing about hazards creates a false sense of security for miners going to the section. Tr. 101.

The hazard identified by Inspector Winebarger was loose falling rock ribs that would cause a fatality. He testified the excessive mine height of 11 feet and the weight of slabs of rock, roughly 4 to 5 tons, would definitely kill you. Tr. 100. He wrote in his notes that rock and coal

had already fallen; there were multiple slickensided slips, clay veins, stack rock, heads, loose draw rock and loose overhanging ribs. GX-5, pp. 32, 33. Winebarger considered a fatality to be highly likely because the conditions were already there. The conditions had caused mining heights to be up to 11' 4'' and miners worked in the area the entire shift. Although they were not then mining coal the ribs were still falling and you could get hurt or killed. Over 3 shifts 30 or 40 people would be exposed but Winebarger thought it reasonable only one person would be hurt or killed. Tr. 100, 101; GX-5, pp. 32, 33.

Inspector Winebarger attributed high negligence to the operator because the hazards were obvious and extensive and no support was being done. He testified it is the examiner's job to look for hazards, observe them, correct them and most definitely record them. Tr. 101, 102. In his notes he wrote the examiner should have observed the widespread conditions during the examination and reported or flagged and recorded the hazards in the record book. GX-5, pp. 31, 32. He found no mitigating circumstances, and stated none were offered. Tr. 102.

Inspector Winebarger also determined the violation was an unwarrantable failure. He testified up to 15 people were exposed all day long going in and out of the entries to do their jobs. The conditions were widespread across the section, obvious and extensive, and some big rocks were falling. Tr. 102.

Rusty Smith, the third shift Crew Leader, testified there was just rib sloughage on May 10, 2011 that they scaled. Tr. 259. He conducted the preshift examination prior to the oncoming day shift, starting at about 4 am. Tr. 261, RX-D. On the examination he found the hazards he reported, a number of loose pins, and a damaged pin. Tr. 262. Smith also testified that conditions not necessarily rising to the level of a hazard would not be recorded in the book. Tr. 264. He had been scaling all night, but this did not rise to the level of a hazard and he was not required to record it. Tr. 264, 265. During that third shift he did not hear or see evidence of ribs taking excessive weight or sloughage off on either side of the Unit. Tr. 265. Smith further testified there were no hazardous ribs or slickensided slips in entries #1 through #5. Tr. 268. He observed no stacked rock or loose unconsolidated material between the roof and the coal seam at these entries. Tr. 269. Further, there were no unsupported heads or loose draw rock in these entries. He did not remember observing any clay veins, but stated clay veins are everywhere in a coal mine and 90 percent of the time they are not a hazard. Tr. 269, 270. He did agree that an unsupported slip is a hazard. Tr. 277. He also agreed the mine was encountering conditions that did not allow it to take full cuts on the left side on May 9th and May 10th and assumed but did not know whether the conditions were also present on May 8th. Tr. 276. After he called out his examination there would not be anyone at the face of the Unit until the coal run got there at 7:00 or 7:15 am. Tr. 272, 273. Smith believed the mine was adequately supporting the roof and ribs at the end of his shift on May 10th. Tr. 275.

Jesse Campbell was an Assistant Mine Foreman on May 10, 2011, substituting for another miner. Tr. 281. He was not assigned to a particular Unit. Tr. 283. He received the preshift call out at 5:20 am. Tr. 285. He wanted to go to the #2 Unit to follow up on the citation written the day before. Tr. 284, 286. At the #7 entry he had two cribs built at the offset. Tr. 287. He then went to the #9 entry and also went from right to left across the Unit. Tr. 287. He found some loose ribs and some corner pins that needed to be spotted, but when at entries #3, #2, and

#1, he considered that more was needed. He talked to Section Foreman Nathaniel Boone, and decided to shut the run down to get "this stuff fixed". Tr. 288. The entire Unit was shut down because in addition to the left side he was concerned about rib rash on the right side. He shut the Unit down at 8:45 am and called General Mine Manager Anderson. Tr. 288, 299. Campbell testified that a pin needed to be spotted in the #3 entry, two miners started pulling ribs down, and a scoop was used where some ribs had sloughed. Tr. 291. He testified that under the roof control plan they were not required to engage in rib bolting because they did not have a truss bolter at the time. Miners were assigned to scale and work on the ribs. Tr. 295. When asked if he believed Smith had performed an inadequate preshift examination, Campbell replied he did not, and added he had followed Smith for years and he never did an inadequate preshift examination. Tr. 296.

