

My name is Dennis O'Dell. First, I want to thank this committee for allowing me the opportunity to share with you the UMWA's thoughts and recommendations regarding how your committee should move forward. I am a thirty-five (35) year veteran of the coal industry beginning my career in 1977. I spent eighteen (18) years working as an underground coal miner at Consol Energy's Robinson Run mine in northern West Virginia; I spent ten (10) years working as an International Health and Safety Representative for the United Mine Workers of America (UMWA); and the last seven (7) years as the Administrator of the UMWA's Department of Occupational Health and Safety.

As part of my duties with the UMWA Health and Safety Department I have traveled throughout the United States and Canada inspecting coal mines. In addition, I have been an accident investigator for the UMWA for far too many mine accidents, coal mine fatalities, mine fires, mine explosions and other such events.

I have authorized or helped author the UMWA's accident investigation reports for numerous mining accidents and disasters including: the 1999 Consol Energy Loveridge mine fire and explosion; the 2001 Jim Walter Resources No. 5 explosion that cost the lives of 13 coal miners; the 2006 Sago mine disaster that resulted in the loss of 12 lives; and the April 5, 2010 Upper Big Branch Mine explosion that cost the lives of 29 coal miners, the worst mining disaster in U.S. history in over 40 years.

I have testified on Capitol Hill on several occasions regarding mine disasters, health and

safety legislation and regulations. I have also prepared the UMWA's comments to several proposed rules and final rules promulgated by the Mine Safety and Health Administration and helped draft mine health and safety legislation at both the state and federal levels. (Miner Act) (PA&WV).

For a two-year period, Alpha has agreed to establish a trust to fund projects designed to improve mine health and safety. The trust document states that these monies will be used solely to fund research and development projects designed to improve mine health and safety in order to redress the harm that is a subject of the Government's investigation of the Upper Big Branch disaster. Thus the reason, and subject of this meeting today.

While being able to respond quickly and efficiently to mine emergencies is very important, our primary focus should be on "accident prevention." Ladies and Gentlemen, colleagues, I am here to tell you that there is a common thread that binds each and every one of the many mining tragedies that have occurred throughout history. I am also here to tell you that if we as an industry ever expect to stop the needless and senseless carnage in the coalfields, we must get "Back to the Basics." The "basics" have improved mine health and safety, however, when the "basics" are ignored, disasters occur. The "Common Threads" and "Basics" I am referring to are found in countless accident investigation reports issued by the Mine Safety and Health Administration (MSHA), State agencies, the UMWA and Independent Investigative Parties for over 50 years. The findings and recommendations of these reports consistently echo the shortcomings and failures to comply with the "Basics." Almost all of the reports state that

the accidents could have been prevented if laws were being complied with and miners were properly trained. Most importantly, coal miners lives could have been saved.

All of the accident investigation reports commonly cite the failure to comply with many of the “Basics” listed below. These are the “Common Threads” I refer to.

- Failure to comply with approved Ventilation Plans
- Failure to comply with approved Roof Control Plans
- Inadequate miners’ training
- Inadequate Rock Dust application
- Failure to make required mine examinations (pre-shift; on-shift; weekly; and supplemental)
- Inadequate mine examinations
- Failure to maintain water sprays and maintain correct water psi (pressure per square inch).

- Worn bits and bitblocks
- Inadequate or leaking seals
- Failed Bleeder Systems
- Not maintaining escapeways
- Tampering with or failing to maintain or regularly use safety equipment - Methane monitors - Atmospheric Monitoring Systems - fire fighting equipment
- Accumulations of Deadly Float Coal Dust
- Poor Maintenance of equipment
- Failed Electrical Systems
- Command Center Inadequacies
- Culture/Philosophy of Production over Safety, including giving advance notice of MSHA or State inspections thereby interfering with inspectors work.

Until this culture of disregard and disrespect of complying with the law changes and we get “Back to the Basics”, disasters will continue to occur and coal miners will continue to die needlessly.

During my tenure in the coal industry, I have witnessed many changes in mining techniques and technology. For example, longwall panels are developed deeper, and longwall faces are wider and reduction of 4-entry mining to 3-entry mining. High voltage equipment is being used at the face, a practice once not permitted. As a result, coal is mined at a faster rate and larger volume. The problem with the development of new technology is that safety improvements do not always keep pace with advancements in mining production. Using my last example with longwalls, safety improvements must be addressed that include: helping miners escape more quickly; locations of SCSR's; roof control (added roof stresses); ventilation (more air is needed to pressurize the gob); rock dust application; and of course electrical safeguards just to name a few.

