EFFECTIVENESS OF THE DISTRICT 11
COAL MINE SAFETY AND HEALTH
INSPECTION PROGRAM
BIRMINGHAM, ALABAMA
MINE SAFETY AND HEALTH ADMINISTRATION

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Executive Summary

This report presents the results of an evaluation, conducted by the Office of Inspector General (OIG), Office of Analysis, Complaints and Evaluations, of the effectiveness of the mine safety and health inspection program in Alabama in response to a letter, dated October 17, 1996, from the United Mine Workers of America (UMWA) to the Inspector General. The UMWA’s correspondence raised concerns that the Mine Safety and Health Administration’s (MSHA) District 11 in Alabama was not fulfilling its responsibility to protect mine workers by conducting enforcement activity in an effective and appropriate manner. Among the allegations we reviewed are that District 11 did not: conduct proper and timely 103(g) inspections in accordance with the Federal Mine Safety and Health Act of 1977 (Mine Act); ensure abatement of long-term mining hazards at several mines; address potential conflicts of interest; cite all violations by mine operators; and conduct appropriate or sufficient enforcement activities. Our review encompassed a broad based evaluation of the effectiveness of the District’s enforcement program and included many of the specific items cited in the UMWA’s correspondence.

In summary, we concluded that the mines in Alabama have better safety records now than prior to the creation of District 11, as indicated by the declining incidence rates of mining accidents and injuries. In addition, violations in District 11 have decreased by 15 percent over the last two years, concurrent with an overall improvement in the quality of citations and orders. On the other hand, enforcement actions have not decreased at the majority of mines considered most hazardous by the UMWA. Our review identified the following areas warranting MSHA’s attention to improve the coal mine safety and health inspection program in Alabama and/or nationwide:

- While the conference process is and has been properly administered in District 11, communication with and the involvement of inspectors can be improved. We have, therefore, recommended that inspectors be provided regular briefings regarding those judicial or Commission decisions that affect the issuance of citations and orders and copies of those rulings that serve as the basis for a Conference Officer’s decision.

- District 11 inspections of above-ground mining structures where fatal accidents subsequently occurred were not sub-standard. District 11 inspectors, however, like their counterparts nationwide, lack training and expertise to evaluate certain potential structural weaknesses that require additional evaluation from MSHA engineers. We recommend that all MSHA inspectors receive training on identifying potential above-ground structural failure as soon as possible.

- Many of the issues raised by the UMWA resulted from a need for more effective communication between MSHA and the Union. We believe the relationship between District 11 and the UMWA can be improved through joint meetings and dialog sessions.

- District 11 generally handled Section 103 (g) investigations expeditiously and appropriately. However, a major complaint filed under Section 103 (g) by the UMWA against Jim Walter Resources (JWR) mines #4 and #7 was not addressed appropriately by District 11, largely as a result of ineffective communication between District 11
supervisors and Union officials.

- District 11 managers have acted to minimize conflicts of interest and have otherwise implemented new policies, in good faith, to improve enforcement. However, we have recommended that additional policies, consistent with MSHA’s ethics guidelines and labor-management agreement, be instituted requiring inspection personnel to disclose to agency management officials both immediate family relationships with mine employees and any other personal relationships that may give the appearance of a conflict of interest.

The Assistant Secretary for Mine Safety and Health’s response to our draft report, dated September 24, 1998, advised that the agency agrees with our conclusions and recommendations. The response also indicates that significant actions are already in process with respect to several of our recommendations, including providing additional information to inspectors concerning the decisions of the Mine Safety and Health Review Commission and the scheduling of quarterly health and safety meetings between District 11 management and inspection personnel, labor officials and representatives, mine operators and other interested parties. MSHA’s detailed response to each recommendation is included in the text of the report and a complete copy of the response can be found in the Appendix.
I. **Background**

On October 17, 1996, the UMWA filed a complaint with the OIG raising concerns that MSHA was not fulfilling its legal responsibility to protect mine workers under the Mine Act, Title 30 CFR and agency policy, by conducting its management and inspections activities in an appropriate manner. The UMWA also contended that as a result of the District’s enforcement practices, Alabama miners worked under unacceptably hazardous conditions in which several accidents and fatalities occurred. Furthermore, the complaint alleges discrimination and/or retaliation against miners who report safety violations in the workplace, which is a violation of Section 105(c) of the Mine Act. The UMWA’s complaint also cites numerous violations concerning: Jim Walter Resources, Inc. (JWR) mines, primarily mines #4 and #7; and, the Drummond Company, Inc. Kellerman Preparation Plant, among others. The complaint focused primarily on issues such as unresponsiveness to 103(g) complaints, conflicts of interest, faulty haulage systems, and severe structural failures that MSHA inspectors had not identified or ensured were abated in a timely manner.

MSHA administers the provisions of the Mine Act and enforces compliance with mandatory safety and health standards as a means to eliminate fatal accidents; reduce the frequency and severity of nonfatal accidents; minimize health hazards; and, promote improved safety and health conditions in the Nation’s mines. MSHA carries out the mandates of the Mine Act at all mining and mineral processing operations in the United States, regardless of size, number of employees, commodity mined, or method of extraction.

MSHA is headed by an Assistant Secretary of Labor who is responsible for administering the broad regulatory program to reduce injuries and illnesses associated with mining. Enforcement of safety and health rules and other responsibilities are carried out by two functional divisions, Metal and Nonmetal Mine Safety and Health and Coal Mine Safety and Health. The latter conducts its mine inspection, investigation, and training programs through eleven district offices and a system of subordinate offices in the nation’s coal mining regions.

Effective October 1, 1995, a new district (District 11) was established in Birmingham, Alabama to encompass the staff and boundaries of the former Birmingham sub-district. The purpose was to allow MSHA to respond more effectively to the unique coal mining conditions and special technical and enforcement problems associated with the large, gassy mines of that region. The mines in the Birmingham area represent the greatest concentration of gassy mines in the country and liberate high quantities of methane gas exceeding more than a million cubic feet during a twenty-four hour period. They are also some of the largest and the deepest, e.g., JWR #5 mine is the deepest vertical shaft mine in North America, at a depth of 2,140 feet. Because of the methane and large numbers of people underground, there is a considerable potential for disasters.

MSHA’s enforcement responsibilities in District 11 currently encompass fifty surface facilities, requiring inspection at least two times per year, and ten underground mines (of which all but two are unionized), requiring inspection at least four times per year. Here, as elsewhere, MSHA’s inspection presence does not, by itself, result in violation-free mines. Therefore, MSHA encourages voluntary compliance with the Mine Act through training, technical assistance, and other non-enforcement activities. In addition, at those unionized mines and facilities, UMWA
safety and health representatives play a valuable role by conducting independent bi-monthly safety inspections and bringing those results to the mine operator’s attention for corrective action.

II. Scope and Methodology

Some of the concerns submitted by the UMWA to the OIG were also submitted to the Federal Mine Safety and Health Review Commission (Commission). Such issues, which involve allegations that MSHA and mine operators engaged in discriminatory, intimidating, and retaliatory actions against miners or their representatives in violation of Section 105 c, of the Mine Act, are pending before the Commission and, as a result, were not examined by OIG. In addition, we also excluded from the scope of our review an allegation that MSI-IA officials had not maintained the confidentiality of mine workers or their representatives filing complaints under Section 103(g) of the Mine Act because of the direct relationship of this incident to the UMWA’s complaint to the Commission.

