LEARNING FROM THE UPPER BIG BRANCH TRAGEDY

HEARING

BEFORE THE

COMMITTEE ON EDUCATION AND THE WORKFORCE
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

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LEARNING FROM THE UPPER BIG BRANCH TRAGEDY

Tuesday, March 27, 2012
U.S. House of Representatives
Committee on Education and the Workforce
Washington, DC

The committee met, pursuant to call, at 10:01 a.m., in room 2175, Rayburn House Office Building, Hon. John Kline [chairman of the committee] presiding.

Present: Representatives Kline, Petri, Goodlatte, Roe, Walberg, DesJarlais, Rokita, Bucshon, Gowdy, Roby, Kelly, Miller, Kildee, Andrews, Woolsey, Tierney, Holt, Altmire, and Fudge.

Also present: Representatives Capito and Rahall.

Staff present: Katherine Bathgate, Press Assistant/New Media Coordinator; Casey Buboltz, Coalitions and Member Services Coordinator; Ed Gilroy, Director of Workforce Policy; Barrett Karr, Staff Director; Ryan Kearney, Legislative Assistant; Donald McIntosh, Professional Staff Member; Brian Newell, Deputy Communications Director; Krisann Pearce, General Counsel; Molly McLaughlin Salmi, Deputy Director of Workforce Policy; Linda Stevens, Chief Clerk/Assistant to the General Counsel; Alissa Strawcutter, Deputy Clerk; Loren Sweatt, Senior Policy Advisor; Joseph Wheeler, Professional Staff Member; Kate Ahlgren, Minority Investigative Counsel; Aaron Albright, Minority Communications Director for Labor; Tylease Alli, Minority Clerk; Kelly Broughan, Minority Staff Assistant; Daniel Brown, Minority Policy Associate; Jody Calemine, Minority Staff Director; John D'Elia, Minority Staff Assistant; Waverly Gordon, Minority Fellow, Labor; Richard Miller, Minority Senior Labor Policy Advisor; Megan O'Reilly, Minority General Counsel; and Michele Varnhagen, Minority Chief Policy Advisor/Labor Policy Director.

Chairman KLINE. A quorum being present, the committee will come to order.

Good morning, Assistant Secretary Main, thank you for being with us today.

On April 5th, 2010, the people of Montcoal, West Virginia suffered a tragic loss. Around 3 o'clock in the afternoon, workers completing their shift at the Upper Big Branch Mine felt a strong blast of wind hit their backs.

It was a chilly morning that a violent explosion was tearing through the mine, one that would kill 29 miners and severely injure two more.

As a nation, we continue to mourn the men and women who died and keep their families in our prayers.

Since that fateful day, the people of West Virginia have been searching for answers.

How could such a catastrophic event take place? Could it have been prevented?

What steps need to be taken to help ensure this kind of tragedy never happens again?

As part of the federal response to the explosion, three teams were assembled to examine the events of Upper Big Branch: an MSHA investigation team to determine the cause of the explosion, an internal review team to examine MSHA's actions, and a team from the National Institute of Occupational Safety and Heath to conduct an independent assessment of MSHA's internal review.

After examining more than 1,000 pieces of evidence, MSHA released its accident report last December. The report documents three events that facilitated the worst mining disaster in 40 years.

First, worn drill bits and faulty water control in the mining machine created a spark or ignition. Then a buildup of methane gas combined with the ignition triggered an explosion. Finally, a massive accumulation of coal dust fueled a fire that quickly spread throughout the mine.

While this explains the physical cause of the disaster, its real genesis lies in Massey's corporate culture that valued profit over safety. By engaging in the reckless disregard of important safety protections, Massey Energy bears the responsibility for the deaths of these miners.

The investigation revealed numerous safety violations including keeping two sets of books and routinely providing advance notice to miners that inspectors were on site, all part of a campaign to conceal the true working conditions underground; disabling multi-gas detectors that could have alerted miners to the accumulation of methane gas; and failing to comply with rock dusting standards that would have contained the fire before it consumed the mine.

The list of violation goes on and on. Safety was clearly not a priority for Massey. And 29 miners and their families paid the price.

Federal prosecutors are to be commended for their efforts to bring justice to those who engaged in criminal activity. Mine operators have a legal and moral responsibility to protect their workers.

Cecil Roberts, president of the United Mine Workers Association, whom we will hear from shortly, once noted that 95 percent of mine operators are trying to do the right thing. Yet bad actors continue to jeopardize miners' safety.

That is why we have the Mine Act and the Mine Safety and Health Administration. When workers are needlessly put in harm's way, federal enforcement must require correction action and hold the mine operator accountable.

As we have learned in startling detail from internal review and independent assessment, regrettably this did not happen in Upper Big Branch. Instead, miners were forced to confront a failed combination of reckless safety practices and enforcement failures.

On numerous occasions, inspectors identified safety violations, yet didn't require abatement of the hazard. Even more shocking are hazards that simply went unnoticed altogether.

For example, in December 2009, MSHA approved a new plan to secure the roof of the mine. However, four subsequent inspections failed to cite Massey for violating the approved plan.

This proved to be a critical enforcement error once a roof collapse altered the mine's airflow and allowed for the buildup of methane gas.

Furthermore, it is difficult, almost impossible, to imagine enforcement personnel missing the inherent dangers of coal dust accumulating throughout the mine. Again, this enforcement error neglected a crucial safety concern that would later enhance the magnitude of this disaster.

We have also learned over the last 2 years that other enforcement tools were either poorly used or never implemented. Bipartisan reforms enacted in 2006 created a new category of flagrant violations, yet they were never imposed against Massey.

Computer glitches allowed Massey to avoid tougher enforcement measures. And technical support audits, including one that outlined concerns of methane in the mine, were never transmitted to the mine operator.

Sadly, the list of enforcement lapses could go on as well. NIOSH states in its assessment that proper enforcement, quote—"would have lessened the chances of, and possibly could have prevented, the UBB explosion."

There may be a number of reasons for these errors. However, no excuse can comfort those who lost a loved one.

Some enforcement failures have plagued the agency for years, and deadly mistakes are always followed with a pledge to do better. Yet Upper Big Branch still happened. Tragedy strikes, promises are made, new laws are passed, and a broken enforcement regime goes on.

Administrator Main, I hope you convince this committee, and the nation's miners, that this time it will be different, that this time, we will learn from past mistakes and keep our promise to do better.

I look forward to discussing these matters further with our witnesses.

I now recognize my distinguished colleague, Ms. Woolsey, for her opening remarks.

[The statement of Chairman Kline follows:]

Prepared Statement of Hon. John Kline, Chairman, Committee on Education and the Workforce

Good morning, Assistant Secretary Main. Thank you for being with us today.

On April 5, 2010, the people of Montcoal, West Virginia suffered a tragic loss. Around three o'clock in the afternoon, workers completing their shift at the Upper Big Branch mine felt a strong blast of wind hit their backs. It was a chilling warning that a violent explosion was tearing through the mine, one that would kill 29 miners and severely injure two more. As a nation, we continue to mourn the men who died and keep their families in our thoughts and prayers.

Since that fateful day, the people of West Virginia have been searching for answers. How could such a catastrophic event take place? Could it have been prevented? What steps need to be taken to help ensure this kind of tragedy never happens again?

As part of the federal response to the explosion, three teams were assembled to examine the events of Upper Big Branch: an MSHA investigation team to determine the cause of the explosion, an internal review team to examine MSHA's actions, and

a team from the National Institute of Occupational Safety and Health to conduct an independent assessment of MSHA's internal review.

After examining more than a thousand pieces of evidence, MSHA released its accident report last December. The report documents three events that facilitated the worst mining disaster in 40 years. First, worn drill bits and faulty water control on the mining machine created a spark or ignition. Then, a build-up of methane gas combined with the ignition triggered an explosion. Finally, a massive accumulation of coal dust fueled a fire that quickly spread throughout the mine.

While this explains the physical cause of the disaster, its real genesis lies in Massey's corporate culture that valued profit over safety. By engaging in the reckless disregard of important safety protections, Massey Energy bears the responsibility for the deaths of these miners. The investigation revealed numerous safety violations, including:

• Keeping two sets of books and routinely providing advance notice to miners that inspectors were onsite, all part of a campaign to conceal the true working conditions underground;

• Disabling multi-gas detectors that could have alerted miners to the accumulation of methane gas; and

• Failing to comply with rock dusting standards that would have contained the fire before it consumed the mine.

The list of violations goes on and on. Safety was clearly not a priority for Massey, and 29 miners and their families paid the price. Federal prosecutors are to be commended for their efforts to bring justice to those who engaged in criminal activity.

Mine operators have a legal and moral responsibility to protect their workers. Cecil Roberts, president of the United Mine Workers Association—whom we will hear from shortly—once noted that 95 percent of mine operators are trying to do the right thing. Yet bad actors continue to jeopardize miners' safety.

That is why we have the Mine Act and the Mine Safety and Health Administration. When workers are needlessly put in harm's way, federal enforcement must require corrective action and hold the mine operator accountable. As we've learned in startling detail from internal review and independent assessment, regrettably this did not happen at Upper Big Branch. Instead, miners were forced to confront a fatal combination of reckless safety practices and enforcement failures.

On numerous occasions, inspectors identified safety violations yet didn't require abatement of the hazards. Even more shocking are hazards that simply went unnoticed altogether. For example, in December 2009, MSHA approved a new plan to secure the roof of the mine. However, four subsequent inspections failed to cite Massey for violating the approved plan. This proved to be a critical enforcement error once a roof collapse altered the mine's airflow and allowed for the buildup of methane gas.

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We have also learned over the last two years that other enforcements tools were either poorly used or never implemented. Bipartisan reforms enacted in 2006 created a new category of flagrant violations, yet they were never imposed against Massey. Computer glitches allowed Massey to avoid tougher enforcement measures. And technical support audits, including one that outlined concerns with methane in the mine, were never transmitted to the mine operator.

Sadly, the list of enforcement lapses could go on as well. NIOSH states in its assessment that proper enforcement "would have lessened the chances of—and possibly could have prevented—the UBB explosion."

There may be a number of reasons for these errors; however, no excuse can comfort those who lost a loved one. Some enforcement failures have plagued the agency for years, and deadly mistakes are always followed with a pledge to do better. Yet Upper Big Branch still happened. Tragedy strikes, promises are made, new laws are passed, and a broken enforcement regime goes on.

Secretary Main, I hope you convince this committee and the nation's miners that this time it will be different; that this time we will learn from past mistakes and keep our promise to do better.

I will now yield to Mr. Miller, the committee's senior Democrat, for his opening remarks.

Ms. WOOLSEY. Thank you, Mr. Chairman.

Certainly, as we examine the lessons learned from the Upper Big Branch mine disaster, we can never lose sight that there are 29 families who lost their fathers, their brothers, their husbands, and their best friends.

Almost 2 years ago, this committee travelled to Beckley, West Virginia where we heard chilling testimony from the families and miners about the unbelievable conditions in that mine.

Most of which you listed just in your opening testimony, Mr. Chairman. So I won't repeat it.

But Leo Long, a lifelong miner and grandfatherof one of the 29 miners who lost his life, testified that day. Mr. Long said, "I am asking for you all to please do something for the rest of the coal miners that are in the mines. I pray for it every night, every day. If you don't do something, something like this is going to happen again."

Mr. Long, we hear your plea.

Since that hearing, there have been four investigative reports on the tragedy. All found that Massey Energy caused the explosion by failing to comply with long established safety standards in mine workplaces.

Massey failed to prevent this tragedy because it didn't maintain the water sprays to quench the ignition, or shore up the mine roof to keep the mine ventilated. And it failed to keep the mine rock-dusted to prevent a coal dust explosion.

On top of Massey's failure to follow basic safety protections, it also engaged in a pattern of obstruction. Massey routinely provided advance notice of inspections which gave foremen time to correct hazardous conditions or stop production before MSHA inspectors arrived underground.

Massey kept two sets of mine examination books. And Massey engaged in a pattern of intimidation by threatening miners' jobs if they tried to stop production to correct unsafe conditions.

The Governor's Independent Panel concluded that these failures were the result of a culture where—and he said it—"wrong doing became acceptable, where deviation became the norm."

Under the Mine Act, the mine operator is responsible for the health and safety of its miners. And if that operator fails, it is up to the safety agency to bend the operator back into line.

But MSHA's effort was compromised at UBB. There were poor inspection practices and a failure to identify violations.

There was a failure to put this mine on Pattern of Violations or apply maximum penalties. There was a failure to investigate Massey managers who may have engaged in knowing and willful violations. And mine plans were approved without resolving previous safety concerns.

Today, Mr. Chairman, we must examine why this happened. We have to know what broke.

We know that budget cuts and retirements incapacitated MSHA's effectiveness, particularly in the early 2000s. Then after three mine tragedies in 2006, Congress finally reversed course and provided resources to put more inspectors back into the mine.

But the new inspectors didn't have the needed experience. And there were not enough technical specialists.

Violations went undetected including critical violations highlighted in the latest NIOSH report.

Only a few weeks before the UBB explosion in fact, MSHA inspectors were underground near the source of the explosion. But the lead inspector had only 13 months experience, and obviously missed a number of violations that may have prevented this accident in the first place.

While MSHA definitely fell short, it was not for lack of trying. MSHA issued $1.3 million in penalties prior to the accident. The agency shut down parts of the mine 52 times in the previous year.

But these citations didn't change Massey's conduct. In fact, rather than fixing problems, MSHA's penalties were met with litigation, not compliance.

At UBB, Massey contested 92 percent of all penalties prior to the explosion. What is clear is that MSHA was no match for Massey or any other mining operation where corporate greed comes before the health and safety of the workers.

Today, we recognize that the entire system failed the miners at Upper Big Branch. Past Congresses shouldn't have slashed funding for mine inspectors.MSHA needed to do a better job with the tools it had. And Massey exploited MSHA's weaknesses and those in the law and hurt their workers.

The law should have been much stronger because that is what it takes when an operator has little or no regard for their workers.

We are prepared to work with our colleagues to enact meaningful reform so that we can honor Leo Long's plea and the lives of our country's miners. Because, Mr. Chairman, the blood spilled by these miners must not be in vain and it must not be forgotten. And we must protect all miners from the errors that led to the UBB disaster.

Mr. Chairman in closing, I want to welcome our witnesses that will be here today and Joe Main, as well as Representatives Rahall and Capito, who have a lot invested in our getting this right.

I yield back.

[The statement of Ms. Woolsey follows:]

Prepared Statement of Hon. Lynn Woolsey, a Representative in Congress From the State of California

Today, as we examine the lessons learned from the Upper Big Branch mine disaster, let us never lose sight that there are 29 families who lost their fathers, their brothers, their husbands and their best friends.

Almost two years ago, this committee traveled to Beckley, West Virginia where we heard chilling testimony from the families and miners about the unbelievably terrible conditions in that mine.

Leo Long, a lifelong miner and grandfather of one of the 29 miners, testified.

He said: "I'm asking for you all to please do something for the rest of the coal miners that's in the mines. I pray for it every night, every day. If you don't do something, something like this is going to happen again."

Mr. Long, we hear your plea.

Since that hearing, there have been four investigative reports on this tragedy. All of them found that Massey Energy caused the explosion by failing to comply with long established safety standards.

Massey failed to prevent this tragedy because:

- It didn't maintain the water sprays to quench the ignition;
- Or shore up the mine roof to keep the mine ventilated; and
- And it failed to keep the mine rock-dusted to prevent a coal dust explosion.

On top of Massey's failure to follow basic safety protections, it also engaged in a pattern of obstruction.

• Massey routinely provided advance notice of inspections, which gave foremen time to correct hazardous conditions or stop production before MSHA inspectors arrived underground.

• Massey kept two sets of mine examination books;

• And, Massey engaged in a pattern of intimidation by threatening miner's jobs, if they tried to stop production to correct unsafe conditions.

The Governor's Independent Panel concluded that these failures were the result of a culture where "wrongdoing became acceptable, where deviation became the norm."

Under the Mine Act, the mine operator is responsible for the health and safety of its miners. And if that operator fails, it is up to the safety agency to bend the operator back into line.

But MSHA's effort was compromised at UBB.

• There were poor inspection practices, and a failure to identify violations;

• There was a failure to put this mine on Pattern of Violations, or apply maximum penalties;

• There was a failure to investigate Massey managers who may have engaged in "knowing and willful" violations; and

• Mine plans were approved without resolving safety concerns.

Today we must examine why this happened. What broke down?

We know that budget cuts and retirements incapacitated MSHA's effectiveness, particularly in the early 2000's.

Then, after three mine tragedies in 2006, Congress finally reversed course and provided resources to put more inspectors back in the mines.

But the new inspectors didn't yet have the needed experience. And there were not enough technical specialists. Violations went undetected, including critical violations highlighted in the latest NIOSH report.

Only a few weeks before the UBB explosion, MSHA inspectors were underground near the source of the explosion, but the lead inspector had only 13-months experience.

While MSHA definitely fell short, it was not for lack of trying. MSHA issued $1.3 million in penalties prior to the accident. The agency shut down parts of the mine 52 times in the previous year.

But these citations didn't change Massey's conduct.

In fact, rather than fixing problems, MSHA's penalties were met with litigation, not compliance. At UBB, Massey contested 92 percent of all penalties prior to the explosion.

What is clear is that MSHA was no match for Massey or any other mining operator where corporate greed comes before the health and safety of their workers

Today we recognize that the entire system failed the miners at Upper Big Branch. Past Congresses shouldn't have slashed funding for mine inspectors. MSHA needed to do a better job with the tools it had. And Massey exploited MSHA's weaknesses and those in the law. The law should have been much stronger because that is what it takes when an operator has little or no regard for their workers.

We are prepared to work with our colleagues to enact meaningful reform, so that we can honor Leo Long's plea and the lives of our country's miners, because Mr. Chairman, the blood spilled by these miners must not be in vain or forgotten, and we must protect all miners from the errors that led to UBB disaster.

In closing, I want to welcome our witnesses, as well as Representatives Rahall and Capito.

Chairman KLINE. I thank the gentlelady.

Pursuant to Committee Rule 7C, all committee members will be permitted to submit written statements to be included in the permanent hearing record.

And without objection, the hearing record will remain open for 14 days to allow statements, questions for the record, and other extraneous material referenced during the hearing be submitted in the official record.

Let me add my welcome today to our colleagues from West Virginia, Mrs. Capito and Mr. Rahall.

Without objection Mrs. Capito and Mr. Rahall be permitted to participate in our hearing today. And I hear no objection.

We have two distinguished panels of witnesses today. And I would like to begin by introducing the first panel.

He is a panel of one, Assistant Secretary of Labor for the Mine Safety and Health Administration, Joe Main.

Mr. Main has been a coal miner and mine safety advocate for over 40 years. He worked for the United Mine Workers of America in various positions from 1974 to 2002, including 22 years as the administrator of UMWA's Occupational Health and Safety Department. Prior to his nomination, he worked as a mine safety consultant.

Welcome back, Mr. Main.

Before I recognize you to provide your testimony, let me remind you of our quaint, but nevertheless important lighting system there. It is a green, yellow, red—pretty self-evident.

We want to hear what you have to say. All of your testimony will be included in the record. You are free to summarize as you wish.

When we get into questions, I will be asking my colleagues to stick to the 5-minute rule so that we can all have a chance to engage in the discussion and have time for the second panel.

And with that, sir, you are recognized.

STATEMENT OF HON. JOSEPH A. MAIN, ASSISTANT SECRETARY, MINE SAFETY HEALTH ADMINISTRATION, U.S. DEPARTMENT OF LABOR

Mr. MAIN. Thank you, Chairman Kline and Ranking Member of the committee, and members of their committee as well.

I appreciate the opportunity to report on the April 5th, 2010 disaster at the Upper Big Branch Mine that caused the death of 29 miners.

MSHA's actions since then, the findings of the internal review into MSHA's activities before the explosion, and why despite our efforts to use all of our tools, legislation still needed to fully protect the nation's miners.

The tragedy, which occurred a few months following my confirmation, was the deadliest coal mine disaster in 40 years, has caused unimaginable grief for the families and loved ones of miners, and it extends well, I think, beyond that.

But they all should want assurance that an explosion like this never happens again. And that we are doing all that we can to keep miners safe.

Our inquiries have been the most transparent MSHA has ever conducted. Throughout, we have held numerous meetings with the families as well as congressional and public briefings.

On December the 6th, 2011, MSHA's action investigation team issued its final report. It found that the explosion was likely started with a methane ignition that when fueled by excessive amounts of coal dust transitioned into a massive coal dust explosion.

The physical conditions that lead to the explosion were the result of a series of violations of basic safety which were disregarded at Upper Big Branch.

But it was also the unlawful practices implemented by Massey that were at the root of the tragedy, such as advanced notice of MSHA inspections, intimidations of miners, and concealing hazards and injuries from regulators.

While most of Massey's top management at UBB exercised their Fifth Amendment rights during the investigation, one official recently validated our investigation's findings.

Gary May, a superintendent at the time of the explosion, recently testified that it was standard practice at UBB to warn employees underground of inspections and to fix or conceal hazards before inspectors could observe them.

He also stated when he was a section boss, he would always spread extra rock dust and make everything look good when he was told an inspector was on the way.

The Massey operation was issued 369 violations totaling $10.8 million in penalties. Alpha Natural Resources, which acquired Massey after the explosion, did not contest these violations and paid the penalties in full.

MSHA also conducted internal review and released its report of March 6th which found that despite MSHA's District 4 aggressive enforcement efforts, which were among the toughest in the nation, there were a number of deficiencies at UBB including MSHA's failure to identify the extent of noncompliance with rock dust standards along belt conveyors, and significant shortcomings in the operators ventilation of roof control plans.

The internal review also identified deficiencies in District 4's adherence to MSHA's policies and procedures including deficiencies cited by the previous internal reviews.

The internal review concluded that these deficiencies were primarily a result of budget constraints and the attrition of experienced staff which left District 4, and elsewhere, short-staffed and with serious experienced deficits.

This was particularly true with our roof control ventilation and other specialists.

The internal review team also acknowledged a fact that we should not lose sight of. The challenges MSHA faced in enforcement at UBB were created by an operator that intentionally evaded the law and interfered with our efforts to enforce it.

The internal review confirmed that the accident investigation team's findings that Massey, not MSHA enforcement, caused the explosion. We have reviewed the internal review's findings and have implemented a number of recommendations including reforms to be done before UBB. We know more needs to be done.

We are also reviewing the conclusions and additional ideas of the NIOSH independent panel. Since UBB, MSHA has worked harder to use every tool at its disposal to ensure operators provide a safe and healthy workplace for miners. We believe our efforts are making a difference.

Our most effective enforcement tools were the impact inspections which began immediately after the disaster.

Since April 2010, we have conducted more than 400 impact inspections arriving at mines during off hours, often monitoring mine communications to prevent unscrupulous operators from giving advance notice.

We have strengthened our Pattern of Violations process to make it as effective as we can under the current regulations. For the first time in history, MSHA has placed two mines on a Pattern of Viola-

tions, and has seen improvements in other mines subject to the POV process.

Despite our efforts the current POV system is still flawed. Our proposed rule that we have announced would address flaws in the current rule that make it less effective than what Congress intended for it to be.

MSHA has also beefed up enforcement of critical health and safety requirements, taking regulatory action to improve operator compliance; required mandatory 2-week, biannual training of all field office supervisors; split District 4 into two co-districts to better manage enforcement; reorganize the Office of Assessments to centralize oversight of accountable audits and the enhanced enforcement actions; and increased efforts to educate miners and protect them from discrimination.

The majority of operators do try to obey the law. However as UBB and our impact inspections illustrate, there are still some operators who flaunt the law.

The administrative and regulatory reforms we are implementing are not enough. As prior congressional hearings on UBB tragedy have made clear, we do need legislative reform without undercutting the critical provisions that have saved many thousands of miners from death, injury, and illness.

The egregious problems MSHA continues to find, and the tactics it must use in trying to outfox—operators validate the administration's support for focused improvements to the Mine Act.

Congress should address an equal certification processes and work to strengthen the criminal provisions of the Mine Act. We cannot tolerate employers who are knowingly risking the lives of workers by cutting corners on safety or providing advance notice of inspections.

Congress should provide MSHA with sufficient authority to act quickly when the protection of miners and miners' health require immediate action. Legislation must ensure miners are fully protected from retaliation.

As this very committee learned during the field hearing on the Upper Big Branch disaster in Beckley, West Virginia, miners were often afraid to speak out because they fear losing their jobs.

I look forward to working with the committee to find the best way to accomplish our shared goal of providing our nation's miners the safety and health protections they deserve.

And thank you, Mr. Chairman.

[The statement of Mr. Main follows:]

Prepared Statement of Hon. Joseph A. Main, Assistant Secretary of Labor for Mine Safety and Health

CHAIRMAN KLINE, RANKING MEMBER MILLER, AND MEMBERS OF THE COMMITTEE: I appreciate the opportunity to appear here today on behalf of the U.S. Department of Labor, Mine Safety and Health Administration (MSHA) to outline for you the results of MSHA's accident investigation into the April 5, 2010 explosion at the Upper Big Branch (UBB) mine in West Virginia that needlessly took the lives of 29 miners, as well as the conclusions of the internal review on MSHA's activities at UBB in the 18 months leading up to the explosion. I also want to report on the actions that we have taken since the explosion and our plans for further actions going forward.

The accident at UBB was the deadliest coal mine disaster this nation has experienced in 40 years. The explosion occurred just months after my appointment as Assistant Secretary, and the tragedy shook the very foundation of mine safety. It caused us all to take a deeper look at the weaknesses in the safety net expected

to protect the nation's miners. The impact the tragedy has had on the families of the miners lost and the mining community is beyond measure.

There has been an intense examination of that tragedy, and MSHA and the mining industry have undergone significant change as we have sought to find and fix deficiencies in mine safety and health. While more needs to be done, we have implemented a number of strategic actions which I believe are improving mine safety.

The safety and health of those who work in the mines in this country is of great concern to President Obama, Secretary of Labor Hilda Solis and me. The Secretary has articulated a forward-looking vision of assuring "good jobs" for every worker in the United States, which includes safe and healthy workplaces, particularly in high-risk industries, and a voice in the workplace. At MSHA, we are guided by that vision.

I arrived at MSHA in October 2009 with a clear purpose—to implement and enforce mine safety laws and improve health and safety conditions in the nation's mines so miners in this country can go to work, do their jobs, and return home to their families safe and healthy at the end of every shift. To honor the memory of the 29 miners who died at Upper Big Branch, as well as their families, we have redoubled our efforts to protect today's miners.

Having been involved in mining since the age of 18, I have a deep respect for those who choose mining as a career. I have spent most of my life with miners, mine operators and mine safety professionals. Mining is critically important to our economy, and it is our collective responsibility to ensure effective health and safety standards are in place and are followed to prevent injury, illnesses and death. Most of the industry shares this belief and accepts its responsibility under the Federal Mine Safety and Health Act (Mine Act) to comply with health and safety standards to protect its workforce. Nevertheless, injuries, illnesses, and fatalities have still taken an intolerable toll on miners, their families, their communities and the mining industry. Unfortunately, at UBB, Performance Coal and Massey Energy (PCC/Massey) cut corners on safety and engaged in other illegal practices that caused the explosion and impeded MSHA's ability to fully enforce the Mine Act. We cannot allow this to happen again.

Upper Big Branch Accident Investigation

On December 6, 2011, MSHA's investigation team issued the results of its investigation at UBB. The investigation, which lasted some 20 months, included a comprehensive underground examination and interviews of nearly 270 individuals. In the course of the investigation, the team reviewed approximately 88,000 pages of documentary evidence, conducted detailed mapping of the mine, tested thousands of pieces of physical evidence, and commissioned outside experts to assist in examining the disastrous explosion. This investigation was the most transparent in MSHA's history. From the time of the explosion through the December 6th release of the accident investigation report, MSHA held 11 meetings with family members, and consistent with Section 7 of the Mine Improvement and New Emergency Response Act of 2006 (MINER Act), MSHA family liaisons have been in continuous contact with the families. MSHA also conducted two public briefings—one on June 29, 2011 and another on the day of the release—regarding the status and findings of the investigation. Leading up to the report release, MSHA continuously posted information on the single-source page of its website as it became available. On the day of the release, MSHA posted the report and appendices, interview transcripts, maps and other documentation related to the explosion. We also have held regular briefings for this Committee's leadership and your staff on the status of the investigation and our findings.

The accident investigation determined that the 29 miners who perished at UBB died in a massive coal dust explosion that most likely started with an initial methane ignition and was fueled by excessive amounts of coal dust transitioning into a massive coal dust explosion. The physical conditions at the mine that led to the coal dust explosion were the result of a series of basic safety violations, which PCC/Massey disregarded. They did not apply adequate amounts of needed rock dust to areas of the mine involved in the explosion, allowing float coal dust, coal dust and loose coal to build up to dangerous levels. They did not comply with the mine's approved ventilation and roof control plans and failed to conduct adequate on-shift, pre-shift, and weekly examinations. They did not maintain the longwall shearer in proper operating condition and failed to maintain a sufficient volume of air in order to dilute or dissipate methane gas present in the mine.

The unlawful policies and practices implemented by PCC/Massey were at the root of this tragedy. The management of PCC/Massey engaged in illegal practices and procedures, including giving advance notice of MSHA inspections, intimidation of miners, keeping two sets of books that hid hazards from MSHA and others, and hid-

ing injuries. The most damning information to date on PCC/Massey's unlawful practices of giving advance notice came to light after the accident investigation and internal review reports were completed.

On February 29, 2012, the UBB mine foreman and block superintendent at the time of the accident, Gary May, testified at the sentencing hearing of Hughie Elbert Stover, UBB's security chief, who had been convicted in Federal court for making false statements and obstruction of justice and subsequently sentenced to three years in prison. For his part, Mr. May recently entered into a plea agreement with the Department of Justice (DOJ), admitting to conspiracy to give advance notification of mine inspections, falsify examination record books and alter the mine's ventilation system before Federal inspectors were able to inspect underground. He explained that it was standard practice at UBB to warn employees underground of Federal and State inspections, and that this advance notice of inspections was used to "fix" hazards such as coal accumulations, ventilation problems, and to apply rock dust to "make everything look good." Through these unlawful practices, Mr. May testified that PCC/Massey was able to avoid detection of violations by Federal and State inspectors. We still do not have a complete picture of the appalling practices at UBB that were designed to hide health and safety violations from inspection agencies, but hope to learn more as events unfold.

Mr. May's testimony affirms findings of the accident investigation team that PCC/Massey promoted and enforced a workplace culture that valued production over safety, including practices that allowed it to conduct mining operations in violation of the law by deliberately hiding violations from MSHA and State regulators. MSHA's findings are consistent with the conclusions of other reports about the tragedy, including the reports from the State of West Virginia, the Governor's Independent Panel and the United Mine Workers of America.

Massey was cited for 12 contributory violations, nine of which were flagrant, and 360 non-contributory violations for total penalties of $10.8 million. Alpha Natural Resources (Alpha), which acquired Massey Energy after the explosion, did not contest these violations and paid the penalties in full.

At the direction of the President, the Department of Labor has fully cooperated with DOJ's investigation into possible criminal wrongdoing at UBB. On the day the accident investigation report was released, DOJ announced it had reached a Non-Prosecution Agreement with Alpha that requires the company to make payments and expenditures totaling $209 million. The Agreement obligates Alpha to implement a number of safety improvements, including the use of coal dust explosibility meters to allow immediate results of the combustibility of mine coal dust to prevent mine explosions, atmospheric monitoring systems to better detect conditions in the mine atmosphere to prevent mine explosions, and oxygen cascading systems to help miners escape during mine emergencies. This Agreement, however, does not relieve any individual from potential criminal prosecution.

Findings of the Internal Review

MSHA conducts an internal review of its enforcement activities after each mining accident that results in three or more fatalities. By MSHA policy, the Director of Program Evaluation and Information Resources (PEIR) forms the team and is responsible for overseeing the review. For UBB, the team primarily focused on MSHA's actions in the 18 months leading up to the explosion, particularly in District 4, which had jurisdiction over UBB. Secretary Solis asked the director of the National Institute for Occupational Safety and Health (NIOSH), Dr. John Howard, to identify a team to conduct an independent analysis of MSHA's internal review in order to assure the transparency and accountability of the review. On March 22, 2012, Dr. Howard transmitted NIOSH's report of its independent analysis to the Secretary. We are currently reviewing this report, including its conclusions and ideas for agency action.

I asked that the internal review team carry out a thorough examination of MSHA's activities at UBB. They produced the most comprehensive and detailed internal review report that I have ever seen. The team's report is the culmination of nearly two years of a singularly focused effort, including interviews with nearly 90 current and former MSHA employees and the examination of more than 12,500 pages of documents. The report acknowledged the challenges the agency faced in enforcing the Mine Act against an operator whose "intentional efforts to evade well-established Mine Act provisions * * * interfered with MSHA's ability to identify and require abatement of hazardous conditions at the mine," and found that MSHA actions or inactions did not cause the explosion. The report did, however, identify a number of deficiencies and make recommendations for improvement. The report examined in depth the root causes of these shortcomings, which will allow the agen-

cy to permanently fix deficiencies that have been identified in internal reviews following other mine tragedies.

District 4 enforcement personnel were responsible for more coal mines than any other coal district in the country. Nearly 30 percent of the nation's underground coal mines and 14 percent of surface mines and facilities were located in District 4. Yet, at the time of the explosion, District 4 had less than 20 percent of the inspectors, trainees and specialists in the Coal Mine Safety and Health Division. During the 18-month review period that was the focus of the internal review, District 4 was responsible for inspecting 193 underground mines and 242 surface mines and facilities, and issued more than 35,000 citations and orders, which accounted for 23 percent of all violations and 34 percent of all unwarrantable failure violations issued at all coal mines nationwide. For years, unwarrantable failure citations and orders have been considered the toughest tool available to inspectors. In Fiscal Year (FY) 2009, for example, District 4 issued more unwarrantable failure citations at UBB than any of the other 14,600 mines in the nation.

While the internal review found that District 4 had one of the toughest enforcement records of all MSHA districts, it also identified a number of instances where enforcement efforts at UBB were compromised because established agency policies and procedures for inspections, investigations and mine plan reviews were not followed. Inspectors did not consistently identify deficiencies in the mine operator's program for cleaning up accumulations of loose coal, coal dust and float coal dust. They did not use PCC/Massey's examination books records effectively when determining the operator's negligence in allowing identified hazards to continue unabated. They did not identify the extent of noncompliance with rock dust standards along belt conveyors and did not identify significant deficiencies in the operator's ventilation and roof control plans. The internal review did note, however, that the thoroughness of District 4 inspections improved over the 18 months preceding the accident.

The internal review also found that MSHA did not effectively use other available elevated enforcement tools. For example, in eight instances, District 4 inspectors did not flag certain violations as potentially "flagrant," even though these violations met the internal guidance criteria for considering a violation for a flagrant designation. In several other instances, it did not conduct special investigations to determine whether PCC/Massey management had knowingly violated mandatory health and safety standards. Moreover, the internal review found that supervisors did not adequately review MSHA inspector documentation related to UBB inspections to identify significant deficiencies, or recognize that some portions of the mine had not been inspected. The turnover of supervisors in District 4's Mt. Hope field office—including untrained acting supervisors—contributed to the inadequate review of inspection reports. The issue of turnover also extended to the district manager position; between June 2003 and July 2004, four different MSHA personnel were temporarily assigned to this position.

In addition, the internal review team extended its review to areas unrelated to the explosion, such as respirable dust, where it found District 4 personnel followed a flawed policy that allowed PCC/Massey to manipulate MSHA procedures to avoid complying with reduced standards for respirable coal mine dust, and allowed the operator to significantly delay corrective action after such unhealthy overexposures were identified. We are in the process of revising this policy to require that reduced standards be maintained and enforced until sampling data shows that it is no longer necessary.

A number of factors led to these shortcomings. For example, as the internal review team noted, the number of coal enforcement personnel had eroded to 584 by the end of FY 2005, a result of attrition and budget constraints. By comparison, there were 653 such personnel in FY 2001. Following the 2006 Sago, Darby and Aracoma disasters, MSHA received additional funds to hire more inspectors. However, despite efforts to re-establish staffing levels, by the time of the UBB explosion, the inspection and supervisory staff was significantly composed of new inspectors, replacing a number of experienced inspectors who retired. For example, from FY 2005 to FY 2008, MSHA lost 252 coal enforcement personnel from its ranks. Some inspectors retired, were recruited by industry, moved to new positions within the agency, or left MSHA for other reasons. As noted in testimony before this Committee in February 2010, when I arrived at MSHA in October of 2009, approximately 55 percent of Coal Mine inspectors and 38 percent of Metal and Nonmetal inspectors had two or fewer years of experience as an inspector. The budget constraints and constant loss of experienced personnel due to attrition adversely affected the entire agency (See: Chart A).

