FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

OFFICE OF ADMINISTRATIVE LAW JUDGES
1331 PENNSYLVANIA AVE., N.W., SUITE 520N
WASHINGTON, DC 20004-1710
TELEPHONE: 202-434-9958 / FAX: 202-434-9949

September 8, 2016

SECRETARY OF LABOR MINE SAFETY AND HEALTH ADMINISTRATION (MSHA), Petitioner	CIVIL PENALTY PROCEEDING Docket No. KENT 2012-0166 A.C. No. 15-17497-269552-01
v.	
LEECO INCORPORATED, Respondent	Mine: No. 68

DECISION AND ORDER ON REMAND

Appearances: Latasha T. Thomas, Esq., Office of the Solicitor, U.S. Dept. of Labor, Nashville, Tennessee for Petitioner

Melanie J. Kilpatrick, Esq., Rajkovich, Williams, Kilpatrick & True, PLLC, Lexington, Kentucky for Respondent

Before: Judge McCarthy

I. Statement of the Case on Remand

The Mine Act is built around Congress's fundamental declaration that "the first priority and concern of all in the coal or other mining industry must be the health and safety of its most precious resource – the miner." 30 U.S.C. § 801(a); *see Int'l Union, United Mine Workers of Am. v. MSHA*, 823 F.2d 608, 617 (D.C. Cir. 1987). Consequently, it is critical to construe the Mine Act in a manner that promotes miner safety.

In this case, continuous miner operator Bobby Smith was killed on June 24, 2010 when he stepped into the "red zone" and was pinned against the rib just two months after he was counseled by the mine superintendent for operating the continuous miner machine in the "outer area [range] of the red zone." Tr. 79-80. After holding a hearing on the issue of negligence, because settlement was stymied by a pending wrongful death suit, the undersigned affirmed the MSHA inspector's determination that the Respondent had displayed moderate negligence by failing to meet "the standard of care that a reasonably prudent operator, with knowledge of the goals of the Mine Act, would have undertaken in the same or similar circumstances to ensure against any recidivism by Smith" after the first red zone incident. *Leeco, Inc.*, 36 FMSHRC 1866, 1872 (July 2014) (ALJ). In what has been described by the dissenting Commissioner as "dangerous precedent" (see *Leeco, Inc.*, 38 FMSHRC ___, No. KENT 2012-0166, slip op. at 8 (July 18, 2016) (Comm'r Cohen, dissenting)), a Commission majority reversed my factual

finding and credibility resolution that it was likely that Smith would revisit the red zone again, and found that the Secretary failed to adduce substantial evidence in the record that Leeco was negligent in any way.[1]

> Without evidence that a reasonably prudent operator would have done more in the circumstances, it was error for the Judge to conclude that Leeco's response to Smith's previous incident was insufficient. Because the Secretary did not explain what a reasonably prudent operator would have done under these circumstances, we cannot find the operator to be negligent.

Leeco, Inc., 38 FMSHRC ___, No. KENT 2012-0166, slip op. at 6 (July 18, 2016).

The Commission recognized, as did I, that there were shortcomings in the Secretary's attempt to show what the operator "should have done" to meet its standard of care. Because the Secretary did not spell out the specific measures the operator should have taken to prevent Smith from approaching the red zone again, the Commission majority faults my reliance on such measures to establish that the operator should have exercised greater care under the roof control plan. What the Commission may not have recognized, given the paucity of the evidentiary record, is that I looked to the public record, to "best practice" measures promulgated by the Secretary to Leeco, the mining industry, and the public, to spell out the specific measures that Leeco should have taken to prevent Smith from approaching the red zone again.

