Mr. Chairman:

Thank you for this opportunity to appear before the Subcommittee to discuss the work of the Mine Safety and Health Administration (MSHA) and its performance at the January 2 Sago Mine explosion in Tallmansville, Upshur County, West Virginia. We have only preliminary information on the mine accident in Logan County, West Virginia, but I will be happy to share what we know thus far with the committee as well.

It is with the heaviest of hearts that every MSHA employee grieves for the miners who died at the Sago mine and the loved ones who mourn their passing.

MSHA’s reason for being is to ensure that miners return home safe and healthy to loved ones at the end of their shifts. That is our mission and our focus, every day. That is our duty to America’s miners and the reason we are conducting the investigation with the greatest care and diligence so we can uncover the full truth of why this tragedy happened and how we can better protect miners in the future.

Although MSHA has significantly stepped-up enforcement in recent years and dramatically reduced injury and fatality rates – mining fatalities dropped 33 percent and total injuries dropped 25 percent from Calendar Year (CY) 2000 to CY 2005 – the Sago mine tragedy must cause us to carefully assess MSHA’s performance, as the Subcommittee is doing today. From CY 2000 to CY 2005, the number of coal mine fatalities dropped 42 percent and the number of coal mine injuries dropped 22 percent, but that is cold comfort to the families of those who are killed, or to miners who suffer injuries. So we can never let up in improving mine safety, and we will not.

In addition to emphasizing increased enforcement of mine safety laws, MSHA has promoted prevention and worked with the mining community – operators, miners, state and local regulators, trade and labor organizations, manufacturers, suppliers and others – to make America’s mines the safest in the world. Collaboration on safety training, technical assistance, and education programs is essential and has been productive in helping miners, supervisors and employers adopt the safest and healthiest mining practices.

These efforts complement our strong enforcement regime and our enforcement results from CY 2000 to CY 2005 are substantial:

- Total Citations and Orders issued by MSHA at all mines increased by 6%, from 120,050 to 127,682;
- Total Citations and Orders issued by MSHA at coal mines increased by 18%, from 58,304 to 68,818; and
- Total “Significant and Substantial” Citations and Orders issued at coal mines increased by 11%, from 23,994 to 26,779.

While enforcement went up, the number of coal mines fell. There were 2,124 coal mines in 2000 and 1,982
in 2005 (through the third quarter).

MSHA enforcement personnel have also significantly increased the issuance of withdrawal orders that force coal mine operators who exhibit an unwarrantable failure to comply with the regulations to shut down areas or operations of the mine affected by the hazard. Unwarrantable failure orders are one of the most severe enforcement actions inspectors can take. And unwarrantable failure orders issued to coal mine operators are up 35% over the last five years compared to the previous five year period.

MSHA’s increased enforcement has also resulted in increased assessments – penalties imposed on mine operators for violating health and safety standards or the Mine Act. From CY2001 to 2005, the number of high-dollar final assessments imposed on all mine operators was 21 percent higher than during the period of 1996-2000. The total dollar value was up by 16 percent during this same period of time. This increase in high dollar assessments occurred while the total number of mines decreased by 8% between 2000 and 2005.

There is more enforcement, more assessments and more scrutiny of mine operators than ever before.

Under the Federal Mine Safety and Health Act, whether issued in a citation or an order of withdrawal, each violation is assessed a penalty (statutorily capped at $60,000) which must be assessed in accordance with the law’s six statutory criteria. The Administration believes that the statutory cap is too low to deter repeat and egregious violations of the Mine Safety and Health Act, and has urged the Congress to increase the statutory cap from $60,000 to $220,000. This would bring the Mine Act’s civil monetary penalties in line with those authorized by the Occupational Safety and Health Act. The Administration again encourages Congress to act on this proposal to aid MSHA in enforcing the Mine Act.

The statute itself provides for a graduated enforcement scheme that provides for increasingly severe sanctions for increasingly serious violations or an operator’s unwarrantable failure to comply with a mandatory standard. A chain of increasingly severe enforcement actions causing all persons, except those necessary to eliminate the condition, to be withdrawn from that area until the condition is abated, serves as an incentive for operator compliance and is the statute’s most powerful instrument for enforcing mine safety.

In every link of the chain, a withdrawal order is limited by statute to the area of the mine affected by the violation or unsafe condition. In some instances, the area affected could be the entire mine, or the area affected could be so critical or integral to the operation of the mine that its closure effectively shuts down the mine (for example, when the area affected includes the hoist used to move personnel and material in and out of the mine, or a blocked escape way). However, as soon as the operator corrects the cited condition and an MSHA inspector terminates the order, the operator is free to re-enter and resume mining work in that area. At the end of the graduated chain of enforcement, even a relatively minor violation can trigger a withdrawal order. A series of severe withdrawal orders affecting critical areas of the mine can inflict a severe economic penalty on the operator and could even lead to an operator ceasing operations. However, the statute does not allow preemptive permanent closure of a mine that has abated all violations.

