U.S. DEPARTMENT OF LABOR
OFFICE OF INSPECTOR GENERAL
Office of Audit

BRIEFLY…

Highlights of Report Number 05-10-005-06-001, to the Assistant Secretary of Labor for Mine Safety and Health.

September 2010

IN 32 YEARS MSHA HAS NEVER SUCCESSFULLY EXERCISED ITS PATTERN OF VIOLATIONS AUTHORITY

WHY READ THE REPORT

On April 5, 2010, an accident at the Upper Big Branch Mine-South in Montcoal, West Virginia killed 29 miners. Concerns were raised about the mine's safety record and the Mine Safety and Health Administration's (MSHA) process for identifying mines with a pattern of violations (POV). Those concerns increased when MSHA reported that an error in its POV computer application caused this mine to be omitted from a list of mines with potential patterns of violations.

POV authority is an important tool that lets MSHA take enhanced enforcement actions when a mine demonstrates recurring safety violations that could significantly and substantially contribute to the cause and effect of health and safety issues.

WHY OIG CONDUCTED THE AUDIT

The OIG conducted a performance audit to determine:

- How MSHA had developed its POV rules, criteria, and procedures and implemented its POV authority;
- Whether MSHA timely and consistently reviewed and monitored mine operators' POV corrective action plans;
- Whether MSHA's POV computer application contained errors in addition to the one MSHA reported after the Upper Big Branch Mine-South accident;
- Whether MSHA's enforcement data was sufficiently reliable to support accurate POV analysis; and
- The affects on the results of MSHA's POV model from various changes in the criteria.

READ THE FULL REPORT

To view the report, including the scope, methodology, and full agency response, go to:

http://www.oig.dol.gov/public/reports/oa/2010/05-10-005-06-001.pdf

WHAT OIG FOUND

MSHA has not successfully exercised its POV authority in 32 years. Administration of this authority has been hampered by a lack of leadership and priority in the Department across various administrations.

MSHA took 13 years to finalize POV regulations. Those regulations created limitations on MSHA's authority that were not present in the enabling legislation and made it difficult for MSHA to place mines on POV status. For the next 17 years, MSHA Districts performed POV analyses based on individual interpretations of requirements, but never put any mine operator on POV status. In 2007, MSHA attempted to implement a standardized method based on quantitative data for identifying potential POV mines. However, (a) the process was unreliable and (b) the criteria were complex and lacked a supportable rationale.

The audit also concluded that:

- MSHA did not monitor the implementation of mine operators' POV corrective action plans;
- Logic errors caused unreliable results from MSHA's POV computer application;
- Tests identified no deficiencies in the reliability of data MSHA used for POV screening; and
- Delays in testing rock dust samples could cause delays in identifying safety hazards.

WHAT OIG RECOMMENDED

We made 10 recommendations to the Assistant Secretary for Mine Safety and Health. In summary, we recommended that MSHA re-evaluate current POV regulations; seek stakeholders input in developing new, transparent POV criteria; use system development life cycle techniques in creating any new POV related computer applications; and re-evaluate the standard for timely completion of laboratory tests.

The Assistant Secretary agreed with our recommendations and committed to developing and implementing corrective actions.