FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

OFFICE OF ADMINISTRATIVE LAW JUDGES
1331 PENNSYLVANIA AVE., N.W., SUITE 520N
WASHINGTON, DC 20004-1710
TELEPHONE: 202-434-9950 / FAX: 202-434-9949

May 5, 2017

SECRETARY OF LABOR, MINE SAFETY AND HEALTH ADMINISTRATION (MSHA), Petitioner, v. M-CLASS MINING, LLC, Respondent.	CIVIL PENALTY PROCEEDING Docket No. LAKE 2015-587 A.C. No. 11-03189-384770 Mine: MC#1 Mine
M-CLASS MINING, LLC, Contestant, v. SECRETARY OF LABOR, MINE SAFETY AND HEALTH ADMINISTRATION (MSHA), Respondent.	CONTEST PROCEEDINGS Docket No. LAKE 2015-285-R Citation No. 7560565; 01/28/2015 Docket No. LAKE 2015-286-R Citation No. 7560566; 01/28/2015 Mine: MC #1 Mine Mine ID: 11-03189

DECISION AND ORDER

Appearances: Rachel L. Graeber, Esq. & Jason Patterson, Esq., Office of the Solicitor, U.S. Department of Labor, Chicago, Illinois, for the Petitioner

Christopher D. Pence, Esq., Hardy Pence PLLC, Charleston, West Virginia, for M-Class Mining, LLC

Before: Judge Rae

I. STATEMENT OF THE CASE

These cases are before me upon a petition for assessment of civil penalties and two notices of contest under section 105(d) of the Federal Mine Safety and Health Act of 1977, as amended, ("the Mine Act"), 30 U.S.C. § 815(d). Initially in dispute were two violations issued by the Secretary of Labor ("the Secretary") to mine operator M-Class Mining, LLC ("M-Class"): Citation Number 7560565 and Order Number 7560566.

A hearing was held in Mount Vernon, Illinois, at which time the parties notified me that they had agreed to settle Citation Number 7560565. I approved the settlement on the record. Tr. 6-8.[1] The parties presented testimony and documentary evidence on the remaining violation, Order Number 7560566, and later filed post-hearing briefs.

I have reviewed all of the evidence at length and have cited to the testimony, exhibits, and arguments I found critical to my analysis and ruling herein without including a detailed summary of the testimony given by each witness. Based on the entire record and my observations of the demeanor of the witnesses, I uphold Order Number 7560566 as written and assess a penalty of $7,000.00 for the violation alleged therein, for the reasons discussed below.

II. STIPULATIONS

The parties have entered into the following stipulations:

1. M-Class is an "operator" as defined in Section 3(d) of the Mine Act, 30 U.S.C. § 802(d), at the coal mine at which the citation and order at issue in these proceedings were issued.
2. MC#1 Mine is operated by M-Class.
3. MC#1 Mine is subject to the jurisdiction of the Mine Act.
4. These proceedings are 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, 823.
5. The individual whose signature appears in Block 22 of the citation and order at issue in these proceedings was acting in his official capacity and as an authorized representative of the Secretary of Labor when the citation and order were issued.
6. A duly authorized representative of the Secretary served the subject citation and order and termination of the citation and order upon the agent of M-Class at the dates and place stated therein as required by the Mine Act, and the citation and order and terminations may be admitted into evidence to establish their issuance.
7. The total proposed penalties for the citation and order will not affect M-Class' ability to continue in business.
8. The citation and order contained in Exhibit A attached to the Petition for Assessment of Penalty for these dockets are authentic copies of the citation and order at issue in these proceedings with all appropriate modifications and terminations, if any.
9. Exhibit S-8, the Assessed Violation History Report, is an accurate and authentic history of M-Class' violation history.
10. The proposed penalty of $5,000.00 is appropriate if Order Number 7560566 is affirmed in all aspects.
11. If the fact of the violation is affirmed, the inspector properly evaluated all aspects of Section 10 of the order.

Joint Exhibit 1; Tr. 8-9, 172-73.

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[1] In this decision, the abbreviation "Tr." refers to the transcript of the hearing. The Secretary's exhibits admitted at hearing are numbered S-2, S-3, S-6, S-7, and S-8. *See* Tr. 94-96, 119, 130, 172. M-Class did not offer any exhibits.

III. FACTUAL BACKGROUND

This proceeding arises out of a November 20, 2014 incident in which miner Todd Davis was seriously injured while working at the MC #1 Mine, a large underground coal mine operated by M-Class in Franklin County, Illinois. Tr. 15, 237. Davis, who is a field service representative for equipment manufacturer Joy Global, was assigned as the life cycle manager for the mine's longwall shearer at the time of the accident. Tr. 51-53. He was at the longwall face at approximately 8:20 PM during the evening shift on November 20 when a hydraulic hose delivering a water and synthetic oil emulsion to a longwall shield at a pressure of 4,200 pounds per square inch (psi) ruptured and released a jet of fluid that struck Davis from below as he sat on or leaned back against a longwall base lift support to let other miners pass by. Tr. 53, 103, 114; Ex. S-3 at 3. The high-pressure fluid sliced through his pants and shot into his body, lacerating his rectum and causing immediate loss of bowel control and bleeding. Tr. 58, 63. "[T]he first thing I remember is [maintenance worker] John Lence coming up, asking if I was okay," Davis testified. "I told him, no, I felt like I had some kind of – my insides were hanging outside of my body is what I felt like. I needed to get out now." Tr. 53.

Lence helped Davis to a Kubota vehicle to transport him out of the mine and called ahead to the surface for an ambulance. Tr. 54-56, 68-69, 98, 115. Davis testified he was in shock and frantic to get out of the mine. Tr. 55-56. Blood had pooled in his seat on the ride and was running onto the floor by the time he and Lence reached the surface. Tr. 58, 115, 258. M-Class management official Gabe Wheeler and mine manager Mike Lily met them there. Tr. 57, 116, 182. Davis' coworkers wrapped him in a blanket and tried to keep him calm until the ambulance arrived to pick him up. Tr. 57-58, 70.

Davis was first taken to Franklin County Hospital, which is a small local hospital in Benton, Illinois. Tr. 15, 20, 61, 78, 84. He was joined there by his wife, Laura; his immediate and second-line supervisors from Joy Global; M-Class safety director Girolamo Intravaia; and M-Class general manager Travis Brown, who furnished the doctors with a copy of the material safety data sheet (MSDS)[2] for the hydraulic emulsion that had been injected into Davis' body. Tr. 66, 77-78, 183-86, 208, 210-12. After undergoing a CT scan, Davis was airlifted in a Life Flight helicopter to Barnes-Jewish Hospital in St. Louis, Missouri, where he was taken into emergency surgery. Tr. 61-65, 79-81, 84-85, 245. He remained hospitalized for seven days and returned for a number of subsequent surgeries to treat his internal injuries, which included a lacerated rectum, damaged colon, and burst bladder. Tr. 61, 66-67, 125, 233, 245, 257.

