INDUSTRIAL HOMICIDE

REPORT ON THE UPPER BIG BRANCH MINE DISASTER

UNITED MINE WORKERS OF AMERICA

"The other question I'd like to pose is,

'Why didn't Don Blankenship SHUT this coal mine down?'

We don't have to question his authority. He runs this place. He could have walked up there and said this mine is shut down. This mine's not going to operate another minute until we correct these problems."

Cecil E. Roberts
President
United Mine Workers of America
Subcommittee of the Committee on Appropriations
United States Senate
May 20, 2010

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October 25, 2011

To the workers at the Upper Big Branch mine and the families of the victims of the explosion:

The 29 miners who died in the Upper Big Branch mine on April 5, 2010, did not go to work that day with the expectation that it was the last day of their lives. They kissed their wives and children goodbye and drove the twisting roads of Raleigh County, W. Va., to make their way to the mine.

Once there, they got into their work clothes, joked around with their buddies, then made ready to go to work. They perhaps knew something about the serious safety problems at the mine. Everyone who worked there knew something was off. But they didn't know just how bad it was, and anyway they figured there was nothing they could do about it. After all, fixing the mine's problems was the responsibility of management, under the oversight of the federal and state safety and health agencies.

The workers were right. But they were also, tragically, let down by the very people who were supposed to be keeping them safe. And because of that, those 29 husbands, fathers, brothers, sons and grandsons never came home.

There were many factors that led to this disaster. But there is only one source for all of them: A rogue corporation, acting without real regard for mine safety and health law and regulations, that established a physical working environment that can only be described as a bomb waiting to go off.

And that same company established a working environment where, operating through subterfuge, fear and intimidation, management prevented any opportunity for the workers to know the full range of dangerous conditions in the mine, or to effectively protest them even if they did know.

Federal and West Virginia mine safety and health law is very clear: It was the responsibility of the mine's operator, Performance Coal Company, and its parent company, Massey Energy, to operate the mine in a safe and healthy manner in compliance with laws and regulations. That did not happen at UBB.

Indeed, the UMWA's investigation reveals that well-established safety and health laws were deliberately flouted at UBB, even after the federal and/or state agencies cited the operator multiple times for breaking the law. The only conclusion that can be drawn is that Massey simply did not care if it broke the law. The safety of its employees was not worthy of its concern. The only thing that mattered was getting the coal out.

This attitude was not a creation solely of management at the UBB mine. Far from it. This was a company-wide practice, fomented and directed by those at the highest corporate levels. The UBB mine was not unique in its manner of operation – other Massey Energy mines were similar.

It is unconscionable, in the 21st Century, for a mine to be operated in the manner that UBB was. That it was allowed to be operated this way by the federal and state agencies is also unconscionable. Though not the perpetrators of the crimes committed at UBB, they failed in their responsibilities to be effective and thorough enforcers of the law.

Once again, miners have died because they were put in harm's way by their employer and not sufficiently protected by those who are charged with doing so. Once again, the television cameras have come and gone in a rural hollow in Appalachia and reinforced the false notion that mining coal is an inevitably deadly occupation.

Once again, those responsible for a mining disaster have tried to deflect blame onto others, while refusing to take responsibility for their own actions. And once again, the safety agencies have thrown a needless cloak of secrecy over the investigation into the disaster, hindering the ability of anyone to shine the full light of day on what happened and on those responsible.

Though the UBB mine was a nonunion mine, miners working there designated the UMWA as their representative in this investigation. Our charge is different from any other party to this investigation. We don't have operational policies from which to divert attention. We don't have regulatory enforcement actions–or inactions–to explain away. We don't have lawsuits to defend against.

All we have are the surviving miners, their families and most of all, the families of the victims. More than anyone, they deserve to know the entire truth about what happened to their loved ones. Because when all the investigations are finished and the lawsuits settled, their husbands will still be gone. Their fathers will still not be at their ballgames. Their sons will still not be there to flash a smile as they head out the door.

The memory of the 29 miners needlessly killed in this tragedy has been our only guide in this investigation. Their untimely deaths must be properly explained and those responsible

brought to justice. Their loss must be matched by a renewed sense of purpose on the part of those charged with protecting miners in the United States and in West Virginia.

To do any less will be an insult to their memory, and will threaten the health and safety of every current and future miner in the United States. We must not, we cannot, fail them.

Cecil E. Roberts
International President

Daniel J. Kane
International Secretary-Treasurer

Dedication

The United Mine Workers of America dedicates this report to the men and women whose job it is to toil within the deepest recesses of the earth, subjected to inherent dangers so that others may enjoy the basic comforts afforded by the coal they produce. These brave individuals, however, do not face this task alone. Like no other profession, the families of coal miners are as closely connected to the work that they do as the miners themselves. We must recognize the sacrifice and struggle of husbands and wives, mothers and fathers, sons and daughters, brothers and sisters and all those who make up the mining community. We must also dedicate this report to those individuals who, long after the cameras and microphones disappear, continue to live with the greatest loss imaginable: the loss of their loved ones.

On behalf of all the officers and members of the United Mine Workers of America, we wish to express our heartfelt sorrow and deepest sympathy to the families of each of these brave miners. The tragic and untimely death of your loved ones causes a pain that is too deep for mere words to provide comfort. The passing of each of these miners is deeply grieved not only in the homes of family and close friends but throughout the entire mining community.

The death of any miner in the performance of their job profoundly affects all miners, and all the members of the UMWA grieve with you. These miners' lives were a testament to love of family, hard work and dedication. Their deaths are a horrific reminder of how tragically short life can be, and how dangerous coal mining will be when profits are placed above safety and mining laws are ignored.

It is with great sympathy that we reflect on 2010 as an especially tragic and troubling year for the entire mining community. The loss of one coal miner is too many, but for 48 to be killed in a single year is unconscionable. Not since 1992 have we witnessed such carnage in the coalfields of this nation. The very reason for this report is rooted in the systemic, widespread failure and disregard for the system that was designed to protect miners. These failures resulted in the worst U.S. mining disaster in over 40 years, causing 29 miners to perish in a single catastrophic event.

Each life is precious, and as the number of deaths are reported over and over in various reports, those who were lost can become another statistic. These numbers strip away the human characteristics of the persons they represent. They make it easier to tell the story and somehow easier to accept. This should never be the case. These individuals were miners, they had families, they were part of our community and in fact were very much part of us. They lived a life of hard work, sacrifice and dedication. The names of the 48 miners who lost their lives in 2010 are:

Miner	Date	Age	Mine	Controlling Co.
Rudolph Lindstrom	1-2-10	57	Mine No. 1	Signal Peak Energy
Travis Brock	1-22-10	29	Abner Branch	Bledsoe Coal Corp.
Christopher Bell	4-5-10	33	Upper Big Branch	Massey Energy
Edward Dean Jones	4-5-10	50	Upper Big Branch	Massey Energy
Ronald Lee Maynor	4-5-10	31	Upper Big Branch	Massey Energy
Joe Marcum	4-5-10	57	Upper Big Branch	Massey Energy
Greg Steven Brock	4-5-10	47	Upper Big Branch	Massey Energy
William I. Griffith	4-5-10	54	Upper Big Branch	Massey Energy
Ricky Workman	4-5-10	50	Upper Big Branch	Massey Energy
Howard D. Payne, Jr.	4-5-10	53	Upper Big Branch	Massey Energy
Steven J. Harrah	4-5-10	40	Upper Big Branch	Massey Energy
Benny Ray Willingham	4-5-10	61	Upper Big Branch	Massey Energy
Carl Acord	4-5-10	52	Upper Big Branch	Massey Energy
Deward Allan Scott	4-5-10	58	Upper Big Branch	Massey Energy
Robert E. Clark	4-5-10	41	Upper Big Branch	Massey Energy
William R. Lynch	4-5-10	59	Upper Big Branch	Massey Energy
Jason Atkins	4-5-10	25	Upper Big Branch	Massey Energy
Joel Price	4-5-10	55	Upper Big Branch	Massey Energy
Michael Lee Elswick	4-5-10	47	Upper Big Branch	Massey Energy
Adam Keith Morgan	4-5-10	21	Upper Big Branch	Massey Energy
Charles Timothy Davis	4-5-10	51	Upper Big Branch	Massey Energy
Cory Davis	4-5-10	20	Upper Big Branch	Massey Energy
Richard K. Lane	4-5-10	45	Upper Big Branch	Massey Energy
Rex Mullins	4-5-10	50	Upper Big Branch	Massey Energy
Nicholas McCroskey	4-5-10	26	Upper Big Branch	Massey Energy
Joshua S. Napper	4-5-10	26	Upper Big Branch	Massey Energy
Dillard Earl Persinger	4-5-10	32	Upper Big Branch	Massey Energy
Gary Wayne Quarles	4-5-10	33	Upper Big Branch	Massey Energy
Grover Dale Skeens	4-5-10	57	Upper Big Branch	Massey Energy
Kenneth Allen Chapman	4-5-10	53	Upper Big Branch	Massey Energy
James E. Mooney	4-5-10	51	Upper Big Branch	Massey Energy
Ray Oney	4-11-10	61	MC#1 Mine	M-Class Mining
John King	4-22-10	28	Beckley Pocahontas	ICG Beckley
Justin Travis	4-28-10	28	Dotiki Mine	Webster County Coal
Michael W. Carter	4-28-10	28	Dotiki Mine	Webster County Coal
James R. Erwin	5-10-10	55	Ruby Mine	Massey Energy
Phillip W. Gustafson	6-8-10	38	Choctaw Mine	Taft Coal Sales
Jimmy Carmack	6-16-10	42	Clover Fork No. 1	Lone Mtn. Processing
Bobby L. Smith, Jr.	6-24-10	29	Leeco 68 Mine	James River Coal
Wilbert Ray Starcher	7-1-10	60	Pocahontas Mine	Massey Energy
Thomas N. Brown	7-9-10	61	Willow Lake	Peabody Energy
Jesse R. Adkins	7-29-10	39	Loveridge Mine	Consol Energy

Brian W. Mason	8-31-10	25	Freelandville	Triad Underground
John Tittle	9-3-10	37	Kansas Mine	Mallards Creek Energy
William R. Dooley	10-11-10	56	Kingston No. 1	Alpha Natural Resources
James Falk	10-27-10	39	River View Mine	River View Coal
Rhett Lee Mosley	11-23-10	32	Rex Strip #1	Rex Coal Company
Charles Qualls	12-4-10	32	Republic Energy	Massey Energy

To the families who lost a loved one: The easier path would have been to bear your tremendous loss alone, withdraw from public view and suffer silently. But you did not. You have confronted this terrible situation head on. Many of you have pressed the companies and your government for answers. You have spoken out in the press and at public meetings. You have asked questions and demanded answers.

By doing so, you have not only greatly honored the memory of your loved ones, but you have focused attention on the abusive culture of some coal operators in the mining industry. Your efforts not only demand that someone be held accountable, but they also offer added protection for miners working today. What we as a mining community owe these fallen miners is to ensure they did not die in vain. We must all learn from these tragedies.

To the members of the many mine rescue teams who served diligently through the days and weeks after the Upper Big Branch (UBB) explosion, we offer a special thanks. The task is never easy and seldom rewarding, but you are always willing to give your best effort. There are few who have the ability to face the dangers and uncertainty of the job you willingly perform. It does not go unnoticed or unappreciated. Thank you for your service to these fallen coal miners.

Finally, as we always do, we must recognize all the men and women who have given their lives in order to build and energize this nation. More than 100,000 coal miners have tragically died in the nation's mines in the past 110 years, and 100,000 others have succumbed to occupational diseases and the horrors of black lung disease. We also dedicate this report to your memory and to your families.

With this dedication, we are serving notice that we pledge to pursue whatever avenues we must to enact greater health and safety protections in our nation's mines. We will, to the extent possible, see that those who caused these tragedies are held accountable. And finally, and most importantly, we continue to work to make it possible for all miners to return home to their families at the end of every shift.

United Mine Workers of America

The United Mine Workers of America (UMWA) has represented the interests of coal miners in the United States and Canada for over 121 years. However, the employees at the Upper Big Branch Mine - South (UBB), despite trying to organize a UMWA local union in the past, were not members of the UMWA or any other union.

Shortly after the explosion, the UMWA was contacted by employees at UBB requesting that the Union represent their interests during the course of the investigation. The UMWA agreed to do so.

The UMWA made arrangements to facilitate a meeting between these miners and representatives of the Secretary of the U.S. Department of Labor. Such a meeting satisfied Section 103 (f) of the Federal Mine Safety and Health Act of 1977 (the Act) which states, in pertinent part:

> "Section 103 (f) Subject to regulations issued by the Secretary, a representative of the operator and a representative authorized by his miners shall be given the opportunity to accompany the Secretary or his authorized representative during the physical inspection of any coal or other mine made pursuant to the provisions of subsection (a), for the purpose of aiding such investigation and to participate in pre- and post-conferences held at the mine."

The determining language for designation as Representative of Miners, is found in 30 CFR §40.1 Definitions.

> "(b) *Representative of miners* means: (1) Any person or organization which represents two or more miners at the coal or other mine for the purposes of the Act..."

The UMWA was notified that as of April 23, 2010, the Federal Mine Safety and Health Administration (MSHA) recognized the Union as the miners' representative (attached). While the UMWA has had a presence at the mine site since the day of the explosion, it was not officially recognized by all parties until 18 days later. The UMWA notified Mr. Robert Hardman, District Manager, MSHA District 4; Mr. Ronald Wooten, then Director of the West Virginia Office of Miners' Health, Safety and Training (WVOMHST), and Mr. Wayne Persinger, General Manager, Performance Coal Company, of its representative status via letters dated April 30, 2010 (attached).

The UMWA's responsibility during this process under the Mine Act is solely to represent the miners at the operation. In order to do this effectively, the Union assembled a team of UMWA staff to participate in nearly all aspects of the physical investigation. These individuals traveled with and participated in the administrative process, the underground and surface investigation and all other processes to the extent MSHA permitted.

This report is the result of, and based on, our involvement in the investigation. The Union has reviewed the relevant, but limited, data we obtained and we have reached conclusions supported by the evidence. Our obligation is to see that the facts of the

investigation are brought to light and that the underlying causes for the accident are revealed.

However, the UMWA was barred by MSHA from participating in a very crucial stage of the investigation. When MSHA decided to conduct private interviews rather than holding public hearings, the families of the miners and the UMWA were excluded from this important process.

The Union believes the refusal by the Agency to permit the Representative of Miners to participate in the interviews was the wrong decision. Without open and transparent hearings, which MSHA is permitted to conduct under the Mine Act, we have unanswered questions regarding the thoroughness and validity of the investigation.

Despite repeated requests to participate in the interviews and for MSHA to hold public hearings (including a lawsuit filed by the Union in the Southern District Court of the State of West Virginia), we were denied an opportunity to participate. Likewise, repeated written and verbal requests for transcripts of the testimony have thus far been denied. The failure by MSHA to give the UMWA access to this critical information delayed the issuance of this report and made it much more difficult to complete.

Finally, it is the intention of the Union to call for those who were responsible for the conditions that led to the disaster to be brought to justice. The Union intends to do what it can to meet this obligation.

We offer this report as the starting point for whatever action may be necessary to bring this tragic event to closure for the families, friends and communities of the miners who perished on April 5, 2010.

Executive Summary

The United Mine Workers of America participated in an extensive investigation into the events of April 5, 2010, at Massey Energy's Upper Big Branch Mine - South[1] (UBB) in Montcoal, Raleigh County, West Virginia. Based on the findings of that investigation, the UMWA issues the following report.

The miners at UBB were not represented by the UMWA, nor were they members of any other union. However, in the aftermath of the explosion, and at the request of the UBB miners, the UMWA was designated as the Representative of Miners on April 23, 2010. It is important to note that representatives of the UMWA were on site well before that date, having been dispatched immediately upon the Union learning there was an accident at the mine.

There is no way of knowing the extent to which miners underground on the afternoon of April 5 were aware of the magnitude of the events that were about to unfold in the mine. Clearly, workers at UBB were fearful, because of management intimidation, to report to anyone that the mine was not safe. The threat of reprisal, including job loss, was so real the employees did not feel they could report hazardous conditions at the mine.

Given the overall poor condition of the mine in general, it is <u>not believable</u> that management personnel did not know that these conditions posed a substantial and immediate hazard to the miners and could possibly escalate into a catastrophic event. Massey's knowledge of the hazardous conditions is confirmed by the practice at the mine of keeping two sets of record books. One set was for Massey's eyes only, that documented the actual conditions, and the other an official record which concealed the truth. Mine management had the ability to act and the responsibility for correcting all conditions, but because of the culture created by management at the highest levels of the company, management failed to correct many hazardous conditions.

The extremely violent explosion that tore through the mine that afternoon created a path of destruction that took the lives of 29 miners located at or inby 66 break of 5 North Mains. The path of the explosion, aided by poor ventilation practices, ineffective water sprays, excessive accumulations of float coal dust and inadequate rock-dusting, sealed these miners' fate.

Many of the conditions created in the days and months before the explosion contributed to the nation's worst mining disaster in 40 years. Before self-extinguishing, the explosive forces, fueled by float coal dust, traveled through more than seven miles of mine entries. The explosive forces were so powerful that they destroyed hundreds of ventilation controls and miles of beltline, and hurled heavy equipment throughout the mine entries.

[1] Performance Coal Company, a subsidiary of Massey Energy, operated the UBB mine. Throughout this report we will generally refer to the company by the name "Massey" or "Massey Energy."

The Union absolutely rejects the self-serving theory advanced by Massey Energy that a massive inundation of natural gas was the fuel that propagated the explosion. There is no evidence to support this theory whatsoever. To the contrary, the direction of the explosion and the extent of the destruction clearly demonstrate that the UBB mine experienced an explosion initiated by methane gas, which was then fueled by float coal dust.

The only logical explanation for an explosion to travel seven miles underground is that it had to have been propagated by a continuing supply of highly explosive fuel. The only available fuel supported by the evidence that is sufficient to propagate an explosion of this magnitude is float coal dust.

Massey claims that a crack in the floor of the mine was the source of a natural gas inundation that caused the explosion. That claim is simply not supported by the evidence revealed in the investigation. When it was excavated, the 'crack' only extended a short way, becoming solid rock again and showing no signs of gas seepage from the underlying coal seam.

It is the determination of the Union that the sparking of the shearer bits and bit blocks, aided by missing and ineffective water sprays, a lack of water pressure and inadequate ventilation, ignited a pocket of methane at the tailgate near the longwall. The ignition traveled into the gob where it encountered an explosive methane-air mixture, resulting in an explosion. The explosive forces picked up and suspended float coal dust in the mine atmosphere in sufficient quantities to initiate a massive dust explosion.

The fact that the UBB mine was not adequately rock-dusted played a significant role in the death of the 29 miners. Massey's failure to adequately rock-dust the mine permitted excessive amounts of float coal dust to accumulate throughout the mine. This float coal dust served as a self-propagating fuel source as the explosion tore through the mine.

MSHA rock dust surveys demonstrate that Massey failed to maintain the incombustible content of the float coal dust at legal levels. The WVOMHST issued over a dozen violations for "cleaning or rock-dusting" in the eight months of 2009 that an inspector was at the mine. Six additional violations were issued for these conditions in the first quarter of 2010.

It is the UMWA's opinion that had Massey Energy adequately rock-dusted the mine, float coal dust would have been inerted and the dust explosion would have been prevented.

This explosion traveled in both directions of the longwall face with the major forces exiting the tailgate entry. The forces traveling outby towards the 5 North Mains split in several directions, following the fuel source back into the longwall headgate entries and the continuous miner sections inby the North Glory Mains.

The dangerous conditions that contributed to the explosion existed at the mine on a daily basis. These conditions, which represented gross violations of mandatory health and safety standards, were not accidental. They were permitted to exist by a corporate management at Massey that created a culture that demanded production at any cost and tolerated a callous disregard for the health and safety of the miners employed at the operation.

This attitude was made very clear when Edward Dean Jones (victim), a Section Foreman at UBB, attempted to keep his men out of the mine because of dangerous conditions and was told, "If you can't go up there and run coal, just bring your bucket outside and go home." (*National Public Radio*, [NPR] June 29, 2011) Gina Jones, Dean Jones's widow, explained that he tried to keep his men outside because, "I told him to." She went on to tell him, "They (Massey) don't live your life. They don't care about you." (*NPR*, June 29, 2011)

The extent to which this attitude existed throughout Massey Energy is made apparent in an October 19, 2005, memo from CEO Don Blankenship. It states, "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 coal pays the bills" (attached).

Massey management bears primary responsibility for this tragedy. Massey Energy is mandated to comply with the mandatory health and safety regulations, yet its mine management failed to comply with these requirements. This responsibility was routinely ignored and in many instances openly disregarded by Massey Energy's management from mine level managers at Performance Coal Company's UBB mine to the highest offices within the company.

Massey Energy must be held accountable for the death of each of the 29 miners. ***Theirs is not a guilt of omission but rather, based on the facts publicly available, the Union believes that Massey Energy and its management were on notice of and recklessly tolerated mining conditions that were so egregious that the resulting disaster constituted a massive slaughter in the nature of an industrial homicide.***[2]

MSHA also bears some responsibility regarding its knowledge of the serious ventilation problems that existed at UBB mine over the past several years. It is the UMWA's opinion that the ventilation plan, along with the numerous revisions submitted by Massey and approved by MSHA District 4, was flawed. MSHA permitted the use of 33 sets of double/airlock doors to control ventilation in lieu of utilizing conventional ventilation controls, such as overcasts, undercasts and regulators. While the doors are not illegal, their use is a very poor practice. We understand that no other mine of that size in the United States utilizes that many sets of double/airlock doors.

In addition, the sheer number of citations MSHA issued to Massey in the 15 months leading up to the explosion, including:105 citations and orders for not complying with the approved ventilation plan covering air reversals; not maintaining the minimum velocity of air on the sections;

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[2] "Industrial homicide" is not a specific criminal act and technically speaking is not one of the classes of homicide in either the State of West Virginia where the tragedy occurred, or in the Commonwealth of Virginia where both the Company and Union headquarters are located. Nevertheless, there is evidence that the Company's conduct interfered with the proper performance of mine health and safety laws and regulations to such an extreme extent that the Union believes that government would be able to prosecute Company representatives under applicable criminal provisions for their roles in permitting the dangerous conditions in the UBB mine that killed 29 miners.

making intentional and illegal air changes with miners working inby; cement blocks missing from brattice walls; airlock doors left open; ventilation controls constructed from non-permissible material; and seals leaking should have raised red flags. Four of the orders were issued six months prior to the explosion for air traveling in the wrong direction and intentional air changes made with miners working inby. This does not include approximately 59 citations issued by MSHA to Massey for failing to make required pre-shift, on-shift and weekly examinations.

While the UMWA applauds the MSHA inspectors for issuing the citations, it is clear that these enforcement actions did not motivate Massey to change its practices to comply with the law. We believe the vast number of citations issued proves that MSHA District 4 had knowledge of the serious ventilation problems that UBB was experiencing, which should have warranted a higher degree of enforcement activity by the Agency including: increasing the gravity of the citations being issued, enhanced enforcement activity and targeting UBB for a Pattern of Violations (POV). Most importantly, the UMWA believes MSHA should have used every tool at its disposal to shut down Massey's UBB mine until the egregious problems were corrected.

However, a culture existed at MSHA District 4 that made the likelihood of increased enforcement all but impossible. For example, MSHA inspector Minnis Justice reported that he was told by his superiors not to cite some violations and reduce the severity of others (*Simple Legal Docs*).

Bob Cavendish, another MSHA inspector, was assigned to UBB and had a run-in with Don Blankenship. He stated that, "...within a month, MSHA supervisors gave him another mine to inspect, in spite of Agency practice that a mine stay with the same inspector for a year." When he complained to his supervisor he was told, "...we are having a work realignment." However, Cavendish stated, "...that was the only mine I know of to be realigned." (*West Virginia Blue 6-23-11*)

We also learned from testimony that Massey routinely knocked holes in ventilation controls and opened double/airlock doors to re-route air. This is a blatant violation of the approved ventilation plan and the law that contributed to the events of April 5. We understand that approximately two weeks prior to the explosion, MSHA conducted a ventilation survey at UBB. The Union does not have the results of that survey. While we again commend MSHA for its action, it was too little, too late.

The UMWA wishes to be very clear: Massey Energy had overall responsibility to maintain the UBB mine in a safe operating condition at all times. Massey had the responsibility to comply with all mandatory health and safety standards. However, it was MSHA's job to oversee compliance and to be the "watch dog."

The UMWA believes that had Massey Energy been in compliance with all the mandatory health and safety standards related to the conditions that contributed to the explosion on April 5, 2010, the explosion would not have occurred.

The evidence also shows that Massey's approved roof control plan was ineffective. There are numerous accounts of roof falls above the anchorage points of the bolts and heaving that crushed out ventilation controls. However, there is no evidence that Massey or MSHA sought to improve the plan

by reducing entry widths, increasing pillar sizes or requiring any other necessary safety precautions.

With both the headgate and tailgate entries becoming impassible because of roof falls and accumulations of water, MSHA required Massey to mine new tailgate entries. However, MSHA permitted the new longwall entries to be mined in exactly the same manner as the previous setup.

The issue of record-keeping must also be questioned at UBB and other Massey Energy operations. Since the explosion, it has been determined that Massey kept two sets of books at UBB: the official record books which everyone at the mine has a right to examine and a second set of "production and maintenance" books that were not made available to inspectors or miners. The official books did not reveal all of the hazards or problems observed by certified examiners during the shift as required by law. Instead the Company hid this information in the "production and maintenance" books where only select management personnel would see them and know what the actual conditions were in the mine.

There are several questions regarding such record-keeping that must be asked. First, why would it be necessary to keep both sets? The only explanation is, like an accountant hiding the true figures, Massey was hiding some of the real conditions at the mine. Second, how could government inspectors and mine management look at the official record books that reported the mine to be safe, then enter the mine and find so many problems and not wonder what was happening? It should not be lost that high ranking Massey officials were required by law to review and countersign the official record books.

The West Virginia Office of Miners' Health, Safety and Training (WVOMHST) must also bear some responsibility for its actions. The WVOMHST is required to review and approve mining plans. Given the hazardous conditions that existed at UBB, the State had the authority to shut the mine down, but it failed to do so. The Union wholeheartedly concurs with the finding of the Governor's Independent Investigation Panel (GIIP) that the relationship between the State and the industry it regulates must be changed.

The UMWA reviewed and assessed the relevant evidence, including the limited documentation provided by the federal and state agencies to the Union regarding the UBB disaster. This evidence, along with the conditions at the mine, led us to our conclusions. We have made recommendations and seek reforms to eliminate the barriers to miners seeking healthier and safer working conditions.

We note that some information, including transcripts of the miners' testimony, has been withheld by MSHA and the State. The only interview transcripts the Union received were the 25 transcripts of mine rescue team members posted by MSHA on the internet. However, we note that over 300 interviews were conducted in the course of the investigation.

While knowing the causes of these types of disasters is important in trying to prevent them in the future, it is also important for lawmakers and regulators to admit that after so many coal mine tragedies, it is time to stop the rhetoric and take real action to protect miners' health and safety.

While taking into consideration the shortcomings of the enforcement agencies, it

is clear that had Massey Energy fulfilled its regulatory obligation to comply with the mandatory standards, there is every reason to believe that all 29 miners at UBB would be alive today.

As an authorized Representative of Miners at UBB, the UMWA has a solemn task. We are not charged by any government or board of directors to issue findings that offer a certain perspective or meet any preconceived conclusions. Rather, we are charged with a much greater undertaking. We are charged by the families of the deceased miners, those miners who lost co-workers and the membership of the UMWA to determine the cause of this tragedy and see that those responsible parties are held accountable. We intend to uphold our obligations to these individuals without reservation.

It is our greatest hope that this is the last such report we will have to ever write.

General Overview

Upper Big Branch Mine – South

The Upper Big Branch Mine–South (UBB), MSHA ID number 4608436, is located at 130 Frontier Street, Raleigh County, Montcoal, West Virginia. It was purchased by Massey Energy on October 15, 1994, in the sale of its parent company, Montcoal, by Peabody Coal Company.

The mine accesses the Eagle Coal Seam through sixteen surface openings and one shaft at the Bandytown Fan. It is ventilated using three fans in a "push-pull" system.

The South Portal Fan is an Industrial Welding Buffalo blowing fan equipped with a six-foot diameter axial blade, operated by a 480-volt, 200 horsepower motor that generates 1,200 rpms. This fan is used primarily to ventilate the South Mains area of the mine.

The North Portal Fan is a Joy Model 12065D blowing fan equipped with a ten-foot axial blade operated by a 4,160-volt,1,000 horsepower motor that generates 900 rpms.

The Bandytown fan is a Robinson Model DA 97AF1029-116 exhausting fan equipped with an eight-foot centrifugal blade operated by a 4,160-volt, 2,000 horsepower motor that generates 890 rpms.

The mine operated five continuous miner sections and one longwall on two production shifts and one maintenance shift every 24 hours. The average coal seam thickness is 54 inches and the average mining height is 84 inches. The mine produced 1,235,462 tons of coal in 2009, the last full production year before the explosion. At the time of the explosion, the mine employed 234 underground and two surface employees.

In 2009 the mine reported fourteen non-fatal days lost accidents (NFDL) for an incident rate of 5.81, almost 45 percent higher than the national average. However, a Part 50 audit conducted by MSHA after the explosion uncovered eleven more incidents in 2009 that had not been reported as required by law, meaning its NFDL rate was actually much higher.

From January 1, 2009, through April 5, 2010, MSHA cited the UBB mine 645 times for violations of the Mine Act, or the applicable regulations found at 30 CFR. The Agency assessed penalties for these violations at $1,249,186.

The company has contested 229 of these citations. While the contested citations represent less than 36 percent of the total number issued, it is important to note that the contested citations represent $929,245–or more than 74 percent–of the assessed fines.

While citations are being contested, MSHA cannot use them to increase enforcement pressure on the operator, including the issuance of a pattern of violations. Fines for contested citations cannot be collected until they are final.

Explosion of April 5, 2010, and the aftermath

Pumpers

The pumper crew; Jason Stanley, a "red hat" or inexperienced miner, David Farley, who had recently become a certified miner and Jeremy Burghduff, a Foreman, entered the mine at approximately 6:28 a.m. from Ellis Portal. They passed 78 break at approximately 7:15 a.m. and proceeded inby. Both Stanley and Farley commented that the air velocity in the mine seemed very low, even for a mine like UBB that experienced routine ventilation problems. Farley stated, "...it was almost like there was nothing." (GIIP at page 17)

The crew proceeded into the mine to the tailgate entries of the longwall. The mine had been idled the previous two days, and upon arriving at their designated work area, the crew realized that sometime over the weekend the pumps had shut down. Stanley and Farley headed inby to begin working on the pumps.