The majority suggests that I must have pulled these measures from the Action Plan, and frolics into a discussion of subsequent remedial measures. As shown below, however, my analysis was informed by the Secretary's pre-existing and regularly published best practices for avoiding red zone accidents as set forth by MSHA in Fatalgrams, which have been issued to Leeco, the mining community, and the public for many years prior to June 24, 2010.[2] Had I

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[1] Credibility determinations reside in the province of the administrative law judge's discretion, are subject to review only for abuse of that discretion, and cannot be overturned lightly. *Dynamic Energy, Inc.*, 32 FMSHRC 1168, 1174 (Sept. 2010) (citing *Buck Creek Coal Co.*, 52 F.3d 133, 135 (7th Cir. 1995)). An administrative law judge's credibility findings can be very significant and affect whether the record supports an agency's contrary decision on administrative appeal. *See Universal Camera Corp. v. NLRB*, 340 U.S. 474, 496 (1951) (considering findings by an ALJ). Furthermore, the Commission has recently reiterated the "well established" principle that "it is not within our power to reweigh the evidence or to enter *de novo* findings of fact based on independent evaluation of the record." *See Knox Creek Coal Corp.*, 38 FMSHRC ___, No. VA 2014-343-D, slip op. at 11 n.13 (Aug. 23, 2016) (citing *Island Creek Coal Co.*, 15 FMSHRC 339, 347 (Mar. 1993)); *see also Wellmore Coal Corp. v. Fed. Mine Safety & Health Review Comm'n*, No. 97-1280, 1997 WL 794132, at *3 (4th Cir. 1997).

[2] Fatalgrams are notices published by MSHA to alert operators, the mining industry and the public to tragic losses of life in the mines and to prevent recurrences in the future by outlining best practices that all in the industry should follow. MSHA, *Preliminary Accident Reports, Fatalgrams and Fatal Investigation Reports*, http://arlweb.msha.gov/fatals/ (last visited Sept. 1, 2016). Leeco is familiar with Fatalgrams. Leeco's witnesses acknowledged that before

failed to consider these best practices in determining the appropriate standard of care, I would have been feigning ignorance of the Fatalgrams and closing my eyes to the fact that red zone accidents have been a focus of MSHA's prevention efforts because the accidents are a leading and recurring cause of serious injury and death. In consideration of MSHA's best practices as set forth in Fatalgrams, I found the following:

> In short, Respondent failed to take sufficient steps to ensure that mining machine operators, including Smith, were outside the machine's turning radius before starting or moving the equipment, or to ensure that they were in a safe location while tramming the continuous miner from place to place, or repositioning the miner in the entry during cutting and loading. Although Respondent generally trained production crews and management to understand the hazards associated with avoiding red zones, there is no evidence that Respondent established any specific programs, policies, and procedures for avoiding red zone areas.[3] There is also no evidence that

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the fatality occurred, MSHA had sent the company Fatalgrams pertaining to other red zone accidents, and management officials had discussed these Fatalgrams in safety meetings. Tr. 75-76, 90-91.

[3] MSHA has repeatedly recommended that mine operators establish specific procedures for avoiding red zone injuries when tramming mobile equipment. For example, in a 2003 Fatalgram issued after a continuous miner operator was fatally pinned to the rib, MSHA suggested the following best practice: "Ensure that a Standard Operating Procedure (SOP) is in place before tramming the remote controlled continuous miner to another entry or crosscut." MSHA, *Fatalgrams and Fatal Reports*, *Fatality #27 – October 22, 2003*, http://arlweb.msha.gov/FATALS/2003/fab03c27.pdf. In 2004, after another red zone crushing fatality, MSHA reiterated: "Develop a Standard Operating Procedure (SOP) for tramming remote-controlled continuous mining machines. Train the production crew in the SOP and ensure that it is followed." *Fatality #7 – April 3, 2004*, http://arlweb.msha.gov/FATALS/2004/fab04c07.pdf. See also *Fatality #23 – October 16, 2008*, http://arlweb.msha.gov/FATALS/2008/fab08c23.pdf ("Develop proactive programs, policies, and procedures for starting and tramming remote-controlled continuous mining machines. Train all production crews and management in the programs, policies, and procedures and ensure that they are followed."), *Fatality #9 – May 18, 2004*, http://arlweb.msha.gov/FATALS/2004/fab04c09.pdf ("Establish safe operating procedures for remote control continuous mining machine operations, including tramming and cable handling."), *Fatality #3 – February 1, 2004*, http://arlweb.msha.gov/FATALS/2004/fab04m03.pdf ("Establish procedures and follow them, especially when employees tram a remote controlled continuous miner."), and *Fatality #18 – August 12, 2002*, http://arlweb.msha.gov/FATALS/2002/FAB02c18.HTM ("Establish procedures for moving machinery and equipment.").

