

BACKGROUND ON THE ACTIVITIES OF THE HOUSE EDUCATION AND LABOR COMMITTEE WITH RESPECT TO MINE SAFETY AND HEALTH

Last month, the nation's eyes were once again riveted on the human drama and tragedy of a mining accident. Six miners trapped in the Crandall Canyon mine in Utah could not be rescued, and three rescuers were killed during the rescue effort. Once again the public is asking why such tragedies occur and what is being done to prevent them.

The Education and Labor Committee of the House of Representatives, headed by Chairman George Miller (D-CA), has been pressing the Bush Administration to take a much more aggressive approach to eliminate these preventable workplace disasters. Early next month, the Committee is planning an investigative hearing into the Crandall Canyon mine disaster. It will then finalize mine safety and health legislation that was being considered before the Crandall Canyon tragedy took place.

The legislation being considered by the Committee is the result of an extensive effort launched at the beginning of this Congress to document the current situation in America's mines and obtain input from all those who have a direct and immediate stake in the matter, including the miners and their families.

The goal of the legislation is to ensure that the U.S. can extract its valuable national resources in a modern, safe and healthful manner. Since Sago, Congress has pushed forward to make mining safer. But it was clear even before the events of last month that these efforts stopped short of what was needed. Indeed, in U.S. coal mines alone, 70 coal miners have been killed on the job in the last 20 months.

This paper presents some background on the Committee's efforts and plans that we hope members and the public will find useful as the House moves forward this fall.

The Situation Prior to January 2006

In 1969, Congress enacted landmark legislation to protect the health and safety of coal miners. Legislation passed in 1977 added significant new protections, placed coal and non-coal miners under a single regulatory framework, and established the Mine Safety and Health Administration (MSHA) in the Department of Labor to administer and implement the law.¹ Unfortunately, it appears that the intent of the Congress in setting up these laws decades ago – that “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” - has never been fulfilled.²

¹ Edward Rappaport, *Coal Mine Safety*, CRS, (June 23, 2006), p. 2. NOTE: The 1977 legislation moved the responsibility for administering the law from the Department of Interior to the Department of Labor to avoid obvious conflicts of interests between the Agency and industry.

² *Testimony of Representative Rahall* before the House Education and Labor Committee, U.S. House of Representatives (May 16, 2007), pp. 10-11. *See also: Testimony of Dan Berconi* before the House Education and Labor Committee, U.S. House of Representatives (May 16, 2007), Transcript, pp. 22-23; *Testimony of Larry Grayson* before the Education and Labor Committee, U.S. House of Representatives

Although there has been a decrease in miner deaths over the past century,³ mining is still one of the most dangerous occupations in the United States. Mining fatalities occur at a rate more than seven times the average for all private industries, exceeding other dangerous occupations such as construction and trucking.⁴

The record of the current Administration in implementing the law prior to January 2006 is particularly abysmal. Early in 2006, the Democrats on the House Committee on Education and Labor documented a very troubling track record by the Bush Administration and the Department of Labor in protecting the health and safety of tens of thousands of hard-working American miners.

The report pointed out that the Bush Administration had:

- **Stacked the Mine Safety and Health Administration (MSHA) and the Federal Mine Safety and Health Review Commission (FMSHRC) with mining industry insiders.**
- **Retaliated against whistleblowers and transferred aggressive inspectors.** In one notable case, three MSHA inspectors were transferred in May 2002 after complaints from Murray Energy that they were being too harsh on its Maple Creek mine. Company President Bob Murray (who also owns the Crandall Canyon mine) then met with MSHA officials to complain about MSHA inspectors at his Powhatan No. 6 Mine. Both mines had injury rates twice the national average. According to press reports, Murray bragged that his earlier complaints had resulted in an MSHA supervisor “riding a desk somewhere.” Murray reportedly said that MSHA’s Morgantown district manager, Tim Thompson, would be “in his sights.” Thompson was soon transferred. One of the MSHA law enforcement personnel transferred after the Maple Creek complaints was Kevin Stricklin, a mining engineer credited with helping plan the successful rescue at the Quecreek mine disaster.
- **Focused on compliance assistance over enforcement.** Subsequently, an internal MSHA report on the Aracoma mine fire reported that some inspectors believed MSHA’s new compliance assistance programs impacted the way inspections were performed, and some were confused about whether they were supposed to be more cooperative with companies that had violated the law. This change in emphasis was also reflected in a significant reduction in the amount of major fines for mine safety and health violations, as compared to the previous administration.

