FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

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May 23, 2023

SECRETARY OF LABOR, MINE SAFETY AND HEALTH ADMINISTRATION (MSHA), Petitioner,	CIVIL PENALTY PROCEEDINGS Docket No. WEST 2021-0188 A.C. No. 42-01566-532508
v.	Docket No. WEST 2021-0229 A.C. No. 42-01566-535306
CANYON FUEL COMPANY, LLC, Respondent, &	Docket No. WEST 2021-0254 A.C. No. 42-01566-536066
DEWEY TANNER, employed by CANYON FUEL COMPANY, LLC, Respondent,	Docket No. WEST 2021-0314 A.C. No. 42-01566-540906 A
SHANE ALLRED, employed by CANYON FUEL COMPANY, LLC, Respondent,	Docket No. WEST 2021-0315 A.C. No. 42-01566-540910 A
JAKE WILSON, employed by CANYON FUEL COMPANY, LLC, Respondent,	Docket No. WEST 2021-0317 A.C. No. 42-01566-540907 A
JED GORDON, employed by CANYON FUEL COMPANY, LLC, Respondent,	Docket No. WEST 2021-0318 A.C. No. 42-01566-540908 A
MICHAEL COOPER, employed by CANYON FUEL COMPANY, LLC, Respondent.	Docket No. WEST 2021-0319 A.C. No. 42-01566-540909 A Mine: Skyline Mine #3

DECISION AND ORDER

Appearances: Jason S. Grover, Office of the Solicitor, U.S. Department of Labor, Arlington, Virginia, for the Petitioner

Rebecca Mullins, Office of the Solicitor, U.S. Department of Labor, Arlington, Virginia, for the Petitioner

R. Henry Moore, Esq., Fisher & Phillips LLP, Pittsburgh, Pennsylvania, for the Respondent

Before: Judge Young

SUMMARY

Order No. 8541891, 30 C.F.R. § 75.202(a): Failure to protect from falls of roof, face, and ribs. A rib burst occurred, covering a miner in coal and resulting in injuries.

Fact of violation	Yes	p. 13
S&S	Yes	p. 14
Negligence	Moderate	p. 16
Unwarrantable Failure	No	p. 18
Penalty	$25,000.00	p. 19

Order No. 8541892, 30 C.F.R. § 50.10(b): Failure to immediately notify MSHA following injury of an individual which has a reasonable potential to cause death.[1] Operator did not immediately report a rib burst that buried a miner in coal and caused significant injuries.

Fact of violation	Yes	p. 20
S&S	Yes	p. 33
Negligence	High	p. 35
Unwarrantable Failure	Yes	p. 37
Penalty	$50,000.00	p. 42

Individual Liability under Order No. 8541892, 30 U.S.C. § 820(c): Aggravated failure to immediately report an accident with a reasonable potential to cause death.

Shane Allred	$1,000.00	p. 47
Michael Cooper	$1,500.00	p. 49
Jed Gordon	No Liability	p. 49
Jake Wilson	No Liability	p. 49
Dewey Tanner	No Liability	p. 49

I. INTRODUCTION

This case is before me upon petition for assessment of civil penalty filed by the Secretary of Labor ("Secretary") pursuant to Section 105(d) of the Federal Mine Safety and Health Act of 1977, as amended ("Mine Act" or "Act"), 30 U.S.C. § 815(d) (2023). At issue are two orders under section 104(d)(1), issued to Respondent, Canyon Fuel Company, LLC ("Canyon Fuel" or "Respondent").[2] The parties presented testimony and documentary evidence at a hearing on May 17–19, 2022, and filed post-hearing briefs.

[1] The violation was originally cited under section 50.10(c). This Court allowed amendment to allege a violation of section 50.10(b) instead. Order Granting Mot. to Amend Order, Docket No. WEST 2021-0188 et al., at 3 (Apr. 27, 2022).

[2] This Court approved settlement of three violations: 8541894, 8541895, and 8541897. Decision

Canyon Fuel owns and operates Skyline Mine #3, located near Scofield, Utah. Joint Stipulations ¶ 1, 2 (May 6, 2022) ("Stips."). Skyline is a large, underground coal mine, subject to the jurisdiction of the Mine Act. *Id.* ¶ 3, 16. Order No. 8541891 alleged a failure to protect miners from mine roof, face, and rib falls. Order No. 8541892 alleged a failure to report an immediately reportable injury that had a reasonable potential to cause death. For reasons set forth below, I **AFFIRM** both violations, but **MODIFY** Order No. 8541891 to "Moderate" negligence and remove the "Unwarrantable Failure" designation. I also find Shane Allred and Michael Cooper personally liable for the violation of Order No. 8541892.

II. STANDARDS

A. Violation

The Secretary must prove the elements of an alleged violation by a preponderance of the evidence. *See Jim Walter Res., Inc.*, 28 FMSHRC 983, 992 (Dec. 2006); *RAG Cumberland Res. Corp.*, 22 FMSHRC 1066, 1070 (Sept. 2000). Mine operators are generally strictly liable for mandatory safety standard violations. *See Freeman United Coal Mining Co. v. FMSHRC*, 108 F.3d 358, 361 (D.C. Cir. 1997); *Nally & Hamilton Enters., Inc.*, 33 FMSHRC 1759, 1764 (Aug. 2011).

B. Significant and Substantial ("S&S")

A violation is properly designated as 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." *Mathies Coal Co.*, 6 FMSHRC 1, 3–4 (Jan. 1984) (citing *Cement Div., Nat'l Gypsum Co.*, 3 FMSHRC 822, 825 (Apr. 1981)). The four elements required for an S&S finding are expressed as follows:

> (1) [T]he underlying violation of a mandatory safety standard; (2) the violation was reasonably likely to cause the occurrence of the discrete safety hazard against which the standard is directed; (3) the occurrence of the hazard would be reasonably likely to cause an injury; and (4) there would be a reasonable likelihood that the injury in question would be of a reasonably serious nature.

Peabody Midwest Mining, LLC, 42 FMSHRC 379, 383 (June 2020) (integrating the refinement of the second *Mathies* step in *Newtown Energy, Inc.*, 38 FMSHRC 2033, 2037 (Aug. 2016)).

An S&S determination must be based on the assumed continuation of normal mining operations. *See Consol Pa. Coal Co.*, 43 FMSHRC 145, 148 (Apr. 2021) (citing *U.S. Steel Mining Co.*, 6 FMSHRC 1573, 1574 (Jan. 1984)) ("A determination of 'significant and substantial' must be based on the facts existing at the time of issuance and assuming continued

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Approving Partial Settlement, Docket No. WEST 2021-0188 et al., at 2 (May 19, 2022). The Secretary also vacated two violations: 8541893 and 8541896. S. Mot. to Approve Partial Settlement, Docket No. WEST 2021-0188 et al., at 2 (May 11, 2021). Individual civil penalties against Messrs. Tanner, Allred, Wilson, Gordon, and Cooper are also before the Court.

normal mining operations, absent any assumption of abatement or inference that the violative condition will cease.").

C. Negligence

Judges may use a traditional negligence analysis, rather than relying upon Part 100 definitions. *Brody Mining, LLC*, 37 FMSHRC 1687, 1701–02 (Aug. 2015) (citing *Jim Walter Res., Inc.*, 36 FMSHRC 1972, 1975 n.4 (Aug. 2014); *Sellersburg Stone Co. v. FMSHRC*, 736 F.2d 1147, 1151–52 (7th Cir. 1984)) ("Part 100 regulations apply only to the proposal of penalties by MSHA and the Secretary of Labor; under both Commission and court precedent, the regulations do not extend to the independent Commission, and thus the MSHA regulations are not binding in any way on Commission proceedings."). The reasonably prudent person standard should be that of one "familiar with the mining industry, the relevant facts, and the protective purposes of the regulation." *Brody Mining, LLC*, 37 FMSHRC at 1702.

D. Unwarrantable Failure

Unwarrantable failure is "aggravated conduct constituting more than ordinary negligence," *Manalapan Mining Co.*, 35 FMSHRC 289, 293 (Feb. 2013) (citing *Emery Mining Corp.*, 9 FMSHRC 1997, 2001 (Dec. 1987)), and characterized by such conduct as "reckless disregard," "intentional misconduct," "indifference," or a "serious lack of reasonable care." *Id.* (citing *Emery Mining Corp.*, 9 FMSHRC at 2003–04); *see also Buck Creek Coal, Inc. v. MSHA*, 52 F.3d 133, 136 (7th Cir. 1995).

Whether conduct is "aggravated" is based on the following factors:

> [1] [T]he operator's knowledge of the existence of the violation, [2] whether the violation was obvious, [3] whether the violation posed a high degree of danger, [4] the extent of the violative condition, [5] the length of time that the violative condition has existed, [6] the operator's efforts in abating the violative condition, and [7] whether the operator has been placed on notice that greater efforts are necessary for compliance.

Peabody Midwest Mining, LLC, 44 FMSHRC 515, 522 (Aug. 2022) (citing *Manalapan Mining Co.*, 35 FMSHRC at 293; *IO Coal Co.*, 31 FMSHRC 1346, 1350–51 (Dec. 2009)). A judge must examine "all relevant factors, rather than relying on one to the exclusion of others." *IO Coal Co.*, 31 FMSHRC at 1351 (citing *Windsor Coal Co.*, 21 FMSHRC 997, 1001 (Sept. 1999)) (acknowledging that a judge may determine that some factors are less important or not relevant but must consider them all).

A high degree of danger posed by a violation alone may support an unwarrantable failure finding. *See BethEnergy Mines, Inc.*, 14 FMSHRC 1232, 1243–44 (Aug. 1992) (finding unwarrantable failure where unsaddled beams "presented a danger" to miners entering the area); *Warren Steen Constr., Inc.*, 14 FMSHRC 1125, 1129 (July 1992) (finding a violation to be aggravated based upon "common knowledge that power lines are hazardous, and . . . that precautions are required when working near power lines with heavy equipment"); *Quinland*

Coals, 10 FMSHRC 705, 709 (June 1998) (finding unwarrantable failure where roof conditions were "highly dangerous"). The absence of significant danger, however, does not necessarily preclude a finding of unwarrantable failure. *Manalapan Mining*, 35 FMSHRC at 294.

An objectively reasonable, good faith belief in a violative practice's compliance is a defense against unwarrantable failure. *IO Coal Co.*, 31 FMSHRC at 1357.[3] A respondent must therefore present facts demonstrating both a good faith belief, and the reasonableness of that belief. *See W. Ala. Sand & Gravel, Inc.*, 37 FMSHRC 1884, 1888 (Sept. 2015) ("A party's conclusory statement that it acted in good faith cannot be treated as a binding determination of material fact.").

E. Penalty

The Commission considers the following factors, from Section 110(i) of the Act, in assessing penalties under the Act:

> [T]he operator's [1] 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) (2006).

F. Individual Liability

Section 110(c) liability for an agent is stated as follows:

> Whenever a corporate operator violates a mandatory health or safety standard or knowingly violates or fails or refuses to comply with any order issued under this Act . . . any director, officer, or agent of such corporation who knowingly authorized, ordered, or carried out such violation, failure, or refusal shall be subject to the same civil penalties, fines, and imprisonment that may be imposed upon a person under subsections (a) and (d).

30 U.S.C. § 820(c) (2023). "Knowingly" requires a finding that the agent knew or had reason to know of the violative condition. *Kenny Richardson*, 3 FMSHRC 8, 16 (Jan. 1981), *aff'd on*

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[3] "[I]f an operator acted on the *good-faith* belief that its cited conduct was actually in compliance with applicable law, and the belief was *objectively reasonable under the circumstances*, the operator's conduct will not be considered to be the result of unwarrantable failure when it is later determined that the operator's belief was in error." *Id.* at 1358 (quoting *Kellys Creek Res., Inc.*, 19 FMSHRC 457, 463 (Mar. 1997) (citing *Cyprus Plateau Mining Corp.*, 16 FMSHRC 1610, 1615–16 (Aug. 1994))) (emphasis added).

other grounds, 689 F.2d 632 (6th Cir. 1982), *cert. denied*, 461 U.S. 928 (1983); *accord Freeman United Coal Mining Co. v. FMSHRC*, 108 F.3d 358, 362–64 (D.C. Cir. 1997).

To establish section 110(c) liability, the Secretary must prove only that an individual knew or had reason to know of the violative condition, not that the individual knowingly violated the regulation. *Warren Steen Constr., Inc.*, 14 FMSHRC 1125, 1131 (July 1992) (citing *United States v. Int'l Miners & Chem. Corp.*, 402 U.S. 558, 563 (1971)); *see also Ernest Matney*, 34 FMSHRC 777, 784 (Apr. 2012) ("[S]ection 110(c) liability does not hinge on whether an agent engaged in 'willful' conduct."). A knowing violation occurs when an individual "in a position to protect employee safety and health fails to act on the basis of information that gives him knowledge or reason to know of the existence of a violative condition." *Kenny Richardson*, 3 FMSHRC at 16.

The Commission recently affirmed a liability finding where a judge used a three-part test for individual liability: (1) that the agent knew or had reason to know about the violative condition; (2) that the agent was in a position to remedy the condition; and (3) that the agent failed to act to correct the condition. *Peabody Midwest Mining, LLC*, 44 FMSHRC at 526–27, 259. The agent's conduct—or failure to act—must be "aggravated." *Id.* at 527.

Section 110(c) liability is predicated on aggravated conduct more than ordinary negligence. *BethEnergy Mines, Inc.*, 14 FMSHRC 1232, 1245 (Aug. 1992).[4] A judge may use the factors for aggravated conduct that the Commission expressed for an unwarrantable failure analysis. *See Matney*, 34 FMSHRC at 784 (citing *Mid-Continent Res., Inc.*, 16 FMSHRC 1218, 1222 (June 1994)) ("The judge erred by failing to reconcile his unwarrantable failure findings with his section 110(c) analysis.").[5] A circuit court recently reviewed and reinstated a judge's

[4] A finding of high negligence may support an individual liability finding when conduct is found to be aggravated. *See Target Indus. Inc.*, 23 FMSHRC 945, 965 (Sept. 2001) (affirming 110(c) liability where the judge found that the violations were "extremely serious" and the result of high negligence); *Austin Powder Co.*, 21 FMSHRC 18, 27 (Jan. 1999) (affirming a finding of liability where the judge found "high negligence," but the record also demonstrated "aggravated conduct").

[5] The Commission in *Matney*, in reversing a judge's finding against individual liability, specifically referenced the cited condition's "readily apparent" character, as well as the nature and extent of the condition and failure to conduct adequate inspections. 34 FMSHRC at 784–86.

Another opinion has also noted this confluence, stating:

> It is well established that section 110(c) liability is predicated on aggravated conduct constituting more than ordinary negligence. Slip op. at 10 (citing *BethEnergy Mines*, 14 FMSHRC at 1245). Similarly, the Commission has held that unwarrantable failure is aggravated conduct constituting more than ordinary negligence. *Emery Mining Corp.*, 9 FMSHRC 1997, 2001 (Dec. 1987). But the Commission has never distinguished between these two holdings and explained what the term "aggravated conduct" means in the context of section 110(c) -- a gap in Commission jurisprudence that I believe needs to be addressed.

individual liability findings based on factors comparable to those for unwarrantable failure. *Northshore Mining Co. v. Sec'y of Labor*, 46 F.4th 718, 729, 739 (8th Cir. 2022) (upholding an unwarrantable failure finding and reinstating individual liability findings against agents for failure to maintain an elevated walkway in good condition, resulting in injury).[6]

A finding of unwarrantable failure for the underlying violation alone is insufficient to hold a prosecuted agent individually liable. The elements of such a finding, however, can be imputed to an agent where he or she is reasonably responsible for the violative area or action and fails to exercise reasonable care to protect miners. *See Matney*, 34 FMSHRC at 785, 786. In *Matney*, the Commission found that the "readily apparent" nature demonstrated that a shift foreman should have known that the condition existed. *Id.* at 785. It was his failure to be sufficiently thorough in his duties that led the Commission to find him liable. *See id.* at 786 ("The evidence compels the conclusion that a preshift examiner, exercising reasonable care, would have identified the hazardous roof conditions and taken action to remedy the hazards.").

Like unwarrantable failure, an agent's reasonable, good faith belief is a defense to individual liability under section 110(c). *LaFarge Constr. Materials*, 20 FMSHRC 1140, 1150 (Oct. 1998) (citing *Wyoming Fuel Co.*, 16 FMSHRC 1618, 1630 (Aug. 1994)). In line with the requirement that the belief be reasonable, an agent cannot defend against individual liability by relying on the existence of "usual procedures" found to be "wholly inadequate." *See LaFarge, Constr. Materials*, 20 FMSHRC at 1150; *see also Matney*, 34 FMSHRC at 786 (quoting *Roy Glenn*, 6 FMSHRC 1583, 1587 (July 1984)) ("[A] supervisor's blind acquiescence in unsafe working conditions would not be tolerated.").

