FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

OFFICE OF ADMINISTRATIVE LAW JUDGES
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September 13, 2010

SECRETARY OF LABOR, MINE SAFETY AND HEALTH ADMINISTRATION, (MSHA), Petitioner	:	CIVIL PENALTY PROCEEDINGS
	:	Docket No. WEVA 2007-600
	:	A.C. No. 46-08791-120481
v.	:	
	:	Docket No. WEVA 2008-247
	:	A.C. No. 46-08791-130758
	:	
WOLF RUN MINING COMPANY, Respondent	:	Sago Mine

DECISION

Appearances: Robert S. Wilson, Esq., Office of the Solicitor, U.S. Department of Labor, Arlington, Virginia, for the Petitioner;
R. Henry Moore, Esq., Jackson Kelly PLLC, Pittsburgh, Pennsylvania, for the Respondent.

Before: Judge Feldman

These civil penalty proceedings concern Petitions for the Assessment of Civil Penalty filed pursuant to section 110(a) of the Federal Mine Safety and Health Act of 1977, as amended ("Mine Act"), 30 U.S.C. § 820(a), by the Secretary of Labor against the respondent, Wolf Run Mining Company ("Wolf Run"). The petitions seek to impose a total civil penalty of $148,400.00 for 15 violations of the Secretary's regulations governing underground coal mines that allegedly occurred at Wolf Run's Sago Mine. The cited violations were identified following a Mine Safety and Health Administration (MSHA) investigation of the January 2, 2006, Sago Mine disaster that resulted in twelve fatalities and one serious injury. The Secretary does not allege that any of the cited violations in these proceedings contributed to the fatal mine explosion.

This Decision concerns the adjudication of 104(d) Order No. 7100920 and 104(a) Citation No. 7100919. Docket No. WEVA 2008-247 contains only 104(d) Order No. 7100920. The civil penalty matter in WEVA 2007-600 initially contained fifteen citations and orders. However, 104(d) Order No. 7100904 was bifurcated from WEVA 2007-600 and assigned to Docket No. 2007-600-A. Order No. 7100904 is the subject of future litigation. Contained among the remaining fourteen citations and orders in Docket No. WEVA 2007-600 is 104(a) Citation No. 7100919, a subject of this litigation.

Prior to the hearing, on July 15, 2009, and January 21, 2010, the parties filed Motions to Approve Partial Settlement with respect to the remaining thirteen citations and orders in WEVA 2007-600. The parties have agreed to a reduction in civil penalty from $133,900.00 to $71,800.00 for these thirteen citations and orders.

The settlement terms include modifying 104(d)(1) Order Nos. 7100907, 7100912, 7100916, 7100918, and 7458180 to 104(a) citations to reflect that the violative conditions were not the result of an unwarrantable failure. The parties have agreed to vacate 104(d) Order No. 7100911 because the cited condition has been merged with the conditions contained in 104(d) Order No. 7100909. Similarly, 104(d) Order No. 7100915 shall be vacated because the cited condition has been merged with the conditions contained in 104(d) Order No. 7100914. Finally, the parties have agreed to vacate 104(d) Order Nos. 7458182 and 7458183.

I have considered the representations and documentation submitted in the motions for approval of partial settlement, and I conclude that the proffered partial settlement is appropriate under the criteria set forth in Section 110(i) of the Mine Act. 30 U.S.C. § 820(i). Consequently, the parties' settlement terms shall be approved and incorporated in this Decision.

The hearing with regard to 104(a) Citation No. 7100919 and 104(d)(1) Order No. 7100920 was conducted on February 2 and February 3, 2010, in Clarksburg, West Virginia. The Secretary proposes a total civil penalty of $14,500.00 for the two cited violations. The citation and order concern a mine operator's responsibility to notify MSHA and mine rescue teams immediately after an accident. The parties filed simultaneous post-hearing briefs and replies that have been considered in the disposition of these matters.

I. **Background**

The Sago Mine, operated by Wolf Run, is an underground coal mine located in Upshur County, West Virginia. International Coal Group, Inc., (ICG) is the parent company of Wolf Run Mining Company. The contested citation and order concern Wolf Run's alleged violations of the reporting requirements in 30 C.F.R. § 50.10 and 30 C.F.R. § 75.1502(a). The subject citation and order were issued because of Wolf Run's delay in notifying the authorities that an underground mine explosion had occurred. Under applicable regulations and the mine emergency evacuation plan, Wolf Run was required to "immediately" notify MSHA, the West Virginia Office of Miners Health Safety and Training (WVOMHST) and the Barbour County Mine Rescue team that an accident had occurred. Federal and state authorities exercise final authority over the implementation of a rescue plan at an accident scene.

At approximately 6:26 a.m. on Monday, January 2, 2006, a methane explosion occurred in a sealed area of the mine known as the 2nd Left Mains or the 2 North Mains area. The explosion and its aftermath occurred during the national observance of the New Years Day holiday. There were 29 miners underground at the time of the explosion. Most of these miners were members of two continuous miner section crews, each consisting of twelve members.

The crews worked in the 1st Left and 2nd Left face areas. When the explosion occurred, the 1st Left crew had not yet reached the face and managed to evacuate without serious injury. The members of the 2nd Left crew, who were further inby, unsuccessfully attempted to evacuate before barricading themselves in the 2nd Left face area.

Several minutes after the explosion, at approximately 6:36 a.m., Wolf Run management personnel located on the surface received a phone call from an underground foreman of the 1st Left crew who had experienced the force of the explosion. The foreman informed them that his crew had survived a significant underground accident. Approximately 15 minutes thereafter, four members of mine management went underground to assist in the evacuation of miners and to determine the nature and extent of the accident. Sometime between 7:15 a.m. and 7:23 a.m., management personnel communicated from underground to the surface that the 2nd Left crew could not be accounted for. At that time, the Wolf Run officials used an underground mine phone that had been patched into the home telephone of John B. Stemple, Jr., the company's Assistant Director of Safety and Employee Development, to advise Stemple to provide notification to the authorities, and to implement the company's rescue program that relied on the Barbour County Mine Rescue.

Instead of immediately attempting to notify the authorities, between 7:24 and 7:28 a.m. Stemple left messages on the home telephone answering machines of several members of the company's upper management. General Manager Charles Dunbar returned Stemple's call at 7:34 a.m. at which time Stemple informed Dunbar of the explosion. Stemple also managed to have his immediate supervisor, Harrison Tyrone (Ty) Coleman, ICG's Manager of Safety for West Virginia and Maryland, informed of the explosion. Coleman directed Stemple to activate the mine rescue plan shortly after 7:40 a.m.