Burghduff did not preshift the area as required by law and the two pumpers were permitted to advance in the unexamined entries without a detector. As they did so, they noticed that this area of the mine, which was usually cold because of the velocity of the air moving through the returns, was hot. Farley stated in testimony that, "...that day it was miserably hot. I ended up taking, because we've got to put our waders on, and I ended up taking my long johns off. I mean I was just in my boxers. I mean it was hot hot." (GIIP at page 18)

Because they did not have the necessary parts, the crew could only repair four of the six pumps during the course of their shift. It is not clear how far the two traveled into the tailgate entries that day. Reports from those familiar with the witnesses' private testimony indicated the tailgate entries were not passable all the way to the back of the longwall panel.

At approximately 1:50 p.m., the pumpers headed outby and located Burghduff lying down at break 92. The Union has not been afforded the opportunity to review the examination books to see if Burghduff signed for making his examination of the area that day. The three men left the area and on their way out picked up Ralph Plumley, Owen Davis and Eric Jackson (track crew) at Ellis 5 belt head. They passed by 78 break at approximately 2:36 p.m., returning to the surface at 3:01 p.m.

Construction Crew: Seven North Belt

Mike Kiblinger, Foreman, entered the mine at approximately 6:05 a.m. from Ellis Portal with two unidentified individuals. The tag reader at Ellis Portal recorded tag numbers 723 and 729, however, these numbers are not assigned in the computer database. The three proceeded inby 78 break at 6:36 a.m. and traveled to the Glory Hole where a construction crew was preparing to set a new belt head in the area where Headgate 22 belt would dump coal onto the Seven North Belt.

While the crew was cutting the belt channel in the roof, Kiblinger notice the airflow in the area had changed. He noted, "The Thursday before the explosion... the air was blowing out of the mine." When he returned Monday, "...the air was blowing into the mine, towards the longwall." (GIIP at page 19) The three left the area at approximately 8:45 a.m. and arrived on the surface at 10:15 a.m.

The remainder of Kiblinger's crew, John Cox, Mark Gilbert and Jerry Weeks, entered the mine at 8:30 a.m. from the North Portal. They traveled past 78 break at approximately 9:10 a.m. and continued inby to take supplies to the Headgate 22 Section. They returned to the mother drive construction area at approximately 9:31 a.m. After spending some time there they exited the mine through the Ellis Portal at 11:45 a.m.

Construction Crew: Ellis Portal

Joshua Williams, Jeremy Reed, Joe Ferrell, Charles Smith and Bobby Baker, Foreman, entered the mine at 6:40 a.m. from the North Portal. They passed Ellis switch at approximately 6:59 a.m. and proceeded to the Ellis Construction site. When the crew arrived, Williams immediately noticed something was different with the ventilation. On Thursday, April 1, 2010, the air was going outby towards Ellis Portal. When they returned on Monday, April 5, 2010, he noticed the air "all going inby, back up towards Ellis switch and... toward the longwall." (GIIP at page 19)

Bob Sullivan and Roger Toney, also members of the construction crew, entered the mine at approximately 9:40 a.m. from the North Portal. They traveled past Ellis switch at 10:54 a.m. and proceeded to the Ellis Construction area. The crew worked in the area cutting the overcast for the new longwall panel until about 2:45 p.m.

The crew boarded their mantrip and began to exit the mine at approximately 2:55 p.m. As they proceeded towards the North Portal, the air velocity in the mine suddenly increased and the power went out. Toney, who was operating the mantrip, noted, "...instantly, you couldn't see anything. It just – dust blew over top of us." (GIIP at page 25) Williams felt his ears pop and noticed "it was throwing blocks. That's when I laid down in the mantrip and threw my jacket over my head and was starting to get my self rescuer out because I didn't know what was going on."

With the power out in the mine, the pressure wave from the explosion pushed the construction crew mantrip about five breaks. When power was restored, a decision was made to exit the mine through the Ellis Portal. Toney began to drive the mantrip towards the Portal. After derailing the mantrip twice, some of the crew got out of the mantrip at the Ellis Construction site and began walking out of the mine. Toney finally moved through the switch and the mantrip proceeded to the surface.

Barrier Section Crew

Melvin Lynch, Chris Cadle, Jeremy Rife, Danny Williams, Eddie Foster, James Bailey and Wes Curry entered the mine at 6:40 a.m. from the North Portal and traveled to the Barrier Section. Because the tracking system was not fully operational, we remain uncertain of who the crew members were that day.

At approximately 6:41 a.m., Mine Foreman Rick Foster and Examiner Jim Boyer, traveling with a federal inspector

(whose name MSHA has not released), entered the North Portal and traveled to the Barrier Continuous Miner Section. They arrived at 6:51 a.m. and started to inspect the area. The inspector wrote two citations; one for failing to keep the escapeway map up to date and a second for an inadequate splice on the trailing cable of the miner.

Boyer left the Section at approximately 7:15 a.m. but remained in the area, however, there is no record of where he traveled. Boyer exited the mine through the North Portal at 2:24 p.m.

Foster and the inspector left the Section at 11:00 a.m. and exited the mine through the North Portal at approximately 11:20 a.m.

The crew completed their shift and left 52 break at 3:27 p.m. They exited the mine through the North Portal at 3:35 p.m., over 30 minutes after the explosion.

Mine Examiners

Belt examiner Scott Halstead entered the mine at 6:07 a.m. from Ellis Portal. He arrived at 78 break at approximately 6:45 a.m. and began his examination. This examination included belts on the Longwall Section, 6 North, 5 North, 4 North and Ellis belts. He was tracked at 78 block at 12:47 p.m. and exited the mine through the Ellis Portal at 2:25 p.m.

Examiner Lacy Stewart entered the mine at approximately 6:45 a.m. and traveled to the Barrier Section. He was also charged with examining the Portal Section, however, that examination has not been confirmed. He exited the mine at approximately 2:25 p.m..

Examiner Charles Semenske entered the mine at 6:35 a.m., most likely from the North Portal. He traveled by 62 break at approximately 6:50 a.m. en route to perform a weekly examination of the Lower Big Branch (LBB) area of the mine. He exited the mine at 12:20 p.m., probably through the North Portal.

Belt examiner Michael Elswick (victim) entered the mine at approximately 6:03 a.m. from the Ellis Portal. He traveled past 78 break at approximately 6:36 a.m. and proceeded inby towards the working sections. He examined Headgate 22, Tailgate 22 and 7 North belts. In his final call outside to report his examination, he noted the belts had coal accumulations and needed to be rock-dusted. Elswick's body was located near the construction area for the new mother belt drive.

Examiner George Curry entered the mine at approximately 6:42 a.m. from the North Portal and arrived at the Barrier Section at 8:14 a.m. During his examination, he reached Ellis switch at 10:53 a.m., 78 break at approximately 11:12 a.m. and returned to the Barrier Section at 12:23 p.m. He left the Barrier Section at 1:59 p.m., exiting the mine through the North Portal at approximately 2:07 p.m. Curry was examining seals and the LBB power centers and pumps.

Belt examiner Tim Williams entered the mine at approximately 6:33 a.m. from the North Portal. He arrived at the Barrier Section at approximately 6:48 a.m. It is not clear where Williams traveled from that point, but he exited the mine through the North Portal at 2:11 p.m.

Track Crew

The track crew, Ralph Plumley, Owen Davis and Eric Jackson, entered the mine at approximately 7:20 a.m. from the Ellis Portal. They traveled inby 78 break at approximately 7:50 a.m. There is no further report of their activities until 2:30 p.m. when they traveled outby 78 break. The crew left their track jeep at Ellis 5 belt head and rode out with the pumper crew. They exited the mine through the Ellis Portal at approximately 3:01 p.m.

Supply Crew

The supply crew entered the mine at approximately 8:16 a.m. from the North Portal. They passed 78 break at 8:57 a.m. There was no further report of their activities until they traveled outby 78 break at approximately 2:30 p.m. They exited the mine through the North Portal at 3:00 p.m.

Supply man Clifton Earls entered the mine at approximately 9:36 a.m. from the North Portal. He traveled past Ellis switch at around 10:01 a.m. on his way to deliver a high-voltage cable to the Ellis Construction Section. He traveled back past the Ellis switch at 12:14 p.m. and arrived at the North Portal at approximately 12:32 p.m.

Earls re-entered the North Portal, arriving at the Barrier Section at 1:05 p.m. He later exited the mine through the North Portal, arriving on the surface at 2:07 p.m.

Electricians Tommy Sheets and Virgil Bowman entered the mine at approximately 10:20 a.m. from the North Portal. They traveled to the Glory Hole area where they strung power cables for the new mother belt drive. They left the area, passing by 78 break at 2:25 p.m., and exited the mine through the North Portal at 2:51 p.m.

Mine Superintendent Everett Hagar and Longwall Coordinator Jack Roles entered the mine at approximately 8:35 a.m. from the Ellis Portal. They traveled to the mother belt drive construction area, arriving at 9:37 a.m. MSHA reported that Roles was also on the Longwall face at some point during the shift. The two traveled outby, passing 78 break at 1:55 p.m., and exited the mine through the Ellis Portal at 2:21 p.m.

Mine Manager Wayne Persinger was tracked around Ellis Portal on April 5, 2010. He indicated he went to the Ellis Construction Section that day. Testimony indicates he was on the surface at the time of the explosion.

According to witness testimony, Charles Athey, Dennis Simms and Jacob Doss were also underground on April 5, 2010. It is believed they were shoveling the belt near the Ellis Construction Section. These individuals were not wearing tags, or the tags they were wearing did not have names associated with the tracking database.

There is also witness testimony that employees were working in the South Mains area of the mine. It is reported that they remained underground until 4:00 p.m., almost an hour after the explosion. It is unclear who these individuals were because the tracking system was not operational in that area of the mine.

At the time of the explosion, second shift longwall employees were approximately 3 breaks underground boarding their mantrip. Kevin Medley, Cody Davis, Kenny Woodrum, Josh Stout, Kevin Brown, Tommy Estep, Dustin Ross, David Shears and another miner whose tag was not read by the system were preparing to travel to the longwall.

Tailgate 22 Crew

William Lynch (victim), Carl Acord (victim), Benny Willingham (victim), Robert Clark (victim), Jason Atkins (victim), Steven Harrah (victim), Deward Scott (victim), Tim Blake (survivor) and James Woods (survivor) entered the mine at 6:42 a.m. from the North Portal. They traveled past 78 break at 7:15 a.m. and proceeded to the Tailgate 22 Section.

The crew completed their shift and boarded the mantrip to exit the mine. At 78 break, James Woods, who was operating the mantrip, called outside to the dispatcher for clearance to proceed to the surface. The mantrip moved outby to 66 break when the explosion occurred. Seven members of the Tailgate 22 crew were killed as a result of the blast.

Headgate 22 Crew

Ricky Workman (victim), Howard Payne (victim), Ronald Maynor (victim), James Mooney (victim), Kenneth Chapman (victim), William Griffith (victim), Joseph Marcum (victim), Gregory Brock (victim) and Edward Jones (victim) entered the mine at 6:05 a.m. from Ellis Portal. They traveled past 78 break at approximately 7:15 a.m. and continued inby to the Headgate 22 Section.

The rescue and recovery records show that the crew had completed its shift and was preparing to leave the section when the explosion occurred. Six of the victims were located in the mantrip and the other three were located in the track heading. It appears these three were walking toward the mantrip in preparation to exit the mine.

Longwall Crew

The longwall crew, consisting of Rex Mullins (victim), Nicolas McCroskey (victim), Joel Price (victim), Gary Quarles, Jr. (victim), Christopher Bell (victim), Dillard Persinger (victim), Richard Lane (victim) and Grover Skeens (victim) entered the mine at approximately 6:04 a.m. from the Ellis Portal. Members of the crew arrived at the longwall and began loading coal.

Adam Morgan (victim) and bolters Cory Davis (victim), Joshua Napper (victim), and Charles Davis (victim) rode to their workplaces with the longwall crew. They were working in the track heading outby the longwall headgate.

Ignition, Explosion and Aftermath

Based on the evidence, the following represents the UMWA's reconstruction of events in the hours and minutes immediately prior to the explosion, and the Union's theory as to the cause of the disaster:

The shearer made two passes by approximately 11:00 a.m. when the "B-Loc," a retainer that holds the hinge pin for the ranging arm in place, malfunctioned, shutting down production. The crew had trouble making the repair, and reports indicate the hinge pin did not line up properly. Finally at about 2:15 p.m., repairs were completed and the crew was ready to load coal. The last call out from headgate operator Rex Mullins was shortly after 2:30 p.m., when he reported the shearer was at shield 115, cutting towards the tailgate.

The shearer continued down the face and shortly before 3:00 p.m., the taildrum cut out into the return entry of the tailgate. It is the consensus of all parties involved in this investigation (except Massey Energy) that sparks caused by the bits striking sand rock on the face ignited methane that had migrated from the gob onto the face. The methane had migrated onto the face as a result of inadequate ventilation. At that moment, MSHA determined that the shearer was de-energized at the tail drum remote control (panic button).

The investigation revealed the water was shut off at the headgate. The evidence indicates that miners Joel Price, Gary Quarles, Christopher Bell and Dillard Persinger realized there was a serious problem and attempted to exit the area in the direction of the headgate. They traveled from the tailgate to shields 104 – 107 (where their bodies were found), which is approximately one-third of the way to the headgate.

The flame from the ignition traveled into the gob and encountered an explosive atmosphere of methane gas, resulting in an explosion. The explosion traveled in both directions of the longwall face – with the major forces exiting into the tailgate entry.

When the explosion exited at the tailgate, it traveled in both directions. The explosive forces traveled more than seven miles underground. The forces picked up and suspended excessive amounts of float coal dust that had been allowed to accumulate throughout the mine.

The suspended float coal dust immediately became a self-perpetuating fuel. It is given that for the explosion to travel in excess of seven miles, there had to be a fuel source. The only logical conclusion is that float coal dust was that fuel source.

As the blast forces traveled outby, they followed the fuel source into the crossover between North Tailgate and North Headgate, at the same time they traveled toward 78 break and turned back in the direction of the working sections. Mine examiner Michael Elswick, Adam Morgan and bolters Cory Davis, Joshua Napper and Charles Davis were killed by the blast as the forces traveled towards the headgate.

The flames and violent forces continued inby, killing headgate operator Rex Mullins and Nicolas McCroskey. The fireball continued to follow the fuel source, traveling down the longwall face and killing Richard

Lane and Grover Sheets at shield 85 and Joel Price, Gary Quarles, Christopher Bell and Dillard Persinger, who were evacuating the longwall face in the direction of the headgate.

So that it is clearly understood, the flames and forces that were traveling outby in the tailgate entries followed the float coal dust into the 1 North Longwall Crossover and the North Mains Entries. They continued inby in the headgate entries and down the longwall face from the headgate towards the tailgate. The flames and forces circled around the longwall panel and killed the crew members as they were attempting to exit toward the headgate (see attached map).

The flames and forces also traveled inby to the Headgate 22, Tailgate 22 and 9 North Sections. Ricky Workman, Howard Payne, Ronald Maynor, James Mooney, Kenneth Chapman and William Griffith were in the mantrip preparing to exit the mine when the explosion tore through the Headgate 22 Section. Edward Jones, Joe Marcum and Gregory Brock were in the track heading walking toward the mantrip when they were killed.

The force of the blast continued to pick up and suspend float coal dust in its wake as the explosion tore through the crossover from 1 North Tailgate towards 1 North Headgate and crossed into the Glory Mains at or around 85 break. The forces from the blast traveled inby their respective locations and into the working sections.

Tailgate 22 section belt and belt structure bent, twisted from forces of explosion.

In the course of mining operations, a hole was drilled between UBB and the Castle mine, which is located in the coal seam immediately above UBB. This hole, known as the Glory Hole, was used to dump coal from the mine above onto UBB's conveyor belt system. The coal would then be transported to the surface for processing and shipping. While the Glory Hole between the two mines had been filled in, a six-inch borehole remained open in the area. The forces and flames from the explosion traveled through the hole and scorched the roof of the adjoining mine.

The explosion traveled in an inby direction in the Glory Mains and 1 North Headgate entries. Forces continued inby in the 1 North Headgate entries, splitting at the crossover traveling from Headgate 21-1 North towards Headgate 22 and further inby Headgate 21-1 North to approximately 40 break, where it appears restrictions prevented it from traveling further inby.

The explosion continued to be fueled by suspended float coal dust as it completed its destructive path into the remaining sections of the mine. The explosion traveled the entire length of the Headgate 22 Section as well as 8 and 9 North Mains.

When the explosive forces and flames reached the deepest penetration of the mine, they reversed themselves, retreating outby in much the same path that they entered each

area. ***This event resulted in some of the most destructive forces released in the explosion***.

Roof bolt plate bent from initial path (left side) and secondary path (right side) of explosion.

These forces traveling outby from the working sections killed most of the crew exiting the mine from the Tailgate 22 Section at 66 break of the North Mains. Despite the heroic efforts of Tim Blake to assist the members of his crew, William Lynch, Carl Acord, Benny Willingham, Robert Clark, Jason Atkins, Steven Harrah and Deward Scott all perished. When James Woods arrived on the surface, he was loaded into an ambulance and taken to the hospital.

The forces of the blast sent the explosive fireball in an outby direction beyond 78 break of the North Mains entries. The extreme pressure generated by the explosion continued to travel outby carrying debris and dust. These forces were so great that dust and debris blew out the surface openings at both the Ellis and North Portals. The North Portals are approximately five miles from the ignition site.

MSHA was notified at 3:30 p.m. by Jonah Bowles, Safety Director of Marfork Mine, that the air at Ellis Portal had reversed, concentrations of CO between 50 and 100 ppm were detected, the mine was being evacuated and no one was trapped. MSHA issued a 103(j) order at 4:00 p.m., setting in motion the mine rescue and recovery operations (maps of explosion path attached).

The UMWA is convinced that the explosion and forces on April 5, 2010, were initiated by a small amount of gas that propagated into a massive explosion fueled by float coal dust which, because of a lack of proper rock-dusting, was allowed to accumulate in excessive quantities throughout the mine. This float coal dust played the most significant role in the disaster at UBB. It permitted the explosion to gain force and travel a great distance, causing vast destruction.

The Union recognizes that face ignitions can occur during normal mining operations. Indeed, it is not uncommon for such ignitions to occur. In the 12 months prior to the UBB explosion, 70 such ignitions were reported to have occurred in the United States. None of them resulted in a fatality (list of ignitions attached).

The fact is that ignitions can be controlled at mines that have adequate ventilation, proper rock-dusting, functioning water sprays, well-maintained machinery and proper overall mine maintenance.

In the case of UBB, none of these necessary preventive steps were taken by Massey Energy. In its focus to increase production, the company turned a blind eye to the requirements that ensure a safe and healthy work environment for miners. Massey ignored the statutory requirements under the Act in it its drive for ever-greater coal production at any cost.

Response to the Explosion

The Federal Mine Safety and Health Administration (MSHA) initially issued a 103 (j) order for the UBB mine at 4:00 p.m. EDT on Monday, April 5, 2010. The Order noted that "An accident occurred at this operation on 04/05/10 at approximately 3:27 p.m." MSHA District Manager Robert Hardman issued the order verbally in a telephone conversation with the mine (attached).

> Section 103 (j) of the Mine Act states, "In the event of any accident occurring in any coal or other mine, the operator shall notify the Secretary thereof and take appropriate measures to prevent the destruction of any evidence which would assist in investigating the cause or causes thereof. In the event of any accident occurring in any coal or other mine, where rescue and recovery work is necessary, the Secretary or an authorized representative of the Secretary shall take whatever action he deems appropriate to protect the life of any person, and he may, if he deems it appropriate, supervise and direct the rescue and recovery activities in such mine."

The issuance of a 103 (j) order was MSHA's initial response to this accident because it had the potential to be massive in scope or it placed the lives of miners at the operation at grave risk. This section of the law gives MSHA broad powers to take control over all areas of the mine, both surface and underground, for the purpose of rescue and recovery. Further, it places MSHA in the role of mine owner as the entity in charge of all plans for rescue and recovery.

Upon arriving at the mine at 5:20 p.m., Mr. Hardman modified the 103 (j) order to a 103 (k) order (attached).

> Section 103 (k) of the Act states, "In the event of any accident occurring in any coal or other mine, an authorized representative of the Secretary, when present, may issue such orders as he deems appropriate to insure the safety of any person in the coal or other mine, and the operator of such mine shall obtain approval of such representative, in consultation with appropriate State representatives, when feasible, of any plan to recover any person in such mine or to recover the coal or other mine or return affected areas of such mine to normal."

The difference between these two sections of the Act is significant. The modification of the order changes the role of the Agency from the active agent pursuing the rescue and recovery to that of an entity that approves plans proposed by the company. The Union has long held that in these types of disasters, the Agency should always take the lead role in a rescue and recovery operation. As noted earlier, the issuance of these orders is a routine response on the part of MSHA.

According to reports, shortly after the explosion occurred, ten Massey Energy officials entered the mine, six from Ellis Portal and four from the North Portal. Those entering at Ellis were: Chris Blanchard, Performance Coal Company President; Jason Whitehead, Vice President of Operations; Jack Roles, Longwall Coordinator; Everette Hager, Section Foreman; Patrick Hilbert,

Section Foreman; and Wayne Persinger, Mine Manager. The individuals entering from the North Portal were: Gary May, Mine Superintendent; James Walker, Safety Director; Berman Cornett, Safety Director; and Rick Foster, Mine Foreman.

At the time these individuals entered the mine, a 103(j) order was in place and there was no plan in place for exploring the mine in a safe, effective and methodical manner. In fact, it does not appear that management personnel entering the portals were aware of the activities of the others. For individuals placed in positions of authority, these actions show a remarkable disregard of basic mine rescue protocol. They put the lives of many at risk and compromised the rescue operations.

This is an extremely important point, because from the moment such a disaster occurs, no one from the surface should, without submitting a written plan to MSHA for approval, enter the underground areas of the affected mine. Such protocols were put in place to both ***protect the lives of the mine rescue teams entering the mine and miners who may be trapped underground***. Unauthorized and unplanned excursions could create dangerous conditions that would not otherwise occur. Such conditions could lead to additional catastrophic events.

Likewise, there is a very real need to secure and prevent any damage to all material evidence that may remain after the disaster. Individuals wandering through the mine, without proper authority and without following appropriate protocols, could, for many different reasons, ***destroy important evidence, jeopardizing the entire rescue and recovery operation and the subsequent investigation*** as well as endangering themselves and others.

While it is not unusual to have some confusion in the early stages of such an accident, this should never be permitted to interfere with the standard mine rescue and recovery efforts that must be conducted. ***The level of confusion and the fact it continued throughout the entire rescue operation was unacceptable.*** Action must be taken to see that this does not occur in the future.

Massey personnel who entered from the Ellis Portal drove a mantrip into the mine, removing debris from the track as they went. At approximately 42 break, they encountered Tim Blake, Roof Bolter, walking outby in the track heading. Blake was a member of the Tailgate 22 crew that included: Steve Harrah, Section Foreman; James Woods, Electrician; Bill Lynch, Carl Acord, Jason Atkins, Benny Willingham, Robert Clark and Deward Scott.

Patrick Hilbert, an EMT, was instructed to stay with Blake. The rest of the unauthorized individuals traveled inby to 66 break, where Blake told them the remaining members of his crew were located. After a brief period, Roles returned to 42 break and instructed Hilbert to take the mantrip inby and assist those already there in loading the injured miners for transport to the surface.

During this period, the mantrip from the North Portal carrying May, Cornett, Walker and Foster arrived in the same area.

Harrah, Woods, Lynch and Acord were placed in the mantrip Hilbert was operating. Wayne Persinger got into the mantrip with Hilbert and the others to assist Harrah and Lynch. Hilbert then began taking the trip outside. On the way they encountered Gary May and Berman Cornett, who got into the trip to assist Persinger with Harrah and Lynch.

The second mantrip that entered from the North Portal, operated by Foster, also began to exit the mine. They saw Roles and Blake at 47 break; the two men got into the mantrip and exited the mine.

A third mantrip, which had originally been transporting the Tailgate 22 crew from the mine at the end of their shift, was operated by Everett Hager and included Atkins, Willingham, Clark and Scott. It also exited the mine.

For reasons that may never be fully known, Blanchard and Whitehead, who had self-contained self-rescuers (SCSRs) but were neither equipped with standard mine rescue apparatus nor trained mine rescuers, stayed underground and illegally traveled throughout the mine.

Since these two individuals asserted their Fifth Amendment rights against self-incrimination during the investigation, there is no record of what activities they performed, nor is it known which areas of the mine they entered. However, it is clear that their travels included the areas where the explosion had claimed the lives of 29 miners just hours before.

Evidence shows that these two individuals continued on foot inby in the North Mains headings, then traveled the Glory Mains to the mouth of the 1 North Headgate and began walking into the section. It was reported that they were forced to retreat from the area before they reached the longwall headgate due to high CO levels. Blanchard and Whitehead then traveled through the crossover from 1 North Headgate toward 1 North Tailgate and proceeded up the tailgate entries to the longwall.

It is unclear how far they traveled in this area. However, the investigators found a methane sensor inby the shearer that appeared to be new. Despite the explosion, it was not damaged, nor was it covered with any soot or dust.

The two men then retraced their path into the 1 North Headgate entries, this time making it to the longwall. After spending an unknown amount of time in the area, they proceeded through the crossover between Tailgate 21-1 North and Headgate 22. Indications are that they traveled the entire length of the entries and into the section.

Deployed SCSRs on top of mantrip and on ground at 1 North 21 Longwall track.

At some point in time, Blanchard and Whitehead exited the area and arrived at 78 break, where members of various mine rescue teams were assembling. It is important to note that neither Blanchard or Whitehead volunteered any information to the rescue teams about where they had been, what they had been doing or what they had observed. Unfortunately, during the underground operation, it does not appear anyone from the State or MSHA pressed them for this information. The fact that they withheld critical information placed lives at risk and severely hindered the rescue and recovery efforts.

This lack of communications was extremely dangerous given the circumstances. Individuals wandering through the mine after an explosion inevitably leave evidence of their travels, as was the case here. Rescue teams who were unaware of their travels post-accident may have mistaken their tracks as evidence that a miner survived the blast. In that instance, the teams may press forward in an effort to locate the miner, placing rescuers at unnecessary risk.

The Union seeks to make this point regarding control of mine property after an accident exceedingly clear. There should be no question that events that unfolded immediately after the accident and continued well into the early morning hours of April 6, 2010, were not permissible given the circumtances underground. Experienced personnel know the protocol for these situations, and Massey management was acutely aware of these rules.

The dangers mine rescue teams face are extreme. Following basic mine rescue protocols, which have been established over many years to deal with unknown conditions after a major accident, is crucial to the safety of the rescuers. It was reported that the initial mine rescue plan submitted by Massey and approved by MSHA and the State did not contain necessary protections, and it became clear to some that the rescue operation was out of control.

CONSOL Energy, which had well-trained and experienced rescue teams on the ground at UBB, refused to participate in the rescue effort because of this lack of adherence to mine rescue protocol. CONSOL contended that the risks posed by the approved plan were unacceptable, especially when a safer alternative plan was possible (GIIP at p. 32).

The Union believes it is impossible to complete a thorough investigation of the UBB mine disaster without knowing what Blanchard and Whitehead did in the minutes and hours immediately after the explosion. These two individuals, after their unauthorzed entrance and exploration of the mine, invoked their Fifth Amendment right against self-incrimination and have refused to disclose significant and material information. Certainly these two high-ranking Massey officials understood that they were ***breaking the law by doing what they did***.

It is important to note that because Massey Energy was in violation of Section 317(p) of the Mine Act, 30 CFR §75-1715 and Section 2 (E) (ii) of the MINER Act at UBB for failing to maintain a check-in/check-out and post accident tracking system, the rescue effort was compromised from the start.

> 30 CFR §75-1715 *Identification check system* states in part that "Each operator of a coal mine shall establish a check-in check-out system which will provide positive identification of every person underground, and will provide an accurate record of the persons in the mine kept on the surface in a place chosen to minimize the danger of destruction by fire or other hazard."
>
> MINER Act Section 2 (E) (ii) POST ACCIDENT TRACKING requires that "Consistent with commercially available technology and with the physical constraints, if any, of the mine, the plan shall provide for above-ground personnel to determine the current, or immediate pre-accident location of all underground personnel. The system so utilized shall be functional, reliable and calculated to

remain serviceable in a post accident setting."

The evidence demonstrates that Massey Energy was not even aware of everyone who was underground at UBB at the time of the explosion, much less where they were located pre-accident.

There were assertions that the Company tracked miners by means of a brass tag check-in/check-out system, however, no such board was ever located on the property. The tracking system required by the 2006 MINER Act was not functional at UBB.

The first reports made available to the public regarding persons who were in the mine at the time of the explosion indicated, "6 people confirmed dead and at least 20 were unaccounted for underground." (GIIP at page 34) This was at approximately 6:00 p.m. Clearly, no one at the operation was keeping track of who entered and exited this mine.

During the course of the evening and into the morning, officials from the Company released the following information: Don Blankenship, Massey Energy CEO, stated at 8:32p.m., "...seven dead and 19 unaccounted for." (GIIP at page 38) Later when Massey Energy Vice President of Safety Elizabeth Chamberlin was asked by an official from West Virginia Office of Homeland Security how many people were underground, she responded, "We are having difficulty establishing a number." (GIIP at page 38)

This is absolutely unacceptable, especially given the tragic events that have occurred in the mining industry over the past 10 years. The MINER Act was enacted in response to the tragedies that occurred in 2006 alone. More to the point: The January 19, 2006, deaths of two Massey Energy employees at Aracoma Alma #1 Mine were part of the catalyst for passage of this legislation. One significant intent of this legislation was to ensure these situations of not knowing who was in the mine and where they were would no longer occur. All miners entering the mine and their locations during the shift must be tracked and recorded on the surface. Massey did not even follow this basic requirement.

It was not until after 1:40 a.m. on April 6, 2010, that anyone at the operation was able to establish that there were 22 miners still underground. At that time it was determined that 25 miners had perished as a result of the explosion and four remained unaccounted for. During the ten-hour period between the explosion and the announcement, family members and friends of missing miners were gathering at the mine to hear any news that was available. Even at the meeting held at 3:20 a.m., where the families were officially informed of the numbers, no one was able to tell them which miners were missing and which were confirmed dead.

Rescue and Recovery Operations

It is extremely difficult to determine when MSHA District 4 and the State effectively took an active role in the rescue and recovery efforts. All indications are that, despite the mine being under orders by MSHA and the State, Massey Energy's Chief Operating Officer, Chris Adkins, was handling all the communications from the surface to the underground.

In large part this demonstrates the rogue attitude of Massey Energy that extended to the highest levels of the Company. The attitude was that this was Massey's mine and despite the fact that management was responsible for allowing hazardous conditions to exist in the mine, they were in charge.

Some time after the first mantrips carrying victims exited the Ellis Portal, Robert Asbury, James Aurednik and Mark Bolen, all trained mine rescue personnel employed by Massey, entered the mine at the Ellis Portal. It does not appear that the Agencies were made aware of their entry at the time. Their stated intent was to repair telephone lines and locate Blanchard and Whitehead.

