FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

OFFICE OF ADMINISTRATIVE LAW JUDGES
7 PARKWAY CENTER, SUITE 290
875 GREENTREE ROAD
PITTSBURGH, PA 15220
TELEPHONE: 412-920-7240 / FAX: 412-928-8689

JUN 30 2017

SECRETARY OF LABOR, MINE SAFETY AND HEALTH ADMINISTRATION (MSHA), Petitioner v. CONSOL PENNSYLVANIA COAL COMPANY, LLC, Respondent	CIVIL PENALTY PROCEEDING Docket No. PENN 2014-816 A.C. No. 36-07230-346706 Mine: Bailey Mine

DECISION AND ORDER

Appearances: Jennifer Gold, Esq., Office of the Solicitor, U.S. Department of Labor, Representing the Petitioner

James P. McHugh, Hardy Pence, PLLC, Representing the Respondent

Before: Judge Lewis

I. Statement of the Case

This case is before me upon a petition for assessment of a civil penalty under section 105(d) of the Federal Mine Safety and Health Act of 1977 ("Mine Act" or "Act"), 30 U.S.C. § 815(d). On May 29, 2014, the Secretary filed an Assessment of a Civil Penalty for Citation No. 7076747 for an alleged violation of 30 C.F.R. § 50.10(b) to Consol Pennsylvania Coal Company, LLC ("Respondent") at Bailey Mine. On July 2, 2014, Respondent filed an answer contesting Citation No. 7076747 and the negligence findings. This case was assigned to the undersigned on April 28, 2016. On December 13, 2016, a hearing was scheduled to take place on March 8, 2017, in Pittsburgh, PA. The parties presented testimony and documentary evidence, filed post-hearing briefs, and reply briefs.

II. Joint Stipulations[1]

The parties have stipulated to the following facts:

1. The Respondent was an "operator" as defined in § 3(d) of the Federal Mine Safety and Health Act of 1977, as amended (hereinafter "the Mine Act"), 30 U.S.C. §§ 802(d) and 803, at the mine at which the Citation(s)/Order(s) at issue in this proceeding were issued.

2. Operations of the Respondent at the mine at which the Citation(s)/Order(s) were issued are subject to the jurisdiction of the Mine Act.

3. Bailey Mine is operated by the Respondent.

4. Payment of the total proposed penalty of $5,000.00 in this matter will not affect the Respondent's ability to continue in business.

5. The individual whose name appears in Block 22 of the Citation(s)/Order(s) in contest was acting in an official capacity and as an authorized representative of the Secretary of Labor when the Citation(s)/Order(s) were issued.

6. The Citation contained in Docket No. PENN 2014-816 was issued and served by a duly authorized representative of the Secretary of Labor upon an agent of Respondent at the date, time, and place stated in the Citations, as required by the Act.

7. Exhibit "A" attached to the Secretary's Petition in Docket No. PENN 2014-816 contains true and authentic copies of Citation No. 7076747 with all modifications or abatements, if any.

8. The R-17 Certified Assessed Violation History Report is an authentic copy and may be admitted as a certified business record of the Mine Safety and Health Administration.

(JX-1).

---

[1] The Joint Stipulations were submitted at hearing as Joint Exhibit 1 (JX-1). Each stipulation will hereinafter be cited to as J.S. followed by the stipulation number. The Secretary's exhibits will be cited to as GX followed by its number and Respondent's exhibits will be cited to as RX followed by its number.

III. Summary of Testimony

Thomas Bochna

Thomas Bochna investigated the accident at issue on August 12, 2013.[2] (Tr. 38).[3] Bochna had first learned of the Bailey Mine accident at issue here on August 12, 2013, shortly after he arrived for work at 5:30 a.m. (Tr. 38). He had inspected Respondent's mine "many times" in the past. (Tr. 43).

On August 12, 2013, Bochna had reduced to writing the initial 103(j) order to a 103(k) order which was terminated that day. (Tr. 45-48; GX-2). Bochna had initially interviewed witnesses at Bailey Mine on the day of the accident, later interviewing the victim, Robert Stern, at Health South Rehab facility. (Tr. 49). As a result of his investigation, Bochna eventually issued his 104(a) citation, Citation No. 7076747, on September 23, 2013. (GX-1).

According to the *MSHA Escalation Report*, GX-3, Respondent's safety supervisor at Bailey Mine, Michael Tennant, first notified MSHA of the accident at 5:09 a.m. (and 55 seconds). (Tr. 51). Bochna's investigation had established that the accident had taken place at around 3:15 a.m. (Tr. 52). Bochna did not know why the escalation report had given 4:45 a.m. as the accident time. (Tr. 52).

Respondent had indicated according to the report that the "types of injuries" sustained were "unknown." (Tr. 53; GX-3).

In his preliminary report of the accident, GX-1, Bochna described the accident as a GMS Repair Employee being injured when he became caught between the bucket of a battery scoop and a supply car. (Tr. 56). Referring to his Accident Investigation-Data Report, Bochna found the "root cause" of the accident to be the employee positioning himself in a "pinch point red zone area" between the scoop bucket and the rail car. (Tr. 57; GX-1).

After conducting both individual and ground interviews at Bailey Mine, Bochna ended his questioning at 10:25 a.m. (Tr. 62-63). He learned that the accident had come about because Mr. Stern had entered the area between the scoop and the end of the rail car to determine why the scoop was stuck. (Tr. 66-67). Due to some slack in a safety chain and drifting forward of a rail

---

[2] He had worked as a supervisory coal health and safety inspector for three years, first beginning work as a regular coal health inspector in 2008. (Tr. 36). His coal mine inspector duties involved conducting E01 and spot inspections, issuing citations, and performing accident investigations. (Tr. 37). Prior to joining MSHA, Bochna had worked for 30 years as a coal miner. (Tr. 37). His positions included continuous miner operator and fire boss. (Tr. 37). Possessing a 2-year degree from Penn State in mine engineering, Bochna had a total of 39 years of experience in coal mining. (Tr. 36-37).

[3] References to the hearing transcript will be cited as Tr. followed by the page number.

car, Stern became crushed between the scoop and the end of the rail car. (Tr. 68-71). Both the scoop and rail car were large objects weighing 5-10 tons. (Tr. 69).

Bochna reviewed his inspection notes at hearing. He had interviewed Daniel Greathouse, who operated the scoop when the accident had taken place and who had participated in a re-creation of the accident. (Tr. 77, 82). Greathouse reported that Stern stated that it felt like his "guts were coming out of his penis." (Tr. 83).