Several of the UMWA’s concerns were potentially criminal in nature and were referred to the OIG’s Office of Investigations (OI). OI has completed its investigation of these items and did not identify any matters meriting referral for prosecutive action. The OIG’s Office of Analysis, Complaints and Evaluations (OACE) reviewed the non-criminal issues within the scope of our program evaluation. The concerns we reviewed included those in the UMWA’s October 17, 1996 submission, as well as additional issues raised during interviews with miners, miner representatives, and MSHA employees. We also reviewed in detail managerial, programmatic, and performance issues not directly raised by the UMWA, but which also impact District 11 performance and, therefore, the health and safety of the miners in Alabama.

Extensive field work was conducted in District 11. Visits were made to the MSHA and UMWA offices in Birmingham, and MSHA field offices in Jasper, and Hueytown. Interviews were conducted with MSHA employees, miners, miner representatives, and mine operators. We reviewed documentation supplied by both MSHA and the UMWA. We also examined, with MSHA and UMWA officials, underground conditions in two of the largest District 11 mines, Jim Walter Resources (JWR) mines #4 and #7. In addition, a mining orientation visit was made to JWR’s #5 mine. MSHA engineers who participated in accident investigations in District 11 were interviewed at MSHA’s Pittsburgh, PA Safety and Health Technology Center. Attorneys with the Solicitor of Labor (SOL), who are responsible for litigating MSHA cases, were also interviewed.

Our review was conducted in accordance with the Quality Standards for Inspections, published by the Presidents Council on Integrity and Efficiency.

III. Review Results

1. Incidence Rates

A central theme articulated by UMWA members is that safety in the Alabama mines has deteriorated since November 1995. This was the period when mines in Alabama came under the oversight of new managers appointed to supervise the newly-created District 11. To evaluate the
UMWA’s allegations, we conducted an analysis of mining incidence (injury) rates in Alabama mines from January 1990 through September 1997. The incidence rate is calculated by adding the number of fatalities, non-fatal accidents that require days off work, and mining injuries that do not involve lost work days, per 200,000 hours of employment. As illustrated in the graph below, short-term incidence rates have improved from their peak in 1994.

**Total Incidence Rates - Alabama Mines**

Our review found that, overall Alabama incidence rates were at their worst in the two years prior to the arrival of the new District 11 management team. In terms of individual categories within the total incidence rate, the most notable short-term incidence improvement is the Non-Fatal Days Lost (NFDL) category, which improved by 26 percent from 1994 (12.68) to 1997 (9.38). It is possible that at least some of the NFDL improvement is a result of operator programs that return injured miners to positions performing light-duty work. For example, our review indicates that there were higher NDL (No Days Lost) rates in 1996 and 1997 than in 1994 and 1995. However, since all injuries are included in the total incidence rate, based on these statistics, Alabama mines appeared safer in 1996-1997 than in 1994-1995.

**Incidence Rates at JWR #4 and JWR#7**

Because many of the UMWA’s complaints involve the JWR#4 and JWR#7 mines, we closely scrutinized incidence rates for these mines. As can be seen below, safety conditions deteriorated in these mines during the years preceding the UMWA complaint. However, incidence rates at
these mines also dropped dramatically in 1996 and 1997.

JWR # 4 Total Incidence Rates

JWR # 7 Total Incidence Rates
2. Violations

The District 11 inspectors and managers used violations and related enforcement tools during the period October 1995 through September 1997 in accordance with the Act, MSHA regulations and procedures to increase the effectiveness of the inspection program and improve safety and health conditions in Alabama mines. While the number of violations issued, considered in isolation, is not a reliable measure of MSHA’s effectiveness, this statistic in combination with other information can provide meaningful insights into the program’s performance. Our review of violations issued by District 11 confirmed a decreasing trend, similar to that of incidence rates, with an overall reduction of 15 percent in violations issued during the two years. However, this trend did not hold true for the majority of mines of particular concern to the UMWA, where the number of violations increased. Our review also confirmed that District 11 is appropriately using a related enforcement tool, Pattern of Violations analysis, to assess whether more aggressive enforcement action is warranted at any of the mines. Concurrent with the decreases in the numbers of violations issued during the two fiscal years was an appreciable improvement in the quality of documentation and support for the District’s enforcement actions according to Department of Labor attorneys and mining industry officials.

The UMWA’s concern that violations were on the decline in District 11, including in mines where Union officials considered conditions especially hazardous, was not substantiated by our review. Between the two reporting periods Fiscal Years 1996 and 1997, violations fluctuated from one month to the next for each mine. A closer analysis of recent violations history and
trends was conducted of those mines that were viewed as problematic for purposes of this review (JWR #7, 4, 3, Boone #1). While overall District 11 violations had declined by 15 percent between the two reporting periods, all except one of the mines of concern actually experienced an increase in the number of violations issued. Violations issued at JWR #3 increased by 26.7 percent; at JWR #4, violations increased by 20.7 percent; JWR #7 experienced a decrease of 3.6 percent; and, Boone #1’s violations increased by 103 percent over the twenty-four month period.

We evaluated District 11’s Pattern of Violations (POV) analyses, an MSHA enforcement tool entailing an annual review of the history of violations accumulated by each mine for the prior two fiscal years, and concluded that District 11 was in compliance with MSHA’s policy and procedures in this regard and had conducted thorough POV analyses. The objective of a POV analysis is to identify operators who habitually allow the recurrence of violations. Mine operators are responsible for compliance and should institute whatever actions are necessary to improve safety. While MSHA expects improvements at mines with poor compliance histories and will assist mine operators where possible, its primary responsibility is to enforce the Mine Act and regulations through fair and impartial inspections. Issuance of a section 104(e) POV notice should be an enforcement tool reserved for those chronic violators who do not respond to other efforts to bring their mines into compliance.

We reviewed District 11's analyses for the two periods, October 1, 1994 through September 30, 1996, and July 1, 1995 through June 30, 1997 and noted that mines were identified for further consideration through the initial screening process in both years’ POV analyses. The initial screening of each mine must be completed by district personnel once every 12 months. Usually, a mine’s 2-year compliance history provides sufficient information for an evaluation of the health and safety conditions. A threshold number of violations, appropriate for the mines in a given District, is used for this screening process to identify those mines having compliance problems. For each mine, District 11 used a threshold of 50 or more Significant & Substantial citations over a 12-month period.

Those mines District 11 identified in this screening as having a compliance problem had the pattern criteria applied to determine if they demonstrated a potential POV. This part of the process focused on the mine’s history of repeated Significant & Substantial violations of a particular standard or standards related to the same hazard. Repeated Significant & Substantial violations caused by unwarrantable failure to comply were also considered. It should be noted that only those citations and orders issued in the compliance history period and that had become final either through the assessment process or through litigation, could be used for pattern criteria. Constructive actions taken by mine operators to improve their compliance records were also considered. Our review confirmed that District 11 officials had appropriately applied the criteria and none of these mines fit the criteria for a pattern of violations.

Concurrent with the reductions in the number of violations issued during Fiscal Years 1996 and 1997, some stakeholders reported an improvement in the quality of District 11’s inspection performance and the documentation of enforcement actions. For example, the Solicitor of Labor (SOL)’s statistical information and observations indicate that there has been an overall improvement in the quality of citations and orders issued by District 11 inspectors. Prior to the above period, SOL found many violations were unsupportable when taken to litigation. Since
In summary, our review determined that while overall violations are on the decline in District 11 mines, this measurement of enforcement action has not decreased at the majority of the mines considered most hazardous by the UMWA. Additionally, we confirmed that District 11 management is analyzing the history of each mine’s violations in accordance with MSHA procedures, to identify whether Pattern of Violations provisions should be invoked to strengthen enforcement actions. Lastly, the quality of violations issued by District 11 improved during our review period while the quantity decreased.

