

**FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION**

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**JUL 29 2015**

SECRETARY OF LABOR  
MINE SAFETY AND HEALTH  
ADMINISTRATION (MSHA),  
Petitioner

CIVIL PENALTY PROCEEDING

Docket No. PENN 2013-385  
A.C. No. 36-07416-331352

v.

CONSOL PENNSYLVANIA COAL  
COMPANY, LLC,  
Respondent

Mine: Enlow Fork

**DECISION**

Appearances: Matthew R. Epstein, Esq., U.S. Department of Labor, Office of the Solicitor, Philadelphia, PA for the Secretary of Labor

James P. McHugh, Esq., Hardy Pence, PLLC, Charleston, WV for Respondent

Before: Judge Harner

This case is before me upon a petition for assessment of civil penalty filed by the Secretary of Labor (“Secretary”), acting through the Mine Safety and Health Administration (“MSHA”), against Consol Pennsylvania Coal Company, LLC, (“Consol” or “Respondent”) at its Enlow Fork Mine, pursuant to Sections 105 and 110 of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. §§ 815 and 820 (the “Act”). This case includes a Citation and Order, both of which were issued under 104(d) of the Act. The Secretary of Labor assessed a civil penalty of \$29,116.00 for these alleged violations. The parties presented testimony and documentary evidence at a hearing held in Pittsburgh, Pennsylvania on November 4-6, 2014.

**STIPULATIONS**

1. Respondent is an operator subject to the Mine Act and the Federal Mine Safety and Health Review Commission has jurisdiction. (Transcript, pg 6).<sup>1</sup>
2. The Court has jurisdiction over the Citation and Order. (Tr. 6-7).

<sup>1</sup> Hereinafter, the official hearing transcript will be referred to as “Tr.” followed by the page number(s). The Secretary’s exhibits will be referred to as “GX” followed by a number and Respondent’s exhibits will be referred to as “RX” followed by a letter.

3. The Citation and Order are true and accurate copies of what was served on Respondent. (Tr. 7).
4. The payment of the proposed penalty will not affect the operator's ability to remain in business. (Tr. 7).

## **FINDINGS OF FACT AND CONCLUSIONS OF LAW**

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

### **I. BASIC LEGAL PRINCIPLES**

#### **A. Significant and Substantial**

The Citation and Order in dispute and discussed below have been designated by the Secretary as significant and substantial and unwarrantable failures to comply with mandatory safety standards. A significant and substantial ("S&S") violation is described in section 104(d)(1) of the Act as a violation "of such nature as could significantly and substantially contribute to the cause and effect of a coal or other mine safety or health hazard." 30 U.S.C. § 814(d)(1). A violation is properly designated S&S "if, based upon the particular facts surrounding that violation, there exists a reasonable likelihood that the hazard contributed to will result in an injury or illness of a reasonably serious nature." *Cement Div., Nat'l Gypsum Co.*, 3 FMSHRC 822, 825 (Apr. 1981).

The Commission has explained that:

[i]n order to establish that a violation of a mandatory safety standard is significant and substantial under *National Gypsum*, the Secretary of Labor must prove: (1) the underlying violation of a mandatory safety standard; (2) a discrete safety hazard--that is, a measure of danger to safety--contributed to by the violation; (3) a reasonable likelihood that the hazard contributed to will result in an injury; and (4) a reasonable likelihood that the injury in question will be of a reasonably serious nature.

*Mathies Coal Co.*, 6 FMSHRC 1, 3-4 (Jan. 1984) (footnote omitted); see also, *Buck Creek Coal, Inc. v. MSHA*, 52 F.3d 133, 135 (7th Cir. 1999); *Austin Power, Inc. v. Secretary*, 861 F.2d 99,

103-04 (5th Cir. 1988), *aff'g Austin Power, Inc.*, 9 FMSHRC 2015, 2021 (Dec. 1987) (approving *Mathies* criteria).

The difficulty with finding a violation S&S normally comes with the third element of the *Mathies* formula. In *U.S. Steel Mining Co., Inc.*, 7 FMSHRC 1125, 1129 (Aug. 1985), the Commission provided additional guidance: We have explained further that the third element of the *Mathies* formula “requires that the Secretary establish a reasonable likelihood that the hazard contributed to will result in an event in which there is an injury.” *U.S. Steel Mining Co., Inc.*, 6 FMSHRC 1834, 1836 (August 1984). We have emphasized that, in accordance with the language of section 104(d)(1), it is the *contribution* of a violation to the cause and effect of a hazard that must be significant and substantial. *U.S. Steel Mining Co., Inc.*, 6 FMSHRC 1866, 1868 (August 1984); *U.S. Steel Mining Co., Inc.*, 6 FMSHRC 1573, 1574-75 (July 1984). The Secretary “need not prove a reasonable likelihood that the violation itself will cause injury.” *Cumberland Coal Resources, LP*, 33 FMSHRC 2357, 2365 (Oct. 2011) (citing *Musser Engineering, Inc. and PBS Coals, Inc.*, 32 FMSHRC 1257, 1281 (Oct. 2010)).

This evaluation is made in consideration of the length of time that the violative condition existed prior to the citation and the time it would have existed if normal mining operations had continued. *Elk Run Coal Co.*, 27 FMSHRC 899, 905 (Dec. 2005); *U.S. Steel Mining Co., Inc.*, 6 FMSHRC at 1574. The question of whether a particular violation is S&S must be based on the particular facts surrounding the violation. *Texasgulf, Inc.*, 10 FMSHRC 498 (Apr. 1988); *Youghiogeny & Ohio Coal Co.*, 9 FMSHRC 2007 (Dec. 1987).

## **B. Negligence and Unwarrantable Failure**

Negligence “is conduct, either by commission or omission, which falls below a standard of care established under the Mine Act to protect miners against the risks of harm.” 30 C.F.R. § 100.3(d). “A mine operator is required to be on the alert for conditions and practices in the mine that affect the safety or health of miners and to take steps necessary to correct or prevent hazardous conditions or practices.” *Id.* MSHA considers mitigating circumstances which may include, but are not limited to, actions taken by the operator to prevent or correct hazardous conditions or practices. *Id.* Low negligence exists when “[t]he operator knew or should have known of the violative condition or practice, but there are considerable mitigating circumstances.” *Id.* Moderate negligence is when “[t]he operator knew or should have known of the violative condition or practice, but there are mitigating circumstances.” *Id.* High negligence exists when “[t]he operator knew or should have known of the violative condition or practice, and there are no mitigating circumstances.” *Id.* See also *Brody Mining, LLC*, 33 FMSHRC 1329 (2011) (ALJ Gill). Finally, the operator is guilty of reckless disregard where it “displayed conduct which exhibits the absence of the slightest degree of care.” 30 C.F.R. § 100.3(d).

The Commission has defined an unwarrantable failure as aggravated conduct constituting more than ordinary negligence. *Emery Mining Corp.*, 9 FMSHRC 1997, 2001 (Dec. 1987). Unwarrantable failure is defined by such conduct as “reckless disregard”, “intentional misconduct”, “indifference”, or a “serious lack of reasonable care”. *Emery Mining Corp.*, 9 FMSHRC at 2003; see also *Buck Creek Coal, Inc.*, 52 F.3d 133, 136 (7<sup>th</sup> Cir. 1995).

The Commission has recognized that whether conduct is “aggravated” in the context of unwarrantable failure is determined by considering all the facts and circumstances of each case to determine if any aggravating factors exist, or if any mitigating circumstances exist. Aggravating factors include the length of time that the violation has existed, the extent of the violative condition, whether the operator has been placed on notice that greater efforts were necessary for compliance, the operator's efforts in abating the violative condition, whether the violation was obvious or posed a high degree of danger, and the operator's knowledge of the existence of the violation. See *Consolidation Coal Co.*, 22 FMSHRC 340, 353 (Mar. 2000). Repeated similar violations are relevant to an unwarrantable failure determination to the extent that they serve to put an operator on notice that greater efforts are necessary for compliance with a standard. *Peabody Coal Co.*, 14 FMSHRC 1258, 1261 (Aug. 1992).

The Commission has made clear that it is necessary for a judge to consider all relevant factors, rather than relying on one to the exclusion of others. *Windsor Coal Co.*, 21 FMSHRC at 1001; *San Juan Coal Co.*, 29 FMSHRC 125, 129-36 (Mar. 2007) (remanding unwarrantable determination for further analysis and findings when judge failed to analyze all factors). While an administrative law judge may determine, in his or her discretion, that some factors are not relevant, or may determine that some factors are much less important than other factors under the circumstances, all of the factors must be taken into consideration and at least noted by the judge. *IO Coal Company*, 31 FMSHRC 1346, 1351 (Dec. 2009).

I rely on the state of the law as discussed herein in considering each issue addressed below and whether the Citation and Order, which are alleged to be S&S and unwarrantable failures, meet the above noted criteria.

## **II. DISCUSSION WITH FINDINGS OF FACT AND CONCLUSIONS OF LAW**

### **A. Background**

The instant citation was issued for alleged violations of safety standards in the Enlow Fork E-tailgate bleeder system. (GX-1 and GX-2). According to the Commission, “bleeder entries” are defined as “panel entries driven on a perimeter of a block of coal being mined and maintained as exhaust airways to remove methane promptly from the working faces to prevent buildup of high concentrations either at the face or in the main intake airways.” *Consolidation Coal Co.*, 20 FMSHRC 227, FN 6 (Mar. 1998) *citing* American Geological Institute, *Dictionary of Mining, Mineral, and Related Terms* 55 (2d ed. 1997).

The bleeders at Enlow Fork were maintained with weekly examinations. (Tr. 31, 69-70, 173). Examiners were foremen; regular miners did not travel in the bleeder. (Tr. 69-70). At the time at issue, examiners walked the bleeders alone but by the time of the hearing a company-wide policy required travel in pairs. (Tr. 490-491, 507, 706, 722). The instant matter occurred in the E-15- to E-22 bleeder system, an older bleeder about 8 miles long. (Tr. 32-35, 470). An experienced examiner would take 4-5 hours to complete an examination run here. (Tr. 33-34). The purpose of a bleeder exam was to ensure proper ventilation at certain “evaluation points.”<sup>2</sup>

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<sup>2</sup> Exams occurred in the No. 3 travel entry. It was possible to reach the evaluation points via other entries, but it was not clear this would be a complete exam. (Tr. 199-200, 229-230, 389,

(Tr. 30). The examiner would check for methane, erratic changes in the amount or direction of air, the quality of the air, air pressure, ventilation controls, roof support, and anything else affecting ventilation. (Tr. 30-32). The examiner would also check for things affecting safe passage, including water accumulations. (Tr. 31, 56).

Most bleeder systems have water in them and all have pumps to remove that water. (Tr. 34, 280). The E-15 to E-22 bleeder was a challenge to keep dry. (Tr. 315). Significant accumulations could occur in a matter of hours. (Tr. 505-506). Most of the water was clear, though it could be cloudy, orange, and murky from magnetite, sulfur and “nasty stuff.” (Tr. 488-489, 756). Clear water might not be a hazard because a miner could see where he was walking. (Tr. 53-54).

To reroute this water, Respondent’s ventilation plan permitted a system of 18-23 air pumps that dumped water into a 12-13 foot deep sump.<sup>3</sup> (Tr. 41-43, 48, 118, 188, 214-215, 471-475, 478). The sump was partially filled with mud and coal fines and could be murky. (Tr. 474, 489). Two four-inch discharge lines transferred water in the sump to an underground retaining pool. (Tr. 216, 272-273, 475-476, 650-651, 763). The discharge lines drained at half capacity 24 hours a day. (Tr. 472, 475-477). Half a pipe of water issuing from the discharge lines meant the pumps were working properly. (Tr. 508, 511-512).

If the water system was disrupted, the sump could fill in two to three hours and then overflow, causing water to cover the walkways in the bleeder. (Tr. 477-478). The mine could not keep up if even one or two air pumps went down. (Tr. 478-480, 510). If the water backed up, it could block the evaluation points and prevent examination of the bleeder. (Tr. 479-480). If the pumps were broken, regulator doors could be opened to allow water to run to the next pump or to the sump (at the lowest spot). (Tr. 480-481, 662).

Daily monitoring of the pumps was not required by the plan but Respondent had two pumpers check the pool and discharge lines three times a day. (Tr. 215, 475-476, 502, 520, 648-649, 651, 706, 753, 777-778). Pumpers were not certified to enter the bleeder, only to check the pool for water discharge and air readings. (Tr. 710, 768, 778). This check only showed how much water went from the sump to the pool, not the level of water in the sump or bleeder. (Tr. 216, 502-503, 508, 656, 710, 768). It also showed that the air pumps were working. (Tr. 217, 502, 656). A large amount of water being discharged would imply that the sump was full. (Tr.

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480, 500-501). Such a bypass occurred about twice a year when the primary entry was blocked. (Tr. 500-501). The examiner only bypassed one block and could see the areas missed. (Tr. 501).

<sup>3</sup> The Consol Enlow Fork Mines Ventilation Plan (GX-3, p. 1) stated:

[T]he means for maintaining safe travel will include compressed air lines routed underground used in conjunction with air pumps to remove water as necessary to permit safe travel through the perimeter bleeder system. Discharge lines will direct pump water to the mine dewatering system. Ditches, bridges, and natural drainage are used to maintain bleeder entries free from standing water that effect ventilation and prevent safe travel.

(Tr. 55-56).

769). Water not coming out of the discharge pipes would indicate that a pipe, booster, or compressor was broken, air was insufficient, or that there was no electricity. (Tr. 476-477, 657-658, 768-769, 778). It could also mean that the sump was empty. (Tr. 769). If water was not discharged, the pumpers called the examiner to check the area. (Tr. 765-766, 769).

A back-up sump pump system was also in place but not included as part of the ventilation plan. (Tr. 43-44, 188-189, 214-215, 472). The sump system was only used in an emergency, like when air pumps broke or when there was too much water for the air system. (Tr. 44, 188-189, 477, 512). The sump pump was located and maintained on the surface and could not be heard underground. (Tr. 473-474, 518, 520-521). Surface fan examiners checked whether the pump was working, the level of water underground, and the status of the surface tanks. (Tr. 282-283, 590). The miners underground and above ground communicated about the sump pump. (Tr. 518, 661-662).

Originally, the sump pump was turned on manually but a bubbler system was later installed that automatically activated when water in the sump reached a set level. (Tr. 188-189, 472-473, 565, 663). A bubbler works by forcing a set amount of air down tubes from the surface to the sump and, if the air displaces water, activates the pump. (Tr. 241-242, 536-539). Craig Yoho set the level at 22 inches.<sup>4</sup> (Tr. 663). Once the water was removed, the pump turned off automatically. (Tr. 559). The bubbler gave an idea of the water level in the sump. (Tr. 538-539, 758, 761). In fact, there may have been a gauge attached to the bubbler at the surface that showed the depth in the sump. (Tr. 542).

A mechanic examined the bubbler daily and kept a log of the bubbler readings to keep track of water levels and plan maintenance (GX-11, RX-N). (Tr. 557-558, 561-565, 753-754). Generally, if the bubbler readout showed “zero inches” the mechanics would not touch the pump. (Tr. 558). However, if the bubbler showed “0” for a long time, the mechanic might suspect there was a problem. (Tr. 754). Mechanics could only test the accuracy of the bubbler reading by forcing air down the tubes and seeing if the pump would run. (Tr. 541, 558-559). Only experienced mechanics and electricians would know to take this action. (Tr. 539-542, 558-560).

In February 2013, the E-15 overflow from the sump deposited water in three outdoor tanks with a total capacity of 63,000-64,000 gallons. (Tr. 44-45, 650-651, 737). The pump moved 250-300 gallons a minute and could fill the tanks in three hours. (Tr. 284). When the tanks were full the sump pump could not run and 4,610-gallon trucks would have to unload the tanks. (Tr. 45-46, 559, 564, 613, 737-738). The tanks were designed so they could not overflow. (Tr. 610, 755-756). There was no sediment pond or overflow system, and the water in the tanks had to be removed by trucks and processed for environmental reasons because it was considered “dirty”. (Tr. 284-285, 761). Burns Trucking was contracted to empty these tanks and did so regularly. (Tr. 564, 612-613). Burns Trucking and the fan man monitored the tanks daily.

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<sup>4</sup> Craig Yoho was present at the hearing and testified. (Tr. 731). At the time of the hearing, Yoho was employed as a maintenance foreman at Consol. (Tr. 731).

(Tr. 282-283, 613-614). Frank Vorhes testified that Burns checked the pumps as a courtesy but never conducted repairs.<sup>5</sup> (Tr. 546-547, 629-632-633).

According to Respondent's witnesses, water in the bleeder only needed to be reported in the examination book if the condition could not be fixed or if more repairs were needed. (Tr. 450-451, 490). The examiner carried tools and spare parts so that conditions could be fixed quickly. (Tr. 502-505). If the examiner could not finish a run, the existence of water would have to be recorded in the book along with any other hazardous conditions that were not corrected. (Tr. 451-452). The condition would be repaired the next day with any assistance necessary. (Tr. 490-492). Water 42-inches or deeper should go in the book so that the inspector and miners would be aware. (Tr. 503). Sometimes the examiner would make additional exams during the week to make repairs, but there were no books for these extra exams. (Tr. 493).

