FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

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December 23, 2013

SECRETARY OF LABOR,	:	
MINE SAFETY AND HEALTH	:	Docket No. WEVA 2007-600
ADMINISTRATION (MSHA)	:	A.C. No. 46-08791-120481-01
	:	
v.	:	Docket No. WEVA 2008-247
	:	A.C. No. 46-08791-130758
WOLF RUN MINING COMPANY	:	

BEFORE: Jordan, Chairman; Young and Nakamura, Commissioners[1]

DECISION

BY: Jordan, Chairman, and Nakamura, Commissioner

This case, under the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 801 et seq. (2012), arose from a citation and an order issued by the U.S. Department of Labor's Mine Safety and Health Administration ("MSHA") to Wolf Run Mining Company for its failure to immediately notify MSHA and mine rescue teams of an accident occurring at its Sago Mine. The Administrative Law Judge reduced the negligence finding in the citation and reduced the negligence finding and vacated the unwarrantable failure finding in the order. 32 FMSHRC 1317, 1331, 1336 (Sept. 2010) (ALJ). The Commission granted the Secretary of Labor's petition for discretionary review of the judge's decision. For the reasons that follow, we reverse the judge's decision in part and assess the original penalties proposed by the Secretary for both violations.

I.

Factual and Procedural Background

On January 2, 2006, at 6:26 a.m., an explosion occurred at Wolf Run's Sago Mine, located in Upshur County, West Virginia. 32 FMSHRC at 1318, 1320. At that time, the mine had two

[1] Commissioner Robert F. Cohen Jr. is recused in this case. Commissioner William I. Althen assumed office after this case had been considered at a Commission meeting. A new Commissioner possesses legal authority to participate in pending cases, but such participation is discretionary. *Mid-Continent Res., Inc.*, 16 FMSHRC 1218 (June 1994). In the interest of efficient decision making, Commissioner Althen has elected not to participate in this matter.

active working sections called 1st Left and 2nd Left. *Id.* at 1320. Beyond the active working sections was an abandoned area referred to as 2 North. A set of seals was constructed across nine entries to seal 2 North from the active areas of the mine. Jt. Stips. 27, 28.

The explosion occurred in 2 North and blew out all of the seals. Jt. Stip. 29. There were 29 miners underground at the time of the explosion. 32 FMSHRC at 1318. The 2nd Left crew had already reached the 2nd Left face, but the 1st Left crew was still in transit in a mantrip to 1st Left face. *Id.* at 1319.

Meanwhile, on the surface, at 6:26 a.m., the same time as the explosion, a flash of lightning and loud thunder occurred as dispatcher William Chisolm was speaking on the phone with Mine Superintendent Jeffrey Toler, who was located in a building next to the dispatcher's office. *Id.* at 1320. Alarms on the Atmospheric Monitoring System ("AMS"), which monitors carbon monoxide, began to sound which Toler could hear over the mine phone. Chisolm told Toler that he had lost the AMS and that the belts were down. *Id.*

At 6:32 a.m., Belt cleaner Pat Boni, who was located underground outby the 1st Left crew when the explosion occurred, called Chisholm on the mine phone located near the No. 4 Belt and asked what had happened. *Id.* at 1321. He informed Chisholm that dust was moving in an inby direction rather than outby, the opposite direction in which the air normally flowed. *Id.*

At 6:36 a.m., while Toler, Chisholm, and Maintenance Superintendent Denver Wilfong were on the phone together, they received a phone call from underground from Owen Jones, a foreman of the 1st Left crew who had felt the force of the explosion when he was knocked down off the mantrip, lost his hard hat, and encountered the resultant smoke, dust, and debris. *Id.* Jones told management that "we had a mine explosion or something in here" and to "get mine rescue here right now." *Id.* No call was made to mine rescue or MSHA at that time.

Nothing had yet been heard from the 2nd Left crew. Thereafter, Toler, Wilfong, Maintenance Foreman Vernon Hofer, and Safety Director James (Al) Schoonover went underground to assist in the evacuation of miners and to determine the nature and extent of the accident. *Id.* Sometime between 7:15 a.m. and 7:23 a.m., while underground, after encountering the 1st Left crew, Wilfong called Chisholm on the surface and told him to call authorities. *Id.*; Jt. Stips. 113-14. During that call, Toler was patched into a call with John B. Stemple, Jr., the company's Assistant Director of Safety and Employee Development, from his home phone. 32 FMSHRC at 1322. Toler also advised Stemple to notify the authorities. *Id.*

However, Stemple still did not immediately make those calls. Instead, between 7:24 and 7:28 a.m., Stemple left messages on the home answering machines of several members of the company's upper management. *Id.* at 1323. At 7:46 a.m., Stemple left a message on the home answering machine of an official of the state mine safety agency. *Id.* at 1324. Stemple's first attempt to contact MSHA did not occur until approximately 7:50 a.m. when he left a phone message at the home of an MSHA supervisor. *Id.* At no time did Stemple call the toll-free

telephone at MSHA headquarters.[2] Tr. 579. He initially unsuccessfully attempted to contact a mine rescue team member at his home at approximately 8:04 a.m. 32 FMSHRC at 1324. At 8:32 a.m., Stemple successfully contacted MSHA Supervisor James Satterfield at his home. *Id.* at 1325. Satterfield immediately issued a verbal order under section 103(k) of the Mine Act, 30 U.S.C. § 813(k), prohibiting anyone from entering the mine. *Id.* Stemple successfully contacted mine rescue at 8:37 a.m. *Id.*