3. The Conferencing Process

While the conference process is and has been properly administered in District 11, communication with and the involvement of inspectors can be improved. Specifically, our review of violations conferenced at a number of mines found the District’s activities to be consistent with MSHA’s procedures and guidelines for safety and health conferences. However, some inspectors asserted that citations and violations are being incorrectly vacated or modified by the Conference Officer with insufficient input and justification from the issuing inspector. Those inspectors indicated that they are demoralized when their citations are “second-guessed” and either vacated or modified.

Our evaluation of District 11 operations included a thorough examination of the conference process for two primary reasons. First, the issuance of violations and MSHA’s internal process of holding conferences with operators to informally resolve contested violations are closely linked. Second, conferencing arose as an issue during our interviews, with some inspectors contending that the conferencing process could be manipulated and skewed by District management in order to artificially prove that violations, particularly Significant and Substantial violations, were decreasing and the mines in Alabama were, therefore, safer.

In contested cases, the Conference Litigation Representative (CLR)/Conference Officer is responsible for conducting safety and health conferences and/or conducting subsequent settlement conferences and appearing before Administrative Law Judges (ALJs) of the Federal Mine Safety and Health Review Commission (FMSHC)/Commission. After initially reviewing all available information, the CLR has the option of contacting the issuing inspector or his or her supervisor, in order to discuss and obtain any additional, relevant information regarding the violation. Additionally, the conference procedures and guidelines do not mandate that the inspector be present at a conference. Based on the complexity and his understanding of the violation(s) to be conferenced, the CLR makes a decision whether additional explanatory information is needed from the inspector and whether his/her presence at the conference is necessary. Frequently, the inspector is not included in the conference in order to minimize the time taken away from inspection duties.

Our review did not substantiate the claim that citations are being incorrectly modified or vacated.
by the CLR, as suggested by some inspectors. At a safety and health conference, questions or problems regarding the issuance of a citation or order (including the inspector’s evaluation of negligence, gravity, and good faith) are reviewed and discussed. After interviewing current and former Conference Officers, we concluded that reasonable individuals might differ in their assessment of such areas as gravity and negligence, particularly after factoring in any extenuating circumstances offered during the conference process.

The CLR may affirm the inspector’s findings or, if facts and circumstances provided during the conference warrant, find that the citation or order be modified or vacated. The CLR’s decision is then forwarded to the appropriate field office supervisor. The supervisor ensures that the citations and orders are modified or vacated as necessary. If the supervisor disagrees with the CLR’s decision, it is his/her responsibility to contact the Assistant District Manager for resolution. If there is no disagreement, the issuing inspector is expected to make the changes and return it to the supervisor within 24 hours of the change request.

Our review of District 11's conferencing data for 1995 through 1997 did not support the contention that the current CLR was modifying and vacating more violations than his predecessor, as suggested by some inspectors. In fact, the data showed that the total number of safety and health conferences actually diminished by 50 percent over those 3 years. In addition, of the violations that the CLR conferenced, his decisions upheld the violations at approximately the same rate (50%) as had the decisions of his predecessor.

A senior SOL attorney further supported this finding. Since 1996, he has experienced a reduction of over 55 percent in the number of contested civil penalty cases and over 60 percent in the number of contested violations that his office handles in the conference litigation process. He attributes this significant decrease in contested cases and violations to both improved case handling by the Conference Officer and an overall improvement in the quality of citations and orders issued by inspectors. Prior to that period, he found many violations were not supportable when taken to litigation. In his opinion, the Alternative Case Resolution Initiative (ACRI) is accomplishing what it was designed to do, as exhibited through the shift in caseload between his office and the CLR, as well as renewed confidence by many company operators in the conference process.

Our review did confirm that at least some inspectors resent changes that are made to citations they have issued. These inspectors expressed concerns that their work is being questioned by a CLR who “doesn’t have all the facts” or that inspectors are not always given the opportunity to state their position fully (either before or at the conference). Some inspectors were also dissatisfied with abbreviated explanations, such as an FMSHC or ALJ ruling influenced the CLR’s decision to modify or vacate a citation or order, without the specific information the inspector should consider during future inspections.

The CLR is functioning within prescribed procedures and guidelines when he communicates through the field office supervisor. However, because of limited direct pre-conference input, as well as infrequent participation in safety and health conferences, some inspectors are left with the impression that they “never get their day in court.” Feedback and communication between the inspectors and the Conference Officer is generally limited, particularly regarding the CLR’s
basis for decisions to modify or vacate, as well as AU and Commission rulings impacting such decisions.

Some inspectors commented that the extent and frequency of communication was better during the tenure of former CLRs. The fact that a previous CLR worked out of the Jasper field office certainly enhanced his ability to more readily communicate with the inspectors in that field office. On the other hand, the inspectors at the Hueytown field office did not hold the same opinion. Nonetheless, since October 1996, the Conference Officer has operated out of the District Office.

District 11 needs to improve communication between the CLR and the inspectors. In this regard, increased efforts should be made by the CLR to directly contact the issuing inspector prior to a conference, allowing that inspector to fully state his or her position. Additionally, a copy should be made available to inspectors and supervisors alike, of those FMSHC and ALJ rulings that served as the basis for the CLR’s decision.

The instructional aspect of the ACRI program, in particular, preparation of the necessary modification by the inspector, can only be fully effective if there is a clear explanation and understanding of the basis for the change. Even with improved communication between the Conference Officer and the inspector, there may continue to be disagreements regarding CLR decisions; what is expected over time, however, is a better understanding on the part of the inspectors as to what forms the basis of those decisions.

4. Training for Structural Inspections

Two fatal accidents in District 11 during November and December 1995 highlight the need for improved training of MSHA inspectors to better ensure that potential safety hazards involving surface mine structures are identified. Our review indicates that the inspectors were not trained to recognize serious decay of the surface structures. MSHA’s accident investigation found that the decay was ultimately responsible for the accidents. It is important to note that these surface structure hazards had also gone undetected by UMWA representatives at these mines who have since received additional training from MSHA in identifying such problems. Subsequent to the accidents, District 11 inspectors also received training on the identification of potential above-ground structural hazards. However, MSHA inspectors nationwide could also benefit from such training.

A fatality at the Drummond-Kellerman preparation plant on November 28, 1995, illustrates why MSHA inspectors need training in order to better identify potential above-ground structural hazards. This above-ground plant was 24 years old at the time when two conveyor belt lines and support structures collapsed, resulting in a fatality. MSHA had conducted a surface inspection on September 18, 1995, but had not cited the No. 16 and No. 17 belt lines or support structures subsequently cited by District 11 during the accident investigation following the fatality. According to engineers from MSHA’s technical support center in Pittsburgh who participated in the accident investigation and who reviewed video and photographic footage of the accident during our interviews, it was evident that the wear and corrosion of the Kellerman structure was long-term in nature. The engineers noted, however, that this was from the perspective of a
trained engineer. The engineers were adamant that MSHA inspectors in District 11 and nationwide had not received training to identify potentially hazardous conditions in above ground structures. Therefore, the engineers were not of the opinion that the September 18 inspection was sub-standard, rather they believed that an MSHA inspector would not necessarily have sufficient expertise to identify potential structural failure.

Similarly, Pittsburgh engineers attributed the November 10, 1995, rock bin collapse at JWR #5 to structural failure that could possibly have been identified prior to the accident if inspectors were trained to recognize serious decay. In this case, poor welds connecting the cone of the rock bin to its flange, and long-term corrosion of the rock bin itself, were the primary reasons for the collapse. As with Kellerman, the engineers could not say that the prior MSHA inspections were deficient, noting that many of the alignment and welding problems would not have been observable during a shift because of rock debris falling through the cone. The engineers did note, however, that holes and gashes that may have compromised structural integrity above the flange plate may have been observable from the ground by an inspector. However, they also advised that an inspector at the time would not have been trained to have an awareness that this was a potential hazard requiring further review from technical support engineers. After the accident investigation, the operator was cited for failing to maintain the rock bin structure in good repair. Although miners and their safety representatives we interviewed stated that they were aware of the structural hazards at Kellerman and JWR #5 prior to the fatal accidents, no 103(g) complaints were filed before either accident.

