FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

OFFICE OF ADMINISTRATIVE LAW JUDGES
721 19th St. Suite 443
Denver, CO 80202-2500
TELEPHONE: 303-844-5266 / FAX: 303-844-5268

May 23, 2017

SECRETARY OF LABOR, MINE SAFETY AND HEALTH ADMINISTRATION, (MSHA), Petitioner, v. WEBSTER COUNTY COAL, LLC, Respondent.	CIVIL PENALTY PROCEEDING Docket No. KENT 2016-233 A.C. No. 15-02132-401970 Mine: Dotiki Mine

DECISION

Appearances: Schean G. Belton, Office of the Solicitor, U.S. Department of Labor
618 Church Street, Suite 230, Nashville, TN 37219

Tyler H. Fields, Webster County Coal, LLC
1146 Monarch Street, Lexington, KY 40513

Before: Judge Simonton

INTRODUCTION

This case is before me on a civil penalty petition filed by the Secretary of Labor, acting through the Mine Safety and Health Administration (MSHA), against Webster County Coal, LLC ("WCC" or "Respondent"), pursuant to the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 815. This docket involves Citation No. 9045176, issued on October 1, 2015 for a specially assessed penalty of $65,000. The citation was designated Significant and Substantial (S&S), reasonably likely to result in a fatal injury, and the result of Webster County Coal's moderate negligence.[1] The parties presented testimony and documentary evidence at a hearing held on February 28-29, 2017 in Madisonville, Kentucky.

At hearing, Inspector Ray Cartwright and Inspector Jeremy Walker testified for the Secretary. WCC Miners Shane Armstrong, Brandon Beach, and Patrick Scott were also called by the Secretary and testified. Mine Foreman Merle Carter, Mine Manager Gary Thweatt and Safety Director Chris Gunn testified for Webster County Coal. I have reviewed the evidence and testimony at length, and for the reasons that follow I **AFFIRM** the underlying violation and S&S designation as alleged and increase WCC's negligence from moderate to high. However, I find

[1] At hearing, the Secretary moved to modify the citation to allege high negligence. See Secretary's Post-Hearing Brief (Sec'y Br.) at 10; Tr. 104-05.

that the Secretary failed to establish that the violation merited a special assessment. I assess a civil monetary penalty of **$20,000**.

I. FINDINGS OF FACT AND SUMMARY OF TESTIMONY

The Dotiki Mine is an underground bituminous coal mine located in Clay, Kentucky, and operated by Webster County Coal, LLC. On September 28, 2015, contract miner Aaron Rickard was replacing suction hoses on his side of a roof bolter when a large rock fell onto him and struck him on the back and hip. Tr. 157-58. Rickard sustained serious injuries, including a displaced hip, lacerated spleen, torn urethra, three broken vertebrae, and internal bleeding. Tr. 297. Miner Shane Armstrong, Rickard's pin buddy, witnessed the rock fall on Rickard before he could suggest backing up the roof bolter. Tr. 158. Armstrong believed that Rickard was dead until he saw him move his head. Tr. 171-72. Unable to move the rock off of Rickard by himself, Armstrong used a five-foot pry bar to lift the rock and allow Rickard to crawl out from under it. Tr. 159. He then left Rickard to get help. Tr. 160.

Armstrong located Mine Foreman Merle Carter and informed him of the incident.[2] When Carter arrived at the scene, he found Rickard kneeling under the ATRS of the roof bolter. Tr. 220. Carter saw the large rock on the roof bolter and assumed that the rock fell and struck Rickard, though he did not know exactly where the rock made contact. Tr. 235. Carter did not discuss the specifics of the accident with Rickard or Armstrong, and was apparently unaware that Armstrong pried Rickard loose prior to getting help. Tr. 225. Rickard remained conscious and complained of pain to his back and stomach. Tr. 224. Carter moved Rickard to protect him from other potential falls and performed a brief physical examination. Tr. 221-22. He tested Rickard's alertness, squeezed his fingertips to check capillary refill, and began feeling around for signs of physical damage. Tr. 222. Carter noticed that Rickard had an obvious hip injury, but he could not tell whether it was a deformity or swelling. Tr. 222-23. Because Rickard was talking, exhibited no breathing issues, and presented stable vital signs, capillary refill, and skin color, Carter did not believe that the injuries were serious. Tr. 222, 224. He was aware of the requirement to call MSHA under § 50.10(b), but did not believe it was necessary in this instance. Tr. 233.

Nonetheless, Carter decided to radio for Rickard to be evacuated from the mine and transported by Life Flight, a type of air evacuation, to Deaconess Hospital in Evansville, Indiana. Tr. 223-24. Carter testified that he chose to arrange Life Flight to ensure that Rickard reached the hospital quickly and avoided additional pain associated with ground travel from the mine. Tr. 223. He quickly moved Rickard on to a stretcher and into an ambulance to evacuate the mine. Tr. 227.

Miners Brandon Beach and Patrick Scott rode with Rickard and Carter in the ambulance to the mine surface. Beach testified that he was instructed to keep conversation with Rickard and note any changes to his condition. Tr. 180. He recalled that Rickard was awake and conscious

[2] Carter was the Rotating Mine Foreman at the time of Rickard's accident. Tr. 218. He has worked at Dotiki for approximately 27 years and has been a certified EMT for approximately 22 years. *Id.*

throughout the 15 to 20 minute ride to the mine surface. Tr. 180. Though he has no medical or EMT training, Beach could tell that Rickard's hip was damaged, and noted that Rickard kept placing his hand on his backside to indicate where he was in pain. Tr. 179-80. He did not believe the injury to be life threatening. Tr. 179, 182. Beach saw the rock that struck Rickard and estimated that the rock was about the size of a table, but could not testify to its thickness. Tr. 178.