At 7:46 a.m., Stemple left a message on the home answering machine of an official of WVOMHST. The information provided by Stemple shortly after the accident reflects Stemple's initial attempt to contact MSHA occurred at approximately 7:50 a.m. when he left a phone message at the home of an MSHA supervisor. Stemple initially unsuccessfully attempted to contact a Barbour County Mine Rescue team member at his home at approximately 8:04 a.m. Stemple ultimately successfully contacted an MSHA official at his home at which time a 103(k) order was verbally issued on the telephone at 8:32 a.m. prohibiting anyone from entering the mine. Generally speaking, section 103(k) of the mine act authorizes MSHA representatives to issue such orders deemed appropriate to insure the safety of persons in a coal mine. 30 U.S.C. § 957(k).

MSHA, the Barbour County Mine Rescue Team, and WVOMHST received actual notice of the explosion at approximately 8:30 a.m. Members of these organizations arrived at the Sago Mine between 10:00 a.m. and 10:30 a.m. The mine rescue team was not able to go underground until 5:30 p.m that evening because of dangerous concentrations of gases. Rescue teams did not reach the 2nd Left face area until the following evening at approximately 11:00 p.m. on January 3, 2006, at which time one survivor was found. There were 12 fatalities.

II. **Statement of the Case**

This case raises difficult and complex issues concerning the effect of MSHA's exercise of its 103(k) authority on a mine operator's compliance with its reporting responsibilities. As discussed below, a management team went underground after the explosion to assist the evacuation and to assess what had happened. The management team advised Stemple to implement mine rescue at approximately 7:23 a.m. However, Stemple was reticent to contact MSHA without the approval of his immediate supervisor because he believed a 103(k) withdrawal order would be issued immediately. Stemple responded to the request for mine rescue by attempting to contact the company's upper management instead of notifying the authorities. Stemple did not attempt to notify MSHA until 7:50 a.m. He attempted to notify the mine rescue team shortly thereafter. The delay from 7:23 a.m. until 7:50 a.m. constitutes a violation of Wolf Run's obligation to timely report accidents. Consequently, the citation and order concerning Wolf Run's alleged reporting violations shall be affirmed.

The Secretary attributes Wolf Run's delay in implementing its mine rescue plan to an unwarrantable failure. The Secretary has failed to demonstrate the requisite unjustified or aggravated conduct to support an unwarrantable failure due to the significant mitigating circumstances that arose out of the particular circumstances of this case.

III. **Findings of Fact**

a. Immediate Aftermath of the Explosion

The material facts are essentially undisputed and have been stipulated by the parties. At approximately 6:26 a.m. on January 2, 2006, an explosion occurred in a recently sealed and abandoned area inby the 2 North Mains seals that destroyed all ten of the seals used to separate that area from the active portion of the mine. At that time, the mine was operating two continuous miner sections, 1st Left and 2nd Left. At the time of the explosion, approximately 29 miners were underground. The twelve member 2nd Left crew boarded a mantrip entering the mine through the track entry at approximately 6:00 a.m. and had reached the 2nd Left face working section at the time of the explosion. (Gov. Ex. 5-A). The twelve member 1st Left crew accompanied by a pumper, a belt cleaner and a mine examiner, entered the mine via a mantrip shortly thereafter, at approximately 6:05 a.m., but this crew was still in the mantrip at the 1st Left switch and had not yet arrived at the 1st Left working face. (Gov. Ex. 5-A). A preshift examiner who had entered the mine earlier in the morning remained underground.

At approximately 6:26 a.m., on the surface, dispatcher William Chisolm was speaking on the telephone with Mine Superintendent Jeffrey Toler, who was located in a building next to the dispatcher's office, when a flash of lightning and loud thunder occurred. (Joint Stip. 75). Chisolm told Toler that the mine's Atmospheric Monitoring System (AMS), that monitors carbon monoxide (CO), was lost and that the belts were down. (Joint Stip. 77). CO is a byproduct of fire and explosion. Data from the AMS system reflect that it alarmed

at 6:31:31 a.m. (Joint Stip. 64). The investigation determined the system alarmed at 6:26:35 a.m. because the clock on the AMS was four minutes and 56 seconds fast. (Joint Stip. 65).

Toler initially thought that lightning may have affected the fuses for the AMS system. (Joint Stip. 80). Toler told Chisolm to radio the 1st Left and 2nd Left crew to ask them to check all CO sensors that were alarming to determine the problem. (Joint Stip. 79). Chisolm also spoke to Maintenance Superintendent Denver Wilfong on the phone. Wilfong told Chisolm that communications on the AMS had been lost. Wilfong also thought that fuses had blown. (Joint Stip. 81, 82). Wilfong directed Maintenance Foreman Vernon Hofer, who was in Wilfong's office at that time, to check the AMS and to replace any blown fuses. Hofer proceeded to the dispatcher's office to obtain his cap light. Hofer checked the CO monitor screen to see which belts were affected. He noted the Nos. 1 and 2 Belts were operating, but the Nos. 3 and 4 Belts had lost power. (Joint Stip. 83, 84).

Meanwhile underground, at approximately 6:26 a.m., pumper John Boni, who was in the No. 3 entry at the 22 crosscut, felt a rush of air he attributed to a small pillar fall. (Joint Stip. 56, 67; Gov. Ex. 5-A). At approximately 6:32 a.m., belt cleaner Pat Boni noticed dust moving in an inby rather than an outby direction, the opposite direction air normally flowed. Boni telephoned dispatcher Chisolm from the No. 4 Belt drive to ask what had happened. (Joint Stip. 85, 86).

At approximately 6:36 a.m., Owen Jones, Section Foreman for the 1st Left crew traveled to a telephone after having experienced the force of the explosion and the resultant smoke, dust and debris approximately ten minutes earlier. Jones communicated to Chisolm, Toler and Wilfong, who were still speaking on the telephone on the surface, that "we had a mine explosion or something in here" and "get mine rescue here right now." (Stip. 92, 93; Tr. 89). Jones was concerned about his brother who was a 2nd Left crew member.

After speaking to Jones, Toler learned that the 1st Left crew was accounted for. Toler was concerned that the 2nd Left crew had not responded. (Joint Stip. 96). Toler's uncle was a member of the 2nd Left crew. Wilfong instructed Chisolm to continue trying to establish communications with the 2nd Left crew. (Joint Stip. 98). Toler, Wilfong, Hofer and Safety Director James (Al) Schoonover prepared to go underground to investigate. They boarded a mantrip and proceeded underground. (Joint Stip. 101). Toler estimated that approximately 15 minutes had elapsed from the time of the explosion until they started underground. (Joint Stip. 103).

At approximately 7:01 a.m., Chisolm called Stemple at his home to relate that Jones had reported a big rush of air accompanied by dust and debris. (Tr. 522-23, 525). Sometime between 7:01 and 7:15 a.m., while Chisolm was speaking to Stemple, Wilfong met the 1st Left crew and learned that the 2nd Left crew had not been heard from. Wilfong called Chisolm from underground. (Tr. 527). Wilfong told Chisolm to alert federal and state agencies, and told Chisolm that mine rescue teams were needed immediately. (Joint Stip. 114).

