Chapter 8

Mine Accident Reporting Obligations and MSHA Enforcement

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§ 8.01. Introduction.

The Federal Mine Safety and Health Act of 1977, or Mine Act, requires
mine operators to report accidents that occur at a mine site to the Secretary
of Labor’s Mine Safety and Health Administration (MSHA).1 Two widely
reported coal mine accidents in January 2006, and a third that May, spurred
new federal and state legislation and regulation touching on any number of
mine safety and health issues.2 Among the targeted areas of new legislation

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and regulation was accident reporting. And with new statutory and regulatory provisions, there has come a heightened, perhaps even strident, focus on enforcement. To keep abreast of mine safety and health regulation, operators must stay informed not only of what the law says, but of how MSHA interprets what the law says when it is applied in an enforcement context. The two—(i) the letter of the law, and (ii) how the letter is read by the enforcement agency—do not always match.

The first part of this chapter gives an overview of an operator’s federal accident reporting requirements; the second part analyzes a recent case concerning accident reporting to illustrate how the law expands not only through formal legislative and regulatory processes, but also more stealthily through the enforcement process. The thesis of the second part of this chapter is that the natural tendency of executive power is to expand, and expand it will if left unchecked. Before concluding, this chapter also notes several other issues touching on accident reporting with which operators should be familiar.

Although a federal agency cannot, in principle, act in a manner that is not authorized by an act of Congress, statutes are vague by nature and thus frequently leave latitude to the agency to define the scope of its authority. Regulations, too—which implement statutory mandates—are frequently worded in such a way as to leave flexibility on how the language must be applied. This is not to say executive agencies act willfully—they may or may not. It is enough to note that, if left alone, the entropic forces of executive power causes it to expand.

In the world of the federal executive agencies, fortunately, some checks on expansive power do exist. The Administrative Procedure Act (APA), generally speaking, imposes certain constraints on the manner by which a federal agency may promulgate regulations.3 The principal protection provided the public in a rulemaking setting is the right to be notified of a proposed rule and to comment on it before the rule can be issued in final

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3 See, e.g., 5 U.S.C. § 553.
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form. In the federal mine safety and health world, the Mine Act incorporates the central rulemaking process of the APA and imposes several additional administrative protections. But even with these statutory constraints, agencies still have a tremendous amount of discretion to carry out their day-to-day functions, and with discretion comes — typically — the desire to do more pursuant to the thinking the agency knows best.

The last few years have created the perfect storm out of which MSHA has assumed greater regulatory authority, some of it by statutory authority, but other parts by enforcement finesse, or regulatory creep — the act of expanding its powers not by express authority, but by virtue of the fact that it is in the pivotal position to do so (or at least try as long as it can get away with it) as the federal agency charged with safeguarding the nation’s miners. Accident reporting is an area where MSHA apparently believes that it needs to assert greater control, to do more, to get tougher, and that it knows best how to make the industry safer. Operators need to be armed with an understanding of what is required of them under various circumstances so they are ready to push back when the agency goes too far.

§ 8.02. Regulatory Background.

[1] — The Definition of “Accident.”

The Mine Act defines “accident” as “a mine explosion mine ignition, mine fire, or mine inundation, or injury to, or death of, any person.” MSHA defines the term more broadly to include a number of mining-related events.

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4 See id.; see also id. § 553(b).
5 See Mine Act § 101(a)(2006), 30 U.S.C. § 811(a). For example, whereas the APA requires an agency to propose the “terms or substance” of a proposed rule in the Federal Register and to entertain comments “with or without opportunity for oral presentation,” the Mine Act requires MSHA to publish the text of proposed rules “in their entirety,” and provides “any interested person” the right to a public hearing to voice objections. Compare 5 U.S.C. § 553(b), (c) with 30 U.S.C. § 811(a)(2), (3).
6 See, e.g., Michigan v. EPA, 268 F.3d 1075, 1084 (D.C. Cir. 2001)(striking agency action not supported by statute and stating that the agency does not have “a roving commission to achieve [any] other laudable goal”).
7 Mine Act § 3(k), 30 U.S.C. § 802(k).
8 See 30 C.F.R. § 50.2(h)(2006). “Accident” is defined as: (1) A death of an individual at a mine; (2) An injury to an individual at a mine which has a reasonable potential to cause
Some of those events are cut and dry, e.g., the death of an individual at a mine.\(^9\) Others are seemingly left open to discretionary judgment calls, e.g., an injury or entrapment of an individual which has a reasonable potential to cause death.\(^{10}\)


All accidents, regardless of type, must be reported to MSHA within 15 minutes “once the operator knows or should know that an accident has occurred.”\(^{11}\) There has not always been a 15-minute rule. Prior to March 2006, the statutory reporting requirement of an operator for any accident was simply to report it to MSHA and prevent the destruction of potentially relevant evidence.\(^{12}\) MSHA, in turn, required that the operator contact MSHA “immediately.”\(^{13}\) In the aftermath of the Sago and Aracoma mine accidents in January 2006, MSHA tightened the reporting requirement by imposing a definitive 15-minute reporting obligation as part of its Emergency Temporary Standard (ETS) for Emergency Mine Evacuations.\(^{14}\)

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9  Id. § 50.2(h)(1).
10  Id. § 50.2(h)(2), (3).
11  Id. § 50.10.
response to those mine accidents, Congress passed the Mine Improvement and New Emergency Response Act, or MINER Act, on June 15, 2006.\footnote{Emergency Temporary Standard, Pub. L. 109-236.} When it passed the MINER Act, Congress confirmed the definitive reporting requirement for accidents involving deaths and injuries or entrapments with a reasonable potential to cause death. In such cases, Congress required operators to report those types of accidents to MSHA within 15 minutes.\footnote{Mine Act § 103(j), 30 U.S.C. § 813(j), as amended.} As MSHA characterized it, the new emphasis on immediacy — \textit{i.e.}, reducing the requirement to a fixed period of time — was driven by the fact that MSHA was not notified of the Sago accident until about two hours after it occurred.\footnote{See Emergency Temporary Standard, 71 Fed. Reg. at 12,256.} And according to MSHA, “[f]ifteen minutes . . . is a concept that is easily remembered even in times of stress.”\footnote{Id. at 12,260.}