Patrick Scott performed a secondary examination of Rickard during the ambulance ride.[3] Scott immediately noticed that Rickard's left foot was turned outward, an indication of a hip or pelvic injury, but testified that he could not determine the precise injury. Tr. 189. Scott checked Rickard's vitals and examined for signs of internal bleeding and potential shock. Tr. 189. He noted that Rickard's heart rate was elevated, but that his blood pressure and oxygen levels appeared normal. Tr. 191-92. Scott was unsure whether Rickard's elevated heart rate was the result of the high amount of pain or a sign of internal injuries. Tr. 191-92. Scott examined Rickard's abdomen to check for internal bleeding. Tr. 193. While Scott stated that Rickard did not exhibit obvious signs of internal bleeding, he testified that he could not definitively rule out the possibility. *Id.* Though he knew that pelvic injuries had the potential to be life-threatening, Scott considered Rickard to be in stable condition. Tr. 191, 194.

Scott next treated Rickard for potential shock despite no outward signs of the condition. Tr. 192. Rickard remained fully conscious throughout his preliminary treatment and evacuation, possessed normal skin coloring, and exhibited no sudden changes in condition. *Id.* He placed Rickard on oxygen and covered him with a blanket while Beach and Carter continued talking to him. Tr. 205. Upon finishing his examination, Scott determined that Rickard's vitals were stable and that the injury was serious but not life-threatening. Tr. 211, 223-24, 228. The time from the injury to reaching the surface appeared to be about 30 to 40 minutes. Tr. 227-28. Rickard was flown to Deaconess Hospital in Evansville, Indiana, the closest trauma center to the Dotiki Mine. Tr. 272. He would later be transferred to Nashville, Tennessee for additional surgery. Tr. 99.

Dotiki's management learned about the injury shortly after Rickard was transported to Deaconess Hospital. General Manager Gary Thweatt was not present at the mine at the time of the accident but received reports of the accident at home. He testified that he was informed that Rickard sustained a hip injury and his vitals were stable. Tr. 280.[4] Thweatt traveled to Deaconess Hospital on the night of the accident to provide support to Rickard's family. Tr. 270. He testified that he learned that Rickard required surgery and was stable, but did not glean additional details pertaining to Rickard's specific injuries. Tr. 277-78. Thweatt did not overhear any information relating to the severity of his injuries, and did not get the impression that Rickard's condition was life threatening. Tr. 283. Furthermore, Thweatt believed that Rickard was not in a life-threatening situation because he was in the hospital and had already undergone

[3] Scott has been a miner for eight years and an EMT for over ten years. Tr. 185. He has responded to between 20 and 25 calls while working for Webster County Coal. Tr. 196-97.
[4] Thweatt has been the General Manager at Dotiki since 2012, and has been a certified EMT and EMT instructor since 1997. Tr. 259-61. He has also served as Assistant General Manager, Safety Director, and Assistant Safety Director since beginning work at Dotiki in 2003. *Id.*

initial surgery. Tr. 327-28. He remained at the hospital until around midnight when Deputy Safety Director Jake Quisenberry arrived. Tr. 281.

Chris Gunn, Safety Director at Dotiki, learned of the accident on the morning of September 29, 2015 when he awoke to missed calls and text messages from Gary Thweatt and Jake Quisenberry.[5] Tr. 334. Gunn was aware that Rickard had undergone surgery for internal injuries but testified that he never believed the injury had the reasonable potential to cause death. Tr. 384, 387. Gunn testified about his internal investigation into the accident. Tr. 353-54. He also testified to his role in Inspector Cartwright's Part 50 Audit. Tr. 353-54. The Part 50 Audit was conducted after an unrelated fatality at the Dotiki Mine, and was completed after the instant citation was issued and specially assessed.[6] Specifically, Gunn testified that many of the citations issued pertained to a miscommunication with a contractor nurse, who mistakenly believed that injuries treated with dermabond were not reportable under the Mine Act. Tr. 347-49.

WCC did not inform MSHA of the accident at any point on the day of the injury. MSHA Inspector Jeremy Walker discovered the accident on September 29 by word of mouth.[7] He began looking on various social media sites to verify the occurrence and discovered that Rickard's girlfriend had posted a brief description and updates relating to the accident on Facebook. Tr. 63-64; Ex. 4. Walker informed his supervisor, who called Dotiki and confirmed the accident. Tr. 65. On September 30, Inspector Walker visited Dotiki to conduct an accident investigation. *Id.* He interviewed the miners that were present at the time of the accident. Tr. 71. Walker found that Dotiki had already removed the rock from the accident scene and had continued mining in the area. Tr. 122.

On October 1, 2017, Inspector Walker issued Citation No. 9045176 alleging a violation of 30 C.F.R. § 50.10(b) for failing to contact MSHA within 15 minutes after discovering that Rickard's injuries had the reasonable potential to cause death. Ex. 7. Walker designated the citation as a Significant and Substantial (S&S) violation that was reasonably likely to result in fatal injuries and the result of Webster County Coal's moderate negligence. Tr. 103-104. At hearing, Walker testified to increase WCC's negligence from moderate to high because he later learned that Gary Thweatt visited the hospital and thus believed that WCC had additional opportunities to contact MSHA but continually failed to do so. Tr. 104-05. WCC abated the

---

[5] Chris Gunn has worked at Dotiki Mine for 20 years and is a certified Mine Emergency Technician. Tr. 331-32. He has been Safety Director at Dotiki since 2011. Tr. 332.

[6] Prior to the hearing, WCC filed a motion in limine to exclude the citations because they were irrelevant to the issue now before the court. On February 8, 2017, this court held that the Secretary may admit evidence and testimony relating to the Audit limited to the citations that were accepted and pertained to events that occurred prior to the September 28, 2015 accident at issue in this case. *See* Order Denying Respondent's Motion in Limine to Exclude the Secretary's Evidence and Testimony Related to the Part 50 Audit of the Dotiki Mine.