Austin Powder Co. & Bruce Eaton, 21 FMSHRC 18, 31 (Jan. 1999) (Verheggen, Comm'r, concurring).

[6] For comparison, the Commission's decision to affirm the judge's unwarrantable failure findings cited the following as substantial evidence: (1) the violation existed for over a year; (2) the physical extent of the violation included the entire walkway; (3) the report clearly notified the operator; (4) there was no evidence that the operator attempted to repair the walkway; (5) while there was no evidence that the condition caused the event that day, or that there was a danger of falling through the walkway due to the existence of wire mesh, the danger of falling in a narrow walkway while walking on taconite (pellets) could not be discounted; (6) the deficiencies were obvious; and (7) "the engineering report made it clear that the walkway was not safe for use." 43 FMSHRC 1, 26 (Jan. 2021); *see also* 41 FMSHRC 50, 64–66, 72–73 (Feb. 2019) (ALJ).

The judge's 110(c) liability findings mirrored those the Commission (and the circuit court) accepted for unwarrantable failure. Regarding knowledge, the judge cited knowledge of the report's recommendations. 41 FMSHRC at 74. The agents' knowledge was also supported by the obviousness of the violation, including that the condition existed for over a year and was extensive. *Id.* at 72, 73. The agents' position to effect a remedy was demonstrated by their ability to implement fall protection and their control of the area generally. *Id.* at 52, 72. Finally, regarding inaction, "there was no evidence that the operator [including the two agents] attempted to repair the walkway." 43 FMSHRC at 26.

III. Factual Findings

On August 25, 2020, just before 5:08 p.m.,[7] Complainant Bryce Adams was working in the 8 Right Longwall when a rib burst occurred. Tr. 15, 33–35.[8] It was strong enough to send rib material 3 feet deep and 5 feet wide from the rib to the 8 Bay, a large piece of equipment that Mr. Adams was maintaining.[9] *Id.* at 33, 449. The material struck him in the back and forced him into the 8 Bay, slamming his forehead on a bolt head on the machine and covering him in coal up to the top of his torso. *Id.* at 16, 35, 232–34. He had blood running down his face, *id.* at 36, 233, and he believed his legs might be broken because of their positioning, though he could not move his extremities, *see id.* at 36–37 ("I was packed in there so tight that I couldn't even -- I couldn't wiggle my fingers; I couldn't wiggle my toes.").[10]

Steve Childs first reacted, yelling for assistance and informing Charlie Wilson—who immediately called to inform Shane Allred, the shift foreman and responsible person on duty. Tr. 36; *see id.* at 263 (testimony of Shane Allred that Mr. Wilson had communicated with Mr. Childs). Mr. Allred was informed that Mr. Adams was "covered up with coal along the 8 Bay of the longwall." *Id.* at 262–63.

Dayna Anderson, a trained emergency medical technician ("EMT") miner, was also immediately called to respond. Tr. 90 (testimony of Dayna Anderson that he heard someone was buried over the mine phone); *id.* at 264–65 (testimony of Shane Allred that he called Conspec[11] from his truck to find Mr. Anderson and have a county ambulance called). Mr. Allred immediately began to drive to the incident site.

Michael Cooper, the mine safety manager, was informed of the incident by Conspec shortly thereafter. Tr. 301–02.[12] He reported the incident to Jed Gordon, the operations

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[7] Shane Allred testified that he was notified at 5:08 p.m. by production foreman, Charlie Wilson. Tr. 262–63; *see also* Ex. JX-6 (noting the "Time of accident" as "5:08 p.m." on the Mine Accident, Injury and Illness Report).

[8] A disparity in terms generally existed between the parties. The Secretary consistently referred to the incident as a "rib burst." Respondent, however, referred to it as a "rib roll," which intuitively seems a less violent description. I would note that one of Respondent's witnesses, and an individual liability respondent, Michael Cooper, did use the term "burst" during cross-examination. *Id.* at 326 (recalling the report from Shane Allred). I need not delineate between the terms, but I will use "burst" throughout the decision. It is sufficient for my evaluation that material from the rib detached and covered Mr. Adams.

[9] The 8 Bay is an approximately 3 feet tall and 20 feet long metal machine that runs a conveyor. Tr. 54, 273, 286, 449.

[10] Mr. Adams claimed he briefly lost consciousness, *id.* at 35–36, 55, but he admitted on cross-examination that he could not recollect if he ever informed anyone, *id.* at 55–56.

[11] Conspec is the mine's communications center. Tr. 20. Conspec personnel made internal notifications and coordinated external medical support. *Id.* at 20, 264–65, 301–02.

[12] Jed Gordon testified that Mr. Cooper called him between 5:20 and 5:25. *Id.* at 336. Mr.

manager, between 5:20 and 5:25. *Id.* at 336. Mr. Cooper then informed Jake Wilson at 5:30. *Id.* at 373. He finally informed Dewey Tanner between 5:30 and 5:40. *Id.* at 435. The same limited information was given to all of them: Mr. Adams had been covered with coal on the longwall. *Id.* at 335–36, 374. 437.

During the 30 minutes these calls were being made, five-or-six miners, Tr. 38, including John Bonnanci, the longwall foreman, and Mr. Childs, were working "feverishly" to dig out Mr. Adams. *Id.* at 235. Mr. Bonnanci noticed the laceration, and he and Mr. Childs wrapped Mr. Adams' head with gauze. *Id.* at 19, 233–34. Mr. Adams also complained of "bad" neck pain, *id.* at 38, so the other miners brought him a cushion on which to rest his head while they continued uncovering him, *id.* at 38–39, 234.

It took approximately 30 minutes to uncover Mr. Adams. Tr. 235.[13] During this time, Mr. Allred spoke with Mr. Wilson again while en route to the site, but he did not ask any questions or receive any further information about Mr. Adams' injuries during the trip. *Id.* at 262–63, 265–66. Mr. Adams was loaded onto a backboard, supplied with oxygen, and covered with a blanket. *Id.* at 39, 236.

When Mr. Allred arrived at the scene, Mr. Adams was wearing a cervical collar. He was conscious and coherent and mentioned pain in his right knee, upper back, neck, and forehead; and the gauze on his head was soaked through with blood. Tr. 92–93, 98.

Mr. Adams joked with Mr. Allred that he could walk out if they needed. Tr. 60, 269. Mr. Allred checked with Mr. Anderson whether Mr. Adams' leg was fractured, whether he might die, and whether he had movement in his extremities. *Id.* at 268–69.

Mr. Anderson did not tell anybody that he thought Mr. Adams' injuries were "life threatening," though he testified that he would have reported the incident based on the injury. Tr. 101–02. Mr. Allred did not assess the injuries as "life threatening." *Id.* at 274; see also *id.* at 291 ("[O]nce I was able to speak with him and talk to him and see what his condition was, yeah, he seemed actually really normal to me.").

Mr. Adams was loaded onto the mine ambulance to be evacuated to the surface. Mr. Anderson and Mike Allred, Mr. Adams' work group supervisor, Tr. 84, rode with him. *Id.* at 270.[14] Mr. [Shane] Allred told miners to stay out of the area until they could evaluate; he knew Messrs. Gordon and Wilson were on the surface and would come inspect. *Id.* at 273. He then

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Cooper had therefore been informed between 5:08 and 5:20.

[13] This is supported by the testimonies of Messrs. Allred and Anderson. Mr. Allred stated it took 10 minutes to walk to his truck upon receiving the report, and then 30 minutes to drive to the site. *Id.* at 286. When he arrived, Mr. Adams was already uncovered and on a stretcher. *Id.* at 266. Mr. Anderson arrived just before Mr. Allred, noting Mr. Adams was no longer covered. *Id.* at 91–92.

[14] There was no testimony about a relationship between Shane and Mike Allred. Mr. Adams only specified that they were "[d]ifferent people." *Id.* at 41.

called Mr. Cooper to review the injuries and decide whether the incident was reportable. *Id.* at 273–74. He told Mr. Cooper that he did not think it was reportable. *Id.* at 274.

Mr. Cooper reported that Mr. Adams' head had been bandaged, the bleeding was under control, and that he had neck and back pain and a possible broken leg. Tr. 274, 303–04. Mr. Cooper relayed this information to Mr. Gordon, *id.* at 326, 361–62, and Mr. Tanner, *id.* at 437. Mr. Allred called Mr. Wilson and gave him the same assessment. *Id.* at 375. All respondent-witnesses stated that they observed, or were informed, that Mr. Adams was conscious and coherent during the time between the incident and when he was transported to the hospital. *Id.* at 267, 325, 339, 376, 439.

While these calls occurred, Mr. Adams was being further tended to on his way out of the mine. Mr. Anderson rewrapped his head wound, noting that "[he] could see his skull," and "it was dented in." Tr. 93.[15] Mr. Adams continued to experience significant pain in his neck, head, and right leg and knee. *Id.* at 41, 42. Mr. Adams recalled feeling sick, cold, and clammy, and Mr. Anderson believed he went into shock. *Id.* at 40–41, 95, 97. Mr. Anderson testified that he ran out of oxygen to give Mr. Adams after 40 crosscuts, about half-way through the trip. *Id.* at 40, 95.

The Carbon County ambulance crew and a flight medic were waiting on the surface when Mr. Adams arrived. Tr. 20, 95. He was transferred from the mine ambulance to be evaluated by the ambulance paramedics. *Id.* at 20, 42, 56–57, 463.

Marty Wilson, a responding county paramedic, testified that Mr. Adams did not seem to be in danger of death at the time. Tr. 471–72. In explaining her conclusion, she said that Mr. Adams was talking and coherent and could move all extremities; his pupils reacted normally; he had good blood pressure; his pulse showed no signs of shock; his respiration and oxygen were acceptable; he had a good Glasgow coma score;[16] he had a perfect revised trauma score; and he had favorable scores regarding a head injury. *Id.* at 464–72.

Messrs. Gordon and Wilson observed and spoke with Mr. Adams during this evaluation. Tr. 42, 56–57, 338–41, 377–78. Mr. Gordon felt the injuries were "not life threatening" based on observation and Mr. Adams' responses to questions. *Id.* at 339, 342–43. Mr. Adams responded to Mr. Wilson's queries, noting that he was cold and wet. *Id.* at 377. He then joked with Mr. Wilson, requesting that someone take the chew can out of his pocket so his wife would not find it. *Id.* at 378. Mr. Wilson similarly did not feel the injuries were "life threatening" based on the interaction. *Id.*

Mr. Wilson spoke with Messrs. Anderson and Allred to review the injuries. Tr. 342. Mr. Anderson described the length and depth of the laceration, but he did not mention the possible

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[15] Mr. Anderson reassured Mr. Adams that the wound was looking good, but he silently shook his head at Mike Allred to indicate that it did not. *Id.* at 99.

[16] This assessment determines a patient's "level of responsiveness," dealing with "eye movement, how they respond verbally, and their motor function," which are combined for a 15-point scale. Tr. 469. Mr. Adams scored a 15. *Id.*

shock and again did not say that he thought the injuries were "life threatening." *Id.* at 342, 379, 388. Messrs. Wilson and Gordon decided the incident was not reportable based on what they were told. *Id.* at 362. Mr. Wilson then called Mr. Tanner to inform him that Mr. Adams seemed to be in good shape, and that it had been determined that the injury was not reportable. *Id.* at 439–40. Mr. Adams had been transported to the Life Flight helicopter, which took him to the hospital. *Id.* at 17, 43. Messrs. Gordon and Wilson then went underground to investigate the incident site. *Id.* at 345, 380.

Messrs. Gordon and Wilson testified that one of the props that had been set prior to the incident that injured Mr. Adams had been dislodged, and that similarly placed rib mesh was still attached to the roof where coal had fallen from beneath. Tr. 345–46, 381–82. These had been installed after a similar incident, at a rib inby the same section, five days earlier [August 20, 2020] that buried an 8 Bay controller. *See id.* at 46, 241, 280, 357, 418; Ex. GX-2, DOL 0037. Though production did not continue that shift,[17] Mr. Gordon testified that he and others continued on to inspect the longwall. *See* Tr. 347 ("[W]e continued on, we traveled the face to make sure there were not more existing conditions or more existing conditions that would cause another problem somewhere.").

Mr. Cooper arrived at the hospital before Mr. Adams' wife, Aubrey, but he was unable to enter to observe Mr. Adams because of COVID restrictions. Tr. 74–75, 308. Ms. Adams testified that her impression was that her husband's injuries were very serious, that multiple doctors were involved in his treatment, and that he was in pain. *Id.* at 77–78.

Mr. Adams was taken to surgery about an hour after she arrived. Tr. 77. Ms. Adams texted Mr. Cooper to update him about her husband's condition. *Id.* at 79, 310 (informing him that Mr. Adams had a skull fracture, was in surgery, and had a C5 vertebra injury). Mr. Cooper forwarded that update to Messrs. Allred, Gordon, Wilson, and Tanner. *Id.* at 275, 311, 344, 390, 440.[18]

Mr. Adams stayed in the hospital for four days. Tr. 77–78. Ultimately, he learned he broke his C1 vertebra, fractured his skull, and tore "a bunch of stuff" in his knee. *Id.* at 43, 79, 292, 310, 362, 390, 440. He had a plate inserted in his head, wore a cervical collar for six weeks, and had surgery on his knee. *Id.* He was not able to return to work until March 2021. *Id.* at 43–44. He testified that several of his coworkers expressed they did not know how he survived the incident. *Id.* at 44–45.

Mr. Madrigal, an MSHA inspector, visited the mine the next morning, August 26, 2020, after hearing about the incident from miners at a different mine. Tr. 114–15. He questioned Mr. Cooper about the incident upon seeing the stretcher outside of his office. *Id.* at 118, 312. Mr. Madrigal then went underground with Darrell Burr and Jason Layton, the engineering manager. *Id.* at 313, 401. He did not issue a Section 103(k) order ("K-Order"), but he informed Daniel

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[17] Mr. Bonnanci testified to this, Tr. 242, and Mr. Tanner stated that the mine could not produce that night because the conveyor was hung up, *id.* at 440.

[18] Messrs. Cooper, Gordon, and Wilson discussed notifying MSHA at that point, but they agreed the injury was not immediately reportable. *Id.* at 390.

Lyons, the citation-issuing inspector, that the rib rolled on a person and caused an injury. *Id.* at 127, 130. Mr. Cooper submitted a 7000-1 [non-"Immediately Reportable"] form to report the incident following Mr. Madrigal's visit. *Id.* at 315, 330; Ex. JX-5.

Mr. Lyons visited the mine on August 27, 2020, with Kendell Whitman, the MSHA assistant district manager for District 9. Tr. 115. They did not go underground to inspect the area—choosing only to interview miners—but noted Respondent had mined past the area where the rib had collapsed. *Id.* at 116, 127, 131. Mr. Lyons issued the citations after the interviews. *Id.* at 116.[19]

John Lewis, an MSHA electrical, roof control and ground control supervisor, visited the mine with Mr. Whitman on August 27 and traveled underground to inspect. Tr. 166–67. He testified that the pillars were "not yielding like they should," claiming they were too big. *Id.* at 167–70.[20] Neither Mr. Lyons nor Mr. Lewis issued a K-Order. *Id.* at 130, 176.

IV. ORDER NO. 8541891

This order was issued by Inspector Lyons on September 10, 2020. Ex. GX-2, DOL 0037. He assessed gravity as "occurred," "permanently disabling," "S&S," and one person affected. *Id.* He assessed negligence as "high," and found that the violation was a result of unwarrantable failure. *Id.* The description reads:

> A serious injury accident occurred August 25th 2020, on the 8 Right Longwall located at the head gate along the stage loader when a violent bounce caused the rib to blow out, striking and covering up a miner, with the coal that was blown off the rib of the yield pillar. No standing support was installed in the area prior to the bounce. He received serious injuries to his head and neck, including a concussion by the blunt force trauma received to his head. Also receiving [sic] an injury to his lower extremity. The roof, face, and ribs of areas where persons work or travel shall be supported or otherwise controlled to protect persons from hazards related to fall of ribs and coal or rock out bursts.
>
> During the accident investigation it was determined that an additional geological event or a bounce occurred on the 20th of August. This event was recorded on the USGS as a 1.6 on the rector [sic] scale as an earthquake. The resulting event buried the 8 bay controller with coal, on the 8 Right Longwall

[19] Mr. Lyons testified that he would think an incident was reportable "[i]f [he] was aware of a miner that was struck by a violent rib burst that caused him to smash into the control panel and suffer neck and back pain as well as bleeding from the head, and was buried for over 45 minutes." *Id.* at 150.

