

Appendix D

MSHA's Response to Draft Report

U.S. Department of Labor

Mine Safety and Health Administration
1100 Wilson Boulevard
Arlington, Virginia 22209-3939



MAR 28 2013

MEMORANDUM FOR ELLIOT P. LEWIS

Assistant Inspector General for Audit

FROM:

JOSEPH A. MAIN
Assistant Secretary of Labor for
Mine Safety and Health

A handwritten signature in blue ink, reading "Joseph A. Main", is written over the typed name and title.

SUBJECT:

Response to OIG Draft Audit Report no. 15-13-003-06-001,
*"MSHA is on Track to Implement Upper Big Branch Internal Review
Recommendations and is Undertaking Actions on the Independent
Panel Report"*

Thank you for the opportunity to review your draft report. My highly dedicated staff and I take the findings in the Internal Review and Independent reports very seriously. We have worked hard to identify shortcomings in mine safety and at MSHA, to implement actions to fix those following the Upper Big Branch tragedy and to improve mine safety and health in the nation's mines. I appreciate the recognition of those efforts as reflected in the draft audit.

MSHA has undertaken a wide range of actions following the Upper Big Branch disaster that have resulted in improvements in mine safety enforcement, and agency policies, procedures and organizational structure. In the wake of the tragedy at the Upper Big Branch mine, MSHA did not wait for the Internal Review to issue findings, but took immediate actions, including the publishing of an emergency temporary standard on rock dust, which became a final rule; implementing impact inspections; and revising its Pattern of Violations (POV) program to rein in chronic violators. For the first time in the history of the Mine Act, MSHA placed mines on a 104 (e) pattern of violations.

Also for the first time, the Department successfully brought an action for injunctive relief under section 108(a)(2) of the Mine Act. In addition to these actions, MSHA issued notices to the mining industry on several issues raised by the Upper Big Branch mine explosion such as advance notice, mine ventilation, rock dusting and miners' rights, and ramped up enforcement on those critical matters. It also overhauled several agency policies and procedures.

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In addition, MSHA made significant structural changes. It divided District 4 into two separate districts, reorganized MSHA's Mt. Hope dust lab into a national dust laboratory and reorganized its Office of Assessments to manage MSHA's special enforcement initiatives, including impact inspections, pattern of violations, scofflaw accountability audits, and special investigations on worker voice and miner claims of retaliation.

We took these and other actions at the same time we were conducting one of the most thorough and methodical accident investigations and agency internal reviews in the history of the Mine Act, and implementing other actions and initiatives that we had started just prior to the disaster. These included the "Rules to Live By" initiative intended to prevent the most common mining deaths, the End Black Lung---Act Now Campaign aimed at eradicating the black lung disease among underground coal miners and an overhaul of a mine emergency response system in need of improvements following a series of mine accidents and disasters.

Just prior to the disaster, MSHA was facing some significant challenges. These included severe losses of managerial and inspection experience through attrition. Reduced hiring due to funding shortfalls resulted in an inexperienced inspectorate, where about half of MSHA inspectors had 2 years or less enforcement experience in 2009. MSHA was also contending with an enormous backlog of more than 80,000 contested citations and orders pending before the Federal Mine Safety and Health Review Commission.

MSHA is continually retraining its inspectors, supervisors, and specialists, including special investigators and other staff, to improve enforcement of the Mine Act. It has also implemented several other new measures to improve mine safety, including the promulgation of MSHA's final rule on examinations, which took effect in August, 2012 and requires operators in underground coal mines to proactively find and fix hazardous conditions; and the final rule on Pattern of Violations aimed at reining in chronic violators.

The comprehensive actions we have taken have made mines safer than at any other time in mining history. Our impact inspection program has resulted in 579 impact inspections, over 10,000 citations, more than 900 orders and over 40 safeguards since it began in April, 2010. A review of mines that received impact inspections between September, 2010 and September, 2012, shows that these impact inspections are making a

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real difference. As of December 31, 2012, violations per inspection hour were down 16%, S&S violations down 21%, unwarrantable failures down 50% and lost time injury rates, down 10%.

