United Mine Workers of America

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June 19, 2009

Mr. Timothy Rehak
Center for Disease Control
P.O. Box 18070
626 Cochrans Mill Road
Pittsburgh, PA 15236

Dear Mr. Rehak:

As indicated in the comments submitted today by the United Mine Workers of America on RIN:0920-AA10; Approval Test and Standards for Closed-Circuit Escape Respirators, we are sending copies of the attachments referenced in our comments under separate cover by mail. The documents were too large to be transmitted electronically via e-mail. Please include these attachments as part of the record with our comments submitted by e-mail on June 19, 2009 on this proposed rule.

I thank you in advance for your cooperation in this matter.

Sincerely,

Dennis O'Dell

Dennis O'Dell, Administrator
Department of Occupational
Health and Safety

Comments of the United Mine Workers of America
On the Notice of Proposed Rulemaking:
Approved Tests and Standards for Closed-Circuit Escape Respirators
73 FR 75027-45, (December 10, 2008)

ATTACHMENTS

The following documents were referenced throughout comments of the United Mine Workers of America:

(1) An Act Federal Mine Safety and Health Act of 1977; Public Law 91-173 as amended by Public Law 95-164 and Mine Improvement and New Emergency Response Act of 2006 (MINER Act) ; Public Law 109-236 (S2803)

(2) The United Mine Workers of America, AFL-CIO/CLC Report on the Sago Mine Disaster of January 2, 2006.

(3) United Mine Workers of America Testimony of Cecil Roberts before the U.S. Senate Appropriations Subcommittee on Labor, Health and Human Services, Education and Related Agencies; Wednesday, February 28, 2007 Hearing Room 124 Dirksen Senate Office Building Washington, DC.

(4) Cecil E. Roberts, International President United Mine Workers of America Testimony before the United States House of Representatives Committee on Education and Labor Wednesday, March 28, 2007 Rayburn House Office Building Room 2175 Washington, DC.

(5) Cecil E. Roberts, President United Mine Workers of America, International Union Testimony before the U.S. Senate Committee on Appropriations Subcommittee on Labor, Health and Human Services, Education and Related Agencies; Wednesday, September 5, 2007 Hearing Room SD-124 Dirksen Senate Office Building, Washington, DC.

(6) Comments of the United Mine Workers of America regarding the Emergency Mine Evacuation Emergency Temporary Standard published in the Federal Register Volume 71, Number 46 on March 9, 2006.

Cecil E. Roberts, President
United Mine Workers of America, International Union
Testimony before the
U.S. Senate Committee on Appropriations
Subcommittee on
Labor, Health and Human Services, Education and Related Agencies

Wednesday, September 5, 2007
Hearing Room SD-124
Dirksen Senate Office Building
Washington, D.C.

Chairman Harkin, Ranking Member Spector, Members of this Subcommittee, as President of the largest Union that represents coal miners, I am honored that you have asked me to offer testimony regarding the August 6, 2007 disaster at Crandall Canyon Mine in Huntington, Utah, and how to prevent future tragedies. It is with a heavy heart that I appear before you to discuss – yet again, and in far too short a span of time – the deaths of mine workers. Our hearts and prayers remain with the families of the six miners who remain trapped in the Crandall Canyon mine.

I also wish to express my deep appreciation to everyone who participated in the rescue efforts. During these most trying of times, many brave miners demonstrated extraordinary courage by contributing to the rescue efforts. Unfortunately, three more miners paid the ultimate price as a result of their bravery. We cannot thank them enough, and we will keep their families in our thoughts and prayers, too.

Mr. Chairman, on February 28 of this year I appeared before this Subcommittee. At that time you asked me about what impact the MINER Act of 2006 had already had on the lives of miners in this country. (See attached testimony.) My response in February was that conditions were not much different from last year, and that miners facing a mine fire or explosion or other accident would face most of the same challenges that miners at Sago, Aracoma and Darby faced over one year ago. I am so sorry to say that the Crandall Canyon disaster has proved this to be true.

Just since the Sago explosion, 64 American coal miners have died on the job, and that number does not include the six miners still trapped in Utah. This Committee 's inquiry into the Crandall Canyon Mine Disaster is terribly important to ensuring that miners' health and safety are protected, so that we do not have to confront more needless death and injury.

My most important message to you today is that the Crandall Canyon disaster began on June 3, 2007, not August 6, 2007, because June 3 is the date when the mine operator submitted to MSHA a plan to engage in retreat mining at the Crandall Canyon Mine.

Likewise, MSHA's best chance for saving the miners was on June 15, not August 6th or 7th. But when MSHA approved the Crandall Canyon mining plan on June 15, that chance was lost.

Make no mistake about it, this disaster was not an act of God, but an act of man. It was preventable.

Experiences at Crandall Canyon

All the factors that lead to the recent disaster at Crandall Canyon may not yet be evident. However, it is apparent that the conditions were man-made. The disaster at Crandall Canyon was the result of decisions made by mine management, and plans approved by MSHA. Contrary to what some may say, there is little doubt that this was a man-made disaster.

It was because of *concerns for worker safety*, the prior operator of Crandall Canyon decided not to engage in the type of mining that Mr. Murray's company was engaged in before disaster struck. MSHA should have been aware of those concerns, as it should have known about the "bump" that occurred a few months prior, which motivated the operator to abandon mining a nearby section.