[20] Mr. Layton obtained two separate engineering evaluation reports following the incident. *Id.* at 403; *see* Ex. GX-5, 6. He claimed the pillars were the same size approved by MSHA in another section. *Id.* at 405. The reports were not determinative that the pillars were oversized. *Id.* at 413–14.

> section. Production on the 8 Right MMU was interrupted for approximately 1 and 1/2 shifts, to clean up the blown out material.
>
> The operator engaged in aggravated conduct constituting more than ordinary negligence, by not protecting the persons by controlling the ribs in the areas where persons work or travel. This violation is an unwarrantable failure to comply with a mandatory standard.

Id. DOL 0037–38.

A. Violation

The cited provision states, "The roof, face and ribs of areas where persons work or travel shall be supported or otherwise controlled to protect persons from hazards related to falls of the roof, face or ribs and coal or rock bursts." 30 C.F.R. § 75.202(a) (2023). The Secretary must demonstrate "(1) that the roof fall occurred in an area where persons work or travel and (2) that the roof was not supported to protect persons from hazards related to falls." *Jim Walter Res., Inc.* (*JWR*), 37 FMSHRC 493, 495 (Mar. 2015); *see also* S. Post-Hr'g Br. 4 (Aug. 5, 2022) ("S. Br.").

Respondent asserts that section 75.202(a) is an objective, performance-based standard. *See* Resp't Posthr'g Br. 39–40 (Aug. 5, 2022) ("Resp't Br.") (citing *Harlan Cumberland Coal Co.*, 20 FMSHRC 1275 (Dec. 1998); *Canon Coal Co.*, 9 FMSHRC 667 (Apr. 1987); *JWR*, 30 FMSHRC 872, 879 (Aug. 2008) (ALJ)). But while the reasonably prudent person standard for evaluating alleged violations of this provision may still be in place, it only applies now to situations in which there has not been a roof fall resulting in an injury to a miner. *See JWR*, 37 FMSHRC at 496 ("The roof fall that pinned [miner] under a piece of rock, resulting in his death, amply demonstrates that the roof was not supported in a manner to protect him from hazards relate to falls.").

The Commission in *JWR* declined to follow *Canon Coal Co*. *Id.* at 496 n7; *see also id.* at 498 (Comm'r Cohen, concurring) (stating that the decision effectively overruled *Canon Coal Co.*, but that it does not affect all subsequent Commission decisions relying on it where, like *Harlan Cumberland Coal Co.*, a roof fall had not actually occurred). The ALJ decisions cited by Respondent were all published before *JWR*.

Here, a rib burst in fact occurred and a miner was injured. Tr. 35, 326; S. Br. 3; Resp't Br. 1. I therefore find *JWR* controlling and hold that such occurrence demonstrated that the roof was not supported in a manner to protect miners from associated hazards. Mr. Adams was working in the area at the time of the burst and his resulting injury. Under *JWR*, and the strict liability approach governing Mine Act violations, the Secretary successfully demonstrated a violation.

B. Gravity

1. Likelihood

The hazard—inadequately supported rib material falling and contacting a miner—in fact occurred. I therefore affirm the likelihood determination.

2. Severity

The likelihood contemplated is that of the expected resulting injury. The severity evaluation assumes the occurrence of the hazard. *See Consolidation Coal Co.*, 18 FMSHRC 1541, 1550 (Sept. 1996) (comparing S&S inquiry, which focuses on "the reasonable likelihood of serious injury," with gravity inquiry, which focuses on "the effect of the hazard *if* it occurs") (emphasis added).

The Secretary asserts the severity of the contemplated injury is permanently disabling. There is sufficient evidence, acknowledged by Respondent, that Mr. Adams suffered a fractured skull, broken vertebra, and damage to his knee. Tr. 43, 79, 292, 310, 362, 390, 440; S. Br. 6–7; Resp't Br. 6. I find that such injuries are reasonably likely to result in total or partial loss of use of any member or function of the body and therefore affirm the severity as characterized by the inspector.[21]

3. Number of Persons Affected

The inspector assessed that one miner would be affected by the hazard. I agree that one miner was likely to be, and in fact was, injured by a roof fall. I thus affirm the inspector's enumeration of persons who would likely be affected.

4. S&S

I affirm the S&S designation for the following reasons.

a. Step 1: The violation has been established.

The occurrence of an injury-causing rib burst demonstrates a failure to adequately protect miners working in the area from hazards related to rib bursts. This is sufficient to constitute an underlying violation of a mandatory safety standard for the purposes of *Mathies* Step 1.

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[21] I hold in this decision, and the record establishes, that Mr. Adams could have been killed by the rib burst, *see* Section V.A.2., *infra*, and the severity might have been assessed as "fatal." The Secretary's characterization in the order apparently flows from the fact that an incident actually occurred, but a miner did not die as a result.

b. Step 2: The violation was reasonably likely to result in the discrete safety hazard against which the regulation is directed—falling material striking a miner.

Mathies Step 2 is a two-part process: (1) determine the specific hazard the standard is aimed at preventing; and (2) determine whether a reasonable likelihood exists that the hazard against which the mandatory standard is directed will occur. *Newtown Energy, Inc.*, 38 FMSHRC at 1868. This finding must be based on "the particular facts surrounding the violation." *Northshore Mining Co.*, 38 FMSHRC 753, 757 (Apr. 2016).

The standard requires that ribs be supported or controlled to protect miners working there from hazards related to bursts. The hazard the standard aims to prevent is falling material striking a miner. The issue is therefore whether a reasonable likelihood exists that rib material would strike a miner.

Here, a rib burst occurred, and Mr. Adams was driven into the 8 Bay and covered in coal, requiring approximately 30 minutes to uncover him. The fact of occurrence is sufficient to find that the violation was reasonably likely to cause the occurrence of the contemplated hazard.

c. Step 3: The falling material striking a miner was reasonably likely to cause an injury—e.g., fractured skull and vertebra, and knee injury.

Mathies Step 3 asks whether the hazard, not the violation itself, is reasonably likely to cause an injury. *Musser Eng'g, Inc.*, 32 FMSHRC 1257, 1280–81 (Oct. 2010). In evaluating the likelihood of injury, judges must assume the occurrence of the hazard. *See Newtown Energy, Inc.*, 38 FMSHRC at 2037.

Both parties acknowledged that Mr. Adams sustained a skull fracture, vertebral fracture, and knee damage. *See* Section IV.B.2., *supra*. That the occurrence of the contemplated hazard resulted in these injuries is sufficient to find the hazard was reasonably likely to cause an injury.

d. Step 4: It is reasonably likely that such an injury would be of a reasonably serious nature.

An inspector's conclusion that a possible injury is of a reasonably serious nature has been held sufficient for *Mathies* Step 4. *See Consol Pa. Coal Co.*, 43 FMSHRC at 149 (finding it sufficient that the inspector characterized the potential injury as "serious" and noted potential injuries). The Commission also does not require a specific type of injury for it to be considered serious. *See S&S Dredging Co.*, 35 FMSHRC 1979, 1981–82 (July 2013).

Here, Inspector Lyons testified that he thought the injury was reportable—i.e., it had a reasonable potential to cause death. Tr. 150–51. There was also, however, particularly compelling testimony from Mr. Anderson that he "could see [Mr. Adams'] skull," *id.* at 93, and that he told another miner "[i]t didn't look good," *id.* at 99. I also credit Mr. Adams' own testimony about the seriousness of his injuries. *Id.* at 43.

Taken together with the circumstances of the accident, the care and treatment required, and the description of the resulting injuries, I find that the injury resulting from the hazard was reasonably likely to be of a reasonably serious nature.

C. Negligence

I find that the negligence was improperly characterized by the inspector as "high." Those charged with ensuring the rib is properly supported are familiar with the mining industry, the relevant facts, and the protective purpose of the provision. While a reasonably prudent person in the position of the mine's management should have recognized that more effort was needed to protect miners from a rib burst in this area, there was mitigation. I therefore assess negligence as "moderate."

The Commission has declined to disturb a moderate negligence finding where a judge found that roof problems were obvious at the time of citation, and credible testimony demonstrated that an exam was completed without noticing the existence of the problem. *See Hubb Corp.*, 22 FMSHRC 606, 614 (May 2000) (vacating the penalty assessments only for judge's failure to adequately address all section 110(i) criteria); 20 FMSHRC 615, 621–22 (June 1998). The Commission has similarly declined to disturb a high negligence finding where the judge found: (1) the conditions were obvious, extensive, and had existed for "quite some time;" the roof fall had potentially fatal consequences to miners; and the operator had made no effort to correct the conditions. *Hidden Splendor Res., Inc.*, 36 FMSHRC 3099, 3103, 3104 (Dec. 2014).

The Secretary asserts that Respondent's actions after the August 20 incident suggested an "aggravated lack of care." S. Br. 7 (citing *Ky. Fuel Corp.*, 40 FMSHRC 28, 31 (Feb. 2018) (quoting *Brody Mining, LLC*, 37 FMSHRC 1687, 1703 (Aug. 2015))). I disagree. *Kentucky Fuel Corp.* involved a failure to block machinery. 40 FMSHRC at 28. The following findings were found to be substantial evidence in support of high negligence: "materials needed to properly block the vehicle against motion were not available at the mine site, mine personnel had not been adequately trained in blocking techniques, and the truck's brake system was not adequately maintained." *Id.* at 32.

In *Brody Mining, LLC*, the Commission reversed a judge's negligence reduction to moderate because it relied on a single mitigating circumstance, but that circumstance—lack of methane at the time—was not relevant to negligence. 37 FMSHRC at 1703. Here, mitigating circumstances relevant to rib bursts were present, and materials and action were not entirely lacking, in contrast to *Kentucky Fuel Corp.*

Respondent did not address negligence directly, but it noted in its unwarrantable failure analysis that a similar [vacated] citation for a roof control plan violation was designated "moderate." Resp't Br. 44.[22] Respondent argued that it planned and maintained adequate pillar

[22] I note here that I do not accept Respondent's contention that the two citations were duplicative. *See id.* at 35–39. I agree with the Secretary that the provisions impose "separate and distinct duties," and that plans can be violated in ways that do not involve the failure alleged here. *See* S. Br. 23 (citing *Ky. Fuel Corp.*, 38 FMSHRC 1614 (July 2016)). Further, the plan

design, conducted rib bolting and meshed the ribs, and installed additional supports between August 20 and the present incident. *Id.* at 45. Respondent only cites its own witnesses' direct examination testimony to make this claim, however.

Inspector Lyons testified that he assessed the violation as high negligence because there was a known geological event five days earlier in a nearby location, and Respondent "did nothing to control the rib." Tr. 120.[23] I disagree that Respondent did nothing, but the Secretary demonstrated a lack of adequate mitigation.

Mr. Lewis testified that he noticed that the pillars in the area were not yielding as they should. Tr. 167–70. Respondent produced Jason Layton, the operator's engineering manager, to testify that the same-sized pillars were approved by MSHA for a new district. *Id.* at 405.[24] He claimed there was no indication that a pillar would fail on August 25, *id.* at 414–15, but was subsequently asked on cross-examination if the failure of the pillar inby the same section on August 20 was an indication, *id.* at 418.

Mr. Layton responded, "I guess I don't recall that that came to my attention. It could have." *Id.* I credit Mr. Lewis' evaluation and find that Mr. Layton did know, or should have known, about the burst five days earlier on the nearby rib, and that should have been an indication of the area's inadequacy.

Regarding mesh and rock props in the violative area, there is evidence that such mitigation existed, but there is also evidence that Respondent knew it was insufficient. Mr. Adams, and the Secretary in her brief, claimed that Respondent failed to take additional measures after August 20. Tr. 46; S. Br. 7.

This, however, is not supported even by Mr. Adams' testimony. Though he claimed Respondent could have done more, he hedged and stated he did "not think any or it [rib mesh and timbers or rib jacks] was done." Tr. 47. He then stated on cross-examination that there was mesh, but only on the top part, and that some was hanging. *Id.* at 54.

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violation citation was vacated, and I find that this citation is properly before me.

[23] Significant testimony was elicited, and documents produced, about the noted geological event/earthquake associated with the August 20 incident. *See* Ex. R-E; Resp't Br. 41; Tr. 119–25, 152, 397–401. The inspector's narrative suggests that the prior burst registered as a geological event. If the Secretary's theory is that the burst was so powerful that it registered on the Richter Scale, Respondent effectively demonstrated that the timing and location of that recorded event did not match the burst. If the Secretary's theory is that the recorded geological event may have been a catalyst for the burst, putting Respondent on notice that further mitigation was needed, such evidence is unnecessary because the rib burst itself would put Respondent on notice. Further, the Secretary did not address the geological event in her brief.

[24] He acknowledged that two engineering reports were not determinative that the pillars were adequate. *Id.* at 409–12. These reports, however, were sought because of the event that injured Mr. Adams, *id.* at 403, so they would have no bearing on Respondent's knowledge, or negligence, at the time of citation.

Mr. Allred testified that there was mesh, though some had come down, and two out of three props remained in place. Tr. 271–72.[25] This was confirmed by Mr. Gordon, who testified that he went underground to check out the area and found one of the props had been dislodged by the rib burst. *Id.* at 346. Mr. Wilson was with Mr. Gordon, and he testified that props remained, and rib mesh was still attached at the top of the roof and coal had fallen from underneath. *Id.* at 381–82. Mr. Gordon, however, did acknowledge that Mr. Bonnanci told him about the August 20 burst—that a bolt had broken, and mesh rolled over onto the 8 Bay. *Id.* at 357–58. Respondent was thus on notice that its mesh and bolts in the area were inadequate to prevent a rib burst.

I do not find the violation here to be the result of the operator's high negligence because, though the condition had potentially fatal consequences, it was not necessarily obvious, the operator was only on notice of possible hazard for five days, and the operator had made efforts to mitigate hazardous conditions in the area. This was nevertheless a significant breach of the duty of care, given the extreme danger posed by the hazard.

D. Unwarrantable Failure

I find that this violation was not the result of the operator's unwarrantable failure to comply with a mandatory standard. I have already found that the cited negligence was overestimated, so Respondent did not display more than ordinary negligence in its violation here. The violation posed a high degree of danger, as demonstrated by the incident and Mr. Adams' injuries, but the Secretary has not sufficiently shown that Respondent's abatement efforts were lacking to an aggravated degree—a factor that I consider paramount here.

Respondent had knowledge of a possible hazard because of the rib burst that occurred nearby five days earlier. This, however, is not necessarily knowledge of the violative condition of the area at issue. The Secretary asserts the violative condition was obvious, specifically citing Mr. Lewis' testimony that the pillars were noticeably too big to yield and the third-party engineering reports. S. Br. 9. The reports, however, were sought after the incident at issue, and are a matter of some dispute. *See supra* notes 20 & 24.

I credit Mr. Lewis' testimony and conclude that there was mitigation, though inadequate. This does not necessarily mean that the condition was obvious to Respondent; Mr. Lewis did not testify that he told Respondent about this inadequacy prior to the incident.

The violative condition likely existed for the duration of mining in the area, but knowledge of the violation cannot be attributed to Respondent until the August 20 incident. The Secretary made no argument specifically to the duration other than to state that Respondent had been aware of the condition since that time. *See* S. Br. 8–9. The extent of the violative condition is unknown. However, there are sufficient facts to support an inference that it extends to the rib

[25] The Secretary noted, in his violation and unwarrantable failure analyses, that Mr. Allred admitted the mesh and rock props were inadequate. S. Br. 4, 9. This, paradoxically, demonstrates that measures were in fact taken.

at issue, the nearby rib that burst on August 20, and any surrounding areas where Respondent found it necessary to install additional mitigation.

The operator had been placed on notice by the August 20 incident that greater efforts were necessary for compliance.[26] The Secretary, however, did not demonstrate that the operator's efforts, while inadequate, were the result of an aggravated lack of care.

I agree with Respondent that the Secretary and her witnesses erroneously claim that the operator did nothing. Resp't Br. 45. While inadequate to prevent a rib burst and sufficient for a finding of violation, Respondent installed additional mitigation to prevent a rib burst, or at least limit the possible severity. *See* Section IV.C., *supra*.

E. Penalty

Respondent has been cited seven times in the last two years at this mine for violation of this regulation. Ex. GX-2, DOL 0038; Ex. GX-3 [MSHA Assessed Violation History Report]. I find that the Secretary has properly considered Respondent's violation history in the calculation. I accept that the Secretary has properly evaluated the size of the mine. The parties have stipulated that payment of this penalty will not affect the Respondent's ability to continue in business, and my penalty assessment would not support such a conclusion. *See* Stips. ¶ 7.

