FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

OFFICE OF ADMINISTRATIVE LAW JUDGES

601 NEW JERSEY AVENUE, NW, SUITE 9500

WASHINGTON, DC 20001-2021

TELEPHONE: 202-434-9958 / FAX: 202-434-9949

April 29, 2011

SECRETARY OF LABOR, MINE SAFETY AND HEALTH ADMINISTRATION (MSHA), Petitioner	:	CIVIL PENALTY PROCEEDING Docket No. WEVA 2010-312 A.C. No. 46-07908-203763
v.	:	
PINE RIDGE COAL COMPANY, LLC, Respondent	:	Mine: Big Mountain No. 16

DECISION

Appearances: Jessica R. Hughes, Esq., Office of the Solicitor, U.S. Department of Labor, Arlington, Virginia, for Petitioner;
Melissa M. Robinson, Esq., and Rodney W. Stieger, Esq., Charleston, West Virginia, for Respondent.

Before: Judge McCarthy

I. Statement of the Case

This case is before me on a petition for assessment of civil penalty filed by the Secretary of Labor ("Secretary"), acting through the Mine Safety and Health Administration ("MSHA"), against Pine Ridge Coal Company, LLC ("Pine Ridge" or "Respondent"), pursuant to sections 105 and 110 of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. §§ 815 and 820 (the "Mine Act").

Respondent operates a large mine called Big Mountain No. 16 in Boone County, West Virginia. This case involves one section 104(d)(1) Order No. 8093139 issued by MSHA inspector Brandon Ellison on August 17, 2009,[1] alleging an unwarrantable failure to report a roof fall accident to MSHA within 15 minutes under 30 C.F.R. § 50.10.

30 C.F.R. § 50.10 provides, inter alia, that the 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 . . . ." 30 C.F.R. 50.2(h)(8) defines accident to mean "[a]n unplanned roof fall at or above the anchorage zone in active workings where roof bolts are in use; or, an unplanned roof or rib fall in active workings that impairs ventilation or impedes passage."

The condition specifically alleged in the August 17 Order is as follows:

[1]All subsequent dates are in 2009, unless otherwise indicated.

> "The mine operator has failed to immediately report a roof fall that occurred on 8-13-2009 that was above the anchorage zone. This fall pulled out 2 roof bolts and damaged 2 roof bolt plates. The fall was in the 6 left face on the 020-0 MMU and fell onto the continuous miner on the day shift. The fall measured 8' wide x 20' long x 7' high. Six foot torque tension bolts were being used in ths area. A 103 (k) Order was issued on 8-17-09 @ 1220 when discovered by MSHA to protect the health and safety of the miners on the 020-0 mmu (East Section). Reference order # 8093136. After the roof fall occurred, the operator has allowed mining to continue on the East Section. Mine Management has engaged in aggravated conduct constituting more than ordinary negligence by not immediately reporting the fall on 8-13-09 within 15 minutes of learning of the condition. This condition is an unwarrantable failure to comply with a mandatory standard."

G. Ex. 1.[2]

On August 20, said Order was modified based on the results of MSHA's additional investigation on August 18. The modified Order reads:

> Upon further investigation, in addition to having a roof fall at or above the anchorage zone in the #6 left face that pulled out 2 permanent roof supports (roof bolts), ventilation to the #6 face has been impaired due to the roof fall and the severe adverse roof conditions in the area. The ventilation control in the form of a line curtain is approximately 47' from the last row of roof bolts and approximately 75' from the unsupported face when measured with a digital range finder. Passage of persons has also been impeded to the last row of roof bolts in the #6 entry. This face area has not been examined by the operator since the occurrence of the roof fall on August 13, 2009. A set of breaker posts dangering the #6 heading off were placed approximately midway from the mouth of #6 heading to the projected #6 left cross cut due to the hazardous conditions present.

The 104(d)(1) Order alleged the gravity of the violation as no likelihood of injury, no lost workdays, and non-significant and substantial (non-S&S), with one miner affected. Negligence was alleged to be "reckless disregard."

The parties stipulated to jurisdictional issues, authorized representative status, and the authenticity of the violator data sheet in G. Ex. 1. Respondent's Answer to the Petition for Civil Penalty denies the following: any violation; the validity of the proposed $2,000.00 civil penalty; the unwarrantable failure finding; and the gravity and negligence findings, particularly "reckless disregard."

An evidentiary hearing was held in Charleston, West Virginia. The parties introduced

---

[2]In this Decision, the Petitioner's or Government's exhibits are designated G. Ex. #, Respondent's exhibits are designated R. Ex. #, and volumes one through three of the transcript are designated as Tr. I, II, or III, followed by the transcipt page number(s).

testimony and documentary evidence. Witnesses were sequestered.[3]

Respondent moved for partial summary judgment with respect to the unwarrantable failure issue, contending that any violation was of a regulation and not a mandatory safety standard. See *Cyprus Emerald Res. Corp. v. FMSHRC*, 195 F.3d 42, 45 (D.C. Cir. 1999). Procedurally, the Secretary opposed the Respondent's motion as untimely filed.[4] Substantively, the Secretary argued that the original regulation was re-promulgated as a mandatory standard in a December 8, 2006 Final Rule published pursuant to Title 1 of the Act. I reserved ruling at the outset of the hearing, pending further briefing on the issue of whether MSHA gave fair notice of its intention to enforce the § 50.10 reporting requirement as a mandatory standard.

For the reasons set forth below in Section III A, I deny Respondent's motion for partial summary decision and find that Respondent's failure to report the roof fall within 15 minutes of its occurrence constitutes an unwarrantable failure to comply with a mandatory safety standard. I increase the penalty from the proposed statutory minimum of $2,000.00 to $6,000.00.

On the entire record, including my observation of the demeanor of the witnesses,[5] and after considering the extensive post-hearing briefs and Respondent's reply brief, I make the following:

II. Findings of Fact

A. The August 13 Unreported Roof Fall

During the day shift on Thursday, August 13, Respondent had one miner crew, one bolt crew, four coal hauler operators and a scoop deployed on the 020-0 MMU (East Section). (Tr. II. 184, 242). John Pauley was the foreman in charge of the East Section (Tr. II 180). Pauley reported to erstwhile mine manager, Dave Belcher, who had been promoted to mine superintendent by the time of the hearing. (Tr. II 193-94, 298, 311). The whole East Section had adverse roof conditions in every entry as Respondent drove on the outcrop with low cover. (Tr. II 243).[6] There were very

---

[3]Respondent's direct examination of its witnesses was replete with leading questions, despite repeated admonitions from the bench.

[4]Prior to the hearing, I declined to dismiss the motion as untimely filed since Respondent would likely raise the issue by way of alternative motion at hearing. The motion was held in abeyance for further briefing and argument, particularly on the fair notice issue.

[5]In resolving conflicts in testimony, I have taken into consideration the demeanor of the witnesses, their interests in this matter, the inherent probability of their testimony in light of other events, corroboration or lack of corroboration for testimony given, and consistency or lack thereof within testimony of witnesses and between the testimony of witnesses.

[6]The immediate roof of the 8-10-foot coal bed being mined varied form less than a foot to 5 feet of shale. Above that was 5- 80 feet of sandstone. (Tr. II 379; Ex. 9, p. 2; R. Exh. 3, p. 1). The mine had considerable subsidence and had been extensively undermined (Dorothy coal seam) and over-mined (Lewis Stockton) (Tr. II 436; G. Ex. 8, p. 4 and 6; R. Ex. 3, p.1), but had no history of liberating methane. (Tr. III 40, 43).

bad roof conditions and cracks across the section, which were very dangerous. (Tr. I 72-73, 76-77; Tr. III 433-34).

Steve Kinder was operating the high-voltage continuous mining machine remotely in the 20-foot wide No. 6 entry, turning the left cross cut. Lee Daniels was his helper. (Tr. II 190, 345; Tr. III 193). The primary air intake from the blowing ventilation system went from right (No. 6 entry) to left (No. 1 entry). (Tr. I 81; Tr. II 20, 345; Tr. III 46). Six-foot torque tension bolts with 24 inches of resin or glue (grout) were used for roof support in the entry. (Tr. I 213-15, 249; Tr. II 351; G. Ex. 9, p. 2 para 2(e); R. Exh. 3, p. 2, para. 2(e)). There were two parallel surface cracks in the roof where the miner was taking the first cut in the No. 6 left cross cut. (Tr. II 221-22).[7] Reflectors were hung two roof bolts back to indicate the red zone,[8] and to signal against walking inby the danger area where cutting was taking place in unsupported top. (Tr. II 198, 223-24). Prior to the roof fall, a ventilation line curtain hung from a roof bolt about four feet from the right rib and had been advanced to within three rows of the roof bolts where the No. 6 left cross cut was being turned. (Tr. II 225, 226, 345).

Toward the end of the day shift, after several haulers had been loaded and the left crosscut had been turned about 20 feet deep, a large piece of sandstone fell between surface subsistence cracks from unsupported top onto the drum of the continuous miner as it was cutting. (Tr. II 186-87, 286-89, 353, 416; G. Ex. 8, p. 5). Although Kinder and Daniels were both employed by Respondent at the time of the hearing, neither were called by Respondent to testify about the fall. (Tr. II 222-23). Nor did the Secretary subpoena them or take their depositions.

Pauley was not present when the rock initially fell on the continuous miner. (Tr. II 221, 289). He was standing in the last open crosscut, where ventilation check flies were present, about 60-70 feet away. (Tr. II 209-10). Pauley heard the fall, however, and Kinder and Daniels hollered. (Tr. II 211, 290). When Pauley approached, he noticed that the two miners were visibly shaken up. (Tr. II 288, 290). Kinder and Daniels told him that a big rock fell out between the parallel cracks onto the continuous miner as they took a cut. (Tr. II 292). Contrary to Order No. 8093139, which represented an approximation, I find that the height of the rock varied between about 4.5 feet and 5.5 feet high, as set forth in R. Ex. 10.

Pauley testified that the rock was not anchored to the roof and the entire rock fell in one solid piece. (Tr. II 188, 210). Pauley, Kinder and Daniels collectively decided to raise the miner head up against the roof and back the machine up so the rock could slide off the miner and fall to the floor.

---

[7]Belcher testified that similar parallel surface cracks existed across the entire East Section. In addition, there was an unusual block of coal that had separated from the roof in the No. 3 entry, and one could look over top of it to the next entry 100 feet away. Belcher had never seen anything like that in 31 years of mining. Tr. II 354. Further, Belcher explained that it was dangerous to mine where double parallel surface cracks were present, because rock was likely to fall. See Tr. 350-51.

[8]Belcher testified that when tramming the continuous miner, the red zone extended from the end of the boom to the cutting head of the miner, but when mining coal, miners were allowed to be in that area and a "red zone area is in an active working place." (Tr. II 364, 367).

(Tr. II 189, 288, 291, 294). Pauley testified that when they did so, the miner pulled or dragged the rock into the supported area of the No. 6 entry. (Tr. II 203-04, 274-76). The rock fell to the ground in both supported and unsupported top after being dragged by the miner. (Tr. II 274-76, R. Ex. 10).[9]

According to Pauley, during this process, the continuous miner tore out a couple of roof bolts that were at the edge of the cut (Tr. II 189, 193, 201), and the boom of the miner caught the line curtain and pulled it down. Thereafter, the line curtain was never moved back up to comply with the 50-foot waiver that MSHA had granted Respondent. (Tr. II 228).[10] Pauley testified that when a curtain is down, ventilation is automatically compromised. (Tr. II 279). Shortly thereafter in testimony, Pauley volunteered that a downed curtain impedes ventilation (Tr. II 280), and then testified that it always impairs the volume of air in the area. (Tr. 280).

After the rock fell to the ground, the continuous miner was backed out to the last open crosscut. (Tr. II 191). Sometime during the next 10 minutes, miner representative, Charlie Mullins, who runs a roof bolting machine, became aware of the incident and had a discussion with Kinder, Daniels, and Pauley. (Tr. II 297-98). Pauley described the discussion as a "confrontation" regarding whether there was a [reportable] roof fall (Tr. II 190-91). "They were making the decision that it was a roof fall." (Tr. II 298). Pauley told them, however, that it was not a roof fall. (Tr. II 298, 236). Pauley made the determination that the event was not reportable. (Tr. 191-93). In his testimony, Pauley explained that it was just a piece of rock coming down in unsupported top during normal mining practice, and it did not damage the bolts in the intersection where the roof supports were present, or compromise the anchorage of the roof bolts in the area. (Tr. II 191-93). Rather, Pauley determined that the roof bolts were damaged by the cutter head of the continuous miner as the rock was raised up to the roof, and the miner was backed up in an effort to remove the rock. (Tr. II 189, 193, 201).

Pauley had enough reservations about his determination, however, to call Belcher on the surface. (Tr. II 193-94, 298). Pauley explained what happened, including his discussion with Mullins and crew. Based on Pauley's explanation, Belcher agreed that the roof fall was not reportable. (Tr. II 194, 299-300). Belcher had to rely on what Pauley told him based on Pauley's

---

[9]All maps or diagrams of the rock fall establish that it extended several feet into the bolted No. 6 entry from unbolted 6 left, about half way to the second row of roof bolts. (G. Ex. 5, p. 4; G. Ex. 6, p. 6; R. Ex. 10).

[10]At one point, Pauley testified that the line curtain was put back up before the crew left the section (Tr. 231), but later testified that there was a piece of curtain missing after the area was dangered off. (Tr. 251). I discredit Pauley's testimony that the line curtain was put back up to ventilate the face, when the day shift left the section. (Tr. II 231). Pauley's own inconsistent testimony (Tr. II 228), and the testimony of his boss, Dave Belcher, establish that after the fall, the line curtain was no longer within 50 feet of the face. For example, on cross-examination, Belcher testified that when he examined the rock fall the next day, the line curtain was 70 feet outby the No. 6 face and had been torn down. (Tr. II 369).

observations at the scene. (Tr. II 237-38). As Belcher put it, "I had to trust his judgment, what he told me on the mine phone that day," to meet the 15-minute reporting requirement. (Tr. II 404). "If I'm wrong, I'm wrong: if I'm right, I'm right." (Tr. II 406).