[7] Inspector Jeremy Walker worked at Dotiki Mine from 2002 to 2011. Tr. 59. Walker has been a certified EMT since 1999. Tr. 60. He also used to be an EMT instructor and a member of the federal mine rescue team. Tr. 62. He has been a mine inspector for MSHA since 2011, and an accident investigator since 2013. Tr. 61-62.

citation when it notified MSHA of the accident on October 5, 2017. Ex. 7.

II. PARTY ARGUMENTS

The Secretary argues that the Respondent violated section 50.10(b) because WCC failed to contact MSHA within 15 minutes of learning that Rickard's injuries had the reasonable potential to cause death. Secretary's Post-Hearing Brief (Sec'y Br.) at 3. The Secretary asserts that Carter and Scott should have notified MSHA because they examined Rickard, immediately noticed the serious injury to his hip, and treated him for potential shock. Sec'y Br. at 6. Furthermore, the Secretary alleges that WCC's decision to call in air evacuation indicated that mine management knew that Rickard sustained serious injuries, and nonetheless chose not to call MSHA within the requisite 15 minutes. *Id.* at 6-7.

The Secretary contends that the violation was S&S because it deprived MSHA of the opportunity to fully investigate the cause of the accident, thus exposing miners to potential uncorrected hazardous conditions. Sec'y Br. at 10. At hearing, the Secretary argued to modify the citation's negligence designation from moderate to high because WCC repeatedly failed to notify MSHA even after receiving additional information that spoke to the severity of Rickard's injuries. *Id.* at 11-12. The Secretary believes that WCC failed to report the accident to MSHA following Carter's initial assessment, again when he decided to radio for Life Flight after learning the rock landed on Rickard, and yet again when Gary Thweatt discovered that Rickard would need additional surgeries. *Id.* at 13. Finally, the Secretary asserts that the violation warrants a special assessment due to WCC's admitted history of underreporting accidents at the Dotiki Mine. *Id.* at 14.

The Respondent argues that the citation should be vacated because Rickard's injury did not have the reasonable potential to be fatal. Respondent's Post-Hearing Brief (Resp. Br.) at 9. While WCC concedes that it did not notify MSHA within 15 minutes after assessing the injury, it contends that Rickard's injuries did not constitute an "accident" as defined by the Act because the injury did not have the reasonable potential to cause death. *Id.* at 10. Specifically, WCC contends that its miners were certified EMTs that properly evaluated Rickard and reasonably determined him to be stable given the facts readily available at the time of the injury. *Id.* at 13-16. WCC asserts that the fact that Rickard was transported via air and was hospitalized do not automatically trigger the reporting standard, and that the mechanism of injury and Rickard's actual condition did not carry a reasonable potential to cause death. *Id.* at 19.

Even if WCC is found to have violated section 50.10(b), WCC argues that the injury was neither S&S nor the result of high negligence. Resp. Br. at 9. WCC contests the gravity of the violation because the failure to immediately report the injury did not contribute to the existence of the hazard of the falling rock that caused the injury at issue. *Id.* at 24. Furthermore, WCC claims that preservation of the accident scene provided little value in preventing similar injuries because the rock fell in an area with an unsupported top inby the t-bar, and only struck Rickard because he was replacing suction hoses on the side of the roof bolter. *Id.* WCC argues that its negligence should be modified to low because Carter and Scott made a reasonable and thoughtful decision regarding the reporting requirement and provided exemplary medical care to Rickard while he remained underground. *Id.* at 25. Finally, WCC argues that the Secretary failed to

provide adequate support for a special assessment because Inspector Walker did not consider the results of the Part 50 Audit in recommending the special assessment, and because the Part 50 Audit revealed a history of underreporting occupational injuries under § 50.20, and thus was not considered in or relevant to the assessment process. *Id.* at 28-29.

III. ANALYSIS

A. The Violation

The cited standard 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:
>
> (b) An injury of an individual at the mine which has a *reasonable potential* to cause death.

30 CFR § 50.10(b) (emphasis added).

Section 50.10(b) requires operators to make a prompt determination of whether an accident has occurred. *Consolidation Coal Co.*, 11 FMSHRC 1935, 1938 (Oct. 1989). The provision allows the operator a reasonable opportunity to investigate the accident before the 15-minute clock begins to run, but the opportunity must be exercised in good faith and tempered with the need to immediately notify MSHA once it is clear that a reportable accident has occurred. *Wolf Run Mining Co.*, 35 FMSHRC 3512, 3517 (Dec. 2013). The Commission has held that "the decision to call MSHA cannot be made upon the basis of clinical or hypertechnical opinions as to a miner's chance of survival. The decision to call MSHA must be made in a matter of minutes..." *Cougar Coal Co.*, 25 FMSHRC 513, 632 (Sept. 2003). Thus, readily available information such as the nature of the accident, which entails the hazard itself and observable indicators of injury or trauma, is highly relevant in determining whether an injury is reportable. *Signal Peak Energy, LLC*, 37 FMSHRC 470, 476 (Mar. 2015). The operator, in making the determination whether to notify MSHA under 30 C.F.R. § 50.10, must resolve any reasonable doubt in favor of notification. *Id.* at 477.

WCC's decision not to notify MSHA of the accident was unreasonable given the readily available information concerning the cause and observable indicators of Rickard's injuries. A reasonable miner would have recognized that the accident had the reasonable potential to cause death and immediately reported it to MSHA within the requisite 15 minutes.

The nature of Rickard's accident was a crushing-type injury to the pelvic area caused by a large rock that fell from the roof of the mine. By all accounts, the rock that struck Rickard was approximately twelve inches thick and large enough to cause serious injury or death. Tr. 158, 221, 234. The rock fell from between eight and ten feet, the standard height of the roofs throughout the Dotiki Mine. Tr. 86. Armstrong testified that the rock landed and came to rest on Rickard. Tr. 159. He was unable to lift the rock on his own. Tr. 172. He had to use a five-foot

pry bar to move the rock sufficiently to allow Rickard to crawl out from under it. *Id.* The contact was so severe that Armstrong believed that Rickard was dead until he saw Rickard move his head. *Id.* at 171.