I have affirmed the reasoning underlying the Secretary's gravity assessment, but the proposed penalty of $74,700.00 was based, in part, on the negligence and unwarrantable failure determinations. I have found that negligence was overestimated, and an unwarrantable failure determination is not supported. Further, Respondent made efforts before the incident at issue, and following the incident [engineering reports] to achieve compliance and better safety.

On the other hand, the history of seven previous violations within the relevant reporting period, including a previous incident in a nearby pillar only five days earlier, and the high degree of danger posed by the hazard, should have prompted a more thoughtful consideration of the circumstances and the potential for the cited area to collapse. I therefore assess a penalty of $25,000.00.

V. ORDER NO. 8541892

This order was issued by Inspector Lyons on September 10, 2020. Ex. GX-1. He assessed gravity as "occurred," "permanently disabling," "S&S," and one person affected. *Id.* He assessed negligence as "high," and found that the violation was a result of unwarrantable failure. *Id.* The description reads:

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[26] It is also relevant that Respondent has been cited for violation of this provision seven times in the last two years. *See* Section IV.E., *infra*. "[T]he Commission may consider these past violations." *Enlow Fork Mining Co.*, Docket No. PENN 94-259, 1997 WL 14346, at *9 (Jan. 15, 1997) (citing *Peabody Coal Co.*, 14 FMSHRC 1258, 1263 (Aug. 1992) ("[T]he Commission has not limited the circumstances under which past violations may be considered by a judge in determining whether an operator's conduct demonstrated aggravated conduct.")).

> The mine operator failed to report an Immediately Reportable Accident which occurred at approximately 17:00 hours on August 25, 2020. The mine conditions present on the Longwall headgate in the 8 Right section created such an unsafe condition that a miner suffered multiple, severe injuries that have a reasonable potential to cause death. The blunt force trauma that created these injuries "concussion, upper body blunt force trauma", [sic] was caused by a violent bounce which blew a rib out onto the miner while he was trouble shooting the face conveyor. Immediate reporting is necessary to address unsafe or potentially life threatening conditions and practices at a mine. The mine operator has had two injuries on the Longwall face in the last 6 months, six in the last two years. This violation is an unwarrantable failure to comply with a mandatory standard. The operator engaged in aggravated conducted constituting more than ordinary negligence by not reporting the accident that occurred on August 25, 2020 that resulted in life threating injuries to a Miner.

Id.

A. Violation

The cited provision states, "The operator shall immediately contact MSHA at once without delay and within 15 minutes . . . once the operator knows or should know that an accident has occurred involving: (b) an injury of an individual at the mine which has a reasonable potential to cause death." 30 C.F.R. § 50.10(b). The Secretary asserts this incident caused at least reasonable doubt which should have favored notification, and that Respondent myopically focuses on assessment of whether Mr. Adams' injuries were life threatening. *See* S. Br. 12 (citing *Signal Peak Energy, LLC*, 37 FMSHRC 470, 474 (Mar. 2015)).

Respondent cites *Signal Peak* to assert that the inquiry is whether a reasonable person, based on readily available information, thought the injury was life threatening. Resp't Br. 11–13 (citing 37 FMSHRC at 474; *Ideal Cement Co.*, 12 FMSHRC 2409, 2415 (Nov. 1990)). It relies heavily on its witnesses' testimony that nobody at the mine thought Mr. Adams' injuries were life threatening or told those to whom they reported that they were. I find that "life-threatening injury" is not the standard, and that this incident should have been reported to MSHA. For the following reasons, I affirm the violation.

1. Standards

a. Whether the injury is "life threatening" is *not* the standard for evaluating whether an incident is reportable.

Respondent states that "'life threatening' is commonly used as a synonym for an injury that has a 'reasonable potential to cause death,'" claiming that the case turns on whether the injury was life threatening. Resp't Br. 12. This is not supported by the cited authority. *Signal Peak* stressed evaluation of the readily available nature of the accident rather than relying merely on the injury itself:

> [R]eadily available information such as the nature of the accident is highly relevant in determining whether an injury is reportable, while permitting operators to wait for a medical or clinical opinion would "frustrate the immediate reporting of near fatal accidents."

37 FMSHRC at 476 (quoting *Cougar Coal Co.*, 25 FMSHRC 513, 520–21 (Sept. 2003)).

The page cited by Respondent only refers to the language in stating the *parties' contentions* regarding the proper evaluation of "reasonable potential to cause death": (1) the judge's statement that it means a "not far-fetched" possibility [of death]," and (2) respondent's statement that it is "synonymous with 'life-threatening.'" *Id.* at 474. Following this description, the Commission concluded that the injuries there had a reasonable potential to cause death and declined to further define the term. *Id.*

Further discussion was provided, however. The Commission noted that the judge rejected the operator's argument that the injury must qualify as life threatening. *Id.* at 474 n.8.

The Commission neither agreed nor disagreed with this finding; it simply acknowledged that Commissioner Cohen agreed with that distinction. *Id.* The Commission then made two statements demonstrating it agreed with the judge that reasonable potential to cause death is *not synonymous* with life threatening.

First, it stated, "The Judge correctly discerned that the reporting requirement . . . contemplates a subjective immediate evaluation governed by the concern for the 'possible,' not an objective clinical examination . . . ." *Id.* Next, it continued, "The Judge's analysis is consistent with the Commission's decision in *Cougar Coal Co.* (citation omitted), in which we stated that 'the decision to call MSHA cannot be made upon the basis of clinical or hypertechnical opinions as to the miner's chance of survival.'" *Id.* These demonstrate that the judge's analysis based on a "not far-fetched" possibility—not respondent's contention that the requirement is synonymous with "life-threatening"—is consistent with Commission precedent.

The other references to "life-threatening" are in its discussion of reckless disregard and in Commissioner Althen's dissent regarding penalty assessment. The majority summarized the judge's findings, noting that "the doctor . . . believed 'absolutely' that Stewart's injuries were life-threatening." *Id.* at 482. This was one of twelve considerations in support of the judge's finding of reckless disregard.

But a doctor's assessment of something as "life-threatening" is irrelevant to the *initial* determination. *See id.* at 477 (citing *Consolidation Coal Co.*, 11 FMSHRC 1935, 1936–38 (Oct. 1989)) ("By waiting for a medical opinion at the hospital rather than spending that time gathering readily available information, information which in this case would have been sufficient to trigger the notification requirement, Rice failed to conduct a sufficiently prompt investigation.").

Commissioner Althen asserted that the judge created a new interpretation of reasonable potential to cause death, arguing that MSHA and other Commission Judges have equated "reasonable potential to cause death" with "life threatening," and that such interpretation was supported by the final rule's preamble. *Id.* at 491 n.6, 492 (Althen, Comm'r, dissenting). "Life threatening" appears, *relevantly*, twice in the "Section 50.10 Immediate Notification" portion of the final rule.

First, the rule states, "Timely reporting can be crucial in emergency, *life-threatening* situations to activate effective emergency response and rescue." *Emergency Mine Evacuation*, 71 Fed. Reg. 71,430, 71,435 (Dec. 8, 2006) (emphasis added). Next, it states:

> Based on MSHA's experience under the ETS, "within 15 minutes" provides adequate time for operators to notify MSHA with sufficient information. For example, the mine operator often knows the general character of an event, such as an explosion or inundation, and can report it under the 15-minute requirement *before knowing whether a person has been injured or killed or whether the event is life threatening*.

Id. (emphasis added).

Prior to this, the language is only used regarding SCSRs, "enabling miners to breathe in the presence of hazardous or life-threatening contaminants," *id.* at 71,431, and regarding emergency training and response to "assure that underground coal miners can respond quickly and appropriate to life threatening mine emergencies." *id.* These two references to "life-threatening" are not directly relevant to what is required for reporting, and to the extent they are relevant, they clearly support reporting in the circumstances presented by this case.

The Commission majority's refusal to adopt a "life threatening" standard where a reasonable potential to cause death is at issue is consistent with the language and structure of the entire standard. Section 50.2(h) identifies twelve circumstances which must be immediately reported in accordance with Section 50.10. Only the first two, involving the death of an individual at the mine, or an injury to a miner with a reasonable potential to cause death, and the last, which is the death or bodily injury of a person not at the mine from an event at the mine, are based on physical injuries to persons. 30 C.F.R. §50.2(h)(1)–(12).

All the other defined "accidents" are based on the *event* itself: an inundation, roof fall, rock burst, instability, damage to a hoist, etc. The inclusion of all these conditions highlights the common element for all twelve, i.e., the agency's need to determine what happened, and why, in order to protect miners from being exposed to similar hazards.

The rule therefore first requires immediate reporting to ensure an effective MSHA response, including inspection to ensure other miners are not exposed to the same hazard, *see* Section V.B.4.b., *infra*. Next, the rule demonstrates that an operator can (and should) report an event—meaning it has a reasonable potential to cause death—based on the general character of the event, without being able to fully evaluate a resulting injury during the reporting window.

This is wholly consonant with the Commission's holding in *Cougar Coal*, *supra*, against waiting on medical confirmation that an injury is life threatening before reporting. Therefore, even if the support provided for Respondent's contention was not in the dissenting opinion, that argument would yet be unpersuasive.

The ALJ cases cited by Commissioner Althen are similarly unsupportive of his explicit contention that the two phrases should be equated. The judge in *Vulcan Construction Materials, L.P.* did not require a "life-threatening" injury. The decision cited the same page of the final rule quoted above, regarding SCSRs and emergency training to claim that the notification requirement "allows MSHA to address unsafe or potentially life-threatening conditions . . . when a quick response could make a difference." 35 FMSHRC 2868, 2879 (Aug. 2013) (ALJ). The case involved a miner found after having a heart attack.

The next mention of "life threatening" in *Vulcan* addressed the Commission's *Cougar Coal Co.* decision, but the judge acknowledged the *Cougar Coal* judge's error in requiring proof of life-threatening injuries from medical records. *Id.* at 2884.

Finally, in response to the operator's argument that it would have called an ambulance if it thought the injury was life threatening, the judge in *Vulcan* again turned to *Cougar Coal* to state:

> This Court recognizes that the ultimate cause of an incident does not control whether it must be immediately reported as an accident. But the apparent cause, or lack thereof, bears heavily on whether a mine operator knew or should have known that an injury with a reasonable potential to cause death has occurred. *See Cougar Coal Co.*, 25 FMSHRC at 520 (noting that the nature of the events surrounding the injury, as well as the actual injury sustained, must be considered when determining whether the accident had a reasonable potential to cause death).

Id. at 2887.

The judge in *Vulcan* therefore held that the nature of the accident is highly relevant, and his decision is consistent with Commission precedent. *See Cougar Coal; see also Signal Peak,* 37 FMSHRC at 476 (noting that the nature of the events surrounding an injury, as well as the injury sustained, must be considered when determining whether the accident had a reasonable potential to cause death.).

The judge in *Cemex, Inc.* did find that the Secretary failed to establish the violation because the injuries—burns to hands—were not life threatening. 35 FMSHRC 1355, 1365 (May 2013) (ALJ). But the context and the underlying authority are crucial. The judge properly distinguished the minor injuries at issue from those in *Cougar Coal*, where after suffering a severe electrical shock, the miner fell from a significant height and suffered a head injury.

However, *Cougar Coal* did not rely on the injury being "life threatening"—*the term was not even used*. The judge therefore incorrectly injected the term "life threatening" from *Cougar*

Coal's description of significant causes and injuries sufficient for notification, depriving Respondent of any relevant support for its position here.

Respondent also cites *Walker Stone Co.*, 23 FMSHRC 180 (Feb. 2011) (ALJ), *Consolidation Coal Co.,* 9 FMSHRC 1950, (Nov. 1987) (ALJ), and *Climax Molybdenum,* 2 FMSHRC 1967, (July 1980), but the ALJ holdings in these cases, in addition to being non-binding, all occurred before the Commission's decisions rejecting a "life-threatening" standard in *Signal Peak* and *Cougar Coal*.

Respondent thus disregards the actual, and inconvenient, state of the law, which requires the decision to report to be based on information available in the immediate aftermath of the event. *See Signal Peak*, 37 FMSHRC at 476 (quoting *Cougar Coal*, 25 FMSHRC at 520–21) ("[P]ermitting operators to wait for a medical or clinical opinion would 'frustrate the immediate reporting of near fatal accidents.'"); *Consol Pa. Coal Co., LLC, v. FMSHRC*, 941 F.3d 95, 111 (3d Cir. 2019) ("The focus of the notification requirement must be on the information available at the time of injury, so post-hoc medical evidence is less probative.").

While Respondent's reliance on the Third Circuit's approximation of the standard's language with "life threatening" in *Consol Coal,* 941 F.3d at 106 n.13, is not facially defective in the same way as the inapt ALJ decisions, it is nonetheless deficient, because it misconstrues the Commission's holding in *Signal Peak,* and glosses over the jurisprudential reasoning and record facts in that case.

The Third Circuit's decision, in noting the Commission's use of the term "life threatening," first observed (correctly) that the Commission "'has not found it necessary to'" define "reasonable potential to cause death." *Id.* (citing *Signal Peak*, 37 FMSHRC at 474). The Court then characterized the Commission as having found "that it was *enough to say the accident was 'life-threatening*[,]' because, in that case, the miner's 'injuries *clearly [fell] within the realm of a reasonable potential to cause death*[.]'" *Id.* (quoting 37 FMSHRC at 474 (citation and internal quotation marks omitted)) (emphasis added).

The Court's analysis improperly implies a relationship that does not exist between the Commission's clear reliance on the actual text of the standard and the term "life threatening:"

> Therefore, the Commission both here and in *Signal Peak* concluded that the *injuries at issue had a reasonable potential to cause death under a "life threatening" standard*. We follow the Commission's lead in that regard and use "life threatening" as a working interpretation of "reasonable potential to cause death.

Id. (emphasis added).[27]

While the term "life threatening" was noted frequently in the factual background of *Signal Peak*, the Commission there, as explained above, did not use it as the basis for its

[27] This problem does not diminish the logical or legal force of the Court's otherwise well-reasoned opinion.

conclusion that respondent failed to notify. In the Commission decision reviewed by the Third Circuit, the phrase "life threatening" was only used once, in the description of judge's findings. *See Consol Pa. Coal Co.*, 40 FMSHRC 998, 1001, 1010 (Aug. 2018) (affirming the judge's decision wherein he concluded there was justifiable concern about possible internal bleeding, "which could be life threatening").

The Commission, therefore, did not *require* the injury to be life threatening in either case. It did not adopt the respondent's asserted interpretation in *Signal Peak*, and it did not specifically analyze the violation under that standard in *Consol*. As noted by the Third Circuit, it was simply "enough to say the accident was 'life-threatening.'" This is because, while the injuries need not be life threatening to require reporting, life-threatening injuries are certainly within the ambit of those that do require it.

b. An operator must err on the side of reporting where the known circumstances of the incident suggest a reasonable potential to cause the death of a miner involved—though the extent of injury may evade immediate determination.

To be held accountable for failing to report an accident under the cited standard, Respondent must have had knowledge, or have had reason to know, of event and injury circumstances that had a reasonable potential to cause death. This knowledge, and Respondent's determination of the severity and requirement to notify MSHA, must be made based on the totality of the circumstances and focus on the information available during the reporting window, rather than on actual medical evidence. *See Consol*, 40 FMSHRC at 109, 111, *aff'd*, 941 F.3d 95 (3d Cir. 2019).

Further, the duty to notify must be interpreted from the perspective of a reasonable person in the circumstances, familiar with the mining industry and the protective purpose of the standard. *Id.* at 107; *Ideal Cement Co.*, 12 FMSHRC 2409, 2415 (Nov. 1990). Finally, and most critically here, any reasonable doubt must be resolved in favor of notification. *Consol*, 40 FMSHRC at 107. Reasonable doubt is based on the facts available during the reporting window. If the operator is unable to conclusively determine, within 15 minutes, that the accident does not involve an injury that has a reasonable potential to cause death, then even if the operator reasonably doubts the potential for fatal injury, it must notify MSHA.

It is possible to learn something—but not everything—from incidents where the Commission has found injuries to have reasonable potential to cause death based on the totality of the circumstances:

- A miner blasted 50 to 80 feet through the air with a back protrusion, severe pain, and difficulty breathing or moving. *Signal Peak*, 37 FMSHRC at 471.
- A miner crusted between multi-ton pieces of equipment, unable to move his legs [or feel one of them], and a distended stomach. *Consol*, 40 FMSHRC at 999.
- A miner suffering electric shock before falling 18 feet and hitting his head, requiring CPR. *Cougar Coal Co.*, 25 FMSHRC at 515.