Training Issues

After the accidents, the technical center engineers conducted training for the District 11 personnel generally responsible for surface inspections. The engineers also developed a training course, using slides from the Drummond-Kellerman accident, that they have conducted for UMWA representatives at MSHA’s Beckley, West Virginia academy. The engineers noted that some of the training that is needed for all inspectors nationwide is very basic. For example, in their opinion, inspectors should be instructed to go beyond a simple visual structural inspection by using binoculars or crane buckets to better observe potential hazards. Training should also ensure that basic tools and techniques, such as hitting a structure firmly with a hammer to gauge rust and corrosion, are utilized. The engineers did not expect that inspectors should or could be so well-trained that they would necessarily be able to definitively identify structural hazards. Rather, they stressed that all inspectors nationwide need to be taught how to identify potential structural hazards that may require more in-depth evaluation from technical support in Pittsburgh.

We contacted MSHA officials to determine if there are plans to address above-ground structural training. Although no training agendas are currently being formulated, training officials indicated that they are evaluating the issue and were receptive to our observations regarding the need for additional training for inspectors in the area of aboveground structures.

5. Timeliness of 103 (g) Investigations at JWR #4 and JWR#7
The UMWA’s complaint to the OIG indicated that District 11 did not conduct immediate 103 (g) inspections, issue notices of negative findings, or provide miners with the right to challenge negative findings. Our review of District 11 files and documentation from 1995 through 1997 indicated that 103 (g) complaints have generally been responded to and negative findings issued in a timely manner. However, a complaint filed by UMWA representatives on February 12, 1996, regarding conditions at Jim Walter Resources (JWR) mines #4, and #7 was not investigated in an appropriate and timely manner, and miner representatives were not provided with notice of negative findings. We concluded that this occurred because District 11 management did not recognize the UMWA’s February 12 submission as a valid 103 (g). After the UMWA complained of District 11’s handling of its February 12 correspondence, MSHA’s national office issued policy guidelines to ensure the proper processing and investigation of 103 (g) complaints. However, effective communications and good-faith efforts between District 11 and the UMWA may have ensured more timely inspection and abatement of serious hazards at the JWR #4 and #7 mines.

UMWA Complaint on February 12, 1996

Although this comprehensive complaint which contained over eighty (80) items was clearly labeled a 103 (g) complaint by the UMWA, District 11 management did not view it as a valid 103 (g), but simply a presentation of the UMWA’s normal bi-monthly inspection. Given the unusually large number of items in the complaint, District 11 management decided to address the issues raised in the 103 (g) during the normal quarterly inspection (AAA). The UMWA international representative was informed that the complaint would be investigated during the AAA and did not appeal this decision to higher level MSHA officials. Ultimately, District 11 personnel also covered some of the 103 (g) issues during accident investigations and winter alert visits. Contrary to the UMWA’s concerns, we found no evidence that an attempt was made to conceal the dates of these inspections or to falsify inspections records. Inspection records were coded based on the primary reason the inspector visited the mine (AAA inspection, winter alert, etc.).

The issues contained in the 103 (g) complaint ranged from serious to minor, although our review indicates that neither the UMWA, in its complaint, nor District 11 in its investigation, placed priority on the most dangerous safety items. As a result, these items were not investigated promptly. Although District 11 investigated a serious haulage issue on February 15, potentially serious float coal dust, methane, and roof control issues were not addressed until March 2, 1996, as part of an ongoing accident investigation. The remaining float coal dust issues items were not addressed until April 18, 1996. Final items in the 103 (g) complaint of a less serious nature (which involved a wide variety of items including electrical, belt-line, ventilation, clean-up, roof control, and walk-ways) were reviewed on April 24, 1996.

Although District 11 management and personnel had extra demands placed on them in February 1996, including a major mine fire at the JWR #5 mine, February 12 complaint issues that did pose a reasonable possibility of imminent danger to miners, such as excessive methane or coal dust accumulations, should have been investigated immediately. Investigations of the serious items could have been conducted quickly by
the resident inspectors at the mines, or by any other readily available MSHA inspectors. Because most of the issues in the February 12 complaint did not pose a threat of imminent danger to miners, these less serious ones could have been deferred, so as not to interfere with adequate inspection coverage for other mines or other areas of the JWR #4 and #7 mines. Nonetheless, because of the very dynamic nature of coal mining, any valid 103 (g) issue must be investigated as soon as possible. A failure of MSHA to investigate a 103 (g) complaint in a timely manner means that the condition, such as float coal dust, may never be properly evaluated, given constantly changing mining conditions. During our interviews and discussions, District 11 management concurred that better supervision could have ensured the timely inspection of priority issues raised by the UMWA.

The UMWA could have been better served by separating the serious from the minor issues in its complaint, rather than combining them with all bi-monthly inspection items and presenting District 11 with a 103 (g) complaint. Again, relatively few of the over 80 items indicated a potentially serious or imminent danger, yet all items were presented together without any prioritization. Indeed, based on our review, it appears that neither the UMWA nor District 11 viewed the February complaint seriously enough, given that findings were not requested by the Union until May and were issued by District 11 only after several written inquiries by the UMWA.

Effective Communication Issues

Effective communication could have ensured that the more serious issues in the UMWA’s February 12, complaint were investigated appropriately, and working relations between District 11 and UMWA officials were not harmed. Similarly, upon receipt of the complaint, District 11 management, including field management responsible for day-to-day operations, could have met with Union safety officials to discuss which issues warranted immediate attention. Union officials, in turn, could have voiced any concerns that they may have had regarding MSHA’s investigative priorities and methods.

Aftermath of the February 12, 103 (g) Complaint

In August 1996, the UMWA formally requested that MSHA evaluate and clarify its policies and procedures regarding the processing and investigation of 103 (g) complaints.

On September 18, 1996, MSHA’s Administrator for Coal Mine Safety and Health responded with a memorandum to all MSHA District Managers. While none of the content of the memorandum was entirely new MSHA policy, it did emphasize those areas where District 11 did not comply in regard to the February 12, 1996, UMWA complaint. The memo emphasized that:

1. All section 103(g) complaints must be reviewed immediately to determine whether the conditions or practices described in the complaint constitute an imminent danger to the miners. If there is a reasonable possibility that an imminent danger exists, the operator must be notified and the inspection must be conducted immediately.
2. Less serious issues must be investigated as soon as possible, with 103 (g) inspections given a high priority (in comparison to all other enforcement activity). 103 (g)’s cannot be deferred until the next regular inspection of the mine.

3. The inspector must issue notice of negative findings at the conclusion of each day’s inspection activities.

This policy memorandum addressed the UMWA’s concerns regarding the 103 (g) complaint. Our review indicates that District 11 management has subsequently complied with these polices and procedures. However, joint meetings and dialogue sessions between District 11 and UMWA safety and health representatives should be conducted regarding 103 (g) issues.

6. **Onsite Inspections of JWR#4 and JWR#7**

On December 3 and 4, 1997, we accompanied UMWA Safety & Health committeemen on their unannounced bi-monthly inspections of the JWR#4 and JWR#7 mines. Although MSHA inspectors from outside District 11 were used by the OIG as expert observers on mining and mining conditions, the inspections were conducted by the UMWA. The purpose of these visits was to assess the overall health and safety conditions of these mines at the time, and to provide us with the opportunity to observe the interactions between inspectors, miner representatives, and miners. At the time of our visit, the MSHA inspectors from outside District 11 determined that the JWR mines were essentially in good standing in terms of overall health and safety conditions, commenting they would rate the conditions observed with a score of 7 on a scale of 1 to 10. This visit also illustrated the different perspectives of MSHA inspectors and committeemen.

