No. 04-759

In the Supreme Court of the United States

UNITED STATES OF AMERICA, PETITIONER

v.

JOSEPH OLSON, ET AL.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

JOINT APPENDIX

PAUL D. CLEMENT
Acting Solicitor General
Department of Justice
Washington, D.C. 20530-0001
(202) 514-2217

Counsel of Record
for Petitioner

THOMAS COTTER
HARALSON, MILLER, PITT,
FELDMAN & MCANALLY, PLC
One South Church Avenue
Suite 900
Tucson, AZ 85701
(520) 792-3836

Counsel of Record
for Respondents

PETITION FOR WRIT OF CERTIORARI FILED: DEC. 3, 2004
CERTIORARI GRANTED: MAR. 7, 2005

TABLE OF CONTENTS

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Docket No. 03-15141

JOSEPH OLSON, HUSBAND; MONICA OLSON, WIFE; JAVIER VARGAS, A SINGLE MAN, PLAINTIFF-APPELLANTS

v.

UNITED STATES OF AMERICA, A POLITICAL ENTITY, DEFENDANT-APPELLEE

DOCKET ENTRIES

DATE	PROCEEDINGS
1/24/03	DOCKETED CAUSE AND ENTERED APPEARANCES OF COUNSEL. CADS SENT (Y/N): no. setting schedule as follows: appellant's designation of RT is due 1/21/03,,; appellee's designation of RT is due 1/29/03; appellant shall order transcript by 2/10/03,,; court reporter shall file transcript in DC by 3/11/03,; certificate of record shall be filed by 3/18/03; appellant's opening brief is due 4/28/03,,; appellees' brief is due 5/27/03; appellants' reply brief is due 6/10/03,,; [03-15141] (dg)

DATE	PROCEEDINGS
1/24/03	Filed Civil Appeals Docketing Statement served on (to CONFATT) [03-15141] [03-15141] (dg)
1/31/03	Filed aplts' ntc of order of transcript. RT ordered 1/28/03. [03-15141] (jr)
2/13/03	Rec'd ntc of appearance of Mark B. Stern and Dana J. Martin as csl for aple. [03-15141] (jr)
2/24/03	Filed order (Deputy Clerk: bls/CONFATT) a settlement assessment conference will be held by telephone on 3/20/03 at 10:00 a.m. PACIFIC (San Francisco) Time. The brfing schedule previously set by the court remains in effect. [03-15141] (jr)
3/24/03	Filed order CONFATT (MAC) this appeal will not be selected for inclusion in the Mediation Program. [03-15141] (jr)
4/23/03	Filed motion of aplts to extend time to file opening brf until 5/26/03 and deputy clerk order (Deputy Clerk: MO) aplts' motion for an extension of time to file the opening brf is granted. [4716919-1] The opening brf is due 5/27/03. The answering brf is due 6/26/03. The optional rpy brf is due 14 days from service of the answering brf. Aplts shall monitor the issuance of the cor. (Motion recvd 4/21/03) [03-15141] (jr)

DATE	PROCEEDINGS
5/28/03	Filed certificate of record on appeal. RT filed in DC 3/10/03. [03-15141] (jr)
5/28/03	Filed original and 15 copies aplts' opening brf (Informal: no) of 27 pages & 5 copies excerpts of record in vol; served on 5/27/03. Minor defcy: no service for excerpts of record and excerpts need white covers. Notified counsel. [03-15141] (jr)
5/28/03	Filed aplts' request for oral argument; served on 5/27/03 (nan per PRO MO). [4750957] [03-15141] (jr)
6/6/03	Rec'd aplts' satisfaction of (minor) brf deficiency (proof of service for excerpts; excerpts served on 5/27/03, and white covers for excerpts). [03-15141] (jr)
6/18/03	14 day oral extension by phone of time to file Appellee USA's brief. [03-15141] appellees' brief due 7/10/03; appellants' reply brief due,, 14 days fr svc of ans br. (terr)
7/2/03	14 day oral extension by phone of time to file Appellant Joseph Olson, Appellant Monica Olson, Appellant Javier Vargas's reply brief. [03-15141] appellants' reply brief due 8/11/03,,; (terr)
7/11/03	Filed original and 15 copies aple's brief of 57 pages; served on 7/10/03. [03-15141] (ld)

DATE	PROCEEDINGS
8/12/03	Filed original and 15 copies aplts' rpy brf (Informal: no) of 23 pages; served on 8/11/03. [03-15141] (jr)
9/18/03	Calendar check performed [03-15141] (mw)
12/15/03	Rec'd Dana J. Martin's ltr dated 12/12/03 re: will not be available for argument 4/20/04 to 5/7/04 to (CALENDAR UNIT). [03-15141] (jr)
1/5/04	Calendar materials being prepared. [03-15141] [03-15141] (mw)
1/9/04	CALENDARED: SAN FRAN Mar 10 2004 0900 am Courtroom 1 [03- 15141] (aw)
2/10/04	FILED CERTIFIED RECORD ON APPEAL: 3 CLERK'S RECORDS, 1 REPORTER'S TRANSCRIPT, & 1 BULKY DOCUMENT #83. (ORIGINAL) [03-15141] (sd)
3/10/04	ARGUED AND SUBMITTED TO Betty B. FLETCHER, Stephen R. REINHARDT, Jane A. Restani [03-15141] (ba)
4/2/04	FILED PER CURIAM OPINION: REVERSED AND REMANDED (Terminated on the Merits after Oral Hearing; Reversed; Written, Signed, Published. Betty B. FLETCHER; Stephen R. REINHARDT; Jane A. Restani.) FILED AND ENTERED JUDGMENT. [03-15141] (crw)

DATE	PROCEEDINGS
4/16/04	Filed aplts' bill of costs in the amount of $761.50; served on 4/15/04. [03-15141] (jr)
4/28/04	Filed aple's response in opposition to bill of costs; served on 4/27/04. [03-15141] (jr)
5/17/04	[5065422] Filed original and 50 copies aple's petition for panel rehearing and petition for rehearing en banc 17 pages; served on 5/14/04 to (PANEL & ALL ACTIVE JUDGES). [03-15141] (jr)
6/8/04	Filed order (Betty B. FLETCHER, Stephen R. REINHARDT, Jane A. Restani): Within 21 days from the date of this order, aplt shall file an orig and 50 copies of a response to aple's pet for rhrg en banc. The response shall not exceed 15 pages in length. [03-15141] (gar)
6/30/04	Filed aplts' response to aple's petition for rehearing and rehearing en banc [5065422-1]; served on 6/29/04 to (PANEL & ALL ACTIVE JUDGES). [03-15141] (jr)
7/21/04	Filed order (Betty B. FLETCHER, Stephen R. REINHARDT, Jane A. Restani) the petition for rehearing and the petition for rehearing en banc are DENIED. No further petitions for panel or en banc rehearing will be entertained. [03-15141] (jr)

DATE	PROCEEDINGS
7/29/04	MANDATE ISSUED. Aplt's bill of cost and request to file and aple's objection referred to OPERATIONS. [03-15141] (jr)
8/17/04	Filed order (Deputy Clerk: lbs/PRO MO) aplts' opposed motion for award of costs is granted in part. Costs are taxed against aple in the amount of $479.31. This order serves to amend the court's prior mdt. [03-15141] (jr)
11/15/04	Rec'd ltr from the Supreme Court dated 11/9/04 extending time to file petition for writ of certiorari to and including 12/3/04 to (PANEL). [03-15141] (jr)
12/7/04	Rec'd ntc from Supreme Court: petition for certiorari filed. Supreme Court No. 04-759 filed on 12/3/04 & placed on dkt 12/3/04 to (PANEL). [03-15141] (jr) petition for certiorari GRANTED on 3/7/05. Supreme Court No. 04-759 PANEL (crw)

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA

No. 02-CV-323

JOSEPH OLSON, HUSBAND; MONICA OLSON, WIFE; JAVIER VARGAS, A SINGLE MAN, PLAINTIFF-APPELLANTS

v.

UNITED STATES OF AMERICA, A POLITICAL ENTITY, DEFENDANT-APPELLEE

DOCKET ENTRIES[*]

DATE	DOCKET NUMBER	PROCEEDINGS
6/28/02	1	COMPLAINT FILED (sjd) [Entry date 07/01/02] [4:02cv323]
7/9/02	2	RETURN OF EXECUTED summons/complaint upon dft USA on 7/3/02 (sjd) [Entry date 07/10/02] [4:02cv323]
7/26/02	3	ORDERED that pla Joseph Olson, pla Monica Olson, pla Javier Vargas show cause for failure to comply with

[*] These docket entries contain references to a separate case brought by the family of another minor, Jose Villanueva, which the district court consolidated with respondents' case. The *Villanueva* claims are not at issue in this Court.

DATE	DOCKET NUMBER	PROCEEDINGS
		Local Rule 1.2(e); show cause hearing set for 9:30 8/12/02 for Javier Vargas, for Monica Olson, for Joseph Olson before Judge John M. Roll (cc: all counsel) (sjd) [Entry date 07/26/02] [4:02cv323]
7/31/02	4	Party agrees to mag judge jurisdiction; show cause hearing ddl satisfied 7/31/02 (sjd) [Entry date 08/01/02] [4:02cv323]
8/6/02	5	MOTION to consolidate cases by dft USA [5-1] (sjd) [Entry date 08/07/02] [4:02cv323]
8/26/02	6	Party elects assignment of case to district judge; mag election form ddl satisfied 8/26/02 (pb) [Entry date 08/26/02] [4:02cv323]
8/26/02	7	MINUTE ORDER Pursuant to Local Rule 1.2(e), a request has been received for a random reassignment of this case to a District Judge. Case reassigned by random draw to Judge William D Browning

DATE	DOCKET NUMBER	PROCEEDINGS
		(with notice sent). All further pleadings should now list the following COMPLETE case number: CIV-02-323-TUC-WDB (cc: all counsel,jcc,wdb) [7-2] (pb) [Entry date 08/26/02] [4:02cv323]
9/3/02	8	ORDER by Judge William D. Browning granting motion to consolidate cases by dft USA [5-1] Case Amparo Villanueva et al v USA CV-01-663-TUC-WDB AND Joseph Olson v USA CV-02-343-TUC-WDB are consolidated for all further proceedings; Clerk of the Court shall use CV-01-663-TUC-WDB as the LEAD case for all filings; parties shall use the above caption on all further pleadings filed in these matters (cc: all counsel) (sjd) [Entry date 09/03/02] [4:02cv323]
9/6/02	—	ORDER by Judge William D. Browning granting motion to exceed the page limit for doc(s) Memorandum in Sup-

DATE	DOCKET NUMBER	PROCEEDINGS
		port of Motion to Dismiss by dft USA in 4:01-cv-00663 [29-1] in 4:01-cv-00663 (cc: all counsel) (sjd) [Entry date 09/06/02] [4:01cv663 4:02cv323]
10/2/02	—	ORDER by Judge William D. Browning granting motion to extend time to 10/18/02 to repond to Amended Complaint by dft in 4:01-cv- 00663 [33-1] in 4:01-cv-00663 (cc: all counsel) (sjd) [Entry date 10/02/02] [4:01cv663 4:02cv323]
10/2/02	—	ORDER by Judge William D. Browning granting motion to extend time to 10/18/02 to repond to dft's motion to dismiss by plas Olson and Vargas in 4:01-cv-00663 [32-1] in 4:01-cv-00663 (cc: all counsel) (sjd) [Entry date 10/02/02] [4:01cv663 4:02cv323]

DATE	DOCKET NUMBER	PROCEEDINGS
12/4/02	—	MINUTE ORDER setting motion to dismiss for lack of jurisdiction by dft USA in 4:01-cv-00663 [36-1] at in 4:01-cv-00663 10:30 12/12/02 in 4:01-cv-00663, in 4:02-cv-00323, setting motion to dismiss case by dft USA in 4:01-cv-00663 [28-1] at in 4:01-cv-00663 10:30 12/12/02 in 4:01-cv-00663, in 4:02-cv-00323 (cc: all counsel) [0-1] (sms) [Entry date 12/04/02] [4:01cv663 4:02cv323]
12/26/02	—	ORDER by Judge William D. Browning granting the motion to permit supplement opposition to motion to dismiss, granting defendant's motion to dismiss all of the claims of the Olson and Vargas plaintiffs. In addition, they shall not have the opportunity to amend their complaint. The Court may deny amendment if such amendments would be futile. The Court believes that any amendments would be futile and accordingly,