As inspector Ashworth testified, the history of coal mining has shown red zone injuries to be "a frequent type accident" that "deserves a little more attention," i.e., this is one of the high-risk areas that mine operators should specifically address when developing safety policies and training programs. Tr. 39-40, 59. As a member of the coal mining industry, Leeco should have been aware of this before Smith died, especially since MSHA had recently called attention to red zone hazards as part of its Safety Targets initiative launched in 2008. *See* U.S. Dep't of

Respondent routinely monitored work habits to ensure that operators were avoiding red zones.[4] No engineering controls were in place to prevent this type of fatality.[5] Nor did Respondent assign another miner or buddy to

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Labor, Office of Public Affairs, *News Release: MSHA announces major initiative to bolster mine safety* (Oct. 16, 2008), http://arlweb.msha.gov/Media/PRESS/2008/NR081016.pdf (noting start of new "Safety Targets Training Program" to address common causes of fatalities); MSHA, *MSHA's Safety Targets Program: Safe Operation and Maintenance of Continuous Miners*, http://arlweb.msha.gov/Safety_Targets/Continuous%20Miner%20Package/RCCM.asp (last visited Sept. 1, 2016) (addressing red zone hazards). Yet there is no evidence that the Respondent implemented policies specifically addressing this common, serious hazard until after the fatality occurred.

[4] MSHA has repeatedly made the common-sense suggestion that mine operators should monitor workers to ensure that training programs have been effective and that proper procedures are being followed to avoid red zone accidents. For example, in the "best practices" section of a Fatalgram issued after a red zone crushing death in 2000, MSHA noted that training for safe operation of equipment includes "observation of all tasks required to be performed" and that "[p]roper follow up is required to assure the training is understood and implemented." *Fatality #12 – May 12, 2000*, http://arlweb.msha.gov/FATALS/2000/FAB00C12.HTM. As another example, in 2008, after yet another fatal red zone accident, MSHA recommended: "Frequently review, retrain, and discuss avoiding the 'RED ZONE' areas when operating or working near a remote controlled continuous mining machine. Follow established safe work practices and provide periodic training along with checks to ensure that the safe work practices have been properly implemented." *Fatality #7 – April 18, 2008*, http://arlweb.msha.gov/FATALS/2008/fab08c07.pdf. In the instant case, as the Commission acknowledges, a section foreman was aware that Smith had approached the red zone on a prior occasion while tramming the continuous miner and was told to "keep an eye out" for this behavior, yet he admitted that he had not, in fact, watched Smith tram the machine very often. Tr. 79-82, 111-12.

[5] Another best practice MSHA recommended after an April 2008 red zone fatality was to "[p]ursue new technology such as proximity detection to protect personnel and eliminate accidents of this type." *Fatality #7 – April 8, 2008*, http://arlweb.msha.gov/FATALS/2008/fab08c07.pdf. Several months later, after another crushing fatality, MSHA reiterated, "Install and maintain electronic proximity detection devices. **See the proximity detection single source page on the MSHA website**." *Fatality #23 – October 16, 2008*, http://arlweb.msha.gov/FATALS/2008/fab08c23.pdf (emphasis in original). MSHA had tested proximity detection technology at certain mines between 2002 and 2006 and launched a "Remote Control Continuous Mining Machine Special Initiative" to inform operators and miners of red zone hazards in 2004, but crushing accidents continued to occur. *See* MSHA, *Request for Information: Proximity Detection Systems for Underground Mines*, 75 Fed. Reg. 5009, 5009-10 (Feb. 1, 2010). As a result, six months before the occurrence of the fatality at issue in the instant case, MSHA publicly concluded that "a safety program based on sound risk management principles should include proximity detection systems, or some other engineering control that addresses the hazard at the source" of the red zone crushing fatalities, and solicited input from interested parties regarding potential regulatory action. *Id.* at 5010. Ultimately, MSHA did promulgate a regulation requiring proximity detection systems on continuous mining machines,

> assist Smith or other continuous miner operators when the miner was being moved or repositioned.[6] In these circumstances, Respondent failed to follow many of the best practices promulgated by MSHA. Accordingly, the citation was appropriately written with moderate negligence.