Belcher testified that the reporting issue was not even a "close call" based on what Pauley told him. "I mean, to me, it's - it's everyday mining. ... To me, it's not a roof fall until you support it with roof bolts. And then if it's above those roof bolts and falls out, then that's a reportable roof fall, in my opinion." (Tr. II 416-17). A truncated version of Belcher's conversation with Pauley follows:

> And John called outside and said, you know, "We had a piece of rock fall up here in the 6 break left." He said, "I just want to try to get some leeway. Do you think I need to report?"
>
> I said, "Well, what's happened?"
>
> He said, "Well, during the cut, the rock fell out."
>
> I said, "Well, did it tear out bolts?"
>
> He said, "No."
>
> And I said, "Well," I said, "unless it's above anchorage or it impedes passage, John, or it impedes your ventilation," I said, "no, it's not reportable."
>
> And he said, "Well, that's what I thought, but," he said, "I just wanted to make sure."
>
> I said, "Well, there's nothing wrong with that."
>
> . . . .
>
> He said, "Well, it's got a -- it fell on top the miner. It's got a bolt in it." He said, "When we backed out with the miner, we broke that bolt off." I said, "Well, John, it still ain't -- you know, it's not above anchorage, so it's not reportable."

(Tr. II 314-17).

After Pauley called out the fall, Belcher told him to put up reflectors because Respondent was going to clean the rock up and roof bolt the area. (Tr. II 194). Pauley testified that the crew had safe passage past the fallen rock to leave the No. 6 entry at the end of their shift. (Tr. II 205, 209).[11]

Pauley testified that he did not indicate what happened in the August 13 on-shift report because he saw no reason to do so. (Tr. II 213). Although acknowledging that he would report dangers in the on-shift book, Pauley testified, "I didn't have no potential hazard ... I didn't see no potential hazard." (Tr. II 214). Pauley's pre-shift report for August 13 for the No. 6 entry under the heading "Violation or Hazardous Condition," indicates that a "scrap" cut was called out at 3:18 p.m. (Tr. II 240; R. Ex. 8, p. 5). Consistent with his discussion with Belcher, Pauley was expecting

---

[11]Although the crew exited safely, I find that the unsupported top created by the dislodged roof bolts between parallel surface cracks made travel in the area hazardous, as Respondent admitted in August 17 and 18 shift reports (R. Ex. 8, pp. 26-27), and through the testimony of Belcher that travel in the No. 6 entry was unsafe after the fall. (Tr. II 348-49).

the next shift to clean up the rock and bolt the area. (Tr. II 240-41).

Instead, the evening shift "dangered off" the No. 6 entry and left crosscut, as reflected in the on-shift report. (Tr. II 241; R. Ex. 8, p. 6). Belcher explained that when he lined out miners for the evening shift, he asked shift manager Jim Martin to "at least go up there and look at [the fall], see if you think we need to do anything additional . . . ." According to Belcher, Martin called back outside, "Dave, this is just normal procedure. We – you know, we've encountered this before. This ain't reportable." (Tr. II 318).

Based on Martin's report, Belcher did not think it was necessary to examine the fall. (Tr. II 32). Belcher further testified that normally, if it was a reportable fall, he would examine the fall immediately and make a judgment call. (Tr. 320). This testimony makes little sense, however, if Belcher could not reach the fall site within 15 minutes to determine reportability, and thus was forced to rely on the reports of others, such as Pauley's report in this case. Moreover, according to Belcher, Martin did not review the fall until around 5 p.m. on the evening shift, about an hour and one-half after the incident, well past the 15-minute reporting deadline. (Tr. II 337). Thus, Belcher had to rely on the judgment of Pauley, as it took more than 15 minutes, indeed about 45 minutes, to reach the site of the fall from the surface. (Tr. I 78; Tr. II 404). Moreover, Belcher did not speak to operator Kinder until later that evening, when Belcher learned that Kinder had expressed concerns to Pauley about reportability, that Pauley had told Kinder that the fall was not reportable, and that Pauley was going to call Belcher and make sure. (Tr. 390). Like Kinder and Daniels, Martin did not testify. I give Belcher's testimony about his conversation with Martin little weight.

Despite Belcher's account of Martin's report, Belcher testified that he then told Martin to "breaker off" the entry. Belcher testified:

> "Well, with the multiple cracks that's in that entry, No. 6 entry," I said, "let's just go ahead and breaker it off." I said, you know, "The rock fell in there." I said, "For the safety and health of -- you know, of everybody that's supposed to be in there, let's just go ahead and breaker it off." And that's what we did.

(Tr. II 318).

Belcher considered the No. 6 entry stopped at that point. As he put it, "[w]e was no longer going to proceed into that crosscut because our ultimate goal was to punch outside [through another entry] and get to pillaring." (Tr. II 318). ". . . [W]e was trying to butt off and punch outside." (Tr. II 324). Frederick Collins, senior safety manager for Respondent's parent, Patriot Coal Corporation, confirmed that Respondent only needed one of the entries "punched to the outside to finish that unit up and get completely out of there, so it wasn't necessary for us to mine that place, in those bad conditions." (Tr. II 435).

B. The Day After the August 13 Roof Fall

Belcher recalled a conversation on Friday, August 14, with state inspector Kerry Herron from the West Virginia Office of Miners' Health Safety and Training (WVOMHST). According to Belcher, Herron had issued a roof control violation during the hoot owl shift on August 13-14 for adverse conditions that required supplemental bolting throughout the East Section. (Tr. II 320,

334).[12] Also according to Belcher, Herron told Belcher that Pine Ridge had done an "outstanding" job on the section, but Herron just wanted to see more. (Tr. II 334).

Belcher testified that when he asked Herron about "6 break left," Herron replied, "Well, you've got that breakered off." When Belcher then asked what Herron thought about the fall yesterday, Herron purportedly replied, "Well, just a normal rock fall, just like getting a cut of coal. I did see the surface cracks in there, but I didn't go inby the breaker line." (Tr. II 322). On questioning from the bench, Belcher testified, as follows:

> And then, of course, I did ask him about the rock in No. 6 left, just for a simple reason, just to try to clear my conscious [sic] a little bit. Because anytime something like that comes up, you want to make sure about something. So not only did my section boss tell me that he didn't think it was reportable, I had a shift manager tell me the same thing.
>
> So I asked Kerry the same question, "Did you think that was a reportable roof fall?"
>
> He said, "Roof fall?" He said, "Well, no, that's just part of the cut, ain't it?"
>
> I said, "Well, that's my opinion too. I just wanted to know what you thought, because there was a question brought up yesterday about should we have reported or not, by the boss, you know, John -- when John had called out." And I said, "I'm just trying to get some confirmation on it." That was pretty much the end of us discussing that in 6 left.

(Tr. II 334-35).

I do not credit Belcher's recollection of this hearsay from Herron. I give it no weight. It is self-serving testimony on the critical legal issue of unwarrantable failure. It is uncorroborated by any notes from Respondent, by any documentation of the alleged August 14 inspection or violation, or by Herron's own affidavit. (Tr. 372-75; R. Ex. 13). In fact, Herron's affidavit makes no mention of this conversation with Belcher. (R. Ex. 13). Significantly, Herron's affidavit places his examination of the fall about a week after the incident, not the day after. Herron's affidavit specifies that "[a]pproximately one week after the fall occurred...," he examined the fall from the breaker line

---

[12]WVOMHST inspector Herron, a former Pine Ridge employee, had worked under current safety and training manager, Dave Ashby. Ashby was Respondent's non-sequestered representative and the last witness to testify at the hearing. (Tr. III 71, 105-06). Herron provided Respondent's counsel with a notarized affidavit dated November 15, 2010 (R. Ex. 13), which I received in evidence over strenuous hearsay and relevancy objections from Petitioner's counsel, who also raised standing objections to receipt of any evidence from WVOMHST. (Tr. 1, 17-26, 33-34; Tr. 11, 322-25; Pet. Br. at 22-26). As I informed the parties in pre-trial conferences and reaffirmed at the hearing, I find Herron's affidavit and the WVOMHST hearsay relevant to the unwarrantable failure issue and admissible evidence under Commission Rule 63. As explained herein, however, I give such evidence no probative weight.

while traveling with an unidentified Pine Ridge supervisor. (R. Ex. 13, para. 3 and 7).[13]

Similarly, I place minimal weight on Herron's November 15 affidavit.[14] Herron did not testify because Respondent never effected service of its subpoena on him. Accordingly, Petitioner was unable to cross examine Herron on the truth of the matter being asserted -- his opinion that the fall was not reportable -- and the basis for that opinion. Similarly, the Petitioner was precluded from inquiring into potential bias in light of Herron's past employment by Respondent. Likewise, Petitioner was precluded from exploring the circumstances surrounding Respondent's counsel's preparation of Herron's affidavit and how Herron obtained personal knowledge of the facts alleged therein. Thus, while Herron's hearsay opinion on the ultimate issue is admissible as relevant evidence under Commission Rule 63 and Fed. R. Evid. 704(a), I find the evidence unreliable and sufficiently lacking in circumstantial guarantees of trustworthiness.

Despite Belcher's testimony that he saw no need to view the roof fall after receiving Martin's report, Belcher and superintendent Ryan Toler did examine the roof fall the next day from the breaker line.[15] Belcher testified that he saw one roof bolt in the rock with the plate still on it, and "as you looked up where it fell out, you could see where it sheared off." (Tr. II 385-87, 389). Belcher unequivocally testified that when he viewed the fall with Toler on August 14, he saw one damaged bolt, which still had the plate on the bottom of it. (Tr. II 386, 388, 391, 398, 416, 419).[16] When shown R. Ex. 10, a diagram of the roof fall prepared by Respondent's surveying agent about a week after the fall, Belcher admitted that if a roof bolt was pulled out by the fall as indicated on R. Ex. 10, then the roof support going across that entry would be compromised. (Tr. II 395-96).[17] Belcher further testified that the fallen rock was pie-shaped and about 4.6 feet tall where the bolt went through it, and that two rows of roof bolts had been compromised by the roof fall, as shown on R. Ex. 10. (Tr. II 396, 414-15).

---

[13]As found below, Herron was part of the state inspection party present on August 18, which was five days after the roof fall at issue, and a day after the 104(d)(1) Order had been issued and thereafter reported by Respondent. Also as found below, on August 18, state roof specialist, John Griffith, issued a control order (R. Ex. 14) and violation for adverse roof conditions throughout the section (R. Ex. 15).

[14]In his affidavit, Herron opines that the roof fall was not a reportable "accident" under West Virginia law §22A-2-66(a)(8), which is identical to the definition of "accident" in 30 C.F. R. 50.2(h)(8). (R. Ex. 13, para. 4; R. Ex. 4)). Herron's opinion is consistent with Respondent's defense on the anchorage zone issue. Herron's affidavit, however, does not address whether the roof fall impaired ventilation or impeded passage.

[15]Belcher "thinks" he told Toler about Pauley's description of the fall. (Tr. II 413-14). Toler did not testify.

[16]Collins testified, however, that there was a roof bolt protruding out of the rock with residue on the bolt, and there was another roof bolt that was sheared off. (Tr. III 33).

[17]R. Ex. 10 indicates where a roof bolt was pulled out by the fall, where a roof bolt plate and head were missing, and where a roof bolt had a damaged plate.

Nevertheless, on cross examination, Belcher testified that the missing roof bolts did not impede access to the No. 6 face, and that a certified foreman would be able to walk inby to fireboss that face by staying over on the right rib side where the roof bolts were intact. (Tr. II 397-98). I find, however, that safe passage to the No. 6 face was impeded. I emphasize Belcher's previous testimony on direct examination that he set the breaker lines because travel to the No. 6 face was unsafe for anybody that worked in the No. 6 entry after the fall. (Tr. II 348-49). In addition, Collins credibly testified that safe travel to the No. 6 face had been breakered off, and the No. 6 entry was pre-shifted at the breaker line. (Tr. III 29-30, 34). Similarly, on cross, Pauley conceded that Respondent was unable to go up to the No. 6 face to conduct required exams every two hours. (Tr. 245). Instead, pre-shift and on-shift exams were conducted outby the breakers. (Tr. 245, 436-37).

In addition, it is noteworthy that Respondent's own pre-shift and on-shift reports indicate unsafe travel impeding passage to the No. 6 face after the fall. The pre-shift exam for the August 13-14 hoot owl shift and for the succeeding shift indicates that the No. 6 entry and left cross cut were dangered off, although no reason was given to communicate what hazard was present or why the area had been dangered off. (Tr. II 244-48, R. Ex. 8, p. 7 and 9). The on-shift report for the first shift on August 14 again indicates "dangered off," and under "action taken," indicates "danger off - breaker off." (Tr. II 249; R Ex. 8, p. 10).

Pauley conceded that the No. 6 entry was so dangerous that it had been breakered off with timbers by August 14. In fact, the pre-shift report for the No. 6 entry indicated "stopped," meaning no one was going inby the timbers (Tr. II 250–51; R. Ex. 8, p. 110). Pauley testified that no one went inby the timbers to the No. 6 face to ensure compliance with the ventilation plan, or to replace the piece of curtain that the continuous miner had torn down. The No. 6 entry was not sealed off, however, and remained in the primary air intake with an incomplete crosscut to the No. 5 entry. (Tr. II 251-52, 256-57).[18]

Belcher opined that the ventilation to the No. 6 face was not impaired by the rock fall because there was a sufficient amount of air traveling up the primary intake. (Tr. II 345-47).[19] Belcher acknowledged, however, that the line curtain takes noxious gas, coal dust, and bad air down the return and back out, and that all ventilation curtains or controls should be in place, even when the section is idle. (Tr. II 346-47). Furthermore, on cross, Belcher admitted that breakering off the

---

[18]MSHA inspector Ellison testified that Respondent's ventilation plan required connection of the entries, but the ventilation plan is not in evidence. (Tr. I 87). Absent such best evidence, I decline to credit any testimony about the actual contents of the ventilation plan.

[19]Similarly, Collins testified that while he was at the breaker line in the primary intake on August 18, he did not see any evidence of impaired ventilation as the curtain "came up to the breaker line" and pre-shift exams were taken at the breaker line. (Tr. III 28-29). Collins did not know, however, how far the curtain extended past the breakers. (Tr. III 48). Collins further testified that the line curtain was allowed to stay 50 feet from the unsupported face, and although he did not know how many feet away it was when he saw it on August 18, he acknowledged that if it was more than 50 feet, it would not be in compliance with Respondent's ventilation plan. (Tr. III 40-42).

No. 6 entry did not relieve Respondent of the obligation to ventilate the No. 6 face (Tr. II 369-70, 392), and he was compelled to concede that the ventilation curtain should have been in place. (Tr. 369-70). Similarly, on unrelenting cross examination, Collins conceded that Respondent could have accounted for the safety of its miners and called MSHA to get a waiver of the requirement that the curtain be within 50 feet of the face. (Tr. III 44-46).

C. MSHA's August 17 Inspection and 103(k) and 104(d)(1) Orders

The August 17, 2009 pre-shift exam was called out at 7:20 a.m. and indicates that the No. 6 entry was "dangered off." Midnight shift foreman Dale Helmandollar wrote, and then crossed out and initialed, "H2O to face." (Tr. II 246, 262-64; R. Ex. 8, p. 23).

