

**Cecil E. Roberts, President  
United Mine Workers of America  
Testimony before the  
Senate Appropriations Committee's  
Sub-Committee on  
Labor, Health and Human Services, Education, and Related Agencies**

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I thank you for this opportunity to appear before Congress. I only regret that I have come to speak on the heels of the terrible tragedy that befell the Sago miners. Our hearts and our prayers go out to the miners' families, their loved ones and their communities. We also wish to extend our deep appreciation for the mine rescue teams that participated in the Sago Mine rescue efforts, and to the federal and state inspectors and UMWA safety committee members who travel and inspect the mines regularly, working tirelessly to protect the nation's miners.

Today I will be reviewing how current mine safety laws came into being; problems with the enforcement of the current laws and regulations and how those deficiencies have contributed to make coal mining one of the most dangerous industries in the nation; how we have the knowledge and ability to substantially improve miners' health and safety; and what Congress can do to help improve miners' health and safety.

For 116 years, the UMWA has been unwavering in its efforts to enhance miners' health and safety.

However, too often remedial activity follows only after another tragedy has focused our nation's attention: in 1968, 78 deaths at Farmington, West Virginia lead directly and quickly to passage of the Coal Act in 1969; it was then expanded to other mining industries and re-named the Mine Act in 1977. Since the Coal Act was passed, fatalities in coal mining have decreased dramatically: while over 300 miners died in 1968, the year before the Coal Act was enacted, fewer than 100 miners have perished in any single year over the last 20 years, since 1985. Attached to my testimony is a copy of MSHA's list of fatalities. While increased

mechanization has meant fewer miners are engaged in coal mining, the fatality rate has also dropped significantly. This is commendable; but we can – and must – do much better. Mining remains the second-most dangerous industry in this country.

This nation possesses the knowledge and ability to substantially improve miners' health and safety, and to reduce the fatality rate. We can direct some of the national attention generated by the Sago tragedy to enhance health and safety conditions for all coal miners today, and the generations to follow.

Unfortunately, what happened at Sago did not really surprise me. Indeed, the underground coal industry has experienced tragedies, as well as near tragedies, on a recurring basis. In just the last few years the underground coal industry experienced these large-scale, well-publicized, events:

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Jim Walters Resources #5 mine explosions; 13 fatalities: There was a terrible series of events on the evening of September 23, 2001, two short weeks after 9-11. What happened there eerily echoed the Twin Towers' experience inasmuch as numerous rescuers also perished at this Alabama mine. In fact, 12 miners lost their lives in a second explosion while trying to rescue a miner who had been immobilized by an explosion that had happened nearly an hour earlier. Communication problems contributed to the deaths of the 12 rescuers; we believe the rescuers were given insufficient and faulty information about the underground conditions, and attempted the rescue without knowing the hazards they faced.

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Queecreek: In July 2002, 9 miners were trapped by a water inundation in a Pennsylvania mine, after 9 others were able to escape. The trapped miners were rescued 4 days later; again, communication inadequacies frustrated an easier and quicker rescue.

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Sago Mine; 12 fatalities: On January 2, 2006, this tragedy claimed the lives of 12 miners, while the full extent of injuries to the 13<sup>th</sup> miner, Randal McCloy, Jr., remain uncertain. Hopefully, with time we will learn all of the conditions that caused and contributed to these lost lives.

These dramatic events represent only the headline-grabbing incidents.

Thousands of miners are still disabled and dying from black lung disease, while other miners also die in mining accidents each year. Typically they die one or two at a time, from roof falls, equipment failures, and other accidents.

There are also countless near-misses that occur on a regular basis. In fact, just since August 2000, the Mine Safety and Health Administration, known as MSHA, has records of well over 400 mine fires, ignitions, explosions and inundations that far too-easily could have developed into significant disasters and fatalities; many other incidents likely went unreported. Attached to this testimony is an overview of MSHA's data on incidents reported to that Agency.

With better regulations, more regular enforcement, and with support from the highest echelons of the Agency, many of these accidents could have been prevented. Senseless deaths and injuries must stop. Mining will probably always be a dangerous job. But we can do a lot more than we are doing today to make it safer. Miners should not have to get sick, or to risk their lives just by going to work.