Wayne McPherson, also a member of the Massey mine rescue team, was left outside to identify the victims who were already on the surface. Not being able to do so, he had his equipment readied and traveled underground to meet up with the other members of the team.

The men traveled to 78 break where they encountered Blanchard and Whitehead outby that location. Bolen reported to Adkins in the Command Center that they had located the two individuals (Blanchard and Whitehead) and that they were okay. This is noted in the Command Center log books at 8:00 p.m. This was just before other rescue teams began arriving at 78 break.

Prior to the arrival of additional rescue teams, Asbury and Aurednik advanced inby 78 break barefaced heading in the direction of the active working sections. Both of these individuals were trained mine rescue team members, and Asbury was a team captain. Yet they violated the most basic mine rescue protocols and traveled deeper into the mine, even though they were not wearing apparatus nor had necessary back-up.

It is unclear why these trained mine rescuers would act this way. They had already spoken with Blanchard and Whitehead, who had been in the area. What compelled the rescuers to re-enter the area?

Some time after 6:30 p.m., Fred Wills, MSHA field office supervisor from Mount Carbon, Jim Hicks, MSHA field office supervisor from Mount Hope, and Jerry Cook, MSHA field office supervisor from Pineville–all trained mine rescue personnel–entered the mine. The three traveled to 78 break where they were surprised to find Blanchard, Whitehead and two Massey mine rescue team members. Wills stated, "I thought we were the first people going underground, I thought the mines were evacuated." (GIPP at page 43)

Despite the fact that neither Blanchard nor Whitehead were trained mine rescue personnel, it appears no one attempted to remove them from the mine. Records indicate Blanchard and Whitehead remained underground until the order was given to pull

all personnel at 12:45 a.m. This is highly unusual in a mine rescue scenario. ***Rescue protocol only permits trained rescuers underground during sensitive operations; all other persons must be removed to the surface***.

When Wills, Cook and Hicks arrived at 78 block, there was some limited discussion with the four Massey managers regarding why they were in the mine and where they had traveled.

In the course of the discussion, Blanchard told Wills, "...that he and Whitehead had traveled toward the longwall on the headgate and tailgate, looking for survivors. They didn't go into particulars exactly where they went to, because I don't think they wanted me to know," he said. MSHA's Command Center notes indicate Blanchard and Whitehead reported encountering high carbon monoxide levels on the tail side of the longwall. They also saw victims on the longwall track, who were later identified as Cory Davis, Timmy Davis, Adam Morgan and Joshua Napper. It was not clear to investigators why the information contained in the Command Center notes was not shared with Wills, Cook or Hicks or other underground rescue team members.

Even after Wills' conversation with Blanchard, no one told Cook or Hicks that the mine managers had discovered four bodies inby 78 break during their travels. This is very strange because the rescue efforts were just getting underway and this information would be important for all rescue teams to know. Why it was not reported is just as perplexing as why the Massey managers went underground in the first place.

As Wills, Cook and Hicks were arriving at 78 break, two Massey Energy teams and two State teams entered the mine. The teams were briefed by Massey COO Adkins while Link Selfe, MSHA Assistant District Manager from Mount Hope, looked on. The Union has not been made aware of exactly when each team entered the mine or the number of individuals that comprised each team, therefore we are unable to determine the total number of people underground at that point.

It is clear that the Massey Energy teams arrived at 78 break first. When the Command Center became aware that the teams had arrived, Adkins told them to split up, with one team to go to the longwall and the other one to Headgate 22.

This was a grave breach of mine rescue protocol. All mine rescue personnel are strictly trained that for every team member going inby the fresh air base to perform any duties, an equal number of rescuers must be in reserve at the fresh air base. The reason for this protocol is that if something unexpected happenes to the advancing team, sufficient personnel would be immediately available to offer assistance.

MSHA Field Office Supervisors Cook and Hicks were acutely aware of this requirement and objected to the orders from the Command Center. In the end Cook traveled with one of the Massey teams to the longwall. Hicks stayed with the other team at the fresh air base in reserve in case problems were encountered inby.

Whitehead discussed the situation with Adkins on the phone. After the conversation, Whitehead directed Hicks to go to Headgate 22. Hicks took the phone from Whitehead and spoke directly with Adkins, who informed him that "we need to find 16 men, not play mine rescue." (GIPP at page

44) Having received this order from Adkins, who was never trained in mine rescue, Hicks asked to speak with MSHA District 4 Manager Robert Hardman.

After expressing his concern regarding proper back-up, Hicks was told by Hardman, "You have other teams coming.....We have to go" (GIIP at page 44).

Once again, and at a critical point in the rescue operation, MSHA's top official in the Command Center allowed the mine operator to call the shots. Hardman had to know this was a serious breach of mine rescue protocol.

Cook would later state in his statement for the investigation, "*...it's bad enough trying to find 29 people, you don't need 40 more to look for....*" (Cook at page 74 - emphasis added). Hicks gathered his team and began to travel into Headgate 22 as ordered.

The GIIP Reports noted, "...that when Cook and Hicks reported to UBB the following day, Tuesday, April 6, they were told they would not be allowed to work together, that they would be assigned to different shifts and that they would not be allowed to go underground. Demoralized and upset, the two veteran mine rescuers pressed for an explanation from MSHA mine rescue team trainer Virgil Brown. They said Brown told them they had been through enough in the mine."

"I thought that was a lot of bull. I'm a mine rescue person. That's what I do," said Cook, who had been involved in rescue efforts at Sago, Aracoma and Crandall Canyon. "And I just never did believe that was the reason why we didn't go back underground. I think because we run our mouth [expressing opposition to the Command Center's decision to go forward without one-to-one backup], and we done what we did when we was in there" (GIIP at page 44).

Shortly after Hicks' departure, Eugene White and two State rescue teams reached 78 break. They worked for some time to move the fresh air base to break 106 on 6 North belt. They could advance no further for a period of time because of high levels of gas inby.

White was soon instructed to take his team and explore the crossover panel in front of the longwall face. White instructed the other State team to remain at the fresh air base as back-up, an acknowledgment of proper mine rescue protocol.

While traveling to the longwall, the team Cook was with noticed reflective material ahead of them. There they discovered the bodies of Cory Davis, Timmy Davis, Adam Morgan and Josh Napper (previously discovered by Whitehead and Blanchard as well as Asbury and Aurednik) around 14 break near a roof-bolting machine (bolter) in the crosscut between number two and three entries. They also located remnants of new self-contained self-rescuers (SCSRs) that had been deployed post-accident.

The evidence at the bolter indicated that someone may have survived the explosion, so Cook began to follow the boot prints (map of SCSR's opened post-explosion attached). It was only later that Cook would find out that <u>these SCSRs and the fresh tracks</u> in the area were left by Blanchard and Whitehead or Asbury and Arudnek in their three-hour post-accident excursion through the mine.

As the evening progressed, the team with Cook continued to travel deeper into the longwall section. Near the stage loader, they located the body of Rex Mullins. The team members continued down the longwall face and discovered the bodies of Richard Lane and Grover Skeens at shield 85. Further inby between shields 104 and 107, the rescuers discovered four more bodies: Christopher Bell, Dillard Persinger, Joel Price and Gary Quarles.

Earlier in the evening while traveling towards Headgate 22, the team with Hicks discovered the body of Michael Elswick at the mother drive at 6 North belt. The information was reported out to the Command Center at about 10:00 p.m. Hicks was unaware at this point that Asbury and Arudenik had previously discovered the body.

The team proceeded into Headgate 22, where they located a mantrip and the bodies of six miners who were preparing to exit the mine at the end of their shift. These miners were later identified as Kenneth Chapman, William Griffith, Ronald Maynor, James Mooney, Howard Payne and Ricky Workman.

High concentrations of carbon monoxide and methane, as well as low oxygen, halted the team's advance. After reporting their finding to the Command Center, the decision was made to evacuate the mine. This process was initiated at the order of the Command Center, and all personnel were outside by 3:30 a.m., Tuesday, April 6, 2010.

The first rescue attempt revealed 25 miners dead and four still unaccounted for. Unfortunately, the teams were unable to identify all the miners who had been located at that time.

Rescue and Recovery Operations Continue

The rescue operation over the course of the next several days was sporadic at best. During that time, several mine rescue teams entered the mine, only to be withdrawn because of hazardous conditions. High levels of toxic and explosive gases as well as low oxygen in many areas of the mine stymied attempts by rescue teams to complete their search.

During this time, Massey Energy began drilling a series of boreholes in an effort to monitor the mine atmosphere and clear the mine of the hazardous gases. In the end it would be necessary to drill ten boreholes to accomplish this. These boreholes were located as follows:

Tailgate 22:
- No. 1 entry at break 34

Headgate 22:
- No. 2 entry at break 36
- No. 2 entry at break 129
- No. 2 entry at break 130
- Between Nos.1 and 2 entries at break 130

8 North Mains:
- No. 4 entry at break 142

9 North Mains:
- No. 1 entry at break 153
- No. 3 entry at break 161
- No. 4 entry at break 161
- No. 5 entry at break 161

Finally, two mine rescue teams entered the mine under breathing apparatus at approximately 4:00 p.m. on Friday, April 9, 2010. One team, led by Eugene White, managed to make its way into Headgate 22

Section of the mine. The team traveled inby the track entry, and between 14 and 18 break found the bodies of Gregory Brock, Joe Marcum and Edward Dean Jones.

The other team, which was sent to explore the Longwall Section, was unable to locate any victims in its search. After a period of time, both of the teams were running low on oxygen and retreated from their respective search areas.

A third team, also under breathing apparatus, was ordered to the Longwall Section and continued to search the area. Their initial search, like the previous two, was unsuccessful. When the team worked its way back to the Headgate, they noticed a body lodged in the headgate shields. At 11:20 p.m., Friday, April 9, 2010, Nicolas McCroskey was the final victim located in the UBB mine.

Despite holding out hope the afternoon of April 9 that survivors would be located, the discovery of McCroskey's body meant that the rescue operation was over, and recovery operations would officially begin.

Recovery of the Victims

The recovery of the 22 miners who still remained underground began on Saturday, April 10. The extremely hazardous conditions in the mine and the fact that power could not be restored complicated an already difficult situation.

Mantrips were stationed at 78 break, the deepest penetration possible by mobile track equipment. Recovery workers were placed in teams of two throughout the mine, and the miners' bodies were carried from team to team until they could be loaded onto a mantrip.

This slow and difficult process continued for almost four days. The last victims, the nine miners of the Headgate 22 crew, arrived on the surface the morning of April 13, 2010.

The single largest recovery of victims from a coal mine disaster since 1970 was completed almost eight days after the explosion tore through the mine. The significance of this should not be lost to the mining industry. The failure of Massey Energy management to comply with mandatory health and safety standards resulted in the death of 29 miners. There needs to be an accounting for their actions and inactions.

Ventilation

The ventilation system at UBB consisted of three surface fans, two blowing and one exhausting. Given the testimony we know of, the Union believes serious questions have been raised regarding the capability of the ventilation system to provide sufficient quantities of fresh air to the entire mine. This fact is confirmed by the numerous citations issued by MSHA.

The Union's review of the underground ventilation system at UBB reveals the plan submitted by Massey was inadequate and included a patchwork of inadequate plan modifications. Testimony given on Capitol Hill and interviews of miners working at UBB reveals a pattern by Massey of making intentional and illegal air changes.

MSHA Order number 8094581, issued on September 1, 2009, substantiates this fact. Many such ventilation changes were made while miners were working underground, a practice that is illegal. The testimony also revealed that air was redirected to certain areas of the mine at times, robbing air from other areas. This "Robbing Peter to Pay Paul" ventilation scheme is a very dangerous practice.

Based on the information we have received and the citations and orders for ventilation issued by MSHA in the 15 months preceding the explosion, it is clear that the system was poorly designed and Massey personnel were continually experimenting with the ventilation. Mine ventilation systems are generally designed months and years in advance based on the projected mining plans.

However, Massey could not, based on reports from MSHA, produce a timely annual mine map to the Agency as required by law. Joe Mackowiak, MSHA District 4 Ventilation Supervisor, stated about the 2009 UBB ventilation map that "...it took four separate submittals in order to approve that map. So it took 11 months to get the annual map. So as soon as the annual map was acceptable at this location, one month later they would do their next annual map."

Keith Sigmon, a ventilation specialist in MSHA District 4, noted, "I would imagine, say, since December 30, [2009] probably 20 some revisions went through our ventilation department." The Union would like to know: Why were all these revisions needed?

Ventilation is one of the most important requirements in protecting the health and safety of miners. Massey's inability to provide a basic ventilation map as required by law is extremely troubling. Why were they unable to produce an accurate map in a timely manner? It is the Union's opinion that ventilation changes were occurring so frequently underground that Massey could not produce the required map. The UMWA believes that the Agencies should have been more aggressive with regard to this issue.

The South fan at UBB was used exclusively to ventilate the old workings in the South Mains area and some sealed longwall panels in the mine. There was one working section in the South Mains, the Portal Section. The beltlines necessary to transport coal to the surface through the Silo Portal were also ventilated by this fan.

After sweeping the South Mains area, the air would exhaust through the Silo Portal. This area was ventilated because the mine's water supply enters here, meaning the area must be ventilated and examined weekly. The Portal Section was an active mining section, requiring it and the beltlines to be examined every eight hours. During the course of the investigation, MSHA Inspector Bill Bane issued an order to the operator because an area of the South Mains, adjacent to #1 North Belt, had not been examined in nearly a year (attached).

The North Portal and Bandytown fans were the only sources of ventilation for the rest of the mine. The information outlined below, gathered during the investigation, demonstrates why the ventilation system did not function adequately.

On May 20, 2010, prior to the beginning of the underground investigation, MSHA was inspecting the mine's fans on the surface and issued the following citation:

> Citation number 8247081 states, "The North Portal Mine fan and the return entry to the right of the fan is not separated properly to prevent the return air from exiting the mine and re-entering through the mine fan. The mine fan is the primary escapeway entry to the Barrier Section. When checked by utilizing a dry chemical fire extinguisher at the return entry, the dry chemical for the extinguisher re-entered the mine through the North fan. This condition prevents the primary escapeway from being ventilated entirely with intake air " (citation attached).

In order to correct the problem, workers were required to extend a wall seventy-five feet on the surface between the two entries. This permitted the return air to remain isolated from the pull of the fan.

The Union is uncertain when the North Portal Fan was put into operation, however, this is one of the oldest areas of the mine. Therefore the question must be asked: How long had this condition been permitted to exist? Just as important: Why was such a dangerous condition never discovered by the operator during regular examinations or cited by the agencies?

These types of events occurred over and over again at UBB, demonstrating the level to which health and safety requirements were permitted to deteriorate. The operator was singularly focused on production.

Based on citations and orders issued by MSHA, there is every reason to believe that Massey Energy's personnel routinely and illegally changed the airflow in the mine without Agency approval and with miners working inby. UBB miner Stanley Stewart noted that on July 26, 2009, his crew was "...told by management to make an air change...stoppings were removed while crews were still working." (GIIP at page 26)

With respect to the Bandytown fan, MSHA had noted that it consistently exhausted 300,000 cubic feet of air per minute, an amount they claim was sufficient to ventilate the UBB mine. They also stated that most of the air entered the mine through the Ellis Portal, traveled through the North Mains into the numbers 1 and 2 entries of the longwall tailgate, and exited the mine through the Bandytown fan. This could have been adequate airflow to ventilate the mine.

However, there is overwhelming evidence, based on the condition of the

mine's ventilation system and through testimony, that the active areas of the mine were inadequately ventilated prior to the explosion. On Saturday, April 3, 2010, Bobbie Pauley–who was working in the Headgate 22 Section–noted that "I wouldn't say it was suffocating, but it was hot" (GIIP at page 16).

James Griffith, a miner on Pauley's crew, told the boss, Brandon Bowling, "You're going to have to get air up here. There's no air up here, Brandon" (GIIP at page 16).

These areas of the mine from the North fan and Ellis Portal to 78 Block would normally be easy to ventilate. There was only one active section, the Barrier Section in the North Mains. Therefore the majority of the air was coursing through the entries to ventilate the active workings inby the Glory Mains.

The North Portal Fan was designed to blow air into the North Mains and Parallel North Mains, splitting off to ventilate the Barrier Section of the mine. The bulk of the air continued inby the Mains to the 4 North Belt area where it split again. Some of the air was directed outby to the Ellis Portal and through Lower Big Branch (LBB), while the remaining air was directed inby toward the active working faces.

The Bandytown fan would pull air from the North Mains into each of the active continuous miner sections and into the longwall section. Some of the air coursing to the longwall traveled into the headgate bleeder entries and through the gob. The remainder would sweep the entire longwall face and pressurize the gob. Finally, as the air traveled to the end of the longwall face, it would course inby to the tailgate bleeder entries and exit through the Bandytown fan.

In the normal mining cycle, as the longwall completes the panel, the headgate entries of that panel will become the tailgate entries for the next longwall panel. However, because conditions in the 1 North Headgate entries had been allowed to deteriorate, mining plans were changed that would cause air entering from North Portal fan to be reduced to the active sections.

The entries in 1 North Headgate were impassible from approximately 40 break inby due to roof falls and water accumulation. MSHA required Massey to begin driving new entries parallel to the current headgate entries. The time required to do this would mean the current longwall panel would be completed before the new entries for the next longwall setup were finished. A decision was made by Massey to move equipment into LBB adjacent to the entries from Ellis Portal to develop two short longwall panels. This was done by Massey to avoid the loss of production while the new 22 Tailgate entries were being developed. This also led to Massey's decision to make the illegal air change at the Ellis Construction site that resulted in the active working sections being ventilated by return air.

A construction crew was assigned to cut overcasts and belt channel in the Ellis Portal Construction Section. The week before the accident, the crew opened a set of double (air lock) doors, allowing air blowing outby toward the Ellis Portal to sweep through the intersection where they were working. This would inevitably have placed the crew in the return path of some of the dust generated by the continuous miner as they cut the overcast. Such a practice is illegal and an extreme health hazard.

Sometime between the Thursday before the explosion (April 1) and the day of

the explosion, Massey made the illegal air change. Ventilation controls in the LBB area of the mine and at Ellis Construction Section were compromised and a part of a regulator was torn out. This change resulted in air being pushed from the North Portal fan, then traveling up the North Mains and North Mains Parallels to the lower end of LBB. The air then split at LBB with an undetermined amount traveling in both directions (citation attached).

After Massey made the illegal air change at the construction site, just days before the explosion, miners were complaining about a lack of air, air reversals and extremely hot conditions.

The Union maintains that once the air change was completed at the Ellis Construction site, the mine from that point inby to the active working sections was being ventilated by return air.

Some of the air exiting the Ellis Construction site was coursed inby to the active working sections, placing all the active sections on return air. Members of the crew immediately noticed the change when they arrived at the Ellis Construction Section on Monday, April 5, 2010. Roof Bolter Joshua Williams stated that he asked the boss about the air reversal, but received no explanation (GIIP at page 19).

Other crew members returning to the mine on April 5 noticed the air had reversed in some areas and was almost stagnant in others. Some of the miners questioned the lack of ventilation. One noted, "It was hot in there, miserably hot" (GIIP at page 16).

Because the configuration of UBB's ventilation plan was designed on a "push-pull system," the UMWA believes that when the North Portal fan used to help ventilate the active working sections was compromised, the ventilation system was rendered ineffective. Based on the UMWA's investigation and a review of Massey's violation history, illegal and intentional air changes were a common practice at the mine.

The Bandytown fan continued to operate, pulling air from the mine. This explains the fact that air reversed in the Glory Hole area where Construction Foreman Mike Kiblinger noted, "Thursday before the explosion... the dust was blowing out of the mine. When he returned on Monday, the crew was cutting the overcast, and the dust was blowing into the mine.." (GIIP at page 19).

The decrease in velocity resulted in the longwall gob not being pressurized as required. Lacking the necessary air velocity along the face inevitably permitted methane to migrate onto the face. At the same time the restrictions in the bleeder entries compounded the problem. It is the UMWA's opinion that this is the most likely explanation for the presence of significant methane in the area to cause the ignition and subsequent explosion.

The investigation showed that poor ventilation must have been a common problem on the longwall. The investigation revealed a burnt remnant of a brattice cloth hanging from shield 173 towards the tailgate drive where a methane sensor was mounted. The curtain o-rings and tie wires indicate it was hung from the shield towards the face to a point just inby the tailgate methane sensor. This would direct all the airflow towards the sensor, diluting the methane at that point and eliminating its ability to detect the actual amount of methane on the face.

Melted canvas and plastic ties on air hose where canvas was used to direct airflow onto methane sensor on the longwall.

Based on evidence uncovered during the investigation, we believe the methane migrated onto the face and was ignited by the shearer. The flame followed the fuel source into the gob area behind the shields, where it encountered a methane-air mixture that resulted in the explosion. This methane explosion exited the gob at or around the shearer at the tailgate with sufficient force to pick up and suspend float coal dust in the area. From that point, the mine was engulfed in a self-propagating dust explosion that entered all the active sections inby 78 block and then reversed with greater force and exited the mine through the portals.

Violation History

The violation history of UBB documents the hazardous conditions at the mine leading up to the explosion. Inadequate ventilation coupled with repeated and unapproved ventilation changes made by Massey personnel set the stage for the tragic events of April 5, 2010. Massey consistently violated the law and provisions of its approved ventilation plan.

The sheer number and magnitude of these violations should have raised a red flag with MSHA District 4. The following is proof of the severity of the problem:

> CFR 30 §75.325 (b) "In bituminous and lignite mines, the quantity of air reaching the last open crosscut of each set of entries or rooms on each working section and the quantity of air reaching the intake end of the pillar line shall be at least 9,000 cubic feet per minute unless a greater quantity is required to be specified in the approved ventilation control plan. This minimum also applies to sections which are not operating but are capable of producing coal by simply energizing the power on the section."

Massey Energy was required to supply at least 15,000 cubic feet of air per minute (cfm) in the last open crosscut, according to its approved ventilation plan.

The UBB Mine was cited six times from January 2009 until the day of the explosion specifically for violating §75.325 (b). The total air velocity reaching the last open crosscut in five of these violations ranged from 4,900 to 7,339 cubic feet per minute, far below Massey's approved ventilation plan.

> Citation number 8082682, issued on March 18, 2009, stated the following: "The operator is failing to maintain 9,000 cfm of air in the last open crosscut of the #2 working section. *When tested there was not enough air present to turn the anemometer*" (emphasis added).

These violations are indicative of ventilation problems that were occurring at UBB. To have such substandard airflow–including being cited for no air movement at all–is unacceptable. What is more troubling is that based on evidence and testimony, the Union believes that had an inspector not been present when these conditions were found, Massey would have operated the sections, despite having inadequate ventilation.

The requirements of §75.333 are minimum requirements that may be increased as mining conditions warrant. Any additional requirements must be included in the mine ventilation plan.

> CFR 30 §75.333 Ventilation controls. Ventilation systems are required to be constructed using materials specified in the regulation. All brattice walls, undercasts, overcast, air locks, seals and any other devices utilized to facilitate proper and adequate air flow through the mine must be built in accordance to these minimal standards. Further, once constructed they are required to be maintained to continuously perform the function for which they were built.

Massey was **cited 48 times** at UBB from January 2009 for violations of §75.333. There are various reasons for these citations, including failing to close air lock doors and blocks missing from brattice walls (ventilation controls).

Some are, however, especially important to note because they demonstrate an obvious disregard for the law by Massey that could materially affect the health and safety of miners.

> Citation number 8082751, issued April 30, 2009, states, "The operator is failing to construct ventilation controls from non-combustible material. *The operator has constructed a regulator, at spad 21083, out of line curtain*" (emphasis added).

Regulators are extremely important structures in the ventilation system, as was pointed out when one was partially torn out at the Ellis Portal Construction site. The possibility of destruction by fire, heaving or force, as pointed out in the citation, is very real.

The decision to build a regulator out of line curtain is yet another indication that Massey disregarded both the law and the health and safety of its employees.

> Citation number 6612932, issued July 15, 2009, states, "The operator failed to maintain ventilation controls to serve the purpose for which they were built in the left return off No. 1 Section in that the return airway was common with the neutral airway in the diagonal connector from No. 1 Tailgate to No. 1 Headgate and in the number 2 Heading outby Break No. 9. Add the following statement: The areas that allowed the return to mix with the neutral air are: 1) the stopping in 3 Heading at the cut through to 1 North Headgate had a door open, 2) the overcast in 3 Heading in the diagonal entries has not been sealed, 3) the stopping between 1 and 2 Headings 1 bk [sic] inby old belt head has a 4' x 4' hole, 4) the scoop air lock doors are damaged at the old belt head, and 5) the scoop

airlock door outby No. 9 break are not adequately sealed."

It was not a single event that led to the issuance of this citation. Incomplete work on ventilation controls, damage to others and general non-compliance noted in five separate locations in the area came together to create a hazardous situation. Massey routinely used airlock doors instead of overcasts to ventilate the mine. This permitted air from different areas of the mine to mix, compromising the mine's ventilation. Management had to be aware of these problems and was required by law to correct them.

> Citation number 8085028, issued on November 19, 2009, states, "In seal set #3, seals numbered 14, 15, 16, 17, 18 and 19 are being crushed out by the hoving bottom. Air can be heard leaking at the seals and when checked with a smoke tube, smoke can be seen entering the seals through cracks. *The seals are in-gassing at this time...*" (emphasis added).

Sealed areas of a coal mine are required to be kept isolated from all active areas of the mine. In sealed areas, gases or oxygen-deficient atmospheres can be created. In this instance the inspector noted the seals were in-gassing. However, should the barometric pressure drop, the seals will out-gas, causing the contaminated air to enter the mine's ventilation system.

These seals are required to be examined weekly. Had management been complying with the law, this condition should have been found and corrected.

> Citation number 8080106, issued December 1, 2009, states, "The permanent stoppings in break #54, #55, #56, #57, #58, #59, #60, #61, #62, #63, #64, #65, #66, #67 and #68 between the #2 and #3 entry of the Headgate 1 North are not being maintained in the intent which they were built due to adverse roof conditions pushing the stoppings out. *The return from the #1 Section is not isolated from the return air from the working longwall panel old works at breaks...*" (emphasis added).

The fact that the inspector found *fifteen consecutive* walls that were damaged, eliminating isolation of the return entries, is significant. Such a vast area of damage could not have gone unnoticed if a proper examination was completed as required. Based on the extent of the damage, Massey cannot claim it was unaware of this situation. It is our opinion that this citation should have been issued as "willful disregard."

> Citation number 8100144, issued December 30, 2009, states, "The operator is failing to maintain the correct direction of air flow in first right panel in the Old No. 3 section. The air flowing threw [sic] the regulator at MP#11 is going in the reverse direction."

The reversal of air flow in a mine is a significant event and we have already discussed the consequences of such events in this report. However, this citation points out a reversal that occurred at a regulator. Regulators control air flow and force air to split in designated directions.

> CFR 30 §75.370 Mine ventilation plan; submission and approval states in part, "The operator shall develop and follow a ventilation plan approved by the district manager. The plan

> shall be designed to control methane and respirable dust and shall be suitable to the conditions and mining system at the mine. The ventilation plan shall consist of two parts, the plan contents as prescribed in §75.371 and the ventilation map with information prescribed in §75.372."

Massey was **cited 47 times** for violating §75.370 since January 2009. Ventilation plans are precise documents describing the layout of the mine and what will be necessary to ensure adequate air is supplied to mining sections and all other areas of the mine. The written details of the plan are necessary for the Agency to ensure the mine operator complies with the law. More importantly, they are necessary so miners know that the conditions they are required to work under are maintained in a manner that protects their health and safety.

None of these 47 citations and orders can be considered incidental or minor infractions. The violations all materially affected the health and safety conditions for miners at the operation. Some are simply more egregious than others, but collectively they demonstrate the obvious disregard management had for the law and the lives of its own miners.

> Order number 8090855, issued June 17, 2009, states in part, "The operator is failing to comply with page 5 of the approved ventilation plan... The miner man is standing in the visible dust in the return of the continuous miner. *The section foreman stated he was aware of the condition.... and failed to take action to correct it"* (emphasis added).

> Order number 8090856, issued June 17, 2009, states in part, "The operator failed to comply with the approved methane/dust control plan... The miner operator was standing in visible dust... *The section foreman stated to MSHA that he was aware of the conditions*" (emphasis added).

These orders not only reveal unhealthy and illegal conditions, but also appear to represent routine occurrences at UBB. Visible dust in the mine atmosphere can be the result of several factors, with inadequate ventilation the most likely in this case. Secondly, the foreman was aware of the condition but allowed it to continue. This demonstrates such mining practices were common and tolerated by Massey Energy. Based on the investigation, the Union suggests such practices were part of the normal operating procedures imposed by Massey on the workers.

The fact that miners worked in such a dusty atmosphere offers great insight into the presence of black lung disease detected in many of the miners killed in the disaster. Of the 24 miners between the ages of 25 and 61 whose lungs could be examined during autopsy, 17, or 71 percent, showed some stage of black lung disease.

Massey was aware of conditions in the mine and expected miners to continue to work in those conditions. The refusal of management to deal with the ventilation problems is reflected in many of MSHA's citations. Some of the bigger problems are listed below.

> Order number 6612934, issued on September 1, 2009, states in part, "The operator failed to follow an approved ventilation revision....The

cited conditions collectively contributed to an air reversal in the longwall setup entries where men were working.... *The air reversal existed since yesterday*...” (emphasis added).

Order number 8094581, issued September 1, 2009, states in part, “An intentional change in the ventilation was in the process of being implemented and unnecessary persons were working in the mine.... *Airflow had reversed in the longwall setup entries* (see citation 6612934), and airflow was reversed in the neutral air courses.... *The condition was mine wide and the existence of the underlying ventilation conditions were extensive and obvious. Foreman travel and worked in the areas which were not properly ventilated*” (emphasis added).

Order number 8087709, issued January 7, 2010, just three months before the explosion, states in part, “The operator is not following the ventilation plan as approved by the District Manager on the No. 1 section (MMU 029-0), air flow was not in the direction shown on the approved map.... *Mine foreman stated he was aware of the condition and that it had existed for approximately 3 weeks*.... This violation is an unwarrantable failure to comply with a mandatory standard” (emphasis added).

Order number 8103337, issued March 9, 2010, states, “The approved ventilation plan, approved 8/09/09 and re-approved 1/22/10, was not being followed in the tailgate entries of the longwall panel. The air was going outby in the No. 5-7 entries from the longwall face (return air) to the mouth of the section instead of intake air going inby from the mouth of the section to the longwall tail.”

These **four orders**, that were issued within the eight months preceding the explosion, demonstrate the problems that repeated occurred at the mine. These conditions were extremely dangerous and easily detectable. These are conditions that Massey should have corrected immediately. Based on the language of order number 8087709, Massey knew the condition existed for three weeks and yet failed to take any corrective action. As with most of its decisions, production trumped all other concerns at UBB.

This fact cannot be more clearly revealed than it was in the report of the GIIP. On January 7, 2010, MSHA Inspector Keith Stone started a quarterly inspection at UBB and issued order number 8087709, mentioned previously. He ordered miners to be withdrawn from the Headgate 22 Section of the mine until the condition was corrected.