Another concern to be considered is the fact that mining conditions can vary from mine to mine and these differences must be addressed through mining plans, training and new technology. These are in addition to the already inherent dangers associated with mining. Conditions and variations such as: roof strata; depth of the mine; seam height; methane liberation; confined spaces; pressures; mining methods; electrical systems; haulage; the number of entries being mined; and isolated escapeways reduced. All of these variables must be considered when developing mining and training plans, as they all are critical to the safe

operation of a coal mine.

The constant development of new mining technology is critical to keeping pace with the ever-changing mining environment. We need improved gas detection devices; the next generation of self contained self rescuers; better communications; tracking systems; improved shelters/chambers; mining equipment that adapts to specific mining conditions; better atmospheric monitoring systems; coal haulage systems; and safeguards incorporated into the construction of mining equipment that will prevent tampering with and aborting safety devices.

Lets look specifically at some of the things we all learned from Upper Big Branch disaster:

The Investigation determined that Performance Coal Company (Upper Big Branch) failed to comply with the approved underground mine training plan in effect at UBB. It was determined that:

- Approximately 112 miners either did not receive experienced miner training or that the experienced miner training they received was incomplete;
- Approximately 42 miners did not receive required task training;
- Approximately 21 miners did not receive required annual refresher training; and
- Approximately 22 miners received experienced miner training from individuals who were not MSHA-approved instructors.

The Investigation determined that the underground conditions at the mine, including the extensive accumulations of loose coal, coal dust, and float coal dust, the lack of adequate rock dusting, and the poor condition of the longwall shearer, were present in part because the Operator failed to provide adequate training to miners on identifying and correcting these hazardous conditions.

The Investigation determined that Performance Coal Company and David Stanley Consultants, a contractor for the Operator, failed to conduct adequate pre-shift examinations in the north area of the mine between January 1 and April 5, 2010, thus allowing numerous hazardous conditions to remain uncorrected.

The Operator was cited for allowing miners to enter the mine prior to the completion of pre-shift examinations. Between March 18 and April 5, 2010, UBB Examiner Jeremy Burghduff failed to conduct pre-shift examinations before miners entered the work area. Additionally, he was found to have conducted examinations with his gas detector turned off. On April 4, 2010, examiner John Skaggs failed to examine the entire length of the longwall face prior to the maintenance shift. The examination encompassed only the stage loader area of the longwall section

Some other examples of deficiencies where the operator failed to conduct adequate examinations included: very obvious accumulations of loose coal, coal dust, and float coal dust present throughout the explosion area, return airways, and the travelways; and the Operator's

failure to follow the roof control plan requirements regarding entry widths in 16 locations. The Operator regularly failed to accurately measure the air quantity in the intake entries at the intake end of the longwall immediately outby the face. The operator was also cited because examiners did not sign pre-shift examination records.

Two separate sets of record books were maintained at UBB. The Operator recorded hazardous conditions in separate production record books and did not record them in the required pre-shift record books. The production records were not available to miners and regulatory inspectors. This practice concealed hazardous conditions from miners and regulatory inspectors and hindered their ability to take appropriate enforcement actions.

The list of improper, inadequate, and lack of examinations goes on and on. My point to all of this is that the investigation concluded the Operator's practice of failing to conduct adequate pre-shift, on-shift, weekly, and supplemental examinations exposed miners to ongoing hazards, and that this practice contributed to the occurrence and severity of the explosion, killing 29 miners.

Another alarming discovery from Upper Big Branch revealed that tests were conducted on lung tissue from 24 of the 29 victims. Five victims were not tested because there were not enough remains from the forces of the explosion to gather tissue. Among the 24 tested, 17 were discovered to have black lung. Some of the workers had spent less than 10 years working in the

mines. The ages of workers with black lung ranged from 25 to 61.

Many other deficiencies were uncovered during our investigation such as equipment not being properly maintained; mining plans not being followed; inefficient mining plans; lack of state and federal inspector accountability; poor mine rescue practices; lack of responsible persons; and command center decision making training.