DATE	DOCKET NUMBER	PROCEEDINGS
		denies any amendments to the Olson and Vargas complaint. Pursuant to FRCP 54(b) there is no just reason for delaying a final judgment as to these plaintiffs, and as such, the Clerk of the Court shall enter a final judgment as to the Olson and Vargas plaintiffs. Defendant's motion to dismiss the Villanueva plaintiffs' claim for intentional infliction of emotional distress is granted. Because the Court believes that any amendment of the complaint on this claim would be futile, any amendments on this claim are denied. Defendant's motion to dismiss the Villanueva plaintiffs' remaining claims is denied. (br) [Entry date 12/26/02] [4:01cv663 4:02cv323]

DATE	DOCKET NUMBER	PROCEEDINGS
12/26/02	—	JUDGMENT by Judge William D. Browning: Decision by Court, ordered and adjudged that defendant's motion to dismiss all of the claims of the Olson and Vargas Plaintiffs is granted. Pursuant to Rule 54(b) of the FRCP there is no just reason for delay and judgment is entered in favor of defendants and against plaintiffs Olson and Vargas. It is further ordered that defendant's motion to dismiss the Villanueva plaintiffs' claim for intentional infliction of emotional distress is granted. Further ordered that defendant's motion to dismiss the Villanueva Plaintiff's remaining claims is denied. (cc: all counsel) (br) [Entry date 12/26/02] [4:01cv663 4:02cv323]
1/9/03	—	REPRESENTANTION STATEMENT by Joseph Olson in 4:01-cv-00663, Monica Olson in 4:01-cv-00663, Javier Vargas in 4:01-cv-00663, pla Joseph Olson in 4:02-cv-00323,

DATE	DOCKET NUMBER	PROCEEDINGS
		pla Monica Olson in 4:02-cv-00323, pla Javier Vargas in 4:02-cv-00323 re: Notice of Appeal (kt) [Entry date 01/16/03] [4:01cv663 4:02cv323]
2/28/03	—	ANSWER to complaint (amended) [24-1] in 4:01-cv-00663, complaint [1-1] in 4:02-cv-00323 by dft USA in 4:01-cv-00663, dft USA in 4:02-cv-00323 (kt) [Entry date 03/04/03] [4:01cv663 4:02cv323]
3/6/03	—	ORDER by Judge William D. Browning; prel scheduling conf set for 10:00 4/23/03 in 4:01-cv-00663, in 4:02-cv-00323 bfr Judge Browning's law clerk Kevin Rudh at 520-205-4512. Pla cnsl shall initiate the status conference by calling the law clerk with both parties on the line (cc: all counsel) (kt) [Entry date 03/06/03] [4:01cv663 4:02cv323]

DATE	DOCKET NUMBER	PROCEEDINGS
3/10/03	—	Court Reporter's Transcript of Proceedings of PRE-TRIAL MOTIONS HEARING by Court Reporter: Melodee Horton for the following date(s): December 18, 2003 re NOTICE OF APPEAL [58- 1] in 4:01-cv-00663 (kt) [Entry date 03/18/03] [4:01cv663 4:02cv323]
4/24/03	—	SCHEDULING ORDER by Judge William D. Browning ; discovery due 10/21/03 in 4:01-cv-00663, in 4:02-cv-00323; dispositive motions due 12/22/03 in 4:01-cv-00663, in 4:02-cv-00323; Status report ddl set for 7/23/03 in 4:01-cv-00663, in 4:02-cv-00323, Joint proposed pretial order 30 days prior to trial (cc: all counsel) re: order (scheduling) [0-1] (lmf) [Entry date 04/24/03] [4:01cv663 4:02cv323]

DATE	DOCKET NUMBER	PROCEEDINGS
4/28/039		Certified Copy of 9th Circuit Order re: Appellants' motion for an extension of time to file the opening brief is granted. The opening brief is due 5/27/03. The answering brief is due 6/26/03. The optional rply brief is due 14 days from service of the answering brief. Court records do not currently reflect that the district court has issued the certificate of record. Appellants shall monitor the issuance of the certificte (cc: judge) [9-1] (kt) [Entry date 04/29/03] [4:02cv323]
6/4/03	—	STIPULATION to extend time to respond by pla Amparo Villanueva in 4:01-cv-00663 (lmf) [Entry date 06/06/03] [4:01cv663 4:02cv323]
2/4/04	—	Clerk's record on appeal transmitted to 9th Circuit re: 1 Court case file (jkm) [Entry date 02/04/04] [4:02cv323]

DATE	DOCKET NUMBER	PROCEEDINGS
3/17/04	10	MINUTE ORDER, setting motion for summary judgment by dft USA in 4:01-cv-00663 [84-1] at in 4:01-cv-00663 10:00 4/12/04 in 4:01-cv-00663, in 4:02-cv-00323 (cc: all counsel) [10-3] (lmf) [Entry date 03/17/04] [Edit date 04/16/04] [4:01cv663 4:02cv323]
7/29/04	11	CERTIFIED COPY of 9th Circuit Mandate; On consideration whereof, it is now here ordered and adjudged by this Court, that the judgment of the said District Court in this casuse be, and hereby is REVERSED AND REMANDED (cc: all counsel/ judge) [11-1] (jkm) [Entry date 08/09/04] [4:02cv323]
8/11/04	—	MOTION by pla Joseph Olson in 4:02-cv-00323, pla Javier Vargas in 4:02-cv-00323 for status conference [0-1] (lmf) [Entry date 08/12/04] [4:01cv663 4:02cv323]

DATE	DOCKET NUMBER	PROCEEDINGS
8/17/04	13	CERTIFIED COPY of 9th Circuit Mandate (AMENDED MANDATE) Appellants' opposed motion for award of costs is granted in part. See 9th Cir. R. 39-1.1. Costs are taxed against the appellee in the amount of $479.31. Appellants are referred to Fed. R. App. P.39(e) with regard to recovering costs for transcripts. This order serves to amend the court's prior mandate. (cc: all counsel/ judge) [13-1] (jkm) [Entry date 08/25/04] [4:02cv323]
8/20/04	—	Original Record Returned from 9th Circuit re 1 original file; (jkm) [Entry date 08/20/04] [4:02cv323]
8/24/04	12	ORDER by Judge William D. Browning; prel scheduling conf set for 10:00 9/16/04 (cc: all counsel) (lmf) [Entry date 08/24/04] [4:02cv323]

DATE	DOCKET NUMBER	PROCEEDINGS
9/22/04	—	SCHEDULING ORDER by Judge William D. Browning ; discovery due 6/1/05 in 4:01-cv-00663, in 4:02-cv-00323; dispositive motions due 7/1/05 in 4:01-cv-00663, in 4:02-cv-00323 ; pretrial order due 8/1/05 in 4:01-cv-00663, in 4:02-cv-00323 ; Status report ddl set for 12/17/04 in 4:01-cv-00663, in 4:02-cv-00323 (cc: all counsel) re: order (scheduling) [0-1] (lmf) [Entry date 09/22/04] [4:01cv663 4:02cv323]
12/23/04	—	ORDER by Judge William D. Browning ; stay deadline set for 4:01-cv-00663, in 4:02-cv-00323 pending writ certiorari., case stayed as to (cc: all counsel) (lmf) [Entry date 12/23/04] [4:01cv663 4:02cv323]
2/15/05	—	MINUTE ORDER Case reassigned to Judge Alfredo C. Marquez (with notice sent) (cc: all counsel) [0-2] (pb) [Entry date 02/15/05] [4:01cv663 4:02cv323]

DATE	DOCKET NUMBER	PROCEEDINGS
2/15/05	—	MINUTE ORDER It is ordered this case is reassigned to Judge Marquez. All future documents must carry the following case number and court designation CV01-663-TUC-ACM (cc: all counsel) [0-1] re: order (minute) [0-1] (lmf) [Entry date 02/15/05] [4:01cv663 4:02cv323]
3/7/05	—	ORDER by Judge Alfredo C. Marquez It is ordered this case shall be reassigned to Judge Bury; Case reassigned to Judge David C. Bury; all future documents shall carry the following case number and designation CV 01-663-TUC-DCB and CV 02-323-TUC-DCB (cc: all counsel) (lmf) [Entry date 03/07/05] [4:01cv663 4:02cv323]

DATE	DOCKET NUMBER	PROCEEDINGS
3/23/05	—	ORDER by Judge David C. Bury denying as moot motion for reconsideration of Courts Order granting stay of proceedings pending review by plaintiffs Olson and Vargas [107-1] in 4:01-cv-00663 (cc: all counsel) (kt) [Entry date 03/23/05] [Edit date 03/23/05] [4:01cv663 4:02cv323]

UNITED STATES DISTRICT COURT
DISTRICT OF ARIZONA

CIV02-323TUC JCC

1. JOSEPH OLSON AND 2. MONICA OLSON, HUSBAND AND WIFE; AND 3. JAVIER VARGAS, A SINGLE MAN, PLAINTIFFS

v.

4. UNITED STATES, DEFENDANT

[Filed: June 28, 2002]

COMPLAINT
(FEDERAL TORT CLAIM)

---

1. This action arises under Title 28, United States Code, Section 2671 et seq. The Court has jurisdiction under 28 U.S.C. § 1346.

2. Venue is proper under 28 U.S.C. § 1402(b) because all acts and omissions complained of herein occurred within this district.

3. Plaintiffs Joseph and Monica Olson are husband and wife.

4. Plaintiff Javier Vargas is a single man.

5. Plaintiffs Olson and Vargas were employed as copper miners at the Mission Mine owned and operated

by Asarco Mining Company where they were seriously injured on January 31, 2000, while working in the mine.

6. Defendant United States of America, through its agency the United States Department of Labor, operates the Mine Safety and Health Administration ("MSHA"). Under the Federal Mine Safety and Health Act of 1977, MSHA is required to conduct inspections of underground mines for the purpose of, among other things, determining whether an imminent danger to the health and safety of miners exists. MSHA has the responsibility to require withdrawal of miners from any portion of a mine where an imminent danger exists.

7. Between May, 1999, and September 22, 1999, the MSHA field office in Mesa, Arizona received five anonymous telephone complaints concerning safety conditions at the Asarco Mission Mine, an underground mine in Pima County, Arizona.

8. James Kirk was the MSHA Mesa field office supervisor who answered each of the calls and received the privileged information communicated by the callers.

9. All acts and omissions complained of herein by Mr. Kirk were within the scope of his employment by the defendant United States.

10. During each of the calls, Mr. Kirk was requested to inspect the Mission Underground Mine for excessive underground heat, lack of roof bolting to prevent rock falls, and lack of ventilation. Mr. Kirk was further informed that miners who had complained about the conditions and safety violations had been subjected to illegal retaliation by Asarco.

11. Asarco's failure to employ adequate roof bolting was corroborated by files maintained by MSHA itself. These files were available to Mr. Kirk when the calls

were received. Specifically, MSHA's Safety and Health Technology Center's Roof Control Division issued a report in November, 1997, which identified weakness at the Asarco Mission Underground Mine in roof bolting and the related areas of scaling of loose rock and stabilizing of rock. MSHA knew that Asarco was resistant to bolting in the mine and had refused to follow the recommendation in the report.

12. Mr. Kirk had also received an anonymous written complaint in January, 1999, which stated that Asarco employed inadequate ground support and roof bolting at the mine, and that the company barricaded areas prior to the arrival of MSHA inspectors so that unsafe conditions would not be observed by those inspectors.

13. MSHA knew that the safety violations described in its files and reported by the callers, including the lack of roof bolting, created hazardous conditions which could kill or seriously injure Asarco Miners. Nonetheless, MSHA failed to conduct an immediate and thorough inspection of the Asarco Underground Mission Mine. The failure of James Kirk to order or conduct an immediate and thorough inspection of the Mission Underground Mine in response to the telephone complaints was a violation of a mandatory duty under MSHA procedures. That violation of a mandatory duty was a proximate cause of the injuries sustained by Plaintiffs Joseph Olson and Javier Vargas on January 31, 2000.