The ventilation plan permitted digging trenches to move or control water and building bridges above them in the bleeder system. (Tr. 48, 50-51). Water still had to be controlled with pumps, but walkways could be used over static puddles, mud holes, and bad bottom. (Tr. 48-49, 51-52). Submerged bridges, especially in muddy or murky water, would be a tripping hazard. (Tr. 53-54). The sump area had a wet walkway above the collected water. (Tr. 43-44, 645, 722, 791). There were two or three other walkways in the E-15 area.<sup>6</sup> (Tr. 47, 55, 155-156). The E-21 walkway was 400-500 feet long and covered a low spot where the continuous miner had dipped that filled with mud and water. (Tr. 482-487). There were valves and pumps in this low spot. (Tr. 487-488). Some of the bridges were 24-36 inches off the bottom while others were only four or five inches from the bottom. (Tr. 54, 484). Most of the walkways in the E-15 to E-22 bleeder were in decent shape, though some were rotted, steep, or muddy. (Tr. 48). Walkways were to be kept clear and cribs and cables were used to mark the path and served as handholds. (Tr. 725, 789).

There was no communication system in the Enlow Fork bleeders. (Tr. 36-37). Miners in the area were tracked manually, meaning they called out at the last tracking signal to explain they would go off the grid and then called again when they left the bleeder. (Tr. 37). If a miner did not check in, someone was sent after him. (Tr. 38). Two years before the hearing a miner at Bailey Mine had a heart attack and died in a bleeder. (Tr. 38, 705-706, 721). If a miner were to fall in murky water and hit his head on rocks, pumps, pipes, or other obstructions he could be rendered unconscious and drown. (Tr. 39). The miner at Bailey and the instant matter were among the reasons Respondent changed its policy to require that two miners conduct examinations together. (Tr. 706).

Power outages occurred often in the bleeder, affecting fans and compressors. (Tr. 493). The examiner would check the pump to ensure that water was still coming out, especially if the outage was close to the regular exam day. (Tr. 493-494). If there was insufficient water there was an indication that the pump or bleeder valve was affected by the outage. (Tr. 493-494).

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<sup>5</sup> Frank Vorhes was present at the hearing and testified. (Tr. 612). At the time of the hearing, Vorhes was employed by Burns Drilling, Excavating, and Trucking as a dispatcher. (Tr. 612).

<sup>6</sup> The exact number and location of the walkways was unclear from the record.

On November 20, 2012, MSHA inspector Walter R. “Bud” Young traveled this bleeder system as part of a normal, quarterly EO-1 inspection.<sup>7</sup> (Tr. 61-63). During that inspection, Young issued a citation (GX-7) for excessive water in sump area of the E-tailgate bleeder system. (Tr. 63-64, 74, 183-184). The water was 24-36 inches deep, murky, and contained tripping hazards including air lines, discharge hoses, cribs, cables, wires, irregular mine floor, and sloughage. (Tr. 64, 198, 200). Young did not know where the water came from but Respondent believed it occurred because a contractor had accidentally cut the surface sump pump cord. (Tr. 64, 66, 187-188, 190, 585). Respondent removed the water with the surface and tailgate pumps and laid a new cable. (Tr. 64, 586). The citation was issued on the last day of the weekly exam period, but Young testified that it would have been a violation on any day. (Tr. 184-186). When Young left the mine he told Jerry Wright, the assistant mine foreman, that every time he went into this bleeder it got worse and Wright promised to take care of it. (Tr. 66).

The citation was issued for a §75.370 violation under Section 104(a) for a tripping hazard. (Tr. 193-194). The citations was marked as “reasonably likely” to occur. (Tr. 193). Young factored in that the area was limited access and that only one miner conducted the weekly exam. (Tr. 193). The citation was marked as lost workday/restricted duty because of the length, depth, and extent of the conditions and the possibility for cellulitis, broken bones, contusions, lacerations, dislocations, and hypothermia. (Tr. 195-196, 199-200). The citation was marked as “low” negligence because there were significant mitigating circumstances, including the fact that the area was lightly traveled, the line was cut, no one knew (though they should have known) about the water, and it was the last day of the exam period. (Tr. 190-191, 197-198).

As a result of the water accumulation, the bleeder inspection could not be completed and Young returned on December 10, 2012 to finish the inspection of the bleeder. (Tr. 63). On that day, he issued another citation for excessive water in the bleeder (GX-8). (Tr. 65, 73-74, 202). There was water at the sump and at the other end of the bleeder. (Tr. 65). The water was hazardous because it was 24 inches deep, contained tripping hazards, and was so dark and murky that the mine floor was not visible. (Tr. 65). Respondent believed the water accumulated because the surface tanks were full and because there was a hole in the pump line. (Tr. 45, 71, 202, 842-843).

This citation was marked as lost workdays because there was wood floating in the area, the water was murky, and there were concealed tripping hazards. (Tr. 209). A miner could have easily fallen, struck his head or body, and been injured. (Tr. 209). Miners could twist an ankle, break a leg, or get sores on their feet. (Tr. 68-69). The water was also orange and contained bacteria. (Tr. 69). Young had once gotten cellulitis, a painful blood borne infection in his feet, from walking through mine water. (Tr. 68). There had also been cases of MRSA. (Tr. 69). The citation was marked as affecting one person because miners only traveled during exams. (Tr. 205-206). The citation was issued six days after the Respondent had completed its last exam of the area. (Tr. 206). The citation was marked as moderate negligence because management

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<sup>7</sup> Walter R. “Bud” Young was present at the hearing and testified. (Tr. 24). At the time of the hearing, he was an MSHA ventilation specialist. (Tr. 25). He had received training and held several certifications. (Tr. 25-30). Young had worked 30 years in the industry at several different positions, including 15 years at the Enlow Fork Mine. (Tr. 26-30). When he worked at Enlow Fork, Young examined the bleeders, but did not examine the E-15 bleeder. (Tr. 28, 30).



was on notice that there was a water problem from the previous citations but did not adequately address the problem. (Tr. 207). The violation was mitigated because the areas were small and could be avoided. (Tr. 208-209, 239).

Young wrote in this citation that Respondent was on notice that increased removal of standing water in the bleeder and clearing of the walkway was necessary or increased enforcement would occur. (Tr. 67-68, 71). He relayed this information to Mine Foreman Mike Giavonelli.<sup>8</sup> (Tr. 66-67, 694). Young had traveled the E-15 bleeder many times and had cited water at least twice before. (Tr. 39-41, 46). Young only cited the bleeder when water went over his 18-inch boots, when it covered a vast area, when it was discolored, or when it contained tripping hazards, but the bleeder always contained some water. (Tr. 40, 46-47, 172-173). This was the worst bleeder system Young had ever seen for water build-up. (Tr. 34-35). Young was concerned about the effect of standing water on the health and safety of miners. (Tr. 68).

Giavonelli promised to install an alarm on the sump pump to monitor the water levels by computer and to devote more miners to keep the area clear. (Tr. 67, 71, 202-203, 275, 294-295, 512). After this citation, additional exams were conducted by the examiners and pump men. (Tr. 662, 698). Respondent also split the bleeder system, though this did not necessarily limit the amount of water in the area. (Tr. 203-205, 699). Respondent may also have added pumping capability to the area. (Tr. 273, 699). The timing of these changes is unclear. (Tr. 700).

At some point management installed the promised monitoring system, allowing them to view the bubbler system on computer screens so examiners would not have to go to the pump. (Tr. 521, 637, 663). The pump was linked with a wireless system to the E-15 fan monitoring system. (Tr. 294, 572, 736-737). The monitor showed air pressure in the bubbler, rather than inches of water in the mine. (Tr. 605, 751-752). The screens showed a visual alarm when the pump activated, when the surface tanks were full or when the power was off. (Tr. 573, 737-739, 753-755). There were monitoring stations at the tracking center, the foreman's office, the electrician's office, both superintendents' offices, the plaza, the communication center, and the corporate office. (Tr. 738-739, 751). Someone watched the screens at all times. (Tr. 738). The system was tested and worked. (Tr. 737). The system could only monitor, not remotely control, the pump. (Tr. 584). After installation, management monitored the bubbler with examiner reports, the pumper reports, and by looking at the computer monitor. (Tr. 664-665). Paper records were maintained even after the remote system was put in place. (Tr. 572).

It was not clear when this system was installed or if it was installed before the instant matter. (Tr. 70, 254-255, 295, 520, 522, 637, 701-702). The evidence is conflicting about the time of the installation and no records were produced at the hearing to disclose when the system was installed. (Tr. 747). Young believed it was installed after December 10. (Tr. 256). Yoho stated that it was completed after December 10 and definitely before February 5. (Tr. 732-734, 736-740, 747, 754). Initially, Christopher E. Demidovich testified it was installed after February

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<sup>8</sup> Michael Giavonelli was present at the hearing and testified. (Tr. 634). At the time of the hearing, Giavonelli had been a mine foreman at Enlow Fork for 10 years. (Tr. 634).

5, 2013.<sup>9</sup> (Tr. 570-571). However, he later stated it was installed starting on December 11, 2012 and was in place on February 5, 2013. (Tr. 573, 577-579). Finally, he stated he was not certain on the timing of the installation. (Tr. 580-582).

### **B. The February 5, 2013 Inspection**

On February 5, 2013<sup>10</sup>, Young's supervisor, Dave Severini, called him at home about a 103(g) complaint (GX-3) at Enlow Fork for accumulation of water in the bleeders and possible problems with the ventilation.<sup>11</sup> (Tr. 56-57, 76, 159-161, 372, 374, 385, 682). Young was sent because he was the ventilation specialist in charge of Enlow Fork. (Tr. 77-78, 160-161, 359-360). Severini said another inspector at the mine needed to be relieved. (Tr. 78, 162, 360-361). Severini and Young did not discuss whether issuances under 104(d) were being considered. (Tr. 161).

Young arrived at Enlow Fork at 9:00 p.m. (Tr. 112-113, 406-407, 805). John Brottish<sup>12</sup>, William Gross<sup>13</sup>, and Rod Henry<sup>14</sup> were highlighting the mine map (GX-3, p. 23-25) for accumulations of water. (Tr. 79, 156-158, 164-166, 223-224). They told Young what they had found and confirmed their findings on the map. (Tr. 167-173, 362, 410-411). Brottish and Gross agreed on the location of the accumulations and measurements. (Tr. 795, 805).

Gross had begun his regular inspection at 7:00 a.m. and was accompanied by Brottish. (Tr. 342, 785). Normally bleeders are not checked in a quarterly inspection, but when Gross got

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<sup>9</sup> Christopher E. Demidovich was present at the hearing and testified. (Tr. 548). At the time of the hearing he was employed by Consol as a surface maintenance supervisor. (Tr. 548-549). In that capacity he maintained surface equipment. (Tr. 549).

<sup>10</sup> Unless otherwise indicated, all dates refer to 2013.

<sup>11</sup> Section 103(g) of the Mine Act provides, *inter alia*, “[w]henever a representative of the miners or a miner in the case of a coal or other mine where there is no such representative has reasonable grounds to believe that a violation of this chapter or a mandatory health or safety standard exists, or an imminent danger exists, such miner or representative shall have a right to obtain an immediate inspection by giving notice to the Secretary or his authorized representative of such violation or danger.” 30 U.S.C. §813(g).

<sup>12</sup> John Brottish was present at the hearing and testified. (Tr. 784). At the time of the hearing, Brottish was employed by Respondent as a “safety mentor.” (Tr. 784-785). Before that, and at the time at issue, he was a safety inspector. (Tr. 785).

<sup>13</sup> William Gross was present at the hearing and testified. (Tr. 334). At the time of the hearing, Gross was an MSHA inspector. (Tr. 334-335, 369). He was trained by MSHA and had extensive experience and certifications. (Tr. 335-339). Gross had been at the Enlow Fork Mine that day conducting a normal, two-week long quarterly inspection. (Tr. 339-340).

<sup>14</sup> Rod Henry was present and testified at the hearing. (Tr. 770). At the time of the hearing Henry was retired but had last worked as a safety supervisor at Enlow Fork. (Tr. 770).

back outside at 11:30, he learned (while in the mine office) that there was a 103(g) complaint regarding the bleeders. (Tr. 105, 132, 341-344, 370-372, 785-786). Gross informed Brottish, Henry, and Giavonelli that the 103(g) complaint was about water accumulations in the E-District bleeders affecting ventilation. (Tr. 343, 682, 771, 773, 777, 786). Brottish recalled telling Gross that the examiner had an issue with water that morning. (Tr. 774, 786). Gross did not recall this conversation; he just knew what he read in the 103(g) complaint. (Tr. 373-375). Henry and Brottish recalled asking Gross how much water was too much and seeing Gross lift his hand to his chin. (Tr. 773, 779, 786-787). Brottish assumed this meant he was not worried about going through that depth of water. (Tr. 787). Gross did not recall this exchange. (Tr. 375).

Gross and Brottish took a mantrip to the E-tailgate area and planned to walk from the mouth, to the corner mentioned in the 103(g) complaint, and then walk the whole perimeter from E-15 to E-22. (Tr. 173, 343-344, 357, 772, 787). Brottish volunteered to go with Gross. (Tr. 399, 786). Gross did not note any violations (with roof, ribs, or any other area) until he found a water accumulation starting at the 47 crosscut. (Tr. 163, 347, 417-418, 787-788, 799). The water ranged from 12 inches to 42 inches at the deepest spot near the sump. (Tr. 80, 156-157, 347-348, 382, 385-389, 788, 799). The whole area near the sump was flooded. (Tr. 388). Despite the water, there was no indication that the visual alarm on the remote monitoring system sounded that day. (Tr. 72). Gross took only one measurement. (Tr. 391, 794, 798). However, water was also halfway up over a man door (which sat 24 inches from the bottom). (Tr. 349, 788-789). The water was rib to rib, very cold, murky (from dirt and coal dust), cloudy, and the bottom could not be seen. (Tr. 172, 348, 411-412). There was no indication that the water was receding. (Tr. 364-366). Gross did not recall Brottish's reaction to the water or if Brottish was already aware of it. (Tr. 423-424).

Gross did not hear the sump pump running or see water rippling from it. (Tr. 365-366, 402). He did not recall anyone saying the pump started at 5 a.m. (Tr. 405). In fact, Gross was not aware of the sump pump system at that time, only the air pump system. (Tr. 409). However, it was possible the discharge lines were feeding into the sump. (Tr. 368). Brottish knew the pump was running because water was coming out of the pipe. (Tr. 795-796).

Gross and Brottish traveled through the water and through a mandoor to reach a dry area near the fan to take air readings and check for methane buildup in the corner. (Tr. 348-349, 788, 790, 799-800). The highest reading was only 0.4% methane and the air flow was adequate; there was no ventilation problem. (Tr. 80-81, 350, 375-377, 774-775, 790). Gross did not think he would die as he walked in the water. (Tr. 398). However, he testified that he would not have entered the water alone because no one could help him if he fell. (Tr. 349, 367, 398). Gross and Brottish shuffled their feet and moved slowly because they could not see the bottom. (Tr. 349, 411, 425). Later, after returning to the MSHA office, Gross was verbally reprimanded by the district manager for entering water that deep, but believed at the time that he acted to ensure the safety of miners. (Tr. 349-350, 366-367, 399, 401). Brottish felt safe walking the area. (Tr. 789, 793).

They continued on and about 300 feet from the corner they reached another accumulation of water. (Tr. 351). Gross believed that this entire area was about 600-700 feet. (Tr. 79-80, 125-126, 167, 169, 351-353, 377). It was later determined that the water accumulation started at

46 crosscut, so it was only 400-500 feet. (Tr. 377-378, 382, 384). Gross believed that this might have dropped because the pumps were later running. (Tr. 384, 387-388).

Gross and Brottish encountered another accumulation of water at E-19. (Tr. 350-351, 353, 791, 800). The water here ranged from 12 to 36 inches deep from the surface of the water to the mine floor (not the bottom of the walkway) and went over Gross' mid-calf boots. (Tr. 125-126, 173, 354, 356, 366, 391-392, 394, 420, 791-792, 801). It was 12 inches from the top of the bridge to the surface of the water. (Tr. 792, 801-802). The deepest point was halfway across the area on the walkway. (Tr. 393-394). The ground was uneven and Brottish believed the deepest location was a low spot on the walkway. (Tr. 395, 792, 801). Gross only made two measurements in this area. (Tr. 392, 794). Gross agreed that he should have taken more, but he already knew the area was unsafe for travel even if some areas may have only been a few inches deep. (Tr. 394-396). The water stretched two panels from E-19 to E-21 (about 2,000 feet) without any dry areas. (Tr. 79-80, 125-126, 167-169, 173, 354, 379-380).