MSHA took the heightened concern for immediate accident reporting a step farther than Congress ultimately did, though, amending the § 50.10 reporting standard to require all accidents to be reported “immediately” and “at once without delay” and “within 15 minutes” of when the operator “should know” that an accident has occurred. In doing so, MSHA expressed the view that the “failure to immediately notify the Agency of mine emergencies can cost lives by delaying rescue services.”\footnote{Id. at 12,257.} The 15-minute rule was carried over into the final Emergency Mine Evacuation rule promulgated in December 2006.\footnote{30 C.F.R. §50.10 (amended 2006).}

\textbf{[3] — Other Requirements.}

Beyond the immediate reporting requirement, an operator is obligated to follow up with MSHA by filing an accident, injury, and illness report, \textit{i.e.}, the MSHA Form 7000-1. This form must be completed or reviewed by the person responsible for mine safety and health and submitted to MSHA within ten working days of the accident.\footnote{See 30 C.F.R. § 50.20(a).} And each quarter, the operator
is required to report the total number of reportable injuries or illnesses for that quarter, though not all reportable accidents.\footnote{See id. § 50.30-1(h)(2004).}

In addition to its reporting requirements, an operator is also obligated to conduct its own investigation of each accident and complete a report explaining the accident.\footnote{See id. § 50.11(b)(2004).} The Form 7000-1 required by § 50.20(a) cannot generally be substituted for the operator’s report,\footnote{The Form 7000-1 may be substituted at mines employing fewer than 20 miners. See id.} and while the report need not be submitted to MSHA, it must be retained for at least five years and available for MSHA inspection.\footnote{See id. § 50.40(a), 50.41 (MSHA can request to inspect and copy information related to the accident).}

The accident site must also be preserved\footnote{See id. § 50.12.} and, of course, the potential always exists for MSHA to conduct its own accident investigation. The MSHA district manager is supposed to decide promptly after notification of the accident whether to conduct an accident investigation, and promptly communicate his decision to the operator.\footnote{See id. § 50.11(a).}

\section*{[4] — The Penalty for Failing to Report.}

In the MINER Act, Congress established a mandatory minimum penalty of $5,000 for an operator’s failure to timely notify MSHA of an accident within 15 minutes, and a maximum penalty of $60,000.\footnote{Mine Act § 110(a)(2)(2006), 30 U.S.C. § 820(a)(2)(1990), (as amended 2006). When it enacted the MINER Act, Congress also created a new violation category — “flagrant” — for which it authorized a penalty of up to $220,000 per violation. \textit{Id.} § 110(b), 30 U.S.C. § 820(b), as amended. It is an open question whether MSHA could penalize a failure-to-report violation as a flagrant violation in light of the express penalty range that Congress deemed appropriate for such violations.} However, the MINER Act’s 15-minute reporting requirement only relates to deaths and injuries or entrapments with a reasonable potential to cause death.\footnote{\textit{Id.} § 103(j), 30 U.S.C. § 813(j)(1979)(amended 2006).}
Consistent with this, MSHA’s revised Part 50 penalty regulations limit the imposition of the mandatory penalties for failure to timely report to the same types of accidents on which the MINER Act imposes the 15-minute reporting requirement. In other words, even though MSHA extended the 15-minute reporting requirement to all accidents, it did not extend the mandatory penalty scheme beyond what the MINER Act already did.

Thus, the penalty for failing to timely report any other type of accident remains subject to the six-factor penalty assessment process, albeit as revised by MSHA’s 2007 regulatory amendments, or the notorious “special assessment” process if, in MSHA’s opinion, the “conditions warrant” it. Of course, if the violation is deemed the result of an “unwarrantable failure to comply” with a mandatory standard, and thus cited under Mine Act § 104(d), there is a mandatory minimum $2,000 penalty if cited under § 104(d)(1), and a $4,000 minimum if the violation is cited in an order issued under § 104(d)(2).

\(^{30}\) See 30 C.F.R. § 100.5(e)(2008).

\(^{31}\) See Mine Act § 110(i), 30 U.S.C. § 820(i); 30 C.F.R. Part 100 (2008).

\(^{32}\) 30 C.F.R. § 100.5(a).

\(^{33}\) See id. § 100.4(a), (b). Consider, though, whether a failure-to-report violation can indeed be a violation of a “mandatory standard,” and thus whether it can be cited under Mine Act § 104(d). A “mandatory health or safety standard” means the mandatory temporary health or safety standards set out in Titles II and III of the Mine Act (30 U.S.C. §§ 201-206 and §§ 301-318), or a standard promulgated pursuant to Mine Act § 101, 30 U.S.C. § 811.

\(^{34}\) See Mine Act § 3(l), 30 U.S.C. § 802(l). The Part 50 accident-reporting standards were originally promulgated under Mine Act § 508 to implement Mine Act § 103(j), which is found in Title I. See 42 Fed. Reg. 65,535 (Dec. 30, 1977). Mine Act § 508 authorizes the promulgation of regulations “appropriate to carry out any provision of [the Mine Act],” 30 U.S.C. § 957. In other words, the Part 50 standards, as originally promulgated anyway, were more or less housekeeping provisions, inasmuch they were promulgated under § 508, and not the more stringent § 101 (which, unlike Mine Act § 508, requires much more process, including notice and comment). And because only regulations promulgated under § 101 are “mandatory,” a violation of a Part 50 standard could not give rise to a citation or order under Mine Act § 104(d). See, e.g., Cyprus Emerald Resources Corp. v. FMSHRC, 195 F.3d 42 (D.C. Cir. 1999). In December 2006, however, MSHA revised its accident-reporting regulation and two of the twelve definitions of “accident.” See 71 Fed. Reg. 71,430, 71,452 (Dec. 8, 2006)(revising definitions at 30 C.F.R. § 50.2(h)(3) and (6) and reporting standard at § 50.10). Whether the failure to timely report some or all accidents can give rise to liability under § 104(d) is, therefore, also an open question.
[5] — When Do You Start Counting?