MSHA also experienced an alarming reduction in the number of specialists in the coal division to assist with plan reviews and conduct technically specialized portions

of inspections. Between FY 2001 and FY 2006, the number of MSHA subject matter specialists in coal mine ventilation, roof control, electrical systems, occupational health, and impoundments fell from 241 to 170, a 29 percent drop (See: Chart B). During this same period, the number of Mechanized Mining Units (MMUs) in the nation rose from 834 to 1,180, a 41 percent increase (See: Chart C), creating a greater need for specialists in underground mines. In addition, in order to complete all mandatory inspections required under the Mine Act, specialists were being asked to assist with more general inspection duties. Even with this extra assistance from our specialists, not all mandatory inspections were being completed.

Mining is a highly technical field, and new hires go through extensive training for up to two years and receive on-the-job training from a journeyman inspector. As a result, even the most experienced of these new inspectors had only been conducting Federal mine inspections for a couple of years. In addition, when new inspectors were hired after 2006, there were not enough experienced inspectors to mentor them or oversee their on-the-job training. For example, in FY 2007, one-third of MSHA enforcement personnel nationwide and in District 4 were still considered trainees. Moreover, agency experience among lead inspectors assigned to UBB during the 18 months preceding the explosion ranged from 13 to 52 months. The reduction of staffing and drain of experienced staff during the early to mid-part of the 2000s, combined with the lack of experience of their replacements, had a significant adverse impact on the agency from which we were only beginning to recover at the time of the April 2010 disaster.

Massey's deceptive and illegal actions significantly interfered with District 4's ability to effectively enforce the law at UBB, as Gary May's recent testimony revealed. Nevertheless, MSHA assumes responsibility for its actions and inactions at UBB and takes the deficiencies and recommendations outlined in the internal review report extremely seriously. We have already implemented many actions to improve enforcement, and set a timetable for implementing the internal review team's recommendations. We are also reviewing the regulatory recommendations of both the accident investigation team and the internal review team to determine which regulatory changes to pursue.

MSHA Actions to Improve Safety

The tragic events of April 5th changed the lives of many people in varying degrees—the miners' families, their communities, miners around the country, and those of us at the Department of Labor dedicated to mine safety. President Obama said shortly after the accident that "we owe [those who perished in the UBB disaster] more than prayers. We owe them action. We owe them accountability." MSHA and the Department of Labor have worked diligently to make good on the President's promise. MSHA's actions—including initiatives started both before and in response to Upper Big Branch—have been strategic and focused, and they are making a difference.

While we will be implementing the recommended improvements contained in Appendix A of the UBB internal review report, I want to share with you some of the significant changes we have already made and the further actions we intend to take to ensure miners' health and safety.

Enforcement

In the months after the disaster, MSHA issued new enforcement policies and alert bulletins addressing hazards identified after the explosion, such as prohibition on advance notice of MSHA inspections, mine ventilation and rock dusting requirements, and the rights of miners to report hazards without being subject to retaliation. The intent of these efforts was to ensure that miners and mine operators understand important enforcement policies, as well as strengthen agency enforcement in key areas related to the disaster. For instance, in September 2010, MSHA issued an emergency temporary standard that strengthened rock dusting requirements in all accessible areas of underground bituminous coal mines to prevent explosions. MSHA issued a final rule in June 2011.

MSHA also started changing the way it does business to ensure that appropriate efforts are focused on operations that pose the greatest risk to the safety and health of miners. One of our most effective enforcement tools to facilitate this change is our impact inspections. Immediately after the disaster at UBB, we began to conduct strategic "impact" inspections at coal mines with a history of underground conditions that indicated potential problems relating to methane accumulations, ventilation practices, rock dust applications and inadequate mine examinations. In August 2010, I issued an agency directive expanding impact inspections to coal and metal/nonmetal mines that merit increased agency attention and enforcement due to their poor compliance history or particular compliance concerns. As I noted in testimony

before this Committee previously, these impact inspections have shaken-up even the most recalcitrant operators. MSHA has shown up at mines during "off hours", such as evenings and weekends, and has monitored mines' phone lines upon arrival to prevent unscrupulous operators from giving advance notice of the inspectors' presence. Since April 2010, we have conducted more than 400 impact inspections at coal and metal/nonmetal mines.

While we believe these strategic inspections are making a difference and improving safety and health conditions in the nation's mines, there are still some operators who continue to flout the law and MSHA continues to encounter operator tactics to prevent inspectors from finding hazards. For example, I previously reported to you on a mine in Claiborne County, Tennessee, where MSHA inspectors monitored company phones during the evening shift and found numerous ventilation, roof support, and accumulation of combustible materials violations. These conditions potentially expose miners to mine explosions, roof falls, and black lung disease. MSHA issued 27 citations and 11 orders as a result of that inspection. In November 2010, this same mine was given notice of a potential pattern of violations (PPOV) of mandatory health or safety standards under Section 104(e) of the Mine Act. In July 2011, MSHA inspectors conducted a sixth impact inspection at the mine, seizing and monitoring mine communications to prevent advance notice of their arrival. MSHA issued 32 citations and orders, including eight closure orders for the operator's unwarrantable failure to correct conditions that could have prevented miners from safely evacuating the mine in the event of a fire, explosion or other emergency. This troubled mine eventually ceased operations. In another example, just last month, our inspectors witnessed a mine employee calling underground to provide advance notice of the inspection during an impact investigation of an underground coal mine in West Virginia.

We have made significant improvements to another of our enforcement tools, the pattern of violations (POV) process, making it as effective as we can under current regulations. The Mine Act provides for an administrative process under which a mine identified to have a pattern of "significant and substantial" (S&S) violations receives closure orders for each S&S violation until it receives a clean inspection. In October 2010, we overhauled the POV process to focus on mines with the worst records and require operators to make significant and lasting safety improvements. MSHA has conducted two screenings under the revised criteria, and issued a total of 28 potential patterns of violations (PPOV) notices at 26 mines. MSHA provides a PPOV notice to operators to give them an opportunity to improve compliance before being placed on a POV. Notably, four of these PPOV notices were issued on the basis of agency audits revealing that mine operators under-reported injuries; otherwise, the mines would have avoided our screening process. Two of the mines have been placed on a POV. Last year was the first time in the Mine Act's 34-year old history that MSHA issued POV closure orders. The POV process is open and transparent. The criteria we use for PPOV screenings are posted on our website, and in April of last year, we announced a new online tool which permits any mine operator, miner or member of the public to see whether a mine is meeting the criteria for a PPOV. Any operator can use the tool to monitor its compliance and implement immediate corrective actions if its violation history could trigger a PPOV notification.

Despite our efforts to improve the current POV process, it is still flawed. On February 2, 2011, MSHA proposed a rule revising the pattern of violations regulations to better reflect the intent of Congress. Under current regulations, a POV notice can only be based on final orders. However, given the backlog of cases pending before the Federal Mine Safety Health and Review Commission (FMSHRC), discussed in more detail below, significant delays lasting years frequently occur before serious violations become final and can be considered part of a POV. In the meantime, miner safety and health is still at risk. The proposed rule would eliminate the requirement that a POV notice be based on final orders. In addition, it would eliminate the PPOV process, requiring operators, not the government, to take responsibility for monitoring their compliance and taking corrective action. We are considering the public comments we have received on the provisions of this proposed rule and expect a final rule to be published this spring.

While improvements are needed, we believe that MSHA's enforcement efforts thus far are bringing about improvements in compliance and in safety and health conditions. A recent review of mines subject to the impact inspection program showed that violations per inspection hour are down 11 percent, S&S violation rates are down 18 percent, closure (104(d)) orders are down 38 percent, and the total lost time injury rate is down 18 percent. An analysis of the 14 mines completing the POV process under our current criteria showed similar overall improvements. The violation rate at those mines is down 21 percent, the total S&S violation rate is down

38 percent, and the rate of closure (104(d)) orders is down 60 percent. The lost time injury rate has dropped 39 percent.

There are also reductions in violations across the mining industry. The number of citations and orders issued by MSHA has decreased from over 170,000 in 2010 to about 158,000 in 2011. For underground coal mines, 77,000 citations and orders were issued in 2011, down from about 80,000 in 2010. We believe the reduction in violations reflects increased compliance.

Training, Administration and Management

We have undertaken a number of actions beyond the enhancements to our enforcement programs, some of which were included in recommendations by the UBB internal review. One of the programs I focused on when I arrived at MSHA was a new training program for all field office supervisors to improve oversight of the inspection program and consistency in enforcement of the Mine Act. With the changeover in agency staffing, training of front-line supervisors to foster effective management and consistent enforcement was critical. I first announced this program to the Committee in February 2010. The training, which field office supervisors must now take on a bi-annual basis, was developed just prior to the UBB disaster and includes subjects identified in past internal reviews and agency audits. It will also be updated to address the findings of the UBB internal review team. All coal and metal/nonmetal field office supervisors have completed this training for the Calendar Year (CY) 2011-2012 cycle.

In 2010, I also required the administrators for Coal and Metal/Nonmetal to establish a plan to review all the policies and procedures inspectors must follow when conducting inspections. The purpose of this review was to identify inefficiencies and impediments in the inspection process; better explain policies to mine operators and employees; and update existing policies to incorporate some of the past findings and recommendations from agency audits internal reviews, and other government studies and investigations. The first review phase, for Coal Mine Safety and Health, was completed in January 2012 and produced a comprehensive draft document that incorporates all identified inspection policies, procedures, forms, and past findings and recommendations for inclusion into a single inspection handbook. An agency task force, established in January 2012, has begun the next phase of reviewing and finalizing the draft, which will culminate in a new, comprehensive inspection handbook that lays out clear, consistent, and easily accessible guidance to MSHA inspectors in a format that can be easily updated and made available electronically. This should result in improved quality and consistency of inspections. Metal/Nonmetal is working on a parallel path with its own handbook.

In February 2012, I directed the reinstitution of a centralized administrative review process for all of the agency's directives. As the internal review found, the agency's directives system was not effectively communicating agency policy to the field. We will fix that, starting with centralized oversight of the development and dissemination of directives and better controls on how they are issued and distributed.

In June of 2011, we announced a new MSHA district in southern West Virginia. To help manage the large number of coal mining operations in that region, we split District 4 into two districts, creating District 12. The split will increase line and management staff in southern West Virginia, providing more enforcement resources and better oversight of enforcement personnel.

Also in June 2011, MSHA transferred the management and operation of the National Air and Dust Laboratory in West Virginia from the coal program to our Office of Technical Support, in response to an Inspector General recommendation that MSHA upgrade the lab to improve its rock dust analysis turnaround time. We have improved the turnaround time, and are taking other actions to improve and modernize the lab, which processes approximately 50,000 inspector rock dust samples for total incombustible content, and 40,000 mine gas samples per year.

In February 2012, I announced a reorganization of MSHA to centralize oversight of certain cross-cutting, compliance-related actions. The Office of Assessments, Accountability, Special Enforcement and Investigations (OAASEI) will now incorporate the management, support, and coordination of routine and special assessments, as well as agency headquarters accountability functions and special enforcement strategies. Under this reorganization, MSHA consolidated its current headquarters accountability functions, as carried out by the Office of Accountability, within the OAASEI. As background, the Office of Accountability originally was created in response to internal reviews of the Sago, Aracoma and Darby mine disasters that were critical of MSHA's pre-accident enforcement activities and questioned whether policies intended to prevent serious mine disasters were being properly and effectively implemented. However, by re-establishing headquarters accountability func-

tions within the OAASEI, MSHA will enhance the management, administrative, and analytical support for this component while retaining OAASEI's independence from the mine inspection program areas.

This reorganization also establishes a single office within OAASEI for the coordination of a number of special enforcement strategies, including: flagrant violations, investigations of retaliation claims and possible criminal violations, impact inspections, the pattern of violations program, and the use of injunctive authority. The formation of OAASEI will enable MSHA to better manage and coordinate its use of special enforcement tools against the most serious violators of the Mine Act.

Finally, as I have mentioned, in the last decade MSHA suffered significant attrition among its experienced personnel. As a result, we are exploring how to address the succession issue at MSHA.

Proactive Accident Prevention

The UBB disaster highlighted the need to ensure that mine operators take seriously their obligation to find and fix the hazards in their mines instead of waiting for MSHA to point out problems. As I have stated since my first hearing before this Committee in February 2010, MSHA cannot be on every shift at every mine, and any effective enforcement regimen must require to operators to take ownership of health and safety at their mines. On December 27, 2010, MSHA published a proposed rule that would revise existing requirements for pre-shift, on-shift, supplemental, and weekly examinations of underground coal mines. The proposed rule would require that operators identify and correct violations of mandatory health or safety standards and review quarterly with mine examiners all citations and orders issued in areas where examinations are required. This rule would reinstate requirements that were in place for some 20 years following the passage of the 1969 Mine Act. We expect the final rule to be published soon.

We have not focused just on preventing mining disasters, but also on the most common causes of mining deaths, such as accidents involving the use of machinery and equipment. As you know, we launched our multi-phase Rules to Live By (RLB) initiative in January 2010, to focus attention on the most common mining deaths and the associated safety standards. In particular, this initiative identifies for operators the standards that will be a focus of enforcement so they can take appropriate preventative measures. The second phase, "Rules to Live By II: Preventing Catastrophic Accidents" followed in November 2010, and in January of this year we announced the next phase, Rules to Live By III: Preventing Common Mining Deaths. RLB III highlights those safety standards cited as a result of at least five mining accidents and resulting in at least five fatalities during the 10-year period from January 1, 2001, to December 31, 2010.

We believe these efforts are saving lives. Preliminary data shows 37 miners died in work-related accidents at the nation's mines in 2011—the second lowest since statistics have been recorded. There were 21 coal mining and 16 metal/nonmetal mining deaths last year compared with 48 and 23, respectively, in 2010—which included 29 at Upper Big Branch. In 2009, we saw the lowest fatality numbers with 34 total mining deaths, of which 18 were in coal. It is also important to note that the mining industry finished fiscal year 2011 with the lowest number of mining deaths ever recorded. However, as low as the fatality numbers have come in recent years, we all know that one death is one too many; that mining deaths are preventable; and there is more that must be done.

Backlog of Contested Cases

The UBB disaster underscored the need to address the backlog of cases at the Federal Mine Safety and Health Review Commission (FMSHRC). At the time of the disaster PCC/Massey was contesting 92 percent of the penalty dollars proposed by MSHA, adding to the backlog. In addition, because its cases were not being resolved in a timely fashion, the penalties did not have the intended deterrent effect on Massey's conduct. In fact, Massey had $1.3 million in pending proposed penalties right before the explosion. We have taken a number of actions to attack this problem. First, the Department is putting to use the appropriations that Congress provided for the Department and FMSHRC to reduce the backlog. These extra resources have helped us to resolve cases and significantly reduce the number of contested violations, from almost 89,000 in January 2011, to fewer than 67,000[1] in December 2011, a 25 percent reduction in the span of just one year.

In January of this year, MSHA began to implement pre-assessment conferencing procedures. The new procedures are based on the results of a pilot program

[1] These numbers are cite violations and are based on MSHA's data. The numbers differ from FMSHRC data, which cites cases not violations.

launched in August 2010, which evaluated the impact of pre-assessment conferencing on operators' decisions whether to contest citations. The evaluation incorporated input from industry stakeholders, including mine operators and miners' representatives. During the pilot program, operators frequently opted not to participate in pre-assessment conferences, but there was a high resolution rate for those that did.

Each MSHA district must determine when to implement the pre-assessment conferencing procedures based on available resources. Implementation may occur slowly, or not at all in some districts, until other backlog reduction strategies take hold and reduce caseloads to more manageable levels. Although no single strategy will reduce the backlog of contested cases before FMSHRC, MSHA believes this may help resolve some cases. Last year, FMSHRC instituted a rule regarding simplified proceedings. To further reduce the number of contested cases, we are also pursuing agreements, such as global and holistic settlements, that would settle a large number of violations at one time. As I noted above, Alpha agreed to withdraw many notices of contest from the Massey legacy companies and pay the penalties in full. This action alone has reduced contested violations pending at FMSHRC by more than 6,600.

Mine Emergency Response

Prior to UBB, I ordered a review to identify gaps in the nation's mine emergency response system. During our response to the disaster, while I was able to witness firsthand the heroic efforts and selfless commitment of company, State and Federal mine rescue crews, I also saw first-hand several critical gaps in communications and logistics that remain unfixed from past emergencies.

As I noted in earlier testimony, MSHA has made progress in this area, but there is more to be done. MSHA is continuing its thorough review of emergency plans and procedures to identify and fix gaps in the system. On May 7, 2012, I am convening a two-day mine rescue summit at the MSHA Academy in Beckley, WV. Mine rescue experts from all sectors of the mining community have been invited to attend. The summit coincides with mine rescue competitions, so those participants can attend the summit as well. The goal of the summit is to provide information from all sectors about the latest improvements in mine rescue, to identify remaining gaps in mine rescue response and preparedness, and to decide what further actions are needed to ensure a swift and comprehensive response from government, industry and others when a mine emergency happens.

Something that should not go unnoticed is that the 2006 MINER Act greatly enhanced our mine rescue response to the UBB tragedy. The MINER Act improved the number, availability and quality of training of mine rescue teams. I can tell you that I and the other mine emergency personnel who coordinated the rescue efforts at UBB greatly appreciated this improvement in mine rescue team strength and preparedness.

Protecting the Rights of Miners

The UBB tragedy crystallized the concern that more needs to be done to provide miners with a voice in the workplace to help ensure that miners are not intimidated from voicing safety concerns when they see poor safety practices and hazards. This was illustrated at the field hearing held by this Committee in Beckley, West Virginia in May of 2010, when the UBB accident brought into public view a culture in mining that many of us here have witnessed for years. That is one in which workers are afraid to speak up about safety hazards because of fear of losing their jobs. Miners raising their voices about safety concerns will serve to make mines safer and healthier places to work.

Having a voice in the workplace is not just a mining issue—it is a right that all workers have. Department of Labor Secretary Hilda Solis has said that her vision for the Department is "Good Jobs for Everyone." One of the components of a good job is that it is safe, secure, and provides workers with a voice in the workplace. I share the Secretary's strong commitment to good jobs and worker voice.

To reflect our commitment to worker voice, we are using all our available tools to protect miners from discrimination when they make complaints about dangerous conditions, or exercise other rights provided to them under the Mine Act. The fear of losing a job—even temporarily until a discrimination claim can be litigated—makes a huge impact on a breadwinner for a working family, and can force a miner to choose the care of his or her family over other safety concerns. At UBB, we discovered from family and friends of the deceased miners, that many of those miners were afraid of the conditions at UBB but needed their jobs to provide for their families. Between 2006 and the date of the UBB explosion, for instance, MSHA received only one complaint about the conditions at UBB.

We have stepped up the use of our authority under the Mine Act to request temporary reinstatement for miners who claim unlawful discharge while we fully investigate the case. From October 2007 to September 2009, the Department of Labor pursued a total of nine temporary reinstatement cases. By comparison, from October 2009, the month I took office, to September 2011, DOL sought 48 temporary reinstatements, an increase of more than 500 percent. For all types of Mine Act discrimination cases during that time period, the number of cases that DOL pursued rose by over 100 percent.

MSHA also has made new efforts to educate miners about the Mine Act. In June 2011, we launched a campaign to inform miners of their rights, including the right to refuse to work in dangerous conditions, the right to file a complaint or report a hazard with MSHA, and the right to select a representative in safety and health matters. We have shipped over a million pieces of information, including guidebooks, wallet cards, flyers and other materials to our field offices, in English and Spanish; our inspectors and Educational Field Services staff are distributing them to miners. MSHA also produced an online guide to miner's rights and responsibilities and a training video on that is available on our website.

Need for Legislation

Almost two years have passed since we lost the 29 miners at Upper Big Branch. We have learned much in that time. One important lesson we have learned is how to better use all of MSHA's available tools and strategies to fully enforce the Mine Act—including targeted enforcement, regulatory reforms and compliance assistance. The strategies the agency has used for its impact inspections have been successful. In addition, proposed regulatory actions, if implemented, will make operators more responsible for finding and fixing violations and will help us more effectively address mines with continuing problems. Our compliance assistance and outreach efforts also will ensure that operators who want to do the right thing have the tools they need to avoid violations and hazards.

Despite our efforts, there are operators who continue to violate the law and place miners at risk. We all know MSHA cannot be at every mine all the time. As we are learning from the DOJ's criminal investigation of UBB, even when MSHA is there, a determined operator that intimidates miners and willfully engages in a pattern of subterfuge will be at least partially successful in hiding hazardous conditions and practices from MSHA, with potentially tragic results. We need to change the culture of safety in some parts of the mining industry, so that operators are as concerned about the safety of their miners when MSHA is not looking over their shoulders as when MSHA is there.

In addition, the egregious problems found during some of our impact inspections and the extreme measures MSHA has had to take to find them—arriving off-shift and monitoring mine phones—validate the Administration's support of focused improvements to the Mine Act to give MSHA the tools it needs to address chronic violators that fail to take responsibility to operate safely and within the law.

I hope that we can work together across the branches and political parties to address at least the following areas:

Certification Procedures: Federal law does not contain comprehensive certification requirements or any means for revoking certifications of miners in the most critical safety sensitive positions, such as mine superintendents, mine foremen, or mine examiners. Legislation enabling MSHA to establish minimum qualifications for certification for these positions, and a decertification process for the failure to properly perform the required duties of such positions, would improve miners' performance of key health and safety functions, and create a strong deterrent against putting profits above safety. Any such legislation should also provide for coordination with state programs.

Criminal Penalties: Legislation should strengthen the criminal provisions of the Mine Act. No mine operator should risk the lives of its workers by cutting corners on health and safety, but for those who do, we need to remove obstacles to prosecution and provide sufficient deterrence against endangering the lives and safety of miners. We hope and intend that criminal prosecutions under an enhanced Mine Act would continue to be rare, but we should remove legal obstacles that currently make cases difficult to prove. Earlier this month, for example, Murray Energy, a subsidiary Genwal Resources, Inc., pled guilty to two misdemeanor counts for its criminal conduct prior to the 2007 Crandall Canyon mine disaster that killed eight miners and an MSHA inspector. In accepting the plea agreement that only required Genwal to pay a fine of $500,000, U.S. District Judge David Sam expressed his "outrage at the minuscule amount of the penalty provided by the federal statute." We hope that although new legislation would remove the obstacles to criminal prosecu-

tion, such prosecution would remain rare for the right reason: because a stronger law provides a successful deterrent.

Enhanced criminal penalties should also extend to those who provide advance notice of MSHA inspections. At UBB, PCC/Massey used advance notice to warn those underground that an inspector was on the premises and to order miners to hide hazardous conditions. As we all know, the consequences of that activity were tragic.

Even in the aftermath of UBB, there have been troubling reports of some operators continuing to provide advance notice of an MSHA inspection to hide violations and carry out other conduct that puts miners at serious risk. Finally, legislative reform should aid prosecutors in holding accountable corporate decision-makers when their actions demonstrate a criminal disregard for the lives of miners.

Expanded Authority to Address Mines with Systemic Health and Safety Problems: The current law does not have a "quick fix" to the safety of mines like the Freedom Energy Mine, where MSHA for the first time ever sought an injunction for a pattern of violation under section 108 of the Mine Act to change a culture of non-compliance that threatened the safety and health of the miners. While MSHA was successful in compelling the mine to implement additional safety and health protections as a result of using section 108(a)(2), the current statute could be simplified to help MSHA adequately protect miners. The lesson learned is this: the litigation process using the existing tool may be slower than needed to protect miners, and new legislation should consider language that clearly provides the Secretary of Labor with sufficient authority to act when she believes protecting miner safety and health requires immediate action.

Whistleblower Protection: New legislation must ensure that miners are fully protected from retaliation for exercising their rights. Because MSHA cannot be in every mine during every shift, a safe mine requires the active involvement of miners who are informed about health and safety issues and can bring dangerous conditions to the attention of their employer or MSHA before tragedy occurs. Yet, as we heard from miners and family members testifying at the House Education and Labor Committee's May, 2010 field hearing in Beckley, West Virginia, miners were afraid to speak up about conditions at UBB. They knew that if they did, they could lose their jobs, sacrifice pay or suffer other negative consequences.

The Mine Act has long sought to protect from retaliation those miners who come forward to report safety hazards. But it is clear that those protections are not sufficient and many miners lack faith and belief in the current system. Legislation that creates stronger remedies and a better process is urgently needed.

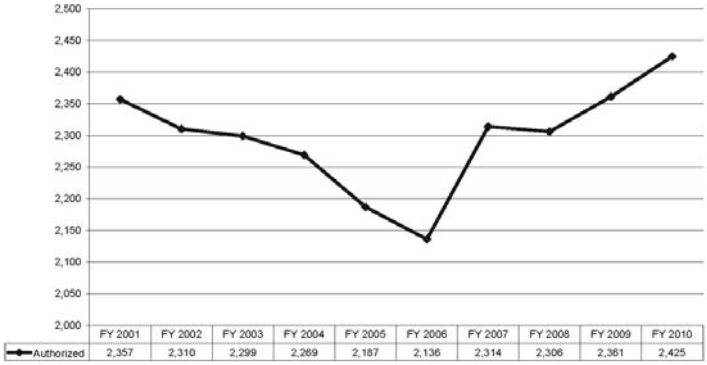
Conclusion

Thank you for allowing me to testify before the Committee. April 5, 2012 will be the two-year anniversary of the tragedy at Upper Big Branch. Along with the families, we mourn the deaths of these 29 miners.

Going forward, it comes down to this: MSHA cannot be at every mining operation every shift of every day. There could never be enough resources to do that, but even if there were, the law places the obligation of maintaining a safe and healthful workplace squarely on the operator's shoulders. Improved mine safety and health is a result of operators fully living up to their responsibilities. Taking more ownership means finding and fixing problems and violations of the laws and rules before MSHA finds them—or more importantly—before a miner becomes ill, is injured or is killed. Mines all across this country operate every day while adhering to sound health and safety programs. There is no reason that every mine cannot do the same.

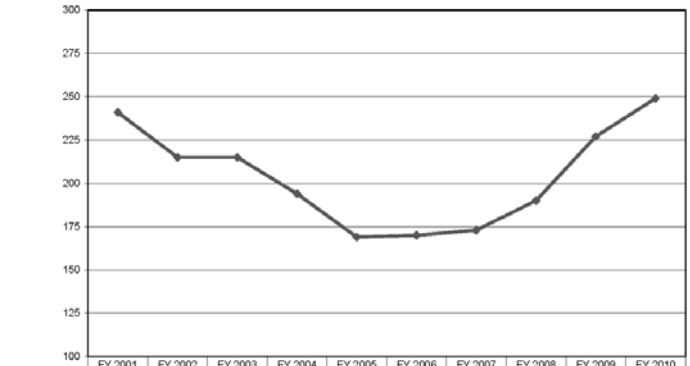
I look forward to working with the Committee to find the best way to accomplish our shared goals of preventing another mine disaster and providing our nation's miners the safety and health protections they deserve. We owe the victims of the Upper Big Branch disaster and their families no less.

Chart A - Mine Safety and Health Administration Authorized FTE

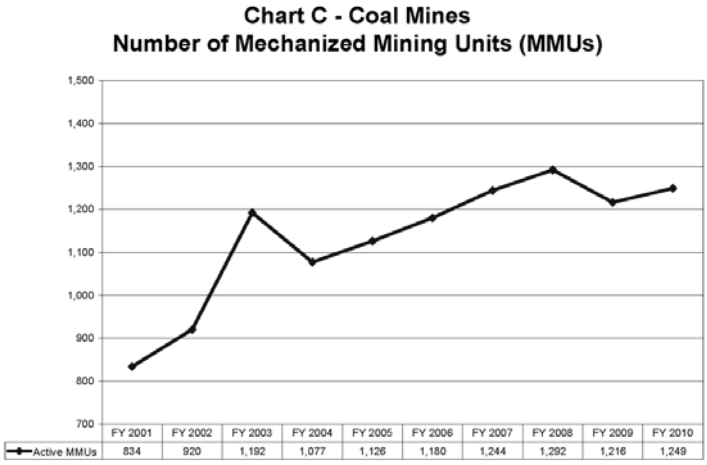


	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Authorized	2,357	2,310	2,299	2,269	2,187	2,136	2,314	2,306	2,361	2,425

Chart B - Coal Specialists FY 2001 - 2010



	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Specialists	241	215	215	194	169	170	173	190	227	249



Chairman KLINE. Thank you, Mr. Secretary.

You mentioned in your testimony and every investigation and every report of the Upper Big Branch disaster has made it perfectly clear that Massey was operating outside the law. There is no question. They are officially one of the bad guys here.

But you are here today representing MSHA, the agency that is tasked with ensuring the safety in our nation's mines. And that included of course, safety at the Upper Big Branch.

So I would like to quote again from NIOSH's independent review where they said, "If MSHA had engaged in timely enforcement of the Mine Act and applicable standards and regulations, it would have lessened the chances of, and possibly could have prevented, the Upper Big Branch explosion."

Do you agree with that statement?

Mr. MAIN. You know, that is a——

If you look at all the investigative findings thus far, and I believe even the NIOSH report pointed this out, that Massey caused this disaster.

Having said that, I can't say for certainty that it could, or could not, have been preventable. I think the—you know, we look at all the facts that are on the table. But what I firmly believe, I haven't seen the facts that tell me that we could have taken the action necessary to have stopped that.

There are a lot of things we should have done differently. There are a lot of things we could have done differently.

But it is my firm belief, Mr. Chairman, that if an inspector had walked into that mine on April the 5th, found what was going on, they would have shut it down in a heartbeat. I really believe that.

Chairman KLINE. So the question sort of remains that MSHA had a number of opportunities, and you have seen that in the reports, your own investigation, and NIOSH's investigation, to see

what was going on even though Massey was engaged in violation of the law.

And this seems pretty clear to me that if MSHA had engaged in timely enforcement of the Mine Act and applicable standards and regulations, it would have lessened the chances of and possibly could have prevented the Upper Big Branch explosion. And your——

Mr. MAIN. Well, I am saying basically what—and I have looked at a lot of the facts in this case and tried to plow through everything that has been developed. And I think some of the issues that have been raised maybe point a closer fix on the question you raised or the inspections that were done over the last inspection period.

The question is did MSHA identify float coal dust in that mine that they didn't take appropriate action on?

I mean if you look at it from that sense.

I have found no case where they identified float coal dust in that mine and did not take action.

With regard to the inspections that you referred to, the four inspections, actually the four inspections that took place, only one of them was a regular inspection.

The others were in—I think, one case a blitz inspection that took place where a team of inspectors went to the mine for the purpose of addressing a serious ventilation problem. Actually issued an order upon their arrival, and spent their time dealing with the ventilation problem. And they had the mine down actually for about 3 days during the order.

And I think the other inspection that was involved in the four inspections was where an inspector went up to the tailgate, but it was in this entry that was the return off of tailgate 22 was isolated from the whole tailgate entries as well.

So I think there is a series of facts there that I think you have to look a little bit deeper at. But, you know, in terms of the rock dusting issue, and let me just swing back to that.

I don't know if folks have had a chance to read the testimony of the superintendent, Gary May, who testified before a proceeding—a sentencing proceeding about 3 weeks ago.

Where he admitted, as the superintendent of the mine, that they used advanced notice to keep MSHA from learning what the hazards were, what the violations were. He even said as a section boss, whenever MSHA would come into their mine, he would scatter a little bit of rock dust around basically to pretty it up and make it look like he had been rock dusting.

In the areas that the inspectors were in, prior to the explosion, they were up on Headgate 22, which was the development section on the northern side of the mine. This is where the explosion forces was the worst in that mine that we found, where the fuel loading was the heaviest.

On March the 15th, inspectors went into that section, did their inspection, sampled the rock dust. That rock dust went to the lab. And what the lab found—and this came out post-explosion—what the lab found was at that time that section was basically in compliance.

All the samples were in compliance with one which is fairly close.

Now between the 15th of March and April 5th, something happened. And the inspectors of course, we knew was not back into that area. But if you look at the company's record books during that period, it appears that there was a lot of float coal dust and combustible material building up.

If you look at the belt entry, which was for the longwall, which was the area that the explosion travelled through, inspectors went into that area on March the 15th, conducted an inspection, issued an order on, I believe, the tail drive of the belt, and had a citation on the entire belt itself, the whole longwall belt.

They went back in, I believe it was on the 24th of March, to make their last inspection which they required the company clean it up and rock dust that belt. That was terminated based on the inspection on the 24th, I believe, of March.

That was the last time an inspector was in that area.

And if you look at the company record books of the float coal dust and the coal spillage that was occurring from the day of the explosion back, you are going to find there is a heavy listing of conditions——

Chairman KLINE [continuing]. My time has expired. And I know I have all of my colleagues are eager to engage in this conversation.

So I am sure we will continue to pull this out.

It is unfortunate that apparently depends on which set of the company's books that you were looking at, the ones that they cooked or the real books.

Mr. Miller?

Mr. MILLER. Thank you very much, my apologies for coming late to the hearing. I want to thank Ms. Woolsey for providing the opening statement and sitting in the chair for that moment.

Mr. Main, thank you very much for your leadership at MSHA. And thank you for your leadership in response to this tragedy, and rebuilding the resources in MSHA so we don't have to go through this again hopefully ever again.

I want to read, you mentioned, Mr. Gary May. I want to read from his court transcript in a back and forth with the U.S. Attorney's office.

And the question is, "Mr. May, while you were up at Upper Big Branch Mine, was there a practice of providing warnings when MSHA inspectors were coming to the mine?"

Answer: "Yes."

Question: "Can you tell us from beginning to end, how these warnings were communicated."

Answer: "It would start usually with someone came through the guard shack. There would be a phone call and it would be announced over the radio. It would be, quote—'company on property'. From that point it would be received at the office. And from the office they would call underground and let them know that we had, quote—'company'."

Skipping forward in this discussion:

Question: "How often at Upper Big Branch Mine were the warnings given that inspectors were coming on the property?"

Answer: "A lot."

Question: "Was it most of the time?"

Answer: "Yes."

Question: "Was the Upper Big Branch Mine able to avoid citations from MSHA because of the practice of advance warning of inspections?"

Answer: "Yes."

Question: "Did you know if it was illegal to give advice notice of a mine inspection?"

Answer: "Yes, I knew it was unlawful."

Question: "Did your superiors at Upper Big Branch Mine know about this practice of giving advance notice to inspections?"

Answer: "Yes."

Question: "Did they encourage it?"

Answer: "They did."

When asked whether he would spread rock dust when he was warned inspectors were coming, Mr. May answered, quote—"I always spread extra rock dust if I knew someone was coming to make everything look good," unquote.

How do you conduct inspections in that kind of atmosphere?

Mr. MAIN. It is almost impossible to be able to enforce the law when those kind of activities are in place.

Mr. MILLER. Does your report corroborate with what Mr. May said that this happened most of the time, all of the time on——

Mr. MAIN. I have to give——

Mr. MILLER [continuing]. Came on the property?

Mr. MAIN. Yes, I have to give our inspectors credit. Despite that plan, the year before this explosion, they issued more closure orders—of one authority closure orders at that mine—any mine in the United States.

So I think that that showed the fact that we had some pretty aggressive inspectors. But there is a lot we didn't know.

There is a lot that they did hide, I believe.

Mr. MILLER. But in this case, the discussion is really about a calculated interference. This was a matter of company policy apparently.

That if inspectors were on the property, efforts were made to move them either to other parts of the operation or to shut down operations, or clean them up prior to letting the inspectors come to that part of the active mine.

Is that correct?

Mr. MAIN. I think they hid a lot of stuff from regulators, yes.

Mr. MILLER. Now, in the NIOSH report, it is pretty clear that there were procedures that just didn't fall in place in terms of looking at some of the report that were filed by inspectors and taking action on those reports.

Is that correct?

Mr. MAIN. I am sorry. I didn't——

Mr. MILLER. In the criticisms of the agency, the suggestion is then that some reports were made and action wasn't taken. They were sort of left on the shelf, if you will, for an extended period of time.

Mr. MAIN. Yes. I don't think there is any question that there was things that we could have done better at Upper Big Branch.

Mr. MILLER. Go ahead.