Gross was less concerned about the depth here and more concerned that the water was murky and obscured the walkway, their feet, and the bottom. (Tr. 172, 354-356, 392, 394-395). Brottish believed the water was clear until they kicked up material. (Tr. 793, 825-826). The pumps were running, but were not effective. (Tr. 366, 401, 424, 792). Gross did not believe he said he would issue citations for the pumps. (Tr. 403).

Gross and Brottish exited the mine around 8:30 to 9:00. (Tr. 406, 682-683, 774-776). Brottish, Gross, and Henry discussed the conditions and then a later meeting occurred with more management covering the same issues. (Tr. 796-797, 825). After traveling through the area, Gross considered the murky water a tripping hazard. (Tr. 356, 411, 775). However, neither he nor Brottish tripped. (Tr. 412, 789-790, 793).

Gross did not issue a citation right away because he wanted to gather more information for the 103(g) complaint.<sup>15</sup> (Tr. 356-357, 398). Management believed Gross said he would write citations that were low negligence and non-S&S. (Tr. 357, 397, 402-403, 790-791, 796, 804, 823-824). Gross did not recall making any comments to this effect.<sup>16</sup> (Tr. 397). Brottish recognized that the alleged comment was made before Gross looked at the books, spoke to the examiners, or saw all of the conditions. (Tr. 796-797, 823-824). Henry recalled Gross saying it would "probably" be S&S, though Brottish may have told him. (Tr. 775, 780-781). Regardless, Gross believed Respondent needed to take immediate action. (Tr. 397-398). Brottish believed the company took all citations seriously but acted more quickly and took more notes for S&S citations. (Tr. 793-794). Respondent also cared more about the justification for S&S citations. (Tr. 794).

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<sup>15</sup> A 103(g) inspections might go on for three weeks without a decision about whether to issue a citation. (Tr. 418). Gross believed that good investigations take time. (Tr. 413).

<sup>16</sup> It does not appear likely that Gross made any comment about the type of violation since he needed to gather more information.

Gross then called Severini, his supervisor, and told him he wanted to speak to the two examiners when they returned to the mine for their shift to determine negligence and unwarrantable failure before issuing anything. (Tr. 357-359, 405, 409-410, 774-775, 777, 797). They discussed that the citation could be a (d)(1) issuance pending that conversation. (Tr. 360). It was not uncommon for an inspector to want to speak with someone before making a determination. (Tr. 816). Gross did not tell Severini he was issuing non-S&S 104(a) citations and did not recall who brought up (d) orders. (Tr. 404). They did not discuss mitigating circumstances and Gross did not take notes about the conversation. (Tr. 407-408). Gross did not know that the bleeder had been cited earlier and that the mine was on notice. (Tr. 364, 369-370). After talking to Severini, Gross decided to wait for Young before writing anything. (Tr. 361).

Sometime after speaking with Severini, Gross told Giavonelli and Brottish there would be two (d) orders. (Tr. 403-405, 683, 804). Giavonelli and Brottish claimed that Gross rescinded his earlier announcement that he would issue two citations after speaking with Severini and stated, "you are not going to believe this I have to write you two Orders." (Tr. 683, 798). Gross claimed that at the time of the hearing he believed the unwarrantable failure designation was appropriate. (Tr. 410). After this conversation regarding (d) Orders, Giavonelli made a note in the book (RX-W) indicating that there was water but that it had not roofed or caused ventilation problems. (Tr. 679-680, 717-721, 720-721, 724).

After Young arrived at the mine, Gross updated him about these circumstances, gave Young his notes and left the mine at 11:00 p.m. before the two examiners, Dan Stalnaker<sup>17</sup> and Kevin Saunders<sup>18</sup>, returned for their shift. (Tr. 112-114, 162-163, 360-363, 379-380, 400, 410-411, 416-417, 419). Gross had no further involvement, as Young completed the investigation. (Tr. 363, 405, 417).

After hearing about the conditions, Young told Brottish and Head of Safety Steve Apperson that he was going to issue a 104(d)(1) Citation for the water conditions unless they presented mitigation. (Tr. 88, 90, 119, 806, 818). This citation was based on Gross' observations, the map, and what the examiners might tell him. (Tr. 90, 164-166, 170, 211-212). He started drafting the body of the citation before he ever saw the water. (Tr. 114, 154-155). Young and Gross never discussed the type of issuance and Young did not know what Gross had told Respondent before he left. (Tr. 174-175).

Young knew that two examiners, Stalnaker and Saunders, had earlier walked through the area. (Tr. 89-89). Young did not know if the exam had been completed and he wanted to talk to

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<sup>17</sup> Dan Stalnaker was present at the hearing and testified. (Tr. 297). At the time of the hearing Stalnaker was retired, but his previous job was working around eight years as a regular mine examiner at Enlow Fork. (Tr. 297-298). Stalnaker did not regularly examine bleeders and had only been in the cited area two or three times. (Tr. 298-299, 314, 496). He encountered water in the area before the instant incident, preventing him from examining the area in its entirety. (Tr. 299, 313-314).

<sup>18</sup> Kevin Saunders was present at hearing and testified. (Tr. 426). At all relevant times he was a foreman at Enlow Fork. (Tr. 426, 436-437). Saunders was regularly assigned to examine a different bleeder and had examined, at most, E-15 twice in the past. (Tr. 427, 436).

them. (Tr. 89). The examiners returned to duty at around 11:00 p.m. (Tr. 90). Young, Brottish, and Apperson spoke to Saunders and Stalnaker together. (Tr. 91, 97, 818).

Stalnaker conducted the bleeder run the previous day because the normal examiner, Jamie Greene, was out.<sup>19</sup> (Tr. 298, 301, 313, 448, 494-495). Greene had examined the area on January 22 and 29 and found that everything was in order.<sup>20</sup> (Tr. 320, 321, 491-492, 667, RX-C). Greene also inspected it two or three days in a row before Stalnaker filled in for him to ensure the area was in good repair. (Tr. 495-496, 519-520). At no time did anyone tell Greene that the mine was on notice to prevent water in the bleeders and he did not know about the previous citations issued by Young. (Tr. 501-502, 509). Further, Greene did not remember any recent power outage. (Tr. 519).

On February 5, Stalnaker went to E tailgate No. 3 Entry and made it to an access door around the 47 crosscut. (Tr. 91, 299, 646-647). He took air readings and signed date board entries. (Tr. 303). At the sump he encountered high areas of water and tried the pumps, but did not retreat. (Tr. 91, 227, 299). The water was relatively clear but had debris, gridlocks, and pieces of wood floating in it. (Tr. 312). Stalnaker usually inspected working areas and would not have let miners work in that amount of water. (Tr. 310-311). However, because the area was remote and he would be the only one working, he entered the water. (Tr. 310-311).

His boots were not tall enough but he found chest waders in the area and put them on so he could continue the exam. (Tr. 300-303). The waders did not have a flotation device, as required by law. (Tr. 310, 419-420, 455). He did not know who placed the chest waders there. (Tr. 301-302). Giavonelli and Midnight Foreman Bob Price did not know the chest waders were present or how they got there.<sup>21</sup> (Tr. 455, 704). According to Giavonelli and Price, Respondent did not want miners to use chest waders in case they filled with water.<sup>22</sup> (Tr. 455, 500, 704).

As Stalnaker walked through the water, the area was fairly clear of obstruction. (Tr. 316). He took shorter steps and used his walking stick. (Tr. 316). The nearest pump at the 49 crosscut was not working and Stalnaker tried to prime it to see if the water would recede. (Tr.

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<sup>19</sup>Jamie Greene was present at the hearing and testified. (Tr. 469). At the time of the hearing, Greene was employed as a fireboss at Enlow Fork. (Tr. 469). He was the normal examiner of the E-15 bleeder at the time of the Citation and Order and was familiar with it, including locations with water. (Tr. 225, 470, 488). Young believed Greene did an excellent job at that difficult task. (Tr. 225-226, 509-511). Saunders and Stalnaker may not have been as familiar with the area as Greene. (Tr. 488).

<sup>20</sup> According to Greene, the bleeder system made him “gray just worrying about it” and “[e]very time I go back, I don’t know what I am going to get.” (Tr. 506).

<sup>21</sup> Robert Price was present at the hearing and testified. (Tr. 445). At the time of the hearing, Price was the continuous miner coordinator for Enlow Fork. (Tr. 445). On February 5, Price was a shift foreman and tasked with keeping the mine safe and efficient. (Tr. 446-447).

<sup>22</sup> Greene claimed that he never used the chest waders during his examinations. (Tr. 499-500).

92-93, 116-117, 127). Some of the pumps were working, but not nearly enough to get the water going into the sump. (Tr. 312). He also believed that the sump pump was not working. (Tr. 308-309). He looked for the date board at the No. 3 outlet and found it was in the water. (Tr. 303). Eventually, he tried to pass into another entry so as to bypass the water and reach the next evaluation point. (Tr. 314-315). He had not been told to bypass the area; he was just trained to complete the run in a timely manner. (Tr. 315). He tried to go through a 3-foot high mandoor between entries and got his methane detector wet. (Tr. 91-92, 94, 127, 227, 280-281, 299-300, 304, 322, 660, 773-774). Water had poured into his waders when he bent over. (Tr. 300, 422).

After that, Stalnaker left the bleeder the way he entered and called Price to say he could not complete the exam due to his wet detector. (Tr. 88-89, 92, 94-95, 300, 304-305, 322, 447-448, 457, 493, 660). This was the first Price learned that there was water in in the sump area. (Tr. 459-460). Much of the exam was not complete when Stalnaker stopped. (Tr. 95-96). Price believed Stalnaker would have pushed through and finished if his detector had not gotten wet. (Tr. 452). Stalnaker went to Price's shanty and gave him his papers. (Tr. 305). Price then called the surface at that time to ensure the pump was running and the air compressor was on (though he never got a report back). (Tr. 448-449, 453-454, 458-459). Stalnaker spoke with Price at 4:00-4:30 a.m. (Tr. 100, 103, 305, 321-322, 455-456).

Sometime between 4:45 and 5:30 a.m., Stalnaker updated Giavonelli who told him Saunders would finish the run. (Tr. 100, 103, 305, 308-309, 321-322, 455-456, 635-636, 711). Giavonelli was concerned about the travel hazard and called Russ Ciapetta on the surface to restart the sump pump.<sup>23</sup> (Tr. 128-129, 226, 234, 239, 272, 308-310, 322, 588-589, 636, 711, 804, 832-833). Jeff Hohman had already told Ciapetta to start the pump 15 minutes earlier. (Tr. 588). Giavonelli knew the ventilation was good because of the fan report. (Tr. 711-712). He believed the pump would be sufficient to clear the area so the exam could be completed by the end of the day. (Tr. 644, 666). He also told Ciapetta to call Burns Trucking to get the water out of the holding tanks if necessary.<sup>24</sup> (Tr. 636, 639-640).

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<sup>23</sup> Russ Ciapetta was present at the hearing and testified. (Tr. 587). At the time of the hearing he worked in the maintenance department. (Tr. 588). In that capacity, Ciapetta would work out of the shop on belt lines, elevators, pumps, or anything broken down. (Tr. 588).

<sup>24</sup> Eventually Demidovich called Burns Trucking. (Tr. 549, 551-552, 761). Four drivers were initially dispatched to the pump (a usual number) and eventually two more were sent (which was unusual) (RX-S and RX-U). (Tr. 623-624). One driver, Gordon Scott, worked 11.5 hours that day and completed six loads of 4,620 gallons each. (Tr. 624-627). Drivers did not take partial loads; they waited until the tank was full. (Tr. 627-628). Water was pumped all day on the February 6; from 8:30 a.m. to 5:00 p.m. on February 7; and from 8:00 a.m. until 5:00 p.m. on February 8. (Tr. 631). A review of the records showed that the tanks were empty on February 4 at 9:00 a.m. and that no one had checked the tanks on February 2 or 3. (Tr. 628-629, 632). Vorhes, the dispatcher was not certain if the tanks had been emptied at any time between December 18, 2012 and February 1, as he did not have the necessary records at hearing to make that determination. (Tr. 630-632).

Ciapetta reached the outside pump at 5:00 a.m. and saw it was not running. (Tr. 589, 593). He bypassed the bubbler by allowing more air into the system and got the pump running around 5:05-5:10 a.m. (Tr. 226, 532, 557, 589, 593, 597, 638). He had never overridden the bubbler before. (Tr. 611). It kicked on at 80 inches of air. (Tr. 597). Once started, it continued to run. (Tr. 593-594). Ciapetta saw the tanks filling and updated Giavonelli. (Tr. 594).

After dealing with the pump, Giavonelli got a report from the discharge lines at the sump from Wendell Hawk showing that water was going into the pool, a favorable indication (RX-I).<sup>25</sup> (Tr. 647-649, 656-660, 707, 710, 764-766, 768). In fact, Hawk checked the pipe twice (at 1:00 a.m. and 6:00 a.m.) and found that between half a pipe and a quarter of a pipe was flowing at all times. (Tr. 765, 767). By the second check, Hawk had already given Stalnaker a ride out of the mine and knew there was water in the area regardless of the water coming out of the discharge pipes. (Tr. 658-659, 767).

After speaking with Giavonelli, Stalnaker went home. (Tr. 306, 310). On his way home, he called Greene and said he could not finish the run. (Tr. 498-499). Greene thought Stalnaker was joking at first, but he recognized that water accumulates quickly. (Tr. 498-499, 519).

After speaking with Stalnaker, Price called Saunders and asked if he could complete a bleeder run from the opposite direction (to avoid problems). (Tr. 88-89, 97, 427-428, 448-453, 457, 498-499, 647, 703-704, 774). Price chose Saunders because he was familiar with the area. (Tr. 457-458). The run had to be completed by the end of the day. (Tr. 459, 433). Price gave Saunders Stalnaker's notes. (Tr. 305, 449). Price did not tell Saunders not to walk in the water or give any cautionary notes, as he believed Saunders knew what Stalnaker had encountered. (Tr. 430, 443, 450). Price knew Saunders would encounter water but believed he would reach the evaluation points without traveling through the water. (Tr. 458).

Saunders entered the E-22 side of the bleeder around 2:00-3:00 a.m. and encountered water at E-21. (Tr. 429-431). He could not recall if it was clear, though water in the mine varied depending on the day and the depth. (Tr. 439, 441-443). He did not retreat when he reached this water and Young believed Saunders walked through water three feet deep. (Tr. 98, 218, 221-222, 224-225, 227). Saunders testified that at that point he was on a wooden bridge and the water reached his ankles; he could not recall if he could see the bridge. (Tr. 438). Saunders encountered more water at E-20, No. 2 (boot high); E-15, No. 1, and the E tailgate. (Tr. 430-432, 439). He stopped at the E-tailgate and could go no further through the water. (Tr. 432, 434-435). The water was waist high; Saunders would not work in water that deep and did not want to get any wetter. (Tr. 98-99, 227, 277, 431-432, 435). He made this decision himself and it was not based on anything management told him. (Tr. 435-437). He did not know if the water got deeper. (Tr. 98, 435). He could not reach two evaluation points because of the water. (Tr. 440-441). Saunders made a note about the water in the books for Greene. (Tr. 431-432).

Saunders retreated back the way he came into the bleeder without examining the areas beyond the deep water. (Tr. 99, 221, 433, 442). He got out around 10:00 a.m. (Tr. 99). Saunders reported to Giavonelli that he could not get the last two readings and showed him the

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<sup>25</sup> Wendell Hawk was present at the hearing and testified. (Tr. 763). At the time of the hearing Hawk was employed as a pumper at Enlow Fork and had worked there for eight years. (Tr. 763).



notes indicating where the water was located. (Tr. 99, 103, 433-434, 655-666, 713). Giavonelli did not recall hearing where the water was located, just that Saunders could not reach the points. (Tr. 713). When he got outside, Saunders filled out the exam book. (Tr. 434).

After hearing these reports from the examiners and management, Young decided to go into the mine. (Tr. 109, 410). Young entered the mine at about 2:00 a.m. with Safety inspector Matt Roebucks, Apperson, and Stalnaker. (Tr. 114, 118-119). Young reached the E-tailgate No. 1 entry at 4:15 a.m. and encountered water stretching from the No. 47 crosscut to the No. 12 crosscut. (Tr. 109-111). The air pump at 49 crosscut was in knee-deep water and was not working because of a suction problem. (Tr. 93, 110, 117, 128, 260). Water was not pumping at the front of the sump. (Tr. 259). Young inspected other entries to see if the exam was completed and to check the water volume. (Tr. 110-111). He also checked the mandoor Stalnaker used and found the water was 2-feet deep, though the pump had been running 20 hours at that time. (Tr. 228-229, GX-14, appendix 3). Young did not hear water at the discharge lines. (Tr. 257-260). However, water in the area seemed to be running back towards the pump and several air lines were running. (Tr. 115, 258). The water levels had dropped at the No. 2 outlet but was still at such a hazardous level that Young would not travel through. (Tr. 115-116, 118).