Bochna also interviewed two GMS "red hats," Travis Barber and Garret Scales, who were working with Stern at the time of the accident. (Tr. 78-80). Although neither Barber nor Scales had actually witnessed the accident take place, they heard and saw Stern immediately thereafter. (Tr. 79). Both Barber and Scales recalled Stern stating that he was hurt "real bad," was in some pain, and felt like something was coming out of his penis. (Tr. 81).

Travis Stillwell was also interviewed. (Tr. 84). Stillwell was at the scene at the time of the accident and heard Greathouse say, "scoop stuck" and then Stern say, "help me." (Tr. 85). When Stillwell approached Stern—the victim was laying on the ground, complaining that his stomach hurt and that he could not feel his legs. (Tr. 85).

Bochna also reviewed his interview of John McDonald, section foreman at Bailey Mine. (Tr. 85). McDonald had been notified about the accident at approximately 3:25 a.m. (Tr. 86). He issued instructions to Colby Watson to bring a gurney and EMT kits to the accident site. (Tr. 85). McDonald had called the bunker, stating that a Life Flight would be needed. (Tr. 86). Life Flight was a helicopter brought in when there was a serious injury and speedy transportation to a hospital was necessary. (Tr. 86). McDonald noticed that Stern was experiencing stomach swelling and was in extreme pain. (Tr. 86).

Bochna had also interviewed Shannon Smith, an EMT, who gave treatment to Stern at the scene. (Tr. 86). Smith found Watson, Greathouse, and McDonald attempting to put Stern on a backboard. (Tr. 87). Stern's head was being held up because no neck brace was available. (Tr. 87). His visible injuries included abrasions on the right side around the waist area, a little (amount of) blood on the right hip area, and bruising around the hip area. (Tr. 87). Stern could not move his left leg and had no feeling in his right leg. (Tr. 87). No oxygen was available at the scene and was only given by EMS when Stern was transported to the surface on a mantrip. (Tr. 87, 88).

Smith related that Stern had never lost consciousness. (Tr. 88). Smith spoke with Stern on the mantrip all the way to the surface. (Tr. 88). Haulage had been cleared all the way out.[4] (Tr. 88).

---

[4] There was a call on the mine radio to signal that all equipment traffic should be stopped so as to make way for Stern's mantrip transport to the surface. (Tr. 88).

Bochna interviewed Stern at a rehab facility on September 4, 2013. (Tr. 89). Stern had a plate inserted into his hip area. (Tr. 89). Bochna's review of hospital records disclosed that after Stern's internal bleeding had stopped, surgery on the pelvis was performed on August 12, 2013. (Tr. 90). Stern was reported to have a crushing injury to his spine/pelvis. (Tr. 90).

Bochna had also spoken with Roy Cumberledge, coordinator for GMS at Enlow and Bailey Mines, who had been at the hospital when Stern had been admitted. (Tr. 91). Cumberledge had been unable to view the injuries well, except for an abrasion on Stern's right hip. (Tr. 91). The doctor at the hospital predicted Stern's bleeding would stop in one to one and a half hours, which it did, without the necessity for surgery to prevent further bleeding. (Tr. 91). Surgery on the pelvis was performed at around 1:00 p.m. (Tr. 91).

Documentary Evidence Regarding the Nature of the Accident

At hearing, the Secretary offered into evidence GX-12A, *MSHA's Accident Prevention Program Safety Idea, Proper Blocking*, in order to establish that failing to block against hazardous motion was one of the most frequently cited regulations when investigating serious accidents and fatalities. [5] (Tr. 95).

The Secretary also introduced into evidence, *MSHA's Accident Prevention Program Safety Idea: Blocking against Motion.* (GX-12B). This document disclosed that "in the past years, seven miners died...[because] safety props [were] not available and block was either not used or ineffective." (Tr. 102). This exhibit also reported the case of a miner who was crushed between the bucket lift arms and front-end loading frame because the loader was not effectively secured from movement. (Tr. 102-03)[6].

Another *MSHA Accident Prevention Program Safety Idea, Stay Seen - Stay Alive* was offered by the Secretary. (GX-12C). In this report, MSHA announced that during the period spanning January 2000-July 2011, there had been 76 fatalities due to miners being struck by surface and underground equipment. [7] (Tr. 103).

---

[5] Over objections of Respondent, this Court allowed the admission of said document and similar documents as being relevant evidence regarding the "nature of the accident." As discussed *intra* this Court holds that the proper test for determining a violation of §50.10(b) is whether, considering the totality of the circumstances, *including the nature of the accident*, an operator knew or should have known that the injury/injuries sustained by the miner had a reasonable potential to cause death. This Court specifically rejects any argument advanced by Respondent that this test is limited to assessing signs and symptoms associated with the miner's injury. (*See also* Parties' arguments regarding such at Tr. 94-100).

[6] For the same reasons above referenced, this Court also allowed admission of such, over objection, into the record.

[7] Given that Stern also had been struck/crushed between large pieces of equipment, this Court once again, over objections of Respondent, allowed this exhibit's admission. This Court, as

The Secretary also offered an *MSHA Accident Prevention Program/Miner's Tip*—work experience around machinery. (GX-12E). This Bulletin, dated April 30, 2002, included the specific advice: "Do not get between two pieces of mobile equipment. They could crush you." (Tr. 105).

Also admitted into evidence, over objection of Respondent[8], were a series of fatalgrams, all of which involved miners being killed when pinned or crushed between heavy machinery and a coal rib. (GX-13B, 13C).

Based *inter alia* upon Bochna's interviews with Bailey Mine, Consol Corporate, and GMS personnel, his personal investigation of the accident, Stern's complaints voiced at the scene, the observations of Stern by on-the-scene witnesses, the calls to clear haulage and for a Life Flight, and the treatment rendered, Bochna concluded that Respondent had violated §50.10(b). (Tr. 111-12).

Cross Examination of Bochna

On cross examination, Bochna was asked to explain why it had taken 43 days for him to conclude that Respondent had failed to call MSHA within 15 minutes of learning of the accident. (Tr. 114). Bochna explained that it had taken this period to fully complete his investigation. (Tr. 115). He had conducted ten or more accident investigations in the past. (Tr. 115).

As far as Stern's injuries were concerned, Bochna did not know what was actually told to John McDonald by the "red hats." (Tr. 118). Neither did Bochna know what Greathouse, Stillwell, or Tennant had actually relayed to McDonald. (Tr. 119).

Bochna had not spoken to EMS personnel regarding Stern's injuries. (Tr. 120). He had been informed that a doctor at the hospital had opined that Stern's bleeding would "stop on its own." (Tr. 121). Bochna did not know the circumstances under which Respondent might call for Life Flight. (Tr. 122).

