FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

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May 15, 2014

SECRETARY OF LABOR, MINE SAFETY AND HEALTH ADMINISTRATION (MSHA), Petitioner	CIVIL PENALTY PROCEEDINGS Docket No. KENT 2011-1354 A.C. No. 15-16734-259098 Docket No. KENT 2011-1385 A.C. No. 15-16734-260061-01
v.	Docket No. KENT 2011-1386 A.C. No. 15-16734-260061-02
CLINTWOOD ELKHORN MINING COMPANY, INC., Respondent	Mine: Clintwood Elkhorn II

AMENDED DECISION

Appearances: Willow Fort, Esq., U.S. Department of Labor, Nashville, Tennessee, for Petitioner

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

Before: Judge Rae

These cases are before me upon petitions for assessment of a civil penalty under section 105(d) of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 815(d). The Secretary's petitions allege that Clintwood Elkhorn Mining Company, Inc. ("Clintwood") is liable for a total of five violations; three violations of the Secretary's mandatory safety standards for surface coal mines and surface work areas of underground coal mines, two violations of "notification . . . of accidents, injuries . . . in mines." 30 C.F.R. §§ 50, 77. They propose the imposition of penalties totaling $168,600.00. The parties presented testimony and documentary evidence at a hearing in Pikeville, Kentucky. Post-hearing briefs were submitted by both parties.

After consideration of evidence on the record and post-hearing briefs submitted by the parties, I find that the Secretary has proven a violation of MSHA standards as alleged in two of the citations. I impose civil penalties in the total amount of $29,600.00 for the violations.

The parties submitted the following stipulations: 1) This proceeding is subject to the jurisdiction of the Federal Mine Safety and Health Review Commission and its designated Administrative Law Judges pursuant to sections 105 and 113 of the Mine Act; 2) Todd Belcher and Nathan Mounts, whose signatures appear in Citation Nos. 8247826 and 8247827, were citing in the official capacity as MSHA employees and authorized representatives of the Secretary of Labor when the citations were issued; 3) True copies of the citations were served on Respondent as required by the Mine Act; 4) The total proposed penalties in this case will not affect Respondent's ability to remain in business; 5) The alleged violations were abated in good faith. Ex. J-1.

Findings of Fact and Conclusions of Law

The Clintwood Elkhorn II mine is a surface coal preparation plant located in Pike County, Kentucky. Tr. 22. The plant contains a series of belts used to transport coal from the deep mine and to stockpiles outside of the plant. Tr. 34, 235. The coal inside the plant is washed and cleaned to remove rock and clay. Tr. 36, 235. The coal is then transferred to one of six clean coal stocker areas depending on its blend. Tr. 34-35, 235, 270. A stocker is a large concrete cone that holds coal. Tr. 269-70. Flop gates, located inside the plant, are used to direct the coal into the stockpiles. Tr.II 18.[1]

On January 18, 2011, MSHA Headquarters in Arlington received a call from a member of the news media who had heard the ambulance dispatch, asking for information on an accident at the Clintwood Elkhorn II Mine. Tr. 125. MSHA Headquarters, not having heard about an accident, called the district office, which also did not have a report of an accident at the mine. Tr. 125. MSHA Inspector Nathan Mounts[2] was instructed to visit the mine the same day and arrived around 1:00 p.m. Tr. 125. MSHA Inspector Todd Belcher[3] arrived at the mine on January 19, 2011 to conduct an accident investigation. Tr. 78.

The details of how the accident happened are largely undisputed. Between 4:30 a.m. and 5:00 a.m. on January 18, 2011, Christopher Bowling, a miner, was standing on an elevated metal

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[1] The use of "Tr." refers to the hearing transcript for December 10, 2013. The use of "Tr.II" refers to the hearing transcript for December 11, 2013.

[2] Nathan Mounts is a health inspector for MSHA. Tr. 13-14. His duties include observing and evaluating respirable dust parameters as well as evaluating noise and health related issues to dust and noise. Tr. 14. At the time that he issued the two citations below, Mounts had been a general inspector for about 3 years. Tr. 15-16. Prior to joining MSHA, he was an underground coal miner, foreman, and equipment operator for Massey Energy for 12 years. Tr. 16.

[3] Todd Belcher has been a ground control surface specialist for MSHA since 2007. Tr. 73-74, 75. His duties include reviewing and sending ground control plans for acknowledgement, inspections as needed, and accident investigations. Tr. 74. Belcher received accident investigation training in 2009 and assisted in investigations prior to that. Tr. 75. Since the training, he has participated in 12 to 15 accident investigations, leading all but one or two. Tr. 77-78. Prior to joining MSHA, Belcher worked at Cam Mining for over a year and was an inspector for the Kentucky Department of Surface Mining for 14 of his 21 years there. Tr. 94-95.

platform, located between the second and third floors of the plant, trying to manually switch the flop gate to the old syn-fuel stacker 6 when he fell from it. Tr. 25, 30-33, 86-87, 251, 353; Ex. S-4 at 3, S-6 at 2, 5. The platform was accessed by going down steps from the third floor and climbing through handrails and was elevated almost 22 feet above the mine floor. Tr. 85, 353. Bowling stated that he had no memory of the fall but believed his hands slipped on the lever operating the flop gate and he fell backwards. Ex. S-5 at 9. No one witnessed the fall but several employees responded shortly thereafter. He had been taken away by ambulance by the time MSHA investigators arrived at the scene.

As a result of Mounts' inspection and Belcher's investigation, the five citations discussed below were issued.

KENT 2011-1354

Citation No. 8247826

Citation No. 8247826 was issued by Mounts on January 18, 2011 at 1:14 p.m., pursuant to section 104(d)(1) of the Act.[4] It alleges a violation of 30 C.F.R. § 77.204[5] which states, "[o]penings in surface installations through which men or material may fall shall be protected by railings, barriers, covers or other protective devices." The violation was described in the citation as follows:[6]

> On Tuesday, January 18, 2011, a serious fall type accident occurred at the Clintwood Elkhorn Mining Company preparation plant.
>
> A plant employee, who was located at the flop gate for the belt conveyor leading to the syn-fuel storage area, fell to the concrete floor located approximately 20 feet below, receiving multiple injuries as a result.
>
> As a result of the accident investigation and based on additional information obtained from witness interviews and an on-site inspection of the area, this violation is being modified to reflect changes that describe the condition or practice being cited.

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[4] This citation was originally issued as a 104(a) citation but was modified to a 104(d)(1) citation by Belcher after further evaluation and gathering of evidence. Ex. S-2 at 2. Mounts was not consulted about this change. Tr. 60-61.

[5] The alleged violated section was amended from 77.205(e) to 77.204 in an Order Granting Secretary's Motion to Amend issued on February 12, 2013. Mounts was not consulted about the modification to the cited section. Tr. 60-61.

[6] Grammatical errors in the descriptions from the "Condition or Practice" sections of the citations and orders have been corrected, and subsequent modifications to the citations and orders have been included.

> The accident investigation revealed that handrails were not provided on the landing between the second and third floors at the flop gate for the belt going to the old syn-fuel storage area. This area is approximately 20 feet above the concrete floor and metal conveyor belt cover below. As a result, at 0430 hours, a serious accident occurred resulting in an employee seeking medical attention due to the fall.
>
> This is an unwarrantable failure to comply with a mandatory standard.

Ex. S-2 at 2.

Mounts determined that an injury occurred as a result of the violation and was reasonably expected to result in lost workdays or restricted duty, that the violation was significant and substantial ("S&S"), that one person was affected, that the level of negligence was high, and that the violation was the result of an unwarrantable failure to comply with a mandatory standard. Ex. S-2 at 1, 2. The Secretary proposed a penalty of $70,000.00.

