U.S. Department of Labor

Office of Inspector General
Washington, D.C. 20210

JAN 10 2003

MEMORANDUM FOR: THE DEPUTY SECRETARY

FROM: GORDON S. HEDDELL
Inspector General

SUBJECT: OIG Investigation of MSHA's Accident Investigation -- Martin County Coal Corporation

The Office of Inspector General has completed its investigation into allegations concerning MSHA's handling of its accident investigation of the impoundment spill at Martin County Coal in Martin County, West Virginia, on October 11, 2000. The OIG initiated its investigation as a result of information that it received from a Department employee. The attached Investigative Report only concerns the Martin County Coal Corporation accident investigation and possible retaliation. Additional allegations related to other MSHA operations and activities remain open within the OIG.

The OIG's Martin County Coal investigation centered on allegations that MSHA officials interfered with, and attempted to cover up, the findings of MSHA's accident investigation team. The OIG conducted interviews and collected evidence concerning 16 specific allegations related to MSHA's accident investigation. After a lengthy inquiry, the OIG did not find evidence to substantiate any of the 16 allegations.

I am providing you with the OIG's Executive Summary, our complete Investigative Report, and copies of 53 exhibits related to the Report. I am requesting that you restrict your distribution of these materials, and the information contained therein, to Department staff who have a real "need to know," and that you minimize any copying of these documents at this time.

The primary reason for making this request is to protect the privacy of sources of information, as well as the privacy of individuals who may be the subject of unsubstantiated allegations. In addition, the OIG's Report contains information about internal MSHA deliberations and decisions which should not be released to those individuals who do not have a need to know, absent additional discussions between my office and MSHA.

The OIG has already received a number of press inquiries concerning our investigation, and several Freedom of Information Act requests for our Report are

pending. Disclosures of the Report's contents by Department staff may affect the OIG's ability to protect the privacy of those individuals who were involved in this investigation when we respond to these requests.

I would be happy to discuss either the OIG Investigative Report or my request to restrict its distribution, at your convenience.

Attachments

EXECUTIVE SUMMARY

In April 2001, Jack Spadaro, the Superintendent of the Mining Safety and Health Administration (MSHA) mining academy, forwarded complaint letters to the U.S. Department of Labor, Office of the Inspector General (OIG), alleging that senior MSHA officials were covering up aspects of the Martin County Coal Corporation (MCCC) accident investigation to protect MSHA and its management. [ ] The case was referred to the Washington Regional Office (WRO) of the OIG's Office of Labor Racketeering and Fraud Investigations (OLFRI).

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During the course of the investigation, Mr. Spadaro lodged numerous complaints; he raised issues related to the MCCC accident investigation, other ongoing MSHA accident investigations, alleged retaliation against him by MSHA officials, and unrelated inappropriate actions on the part of MSHA officials. Mr. Spadaro's allegations concerning other MSHA accident investigations and inappropriate actions were forwarded to other OIG offices for action. The allegations investigated by the WRO only concerned the MCCC accident investigation and the alleged retaliation against Mr. Spadaro.

The investigation has been completed and an Investigative Report has been prepared, along with this Executive Summary. During the investigation, numerous current and former MSHA employees were interviewed in an effort to corroborate the information provided by Mr. Spadaro. Interviews with contractors and other involved parties were also conducted. The investigators also reviewed an internal review which was conducted by MSHA officials between August 2001 and September 2002, the MSHA accident investigation report, supporting engineering reports, and various notes and memoranda obtained from involved parties.

The following alleged events were addressed in the OIG Report: [ ] Team Leader Transition, Investigative File Transfer to MSHA District 3, Access denied to Shared [ ] Drive, Report Signing Issues, "Post Script" to Draft Report, Skiles' Draft Memorandum, District Response Memorandum, Citations Issued Against MCCC, [ ] Mapping Accuracy, Triad Engineering Qualification Letter, Former Special Assistant Secretary Departure, Retaliation against Spadaro, Personnel Action Resulting from MCCC Investigation, and Validity of MCCC Accident Investigation.

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The OIG found that certain events, as reported by Mr. Spadaro, actually occurred, but the OIG concluded that these events did not demonstrate that MSHA officials were attempting to cover up any facts or issues concerning the investigation.

Our investigation also did not substantiate Mr. Spadaro's allegations concerning retaliation. We concluded that, while some of the retaliation events reported by Mr. Spadaro may have occurred, they were more closely related to his duties as the Superintendent of the MSHA Mining

Academy and appeared unrelated to his involvement in the MCCC accident investigation. There appeared to be no meaningful relationship or dialog between the managers who supervised the accident investigation (who logically would have initiated actions against Mr. Spadaro) and those who supervised Mr. Spadaro in his role with the Mining Academy. We found no evidence that demonstrated any retaliatory actions had been initiated or planned.

In conclusion, none of the allegations brought forward by Mr. Spadaro were substantiated.

The attached Investigative Memorandum provides more details of our investigative findings. Should you require additional information, please feel free to contact our National or Regional offices for assistance.