During his interview of John McDonald, Bochna was informed that subsequent to the accident Stern had not lost consciousness, was speaking, and was answering questions. (Tr. 123-24). Bochna had been further informed that no CPR was given. (Tr. 124). Bochna had never asked McDonald if McDonald thought Stern's injuries had a reasonable potential to cause death. (Tr. 125). Nor did he pose this question to anyone else. (Tr. 125). Bochna had not called any

---

noted *intra*, found such evidence relevant in considering the "nature of the accident" vis-à-vis the reasonable potential for fatal injury and Respondent's at least constructive knowledge of its duty to immediately notify MSHA under such circumstances.

[8] As in the foregoing instances, this Court allowed the admission of the fatalgrams to establish that Respondent had been put on notice of the potentially fatal nature of crush injuries.

medical professional at the hospital to determine whether there was any surgery for internal bleeding. (Tr. 128).

Bochna acknowledged that he had commended Respondent for its speedy treatment of Stern. (Tr. 131).

Given that the accident involved two very heavy pieces of equipment crushing an individual, the victim's stomach distention and inability to move his legs, Bochna reiterated that Respondent should have been "pretty quickly" aware that Stern's injuries required immediate MSHA notification. (Tr. 133).

Shannon Smith

At hearing, Shannon Smith, the fire boss mine examiner at Bailey Mine, testified that he had worked in such position since 2009.[9] (Tr. 163-64). Smith had first learned via a radio call at Bailey Mine that "there was a man crushed." (Tr. 165). Together with a fellow fire boss, Donald Wolf, Smith arrived at the accident site within 12 minutes of the call. (Tr. 166). When he first arrived upon the scene, Smith found John McDonald, Danny Greathouse, and some contractors. (Tr. 167). Stern was lying on his side. (Tr. 169). He had a bend to his knee—"like his leg's broken." (Tr. 170). Stern complained of being in pain. (Tr. 171). He was unable to move one of his legs. (Tr. 171). Don Wolf applied a "C spine," which holds the neck straight. (Tr. 171). Stern's stomach "felt like it was getting hard," and it was distended. (Tr. 172). Smith acknowledged that this could be a sign of internal bleeding. (Tr. 172). There was a "little dab" of blood on his leg. (Tr. 173).

Stern further complained that he felt like something was coming out of his penis. (Tr. 173). Upon examining Stern, Smith, however, did not see "anything coming out." (Tr. 173).

Stern further asked Smith that if something happened to him, to tell Stern's wife and family that he loved them. (Tr. 174).

Smith characterized Stern's injury as "pretty bad" and traumatic, Stern's accident being the worst he had ever been involved with. (Tr. 174).

Smith himself had never called for Life Flight, nor has Life Flight been called since the accident at issue. (Tr. 175). However, Smith had heard that it had been called in the past. (Tr. 175).

Smith had not administered oxygen—because none was available at the scene, and Smith did not want to stop as he wanted to get Stern outside as quickly as possible. (Tr. 176-77). Smith did not take Stern's blood pressure because he did not have a cuff with him. (Tr. 177).

[9] Smith was also a licensed and certified EMT. (Tr. 164). He had previously worked in mining as a bolter operator and bolter helper. (Tr. 165).

Smith called the bunker in order to have Life Flight contacted. (Tr. 179). In calling for Life Flight, Smith "wanted to err on the side of caution" because Stern might have possible internal bleeding that could lead to death. (Tr. 180).

Cross Examination of Smith

On Cross Examination, Smith said he had utilized an assessment phase called DCABPTLS[10] in examining Stern. (Tr. 183). Once he had gone through the assessment, Smith knew he "had to get him (Stern) out of the mine...fairly quickly." (Tr. 183).

Stern did not lose consciousness at the scene and was able to understand questions. (Tr. 184). He did not have any problems with his pulse. (Tr. 184). There was a "bruising-type thing" across Stern's belly[11]. (Tr.185). There was no evidence of head injury. (Tr. 186). Stern was able to answer "sample questions." (Tr. 187). Smith noted no change in Stern's condition when he was handed-off to the paramedics. (Tr. 188).

John Henry McDonald, Jr.

John McDonald, Jr., a section supervisor at Bailey Mine since 2007 appeared and testified at hearing.[12] (Tr. 192-93). McDonald first learned of Stern's accident from Stern's fellow GMS worker, Garret Scales. (Tr. 194). It was approximately quarter after 3:00 a.m. when McDonald was first contacted. (Tr. 195). He was approximately 900 feet from Stern's accident site. (Tr. 195). Three to four minutes elapsed before McDonald arrived at the scene. (Tr. 195). McDonald found Stern lying on his side, saying he had gotten "pinched" and was in a lot of pain. (Tr. 196). McDonald called the bunker to contact 9-1-1 to get an ambulance. (Tr. 196). McDonald called MSHA with the same bell phone[13] that he had used to call the bunker. (Tr. 196).

McDonald had called Shannon Smith on the radio to come to the scene. (Tr. 198). All McDonald understood as to the nature of the accident was that Stern "got pinched between the scoop and the [rail] car." (Tr. 200). Initially, McDonald thought Stern had sustained a femur injury; but after talking to Stern, Smith thought it was higher up in the hip area. (Tr. 201).

---

[10] This acronym stands for: deformities, contusions, abrasions, punctures, bruising/burns, tenderness, lacerations, and swelling.

[11] In pointing to where the bruising was located on Stern's body, Smith placed his hand a little above his belt. (*See also* Tr. 185-86).

[12] McDonald had also worked at Bailey Mine as a foreman trainee. (Tr. 193). He had received an associate degree in mining technology at Penn State University. (Tr. 193). McDonald had at least 15 years of total mining experience. (Tr. 194).

[13] Bell phones can be used to call outside lines. (Tr. 196).

McDonald had noticed "a lump" in Stern's stomach and felt "hardness" on his stomach. (Tr. 201). Colby Watson had accompanied McDonald to the scene and had been instructed by McDonald to get a gurney and EMT kits. (Tr. 202).

Daniel Greathouse had informed McDonald that he had backed the scoop up in order to let Stern free. (Tr. 202). Stern was unable to move his legs and could only feel a pinch in one of his legs. (Tr. 203). When Stern's legs were moved, he screamed in extreme pain. (Tr. 203). McDonald had requested haulage be cleared for Stern's exit.[14] (Tr. 204). It took approximately 40 minutes for Stern to be taken out. (Tr. 204). Once Stern was placed in the ambulance, McDonald did not know where Stern was headed. (Tr. 204).