After being notified, MSHA personnel arrived at the mine at 10:30 a.m. Jt. Stip. 166. The Barbour County mine rescue team assembled at their Volga, West Virginia station, prepared equipment and headed for the mine at approximately 10:30 a.m. and arrived between 11:40-11:45 a.m. Jt. Stip. 169; Tr. 176-77, 181-83. Monitoring of the mine atmosphere was commenced and continued throughout the day. Jt. Stip. 173. Air quality measurements indicated a downward trend in the levels of dangerous gases. Jt. Stip. 174. At 5:25 p.m., MSHA permitted the first mine rescue team to enter the mine. Jt. Stip. 175. The 2nd Left crew members were discovered in the face area of the section. Jt. Stip. 177. Eleven miners were found dead and one miner was found alive. Jt. Stip. 178. Another deceased miner was found outby the 2nd Left section. Jt. Stip. 179.

As a result of these events, MSHA issued the citation and order involved in this case to Wolf Run. Citation No. 7100919 alleged that Wolf Run violated 30 C.F.R. § 50.10 because it failed to immediately notify MSHA of the explosion. 32 FMSHRC at 1326. Order No. 7100920 alleged that Wolf Run violated 30 C.F.R. § 75.1502(a)[3] because it failed to comply with the

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[2] At the time the citation was issued, section 50.10 explicitly required that in the event that a mine operator is unable to contact the local MSHA District Office *immediately* after an accident has occurred, it "shall *immediately* contact the MSHA Headquarters Office in Arlington, Virginia" and provided a toll free phone number. 30 C.F.R. § 50.10 (emphasis added). There was a subsequent amendment to the regulation eliminating the requirement that the operator immediately contact the MSHA District Office. 71 Fed. Reg. 71430-01 (Dec. 8, 2006). In this case, Wolf Run clearly failed to comply with this mandated procedure.

[3] Section 75.1502 provides:

> Each operator of an underground coal mine shall adopt and follow a mine emergency evacuation and firefighting program that instructs all miners in the proper procedures they must follow if a mine emergency occurs. (a) Program approval. The operator shall submit this program of instruction, and any revisions, for approval to the District Manager of the Coal Mine Safety and Health district in which the mine is located. Within 30 days of approval, the operator shall conduct training in accordance with the revised program.

30 C.F.R. § 75.1502(a).

mine's emergency evacuation and firefighting program and immediately contact the mine rescue team.[4] *Id.* at 1332. MSHA alleged that both violations involved high negligence and that the emergency plan violation was significant and substantial ("S&S") and constituted an unwarrantable failure to comply.[5] MSHA subsequently proposed penalties of $1,500 for Citation No. 7100919 and $13,000 for Order No. 7100920. *Id.* at 1326, 1332.

In his decision, the judge affirmed both violations and the S&S designation for the emergency plan violation. *Id.* at 1330-34. He reduced the negligence levels for both violations from high to moderate, reduced the penalties for both violations from $1,500 to $1,000 and from $13,000 to $10,000 respectively, and vacated the unwarrantable failure designation associated with the emergency plan violation. *Id.* at 1331, 1334-37.

The judge found that the operator's duty to contact MSHA did not begin until 7:23 a.m., when Toler first told Stemple to report the incident, rather than at 6:36 a.m., as the Secretary asserted, when Jones first reported the circumstances of the explosion to Chisolm, Toler, and Wilfong. *Id.* at 1330-31. The judge concluded that Commission case law permitted the operator a reasonable opportunity to investigate the event prior to being required to contact authorities. *Id.* at 1327-28. He also reasoned that the operator's negligence in not immediately reporting the incident was mitigated by mine management's wish to execute a rescue attempt and to not be barred from entering the mine. He also took into account the fact that the event occurred on a national holiday when MSHA and state offices were closed, making it difficult to reach authorities. *Id.* at 1331, 1336.

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[4] The mine's emergency evacuation plan states "[i]n the event of a mine fire or explosion the Barbour County Mine Rescue team is to be notified immediately at 457-2745." G. Ex. 6 at 12; G. Ex. 2.

[5] The S&S terminology is taken from section 104(d)(1) of the Act, 30 U.S.C. § 814(d)(1), which distinguishes as more serious any violation that "could significantly and substantially contribute to the cause and effect of a . . . mine safety or health hazard." The unwarrantable failure terminology is also taken from section 104(d)(1) of the Act, 30 U.S.C. § 814(d)(1), which establishes more severe sanctions for any violation that is caused by "an unwarrantable failure of [an] operator to comply with . . . mandatory health or safety standards."

MSHA could not designate the violation of section 50.10 as S&S and unwarrantable failure because, at the time, section 50.10 was a "regulation" rather than a "standard." *See Cyprus Emerald Res. Corp. v. FMSHRC*, 195 F.3d 42, 45-46 (D.C. Cir. 1999). In December 2006, MSHA promulgated a new section 50.10 as a "standard." *See* 71 Fed. Reg. 71430-01 (Dec. 8, 2006).

II.