Having fully and properly trained coal miners is one of the key elements in preventing accidents and saving lives. Coal miners are the “First Line of Defense” in identifying and preventing accidents and disasters. They must understand their mine’s ventilation, roof control and escapeway plans. They must understand the hazards associated with the safe operation of the equipment they operate or are exposed to. Most importantly they must know their escapeways should a mine emergency occur. They must understand how to traverse through a smoke filled entry or mine. Donning SCSR’s should be automatic (especially in smoke or in a bad atmosphere) and they should be trained on the restricted breathing they will encounter when donning an SCSR. They must know how to locate and use an emergency shelter. During any given week a miner could work in different locations in a mine and it is critical that they know the various locations of shelters, escape routes and safety protections available throughout the mine. Added emphasis needs placed on miners’ escape training. Miners should also be trained in basic fire fighting technologies. They will be the first responders and can be the difference between saving or losing lives, as well as the coal mine.

Equally important is the training of company foremen. After all, they are responsible for the miners under their charge and are looked to for guidance and direction especially if a mine emergency would occur. They are also responsible for making required mine examinations. MSHA and State rules, regulations and policies periodically change and it is critical that foreman are informed and properly trained of these changes.

Further, MSHA inspectors should be trained to enforce the Mine Act in a more consistent manner.

Upper Big Branch brought to light a major problem that still exists in certain segments of the coal industry involving a company's culture and overall philosophy towards production at any cost. A miner should not have to live under the constant threat of losing his job if he reports an unsafe condition or hazard. Miners at Upper Big Branch were intimidated and threatened on a daily basis. This became evident by the October 19, 2005 memo CEO 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.*" Massey and its subsidiaries did not have a monopoly on these illegal practices, but its rogue attitude had become well known in the industry, as an integral part of the operating culture at the Massey Energy's operations. 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 provide for their families. 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.

This culture was cited as a contributing factor to the explosion. Miners should be encouraged by companies to report unsafe conditions and the penalty for operators who violate this rule should be severe. Miners should be trained on:

- Miners' Rights
- Hazard Recognition
- MSHA's Hazard Reporting Hot Line. Companies should be required to post MSHA's Hazard Reporting Number at all mines.

As I previously stated, many of the issues I just outlined from the investigation of the Upper Big Branch explosion, can also be found in previous investigative reports dating back to 1968. And I am sad to report to you today, that MSHA's impact inspections show that they continue to exist today. Since April 2010, MSHA has conducted 464 impact inspections, which have resulted in a total of 8,283 citations, 833 orders and 33 safeguards.

As an example, MSHA conducted an impact inspection on June 21 of this year during the second shift at Bledsoe Coal Corp.'s Abner Branch Rider Mine in Leslie County, Ky. Inspectors immediately seized and monitored the mine's communications systems to ensure that advance notification was not provided to the miners underground.

The 19 citations and 12 withdrawal orders inspectors issued as a result of violations found effectively shut down the entire mine for eight days. Violations included accumulations of combustible materials in the motor compartment of a utility vehicle located in the primary escapeway; accumulations of loose coal, coal dust, black float coal dust and hydraulic oil on the roof bolting machine, along the mine floor and against the ribs; and an improperly functioning methane monitor, which did not provide a warning or de-energize the mechanized mining unit when necessary. MSHA also cited the operator for defective, bare electrical wires and inadequate splices on the utility vehicle in the primary escapeway. If left uncorrected, these conditions could spark a methane ignition, which, combined with inadequate rockdusting, could cause or contribute to a coal dust explosion.

Additionally, the mine operator did not provide adequate roof/rib control and failed to follow the mine's approved roof control plan. The operator also failed to identify, record and correct the absence of mesh that would prevent the fall of sections of the mine's ribs and roof.

As a second example, MSHA personnel conducted an impact inspection on June 20 of this year at Tunnel Ridge LLC's Tunnel Ridge Mine in Ohio County, W.Va., during the evening shift. The inspection party secured the mine's phones to prevent advance notice of the inspection. MSHA issued 34 enforcement actions, including 29 citations and five unwarrantable failure orders. This impact inspection was not the first impact inspection, but the second of the Tunnel

Ridge Mine.

An unwarrantable failure order was issued for failure to maintain the intake escapeway on the longwall section from the mine's working face. The escapeway was obstructed with mud and water up to 15 inches deep for a distance of 300 feet. A subsequent order was issued for the mine operator's failure to identify this hazardous condition during the pre-shift examination. By not recognizing and recording this hazard, the mine operator placed miners at risk of not having a safe way to exit the mine.