The Violation

Secretary's Evidence

When Mounts arrived at the mine, he was met by foremen Robert Hinkle and Jim East and taken to the accident scene. Tr. 28. Before arriving at the area where the accident occurred, Hinkle and East informed Mounts that handrails had been installed on the platform. Tr. 28; Ex. S-4 at 3, S-6 at 4, 5. The handrails were installed around the platform from which Bowling fell. Tr. 32; Ex. S-4 at 3, S-6 at 4, 5. Based on this information, Mounts issued Respondent a citation for not having handrails prior to the accident. Tr. 28, 32-33.

The Secretary's initial theory of the case was that this elevated platform required handrails around it under section 77.205(e), which states "[c]rossovers, elevated walkways . . . shall be . . . provided with handrails . . . ." Just prior to hearing, the Secretary sought and was granted leave to amend the standard to section 77.204, which states that "[o]penings in surface installations through which men or material may fall shall be protected by railings, barriers, covers or other protective devices." The later theory being that the space between the edge of a platform and an adjacent wall could be considered an "opening" under the standard.

Mounts believed the work platform was hazardous because there was no barrier to protect miners from falling off of it. Tr. 33, 40. He stated that Hinkle and East informed him that Bowling was on the platform, attempting to manually flop the gate, because the mechanical switch was broken. Tr. 33-34, 36. When questioned about the "opening" between the edge of the platform and the wall, Mounts confirmed that he interpreted it to mean that openings do not need to have handrails if it can be covered by other protective devices that are deemed safe. Tr. 61-62.

Belcher believed the area between the edge of the platform and the wall was a hazard because there were no handrails or cover present and it was big enough for a person to fall

through. He posited that pushing or pulling a lever to switch the flop gate could cause a miner to slip and lose his balance, which likely happened to Bowling. Tr. 105, 106-07.

Respondent's Evidence

Superintendent Sullivan[7] confirmed during his testimony that prior to this accident, handrails were not present on the platform. Tr. 254. He believed that handrails were not required if a safety device was worn and considered fall protection a protective device that satisfied the requirements of section 77.204. Tr. 254, 295. Sullivan stated that a miner wearing fall protection would tie off on round metal eyes attached to the chute in the plant. Tr. 254.

Analysis

Respondent argues that the Secretary is trying to avoid the issue that handrails are not required by part 77 by changing the cited standard and claiming that the edge of the platform is an opening. Resp. Br. at 7. Mounts clearly believed that the regulations called for handrails around the elevated platform and the Secretary amended the citation in an attempt to salvage it. What the Secretary refers to as an opening is really the edge of a platform that happens to have a wall nearby. There were other platforms in the plant that were similarly situated for which citations were never issued. Tr. 258-59. Belcher also focused on the fact that there were no handrails present on the platform. Ex. S-5 at 13. While Respondent believed that it was a hazard to not have handrails on the platform and it installed them, there is unfortunately no requirement in part 77 for elevated work platforms to have handrails.[8] In addition, the presence of handrails, even though used to abate the citation, would not have prevented small objects from falling off the platform because there was large gap between the platform and the first railing Ex. S-6 at 5; Resp. Br. at 9 n.10. This further evidences the fact that neither Belcher nor Mounts were concerned about or considered the area between the edge of the platform and the nearby wall to be an "opening" as set for in section 77.204 at the time that the citation was originally issued. It is further noted that the Secretary failed to prove that the miner fell through this alleged opening. Bowling stated that he believed he fell backwards, which would mean he fell off the long edge of the platform behind the flop gate. Ex. S-5 at 9. No one witnessed his fall.

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[7] Homer Sullivan has been the plant superintendent for the past 6 years. Tr. 234. He has a duty to oversee the production of coal and the safety of all employees. Tr. 235. Prior to becoming superintendent, Sullivan was a plant foreman for 7 years. Tr. 236. He is also a certified mine emergency technician (MET). Tr. 236.

[8] As being familiar with the mining industry and from previous ALJ decisions, MSHA has been put on sufficient notice that it should clarify what an opening is and promulgate regulations to require handrails on elevated working platforms. *Sunbeam Coal Corp.*, 2 FMSHRC 192, 221 (Jan. 1980) (ALJ) ("[I]f MSHA desires to provide barriers and other protective devices to prevent personnel from falling off an elevated platform [also used as a work station], it should promulgate a precise standard to cover that situation."). As it stands now, travelways and work platforms are distinguished from elevated walkways in section 205(b) in that they must only be kept clear of extraneous materials and slipping hazards. 30 C.F.R. § 205(b).

Therefore, I find that the area between the edge of a platform and a nearby wall is not an opening as a matter of law and that Respondent did not violate the cited standard. Citation No. 8247826 is hereby VACATED.

Fair Notice Argument

Assuming, arguendo, that the space between the edge of the platform and the wall could be considered an opening, I find that Respondent did not have fair notice.

"[D]ue process considerations preclude the adoption of an agency's interpretation which 'fails to give fair warning of the conduct it prohibits or requires.'" *LaFarge North America*, 35 FMSHRC 3497, 3500 (Dec. 2013); *Gates & Fox Co. v. OSHRC*, 790 F.2d 154, 156 (D.C. Cir. 1986). "The Commission's test for notice under the Mine Act is 'whether a reasonably prudent person familiar with the mining industry and the protective purposes of the standard would have recognized the specific prohibition or requirement of the standard.'" *Wolf Run Mining Co.*, 32 FMSHRC 1669, 1682 (Dec. 2010). A number of factors are relevant to this determination, including "the text of a regulation, its placement in the overall regulatory scheme, its regulatory history, the consistency of the agency's enforcement, and whether MSHA has published notices informing the regulated community with ascertainable certainty of its interpretation of the standard in question." *Id.*

Sullivan testified that the platform was installed in 2006 and MSHA was made aware of this because it gave a courtesy inspection. Tr. 255. MSHA did not tell Respondent that handrails or any other protective devices were needed. Tr. 255. Since 2006, two inspections per year have been done by MSHA, none of which resulted in the issuance of a citation, despite the fact that the platform is easily visible from the steps that lead to a new addition. Tr. 256-57, 258. In addition, there were several other platforms without handrails in the plant and citations were never issued for those areas either. Tr. 258-59. Sullivan stated that when he asked Silas Adkins, now the manager of the Elkhorn Office, why the plant had never been cited for the condition before, Adkins replied that it was not an issue until the accident happened. Tr. 260. I find this testimony by Sullivan to be credible.

Belcher confirmed that the plant is inspected in its entirety every 6 months. Tr. 172. He did not ask past inspectors whether they ever inspected the platform and just assumed that no one from MSHA ever saw the platform. Tr. 172-73. I find this statement to be improbable at best, particularly in light of Sullivan's testimony that the lack of handrails was not an issue until someone was injured.

What constitutes an opening and the devices that can be used to protect an opening are open to broad interpretation. MSHA has not published any notices informing the regulated community of its interpretation of the standard, it performed a courtesy inspection of the platform when it was installed, and it has performed about 12 full inspections of the plant over the course of 6 years and has never issued a citation under section 77.204. Just because an accident occurs does not mean that a condition never considered by MSHA to be a violation in the past, automatically becomes one for MSHA's convenience of imposing a penalty. Under these circumstances, I find that a reasonably prudent person familiar with the mining industry

and protective purposes of the standard would not have recognized the requirements of section 77.204 as being applicable to the area between the edge of a platform and a nearby wall. Therefore, I find that Respondent lacked fair notice.