M-Class did not notify MSHA of Davis' accident the day it occurred. However, the next morning, the company's President of Underground Operations, Anthony Webb, placed a "courtesy call" to a supervisor at the local MSHA field office to inform him of the accident. Tr. 27, 215, 245-47. The MSHA supervisor, Dean Cripps, believed further investigation may be warranted based on past experiences in which he had received inaccurate accident information from M-Class. Tr. 29-30. Accordingly, after consulting with his district supervisor, Cripps

[2] An MSDS is an information sheet that describes the chemical composition of a material and any human health risks it poses. Tr. 221-22.

issued a section 103(j) order[3] and initiated an accident investigation. Tr. 29-30; *see* Ex. S-2. He first phoned a Joy Global representative, who informed him that Davis had undergone surgery and was in a critical care unit at Barnes-Jewish Hospital with "some pretty serious injuries"; this indicated to Cripps that the accident was more serious than he had initially been led to believe. Tr. 30-31, 39, 152. He then traveled to the mine with MSHA Inspector Chad Lampley to interview witnesses and inspect the accident scene. Tr. 31, 90-91, 102; 250; *see* Ex. S-3. Cripps and Lampley did not issue any violations while at the mine because they wanted to interview Davis first. Tr. 126-27, 141. After giving him some time to recover from his injuries, Lampley interviewed him by phone on January 27, 2015. Tr. 127, 130.

The next day, January 28, 2015, Inspector Lampley issued the two enforcement actions that spurred this litigation. Tr. 130; *see* Ex. S-7. Citation Number 7560565 was issued under section 104(a) of the Mine Act and alleged that M-Class violated 30 C.F.R. § 75.1725(a) by operating the #7 longwall shield with a frayed hydraulic hose that ultimately ruptured, injuring Davis. M-Class has accepted this violation in settlement.[4] The remaining enforcement action, Order Number 7560566, was issued under section 104(d)(2) of the Mine Act[5] and alleges that M-Class violated 30 C.F.R. § 50.10(b) by failing to notify MSHA of the accident within 15 minutes of the time mine management knew or should have known that Davis had sustained injuries having a reasonable potential to cause death.

IV. LEGAL PRINCIPLES

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[3] A j-order is a type of enforcement action issued after an accident that usually directs the mine operator to preserve the accident scene for investigative purposes and to cease work in the affected area until MSHA determines that no further hazard exists. Tr. 89-90, 255-56; *see* 30 U.S.C. § 813(j).

[4] M-Class also accepted the Secretary's gravity and negligence designations and agreed to pay a reduced penalty. The violation is designated "significant and substantial" (S&S), with the likelihood of injury marked "highly likely" and the expected injury "fatal" and affecting one person. The negligence is designated "moderate." The Secretary originally proposed a "specially assessed" penalty of $52,500.00 for the violation, but agreed to accept a settlement amount of $15,750.00 (which is slightly more than the amount that would have been proposed under the Secretary's "regular assessment" formula) on grounds that there are no extenuating circumstances to justify the special assessment other than the fact that a "Rules to Live By" standard was violated. Tr. 6-8; *see* 30 C.F.R. Part 100. I have considered the representations and documentation submitted by the parties with respect to Citation Number 7560565, and I conclude that the proffered settlement is appropriate under the criteria set forth in section 110(i) of the Mine Act.

[5] The issuance of an order under section 104(d)(2) denotes that the alleged violation was caused by the mine operator's "unwarrantable failure" to comply with a mandatory health or safety standard and that the operator previously received other unwarrantable failure violations without an intervening clean inspection. *See* 30 U.S.C. § 814(d)(2); *Lodestar Energy, Inc.*, 25 FMSHRC 343, 345 (July 2003).

A. Violation

A mine operator is strictly liable for Mine Act violations that occur at its mine. *Spartan Mining Co.*, 30 FMSHRC 699, 706 (Aug. 2008). The Secretary bears the burden of proving any alleged violation by a preponderance of the evidence. *In re: Contests of Respirable Dust Alteration Citations*, 17 FMSHRC 1819, 1838 (Nov. 1995), *aff'd sub nom. Sec'y of Labor v. Keystone Coal Mining Corp.*, 153 F.3d 1096 (D.C. Cir. 1998).

B. Gravity

Gravity is generally expressed as the degree of seriousness of a violation. *Hubb Corp.*, 22 FMSHRC 606, 609 (May 2000); *Consolidation Coal Co.*, 18 FMSHRC 1541, 1549 (Sept. 1996). The Secretary assesses gravity in terms of the reasonable likelihood of injury, the severity of the expected injury, the number of persons affected, and whether the violation is S&S. The Commission has pointed out that the focus of the gravity inquiry "is not necessarily on the reasonable likelihood of serious injury, which is the focus of the S&S inquiry, but rather on the effect of the hazard if it occurs." *Consolidation Coal*, 18 FMSHRC at 1550; *see also Harlan Cumberland Coal Co.*, 12 FMSHRC 134, 140-41 (Jan. 1990) (ALJ) (explaining that some violations are serious notwithstanding the likelihood of injury, such as a violation of an important safety standard, a violation demonstrating recidivism or defiance on the operator's part, or a violation that could combine with other conditions to set the stage for disaster).

C. Negligence and Unwarrantable Failure

Negligence is conduct that falls below the standard of care established under the Mine Act. Under the Secretary's regulations, an operator is held to a high standard of care and is required to be on the alert for conditions and practices that may cause injuries and to take necessary precautions to prevent or correct them. 30 C.F.R. § 10.0(d). The Secretary defines high negligence as having occurred in connection with a violation when "[t]he operator knew or should have known of the violative condition or practice, and there were no mitigating circumstances." *Id.* § 100.3, Table X. The Commission generally assesses negligence by considering what actions a reasonably prudent person familiar with the mining industry, the relevant facts, and the protective purpose of the cited regulation would have taken under the circumstances. *Leeco, Inc.*, 38 FMSHRC 1634, 1637 (July 2016); *see also Brody Mining, LLC*, 37 FMSHRC 1687, 1701-03 (Aug. 2015) (explaining that Commission ALJs "may evaluate negligence from the starting point of a traditional negligence analysis" rather than adhering to the Secretary's Part 100 definitions); *accord Mach Mining, LLC v. Sec'y of Labor*, 809 F.3d 1259, 1263-64 (D.C. Cir. 2016).

More serious consequences can be imposed under the Mine Act for violations that result from the operator's unwarrantable failure to comply with mandatory health or safety standards. The unwarrantable failure terminology is taken from section 104(d) of the Mine Act, 30 U.S.C. § 814(d), and refers to more serious conduct by an operator in connection with a violation. The Commission has determined that unwarrantable failure is aggravated conduct constituting more than ordinary negligence. *Emery Mining Corp.*, 9 FMSHRC 1997, 2001-04 (Dec. 1987). Unwarrantable failure is characterized by such conduct as "reckless disregard," "intentional

misconduct," "indifference," or a "serious lack of reasonable care." *Id.* at 2003-04; *Rochester & Pittsburgh Coal Co.*, 13 FMSHRC 189, 193-94 (Feb. 1991); *Buck Creek Coal, Inc. v. FMSHRC*, 52 F.3d 133, 136 (7th Cir. 1995).