At the time Mr. Murray purchased the Crandall Canyon Mine the previous owner had partially or completely extracted over 30 coal panels using the longwall mining technique. In essence the only coal remaining in the mine was in the barriers and pillars necessary to support the roof of the Mine's main entries. Because extensive longwall mining had been done on both sides of the main entries there can be no doubt that the mountain over the mine was exerting extreme pressure on the remaining coal, which was supporting the mine roof. Murray Energy was extracting that very coal, using the pillar extraction method, at the time of the catastrophic collapse.

The prior operator, Andalex Resources, filed a document with the Utah Division of Oil, Gas and Mining in which it stated, "Although maximum recovery is a design criteria, other considerations must be looked at in the final analysis in the extraction of coal. These factors consider the insurance of protection of personnel and the environment. Solid coal barriers will be left to protect the main entries from mined out panels and to guarantee stability of the main entries for the life of the mine."

Despite this assessment, Murray Energy submitted the plan to MSHA for approval to mine all the remaining coal reserves including the barrier pillars. The Agency took just seven business days to approve the request.

It is also unfortunate that the management team at this operation has spent so much energy trying to deflect blame in this tragedy. It is equally unfortunate that MSHA, yet again, ignored the will of Congress in its reaction to this disaster.

Section 7 of the MINER Act states that MSHA "shall serve as the primary communicator with the operator, miners' families, the press and the public." Nevertheless, in Utah MSHA surrendered its role as chief communicator. As a result, a great deal of inaccurate and misleading statements and information was allowed to get out over the airwaves. The effect has been that millions of Americans were given incorrect and misleading information right from the start of this disaster, and MSHA allowed it to happen. Here are some examples:

1) From the very beginning, Murray Energy's Owner and Chief Operating Officer, Robert Murray, asserted that "an act of God" in the form of a natural earthquake caused this catastrophe. He suggested that the "seismic activity" at the mine is uncontrollable and unrelated to his company's activity. However, from tapes made of calls to the local Sheriff's office that same morning, it is apparent that from the time it occurred, University of Utah seismologists believed the activity was the result of coal mining.

2) Time and time again Mr. Murray emphatically stated that he knew exactly where the trapped miners were. Yet many weeks and many boreholes later he still has not been able to locate the miners.

3) Mr. Murray also strenuously objected to reports that miners were performing a final method of mining referred to by the media as "retreat mining." Again, he was not giving true information: from the approved mining plan it is evident that this mine was in the process of "pulling pillars." It is important to note this distinction: There has been a great deal of reporting about Crandall Canyon performing "retreat mining." The term retreat mining has different meanings to different people. In fact, this operation was performing a method of mining known in the industry as "pillar mining" or "pillar extraction."

4) Mr. Murray claimed that the mine was perfectly safe when he invited non-essential personnel from the media and families to tour the underground rescue work. However, not only did they experience a "bump" while they were underground, but it was in the same vicinity where nine rescuers were injured and killed just days later.

5) Mr. Murray stated that he had not had any major accidents at any of his mines prior to this. The truth is that four miners have been killed at Mr. Murray's mines. Any time a miner is killed, that constitutes a major accident.

6) Mr. Murray continually said that the UMWA was trying to organize the Crandall Canyon mine, and that somehow meant that nothing we had to say about this incident could be trusted. While we strongly believe that all miners should have the benefits of a union contract–not the least of which is the enhanced safety language written into our contracts–we were not engaged in an organizing campaign at that mine at the time of the incident there, nor had there been any organizing activity at that mine for years.

7) Mr. Murray also claimed that the UMWA was responsible for the stories about the company intending to reopen a part of the mine to production, when in fact it was his own Murray Energy Vice President who made those statements to reporters.

These are but some examples of the inaccurate and misleading statements Mr. Murray made that met with no contradiction from MSHA–statements that were seen by many as having an "official" stamp of approval since in most cases they were made with MSHA officials looking on, making no attempt to correct him.

What is so astounding about the press conferences at Crandall Canyon is that the conduct of Mr. Murray, and MSHA's indulgence of him, were directly contrary to Section 7 of the MINER Act, which Congress expressly added to prevent the kind of misinformation debacle that occurred at the Sago mine. There, the families were first told their loved ones were alive and were leaving the mine, whereas the reality was that only one of the thirteen survived; it was hours before the misinformation was corrected.

Regardless of whether Mr. Murray may have wanted to convene and conduct press conferences, there is no reason, requirement or benefit to the miners, their families or the public for MSHA to participate in the events he, as the private operator, staged. As the federal Agency affirmatively charged with communicating with the families and press, MSHA should have exercised its power and conducted independent press conferences to provide objective reports of developments at the disaster site. Instead MSHA representatives yielded their authority; at best they stood in the shadows as the coal operator spun his story, at worst they

cowered out of view refusing to correct the half truths and misstatements. Further, it has been widely reported that Mr. Murray's attitude was abrasive and demeaning to these grieving individuals. MSHA's responsibility to serve as the liaison should have protected the families from him.

Has the MINER Act changed the post-accident situation?

Miners working today do not have many of the health and safety benefits that Congress demanded through the MINER Act in 2006. The additional oxygen devices you insisted be available to underground miners are still on back order, effective wireless communication or tracking devices have not been installed, and MSHA has approved Emergency Response Plans (ERPs) that do not require operators to provide the safety and health protections Congress expected.

For example, in most instances tracking of miners is still being done today the same way it was done before the Sago disaster: operators rely on their dispatcher, and only know in which "zone" a miner is assigned to work. As we all know from Crandall Canyon, despite assurances that the operator knew exactly where the trapped miners could be found, without reliable tracking devices, rescue efforts are delayed and mis-directed.