Safety Director Morris also testified regarding this order. At the meeting with Kessinger and Anderson he understood the conditions on the #2 Unit included rib sloughage and the top coming out. Tr. 181, 183. When on the Unit there were miners scaling and pinning. Tr. 185. An outby corner rib between #4 and #5 had a piece of coal 2' by 2½' by 8" that appeared to be broken loose from the remainder of the rib. RX-A, p. 1, # 5. The right outby rib in #3 had loose coal that he and Kessinger scaled. *Id*, # 7. Morris agreed that an examiner needed to record a hazardous condition even if it is corrected. Tr. 221. Morris opined that in the year prior to that day there had been 7 or 8 citations for violations of the preshift examination standard. Tr. 201, 202. He testified that Smith was the "lead man" on the third shift, an agent of the operator. Tr. 206.

General Mine Manager Anderson testified he was not actually down on the Unit that day. Tr. 163. But he wrote in his notes the hazards were being corrected when MSHA was there. RX-G. Since the conditions were being addressed as they arose, he stated the hazards might not make it into the record book. Tr. 145. However, Anderson agreed an examiner must list all hazards encountered during their examination. Tr. 160.

The safety standard cited provides, in pertinent part:

> Except as provided in paragraph (a)(2) of this section, a certified person designated by the operator must make a preshift examination within 3 hours preceding the beginning of any 8-hour interval during which any person is scheduled to work or travel underground. No person other than certified examiners may enter or remain in any underground area unless a preshift examination has been completed for the established 8-hour interval. The operator must establish 8-hour intervals of time subject to the required preshift examinations.

30 C.F.R. § 75.360(a)(1).

Contentions

Respondent contends the order should be vacated because in accordance with 75.360(a)(1) a preshift examination was performed by Smith between 4 and 5 am. Also, Smith reported and flagged for correction a number of conditions. Further, the Secretary failed to

demonstrate the existence of a hazard at the time of the preshift examination. RPHB pp. 40-45; RRB pp. 15, 16; RX-D.

The Secretary contends the geological conditions of slips, clay veins, stacked rock and heads are exposed from the moment an area is mined. The widespread hazardous conditions were present and observable during the preshift examination. Also, a preshift examiner must adequately find and record hazardous conditions in the preshift examination book. Further, the safety standard requires that an adequate examination be performed. SPHB pp. 35-38; SRB pp. 3,4.

Findings and Conclusions

Well before Smith's preshift examination in the early morning hours of May 10, 2011 the adverse geological conditions on the #2 Unit had been observed. The morning of the day shift on May 9, 2011 Inspector Hardison had seen ribs rashing badly, sloughage, draw rock falling, slips around the ribs and clay veins and heads in the roof. Smith's testimony was essentially that he did not see any of these conditions, and in his opinion the roof and ribs were adequately supported at the end of his shift. But his testimony was inconsistent, since he also acknowledged that conditions were being encountered that did not allow for full cuts of coal to be taken. Further, mine management had been informed by the third shift Foreman of his concerns about the conditions, and that was the topic of the conversation early that morning between Kessinger, Morris and Anderson. This was only about an hour after Smith's examination. At about 7:45 a.m. Campbell was on the Unit and an hour later he halted mining because of the conditions. Smith's testimony was not credible; the widespread hazards were present and observable at the time of his examination on May 10th.

The Commission long ago discussed the requirements under the preshift safety standard:

> Under 75.360(a), a certified examiner must conduct a preshift examination within 3 hours before 'the beginning of any shift and before anyone on the oncoming shift . . . enters any underground area of the mine . . . ." Subsections (b) through (g) of section 75.360 set forth the *required elements* of the examination.

Enlow Fork Mining Company, 19 FMSHRC 5, 12 (Jan. 1997) (emphasis added).

Subsection (a)(1) cannot, as argued by Respondent, be read in isolation. To do so could produce the absurd result that virtually any examination of an underground area, however cursory, would satisfy the safety standard. In the instant case, involving hazardous conditions in an active mining area, Subsection (b) is applicable:

> 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).[41]

Smith did report loose pins and a damaged pin. In his testimony he denied there was sloughage on either side of the Unit or hazardous ribs or slips in entries #1 through #5. He testified in these entries he observed no stacked rock or loose unconsolidated material between the roof and the coal seam, and no unsupported heads or loose draw rock. He did not remember any clay veins. His justification for not reporting these types of conditions was essentially that conditions not rising to the level of a hazard would not be recorded in the book. I have found there were multiple hazards present in the #2 Unit at the time and that Smith's testimony was not credible. It was more likely than not that the hazards observed by Inspector Winebarger during the imminent danger run existed 4 hours earlier during Smith's preshift examination. The Secretary has met his burden and there was a violation of the preshift examination safety standard.