Citation No. 8247827

Citation No. 8247827 was issued by Mounts on January 18, 2011 at 2:16 p.m., pursuant to section 104(a) of the Act. It alleges a violation of 30 C.F.R. § 77.1710(g) which states, "each employee . . . shall be required to wear protective clothing and devices as indicated below . . . [s]afety belts and lines where there is a danger of falling . . . ." The violation was described in the citation as follows:

> An accident occurred on 1/18/2011 due to an employee (Christopher Bowling) not wearing fall protection while working from an elevated platform. The employee fell approximately 20 feet onto the concrete floor and metal conveyor belt cover below. No handrails were in place to prevent a person from falling and Citation No. 8247826 was issued for this condition. The employee had to seek medical attention from injuries sustained from the fall.
>
> Standard 77.1710(g) was cited two times in the two years at mine 1516734 (0 to the operator, 2 to a contractor).

Ex. S-3 at 1.

Mounts determined that an injury occurred as a result of the violation and was reasonably expected to result in lost workdays or restricted duty, that the violation was S&S, that one person was affected, and that the level of negligence was high. Ex. S-3 at 1. The Secretary proposed a penalty of $31,000.00.

The Violation

Secretary's Evidence

Mounts stated that he issued this citation because East and Hinkle made statements that Bowling was not wearing fall protection when he was switching the flop gate on the platform and fell through an opening. Tr. 52. Mounts was of the opinion that even with handrails installed, fall protection needed to be worn. Tr. 53-54. In addition, Belcher testified that there were no warning signs to use fall protection posted in the area where Bowling fell. Tr. 224.

In *Southwestern Illinois*, the Commission approved the ALJ's interpretation of the language, "shall be required to wear" in section 77.1710(g) to mean that the operator must require each employee to wear safety belts when needed. *Southwestern Illinois Coal Corp.*, 5 FMSHRC 1672, 1674-75 (Oct. 1983). Specifically, the Commission stated,

> "[t]he regulation does not state that the operator must guarantee that belts and safety lines are actually worn, but rather says only that each employee shall be required to wear them. The plain meaning of "require" is to ask for, call for, or demand that something be done. . . . Accordingly, when an operator requires its employees to wear belts when needed, and enforces that requirement, it has discharged its obligation under the regulation."

Southwestern Illinois Coal Corp., 5 FMSHRC at 1675; see also *Southwestern Illinois Coal Corp.*, 7 FMSHRC 610 (1985) (hereinafter *SOCO II*).

The Secretary maintains that based on *Southwestern Illinois*, Respondent violated the standard, stating that the Commission found a violation even though its safety rules required miners to wear belts and miners were disciplined for not wearing belts, the operator failed to show that the guidelines were "sufficiently specific." Sec'y Br. at 26.

In *Southwestern Illinois*, the general director of safety and training testified that the decision to wear fall protection was largely up to the miner. This viewpoint was reiterated at oral argument where counsel stated that the use of a safety belt was optional. *Southwestern Illinois Coal Corp.*, 5 FMSHRC at 1676. There were no signs in the mine reminding employees to wear belts and no safety analysis or directives were issued to identify situations where belts should be worn. *Id.* The Commission found that the evidence fell short of "demonstrating due diligence in enforcement" and contrasted the case with that of *North American* where the operator had a specific program for avoiding hazards through prominent signs, verbal warnings and reinforcement of safety considerations. *Id.*; *North American Coal Corp.*, 3 IBMA 93 (1974).

Respondent's Evidence

Sullivan stated that the mine has annual refresher training once a year, which in 2011, was January 15, 3 days before the accident. Tr. 283; Ex. R-15. Bowling signed in for the training and Sullivan contended that, even though he did not attend the annual training, fall protection would have been covered under the accident prevention heading on the agenda. Tr. 284-85, 322, 355; Ex. R-15. Sullivan did however confirm that when he arrived at the scene after Bowling fell, it did not appear that Bowling was wearing fall protection. Tr. 313. Sullivan and Brian Hurley[9] also testified that safety meetings were held once a week with miners on all shifts, Bowling being one of them. Tr. 283, 358. Hurley stated that he covered fall protection at least once a month. Tr. 283, 357. Respondent presented a safety meeting agenda from September 2010 that included a fatality at another mine from failure to use fall protection. Tr. 287-88; Ex. R-2.

[9] Brian Hurley has been employed at the Clintwood Elkhorn II Mine for about 13.5 years. Tr. 333. He held the position as third shift foreman in January 2011. Tr. 333. Hurley had been a foreman for about 7 years at that time and a certified MET since 2001. Tr. 333, 334. Prior to joining Clintwood, he worked for two other coal mine companies as an equipment operator and mechanic. Tr. 336.

In addition, all employees received handbooks that address fall protection. Tr. 293. The handbook specifically states that if there is a 'potential' to fall from an unprotected work station, safety belts are required. Ex. R-14 at 8. Miners were also aware that they had to wear protection in any area without handrails and toe boards, and if using a ladder over 6 feet in height, according to Sullivan. Tr. 284.

Further, Bowling was issued his own personal safety belt less than 6 months prior to the accident because of his size and there was fall protection gear readily available. Tr. 358. There were signs to wear fall protection located at various places in the plant. Tr. 284, 358. Pete Maynard, electrician, testified that safety belts were provided on every floor, including the third floor which you had to ascend to in order to access the platform. Tr.II 5, 13. There was also a sign at the entrance to the third floor to wear fall protection which was about 15 to 20 feet from where Bowling was working. Tr. 291, Tr.II 31.

Finally, the mine had a disciplinary program in place that consisted first of a verbal warning and then referral of the issue to human resources. Tr. 292, 294. Sullivan had never seen employees working without fall protection on elevated platforms and Maynard had seen Bowling wearing fall protection in the past. Tr. 294, Tr.II 14-15. The Secretary presented no evidence that Respondent was previously issued citations for failing to wear fall protection and Mounts testified that there was no evidence that anyone was aware, management or otherwise, that Bowling was working on the platform without it. Tr. 63.

Analysis

In this case, evidence was presented of annual refresher training, that occurred only three days prior to the accident, which addressed fall protection. There were weekly meetings with miners that addressed safety issues and it appears that Bowling attended these. Fall protection was covered in at least one of these meetings per month. Handbooks were distributed to all miners with clear language of the fall protection requirement. In addition, I credit the testimony of Maynard, Sullivan, and Hurley that there was wide availability of fall protection gear, warning signs close to the platform area that had to be passed by miners to reach the platform, a disciplinary program for violations of mandatory standards, and no previous citations issued under this standard. There was also no mention by any witness that the requirement was lax or left up to the employee's discretion to wear it, making the facts of this case distinguishable from those of *Southwestern Illinois*.

I find that Respondent has demonstrated due diligence in requiring fall protection to be worn and hereby VACATE Citation No. 8247827.

Order No. 8258182

Order No. 8258182 was issued by Belcher on January 21, 2011 at 9:00 a.m., pursuant to section 104(d)(1) of the Act. It alleges a violation of 30 C.F.R. § 77.1713 which requires that an examination in each active working area be conducted for hazardous conditions and that any hazardous conditions be noted, reported and corrected. The violation was described in the order as follows:

> On Tuesday, January 18, 2011, a serious fall type accident occurred at the Clintwood Elkhorn Mining Company preparation plant.
>
> A plant employee, who was located at the flop gate for the belt conveyor leading to the syn-fuel storage area, fell to the concrete floor located approximately 20 feet below, receiving multiple injuries as a result.
>
> The accident investigation revealed that the preparation plant foreman assigned to perform the daily examination of the facility on this date had failed to conduct an adequate on-shift examination during the night shift of 1/17/2011 to 1/18/2011. A safety hazard existed on a landing between the second and third floors at the flop gate for the belt going to the old syn-fuel storage area and was not recorded in the daily on-shift book. A handrail was not provided for the landing at this work area, resulting in a mine employee falling, striking the belt chute cover, and then landing onto the first floor of the plan. The employee was transported to the hospital by ambulance for medical treatment for the injuries he sustained.
>
> The foreman has engaged in aggravated conduct constituting more than ordinary negligence by not making adequate examinations of active work areas.
>
> This violation is an unwarrantable failure to comply with a mandatory standard.