Disposition

On appeal, the Secretary argues that the judge erred in his negligence and unwarrantable failure analyses by failing to correctly determine the amount of time the operator delayed in reporting the explosion; by treating the operator's intentional delay in reporting the explosion as a mitigating factor, as opposed to an aggravating factor; by failing to take into account the fact that the delay in reporting the explosion posed a significant degree of danger; and by holding that the operator's negligence was mitigated because the explosion occurred on a national holiday. He asks the Commission to reverse the judge's decision on negligence and unwarrantable failure and to assess the penalties proposed by MSHA.

A. The Judge Erred in Reducing the Degree of Negligence Associated with the Violations from High to Moderate.

1. The judge incorrectly concluded that Wolf Run's duty to report the accident arose at 7:23 a.m. rather than at 6:36 a.m.

The judge made a critical error in his analysis of the violations by concluding that Wolf Run's duty to contact MSHA and mine rescue teams began at 7:23 a.m. rather than at 6:36 a.m. The record clearly shows that mine management knew about the accident as early as 6:36 a.m. when Owen Jones, the foreman underground at the time of the incident and closest to the location of the explosion, called up to the surface to inform Mine Superintendent Jeffrey Toler that a forceful blast of air had struck him and his crew while on the mantrip. 32 FMSHRC at 1327; Tr. 85, 87, 88, 130-32, 448-50, 468. Jones testified that when he initially spoke with Chisholm and Toler, at 6:36 a.m., he stated that "we had a mine explosion or something in here" and "get mine rescue here right now." Tr. 87-88. The judge credited Jones' testimony. 32 FMSHRC at 1327. In fact, the judge himself concluded that mine management "knew, or should have known, as early as 6:36 a.m. that an explosion had occurred." *Id.*

While Jones' testimony by itself shows that management should have known by 6:36 a.m. that a reportable accident had occurred, other circumstances add further support to that conclusion. The lightning strike at 6:26 a.m. had concurrently caused the carbon monoxide monitors to set off alarms, signaling elevated readings of carbon dioxide, before completely shutting down. *Id.* at 1320-21. The phone call from Pat Boni, who was located outby the 1st Left crew at the time of the explosion, at approximately 6:32 a.m., informing Chisholm that dust was moving in the opposite direction of normal airflow, inby instead of outby, indicated that there had been a disruption in the ventilation system. *Id.* at 1321. The 2nd Left crew, located further inby the mine, closer to the location of the explosion, could not be contacted either by Jones underground or by the dispatcher at the surface. *Id.* at 1321-23.

Despite these circumstances, Wolf Run did not immediately attempt to contact MSHA and mine rescue teams. No one tried to contact authorities until Stemple attempted to contact MSHA at 7:50 a.m. and the mine rescue team at 8:04 a.m. *Id.* at 1324, 1330. This was a time lag of

approximately 75 minutes and 90 minutes, respectively, after mine management first knew or should have known of the reportable incident. After Stemple spoke with Toler, he waited approximately 25 minutes before he attempted to contact MSHA, and approximately 40 minutes before he tried to call mine rescue. Clearly, substantial evidence[6] does not support the judge's conclusion that Wolf Run's duty to "immediately contact" MSHA arose at 7:23 a.m.

Not only is there a lack of substantial evidence supporting his conclusion, but the judge also erred as a matter of law by relying on *Consolidation Coal Co.*, 11 FMSHRC 1935, 1938 (Oct. 1989) ("*Consol*"). Citing *Consol*, the judge stated that "the Commission has acknowledged that mine operators must be accorded a degree of discretion in investigating accidents prior to notifying MSHA." 32 FMSHRC at 1327. The judge misinterpreted the Commission's decision in *Consol*. In *Consol*, an unplanned roof fall had occurred in an underground coal mine. The Commission was careful to explain that an operator's opportunity to investigate is tempered by the urgent need to notify MSHA *immediately* once it is clear that an accident has occurred:

> Section 50.10 therefore necessarily accords operators a reasonable opportunity for investigation into an event prior to reporting to MSHA. Such internal investigation, however, must be carried out by operators in good faith without delay and in light of the regulation's command of prompt, vigorous action. The immediateness of an operator's notification under section 50.10 must be evaluated on a case-by-case basis, taking into account the nature of the accident and all relevant variables affecting reaction and reporting.

11 FMSHRC at 1938.

In *Consol*, even though it was not readily determinable whether the roof fall occurred above the anchorage zone,[7] the Commission concluded that the operator violated the reporting standard because: (1) the responsible management official should have known that a reportable accident had occurred when he received a phone call from the longwall section informing him that conditions in the entry impeded passage, and (2) after his investigation at the site, he could have reported the accident to MSHA using the underground mine phone instead of waiting 20 to 25

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[6] When reviewing an administrative law judge's factual determinations, the Commission is bound by the terms of the Mine Act to apply the substantial evidence test. 30 U.S.C. § 823(d)(2)(A)(ii)(I). "Substantial evidence" means "'such relevant evidence as a reasonable mind might accept as adequate to support [the judge's] conclusion.'" *Rochester & Pittsburgh Coal Co.*, 11 FMSHRC 2159, 2163 (Nov. 1989) (quoting *Consolidated Edison Co. v. NLRB*, 305 U.S. 197, 229 (1938)).

[7] An "accident" is defined as including "[a]n unplanned roof fall at or above the anchorage zone in active workings . . . or an unplanned roof or rib fall in active workings that impairs ventilation or impedes passage." 30 C.F.R. § 50.2(h)(8).

minutes to call from the surface. *Id.* Thus, *Consol* stands for the proposition that although an operator should be afforded a reasonable opportunity to investigate, once it is determined that a reportable accident has occurred, an operator must act immediately to report the incident.