(May 16, 2007), Transcript, pp. 36-39; *Testimony of Davit McAteer* before the Education and Labor Committee, U.S. House of Representatives (May 16, 2006) Transcript, pp. 42-45; and *Testimony of Cecil Roberts, supra*.

³ In 1925, over 2,500 miners were killed as compared to 22 in 2005 and 47 in 2006. Of course employment in this industry has also declined from 749,000 in 1925 to 110,000 currently. *Id.* at p. 2.

⁴ *Id.* at p. 3. *See also:* *Testimony of Cecil Roberts* before the House Education and Labor Committee, U.S. House of Representatives (March 28, 2007), Transcript, p. 33.

- **Sought budget cuts and staff reductions at the enforcement agency.** Between 2001 and 2005 the MSHA staff was reduced from 2,357 to 2,187, with most of the cuts coming from safety enforcement staff. Coal enforcement personnel, in particular, were reduced by 9 percent between 2001 and 2005
- **Rolled back proposed safety and health regulations, while implementing industry-favored changes.** In its first few years, the Bush Administration dropped more than a dozen proposed health and safety rules left over from the Clinton Administration. These included rules to make mine rescue teams more available, to establish new standards for self-contained self-rescuers, and to update 40-year-old requirements to reduce the risk of conveyor belt fires. In 2004, MSHA adopted a rule allowing mine operators to use conveyor belts to draw fresh air to the working face of a mine, despite the fact that in 1969, Congress made such ventilation plans unlawful. In another case, the Administration was embarrassed into withdrawing a proposal to permit miners to be exposed to higher levels of coal dust.

The Enactment of the MINER Act

On January 2, 2006, an explosion ripped through the Sago mine in Upshur County, West Virginia, trapping 13 miners underground. Fifty-two hours later, 12 of the 13 miners were brought out dead. Just over two weeks later, a fire at the Aracoma Alma Mine No. 1 killed two miners, and on May 20, 2006, an explosion rocked the Kentucky Darby Mine No. 1, killing five miners. In all, 47 coal miners would die on the job in 2006 – a ten-year high and more than twice as many as in 2005.

In the absence of any official Congressional committee hearing on the Sago tragedy, the Democratic Members of the House Education and the Workforce Committee (the name of the committee was changed to Education and Labor in January 2007) held a Forum on Mine Safety on February 13, 2006. The witnesses, including family members of miners killed on the job, shared accounts and perspectives on how to improve mine safety conditions in order to prevent further mining tragedies.

Following the forum, and the disasters at the Aracoma and Darby mines, then Congressman Miller and others introduced the “Protecting America’s Miners Act” (H.R. 5389) in May 2006, to revise safety, inspection, rescue, and emergency standards contained within the Federal Mine Safety and Health Act of 1977. Following the Darby incident, a more limited mine safety bill, the MINER Act, was overwhelmingly passed by the Congress and was signed into law on June 15, 2006.

At the time, Congressman Miller and others pointed out that the MINER Act was only a first step, and that much unfinished business remained.

Oversight and Investigative Activities During 2007

In 2007 in the new 110th Congress, the Education and Labor Committee initiated the first detailed oversight of MSHA activities in many years. Its first step was to take a careful look at the actions of the Administration in implementing the MINER Act.