Significant and Substantial

Respondent contends that the Secretary failed to demonstrate the violation was likely to cause an injury and the gravity determinations should be reduced. RPHB pp. 46, 47.

The Secretary contends there was a high likelihood of a reasonably serious injury and the failure to perform an adequate examination exposed miners to unknown and unknowable hazards. SPHB pp. 39-41.

The Federal Mine Safety and Health Act of 1977 retained verbatim the requirements for the preshift, on-shift, and weekly examinations from the Federal Coal Mine Health and Safety Act of 1969.[42] These three types of mine examinations are required and together constitute several layers of examinations to ensure miner safety. They are designed to create a multi-layer, prophylactic approach to the identification and correction of hazardous or unsafe conditions in the mine. The preshift examination focuses on ensuring that any hazardous or unsafe conditions manifested since the last examination can be identified and altered before anyone enters the mine.

The Commission has recognized that preshift examinations are "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). The preshift requirement has been described as "the linchpin of Mine Act safety protections." *Manalapan Mining Co., Inc.*, 18 FMSHRC 1375, 1391 (Aug. 1996). If certain hazardous conditions are observed during a preshift examination, the conditions can be

[41] As constituted prior to April 6, 2012.

[42] Sections 303(d)(1), (e), and (f) of the Act.

communicated by the preshift examiner's report to the incoming shift of miners so they may prepare to work in the conditions reported. Working conditions in underground coal mines are dynamic, and without an adequate preshift examination the incoming miners are vulnerable to potentially unsafe conditions. The crew accessing the working area of the mine may not be aware of the hazards around them until it is too late to correct those hazards and prevent an accident.

The first element of the S&S analysis has been satisfied; I have found there was a violation of the preshift safety standard.

The failure in this case to conduct a preshift examination during the non-producing third shift that was adequate to communicate the types of hazardous rib conditions that were present meant that the day shift crew would access the #2 Unit mining area unaware of the extensive nature of the hazardous conditions, particularly on the left side. The extensive rib conditions, which could not be properly supported or controlled, constituted a measure of danger to the safety of those day shift miners. The hazardous conditions have been described in this decision and included unsupported slips in the ribs with loose rock above the ribs, clay veins weakening pillar support, unsupported stack rock in the ribs, loose and cracked ribs that were not supported, and overhanging rib rock. Scaling alone was not able to correct the hazards. The violation of the safety standard did contribute to the hazard of miners proceeding to work in dangerous conditions without advance warning of what they would encounter.

The preshift safety standard is directed against hazardous conditions required to be identified and communicated in such a manner that incoming shift miners will be aware of any dangers and challenges they will face in their assigned work areas. The danger that was present on the #2 Unit, especially the left side, was the fall, roll or burst of loose, unconsolidated and unsupported rib material.

I have found the hazardous conditions had existed for at least 24 hours before the MSHA inspection, and under continued normal mining operations the hazards would have continued to exist because equipment was not available to properly support or control the ribs. Inspector Winebarger testified to his opinion that some conditions he found had lasted up to three days; however, I have found the best evidence to be the observations of Inspector Hardison at the time of the first shift the day before Winebarger's inspection. Inspector Winebarger testified the hazards he found underground were not recorded in the record book. For the morning of May 10, 2011, only a number of loose pins and a damaged pin were reported as corrected. But Winebarger found, among other hazards, unsupported loose ribs that had not been reported. The danger as a result was a false sense of security created for miners going to the section, where loose falling coal and rock ribs could kill them. The defensive and contradictory testimony of preshift examiner Smith that the ribs were adequately supported at the end of his shift, about 7:15 am, was not credible. Further, it was Campbell who soon after the start of the next day shift at about 7:45 am found loose ribs on the Unit and even more that needed to be fixed on the left side. By 8:45 am Campbell and Boone decided to shut the entire #2 Unit down. The facts and circumstances surrounding the violation show that the hazard of a fall, roll or burst of loose, unsupported rib material was reasonably likely to occur.

Therefore, the second element is established.

Over the period of 3 shifts of the #2 Unit in the second west panel 30 to 40 people would work their entire shift and be exposed to the hazards that were not reported on the preshift examinations. Considering the extensive and serious nature of the hazards presented to the miners, I agree with Inspector Winebarger's testimony that a fatality was highly likely. He observed coal and rock that had fallen and was still falling. Therefore, I find injury could be reasonably expected to occur, and such injury could be reasonably likely to be very serious, even fatal.