It was readily apparent that a crushing-type injury may have occurred. Even those WCC miners with no medical experience immediately noticed that Rickard's hip was damaged. Carter and Scott, both certified EMTs, testified that they were unable to identify the exact type of hip injury, raising doubts about the possibility of severe internal injuries.[8] Tr. 222-23. The cause and extent of the injury was readily apparent, and Carter and Scott acknowledged that a hip injury was potentially life-threatening. Tr. 193-94, 234. Carter testified that the size of the rock posed a risk of a serious crushing injury if it came to rest on Rickard. Tr. 234. Rickard was complaining of back and stomach pains, indicating that the damage extended beyond his visible hip injury. Tr. 224. Upon learning this information, a reasonable miner would have realized that the accident had the reasonable potential to cause death and thus known to notify MSHA as required under § 50.10(b).

I find that WCC violated section 50.10(b) when Carter opted not to notify MSHA within 15 minutes after his initial assessment of Rickard's injuries. Carter was Rotating Foreman, and therefore responsible for the entire mine at the time of the accident, and possessed the authority to notify MSHA of the accident. Tr. 228-29. He was aware of the Part 50 reporting requirements and had notified MSHA under the standard in the past. Tr. 232-33, 237-38. He was the first member of management to arrive at the scene and the first certified EMT to examine Rickard. The scene was undisturbed, and both Rickard and Armstrong were available to answer any questions regarding the cause or details of the accident. Given Carter's authority and experience and the nature of the accident, I find that a similarly situated reasonable miner would have assessed Rickard's injuries and the scene of the accident and determined that Rickard had likely sustained serious and reportable internal injuries.

WCC asserts that Carter's preliminary assessment of Rickard indicated that he was stable and that its decision not to notify MSHA was therefore reasonable. I disagree. Section 50.10(b) requires merely that the injury has the *reasonable potential* to cause death, not that the injury is actually life-threatening. *See Red River Coal Co.*, 39 FMSHRC 368, 393 (interpreting the Commission's decision in *Signal Peak*, 37 FMSHRC 470, 474 (Mar. 2015) to apply a common sense approach to what constitutes a "reasonable potential to cause death."). The provision therefore requires a reasonable possibility that an injury may be fatal to trigger the requirement. With this in mind, I find that the fact that Rickard was conscious, alert, and that his initial vitals were stable do not overcome two important factors that should have prompted the Respondent to report the accident.

First, the readily observable nature of Rickard's injuries and his own comments indicated

---

[8] Section 50.10(b) does not require operators to wait to determine the exact injury that occurs after an accident. *See Cougar Coal Co.*, 25 FMSHRC at 632. However, the fact that Carter and Scott noted an obvious hip injury but could not determine whether the injury was a swelling, deformity, or a displacement or the like indicated a reasonable doubt regarding the severity and implications of the injury.

the potential existence of serious internal injuries. Carter observed the size of the rock and immediately noted damage to Rickard's hip and pelvic area, in close proximity to vital organs. Although Rickard remained conscious and responsive, he complained about back and stomach pains, neither directly related to his hip. Tr. 222-24. These comments should have indicated the reasonable likelihood of undetectable internal injuries, and indeed, Rickard sustained severe internal injuries that went undetected until he arrived at the hospital. At the very least, the readily apparent information at the accident scene should have prompted WCC to resolve its doubts in favor of notification. *See Signal Peak Energy, LLC*, 37 FMSHRC at 477.

Second, the discrepancy over whether or not Carter was aware that the rock fell on top of Rickard indicates that his assessment of the nature of the injury was incomplete and therefore unreasonable. When Carter arrived at the scene, the rock was no longer on top of Rickard, and Carter apparently assumed that the rock merely struck him and did not land on him. Tr. 234-35. He did not recall asking Armstrong how the rock struck Rickard. Tr. 235. Armstrong however, credibly testified that Carter asked him if he moved the rock off of Rickard when he arrived at the scene. Tr. 161. Carter stated that had he known that the rock fell on Rickard, he would have reported the injury to MSHA for fear of a life-threatening crushing injury. Tr. 234.

It is undisputed that the rock landed on top of Rickard and had to be pried off of him. Regardless of whether Carter knew that the rock rested on Rickard or simply failed to ascertain that fact, it is clear that the information was readily available and would have impacted his decision to call MSHA. At the very least, Carter should have assumed that a crushing-type injury was a distinct possibility, and asked either Rickard or Armstrong to specify precisely what happened or assumed that a crushing type injury occurred. To fail to determine the available details of the accident while performing a medical examination is inherently unreasonable.

Inspector Walker testified that Carter also should have notified MSHA after his decision to radio for Life Flight. Tr. 397-98. He believed that Carter's decision to call for air evacuation indicated that his assessment of the accident had increased from stable to critical. Tr. 398. While I find Inspector Walker's testimony to be credible on the whole, I do not credit this assumption. Walker admitted that Carter never explicitly told him that he made the call to Life Flight because his assessment of the accident had changed. Tr. 411. Walker testified that this was merely an assumption based on Carter's actions. *Id.* I credit Carter's testimony that he radioed for Life Flight to ensure that Rickard reached the hospital as quickly and comfortably as possible, not because he believed the accident was life-threatening. Tr. 223.

Additionally, I do not find that the use of Life Flight automatically triggers the reporting requirement. Life Flight is intended for serious injuries, but it is also the best way to ensure rapid and comfortable transportation for injured miners, regardless of whether their life is at stake. Section 50.10(b) does not specify the conditions required for an injury to carry the "reasonable potential to cause death," and to read use of Life Flight into that definition may deter operators from employing what is a safe and effective method of emergency transportation.