Whether conduct is "aggravated" in the context of unwarrantable failure is determined by looking at all the facts and circumstances of each case to see if any aggravating factors or mitigating circumstances exist. These factors often include (1) the extent of the violative condition, (2) the length of time the violative condition existed, (3) whether the violation posed a high degree of danger, (4) whether the violation was obvious, (5) the operator's knowledge of the existence of the violation, (6) the operator's efforts in abating the violative condition, and (7) whether the operator had been placed on notice prior to the issuance of the violation that greater efforts were necessary for compliance. *See CAM Mining, LLC*, 38 FMSHRC 1903, 1909 (Aug. 2016); *Wolf Run Mining Co.*, 35 FMSHRC 3512, 3520 (Dec. 2013); *IO Coal Co.*, 31 FMSHRC 1346, 1350-57 (Dec. 2009). Because supervisors are held to a high standard of care, another important factor supporting an unwarrantable failure determination is the involvement of a supervisor in the violation. *Lopke Quarries, Inc.*, 23 FMSHRC 705, 711 (July 2001).

The factors listed above must be viewed in the context of the factual circumstances of a particular violation, and it is not necessary to find that all factors are relevant or deserving of equal weight in order to determine that the violation is unwarrantable. *Wolf Run*, 35 FMSHRC at 3520-21; *E. Assoc'd Coal Corp.*, 32 FMSHRC 1189, 1193 (Oct. 2010); *IO Coal*, 31 FMSHRC at 1351. However, all factors that are relevant should be considered. *San Juan Coal Co.*, 29 FMSHRC 125, 129 (Mar. 2007).

V. FINDINGS OF FACT AND ANALYSIS

A. Violation of 30 C.F.R. § 50.10(b)

Order Number 7560566 alleges:

> The operator failed to immediately contact MSHA at once without delay and within 15 minutes once the operator knew or should have known that an accident occurred involving injury to a miner which had reasonable potential to cause death. An accident occurred at this mine on November 20th, 2014 involving a high pressure hydraulic hose. The actuation of hydraulic pressure to retract the base lift cylinder for the No. 7 shield at the Viking Portal longwall, MMU-005 caused the hose to rupture at the base lift. This allowed high pressure hydraulic fluid (4,200 psi) to strike the miner, resulting in internal injuries with reasonable potential to cause death. The operator engaged in aggravated conduct constituting more than ordinary negligence in that the operator, once aware of the injured miner[']s condition, failed to call the MSHA hotline. This violation is an unwarrantable failure to comply with a mandatory standard.

Ex. S-6.

The standard alleged to have been violated is 30 C.F.R. § 50.10(b), which provides: "The operator shall immediately contact MSHA at once without delay and within 15 minutes at the toll-free number, 1-800-746-1553, once the operator knows or should know that an accident has occurred involving ... [a]n injury of an individual at the mine which has a reasonable potential to cause death."[6]

The regulation necessarily accords the operator a reasonable opportunity for investigation before the 15-minute clock begins to run, but this opportunity must be exercised "in good faith without delay and in light of the regulation's command of prompt, vigorous action" and is "tempered by the urgent need to notify MSHA *immediately*" once it is clear that a reportable accident has occurred. *Wolf Run Mining Co.*, 35 FMSHRC 3512, 3517 (Dec. 2013); *Consolidation Coal Co.*, 11 FMSHRC 1935, 1938 (Oct. 1989). Because the decision to notify MSHA must be made in the field in a matter of minutes after a serious accident, the Commission has stated it should not be based on "clinical or hypertechnical opinions as to a miner's chance of survival." *Cougar Coal Co.*, 25 FMSHRC 513, 521 (Sept. 2003). Rather, the operator should rely on readily available information such as the nature of the accident and any observable indicators of trauma, "resolv[ing] any reasonable doubt in favor of notification." *Signal Peak Energy, LLC*, 37 FMSHRC 470, 476-77 (Mar. 2015).

In *Signal Peak*, the Commission held that MSHA should have been notified of a roof fall within 15 minutes when a miner was thrown fifty to eighty feet by the force of the falling material, had a visible protrusion on his back from the impact, and told those around him that he was in great pain and was having trouble moving and breathing, even though he had good respiration and circulation and no obvious signs of internal bleeding. *Id.* at 471, 474-77. "Clearly, [the victim] was severely injured and the fortunate fact that he did not die from the injuries does not detract from a finding that the readily observable nature of his injuries presented a reasonable potential to cause death," the Commission stated. *Id.* at 476. "[A] reasonable person would have concluded that [his] injuries posed a reasonable potential for death based on the available information." *Id.* at 477.

The Secretary asserts that in this case, like in *Signal Peak*, a reasonable person familiar with the factual circumstances surrounding Davis' accident would have recognized a potential for severe, life-threatening internal injuries. According to the Secretary, M-Class should have

[6] This regulation was promulgated under the authority of section 103(j) of the Mine Act. 30 U.S.C. § 813(j). The statute states in pertinent part: "In the event of any accident occurring in any coal or other mine, the operator shall notify the Secretary thereof and shall take appropriate measures to prevent the destruction of any evidence which would assist in investigating the cause or causes thereof. For purposes of the preceding sentence, the notification required shall be provided by the operator within 15 minutes of the time at which the operator realizes that the death of an individual at the mine, or an injury or entrapment of an individual at the mine which has a reasonable potential to cause death, has occurred." *Id.* The second sentence, from which the 15-minute notification requirement derives, was added to the statute by the 2006 MINER Act as part of a Congressional push to improve mine emergency responses in the wake of several mine disasters. *Mine Improvement & New Emergency Response Act of 2006*, Pub. L. No. 109-236, sec. 5(a), § 103(j), 120 Stat. 493, 498 (June 15, 2006); *see Big Ridge, Inc.*, 37 FMSHRC 1860, 1866 (Sept. 2015) (discussing effect of amendment).

reported the accident at three separate points: first, when Davis was brought out of the mine; second, when General Manager Brown brought the MSDS for the hydraulic emulsion to Franklin County Hospital and expressed concern about Davis' risk of infection; and third, when Davis was airlifted to Barnes-Jewish Hospital in St. Louis. Sec'y Br. 14-18.

M-Class' witnesses concede that this was a serious accident, (Tr. 215-16, 238, 240), but M-Class nonetheless contends that the violation should be vacated because there was no point when mine management knew or should have known that Davis' injuries had a reasonable potential to cause death. According to M-Class, the injuries were not readily apparent on the day of the accident and the company had no reason to suspect the extent of the "hidden injury" until management learned the next morning that Davis had undergone surgery, at which time he was no longer at risk of death. Resp. Br. 1-3, 11-14.

I reject M-Class' contention that the injuries were not readily apparent. In this case, like in *Signal Peak*, a reasonable mine operator would have realized the accident was life-threatening and needed to be reported within 15 minutes on the basis of the information that was readily available to management, including the nature of the accident and numerous readily observable indicators that Davis had sustained serious internal injuries.

The nature of the accident was penetrating trauma to the rectum by high-pressure hydraulic fluid released from a ruptured hose. The fluid was pressurized at 4,200 psi. Tr. 33, 104-05. The Secretary's two MSHA witnesses, Cripps and Lampley,[7] described this as a "massive amount of pressure" that is three times what a power washer would exert and discussed past incidents where miners have suffered severe and even fatal injuries after being struck by fluid at similar pressures or by hoses or fixtures propelled by such fluid. Tr. 32-33, 43-44, 47-49, 106-09. Any reasonable person familiar with high-pressure hydraulic equipment, including anyone operating a longwall, would be expected to immediately realize that a struck-by accident involving a ruptured 4,200 psi hydraulic hose is very serious. *See* Tr. 48-49, 113, 219.