During discussions with the foreman and some crew members, it was learned that Mine Superintendent Everett Hagler; Performance Coal Co.Vice President Jamie Ferguson; and Performance President Chris Blanchard were all aware the condition existed. (GIIP at page 63) There is no record that any of these high-ranking Massey officials did anything to correct it.

Further, when this order was abated, Stone continued his inspection and found that air traveling in the belt entry was reversed. He issued another order and had all the miners on the Longwall Section removed. When Blanchard learned the longwall was

shut down, he confronted the inspector. He told Stone the situation was unacceptable. It is difficult to understand why Blanchard was not concerned about the air reversal, a condition that placed the miners at great risk; rather, he was upset that the longwall was not producing.

Time and time again when conditions presented a hazard to miners, management chose to place production above health and safety. The structure of the company and the control exerted by its officers make it clear this culture of production over safety reflected the policy of Massey Energy.

Mine Examinations

These ventilation regulations are intended to reduce the risk of methane ignitions and explosions. However, they are not the only laws in place to prevent such occurrences. Examinations of the mine are required at predetermined intervals. The purpose of these examinations is to identify hazardous conditions and to ensure they are corrected.

Three types of these examinations are outlined below. Each is extremely important to ensure the health and safety of all persons working at the mine.

> CFR 30 §75.360 Preshift examinations at fixed intervals. "(a)(1) except as provided in paragraph (a)(2) of this section, a certified person designated by the operator must make a preshift examination within 3 hours preceding the beginning of any 8 hour interval during which any person is scheduled to work or travel underground. No person other than a certified examiners may enter or remain in any underground area unless a preshift examination has been completed for the established 8 hour interval."

In the fifteen months prior to the explosion, Massey was cited 37 times for failing to carry out the requirements of §75.360. In essence, miners were permitted to enter areas without these areas first being examined by a certified person.

> CFR 30 §75.362 On-shift examinations. "(a)(1) At least once during each shift, or more often if necessary for safety, a certified person designated by the operator shall conduct an on-shift examination of each section where anyone is assigned to work during the shift and any area where mechanized mining equipment is being installed or removed during the shift. The certified person shall check for hazardous conditions, test for methane and oxygen deficiency, and determine if the air is flowing in the proper direction."

Mining is a dynamic industry and changes in working conditions can happen rapidly. Therefore, management is required to designate a person who is certified to examine the areas where miners are working during their shift. Most often the person designated to perform this examination is the foreman assigned to the mining section. These examinations should identify hazards that are created while mining. Massey was **cited four times** in the fifteen months prior to the accident for failing to make these examinations.

> CFR 30 §75.364 Weekly examination. "(a)*Worked-out areas.* (1) At least every 7 days, a certified person shall examine unsealed worked-out areas where no pillars have been recovered

by traveling to the area of deepest penetration; measuring methane and oxygen concentrations and air quantities and making tests to determine if the air is moving in the proper direction in the area. The locations of measurement points where tests and measurements will be performed shall be included in the mine ventilation plan and shall be adequate in number and location to assure ventilation and air quality in the area. Air quantity measurements shall also be made where the air enters and leaves the worked-out area. An alternative method of evaluating the ventilation of the area may be approved in the ventilation plan. (2) At least every 7 days, a certified person shall evaluate the effectiveness of bleeder systems required by §75.334 as follows:..."

These examinations are required to be performed in areas of the mine where work is not performed on a daily basis, including worked-out areas that are still accessible, intake and return entries as well as outby areas and along the perimeters of sealed areas. Certified persons are required to examine for hazardous conditions, test for methane and oxygen deficiency and ensure the velocity of the air meets the plan requirements and is moving in the proper direction.

Like the other examinations, these weekly examinations are critical to the health and safety of the miners. Changing conditions outby the active working sections can create hazardous conditions affecting the entire mine. From January 2009 until the time of the explosion, Massey was **cited 18 times** for failing to perform weekly examinations as required.

MSHA has released information regarding the Massey mine examiner who was assigned to perform weekly examinations of the longwall bleeders and make preshift examinations for the pumpers at UBB: The multigas detector assigned to this examiner had not been turned on since March 18, 2010. This simple fact means that it would have been impossible for this individual to perform any proper and legal examinations since that date, at least.

Belt Air

Massey Energy officials have raised the issue of belt air on several occasions since the explosion. They contend that MSHA singled out UBB and prohibited them from continuing to use belt air to ventilate the working faces. The Union would argue given the facts surrounding the use of this controversial method of ventilation that MSHA's decision was warranted.

Under the provisions of the 2006 MINER Act, Congress created a Technical Study Panel (Panel) under Section 514 of the Mine Act to, "...provide independent scientific and engineering review and recommendations with respect to the utilization of belt air and the composition and the fire retardant properties of belt materials in underground coal mining."

The Panel completed its work on December 20, 2007, and submitted its report and recommendations to the Agency. MSHA then used the information to promulgate new rules regarding the use of belt air to ventilate the working face(s) of a coal mine. The

pertinent regulatory language is contained in 30 CFR:

> 30 CFR § 75.350 Belt air course ventilation**.** "(a) The belt air course must not be used as a return air course; and except as provided in paragraph (b) of this section, the belt air course must not be used to provide air to working sections or to areas where mechanized mining equipment is being installed or removed."
>
> "(1) The belt air course must be separated with permanent ventilation controls from return air courses and from other intake air courses except as provided in paragraph (C) of this section."
>
> "(2) Effective December 31, 2009, the air velocity in the belt entry must be at least 50 feet per minute. When requested by the mine operator, the district manager may approve lower velocities in the ventilation plan based on specific mine conditions. Air velocities must be compatible with all fire detection systems and fire suppression systems used in the belt entry."
>
> "(b) The use of air from a belt air course to ventilate a working section, or an area where mechanized mining equipment is being installed or removed, shall be permitted only when evaluated and approved by the district manager in the mine ventilation plan. *The mine operator must provide justification in the plan that the use of air from a belt entry would afford at least the same measure of protection as where belt haulage entries are not used to ventilate working places*." (emphasis added)

In plain terms, this language effectively eliminated the routine use of belt air in the nation's mines unless the affected companies could justify its use. All mines affected by this regulation were notified of the action and the Agency made arrangements to phase in the revocation of belt air petitions at mines that required it to complete current mining.

No operator was singled out for application of this regulation. Massey's statements to the contrary are, therefore, completely false.

Massey Energy bears the responsibility for creating and permitting the hazardous conditions that contributed to the explosion to exist. The question is: Does Massey's conduct constitute criminal negligence and industrial homicide? If the answer is yes, the individuals who perpetrated these crimes must face justice.

Coal Accumulations and Float Coal Dust

The history of violations at UBB demonstrates that Massey did relatively little to comply with the nation's mining laws. In fact, ample evidence exists to show it routinely ignored health and safety regulations in order to maintain production levels. This is especially true with respect to the hazardous conditions that contributed to the April 5 explosion.

Dust generated during the mining process or crushed under mobile equipment can create a serious problem in any coal mine. Float coal dust, if not controlled by ventilation, water sprays, rock-dusting and routine maintenance, can be suspended in the mine atmosphere, creating an explosion hazard. The Mine Act and federal regulations prohibit these conditions from existing in the mine.

> Section 304 of the Mine Act states "(a) Coal dust, including float coal dust deposited on rock-dusted surfaces, loose coal, and other combustible materials, shall be cleaned up and not be permitted to accumulate in active workings, or on electric equipment therein."
>
> "(b) Where underground mining operations in active workings create or raise excessive amounts of dust, water or water with a wetting agent added to it, or other no less effective methods approved by the Secretary or his authorized representative, shall be used to abate such dust. In working places, particularly in distances less than forty feet from the face, water, with or without a wetting agent, or other no less effective methods approved by the Secretary or his authorized representative, shall be applied to coal dust on the ribs, roof, and floor to reduce dispersibility and to minimize the explosion hazard."
>
> "(c) All underground areas of a coal mine, except those areas in which the dust is too wet or too high in incombustible content to propagate an explosion, shall be rock-dusted to within forty feet of all working faces, unless such areas are inaccessible or unsafe to enter or unless the Secretary or his authorized representative permits an exception upon his finding that such exception will not pose a hazard to the miners. All crosscuts that are less than forty feet from a working face shall also be rock-dusted."
>
> "(d) Where rock dust is required to be applied, it shall be distributed upon the top, floor, and sides of all underground areas of a coal mine and maintained in such quantities that the incombustible content of the combined coal dust, rock dust, and other dust shall be not less than 65 per centum, but the incombustible content in the return air courses shall be no

> less than 80 per centum. Where methane is present in any ventilating current, the per centum of incombustible content of such combined dusts shall be increased 1.0 and 0.4 per centum for each 0.1 per centum of methane where 65 and 80 per centum, respectively, of incombustibles are required."

Some of the most deadly mine disasters in history have been the result of mine operators violating the mandatory requirements of this section of the Mine Act. This is what happened at UBB. The final deadly event was played out on April 5, 2010, but one of the major causes of the explosion–float coal dust–was permitted to accumulate for months before the explosion. These accumulations were widespread, encompassing almost all of the active sections and intake and return air courses. Many of the citations issued in just the fifteen months before the explosion demonstrate how imminent this danger was.

MSHA issued eight citations for inadequate rock dust from January 15, 2009, through February 8, 2010, based on rock dust surveys performed at the mine that did not meet the statutory requirements of the federal regulations. The percentage of each survey that was out of compliance ranged from 24 to 100 percent. Six of the eight samples taken were out of compliance by at least 51 percent. These citations represented large areas of the underground workings at UBB. While the rock dust surveys are a snapshot of the conditions in a particular area of the mine, they represent a reliable measure of how the operator maintains the mine in general.

Further evidence of Massey's knowledge of the dust problems at the mine are contained in other citations issued for violations of 30 CFR §75.400, Subpart E, Combustible Materials and Rock Dusting. The company was cited numerous times for loose coal, coal dust and float coal dust throughout the mine. In the time period noted above, MSHA issued <u>forty citations and orders</u> to Massey for violating §75.400 of Subpart E.

> Citation number 8082721 issued April 14, 2009, states, "The #2 belt on the #1 section is not being maintained free of combustible materials. The belt has accumulations of float coal dust, float coal and coal spillage *along its entire length* in multiple locations under the belt and between the belt and the offside coal rib. *There is obvious evidence that the belt has been advanced several times without cleaning up spillage around the tail piece or feeder before advancing*." (emphasis added)

This citation is telling because it notes that coal and float coal dust were present along the entire length of the belt. Also, the feeder had been moved as the section advanced, but no clean-up and rock-dusting was performed after the moves. This demonstrates it was a practice at the mine to ignore these general and necessary maintenance tasks. It becomes obvious that moving the belt closer to the production equipment was Massey's only objective. Once the belt was advanced, mining commenced, and any hazards that were present were simply ignored by management.

> Order number 8086127 issued July 9, 2009, states, "The operator is failing to properly maintain the 029-040 MMU section. Loose coal has been allowed to accumulate in several locations of the section. The No. 4

entry has coal measuring 1 inch to 24 inches deep for a distance of 112 feet on both ribs and the roadway. The 3 right cross-cut has coal accumulations measuring 1 inch to 24 inches deep on both ribs and the roadway for a distance of 79 feet in length. The No. 3 entry, just outby the last open cross-cut has coal measuring 1 inch to 24 inches deep on both ribs and the roadway. The 2 left cross-cut has coal accumulations measuring 1 inch to 15 inches deep on both ribs and the roadway for a distance of 40 feet. With the citation issued on 07/08/2009 citing over 2% methane in the same location and the problems encountered today with excessive methane, the above conditions create a hazard. *This violation is an unwarrantable failure to comply with a mandatory standard*" (emphasis added).

Like the previous citation, this order demonstrates the failure of Massey to correct known hazards as they were found. This mining section had been cited on July 8, 2009, for an accumulation of methane. When the inspector returned the following day, he not only found excessive methane, but excessive coal spillage on the section as well. Either of these conditions posed a hazard to the safety of miners underground, but to have the condition worsen from one day to the next shows Massey's contempt for the law.

The problems created by management's refusal to address dangerous float coal dust did not end here, however. The lack of ventilation and reversals of the air flow, discussed previously, played a significant role leading up to the explosion. The orders noted in the ventilation portion of the report, numbers 8090855 and 8090856, described miners working in visible dust. The lack of adequate ventilation meant the contaminated air could not course into the returns and out of the mine; instead it slowly pushed the air down the entries, allowing dust to settle on the mine's surfaces. The air reversals meant that float coal dust that would normally be carried to the return was not.

Rock-Dusting

The first line of defense in controlling float coal dust from becoming a dust explosion, like what occurred at UBB, is rock dust. This, too, was ignored by Massey. There is ample evidence to demonstrate that in Massey's never-ending push for greater production, rock-dusting became a casualty. Virtually every credible report regarding rock dust application at UBB has concluded that the operator failed to implement a rock-dusting plan that complied with the requirements of the law.

This failure resulted in the difference between a manageable ignition on the longwall face being contained and extinguished and an explosion involving float coal dust that killed 29 miners.

The accepted practice at longwall mines when the gate entries are completed for a longwall panel is to heavily rock-dust the entire area before production begins. This coating of rock dust serves to mitigate the hazard that is created from float coal dust generated during the mining process.

This "blanket" of rock dust should cover both sets of bleeder entries and extend from the mouth of the section to the starting location of the longwall. In many instances, these areas can be dragged or raked to render float coal dust inert. However, MSHA has reported that prior to the start of the last

active longwall panel at UBB, the bleeder entries were not rock-dusted.

MSHA reported that on the day of the explosion, of the ten belts where examinations were recorded, five needed cleaning and six needed rock-dusting. In fact, on the day of the explosion, foreman Mike Elswick (victim) called out his preshift report stating that the belts needed rock-dusting.

While MSHA reported that Massey hid many violations in the second set of books ("production and maintenance"), it also reported that ***in a little over a month, just prior to the explosion, mine examiners reported that belts were in need of rock dust over 560 times. Management responded to these reports only 65 times in that period.*** The preshift examination books for the belts at UBB also show that management at Massey did not place a high priority on rock-dusting.

A mine the size of UBB would require regular rock-dusting. Generally mines as large as this would have designated rock-dust crews whose sole assignment would be to clean and dust the areas of the mine from the active sections' loading point outby. In order for rock-dusting to be done effectively, these crews would need to be assigned on each shift and provided with equipment suitable to complete their work.

This was not the case at UBB. Massey designated a two-man crew to rock-dust the entire mine. While this in itself would be an impossible task, the crew was frequently taken off its rock-dusting job to perform other work. Finally, the equipment they were given to use was a 1980's model twin tank duster, which routinely broke down. The duster was not even in the mine at the time of the explosion–it was on the surface. When MSHA put power on the machine to test it as part of the investigation, the motor burned up.

UBB rock-dusting machine where it was found outside the mine.

The rock-dust crew and other miners at the operation were aware that rock dust was not being applied as required. The GIIP reported that Charles Semenske and Tim Blake, both veteran miners, testified that they believed rock-dusting was inadequate at the mine.

From February 5-9, 2010, five different individuals were assigned to the rock-dust crew. Nathaniel Jeter and Curtis Irwin, who were the dusting crew until February 5, reported problems performing their job. Jeter stated that the duster, "...would clog up, so we would have to spend 30 minutes trying to unclog the hoses to get dusted. Then they would clog up again." Irwin complained, "It would break a lot." (GIIP at page 50)

On February 5, Gary Young and Dustin Richardson were assigned to the rock-dust crew. Shortly thereafter, Richardson was given another assignment and Clifton Stover became the second member of the crew.

The crew kept notes regarding their inability to perform the job because of broken equipment, clogged hoses or being assigned other duties. One record in the rock-duster's notebook states, "NO RIDE, NO help, No Spotter. I'll call you today. I'm set up to fail here." (GIIP at page 52) The gap in the notes indicating that they were not rock-dusting on those days is perhaps even more telling than the problems they experienced while trying to perform their job. Twice there are no notations regarding rock-dusting, each for a period of six days.

James Fleming, third shift belt move crew member who had worked at UBB for four years, noted, "As far as I can remember they only had two men on one shift trying to rock-dust this whole mines. And then when they do rock-dust, the only place they rock-dust is the track and belt entry. That's it." (GIIP at page 52) MSHA has reported that heaving in the Longwall return entries, an area that would require regular dusting, prevented the dusters from entering that area.

There are many other accounts from MSHA, the GIIP and in the media regarding the lack of rock dust in the mine. Put together, they paint another part of a frightening picture of a coal mine that was a bomb waiting to go off and a coal operator with matches in its hands.

Longwall Shearer - Bits and Sprays

How they should typically work

Maintaining the longwall shearer, including mining bits and water sprays, in good operating condition is extremely important. The bits are the contact point between the mining machine and the coal face. They spin rapidly on the drum of the shearer, penetrating the coal of the solid mining face. Bits striking rock surfaces within the coal or on the roof and bottom of the mining face will cause sparking. It should be noted that at UBB, the coal seam measured 54 inches and the longwall was cutting 84 inches. This would require the shearer to cut through 30 inches of rock at all times.

Frictional sparks are reduced when the bits of the machine are well-maintained and changed as necessary. The design is such that the angle of the bit allows the point to engage the cutting surface first, shearing off the material and reducing the possibility of the bit shank or bit block contacting the solid surface. As bits wear or are broken, the likelihood of the shank or bit block, which are made from softer metals, coming in contact with the cutting surface is greatly increased. This increases the amount and intensity of the sparking at the point of contact. In some instances, worn bits and bit blocks will leave a trail of sparks on the cutting surface that can last for several seconds.

Water sprays are also intended to play a key role in reducing sparking, cooling bits and controlling dust. Spray systems are engineered to apply a sufficient volume of water in a precise pattern. It is extremely important to note that these systems dispense water over the bits and face area in a mist. The mist effect is generated by water under pressure passing through the small holes in the tips of the sprays. This significantly reduces the possibility of ignitions. They also knock down coal dust created during the mining process. However, the sprays must be maintained to operate properly.

Clogged or missing water sprays severely reduce the system's effectiveness. A clogged spray is useless because it cannot generate the water mist as required. A missing water spray, while generating significantly more water at the point of exit, is also useless. Large volumes of water gushing out of the spray opening, much like what would come out of a garden hose, cannot generate the same targeted mist required to cool the bits and reduce or eliminate the possibility of a frictional ignition. Likewise, they will do nothing to control coal dust. In fact, each missing spray decreases the water pressure within the drum. This pressure drop reduces the volume of water being dispensed at each active spray. When a sufficient number of sprays are missing, the remaining sprays will fail to emit any mist, rendering the entire system ineffective.

UBB Longwall Shearer - Bits and Sprays

Removing water sprays on the shearer appears to have been a common practice at UBB. Massey, in its effort to hide such practices, did not record such events in the official examination book. However, in the Production and Maintenance book for March 1, 2010, the record states, "Had no water on either drum, cleaned several and stopped right back up, removed 8 on each end, ran like that rest of shift to try and flush drums, told 3rd shift" (MSHA June 29, 2011, briefing [attached]). This would permit water to gush out from the shearer, rendering the spray system ineffective. However, it would also permit water to pass through the shearer motors, keeping them from overheating. In other words, production continued, but safety was compromised.

The longwall shearer at UBB was not maintained in a manner that allowed it to function as designed. The evidence shows that bits on the shearer were broken and worn to such a degree that they would cause significant sparking as they came in contact with the mine's sand rock roof. The heat generated by this frictional sparking would be sufficient to ignite methane generated during the mining process or migrating from the gob onto the face.

MSHA attempted, for several months after the explosion, to test the water sprays on the shearer. The testing was necessary to determine the effectiveness of the spray system at the time of the explosion and if Massey complied with its approved ventilation plan.

Massey refused to supply water to the longwall area for this testing, citing its own ongoing investigation. It was not until November 10, 2010, when MSHA issued a 104(a) citation for impeding the investigation (attached), that work on installing a waterline to the shearer was started by Massey Energy.

While installing the waterline was a large undertaking, MSHA became concerned that Massey was not putting enough effort into completing the job. In fact, a letter from Charles Bearse III of Performance Coal Co. to MSHA, dated December 13, 2010, stated that the pipe necessary to complete the work was ordered and would be on property soon (attached). When Massey further delayed installing the waterline, MSHA began threatening the operator with stiffer enforcement action in the form of a 104(b) order (for failing to abate a cited condition) if work on the waterline was not completed quickly. However, MSHA repeatedly yielded as the original citation was modified, extending the time allotted for compliance twelve times before it was terminated on December 20, 2010.

Testing of the water spray system on the shearer was conducted on December 20, 2010.

The condition of the water sprays is very troubling. When water was supplied to the shearer during the investigation, it was determined that both drums and ranging arms had sprays that were not operating at the time of the explosion. The tailgate drum was also missing several water sprays.

The investigation revealed the following evidence regarding the water sprays that could be seen on the shearer:

- Headgate drum - of the twenty-eight sprays visible, nineteen were operating and nine were plugged.
- Headgate ranging arm - of the ten spays visible, five were plugged.
- Tailgate drum - of the forty-two sprays visible, twenty-seven were operating, eight were plugged and seven were missing.
- Tailgate ranging arm - of the ten sprays visible, five were plugged.

Headgate ranging arm sprays on the UBB longwall. Five of the ten sprays were plugged and did not work.

With almost forty percent of the visible water sprays plugged or missing, the spray system was unable to function as designed. The fact that thirty-four of the sprays were plugged is problematic and should be cited by the Agencies. However, in this particular case, the Union believes none of the sprays on the shearer drums were working properly, because the missing sprays reduced the water pressure significantly, thus rendering the system useless for purposes of safety.

The water-flow testing conducted during the investigation demonstrated that the seven missing water sprays reduced the pressure within the drums to the point that the system would not operate as designed. The water from the surface was piped through a manifold that controls the amount of pressure that enters the shearer drums. Even when the water pressure from the manifold was increased to 450 psi and a flow rate of 223 gallons per minute, the pressure gauge on the tail drum registered zero psi. It was not until the seven sprays were replaced during testing and the water pressure at the manifold increased to 450 psi and a flow rate of 211 gallons per minute that the pressure gauge on the tail drum registered 120 psi.

There can be no question that the water sprays on the shearer were not adequately maintained to control dust or reduce sparking. This raises the question: why was the shearer being operated in this manner? It is probable, based on Massey's history, that shutting down the longwall–even for necessary routine maintenance–was not permitted. Water sprays do not produce coal; therefore they were not important to Massey Energy's management personnel.

The maintenance on the longwall that was reported to have been completed the previous shift must also be questioned. The report states that a number of bits were replaced and general maintenance was completed, yet the condition of the shearer after the explosion contradicts that information. If maintenance was performed on the midnight shift, why were so many bits worn or missing and the sprays not functioning?

The water-flow testing revealed another possible answer. The water supplied to the sections in the mine was pumped from the Marfork River adjacent to the mine. This water, filled with river sediment, was stored in a tank on mine property and used gravity to flow into the mine. The sediment in the water

had a great potential to clog the water sprays on the mining equipment.

During testing, the water flowing through the manifold into the shearer was so thick with sediment that after approximately six-and-one-half hours, the testing had to be stopped because the filters had become clogged. The testing resumed after the filters were changed and water could flow through the manifold.

Removing water sprays would permit the water to flow and protect the motors. However, they would not be able to perform their primary function: controlling dust and suppressing face ignitions. At the same time, removing sprays would eliminate any protection offered by a functional spray system.

Two sets of books

In all instances, information about conditions within the mine must be available to all interested parties at the mine. However, Massey Energy regularly disregarded these requirements by keeping two sets of books.

On June 29, 2011, MSHA released six pages from these books, three from the official record books and three from Massey's production and maintenance books (attached). The entries are dated March 1, 2 and 16, 2010. The official reports do not indicate anything of consequence, no hazards or unusual events. These are the records that Massey made available to the inspectors and others on the property, including the miners themselves.

However, the mine's production and maintenance books tell a much different story. As noted above, the report for March 1, 2010, reads, "Added 5 gal oil to the T/E ranging arm. Had no water on either drum, cleaned several and stopped right back up, removed 8 on each end, ran like that rest of shift to try and flush drums, told 3rd shift."

Running the shearer with no water sprays, as would be the case here, is a serious violation. Obviously, this would be a violation of the ventilation plan and because it was done knowingly, this action demonstrates a reckless disregard for the law. More importantly, the action places the miners on the section at immediate risk for an ignition of gas or dust accumulating on the coal face. And over the long term, exposure to uncontrolled coal mine dust greatly increases miners' chances of contracting black lung disease.

The production maintenance book for March 2 states, "25 min Reventelating [sic] to get methane out of #3 1.5 Reduced to .30."

The production maintenance book for March 16 notes, "Low Air in LOB outby going to HG22 Tail open 7:00-8:10.... Adverse Roof condition their coal streak four ?5' up. Falling out to in # 1 2."

Since these incidents were not recorded in the official record book, there was no way for the oncoming shift to know that these hazards existed. Miners entering the mine would be absolutely unaware of potentially dangerous conditions present when they arrived on the section. Further, when MSHA reviewed the "official" books, it would not get any sense of what conditions were actually like in the mine.

The Mine Act requires operators to examine the entire mine at regular intervals. The scope and timing of the examination is determined by the particular examination being performed. Required examinations are listed in 30 CFR Subpart D – Ventilation, previously referred to in this report.

The results of these examinations are required to be recorded in an official record book designated for that purpose, signed or initialed by the person making the examination and countersigned by the mine foreman or equivalent company official. The report must contain a record of hazardous conditions and their locations found by the examiner during each examination and of the results and locations of air and methane measurements.

The reason for recording this information in a designated book is not simply to have an official record of the conditions in the mine, but to ensure all persons entering the mine are able to review the information and know what to expect. Further, the Mine Act makes clear such data is necessary in order to assist representatives of the Secretary in doing their job.

> Section 103 of the Mine Act states in subsection (d): All accidents, including unintentional roof falls (except in any abandoned panels or in areas which are inaccessible or unsafe for inspections), shall be investigated by the operator or his agent to determine the cause and the means of preventing a recurrence. *Records of such accidents and investigations shall be kept and the information shall be made available to the Secretary or his authorized representative and the appropriate State agency. Such records shall be open for inspection by interested persons*. Such records shall include man-hours worked and shall be reported at a frequency determined by the Secretary, but at least annually. (emphasis added)
>
> (h) In addition to such records as are specifically required by this Act, every operator of a coal or other mine shall establish and maintain such records, make such reports, and provide such information, as the Secretary or the Secretary of Health, Education, and Welfare may reasonably require from time to time to enable him to perform his functions under this Act. The Secretary or the Secretary of Health, Education, and Welfare is authorized to compile, analyze, and publish, either in summary or detailed form, such reports or information so obtained. Except to the extent otherwise specifically provided by this Act, *all records, information, reports, findings, citations, notices, orders, or decisions required or issued pursuant to or under this Act may be published from time to time, may be released to any interested person, and shall be made available for public inspection*. (emphasis added)

These official records are to be recorded in ink or on a computer using a program that cannot be altered and retained for a year at the mine. These are the official examination books all mine operators are required to complete and maintain.

MSHA also requires the recording of hazardous conditions in a mine that are discovered at a time other than one of the specifically required examinations.

> **§75.363(b)** A record shall be made of any hazardous condition found. This record shall be kept in a book maintained for this purpose on the surface at the mine. The record shall be made by the completion of the shift on which the hazardous condition is found and shall include the nature and location of the hazardous condition and the corrective action taken. This record shall not be required for shifts when no hazardous conditions are found or for hazardous conditions found during the preshift or weekly examinations inasmuch as these examinations have separate record keeping requirements.

Responsibilities of the Mine Safety and Health Administration

Although some members of Congress have consistently been great advocates for protecting coal miners' health and safety, legislative action to improve miners' safety and health has only occurred in the aftermath of horrific tragedies in the coalfield communities of the country.

Passage of the Coal Act of 1969 was the result of the Farmington #9 explosion in 1968. The disaster resulted in the death of 78 miners, 19 of whom are still entombed in that mine. The Coal Act was a significant step forward, but because enforcement of Congress' mandate was generally ineffective, it was amended in 1977. This legislation created the Mine Safety and Health Administration (MSHA) to police the industry, enforce mining laws and penalize operators that did not comply.

In 2006, after three deadly accidents claimed the lives of nineteen miners: twelve at ICG's Sago Mine; two at Massey Energy's Aracoma Alma Mine #1; and five at Kentucky Darby's Darby Mine No. 1; Congress felt compelled to act again. On June 15, 2006, the Mine Improvement and New Emergency Response Act of 2006 (MINER Act) was enacted. These pieces of legislation have afforded MSHA broader powers to regulate the mining industry.

The industry that has proven time and time again that it cannot police itself. History has shown that, left to their own devices and without strict regulatory requirements, some mine operators will do virtually nothing to afford miners a safe and healthy working environment.

With these legislative powers in place however, MSHA, as the agent for the Secretary of Labor, is also charged by Congress to "...develop, promulgate, and revise as may be appropriate improved mandatory health and safety standards for the protection of life and prevention of injuries in coal or other mines." (Section 101(a) Mine Act).

Moreover, MSHA's consistent and aggressive enforcement is necessary to compel renegade operators to comply with the laws and regulations. It is the Agency's responsibility to see that unsafe and unhealthy conditions and practices are not tolerated. MSHA's inspectors must cite all violations that exist during their inspections. They are required to be the cop on the beat.

The preamble of the Mine Act demonstrates Congress' desire for the Agency to be a proactive and technology driving institution. It is MSHA's job to help prevent accidents and illness. It is to force an intractable industry to continuously improve its health and safety practices.

Furthermore, the overall intent of the Mine Act is clear on the face of the statute:

> Sec. 2. Congress declares that –
>
> "(a) 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;

"(b) death and serious injuries from unsafe and unhealthful conditions and practices in the coal and other mines cause grief and suffering to the miners and to their families;

"(c) there is an urgent need to provide more effective means and measures for improving the working conditions and practices in the Nation's coal and other mines in order to prevent death and serious physical harm, and in order to prevent occupational disease originating in such mines,"

...(g) it is the purpose of this Act –

> "(1) to establish interim mandatory health and safety standards and to direct the Secretary of Health, Education and Welfare and the Secretary of Labor to develop and promulgate improved mandatory health or safety standards to protect the health and safety of the Nation's coal or other miners;
>
> "(2) to require that each operator of a coal or other mine and every miner in such mine comply with such standards;
>
> "...(4) to improve and expand, in cooperation with the States and the coal or other mining industry, research and development and training programs aimed at preventing coal or other mine accidents and occupationally caused diseases in the industry."

Further, the legislative history of the Mine Act eliminates any ambiguity that it was the intent of lawmakers to create an Agency that has real enforcement power. The legislative history states, "The bill creates a new Assistant Secretary of Labor for Mine Safety and Health, to provide *specialized treatment and enforcement of the mine safety and health amendments"* (emphasis added).

