STATEMENT OF

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BEFORE THE

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UNITED STATES HOUSE OF REPRESENTATIVES

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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 hiding 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 agency 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 functions 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.

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

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 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 first-hand 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 prosecution, 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.

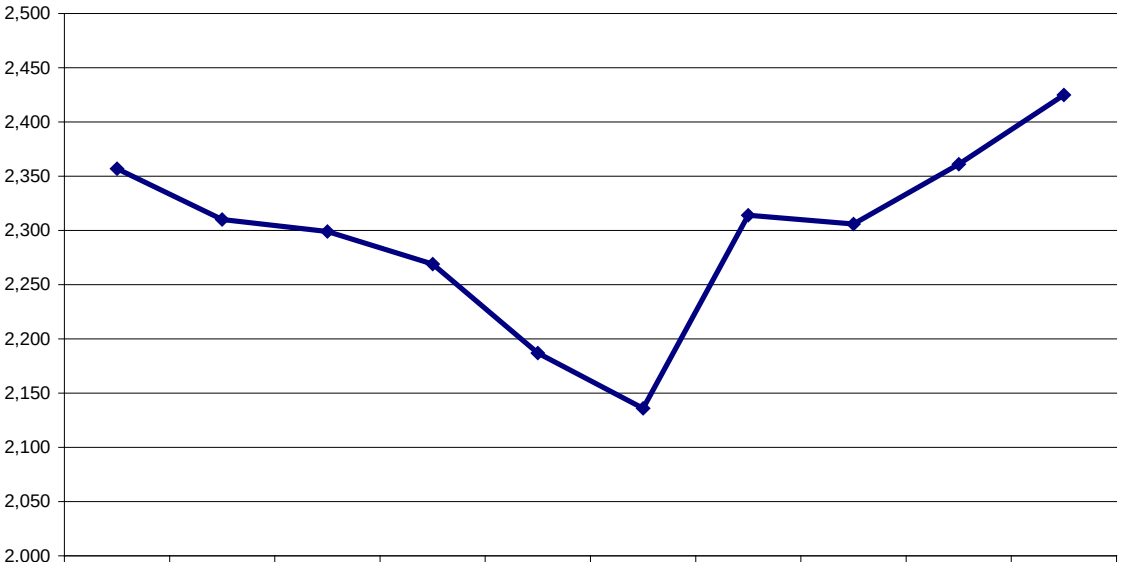
Conclusion

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.

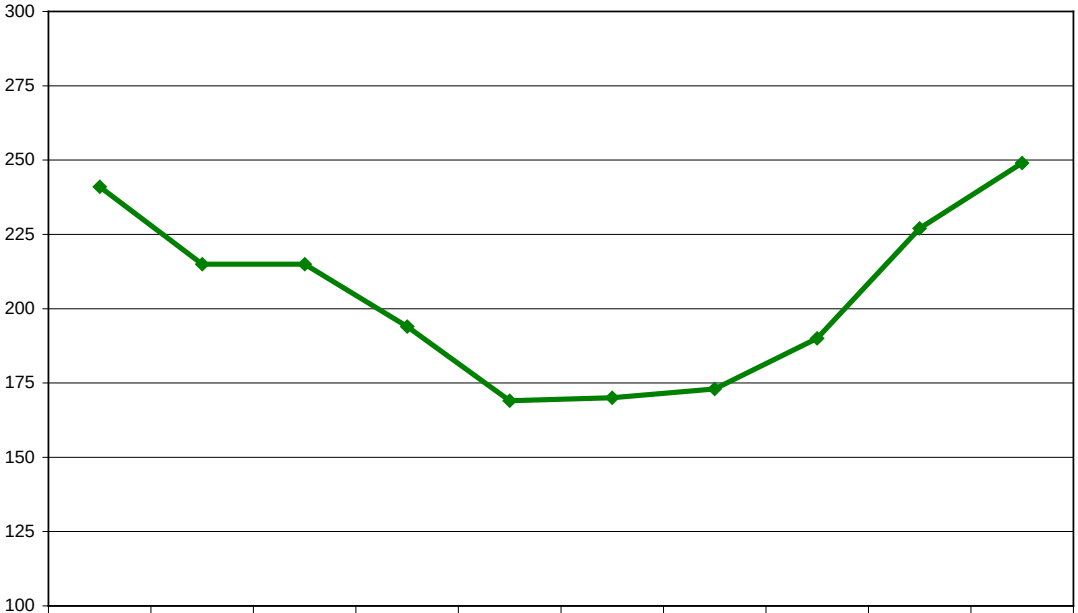
I look forward to working with the Committee to find the best way to accomplish our shared goals of preventing another mine disaster and providing our nation's miners the safety and health protections they deserve. We owe the victims of the Upper Big Branch disaster and their families no less.

Chart A - Mine Safety and Health Administration
Authorized FTE



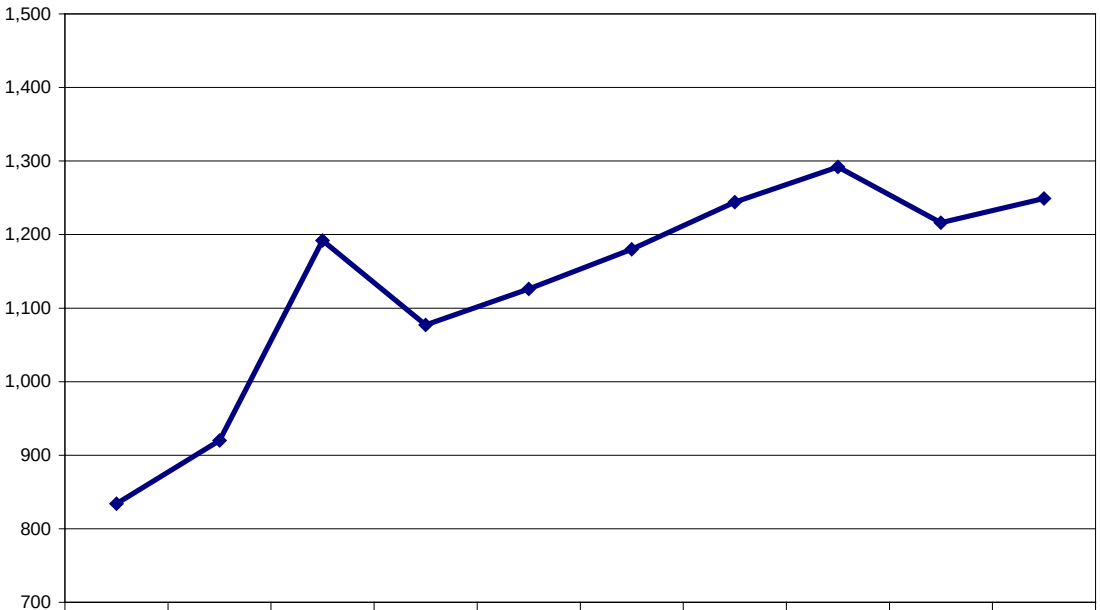
	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Authorized	2,357	2,310	2,299	2,269	2,187	2,136	2,314	2,306	2,361	2,425

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

Chart C - Coal Mines
Number of Mechanized Mining Units (MMUs)



	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Active MMUs	834	920	1,192	1,077	1,126	1,180	1,244	1,292	1,216	1,249