McDonald testified he was familiar with a document entitled *Immediately Reportable Accident* as contained in GX-8. (Tr. 206-07). This document was posted on the bulletin board in the shift foreman's office and on bulletin boards around Bailey Mine. (Tr. 207). This document had at one time also been in McDonald's locker. (Tr. 206).

McDonald testified that during his years at Consol, he had never been given specific instruction as to how to interpret the reportable event: "an injury to an individual at a mine which has a reasonable potential to cause death." (Tr. 208; GX-8). McDonald was acquainted with GX-7—a Bailey Mine document entitled *Reportable Incident Guidelines*. (Tr. 209). McDonald also acknowledged that GX-10 was a Consol Energy safety presentation regarding "Pinch Points/Red Zones" that described the Bailey Mine Incident at issue as being one which "had a high potential for a fatal accident." (Tr. 213).

GX-9 contained another Consol Energy safety talk entitled "proper blocking," dated June 20, 2011. (Tr. 2014-15). McDonald agreed with the first sentence of the presentation, which read: "one of the most frequently cited regulations when serious accidents and fatalities are investigated is the failure to block equipment against motion." (Tr. 215).

McDonald was an unlicensed EMT at the time of the instant accident. (Tr. 217). McDonald had called the bunker to contact an ambulance. (Tr. 219). It had taken Shannon Smith 8 to 10 minutes to arrive at the accident site. (Tr. 218). Stern was on the ground, was in pain, and could not move his leg. (Tr. 218). He could speak and answer questions intelligibly. (Tr. 219). He did not exhibit any breathing problems. (Tr. 219). He did not appear to a have head injury or to be in shock. (Tr. 220). McDonald could not detect any deterioration in Stern's condition from when he first observed Stern until Stern was handed off to the EMTs. (Tr. 220).

Based upon his observations of Stern, McDonald had concluded that his injuries did not have a reasonable potential to cause death. (Tr. 222). McDonald did not have specific responsible person training as to immediate reportable accidents. (Tr. 224; *See also* GX-8). But he had participated in a group presentation when he had received his foreman papers. (Tr. 224).

[14] Haulage was cleared anytime someone became sick or needed to leave the mine. (Tr. 222).

Red zone training was given because of all the tight areas and mobile equipment at Bailey Mine, red zone violations being particularly dangerous. (Tr. 224).

On redirect examination[15] McDonald stated that Life Flight had been called for on the ride out "for precaution" because "when we felt his stomach, we got nervous." (Tr. 225). Testifying that he and Shannon Smith tried to hide their conversation about Stern's stomach hardening from Stern, McDonald explained that stomach swelling could indicate internal bleeding and internal bleeding had a reasonable potential to cause death. (Tr. 225).

Michael Tennant

Michael Tennant had been safety supervisor at Bailey Mine since September 2008.[16] (Tr. 231). Tennant had first learned of Stern's accident when he had been called by Eric Cecil from the bunker at approximately 3:30-3:45 a.m. (Tr. 233). Tennant had been advised that Stern "was pinched between two cars and EMTs were on their way." (Tr. 233). Tennant was at his home at the time, and during his drive to the mine, he received a second call in which he was informed that Life Flight had been called. (Tr. 234). Stern's injuries were described as involving "a broken leg, dislocated hip or some lower-type pelvis-type incident..." (Tr. 234). Stern was reported to be conscious and alert. (Tr. 234). Tennant did not make any calls from his car regarding the accident but did initially call from his home, notifying his supervisor, Eric Shuble, who was the general superintendent. (Tr. 235).

Tennant reported initially to Steve Apperson, manager of safety. (Tr. 235-36). Apperson would report to Chuck Shaynak, who was vice president of Consol's Pennsylvania operations. (Tr. 236).

Tennant arrived at the mine at about 4:50 a.m., approximately one hour after the bunker person's original call. (Tr. 237). Stern was already gone. (Tr. 245). Tennant did not call Steve Apperson or anybody from GMS. (Tr. 238). He eventually called MSHA at around 5:09 a.m. (Tr. 239). Tennant had received a call from Randy Cumberledge, a GMS coordinator, to update Tennant on Stern's condition. (Tr. 219). Stern was reported to have a broken pelvis and internal bleeding. (Tr. 239).

Tennant did not go to Bailey Mine every time that there was an accident but had chosen to go to Bailey Mine because Stern had been pinched between two large pieces of equipment.

---

[15] As discussed *infra* McDonald's statements on redirect examination essentially contradict Respondent's argument that Stern's injuries did not appear to have a reasonable potential for death.

[16] From 2001 to 2008, he had been a safety inspector at the mine. (Tr. 231). Tennant possessed a bachelor's degree in safety engineering and had an assistant mine foreman certification. (Tr. 232).

(Tr. 243). Tennant did not know why the MSHA Escalation Report gave 4:45 a.m. as the time of the accident. (Tr. 243; GX-3).

Tennant testified that, subsequent to mine accidents, safety talks as contained in GX-10 were generally given as soon as possible. (Tr. 246). Tennant agreed with the final sentence under Pinch Points/ Red Zones, which read: "This had a high potential for a fatal accident." (Tr. 247). Tennant further agreed that, as outlined in *Bailey Mines/ Reportable Incident Guidelines* bulletin, he was to be immediately notified following any agency notification of an injury, which had the reasonable potential to cause death. (Tr. 251; GX-7). Tennant also confirmed that a Consol Energy safety talk on "proper blocking," dated June 20, 2011, indicated that the failure to block equipment against motion was one of the most frequently cited regulations when serious accidents and fatalities are investigated. (Tr. 253; GX-9).

According to Consol documents, the Bailey Mine incident[17] at issue was reported to have fatal potential of "5" and the "high probability to cause death." (Tr. 262-67; *See also* GX-14).

Based upon the information given to him by Cecil over the phone—that there was something wrong about Stern's leg or pelvis, that Stern might have a dislocated hip or broken leg, but that he was conscious and alert—Tennant did not believe that any of Stern's injuries posed a reasonable potential to cause death. (Tr. 269-70). Tennant received basically the same information from EMT Smith that he received from Shift Foreman Tomlin at the mine site. (Tr. 270-71). He did not receive any information from the hospital to alter his opinion. (Tr. 271). Given that Life Flight had been called and there was a serious accident, Tennant decided to call MSHA so that inspectors coming in would know something "about the event." (Tr. 272).

In addition to Tennant, Danny Tomlin was the "responsible person" to make the call to MSHA. (Tr. 272). In the past, Tennant had made approximately 15-25 (or less) calls to MSHA to report injuries which had the reasonable potential to cause death. (Tr. 274). Tennant "typically use[d] common sense" in deciding to make such calls; he considered such factors as amputations, CPR, attempts to stop bleeding, lack of alertness, unconsciousness, blunt force trauma to the head or upper extremities to be triggers to call MSHA. (Tr. 274). Tennant never took into account the nature of the event in determining "reportability" under § 50.10(b), but only the seriousness of the injuries. (Tr. 275).