As Crandall Canyon has revealed, miners caught underground have little better chance of survival than did the miners at Sago, Aracoma and Darby in 2006 – or even those who perished in the disaster at Farmington in 1968. Although we have advanced the calender some 40 years since the Farmington disaster, in many instances miners are caught in a time warp, still trying to adapt the health and safety technology of the 1960's into today's mining environment. For example, Congress directed MSHA to consider safety chambers in the 1969 Mine Act, but they still remain largely absent from our mines. Moreover, the regulation MSHA implemented requires operators to provide supplies to build a barrier after an accident occurs. This was required before the MINER Act, though since the MINER Act operators now must provide breathable air and other requirements to sustain life. However, having supplies available for *construction* of a safe haven *after* an accident will often be too late: the post-accident atmosphere can be toxic and so smoky that miners cannot even see their own hands, and they may well be disoriented, making it impossible for miners to *then* construct a safe haven.

After the three high-profile disasters last year that claimed 19 lives, Congress passed the MINER Act. That historic legislation was the first miners' safety and health legislation in 30 years. It placed new requirements on mine owners and operators to improve miners' safety. Some, like directional lifelines, additional self-contained self-rescuers (SCSRs) and Emergency Response Plans (ERPs) were required immediately. Others, including advanced wireless communication and tracking devices were to be phased in over 3 years as they become available. We said then and still believe that the MINER Act represented a good "first step," but so much more is required.

As the MINER Act is being implemented, MSHA has been too tolerant of operator delay. While directional lifelines require no new technology, and could be immediately placed into use to guide miners out of a mine during an emergency, MSHA is allowing some operators to set their own time frames for meeting this requirement. As for the miners' need to have supplemental oxygen, though the MINER Act required operators to store additional supplies for miners' use if trapped, MSHA's regulation permits the supplies to be stored in a location that is too remote. Based on the existing regulation, if the Crandall Canyon miners survived the initial event, they would not have been able to access what oxygen *should* have been stored because it would have been too far away, on the other side of the collapsed area of the mine. Moreover,

though the MINER Act required operators to submit their ERPs by August 2006, the Crandall Canyon ERP was only approved in June, 2007 and the supplemental oxygen need only to have been in place 60 days later...*after* the miners were trapped on August 6. Why the operator was given 60 days to provide the oxygen is puzzling, as the oxygen canisters should be readily available and there was no good reason for the delay.

Some of the MINER Act requirements, including advanced wireless communication and tracking devices were to be phased in within 3 years, as they become available. However, rather than demanding that operators quickly utilize improved equipment and technology *as soon as* it becomes available, MSHA is allowing operators to wait out the clock until the 3-year deadline comes to a close.

You probably recall the stories last year of the Polish miner pulled from wreckage after he was located through use of a tracking device, and that of the Canadian miners trapped underground but safely retrieved from the safety chamber to which they had retreated. The Crandall Canyon miners did not have these advantages. However, if other countries' miners can survive and escape these disasters, then so should American miners. We need change, and we need it now.

We wish to note that some operators have gone beyond the minimum requirements to protect miners, but many more meet only MSHA's minimum standards. MSHA could and *should* be pushing operators to utilize the *best* available technology to better communicate with and track miners. We believe that was what Congress expected when it enacted the MINER Act last year. Crandall Canyon graphically demonstrates the consequences of operators' and MSHA's intervening complacency.

Cultural problems at the top of MSHA

The problems within MSHA begin at its highest levels. Indeed, there has developed at MSHA a culture of cooperation rather than enforcement. When then-Assistant Secretary of Labor for MSHA, David Lauriski, initiated a new "compliance assistance" plan, he sanctioned a different way of pursuing the Agency's mission. That new program chilled enforcement efforts at the mine level and allowed operators to essentially negotiate workplace health and safety matters.

The notion that MSHA should foster compliance assistance when its first priority is supposed to be miners' health and safety is preposterous. In MSHA's internal reviews of the three major disasters in 2006 it found plan reviews to be an area where better oversight is required. This lack of oversight and accountability played out to dire consequences at Crandall Canyon: the mine plan that was submitted should never have been submitted; and MSHA should not have approved it.

The UMWA argued strenuously against MSHA's policy of compliance assistance ever since its inception. Our objections to the culture of cooperation have been dismissed by the Agency's highest officials. It is no consolation to sit before this Committee and remind you of our continuing assertion that MSHA's effectiveness is compromised. The disasters at Sago, Aracoma, Darby – and now Crandall Canyon – represent the consequences of Agency misdirection and inaction.

Lessons learned from decade after decade of miners' injuries, illnesses and deaths teach that strict enforcement is needed to protect miners' health and safety. These facts were reinforced by MSHA's own internal reviews of the tragedies at Sago, Aracoma and Darby. In each instance, the Agency discovered significant problems of non-accountability and lack of oversight.

There is a culture at the highest levels of Agency that not only ignores the needs of miners, but the input and expertise of longtime MSHA field employees and specialists. MSHA's inspectors and specialists have years of practical experience, they work in the same conditions as do miners they seek to protect, they know the laws and regulations, and they strive to perform their jobs. However, to successfully protect miners' health and safety, inspectors must receive uniform direction and support from their superiors. If we are to achieve the health and safety improvements anticipated by the Mine Act and the MINER Act, there must first be a cultural change within the Mine Safety and Health Administration. I submit to you that the reality of this situation is stark. If we fail to force a cultural change at MSHA it will continue to decline and eventually implode. We cannot allow that to happen.