Investigative Report		U.S. Department of Labor Office of Inspector General	
Subject	Violation Character	File No.	11-0801-0006-PC
Martin County Coal Corporation Accident Investigation	18 U.S.C. § 1505 (obstruction of proceedings)	Report Type	Memorandum of Investigation
		By	SA [ ] b7c
		At	Washington Regional Office
		Date	12/09/02

Introduction

This investigation is predicated on a complaint letter from Jack Spadaro, an employee of the DOL Mine Safety and Health Administration (MSHA). Spadaro, who is the Superintendent of the National Mine Health and Safety Academy (NMHSA), was assigned as a member of the MSHA accident investigation team that investigated an impoundment spill at the Martin County Coal Corporation (MCCC) mine in Martin County, KY, on October 11, 2000. According to Spadaro, MSHA Management, including the Acting Assistant Secretary, attempted to interfere regarding the scope and content of the MCCC accident investigation report. During the course of the investigation, the Office of Inspector General received other allegations from Spadaro related to the MCC accident investigation. Each of these allegations was investigated.

Reports of Interviews are referenced in this Memorandum of Investigation and are listed as exhibits. Some individuals were interviewed multiple times and the information they contributed applies to several separate sections in this report. When information included in this report is drawn from an interview, the Report of Interview will only be referenced as an exhibit the first time it is referenced in the report. Subsequent uses of the information each witness provided can be referenced in the attached Table of Contents. The accident investigation report MSHA produced to document its findings is not attached as an exhibit, but is available at:
www.msha.gov/impoundments/martincounty/martincounty.htm

Background

From September 1990 to September 1994, Jesse Cole was the MSHA District Manager for District 6 located in Pikeville, KY. Included in District 6 is the MCCC operation near Inez, KY. Following an impoundment breakthrough at the MCCC mine in 1994, Cole

requested MSHA Technical Support review the breakthrough and make recommendations for the continued use of the impoundment.

A MSHA Technical Support engineer, Larry Wilson, visited the impoundment on May 25, 1994, and issued a memorandum outlining nine recommendations regarding the continued use of the impoundment. Cole forwarded those recommendations to MCCC for consideration in their future plans. In August 1994, MCCC responded with a proposed impoundment use plan that Cole rejected because he felt it did not adequately address all of the issues that Larry Wilson had raised. In October 1994, under Cole's replacement, Carl Boone, and following District review, the District approved an impoundment plan for MCCC. The plan was developed by Ogden Environmental & Energy Services Company (Ogden). Between the initial plan approval in 1994 and the subsequent impoundment failure in 2000, MSHA approved several modifications to the plan. The plan consisted, in part, of using overburden from the higher elevation Stockton coal seam to construct a seepage barrier in the impoundment. The seepage barrier was designed to prevent drainage in the impoundment from entering the mined areas of the Coalburg seam, below and near the impoundment. The plan also called for the drainage outflow from the Coalburg seam mines to be monitored by MCCC to identify unusual drainage levels from the impoundment and for seals to be constructed in the mine entrances of the mined Coalburg seam to provide protection to the active areas in the Coalburg seam mines.

Following the impoundment failure at MCCC on October 11, 2000, former MSHA Assistant Secretary Davitt McAteer created an accident investigation team and appointed his Special Assistant, Tony Oppegard, as the team leader. The team's investigation included interviews and sworn testimony of company officials, former miners, various witnesses, geo-technical analysis (a portion of which was contracted through Triad Engineering), and document reviews. Following the change in Presidential Administrations in late January 2001, Tony Oppegard, a political appointee, was removed as the team leader and Timothy Thompson, District Manager for MSHA District 3 in Morgantown, WV, was appointed as the new team leader.

Summary of Investigation

The MCCC case was opened by the Office of Labor Racketeering and Fraud Investigations (OLRFI) and assigned to SA[ ] on May 31, 2001. On May 31, 2001, OLRFI agents seized the MSHA administrative files pertaining to the Martin County Coal Corporation accident investigation, from the MSHA District Office in Morgantown, West Virginia. The OLRFI conducted over 40 interviews during the investigation. In July 2002, SA[ ] was reassigned the MCCC investigation.

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During the course of the OLRFI investigation, the agents received allegations concerning the MCCC accident investigation and other matters. Only those allegations related to the MCCC are addressed in this report. Allegations related to other matters have been forwarded to the appropriate offices to evaluate and investigate, as appropriate.

Based on the allegations related to the MCCC accident investigation and information received during the investigation, the following areas of investigative interest have been included in this report: [ ] Team Leader Transition, Investigative File Transfer to MSHA District 3, Access Denied to Shared [ ] Drive, Report Signing Issues, "Post Script" to Draft Report, Skiles' Draft Memorandum, District Response Memorandum, Citations Issued Against MCCC, [ ] Mapping Accuracy, Triad Engineering Qualification Letter, Former Special Assistant to Assistant Secretary Departure, Retaliation against Spadaro, Personnel Actions Resulting From MCCC Investigation, and Validity of MCCC Accident Investigation Report.