- A miner pulled through a roller—7-inch space—with a "misshaped" head, that required months of surgeries. *Mainline Rock & Ballast, Inc.*, 693 F.3d 1181, 1183, 1189 (10th Cir. 2012).
- And finally, a miner suffering an obvious hip injury [noting the likely attendant complications] from a roof fall. *Webster Cty. Coal, LLC*, 39 FMSHRC 1131, 1136, 1137 (May 2017) (ALJ).

In each case, the Commission, court, or ALJ held that readily available information regarding the mechanisms of injury did not allow for any reasonable doubt as to whether the incident had a reasonable potential to cause death. But the severity of the injuries cited has been misinterpreted by Respondent as requiring that injuries be *at least* this severe, and that reporting is not required if the operator believes a miner's injuries are somehow distinguishable from the particular examples found in Commission case law.

There are several problems with this approach. First, the language of the standard is clearer than Respondent suggests. The primary term governing the requirement to "*immediately contact MSHA at once without delay*." The standard then goes on to reinforce this by imposing a duty to report "within 15 minutes . . . once the operator knows or should know that an accident has occurred." 30 C.F.R. § 50.10(b).

The reporting policy is not susceptible to a case-by-case approach at the scene of a serious incident, where a decision must be made "immediately," or within 15 minutes. Recognizing this, the Commission has not endorsed this approach. Rather, the Commission has determined that operators "must resolve any reasonable doubt in favor of notification." *Consol*, 40 FMSHRC at 1002 (quoting *Signal Peak*, 37 FMSHRC at 477). The Commission, and the Third Circuit in *Consol*, noted the impropriety of waiting for a more definitive medical analysis of a miner's condition. *See* 941 F.3d at 111; 40 FMSHRC at 1004 (holding that "[t]he notification requirement does not, and cannot, rest upon a post-medical treatment analysis," and that "[t]he decision whether to call must be made immediately and often by persons with little medical expertise").

This determination, which controls my decision, is consistent with the purpose of the standard. That purpose is not to enable care for the injured miner in circumstances such as this—it is to ensure that the agency is aware of the incident so that it may conduct its own investigation and ensure that other miners are not in danger or will not be threatened in the future by the practices or conditions that led to the reportable incident.

I emphasize that 15 minutes is the absolute limit of the time available for an operator to make a reporting determination. MSHA used three different terms, or phrases, to stress the requirement to speedily investigate and make the determination before the 15 minutes runs: "immediately," "at once," and "without delay." I would first note that regulations should be read with the understanding that MSHA intended each term to have a particular, nonsuperfluous meaning.[28] Next, even if it was not reasonable to read these other terms as having a separate and

[28] *See Bailey v. United States*, 516 U.S. 137, 146 (1995). Canons of statutory construction may be applied to regulations as well as statutes. *See Northshore Mining Co. v. Sec'y of Labor*, 709

distinct meaning from 15 minutes, I find that MSHA at least emphasized—three times in one sentence—the limited inquiry a miner can make before reporting.

"Immediately" means "[o]ccurring without delay; instant." *Immediate*, BLACK'S LAW DICTIONARY (11th ed. 2019). By adding "at once," the regulations underscore the need for immediate reporting and suggest that the requirement to report arises and must be carried out instantaneously with the recognition of the duty.

By adding "without delay," the regulation utterly refutes the notion that the duty to report may extend beyond the absolute limit imposed by the final requirement of the rule. Thus, an operator may not continue to investigate, examine, or otherwise look for reasons not to report beyond the final limit imposed by Congress—15 minutes.

There may be circumstances where reporting within 15 minutes is not possible or may be inadvisable. A situation where a manager is the only miner available to provide first aid, away from any means of calling MSHA or directing others to do so, would obviously better serve the intent of the Act by taking measures to care for an injured miner. In such circumstances, the Secretary should use her prosecutorial discretion not to cite the operator.

Even if the operator is cited because of the Act's strict liability provision, a *de minimis* penalty should be assessed. But the Commission may not substitute its judgment for that of Congress, which spoke clearly in drafting this provision.

I find the failure to notify here especially troubling because the Commission has held that reporting an accident is non-prejudicial. Any actions that the operator takes that are inconsistent with the appropriate response to an accident may not be cited if there was not, in fact, an accident. *Black Beauty Coal Co*., 37 FMSHRC 687, 690 (April 2015). While there is certain to be inconvenience and cost involved with notifying MSHA, this is a policy decision that has been made by Congress to protect miners from dangerous practices and conditions. *See* 30 U.S.C. § 813(j).

Finally, it is worth noting that the final rule provided examples for when the operator's knowledge of the general character of an event should prompt notification, including "an explosion or inundation." *See* Section IV.A.1.a., *supra*. MSHA also provided examples of reportable injuries: "concussions, cases requiring cardio-pulmonary resuscitation (CPR), limb amputations, major upper body blunt force trauma, and cases of intermittent or extended unconsciousness." 71 Fed. Reg. at 71,434.[29] The rule further says, "These injuries can result from various *indicative events*, including . . . *roof instability*." *Id.* (emphasis added).

F.3d 706, 710 (8th Cir. 2013) (citing *Fla. Dep't of Revenue v. Piccadilly Cafeterias, Inc.*, 554 U.S. 33, 46–52 (2008)); *Cremeens v. City of Montgomery*, 602 F.3d 1224, 1227 (11th Cir. 2010); *Resnik v. Swartz*, 303 F.3d 147, 152 (2d Cir. 2002); *Black & Decker Corp. v. Comm'r of Internal Revenue*, 986 F.2d 60, 65 (4th Cir. 1993).

[29] I find it notable that the inspector's citation specifically cited conditions listed in the preamble—i.e., "concussion" and "upper body blunt force trauma."

The agency has thus provided the public with notice of its expectations. As with the exemplars provided by Commission cases, one can learn something from the examples provided. But the list is not exhaustive. Even so, most concussions are not "life threatening," and major upper-body blunt force trauma may or may not be. The problem is not merely the nature of the injuries, but the "indicative events" that produced them. As the Commission has held, these circumstances are crucial to the need to report an incident to MSHA as an accident, and they were not fully considered here.

2. Respondent was required to notify MSHA about the incident because the known character of the injury-causing event at the time it was first reported sufficiently demonstrated a reasonable potential to cause death.

a. Totality of the Circumstances

The notification from which the 15-minute MSHA notification window began to run was made to Mr. Allred at 5:08 p.m. *See Signal Peak*, 37 FMSHRC at 476 ("Once a person with sufficient authority to call learns of an event injuring a miner, the clock begins to run on the period for evaluation of whether the injury presents a reasonable potential to cause death and a determination of whether a call is required.").[30]

Though Respondent claims the event was not violent—a "rib roll," rather than a "rib burst"—the record demonstrates that at least two, and possibly three, management personnel knew within 15 minutes that material fell from the rib and covered Mr. Adams. And though neither Mr. Allred nor Mr. Cooper knew at the time, the record demonstrates that it took approximately 30 minutes to remove Mr. Adams from the coal.

The Secretary pointed to the severity of the injuries Mr. Adams suffered, as well as the fact that the burst threw him into the 8 Bay, causing a serious head wound. S. Br. 10; *see also id.* at 14 (emphasizing that Mr. Bonnanci knew of a "pretty good gouge in his forehead"). She claimed what was known was that a rib burst blew coal 3 feet deep into the 8 Bay, Mr. Adams was buried under coal, had a 1.5-inch cut on his head from striking the 8 Bay, and was complaining about back, neck, and leg pain. *Id.* at 15–16. She acknowledged, however, that *at the time of notification*, Mr. Allred knew that Mr. Adams was buried under coal to his neck, and he called Conspec to send an EMT and get an ambulance as soon as he learned about the accident. *Id.* (citing Tr. 262).

Regarding Mr. Cooper, the Secretary stated that he was aware of the burst, that miners had to dig Mr. Adams out, and that Mr. Adams was complaining about leg and neck pain. *Id.* at 16 (citing Tr. 303–04, 323, 326). The record demonstrates that knowledge of the head wound

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[30] Mr. Cooper was notified by Conspec. Tr. 301–02. Mr. Allred called Conspec, to request Mr. Anderson [EMT], upon report of the incident from Charlie Wilson. *Id.* at 264. Nothing in the record demonstrates whether Conspec was already aware and had notified Mr. Cooper, or if it notified Mr. Cooper after the call from Mr. Allred. Mr. Gordon testified that Mr. Cooper called him between 5:20 and 5:25. *Id.* at 336. I therefore can only infer that Mr. Cooper was notified before 5:20, not that anyone was notified before 5:08.

and neck and leg pain was not obtained until Mr. Allred was at the incident site approximately 40 minutes later. Tr. 266–67.

Respondent similarly mostly focuses on the severity of injuries, based on information available after the 15-minute reporting window had lapsed—i.e., known by Messrs. Allred and Cooper, and reported to other individual liability respondents, after Mr. Allred arrived at the incident site and observed Mr. Adams. These included a knee injury, possible back and neck injuries, and head laceration. Resp't Br. 14.

Respondent relies heavily on the arguments that Mr. Adams was conscious and coherent,[31] and that nobody thought or stated that his injuries were life threatening. *Id.* at 14, 16–17. Both are irrelevant, however.

The Commission has repeatedly rejected the assertion that because a miner is alert after an accident, a reasonable person could conclude there was no potential for death. *Cougar Coal*, 25 FMSHRC at 520; *Signal Peak*, 37 FMSHRC at 476 (noting that while the miner presented some stable vital signs, all vitals were not taken, thus evaluation was not exhaustive or conclusive and did not establish that the miner's injuries posed no reasonable potential for death); *see also Consol* 40 FMSHRC at 998-1010. Further, "life-threatening" injury is not the standard, *see* Section IV.1.a., *supra*, and knowledge of the injuries was not obtained until after the reporting window had expired.

Respondent correctly conceded that assessment of reasonable potential to cause death does not require a medical determination. Resp't Br. 13 (citing *Signal Peak*, 37 FMSHRC at 470). It then attempts, however, to use medical findings to argue that the rib burst was not violent, and that Mr. Adams' vitals upon evacuation from the mine did not show that he had suffered injuries that in fact placed him in grave peril. *See id.* at 17–19 (noting that hospital tests did not show a violent impact because the head wound was a "surface fracture without significant trauma to the brain," and that the ambulance crew reported maximum cognitive scores and fine vitals).

Respondent cannot have it both ways, though. I agree with its original contention that it cannot rely on, and should not have waited for, a medical determination to decide whether the incident was reportable. My conclusion rests on the standard under the law as it has in fact been developed. *See Consol*, 40 FMSHRC at 111; *Signal Peak*, 37 FMSHRC at 476 (quoting *Cougar Coal*, 25 FMSHRC at 520–21).

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[31] As noted elsewhere in this decision, *supra* note 35, citing another ALJ's correct assessment, the nature and extent of head injuries cannot be precisely known. In particular, the fact that someone is conscious and coherent following such an injury may not be probative of the reasonable potential of the injury to cause death. *See* Ian Lovett & Brett Forrest, *The Navy SEAL Who Went to Ukraine Because He Couldn't Stop Fighting*, WALL ST. J., May 12, 2023, at A1 (Under the sub-heading "I'll walk out," a sailor who had been wounded by a projectile that penetrated his head remained conscious and walked away from a fire fight, but lapsed into unconsciousness and died three days later.).

Based on testimony from Messrs. Adams, Anderson, Allred, and Cooper, the only information available to Respondent during the reporting window was that material had fallen from the rib and covered Mr. Adams, and that he was bleeding from a head wound.[32] This is sufficient for a determination that the incident had the reasonable potential to cause death, based on the totality of the circumstances then known, and Respondent should have notified MSHA.[33]

I find that a rib burst or roll that buries a miner and results in a head wound is an event that has a reasonable potential to cause death. Immediately after this incident, the mine focused appropriately on uncovering Mr. Adams. Doing so took longer than the time afforded for reporting an accident. *See* 30 C.F.R. § 50.10 (requiring notification "immediately . . . at once without delay *and* within 15 minutes" when it knows or should know that an accident has occurred).[34]

Additionally, the operator may have no information, even if the miner is conscious, about the extent of the injuries, and whether they have a reasonable potential to cause death. Respondent therefore should have erred on the side of reporting*, see Consol*, 40 FMSHRC at 107, because there was, at best, reasonable doubt as to whether Mr. Adams' [unknown] injuries had a reasonable potential to cause death.

Mr. Adams' head wound, while unnecessary to determine this incident was in fact reportable, further demonstrated a reasonable potential to cause death.[35] Mr. Adams had a skull

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[32] I clarify here that the fact that Mr. Adams was bleeding from a head wound was "available" information, as it was known by Mr. Bonnanci and those working to uncover Mr. Adams. I acknowledge that Messrs. Allred and Cooper were not aware of the head injury until Mr. Allred's arrival at the site. This, however, does not challenge the availability of the information to the operator, as I have found, *infra*, that Messrs. Allred and Cooper were required to be more inquisitive about the extent of the injuries.

[33] I note here that this violation was initially cited under a different subsection, which requires reporting an accident involving "an entrapment of an individual at the mine which has a reasonable potential to cause death." 30 C.F.R. § 50.10(c); *see* Order Granting Motion to Amend Order, Docket no. WEST 2021-0188 et al., at 2 (Apr. 27, 2022). Based on the amount of time it took to uncover Mr. Adams, there was a possibility that this action ultimately could have been affirmed under another provision of section 50.10 as well. This is further evidence that should have compelled reporting of this accident.

[34] This is the shortest time specified in the Act or regulations for taking any action, and was added by Congress ("*and* within 15 minutes") in the MINER Act. There is also a requirement to withdraw all miners from the mine if the main mine fan stops and ventilation is not restored within 15 minutes. 30 C.F.R. § 75.313(c)(1). This reflects the agency's clear concern that miners be protected by prompt action and underlines the urgency of the reporting requirement.

[35] Another Commission judge has aptly described the danger of head wounds:

> [G]etting hit on the head by a heavy object can lead to an intracerebral hemorrhage, i.e., bleeding in the brain. One of the most common causes of brain hemorrhage is head trauma. This fact is now common knowledge and is certainly something

fracture diagnosed at the hospital. Reacting miners at least knew he had a head laceration through which they could "see his skull."

That information was not initially known to Messrs. Allred or Cooper (or Mr. Gordon, though the record does not definitively demonstrate that he was notified within the 15-minute window). But importantly, neither *inquired* into any of Mr. Adam's injuries.[36] An operator cannot escape its duty to report by remaining uninformed of possible injuries. *See Mainline Rock & Ballast, Inc.*, 693 F.3d at 1189. Like *Mainline*, knowledge of a significant laceration, and likely skull fracture, *if inquired about*, would have demonstrated a need to notify MSHA. *See* Tr. 93, 243 (demonstrating that Mr. Anderson "could see his skull" and it was "dented in," and that Mr. Bonnanci saw "a pretty good gouge in his forehead").

I also note that the extent of injury posed by closed-head trauma cannot be known without expert medical diagnosis, but such injuries must be assumed to be extremely serious until a medical evaluation may be obtained. *See Solvay Chems., Inc.*, 43 FMSHRC at 489–90. If the standard requires reporting if there is any reasonable doubt—and it does—the potential and unknown health risks posed by a closed head injury must compel reporting.

> management of a large mine should know. These hemorrhages have a reasonable potential to cause death if not diagnosed and treated quickly. Adverse symptoms of a brain hemorrhage will often not be visible within 15 minutes of an accident.

Solvay Chems., Inc., 43 FMSHRC 477, 489–90 (Nov. 2021) (ALJ). Though this is a non-binding ALJ decision, I find it persuasive regarding "known unknowns" associated with head or other injuries attendant to rib falls and burials. The operator petitioned the Commission for review of this decision, which was granted. *See* Direction for Rev., *sub nom Sec'y v. American Soda, LLC Formerly Known as Solvay Chemicals, Inc.* (May 12, 2021). The Commission heard oral argument in the case on May 16, 2023. On May 18, two Commissioners said they would vote to affirm the ALJ's holding that the accident was reportable. If the Commission holds in accordance with their statements at the public meeting, the ALJ's decision would stand as if affirmed but would be non-precedential. *See Sec'y of Labor v. Consolidation Coal Co.*, 895 F.3d 113, 116, 117 n.2 (D.C. Cir. 2018) (holding that a two-to-two division results in the ALJ's decision being the final, reviewable, agency action). The facts in this case are similar to the facts in *Solvay/American Soda*, but distinguishable. Thus, the Commission's decision is not likely to have any precedential effect on my decision here.