In this case, the 4,200 psi hydraulic fluid was injected into Davis' body, increasing the likelihood the injuries would be life-threatening. It was readily apparent that a fluid injection injury had occurred, as Davis was bleeding, had a hole in the back of his pants at the point of impact, and said that the fluid had shot inside of him. Tr. 58, 114-15, 162; Ex. S-3 at 27. The fluid was an emulsion composed of 95% water and 5% synthetic oil. Tr. 32, 262. M-Class presented testimony purporting to establish that this was not a hazardous substance. Brown testified that synthetic emulsions are less harmful than petroleum-based emulsions and are advertised as posing no risk of death, and Webb went so far as to opine that this particular emulsion was perfectly safe and would pose no human health risks at all even if injected into the bloodstream or ingested. Tr. 208-09, 227-31, 260-61. M-Class did not identify the emulsion or provide a copy of the MSDS to corroborate this testimony, and neither of the MSHA witnesses

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[7] Cripps is the electrical supervisor for MSHA District 8 and has more than twenty years of experience with the agency. He holds a Bachelor's degree in electrical engineering technology and previously worked in the mining industry as an electrical engineer, underground maintenance foreman, and longwall foreman from 1983 until he was hired by MSHA in 1991. Tr. 25-26. Lampley is a regular coal mine inspector. He worked as a longwall mechanic in an underground coal mine from 2005 to 2007, when he was hired by MSHA. Tr. 86-89.

were familiar with the claimed safety advantages of synthetic emulsions. Tr. 43, 159, 264-65. Regardless, I agree with the Secretary's witnesses that the risk of injury or infection is very high any time a fluid pierces a person's skin at 4,200 psi irrespective of the chemical composition of the fluid. Tr. 32, 121, 132-33. As Webb conceded, any open wound presents an infection risk, even if the penetrating material is pure water. Tr. 262-63. In addition, the fluid shot through Davis' work bibs in this case. The fabric could have carried numerous contaminants which would have been forced into his body, posing a serious risk of infection. Further, the precise manner the injection injury occurred was gruesome and posed a particularly high risk of internal harm. The hydraulic fluid did not just pierce Davis' skin, but impaled him through the rectum at an extremely high pressure. The nature of this accident alone would have led a reasonably prudent person to conclude there was a reasonable potential for death.

Moreover, there were other readily observable indications that Davis had sustained serious and potentially life-threatening internal injuries. Relying on the testimony of three management officials who did not examine Davis, did not witness the accident, and were not present when he was brought out of the mine, M-Class argues that the severity of the injuries was not immediately obvious because Davis was conscious, responsive, and mobile after the accident with stable vital signs and no overt signs of shock. Resp. Br. 12. This argument ignores key facts and trivializes the seriousness of the situation at the mine that day. After being struck by the hydraulic fluid, Davis had soiled himself and was bleeding profusely from the rectum. Tr. 58-60. He told Lence that the 4,200 psi hydraulic fluid had shot inside of him, that he was not okay and needed to get out of the mine immediately, and that he felt as if his intestines were hanging out and as if "there was something wrong inside." Tr. 53-54, 114-15, 145. It is true that he was "mobile" in the sense that he walked partway from the longwall to the Kubota on his own power, but this was more a reflection of his panicked desire to get to the surface than a sign of healthy vigor. Lence had initially helped him off the longwall face and walked with him some distance before running ahead to get the Kubota, not realizing Davis had the keys in his bibs. Tr. 54-55. Davis continued walking by himself until Lence returned because he "was very frantic" and wanted to get out of the mine. Tr. 55. By his own account, which I find entirely credible, he was in shock and extremely worried. Tr. 55-56. His coworkers wrapped him in a fire blanket when he finally reached the surface, presumably because he was shaking. Tr. 57-58, 70. He was still bleeding heavily to the extent that when he was loaded into the ambulance he left behind a pool of blood on the seat of the Kubota and running down the side. Tr. 58, 115, 258. All of these factors clearly indicated he had sustained serious internal injuries.

To summarize, although Davis was conscious and alert after the accident, he had been impaled in the rectum by a 4,200-psi hydraulic oil emulsion, had soiled himself and was bleeding profusely, was in shock, and said that he felt like his insides were hanging out. The wound was not, as Webb suggested, akin to an "overglorified paper cut," and I wholly reject M-Class' argument that the injuries "appeared superficial." Tr. 243; Resp. Br. 3. Any reasonable person aware of the nature of the accident and Davis' symptoms and presentation would have recognized he was suffering from potentially life-threatening internal injuries.

Mine management was or should have been aware of both the nature of the accident and Davis' condition before he left the mine and should have called the MSHA hotline to provide notification of the accident within 15 minutes of the time he reached the surface. From the

managers who were onsite that day to the supervisor of the entire mining complex, Webb, management personnel all the way up the chain of command were aware of the accident almost immediately after it happened and knew or could have easily learned of the circumstances surrounding it. Lence radioed warehouse personnel on the surface and notified them of the accident while he was transporting Davis out of the mine. Tr. 56-57, 69. He also called management official Gabe Wheeler. Ex. S-3 at 26. Wheeler and mine manager Mike Lily met Lence and Davis on the surface and were present when Davis was loaded into the ambulance to be taken to Franklin County Hospital. Tr. 57, 116, 182, 259. Meanwhile, warehouse personnel had called the mine's safety director, Intravaia, and general manager, Brown, to notify them of the accident, and Intravaia in turn had notified Webb. Tr. 181, 206, 241-42. Both Intravaia and Brown immediately began driving to the mine, and on the way, Intravaia spoke to Lily by phone to obtain more information and then called Brown, who called the warehouse and instructed that the MSDS for the synthetic oil emulsion be sent to the hospital. Tr. 182-83, 207-08. Although Intravaia and Brown did not arrive at the mine in time to see Davis, both proceeded to Franklin County Hospital. Tr. 183, 210. Brown was able to briefly speak to Davis, his wife, and his Joy Global boss, and both Brown and Intravaia remained at the hospital until Davis was loaded into a helicopter to be airlifted to Barnes-Jewish Hospital in St. Louis. Tr. 184-86, 210-13.