Therefore the third and fourth elements are satisfied. It was reasonably likely that the violation of the preshift standard contributed to the hazard of miners exposed to dangerous rib conditions and that this was reasonably likely to result in injury causing events that would be reasonably serious in nature. I find the violation was S&S.

Gravity

I also affirm the other gravity determinations. Although many people would be exposed, it was reasonable to conclude that in the event the hazard occurred only 1 person would be hurt or killed.

Negligence

Respondent argued the Secretary failed to demonstrate high negligence on the part of Warrior because there had been extensive efforts to recognize report and correct hazards in the #2 Unit.

The Secretary argued there were inadequate examinations for up to 3 days. The examiner should have seen the obvious and extensive hazardous conditions that were present at the time of the examination.

Inspector Winebarger testified it is the examiner's job to look for hazards, observe and correct them, and most definitely record them. And that is what a reasonably prudent person familiar with the mining industry and the protective purpose of the examination regulation would do to avoid a violation of the standard. But Winebarger saw on his inspection that no support of the ribs was being done. Campbell testified they did not have a truss bolter for rib bolting at the time, but that only served to show that the rib conditions were such that the hazards were beyond the mine's ability to install rib support. Winebarger wrote the preshift examiner should have observed the widespread hazards and flagged and recorded them in the record book. He testified no mitigating circumstances were offered, and he found none. It is true that the mine's roof control plan in effect at the time did not address rib bolting, but hazards are required to be reported. If Warrior personnel were recognizing, reporting and correcting the hazards as contended by Respondent, the claimed reports were not recorded in the record book. The preshift examiner did not report and record obvious and extensive hazards that existed on the #2 Unit the morning of May 10, 2011. I agree with the determination of high negligence on the part of the operator.

Unwarrantable Failure

Respondent contended the alleged hazardous conditions were not present at the time of the preshift examination, that it existed for only 4 to 5 hours, and the conditions posed little danger since the Unit was shut down at approximately 8:45 am before the order was even issued.

The Secretary argued the important factors were the obvious and extensive nature of the conditions, and that miners had worked underground without the benefit of an adequate preshift examination.

Extent of the violative condition.

The unreported rib hazards existed across the mining unit. Most of the hazards were on the left side, entries #1 through #5, as recorded in the order, but there were some loose, rashing ribs on the right side also. This was not an isolated failure limited to one rib location. Inspector Winebarger testified, and the map he marked up revealed, that the rib conditions were so widespread they were difficult to map. Further, there were many types of adverse geologic conditions present that should have been reported for the safety of the incoming day shift. The number and type of hazardous conditions identified by the Inspector in many entries were such that the reporting violation here was very extensive.

Length of time the violative condition existed.

Although adverse rib conditions had not been reported on any of the preshift examinations beginning on May 8, 2011, the last examination conducted before this order was issued was between approximately 4 and 5 am on May 10, 2011. Inspector Winebarger credibly testified the hazardous conditions did not happen all at once. The dangerous conditions existed on the left side for at least 24 hours and until Kessinger and Morris approached Inspector Winebarger and told him that side was being flagged off. This was perhaps about 5 hours after the preshift examination. At first thought, this would not appear to be a long period of time. But it was long enough for the day shift crew to access the area and begin working, including some mining. Since the time bridged two shifts and affected outgoing and incoming miners, in the context of this violation, this period of time was significant.

Whether the violation was obvious.

Inspector Winebarger reviewed the preshift reports on the surface, but upon accessing the Unit was confronted by unreported rib and roof conditions. As he proceeded from entry #4 to the left to entry #1, the hazardous conditions became more numerous in the entries and crosscuts. He described many ribs and corners with loose material, ribs rashing off, and slips in the ribs, and he could hear the roof working, falling out and dribbling rock. Based on the record before me and the evidence found credible, the failure to perform an adequate preshift examination was very obvious.

Whether the violation posed a high degree of danger.

In the opinion of the undersigned, the danger presented to the incoming miners on that morning cannot be overstated. The outgoing miners on the maintenance shift had been exposed to rib conditions they were not equipped to control. Inspector Winebarger testified just being on the Unit, even without mining, an injury would occur. The incoming day shift miners had no warning of the multiple dangerous rib conditions in the entries and crosscuts on the left side of the Unit. Although not much mining was accomplished, the short cuts that were taken were in the #2 entry, in the area found to be particularly dangerous with the top working and dribbling out rock. The day shift miners were still on the Unit until Morris and Kessinger flagged the left side off. The fact that mine management, upon evaluating the left side of the Unit, quickly decided to abandon that area supports a determination that the failure to report the hazardous rib conditions posed a very high degree of danger.