After walking the perimeter, Young had seen enough. (Tr. 118). He did not look at the entire area. (Tr. 156, 165). Young was not going to walk through water as Brottish and Gross had already determined the water's location. (Tr. 118). They left the mine and Young issued a (d)(1) Citation and (d)(1) Order to Brottish. (Tr. 118, 128, 149, 158, 806-807). He did not see anything underground that changed his mind regarding the appropriateness of 104(d) issuances. (Tr. 211). The body of the citation was based on the highlighted map. (Tr. 167).

Young and Gross agreed that determining the root cause of a condition was important. (Tr. 198, 287-291, 412-413). Young did not know the exact cause of the water accumulation but believed it was caused by a failure to check the bleeder and equipment after a 12-hour power outage earlier in the week. (Tr. 134, 271-272, 292-293, 514-516). The outage could have caused the air pumps to lose prime and stop functioning and that would have allowed water to accumulate for days. (Tr. 271, 514, 515-516). Respondent believed that "a majority of the time," the pumps came back on with the power. (Tr. 516-517). But Young believed Respondent knew this was a problem area and should have checked after the outage. (Tr. 271). The water could also have been caused by overly filled holding tanks outside preventing the pump from turning on. (Tr. 284, 517).

There may also have been a problem with the bubbler system as evidenced by the fact that it had to be bypassed to work. (Tr. 189, 232, 241, 251, 272). That day, Demidovich and the other mechanics went to the surface pump several times starting at 9:00-10:00 a.m. (Tr. 551, 556, 761). Multiple trips were required because the pump would run for a while and then stop and the air volume would have to be increased to get it running again. (Tr. 555). Demidovich called Mon Valley Integration ("MVI"), a contractor, to look at the bubbler at 1:00 a.m. (Tr. 525-527, 541, 552-553, 555). MVI employee William Batten worked for five hours that day to

troubleshoot the bubbler.<sup>26</sup> (Tr. 526-527). When Batten arrived and conducted a visual examination, the pump had already been overridden and was running. (Tr. 530, 532-533, 546). He did not know at that time there was a problem with the bubbler, but the air readings did not correspond to the observed high water. (Tr. 531-532, 542, 544).

Batten eventually determined that the bubbler tube was damaged and that it needed to be repaired. (Tr. 534). The bubbler tube contained holes that prevented pressure from building and gave an incorrect reading. (Tr. 539, 542, 744-745). If the bubbler system gave a low reading it would send incorrect data to the monitoring system and prevent an alarm. (Tr. 745-746). The remote monitoring system relied entirely on the bubbler for data about water levels and would reflect any inaccurate data provided by the bubbler. (Tr. 582-584). The remote monitoring system would still show the power, the tank level, and pump faults. (Tr. 750-751).

It was not clear when the bubbler had begun malfunctioning. (Tr. 557). Demidovich first learned about the problem on February 5, when the water accumulation was found but it could have been broken a month earlier. (Tr. 557). The bubbler records for the end of January and start of February showed the pump had never run. (Tr. 561). It also showed that the surface tanks were empty because the pump was not running. (Tr. 562).

While he acknowledged possible problems with the bubbler, Young testified that it only dealt with the sump, not the entire area. (Tr. 232). Young did not know if the other air pump system was working or if the water came from the sump or elsewhere. (Tr. 236).

Regardless of the physical cause of the violation, Young believed what mattered was that a violation existed based on the facts (including the size, area, and location of the condition). (Tr. 234, 237, 291). In Young's opinion, the root cause of the violation was Respondent's failure to maintain the bleeder system in a manner safe for travel despite being placed on notice and receiving two previous citations. (Tr. 237-238). If Respondent removed all the water or it evaporated before exposure, he would not issue a violation regardless of the water source. (Tr. 236-237).

Young issued a 104(d) citation (GX-1) for failure to maintain the bleeder perimeter in a safe manner for exams as required by the ventilation plan at E-15 and between E-19 and E-21. (Tr. 119-120, 125, 148, 194-195, 208, 356). Brottish confirmed as accurate the depths and locations listed in the citation. (Tr. 824-825). However, MSHA does not have a specific depth of water in total or over the bridge that violates the standard, it was somewhat subjective. (Tr. 210-211, 217). An agency policy given to operators states that water over a bridge was a violation. (Tr. 218). Young only cited when, like here, he could not see his feet in the water. (Tr. 218).

The citation was marked as highly likely to result in injury because of the depth of the water, the condition of the travel ways, the pump lines, the crib blocks, the previous citations, and the conditions Gross observed. (Tr. 121). A miner could fall, hit his head and drown, break

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<sup>26</sup> William Batten was present at the hearing and testified. (Tr. 524). At the time of the hearing he was an electrical technician at MVI. (Tr. 524). He was an MSHA electrician for 10 years and attended technical college. (Tr. 524-525).

an arm or leg, or, if he had a weak heart, go into shock and die before being found. (Tr. 121-122). Miners would be wearing a 10-12 pound belt and would wear an SCSR (weighing a few pounds), a methane detector, cordless cap lamp, hammers, channel locks, and various items. (Tr. 122). The lack of uniformity in the mine floor would contribute to a tripping hazard. (Tr. 724). Young may have marked the condition as less likely if Respondent began fixing it before anyone was exposed. (Tr. 232). Brottish and Gross did not trip while they walked the bleeder. (Tr. 174). Giavonelli was not aware of anyone being injured in any of the Enlow Fork Bleeders at any time and did not expect miners to trip each time the mine flooded. (Tr. 660, 725).

The citation was marked as fatal because if a miner fell, he may not be able to get his head above water and would die from drowning. (Tr. 122, 230). Young recalled an instance in which a miner fell into water after having a heart attack and the coroner's report listed the cause of death as drowning. (Tr. 230-231). The cited area had pipes and supports that a miner might strike in a fall. (Tr. 123). The bridge was only three to four feet wide (not rib to rib) and had only a steel wire to mark the edge, no handrail. (Tr. 124-125). The water under the bridge was up to 42 inches. (Tr. 123). The sump was ten or eleven feet deep and had a foot or two of sediment in the bottom. (Tr. 123). If a miner fell in the sump, the water level would be over his head. (Tr. 123).

The citation was marked as S&S because Young believed it met all the factors and believed an injury was reasonably likely. (Tr. 126). The citation was marked as affecting two people because Stalnaker and Saunders had traveled the area that day, although normally only one did. (Tr. 125).

The citation was marked as high negligence because Young believed the operator knew or should have known of the condition and there were no mitigating circumstances. (Tr. 126, 239-240, 243). Respondent knew about the violation when Stalnaker informed his shift foreman about the hazardous amount of water at 4:30 a.m. (Tr. 126-127, 131-133). No one else knew about the water until Stalnaker left the bleeder. (Tr. 130-131). However, Stalnaker and Saunders were both Respondent's agents. (Tr. 128). Young did not believe Respondent exercised the necessary degree of care because both examiners went through the water and Stalnaker used disallowed chest waders in the area. (Tr. 264). Young was also concerned because something was wrong every time inspectors entered the area; it was not maintained for safe travel. (Tr. 274, 288). In this regard, on November 20, 2012, the line was cut, on December 10, 2012, the tanks were full, and on February 5 the alarm did not work. (Tr. 288).

Brottish noted that authorized miners could stay in a hazardous area to assess or correct a violation. (Tr. 829-831). However, he also testified that those repairs must follow proper procedure and be conducted cautiously. (Tr. 831). MSHA believed the examiners should have stopped and pumped out the water before continuing on or correcting the problems. (Tr. 147-148, 186).

Young stated he would change the negligence level if Respondent could produce facts to support a finding of mitigation but none of those offered by Respondent occurred before the miners traveled through the hazardous water. (Tr. 235, 240, 243). Brottish provided what he believed was mitigation to Young on several occasions, including things done since the

December citation. (Tr. 802-803, 805-806, 832, 835-836). Young told Respondent that nothing they listed was mitigation based on the confluence of factors and the fact that Respondent was on notice. (Tr. 243, 269, 806). Young testified that something was not mitigation if it failed to prevent or limit exposure. (Tr. 146, 232-233, 238, 243, 253-255). The timeline was key to Young, measures taken after someone travels through the hazard there were not mitigation. (Tr. 148, 192, 232-233, 238, 243, 253-255, 262-264, 273-274). The suggested mitigation included the following:

Brottish explained to Young that the power had been out on February 1 and that it may have led to the water accumulation. (Tr. 803, 832-833). Young did not consider this mitigation because this was a problem area and Respondent had been put on notice. (Tr. 133-134). Also, Respondent knew of the power outage and had time after February 1 to ensure the pump system was working properly; however Respondent did not check on the pump system. (Tr. 133-136, 833). Gross also believed this was not mitigation because the power outage was not placed in the book. (Tr. 363). Brottish later learned that Greene went back to the area around the time of the power outage. (Tr. 135, 266-267, 833-834). Young did not believe Greene's earlier access of the area was mitigation because it did not prevent miners from entering the water. (Tr. 267-268).

Brottish also argued that Respondent got sump reports each shift starting no later than December 10. (Tr. 804, 810-811, 832-833). Young believed Respondent should have had someone monitoring the sump and checking the air pumps in addition to the checks on the discharge lines; further, given the scope of the issue Respondent should have checked the water level and made repairs every day or every third day if necessary. (Tr. 270-271).

Young also did not consider the existence of the surface pump to be mitigation because it was only run when the underground air system was overwhelmed. (Tr. 136). Young believed it was reasonable to start the sump pump at the cited time but did not believe that turning it on was mitigation because someone had already traveled through the water in the unsafe travel way instead of backing out and marking the hazard. (Tr. 89, 129-133, 244-249). Both Stalnaker and Saunders entered the water to complete the exam before the pump was activated. (Tr. 131-133, 249). Pumping would only be mitigation if the water came down before the first examiner went through. (Tr. 245-248). Similarly, Young did not believe that two pumping systems constituted mitigation. (Tr. 265). While he had stated in his deposition two systems might be mitigation, he also stated that there could be thirty systems and it would not matter if the systems were not properly maintained. (Tr. 266).

Respondent also claimed that the bubbler was broken. (Tr. 240). Brottish explained the bubbler gave a false indication that the water was low in the sump. (Tr. 803, 832-833). Young believed it was not mitigation if the bubbler broke before Stalnaker entered the area because Respondent did not find the problem; the fact that something was broken was not mitigation. (Tr. 254, 263).

On a related point, Respondent's witnesses claimed that there was a remote monitoring system but that the sump pump alarm did not work and did not register on the monitoring screens. (Tr. 239-240, 242, 275, 295, 811). The system said there was only 40 inches of water

in the sump when the Order was issued. (Tr. 208, 255-256). While Young believed this could give someone a false sense of security, he believed that if the alarm was not working properly that proper attention was not being paid. (Tr. 208, 252). Young further testified that the fact that the alarm did not show in the offices was not mitigation; the alarm was in place but not adequate to address the situation or prevent recurrences. (Tr. 256, 275).

Brottish also believed that there was a broken discharge line in the area and he made a note to repair it later. (Tr. 792, 802). Young did not believe this was mitigation if it occurred before February 5 because it meant the system had failed and Respondent did not maintain safe travel; it may have constituted mitigation if something was done to prevent, correct, or limit exposure before miners entered the water. (Tr. 261-263). Further, Gross noted that if there was a broken pipe causing the condition, it should have been listed in the book. (Tr. 396-397). Young believed that some of the equipment issues may have mitigated the condition if this was the first time the issue arose. (Tr. 253).

Young did not believe calling contractors to correct the situation constituted mitigation. (Tr. 260-262, 285). Young saw no evidence Respondent called MVI before MSHA was involved; Respondent needed to call before the examiners entered the water to be mitigating. (Tr. 260-261). Similarly, Young believed Respondent calling Burns Trucking to haul away the water was not mitigation because most of the water was hauled after the citations were issued. (Tr. 285).

Brottish also argued that Respondent had no way of knowing about the condition and took immediate action to correct the problem when it learned about it. (Tr. 809). Young agreed that an operator cannot correct a condition it does not know about; however Respondent had been previously put on notice about the area and it also knew about the power loss. (Tr. 233).

Brottish also found that Enlow Fork had received only seven 75.370(a) citations which was 3.68% of their total citations, while the national average was 5.28%. (Tr. 814). Previous years showed a similar trend. (Tr. 814).

Young testified that the condition was an unwarrantable failure and was aggravated conducted constituting more than ordinary negligence and that Respondent did not act or did not act properly. (Tr. 137-138). Young also believed the condition was obvious and extensive and the examiner knew it when he entered the area. (Tr. 137-138). Several witnesses confirmed that the problem had to exist for at least three of four shifts for that volume of water to build up. (Tr. 137, 268, 281-282). Credible testimony also established that similar issues had occurred in the recent past and Respondent was on notice that it needed to do more. (Tr. 137-138, 835). Young noted that mine management was aware of the condition as soon as the examiner reported it. (Tr. 138). He further testified that while Respondent started the sump pump, this only dealt with water in the corner and gave Respondent no indication of what existed in the other areas of the bleeder where the two miners traveled and could not complete the exam safely. (Tr. 138-139). Finally, Young noted the conduct was aggravated because miners walked through the water after a state inspector told them not to travel in boot deep water. (Tr. 139).

The first citation was abated on February 8, 2013. (Tr. 153). Thus, it took three days of pumping in a difficult to reach area to fix the problems and get the water out. (Tr. 153-154, 233). The day after the Citation and Order were issued, Giavonelli went back into the area, listed all of the conditions he saw, and marked them on a map (RX-X). (Tr. 684-686). He started from the E-21 outlet and walked to E-15 from 9:00 a.m. to 1:00 p.m. (Tr. 686-688, 696). The water was still present but in many places it was clear. (Tr. 688-690, 697). He found one location where the water was 12 inches over the top of a walkway which sat 22 inches above the bottom. (Tr. 686-687, 715). There was also water near the sump 32 inches deep and above the knee that Giavonelli had to walk through. (Tr. 693, 716, 723). There were various other places with small amounts of water and a spot near a mandoor where water was at least 28 inches deep. (Tr. 687, 694). Giavonelli found a broken discharge line which he repaired. (Tr. 687). He did not see any additional issues and did not see any location where the water was at the roof. (Tr. 689-690, 693). All of the air pumps were running, and the sump pump was off because it was not necessary. (Tr. 697-698).

On February 6, Demidovich, Jobs, and Batten spent the day attempting to figure out what was wrong with the bubbler. (Tr. 534, 567). The next day, they dropped the new tubes down the shaft to the sump while Craig Yoho worked underground and communicated via radio. (Tr. 535-536, 567-569, 596, 743-745). An electronic display and a new hand dial were also added to the surface pump after the instant event. (Tr. 596-597, 603-605). On February 8, Demidovich corrected the problem that was causing the pump to repeatedly start and then shut off. (Tr. 569-570). Batten continued to make adjustments for a few more days. (Tr. 538). During the abatement period, Young did not issue any danger orders on the area. (Tr. 154).

In addition to the water accumulations, Young and Gross discovered in the investigation that the exams for the E tailgate overcast and E tailgate No. 2 entry had not been completed for air quality, error measurement, or signature.<sup>27</sup> (GX-3, tab 3, p. 45, RX-F). (Tr. 81-83, 105-106, 113, 175-176, 345-347, 358-359, 372-374, 400, 782). An Order was issued for this condition. (Tr. 683-684, GX-2). Young and Gross were not sure why the book was not filled out. (Tr. 83, 86, 89, 399-400). They later learned that the book was not filled out because the examiners could not reach the area. (Tr. 177-178). Respondent had 24 hours, or until midnight on February 6, to complete the exam and have it signed by the foreman. (Tr. 178-179, 680, 819). Presumably, the examiner could make corrections to the book if he believed he missed something in that time. (Tr. 179).

Giavonelli nevertheless signed the book despite the fact that the dark, murky water and tripping hazards were not listed as hazards. (Tr. 84-85, 87, 99, 671, 677). Giavonelli knew that the run was not complete but claimed he signed it only to signify that he read the pages and knew there was an issue. (Tr. 671-672, 681-682). Giavonelli did not know why the examiners did not list any hazards. (Tr. 725). He believed it was apparent to everyone the run was not completed because of the water. (Tr. 672). The book was important because it is supposed to inform inspectors and miners about hazards. (Tr. 103-104). It also allowed examiners to report hazardous conditions to management. (Tr. 104). Young also reviewed the fan charts and saw no ventilation hazards. (Tr. 85-86).

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<sup>27</sup> Henry and Brottish recalled that Young was always very thorough when reviewing exam records; sometimes he would ask for additional books. (Tr. 782-783, 822).

When Young spoke with Stalnaker and Saunders about the books, they explained that they forgot to fill them out. (Tr. 100). A few days later Stalnaker called Young to explain that he kept notes underground and then filled the book in later on the surface. (Tr. 100-102, 306). On the day at issue, Stalnaker only filled the final three entries in the book. (Tr. 317, 319). Stalnaker gave his notes to Saunders to finish the run. (Tr. 102, 306, 319). Young explained that the failure to fill in the readings could be a technical violation, but the water hazard should have been listed. (Tr. 102). Stalnaker also explained that he was wet and miserable and “that is just the way you fill the book out.” (Tr. 102). Young did not place much stock in this explanation. (Tr. 103). He believed two people saw a hazard but did not record it and a mine foreman signed the book and did not note the problem even though he knew about the hazard. (Tr. 103). Young believed Stalnaker was a good miner who made an honest mistake, but that it was still a violation. (Tr. 276).