Contemporaneous with hearing that Wilfong had requested notification of mine rescue teams, while continuing to speak to Wilfong, Chisolm patched the land line phone into the mine phone enabling Stemple to speak directly to Toler underground. (Joint Stip. 115). Toler advised Stemple that he was not sure what had happened, that they had found the 1st Left crew, and, that they were helping to bring the crew members to the surface. Toler also told Stemple that there had been no contact with the 2nd Left crew. (Joint Stip. 116-18).

Toler further related to Stemple that the 1st Left crew stated that several intake stoppings were out, and that there was smoke and dust in the air as they traveled along the primary intake escapeway. (Joint Stip. 117). Stemple told Toler that he needed to re-establish ventilation as deep into the mine as possible to prevent a shortage of fresh air at the 2nd Left section. (Joint Stip. 119). Toler testified that his conversation with Stemple began at approximately 7:15 a.m. (Tr. 451). Stemple testified that the telephone conversation ended at 7:23 a.m. (Tr. 572). Sometime between 7:15 and 7:23 a.m. Toler told Stemple to contact mine rescue teams. (Joint Stip. 120). Stemple told Chisolm to continue to try to establish contact with the 2nd Left crew and that he would take care of notifying the parties who needed to be notified. (Tr. 526-27).

Toler instructed Wilfong to assist the 1st Left crew to the surface while he, Schoonover and Jones remained underground. (Joint Stip. 121). One 1st Left crew member had a prosthetic leg. (Tr. 106). Hofer operated a mantrip to transport the 1st Left crew, pumper John Boni, and Wilfong to the surface. The men arrived on the surface at approximately 7:30 a.m. (Joint Stip. 122).

Jones met Toler and Schoonover at the mine phone at the intersection of the No. 25 crosscut at the No. 4 belt entry. (Joint Stip. 123). Jones insisted on remaining underground due to his concern for his brother's safety. Toler instructed Jones to remain at the phone because Jones did not have a hard hat, while he and Schoonover traveled inby to assess the damage. (Joint Stip. 124). Toler and Schoonover observed multiple blown out stoppings from the intake entry towards the track entry. (Joint Stip. 125-27).

Toler and Schoonover decided to withdraw because they did not have CO detectors and atmospheric conditions were uncertain due to multiple damaged stoppings. (Joint Stip. 127). They traveled outby to the intersection of the No. 41 crosscut and No. 4 belt entry where another mine phone was located. Toler called to the surface and instructed Wilfong and Hofer to bring into the mine curtains, nails, boards, saws, all available detectors, and a hard hat for Jones. (Joint Stip. 127-28).

Toler and Schoonover then walked further outby joining Jones who was waiting at the phone location at the No. 25 crosscut and No. 4 belt entry where they waited for Wilfong and Hofer to return with supplies. (Joint Stip. 129). Wilfong and Hofer disconnected the mine power before reentering the mine. (Joint Stip. 130). After gathering supplies, Wilfong and Hofer proceeded inby meeting Toler, Schoonover and Jones. (Joint Stip. 131). After installing check curtains across damaged stoppings at the No. 32 crosscut between the Nos. 6 and 7 entries

on the intake side, the five men boarded a mantrip and rode inby to the No. 42 crosscut. (Joint Stip. 132-33). The CO detectors carried by Toler and Hofer started to alarm between crosscut Nos. 42 and 43. (Joint Stip. 134, 136). Concerned about another explosion, the men disconnected the mantrip batteries and unloaded the supplies at the No. 42 crosscut and the No. 4 belt. (Joint Stip. 137-38). The five men then started to repair stoppings between the No. 6 and 7 entries as they traveled inby. (Joint Stip. 139).

The five men continued to repair stoppings advancing as far as the No. 58 crosscut. (Joint Stip. 142, 149). However, the density of the smoke prevented them from hanging additional curtains. (Joint Stip. 149). Toler, Wilfong and Schoonover exited the mine at approximately 10:35 a.m., unaware that a 103(k) order had been verbally issued by MSHA supervisor James Satterfield at 8:32 a.m. requiring all personnel to evacuate the mine. (Joint Stip. 148, 150). The exact time Jones exited the mine is unclear. All efforts to contact the 2nd Left crew had failed. (Joint Stip. 151).

b. Stemple's Efforts to Reach Federal, State and Rescue Personnel

After his conversation with Toler that ended at approximately 7:23 a.m., Stemple began attempting to contact the company's upper management. (Joint Stip. 152). Immediately after his conversation with Toler, Stemple phoned purchasing manager Jerry Waters at the company's division office at 7:24 a.m. to obtain the phone numbers of mine manager Raymond Coleman, General Manager Chuck Dunbar, and Stemple's supervisor Harrison Tyrone (Ty) Coleman, ICG's Manager of Safety for West Virginia and Maryland, Raymond Coleman's brother. (Tr. 534). Between 7:24 and 7:28 a.m. Stemple left messages on these three individuals' phones. (Tr. 534-35). Dunbar returned Stemple's call at approximately 7:34 a.m. at which time Stemple informed him about the accident at the mine. (Tr. 537). Dunbar's telephone conversation with Stemple ended at approximately 7:40 a.m. (Tr. 537-38).

Stemple was determined to contact Ty Coleman who was his "boss." (Tr. 534). The company's division office is located approximately one mile from Ty Coleman's house. (Tr. 545). Stemple testified that Waters, who was aware of the explosion since 7:24 a.m., went to Ty Coleman's home and informed him of the accident. Stemple testified that "Jerry [Waters] got back to me" sometime "previous to 8:20" and informed him that he "got Ty out of bed and informed Ty of what was going on." (Tr. 545). Although the record does not reflect when Waters initially advised Ty Coleman of the explosion, the parties have stipulated that sometime after Stemple's conversation with Dunbar ended at 7:40 a.m., Ty Coleman called Stemple and told him to activate the mine rescue teams and to put them on standby. (Joint Stip. 153, 155).

Stemple's initial attempt to notify MSHA is in dispute. Although Ty Coleman did not advise Stemple to notify the authorities until sometime after 7:40 a.m., Stemple testified that he initially attempted to notify MSHA by calling the Bridgeport field office at approximately 7:30 a.m. (Tr. 536-37). There was no answer to his phone call and Stemple did not leave a

message. (Tr. 537). Stemple further testified that he next attempted to contact WVOMHST authorities by calling their Fairmont office at 7:32 a.m. Once again, there was no answer and Stemple did not leave a message. (Tr. 537). Stemple explained that he knew January 2, 2006, was a national holiday and he did not want to leave a message on an office answering machine that he believed would not be heard until the following day. (Tr. 539-40).

Stemple testified that while he was making phone calls to federal and state agencies, Wolf Run's upper management were calling him for status. (Tr. 537). Between 7:34 and 7:40 a.m. Stemple was on the phone with Dunbar. (Tr. 537-38). At 7:40 a.m. Stemple reportedly called both the MSHA Bridgeport field office and the WVOMHST's Fairmont office again to obtain alternative phone numbers from automated recordings. (Tr. 537-38). Again, the phones were not answered, but the recordings provided names and numbers to call.