Mr. MAIN. But I think by the same token, what you are expressing here—what the agency was up against that was well articu-

lated by the Superintendent May, was a challenge sometimes beyond the capability of any inspector, even experienced inspector to catch up with.

Mr. MILLER. But in your internal review, you say however—on page 107—however, District Four did not collect rock dust samples in the longwall gate entry at UBB after the longwall began production. Nor did MSHA proceed just specifically direct them to do so.

So was the guidance wrong? Or was this inspectors not doing their job? Or was there an improper guidance for——

Mr. MAIN. There is a guidance issue. And this is something the report gets into

There was a serious problem with the policies of the agency. There was a system that was in place up to 2002. It was dismantled for whatever reason.

From that point forward, every programmer really was on their own to develop policies and to implement those in what the internal review team found was that the—I think there was like 199 policies that was generated from 2004 forward. And depending on when he was hired, he may or may not have known about those. And one of them dealt with rock dusting.

Different inspectors had different instructions about how to do rock dust sampling in the mine.

Mr. MILLER. Thank you.

Chairman KLINE. I thank the gentleman.

Dr. DesJarlais?

Mr. DESJARLAIS. Thank you, Mr. Chairman.

Mr. Main, one of the conditions that led to the catastrophic explosion at UBB was the accumulation of coal dust. In fact, MSHA's investigation report contained pictures of belts that had been rolling through coal dust.

The NIOSH independent panel stated the mine operation did not and could not conceal readily observable violate conditions such as float dust accumulations throughout the UBB mine.

And as Ms. Woolsey alluded to in her opening testimony, how can MSHA attribute the existence of these conditions to inspector inexperience and resource constraints?

Mr. MAIN. Yes, I think—and I am looking at two pieces.

One is the conditions that are directly involved in the explosion itself. And if you start with that and look at the area where the explosion occurred, and where the fuel was at to cause that explosion, we have examined three areas.

There is something that we missed in that area that was part of that explosion.

You know, what I was trying to explain is that in that area, I didn't see any evidence from any of the reports that I found that inspectors had walked by an area and did not take appropriate enforcement action.

As a matter of fact, what I was pointing out is where they did inspect and what they did find in the critical areas.

One area that is probably the most important is the question I asked myself. You know, in knowing mines is how did we have such an explosion right off the tailgate?

And there was no evidence the company had any real methodology in their post explosion investigation of continually rock dusting that area.

What we found was that the inspection was made of that area really happened over a 3-day period, March 9th through the 11th. And we had a ventilation specialist in that area. We had an entry supervisor and a trainee in that area. And we had an inspector in that area.

And it all dealt with—that was an area they went to where they issued an order to close down the mine because of the ventilation problem.

And this was an area—and let me just give you this picture. When the inspector showed up to do this last inspection, here comes the gang of six inspectors into the parking lot of the Massey Energy Upper Big Branch Mine.

And I think the word that was used was, hell storm, whenever more than one inspector showed up. It took an hour and a half for those inspectors to get up to that spot.

And we know that just before they got to that location, at about—I think it was about 9:48 a.m., the company shut down the shearer and claimed that they had a problem.

This is according to their records.

It was so convenient for that to happen.

The inspectors arrived at the area an hour and a half to 2 hours, somewhere in that timeframe, after they showed up on the property, and if Mr. May's instructions that they used to get was correct, and the area that we are talking about where the rock dusting would have been visible, where they were out at the tailgate, is not a large area.

The question everybody has to ask was did those inspectors spend 3 days in an area tramping over this and see totally black stuff he didn't do anything with, or was there something done ahead of them?

And that is what has bothered me all the way through is how these inspectors could have missed that float coal dust, unless it wasn't there to be seen. It was masked by throwing some rock dust on it.

I don't know. I mean that is—when we get to the bottom of——

Mr. DESJARLAIS. Okay, let us talk about MSHA's internal review where they repeatedly cite inspector inexperience in the District 4 as a root cause of MSHA's deficient inspections at UBB.

You know, it sounds like you are saying regardless whether we had experience or inexperience inspectors, this probably would have been missed. Yet if they were there on the day of the explosion, they would have caught it.

Mr. MAIN. Yes, some of the conditions were bothersome that were identified. But in terms of the conditions that actually existed.

And the $64 question is—and I think it has to be asked—did that company do something the day that the last inspection was made that masked what they were doing?

Mr. DESJARLAIS. Okay, I am trying to focus on——

Mr. MAIN [continuing]. You know——

Mr. DESJARLAIS [continuing]. The inspector inexperience. Do you agree that the inspectors were inexperienced?

I mean, yes or no.

Mr. MAIN. Oh, absolutely.

Mr. DESJARLAIS. Okay. When do you think the MSHA inspectors will be adequately trained? And are they ready now?

Mr. MAIN. Well, and let me talk about that, because this was not something that just happened overnight. I think if you look at both the reports. And the NIOSH report, I think, pointed this out as well.

There was a severe staffing problem at MSHA that was created starting back around 2001, when there was a flat line budgeting of MSHA, which caused the agency to have to eat itself, so to speak, by cutting back on FTEs just to be able to stay at its funding's level.

In 2004, there was a budget cut in the co-enforcement program that further reduced the staff.

At the same time, you saw a major retirement take place in MSHA, and it was pretty overwhelming when you look at the numbers. I think between 2001 and 2006, there are over 1,000 people left that agency.

And the agency had an average of about 2,300 folks. I think there was 690 some out of about 1,100 that left the coal enforcement ranks. So you had an agency that was basically devastated.

Congress made a wise decision 2006. Added new funding which wasn't realized until 2007 when it was able to start hiring back up again. But it takes 2 years to get the inspectors through the training programs.

So just about the time that UBB was hitting—MSHA was getting its ranks back up to a level that they were able to start managing it.

The problem is they had a lot of inexperience.

If you look through that same period, managers was leaving out right and left. We had six different district managers running District 4 from 2003 to 2006. And that was at a time when those ventilation records sort of didn't get handled.

And you had at the time of the explosion, management of the field offices that was changing out. There was three different managers, field office managers, two of them acting during the time of the last couple of inspections at UBB, so all this stuff caught up with the agency.

Specialists were just wiped out to the core, where they were unable to keep up the specialty work.

I knew at the first part of the review process the IR team found that there was two ventilation specialists in the whole district.

This is a district that had over 50 Massey mines. They were down to two ventilation specialists.

That ramped up to about six by the end, but there is no question there is an experience problem. There is no question that the experience losses had to do with both the budget constraints and the attrition of the agency that left it where it was at.

Chairman KLINE. The gentleman's time has expired, more than expired.

Ms. Woolsey?

Ms. WOOLSEY. Thank you, Mr. Chairman.

Mr. Secretary, Federal District Judge David Sam noted recently at a court hearing where during the sentencing of Murray Energy for two Mine Act violations connected to the Crandall Canyon mine disaster.

This is going to get me to a question I am going to ask you. That is why I am going to that.

He said, and I quote him. He said, "I am outraged because of the miniscule amount provided by the criminal statute" in the sanctions and the fining these criminals from Crandall Canyon.

So, Mr. Chairman, I have a copy of that. And I would ask unanimous consent to insert it in the transcript.

[The information follows:]

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4 IN THE UNITED STATES DISTRICT COURT
5 FOR THE DISTRICT OF UTAH, CENTRAL DIVISION
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9 _____)
UNITED STATES OF AMERICA,)
10)
)
11)
Plaintiff,)
12)
vs.) Case 2:12CR113
13)
)
14 GENWAL RESOURCES,)
)
15 Defendant.)
)
16 _____)
17
18 BEFORE THE HONORABLE DAVID SAM
19 MARCH 14, 2011
20 REPORTER'S TRANSCRIPT OF PROCEEDINGS
21 CHANGE OF PLEA AND SENTENCING HEARING
22
23
24
25 Reported by: KELLY BROWN, HICKEN CSR, RPR, RMR

1

2 A P P E A R A N C E S

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SALT LAKE CITY, UTAH, WEDNESDAY, MARCH 14, 2012

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THE COURT: Good afternoon, counsel, and parties and all who are here to be present for this hearing. The Court welcomes you here.

We're here to address case Number 2:12-CR-113. The United States of America vs. Genwal Resources. This has been calendared for a plea and sentencing.

Counsel, are you ready to proceed?

MR. WALZ: Yes, Your Honor. The United States is ready.

MR. KAPLAN: Yes, Your Honor. Genwal Resources is ready.

THE COURT: All right. Very well. Let me just for the record recognize you individually. For the United States, we have Mr. David Barlow, who's the United States attorney from the District of Utah; and Mr. Stu Walz, assistant United States attorney; Mr. Jared Bennett, assistant United States attorney; Ms. Karen Fojtik, assistant United States attorney. For the defendant, Mr. Neil Kaplan and Ms. Anneli Smith, who are at counsel table.

All right. Counsel, we'll proceed first with the taking of a plea. Now, this is a corporate defendant. And, Mr. Kaplan, you have been authorized to act as the agent for this corporation; is that correct?

1 MR. KAPLAN: Yes, I have, Your Honor.
2 THE COURT: All right. Now I'm going to ask that
3 you be placed under oath after which I'm going to have you
4 questioned regarding this matter.
5 (Whereupon, Mr. Kaplan was sworn.)
6 MR. KAPLAN: I do.
7 THE COURT: All right. Mr. Kaplan, you are the
8 duly authorized agent for the defendant Genwal Resources, and
9 you have stated that; is that correct?
10 MR. KAPLAN: Yes, Your Honor, that's correct.
11 THE COURT: And you certify and acknowledge that on
12 Genwal's behalf you have been advised of and you understand
13 the following facts and rights and that Genwal has had the
14 assistance of counsel in reviewing, explaining and completing
15 on behalf of Genwal; is that correct?
16 MR. KAPLAN: That's correct, Your Honor.
17 THE COURT: All right. Now I'm going to read
18 portions of this statement in advance of plea. And this is a
19 plea entered pursuant to Federal Criminal Rule 11C1C. I'm
20 going to read now starting with Paragraph 1.
21 As part of this agreement with the United States,
22 Genwal will plead guilty to Counts One and Two of the
23 information. Genwal's attorneys have explained to you the
24 nature of the charges against Genwal, and you've had an
25 opportunity to discuss the nature of the charges with Genwal's

1 corporate secretary. You on behalf of Genwal understand the
2 charges and what the United States is required to prove in
3 order to convict Genwal.
4 The elements of Count One are, one, a mine operator
5 that is Genwal; 2, willfully violated; number 3, a manditory
6 health and safety standard, to wit, failing to notify MSHA
7 within 15 minutes once the operator knew or should have known
8 that an incident had occurred, all in violation of 30 USC
9 Section 820(d) and 30 CFR Section 50.10.
10 The elements of Count Two are, 1, a mine operator,
11 that is, Genwal; 2, willfully violated; 3; a manditory health
12 and safety standard, to wit, mining in an area that was
13 prohibited under the roof control plan, all in violation of
14 30 USC Section 820(d).
15 Do you understand all that?
16 MR. KAPLAN: Yes, I do, Your Honor.
17 THE COURT: Number 2. You on Genwal's behalf know
18 that the maximum possible penalty is a $250,000 fine for each
19 count because, as the United States agrees, the evidence does
20 not support applying the increased penalty under
21 18 USC Section 3571(C)(4). You also acknowledge that a term
22 of probation up to five years may apply. You also know that
23 the Court is required pursuant to 18 USC Section 3013 to
24 impose an assessment in the amount of $125 for each offense of
25 conviction.

1 You understand all of that, sir?
2 MR. KAPLAN: Yes, I do, Your Honor.
3 THE COURT: Number 3. Because Genwal's plea of
4 guilty is being entered pursuant to Federal Rules of Criminal
5 Procedure 11C1C as explained below, you know that Genwal will
6 be able to withdraw its plea if the Court does not accept the
7 Rule 11C1C agreement.
8 MR. KAPLAN: Yes, Your Honor, I understand that.
9 THE COURT: All right. Now I'm going to skip some
10 of the reading. If there's any portions that I skip that you
11 would like the Court to read into the record, counsel for
12 either side, indicate that to the Court and I will read that
13 portion that I skipped verbatim.
14 I'm going to drop down to Paragraph 6. Paragraph 6
15 contains the constitutional rights that you have pursuant to
16 our Constitution and pursuant to the Federal Rules of Criminal
17 Procedure. Those are outlined in Paragraph 6A through I. You
18 understand that you have all of those rights?
19 MR. KAPLAN: Yes, Your Honor. And I've advised
20 Genwal that they have those rights, yes.
21 THE COURT: All right. Very well. And you also
22 understand the circumstances under which an appeal may be
23 taken from this case.
24 MR. KAPLAN: Yes, we do, Your Honor.
25 THE COURT: All right. Let's drop down to

1 Number 10. You know under a plea of guilty the Judge may ask
2 you questions under oath about the offense. The questions if
3 asked on the record in the presence of counsel must be
4 answered truthfully. And if you give false answers on behalf
5 of Genwal you can be prosecuted for perjury in your personal
6 capacity.
7 MR. KAPLAN: I understand that, Your Honor.
8 THE COURT: All right. I'm going to read now
9 Paragraph 11. You stipulate and agree that the following
10 facts accurately describe Genwal's conduct. These facts
11 provide a basis for the Court to accept Genwal's guilty plea
12 and for calculating the sentence in Genwal's case. You
13 understand and you will stipulate to those facts?
14 MR. KAPLAN: Yes, we do, Your Honor.
15 THE COURT: All right. I'm going to read those to
16 you and ask you several questions regarding them.
17 On or about March 10, 2007, Genwal through its
18 agents knew that it had a duty to report to the Mine Safety
19 and Health Administration, MSHA, M-S-H-A, within 15 minutes at
20 the toll free number 1-800-746-1553, once Genwal knew or
21 should have known that an accident occurred. On or about
22 March 10, 2007, an accident as defined under CFR Section 50.2
23 Paragraph 9 occurred when a coal outburst disrupted regular
24 mining activity for more than one hour. Genwal willfully did
25 not report the accident to MSHA within 15 minutes at the above

1 stated toll free number once it knew or should have known that
2 an accident occurred.
3 On June 15, 2007, MSHA approved an amendment to the
4 roof control plan that authorized Genwal to conduct secondary
5 mining or pillar recovery operations in an area of the mine
6 known as Main West South Barrier. Genwal through its agents
7 was aware that this approved roof control plan amendment
8 prohibited Genwal from mining the barrier pillar between
9 crosscuts 142-139 in the Number 1 entry. On about August 3,
10 2007, Genwal willfully mined in the barrier pillar between
11 crosscuts 142-139 in the Number 1 entry.
12 Now, did you hear those facts as I read them into
13 the record?
14 MR. KAPLAN: Yes, I did, Your Honor.
15 THE COURT: Do you understand them?
16 MR. KAPLAN: Yes, I did, Your Honor.
17 THE COURT: Are they all true and correct?
18 MR. KAPLAN: Yes, they are.
19 THE COURT: Now, Paragraph 12 contains the terms
20 and conditions pertaining to your plea agreement with the
21 United States. Those are outlined on Page 3 and Page 4. Now,
22 you understand and agree to all of those terms on behalf of
23 the defendant?
24 MR. KAPLAN: Yes. Pardon my coughing, Your Honor.
25 Yes, I understand.

1 THE COURT: Are there any portions of that plea
2 agreement that you wish the Court to read verbatim into the
3 record?
4 MR. KAPLAN: No, we do not, Your Honor.
5 THE COURT: On behalf of the United States?
6 MR. WALZ: No, Your Honor.
7 THE COURT: I want to ask you, Mr. Walz, if this
8 paragraph contains full and complete agreement between the
9 defendant and the United States.
10 MR. WALZ: It does, Your Honor.
11 THE COURT: And is that correct, Mr. Kaplan?
12 MR. KAPLAN: Yes, it is, Your Honor.
13 THE COURT: All right. I'm going to drop now down
14 to Page 4 in the middle. Mr. Kaplan, Number 1. You indicate
15 that you're over and you admit to being over 21 years of age;
16 is that correct?
17 MR. KAPLAN: Yes, Your Honor.
18 THE COURT: And your education consists of a
19 bachelor's and juris doctorate degree, and you can read and
20 understand English.
21 MR. KAPLAN: Yes, Your Honor.
22 THE COURT: And, Number 2, the statement in advance
23 contains all the terms of the agreement between Genwal and the
24 United States. If there are exceptions, the Court will be
25 specifically advised on the record at the time of Genwal's

1 guilty plea of the additional terms. You understand the Court
2 and the United States -- that the United States and Genwal
3 cannot have terms of this plea agreement that are not
4 disclosed to the Court. You understand that?
5 MR. KAPLAN: Yes, Your Honor.
6 THE COURT: And 3. No one has made threats,
7 promises or representations to Genwal or to you that have
8 caused Genwal to enter a plea of guilty on Genwal's behalf.
9 MR. KAPLAN: That's correct, Your Honor.
10 THE COURT: And 4. You understand that the Court
11 can accept or reject this agreement and the parties retain
12 their rights in that event as set forth above.
13 MR. KAPLAN: That's correct, Your Honor.
14 THE COURT: And 5. You have discussed this case
15 and -- this case with Genwal's corporate secretary as much as
16 you wish, and you on behalf of Genwal have no additional
17 questions; is that correct?
18 MR. KAPLAN: That's correct, Your Honor.
19 THE COURT: And Number 6. You have discussed this
20 statement with Genwal's corporate secretary, and you have
21 fully explained Genwal's rights to him and have assisted him
22 in completing this agreement. He has provided you appropriate
23 documentation of action by Genwal's board of directors
24 authorizing you to knowingly and voluntarily enter a plea
25 undertaken with full knowledge of Genwal's legal rights, and

1 that there is a factual basis for the plea; is that correct?
2 MR. KAPLAN: That's correct, Your Honor.
3 THE COURT: And 7. Genwal's corporate secretary
4 advised you that Genwal is satisfied with its lawyers; is that
5 correct?
6 MR. KAPLAN: That's correct.
7 THE COURT: And 8. Genwal's decision to enter this
8 plea was made after full and careful thought with the advice
9 of counsel and with its full understanding of its rights, the
10 facts and circumstances of a case and the consequences of a
11 plea. And you are not now under the influence of any drugs,
12 medication or intoxicants; that is right?
13 MR. KAPLAN: That's correct.
14 THE COURT: And 9. On behalf of Genwal's behalf,
15 you have no mental reservations concerning the plea.
16 MR. KAPLAN: That's correct, Your Honor.
17 THE COURT: And 10. You on behalf of Genwal
18 understand and agree to all of the above. You know that you
19 on behalf of Genwal are free to change or delete anything
20 contained in this statement, and you do not wish to make
21 changes to this agreement because Genwal agrees with the
22 terms, and all of the statements are correct; is that right?
23 MR. KAPLAN: That's right, Your Honor.
24 THE COURT: All right. Now I'm going to turn to
25 the information now. And, Count One, I'm not going to read

all the terms of Count One, except that this is an alleged violation of 30 USC Section 820(d), violation of a manditory health or safety standard.

MR. WALZ: Your Honor --

THE COURT: Yes.

MR. WALZ: I hesitate to interrupt. But since this is the first appearance of this defendant in court, perhaps the record should reflect the fact that the information has been furnished to Mr. Kaplan, he's read it and understands it.

THE COURT: All right. Very well.

You have received a copy of the misdemeanor information; is that correct?

MR. KAPLAN: That's correct, Your Honor. And I have gone over it with Genwal's officers.

THE COURT: And you have reviewed it and understand it?

MR. KAPLAN: Yes.

THE COURT: And have no questions regarding it.

MR. KAPLAN: No questions, Your Honor.

THE COURT: All right. Very well. To Count One, what is your plea on behalf of the defendant?

MR. KAPLAN: Genwal Resources pleads guilty.

THE COURT: All right. Very well. As to Count Two, this is a violation, alleged violation of 30 USC Section 820(d), a violation of manditory health or

1 safety standards. And this is alleged to have occurred,
2 Count One alleged to have occurred March 10, 2010, and
3 Count Two on or about August 3rd, 2007.
4 To Count Two what is your plea on behalf of the
5 defendant?
6 MR. KAPLAN: Genwal Resources, Inc., pleads guilty
7 to Count Two, Your Honor.
8 THE COURT: Very well. The Court will accept the
9 pleas of the defendant to Counts One and Two and finds the
10 pleas are made freely and voluntarily with full knowledge of
11 your legal rights, and that there is a factual basis for the
12 acceptance of the pleas.
13 Now with respect to sentencing, counsel, what is
14 your pleasure regarding sentencing?
15 MR. WALZ: We would like sentencing to occur today,
16 Your Honor.
17 THE COURT: Is that the request of the defendant,
18 as well?
19 MR. KAPLAN: Yes, it is, Your Honor.
20 THE COURT: Is there any legal reason that you know
21 of why sentence should not proceed at this time?
22 MR. WALZ: No, Your Honor, there is none.
23 THE COURT: All right. Do you wish to make any
24 comment before the Court before imposing sentence?
25 MR. WALZ: Yes, Your Honor, if I may.

1 THE COURT: You may.
2 MR. WALZ: May it please the Court, this case
3 because of the tragic loss of life and magnitude of the
4 tragedy has caused as the Court is aware immense public
5 interest. The plea by the company has sharpened the public
6 interest and raised questions about the role of the criminal
7 law and the prosecutor in our system and in this case. And I
8 am happy to take an opportunity to answer some of those
9 questions.
10 I know the Court is aware that not every evil in
11 society, not every wrong that has happened is to be redressed
12 by the criminal process. Wrongs are frequently addressed
13 through civil, civil suit between parties and through the
14 regulatory process, and both have been or will be brought to
15 bear in this particular case.
16 The public has a right to expect our office to
17 bring well-founded charges where provable facts established
18 violations of specific criminal statutes beyond a reasonable
19 doubt, and the fact that these statutes are violated by
20 specific parties, we have found that the facts establish the
21 two criminal charges in the information and believe that we
22 could succeed on those charges at trial if required beyond a
23 reasonable doubt. The same cannot be said for some other
24 charges that have been the subject of the investigation.
25 There has been and is a great and understandable tendency to

1 expect that serious consequences such as occurred in this case
2 demands more serious charges. People ask, why isn't there
3 more? But the application of the law to the facts must result
4 in provable charges and not the result of circumstances that
5 are serious, that are tragic and that leave us all breathless.
6 We believe that these charges are serious, and it
7 is for that reason that we brought them and demanded that the
8 defendant agree to the maximum fine for each in this
9 particular case.
10 The United States Attorney's Office has considered
11 all of the evidence upon which our investigation was based.
12 The office has determined that the enhancement that certain
13 people have said applies cannot be sustained in this case, and
14 therefore, we urge the Court to accept the plea agreement and
15 sentence according to its terms.
16 THE COURT: All right. Very well, counsel. Is
17 there a signed statement in advance, counsel? Do you have a
18 copy?
19 MR. WALZ: I think one was filed with the court
20 clerk's office on Friday. We can certainly sign and file
21 another one.
22 THE COURT: All right. Would you do that also in
23 open court?
24 MR. KAPLAN: Your Honor, while we're doing that,
25 Ms. Smith noted that there's a typographical error on the

1 information. It alleges that the offense occurred in 2010.
2 We certainly agree to that amendment. It should be 2007.
3 THE COURT: Count one is amended on or about
4 March 10, 2007; is that correct?
5 MR. KAPLAN: Yes, Your Honor. That's good.
6 THE COURT: All right. Very well.
7 After that is signed, counsel present that to the
8 Court.
9 MR. WALZ: What we have, Your Honor, is a signed
10 plea agreement signed by Mr. Kaplan on the 8th day of March,
11 and it was signed by Mr. Barlow, the United States attorney,
12 on the 9th of March at the time it was filed with the Court.
13 May I lodge this with the Court?
14 THE COURT: You may do so.
15 Mr. Kaplan, do you wish to make any comment on
16 behalf of the defendant?
17 MR. KAPLAN: No, Your Honor.
18 THE COURT: All right. Counsel, let me just make a
19 few comments.
20 MR. FOJTIK: Your Honor?
21 THE COURT: Yes.
22 MR. FOJTIK: I believe there were some family
23 members that had come and family members wanted to speak. Did
24 you want to allow them first to --
25 THE COURT: Yes. I want the record to reflect that

1 I have received some communications from various individuals.
2 I have provided a copy -- whenever the Court receives a
3 communication, I provide copies to counsel for each side and
4 also a copy for US probation. I have read those and
5 considered those, and I have some comments to make. But maybe
6 I'll reserve those until after anyone wishes to address the
7 Court.
8 I may say that normally all communications
9 regarding sentencing are made by written communications to the
10 Court. However, the Court on occasion has and does make some
11 exception if there is a brief comment that anyone wishes to
12 make in this matter. I understand that Mr. Havas, you wish to
13 make a comment on behalf of the victims; is that correct?
14 MR. HAVAS: That's correct, Your Honor. And thank
15 you for that opportunity.
16 I'm Edward Havas. And along with Colin King and
17 Alan Mortensen of my office, we are here on behalf of a number
18 of families and victims of this senseless and voidable
19 tragedy. And I appreciate the Court to be willing to hear my
20 comments. I'll be brief.
21 The family wishes me to communicate to the Court
22 that it responds to the charges and the guilty pleas with
23 mixed emotions. Obviously having this chapter of proceedings
24 behind them is beneficial to allowing them to continue the
25 healing process and move forward. But the families are

1 disappointed that the combination of this many years of
2 investigation and the efforts of the US Attorney's Office has
3 resulted in nothing more than a couple misdemeanors, which is
4 I guess a corporate defendant, and individuals that the
5 families believe have some responsibility or should be held to
6 account are not here before the Court to answer. We recognize
7 the limitations that the US Attorney's Office operates under,
8 and we appreciate their efforts.
9 It is also acknowledged, Your Honor, that the
10 proposed find is the maximum for each count, and we appreciate
11 that. And yet, it is with some reluctance that the families
12 acknowledge that a half million dollars to this corporate
13 defendant is nothing more than a slap on the wrist. If it
14 were possible to do more, we would urge the Court to do so.
15 We understand that this is the maximum fine.
16 Perhaps the most disappointing thing to the
17 families, however, is despite admitting to the knowing and
18 wilful violations that underline these counts, this corporate
19 defendant has yet to acknowledge responsibility for the actual
20 tragedy that caused these families their lives and hurt these
21 victims and, in fact, recently publicly denied and persist in
22 denying responsibility for this tragedy. That's hurtful to
23 the families. Genwal has bypassed a golden opportunity to say
24 I'm sorry to these families, and that's something that should
25 have been said long before now.

1 We realize the limitations that the US Attorney's
2 Office operates under. There is a sad lack I think of
3 applicable mine safety and health regulations that can
4 underpin criminal conduct, and the US Attorney's Office is
5 bound by that. We recognize that, and we appreciate their
6 efforts. It is fitting that those statutes be revised and
7 revisited, but we also accept them with resignation, the
8 understanding that that's something for a different forum and
9 not something we can ask Your Honor to do.
10 Thank you for considering our comments.
11 THE COURT: Thank you very much, Mr. Havas.
12 Let me comment. My initial review of this, and I
13 want the families and the victims to understand this, that I
14 certainly am not without compassion and concern for them at
15 this very tragic loss. No amount of money can be adequate to
16 compensate for the loss of a loved one, and I understand that.
17 I want them to know that my initial take on this is outrage at
18 the miniscule amount of penalty provided by the criminal
19 statute involved in this matter. And I have taken upon myself
20 to review some of the statutes that are applicable to this
21 case. And I have some questions regarding the matter under
22 18 USC Section 3571(C), fines for organizations; and also the
23 statute referred to in the information 30 USC Section 820(d);
24 and also the amendment to that statute which also has amended
25 some of the fines provided by law.

1 Now, I want them to know that I have weighed
2 whether I should accept or reject this plea agreement. The
3 alternatives as I weigh that very carefully was to put this
4 matter on further hold, to what end? It seemed to me as I
5 considered this it would be delaying another proceeding. I
6 understand the MSHA administrative proceeding, which is
7 ongoing but on hold because awaiting the outcome of the
8 criminal disposition in this court. And it's my understanding
9 that that hearing may further result in fines and penalties.
10 I have also been concerned about whether the victims of this
11 terrible tragedy pursued any recourse through the civil
12 courts. And again, I'm not familiar with what occurred there,
13 but I understand that their interests have been in the hands
14 of very capable counsel who I am very familiar with. And I
15 understand that those proceedings have resulted in -- again, I
16 don't know what amounts, I know that no amount is adequate to
17 pay for the loss of a loved one.
18 And I want to say again that my initial take is
19 outrage because of the miniscule amount provided by the
20 criminal statute. I also reviewed what has gone on in this
21 case being new to it since its investigation, which was
22 commenced I understand in 2008. And I am satisfied having
23 reviewed what has occurred that the US Attorney's Office has
24 done a very thorough and as complete a review as can be
25 conducted in this type of a case. And they came to the

1 conclusion as they did that the maximum that could, that was
2 provided by law was the two statutes -- of the two counts to
3 which this matter was brought before this Court.
4 And to which the Court because of all that I
5 examined, all that I determined because of what further delays
6 would take place, what good would that do to further prolong
7 what already has been suffered in this case, it seemed to me?
8 That overruling, my putting it on delay to no avail would just
9 be further compiling of the sorrow and grief of you who have
10 suffered your loss. And I want you to know that I certainly
11 am not without my compassion and concern for you. But because
12 of all of that, it is my view that it is best to proceed and
13 to accept the plea as I have and to pronounce judgment.
14 Now, counsel, is there anything else that need be
15 said for the record?
16 MR. WALZ: Nothing from the United States, Your
17 Honor.
18 MR. KAPLAN: No, Your Honor.
19 THE COURT: All right. Very well. Thank you very
20 much. And I ask, is there any legal reason why sentence
21 should not be imposed at this time?
22 MR. WALZ: There is none, Your Honor.
23 MR. KAPLAN: None, Your Honor.
24 THE COURT: All right. Let me just take a moment.
25 All right. It is the judgment of the Court that

1 the defendant is ordered to pay $250,000 fine as to Count One
2 and $250,000 fine as to Count Two, making a total fine of
3 $500,000. In addition, there's a requirement for a special
4 assessment of $125 as to each count, making a total of $250,
5 and that is to be paid immediately.
6 All right. Anything else, counsel?
7 MR. WALZ: No, Your Honor.
8 MR. KAPLAN: No, Your Honor.
9 THE COURT: All right. Thank you very much. I
10 appreciate the comments that you have made and the comments,
11 Mr. Havas, that you made on behalf of these aggrieved
12 defendants of which I concur in what you said.
13 With that, we'll be in recess. Thank you very
14 much.
15 (Whereupon, the court proceedings were concluded.)
16 * * * * *
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1 STATE OF UTAH)
2) ss.
3 COUNTY OF SALT LAKE)
4 I, KELLY BROWN HICKEN, do hereby certify that I am
5 a certified court reporter for the State of Utah;
6 That as such reporter, I attended the hearing of
7 the foregoing matter on March 14, 2011, and thereat reported
8 in Stenotype all of the testimony and proceedings had, and
9 caused said notes to be transcribed into typewriting; and the
10 foregoing pages number from 3 through 22 constitute a full,
11 true and correct report of the same.
12 That I am not of kin to any of the parties and have
13 no interest in the outcome of the matter;
14 And hereby set my hand and seal, this ____ day of
15 _____ 2012.
16
17
18
19
20 _____
KELLY BROWN HICKEN, CSR, RPR, RMR
21
22
23
24
25

Chairman KLINE. Without objection.

Ms. WOOLSEY. Thank you.

So the Mine Act classifies a willful violation of a mandatory safety standard as a misdemeanor, even when miners are injured or killed.

So that is true even when making a false statement under the Mine Act. And that is a felony only.

So would it make a difference, why would it make a difference, if instead of these weak miniscule criminal statutes, we had stronger felonies—whatever you call them under the—if we treated these endangered miners that were hurt and willful violations of mandatory safety standards were treated as a felony under the Mine Act instead of a misdemeanor?

Mr. MAIN. I believe the judge expressed his frustration of his inability to take tougher action where he believes, from why I have read, tougher action was needed because of the constraints of the Mine Act.

I think it is pretty straightforward. I think the U.S. Attorney's office expressed similar concerns of what they believe that their limitations to bring forward other actions.

And I think it is a classic case, if you have to step back and take a look at to determine whether or not there are sufficient tools under the Mine Act to deal with circumstances like that.

And I will just point back to some of the things that we are still finding through some of our impact inspections.

You know, if anybody thought that advance notice of inspections was a piece of history, we are living in a different world. I mean, that is something we constantly find.

This kind of conduct is so ongoing that it doesn't seem that there is enough deterrent under the Mine Act to prevent that from happening.

Ms. WOOLSEY. Thank you for asking my convoluted—answering my convoluted question in a way we could understand what I was asking.

Thank you very much.

The MSHA internal review, Joe, found that in six separate cases managers at the Upper Big Branch Mine should have been investigated for willfully violating safety laws.

Why weren't these cases investigated? And is MSHA conducting those investigations now?

Mr. MAIN. There is about three reasons, I think, to answer the question why weren't they.

In addition to the ventilation and roof control specialist staff, these cuts also affected special investigations throughout MSHA as part of our special investigations staff that was cut.

And I think if you look at our testimony, I think there is a chart in there that shows this whole specialist dip. So there is a real resource problem of what the inspectors could do.

The other problem that existed, which was raised in the internal review, was that around 2006, I believe it was, MSHA was only able to carry out about 83 percent of its inspection responsibilities. They were shifting people over just to do, you know, you know, targeted inspections at mines they couldn't get to.

They were pulling off ventilation specialists and special investigators and others to go just try to keep the mandatory inspection program up because they were so short-staffed and couldn't keep up.

Ms. WOOLSEY. Well with that in——

Mr. MAIN. But that is——

Ms. WOOLSEY [continuing]. With that in mind, do you agree with NIOSH, their independent panel recommendation, to conduct four

complete inspections each year at underground mines as a way to reprioritize resources.

I mean, would that help?

Mr. MAIN. Yes, to finish up the last question. All of those cases were shipped off to the U.S. Attorney's Office that were identified.

So those were processed.

To answer your second question, you know, I went to work before there was ever a Mine Act in this country in 1967. I don't know if there is anybody else around here that did.

But I remember the first time the federal inspector showed up at the mine. It was a game changer.

And I can tell you from my own personal experience that the two and four mandatory inspection program has saved more miners' lives out of that Mine Act than probably any other single thing.

If you look at 178 or 278 miners, I think, that was dying on the job in 1977 when that act was passed, we are down to—and we hope to get even to zero—but we are down in the high 30s to around 40 today. And I think that had a lot to do with protecting these miners.

It is like taking to strip that away, I think, is like taking two brakes off of a car because we don't have as many car wrecks now. I mean, this is a fundamental piece of the 1969 Mine Act that miners were given.

I think, the most fundamental protection they have.

Chairman KLINE. The gentlelady's time has expired.

Mrs. Roby?

Mrs. ROBY. Thank you, Mr. Chairman.

Thank you, Mr. Main, for being here today, we appreciate you taking the opportunity to answer our questions. And I have a few questions about the MSHA inspectors' work, especially about the days and the hours that they worked, especially on weekends.

And unfortunately, I would preface my set of questions by admitting that for the past 5 weekends one of our nation's miners has died in a mine, including last Friday night at the Shoal Creek Mine in my home state of Alabama.

And now that MSHA's internal review found that the agency conducted spot inspections at the Upper Big Branch at irregular intervals, and that none of the inspections occurred on a Saturday. And the internal review also found, and I quote—"inspectors were contractually required to begin their work week no later than Tuesday," which, quote—"limited the opportunities for inspecting on Fridays and Saturdays."

So if I understand this correctly, does this mean that there were no inspections on Sundays? And you know, is this issue of not having or having infrequent Friday and weekend inspections widespread?

Mr. MAIN. I think to answer the question was there anything on Sundays. You may be correct. There may not have been. I have to go back and check that. But I will tell you what we have done.

We have made a lot of changes since the Upper Big Branch tragedy. And some of them started pretty quick. And one of them, you know, I directed my staff, we are going to do a better targeting of the problem mines that are out there, and approach these problems differently.

If you look at the impact inspections that we do every month, a lot of those are done on off shifts when they are least expecting MSHA to show up. And at a time for capturing the phones to prevent the mine operators from changing the conditions underground, prevent advance notice, so that is a tactic that we are using more readily now.

The agencies have had to shift their personnel to address that. But they are.

And you are right about the past 5 weekends. We have wound up, and you start wondering are we so much now on the weekends, we are shifting some of the, you know, some of the activities to a time they still don't think we are going to show up. I don't know.