Next, Inspector Walker alleged that WCC should have notified MSHA once Patrick Scott began treating Rickard for potential shock. Tr. 100. Walker testified that an EMT would not normally treat a patient for shock unless the patient exhibited signs of shock. Tr. 136. I decline

to find that the decision to treat an injured miner for potential shock automatically triggers the reporting standard in § 50.10(b). Although the onset of shock has a reasonable potential to cause death, merely treating for the possibility of shock does not elevate the severity of the injury in itself. Scott testified that Rickard did not exhibit symptoms of shock during his examination, but he administered treatment for potential shock, such as providing a blanket and oxygen, to ensure Rickard's comfort, and would do the same for any injury for which shock remained a distinct possibility. Tr. 192. He noted Rickard's injury could have been life-threatening and that while he checked Rickard for symptoms of internal bleeding he could not definitively rule out the possibility. Tr. 193. I credit Scott's testimony that Rickard did not exhibit any outward signs of shock and that his decision to treat for potential shock was to err on the side of caution and also to keep Rickard as comfortable as possible during his evacuation to the mine surface. Tr. 211. Though WCC should have already notified MSHA after Carter's assessment, Scott's decision to treat for shock does not in itself suggest that WCC knew Rickard's injury had the potential to cause death.

Even assuming that WCC's initial assessment of Rickard's injury was reasonable, I find that WCC knew or should have known that Rickard's condition merited contacting MSHA when Gary Thweatt learned of Rickard's need for surgery and internal injuries the night of and the day after the accident.[9] Tr. 259-61. On the night of the accident, Dotiki contacted Thweatt and told him that Rickard sustained a hip injury, that his vital signs were stable, and that Rickard was being flown to the nearest trauma center in Evansville. Tr. 272. Thweatt traveled to Deaconess Hospital and introduced himself to Rickard's family, but testified that they had no additional information regarding his condition at that time. Tr. 275. Thweatt overheard the doctor inform the family that Rickard would need additional surgery and was stable, but did not learn any specific details at that time. Tr. 279.

Thweatt testified that he learned more about the details of Rickard's accident and injuries the following day. He knew that the rock was large enough to kill or seriously injure a miner, and learned that the rock fell and pinned Rickard against the ATRS. Tr. 301. He also learned of Rickard's lacerated urethra and that Rickard needed multiple surgeries. Tr. 298-300. I find Thweatt's testimony on these points to be inconsistent. Thweatt testified that he knew of the lacerated urethra the day after the accident, but walked back that testimony to state that he was unsure that he ever got all of the details concerning Rickard's condition. Tr. 298-300. It is unlikely that Thweatt, the General Manager of Dotiki Mine, was only informed of some of Rickard's serious injuries but remained in the dark about others. I find it probable that if Thweatt knew about the lacerated urethra, he likely knew or should have known of Rickard's other serious internal injuries and made the decision to notify MSHA.

Nevertheless, Thweatt did not notify MSHA after learning this additional information

[9] I wish to emphasize that I do not find WCC or Mr. Thweatt's decision to travel to a hospital in support of an injured miner as evidence of knowledge that an injury has the potential to cause death. I commend and encourage providing miners and their families support during difficult times. However, information learned in this context can and should inform an operator's decision to notify MSHA if it leads mine management to believe that an injury has the reasonable likelihood to be fatal.

because Rickard was already in the hospital having surgery. Tr. 298. In fact, WCC did not notify MSHA as required under the standard until after Inspector Walker issued the citation on October 1, three days after Rickard's accident. Tr. 303. I find it unlikely and unreasonable that, after commencing an investigation and learning more about Rickard's injuries, Thweatt was not aware that his condition merited notifying MSHA. Thweatt clearly explained his understanding of the accident, what he remembered of the details of Rickard's injuries, and his knowledge that Rickard was airlifted to Nashville for multiple surgeries. Tr. 319.

WCC argues that Thweatt did not learn of the severity of Rickard's injuries until after he had undergone surgery, and thus the injuries were repaired and no longer posed a reasonable potential for death. Resp. Br. at 21. While this may be true, the fact remains that WCC did not call MSHA until well after the disputed citation was issued. Thweatt learned of the extent and specifics of the accident by September 30 and still did not report the accident to MSHA as required by the standard. I find it unreasonable that neither Carter nor Thweatt, in their capacities as EMTs and authority figures at the mine, took it upon themselves to fully understand the accident or to err on the side of caution and notify MSHA of the accident based on what they understood about Rickard's condition. Even after receiving significant detail regarding the incident and talking with MSHA the following day, WCC still failed to fulfill their obligation under § 50.10(b) until October 5, well after the citation was issued on October 1. Tr. 305-06; Ex. 7.

WCC cites ALJ Manning's decision in *Newmont USA Limited*, 32 FMSHRC 391 (Apr. 2010) (ALJ) to argue that the citation should be vacated. In *Newmont USA Limited*, MSHA alleged a violation of section 50.10(b) when an employee sustained a fractured leg from being run over by a haul truck. *Id.* at 934. The Secretary alleged that the fractured femur had a reasonable potential to cause death because of risks inherent with hospitalizations and complications in surgery. *Id.* ALJ Manning found that Newmont was entitled to summary decision and vacated the citation because the risk of death from surgery or hospitalization was too remote from the leg injury itself and that the regulation did not require mine operators to report every injury that required off-site emergency care. *Id.* at 396.