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[ ] The MCCC operation near Inez, KY is included in District 6. Following the first impoundment breakthrough at the MCCC mine in 1994, [ ] Cole requested MSHA Technical Support review the breakthrough and make recommendations for the continued use of the impoundment. [ ] The MSHA Technical Support engineer, Larry Wilson, issued a memorandum outlining nine recommendations regarding the continued use of the impoundment [ ] Cole forwarded those recommendations to MCCC for consideration in their future plans. In August 1994, MCCC responded with its proposed impoundment use plan and Cole rejected the plan because he felt it did not adequately address all of the issues that Larry Wilson had raised. [ ]

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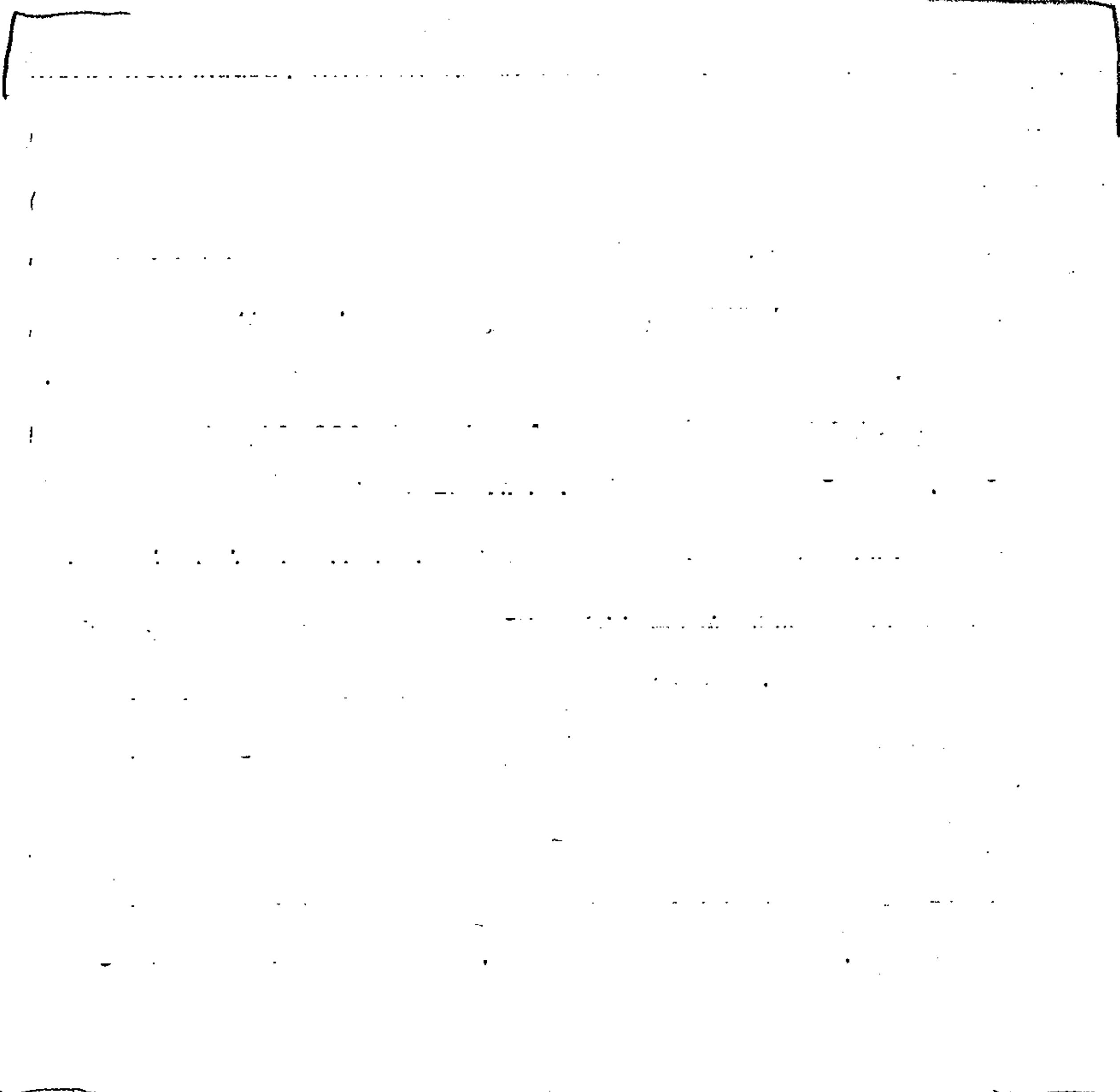
In October 1994, following District review, the District, now under District

Manager Carl Boone, approved an impoundment plan for MCCC. The plan was developed by Ogden Environmental & Energy Services Company (Ogden). Between the initial plan's approval and the impoundment failure in October 2000, MSHA approved several modifications to the plan. The plan consisted, in part, of using overburden from the higher elevation Stockton coal seam to construct a seepage barrier in the impoundment. The seepage barrier was designed to prevent drainage from the impoundment from entering the mined areas of the Coalburg seam, near the impoundment. The plan also called for the drainage outflow from the Coalburg seam mines to be monitored by MCCC to identify unusual drainage levels from the impoundment and for seals to be constructed in the mine entrances of the mined Coalburg seam to provide protection to the active areas in the mines (see MSHA Report of Investigation, *www.msha.gov/impoundments/martincounty/martincounty.htm*).