The most basic point I wish to make today is that as a nation, and as an industry, we already possess the knowledge and the ability to prevent most of the deaths that are still occurring in the coal mining industry. What is needed is a real commitment by our government – in this case, MSHA – to do better.

For example, if MSHA would require additional oxygen units (“self-contained self-rescuers”) to be stored on the section where miners work, and throughout the underground mine in addition to the self-rescuers that each miner is required to have, then miners trapped in an emergency would have a better chance of surviving. Self-contained self-rescuers are what miners don to escape, when noxious air fills an underground mine after a fire or explosion. They typically last for about one hour. We understand that miners trapped at Sago wore self-rescuers. However, there is now no MSHA requirement that coal operators store any additional oxygen units in their underground mines. We can only speculate about whether more miners would have survived at Sago if additional self-rescuers had been stored underground. What we do know, is that they would have had a *better chance* of surviving until help arrived if they had more fresh air to breathe. MSHA should implement a rule requiring additional units to be maintained in strategic locations around the mine in order to provide miners with oxygen from the deepest penetration of the mine out to the surface. No new technology is required to

implement this improvement. Self-rescuers can save lives. Are they worth some modest additional costs? We submit the clear answer is “Yes.”

There is also technology available today that would enable trapped miners to maintain better communications in an emergency situation. If MSHA would require secondary telephone lines to be placed in a separate entry, that would increase the likelihood that communications could be maintained between miners and those on the surface, even after an explosion or other emergency event. Also, if MSHA would require operators to place walkie-talkies in underground locations, this would facilitate communications during an emergency. Rescue teams rely on walkie-talkies while they travel underground. The equipment is effective for a distance of about 1000 feet. If trapped miners could communicate with their would-be rescuers, the trapped miners could both provide and receive critical information that could assist in their survival. By not having this ability to communicate, their own rescue is hampered and rescue teams may confront additional hazards that could be avoided if trapped miners would report on what they know. These proposed communications’ improvements could be implemented easily; the UMWA urges MSHA to quickly implement these changes. If we can talk to people on the moon, we should be able to talk to those trapped underground.

After the Jim Walters tragedy, and again after the Quecreek near-disaster, the need for better underground communications was crystal clear. Yet, MSHA made no changes to implement any such improvements.

If we could locate trapped underground miners, we could also do a much better job rescuing them. MSHA should draw on all the nation’s resources to address this compelling need. We are encouraged by communications we have had with people at the Pentagon about equipment originally developed for aviation security, which might also be applicable to the mining industry. We do know that since the 1970's, there has been electromagnetic technology available that would enable us to locate trapped underground miners. The then-Bureau of Mines reported about this equipment in the 1970's; the equipment was tested and deemed reliable some 30 years ago. Why then aren’t we using it today? MSHA should take a look at this electromagnetic technology and all other available technology to see which should be required throughout this industry. I attach a copy of that Bureau of Mines’ report to my testimony.

Another way to enhance the chances of survival for trapped miners is to strengthen and expand mine rescue teams. The Mine Act required MSHA to implement regulations ensuring that “mine rescue teams shall be available for rescue and recovery work to each underground coal or other mine in the event of an emergency.” 30 U.S.C. § 825(s). MSHA’s regulation now provides that every operator must establish at least two mine rescue teams, consisting of five members and one alternate, and that these teams be available at all times miners are underground. The regulations also permit an operator “to enter into an arrangement for mine rescue teams” whereby at least two mine rescue teams are available whenever miners are underground. Further, to be deemed “available” the mine rescue teams must be capable of presenting themselves “at the mine site(s) within a reasonable time after notification of an occurrence which might require their services.” 30 C.F.R. Part 49. Pursuant to MSHA policy, if a team can arrive in two hours, it is deemed “available.” MSHA includes exceptions for small and remote mines, but those exceptions would not have applied to the Sago Mine.

At the Sago Mine on January 2, it was between three and five hours before the first mine rescue teams arrived. Once mine rescue teams arrived on property, including six teams comprised of UMWA members, the sole activity they engaged in revolved around safely extracting the trapped miners. It is extremely important for you to understand that procedures followed during mine rescues are designed to save the lives of trapped miners while also protecting the team members. Rushing into the mine without a complete understanding of its conditions, would be inviting additional problems. You need only review mining history briefly to see examples of rescuers rushing in only to become additional victims. We cannot permit that to occur. Even if underground conditions may not have allowed the rescuers to immediately travel underground at Sago, the five hours’ lapse before the first teams arrived constituted valuable time that was simply forfeited. We do not know what arrangements the Sago Mine had to address its mine rescue team obligations, but we do know that a five hour lag before mine rescue teams arrive is unacceptable.