Ex. S-7 at 1, 2.

Belcher determined that an injury occurred as a result of the violation and was reasonably expected to result in lost workdays or restricted duty, that the violation was S&S, that one person was affected, that the level of negligence was high, and that the violation was an unwarrantable failure to comply with a mandatory standard. Ex. S-7 at 1. The Secretary proposed a penalty of $38,000.00.

The Violation

Secretary's Evidence

During Belcher's investigation, he reviewed the on-shift examination books for the night shift of January 17-18, 2011, and found that the "hole" in the floor had not been marked as a hazard and had not been adequately protected to prevent a fall. Tr. 110, 111-12; Ex. S-11. This indicated to Belcher that an examination of the platform had not been performed prior to miners accessing it to conduct work, and if it had been examined, the exam was inadequate. Tr. 114, 115. In addition, Belcher spoke to the foreman on the January 17, 2011 night shift and stated that the foreman did not say that he failed to inspect the platform area. Tr. 166. As a result, he issued the above order for an inadequate on-shift examination.

Belcher explained that the cited standard requires that all workplaces be inspected at least once a shift in order to identify and correct hazards. Tr. 113. If work was not going to be

conducted in a particular area during the shift, an exam would not need to be performed. Tr. 113. While Belcher acknowledged that a miner could guard themselves with fall protection, he contended that it would not change the fact that there was an "opening" in the floor. Tr. 115, 116.

Respondent's Evidence

As discussed above, Sullivan stated that the platform was installed in 2006, MSHA was aware of the installation, conducted a courtesy inspection, and has never issued a citation for an inadequate exam for failure to list the area between the edge of the platform and the wall as a hazard, or notified Respondent that handrails were needed. Tr. 255, 256-57, 260-61. He maintained that the lack of handrails did not need to be listed as long as fall protection was worn in the area. Tr. 261.

Hurley was the foreman on duty when Bowling fell. He testified that he examined the platform from which Bowling fell on January 17 during a pre-shift examination as required by state law. Tr. 380. In the 7 years that Hurley had been performing on-shift examinations, he had never recorded missing handrails as a hazard. Tr. 359. He further contended that the only reason to flop the gate that Bowling was attempting to flop on January 18 was if the belts were torn or stopped working, but neither of those things happened that day. Tr. 373-74.

On January 18, 2011, Hinkle, a foreman, reported the lack of handrails on the platform as a hazard because Bowling fell from it. Tr.II 37. He stated that he never recorded it in prior exam records because he thought fall protection was sufficient. Tr.II 38; Ex. S-11.

Analysis

Because neither section 204 nor 205 under part 77 require handrails on elevated platforms, and I found that the area between the edge of a platform and a nearby wall did not constitute an opening, I find that Respondent did not violate section 77.1713, Order No. 8258182 is hereby VACATED.

KENT 2011-1385

Order No. 8258183

Order No. 8258183 was issued by Belcher on January 21, 2011 at 9:00 a.m., pursuant to section 104(d)(1) of the Act. It alleges a violation of 30 C.F.R. § 50.10(b) which states, "[t]he operator shall immediately contact MSHA at once without delay and within 15 minutes . . . once the operator knows or should know that an accident has occurred involving . . . [a]n injury of an individual at the mine which has a reasonable potential to cause death." The violation was described in the order as follows:

> On Tuesday, January 18, 2011, a serious fall type accident occurred at the Clintwood Elkhorn Mining Company preparation plant.

> The accident investigation revealed that a plant employee, who was located at the flop gate for the belt conveyor leading to the syn-fuel storage area, fell to the concrete floor located approximately 20 feet below, receiving multiple injuries as a result.
>
> The mine operator has failed to immediately report an accident that occurred on 1/18/2011 to MSHA without delay and within 15 minutes. A mine employee fell approximately 20 feet from the landing between the second and third floors at the flop gate for the belt going to the old syn-fuel storage area, striking the belt chute cover, and then landing onto the first floor of the plant, sustaining serious injuries. The employee received multiple injuries to the head, leg, and wrist. Based on information gathered during the accident investigation, the mine employee was found temporarily unconscious and unresponsive after the fall.
>
> The employee was transported from the mine site to an area hospital for medical treatment. Injuries sustained from this type of fall have reasonable potential to cause death.
>
> The mine foreman has engaged in aggravated conduct constituting more than ordinary negligence by not immediately reporting this accident to MSHA without delay within 15 minutes.
>
> This violation is an unwarrantable failure to comply with a mandatory standard.

Ex. S-8 at 1, 2.

Belcher determined that an injury occurred as a result of the violation which was reasonably expected to result in lost workdays or restricted duty, that the violation was S&S, that one person was affected, that the level of negligence was high, and that the violation was an unwarrantable failure to comply with a mandatory standard. Ex. S-8 at 1. The Secretary proposed a penalty of $21,900.00.

The Violation

Secretary's Evidence

Belcher arrived at the mine to lead the accident investigation on January 19, 2011. Tr. 78. Prior to arriving, he was only aware that someone had fallen from a platform area and sustained injuries on January 18. Tr. 126. No report of an accident had been made by Respondent. Tr. 125.

During the investigation Belcher took measurements from the platform to the areas below, where Bowling landed. He determined that Bowling fell 17 feet 1 inch from the platform to the belt chute cover, and another 4 feet 9 inches from the top of the conveyor belt chute cover to the concrete floor, a total of 21 feet 10 inches. Tr. 85; Ex. S-5 at 2. Belcher determined that the accident was reportable because of the distance fallen and types of injuries Bowling received. Tr. 126.

In regards to the distance, Belcher testified that there have been numerous falls from lesser distances, some as little as 8 feet, that resulted in fatalities. Tr. 97. He stated that Bowling could have fallen straight to the floor, but because the area was between a wall and the edge of the platform, Belcher opined that Bowling slid down the wall which helped to break his fall. Tr. 97.[10]

Belcher received information on Bowling's injuries through interviews with miners who responded to Bowling after he fell and from reviewing the ambulance records. According to Belcher's notes, Bowling received stitches to his head and right ear as a result of lacerations, a splint on his wrist for a fracture, and a cut on his chin. Tr. 131-32; S-5 at 10. Upon contacting the witnesses on January 19, Belcher was told by Shawn Newsome, tipple operator and MET, that Bowling was knocked unconscious for approximately 3 minutes. Ex. S-5 at 5. He thought Bowling was dying. *Id.* Bowling's neck was swollen and he helped to bandage the wounds and administer oxygen. Tr. 127, 135; Ex. S-5 at 5. A second witness, Quentin Harr, equipment operator and MET, said that he gave treatment for shock. Tr. 136; Ex. S-5 at 5. A third witness, Will McCoy, clean coal dozer operator, stated that he arrived a minute after the accident and found Bowling was not responding, talking, or moving. He believed Bowling was hurt badly. Tr. 136; Ex. S-5 at 5.

Hurley, told Belcher that he was the first or second person to reach Bowling after the fall and he called 911 and applied bandages. Bowling knew his name, was responding, and his blood pressure and pulse were okay. Tr. 137; Ex. S-5 at 7-8. Belcher also spoke with Bowling who said he could not remember what happened but did not recall being unconscious. He stated that he was disoriented. Tr. 196.