**Conditions of the Mines**

JWR#4 was inspected by the above referenced team, during the evening shift of December 3. Travel was by mantrip and on foot to areas where continuous mining and longwall mining were underway. JWR#7 was inspected in the same manner during the morning shift on December 4. Both mines had violations of the Mine Act, although the vast majority of these violations were not Significant & Substantial in nature nor indicative of long-term neglect on the part of the operator. The MSHA inspectors from District 4 stated that the number and type of violations observed at the JWR mines were not unusual, and that the JWR mines seemed in fairly safe condition.

**Perspectives of Safety and Health Committeemen vs. MSHA Inspectors**

We observed during the mine visits that the MSHA inspectors and UMWA committeemen did not always agree on what constituted mine safety violations. In some cases, the UMWA documented conditions that the inspectors did not consider to be violations of the Mine Act. In others, there was disagreement regarding the severity of violations. Beyond simply the varying degrees of technical expertise between the UMWA committeemen and MSHA inspectors, it became apparent that the role of a UMWA
committeeman differs significantly from that of an MSHA inspector.

A committeeman’s sole role is to promote mine safety. We noted that some of the committeemen were very knowledgeable of MSHA enforcement policies and procedures, and use MSHA regulations as guidelines for their own inspections. However, a committeeman is not constrained by formal statute and regulation. Thus, in making an inspection of a mine, the committeeman can present to an operator any and all conditions that can impact health and safety, regardless of whether all the conditions are actual violations of the Mine Act. The committeeman may, or may not, be capable of convincing the operator to correct any unsafe or potentially unsafe condition(s), but can always attempt to negotiate with the operator to do so. However, MSHA inspectors can only cite those conditions that appear to be legally enforceable under the Mine Act. Many such citations involve on-the-spot judgements and regulatory interpretations that can be, and frequently are, challenged by the operator through District conferences, the courts or the Commission. As a result, an MSHA inspector cannot cite legally unsupportable mining conditions, without seriously undermining his own credibility or that of MSHA.

7. JWR #4 Haulage Accident and 103 (g) Issues

Our review did not substantiate that a February 26, 1996 accident which severely injured a miner at JWR #4 resulted from long-term haulage hazards at the mine which had been ignored by MSHA inspectors, as indicated by UMWA members. Rather, as the accident investigation found, it was caused by the excessive speed of the locomotive which struck the mantrip the miner was riding. The excessive speed of the locomotive was due to recklessness on the part of the driver, as well as oversized gravel used in the sanding devices. Neither of these factors can be reasonably attributable to MSHA negligence. It does appear, however, that several of the UMWA’s overall concerns about track and haulage issues at JWR#4, communicated to MSHA in 103 (g) complaints in January, were valid and appropriately addressed by MSHA. Other haulage and track complaints raised by the UMWA through letters, rather than 103 (g) complaints, addressed issues over which MSHA has limited or, in some cases, no enforcement authority.

From 1992 through 1996, UMWA representatives submitted letters to various MSHA officials regarding a variety of track and haulage issues at JWR #4. The dominant and recurring issue involved the Union’s objection to JWR’s block-light system for traffic control of mantrips, locomotives, and other mining equipment. The UMWA has never approved of the block-light system, and has repeatedly requested that MSHA require JWR to implement a dispatcher system. MSHA does not have the authority to require operators to use dispatchers and, unlike West Virginia, Alabama state mining laws also do not require dispatchers.

On January 18, 1996, UMWA representatives lodged very broad 103(g) complaints regarding track and haulage issues at JWR #4, requesting that District 11 “scrutinize all transportation and haulage activities.” District 11 investigated the complaints the next day. Although no citations were issued during their investigations, JWR #4 was required to implement various safeguards to enhance haulage safety. The safeguards directly addressed many of the UMWA’s concerns.
A miner was injured on February 26, 1996, when a runaway locomotive collided with the mantrip in which he was riding. MSHA investigated the accident immediately and concluded that the accident was a result of the following factors:

- Sanding devices that were inoperative, causing sand flow to be restricted by oversized gravel;
- Improper brake-shoe adjustment on the runaway locomotive (citation issued);
- Failure to maintain the locomotive under control, resulting from excessive speed; and,
- Operator’s failure to have a program in place to systematically maintain the haulage vehicles and the track (103 (k) order to withdraw issued).

Brakes were an issue in the UMWA’s January 18th Section 103 (g) complaint, and brakes were cited during the 103 (g) investigation. However the brake-shoe citation was later dropped by the Solicitor of Labor (SOL) when the brake manufacturer established that the wear on the brake shoes was not excessive, but rather, the result of a normal period of contour adjustment to the locomotive wheel. The gravel and excessive speed issues were not directly referenced or implied in the 103 (g)’s.

**Aftermath of the Accident**

As noted in the District 11 accident investigation report, in addition to the accident, there had been several previous haulage accidents at JWR #4, some involving injuries. JWR#4 was required to improve its haulage and traffic control procedures as a result of the 103 (k) order to withdraw from the mine that was issued by District 11 during the accident investigation. Meetings took place during February 26-29, 1996, between JWR and union officials. MSHA’s role in the 103 (k) process is to evaluate the adequacy and reasonableness of the operator’s traffic control proposals. MSHA is not required to design a plan for the operator, or enforce the degree of regulatory specificity, such as would be found in roof-control or ventilation-control plans. District 11 worked with both JWR and the UMWA, reviewed various proposals, and accepted JWR’s March 1, 1996 proposal. The UMWA protested many of the procedures and again requested in writing that MSHA require JWR#4 to implement a dispatcher system. Our review indicates that District 11’s acceptance of JWR’s new procedures was reasonable, and that track and haulage conditions significantly improved, thereafter. However, District 11 could have better communicated its role and limitations as an enforcement agency to the UMWA. For example, District 11 management did not respond in writing to correspondence from the UMWA protesting haulage procedure acceptance, although supervisory inspectors met with Union officials to discuss the concerns.

8. **Conflict of Interest at JWR#4**

We evaluated concerns with respect to a potential conflict of interest at JWR #4 raised by the UMWA to determine whether such a conflict existed for a District 11 inspector and, if so, had MSHA personnel failed to cite obvious violations during a July 13, 1996 inspection conducted at the mine. MSHA has previously examined these accusations and, like our review, found some conflicting information.
The UMWA indicated that on the above date, the following specific conditions existed at JWR #4: severe accumulations of float coal dust; loose coal and other combustibles; inadequate rock dusting; improper handling of explosives; and, that the inspector conducting the inspection refrained from issuing citations because of her personal relationship with the mine foreman. Our review of MSHA’s inspection activities, as well as interviews that were conducted, confirmed the contention that the inspector in question had been previously employed by JWR and had a dating relationship with the JWR #4 mine foreman. However, our review did not support that MSHA inspectors and engineers had failed to cite obvious violations during that inspection.

Analysis of the documentation from MSHA’s official files showed that an inspection at JWR #4 had not been scheduled for July 13, 1996. Rather, earlier that day, the inspector and two engineers from MSHA’s Pittsburgh Technical Support Center had been inspecting seals at JWR #5 mine. Since the engineers were scheduled to return to the Technical Center the following day, District management requested that the three of them proceed to JWR #4 mine after they completed their work at #5 to examine some concerns about pillar stability at the No. 2 longwall.

According to MSHA documentation, when the MSHA inspection team entered JWR #4 mine, they were accompanied by the JWR Manager of Strata Control, the mine foreman, and the UMWA Local 2245 President. They traveled underground to a number of sections within the mine, including the No. 2 longwall, where they examined pillar stability during extraction of longwall equipment. MSHA conferred with the UMWA representative throughout the inspection.