The UMWA submits that every underground coal mine should have mine rescue capabilities on site. These team members should be employees at the facility who would be acutely familiar with the mine. These individuals would not only be best able to carry out many of the duties required in these situations, but would also be uniquely qualified to brief additional offsite teams that may be necessary to complete the rescue. For even small and remote mines, MSHA should require

mine rescue teams to be ready when disasters strike. No trapped miners should ever again have to wait three to five hours for rescue efforts to begin.

While we all share the hope that all mining accidents will cease, all of our hopes probably won't prevent more accidents from happening. What we can do, and what we should do, is to give miners their best chance at surviving a mine emergency. I have just described a number of improvements that would be easy to implement; they would also go a long way to furthering miners' ability to survive disasters. However, unless MSHA requires that these improvements be implemented throughout the industry, miners will continue to face emergencies from a position of compromise.

If the Sago miners had been able to communicate with persons on the surface and the mine rescue teams underground, those miners might have been successfully lead to fresh air. If the location of those trapped miners could have been more-quickly determined, we could have enhanced the possibility of their rescue. These "only-ifs" are too late to change what happened at Sago, but it would be inexcusable if our inaction now would contribute to any more deaths.

There was a national outcry when 78 miners died in West Virginia in 1968. Unfortunately, after the Jim Walters' disaster and the recommendations made from the lessons learned there, no lasting improvements to miners' health and safety came after those 13 miners perished. We cannot allow that to happen again. We need to make real changes so that another tragedy like what happened at Jim Walters and what happened at Sago will not happen again.

MSHA knows how to do better. The Agency itself has performed countless internal reviews and self-analyses; the federal government's watchdog agency, the GAO, has given it direction, and the UMWA has communicated both formally and informally about how MSHA can and must do better.

GAO recently focused on shortcomings in MSHA's performance with regard to the underground coal industry. The underground coal industry is the same part of MSHA's jurisdiction that was at issue in all three incidents I highlight in this testimony: Jim Walters, Quecreek, and Sago.

GAO issued its report in September 2003, two years after the Jim Walters tragedy. In its report, which I attach to my testimony, GAO noted that MSHA

headquarters was not performing adequately in several key areas. Specifically, the GAO found MSHA failed to ensure violations cited to mine operators were corrected in a timely fashion. In fact, GAO found that of all the citations issued by the Agency, including those written as “significant and substantial,” despite inspector-imposed deadlines by which problems were to be abated, 48% of the time the Agency failed to follow-up in a timely fashion to see if the operator fixed the hazards.

GAO also found that MSHA collected information about accidents and investigations, but then failed to use the information effectively to prevent future accidents. GAO noted that MSHA does not even collect information about how many hours contractors work at mine sites, making it impossible to compute the fatality and injury rates for particular mines. It further found that MSHA failed to ensure that the ventilation and roof control plans are reviewed every six months, even though the Mine Act and applicable regulations, as well as MSHA’s long-standing policies, require that these reviews occur on a semi-annual basis.

After MSHA completed its investigation into the Jim Walters disaster, the Agency also performed an Internal Review of MSHA’s actions before the explosions to “improve our inspection process to better protect our nation’s miners.” The review compared what MSHA actually did with what the Mine Act requires it to do. A number of problems were identified as deficiencies “at both the district and headquarters level”, deficiencies “relevant to inspection procedures, level of enforcement, plan reviews, the [Alternative Case Resolution Initiative] and accountability programs, supervision and management, and headquarters oversight.” I attach a copy of MSHA’s Internal Review, along with a copy of the UMW’s investigation report.

Unfortunately the Agency’s top managers have done little to move any of the necessary improvements from recommendation to reality. We hope that by having Congress add its voice now, along with the public’s demand for its better performance on the heels of Sago, MSHA will finally re-focus its attention.

MSHA should promulgate regulations that meaningfully improve miners’ health and safety, and MSHA must consistently enforce the regulations it has. The circumstances that played out on January 2, 2006 have become all too familiar. The events that unfold at these mine disasters change very little, they focus attention for a brief moment but, as the spotlight fades, MSHA is content to ignore

demands for change. We cannot and will not permit that to happen here.