To make the point crystal clear the Senate noted, "*A separate enforcement structure with separate attention to mine safety and health problems is mandated by the very high fatality and injury rates for the industry*" (emphasis added).

The Senate was acutely aware of the additional responsibility it was placing on the newly created Mine Safety and Health Administration. Therefore, it took steps within the legislation to ensure sufficient funding. In doing this, the legislative history notes, "the *increased enforcement* and administrative responsibilities under the bill, *including increased inspection, enforcement, legal services*, and administrative responsibilities, it is anticipated that additional resources may be needed by the Department for personnel and support services. *Such resources can be provided through the normal appropriation process as becomes necessary*" (emphasis added).

Despite this, the UBB investigation has raised some very serious concerns regarding some of the actions of MSHA District 4. There are reports of the District not supporting inspectors who attempt to strenuously enforce the law. Minness Justice, a retired MSHA inspector, was quoted in *Simple Legal Docs* saying, "MSHA offices in West Virginia often had an environment that discouraged the writing of S&S citations, also D citations...the constant resistance from coal

operators created an air of bureaucratic caution."

Truthout reported, "Days before the fire broke out in the Aracoma mine, a federal inspector tried to close down that section of the mine, but was told by his supervisor to back off and let them run coal, that there was too much demand for coal."

The questions regarding MSHA's enforcement activity, especially with regard to Massey Energy operations, does not appear to be a failure by MSHA inspectors. The coal mine inspectors, and even some of their supervisors, were trying to carry out their mandate.

However, the UMWA believes that MSHA District 4 managers did not use all of the tools provided by Congress to force Massey to comply with the law. MSHA District 4 should have shut down the UBB mine until Massey corrected all the hazardous conditions that existed We recognize that District 4 had been issuing more citations since the first quarter of 2009. However, even that effort was insufficient to effect compliance.

Tony Oppegard, a safety attorney from Lexington, Ky., noted with regard to UBB, "It doesn't matter whether you have more or less violations than the average mine. This mine blew up. Mines don't blow up unless there were violations." He further stated, "Any mine that accumulates almost 50 unwarrantable failure violations in a single year deserves the heightened scrutiny..." (*Coal Tattoo*)

After the passage of the MINER Act, the number of citations contested by operators nationwide rose from 5 percent prior to 2006 to 30 percent at the time of the explosion. The *Tennessean* noted on April 9, 2010, "Coal mine operators have paid just 7 percent of the fines they have been assessed for major health and safety violations in the past three years.... They have paid just $8 million of the $113 million in major penalties since April of 2007 when fines increased...."

In reality, although citations were being written, they were having no tangible impact on many operators. Contested citations and orders are held up for years in the appeals system, during which time the operator is not obligated to pay any fines. Moreover, MSHA lawyers routinely negotiate reduced fines in order to settle contested citations.

The Union is aware that the number of closure orders at UBB increased from three in 2008 to 48 in 2009. While the inspectors on the ground should be commended for attempting to increase enforcement, we must again question the response of District 4 management. Such a significant increase in 104(d)(2) orders should have raised serious concerns among senior MSHA personnel at the District. Yet our investigation did not reveal a plan on the part of District 4 to address the problems at UBB.

Based on information released by MSHA, conditions continued to deteriorate at UBB in the months leading up to the explosion. With the exception of a ventilation survey completed by MSHA at the mine two weeks prior to the explosion, there is no record of an inspection blitz that would have placed inspectors in every area of the mine to determine if Massey was in compliance. Nor did the District use its authority under Section 8(a)(2) of the MINER Act to issue a single "flagrant" violation at UBB. That action would have imposed an automatic $200,000 fine.

The conditions that existed in the mine on April 5, 2010, did not occur overnight. Instead, they were the result of weeks, months and years of neglect. Massey's ventilation plan was flawed. The lack of adequate rock dust extending from the mouth of the mine to the working sections was the result of blatant neglect. Water spray systems were not properly functioning and worn bits were ignored. Float coal dust was permitted to accumulate throughout the mine.

Massey Energy has a history of manipulation and intimidation, including of MSHA inspectors and their supervisors. There should have been a realization on MSHA's part that Massey's willingness to be confrontational with agents of the U.S. Government placed the health and safety of the workers at the operation at greater risk, requiring greater oversight and control to ensure miners were protected. ***If Massey would treat MSHA personnel with such disdain, the Agency should have realized it had to be even more protective of the miners.***

It should be noted that except for a computer error, the UBB mine would have been targeted for a Pattern of Violations.

Roof Control

Another significant aspect for ensuring the safety of miners is roof control. Such plans are required to be submitted to MSHA in writing for approval by the District Manager and reviewed regularly. They are to be mine-specific and contain detailed descriptions of the methods that will be used to not only support the roof, but to protect against rib rolls, rock or coal outbursts and any other conditions created because of the geological make-up of the mine.

Sec. 302. (a) of the Mine Act states, "Each operator shall undertake to carry out on a continuing basis a program to improve the roof control system of each coal mine and the means and measures to accomplish such system. The roof and ribs of all active underground roadways, travelways, and working places shall be supported or otherwise controlled adequately to protect persons from falls of the roof or ribs. *A roof control plan and revisions thereof suitable to the roof conditions and mining system of each coal mine and approved by the Secretary shall be adopted and set out in printed form within sixty days after the operative date of this title.* The plan shall show the type of support and spacing approved by the Secretary. *Such plan shall be reviewed periodically, at least every six months by the Secretary, taking into consideration any falls of roof or ribs or inadequacy of support of roof or ribs*. No person shall proceed beyond the last permanent support unless adequate temporary support is provided or unless such temporary support is not required under the approved roof control plan and the absence of such support will not pose a hazard to the miners. A copy of the plan shall be furnished the Secretary or his authorized representative and shall be available to the miners and their representatives." (emphasis added)

§75.220 (a)(1) states, "Each mine operator shall develop and follow a roof control plan, approved by the District Manager, that is suitable to the prevailing geological conditions,

and the mining system to be used at the mine. *Additional measures shall be taken to protect persons if unusual hazards are encountered*." (emphasis added)

The UBB mine also had a history of adverse roof conditions. There were many instances where roof falls were reported above the anchorage point of the bolts and walls crushing out because of excessive pressures. This report notes many instances where adverse roof conditions were cited by inspectors, including those that were discovered during a MSHA Part 50 audit because the adverse roof conditions were not reported as required. Bottom heaving, a condition where the coal pillars are pushed into the mine floor, causing the mine entries to push upward, was also a regular occurrence in the mine.

Another glaring problem regarding roof control was that Massey failed to follow its approved plan. The investigation revealed entries exceeded maximum widths outlined in the roof control plan in almost every section of the mine. The maximum distance between bolts and between roof bolts and the rib also routinely exceeded the parameters required under the plan. Such practices were so prevalent that they became the norm at UBB.

MSHA District 4 should have taken the appropriate action to force Massey to comply with the roof control plan, or revoked the plan.

Tracking Systems

The MINER Act requires the installation of post-accident communications and tracking systems. In December 2009, the Agency determined that these systems were commercially available in sufficient quantities for use in the Nation's mines. It notified mine operators that by June 15, 2010, they would be expected to have an approved system installed and operational.

It appears that UBB had purchased a system, but on April 5, 2010, it was not fully installed nor was it fully operational. Based on the GIIP report, the system installation was only about 20 percent complete, and it was doubtful that the operator would have it fully installed by the required date.

Because the tracking system at UBB was not fully functional on April 5, there was no record of who was underground, nor was there a record of their locations. It was not until 1:40 a.m. the next morning that this information became available. Redundant systems were required by MSHA, yet none were in use.

To reiterate: The tracking system was not functional. Massey's responsible person had recorded no log of miners entering or moving around the mine. And the simplest form of tracking miners going underground–the check-in check-out board–was not used.

In conclusion, MSHA possesses the authority to take enforcement action necessary to force compliance with regulations and increase protection for miners. UBB was a mine crying out for the federal government to step in and shut it down. MSHA should have used all the tools at its disposal to do just that until the hazardous conditions were corrected.

West Virginia Office Of Miners' Health, Safety and Training

The West Virginia Office of Miners' Health, Safety and Training (WVOMHST or State) operates much like MSHA, but within the state of West Virginia. It is charged with enforcing the mining laws adopted by the State Legislature and signed by the Governor and rules promulgated by the state's board of Coal Mine Health and Safety. In general, the West Virginia state laws are more encompassing than the federal regulations, and in some instances they are more restrictive.

The WVOMHST declares its "Mission Statement" as follows:

> "The West Virginia Office of Miners' Health, Safety & Training is responsible for the supervision of the execution and enforcement of the provisions of the state's mining laws and rules. *Prime consideration is given to the protection of the safety and health of persons employed within or at the mines of the state*. In addition, the agency protects and preserves mining property and property used in connection with mining activities." (emphasis added)
>
> "The agency pursues this mandate by impartially executing and enforcing the state's mining laws and administrative rules in a co-operative spirit through a comprehensive approach that includes not only inspection, enforcement, and investigative activities, but also, and perhaps more importantly, by aggressively conducting timely and functional training activities focused on all segments of the mining industry."

The WVOMHST has sufficient tools at its disposal to force mine operators to comply with the state's mining laws and protect the health and safety of its miners. In the case of the UBB explosion however, it does not appear that the state utilized its full authority to force Massey Energy to obey the state's mining code and regulations. WVOMHST had the authority to approve and monitor UBB's ventilation plan. It had the power to ensure that UBB was adequately rock-dusted and the roof control plan was adequate. Finally, WVOMHST had the ability to ensure proper mining methods were used.

The WVOMHST is responsible for the approval and enforcement of ventilation plans at mines throughout the state. As such, it is charged with ensuring that mining laws are obeyed. It is also required to take appropriate action when mine operators break the law. Its code provides:

> **"**§22A-2-1 Supervision by professional engineer or licensed land surveyor; and certification; contents; extensions; repository; availability; copies; final survey and map; penalties.
>
> "...(27) The operator of every underground coal mine shall extend, or cause to extend, on or before the first day of March and on or before the

> first day of September of each year, such mine map thereof to accurately show the progress of the workings as of the first day of July and the first day of January of each year."

The statutory language of this section and the fact that MSHA was unable to obtain an up-to-date and accurate map for 2009 until November of that year raises the question whether the state ever received an up-to-date map. It is extremely doubtful that Massey Energy satisfied the state requirements, but failed to do so with the federal agency.

The UMWA is on record stating that there is no doubt that the content of the mine's ventilation plan was flawed. For instance, Massey failed to meet the state's requirements with regards to doors.

> "§22A-2-4 Ventilation of mine in general.
>
> "...(k) The ventilation of any mine shall be so arranged by means of air locks, overcasts, or undercasts, that *the use of doors on passageways where men or equipment travel may be kept to a minimum"* (emphasis added).

The company used a series of 79 doors, including 33 sets of double/airlock doors, to direct air through the mine to the working faces (see map attached showing 16 double airlock doors and 20 single airlock doors into 78 Break). This is not only a poor practice, but it is prohibited by state statute. Yet there is no record of the state agency ever requiring the operator to change this practice and install necessary overcasts or undercasts.

The law is specific in restricting the use of doors in this manner, but the state never exercised its authority and demanded that the mine be made safer.

Furthermore, the evidence and testimony after the explosion shows that ventilating the working faces was increasingly difficult. Miners testified that the air on the sections would ebb and flow throughout the shift when they were working. Some days they would have only a little air, and some days they would not have any. We now know that air reversals were a common problem at the mine.

Management would routinely and illegally change the ventilation in the mine while miners were underground. A citation issued on January 27, 2010, states, "A mine ventilation change was made on MMU 029-0 beginning on Dec. 18, 2009 to Dec. 21, 2009. This change was made without prior approval by the Office of Miners Health, Safety and Training, and a violation was written on 12-31-09. The original plan submitted by Performance Coal - UBB was rejected on 12-31-09.... The rejected plan is still being used. This violates a health and safety provision or safety rule, is of a serious nature and involves an extraordinarily high degree of negligence or gravity." The citation was recommended by the issuing inspector for special assessment.

The condition above existed for over a month while miners were operating equipment underground. While the inspector was correct to write the citation, questions remain. Given the ventilation problems at the mine, the Union believes the state should have forced Massey to properly ventilate the mine using acceptable ventilation controls.

The problems that existed were serious and systemic. Ventilation was unpredictable from one day to the next. The

state did not conduct an inspection blitz to determine the extent of the problems, nor was a ventilation survey ordered to determine what the root problem was with the ventilation.

Another area in which this systemic failure can be seen is with ventilation fans in the mine. The West Virginia mining laws provide:

> "§36-1-15 Ventilation - fans.
>
> "15.1 Ventilation fans shall be:
>
> "...(3) Designed to permit the reversal of air and located in an area which will prevent a recirculation of air from the shaft and/or slope or contamination from any other source."

The Union has determined that the North Portal fan was actually recirculating air from the return entry near its location. This North Portal fan had been in operation for many years, yet it was not until after the explosion that this violation was discovered.

The WVOMHST had an obligation to review the ventilation system at UBB in its entirety. The Agency has the authority to revoke the operator's ventilation plan and stop the mining process until conditions are corrected.

With respect to float coal dust and rock-dusting, West Virginia state law requires the following:

> **"**§22A-2-24 Control of coal dust; rock dusting.
>
> "(a) In all mines dangerous accumulations of fine, dry coal and coal dust shall be removed from the mine, and all dry and dusty operating sections and haulageways and conveyor and back entries shall be rock-dusted or dust-allayed by such other methods as may be approved by the director."

The state issued seven citations for accumulations of loose coal and float coal dust at UBB from February 2, 2010 through March 23, 2010. These citations cover thousands of feet of entries throughout the mine and demonstrate a practice on the part of Massey Energy to blatantly disregard the law.

> Citation number 31078 issued March 2, 2010, states, "The #5 North Mains conveyor belt head and take up area including the starter box [illegible] has a heavy coating of very dry float coal dust, and float coal dust is present at various locations from head to tail of this belt."
>
> Citation number 31080 issued March 2, 2010, states, "The track entry and break throughs connected thereto from the longwall track switch to the #1 / HG22 working section needs rock-dusted due to float coal dust in this area."
>
> Citation number 31091 issued March 23, 2010, states, "The Head Gate 22 conveyor belt (section) which is close to a mile long is not being maintained properly due to the need for spot cleaning under the belt as well as the spillage in the walkway and rocks and coal from ribs in the walkway as well and in addition float coal dust is present from the belt head to the belt tail."

Massey's lack of proper rock-dusting at the mine is perhaps the most perplexing

problem to understand with regard to the state agency. It appears from the citations issued in the first quarter of 2010 that the state understood the problem existed. The seven citations chronicle the fact that Massey permitted miles of float coal dust to accumulate in the mine. The state understood that this presented a significant hazard that needed to be corrected. The number and severity of the citations issued by the inspector should have raised a red flag with the Director of the WVOMHST.

However, in the days between the issuance of the citations and the explosion, only two of the seven violations were abated. There should be no doubt, given the circumstances, that in those ensuing days additional float coal dust was permitted to accumulate throughout the mine. The very conditions cited contributed to the deadly coal dust explosion.

Roof Control Plan

With respect to roof control the West Virginia law states:

> "§22A-2-5 Roof control program and plans; refusal to work under unsupported roof.
>
> "(a) Each operator shall undertake to carry out on a continuing basis a program to improve the roof control system at each coal mine and the means and measures to accomplish such system. The roof and ribs of all active underground roadways, travelways and working places shall be supported or otherwise controlled adequately to protect persons from fall of roof or ribs. A roof control plan and revisions thereof suitable to the roof conditions and mining system of each coal mine and approved by the director shall be adopted and set out in print form before new operations.
>
> "§36-10-4 Mining methods.
>
> "The method of mining shall not expose any person to hazards caused by excessive widths of rooms, crosscuts and entries, or faulty pillar methods. Pillar dimensions shall be compatible with effective control of the roof, face and ribs and coal or rock bursts."

The roof control plan at UBB, like all other mining plans, must be submitted to the state and approved before mining is initiated. The plan must be sufficient to protect miners from roof falls, rib rolls, coal or rock outbursts and other conditions caused by inadequate controls.

The Union contends that, based on the conditions at the mine both before and after the explosion, Massey was not complying with its approved roof control plan. The fact that after the explosion, both the federal and state Agencies required over 9,000 additional roof supports be set in order to conduct the investigation, confirms Massey's non-compliance.

Before April 5, there were numerous reports of roof falls above the anchorage point of the roof bolts. Some of these were reported as required by law, while more were discovered during the post explosion inspections by the federal and state Agencies. Such events present serious hazards to miners and should have been evaluated to determine if there was a need to supplement the roof control plan.

The fact that the longwall bleeder system was caved to the point that it became impassible should also have caused the state to re-examine the roof control plan. To make matters worse, heaving in one area of the mine crushed out 16 consecutive stoppings. In another area, it damaged seals designed to separate the old workings from the active mine entries. It became apparent that the conditions that existed in the headgate bleeder were so severe that new entries had to be driven for the next longwall panel.

The state agency has a responsibility to ensure that all mine operators comply with its law. Proper enforcement of the law – and in this case, aggressive application of the law to an employer with a history of noncompliance – was required. The state had been dealing with Massey Energy long enough to know that without strict application and rigid enforcement, the company would ignore health and safety laws that interfere with maximum production.

Like MSHA, the state should have used every tool at its disposal to shut down Massey's UBB mine until all the hazardous conditions were corrected.

Hearing Process

For years, the UMWA has consistently advocated and called on MSHA to exercise its authority under the Mine Act to hold public hearings as part of disaster investigations like the UBB investigation. The Agency has the statutory authority to require such hearings under Section 103(b) of the Mine Act, which authorizes the following:

> "For the purpose of making any investigation of any accident or other occurrence relating to health or safety in a coal or other mine, the *Secretary may, after notice, hold public hearings, and may sign and issue subpoenas for the attendance and testimony of witnesses and the production of relevant papers, books, and documents, and administer oaths*. Witnesses summoned shall be paid the same fees and mileage that are paid witnesses in the courts of the United States. In case of contumacy or refusal to obey a subpoena served upon any person under this section, the district court of the United States for any district in which such person is found or resides or transacts business, upon application by the United States and after notice to such person, shall have jurisdiction to issue an order requiring such person to appear and give testimony before the Secretary or to appear and produce documents before the Secretary, or both, and any failure to obey such order of the court may be punished by such court as a contempt thereof" (emphasis added).

The Union is convinced that the public hearing process is the only forum that will assure that all information necessary to determine the cause and events that led up to the disaster is discovered.

When MSHA refused our request for public hearings, the UMWA filed suit in the United States District Court for the southern District of West Virginia, seeking injunctive relief. The Union argued that the private interview process that MSHA was proposing and later employed during the UBB investigation was detrimental to the process. Instead of holding a transparent investigation into the cause(s) of the UBB disaster, MSHA would allow the credibility of the investigation to be called into question by purposely excluding entities who have an interest in participating in the process.

The private interview process excludes interested parties. These individuals should have the same opportunity as others to participate in the process. The restrictions placed on those parties by the Agency leaves them to speculate about what was said or not said.

The UMWA, as a recognized Representative of Miners, was not privy to either the interviews or the transcripts. Likewise, documents pertinent to the investigation, including preshift, on-shift, weekly examinations and other documents containing important information were withheld from the Miners' Representatives, solely at the discretion of MSHA, its attorneys and the solicitors office. The Union has long asserted that mine operators cannot be trusted to police themselves. There must

be an open hearing process where all interested parties are given the opportunity to participate.

The frustration with the system imposed by MSHA does not end there. While the families and miners' representatives were excluded, Massey Energy, the entity responsible for this deadly tragedy, had representatives present at some of the "private interviews." The inclusion of these individuals should bring into question the entire process. MSHA claims the reason for this type of interview process is to "protect" the individuals testifying. If the operator, his agent or attorney are present, one must ask: Who are they protecting the miner from? This is absurd on its face.

The lack of resolve on the part of MSHA to hold public hearings also eliminated the possibility that corporate and mine management personnel could be compelled to testify – or at least brought before a public forum and asked questions. The private interview process does not give MSHA the authority to issue subpoenas – as is the case with public hearings.

High-ranking individuals played key roles in the day-to-day operations of the mine. They made decisions leading up to and after the explosion that are relevant to the investigation. When the State of West Virginia tried to compel their testimony, they invoked their Fifth Amendment right against self-incrimination. These individuals did not even show up in person to take the Fifth.

The following individuals from Massey Energy possess information that is vital to the investigation of the Upper Big Branch Mine-South disaster. They should have been compelled to testify in open public hearings by MSHA, or at least to publicly take the Fifth. Failing to do so, they should have been found in contempt of court and made to suffer the requisite penalty:

- **Don Blankenship**, Chairman and Chief Executive Officer, created the climate of intimidation and harassment that was Massey Energy's operating policy. He was in control of the company from the board room to the mine level. He was so intricately involved with managing Massey operations that he required longwall tonnage reports be submitted to him every half-hour. He micro-managed this company and should be held accountable for his actions.

- **Chris Adkins**, Senior Vice President and Chief Operating Officer, carried out the policy directives of upper management. On more than one occasion, it was reported that miners who shut equipment down for unsafe conditions were told by him to run coal or go home. Although not trained in mine rescue, during the rescue at UBB, he took control of the underground activities, placing the lives of rescuers at risk.

- **Chris Blanchard**, President, Upper Big Branch Mine, and **Jason Whitehead**, Vice President, Upper Big Branch Mine, possess important information regarding the conditions at the mine, prior to and immediately after the explosion. They were the senior management employees whose purpose it was to oversee the operation. They need to be asked about the three hours they spent underground immediately after the explosion. Where did they go, what

did they do and under what authority did they take these actions?

- **Elizabeth Chamberlin**, Vice President of Safety at Massey Energy, who was the senior person in charge of the health and safety of the miners at all of Massey's operations. What does she know about the conditions at the mine? The Union is concerned that based on her limited participation in such a high-level incident, Ms. Chamberlin was in charge of health and safety by title only. If this is true, it not only violates a court order in the wake of Aracoma, but places safety in the hands of Massey's production personnel.

- **Wayne Persinger**, Mine Manager, Upper Big Branch Mine, was the individual charged with managing the underground operations at the mine. It was his responsibility to know what was occurring at all times and to carry out all corporate policies.

- **Everett Hager**, Superintendent for north side, Upper Big Branch Mine, was reportedly aware of hazardous conditions that existed at the mine. In one instance, a foreman noted that Hager had known for three weeks that air was reversed in the mine and did nothing.

- **Robert Asbury**, Captain, Massey Energy's Southern West Virginia mine rescue team, would presumably be the most qualified Massey employee on site with regard to mine rescue. However, shortly after the accident, he and two team members disregarded mine rescue protocol, entered the mine and explored areas without proper back-up or notifying the Command Center. It is not clear what areas of the mine they were in or what they were doing there.

Also taking the Fifth were:

- **Jamie Ferguson**, Vice President, Performance Coal Company
- **Rick Foster**, Mine Foreman, Upper Big Branch Mine
- **Gary Frampton**, Chief of Safety, Route 3 Engineering
- **Eric Lilly**, Route 3 Engineering
- **Gary May**, Superintendent of the south side, Upper Big Branch Mine
- **Paul McCombs**, Chief Engineer, Route 3 Engineering
- **Terry Moore**, Longwall Section Foreman, Upper Big Branch Mine
- **Rick Nicolau**, Longwall Coordinator, Upper Big Branch Mine
- **Jack Roles**, Longwall Coordinator, Upper Big Branch Mine
- **Bill Ross**, Coal Services

The individuals above should be subpoenaed by the government and required to testify, publicly take the Fifth or face the appropriate penalty(s) for their refusal.

Massey Energy Company

"It's like a jungle, where a jungle is the survival of the fittest; unions, communities, people–everyone is going to have to learn to accept that in the United States, you have a capitalist society, and that capitalism, from a business standpoint, is survival of the most productive."
Donald Blankenship, 1984

This business model was expressed by Blankenship while he was President of Rawl Sales & Processing, an A.T. Massey subsidiary. It was more than just a statement of his belief in how corporate America should operate: In his years at Massey Energy in varying capacities, most notably his years as Chief Executive Officer, this became the company's operational policy. Nothing and no one would stand between Blankenship and his desire for continually increasing production and ever-increasing profits.

There was no cost too steep for the miners, mining communities and the general public living in or near the areas where Massey Energy operated to ensure that Blankenship's vision of production at any cost would flourish. Blankenship's name would become synonymous with Massey Energy, and he came to manage the company down to the smallest details. He created the corporate culture that defined Massey Energy.

In a sworn deposition, Blankenship admitted knowledge of every significant event at Massey operations immediately upon them occurring or as soon as possible thereafter. However, the depth of his power and control were even greater. A former Human Resource manager at Massey's Black Castle Mine testified that Blankenship, "micromanaged every mine and signed off on every hire, even the janitors." He explained "that if he wanted to hire a person at Black Castle, he would have to send a memorandum to Blankenship with the applicant's qualifications and salary requirements. [The Human Resource manager] would then receive a fax with Blankenship's signature if the proposed hire was approved." (Massey Energy Co. Securities Litigation at page 37)

Blankenship oversaw all aspects of Massey Energy. In an interview with Vanity Fair, a manager stated, "...his amazement in learning, soon after arriving at Massey, that Don had to sign off on a tankful of gas for the manager's truck." Blankenship controlled everything that happened at Massey Energy during his tenure at the helm. Massey Energy made all its decisions based on Blankenship's recommendations–and his concern was always the bottom line, without regard for any other consequences.

Massey Energy: Safety last

The following highlights some of the events that created Massey Energy's image as a company that cared about production first and safety last:

White Buck Coal Company: Guilty plea

Significant health and safety problems were not limited to Massey's UBB mine. For example, Massey Energy supervisors at White Buck Coal Company pleaded guilty to failing to perform required preshift examinations.

Examinations of all areas of the mine where miners will be working or traveling prior to miners entering the area must be done on eight-hour intervals (30 CFR §75.260). Yet Larry Roop, President of White Buck Coal Co., pleaded guilty on behalf of Gassy Creek Mine, and Foreman William Wine pleaded guilty to performing inadequate preshift examinations at White Buck #1 mine.

While the plea agreement for Wine specifically dealt only with an inadequate preshift on June 27, 2002, the *Charleston Gazette* reported that the failure to perform the preshift actually covered a period of two-and-one-half months. In a sworn statement, Wine said, "Roop specifically told him to fireboss as the men were going into the mine. I thought it was an order and how they wanted the preshift examination to be conducted."

Massey's Board of Directors was acutely aware of the White Buck case and a later case that led to a guilty plea at the Aracoma-Alma mine. Legal actions were regularly discussed as part of its Board meetings. However, instead of looking at the circumstances that brought about legal action and the need to hire outside counsel to litigate, Massey simply looked to the bottom line. It mitigated the exposure, paid less in fines and moved on as if nothing unusual had occurred. These actions and others like them by the Board played a major role in Massey becoming the most dangerous mining company in the nation.

Court Order: Manville Trust case

In the wake of the Aracoma Alma Mine #1 fire, the Manville Personal Injury Trust filed a derivative case on behalf of Massey Energy Company shareholders. The case was joined by other institutional shareholders claiming that Blankenship and the Massey Board were devaluing the stock price of the company by "...failure, among other things, to implement adequate internal controls to ensure the company's compliance with applicable laws and regulations concerning worker safety and environmental protection." The case was settled between the parties, and a binding Court Order was signed in June 2008.

The Settlement Order, among other things, required Massey Energy's Board of Directors to create a Safety, Environmental and Public Policy Committee (SEPPC). The SEPPC would consist of a minimum of three directors, the majority of whom must be independent.

The SEPPC was to meet at least four times per year and attend all annual and special meetings of the shareholders. Its members were to monitor the company's safety and environmental policies, including training plans, regulatory compliance and safety compliance at the company's operations. It was given authority to make necessary changes to any areas of the company's safety and environmental plans to enhance the company's effectiveness.

Massey was also to create the positions of Vice President for Best Environmental Practices (Environmental Compliance Officer) and Vice President for

Best Safety Practices (Safety Compliance Officer). These officers were to be present at all meetings of the SEPPC and offer necessary reports showing the effectiveness of the policies, plans and programs in their receptive capacities.

> Further in the Order it stated, "The Compliance Officers in consultation with the SEPPC and the General Counsel of the Company, shall have the duty and authority to create, implement and oversee a system by which corporate employees, suppliers, customers and advisor professionals can, on a confidential basis and without fear of reprisal, provide information concerning possible illegal or unethical conduct regarding the Company's compliance with safety and environmental issues."

The company was also required to adopt written policies that would protect whistleblowers, and the policies were to be included in the employee handbook; the handbook was to be provided to each employee at least annually. A whistleblower hotline was also to be established, to provide an alternative reporting mechanism.

Massey Energy hired Elizabeth Chamberlin as Vice President for Safety and Training. However, though the Court Order required her to answer to the SEPPC on a quarterly basis, this was substantially altered by Blankenship. The reporting process was circumvented such that relevant information regarding safety and compliance at Massey operations was first filtered through Blankenship, Chris Adkins and Shane Harvey, General Counsel for Massey.

When Chamberlin would finally meet with the SEPPC, she presented them with comparisons of Massey's Non-Fatal Day Lost (NFDL) data to that of the industry as a whole. This was problematic.

NFDL data is not an accurate assessment of the mine's safety and compliance record, which is especially true at Massey, given its incomplete records. Chamberlin was presenting such inaccurate numbers to the Board. The numbers presented by Chamberlin were as follows.

Year	Chamberlin's data	Actual Data
2007	2.05	2.63
2008	1.94	2.52
2009	1.67	2.33

These numbers also represent a manipulated reporting system, whereby Massey encouraged miners who were injured to not fill out the required accident forms. This practice illegally deflated the actual numbers. This was a common practice at all the Massey operations. While there were those (including Adkins and Chamberlin) who promoted the contrived data as "fact," the entire Board had to be aware of the policy insofar as there was a lot of other information available, and its record of fatal injuries alone showed Massey was the worst operator in the nation.

This becomes clear in testimony given by miners before the Senate HELP Committee in April 2010. Jeffrey Harris, a one-time miner at Massey, stated, "...If you got hurt, you were told not to fill out the lost-time accident paperwork. The company would just pay guys to sit in the bathhouse or to stay at home if they got hurt – anything but fill out the paperwork."

This blatant disregard for the law demonstrates the lengths to which Massey

Energy would go to shield itself from shareholder and public scrutiny. Those within the industry knew what was happening, but someone detached, like an institutional investor or potential investor, would likely be unaware.

These erroneous numbers were also reported by various officers and members of the Board at stockholder meetings, coal conferences and investor gatherings. Blankenship often touted these lies at functions he attended. Significantly, what he failed to say was that the lower the company's NFDL, the bigger his bonus.

Secondly, the SEPPC members were acutely aware of their responsibility under the Court Order. Further, each of them has to know that a report of NFDL did not really reflect the safety and regulatory compliance of the company, insofar as they all had long tenures with Massey, the mining industry or both. They were not being scammed, but they woefully failed their obligations as members of the court-ordered SEPPC and further as members of the Board of Directors.

