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MANALAPAN MINING V. SOL (MSHA)  
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Federal Mine Safety and Health Review Commission  
Office of Administrative Law Judges

MANALAPAN MINING COMPANY,  
CONTESTANT

v.

SECRETARY OF LABOR,  
MINE SAFETY AND HEALTH  
ADMINISTRATION (MSHA),  
RESPONDENT

CONTEST PROCEEDING

Docket No. KENT 86-119-R

Citation No. 2596792-04; 6/5/85

Harlan No. 1 Mine

SECRETARY OF LABOR,  
MINE SAFETY AND HEALTH  
ADMINISTRATION (MSHA),  
PETITIONER

v.

MANALAPAN MINING COMPANY,  
RESPONDENT

CIVIL PENALTY PROCEEDING

Docket No. KENT 86-130

A.C. No. 15-05423-03563

Harlan No. 1 Mine

DECISION

Appearances: Karl S. Forester, Esq., Forester, Forester, Buttermore & Turner, P.S.C., Harlan, Kentucky for Manalapan Mining Company; Theresa Ball, Esq., Office of the Solicitor, U.S. Department of Labor, Nashville, Tennessee for the Secretary of Labor.

Before: Judge Melick

These consolidated cases are before me pursuant to section 105(d) of the Federal Mine Safety and Health Act of 1977, 30 U.S.C. 801 et. seq., the "Act," to challenge the issuance by the Secretary of Labor of one citation and two withdrawal orders charging the Manalapan Mining Company (Manalapan) with violations of regulatory standards. The general issues before me are whether Manalapan violated the cited standards and, if so, whether the violations were of such a nature as could significantly and substantially contribute to the cause and effect of a mine safety or health hazard, i.e., whether the violations were "significant and substantial". If violations are found it will also be necessary to determine the appropriate civil penalty to be assessed in accordance with section 110(i) of the Act.

During the course of an investigation of a June 4, 1985, fatal rib fall accident at the Harlan No. 1 Mine several withdrawal orders and citations were issued, three of which

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are before me in these proceedings. At hearings the parties agreed to settle Order No. 2594901 for the \$1,000 penalty proposed by the Secretary. I have considered the representations and documentation submitted in support of the proposed settlement and find that it meets the criteria set forth in section 110(i) of the Act. Accordingly the proposed settlement of Order No. 2594901 is approved.

Citation No. 2596792 alleges a "significant and substantial" violation of the operator's roof control plan under the standard at 30 C.F.R. 75.200 and charges as follows:

Dangerous loose overhanging ribs were present in all active workings of the 004-0 section, and also the supply track from the subject section to the No. 4 cross entry belt outby. This condition was the contributing factor which led to the issuance of imminent danger order issued during a fatal accident investigation; order No. 2596791 issued 6-5-85.

The citation was subsequently modified on May 14, 1986 as follows:

This violation is hereby modified to read item (20) negligence as being (e) (Reckless Disregard) because the operator had been warned prior to the fatal accident by two (2) other persons being injured and by previous citations issued that the ribs were dangerous and also memo written concerning rib controls and no action was taken until after the fatal to control ribs in high coal bed. Also modified to read item (21) Gravity (A) as being (occurred) because (1) man was killed as a direct result of no measures taken to control ribs in the high coal bed.

The cited standard, 30 C.F.R. 75.200, provides in part that "the roof and ribs of all active underground roadways, travelways, and working places shall be supported or otherwise controlled adequately to protect persons from falls of the roof or ribs."

There is indeed no dispute that on June 5, 1985, the date of the violation alleged in the citation at bar, loose and overhanging ribs were present in the active workings of the 004-0 section of the Harlan No. 1 Mine. Indeed Mine Superintendent Ralph Napier admitted that there were a "pretty lot" of loose and overhanging ribs in the section on June 5. The violation is accordingly proven as charged.