Stemple also began looking up in his local telephone book the phone numbers of federal and state agency personnel he knew lived in his area. At 7:46 a.m. Stemple left a message on John Collins' answering machine at his home. Collins is a WVOMHST official. Stemple's message informed Collins that there had been a lightning strike at the mine; the mine had lost power; the 1st Left crew felt a gush of air; there was dust, dirt and debris in the air; and that the 1st Left crew was accounted for but the 2nd Left crew was not. (Tr. 539-40).

After two unsuccessful attempts to reach personnel identified in the MSHA office recordings, at 7:50 a.m., Stemple testified he successfully left a message on MSHA supervisor Tenney's answering machine at his home. (Joint Stip. 156; Tr. 538-39; Gov. Ex. 7). Stemple left Tenney the same message he had left Collins. (Tr. 538-39).

At 7:56 a.m., Collins returned Stemple's call at which time Stemple notified him of the incident. (Gov. Ex. 7). After finally providing notification to both federal and state agencies, Stemple called the Sago Mine to obtain the local mine rescue phone numbers. (Tr. 541). At 8:04 a.m., Stemple called Jeff Rice of the Barbour County Mine Rescue Team at Rice's home. (Tr. 541; Gov. Ex. 7). A woman who answered the phone advised Stemple that Rice was not home, but she did not provide his whereabouts. (Tr. 542). Stemple called the local mine rescue station at 8:05 a.m., but there was no answer and there was no answering machine in operation. (Tr. 542, 544; Gov. Ex. 7).

At this point, Stemple testified he had been on the telephone continuously from 7:30 a.m. until 8:05 a.m. calling federal, state and mine rescue agencies and individuals, and he had only managed to speak to Collins and a woman at Rice's home. (Tr. 542, 552; Gov. Ex. 7).

Between 8:05 and 8:25 a.m., Stemple reportedly called the MSHA District 3 office in Morgantown several times to obtain other phone numbers to call from the office's recording system. Stemple left three more messages on the answering machines of MSHA District Manager Kevin Stricklin, and MSHA Assistant District Managers Carol Mosely and William Ponceroff. (Tr. 544-45).

Having not received a response from Tenney, at 8:28 a.m., after attempts to reach two individuals named "James Satterfield" who were listed in Stemple's local telephone book, Stemple reached MSHA supervisor James Satterfield at home. After receiving the information from Stemple, at 8:32 a.m., Satterfield issued a verbal 103(k) order over the phone requiring the withdrawal of all personnel from the mine. (Tr. 545-46). Specifically, Satterfield instructed Stemple that "no one is to enter the mine or do any work at the mine from 8:32 on." (Joint Stip. 147).

Immediately after Stemple spoke to Satterfield, Stemple called the Sago Mine to advise that a 103(k) order had been issued and to request additional phone numbers for other rescue team personnel. (Tr. 546-48). Stemple successfully reached Chris Height, Vice-President of the Barbour County Mine Rescue Association at 8:37 a.m. (Tr. 549; Joint Stip. 167).

Stemple related that he was continuously on the telephone, either making or receiving calls, between 7:01 a.m. and 10:40 a.m. He estimated that he had made or received 48 phone calls during this period. (Tr. 552). At the time of his last phone call, when he called the Sago Mine at 10:40 a.m. for an update, the mine rescue teams had arrived but could not enter the mine without MSHA approval due to the 103(k) order and the atmospheric conditions existing in the mine. (Tr. 559, 568-69).

The Secretary, relying on information Stemple provided shortly after the accident, contends that Stemple's initial attempt to notify MSHA occurred at 7:50 a.m. when Stemple left a message on MSHA supervisor Kenneth Tenney's answering machine. The Secretary's assertion is consistent with Stemple's initial documented 7:46 a.m. telephone message for WVOMHST's John Collins. Both the 7:46 a.m. and 7:50 a.m. telephone messages were left by Stemple after Ty Coleman advised Stemple sometime after 7:40 a.m. to activate mine rescue. Thus, the evidence does not support Stemple's undocumented claim that he attempted to contact MSHA's Bridgeport field office as early as 7:30 a.m.

MSHA personnel first arrived at the Sago Mine shortly before 10:30 a.m. (Joint Stip. 166). Height assembled the Barbour County team members at their Volga, West Virginia station where they prepared their equipment and departed for the mine at approximately 10:30 a.m. (Joint Stip. 169). Several other mine rescue teams were alerted and arrived at the mine after the Barbour County team.

MSHA and WVOMHST exercised final authority over the rescue plan. (Joint Stip. 172). Monitoring of the mine atmosphere was commenced and continued throughout the day. Air quality measurements reflected a downward trend in the levels of dangerous gases. (Joint Stip. 173-74). At 5:25 p.m. on the day of the accident the first mine rescue team entered the mine through the fan house and proceeded inby exploring the mine. (Joint Stip. 175). This was the first time MSHA permitted entry into the mine. (Joint Stip. 169).

The mine rescue teams reached the 2nd Left section the following evening sometime after 11:00 p.m. on January 3, 2006. (Joint Stip. 176). Eleven crew members had died near the face area of the section. There was one survivor. (Joint Stip. 178). Another deceased victim was located outby the 2nd Left section. (Joint Stip. 179).

IV. **Further Findings and Conclusions**

a. Citation No. 7100919

The thrust of the Secretary's case is that immediately after learning of the underground mine explosion from Owen Jones at 6:36 a.m., Wolf Run management went underground to assist or attempt to establish contact with survivors instead of notifying the authorities of the accident. Consequently, 104(a) Citation No. 7100919 alleges that Wolf Run violated 30 C.F.R. § 50.10 because it failed to notify MSHA immediately following the explosion. The violation was attributed to a high degree of negligence. The Secretary proposes a civil penalty of $1,500.00 for Citation No. 7100919. The citation states:

> An explosion occurred at the Sago mine in the sealed area of the 2 North Mains on January 2, 2006, at 6:26 a.m. MSHA was not immediately notified of the explosion as required. According to testimony during the investigation, the 1st Left section foreman [Owen Jones], who was underground at the track switch at 49½ crosscut at the time of the explosion made a call to the surface approximately 5 minutes after the explosion. He informed mine management, that we've had an explosion in here" and "get mine rescue teams here now." According to testimony the Director of Safety and Employee Development [John B. Stemple, Jr.] initiated the notification to MSHA. His telephone call log, provided to MSHA during the investigation, indicated that the first attempt to notify MSHA of the explosion was made at 7:50 a.m. on January 2, 2006.
>
> The violation is not marked "significant and substantial" only because, at the time of the violation, 30 C.F.R. 50.10 was a regulation and not a standard and because of a Court decision holding that only violations of mandatory standards can be "significant and substantial." Otherwise, this violation is reasonably likely to be (sic) cause a reasonably serious injury since failing to notify MSHA of emergency accident events could delay important health and safety decisions affecting miners at the mine.