14. At all relevant times Alan Varland was employed as a mine inspector by MSHA. All acts and omissions complained of herein were undertaken by Mr. Varland within the scope of his employment by defendant United States.

15. On September 28, 1999, Mr. Varland was in the course of conducting a regularly scheduled inspection of the mine when a miner approached him and spoke with him. The miner complained to Mr. Varland that conditions in the mine were unsafe. He specifically stated that Asarco did not employ sufficient measures to prevent rock falls. In spite of the specific complaints, Mr. Varland did not conduct a thorough inspection of the mine. His failure to do so violated mandatory MSHA policies. His violation of mandatory MSHA policies was a proximate cause of the injuries suffered by Joseph Olson and Javier Vargas on January 31, 2000.

16. On January 31, 2000, Asarco instructed Joseph Olson and Javier Vargas to load explosives in an area of the mine known as "Stope 215 North." Asarco originally developed Stope 215 North using artificial ground support. Stope 215 North had not been mined between 1997 and 1999. When Asarco began mining ore from Stope 215 North in 1999, it changed the mining plan from "breast down mining" to "fan back stopping." The fan back stopping method used by Asarco in Stope 215 North required miners to work beneath unsupported and unstable rock ceilings.

17. On January 31, 2000, Asarco ordered Joseph Olson and Javier Vargas to work in Stope 215 North beneath an unstable rock ceiling from which the artificial ground support had been removed. That ceiling had also been subjected to drilling, blasting, and a second round of drilling. It could not be properly supported because the ore from the previous mining cycle had been mucked out and the back was too high for the ground support to be installed.

18. Joseph Olson and Javier Vargas were seriously and permanently injured on January 31, 2000, when a

nine-ton slab of rock fell from the roof of Stope 215 North.

19. The violations described herein of mandatory duties under MSHA policies and procedures caused the injuries to Joseph Olson and Javier Vargas.

20. The violations described herein of mandatory duties under MSHA policies and procedures increased the risk that Joseph Olson and Javier Vargas would be killed by falling rock at the Mission Underground Mine. Alternatively, Joseph Olson and Javier Vargas were injured because they relied on MSHA to respond to the complaints.

21. Under the circumstances, the defendant United States would be liable under the law of the State of Arizona for personal injury if it were a private person. Alternatively, mine inspection for miner safety is a uniquely governmental activity. Under Ninth Circuit case law, the test is whether the state or local government would be liable and in Arizona, they would.

22. As a result of defendant's negligence, Plaintiffs Joseph Olson and Javier Vargas suffered severe, permanent and disabling injuries.

23. As a further proximate result of defendant's negligence, Plaintiffs have expended and will expend in the future large sums of money for medical bills.

24. As a further proximate result of defendant's negligence, Plaintiffs have lost income and are likely to incur further income loss and diminished earning capacity in the future.

25. As a further proximate result of defendant's negligence, Plaintiff Monica Olson has been deprived of

the love, comfort, support and companionship of her husband, Joseph Olson.

26. As a further proximate result of defendant's negligence, Plaintiffs have suffered emotional injuries and a diminishment in enjoyment of life.

27. Plaintiffs Joseph and Monica Olson presented their claim in writing to the United States Department of labor for damages in the amount of $2,500,000. The Department of Labor denied this claim on April 24, 2002. This complaint is being filed within 6 months of the denial of the plaintiffs' tort claim.

28. Plaintiff Javier Vargas presented his claim in writing to the United States Department of Labor for damages in the amount of $2,500,000. The Department of Labor denied this claim on April 24, 2002. This complaint is being filed within 6 months of the denial of the plaintiffs' tort claim.

WHEREFORE, plaintiffs request relief as follows:

1. General and special damages in amount to be proven at trial, including but not limited to, damages for past, present and future medical expenses, loss of earnings, and an amount that will fully compensate plaintiffs for the injuries sustained and for their pain and suffering.

2. An amount to compensate plaintiff Monica Olson for her loss of consortium;

3. For such other relief as this Court deems just and proper.

DATED this 28 of June, 2002.

HARALSON, MILLER, PITT & McANALLY, P.L.C.

BY: /s/ THOMAS G. COTTER
THOMAS G. COTTER
Attorney for Plaintiffs

UNITED STATES DEPARTMENT OF LABOR
MINE SAFETY AND HEALTH ADMINISTRATION
METAL AND NONMETAL MINE SAFETY AND HEALTH

Report of Investigation
Underground Metal Mine (Copper)

Fatal Fall of Ground Accident
January 31, 2000

Mission Mine
ASARCO, Incorporated
Sahuarita, Pima County, Arizona
ID No. 02-02626

Accident Investigators
Larry O. Weberg

Supervisory Mine Safety and Health Inspector
Robert V. Montoya

Mine Safety and Health Inspector
Joseph A. Cybulski, P.E.

Supervisory Mining Engineer
Michael A. Evanto, P.G. Geologist
Thomas E. Lobb

and

Michael J. Getto
Physical Scientists Explosives & Blasting
Originating Office
Mine Safety and Health Administration
Rocky Mountain District
P.O. Box 25367, DFC, Denver, CO 80225-0367
Claude N. Narramore, District Manager

OVERVIEW

Jose Villanueva, miner, age 59, was killed and Joseph A. Olson, Jr., miner, age 52, and Javier Vargas, operator, age 44, were seriously injured on January 31, 2000, when a slab fell from the back of a stope where they were loading blastholes.

The accident occurred because ground support had not been installed after a series of first back-lifts had been taken out. An examination and test for loose ground had not been conducted prior to work commencing.

Villanueva had a total of 37 years experience as an underground miner. He had worked at this operation for 14 months. All three miners had received training in accordance with 30 CFR Part 48.

GENERAL INFORMATION

The Mission Mine, a multi-level underground copper mine, owned and operated by ASARCO, Incorporated, was located near Sahuarita, Pima County, Arizona. The principal operating official was John D. Low, general manager. The mine was normally operated three, 8-hour shifts a day, 7 days a week. A total of 85 persons was employed; of this number 64 worked underground.

The ore body rested within a block of paleozoic-era, carbonate rocks which had been altered to skarns, locally known as tactites. These mineralized rocks were faulted into contact with unmineralized mesozoic-era argillite. Copper-bearing ore was drilled and blasted from stopes at various levels in the mine. Broken material was transported to the surface on trucks where it was dumped near the mine opening. The material was then loaded onto surface haulage trucks and transported to the mill for crushing, grinding and processing.

The last regular inspection at this operation was completed on November 23, 1999. Another inspection was conducted in conjunction with this investigation.

DESCRIPTION OF THE ACCIDENT

On the day of the accident, Jose Villanueva (victim) reported for work at 4:00 p.m., his normal starting time for the afternoon shift. He, Joseph Olson, Jr. and Javier Vargas were assigned to load blastholes in the 215-north stope, which had been drilled during the previous shift. Approximately 85 holes were to be loaded with ANFO prill blasting agent. A Getman series 2-500 ANFO loading boom truck was brought into the stope, but the back was too high, so a JLG 600S telescopic boom lift was brought in to reach the top holes. The Getman truck contained the ANFO loading equipment which included two, 1,000 pound capacity stainless steel lined ANFO pots, a vibrator and 50 feet of delivery hose.

The crew worked without unusual incident until about 8:00 p.m., when the slab fell from the back of the stope. The slab measured approximately 9-1/2 feet by 11-1/2 feet by 1-1/2 feet and weighed an estimated nine tons. It struck the boom of the JLG manlift. Villanueva and Olson were loading holes from the man basket and were jostled out. They fell approximately 20 feet to the floor. Vargas was operating the Getman prill dispenser and was injured when the slab rolled off the boom and struck him.

Louis Marrujo, shift supervisor, came to the area moments after the accident occurred. Mechanics from the surface shop and miners from other working places came to assist. Emergency medical technicians and an ambulance crew assisted the victims and prepared

them for transportation. Olson was airlifted and Vargas was taken by ambulance to a hospital in Tucson, Arizona. Villanueva was pronounced dead at the scene by the County Coroner. Death was attributed to crushing injury to the torso.

INVESTIGATION OF THE ACCIDENT

MSHA was notified at 9:30 p.m., on the day of the accident by a telephone call to Ronald Renowden, safety and health specialist, from Robert Jordan, safety administrator for the mining company. An investigation was started the next day. MSHA's investigation team traveled to the mine and made a physical inspection of the accident site, interviewed a number of persons, and reviewed documents relative to the job being performed by the victim, his co-workers and their training records. An order was issued pursuant to Section 103(k) of the Mine Act to ensure the safety of miners. The miners' representative participated in the investigation.

DISCUSSION

The accident occurred in the 215-north stope at the intersection of the L and 9 drifts. Initial development of this stope began in 1996. It had not been worked for about two years until two weeks prior to the accident. Drifts were mined typically 20 to 25 feet wide and approximately 25 feet high. Artificial ground support consisted of 8-foot long split-set friction rock stabilizers, installed in conjunction with 6-inch by 6-inch bearing plates, and 8-foot long steel mats. The split-sets were installed on roughly 4-foot by 4-foot centers with the steel mats typically oriented longitudinally down a drift. At the time of the accident, portions of the 215-north were being back stoped. This mining method

involves taking two additional lifts from the back in a previously developed stope, each about 10 to 12 feet high, leaving a final stope height of 40 to 44 feet. A series of first back-lifts was completed east of the K access drift and included the 9, 10, and L drifts, including the accident site.

The ore being mined in the 215-north stope generally consisted of hanging-wall garnet skarn bounded by footwall argillite waste rock. The rock composing the back and ribs consisted of the hanging wall high-grade garnet skarn, footwall waste argillite, an intrusive igneous dike, and a lens of waste wollastonite skarn.

Total overburden above the underground mine varied from 300 feet to 1,500 feet, depending upon location in the ore body relative to the pit wall. Overburden at the accident site was estimated to be 430 feet.

Over-mining had taken place in the 221 stope directly above the accident site. After one back-lift had been taken, sill thickness was estimated to be 36 feet at the time of the accident. Reportedly, the designed minimum sill thickness after completion of the second back-lift was 20 feet. The closest undermining to the accident site was in the 213 stope and was located below drift 10 on the 215 stope.

Prior to mining the first series of back-lifts in the 215 stope, a mechanical scaler was used to remove the steel mats from the back. Reportedly, during this process some of the split sets were also brought down. The first series of back-lifts then brought down the remaining split-sets. No split-sets were installed after the back-lifts had been taken. Stope height, measured at several locations in this area, ranged from 29 to 34 feet. At the time of the accident, about 85 blastholes were being

loaded with explosives. The holes were 1-1/2 inches in diameter and drilled to a depth of ten feet. These holes were to be the completion of the first series of back-lifts and the start of the second back-lift. Two holes for the second back-lift had been drilled through the slab that fell.

The failed slab was composed of wollastonite skarn. Maximum dimensions of the fallen slab were approximately 11-1/2 feet by 9-1/2 feet and 1-1/2 feet in thickness. The fall cavity in the back was bounded on the southeastern side by a joint striking approximately north 20 degrees to 30 degrees east and dipping approximately 70 degrees southeast. This southeastern side was the thick side (18-inches) of the failed rock. The northern and western edges of the fall cavity were feathered and did not follow any observed geological discontinuity. The northern edge appeared to coincide with the lateral extent of the wollastonite skarn. The distance that the rock broke into the back was within the wollastonite lens and did not follow any observed geological discontinuity, suggesting that the top failure surface was likely created by previous blasting of the back.

A visual inspection revealed explosives scattered throughout the accident scene and additional explosives loaded in the back. No potential source for detonation was observed and it was determined that the first step in the recovery operation was to remove the explosives that had not been loaded. Thirty holes had been loaded, primed and tied together with detonating cord. It was determined that the loaded explosives did not pose a hazard once the detonation cord was cut.

Removal of the scattered explosives from the accident scene and their return to the magazine, along with the

severing of the detonating cord from the roll and the flushing of the ANFO pots, effectively remediated the potential explosives hazards that existed at the scene.