During his initial phone conversation with Cecil, Tennant had not asked questions about whether Stern had upper body or lower body injuries, whether CPR had been performed, whether there were any amputations, any kind of profuse bleeding or internal bleeding, whether there were any blood pressure issues, or why EMT had thought it necessary to call Life Flight. (Tr. 282-83). After learning of the accident, Tennant was initially concerned about Stern receiving proper care—not calling MSHA. (Tr. 284-85).

---

[17] As argued at hearing and indeed throughout these proceedings, both parties contested whether this and similar phrases referred to the type of injury or the type of accident. (*See also* Tr. 266).

Susan Bealko

Susan Bealko, corporate safety director for GMS, testified at hearing.[18] (Tr. 288). Bealko had first learned of Stern's accident on August 12, 2013, at approximately 3:45-4:00 a.m. from Mike Fleece, GMS's PA ops coordinator. (Tr. 289-90). After getting dressed and dropping off grain for her horse, she left for the hospital at approximately 4:15-4:20 a.m. (Tr. 291). She met Fleece at the hospital; Fleece advised her that Randy Cumberledge, the site coordinator, was speaking with Stern. (Tr. 290-91). At some point, a doctor came out, announcing that Stern was stable and was being prepped for surgery. (Tr. 293). There had been a "small bleed" that had since ceased. (Tr. 293). Surgery was performed at around 1:00 p.m. (Tr. 293).

Bealko had heard nothing that led her to believe that Stern's injuries had a reasonable potential to cause death. (Tr. 293). She did not contact MSHA regarding such because as GMS's safety director she felt Stern's injuries were not life threatening. (Tr. 294).

Bealko had not gone to Bailey Mine before going to the hospital and had therefore not observed Stern at the accident site. (Tr. 300).

Richard Marlowe

At hearing, Richard Marlowe testified on behalf of Respondent.[19] (Tr. 301-02). Marlowe testified that in August 2013, Marlowe was "probably" the director of safety awareness. (Tr. 302). Referring to RX-5, "RPI's August 2013," Marlowe stated that reports of personal injury were put together and distributed to various business units in mines. (Tr. 303). He had circulated the August 2013 RPI in question. (Tr. 304). Based upon his review of the (Stern) incident, Marlowe had determined the situation had a potential for fatality. (Tr. 305). The form was not meant to indicate the likely outcome of injuries. (Tr. 310). In a situation involving an individual getting pinched between two pieces of equipment, Marlowe testified that, if such a condition was allowed to continue, a fatality could reasonably be expected to take place. (Tr. 310-11). There could be a situation with a high fatal potential but with no actual injuries involved. (Tr. 311).

Marlow had not been present at the Bailey Mine when Stern was injured, had not directly observed any of Stern's injuries, and had not specifically participated in the accident investigation. (Tr. 315).

[18] She had been corporate safety director for 5 years and had been in the mining industry for 27 years. (Tr. 288). Bealko had a mining engineer degree from Penn State. (Tr. 288). She had also worked for NIOSH, the mining research branch of MSHA. (Tr. 288).

[19] Marlowe had an undergraduate degree in mining engineering technology and a master's in safety management. (Tr. 302).

IV. Contentions of the Parties

Respondent argues that the Secretary failed to meet its burden of proof in proving a §50.10(b) violation for Citation No. 7076747. *Resp't Post-Hearing Br.* at 11-26. Respondent contends that Stern's injuries were not life-threatening and did not have the reasonable potential to cause death. *Resp't Post-Hearing Br.* at 12-21. Respondent also contends that the surrounding circumstances of the accident are not relevant and that the accident did not involve an injury with the reasonable potential to cause death. *Resp't Post-Hearing Br.* at 21-22, 26-27. Respondent further contends that the statutory provision in 30 U.S.C. § 813(j) is in conflict with the regulation in 30 C.F.R. § 50.10(b), and in such instances the statute prevails. Furthermore, it argues that the reporting requirement is subjective and should be subjectively applied. *Resp't Post-Hearing Br.* at 22-26. Additionally, Respondent argues the negligence should be assessed at low, there was no fair notice of the violation's interpretation, and the penalty should be decreased from $5,000.00. *Resp't Post-Hearing Br.* at 31-33. Respondent also essentially argued that neither a totality of the circumstances test nor a reasonable person test are not appropriate for §50.10(b). *Resp't Reply Br.* at 12-17.

The Secretary argues that Respondent violated 30 C.F.R. § 50.10(b), that the Respondent was moderately negligent, and that the penalty should be assessed at $5,000.00. *Sec'y Post-Hearing Br.* at 12-30. The Secretary contends that the Respondent knew or should have known within 15 minutes of its occurrence that Stern's accident involved injuries with a reasonable potential to cause death. *Sec'y Post-Hearing Br.* at 14-28. The Secretary further contends that the Respondent had adequate notice of the standard. *Sec'y Reply Br.* at 9-12.

V. Issue Presented

In determining whether 50.50(b) has been violated, should a "totality of the circumstances" test be utilized, including such factors as a "nature of the accident" and signs and symptoms of injury at the time of accident and immediately thereafter?

VI. Law and Regulations

30 C.F.R. § 50.10(b) Immediate notification in pertinent part provides as follows:

> The operator shall immediately contact MSHA at once and 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.

VII. Findings of Fact and Conclusions of Law

In arriving at its within decision that Stern's injuries evinced a reasonable potential to cause death and that Respondent had correspondingly failed in its notification duty under § 50.10(b), this Court recognizes that operators are not expected to be experts in diagnosis or prognosis at the scene of a mine accident. This Court also recognizes that there is not a statutory

or a regulatory definition of "reasonable potential to cause death" and further notes the Commission's declining to define such in *Signal Peak Energy, LLC*, 37 FMSHRC 470 (Mar. 2015).[20]

Moreover, there is undoubtedly *a gray area* in determining whether an injury is *potentially* fatal and *actually* fatal.[21]

However, operators are not left at sea—without direction—as to when to notify MSHA of an accident. There are numerous navigational instruments to guide them to a proper determination.

A. Any Reasonable Doubt Must Be Resolved in Favor of Notification

As the Commission has made abundantly clear in *Signal Peak Energy, LLC,* any "reasonable doubt" in determining whether MSHA should immediately be notified *must* be resolved in favor of notification. 37 FMSHRC 470, 477 (Mar. 2015).