On February 27, 2007, more than eight months after the signing of the MINER Act, the House Education and Labor Committee released a [staff report](#) which clearly documented that MSHA was moving far too slowly in implementing the new law, putting miners' lives at unacceptable risk.

That same month, the Committee also requested that the Government Accountability Office to do its own analysis of the implementation of the MINER Act, because the MINER Act permits MSHA to set separate schedules for implementation of various requirements at each mine. This analysis is now well underway. The Committee has recently been provided with detailed spreadsheets that show the status of implementation at each mine, including any delays in the actual implementation date at each mine that were approved by MSHA, and is carefully reviewing this documentation.

In addition, a number of letters were sent to the Department requesting information on specific oversight concerns and seeking specific action where appropriate. For example, on March 16, 2007, Chairman Miller wrote to Secretary Chao requesting that the Department issue an emergency temporary standard to immediately require the use of underground refuge chambers in underground coal mines throughout the nation (the Secretary declined).

The full Committee also held two oversight hearings on mine safety and health in 2007.

On March 28, 2007, the Committee on Education and Labor conducted an oversight hearing on the need for further reform of the current law on mine safety regulation. This hearing, "[Protecting the Health & Safety of America's Mine Workers](#)," revealed that, despite enactment of the MINER Act, many of the hazards that led to disaster at Sago, Aracoma Alma, and Darby remain just as real today as they were 18 months ago.

On May 16, 2007, the Committee on Education and Labor conducted a second oversight hearing to determine the effectiveness and progress of MSHA and its safety programs and initiatives since the enactment of the MINER Act of 2006. At this hearing, the Assistant Secretary for Mine Safety made very clear to the Committee that the Administration did not intend to go further than it was required to do under the MINER Act. Nor did it intend to move more swiftly than the deadlines established in that Act, notwithstanding new evidence that quicker action is feasible and necessary to ensure the safety of miners.⁵

The Committee's oversight role is continuing. Immediately following the accident at the Crandall Canyon mine, the Committee obtained and posted on its website a copy of the emergency response plan required of that mine pursuant to the MINER Act. The plan,

⁵ See, e.g., dialogue between Mr. Stickler and Chairman Miller, hearing of May 16, 2007, transcript p.49 et seq.

although approved by MSHA, revealed that the mine did not yet have the required supplies of breathable air. On August 24, 2007, Chairman Miller wrote to Secretary Chao reminding her of the importance of these emergency response plans, and requesting detailed information on each mine which did not have a fully approved plan and implementing equipment and procedures in place.

The Committee has recently initiated its own investigation into the Crandall Canyon mine disaster. As part of this investigation, the Committee will, among other things, specifically consider whether the mine operator and MSHA complied with the requirements of the MINER Act, as well as other requirements of existing law. The Committee will also consider whether, in light of the Crandall Canyon tragedy, improvements in the Miner Act are needed.

Development of New Legislation to Improve Mine Safety and Health

In June of this year, one year after the passage of the MINER Act, Education and Labor Committee Chairman George Miller, Subcommittee on Workforce Protections Chairwoman Lynn Woolsey, Resources Committee Chairman Nick Rahall, and other members of Congress introduced [the S-MINER Act \(H.R. 2768\)](#) and [the Miner Health Enhancement Act of 2007 \(H.R. 2769\)](#) to address the problems documented by the committee's oversight efforts.

As Chairman Miller noted on introduction of the bills, the MINER Act was "intended as only a down payment on what is needed to clean up years of neglect and backsliding by this Administration and an industry that had become, by its own admission, overly complacent."⁶ On July 26, 2007, the Subcommittee on Workforce Protections conducted a [legislative hearing](#) on the S-Miner Act and the Miner Health Enhancement Act of 2007.

Although a full investigation of the Crandall Canyon mine tragedy will take many months, there is a clear need for Congress to move forward on identifying some of the key issues raised by Crandall Canyon, as well as preventing many other types of serious accidents and diseases that continue to threaten miners' safety.