CONCLUSION

The accident was caused by previous blasting of the back that probably loosened the slab of rock. A thorough examination and test of ground conditions had not been done prior to work activities commencing in the stope. Ground support, which had been installed during the development phase of the stope, had not been replaced in the back after being blasted out during the back-lift mining cycle. Failure to wear safety belts while working from the elevated basket likely contributed to the severity of the accident.

ENFORCEMENT ACTIONS

Order No. 7934317 was issued on January 31, 2000, under the provisions of Section 103(k) of the Mine Act:

> A serious accident resulting in a fatality to one miner and serious injuries to two others occurred at this operation on January 31, 2000, when a fall of ground occurred. This order is issued to assure the safety of persons at this operation until the mine or affected areas can be returned to normal operations as determined by an authorized representative of the Secretary. The mine operator shall obtain approval from an authorized representative for all actions to recover persons, equipment, and/or return affected area of the mine to normal operations.

This order was terminated on February 4, 2000, after it was determined that the mine could safely resume normal operations.

Citation No. 7904504 was issued on February 2, 2000, under the provisions of Section 104(d)(1) of the Mine Act for violation of 30 CFR 57.3200:

> One miner was fatally injured and two others were seriously injured at this operation on January 31, 2000, when a slab of rock fell from the back while they were working in the 215-north stope. The loose ground that created the hazard had not been taken down or supported. Failure to scale or support hazardous ground is a serious lack of reasonable care constituting more than ordinary negligence and is an unwarrantable failure to comply with a mandatory safety standard.

This citation was terminated on April 24, 2000. The 215-north stope was abandoned and the area was barricaded and posted to prevent entry.

Order No. 7904505 was issued on February 2, 2000, under the provisions of Section 104(d)(1) of the Mine Act for violation of 30 CFR 57.3401:

> One miner was fatally injured and two others were seriously injured at this operation on January 31, 2000, when a slab of rock fell from the back while they were working in the 215-north stope. Examination and testing for loose ground had not been conducted prior to commencement of work. Failure to examine and test ground is a serious lack of reasonable care constituting more than ordinary negligence and is an unwarrantable failure to comply with a mandatory safety standard.

This order was terminated on April 24, 2000. The 215-north stope was abandoned and the area was barricaded and posted to prevent entry.

Order No. 7904506 was issued on February 2, 2000, under the provisions of Section 104(d)(1) of the Mine Act for violation of 30 CFR 57.3360:

> One miner was fatally injured and two others were seriously injured at this operation on January 31, 2000, when a slab of rock fell from the back in the 215-north stope. Ground support had not been installed and maintained to control the ground. Failure to support ground where persons work or travel is a serious lack of reasonable care constituting more than ordinary negligence and is an unwarrantable failure to comply with a mandatory safety standard.

This order was terminated on April 24, 2000. The 215-north stope has been abandoned and the area was barricaded and posted to prevent entry.

Order No. 7904507 was issued on February 3, 2000, under the provisions of Section 104(d)(1) of the Mine Act for violation of 30 CFR 57.15005:

> One miner was fatally injured and two others were seriously injured at this operation on January 31, 2000, when a slab of rock fell from the back while they were loading blastholes in the 215-north stope. Two of the miners were working from an elevated work basket and fell to the floor when the slab struck the boom. Safety belts and lines were not being worn. Failure to assure the use of safety belts and lines is a serious lack of reasonable care constituting more than ordinary negligence and is an unwarrantable failure to comply with a mandatory safety standard.

This order was terminated on April 24, 2000. The mine operator has reinforced the requirements of this standard through safety meetings and training.

Related Fatal Alert Bulletin:

FAB2000M05

APPENDIX A

Persons participating in the investigation

ASARCO, Incorporated

Peter Graham, general mine supervisor (underground)
Gary Torres, mine supervisor (underground)
Tomm Heyn, corporate safety director (Tucson)
Robert Jordan, safety administrator
George Zugel, safety engineer (underground)
Gary Byers, miners' representative, International Union of Operating Engineers

Patton Boggs LLP

Mark Savit, counsel

BLM Engineering of Canada

Dave West, consultant

State of Arizona

David Hamm, chief deputy state mine inspector
Tim Evans, deputy mine inspector
Phillip Howard, assistant mine inspector

Mine Safety and Health Administration

Larry O. Weberg, supervisory mine safety and health inspector
Robert V. Montoya, mine safety and health inspector

Joseph A. Cybulski, P.E., supervisory mining engineer
Michael A. Evanto, geologist
Thomas E. Lobb, physical scientist
Michael J. Getto, physical scientist

APPENDIX B

Persons Interviewed

ASARCO, Incorporated

Peter Graham, general mine supervisor (underground)
Gary Torres, mine supervisor (underground)
George Zugel, safety engineer (underground)
Louis Marrujo, supervisor (underground)
Ralph Bejarno, miner
Joey Miller, miner
Raymond Barragan, shift mechanic
Joseph Olson, Jr., miner
Javier Vargas, operator

International Union of Operating Engineers

Gary Byers, miners' representative

[Seal Omitted]

Evaluation of Hazard Complaint Handling in MSHA's Office of Metal and Nonmetal Mine Safety and Health

Mine Safety And Health Administration

REPORT NO.: 2E-06-620-0001
DATE ISSUED: MARCH 29, 2001

TABLE OF CONTENTS

ACRONYMS AND GLOSSARY

ACRONYMS

FY	Fiscal Year
MSHA	Mine Safety and Health Administration
M/NM	Metal and Nonmetal
OIG	Office of Inspector General
POV	Pattern of Violation

GLOSSARY

miner:	Any individual working in a coal or other mine.
imminent danger:	Existence of any condition or practice in a coal or other mine which could reasonably be expected to cause death or serious physical harm before such condition or practice can be abated.
representative of miner:	Any person or organization which represents two or more miners at a coal or other mine for the purposes of the Act, and who is registered with the appropriate MSHA district.

stope:	An underground excavation (usually steplike) for the removal of ore that is formed as the ore is mined in successive layers.
code-a-phone call:	Hazard complaint called into MSHA headquarters on the national toll-free (1-800) telephone number and referred to the appropriate district for complaint investigation.
103(g):	Section of Mine Act which specifies conditions of notification under which a miner or representative shall have (1) a right to obtain an immediate inspection and (2) a right to informal review of refusal to issue a citation with respect to alleged violation.

EXECUTIVE SUMMARY

From January through September 1999, six written and verbal hazard complaints were lodged with the Mine Safety and Health Administration's (MSHA) Mesa field office. Five of the complaints were established to have been lodged by a miner's grown daughter and a family friend, alleging unsafe conditions at the ASARCO Mission Mine. An accident subsequently occurred at the mine leaving the aforementioned miner dead and two of his colleagues permanently disabled.

MSHA, in partnership with the American mining community, works to eliminate fatalities, reduce the frequency and severity of accidents, and minimize health hazards associated with the mining industry in accordance with the Federal Mine Safety and Health Act of 1977 (Mine Act).

In August 2000, the Secretary of Labor requested the Office of Inspector General to review MSHA's activities surrounding the ASARCO Mission Mine accident, including whether:
(1) MSHA had adequate procedures and policies in place to ensure compliance with the Mine Act,
(2) those policies and procedures were followed by MSHA personnel, and (3) any necessary corrective actions have been taken.

RESULTS OF EVALUATION

During our evaluation, we found that MSHA's Division of Metal/Nonmetal can be more effective in responding to hazard complaints by improving the intake, manage-

ment, tracking, and analysis of complaints. While MSHA has already implemented changes in complaint handling since the fatal accident of January 2000, the further development of a more efficient and systematic complaint system is needed. The following findings identify our areas of concern.

FINDING A - MSHA Personnel Did Not Follow Hazard Complaint Handling and Inspection Policies and Procedures Regarding the ASARCO Mission Mine

Our evaluation determined that the MSHA Mesa field office supervisor and mine inspector did not follow various MSHA policies and procedures for at least six hazard complaints received from January through September 1999. Additionally, the inspection actions in response to these complaints were not conducted in a prompt and thorough manner. Subsequently, an accident occurred at the ASARCO Mission Mine which left one miner dead and two others permanently disabled.

FINDING B - Hazard Complaint Handling Procedures and Practices Are Not Consistent

Hazard complaint handling procedures and practices lack uniformity. This lack of uniformity is evidenced in the following areas: (1) hazard complaint intake and documentation procedures across districts and field offices, (2) complaint analysis as a management tool, (3) implementation of "best practice" procedures, and (4) nationwide training on hazard complaint procedures.

Finding C - **MSHA's Policies and Guidelines on the Enforcement of the Mine Safety Act Need to Be Updated**

Differences exist between the Mine Act and various MSHA policies and guidelines which interpret the Act and its accompanying regulations. These inconsistencies result in complaint handling practices frequently differing according to the interpretations of the field office supervisors and mine inspectors.

RECOMMENDATIONS

We recommend that MSHA take the following actions to improve the intake, management, tracking, and analysis of complaints. A more effective complaint process not only ensures greater accountability and public confidence but also would allow MSHA to enhance inspection activity.

Ultimately, we believe implementation of our recommendations will reduce the likelihood of the recurrence of hazard complaint handling and inspection actions similar to those surrounding the ASARCO Mission Mine accident.

Therefore, MSHA should:

(1) standardize and mandate the use of hazardous complaint handling intake, inspection and reporting forms.

(2) nationally adopt "best practices" currently used in certain districts.

(3) update and implement hazard complaint procedures to require that the mine file be reviewed by field office supervisors and mine inspectors upon receipt of a hazard complaint.

(4) develop a complaint analysis system to:

a) capture all complaints,
b) specifically track or accurately account for complaints, and
c) follow up on complaints to ensure that appropriate corrective action has been taken.

(5) further develop and update classroom training for new mine inspectors, and implement hazard complaint handling refresher courses for all journeymen mine inspectors, and for all MSHA personnel who receive hazard complaints.

(6) reconcile inconsistent language on complaint handling found between the various MSHA guidelines in accordance with the July 2000 directive.

(7) develop guidelines for district management's approval or disapproval of proposed actions on hazard complaints outside of MSHA's jurisdiction and hazard complaints deemed frivolous.

(8) establish a policy on whether and when to incorporate hazard complaints into regular inspections.

AGENCY RESPONSE AND OIG CONCLUSION

In response to OIG's official draft report, MSHA generally agreed with our findings and recommendations. MSHA provided suggested clarifications and modifications which are addressed in the findings and recommendations section of this report. As a result of corrective actions planned by MSHA, we consider all eight recommendations to be resolved. The recommen-

dations will be closed after those corrective actions are completed. The agency's complete response is found in Appendix B.

BACKGROUND

MSHA, in partnership with the American mining community, works to eliminate fatalities, reduce the frequency and severity of accidents, and minimize health hazards associated with the mining industry in accordance with the Federal Mine Safety and Health Act of 1977 (Mine Act). The Mine Act requires MSHA to inspect every underground mine four times annually and all surface mines two times annually to determine compliance with Federal safety and health regulations.

On January 31, 2000, an accident occurred at the ASARCO Mission Mine (an underground mine) in Pima County, Arizona, in which a miner with 37 years' experience was killed by a 9-ton slab of falling copper ore. The two other miners present in the area were critically injured by the rock fall.

Six Hazard Complaints Were Lodged Prior to the Accident

Prior to the accident, six written and verbal hazard complaints were lodged with MSHA's Mesa field office. The five verbal hazard complaints were lodged by that miner's grown daughter and a family friend and included charges of inadequate ground support, roof bolting and ventilation.

The first complaint, a letter dated January 25, 1999, was signed by "a concerned worker for safety of all", and was received by MSHA's Mesa field office supervisor. The letter outlined specific complaints against ASARCO Mission Mine regarding inadequate ventilation, ground support, roof bolting, and the company practice of barricading stopes before the inspector's arrival. The

Mesa field office supervisor did not assign the complaint to an MSHA inspector until six weeks later, for inclusion in a regular inspection. The inspector issued no citations.

The miner's daughter subsequently called the MSHA supervisor three times, beginning in May 1999. She did not identify herself or her father for fear of company retaliation. The miner's daughter stated that she requested that underground heat, bolting, ventilation and oxygen levels at the mine be inspected. She also reported to the Mesa field office supervisor that employees were being retaliated against for complaining about mine conditions.