Not all accidents are created equal. Some are obvious: death or grievous injury.\(^{34}\) Others, not so much, and turn on judgment calls. For example, who determines whether a bounce or rock burst has disrupted “regular mining activity” for more than an hour?\(^{35}\) What if it is not obvious whether, with an injury or entrapment, there is a “reasonable potential to cause death”?\(^{36}\) What if it is not obvious that damage to hoisting equipment at the slope endangers an individual?\(^{37}\) The 15-minute reporting clock runs from the time an operator “knows or should know” that an accident has occurred.\(^{38}\)

Has the new “15-minute clock” materially affected reporting patterns? It is difficult to say. In *Consolidation Coal Co.*,\(^{39}\) the Commission held that the meaning of the term “immediately” had to be determined on a case-by-case basis, and that the safety supervisor’s report of an accident within 20 minutes of the completion of his accident investigation violated (former) § 50.10. According to the Commission, the supervisor could have acted more immediately had he called MSHA from underground “rather than waiting 20 to 25 minutes to make the call from the surface.”\(^{40}\)

Compare that case to the more recent *Premier Chemicals, LLC*,\(^{41}\) in which Judge Manning vacated a § 50.10 violation which implicated the new 15-minute reporting requirement. There, a mechanic collapsed around 6:35 a.m. First aid was administered, and the mine safety coordinator was notified around 6:45, and she in turn arrived on the scene around 7:05, by which point the collapsed miner was deemed dead.\(^{42}\) After conducting about

\(^{34}\) See 30 C.F.R. § 50.2(h)(1), (2).
\(^{35}\) See id. § 50.2(h)(9).
\(^{37}\) See id. § 50.2(h)(11).
\(^{38}\) See id. § 50.10.
\(^{40}\) Id. at 1938.
\(^{42}\) See id. at 687.
a 20-minute investigation, the safety coordinator returned to the main office and notified MSHA of the death by telephone.\textsuperscript{43} MSHA took the position that \textit{Premier} was in violation of § 50.10 when the safety coordinator failed to call MSHA by 7:20 — 15 minutes after concluding the miner had died.\textsuperscript{44} Citing the March 2006 Emergency Temporary Standard (ETS) preamble, Judge Manning observed that an operator must be given a “reasonable opportunity to investigate” the incident before it notifies MSHA that an accident has occurred.\textsuperscript{45} Finding that the safety coordinator immediately set about investigating the miner’s collapse, and then called MSHA promptly after returning to the main mine office — necessitated by the fact that the facility was in a remote location and only the main office had a reliable land line — Judge Manning held that there was no violation.\textsuperscript{46}

\textit{Consolidation Coal} thus shows that the old requirement to report accidents “immediately” had teeth, while \textit{Premier} shows that the new hard deadline of 15 minutes will be scrutinized by administrative law judges to make certain that MSHA has given operators a reasonable period to investigate accident situations in light of the vagaries of a given incident.\textsuperscript{47}

\section*{\textsection 8.03. Making the Rule by \textit{Ad Hoc} Enforcement.}

This section looks at one recent case illustrating how executive agencies seek to expand their power outside of formal processes. \textit{Webster County Coal, LLC}\textsuperscript{48} stemmed from an informal MSHA district policy, at least as understood by the inspector of the subject mine, that all unplanned roof falls, regardless of location underground (\textit{i.e.}, whether or not in “active workings” as that term was historically understood), had to be reported to MSHA as

\begin{itemize}
\item \textsuperscript{43} See \textit{id}.
\item \textsuperscript{44} See \textit{id.} at 688.
\item \textsuperscript{45} See \textit{id.} at 691.
\item \textsuperscript{46} See \textit{id.} at 691-92.
\item \textsuperscript{47} It is interesting to observe, though, that Judge Manning opined in \textit{Premier} that there was “little question” that the facts of that case would not have resulted in a citation prior to the 2006 implementation of the 15-minute reporting rule. See \textit{id.} at 690. That is at least one judge’s tacit opinion that MSHA is taking a tougher approach.
\item \textsuperscript{48} Webster County Coal, LLC, 30 F.M.S.H.R.C. 457 (May 2008)(ALJ).
\end{itemize}
“accidents.” This interpretation of what the accident-reporting standard required in turn led MSHA to perceive a higher-than-usual number of roof falls in the district, which further prompted MSHA to require operators to modify their roof control plans to address the supposed greater falls.

The trouble with MSHA’s policy was that the law did not require it. MSHA — based on its own belief that it knew what was best for the safety of the miners — apparently thought it could essentially re-write the key regulatory provisions without formally doing so (through notice-and-comment rulemaking). Fortunately, in this case, the historical understanding of what the law requires prevailed.

Before discussing the facts of the case in particular, though, a review of related case decisions is useful to give some historical perspective to the issue.

[1] — Prior Interpretations of “Active Workings.”

An unplanned roof fall constitutes an accident if it occurs “at or above the anchorage zone in active workings where roof bolts are in use” or “in active workings” and “impairs ventilation or impedes passage.”\(^{49}\) The term “active workings,” in turn, is defined as “[a]ny place in a coal mine where miners are normally required to work or travel.”\(^{50}\) The Federal Mine Safety and Health Review Commission (Commission) has interpreted this provision in a practical manner: an area constitutes active workings if it is a place where the work of actual mining is performed, and also if miners are required to travel to the area to perform inspections, examinations or maintenance.\(^{51}\)

The corollary to the recognized meaning of “active workings” is that if miners are not required to work or travel an area of a mine in the normal course of mining operations, that area is not part of the active workings. This is consistent with the plain language of § 50.2(h)(8), which defines

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\(^{49}\) 30 C.F.R. § 50.2(h)(8).

\(^{50}\) Id. § 75.2(g)(4). See also Mine Act § 318(g)(4), 30 U.S.C. § 878(g)(4).

\(^{51}\) See Southern Ohio Coal Co., 12 F.M.S.H.R.C. 1498, 1501 (Aug. 1990)(tailgate entry maintained as escapeway and examined weekly was active workings).
“accident” to include only those unplanned roof falls that occur in the “active workings.” While the Commission has not addressed this precise issue, decisions of several Administrative Law Judges (ALJ) make clear why § 50.2(h)(8) — and also § 50.20(a) where the reportable accident was an unreported roof fall — should be construed as strictly limited to roof falls that occur in the active workings.

