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Testimony before the
House Committee on Education and the Workforce,
Full Committee on Workforce Protections on
Learning from the Upper Big Branch Tragedy

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Thank you for the opportunity to address the *House Committee on Education and the Workforce, Full Committee on Workforce Protections about Learning from the Upper Big Branch Tragedy*. I am the International President of the United Mine Workers of America (UMWA), a union that has been an unwavering advocate for miners' health and safety for over 122 years.

Before I speak about what we can learn from the Upper Big Branch tragedy, I want to acknowledge all of the families that lost a loved one and neighbors who lost a friend in the senseless methane/coal dust explosion on April 5, 2010. The 29 families all suffered a loss that we can never forget. The victims paid with their lives for the deliberate greed of Don Blankenship and his underlings.

The UMWA has long held that three things are necessary for a safe and productive mine:

- An operator who is willing to follow the law.
- An agency which fully enforces the law.
- Workers who are empowered to speak out for themselves.

None of these things happened at the non-union UBB mine.

Don Blankenship's team pursued a game of cat and mouse with the Mine Safety and Health Administration (MSHA). While MSHA inspectors were trying to determine whether Massey was following mine health and safety laws and regulations, as all operators are required to do,

Blankenship's management was regularly doing what it could to *subvert* MSHA's efforts. Every day they did that, they jeopardized the safety of all miners working under their control and direction. On April 5, 2010, the vulnerable miners at the Upper Big Branch mine fell victim to the needlessly dangerous and neglected mine environment.

It is not a secret in the coalfields that some operators give advance notice to miners working underground of MSHA inspections. Mine Managers make quick and superficial adjustments to the ventilation, quickly rockdust the entries where an inspector would be headed or shut down production entirely on a working section in order to avoid being cited for violating MSHA's standards. Through the work of the United States Attorney's office in Charleston, West Virginia, we finally have public confirmation from one of the Massey managers who affirmatively engaged in such deceptive practices. Earlier this month, Upper Big Branch Mine Superintendent Gary May gave testimony in Hughie Elbert Stover's sentencing hearing about that mine's practice and system for providing information to miners working underground whenever federal and state safety inspectors were on the property, with details about where the inspectors would be traveling and inspecting. Stover was convicted and sentenced to three years in prison on February 29, 2012. Mr. May further explained that he acted deliberately to change underground mining conditions to make them temporarily appear better and more compliant than they had been while the mine was actively operating but before learning about the inspector's underground presence.

We don't mean to claim that Massey and its subsidiaries had a monopoly on these illegal practices, but its rogue attitude had become an integral part of the operating culture at the Upper Big Branch mine. It became so bad that miners came to view the unlawful mining practices as the norm. Some of the more experienced miners probably knew that what Massey was doing was wrong, but they had to work. Tolerating unsafe conditions was necessary if they wanted to keep their jobs. On a daily basis, these miners worked in an atmosphere of fear and intimidation. However, there can be no question that for Don Blankenship and his Massey mines, production was the top priority; and the second priority; and the third priority… This is demonstrated by the October 19, 2005 memo Don Blankenship sent to All Deep Mine Superintendents entitled "Running Coal" which stated *"If any of you have been asked by your group presidents, your supervisors, engineers or anyone else to do anything other than run coal*

(i.e. – build overcasts, do construction jobs, or whatever), you need to ignore them and run coal. This memo is necessary only because we seem not to understand that the coal pays the bills."

One stark example of Massey's unlawful behavior was revealed in the report from MSHA's Internal Review where it described Massey's frequent re-staging of its continuous mining machines/mechanized mining units (MMU's) to avoid citations for excessive respirable dust. Cutting coal creates mine dust that must be both reduced and controlled through ventilation, water sprays and rock dust to protect miners' lungs and to prevent explosive coal dust accumulations. Autopsy records of the UBB miners who were killed in the explosion uncovered surprisingly high levels of black lung and other lung disease within this workforce, including among the youngest victims. Seeing what the Internal Review discovered about MSHA's ineffective enforcement of the respirable dust standard (30 CFR Part 70) at UBB suggests miners at this operation were often exposed to excessive levels of respirable dust.