Leeco, Inc., 36 FMSHRC 1866, 1872 (July 2014) (ALJ) (footnotes added).

The footnotes above identify the Fatalgram principles that I relied on to pinpoint the sources of my knowledge of red zone hazards. I could have, and perhaps should have, expressly taken notice of the Fatalgrams and other MSHA public documents in my original decision under Commission precedent. *See Brody Mining, LLC*, 36 FMSHRC 2027, 2030 n.4 (Aug. 2014); *Sec'y of Labor on behalf of Acton v. Jim Walter Res., Inc.*, 7 FMSHRC 1348, 1355 n.7 (Sept. 1985). I could have, and perhaps should have, also taken notice pursuant to the broad doctrine of official notice under the Administrative Procedure Act. 5 U.S.C. § 556(e) (applicable to Commission proceedings under Commission Procedural Rule 1(b), 29 C.F.R. § 2700.1(b)); *see Sykes v. Apfel*, 228 F.3d 259, 272 (3d Cir. 2000) (noting that APA provision is broader than judicial notice provision at Federal Rule of Evidence 201, in that APA provision permits notice of "technical or scientific facts that are within the agency's area of expertise").

Even without such explicit notice, however, it was apparent to me, based on specialized knowledge acquired from the specified Fatalgram best practices, that a reasonably prudent person who was familiar with the history of red zone accidents in the underground coal mining industry and the guidance and recommendations that MSHA has produced on this subject, and who was also familiar with the fact that Smith was counseled after approaching the red zone just two months earlier, would conclude that additional measures could have and should have been taken by Leeco to prevent Smith from approaching the red zone again. Indeed, the Supreme Court has taken a permissive stance toward allowing administrative agencies to make decisions based on facts within their "special knowledge," even if these facts are not part of the formal record. *See, e.g., City of Erie v. Pap's A.M.*, 529 U.S. 277, 298 (2000) (noting that an administrative agency "is not confined to the evidence in the record in reaching its expert judgment"); *Republic Aviation Corp. v. NLRB*, 324 U.S. 793, 800 (1945) (rejecting argument that administrative tribunal had impermissibly "substitute[d] its knowledge of industrial relations for substantive evidence"). *See also American Coal Co.*, 38 FMSHRC __, No. LAKE 2011-13, slip op. at 7 (Aug. 25, 2016) (citing 30 U.S.C. § 823(a) and *Thunder Basin Coal Co. v. Reich*,

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although the process took several years and the regulation became effective too late to have any impact on the events of this case. *See* MSHA, *Final Rule: Proximity Detection Systems for Continuous Mining Machines in Underground Coal Mines*, 80 Fed. Reg. 2188 (Jan. 15, 2015) (codified at 30 C.F.R. § 75.1732). However, it is very likely that long before the regulation was finalized, and before Smith died, coal industry players including the Respondent would have been well aware of MSHA's public push to promote proximity detection or similar engineering controls to prevent red zone crushing accidents.

[6] It is common knowledge that a "miner helper" is sometimes assigned to aid a relatively inexperienced continuous miner operator with tasks such as pulling cable and moving the machine.

510 U.S. 200, 214 (1994), to emphasize the "Commission's expertise" in construing the Mine Act).

In my view, a Commission administrative law judge should be permitted to rely on the type of specialized knowledge set forth by MSHA in Fatalgrams promulgating best practices in red zone cases. Those best practices, which were summarized in my initial decision in this case, were not based on the Action Plan or subsequent remedial measures. They arise from MSHA's pre-existing and widely publicized best practices in red zone Fatalgram cases, which the Commission has discounted because of insufficient evidence of record put on by the Secretary.