In *Peabody Coal Co.*, the Secretary alleged a violation of § 50.10 based on a roof fall that occurred in an area adjacent to an intake escapeway that was required to be examined on a weekly basis and was thus an active working. The inspector based the violation on the fact that timbers were set around that roof fall area and on his opinion that an area constitutes active workings if work is *ever* done there or if anyone *ever* travels there. The ALJ rejected the Secretary’s expansive interpretation of “active workings” and stated that “[b]y modifying the requirement for work or travel with the adverb ‘normally,’ the Secretary in promulgating the regulation signaled that ‘active workings’ are those places where miners are required constantly or periodically or with a certain degree of frequency to work or travel.” The ALJ then found that the timbering around the roof fall was a one-time activity, that the area where the coal was mined was “some distance” from the entry where the roof fall occurred, and that no miners examined or traveled to the roof fall area on a regular basis.

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52 30 C.F.R. § 50.2(h)(8). *See* Utah Power & Light Co., 11 F.M.S.H.R.C. 1926, 1930 (Oct. 1989)(where regulatory provision is clear, its terms must be enforced as written unless agency clearly intended the words to have a different meaning or unless such a meaning would lead to absurd results).

53 The likely reason this issue has not reached the Commission is because MSHA (and the Solicitor) had historically recognized what is so obvious on the face of its own Part 50 reporting standards: a roof fall that does not occur in the “active workings” is not a reportable “accident.” *See* Auer v. Robbins, 519 U.S. 452, 461 (1997)(agency interpretation not controlling where it is “plainly erroneous or inconsistent with the regulation”).


55 *Id.* at 1854-55.

56 *Id.* at 1855.

57 *Id.*

58 *Id.*
The ALJ also rejected the Secretary’s argument that the fall was located in an active working by virtue of its discovery by a foreman passing by the area of the fall. The ALJ found that there was no evidence that the foreman was in the entry where the fall was located; rather it was more likely that the foreman was in the entry adjacent to the fall location when he discovered it. Thus, even though the intake entry adjacent to the fall location was traveled at least once a week for examination and the roof fall could be clearly seen from this entry, the ALJ nonetheless found that because the roof fall was not located in the “active workings,” § 50.2(h)(8) did not apply.

Finally, the ALJ also rejected the Secretary’s claim that, because the area at issue could not be defined by any other regulatory or statutory term, i.e., “working face,” “working place,” “working section” or “abandoned area,” then it must fall within the definition of “active workings.” The ALJ concluded that regulatory definitions are provided for “those terms that are used in the mandatory safety standards and which require definition” and are not “an exhaustive classification of all areas of the mine.” The ALJ then reiterated that if the Secretary cannot show that the fall occurred where miners are normally required to work or travel, § 50.2(h)(8) does not apply.

In other cases involving the treatment of hazards in close proximity to areas where miners work or travel, similar conclusions have been reached. For example, in Cyprus Emerald, the Commission held that 30 C.F.R. § 75.202(a) — which requires that the “roof, face and ribs of areas where persons work or travel . . . be supported or otherwise controlled to protect persons from hazards. . . .” — was not violated when an area of bad roof had been dangered off and the only persons permitted in the area were miners installing additional support. The Commission found that, with the

59 Id. at 1856.
60 Id. n. 15.
61 Id. at 1856.
62 Id.
63 Id.
64 Cyprus Emerald, 12 F.M.S.H.R.C. 911, 917 (May 1990).
exception of the miners installing support, there was no evidence that any miners either did travel to that area or were required to work or travel in that area after it was dangered-off.  

Similarly, in *Canyon Fuel Co., LLC*, the Secretary alleged a violation of § 75.202(b) — which prohibits, with certain exceptions, work or travel under unsupported roof — because a longwall foreman traveled through a passageway adjacent to an area of unsupported roof caused by a roof fall in a working section of the mine. The Secretary alleged a violation based on the risk that the poor roof conditions would spread and “encompass an area of the mine larger than the original immediate area of the fall” thus creating a hazard to miners traveling in the adjacent passageway. While the ALJ recognized the potential hazard, he held that the mere possibility of the fall continuing into the supported passageway was “insufficient to carry the Secretary’s burden of proof establishing a violation of the plain wording of the cited section, which prohibits walking under an unsupported roof.”

Likewise, in *San Juan Coal Co.*, an ALJ found that the air quality requirements of § 75.321(a)(1) did not apply to an area adjacent to the longwall panel that had been “dangered off” after low concentrations of oxygen were discovered. The ALJ found that, because the area at issue was effectively dangered off, it was not an area where persons work or travel within the plain meaning of the regulation.

The ALJ refused the Secretary’s attempt to expand the reach of the regulation due to hazards that theoretically existed in areas adjacent to the dangered-off area, where miners did work or travel. Specifically, the ALJ found “unconvincing” the Secretary’s claim that a roof fall in the dangered-off area could force sub-standard air into the active workings and lead to an explosion. The Secretary explained that even if a roof fall did force bad air

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65 *Id.*
67 *Id.* at 1328.
68 *Id.*
69 *San Juan Coal Co.*, 26 F.M.S.H.R.C. 427 (May 2004)(ALJ).
70 *Id.* at 439.
71 *Id.* at 437-38.
72 *Id.* at 438.
out of the dangered-off area, the air would be quickly dissipated by ventilation air flowing in the working areas. The ALJ also rejected the Secretary’s argument that because miners had traveled through the area in the past before the area was dangered off, that rendered the area one where miners worked or traveled. Finally, the ALJ concluded that limiting the reach of § 75.321 to those areas where miners actually work or travel, in accordance with the standard’s plain meaning, was “consistent with both the design of the regulations and the objective of the Act,” whose purpose “is to protect miners, not to regulate air quality where persons are not exposed.”

As the cited cases illustrate, a standard governing a specified area or condition cannot be stretched to also reach other areas, even those in close proximity.