Our revised POV program has also produced positive results and reduced the number of chronic violators. In our first year screening in 2010, fifty-three mines were identified and 17 mines received Proposed Pattern of Violation (PPOV) notices as a result. By October 2012, during the third screening, 20 mines were identified and 3 were identified as having a potential pattern of violations. This demonstrates a significant reduction in mines meeting the agency's criteria for measuring mines with the most serious compliance issues. MSHA has also reviewed the violation and injury records of the 19 coal mines and 3 metal/nonmetal mines that received PPOV notices and have had at least one complete inspection since undergoing the PPOV process. As of December 31, 2012, the total violation rate among these mines was down 34 percent, the total S&S violation rate down 56 percent, the rate of unwarrantable failure violations down 80 percent, and the lost time injury rate down 39 percent.

In 2012, MSHA and the Office of the Solicitor (SOL) filed the most temporary reinstatement requests in history to return miners back to their jobs while their claims for retaliation are pending. Since we began our campaign to end Black Lung, a disease that has afflicted coal miners since the start of mining, the respirable coal dust levels in underground coal mines have dropped. In FY2012 the levels dropped approximately 14% to the lowest levels in history. MSHA has worked earnestly to respond to an unprecedented number of FOIA requests, and despite its other ongoing activities, was able in 2012 to reply to the most FOIA requests in MSHA's history. We have also made improvements in mine emergency response and have, with the assistance of SOL, reduced the contested citation and order backlog to about 50,000 violations from a high of 89,000, resolving about 100,000 citations and orders in the process.

Most importantly, the year 2011 was the safest year in mining history as measured by both fatal rates and injury rates; and preliminary data show even more improvement, with 2012 at new historic lows. MSHA's hard work is yielding results.

MSHA's mission is to enforce the Mine Act to protect the nation's miners from injury, illness and death. The Agency is working hard to carry out that mission, while at the same time carrying out the actions outlined above, and as the draft report notes, aggressively implementing the 100 Internal Review recommendations we committed to

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and responding to the Independent Panel report. MSHA's dedicated staff from virtually all parts of the agency has invested considerable time and effort in this massive undertaking.

As your draft report notes, by December 31, 2012, the agency had completed over one-half of its corrective actions and is on track to meet its milestones for implementing the remaining Internal Review recommendations that have due dates, subject however to budget impacts or unforeseen circumstances.

There are some Internal Review recommendations for which MSHA cannot reasonably set due dates at this time. These recommendations involve rulemaking, research, legal reviews and funding contingencies. The rulemaking agenda going forward is subject to OMB review before release. However, as per your Recommendation (2), MSHA will continue to work on those recommendations to ensure they are being diligently pursued.

Your draft report also finds that MSHA is undertaking action on many of the recommendations of the Independent Panel, some in conjunction with the Internal Review recommendations. MSHA has already completed some actions, including the Independent Panel's suggestion to establish a transparent process to oversee the effective implementation of corrective actions and to ensure their effectiveness. MSHA has taken a different but equally effective approach to this Independent Panel suggestion by establishing an internal review process, and in the interest of transparency, posting its actions on its website. I appreciate that your report notes that MSHA has "adopted a transparent web-based public reporting mechanism and robust process for verifying the implementation of recommendations before reporting them as complete."

To implement the Internal Review's recommendation on this issue, I issued a directive to the Office of Assessments, Accountability, Special Enforcement and Investigations (OAASEI) to develop a means for evaluating the effectiveness of corrective actions. The OAASEI revised the Accountability Program Handbook to address this recommendation, completing its work by December 31, 2012. MSHA has undertaken other actions to respond to the Independent Panel suggestions, posted on MSHA's website.