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Team Leader Transition

At the direction of MSHA management, Tim Thompson is alleged to have stopped the investigative phase and changed the scope of the MSHA accident investigation, after he replaced Oppegard

According to team members Spadaro, Brock and Sorke Tony Oppegard had instructed the team to review the previous impoundment breakthrough at the MCCC mine in 1994 to trace the cause of the October 2000 breakthrough. Harold Owens and Ronnie Brock understood Oppegard's directions to mean that only the cause of the breakthrough was to be investigated and that an internal review of the MSHA approval process following the 1994 breakthrough would be conducted later. Brock, Spadaro, and Sorke also stated that Oppegard had instructed the team that Spadaro was second in charge of the team when Oppegard was absent. According to Brock, Spadaro, Owens, and Sorke, when Thompson became the Team Leader he directed the team to finish the interviewing and evidence gathering phases of the investigation and begin assembling the draft report. According to Spadaro's complaint letter on April 11, 2001

to investigative records, the inclusion of Thompson's "postscripts," the accuracy of MCCC impoundment maps, the Triad Engineering report, MSHA management influence,

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Thompson denied ending the evidence-gathering phase of the investigation

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He believed it was wrapping up when he took over from Oppegard. He participated in several interviews and supported authorizing additional Triad Engineering core borings after his arrival. Thompson included a historical background relating to the MCCC impoundment process in the final report, but he was only concerned with what was approved, not how it was approved. He believed the latter was only relevant to an internal review. Thompson discussed this point with Lawless and Nichols and they concurred.

On July 17, 2002, OLRFI obtained a draft copy of the MSHA internal review conducted on the MCCC impoundment process The report addresses seventeen (17) issues related to the MCCC impoundment approval process and subsequent failure. The draft report did not identify any individuals who may have violated MSHA policy.

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was concerned that the team expected to include information that should be addressed in an internal review in the accident report.

The MSHA Accident/Illness Investigation Handbook (MSHA Handbook Number PH00-I-5), promulgated November 2000, established the purpose of the accident investigation for the MCCC accident investigation team. The handbook defines the objective of an accident investigation as follows:

> *The objective of an accident investigation is to determine the root cause(s) of the mine accident and to utilize and share this information with the mining community and others for the purpose of preventing similar occurrences. The Mine Safety and Health Administration's (MSHA) accident investigations include determinations of whether violations of the Federal Mine Safety and Health Act of 1977 (Mine Act) or implementing regulations contributed to the accident. In addition to providing critical, potentially life-saving information, the findings of these investigations provide a basis for formulating and*

evaluating MSHA health and safety standards and policies.

The MSHA Administrative Policy and Procedures Manual covering Internal Review Policy and Procedures dated September 24, 1992, directs MSHA to conduct an internal review of its enforcement activities after each mining accident that results in three or more fatalities, or at the direction of the Assistant Secretary, as was the case involving the MCCC impoundment failure. The manual lists the objective of the internal review as follows:

a. thoroughly and objectively evaluate the quality of its enforcement activities at a mine that has experienced and accident resulting in three or more fatalities;
b. identify any weakness in its enforcement activities at the mine;
c. provide appropriate recommendations for addressing any weaknesses found; and
d. disseminate internal review findings, conclusions, and recommendations to Agency managers and employees, members of Congress, and other interested parties.

Spadaro alleged an effort by senior management to cover-up serious deficiencies identified during the investigation.

Spadaro was quoted in The Courier-Journal, a Louisville, KY newspaper, alleging a "concerted effort" by MSHA management to influence the investigative report

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Spadaro mailed letters to the Department of Labor Inspector General on April 11 and April 16, 2001 alleging improper management involvement in the investigation. b2

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First time

Investigative File Transfer to MSHA District 3

The MSHA accident investigation administrative file was moved from Beckley, WV to Morgantown, WV. It is alleged that it was moved in an effort to further a cover-up.

From the beginning of the accident investigation, the team had maintained the accident investigation administrative file at the NMHSA in Beckley, WV. In April 2001, following his first complaint letter to the DOL-OIG, the press contacted Spadaro regarding his allegations and he provided details to the press in response to their inquiries. According to Ronnie Brock, who was the investigative file evidence custodian, within a week of Spadaro's allegations becoming public, Thompson ordered the accident investigative file moved to the conference room at the MSHA District 3 Office in Morgantown, WV. According to Brock, after the move, the file was disorganized and no longer up-to-date.

Thompson acknowledged moving the administrative investigative files from the NMSHA to his office in Morgantown, WV.

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wanted to prevent future unauthorized press releases. Thompson also wanted the records close to his office. In his interview, Thompson stated that sufficient access was provided to team members to complete the accident investigation report. Thompson pointed out the records were ultimately seized by the Office of the Inspector General on May 31, 2001 and were not available to MSHA.

Robert Elam, the acting Assistant Secretary from January 2001 until May 2001,

knew Thompson moved the records. He did not think it was unusual for a team leader to maintain administrative records at a convenient location. Marvin Nichols believed Thompson decided to move the records to prevent unauthorized press releases. Nichols thought Spadaro's comments to the press were disruptive and inaccurate; he supported Thompson's decision to move the records to prevent releases to the press.

Access Denied to Shared[ ]Drive

Several investigative team members reported being denied access to the MSHA administrative investigation file stored on a common or shared[ ]drive. When accessible, the file allowed members to input, review, and discuss investigative materials from their respective offices, without traveling to a common location. b2

Thompson admitted denying access to the[ ]drive to team members. He became frustrated with the unauthorized press releases and although he suspected Spadaro was releasing the information, he was not sure who was responsible. He denied access to everyone. Team members were given access on a need-to-know basis. By the time he took this action, the team had already formulated a fairly thorough draft report.