The point when mine management should have known of the need to report the accident within 15 minutes was when Wheeler and Lily met Davis on the surface after he was brought out of the mine. Davis said he discussed how he was feeling with Wheeler at that time. Tr. 57. "[T]here was blood on the ride, and I told him that I was really worried," Davis testified. Tr. 57. Wheeler and Lily, neither of whom testified at the hearing, would have seen that Davis was bleeding on himself and the Kubota, had a hole in his pants, had experienced a spontaneous bowel movement, and was in shock. They would have watched as he was wrapped in a blanket and loaded into the ambulance, and they would have been able to talk to Lence about the accident after the ambulance departed, since they did not travel to the hospital. In other words, they had every reason and opportunity to find out what had happened and recognize the seriousness of Davis' injuries. At this point, as members of mine management, they should have ensured the accident was promptly reported to MSHA. Webb stated they did not do so because "although it being a bad accident, severe, in their minds there was no life-threatening injuries" because Davis was walking and talking. Tr. 240. But Webb's later testimony suggested that the decision not to call the MSHA accident hotline was actually made by upper management officials who were not present and did not observe Davis' condition. "[W]e have a protocol that we follow. And if you err from that protocol, then it opens up for lower level managers to make decisions that they don't need to make," he stated. Tr. 263. The Commission has frowned on this sort of attitude. "[A]n operator may not designate one specific person, such as a safety manager, to place the immediate call to MSHA. Once a person with sufficient authority to call learns of an event injuring a miner, the clock begins to run," according to the Commission. *Signal Peak*, 37 FMSHRC at 476. I find that the foremen onsite should have realized that Davis had suffered potentially life-threatening injuries, at which point the clock began to run for M-Class to notify MSHA of the accident within 15 minutes.

M-Class presented testimony from Intravaia, Brown, and Webb purporting to explain why mine management did not timely report the accident. However, I find that each of these men had the information necessary to realize the life-threatening nature of Davis' injuries and, as

members of mine management, they should have ensured MSHA was notified of the accident promptly.

At the time of the accident, Intravaia was the mine's safety director, in which capacity he received notification of all accidents that occurred at the mine and was responsible for ensuring compliance with the Part 50 reporting requirements. Tr. 175-76, 180, 195. When he called mine manager Lily immediately after hearing of the accident, he learned that a hydraulic hose had ruptured and struck Davis and that Davis "might have a little laceration above either his lower back and then on one of his buttocks areas." Tr. 182-83, 188. Intravaia traveled to Franklin County Hospital and observed Davis in an examination room sitting upright on a gurney while talking on his cell phone. Tr. 184, 198. Intravaia made eye contact with Davis but did not talk to him or his wife. Tr. 185. "It seemed like there was no concern," he testified. Tr. 185. Davis was "conscious, alert, oriented times three, [and] was not complaining of anything." Tr. 195. No one told him that Davis had suffered internal injuries or was bleeding, Intravaia said. Tr. 197, 199. He had been a firefighter and emergency medical responder for twelve years before he began working for M-Class. Tr. 177-80. He asserted that after visiting the hospital, based on his knowledge and experience as an EMT, he did not believe Davis' injuries were an emergency or life-threatening. Tr. 189.

I do not credit this assertion. Intravaia leaned on his paramedic experience as proof of his qualifications to determine whether the injuries were life-threatening, but admittedly, he did not see the injuries, examine Davis, or even speak to Davis or his wife. Tr. 185, 192, 198-99. In fact, he spent much of his time on the witness stand attempting to disclaim any knowledge of Davis' condition or the extent of the injuries. He said he did not view the damage to Davis' rectum as a traumatic injury because "I'm not a doctor so I can't really assess that." Tr. 190. Asked how his firefighter training prepared him to handle internal injuries, he responded, "Internal injuries, nobody can inspect." Tr. 190. He testified that as long as an injured person is conscious and alert, he would not consider the person's injuries life-threatening because "I don't know what effects he has going on in the inside." Tr. 191. He admitted shock can be an indicator of internal injuries, but stated, "The only one who can diagnose shock would be a medical director or a physician." Tr. 202. Yet he conceded that as an EMT, if he observed signs of shock and knew that a patient had sustained blunt force trauma, he would treat the patient for suspected internal injuries, which can be life-threatening and should be reported to the hotline. Tr. 192, 201-03.

I find it implausible to believe that Intravaia had no suspicion of internal injuries after speaking to mine manager Lily and learning that Davis had been struck by an extremely high pressure hydraulic hose. Even if he was genuinely unaware of Davis' condition, the circumstances of the accident should have alerted him, in his vast experience as an EMT, to the need for further inquiry. *See Mainline Rock & Ballast, Inc. v. Sec'y of Labor*, 693 F.3d 1181, 1189 (10th Cir. 2012) (upholding violation of § 50.10 when "the obvious circumstances of the accident would have triggered some minimal degree of inquiry in a reasonable person" but supervisor "chose to remain blind"). A mine operator has a duty to investigate accidents under § 50.10 to determine whether notification is required. Tr. 44-45, 163. And even though further investigation may not have revealed the precise character of Davis' internal injuries, the Commission has indicated that a mine operator should not wait for a clinical or hypertechnical

opinion regarding the nature of a miner's injuries. Instead, the operator should err on the side of caution and provide prompt notification of any injury that may be life-threatening.

Moreover, Intravaia should have had no doubt that the accident needed to be reported once he knew that Davis had been airlifted to Barnes-Jewish Hospital in St. Louis via a Life Flight helicopter. According to Davis, he was transferred so he could be taken into surgery as quickly as possible, and indeed, he underwent emergency surgery shortly after his arrival at Barnes-Jewish. Tr. 63-65. Laura Davis also testified that the doctor at Franklin County Hospital knew from the moment her husband arrived that he would need to be sent somewhere else because "this was way above him [the doctor]." Tr. 80-81. However, Intravaia indicated he still did not realize Davis' injuries were life-threatening at this point, but simply believed the patient was being transferred for further diagnostics. Tr. 185-88. I do not credit this testimony. If Intravaia truly still believed that Davis' injuries consisted of superficial lacerations on the lower back and buttocks, it would be patently unreasonable to think the patient was being airlifted to St. Louis in a Life Flight helicopter simply so the cuts could be evaluated and stitched up by a different doctor. *See* Tr. 118, 168-69. The use of a helicopter indicated this was a more complicated and serious injury requiring urgent care.

Intravaia testified that he went to Franklin County Hospital that day "because I have a general concern for all our employees and anybody that's on our facility. I care. And I also have a duty that I want to make sure myself and see what actually – what [Davis] looked like." Tr. 193. And yet, if his testimony is to be believed, he asked no questions of the victim, his wife, or the medical staff and remained unaware of the mechanism and nature of the injury (a hydraulic injection injury causing penetrating trauma to the rectum) and the reason for Davis' transfer to St. Louis (to have surgery for internal injuries). He simply showed up at Franklin County Hospital, saw that Davis was conscious and alert, and departed, satisfied that the accident was not serious enough to warrant reporting. If so, I would find Intravaia's investigation of the accident to be woefully inadequate. But I find it more likely that Intravaia was aware the accident involved a hydraulic injection injury and a risk of life-threatening internal injuries and simply failed to report it to MSHA within 15 minutes, in violation of § 50.10.

Like Intravaia, General Manager Brown, who is the highest ranking official at the mine, receives notification of all accidents that occur onsite and is familiar with the 15-minute reporting requirement. Tr. 204-06, 214, 217. Brown testified that after being notified of the November 20, 2014 accident and traveling to Franklin County Hospital, where he spoke briefly with Davis and his wife, he did not believe Davis' injuries had the potential to cause death. Tr. 211-15. Brown admitted that blunt force trauma and a suspicion of internal injuries would trigger a reporting obligation under § 50.10. Tr. 220-21. But he testified he did not suspect internal injuries, noting that Davis was conscious and "said he was doing okay." Tr. 211, 215, 226. Although Brown was in charge of investigating the accident on M-Class' behalf and determining whether it needed to be reported, he conceded he did not ask Davis about his injuries and said he did not interview Lence or anyone else at the mine about the accident. Tr. 220-21, 223-25, 232. He stated he did not learn until the next day that the hydraulic fluid had penetrated Davis' body. Tr. 225-26.