In Webster County Coal, LLC, MSHA cited the Dotiki Mine in Kentucky for failing to submit a Form 7000-1 under § 50.20(a) for a roof fall that the agency alleged had occurred in the active workings. Relying on the body of Commission and ALJ decisions discussed in Part § 8.03[1] of this chapter, the operator contested the citation because the roof fall occurred in a return air entry in a worked-out area of the mine that was no longer part of the active workings, and thus was not a reportable accident. This was

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73 Id.
74 Id. at 439.
75 Id. at 440 (quoting 61 Fed. Reg. 9764, 9776 (1996)).
76 Accord Jim Walter Resources, Inc., 18 F.M.S.H.R.C. 508, 515, 516 (April 1996)(finding prohibition of accumulations in areas outside the active workings based on collateral risk to those working in close proximity to be unsupported under regulatory language)(concurring opinion), aff’d 111 F.3d 913, 918 (D.C. Cir. 1997)(“If collections of trash outside active workings can be both permissible and hazardous, the fault lies . . . with the Secretary's combustible materials regulation, which forbids accumulations of combustible materials in active workings.”)(emphasis added).
77 Webster County Coal, 30 F.M.S.H.R.C. 457 (2008)(ALJ). The operator was not cited under § 50.10 for failing to report the roof fall in the first instance.
78 See 30 C.F.R. § 50.2(h)(8)(defining accident to include unplanned roof falls that occur in the active workings and impair ventilation or impede passage).
true for two reasons: (1) the roof-fall area of the worked-out return air entry was not required to be examined as part of the mine’s weekly examination of worked-out areas; and (2) the fall area had, in any event, already been dangered off prior to the fall, thus precluding miners from traveling to or working in that area even had they otherwise been scheduled to. Simply put, interpreting the Part 50 standards to require operators to report, and submit a Form 7000-1 for, roof falls occurring in areas where persons do not normally work or travel — which includes areas that are dangered off — is contrary to the plain meaning of § 50.2(h)(8).

On the first point, MSHA countered that worked-out areas were, by law, required to be examined weekly.\(^79\) MSHA did not show, however, that the area of the roof fall was itself subject to the examination requirement of § 75.364(a), and cited no authority — because none existed — that every square foot of every worked-out area had to be examined.\(^80\) On the second point, MSHA contended that if dangering off a fall area were enough to avoid liability, it would give all operators the incentive to danger off every roof fall to avoid their reporting obligations. MSHA ignored the fact that, in this case, the area was dangered off before the fall occurred. Essentially, MSHA ignored the predicate facts and took a “we know what is best” approach in an effort to convince the judge that the safety of the miners would be jeopardized if its view was not followed.

The ALJ ruled in favor of the operator on the second ground, finding that the facts were undisputed that the area had been dangered off and, as such, was not an area of the mine where miners were “normally required to work or travel.”\(^81\) In response to MSHA’s contention that such an outcome would encourage operators to danger off all roof falls in order to avoid reporting them as accidents, the ALJ noted that the dangering off at the Dotiki Mine had unquestionably occurred prior to the fall itself, so MSHA’s speculation about alternative motives was not persuasive.\(^82\)

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79 See 30 C.F.R. § 75.364(a).
80 The parties’ briefs filed with the administrative law judge are on file with the author, who was counsel to the operator in the case.
81 Webster Co. Coal, 30 F.M.S.H.R.C. at 457.
82 See id. at 458.
Indeed, despite MSHA’s litigating position that the fall area was part of the active workings, the inspector who issued the citation told a mine official that MSHA — at least in that district — had actually adopted an enforcement policy that all known roof falls occurring underground would have to be reported regardless of whether they were in the active workings.83 In other words, MSHA — through its litigation counsel — came up with its expanded notion of “active workings” only after the agency was unsuccessful pressuring the operator to report all unplanned falls regardless of their location underground. It was a 1-2 punch effort to increase its regulatory leverage over the operator.

The Webster County Coal case is thus a classic example of MSHA trying to accomplish through an ad hoc enforcement action (and an ensuing litigating position) what it should have to do, if its objective is meritorious, through notice-and-comment rulemaking, at the very least. After all, “active workings” and “accident” are defined terms. Operators rely on MSHA’s regulations to train their management and miners. To adopt a district policy that expands the meaning of “accident,” or “active workings,” or both, directly contradicts the legal obligation to promulgate new regulations only after notice-and-comment rulemaking has been conducted.84

So, what is an operator to do? Even if no “unwarrantable failure” or “significant and substantial” allegation is made, a no-frills § 104(a) citation still carries with it an obligation to abate. An operator can contest the citation before a Commission ALJ but, barring grounds justifying expedited review, the case is going to be stayed pending the assessment of the civil penalty.85

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83 See Webster County Coal, Contestant’s Motion for Summary Decision at 4.
84 Cf. Appalachian Power Co. v. Env’tl Prot. Agency, 208 F.3d 1015, 1020 (D.C. Cir. 2000)(pointing out tendency of agencies to make up rules informally to avoid judicial review of formal rulemaking). The Webster County Coal case is not unique. Shortly after that case was decided, MSHA cited Hopkins County Coal, LLC for the identical type of violation at the Elk Creek Mine in Kentucky. A contest of that citation is currently stayed pending assessment of the civil penalty. See KENT 2009-45-RM (case docketed Oct. 9, 2008).
85 See Markf’rk Coal Co., Inc., 29 F.M.S.H.R.C. 626 (2007)(establishing rule of staying all contest cases pending civil penalty case unless “sufficient reason” exists to proceed immediately).
As of this writing, the backlog of cases at the Commission is staggering, in excess of 12,000 and growing every day. The chance for a quick judicial resolution, therefore, is low — cases are languishing. Meanwhile, the operator will have its marching orders from MSHA or otherwise may risk future § 104(d) citations or orders. And a refusal to abate exposes the operator to $7,500 in daily penalties. Moving forward, to the extent an operator is required to make a judgment call on whether an “accident” has occurred, it risks further citations and/or orders if MSHA disagrees with its judgment. A natural tendency might therefore be to over-report and avoid a violation, but this then increases the accident rate, potentially for no good reason. There is also safety to consider: the very act that MSHA demands the operator perform to determine whether accidents are occurring (e.g., examine non-active-workings for all roof falls) might well be dangerous in itself. Indeed, the countervailing safety concerns are precisely why agency tinkering with the interpretation and application of its regulations should be subject to notice-and-comment rulemaking — revised agency thinking needs to be scrutinized, and differing viewpoints need to be considered before changes are made.