MSHA enforcement personnel were vigilant in dealing with Anker Mining, the operator of Sago mine until May of 2005 and International Coal Group (ICG), the successor mine operator. As incidents increased at the mine in 2005, so did the issuance of MSHA citations and increasingly severe withdrawal orders, in accordance with the Mine Act. The enforcement hours spent at the mine in 2005 demonstrate the increased attention the mining operation received: MSHA spent 744 on-site inspection hours in 2005 at the Sago mine, up by 84% over the 405 hours spent during calendar year 2004. MSHA inspectors were at the Sago Mine on 93 different days in 2005, and often more than one inspector was at the mine. Inspectors issued 208 citations, orders, and safeguards in 2005, including withdrawal orders that shut down areas of the mine on 18 occasions. In addition, between April 27, 2005 and December 15, 2005, MSHA managers and supervisors met with ICG officials approximately 21 times.
MSHA was ramping up enforcement activity at this mine by issuing these citations and insisting that the cited hazards be promptly corrected. Each one of those citations represented a hazard that was required to be eliminated within a fixed abatement time specified by the inspector – and the inspector followed up to ensure the hazards were indeed fixed. That meant extra inspector time in the mine, and inspector time talking with mine operators, management and supervisors to ensure that those hazards were indeed corrected. Sago Mine management also received substantial engineering consulting services from MSHA’s Office of Technical Support on major issues at the mine including water removal, roof control, dust control and other problems. We were beginning to see positive results as the all-injury incidence rate at this mine dropped from 55.8 in the 2nd Quarter to 8.3 in the 3rd Quarter.

While there were many problems at the Sago Mine, liberation of large quantities of methane had not been among them. Methane is explosive between 5-15%. At one percent, MSHA requires operators to take action. At the Sago Mine, the highest readings never exceeded two-tenths of one percent, which is 1/25th of the explosive level. MSHA’s routine monitoring of methane in the mine never warranted a citation for excess accumulations of methane gas.

At this time, we have no information that would suggest that the explosion was related to a recurrence of any of the conditions that were required to be abated before the explosion. We will, of course, aggressively pursue these and all other potential causes in our joint accident investigation.

Until the joint investigation team can safely enter the mine to thoroughly examine the site, we will not know the answers to these questions.

It is a sense of duty, fellowship and a strong measure of heroism that mine rescue teams took with them into the Sago Mine in the quest to save their colleagues. Thirteen teams comprised of 109 dedicated team members participated in the rescue and recovery operation, putting their lives on the line for their fellow miners. Their bravery and dedication are emblematic of the 314 mine rescue teams around the country. It is noteworthy that the vast majority of rescue team members are volunteers --- good Samaritans in the highest American tradition. It is extraordinarily courageous and generous to take on the responsibility of such perilous rescue missions, knowing that heartache may mark the end of the day. We cannot thank them enough for their help and their sacrifice.

Some observers have raised concern that the Sago explosion occurred at 6:30 a.m. and the first rescue team did not enter the mine until 5:25 p.m. The delay was out of concern for these rescuers’ lives. MSHA and the mining community have a history of hard-learned lessons on the peril of rushing into mine accident scenes.

Those lessons were at the cost of the lives of rescuers who went into mines too quickly and died in rescue attempts. As recently as 2001, 12 miners in Alabama attempted to rescue a miner gravely injured after an explosion. Those miners were killed by a secondary explosion. In 1976, 26 miners lost their lives in mine explosions in Overfork, Kentucky. Fifteen miners were killed in the first explosion and 11 miners died in a second explosion, including 3 Federal coal mine inspectors.

At 5:25 p.m. at the Sago Mine, the carbon monoxide and methane readings finally started trending downward to a level where MSHA, West Virginia’s state mine regulators and the Robinson Run No. 95 rescue team felt we could take a carefully managed and calculated risk allowing rescue teams to enter the mine.

Mr. Chairman, we at MSHA are determined to find out how this tragedy occurred. While I cannot comment on substantive aspects of the accident investigation, I can promise you that it will be thorough and meticulous. The investigation will examine the circumstances of the accident, the circumstances of the rescue efforts, and every other germane piece of information. All of the data and information collected will be carefully scrutinized and analyzed, and a thorough report prepared and made available to the public. We
will finish this investigation as soon as possible, consistent with the need for accuracy, and we will promptly take any action indicated by the investigation’s results to improve safety and health in America’s mines.

As standard operating procedure, MSHA also conducts an internal review after every major accident. We will carefully examine whether MSHA followed its own policies and procedures with respect to the accident, including the enforcement activities preceding the accident. This report will be provided to the committee and made public on our web site. We view this internal review process as an opportunity to take a hard and honest look at how we do our job and use that information to improve our performance on behalf of America’s miners.

Miner health and safety is our bottom line and our only priority.

Thank you.