The mine operator also was cited for failing to conduct required methane tests at each working face. The Tunnel Ridge Mine has a history of methane liberation. Failure to perform adequate methane checks during the mining and roof bolting cycle could allow an unknown quantity of methane gas to accumulate without miners' knowledge and lead to a possible methane ignition.

An additional order was issued for the mine operator's failure to conduct an adequate pre-shift examination of the section. Conducting proper examinations and correcting hazardous conditions are essential to protect the health and safety of miners. Inadequate examinations allow miners to remain in areas where hazardous conditions may exist which, if left uncorrected, expose miners to the risk of severe injuries, illnesses or death.

Unfortunately, there are still mines that haven't gotten the message. Another example found during MSHA's May impact inspections was an underground operation where a continuous mining machine operating had the ventilation curtain rolled up and a 60-foot deep visible cloud of dust was present. The water pressure on the machine was inadequate and several sprays were inoperative. MSHA issued 43 violations including 16 unwarrantable failure orders.

With the charge that your committee has been given, an opportunity exist that can help advance and further enhance the safety protections of miners in this country. The uniqueness is that you can decide how to advance those protections and possibly prevent a mine disaster. There is a very old saying that every piece of health and safety legislation is written in the blood of a dead coal miner.

The UMWA recommends the following areas for to the Committees attention for needed improvements:

- An Escapeway Training Program
 1. Developing a Self-Escape Training Program.
 2. Developing simulated escape scenarios for miners to experience involving smoke, methane, fire, decision making, blocked escapeways, directional life-lines, etc.

and:

- a) Evaluating the effectiveness of the training (through interviews with participants of the training), and
- b) Developing a database of this information and making it available to all operators to assist in the development of Evacuation and Escapeway Plans.

3. Develop a Command Center Protocol

- Hazard Recognition

1. Developing a Hazard Recognition Training Program to be used in refresher training.

2. Conducting a study of hazard recognition with miners in a simulated mine.

- a) Evaluating the effectiveness of the training.

- b) Developing a database of information for all operators to use in improving hazard recognition training.

- Miners' Rights

1. Developing a comprehensive Miners' Rights Training Program and implementing it to allow for feedback and improvement; then sharing the lessons for all operators to implement.
- Foremen Training
 1. Developing a comprehensive training program for Foreman to include:
 - Compliance with Mandatory Standards
 - Hazard Recognition
 - Recordkeeping
 - Air readings
 - Gas detection
 - Safety Culture, including how to effectively encourage miners to serve as an integral part of a safety first approach; after developing the program, test it, study it and improve it; then share it so all operators can implement the improvements.
- Research & Development
 1. Developing and testing detection equipment to enhance required mine

examinations. After developing the protocol, test run it, study the feedback and improve it.

a) Create a database of information

2. Developing and testing Improved Tracking Systems and Atmospheric Monitoring Systems

- Mine Rescue Training

- Develop a Gas analysis and interpretation training program
- Develop a Gas Sampling Program
- Develop Command Center Protocol
- Develop Mine rescue training to include map reading; when to advance and when not to
- Who is in charge during a mine emergency operation?
- Briefing and Debriefing of Mine Rescue Teams
- Develop Mine Emergency Response Development (MERD) Exercises
- Development of advanced training courses for mine rescue specialists
- Training for emergency response decision-making and command center protocol
- Develop procedures for rescue teams to enter refuge chambers
- Identify circumstances that would allow command centers to deviate from existing mine rescue and recovery protocols. Further, identify specific procedures

and protocols that cannot be deviated from under any circumstance

- Post-accident evaluation of the mine environment, including the potential use of AMS and tube-bundle systems
- Methods to ensure that future rescue and recovery operations are conducted in accordance with accident-specific factors and not disproportionately driven by experience from previous mine emergency responses.

With the collection of this data, the mining community can use this information as a reference during mine emergencies. Operators in conjunction with training centers could use this information to conduct training for employees in a MERD exercise to better prepare the workforce in the event a disaster would occur.

As witnessed by my presentation, we have learned a lot from the Upper Big Branch disaster. The question is what are we going to do with this information. We have also learned from MSHA's recent impact inspections, that a culture still exists where the production of coal is still some mine operators' first priority. The UMWA applauds the work of this Committee and welcomes the opportunity to assist you in any way we can. The UMWA has over 112 years of experience representing the health and safety of coal miners and we firmly believe that coal can be mined in a safe, productive and efficient manner. Thank you again for the opportunity to address this body and I am available to answer any questions.