The Webster County Coal case illustrates an example of MSHA trying to “interpret” its way into a position from which it could justify an enforcement action that was not authorized on the face of the cited regulations. In this respect, it engaged in what might be called regulatory creep — the tendency of an enforcement agency to enlarge its powers outside the formal processes of legislation or notice-and-comment rulemaking. With legislation and

86 But see supra note 33.
87 See 30 C.F.R. § 100.5(c). There is no good reason for this to be so, however. Abatement should be self-executing under § 50.10, inasmuch as if MSHA learns of what it thinks was an unreptored accident, knowledge of that by itself should abate the violation. However, MSHA has in some cases at least required the operator to make a perfunctory call to MSHA to report the previously unreported alleged accident.
88 See also Part 8.03[4], infra (noting other downsides to the over-reporting of “accidents”).
rulemaking, operators at least have the opportunity to participate in the process — *e.g.*, by petitioning representatives about a bill or submitting comments to MSHA on a proposed rule — even if the final result is not to the liking. Regulatory creep affords no such process — it is the arrogation of authority by stealth, made known to an operator only during the process of enforcement. Prior notice does not exist because the position of the agency is not the product of a formal process on which the public was invited to comment.

Of course, inasmuch as the interpretation of a statute or regulation is frequently a subjective process, it is doubtful MSHA would itself acknowledge that it is prone to regulatory creep. Rather, in the typical case, MSHA would — and does — argue that it is doing no more than giving the words of a statute or regulation their natural reading with respect to the factual predicate at hand.

In this regard, MSHA has a powerful ally in the courts. Regulatory creep should be of no small concern to operators given traditional principles of judicial deference to agency decision-making. Deference arises both with respect to interpretations of the statute the agency is authorized to enforce and to an agency’s interpretations of its own regulations.

Under the well-known “*Chevron*” doctrine, courts engage in a two-step analysis. If the statute is plain on its face in what is required, then the analysis ends there and the court rules on the basis of what the statute says, irrespective of the agency’s interpretation. If the statute is ambiguous, then the court will defer to the agency’s interpretation of the statute as long as that interpretation is a reasonable one. By “reasonable,” the court does not ask whether the agency’s interpretation is the *best* interpretation or is the one that, out of several alternative interpretations, makes the most sense; it matters only that the interpretation is reasonably consistent with the statutory language, and thus a permissible reading of the statute. Where a statute is

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90 See *id.* at 842-43.
91 See *id.* at 843-44.
92 See *id.* at 844.
ambiguous, therefore, the deference given an agency’s interpretation under *Chevron* poses a very difficult hurdle for an operator to overcome.

It is even more difficult to undermine an agency’s interpretation of one of its own regulations. In *Auer v. Robbins*,93 the Supreme Court held that the Secretary of Labor was entitled to deference on the interpretation of an ambiguous regulation.94 On the surface, this rule seems to make sense — who better than the author of a regulation to explain its meaning. But therein lies the potential mischief: if one of the hallmarks of notice-and-comment rulemaking is to give the public the opportunity to comment on a proposed enforcement policy or standard and help direct the final wording of the regulation implementing such policy, the *sunshine* of that process can be clouded out if, upon application, the regulation is deemed “ambiguous” and given an interpretation that effectively undermines the understanding of the regulation extant at the time of its promulgation or as it had been applied on previous occasions.95

Importantly, for Mine Act enforcement purposes, *Chevron* and *Auer* deference is not just an interpretative device of the courts; the Commission, too, gives deference to MSHA.96 What this means is that anytime an enforcement action is premised on MSHA’s interpretation of the Mine Act or one of its regulations, unless an operator can demonstrate that the interpretation flies in the face of the wording of the statute or regulation in light of the facts of that case, MSHA’s interpretation is likely to prevail.

94 *Id.* See also *Thomas Jefferson Univ. v. Shalala*, 512 U.S. 504, 512 (1994).
95 See *Caruso v. Blockbuster-Sony Music Entertainment Centre at the Waterfront*, 193 F.3d 730, 737 (3d Cir. 1999)(“An agency is not allowed to change a legislative rule retroactively through the process of disingenuous interpretation of the rule to mean something other than its original meaning.”) (*quoting* 1 K.C. Davis and R.J. Pierce, Jr., “Administrative Law Treatise” § 6.10, at 283 (1994)).
96 Notwithstanding the Supreme Court’s recognition that the interpretation of the Mine Act is within the expertise of the Commission, see *Thunder Basin Coal Co. v. Reich*, 510 U.S. 200, 214 (1994), the courts of appeals have consistently held that where the Commission and MSHA split on their interpretations of the Mine Act or an MSHA regulation, MSHA’s interpretation is owed deference. *See, e.g.*, *Sec’y of Labor v. Twentymile Coal Co.*, 456 F.3d 151 (D.C. Cir. 2006); *Speed Mining, Inc. v. F.M.S.H.R.C.*, 528 F.3d 310 (4th Cir. 2008).
Webster County Coal demonstrates a successful effort to contain MSHA to the plain meaning of its regulation. MSHA did not prevail in Webster County Coal because its interpretation of its regulations, as applied to the facts as found by the ALJ, was inconsistent with the very language of those regulations. Unplanned roof falls are only reportable if they occur in the “active workings,” 97 and “active workings” means an area of the mine “where miners are scheduled to work or travel.” 98 Given the ALJ’s finding that, as a dangered-off area, miners could not have been scheduled to work or travel in the area of the roof fall, MSHA’s argument that the roof fall was reportable was not entitled to deference. Essentially, this was a “step one” case. 99

Be that as it may, operators should not rest easily in the face of this assault on the plain meaning of MSHA’s standards. Even under similar facts, a different ALJ might agree with MSHA’s more expansive view of “active workings,” perhaps agreeing that the entirety of a “worked out” area of which any part is subject to weekly inspections remains part of the active workings, or accepting MSHA’s stock canard that its interpretation is consistent with the “purpose” of the Mine Act and that a failure to adopt the agency’s point of view would undermine miner safety. Regulatory ambiguity — the scourge of regulated industries — is frequently in the eye of the beholder, and when the notion of ambiguity infects an adjudicator’s understanding of a legal dispute with the agency, the scales tip decidedly in favor of the agency.


The anxiety that comes with accident reporting stems from more than simple regulatory annoyance and the associated penalties. It is compounded by the fact that reported accident information is gathered by MSHA and is open for public inspection and is required to be publicized at least annually. 100 A higher rate of reported accidents could mean stepped up enforcement.