This Congress possesses the power to make vital changes to restore the direction of MSHA and ultimately offer miners the health and safety protections they deserve. Congress must require MSHA to focus first and foremost on the health and safety of miners. We urge this Congress to move swiftly to require immediate action on the mandates contained in the MINER Act and to be prepared to demand through appropriate legislative initiatives the *next* level of protections.

Families facing a mine disaster deserve better

Just last year Congress moved to ensure that families facing mining disasters would be treated with the dignity they deserve and would be kept abreast of the most accurate information available. This did not happen for the families of the trapped miners at Crandall Canyon. Like the Sago families in January of 2006, they were held almost as captives, awaiting any bits of information (or misinformation) delivered by the coal operator.

How is it possible that MSHA could get it so wrong in Utah? How could it ignore the mandates of Congress, which requires the Agency to take charge of such accidents and serve as the liaison with the families and press? By allowing this mine owner to take center stage, MSHA ignored the directives of the MINER Act. In so doing, it failed the families at Crandall Canyon. They deserved – and still deserve – much better. If the leadership of MSHA is not willing or able to limit the activity of a single mine operator in the face of express authority to take such control, how can we expect them to effectively lead the Agency that is charged with regulating an entire industry?

On behalf of their loved ones, the families of those trapped at Crandall Canyon asked the UMWA to serve as their miners' representative. This would ensure that their designated representative would be able to participate in the accident investigation. However, MSHA has rejected their request, claiming that it would have to first verify that the miners themselves made the designations. Obviously, a trapped miner cannot provide that assurance. Yet, in denying the families the right to make such a designation *for* their trapped miners, MSHA has prevented those most affected by the tragedy to have a voice at the table during the investigation.

MSHA's spokesperson has criticized the UMWA for attempting to serve as the trapped miners' designated representative, claiming that we "are trying to use a law enforcement investigation for its own purposes." We will confirm that the UMWA *does* want to participate in this matter. The reason is simple: we want honest and complete information about everything that happened -- from before the latest mining plan got prepared, submitted and approved. We want to make sure no more miners' lives are lost. The UMWA is the ONLY organization in this country that is dedicated to advocating for miners' health and safety. We are proud of advancements that have been made at our urging, and we don't plan to stop anytime soon.

So yes, the UMWA does have a purpose of our own here: to fight for and improve mine safety in America. We invite MSHA to join us in that endeavor, instead of casting veiled aspersions on our efforts on behalf of coal miners and their families.

To the extent that MSHA feels current law does not allow it to recognize the UMWA as a miners' representative absent proof that the miners themselves have made the designations – something the trapped miners obviously cannot satisfy – we urge Congress to change the law. Family members of those trapped or killed in a mine accident should have the right to designate a trusted representative to participate in the accident investigation.

Further, and as we have written to you, the UMWA feels that it is imperative that there be an *independent* investigation of this tragedy. (Letter attached.) Otherwise, MSHA and the operator will simply be investigating what they themselves did. That is not the best way to ask the hard questions or to get the full truth. Our goal must be to learn from what went wrong at Crandall Canyon so that no more families will suffer such needless loss of life.

Control of a mine post-accident

Since 1977 MSHA has had the right to control all activity at the mine when disasters occur. By issuing a Section 103(j) Order, MSHA could have secured this control. Yet, with but one exception at Scotia, MSHA chooses to utilize its authority under Section 103(k) which permits the operator greater latitude in directing a rescue operation.

Under a (k) order, the operator prepares plans and submits them to MSHA, which must approve each component before it can then be implemented. That is the procedure that must have transpired when, just days before the rescuers were killed and injured, the operator proposed and MSHA approved a plan that permitted non-essential personnel (that is, press and family members) to travel underground with Mr. Murray to observe the rescue.

We understand the curiosity of some within the media and the dire concern of family members, however the conditions at the mine were so unstable that some workers engaged in the rescue effort requested work away from the mining operation. There is no reasonable explanation for allowing non-essential personnel to be subjected to such dangerous conditions. They easily could have confused and hindered the rescue had the "bump" they did experience been larger in scale. While we thank God that there was only a minor mountain bump while these individuals were underground, we also recognize the situation could have become much more disastrous. They could have suffered the same tragic result that rescuers experienced when the large bump caused a cave-in, claiming the lives of three rescuers and injuring six others. Mr. Murray should not have submitted a plan to take guest travelers into the mine, and MSHA certainly should have known better than to permit it. That incident represented an extraordinary amount of poor judgment by both key parties to this rescue and recovery effort.

MSHA should have brought to the site at a much earlier date experts who could address the unique geological conditions to help develop a safe procedure for rescuing the trapped miners. We recommend that there be designated a variety of mine emergency response experts who could be immediately called upon to service mining emergencies like those at Crandall Canyon, Sago, Aracoma, and Quecreek Even now, we call upon Congress to consult with a variety of geological, engineering, and other experts, public and private, to determine if the trapped miners can be safely recovered. The families deserve to have their loved

ones back if that can be accomplished without sacrificing any more lives.

We also seek an independent investigative body to analyze the rescue process to report on how that procedure could have been improved. At the end of the day, the most important thing we can take away from such a tragic experience is to learn from the mistakes so they will not be repeated. Only an independent investigation can hope to uncover the needed truths.

Since the MINER Act was passed last year, we have heard a lot of operators complain about how much money they have to spend to comply with it. However, let me suggest that it is better to invest up front. Mining disasters are very costly - first and foremost in lost lives and the destruction of families. But accidents also consume huge amounts of time and energy on the part of the particular operator, not to mention federal and state governments, too: first the rescue and recovery efforts are expensive, and then the investigation takes another substantial commitment of capital. Wouldn't we all be so much better served if these resources would be dedicated to protecting miners from the problems in the first place? I am certain that was your intent when you enacted the MINER Act. Unfortunately, this goal has not yet been adequately realized.