Whether the operator was placed on notice that greater efforts were necessary for compliance.

There is no evidence of actual notice to the operator regarding inadequate preshift examinations and efforts towards compliance. Here, there did not need to be any such notice. Part of the mine safety landscape since the Coal Act, the examinations are routine and well understood, even if from time to time the requirements are ignored. In this case, the most important factors are the obvious, extensive and dangerous unreported hazardous conditions. And, the length of time the unreported hazards existed was sufficient to expose third shift and day shift miners to the danger of falling material.

The operator's effort in abating the violative condition.

Not until mine management in the persons of Morris and Kessinger actually travelled to and evaluated the conditions in the left side of the Unit was there an abatement by flagging off and moving out of the left side. The evidence shows that the scaling efforts, which were ongoing in the Unit, could not control the loose rib hazards. The day shift had already performed some mining. Simply put, the abatement efforts were too little, and too late.

The operator's knowledge of the existence of the violation.

It was the third shift Foreman, not Crew Leader Smith, who alerted mine managers to the conditions on the #2 Unit and prompted the meeting of Morris, Anderson and Kessinger, that began about 5:30 am on May 10th. Adverse conditions had already been observed the day before by Inspector Hardison, but not reported on mine examinations. Smith testified that during the third shift there were none of the conditions found by Inspector Winebarger including sloughage on either side of the Unit. But he also testified that conditions not necessarily rising to the level of a hazard would not be recorded in the book. There was knowledge of hazardous conditions not reported by Smith. The third shift Foreman had alerted mine management to the conditions, motivating the early morning meeting of the three upper level managers. It was Campbell who received the preshift call out at 5:20 am, but when he went to the Unit and observed entries #3 to #1 he consulted with Boone and shut the entire Unit down. Campbell was

an Assistant Mine Foreman that day, and with knowledge of the preshift examination his testimony that Smith had not performed an inadequate preshift examination is not credible. Warrior's managers knew or should have known the preshift examination was inadequate.

I find the inadequate preshift examination was an unwarrantable failure on the part of the operator.

Penalty

There is a history of past preshift examination violations, the standard here was cited 2 times in 2 years at the Warrior mine. The overall number of past violations is more extensive. For this large mine, however, the rate of either is not high. The specially assessed penalty is appropriate to the size of the operator's business and would not affect the operator's ability to remain in business. I have found high negligence because the failure to observe and record very obvious and very extensive rib hazards did not meet the required high standard of care under the Mine Act to protect miners against the risks of harm. There was an aggravated lack of care that was more than ordinary negligence. This was a particularly serious violation. The inadequate preshift examination was S&S, and an unwarrantable failure. This very serious failure to report hazards occurred in the #2 active mining Unit and exposed miners to the danger of injury, even death. The area was abandoned soon after higher level management personnel personally evaluated the conditions.

The most important factors in assessing the penalty, similar to the rib control violation, are gravity and negligence, both in this order *very* serious in nature. Preshift examinations are critical to the safety of miners. I find, for the reasons expressed, that this was an egregious violation and the specially assessed penalty of $70,000 was fully justified.

Citation No. 8498877

Summary of the Evidence

This citation alleged a violation of 30 C.F.R. § 75.223(a)(1). The Condition or Practice set forth:

> Revisions to the roof control plan were not proposed by the operator when conditions indicated that the plan is not suitable for controlling the ribs. The plan is inadequate that excessive mining heights up to 11 ft. 4 inches) existed on the #2 In the 2nd west panel. These excessive mining heights were caused by abnormal mining conditions such a stack rock, loose heads, clay veins, slips in the roof ribs which caused the mine roof to fall out during the mining process. The operator shall revise the current roof control plan to address rib support during the mining process.

Revision to the roof control plan was submitted on May 10, 2011 but not approved. The citation was terminated on May 12, 2011 after a revision to the roof control plan was approved.

Inspector Winebarger determined injury was highly likely and could reasonably be expected to be fatal to 1 person. He also determined the gravity to be S&S, and the negligence on the part of the operator to be high.

GX-9.

Inspector Winebarger testified there were rib conditions in the area of mining that were not addressed in the roof control plan. Tr. 104. He wrote in his notes the plan did not address how the ribs would be controlled in the excessive mining heights as found on the #2 Unit on May 10th. GX-5, p. 34. He also testified the operator is required to revise their plan when it is not suitable for the conditions present, and the plan did not address rib support. Tr. 103, 104. In the morning discussions with the mine managers he had learned the mine had faced similar conditions during the past week and had chosen to move out of that panel. Tr. 105. Winebarger further testified the roof control plan is important because it provides a mine-wide minimum to protect people. The plan in effect at the time had been approved in March 2011. Tr. 104, 128, 130.