The evidence is also undisputed that such loose and overhanging ribs existing in active workings constitute a serious

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hazard. In the absence of any rib control in this section of the mine where the extracted height was 12 feet, where they were retreat mining (and not all of the pillars were being extracted during the process thereby creating excess pressure on the ribs), and where there existed a rockband some 2 feet from the mine roof thereby placing additional pressure on the 2 feet of coal between the roof and rockband, the violation was also "significant and substantial." Secretary v. Mathies Coal Company, FMSHRC 1 (1984).

Whether this violation was caused by Manalapan's negligence depends on whether Manalapan officials knew or should have known of the violative conditions, or regardless of whether they knew or should have known of those conditions whether they nevertheless failed to follow safe industry practice in providing additional rib support under the circumstances as they existed on June 5, 1985.

The Secretary argues that the dangerous loose and overhanging ribs cited on June 5, 1985, had existed since before the fatal rib fall at around 2:45 p.m. on June 4, 1985. According to Inspector Ronny Russell of the Federal Mine Safety and Health Administration (MSHA) the overhanging rib conditions in the 004 section were about the same on June 5 as they were on the date of the fatality June 4. Russell was in the 004 section on June 4 after the fatal accident and testified that he then saw dangerous, loose overhanging ribs throughout the active working section. Russell was however the only witness to claim that he actually saw such dangerous loose and overhanging ribs on June 4. Moreover Russell never did issue an order or citation for these alleged conditions on June 4. It is also interesting that although Russell had been the regular MSHA inspector at the Manalapan Mine and had in fact inspected it on the preceding May 22nd and May 30th 1985, he had never issued any citations for roof or rib violations. All of the remaining witnesses who were present in the cited section on June 4, disagreed moreover with Russell's observations.

Frank Curry a Manalapan roof bolter was working in the vicinity of the fatal accident before it occurred. While he thought there may have been some loose ribs behind them none were overhanging. According to Curry the deceased had tested the rib that fell with a steel drill. Moreover the rib was "straight up and down" with no cracks or fractures to be seen.

Richard Cohelia, the Manalapan Safety Director, did not remember seeing any loose or overhanging ribs in the 004 section after the accident. According to Cohelia the conditions had significantly deteriorated overnight so that on June 5, 1985, several loose ribs had slabbed out from the permanent rib.

Johnny Helton the Manalapan General Mine Foreman, and Ralph Napier both went into the 004 section shortly after the accident on June 4 and neither saw any loose or overhanging ribs in that section. They both returned on June 5, and found that some of the ribs had since rolled out from the weight of the roof and there were loose and overhanging ribs at that time.

Gary Cochran the 004 Section Foreman on June 4th testified that the section was being retreated in an area of 12 foot coal. Cochran entered the mine at around 6:45 that morning to perform his on-shift examination. They began cutting coal at around 11:30 that morning and were in the second cut when they saw some loose ribs. The continuous miner was then moved in. According to Cochran the ribs were then trimmed back to an angle of 45 degrees and they "looked good" when the miner was backed out. Cochran also saw the deceased and Curry each take down some loose coal with an 11 foot drill steel bar. Cochran testified that he then checked both the right and left side visually before he left. 15 minutes later he heard that Boggs had been killed in the heading. According to Cochran there was only 1 overhanging rib in his section which was taken down prior to Bogg's accident.

Raymond Gross, Jr. was working on June 4, 1985, in the 004 section for Foreman Cochran. According to Gross the ribs were "in good shape" at that time although there had been some sloughing.

Within this framework of evidence I do not find that the Secretary has proven his claim that the loose overhanging ribs found on June 5, 1985, had existed since before the fatal accident on June 4th. The Secretary also maintains however that the operator was negligent because it had been warned of the dangerous rib conditions on June 5th by the fact that two other persons had previously been injured by rib rolls, by previous citations issued for dangerous ribs, and also "from a memo written concerning rib controls and no action was taken until after the fatal to control ribs in high coal bed."