(Gov. Ex. 1).

At the time of the accident 30 C.F.R. § 50.10 provided:

> If an accident occurs, an operator shall immediately contact the MSHA District Office having jurisdiction over its mine. If an operator cannot contact the appropriate MSHA District Office, it shall immediately contact the MSHA Headquarters Office in Arlington by telephone at (800) 746-1153.

Section 50.2(h)(5) of the regulations, 30 C.F.R. § 50.10, defines "accident" to include "an unplanned ignition or explosion of gas or dust."

To establish the fact of the cited violation the Secretary must demonstrate: that an accident occurred; the operative time when the mine operator had sufficient knowledge to meaningfully report the material facts and circumstances surrounding the accident; and an unreasonable delay of the mine operator's responsibility to "immediately" notify MSHA of the accident.

i. Fact of the Violation

Obviously, a tragic explosion constituting a reportable accident occurred at approximately 6:26 a.m. Toler and Wilfong contend Owen Jones did not use the word "explosion" when he called the surface at approximately 6:36 a.m. "right about 10 minutes" after the force of the explosion blew Jones off of the mantrip. (Tr. 85, 448, 468; Joint Stip. 93). Rather, they claim Jones only stated that something bad had occurred. Jones testified, consistent with the information he provided during the investigation, that he told Chisolm and Toler that "we had a mine explosion or something in here" and "get mine rescue here right now." (Tr. 87, 89).

Owen Jones' account of what he said during his initial phone call is entitled to great weight because it is consistent with the information he provided to investigators shortly after the explosion. Moreover, the testimony of Toler and Wilfong is self-serving.

However, the fact that Wolf Run's management knew, or should have known , as early as 6:36 a.m. that an explosion had occurred does not end the analysis. Commission case law, as well as the language of section 103(k) of the Mine Act, recognize that the propriety of actions to be taken immediately following a mine accident is best determined based on personal on-the-scene knowledge of the particular circumstances and conditions at the accident site.

Consequently, in evaluating a mine operator's reporting obligations under section 50.10, the Commission has acknowledged that mine operators must be accorded a degree of discretion in investigating accidents prior to notifying MSHA. The Commission has stated:

> Section 50.10 therefore necessarily accords operators a reasonable opportunity for investigation into an event prior to reporting to MSHA. Such internal investigation, however, must be carried out by operators in good faith without

> delay and in light of the regulation's command of prompt, vigorous action. *The immediateness of an operator's notification under section 50.10 must be evaluated on a case-by-case basis, taking into account the nature of the accident and all relevant variables affecting reaction and reporting*.

Consolidation Coal Company, 11 FMSHRC 1935, 1938 (Oct. 1989) (emphasis added).

Moreover, the language of section 103(k) manifests Congressional recognition that MSHA's oversight of rescue and recovery efforts is best exercised after it has arrived at the mine site and had the opportunity to observe and evaluate the circumstances and conditions that exist at the accident scene. In this regard, the Mine Act provides:

> In the event of any accident occurring in a coal or other mine, *an authorized representative of the Secretary*, *when present*, may issue such orders as he deems appropriate to insure the safety of any person in a coal or other mine, and *the operator of such mine shall obtain the approval of such representative* in consultation with appropriate State representatives, *when feasible, of any plan to recover any person in such mine* or to recover the coal or other mine or return affected areas of such mine to normal.

30 U.S.C. § 957(k). (Emphasis added).

Subsequent to the Sago Mine disaster, the Secretary has recognized policy issues raised by the issuance of a verbal 103(k) withdrawal order issued before MSHA arrives at the scene of a mine accident. *See* MSHA Program Policy Letter ("PPL") No. P09-V-01 (August 12, 2009) (the need of a uniform policy for responding to accident notification by issuance of a verbal section 103(j) order until MSHA personnel arrive at the mine site at which time rescue activities can be directed under the authority delegated in section 103(k)).[1] [2] Thus, the exercise of section 103(k) authority prior to MSHA's arrival at an accident site must be balanced with the possible risk to victims caused by a withdrawal order issued without personal knowledge of the nature and variables of the accident. That is why a mine operator's section 103(k) obligation to obtain MSHA's prior approval of any of its efforts to assist and/or recover accident victims is qualified to apply "when feasible."

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[1] Although PPL No. P09-V-01 was not admitted in evidence, it is a publically available official record of the Secretary.

[2] Section 103(j) of the Mine Act, 30 U.S.C. § 957(j), authorizes MSHA to verbally direct operators to take specific actions in response to an accident without the complete control over rescue and recovery operations delegated to MSHA under section 103(k).

Thus, judgment of Wolf Run's actions must be viewed in the context of "all relevant variables" affecting its reaction and reporting, including its preoccupation with assisting victims who were still underground. Toler, Wilfong, Schoonover and Hofer went underground at approximately 6:45 a.m., approximately 15 minutes after the explosion, to determine the nature and extent of the accident and to assist the evacuation. Toler and his associates would have been precluded from entering the mine if, as the Secretary suggests, MSHA was notified at 6:36 a.m at which time it is likely that a verbal 103(k) withdrawal order would have been issued.[3] As it turned out, mine rescue teams were unable to enter the mine until 5:25 p.m. in the evening.

Having not been precluded by MSHA from going underground, sometime between 6:45 and 7:00 a.m. Toler and his associates met the members of the 1st Left crew, including Owen Jones, who had abandoned the mantrip and were traveling outby on foot in an effort to get fresh air. Visibility was very poor. At that time, they learned of the trauma experienced by the crew from the force of the explosion as well as the resultant dust and debris that was created. They also observed some of the missing and damaged stoppings. Toler and Wilfong were concerned for the 1st Left crew's safety. Toler directed Wilfong to assist in the evacuation. Wilfong and the crew reached the surface at approximately 7:30 a.m. While the evacuation efforts continued, Wolf Run made repeated attempts to establish communications with the missing victims of the 2nd Left crew.

After obtaining information from survivors, ensuring the safe evacuation of the 1st Left crew, observing the degree of damage to stoppings, and determining that the 2nd Left crew could not be accounted for, Toler and Wilfong informed Chisolm and Stemple to notify MSHA and mine rescue teams immediately during a telephone conference that ended at 7:23 a.m. Thus, the urgency of Wolf Run's responsibility to notify MSHA and mine rescue started at approximately 7:23 a.m.