At the hearing, Stalnaker explained, that he did not consider placing a note about the water in the book because he had walked forty blocks and taken two readings that were dry. (Tr. 307). He could have taken a reading at the No. 3 outlet, but the date board was in the water. (Tr. 307, 383). In retrospect, he admitted he should have put the condition in the book. (Tr. 307). He also admitted he was complacent because the area had a history of water and he was not surprised to find it there. (Tr. 311). If he thought there was an imminent danger, he would not have tried to travel through the water at all. (Tr. 316).

Saunders never admitted to Young that the condition was a hazard and he did not put it in the book. (Tr. 132-133, 434). Saunders told Young that he stopped going through the area because he did not want to get any wetter, but still did not enter any hazards into the book. (Tr. 277). Saunders was already soaked and could not finish the last few evaluation points. (Tr. 277-280). Saunders knew Stalnaker had not completed an examination of all the evaluation points either. (Tr. 278) Young believed this meant it was too dangerous to finish the run and that, under the law, Saunders should have listed the water as a hazard. (Tr. 277-280). Young agreed with Saunders’ decision to back out but believed he should have filled in the book. (Tr. 277). Saunders maintained at all times that the water at 36-inches can be hazardous, but that he felt that in the cited situation it was not particularly dangerous. (Tr. 277-278, 280, 433, 441-442). He did not trip, fall, or have any trouble getting through the water. (Tr. 439-440). Greene agreed at hearing that he had never fallen or been injured during an exam and felt comfortable in the area. (Tr. 489-490).

Young also spoke with Brottish and Apperson about the incomplete books and whether the exam was completed. (Tr. 107, 113, 224). Young also told Brottish and Apperson that they needed to get the water level down and complete the run or they would get another citation. (Tr. 107). Brottish and Apperson assigned a fireboss, Andy Yablonsky, to complete the task.<sup>28</sup> (Tr. 107-108). Young spoke to Yablonsky and told him the areas he needed to examine in the bleeder. (Tr. 108-109). Yablonsky started around 9:30-10:00 p.m. and completed it just around the time Young was entering the mine. (Tr. 109, 179-182, 671, RX-F). Yablonsky finished the

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<sup>28</sup> For the purposes of hearing, the fireboss will be referred to as Andy “Yablonsky.” At times in the transcript he is referred to as “Yablonski.” Further, Respondent’s pre-hearing report refers to him as “Yackuboskey.” It is unclear which name is correct, but “Yablonsky” will be used at all times in the interest of consistency.

run and Respondent did not receive a citation for failure to complete the exam. (Tr. 182-183, 677, 819).

An Order was issued for this condition (GX-2). (Tr. 683-684). This Order was marked as reasonably likely because miners other than Saunders, Stalnaker, Giavonelli, and Price who entered the area might not be aware of the water. (Tr. 139-140). The books are the only way other foremen know about conditions in the mine. (Tr. 142). Mental notes are not enough. (Tr. 140-141). When a foreman signs a book listing no hazards, he indicates that there are no problems. (Tr. 141-142).

The violation was marked as fatal for the same reasons as the first citation. (Tr. 143). A miner entering the bleeder without knowledge of the water could trip in the murky water and fall and hit his head, which could cause a drowning fatality. (Tr. 143).

The violation was marked as S&S because there was a violation of a mandatory health and safety standard, there was a discrete safety hazard because the conditions were not placed in the book as required, and it was reasonably likely that a reasonably serious injury would result. (Tr. 144). Two people were affected for the same reasons as the first citation. (Tr. 143).

This violation was higher negligence than the first condition because two examiners conducted partial exams, walked through water, and yet entered no hazards. (Tr. 144). Also, the foreman knew about the water and signed the book indicating no hazards. (Tr. 144-145). If MSHA had not caught the missing entry in the book, no one would have finished the exam or gotten the pump in the corner running. (Tr. 145). Respondent's monitoring was inadequate and a pumper should have been in the area around the clock to ensure the system worked. (Tr. 145).

The violation was also marked as aggravated conduct. (Tr. 145). There were people making an exam and there was an obvious and extensive condition. (Tr. 145). Two miners traveled in the hazard. (Tr. 146, 191-192). Further, there was a pattern of people walking through water to complete exams and then claiming that a pumping problem was mitigation. (Tr. 191-192, 207). The water had to be there more than a shift to grow so large. (Tr. 145). No one did anything beyond start the surface pump for two shifts. (Tr. 145). This pump would only have cleaned the corner. (Tr. 146). This was the third time the pumps had failed since November 20 and Respondent was on notice regarding the need for increased efforts. (Tr. 146). Young did not know how many other citations were issued in the last five years under the instant standard. (Tr. 283-284). He doubted there were many as Enlow Fork's books were usually good. (Tr. 284).

### **C. Citation No. 7024068**

#### **1. Contentions of the Parties**

With respect to Citation No. 7024068, the Secretary asserts that Respondent violated 30 CFR § 75.370(a)(1), that this violation was "Highly Likely" to result in "Fatal" injuries to two miners, that the violation was S&S, and that it resulted from "High Negligence" and an unwarrantable failure to comply. (GX-1)(*Secretary's Post-Hearing Brief* at 14-26). The



Secretary believes that the proposed penalty of \$14,373.00 is appropriate. (*Id.* at 31-33).

Respondent argues that no injury was reasonably likely to occur as a result of the violation and that, as a result, it was not S&S. (*Respondent's Post-Hearing Brief* at 25-26 and 34-35). It argues in the alternative that any injury that would occur would result only in "Lost Workdays/Restricted Duty" rather than death. (*Id.* at 30-33). It also argues that its actions did not display "High Negligence" or an unwarrantable failure to comply. (*Id.* at 21-25 and 36-46).

## **2. The Secretary Has Carried His Burden Of Proof By A Preponderance Of The Evidence That Respondent Violated 30 CFR § 75.370(a)(1)**

On February 5, 2013, Young issued Citation No. 7024068 under 104(d)(1) of the Act for a violation of 30 CFR § 75.370(a)(1). Section 8 of that Order, Condition or Practice, reads as follows:

The operator failed to comply with their approved mine ventilation plan, in that, the bleeders were not maintained for safe travel in the E tailgate to E-21 panel bleeder district. Obvious and extensive accumulations of water were permitted to accumulate from 12 to 42 inches in depth, rib to rib, for a total distance of 2350 feet at the listed locations.

1. In the number 3 entry of E tailgate from 46 crosscut to 50 crosscut and in the inby bleeder entry from 50 crosscut, north for just over 2 blocks inby (a distance of 500 feet). Water measured from 12 to 42 inches in depth.

2. In the inby bleeder entry (travelable entry), from 20 feet outby E-19 number 3 entry to 200 feet inby E-21 number 3 entry (a distance of 1800 feet), water measured 12 to 36 inches in depth.

The mine floor in these [areas] can be irregular, contain rib sloughage and other various other tripping hazards, which can be hidden by the depth of the water. Page 4, Line AA, of the approved mine ventilation plan (5958-B13, MAY 29, 2012), states that, "the means for maintaining the bleeders safe for travel will include compressed air lines routed underground, used in conjunction with air pumps to remove water as necessary to permit safe travel through he [sic] perimeter of the bleeder system."

This constitutes more than ordinary negligence on the part of the mine management, in that, it would have taken at least several days for the water to flood to this level. Part of this same area was cited twice last quarter and the mine operator was placed on "notice" that increased attention to the pumping water was necessary in these areas. This high negligence demonstrates a lack of due diligence by the miner operator to provide a safe work environment by not maintaining the water in the bleeders to a safe level. This unique aggravated circumstances [sic] puts the miners at a high risk to be injured. This a [sic] lack of reasonable care on the part of the mine operator to provide a safe work

environment for their employees demonstrates indifference in complying with the regulations.

This is being issued in conjunction with 104(d)(1) Order Number 7024069.

Standard 75.370(a)(1) was cited 16 times in two years at mine 3607416 (16 to the operator, 0 to a contractor). This violation is an unwarrantable failure to comply with a mandatory standard.

(GX-1)

On February 8, 2013, the citation was abated, after the water was pumped down sufficiently to provide for safe travel. (GX-1).

On February 11, 2013, Young issued an amendment to the citation, following further investigation and plotting the area on a strip map. This amendment provided:

The starting location of the accumulation of water in the E tailgate number 3 entry should have been at 47 crosscut, not 46 crosscut. This correction reduces the distance of water accumulations in the E-tailgate area from 500 feet in length to 400 feet in length. The total distance of water accumulations is reduced from 2350 feet in length to 2250 feet in length.

(GX-1).

The cited standard, 30 CFR § 75.370(a)(1) (“Mine ventilation plan; submission and approval”), provides the following:

The operator shall develop and follow a ventilation plan approved by the district manager. The plan shall be designed to control methane and respirable dust and shall be suitable to the conditions and mining system at the mine. The ventilation plan shall consist of two parts, the plan content as prescribed in § 75.371 and the ventilation map with information as prescribed in § 75.372. Only that portion of the map which contains information required under § 75.371 will be subject to approval by the district manager.

30 CFR § 75.370(a)(1).

In the instant matter, it is uncontested that Respondent had an approved ventilation plan that required, *inter alia*, walkways in the bleeder be maintained in a manner safe for travel. (GX-1)(Tr. 56). It is likewise uncontested that the E-Tailgate through E-21 bleeder district contained large accumulations of water. Water at the 46 crosscut stretched 600-700 feet and ranged in depth from 12-42 inches. (Tr. 79-80, 125-126, 156-157, 167, 169, 347-348, 351-353, 377, 382, 385-389, 788, 799). Water from E-19 to E-21 stretched 1,800 feet and ranged in depth from 12-36 inches. (Tr. 79-80, 125-126, 167-169, 173, 354, 356, 366, 379-380, 391-394, 420, 791-792, 801). Witnesses credibly testified that this water was murky, cold, contained debris and tripping

hazards, and constituted a hazard to miners traveling in the area. (Tr. 121, 172, 312, 354-356, 392-395, 348, 411-412). Further, Respondent conceded that in the instant matter, “there was a violation of the ventilation plan.” (*Respondent’s Post-Hearing Brief* at 21). In light of these facts, I find that the violation occurred.

### **3. The Violation Was Highly Likely to Result in Fatal Injury to Two Miners And Was Significant And Substantial In Nature.**

Inspector Young marked the gravity of the cited danger in Citation No. 7024068 as being “Highly Likely” to result in “Fatal” injuries to two persons. (GX-1). Young also determined that the violation was S&S. (GX-1). These determinations were supported by a preponderance of the evidence at the hearing.

As noted *supra*, the first element in determining whether a violation is S&S is whether there was an underlying violation of a mandatory safety standard. *Mathies* at 3-4. As demonstrated above, Respondent violated 30 C.F.R. §75.370(a)(1) in the instant matter. Therefore, the first *Mathies* element is met.

In its brief, Respondent argues that a 30 C.F.R § 75.370(a)(1) violation based “solely” on a tripping hazard cannot be S&S because that standard is not directed at tripping hazards, but rather at ventilation issues. (*Respondent’s Post-Hearing Brief* at 33, citing *Oak Grove Resources*, 34 FMSHRC 594, 610 (Mar. 2012)(ALJ Moran)). Respondent argues that a citation can only be S&S if a specific hazard implicated by the cited standard is raised by the violation. Respondent further notes “[t]his goes to the first element in *Mathies*...” (*Id.* at 33).

It is unclear exactly how this particular argument, “goes to the first element in *Mathies*...” As shown *supra*, the first element of *Mathies* is whether there was an underlying violation of a mandatory safety standard. Here, the facts support, and Respondent conceded, that Respondent violated 30 C.F.R. §75.370(a)(1). Whether the standard was primarily intended to prevent any given hazard has no bearing on the question.

Regardless of whether this argument concerns the first element of *Mathies*, it is unpersuasive on its merits. Nothing in the Mine Act, Title 30 of the Code of Federal Regulations, or Commission and judicial case law limits S&S designations in the manner urged by Respondent. The only issues in determining whether a violation of a mandatory safety standard is S&S are whether it contributes to a discrete safety hazard and that hazard is reasonably likely to contribute to a reasonably serious injury. *Mathies, supra*. There is no additional requirement that the “true” or “real” purpose of the standard be analyzed. If an operator’s conduct violates the cited standard, then by necessity that conduct implicates the hazards considered in that standard. In the instant matter that means that if Respondent violated 30 C.F.R. §75.370(a)(1), and it is uncontested that it did, then the violation must at least concern the hazards that 30 C.F.R. §75.370(a)(1) was promulgated to address.<sup>29</sup> In this regard,

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<sup>29</sup> That is not to imply that any violation contributes to a discrete safety hazard (the question asked in the second prong of *Mathies*). For example, many violations are merely technical and do not raise hazards. Nonetheless, even a technical violation with no contribution to an actual hazard in a given instance still concerns the hazard addressed by the violated standard.

Commission ALJs have, in the past, accepted citations as S&S for trip and fall hazards, even when the standard cited dealt with ventilation issues. *See e.g. Consolidation Coal Co.*, 15 FMSHRC 1408 (July 1993)(ALJ Weisberger).

Even if it were necessary to determine the purpose of the cited standard, Respondent's interpretation of 30 C.F.R. §75.370(a)(1) is far too narrow. The purpose of the standard is clear from the first sentence: to require operators to make and follow an approved ventilation plan. While that plan is primarily designed to ensure proper ventilation, it is clearly not limited to that purpose. In fact, it is undisputed that Respondent's ventilation plan required maintenance of walkways to ensure safe travel. By admittedly failing to maintain those walkways, Respondent violated the plan and implicated this standard. Respondent's argument erroneously focused on certain goals in the plan, rather than the overall purpose of the standard. As a result, its argument is unpersuasive and I reject it.

Respondent's argument relies entirely on Judge Moran's statement in *Oak Grove Resources* that, "the Court finds despite the record evidence establishing a significant slipping and tripping hazard, such conditions cannot form the basis for a 'S&S' ...because that is not the focus of that standard." (*Id.* at 34 citing *Oak Grove Resources* at 610). I respectfully decline to follow the reasoning in *Oak Grove Resources* to the extent it mirrors Respondent argument, for the reasons discussed above. I find that the tripping hazard present in this case can form the basis of an S&S designation.

The second element of *Mathies*, a discrete safety hazard – that is a measure of danger to safety – contributed to by the violation – was also met. Credible testimony established that the bleeder entry contained deep water with various tripping hazards, including uneven floor, and debris. (Tr. 724). Two miners walked through the water and got extremely wet in the process and one of them had his methane detector fail as a result of the water. (Tr. 91-94, 98-99, 127, 221-227, 277, 280-281, 299-300, 304, 322, 422, 431-435, 660, 773-774). The water was cold and so murky that a miner could not see his feet or tripping hazards as he walked through the water. (Tr. 121, 172, 312, 354-356, 392-395, 348, 411-412). Tripping miners could suffer broken bones or head injuries. (Tr. 121-122, 143, 230). Given the depth and temperature of the water, the various structures and equipment in the area, and the heavy equipment the miners carried, the miners also faced hazards of shock or drowning. (Tr. 121-123). In short, the cited condition contributed to several discrete safety hazards and, therefore, the second element of *Mathies* is met.

The third element of the *Mathies* test – a reasonable likelihood that the hazard contributed to will result in an injury – was also met. Specifically, a miner slipping or falling in the bleeder could be injured in the fall. (Tr. 121-122). Injuries could occur to the limbs or the head. (Tr. 121-122). Further, the deep water in the area would contribute to a drowning hazard. (Tr. 121-122). In fact, the record fully supports the Secretary's determination that an injury would be "Highly Likely" to result from a slip and fall in the bleeder entry. Also, Young credibly testified that the water contained bacteria that could cause cellulitis – a blood infection – should a miner be cut by debris or machinery. The depth of the water, the size and length of the accumulations, the fact that two miners actually entered the water, and the fact that management ordered miners

to attempt to complete the entire exam despite the existence of water, all support a finding of “Highly Likely.”

In its brief, Respondent presents several arguments for why an injury was unlikely to result from a trip and fall accident in the bleeder. (*Respondent’s Post-Hearing Brief* at 25-26 and 35). However, none of these arguments was persuasive.

First, Respondent argues that the area was controlled access and only the weekly examiner traveled in the area. (*Respondent’s Post-Hearing Brief* at 25). This point was uncontested. (Tr. 69-70). Inspector Young credibly testified that this citation was marked as affecting two miners because two inspectors, Stalnaker and Saunders, actually entered the area in an attempt to complete the required exam. (Tr. 146, 191-192). However, the fact that only two miners entered the area in no way minimizes the hazards those miners faced. Any examiner in the area (Stalnaker, Saunders, Greene, or any other member of management) faced tripping hazards and deep water in the bleeders. The fact that access was limited only to those examiners does not change the hazard.