97 30 C.F.R. § 50.2(h)(8).
98 Id. § 75.2.
99 The concept of “deference” was not actually raised before the ALJ, but the analysis tracks a “step one” approach of determining that the governing language (here, the language of the regulations) is plain as applied to the facts and thus determinative of the outcome.
100 See Mine Act § 103(d), 30 U.S.C. § 813(d).
Indeed, it is one criteria considered by MSHA during its annual pattern-of-violation screening.\textsuperscript{101} And things can get particularly problematic when MSHA starts demanding additional concessions based on its view of what constitutes a reportable accident. The \textit{Webster County Coal} case is an example. There, on the apparent belief that some of the mines in its jurisdiction were experiencing higher-than-average unplanned roof falls, the agency adopted a program of taking closer scrutiny of the number of unplanned roof falls mines were having and requiring the mines to modify their roof control plans to account for them. This, even though many of the falls that were the subject of MSHA’s concern had occurred or were occurring outside of the active workings. MSHA sought to remedy that by simply adopting a more expansive notion of “active workings,” requiring litigation to rein the agency back in.\textsuperscript{102}

Reporting accidents where there is really no accident to report, thus resulting in a perceived higher accident rate, could also mean potentially bad, or at least heightened, publicity, especially if the mine experiences a news-worthy accident that triggers deeper probing into the operator’s accident history. And where a mine is part of a larger corporation, bad publicity over a perceived high accident rate could put mine management in jeopardy with corporate management or the board. The point to be made is that there are downsides to overreporting incidents as “accidents” and operators need to make the appropriate judgment calls.

\section*{§ 8.04. Other Issues.}

In \textit{Webster County Coal}, MSHA tried to enlarge its enforcement authority through an overly expansive (and impermissible) interpretation of the term “active workings” — it lost because, on the facts of that case, its

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\begin{enumerate}
\item \textsuperscript{101} See 30 C.F.R. § 104.2(b)(3). If MSHA determines that a mine has a pattern of violations of one or more mandatory standards, the potential exists (after notice and an opportunity to respond) for MSHA to close the mine until the agency determines the pattern no longer exists. See Mine Act § 104(e), 30 U.S.C. § 814(e).
\item \textsuperscript{102} See discussion supra regarding the \textit{Webster County Coal} case. Notes about the facts and background of the matter are on file with the author.
\end{enumerate}
\end{footnotesize}
position was inconsistent with that language. MSHA frequently prevails, though, typically because its interpretation is accorded deference. Other times, MSHA extends its reach in a manner that is consistent with the language of the statute or regulation, but arguably at odds with the subject provision’s purpose. Operators, therefore, should not assume that merely because something appears to be outside the scope of MSHA’s statutory mandate MSHA will not require strict adherence to the letter of the law.


On January 11, 2008, for example, MSHA issued a Program Information Bulletin (PIB) aimed at the reporting of deaths on mine property.103 The PIB “clarifie[d] the responsibility of mine operators and contractors to report all deaths that occur on mine property, including suicides, homicides, and deaths involving trespassers, customers, and visitors.” According to MSHA, it felt the PIB was necessary because of “numerous occasions” in which operators have not reported such deaths — the deaths of trespassers in particular — because operators believed they were not reportable.104 This belief was wrong, MSHA stated, and in violation of the Part 50 accident reporting requirements.

Looking only at the words of Part 50, it is difficult to argue with the Program Information Bulletin. The death of an individual at a mine is an accident.105 And all accidents are required to be reported in 15 minutes.106

On the other hand, the very basis for why MSHA thought it was necessary to issue the PIB demonstrates its shortcoming: the death or suicide of anyone at a mine site is not obviously the concern of MSHA. Arguably, the death should at least be mining-related before the obligation to notify MSHA is triggered. Moreover, even if one were to accept for the sake of argument that

103 See PIB No. P08-02, “Reporting Deaths on Mine Property” (Jan. 11, 2008).
104 See id. at 2.
105 See 30 C.F.R. § 50.2(h)(1); see also 30 U.S.C. § 802(k).
106 See 30 C.F.R. § 50.10.
MSHA has an interest in knowing of all deaths at mine sites if for no other reason than for statistical purposes — *i.e.*, that the occurrence of the death at a mine is sufficiently mining-related to trigger MSHA interest — requiring that the death of a trespasser be reported in *15 minutes* moves beyond the purpose of the 15-minute reporting requirement.

As noted above, the 15-minute reporting requirement was implemented in the wake of the January 2006 Sago Mine accident.\(^{107}\) In the March 2006 Emergency Temporary Standard, MSHA stated that “the lack of timely notification of an accident can play a lethal role resulting in grave consequences for miners caught underground in a mine emergency.”\(^ {108}\) It stated further that “MSHA is particularly concerned that failure to immediately notify the Agency of mine emergencies can cost lives by delaying rescue services.”\(^ {109}\) Three months later, in passing the MINER Act, Congress reiterated the concern for immediate reporting of mine emergencies by amending Mine Act 103(j) to require an operator to report a death or an injury or entrapment of an individual at a mine which has a reasonable potential to cause death.\(^ {110}\)

In the case of a trespasser who commits suicide on mine property, or a case of homicide, the purpose for which the 15-minute reporting requirement was implemented simply is not implicated — it was not the concern of MSHA when the agency promulgated the Emergency Temporary Standard in March 2006 or of Congress when it passed the MINER Act. The January 2008 Program Information Bulletin, however, insists that there is no qualitative difference between such deaths and that of a miner who dies in a mining-related accident.

This is not a purely academic concern. In January 2009, for example, the Mount Carmel Co-Generation facility in Pennsylvania was cited under § 50.10 for failing to report the death of an individual who was found in her

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108 *Id.*
109 *Id.* at 12,257.
private automobile parked on the facility’s premises. According to the police report, the decedent — a contract truck driver for a trucking company that did work for Mount Carmel — was found dead next to several empty bottles of over-the-counter medication. She was not working at the time she overdosed. The MSHA inspector found that Mount Carmel’s failure to report this event within 15 minutes of discovering the decedent’s body constituted “high negligence” and it was specially assessed a $5,000 penalty.