At about 9 a.m. on August 17, 2009, certified MSHA inspector, Brandon Ellison, from the District 4 field office in Madison, West Virginia, traveled to Big Mountain No. 16 mine to continue his quarterly EO1 inspection. (Tr. I 51–53, 69, 71).[20] It took several months to inspect the whole mine and Ellison had already completed his inspection of the 020-0 MMU (East Section) (Tr. I 55, 73).

When Ellison arrived, the United Mine Workers of America (UMWA) representative asked him to look at some specific conditions on the previously inspected 020-0 MMU (East Section) because of some very bad roof conditions and cracks across the section, which were very dangerous. (Tr. I. 72-73, 76-77). Ellison checked the pre-shift/on-shift reports. As noted, they indicated that the No. 6 entry was dangered off without explanation of hazard. Moreover, Respondent's safety supervisor, Justin Ray, could not provide Ellison with any rationale for the danger. (Tr. I 73-75, Tr. II 122).

An inspection party of Ellison, Ray and Mullins then traveled underground for about 45 minutes on what Ray described as an "imminent danger" run to the East Section and No. 6 entry. (Tr. I 78; Tr. II 126). As noted, the No. 6 entry had been dangered off with timbers and Ellison could see a single, large rock of varying thickness, approximately 20' feet long, 8' wide and 7' feet thick.[21] Ellison also saw 6 to 8 inches of two, six-foot-long, tension rebar roof bolts with resin glue at the end, protruding upward through the rock. Ellison credibly testified that the rock had fallen under cracked roof that dropped three or four inches. (Tr. I 78-80, 91-93).

When Ray and Mullins could not answer Ellison's inquiries about the fall, they summoned Pauley. (Tr. I 103; Tr. II 127). Pauley told Ellison that the fall occurred about the end of the day shift on August 13, and that Pauley reported to management (Belcher) that a rock had fallen on top of the miner, which was the last Pauley heard about the incident. (Tr. I 105).[22]

---

[20]At the time of the inspection, Ellison had been been with MSHA only 14 months, since June 2008. He had three prior years of experience in the mining industry as a general laborer and safety technician for a coal company. While not green, Ellison was not very seasoned. (Tr. I 51-52).

[21] As noted, contrary to Ellison's approximation of a rock 7 feet thick, I find that the height of the rock varied at points between about 4.5 feet and 5.5 feet high, as set forth in R. Ex. 10.

[22]Pauley could not recall speaking to Ellison on August 17. (Tr. II 265).

After viewing the fall, the August 17 inspection party traveled across the rest of the section. (Tr. II 128). A scoop operator was rock dusting in the No. 5 entry about 120 feet from the fall. (Tr. I 83). Somewhere en route, Kinder told Ellison in Ray's presence that the roof fall came close to hitting Daniels, although Ray does not recall the remark. (Tr. I 107-08; Tr. II 169). Based on demeanor and Pauley's testimony that Kinder and Daniels were visibly shaken after the fall, I credit this hearsay testimony from Ellison.

After traveling the East Section, the inspection party returned to the No. 6 entry so Ellison could ask additional questions and take another look at the fall. (Tr. II 128). Ellison traveled about four to five feet inby the breaker posts, but two parallel cracks that extended from the fall across the whole entry, impeded Ellison's further safe passage inby the fall. "You could see where the roof had sat down, where the top had been broken," Ellison testified. (Tr. I 86).

Ellison further testified that despite the fall, Respondent was still obligated to examine the No. 6 face as part of its pre-shift and on-shift examinations, and to ensure that there was actual air movement at said face to eliminate dust, gas and other hazardous conditions, even though actual mining had ceased in that entry. Ellison opined that Respondent could not meet such obligations without conducting examinations at the No. 6 face, and the "[t]he conditions were too bad for anyone to travel up to that area." (Tr. I 87-90). He testified that one could not travel to the face under fully supported roof because the fall had pulled out two bolts and broke two of the plates off. (Tr. 96).

In addition, Ellison testified that a line curtain extended about three rows of bolts past the breaker posts and was much more than 50 feet from the No. 6 face, thereby exceeding Respondent's ventilation waiver from MSHA. Since the line curtain was not providing the ventilation the way it should have been, Ellison concluded "there's no way they could've really had the No. 6 face ventilated with the location of the curtain." (Tr. I 96-97, 111-12: G. Ex. 3). In fact, Ellison's contemporaneous notes state, "no way to ventilate face" and "pulled out two roof bolts above anchorage." (Tr. I 111, 113; G. Ex. 5, p. 3 and 5). Ellison explained that he could see the bolts with resin sticking out of the top of the rock, thereby indicating that the two-foot or 24-inch anchorage zone had been compromised. (Tr. I 113).[23]

After revisiting the rock fall, and noting several other hazardous conditions during his "imminent danger" run across the section, Ellison issued 103(k) Order No. 8093136 at 12:10 p.m.[24]

---

[23]Contrary to the testimony of Ellison and the other MSHA inspectors, Belcher, Collins, and Ashby testified that there was nothing in Respondent's minimum roof control plan (see R. Ex. 3; G. Ex. 9) that informed them what the "anchorage zone" was for the six-foot torque tension bolts in use in the No. 6 entry. (Tr. II 341-44, 440-41; Tr. III 9, 130). Nor does MSHA provide any definition of anchorage zone. (*See also* Tr. III 131-132). Based on decades of collective mining experience, Belcher, Collins and Ashby testified that reportability was triggered at or above the length of the bolt, and that MSHA had never informed them differently. (Tr. II 344, 440-41; Tr. III 12, 152-154).

[24]Section 103(k) of the 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

That control order prohibited all activity on the East Section from spad #13331 inby until MSHA determined that it was safe to resume normal operations in this area. Only those persons selected from company officials, state officials, miner's representative(s) and others deemed by MSHA to have information relevant to the investigation were permitted to enter the affected area. G. Ex. 2.

At 3 p.m., Ellison issued the 104(d)(1) Order No. 8093139 at issue. Ellison explained why, in his opinion, the roof fall met each of the three disjunctive prongs of the regulatory definition of "accident," and should have been immediately reported. First, the operator should have recognized that the fall pulled roof bolts out and was above the anchorage zone. In addition, the area could not be traveled due to the hazardous conditions caused by the fall. Finally, by breakering off the No. 6 entry, the area could not be properly ventilated. (Tr. I 114).[25]

On direct examination by counsel for the Secretary, Ellison was presented with each of the Commission's factors for determining whether Respondent's failure to report the roof fall was an unwarrantable failure. Ellison testified that he considered each factor. I find that Ellison did not independently assess each factor before preparing the 104(d)(1) Order as he could not recall each of the factors when I questioned him. (Tr. I 221). I find, however, that Ellison was generally familiar with the relevant factors and credibly testified about his general thought processes and considerations at the time he issued the Order.

Ellison considered the extent of the hazardous condition, a large roof fall that occurred in active workings, where people actually were working. Ellison testified that the purpose of the reporting requirement is to inform MSHA of the accident so that MSHA can issue orders and approve rehabilitations plans to insure the safety of miners. (Tr. 116-17, citing section 103(k)). Ellison also considered the length of time that the violation existed. He testified that the failure to report lasted four days, from the afternoon of August 13 until the afternoon of August 17, and no one from management made any effort to inform Ellison of the roof fall when he arrived on August 17 to continue his quarterly inspection in other areas of the mine. (Tr. I 117). Ellison also considered the fact that Pine Ridge was knowledgeable about its reporting obligations and had a history of unplanned roof falls at the mine. (Tr. I 118; G. Ex. 12). Ellison further determined that the failure to report the roof fall could cause a high degree of danger, even though the area had been "breakered off," because miners were expected to return to the area during rehabilitation or cleanup, and the rock fall itself posed a high degree of danger to any miners working in the area. (Tr. I 118-19). Finally, Ellison considered Respondent's "very, very poor efforts" to abate the violation. (Tr. I 119). He concluded that the condition was obvious and should have been reported immediately. (Tr. I 121, 219).

---

deems appropriate to insure the safety of any person in the 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."

[25]As District 4 Supervisor Terry Price told Ellison when observing the roof fall with an inspection party the next day, "[t]his looks like they hit the trifecta here," a roof fall in the 6 left crosscut at or above anchorage that impaired ventilation or impeded travel. (Tr. I 371-72).

Ellison credibly testified that when he initially observed the condition underground on August 17, he told safety specialist Ray that the fall was reportable and explained why. (Tr. I 19; G. Ex. 5, p. 7) Thereafter, at 1:15 p.m., Ellison told shift foreman Martin and section foremen Pauley that the fall needed to be reported. Once on the surface at about 2 p.m., Ellison told Belcher and Ashby about the 15-minute reporting rule and why Respondent was required to report the fall to the MSHA hotline. (Tr. 119; G. Ex. 5, pp. 7-8). Ashby told Ellison that he would make the call. Nearly an hour later at 2:55 p.m., when Ellison asked if Ashby had reported the fall, Ashby replied, "Not yet. I'm getting ready - - getting ready to." (Tr. I 120; G. Ex. 5, p. 8). At that time, Ellison called supervisor Price to discuss the situation and began writing up the instant 104(d)(1) Order.

Ellison considered mitigating circumstances, including Respondent's only argument that the fall did not occur in "active workings," and concluded that Respondent's continued refusal to report the roof fall despite his multiple requests, exhibited reckless disregard for the reporting requirement. (Tr. I 121-23, 219-220). As Ellison explained on probing for the bench:

> To me, the condition was obvious, at first, that they should've reported it
>
> . . . .
>
> I was borderline on the unwarrantable failure at that point; but after talking to them and telling them, "Hey, you know, you need to report this" -- I mean, I had two multiple discussions, and I have the times documented, and they still failed to report it. I felt that that just increased their negligence to high and reckless disregard.
>
> And they didn't actually call it in until after I wrote the order. I mean, I'd typed it up and everything. I mean, it was blatant that they didn't – it wasn't going to get called in.

(Tr. I 219-20).

Belcher testified that after the 104(d)(1) Order was written, he told Ellison, "We can agree to disagree, but there's no way that's a roof fall, Brandon. That's everyday activity.... It happens every time you get a cut of coal, if you're in adverse roof conditions . . . . Even the state went up and looked at it and agreed with what we had to say about it. We didn't feel like it was a reportable fall." (Tr. II 374).

While the 103(k) and 104(d)(1) Orders were being issued, the on-shift report for August 17 indicated "section idle" and that "unsupported top" created a hazardous condition in the "dangered off" No. 6 entry and crosscut left, with "ventilation down." (Tr. II 142; R. Exh. 8, p.26). Similarly, the pre-shift report for the August 17 hoot owl indicated "unsupported top" and "ventilation down," i.e., hazardous conditions in the "dangered off" No. 6 entry and left crosscut. (R. Exh. 8, p.27).

Respondent eventually reported the roof fall at 3:11 p.m. on August 17. (G. Ex. 1).

D. The August 18 Inspection by WVOMHST and MSHA

On August 18, Collins was called to visit the mine by Ashby because both state and federal inspectors were examining adverse roof conditions throughout the East Section that day. (Tr. II 426-27). Collins credibly testified that the state inspectors (apparently Griffith, Herron, and Hiebe) arrived at the mine before MSHA inspectors Ellison, Price, Barker and Winston arrived, and that part of management traveled the section with the state, and Collins traveled with MSHA. (Tr. II

438-39; Tr. III 24)). When MSHA arrived, Collins testified that he asked MSHA inspector Ellison where the roof fall was, and Ellison replied, "6 break left that impeded ventilation." (Tr. II 430; Tr. III 22).

The August 18 inspection parties visited the fall. (G. Ex. 8, p. 2-4; Tr. II 426-27). Collins testified that the area was breakered off because the chunk of sandstone had fallen out between two parallel cracks, which started in the bolted area of the main roof and widened out into the adjacent crosscut, rendering continued mining in the No. 6 entry unviable. (Tr. 433-34).[26] MSHA inspector Lee Barker took measurements of the rock with a handheld Hilti laser. The laser, however, could not measure the height of the rock from where Barker and Ellison were standing, about three feet away. (Tr. II 432).

WVOMHST inspector Griffith issued a control order (R. Ex. 14) during the roof control inspection for the East Section from the feeder inby the faces. He also issued a notice of violation (R. Ex. 15) in which all workable headings and crosscuts in the East Section would cease normal operations until a plan of action for adverse roof conditions was approved by the state. In addition, no further work was permitted in the No. 6 headings from 25 feet outby the No. 6 left crosscut to the unbolted face area, due to deteriorating roof conditions. (R. Ex. 15).

Collins testified that he had a conversation with Herron and Griffith about the unreported roof fall violation in the No. 6 left crosscut written by Ellison the previous day. Collins testified that both Herron and Griffith told him that they had investigated and did not think there was a reportable roof fall under West Virginia law, which is identical to federal law.

> THE COURT: And did they say what specifications under state law it didn't meet?
>
> THE WITNESS: It didn't meet because it was just a face area, and it was normal mining. That happens every day. You know, we're subject to have a piece of rock fall out of unsupported top and damage or dislodge one or two roof bolts at any time.
>
> THE COURT: That's what they said?
>
> THE WITNESS: Yes, sir.
>
> THE COURT: Thank you, sir.

(Tr. II 426-28).

Based on demeanor and the substance of Collins' testimony, I do not credit Collins' uncorroborated account of this hearsay. Neither Herron nor Griffith testified. Furthermore, I find it inherently implausible that experienced state inspectors would express an opinion in such general terms on the technical and precise requirements of a complex definition of a reportable roof fall accident, which had raised much recent controversy at Big Mountain No. 16 mine.

Section 104(d)(1) Order No. 8093139 was terminated on August 18 at 3:30 p.m., after Respondent provided documentation that it had reported the roof fall at 3:11 p.m. on August 17. (G. Ex. 1). As noted above, said Order was modified by inspector Ellison on August 20, based on

---

[26]Notes from MSHA roof specialist, Don Winston, state that the "sandstone fell in the unbolted area and pulled a couple rows of bolts in the #6 entry," although he corrected his notes through testimony establishing that only two bolts were pulled. (G. Ex. 8, p. 5; Tr. II 83-84).

the results of MSHA's additional investigation on August 18. (G. Ex. 1).[27] On or about August 24, Ellison completed an Accident Report(G. Ex. 4), describing the accident as follows:

> A roof fall at or above the anchorage zone in the #6 left face that pulled out 2 permanent roof supports (roof bolts), ventilation to the #6 face has been impaired due to the roof fall and the severe adverse roof conditions in the area. The ventilation control in the form of a line curtain is approximately 47' from the last row of roof bolts and approximately 75' from the unsupported face when measured with a digital range finder. Passage of persons has also been impeded to the last row of roof bolts in the No. 6 entry.