Respondent next argues that “Inspector Young decided to give the Operator three days to abate the water condition with no additional requirements other than Section 104(c).” (*Respondent’s Post-Hearing Brief* at 25). It is unclear how Respondent believes this limited the likelihood of injury to miners traveling in the water on February 5. This argument fails.

Additionally, Respondent argues that 11 people traveled in the bleeders, including Gross, and none tripped. (*Respondent’s Post-Hearing Brief* at 25 and 35). Further, Respondent noted that no previous injuries were observed in the bleeder entry, despite frequent water inundations. (*Id.*). As the Commission noted in *U.S. Steel Mining Company, Inc.*, “[t]he fact that injury had been avoided in the past or in connection with a particular violation may be ‘fortunate, but not determinative,’” to the question of whether a citation was S&S. *U.S. Steel Mining Company, Inc.*, 18 FMSHRC 862, 867 (Jun. 1996) quoting *Ozark-Mahoning Co.*, 8 FMSHRC 190, 192 (February 1986). It is fortunate that none of the miners or inspectors in this matter were injured by the tripping hazards in the bleeder system, but that does not change the fact that such an injury was highly likely. That likelihood was supported by both inspectors’ credible testimony.

Next, Respondent argues that the two examiners exposed to deeper water retreated rather than complete their exams. (*Respondent’s Post-Hearing Brief* at 26). While it is true that two miners, Stalnaker and Saunders, eventually retreated from the mine, as noted repeatedly at hearing, this retreat only occurred after the miners had already been exposed to the cited danger and because they chose not to go further, likely because of the danger involved. (Tr. 88-89, 92-95, 98, 218, 221-227, 300, 304-305, 322, 432-435, 447-448, 457, 493, 660). The inspectors credibly testified that the water Stalnaker and Saunders traveled in was hazardous. (Tr. 98, 218, 221-227, 314-316, 438). The miners might not have been exposed to all of the hazards in the area, but they were undoubtedly exposed to some of them. It was possible that Stalnaker would have finished the run, had his gas detector not been damaged by the water. (Tr. 452). In sum, the fact that Stalnaker and Saunders eventually retreated in no way limited the likelihood of injury.

Further, Respondent argues that after 5:00 a.m., Respondent began to pump down the water and therefore reduced the likelihood of injury. (*Respondent's Post-Hearing Brief* at 26). Respondent also noted that when remedial efforts were already underway when the inspector arrived, an injury was unlikely. (*Id.* at 35 citing *Knox Creek Coal*, 36 FMSHRC 1128, 1139 (May 28, 2014)). Respondent was correct that remedial efforts began (albeit with limited success) before the inspector arrived in the area. (Tr. 84, 128-129, 226, 234, 239, 272, 308-310, 322, 586-589, 593, 636, 711, 832-833). However, the remedial efforts did not occur until after Stalnaker had already been exposed to the dangerous conditions.

This situation is inapposite to that in *Knox Creek Coal*, cited by Respondent. In that case, the trailing cables on a continuous miner were nicked and the insulated inner conductors were exposed. *Knox Creek Coal*, 36 FMSHRC at 1137. However, in that case the machine was shut down and the cables were undergoing repair. *Id.* at 1139. The Commission found that the only likelihood of injury would be if miners were “willfully grossly neglectful in completing repairs.” *Id.* In the instant matter, the cited area, unlike *Knox Creek Coal*, was not “shut down.” Instead, Respondent ordered another miner, Saunders, into the area to be exposed to the hazards long before the pumps could have possibly eliminated all of the water. Further, Saunders was not sent into the area to cautiously repair the water condition, he was sent to complete the ventilation examination. (Tr. 88-89, 97, 427-428, 448-453, 457, 498-499, 647, 703-704, 774). As such, Respondent’s remedial actions here in no way limited the likelihood of injury.

Next, Respondent argues that there was an alternative route and bridging by which the bleeder examination could be conducted without entering the hazardous area. (*Respondent's Post-Hearing Brief* at 26). Leaving aside the fact that Inspector Young testified that such an examination would not walk the entire entry and therefore would not be legally complete, the facts do not support this assertion. Specifically, Stalnaker was attempting to enter the alternate route to complete the examination when his mutli-gas detector got wet, forcing his retreat. (Tr. 300, 314-315, 422). Stalnaker testified that the water was halfway up through the man door, a door that was three feet from the bottom. (Tr. 349, 788-789). Even if the alternate entries were dry, miners had already traveled through deep, hazardous water to reach those alternate entries. With respect to the bridged walkways, Gross credibly testified that the water was a foot above the walkway and so murky his feet could not be seen. (Tr. 172, 354-356, 392, 394-395, 792, 801-802). The same hazards existed on the walkway as on the bottom. Therefore, the likelihood of the hazard was in no way limited.

Additionally, Respondent argues that the entry was five feet wide, kept clear by the regular examiner, and had supports every six feet for miners to use for handholds. (*Respondent's Post-Hearing Brief* at 26). The record supports a finding that the water was rib to rib in the area. (Tr. 172, 348, 411-412). Therefore, the width of the entry did not limit the likelihood of injury as there were no dry spots to walk through. While examiners were tasked with clearing debris from the entry, the uneven bottom itself could have been a tripping hazard. (Tr. 395, 792, 801). This hazard was exacerbated because the water was murky, meaning miners could not tell if the ground was uneven or if some tripping hazard had arisen since the last weekly examination. (Tr. 172, 354-356, 392-395, 411, 775.). Further, the supports did not change the fact that examiners walked through the area and were reasonably likely to trip in the murky water. Indeed, the supports (which were not primarily designed as handholds) provided yet another item against

which a miner might strike his limbs or head when falling. The likelihood of injury, therefore, was not limited.

Finally, Respondent argued that the examiners were experienced and used care to avoid injury. (*Respondent's Post-Hearing Brief* at 26). The Commission has held that the exercise of caution is not an element in determining whether a violation is S&S, noting, “[w]hile miners should, of course, work cautiously, that admonition does not lessen the responsibility of operators, under the Mine Act, to prevent unsafe work conditions.” *Eagle Nest, Inc.*, 14 FMSHRC 1119, 1123 (July 1992). The Commission has also consistently emphasized that, in evaluating the risk of injury, the vagaries of human conduct cannot be ignored. *See, e.g., Great Western Electric*, 5 FMSHRC 840, 842 (May 1983); *Lone Star Industries, Inc.*, 3 FMSHRC 2526, 2531 (November 1981); *Thompson Bros. Coal Co.*, 6 FMSHRC 2094, 2097 (Sept. 1984). As a result, whether or not the miners were experienced or used care to avoid injury is immaterial and does not, in any way, limit the hazard that existed.

The fourth and final element of *Mathies*, a “reasonable likelihood that the injury in question will be of a reasonably serious nature,” was also met. Young credibly testified that a miner slipping and falling in the bleeder could suffer broken bones. (Tr. 121-122). The Commission has consistently recognized that broken bones and other injuries likely to result from a slip-and-fall are sufficiently serious in nature to support an S&S designation. *See e.g. Maple Creek Mining, Inc.*, 27 FMSHRC 555, 562-63 (Aug. 2005) (affirming a judge's conclusion that serious injuries such as leg or back injuries would arise from the failure to maintain an escapeway in a safe condition); *Buffalo Crushed Stone Inc.*, 19 FMSHRC 231, 238 n.9 (Feb. 1997) (concluding that slipping on a walkway would result in reasonably serious injuries such as a finger or a wrist fracture); and *Southern Ohio Coal Co.*, 13 FMSHRC 912, 918 (June 1991) (affirming a judge's conclusion that a trip and fall would result in reasonably serious injuries such as “sprains, strains, or fractures”). Therefore, the broken bone hazard in the instant matter is sufficiently serious to meet the fourth element of *Mathies* and the violation is S&S.

However, the record establishes that even more serious injuries were reasonably likely to occur from the cited condition. Inspector Young credibly testified if a miner fell and struck his head or was weighed down by equipment and fell into the water he would very likely drown. (Tr. 122, 230). The cited area had plenty of pipes, supports, and other debris that could be struck in a fall. (Tr. 123). The cold water increased the chances that the miner would go into shock. (Tr. 121-122). Young recalled a specific instance in which a miner had a heart attack after falling into water and drowned. (Tr. 230-231). The risk of drowning was increased in this instance because Stalnaker used illegal waders while traveling in the area. Waders were not permitted because they fill with water and drag miners under the surface of the water. (Tr. 455, 500, 704). In fact, in this case water entered Stalnaker's waders and broke his multi-gas detector. (Tr. 300, 422). Several other Commission ALJs have found that death is reasonably likely under certain slip-and-fall circumstances. *See e.g. Independence Coal Company, Inc.*, 32 FMSHRC 654, 664 (Jun. 2010)(ALJ Miller)(Judge found tripping hazards in an escapeway to be reasonably likely to result in fatal injury) and *Palmer Coking Coal Company*, 22 FMSHRC 887 (Jul. 200)(ALJ Manning)(Judge found tripping hazards over freezing water to be reasonably likely to result in fatal injury). It is reasonably likely that a miner, particularly a miner in waders, falling in the area could suffer a fatal injury in the deep water.

In addition to the drowning risk, Inspector Young credibly testified that the murky water was full of chemicals and bacteria. (Tr. 69). He noted that there was a risk of cellulitis and MRSA as a result of these substances. (Tr. 68). Respondent's own witnesses explained that the water was full of dangerous materials. (Tr. 312). In fact, the water that the miners walked through had to be trucked away from the mine because of the environmental dangers it posed and processed before being released into the environment. (Tr. 284-285, 761). The water therefore posed additional dangers to the health of miners.

In its brief, Respondent argues that the cited condition would not result in fatal injury. However, none of Respondent's arguments were persuasive.

First, Respondent argues that eleven different people entered the bleeder during the investigation of the cited condition and no one was injured. (*Respondent's Post-Hearing Brief* at 31). Similarly, Greene could not recall ever falling in the bleeder and Giavonelli could not recall anyone else falling or being injured. (*Id.*). It is fortunate that no one was injured in this instant matter. However, as discussed with respect to the third *Mathies* element, Respondent's fortune does not change the likelihood of an injury. Miners were likely to suffer a fatal injury from one of the various hazards in the bleeder system and Respondent was lucky that a death did not occur. However, such luck could, eventually, run out. See e.g. *Lone Star Industries, Inc.*, 3 FMSHRC 2526, 2532 (Nov. 1981)(Operator had "20-year history of apparently fatality-free" history of unsafe train operation that eventually ended with the death of a miner).

Next, Respondent argues that fatal injury could only occur if an unlikely series of events were to occur. (*Respondent's Post-Hearing Brief* at 31). Specifically, Respondent asserts,

First, the person would have to encounter a tripping hazard. Second, they would have to fail to bypass the hazard. Third, they would have to fail to catch themselves on a handhold. Also, it is common sense that tripping in water when a person is already in the water is less severe because of the buoyancy of the water. Fourth, they have hit their head. Finally, the potential injury would have to render the miner unconscious.

(*Id.* at 31-32). Respondent's argument attempts to show that a serious trip and fall is unlikely by unnaturally splitting the action into discrete units. Adding additional steps in the sequence (for example describing the way in which the toe must come in contact with a tripping hazard and then the way in which the foot must wrench around the tripping hazard) does not make the ultimate injury less likely. Respondent's argument does not take into account that tripping and falling into water would happen in only a few seconds and the miner would not have time to take the discrete steps suggested by Respondent. I conclude that fatal injury is reasonably likely for the reasons discussed *supra*; imaginative explanations of the act of tripping do not change those determinations.

Finally, Respondent argued that the facts in the instance matter were substantially similar to those in *Oak Grove Resources, LLC*, *supra* where the ALJ found the likely injuries were lost workdays/restricted duty. (*Respondent's Post-Hearing Brief* at 32). It argues that the fact that



Young's previous citations were also lost workday/restricted duty further support this designation. (*Id.*). Once again, I respectfully decline to follow the reasoning in *Oak Grove Resources* to the extent it mirrors Respondent's argument, for the reasons discussed above. In the instant matter, I fully credit Young's testimony and find that a fatal injury was reasonably likely.

In short, I find that a preponderance of the evidence supports the Secretary's finding that the condition listed in Citation No. 7024068 was Highly Likely to result in Fatal injuries to two miners and that it was S&S.

#### **4. Respondent's Conduct Constituted "High" Negligence and an Unwarrantable Failure to Comply.**

With respect to Citation No. 7204068, I find that Respondent knew or should have known about the condition and that there were no mitigating circumstances as argued by Respondent. As a result, a finding of "High Negligence" is warranted.

With respect to knowledge, well-settled Commission precedent recognizes that the negligence of an operator's agent is imputed to the operator for penalty assessments and unwarrantable failure determinations. *See Whayne Supply Co.*, 19 FMSHRC 447, 451 (Mar. 1997); *Rochester & Pittsburg Coal Co.*, 13 FMSHRC 189, 194-197 (Feb. 1991); and *Southern Ohio Coal Co.*, 4 FMSHRC 1459, 1463-1464 (Aug. 1982). An agent is defined as someone with responsibilities normally delegated to management personnel, has responsibilities that are crucial to the mine's operations, and exercises managerial responsibilities at the time of the negligent conduct. *Martin Marietta Aggregates*, 22 FMSHRC 633, 637-638 (May 2000). Further, "in carrying out... required examination duties for an operator, an examiner... may appropriately be viewed as being 'charged with responsibility for the operation of . . . part of a mine,' and, therefore, the examiner constitutes the operator's agent for that purpose." *Rochester and Pittsburg Coal Co.*, 13 FMSHRC at 194 quoting 30 U.S.C. §802(e).

In the instant matter, Stalnaker was a miner examiner, member of management, and an agent of Respondent. (Tr. 128, 297-298). Stalnaker entered the area and discovered the hazardous water. (Tr. 91, 227, 299). At that moment, Respondent had knowledge of the condition. Rather than immediately retreating and reporting the condition, Stalnaker tried to wade through the water and only retreated when he damaged his equipment. (Tr. 91, 277, 299, 316). Once he left the area after donning unauthorized waders, Stalnaker informed two other members of management, Price and Giavonelli, about the water. (Tr. 88-89, 92-95, 100, 103, 300, 304-309, 321-322, 447-448, 455-457, 493, 635-636, 660, 711). Giavonelli then ordered the pumps on. (Tr. 128-129, 226, 234, 239, 272, 308-310, 322, 588-589, 636, 711, 804, 832-833). Without giving those pumps time to actually clear the area, Price contacted Saunders, another member of management, and ordered him to walk through the area from a different direction. (Tr. 88-89, 97, 427-428, 448-453, 457, 498-499, 647, 703-704, 774). Saunders, knowing of the hazard, attempted to wade through the water as well. (Tr. 98, 218, 221-227, 438, 480). In short, no fewer than five members of underground management were aware of the condition (and caused exposure to the condition) before the citation was issued. Beyond this specific knowledge, Respondent should have known that the area often filled with water and should have

taken action to prevent the hazards created by the high water. Therefore, Respondent was negligent. The question that remains is the degree of that negligence.

In its brief, Respondent argues that its negligence was substantially mitigated in this matter. However, none of those arguments are persuasive.

First, Respondent argues that when it first learned about the condition after Stalnaker reported the condition, the pump was turned on. (*Respondent's Post-Hearing Brief* at 22). Respondent's argument leaves out one crucial detail about Stalnaker's actions: Exposure. After Stalnaker discovered the condition and before he reported it, he walked through the water and exposed himself to the hazards. The danger had already been realized and, in fact, exacerbated. Perhaps if Stalnaker had noticed the water and immediately ceased his examination until the hazard was removed, the negligence would be lower. But, that is not what happened here.

The fact that Respondent started the pump after Stalnaker made his report did not mitigate the negligence. Then, before the pump had time to remove even a fraction of the water in the area, Price dispatched Saunders into the same area from a different direction. (Tr. 88-89, 97, 427-428, 448-453, 457, 498-499, 647, 703-704, 774). Price knew that Saunders would get wet and even apologized for it. (Tr. 450). While turning the pump on was appropriate, it does not mitigate subsequent willful exposure to the hazard.

In its brief, Respondent addresses this issue. It asserts that Young's testimony that something was not mitigation if it happened after exposure is not correct. (Respondent's Post-Hearing Brief at 24). It notes that the case law indicates instead that the issue is whether the mitigation occurred before the issuance of the citation. (*Id. citing Enlow Fork Mining Co.*, 19 FMSHRC 5, 17 (Jan. 1997)). Respondent claims that Young's definition of mitigation would mean that there was never would be mitigation because mitigating circumstances never exist before a violative condition is discovered. (*Id.*).