This should be the North Star directing all mine operators in their search for a proper determination under §50.10(b).

The Respondent had advanced various arguments (of varying merit) explaining its failure to immediately notify MSHA. However, the circumstances surrounding Stern's injuries should have raised multiple red flags of doubt to any prudent operator—doubt that should have been resolved in favor of notification.

B. Operators Must Be Guided by the Protective Purpose of the Act and the Standard

As held by the Commission in *Signal*, in determining whether or not to call MSHA, an operator should be guided by the protective purpose of the Act and § 50.10(b) mandatory standard. *Signal* at 477. The preamble to the final rule addressing 30 C.F.R. § 50.10 in 2006 stated:

> In emergencies, where delay in responding can mean the difference between life and death, immediate notification leads the mobilization of an effective mine emergency response. Immediate notification activates MSHA emergency response efforts, which can be critical in saving lives, stabilizing the situation, and preserving the accident scene. Immediate notification also promotes Agency assistance of the mine's first responder efforts. In other situations, it allows for a

[20] *See also* Commissioner Cohen's dissent calling for a definition in *Signal Peak Energy, LLC*, 37 FMSHRC at 477 n. 8.

[21] T.S. Eliot's lines in *The Hollow Men* are called to mind "between the potency and the existence...falls the shadow."

> range of appropriate Agency responses depending on the circumstances. It alerts MSHA to trends or warning signals that can trigger a special inspection, an investigation, or targeted enforcement. This communication also encourages operators and miners to work with MSHA to develop procedures that prevent incidents from resulting in more hazardous situations, ultimately leading to disasters.

71 Fed. Reg. at 71, 431.

Thus, in addition to *Signal's* directive that all reasonable doubts be resolved in favor of notification, operators have two other bright beacons directing their § 50.10(b) considerations: the protective purpose of the Act and mandatory safety standard.

It is clear that the circumstances surrounding the accident and injury must be considered. For example, under the definition of accident provided in §50.2, several examples are given as to what constitutes an accident, including an injury at a mine with the reasonable potential to cause death, entrapment for more than 30 minutes, unplanned inundation, and an unplanned fire. *See* 30 C.F.R § 50.2. Most of the enumerated examples describe circumstances, rather than injuries. Thus it is clear that §50.10(b) does not exclude and in fact encourages an analysis of the circumstances surrounding the event causing a mine injury. *See id.*

Similar to most controversies arising out of the Mine Act, determinations regarding § 50.10(b) notifications are necessarily fact specific and must be evaluated on a case-by-case basis with due consideration for the totality of the circumstances. *See e.g.*, *Black Beauty Coal Co.*, 36 FMSHRC 1821 (March 10, 2014) (ALJ) (holding safeguard notice requirements for a water accumulation violation are analyzed on a case-by-case basis).

This Court rejects the Respondent's arguments that a totality of the circumstances approach, including consideration of the nature of the accident, should not be employed in determining whether a miner's injury is reportable under § 50.10(b).

In *Signal Peak Energy,* the Commission unequivocally held that all "readily available information"—"including the nature of the accident" should be considered in determining whether an injury was reportable. *Signal Peak Energy, LLC*, 37 FMSHRC at 476. The Commission noted that such evidence was "highly relevant." *Id.* Because the extent of an injury is not always immediately apparent, the Commission reasoned that the specific circumstances, including how the injury occurred, should be considered by the mine operator.[22] *Id.* As discussed *intra*, the Secretary has presented persuasive documentary and testimonial evidence that the type

[22] In *Red River Coal Co.*, 39 FMSHRC 368, 391 (Feb. 2017)(ALJ) Judge Feldman considered the nature of the miner's accident in concluding that the operator had violated § 50.10(b).

of accident in which Stern was involved—being crushed[23] in a red zone between two large pieces of machinery—often leads to fatal injury.

In arguing that the nature of Stern's accident should not be taken into account, Respondent ignores *Signal's* holding that "the nature of the accident" is highly relevant information in determining whether an injury should be reported. This Court cannot accept Respondent's suggested analytical approach. Any prudent operator, familiar with the industry, knew or should have known that the type of accident that Stern suffered often leads to death.[24] To ignore this elephant in the room is a sophistic misadventure that no mine operator, including Respondent, should engage in when determining to alert MSHA.

C. <u>Reasonable Potential to Cause Death Interpretation</u>

Respondent argued that §50.10(b) is not clear, and does not include an analysis of the nature of the accident.[25] When the plain language of a standard is clear and unambiguous, the Commission has held that the standard provides operators with fair notice. *Dynamic Energy, Inc.*, 32 FMSHRC 1168, 1172 (Sept. 2010); *Bluestone Coal Corp.*, 19 FMSHRC 1025, 1031 (June 1997). The Commission has held that the "reasonable potential to cause death" uses a reasonable person standard. *Signal Peak, LLC*, 37 FMSHRC at 477. The Commission has specifically stated that the reasonable potential to cause death is case specific and requires consideration of the accident causing the injury. *Wolf Run Mining Co.*, 35 FMSHRC 3512, 3517 (December 2013). It is this Court's view that a reasonable potential to cause death is a clear standard.

If the meaning of a standard is ambiguous, the Secretary's interpretation of its own regulation may be given deference. *See Auer v. Robbins,* 519 U.S. 452 (1997); *Udall* v. *Tallman,* 380 U.S. 1, 16-17 (1965); *Dynamic Energy, Inc.*, 32 FMSHRC 1168, 1171-72 (2010). Deference is not appropriate when an agency's interpretation is unreasonable or

---

[23] Although the word "pinched" is used in the technical sense to describe the type of Red Zone incident in which Stern was involved, the word "crushed" more accurately describes the injury process actually suffered by Stern.

[24] Additionally, it should be noted that many injuries, such as inhalation, internal bleeding, and the like are not visible. Therefore, the circumstances surrounding the injury are highly relevant in determining the extent of the possible injury.

[25] Respondent also argues that 30 U.S.C. § 813(j) conflicts with 30 C.F.R. § 50.10(b) in that §813(j) states that an operator must call MSHA when he *realizes* an injury has occurred with the reasonable potential to cause death. Whereas §50.10(b) states that an operator must call MSHA when an operator *knows or should have known* of an accident involving an injury with the reasonable potential to cause death. (*Resp't Post-Hearing Br.* at 22-27). This Court finds there to be no conflict in this case as the facts and testimony provide the same result. Due to the circumstances surrounding the accident and injury, it is clear that MSHA should have been called within 15 minutes of the accident.

inconsistent with the regulation. *Christopher v. SmithKline Beecham Corp.*, 567 U.S. 142, 155 (2012) (citing *Auer,* 519 U.S at 462). An agency's interpretation may also not be given deference when it conflicts with a prior interpretation. *See, Christopher v. SmithKline Beecham Corp.*, 567 U.S. at 155 (2012)(citing *Thomas Jefferson Univ. v, Shalala, 512 U.S. 504, 515* (1994)). While this Court does find §50.10 to be clear and unambiguous, the Secretary's interpretation that a totality of the circumstances test should be used is also reasonable and should be given deference. The Mine Act was written in order to protect miners' health and safety. When analyzing MSHA's reporting requirement under §50.10(b), it is reasonable that the Secretary should consider the circumstances that resulted in an injury. Thus, a totality of the circumstances test is appropriate under the regulations.