III. Legal Analysis and Conclusions of Law

A. Order Denying Respondent's Motion for Partial Summary Decision

As noted at the outset, Pine Ridge filed a Motion for Partial Summary Decision under Commission Rule 67, arguing that Order No. 8093139 was not properly issued pursuant to section 104(d)(1) of the Act because it did not allege a violation of a mandatory safety standard.[28] Pine Ridge contends that an order issued pursuant to section 104(d)(1) of the Act must allege a violation of a mandatory health or safety standard, and that the regulations at Part 50, including § 50.10, are not mandatory standards. The Petitioner concedes that the Part 50 regulations were not mandatory standards as originally promulgated. Petitioner argues, however, that § 50.10 was re-published or promulgated as a mandatory standard in 2006 rule making proceedings, and that the violation in 104(d)(1) Order No. 8093139 is charged properly as an unwarrantable failure. Pine Ridge counters that § 50.10 was simply revised, and not promulgated as a mandatory standard.

The identical issue was presented in *Wolf Run Mining Company,* July 2, 2010, Docket No. WEVA 2008-1417, in which Senior Administrative Law Judge Michael E. Zielinski issued an unpublished Order Denying Respondent's Motion for Partial Summary Decision (hereinafter cited as *Wolf Run,* unpublished Order).[29] While Senior Judge Zielinski's Order is non-precedential, I find it well written and persuasive. Accordingly, I adopt the crux of Judge Zielinski's analysis here and find that Pine Ridge's motion must be denied. I further find that after the 2006 final rule making proceedings described below, the 2009 violation of 30 C.F.R. § 50.10 at issue was charged properly as an unwarrantable failure.

1. Legal Framework

a. Statutory Provisions

---

[27]Ellison's modification should have accounted for Barker's new measurements of the rock, as Ellison was with Barker on August 18, in close proximity to the fall. Ellison inexplicably failed to modify his approximation, and Respondent understandably faults him for failing to do so.

[28]Commission Procedural Rule 67 provides that a motion for summary decision shall be granted if there is "no genuine issue as to any material fact" and "the moving party is entitled to summary decision as a matter of law." 29 C.F.R. § 2700.67(b).

[29]Wolf Run was represented by the same law firm as Pine Ridge.

Section 3(1) of the Mine Act defines "mandatory health or safety standard" as "the interim mandatory health or safety standards established by Titles II and III of this Act, and the standards promulgated pursuant to Title I of the Act." 30 U.S.C. §802(l). In *Cyprus Emerald Res. Corp. v. FMSHRC*, 195 F.3d 42, 45 (D.C. Cir. 1999), the D.C. Circuit made clear that violations of regulations or other provisions that are not mandatory standards cannot be designated as significant and substantial or unwarrantable failures under section 104(d).

The Secretary's authority to issue mandatory health and safety standards is contained in section 101 of Title I of the Act. 30 U.S.C. § 811. Section 101(a) of the Act directs that the Secretary shall by rule in accordance with the notice and comment rule making procedures set forth in section 101 and section 553 of the Administrative Procedure Act (APA) (5 U.S.C. §553), "develop, promulgate, and revise as may be appropriate, improved mandatory health or safety standards for the protection of life and prevention of injuries in coal or other mines." 30 U.S.C. § 811(a). Section 101(a)(2) of the Act directs that "[t]he Secretary shall publish a proposed rule promulgating, modifying or revoking a mandatory health or safety standard in the Federal Register."

Section 101(b)(1) of the Act states that the Secretary shall provide, without regard to the requirements of the APA, for an "emergency temporary health or safety standard to take immediate effect upon publication in the Federal Register if [she] determines (A) that miners are exposed to grave danger from exposure to substances or agents determined to be toxic or physically harmful, *or to other hazards*, and (B) that such emergency standard is necessary to protect miners from such danger." 30 U.S.C. § 811(b)(1)(italics added). Once the Secretary publishes an emergency temporary standard ("ETS"), she must initiate a formal rule making proceeding pursuant to section 101(a). The temporary standard serves as a proposed rule for that proceeding, and remains effective until superseded by the mandatory standard. 30 U.S.C. § 811(b)(2) and (b)(3).

Under section 508 of the Act, the Secretary also has general authority to promulgate rules and regulations that are not mandatory standards. 30 U.S.C. § 957. The regulations in Part 50, which address "Notification, Investigation, Reports and Records of Accidents, Injuries, Illnesses, Employment and Coal Production in Mines," were originally promulgated pursuant to the Secretary's general rule making authority. They were not promulgated pursuant to section 101. Accordingly, after *Cyprus Emerald*, they could not be enforced pursuant to section 104(d) as mandatory standards, unless developed, re-promulgated or revised as mandatory standards.

b. The Emergency Temporary Standard (ETS)

The legal landscape for § 50.10 changed on March 9, 2006. On that date, the Secretary issued an ETS pursuant to section 101(b) of the Act in response to the grave danger to which underground miners are exposed during underground coal mine accidents and subsequent evacuations. 71 Fed. Reg. 12252 (Mar. 9, 2006). In response to tragic accidents at the Sago Mine on January 2, 2006 and the Aracoma Alma No. 1 Mine on January 19, 2006, MSHA determined that "new" accident notification, safety, and training standards were necessary to further protect miners when a mine accident takes place. 71 Fed. Reg. 12253. Thus, the ETS added several new training requirements, re-published § 50.10 with the addition of a specific definition of the word "immediately," and added numerous new provisions to mandatory standards for underground coal mines, which were designed to enhance miners' chances for survival in the event of an accident.

In revising § 50.10 to require that mine operators immediately notify MSHA within 15 minutes after determining that an accident has occurred, the ETS defined "immediately" to mean at once without delay, and within 15 minutes. 71 Fed. Reg. 12256. The Secretary determined that miners are exposed to grave danger when a mine accident occurs and the mine operator does not immediately, that is, within 15 minutes, notify MSHA about the accident. Delay in notification may slow down the arrival of mine rescue assistance and the arrival of MSHA personnel, who can provide assistance at the mine site. 71 Fed. Reg. 12256; *see also* 71 Fed Reg. 12253-12254. Consequently, the ETS incorporated a definitive standard into § 50.10 of what is meant by "immediately contact, " i.e., "at once without delay," and "within 15 minutes," which sets a maximum time within which the contact must be made. The ETS was intended to impress upon mine operators that notification is urgent and must be made a priority. 71 Fed. Reg. 12260.

The ETS did not, however, change the basic interpretation of § 50.10 that the 15-minute time period begins when mine operator determines that an "accident" within the meaning of paragraph 50.2(h) has occurred, thereby affording operators a reasonable opportunity to investigate an event prior to notifying MSHA. Accordingly, an operator is responsible for immediately notifying MSHA about those accidents that the operator knows or should know about. 71 Fed. Reg. 12260. Thus, § 50.10 notification "[s]hould be carried out in good faith and without delay, and in light of the regulation's command of prompt, vigorous action." *Id*., *citing Consolidation Coal Co.*, 11 FMSHRC 1935, 1938 (Oct. 1989).

The ETS served as a proposed rule and was effective immediately upon publication. After comments were submitted, the Secretary further revised § 50.10 and published a Final Rule on December 8, 2006. 71 Fed. Reg. 71430.

c. The MINER Act and the Final Rule

As published in the Final Rule, section 50.10 now reads as follows:

> 50.10 Immediate Notification
>
> The operator shall immediately contact MSHA at once without delay and within 15 minutes at the toll-free number, 1-800-746-1553, once the operator knows or should know that and accident has occurred.

71 Fed. Reg. 71452.

Prior to publication of the Final Rule, Congress responded to the Sago and Aracoma Alma mine tragedies by enacting the Mine Improvement and New Emergency Response Act of 2006 (MINER Act). The MINER Act was signed into law by President George W. Bush on June 15, 2006. The MINER Act included requirements for Self-Contained Self-Rescuer (SCSR) storage, training, lifelines, and accident notification. In the Final Rule, MSHA reconciled the ETS with applicable provisions of the MINER Act. 71 Fed. Reg. 71431.

With respect to accident notification, MSHA noted the following in its general discussion of the Final Rule:

> In emergencies, where delay in responding can mean the difference between life and death, immediate notification leads to the mobilization of an effective mine emergency response. Immediate notification activates MSHA emergency response efforts, which can be critical in saving lives, stabilizing the situation, and preserving

> the accident scene. Immediate notification also promotes Agency assistance of the mine's first responder efforts. In other situations, it allows for a range of appropriate Agency responses depending on the circumstances. It alerts MSHA to trends or warning signals that can trigger a special inspection, an investigation, or targeted enforcement. This communication also encourages operators and miners to work with MSHA to develop procedures that prevent incidents from resulting in more hazardous situations, ultimately leading to disasters.

71 Fed. Reg. 71431.

The Final Rule added new requirements to 30 C.F.R. parts 48, 50, and 75. *Id.* With respect to Part 50, MSHA noted that notifying MSHA of accidents must be a priority of the mine operator. Any unnecessary delay can result in loss of life or other harmful consequences. 71 Fed. Reg. 71433. Accordingly, the Final Rule retained the requirement in the ETS that mine operators notify MSHA of all accidents immediately and within 15 minutes. *Id.* The Final Rule, like the MINER Act, did not include any exception to the 15-minute notification provision, and eliminated the exception for lost communications that had existed under the ETS. 71 Fed. Reg 71434-71435.

In its analysis of the immediate notification requirement, MSHA summarized the divergence of views from commenters. 71 Fed. Reg 71434. MSHA then concluded that the 15-minute requirement for reporting all accidents was working. 71 Fed. Reg 71435. MSHA emphasized that the requirement was not only vital for saving lives, but instrumental in having expert Agency personnel at the scene with authority to assure that the accident site remains undisturbed and preserved for investigation into causes. *MSHA further noted that although many reported accidents do not involve an injury or are non-emergencies, they may be near misses or signify a trend or problem that left uncorrected can be extremely hazardous. For example, the reporting of roof falls may necessitate critical, pro-active corrective actions and the need for emergency response assistance.* MSHA also noted that even when MSHA does not activate an emergency response, the Agency conducts an investigation. Thus, prompt notification enables MSHA to secure an accident site, preserve vital evidence that can otherwise be lost, and examine data to accurately determine trends and means of prevention. *Id*. (italics added).

MSHA also considered what triggers the 15-minute reporting requirement. The final rule provides that "once the mine operator knows or should know," that a reportable accident has occurred based on the judgment of a reasonable person, it has an obligation to report such accident. 71 Fed. Reg. 71435. Thus, an operator, like any reasonable person under the circumstances, is held to know or realize that an accident has occurred. 71 Fed. Reg. 71436.

Finally, MSHA improved the method of notification. MSHA acquired a nationwide call system and eliminated the requirement in the ETS and prior standard that mine operators first notify the appropriate District Office. The Final Rule provides a person to answer calls 24 hours per day, 7 days per week. Accordingly, once the mine operator calls the toll-free service, notification to MSHA is achieved. 71 Fed. Reg. 71436.

2. Positions of the Parties

Pine Ridge contends that § 50.10 was not "promulgated" in the Final Rule, but merely "revised," and since it was not a mandatory standard prior to the 2006 rule making, it was not converted into one. Pine Ridge argues that there was no clear indication in either the ETS or the

Final Rule, to convert § 50.10 from a regulatory provision into a mandatory standard. In essence, Pine Ridge further maintains that the Secretary did not provide actual notice that she intended to apply § 50.10 as a mandatory standard subject to an unwarrantable failure penalty under section 104(d)(1). Pine Ridge further argues that the ETS's revised statement of authority for the Part 50 regulations cites only the Secretary's general rule making authority, and the primary change to § 50.10 was described as a modification that did "not change the basic interpretation of §50.10." 71 Fed. Reg. 12256, 12260. Although acknowledging that the citation to section 101 was added to the statement of authority for the Part 50 regulations in the Final Rule, Pine Ridge argues that such change was not explained. Thus, Pine Ridge argues that the rule making was insufficient to convert the regulatory provision into a mandatory standard.

The Secretary rejoins that the ETS and Final Rule were published pursuant to section 101, the Secretary's statutory authority for the issuance of mandatory standards. The ETS included findings that delays in notification of accidents subjected miners to grave danger, a prerequisite to issuance of a temporary mandatory health or safety standard. The Secretary further argues that the December 8, 2006, Final Rule was the culmination of the rule making proceeding initiated pursuant to section 101. In fact, a reference to section 101 as authority for the Part 50 regulations was included in the Final Rule. Consequently, because §50.10 was promulgated pursuant to Title I of the Act, the Secretary contends that it is a mandatory standard that can be enforced as an unwarrantable failure pursuant to section 104(d).

With regard to the fair notice issue, the Secretary contends that she already provided adequate notice to the regulated community of the substance of the changes to § 50.10 by promulgating the ETS and Notice of Final Rule Making in the Federal Register. *See Satellite Broadcasting Co., Inc. v. Federal Communications Commission*, 824 F. 2d 1, 3 (D.C. Cir. 1987), citing *Gates & Fox Co., Inc. v. OSHRC* , 790 F. 2d 154, 156 (D.C. Cir. 1986).[30] The Secretary contends that Pine Ridge could and should have read the new § 50.10 in the Federal Register at 71 Fed. Reg. 71430 *et. seq*. (Dec. 8, 2006). Therefore, the Secretary argues that Pine Ridge did not need to be placed on actual notice that 30 C.F.R. § 50.10 was now a mandatory standard.[31]

---

[30]The Secretary also argues that Pine Ridge had notice of and could have, but did not, attend public meetings that MSHA Coal District 4 held to educate the public and regulated community about the substantive changes to § 50.10. (Tr. II 162). While true, I give this argument little weight absent evidence that MSHA informed those present at said meetings that it intended to apply § 50.10 as a mandatory standard subject to an unwarrantable failure penalty.

[31]Even assuming Pine Ridge was entitled to actual notice that the Secretary intended to apply § 50.10 as a mandatory standard, the Secretary argues that the issue is irrelevant because there is no evidence that Pine Ridge placed any reliance of whether 30 C.F.R. § 50.10 was a mandatory standard at the time of the roof fall. In any event, the Secretary notes that the notice issue only implicates what type of enforcement action can be undertaken, not whether Pine Ridge is subject to sanction in the first instance. *See Satellite Broadcasting, supra,* 824 F. 2d at 3 (due process triggered when agency will begin to penalize private party). The Secretary argues that Pine Ridge certainly had notice that MSHA was enforcing violations of 30 C.F.R. § 50.10, and Pine Ridge presented no evidence that its considered whether its failure to report the instant roof fall subjected it

3. Analysis Denying Respondent's Motion for Partial Summary Decision on the Unwarrantable Failure Issue

Having duly considered the matter, I reject Respondent's arguments and find that the Secretary made § 50.10 a mandatory standard by promulgating it pursuant to section 101. Carried to its logical extreme, Respondent's argument would mean that the Secretary could never promulgate any new requirement as a "standard" if the Secretary carried over any existing requirements from the regulation. As Senior Judge Zielinski observed, both the ETS and the Final Rule set forth a complete revised text of § 50.10, not piecemeal amendments to the wording of the earlier regulatory provision. *Wolf Run,* unpublished Order at 5**.** The ETS and Final Rule incorporated a definitive standard into § 50.10 of what is meant by "immediately contact, " i.e., "at once without delay," and "within 15 minutes," which sets a maximum time within which notification to MSHA of a reportable accident must be made. 71 Fed. Reg. 12260.