I find the present facts distinguishable from those in *Newmont*. The nature of Rickard's injury was significantly more serious than the miner's broken leg in *Newmont*. A crushing injury to the pelvic area carries a high risk of internal injury and damage to vital organs. This risk is inherently more likely to cause death than a broken leg. Furthermore, in *Newmont*, at no time did the EMT believe that the miner suffered an injury with the reasonable potential to cause death. *Id.* at 396. Here, both Carter and Scott admitted that injuries on or near the pelvic area could result in such injuries, and only changed their minds after checking Rickard's vital signs and without considering the possibility that a crushing injury had occurred. Tr. 194, 234. As noted by the Respondent, their decision not to notify MSHA was carefully and cautiously considered, thus indicating some uncertainty to whether Rickard's injury had the potential to be fatal. Resp. Br. at 25. Carter and Scott's examinations, while instructive, did not alleviate doubt that Rickard was bleeding internally or had severe internal injuries. Rickard's hip injury was immediately noticeable, and the size of the rock, the height from which it fell, and the fact that it had to be pried off of Rickard all indicate an injury with the potential to cause death.

For the reasons discussed above, I find that WCC violated § 50.10(b) when Carter opted not to call MSHA within 15 minutes of examining the scene of the accident and Rickard's sustained injuries and when Thweatt learned of Rickard's specific injuries the day after the accident.

B. Significant and Substantial (S&S)

A violation is significant and substantial (S&S), "if based upon the particular facts surrounding the violation there exists a reasonable likelihood that the hazard contributed to will result in an injury or illness of a reasonably serious nature." *Cement Division, National Gypsum Co.*, 3 FMSHRC 822, 825 (Apr. 1981).

In order to uphold a citation as S&S, the Commission has held that the Secretary of Labor must prove: (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 in question will be of a reasonably serious nature. *Mathies Coal Co.*, 6 FMSHRC 1, 3-4 (Jan. 1984).

The Commission has held that the second element of the *Mathies* test addresses the extent to which a violation contributes to a particular hazard. *Newtown Energy, Inc.*, 38 FMSHRC 2033, 2037 (Aug. 2016). Analysis under the second step should thus include the identification of the hazard created by the violation and a determination of the likelihood of the occurrence of the hazard that the cited standard is intended to prevent. *Id.* at 2038. At the third step, the Secretary must prove there was a reasonable likelihood that the hazard contributed to by the violation will cause an injury, not a reasonable likelihood that the violation, itself, will cause injury. *West Ridge Resources, Inc.*, 37 FMSHRC 1061, 1067 (May 2015) (ALJ), citing *Musser Eng'g, Inc.*, 32 FMSHRC 1257, 1280-81 (Oct. 2010). Evaluation of the four factors is made assuming continued normal mining operations. *U.S. Steel Mining Co.*, 6 FMSHRC 1573, 1574 (July 1984).

As an initial matter, the Commission has held that violations of section 50.10 are mandatory standards to which S&S designations are applicable. *See Red River Coal Co., Inc.*, 39 FMSHRC 368, 392 (Feb. 2017) (ALJ) (citing *Signal Peak Energy, LLC*, 37 FMSHRC 470, 479 (Mar. 2015). Thus, the first prong of the *Mathies* test is satisfied.

The specific hazard posed by section 50.10(b) is the preclusion of MSHA's ability to investigate the cause of Rickard's accident. The Commission has held that in cases where rescue efforts are not concerned, Section 50.10 is intended to facilitate MSHA's ability to investigate and remedy the cause of an accident. *See Signal Peak*, 37 FMSHRC at 480. Thus, failure to report a potentially fatal accident creates a discrete safety hazard because it precludes MSHA's investigatory role in determining and remedying the cause of the accident. *Id.* Here, Rickard's injury posed two concerns: the stability of the roof of the Dotiki Mine and whether Rickard's decision to repair the suction hose prior to backing up the roof bolter was an isolated occurrence. WCC failed to notify MSHA of the accident, removed the rock that injured Rickard, and continued to mine in the accident area shortly thereafter. Tr. 122. WCC thus prevented MSHA

from investigating Dotiki's roof conditions and roof bolting procedures and determining whether Rickard's accident was an isolated occurrence or part of a widespread problem that put miners at risk and merited additional remedy.

The preclusion of MSHA's investigatory role is reasonably likely to expose miners to uncorrected hazardous conditions or behaviors. The failure to report the injury prevented MSHA from investigating and remedying potentially adverse roof conditions in the mine and ensuring that Dotiki's miners were following proper safety procedures while operating machinery. WCC contends that the hazard was unlikely to result in an injury because the rock fell from an area of unsupported top, and only struck Rickard because he was repairing suction hoses by the roof bolter's t-bar. Resp. Br. at 24. The record indicates, however, that miners were already taking shorter cuts due to adverse roof conditions in Dotiki, and that WCC continued to mine in the same area shortly after Rickard was evacuated from the mine. Tr. 83-84, 122. Furthermore, Thweatt testified that Rickard's decision to try to repair the suction on the roof bolter without backing up was not typical, suggesting that proper safety procedures may not have been followed. *See* Tr. 301-02. Thus, the hazard of precluding MSHA's investigatory ability was reasonably likely to result in an injury in the context of continuous mining operations because it prevented implementation of additional safety measures and exposed miners to uncorrected hazards.

Finally, exposure to dangerous roof conditions is reasonably likely to result in a serious injury similar to Rickard's. Rock falls of roughly the same size and from the same height as the one that impacted Rickard are likely to result in serious crushing injuries. Accordingly, I affirm the Secretary's S&S designation.

C. Negligence

Inspector Walker initially designated the violation as the result of WCC's moderate negligence, but moved to modify the citation to high negligence at hearing. Sec'y Br. at 10; Tr. 104-05. The Secretary argues that the violation was the result of WCC's high negligence because it failed to report the accident to MSHA on multiple occasions, namely after Carter's decision not to contact MSHA following his initial assessment and decision to radio for Life Flight, after Carter learned that the rock fell on to Rickard and posed a potential crushing injury, and after Thweatt visited the hospital and learned that Rickard's injuries required surgery. Sec'y Br. at 12-13; Tr. 403-04, 411-12, 420-22.