The hazard, Winebarger testified, was the fall of ribs due to excessive mine heights, the slips, the stack rock, the heads and all of the conditions that were present. The concern for rib control was predominantly the rock above the coal seam; the slips in the ribs were not supported. Tr. 104, 130, 134. Injuries would be fatal, the same as for the 75.202(a) citation and the imminent danger order he had issued because the rock was heavy, the ribs were loose, and slips and clay veins were present. These conditions were not addressed in the roof control plan. Tr. 105. He wrote roof support alone would not control the ribs and rock ribs, and the plan was inadequate. The conditions had existed for 3 production days, since the Unit moved into the section on May 5. GX-5, p. 35.

Inspector Winebarger testified injury was highly likely because the triggering effect was already present. Tr. 106. He also wrote if mining continued in the conditions it was highly likely a miner would be killed since the slabs and chunk rock were large and heavy. Of the 15 miners there, one person would be exposed. GX-5, p. 36. Winebarger also testified he attributed high negligence to the operator because the section foreman, the mine examiner and other management persons knew or should have known of the conditions but choose to ignore them. Tr. 106, 107. Other than the decision to move the Unit, no mitigating circumstances were taken or offered. Tr. 107.

Assistant Mine Foreman Campbell testified that under the roof control plan, they were permitted to scale on ribs, but not engage in rib bolting because they did not have a truss bolter at the time. Tr. 295. In subnormal conditions they always narrowed entries and put in extra support. In his opinion, the mine's roof and rib control plan was adequately supporting the roof. Tr. 296, 297. He recalled they hit abnormal conditions in both the first west and second west areas, took care of it, and moved out. Tr. 298-300. Campbell further testified the mine is not required to submit a plan addendum upon encountering subnormal conditions. Tr. 297.

General Manager of Operations Anderson testified that at the time of the morning meeting he knew of no violations of the approved roof control plan. Tr. 144, 162. He wrote in

his notes they had only been mining in the setup for 3 days, barely enough time to determine if the conditions would persist. When MSHA got there the Unit was shut down to correct the hazards they, not MSHA, had found. The decision was made to move the #2 Unit after Kessinger evaluated the conditions. RX-G. He also testified to abate the citation they had to submit a plan change. While he did not recall the measures put in at the time, he believed the addendum provided for mining heights, controlling the ribs, and relocating the Unit. Tr. 157.

Safety Director Morris testified the roof control plan is reviewed every 6 months. He thought the mine had maybe been cited once for this safety standard. Tr. 205.

The safety standard cited provides, in pertinent part:

(a) Revisions of the roof control plan shall be proposed by the operator –
(1) When conditions indicate that the plan is not suitable for controlling the roof, face, ribs, or coal or rock bursts...

30 C.F.R. § 75.223(a)(1).

The Warrior Cardinal Mine Roof Control Plan in effect on May 10, 2011 contained the following provisions:

Under the heading of "Safety precautions for roof control plan":

1. This is the minimum Roof Control Plan and was formulated for normal roof conditions and the mining system described. Additional measures will be taken in accordance with 75.220 (a) (1) to protect persons if unusual hazards are encountered.[43]

Under the heading of "Safety Precautions for the Installation of Arches and Square sets":

1. Prior to the installation, a company official shall examine the area to be supported. Loose material from the roof and ribs that pose a hazard to the miners shall be taken down. When material cannot be removed, other protection, such as a canopy, shall be provided.

GX-3, pp. 7, 18.

Contentions

Respondent contends the citation should be vacated because a revision of the roof control plan was not indicated on May 10, 2011 and was rendered unnecessary by the shutdown of the #2 Unit at 8:45 am and the later decision to relocate the Unit. RPHB, p. 52. The testimony of Anderson was that only one change was made to the RCP, that when encountering high

[43] As set forth in citation #8503299, safety standard 75.220(a)(1) requires the roof control plan to be suitable to the prevailing geological conditions.

conditions Warrior could relocate to another location, something Warrior always had the ability to do. In the alternative, Respondent requests that the citation be modified to a technical violation of the standard. RRB, p. 18.

The Secretary contends that at the time of the inspection the roof control plan did not contain any provision to control the numerous, widespread hazardous rib conditions observed on the #2 Unit, and there were no known proposed revisions. The rib conditions were not supported in any way, and the plan did not cover any form of support related to any type of rib condition. The plan provisions were not just unsuitable, they were nonexistent. Respondent did not revise the plan until after the issuance of the citation. SPHB, pp. 44, 45. The #2 Unit had not been relocated upon the Inspector's arrival, and Respondent's ability to move the production unit was irrelevant. For the conditions, no revisions had been submitted and no MSHA review had been conducted. SRB, p. 4.