In addition, MSHA acted to protect miners from grave dangers associated with mine emergencies and evacuations, including certain roof fall accidents. The reporting requirement change was intended to impress upon operators that notification is urgent and must be made a priority, without exception, so that MSHA can bring its varied expertise to bear once the operator knows or should know that a reportable accident has occurred based on the judgment of a reasonable person. Clearly, therefore, the ETS enhanced the protection for miners from grave dangers associated with failure to report ceratin roof falls, and certainly did not reduce such protection. 71 Fed. Reg. 12260. Moreover, the Final Rule eliminated the extant requirement that mine operators first notify the appropriate District Office. Under the Final Rule, MSHA acquired a nationwide call system, which provides a person to answer calls 24 hours per day, 7 days per week, thereby assuring that prompt and facile notification to MSHA is achieved.

As in *Wolf Run*, Respondent argues that the Final Rule's addition of a "passing reference" to section 101 in the citation to authority is insufficient to transform § 50.10 into a mandatory standard. As Senior Judge Zielinski cogently deduced, however, it is not the addition of the reference to section 101 in the Final Rule that rendered the new reporting requirements in § 50.10 a mandatory standard. Rather, the fact that the current text of § 50.10 was promulgated pursuant to a section 101 rule making proceeding brings it within the Act's definition of a mandatory standard. *Wolf Run,* unpublished Order at 5.

Respondent further argues that changing settled expectations concerning the consequences of violations of § 50.10 cannot be sustained absent a clear expression of intent by the Secretary. I agree with Judge Zielinski that there is little question that a clear statement of an intention by

---

only to a 104(a) citation. Rather, the Secretary argues that Pine Ridge deliberately chose to refrain from reporting the fall. Therefore, the Secretary argues that because 30 C.F.R. § 50.10 was properly promulgated as a mandatory standard, and the notice issue lacks merit, Pine Ridge committed an unwarrantable failure by failing to report the August 13 roof fall.

MSHA to make § 50.10 a mandatory standard would have been helpful to the regulated community, given the more serious consequences attendant certain violations of mandatory standards. *Wolf Run,* unpublished Order at 5. As Judge Zielinski explained, a mine that remains subject to withdrawal orders is commonly referred to as being on a "d-chain," and some very large operators can remain in that status for several years. *Wolf Run,* unpublished Order at 5, n. 8. Accordingly, I informed the parties during pre-hearing conferences, and again at the outset of the hearing, that I was concerned about this "fair notice" issue in light of the possibility of conflicting statements from MSHA in the public domain.[32] Accordingly, I asked the parties to further brief this issue. (Tr. I 13-14).

In *Wolf Run*, Judge Zielinski found that respondent cited no authority for its "clear statement of intention" requirement. *Wolf Run,* unpublished Order at 5-6. The Final Rule was the end product of what a section 101 rule making proceeding and should have provided notice that the revised § 50.10 was a mandatory standard, he observed. *Wolf Run,* unpublished Order at 6. Judge Zielinski further emphasized the following salient points: that the version of § 50.10 that Wolf Run was charged with violating was published on December 8, 2006 in the Final Rule; that the Final Rule was published pursuant to section 101, part of Title I of the Act; and that the Final Rule fit squarely within the Act's definition of a mandatory standard, which is clear on its face. *Id.* Moreover, Judge Zieilinski found no ambiguity in either the Act's definition of mandatory standards or in § 50.10, and therefore found that the Secretary's interpretation of § 50.10 as a mandatory standard was reasonable and entitled to deference. *Wolf Run,* unpublished Order at 6, n. 10, citing *Sec'y of Labor v. Excel Mining, LLC*, 334 F.3rd 1 (D.C. Cir. 2003). Finally, Judge Zieilinski discounted the argument that the Secretary has referred to the standard as a regulation, noting that the Secretary, the Commission, and the courts have often interchanged such terminology when discussing mandatory standards. *Id*., citing *Cyprus Emerald*, 195 F.3d at 44 n.3.

I concur with Judge Zieilinski's analysis. It cannot be gainsaid that the Secretary must provide fair notice of the requirements of her safety and health standards. The Commission summarized this requirement in *Island Creek Coal Co.*, 20 FMSHRC 14, 24 (Jan. 1998), as follows:

> Where an agency imposes a fine based on its interpretation, a separate inquiry may arise concerning whether the respondent has received "fair notice" of the interpretation it was fined for violating. *Energy West Mining Co.*, 17 FMSHRC 1313,1317-18 (Aug. 1995). "[D]ue process . . . prevents . . . deference from validating the application of a regulation that fails to give fair warning of the conduct

---

[32]In the *Wolf Run* matter, Wolf Run pointed out that MSHA's "Citation and Order Writing Handbook for Coal Mines and Metal and Nonmetal Mines" (2005) continued to instruct MSHA inspectors that Part 50 regulations were not mandatory standards and could not be enforced pursuant to section 104. The Secretary did not refute that assertion, but countered that the Handbook was obsolete to the extent it conflicted with the current version of § 50.10. In this case, the MSHA Handbook on Citation and Order Writing for Coal Mines and Metal and Non-Metal Mines (3/08) is not in evidence, and the Secretary correctly points out that neither Pine Ridge's Motion for Partial Summary Decision nor its Reply in Support cite to the MSHA Handbook, although Respondent raised this issue in argument.

> it prohibits or requires." *Gates & Fox Co. v. OSHRC*, 790 F.2d 154, 156 (D.C. Cir. 1986). An agency's interpretation may be "permissible" but nevertheless fail to provide notice required under this principle of administrative law to support imposition of a civil sanction. *General Elec*., 53 F.3d at 1333-34. The Commission [does not require] that the operator receive actual notice of the Secretary's interpretation. Instead, the Commission uses an objective test, i.e., "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." *Ideal Cement Co.*, 12 FMSHRC 2409, 2416 (Nov. 1990).

In essence, the critical issue that I must decide is whether the Secretary must provide actual notice in notice and comment rule making that § 50.10 will no longer be enforced as a regulation, but as a mandatory standard subject to an unwarrantable failure finding and a statutory minimum penalty of $2,000.00. Although actual notice of such intent would have been prudent, I find that the Secretary need not provide such notice of its interpretation through rule making, but may and has done so through her litigation and enforcement efforts. That is, the Secretary is not required to promulgate interpretations through rule making or the issuance of policy guidance, but may do so through litigation. *See National Wildlife Fed'n. v. Browner*, 127 F.3d 1126, 1129 (D.C. Cir. 1997)). Deference to an interpretation offered in the course of litigation is proper as long as it reflects the "agency's fair and considered judgment on the matter." *Auer v. Robbins*, 519 U.S. 452, (1977); accord, *Tax Analysts v. IRS,* 117 F.3d 607, 613 (D.C. Cir. 1997).

Despite additional briefing and a full hearing, Respondent offered no evidence that MSHA's interpretation represents anything less than the agency's considered opinion after final rule making. Further, Respondent offered no evidence that MSHA has taken an inconsistent enforcement position in litigating cases before the Commission.[33] The Secretary's enforcement history provides notice of her consistent interpretation of the standard. In fact, the *Wolf Run* case and this case show that MSHA has acted consistently and interpreted § 50.10 as a mandatory standard consistent with the Act's definition of mandatory standard after appropriate rule making under Section 101 of the Act.

In these circumstances, I find that the Secretary has provided fair notice of her interpretation of § 50.10 as a mandatory standard and that such interpretation is reasonable and entitled to deference. *See Sec'y of Labor v. Excel Mining, LLC*, 334 F.3d 1 (D.C. Cir. 2003). Accordingly, Respondent's Motion for Partial Summary Decision on the unwarrantable failure issue is denied.

---

[33]As noted above, the MSHA Handbook on Citation and Order Writing is not in evidence. Furthermore, as the Secretary points out in her post-hearing brief at 52, the Handbook represents internal agency guidance and policy directives that are not binding on the Secretary in her enforcement actions. See, e.g., *Mingo Logan Coal Co.*, 19 FMSHRC 246, 250 (1977), aff'd *Mingo Logan Coal Co. v. Sec'y of Labor*, 133 F. 3d 916 (4th Cir. 1988). Consequently, the Secretary need not give notice by publication in the Federal Register where she does not follow internal guidelines. *Id.*

B. Order No. 8093139

1. The Violation

30 C.F.R. § 50.10 required Pine Ridge to contact MSHA within 15 minutes once Pine Ridge knew or should have known that a reportable "accident" occurred. 30 C.F.R. § 50.2(h)(8) defines "accident" to mean "[a]n unplanned roof fall at or above the anchorage zone in active workings where roof bolts are in use; or, an unplanned roof or rib fall in active workings that impairs ventilation or impedes passage." Under this disjunctive test, Pine Ridge was required to report the roof fall if either of three conditions were met: 1) an unplanned roof fall at or above the anchorage zone in active workings where roof bolts are in use; 2) an unplanned roof fall in active workings that impairs ventilation; or 3) an unplanned roof fall in active workings that impedes passage.

The parties disagree on the definition of anchorage zone and whether the roof fall was at or above the anchorage zone.[34] I find it unnecessary to resolve the parties disagreement, however, because both of the other prongs of the disjunctive test were met here. Thus, the Secretary established by a preponderance of the evidence that there was an unplanned roof fall in active workings that impairs ventilation. In addition, the Secretary established by a preponderance of the evidence that there was an unplanned roof fall in active workings that impedes passage. Moreover, testimony from Respondent's own witnesses establish that Respondent knew or should have known that toward the end of the day shift on August 13, there was an unplanned roof fall in active workings that impaired ventilation and impeded passage. Accordingly, I do not pass on whether there was an unplanned roof fall at or above the anchorage zone in active workings where roof bolts are in use.

a. Unplanned Roof Fall

There is no dispute based on testimony from foreman Pauley that toward the end of the day shift on August 13, a large piece of sandstone fell from the mine roof between surface subsistence cracks onto the drum of the continuous miner as it was turning the No. 6 left crosscut. (Tr. II 186-87, 286-89, 353, 416; G. Ex. 8, p. 5). Pauley heard the fall from 60-70 feet away, and miner operator Kinder and helper Daniels hollered. (Tr. II 211, 290). The rock came close to hitting Daniels. (Tr. I 107-08). When Pauley immediately approached the rock fall location, he noticed that the two miners were visibly shaken up. (Tr. II 288, 290).

Based on the foregoing, I find that the roof fall was unplanned. Respondent makes no argument to the contrary.

b. Active Workings

"Active workings" is defined in section 75.2(g)(4) of the regulations, consistent with Section 318(g)(4) of the Act, 30 U.S.C. § 878 (a)(4), as "any place in a coal mine where miners are normally required to work or travel." I find that the Secretary established by a preponderance of the evidence that the instant roof fall occurred in "active workings."

First of all, Commission Rule 2700.58(b), 29 C.F.R. §2700.50(b), addresses requests for admissions, and provides in relevant part that ". . . [a]ny matter admitted under this rule is

---

[34]As noted, MSHA nowhere defines anchorage zone in its regulations!

conclusively established for the purpose of the pending proceeding unless the Judge, on motion, permits withdrawal or amendment of the admission." In its discovery responses, Pine Ridge admitted that the August 13 roof fall occurred in "active workings." (Tr. III 137; G. Ex. 15). Pine Ridge made no motion or request for withdrawal of the admission. Accordingly, I find that Ridge admitted as a matter of law that the roof fall was in active workings.

At trial, despite such prior admission, Pine Ridge witnesses Pauley, Collins and Ashby attempted to deny that the roof fall occurred in "active workings" because it occurred in the "red zone" where miner are not supposed to work or travel. (Tr. II 82, 198; Tr. III 66, 133-35). Belcher, by contrast, directly admitted that a "[a] red zone is an active working place." (Tr. II 364, 367). Similarly, MSHA inspectors Ellison, Barker, Price and Winston all testified that Pine Ridge was actively mining coal in an active working face when the roof fall occurred. (Tr. I 86, 126, 205, 265, 300, 354; Tr. II 10, 37 and 79). I credit the MSHA inspectors and Belcher over Respondent's other witnesses, who contradict Respondent's own discovery admissions.

I further find that the roof fall indeed occurred in active workings where miners normally work or travel.[35] The roof fall occurred during active mining while turning the left cross cut. The miner pulled or dragged the rock into the supported area of the No. 6 entry (Tr. II 203-04, 274-76), and the rock fell to the ground in both supported and unsupported top after being dragged by the miner. (Tr. II 274-76, R. Ex. 10). The fall extended several feet into the bolted No. 6 entry from unbolted 6 left, about half way to the second row of roof bolts. (G. Ex. 5, p. 4; G. Ex. 6, p. 6; R. Ex. 10). Miners regularly work or travel there. In fact, the roof fall nearly missed Daniels. (Tr. I 107-08). Moreover, Ashby testified that the continuous miner would take a cut and back out so the roof bolting crew could come in and support the top. Additionally, if the machine broke, miners would travel into the "red zone" to fix it. (Tr. III 133). In short, the Secretary established that the August 13 roof fall occurred in "active workings."

c. Impairs Ventilation

The Commission has held that in the absence of a regulatory definition of a word, the ordinary meaning of that word may be applied. *See Bluestone Coal Corp.*, 19 FMSHRC 1025, 1029 (June 1997); *Peabody Coal Co.*, 18 FMSHRC 686, 690 (May 1996), *aff'd*, 111 F.3d 963 (D.C. Cir. 1997). The dictionary defines the verb "impair" as "diminish in quantity, value, excellence or strength: do harm to: damage: lessen: deteriorate." *Webster's Third New International Dictionary* 1131 (1993). Applying this definition, I find that the Secretary established by a preponderance of evidence that the roof fall impairs ventilation, even though no air readings were taken by MSHA.