When the miner's daughter felt that her complaints were being ignored by the Mesa field office supervisor, she enlisted the help of a family friend, who stated that he called the supervisor twice with the same allegations. After the last call on September 22, the field office supervisor orally passed the complaint on to the same inspector who had conducted the March 1999 inspection. Five days later (September 27), the inspector once again conducted a complaint investigation during the course of an already scheduled regular inspection, resulting in one citation for hazardous conditions (loose rock). A subsequent regularly scheduled inspection conducted in November by another mine inspector resulted in no citations.

Steps Taken By MSHA After the Accident

Beginning on February 1, 2000, a team of accident investigators from MSHA investigated the facts and conditions surrounding the accident at the ASARCO Mission Mine. Their inspection resulted in one citation and three orders issued for failure to correct hazardous

ground conditions or to examine for loose ground conditions; failure to replace previously installed ground support; and failure of miners to wear safety belts while working.

In the year 2000 after the accident, MSHA issued a total of seventeen citations related to some of the very same allegations contained in the six hazard complaints at Mission Mine. In 1999, one citation was issued in the previous year related to the hazard complaints.

An internal investigation conducted by MSHA (dated March 7, 2000) concluded that legitimate complaints were received but were not promptly investigated or properly documented. The investigation also determined that the Mesa field office supervisor failed to ensure that all complaints were handled in accordance with policy and Metal/Nonmetal procedures in place at the time of the complaints.

During May 2000, MSHA's Assistant Secretary and the Administrator for Metal/Nonmetal visited the Mesa field office to underscore the importance of responding to complaints immediately. On July 31, 2000, the Assistant Secretary issued a memorandum to all MSHA employees directing them that all complaints are to be investigated immediately irrespective of whether an official complaint was filed, and regardless of the source of the complaint. (See Appendix A.)

PURPOSE AND METHODOLOGY

On August 10, 2000, the Secretary of Labor requested the Office of Inspector General (OIG) to review MSHA's activities surrounding the January 31, 2000 accident at ASARCO Mission Mine in Pima County, Arizona. Specifically, the Secretary requested that the OIG:

> *"Review the events that occurred both before and after the accident, including whether MSHA had adequate procedures and policies in place to ensure compliance with the requirements of the Mine Safety Act, whether those policies and procedures were followed by MSHA personnel, and if not, whether corrective actions have been taken."*

PURPOSE

Our evaluation assessed the effectiveness of MSHA's complaint handling both prior and subsequent to the January 31, 2000 accident at the ASARCO Mission Mine which left one miner dead and two others permanently disabled. We reviewed complaint handling at the Mesa, Arizona field office, six Metal-Nonmetal district offices, and MSHA headquarters, in the following areas:

- whether MSHA policies and procedures were followed by MSHA personnel at the Mesa Field Office, and the adequacy of any corrective actions taken;

- whether and how effectively MSHA policies and procedures are followed by MSHA personnel nationwide; and,
- the adequacy of MSHA policies and procedures to ensure compliance with the requirements of the Mine Safety Act.

METHODOLOGY

We conducted our fieldwork on site at the MSHA National office in Arlington, Virginia; the Rocky Mountain District office; and the Denver, Colorado and Mesa, Arizona field offices with mine inspectors, field and district supervisors, and other managerial, technical and professional staff members. Our evaluation involved telephone and in-person interviews with the other five district and assistant district managers. MSHA's Directorate of Program Evaluation and Information Resources provided us with data on hazard complaint and inspection files from their Teradata database and MSHA's Metal/Nonmetal database. We reviewed a judgmental sample of actual complaint and inspection files in the Rocky Mountain district, including the Mesa field office, for the period from 1997 - 2000. Our review included related MSHA documents, such as policy and procedures, inspection and training manuals, handbooks, directives, and memoranda related to hazard complaint handling.

The detail of events surrounding the ASARCO Mission Mine fatal accident was taken from the following: court depositions of MSHA inspectors; regular inspection files including field notes; a fatality report surrounding the accident; and, an MSHA internal investigation re-

port conducted by an assistant district manager outside the Rocky Mountain district.

We conducted our evaluation in accordance with the *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency. A meeting was held on January 25, 2001, with MSHA's Division of Metal/Nonmetal to discuss our findings.

FINDINGS AND RECOMMENDATIONS

Finding A - MSHA Personnel Did Not Follow Hazard Complaint Handling and Inspection Policies and Procedures Regarding the ASARCO Mission Mine

Our evaluation determined that the MSHA Mesa field office supervisor and mine inspector did not follow various MSHA policies and procedures for at least six hazard complaints received from January through September 1999. Additionally, the inspection actions in response to these complaints were not conducted in a prompt and thorough manner. Subsequently, an accident occurred on January 31, 2000 at the ASARCO Mission Mine which left one miner dead and two others permanently disabled.

Hazard Complaint Handling

We found that MSHA's Mesa field office supervisor did not effectively follow two components of hazard complaint policies and procedures in relation to the ASARCO Mission Mine hazard complaints:

1. Determination of Who May File a Complaint
2. Determination of Imminent Danger or Health and Safety Violation

We determined that MSHA's mine inspector assigned to investigate the complaints violated MSHA policy in the following area:

3. Protecting Miner Confidentiality

We also found that the inspection actions in response to the hazard complaint allegations were not conducted in a prompt and thorough manner.

1. Determination of Who May File a Complaint

We believe that the Mesa field office supervisor improperly determined that the six complaints received were not *valid* hazard complaints.

During the period January through September 1999, a total of six hazard complaints (both written and verbal) were received by MSHA's Mesa field office supervisor. Five of these complaints were later established by MSHA to be lodged by the deceased miner's daughter and a family friend. The anonymous complaints requested that underground heat, roof bolting, ventilation and oxygen levels at the mine be inspected. These complaints alleged conditions similar to those that resulted in the miner's death.

According to MSHA's March 7, 2000 internal investigation, the Mesa field office supervisor evaluated the complaints and made the determination that these complaints were not valid because the person(s) did not identify themselves. Moreover, the mine inspector stated in sworn testimony that both he and the field office supervisor believed these were not valid complaints because the verbal complaints received by the field office supervisor were not specific enough.

The Mesa field office supervisor stated that he was acting in accordance with Section 103(g) of the Mine Act which stipulates that for official hazard complaints to be registered with MSHA, the notice shall be provided in writing and signed by a representative of miners or a miner.

> *"Any such notice shall be reduced to writing, signed by the representative of the miners or by the miner, and a copy . . . provided the operator or his agent no later than at the time of inspection, except that the operator or his agent shall be notified forthwith if the complaint indicates that an imminent danger exists."*—Federal Mine Safety and Health Act of 1977, section 103(g)(1).

As a result of making this determination, the field office supervisor did not document these complaints and subsequently discarded all related notes.

We believe that the specific allegations of inadequate ventilation, ground support, and improper roof bolting were valid complaints in accordance with MSHA policies and procedures. While the Mine Act is specific about the requirements of a formal hazard complaint, MSHA has further procedures for hazard complaint handling:

> *". . . Many times, complaints concerning hazardous conditions do not meet the technical requirements of Section 103(g). The health and safety of miners are best served by examining all notifications of the possible existence of hazardous conditions, even though a specific complaint may not strictly adhere to these requirements. Accordingly, all complaints of alleged hazards . . . must be evaluated. If appropriate, inspection steps must then be taken."*—MSHA General Inspection Procedures Handbook, p. 27, dated April 1989.

We concluded that the field office supervisor did not effectively evaluate the complaints in determining a course of action. We also determined that he did not act prudently in failing to document the complaints.

2. Determination of Imminent Danger or Health and Safety Violation

MSHA policies stipulate procedures for a miner or miner's representative to request an immediate mine inspection if an imminent danger exists. The Mesa field office supervisor stated that the complaints he received did not meet the threshold test of "imminent danger," and that it was indeterminable where the alleged hazardous conditions were located in the mine. Therefore, at no time did the Mesa field office supervisor assign an inspector to conduct an immediate complaint inspection *separate from and prior to* regularly scheduled inspections.

We believe that the specific allegations of inadequate ventilation, ground support, and improper roof bolting described serious hazards and merited a complete evaluation and prompt complaint inspection separate from and prior to regularly scheduled inspections. We reached this conclusion based on our review of MSHA documents and through interviews with MSHA district supervisors and managerial and technical staff at MSHA headquarters.

Furthermore, the Mesa field office supervisor could have taken additional steps before determining that the hazard complaints received posed no threat of "imminent danger" or other serious hazard. There was information available in the ASARCO Mission Mine file maintained at the Mesa office which indicated that, in November 1997, MSHA's Safety and Health Technology Center's Roof Control Division issued a report on its evaluation of ground support and mining methods at the ASARCO Mission Mine. The report identified weaknesses in the areas of scaling, roof bolting and split-set stabilizers. These issues were similar to some

of the same allegations contained in the complaints received by the Mesa field office supervisor.

Despite the fact that the information from the November 1997 report was contained in the ASARCO Mission Mine file kept in the Mesa office, we found no indication that the Mesa field office supervisor utilized this information in making the determination whether these were valid complaints.

Finally, we believe that the information contained in the written and verbal complaints were sufficiently specific regarding the name of the mine and the hazardous conditions present to warrant a timelier inspection. The Mesa field office supervisor's explanation that it was indeterminable where the alleged hazardous conditions were located in the mine was not a sufficient rationale for delaying the investigation of the complaints for as long as six weeks initially, and for failure to more effectively evaluate and document four subsequent complaint allegations.

3. Protecting Miner Confidentiality

In his court deposition, the Mesa inspector testified that he told ASARCO Mission Mine's safety engineer the source of complaints. Hence, the confidentiality of the source was in this case breached by the MSHA inspector investigating the complaints, in violation of MSHA's confidentiality policy and procedure.

MSHA policy and procedure surrounding protection of miner's confidentiality in registering and inspecting hazard complaints state:

> "*Information received about violations or hazardous conditions should be brought to the attention of the mine operator without disclosing the identity of the person(s) providing the information.*"—

MSHA Program Policy Manual, Vol. III 43-1, April 1996.

Inspection Actions

We determined that MSHA's inspection actions in response to these hazard complaints and previously identified hazardous conditions at the ASARCO Mission Mine were not conducted in a prompt and thorough manner.

1. Inspection Actions in Response to Hazard Complaints

As previously stated, the Mesa field office supervisor did not assign an inspector to conduct an immediate complaint inspection separate from and prior to regularly scheduled inspections. Instead, he incorporated the written complaint (the first complaint received) into a regular inspection approximately six weeks (March 1999) after the letter dated January 25, 1999. No citations were issued as a result of that inspection.

A second regularly scheduled inspection occurred during April 1999, which yielded one citation pertaining to the allegations. Both the miner's daughter and the Mesa field office supervisor recalled that, beginning in May 1999, the Mesa field office supervisor received four additional phone calls alleging the same hazards. The Mesa field office supervisor did not document these complaints or take any action. He finally instructed his inspector to investigate the alleged conditions during a third regular inspection beginning on September 27, 1999, after receiving the sixth complaint on September 22, 1999. That inspection resulted in one citation for ground conditions (loose rock).

While there is evidence that the mine inspector, during the March 1999 inspection, inspected areas that were barricaded, we found no evidence that barricaded areas were subsequently inspected. During the course of the September 1999 regular inspection, the mine inspector did not enter areas barricaded off by ASARCO management. Another inspector, who inspected the area during a fourth regular inspection in November 1999, testified that the barricades implied that the area was too dangerous for MSHA inspectors to enter, and hence he did not inspect or cite ASARCO. He stated that he only entered areas of the mine that were actively working at the time of his inspection. These actions occurred despite the fact that the initial written complaint contained the allegation that "in the past, management have prepared, closed, chained, or burned off certain stopes prior to inspectors arrival only for workers to again be sent back to those areas a few days later to work under poor conditions."

We concluded, through our own review of inspection documents and through discussion with the MSHA official who conducted an internal investigation of the events surrounding the accident, that the inspections conducted in March, April and September, 1999 were not thorough in investigating the allegations of hazards described in the six hazard complaints.