Although Stemple now asserts he initially attempted to telephone MSHA's Bridgeport office at 7:30 a.m., on balance, the weight of the evidence reflects that Stemple initially attempted to contact Dunbar and Ty Coleman, his superiors in upper management, to obtain their approval before contacting MSHA despite the requests of Toler and Wilfong for implementation of mine rescue. In this regard, Stemple apparently was reluctant to notify MSHA because, as he told Toler, ". . .if we call MSHA, they're going to issue a (k) order, and they'll expect you to come out of the mines." (Tr. 452). Stemple did not obtain Ty Coleman's directive to activate the mine rescue plans until sometime after 7:40 a.m. Stemple testified:

> So I hung up with Jeff (Toler), and I called our division office, at 7:24. I hung up the phone with Jeff (Toler) at 7:23, and in my notes I wrote down that I called the

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[3] Although the verbal 103(k) order was effective as of 8:32 a.m., after the mine was evacuated with the assistance of Wilfong and Hofer at 7:30 a.m., the Secretary does not allege that MSHA would have permitted Toler and his associates to go underground if MSHA had been contacted at 6:36 a.m.

> division office at 7:24. I realized that I didn't have Chuck Dunbar's home phone number or cell phone number.
>
> Chuck Dunbar is the general manger. I didn't have Ty Coleman's home phone number or cell phone. He's my boss, who was the director of safety and employee development. I didn't have Raymond Coleman's phone number or cell phone number. Raymond was the mine manager at the mine.
>
> So I called the division office and spoke to Jerry Waters, who is a purchasing manager. And I believe Jerry was working that day. And I asked Jerry for those three individuals' home phone numbers, cell phone numbers, any contact information that he could give me for those three individuals.
>
> When I hung up the phone from Jerry, my first attempt was with Chuck Dunbar, at 7:25, I wrote down: 7:25 a.m, Chuck Dunbar. And I called up Chuck's home phone number and . . . I left a message that there had been a lightning strike at the mine; we had lost power underground; the 1 Left crew had called out there was a gush of air that went over the top of them, a lot of dust, dirt and debris was in the air; they were all accounted for; they were on their way out of the mine; but we have not been able to get a hold of the 2 Left crew at this time. I hung up the phone.
>
> Then I called Ty Coleman. I called him on his cell phone, he had no home phone number, so I called his cell phone. I left Ty the exact same message.
>
> Then at 7:20 — I want to say 7:28, I called Raymond. I called Check at 7:24; I called Ty, I think, 7:25; Raymond is 7:28. And [I] left the message on Raymond's cell phone.

(Tr. 534-35).

Stemple's telephone call log, provided to investigators shortly after the accident, indicates that his first attempt to notify MSHA of the explosion occurred at 7:50 a.m. on January 2, 2006, when he left a message on Tenney's answering machine. (Gov. Ex. 7). Stemple's contemporaneous telephone log, furnished to MSHA during the investigation, is the best evidence.

The approximate 27 minute delay in notifying MSHA, from 7:23 a.m. until 7:50 a.m., constitutes a serious violation of the requirement in section 50.10 that accidents, including explosions, must be reported immediately. However, the Secretary has not designated this reporting violation as significant and substantial (S&S) because of the Court decision in *Cyprus Emerald Resources Corp.*, 195 F.3d 42 (D.C. Cir 1999), *rev'g Cyprus Emerald Resources Corp.*, 20 FMSHRC 790 (Aug. 1998). *Cyprus Emerald* dealt with whether section 50.11(b) of the

Secretary's regulations, governing the investigation and reporting of accidents, was a "mandatory safety standard" that could be designated as S&S. The Court held that: "[s]ection 104(d) [of the Mine Act] unambiguously authorizes a 'significant and substantial' violation finding for a violation only of a mandatory health or safety standard." *Id.* at 44. Thus, the Court concluded section 50.11(b) was not a mandatory safety standard because it was promulgated by Congress under the "Administration" provisions in Title V, section 508 of the Mine Act, rather than by a section 101 rulemaking.[4] Although reporting standards may not be designated as S&S, it is clear that the hazard created by the subject violation, that deprives MSHA of timely notice and oversight of mine accidents, is serious in gravity.

The Secretary attributes a high degree of negligence to Wolf Run's notification delay. However, the Secretary's assertion that Wolf Run's obligation to notify authorities began after Owen Jones' initial telephone call approximately ten minutes after the 6:26 a.m. explosion has been rejected because it ignores the nature of this accident that involved the evacuation of survivors. Rather, the termination of Stemple's call with Toler at 7:23 a.m. provides the beginning point for Wolf Run's obligation to notify MSHA. Thus, the actionable delay was approximately 25 minutes rather, than more than one hour as the Secretary argues.

Moreover, there are several other mitigating circumstances. The accident occurred in the early morning hours on Monday, January 2, 2006, when the New Years Day holiday was observed because January 1 was on a Sunday. Consequently, MSHA and WVOMHST offices were closed at the time of the Sago Mine accident. In addition, Wolf Run's management officials were difficult to contact during this holiday period. The Secretary does not dispute that officials were difficult to reach during the New Years Day holiday.

Finally, and most importantly, Wolf Run's delay was not motivated by a desire or reluctance to avoid notification. Rather, the delay is attributable to the fact that Wolf Run was conflicted over its concern for evacuating survivors, its preoccupation with establishing contact with the missing victims, and its responsibility to notify MSHA. In the final analysis, Wolf Run was confronted with either notifying MSHA and subjecting itself to a violation of a 103(k) order, or, violating the reporting provisions of section 50.10. Thus, Wolf Run's actions constitute no more than a moderate degree of negligence. Consequently, the $1,500.00 proposed by the Secretary for 104(a) Citation No. 7100919 shall be reduced to $1,000.00.

[4] Section 508 provides, "[t]he Secretary [of Labor], the Secretary of Health, Education, and Welfare and the Panel are authorized to issue such regulations as each deems appropriate to carry out any provision of this Act." 30 U.S.C. § 957.

b. Order No. 7100920

The mandatory safety standard in section 75.1502(a), 30 C.F.R. §75.1502(a), requires each mine operator to adopt and follow an MSHA approved emergency evacuation and firefighting program. 104(d)(1) Order No. 7100920 alleges that Wolf Run violated 30 C.F.R. § 75.1502(a) because it failed to comply with the mine's emergency evacuation and firefighting program of instruction provision that mine rescue teams be contacted immediately in the event of an emergency. (Gov. Ex. 6 at 12). The violation was designated as S&S in nature. The violation also was attributed to a high degree of negligence that evidenced an unwarrantable failure. The Secretary proposes a civil penalty of $13,000.00 for Order No. 7100920. The citation states:

> A (sic) explosion occurred at the Sago mine, I.D.46.08791 in the sealed area of the No. 2 Mains on January 2, 2006, at 6:26 a.m. The Mine Emergency Evacuation and Firefighting Program of Instruction approved on February 3, 2004 was not complied with. On page 12 of the plan under "Mine Rescue" it states "In the event of a mine fire or explosion the Barbour County Mine Rescue team is to be notified immediately at 457-2745." The Barbour County Mine Rescue team was not immediately notified of the explosion. According to testimony during the investigation, the 1st Left section foreman, who was underground at the track switch a 49½ crosscut at the time of the explosion made a call to the surface approximately 5 minutes after the explosion. He informed the mine dispatcher, and mine management that "we've had a mine explosion in here" and "get mine rescue team here now."
>
> According to testimony, no attempt was made by those people informed by the 1st Left foreman to get a mine rescue team. According to testimony the Director of Safety and Employee Development initiated the first attempt to contact the Barbour County Mine Rescue team. His telephone call log, provided to MSHA during the investigation, indicated that the first attempt to notify the rescue team after the explosion was at 8:04 a.m. on January 2, 2006.