Further review disclosed that the group specifically examined and commented on areas such as the #4 and #1 entries as having been “heavily rock dusted.” The UMWA representative and the MSHA inspector examined two wooden explosive magazines and found no problems with their contents. According to the inspector, the union representative was asked his opinion of the overall condition of the No. 2 longwall, and indicated that he thought “it looked pretty good....a lot better than he had heard.” While there is no way to know the exact conditions that existed during the evening shift of July 13, 1996, we did not identify evidence supporting the Union’s position that the inspector had refrained from citing obvious violations during the inspection.

MSHA policy and procedures state that all personnel must have at least 2 years current employment with MSHA prior to conducting assignments at mines where they were formerly employed. While MSHA was in compliance with this policy, that policy does not address the specific issue of immediate family, marriage or dating relationships between MSHA inspectors and mine employees. Nevertheless, when this issue of possible conflict of interest was raised to District 11 management, they took the necessary steps to reassign the inspector to mines not owned by JWR.

Because of the relatively static labor pool that supplies personnel to both the mining industry and MSHA, some individuals who fill mining jobs will eventually migrate into MSHA inspector and technical positions. This interchange has advantages for the individuals, the industry and MSHA but complicates the establishment of rigid policies restricting all family, marriage or dating relationships. Many of those relationships are inevitable and already exist. Nonetheless, MSHA
should continue to vigorously enforce its policy regarding prior employment. In addition, MSHA should develop a policy, consistent with its ethics guidelines and labor-management agreement, that requires inspection personnel to disclose to agency management officials both immediate family relationships with mine employees and any other personal relationships that may give even the appearance of a conflict of interest. As those instances arise, MSHA should take appropriate steps to address the potential for actual or perceived conflicts of interest.

9. District 11 Management Issues

As part of our overall review of District 11 operations, we examined a number of issues pertaining, especially, to new management initiatives introduced during the establishment of District 11. Some of the new inspection practices generated initial expressions of concern from various MSHA inspectors and stakeholders. Based on our analysis of documentation from MSHA’s files, as well as interviews conducted with management officials, staff, mining industry officials and UMWA officials, we concluded that many of the management initiatives have contributed to improving the effectiveness of the inspection program in the District and have gained substantial acceptance as their positive impacts have become evident.

Soon after MSHA established the District 11 Office in October 1995, the newly assigned manager and assistant manager began their internal assessment of office operations. Since the new office was being upgraded from what had previously been a field office, management determined a need to make certain changes to existing systems and procedures, and to establish new ones. As is often the case with reorganizations, our interviews confirmed that management faced initial resistance to many of its proposed changes.

Predictably though, resistance to such changes has diminished over time. While some inspectors interviewed had voiced early concerns, those concerns were not universally held, and many of those who had indicated initial resistance now admitted their gradual understanding and acceptance of the changes. This is attributable to a number of factors including, the two years that have elapsed, the maturing of the workforce, as well as the introduction of staff from other districts.

When the new management team arrived in Birmingham, they found an inspection staff who had been working out of the field office for quite some time. As inspectors retired or transferred, a number of replacements were brought in from other MSHA districts. The new staff were initially viewed with some skepticism but, ultimately, have been received as positive additions. These new inspectors brought their inspection experience and techniques from other parts of the country, thereby enhancing both the enforcement activities and overall professionalism of District 11.

Another issue that prompted considerable discussion among the inspectors interviewed was that of unsupportable violations. As has already been discussed elsewhere in our report, this was an area that concerned not only District 11 management but also the Office of the Solicitor. The management team’s efforts to improve the overall quality of citations and orders issued by inspectors, and their insistence on inspectors citing violations that would be supportable if taken to litigation, has resulted in a 60 percent decrease in contested violations. These actions have
further enhanced the professionalism of the inspection workforce and also resulted in renewed confidence in MSHA’s enforcement efforts by many company operators.

Our interviews with several mining industry officials confirmed that the practices instituted with the establishment of the District have improved MSHA’s image for performing quality inspections. As with any change in leadership, some of the mine operators were skeptical at first of the initiatives proposed by the new District 11 management team. As a result of early meetings and discussions encouraged by MSHA, the operators’ initial perceptions have changed and they now view the agency as a more professional and efficient partner in the effort to keep the mines safe.

During interviews, the UMWA raised a concern regarding a general lack of presence in the mines by supervisory inspectors. Likewise, MSHA management saw the need to improve supervisory oversight. Therefore, District management instituted a requirement that field office supervisors and specialist supervisors must observe an inspector in the performance of a mine inspection at least 20 times per quarter. That requirement was further enhanced by having inspectors turn in their citations on a daily basis. These two changes alone have increased supervisory field presence and improved oversight.

Coverage on all shifts is always a concern for MSHA management. Inspectors are required to observe mining operations on all shifts, including weekends. While neither the Mine Act nor MSHA regulations or policies prescribe the extent of inspections required on any shift, inspections must include representation across each of the shifts. Although the number of owl shift inspections is low (approximately 5% in 1995 and 1996), the proportion of accidents occurring on the owl shift that resulted in lost-time injuries is 30 percent, which does not appear disproportionate to the other shifts.

Analysis of the inspection data supported the position that the issue of inspection coverage, while complicated by MSHA’s “First 40” work schedule restrictions, has not been a problem. The “First 40” work schedule requires an inspector to work five consecutive days, beginning on Sunday (but no later than Monday). While management is not permitted by the labor-management contract to schedule an inspector’s tour of duty to begin on Tuesday, supervisors have the authority to approve an inspector’s request to begin his or her tour on a day other than Sunday or Monday. In addition, two inspectors per field office provide Saturday inspection coverage on an overtime basis. As the workforce continues to mature, non-standard work shifts are becoming more predominant in order to further ensure a reasonable presence in the mines, seven days a week.

Another initiative undertaken by the management team was the formation of an Accident Prevention Group (APG). Previously, two resident inspectors had been assigned to each of eight underground mines: JWR #3, #4, #5, and #7; Drummond’s Chetopa, Shoal Creek and Mary Lee #1; and Pittsburg & Midway’s North River. The decision was made to form an APG by taking one inspector from each of these mines. In addition to their accident prevention activities, these inspectors were also used to assist the resident inspectors in the completion of AAA inspections at any of the mines, as needed. While this was seen as a positive change by many inspectors, attrition gradually reduced the size of the group to two inspectors. As a consequence,
management redeployed two resident inspectors to each of the following five mines: JWR #3, #4, and #7; Shoal Creek; and USX’s Oak Grove. Now, inspectors are shifted where resources are needed and availability permits, particularly at the end of a quarter.

In summary, our review determined that the efforts undertaken by District 11 management were generally based on sound management practices and principles. Not every decision made by them has been received favorably, nor has every decision remained unchanged. We have concluded though, that those management decisions were made in a sincere effort to improve the overall effectiveness of District 11 enforcement activities.

IV. Conclusions

The UMWA’s concerns are symptomatic of significant problems in achieving effective communication between District 11 and UMWA officials. First, certain issues, such as the UMWA’s February 12, 1996, complaint, could possibly have been avoided through early and open good-faith meetings between the parties, including the District manager. Second, District 11 personnel from the inspector-level to the District manager must endeavor to fully communicate to the Union MSHA’s policies on enforcement of the Mine Act, as well as evolving legal issues. This could help avoid any UMWA perception of lax enforcement, such as in the JWR haulage case, by clearly establishing certain MSHA jurisdictional limitations. Third, even in those instances when the UMWA inaccurately or unfairly maligns MSHA officials, the agency can still learn from UMWA concerns. For example, although the UMWA used inflammatory rhetoric in claiming malfeasance on the part of MSHA inspectors in the fatal accidents at Drummond-Kellerman and JWR #5 in November 1995, we did find that all MSHA inspectors could greatly benefit from increased training in the area of above-ground structural inspections.