WCC argues that it exhibited low negligence because it provided exemplary medical care to Rickard and its decision not to immediately report the injury was a conscious and reasonable one made with thoughtful consideration. Resp. Br. at 25.

I find that WCC was highly negligent in its repeated failure to notify MSHA of the accident. Under the Mine Act, operators are held to a high standard of care, and "must 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." 30 C.F.R. § 100.3(d). High negligence occurs when the operator "knew or should have known of the violative condition and there are no mitigating circumstances." 30 CFR § 100.3: Table X. Moderate

negligence occurs when the operator "knew or should have known of a violative condition or practice, but there are mitigating circumstances." *Id.*

The Commission has held that the operator, in making the determination whether to notify MSHA under 30 C.F.R. § 50.10, must err on the side of caution and resolve any reasonable doubt in favor of notification. *Signal Peak Energy, LLC*, 37 FMSHRC 470, 477 (Mar. 2015). Carter and Scott testified that injuries to the hip area could be potentially fatal and that while Rickard's vital signs were stable, they could not precisely identify the injury to his hip or foreclose on the possibility of serious internal injuries. Tr. 194, 235. Yet inexplicably, WCC opted not to notify MSHA in spite of these doubts. As discussed in detail above, Carter was clearly aware of the reporting requirement and should have known, given the readily available evidence, that Rickard's injury had the potential to cause death. Carter did not properly assess the scene of the accident and the mechanism of the injury, which in combination indicated that Rickard sustained a potential crushing injury to his pelvic region. Carter should have known that Rickard was pinned under the rock, and should have notified MSHA immediately once he learned that the rock landed on Rickard and pinned him to the ATRS. Carter testified that such knowledge would have led him to contact MSHA for fear of a serious crushing injury, and yet upon learning that information, he still did not contact MSHA. Tr. 235.

Furthermore, Thweatt's decision not to contact MSHA after being notified that Rickard had to undergo additional surgeries and was eventually air lifted to Nashville exacerbates WCC's negligence. It is at this point that WCC certainly learned of Rickard's serious internal injuries. The details of Rickard's serious injuries conflicted with WCC's initial assessment of Rickard and should have prompted an immediate call to MSHA. However, WCC again failed to report the accident for a number of days and until Inspector Walker issued his citation on October 1, at which point MSHA was unable to conduct any investigation of the accident scene.

I acknowledge that WCC's rapid and thorough response to Rickard's injury was commendable but its efforts in this regard do not mitigate its negligence. Throughout the treatment of Rickard there remained a reasonable doubt as to the severity of Rickard's injuries and there is no dispute that mine management was aware of the reporting requirement. Mine management continued to assume that Rickard's stable vitals foreclosed the need for notification despite learning additional details regarding his injuries. I thus find that WCC was highly negligent in its repeated failure to contact MSHA under section 50.10(b), even after learning that Rickard had severe internal injuries and required extensive surgery.

D. Penalty

It is well established that Commission administrative law judges have the authority to assess civil penalties de novo for violations of the Mine Act. *Sellersburg Stone Company*, 5 FMSHRC 287, 291 (March 1983). The Act requires that in assessing civil monetary penalties, the Commission ALJ shall consider the six statutory penalty criteria:

> (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).

These criteria are generally incorporated by the Secretary within a standardized penalty calculation that results in a pre-determined penalty amount based on assigned penalty points. 30 CFR 100.3: Table 1- Table XIV. If the conditions of the violation so warrant, the Secretary may waive the regular assessment under § 100.3(a) and specially assess a penalty. 30 C.F.R. § 100.5(a). The special assessment must also be based upon the six criteria outlined above, and all findings must be in narrative form. 30 C.F.R. § 100.5(b).

I find that the Secretary failed to establish that the violation merited the proposed special assessment. The Secretary primarily argues that WCC demonstrated a "pattern of conduct" in failing to report or underreporting violations that would only be deterred by upholding the specially assessed penalty. *See* Sec'y Br. at 14-15. The Secretary offered a Part 50 Audit conducted after an unrelated fatality occurred at the Dotiki Mine in early 2016. Tr. 17-18; Ex. 10. For the following reasons, I find the audit to be of minimal evidentiary value and do not believe that it justifies the proposed special assessment.

First, the audit alleges numerous § 50.20 violations for failing to report occupational injuries or illnesses but does not allege any § 50.10 violations. *See* Ex. 10. Section 50.10 is triggered under vastly different circumstances and permits the operator much less time to comply with the requirement. *See* 30 C.F.R. § 50.10 (requiring the operator to call MSHA's hotline within 15 minutes); § 50.20(a) (requiring the operator to mail the completed injury forms within 10 working days). Evidence of WCC's failures to report occupational illnesses or injuries does not prove or support the assertion that WCC likewise consistently failed to report injuries with the reasonable potential to cause death.

Additionally, neither MSHA nor Inspector Walker considered the Part 50 Audit when recommending and proposing the special assessment. Tr. 426-28. MSHA initiated the Part 50 Audit well after the issuance of the instant citation, and the Secretary had already issued the proposed special assessment when the audit was completed. Tr. 17-18, 26-27. Inspector Walker testified that he based his recommendation for special assessment on the facts of the citation and that the Part 50 Audit offered played no part in his decision. Tr. 425-26. In fact, he was not involved in the audit procedure at all. *Id.* Yet the Secretary submitted the Part 50 Audit as evidence for the special assessment without addressing why either its post hoc citations or Inspector Walker's findings merited a special assessment in this case. *See* Sec'y Br. at 14-15. I therefore do not find the Part 50 Audit to support the proposed special assessment and assign WCC's violation history minimal weight.

