U.S. Department of Labor
Office of Inspector General
Office of Audit

BRIEFLY…

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MSHA CAN IMPROVE HOW IT RESPONDS TO AND TRACKS HAZARDOUS CONDITION COMPLAINTS

WHY OIG CONDUCTED THE AUDIT

Mine hazards contributed to 151 miner deaths and 30,350 injuries between January 2012 and December 2015. A 2006 OIG audit found MSHA had not evaluated or inspected a significant number of hazardous condition complaints in a timely way. These complaints included malfunctioning equipment, missing safety measures, and toxic gasses, any of which miners can encounter daily.

Effective management of the Hazardous Condition Complaints program is vital to ensuring appropriate and prompt action is taken to identify and abate hazardous mine conditions. This program is the crucial component of a comprehensive approach to improving mine safety. Miners and miners' representatives can file complaints if they believe there are violations of the Mine Act, health or safety standards, or if they believe an imminent danger exists. The Mine Act gives these complainants the right to obtain an MSHA inspection following a complaint.

WHAT OIG DID

We conducted this performance audit to determine the following: Did MSHA districts log, assess, and respond to complaints of hazardous mine conditions consistently?

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/2016/05-16-002-06-001.pdf

WHAT OIG FOUND

MSHA districts did not log, assess, and respond to complaints of hazardous mine conditions consistently.

MSHA districts treated complaints inconsistently because each district had developed its own processes based on its own interpretation of the MSHA Hazard Complaint Procedures Handbook. For example, districts developed different criteria for when to notify mine operators of imminent dangers. Also, two of the six districts we visited had not established timeliness goals. Any delay in providing information about an imminent danger places miners' safety and health at unnecessary risk.

Call center staff sometimes did not ask important follow-up questions and thus some complaints sent to MSHA lacked critical information that would have better focused inspections.

MSHA did not follow its own policy when using its triage mechanism, which allows the timing of complaints investigations to be adjusted according to the perceived severity of the complaint. Some complaints did not address actual hazards. Time inspectors spend investigating complaints not involving actual hazards is time taken away from other safety and health inspections and enforcement, decreasing the chances of discovering actual hazards. In each case, MSHA has not provided appropriate oversight to ensure that this national program operates the same way in every district.

WHAT OIG RECOMMENDED

We recommended the Assistant Secretary for Mine Safety and Health implement consistent guidelines for handling complaints, establish standard completion goals for post-complaint inspections, provide additional training to district personnel, improve call center scripts and training for call center staff, and establish a stronger triage mechanism for incoming complaints.

The Assistant Secretary agreed with some, but not all, of the OIG's recommendations. MSHA believes its operating plan currently tracks investigation timeliness for 103(g) imminent danger complaints, the most serious hazard complaint, to ensure an investigation is started within one day of receipt.