D. Preamble to Final Rule for Section 50.10

Contrary to Respondent's suggestions otherwise, the preamble to section 50.10 does not contain an exhaustive all-inclusive list of injuries requiring immediate MSHA notification. Rather it is a practical guide to operators citing "some" types of injuries that, based upon MSHA's past experience and based upon common medical knowledge, have the reasonable potential to cause death.[26]

E. Signs and Symptoms of Injury

When considering the totality of the circumstances, the Respondent argues correctly that signs and symptoms of injury are important factors in considering a § 50.10(b) MSHA notification.

However, in considering Stern's mental and physical signs and symptoms, this Court has given much more probative weight to the evidence of injury available *at the scene of the accident and at the time of the accident and immediately thereafter*. Medical information gathered from treatment sources at the hospital and thereafter—for example, reports that Stern's condition was improving and that, with or without surgical intervention, Stern's intestinal bleeding had ceased—has been accorded much less substantive weight in assessing the propriety of operator's § 50.10(b) determination than the signs and symptoms witnessed at the accident scene and time.

In proceeding thusly, this Court has been guided by the Commission's holdings in *Signal* and *Cougar Coal* that the need for a *prompt* determination is inherent in § 50.10 and that permitting operators to wait for a medical or clinical opinion would frustrate the immediate reporting of accidents.[27]

---

[26] The ALJ notes a back and forth between counsel questioning Shannon Smith as to whether Stern's blunt force trauma was in the upper or lower body. Any doubt regarding such at the accident scene should again have been resolved in favor of MSHA notification.

[27] If an operator is permitted to wait for and consider information beyond the narrow confines of time and space addressed herein, all types of speculation and delay may enter his determination. For instance, in this case, Stern had to undergo hospitalization and surgery. Given that medical

1. Consciousness and Alertness

This Court further agrees with Respondent that consciousness and alertness are factors which may indicate a non-fatal injury. However, standing alone, they are not necessarily contra indicative of a potentially fatal injury. Bartlett's Familiar Quotations is full of memorable dying declarations which—though quite lucid and profound—were uttered by individuals close to death.[28]

Likewise, the Commission and its judges have recognized that the maintenance of consciousness at the scene does not by itself preclude a finding of a § 50.10(b) violation. *Webster County Coal, LLC*, 2017 WL 2306333 (May 23, 2017)(ALJ).

In *Red River Coal*, a miner had been struck in the head by a pressurized end cap. *Red River Coal*, 39 FMSHRC 368, 389 (Feb. 21, 2017)(ALJ). The maintenance shop foreman, a certified EMT, found *the miner conscious at the scene with stable vital signs and minimal blood loss*—as in the case *sub judice*. *Id.* at 389-90. After considering however, the totality of the evidence, including the nature of the accident which involved blunt force trauma to the head and the fact that Life Flight had been called, Judge Feldman concluded § 50.10(b) had been violated. *Id.* at 391-92.

In *Cougar Coal Co.*, 25 FMSHRC 513 (Sept. 2003) the Commission on its own motion reviewed an ALJ's dismissal of a citation under 30 C.F.R. § 50.10. In *Cougar Coal* the victim had received an electric shock of exposure to 7,200 volts of electricity and had fallen a distance of 18 feet. *Cougar*, 25 FMSHRC at 514. Rejecting the ALJ's reliance upon the operator's assertion that the victim was conscious and alert when management personnel arrived at the scene, the Commission specifically found that the judge "incorrectly discounted testimony related to 'the nature of the accident' as irrelevant to the question of whether the injuries had a reasonable potential to cause death." *Id.* at 520

2. Complaints of Pain

At hearing, there was consistent testimony that Stern had voiced complaints of being in severe pain to Bailey Mine and GMS personnel. A prudent miner might reasonably consider such a symptom as being indicative of potentially fatal injury.

At hearing, it was reported that Stern had also described a sensation that his "guts were coming out of his penis." (Tr. 83). This symptom was so severe in nature that Shannon Smith

---

error is now the 3rd leading cause of death in the U.S. and given that thousands of our citizens die annually due to hospital borne infection—should an operator be required to deem any injury requiring later surgery and/or hospitalization to have a reasonable potential to cause death?

[28] Witness Moliere's reported last words: "Draw the curtain, the farce is over."

was compelled to check Stern's genitals. (Tr. 173). Such a bizarre and extreme sensation might also be reasonably interpreted as indicative of a potentially fatal injury.

3. Bent Leg and Lower Extremity Paralysis

At hearing it was also reported that Stern also had an odd bend to one of his legs and had complained of being unable to move a leg. (Tr. 270-71). Signs of fracture and complaints of lower extremity paralysis would be additional symptoms alerting a prudent miner of his duty to immediately notify MSHA.

4. Abrasions and Blood Loss

Visible signs of abrasions and some blood loss were also witnessed at the accident scene. (Tr. 87). Considered alone, these signs may not have been indicative of injuries with the reasonable potential to cause death. However, when viewed in combination with Stern's other signs and symptoms, a reasonably prudent miner would be motivated to immediately notify MSHA.

At hearing, Respondent argued that bruising could be associated with relatively minor injuries. (Tr. 180-81). The ALJ took Respondent's point that there are different degrees of bruising and associated internal bleeding dependent upon the type of trauma and body part affected. However, in the instant matter, there was obvious major trauma to Stern's torso.

5. Stomach Swelling and Internal Bleeding

One of the most ominous signs of potentially fatal injury testified to at hearing was that of Stern's reported stomach swelling/distention. (*See* Tr. 83).

At hearing, Smith acknowledged that Life Flight had been called due to fear that Stern might be experiencing internal bleeding which could lead to death. (Tr. 179-80).

The fact that Stern's internal bleeding had eventually receded, does not diminish the point that such a sign at *the mine accident site immediately after the accident* would have alerted a prudent operator to notify MSHA under § 50.10(b).