But in three of those, I believe, they were foremen that died, in these weekend deaths.

Now, we just put alert out to the mining industry this past week to get them to focus on that as well. But the short answer is that we have changed the way we do business. We are focusing more time on the off shifts.

We are plowing through both the data and the human information we have to figure out which mines do we really need to be at more often. And at times when they least expect us to be there.

And I think that folks could pretty much realize that there is probably going to be even more weekend inspections at mines across the country.

Mrs. ROBY. That is good to hear.

And I also understand that you were involved in the Jim Walter's mine investigation in Alabama.

Mr. MAIN. Yes.

Mrs. ROBY. And during that investigation, MSHA discovered that the mine operator essentially kept two set of books. And——

Mr. MAIN. There was a problem that dates back that far, yes.

Mrs. ROBY. Right. And so I understand that the investigation at Upper Big Branch also showed that Massey was keeping two sets of books by illegally reporting hazards in the coal production report.

And so the question is given your experience at Jim Walter's mine in Alabama, what are you doing? And what will you be doing to ensure that mine operators are recording hazards in the official examination books rather than these, quote—"two sets of books?"

Mr. MAIN. Yes. I would say that if I had been assistant secretary back in 2001, we would probably have taken a more aggressive action after that to not be talking about it so much in 2010.

Having said that, there are a number of things that we are doing, and there are things that we were asking Congress to take a look at.

We have pretty well made this clear to all of our inspectorate staff about what is going on. There is absolutely no problem for an operator to keep a set of books that lists hazards, as long as they put them in the required books.

And that is one thing I want to make clear. What we were finding at Upper Big Branch was that they were listing hazards in their production books. They weren't in their routine books.

This is conduct that you have to get into the books to find. This is conduct that—you know, we don't have the powers to do sub-

poenas, for example, to go in a demand those kind of records, just something to think about.

But our inspectors are alert to the fact that this is a problem. We have made them totally alert to the fact that we need to be doing a much better job of looking at the examination books.

That was a failure that we found that Upper Big Branch that the inspectors were not as focused on what was actually in those books the way they should have been.

So with the additional attention, the notice has been given to the mining industry, we are using all the tools we have. But we could use a few more.

Mrs. ROBY. Thank you, my time has expired.

Chairman KLINE. I thank the gentlelady.

Mr. Andrews?

Mr. ANDREWS. Thank you, Mr. Chairman.

Mr. Chairman thank you for calling this hearing and the seriousness which I think all the members are approaching it.

I think for 29 of our fellow citizens we have all engaged in an inexcusable failure. And I would start with us.

I think that we failed to give prosecutors the tools to convict people of serious offenses and have sufficient punishment when they do. I think it is really outrageous that some of these offenses that were involved in the Massey prosecutions were not felonies.

And we need to fix that.

I think we have a responsibility for not giving MSHA all of the tools and resources and personnel that it has needed over time. And I think it is our responsibility to fix that.

Mr. Main, I know the record is still being developed. But I think a fair statement is that some of the inspectors from MSHA failed to catch things that really can't be written off for lack of experience or lack of personnel. They just didn't do their jobs very well.

And I think there should be some consequences in those cases.

And certainly at the root of this problem is absolutely deplorable, criminally irresponsible behavior by a mine operator. And I know there are vigorous prosecutions going on as we speak with whatever tools we have given the prosecutors.

I think obviously our focus should be on finding out what happened in this senseless loss of 29 lives. But our focus also ought to be on preventing something like this from happening again.

And one of the things I am confident that you are doing is to think about how you train and how you supervise and how you manage the people who work for you. And I will leave that to your discretion.

But I do want to take a look at whether we have given this agency that you run the resources and the experienced personnel or not that we should.

And it bears mentioning that in 2001, we had spent $122 million to run your agency. By 2006, it was down to $117 million, which in real dollar terms is about a 15 or 20 percent cut.

And not coincidentally, and I would like that chart [KB1]that was just up to be back again. What happened during that period of time, it looks as if many of your experienced inspectors, which is represented by that green—by the red line, the declining line, that the number of experienced inspectors you had, the average ex-

perience dropped precipitously, as I understand it, from about 12 years of experience to about 5.

Why were experienced people leaving the agency during that period of time?

I know you weren't running it. But I am sure you have talked to people.

Why were experienced people leaving the agency during that time?

Mr. MAIN. In the period of?

Mr. ANDREWS. This would be the period from say 2002 to 2006 or 2009.

Mr. MAIN. I can't speak for the motives of the folks, why they left. But there was a large number of employees that were retirement eligible.

You know, why they decided to exercise that—I mean, that is something that I think you would have to ask them.

You know, a couple of other items that you raised too. One is, you know, there is absolutely—could we have done better. There is absolutely no question about that. And we are on a path to really just take a step back and fix the problems in MSHA.

And we are not taking the same approach that was done in the past internal reviews because I have said from the outset, if we do the same thing the last folks did——

Mr. ANDREWS. Yes——

Mr. MAIN [continuing]. We are going to compound the problem.

Mr. ANDREWS. I know you are not saying—and I don't believe that simply spending more money on a problem like this works. But I sure do think that spending less, then it may exacerbate the problem.

The budget that is going to be under consideration on the House floor probably this week, if you take the projections across the budget, if you prorate them, which they may or may not do in the appropriations process.

If you prorate them, you would have 5.4 percent less money to operate on this coming year than you have right now.

And if you prorate these for 2014, you would have 19 percent less than you have to operate on right now.

What impact would that have on your ability to protect these miners?

Mr. MAIN. I think take a look at the IR report and see what they found, what the last impact of that was. And I think you could pretty——

Mr. ANDREWS. What does it say?

Mr. MAIN [continuing]. Pretty well predict the future. You cannot—if you expect to have an effective enforcement agency, you have got to pay for it.

I think it is that simple.

And I think that in terms of the lesson that have been learned from the Upper Big Branch is that if we could all go back and redo history through 2001 through 2006, we would probably all agree to do that.

And having said that, I think it is a step that we don't want to take in the future to go down that same road.

Mr. ANDREWS. Thank you, Mr. Main. Thank you, Mr. Chairman.

Chairman KLINE. I thank the gentleman.

Dr. Roe?

Mr. ROE. Thank you, Mr. Chairman and thank you, Mr. Main.

And to start with, just to offer my sympathy to the families, obviously the 29, plus the friends, acquaintances and so forth of this horrible tragedy.

And it seems to me that it was a perfect storm. It was an unscrupulous company that wasn't following the rules. And MSHA who didn't really inspect those or follow those rules very carefully themselves.

It is absolutely a perfect storm had this tragedy happen.

I agree with you, the MSHA didn't cause the explosion. They did not do that.

And in reference to Mr. Andrews' chart that he just had up, just for the record, the chart does not show the experience that MSHA folks are required to have before they come to work for MSHA.

Mr. Main, as you know, your agency received significant funding increases over the last 6 years, funding which has increased from $278 million in 2006 to $373 million this year, a 34 percent increase over 6 years.

With respect to funding dedicated specifically to coal enforcement, funding levels increased from $117 million in fiscal year 2006 to $165 million in fiscal year 2012, a 41 percent increase over 6 years.

In 2010, the late Robert Byrd, Senator from West Virginia, said of this MSHA and the Upper Big Branch disaster, "I am perplexed as to how such a tragedy on such a scale could happen given the significant increases in funding and in manpower for the MSHA that had been provided by this subcommittee."

Senator Byrd went on to say, "I don't believe it was because of lack of funding. I don't believe that MSHA lacked enforcement authorities. I don't believe that."

Without objection, Mr. Chairman, I would like to include Senator Byrd's opening statement from a Senate hearing held on May 20th, 2010 into this records hearing.

[The information follows:]

S. HRG. 111–812

INVESTING IN MINE SAFETY: PREVENTING ANOTHER DISASTER

HEARING

BEFORE A

SUBCOMMITTEE OF THE

COMMITTEE ON APPROPRIATIONS

UNITED STATES SENATE

ONE HUNDRED ELEVENTH CONGRESS

SECOND SESSION

SPECIAL HEARING

MAY 20, 2010—WASHINGTON, DC

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Senator HARKIN. Well, we probably thought, when we passed the MINER Act, that we had taken care of a lot of this stuff. And now it just keeps happening, and even worse.

Ms. SMITH. I think that, you know, this is something about the law of unintended consequences. We're now going to get a second chance to look at that and try to fix that.

Senator HARKIN. Well, I can guarantee you, we are going to take a look at it. And we are going to do something to fix it. We just need to know, from the experts, just what course of action you think we ought to take.

Now, I see we're on the second bell, so—Dr. Howard, Ms. Jordan—I'm going to recess the subcommittee now, and go over and vote. And I will return, hopefully within the next 10 to 15 minutes.

We'll stand in recess for just a few minutes.

The subcommittee will resume its sitting.

We have been joined by the individual that I have admired so much for his leadership in so many areas, especially this Appropriations Committee, and his leadership in fighting so hard for our miners in this country. I can say this without any hesitation whatsoever. No one has done more for miners in this country than Senator Robert C. Byrd, of West Virginia. No one. And it's just an honor to have him here today, because I know how deeply Senator Byrd cares about his people in West Virginia, and how he cares about miners everywhere. I've often said that I have such a great affinity for him because we both have coal miner's blood in our veins, and we care very deeply about it.

And so, it's just a great honor to have you here, Senator Byrd. And I will yield to you for whatever statement and questions you might have for this panel.

STATEMENT OF SENATOR ROBERT C. BYRD

Senator BYRD. Thank you, Mr. Chairman.

I very much appreciate your holding this hearing. You and your staff, Senator, have been very gracious in accommodating my request for supplemental funding and for this oversight hearing in the wake of the terrible tragedy that took the lives of 29 coal miners in the coal fields of southern West Virginia.

Nearly 2 months after that horrific explosion, I am perplexed—let me spell that—P-E-R-P-L-E-X-E-D—perplexed as to how such a tragedy on such a scale could happen, given the significant increases in funding and in manpower for the MSHA that have been provided by this subcommittee.

Congress has authorized the most aggressive miner protection laws in the history of the world—history of the universe. But, such laws aren't worth a dime if the enforcement agency is not vigorous about demanding safety in the mines.

These laws are also jeopardized when the miners themselves are not incorporated into the heart of the inspection and enforcement process, as Congress intended for them to be. Now's the time—long past the time—to cast off the fears, the cronyism, and other encumbrances that have shackled coal miners and MSHA in the past.

Assistant Secretary Main and his team at the MSHA still have much to explain regarding this tragedy at Upper Big Branch that happened on their watch their watch. I don't believe it was because

of a lack of funding. I don't believe that MSHA lacked—L-A-C-K-E-D—lacked enforcement authorities. I don't believe that.

Massey Energy officials, who bear the ultimate, final responsibility for the health and safety of their workers, still have much to explain to the country and to the families of the miners who perished. I cannot fathom how an American business could practice such disgraceful health and safety policies while at the same time boasting about its commitment to safety of its workers. I can't understand that.

The Upper Big Branch mine had an alarming record of withdrawal orders. Now, where on Earth—where was the commensurate effort to improve safety and health? Where was it?

Presently, there are several ongoing investigations, including an ongoing criminal investigation an ongoing criminal investigation. Perhaps, so just maybe these will provide some solace and comfort to the families who are looking for accountability.

PREPARED STATEMENT

Let us also hope that his hearing will provide information on the Government and company officials who should be held accountable and lead us to some additional steps that may be taken to avoid such horrific, such terrible loss of life in the future.

[The statement follows:]

PREPARED STATEMENT OF SENATOR ROBERT C. BYRD

Mr. Chairman, I very much appreciate your holding this hearing. You and your staff have been very gracious in accommodating my requests for supplemental funding and for this oversight hearing, in the wake of the terrible tragedy that took the lives of 29 miners in the coal fields of southern West Virginia.

Nearly 2 months after that horrific explosion, I am perplexed as to how such a tragedy, on such a scale, could happen, given the significant increases in funding and manpower for the Mine Safety and Health Administration (MSHA), which have been provided by this subcommittee.

In recent weeks, MSHA has announced so-called inspection blitzes. MSHA has announced new rules concerning preshift examinations and pattern violators, and has displayed a new-found willingness to use injunctive relief to close dangerous mines. It is tragic that miners had to perish in order to precipitate such enforcement. The Congress has authorized the most aggressive miner protection laws in the history of the world, but such laws are useless if the enforcement agency is not vigorous about demanding safety in the mines.

These laws are also jeopardized when the miners themselves are not incorporated into the heart of the inspection and enforcement process—as Congress has intended them to be. Now is the time—in fact, long past the time—to cast off the fears, cronyism, and other encumbrances that have shackled coal miners and MSHA in the past.

Assistant Secretary Main, and his team at MSHA, still have much to explain regarding this tragedy at Upper Big Branch (UBB) mine, which happened on their watch. I do not believe it was because of a lack of funding. I do not believe that MSHA lacked enforcement authorities.

Massey Energy officials, who bear the ultimate responsibility for the health and safety of their workers, still have much to explain to the country and to the families of the miners who perished.

I cannot fathom how an American business could practice such disgraceful health and safety policies while simultaneously boasting about its commitment to the safety of its workers.

The UBB mine had an alarming record of withdrawal orders—where was the commensurate effort to improve safety and health?

Presently there are several ongoing investigations, including an ongoing criminal investigation. Perhaps these will provide some solace to the families who are looking for accountability. Let us also hope that this hearing will provide information on the Government and company officials who should be held accountable, and lead us to

some additional steps which may be taken to avoid such horrific loss of life in the future.

Senator HARKIN. Senator Byrd, thank you very much for a very profound statement, one that really gets to the nub of why we're here.

I had opened with some questions earlier, for Mr. Main and Ms. Smith. If you want to pose some questions, Mr. Chairman, I would yield to you for any questions you might have for Mr. Main.

Senator BYRD. Thank you, Mr. Chairman.

Yes, my first question is addressed to Assistant Secretary Main—M-A-I-N. Given the disturbing safety record—and I mean disturbing safety record—and the reputation of this particular mine, why oh, why, oh, why did MSHA wait until after the tragedy to launch an inspection blitz at coal mines with a history I mean, a history of pattern violations?

Senator HARKIN. Mr. Main.

Mr. MAIN. Senator, that's a fair question, I think, from this body. I think, for those to understand why we did the blitzes we did is to make sure darn sure we had no other Big Branches that existed.

Senator BYRD. Can you understand him?

Senator HARKIN. I'm trying to listen.

Say that again, Mr. Main.

Mr. MAIN. I think that is a very fair question to be asked of us. And I can report why we did what we did, in terms of the blitzes, to make sure there were no other Upper Big Branches that existed with regard to conditions that pose those kind of threats.

Senator HARKIN. Again, let me just emphasize. Senator Byrd's question asked, Why did you wait until after this tragedy to launch this blitz of inspections, especially in a mine that had a pattern and a history of violations?

Mr. MAIN. As we examine what we did, we're going to take a look, to figure out what we did or didn't do. I think that what was happening on the ground in West Virginia with the enforcement folks that were there, they were using the tools that they had been using constantly over the years, and a tool that has been somewhat useful, to a great degree, to help fix some of these problems; that's the 104(d) closure orders. And as the record reflects, that mine did receive the most closure orders of any mine in the United States last year. And, you know, there's a question, I think, on all of our minds, you know, What else could we have done there?

In retrospect, you know, I think that the—there would have been more enforcement tools that were used, without anybody's—without any question, at that mine. And having learned the lessons that we have from that experience, we don't want to do anything to ever repeat them again. And I think that we're struggling right now to figure out what tools we can grab out of the toolbag and create. And one of those is this 108 closure order—injunctive order that we're looking at to move forward. It's been in the MINE Act, I think, since 1969, and never used—and trying to find tools like that.

We had the pattern of violations that—when we looked at it, it was basically a broken system. That law was passed by Congress after Scotia, in 1977. There hasn't been one single mine ever put on the pattern of violations, except for one mine, for a short period

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Chairman KLINE. Without objection.

Mr. ROE. I thank the chairman.

Now, Mr. Main, your agency did in fact receive increased funding every year for the last 6 years did it not?

Mr. MAIN. Yes, but I think you had to put this thing in context and look at the investigation findings which—the agency was depleted to probably its lowest point about 2006.

In 2006, that is when Congress made a decision to add more resources.

Those resources by the time it went through the process things have to go through, to where the agency could start hiring up was in mid-2007.

In mid-2007 as the agency started to hire, the amount of time it took for those inspectors to go through the training process was about 18 months to 2 years.

Now keep in mind, you still have people retiring that was coming out of the system as well.

But the bottom line is, you know, as far as the healthiness of where we are at in these later years, and having more stability and having more people experienced——

Mr. ROE. Let me interrupt you just a second.

As a physician, we have young doctors that come out that are fully trained. And when they are fully trained, they are expected to do the same job that a senior physician like I would do. So I don't think that is an excuse.

When you are trained up to do the job, you ought to be—we can't use that as an excuse when someone does a cesarean section or whatever, or a cancer operation. You are either qualified to do it or you are not.

Mr. MAIN. I do look for the older doctor myself. But that is okay.

Mr. ROE. Well, let me—a second question. And I might do the same.

Do you agree or disagree with the statements made by Senator Byrd less than 2 years ago about this very tragedy and the actions of your agency?

And if you disagree, why do you disagree?

Mr. MAIN. No, I think—yes, I think what the senator and probably a lot of folks were of that belief until folks really had a chance—unfortunately the senator didn't get to live long enough to see this all the way through.

But to see how much the agency was shorted. And how long it took for the money they put back in to have a real effect.

At the time of the Upper Big Branch tragedy, of the lead inspectors that was at Upper Big Branch, I think five out of six of them was hired in this latest class of 2006 forward.

If you look back at 2007 and look at the make-up of District 4 and the agency, 33 percent of District 4 and the agency were trainees——

Mr. ROE. Okay. Let me ask one question before you—I think my time has almost expired.

It would be egregious findings there. Could you have just shut this mine down? Just said, look, it is closed. It is too unsafe for miners to go in there.

Mr. MAIN. On 48 occasions, MSHA went in that mine in 2009 and shut them down using the full measure of the law they had.

And the authority under the law which says that once you correct the problem, you can put it back to work.

Okay. And the mine did that.

This is an issue that has been talked about. But there is no silver bullet. We have asked Congress to consider that.

We have tried to come up with ways to have a holistic way to deal with the mine that is seen as an immediate danger. We use that at the Freedom Mine.

In 2010——

Mr. ROE. They didn't shut down——

Mr. MAIN [continuing]. It took us 3 months to get there.

Mr. ROE. They didn't shut it down and disaster occurred. That is a fact.

Chairman KLINE. The gentleman's time has expired.

Ms. Fudge?

Ms. FUDGE. Thank you very much, Mr. Chairman, and thank you, Mr. Assistant Secretary, for being here today.

This may seem a little repetitive, but I want to be clear.

The first question, Mr. Assistant Secretary, is if you look at MSHA's fiscal year 2013 congressional budget justification, it provides that MSHA is vigorously pursuing policies and procedures to ensure miners are aware of their rights to report hazards without fear of discrimination.

Can you tell me what you were doing in that regard specifically?

Mr. MAIN. I am sorry. I missed the last part of your question. I apologize.

Ms. FUDGE. It indicates that you are pursuing policies and procedures to ensure miners are aware of their rights to report hazards without fear of discrimination.

What are you doing in that regard?

Mr. MAIN. Well, there is a number of things that we have done. And particularly after Upper Big Branch, and particularly after lessons—the information from the hearing that this very committee held in Beckley, West Virginia.

We developed a lot of new training programs. We are getting information back out to the miners. We are getting more information to miners about their rights which are coal enforcement and metal and nonmetal enforcement program do as they reach the miners at the mine.

We have beefed up our response to miners who file complaints. We have an obligation to protect them when they do.

We beefed up protection particularly for those who are fired for speaking up about the safety rights if it is a protected activity in the Mine Act.

And we have considerably increased the number of cases that we now take to the Review Commission for temporary reinstatement.

So there are a lot of things that we are doing with regard to the miner voice issue to—and we think this is something that again was part of legislative processes that was discussed last year and contained in some of the bills, that we really think is something that needs to address giving miners additional protections beyond what they have now.

Ms. FUDGE. And that is what I was trying to get to. To be sure that they do have the protections they need, because I think that that contributed to the problem.

Mr. MAIN. The last complaint—everybody saw the numbers that came out of here as far as what the violation issue was.

The last complaint we received from that mine was in 2006, 4 years prior to the explosion. And that is a sign that we really need to figure out a better way to give miners a voice to help them.

Ms. FUDGE. Thank you.

And the other question you touched on just briefly in—I think when you were talking to my colleague, Mr. Andrews.

Do you believe that MSHA should have subpoena powers?

And do you think that had there been subpoena powers, it could have changed the outcome of the Upper Big Branch case?

Mr. MAIN. I can't—I don't know if it would have changed the history back, because I don't know how it would have been utilized. It would have been a tool that could have been better utilized.

This is something that was in the legislation. It was sponsored over the last couple of years, and something that we supported.

I think if you look at the history, we had a number of witnesses that exercised their Fifth Amendment rights during Upper Big Branch tragedy.

But even to get to that spot where they could be subpoenaed, we had to work with and utilize the State of West Virginia's subpoena power to even get to that point.

We don't have that.

Ms. FUDGE. Thank you very much.

Mr. Chairman, I——

Chairman KLINE. Would the gentlelady yield——

Ms. FUDGE. I would yield to the ranking member.

Mr. MILLER. Absent the subpoena power and absent some kind of whistleblower protection, Mr. Main, what you described here this morning is just a continued cat and mouse game where people continue to warn mining companies that inspectors are on the property after Upper Big Branch. And they continue apparently to cook the books.

And so they continue along because basically they are immunized against the downside of that because Congress hasn't given you subpoena power. And workers don't have worker protection.

So we are right back where we were before.

All of the internal reviews and the rest of that, you are still citing people—you just cited somebody 32 times. You had to grab the phones and that on warning people that the government is on the property.

And in answering the question here, yes, but the books continue—two sets of books continue to be kept. But we can't get to them because we don't have the subpoena power.

So as long as Congress is going to insulate the mine owners from irresponsible and illegal behavior, I don't care how many people we give you to staff up. You are going to be playing on the short end of the field.

And that is just not acceptable. You can't sit here and continue to lament the 29 deaths and the deaths that went before them and the deaths that are continuing to come, and then suggest that

somehow you have got to do this with the blindfold and one hand behind your back.

I mean that is where—at the end of the day—that is what you are describing to us.

Mr. MAIN. I can tell you this. With regard to the question that was asked about the two sets of books, we can go ask the mine operator to produce books. It is not required to be legally maintained under the Mine Act. And they can say no.

And what we do beyond that is what we are creative enough to do. We do not have the ability to demand those through such a subpoena power.

Chairman KLINE. The gentlelady's time has expired.

Mr. Kelly?

Mr. KELLY. I thank you, Mr. Chairman.

Mr. Secretary, thank you for being here. I don't think there is anybody on the dais today that would question the desire to make sure that people were safe all the time.

And unfortunately though, change doesn't usually take place unless there is a tragedy or a crisis. Now if I understand correctly, your inspectors have to have a knowledge in your policies and procedures of 4,500 pages of inspection.

Is that right?

Mr. MAIN. Probably more than that. But that is probably a fair number.

Mr. KELLY. Okay.

So how would you change what you have now? And I—listen, I understand about spending more money. But throwing money at a problem——

Mr. MAIN. Right——

Mr. KELLY [continuing]. Without having a definitive plan of how you are going to fix it, usually isn't a fix. It is just——

Mr. MAIN. Yes——

Mr. KELLY [continuing]. A waste of money. What would you do differently?

What could you do differently?

Mr. MAIN. Well, yes, what we are doing differently—here is the way I view life.

I think that what has happened—and if you look at the number of the past tragedies, we have taken an inspection procedure and process that was pretty challenging for an inspector to do, and as a theory I use, we expect him to do 1,000 things, they can do 750.

And after Sago and after Jim Walter's and after Darby, after Crandall Canyon, there was a number of different policies layered on top of that.

I think the investigation or the internal review team came up with about 200 since 2004 that was layered on.

What I said back in July of 2010, I am not doing this. I put together a crew to go back. We are rewriting the entire manual from base zero. We are cleaning out a lot of the controversy.

We are making sure that all these internal reviews, and all these accountability audits, get placed into there in a very clear and straightforward way, so an inspector knows exactly what they are supposed to do. And we can have a greater clarity.

We have held up the completion of this until we are finished up the internal review, because I asked our folks go to the root of this. We have got to figure out what all the problems are here if we are going to fix them.

Mr. KELLY. Yes.

Mr. MAIN. So I can tell you that we are rewriting the entire inspection procedures——

Mr. KELLY. Yes.

Mr. MAIN [continuing]. To clean up, you know——

Mr. KELLY. Yes, and I understand that. I have been through several mines back in the area that I represent. And I have got to tell you, part of the problem is—and I don't know the experience that the people that you have going on inspecting.

But when people get cited for having a fluorescent light that is not the proper height above the desk, or not having a cover on a trash can, or not having two sets of chocks under truck wheels, and things like that——

Mr. MAIN. Right.

Mr. KELLY [continuing]. You start to wonder if it is really a loss prevention, if it is really a tragedy prevention.

Sometimes we get to the point where we are placing too many things in the same level. Obviously, if I am understanding with Upper Big Branch that there were 48 citations, now, I know you don't have subpoena power, at least I am understanding that.

What would your next——

Mr. MAIN. Well then——

Mr. KELLY [continuing]. Place would have been. I mean, I can't believe that if we know something is wrong, if we know these people are bad actors and if the people that work for them——

Mr. MAIN. Yes.

Mr. KELLY [continuing]. Are complicit in hiding things from mine inspectors——

Mr. MAIN. Right.

Mr. KELLY [continuing]. Then I don't know how you clear that up.

I mean, again, it comes down to if people don't have that in their heart to stand up and do it. And the question about what are the whistleblowers——

Mr. MAIN. Right.

Mr. KELLY [continuing]. Protections?

Mr. MAIN. Right.

Mr. KELLY. But certainly, after 48 citations, somebody would have been able to go to somebody in the Department of Justice and say, we have got a bad actor. We have got to shut these folks down.

Mr. MAIN. Easier than it seems.

If you look at the history of the Mine Act up until Upper Big Branch, I can tell you the tool of choice for this agency was the 104(d) orders, which allowed them to quickly go in—this is a company that didn't pay their fines. So fining them, you know, $1 million a day, and by the way, one longwall running off of Upper Big Branch in a shift produced about $750 or $700,000. That is $2 million a day. So if you even give them a flagrant—I mean, that is—run that long wall, what, a fourth of the day.

This was a company that did not pay its fines. This is a company that challenged the law. And——

Mr. KELLY. But——

Mr. MAIN [continuing]. And——

Mr. KELLY [continuing]. But that is my point. If you know this is going on and they habitually do this—you have to be able to go to somebody up the ladder to say, listen, we have got to stop this. This is a bad actor that we have got to take out.

Mr. MAIN. Today we have instituted a number of tools to target that. But I am going to tell you, we are not there yet.

The tools that we are using is these impact inspections to deal with mine operators before they get too far out of control. The potential Pattern of Violations process that measures their—both their safety and their compliance record and puts them on a program, the potential Pattern of Violation Program.

Those are two tools that I think have been very effective post UBB.

But I will tell you, if you are still looking for that magic bullet, it is not there.

And what we did was, a mine in East Kentucky, Freedom Energy, that had a record similar to Upper Big Branch, we went after them to try to create a tool which was out of Section 108 Injunctive Action. It took us 3 months to get there.

You know, so I think that we need to relook at creating a better tool that gives us a swift ability to go in, as you say, if we had looked at UBB today, what could we do to go in and shut them down when they are that bad.

We still have a gap to get us there. We are using the impacts, the 104(d)s, the other enforcement tools.

But we are still short.

Mr. KELLY. Okay.

Chairman KLINE. The gentleman's time has expired.

Mr. Kildee?

Mr. KILDEE. Thank you, Mr. Chairman.

Mr. Main, I have been serving on this committee for 36 years trying to make safety a more important issue for our miners.

When I came on this committee 36 years ago, Carl Perkins, whom we affectionately called, Pappy Perkins, was chairman of this committee.

And we had a hearing on mining safety. And I was shocked what I heard then. But I am shocked 36 years later of what is happening.

I could recall the—one of the representatives of the mine owners testify how safe, and how safety was such a high priority in their mines.

And you still get that same testimony from many of the owners who have come here. I can't think any who didn't.

But I can recall one time the person went so far that Pappy Perkins, or Carl Perkins who was such a kindly gentle person, finally said, when I was a child my daddy put me on the back of a buckboard and took me over to the next hollow for the funeral of my cousin who was killed with others in one of your mines.

That is 36 years later. And I feel that we should have made much more progress in 36 years. We fought wars in that time. We spent money here and there.

But 36 years later I still hear the same stories and the same attitude very often of the owners of trying to get by as cheap as they can so they can make greater profits.

What area should we strengthen to make sure that their banality, their stupidity, is brought into rein? Stronger regulation, a more stringent enforcement, greater penalties, where would you emphasize the greatest effort of this Congress in working with you to make sure that these people really put in mind the safety of their workers?

Mr. MAIN. You know, I firmly believe that there are a number of mine operators in this country that do manage their systems to have systems in place to operate under the Mine Act.

That doesn't mean that they always are totally successful with that. But I believe that, you know, many mine operators try to do what is right.

And I believe that there are those that just do not. And I think if you take a look at our impact inspection list, mines that have shown up on a potential Pattern of Violations, those are showing you some of the mines that are operating outside the mainstream.

Dealing with some of those mines—and I am just going to start down the list.

I do believe that there needs to be more respect of the law and a greater fear of the penalties that exist to deter them from continuing to do the conduct that we are finding with the advance notice, and with some of these mines still operating without enough curtain up to control methane that could have another coal mine dust explosion.

On a regulatory front, we have the list of recommendations from both the—acts investigation internal review team. We are going to take a hard look at to figure out what it is that we need to do better there.

Administratively, I am going to tell you, we are doing a lot of things differently here to make sure that we have the best inspection agency that the miners should expect and money could buy. And there is going to be a lot of changes that we have already—that has been laid out in the internal review reports that we are working toward to correct.

But at the end of the day, I think that, you know, the legislation that has been sitting here on the Hill, that has different pieces to address the issues we have talked about today is something that this Congress needs to take a look at.

And I think too the issue that was raised here, we have got to be—you cannot undercut this staff and this agency to the point that you are scrambling with trainees trying to just get into mines, let alone inspect them. And expect to have a competent inspection program.

And going forward, I think that is something that we really have to take a good look at——

Mr. KILDEE. And I say that I really think that through the lord is the beginning of wisdom. And I think that put a little fear that the government means business, that we just don't use ink.

We put our spirit, our beliefs and the dignity of every human being when we write those laws.

Chairman KLINE. The gentleman's time has expired.

Mr. Walberg?

Mr. WALBERG. Thank you, Mr. Chairman and thank you, Mr. Main, for being here.

I would like to highlight an issue related to miner training cited in the internal review that seems startling to me.

Now in my getting up to speed over the course of this past year, I have had the opportunity to view mining operations in North Dakota, surface mining. And I have had the opportunity to go 1,200 feet below Detroit and see the salt mines, which is a totally different ballgame.

Look down 1,200 feet into an iron ore operation in Marquette, beautiful area of our state, and then to be with you in your home area, in fact to see your home. But in a coal mine 800-900 feet below and eight miles back into that longwall.

I know that I am not a miner. And I know you are a miner. And you understand that.

And I know that you weren't around leading when this all happened.

But as I look at the record, Upper Big Branch was operating under a petition for modification to permit mining through any oil and gas wells. The petition was granted, according to record, on October 16th, 1995.

And the mine was required to submit a training plan 60 days after the petition became final.

As I understand it, that plan would have included initial and refresher miner training requirements, so forth and so on. But the internal review found that the training plan was never submitted. And the requirements were never part of the mine's training plan when the explosion occurred.

Director Main, how did that happen?

Mr. MAIN. I think if you look at—one of the things that you will find in this internal review that you are not going to find in other internal reviews is really just looking back through everything that we could find that was wrong here to get it fixed.

I don't think there is any other internal review that looked back beyond a couple of years.

That was one of the things we asked the folks to go back and take a harder look, they found. In 1995 apparently, they didn't implement the plan. I mean, I think it is pretty much that simple from all the——

Mr. WALBERG. Did MSHA ever demand the plan? Did you find——

Mr. MAIN. I don't think there is—I believe that somehow in 1995 that provision was put in a petition modification. And apparently we could find no follow up to require the operator to do what—now I don't know if there is a plan put in place or not by the operator. But there is none that was incorporated that the——

Mr. WALBERG. That MSHA knew——

Mr. MAIN [continuing]. They found.

Mr. WALBERG. I guess then moving forward, we don't live in the past. We look at the past to plan for the future.

But I guess my question then comes to you.

Does MSHA intend to undertake the comprehensive review of all mining plans to determine that this isn't a widespread problem? That what happened at Upper Big Branch, and the fact that this training wasn't done, requirement wasn't in place, and MSHA apparently didn't even ask for it, I mean, is that widespread?

Are we worried that there are other mines operating right now who have a similar situation?

Mr. MAIN. Well, the problem that I think that we face as an agency was that there was a lot of policies and procedures that was put in place. And I will use that along with the plans that somehow a lot of communication sort of broke down somewhere in the back years in this agency.

And I think there are different reasons for that. One as far as policies, they did centralize the whole policy review process.

On the training programs, we may or may not find others back in those years. But what we are trying to do is start from fresh and just identify everything that we can. We are training everybody to those things.

As a matter of fact, the findings of the internal review team of the things that came out of it, we have already had a set through with all of our District 4 and District 12 staff and the district managers. And we are getting——

Mr. WALBERG. But are we looking for this problem right now? Even as we are training for it, are we looking for it that there might be some ready to explode?

Mr. MAIN. As far as that kind of training plan, I will tell you we will go back and look to see if that is something that we are looking at right now.

I know we are looking at a ton of things. And I will make sure that that is on the list of things that we are looking at.

But one of the things I would like to say is that when I—this is the first committee I have testified before when I became assistant secretary. I will never forget that.

It is an awesome experience for those who have never had it, to take your first trip to the Hill.

And, you know, when I was here, one of the things I was laying out is sort of like the path that I was going to take with this agency. And this was about, I think, what, 2 months before Upper Big Branch hit. It was in February of 2010.

And some of the things that I had talked about at that time was the fact that the day I took this job, 55 percent of the MSHA inspectors that I had had 2 years or less inspection experience, and 38 percent of the metal and nonmetal inspectors that I had had less than 2 years or less of inspection experience.

And one of the things that I decided to do fairly quickly was to bring in every one of our field office supervisors, set up a training program to train them on how to be a supervisor, because a lot of those had left as well and a lot of them were new, and to be able to manage the inspection enforcement program.

We had complaints about consistency. And I think rightfully so, that was coming from The Hill. But to figure out a way to get quickly those who managed our whole enforcement program under control.

We had that put in place and we had to actually—was kicking off the first training right as UBB struck.

The second thing is to take a look at how we are training our folks and how we are identifying the core—the auditing. Are we doing enough self-audits in this agency to find the things like you are talking about.

Chairman KLINE. I am sorry. The gentleman's time has expired.

Mr. Tierney?

Mr. TIERNEY. Thank you, Mr. Chairman.

I will just yield my time to the ranking member.

Mr. MILLER. Secretary Main, Mr. Kelly was discussing with you the fact that there were 48 shutdown D2 inspections, shutdowns of Upper Big Branch Mine.

There are 52 weeks in the year. Forty-eight of those apparently ended up with the shutting down order at some point in this mine.

And then he said to you, there must be something you can do. And you started to lay out the idea that you could go and seek and injunction. Which when you did it in the case of the Freedom Mine, it took you about 3 months.

If this mine continued to operate under its consistent pattern, that would be another 12 violations roughly, that warrant an unwarrantable safety hazard and justify shutting them down.

So that doesn't look like a very good remedy if you are a miner that you are going to get to spend another 3 months in a mine that has this track record, while you go to see if you can put together enough of a finding to have an injunction.

Mr. MAIN. Yes.

Mr. MILLER. So once again, we are left here because of some glitch in the law, some failure to get from one point to the other.

The miners are left in an unsafe condition—working in an unsafe condition.