Each of them had enough experience to know that fatal accidents, severe accidents, near misses and the number and severity of MSHA citations and other factors played a much more significant role in the company's overall safety performance than what they were receiving from Ms. Chamberlin. Yet, for their own reasons, they seemingly ignored reality. They permitted the lies to continue, and the mines of Massey Energy became more and more dangerous. They permitted the conditions at UBB to exist, and accordingly, they bear some responsibility for what happened there.

The Blankenship Memos

The extent of the Massey Board members' knowledge regarding the operation of the company's mines and facilities was vast. The fact that Blankenship ran the operations in such a "public" manner makes it impossible for them not to know what was occurring within the company.

The infamous October 19, 2005, "run coal memo" from Blankenship to all Deep Mine Superintendents demonstrated the attitude of the company regarding the health and safety of the workers. It states, "If any of you have been asked by your group presidents, your supervisors, engineers or anyone else to do anything other than run coal (ie – 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 coal pays the bills."

The message, which was reported in major newspapers across the country, was clear: Nothing got in the way of production at Massey Energy mines. The Board was well aware of the memo, and by failing to re-direct Blankenship, one can assume they agreed with it.

The following week, on October 26, 2005, Blankenship tried to tamp down the firestorm he created by issuing another memorandum (attached). However, the wording in the document actually reinforces the "production at all cost" mentality of the company.

In part, the memo states, "...each of you is responsible for coal producing sections, and our goal is to keep them running. If you have construction jobs at

your mine that need to be done to keep it safe *or productive*, make every effort to *do those jobs without taking members and equipment from coal producing sections that pay the bills*" (emphasis added).

It should be noted that the UMWA attended Massey shareholder meetings and provided this information to the Board of Directors and the shareholders in attendance.

Aracoma Alma Mine #1

Three months after Blankenship's October "run coal" memorandum, on January 19, 2006, a fire broke out on the beltline at Aracoma Alma Mine #1. The fire claimed the lives of Donald Bragg and Ellery Hatfield, who became lost in dense smoke while attempting to escape. Friction between the belt and belt structure caused coal fines and other combustible material to catch on fire. However, there was no water in the waterline as required by law. And even if there had been, the fire hose couplers were not compatible with the ones on the water line.

When the inby crew attempted to evacuate, Bragg and Hatfield became separated from the group and succumbed to carbon monoxide poisoning.

This tragic event did not seem to have any effect on Blankenship. A few weeks after the deaths, he spoke at the Berkeley County Republican Club, and the Herald-Mail of Hagerstown, Md., reported he stated, "...the fire at Arocoma Coal's No. 1 Mine and the January 2, 2006, explosion at International Coal Group's Sago Mine...were rare events and statistically insignificant." These are extremely harsh comments when you consider Blankenship was referring to the lives of fourteen miners.

Early Warning of MSHA Inspections

The Mine Act requires that MSHA inspect each underground mine at least four times per year. It also specifies in Section 108(e) that, "Unless otherwise authorized by this Act, any person who gives advance notice of any inspection to be conducted under this Act shall, upon conviction, be punished by a fine of not more than $1,000 (see note) or by imprisonment for not more than six months, or both" (note: Information regarding Criminal Monetary Fines and Alternate Sentencing attached).

Massey Energy routinely violated this section of the Mine Act at its operations. Such violations interfere with inspectors' ability to carry out a thorough inspection of the mine. It permits management to correct violations immediately before the inspector arrives in an area. It also allows management to suspend operations in an area while the inspector is present, thereby reducing the gravity of the citation or eliminating it altogether.

Several miners testified that these events regularly occurred at the Massey mines where they worked. Gary Quarles, a former Massey employee, testified before the House Labor Committee, "The code word would go out we've got a man on the property...When the word goes out, all effort is made to correct the deficiencies."

On July 13, 2010, Stanley Stewart testified before the House Labor Committee, "A section boss underground would be called from the outside and told its cloudy outside or there's a man on the property, meaning there's an inspector outside, get things right to pass inspection."

Hughie Stover, Chief of Security at Massey Energy's Performance Coal Company, was indicted on February 28, 2011. The indictment states that "Stover and his team allegedly used a clandestine radio channel called the "Montcoal Channel" to warn miners of MSHA inspectors' arrivals so they could improvise safer conditions and cure violations." His trial was set for late October 2011, as this report went to publication.

Finally, Randy Lester, a miner at Massey Energy's Tiller No. 1 mine, was quoted in the *Washington Post* on June 2, 2010, that "...he and his co-workers usually sounded an alarm when they see state or federal inspectors approaching, radioing down to give the crew inside the mine as much as 45 minutes to spruce things up."

Intimidation of the workforce

It is clear that miners at Upper Big Branch worked under fear of retribution if they made a complaint about safety conditions. The report of the GIIP cited examples of two foremen, Dean Jones (victim) and Brian "Hammer" Collins, who tried to resolve ventilation problems on their sections. They were threatened with job loss or being disciplined as a result of trying to properly ventilate the mine.

Jones, one of the explosion victims, received a "get it in the coal" message from Chris Blanchard through the dispatcher when he shut down his section because of lack of air. Clearly, Blanchard wasn't as concerned about what dangers the miners faced as he was about production.

Further, when Brian Collins did his pre-shift examination and found insufficient air in the last open crosscut, he stopped his crew from running coal until the problem was fixed. The next day, Collins was suspended for three days for "poor work performance." When the miners saw their foremen reprimanded in such a manner, the fear of retribution was amplified. No one was going to complain if they knew retaliation was forthcoming.

As testament to the effectiveness of Massey's intimidation policies, MSHA reported at its June 29, 2011, public briefing on the Upper Big Branch investigation that miners at UBB had submitted only one underground hazard complaint since 2006. It is clear the miners understood if they complained and they were identified, they wouldn't be working at Massey for long.

In testimony from Gary Quarles before the House Committee on Education and Labor on May 24, 2010, in Beckley, W. Va., he stated, "When the MSHA inspector comes to a Massey mine, the only people accompanying him are Massey company people. No coal miner at the mine can point out areas of concern to the MSHA inspector. In fact, for a miner working for Massey, the feeling is, if an MSHA inspector fails to say anything about all of these safety problems, what right do I have to say anything about them, and I definitely would be terminated or retaliated against if I said anything."

Knox Creek Coal: Tiller No. 1

Shortly after the UBB explosion, MSHA launched impact inspections at 57 mines throughout the nation. Nine mines operated by Massey Energy, almost 16 percent of the total, were on the list. Knox Creek Coal Corporation's Tiller No. 1 was one of the operations designated for an impact inspection.

According to the *Washington Independent*, MSHA considered Tiller No. 1 "one of the most unsafe mines in the country." The injury rate at the mine was 40 percent higher than UBB at the time of the explosion and over two times the national average, at 9.78. The mine had also been cited by MSHA 1,395 times from January 1, 2008 through December 31, 2010.

The impact inspection at Tiller No. 1 was an effort by the Agency to have the mine placed on a pattern of violations program (POV). A mine being placed on a POV is targeted for more serious enforcement action and increased penalties for the mine operator. The Agency outlines the POV process as follows:

> "A mine operator that has a potential pattern of recurrent S&S violations at a mine will receive written notification from MSHA. An S&S violation is one that could reasonably be expected to lead to a serious injury or illness. The operator will have an opportunity to review and comment on the documents upon which the potential pattern of violations is based, and develop a corrective action program to reduce S&S violations. MSHA will closely monitor the affected mine's compliance. If the operator significantly reduces its S&S violation rate, it can avoid being issued a Notice of a Pattern of Violations pursuant to Section 104(e) of the Federal Mine Safety and Health Act of 1977. If the improvement falls short of prescribed goals, MSHA will issue the notice. For each S&S violation subsequently found, MSHA will issue an order withdrawing miners from the affected area until the cited condition has been corrected. An operator can be removed from a pattern of violations when 1) an inspection of the entire mine is completed and no S&S violations are found; or 2) no withdrawal order is issued by MSHA in accordance with Section 104(e)(1) of the Mine Act within 90 days of the issuance of the pattern notice."

The inspection at Tiller resulted in the issuance of 29 citations, all classified as significant and substantial (S&S). Upon appeal, the Agency would need an Administrative Law Judge to uphold at least 25 to meet the threshold to issue a pattern of violations at the mine. While the Judge agreed that Massey had committed all 29 violations, he upheld only 19 as being S&S. The mine operator thereby successfully avoided the POV designation at Tiller.

In 2009, four Massey Energy mines, including Tiller No.1, had accident rates more than two times the national average. The others were:

- Slip Ridge Cedar Grove, W. Va.
- M 3 Energy Mining Mine No. 1, Ky.
- Solid Energy Mining Mine No 1, Ky.

Inman Energy: Randolph Mine

The Mine Safety and Health Administration conducted an "impact inspection" at Massey Energy's Inman Energy's Randolph Mine on April 29, 2011. MSHA inspectors arrived at the mine and took control of the phones at the guard shack and mine office to prevent notification of the inspection to underground personnel.

The inspection resulted in twenty withdrawal orders and five citations being written for violations of mining regulations.

Eleven of the orders were for violations of the ventilation plan. Others included inadequate water spray systems on the continuous mining machines and failure to remove coal and float coal dust from the mine.

These are the three of the areas of the law that mine management ignored at UBB resulting in the April 5, 2010, explosion. MSHA inspectors found some of the same violations existed at the Randolph Mine during a surprise inspection a year earlier.

The *Boone Examiner* noted, "According to MSHA, the violations at Randolph Mine allege the mine operator engaged in aggravated conduct, constituting a more than ordinary negligence, by not following mandatory safety standards, and allowing unhealthy and unsafe mining practices to continue."

The "Production Phone"

The extent of Blankenship's control of all aspects of the mining operations at Massey Energy are highlighted in the book *Coal River* by freelance writer Michael Shnayerson. He writes, "There's no question in my [Shnayerson's] mind that Blankenship knew about the repeated safety citations at Upper Big Branch. Don was a complete micro-manager. He knew everything that was going on at Upper Big Branch. A lot of the fault for the explosion would have to be laid at his feet."

Blankenship went so far as to have a red phone installed at UBB so he could immediately contact the mine's managers whenever he wanted. According to Shnayrerson, "it was the hotline to the boss...Frequently and without fail, the manager on duty had to fax a production update to Massey's Chairman. If the report was late or the numbers weren't good, or the mine was shut down for any reason, the red phone would ring. The terrified manager would pick it up to hear Mr. B [Blankenship] demanding to know why the numbers weren't right."

According to the GIIP, the production reports Shnayerson is referring to were required every 30 minutes. Even on April 5, 2010, purchasing agent Greg Clay was to receive production reports every 30 minutes during the day shift. The information would be sent to "...UBB President Chris Blanchard, Vice President Jason Whitehead and Lisa Williams, executive secretary of Marfork Coal. Lisa Williams would then send the information to Chris Adkins, Chief Operating Officer, and Don Blankenship, Chairman and Chief Executive Officer, of Massey Energy."

This arrangement confirms two very important aspects regarding the involvement and responsibility of Massey Energy's executive officers regarding the explosion at UBB. First, they were acutely aware of events occurring at the mine on a continuous basis. This type of minute-by-minute information is only relevant in the hands of the individuals who are actually running the operation on the ground.

Secondly, knowing exactly what is occurring at the mine requires those with that knowledge to correct hazards and make the mine safe for the workers. The red phone, however, was apparently not part of Massey's S-1 P-1 program (Blankenship's signature health and safety program). It was used strictly to make certain production was meeting the quota set by Blankenship.

Statements by Upper Big Branch miners

Stanley "Goose" Stewart stated to the House Committee on Education and Labor at its July 13, 2010, hearing that, "In 2009, we were made by Chris Blanchard, the President of Performance Coal, to cut coal going into our air supply. We mined that way for 2,000 feet...."

Jeffrey Harris told the Senate HELP Committee on April 27, 2010, "If you got hurt [at Massey], you were told not to fill out the lost-time accident paperwork. The Company would just pay guys to sit in the bathhouse or stay at home if they got hurt–anything but fill out the paperwork."

National Public Radio interviewed 10 supervisors and miners from UBB who made similar statements regarding ventilation, including, "They would never fix the ventilation;' "I told them I needed more air [and] they threatened to fire me if I didn't run enough coal" (Consolidated Amended Class Action Complaint at page 47).

Chuck Nelson (a former Massey miner) told the *Washington Independent* on April 27, 2010, "I knew that if I said something [about safety], I wouldn't have a job tomorrow."

Steve Morgan, whose son Adam was killed at UBB, said when his son raised concerns about dust, methane, ventilation and working in unsafe conditions as a trainee, his boss responded, "If you're going to be that scared of your job there, you need to rethink your career." (Consolidated Amended Class Action Complaint at page 69)

"When moving the longwall to a new face, we were made to load coal before all the shields and ventilation were in place so someone could call Mr. Blankenship and say we were in the coal." (House Committee on Education and Labor, July 13, 2010)

"At all Massey mines, we'd shut down equipment when the inspectors were at the mine so they couldn't take readings while we were mining. We'd have to say the machine was down. But as soon as the inspector left, we'd kick it right back into service." (Jeffrey Harris, Senate HELP Committee)

And then there is this:

"I don't care what people think, at the end of the day, Don Blankensip is going to die with more money than he needs."
Don Blankenship at a West Virginia Republican Party meeting

Don Blankenship, former Chairman and Chief Executive Officer of Massey Energy, along with his underlings who carried out his corporate policy of production over safety, must be held accountable for their actions that contributed to the death of these 29 miners.

Workers killed at Massey Energy Operations Since January 2001[3]

Miner	Date	Age	Mine	Parent Company
Allen Harris, Jr.	2-2-01	48	Brushy Eagle	Marfork Coal Co.
Herbert J. Meadows	3-29-01	48	Upper Big Branch	Performance Coal
Gregory Barron	8-27-01	47	Cedar Grove Mine	Independence Coal
Paul Miller	9-14-01	28	Twilight MTR Surface	Progress Coal Co.
Danny Atkins	2-2-02	44	Justice #1 Mine	Independence Coal
Keith L. Casey	3-22-02	33	Mine #1	Rockhouse Energy
Rodney Alan Scurlock	7-19-03	27	Upper Big Branch	Performance Coal
William P. Burchfield	9-17-03	37	Twilight Mtn Surface	Progress Coal Co.
Rodney W. Sheets	9-17-03	47	Twilight Mtn Surface	Progress Coal Co.
Kenneth McNeely	2-5-04	33	Ruby Energy Mine	Spartan Mining Co.
Kevin Lupardous	10-20-04	41	Red Cedar Surface	Endurance Mining
Christopher McGuire	3-29-05	21	Mine #1	Rockhouse Energy
Russell Cole	8-3-05	39	Mine No. 1	Stillhouse Mining
Brandon Wilder	8-3-05	23	Mine No. 1	Stillhouse Mining
Donald Bragg	1-10-06	33	Aracoma Alma Mine #1	Aracoma Coal Co.
Ellory Hatfield	1-10-06	46	Aracoma Alma Mine #1	Aracoma Coal Co.
Paul Moss	1-1-06	58	Black Castle Mine	Elk Run Coal Co.
David J. Neal	12-4-07	57	No. 130 Mine	Mammoth Coal Co.
Nathan Dove	5-16-08	24	Aracoma Alma Mine #1	Aracoma Coal Co.
James Woods	9-19-08	61	No. 1 Surface	Massey Energy Co.
Steven Cain	10-16-08	32	Justice #1	Independence Coal
William Wade	2-6-09	70	Republic Energy	Elk Run Coal Co.
Christopher Bell	4-5-10	33	Upper Big Branch	Performance Coal
Edward Dean Jones	4-5-10	50	Upper Big Branch	Performance Coal
Ronald Lee Maynor	4-5-10	31	Upper Big Branch	Performance Coal
Joe Marcum	4-5-10	57	Upper Big Branch	Performance Coal
Greg Brock	4-5-10	47	Upper Big Branch	Performance Coal
William Griffith	4-5-10	54	Upper Big Branch	Performance Coal
Ricky Workman	4-5-10	50	Upper Big Branch	Performance Coal
Howard Payne, Jr.	4-5-10	53	Upper Big Branch	Performance Coal
Steven J. Harrah	4-5-10	40	Upper Big Branch	Performance Coal
Benny Ray Willingham	4-5-10	61	Upper Big Branch	Performance Coal
Carl Acord	4-5-10	52	Upper Big Branch	Performance Coal
Deward Allan Scott	4-5-10	58	Upper Big Branch	Performance Coal
Robert E. Clark	4-5-10	41	Upper Big Branch	Performance Coal
William R. Lynch	4-5-10	59	Upper Big Branch	Performance Coal

[3] Through June 1, 2011, when Massey was acquired by Alpha Natural Resources, Inc.

Jason Atkins	4-5-10	25	Upper Big Branch	Performance Coal
Joe Price	4-5-10	55	Upper Big Branch	Performance Coal
Mike Elswick	4-5-10	47	Upper Big Branch	Performance Coal
Adam Morgan	4-5-10	21	Upper Big Branch	Performance Coal
Charles Davis	4-5-10	51	Upper Big Branch	Performance Coal
Cory Davis	4-5-10	20	Upper Big Branch	Performance Coal
Richard Lane	4-5-10	45	Upper Big Branch	Performance Coal
Rex Mullins	4-5-10	50	Upper Big Branch	Performance Coal
Nick McCorskey	4-5-10	26	Upper Big Branch	Performance Coal
Josh Napper	4-5-10	26	Upper Big Branch	Performance Coal
Dillard Persinger	4-5-10	32	Upper Big Branch	Performance Coal
Gary Wayne Quarles	4-5-10	33	Upper Big Branch	Performance Coal
Grover Skeens	4-5-10	57	Upper Big Branch	Performance Coal
Kenneth Chapman	4-5-10	53	Upper Big Branch	Performance Coal
James Mooney	4-5-10	51	Upper Big Branch	Performance Coal
James Erwin	5-10-10	55	Ruby Mine	Spartan Mining Co.
Wilbert R. Starcher	7-1-10	60	Pocahontas Mine	White Buck Coal
Charles Qualls	12-4-10	32	Republic Energy	Elk Run Coal

A massive gas inundation? Hardly.

There is **no evidence** to support Massey's theory that a massive inundation of natural gas was the fuel source for the explosion at UBB. In fact, the path of the explosion and the forces it generated clearly demonstrate that the primary fuel source of the explosion was float coal dust.

The investigation revealed that the floor crack Massey claims to be the source of a natural gas inundation that caused the explosion cannot be supported by the evidence. When it was excavated, the crack became solid rock, showing no signs of gas seepage from the underlying coal seam.

Perhaps the most important factor is this: If there was a natural gas inundation, then once the gas exploded, the fuel source would have been spent. There is no scientific basis for the theory being put forward by Massey Energy. It simply serves to cloud the issues in an attempt to cover-up the apparently criminal acts committed by the operator.

Conclusions and Recommendations

Conclusion #1

Massey Energy Company is solely responsible for creating the conditions that led to the deaths of 29 miners at the Upper Big Branch Mine – South on April 5, 2010.

Officials of Massey Energy, including Donald Blankenship and his underlings who carried out his corporate policy of production over safety, must be held accountable for their actions that contributed to the death of these 29 miners These individuals, separately or as a group, and because of their personal knowledge of these conditions, played an integral role in the events leading up to and resulting in the explosion of April 5, 2010.

Recommendation

Proper and immediate action should be taken to determine the depth of knowledge and extent of each person's culpability regarding this matter. The Union believes that in order for this to be effectively and fairly accomplished, a Grand Jury should be empaneled and subpoenas issued to at least the Massey management officials listed on pages 71 and 72 of this report.

Upon the completion of the work of the Grand Jury, warrants and indictments should be handed down as appropriate. Criminal trials for those indicted should commence as soon as possible after the affected individuals are served.

Conclusion #2

The Mine Safety and Health Administration and the WVOMHS&T did not use all the tools available to them to compel Massey Energy to comply with the law.

Recommendation

A thorough review should be immediately initiated into the actions of MSHA District 4. This review should be conducted by an independent panel of experts not associated with the Agency or the U.S. Department of Labor. The findings of that review should be released to all interested parties.

The State should follow the recommendations of this report and the report issued by the Governor's Independent Investigation Panel.

Also, Congress should amend the Mine Act so that future multi-fatal incidents are investigated by an independent body so that all parties' conduct is impartially considered and evaluated.

Conclusion #3

Massey's ventilation plan approved by MSHA District 4 and the WVOMHS&T at UBB was flawed.

Recommendation

The Agencies should employ additional ventilation specialists.

Ventilation plans submitted by a mine operator for approval by MSHA and the State must be complete and contain all the

requirements outlined in 30 CFR and applicable State regulations. Plans that do not meet this standard must be rejected and production halted until an adequate plan is submitted and approved for the mine.

The approval of all ventilation plans should be contingent upon the successful completion of a ventilation survey of the entire mine. These surveys should be conducted each time the ventilation plan is reviewed. Plans that do not pass the ventilation survey should be immediately revoked.

The current standards governing acceptable ventilation controls are not adequate. MSHA must promulgate new regulations requiring conventional ventilation controls and limiting the use of doors to control ventilation.

Conclusion #4

Massey Energy routinely made changes to the underground ventilation without required approval from the Agencies, many times while miners were working underground, which endangered their lives.

Recommendation

The Agencies should cite all such air changes as flagrant violations of the law.

When illegal and intentional air changes are discovered by an MSHA or State inspector, the inspector should be required to immediately issue an order to evacuate the entire mine until the condition is corrected. The penalty assessed for the violation should be issued, with all persons underground at the time considered to be affected by the condition.

Conclusion #5

Massey routinely failed to comply with the approved roof control plan.

Recommendation

The Agencies should employ additional roof control specialists.

The six-month review of a mine's roof control plan should include a comprehensive roof control survey. This survey should note all roof conditions in the mine that pose a risk to miners' safety. All such conditions must be noted in the roof control plan along with the appropriate remedy.

Roof control plans that do not adequately control roof falls, bottom-heaving or other dangers the plan is designed to eliminate should be immediately revoked. No work should be conducted in the mine until an adequate roof control plan is submitted and approved.

Special attention should be paid to roof support in bleeder entries.

Conclusion #6

Massey Energy continually contested citations and orders to avoid increased enforcement action and avoid paying fines. This has become a standard tactic used by operators to leverage the Agency into negotiating reduced fines.

Recommendation

Congress should pass legislation requiring mine operators who contest citations to place the amount of money assessed in fines into a non-interest bearing escrow account until the case is resolved.

If a contest is found to be frivolous, additional penalties and fees should be applied to such contested citations and orders.

Conclusion #7

The rights of the families of the deceased miners and the UMWA, as the authorized Representative of Miners, to participate in all aspects of the investigation were severely restricted when the Agencies decided to conduct private interviews instead of holding public hearings.

Recommendation

The Mine Act and appropriate state law should be amended to give the investigative agencies authority to subpoena documents and to compel testimony for incident investigations. Unless and until that happens, MSHA should be prepared to conduct public hearings.

In addition, the law should give family members of miners killed as the result of a mine accident the right to designate a Representative of Miners. Miners' representatives should have the right to attend investigative interviews even when hearings are not public.

Conclusion #8

The harassment and intimidation of the miners and inspectors by Massey Energy management personnel played a role in the hazardous conditions that existed at UBB.

Recommendation

The Mine Act should be strengthened to improve whistleblower protections for miners. Also, penalties on mine operators that interfere with or impede the representatives of the Agencies from performing their jobs, including giving advance notice of inspections, must be enhanced.

Violations should be a federal crime with substantial penalties, including incarceration, with intentional violations made a felony.

Conclusion #9

Massey Energy employees did not know about and/or did not feel able to exercise their rights to report unsafe and unhealthy conditions in the mine.

Recommendation

MSHA, not the operator, should provide a session on miners' rights under the Mine Act as a part of the annual retraining.

Conclusion #10

The Command Center at UBB did not operate according to regulations and protocol during the rescue and recovery. Massey Energy ran the rescue and recovery efforts without regard for the safety of the mine rescue teams and with limited input from the Agencies. It was reported to be chaotic in the Command Center.

Recommendation

The Agencies must ensure that there is control in the Command Center at all times.

Mine rescue protocol must be adhered to at all times. Individuals who seek to circumvent or ignore these protocols should be immediately removed from the property and cited for interfering and impeding with the Agency.

Conclusion #11

Massey Energy kept two sets of record books at the mine. The official examination books, that can be reviewed by all interested individuals at the mine, did not report all of the violations and hazardous conditions. The production and maintenance books, which were only seen by management, listed additional hazardous and dangerous conditions in the mine.

Recommendation

All required examination books must contain all violations and hazardous conditions observed by a certified examiner during the course of his examination. Operators who fail to adhere to these regulations should be fined to the maximum extent possible. In the case of MSHA, these violations should be cited as flagrant.

The Agencies must do a better job of reconciling what is recorded in the examination books with the conditions they find underground. If conditions found underground do not accurately reflect what is recorded, a citation should be immediately issued and the inspectors should increase their scrutiny of the operators' examinations and record-keeping.

Conclusion #12

Immediately after the explosion, several members of mine management entered the underground area of the UBB mine. Jason Whitehead and Chris Blanchard remained underground until the rescue efforts were suspended. Four Massey managers wandered throughout the mine. There is no record of where they traveled to or what they did during the three hours they were underground without the knowledge or permission of the Agencies. All of these individuals were aware of the regulations in 30 CFR and state regulations regarding limiting entry into mine after a disaster.

Recommendation

These individuals must be cited for the willful disregard of the law.

In the future, the Agencies must remove all non-mine rescue team personnel from the mine after a disaster. Further, mine rescue personnel who are underground without the express permission of the Agencies must be removed.

Mine rescue protocol must be adhered to at all times.

Conclusion #13

Massey Energy did not adequately rock-dust the mine as required by law. That act by mine management was a major contributing factor to the coal dust explosion.

Recommendation

The Agency has already increased the required incombustible content of combined coal mine dust and rock dust to 80 percent in all areas of the mine. This change, which occurred after the UBB explosion, is an important step to protect miners. However, there is no more incentive for an operator like Massey Energy to comply with these more rigorous requirements now than they did under the previous regulation.

Therefore, the Agencies must aggressively target operators who are found to be out of compliance.

The approval and deployment of the Coal Dust Explosibility Meter would be a significant improvement in enforcing rock dust standards. The Agency should immediately initiate this process.

Likewise, increased enforcement pressure should be applied to operators who are found guilty of noncompliance. The Agency should issue closure orders to areas found to be in violation of the regulation and evacuate all miners inby the affected area.

United Mine Workers of America

Cecil E. Roberts	International President
Daniel J. Kane	International Secretary-Treasurer
Marty Hudson	Executive Assistant to the President
Ronald Airhart	Executive Assistant to the Secretary-Treasurer
Robert Scaramozzino	Administrator, President's Office
Timothy J. Baker	Assistant to the Secretary-Treasurer
Dennis O'Dell	Administrator, Department of Occupational Health and Safety
Ronald Bowersox	Acting Administrator, Department of Occupational Health and Safety
Linda Raisovich-Parsons	Deputy Administrator, Department of Occupational Health and Safety
Philip Smith	Director of Communications
Judith Rivlin	Associate General Counsel
David Kameras	Communications Coordinator
Joseph Carter	International District 17 Vice President
Donnie Samms	International At-Large Vice President
Gary Trout	Director, Region II
Emily Smith	Communications Specialist
Max Kennedy	International Representative
Theodore Hapney	International Representative
James Lamont	International Representative
Leon Moscalink	International Representative
Leo Cogar	International Representative
Kris Mallory	International Representative
Gary Butler	International Representative
Ron Stipanovich	International Representative
Adam Vance	International Representative
Charles Mills	International Representative
Colby Cunningham	International Representative
Donald Cogar	International Representative
Donnie Gray	International Representative
George Hill	International Representative
George Tudor	International Representative
Gerald Snyder	International Representative
Henry McGinnis	International Representative
James Summerfield	International Representative
Jeff Harris	International Representative
Joe Weldon Craig	International Representative
John Palmer	International Representative
John Toothman	International Representative
Justin Scott	International Representative
Larry Turner	International Representative
Mark Cochran	International Representative

Mike Payton	International Representative
Randy Henry	International Representative
Richard Matheny	International Representative
Roger Sparks	International Representative
Ronnie Huff	International Representative
Tanya James	International Representative
Thomas Mills	International Representative
Thomas Stern	International Representative
Tim Fleemont	International Representative
Tyler Peddicord	International Representative
Chuck Wilson	International Representative
James Summerfield	International Representative
Michael Payton	International Representative

Attachments

- Investigation photographs
- Analysis of payouts to Massey Energy corporate personnel as a result of merger with Alpha Natural Resources
- UBB accident rates
- UBB Citations and Orders
- 103(j) order
- 103(k) order
- Map: Initial path of flames and forces
- Map: Second path of flames and forces
- Map: Evidence of two paths of flames and forces
- Map: Encircled by the blast
- Map: Victim locations
- Map: SCSRs opened post-explosion
- Abatement: North Portal fan recirculation of return air
- Citation: Providing water to the longwall shearer
- Chart: Gas ignitions at underground coal mines
- Notice from MSHA to the UMWA: Designation as representative of miners
- Letter from UMWA to MSHA District 4: Designation as representative of miners
- Letter from UMWA to WVOMSHT: Designation as representative of miners
- Letter from UMWA to Performance Coal Co.: Designation as representative of miners
- Blankenship “run coal” memorandum
- Blankenship memorandum following “run coal” memorandum
- MSHA notice regarding civil monetary fines
- Pages from UBB production and maintenance books (the “second set” of books)
- MSHA citation regarding air flowing in opposite direction of approved ventilation plan at UBB
- MHSA citation regarding failure to examine the mine for hazardous conditions

Investigation Photographs

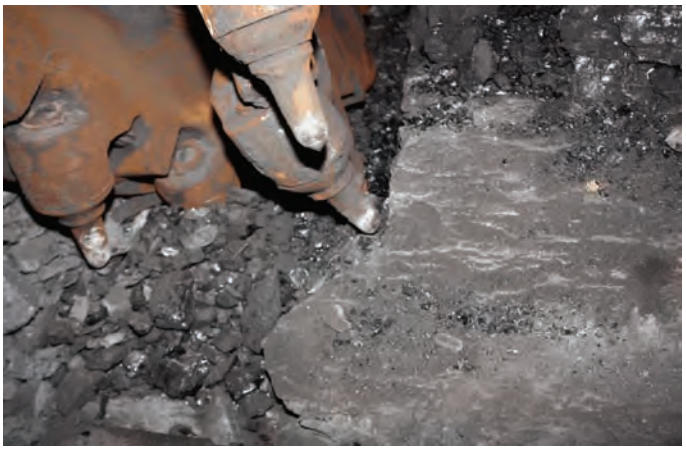


Photo 1. The longwall taildrum bits in a cut-out at the tail. The UMWA believes sparking from this area caused an initial methane ignition, which then grew into a coal dust explosion.