Conclusion

How many times must we demand that MSHA's practices change only to be ignored? How many more times will mine owners and MSHA thumb their nose at your mandates? Something must be done to change the status quo. Leaders must be held accountable for their actions and inactions. Just as mine operators cannot self-regulate, MSHA cannot function without being subject to the routine scrutiny of Congress and appropriate sanctions when necessary.

The miners of this nation can no longer be asked to sacrifice their safety when their employers are focused on monetary profit with little regard to their employees' well being. It is time to place effective measures in place so that a miner may engage in his primary job of mining, without jeopardizing his life.

I thank you for this opportunity to share our on-going concerns about the state of miners' health and safety in this country. I urge you to do all that you can to ensure that the investigation of the Crandall Canyon disaster is full and independent and that the families of trapped miners get all the answers they want and deserve.

United Mine Workers of America
Testimony of Cecil Roberts
before the
U.S. Senate Appropriations Subcommittee on
Labor, Health and Human Services, Education and Related Agencies

Wednesday, February 28, 2007
Hearing Room 124
Dirksen Senate Office Building
Washington, D.C.

IMPROVING MINE SAFETY: ONE YEAR AFTER SAGO AND ALMA

Thank you for allowing me this opportunity to appear before your Committee. As President of the United Mine Workers of America ("UMWA"), I represent the union that, for 117 years, has been an unwavering advocate for miners' health and safety.

This entire Committee has played a significant role in advancing miners' health and safety. I would like to express my appreciation to the leadership of this Committee for your efforts to protect the health and safety of all miners. Your continued oversight is critical to ensuring miners will go home safely at the end of their shift.

One year ago I testified about miners' health and safety shortly after the Sago and Alma disasters; even after those two dramatic tragedies occurred, 32 more coal miners were killed in 2006.

Following the Sago and Alma disasters and after five more miners were killed on May 20, 2006 at the Darby Mine in Kentucky, Congress moved to enact the MINER Act. That law includes several important provisions aimed at helping miners *after* a mine emergency develops. It is most appropriate for you to consider whether the improvements Congress intended to accomplish through the MINER Act are being realized. The Union supports MSHA's efforts to require substantially more oxygen for every miner. The emergency mine evacuation rule also contains a number of important improvements. Having said that, my testimony will focus attention on areas that MSHA needs to dedicate additional resources to fully implement the MINER Act.

Some of the inadequacies in implementing the MINER Act may be linked to insufficient resources. However, others can be tracked to decisions made by the Agency. In 2001, then Assistant Secretary for Mine Health and Safety, David Lauriski told members of the National Mining Association that MSHA would, "collaborate more with mine operators on regulatory initiatives" and become "less confrontational with mine operators, in an effort to provide companies with better compliance assistance." At a meeting with mine operators in Hindman, Kentucky, he bragged about his diminutive regulatory agenda. He noted, "if you've seen it you noticed its quite a bit shorter than some past

agendas." These policy statements were accompanied by a withdrawal of many proposed regulations by MSHA and a noticeable shift to compliance assistance. These compliance assistance programs divert precious resources away from enforcement. Perhaps most tragically, in many cases, MSHA has ignored the mandate of Congress by adopting regulations and policies that place miners at greater risk.

Mine Inspectors / Mine Inspections

The Agency is experiencing great difficulty in fulfilling the mandatory inspections required under the Mine Act. The Union is convinced that the hiring and training of more MSHA inspectors must be a top and continuing priority. The Agency must have a full complement of properly trained personnel if it is to perform its primary job of enforcing the Mine Act. The ranks of the inspectors have been diminished over the years and we can expect further reductions as more of MSHA's long-time inspectors leave the profession as they reach retirement age. These needs can only be filled by hiring qualified individuals from all segments of the industry, including rank and file miners. These new inspectors must also be outfitted with state of the art equipment for personal protection and to perform their inspection duties. Sufficient monies must be allocated to ensure this equipment is readily available to these inspectors.

As the number of inspectors have decreased, MSHA's field office specialists, including ventilation specialists and its electrical and roof control support staff, have been forced to carry out routine mine inspections. These specialists must be returned to their areas of expertise. The only way to accomplish this is to hire an adequate number of inspectors which will permit the specialists to focus on the job they are trained to do. In addition, the Agency must move immediately to train a sufficient number of inspectors to perform these technical tasks in the future.

I would like to thank Senator Byrd and the other members of the Committee who worked to secure 25.6 million dollars to hire an additional 170 mine inspectors and your continuing efforts to secure future funding. Congress must ensure that funding levels at the Mine Academy in Beckley, WV remain sufficient to meet future training needs for mine inspectors. This facility is used to train mine inspectors and also offers comprehensive training for miners and other health and safety experts.

Seals

In 1969 and again in 1977 Congress mandated that "explosion proof seals or bulkheads" be used to isolate abandoned or worked out areas of the mine from active workings. However, in the years since, MSHA has promulgated regulations regarding seals that are much less protective than what Congress mandated. The current regulation simply requires that seals withstand static pressure of 20 pounds per square inch (psi) in order to be approved for installation in the mine. The standard was further eroded when MSHA approved the use of Omega Block type seals, such as those that were used at Sago. These Omega Block seals catastrophically failed as a result of the explosion at Sago and contributed to the deaths of all twelve miners.