Respondent fails to appreciate the issue is not that the examiners were exposed to a hazard, but instead the willfulness of Respondent's action. As Respondent correctly pointed out, miners are often exposed to unknown hazards and actions taken after discovery of that hazard constitute mitigation. In this case, there was no hidden or unknown danger. Respondent discovered the hazard and then members of management were willfully and negligently exposed. Rather than being unaware of a condition, Respondent ignored a known danger about which Young had previously warned management in December 2012 when he explained that more effort was needed to keep the level down in the bleeder. Only after the water level became dangerously high did Respondent begin to correct the condition. Consider a situation in which a miner knowingly walks under an unsupported roof during an examination and then, after completing the exam, begins the process of supporting the roof. In that situation, the fact that the roof was later supported, before any citation was issued, does not mean that walking under unsupported roof was in any way mitigated. The risk had already been run. That is analogous to the situation here. Therefore, actions taken after exposure cannot be mitigation.

The second possible mitigating circumstance Respondent raises is that the accumulation of water occurred, in part, because the bubbler was broken and the water would have remained low if it was working. (*Respondent's Post-Hearing Brief* at 23). Respondent asserts that the

pump and the monitoring system had been installed to correct the problem and that the failure of that system to activate was mitigation. (*Id.*). Respondent lists additional mechanical problems including the fact that the monitor screen showed 40 inches of water, broken discharge lines, and the power outage. (*Id.* at 14-16). The brief notes that Young had considered mechanical failure mitigation in the past. (*Id.* at 23). Respondent contends management did not have any reason to doubt the system in place. (*Id.*).

Regardless of the efficacy of the monitoring and bubbler system, Respondent's system cannot serve as a mitigating circumstance because Stalnaker and Saunders traveled through the water. Saunders was ordered into the water by other members of management. Efforts made to limit the water in the area were appropriate, but the purpose of these systems is to avoid exposure to hazards. If miners are exposed to hazards anyway, those efforts cannot be effective. Whatever mitigation occurred as a result of the installation of the system was completely negated by the willfully negligent actions of Stalnaker, Price, and Saunders.

Beyond that, the evidence clearly shows that Respondent's system was wholly inadequate to the challenge of keeping water out of the bleeder. Respondent's witnesses testified that the mine could not keep up with the water even if only one of the two dozen air pumps in the area went down. (Tr. 478-480, 510). If the system was disrupted, the sump would fill in two or three hours and then overflow. (Tr. 477-478). The monitoring system, which may or may not have been totally installed at the time at issue, only monitored the bubbler. (Tr. 582-584, 745-746). When the bubbler broke, the monitoring system no longer produced accurate data. (Tr. 582-584, 745-745). The system essentially only worked in laboratory conditions and was completely ineffective in the dynamic environment of a working mine. Actions are not mitigation when they are inadequate to the task of preventing, correcting, or limiting exposure. *See e.g. Cemex de Puerto Rico*, 36 FMSHRC 1386, 1427 (May 2014)(ALJ Andrews) and *Maple Creek Mining, Inc.*, 26 FMSHRC 539, 555 (Aug. 2005)(ALJ Bulluck). As a result, the various systems and equipment failures did not constitute mitigation.

Next, Respondent argues that it conducted additional monitoring in the area, including monitoring the discharge pipe, daily surface pump examinations (with records), and Greene's additional examinations. This argument is rejected for the same reasons as the previous argument. Stalnaker and Saunders willfully traveled through the hazards, so any efforts to limit exposure to hazards were in vain. Further, the actions taken clearly did not give Respondent any indication that water was collecting in the area at dangerous levels and therefore were grossly inadequate. As a result, the additional examinations did not constitute mitigation.

Additionally, Respondent argues that it did not know about the cited condition until February 5, which was the last day of the weekly examination period. (*Respondent's Post-Hearing Brief* at 15). Substantial evidence supports this assertion. However, given the willfully negligent conduct of management and the fact that Respondent should have known that the bleeder was prone to flooding, the lateness of the discovery cannot constitute mitigation.

Respondent also argued that it had two different contractors, MVI and Burns Trucking, come to the mine after the discovery of the condition to pump water and correct problems with the pumping System. (*Respondent's Post-Hearing Brief* at 15-16). Once again, these actions

came after management willfully exposed miners to a known hazard and therefore are not mitigation.

As none of the actions presented by Respondent constituted mitigating circumstances, the “High Negligence” designation is appropriate.

The Commission has recognized the close relationship between a finding of unwarrantable failure and a finding of high negligence. *San Juan Coal Co.*, 29 FMSHRC 125, 139 (Mar. 2007) *see also Consolidation Coal Company*, 22 FMSHRC 340, 353 (2000) (holding that if there is mitigation, an unwarrantable failure finding is inappropriate). Having found that the instant violation resulted from “High negligence,” it is appropriate to consider whether the six *IO Coal* factors establish aggravated conduct. 31 FMSHRC at 1346. I will consider each of those factors in turn:

**a. Extent Of The Violative Condition**

The water accumulations in the instant bleeder system were very extensive. Water at the 47 crosscut stretched 400 feet and ranged in depth from 12-42 inches. (Tr. 79-80, 125-126, 156-157, 167, 169, 347-348, 351-353, 377, 382, 385-389, 788, 799). Water from E-19 to E-21 stretched 1,800 feet and ranged in depth from 12-36 inches. (Tr. 79-80, 125-126, 167-169, 173, 354, 356, 366, 379-380, 391-394, 420, 791-792, 801). The water was rib to rib in these areas. (Tr. 172, 348, 411-412). In its brief, Respondent concedes that the accumulations were extensive in length. (*Respondent's Post-Hearing Brief* at 39).

Despite this concession, Respondent contends that, for the purposes of the unwarrantable failure analysis, the condition was not extensive. Specifically, it notes that some of the water was not particularly deep. (*Respondent's Post-Hearing Brief* at 39). The brief draws attention to the fact that the water was only 6 inches deeper than on December 10 and Respondent's actions then were not aggravated conduct. (*Id.*). The record establishes that the water in some locations was only a few inches deep. (Tr. 395-396). However, this in no way changes the fact that the water stretched for nearly half a mile and some of the locations were three and a half feet deep.

**b. The Length of Time of the Violation Existed**

It is unclear from the record exactly how long the condition existed. Young testified that the water would had to have existed for several shifts to reach the cited extensiveness. (Tr. 271, 514-516). At the very least, Young believed that the condition that led to the accumulation (the power outage, the broken discharge line, broken pumps, or any other factor) had to have happened a considerable time before the cited condition was found. Common sense would support this determination: there were thousands of gallons of water in the bleeder and it would have to be collecting very rapidly to appear even in a few days. In fact, it took three days to pump the water back out of the area. However, Greene testified he had been in the bleeder the Monday (February 4) before the citation was issued. (Tr. 495-496, 519-520). Respondent's witnesses credibly testified that water could accumulate very quickly in the area. (Tr. 498-499, 505-506, 519). In light of the Secretary's burden, I find that the accumulation likely occurred

sometime after Greene's last examination, which was less than 48 hours from the time the citation was written.

**c. Whether the violation is obvious or poses a high degree of danger**

As discussed at length in the discussion on gravity, the cited condition posed a high level of danger. Miners, especially those wearing waders, faced trip-and-fall and drowning danger. (Tr. 121-123, 230, 455, 500, 704, 724). Further, miners traveling through the water ran the risk bacterial infection. It is significant that miners were willfully and negligently exposed to this high degree of danger. In its brief, Respondent argues that the cited condition did not pose a high degree of danger for largely the same reasons given with respect to gravity. (*Respondent's Post-Hearing Brief* at 45-46). These arguments are rejected for the same reasons discussed *supra*.

With respect to obviousness, the accumulations were massive and the examiner had to travel through them to complete the examination. There was no way anyone could enter the area without seeing the cited condition. There is no question the condition was obvious.

In its brief, Respondent argued that the condition could not be obvious because it was in a "remote area," namely a bleeder entry that was only traveled by certified examiners on weekly examination. (*Respondent's Post-Hearing Brief* at 40 citing *Carmeuse Lime, Inc.*, 29 FMSHRC 266, 270 (March 2007)(ALJ Zielinski). Respondent misapprehends the nature of the obviousness determinations both in *Carmeuse* case in particular and Commission case law in general. In *Carmeuse*, Judge Zielinski held, *inter alia*, "the condition was not obvious, and was located in a somewhat remote area." 29 FMSHRC at 266. However, he went on to explain:

I conclude that the condition was not obvious because of its nature and location. Ex. G-4. Aside from the fact that persons rarely traveled the walkway, the condition was located almost seven feet above the walkway surface, and it is not likely that a person would look up and see it. There is no evidence that the condition had been reported in any other workplace examination reports.

*Id.* at FN 7. The question of obviousness in *Carmeuse*, therefore, did not turn solely on the act that the area was "somewhat remote." According to Judge Zielinski's reasoning, it was perhaps more important that the condition was hard to see from the walkway and that the condition had never been seen in the area before. In the instant matter, Respondent was clearly aware of previous water issues in the area and it was impossible to enter the area without noticing it. Therefore, the condition was obvious and also posed a high degree of danger.

**d. Whether the operator had been placed on notice that greater efforts were necessary for compliance or that this condition was an issue.**

Respondent was on notice that additional efforts were needed in the cited area. Specifically, Young had issued two citations for excessive water in the same bleeder system less than three months before the instant problem arose. (Tr. 63-65, 73-74, 183-184, 202). Beyond the notice these citations would naturally give, Young specifically wrote that Respondent was on notice. (Tr. 67-68, 71). Further, in December 2012, he discussed this notice and the water problem in the bleeder with members of mine management. (Tr. 66-67, 694).

It strains credulity but Respondent argues that previous “moderate” citations could not serve as notice that additional efforts were necessary. (*Respondent’s Post-Hearing Brief* at 42 citing *Cyprus Emerald Resources Corporation*, 11 FMSHRC 2570 (Dec. 1989)(ALJ Koutras). Once again, Respondent misunderstands the holding in the cited case. It is true Judge Koutras in *Cyprus Emerald Resources Corporation* expressed concern that four previous citations relied upon by the Secretary in that matter to show notice were only “moderately” negligent. However, he ultimately stated:

In any event, I cannot conclude that the prior citations *which were issued for different conditions, and at different locations far removed from the scene of the conditions* which prevailed at the time of the inspection on August 31, 1988, may serve to support a finding of aggravated conduct. In my view, in order to support an unwarrantable failure order, which is a severe sanction, an inspector must make an informed judgment, on a case-by-case basis, with respect to the prevailing conditions which he believes justifies such an order.

11 FMSHRC at 2585 (emphasis added).

In short, Judge Koutras was most concerned that the previously cited conditions were so different from the condition at issue that they could not serve as notice for unwarrantable failure issues. In the instant matter, the previous citations were issued in the same location in the same bleeder for the identical condition. Perhaps more importantly, notice in this matter relies less on the fact that there were previous citations and more on the fact that Young gave an explicit message to Respondent that additional efforts were needed when those citations were issued. Whether Respondent could imply notice from previous enforcement is not at issue when Respondent has actual notice. Therefore, Respondent had meaningful notice that additional efforts were needed.

Respondent further argues that the additional precautions it took after receiving notice, including the remote monitoring system of the bubbler, meant that the “notice” factor should not be held against the company. (*Respondent’s Post-Hearing Brief* at 43 citing *Big Ridge*, 35 FMSHRC 1531). It argued that equipment defects intervened, but that it had acted to correct the problems cited. (*Id.*). It argued “at some point, the clock should be re-started or at least not progressed,” on notice. (*Id.*). As discussed previously, Respondent’s actions in setting up the remote monitoring and bubbler system were wholly inadequate to the challenge posed by this

bleeder. Every time the bleeder was inspected, equipment defects and accumulations were observed. While it is true that at some point, efforts made after notice should “restart the clock” on notice, the inadequate efforts made by Respondent were not sufficient to do so in this case.

**e. The operator’s efforts in abating the violative condition**

Respondent acted to abate the condition in the hours and days after the discovery of the cited condition. This point is essentially uncontested.

However, in its brief, Respondent attempts to stress that their abatement efforts were so substantial and important that it would essentially negate all of the other unwarrantable failure factors. In its brief Respondent argues that the time the condition existed, the extent of the condition, the obviousness of the condition, notice of greater effort, and knowledge had to be considered in light of abatement efforts taken. (*Respondent’s Post-Hearing Brief* at 38-43). For instance, Respondent stated that with respect to length of time, obviousness and extent, “the real issue is that Consol responded to the water problem by taking aggressive action to abate the conditions.” (*Id.* at 40). However, Respondent cites no authority for the proposition that abatement is the ultimate issue in unwarrantable failure determinations. Further, Respondent failed to reckon with the fact that, before any abatement occurred or could be effective, miners were willfully and negligently exposed to the cited condition. I find no reason to believe that abatement after miners are exposed to a hazard alone makes an unwarrantable failure determination inappropriate.

**f. Operator’s knowledge of the existence of the violation**

“It is well-settled that an operator’s knowledge may be established, and a finding of unwarrantable failure supported, where an operator reasonably should have known of a violative condition.” *IO Coal Co.*, 31 FMSHRC at 1356-1357 (*citing Emery*, 9 FMSHRC at 2002-2004). A supervisor’s knowledge and involvement is an important factor in an unwarrantable failure determination. *See Lopke Quarries, Inc.*, 23 FMSHRC 705, 711 (July 2001) *citing (REB Enterprises, Inc.*, 20 FMSHRC 203, 224 (Mar. 1998) and *Secretary of Labor v. Roy Glenn*, 6 FMSHRC 1583, 1587 (July 1984). In fact, a supervisor’s actual knowledge can be imputed to the Respondent for purposes of determining an unwarrantable failure, in addition to the penalty. *Whayne Supply Co., supra; Rochester & Pittsburgh Coal Co., supra; and Southern Ohio Coal Co., supra.* As discussed *supra*, the preponderance of the evidence shows that Stalnaker knew about the condition when he encountered it in the bleeder. In the hours that followed, several other members of management learned about the condition. Despite this knowledge, miners were willfully exposed to the condition.

In its brief, Respondent argues that knowledge is unimportant when a condition exists for a short period of time and Respondent took appropriate corrective action. (*Respondent’s Post-Hearing Brief* at 41 *citing Oak Grove, supra* \*12). For the reasons described *supra*, Respondent’s corrective actions are insufficient to negate all the other unwarrantable failure factors. Further, I find that the time the condition existed is unimportant given Respondent’s actual knowledge of the condition and the willful exposure to the hazards.

In light of the extent of the condition, its obviousness and high degree of danger, the notice of greater efforts needed in the area, Respondent's actual knowledge of the cited condition, and the fact that Respondent's actions were best characterized as "High" negligence, I find that this violation as an unwarrantable failure to comply on the part of Respondent.

**D. Order No. 7024069**

**1. Contentions of the Parties**

With respect to Citation No. 7024069, the Secretary asserts that Respondent violated 30 CFR § 75.364(h), that this violation was "Highly Likely" to result in "Fatal" injuries to two miners, that the violation was S&S, and that it resulted from "High Negligence" and an unwarrantable failure to comply. (GX-1)(*Secretary's Post-Hearing Brief* at 27-31). The Secretary believes that the proposed penalty of \$14,743.00 is appropriate. (*Id.* at 31-33).

Respondent argues that no injury was reasonably likely to occur as a result of the violation and that, as a result, it was not S&S. (*Respondent's Post-Hearing Brief* at 30-35). In the alternative, it argues that if any injury occurred it would result in "Lost Workdays/Restricted Duty" rather than death. (*Id.* at 30-33). It also argues that its actions did not display "High Negligence" or an unwarrantable failure to comply. (*Id.* at 26-29 and 36-46).

**2. The Secretary Has Carried His Burden Of Proof By A Preponderance Of The Evidence That Respondent Violated 30 CFR § 75.370(a)(1)**

On February 5, 2013, Young also issued Order No. 7024069 under 104(d)(1) of the Act for a violation of 30 CFR § 75.364(h). In the Condition or Practice section, he stated:

The operator failed to record at the completion of any shift during which a portion of a weekly examination is conducted, a record of obvious and extensive hazardous conditions found during a weekly examination conducted on 02/05/2013 on the midnight shift of the E tailgate through E-21 bleeder district. The record book on the surface showed that no violations or hazards existed and obvious and extensive accumulations of water were found during 103(g) complaint investigation number 47336. Water measuring 2350 feet in total length by 12 to 42 inches in depth from rib to rib were found in this bleeder system. The record book on the surface was signed by one examiner and the mine foreman/superintendent. The second examiner also failed to sign for his portion of the exam by the end of the shift on which it was made. None of the three persons, who signed the record and had knowledge of these hazards, entered the hazards into the record book.

This constitutes more than ordinary negligence on the part of the mine management, in that, hazards are required to be reported and corrected immediately to protect the health and safety of the miners. This high degree of negligence demonstrates a lack of due diligence by the mine operator to provide a safe work environment by not recording hazardous conditions. This unique



aggravated circumstances [sic] puts the miners at a high risk to be injured. This a [sic] lack of reasonable care on the part of the mine operator to provide a safe work environment for their employees demonstrates indifference in complying with the regulations.

This is being issued in conjunction with 104(d)(1) Citation Number 7024068.

This violation is an unwarrantable failure to comply with a mandatory standard.

(GX-2).

The Order was terminated on February 7, 2013, after Respondent's management reviewed with all certified mine examiners who examine the E-22 bleeder district that all violations and observed hazards shall be recorded in the record book. (GX-2).