[36] Mr. Allred did not ask about any injuries during the initial call, or during his next call with Charlie Wilson while he was driving to the incident site. Tr. 262–63, 265–66. Knowledge of the head laceration, along with his assessment that Mr. Adams' injuries were not life threatening, did not occur until his arrival at the incident site much later. Mr. Cooper only testified to assessments reported to him by Mr. Allred. *Id.* at 303–304. He was informed of the incident by Conspec, but nothing in the record demonstrates that he made further inquiry into Mr. Adams' injuries for over half an hour. *Id.* at 301–02.

b. A reasonably prudent, experienced miner would have known that such an incident had reasonable potential to cause death, or would have at least had reasonable doubt as to whether it did not.

As discussed above, such an incident—even with unknown injuries—has a reasonable potential to cause death. Respondent's witnesses relied heavily on personal observation, or the lack of verbal reporting, that Mr. Adams' injuries were "life threatening." Some may have relied on personal experience, such as the manager who claimed, "I've been buried under coal myself." Tr. 387 (testimony of Jake Wilson). This was incorrect. With full appreciation for Mr. Wilson's grit, and the toughness and resiliency displayed on the job routinely by other miners, the Commission's precedents require a more sober reflection about miner safety and the possible injuries attendant to the entrapment of miners by falling material and other such incidents.

It doesn't matter whether Respondent inappropriately relied upon a "life-threatening injury" standard honestly or to minimize its required incident reporting. I need not make such a determination, as it is sufficient that a reasonably prudent, experienced miner should have known that a rib burst burying a miner has a reasonable potential to cause death, because such movements regularly have been the cause of fatal injuries to miners. Even if it relied on what it learned later, though, Respondent also would have been on such notice had it made proper inquiry into known or possible injuries.

At best, the operator would have had reasonable doubt as to whether the Mr. Adams' injuries had a reasonable potential to cause death, as it could not conclusively determine they did not. First, there was insufficient inquiry into whether there was a reasonable potential to cause death until Mr. Allred observed Mr. Adams, spoke with Mr. Anderson, and reported to Mr. Cooper that he did not think Mr. Adams' injuries were life threatening. All other reports of such potential were relayed to higher management or personally observed once Mr. Adams was evacuated from the mine—more than an hour after the incident.

Next, there are "known unknowns" associated with rib bursts, burials, and head injuries.[37] Miners worked to uncover Mr. Adams for approximately 30 minutes. Mr. Bonnanci was aware of Mr. Adams' head laceration from contact with the 8 Bay during that time. The miners working to uncover Mr. Adams, and those to whom the incident was reported, did not, and could not, know about possible further injuries during the reporting period.

The facts available to Messrs. Allred and Cooper in the 15 minutes after notification would not enable a reasonable miner to conclusively determine that the accident that injured Mr. Adams, and his unknown injuries, did not have the reasonable potential to cause death. This is demonstrated by the fact that such conversations about whether the accident was reportable continued throughout the efforts to uncover Mr. Adams, his evacuation from the mine, his departure to the hospital, and even after hearing about the extent of his injuries assessed at the hospital.

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[37] Respondent should have known about—i.e., should have made adequate inquiry into—Mr. Adams' head laceration and any other possible injuries. *See* Section V.A.2.a., *supra*.

Though I have already found that the operator's agents should have been more inquisitive about the extent of the accident and Mr. Adams' injuries, one might argue that anybody who could have informed Mr. Allred further was working—"feverishly," no less—to uncover Mr. Adams. Such a defense is inadequate for two reasons. First, the record demonstrates that Mr. Allred in fact spoke to Charlie Wilson during his drive to the site. Second, this reinforces the existence of reasonable doubt. It is doubtful that the responsible person with authority to call MSHA will be at, or even near, an accident site when it occurs. If every available person is engaged in trying to save an injured miner, causing inability to obtain further information from them, that is sufficient to demonstrate reasonable doubt that the injuries do not have a reasonable potential to cause death. Respondent was therefore required to err on the side of reporting—enabling MSHA response and inspection to prevent others from being similarly hurt. *See Signal Peak*, 37 FMSHRC at 477 (citing 71 Fed. Reg. at 71,431).

B. Gravity

1. Likelihood

The hazard—inability of MSHA to respond or investigate—in fact occurred. MSHA was not informed until the next day, and the incident area had been mined past before an accident investigation was ordered. I therefore affirm the likelihood determination.

2. Severity

The Secretary asserts the severity of the contemplated injury is permanently disabling. The severity here is that of an injury resulting from the contemplated hazard, i.e., a similar incident caused by MSHA's inability to investigate and validate the safety of the violative area. I have already found that Mr. Adams' injuries were appropriately designated as permanently disabling and had the reasonable potential to cause death. Any other miner affected by a similar incident would therefore be exposed to similar injuries. I therefore affirm the severity as characterized by the inspector.

3. Number of Persons Affected

The inspector assessed that one miner would be affected by the hazard. I find it reasonable that at least one miner was vulnerable to a similar hazard during continued mining before MSHA inspection. I thus affirm the assessment of persons likely to be affected.

4. S&S

I affirm the S&S designation for the following reasons.

a. Step 1: The violation has been established.

I have found that a failure to notify MSHA about an incident with a reasonable potential to cause death occurred. *See* Section V.A.2., *supra*. This is sufficient to constitute an underlying violation of a mandatory safety standard for the purposes of *Mathies* Step 1.

b. Step 2: The violation was reasonably likely to result in the discrete safety hazard against which the regulation is directed—another similar occurrence due to MSHA's inability to promptly investigate.

The standard requires that operators notify MSHA within 15 minutes of an accident with the reasonable potential to cause death. An ambulance and life flight were on site when Mr. Adams was evacuated to the surface, so there is no contention that the failure to notify MSHA would have resulted in impairment of otherwise mobilized MSHA rescue efforts. But another purpose of reporting is to enable MSHA to investigate immediately. The Commission has held:

> [The operator] contends that the failure to timely report the accident to MSHA did not contribute to a hazard, because MSHA's involvement was not necessary to remedy [the] injuries. This interpretation unduly narrows the purpose of section 50.10. While immediate rescue efforts are a significant concern, *section 50.10 is also intended to facilitate MSHA's ability to investigate and remedy the cause of the accident*.

Signal Peak, 37 FMSHRC at 480 (emphasis added). The contemplated hazard here then is a similar rib fall incident caused by lack of MSHA investigation and remedy.

The Secretary correctly asserts the failure to report interfered with MSHA's ability to investigate. S. Br. 16. Respondent counters that the standard is not what "could" occur, Resp't Br. 26 (citing *Wolf Run Mining Co.*, 32 FMSHRC 1669, 1677 (Dec. 2010)), thereby arguing that another similar accident is not reasonably likely, *id.* at 27. Respondent incorrectly asserts that the Secretary's analysis is directed at the rib roll, rather than the failure to report. *Id.* at 27–28.

The analysis is focused on *another* rib incident at a nearby or similarly inadequately supported area, during continued mining operations, due to lack of MSHA investigation of the violative incident. There is sufficient evidence in the record demonstrating that this hazard is reasonably likely. There was a similar incident nearby five days prior. This incident occurred with additional mitigation apparently added following the first incident.

Miners worked in the area—even if only to inspect, clear the accident site, and conduct further mitigation—between the accident and Mr. Madrigal's visit. *See* Tr. 347. It is therefore reasonably likely that the violation would cause another similarly hazardous occurrence prior to an MSHA inspection. *See Signal Peak*, 37 FMSHRC at 473, 481 (affirming a judge's S&S finding where a failure to report delayed MSHA involvement and exposed miners to uncorrected conditions, a similar fall, and similar resulting injuries).

Respondent claims MSHA had ample opportunity to inspect after being informed the next morning, and that Messrs. Gordon, Wilson, and Roberts inspected and remedied the conditions the previous night. Resp't Br. 28. Neither contention allays the hazard because MSHA was unable to inspect and propose a remedy, which is the point of the provision, and the same operator installed mitigation after the first incident that was clearly ineffective.[38]

[38] Also, the standard not only provides when the report to MSHA must be made, but how,

c. Step 3: Lack of MSHA investigation was reasonably likely to result in similar injury from falling rib material.

The Secretary asserts that miners working in the area following the incident were exposed to dangers from an uncontrolled rib. S. Br. 16. Respondent, without specifically referencing Step 3, relies on the same contentions regarding its own inspection and mitigation to argue that further miners would not likely suffer similar injury from a similar event. Resp't Br. 28.

Assuming the hazard—a similar incident due to MSHA's inability to promptly investigate—occurs, a miner is reasonably likely to be injured by falling rib material. I have already found that a fractured skull or vertebra are reasonably likely to occur from a rib burst. *See* Section IV.B.4.c., *supra*. Given that such injury did in fact occur, it is reasonably likely that the failure to notify MSHA would result in a similar occurrence during continued mining, and that another miner would suffer similar injuries to those of Mr. Adams.[39]

d. Step 4: It is reasonably likely that such an injury would be of a reasonably serious nature.

I have found that the same injuries from falling rib material are reasonably likely. I have already found such injuries to be of a reasonably serious nature. *See* Section IV.B.4.d., *supra*. The resulting injuries from this violation are therefore reasonably likely to be of a reasonably serious nature.

C. Negligence

I find the negligence was properly characterized by the inspector as "high." Management personnel in the position to stop work and notify MSHA are familiar with the mining industry, the relevant facts, and the protective purpose of the provision. This was evidenced by their consistent questioning and reporting regarding whether Mr. Adams' injuries were life threatening. A reasonably prudent person in their position should have recognized that the incident had a reasonable potential to cause death and required MSHA notification.

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including the agency's toll-free number in the regulation. 30 C.F.R. § 50.10. The ease of compliance for this provision also bears on my decision. First, it is non-prejudicial if it turns out the incident was not reportable. Second, Congress' emphasis on the haste with which the decision must be made requires miner training that makes reporting almost a reflex. The stakes are too high, and every miner and manager should train to immediately report an incident where reasonable doubt exists as to a miner's condition.

[39] This is based on the likelihood—and occurrence—of the injury that I affirmed as "permanently disabling." The fact that the injury was not fatal, and not designated as such on the citation because the inspector assessed the actual outcome here, *see supra* note 21, does not preclude the fact of violation. While this injury was "permanently disabling," it is the character of the accident that had the reasonable potential to cause death.

The Commission has affirmed a moderate negligence finding where an operator should have known a reportable accident occurred, but the judge acknowledged that it acted quickly and efficiently to help the miner and did eventually alert MSHA. *Consol Pa. Coal Co.*, 40 FMSHRC at 1001, 1010. The Commission has also found high negligence, however, where an operator purportedly delayed notification because of its focus on evacuating survivors. *Wolf Run Mining Co.*, 35 FMSHRC 3512, 3518 (Dec. 2013). The record there demonstrated that the operator was concerned about a shut-down, and it was also sufficient for high negligence that nobody tried to contact MSHA at all, nor was there any real effort to investigate the incident for more than an hour, after Respondent knew there had been a rib burst that had buried a miner in coal. *Id.* at 3516, 3518.

In the oft-cited *Signal Peak* decision, the Commission found reckless disregard where the operator failed to take any steps to ensure the roof fall was investigated, thereby placing miners at future risk. 37 FMSHRC at 481–82. It held that the duty to report was obvious at multiple points in time. *Id.* at 482. The Commission cited the significant damage and severe and obvious injuries caused by the accident.

It took one-and-a-half hours to transport the injured miner out of the mine in *Signal Peak*, and he required a life flight. *Id.* The operator never contacted MSHA and was concerned about resuming production. *Id.* In resuming production, it changed conditions at the accident scene. It did nothing to investigate and prevent recurrences. *Id.* MSHA found out about the accident from a newspaper reporter days later. The operator filed a 7000-1 accident report one-and-a-half hours after the safety director spoke with MSHA and was "anything but forthcoming." *Id.*

The Secretary claimed the injuries in this case were obvious, and management was uninquisitive. S. Br. 17–18. It further asserted that Respondent prevented MSHA from investigating, maintaining a high degree of danger to miners during continued work. *Id.* Respondent emphasized that only knowledge of laceration, knee injury, and possible back or neck injury was available. Resp't Br. 24–25. It also noted that Mr. Cooper filed the accident report the next morning. *Id.* at 24.

I have found that the duty to report was obvious from the time of notification—a rib burst burying a miner in coal with unknown injuries. *See* Section V.A.2., *supra*. I have not found that Respondent was more concerned with resuming production. Though one might infer it from the failure to report both the August 20 and Mr. Adams incidents, and continued work in the area without an MSHA inspection, it is clear from the record that Respondent relied heavily on whether there was an assessed life-threatening injury to evaluate reportability.

Though the head laceration, signifying some blunt force trauma, was obvious, Mr. Adams' injuries and the cause were not as severe as the circumstances in *Signal Peak*. It took a significant time to evacuate Mr. Adams, both from under the coal, and from the mine, and Respondent did not notify MSHA until an inspector came and inquired about the incident.

Respondent also changed conditions at the accident scene by continuing to clean, inspect, and mitigate the area.[40] Operator managers investigated the incident themselves and installed mitigation, but there was never an MSHA investigation to assist in preventing recurrence. Finally, Mr. Cooper filed the report after being questioned by Mr. Madrigal.

I agree that the operator did not exhibit reckless disregard because there has been no demonstration that Respondent did not report specifically because of concern for continued production and a desire to avoid MSHA enforcement. The circumstances are, however, more severe than those demonstrating moderate negligence. Respondent demonstrated a serious lack of reasonable care in failing to enable MSHA to investigate an obvious injury. The Secretary therefore demonstrated that this violation was the result of the operator's high negligence.

D. Unwarrantable Failure

The Secretary argues that multiple managers knew of the incident and had sufficient information about the laceration and neck, back, and leg pain to prompt reporting. S. Br. 17. She claims the injuries were obvious, citing the deep laceration, blood through the gauze, and obvious pain. *Id.* at 17–18. The Secretary further asserted no management asked if the injuries were life threatening,[41] and the failure to report prevented MSHA investigation, creating significant danger for miners continuing to work. *Id.* at 18.

Respondent asserts reporting violations do not fit readily with an unwarrantable failure analysis. Resp't Br. 23–24. It emphasizes that the time the violation existed was until the next

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[40] Respondent demonstrated that Mr. Madrigal investigated the injury scene and other inspectors took three days to attempt to inspect. Resp't Br. 24. The circumstances surrounding the investigation are admittedly strange. The record shows that Mr. Madrigal went underground the day after the incident, measured the accident site rib deformation, and was informed about injuries, which he reported to Mr. Lyons. Tr. 126–27, 312. Operations continued, and the violative area had been mined past by the time Mr. Lyons went to the mine. *Id.* at 128. Neither inspector issued a K-Order. *Id.* at 130, 176. Mr. Lyons issued the citation based on Mr. Madrigal's information and mine employee interviews. Such actions likely caused confusion for Respondent as to whether it was in violation or could continue operation. It is not, however, inappropriate for an inspector to issue a citation based on information obtained without inspecting a site. It was not demonstrated that Respondent continued coal production between the incident and Mr. Madrigal's visit. Miners did, however, continue working to clean the area and install mitigation. This occurred without an MSHA inspection and validation of the area, *see* Section V.B.4.b., *supra*, posing the contemplated risk of similar incident for those still working in the area where there had been two recent falls.

[41] This contention is only true to the extent that these inquiries were not made, or at least confirmed, until after the reporting window. The record demonstrates that each respondent-manager discussed whether Mr. Adams' injuries were life threatening with the person who notified them, or they came to that conclusion based on their own observations. Tr. 303, 318–19, 326, 338, 376, 439–40. I found management did not seek to assess the severity of Mr. Adams' injuries until Mr. Allred arrived on site 40 minutes later and as such, were inexcusably uninquisitive about the injuries during the reporting window. *See* Section V.D.1., *supra*.

morning, and that it was not on notice that greater efforts were required. *Id.* at 24. It described its abatement as describing the injury to the inspector and field office supervisor and filing the 7000-1 form. *Id.*

Respondent claims there was no degree of danger because Mr. Madrigal investigated the injury scene and others neglected attempts to inspect for days. *Id.* Finally, it relies heavily on lack of operator knowledge, claiming direct observations did "not indicate a danger of death" and that nobody reported "life-threatening" injuries. *Id.*[42]

For the following reasons, I find the violation was the result of Respondent's unwarrantable failure to comply with a mandatory standard.

1. Respondent should have known of the existence of the violation because of the nature of the incident and probable, yet unknown, injuries.

Both parties are incorrect in their use of Mr. Adams' determined injuries to claim knowledge or lack thereof. Respondent should have known[43] of the violation—that it was required to notify MSHA—within 15 minutes after the report to Mr. Allred because of the nature of the incident and its inability to know the attendant injuries. I have found that material falling from a rib and covering a miner are sufficient for a reasonably prudent, experienced miner to assess that an incident has a reasonable potential to cause death. *See* Section V.A.2., *supra*.