Elam was not aware of Thompson denying access to the[ ]drive. Nichols knew of Thompson's action and supported it. MSHA accident investigators informed Lauriski of the access issue when the final report was signed. Lauriski told OLRFI [ ]that he believed Thompson had denied access to the[ ]drive as a result of a discussion the two had had. Lauriski, shortly after his arrival, had told Thompson to secure the investigative materials to prevent unauthorized press releases. b2

Report Signing Issues

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In a January 15, 2002 interview, Spadaro alleged MSHA management coerced a team member to sign the final MCC accident investigative report[ ] b2

Joe Pavlovich, the District 7 District Manager, provided information regarding the report-signing incident. Team members Sorke and Brock work for Pavlovich. On October 10, 2001, Brock Emailed Thompson and stated he did not want to sign the report because he had been removed from a committee working on the citations and that he had been left out of conference calls concerning citations [ ] b7c b6 b5

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[ ]Thompson forwarded Brock's Email to Lauriski. Pavlovich, Brock and Lauriski subsequently spoke in a conference call. Prior to the conversation, Pavlovich told Brock that Brock was not responsible for every detail in the report – only his contributions. During the conversation with Lauriski, Brock said he had reconsidered his position and agreed to sign the report.

OLRFI interviewed every team member who signed the report. Brock, Sorke, Fredland, and Owens stated that together they had all met Thompson to sign the final report[ ] Thompson provided them with the signature page to sign. They all refused to sign the signature page without the benefit of reviewing the entire final report and making appropriate corrections. Thompson insisted they had reviewed the report "to death" and just needed to sign the signature page. They refused and Thompson made a conference call to Assistant Secretary Lauriski. The team members expressed their reluctance to sign the report without review, having been denied access to the[ ]drive, to Lauriski. Lauriski agreed with the team members and had Thompson allow them to review and make corrections to the latest version. Thompson provided a copy, which the team members reviewed and edited. Only a few typographical errors were identified and corrected. The four members willingly signed the final report without reservation. They all stated that they stood by the accuracy of the report. b2

Thompson corroborated the team members' story, except that he did not remember showing them a copy of the final report before they signed. Lauriski recalled the details of the event the same as described by the team members.

Weaver, Evanto, and Betoney acknowledged willingly signing the report, without any reservations[ ] Spadaro did not sign the report; his name was removed from the report. b2

"Post Script" to Draft Report

During the course of Inspector General's (IG) investigation, a document titled "Response to Pre-report Information Release," commonly referred to as the Post Script, written by Thompson, was presented to the team members for signature and inclusion in the report. The document concerned the team members.

In mid-April, 2001, the local press in West Virginia and Kentucky ran newspaper articles regarding the disagreements on the accident investigation team and Spadaro's allegations of a cover-up by MSHA management. In response to the press coverage, Timothy Thompson drafted a "post script" to the draft accident investigation report[ ] This "post script" attempted to refute Spadaro's allegations, and, it included points made in a "District Response" memo b2

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purportedly dated November 2, 2000 (This "District Response" will be addressed under a separate heading). Thompson instructed the team members to sign the "post script," and according to Ronnie Brock, Harold Owens, Jack Spadaro and Steve Sorke, the team members refused.

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According to Brock and Sorke, the team members had concerns regarding the truthfulness of the "post-script," and in particular, the truthfulness of the "District Response" memo, that addressed the installation of weirs at the MCCC impoundment. Neither Brock nor Sorke had seen any evidence that weirs had been installed at the MCCC site. The "post script" was eventually dropped, and was not included in the final version of the accident investigation report. b7c/b6

Thompson admitted to writing the "post script" believing it would provide MSHA the opportunity to address erroneous information raised in the press.

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Skiles' Draft Memorandum

During the investigation, it was alleged MSHA senior managers attempted to improperly influence the content of a memorandum written by Mark Skiles, MSHA's Director of Technical Support.

Following the MCCC impoundment breakthrough, then Assistant Secretary Davitt McAteer instructed Mark Skiles to travel to Pittsburgh, PA to review the MSHA Technical Support's records regarding the previous impoundment breakthrough in 1994 (MSHA's regional Technical Support office is located in Pittsburgh, PA). Skiles, assisted by Stephen Gigliotti, MSHA Accident Reduction Program Manager, traveled to Pittsburgh and reviewed the Technical Support records pertaining to Technical Support's analysis and recommendations following the impoundment breakthrough at MCCC in 1994.

Because of the volume of information he obtained, Skiles wrote a draft memo to McAteer dated October 31, 2000, describing his initial findings from the MSHA Technical Support files. b2

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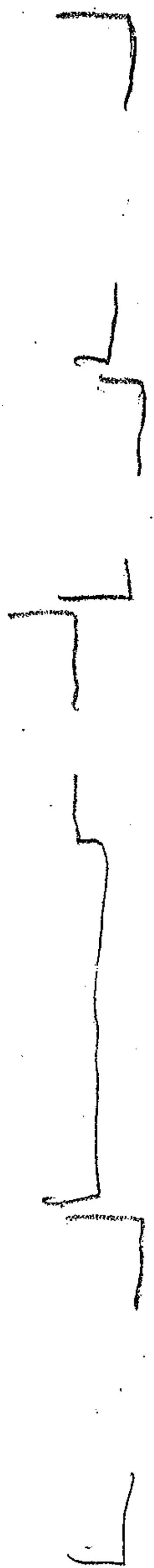

involved in requesting Skiles to qualify his memorandum.

District Response Memorandum

District 6 produced a memorandum, in response to Skiles' memorandum that allegedly contained false information.