I decline to credit Brown's testimony that he was unaware the hydraulic fluid had penetrated Davis' body. Shortly after learning of the accident, Brown called the mine and made sure the MSDS was submitted to the hospital. Tr. 207-08. This indicates mine management was aware a hydraulic injection injury had occurred, despite protestations by Brown and Webb that they simply wanted the doctors to know what type of fluid was involved in order to forestall any unnecessary treatment. Tr. 208-09, 223, 242, 260. In addition, Laura Davis testified that while she was at Franklin County Hospital, Brown "grabbed me and pulled me aside and said that based on the emulsion which is in the hose, and it was injected into Todd, that he was really concerned about how serious the emulsion could be for his body and thought that we should transfer him to St. Louis" rather than to a different hospital in Evansville. Tr. 79-80. Brown denied recommending one hospital over the other, but did not address whether he had discussed the hydraulic emulsion with Laura Davis. Tr. 211-12, 226-27. I credit her testimony that he did mention his concerns about the emulsion. This further supports a finding that Brown was aware Davis had suffered a serious hydraulic injection injury. Considering Brown's position, his knowledge of the 15-minute reporting requirement, and the information known to him on November 20 regarding the accident and Davis' condition, he should have ensured MSHA was notified promptly pursuant to § 50.10(b).

Webb, supervisor of the mining complex, was also aware of the Part 50 reporting requirements and had the authority to notify MSHA of the accident. Tr. 236-37, 244. After Davis was injured, he received enough information about the accident that he should have ensured it was reported. Intravaia had called him just after the accident and advised that a hydraulic hose had ruptured and struck Davis. Tr. 241-42. Webb was aware that Davis' skin had been pierced and that there was blood on the Kubota, and he later learned that Davis had been transferred from Franklin County Hospital to St. Louis by helicopter. Tr. 242-43, 258. He did not travel to the mine or hospital, so he had no firsthand knowledge of Davis' condition, but he apparently participated in making the decision not to notify MSHA. Management believed Davis' injuries were not life-threatening, he explained. Tr. 244, 253, 257-58. He further stated that "MSHA has a lot of things to do, and they don't have the resources to come out and investigate what I would call frivolous calls." Tr. 263. I find this to be a self-serving and disingenuous attempt to excuse mine management's many failings in this case, including failure to err on the side of caution in reporting the accident and failure to adequately investigate it. Webb asserted that management "did our due diligence when it came time to investigate," (Tr. 263), but if this were the case they should have recognized the life-threatening nature of the accident and notified MSHA immediately, for the reasons discussed above.

The morning after the accident, Webb sent a text message to a supervisor at Joy Global inquiring about Davis' condition. Tr. 244-45. The supervisor advised that Davis had undergone emergency surgery and had a lacerated rectum and damaged colon. Tr. 245. Webb said that was the point when he realized the injuries were more serious than he had previously thought, so he decided to call MSHA even though the time for immediate notification under § 50.10 had passed and Davis was no longer at risk of death. Tr. 238-39, 245-46. M-Class was "on shaky ground" and "looked upon with some distrust from MSHA" at the time because it was on the cusp of a

pattern of violations (POV).[8] Tr. 174, 237-39. Thus, according to Webb, his call to MSHA represented a good faith effort to build a better rapport with the agency rather than a belated bid to avoid receiving a Part 50 violation. Tr. 238-39, 246. Webb also asserted that M-Class had no incentive not to report the accident in the first place; management simply had not realized the injuries posed a reasonable potential for death. Tr. 238, 254.

Citing Webb's testimony, M-Class argues that even if its decision not to report the accident was a mistake, it acted in good faith. Resp. Br. 15. I reject this argument, for the following reasons.

First, as discussed above, multiple members of mine management had enough information about the accident to realize it was reportable. There was no plausible good faith reason not to report it right away.

On the other hand, M-Class had a motive not to notify MSHA immediately: avoiding a longwall shutdown. If the accident had been reported within 15 minutes, MSHA likely would have immediately issued a 103(j) order prohibiting alteration of the accident scene, and because the accident occurred on a longwall shield, this would have shut down coal production. Tr. 124, 171, 255-56. Indeed, after learning of the accident, Cripps issued a 103(j) order prohibiting M-Class from moving the longwall shield at the accident site, which prevented the longwall from being advanced and thereby halted production. Tr. 29, 91-93, 157-58. Inspector Lampley noted that while he and Cripps were at the mine conducting the investigation under the j-order, M-Class representatives asked several times if the investigation was finished yet so the j-order could be terminated and production could resume. Tr. 110. In addition, M-Class had already disconnected the ruptured hose from the longwall equipment and replaced it with a functional hose before the investigation. Tr. 97-98, 251. Had a 103(j) order issued immediately, the mine likely would have had to wait to make these repairs, further delaying production. Tr. 256.

In addition, M-Class failed to investigate the accident in good faith. Webb asserted that mine management "did our diligence when it come time to investigate the accident, and then we made a decision [not to notify MSHA] based off of that." Tr. 263. But it is clear from the testimony of Intravaia and Brown, who – unlike Webb – were actually involved in investigating the accident, (Tr. 200, 232), that management's investigative efforts prior to the issuance of the j-order were wholly inadequate. Although Intravaia and Brown were apparently in charge of the investigation, there is no evidence that either of them visited the mine the night of the accident. Neither of them ever interviewed Lence, the key eyewitness. Tr. 200, 224. Although they made an appearance at the hospital, Intravaia did not speak to anyone there and apparently learned nothing about the extent of Davis' injuries. Brown spoke to Davis' wife and boss from Joy Global, but indicated he learned nothing about Davis' condition from either of them. Tr. 210-12. He said he spoke to Davis himself "for, maybe, less than five minutes" and asked only how he was doing, to which Davis responded "he was doing okay, and that was about it." Tr. 211 He did not ask any more pointed questions which would indicate a bona fide investigation was being made, such as where Davis' injuries were, what he was feeling, what the doctors were saying,

[8] A "pattern of violations" can trigger enhanced enforcement action against a mine under section 104(e) of the Mine Act. MSHA sends the mine operator a POV notice before placing it on a POV. 30 U.S.C. § 814(e).

and why they wanted to transfer him to a larger hospital. Tr. 224-26, 232. It appears that M-Class' management officials intentionally failed to investigate the accident and closed their eyes to the severity of Davis' injuries in hopes of later being able to disclaim knowledge of their extent. This indicates bad faith.