The Mine Act is an important piece of legislation. I am not here to advocate an opening of any part of that historic and effective law. The UMWA is here to simply demand that it be enforced by MSHA as Congress intended. The real problems that exist with the current application of the Act lie in an administrative malaise. Instead of enforcing it aggressively, the Department of Labor has been whittling away at the Mine Act. Too often MSHA relies on “policies,” which are developed internally and without public comment, to circumvent the Mine Act. This reduction in MSHA’s effectiveness didn’t happen overnight; it has been a problem for much too long. We have been critical of MSHA under both Democratic and Republican administrations. But now we call upon Congress to put a stop to MSHA’s inadequacies, to turn the Agency around so it can enforce the Act the way Congress intended in 1969, and again in 1977.

To make the needed changes will require MSHA to take a new direction, beginning at the top. MSHA needs to have a larger budget for coal enforcement. The Agency spends too much effort at “compliance assistance,” and too little on enforcement. It needs to bolster its expertise. MSHA has some excellent mine health and safety experts working in field offices throughout the Country. Yet, they have not been receiving support from those above them. Too often, an inspector will write citations and orders upon finding violations of regulations, only to have them compromised away through conferences and settlements. While MSHA employs many experienced and dedicated inspectors, there is a failure on the part of individuals sitting at the higher levels of power to support the efforts of the MSHA field staff to enforce the Mine Act.

MSHA’s failure to aggressively enforce the Mine Act is the result of many factors. MSHA is full of former mine management executives who spend too much time trying to appease their friends, and too little time looking out for miners’ interests. How can we expect a regulatory Agency to effectively and fairly carry out its duties and responsibilities when it is run by some of the very coal operators it was designed to regulate? Many of MSHA’s top-level administrators spent years opposing any regulatory efforts attempted by the Agency. They continue to be influenced by other coal operators, effectively muting the voices of miners who need a healthy and vibrant enforcement Agency.

For years, the fox has been inside the henhouse at MSHA. During his



tenure as Assistant Secretary for MSHA, David Lauriski, scrapped 18 proposed rules on topics MSHA had already identified as needing attention. I attach to this testimony a list of those proposed rules that former-Administrator Lauriski withdrew, and will discuss the importance of a few of them. However, withdrawing proposed rules was not the extent of his actions at the Agency. He also pushed to completion several regulations that weakened health and safety, because they benefitted mine operators. For instance, under his watch MSHA implemented a regulation that allows mine operators to ventilate areas of the mine where miners work with air that has already passed through the conveyor belt entry, a practice Congress specifically prohibited in the Mine Act (30 U.S.C. § 863 (y)); and under his leadership MSHA implemented a regulation that permits the use of diesel-powered generators in confined areas of underground mines. While these practices may increase production for mine operators, they also pose new and significant risks to miners.

Unless something changes soon, history will repeat itself at the Agency. Later this month, on January 31, 2006, a hearing is scheduled to consider the Administration's nominee for Assistant Secretary of Labor for MSHA. This second nominee by this Administration has been a coal mine supervisor for most of his life. His lone excursion into health and safety was marked by repeated attempts to limit regulations and reduce the health and safety protections of miners in the Commonwealth of Pennsylvania. MSHA – and our nations' miners – cannot afford having another coal operator sitting as the Assistant Secretary. Miners deserve an advocate and an ally, not another coal boss. There should be no doubt that when top-level appointees are too cozy with the industry, miners ultimately pay the price.

Among the regulations MSHA stopped developing, and withdrew from its agenda were those addressing coal dust exposure; self-rescuers; mine rescue teams; accident investigations; and training/re-training.

The proposed rule on Occupational Exposure to Coal Mine Dust was withdrawn on September 4, 2002. That proposed rule was drafted to comply with the Secretary of Labor's Advisory Committee on the Elimination of Pneumoconiosis Among Coal Mine Workers, and was intended to decrease the level of respirable coal dust miners could be exposed to during a working shift. By cutting the permissible exposure level in half, miners would be less likely to contract debilitating black lung disease. Application of such a standard would also

have significantly reduced the amounts of highly-explosive float coal dust released into the mine atmosphere. Such a regulation would have significant health and safety benefits for underground miners. Unfortunately, the only efforts regarding coal dust that MSHA made under former Assistant-Secretary Lauriski was a proposal that would have allowed respirable dust levels to *increase by* four fold. To put it mildly, his proposal was not well-received and he ultimately withdrew it.