After receiving Skiles' draft memorandum regarding Technical Support's involvement in the MCCC impoundment approval process, from McAteer, Elam forwarded it to Nichols, the Administrator for Coal Mine Safety and Health with instructions to have the District respond. Nichols, through his Deputy, Mike Lawless, forwarded Skiles' memorandum to the District Manager for District 6, Carl Boone. Boone instructed his staff to respond to the memorandum. His staff produced the "District Response" memorandum [ ], dated October 31, 2000. b2

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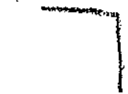
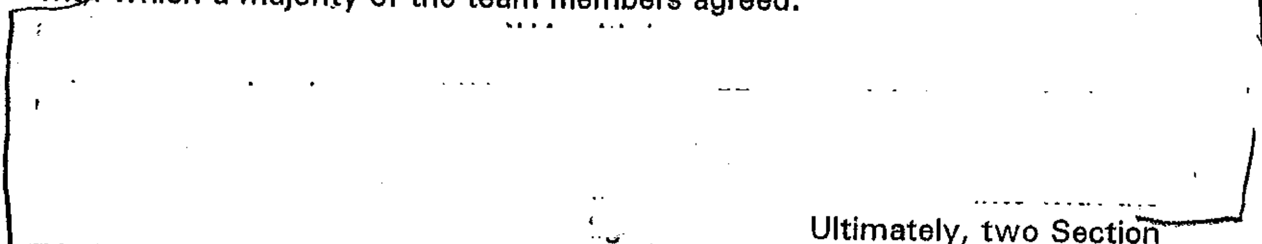


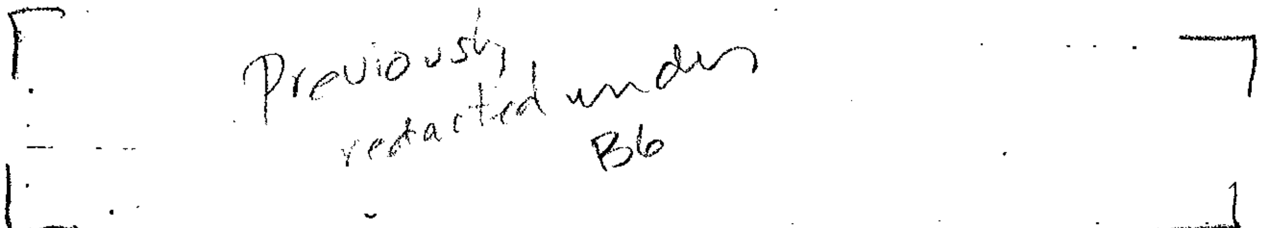
Citations Issued Against MCCC

Allegedly, appropriate citations were not issued against MCCC due to improper influence by MSHA management.

Team members Ronnie Brock, Harold Owens, Pat Betoney, and Steve Sorke were assigned to the violations committee, and they were responsible for drafting and preparing the proposed citations that were to be issued against MCCC. According to Brock and Owens, the committee developed eight possible violations, three of which were Section 104(d) violations (willful and negligent), with which a majority of the team members agreed.



Ultimately, two Section 104(d)] citations were issued against MCCC in the final accident investigation report.



The process of determining appropriate citations was contentious and addressed in over 20 interviews. The investigative team members and team leader, MSHA management, the MSHA Solicitor's Office, and the internal review team leader were interviewed regarding the process. Two violations, one regarding mine seal construction and another regarding mapping, are addressed in detail by OLRFI, under separate headings. The numerous recollections, statements, and opinions obtained by OLRFI regarding the process in general are too lengthy to be presented in detail, but are provided in the extensive list of exhibits attached to this report.

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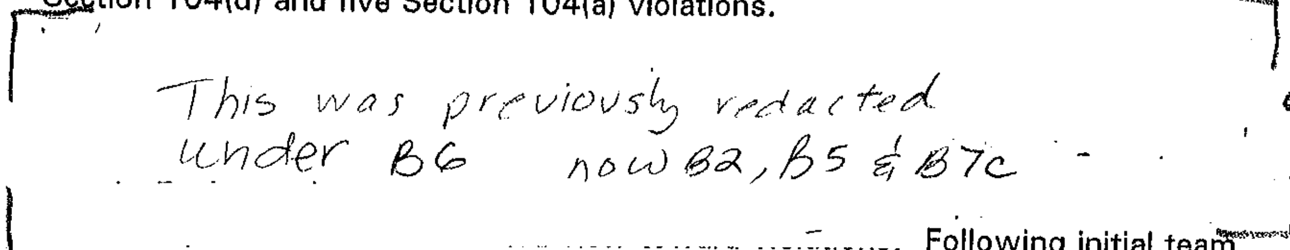
Brock stated that initially, under team leader Oppegard, the investigative team established a list of eight tentative violations by MCCC. Spadaro provided a list of the initial violations, dated 05/17/01[ ] The initial list contained three Section 104(d) and five Section 104(a) violations. b2



Following initial team discussions, Thompson assigned the team members who were MSHA Authorized Representatives (AR) the responsibility of finalizing a draft list of citations to be reviewed by the Solicitor's Office and MSHA management. ARs are the MSHA employees who have the statutory authority to issue citations on behalf of MSHA.

They have specialized training and are typically associated with MSHA's inspections branch.