2. Inspection Actions In Response To Previously Identified Hazardous Conditions

As previously mentioned, in November 1997, MSHA's Safety and Health Technology Center's Roof Control Division issued a report on ground support and mining methods at the ASARCO Mission Mine. The report identified weaknesses in the areas of scaling, roof bolting and split-set stabilizers. These issues were

similar to some of the same allegations contained in the six hazard complaints received by the Mesa field office supervisor. We were told by an MSHA official that the mine file does not contain any information which demonstrates that specific followup actions were taken by either Mesa field office or the District management regarding the weaknesses identified in the November 1997 report.

In the two years after the report, and prior to the accident, only three citations related to the weaknesses identified in the November 1997 report were issued to the ASARCO Mission Mine. An MSHA internal investigation report dated March 7, 2000, concluded that the recommendations contained in the November 1997 report were not being followed at the ASARCO Mission Mine.

Additionally, during FY 2000 and after the fatal accident, MSHA conducted numerous inspection activities and issued a total of seventeen citations that addressed the types of conditions referred to in both the November 1997 Safety and Health Technology Center Report and the six hazard complaints that were received. In a report dated April 27, 2000, the MSHA Safety and Health Technology Center again evaluated the ASARCO Mission Mine, as a follow-up to the January 31, 2000 Mission Mine accident. Many of the same weakness were identified as in the November 1997 report.

Corrective Actions Taken After the Accident

The Mesa field office supervisor was placed on administrative leave and in April 2000, he was transferred to the Rocky Mountain Coal Mine Health and Safety Division office in a non-supervisory position. In August, 2000, the inspector who investigated the hazard com-

plaints was sent a memorandum proposing his dismissal from MSHA for revealing the source of the complaints.

The Administrator for Metal/Nonmetal and the Assistant Secretary for MSHA visited MSHA's Mesa field office in May 2000 to underscore the importance of replying to complaints immediately. On July 31, 2000, the Assistant Secretary for MSHA issued a memorandum to all MSHA employees directing them that all complaints were henceforth to be investigated immediately, irrespective of whether an official complaint was filed, and regardless of the source of the complaint. At the Mesa field office, the Assistant Secretary's memorandum was distributed to all staff and the new procedures verbally reviewed in staff meetings. The field office supervisors mandated that all complaints received would be documented and investigated. These practices have continued to be enforced and monitored in the Mesa field office.

– – – – – –

In summary, the MSHA Mesa field office supervisor did not effectively follow various MSHA policies and procedures for at least six hazard complaints received from January through September 1999. The MSHA Mesa mine inspector violated MSHA policies and procedures by betraying a miner's confidentiality. Additionally, the inspection actions in response to these complaints were not conducted in a prompt and thorough manner. Corrective actions taken by MSHA are positive steps towards improving hazard complaint handling and inspection policies, procedures and practices. However, as indicated in the following findings, we identified areas where additional steps can be taken.

MSHA's Response to Findings

"The report needs to specifically differentiate between the acts of the field office supervisor and the acts of the inspector. The report leads one to believe that both the supervisor and the inspector committed all three of the acts listed on page 5. In fact, the supervisor may have failed on the first two, but only the inspector failed on the third item. This point needs to be clarified."

OIG's Conclusion

The aforementioned concerns were addressed in Finding A by separating the summaries of the actions of the supervisor from those of the inspector. The facts remain unchanged.

MSHA's Response to Findings

"The report does not adequately distinguish between a Section 103(g) hazard complaint and the more common informal hazard complaints. MSHA's regulations and policies set forth procedures for responding to hazard complaints. These include complaints that meet the requirements of Section 103(g) of the Mine Act and other, more informal complaints."

OIG's Conclusion

Our discussions of 103(g) complaints and non-103(g) complaints throughout the report are accurate and should not be altered.

MSHA's Response to Findings

"The report consistently refers to six hazard complaints lodged by the family and friends of the family. In fact, the identity of the person filing the written complaint could not be verified. The identities of the persons filing the five verbal complaints are known."

OIG's Conclusion

We have clarified throughout the body of the report that only the identities of the persons filing the five verbal complaints have been verified.

MSHA's Response to Findings

"Their (inspectors') failure to find a significant hazard does not necessarily mean that they failed to conduct a thorough investigation."

OIG's Conclusion

The report clearly states how and why thorough inspections were not conducted, that the recommendations of the 1997 Technical Report were not adequately considered in inspection activity, and that the volume of citations issued is adequately separated in the report from the thoroughness of inspections.

MSHA's Response to Findings

"We agree that the complaint should have been investigated promptly; however, without additional information regarding the conditions, location in the mine and miner exposure, the supervisor could not necessarily conclude that an imminent danger existed. He determined that the complaints addressed serious issues as evidenced by his instructions to the inspectors. Under MSHA's policies, enforcement personnel who receive non-103(g) complaints that can not be concluded to be imminent danger, have a greater degree of discretion in responding to the complaints."

OIG's Conclusion

We have modified "imminent danger" to "serious hazard" on page 7.

MSHA's Response to Findings

"The conditions complained of were not the ones that caused the accident. The accident did not occur in the area referenced in the complaint. The conditions in the stope where the fatal accident occurred were completely different than the conditions during the time that the complaints were filed. When the complaints were filed, the area where the accident occurred was an inactive section . . ."

OIG's Conclusion

We have changed the wording on page 5 of the "complaints related to some of the very conditions that resulted in the miner's death" to "these complaints alleged conditions similar to those that resulted in the miner's death."

All other miscellaneous corrections/adjustments requested in MSHA's response have been incorporated into the final report.

Finding B-	**Hazard Complaint Handling Procedures and Practices Are Not Consistent**

Hazard complaint handling procedures and practices lack uniformity. This lack of uniformity is evidenced in the following areas: (1) hazard complaint intake and documentation procedures across districts and field offices, (2) complaint analysis as a management tool, (3) implementation of "best practice" procedures, and (4) nationwide training on hazard complaint procedures.

Hazard Complaint Intake and Documentation Vary Across Districts and Field Offices

After interviewing all six district managers and their assistant district managers, we concluded that hazard complaint intake and documentation procedures are not uniform among the six MSHA Metal/Nonmetal district offices and the different field offices within the districts. For example, most of the six districts we spoke with use some variation of a hazard complaint intake form; however, we found that this practice is not uniformly applied. In some instances, instead of using this intake form, inspectors and field supervisors simply refer to the complaint in their field notes. Important information (i.e. time, date and location of complaints) may not be captured in these notes. While MSHA does include a suggested form for the intake of hazard complaints in its program policy manual, it is not an official MSHA form. Mandatory use of the form by inspectors would have to be negotiated with the National Council of Field Labor Locals, which represents the MSHA inspectors.

Another example is the handling of the hazard complaint telephone calls which come in to the district or field offices. Most of the calls are answered by the district management or field office supervisor; occasionally the calls are answered by administrative staff, who may not be trained on complaint handling. Only one district voiced its concern that administrative staff be properly trained on complaint intake.

Finally, our review disclosed that code-a-phone complaints (the 1-800 number for hazard complaints received in the National office and forwarded to the districts) may be treated with more efficiency and thoroughness than complaints directly received by

some district and field offices. Code-a-phone complaints received from the National office are often prioritized and given immediate inspection attention, and are reported back to the National office via detailed memorandum and logged into the national code-a-phone database. The code-a-phone complaint system provides an illustration of a clearly "closed loop" system wherein complaints are tracked from intake to the results of inspection findings and reported back for tracking purposes. Ideally, all complaints received at all levels—whether from a miner at a mine, or by a field or district office—should receive the same level of scrutiny, review and documentation as a code-a-phone complaint.

Complaint Analysis Can Be Utilized As A Management Tool

We believe that MSHA can be more proactive in utilizing complaint analysis to: (a) identify any relationship between hazard complaints received and previous deficiencies reported at the mine site, and (b) identify broader areas of complaint activity (i.e., by complaint type, within the mine, within field offices and/or districts, and across time).

1. Qualitative Analysis of Complaints

The mine files contain all the regular inspections conducted in a mine, and the MSHA inspection procedures require that enforcement personnel comprehensively review it prior to conducting the first inspection after receiving the assignment. However, MSHA hazard complaint procedures do not specify that the mine file should be reviewed by field supervisors or inspectors upon receipt of a hazard complaint. We believe that hazard complaint procedures should be updated to re-

quire that the mine file be reviewed by field supervisors or inspectors upon receipt of a hazard complaint.

2. Quantitative Analysis of Complaints

Analyses of complaints are not regularly or consistently conducted by district or field offices. Our evaluation determined that complaint analysis could identify patterns and trends in complaints across field offices, particular inspector travel areas, or across years, and within mines, in a similar fashion as the current practice of monitoring Patterns of Violation (POV). In October 1990, regulations to identify mine operators who meet the criteria for a Pattern of Violation became effective. These include procedures for initial screening of mines that may be developing a Pattern of Violations; criteria for determining whether a POV exists at a mine; procedures for issuance of potential pattern notice and final pattern notice; and, procedures for termination of a Notice of POV. The pattern of violation analysis allows MSHA to decide which mines warrant further consideration by the agency, which will be issued potential notices, and allows MSHA to provide assistance to the districts where requested. A complaint analysis system could similarly be developed to aid as a management tool in monitoring and tracking complaints.

The development of a complaint analysis system should: 1) capture all complaints; 2) specifically track or accurately account for complaints; and, 3) follow up on complaints to ensure that appropriate corrective action has been taken. Examples of analyses which could be conducted could compare the volume and percentage of citations and enforcement actions which result from code-a-phone calls to the comparable figures for calls received in various district and field offices and to evaluate possible reasons for any statistically signifi-

cant differences. There may also be merit in analyzing complaints later determined to be "frivolous" to better understand where and when complaints may emanate.

"Best Practice" Procedures Are Unevenly Implemented

Our review identified a number of promising practices at the district level, which could be adopted nationwide. Two districts mandate the use of a memorandum format to "narrate" the entire sequence of events surrounding a complaint, from intake/nature of complaint to inspection, findings, and resolution. We noted that this practice was effective in documenting the process from complaint intake to enforcement action. Other districts use a memorandum format sporadically.

Additionally, our review of documents at the field level suggests that the practice varies vastly, with differences both between field offices and between different supervisors in one office during different time periods.

The Southeast District has developed a handbook which systematically details how complaints should be handled. This 35-page handbook is concise; chapters are clearly indexed for easy reference and forms and templates (included on computer disks) have been developed for complaint intake. The handbook catalogues excerpts from MSHA documents which refer to complaint handling (i.e., Section 103(g), Program Policy Manual, Inspection Manual, Field Procedures Handbook, the July 2000 Assistant Secretary's Directive and OSHA/MSHA interagency agreement). It also includes the district's own directive on how complaints are to be handled. The handbook highlights the importance of complaint handling and provides inspectors with a uniform, readily-available reference guide for complaint handling.

Our review disclosed the need for improved complaint handling forms. For example, as suggested to us by one field supervisor, M/NM may want to develop a standardized "checklist" of complaint inspection activity, as an alternative to the current practice of using a Miscellaneous Inspection checklist form.

Relatedly, MSHA should look to other customer complaint systems such as "911" and the IRS customer complaint handling systems as examples of comprehensive systems which emphasize the efficient handling of customer complaints through the identification, management, tracking and analysis of complaints.

Nationwide Training on Hazard Complaint Procedures Is Inadequate

Our review determined that the area of complaint handling is inadequately covered in both new inspector and refresher training. Training for new inspectors is held at the National Mine Health and Safety Academy in Beckley, West Virginia, for a total of twenty-four weeks. The Mine Act is covered in detail in the three-day course, "Law, Regulation and Policy," which includes a module on Complaint Handling. The curriculum for the course, which emphasizes the authority of the inspector, has not been updated for over three years. The module on Complaint Handling within that curriculum focuses on the handling of Section 103(g)(1) and (2) complaints, and has not been updated to reflect the Assistant Secretary's Directive of July 31, 2000. The complaint handling module comprises two pages out of a forty-five page training manual, and includes approximately half an hour of classroom instruction and discussion.