Belcher testified that he read the ambulance report in an attempt to verifty the witness' statements. Tr. 220. He noted that the report stated, "LOC, [d]oesn't remember falling" and based on his MET experience, assumed that LOC meant loss of consciousness. Tr. 138, 140; Ex. S-9 at 2. However, on cross-examination, Belcher did concede, based on the definition of LOC in a medical dictionary, that the acronym could mean loss of consciousness or level of consciousness. Tr. 185.

Based on all of this information, Belcher believed that the operator should have known that the accident had a reasonable potential to cause death. Tr. 141. As he testified, the extent of head injuries is not immediately known until further tests are conducted at the hospital. In his opinion, it is not easy to determine whether someone has injuries that would not lead to death within the 15-minute time-frame. Tr. 127. Belcher's understanding was that as soon as a person who is responsible for reporting the accident becomes aware of one, and there is a likelihood that a reasonable potential for death exists, the person must call to notify MSHA within 15 minutes.

[10] Neither Belcher nor Mounts made a definitive determination that Bowling fell off the right hand edge of the platform where the Secretary, through his amendment, claimed the opening was. No one witnessed the fall, there was no evidence that Bowling was found lying next to the wall below the "opening" and he had no recollection of it himself. This assumption was made by Belcher at the hearing after the Secretary amended his order. I do not find any facts to substantiate this claim.

Tr. 200-01. He agreed that when an accident does not have a reasonable potential to be life threatening, there is a 10-day reporting requirement. Tr. 178-79.

Belcher explained that the purpose of the 15-minute reporting requirement is to prevent injuries to other miners from the same or similar conditions that may be present in the mine. Tr. 128. Another reason is to ensure that evidence is preserved, the accident is investigated properly, and the area is analyzed to determine what hazards need to be corrected to prevent that type of accident from reoccurring. Tr. 129.

Respondent's Evidence

Sullivan, who usually arrived at work around 5:00 a.m., testified that his brother, a mine employee, called him on his way to work and notified him of the fall. Tr. 239. Both he and Hurley, the foreman, had the authority to report the accident to MSHA. Tr. 241, 347. Because Sullivan was not present at the mine at the time of the accident, Hurley would have been responsible for making the call. Tr. 239, 241.

According to Sullivan, Bowling was moved onto a backboard so that he did not have to sit up, he checked Bowling for rib and pelvic fractures, and put Bowling on oxygen for shallow breathing and to prevent shock. Tr. 243. Sullivan maintained that Bowling never went into shock and he never saw or heard from another miner that Bowling lost consciousness. [11] Tr. 243, 244, 247-48. He also stated that he performed a pupil check which was normal, and there was not a lot of bleeding. Tr. 244-45.

Sullivan followed the ambulance from the mine to the hospital and contended that he did not learn anything at the hospital that was different than his first assessment. Tr. 246. He overheard the physician tell Bowling's family that Bowling would be okay. Tr. 246-47.

After speaking with the safety director, a decision was made not to report the accident to MSHA because Bowling knew his name, phone number, and was "pretty conscious." Tr. 244. Sullivan contended that if an injury requires stitches or broken bones are involved, the 10-day reporting period applied. Tr. 241. However, Sullivan testified that he was an MET and admitted that a person can suffer a brain injury that may not be apparent within 15 minutes. Tr. 301. He did not remove bandages around Bowling's head to evaluate the laceration and determined that the injury was not life-threatening before Bowling received brain scans at the hospital. Tr. 304.

Hurley testified that he was the first person to reach Bowling after the fall. Tr. 338. As an MET, he first assessed Bowling's level of consciousness as alert by talking to him and then drove to the foreman's office to get the MET bag. Tr. 340, 341, 360-61. After retrieving the bag, Hurley checked Bowling's pupils, blood pressure and respirations, which he found to be

[11] Sullivan did concede that he heard other employees talking about Bowling losing consciousness the night of January 18 but trusted Hurley and Maynard's account because he believed they got to Bowling first. Tr. 247-48.

normal.[12] Tr. 340, 341. He did not notice swelling. Tr. 362. Hurley detailed Bowling's injuries in his patient care report as several cuts on the right hand and head, and a 1.5 inch cut on the right leg. Tr. 341; Ex. R-3. He maintained that if there was a brain injury, there would be a lot of blood loss, dilated pupils, and confusion. Tr. 343. Oxygen was administered as a precaution and there was no indication that Bowling was in or going into shock. Tr. 344. As a result of his evaluation, Hurley did not believe Bowling's injuries were life-threatening and did not report the accident. Tr. 346. He stated that the paramedic told him he thought Bowling would be okay and that he heard the physician at the hospital say that the test results looked good. Tr. 348, 349.

During cross-examination, the Secretary confronted Hurley with the ambulance report. He specifically pointed out the findings that Bowling received nausea medication, and that under the injuries section for "head," the columns for "blunt," "laceration," "pain," and "swelling" were checked off. Tr. 363, 365; Ex. S-9 at 2. Hurley questioned how the EMT could have noticed swelling if Bowling was already bandaged and disagreed that there was swelling. Tr. 364. Hurley was also unaware that Bowling had nausea but agreed that nausea could be a sign of a brain injury which could have a reasonable potential to cause death. Tr. 365, 366-67. He also admitted that head injuries could take time to increase in severity. Tr. 367.

Maynard, an electrician without MET certification, testified that after Bowling fell, he reached Bowling at about the same time as Hurley did. Tr.II 8, 15. Belcher's notes indicate that Maynard arrived first. Ex. S-5 at 9. Maynard stayed with Bowling when Hurley went to retrieve the MET bag and maintained that while Bowling had injuries to his head and ear, Bowling never lost consciousness and that there was not a lot of blood. Tr.II 9. As a result, he did not think that there was a reasonable potential for death. Tr.II 9. However, when I asked Maynard what Bowling's complaints were, he stated, "[a]nd we was just trying to, you, know, get him calm to see what actually was wrong. . . . He was a little disoriented . . . [for] [m]aybe ten minutes, maybe. I don't know. I'm not sure." Tr.II 18-19.

Analysis

Respondent cited several cases where judges have vacated section 50.10 citations because the Secretary failed to prove that injuries to the miner did not have a reasonable potential to cause death and cited a Commission case where a violation of section 50.10 was found where a miner had stopped breathing and required CPR. Resp. Br. at 28-32; *Cougar Coal Co.*, 25 FMSHRC 513 (Sept. 2003). In addition, Respondent highlighted that the analysis should focus on whether mine management representatives acted reasonably in concluding that there was no reasonable potential for death. Resp. Br. at 30; *Oneida Coal Co.*, 11 FMSHRC 810, 832-33 (May 1989) (ALJ). Respondent also posed questions during the hearing in an attempt to argue that an MET is more qualified to make a determination as to whether an injury has a reasonable potential to result in death than someone without this certification. Tr. 181-84.

[12] Hurley testified that he never saw Bowling lose consciousness and did not hear anyone say otherwise until days or weeks after Belcher conducted his investigation. Tr. 344-45. He believes that the other miners Belcher spoke to essentially exaggerated because they were young, not trained, and scared of what had happened. Tr. 345.

In this situation, Respondent's arguments fail for several reasons. First, in *Cougar Coal*, the Commission rejected the judge's construction that "a medical or clinical opinion of the potential of death would be needed before an accident is even determined to be reportable," stating that to do so would frustrate the immediate reporting of near fatal accidents." *Cougar Coal Co.*, 25 FMSHRC at 521. The Commission goes on to say that "[i]n the field, the decision to call MSHA cannot be made upon the basis of clinical or hypertechnical opinions as to a miner's chance of survival. The decision to call MSHA must be made in a matter of minutes after a serious accident." *Id.* The focus is on the nature of the accident and the type of injuries, i.e. head trauma, not the measurement of the probability of resulting death. Here, a fall of over 20 feet with resulting head injuries per se had the potential to cause death.