(Gov. Ex. 2).

i. Fact of the Violation

As discussed above, Wolf Run's obligation to immediately notify MSHA and mine rescue teams began at 7:23 a.m., after Stemple's telephone conversation with Chisolm and Toler. At that time, Wolf Run had ascertained the nature and extent of the emergency, and it had taken measures to ensure the safe evacuation of victims. However, Stemple admits he did not make any effort to contact rescue teams until 8:04 a.m. when Stemple phoned Jeffery Rice, a member of the Barbour County Mine Rescue team, at his home. Stemple finally reached Chris Height, Vice-President of the Barbour County Mine Rescue Association at 8:37 a.m. The approximate 40 minute delay from 7:23 until 8:04 a.m, constitutes a section 75.1502(a) violation of

Wolf Run's emergency evacuation and firefighting program that requires immediate notification. Stemple's apparent preoccupation with his attempts to notify federal and state agencies does not absolve Wolf Run's concurrent responsibility to notify mine rescue.[5]

ii. S&S

With respect to the issue of S&S, as a general proposition, a violation is properly designated as S&S, if, based on the particular facts surrounding that violation, there exists a reasonable likelihood that the hazard contributed to by the violation will result in an injury or an illness of a reasonably serious nature. *Cement Division, National Gypsum*, 3 FMSHRC at 825. In *Mathies Coal Co.*, 6 FMSHRC 1 (Jan. 1984), the Commission explained:

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

6 FMSHRC at 3-4; *see also Austin Power Inc., v. Secretary,* 861 F.2d 99, 103-04 (5th Cir. 1988), aff'g 9 FMSHRC 2015, 2021 (Dec. 1987) (approving *Mathies* criteria).

The hazard created by a failure to timely notify MSHA and rescue teams in the face of an emergency is self evident. After the explosion, MSHA and WVOMHST exercised final authority over the rescue plan. The fact that rescue teams were prevented from entering the mine until 5:25 p.m. on January 2, 2006, because of dangerous concentrations of gases does not diminish the importance of their prompt arrival. Rescue teams have the experience and equipment to safely attempt to recover victims of mine accidents. The presence of rescue teams also minimizes the exposure of mine personnel who, as in this case, subordinate their personal safety in an effort to save friends, colleagues or family members. In this regard, in their haste to go underground, mine management entered the mine without turning off power and without carrying gas detectors.

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[5] Under the applicable regulations, Wolf Run was required to immediately notify all relevant authorities of the accident. Implementation of mine rescue involves the coordinated efforts of federal, state and mine rescue authorities. Thus, notification of one entity is, in effect, notification of all. Even if Wolf Run is credited with notifying the authorities as of 7:50 a.m. (or 7:46 a.m. when Stemple initially left a telephone message for WVOMHST), such notification was still untimely. Moreover, notification in this case is problematic as the initial contacts were telephone messages rather than direct communications.

Here, Toler's attempt to repair stoppings was well intentioned and there is no evidence that the effort to direct fresh air to the 2nd Left section was harmful. However, Ron Hixon, a member of the rescue team that initially reached the 2nd Left victims, explained how rescue teams proceed into a mine following an explosion. They airlock areas to prevent pushing methane over an ignition source, or to prevent directing CO gases towards trapped victims. (Tr. 238).

Thus, as a general matter, it is reasonably likely that the existing hazards posed by an underground mine emergency will be exacerbated by a delay in the arrival of rescue personnel. It is also reasonably likely that this increased exposure to danger will result in serious or fatal injuries of would be rescuers or the victims of an accident. Consequently, the section 75.1502(a) violation was properly designated as S&S.

iii. Unwarrantable Failure

The remaining question of unwarrantable failure in this case raises difficult issues. Generally speaking, an unwarrantable failure is evidenced by aggravated conduct. *Emery Mining Corp*., 9 FMSHRC 1997 (Dec. 1987). I recognize the Secretary's concern for the safety of would be rescuers who may expose themselves to extreme danger because of their desire to save friends and family. I am also cognizant of the Jim Walter Resources mine tragedy noted by the Secretary in which twelve miners who went into a mine to rescue one miner following an explosion were killed by a secondary explosion. (Sec'y br. at 41-42). However, the Jim Walter accident did not involve the evacuation of miners that were known to have survived the explosion. *Jim Walter Resources, Inc.*, 28 FMSHRC 579 (Aug. 2006).

Similar to the delay in notification of MSHA, the Secretary attributes a high degree of negligence to Wolf Run's delay in notifying mine rescue. However, the Secretary's assertion that Wolf Run's obligation to notify rescue teams began after Owen Jones' initial telephone call that occurred at approximately ten minutes after the 6:26 a.m. explosion has been rejected because Wolf Run had not yet determined the nature and extent of the accident. Rather, the termination of Stemple's call with Toler at 7:23 a.m. provides the beginning point for Wolf Run's obligation to notify mine rescue. Thus, the actionable delay from 7:23 until 8:04 a.m is approximately 40 minutes rather than the approximate 1½ hour delay from 6:36 to 8:04 a.m. alleged by the Secretary.

As a threshold matter, it is easy to question the propriety of Wolf Run's conduct by asking why it did not contact MSHA and mine rescue at 7:23 a.m. while Toler and his associates continued their attempts to help victims underground. The simple answer is that they knew they could not legally remain underground once MSHA was notified as exemplified by Satterfield's 8:32 a.m. verbal 103(k) order requiring a total withdrawal from the mine.

In this regard, Gary Marsh, a supply motorman, testified that Stemple told him that morning "[t]hat once we notified MSHA that they would shut us down to where no one would be allowed in the mines and we wouldn't be able to try to go in there and try to get our people." (Tr. 142). As previously noted, Toler testified that Stemple told him: "You know if we call MSHA, they're going to issue a (K) order, and they'll expect you to come out of the mines." (Tr. 452). Toler testified he replied: "Don't let that stop you from calling, because we're not going to come out." (Tr. 452). Although Toler testified he told Stemple to call MSHA and mine rescue teams anyway, it is clear that the prospect of the issuance of a 103(k) order in response to Wolf Run's notification had a chilling effect on Stemple's reporting responsibilities. (Tr. 454). Toler estimated this conversation occurred at 7:15 a.m. (Tr. 451). Stemple testified the conversation ended at 7:23 a.m. (Tr. 572).