Our evaluation determined that training in complaint handling, including the written training module procedures, does not sufficiently address procedural issues of the evaluation, documentation and investigation of complaints. In particular, little or no emphasis is given to those complaints which may fall outside of 103(g). The training should be broadened to encompass these broader areas. Some of the field inspectors we spoke with suggested that inspectors seasoned in complaint handling be brought in to assist in that portion of the training, possibly through conducting presentations in the classroom setting. Refresher training for experienced miners, held every two years, was also reported to be lacking in addressing complaint handling. Both inspectors and field supervisors we interviewed stated the need for more refresher training on hazard complaint handling.

In summary, we found that hazard complaint handling procedures lack uniformity across districts and field offices. Increased uniformity will result in a more efficient handling of hazard complaints through the systematic evaluation, management, tracking and analysis of complaints.

RECOMMENDATIONS:

We recommend that MSHA take the following actions:

(1) standardize and mandate the use of hazardous complaint handling intake, inspection and reporting forms.
(2) nationally adopt "best practices" currently used in certain districts.
(3) update and implement hazard complaint procedures requiring that, where practicable, the mine file be reviewed by field supervisors or inspectors after receipt of a hazard complaint. An exception can be made in the event that a complaint is received at the mine.
(4) develop a complaint analysis system to:
    a) capture all complaints;
    b) specifically track or accurately account for complaints; and,
    c) follow up on complaints to ensure that appropriate corrective action has been taken.
(5) further develop and update classroom training for new mine inspectors, and implement hazard complaint handling refresher courses for all journeymen mine inspectors, and for all MSHA personnel who receive hazard complaints.

MSHA's Response to Recommendations

(1) "M/NM is currently developing standardized forms for the receipt, handling, and disposition of hazard complaints. Where possible, standard forms will be used to record the receipt of hazard complaints, however, because of the nature of our

work, many field situations will preclude the use of the forms. Once the inspector returns to the office, however, the standard forms will be completed."

(2) "*A handbook, the Hazard Complaint Processing Handbook (HCPH), will be created so that M/NM management personnel and inspectors can address hazard complaints in a uniform fashion.*"

(3) "*This recommendation will be incorporated into the HCPH, see Recommendation #2. This recommendation, however, can not be mandatory because many complaints are received in the field and access to the files is impractical.*"

(4) "*M/NM is currently developing a system that tracks the complaint from initial notification to final resolution and ultimate closing of the complaint.*"

(5) "*M/NM's existing program will be modified to incorporate new procedures and database use. The training will deal with processing and investigating hazard complaints, and bringing the hazard complaints to final resolution. New mine inspectors will be given the training as part of the new inspector training at the Mine Academy; journeymen inspectors will be trained at their next scheduled journeymen training session; and appropriate administrative personnel will be trained.*"

OIG's Conclusion

We concur with the proposed corrective actions and consider recommendations 1 through 5 resolved. The recommendations will be closed after those corrective actions are completed. In that regard, please submit a

detailed action plan and timetable for each recommendation by no later than **May 31, 2001.**

Finding C –	MSHA's Policies and Guidelines on the Enforcement of the Mine Safety Act Need to Be Updated

Differences exist between the Mine Act and various MSHA policies and guidelines which interpret the Act and its accompanying regulations. These inconsistencies result in complaint handling practices frequently differing according to the interpretations of the field office supervisors and mine inspectors.

Differences Exist Between Various MSHA Policies and Guidelines

As depicted earlier in Finding A, the Mine Act specifies that complaints coming from a miner or representative of miners (registered with the district, representing at least 2 miners) are in accordance with Section 103(g) of the Mine Act. However, various MSHA guidelines differ from the definition contained in the Mine Act, each other, and the latest directive, dated July 31, 2000, issued by MSHA's Assistant Secretary. For example, MSHA's Program Policy Manual extends valid complaints as follows:

> *"A different situation exists when an inspector receives information about violations or hazards in a mine, and the information is given in an informal manner that does not meet the requirements of Sections 103(g)(1) or 103(g)(2) in that the notice is not in writing. In these situations, the inspector receiving the information must evaluate and determine a course of action, which in some cases may result in an immediate inspection, but*

> *in other cases may not.*"—MSHA Program Policy Manual, Vol. III Part 43-1, dated April 1996.

In comparison, MSHA's Field Reports Procedures Handbook, limits consideration of hazard complaints to those that are filed by a representative of miners, etc.

> "*Hazard complaints are filed by a representative of miners or union officials or any miner who has reasonable grounds to believe that a violation of the Act or of a mandatory health or safety standards exists or that an imminent danger exists.*" —MSHA Field Reports Procedures Handbook, p. 9-1, dated February1989.

The above excerpt is incongruous with the broader interpretation of the Policy Program Manual, as well as the spirit and intent of an earlier version of MSHA's publication, "A Guide to Miners' Rights," which stipulated that:

> "*At any time any person may, and is encouraged to, notify MSHA of any violation of the Act or safety or health standards, or of an imminent danger.*"—A Guide to Miners' Rights, p. 8, reprinted 1989.

It should be noted that the FY 2000 update to the "Guide to Miners' Rights," deletes the above section and, instead limits hazard complaints to miners and miner's representatives.

Notwithstanding that differences exist between the various guidelines listed above, the inconsistency continues with the Assistant Secretary's July 2000 directive issued to all MSHA employees stating:

> "*No matter who makes the complaint or how we receive it, any complaint about a safety or health*

> *concern in MSHA's jurisdiction must be taken seriously. If the complainant provides enough information to identify the location and the hazard of concern, it must be promptly investigated. . . . A complaint can come from a miner, family member, or <u>any</u> concerned person . . . If someone informs you that a specific hazard exists in a specific mine, then that should be treated as a complaint."*—July 31, 2000 memorandum of the Assistant Secretary for MSHA.

We believe that the July 2000 directive, while sweeping in its intent, could be further developed in procedural terms. The investigation of complaints outside of the letter of the Mine Act's sections 103(g)(1) and (2) is very important, and various MSHA policies and guidelines should be updated to reflect the latest directive. Various documents including the Program Policy Manual, the Field Reports Procedures Handbook, and the Inspection Handbook should be updated to reflect the July 2000 directive.

Furthermore, we identified certain additional written guidelines issued by the Southeast District which we believe should also be considered when updating the various MSHA guidelines. For example:

> *"All verbal complaints 'shall be reduced to writing' by the MSHA employee receiving the complaint . . . A verbal complaint information form is to be completed when a telephone complaint is received."*—Hazard Complaints Conditions Handbook, Southeast District, Section 1, page 1, FY 2000.

The Southeast District also states its prioritization of verbal complaints as requiring equal attention to written complaints:

> "*Telephone and verbal complaints are general notices of alleged violations and are given the same attention and consideration as written complaints.*"—Hazard Complaints Conditions Handbook, Southeast District, Section V.f, page 4, FY 2000.

No comparable language on documentation or prioritization of verbal complaints exists in National-level policies and guidelines. We believe that all existing MSHA policies and guidelines should be reviewed to ensure consistency.

Some Complaints Are Not Covered by the Mine Safety Act

According to several MSHA district managers, the July 2000 directive is now *literally* interpreted, leaving field supervisors little room for discretion about: (1) complaints in which MSHA's jurisdiction is unclear; and, (2) complaints which can be established as "frivolous" in nature. Currently, there is no formal system for field supervisors to confer with district management in deciding, on a case-by-case basis, which complaints do not fall within MSHA's jurisdiction or are frivolous in nature.

(1) Regarding unclear jurisdiction, district managers and field supervisors now immediately inspect environmental complaints from neighborhoods adjacent to mines, i.e. excessive dust, noise, and explosion vibrations. Several district managers stated that they do not have the discretion or adequate guidelines to refer the call out to a more appropriate agency. While an exist-

ing OSHA-MSHA interagency agreement outlines enforcement guidelines on unsafe and unhealthy working conditions, OSHA's jurisdiction does not extend to environmental complaints outside of work areas.

(2) The July 2000 directive does not differentiate between "frivolous" complaints, which are now responded to immediately and not clearly distinguished from imminent danger calls. Some managers and field inspectors viewed the investigation of frivolous and even some non-imminent danger complaints as taking away from regular inspection responsibilities; yet, a literal interpretation of the July 2000 directive does not permit a distinction in the prioritization of such complaints.

We believe that guidelines should be developed to formally document district management's approval or disapproval of field offices' proposed actions surrounding environmental complaints outside of MSHA's jurisdiction and complaints deemed frivolous by both field and district offices.

MSHA Lacks a Policy on the Incorporation of Complaints into Regular Inspections

Currently, MSHA does not have a clear policy on the practice of "folding" hazard complaint inspections into regular inspections. Several district supervisors stated that, unless a miner cites a complaint during the course of a regular inspection, all written and verbal hazard complaints are to be investigated separately and issued a separate event number in MSHA's Management Information Systems. However, one district manager and his assistant voiced the concern about miner confidentiality, particularly in small mines. They felt that, in order to preserve such confidentiality, the option to fold

hazard complaints into regular inspections was a discretionary judgement which should not be unilaterally removed from MSHA policy.

The issues of timing of inspection activity and of coding complaints are also involved. If a hazard complaint about a mine comes directly to a district or field office shortly before a regularly scheduled inspection at that mine, it may be prudent to send an inspector out on the regular inspection and to simultaneously investigate the complaint. We believe MSHA should explore developing a procedure wherein hazard complaints, in *exceptional* cases and with the consultation of district supervisors, can be permitted to be folded into regular inspections. This procedure should allow for both documentation and coding of complaint activity to identify, track and monitor complaints.

We believe that differences exist between the Mine Safety Act and the various MSHA guidelines on hazard complaint handling. A review and update of existing MSHA guidelines that are consistent with the July 2000 directive will be a positive step in assuring that all hazard complaints are properly handled.

RECOMMENDATIONS:

We recommend that MSHA take the following actions:

(6) reconcile inconsistent language on complaint handling found between the various MSHA guidelines in accordance with the July 2000 directive.
(7) develop guidelines for district management's approval or disapproval of proposed actions on complaints outside of MSHA's jurisdiction and complaints deemed frivolous.
(8) establish a policy on whether and when to incorporate complaints into regular inspections.

MSHA's Response to Recommendations

(6) *". . . Any inconsistencies in MSHA's Program Policy Manual, MSHA's Inspection Procedures Handbook, and Internet postings will be reconciled in the HCPH."*

(7) *"This procedure is already in place for the code-a-phone complaints handled by the headquarters office and will be incorporated into the HCPH referred to earlier. Guidelines will be developed and incorporated into the HCPH for dealing with trivial hazard complaints."*

(8) *"M/NM will establish a procedure on whether and when to incorporate hazard complaints into regular inspections."*

OIG's Conclusion

We concur with the proposed corrective actions and consider recommendations 6 through 8 resolved. The recommendations will be closed after those corrective actions are completed. In that regard, please submit a detailed action plan and timetable for each recommendation by no later than **May 31, 2001**.

APPENDIX A

July 31, 2000 Memorandum for MSHA's Assistant Secretary to all MSHA Employees Regarding Complaint Handling

[Seal Omitted]

U.S. Department of Labor Mine Safety and
Heath Administration
4015 Wilson Boulevard
Arlington, Vrginia 22203-1984

[Dated: JUL 31 2000]

TO ALL MSHA EMPLOYEES:

This is to remind everyone in MSHA of how important it is that we recognize and respond promptly to all safety and health complaints.

No matter who makes the complaint or how we receive it, any complaint about a safety or health concern in MSHA's jurisdiction must be taken seriously. If the complaint provides enough information to identify the location and the hazard of concern, it must be promptly investigated.

In addition, if a complainant asks to be anonymous, that request must be respected.

MSHA maintains a 24-hour "Hot Line" for safety and health complaints:
telephone (804) 746-1554.

However, miners and others do not have to use the agency "Hot Line" to make a mine safety or health complaint. A complaint can be made in person, by telephone, through 'the "Hot Line," by e-mail or in writing.

A complaint can come from a miner, family member, or *any* concerned person.

The complainant does not need to say, "I am making a safety (or health) complaint." If someone informs you that a specific hazard exists in a specific mine, then that should be treated as a complaint.

If you receive a complaint, and you have not been trained to handle complaints as part of your job, then write down the information and the person's name and phone number—if provided—and *immediately* contact the appropriate district manager, the Administrator's Office of Coal Mine Safety and Health on (703) 235-9423 or the Administrator's office for Metal/Nonmetal Mine Safety and Health on (703) 235-1565 for instructions.