Photo 2. Steel overcast cover panels twisted and crumpled at #1 Crosscut in the Tailgate 22 Section.

Photo 3. A shuttle car inby the belt dump point in the Tailgate 22 Section shows evidence of the flames and forces of the explosion.

Photo 4. Bent and twisted steel belt structure at #4 crosscut of Tailgate 22 Section shows evidence from the forces of the explosion.

Photo 5. Evidence of coking on mine roof inby the first open crosscut in the #1 Entry. This type of coking is a residue of a coal dust explosion.

Photo 6. 1 North Longwall belt structure at a blown-out overcast. The belt structure has been completely overturned.

Photo 7. Shield hauler with a steel ventilation door wrapped around the top, found at Headgate 22.

Photo 8. Airlock door blown from hinges and twisted, one block outby Tailgate 22 belt dump.

Photo 9. Stopping blown out toward the north as a result of the initial path of forces, at 73 crosscut, northeast of 78 switch.

Photo 11. Shuttle car showing heat damage from the flames and forces, in the Tailgate 22 Section.

Photo 10. Tail drive assembly lid wedged between top of longwall shield and toes of shield at Shield #158.

Payout Analysis

Executive Officers and Non-employee Members of the Massey Energy Company Board of Directors will receive payouts as part of the merger deal with Alpha. The person and amount each will receive is as follows.

Executive Officers

Baxter F. Phillips, Jr.	President and Chief Executive Officer	$45, 105,213
J. Christopher Adkins	Chief Operating Officer	$11,127,614
Mark A. Clemens	Senior Vice President	$8,753,422
Michael K. Snelling	Vice President	$6,035,811
Eric Tolbert	Vice President and Chief Financial Officer	$4,987,434
M. Shane Harvey	Vice President and General Counsel	$4,445,309
John M. Poma	Vice President and Chief Administrative Officer	$3,399,697
Steve E. Sears	Vice President	$4,590,501
David W. Owings	Corporate Controller	$1,859,596
Total		**$90,304,597**

Non-employee Directors

James B. Crawford	$2,320,936
Richard H. Foglesong	$2,084,456
Richard M. Gabrys	$1,722,138
Robert B. Holland III	$1,124,291
Bobby R. Inman	$4,938,189
Dan R. Moore	$4,532,445
Stanley C. Stuboleski	$1,437,338
Linda Welty	$1,209,339
Total	**$19,414,133**
Donald L. Blankenship	$86,236,494
Total Payout	**$195,982,224**

This data was compiled by Cypress Associates LLC a New York based investment banking firm.

UPPER BIG BRANCH MINE-SOUTH

Lost Time Accidents Compared to National Data

Year	Operator Injuries	Cotractor Injuries	Mine Incident Rate	National Incident Rate
2000	12	11	5.06	8.3
2001	10	5	3.59	7.13
2002	21	0	8.21	7.14
2003	18	0	8.51	6.27
2004	16	0	6.87	5.6
2005	16	0	6.34	5.11
2006	11	0	5.09	4.79
2007	5	1	2.41	4.74
2008	12*	1	6.07	4.25
2009	14**	2	5.81	4.04
2010	7***	0	5.82	3.58

* MSHA Part 50 Audit found 9 Unreported Accidents
** MSHA Part 50 Audit found 13 Unreported Accidents
*** MSHA Part 50 Audit found 3 Unreported Accidents

Fatal Accidents Compared to National Data

Year	Operator Fatal Accidents	Contractor Fatal Accidents	Mine Incident Rate	National Incident Rate
2000	0	0	0	0.0455
2001	1	0	0.36	0.0757
2002	0	0	0	0.0366
2003	1	0	0.47	0.034
2004	0	0	0	0.0368
2005	0	0	0	0.0336
2006	0	0	0	0.0721
2007	0	0	0	0.0423
2008	0	0	0	0.0213
2009	0	0	0	0.0117
2010	28	1	23.29	0.0762

UPPER BIG BRANCH MINE-SOUTH

Citations / Orders **Type Issued by Year** **Penalty**

Year	103(k)	104(a)	104(b)	104(d)(1)	104(d)(2)	104(g)(1)	107(a)	314(b)	Proposed Penalty	Assessed Penalty	Amount Paid
2000	0	239	0	1	0	0	0	0	55,325.00	55,325.00	55,325.00
2001	2	154	0	0	0	0	0	3	51,301.00	48,761.00	48,761.00
2002	0	214	1	4	0	0	0	2	71,610.00	64,726.80	64,726.80
2003	1	169	0	2	0	0	1	2	46,011.00	41,934.10	41,405.76
2004	2	230	3	0	0	0	0	3	54,223.00	48,371.00	48,371.00
2005	1	137	3	0	0	0	0	2	33,067.00	32,577.00	32,576.60
2006	2	148	4	12	5	0	2	0	212,127.00	191,249.00	84,411.00
2007	0	269	1	0	0	0	1	0	263,219.00	253,984.00	61,745.00
2008	2	188	0	2	3	1	0	1	290,340.00	239,566.00	105,965.00
2009	1	458	4	2	48	1	1	0	897,325.00	897,325.00	292,953.00
2010	1	846	35	0	29	0	3	10	1,075,400.00	1,075,400.00	61,527.00

Upper Big Branch Mine-South: Citations / Orders, January 1, 2009 to December 31, 2009

2009

First Quarter (January 1, 2009 to March 31, 2009)

Citations	106
Orders	1
Safe Guards	0
Written S&S	46
Total	**107**

Second Quarter (April 1, 2009 to June 30, 2009)

Citations	133
Orders	16
Safe Guards	0
Written S&S	83
Total	**149**

Third Quarter (July 1, 2009 to September 30, 2009)

Citations	156
Orders	28
Safe Guards	0
Written S&S	53
Total	**184**

Fourth Quarter (October 1, 2009 to December 31, 2009)

Citations	66
Orders	11
Safe Guards	0
Written S&S	20
Total	**77**

Calander Year 2009

Citations	461
Orders	56
Safe Guards	0
Written S&S	202
Total	**517**

Upper Big Branch Mine-South: Citations / Orders, January 1, 2010 to June 30, 2010

2010

First Quarter (January 1, 2010 to March 31, 2010)

Citations	115
Orders	7
Safe Guards	0
Written S&S	35
Total	**122**

Second Quarter (April 1, 2010 to June 30, 2010)

Citations	64
Orders	3
Safe Guards	1
Written S&S	11
Total	**68**

January to June 2010

Citations	179
Orders	10
Safe Guards	1
Written S&S	46
Total	**190**

Upper Big Branch Mine-South: Citations / Orders, January 1, 2009 to December 31, 2009

2009

First Quarter (January 1, 2009 to March 31,2009)

104(a) Citation	3
45.400 Series [Independent Contractors]	1
70.200 Series [Sampling Procedures]	1
72.600 Series [Miscellaneous]	1
75.200 Series [Roof Control]	8
75.300 [Ventilation]	46
75.400 Combustible Materials and Rock Dusting]	6
75.500 Series [Electrical Equipment - General]	9
75.600 Series [Trailing Cables]	1
75.700 Series [Grounding]	2
75.1100 Series [Fire Protection]	11
75.1200 Series [Maps]	2
75.1500 Series [Mine Emergencies]	1
75.1600 Series [Communications]	1
75.1700 Series [Miscellaneous]	8
77.200 Series [Surface Installations]	2
77.700 Series [Grounding]	2
77.1000 Series [Ground Control]	1
77.1600 Series [Loading and Haulage]	1
Total	**107**

Second Quarter 2009 (April 1, 2009 to June 30, 2009)

104(a) Citation	1
104(b) Order	1
50.2 Accident, Injury Reporting	3
70.100 Series [Dust Standards]	1
72.600 Series [Miscellaneous]	1
75.200 Series [Roof Control]	14
75.300 [Ventilation]	50
75.400 Combustible Materials and Rock Dusting]	11
75.500 Series [Electrical Equipment - General]	11
75.600 Series [Trailing Cables]	2
75.700 Series [Grounding]	1
75.800 Series [Underground High-Vpltage Distribution]	1
75.1100 Series [Fire Protection]	16
75.1200 Series [Maps]	1
75.1400 Series [Hoisting and Mantrips]	5
75.1500 Series [Mine Emergencies]	5
75.1700 Series [Miscellaneous]	21
77.200 Series [Surface Installations]	2
77.700 Series [Grounding]	1
90.200 Series [ling Procedures][	1
Total	**149**

Upper Big Branch Mine-South: Citations / Orders, January 1, 2009 to December 31, 2009

Third Quarter 2009 (July 1, 2009 to September 31, 2009)

104(b) Order	1
48.3 Compensation for Training	1
48.9 Annual Refresher Training	1
70.100 Series [Dust Standards]	1
72.600 Series [Miscellaneous]	2
75.100 Series [Qualifed and Certified Persons]	1
75.200 Series [Roof Control]	22
75.300 [Ventilation]	76
75.400 Combustible Materials and Rock Dusting]	11
75.500 Series [Electrical Equipment - General]	10
75.600 Series [Trailing Cables]	2
75.800 Series [Underground High-Vpltage Distribution]	4
75.900 Series [Underground Low and Medium Voltage AC]	2
75.1100 Series [Fire Protection]	10
75.1200 Series [Maps]	3
75.1400 Series [Hoisting and Mantrips]	6
75.1500 Series [Mine Emergencies]	7
75.1700 Series [Miscellaneous]	13
77.200 Series [Surface Installations	2
77.400 Series [Safeguards, Electical Equipment]	2
77.1000 Series [Ground Control]	1
77.1100 Series [Fire Protection]	4
77.1600 Series [Loading and Haulage]	2
Total	**184**

Fourth Quarter 2009 (October 1, 2009 to December 31, 2009)

103(k) Order	1
104(a) Citation	1
104(b) Order	1
107(a) Order	1
70.100 Series [Dust Standards]	1
70.200 Series [Sampling Procedures]	2
72.600 Series [Miscellaneous]	2
75.200 Series [Roof Control]	5
75.300 [Ventilation]	27
75.400 Combustible Materials and Rock Dusting]	4
75.500 Series [Electrical Equipment - General]	7
75.600 Series [Trailing Cables]	3
75.1100 Series [Fire Protection]	6
75.1400 Series [Hoisting and Mantrips]	2
75.1700 Series [Miscellaneous]	10
77.1000 Series [Ground Control]	1
77.1100 Series [Fire Protection]	2
77.1300 Series [Explosives and Blasting]	1
Total	**77**

Upper Big Branch Mine-South: Citations / Orders, January 1, 2009 to December 31, 2009

Calander Year 2009

103(k) Order	1
104(a) Citation	5
104(b) Order	3
107(a) Order	1
45.400 Series [Independent Contractors]	1
48.3 [Compensation for Training]	1
48.9 Annual Refresher Training	1
50.2 Accident, Injury Reporting	3
70.100 Series [Dust Standards]	3
70.200 Series [Sampling Procedures]	3
72.600 Series [Miscellaneous]	6
75.100 Series [Qualifed and Certified Persons]	1
75.200 Series [Roof Control]	49
75.300 [Ventilation]	199
75.400 Combustible Materials and Rock Dusting]	32
75.500 Series [Electrical Equipment - General]	37
75.600 Series [Trailing Cables]	8
75.700 Series [Grounding]	3
75.800 Series [Underground High-Vpltage Distribution]	5
75.900 Series [Underground Low and Medium Voltage AC]	2
75.1100 Series [Fire Protection]	43
75.1200 Series [Maps]	6
75.1400 Series [Hoisting and Mantrips]	13
75.1500 Series [Mine Emergencies]	13
75.1600 Series [Communications]	1
75.1700 Series [Miscellaneous]	52
77.200 Series [Surface Installations]	6
77.400 Series [Safeguards, Electical Equipment]	3
77.700 Series [Grounding]	3
77.1000 Series [Ground Control]	3
77.1100 Series [Fire Protection]	6
77.1300 Series [Explosives and Blasting]	1
77.1600 Series [Loading and Haulage]	3
90.200 Series [Sampling Procedures]	1
Total	**517**

Upper Big Branch Mine-South: Citations / Orders, January 1, 2010 to June 31, 2010

First Quarter 2010 (January 1, 2010 to March 31, 2010)

104(b) Order	1
70.100 Series [Dust Standards]	1
70.200 Series [Sampling Procedures]	2
70.600 Series [Sampling Procedures]	1
75.200 Series [Roof Control]	19
75.300 [Ventilation]	42
75.400 Combustible Materials and Rock Dusting]	13
75.500 Series [Electrical Equipment - General]	8
75.600 Series [Trailing Cables]	4
75.700 Series [Grounding]	1
75.800 Series [Underground High-Voltage Distribution	1
75.900 Series [Underground Low and Medium Voltage AC]	2
75.1100 Series [Fire Protection]	3
75.1200 Series [Maps]	1
75.1400 Series [Hoisting and Mantrips]	4
75.1500 Series [Mine Emergencies]	2
75.1700 Series [Miscellaneous]	13
77.200 Series [Surface Installations]	2
77.1100 Series [Fire Protection]	2
Total	**122**

Second Quarter 2010 (April 1, 2010 to June 30, 2010)

103(k) Order	1
104(b) Order	1
314(b) Safeguard	1
50.2 Accident, Injury Reporting	1
75.300 [Ventilation]	3
75.400 Combustible Materials and Rock Dusting]	5
75.500 Series [Electrical Equipment - General]	10
75.600 Series [Trailing Cables]	1
75.800 Series [Underground High-Voltage Distribution]	11
75.900 Series [Underground Low and Medium Voltage AC]	2
75.1100 Series [Fire Protection]	2
75.1400 Series [Hoisting and Mantrips]	1
75.1500 Series [Mine Emergencies]	1
77.200 Series [Surface Installations]	6
77.500 Series [Electrical Equipment]	15
77.700 Series [Grounding]	1
77.900 Series [Low and Medium Voltage AC]	1
77.1100 Series [Fire Protection]	2
77.1600 Series [Loading and Haulage]	3
Total	**68**

Upper Big Branch Mine-South: Citations / Orders, January 1, 2010 to June 31, 2010

Januarry to June 2010

103(k) Order	1
104(b) Order	2
314(b) Safeguard	1
50.2 Accident, Injury Reporting	1
70.100 Series [Dust Standards]	1
70.200 Series [Sampling Procedures]	2
72.600 Series [Sampling Procedures]	1
75.200 Series [Roof Control]	19
75.300 [Ventilation]	45
75.400 Combustible Materials and Rock Dusting]	18
75.500 Series [Electrical Equipment - General]	18
75.600 Series [Trailing Cables]	5
75.700 Series [Grounding]	1
75.800 Series [Underground High-Vpltage Distribution]	12
75.900 Series [Underground Low and Medium Voltage AC]	4
75.1100 Series [Fire Protection]	5
75.1200 Series [Maps]	1
75.1400 Series [Hoisting and Mantrips]	5
75.1500 Series [Mine Emergencies]	3
75.1700 Series [Miscellaneous]	13
77.200 Series [Surface Installations]	8
77.500 Series [Electrical Equipment]	15
77.700 Series [Grounding]	1
11.900 Series [Low and Medium Voltage AC]	1
77.1100 Series [Fire Protection]	4
77.1600 Series [Loading and haulage]	3
Total	**190**

Upper Big Branch Mine-South

Citations / Orders / Penalties, January 1, 2009 to March 31, 2009

29	$100.00
1	$117.00
2	$127.00
3	$138.00
1	$150.00
6	$176.00
3	$224.00
1	$243.00
5	$263.00
3	$392.00
1	$499.00
1	$540.00
1	$634.00
2	$687.00
12	$873.00
1	$946.00
5	$1,111.00
3	$1,203.00
2	$1,304.00
1	$1,412.00
2	$1,530.00
5	$1,944.00
2	$2,282.00
5	$3,143.00
1	$3,405.00
2	$4,329.00
1	$6,996.00
2	$7,578.00
2	$9,634.00
1	$11,597.00
1	$29,529.00

Total	**107**	**$163,442.00**
Average Per Violation		**$1,527.50**

Upper Big Branch Mine-South

Citations / Orders / Penalties, April 1, 2009 to June 30, 2009

	2	$0.00
	18	$100.00
	3	$117.00
	3	$150.00
	2	$176.00
	2	$190.00
	2	$224.00
	2	$243.00
	3	$285.00
	1	$334.00
	1	$362.00
	2	$392.00
	3	$425.00
	2	$460.00
	2	$499.00
	3	$540.00
	7	$585.00
	3	$634.00
	4	$873.00
	1	$946.00
	17	$1,111.00
	8	$1,203.00
	1	$1,235.00
	6	$1,412.00
	3	$1,530.00
	4	$1,657.00
	2	$1,944.00
	1	$2,282.00
	10	$2,473.00
	1	$2,678.00
	6	$3,143.00
	2	$3,405.00
	1	$3,493.00
	11	$4,000.00
	1	$4,329.00
	1	$5,503.00
	2	$6,996.00
	2	$7,578.00
	1	$11,306.00
	2	$12,563.00
	1	$15,971.00
Total	**149**	**$269,408.00**
Average Per Violation		**$1,808.11**

Upper Big Branch Mine-South

Citations / Orders / Penalties, July 1, 2009 to September 30, 2009

1	$0.00
35	$100.00
1	$108.00
2	$117.00
3	$127.00
12	$150.00
1	$162.00
4	$176.00
3	$190.00
6	$224.00
4	$243.00
6	$285.00
3	$308.00
1	$334.00
2	$362.00
9	$392.00
2	$425.00
1	$460.00
11	$499.00
1	$540.00
4	$585.00
3	$634.00
2	$745.00
3	$873.00
1	$1,026.00
7	$1,111.00
4	$1,203.00
1	$1,304.00
4	$1,530.00
2	$1,657.00
3	$1,944.00
1	$2,106.00
1	$2,161.00
5	$2,473.00
1	$2,678.00
3	$2,901.00
1	$3,143.00
1	$3,405.00
9	$4,000.00
2	$4,810.00
1	$5,211.00
1	$5,645.00
1	$5,961.00
4	$6,115.00
1	$8,209.00
1	$8,421.00
1	$9,122.00
2	$10,705.00
1	$11,597.00
2	$15,971.00
1	$18,742.00
1	$35,543.00
1	$66,142.00

Total	**184**	**$395,465.00**

Average Per Violation	**$2,149.27**

Upper Big Branch Mine-South

Citations / Orders / Penalties, October 1, 2009 to December 31, 2009

	3	$0.00
	14	$100.00
	2	$117.00
	2	$127.00
	9	$150.00
	1	$162.00
	3	$176.00
	3	$190.00
	1	$224.00
	4	$243.00
	1	$263.00
	1	$285.00
	2	$334.00
	1	$425.00
	2	$460.00
	1	$499.00
	1	$540.00
	2	$585.00
	1	$687.00
	5	$745.00
	1	$946.00
	1	$1,026.00
	1	$1,203.00
	1	$1,944.00
	1	$2,282.00
	4	$2,473.00
	1	$3,405.00
	7	$4,000.00
	1	$5,645.00
Total	**77**	**$69,219.00**
Average Per Violation		**$898.95**

Upper Big Branch Mine-South

Citations / Orders / Penalties, January 1, 2009 to December 31, 2009

6	$0.00
96	$100.00
1	$108.00
8	$117.00
7	$127.00
3	$138.00
25	$150.00
2	$162.00
15	$176.00
8	$190.00
12	$224.00
11	$243.00
6	$263.00
10	$285.00
3	$308.00
4	$334.00
3	$362.00
14	$392.00
6	$425.00
5	$460.00
15	$499.00
6	$540.00
13	$585.00
7	$634.00
3	$687.00
7	$745.00
19	$873.00
3	$946.00
2	$1,026.00
29	$1,111.00
16	$1,203.00
1	$1,235.00
3	$1,304.00
7	$1,412.00
9	$1,530.00
6	$1,657.00
11	$1,944.00
1	$2,106.00
1	$2,161.00
4	$2,282.00

2009 Continued

19	$2,473.00
2	$2,678.00
3	$2,901.00
12	$3,143.00
5	$3,405.00
1	$3,493.00
27	$4,000.00
3	$4,329.00
2	$4,810.00
1	$5,211.00
1	$5,503.00
2	$5,645.00
1	$5,961.00
4	$6,115.00
3	$6,996.00
4	$7,578.00
1	$8,209.00
1	$8,421.00
1	$9,122.00
2	$9,634.00
2	$10,705.00
1	$11,306.00
2	$11,597.00
2	$12,563.00
3	$15,971.00
1	$18,742.00
1	$29,529.00
1	$35,543.00
1	$66,142.00

Total 517	**$897,543.00**
Average Per Violation	**$1,736.06**

Upper Big Branch Mine-South

Citations / Orders / Penalties, January 1, 2010 to March, 31, 2010

1	$0.00
2	$100.00
1	$117.00
16	$127.00
5	$138.00
5	$162.00
3	$176.00
6	$190.00
4	$207.00
3	$224.00
1	$243.00
3	$263.00
4	$285.00
1	$308.00
1	$334.00
1	$362.00
1	$425.00
1	$460.00
5	$499.00
2	$540.00
1	$634.00
3	$687.00
2	$807.00
1	$873.00
2	$946.00
1	$1,026.00
5	$1,111.00
1	$1,203.00
1	$1,304.00
5	$1,412.00
1	$1,657.00
1	$1,795.00
2	$2,106.00
2	$2,282.00
2	$2,473.00
1	$2,748.00
5	$3,143.00
4	$3,405.00
3	$3,689.00
2	$4,000.00
1	$4,329.00
2	$4,689.00
2	$5,503.00
1	$6,996.00
1	$16,867.00
1	$21,993.00
1	$38,503.00
1	$66,142.00
1	$70,000.00

Total	**122**	**$351,413.00**

Average Per Violation	**$2,880.44**

Upper Big Branch Mine-South

Citations / Orders / Penalties, April 1, 2010 to June 30, 2010

	3	$0.00
	11	$100.00
	1	$150.00
	15	$190.00
	17	$224.00
	1	$285.00
	3	$308.00
	1	$334.00
	1	$362.00
	1	$634.00
	2	$745.00
	3	$946.00
	1	$1,111.00
	1	$3,143.00
	2	$3,405.00
	1	$3,689.00
	1	$3,996.00
	1	$5,503.00
	1	$14,373.00
	1	$25,810.00
Total	**68**	**$79,210.00**
Average Per Violation		**$1,164.84**

Upper Big Branch Mine-South

Citations / Orders / Penalties, January 1, 2010 to June, 30, 2010

4	$0.00
13	$100.00
1	$117.00
16	$127.00
5	$138.00
1	$150.00
5	$162.00
3	$176.00
21	$190.00
4	$207.00
20	$224.00
1	$243.00
3	$263.00
5	$285.00
4	$308.00
2	$334.00
2	$362.00
1	$425.00
1	$460.00
5	$499.00
2	$540.00
2	$634.00
3	$687.00
2	$745.00
2	$807.00
1	$873.00
5	$946.00
1	$1,026.00
6	$1,111.00
1	$1,203.00
1	$1,304.00
5	$1,412.00
1	$1,657.00
1	$1,795.00
2	$2,106.00
2	$2,282.00
2	$2,473.00
1	$2,748.00
6	$3,143.00
6	$3,405.00

2010 Continued

4	$3,689.00
1	$3,996.00
2	$4,000.00
1	$4,329.00
2	$4,689.00
3	$5,503.00
1	$6,996.00
1	$14,373.00
1	$16,867.00
1	$21,993.00
1	$25,810.00
1	$38,503.00
1	$66,142.00
1	$70,000.00

Total	**190**	**$430,623.00**
Average Per Viloation		**$2,266.44**

Mine Citation/Order

U.S. Department of Labor
Mine Safety and Health Administration

Section I—Violation Data

1. Date: Mo 04 Da 05 Yr 10 | 2. Time (24 Hr. Clock): 1608 | 3. Citation/Order Number: 4642503

4. Served To: David Taraczkozy | 5. Operator: Performance Coal Company

6. Mine: Upper Big Branch Mine-South | 7. Mine ID: 46-08436 (Contractor)

8. Condition or Practice | 8a. Written Notice (103g) ☐

An accident occured at this operation on 04/05/2010 at approximately 3:27 pm. This order is being issued under the Federal Mine Safety and Health Act of 1977 Section 103(j), to prevent destruction of any evidence which would assist in investigating the cause or causes of the accident. It prohibits all activity in the underground areas of the mine except to restore and recover miners.

See Continuation Form (MSHA Form 7000-3a) ☐

9. Violation | A. Health ☐ Safety ☐ Other ☐ | B. Section of Act | C. Part/Section of Title 30 CFR

Section II—Inspector's Evaluation

10. Gravity:

A. Injury or Illness (has) (is): No Likelihood ☐ Unlikely ☐ Reasonably Likely ☐ Highly Likely ☐ Occurred ☐

B. Injury or Illness could reasonably be expected to be: No Lost Workdays ☐ Lost Workdays or Restricted Duty ☐ Permanently Disabling ☐ Fatal ☐

C. Significant and Substantial (See Reverse): Yes ☐ No ☐ | D. Number of Persons Affected

11. Negligence (check one)

A. None ☐ B. Low ☐ C. Moderate ☐ D. High ☐ E. Reckless Disregard ☐

12. Type of Action: 103-j- | 13. Type of Issuance (check one): Citation ☐ Order ☒ Safeguard ☐

14. Initial Action: A. Citation ☐ B. Order ☐ C. Safeguard ☐ D. Written Notice ☐ | E. Citation/Order Number | E. Dated Mo Da Yr

15. Area or Equipment

16. Termination Due: A. Date Mo Da Yr | B. Time (24 Hr. Clock)

Section III—Termination Action

17. Action to Terminate

Terminated: A. Date Mo Da Yr | B. Time (24 Hr. Clock)

Section IV—Automated System Data

Type of Inspection Activity code: E09 | 20. Event Number: 6286065 | 21. Primary or Mill

Signature: Robert M. Hardman | 23. AR Number: 23429

MSHA Form 7000-3, Mar 85 (Revised)

Mine Citation/Order Continuation

U.S. Department of Labor
Mine Safety and Health Administration

Section I—Subsequent Action/Continuation Data

1. Subsequent Action ☑	1a. Continuation ☐	2. Dated (Original Issue) Mo	Da	Yr	3. Citation/Order Number
		04	05	10	4064253-01

4. Served To: Elizabeth Chamberlain
5. Operator: Performance Coal Company
6. Mine: Upper Big Branch Mine-South
7. Mine ID: 46-08436 (Contractor)

Section II—Justification for Action

The initial order is modified to reflect that MSHA is now proceeding under the authority of Section 103(K) of the Federal Mine Safety and Health Act of 1977. This Section 103(K) order is intended to protect the safety of all persons on-site, including those involved in rescue and recovery operations or investigation of the accident. The mine operator shall obtain prior approval from an Authorized Representative of the Secretary for all actions to recover and/or restore operations in the affected area. Additionally, the mine operator is reminded of its existing obligations to prevent the destruction of evidence that would aid in investigating the cause or causes of the accident.

Section II, Item 12 is modified to 103(K).