Second, in 2006, MSHA issued a final rule in the Federal Register amending the definition of two types of reportable accidents. 71 Fed. Reg. 71430-1 (Dec. 2006). The announcement stated that "[b]ased on MSHA experience and common medical knowledge, some types of 'injuries which have a reasonable potential to cause death' include concussions . . . major upper body blunt force trauma, and cases of intermittent or extended unconsciousness." 71 Fed. Reg. at 71433-34.

Third, in a recent decision, the Commission clarified a prior decision, stating that "*Consol*, stands for the proposition that although an operator should be afforded a reasonable opportunity to investigate, once it is determined that a reportable accident has occurred, an operator must act immediately to report the incident." *Wolf Run Mining Co.*, 35 FMSHRC 3512, 3518 (Dec. 2013).

The cases cited where ALJs vacated the section 50.10 citations did not involve miners with head injuries[13], and the *Oneida* case, which involved a miner with possible internal injuries from being pinned against a rib by a continuous miner, was decided in 1989, prior to the *Cougar Coal* decision and Federal Register announcement. While the injuries that the miner in *Cougar Coal* sustained were clearly more serious than Bowling's, the Commission in no way restricted 50.10(b) violations to situations where a miner requires CPR.

Here, Bowling fell over 20 feet onto a metal-framed piece of machinery and then to a concrete floor. He had lacerations on his head, was disoriented for a period of time, and three witnesses who Belcher spoke with, two being METs – one who responded first to Bowling contrary to Hurley's testimony, stated that Bowling was unconscious, not responding, had swelling in his neck, and was treated for shock. I find Maynard's statements that Bowling was a little disoriented for "[m]aybe ten minutes, maybe. I don't know. I'm not sure" to be evasive and non-responsive compared to his statements at the scene as recorded in Belcher's notes.

[13] The cited cases included a past Order I issued, Granting a Motion for Summary Decision and Order of Dismissal. *PCS Phosphate-White Springs*, Unpublished Order dated Jan. 10, 2011. The facts of PCS are distinguishable from those in this case because there, the miner fell 10 feet and was examined by an employee of the mine who was a Licensed Practical Nurse (LPN) with training in emergency and intensive care treatment. The employee had also been a U.S. Army medic for 2 years. *Id.* at 2. An LPN is more qualified than an MET to make a determination as to whether an injury has the potential to be life threatening and the miner fell about half the distance of Bowling. In addition, the Order was issued prior to the *Cougar Coal* decision.

Belcher's notes make it clear the majority opinion was that Bowling was unconscious and hurt very badly. I credit the statements recorded in Belcher's notes as a more accurate description of Bowling's medical symptoms following the fall. Hurley tried to explain the discrepancy, stating that the miners were young and frightened. Tr. 345. This makes no sense in light of the fact that some of them were trained METs. It also begs the question of how accurate an MET's decision is on the probability of death on the scene of a traumatic head-injury type of accident. While Sullivan and Hurley's testimony indicated that Bowling was fine, I find them to be less credible on this issue because they had a motive for not reporting the accident.

Belcher testified that under normal circumstances, when an accident is reported under section 50.10, the entire plant is closed down until it is inspected and considered safe. Tr. 128-29. Sullivan testified that in October 2010, about 3 months prior to the accident, a truck accident occurred and was immediately reported to MSHA. Tr. 299. The entire plant was shut down until an expedited hearing was held and it was ruled by the judge that the event did not constitute an immediately reportable accident under section 50.10. Tr. 326-27. Sullivan was clearly agitated when discussing this at hearing. He also stated that at that time of the year, the only reason to send coal to stacker 6 was because production was high and all of the other ones were full. In fact, directly after the accident, that the plant was up and running again after someone else climbed onto the platform and manually flopped the gate. Tr. 271, 302. Clearly Respondent's foreman had a very strong motive not to report this accident immediately and have production shut down for an indeterminate amount of time as they knew would happen once MSHA investigators arrived on the scene and a 103(k) order was issued. Ex. S-1 at 6.

A medical opinion of potential death was not needed before the accident was reported, both Sullivan and Hurley conceded that brain injuries are not necessarily immediately apparent, the symptoms reported by witnesses were serious, and Belcher stated that numerous falls from lesser distances have resulted in fatalities. In addition, the actions taken by mine management to determine whether or not to report the accident once they were aware of it, i.e. checking vital signs, retrieving the medical bag, calling 911, and then discussing the situation with the safety director, took an unreasonable amount of time. Based on these facts and mine management's motive for not reporting the accident, I find that Respondent knew that the accident had a reasonable potential to cause death and therefore, that Respondent violated section 50.10(b).

S&S

An S&S violation is a violation "of such nature as could significantly and substantially contribute to the cause and effect of a . . . mine safety or health hazard." 30 U.S.C. § 814(d). A violation is properly designated S&S, "if, based upon the particular facts surrounding the violation, there exists a reasonable likelihood that the hazard contributed to will result in an injury or illness of a reasonably serious nature." *Cement Div., Nat'l Gypsum Co.*, 3 FMSHRC 822, 825 (Apr. 1981). As is well recognized, in order to establish the S&S nature of a violation, the Secretary must prove: (1) the underlying violation; (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 will be of a reasonably serious nature. *Mathies Coal Co.*, 6 FMSHRC 3-4 (Jan. 1984); *accord Buck*

Creek Coal Co., Inc. 52 F. 3rd 133, 135 (7th Cir. 1995); *Austin Power Co., Inc. v. Sec'y of Labor*, 861 F. 2d 99,103 (5th Cir. 1988) (approving *Mathies* criteria).

It is the third element of the S&S criteria that is the source of most controversies regarding S&S findings. The element is established only if the Secretary proves "a reasonable likelihood the hazard contributed to will result in an event in which there is an injury." *U.S. Steel Mining Co., Inc.*, 7 FMSHRC 1125, 1129 (Aug. 1985). An S&S determination must be based on the particular facts surrounding the violation and must be made in the context of continued normal mining operations. *Texasgulf, Inc.*, 10 FMSHRC 1125 (Aug. 1985); *U.S. Steel*, 7 FMSHRC at 1130. The Commission has emphasized that 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.,* 6 FMSHRC 1824, 1836 (Aug. 1984).

I have found that the violation has been established. The Secretary charges that failure to report the accident contributed to the discrete safety hazard, exposing other miners at the plant to an increased likelihood of future, similar accidents. Sec'y Br. at 35. The validity of the S&S finding turns on whether the failure to report the accident contributed to a discrete safety hazard, and whether the hazard was reasonably likely to cause an injury or injuries of a reasonably serious nature.

The purpose of the 15-minute reporting requirement is to prevent injuries to other miners from the same or similar conditions that may be present in the mine and to preserve evidence so that the accident can be properly investigated and corrective measures determined. By failing to immediately report the accident, mine management exposed other miners to the possibility of having similar accidents.

Belcher's concern for the likelihood of a similar accident occurring and causing serious injuries was well-founded. Because Respondent did not report this accident immediately, there was no immediate issuance of a 103(k) order that restricted access to the platform. As a result, another person climbed up to flop the gate and production continued throughout Bowling's shift. It was not until the following shift that the handrails were installed. The mine also had a number of similar situated platforms, thus, under continued normal mining operations, other miners were put at risk of comparable injuries by not reporting the accident.

Therefore, I find that the violation was S&S. The gravity of the violation was also serious. A miner fell from over 20 feet and suffered head and wrist injuries that had the reasonable potential to result in death and the accident went unreported. This also put other miners in the plant at risk of similar injuries.