Thus, the Secretary alleges that Wolf Run intentionally delayed notifying MSHA and rescuers immediately because they knew MSHA would immediately issue a 103(k) withdrawal order that would prevent Toler and others from trying to reach the 2nd Left crew. (Sec'y br. at 40). The Secretary argues that such deliberate disregard of the requirements of the law is an aggravating rather than a mitigating factor.

The Secretary's position is understandable from an enforcement perspective. The failure to timely notify MSHA and rescue teams immediately after an accident is a serious violation. However, notification violations are not *per se* unwarrantable. Wolf Run's conduct must be analyzed on a case-by-case basis based on what was known at the time without the benefit of hindsight . In this case, unlike the Jim Walters accident, mine management knew that miners had survived the explosion. Thus, management was focused on evacuating the 1st Left crew and determining whether the 2nd Left crew members could be helped.

While the *Nacco* defense may not be used to mitigate an unwarrantable failure, it nevertheless is significant that only mine management personnel, rather than hourly employees, went underground before rescue teams were contacted. *Capitol Cement Corp.*, 21 FMSHRC 883, 893-95 (Aug. 1999), *aff'd,* 2000 WL 1205389 (4th Cir. 2000) (*Naaco* defense unavailable when conduct of supervisory personnel results in unwarrantable section 104(d) violations regardless of whether that conduct exposes other miners to risk). Thus, subordinate hourly employees were not put at risk by management's actions. Finally, Toler, Jones, Wilfong, Schoonover and Hofer's presence underground furthered the rescue efforts because they were able to brief the rescue teams about underground conditions while the rescuers remained on the surface until later that evening because of dangerous gases.

As noted, an unwarrantable failure is aggravated conduct constituting more than ordinary negligence. *Emery Mining,* 9 FMSHRC 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, 193-194 (Feb. 1991); see *also Buck Creek Coal*, 52 F.3d at 135-36 (approving the Commission's unwarrantable failure test). All relevant factors must be viewed in the context of the factual circumstances, and all material facts and circumstances must be examined to determine if a mine operator's negligence is mitigated. *Consolidation Coal Co.*, 22 FMSHRC 340, 353 (Mar. 2000).

Here, the Secretary fails to distinguish between imprudent or ill-advised conduct, and aggravated or unjustified conduct. Wolf Run's delay was not motivated by a desire to avoid notifying MSHA of the accident. Nor was it an attempt to alter an accident scene. Rather, Wolf Run's delay was caused by its preoccupation with determining the condition of its miners who were underground at the time of the explosion.

Toler was concerned about the safety of his uncle who was a 2nd Left crew member. Jones was motivated by a concern for the well being of his brother, also a member of the 2nd Left crew. Toler and his associates were also motivated by a concern for their colleagues. The subordination of their personal safety in an attempt to save others instead of relinquishing their ability to go underground by immediately calling MSHA, given the circumstances in this case, is understandable, if not admirable. Their actions are not attributable to intentional misconduct, or a manifestation of indifference. Their behavior manifested a conscious awareness of an exigent situation rather than a reckless disregard of it. Simply put, it is obvious that the facts surrounding their conduct mitigates their negligence. There was no unwarrantable failure.

Accordingly, 104(d)(1) Order No. 7100920 shall be modified to a 104(a) citation to reflect that the violation was attributable to a moderate degree of negligence. In addition to mine management's efforts to evacuate or locate colleagues, that included family members, the difficulties of notification of an early morning accident that occurred on a federal holiday are additional mitigating factors. In this regard, the Secretary does not dispute that the authorities were difficult to contact during this holiday period.

The Secretary proposes a civil penalty of $13,000.00. I share the Secretary's concern that mine operators must not be encouraged to delay notification of an accident because of a desire to conduct their own rescue. However, I am troubled by the exercise of MSHA's authority and control, prior to its arrival at the mine, over the conduct of mine management personnel who have personal knowledge of the conditions at the accident site. The strict exercise of such authority may, as in the current case, discourage prompt notification. Depending on the particular circumstances, mine operators must be permitted to take prudent action in the moments following a mine accident that furthers the evacuation of victims or helps to determine their location in the mine**.** Accordingly, the provisions of section 103(k) recognize that mine operators must obtain MSHA's prior approval of any plan to recover accident victims "when feasible." Although the Secretary emphasizes that Wolf Run has not been charged with violating the verbal 103(k) order, the prospect of its issuance had a chilling effect in this case. Thus, the prospect of the issuance of a 103(k) order in this case is relevant and material.

The determination that Wolf Run's notification delay is not attributable to an unwarrantable failure is based on the totality of the particular circumstances in this case and should not be broadly construed. In the final analysis, the goal is achieving the most effective way to promote the health and safety of both rescuers and victims in the moments immediately following an accident. There are no easy answers to this difficult dilemma.

Nevertheless, the delayed notification of mine rescue teams in violation of an approved mine evacuation plan is a violation that is serious in gravity. Given the serious gravity, a civil penalty of $10,000.00 shall be assessed for 104(a) Citation No. 7100920. This relatively small reduction of the $13,000.00 proposed penalty balances the Secretary's concern over the prompt reporting of accidents with the exigent mitigating circumstances that place the propriety of mine management's actions in this case in the proper perspective.

ORDER

Consistent with this Decision, **IT IS ORDERED** that 104(a) Citation No. 7100919 in Docket No. WEVA 2007–600 **IS AFFIRMED**.

IT IS FURTHER ORDERED that Wolf Run Mining Company shall pay a civil penalty of $1,000.00 in satisfaction of Citation No. 7100919.

IT IS FURTHER ORDERED that the parties' motions to approve partial settlement **ARE GRANTED**. Consistent with the parties' settlement terms, **IT IS ORDERED** that Wolf Run Mining Company shall pay a total civil penalty of $71,800.00 in satisfaction of the remaining 13 citations and orders that are in issue in Docket No. WEVA 2007–600.

IT IS FURTHER ORDERED that 104(d)(1) Order No. 7100920 in Docket No. WEVA 2008-247 **IS MODIFIED** to a 104(a) citation to reflect that the cited violation was not attributable to an unwarrantable failure.

IT IS FURTHER ORDERED that Wolf Run Mining Company shall pay a civil penalty of $10,000.00 in satisfaction of Citation No. 7100920.

Consistent with the total civil penalty assessment of $11,000.00 for the two citations that were adjudicated in these matters, as well as the parties' settlement terms, **IT IS ORDERED** that Wolf Run Mining Company pay, within 45 days of the date of this Decision, a total civil penalty of $82,800.00 in satisfaction of the 15 citations and orders that are the subject in these proceedings.

IT IS FURTHER ORDERED that, upon receipt of timely payment, the civil penalty proceedings in Docket Nos. WEVA 2007-600 and WEVA 2008-247 **ARE DISMISSED**.

Jerold Feldman
Administrative Law Judge

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