Regular mine inspections detect many hazards. However, the mining environment can change daily, even hourly. Sometimes the only way MSHA can learn about a potentially deadly hazard is when someone tells us about it.

Last year, MSHA responded to 783 mine safety and health complaints, and as a result many safety and health hazards were detected and corrected.

Every one of us need to be aware, to recognize and take all mine safety and health complaints seriously. Miners and their families depend on us.

Sincerely,

/s/ J. DAVITT MCATEER
J. DAVITT MCATEER
Assistant Secretary for
Mine Safety and Health

APPENDIX B

Agency Response

[Seal Omitted]

U.S. Department of Labor Mine Safety and
Heath Administration
4015 Wilson Boulevard
Arlington, Vrginia 22203-1984

[Dated: MAR 16, 2001]

MEMORANDUM FOR JOSE M. RALLS

Assistant Inspector General
Office of Analysis, Complaints, and Evaluations

FROM: ROBERT A. ELAM /s/ Robert A. Elam
Acting Assistant Secretary for
Mine Safety and Health

SUBJECT:

Evaluation of Hazard Complaint Handling in MSHA's
Office of Metal and Nonmetal Mine Safety and Health
Report No. 2E-06-620-000l

Thank you for the opportunity to comment on your draft Report No. 2E-06-620-000l, titled "Evaluation of Hazard Complaint Handling in MSHA's Office of Metal and Nonmetal Mine Safety and Health (M/NM)." The report thoroughly addresses relevant issues.

Generally, we agree with the recommendations set forth. We believe, however, that the report should be clarified and modified as described below. We would welcome the chance to meet and explain our concerns and reasons for the recommended changes. There are sections of the report that do not accurately reflect MSHA's policies and procedures or the facts and

circumstances surrounding the accident and the events preceding the accident.

The report needs to specifically differentiate between the acts of the field office supervisor and the acts of the inspector. The report leads one to believe that both the supervisor and the inspector committed all three of the acts listed on page 5. In fact, the supervisor may have failed on the first two, but only the inspector failed on the third item. This point needs to be clarified.

The report does not adequately distinguish between a Section 103(g) hazard complaint and the more common informal hazard complaints. MSHA's regulations and policies set forth procedures for responding to hazard complaints. These include complaints that meet the requirements of Section 103(g) of the Mine Act and other, more informal complaints. In this case, there was one anonymous written complaint. The other five were verbal and did not identify the complainant, were not signed by a representative of the miners or by a miner with reasonable grounds to believe a violation existed; and did not identify the area of the mine, or in some cases the mine itself, where the hazard or violation existed. As you note in the report, inspectors were, however, dispatched to conduct regular inspections in March and September with specific instructions to look into the conditions reported. Their failure to find a significant hazard does not necessarily mean that they failed to conduct a thorough investigation.

We agree that the complaint should have been investigated promptly; however, without additional information regarding the conditions, location in the mine and miner exposure, the supervisor could not necessarily conclude that an imminent danger existed. He determined that the complaints addressed serious

issues as evidenced by his instructions to the inspectors. Under MSHA's policies, enforcement personnel who receive non-103(g) complaints that can not be concluded to be imminent danger, have a greater degree of discretion in responding to the complaints.

The conditions complained of were not the ones that caused the accident. The accident did not occur in the area referenced in the complaint. The conditions in the stope where the fatal accident occurred were completely different than the conditions during the time that the complaints were filed. When the complaints were filed, the area where the accident occurred was an inactive section. That area did not go into production until approximately two weeks before the accident at which time the first slab round was taken from the back, opening the ground that subsequently fell. During the time when the complaints were being filed, this area was roof bolted with split set bolts. This point is never mentioned in the report.

The following is a specific list of corrections we feel are needed in addition to the general statements above:

Throughout the Report

The report consistently refers to six hazard complaints lodged by the family and friends of the family. In fact, the identity of the person filing the written complaint could not be verified. The identities of the persons filing the five verbal complaints are known.

Page 1, Paragraph 2

The last sentence sounds like only three miners were working in the mine at the time of the accident. This should say that they were in the area.

Page 1, Paragraph 4

The statement that this was the first inspection at this mine by this inspector is irrelevant and should be deleted.

Page 2, Paragraph 1

MSHA did not inspect the mine in response to the accident, rather the agency investigated the facts and conditions surrounding the accident.

Page 2

The second sentence of paragraph 2 should be deleted.

Page 2, Paragraph 4

MSHA responds to complaints rather than replying to them.

Page 2

The McAteer memo mentioned in paragraph 4 was issued after the complaints had been filed and after the accident occurred. As a result, the field office supervisor could not be responsible for handling the subject complaints according to the memo's instructions. This fact should be clearly stated.

Page 4, Paragraph 2

There has only been one report issued relative to the December 1999 fatal accident.

Page 5, Item 1 - Determination of Who May File a Complaint

The second paragraph makes it sound like the supervisor knew the complaints were from the deceased miner's family and friends. The identity of the person filing the written hazard complaint has yet to be determined (see above). A statement should be included

to note that the complaints were filed anonymously. Also, the second paragraph sounds like the complaints were ignored because they were deemed not valid. In fact, the allegations were investigated on two separate occasions. This needs to be clarified.

Page 6, Paragraph 2

There is no MSHA policy requiring that anonymous verbal complaints be reduced to writing and investigated immediately unless an imminent danger exists. This page makes it sound like there is. The statement "did not properly document these complaints . . ." should be altered to delete the word properly.

Page 6, Paragraph 4

The statement that ". . . (b) . . . on a hazard complaint intake form" is not a fair statement. MSHA neither had such a form nor required the use of a form.

Page 7, Paragraph 1

The phrase ". . . presented an imminent danger. . ." be replaced with ". . . described a serious hazard." It is not possible to determine that an imminent danger exists without specifics or an investigation of the conditions. The supervisor had neither of these at his disposal.

Page 7, Paragraph 4

Should the statement ". . . disregarding the complaint." read ". . . disregarding the complaints." or are you referring to a specific complaint? More importantly, although the supervisor did not immediately investigate the complaints, he did not disregard them.

Page 8, Paragraph 1

The Inspector General accurately notes that MSHA did respond to the complaints, albeit not in a prompt manner.

Page 9, Paragraphs 1 & 2

Replace the phrase 'hazardous conditions citations' with 'citations'.

[Excerpts of Mine Safety and Health Administration
General Inspection Procedures Handbook]

MSHA Handbook Series

[Seal Omitted]

United States Department of Labor
Mine and Safety and Health Administration
Metal and Nonmetal Safety and Health
April 1989

Handbook Number 89-IV-2

General Inspection Procedures

---

however, that regular inspections will be made of the operations once they have begun and that during the regular inspections the inspector will look at all of the notices issued during the CAV to ensure that the conditions and practices noted have been corrected. If the correction has not been made, an appropriate citation or withdrawal order will be issued. No additional penalty, monetary or otherwise, will be proposed solely because of the previous CAV.

The inspector, in conducting the CAV, is to proceed directly to the site of the CAV and is not to conduct a regular inspection of the premises. However, should an imminent danger situation be observed, an appropriate order will be issued.

5. Special Inspections - Procedures for Processing Hazardous Conditions Complaints

   a. Processing Hazardous Conditions Complaints

      Section 103 (g) of the Act provides representatives of miners or a miner (if there is no representative of miners), the right to obtain an immediate inspection when he or she has reasonable grounds to believe that a violation of the Act or of a mandatory health or safety standard exists, or that an imminent danger exists.

      In order to invoke the procedures of Section 103 (g) (1) or (g) (2) , the complaint must be reduced to writing and must be signed by the representative of miners or by the miner. However, many times, complaints concerning hazardous conditions do not meet the technical requirements of Section 103 (g). The health

and safety of miners are best served by examining all notifications of the possible existence of hazardous conditions, even though a specific complaint may not strictly adhere to these requirements. Accordingly, all complaints of alleged hazards, both from within and outside the context of the Procedures for Processing Hazardous Conditions Complaints in 30 CFR Part 43, must be evaluated. If appropriate, inspection steps must then be taken.

[Excerpts of Mine Safety and Health Administration Program Policy Manual, Volume III]

MSHA PROGRAM POLICY MANUAL VOLUME III
PART 43

PART 43 PROCEDURES FOR PROCESSING HAZARDOUS CONDITIONS COMPLAINTS

III. 43-1 Processing Hazardous Conditions Complaints

Section 103 (g) (1) of the Mine Act stipulates procedures and requirements for a representative of the miners, or a miner, to request an immediate inspection of a mine if there are reasonable grounds to believe that a violation of a mandatory standard or an imminent danger exists in the mine. Under Section 103 (g)(1), the notice must be in writing, signed by the representative of miners, or a miner, and a copy must be given to the operator by MSHA in a manner that withholds the identity of the person giving, or involved in, the notice. MSHA instructions and regulations, under 30 CFR Part 43, exist for responding to such notices received under Section 103 (g)(1), or by code-a-phone messages. These instructions and regulations also address MSHA's response to a notice of alleged violation or imminent danger given under Section 103(g)(2). These requests or notices have normally been investigated and handled in an expeditious manner.

A different situation exists when an inspector receives information about violations or hazards in a mine, and the information is given in an informal manner that does not meet the requirements of Sections 103 (g) (1) or 103 (g) (2) in that the notice is not in writing. In

these situations, the inspector receiving the information must evaluate and determine a course of action, which in some cases may result in an immediate inspection, but in other cases may not.

Inspectors should be willing to listen to all interested parties alleging violations, imminent dangers or hazards. Otherwise, the trust and cooperation that are the foundation of an effective safety effort will not be maintained. Depending upon the circumstances, the inspector may make an immediate inspection, or may incorporate the area or practices into his or her inspection schedule for attention at a later date. Likewise, the inspector may determine that the area in question has been inspected since the alleged occurrence and, consequently, the situation does not warrant further investigation. Any subsequent action by an inspector on information received outside the context of Section 103 (g) should not be considered a 103 (g) inspection; therefore, the procedures of Part 43 would not apply.

Information received about violations or hazardous conditions should be brought to the attention of the mine operator without disclosing the identity of the person (s) providing the information.

STATE OF ARIZONA)
)
ss.)
)
COUNTY OF PIMA)

The undersigned, Javier Vargas, being first duly sworn according to law, deposes and says:

1. I am one of the plaintiffs in the case of Villanueva, et al. v. United States of America, CV01-663-TUC-WDB.

2. I worked as a miner at the ASARCO Mission Underground Mine.

3. I went to work each day with the understanding that the MSHA inspectors were supposed to inspect the ASARCO Mine with the goal of making the mine a safe place for me and other miners to work. I relied on that fact, as well as the assumption that the inspectors had expertise and would use it to exercise reasonable safety practices.

Dated this 18th day of October, 2002.

/s/ JAVIER B. VARGAS
JAVIER B. VARGAS

SUBSCRIBED AND SWORN to before me this 18th day of October, 2002, by Javier Vargas.

/s/ DANIELLE R. BORDEN
DANIELLE R. BORDEN
Notary Public

My Commission Expires:

[SEAL OMITTED]

STATE OF ARIZONA)
)
ss.)
)
COUNTY OF PIMA)

The undersigned, Joseph Olson, being first duly sworn according to law, deposes and says:

1. I am one of the plaintiffs in the case of Villanueva, et al. v. United States of America, CV01-663-TUC-WDB.

2. I worked as a miner at the ASARCO Mission Underground Mine.

3. I went to work each day with the understanding that the MSHA inspectors were supposed to inspect the ASARCO Mine with the goal on making the mine a safe place for me and other miners to work. I relied on that fact, as well as the assumption that the inspectors had expertise and would use it to exercise reasonable safety practices.

Dated this 18 day of October, 2002.

/s/ JOSEPH OLSON, JR.
JOSEPH OLSON, JR.

SUBSCRIBED AND SWORN to before me this 18th day of October, 2002, by Joseph Olson.

/s/ DANIELLE R. BORDEN
DANIELLE R. BORDEN
Notary Public

My Commission Expires:

[SEAL OMITTED]