MSHA's proposed rule on Underground Coal Mining; Self-Contained Self-Rescuer was withdrawn on September 24, 2001. Self-contained self-rescuers have not been updated to keep up with technology. They were first required in 1981 and little has changed since then. Some of these devices were found to be inoperable for a variety of reasons including deteriorating hoses, contaminated chemical beds, and unrealistically long shelf lives being approved by MSHA. The industry has also been plagued with the fact that miners sometimes cannot properly don the units in emergency situations. Moreover, with MSHA's continued acceptance of the status quo, technological advances of these breathing devices is being stymied. In the legislative history of the Mine Act, Congress indicated that mining regulations should be technology-driving, to maximize miners' protections. We had hoped that with the promulgation of a new rule addressing self-rescuers, the existing problems would be addressed, and technological advances encouraged. The UMWA is convinced that such a rule would have been the catalyst for a new generation of self-rescuer devices. While operators are willing to invest in new technology when it increases production, it appears that they are not so willing to invest when in miners' health and safety.

The proposed rule on Mine Rescue Teams was withdrawn on September 4, 2002. The basis for moving this rule forward is quite simple: the UMWA and many industry officials recognize that, with mining operations contracting in the late 1980's through the 1990's, the number of mine rescue teams was disproportionally reduced. This left large coverage gaps. The industry is also facing an overall aging of the workforce, and this also adversely impacts participation in those rescue teams that remain active. In May of 2000, when it published this pre-rule, MSHA stated: "We are assessing the current regulations to identify problem areas where we might increase flexibility and increase safety for miners." However, instead of promulgating a rule that would improve rescue teams' availability and capabilities, MSHA eliminated further work on rescue teams regulations. Meanwhile, it permits operators to expand on the ill-advised

practice of contracting out such work. Withdrawing the proposed rule effectively eliminated any meaningful improvement in comprehensive mine rescue activity, but it also afforded some mine operators the opportunity to disband teams so they could increase their profits.

On August 16, 2001, the Agency withdrew its proposed rule on Accident Investigation Hearing Procedures. MSHA has no formal rules for conducting investigations. While it has established policies, the investigation process is subject to change on the whim of the individuals running the Agency. This is exactly what developed in the early stages of the investigation of the Sago Mine disaster. Not only do questions arise about who should participate in various parts of the investigation, but for the Jim Walters' investigation, for example, MSHA did not conduct a single public hearing to ensure that all relevant information was presented.

On September 24, 2001, MSHA withdrew its proposed rule on Training and Retaining of Miners. This critical proposal would have increased the number of hours operators are required to set aside annually for health and safety training of miners. This training includes first aid, donning and using self-contained self-rescue devices, fire drills, and exiting the mine in the event of an emergency. Miners' lives may turn on the quality of their training. The training must be updated and improved. There should be no doubt that the better trained miners are, the better equipped they will be to escape a mine emergency.

These are only five examples of the 18 regulations the Agency, under this Administration, determined to be insignificant, too burdensome, or too costly to promulgate. Several of them may have had significance in what developed at the Sago Mine. We may never learn that for a certainty, but now is the time to require better rules, offering better protections so that miners have a better chance of surviving mine emergencies.

Congress can, and should demand that MSHA do in 2006 all that Congress demanded in 1969 and again in 1977. Regulations that were in the pipeline in 2001 and 2002 should be reactivated and finalized in a timely fashion; regulations that are already in place must be enforced regularly and aggressively. Now that the spotlight is on the issue of miners' health and safety, we have a unique opportunity to make improvements.

The status quo is inadequate. The government failed the Sago miners, and when it failed them it failed *all* miners. In enacting the Mine Act, Congress plainly stated: “Congress declares that (a) the first priority of all in the coal or other mining industry must be the health and safety of its most precious resource – the miner.” (30 U.S.C. §801.) We take that admonition seriously; everyone else associated with the mining industry must re-establish miners’ health and safety as their top priority, too.

I thank you for your interest in miners’ safety and would be happy to answer your questions.