Concerning MSHA's communications with the Independent Panel, the agency has had ongoing discussions with Dr. Jeffery Kohler, Associate Director of Mining at NIOSH's Office of Mine Safety and Health Research (OMSHR). Dr. Kohler is a member of the Independent Panel and the individual who testified on behalf of the Panel about the Independent Panel Report at a hearing of the House Education and the Workforce Committee in March 2012. MSHA has communicated with Dr. Kohler and NIOSH staff regularly on projects critical to mine safety and health, including matters discussed in the Independent Panel report such as rock dusting, the Coal Dust Explosibility Meter and Atmospheric Monitoring Systems.

Section 501 of the Mine Act provides a vehicle for NIOSH to transmit research findings and recommendations on mine safety and health matters to MSHA. We would fully expect NIOSH to continue to bring any important mine safety or health matter to our attention. With regard to our discussions with the Independent Panel on its recommendations, NIOSH will need to do additional research and support work. We will be in communication with NIOSH to follow up on those discussions.

Recently, MSHA published its new rock dust protocol aimed at preventing coal dust explosions, such as the one that caused the tragedy at the Upper Big Branch mine. Rock dusting was identified as an issue in the Internal Review and the Independent Panel reports, and MSHA developed the protocol in collaboration with NIOSH. MSHA has briefed stakeholders, conducted training for its enforcement personnel and had follow-up meetings with stakeholders in the coal fields. In addition, in January 2013, MSHA issued a Program Information Bulletin to the mining industry advising operators of the need to use Coal Dust Explosibility meters to check coal mine dust to prevent explosions. The Bulletin cited NIOSH research on the device. This was another issue cited in the Internal Review and Independent Panel reports and was implemented in conjunction with NIOSH.

As your draft report notes, MSHA supports improvements to atmospheric monitoring systems. It has requested that NIOSH provide recommendations for the implementation of this improved technology. We look forward to working with NIOSH in this important area.

We previously provided you with much of this information, including information on the discussions we have had with NIOSH; however, the draft report does not reflect it. The report should be revised to acknowledge this interaction and ongoing dialogue.

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Also, as a matter of clarification, page 8 of the draft report states that MSHA's contented the Recommendation #1 is outside of the scope of the Independent Panel's charge. However, it was the Independent Panel that noted in its report it was making the recommendation even though it was beyond the scope of its review.

In addition, while the draft report states that MSHA did not concur with two of the Independent Panel's recommendations, it should also note that NIOSH, in a letter to a stakeholder (the UMWA), stated it did not support a number of Independent Panel recommendations.

Below are MSHA's specific responses to your recommendations.

OIG Recommendation No. 1: *Build a process into its Internal Review Framework to rank and prioritize recommendations*

MSHA prioritized the implementation of the Internal Review recommendations. It agrees that the agency should build a process into its internal review framework to prioritize recommendations similar to the process it utilized with the Upper Big Branch Internal Review recommendations. As a result, MSHA is currently revising its internal review policies and procedures, in place since the 1989 Pyro mine disaster to include such a process.

A note of caution: when tragedy strikes, MSHA needs the ability to respond quickly and cannot wait months or years for an internal review to complete its work. I want to be careful that any new processes do not hamstring agency leadership from taking action to protect miners. We undertook actions quickly following the Upper Big Branch tragedy and many others were well underway when the Internal Review report was released on March 6, 2012.

As a result, Objective 1 should be revised to clarify that appropriate actions such as the type of actions MSHA undertook following the Upper Big Branch tragedy should be undertaken in response to a future mine accident where delay could result in unnecessary risks. For MSHA to await the investigation, formulation, ranking and prioritizing of findings and recommendations of an internal review before taking corrective actions would in fact place miners at risk.

OIG Recommendation No. 2: *Continue work on those recommendations that do not currently have anticipated due dates to ensure they are being diligently pursued*

As further outlined in Exhibit 2 to your draft report, there are some Internal Review recommendations for which MSHA cannot reasonably set due dates at this time. As we have stated, these recommendations involve rulemaking, research, legal reviews and funding contingencies. The rulemaking agenda going forward is subject to OMB review before release. MSHA agrees and will continue to work on those recommendations to ensure they are being diligently pursued.

If you have any questions, please feel free to contact me or my staff.