MSHA's regulations set maximum permissible respirable dust levels and require reductions to the dust levels depending on how much quartz is also present. However, as the Internal Review explained, MSHA District 4 allowed Massey to re-establish (that is, to increase) its permissible dust levels whenever it rotated its MMUs. Therefore, even though MSHA would establish a reduced respirable dust level for a certain area based on the level of respirable coal dust and the percentage of quartz generated by a MMU, Massey was able to avoid compliance with that reduced respirable dust standard simply by rotating out the MMU that was used to set the reduced level. With a different MMU in place, MSHA terminated any citation that was issued for excessive dust and allowed Massey to operate its replacement MMU with dust at the unreduced standard of 2.0 mg/m^3 even though the same amount of quartz would have been present. This deliberate manipulation of the dust standard, established by the law, was the practice according to the Internal Review. MSHA District 4 also regularly allowed Massey to have abnormally long abatement periods for its dust citations. Massey was manipulating the law and too often MSHA District 4 allowed the company to get away with it.

MSHA's Internal Review outlines numerous deficiencies on the part of the Agency. These MSHA shortcomings, in particular MSHA District 4, allowed miners to remain in harm's way though the Agency should and

could have prevented such exposures. In other words, although Massey failed in its duty to comply with mine safety laws and regulations, MSHA had a duty to utilize every enforcement tool at its disposal so that miners' safety would not be jeopardized. Massey made MSHA's job much more difficult by its subterfuge, but that doesn't excuse or explain MSHA's shortcomings.

We now know that MSHA District 4 inspectors failed to:

- Inspect some areas of the mine (including in its last inspection, the Old No. 2 Section and the belt/return entries of Tailgate #22 tailgate, both areas where the explosion propagated), and rushed their inspections through other areas.
- Cite lack of adequate roof support controls that the roof control plan specified.
- Identify inadequacies in the coal and coal dust program including failures in the cleaning of loose coal, coal dust and float coal dust and the extent and duration of noncompliance with rock dust standards along belt conveyors.
- Use current rock dust survey procedures and to collect spot samples from older sections of the mine to see that UBB had the required incombustible content of rock dust to mine dust.
- Scrutinize the operator's examination records and require timely abatement of hazards cited and consider the hazards for purposes of determining the operator's degree of negligence.

MSHA District 4 Supervisors, who had jurisdiction over the Upper Big Branch mine, did not provide effective oversight of the inspectors. District 4 failed to:

- Conduct 110 (c) special investigations (to determine if mine management knowingly violated mandatory standards) when established protocols indicated that would have been appropriate in six cases.
- Forward to MSHA's Arlington Headquarters eight violations that should have been considered for "flagrant" violations.

Further, in reviewing mining plans for approval, experienced MSHA District 4 personnel made a number of mistakes, including:

- Not requiring methods in the ventilation plan that would mitigate methane inundations like the one that occurred in 2004.
- Not recognizing that (a) the roof control plan did not provide necessary pillar stability for ventilation in some areas and (b) the roof control plan did not include any of the required stability calculations to show the plan would be adequate.

MSHA headquarters also failed to:

- Realize - due to a computer glitch – that the mine's violation history qualified UBB for the "Potential Pattern of Violation" list.
- Use or distribute its directives and policies effectively, some of which conflicted with each other. MSHA employees did not always understand the policies.
- Ensure that all entry-level or journeymen inspectors had the required training. Some of those responsible for inspecting or supervising inspectors at Upper Big Branch did not have all the required training. MSHA's own policy does not permit entry-level inspectors to travel by themselves, which occurred at UBB.

The scope of internal MSHA problems ran from top to bottom. However, MSHA District 4 Supervisors dropped the ball by ignoring several red flags as I previously stated.

The Internal Reviews following the previous five underground coal mine tragedies of the preceding decade (Jim Walter Resources in 2001; Sago, Aracoma and Darby in 2006; and Crandall Canyon in 2007) identified a number of problems that persisted into 2010. It is time that we stop talking about these problems and fix them.