Thus, the judge's reduction of the degree of negligence based on a finding that Wolf Run's duty to report the accident began at 7:23 a.m. rather than 6:36 a.m. was error.

2. The judge erred by considering Wolf Run's intentional delay in reporting the accident to MSHA and mine rescue teams as a mitigating factor.

Further evidence of high negligence is Wolf Run's apparently intentional delay in contacting MSHA and mine rescue teams. The judge erred in treating Wolf Run's intentional delay in contacting authorities as a mitigating circumstance, stating that "Wolf Run's delay was not motivated by a desire or reluctance to avoid notification. Rather, the delay is attributable to the fact that Wolf Run was conflicted over its concern for evacuating survivors, its preoccupation with establishing contact with the missing victims, and its responsibility to notify MSHA." 32 FMSHRC at 1331.

Although the operator denies intentionally delaying contacting MSHA, the record strongly suggests that Wolf Run management was motivated not to contact MSHA immediately in order to avoid MSHA enforcement. Toler could have called MSHA and mine rescue teams as soon as he received the call from Jones verifying that an accident had occurred underground. Instead, he chose to go underground, and delayed efforts to contact MSHA and the mine rescue team. Toler testified that Stemple had mentioned the prospect of receiving a section 103(k) order, which would have prevented the operator from sending anyone back into the mine. Tr. 452. Gary Marsh, a supply motorman, also testified that Stemple told him that "once we notified MSHA, that they would shut us down." 32 FMSHRC at 1335; Tr. 142. We agree with the Secretary that an intentional delay in contacting MSHA in an effort to deliberately avoid MSHA enforcement action, for whatever reason, cannot be construed as mitigating its negligence, but is rather evidence of high negligence.[8]

The operator's intention to assist underground personnel during this emergency, while admirable, is exactly the type of conduct that the Mine Act and the Secretary's regulations are intended to address and avoid. The moments after a mining accident are difficult and frantic, but crucial to an effective response is strict adherence to an operator's emergency plan and to the relevant MSHA standards governing conduct after an accident occurs. We laud the miners' deep concerns for their colleagues trapped underground. However, emergency response plan procedures are crafted and put in place to counteract the intense pressures of this type of high-stress incident in the most rational, calmest, and safest manner for all involved. *See* 30 U.S.C. § 876 (granting MSHA oversight authority in the execution and enforcement of emergency response plans).

[8] The Commission has held that intentional misconduct supports a high negligence finding. *See, e.g., Consolidation Coal Co.,* 14 FMSHRC 956, 969-70 (June 1992).

Sending miners underground in the aftermath of an explosion puts additional miners at risk before a mine is secured and deemed safe to enter. *See Consolidation Coal Co.*, 14 FMSHRC at 970 ("no operator is free to take the law into its own hands by deciding for itself what the law means and how it can best be applied"); *IO Coal Co.*, 31 FMSHRC 1346, 1359 (Dec. 2009). This exact circumstance has resulted in dire consequences in other cases. *See, e.g.*, *Jim Walter Res., Inc.*, 28 FMSHRC 579, 583 (Aug. 2006) (13 miners perished in a secondary explosion when they attempted to rescue an injured miner unable to escape).[9] Congress has made a policy decision by requiring mine operators to contact MSHA *immediately* in the aftermath of an accident and granting MSHA the authority to direct rescue and recovery efforts. *See* 30 U.S.C. § 813(k) (granting MSHA broad authority to "issue such orders as [it] deems appropriate to insure the safety of any person in the . . . mine" in the event of an accident). The deliberate contravention of this requirement is not a mitigating factor.

3. The judge erred in concluding that the fact that the accident occurred on a Federal holiday was a mitigating factor.

The judge also concluded that the operator's negligence in delaying any actions to contact MSHA was mitigated by the fact that the event occurred on a Federal holiday, making it difficult to contact members of Wolf Run's upper level management and MSHA's employees. 32 FMSHRC at 1331. We disagree.

The fact that the date of the accident was a national holiday is irrelevant to a negligence determination.[10] The correct analysis is based on a review of the operator's actions in *attempting* to contact MSHA. The judge incorrectly focused on why the operator did not succeed. It was incumbent on the operator to ensure that efforts were made to notify MSHA and mine rescue teams *immediately*, especially if circumstances, such as a holiday, might make it difficult to reach individuals.

4. The manner in which Wolf Run tried to contact authorities was highly negligent.

Even when it finally did make the attempt to contact the authorities, Wolf Run's management relied solely on one off-site management official (Stemple), who had very limited knowledge of the accident and limited resources and information available to him at his home. While Stemple testified that he made diligent, yet unsuccessful, attempts to contact numerous

[9] We note that after the explosion in this case the initial management party entered the mine while the AMS system was not functioning and without the aid of personal gas detectors. 32 FMSHRC at 1322; Jt. Stip. 102.

[10] An emergency plan should be self-executing in order to avoid the pitfalls that may arise, such as difficulties in contacting upper management and authorities should an emergency event occur after business hours or during the weekend or on a holiday, when individuals may be difficult to contact.

MSHA officials and mine rescue team members, he was not in the best position to take on that responsibility, as he was not at the mine site and did not have the contact information necessary. *Id.* at 1323-25. Wolf Run could have had multiple individuals attempt to contact required personnel and authorities. Furthermore, it was highly negligent for Wolf Run not to have clearer lines of communication established during such an emergency. With 13 miners unaccounted for, the delay caused by the absence of an effective contact plan was serious and highly negligent.