The existence of the skull fracture, vertebra fracture, and knee injury were not conclusively known until Mr. Adams' treatment at the hospital. At best, the Secretary may appropriately point to the existence of Mr. Adams' obvious head laceration to claim that blunt force trauma occurred, and immediate knowledge of that injury should be sufficient for notification.

I have found that such a head injury is reportable because of unknown, but probable, brain injury, and that Respondent was inexcusably uninquisitive about Mr. Adams' injuries between the first report and Mr. Allred's observation. *See* Section V.A.2.a., *supra*. Respondent's knowledge is therefore an aggravating factor in favor of unwarrantable failure.

2. The violation was sufficiently obvious for the same reasons as above.

Because Respondent should have known of the existence of the violation based on a rib burst's reasonable potential to cause death, and emphasizing the immediately apparent head

[42] Respondent reiterates here that the only available information before medical evaluation at the hospital was the laceration, knee injury, and possible neck or back injury. *Id.* at 24–25.

[43] "[T]he Commission . . . explicitly stated that aggravated conduct more than ordinary negligence can be demonstrated through a "knew or should have known standard." *The Am. Coal. Co.*, 38 FMSHRC 2062, 2081 n.27 (Aug. 2016) (citing *Emery Mining Corp.*, 9 FMSHRC 1997, 2002–04 (Dec. 1987); *E. Associated Coal Corp.*, 13 FMSHRC 178, 187 (Feb. 1991) ("A lack of actual knowledge by . . . management . . . does not necessarily bar an unwarrantable failure finding.")); *see also Brody Mining, LLC*, 37 FMSHRC 1687, 1699 (Aug. 2015).

injury, I find that the violative condition was obvious. The obviousness of the condition is an aggravating factor in favor of an unwarrantable failure finding.

3. The violation posed a high degree of danger because of the risk of injury to miners continuing to work in the area from a similar incident.

As with the S&S analysis, I find the danger associated with this reporting violation is that of a similar rib burst and injury to miners continuing to work in the area without MSHA investigation. *See* Section V.B.4.b., *supra*; *Signal Peak*, 37 FMSHRC at 480. This element does not include duration, only the degree of danger posed by any work conducted where the danger continues due to MSHA's inability to inspect. *See Midwest Material Co.*, 19 FMSHRC 30, 35 (Jan. 1997) ("The judge's reliance on the relatively brief duration of the violative conduct was misplaced, in view of the high degree of danger posed by the hazardous condition and its obvious nature.").

Respondent incorrectly conflates its argument for this element with that relating to the length of time the condition existed. The fact that Mr. Madrigal investigated the injury scene the next morning does not effectively challenge the degree of danger. At best, its statement that others neglected to inspect for days after learning of the incident could be construed as an MSHA acknowledgement that the danger posed was not high. I do not accept that, as I have already found that serious injury is reasonably likely to result from this violation.

Managers went to the incident site to inspect and ensure mitigation, but they did not enable MSHA to do so. Mr. Allred testified he told miners to stay out of the area until Messrs. Gordon and Wilson—whom he knew were on the surface—could evaluate. Tr. 273. Messrs. Gordon and Wilson testified that they checked the site and found that a prop had been dislodged, and that much of the rib mesh was still attached. *Id.* at 346, 380–82. Mr. Gordon testified that they further inspected the area that evening. *Id.* at 347. This sufficiently demonstrates that miners were working in the area after the incident but before an MSHA investigation.

I have found that the lack of an MSHA investigation resulted in significant danger to miners continuing to work in an area with clearly inadequate rib support—demonstrated by two rib bursts in the previous five days and no MSHA investigation following either incident. This violation therefore posed a high degree of danger and is an aggravating factor in favor of an unwarrantable failure finding.

4. The extent of the violation was significant because it affected the safety of the entirety of the long wall.

The extent is the scope or magnitude of the violation. *See E. Associated Coal Corp.*, 32 FMSHRC 1189, 1195 (Oct. 2010) (citing *Peabody Coal Co.*, 14 FMSHRC 1258, 1261 (Aug. 1992)). A judge has found an extensive violation of a reporting violation, considering the abatement measures taken to terminate the relevant orders. *See Pine Ridge Coal Co.*, 33 FMSHRC 987, 1017 (Apr. 2011) (ALJ) (citing *E. Associated Coal Corp.*, 32 FMSHRC at 1196; *Peabody Coal Co.*, 14 FMSHRC at 1263) ("[T]he failure to report the "near miss" accident . . .

extensively inhibited the use of MSHA expertise to timely investigate and institute critical, pro-active corrective actions through the [section] . . . .").

Having found that the danger of this violation is the occurrence of a similar event in a working area that has been demonstrated to be inadequately supported, I find that the extent of the violation includes the entire 8 Right Longwall. Ex. GX-1, 5. I further find the cited ALJ decision instructive, and I hold that the failure to report "extensively inhibited" MSHA's investigation and possible mitigation.[44] The extensiveness of this violation is therefore an aggravating factor in favor of an unwarrantable failure finding.

5. The length of time the violative condition existed was minimal because, though initiated by the inspector, Respondent informed MSHA the next morning.

The violation was marked "terminated" on the same day it was issued. *See* Ex. GX-1 ("This event has already occurred, discussions with the mine operator were held about this subject."). Mr. Madrigal visited the mine the next day—August 26—and the citing inspector visited the day after. Tr. 114–15.

The record demonstrates that Mr. Lyons did not go underground to inspect the area. Tr. 128. Mr. Lewis went underground on August 27. *Id.* at 166–67. At the latest, the condition was abated on August 27—approximately 36 hours after the incident—upon Mr. Lewis' inspection. I find it more likely, however, that the condition was abated following Mr. Madrigal's inspection on the morning of August 26. This is because Mr. Lyons testified that Mr. Madrigal informed him about the incident, his inspection, and Mr. Adams' injury, and Mr. Lyons did not conduct an inspection himself.

The length of time the violative condition existed was therefore approximately 14 hours. The Commission has found that the duration of a minimum of two shifts was an aggravating factor in favor of an unwarrantable failure finding. *See The Am. Coal Co.*, 39 FMSHRC 8, 22 (Jan. 2017). I find that the duration here is not an aggravating factor.

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[44] Though I find it sufficient that the extent of the violation affected the entire longwall, and the failure to report extensively inhibited investigation, I note that another judge has found a violation extensive based on the number of mine management with knowledge. *See M-Class Mining, LLC*, 39 FMSHRC 1013, 1030 (May 2017) (ALJ) (noting that five management officials had knowledge and neglected to comply, and that upon the inspector's instruction that it was reportable, delayed reporting and was evasive). Here, it is only determinative that Messrs. Allred and Cooper had knowledge within the first 15 minutes, but three other mine managers were informed in short order. Respondent never did notify MSHA via the provision's stated method. *See* Tr. 148 (receiving confirmation from Mr. Lyons that "telling Rudy [Madrigal]" is not "contacting MSHA at the . . . number within 15 minutes"); *id.* at 327 (receiving confirmation from Mr. Cooper that he only emailed MSHA representatives after seeing Mr. Madrigal). I acknowledge that there may have been confusion as to whether informing Mr. Madrigal, and his subsequent inspection, was sufficient, and I therefore find this is not comparable regarding not reporting.

6. Respondent’s efforts in abating the condition were sufficient because an MSHA representative was aware and able to inspect.

I have found that the condition was obvious, and Respondent clearly relied on the wrong standard—"life-threatening” injury—to conclude the incident was not reportable. Mr. Cooper intended to, and did, file a 7000-1 form. Even if prompted by questions at the presence of the stretcher, Tr. 118, he informed Mr. Madrigal about the incident, and Mr. Madrigal inspected. Likely believing this sufficient, Mr. Cooper still emailed other MSHA personnel.

I take the “discussions” cited for termination of the citation as those that occurred between Messrs. Madrigal and Cooper. First, there was no call to the hotline and no further notification to Mr. Lyons following Mr. Madrigal’s inspection. Mr. Lyons did not inspect the site. The abatement—which would require such inspection—was therefore based on either Mr. Madrigal’s inspection on August 26, or Mr. Lewis’ on August 27, and the associated discussions. And since Mr. Cooper contacted MSHA officials on August 26, I take that as the abatement time recognized in Mr. Lyons’ September 10 citation. Respondent’s abatement efforts are therefore not an aggravating factor in favor of an unwarrantable failure finding.

7. Respondent had not been placed on notice that greater efforts were necessary for compliance because it had few similar citations, and MSHA provided no prior warnings in that regard.

An operator’s history of similar violations puts the operator on notice that greater efforts are necessary. *See Brody Mining, LLC*, 37 FMSHRC at 1699; *Big Ridge, Inc.*, 35 FMSHRC 1525, 1530 (June 2013) (disagreeing with the contention that past violations can only provide notice if they are factually indistinguishable from the cited condition). The record demonstrates only one other reporting violation. Ex. GX-3. The Secretary did not demonstrate any communications wherein MSHA warned Respondent about failures to report.

The inspector noted prior injuries in the citation before assessing unwarrantable failure. *See* GX-1, DOL 0036 (“The mine operator has had two injuries on the Longwall face in the last 6 months, six in the last two years.”). These injuries would likely be more appropriately cited in the rib control citation—even though I can only assume that they were the product of such a violation. No evidence was presented that Respondent failed to notify MSHA about any such injuries. They are therefore irrelevant. This element is therefore not an aggravating factor in favor or an unwarrantable failure finding.

8. Conclusion

The factors in favor of an unwarrantable failure finding include Respondent’s knowledge, the obviousness of the violation, the high degree of danger, and the extent of the violation. The duration, abatement efforts, and whether Respondent was on notice that greater efforts were necessary, are not supportive of such a finding. I conclude that this violation was the result of Respondent’s unwarrantable failure to comply with a mandatory standard. *See Peabody Midwest Mining, LLC*, 44 FMSHRC at 525 (“[T]he Commission has held that brief duration does not

militate against a finding of unwarrantable failure where the condition is distinguishable by its high degree of danger and obvious nature . . . .”).

E. Penalty

Respondent has been cited once in the last two years at this mine for violation of this regulation. Ex. GX-3. This is a low rate of repeat violations, but does reflect a misperception of the duty to report. I accept that the Secretary has properly evaluated the size of the mine. The parties have stipulated that payment of this penalty will not affect the Respondent’s ability to continue in business. Stips. ¶ 7.

Respondent made efforts to achieve compliance through its verbal report to Mr. Madrigal and its 7000-1 report, though I have found such efforts prompted and lacking overall.

I have affirmed the Secretary’s gravity, negligence, and unwarrantable failure determinations. While the failure to report was made by a lower-level manager, and ratified by the mine’s safety director, I find that the violation results from a failure of mine management generally to consider the important purposes served by the immediate notification requirement and, flowing from that, a failure to ensure that responsible persons are properly trained to notify the agency immediately when an accident occurs.

I do not, however, find this to be willful or intentional misconduct. I consider this a serious lack of reasonable care due to the operator’s improper reliance on a faulty assessment of the injury over an inappropriately protracted timeline.

MSHA proposed what is effectively a maximum penalty in this case. Yet there must be a difference in penalties between a failure such as the one here and a finding, for instance, of a purposeful failure to report, based on the chance that the injury will eventually not be assessed to have a reasonable potential to cause death, or directing that a known injury not be reported to avoid a halt to production. Considering the circumstances and all the factors in Section 110(i) of the Act, I therefore assess a penalty of $50,000.00.

VI. INDIVIDUAL LIABILITY FOR VIOLATION OF SECTION 50.10(B)[45]

A. Each Cited Respondent Was an Agent.

Each cited respondent here was an agent of Canyon Fuel Company, LLC. An agent is defined as “any person charged with responsibility for the operation of all or a part of a . . . mine or the supervision of the miners . . . .” 30 U.S.C. § 802(e).[46]

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[45] Though not contested, I note that section 50.10 is a mandatory health or safety standard. *See Signal Peak Energy, LLC*, 37 FMSHRC 470, 479 (Mar. 2015). A violation of the requirement may therefore be the basis for section 110(c) liability.

[46] A “person” includes “individual[s],” *id.* § 802(f), and Skyline is a mine, Stips. ¶ 2.

The Commission has held that an agent is one who "is authorized by another, the principal, to act on the other's behalf," having authority to represent the principal in "dealings that affect the principal's legal rights and obligations." *Rochester & Pittsburgh Coal Co.*, 13 FMSHRC 189, 195 (Feb. 1991) (citing *Johnson v. Bechtel Assocs. Pro. Corp.*, 717 F.2d 574, 579 (D.C. Cir. 1983); *Agent*, BLACK'S LAW DICTIONARY (5th ed. 1979); RESTATEMENT (SECOND) OF AGENCY § 10 (AM. L. INST. 1958)). Messrs. Tanner, Allred, Wilson, Gordon, and Cooper were, at the time of citation, the general manager, shift foreman, superintendent, production manager, and safety manager, respectively. Stips. ¶ 9–13.

Mr. Allred was acknowledged to be the "responsible person" on the shift. *Id.* ¶ 29, 35; Tr. 258–59. Each of the others was also entrusted with some authority to control aspects of the mine's operations.

B. Each Cited Respondent Was in a Position to Remedy the Condition.

In the context of a reporting violation, this element of individual liability means that the agent was in a position to notify MSHA upon learning about the incident. Because reporting does not, and cannot, require a designated miner, *see Signal Peak Energy, LLC*, 37 FMSHRC at 476, I address collectively whether the agents were positioned to remedy the condition.

Section 50.10 requires "an operator" to notify MSHA. As an agent of the operator, each respondent was authorized to act on behalf of the operator with respect to mining operations, and the actions of each affected the operator's legal rights and obligations.

Mr. Allred acknowledged that he was the "responsible person" on shift, that he was in a position to stop work and call MSHA, and that he had the ability to do so. Tr. 283, 285. Mr. Cooper testified that he had the ability to stop work in response to unsafe conditions. *Id.* at 329.

Though Messrs. Gordon, Wilson, and Tanner made no such acknowledgements, common sense informs me that their positions in mine management enabled them to make the decision to notify MSHA upon learning of the incident. All respondents were therefore in a position to remedy the condition.

C. Each Respondent Failed to Act on the Basis of Information That Gave Them Knowledge or Reason to Know of the Existence of the Violative Condition.

The "knowing" language of section 50.10 mirrors the Commission's requirement for knowledge under section 110(c). *Compare* 30 C.F.R. § 50.10 ("[O]nce the operator *knows or should know* that an accident has occurred . . . .") (emphasis added), *with Richardson*, 3 FMSHRC at 16 ("If a person in a position to protect employee safety and health fails to act on the basis of information that gives him *knowledge or reason to know* of the existence of a violative condition, he has acted knowingly and in a manner contrary to the remedial nature of the statute.") (emphasis added).

I have already found that the operator had reason to know that an accident had occurred with the reasonable potential to cause death. *See* Section V.A.2., *supra*. As discussed above, having knowledge that a rib burst occurred, covering a miner in coal, would give an experienced

miner reason to know that an injury with the reasonable potential to cause death occurred, even if one did not know exactly what the injury was. *Id.*

The narrow issue is therefore whether and how this knowledge can be imputed to the individual Respondents.

For purposes of Section 110(c), the duty to report only arises when the officer or agent has knowledge or reason to know of the existence of the violative condition. Because these are individual charges, and because each of the individuals learned about the incident at a different time and in a different manner, it is important to consider carefully each person's liability.

Mr. Allred was the first of the individual respondents to be informed of the incident. He testified that he was informed at 5:08 p.m. by the production foreman, Charlie Wilson, that Mr. Adams had been "covered up with coal along the 8-Bay." Tr. 262–63; *see also* Stips. ¶ 20; JT-6.

Mr. Allred's first reference to Mr. Cooper was that he called him and gave an assessment of his injuries. Tr. 273–74. But that was about forty minutes after the report, when Mr. Allred was finally at the site and had seen Mr. Adams. *Id.* at 286.

Mr. Cooper testified, however, that he was notified by Conspec, and Mr. Allred testified that he had notified Conspec immediately upon receiving the call about the incident. Tr. 264, 301–02. I therefore find Mr. Cooper knew of the accident within minutes of Mr. Allred.

This is further supported by Mr. Gordon, who testified that Mr. Cooper called him between 5:20 and 5:25. Tr. 336. Mr. Gordon was therefore informed within 12–17 minutes about a miner being buried, though Mr. Cooper did not describe any of the injuries. *Id.* at 335–36. Mr. Cooper did testify that he later spoke with Mr. Gordon and told him the injuries were not life threatening. *Id.* at 326.

Mr. Wilson testified that Mr. Cooper called him at 5:30. Tr. 373. He later received a call from Mr. Allred informing him of what occurred. Mr. Wilson said he was told that they had to remove Mr. Adams from the coal, that the ambulance was on the way, and that there were possible injuries to his knee, neck and head. He also said he asked Mr. Allred if he thought it was immediately reportable, "if it was life-threatening," and Mr. Allred told him, "[N]o, I don't think it would be." *Id.* at 376.