Unwarrantable Failure

In *Lopke Quarries, Inc.*, 23 FMSHRC 705 (July 2001), the Commission stated the law applicable to determining whether a violation is the result of an unwarrantable failure:

> The unwarrantable failure terminology is taken from section 104(d) of the Act, 30 U.S.C. § 814(d), and refers to more serious conduct by an operator in connection

with a violation. In *Emery Mining Corp.*, 9 FMSHRC 1997 (Dec. 1987), the Commission determined that unwarrantable failure is aggravated conduct constituting more than ordinary negligence. *Id.* at 2001. Unwarrantable failure is characterized by such conduct as "reckless disregard," "intentional misconduct," "indifference," or a "serious lack of reasonable care." *Id.* at 2003-04; *Rochester & Pittsburgh Coal Co.*, 13 FMSHRC 189, 194 (Feb. 1991) ("R&P"); *see also Buck Creek Coal, Inc. v. FMSHRC,* 52 F.3d 133, 136 (7th Cir. 1995) (approving Commission's unwarrantable failure test). Whether conduct is "aggravated" in the context of unwarrantable failure is determined by looking at all the facts and circumstances of each case to see if any aggravating factors exist, such as 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 are necessary for compliance, the operator's efforts in abating the violative condition, whether the violation is obvious or poses 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) ("*Consol*"); *Cyprus Emerald Res. Corp.*, 20 FMSHRC 790, 813 (Aug. 1998), *rev'd on other grounds*, 195 F.3d 42 (D.C. Cir. 1999); *Midwest Material Co.*, 19 FMSHRC 30, 34 (Jan. 1997); *Mullins & Sons Coal Co.*, 16 FMSHRC 192, 195 (Feb. 1994); *Peabody Coal Co.*, 14 FMSHRC 1258, 1261 (Aug. 1992); *BethEnergy Mines, Inc.*, 14 FMSHRC 1232, 1243-44 (Aug. 1992); *Quinland Coals, Inc.*, 10 FMSHRC 705, 709 (June 1988). All of the relevant facts and circumstances of each case must be examined to determine if an actor's conduct is aggravated, or whether mitigating circumstances exist. *Consol*, 22 FMSHRC at 353. Because supervisors are held to a high standard of care, another important factor supporting an unwarrantable failure determination is the involvement of a supervisor in the violation. *REB Enters., Inc.*, 20 FMSHRC 203, 225 (Mar. 1998).

Lopke Quarries at 711.

Obviousness, Degree of Danger, Length of Time and Extent of the Violation

The nature of the accident and the type of injuries sustained – a fall from over 20 feet with head injuries – made this a per se obviously reportable accident. Failure to report the accident put other miners in the plant at a high risk of falling off the same platform as Bowling or falling off another similarly situated platform. In addition, Respondent never reported the accident to MSHA. MSHA only arrived at the mine after an inquiry was made by the media to MSHA Headquarters asking about the accident. The violation existed for an extended period of time.

The extensiveness factor involves consideration of the scope or magnitude of a violation. *Eastern Associated Coal Corp.*, 32 FMSHRC 1189, 1195 (Oct. 2010). Respondent had no intention to report this accident until the 10-day report was due. Management took an extensive amount of time to retrieve the MET bag, examine Bowling, bandage him, report their findings, and consult the safety director before deciding whether to report the accident. The violation was moderately extensive.

Operator's Knowledge of the Existence of the Violation

Management was clearly aware of the accident and the nature of it shortly after Bowling fell. The foreman was the one who sent Bowling up to the platform to flop the gate, as they had been doing this manually for 5 years. It was also a foreman who had the gate flopped to resume production immediately after Bowling was taken to the hospital and it was management, Hurley, Sullivan, and the safety director, who made the decision not to report the accident.

The plant was running at full capacity when the accident occurred and the events of October 2010 gave Sullivan and Hurley motive to not report it in order to prevent the entire plant from being shut down. Based on the fact that the accident was obvious in that in needed to be immediately reported and mine management had motive for not reporting it, I find that the operator had knowledge of the existence of the violation.

Operator Placed on Notice that Greater Efforts at Compliance were Necessary and Operator's Efforts in Abating the Violation

There was no evidence presented by either party that Respondent was placed on notice that greater efforts at compliance were necessary.

The focus of the abatement effort factor is on compliance efforts made prior to the issuance of a violation. In general, the factor measures an operator's response to violative conditions that were known to it or that should have been known to it. *Enlow Fork Mining Co.*, 19 FMSHRC 5, 17 (Jan. 1997). It must then be determined whether the efforts "were taken with sufficient care under the circumstances, even if ultimately unsuccessful in completely preventing a violative condition." *Windsor Coal Co.*, 21 FMSHRC 997, 1005 n.9 (Sept. 1999). There was no evidence presented that Respondent made any effort to notify MSHA and abate the violation. The evidence established that management had no intention of reporting the accident until the 10-day section 50.20 report was due.

I find that Respondent's failure to report this fall from almost 22 feet, resulting in a loss of consciousness and open head injuries to be a complete disregard for the miners' safety. It per se posed a reasonable potential of death. It appears that the decision not to report it was to avoid another 103(k) order at a time when production was high. Failure to report the accident was not because Respondent was unaware of the requirement to do so. I find that Respondent's knowledge of the violation and the high degree of danger posed by failing to report it are most significant. I do not find that the Respondent had a good faith belief that there was not a reportable accident under section 50.10, particularly in light of its previous experience with reporting one in October of the prior year. I find that that violation was caused by Respondent's unwarrantable failure to comply with section 50.10.

Negligence

Belcher determined the level of negligence to be high because of the seriousness of the accident and the severity of injuries incurred by Bowling, including loss of consciousness. Tr. 146. In addition, mine management was aware of the accident and never reported it. Tr. 147.

In addition to the facts above, Sullivan and Hurley had motive for not reporting the accident, making their analysis of the situation skewed and unreliable, as exemplified by several other witnesses reporting to Belcher a number of details that they failed to mention. I find the level of negligence was properly marked as high.

KENT 2011-1386

Citation No. 8258184

Citation No. 8258184 was issued by Belcher on January 20, 2011 at 4:00 p.m., pursuant to section 104(a) of the Act. It alleges a violation of 30 C.F.R. § 50.12 which states, "[u]nless granted permission by a MSHA District Manager . . . no operator may alter an accident site or an accident related area until completion of all investigations pertaining to the accident except to the extent necessary to rescue or recover an individual, prevent or eliminate an imminent danger, or prevent destruction of mining equipment." The violation was described in the citation as follows:

> On Tuesday, January 18, 2011, a serious fall type accident occurred at the Clintwood Elkhorn Mining Company preparation plant.
>
> A plant employee, who was located at the flop gate for the belt conveyor leading to the syn-fuel storage area, fell to the concrete floor located approximately 20 feet below, receiving multiple injuries as a result.
>
> The accident investigation revealed that the operator had altered the accident site without receiving permission from an MSHA District Manager. Handrails were installed at the landing between the second and third floors at the flop gate for the belt where an accident occurred on 1/18/2011 prior to the completion of the accident investigation. A handrail was not provided for the landing at this work area, resulting in a mine employee falling, striking the belt chute cover, and then landing onto the first floor of the plant. The employee was transported to the hospital by ambulance for medical treatment for the injuries he sustained.

Ex. S-10 at 1, 2.

Belcher determined that an injury occurred as a result of the violation which was reasonably expected to result in no lost workdays, that one person was affected, and that the level of negligence was high. Ex. S-10 at 1. The Secretary proposed a penalty of $7,700.00.

Secretary's Evidence

When Belcher conducted the accident investigation on January 19, 2011, he observed that handrails had been installed on the platform at the location where Bowling fell. Tr. 149. He stated that preserving the scene is necessary to prevent evidence from being destroyed. Tr. 204. Installing the handrails, even though it made the platform safer, altered the original accident scene. Tr. 208.