Mr. MAIN. I am here to tell everyone that we are using all the tools that we can amass under that——

Mr. MILLER. That is my worry. You have used all the tools——

Mr. MAIN [continuing]. And——

Mr. MILLER [continuing]. You still can't get to the end of the story where an unsafe mine is either permanently shut down or something happens.

Mr. MAIN. There is no silver bullet that we have in the Mine Act——

Mr. MILLER. I don't want a silver bullet, I want an effective tool.

And you have made it very clear you are working very hard to see how you can piece together the authorities you have under the law.

But it appears to me in your response that you can't get to where we would need to provide that protection because you don't have subpoena power in the case of cooking the books. And you don't have enough authority to keep a mine from racking up 48 D2 citations.

Mr. MAIN. There is a point of which we lack the ability to go in and shut down a mine because of its overall conditions. We can use all the tools as identified in the law to selectively, and with regard to the specific issue at hand, to take enforcement action.

But I think what you are describing doesn't exist.

Mr. MILLER. You issued the results of your inspections. This was in January. And in the release here you refer to Coal Creek mining.

And you said that the agency seems—secured and monitored the phones during the inspection, issued 32 citations, 12 orders which subsequently shut down the mine.

MSHA issued an imminent danger order when an inspector observed a coal pile five feet high, 10 feet in diameter on fire approximately 23 feet away from explosive storage magazine outside the mine.

Mr. MAIN. That is the conditions they found.

Mr. MILLER. That is the conditions they found. In that case when you secured the phones, did you have the finding of prior notice or not?

Mr. MAIN. On that one, I am not sure. I would have to go back and take a look at.

Mr. RAHALL. Would the gentleman yield?

Mr. MILLER. But we have an inherently dangerous process going on here.

And somehow we can't get to the remedy.

Mr. MAIN. Yes.

Mr. MILLER. Because you just keep going through shutting down, opening up, shutting down, opening up, shutting down, opening up, and you continue to find these unwarranted hazards.

Mr. MAIN. Yes.

I believe that there is a mine that I identified in the testimony that I presented. It was a mine that we did a number of impacts inspections at. I think about seven.

Mr. MILLER. Okay.

I will yield to Mr. Rahall.

Mr. RAHALL. Very quickly in response—to follow up on the gentleman's question.

Could the operator of this mine shut it down? Could Mr. Blankenship have shut it down?

Mr. MAIN. Mr. Blankenship could have shut this mine down any moment that they decided to do it. They could have decided not to have provided advance notice of the inspections underground to the mining operator, or to the mining personnel, so we could have had a fair view of the conditions that are there.

But yes, we all have to understand, it is a mine operator's responsibility to run these mines safely and to have them in place, programs and procedures to protect the miners.

Many of them do every day of the week. Some don't. And some like Upper Big Branch really the miners pay just a hell of a price, excuse my French, whenever they don't.

Mr. MILLER. So whatever number, but you point out, whatever number of shifts that mine operator, that irresponsible mine operator, can get in between the next shut down, in this case you said you thought it was worth about $700,000 a shift to run the longwall.

Mr. MAIN. Well let me just say this——

Chairman KLINE. The gentleman's time has expired.

Mr. Rokita?

Mr. ROKITA. Thank you, Mr. Chairman, and thank you, Mr. Main, for being back here today.

I want to focus on the internal review. And it seems like the tone and breadth of that document almost intentionally focused on District 4, almost shielding headquarters from any culpability in this. I mean it is not until page 193 that the report even speaks directly to headquarter deficiencies.

Do you have a comment on that?

Mr. MAIN. Well, I think the way policy is constructed, it has the focus of the investigation basically starting with the mine and working itself back.

And this is a process that has been in place, I think, since about 1992 in terms of the process for conducting——

Mr. ROKITA. Yes. The problem, I am seeing and reading in the report though is that with the sheer magnitude of the identified shortcomings, it can't be limited to just District 4.

And before this happens again——

Mr. MAIN. Yes.

Mr. ROKITA [continuing]. Like the other tools that you said you are starting to use, I would advise and ask that you look into restructuring how you are doing these reports.

Mr. MAIN. We will. I think that is a valid recommendation. And I think some of the findings from the report itself, some of their findings from the NIOSH report, really gives us an understanding.

We really need to go back and retool the way that we do internal reviews

Although having said that, I think that the internal review team was instructed to go overboard in terms of not being restricted to the balance of that. And really figure out what went wrong here.

Mr. ROKITA. Thank you.

Also on page 66 of the report, it states, quote—"the decision not to pursue 1610(c) investigations at UBB was driven by resource considerations rather than the merits of the case."

Were you aware of this? Was headquarters aware that that was the reason that this happened?

Mr. MAIN. Well, I doubt if they were because basically what happens is the district inspectors would be the ones would normally identify the cases. They would then transfer that information over to the special investigations branch.

The special investigations branch then would assess those and deal with the district in terms of what their recommendations were.

Mr. ROKITA. So you don't know.

Mr. MAIN. I don't know how far, but I just sort of believe that what was happening was there was determinations made about what they could or couldn't handle.

And keeping in mind out of all six of those, I think it was a thorough review, the internal review found that six of those was notorious. I am not sure then on a normal day that the district staff would have really identified all six of those.

But in this particular case, I am not sure that they went beyond the discussions between——

Mr. ROKITA. Thank you.

This hearing focused on some short-term inexperience. And I want to say that on page 78 of the internal review there appears to be an 11-year gap between an agency requirement of the operator that new elements be included in the training plan.

And these were never included. And the agency failed to notice this during an 11-year period.

So it seems to me this is more than just near and short-term inexperience.

Mr. MAIN. Yes, I think that there is a lot of things that played in—it is just like the 1995 plan. I can't explain why that was not, you know, implemented.

Some of the things that——

Mr. ROKITA. It just seems the headquarters and the district missed some of this for far too long.

And again, I would appreciate going through—I used to run—I used to be a regulator. I used to be running one of—you—not in the coal industry, but for other industries.

Mr. MAIN. Yes.

Mr. ROKITA. And these would be warning signs to me to go back and review processes.

Mr. MAIN. Yes.

Mr. ROKITA. Let me yield the rest of my time to Mr. Walberg.

Mr. MAIN. Okay.

Mr. WALBERG. I thank the gentleman.

Going along that train here, assuming the fact that—or knowing the fact that we had a bad actor and operator of that mine, who may indeed have covered certain things so that your inspectors couldn't see them, yet the internal review found many instances where MSHA inspectors observed serious problems, but did not issue a citation.

For example, District 4 personnel inspected the tailgate entry of the longwall on four occasions, but never cited Massey for failing to install the required level of roof support.

And on page 83, the panel concluded, and I quote—"with the proper quantity of air there would not have been the accumulation of methane, thereby eliminating the fuel sources for the gas explosion."

My question is how can we be confident inspectors are going to find these failures in the future?

Mr. MAIN. Yes. I think with regard to both of those, I provided some insight of those a little bit earlier.

On the tailgate issue, there is actually only one inspection that took place involving the roof supports. The other inspectors who were there is over a 3-day period when they went in and shut down—that was a—I don't know if you caught that part of the story or not.

But when the inspectors arrived at the mine site with the carload of inspectors, went underground and issued a closure order over the ventilation system. And that is what they were there looking at. Then trying to deal—and they had the mine down actually for 3 days over a ventilation issue.

So, you know, those were not all—I think there are some differences about what may have been in the internal review report and what was in the other report.

As far as the——

Chairman KLINE. The gentleman's time has expired.

Mr. Rahall?

Mr. RAHALL. Thank you, Mr. Chairman. I appreciate your courtesies and that of the ranking member in allowing me to be part of this panel today.

The UBB mine does sit in my congressional district, in fact, in my home county. So the disaster that occurred on April 5th, 2010 hits very close to home on multiple fronts.

Beyond knowing with certainty, as we now do, what caused that tragedy, I do ask for two things of this committee.

First, that the committee look responsibly at what the Congress should do to prevent another UBB. And then just do it.

If that means legislation, and I believe it does, then legislation should be passed.

I do not excuse MSHA's failures, but the Congress should not withhold effective lifesaving legal authorities from the agency as some kind of penalty. Because ultimately the only people penalized by that cockeyed approach will be our miners.

Second, I ask that whatever action is taken ensures that bad actor company executives, and they are a very minute minority, who make the decisions and set the policies that lead to tragedies like UBB, are no longer able to hide from the law or to exploit the weaknesses of MSHA, as the gentlelady from California, Ms. Woolsey, referred to earlier.

The families of miners are sick of watching lower level employees take the fall for upper management. In the case of UBB, investigation witnesses have testified that Massey CEO, Don Blankenship, and members of top management, received reports as often as every 30 minutes or more of every day, of every day of the week, about the production at that mine.

What happened at UBB is absolutely criminal. And the Congress should do everything in its power to stop the protection, in fact the reward, of this kind of sick profit over people behavior.

Indeed in response to numerous questions, especially from the majority side, about why MSHA didn't shut down this mine, Mr. Don Blankenship himself could have shut down the mine at any moment, quicker than any government entity or any person on the face of the earth.

None of us ever want to see another disaster like UBB happen again.

And with that stated, I do have a question that I would like to ask Mr. Main. And perhaps it is a follow up to the previous question.

But investigation after investigation points to the fact that MSHA does need more staff. We know that it was a systematic problem that occurred with MSHA. You do need more highly trained staff, and that the existing staff is often spread too thin trying to address too many needs.

In southern West Virginia, you have split the former District 4 largely to address these kinds of problems creating District 12 in June of last year. And I understand that both districts are—or neither district rather is fully staffed, though MSHA is working toward that.

This concerns me. And I would like to know, Mr. Main, what MSHA is doing to ensure that both of these districts are fully staffed and that we have sufficient number of specialists to review technical issues like ventilation?

And what resources does the agency need to make sure that both of these district offices are functioning at an optimal level and that we are able to retain employees with sufficient experience?

[The statement of Mr. Rahall follows:]

Prepared Statement of Hon. Nick J. Rahall, II, a Representative in Congress From the State of West Virginia

Thank you, Chairman Kline and Ranking Member Miller. I appreciate the courtesies extended to me by the Committee.

The Upper Big Branch Mine sits in my District, in fact, in my home county. So the disaster that occurred on April 5, 2010, hit very close to home in multiple respects.

Beyond knowing with certainty—as we now do—what caused that tragedy, I ask for two things.

First, I ask that this Committee look responsibly at what the Congress should do to prevent another UBB, and then do it. If that means legislation—and I believe it does—then legislation should be passed. I do not excuse MSHA's failures, but the Congress should not withhold effective, life-saving legal authorities from the agency as some kind of penalty, because, ultimately, the only people penalized by that cockeyed approach will be our miners.

Second, I ask that whatever action is taken ensures that bad-actor company executives, and they are a minority, who make the decisions and set the policies that lead to tragedies like UBB are no longer be able to hide from the law. The families of miners are sick of watching lower level employees take the fall for upper management.

In the case of UBB, investigation witnesses have testified that Massey CEO Don Blankenship and members of top management received reports as often as every 30 minutes or more, every day, about the production at that mine.

What happened at UBB is absolutely criminal and the Congress should do everything in its power to stop the protection—in fact, the reward—of that kind of sick "profit-over-people" behavior.

Mr. Chairman, I NEVER, EVER want to see another disaster like the one at Upper Big Branch, and at other mines across my home state in recent years.

Mr. MAIN. Thank you, Congressman.

I think—we split the district about June, I believe, of last year.

Mr. RAHALL. Right.

Mr. MAIN. And actually we moved into the MSHA academy, we are looking for office space to move into so we can expand.

We are probably going to be taking over more and more of the academy space. But Kevin Stricklin is on tap to figure out—we have got a number that we are moving to. We are ramping up. We are finding space for those.

And we still have a ways to go, as you said, to move some more folks in there to get where we want to be. And we are providing additional support from the outside to get there.

But I would hope by within the next 3 to 4 months that we have that—both of those districts ramped up to where we have a full complement of staff.

It is still—so this is staffing within MSHA. There are people bidding in from other areas coming in.

We have moved some folks from District 4 into District 12. But this will be staffed up with the—I think more experienced folks than we had before.

One of the benefits of the hiring in 2007-2008 was—the crew that we brought in was probably some of the most experienced mining people that we have. I think about an average of about 15 years mining experience.

So that is the benefit we have as we get the procedures trained into them as far as the agency requirements. But we are moving quickly to try to get that fully staffed.

Mr. RAHALL. Okay.

Let me ask one last question.

Earlier you mentioned that rock dust samples were taken out of the UBB mine on March 15th——

Mr. MAIN. Right.

Mr. RAHALL [continuing]. Taken to a lab——

Mr. MAIN. Right.

Mr. RAHALL [continuing]. And that the report from that lab was not back until post UBB——

Mr. MAIN. Right.

Mr. RAHALL [continuing]. Disaster. Why the lag time? And is there still a lag time in such analysis of report——

Mr. MAIN. When I took this job, I got a lot of surprises. And one of those surprises was we had a lab that handled the rock dust sampling that was actually under a district, which is actually not a national lab, under District 4 control.

And it was a lab that was actually one of the responsibilities of the district itself.

What we did is we have pulled that lab out. It is now a national lab. We have staffed it up. We have put more resources in in terms of the sampling equipment. And we are doing much faster sampling now.

One of the things that was going on with the samples was a bit of a delay at that time was that they were doing some experimental research with the CDEM device that is being developed to try to figure out. That is going to be a quick tool to be able to quick sample.

So that was part of the delay that was involved in that.

Mr. RAHALL. Will we ever get——

Chairman KLINE. The gentleman's time has expired.

Dr. Bucshon?

Mr. BUCSHON. Thank you, Secretary Main for being here today.

And I grew up in a coal mining community. My dad was a United Mine Worker for 37 years. And any time a disaster like this happens, it hits close to home because basically everyone I grew up with and everyone I knew were coal miners.

So with that, I am interested in finding out, you know, it says in the internal review that the abatement time for the one respirable dust citation was 33 days when the allowable standard is 7 days.

Why is MSHA setting abatement deadlines weeks beyond what was allowed?

Mr. MAIN. I think one of the things that we found from the internal review was two things.

One is that the mining company was abusing the system, and that we were not doing enough to keep up with the system. And some of those delays I don't think should have been in place.

I think that there was extensions——

Mr. BUCSHON. Who makes the final decision on that?

I mean, it probably doesn't come to the secretary's office——

Mr. MAIN. Well——

Mr. BUCSHON [continuing]. I mean, where does that—say you have an inspector, they are in the mine. They say this is a problem. It goes—run me through the track and where the buck stops.

Mr. MAIN. Yes. There are over 14,000 mines we inspect; on the coal side, about 2,000. So yes, sometimes things are slow getting all the way to the top.

But if you look at the administrative process, the inspector does the action at the mine. It goes to a field office supervisor who does the review. He goes up to a higher level supervisor, up to administrative——

Mr. BUCSHON. Can I answer——

Mr. MAIN. Sure.

Mr. BUCSHON. Why does it go to a higher level supervisor?

I mean we have known—I mean it seems to me that that may be part of the issue is that if you go—the more people—it is like we are playing telephone when you are a kid.

I mean, the more people you have——

Mr. MAIN. But——

Mr. BUCSHON [continuing]. In the system, it is going to leave more places where the ball can be dropped. I mean——

I am sorry to interrupt——

Mr. BUCSHON. Yes.

Mr. MAIN [continuing]. But you got up to another level of supervisor——

Mr. BUCSHON. Yes.

Mr. MAIN [continuing]. And then—but I think, you know, there are different—we have a health wing and the—in the districts. They are responsible for oversight of the health issues.

And you have an inspector who as part of their job inspecting deals with the occupational health issues. That inspector has to report to the field office supervisor, the one I said we just brought in——

Mr. BUCSHON. Yes.

Mr. MAIN [continuing]. And trained them all.

But also to review the health things to make sure that we are doing our job, there is a health supervisor that takes a look at the health related things, which I think is a critical part of our operation.

Somehow there was a breakdown that that did not get taken care of the way that it should. And that is something that we are taking a strong look about how we revamp not only the supervision of our field offices, but our whole agency to make sure that we are fixing those kind of problems.

But yes, there was something, I agree, that was a problem.

Mr. BUCSHON. Yes, and my point, I guess, was that I am not expecting every decision like these to go to the secretary of MSHA, you know. I mean, in every organization there has to be a point where the buck stops.

And it seems to me that, you know, the more points—the more bureaucratic——

Mr. MAIN. Right.

Mr. BUCSHON [continuing]. Your system, the more chance where you are going to have to lose—drop the ball.

Now I also want to ask, NIOSH also found that MSHA essentially has repeated the same failures and shortcomings in each of the most recent mine disasters. And so my question is that—and I know you are taking a lot of action. And I appreciate that.

But I really need to know what MSHA, you know, what ultimately is going to stop us from not learning from our mistakes——

Mr. MAIN. Right.

Mr. BUCSHON [continuing]. And what is going to fix this problem?

I mean if you were to identify a few things that you would need to ultimately fix this issue, what would that be?

I mean, we are having—we can't continue to do the same——

Mr. MAIN. Right.

Mr. BUCSHON [continuing]. Things over and over again. And every time have congressional hearings and say, here is where our mistakes were if we haven't fixed it.

Mr. MAIN. And I agree with that.

I think that is the reason that we have said as far as inspectors are going back and just rewriting the entire policy manual to clean up some of the lack of clarity, the cross directions that was in it, the lack of direction.

And also to make clear the things that we found in these internal reviews and audits are clearly stated in these policies. And what we do is have a check system that is effective in checking those.

I think what happened in the past, you have an accident. You have internal review. You would have a bunch of policies. You just keep piling them on to the point that the wagon, the wheels broke on the wagon.

And I think that is the core of trying to fix, as a starting point, fix the problem. Go back and rebuild the wagon.

Mr. BUCSHON. So the internal review is good. But that is after it has happened.

So what—you know, proactive—I mean there are two ways to manage——

Mr. MAIN. Right.

Mr. BUCSHON [continuing]. Things either proactively or reactively.

Mr. MAIN. Right.

Mr. BUCSHON. And it seems like MSHA continues to manage things in a reactive fashion rather than a proactive——

Chairman KLINE. The gentleman's time has expired.

Mrs. Capito?

Mrs. CAPITO. Thank you. I would like to thank the chairman and the ranking member for letting me participate in the hearing today.

Good afternoon, or good morning still, Mr. Main.

I thank you for your service to our country and our state and to the beloved miners that I know that you care about quite a bit.

So I would like to also thank the committee for coming to Beckley. I think that was a really enlightening hearing that we had there.

There is no question the mine operator put production above safety every single day, resulting in a huge tragedy at UBB.

But if we go back to 2006, we had a huge tragedy in my district, Mr. Rahall. Unfortunately, UBB is in his district. Sago was in my district. We lost a lot of miners there.

That is what this chart is all about here. Because the resources were really upped in terms of the numbers of inspectors that were hired post Sago, correct?

I mean that was the reason——

Mr. MAIN. Correct. Yes——

Mrs. CAPITO [continuing]. The resources were put in.

But then you and I attended a—and help me with my memory here. We attended a reception in Charleston at the Charleston Civic Center. I think it was at the end of 2009 where we were celebrating that that had been the safest year.

Is that correct? Was it 2009?

Mr. MAIN. 2009, yes it was the safest year in the entire mining industry.

Mrs. CAPITO. And then 4—3½ months later——

Mr. MAIN. Yes.

Mrs. CAPITO [continuing]. The most devastating tragedy in 40 years.

I remember at that time you talked a lot about vehicle accidents and most of the lives that were lost were carelessness with operating the vehicles.

I wouldn't say that you had taken your eye off the ball, but have you reshifted? Obviously, you have reshifted your resources, I would think, towards the life threatening massive kinds of things that could occur in a mine, and did occur on that tragic day.

What have you done since then to reprioritize since that meeting we had in 2009?

Mr. MAIN. Well, I think there were things that we were working on at the time that we have had a chance to get on track.

One of them is our—it is a program we don't talk much, but the "Rules to Live By". I am a firm believer that really we really have to stay focused on the things that most apt to take a miner's life.

And the Rules to Live By that I kicked off, I think, in January 2010 was aimed at targeting in as we do our inspections, and to educate the mining industry on the most common causes of mining deaths.

We just launched "Rules to Live By" version III which dug a little bit deeper into the cause of fatalities and "Rules to Live By II" deals with the catastrophic kind of fatality.

So we are paying attention as an industry to those.

And then the last gentleman that raised the question, we do need to do things differently.

And some of the things we started off right at the time we were speaking, as well as the thing that worried me when I took this job most of all, when I saw that 55 percent of my inspectors had 2 years or less, growing up in this mining industry is something that got my attention.

And one of the places I thought we needed to start the quickest is to get a control over the management of our whole system was to bring in all of our field office supervisors, retrain them, make

sure they knew how to manage the programs, make sure they knew what they need to focus on.

And to make sure that they understood some of the deficiencies of these past audits and the reviews have found.

Unfortunately, we were just starting that at the time of UBB. But things like that that I think are critical, and then taking a look back at some—a better targeting or finding out who the bad actors are in this industry.

Mrs. CAPITO. Right. I don't mean to interrupt you, but I have only got 5 minutes.

I just want to give you a chance to clarify this. It showed that there was a complete—excuse me—a computer glitch that prevented this particular mine from going into the Pattern of Violation which is obviously a category in which closure would be more readily available as an enforcement mechanism.

I am going to give you a chance to say have you fixed this computer glitch?

Mr. MAIN. It got fixed pretty quick. We found it. We fixed it.

And we actually spent a lot of quality time with the Inspector General's Office, quite frankly, with a lot of help from them to have them look around and see if we had anything else that was a problem.

This was a program that unfortunately, the Mine Act went into effect in 1977. This program was put in effect, I think, in 2007. And the folks who were putting the data in failed to, I guess, put in certain data—a certain category. But that was fixed.

Mrs. CAPITO. Let me just say, finally too, in terms of the inexperience of inspectors, I mean, we can't fast forward the clock here. We can't give somebody 2 more years of experience.

So we have got to make sure——

Mr. MAIN. Right.

Mrs. CAPITO [continuing]. The training and experience that they get right now assures those miners that are right there now, that they are not going to overlook or oversee.

These two reports have shown that there were some lack of enforcement or lack of knowledge, or too much complexity as to what the actual mine inspector was actually asking to do.

But I want to be assured when I leave this hearing today that the inspectors that are there now, regardless of the years of experience, do have this depth of experience that they need to have.

Mr. MAIN. All right——

Mrs. CAPITO. And my time is up.

Chairman KLINE. The gentlelady's time has expired.

I want to thank Secretary Main for being with us today. Your patience and forthright answers are very helpful——

Mr. Holt?

Chairman KLINE. You are recognized.

Mr. HOLT. Thank you very much, Secretary Main.

It seems to me the key question that we come back to is whether there are teeth. Whether the sanctions are so minor that—I mean, M-I-N-O-R, that the poor performers have very little incentive to clean up their acts.

What—forgive me if I am retreading ground that you have already been over. But it seems to me it is the key question.

What do we need to do legislatively to strengthen the sanctions?

Mr. MAIN. I think—I have talked about a number of this today. I think they are contained in legislation that was already reported as a body.

And it deals with things that I think are very fundamental.

One is, you know, giving miners better protection to be able—for them to be able to speak out. I believe that those mine operators are flaunting the law given the best tools we are throwing at them. And given the use of—our actions to curb things like advance notice that some still don't get it, that we need to deal with.

Mr. HOLT. But the State of West Virginia has done that, I guess. But this needs to be done at a federal level, I believe. Is that——

Mr. MAIN. Yes, I think there are more tools that we need to effectively do our job. Yes.

Mr. HOLT. Okay.

Well, I want to thank you for your work. Some might ask why would a representative from New Jersey be involved in this.

And as I think you know, I grew up around miners. I really respect the work they do. And it is really criminal the way they have been treated.

So I want to make sure that those who engage in criminal behavior are treated like criminals. And we have to make sure that the sanctions are real and felt.

So I thank you very much for your work——

Ms. WOOLSEY. Will the gentleman yield?

Mr. HOLT. I would be happy to yield.

Ms. WOOLSEY. Thank you.

Joe, you are about ready to leave here. Could you succinctly tell us what legislation we have to pass to make a difference to the miners? Because we can't just clear up bureaucracy——

Mr. MAIN. Right.

Ms. WOOLSEY [continuing]. Because we are going to be right back where we started because the bad actors are not going to change.

What is missing in this picture?

Mr. MAIN. Well, yes, I am going to start with one of the things that we have said, there are a lot of things that we can do better and we need to. And we are. We are——

Ms. WOOLSEY. But I am talking about us.

Mr. MAIN. Yes. But I am just like working up the ladder to the point that, there are a lot of things we are undertaking to fix. We are looking at regulatory improvements out of Upper Big Branch.

But even with those, at the end of the day, there is still those things that are left that we do not think that we have A, the current tools to fix, nor the ability to fix them.

And that is to figure out a way to give miners a better voice. That is to have a law that has respect where the criminal sanctions are one that really deters bad behaviors, that gets the bad folks acting like the good folks out there, ways that we can get information, and ways to make sure that we are fully effective—enforcing the law.

Ms. WOOLSEY. So how important is subpoena power?

Mr. MAIN. I would just say that in West Virginia, if it hadn't been for UBB, we would not have been able to even ask in a legal

way, or demand in a legal way, people to come even answer questions.

Ms. WOOLSEY. But we——

Mr. MAIN. We had to go to West Virginia.

Ms. WOOLSEY [continuing]. Do we even need to make that possible for you, for MSHA?

Mr. MAIN. That was in the past legislation as something that we supported then. And I don't think anything has changed.

Mr. RAHALL. Would the gentlelady yield?

Ms. WOOLSEY. Yes.

Mr. HOLT. For both I believe I have the time that I——

Yield. Sorry.

Ms. WOOLSEY. I would be happy to yield to my friend from West Virginia——

Mr. RAHALL [continuing]. Quick question for both investigations and inspections, subpoena power?

Mr. MAIN. You have to be able to get the facts regardless of what the issue is if you want to get the facts to whether it is an investigation or an accident.

Because if you don't get the questions that could be a problem in an investigation. You may not prevent an accident that you want to investigate later.

So yes.

Mr. RAHALL. Thank you, Mr. Secretary. Thank you, Mr. Chairman.

Chairman KLINE. Thank the gentleman.

And now, Mr. Secretary, thank you very much for being with us today. We appreciate your patience.

We will, I will ask the second panel to come forward now please.

Mr. MAIN. Thank you, Mr. Chairman.

Chairman KLINE. It is my pleasure to introduce our second distinguished panel of witnesses.

Mr. Howard Shapiro is Counsel to the Inspector General at the Department of Labor. Mr. Cecil Roberts is president of the United Mine Workers of America. And Dr. Jeffery Kohler is a director in the Office of Mine Safety and Health Research with the National Institute for Occupational Safety and Health.

Before I recognize each of you for your testimony, I will just remind you of the lights. I know all of you have been here.

We have got a green light, a yellow light, and a red light. The green light will indicate that you have 5 minutes. The yellow light, you have 1 minute. And the red light we would ask you to wrap up your testimony.

Your entire written testimony will be included in the record. So you can summarize if you would like.

With that, we will start with Mr. Shapiro.

You are recognized, sir.

STATEMENTS OF HOWARD SHAPIRO, COUSEL TO THE INSPECTOR GENERAL, U.S. DEPARTMENT OF LABOR; CECIL EDWARD ROBERTS, JR., PRESIDENT, UNITED MINE WORKERS OF AMERICA; DR. JEFFERY KOHLER, DIRECTOR, OFFICE OF MINE SAFETY AND HEALTH RESEARCH, NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH

STATEMENT OF HOWARD SHAPIRO

Mr. SHAPIRO. Thank you, Mr. Chairman.

I will summarize my written statement that has already been provided.

Is it on now? Okay.

Thank you, Mr. Chairman. Thank you for inviting me to testify this morning with respect to the OIG report on allegations of retaliation and intimidation related to the UBB accident investigation.

In March of 2011, we received a complaint from the United Mine Workers of America alleging that attorneys for Performance Coal and the attorneys for MSHA were holding private meetings to discuss important issues, and that they were inappropriately making deals, which in some cases resulted in vacating safety citations and orders.

Subsequently in April, we received a complaint from an attorney for Performance Coal, representing Performance Coal, alleging misconduct by Norman Page, who was heading up the UBB accident investigation for MSHA.

What the OIG decided to do was to address both of these complaints by looking at five separate incidents that were cited in the Performance Coal complaint, one of which was also referenced in the UMWA complaint.

The first incident involved MSHA's issuance of a safety order and citation to Dr. Christopher Schemel, who was one of Performance's expert consultants. And the order and citation would have required him to withdraw from the mine until he received 40 hours of new miner training.

What we found was that Mr. Page was not the impetus for this action. And that he was only marginally involved in it.

The second incident involved another order and citation, in this case, issued to another consultant, Dr. Pedro Reszka. And this order and citation required—would have required Mr. Reszka, or Dr. Reszka, to withdraw from the mine until such time as he could receive some refresher safety training.

In this case, Performance Coal alleged that the order and citation were issued in retaliation for a complaint which they, Performance Coal, had filed regarding an incident which took place in the mine and involved Dr. Reszka.

Again in this case, we found that the citation and order were not issued as a result of any retaliation by Mr. Page or anybody at MSHA. It was issued as the result of the personal observations of several MSHA inspectors regarding Dr. Reszka's conduct and behavior in the mine.

And I would note that this was the order and citation that was also cited by the UMWA in their complaint to us, albeit from a very different perspective.

The third incident involved a meeting between Mr. Page and Dr. Schemel to discuss the Reszka citation and order. And that took place because Dr. Reszka was a subcontractor for Dr. Schemel.

During this meeting, Mr. Page allegedly threatened Dr. Schemel with further citations and orders, and other negative effects on his company, if he did not accept the citation issued with respect to Dr. Reszka.

We found that Mr. Page did not intend to retaliate against Performance Coal or Dr. Schemel during this meeting.

The fourth incident involved MSHA's scheduling of an inspection of the mine rescue station that serviced the UBB mine. We found that the decision to schedule the inspection by two District 6 inspectors who were unaware that a recent inspection of the rescue station had already been done by District 4.

When they learned of this recent inspection, they cancelled the inspection that they were going to do. So again, we found no evidence of retaliation.

And the fifth incident involved MSHA's issuance of another order banning another employee of another consultant from entering the mine until he received new miner training. And again, we found that Mr. Page was not involved in the decision to issue the order and citation in this case.

So in summary, Mr. Chairman, our review of these five incidents did not substantiate the allegation that Mr. Page engaged in any sort of pattern of intimidation or retaliation, and nor did we find that MSHA, as an entity, engaged in such a pattern at Mr. Page's behest or otherwise.

However during our review, we did identify three questionable management actions.

One of these was that the ultimate decision made by officials from MSHA and the Office of the Solicitor to vacate the citation and order related to Dr. Reszka was made not based upon the safety merits, but rather was made to avoid an appearance of retaliation and to avoid possible congressional scrutiny.

In response to our report, the department generally agreed with our findings and stated that MSHA decided to vacate the citation and order related to Dr. Reszka on the condition that he receive additional safety training, which he did.

So in conclusion, Mr. Chairman, I would reiterate that our primary objective was to review the allegations against Mr. Page. We did not substantiate those allegations.

And I would certainly be pleased to answer any questions that you may have or any other members of the committee.

[The statement of Mr. Shapiro follows:]

Prepared Statement of Howard L. Shapiro, Counsel to the Inspector General, Office of Inspector General, u.s. Department of Labor

Good morning, Mr. Chairman and Members of the Committee, I appreciate the opportunity to discuss the Office of Inspector General's (OIG) report of inquiry regarding allegations of retaliation and intimidation related to the Upper Big Branch (UBB) accident investigation.

As you know, the OIG is an independent entity within the Department of Labor (DOL); therefore, the views expressed in my testimony are based on the findings of my office's work and not intended to reflect the Department's views.

Background

Following the April 5, 2010, underground explosion at the UBB mine in West Virginia, the Mine Safety and Health Administration (MSHA) initiated an investigation into the causes of the accident. At the time of the explosion, Performance Coal Company operated the UBB mine as a subsidiary of Massey Energy Company.

On March 16, 2011, the OIG received a complaint from the United Mine Workers of America (UMWA) alleging that the attorneys for Performance Coal, and the attorneys for MSHA in the DOL's Office of the Solicitor (SOL), were excluding other parties involved in the investigation by holding private meetings to discuss "issues of importance to the investigation." The complaint also alleged that MSHA's attorneys in SOL were inappropriately "making deals" with Performance Coal attorneys, resulting in MSHA vacating legitimate safety citations and orders. In a subsequent phone call, UMWA clarified that this allegation had to do specifically with MSHA's attorneys in SOL forcing MSHA to vacate a citation and order involving Dr. Pedro Reszka, one of Performance Coal's expert consultants for the accident investigation.

On April 29, 2011, while we were reviewing the UMWA complaint, we received a complaint from an attorney representing Performance Coal. This complaint alleged that MSHA's District 6 Manager, Norman Page, who was leading the accident investigation for MSHA, had engaged in misconduct by launching a campaign of intimidation and retaliation against the company's accident investigation team and, in particular, its expert consultants. The complaint alleged that Mr. Page had repeatedly ordered the withdrawal of the company's scientific experts from the mine without a good faith basis; attempted to intimidate the company's experts with retaliatory citations and orders; and threatened future retaliatory orders against one of the company's experts in an attempt to influence the expert's work product and opinions.

OIG's Review

The OIG decided to address these two complaints by looking at five incidents referenced in the Performance Coal complaint, of which one was also referenced in the UMWA complaint, albeit from a different perspective. The OIG's Office of Legal Services reviewed pertinent documents, and conducted in-person and/or telephone interviews with 26 individuals from MSHA, SOL, UMWA and Performance Coal Company.

It is important to note that this review was limited to the specific allegations made against Mr. Page. This review did not include any matters related to the causes of the explosion, MSHA's inspection and enforcement activities at the UBB mine prior to the explosion, or any aspects of the accident investigation other than the five matters cited by Performance Coal and/or UMWA:

- The first incident involved MSHA's issuance of a citation and order requiring Dr. Christopher Schemel, Performance Coal's lead scientific consultant with respect to the UBB investigation, to withdraw from the mine until he received 40 hours of "new miner" training. We found that Mr. Page was not the impetus for the citation and order and he was only marginally involved in the matter. Other MSHA officials informed us that the issue of Dr. Schemel's training was not addressed for several months, and simply "fell through the cracks," due to the hectic and busy atmosphere surrounding the first few months of the accident investigation.
- The second incident involved MSHA's issuance of a citation and order requiring Dr. Pedro Reszka, another scientific consultant hired by Performance Coal, to withdraw from the mine until such time as he could receive refresher safety training. Performance Coal alleged that the citation and order were issued in retaliation for a complaint which Performance Coal raised regarding an incident which occurred in the mine wherein a UMWA representative dislodged a piece of roofing and allegedly endangered Dr. Reszka's safety. We found that the citation and order were not issued as the result of any retaliatory intent by any MSHA officials. Rather, the decision to issue the citation and order was made independently by an MSHA inspector based on his personal observations of Dr. Reszka, and upon input he received from other MSHA inspectors who had spent time with Dr. Reszka in the mine, at a time when the inspector was unaware that any complaint had even been raised about the actions of the UMWA representative. Notably, the citation and order were similarly cited by the UMWA, but from the perspective of alleging that MSHA's attorney's in SOL were inappropriately "making deals" with Performance Coal attorneys, resulting in MSHA vacating legitimate safety citations and orders, including the one relating to Dr. Reszka.
- The third incident involved a meeting between Mr. Page and Dr. Schemel, who met to discuss the Reszka citation and order. During the meeting Mr. Page allegedly threatened Dr. Schemel with further citations and orders, with increased scrutiny by MSHA, and with other negative effects on his company, if he did not accept the

citation issued with respect to Dr. Reszka, who was a subcontractor for Dr. Schemel. We did not find that Mr. Page intended to retaliate against Performance Coal or Dr. Schemel. Although MSHA officials and attorneys from the Office of the Solicitor had tentatively agreed to vacate the citation and order, we found that Mr. Page's contention that his objective was to reach a compromise between Performance Coal and the UMWA was credible and corroborated. In particular, Mr. Page hoped that such a compromise would prevent the UMWA from initiating a campaign of filing multiple safety complaints against Performance Coal that would require significant MSHA resources to investigate. Although we did question Mr. Page's judgment with respect to how he proceeded with this meeting and some of the things which he said to Dr. Schemel, we did not find any support for the claims of intimidation or retaliation.