The UMWA urges MSHA to promulgate a regulation that would require the construction of seals that meet the mandates of Congress and the recommendations in NIOSH's draft report on mine

seals.

Regulations

The UMWA believes that MSHA should adopt an aggressive regulatory agenda to address important issues in addition to those contained in the MINER Act, including:

1. Improved Atmospheric Monitoring Systems
2. Develop a Nationwide Emergency Communication System
3. Revise MSHA's Approval and Certification Process for Equipment Approval
4. Occupational Exposure to Coal Mine Dust (lowering exposure limits)
5. Collection of Civil Penalties (mandatory mine closures for non-payment)
6. Air Quality Chemical Substances and Respiratory Protection Standards (update personal exposure limits)
7. Surface Haulage (truck, haul road, train and loadout safety)
8. Respirable Crystalline Silica Standard (reducing quartz standard)
9. Requirements for Approval of Flame Resistant Conveyor Belts
10. Confined Spaces (tight quartered work areas)
11. Training and Retraining of Miners (revision of Part 48)
12. Surge and Storage Piles (dozer/feeder safety surface)
13. Escapeways and Refuges
14. Accident Investigation Hearing Procedures (make them public)
15. Verification of Surface Coal Mine Dust Control Plans
16. Continuous Monitoring of Respirable Coal Mine Dust in Underground Coal Mines
17. Modify Conferencing Process (Appeals of Citations)
18. Underground Coal Mining, Self-Contained Self-Rescuer Service Life Approval and Training.

Recording Fatal Accidents

Just last week MSHA issued new guidelines for determining what constitutes a mine related fatality. The "Fatal Injury Guideline Matrix" narrows the scope of what the Agency will define as a fatal accident chargeable to the mine operator. This will allow the Agency to report numbers that are artificially low and possibly skew the actual health and safety record of the mine and the industry. In addition, fatals not listed as mine-related will not get the same scrutiny as a chargeable accident. Without the formal investigation process, lessons learned will not be available to prevent similar events in the future.

The Union also disagrees with the Committee established by the Agency to review deaths where chargeability is in question. The Committee is made up of upper-level MSHA employees and not open to other agencies, organizations or the public. This type of structure does not lend itself to a fair, unbiased review of the situation.

Implementation of the MINER Act

In the MINER Act, Congress mandated timelines for its implementation. In some cases, MSHA has failed to meet these deadlines. The Union urges Congress to allocate adequate funding to MSHA so it can fully implement this Act within the timeframes set by Congress.

The *Emergency Mine Evacuation Rule*, which is separate from the MINER Act but ties into the self-contained self-rescuers (SCSRs) requirements, was finalized and made effective December 8, 2006. However, miners working underground today do not have all the protections that Rule addresses. MSHA deems the operator to be in compliance with the Rule if it has placed an order for additional SCSRs. Although the Rule requires increased availability and storage of SCSRs, there is a backlog of orders for these life-sustaining units. While the Union is extremely frustrated that more than a year after the Sago and Alma disasters, many miners only have one additional hour of oxygen, in light of this backlog, the Union supports MSHA's approach to make the additional oxygen units equally available to all miners. In reality, it will still take a number of years before miners receive the protections mandated by Congress. Miners cannot wait for another mine disaster to occur to drive new technology, therefore, the Union strongly urges the development and approval of the next generation SCSR.

The Rule also requires "expectations" training on SCSRs. This would allow miners to experience the actual effects of donning a unit and attempting an escape. The practice units would allow miners to experience the breathing restriction and heating that SCSRs create, without risking their safety. While MSHA claims these practice units are not available for purchase, they are in fact available. The reason these devices are not being used by miners today is not availability, it is cost. Many mine operators simply do not want to spend the money to buy them. This is unacceptable and while we commend MSHA for promulgating a rule that is intended to be "technology-driven," it must now enforce that rule.

Moreover, the finality of this emergency response and evacuation rule is somewhat uncertain as the National Mining Association (NMA) filed a court challenge. The Union is not certain which aspects of the rule NMA is contesting, but it is certain that such legal maneuvers delays the protections Congress mandated only last year.

Congress understood the importance of requiring that mine operators have comprehensive emergency response plans at all their operations. The MINER Act permitted operators a 60 day period to prepare these plans and submit them to the Agency for review and approval. However, many of the mine emergency response plans that operators submitted were grossly inadequate, and not worthy of approval. We are now over six months beyond the deadline established by Congress. While we commend MSHA for not approving these faulty plans, we do believe it must be more aggressive and apply more pressure on the operators to get these plans completed. Unless MSHA takes decisive action and resolves all the remaining issues, miners will not get the mine emergency response improvements that Congress intended.

Further, the mine emergency response plans are to be reviewed and re-approved by MSHA every six months. We are already six months beyond the original plan due date. If those first plans are

not yet approved and fully implemented, how can we expect MSHA to handle these semi-annual reviews? Perhaps MSHA needs more manpower to handle this task, but whatever the answer, until every operation has an approved plan in place, miners are not getting the protections Congress intended.

Very little has changed in the last year concerning the ability to communicate with and locate trapped miners. While we have learned more about this technology and understand that much is available, very few operators have taken advantage of it. Communication systems and tracking devices are areas that MSHA must pursue more aggressively. Current communication and tracking technology, including one-way text messaging and two-way wireless systems, some of which are available now, must be immediately installed in all mines. Any system that can increase the ability for miners to escape a mine emergency, even if it is limited in scope, must be utilized. The federal government, through NIOSH and MSHA, must fund and direct continued studies and research to develop the next generation of tracking and communication devices. As this newer technology becomes available, mine operators must be required to upgrade existing systems at all its operations.