In sum, the record compels the conclusion that the operator's delay in contacting MSHA and the mine rescue team amounted to a high degree of negligence. *See American Mine Servs., Inc.*, 15 FMSHRC 1830, 1834 (Sept. 1993) (remand not necessary when record supports no other conclusion).

B. The Judge Erred in Concluding that Order No. 7100920 Was Not the Result of an Unwarrantable Failure to Comply.

For the same reasons, we conclude that the evidence compels the conclusion that the operator's conduct amounted to an unwarrantable failure to comply with the mine's emergency evacuation and firefighting program as required by section 75.1502(a). *See Midwest Material Co.*, 19 FMSHRC 30, 36-37 (Jan. 1997). The mine's plan required it to notify *immediately* the local mine rescue team in the event of a fire or explosion at the mine. G. Ex. 6 at 12; G. Ex. 2.

The Commission has determined that unwarrantable failure is aggravated conduct constituting more than ordinary negligence. *Emery Mining Corp.*, 9 FMSHRC 1997, 2001 (Dec. 1987). 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).

Whether conduct is "aggravated" in the context of unwarrantable failure is determined by looking at all the facts and circumstances of each case to see if any aggravating factors exist. These factors often include (1) the extent of the violative condition, (2) the length of time that the violative condition existed, (3) whether the violation posed a high degree of danger, (4) whether the violation was obvious, (5) the operator's knowledge of the existence of the violation, (6) the operator's efforts in abating the violative condition, and (7) whether the operator had been placed on notice that greater efforts were necessary for compliance. *See IO Coal*, 31 FMSHRC at 1351-57; *Cyprus Emerald Res. Corp*., 20 FMSHRC 790, 813 (Aug. 1998), *rev'd on other grounds*, 195 F.3d 42 (D.C. Cir. 1999). These seven factors are viewed in the context of the factual circumstances of a particular case, and as in the present case, some factors may be irrelevant to a particular factual scenario. *Consolidation Coal Co.*, 22 FMSHRC 340, 353 (Mar. 2000).[11]

[11] Because of the nature of the violation in this case – a failure to immediately contact the mine rescue team – we do not think that certain factors are relevant to the consideration of whether the violation resulted from the operator's unwarrantable failure to comply and do not address them. Specifically, three of the seven factors are not relevant: the extent of the violation, the

Nevertheless, all of the relevant facts and circumstances of each case must be examined to determine if an operator's conduct is aggravated, or whether mitigating circumstances exist. *Id.*; *IO Coal*, 31 FMSHRC at 1351.

In making his unwarrantable failure determination, the judge either failed to consider several of the relevant factors or misconstrued the evidence relevant to those factors. We address the four relevant factors in turn.

(1) Length of Time. Because the operator's duty to contact the mine rescue team began at 6:36 a.m. when Jones contacted mine management at the surface, instead of at 7:23 a.m. as the judge determined below, the operator's delay of approximately 90 minutes before contacting mine safety teams after mine management first knew or should have known of the accident was substantial and should have been considered by the judge as an aggravating factor. Because the judge erred in determining the time at which the operator was required to contact the mine rescue team, he also erred in failing to take into account the aggravated nature of the operator's delay in reporting the accident. The plan's requirement to contact the mine rescue team *immediately* clearly indicates that the duration of the violation was aggravated conduct for unwarrantable failure purposes.

(2) Knowledge and (3) Obviousness. The evidence establishes that Wolf Run knew about the violation and that it was obvious. Toler, a member of Wolf Run's management, knew about the incident shortly after it occurred at 6:26 a.m., 32 FMSHRC at 1327, and should have ensured that the mine rescue team was called immediately. As previously noted, the evidence indicates that Wolf Run intentionally delayed in contacting the mine rescue team, in favor of attempting its own rescue. *Id.* at 1335; Tr. 452. This clearly constitutes aggravating conduct in support of an unwarrantable failure determination. *See Jim Walter Res., Inc.*, 19 FMSHRC 1761, 1770 (Nov. 1997); *Rochester & Pittsburgh Coal Co.*, 13 FMSHRC at 194. The judge's consideration of this evidence as mitigating is clear error.

(4) Degree of Danger. Given the high degree of danger and the immense risk of injury and potential death posed to the miners, Wolf Run's failure to immediately contact the mine rescue team amounted to a serious lack of reasonable care. The judge even noted the high degree of danger involved in the operator's failure to immediately notify mine rescue after the accident in his analysis concluding that the violation was significant and substantial. 32 FMSHRC at 1333-34 (finding it "reasonably likely that the existing hazards posed by an underground mine emergency will be exacerbated by a delay in the arrival of rescue personnel . . . [and] also reasonably likely that this increased exposure to danger will result in serious or fatal

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operator's efforts in abating the violative condition, and whether the operator was placed on notice that greater compliance efforts were needed.

injuries of would be rescuers or the victims of an accident"). The Commission has relied upon the high degree of danger posed by a violation to support an unwarrantable failure finding. *See, e.g.*, *Midwest Material*, 19 FMSHRC at 34-35 (concluding that foreman's negligent conduct resulted in highly dangerous situation to miner supporting an unwarrantable failure finding).[12]

III.