Validity

Despite the fact that this hearing was years after the citation was issued, a copy of the roof control plan as revised and approved on May 12, 2011 is not of record. Respondent's Anderson was asked about the revisions:

> Q Do you recall what – what types of provisions were required under the MSHA approved roof control plan addendum?
>
> A Not on top of my head. I believe it related to the mining height and—and controlling the ribs. I don't recall what the measures were put in at that time. I know I've seen it. I just can't recall right off the top of my head.
>
> Q Do you recall if one of the potentially corrective actions for encountering high roof conditions would be for the mine to choose to re-locate the unit?
>
> A Yes.

Tr. 157.

While professing he could not recall the revisions Anderson nonetheless believed that mine heights, controlling the ribs, and re-location of the unit were the revisions at the time.

The Secretary is correct that the roof control plan in effect did not contain any form of support related to any type of rib condition such as the hazardous ribs on the #2 Unit. The reference to 75.220(a)(1) is the general requirement that the plan be suitable to the prevailing geologic conditions. The only specific reference to ribs in the mine's plan was in the context of the installation of arches and square sets. In those circumstances loose material from the roof and ribs that pose a hazard to miners shall be taken down. GX-3, p. 18, #1. Rib support was not addressed. The safety standard is clear that *when* conditions indicate the plan is not suitable for controlling the ribs or coal or rock bursts *revisions shall* be proposed by the operator.

There is testimony indicating the operator had encountered similar adverse conditions in another area of the mine. The #2 Unit had just moved out of the first west panel before turning into the second west panel. However, evidence of the specific conditions prompting abandoning first west was not developed, and this citation was issued regarding the circumstances encountered in the second west panel.

As already discussed, Inspector Winebarger's opinion that the multiple hazardous rib conditions existed from the first day of mining on May 8, 2011 may be correct; however as also discussed I have found the best evidence of the conditions to be the observations of Inspector Hardison on the first, day shift on May 9, 2011. Hardison was troubled by what he saw, but deferred to the experience and area of responsibility of the District's Roof Control Specialist.

Since mine management was present in the active mining area for the two production shifts on May 9th, this was *when* revisions to the roof control plan should have been proposed, if not sooner depending on the experience and knowledge gained in the first west panel. Failing those opportunities, during the third, maintenance shift scaling was performed but failed to *control* and could not *support* the hazardous rib conditions. The third shift foreman alerted upper level mine management to the conditions and the meeting of the managers took place before the MSHA inspectors arrived. This was the next opportunity to timely submit proposed revisions. Then, when on the Unit at the time of the imminent danger run, Morris and Kessinger personally observed the conditions and quickly decided to abandon the left side of the Unit. The hazardous ribs at that time were not controlled by the ongoing scaling. A truss bolter was not available to support the ribs. As set forth in the citation, the roof control plan needed to be revised to address *rib* support. I find there was a violation of the cited safety standard and the citation was validly issued.

Significant and Substantial

The fact of the violation has been established, and the first element has been satisfied.

Respondent contends this was a technical violation. I disagree. In failing to revise the roof control plan in the face of hazardous rib conditions not covered in the plan, miners could form the belief that addressing loose, unstable ribs with more than scaling was not required. Campbell testified they were not required to support the ribs because they did not have a truss bolter. Third shift crew leader and examiner Smith ignored the readily apparent conditions, claiming no need to report conditions not rising to the "level of a hazard". Yet on the same third maintenance shift the foreman was so concerned he alerted upper mine management to the conditions. The management members were concerned enough to meet in the early morning hours, even before that shift ended. Under these circumstances, the hazard contributed to by the violation comes into clear focus – hazardous rib conditions were not required to be properly supported or controlled by the mine's own roof control plan, and would exist under continued normal mining operations with the consequence of rib falls, rolls or bursts.

As discussed *supra* in citation #8498874 such a hazard, a fall of rib rock or coal, was highly likely to occur. Scaling alone did not address the hazard. The miners did not have the equipment to support the ribs and correct the hazard. Inspector Winebarger described the slabs

of rock and chunk rock as large and heavy, and credibly determined injury was highly likely and it was reasonably likely a miner would be killed. The remaining elements of the analysis are satisfied; the failure of mine management to provide the minimum requirements for hazardous rib support and control in the mine's roof control plan was S&S.