We are also troubled by MSHA's failure to undertake action to facilitate the creation and training of additional mine rescue teams. Congress in the MINER Act clearly outlined its intent regarding the need for additional mine rescue teams. In addition, the language clearly defines how this is to be applied at both large and small mines. While Congress allowed MSHA 18 months in which to prepare, finalize, and give effect to rules that increase and enhance mine rescue team requirements, so far MSHA has not addressed this need. The need is real, and it is immediate. In the not-too-distant future MSHA will need additional funding to certify that mine rescue teams are qualified, as contemplated by the MINER Act.

Over the past 20 years MSHA and some operators have weakened the intent of the current regulations regarding mine rescue protections. The existing mine rescue team structure is spread too thin. It takes a lot of time and much practice for any mine rescue team to function well. The UMWA has training facilities and is willing to provide mine rescue training and first responder training if we receive the necessary funding. Miners cannot afford to wait any longer for the training of new teams to begin.

Collection of Civil Penalties

In the MINER Act, Congress charged MSHA with revising and enhancing its penalty structure. MSHA proposed a revised schedule, but it is not yet final, so it is difficult for us to comment about whether it will induce any better compliance by operators.

However, even without a new fine structure, the Agency needs to do a better job of tracking and collecting the fines it imposes, and it should escalate the pressure when an operator refuses to pay a final penalty. Last year MSHA blamed computer problems on its inability to track fines. We understand that it still faces some technological challenges. If that is the case, then MSHA needs to fix the problem. When fines go unpaid it not only gives an unfair competitive advantage to the delinquent operator, but that operator's disregard for the mine health and safety laws and regulations imposes

excessive risk on its employees.

To the extent that MSHA takes the position that it cannot close an operation for having substantial unpaid fines, we submit that Congress should grant the Agency such authority. MSHA's top personnel claim that if it had that authority the Agency would exercise it to close operators who refuse to pay their fines. We would welcome that.

MSHA Hotline

The Union has complained for some time that the current hotline system miners use to report hazardous conditions is ineffective. Recently, a member of the UMWA called the 800 number listed on MSHA's website to report a problem at the mine where he worked and was frustrated by problems he encountered. The individual who answered the call, a contract employee, did not have any knowledge of mining, making it extremely difficult for the miner to convey the message. Further, the individual at the call center was not remotely familiar with MSHA's District structure and was therefore uncertain which office should receive the complaint.

The Union has stressed on many occasions that the MSHA hotline should be staffed 24 hours a day, 7 days a week by MSHA personnel with an understanding
of the mining industry and the Agency. The current practice of contracting this work out to call centers lessens miners' health and safety.

Belt-Air

In keeping with the mandates of Congress in the 1969 Coal Act, and the 1977 Mine Act, which strictly prohibits the use of belt-air to ventilate working places, the Union has historically been opposed to the use of belt-air to ventilate the working places. The 2006 Alma disaster is a reminder that there is no safe way to ventilate working sections using belt-air. This mine fire was intensified by air from the belt entry, and the contaminated air was dumped onto miners working inby. In addition, conveyor belts used in the mining industry must be made of non-flammable material.

In the MINER Act, Congress directed that there be created a Technical Study Panel to provide independent scientific and engineering review and recommendations with respect to belt air and belt materials; the Study Panel is then to issue a report to the Secretaries of Labor and Health and Human Services, as well as the Senate Committee on Health, Education, Labor, and Pensions, and the House Committee on Education and Labor. While this Technical Study Panel has been constituted and had its first meetings last month, we harbor reservations about its administration. Congress was silent as to its administration, but MSHA staff is providing the support personnel. If its first meetings are any indication, MSHA seems more invested in defending the belt air decisions it has already made, than simply servicing the Study Panel. Congress assigned this Study Panel to offer an "independent" review and recommendations, and we hope it can overcome MSHA's bias in favor of belt air.

Funding for Additional Programs and Health and Safety Protections

The Union would urge Congress to adequately fund other agencies and programs that advance the Health and Safety of the nation's miners. These include:

- Pittsburgh Research Center
- Lake Lynn Facility
- Appalachian Laboratory for Occupational Health and Safety in Morgantown, WV
- Approval and Certification Center
- Personal Dust Monitors (PDM)
- Colorado School of Mines

Conclusion

One year ago many of you were present when I testified before the Senate Committee on Health, Education, Labor and Pensions to discuss and review the performance of MSHA and the overall state of mine health and safety. That testimony followed the first two disasters of 2006 at the Sago and Alma Mines. At that time, I described many of the shortcomings in miners' health and safety.

I am sorry to report that MSHA's efforts over the past year would do little to change matters today if a mine were to experience an explosion like the one at Sago, or a mine fire like the one at Alma; indeed the underground miners would likely fair no better than those who perished over one year ago. Thanks to the MINER Act, I can presume that any incident would be *reported* within the initial 15 minutes. However, there is no reason to expect that a sufficient number of mine rescue teams would respond quickly. This is because the last year has seen virtually no progress in either expanding the number or improving the proximity of qualified mine rescue teams.

MSHA still allows mine operators to ventilate working sections with belt-air, and non-flammable belts are still not required. Today there are no requirements that operators provide systems that would enable miners to communicate with the surface or vice versa. There is nothing in place that requires an operator to be able to locate trapped miners, and very few could do so. Safety chambers are not required, nor are safe havens prescribed. Most operators do not have a complete approved emergency response plan as required by the MINER Act. Many miners caught in a disaster would likely have one additional hour of oxygen as opposed to early 2006, but please remember that it took more than 40 hours for the first mine rescue teams to reach the miners at Sago.