The 15-minute reporting provision was written with the Sago accident in mind and in order to address unjustified delays in notifying MSHA about the miners trapped underground. In the legislative record of the MINER Act, Senator Enzi stated with respect to the statutory 15-minute notification requirement of Mine Act § 103(j) that “in the case of serious life-threatening accidents notification must be made to Federal Mine Safety officials within 15 minutes.” The 15-minute reporting requirement serves little purpose in the case of suicides. Similarly, in the case of a homicide, immediate notification might sensibly be given to local or federal law enforcement authorities as a matter of common sense, but it is not at all apparent why MSHA should be promptly notified, or what that agency could do even if it were.


Whereas the January 2008 PIB is a reminder that all deaths must be reported, a case that remains pending at the time of the submission of this chapter illustrates MSHA’s willingness to expand its interpretation of “operator” in an effort to zealously enforce its accident reporting regulations. In Sec’y of Labor v. Nat’l Cement Co. of California, Inc., the principal

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111 See MSHA Penalty Case. No. 000179635; Citation No. 7000418; Mount Carmel Township Police Department Complaint Report on Complaint No. MCT2009-00003 (“Mt. Carmel Police Report”).
113 See Citation No. 7000418; MSHA Penalty Case No. 000179635.
114 152. Cong. Rec. S4619 (daily ed.).
115 Sec’y of Labor v. Nat’l Cement Co. of California, Inc., Case No. 08-1312 (D.C. Cir.) (oral argument heard May 12, 2009).
question is whether a 4.3-mile stretch of road leading from a state highway to a quarry and cement plant operated by the National Cement Company under lease with the Tejon Ranch, the property owner, is a “mine” within the meaning of Mine Act. The Mine Act includes within its definition of “coal or other mine” locations that constitute “private ways and roads appurtenant” to areas of land from which minerals are extracted.\textsuperscript{116} The question is complicated by the fact that numerous persons and entities other than National Cement, and having no business relationship with National Cement, used the road. Because of this, and because Tejon controls the road as a legal matter (as the owner), many concerns were raised by National Cement and Tejon over MSHA’s treatment of the road as a mine.

Among the concerns raised were National Cement’s apparent obligation to report all accidents occurring on the road, including those involving persons and entities that had no business relationship with the mining operation, and the assertion by MSHA that Tejon itself could be treated as a mine “operator” under the Mine Act, and thus be subject to all the strictures of the statute.\textsuperscript{117}

Indeed, in a decision handed down by a panel of the court in an earlier iteration of the case,\textsuperscript{118} the D.C. Circuit expressed concern with MSHA’s statement in its brief to the court that MSHA would hold Tejon liable as an operator in its own right, subject to all of the requirements imposed by the Mine Act, including accident reporting.\textsuperscript{119} Given these and other concerns about MSHA’s legal position, the court remanded the case for MSHA to further brief the justification for its treatment of the ranch road as a mine.\textsuperscript{120}

Before the Commission on remand, in an apparent attempt to side-step one of the concerns that the D.C. Circuit had had with its earlier interpretation,

\textsuperscript{117} See 30 U.S.C. § 801(d)(defining “operator” to include any person who “controls” a mine); see id. § 801(f)(defining “person” to include business organizations).
\textsuperscript{118} Case No. 06-1094 (D.C. Cir.).
\textsuperscript{119} Nat’l Cement, 494 F.3d 1066, 1076 (D.C. Cir. 2007).
\textsuperscript{120} Id. at 1077.
MSHA argued that it would not require National Cement to report any accident that was “not the result of road conditions over which National Cement has control.”\(^{121}\) This position, of course, could not be harmonized with the Mine Act’s requirement requiring the reporting of “any” accident.\(^{122}\) After the Commission ruled against MSHA on remand, MSHA petitioned for further review by the D.C. Circuit, and on the question of National Cement’s reporting requirement took a revised position that National Cement would indeed be obligated to report any and all accidents, regardless of by whom, and that such a requirement was justified because it was protective of miners and would not be “overly burdensome.”\(^{123}\)

As for the apparent “operator” status of Tejon, MSHA took the position that Tejon had made a “business decision” when it leased its land to National Cement for purposes of operating a mine, that Tejon benefited from that decision in the form of royalty payments on the sale of cement, and that the ranch road was a necessary conduit over which the cement product was required to be shipped, such that it was fair and consistent with the purposes of the Mine Act to treat Tejon as an operator.\(^{124}\) If true, then, the same accident-reporting obligations (and all other Mine Act obligations) that were carried by National Cement would be carried by Tejon.

It is not the point of this chapter to analyze the merits of MSHA’s position in the National Cement case.\(^{125}\) Rather, the case is raised here to flag another potential pitfall for the unwary operator or the unwary entity that does not even appreciate its Mine Act “operator” status. Many mines utilize access roads or other facilities that have multiple uses and users. It may not always be obvious that such a facility is a “mine” subject to MSHA jurisdiction.\(^{126}\)

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\(^{121}\) Case No. WEST 2004-182-RM, Brief to the Commission on Remand of the Sec’y of Labor at 30 (filed Nov. 13, 2007).


\(^{123}\) Case No. 08-1312, Brief of the Sec’y of Labor at 44 (filed Feb. 17, 2009).

\(^{124}\) See id. at 49.

\(^{125}\) A decision in the latest appeal is expected summer 2009.

\(^{126}\) In the case of the ranch road at issue in National Cement, the road was paved in the 1960s. See National Cement, 494 F.3d at 1069. MSHA issued a citation to National Cement for an alleged road-related violation in 1992, but vacated the citation based on an internal
And it is certainly not obvious to those who do not regularly deal with MSHA and the Mine Act regulatory scheme. The potential for Mine Act liability at such facilities extends beyond accident reporting, of course, but because the window for reporting a known accident is so narrow, it is important for business entities to understand their exposure as “operators” for Mine Act purposes, and for operators to understand ahead of time the potential for a facility that might not usually be thought of as a “mine” to be so regarded by MSHA if an accident occurs there.

§ 8.05. Conclusion.

Accident reporting serves a valuable function. But like any form of regulation, the agency’s enforcement of the current requirements must follow the letter of those requirements. When the agency strays from the letter of the law, administrative order suffers. This potentially exposes operators, unfairly, to confusion, increased penalties, stricter enforcement, and bad publicity. The review process remains the key check on agency overreaching, but success in litigation is never easy, and never assured.

determination that the road was not a mine. See id. at 1071. It did not indicate a contrary position until 2003, which gave rise to the current litigation. See id.