On February 11, 2013, Young modified this Order to note a change in time (to use military time) and to reduce the total distance involved from 2,350 feet to 2,250 feet. (GX-2).

The cited standard, 30 CFR § 75.364(h) ("Weekly examination"), provides the following:

At the completion of any shift during which a portion of a weekly examination is conducted, a record of the results of each weekly examination, including a record of hazardous conditions and violations of the nine mandatory health or safety standards found during each examination and their locations, the corrective action taken, and the results and location of air and methane measurements, shall be made. The results of methane tests shall be recorded as the percentage of methane measured by the examiner. The record shall be made by the person making the examination or a person designated by the operator. If made by a person other than the examiner, the examiner shall verify the record by initials and date by or at the end of the shift for which the examination was made. The record shall be countersigned by the mine foreman or equivalent mine official by the end of the mine foreman's or equivalent mine official's next regularly scheduled working shift.

30 C.F.R. §75.364(h).

In the instant matter, it is uncontested that four of Respondent's foremen (Stalnaker, Saunders, Price, and Giavonelli) knew about the water in the bleeder. This condition was a hazard and, as a result, should have been recorded in the book. However, the hazardous water was not noted in the record book when Giovanelli signed the book. (Tr. 84-85, 87, 99, 671, 677). Further, Respondent conceded that "there was a violation of the standard..." (*Respondent's Post-Hearing Brief* 26). In light of these facts, I find that the citation was properly issued.

### **3. The Violation Was Highly Likely to Result in Fatal Injury to Two Miners And Was Significant And Substantial In Nature.**

Inspector Young marked the gravity of the cited danger in Order No. 7024069 as being “Highly Likely” to result in “Fatal” injuries to two persons. (GX-1). Young also determined that the violation was S&S. (GX-1). These determinations were supported by a preponderance of the evidence at the hearing.

As noted *supra*, the first element in determining whether a violation is S&S is whether there was an underlying violation of a mandatory safety standard. *Mathies* at 3-4. As demonstrated above, Respondent violated 30 C.F.R. §75.364(h) in the instant matter. Therefore, the first *Mathies* element is met.

As with the previous citation, Respondent argues that a 30 C.F.R § 75.364(h) violation based “solely” on a tripping hazard cannot be S&S because that standard is not directed at tripping hazards, but rather at ventilation issues. (*Respondent’s Post-Hearing Brief* at 33 citing *Oak Grove Resources, supra*). Respondent asserts that “all of the factors” outlined in its brief with respect to Citation No. 7024068 are incorporated for Order No. 7024069. For these reasons fully discussed above, those arguments are once again rejected here.

The second element of *Mathies*, a discrete safety hazard – that is a measure of danger to safety – contributed to by the violation – was also met. Because the condition was not listed in book, miners would not be aware of the hazards cited in Citation No. 7024068. As a result, the failure to list the cited hazard contributed to the chances miners would be exposed to those hazards. Further, failure to list the cited condition meant that Respondent would not take notice or fully appreciate that its previous efforts to control water in the area were grossly inadequate. Therefore, Respondent would not take additional efforts to control the area. This meant that more miners in the future would face exposure to water in the bleeder system.

The third element of the *Mathies* test – a reasonable likelihood that the hazard contributed to will result in an injury – was also met. If miners entered the area, they would be exposed to the hazards discussed with respect to Citation No. 7024068. Specifically, these hazards would include trip-and-fall, fractures, drowning, and bacterial infection. (Tr. 121-122, 143). Such an injury would be more than reasonably likely; I find that the injury would be highly likely.

In its brief, Respondent argues that the hazard contributed to in this situation, the exposure of miners to hazards in the bleeder, was unlikely to occur and unlikely to result in injury. (*Respondent’s Post-Hearing Brief* at 30). Specifically, Respondent argues that the cited area was controlled access and abatement was underway. (*Id.*). Any person who had any reason to read the record book or to enter the Bleeder, including Greene, was already aware of the water from word of mouth. (*Id.*). Also, by February 5, Yablonsky’s entries noting the water were already in the book. (*Id.*).

While remedial efforts with respect to the underlying condition were started before Inspector Gross discovered the condition, remediation of the inadequate examination did not occur until later. Specifically, the examination was not completed and the water condition was

not added to the books until after Young told Respondent he would issue citations. (Tr. 81-83, 105-107, 113, 175-176, 345-347, 358-359, 372-374, 400, 782). Young actually spoke to Yablonsky before the examiner entered the bleeder. (Tr. 108-109). Therefore, completion of the examination and the examination book occurred only after the condition was cited, near the end of the day on February 5.

Further, whether some or all of Respondent's employees had actual knowledge of the water condition is immaterial. Without the examination record, Respondent's miners had to rely entirely on word-of-mouth. Respondent provided no legal support for its contention that the Mine Act permits informal, ad hoc pre-shift reports. Certainly Greene, the regular examiner, should not have to rely solely on an informal conversation with Stalnaker to learn about the nature and extent of an extremely hazardous condition.<sup>30</sup> Greene should have been able to read the book to determine the hazards he would encounter. Further, reliance on informal reporting would not provide a means to later verify what information the various miners received when they learned about the water accumulation. The fact that Saunders was eventually sent into the area also shows that Respondent cannot predict who would need to be sent into the area, as originally only Stalnaker was supposed to examine the bleeder. Further, once Saunders entered the area, he was obviously not told about the nature, extent, or danger of the condition because he simply walked through the water hazard. Miners should have been informed about the water accumulation in the record book.

Perhaps more importantly, because the water was not included in the examination book Respondent would not have a record of the accumulation. This would mean that MSHA inspectors would not know that the condition existed and that hazards continued to occur in this bleeder. Without the 103(g) complaint, MSHA never would have known about the water in the bleeder.<sup>31</sup> (Tr. 105). Further, Respondent would not have a record that their efforts to keep water out of the bleeder were wholly inadequate and therefore would have no reason to plan future efforts to improve the plan. Eventually, the bleeder would flood again and miners would, once again, be exposed to hazards. Therefore, I find the fact that some miners may have been aware of the existence of the cited condition (to some degree) does not change the fact that an injury from the inadequate examination was highly likely.

The fourth and final element of *Mathies*, a "reasonable likelihood that the injury in question will be of a reasonably serious nature," was also met. As discussed with respect to Citation No. 7024068, serious, or even fatal, injury was likely to result from the water accumulations. Respondent argues, for the same reasons described in Citation No. 7024068, that fatal injury was unlikely. (*Respondent's Post-Hearing Brief* at 30-33). Those arguments are rejected for the same reasons given above.

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<sup>30</sup> It is true that by the time Greene returned to the mine, Yablonsky had completed his examination and noted the cited condition in the book. However, as noted supra, Yablonsky was only sent in after a further citation was threatened. (Tr. 107-109). Without this threat, no note would have been included, as various Respondent's witnesses testified they did not believe there was a hazard. (Tr. 132-133, 307, 434).

<sup>31</sup> Also it is questionable if Respondent would have taken adequate measures to control the water condition in the bleeder system since no one deemed it enough of a hazard to record the problem.

In short, a preponderance of the evidence supports the Secretary's finding that condition listed in Citation No. 7024068 was "Highly Likely" to result in "Fatal" injuries to two miners and that it was S&S.

#### **4. Respondent's Conduct Constituted "High" Negligence and an Unwarrantable Failure to Comply.**

With respect to Order No. 7204069, I find that Respondent knew or should have known about the condition and that there were no mitigating circumstances. As a result, a finding of "High Negligence" is warranted.

Several members of management knew that the examination had not been properly completed and that the water accumulation was not listed, including Stalnaker, Saunders, and Giavonelli. Nevertheless, Giavonelli signed the exam book knowing that water was present and that it was not listed. (Tr. 671-672, 681-682). Therefore, Respondent was negligent. Once again, the question remains as to the degree of negligence.

In its brief, Respondent argued that its negligence was substantially mitigated in this matter. However, none of those arguments are persuasive.

Respondent argues that this condition was merely a technical paperwork violation. (*Respondent's Post-Hearing Brief* at 27). Respondent notes that the record was incomplete but that everyone knew there was water in the bleeder and that it was being pumped. (*Id.*). Stalnaker did not complete the record because he did not finish the exam. (*Id.*). Saunders could not complete the final two sections and did not add the water to the record because he believed it was not a hazard. (*Id.* at 28). Giavonelli signed the document but he knew there were areas that weren't examined and that there was extensive water in the area. (*Id.*). Therefore, Respondent argued that there was no negligence, just a minor paperwork error.

As discussed with respect to gravity, the issue is not whether some miners had actual knowledge of the water accumulation. A record of the hazards in the bleeder was required. Without that record, it was impossible to know what miners were aware of the nature and scope of the condition. Even those who knew that water was present did not recognize it as an obvious hazard. Specifically, Saunders said he did not believe that the water was a hazard despite the fact that it was cold, murky, contained tripping hazards, and was so deep that he did not continue to travel through it to complete his exam. Respondent should have ensured that the water accumulation was placed in the record book so that Saunders and others would recognize it as a hazard before being exposed to the hazard.

Further, a record would have ensured that management was aware and remembered the inadequacy of the existing systems to handle the water. By recording the condition, Respondent would have been aware that additional efforts were needed to keep the bleeder clear. Finally, a record ensured that MSHA inspectors were aware of the cited condition. This was especially important because Young had placed Respondent on notice regarding this bleeder. As the two inspectors noted, without the 103(g) complaint, they never would have known there was water in

the bleeder because it was not recorded. (Tr. 105). This was not a mere paperwork error, rather this went to the heart of miner safety in the bleeder.

The next possible mitigating circumstance raised by Respondent is that Respondent had no previous citations for the cited condition. (*Respondent's Post-Hearing Brief* at 29). It is true that Respondent did not have any previous citations for inadequate examinations in the bleeder. However, Respondent had a history of failing to notice and address water conditions in the bleeder. Whether or not Respondent was cited, it had consistently failed to ensure the area was safe for travel. As a result, history supports a finding of high negligence and the lack of any prior citations is in no way mitigation.

Respondent also argues that management had ensured abatement before issuance of the citation. (*Respondent's Post-Hearing Brief* at 29). As noted with respect to gravity, Respondent began pumping the water in the bleeder before Citation No. 7204068 was issued. However, the examination was only completed after Young told Respondent he was issuing citations. (Tr. 107). Further, Yablonsky only completed the exam and noted the water after speaking with Young. (Tr. 108-109). This condition was not abated before issuance and there was no mitigation.

Respondent further notes that Stalnaker was not the usual examiner and that he reported the condition immediately. (*Respondent's Post-Hearing Brief* at 29). Stalnaker was a foreman and regularly conducted examinations. Respondent provided no legal support for its argument that one examiner filling in for another should be held to a lower standard. Regardless of Stalnaker's lack of familiarity with the area, he still should have recognized a massive water accumulation as a hazard. Further, although Stalnaker may have immediately orally reported the condition to Price and Giavonelli, he never reported the condition in the one way required by the cited standard: he never placed the condition in the book. Therefore, this is not mitigation.

Respondent next argues that the time given to complete the examination had not run when Young wrote the order. (*Respondent's Post-Hearing Brief* at 29). Presumably, Respondent means that the examination could still be completed and all the hazards listed before the time period had run. However, at the time the citation was issued, Giavonelli had already signed the record book, that noted no hazards. (Tr. 84-87, 99, 671, 677). Respondent unpersuasively argues that Giavonelli only signed the exam record to indicate that he had read it and recognized that the exam was not completed. (*Respondent's Post-Hearing Brief* at 29). It also notes that Giavonelli was not required to correct any problems when countersigning the book. (*Id.*). This argument is misplaced, as Respondent, as well as Giavonelli, apparently misunderstand the importance of signing the record book. In pertinent part, the standard states:

At the completion of any shift during which a portion of a weekly examination is conducted, a record of the *results* of each weekly examination, including a record of hazardous conditions and violations of the nine mandatory health or safety standards found during each examination and their locations...shall be made...The record shall be countersigned by the mine foreman or equivalent mine official by the end of the mine foreman's or equivalent mine official's next regularly scheduled working shift.

30 C.F.R. §75.364(h)(emphasis added). Inspector Young clearly explained that when a foreman signs a book listing no hazards, he indicates that there are no problems. (Tr. 141-142). Put simply, Giavonelli signing the record indicated that that the examination was complete. It did not indicate that he was reading an incomplete report. A miner looking at the record could only assume that the examination was complete and no hazard was found. Further, whether or not Giavonelli was required to correct errors made in a record book when countersigning, he still should not have signed a record he knew to be incomplete and inaccurate. Nothing about the record book or the countersigning of the record book mitigates the negligence here. In fact, by creating a false impression about the area, the countersigned record book exacerbated the problem.

Additionally, Respondent argues that the failure to adequately examine the area was mitigated by the fact that Respondent had started to pump in the area. (*Respondent's Post-Hearing Brief* at 29). This is completely irrelevant to the issue. The dangers associated with an inadequate examination are not completely eliminated by correcting the underlying condition. Even if Respondent had acted entirely properly with respect to the underlying condition (and, as noted in the discussion regarding Citation No. 7204068, it did not), that does not change the fact that the hazard should have been recorded. Miners and MSHA need to be aware of the exact nature and extent of the conditions in the area. Also, management needed to be aware and remember that their efforts to control water in the area were inadequate.

Finally, Respondent noted that the area was controlled access and that only management would enter the area. (*Respondent's Post-Hearing Brief* at 29).<sup>32</sup> As is clearly demonstrated by the fact that both Saunders and Stalnaker attempted to walk through the water, management can be exposed to hazards. While fewer people entered this area than perhaps other areas of the mine, this is reflected in the finding that only two persons are affected. It in no way affects Respondent's negligence.

As none of the actions presented by Respondent constituted mitigating circumstances, the "High Negligence" designation is appropriate.

The facts and the arguments of the parties regarding the unwarrantable failure designation in Order No. 7204069 are identical to those in Citation No. 7204068. (*See Respondent's Post-Hearing Brief* at 36-46). Therefore, the findings regarding unwarrantable failure in Citation No. 7204068 are incorporated here by reference. I find the preponderance of the evidence shows that this violation as an unwarrantable failure to comply on the part of Respondent.

## **APPROPRIATE CIVIL PENALTY**

The principles governing the authority of the Commission's administrative law judges to assess civil penalties de novo for violations of the Mine Act are well established. Section 110(i) of the Mine Act delegates to the Commission and its judges the authority to assess all civil penalties provide in the Act. 30 U.S.C. 820(i). The Act delegates the duty of proposing penalties to the Secretary. 30 U.S.C. §§ 815(a), 820(a). Thus, when an operator notifies the

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<sup>32</sup> Certainly Respondent does not mean to imply that the safety of management personnel is less important than the safety of its rank and file miners.

Secretary that it intends to challenge a penalty, the Secretary petitions the Commission to assess the penalty. 29 C.F.R. §2700.28. The Act requires that in assessing civil monetary penalties, the Commission and its judges shall consider the six statutory penalty criteria:

[1] the operator's history of previous violations, [2] the appropriateness of such penalty to the size of the business of the operator charged, [3] whether the operator was negligent, [4] the effect on the operator's ability to continue in business, [5] the gravity of the violation, and [6] the demonstrated good faith of the person charged in attempting to achieve rapid compliance after notification of a violation

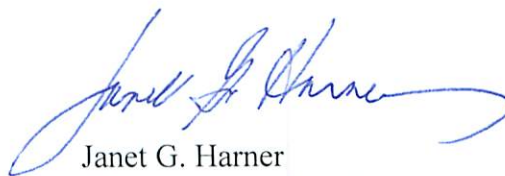
30 U.S.C. § 820(i)

The Secretary seeks civil penalties in the amounts of \$14,373.00 for Citation No. 7024068 and \$14,743.00 for Order No. 7024069. Given all of the evidence and my findings above, I find that these penalties are appropriate

In assessing a \$29,116.00 penalty, I have given full consideration to the Section 110(i) criteria. Specifically, I note that Respondent had a history of water accumulations in this particular bleeder and received several citations for that condition. Respondent is a large operator and the Enlow Fork is a very large mine and therefore the penalty is appropriate to the size of the business. The parties stipulated that this penalty amount would not affect Respondent's ability to stay in business. As noted above, with respect to both citations Respondent's actions constituted high negligence and an unwarrantable failure to comply. Further, the dangers cited with respect to each violation were highly likely to result in fatal injuries to two miners. Finally, although I find Respondent's actions were insufficient to constitute mitigation, I considered Respondent's efforts in abating the condition once the Citation and Order were issued.

### ORDER

It is **ORDERED** that Citation No. 7024068 and Order No. 7024069 are **AFFIRMED**. It is further **ORDERED** that Consol Pennsylvania Coal Company, LLC, **PAY** the Secretary of Labor the sum of \$29,116.00 within 30 days of the date of this Decision.<sup>33</sup> Upon receipt of payment, this case is hereby **DISMISSED**.



Janet G. Harner  
Administrative Law Judge

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<sup>33</sup> 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

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