During the roof fall process, the continuous miner tore out a couple of roof bolts that were at the edge of the cut (Tr. II 189, 193, 201), and the boom of the miner caught the line curtain and

---

[35]I agree with the Secretary that although the red zone may have kept miners from direct contact with the continuous miner, that area was still "active workings" because men were working and traveling in the immediate and adjacent area. *Cf. Consolidation Coal Co.*, 22 FMSHRC 340 (Mar. 27, 2000).

pulled it down. Thereafter, the credible evidence establishes that the line curtain was never moved back up to comply with the 50-foot waiver that MSHA had granted Respondent. (Tr. II 228 and n. 10, *supra*). Rather, as a result of the roof fall, there were no ventilation controls in the face area and the line curtain was greater than 50 feet outby the face of the No. 6 entry, about 67-70 feet back. (Tr. I 97, 254, 355, 359; Tr. II 15, 159, 369; R. Exh 10).

Inspector Ellison testified that Respondent was still obligated to examine the No. 6 face as part of its pre-shift and on-shift examinations to ensure actual air movement to eliminate dust, gas and other hazardous conditions, even though actual mining had ceased after the fall. I credit Ellison's testimony that Respondent could not meet such obligations without conducting examinations at the No. 6 face, and the "[t]he conditions were too bad for anyone to travel up to that area." (Tr. I 87-90). As Ellison explained, no one could travel to the face under fully-supported roof across the entry, because the fall had pulled out two bolts and broke off two of the plates. (Tr. 96). In addition, the line curtain extended about three rows of bolts past the breaker posts and was much more than 50 feet from the No. 6 face, thereby exceeding Respondent's ventilation waiver from MSHA. Since the line curtain was not providing the ventilation the way it should have been, Ellison concluded "there's no way [Respondent] could've really had the No. 6 face ventilated with the location of the curtain." (Tr. I 96-97, 111-12: G. Ex. 3). Ellison's contemporaneous notes confirm that there was "no way to ventilate face." (Tr. I 111; G. Ex. 5, p. 3).

Inspector Ellison testified that he did not take an air reading because the line curtain was down and the roof fall made it too dangerous to proceed to the face to take a reading. (Tr. I 141, 145). Ellison explained, "There was no place to take an air reading. The curtain was torn down. They didn't have ventilation established. You have to have a curtain to provide ventilation." (Tr. I 141).

Respondent argues that an MSHA air reading could have been taken at the breakers and emphasizes record evidence that there was sufficient air at the last open break as the air swept left to right. (Tr. I 144). I am persuaded, however, by inspector Ellison's testimony that "just because you have enough [air] in the last open break does not mean you have enough in the working faces" (Tr. I 173), particularly the No. 6 face where the roof fall precluded proper placement of the line curtain, which was necessary for the ventilation system to work properly. I note that Ellison refused to concede on cross examination that air swept across the No. 6 face because his passage to the face was hindered by the rock fall, so he could not determine the air at the face. (Tr. I 145, 186). He testified with confidence, however, that ventilation was "impaired" because the curtain was too far from the face. (Tr. 1 171).

MSHA Supervisor Price confirmed that there were no other ventilation controls besides the line curtain in the No. 6 entry, and that placement of the line curtain 67 feet outby the No.6 face automatically impaired ventilation to that face. (Tr. I 359-361.) I credit Price's testimony, particularly since it was consistent with Ellison's testimony and corroborated by Respondent's own witnesses and documents.

Respondent's own witnesses and pre- and on-shift reports establish that ventilation was impaired after the rock fall. Foreman Pauley admitted that when a curtain is down, ventilation is automatically compromised. (Tr. II 279). Pauley volunteered that a downed curtain impedes ventilation (Tr. II 280), and then testified that it always impairs the volume of air in the area. (Tr.

280). In addition, Pauley testified that after the roof fall, no one went inby the timbers to the No. 6 face to ensure compliance with the ventilation plan, or to replace the piece of curtain that the continuous miner had torn down. The No. 6 entry was not sealed off, and remained in the primary air intake with an incomplete crosscut to the No. 5 entry. (Tr. II 251-52, 256-57). In order to abate the 103(k) Order and eventually abandon the section, Respondent needed to implement a rehabilitation plan that would complete the cross cut between the No. 6 and No. 5 entries. (G. Ex. 3 at 4). Collins conceded that additional ventilation was needed subsequent to the roof fall to ventilate the No. 6 crosscut because any inspector would have shut the mine down if the crosscut was left undone. (Tr. III 51-52).

Although Respondent attempted to establish through the testimony of Belcher, Collins, and Ashby that the ventilation to the No. 6 face was not impaired by the rock fall because there was a sufficient amount of air traveling up the primary intake, and because pre-shift exams were taken at the breaker line (Tr. II 345-47, 436-437; Tr. III 87), I am unpersuaded by this testimony. Belcher acknowledged that the line curtain takes noxious gas, coal dust, and bad air down the return and back out, and that all ventilation curtains or controls should be in place, even when the section is idle. (Tr. II 346-47). In fact, on cross examination, Belcher reluctantly conceded that the ventilation curtain should have been in compliance. (Tr. 369-70). Similarly, Collins and Ashby testified that the ventilation curtain should have been within 50 feet of the face. (Tr. III 44, 86).

Moreover, Respondent's pre-shift and on-shift reports on the day of the inspection, establish impaired ventilation. The August 17, 2009 pre-shift exam had the words "H2O to face," crossed out and initialed. (Tr. II 246, 262-64; R. Ex. 8, p. 23). While the 103(k) and 104(d)(1) Orders were being issued, the on-shift report for August 17 indicated "section idle" and "unsupported top," creating a hazardous condition in the "dangered off" No. 6 entry and crosscut left, with "ventilation down." (Tr. II 142; R. Exh. 8, p.26). Similarly, the pre-shift for the August 17 hoot owl indicated that "unsupported top" and "ventilation down" were hazardous conditions in the "dangered off" No. 6 entry and left crosscut. (R. Exh. 8, p.27).

In sum, I conclude that the preponderance of record evidence establishes that the August 13 roof fall "impairs" ventilation in the No. 6 entry.

d. Impedes Passage

As set forth above, the credible evidence establishes that the roof fall impedes passage to the No. 6 face. The dictionary defines the verb "impede" as "to interfere with or get in the way of the progress of: hold up: block. *Webster's Third New International Dictionary* 1132 (1993). Webster's uses the synonym "hinder." Applying this definition, I find that the Secretary established by a preponderance of evidence that the August 13 roof fall impedes passage to the No. 6 face under fully supported top.

Without prior waiver from MSHA, Respondent's examiners were required to travel to the No. 6 face several times per day to conduct required pre-shift and on-shift examinations. (Tr. I 87-88, 253, 355; Tr. II 167, 183).[36] Pauley conceded that Respondent was still obligated to examine

[36]MSHA had no opportunity to grant a waiver because Respondent did not report the roof fall.

and ventilate the No. 6 face even though it was breakered off after the fall, but no one went inby the breaker line to do so. (Tr. II 267-68). Ellison explained that Respondent was still required to inspect that area. "That's an active working face that was unbolted at both locations. They're still required to check it for methane and hazardous conditions." (Tr. I 126).

I credit Ellison's testimony that there was no way to assess proper air movement at the No. 6 face without examining the air there, however, the roof conditions after the fall were too precarious for anyone to travel up to the face to examine the air. (Tr. I 89-90). As Ellison and Supervisor Price explained, no one could travel to the No. 6 face under fully supported roof, and there was no safe way for anyone to travel to that face to take an examination. (Tr. I 96, 207, 356). MSHA Roof Control Specialist Barker and Supervisor Price confirmed that Respondent was obligated to pre-shift and on-shift all faces on every working section, and there was no way for Respondent to conduct the required examinations at the No. 6 face because the roof fall compromised the support in the entry and precluded travel to the face under fully supported roof as required by 30 C.F.R. §75.202.[37] (Tr. I 253, 317, 355-57; Tr. II). In fact, MSHA inspectors Ellison and Barker concluded that it was too dangerous to inspect the No. 6 face because the conditions created by the roof fall impeded their passage. (Tr. I 145, 242). As Price put it, only if one traveled inby "some obvious extremely dangerous and unsupported top" could one have ventured to the No. 6 face. (Tr. II 27).

I agree with the Secretary's argument that Pine Ridge's decision to danger off the No. 6 entry and conduct examinations at the breaker posts after the roof fall is persuasive evidence that the roof fall impedes passage. Sec'y Br. at 40-41. The roof fall dislodged roof supports creating an area of unsupported top, which caused Respondent to breaker off the area the next shift, and begin conducting examinations at the breaker posts. (Tr. I 206-07, 356; Tr. II 245; Tr. III 34). Respondent's witnesses Pauley and Collins acknowledged that once the area was dangered off, safe travel to the face was impeded. (Tr. II 245, 256; Tr. III 29-30). In fact, Belcher explained that once he set the breaker lines after the fall, they "prohibited anyone" from traveling to the No. 6 face because it was "[u]nsafe," and Respondent did not need that entry, with two parallel surface cracks on the outcrop, to punch outside. (Tr. II 348-49). In short, I agree with the Secretary that Respondent's decision to breaker off the No. 6 entry to travel shortly after the roof fall demonstrates that the roof fall impedes passage. See Sec'y Br. at 41.

e. Conclusion as to Violation

Based on the foregoing, I conclude that Respondent's failure to immediately report the roof fall on August 13, was a violation of 30 C.F.R. § 50.10 because there was an unplanned roof fall in active workings that impairs ventilation *and* impedes passage, although either is sufficient.

---

[37]C.F.R. §75.202 provides:

> (a) The roof, face and ribs of areas where persons work or travel shall be supported or otherwise controlled to protect persons from hazards related to falls of the roof, face or ribs and coal or rock bursts.
> (b) No person shall work or travel under unsupported roof unless in accordance with this subpart.

C. Unwarrantable Failure Principles

I have denied Respondent's motion for partial summary decision on the unwarrantable failure issue. Accordingly, Respondent's failure to report the roof fall in the No. 6 entry and left crosscut of the 020-0 MMU (East Section) within 15 minutes of its occurrence on August 13, may constitute an unwarrantable failure to comply with a mandatory safety standard.

The Secretary bears the burden of proving all elements of the 104(d)(1) Order by a preponderance of the evidence. The Secretary must prove that the Respondent's failure to report the "accident" was "aggravated conduct" after considering all the relevant facts and circumstances as set forth in Commission precedent. Having duly considered such factors, I find that the Secretary established by a preponderance of the evidence that Respondent, at a minimum, exhibited "serious lack of reasonable care," if not "intentional misconduct" or "reckless disregard," in failing to immediately notify MSHA within 15 minutes of the roof fall accident.

The unwarrantable failure terminology is taken from section 104(d) of the Act, 30 U.S.C. § 814(d). It 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); see also *Buck Creek Coal, Inc. v. MSHA*, 52 F.3d 133, 136 (7th Cir. 1995) (approving Commission's unwarrantable failure test).

The Commission has recognized that whether conduct is "aggravated" in the context of unwarrantable failure is determined by considering the facts and circumstances of each case to determine if any aggravating or mitigating circumstances exist. Aggravating factors include the length of time that the violation has existed, the extent of the violative condition, whether the operator has been placed on notice that greater efforts were necessary for compliance, the operator's efforts in abating the violative condition, whether the violation was obvious or posed a high degree of danger, and the operator's knowledge of the existence of the violation. *See Consolidation Coal Co*., 22 FMSHRC 340, 353 (Mar. 2000) ("*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, 43 (Jan. 1997); *Mullins & Sons Coal Co*., 16 FMSHRC 192, 195 (Feb. 1994); *Peabody Coal Co*., 14 FMSHRC 1258, 1261 (Aug. 1992). A judge may determine, in his discretion, that some factors are not relevant, or may determine that some factors are much less important than other factors under the circumstances. *IO Coal Co*., 31 FMSHRC 1346, 1351 (Dec. 2009). I discuss below, the applicability, *vel non*, of all of the relevant factors.

1. The Extent of the Violative Condition

The Commission has viewed the extent of a violative condition as an important element in the unwarrantable failure analysis. *IO Coal* Co., 31 FMSHRC 1346, 1351-52 (Dec. 2009). This factor considers the scope or magnitude of the violation. *See Eastern Associated Coal,* 32 FMSHRC at 1195, citing *Peabody Coal Co.*, 14 FMSHRC 1258, 1261 (Aug. 1992); *Quinland*

Coals, Inc., 10 FMSHRC 705, 708 (June 1988). Here, the violation is the failure to report the roof fall to MSHA within 15 minutes; it is not a roof control violation.[38]

As Ellison testified, the purpose of the reporting requirement is to inform MSHA of the accident so that it can issue orders and approve rehabilitations plans to insure the safety of miners. (Tr. 116-17, citing § 103(k)). Respondent's failure to report the accident immediately resulted in a § 103(k) control order four days later that prohibited all activity on the East Section from spad #13331 inby until MSHA determined that it was safe to resume normal operations in this area. Only those persons selected from company officials, state officials, miner's representative(s) and others deemed by MSHA to have information relevant to the investigation were permitted to enter the affected area. G. Exh. 2. Thus, the whole East Section and miners working throughout the section were affected by the failure to report the violation, not just the No. 6 entry and miners working in such entry. *Cf. Eastern Associated Coal,* 32 FMSHRC at 1195 (rejecting analysis that extensiveness of a roof control violation is limited to measuring area of inadequately supported roof and comparing it to relevant area examined by inspector, particularly since violative conditions could easily be considered much more extensive within a concentrated area).

Another relevant consideration in determining whether the violation is extensive is the abatement measures taken to terminate the relevant Order(s). *Eastern Associated Coal,* 32 FMSHRC at 1196; *Peabody Coal Co.*, 14 FMSHRC at 1263 (providing that extensiveness can be shown by condition that requires significant abatement efforts). In this case, Pine Ridge submitted a rehabilitation plan for the 020-0 MMU to terminate the 103(k) Order. G. Ex. 2. That mining plan encompassed extensive safety precautions across the entire East Section in all remaining entries and crosscuts and required, inter alia, the establishment of additional ventilation between the No. 5 and No. 6 entries and installation of a curtain in the No. 6 and No 2 entries. (G. Ex 3; Tr. III 52).

In addition, the failure to report the roof fall extended for four days, while abatement required a mere precautionary phone call to MSHA consistent with the rationale set forth in the Final Rule to assure that the accident site was secure, undisturbed and preserved for investigation into causes, trends, and means of prevention. Collins intimated that Respondent deliberately chose to engage in self-help and deemed it more expedient to ignore MSHA, but conceded that Respondent could have protected the safety of its miners by breakering off the No. 6 entry *and* complying with its legal obligations to immediately notify MSHA of the roof fall accident. (Tr. III 44-46). Thus, the failure to report the "near miss" accident (Tr. I 106-07) extensively inhibited the use of MSHA expertise to timely investigate and institute critical, pro-active corrective actions through the East Section that were eventually set forth in the rehabilitation plan.