Conclusion

For the foregoing reasons, we vacate and reverse the judge's decision reducing the negligence of both violations, removing the unwarrantable failure designation of Order No. 7100920, and modifying it from a section 104(d)(1) order to a section 104(a) citation. We uphold the citation and order in all respects and assess the penalties originally proposed by the Secretary of $1,500 for Citation No. 7100919 and $13,000 for Order No. 7100920.

/s/ Mary Lu Jordan
Mary Lu Jordan, Chairman

/s/ Patrick K. Nakamura
Patrick K. Nakamura, Commissioner

[12] The judge erred in applying the so-called *Nacco* defense when he concluded that the operator's negligence was mitigated because only management officials (rather than hourly miners) entered the mine immediately after the accident and were put at risk. 32 FMSHRC at 1335. In *Nacco Mining Co.*, 3 FMSHRC 848, 850 (Apr. 1981), the Commission held that when an operator has taken reasonable steps to avoid a particular type of accident and the erring supervisor unforeseeably exposes only himself to risk, the operator should not be penalized for the supervisor's negligence. As the judge himself acknowledged, 32 FMSHRC at 1335, in *Capitol Cement Corp.*, 21 FMSHRC 883, 893 (Aug. 1999), the Commission clarified that it would not extend the *Nacco* defense to violations that result from an operator's unwarrantable failure to comply. Nonetheless, the judge wrongly considered as a mitigating circumstance the fact that only mine management was exposed to danger by entering the mine in the aftermath of the accident prior to the mine rescue team being contacted. The judge also failed to consider that the delay in contacting mine rescue put hourly miners still underground after the explosion at risk.

Commissioner Young, dissenting:

I dissent from my colleagues because I believe substantial evidence supports the Administrative Law Judge's ultimate conclusions on the negligence and unwarrantable failure issues. While some of the judge's factual determinations are not entirely consistent with the evidence, application of the law to the facts of record nonetheless compels us to respect his decision, which is yet supported by substantial evidence.

While I would affirm the judge, I acknowledge that the gaps in the operator's pre-accident planning and preparation, and in its delegation of tasks and coordination in the aftermath of the tragedy, are deeply troubling. The majority correctly notes that pre-accident planning and preparation are essential to avoiding panic under the stress of a mine disaster. The absence of such planning in this case, and the fact that the disaster fell on a major holiday, contributed greatly to the confusion and poor coordination in the wake of the explosion.

Nonetheless, I would affirm the judge's conclusion that the operator's violation did not arise from an unwarrantable failure to obey the command of the law, due to mitigating factors. Because the issue of whether conduct rises to the level of unwarrantable failure necessarily involves a subjective inquiry into the actions and intentions of the operator's personnel, as well as the surrounding circumstances, to determine whether their conduct was reckless, indifferent, or aggravated, I believe that it was proper for the judge to account for the operator's intent here, which was not to avoid compliance, and to consider mitigating factors, such as the fact that it was a national holiday. The judge took into account all of the extraordinary facts and circumstances of this case in making his decision, heard the evidence, and evaluated the operator's culpability based on that evidence. He found that the operator's negligence was moderate, and therefore did not amount to an unwarrantable failure to comply with the cited standards. 32 FMSHRC at 1331, 1334-37. In general, the judge's decision is well-reasoned and thoughtful on issues that require an insight into human nature under extraordinary stress.

The exigencies of that stress may explain, but do not excuse, the operator's conduct. As we are required to respect the judge's other factual findings, I concede that the evidence supports his conclusion that the operator knew, at 6:36 a.m., that there had been an explosion in the mine. However, due to the poor coordination and confusion in the ensuing moments after the incident, there was never a clear line of responsibility or a sharing of knowledge, and hence direct delegation and assignment of responsibilities based on that knowledge.

Thus, it is beyond question that the operator did not report the accident to MSHA without delay upon being presented with facts that provided *constructive* knowledge of the accident. However, the operator's management personnel did not receive all of the available information and process it as part of an integrated plan. While the lack of clear and effective communication is not itself a mitigating circumstance, it is a fact that affected the ability of the operator to act as promptly as it should have in notifying authorities after the explosion. The issue, then, is the operator's culpability for its failures, and whether they constitute aggravated conduct as a matter of law.

In considering this, I am mindful that it was reasonably likely that failing to notify MSHA immediately and permitting management personnel to enter the mine placed those miners in

danger in the aftermath of events in an unknown, and probably unstable, mine environment. As a purely legal matter affecting the significant and substantial nature of the violation, the fact that these were management personnel subjecting themselves knowingly to the risk, as opposed to rank-and-file miners, matters not at all.[1] Their motivations in subjecting themselves to peril, however, carry much greater significance in determining whether their conduct was "aggravated."

Even the Solicitor's counsel, in arguing this case before us, acknowledged that the operator's actions were simply the result of basic human nature taking over. When asked how conduct she herself had characterized as "commendable" could be simultaneously condemned as unwarrantable, she replied:

> It's commendable from a human perspective because it's understandable that they want to help. I'm sure everybody in this room would want to help if somebody is hurt. . . . [I]t's the human aspect that we're all thinking about, but it's not a reasonable person standard. A reasonable person would know that there are dangers in this mine and they shouldn't go into this mine without the expertise that MSHA brings.

Oral Arg. Tr. 52-53.