Belcher explained that the purpose of not altering an accident scene is so that the investigators are able to visualize exactly what the scene looked like when the accident happened in order to put measures in place to prevent it from happening again, either at the same location or another similarly situated location in the plant. Tr. 122. When the scene is altered, the investigators must rely on company officials to describe the scene prior to the accident and they therefore cannot say with certainty what the scene looked like. Tr. 122, 149, 150.

In addition, based on the facts that Belcher gathered about the accident, he did not think that the accident scene needed to be altered in order to prevent or eliminate an imminent danger. Tr. 152, 154. Because no imminent danger existed, Belcher maintained that the MSHA District Manager needed to be notified and give permission for any alterations to be done. Tr. 151.

Belcher marked the likelihood of injury as occurred with no lost workdays reasonably expected and one person affected. Tr. 155. He also determined that the level of negligence was high because Respondent knew that an accident had occurred, it installed the handrails intentionally, and Respondent did not receive permission from MSHA to alter the scene. Tr. 157.

Respondent's Evidence

Sullivan testified that after Bowling fell and was picked up by an ambulance, all of the coal was cleaned up off the floor, including the coal that Bowling knocked over when he fell, handrails were installed, a ratchet was replaced where Bowling was attempting to flop the gate, and production started again. Tr. 302-303, 309. At the time that production started, the results from the brain scans at the hospital were not available. Tr. 302-03. Sullivan maintained that installing the handrails was not an attempt to alter the scene or hinder an accident investigation. Tr. 278.

Analysis

In *Cougar Coal*, the Commission found that where a power line, which was involved in an accident, was removed from the scene before MSHA was notified of the accident or began its investigation, a violation of 50.12 existed. *Cougar Coal Co.*, 25 FMSHRC at 521. In addition, several ALJs have made similar determinations where MSHA had not yet been notified of an immediately reportable accident. In *Signal Peak Energy*, Judge Moran stated that Respondent would be excused from liability for failure to preserve the accident scene only if it did not have an obligation to report the accident. *Signal Peak Energy, LLC*, 34 FMSHRC 1346, 1375 (June 2012). In *Chino Mines*, Judge Hodgdon found a violation of 50.12 where a reportable accident occurred, a circuit breaker that exploded was replaced, and MSHA was not notified of the accident until the day after. *Chino Mines Company*, 24 FMSHRC 189, 196-97 (Feb. 2002).

Even though the operators in the above cases had not reported the accident to MSHA at the time that the alterations were made, the Commission has found that an operator still had notice of section 50.10's requirements and impliedly, section 50.12's requirements. In *Cyprus Emerald Resources Corp.*, the Commission concluded that adequate notice is provided when a regulation is unambiguous. *Cyprus Emerald Resources Corp.*, 20 FMSHRC 790, 797-98 (Aug. 1998). It stated that "[f]rom our conclusion that the definition of accident in section 50.2 is plain, it follows that section 50.10 provided the operator with adequate notice of its requirements. *Id.* If Respondent had adequate notice of the requirements under section 50.10, it follows that Respondent also had adequate notice of its obligation to preserve the accident scene under section 50.12.

Based on the above case law, the fact that handrails were installed on the platform from where Bowling fell, coal was cleaned up off the ground where he landed, and a ratchet was replaced, the scene of the accident was altered without the permission of an MSHA District Manager. Whether the alterations hindered the investigation was immaterial as the only acceptable reasons to alter an accident scene are "to rescue or recover an individual, prevent or eliminate an imminent danger, or prevent destruction of mining equipment." 30 C.F.R. § 50.12. There was no testimony presented by either party that these exceptions applied in this particular instance. Additionally, it is not within the Respondent's authority, absent these narrowly delineated circumstances, to determine whether alterations may hinder or impede an investigation by MSHA.

Therefore, I find that Respondent violated section 50.12 and knew of the standard's requirements.

Negligence

The alterations made to the scene of the accident were intentional and the decision to alter the scene was made by management. Respondent has not presented any mitigating evidence. As a result, I find that Belcher properly determined the level of negligence to be high.

Civil Penalties

The Commission has reiterated in *Mize Granite Quarries, Inc.*, 34 FMSHRC 1760, 1763-64 (Aug. 2012):

> Section 110(i) of the Mine Act grants the Commission the authority to assess all civil penalties provided under the Act. 30 U.S.C. §820(i). It further directs that the Commission, in determining penalty amounts, shall consider:
>
> The operator's history of previous violations, the appropriateness of such penalty to the size of the business of the operator charged, whether the operator was negligent, the effect on the operator's ability to continue in business, the gravity of the violation, and the demonstrated good faith of the person charged in attempting to achieve rapid compliance after notification of a violation.

30 U.S.C. § 820(i).

The Commission and its ALJs are not bound by the penalties proposed by the Secretary nor are they governed by MSHA's Part 100 regulations, although substantial deviations from the proposed penalties must be explained using the section 110(i) criteria.[14] *See Sellersburg Stone Co.*, 5 FMSHRC 287, 293 (Mar. 1983). In addition to considering the 110(i) criteria, the judge must provide a sufficient factual basis upon which the Commission can perform its review function. *See Martin Co. Coal Corp.*, 28 FMSHRC 247 (May 2006).

Ability to Continue in Business, Good Faith, and Size of the Operator

The parties have stipulated that the proposed penalties will not affect the Respondent's ability to continue in business and that Respondent abated the violations in good faith. Ex. J-1. The parties did not stipulate to the size of the operator, however, on the forms reflecting calculations of the proposed penalties (Secretary's Exhibit A), the mine tonnage is 0 and the controller tonnage is over 5 million. Based on Tables I and II in section 100.3, I find the size of the mine to be small but the overall size of the operator to be large. Therefore, I find that the penalties assessed herein are appropriate to the size of the business.

History of Previous Violations and Negligence

The history of violations provided is over a 2 year period, not the required 15-month period, and reflects that 47 violations became final. Ex. S-13. I accept the figures reflected in the report as accurate. However, the overall violation history set forth in the exhibit is deficient in that it provides no qualitative assessment, i.e., whether the number of violations is high, moderate or low. *See Cantera Green,* 22 FMSHRC at 623-24. In addition, because the violations were specially assessed, no points were assigned by the Secretary for the number of violations per inspection day in Secretary's Exhibit A. Therefore, without the number of inspection days, it is not possible to determine whether the history of violations is an aggravating, neutral, or mitigating factor. The negligence and gravity of each violation is discussed at length above.

I assess the following penalties:

1. Citation No. 8247826 is VACATED.

2. Citation No. 8247827 is VACATED.

3. Order No. 8258182 is VACATED.

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[14] Respondent has raised an objection to the special assessments levied by the Secretary, stating that there was no explanation for the extreme divergence between the standard penalty calculated according to the section 100.3 formula and the assessed penalties, and that because the penalties assessed are arbitrary, they should not be considered a benchmark or guideline for *de novo* penalty assessments. Resp. Br. at 33. My assessment of penalties is based upon all of the statutory criteria above as they relate to the facts of each violation as established by the record evidence. The special assessments levied by the Secretary are immaterial.

4. Order No. 8258183 is affirmed. I assess a penalty of $21,900.00. I find the failure to report a fall under the circumstances here to be extremely serious with no mitigating factors. I find that the penalty is appropriate.

5. Citation No. 8258184 is affirmed. I assess a penalty of $7,700.00. While the Respondent alleges the alteration of the scene was for the protection of miners, as stated herein, there were ulterior motives involved. I find that the penalty is appropriate.

ORDER

It is **ORDERED** that the operator pay a total penalty of $29,600.00 within 30 days of the date of this order.[15]

Priscilla M. Rae
Administrative Law Judge

Distribution (Certified Mail):

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[15] 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.