• The fourth incident involved MSHA's allegedly retaliatory scheduling of an inspection of the mine rescue station that serviced the UBB mine since, according to Performance Coal, that same mine rescue station already had been inspected several times after the UBB accident by District 4 inspectors. We found that the decision to schedule the inspection of the mine rescue station was made by two District 6 MSHA inspectors at a time when neither of them knew that a recent inspection of the rescue station had been done by District 4 and, when they learned of the recent inspection, they appropriately cancelled their own planned inspection of the rescue station.

• The fifth incident involved MSHA's issuance of an order banning John Montoya, an employee of another consultant hired by Performance Coal, from entering the mine until he completed the 40-hour new miner training. We found that Mr. Page was not involved in the decision to issue the order relating to Mr. Montoya, and we were therefore unable to conclude that the order was part of a pattern of intimidation or retaliation on Mr. Page's part, or by MSHA officials in general.

In summary, our review of these five incidents did not substantiate the allegation that Mr. Page engaged in a campaign or pattern of intimidation or retaliation. Further, we found no evidence that MSHA, as an entity, engaged in such a campaign or pattern, at Mr. Page's behest or otherwise. However, during our review, we did identify three questionable management actions:

• We found that the ultimate decision made by officials from MSHA and the Office of the Solicitor to vacate the citation and order related to Dr. Reszka was not based on the merits, but rather was made to avoid an appearance of retaliation and any potential congressional scrutiny.

• We found that Mr. Page used poor judgment when he met with Dr. Schemel to discuss the Reszka citation and order, without any other individuals being present, and when he made statements that could have been perceived and/or interpreted as intimidating.

• We also found that it may have been appropriate for MSHA to consider other, less punitive approaches, short of issuing a citation and order, with respect to the order and citation issued against Dr. Schemel, given that MSHA allowed him to go underground in this mine for some three months before realizing he did not have the proper training.

DOL's Response

In responding to our report, the Department indicated that the Office of the Solicitor had conducted its own review of the allegations against Mr. Page, and that its conclusions were in agreement with the OIG conclusions.

Regarding the specific management actions questioned by the OIG, the Department stated that MSHA decided to vacate the citation and order related to Dr. Reszka on the condition that he receive additional safety training prior to returning to the mine, which he did. The Department stated that this result was appropriate, and therefore planned no further action for this finding.

Further, the Department agreed with the OIG finding that Mr. Page had used poor judgment when he met with Dr. Schemel without any other individuals being present. The Department stated that while Mr. Page's actions could be viewed as imprudent, he had no intention to intimidate Dr. Schemel or engage in retaliation; therefore, the Department planned no further action for this finding.

Regarding the citation and order related to Dr. Schemel, the Department stated that it could not comment on the OIG finding that MSHA could have considered less punitive measures to resolve this situation because the order and citation were still in litigation. However, the Department agreed to provide guidance to assure consistency of enforcement regarding the applicability of its training regulations.

Conclusion

In conclusion, Mr. Chairman, I would reiterate that our primary objective was to review the allegations against Mr. Page, and we did not substantiate these allegations. Thank you, Mr. Chairman, for the opportunity to present the results of our review. I would be pleased to answer any questions that you or other Members of the Committee may have.

Chairman KLINE. Thank you, Mr. Shapiro.

Mr. Roberts?

STATEMENT OF CECIL ROBERTS

Mr. ROBERTS. Thank you very much, Mr. Chairman and Ranking Member Miller for calling this hearing.

I want to thank all of the panel members who have participated in this.

And thank you so much on behalf of the coal miners of the United States for Congress' concern about the health and safety of coal miners in the United States.

Excuse me.

I want to also very much thank you for remembering the families of the lost miners. Many of these people were my friends. I grew up with some of these people who lost their lives. And if I didn't know the miners themselves, I knew someone in their families.

This morning, I would like to remember in particular the Davis family. Linda Davis and Charles Davis lost a son and two grandsons in this tragedy.

The past 2 years have been very difficult for that family. And unfortunately on Friday, the funeral of Linda Davis took place. And I wanted to say to you, she was a wonderful lady.

One of the things that I would recommend—people have been asking what can we do and what can we do? One of the first things I would suggest that should be bipartisan here is that these families get treated better when these tragedies occur.

A miner working at a nonunion mine, or for that matter a union mine, can designate someone to represent them in an investigation. That happened at Upper Big Branch where more than two miners had designated the United Mine Workers to represent them. So we were a representative of those miners at Upper Big Branch.

The families do not enjoy that right. And I have to tell you that that is something that is discussed very much throughout the coalfields and how tragic that is that the people who have suffered the most can't have someone representing them when these hearings are ongoing, and when the investigation itself is ongoing.

I don't think anyone sitting in front of me believes that is correct, so one of the easy things that I believe that we can do here is correct that situation.

We have to have three things in order for something like Upper Big Branch not to occur again.

Number one, we have to have an operator who is willing to follow the law. The first obligation here is for the industry to protect these coalminers.

Number two, we have to have an agency which fully enforces the law.

And three, we have to have workers who are empowered to speak out for themselves.

I want to report to you today that none of these three ingredients existed at Upper Big Branch.

We know and we have heard testimony repeatedly here, that we had an operator who was recalcitrant and who was dictatorial. And it wasn't just the Upper Big Branch mine. All of these mines operated by Massey Energy, you could find similar situations.

And in fact MSHA has found those same kinds of situations existing, the same dangerous conditions existing before Massey turned these operations over or sold them to Alpha Natural Resources.

And I wanted to remind you of the famous, infamous memo sent out in October of 2005 by Don Blankenship, sent to all deep mine superintendents entitled, Running Coal. This is from the man—this is from the top person in this company.

And he believed, and the miners believed, and most people in West Virginia believed that he was above the law. He was above the governor. He was above this Congress right here.

So that you will know that is how he was perceived in southern West Virginia.

"If any of you have been asked by your group presidents, your supervisors, engineers or anyone else to do anything, anything other than run coal such as build overcasts," which happens to take ventilation to the working sections, "do construction jobs or whatever, you need to ignore them and run coal. This memo is necessary only because we seem not to understand that the coal pays the bills."

We have consistently said that people like Don Blankenship, and I have called for him to be led away in chains and locked up in jail because that is where he deserves to be, because if any one person is responsible for what happened at Upper Big Branch it is Don Blankenship.

Number two, what we need to do is clarify the authority of MSHA. We have repeatedly said well why didn't MSHA close this mine down?

Well, let us clarify that authority. If we believe that that is what they should do, when they find circumstances like they found, let us clarify that authority and say, you do have it.

If you want to do something for the coal miners of the United States of America, you stand behind whoever is running MSHA and say to the operators, you may choose to operate like Don Blankenship did, that you, the Congress of the United States, Republican and Democrat alike, will stand behind the enforcement agency of the United States and see that we do not see these conditions again.

Number three, workers need to be empowered. And if you can do one thing before you leave this session of Congress, let us give the power to the coal miner himself, because as we are sitting in this room today, I guarantee you, that some foreman somewhere is telling a miner to go under unsupported top, telling that miner to do something that is going to get him hurt, telling that miner to do something that is going to get him killed.

And that should be a felony. That coalminer should be able to say I am not doing that. I am exercising the right that Congress

gave me. And if you continue to tell me to do something dangerous, you are going to jail.

They don't have that ability today as we speak, because they know they will be fired. And they won't have a job. And they won't find another job.

Thank you. And I will be glad to answer any questions that you have.

[The statement of Mr. Roberts follows:]

Prepared Statement of Cecil E. Roberts, President, United Mine Workers of America

Thank you for the opportunity to address the House Committee on Education and the Workforce, Full Committee on Workforce Protections about Learning from the Upper Big Branch Tragedy. I am the International President of the United Mine Workers of America (UMWA), a union that has been an unwavering advocate for miners' health and safety for over 122 years.

Before I speak about what we can learn from the Upper Big Branch tragedy, I want to acknowledge all of the families that lost a loved one and neighbors who lost a friend in the senseless methane/coal dust explosion on April 5, 2010. The 29 families all suffered a loss that we can never forget. The victims paid with their lives for the deliberate greed of Don Blankenship and his underlings.

The UMWA has long held that three things are necessary for a safe and productive mine:

- An operator who is willing to follow the law.
- An agency which fully enforces the law.
- Workers who are empowered to speak out for themselves.

None of these things happened at the non-union UBB mine.

Don Blankenship's team pursued a game of cat and mouse with the Mine Safety and Health Administration (MSHA). While MSHA inspectors were trying to determine whether Massey was following mine health and safety laws and regulations, as all operators are required to do,

Blankenship's management was regularly doing what it could to subvert MSHA's efforts. Every day they did that, they jeopardized the safety of all miners working under their control and direction. On April 5, 2010, the vulnerable miners at the Upper Big Branch mine fell victim to the needlessly dangerous and neglected mine environment.

It is not a secret in the coalfields that some operators give advance notice to miners working underground of MSHA inspections. Mine Managers make quick and superficial adjustments to the ventilation, quickly rockdust the entries where an inspector would be headed or shut down production entirely on a working section in order to avoid being cited for violating MSHA's standards. Through the work of the United States Attorney's office in Charleston, West Virginia, we finally have public confirmation from one of the Massey managers who affirmatively engaged in such deceptive practices. Earlier this month, Upper Big Branch Mine Superintendent Gary May gave testimony in Hughie Elbert Stover's sentencing hearing about that mine's practice and system for providing information to miners working underground whenever federal and state safety inspectors were on the property, with details about where the inspectors would be traveling and inspecting. Stover was convicted and sentenced to three years in prison on February 29, 2012. Mr. May further explained that he acted deliberately to change underground mining conditions to make them temporarily appear better and more compliant than they had been while the mine was actively operating but before learning about the inspector's underground presence.

We don't mean to claim that Massey and its subsidiaries had a monopoly on these illegal practices, but its rogue attitude had become an integral part of the operating culture at the Upper Big Branch mine. It became so bad that miners came to view the unlawful mining practices as the norm. Some of the more experienced miners probably knew that what Massey was doing was wrong, but they had to work. Tolerating unsafe conditions was necessary if they wanted to keep their jobs. On a daily basis, these miners worked in an atmosphere of fear and intimidation. However, there can be no question that for Don Blankenship and his Massey mines, production was the top priority; and the second priority; and the third priority * * * This is demonstrated by the October 19, 2005 memo Don Blankenship sent to All Deep Mine Superintendents entitled "Running Coal" which stated "If any of you have been asked by your group presidents, your supervisors, engineers or anyone else to

do anything other than run coal (i.e.—build overcasts, do construction jobs, or whatever), you need to ignore them and run coal. This memo is necessary only because we seem not to understand that the coal pays the bills."

One stark example of Massey's unlawful behavior was revealed in the report from MSHA's Internal Review where it described Massey's frequent re-staging of its continuous mining machines/mechanized mining units (MMU's) to avoid citations for excessive respirable dust. Cutting coal creates mine dust that must be both reduced and controlled through ventilation, water sprays and rock dust to protect miners' lungs and to prevent explosive coal dust accumulations. Autopsy records of the UBB miners who were killed in the explosion uncovered surprisingly high levels of black lung and other lung disease within this workforce, including among the youngest victims. Seeing what the Internal Review discovered about MSHA's ineffective enforcement of the respirable dust standard (30 CFR Part 70) at UBB suggests miners at this operation were often exposed to excessive levels of respirable dust.

MSHA's regulations set maximum permissible respirable dust levels and require reductions to the dust levels depending on how much quartz is also present. However, as the Internal Review explained, MSHA District 4 allowed Massey to re-establish (that is, to increase) its permissible dust levels whenever it rotated its MMUs. Therefore, even though MSHA would establish a reduced respirable dust level for a certain area based on the level of respirable coal dust and the percentage of quartz generated by a MMU, Massey was able to avoid compliance with that reduced respirable dust standard simply by rotating out the MMU that was used to set the reduced level. With a different MMU in place, MSHA terminated any citation that was issued for excessive dust and allowed Massey to operate its replacement MMU with dust at the unreduced standard of 2.0 mg/m3 even though the same amount of quartz would have been present. This deliberate manipulation of the dust standard, established by the law, was the practice according to the Internal Review. MSHA District 4 also regularly allowed Massey to have abnormally long abatement periods for its dust citations. Massey was manipulating the law and too often MSHA District 4 allowed the company to get away with it.

MSHA's Internal Review outlines numerous deficiencies on the part of the Agency. These MSHA shortcomings, in particular MSHA District 4, allowed miners to remain in harm's way though the Agency should and could have prevented such exposures. In other words, although Massey failed in its duty to comply with mine safety laws and regulations, MSHA had a duty to utilize every enforcement tool at its disposal so that miners' safety would not be jeopardized. Massey made MSHA's job much more difficult by its subterfuge, but that doesn't excuse or explain MSHA's shortcomings.

We now know that MSHA District 4 inspectors failed to:

- Inspect some areas of the mine (including in its last inspection, the Old No. 2 Section and the belt/return entries of Tailgate #22 tailgate, both areas where the explosion propagated), and rushed their inspections through other areas.
- Cite lack of adequate roof support controls that the roof control plan specified.
- Identify inadequacies in the coal and coal dust program including failures in the cleaning of loose coal, coal dust and float coal dust and the extent and duration of noncompliance with rock dust standards along belt conveyors.
- Use current rock dust survey procedures and to collect spot samples from older sections of the mine to see that UBB had the required incombustible content of rock dust to mine dust.
- Scrutinize the operator's examination records and require timely abatement of hazards cited and consider the hazards for purposes of determining the operator's degree of negligence.

MSHA District 4 Supervisors, who had jurisdiction over the Upper Big Branch mine, did not provide effective oversight of the inspectors. District 4 failed to:

- Conduct 110 (c) special investigations (to determine if mine management knowingly violated mandatory standards) when established protocols indicated that would have been appropriate in six cases.
- Forward to MSHA's Arlington Headquarters eight violations that should have been considered for "flagrant" violations.

Further, in reviewing mining plans for approval, experienced MSHA District 4 personnel made a number of mistakes, including:

- Not requiring methods in the ventilation plan that would mitigate methane inundations like the one that occurred in 2004.
- Not recognizing that (a) the roof control plan did not provide necessary pillar stability for ventilation in some areas and (b) the roof control plan did not include any of the required stability calculations to show the plan would be adequate.

MSHA headquarters also failed to:

• Realize—due to a computer glitch—that the mine's violation history qualified UBB for the "Potential Pattern of Violation" list.

• Use or distribute its directives and policies effectively, some of which conflicted with each other. MSHA employees did not always understand the policies.

• Ensure that all entry-level or journeymen inspectors had the required training. Some of those responsible for inspecting or supervising inspectors at Upper Big Branch did not have all the required training. MSHA's own policy does not permit entry-level inspectors to travel by themselves, which occurred at UBB.

The scope of internal MSHA problems ran from top to bottom. However, MSHA District 4 Supervisors dropped the ball by ignoring several red flags as I previously stated.

The Internal Reviews following the previous five underground coal mine tragedies of the preceding decade (Jim Walter Resources in 2001; Sago, Aracoma and Darby in 2006; and Crandall Canyon in 2007) identified a number of problems that persisted into 2010. It is time that we stop talking about these problems and fix them.

While it may be appropriate to criticize the mistakes MSHA made before the UBB tragedy, it would be a huge disservice to the miners who perished at UBB and to their families if that is all we did. Instead, we should think proactively and take affirmative steps to make mines safer.

Immediately after the Upper Big Branch tragedy MSHA began its program of impact inspections, targeting operations where it has reason to be concerned about Mine Act compliance. MSHA captures the mine communications system to prevent advance warnings of inspections. MSHA's impact inspections have uncovered large numbers of significant and potentially dangerous conditions. The Agency has also gone to court to test its authority to seek injunctions. These techniques have been successful in preventing operators from continuing to operate in the most hazardous of conditions.

Even a more aggressive MSHA, one that uses the array of enforcement tools never used before the UBB tragedy, cannot protect miners if mine operators continue to flaunt the law. And too many do.

The UBB disaster serves as a stark reminder that the culture of production over health and safety still exists in the coalfields. Don Blankenship and Massey represented the worst of the coal industry. They flagrantly violated and ignored the law at the expense of the miners. Don Blankenship's philosophy cost the lives of 29 miners at UBB and countless others that lost their lives at Massey's mines.

The UMWA applauds the U.S. Attorney's office for pursuing criminal prosecution against individuals who contributed to the April 5, 2010 tragedy at UBB. However, allowing Don Blankenship to walk away from the crimes he and his underlings committed at UBB would be a gross miscarriage of justice. He laid out the rules under which UBB operated and kept a watchful eye to ensure that his policies were being followed. Don Blankenship should be prosecuted for his actions and I stand here today saying to this Committee that until corporate heads like Don Blankenship are held accountable for their actions, we have not witnessed the last senseless tragedy and loss of life in the coal industry.

What is also upsetting to me is the misdemeanor plea deal that federal prosecutors recently reached in the 2007 deaths of nine workers at the Crandall Canyon Mine in Utah. Murray Energy's subsidiary, Genwal

Resources, agreed to plead guilty to two mine safety crimes and pay $250,000 for each of the two criminal counts. The travesty of justice is that the plea agreement states that no charges will be brought against any Genwal mine managers or any executives. Once again, the real guilty parties escaped justice. I guess the cost of nine lives is $500,000.

MSHA cannot be everywhere all of the time. That is why the law correctly charges operators with the duty of operating in a safe and healthful way. If an operator wants the privilege of running a coal mine, it must assume the obligation of doing so in a way that doesn't put its employees' lives in jeopardy. Yet, this doesn't always happen. Too often corporate greed takes precedence. We urge Congress to increase the penalties for egregious mine health and safety violations.

So what else can we do to reduce the likelihood of any more coal mining disasters? We owe it to all miners to learn from the problems that led to the Upper Big Branch tragedy as well as from other disasters.

What this Committee and Congress does really matters to the coal miners of this nation. After the Sago mine disaster and others in 2006, Congress required that coal operators make underground shelters available to protect miners who survive but cannot escape an explosion or mine fire. Despite the tremendous explosive forces that rocked the Upper Big Branch mine, a shelter near the explosion survived intact and could have sheltered miners if they had survived the explosion. That Strata shelter was under water for weeks, and yet it remained dry inside. Had that shelter

been at the Sago mine in January 2006, eleven of the twelve miners killed would still be with us today. Without Congress advancing the issue in the 2006 MINER Act, we still would not have shelters underground.

Again, through the MINER Act, Congress required significant improvements in tracking and communications' technology and equipment. Coal operators claimed it couldn't be done, or the costs were too high to allow them to remain in business, but Congress appreciated that changes were necessary and demanded that the industry implement the improvements. By legislating these changes, there was a flurry of imaginative and creative work done to develop practical equipment that could survive the harsh mine environment. These state of the art systems are in place all over the United States today.

We appreciate that some operators are spending more money on equipment and technology to make the mine environment safer for miners. However, more improvements can be made. For example, rock dust sampling results are not completed in a timely fashion. The mine environment can become extremely explosive in a very short period of time if rock dust is not applied regularly. Rock dust is required to minimize the explosiveness of coal dust in case there is an ignition source present. While better and newer dust explosibility meters exist, most operators—as well as MSHA—are not purchasing them because they are not required to use them. This equipment can provide immediate, real time information about the incombustibility of rock dust to coal dust levels. Instead, the current protocol provides for the samples to be sent to MSHA's lab, where the Agency uses antiquated equipment to test the samples. It takes 2-3 weeks to return the results. I would like to point out that operators like Consol, Patriot and Alpha are taking advantage of this new technology. At Upper Big Branch, samples taken before the April 5 explosion showed that the mine had inadequate rock dust—but those sample results were not reported until after the disaster. We are left to wonder whether having the results in real time would have averted this disaster.

The illegal practice of advance notice of safety inspections is not limited to Upper Big Branch but occurs at many operations. MSHA's recent tactic of taking control of the communications systems when inspectors travel to operations has demonstrated that advance notice is not uncommon: the kind and extent of violations found when the communications are taken over exceed those MSHA had previously discovered. Clearly, the existing penalties for advance notice are ineffective and should be increased to help effect compliance.

Another area where the Mine Act should be updated concerns its whistleblower protections. The Mine Act was one of the first to provide whistleblower protections against discrimination or retaliation for reporting safety violations. However, these provisions are now inferior to recent and more-protective whistleblower provisions included in other statutes. Miners under the Mine Act now have only 60 days to blow the whistle. This window should be lengthened to give miners a better chance to pursue actions when they suffer discrimination or retaliation for exercising their health and safety rights.

The compensation provisions in Section 111 of the Mine Act should also be expanded. As it now stands, miners generally can collect no more than one week's worth of wages when an operator's violations require MSHA to shut down the mine. Too often miners have to make the choice between putting food on the table and protecting their own safety. By expanding the compensation provisions, miners' health and safety would be better protected.

MSHA's accident investigation procedures must also be modernized. The UMWA has always advocated that an independent agency should conduct all accident investigations much like the National Transportation Safety Board. Asking MSHA to critique its own actions following a disaster does not always lead to the most objective point of view. We further believe that the law should be changed to include in the investigation those most affected: the miners and family members of deceased miners. We also believe that MSHA must have the power to subpoena witnesses, rather than rely on voluntary interviews.

The UMWA is not convinced that any one action by MSHA would have resulted in substantially better compliance on the part of Massey. It is clear that UBB should not have been operating at the time of the explosion. Had MSHA District 4 used all of the enforcement tools at their disposal, the disaster may have been prevented. However, no one should ever lose sight that Massey Energy, including Don Blankenship and his underlings, were mandated by law to comply with all health and safety standards and maintain UBB in a safe operating condition. Instead, the mine was operated in a manner compliant with a corporate policy that put production over safety. This is why I will once again call for the criminal prosecution of these individuals.

The authors of the Internal Review have recommended that the Assistant Secretary consider rulemaking that would modify several health and safety standards. The recommendations are found in Appendix C—Recommendations for Regulatory Changes. There are 23 separate provisions outlined in Appendix C, all of which would improve health and safety protections for miners. The UMWA is in complete agreement with these recommendations in addition to the changes we outlined in our report.

This gets me to my last point. Congress needs to act quickly to pass legislation that will build on the protections of the 2006 Miner Act. As Congress so eloquently stated in the Act: "the first priority and concern of all in the coal or other mining industry must be the health and safety of its most precious resource—the miner."

In conclusion, I thank you for the chance to appear before this Committee and appreciate your interest and concern for miners' health and safety.

EXHIBITS

- Internal Review of MSHA's Actions at the Upper Big Branch Mine—South, Performance Coal Company, Montcoal, Raleigh County, West Virginia
  U.S. Department of Labor, Mine Safety and Health Administration, Program Evaluation and Information Resources, March 6, 2012.
- Industrial Homicide—Report of the Upper Big Branch Mine Disaster
  United Mine Workers of America.
- October 19, 2005 Don Blankenship memorandum on "Running Coal"
- West Virginia House Bill 4351

Chairman KLINE. Thank you, sir.

Dr. Kohler?

STATEMENT OF JEFFERY KOHLER

Dr. KOHLER. Good afternoon, Mr. Chairman, Ranking member, other members of the committee.

My name is Jeffery Kohler and I am the associate director for mining at the National Institute for Occupational Safety and Health, and the director of NIOSH's Office of Mine Safety and health Research.

I am pleased to be here today to provide a brief update on our activities related to the miner act and to speak to you about the work of an independent panel that assessed the process and outcomes of the Mine Safety and Health Administration's internal review of the UBB mine disaster.

NIOSH continues to work with our partners in labor, industry and government to develop and implement practical solutions to mining safety and health problems.

Our primary focus remains on prevention. And towards that end, we have implemented interventions to reduce respirable dust, to prevent roof falls, and to prevent coal dust explosions among others.

For example, the Coal Dust Explosibility Meter, you know, became available this past June.

Our work in the technology area has led to the commercialization and in-mine use of communications and medium frequency systems, such as the CDEM frequency system, also the Lockheed Martin Through-The-Earth system for post-accident functionality.

Despite all of the progress, the explosion at UBB serves as a poignant reminder that more remains to be done. Following that disaster, the secretary of labor requested the director of NIOSH to appoint a panel of experts who would be independent of MSHA and

DOL, to assess the processes and outcomes of MSHA's internal investigation.

I was appointed to that panel. And I speak to you next about my role as a panel member.

The panel's report was not reviewed or cleared by NIOSH, CDC, OR HHS, prior to its release.

All mine operators must take a proactive role in ensure the safety of mine workers. And as the accident investigations have concluded, Massey Energy's highly noncompliant practices directly caused the explosion at the UBB mine.

It is impossible to know how many thousands of deaths have been prevented through MSHA's enforcement action. Yet in those instances when the operator's actions have caused the disaster, we must understand why, learn from, and take actions to prevent future occurrences.

MSHA's internal investigation team was thorough. And it disclosed fully every deficiency it found at MSHA's enforcement performance.

A review of MSHA's internal reviews for other mine disasters also revealed a candid and detailed disclosure of shortcomings in MSHA's enforcement performance. The same or very similar deficiencies show up in many of these internal reviews. And now, as in previous internal reviews, a detailed set of recommendations has been put forth to fix the identified problems.

No doubt, those recommendations will be helpful if implemented. But we do not believe, the panel does not believe, that only doing more of the same, more training, changes to handbooks, or administrative procedures and policies, will fully achieve the desired performance that MSHA expects.

We believe there are underlying problems which have developed over the years that must be solved. The report Of MSHA'S internal review and the interview transcripts detail a workforce of inspectors, specialists, and supervisors that is severely overloaded and trying to accomplish a lengthy set of duties that is not fully doable.

With the insights that we gained from our assessment, we have developed four overarching recommendations that we believe should be implemented.

Our first recommendation is for a comprehensive analysis of the current enforcement paradigm to identify and repair any underlying weaknesses. Collectively, we cannot continue to do the same thing and expect a different and better outcome.

As part of this recommendation, we have suggested several topics that we believe should be included in the comprehensive discussion: workforce and workforce readiness issues, continuing challenges in the plan approval process, and better use of information technologies to aid enforcement, among others.

Second, we have recommended a few changes to MSHA's internal review policy itself to enhance the value of their process.

Third, we have recommended independent oversight to ensure successful implementation of their recommendation.

Finally, we have recommended technical investigations to support development of best practices guidelines, and to inform statutory or regulatory activities, in particular, improve monitoring explosion prevention, and ventilation practices.

In closing, NIOSH continues to work diligently to protect America's mine workers. And our research activities will enable NIOSH together with MSHA, labor, and industry to better protect mine workers.

Thank you, Mr. Chairman. And I would be pleased to answer any questions.

[The statement of Dr. Kohler follows:]

Prepared Statement of Jeffery Kohler, Associate Director for Mining; Director of the Office of Mine Safety and Health Research (OMSHR), National Institute for Occupational Safety and Health (NIOSH)

Good morning Mr. Chairman and other distinguished Members of the Committee. My name is Jeffery Kohler, and I am the Associate Director for Mining and the Director of the Office of Mine Safety and Health Research (OMSHR) at the National Institute for Occupational Safety and Health (NIOSH), which is part of the Centers for Disease Control and Prevention (CDC), within the Department of Health and Human Services.

NIOSH continues to develop and deploy new practices and technologies that make mines safer and help miners remain healthy. Some of these have been described to you in the past, when they were in the developmental stage. Today, I will give you an update on a few of them, and I will tell you about newer projects that are currently underway.

The MINER Act of 2006 (P.L. 109-236) placed a special emphasis on the development, adaptation, and transfer of technologies to improve safety and health in the mining industry. New technologies to improve the post-accident survivability of miners, envisioned after the Sago Mine disaster in 2006, are commercially available today, and many have been deployed in the industry. Many of these were made possible through the work of NIOSH and because of the support provided by the Congress.

Ongoing partnerships with labor, industry, and government continue to facilitate the development of practical solutions to challenging and pervasive mining safety and health problems, and today I will tell you about one such effort. I will also speak to you about the work of the Independent Panel that assessed the process and outcomes of the Mine Safety and Health Administration's (MSHA) Internal Review of the Upper Big Branch Mine disaster. I was appointed to serve as the Executive Secretary of the panel.

NIOSH's mining research priorities address disaster prevention and response, traumatic injuries, cumulative trauma disorders, respiratory diseases, and hearing loss. In the area of disaster prevention, rock dust is applied to coal mine surfaces to prevent coal dust explosions, but to be effective, it must be applied in sufficient quantity to achieve an 80% or greater ratio of incombustible material. A laboratory test is the only way to determine whether the coal dust is no longer explosive. Historically, a sample was collected, sent to a laboratory for testing, and then the result was reported—usually a week or more later. Over the years, NIOSH developed and has attempted to commercialize a Coal Dust Explosibility Meter (CDEM). The CDEM is an instrument used to assess the explosibility of coal dust in real-time. In June 2011, a commercial manufacturer began production of the CDEM. This commercialization was preceded by extensive in-mine testing throughout the United States, which demonstrated the utility and accuracy of the device. Presently, some mine operators are beginning to use the CDEM to assess the explosion hazard and make adjustments in real time. NIOSH has drafted a report entitled "Coal Dust Explosibility Meter Evaluation and Recommendations for Application" and is planning to finalize it soon.

The personal dust monitor (PDM) is not only commercially available but is now certified in accordance with 30 CFR Part 74 (Coal Mine Dust Sampling Devices) as an approved dust sampling device—a prerequisite to its use in compliance monitoring. This device represents a significant advancement in the campaign to eliminate coal worker pneumoconiosis (black lung disease). Already some operators have begun to use this device, and limited NIOSH studies to date find that when empowered with this technology, miners will use it to reduce their exposure to respirable dust.

The reduction of respirable dust in the production environment is as important as ever, and NIOSH has developed a best practices handbook and conducted several "train-the-trainer" workshops to disseminate these practices throughout the industry. At the same time, our scientists and engineers are studying new and potentially

more effective technologies for further reducing respirable dust levels. The "canopy air curtain" for use on roof bolters, for example, envelops the operator inside a "canopy" of filtered air. If the in-mine trials are as successful as those in the laboratory, it will eliminate one of the highest respirable dust exposures.

Equipping miners with the knowledge, skills, and technology to escape successfully during mine emergencies is a continuing priority. NIOSH has developed training and technology in this area, and recently, we funded the National Academies to conduct a comprehensive analysis of self-escape in the context of mining safety. They will examine judgment and decision making under conditions of stress and uncertainty, essential competencies for escape, training methods to impart the skills needed to plan and execute an escape, and technologies that could improve the chances of self-escape, among others.

A few months ago, NIOSH researchers conducted a workshop with industry, labor, and government stakeholders from the metal/nonmetal and coal sectors to identify training successes and gaps, and to set priorities for improvement over the next five years. Recently, a set of training programs on the use of refuge chambers was completed. We are also seeking more effective ways to train miners, and over the past year we have adapted a 360-degree virtual reality theatre that we observed being used in Australia to train mine rescue teams. Building on their work, we are already developing advanced training simulations that will allow teams of miners to interact simultaneously. One of our initial efforts is focusing on means to train miners more effectively to escape under emergency conditions.

Of course, practices to prevent emergencies in the first place should be everyone's priority, and toward that end, NIOSH researchers have developed improved techniques to prevent mine explosions and roof falls, and we will continue to conduct research in priority areas such as methane flows into and out of gob areas of active longwall panels (mined out areas made up of caved in rock).

Since the passage of the MINER Act, NIOSH has awarded 94 technology development and research contracts, targeting innovations in communications and tracking, escape, rescue, sensory systems to improve hazard recognition, and prevention efforts with an emphasis in mine explosion prevention and fire suppression.

These efforts have produced several technological advancements that have significantly improved post-accident survivability, provided a framework to enhance detection of hazardous conditions as they develop, and aided in fundamental understanding of mechanisms that contribute to disastrous events, which are leading to enhanced intervention technologies and strategies to prevent their occurrence.

Prior to the MINER Act, communication in most underground mines was equivalent to a simple, land-line-style telephone system that was highly vulnerable to disruption due to local and large-scale mine catastrophes, such as explosions and ground falls. All mines now have installed some form of primary wireless, two-way communication, reaching to all locations within the mine with sufficient redundancy to enhance survivability in local-scale mine disasters. Secondary systems which require much less infrastructure have also been developed to enhance survivability in large-scale mine disasters. Commercially available systems include the medium frequency system and the Through-the-Earth (TTE) systems. "Gateways" have been developed to allow interoperability among these systems, and this provides for greatly improved post-accident survivability and functionality, even when parts of systems have been compromised.

Collaborations with the Navy, the National Aeronautics and Space Administration (NASA), the National Institute of Standards and Technology (NIST), and the Department of Energy (DOE), among others, are being used to leverage taxpayer investments in one agency to the solution of problems in another. Similarly, working collaborations are underway with mining safety and health agencies in other countries. For example, the Safety in Mines Testing and Research Station (SIMTARS), a mining safety agency in Queensland, Australia, and NIOSH are jointly developing a mine escape vehicle, which incorporates enhanced breathing capacity, communication, and guidance into a conventional mine transport vehicle. A prototype has been designed and built to provide life-support functions for 10 to 12 miners, operate in an oxygen-deficient, low- or no-visibility atmosphere, and travel at speeds faster than miners can walk out of a mine. Underground field trials of the prototype vehicle will occur later this fiscal year.

There are many examples to illustrate the mine safety and health improvements that are attributable to the research, development, and translating activities of NIOSH, as well as to the collaborations of NIOSH with MSHA and labor and industry partners. It is impossible to quantify how many disasters have been prevented and how many lives have been saved as result of the work of NIOSH and its partners at MSHA, labor, and industry. On the other hand, when something goes terribly wrong, the human cost is all too apparent—and then there is a responsibility

to understand what went wrong and what needs to be done to ensure that it never happens again.

Following the explosion at Performance Coal Company's Upper Big Branch Mine South (UBB), which resulted in the death of 29 miners and serious injuries to two other miners, Hilda Solis, Secretary of the U.S. Department of Labor, requested that the Director of NIOSH identify a panel of individuals with relevant experience to conduct an independent assessment of the MSHA Internal Review (MSHA IR). Secretary Solis asked the UBB Independent Panel to assess the MSHA IR Team's processes, conclusions, and recommendations.

Dr. John Howard, the Director of NIOSH, appointed four experts in areas relevant to the MSHA IR Review and MSHA's UBB enforcement activities to serve on the independent panel. Members of the independent panel included Lewis Wade, Ph.D., (Chair); myself (Executive Secretary); Michael Sapko, M.S; and Alison Morantz, Ph.D., J.D. Susan Moore, Ph.D., of the NIOSH Office of Mining Safety and Health Research served as staff assistant and Recording Secretary. The Assessment produced is not a NIOSH publication. The views expressed by the

Panel members are their own professional views and not necessarily those of NIOSH, CDC or HHS.

In April 2010, Joseph Main, Assistant Secretary of Labor for Mine Safety and Health, instructed MSHA's Director of Program Evaluation and Information Resources (PEIR) to assemble a team to conduct an internal review of MSHA enforcement activities at UBB in accordance with applicable MSHA policy and procedures. The PEIR Director assembled a group of MSHA employees without current enforcement responsibilities in Coal Mine Safety and Health District 4 to serve on the MSHA IR Team.

Over a period of nearly two years, the MSHA IR Team reviewed thousands of pages of records on enforcement activities (including ventilation and roof control plans, correspondence files, handbooks, policy manuals, and enforcement inspectors' notes) and interviewed 87 MSHA employees.

In June 2010, the independent panel met with the MSHA IR Team for the first time. Over the ensuing 18 months, seven follow-up meetings took place via conference call between the MSHA IR Team and the independent panel. At each of these meetings, the MSHA IR Team briefed the independent panel on its progress and consulted with the panel on specific methods being used to examine discrete aspects of MSHA's actions or inactions prior to the UBB explosion. Meanwhile, the independent panel periodically asked the MSHA IR Team to provide it with specific documents, including prior MSHA Internal Review Reports, Internal Policy and Procedures, and the Ventilation Plan Approval Handbook. The independent panel analyzed all materials that it received from the MSHA IR Team, including reports from internal reviews that MSHA had conducted in the wake of earlier mine disasters from 2001 onwards.

On January 11, 2012, the MSHA IR Team provided NIOSH with a draft report and requested the independent panel's views about the report. On February 3, 2012, the independent panel conveyed its comments to the MSHA IR Team. On February 23, 2012, the MSHA IR Team provided its final IR report to the independent panel.