While it may be appropriate to criticize the mistakes MSHA made before the UBB tragedy, it would be a huge disservice to the miners who perished at UBB and to their families if that is all we did. Instead, we should think proactively and take affirmative steps to make mines safer.

Immediately after the Upper Big Branch tragedy MSHA began its program of impact inspections, targeting operations where it has reason to be concerned about Mine Act compliance. MSHA captures the mine communications system to prevent advance warnings of inspections. MSHA's impact inspections have uncovered large numbers of significant and potentially dangerous conditions. The Agency has also gone to court to test its authority to seek injunctions. These techniques have been successful in preventing operators from continuing to operate in the most hazardous of conditions.

Even a more aggressive MSHA, one that uses the array of enforcement tools never used before the UBB tragedy, cannot protect miners if mine operators continue to flaunt the law. And too many do.

The UBB disaster serves as a stark reminder that the culture of production over health and safety still exists in the coalfields. Don Blankenship and Massey represented the worst of the coal industry. They flagrantly violated and ignored the law at the expense of the miners. Don Blankenship's philosophy cost the lives of 29 miners at UBB and countless others that lost their lives at Massey's mines.

The UMWA applauds the U.S. Attorney's office for pursuing criminal prosecution against individuals who contributed to the April 5, 2010 tragedy at UBB. However, allowing Don Blankenship to walk away from the crimes he and his underlings committed at UBB would be a gross miscarriage of justice. He laid out the rules under which UBB operated and kept a watchful eye to ensure that his policies were being followed. Don Blankenship should be prosecuted for his actions and I stand here today saying to this Committee that until corporate heads like Don Blankenship are held accountable for their actions, we have not witnessed the last senseless tragedy and loss of life in the coal industry.

What is also upsetting to me is the misdemeanor plea deal that federal prosecutors recently reached in the 2007 deaths of nine workers at the Crandall Canyon Mine in Utah. Murray Energy's subsidiary, Genwal

Resources, agreed to plead guilty to two mine safety crimes and pay $250,000 for each of the two criminal counts. The travesty of justice is that the plea agreement states that no charges will be brought against any Genwal mine managers or any executives. Once again, the real guilty parties escaped justice. I guess the cost of nine lives is $500,000.

MSHA cannot be everywhere all of the time. That is why the law correctly charges operators with the duty of operating in a safe and healthful way. If an operator wants the privilege of running a coal mine, it must assume the obligation of doing so in a way that doesn't put its employees' lives in jeopardy. Yet, this doesn't always happen. Too often corporate greed takes precedence. We urge Congress to increase the penalties for egregious mine health and safety violations.

So what else can we do to reduce the likelihood of any more coal mining disasters? We owe it to all miners to learn from the problems that led to the Upper Big Branch tragedy as well as from other disasters.

What this Committee and Congress does really matters to the coal miners of this nation. After the Sago mine disaster and others in 2006, Congress required that coal operators make underground shelters available to protect miners who survive but cannot escape an explosion or mine fire. Despite the tremendous explosive forces that rocked the Upper Big Branch mine, a shelter near the explosion survived intact and could have sheltered miners *if* they had survived the explosion. That Strata shelter was under water for weeks, and yet it remained dry inside. Had that shelter been at the Sago mine in January 2006, eleven of the twelve miners killed would still be with us today. Without Congress advancing the issue in the 2006 MINER Act, we still would not have shelters underground.

Again, through the MINER Act, Congress required significant improvements in tracking and communications' technology and equipment. Coal operators claimed it couldn't be done, or the costs were too high to allow them to remain in business, but Congress appreciated that changes were necessary and demanded that the industry implement the improvements. By legislating these changes, there was a flurry of imaginative and creative work done to develop practical equipment that could survive the harsh mine environment. These state of the art systems are in place all over the United States today.