The Solicitor is undoubtedly correct that the law holds mine management accountable for failure to do what a reasonable person would have done in this context. But the absence of reasonable care is garden-variety negligence. Unwarrantable failure requires more than that. It requires aggravated conduct approaching a reckless disregard for the law. Here, reason was shunted aside by the basic commands of human nature. The operator's personnel ignored their responsibility to call MSHA immediately, but only because they were commanded by a more fundamental instinct – one universally recognized, and in other contexts, applauded[2] – to go to the aid of their fellow miners.

Accordingly, the judge did not absolve the operator for its failure to notify MSHA immediately. He found that Wolf Run's conduct violated sections 50.10 and 75.1502(a), the accident reporting requirements, and affirmed the S&S designation for the emergency plan violation. However, he also held that the surrounding circumstances mitigated the high level of

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[1] The majority's refutation of the *Nacco* defense is somewhat circular, in that it uses the exception to the defense (the operator's unwarrantable failure) to support a showing that the exception should apply in the first place. However, while the Judge discusses *Nacco*, he does not use it to excuse management's conduct here, and any imputation to the contrary would be harmless error, given the record support for his finding of moderate negligence and the lack of evidence to support an unwarrantable failure determination. 32 FMSHRC at 1335.

[2] *See* Medal of Honor Citation, Sgt. Gary B. Beikirch, U.S. Army, (April 1, 1970) (Sgt. Beikirch, "with complete disregard for his personal safety, moved unhesitatingly through the withering enemy fire to his fallen comrades"). *Medal of Honor Recipients, Vietnam War*, www.history.army.mil/html/moh/vietnam-a-l.html#BEIKIRCH (last visited Dec. 23, 2013).

negligence charged by the Secretary and concluded that Wolf Run exhibited moderate negligence in its failure to timely report the accident to MSHA and mine rescue teams. 32 FMSHRC at 1331.

He therefore concluded that the operator's conduct in violation of section 75.1502(a) did not amount to an unwarrantable failure. *Id.* at 1334-37. Substantial evidence supports the judge's conclusion. While the mine management personnel on the scene were almost certainly guided by emotion more than reason in some of their actions, they did not display an absence of care – except, perhaps, for their own safety – and appeared to be motivated by a desire to locate and help evacuate miners.[3] The judge was entitled to consider this motivation as a factor in mitigation, and he did so.

In fact, the record in this case is replete with examples of safety consciousness, even in this terrible setting. Owen Jones, for example, began immediate withdrawal of his 1st Left crew upon experiencing the accident. Tr. 84; Jt. Stips. 69-71, 74, 105. He contacted mine management on the surface as soon as he was able to get his crew to safety in the primary escapeway, and reported to dispatcher William Chisolm and Mine Superintendent Jeffrey Toler the circumstances underground. 32 FMSHRC at 1321; Jt. Stips. 74, 92; Tr. 84-85, 87-88.

Mine management also did not travel underground with full knowledge of the nature or extent of the explosion. Toler, who entered the mine after the incident with two other fellow miners, Safety Director Al Schoonover and Maintenance Superintendent Denver Wilfong, testified that they did not know of the explosion upon entering the mine. All he knew is that the AMS had alarmed and then shut down. 32 FMSHRC at 1321; Tr. 447-50; Jt. Stips. 78-82. Before entering the mine, Denver Wilfong checked the mine fan pressure recording gauge and did not notice anything unusual. Jt. Stips. 99.

Furthermore, there was no reckless procession into the mine. While Toler and the other miners who entered the mine after the incident should have been aware that their decision would expose them to significant and unknown danger, their response otherwise showed safety consciousness, given the circumstances. For example, Toler instructed Wilfong to take the 1st Left crew outside, while he, Schoonover and Jones remained underground. 32 FMSHRC at 1322; Jt. Stip. 121. Because Jones had lost his hard hat during the explosion, upon meeting him at crosscut 25, Toler instructed him to stay at the phone while he and Schoonover traveled inby to assess the damage. 32 FMSHRC at 1322; Jt. Stip. 124.

Only after meeting Jones and the 1st Left crew did Toler learn of the conditions, and at that point determined that a reportable accident had occurred. This was reported immediately to Safety Director John Stemple, who was on the phone with Toler between 7:15 and 7:23 a.m. 32 FMSHRC at 1322; Tr. 453-54. At Toler's direction, Stemple proceeded to make the round of

[3] I am of course aware of the high degree of danger that miners may confront in such an environment. *See Jim Walter Res., Inc.*, 28 FMSHRC 579 (Aug. 2006) (thirteen miners killed or fatally injured in an attempt to rescue miners after an explosion in September, 2001).

calls to inform upper level management and authorities. Jt. Stips. 113-116, 120.[4] At the same time, Stemple told Chisolm that he, Stemple, would make the necessary calls to outside parties while Chisolm continued efforts to reach the 2nd Left Crew. Tr. 526-27.

Additionally, Stemple continued to search for phone numbers of agency officials who lived in the local area, and at 7:46 a.m. was able to leave a message on the home answering machine of state inspector John Collins, informing him of the situation at the mine. 32 FMSHRC at 1324; Tr. 539-41; G. Ex. 7. At 7:50 a.m., he was able to leave a similar message on the home answering machine of MSHA Field Office Supervisor Ken Tenney. 32 FMSHRC at 1324; Tr. 538-39; G. Ex. 7. The Judge held that this was the first attempt to contact MSHA. 32 FMSHRC at 1330.