Mr. Tanner testified that Mr. Cooper called him between 5:30 and 5:40. Tr. 435. He received a second call from Mr. Cooper that Mr. Adams was being brought up with a cut on his forehead and possible back injury resulting from a rib fall or roll. *Id.* at 437.

Mr. Cooper could not have known this until his conversation with Mr. Allred at 5:48, at the earliest. Further, he received a call from Mr. Wilson, who had arrived at the surface and seen Mr. Adams loaded into the county ambulance. Tr. 439. Mr. Wilson informed him that Mr. Adams was in good shape, that material had rolled out underneath the rib, and that the incident was not immediately reportable. *Id.* at 439–40.

Each respondent was therefore notified about a miner buried in coal within 32 minutes of the incident. Any one of them could have notified MSHA. *See* Section VI.B., *supra*.

Respondent cites *Freeman* extensively, arguing both that the agents did not have the required knowledge of the violative condition, and that they did not have an unwarrantable failure-level of culpability. Resp't Br. 29–30.

In *Freeman*, the D.C. Circuit reversed the judge, finding no individual liability. 108 F.3d at 364. It held that the record did not support that the agents had actual or constructive knowledge of the hazardous level of deterioration of the violative beam. *Id.* Importantly, the decision held that while the agents knew of the instability risk from corrosion, they were addressing the condition responsibly through inspections and repairs, and numerous regulatory inspections never reported any concern with the condition. *Id.*[47]

I have already found that the agents had knowledge of the condition—a miner covered by coal from a rib burst being reasonably likely to cause death. *Freeman* does not preclude liability arising from this finding. The Commission's holding that the agents had neither actual nor constructive knowledge concerned knowledge of the "hazardous level of deterioration" of the specific beam that collapsed. *Id.*[48]

Respondents here had constructive knowledge of the specified hazard—the risk of similar injuries with the reasonable potential to cause death resulting from further rib bursts in an uninspected, and potentially inadequately supported, work area. Even if I were to find that *Freeman* controlled the outcome here (it does not), whether the agents were addressing the condition responsibly is the only relevant issue. But many of Respondents' arguments don't directly address the issue as it relates to the failure to report the accident.

Much Respondent-elicited testimony was dedicated to the efforts the operator took to address the roof control risk, noting that mesh and props had been installed as a precaution. The alleged 110(c) liability here, however, is based on the failure to report an incident in which those measures had proved inadequate, so efforts to mitigate the roof and rib conditions do not avert

[47] Though not directly pertinent here, other jurists, including the ALJ, the dissenting judge in *Freeman*, and the Court of Appeals for the Sixth Circuit, have been critical of the failure of MSHA to cite violations as excusing a breach of an operator's duty, and that of its agents and officers, to protect their miners under the Act. "MSHA inspectors do not undertake to perform a duty owed by the mine operator to its employees." 18 FMSHRC 483, 456 (Mar. 1996) (ALJ) (citing *Raymer v. United States*, 660 F.2d 1136, 1143 (6th Cir. 1981), *cert. denied*, 456 U.S. 944 (1982)); *see also* 108 F.3d at 366 (Wald., J., dissenting) (asserting that other inspections are irrelevant because those inspectors do not have the information held by agents and "lack[] the expertise and intimate knowledge" of the facility and condition). The agency in the present case probably should have more thoroughly investigated the accident when it learned about it. The failure to do so has no impact on the duty owed by the Respondents.

[48] The Commission also reversed the ALJ for failing to find the agents knowingly violated the standard, rather finding high negligence. *Id.* The finding of violation here, however, is not based solely on a negligence finding.

Respondents' culpability for not reporting the failure. Respondents therefore are not absolved under *Freeman*'s reasoning.

Respondents also cite *Target Industries, Inc.*, 23 FMSHRC 945 (Sept. 2001), to argue against a finding that they had knowledge. Resp't Br. 29. While the affirming decision laid out the standard description of requirements for knowledge, the facts of the case, when compared to those here, are damaging to Respondents.

The Commission affirmed the individual liability finding against one respondent who was notified, while at home, of dangerous conditions and failed to notify anyone at the mine or take any action. 23 FMSHRC at 950, 963.[49] Similarly, all the agents here, whether at the mine or at home, were notified of a dangerous condition and failed to act.

Respondents might attempt to distinguish themselves from the respondent in *Target Industries* because he was part of the *formal* notification procedure—meaning that he was specifically responsible. *Id.* at 948. But each of the Respondents here had important duties and responsibilities in response to the rib burst and Mr. Adams' injuries. To their credit, each individual respondent acted promptly and conscientiously to attend to Mr. Adams. But that is irrelevant to whether they were in a position to report an accident, knew the facts giving rise to the duty to do so, and failed in that responsibility.

Mr. Allred is the direct comparison to the individual charge in *Target Industries*, as the responsible person. Each of the others, however, was subsequently in a position to protect miner safety and was notified. *Target Industries* provides no basis for excusing a failure to do so, because Respondents knew it was important to inform mine management of the status of events, yet none believed at any time that it was necessary to inform MSHA.

The Commission also found aggravated conduct in *Target Industries* because of blatant disregard for miner safety, rejecting the asserted justification that a false alarm must have occurred. *Id.* at 965. The Commission emphasized that it has rejected reliance on "'best-case scenario' assumptions as a basis for failing to take action despite evidence of a potentially dangerous condition." *Id.*

Mr. Allred, in contrast, assumed the worst here—an appropriate response when arranging a potential rescue and evacuation. That concern, though, did not extend fully to the implications raised by the incident, and the need to ensure miners would be protected, to the maximum extent possible, from a subsequent ground movement.

The notification requirement exists, in part, because of the tremendous operational pressures imposed on mine management. Miners and bills must be paid regardless of whether the mine produces coal, but revenue stops when production ceases. Involving the agency in the

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[49] The Commission found that respondent knew the production shift was currently in the mine, and that another was due in soon; that he chose not to ensure miners were removed or even knew of the fan stoppage; and that he did so despite instruction to go to the mine to check out the alarm in the event he could not contact someone over the phone. *Id.* at 964.

inspection and investigation of mines is intended to counter the tendency toward wishful thinking and best-case assumptions.

I have already found that the failure to report was the result of the operator's high negligence, *see* Section V.C., *supra*, and unwarrantable failure, and therefore "aggravated." *See* Section V.D., *supra*. The remaining issue is therefore whether the finding of aggravated conduct against the operator can be imputed to Respondents. I hold the reasonableness of imputing aggravated conduct to individuals depends on the attenuation from the action and reasonable expectation of response from each of them.

D. Messrs. Allred's and Cooper's Failure to Act was Aggravated Because of Time, Proximity to the Incident, and Expertise.

1. Shane Allred

Mr. Allred was the shift foreman and the mine had designated him as the "responsible person" for reporting accidents to MSHA. He was therefore in a position to protect employee safety and health, and he was informed of a serious incident for which he called Conspec to contact a known EMT-trained miner, Dayna Anderson, and the county ambulance. Tr. 264, 265. Based on his experience and information available, I find Mr. Allred had reason to know that MSHA notification was required—both to ensure all assets were properly mobilized to help an injured miner, and to inspect the incident area to ensure the safety of others.

The dispositive issues are therefore whether Mr. Allred's omission was "aggravated," and as a subsequent defense, whether he had a reasonable, good faith belief that he was not required to report it. Because of the finding of failure to report, I find Mr. Allred failed to act to correct the condition. His inaction was also a result of aggravated conduct more than ordinary negligence.

The following unwarrantable failure findings are imputed to Mr. Allred, as he was at the mine and was the first person notified. First, as found above, he had knowledge of the violation. Next, I consider the incident to be sufficiently obvious to require reporting. His violation posed a high degree of danger because MSHA was unable to assist in ensuring an optimal response to the accident, and miners continued to be present and work in the area without an MSHA inspection to validate the safety of the longwall for other miners. This danger is further demonstrated by the fact that there was a similar rib roll days earlier that, *luckily*, did not injure any miners. Finally, his violation was extensive in that it affected the entire working longwall.

I do not even consider this from the point of Mr. Allred actually observing Mr. Adams and his injuries. Messrs. Allred, Bonnanci, and Anderson all testified that Mr. Allred's travel time and the time required to uncover Mr. Adams took nearly or more than thirty minutes after notification. Tr. 92, 235, 266. There is testimony that Mr. Allred immediately called Conspec, and other testimony demonstrates that he could have inquired further into Mr. Adams' on the call with Charlie Wilson while he drove to the site. *See supra* note 36.

As in *Matney*, Mr. Allred should have known of the high degree of danger from the readily apparent nature of the incident. Further, Mr. Allred had the primary responsibility to gather information about incidents, assess the hazardous conditions, and take necessary steps to address it to protect miners. He was clearly in a position to protect miners by notifying MSHA of the accident, but failed to do so. The evidence indicates that Mr. Allred conducted minimal fact-finding regarding the accident and attendant injuries during the reporting period. Had Mr. Allred taken more careful and thorough action, he would have noted the obvious and highly dangerous nature of the accident and the potential for continuing danger. The record thus compels the conclusion that a foreman, exercising reasonable care, would have apprehended the full scope of the danger presented by the hazardous rib conditions and notified MSHA.

A good faith belief that an incident is not reportable based on remaining uninformed for the statutory fifteen-minute duration is unreasonable. *See Mainline Rock & Ballast, Inc.*, 693 F.3d at 1189 (affirming a reporting violation because the superintendent was "remarkably non-inquisitive" about the injuries and holding that he did not "have the discretion to remain uninformed"). Mr. Allred's belief that he was not in violation of the reporting standard was not reasonable. He could have reported the accident based on the nature of the ground movement and the same concerns that prompted him to direct Conspec to call an ambulance and to send Mr. Anderson to the scene of the accident.

For at least thirty minutes, apparently with a working means of communication, Mr. Allred remained "remarkably uninquisitive" about Mr. Adams' possible injuries. He had fifteen minutes from notification at 5:08 to comply by notifying MSHA. He had sufficient information—based only on a miner covered in coal, and no further updates—to require a prudent miner of his experience to notify MSHA.

Even if he believed in good faith that he did not have enough information, there is no evidence in the record showing that he inquired in detail about Mr. Adams' condition. He could have done so while on the way to the scene, and certainly could have at the scene. While a late accident report might have been a violation, it would have enabled the agency to respond promptly, and the omission would not have been aggravated.

When asked why he requested an ambulance, Mr. Allred said, "I assumed the worst." Tr. 288. This was the appropriate response to a serious unplanned ground movement that covered a miner in coal. At the moment Mr. Allred learned of the incident, he knew enough to act quickly—immediately, at once, and without delay—to seek medical attention for Mr. Adams, based on the circumstances reported to him, but he did not call MSHA.

I therefore find Shane Allred individually liable under section 110(c). While I find that his good faith belief was unreasonable, it appears that Mr. Allred's understanding is consistent with that of upper mine management and that his failure to notify the agency was the result of improper training and a misapprehension of the law by his superiors.

I further note that at the hearing he was a forthright witness who did not try to avoid accountability for his actions, and that his response to ensure care and assistance for Mr. Adams was commendable. I therefore assess a penalty of $1,000.00.

2. Michael Cooper

Mr. Cooper was the safety manager and was immediately informed by Conspec about a miner being buried in coal. He was therefore in a position to protect employee safety and health, and he personally informed three of the other respondents about the incident. Based on his experience, information available, and the specialized nature of his position, I find Mr. Cooper had reason to know that MSHA notification was required.

The dispositive issues are therefore whether Mr. Cooper's omission was "aggravated," and as a subsequent defense, whether he had a reasonable, good faith belief that he was not required to report it. Because of the finding of failure to report, I find Mr. Cooper failed to act to correct the condition. His inaction was also a result of aggravated conduct more than ordinary negligence.

The same unwarrantable failure findings attributed to Mr. Allred are similarly attributable to Mr. Cooper. At best, it is possible to assert that Mr. Cooper had little familiarity with the August 20 rib roll, because he was on vacation at the time. Tr. 320. It is likely, however, that as the safety manager, he would have reviewed the occurrence upon return; especially since mitigating actions were apparently taken—e.g., mesh and props were installed in the wake of the incident.

Mr. Cooper is particularly liable regarding the degree of danger because as a safety professional, he should have better understood the potential risks stemming from MSHA's inability to inspect safety for other miners before they continued operations in the area. Mr. Cooper, as the safety manager, should understand that requirement more than any other respondent. Finally, his violation was extensive because it affected the entire working longwall.

Mr. Cooper's belief that he complied with the standard in not reporting was not reasonable. He similarly remained "remarkably uninquisitive" about the possible injuries after he was informed of the burial by Conspec and notified each of the Respondent managers. At the same time, it is apparent that Mr. Cooper also was not properly trained by the mine to fully appreciate the duty to report immediately if there is any doubt about the seriousness of the injuries. As a safety professional, he should have known better than Mr. Allred, but I do find some mitigation for his failure.

I therefore find Michael Cooper individually liable under section 110(c) and assesses a penalty of $1,500.00.

3. The remaining respondents are not individually liable because of the notification time, lack of evidence of personal involvement in the violation, and attenuation.

It was not determinatively established at hearing that Messrs. Gordon, Wilson, or Tanner were notified within the reporting window. Technically and narrowly, then, the violation had already occurred before they were in a position to have done anything about it.

Nor was there any evidence that any of the three participated in, directed, or authorized the failure of Mr. Allred or Mr. Cooper to notify MSHA. While managers should be on notice that such an event has the reasonable potential to cause death and is immediately reportable, a finding that higher-level managers are liable for failure to report after the initial window would incentivize a policy of limiting access to possible reports to prevent liability.

Operators need to educate and empower first-line supervisors, or "responsible person(s)," to notify MSHA, and those persons are rightly responsible, especially when they are the first ones notified and closest to the accident site and thus most able to assess the situation. In this case, the decision-making authority was appropriately delegated to Mr. Allred, but it appears that neither he nor Mr. Cooper was properly instructed on the requirements of the rule, as MSHA has explained them in its preamble and as the Commission has further elaborated in its decisions.

This is a failure of the mine management generally, but there is insufficient evidence to specifically hold that either Mr. Gordon, Mr. Wilson, or Mr. Tanner did anything to repress or discourage reporting to MSHA.

I am concerned that the same incuriosity exhibited by Messrs. Allred and Cooper could be attributed to the other three individual Respondents. But they appeared to be laboring under the same misapprehension of the law.

Further, Messrs. Gordon, Wilson, and Tanner were notified secondarily by Mr. Cooper, specifically a safety professional, and may have assumed he was getting direct information. They appropriately relied on his assessment of the severity, even if he, and they, misperceived the standard for reporting.

It might have been possible for the Secretary to argue, and show, that the failure to ask more probing questions about Mr. Adams' condition or how they occurred constituted a continuation of the violation that materially impeded MSHA's response. But I decline to extend the reporting requirement in this context. It might be wise for MSHA to incentivize corrections by upper-level management by providing a safe harbor for managers and operators who correctly determine that a duty to report exists after the 15 minute reporting limit has expired, but this is a policy question beyond the scope of my duties.

I therefore find that there is insufficient evidence to sustain individual Section 110(c) liability against Respondents Gordon, Tanner, and Wilson. However, I have taken into account the mine's failure to properly educate its personnel in the need to notify MSHA when in doubt in imposing a high penalty against the operator for this violation.

VII. CONCLUSION

It is **ORDERED** that Order No. 8541892 be **AFFIRMED** as assessed.

It is also **ORDERED** that for Order No. 8541891, the negligence be **MODIFIED** from "High" to "Moderate," and the "Unwarrantable Failure" designation be **REMOVED**.

It is also **ORDERED** that individual liability assessments against Shane Allred and Michael Cooper be **AFFIRMED**, and those against Jed Gordon, Jake Wilson, and Dewey Tanner be **VACATED**.

It is also **ORDERED** that Shane Allred and Michael Cooper pay the Secretary of Labor the assessed penalties of $1,000.00 and $1,500.00, respectively.

Finally, it is **ORDERED** that the Respondent pay the Secretary of Labor the assessed penalty of $75,000.00 within 30 days of the date of this decision.[50]

Michael G. Young
Administrative Law Judge

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[50] Please pay penalties electronically at Pay.Gov, a service of the U.S. Department of the Treasury, at https://www.pay.gov/public/form/start/67564508. Alternatively, send payment (check or money order) to: U.S. Department of Treasury, Mine Safety and Health Administration, P.O. Box 790390, St. Louis, MO 63179-0390. Please include Docket and A.C. Numbers.