In sum, despite the ample public information regarding what Leeco could have done – and, in my view, should have done – to prevent Smith's recidivism and death, I accept the Commission majority's decision that Leeco was in no way negligent as the law of the case. Accordingly, as directed on remand, I determine the appropriate penalty based on the Commission majority's finding that Respondent was in no way negligent on this record when Smith was killed after again visiting the red zone just two months after being counseled not to do so.

II. Penalty Assessment Principles

The Act requires that the Commission consider the following statutory criteria when assessing a civil penalty: (1) the operator's history of previous violations; (2) the appropriateness of the penalty to the size of the business; (3) the operator's negligence; (4) the operator's ability to stay in business; (5) the gravity of the violation; and (6) any good-faith compliance after notice of the violation. *Douglas R. Rushford Trucking*, 22 FMSHRC 598, 600 (May 2000); 30 U.S.C. § 820(i). The Commission is not required to give equal weight to each of the criteria, but must provide an explanation for any substantial divergence from the proposed penalty based on such criteria. *Spartan Mining Co.*, 30 FMSHRC 699, 723 (Aug. 2008).

As I discussed in my final *Big Ridge* decision, in an effort to avoid the appearance of arbitrariness, I look to the Secretary's penalty regulations and assessment formula as a reference point that provides useful guidance when assessing a civil penalty. *Big Ridge Inc.*, 36 FMSHRC 1677, 1681-82 (July 2014) (ALJ); *see also Wade Sand & Gravel*, 37 FMSHRC 1874, 1880 n.1 (Chairman Jordan and Commissioner Nakamura, concurring); *Bowles v. Seminole Rock & Sand Co.*, 325 U.S. 410, 414 (1945) (holding that an agency's interpretation of its own regulation should be given controlling weight unless it is plainly erroneous or inconsistent with the regulation). This formula is not binding, but operates as a lodestar, since factors involved in a violation, such as the level of negligence, may fall on a continuum rather than fit neatly into one of five gradations. Unique aggravating or mitigating circumstances will be taken into account and may call for higher or lower penalties that diverge from this paradigm. My independent and de novo penalty assessment of the citation in this case is explained below.

The Secretary proposed a penalty of $21,442 for the violation after considering the six statutory penalty criteria under the penalty formula set forth in 30 C.F.R. Part 100. The parties stipulated to the fact of the violation under 30 C.F.R. § 75.220(a)(1) and to the fact that the violation was significant and substantial ("S&S"), that one miner was fatally injured, and that Respondent abated the citation in good faith and in a timely manner. Tr. 8; Sec'y's Br. 2;

Resp't's Br. 1. Accordingly, I find that the gravity of the violation is serious. Because the Secretary failed to explain what a reasonably prudent operator would have done under the circumstances, the Commission majority stated that it "cannot find the operator to be negligent." *Leeco, Inc.*, 38 FMSHRC __, slip op.at 6 (July 18, 2016). Exhibit A to the Secretary's penalty petition shows Leeco's size and violation history, and Leeco has not challenged the Secretary's findings in this regard. Ex. S-5 (MSHA's Assessed Violation History Report). The parties have also stipulated that the proposed penalty will not affect Leeco's ability to remain in business. Tr. 8.

Based on the legal principles outlined above, after considering the six statutory penalty criteria under section 110(i) of the Act, I assess a civil penalty of $4,500 for Respondent's violation of 30 C.F.R. § 75.220(a)(1).

III. Order

It is **ORDERED** that Citation No. 8359591 is **AFFIRMED, AS MODIFIED** by the Commission, with a finding of no negligence attributable to Respondent Leeco. It is further **ORDERED** that Respondent pay a civil penalty of $4,500 within thirty days of this Order.

Thomas P. McCarthy
Administrative Law Judge

Distribution:

Melanie J. Kilpatrick, Esq., Rajkovich, Williams, Kilpatrick & True, PLLC, 3151 Beaumont Centre Circle, Ste. 375, Lexington, KY 40513

Latasha T. Thomas, Esq., Office of the Solicitor, U.S. Dept. Of Labor, 211 7th Ave. North, Ste. 420, Nashville, TN 37219