The record shows that citations had been issued to Manalapan on September 4, 1984, for a violation of loose and overhanging ribs in another section of the mine and again on October 17, and November 9, 1984, for similar problems. I cannot find however that these violations constituted any notice of the rib conditions more than 6 months later on June 5, 1985, in another section of the mine. The mere existence of these prior violations without more, does not suggest that the operator was negligent on this occasion.

In addition, while MSHA Inspector Paul Helton noted on the citation issued September 4, 1984, that the operator needed a modification to his roof and rib control plan to take care of sloughing ribs, this was not made a condition of abatement nor was the operator subsequently required by MSHA to so modify its plan. Indeed the evidence shows that Inspector Helton's supervisor thought it would be "fruitless to pursue" such a requirement. Since MSHA itself therefore apparently did not deem such a modification to be sufficiently important to compel the operator to make such changes, either as a condition of abatement or as a condition in its roof and rib control plan, I find its argument now that the operator was negligent solely for failing to adopt such changes to be unpersuasive.

Manalapan is not totally without negligence however in light of its history of rib problems. The evidence is undisputed that in a 10 to 12 foot coal seam as here there is an increased danger of bursting ribs. Here there was also a history of rib rolls particularly during retreat mining and only partial pillar recovery. Moreover based on the credible expert testimony of MSHA Special Investigator, Lawrence Layne, it is clear that the additional stresses placed upon the roof and ribs under such conditions clearly warranted additional safeguards to protect the miners from rib rolls. This evidence establishes that safe and accepted industry practice warranted such measures. The fact that Manalapan took no additional precautions, which were shown to be feasible, supports a finding of operator negligence.

Citation No. 2596793 alleges a "significant and substantial" violation of the standard at 30 C.F.R. 75.304 and charges as follows:

Sufficient and adequate on shift examinations had not been conducted in the 004-0 section, in that on 6-4-85 loose overhanging ribs were present, also the approved roof control plan was not being fully complied with in that turnposts were not set going into the pillar split, and only (3) roadway posts were set on 1 block outby the block being mined, and the power center for subject section was within 150 feet of the pillar being mined.

The cited standard provides in relevant part as follows:

At least once during each coal-producing shift, or more often if necessary for safety, each working section shall be examined for hazardous conditions by certified persons designated by the operator to do so. Any such conditions shall be corrected immediately.

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As noted, the Secretary's evidence has been found insufficient to sustain a finding that loose overhanging ribs were present on the 004-0 section on June 4, 1985. Manalapan acknowledges however that it was in violation of the approved roof control plan as cited in that turnposts were in fact not set into the pillar split and that only 3 roadway posts were set for 1 block outby the block being mined. The foreman in charge of the section, Gary Cochran, said that he was not even aware of the requirement to have line posts set before the second cut into the pillar. Manalapan also admits that the power center for the section was indeed within 150 feet of the pillar being mined. The existence of these violative conditions either through ignorance or by intent clearly supports the violation.

The Secretary concedes that these conditions were not the causative factors in the fatal rib fall on June 4, 1985, however it nevertheless maintains that the violation was "significant and substantial." I must agree. It may reasonably be inferred from the fact that inadequate on-shift examinations were being conducted in the 004-0 section that any number of hazardous conditions were not being detected. It may also reasonably be inferred from the failure to have corrected the two admitted violations that reasonably serious injuries would result. The violation is accordingly serious and "significant and substantial." Mathies, supra.

In determining the appropriate civil penalties in this case I have also considered that Manalapan is of moderate size and has a moderate history of violations. There is no dispute that the violative conditions cited in this case were abated as required by the Secretary. Accordingly I find that civil penalties of \$500 for Citation No. 2596792 and \$500 for Order No. 2596793 are appropriate.

ORDER

Manalapan Mining Company is hereby ordered to pay civil penalties of \$2,000 within 30 days of the date of this decision.

Gary Melick  
Administrative Law Judge