Herman Narcho and James Crawford, attorneys from the MSHA Division of the Solicitor's Office helped the ARs evaluate the proposed violations in regard to supporting evidence and case law.

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During part of the violation discussion phase, team members and the Solicitor's Office did not have access to the shared [ ] drive and had to travel to Morgantown, WV to review the draft report and administrative record. b2

The team ultimately drafted a list of citations that was presented to MSHA management and the Solicitor's Office for review. It consisted of only one Section 104(d) violation. The draft citations were not reached unanimously, but a majority of participants did agree on each change to the list. Crawford stated he did not discuss or participate in any changes to the single violation list, with the investigation team or MSHA management, after it was forwarded to MSHA management [ ] The list was subsequently modified by upgrading a citation, "Fine refuse not directed along barrier per plan" 30 CFR § 77.216(d), to a Section 104(d) level citation. Crawford presumes that the change was made by MSHA management and noted that it is normal for MSHA management to make adjustments in citations. All parties interviewed acknowledged the contentious process, at times, of finalizing the citations, but stated that they believed they achieved a fair and accurate result. b2

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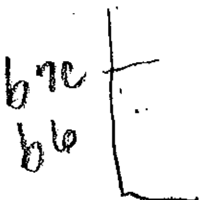
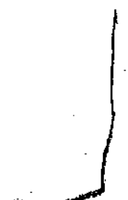

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Mapping Accuracy

MSHA's failure to cite a violation for inaccurate mapping resulted in the allegation that management was attempting to cover-up findings that may reflect poorly against the agency.

No citation for inaccurate maps was listed on the tentative violation list provided by Spadaro, dated May 17, 2001. Initially Spadaro and other team members supported a mapping citation. Ensuing discussions resulted in the violation not being included.

b2 In 1994, MCCC provided MSHA with a "typical" barrier plan illustrating the makeup of the barrier between the impoundment and the mine entrances[ ] b2 [ ] This "map" was a typical drawing and did not accurately reflect distances or materials for any given location around the perimeter of the impoundment. MCCC intended the document to simply illustrate the basic layout of the impoundment sealing plan. MCCC did not submit any testing results (e.g. core samples) or

other documents proffering specific details related to the makeup of the barrier between the impoundment and the mines. MSHA accepted the "typical" barrier plan as a part of the impoundment sealing plan and did not question its intent or request further data to substantiate the existence or makeup of the barrier. MSHA ultimately approved MCCC's sealing plan based on the plan's basic principles. Some of the basic features of the plan included constructing an adequate barrier between the impoundment and the underground mine, sealing the barrier by depositing slurry fines around the barrier, building seals in the mine entrances, and measuring drainage outflow from the impoundment. The plan proposed, based on existing conditions and added barrier material, to create an acceptable seal consisting of the materials in varying amounts and thickness.

Team members reviewed Triad Engineering's analysis of the 47 test borings taken at the impoundment following the 2001 failure. With the exception of two samples that appeared off by short distances, each boring sample produced materials, at depths and locations, that indicated the MCCC underground maps were accurate -- indicating that pillars and entrances were accurately mapped. Other maps provided by MCCC were verified for accuracy as well.

The majority of the team members ultimately agreed that a citation for inaccurate maps should not be issued.

Triad Engineering Qualification Letter

Some team members alleged that, after receiving the Triad Engineering report detailing Triad's findings in the MCCC investigation, MSHA management inappropriately attempted to influence Triad's findings.

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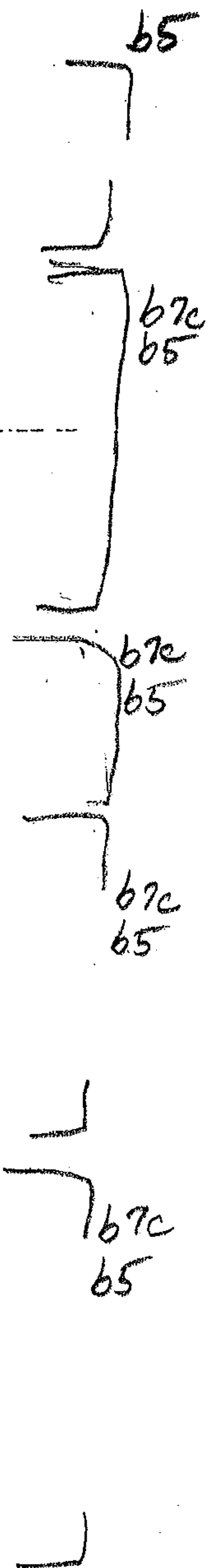
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Former Special Assistant to Assistant Secretary Departure

Celeste Monforton, a former Special Assistant to the Assistant Secretary for MSHA, was alleged to have been forced to leave her government position with MSHA, based on her involvement with Skiles' draft memorandum.

Monforton worked as a special assistant to the Assistant Secretary for MSHA, and she recalled receiving Skiles' original draft memorandum from Steve Gigliotti in late October 2000[ ]Monforton gave the original memo to Assistant Secretary McAteer and she was later surprised to learn that the memo had been distributed because it was clearly labeled as a draft. Monforton did not know about the "District Response" memorandum until late April or early May 2001 when Skiles showed it to her following his meeting with Acting Assistant Secretary Robert Elam. Monforton later saw an unsigned version of the "District Response" memo on Elam's desk and she questioned Elam about it. Later that same day, Elam provided Monforton with a signed copy of the "District Response" memorandum.

b2

b6

She was not forced out, or treated poorly. She left of her own volition.