We appreciate that some operators are spending more money on equipment and technology to make the mine environment safer for miners. However, more improvements can be made. For example, rock dust sampling results are not completed in a timely fashion. The mine environment can become extremely explosive in a very short period of time if rock dust is not applied regularly. Rock dust is required to minimize the explosiveness of coal dust in case there is an ignition source present. While better and newer dust explosibility meters exist, most operators – as well as MSHA – are not purchasing them because they are not required to use them. This equipment can provide immediate, real time information about the incombustibility of rock dust to coal dust levels. Instead, the current protocol provides for the samples to be sent to MSHA's lab, where the Agency uses antiquated equipment to test the samples. It takes 2-3 weeks to return the results. I would like to point out that operators like Consol, Patriot and Alpha are taking advantage of this new technology. At Upper Big Branch, samples taken *before* the April 5 explosion showed that the mine had inadequate rock dust – but those sample results were not reported until *after* the disaster. We are left to wonder whether having the results in real time would have averted this disaster.

The illegal practice of advance notice of safety inspections is not limited to Upper Big Branch but occurs at many operations. MSHA's recent tactic of taking control of the communications systems when inspectors travel to operations has demonstrated that advance notice is not uncommon: the kind and extent of violations found when the communications are taken over exceed those MSHA had previously discovered. Clearly, the existing penalties for advance notice are ineffective and should be increased to help effect compliance.

Another area where the Mine Act should be updated concerns its whistleblower protections. The Mine Act was one of the first to provide whistleblower protections against discrimination or retaliation for reporting safety violations. However, these provisions are now inferior to recent and more-protective whistleblower provisions included in other statutes. Miners under the Mine Act now have only 60 days to blow the whistle. This window should be lengthened to give miners a better chance to pursue actions when they suffer discrimination or retaliation for exercising their health and safety rights.

The compensation provisions in Section 111 of the Mine Act should also be expanded. As it now stands, miners generally can collect no more than one week's worth of wages when an operator's violations require MSHA to shut down the mine. Too often miners have to make the choice between putting food on the table and protecting their own safety. By expanding the compensation provisions, miners' health and safety would be better protected.

MSHA's accident investigation procedures must also be modernized. The UMWA has always advocated that an independent agency should conduct all accident investigations much like the National Transportation Safety Board. Asking MSHA to critique its own actions following a disaster does not always lead to the most objective point of view. We further believe that the law should be changed to include in the investigation those most affected: the miners and family members of deceased miners. We also believe that MSHA must have the power to subpoena witnesses, rather than rely on voluntary interviews.

The UMWA is not convinced that any one action by MSHA would have resulted in substantially better compliance on the part of Massey. It is clear that UBB should not have been operating at the time of the explosion. Had MSHA District 4 used all of the enforcement tools at their disposal, the disaster may have been prevented. However, no one should ever lose sight that Massey Energy, including Don Blankenship and his underlings, were mandated by law to comply with all health and safety standards and maintain UBB in a safe operating condition. Instead, the mine was operated in a manner compliant with a corporate policy that put production over safety. This is why I will once again call for the criminal prosecution of these individuals.

The authors of the Internal Review have recommended that the Assistant Secretary consider rulemaking that would modify several health and safety standards. The recommendations are found in Appendix C – Recommendations for Regulatory Changes. There are 23 separate provisions outlined in Appendix C, all of which would improve health and safety protections for miners. The UMWA is in complete agreement with these recommendations in addition to the changes we outlined in our report.

This gets me to my last point. Congress needs to act quickly to pass legislation that will build on the protections of the 2006 Miner Act. As Congress so eloquently stated in the Act: *"the first priority and concern of all in the coal or other mining industry must be the health and safety of its most precious resource – the miner."*

In conclusion, I thank you for the chance to appear before this Committee and appreciate your interest and concern for miners' health and safety.

Exhibits

- Internal Review of MSHA's Actions at the Upper Big Branch Mine – South, Performance Coal Company, Montcoal, Raleigh County, West Virginia
  U.S. Department of Labor
  Mine Safety and Health Administration
  Program Evaluation and Information Resources
  March 6, 2012

- Industrial Homicide – Report of the Upper Big Branch Mine Disaster
  United Mine Workers of America

- October 19, 2005 Don Blankenship memorandum on "Running Coal."

- West Virginia House Bill 4351