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

BRIEFLY…

Highlights of Report Number 05-08-002-06-001, *MSHA's Process for Determining the Chargeability of Reported Fatalities Would Benefit from Additional Controls*, to the Assistant Secretary for Mine Safety and Health, dated November 14, 2007.

WHY READ THE REPORT

Federal regulations require mine contractors and operators to report all fatalities to the Mine Safety and Health Administration (MSHA). Criteria established by MSHA classify a fatality as chargeable to the mine industry if the incident resulted in a death on mine property and from mine related work or the death was caused by mining activities. The number of chargeable fatalities impacts MSHA's performance measures and potentially the public's perception of how well it is fulfilling its mission. During Calendar Year 2006, there were 145 reported fatalities at U.S. mining operations. Of these, MSHA determined 72 to be chargeable.

In January 2007, MSHA initiated and completed an in-house review of how it determined which reported fatalities were chargeable. As a result, on February 9, 2007, MSHA's Assistant Secretary revised the procedure and changed the members of the Fatality Review Committee.

WHY OIG CONDUCTED THE AUDIT

In response to a request from Congressman George Miller, Chairman of the House Committee on Education and Labor, the Office of Inspector General (OIG) conducted a performance audit of MSHA's process for deciding whether reported fatalities were chargeable to the mining industry. Our objective was to determine whether MSHA's process and controls ensured that its decisions were consistent, supported by appropriate evidence, and in accordance with Federal regulations and MSHA policies.

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/2008/05-08-002-06-001.pdf

November 2007

MSHA'S PROCESS FOR DETERMINING THE CHARGEABILITY OF REPORTED FATALITIES WOULD BENEFIT FROM ADDITIONAL CONTROLS

WHAT OIG FOUND

In a sample of 152 fatality decisions made between January 1, 2004 and December 31, 2006, and a sample of 24 decisions made between February 9, 2007, and June 30, 2007, the OIG did not identify any instances in which similar circumstances produced different decisions or instances where a chargeability decision was clearly contradicted by available evidence. However, we did identify instances of non-compliance with MSHA policies and control and procedural weaknesses that increased the risk that such errors could occur. Specifically, investigators and decision-makers lacked independence, investigative procedures were inconsistent, and investigative documentation was sometimes lacking.

WHAT OIG RECOMMENDED

We made seven recommendations to the Assistant Secretary for Mine Safety and Health aimed at reducing the actual and perceived risk of independence impairments and assuring that decisions are based on complete, well documented evidence.

Key recommendations included:

- defining a standard protocol for first responders;
- including an independent member on the Fatality Review Committee;
- implementing a standardized investigative protocol for all fatality investigations; and
- establishing a quality assurance process for documentation of investigative information.

The Assistant Secretary for Mine Safety and Health generally agreed with our recommendations, but MSHA needs to provide additional information before the OIG will consider the recommendations resolved.