Retaliation against Spadaro

In interviews with OLRFI, Spadaro alleged MSHA management was preparing to retaliate against him for his contact with the press.

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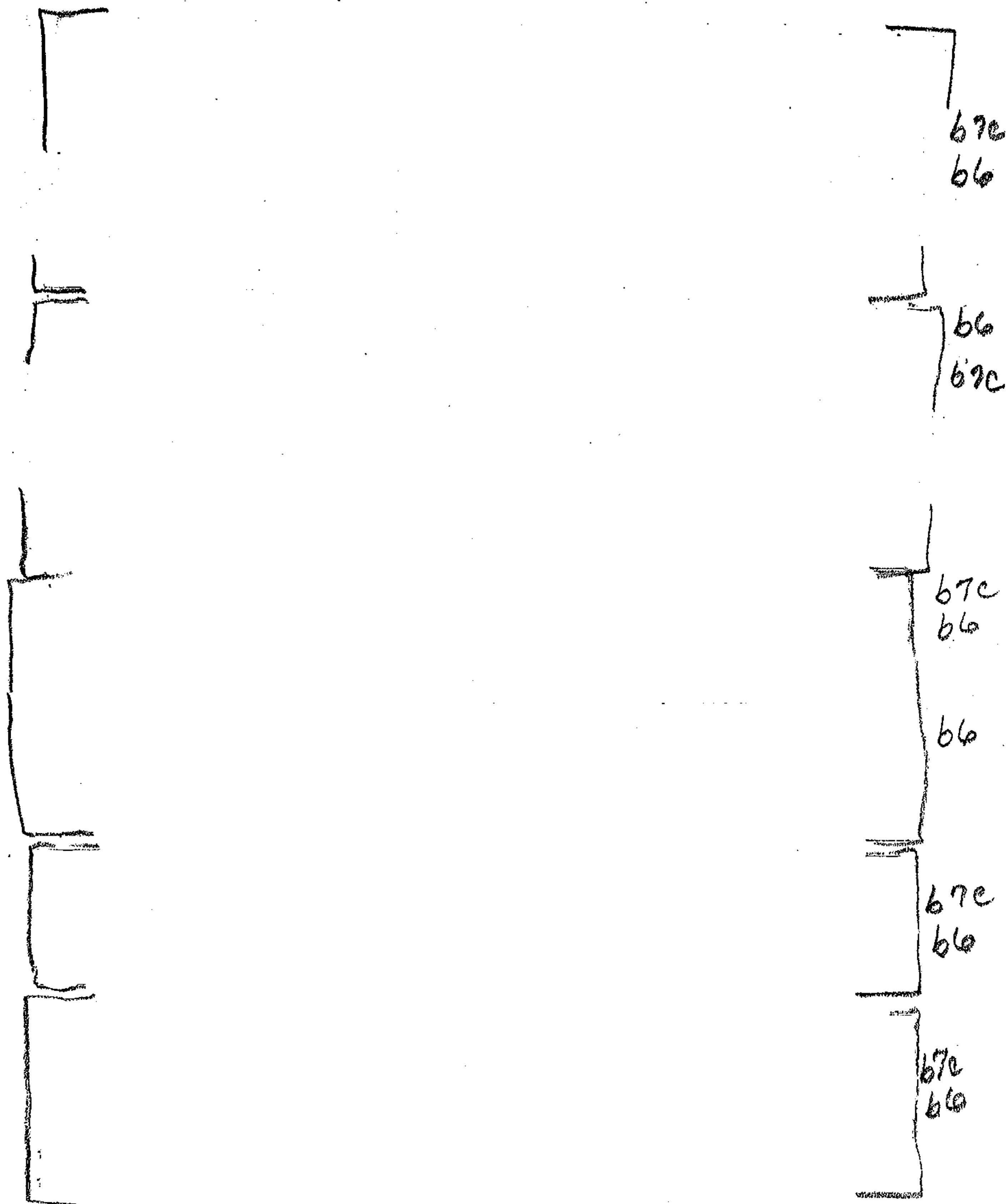

The IG complaint files were reviewed as part of this investigation. All complaint

letters received related to the MCCC case were accounted for and handled in accordance with the IG's standard operating policies. No evidence surfaced to indicate any letter was released outside of the receiving office's file, except to the case agent's control.

Personnel Actions Resulting From MCCC Investigation

OLRFI questioned each interviewee about actual or possible personnel actions resulting from the MCCC investigations, both the accident investigation and the internal review.

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b5

Robert Elam, former Deputy Assistant Secretary and former acting Assistant Secretary retired from government service in February 2002.

Michael Lawless, former Deputy Administrator for Coal Mine Safety retired from government service in June 2002.

Validity of MCCC Accident Investigation Report

With the exception of Jack Spadaro, every individual interviewed in connection with the MCCC accident investigation and internal review affirmed their belief that the report was accurate, truthful and fairly presented the facts associated with the MCCC impoundment failure. OLRFI did not obtain evidence of improper influence on behalf of MCCC, its parent company, A.T. Massey, MSHA management, or MSHA employees. The OLRFI investigation did not disclose any criminal activity or willful negligence on the part of any participants.

Summary

During the entire investigation, no evidence was uncovered to substantiate any allegations relating to MSHA's MCCC impoundment failure accident investigation.