M-Class cites Webb's November 21 phone call to MSHA as evidence of good faith, but during the call, Webb misrepresented the nature and extent of Davis' injuries. Cripps did not take notes during the call because Webb termed it a "courtesy call" rather than a formal accident notification; for this reason, Cripps could not remember the exact substance of the conversation. Tr. 27-28, 45-46. But he did recall that when he spoke to a Joy Global representative later in the day, he was surprised to learn that Davis had undergone surgery for serious internal injuries and was in a critical care unit in the hospital in St. Louis. Tr. 30-31, 39. This was inconsistent with the information he had received from Webb. Tr. 31, 39. It was not until Cripps and Lampley traveled to the mine to investigate that they learned "the extent of the injuries and actually what happened, you know, about the high-pressure hose blowing and ... possibly ... hydraulic oil being actually injected into Mr. Davis." Tr. 31, 41-42. Webb, for his part, denied misleading Cripps and asserted he had recounted everything he knew at the time of the phone call, including that Davis had lacerated his rectum and undergone surgery. Tr. 246-50. However, I credit Cripps' testimony that if this information had been relayed to him during the call, he would have issued a 103(j) order immediately, requested more details, and asked why the accident had not been reported through the hotline. Tr. 35-38. Instead he initiated an investigation later in the day after talking to his supervisor. Mine management continued to downplay the seriousness of the accident even after MSHA begun investigating, with Intravaia still referring to the victim's injuries as "a one-inch cut on his backside" when he met with the investigators at the mine. Tr. 117-18, 161, 164-66. I find that mine management failed to provide MSHA with complete, trustworthy information about the accident, showing a lack of good faith.

For all the reasons discussed above, I find that M-Class violated § 50.10(b), and I reject the operator's suggestion that the violation should be dismissed as a good faith mistake.

B. <u>Gravity</u>

In Section 10 of the order (the section titled "Gravity"), Inspector Lampley designated the violation as non-S&S with no likelihood of causing injury and marked the expected injury as an injury causing "no lost workdays" and affecting zero miners. According to his field notes, he made these minimal gravity designations because this was a mere reporting violation that did not affect Davis' condition, the severity of his injuries, or the outcome of the accident. Ex. S-7 at 13-14. The parties have stipulated that Inspector Lampley properly evaluated all aspects of Section 10 of the order. Joint Ex. 1; Tr. 172-73.

Although I accept the parties' stipulation, I find that the gravity of this violation was extremely serious despite the inspector's minimal gravity designations. The regulation that was violated, § 50.10(b), derives from an express and relatively recent Congressional mandate added to section 103(j) of the Mine Act in 2006 with the intent of improving MSHA's ability to respond to mine emergencies promptly and effectively. *See supra* n.6. Prompt, accurate accident reporting enables MSHA to swiftly mobilize an appropriate response, including

securing the scene of the accident and investigating what caused it. *See Signal Peak*, 37 FMSHRC at 477; *Final Rule – Emergency Mine Evacuation*, 71 Fed. Reg. 71430, 71434-35 (Dec. 8, 2006). M-Class' utter failure to comply with this mandate may not have directly endangered any particular miners, but still constituted a very serious violation in light of the importance of section 103(j) and the 15-minute notification requirement.

C. Negligence and Unwarrantable Failure

The Secretary contends that M-Class' negligence in connection with this violation was high because Davis suffered severe injuries and members of mine management were present at the mine and hospital and aware of the injuries, yet no one called the hotline at any point, presumably because M-Class was trying avoid the issuance of a 103(j) order. Further, when M-Class finally did notify MSHA of the accident, the information provided by the company did not accurately reflect Davis' condition. The Secretary also argues that this violation amounted to an unwarrantable failure to comply with § 50.10(b), citing factors including the length of time it existed, its obviousness, and the operator's knowledge of it. Sec'y Br. 19-24.

M-Class counters that this violation did not involve high negligence and was not an unwarrantable failure because even if mine management made the wrong decision in failing to call the hotline, they acted in good faith – an argument I have already rejected. M-Class also asks to be credited for mitigating circumstances including the fact that Davis was quickly and efficiently transported out of the mine to the hospital. Resp. Br. 15-17.

Knowledge of Violation; Obviousness

Knowledge of a violation is established where the operator knew or reasonably should have known of the violation. *Coal River Mining, LLC*, 32 FMSHRC 82, 95 (Feb. 2010). The knowledge or negligence of an agent may be imputed to the operator. *Excel Mining, LLC*, 37 FMSHRC 459, 467-68 (Mar. 2015); *Martin Marietta Aggregates*, 22 FMSHRC 633 (May 2000).

In this case, for the reasons discussed at length above, I find that the nature of the November 20, 2014 accident and the type of injuries Davis sustained were obviously reportable under § 50.10(b). He was struck from below by a 4,200-psi hydraulic oil emulsion. He told Lence that the hydraulic fluid had shot into his body and that it felt like his intestines were hanging out. He had a hole in his pants and had soiled himself, was bleeding onto his clothing and the vehicle that transported him out of the mine, and was in shock. After being taken by ambulance to the local hospital and briefly evaluated, he was airlifted by Life Flight helicopter to a critical care unit in St. Louis where he was taken into surgery in short order. These factors made it obvious that he had suffered life-threatening internal injuries.

Mine management was aware of all the circumstances listed above. Two management officials, Wheeler and Lily, were present when Davis was brought out of the mine and would have been able to observe his condition and ask Lence what happened. Management officials Intravaia and Brown, both of whom are aware of the requirements of § 50.10 and are responsible for ensuring compliance with these requirements, were in contact with personnel at the mine regarding the accident, traveled to Franklin County Hospital with Davis, and were present when

he was airlifted to St. Louis. Webb was also notified of the accident and should have investigated it and ensured that it was reported. Given the nature of the accident and the blatant signs of trauma and internal injuries, mine management would have had to be blind or willfully ignorant not to realize that the accident was reportable under § 50.10(b). I find that this was a knowing violation on the part of mine management, including Wheeler, Lily, Intravaia, Brown, and Webb, whose knowledge is imputable to M-Class.

Notice of Need for Greater Compliance Efforts

An operator's history of past similar violations or other specific warnings from MSHA is relevant to the unwarrantable failure analysis to the extent the past violations and warnings placed the operator on notice that greater efforts were necessary for compliance with the cited safety standard.

Inspector Lampley testified that at the time this violation was written in January 2015, the mine had received six prior violations of § 50.10 since September 2013, including a 104(d)(2) order. Tr. 123, 153-55; Ex. S-7 at 17. This was one of the main factors influencing his finding of aggravated conduct. Tr. 135; Ex. S-7 at 17. I agree that the prior violations support a finding of aggravated conduct. Being cited for the same violative conduct six times in the preceding fifteen months and receiving an unwarrantable failure withdrawal order should have placed M-Class on notice of the need to make greater efforts to comply with the requirements of § 50.10.

In addition, as noted above, M-Class was on the cusp of being placed on a POV at the time this violation occurred, which is a symptom of poor overall compliance efforts. Given M-Class' admittedly "shaky" footing with MSHA, (Tr. 239), and the looming prospect that MSHA would take enhanced enforcement action against the company through the POV process, management should have been on notice of the need for greater compliance efforts all around and the need to be forthright with MSHA in all dealings in order to demonstrate good faith, which would include erring on the side of full, prompt disclosure of accidents under § 50.10.

Duration of Violation

Davis was injured at approximately 8:20 PM on November 20, 2014. Ex. S-3 at 3. When Lence brought him out of the mine shortly thereafter, the two foremen who met them on the surface should have assessed the situation and realized that the company needed to notify MSHA of the accident. The 15-minute clock began running at that point, but notification was not provided until the "courtesy call" was made the next morning. Webb made the call after arriving at the mine at his usual time, which was around 5:30 or 6:00 AM, and exchanging text messages with a Joy Global representative. Tr. 244-45. MSHA did not learn the full extent of Davis' injuries until Cripps and Lampley further investigated the accident later that day. I conclude that the violative condition lasted for more than one shift but less than a day.