Finally, we conclude that both MSHA employees and UMWA officials in District 11 are very dedicated to the safety and health of miners in Alabama. Ideally, MSHA and the UMWA can find additional approaches to communicate and work better together to achieve their mutual goals.

V. Recommendations

We recommend that the Assistant Secretary for Mine Safety and Health:

1. Ensure that the District 11 Conference Officer improves communications with inspectors by providing regular briefings regarding those judicial or Commission decisions that affect the issuance of citations and orders.

MSHA Response

“We agree that communications between the District 11 Conference/Litigation Representative (CLR) and the inspectorate regarding judicial and Federal Mine Safety and Health Review Commission (Commission) decisions that affect the issuance of citations and orders can be
improved. To accomplish this goal, we have instructed the CLR to conduct monthly briefings with the inspectorate and advise them of any new Administrative Law Judge (ALJ) or Commission decisions which have impacted Agency enforcement actions. To ensure that the CLR has the most current information regarding these decisions, we have subscribed to the *Legal Quarterly Digest of Mine Safety and Health Decisions (Digest)*. This is a quarterly newsletter which captures all of the latest ALJ and Commission decisions. In addition, we have also provided the CLR with a software application and the necessary training which will enable the CUR to access the *Westlaw database*. This database has a compendium of several years of ALJ, Commission, Circuit Court and Supreme Court decisions which have affected Agency enforcement strategies and inspection activities.

**OIG’s Conclusion**

On the basis of MSHA’s response, we consider this recommendation resolved. To close this recommendation, we would appreciate receiving a copy of the instructions to the CLR, if provided in writing. In addition, please provide the dates of any monthly briefings conducted thus far for the inspectors and the meeting agendas, if prepared.

2. Provide copies to inspectors and supervisors alike of those FMSHC and AU rulings that serve as the basis for a CLR’s decision.

**MSHA Response**

“In conjunction with the above recommendation, the CLR will retrieve from both the Digest and the Westlaw database, all judicial and Commission decisions that impact the manner in which an inspector conducts an inspection and/or enforces a regulation. The CLR will provide copies of these decisions to the inspectorate and their first line supervisors. The CUR will also ensure that any related questions or issues are promptly addressed.”

**OIG’s Conclusion**

We concur with the corrective actions described by MSHA and have, therefore, resolved and closed this recommendation.

3. Ensure that thorough training is provided to all inspectors on identification of potential above-ground structural hazards. This training could include the course that has already been developed by the engineers at MSHA’s Pittsburgh technical center and presented to members of the UMWA. This training should be provided to all new inspectors as part of their normal Academy curriculum, and incorporated with the normal training and instruction activities conducted with UMWA safety and health officials.

**MSHA Response**

“The Agency agrees that the training for inspectors who are responsible for inspecting surface structures can be improved. We will supplement the current training curriculum for surface
inspectors with the subject matter developed by the Pittsburgh Technical Support Center (PTSC) and recently presented to the United Mine Workers of America (UMWA) and the surface inspectors in District 11. This course focused on a visual safety evaluation of surface structures. If the person inspecting the structure identified potential physical problems such as erosion, cracking, shifting and settling, he would contact the appropriate regulatory authority for a more in-depth evaluation. In our case, it would mean that we would contact the structural engineers from the PTSC. We will also incorporate this training into the curriculum for new inspectors and periodically discuss this inspection activity at district health and safety meetings, UMWA Safety Committee training seminars and Surface Health and Safety seminars.”

**OIG’s Conclusion**

We concur with MSHA’s proposed corrective actions and consider this recommendation resolved. In order to close this recommendation, please provide us with a copy of the training curriculum for surface inspectors and new inspectors when these materials are available.

4. Encourage continuation of the joint meetings and dialog sessions initiated in Alabama between MSHA District management and inspectors, UMWA safety and health committeemen, Local and International Union representatives, and industry officials each quarter to foster increased communication and understanding. Such meetings should focus on the issues highlighted in this report, particularly the subjects listed below.

- How do the Mine Safety and Health Act’s statutory and regulatory limitations influence MSHA’s enforcement activities?
- What are MSHA’s policies and procedures regarding the inspection of coal mines, especially in regard to 103 (g)s, haulage, above-ground structural inspections, conflicts of interest, and the nature and severity of violations?
- What are the safety and health concerns of the UMWA at specific mines?
- In what areas have MSHA enforcement policies and procedures changed or evolved in recent years?

The benefits of these sessions should be evaluated six months after the date of this report. If these sessions do not prove useful, MSHA should seriously consider obtaining the services, on a pilot basis, of a facilitator with training expertise in problem-solving skills and win/win negotiating or similar conflict resolution strategies to guide and enhance the meetings.

**MSHA Response**

“We agree that it is vitally important to the success of any health and safety program to ensure that there is a viable communication link between all interested parties. Accordingly, we will continue to conduct quarterly health and safety meetings between our management and inspection personnel, labor officials and representatives, and mine operators and other
interested parties. These meetings will focus on all health and safety issues, particularly those that deal with (1) the Mine Act’s statutory and regulatory influence on MSHA enforcement activities; (2) MSHA’s inspection procedures for 103 (g) inspections, haulage inspections, above-ground structural inspections and the Agency’s position on conflicts of interest and the nature and severity of violations; (3) the safety and health concerns of the UMWA at specific mines; and (4) the evolution of MSHA’s enforcement policies and procedures over recent years.

We will evaluate the outcome of these meetings on a semiannual basis. If the meetings do not provide the forum for discussing and developing substantive solutions to health and safety issues, MSHA will explore the possibility of enlisting an individual(s) with subject matter expertise in problem solving and conflict resolution.”

OIG’s Conclusion

Prior to the issuance of our draft report, District 11 had initiated credible efforts, through the quarterly health and safety meetings, to address the communications issues we cited. We, therefore, consider this recommendation to be resolved. We would appreciate receiving a copy of your first semi-annual evaluation of the outcome of these meetings. Based upon the evaluation’s results, we will determine whether the recommendation should be closed or whether further actions are appropriate.

5. Institute a policy, consistent with MSHA’s ethics guidelines and labor-management agreement, requiring inspection personnel to disclose to agency management officials both immediate family relationships with mine employees and any other personal relationships that may give the appearance of a conflict of interest. Following the issuance of the policy, provide guidance to managers regarding appropriate considerations and steps for addressing potential personal conflicts of interest.

MSHA Response

“We agree that MSHA employees must conduct their work in a highly professional manner and that there is no room for even the appearance of a conflict of interest in the workplace. Accordingly, we will conduct focused employee ethics training with particular emphasis on any personal relationship which creates the appearance of a conflict of interest. We will review current Agency policy on this matter and if a revision is warranted, we will implement that change. Additional guidance on how to address potential personal conflicts of interest will be provided to the managers and first-line supervisors.”