We are most appreciative that Congress has worked towards increasing MSHA's budget so more mine inspectors can inspect mines to ensure compliance with the Mine Act. We implore MSHA to demonstrate a similar commitment to enforcing the Mine Act and to improving miners' health and safety so that our industry will never again experience another mine disaster like Sago or Alma. Technology is progressing on a daily basis and the UMWA urges MSHA to require mine operators to employ improvements as they become available.

United Mine Workers of America

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August 21, 2007

The Hon. Harry Reid, Senate Majority Leader
The Hon. Nancy Pelosi, Speaker of the U. S. House of Representatives
United States Congress
Washington, DC

Dear Senator Reid and Representative Pelosi:

I write to urge Congress to appoint an independent bi-partisan committee of coal mine safety experts to investigate the Crandall Canyon disaster. The public needs a reliable way to obtain meaningful information and insights about this horrific tragedy: both the initial trapping of six miners and the subsequent rescue efforts, which resulted in three deaths last week. I do not believe the American public and our nations' coal miners will be well-served by another instance of MSHA investigating itself in this disaster.

Just last year this nation was witness to three dramatic multi-fatal accidents beginning with the Sago mine explosion on January 2, 2006, followed less than three weeks later by a mine fire at Aracoma, and then an explosion at the Darby mine. Together these three disasters took 19 lives, and devastated entire communities. Since the beginning of last year, 64 coal miners have been killed on the job. That's an average of three each month.

In a demonstration of bi-partisan support for the nation's coal miners, Congress enacted the MINER Act which President Bush signed into law on June 15, 2006. The MINER Act served as an important first step for improving miners' health and safety. However, it was the first piece of miners' safety and health legislation in nearly 30 years, and did not address all the shortcomings in the laws that are needed to protect miners. One of the many things that bill did *not* accomplish was to change the way mining accidents are investigated.

The problem with the status quo is that the Mine Safety and Health Administration ("MSHA") investigates mine accidents. However, *time and again* MSHA's performance has been found to have had a role in sanctioning the very conduct that developed into subsequent disasters. For example, MSHA must approve mining plans, ventilation plans and roof control plans, not to mention to ensure through enforcement procedures that each operator adheres to all the plans once the respective MSHA District approves them. Yet, after the disasters of 2006, MSHA's Internal Review determined that:

> [At] Aracoma... the majority of contributory violations were obvious and should have been identified by MSHA inspectors prior to the fatal fire that killed two miners. The team determined that inspection personnel failed to exercise their authority in a manner that demonstrated an appreciation for the importance of strict enforcement of the Mine Act and failed to conduct inspections in a manner that reliably detected violations.
>
> Inspection personnel also demonstrated a lack of technical know-how necessary to effectively evaluate and address complex safety and health conditions, and failed to

comply with MSHA policies and procedures that, if followed, would have significantly improved the scope, quality and effectiveness of mine inspections. The lack of effective management oversight and controls also contributed to enforcement deficiencies at Aracoma. MSHA has referred its findings at Aracoma to the Labor Department's Office of Inspector General for further investigation of employee misconduct.

The Sago internal review found that ...failure by personnel to follow inspection procedures, coupled with inadequate managerial oversight, resulted in a number of enforcement deficiencies. Among the areas cited as needing improvement was the district's mine emergency response capabilities.

The Darby internal review found that district personnel did not effectively utilize the mine operator's history of repeat violations to elevate the level of enforcement. Failure to follow inspection procedures, along with inadequate managerial oversight, resulted in many of the deficiencies identified in the report.

From MSHA press statement 07-975-NAT, dated June 28, 2007.

Three different MSHA District offices, but all three substantially failed in their primary responsibility of protecting the miners. What makes this MSHA statement especially frustrating is that the Agency came to the *same* kind of conclusions following an explosion that took 13 miners' lives at the Jim Walters Mine #5 in Alabama back in 2001. There is an integral problem at the very heart of the Agency where there seems to have developed a culture of accepting the status quo and not rocking the boat.

MSHA has had many opportunities to correct what is wrong; yet it still has not arrested its well-documented problems. We need an outside group of experts to analyze what happened at the Crandall Canyon mine in Utah, not only on August 6, 2007 and during the subsequent rescue efforts, but also the events that set the stage for the August 6 disaster. We also would welcome the recommendations such independent experts could make about how the Agency should change to better keep all miners safer.

The status quo simply isn't working to protect miners. Miners at Crandall Canyon and their families deserve better. In the same bi-partisan fashion that Congress demonstrated on the heels of the three coal mining disasters last year, we urge you to appoint an independent committee of experts to investigate what went wrong for the Crandall Canyon workers.

Respectfully,

Cecil E. Roberts

Cecil E. Roberts

cc: Elaine L. Chao, Secretary of Labor
Richard Stickler, Assistant Secretary of Labor for Mine Safety and Health
Jon Huntsman, Governor of Utah
Senator Mitch McConnell, Senate Minority Leader
Senator Edward Kennedy, Senate HELP Committee
Senator Michael Enzi, Senate HELP Committee
Senator Orrin Hatch
Senator Robert Bennett
Representative John Boehner, House Minority Leader
Representative George Miller, House Committee on Education & Labor
Representative Howard "Buck" McKeon, House Committee on Education & Labor
Representative Jim Matheson