In this regard, the following is a summary of some of the provisions of the S-MINER Act which may be particularly relevant to what occurred at Crandall Canyon, including some initial thoughts about new issues raised by the Crandall Canyon tragedy.

Provisions of S-MINER Act particularly relevant to Crandall Canyon incident

*** Improving Tracking of Miner Location and Communication With Miners**

Crandall Canyon provided yet another reminder of how difficult it is to rescue miners when you don't know exactly where they are or their conditions following an accident. The MINER Act does not require new technology to track miner location and facilitate post-accident communication to be introduced into underground coal mines until June

⁶ Statement by Rep. George Miller, June 19, 2007

2009. NIOSH has now developed a roadmap for installing such new technology – a roadmap that calls for the prompt installation of the backbone of a new communications system. The S-MINER Act requires mines to be outfitted with this backbone within 120 days of passage, and to enhance it as quickly as possible as the NIOSH roadmap unfolds (Section 4(a)).

*** Keeping trapped miners alive**

The MINER Act required that miners be provided with a multi-day supply of breathable air near where they were working in order to sustain them should they become trapped. It appears from the mine’s Emergency Response Plan that these air supplies had not yet been provided at Crandall Canyon.

The MINER Act did not, however, require mine operators to provide underground shelters that would provide not only air but also food and water in a safe environment to await rescue, even though such shelters are commercially available. Instead, it only required that the matter be studied.

The S-MINER Act would require mine operators to install rescue chambers within the working areas of mines. (Section 4(b)). Earlier this year, Chairman Miller noted that “the state of West Virginia has required mine operators to install shelters in all underground coal mines... There is no reason why MSHA can’t require the same thing nationwide.”

The bill also requires atmospheric monitoring systems capable of surviving and functioning after an explosion so that air quality can continue to be monitored during and after an emergency – so they can determine whether rescue efforts can proceed. (Section 4(f)).

*** Rescue operations**

The S-MINER Act would clarify that no person can interfere with the Secretary’s rescue or recovery activities (Section 5(a)), and would add a new civil penalty for any such interference or retaliatory action against miners who report safety violations (Section 6(i)).

*** Accident prevention**

The S-MINER Act would provide for prompt notification to MSHA of serious incidents at mines that don’t cause immediate miner harm but are indicators of serious problems, such as a rib fall that impairs ventilation or impedes escape, or a coal or rock outburst that causes the withdrawal of miners. (Section 6(d)). This kind of reporting can help catch ground control problems that develop as mining progresses.

The S-MINER Act also provides for a two-year study of whether Federal licensing of mines, mine operators, mine controllers or other mine personnel would be valuable to ensure that those engaged in mining activities are not frequent violators of safety and

health requirements. (Section 4(l)). Committee staff members are currently developing additional options that may be appropriate in light of the Crandall Canyon incident.

The S-MINER Act includes a number of provisions to ensure that MSHA will be able to keep up with its workload and maintain its technical expertise during a time of transition to a new generation of inspectors. (Section 5(b)). While new inspectors are being hired, it takes time to get them in place, and more must be done to encourage existing experts who are eligible for retirement to stay on during this transition. It has been asserted that MSHA personnel responsible for approving various types of mining plans have been reassigned to inspection duties to ensure the agency can perform the minimum number of inspections it must do on each mine each year. Careful attention to such plans is critical to mine safety.

The S-MINER Act would require that MSHA create a Miner Ombudsman in the Office of Inspector General. This ombudsman would, among other things, help encourage miners and their families to report unsafe working conditions at their mines without risking the disclosure of their identities and subsequent loss of their jobs.

In addition, the S-MINER Act would ensure that mine operators who engage in a pattern or practice of violating the law are stiffly fined (Section 5(d)) and take a number of other actions to ensure that those really responsible for operations at a mine cannot hide behind a legal smokescreen.

*** Improvements to the Investigatory Process**

The S-MINER Act would bring about some badly needed changes in the way that mine accidents are investigated.

