

**FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION**

OFFICE OF ADMINISTRATIVE LAW JUDGES  
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**AUG 20 1981**

SECRETARY OF LABOR, MINE SAFETY AND HEALTH ADMINISTRATION (MSHA),	:	Civil Penalty Proceeding
	:	
	:	Docket No. PENN 81-24
	:	Petitioner : A.C. No. <b>36-00856-03037F</b>
	:	
v.	:	
	:	<b>Rushton Mine</b>
	:	
RUSHTON MINING COMPANY,	:	Respondent :

DECISION APPROVING SETTLEMENT

The parties have reached a settlement of the five violations involved in the above docket in the total sum of \$22,000. MSHA's initial assessment therefor was \$35,000. The terms of the settlement are as follows:

<u>Citation/Order Number</u>	<u>Original Assessment</u>	<u>Compromised Settlement</u>
615758	\$ 2,000	\$ 750
802229	10,000	6,500
802230	10,000	6,500
802228	10,000	7,000
802232	<u>3,000</u>	<u>1,250</u>
	\$35,000	\$22,000

The reductions from the original assessment appear warranted.

1. Order No. 615758 was issued for a violation of 30 C.F.R. § 75.201-1(b) and originally involved a penalty assessment by MSHA of \$2,000. In conjunction with this order, section 104(d)(2) Order No. 802229 was issued for a violation of 30 C.F.R. § 75.200 for which Respondent was initially assessed a penalty of \$10,000. These two orders were both assessed for excessive roof-control widths. The first order was issued because no additional support was provided as required by the regulation. The inspector observed that for 350 to 400 feet, the width of the area was 21 to 24 feet instead of 20 feet as required by the regulation. The second violation, of drawings 7, 8, and 9 of the approved roof-control plan, was issued because the plan requires the roadway to be limited to 16 feet in width. These two violations were issued for the same length of roadway. Therefore, they duplicate each other. Accordingly, it is appropriate to reduce these penalties. Although these orders were issued in the course of a fatality investigation, it is conceded

by MSHA that the excessive widths did not contribute to the fatality. The fatality occurred during pillaring operations. This area had been developed many years before. When it was developed, the widths did not have to be narrowed as currently required. The Respondent mine operator was in the process of adding additional support to this roadway. The operator had not yet started pillaring the area. The approved roof-control plan provides, in relevant part, that roadways must be narrowed to 16 feet where pillaring is being done. However, as stated above, pillaring was not yet being performed. Rather, the operator was adding additional support to the entries surrounding the pillars and MSHA concedes that the operator was not unreasonable in interpreting the plan to allow additional support to be installed prior to narrowing the roadway. Additionally, MSHA indicates that the operator did intend to narrow the roadway after adding the additional support. **Accordingly**, because the two orders duplicate each other, because MSHA concedes it initially overevaluated the operator's negligence, and since this violation did not contribute to the fatality which occurred, penalties of \$750 and \$6,500, respectively, as agreed upon by the parties, are approved.

2. Order No. 802230 was issued for a violation of 30 C.F.R. § 75.201. MSHA originally assessed a penalty of \$10,000., MSHA has submitted the fatality investigation report relevant to this order. As MSHA points out, this report has in it a sketch of a mine map showing the section as it appeared when the fatality occurred. The Respondent operator was in the course of pillar recovery. It had begun pillaring in sequence along one row. Thereafter, it left several blocks of coal unmined due to bad roof surrounding the area. It then continued mining this same row of pillars. Upon completion of this row, the operator moved one row **outby** and began pillaring across the entries. At this point, the operator did not intend to go back **inby** to remove the pillars it had omitted. MSHA concedes that this is an acceptable mining method, i.e., where the operator believes that it is unsafe to mine certain pillars, the operator may omit those pillars provided it continues in sequence from that point. However, the state mine safety and health inspectors disagree with the Federal Government's position. The day prior to the fatality, the state inspectors were in the mine. They told the operator that it was necessary to return **inby** to the three pillars that had been omitted. Thus, the operator was required to add additional support throughout the area going toward the pillars that had originally been omitted. These particular pillars are designated as Nos. 6, 7, and 8 on the sketch provided by MSHA. By mining in this fashion, that is, going partially through one row then going **outby** another row and then returning **inby**, the operator failed to maintain a uniform pillar line. This is a violation of 30 C.F.R. § 75.201 and exposed miners to unusual dangers because it is, according to MSHA, a faulty pillar recovery method. This contributed to the accident as it caused excessive heaviness in an area of already poor roof. Accordingly, because the operator was following the instructions of the state inspector, MSHA concedes that the operator's negligence was initially overevaluated. MSHA also indicates that if this matter was to proceed to hearing, an expert witness for Respondent would testify that mining in this fashion does not create pillar points and is not less safe than mining straight across. Accordingly, the reduction to \$6,500 is approved.

3. Order No. 802228 was originally assessed at \$10,000. It involved a fatality. The operator was adding additional support to a developed entry in the course of pillaring operations. Respondent's old roof-control plan did not require 4-foot centers nor as extensive a bolting pattern as required by the current plan. The victim, who was a bolter helper, and the bolter himself were in the process of installing additional supports in accordance with the new plan when the fall occurred. MSHA indicates that there is a dispute as to whether this was spot bolting or rebolting. In either case, MSHA concedes the operator was acting in good faith. MSHA also concedes that the operator was taking extensive measures to make sure that this potentially dangerous area was given care. It is also significant to note that during this additional bolting stage, the section foreman told the bolters to be sure to make the roof safe by doing whatever was necessary. At first, 6-foot bolts were being used. When it was determined that this may not be sufficient, 8-foot bolts and metal straps were used. One of these straps was already in and more were to be inserted when the accident occurred. For these reasons, MSHA concedes that the degree of the operator's negligence was not high. The reduction to \$7,000 appears appropriate and is approved.

4. Citation No. 802232 was issued for a violation of 30 C.F.R. § 75.200. The citation charges the operator with not adequately training its bolting personnel in compliance with safety precaution No. 2 of the plan. MSHA indicates that the object of this citation was to charge the operator with not properly instructing its bolters on "rebolting" requirements. However, the bolter felt, and the operator agreed, that "spot" bolting was being conducted. MSHA concedes that this discrepancy does not indicate inadequate training, but rather the inherent conflict between what spot bolting and rebolting actually are. MSHA concedes the operator's negligence is lower than initially evaluated. The agreed-on penalty of \$1,250 is approved.

ORDER

Respondent, if it has not previously done so, **is** ORDERED to pay the stipulated penalties totaling \$22,000 to the Secretary of Labor within 30 days from the issuance date of this decision.



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Michael A. Lasher, Jr., Judge

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