Stemple testified that he was on the phone or searching for phone numbers continuously for nearly an hour, trying to reach State and Federal officials – partially due to the difficulties in reaching authorities because Federal and State offices were closed due to the holiday – before he was able to speak personally with James Satterfield of MSHA at 8:28 a.m. Satterfield issued a verbal order under section 103(k) at 8:32 a.m. 32 FMSHRC at 1325; Tr. 542-46, 552. Stemple immediately called the mine to relay the 103(k) order and to request other phone numbers for mine rescue personnel. 32 FMSHRC at 1325; Tr. 546-48. He was able to reach Chris Height, Vice President of Barbour County Mine Rescue Association at 8:37 a.m. 32 FMSHRC at 1325.

While Stemple was trying to alert Federal and State regulators and upper-level mine management, Toler's party continued to try to locate the 2nd Left Crew. Importantly, they proceeded further into the mine only as far as conditions permitted, noting the damaged and blown stoppings at crosscut 32 and at about 42 or 43, and decided not to proceed further because they did not have detectors. Jt. Stips. 125-27.

Toler thus called outside and gave instructions for Wilfong and Hofer to bring necessary supplies into the mine to repair the stoppings, as well as detectors and a hard hat for Jones. Jt. Stip. 128. They did not proceed until they had received the requested supplies, at which point they began repairing damaged curtains in an effort to improve ventilation and facilitate their rescue

[4] Stemple testified that he made his first attempt to contact MSHA at 7:30 a.m., but was unable to reach anyone at the agency's Bridgeport Field Office. Tr. 536-37. Stemple said he then tried to call the WVOMHST Fairmont office, but was not able to reach anyone. Tr. 537. He did not leave a message at either office. Tr. 536-37. Because this was a major holiday, Stemple said he did not see the point in leaving a message that would not be retrieved until the next day. Tr. 539-40. He instead called the offices again at approximately 7:40 to retrieve other phone numbers from the recorded messages. Tr. 537-38. The judge found that the contemporaneous log of phone calls made by Stemple was the best evidence of the calls that were actually made, and thus held that Stemple did not attempt to contact MSHA until 7:50. 32 FMSHRC at 1330. While I am aware of the deference due to the judge's findings of fact, this period of time when Stemple claims he made the calls is virtually the only time not otherwise accounted for in his contemporaneous record. Furthermore, it seems wholly unreasonable that Stemple would have made the extraordinary effort to contact agency officials at home without first attempting to contact the field offices, for which he had numbers.

efforts. However, when they reached the 58 crosscut, conditions became too hazardous due to heavy smoke, and they withdrew from the mine. Jt. Stips. 142, 149-50.

The judge found that MSHA's local offices and mine rescue teams' offices were not open on the day of the accident because it was a national holiday, which added to the operator's delay in finally reporting the accident.[5] 32 FMSHRC at 1331. Concerning the operator's motivations, no bad faith was asserted on the part of the operator, nor did the judge find any evidence of bad faith. 32 FMSHRC at 1331, 1336. As the judge held, "the Secretary fails to distinguish between imprudent or ill-advised conduct, and aggravated or unjustified conduct. Wolf Run's delay was not motivated by a desire to avoid notifying MSHA of the accident. Nor was it an attempt to alter an accident scene. Rather, Wolf Run's delay was caused by its preoccupation with determining the condition of its miners who were underground at the time of the explosion." *Id.* at 1336.

The agency asserts before us, and the majority has held, that Wolf Run delayed notification to MSHA because it feared that a 103(k) order would require it to abandon the 2nd Left Crew. However, while Stemple did raise this issue with Toler, Toler told Stemple to make the calls anyway. The judge did find that the delay in making the calls was a violation, but properly held that it was driven not by a "reluctance to avoid notification," *id.* at 1331, but by concern for their fellow miners, particularly family members:

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

Id. at 1336. I find no basis for overturning this credibility determination made by the judge. *See Farmer v. Island Creek Coal Co.*, 14 FMSHRC 1537, 1541 (Sept. 1992) (stating that a judge's credibility determinations are entitled to great weight and may not be overturned lightly).

[5] The majority and MSHA would hold that the holiday does not mitigate the operator's failure. Slip op. at 8. The operator, however, was confronted with significant resource limitations that refute the majority's position. Furthermore, the difficulty of an expeditious response is evident in the fact that MSHA did not approve mine rescue to enter the mine until approximately 5:25 p.m., nearly 11 hours after the explosion. Jt. Stip. 175. I'm not going to second-guess the agency's response under the circumstances, but I am going to take issue with the majority's second-guessing of the operator's response, which anticipated significant impediments to prompt relief for the miners on the 2nd Left Crew.

Based on the foregoing, I conclude that the facts of record support the judge's decision. Substantial evidence supports the judge's finding of moderate negligence. Accordingly, based on the particular circumstances in this case, substantial evidence supports his finding that the operator's failure to immediately contact MSHA and mine rescue did not amount to an unwarrantable failure.

This is an extraordinary and difficult case, which was a primary driver in the first major overhaul of the Mine Act in nearly 30 years. Some of the specific failures and shortcomings exhibited here have been the impetus for changes in the law, and I question whether the majority and the Secretary view the events on that date in their proper context, before those changes were made. I believe the Judge evaluated the operator's actions correctly in that context, and I would therefore agree with him that there was no unwarrantable failure here.

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