Injury was highly likely and could reasonably be expected to be fatal to 1 person. The gravity determinations are affirmed.

Negligence

The operator's duty to miners, in the context of this citation, is to maintain a current, approved roof control plan that provides the minimum standards suitable for controlling the roof, face, ribs or coal or rock bursts. Under the safety standard, revisions must be proposed *when* the plan in place is not suitable to control hazardous ribs. Cardinal's plan was not suitable when the #2 Unit turned into the second west panel and soon encountered adverse geologic rib and roof conditions. Efforts were made to control the roof, but the miners could not control the extensive rib hazards, particularly on the left side of the panel. By the time of the day shift on May 9, 2011 the mine foremen and examiners knew, or should have known that revision to the roof control plan was required. During the third, maintenance shift, even if the examiner failed to report the hazards, the mine foreman alerted upper level management about the adverse conditions and there was another opportunity to submit a revision for approval. Not until the inspection uncovered the inadequate plan and the citation was issued was a revision proposed.

Inspector Winebarger's testimony appears to suggest the mine's ability to move a mining Unit is a mitigating circumstance. But timing is important. The first encounter with hazardous conditions not covered in the roof control plan is when revision must be proposed. A decision may also be made to move the mining Unit away from the hazards; but this does not mitigate the operator's duty to revise the plan even if the mining Unit is moved.

Proposing revision to a roof control plan when newly encountered and hazardous mining conditions are discovered is not an onerous task for experienced mine managers. The first revision was submitted the day of the inspection, showing that the task is not very time consuming. While there were opportunities over about a 24 hour time period to timely prepare and submit a revision for approval, I do observe there is evidence mine personnel were heavily engaged in dealing with a very challenging mining environment during that time. The relatively short time frame and the distraction of working in adverse geologic conditions that defied safe control may be viewed as a mitigating circumstance in the failure to timely submit a plan revision. Under the facts and circumstances presented, an aggravated lack of care is not demonstrated here.

Therefore, I find that the negligence to be attributed to the operator is more appropriately designated as moderate.

Penalty

The Secretary proposed a specially assessed penalty in the amount of $45, 000. I have affirmed that the violation was S&S, but reduced the negligence to moderate, and this was not an unwarrantable failure on the part of the operator. I do not affirm the special assessment proposed, but independently assess a penalty under the statutory criteria.

As with the citations already discussed, even the penalty charged would not affect the operator's ability to continue in business, and would not be inappropriate to the very large size and high productivity of this mine. There was perhaps one past violation of this standard and further the *rate* of previous violations does not suggest an egregious violation history. The operator did, on the date the citation was issued, submit the first proposed revision.

Also as with other violations, the most important considerations in determining the penalty are the gravity of the violation and the negligence of the operator. The failure of mine management to propose a revision to their roof control plan in a timely manner when the prevailing geologic conditions warranted attention to this requirement is a serious matter. Miners could have, and here apparently did, form a belief that support and control of ribs other than by scaling was not required. The potential consequences of such a belief system in the context of the hazards that existed in the second west panel are dire. While ideally mine management should have been aware their roof control plan was not suitable to address the rib conditions that existed, and acted with more urgency to submit revisions, I have reduced the negligence to moderate in recognition of the distraction possibly caused when miners were struggling to maintain a safe environment but were unable to do so.

Considering the facts and circumstances surrounding this violation, and the deterrent purposes of the Act, I assess a penalty of $8,000.

ORDER

It is **ORDERED** that Citation No. 8503299 is **AFFIRMED**; the civil penalty assessment is reduced to $20,750.

It is **ORDERED** that Order No. 8498873 is **AFFIRMED** as written.

It is **ORDERED** that Citation No. 8498874 be **MODIFIED** to reduce the negligence from "high" to "moderate" and to delete the finding of unwarrantable failure; the civil penalty assessment is reduced to $30, 500.

It is **ORDERED** that Order No. 8498875 is **AFFIRMED** as written; the civil penalty assessment is $70,000.

It is **ORDERED** that Citation No. 8498877 be **MODIFIED** to reduce the negligence from "high" to "moderate"; the civil penalty assessment is reduced to $8,000.

The Respondent is **ORDERED** to pay a total civil penalty assessment of $129,250 within 30 days of the date of this decision.[44] Upon receipt of payment, this case is **DISMISSED**.

Kenneth R. Andrews
Administrative Law Judge

Distribution: (Certified Mail)

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Gary D. McCollum, Esq., Assistant General Counsel, Warrior Coal, LLC, 1146 Monarch Street, Lexington, KY 40513.

[44] 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.