MSHA's Administrative Policy and Procedures Manual, Volume III, Section 1200, entitled "Internal Review Policy and Procedures," establishes the objectives, responsibilities, and procedures for conducting an internal review of an incident in an underground mine resulting in three or more fatalities. The independent panel assessed the MSHA IR process, conclusions and recommendations against this policy.

The independent panel prepared a report that summarizes its assessments of MSHA's Internal Review, and specifically the processes it used, its conclusions, and its recommendations. Further, the independent panel report provides a set of recommendations that it believes will lead to a lasting improvement in MSHA's enforcement performance.

I appreciate the opportunity to testify this morning and thank you for your continued support. I am pleased to answer any questions you may have.

Chairman KLINE. Thank you, Dr. Kohler.

Thanks to all three of you.

Dr. Kohler, it looks to me like you have got something next to you on the table there. That I would—from here the Coal Dust Explosability Meter, I think.

Is that ready for prime time?

Dr. KOHLER. Yes it is.

Chairman KLINE. Excellent. So you believe it can be used as a compliance tool right now.

Dr. KOHLER. That is correct.

Chairman KLINE. I just wanted to give you the opportunity to raise it up. I——

Dr. KOHLER. Yes.

Chairman KLINE. Well, you brought such a nice device there and I just hate for it to sit on the table.

Thank you. Thank you very much.

Again, Dr. Kohler, West Virginia, as so many investigations—West Virginia's UBB report made a recommendation to NIOSH to further study active and passive barriers.

Can you explain what those are? Describe NIOSH's previous work in this area, and what you need to complete this study.

Dr. KOHLER. Yes. Active and passive barriers serve as secondary means of quenching an explosion once it has started.

Active and passive barriers would offer the opportunity to be placed in certain strategic locations, for example in certain belt entries, so that if the other mechanisms failed and there were a dust explosion, the barriers would most likely quench that explosion.

In order to implement these barriers, there are a few remaining questions, some experiments that need to be done. And as the State of West Virginia recommended, there is some additional research that we need to build on the work that we did several years ago.

At our Lake Lynn Experimental Mine, for example, that facility has the ability to do the kind of work that needs to be done to verify and to provide the best practices for applying active and passive barriers.

Chairman KLINE. Okay. I am not sure I understand fully what you need to complete the study. But thank you for the answer.

I want to pick up on something I talked about earlier and we have been sort of stepping around this all day.

NIOSH's independent review stresses that MSHA's internal review perhaps failed to address the broader more important issue, that is, quote—"would a more effective enforcement effort," by MSHA, "have prevented the UBB explosion?"

Looking beyond the specifics of this question for the moment, how do you believe MSHA could best understand the underlying issues concerning its involvement in Upper Big Branch?

Dr. KOHLER. I think the panel believes that there are a number of underlying systemic issues in terms of the workforce, workforce readiness, the expectations placed on the inspectors, a wide range of issues that need to be examined.

It is simply not a matter of improving training for inspectors or simply a matter of rewriting books and handbooks. But rather trying to probe more deeply into why these things persist in event after event.

Chairman KLINE. Did NIOSH provide experts to MSHA during the accident investigation?

Dr. KOHLER. Yes. The agency provided some technical analyses, some laboratory work, and advice.

Chairman KLINE. So they were onsite or not onsite or a mixture?

Dr. KOHLER. Not on site.

Chairman KLINE. So they were just there to answer questions?

Dr. KOHLER. Or to conduct laboratory work at the Burson facility.

Chairman KLINE. I am just keeping with you here, Dr. Kohler. I am sure we are going to get to everybody else here in a minute.

We were talking about mining technology a lot, ever since I have been on this committee. We talked about communications devices and safe chambers and so forth.

One thing that has been discussed is foam rock dusting. Can you explain what that is and is it ready?

Dr. KOHLER. I can't speak specifically to whether or not it is ready. There is certainly some experimental validation that needs to be done before it could be applied in the mines to meet regulatory requirements.

It is a newer process of applying rock dust, so that it adheres better to the walls of the coal without producing respirable dust downwind.

It is a new process that is being advocated as an improvement. And I think that it—pending further study, it may represent an important improvement.

Chairman KLINE. Okay. Thank you very much.

I see my time is about to expire.

Mr. Miller?

Mr. MILLER. Thank you.

Mr. Kohler, one of your recommendations, I believe, is to reevaluate the requirement of quarterly inspections of all mines.

Is that correct?

Dr. KOHLER. Not exactly. No. We are not recommending that.

The recommendation was to look more broadly at our current enforcement expectation or model, and to put on the table some ideas to begin that discussion.

We suggested seven or eight topics. One of which is the number of inspections.

The transcripts and the internal review detail a workforce stretched so thin that it is very difficult for them to be successful in their work. And so——

Mr. MILLER. By successful you mean effective?

Dr. KOHLER. Yes. And so if the resource is ineffective, then it begs the question how are we allocating the resources?

Is it important? Should we be doing more or less of it?

Mr. MILLER. President Roberts, have you looked at those recommendations?

Mr. ROBERTS. Yes, I have.

Mr. MILLER. Your opinion?

Mr. ROBERTS. As some of the recommendations—and I am glad Dr. Kohler clarified the one on the quarterly inspections. We feel that those fours and twos, as they are referred to in the industry, are extremely important.

Some of the other recommendations appear to be saying let us give more responsibility to the coal operators and mine management and take some of that responsibility away from MSHA.

We would be totally opposed to that.

And I think if we can just point to pre-1969 when that existed, and I would remind this panel if you go back the 40 years pre-

ceding the 1969 Act and do the analysis of what happened to the 40 years after, you will find that 30,000 some miners lost their lives before the passage of the Mine Act. And less than 3,000 lost their lives 40 years afterwards.

So we would have to say that legislation that was passed by Congress has saved a lot of lives. And the things that you do here are important.

Mr. MILLER. But in terms of this relooking at the inspection regime, you don't have a problem with that. In a sense, I assume what you are trying to determine is what is effective and what isn't effective. And what could be changed to make it more effective.

Because obviously, you know, the record is replete with a series of inspections where we just end up doing more inspections and finding the violations over and over again.

I mean that is the problem you heard discussed here earlier.

What is the next step after that?

But are we using the mine inspector's time in the best interest of creating a safer workplace?

Dr. KOHLER. Yes, and also asking the question, what can we do to change the fact that in internal investigation after internal investigation, we see a similar pattern of deficiency——

Mr. MILLER. Are the mine workers are part of that discussion?

Mr. ROBERTS. The most recent recommendations or suggestions by the panel, no.

Mr. MILLER. Well, what happens to the follow on to this? Is that all internal?

Dr. KOHLER. In terms of a follow on, we are hoping that someone will constitute a group of people——

Mr. MILLER. Okay, so that hasn't been determined yet, whether——

Dr. KOHLER. No. not at all. We simply.

Mr. MILLER [continuing]. Bring in the industry. You bring in the mine workers and others to discuss.

Dr. KOHLER. We said that this body should include labor, industry, academia, government.

Mr. MILLER. President Roberts, before I run out of time here, three or four of us have asked the question when you have a bad actor, how do you get rid of the bad actor because we have been unable to do that to date?

We get into a lot of penalties. We get into a lot of citations. We get into a lot of court actions back and forth.

But we don't get rid of the bad actor. And the pattern appears to continue until there is a tragedy.

So how do we do that?

Mr. ROBERTS. I would suggest to you that the government charged with protecting the miners does not possess the tools to achieve the goals that everyone up here seems to be interested in achieving.

That is if you have a Massey Energy and you have someone like Don Blankenship running a number of mines that are extremely dangerous, how do you stop that?

Well, number one, the penalties, criminal penalties under the Mine Act are ridiculously low. We just saw that at Crandall Can-

yon where $500,000 for two criminal acts is all they had to pay. That is not even a half a day's work for production on a longwall.

So the penalties are extremely low. No one is going to pay particular attention to that.

I think there needs to be more severe penalties. And I think those penalties have to go up the ladder higher than they do currently.

When we put mine foremen in jail, the person who told them the mine foreman what to do is still walking around free and clear. So we have to be able to go up the ladder, all the way up to the chief executive of the company if that is who is making these decisions and putting others at risk.

Mr. MILLER. But that is beyond a misdemeanor.

Mr. ROBERTS. Oh, absolutely. That has got to be a felony. And it has got to be written into the law. And it doesn't exist right now.

Mr. MILLER. Thank you.

Mr. WALBERG [presiding]. The gentleman's time has expired.

I recognize myself.

Mr. Shapiro, thanks for being here.

Your written testimony notes that OIG found Mr. Page the leader of MSHA's investigation team, who have used, and I quote—"poor judgment," in dealing with some of Massey's representatives, and that he, quote—"made statements that could have been perceived or interpreted as intimidating," significant statement there.

First, can you please explain what Mr. Page said that could have been perceived as intimidating?

Mr. SHAPIRO. Well, Mr. Page, when he discussed this matter with Dr. Schemel, had brought up the possibility that if the order was not vacated—the order that involved Dr. Reszka—if that order was not vacated, that there was a possibility that complaints would be filed against his company, against Dr. Schemel, against his company; that these complaints would have to be investigated by MSHA; that these complaints could end up leaving a black mark upon his reputation in the industry.

At one point Mr. Page referred to a picture that he had gotten reportedly from the UMWA. And Dr. Schemel believed that that was a picture of—might have been a picture of him, and so all of this was the sort of dialogue that went on that led Dr. Schemel—led us to conclude that he—Dr. Schemel could have perceived that he was being intimidated if he did not agree to vacate the safety order that involved Dr. Reszka.

As we explained inn our report, it appeared that Mr. Page was trying to legitimately broker a deal and try to please all the parties, the parties here being Performance, and the UMW, and MSHA.

Because Mr. Page was legitimately concerned—and several people told us this, even people with Performance—legitimately concerned that the accident investigation would be impeded if MSHA had to investigate all types of safety complaints, whether they came from UMWA or anywhere else.

Because they statutorily have to investigate all of these complaints, Mr. Page's primary objective was to complete this investigation, the accident investigation.

So that was the scenario in which we concluded that there could have been at least a perception of intimidation by Dr. Schemel. But we did not conclude that that was Mr. Page's intent in that connotation——

Mr. WALBERG. Well, I guess in light of all that, secondly, can you explain your understanding of why Mr. Page was in a position where he was having closed door meetings with Massey's representatives, and making comments that could have been perceived as intimidating?

Mr. SHAPIRO. Well, I am not sure I can answer for MSHA to say why he was in that position. What we were told was that an agreement had been reached between the Performance attorneys and the MSHA attorneys to vacate the order and citation of Dr. Reszka receive the training.

But Mr. Page was concerned that if that occurred, if the order and citation were vacated, that there maybe this flurry of complaints that he would have to investigate, that MSHA would have to investigate. And therefore impede the investigation.

And Mr. Page asked if I could try to sit down with Dr. Schemel and work this out. And that led to this meeting. He was advised by officials in MSHA, yes, why don't you see what you can do.

Mr. WALBERG. But it appears that that then indeed could have taken away from Mr. Page's ability to conduct the investigation of the explosion.

Would you agree or wouldn't you?

Mr. SHAPIRO. I am sorry. That what could have taken away?

Mr. WALBERG. That it could have taken away. These activities he was involved with took away from Mr. Page's ability to conduct investigation of the explosion.

Mr. SHAPIRO. I am still not sure which activities you are referring to, sir.

Mr. WALBERG. The activities of Massey—being with Massey, involved in the closed door meetings, the intimidation perception that was there.

Mr. SHAPIRO. Frankly, I am not sure how I see how the meeting itself would have taken away from his——

Mr. WALBERG. Okay.

Mr. SHAPIRO [continuing]. His role as the head of the accident investigation.

What he was concerned about was that complaints would be filed. And those complaints, those safety complaints, would have to be investigated and they would impede the investigation.

It wasn't the meeting itself——

Mr. WALBERG. Okay.

Mr. SHAPIRO [continuing]. That was the real concern.

Mr. WALBERG. I appreciate that. I think that is what—with lack of art—I was trying to get at there.

Thank you very much.

My time has expired.

Ms. Woolsey?

Ms. WOOLSEY. Thank you very much.

So Mr. Roberts, it appears that MSHA doesn't have the power they need to stop the bad actors. Workers—that doesn't even appear—it is certain they don't.

And workers are unable to work within their company, at their jobsite, and when they are the ones that know if there is a danger, they can't identify these hazards. They can't do anything about them without fear of losing their jobs.

And Congress hasn't, as of this moment anyway, done anything to change this.

Will you tell us from your perspective, as a representative of these workers, why don't they just walk off the job?

Mr. ROBERTS. If they walk off the job, Congresswoman, they are going to be fired.

And in the case—if you go back to prior to Massey selling these operations to Alpha, most of the mines in southern West Virginia were Massey mines.

And so it is not just a matter if you were terminated at mine A, you just went down to mine B and got a job. You ran into the same employer at mine B, mine C, mine D, mine E. And you probably would never work in southern West Virginia again. You would probably have to leave the area to find a job in the mining industry.

Ms. WOOLSEY. So——

Mr. ROBERTS. It is a more sophisticated form of blackballing.

Ms. WOOLSEY. Right. And one of the—I think we all remember when we were at Beckley, one of the mothers of one of the miners who had lost his life, she said he would come home every night and it was like he was unbelievable that he could drive home. Because by the time he got through with his day in the mine, the oxygen in his blood was so contaminated that he would flop down on the sofa and pass out.

And she would say to him, "Son, why don't you first go to your management." "I can't." "Then why do you keep this job?"

And he said, "Mother, there are no other jobs. And this is—I will—I am risking my life and I know it for this job."

OSHA would not allow—Dr. Kohler, OSHA would not allow an employer to retaliate against an employee who pointed out a hazard in the worksite.

Why do you think the miners have to put up with that?

What do we need to do to change that? Let me ask you that.

That I guess——

Mr. ROBERTS. Well, I can answer——

Ms. WOOLSEY. All right——

Mr. ROBERTS [continuing]. That if you would like.

Ms. WOOLSEY. All right.

Mr. ROBERTS. First of all I think technically the law supposedly protects miners. But there is the law and there is reality.

Miners in southern West Virginia do not believe, or did not believe particularly when Don Blankenship was running these mines, that anybody could protect them.

They didn't believe the governor could. They didn't believe this Congress could. They didn't think the president of the United States could keep their job or protect them from Don Blankenship.

And you have to understand the type of individual this was who—he visited these mines. He flaunted his power and authority. And he was retaliatory. And he had a long, long history of that.

So what you have to do if you want to prevent this in the future, we don't have many of these type people. I am just——

Ms. WOOLSEY. I know that——

Mr. ROBERTS [continuing]. I want to make sure that we are clear on that. Most operators don't act like this.

Ms. WOOLSEY. Right.

Mr. ROBERTS. But you are going to have those type people from time to time, and you have to protect these miners from them. And you have to write it in the law that the people who put miners in unsafe conditions, it is jail time.

Ms. WOOLSEY. So had you been sitting in Secretary Main's seat, what would you have said we need to do?

Mr. ROBERTS. Had I been sitting in Secretary Main's—let me—we have publicly said that this mine should have been closed. And there has been a debate about these situations for 30 years now, whether MSHA really has the authority or not.

And we said that this mine should have been closed. We think there could have been enough of paperwork and things, maybe going to court or whatever, but as has been pointed out, would have taken a long time.

We need to grant whoever the assistant secretary is that authority. So we don't have this again.

Because I don't think it is clear in the law that they have this kind of authority.

Ms. WOOLSEY. Thank you, Mr. Chairman.

Thank you, Mr. Roberts.

Mr. WALBERG. I recognize Dr. Bucshon.

Mr. BUCSHON. Thank you.

Dr. Kohler, NIOSH's independent panel found three critical events that led to the Upper Big Branch tragedy. And friction at the ignition at the longwall shearer—ignition of accumulated methane gas and then the explosion of float coal dust.

Can you kind of walk us through each one of those and find out—and give me a kind of a synopsis of where MSHA's involvement and actions in respect to these, had they been done properly, could have prevented this?

First let us just take friction ignition at the longwall shearer. Describe what that is briefly. And then tell us what could have been done.

Dr. KOHLER. As the cutting drum is rotating, the cutting drum has cutting picks on it. And those picks tear into the coal and to the roof rock.

When those picks in particular strike harder roof rock, you create some heat. And if the bits are dull or broken, you can create quite a bit of heat, and you can leave up a thermal smear which indeed can become hot enough to ignite methane. And when that occurs, it is known as a frictional ignition.

So one question: was there anything that could have been done to have previously detected, through enforcement action, to prevent the cutting drum from being in the condition it was found in where there were broken and missing cutter bits, and also in operative water sprays?

And the panel in looking at the findings in the internal review decided that no, there was nothing that MSHA could have done in

an enforcement sense to ensure that a frictional ignition would not have occurred.

Mr. BUCSHON. Okay, how about the methane gas?

Okay, so let me just tell you the background. Like I said before, my dad was a coal miner. The last job that he had before he retired was as a—basically he walked around and checked the coal mine for methane and air quality and all that.

He was the examiner. And so I know a little bit about that.

What could have been done about that?

Dr. KOHLER. All right, so based on the findings of the accident investigations, there was an accumulation of methane which then ignited, probably from this frictional ignition. And the question is——

Mr. BUCSHON. Was that a bigger problem in the coal mine with their ventilation—with the way they controlled the airflow through their mine? I mean specifically why there was any accumulation.

Were they not putting up the appropriate things to direct the air the way it needed to be, because I mean that is a bigger issue, right?

Dr. KOHLER. That is a bigger issue. And the panel I served on did not redo any part of the accident investigation. We simply used the facts that they gleaned.

So there was an excess amount of methane that had accumulated. A very effective way to reduce accumulations of methane is through ventilating, proper ventilating air.

There was not proper ventilating air according to the investigations; one of the reasons that there was improper ventilating air down in that area of the mine was because of a partial blockage in the tailgate entry from a roof fall.

Mr. BUCSHON. Now I can—sorry to interrupt, but I can tell you my dad, I have talked to him about this type of situation. As an examiner if he would have come in a previous shift and saw that that was improper, he would have reported that up and that would have been corrected, or the shift, the next shift couldn't come down that coal mine.

So why—did you find out why that happened?

Dr. KOHLER. Yes. I can't speak to why the operator's preshift examination or the operator's personnel didn't detect and doing anything about that——

Mr. BUCSHON. Well, I guess my argument is they probably did. And the question is where—did you find where that—I mean, I can't imagine the examiner or whatever you call him today, would have not reported that. And say, hey, there is, you know, we don't—I mean it is pretty simple. You holdup an air flow meter, right, and it tells you whether the air is moving and which direction and——

Dr. KOHLER. Or a visual inspection. The MSHA's internal investigation revealed that that portion of the tailgate had been visited, inspected four times. And that would have been an opportunity to notice that there were missing supplemental roof supports.

If those roof supports had been in place, it is less likely that there would have been such a roof fall that blocked the air.

Mr. BUCSHON. So I guess my final question is—and this will be something that—and I am not implying any impropriety anywhere along the line.

But was there any evidence anywhere along the line for financial incentive of anyone in this process other than the operator, not to correct these problems?

I mean, or that if there were problems were identified financial incentive not to report them properly?

Dr. KOHLER. There was nothing that we found in the internal review report that would suggest that.

Mr. BUCSHON. And as a follow up, do you think based on what MSHA—well it seems my time has expired. So I will yield back.

Thank you.

Mr. WALBERG. Thanks for being observant.

The gentleman from West Virginia, Mr. Rahall.

Mr. RAHALL. Thank you, Mr. Chairman.

I thank the panel for their testimony you had this morning as well as you, Mr. Roberts, President Roberts, for all that you do for our nation's coal miners.

I agree with you that one of the critical voices or perhaps you didn't say this, but I am, that's missing from today's hearing are those of the families of the UBB miners.

For that reason, I would like to read a part of a statement that was sent to the committee by Gary and Patty Quarles, the parents of Gary Wayne Quarles, I am sorry, who perished at UBB. And then perhaps get your thoughts on it.

Quote—"Something is going to have to be changed that these people that are in charge of running these mines need to be accountable. This is going to keep happening because our laws say we will protect you to these companies, not the miners. How many more will go unpunished because of out of date laws that go back to 1969? This state was afraid to touch Blankenship, so he was let go with however he wanted to run this company. My son and 28 others were just at work. They had no one protecting them. Please don't let their deaths be in vain. And let another family be destroyed."

This is from Mr. Quarles' letter. And I would ask unanimous consent that his entire letter be made a part of the record, if not now, at the proper time.

[The information follows:]

Prepared Statement of Gary and Patty Quarles, Naoma, WV

We are the parents of Gary Wayne Quarles. He was one of the miners that was killed in the UBB explosion.

Something is going to have to be changed that these people that are in charge of running these mines need to be accountable. When there is criminal conduct, they should get charged for a felony not a misdemeanor. This is going to keep happening, because our laws say we will protect you to these companies—not the miners.

How many more will go unpunished because of out of date laws that go back to 1969?

If MSHA or the state finds problems at the mines, then give them time to fix them. But when MSHA or the state comes back and unwarrantable violations remain, then there needs to be a punishment to the boss for not getting it fixed, and the punishment that we think should be, is by losing his underground papers. If that doesn't work, then pull the permits for the mine.

This state was afraid to touch Blankenship, so he was let go with however he wanted to run this company.

My son and 28 others was just at work. They had no one protecting them.

Please don't let their deaths be in Vain! And let another family be destroyed.

There was a boss at UBB, Dean Jones, that wanted to bring his crew out, not once but several times because they had no air.

He was told if you do, then bring your bucket and look for another job.

This man and his crew stayed because he needed his job, even if his life was in danger.

Because of these men being threatened, they are now dead.

Something also needs to protect these guys for calling someone for help, because there is no help out there because they are afraid of it getting to the company and being fired.

We asked you to change the law to get miners protection, but it was shot down fast. It's up to all of you.

Mr. WALBERG. Without objection.

Mr. RAHALL. Thank you.

"There was a boss at UBB by the name of Dean Jones, who perished, that wanted to bring his crew out. Not once, but several times because they had no air. He was told if you do so, then bring your bucket and look for another job. This man and his crew stayed because he needed his job, even if his life was in danger. Because of these men being threatened, they are now dead."

So I know you have touched upon this already, President Roberts in response to an earlier question. And I know Ms. Woolsey brought up the situation where there are no other jobs and how these coal miners really need the good pay that is associated with working in our underground mines.

But there is still something missing here when there is that production factor put over the people factor, and over the safety factor.

Perhaps if—and as I said, I know you have already commented on the gist of this letter.

But could you relate to us what the inspections are like in a union versus a nonunion mine.

Mr. ROBERTS. Thank you very much, and thank you for your interest in health and safety for so many years, Congressman.

I would just like to follow up on the Edward Dean Jones. I met his widow at the time we released our report. She is a very young person.

And Mr. Jones did keep his men off the section because he didn't think it was safe. And for that, he was told he would be discharged if he didn't go up on the section and work in an unsafe area.

If this management had listened to him, maybe we would have more people alive today. And maybe this wouldn't have happened.

So we have good people everywhere trying to do the right thing. If we just gave them a little more authority and a little more power.

But there is a world of difference between an inspection in a union mine and a nonunion mine; there are three minimum health and safety committee representatives of the United Mine Workers at every union mine.

They travel with the federal inspectors. They travel with the state inspectors. And they have filed reports on their own.

They inspect the mines themselves at least four times a year. And some places they inspect an entire mine every month.

So there is another set of eyes that being a representative to workers in all the union mines. And that is not true at most nonunion mines.

The protections that they have at the nonunion mines are to federal inspectors, in some instances, the state inspectors. So it is a world of difference.

Mr. RAHALL. Thank you for that response.

Dr. Kohler, let me ask you.

Do you feel that you have sufficient personnel at NIOSH and experienced personnel? And if so, how do you keep them with you?

Dr. KOHLER. Yes, the workforce challenge is spread across the mining industry. They are not just confined to MSHA.

We experience them at NIOSH. The universities, the operators, everyone is struggling to hire and recruit talented personnel into mining.

Just to give you an example, MSHA and NIOSH both compete for entry level mining engineers. A mining engineering student coming out of WVU or Virginia Tech, or University of Kentucky for example, starts somewhere around $65,000 to $70,000 a year.

We can offer that same graduating student $33,000 a year. Now, it is easy to see the difficulty we have in competing.

It is a big, big problem.

Mr. RAHALL. How do you suggest we remedy it besides more pay?

Dr. KOHLER. Yes, I think that if we want to be able to recruit and retain competent people, we have to have compensation schedules which don't necessarily match those available outside of the government. But they have to close the gap.

Mr. RAHALL. We will never be able to—the public sector would never be able to compete with the private sector.

Dr. KOHLER. Not fully. But if we are serious about recruiting and retaining quality people in these key positions, something has to be examined and action taken.

Mr. RAHALL. Thank you.

Thank you, Mr. Chairman.

Mr. WALBERG. I thank the gentleman.

I now recognize the ranking member on Workforce Protections, Ms. Woolsey.

Ms. WOOLSEY. Thank you, for closing remarks, no doubt?

Mr. WALBERG. Yes, please. Thank you.

Ms. WOOLSEY. Thank you.

Well, it is clear that today we recognize that the entire system failed the miners at Upper Big Branch. Past Congresses should not have slashed funding for mine inspectors.

MSHA needed to do a better job. We, the bureaucracy obviously needs to be scrubbed, to bring it into the 21st century, but they didn't do anything on purpose.

And Massey exploited MSHA's weaknesses in the law. And they hurt the workers.

This is the 21st century. Together in a bipartisan way, Mr. Chairman, and it is your subcommittee that I am honored to be the ranking member of,We have to put our heads together. We have to ensure that we move into the 21st century, that we enact meaningful reform.

Otherwise, we are not going to be honoring the lives or the deaths of the 29 workers who spilled their blood in Upper Big Branch. And we cannot let them be forgotten.

They should have taught us a lesson. If they didn't, then we are dumber than nails. And we won't go forward. We will just keep spinning in a circle talking about it until the next disaster occurs.

I don't want that to happen. So let us work together so that it doesn't.

I yield back.

Mr. WALBERG. I thank the gentlelady. And certainly there is a commitment to work toward fostering better results, better safety.

The Mine Act, as you know, declares, and I quote from it, "The first priority and concern of all in the coal or other mining industry must be the health and safety of its most precious resource, the miner."

And I think in this room we understand that. There may be differences of opinion and perception of facts in the way we look at facts.

Certainly, we have seen evidence today that the funding issue has continued to increase. Now, how that has worked out, there may be question how we use it.

What bureaucratic problems we put in the way. What things we neglect to encourage more.

In the opportunities we have had to visit mines together, we have seen some best practices that are very useful in promoting health and safety for workers, as well as promoting economic stability for the mine itself. And I think we need to capitalize on those things.

I appreciate the panel here in front of me, as well as Director Main, Secretary Main, in being in front of us this morning as well.

The questions that were brought up, comments that were made, are helpful to making a final—I take that back—not a final conclusion, but an ongoing conclusion of how we move forward.

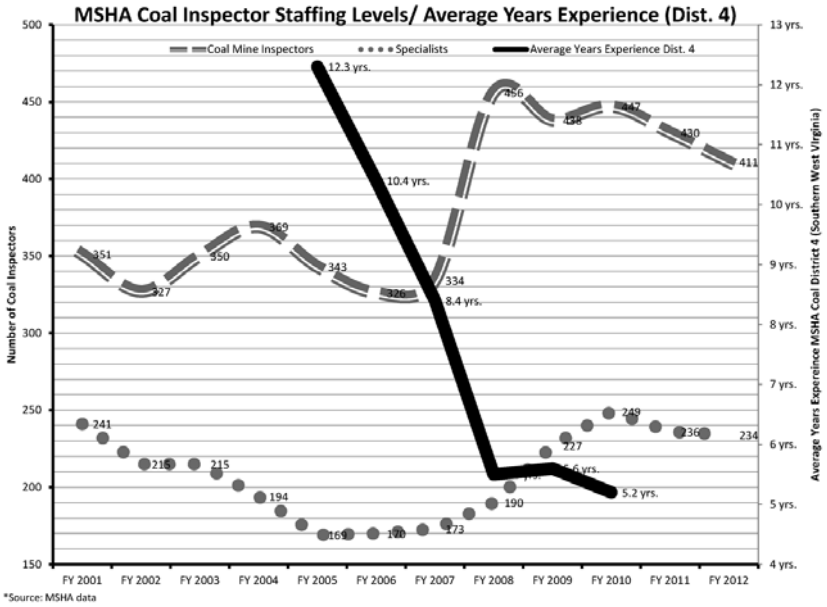
In making sure that this extremely important industry, with people who do things that—I have already indicated to you I am not a miner. I don't intend to be—other than mining for ways of encouraging the mining industry, and those that work in it, to foster a situation that moves our country forward.

That comes by carefully looking at the problems, looking for solutions, and looking for ways that we can be as little—as in the sense of being intrusive in the industry, but also doing the proper oversight that makes sure that we all move forward with safety and security.

I think the testimonies given today, the comments made, will assist us in doing exactly what my ranking member said in working out a suitable agreement in the not too distant future.

Having said that, there being no further business, the committee stands adjourned.

[Additional submission of Mr. Andrews follows:]



[Additional submissions of Mr. Miller follow:]

ALL CITATIONS AND ORDERS ISSUED BY MSHA FOR ADVANCE NOTICE

[April 1, 2010–April 12, 2012]

Coal or MNM	Mine ID	Mine Name	Controller Name	Operator/Contractor Name	Violator Type
Coal	4608384	Seng Creek Powellton	Alpha Natural Resources, Inc	Elk Run Coal Company Inc	Operator
Coal	4202074	Horizon Mine	America West Resources, Inc	Hidden Splendor Resources Inc	Operator
Coal	1518522	Classic Mine	Arch Coal Inc	ICG Knott County LLC	Operator
Coal	1518771	RB #12	Ben Bennett	Manalapan Mining Co., Inc	Operator
Coal	1512564	Straight Creek #1 Mine	Ben Bennett	Left Fork Mining Co Inc	Operator
Coal	1518547	Onton #9	Chester M Thomas	Advent Mining LLC	Operator
Coal	3609549	Kimberly Run	Citicorp Venture Capital Ltd	RoxCoal, Inc	Operator
Coal	4609136	Broad Run Mine	Coalfield Transport Inc	Big River Mining LLC	Operator
Coal	4404856	Buchanan Mine #1	CONSOL Energy Inc	Consolidation Coal Company	Operator
MNM	5400201	PROCAN	Efrain S Daleccio	Productos De Cantera Inc	Operator
Coal	3609326	4 West Mine	GenPower Holdings LP; James L Laurita Jr	Dana Mining Company of Pennsylvania LLC	Operator
Coal	3609371	Mine 78	J Clifford Forrest III	Rosebud Mining Company	Operator
Coal	3608603	Tracy Lynne	J Clifford Forrest III	Rosebud Mining Company	Operator
Coal	1517903	Mine No.17	Jack H Ealy	K and D Mining Inc	Operator
Coal	4407275	Wilson #2	James C Justice II	Virginia Fuel Corporation	Operator
Coal	1517478	#75	James River Coal Company	Blue Diamond Coal Company	Operator
Coal	4608812	Upper Cedar Grove No 4	Joe Valis	Glen Alum Operations, LLC	Operator
Coal	4609172	Mountaineer Pocahontas Mine No 1	John B Preece	West Virginia Mine Power, Inc	Operator
MNM	0504875	Crusher #4	John L Ary	A & S Construction Co	Operator
Coal	1512602	Highsplint Preparation Plant	Joseph T Bennett	Harlan Cumberland Coal Company LLC	Operator
Coal	1519455	Highsplint Strip #2 Dixie 25	Joseph T Bennett	Dixie Fuel Company LLC	Operator
Coal	4609244	Randolph Mine	Massey Energy Company	Inman Energy	Operator
Coal	4608436	Upper Big Branch Mine-South	Massey Energy Company	Performance Coal Company	Operator
Coal	1502057	Advantage #1	Metinvest B V	Sapphire Coal Company	Operator
Coal	4608878	Affinity Mine	Metinvest B V	Affinity Coal Company, LLC	Operator
Coal	1517610	No 3	Minerva Ruth Mead	MRM Mining Inc	Operator
Coal	4609201	Eagle #2 Mine	N/A	Appalachian Security Inc	Contractor
Coal	4609187	No 2 Deep Mine	N/A	Ft Division Lst Trucking	Contractor
Coal	4609073	Sugar Maple Mine	N/A	J & N Trucking	Contractor
Coal	4607908	Big Mountain No 16	Patriot Coal Corporation	Pine Ridge Coal Company LLC	Operator
Coal	4609073	Sugar Maple Mine	Patriot Coal Corporation	Gateway Eagle Coal Company, LLC	Operator
Coal	4609201	Eagle #2 Mine	Patriot Coal Corporation; Rhino Resource Partners LP	Rhino Eastern LLC	Operator
Coal	1518911	Mine #28	Rhino Resource Partners LP	CAM Mining LLC	Operator
Coal	4608570	Coalburg No 2 Mine	Richard H Abraham	Rio Group, Inc	Operator
Coal	4406499	Dominion No 7	Sunoco, Inc	Dominion Coal Corporation	Operator
Coal	4406868	No 6	Susie A Smith; Elmer Fuller	A B & J Coal Company, Inc	Operator

Source: MSHA.

MSHA Monthly Impact Inspection List

(January 2012)

January 2012 — **Coal**

Mine Information						Type of Issuance				S&S Information				Issuances - Type of Action											Justifications							
District	State	Mine ID	Controller Name	Operator Name	Mine Name	Cit	Orders	Safe -guards (Coal only)	Total	S&S	Non-S&S	Total	S&S Rate	104(a)	104(b)	104(d)(1) Citation	104(d)(1) Order	104(d)(2)	104(e)(2)	314(b)	103(k)	104(g)(1)	103(j)	107(a)	Total	1. Operator Tactics	2. Hazard Complaints /Hotline Calls	3. Plan Compliance Issues	4. Inadequate Exams	5. Accidents, Injuries, Illnesses	6. Fatal Accidents	7. Enforcement History	8. Adverse Conditions
District 02	PA	3608603	J Clifford Forrest III	Rosebud Mining Company	Tracy Lynne	2	0	0	2	2	0	2	100.00%	2	0	0	0	0	0	0	0	0	0	0	2							1	1
District 03	WV	4604367	GenPower Holdings LP, James L. Laurita Jr	Dana Mining Company LLC	Prime No. 1 Mine	10	0	0	10	1	9	10	10.00%	10	0	0	0	0	0	0	0	0	0	0	10	1		1					
District 04	WV	4604236	Walter Energy Incorporated	Maple Coal Co	Maple Eagle No 1 Mine	7	3	1	11	5	5	10	50.00%	7	0	0	0	3	0	1	0	0	0	0	11		1					1	
District 05	VA	4407223	Alpha Natural Resources, Inc.	Paramont Coal Company Virginia LLC	Deep Mine 41	5	0	1	6	3	2	5	60.00%	5	0	0	0	0	0	1	0	0	0	0	6		1			1			1
District 06	KY	1518839	Alliance Resource Partners LP	Excel Mining, LLC	Van Lear Mine	29	2	0	31	15	16	31	48.39%	29	0	0	0	2	0	0	0	0	0	0	31	1						1	1
District 07	KY	1517903	Jack H Early	K and D Mining Inc.	Mine No.17	21	7	0	28	17	11	28	60.71%	20	0	1	7	0	0	0	0	0	0	0	28	1		1	1			1	1
District 07	KY	1518565	TECO Energy Inc	Perry County Coal Corporation	E 4-1	35	3	0	38	14	24	38	36.84%	34	0	1	3	0	0	0	0	0	0	0	38			1	1	1		1	1
District 07	KY	1518182	Horace Garrison Hill	D & C Mining Corporation	D & C Mining Corporation	18	0	0	18	7	11	18	38.89%	18	0	0	0	0	0	0	0	0	0	0	18	1			1		1	1	
District 08	IL	1103054	Peabody Energy	Big Ridge Inc	Willow Lake Portal	11	0	0	11	3	8	11	27.27%	11	0	0	0	0	0	0	0	0	0	0	11							1	
District 09	CO	0503505	Deseret Generation & Transmission Co-operative	Blue Mountain Energy Inc	Deserado Mine	7	0	0	7	2	5	7	28.57%	7	0	0	0	0	0	0	0	0	0	0	7		1			1			
District 09	TX	4103161	NACCO Industries Inc	The Sabine Mining Company	South Hallsville No 1 Mine	3	0	0	3	0	3	3	0.00%	3	0	0	0	0	0	0	0	0	0	0	3		1						
District 12	WV	4608268	James River Coal Company	Rockhouse Creek Development, LLC	No. 6	23	0	0	23	11	12	23	47.83%	23	0	0	0	0	0	0	0	0	0	0	23							1	
		12			National Totals	171	15	2	188	80	106	186	43.01%	169	0	2	10	5	0	2	0	0	0	0	188	4	4	3	3	3	1	8	5

January 2012 — **Metal/Nonmetal**

Mine Information						Type of Issuance				S&S Information				Issuances - Type of Action											Justifications							
District	State	Mine ID	Controller Name	Operator Name	Mine Name	Cit	Orders	Safe -guards (Coal only)	Total	S&S	Non-S&S	Total	S&S Rate	104(a)	104(b)	104(d)(1) Citation	104(d)(1) Order	104(d)(2)	104(e)(2)	314(b)	103(k)	104(g)(1)	103(j)	107(a)	Total	1. Operator Tactics	2. Hazard Complaints /Hotline Calls	3. Plan Compliance Issues	4. Inadequate Exams	5. Accidents, Injuries, Illnesses	6. Fatal Accidents	7. Enforcement History	8. Adverse Conditions
SC	NM	2900159	Freeport-McMoRan Copper & Gold Inc	Freeport-McMoRan Tyrone Inc	Tyrone Mine	15	1	0	16	8	7	15	53.33%	14	0	1	0	0	0	0	0	0	0	1	16					1			
NE	VT	4300351	Omya Industries Inc	Omya Inc	Verpol Plant	6	0	0	6	1	5	6	16.67%	6	0	0	0	0	0	0	0	0	0	0	6	1			1			1	
WE	ID	1000062	U S Silver Corporation	U.S. Silver - Idaho, Inc	Galena	27	0	0	27	8	19	27	29.63%	27	0	0	0	0	0	0	0	0	0	0	27		1			1		1	
WE	CA	0404075	Heidelberg Cement AG	Lehigh Southwest Cement Co.	Lehigh Permanente Cement Co.	16	0	0	16	6	10	16	37.50%	16	0	0	0	0	0	0	0	0	0	0	16	1	1					1	1
		4			National Totals	64	1	0	65	23	41	64	35.94%	63	0	1	0	0	0	0	0	0	0	1	65	2	2	0	1	2	0	3	1

Total		16			National Totals	235	16	2	253	103	147	250	41.20%	232	0	3	10	5	0	2	0	0	0	1	253	6	6	3	4	5	1	11	6

Last Revised 02/16/2012

Orgas, WV, March 29, 2012.