Furthermore, such extensiveness must be weighed in the context of my findings that the hazard created by the failure to report was obvious, lengthy in duration (given the nature of the violation), and contributed to the potential for a high degree of danger to other miners working in

---

[38]The Secretary argues that the size of the fall made it extensive, but the actual violation was the failure to report the accident. Accordingly, unlike inspector Ellison, I discount the extent of the hazardous condition, a large roof fall that occurred in active workings, where people actually were working, and I consider the extensiveness and ramifications of the actual failure to report.

other adverse roof areas throughout the section until MSHA controlled the scene. *Eastern Associated Coal,* 32 FMSHRC at 1198. Accordingly, on balance, I find that the extensiveness factor tips in favor of an unwarrantable failure finding.

2. The Duration of the Failure to Report the Roof Fall Accident

The Commission has emphasized that the duration of the violative condition is a necessary element of the unwarrantable failure analysis. *See, e.g., Windsor Coal Co.*, 21 FMSHRC 997, 1001-04 (Sept. 1999) (remanding for consideration of duration evidence of cited conditions). Inspector Ellison considered the length of time that the violation existed. Consistent with his testimony, the record establishes that the failure to report lasted four days, from the afternoon of August 13 until the afternoon of August 17, and no one from management made any effort to inform Ellison of the roof fall when he arrived on August 17 to continue his quarterly inspection in other areas of the mine. (Tr. I 117).

The record further establishes that it took several months to inspect the whole mine and Ellison had already completed his inspection of the 020-0 MMU (East Section) (Tr. I 55, 73). It was only after the miner's representative asked Ellison to look at some specific conditions on the previously inspected 020-0 MMU (East Section) because of some very dangerous roof conditions and cracks across the section, that Ellison checked the pre-shift/on-shift reports and discovered that the No. 6 entry was dangered off without explanation of hazard. (Tr. I. 72-73, 75-77). Ellison began his inspection when Respondent's safety supervisor, Justin Ray, could not provide any rationale for the danger. (Tr. I 73-75, Tr. II 122).

In sum, the failure to report lasted four days and the accident triggering the reporting requirement might not have been discovered if not for the assiduity of the miner representative and Ellison. An unwarrantable failure finding has been found when the violative condition has lasted for several days, as here. *See, e.g. Watkins Engineers & Constructors*, 23 FMSHRC 81, 93 (Jan. 2001) (ALJ Manning). Accordingly, in the circumstances of this case, I find that the duration of the violation weighs heavily toward a finding of unwarrantable failure.

3. Whether Respondent Was Placed on Notice that Greater Compliance Efforts Were Necessary

The Commission has stated that repeated similar violations are relevant to an unwarrantable failure determination to the extent that they serve to put an operator on notice that greater efforts are necessary for compliance with a standard. *IO Coal*, 31 FMSHRC at 1353-55; *Amax Coal Co.*, 19 FMSHRC 846, 851 (May 1997); see also *Consolidation Coal Co.*, 23FMSHRC 588, 595 (June 2001). The purpose of evaluating the number of past violations is to determine the degree to which those violations have "engendered in the operator a heightened awareness of a serious . . . problem." *San Juan Coal Co.*, 29 FMSHRC 125, 131 (Mar. 2007), *citing Mid-Continent Res., Inc.*, 16 FMSHRC 1226, 1232 (June 1994). The Commission has also recognized that "past discussions with MSHA" about a problem "serve to put an operator on heightened scrutiny that it must increase its efforts to comply with the standard." *Id.*, *citing Consolidation Coal*, 23 FMSHRC at 595.

Inspector Ellison considered the fact that Pine Ridge was knowledgeable about its reporting obligations because it had a history of unplanned roof falls at the mine. (Tr. I 118; G. Ex. 12). The Secretary emphasizes that Respondent had about fifteen reportable roof falls in the year preceding

the August 13 roof fall, including another one that same day. (G. Exh 12; Tr. I 62-68). The Secretary further asserts that Pine Ridge's known history of roof falls and poor roof conditions motivated it to refrain form reporting the instant roof fall because it might cause an increase in its incident rate in MSHA's statistics. I decline to engage in such speculation.

Although Pine Ridge knew how to report a roof fall accident based on its recent history as set forth in G. Ex. 12, there is no record evidence that MSHA had previously communicated to Pine Ridge that it needed to make additional efforts to comply with 30 C.F.R. § 50.10. (Tr. I 204). In fact, inspector Ellison was not aware of any other failure to report roof fall accidents by Respondent. (Tr. I 204-05) In these circumstances, I find that the Secretary has failed to establish that Respondent was placed on notice that greater compliance efforts with 30 C.F.R. § 50.10 were necessary. Accordingly, this factor mitigates against a finding of unwarrantable failure.

4. Whether the Violation Posed a High Degree of Danger

The Commission has relied upon the high degree of danger posed by a violation to support an unwarrantable failure finding. *See, e.g., BethEnergy Mines,* Inc., 14 FMSHRC 1232, 1243-44 (Aug. 1992) (finding unwarrantable failure where unsaddled beams "presented a danger" to miners entering the area); *Quinland Coals*, 10 FMSHRC at 709 (finding unwarrantable failure where roof conditions were "highly dangerous").

The relevant inquiry here is whether the failure to report the roof fall accident posed a high degree of danger to miners or heightened their exposure to such danger. Hence, even though the failure to report is the actual violation, I must examine whether the failure to report the roof fall aggravated the danger posed by the extant roof conditions after the fall, and whether Respondent took any actions that mitigated its failure to report.

Respondent's own witnesses established that the roof conditions in the No. 6 entry following the fall were was so dangerous that the entry was breakered off with timbers by the following shift. The unsupported top created by the dislodged roof bolts between parallel surface cracks made travel in the area hazardous, as Respondent admitted in August 17 and 18 pre- and on-shift reports (R. Ex 8, pp. 26-27), and through the testimony of Belcher that travel in the No. 6 entry was unsafe after the fall. (Tr. II 348-49). Moreover, by the time of the inspection four days later, Ellison observed that the rock had fallen under cracked roof that dropped three or four inches. (Tr. I 78-80, 91-93). Additionally, Collins testified that the area was breakered off because the chunk of sandstone had fallen out between two parallel cracks, which started in the bolted area of the main roof and widened out into the adjacent crosscut, rendering continued mining in the No. 6 entry unviable. (Tr. 433-34). I credit Ellison's testimony that the failure to report the roof fall could cause a high degree of danger, even though the area had been "breakered off," because miners were expected to return to the area during rehabilitation or cleanup, and the roof fall itself posed a high degree of danger to any miners working in the area. (Tr. I 118-19).

Concededly, the present danger that miners faced under continued normal operations *in the No. 6 entry* was ameliorated by Respondent's prompt decision to breaker off that entry. Indeed, inspector Ellison marked the gravity in Order No. 8093139 as "no likelihood," "no lost workdays," and not "significant and substantial" (S&S). *But the failure to report had danger ramifications that extended beyond the No. 6 entry where the instant roof fall occurred.* The record clearly establishes that the whole East Section had adverse roof conditions in every entry as Respondent

drove on the outcrop with low cover. (Tr. II 243).[39] There were very bad roof conditions and cracks across the section, which were very dangerous. (Tr. I 72-73, 76-77; Tr. III 433-34). Even after the No. 6 entry was dangered off, mining continued for four days in other entries until the 103(k) order issued on August 17. That Order was issued to ensure the safety of all persons by prohibiting all activity on the East Section 020-0 MMU from spad #13331 inby because the whole section, and not just the No. 6 entry, had several adverse conditions present in the form of cracks, slips, and mud streaks. G. Ex. 2. Miners were working and traveling in this section from August 13 through August 17.

Thus, contrary to the rationale set forth in the Final Rule at 71 Fed. Reg. 71435, the failure to immediately report the August 13 "near miss" roof fall accident, hampered the timely mobilization of MSHA's expert personnel to the scene. Such immediate notification would have permitted MSHA to more quickly address a problem with adverse roof conditions throughout the East Section, which required a detailed rehabilitation plan, and left uncorrected, could have been extremely hazardous to miners continuing to work there.

Consequently, despite Respondent's laudable and prudent decision to breaker off the No. 6 entry, Respondent could have and should have immediately notified MSHA so that it could bring its expertise to bear to rehabilitate the entire section. (Cf. Tr. III 46). Respondent's failure to do so exposed miners to additional roof fall hazards throughout the section. Accordingly, I find that the violation heightened the exposure of miners working throughout the East Section to potential grave danger for four days, and this factor, on balance, tips in favor of an unwarrantable failure finding. (Tr. III 44-46).

5. The Operator's Knowledge of the Existence of the Violation, Whether the Violation was Obvious, and the Reasonableness of the Operator's Purported Good-Faith Disagreement with MSHA as to What Constitutes a Reportable Roof Fall

I agree with the Secretary that the record evidence establishes that the violation was obvious and that Pine Ridge knew or should have known that the roof fall was reportable. As explained

---

[39]As the record evidence established before Judge Paez recently in *Stillhouse Mining LLC*, Docket No. KENT 2007-309, Slip op. at 7 (Mar. 28, 2011), http://www.fmshrc.gov/decisions/alj/Kt2007-309.htm, underground areas near where the coal is exposed to the surface, called the outcrop, are known to have weaker roofs than other areas of the mine. In addition, the deaths of most underground miners are caused by roof falls. Slip op. at 7. *See also Big Ridge, Inc.*, Docket No. 2009-532, Slip op. at 19 (Mar. 1, 2011)(Judge Miller), http://www.fmshrc.gov/decisions/alj/Lk2009-490.htm, reaffirming Commission precedent in *Consolidation Coal Co.*, 6 FMSHRC 34, 37 n. 4 (Jan. 1984) that roof falls continue to be recognized by Congress, the Secretary of Labor, the Commission, and the mining industry as one of the most serious hazards in mining and remain the leading cause of death in underground coal mines).

above, irrespective of the anchorage zone issue,[40] there was an unplanned roof fall in active workings that impaired ventilation and impeded passage. The record evidence establishes that these conditions were obvious and triggered a reporting obligation by foreman Pauley and mine manager Belcher. Accordingly, I find that Pine Ridge did not have any reasonable, good-faith belief that the unplanned roof fall did not occur in active workings, did not impair ventilation, and did not impede passage.

As found above, foreman Pauley was in close proximity to the roof fall when it fell on the continuous miner during active mining while turning the left cross cut. The fall was obviously unplanned. When Pauley approached the rock fall location, he noticed that Kinder and Daniels were visibly shaken up. (Tr. II 288, 290). The roof fall nearly missed Daniels, where he was working. (Tr. I 107-08). In discovery, Respondent conclusively admitted "active workings." Reliance on hearsay to the contrary from WVOMHST inspectors has been specifically discredited.

Foreman Pauley further noticed that during the roof fall process, the continuous miner tore out a couple of roof bolts that were at the edge of the cut (Tr. II 189, 193, 201), and the boom of the miner caught the line curtain and pulled it down. As a result of the roof fall, there were no ventilation controls in the face area and the line curtain was greater than 50 feet outby the face of the No. 6 entry, about 67-70 feet back. (Tr. I 97, 254, 355, 359; Tr. II 15, 159, 369; R. Exh 10). The fall extended several feet into the bolted No. 6 entry from unbolted 6 left, about half way to the second row of roof bolts. (G. Ex. 5, p. 4; G. Ex. 6, p. 6; R. Ex. 10).

A "confrontation" ensued when the UMWA representative challenged Pauley concerning whether the fall was a reportable accident. (Tr. II 190-91). Despite the confrontation; the fact that mere reporting was not a violation; the fact that there were parallel surface cracks in the roof even before the fall; the fact that the fall extended into the bolted entry and roof bolts had been pulled out, thereby compromising safe passage to the face under fully supported top; and the fact that the only ventilation control in the entry had been torn down and remained non-compliant with MSHA requirements, Pauley decided that the roof fall was not reportable.

At trial, Pauley admitted that when a curtain is down, ventilation is automatically compromised (Tr. II 279), and he testified that a downed curtain impedes ventilation (Tr. II 280), and always impairs the volume of air in the area. (Tr. 280). Belcher conceded that line curtain takes noxious gas, coal dust, and bad air down the return and back out, and that all ventilation curtains or controls should be in place, even when the section is idle. (Tr. II 346-47). On cross examination, Belcher conceded that the ventilation curtain should have been within 50 feet of the

---

[40]Respondent raised substantial arguments concerning good-faith disagreement with MSHA over whether the unplanned roof fall was at or above the anchorage zone. Based on decades of collective mining experience, Respondent's witnesses testified that reportability was triggered at or above the length of the bolt, and that MSHA had never informed them differently. (Tr. II 344, 440-41; Tr. III 12). Since I have found it unnecessary to pass on prong one of the disjunctive definition of "accident," which is the only prong that addresses "anchorage zone," I find it unnecessary to decide whether Respondent held an objectively reasonable belief that the roof fall was below the anchorage zone.

face. (Tr. 369-70). Respondent's shift reports further establish that ventilation was impaired after the rock fall.

The credible evidence also establishes that as a result of the roof fall, it was obvious that passage to the No. 6 face under fully supported top was impeded. Pauley knew that the roof fall dislodged roof supports creating an area of unsupported top. Thus, Pauley knew or should have known that there was no way for Respondent to conduct the required examinations at the No. 6 face because the roof fall compromised the support in the entry and precluded travel to the face under fully supported roof as required by 30 C.F.R. §75.202. (Tr. I 253, 317, 355-57; Tr. II). The danger impeding passage caused Belcher to breaker off and begin conducting examinations at the breaker posts. (Tr. I 206-07, 356; Tr. II 245; Tr. III 34).

Pauley's report to Belcher is telling as Pauley failed to give Belcher a full and accurate account of the situation so that Belcher could make an accurate judgment call on reportability.[41] In fact, based on discussions with his crew, Pauley had already made up his mind that the fall was not reportable, and I find that his report to Belcher was tailored to arrive at this conclusion. Based on Pauley's explanation, Belcher agreed that the roof fall was not reportable. (Tr. II 194, 299-300). As Belcher put it, "I had to trust his judgment, what he told me on the mine phone that day," to meet the 15-minute reporting requirement. (Tr. II 404). "If I'm wrong, I'm wrong: if I'm right, I'm right." (Tr. II 406).

Belcher was wrong and failed to make reasonable inquiry. Pauley was not forthcoming. The fall did pull out roof bolts and resulted in unsupported top and a downed ventilation control. Pauley knew this, but did not tell Belcher, at least not according to Belcher. Pauley never explained why he called out a fall that purportedly was just part of normal mining and not reportable. Further, Belcher performed a perfunctory investigation and inquiry. His testimony indicated an initial cavalier attitude toward the roof fall, describing it as not even a close call based on Pauley's account, but one wonders why Belcher would need to clear his conscience when purportedly talking to Herron on August 14, if this was the case. Belcher never asked Pauley why the rock had a bolt in it, if the fall did not pull out roof bolts. Belcher did not talk to Kinder or Daniels, who were directly involved in the roof fall. Belcher did not ask anyone underground to immediately confirm Pauley's assessment, as Martin did not examine the fall until shortly after commencement of the next shift.