6. Stern's Farewell to Family

In addition to Stern's physical symptoms and signs which supported a determination that his injuries might be fatal in nature, Stern exhibited mental symptoms in support of such.

At the accident scene Stern requested that, if anything happened to him, Shannon Smith tell Stern's wife and family that he loved them. (Tr. 174). Individuals do not normally make such a request unless they themselves fear that their injuries are life threatening.

A prudent operator would reasonably find such a fear-filled family farewell to have been further evidence of a potentially fatal injury.

7. Call for Life Flight

Regardless of Respondent's various explanations minimizing its call for Life Flight—a reasonable inference to be drawn was that Respondent was justifiably concerned that Stern's injuries might be life-threatening. Smith's essential admission that Stern's injuries may be life-threatening pulled the lynch pin out from under Respondent's arguments otherwise. (Tr. 180).

F. Given the Totality of the Circumstances a § 50.10(b) Notification was Mandated

Respondent has raised various points of arguable merit justifying its failure to notify MSHA under § 50.10(b). Further, this Court grants that Respondent may have been acting in good faith in its violative actions. However, considering the totality of the circumstances in light of the protective purpose of the Act and mandatory safety standard, a prudent operator, knowledgeable of the industry would have or should have known that Stern's injuries had the reasonable potential to cause death, and therefore, had a duty to immediately notify MSHA.

G. Negligence

Respondent has argued that the Secretary's assessment of moderate negligence should be modified to low negligence. (*Resp't Post-Hearing Br.* at 31-33). An operator is moderately negligent when "the operator knew or should have known of the violative condition or practice but there are mitigating circumstances." 30 C.F.R. § 100.3 Table X. Low negligence conversely requires "considerable mitigating circumstances." *Id.*

As stated above, this Court finds that Respondent knew or should have known that an accident occurred with the reasonable potential to cause death. The nature of the accident, Stern being crushed between two several ton machines, Stern's belief that he might die, Stern's description of his injury including the feeling of something coming out of his genitals, Stern's stomach swelling indicating internal bleeding, and his inability to move his legs properly—all indicated that the Respondent knew or should have known that an accident occurred that had the reasonable potential to cause death.

Respondent did not call MSHA within the 15-minute time limit as §50.10(b) required when an accident with the reasonable potential to cause death has occurred. Although Respondent called Life Flight and seemed to react quickly and efficiently to help Stern after his injury, and although Respondent eventually called MSHA approximately two hours after Stern's injury occurred, nonetheless this Court does not find considerable mitigating circumstances, and affirms the Secretary's moderate negligence assessment.

H. Fair Notice

Respondent also argues that it did not have fair notice of the meaning and interpretation of the phrase "Operator realizes that...an injury...which has a reasonable potential to cause death." *Resp't Post-Hearing Br.* at 27-31.

To satisfy constitutional due process requirements, regulations must be sufficiently specific to give adequate notice of the conduct they prohibit or require. *See Grayned v. Rockford*, 408 U.S. 104,108 (1972). The Commission has stated that notice for an ambiguous regulation asks "whether a reasonably prudent person familiar with the mining industry and the protective purposes of the standard would have recognized the specific prohibition or requirement of the standard." *DQ Fire & Explosion Consultants*, 36 FMSHRC 3083, 3087 (Dec. 2014) (internal quotations omitted)(*quoting* Ideal Cement Co., 12 FMSHRC 2409, 2416 (Nov. 1990)). Thus, a reasonably prudent miner has adequate notice of a regulation when he knows—after considering the purpose of the provision—that said provision applies to a particular situation. *See e.g. Grayned*, 408 U.S. at 112; *Freeman United Coal Mining Co. v. FMSHRC*, 108 F.3d 358, 362 (D.C. Cir. 1997).

In this case, Stern was crushed between a scoop and railcar, both of which weighed between 5 and 10 tons. Stern complained of extreme pain, could not move his legs properly, believed something was coming from his genitals. Futher, he had stomach swelling, which indicated internal bleeding. Respondent's witness Smith, a fire boss examiner, believed that Stern's internal bleeding had the potential to cause death. *See* (Tr.180). All of these circumstances demand that a reasonably prudent miner would believe that Stern's condition had the potential to cause death.

VIII. Penalty

The Act requires that in assessing civil monetary penalties, the Commission ALJ shall consider the six statutory penalty criteria:

> ...the operator's history of previous violations, the appropriateness of such penalty to the size of the business of the operator charged, whether the operator was negligent, the effect on the operator's ability to continue in business, the gravity of the violation, and the demonstrated good faith of the person charged in attempting to achieve rapid compliance after notification of a violation.

30 U.S.C. 820(i).

30 C.F.R. §100.4(c) states that the penalty for failure to provide timely notification to MSHA "will not be less than $5,000 and not more than $65,000 for the following accidents:...2) An injury...of an individual at the mine, which has a reasonable potential to cause death." Section 110(a)(2) of the Act similarly states that an operator "who fails to provide timely notification to the Secretary as required under 103(j) of [the Act] (relating to the 15 minute

requirement) shall be assessed a civil penalty by the Secretary of not less than $5,000 and not more than $60,000."[29] 30 U.S.C. §820(a)(2).

The Secretary assessed a penalty of $5,000.00, and for the following reasons, this Court affirms the assessment of $5,000.00.

The Secretary has brought forward no evidence of previous §50.10(b) violations. Additionally, Bailey Mine is a large mine with an annual production capacity of 10.2 million tons in 2015 and 12.3 million tons in 2014. (GX-15). Respondent was moderately negligent as set forth above. The parties have stipulated that an assessment of $5,000.00 would not affect the operator's ability to continue in business. J.S.-4.

The gravity of the violation is "No Likelihood" of a "No Lost Workdays" injury. Based on the foregoing, this Court finds that a penalty of $5,000.00 is appropriate.

ORDER

The Respondent, Consol Pennsylvania Coal Company, LLC, is **ORDERED** to pay the Secretary of Labor the sum of $5,000.00 within 30 days of this order. [30]

John Kent Lewis
Administrative Law Judge

Distribution:
Jennifer Gold, Esq., Office of the Solicitor, U.S. Department of Labor, The Curtis Center, 170 S. Independence Mall West, Philadelphia, PA 19106

James P. McHugh, Hardy Pence, PLLC, P.O. Box 2548, Charleston, WV 25329

---

[29] In 2012, the $60,000 maximum was raised to $65,000 to account for inflation. *Signal*, at 484, n. 21.

[30] Payment should be sent to: MINE SAFETY AND HEALTH ADMINISTRATION, U.S. DEPARTMENT OF LABOR, PAYMENT OFFICE, P. O. BOX 790390, ST. LOUIS, MO 63179-0390