OIG’s Conclusion

We concur with MSHA’s proposed corrective actions and have resolved this recommendation. In order to close this recommendation, please provide us a copy of the curriculum for the focused ethics training and the additional guidance to managers and first-line supervisors. In addition, we would appreciate being advised of your decision regarding the need for revisions to Agency policy and receiving a copy of any such revisions.
Major Contributors to this Report:

Brent Carpenter, Team Leader
Keota Fields
Clifford Hopkins
Kevin Malone, Team Leader
Dennis Raymond
Appendix A
<table>
<thead>
<tr>
<th>Glossary</th>
<th>Definition</th>
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<tbody>
<tr>
<td>AAA</td>
<td>Quarterly mine inspection</td>
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<td>ACRI</td>
<td>Alternative Case Resolution Initiative</td>
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<td>ALJ</td>
<td>Administrative Law Judge</td>
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<tr>
<td>APG</td>
<td>Accident Prevention Group</td>
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<tr>
<td>Block-light</td>
<td>System used for underground traffic control. Very similar to traffic lights, mantrips may enter sections of track (blocks) only when the light is green and must stop and wait for the block to clear, when the light is red.</td>
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<tr>
<td>CMI</td>
<td>Coal Mine Inspector</td>
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<tr>
<td>CLR</td>
<td>Conference Litigation Representative</td>
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<tr>
<td>Commission</td>
<td>Federal Mine Safety and Health Review Commission</td>
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<tr>
<td>Conference Officer</td>
<td>Conference Litigation Representative</td>
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<tr>
<td>Continuous and longwall mining</td>
<td>Using machines with spiked, rotating drums or blades that extract coal by cutting/grinding it</td>
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<tr>
<td>District 11</td>
<td>MSHA’s Birmingham, AL district</td>
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<tr>
<td>DOL</td>
<td>Department of Labor</td>
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<td>Float coal dust</td>
<td>Dust carried by the air in a mine, which was produced by the cutting and grinding of coal</td>
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<tr>
<td>FMSHRC</td>
<td>Federal Mine Safety and Health Review Commission</td>
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<tr>
<td>GCJS</td>
<td>Granular Coal Injection System</td>
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<tr>
<td>Haulage</td>
<td>Transport of personnel, supplies, equipment, etc. inside a mine.</td>
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<tr>
<td>JWR</td>
<td>Jim Walter Resources, Inc.</td>
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</table>
Mantrip  Railroad vehicle that transports miners in and out of some mines.

Methane  Explosive gas present in coal mines

Mine Act  Mine Safety and Health Act of 1977

MSHA  U.S. Mine Safety and Health Administration

NDL  No Days Lost incidence category

NFDL  Non-fatal Days Lost incidence category

OACE  Office of Analysis, Complaints and Evaluations

OI  Office of Investigations

OIG  Office of Inspector General

Owl shift  Night shift in coal mines

POV  Pattern of Violations

Rock dust  Crushed limestone spread around the walls and roof of a mine to prevent explosions fueled by coal dust

Section  Active, working part of a mine

SOL  Department of Labor’s Office of Solicitor

S&S  Significant and Substantial violation

UMWA  United Mine Workers of America

USX  U.S. Steel Corporation

Working Face  Any place in a coal mine in which work of extracting coal from its natural deposit in the earth is performed during the mining cycle.

103 (g)  Section of the Mine Act specifying a miner’s right to request an MSHA spot inspection.
<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
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<tbody>
<tr>
<td>103 (k)</td>
<td>Section of the Mine Act - order to withdraw personnel from a mine</td>
</tr>
<tr>
<td>104 (e)</td>
<td>Section of the Mine Act - Pattern of Violations</td>
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</table>
MEMORANDUM FOR F.M. BROADWAY  
Assistant Inspector General for Analysis,  
Complaints and Evaluations  

FROM: J. DAVITT McATEER  
Assistant Secretary for  
Mine Safety and Health  


This is in response to your memorandum of August 31 and the attached subject draft report. We have thoroughly reviewed the report and we agree with its stated conclusions and recommendations. Following is our response to each of the recommendations and the corrective actions we will implement to satisfactorily address these recommendations:

1. We agree that communications between the District 11 Conference/Litigation Representative (CLR) and the inspectorate regarding judicial and Federal Mine Safety and Health Review Commission (Commission) decisions that affect the issuance of citations and orders can be improved. To accomplish this goal, we have instructed the CLR to conduct monthly briefings with the inspectorate and advise them of any new Administrative Law Judge (ALJ) or Commission decisions which have impacted Agency enforcement actions. To ensure that the CLR has the most current information regarding these decisions, we have subscribed to the Legal Quarterly Digest of Mine Safety and Health Decisions (Digest). This is a quarterly newsletter which captures all of the latest ALJ and Commission decisions. In addition, we have also provided the CLR with a software application and the necessary training which will enable the CLR to access the Westlaw database. This database has a compendium of several years of ALJ, Commission, Circuit Court and Supreme Court decisions which have affected Agency enforcement strategies and inspection activities.

2. In conjunction with the above recommendation, the CLR will retrieve from both the Digest and the Westlaw database, all judicial and Commission decisions that impact the manner in which an inspector conducts an inspection and/or enforces a regulation. The CUR will provide copies of these decisions to the inspectorate and their first line supervisors. The CUR will also ensure that any related questions or issues are promptly addressed.
3. The Agency agrees that the training for inspectors who are responsible for inspecting surface structures can be improved. We will supplement the current training curriculum for surface inspectors with the subject matter developed by the Pittsburgh Technical Support Center (PTSC) and recently presented to the United Mine Workers of America (UMWA) and the surface inspectors in District 11. This course focused on a visual safety evaluation of surface structures. If the person inspecting the structure identified potential physical problems such as erosion, cracking, shifting and settling, he would contact the appropriate regulatory authority for a more in-depth evaluation. In our case, it would mean that we would contact the structural engineers from the PTSC. We will also incorporate this training into the curriculum for new inspectors and periodically discuss this inspection activity at district health and safety meetings, UMWA Safety Committee training seminars and Surface Health and Safety seminars.

4. We agree that it is vitally important to the success of any health and safety program to ensure that there is a viable communication link between all interested parties. Accordingly, we will continue to conduct quarterly health and safety meetings between our management and inspection personnel, labor officials and representatives, and mine operators and other interested parties. These meetings will focus on all health and safety issues, particularly those that deal with (1) the Mine Act’s statutory and regulatory influence on MSIHA’s enforcement activities; (2) MSHA’s inspection procedures for 103 (g) inspections, haulage inspections, above-ground structural inspections and the Agency’s position on conflicts of interest and the nature and severity of violations; (3) the safety and health concerns of the UMWA at specific mines; and (4) the evolution of MSHA’s enforcement policies and procedures over recent years.

We will evaluate the outcome of these meetings on a semiannual basis. If the meetings do not provide the forum for discussing and developing substantive solutions to health and safety issues, MSHA will explore the possibility of enlisting an individual(s) with subject matter expertise in problem solving and conflict resolution.

5. We agree that MSHA employees must conduct their work in a highly professional manner and that there is no room for even the appearance of a conflict of interest in the workplace. Accordingly, we will conduct focused employee ethics training with particular emphasis on any personal relationship which creates the appearance of a conflict of interest. We will review current Agency policy on this matter and if a revision is warranted, we will implement that change. Additional guidance on how to address potential personal conflicts of interest will be provided to the managers and first-line supervisors.

We thank you for the opportunity to review and comment on the subject draft report. We always welcome any constructive criticism which will enable us to do a better job protecting the working environment of our Nation’s miners. If you have any questions concerning our comments, please contact Robert A. Elam at (703) 235-9423.
1 Under section 103(g)(1) of the Mine Act, miners and their representatives have the right to obtain an immediate (103(g)) MSHA inspection when there are reasonable grounds to believe that a violation of the Mine Act has occurred, or an imminent danger exist. Miners also have the right to be notified of negative findings of MSHA inspection results (30 CFR 43.6) before an inspector leaves the mine, and may request an informal hearing with MSHA to challenge any negative findings (30 CFR 43.7). In terms of immediacy, the Mine Act stipulates that 103(g) complaints must be investigated as “soon as possible.”

2 The 103(g) process exists because of the reality that MSHA inspectors cannot be everywhere. The Mine Act assumes that miners and their representatives are an integral part of assuring mine safety through 103(g) complaints.