Hon. JOHN KLINE, *Chairman;* Hon. GEORGE MILLER, Ranking Member,
Education and Workforce Committee, U.S. House of Representatives, Washington DC 20515.

DEAR CHAIRMAN KLINE AND RANKING MEMBER MILLER: This letter is submitted to the Committee with respect to the hearing entitled "Learning From the Upper Big Branch Tragedy" on March 27, 2012.

Bear with me a moment and imagine that the following happens:

I gather all of Congress into a room and tell you that your offices are being moved from the Capitol Complex. I am the new boss and this is what I would explain to you about your new workplace:

"Your new office is not like where you work now.

First, there is a chance that an odorless gas might leak into your new office and it could kill you, but, just in case, I will give you a breathing apparatus designed to save you IF you locate it in time. One person will have a device that reads the levels of this gas and the oxygen levels but that device will only work IF he or she is actually using it. Let's not forget that they will be keeping records in two separate books, but that's just between us right?

Next, there is a slim chance that the walls could cave in or the roof could collapse, but that's so remote that we won't worry about it. In fact, just part of the roof could cave in, but please don't concern yourself with that either.

Now I know it sounds bad, but really, it's dark in there so you won't have to see the walls buckling and you should feel safe. I will provide a light for you so that you can do your job, and please ignore the sounds of things falling because it will only distract you from your job.

No one is claustrophobic or afraid of the dark, right? And bugs, snakes and rats don't bother you either correct?

Oh, and let me tell you this too, there is a chance that there could be an explosion. Don't get excited, I don't want to alarm you. That rarely happens and if it does, well, there is usually time to get most of you out of the building before you get trapped or die. An explosion is rare and is usually in a confined area of the building, so you could be in a pretty safe area and not be affected at all! In fact, you will probably be safe enough to go to the funerals of your friends. But you can only go to these funerals on your "off" time. You aren't allowed to go if it happens during your normal work hours.

Now most importantly, if you should happen to see something that is unsafe and could endanger your life, please don't tell anyone! If you do, you will be fired. Your life is forfeit to me and my company. You just aren't as important as me as my profits. I can always find another person to fill your job, so if you don't like how I'm running things, you can just grab your jacket and leave. I'll pay you more than your contemporaries, but I'm not buying your loyalty or your silence. I know you can't work for anyone else and make this kind of money. Go ahead—try and survive and support your family without this job and this paycheck. Not that it's all about money, right?"

I know this sounds like a poorly written script for a B-Movie. And it's too weird to be fiction, isn't it?

I doubt there is even one member of Congress who would even think about working in the environment described above and yet they want every coal miner to work in these conditions and under the threat of silence. If it's too good for the members of Congress, why is it expected and allowed for coal miners?

And do you want to know what's worse? Knowing that the person you love is going into that situation every day, every shift and while there, they are demeaned and devalued and that black rock is more important than their safety and their life.

What makes this worse yet is that some members of Congress are very aware of this because they are sitting in Congress simply because Mr. Blankenship "donated them into office". I hope you are ashamed—you know who you are. I hope you never know the fear that a spouse feels when they watch their loved one leave the house to begin a shift in a mine. It paralyzes the soul and yet there is NOTHING any spouse can do but pray for their loved one's safety.

When April 5, 2010 exploded into my life (pun intended), I needed my husband to hold me while I shook uncontrollably, comfort me, to tell me things would be ok and to give me mental strength when I thought I would snap. But he couldn't do that because he was at that mine, dying on the inside and changing into a man who is tortured every single day he is alive.

I have watched an active, healthy outdoorsman disappear into himself and disconnect with the world and stop doing the things that made him happy. I've watched him stop caring about himself, stop caring about hunting and fishing, stop

caring about his kids, me, stop caring about his life. I do my best to comfort him when he awakes from nightmares or breaks down when he's assaulted by memories of that day.

Massey Energy killed the man I love on a level that most people don't understand. His body is here, but he is not the same man. He's changed simply because the poorly written script from above wasn't fiction for him. This was his reality every day and it killed his spirit.

I want to ask Congress why it is okay that conditions are allowed to be this way. Why can't Congress see it's not Democrat against Republican? Isn't it your job? Weren't you elected, in part, to protect Americans?

Stop looking to each other and pointing fingers to distract the public from the real situation that occurred at Upper Big Branch Mine April 5, 2010. Massey Energy ignored the laws. Mr. Blankenship flagrantly flaunted his power and did as he pleased to insure huge profits and put lives in danger for that profit.

It's time for our Congress, and that's everybody's Congress—we voted for you, to unite and regain your power to make stronger laws to protect miners who put their lives in danger every shift produce coal for the American economy.

Let's be honest, Massey imploded due to their own self-important leader, but Congress needs to take on the role of leaders again. You need to make the changes you were elected to make to keep AMERICANS safe. It's too late for my husband, it's too late for the 29 men who died April 5, 2010, it's too late for the countless family members who lost someone in the mines. But it's not too late for the men and women who are working now and it's not too late for future miners many of whom are our children.

My husband begged you to put aside partisanship to make changes when he spoke before Congress and I'm begging you now to follow through on the promises you made to the American people to work together for the safety of American workers, most particularly miners.

MINDI STEWART,
wife of UBB Survivor Stanley "Goose" Stewart.

MSHA News Release, Feb. 29, 2012

MSHA Announces Results of January Impact Inspections

ARLINGTON, VA—The U.S. Department of Labor's Mine Safety and Health Administration today announced that federal inspectors issued 253 citations, orders and safeguards during special impact inspections conducted at 12 coal mines and four metal/nonmetal mines last month. The coal mines were issued 171 citations, 15 orders and two safeguards, while the metal/nonmetal operations were issued 64 citations and one order.

These inspections, which began in force in April 2010 following the explosion at the Upper Big Branch Mine, involve mines that merit increased agency attention and enforcement due to their poor compliance history or particular compliance concerns, including high numbers of violations or closure orders; frequent hazard complaints or hotline calls; plan compliance issues; inadequate workplace examinations; a high number of accidents, injuries or illnesses; fatalities; and adverse conditions such as increased methane liberation, faulty roof conditions and inadequate ventilation.

As an example from last month, on Jan. 13, an impact inspection was conducted during the second shift at Perry County Coal Corp.'s E4-1 Mine in Perry County, Ky. The inspection team, which captured and monitored the phones to prevent advance notice of its arrival, issued 35 citations and three orders. The mine's last impact inspection, conducted in May 2011, had resulted in 27 citations and one order.

Following January's inspection, the mine was issued unwarrantable failure orders for noncompliance with the ventilation plan by failing to maintain a sufficient air volume at the end of the wing curtain when more than 18 inches of rock is being mined. (A wing curtain is a piece of flame-resistant brattice cloth used to direct air current to temporarily ventilate faces, seals or other areas of the mine.) This violation exposed miners to the risk of silicosis, black lung and a potential explosion. The mine operator also failed to control draw rock that extended from 32 crosscuts outby to the working face (approximately 2,080 feet), which exposed miners to the risk of being struck, injured or killed by pieces of falling roof. The mine operator further failed to maintain a scoop in permissible condition so that it was not a potential ignition source for explosive gasses as well as to conduct an adequate weekly examination of the same scoop.

Inspectors also found that the primary and secondary escapeways, along with required lifelines, were improperly maintained, which could severely hamper miners' efforts to evacuate the mine in the event of an emergency.

As a second example from last month, on the same day, MSHA conducted an impact inspection during the second shift at K and D Mining Inc.'s Mine No. 17 in Harlan County, Ky. The inspection team, which captured and monitored the mine phones, issued 21 citations and seven orders. The last impact inspection conducted at this mine had occurred in August 2010, resulting in 14 citations and six orders.

During January's visit, inspectors observed eight conditions that were the result of unwarrantable failures by the mine operator. Six involved failure to maintain the conveyer belts in safe operating condition and accumulation of combustible materials along the belt lines. Two belt lines were found to have missing or stuck rollers, causing friction and creating the potential for an ignition. Accumulations of combustible material were found along three belt lines, which are required to be examined at each shift.

Two 104(d) withdrawal orders were issued for the mine operator's failure to conduct an adequate exam of the section power center, which was found to be improperly maintained. Inspectors found evidence of severe arcing between receptacles on the power center, as well as on the male plugs of electrical equipment.

The mine operator also failed to comply with the roof control plan, according to inspectors. They observed a hill seam (rock fissure) that was tied in with several stress cracks. The hill seam and stress cracks extended across the pillar line for a distance of approximately 115 feet. The mine operator had not installed additional support as required by the roof control plan.

"While the impact inspection program has resulted in improved compliance in mines across the country, the seriousness of the violations found at these two operations demonstrates why targeted enforcement continues to be necessary to protect the health and safety of miners," said Joseph A. Main, assistant secretary of labor for mine safety and health.

Since April 2010, MSHA has conducted 403 impact inspections, which have resulted in a total of 7,162 citations, 718 orders and 26 safeguards.

Editor's note: A spreadsheet containing the results of impact inspections in January 2012 accompanies this news release.

U.S. Department of Labor News Release, March 28, 2012

MSHA: Advance Notification of Federal Mine Inspectors Still a Serious Problem

ARLINGTON, VA—Despite stepped-up enforcement efforts over the past two years by the U.S. Department of Labor's Mine Safety and Health Administration, some mine operators continue to tip off their employees when federal inspectors arrive to carry out an inspection. The Federal Mine Safety and Health Act of 1977 specifically prohibits providing advance notice of inspections conducted by MSHA.

There have been several recent instances in which MSHA has been able to detect the occurrence of advance notice. For example, on March 22, agency inspectors responded to a hazard complaint call about conditions at Gateway Eagle Coal Co. LLC's Sugar Maple Mine in Boone County, W.Va. A truck driver with J&N Trucking reportedly alerted mine personnel by citizens band radio of the inspectors' arrival. The inspection turned up 14 violations for advance notification, accumulations of combustible material, and inadequate preshift and on-shift examinations, as well as a failure to comply with the current ventilation plan, maintain the lifeline, maintain permissibility of mobile equipment and maintain fire fighting equipment.

As a second example, during a Feb. 29 inspection at Rhino Eastern LLC's Eagle No. 2 Mine in Wyoming County, W.Va., a dispatcher's decision to shut down the belts prompted a call from the section foreman about his actions. The dispatcher responded that an MSHA inspector was at the mine. During this inspection, three citations were issued for failure to comply with the roof control and ventilation plans. In addition, a citation was issued to Applachian Security, a contractor, for providing advance notification of the MSHA inspection. Rhino Eastern's Eagle No. 1 Mine was placed on potential pattern of violations status in November 2010 and again in August 2011 after a miner was killed in a rib collapse, and the mine's compliance record deteriorated.

A third example is from Feb. 13, when the dispatcher for Metinvest B V's Affinity Mine in Raleigh County, W.Va., notified the belt foreman over the mine telephone that federal and state inspectors were headed underground. The mine operator was issued a citation and, to abate it, MSHA required that all certified foremen and dispatchers be trained in the requirements of the Mine Act regarding advance notifica-

tion, and that a notice be conspicuously posted in the mine office to ensure future compliance with the Mine Act.

"Providing advance notice of an inspection is illegal," said Joseph A. Main, assistant secretary of labor for mine safety and health. "It can obscure actual mining conditions by giving mine employees the opportunity to alter working conditions, thereby inhibiting the effectiveness of MSHA inspections. Furthermore, it appears that current penalties are not sufficient to deter this type of conduct."

Upper Big Branch Mine superintendent Gary May recently entered into a plea agreement with the U.S. Department of Justice, admitting to conspiracy to give advance notification of mine inspections, falsify examination of record books and alter the mine's ventilation system before federal inspectors were able to inspect underground. May testified that, through these unlawful practices, the mine operator was able to avoid detection of violations by federal and state inspectors.

"Despite the attention to the issue that has resulted from the Upper Big Branch investigation and recent testimony from Gary May, advance notice continues to occur too often in the coalfields," said Main. "Upper Big Branch is a tragic reminder that operators and miners alike need to understand advance notice can prevent inspectors from finding hazards that can claim miners' lives."

[Questions submitted for the record and their responses follow:]

MAJORITY MEMBERS:

JOHN KLINE, MINNESOTA, Chairman

THOMAS E. PETRI, WISCONSIN
HOWARD P. "BUCK" McKEON, CALIFORNIA
JUDY BIGGERT, ILLINOIS
TODD RUSSELL PLATTS, PENNSYLVANIA
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VIRGINIA FOXX, NORTH CAROLINA
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MARTHA ROBY, ALABAMA
JOSEPH J. HECK, NEVADA
DENNIS A. ROSS, FLORIDA
MIKE KELLY, PENNSYLVANIA

COMMITTEE ON EDUCATION
AND THE WORKFORCE
U.S. HOUSE OF REPRESENTATIVES
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MARCIA L. FUDGE, OHIO

April 18, 2012

Cecil Edward Roberts, Jr.
President
United Mine Workers of America
18354 Quantico Gateway Drive
Suite 200
Triangle, VA 22172-1179

Dear Mr. Roberts:

Thank you for testifying at the Committee on Education and the Workforce's March 27, 2012 hearing on, "Learning from the Upper Big Branch Tragedy." I appreciate your participation.

Enclosed are additional questions submitted by Committee members following the hearing. Please provide written responses no later than May 1, 2012 for inclusion in the official hearing record. Responses should be sent to Ryan Kearney of the Committee staff who may be contacted at (202) 225-7101.

Thank you again for your contribution to the work of the Committee.

Sincerely,

John Kline

John Kline
Chairman

Questions from Ranking Member Miller:

1) Please provide your views on the recommendations made in the March 22, 2012, Independent Panel Assessment prepared by the NIOSH Ad Hoc Panel.

United Mine Workers of America

CECIL E. ROBERTS
INTERNATIONAL PRESIDENT

TELEPHONE
(703) 291 2420
FAX (703) 291 2451

UNITED MINE WORKERS' HEADQUARTERS
18354 QUANTICO GATEWAY DRIVE, SUITE 200
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April 30, 2012

John Kline, Chairman
Committee on Education and the Workforce
U.S. House of Representatives
2181 Rayburn House Office Building
Washington, DC 20515-6100

Dear Chairman. Kline,

By your letter dated April 18, 2012, you requested that I respond to a follow-up question from the March 27 hearing on "Learning from the Upper Big Branch Tragedy." In particular, you indicated that Ranking Member Miller asked that I respond to the following: Please provide your views on the recommendations made in the March 22, 2012, Independent Panel Assessment prepared by the NIOSH Ad Hoc Panel.

While we appreciate the government's efforts that have focused on rooting out the underlying problems that contributed to the Upper Big Branch disaster, the Report that the Independent Panel ("IP") issued on March 22 deviated in many ways from the Panel's assigned task. We believe that the IP's overreaching involved a number of misjudgments that served to diminish the usefulness of the IP's Report.

Before addressing the substantive problems of the IP's Report, I wish to note that the IP did not include any labor representative. This omission deprived the IP of a valuable voice and perspective that could have prevented its serious missteps. Labor has a tremendous amount of experience in the areas pertinent to MSHA's Internal Review, which was the assigned subject for review.

That the IP considered and commented on subjects that far exceeded what they were asked to do by Secretary Solis is beyond dispute. Indeed, when Dr. Jeffery Kohler testified during the March 27, 2012, hearing before the House of Representatives Committee on Education and the Workforce, he expressly admitted that the Report went beyond the scope of the Panel's charge. He also explained that some of suggestions contained within the IP Report do not really mean what they seem to say, which makes

the entire Report suspect. For example, Dr. Kohler indicated that despite the Report's recommendation (#4 on p. 13 of its Report) to reevaluate the current requirement that underground mines be inspected on a quarterly basis, his testimony clearly revealed that the Panel's intent was NOT to reduce the current statutory requirements for underground mine inspections.

Insofar as Dr. Kohler's testimony cast doubt about what was the intent of those portions of the IP Report he had the chance to address during the hearing, we are somewhat confused about all the Report's recommendations. Nevertheless, we will state unequivocally that the UMWA believes that the current statutory language that requires quarterly inspections for underground mines (as well as semi-annual inspections for surface operations) must be preserved. These inspections are essential to ensuring miners' health and safety; they should not be reduced in either frequency or scope.

Other areas where we disagree with the apparent recommendations of the IP Report include:

- Changing the enforcement paradigm, and appointing a panel to re-evaluate the Mine Act;
- Replacing technical rules with performance standards;
- Incentivizing mine operators to hire in-house specialists;
- Encouraging safety and health management systems;
- Placing the responsibility of data collecting on mine operators; and
- Suggesting that additional training or revisions to manuals and handbooks would not address the problems identified in MSHA's internal review.

These recommendations in the IP's Report do not constitute new ideas. Rather, they reiterate ideas that *some* in mine management have voiced for many years. They are ill advised and all interested parties have *not* embraced these ideas. They by no means represent the view of safety professionals throughout the industry. In fact, they would reverse mine safety advances we have witnessed since the 1969 Coal Act, the 1977 Mine Act, and the 2006 MINER Act.

Turning back the clock to the days when coal mine operators were left to their own devices is not the answer. History shows that operators have demonstrated time and again that they are unable to police themselves. To the extent that the IP Report recommended any more self-policing by operators, we vehemently oppose those suggestions.

Finally, we note that Dr. Kohler testified: "the assessment produced is not a NIOSH publication. The views expressed by the Panel members are their own professional views and not necessarily those of NIOSH, CDC, or HHS."

We appreciate having this opportunity to explain why we are convinced that the IP Report contains a number of suggestions that would diminish miners' health and safety, and thus should not be pursued. We look forward to working with you to pass legislation that will further improve miners' health and safety.

Sincerely yours,

Cecil E. Roberts

cc: The Honorable George Miller
The Honorable David B. McKinley
The Honorable Shelley Moore Captio
The Honorable Nick Rahall
The Honorable Joe Manchin
The Honorable Jay Rockefeller
The Honorable Tom Harkin

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April 18, 2012

The Honorable Joseph A. Main
Assistant Secretary
Mine Safety and Health Administration
United States Department of Labor
1100 Wilson Boulevard
Arlington, VA 22209-3939

Dear Assistant Secretary Main:

Thank you for testifying at the Committee on Education and the Workforce's March 27, 2012 hearing on, "Learning from the Upper Big Branch Tragedy." I appreciate your participation.

Enclosed are additional questions submitted by Committee members following the hearing. Please provide written responses no later than May 1, 2012 for inclusion in the official hearing record. Responses should be sent to Ryan Kearney of the Committee staff who may be contacted at (202) 225-7101.

Thank you again for your contribution to the work of the Committee.

Sincerely,

John Kline

John Kline
Chairman

Questions from Representative Noem:

1) Assistant Secretary Main, in October 2011 you stated that the Mine Safety and Health Administration (MSHA) was working with the Federal Railway Administration (FRA) on a Memorandum of Agreement (MOA) to clarify jurisdictional issues for operators when a railroad carrier enters mine property or has facilities and equipment on mine property. What is the status of this MOA?

Questions from Ranking Member Miller:

2) According to the MSHA Upper Big Branch (UBB) Internal Review, a lack of inspector experience allowed violations at the mine to go undetected. You testified that more than half of MSHA's inspectors were hired after 2006, and due to the lack of staff, MSHA District 4 (which covers southern West Virginia) employed only 2 ventilation specialists at times during the 18 month period prior to the UBB explosion. The average experience level for enforcement personnel dropped from 12 years to only 5 years between FY 2005 and FY 2010. In light of MSHA's findings in the Internal Review and the consequences of an experience gap, please address each of the following:

   A. Please provide the number of mine inspectors, supervisors and technical specialists MSHA estimates will be eligible to retire during FY 2013 and FY 2014.
   B. What steps is MSHA taking in succession planning, including with respect to identifying future resource requirements, to ensure that the agency does not have a shortage of trained enforcement personnel and technical specialists as its more experienced and older personnel retire? When will MSHA's succession plan be completed?
   C. Do personnel rules allow MSHA mine inspectors to earn more than MSHA technical specialists (such as engineers), because unlike technical specialists mine inspectors are able to earn overtime pay and engineers do not? What can MSHA do to more effectively to compete with private industry which can lure and hire away from MSHA experienced ventilation and roof control engineers because they can offer more pay and better benefits? What retention tools are available to MSHA? Are there gaps in the tools MSHA needs to solve this problem?

3) Between 2006 and 2010, contested citations in District 4 rose from 339 to 19,618, according to the Internal Review. Because the District 4 office was understaffed, it was unable to manage this increased paper flow, and filing deadlines were sometimes missed. Missed MSHA deadlines led to additional litigation. In light of the Internal Review's findings and concerns about the staffing level of MSHA's District 4 operations, please address each of the following:

   A) Are Districts 4 and the newly created District 12 staffed adequately at this time to manage the flow of enforcement-related paperwork and meet filing deadlines? If not, what additional resources are needed?

   B) Do any other MSHA Districts have staff shortages that impair their ability to manage the flow of enforcement-related paperwork and meet filing deadlines? If so, which Districts are impacted?

4) Does the Robert C. Byrd Mine Safety Protection Act of 2011 (HR 1579) meet MSHA's stated need for additional enforcement authority and tools to help prevent mine disasters such as the Upper Big Branch tragedy? If not, what additional tools are needed?

Assistant Secretary Main's Response to Questions Submitted for the Record

QUESTION FROM REPRESENTATIVE NOEM

1. Assistant Secretary Main, in October 2011 you stated that the Mine Safety and Health Administration (MSHA) was working with the Federal Railway Administra-

tion (FRA) on a Memorandum of Agreement (MOA) to clarify jurisdictional issues for operators when a railroad carrier enters mine property or has facilities and equipment on mine property. What is the status of the MOA?

Mr. Main: MSHA expects to execute an MOA with the FRA over the next couple of months. We know that an agreement between the two agencies is of great interest to many members of Congress; please be assured that MSHA is working diligently with the FRA to finalize an MOA that properly reflects the jurisdictional authority of each agency, as defined by our respective governing statutes.

QUESTIONS FROM RANKING MEMBER MILLER

2. According to the MSHA Upper Big Branch (UBB) Internal Review, a lack of inspector experience allowed violations at the mine to go undetected. You testified that more than half of MSHA's inspectors were hired after 2006, and due to the lack of staff, MSHA District 4 (which covers southern West Virginia) employed only 2 ventilation specialists at times during the 18 month period prior to the UBB explosion. The average experience level for enforcement personnel dropped from 12 years to only 5 years between FY 2005 and FY 2010. In light of MSHA's findings in the Internal Review and the consequences of an experience gap, please address each of the following:

A. Please provide the number of mine inspectors, supervisors and technical specialists MSHA estimates will be eligible to retire during FY 2013 and FY 2014.

Mr. Main: In FY 2013, 350 Coal and Metal Non Metal inspectors, 51 engineers (technical specialists) and 146 supervisors will be eligible for retirement. Our estimates for FY2014—432 Coal and Metal Non Metal inspectors, 62 engineers and 166 supervisors—include the FY 2013 numbers. However, based on historical attrition data, MSHA expects that only about 20 percent of the employees who are eligible to retire actually retire in the year they become eligible.

B. What steps is MSHA taking in succession planning, including with respect to identifying future resource requirements, to ensure that the agency does not have a shortage of trained enforcement personnel and technical specialists as its more experienced and older personnel retire. When will MSHA's succession plan be completed?

Mr. Main: MSHA has been engaged in planning for the Agency's future for a number of months. This planning has included a consideration of the UBB Internal Review Report's findings on MSHA's staffing deficiencies. The draft FY 2012-2016 Succession Management Plan goes beyond a succession planning approach that focuses on simply replacing individuals, and instead engages in broad, integrated succession planning and management efforts that focus on strengthening both current and future organizational capacity. The draft plan uses a systematic approach to filling our mission-critical occupations and key leadership positions over the next several years.

The plan includes a detailed workforce analysis to project levels of attrition in our enforcement programs looking out five years. In addition, in order to find gaps in our workforce, managers in each program identified trends likely to affect their programs' delivery of services, and we reviewed data describing the competencies that our workforce needs to address. The draft plan is in the final stages of review and we anticipate a summer 2012 completion.

C. Do personnel rules allow MSHA mine inspectors to earn more than MSHA technical specialists (such as engineers), because unlike technical specialist mine inspectors are able to earn overtime pay and engineers do not? What can MSHA do to more effectively compete with private industry which can lure and hire away from MSHA experienced ventilation and roof control engineers because they can afford more pay and better benefits. What retention tools are available to MSHA? Are there gaps in these tools MSHA needs to solve this problem?

Mr. Main: Mine Inspectors are generally entitled to standard overtime compensation under the Fair Labor Standards Act, while engineers generally are not. The U.S. Office of Personnel Management (OPM) administers the provisions of the Fair Labor Standards Act with respect to Federal employees. A non-exempt determination for engineers therefore may require coordination with OPM. We are in discussions within the Department of Labor to determine our options for a possible non-exempt determination for specific engineering positions within MSHA.

MSHA is expanding its recruitment efforts at various universities and colleges, including engineering schools, to attract potential candidates. This collaborative effort between MSHA's Human Resources Department, Office of Diversity and Equal Opportunity, and program areas will enhance the ability to attract and retain a diverse and highly qualified pool of candidates to fill mission-critical occupations. In the past, MSHA has not taken full advantage of the recruitment and retention tools

at its disposal. However, MSHA is now increasing its utilization of recruitment and retention incentives—such as relocation incentives and recruitment and location bonuses—that Congress provided to enable the Federal agencies to address exceptional needs to recruit, retain, and relocate essential employees for critical positions. MSHA also has the ability to offer students loan repayments and intends to use this tool in our efforts to recruit those still in school.

3. Between 2006 and 2010, contested citations in District 4 rose from 339 to 19,618, according to the Internal Review. Because the District 4 office was understaffed, it was unable to manage this increased paper flow, and filing deadlines were sometimes missed. Missed MSHA deadlines led to additional litigation. In light of the Internal Review's findings and concerns about the staffing level of MSHA's District 4 operations, please address each of the following:

A. Are District 4 and the newly created District 12 staffed adequately at this time to manage the flow of enforcement-related paperwork and meet filing deadlines? If not, what additional resources are needed?

Mr. Main: The UBB disaster underscored the need to address the growing backlog of contested cases at the Federal Mine Safety and Health Review Commission (FMSHRC), especially those cases in District 4. I cannot overstate the importance of the continued funding that Congress is providing DOL to resolve this backlog.

MSHA has made a number of changes that are also helping in managing contested cases. In June, 2011, MSHA split District 4 into four separate districts. This has enabled us to divide the caseload among those districts and increase the size of our staff handling these cases. As of March 31, 2012, District 4 had four Conference Litigation Representatives (CLRs) and two clerks; District 12 had two CLRs and two clerks. There is currently an opening for another CLR in District 12. MSHA has already selected a candidate to take that position and is in the final stages of hiring that individual. Once this position is filled, MSHA will have twice as many CLRs in the Southern West Virginia area as it did in the months leading up to UBB.

In addition, MSHA has hired two full-time coordinators located in Headquarters to manage the Alternative Case Resolution (ACR) program in the Districts. The coordinators have been identifying districts with the greatest backlogs, allowing us to transfer a significant number of cases in these districts to the backlog project. In April and the first part of May, Districts 4 and 12 will have transferred 250 cases. Finally, Alpha Natural Resources has withdrawn its contest of over 4,416 violations (754 cases) involving legacy Massey companies pending in Districts 4 and 12, and paid over $15 million in assessed penalties (the full amount assessed). As a result of these actions, District 4 and District 12 have the current ability to manage the flow of enforcement-related paperwork and meet filing deadlines. Without the continuation of backlog funding from Congress, it is unlikely that District 4 and 12 would be able to manage their case load.

B. Do any other MSHA Districts have staff shortages that impair their ability to manage the flow of enforcement-related paperwork and meet filing deadlines? If so, which Districts are impacted?

Mr. Main: At their current staffing levels, and because they have also been able to transfer cases to the backlog project, the other MSHA districts are able at this time to manage the flow of enforcement-related paperwork and meet filing deadlines. Any reduction in funding or staffing levels would seriously compromise the Districts' ability to meet their deadlines. Continuing the funding provided through Congress is essential and allows MSHA to maintain proper staffing of CLRs and support staff to effectively address the contested cases.

4. Does the Robert C. Byrd Mine Safety Protection Act (H.R. 1579) meet MSHA's stated need for additional enforcement authority and tools to prevent mine disasters such as the Upper Big Branch tragedy? If not, what additional tools are needed?

Mr. Main: As I testified at the March 27, 2012 hearing, since the tragedy at UBB, MSHA has learned how to better use all of its available tools and strategies to fully enforce the Mine Act—including targeted enforcement, regulatory reforms and compliance assistance. Since April, 2010, MSHA has conducted over 420 impact inspections of mines that merit increased agency attention and enforcement due to their poor compliance history or particular compliance concerns. During many of these inspections, MSHA monitored the phones so that those underground cannot be notified to clean up hazards before MSHA inspectors have an opportunity to observe them. Sadly, we are finding that there are still operators who continue to flout the law and put miners at risk.

MSHA cannot be at every mine all the time, and as we have learned from various investigations into UBB, even when MSHA is present at a mine, a determined oper-

ator that intimidates miners and willfully engages in a pattern of subterfuge will be at least partially successful in hiding hazardous conditions and practices from MSHA, with potentially tragic results. We need to change the culture of safety in some parts of the mining industry, so that operators are as concerned about the safety of their miners when MSHA is not looking over their shoulders as when MSHA is there.

The Robert C. Byrd Mine Safety Protection Act contains provisions that address these gaps in MSHA's enforcement powers.

Upon request by members of Congress, including members of this Committee, we have provided and will continue to provide technical assistance for this and other mining legislation. It is imperative that Congress enact legislation that gives MSHA the additional tools it needs to improve the health and safety of all the nation's miners.

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April 18, 2012

Jeffery Kohler, Ph.D.
National Institute for Occupational Safety and Health
Associate Director for Mining and Construction
626 Cochrans Mill Road,
Pittsburgh, PA 15236

Dear Dr. Kohler:

Thank you for testifying at the Committee on Education and the Workforce's March 27, 2012 hearing on, "Learning from the Upper Big Branch Tragedy." I appreciate your participation.

Enclosed are additional questions submitted by Committee members following the hearing. Please provide written responses no later than May 1, 2012 for inclusion in the official hearing record. Responses should be sent to Ryan Kearney of the Committee staff who may be contacted at (202) 225-7101.

Thank you again for your contribution to the work of the Committee.

Sincerely,

John Kline

John Kline
Chairman

Questions from Ranking Member Miller:

1) The West Virginia Governor's Independent Investigation Panel report on the UBB mine tragedy issued a number of recommendations, one of which was to require the use of Coal Dust Explosion Meters (CDEM) to assess compliance with rock dusting requirements. Several mine operators have acquired CDEMs, and are now using these for compliance checks. Please provide NIOSH's views on the following:

   A. Do these meters provide real-time results that are sufficiently accurate?
   B. How much does a CDEM cost?
   C. Why has the coal mining industry been so slow to adopt the use of this technology?
   D. As a matter of MSHA policy, should mine operators be required to use the CDEM to provide real-time results?
   E. Has NIOSH field-tested meters? What are the results? Have they been published?
   F. What further refinements, if any, would be required before these meters will be sufficiently accurate and reliable so that they can be used by MSHA for enforcement purposes?

2) The March 22, 2012, Independent Panel Assessment of MSHA's Internal Review recommended that certain issues be researched to provide a better technical foundation for safety improvements, such as "inertization" of float coal dust.

   A. Please explain what is meant by "inertization" of float coal dust?
   B. Would mine research of this type require the use of a laboratory such as NIOSH's Lake Lynn Experimental Mine in Pennsylvania?
   B. The Lake Lynn Experimental Mine has been an important resource to the federal government and the mining industry for conducting research into issues such as the prevention of coal dust explosions. What is the status of this facility's lease and its renewal?
   C. What is the dollar amount of the government's investment in the Lake Lynn Experimental mine?
   D. If the lease is in jeopardy, is there another facility that NIOSH could use in the United States instead of the Lake Lynn facility? If there is no other ready facility, what is the cost of replacing Lake Lynn at another location?
   E. If the lease is in jeopardy, given that Congress has provided appropriations for acquisition and repair of the Lake Lynn Experimental Mine, what steps is the Centers for Disease Control taking to secure this facility before it would otherwise have to be dismantled, including consideration of any appropriate eminent domain measures?

3) While the Independent Panel Assessment notes MSHA inspectors' lack of experience, did the Panel explore why MSHA's staff had so little experience? Did Panel assess whether the Department's failure to request and Congress's failure to provide adequate resources to MSHA prior to a string of mine disasters in 2006 was a contributing factor to MSHA's staffing woes? If so, what did the Panel find?

4) The Independent Panel Assessment identifies MSHA's difficulty in retaining enough engineers to adequately review ventilation and roof control plans. As a solution, the Independent Panel Assessment recommends turning more responsibility for plan validation to the operators and to remove this responsibility from MSHA. The report states: "For

example, this would allow mine operators to certify they had used acceptable methods for devising mine plans, and relieve MSHA from having to actually review and approve each mine plan."

A. In your opinion, how well would this proposed solution have worked with the operator of the Upper Big Branch mine, which MSHA found had a poorly engineered ventilation plan which required repeated modifications? Would placing even greater responsibility with the UBB mine operator have assured a better mine ventilation plan?

B. Under the solution proposed by the Independent Panel on which you served, how would MSHA know if the mine operator submitted a mine plan with calculations that were in error (as was found with Massey's pillar support calculations), or that a mine plan is deficient despite the operator certifying it was properly engineered?

5) The Independent Panel Assessment also called for incentivizing mine operators to hire roof control and ventilation officers. What specific "incentives" does the panel have in mind? Isn't it already the responsibility of mine operators to develop valid plans? Could these incentives result in the mining industry drawing even more technical specialists away from MSHA?

[EDITOR'S NOTE: As of August 14, 2012, Dr. Kohler's response to questions submitted remains pending.]

[Whereupon, at 12:52 p.m., the committee was adjourned.]

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