First, the S-MINER Act would require the Department of Labor to consult widely (including with family members of miners who perished in the last 10 years and state and local authorities) on rules to ensure consistency in its own incident investigation procedures (Section 6(g)). At the present time, MSHA develops the rules for each accident investigation on an ad-hoc basis.

Such regulations would also ensure that MSHA is able to undertake effective investigations by ensuring that witnesses are not coerced and are allowed to speak freely with investigators. Further, it would require that the reports include recommendations for avoiding similar accidents in the future and that they track progress on such recommendations and report it regularly to the Congress.

Recent decisions by MSHA about the representation of families in MSHA's investigation of the Crandall Canyon incident may warrant specific mention in the legislation.

Second, the S-MINER Act would establish a mechanism for independent investigation of mine accidents. As introduced, the bill provided a way to engage the Chemical Safety Board in such investigations. Following consultations with the Board, it appears that

while this would be an appropriate use of the Board for activities on which it has expertise (e.g., the propagation of explosions), an alternative mechanism for an independent investigation might have to be created to deal with mining accidents involving roof and ground control issues. Such a mechanism would have to ensure the investigation is truly independent.

Some initial thoughts on the Lessons of Crandall Canyon

While we are many months away from determining the causes of the Crandall Canyon tragedy and the problems with the rescue operation, there are a number of issues that the Education and Labor Committee will be investigating in order to consider possible legislation and to assist MSHA in addressing identified problems.

- **Need for faster development and introduction of tracking and communications technologies.** The rescue operation was clearly hampered by the inability to locate the trapped miners. As noted above, the S-MINER bill will accelerate the introduction of tracking and communications technologies, but we may need to do even more to stimulate research and development in this area.
- **MSHA's oversight of potentially hazardous mining plans.** In considering what happened at Crandall Canyon, the Committee will ask whether the process which MSHA is currently using to review plans for controlling the risks of roof fall and rib bursts requires changes or additional resources. It will also look at the adequacy of MSHA's inspections program in mines like Crandall, and whether MSHA's emphasis on compliance assistance and cooperation with employers compromised the agency's obligation to provide strong oversight and enforcement.
- **Hazards of retreat mining.** As coal prices rise, the mining of coal previously considered too dangerous to safely recover is becoming more common. As it examines what happened at Crandall, the committee will consider whether MSHA is equipped to deal with this new era, whether practices such as retreat mining should be banned in some cases, and whether additional research is needed.
- **MSHA's failure to ensure the Emergency Response Plans are complete.** The Committee has already drawn attention to the slow manner in which MSHA is implementing the requirements of the MINER Act. Parts of the Crandall Canyon Emergency Response Plan dealing with breathable air had not been completed at the time of the incident. The Committee is in the process of obtaining and evaluating mine-by-mine information in this regard.
- **Control of communications during mine rescue.** Although the MINER Act, passed little more than a year ago, clearly put MSHA in control of communications with the public and families during mine rescue efforts, to ensure that both got accurate information, the agency's efforts in this regard at the Crandall Canyon rescue fell short. There were a variety of different and sometimes conflicting or irrelevant messages issued at press conferences by the company with MSHA officials in

attendance. In reviewing what happened, the Committee will also look into the unprecedented approval of an underground visit by journalists and family members during a potentially dangerous rescue operation.

- **Safety of rescue personnel:** Three rescue workers were tragically killed during the rescue operation at Crandall Canyon. In reviewing the decision making that took place during this rescue, the Committee will consider what additional actions can be taken, or technology developed, to make rescue operations less of a risk to those brave enough to participate.
- **MSHA's Technical Expertise:** MSHA's personnel resources are known to be a problem, particularly given the age of the workforce and competition from the mining industry which is expanding. In examining what happened at Crandall Canyon, the Committee will consider whether the agency still has the resources it needs to evaluate mine plans and conduct inspections requiring expert knowledge.