Inspector Walker testified that he recommended the special assessment in light of the mechanism of Rickard's injury and because Carter, as an EMT and Rotating Foreman, should have known that the situation required immediate notification to MSHA after radioing Life Flight. Tr. 430-31; 439. As discussed above, WCC violated the standard after Carter's initial

assessment, but that his decision to radio Life Flight should not factor into the violation. I agree that Life Flight is intended for critical situations, but I credit Carter's testimony that his decision to do so was to provide Rickard with the quickest and most comfortable access to the nearest hospital. I decline to penalize WCC for using Life Flight and do not wish to deter the practice when operators determine that it is warranted.

I also decline to find that Carter and Thweatt's EMT certification justifies the special assessment. *See* Tr. 430. EMT certification is undoubtedly useful in assessing injuries and administering treatment in mine accidents. However, it does not raise the standard of care under section 50.10(b). The Commission has held that clinical or hypertechnical opinions are not required to merit notifying MSHA under the standard. *See Cougar Coal Co.*, 25 FMSHRC 513, 521 (Sept. 2003). While EMTs may be able to provide a more specific injury diagnosis than the average miner, their responsibility under section 50.10 remains the same; they must quickly assess whether the injury is severe enough to reasonably conclude there is a potential for the injured miner to die and notify MSHA if that is the case. Holding EMTs to a higher standard would frustrate the immediate notification requirement by encouraging more time-consuming technical examinations of injured miners before making the decision to notify MSHA. *See generally* 25 FMSHRC at 521. While Carter and Thweatt should have been able to determine that Rickard's injuries had a reasonable potential to cause death, their EMT certification is not an aggravating factor that justifies the special assessment. In light of these findings, I vacate the Secretary's proposed special assessment.

Turning now to my independent assessment, I nonetheless hold that the violation is serious and deserves a significant penalty. Based on the following review of the statutory penalty criteria, I assess a penalty of $20,000.

I have already noted that WCC does not have an extensive violation history of § 50.10. Ex. 10. WCC is a large operator and there is no indication that the penalty will have an impact on its ability to continue in business. Neither party raised WCC's size or ability to pay as an issue during the hearing or in post-hearing briefs.

I have discussed my findings regarding gravity in the preceding sections. WCC's failure to notify MSHA of Rickard's injury was S&S and reasonably likely to result in a fatal accident. A violation of § 50.10 precludes MSHA's investigatory abilities and forecloses the possible discovery and remedy of widespread issues in the mine. *Signal Peak Energy*, 37 FMSHRC 470, 480 (Mar. 2015). Here, MSHA was precluded from investigating the existence of unstable or adverse roof conditions in Dotiki Mine and whether proper safety procedures were followed when making equipment repairs or adjustments. Both of these potential issues pose serious threats to miners' safety. Given the severity of Rickard's injuries, any additional injuries caused by WCC's violation of section 50.10 were likely to be serious if not fatal.

WCC's violation was the result of high negligence with no mitigating factors. Carter and Thweatt, both high-ranking members of Dotiki's management, independently failed to notify MSHA of Rickard's accident on multiple occasions. Carter should have notified MSHA after his initial assessment of Rickard which revealed that he may have sustained a crushing injury and certainly when he discovered that the rock fell on to Rickard and had to be pried off of him. *See*

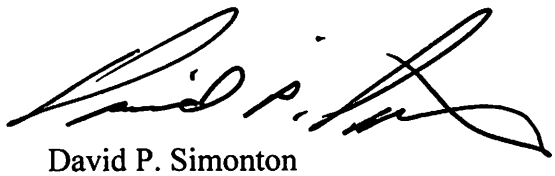
Tr. 161, 234-35. Thweatt should have notified MSHA when he learned that Rickard needed surgery on the night he visited his family at the hospital and again when he subsequently learned of Rickard's internal injuries and of his transfer to Nashville for additional surgeries. *See* Tr. 298-300, 319. Upon learning this information, WCC did not notify MSHA even days after the accident. Tr. 298, 305-06. The failure of one member of Dotiki's mine management, let alone two, to notify MSHA in light of the information progressively gathered during and subsequent to the accident, is inexplicable. Thweatt and Carter's continual failure to notify MSHA demonstrate high negligence and a disregard for the importance and purpose of section 50.10(b).

I do not find that WCC demonstrated good faith in abating the citation. Inspector Walker issued the citation on October 1, 2015, over three days after the accident. Ex. 7. WCC had not called to notify MSHA at that time, and WCC did not terminate the citation until October 5, four days after MSHA issued the citation. *See* Ex. 7; Tr. 305-06. WCC offered no justification or explanation for waiting so long to terminate the citation. I do not consider a four day delay in abatement to be a good faith effort when all that was necessary to abate the citation was to place a brief phone call to MSHA.

The notification requirement of section 50.10 is an important standard that promotes MSHA's role in investigating and remedying the causes of serious accidents. *See Signal Peak Energy*, 37 FMSHRC 470, 480 (Mar. 2015). Any injury that creates a reasonable doubt as to whether it has potential to cause death should trigger the operator's decision to notify MSHA, as compliance with the standard is neither difficult nor time consuming. Given the gravity and negligence of this particular accident and WCC's failure to quickly terminate the citation, I find the Congressionally-prescribed minimum penalty to be an insufficient deterrent for this violation. Considering the above mentioned criteria, I assess a penalty of $20,000.

IV. ORDER

The Respondent, Webster County Coal, LLC, is **ORDERED** to pay the Secretary of Labor the sum of **$20,000.00** within 30 days of this order.[10]



David P. Simonton
Administrative Law Judge

[10] 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

Distribution: (U.S. First Class Mail)

Schean G. Belton, Office of the Solicitor, U.S. Department of Labor, 618 Church Street, Suite 230, Nashville, TN 37219

Tyler H. Fields, Webster County Coal, LLC, 1146 Monarch Street, Lexington, KY 40513