Degree of Danger Posed by Violation

The Secretary contends that the operator's delay in reporting Davis' accident placed other miners at risk of being injured by defective hoses. Sec'y Br. 23-24. This argument conflicts

with the parties' stipulation that there was no likelihood of injury. Tr. 172-73. There is no evidence there were any defective hoses on the longwall other than the one that ruptured, which was removed and replaced immediately after the accident because it was no longer functional (Tr. 251), nor is there evidence that any miners were endangered by the operator's delay in notifying MSHA of the accident. I find that this violation did not pose a direct danger to anyone. However, by their nature, reporting violations indirectly affect mine safety by hampering MSHA's ability to respond effectively to accidents.

Extensiveness; Abatement Efforts

The extensiveness of a violation is usually analyzed in terms of the physical dimensions of the affected area, the number of miners endangered, how many man-hours are required to abate it, or other similar factors. Anyone working on the longwall near the frayed hose could have been the victim of this accident. In addition, I find that this violation was extensive in other ways. Specifically, it involved five management officials and an extensive number of missed opportunities to comply with § 50.10. Wheeler, Lily, Intravaia, and Brown all were members of mine management who had the knowledge and opportunity to report the accident to MSHA on November 20 yet failed to do so. Webb did finally report the accident on November 21, but failed to call the hotline, instead choosing to call the local district office, and provided incomplete information about Davis' condition. When MSHA investigators conducted interviews at the mine later that day, mine management still seemed to be trying to downplay the seriousness of Davis' injury, referring to it as a "one-inch cut on his backside" even though by then the victim was in a critical care unit in St. Louis recovering from emergency surgery for multiple internal injuries. Tr. 117-18, 161, 164-66. In short, five management officials ignored multiple opportunities to ensure that MSHA received a prompt and accurate report of the accident, ultimately leaving the agency to ascertain the nature of the accident and extent of the injuries through its own investigation. This string of negligent conduct is extensive enough to undercut M-Class' assertion that mine management was acting in good faith.

For the same reasons, I also conclude that M-Class' abatement efforts undertaken prior to the issuance of the order were insufficient.

Conclusions

Based on the factors discussed above, particularly the obviousness of the violation, the fact that M-Class had a troubling history of prior similar violations placing it on notice of the need to make greater efforts to comply with § 50.10, and the knowledge and involvement of five members of mine management, I find that M-Class engaged in aggravated conduct constituting more than ordinary negligence. I reject M-Class' argument that its negligence was offset by its prompt and diligent efforts to investigate the accident and by the fact that Davis was quickly evacuated from the mine. The record does not support a finding that management made prompt and diligent investigative efforts. It is true that Davis was quickly and efficiently evacuated from the mine. In fact, Inspector Lampley praised the evacuation effort at hearing, stating that "they did an excellent job of getting him out of there, and that's great, and I hope they continue to do so." Tr. 116. But the speedy evacuation, while laudable, is unrelated to the notification violation.

I find that this violation constituted an unwarrantable failure to comply with § 50.10(b), and it was appropriate for Inspector Lampley to issue the order under 104(d)(2). For the same reasons, I also find that M-Class' negligence was high.

VI. PENALTY

The Commission has reiterated in *Mize Granite Quarries, Inc.*, 34 FMSHRC 1760, 1763-64 (Aug. 2012):

> Section 110(i) of the Mine Act grants the Commission the authority to assess all civil penalties provided under the Act. 30 U.S.C. § 820(i). It further directs that the Commission, in determining penalty amounts, shall consider:
>
> The operator's history of previous violations, the appropriateness of such penalty to the size of the business of the operator charged, whether the operator was negligent, the effect on the operator's ability to continue in business, the gravity of the violation, and the demonstrated good faith of the person charged in attempting to achieve rapid compliance after notification of a violation.
>
> 30 U.S.C. § 820(i).

The Commission and its ALJs are not bound by the penalties proposed by the Secretary, nor are they governed by MSHA's Part 100 regulations, although substantial deviations from the proposed penalties must be explained using the section 110(i) criteria. *See Am. Coal Co.*, 38 FMSHRC 1987, 1992-93 (Aug. 2016); *Sellersburg Stone Co.*, 5 FMSHRC 287, 293 (Mar. 1983). In addition to considering the 110(i) criteria, the judge must provide a sufficient factual basis upon which the Commission can perform its review function. *See Martin Co. Coal Corp.*, 28 FMSHRC 247, 266 (May 2006).

The Secretary asks me to assess a penalty of $5,000.00 for this violation, which is the statutory minimum for violations of the 15-minute notification requirement. *See* 30 U.S.C. § 820(a)(2). The parties have stipulated that the proposed penalty is appropriate if the order is affirmed in all aspects. Joint Ex. 1.

The Secretary has submitted a violation history form showing that the MC #1 Mine received 1,130 violations from MSHA that became final during the two years preceding the issuance of this order. Ex. S-8. A number of these were Part 50 reporting violations, and Inspector Lampley testified M-Class' recent violation history included six § 50.10 violations. Tr. 123; Ex. S-8.

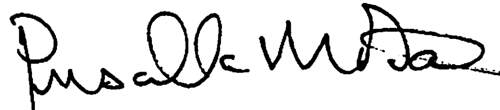
The size of M-Class' business is large. The parties have stipulated that the proposed penalty will not affect its ability to remain in business. Joint Ex. 1.

My findings regarding gravity and negligence are discussed at length above in the body of my decision. In addition, I have discussed why I do not believe M-Class exhibited good faith in attempting to achieve rapid compliance after notification of the violation. Even after MSHA issued a 103(j) order and launched an accident investigation, M-Class left it to the MSHA investigators to discover what had actually happened and the extent of Davis' injuries on their own. *See* Tr. 31.

Considering the foregoing, it appears that the deterrent effect of the mandatory minimum penalty set forth in section 110(a)(1) is not sufficient. Prompt accident notification was important enough to Congress that it codified the 15-minute reporting requirement in section 103(j) and specified a minimum penalty. Yet M-Class, despite an alarming history of reporting violations, demonstrated a total indifference both to the statutory requirement and to Davis' condition, altering the scene of the accident and apparently purposefully failing to conduct a bona fide investigation in order to avoid a coal production shutdown and being placed back on POV watch. After considering the six statutory penalty criteria, I find that a penalty of $7,000.00 is appropriate for this violation.

ORDER

M-Class is hereby **ORDERED** to pay a total penalty of $22,750.00 for the two violations at issue in this docket within thirty (30) days of the date of this Decision and Order.[9]



Priscilla M. Rae
Administrative Law Judge

Distribution:

Rachel L. Graeber, Esq. & Jason R. Patterson, Esq., U.S. Department of Labor, Office of the Solicitor, 230 South Dearborn Street, Suite 844, Chicago, IL 60604

Christopher D. Pence, Esq., Hardy Pence PLLC, 500 Lee Street East, Suite 701, Charleston, WV 25301

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[9] 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.