US mine safety agency did not enforce regulations, audit shows

Samuel Davidson
7 October 2010

An audit of the federal agency in charge of overseeing safety at US coal mines found it failed for over 30 years to take tougher enforcement action against mines with a pattern of serious safety violations.

The report gives further proof of what many miners and their families already know: the federal Mine Safety and Health Administration (MSHA) works as a tool of the coal operators rather than in the interests of the miners.

The audit of the MSHA was conducted by the US Department of Labor's Office of the Inspector General and was ordered after the April 5 explosion at Massey Energy's Upper Big Branch mine in Montcoal, West Virginia, that killed 29 miners.

It was quickly revealed after the explosion that the Massey mine had been cited more than 600 times for safety violations in the previous 18 months, but that MSHA officials had not taken any additional steps to close the mine or otherwise enforce safety.

While the official cause of the April 5 disaster has not yet been determined, most miners and mine safety experts believe it started with a methane explosion that then set off a more powerful coal dust explosion. The second blast traveled through the mine's underground pathways with such force that it killed men who were more than two miles from the explosion's origin.

Detailed reviews of MSHA records showed that in 2009, mine safety inspectors issued 54 "withdrawal orders," which are issued when a safety problem threatens the immediate health of miners. Then in the months leading up to the deadly explosion, withdrawal orders were issued at a rate of one per week.

Inspectors also issued many "unwarrantable failures" citations against Massey's Upper Big Branch mine. These are issued when violations are so blatant that MSHA inspectors conclude that mine officials have purposefully ignored them.

Many of the withdrawal orders and unwarrantable failures related to violations of ventilation and control of coal dust. At one point Upper Big Branch officials changed the direction of fresh air so that miners working on the longwall face were receiving the air that should have been expelled from the mine. Another time, the air flow was cut in half from 100,000 cubic feet per minute to just 50,000 CFM.

Yet despite this horrendous record, MSHA never declared that a "pattern of violations" existed, which would have given it authority to order the mine shut down or placed under greater control.

A few days after the Upper Big Branch disaster, MSHA officials revealed that a computer error caused them to miss placing the Massey mine on the list of mines targeted for greater review. The inspector general's report found that the computer program used by MSHA to determine which mines meet its standards for greater enforcement had severe internal errors that caused it to miss identifying many mines for greater enforcement.

The audit revealed that the computer program was never properly "developed, tested, maintained, and documented in the disciplined and structured manner normally associated with major computer applications." MSHA officials did not even keep copies of the data that it fed into the program so it is impossible to tell today which other mines are in violation when using the corrected program.

The situation of lack of regulatory enforcement by the MSHA is not limited to Massey, the inspector general's report makes clear. Even after Congress enacted the Mine Safety and Health act in 1977, which gave MSHA the authority to increase oversight of a mine found to demonstrate a "pattern of violations," it took the agency 13 years before it finalized regulations in accordance with the legislation.

Proposed MHSA regulations in the early 1980s were vigorously opposed by the coal operators in a set of public

hearings, and were finally withdrawn in 1985. It took another four years before MSHA again proposed regulations in 1989 that were then accepted in 1990. Even then, however, no national standards were established for what constituted a “pattern of violations.”

The disregard of regulations has continued under both Republican and Democratic administrations. Davitt McAteer, who headed the MSHA under the Clinton administration and today is much hailed as a safety expert, delayed implementation of regulations that would have required mines to maintain the following safety resources: rescue chambers, more and better emergency oxygen supplies, better communication systems, and safer exit paths. Had these simple regulations been implemented many miners would still be alive, including 11 of the 12 miners who were trapped and died after an explosion in Sago, West Virginia, on January 2, 2006.

In the 1990 regulations, MSHA also set limits on its own authority not written into the original law. For example, it determined that it would first advise mine operators in violation of safety regulations they were being considered as a pattern-of-violations target and give them time for self-improvement.

Only in 2007, after the Sago disaster and other accidents combined to kill 47 coal miners—most of them in mines that had hundreds of safety violations—did MSHA set national standards to be used to determine if mines had established a pattern of violations.

Yet even then MSHA officials set an almost impossible standard, requiring inspectors to address 10 different criteria to demonstrate that a pattern of violation exists.

In all of the 33 years since MSHA’s inception there has never been a mine found to fall under a pattern of violations.