Based on the totality of record evidence, I reject any argument that Pine Ridge did not know or should not have known that there was unplanned roof fall in active workings that impaired ventilation and impeded passage, or that such conditions were not obvious. The Commission has held that an operator's supervisors are held to a high standard of care, and that a foreman's involvement by failing to recognize the violation and take reasonable precautionary measures may be a factor supporting an unwarrantable failure finding. *See e.g.*, *Lafarge Construction Materials*, 20 FMSHRC 1140, 1145-1148 (Oct. 1988), citing *Midwest Material Co.*, 19 FMSHRC 30, 34-35 (Jan. 1997).

Based on the foregoing, I find that foreman Pauley and mine manager Belcher failed to exercise the heightened standard of care required of them, respectively, in reporting and

---

[41]See page 6, *infra*, citing Tr. II 314-17.

investigating the rock fall to assess reportability. Accordingly, I find that Respondent knew or should have known that the roof fall was reportable based on facts that made it obvious that there was an unplanned roof fall in active workings that impaired ventilation and impeded passage.

6. The Operator's Efforts in Abating the Violation

An operator's efforts to abate the violative condition is a factor relevant to determining whether a violation is unwarrantable. Thus, where an operator has been placed on notice of a problem, the level of priority that the operator places on the abatement of the problem is relevant. *IO Coal*, 31 FMSHRC at 1356, citing *Enlow Fork Mining Co.*, 19 FMSHRC 5, 17 (Jan. 1997). The focus on the operator's abatement efforts is on those efforts made prior to the citation or order. *Id.*

In this case, I place great weight on inspector Ellison's detailed testimony, as corroborated by his contemporaneous notes, that Pine Ridge engaged in "very, very poor efforts" to abate the violation. (Tr. I 119). As noted, the condition was obvious and should have been reported immediately. (Tr. I 121, 219). Ellison credibly testified that when he initially observed the condition underground on August 17, he told safety specialist Ray that the fall was reportable and explained why. (Tr. I 19; G. Ex. 5, p. 7) Thereafter, at 1:15 p.m., Ellison told shift foreman Martin and section foremen Pauley that the fall needed to be reported. No call was made. Once on the surface at about 2 p.m., Ellison told Belcher and Ashby about the 15-minute reporting rule and why Respondent was required to report the fall to the MSHA hotline. (Tr. 119; G. Ex. 5, pp. 7-8). Ashby told Ellison that he would make the call. No call was made. Nearly an hour later at 2:55 p.m., when Ellison asked if Ashby had reported the fall, Ashby replied, "Not yet. I'm getting ready -- getting ready to." (Tr. I 120; G. Ex. 5, p. 8). After consulting supervisor Price, Ellison began drafting the instant 104(d)(1) Order.

As noted, Respondent was required to report the fall immediately on August 13, i.e., within 15 minutes of its occurrence when Pauley had the requisite knowledge of its reportability. By the time Ellison inspected, it was four days later, and Respondent continued its failure to report the roof fall accident despite Ellison's repeated requests that it do so. In these circumstances, I agree with inspector Ellison's conclusion that Respondent's unjustifiable intransigence exhibited "reckless disregard"[42] for the reporting requirement. (Tr. I 121-23, 219-220). Respondent's inaction exhibited a gross and continuing lack of care for the reporting requirement that it deemed unworthy

---

[42]As Judge Paez recently noted in *Stillhouse Mining*, supra, Slip op. at 7, the term "reckless" is commonly understood as "without thinking or caring about the consequences of an action [or inaction]," *citing The New Oxford American Dictionary* 1414 (Erin McKean ed., 2d ed. 2005). As a legal term, "reckless" conduct is "[c]haracterized by the creation of a substantial and unjustifiable risk of harm to others and by a conscious (and sometimes deliberate) disregard or indifference to that risk; heedless; rash . . . . more than mere negligence: it is a gross deviation from what a reasonable person would do." *Black's Law Dictionary* 1298 (8th ed. 2004). The term "disregard" is commonly understood as "to treat without fitting respect or attention: to treat as unworthy of regard or notice: to give no thought to: pay no attention to. *Webster's Third New International Dictionary (Unabridged)* 665 (1993). I note that for civil penalty purposes, 30 C.F.R. §100.3, Table X, defines "reckless disregard" as "conduct which exhibits the absence of the slightest degree of care."

of its attention. In fact, Respondent did not even report the accident to MSHA until after inspector Ellison wrote the Order.

In these circumstances, I agree with inspector Ellison that the abatement efforts of Respondent exhibited reckless disregard for the reporting requirement and MSHA's statutory authority. Accordingly, this factor supports the unwarrantable failure determination.

D. Conclusion on Unwarrantable Failure Issue

In sum, after considering the relevant Commission factors, I find that the violative condition was extensive, obvious, and lengthy. Further, the failure to report the roof fall accident heightened miners' continuing exposure to potential grave danger from other roof falls as miners continued to work under dangerous, adverse roof conditions throughout the section. Pine Ridge's supervisors knew or should have known through reasonable inquiry that the roof fall was reportable. Pine Ridge did not harbor any reasonable, good-faith belief that the unplanned roof fall did not occur in active workings, did not impair ventilation, and did not impede passage. Pine Ridge's abatement efforts manifested "reckless disregard" for the reporting requirement.

Given the fact that the violation was obvious, dangerous, and extensive; the fact that inspector Ellison had completed his inspection of the section and Respondent did not bring the fall to his attention; the fact that Respondent planned on cleaning up the fall and punching to the surface through another entry; and the fact that Respondent engaged in self-help without simple notification to MSHA, I conclude that the totality of record evidence supports the inference that Respondent, acting through Pauley, Belcher, or both, made a conscious decision to refrain from reporting what should have been known as a reportable roof fall. I infer that Respondent acted intentionally and at least with a "serious lack of reasonable care" in failing to report the fall immediately to MSHA. In my view, the entire record supports the inference that Pine Ridge consciously and deliberated failed to report the fall based on a calculated risk that it would not get caught. As the Secretary points out near the outset of her brief, Respondent "was caught, and the Secretary's 104(d)(1) order must be affirmed and an appropriate penalty imposed."

E. Civil Penalty Principles

The Commission outlined the parameters of its responsibility for assessing civil penalties in *Douglas R. Rushford Trucking*, 22 FMSHRC 598 (May 2000). The Commission stated:

> The principles governing the Commission's authority to assess civil penalties *de novo* for violations of the Mine Act are well established. Section 110(i) of the Mine Act delegates to the Commission "authority to assess all civil penalties provided in [the] Act." 30 U.S.C. § 820(i). The Act delegates the duty of proposing penalties to the Secretary. 30 U.S.C. § § 815(a) and 820(a). Thus, when an operator notifies the Secretary that it intends to challenge a penalty, the Secretary petitions the Commission to assess the penalty. 29 C.F.R. §§ 2700.28 and 2700.44. The Act requires that, "[i]n assessing civil monetary penalties, the Commission [ALJ] shall consider" six statutory penalty criteria:
>
> [1] the operator's history of previous violations, [2] the appropriateness of such penalty to the size of the business of the operator charged, [3] whether the operator

> was negligent, [4] the effect of the operator's ability to continue in business, [5] the gravity of the violations, and [6] the demonstrated good faith of the person charged in attempting to achieve rapid compliance after notification of a violation.

22 FMSHRC at 600, citing 30 U.S.C. § 820(I) (italics added).

In keeping with this statutory requirement, the Commission has held that "findings of fact on the statutory penalty criteria must be made" by its judges. *Sellersburg Stone Co.*, 5 FMSHRC 287, 292 (Mar. 1983). Once findings on the statutory criteria have been made, a judge's penalty assessment for a particular violation is an exercise of discretion, which is bounded by proper consideration for the statutory criteria and the deterrent purposes of the Act. *Id.* at 294, *Cantera Green*, 22 FMSHRC 616, 620 (May 2000).

In exercising this discretion, the Commission has recently reiterated that a judge is not bound by the penalty recommended by the Secretary. *Spartan Mining Co.*, 30 FMSHRC 699, 723 (Aug. 2008). In addition, the *de novo* assessment of civil penalties does not require "that equal weight must be assigned to each of the penalty assessment criteria." *Thunder Basin Coal Co.*, 19 FMSHRC 1495, 1503 (Sept. 1997). However, when a penalty determination "substantially diverge[s] from those originally proposed, it behooves the . . . judge[] to provide a sufficient explanation of the bases underlying the penalties assessed. *Spartan Mining,* 30 FMSHRC at 699. Otherwise, without an explanation for such a divergence, the "credibility of the administrative scheme providing for the increase or lowering of penalties after contest may be jeopardized by an appearance of arbitrariness." *Sellersburg*, 5 FMSHRC at 293.

F. Explanation for Civil Penalty Assessed

As noted, Section 110(i) of the Mine Act sets forth the criteria to be considered in determining an appropriate civil penalty. In addition, since Order No. 8093139 was issued under § 104(d)(1), § 110(a)(3)(A) of the Act requires that the minimum penalty shall be $2,000.00. Here, the Secretary's Petition has proposed assessment of the statutory minimum penalty of $2,000.00 for the § 104(d)(1) violation.[43] Addressing the appropriate penalty criteria in light of the facts in the record and the rationale in the Final Rule, I find that the statutory minimum penalty of $2,000.00 is insufficient to have the requisite deterrent effect for the unwarrantable failure at issue.

The parties stipulated to the authenticity of the Violator Data Sheet attached to the Secretary's Petition for Assessment of Civil Penalty. (Tr. I, 15-16; see G. Ex. 1). Respondent introduced no evidence to the contrary. Pine Ridge's history of previous violations is based on both the total number of violations and the number of repeat violations of the same provision of a standard in the preceding-15 month period prior to August 17, 2009. 30 C.F.R § 103.3(c). The un-rebutted record establishes that Pine Ridge has approximately 1.43 violations per inspection day and a repeat history of violating 30 C.F.R. § 50.10 three times in the 15 months preceding the instant 104(d)(1) Order.

[43] I note that § 110(a)(3)(B) of the Act requires a minimum penalty of $4,000.00 for any order issued under section 104(d)(2).

As noted, Pine Ridge was more than negligent with respect to the actual violation, i.e, the failure to report the roof fall accident immediately.[44] Rather, as explained above, Respondent's unjustifiable intransigence in failing to report the accident exhibited "reckless disregard," defined in Part 100.3(d) table X for penalty purposes as ". . . display[ing] conduct which exhibits the absence of the slightest degree of care." As found herein, Respondent's inaction exhibited a gross and continuing lack of care for the reporting requirement that it deemed unworthy of its attention.

I have found that Pine Ridge did not have any reasonable, good-faith belief that the unplanned roof fall did not occur in active workings, did not impair ventilation, and did not impede passage. Similarly, Pine Ridge did not demonstrate good-faith by attempting to achieve rapid compliance after notification of the violation. Only after multiple discussions and the 104(d)(1) order was drafted did Respondent belatedly notify MSHA four days after the "near miss" accident. Although the gravity of the violation as set forth in inspector Ellison's Order was no likelihood of injury, no lost work days, and non-S&S, I have found that the failure to immediately report the roof fall, hampered the timely mobilization of MSHA's expert personnel and heightened the exposure of miners to potential grave danger from adverse roof conditions throughout the East Section for several days before a detailed rehabilitation plan was in place.

Finally, the appropriateness of the penalty to the size of Pine Ridge's business is calculated by using the size of the mine cited and the size of the mine's controlling entity. Pine Ridge's Big Mountain No. 16 is a very large underground coal mine, which takes several months to fully inspect (Tr. I 55), has annual tonnage of over 1,000,000 to 2,000,000, and has a controlling entity, Patriot Coal Corporation, with annual tonnage of over 10,000,000. (G. Exh. 1 and 30 C.F.R § 103.3(b) Tables I and II). Pine Ridge declined to stipulate that payment of civil penalties would not affect its ability to remain in business, but it failed to offer any argument or evidence that its ability to continue in business would be impaired. *Sellersburg*, 5 FMSHRC at 294, *citing Buffalo Mining Co.*, 2 IBMA 226, 247-48 (Sept. 1973). Moreover, Pine Ridge failed to introduce any financial information or other specific information on the issue of whether the proposed penalty, which merely adopted the statutory minimum of $2,000.00, was inappropriate to the size of Respondent's business or adversely affected its ability to remain in business. Absent proof that the imposition of authorized penalties would adversely affect Pine Ridge's ability to stay in business, it is presumed that no such adverse affect will occur. *See Broken Hill Mining Co.*, 19 FSSHRC 673, 677 (Apr. 1997) (*citing Sellersburg*, 5 FMSHRC at 294, which cited *Buffalo Mining Co.*, 2 IBMA 226, 247-48 (Sept. 1973); *accord Spurlock Mining Co.*, 16 FMSHRC 697, 700 (Apr. 1994). *See also Steele Branch Mining*, 18 FMSHRC 6, 15 (Jan. 1996).

Given the large size of Respondent's business and the other penalty criteria discussed above, I find that an increased penalty of $6,000.00 against Pine Ridge is based on a proper consideration of the statutory criteria, the deterrent purpose of the Act, and the rationale in the Final Rule. *Cf. Sellersburg*, 5 FMSHRC at 294-95. This results in an increase from the required statutory minimum penalty of $2,000.00 by the amount of $1,000.00 for each day the failure to report the

[44]Respondent's prudent action in breakering off the No. 6 entry where the roof fall occurred is not a mitigating factor with respect to the actual violation, i.e., the failure to report.

roof fall accident continued while miners were exposed to adverse roof conditions throughout the East Section.

IV. ORDER

For the reasons set forth above, Order No. 8093139 is **AFFIRMED**, as written, thus establishing an unwarrantable failure to report a roof fall accident within 15 minutes under 30 C.F.R. § 50.10. Within 40 days of the date of this decision, Respondent, Pine Ridge Coal Company is **ORDERED TO PAY** a civil penalty of $6,000.00 for its unwarrantable failure to report the roof fall accident. Upon payment of the penalty, this proceeding is **DISMISSED**.

Thomas P. McCarthy
Administrative Law Judge

Distribution: (E-Mail and Certified Mail)

Jessica R. Hughes, Esq., Office of the Solicitor, U.S. Department of Labor, 1100 Wilson Blvd., 22nd Floor West, Arlington, VA 22209-2247

Melissa Robinson, Esq., Jackson & Kelly, PLLC, 500 Lee St. East, Suite 1600, P.O. Box 553, Charleston, WV 25322

/cp