See Continuation Form ☐

Section III—Subsequent Action Taken

Extended To	A. Date Mo	Da	Yr	B. Time (24 Hr. Clock)	C. Vacated ☐	D. Terminated ☐	E. Modified ☑

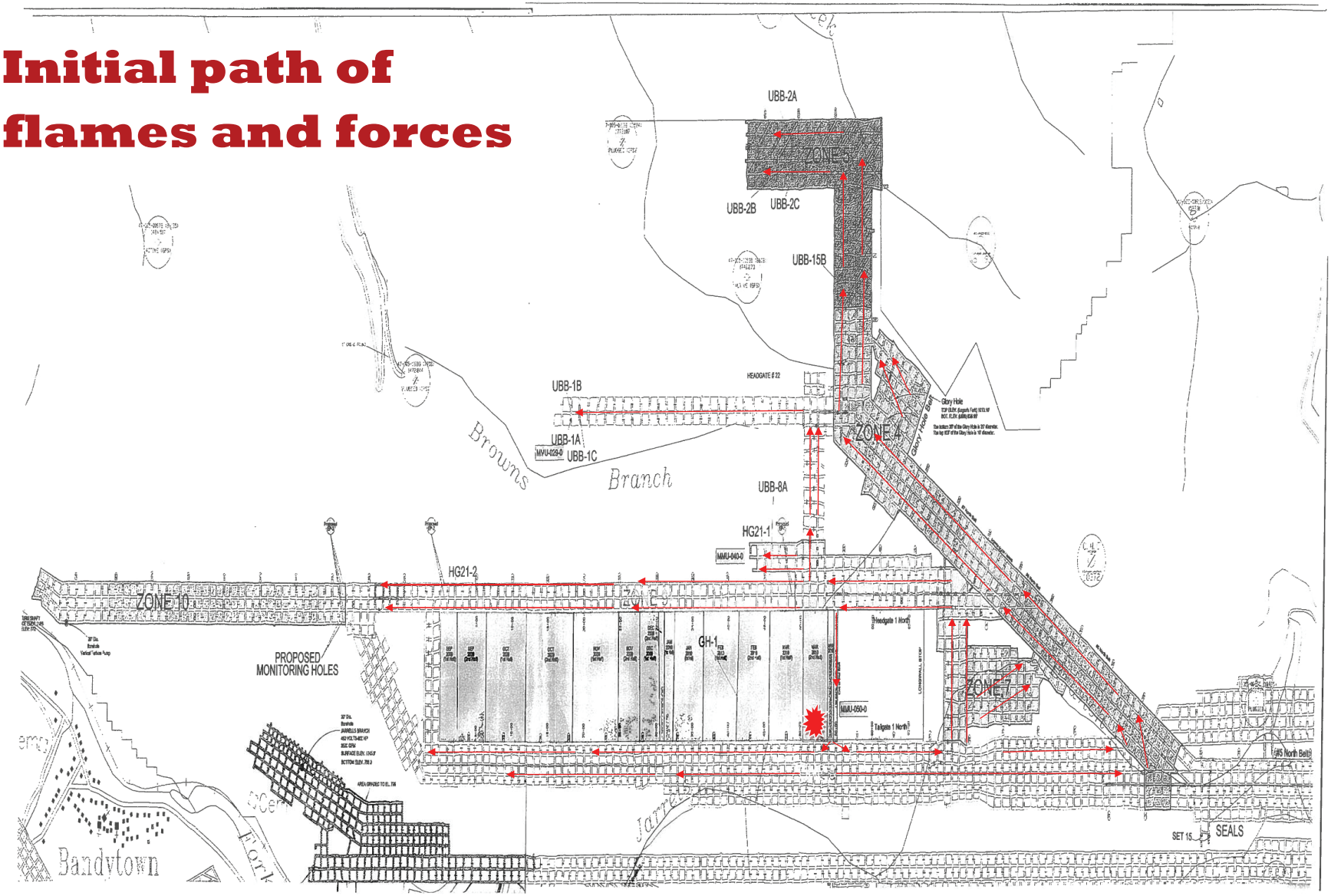
Section IV—Inspection Data

Type of Inspection: E09 | 10. Event Number: 2860065

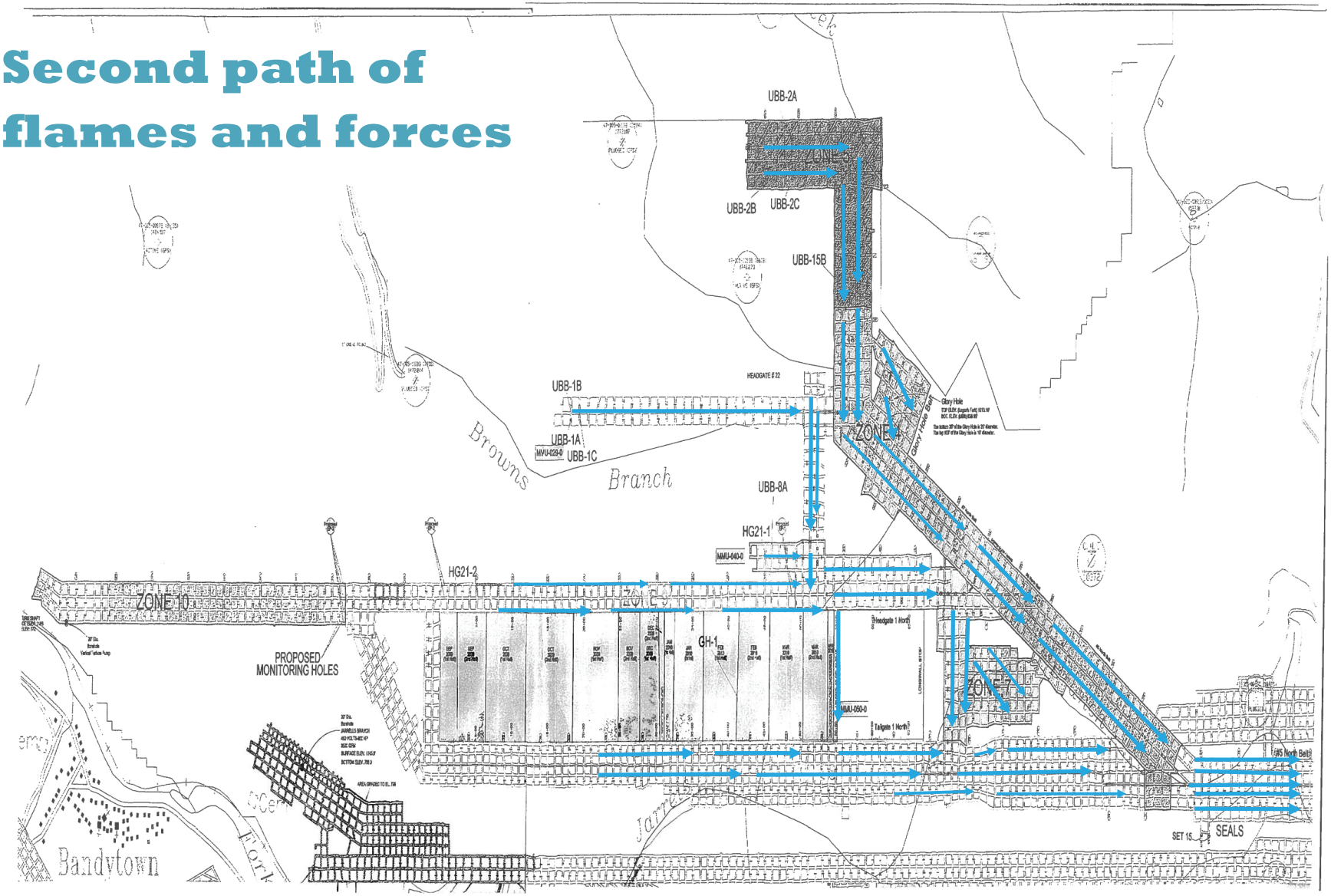
Signature: Robert G. Hardman | AR Number: 23429 | 12. Date Mo 04 Da 05 Yr 10 | 13. Time (24 Hr. Clock): 1720

MSHA Form 7000-3a, Mar 85 (revised)

Initial path of flames and forces



Second path of flames and forces



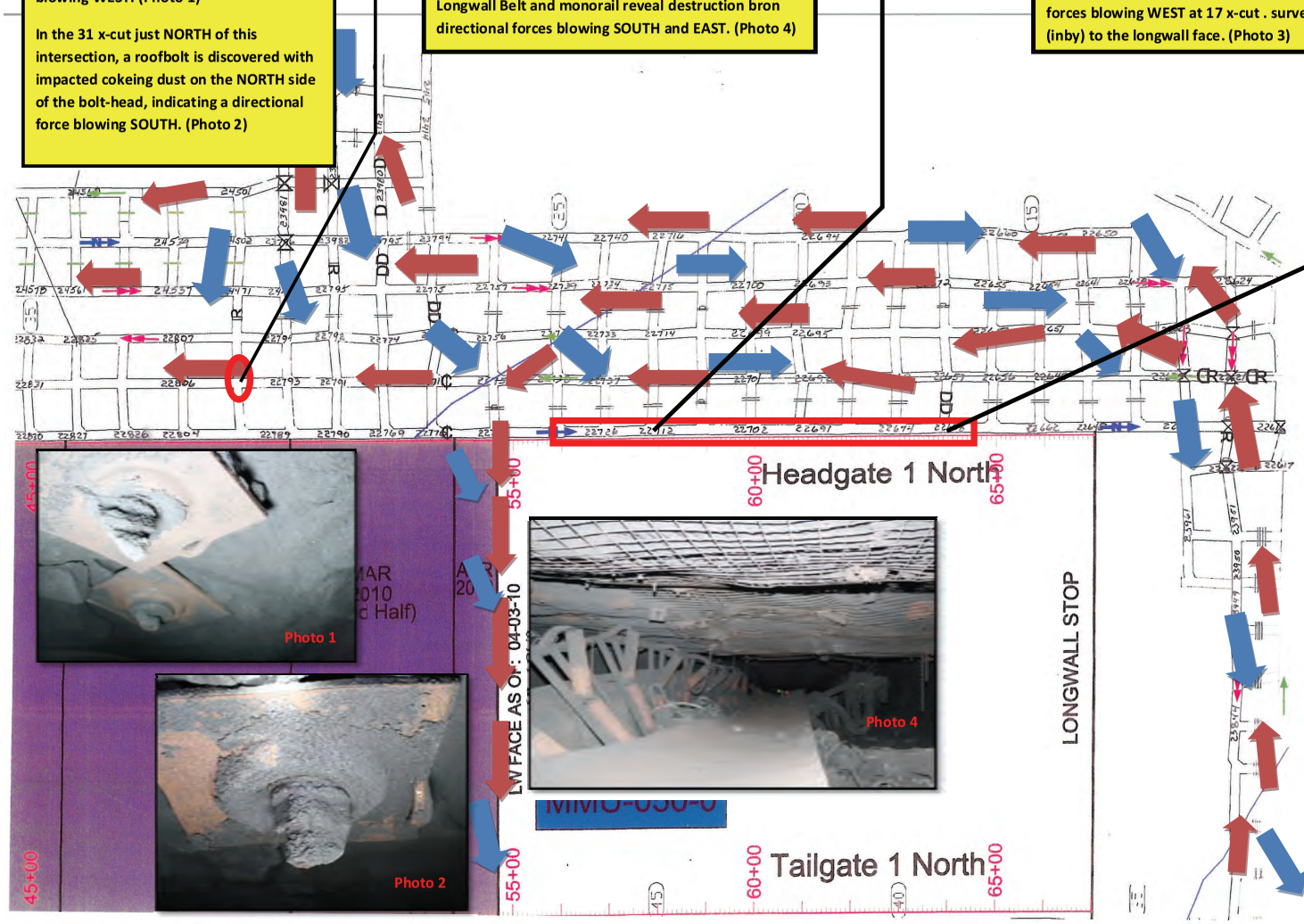
Paths of Flames and Forces

At 31 x-cut one intersection (indy) WEST of Survey Spud 22793 in #2 Entry, two roofbolts are discovered with impacted coking dust on the EAST side of the bolt-heads, indicating directionsl forces blowing WEST. (Photo 1)

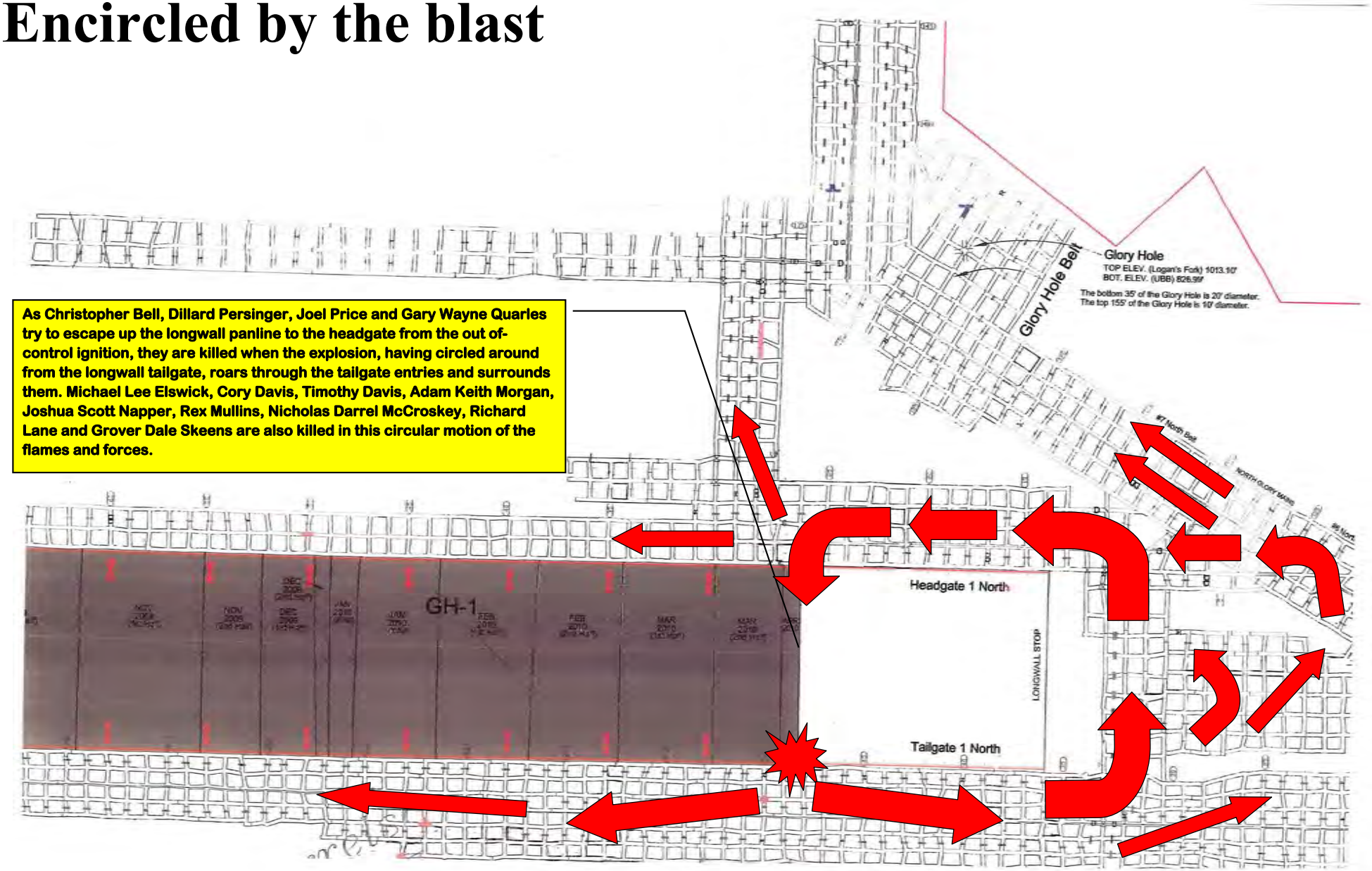
In the 31 x-cut just NORTH of this intersection, a roofbolt is discovered with impacted cokeing dust on the NORTH side of the bolt-head, indicating a directional force blowing SOUTH. (Photo 2)

At 23 x-cut, Survey Spud 22712, the 1 North 21 Longwall Belt and monorail reveal destruction bron directional forces blowing SOUTH and EAST. (Photo 4)

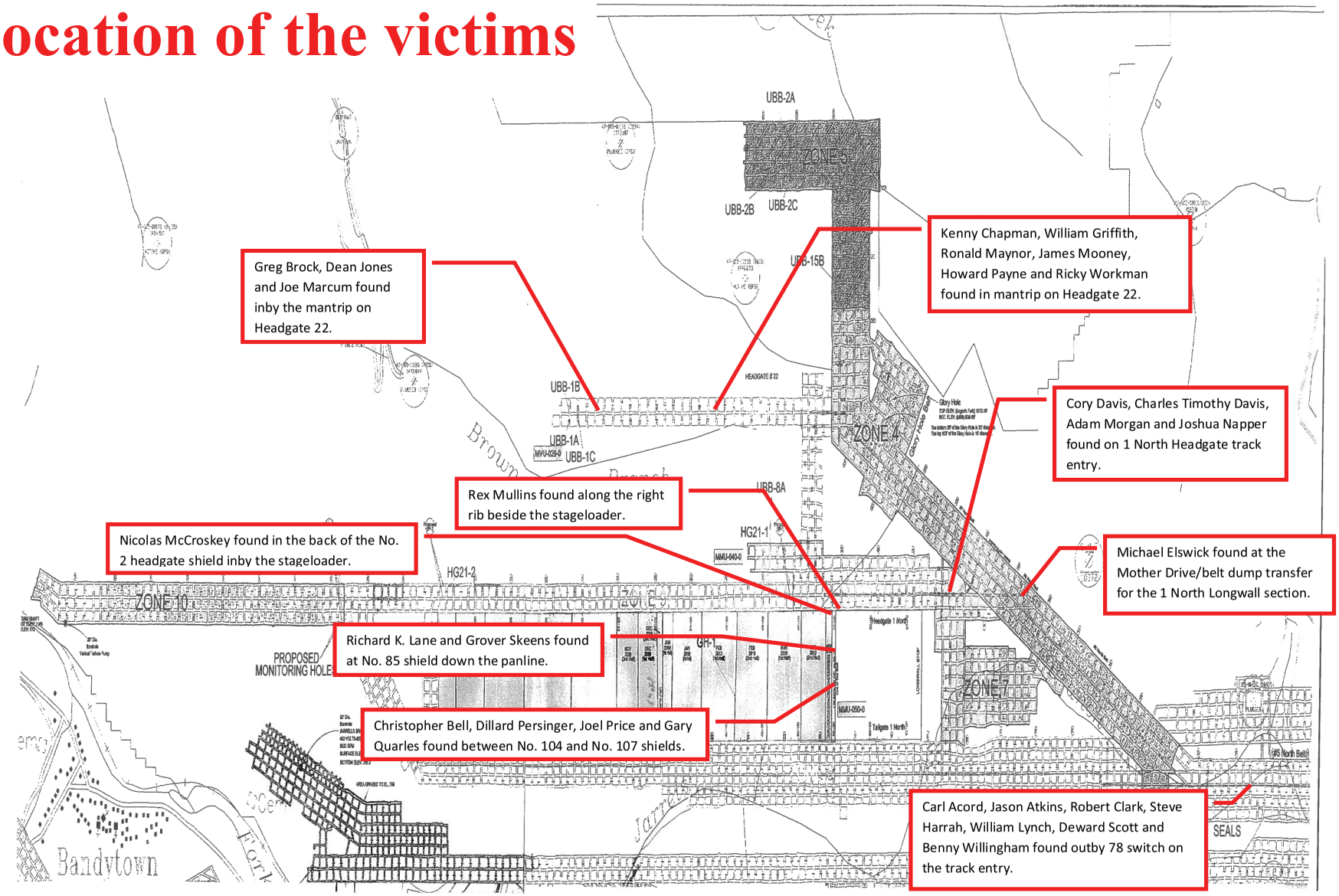
In the Belt Heading (#1 Entry) the North 21 Longwall Belt and the monorail reveal destruction from directional forces blowing WEST at 17 x-cut . survey Spud 22674 (inby) to the longwall face. (Photo 3)

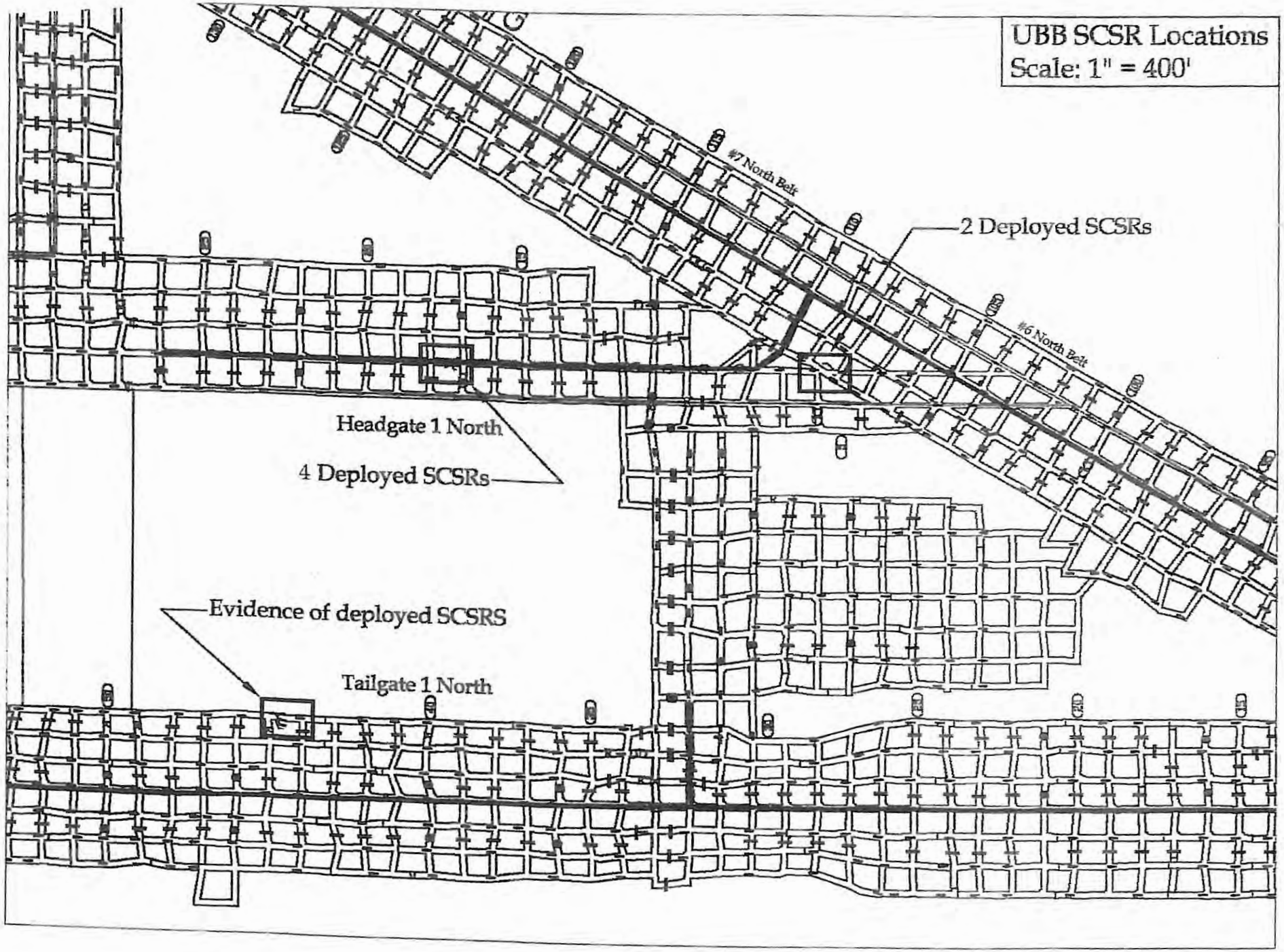


Encircled by the blast



Location of the victims




UBB SCSR Locations
Scale: 1" = 400'
#7 North Belt
2 Deployed SCSRs
#6 North Belt
Headgate 1 North
4 Deployed SCSRs
Evidence of deployed SCSRS
Tailgate 1 North

U.S. Department of Labor
Mine Safety and Health Administration

4. Served To Wayne Persinger - Mine Manager	5. Operator PERFORMANCE COAL COMPANY
6. Mine UPPER BIG BRANCH MINE-SOUTH	7. Mine ID 46-08436 (Contractor)

8. Condition or Practice — 8a. Written Notice (103g) ☐

The North Portal Mine fan and the return entry to the right of the fan is not separated properly to prevent return air from exiting the mine and re-entering through the mine fan. The mine fan entry is the primary escapeway entry to the Barrier Section. When checked by utilizing a chemical fire extinguisher at the return entry, the dry powder of the extinguisher re-enterd the mine through the North Fan. This condition prevents the primary escapeway from being ventilated entirely with intake air.

See Continuation Form (MSHA Form 7000-3a) ☐

9. Violation	A. Health ☐ Safety ☑ Other ☐	B. Section of Act	C. Part/Section of Title 30 CFR: 75.380(f)(1)

Section II--Inspector's Evaluation

10. Gravity:

A. Injury or Illness (has) (is): No Likelihood ☐ Unlikely ☐ Reasonably Likely ☑ Highly Likely ☐ Occurred ☐

B. Injury or illness could reasonably be expected to be: No Lost Workdays ☐ Lost Workdays Or Restricted Duty ☐ Permanently Disabling ☐ Fatal ☑

C. Significant and Substantial: Yes ☑ No ☐ — D. Number of Persons Affected: 020

11. Negligence (check one) A. None ☐ B. Low ☐ C. Moderate ☑ D. High ☐ E. Reckless Disregard ☐

12. Type of Action 104(a) — 13. Type of Issuance (check one) Citation ☑ Order ☐ Safeguard ☐

14. Initial Action A. Citation ☐ B. Order ☐ C. Safeguard ☐ D. Written Notice ☐ — E. Citation/ Order Number — F. Dated Mo Da Yr

15. Area or Equipment

16. Termination Due	A. Date Mo Da Yr 05/24/2010	B. Time (24 Hr. Clock) 0800

Section III--Termination Action

17. Action to Terminate

18. Terminated	A. Date Mo Da Yr	B. Time (24 Hr. Clock

Section IV--Automated System Data

19. Type of Inspection (activity code) E16	20. Event Number 4440348	21. Primary or Mill

22. Signature [signature] — 23. AR Number 23958

MSHA Form 7000-3, Mar 85 (revised) In accordance with the provisions of the Small Business Regulatory Enforcement Fairness Act of 1996, the Small Business Administration has established a National Small Business and Agriculture Regulatory Ombudsman and 10 Regional Fairness Boards to receive comments from small businesses about federal agency enforcement actions. The Ombudsman annually evaluates enforcement activities and rates each agency's responsiveness to small business. If you wish to comment on the enforcement actions of MSHA, you may call 1-888-REG-FAIR (1-888-734-3247), or write the Ombudsman at Small Business Administration, Office of the National Ombudsman, 409 3rd Street, SW MC 2120, Washington, DC 20416. Please note, however, that your right to file a comment with the Ombudsman is in addition to any other rights you may have, including the right to contest citations and proposed penalties and obtain a hearing before the Federal Mine Safety and Health Review Commission.

Mine Citation/Order Continuation

U.S. Department of Labor
Mine Safety and Health Administration

Section I--Subsequent Action/Continuation Data

1. Subsequent Action 1a. Continuation	2. Dated (Original Issue) Mo Da Yr	3. Citation/ Order Number
✓	05/20/2010	8247081 - 03

4. Served To	5. Operator
Wayne Persinger - Mine Manager	PERFORMANCE COAL COMPANY
6. Mine	**7. Mine ID** (Contractor)
UPPER BIG BRANCH MINE-SOUTH	46-08436

Section II--Justification for Action

The return entry portal has been extended to approximately 75 feet from the intake and more time is needed to have the engineers to evaluate the installation.

See Continuation Form ☐

Section III--Subsequent Action Taken

Extended To	A. Date Mo Da Yr	B. Time (24 Hr. Clock)	C. Vacated	D. Terminated	E. Modified
	06/24/2010	0900	☐	☐	☐

Section IV--Inspection Data

Type of Inspection	10. Event Number
E16	4440348

Signature	AR Number	12. Date Mo Da Yr	13. Time (24 Hr. Clock)
	23958	06/11/2010	1100

MSHA Form 7000-3a, Mar 85 (revised)

Mine Citation/Order Continuation

U.S. Department of Labor
Mine Safety and Health Administration

Section I–Subsequent Action/Continuation Data

1. Subsequent Action	1a. Continuation	2. Dated (Original Issue) Mo Da Yr	3. Citation/ Order Number
☑	☐	05/20/2010	8247081 - 05

4. Served To	5. Operator
Wayne Persinger - Mine Manager	PERFORMANCE COAL COMPANY

6. Mine	7. Mine ID	(Contractor)
UPPER BIG BRANCH MINE-SOUTH	46-08436	

Section II–Justification for Action

The fan is now installed to prevent recirculation of the return air.

See Continuation Form ☐

Section III–Subsequent Action Taken

Extended To	A. Date Mo Da Yr	B. Time (24 Hr. Clock)	☐ C. Vacated	☑ D. Terminated	☐ E. Modified

Section IV–Inspection Data

Type of Inspection	10. Event Number
E16	4440348

Signature	AR Number	12. Date Mo Da Yr	13. Time (24 Hr. Clock)
	23958	07/21/2010	1547

Form 7000-3a, Mar 85 (revised)

Mine Citation/Order

U.S. Department of Labor
Mine Safety and Health Administration

Section I--Violation Data

1. Date Mo Da Yr	2. Time (24 Hr. Clock)		3. Citation/ Order Number
11/10/2010	0745		8256942

4. Served To	5. Operator
CHARLIE BEARSE	PERFORMANCE COAL COMPANY

6. Mine	7. Mine ID	(Contractor)
UPPER BIG BRANCH MINE-SOUTH	46-08436	

8. Condition or Practice — 8a. Written Notice (103g) ☐

CHARLIE BEARSE HAS DIRECTLY DENIED ENTRY TO MSHA's INVESTIGATION TEAMS BY REFUSING TO CONTINUE TO WORK TOWARD PROVIDING THE LONGWALL SHEAR(s) WITH WATER. THIS DECISION WAS MADE ON TODAY'S DATE BY MR. BEARSE WHICH IMPEDES THE INVESTIGATION INTO THE ACCIDENT THAT OCCURRED ON 4-5-10 THAT RESULTED IN 29 FATALITIES.

MR. BEARSE WAS TOLD THAT THIS ACTION IMPEDES MSHA's INVESTIGATION AND THAT A VIOLATION OF SECTION 103(a) WOULD BE ISSUED TO WHICH HE REPLIED "SERVE IT TO MY NAME".

THIS THE SECOND TIME THE OPERATOR HAS VIOLATED THIS SECTION OF THE MINE ACT FOR DELAYING MSHA's INVESTIGATION PROCESS.

THIS CITATION HAS NOT BEEN DESIGNATED AS "SIGNIFICANT & SUBSTANTIAL" BECAUSE THE CONDUCT VIOLATED A PROVISION OF THE MINE ACT RATHER THAN A

See Continuation Form (MSHA Form 7000-3a) ☑

9. Violation	A. Health ☐ Safety ☑ Other ☐	B. Section of Act: 103(a)	C. Part/Section of Title 30 CFR

Section II--Inspector's Evaluation

10. Gravity:

A. Injury or Illness (has) (is): No Likelihood ☑ Unlikely ☐ Reasonably Likely ☐ Highly Likely ☐ Occurred ☐

B. Injury or illness could reasonably be expected to be: No Lost Workdays ☑ Lost Workdays Or Restricted Duty ☐ Permanently Disabling ☐ Fatal ☐

C. Significant and Substantial: Yes ☐ No ☑

D. Number of Persons Affected: 000

11. Negligence (check one) A. None ☐ B. Low ☐ C. Moderate ☐ D. High ☐ E. Reckless Disregard ☑

12. Type of Action 104(a)

13. Type of Issuance (check one) Citation ☑ Order ☐ Safeguard ☐ Written Notice ☐

14. Initial Action A. Citation ☐ B. Order ☐ C. Safeguard ☐ D. Written Notice ☐ — E. Citation/ Order Number — F. Dated Mo Da Yr

15. Area or Equipment

16. Termination Due	A. Date Mo Da Yr	B. Time (24 Hr. Clock)
	11/11/2010	1100

Section III--Termination Action

17. Action to Terminate

18. Terminated	A. Date Mo Da Yr	B. Time (24 Hr. Clock

Section IV--Automated System Data

19. Type of Inspection / Activity code: E01	20. Event Number 4440347	21. Primary or Mill

22. Signature [signature] — 23. AR Number 24136

Form 7000-3, Apr 08 (revised) In accordance with the provisions of the Small Business Regulatory Enforcement Fairness Act of 1996, the Small Business Administration has established a National Small Business and Agricultural Regulatory Ombudsman and 10 Regional Fairness Boards to receive comments from small businesses about federal agency enforcement actions. The Ombudsman annually evaluates enforcement activities and rates each agency's responsiveness to small business. If you wish to comment on the enforcement actions of MSHA, you may call 1-888-REG-FAIR (1-888-734-3247), or write the Ombudsman at Small Business Administration, Office of the National Ombudsman, 409 3rd St SW MC 2120, Washington, DC 20416. Please note, however, that your right to file a comment with the Ombudsman is in addition to any other rights you may have, including to contest citations and proposed penalties and obtain a hearing before the Federal Mine Safety and Health Review Commission.

Mine Citation/Order Continuation

U.S. Department of Labor
Mine Safety and Health Administration

Section I–Subsequent Action/Continuation Date

1. Subsequent Action	1a. Continuation	2. Dated (Original Issue) Mo Da Yr	3. Citation/ Order Number
☐	☑	11/10/2010	8256942

4. Served To	5. Operator
CHARLIE BEARSE	PERFORMANCE COAL COMPANY
6. Mine	**7. Mine ID** (Contractor)
UPPER BIG BRANCH MINE-SOUTH	46-08436

Section II--Justification for Action

Continuation of 8. Condition or Practice

MANDATORY SAFETY OR HEALTH STANDARD.

See Continuation Form ☐

Section III–Subsequent Action Taken

Extended To	A. Date Mo Da Yr	B. Time (24 Hr. Clock)	☐ C. Vacated	☐ D. Terminated	☐ E. Modified

Section IV–Inspection Data

Type of Inspection	10. Event Number
E06	4440347

Signature	AR Number	12. Date Mo Da Yr	13. Time (24 Hr. Clock)
Kenneth Lowe	24136	11/10/2010	0745

MSHA Form 7000-3a, Mar 85 (revised)

Performance Coal Company

P.O. Box 69, Naoma, WV 25140

Phone: 304.854.3401 Fax 304.854.3412

December 13, 2010

Mr. Norman G. Page
National Mine Health and Safety Academy
1301 Airport Road
Beaver, West Virginia 25813-9426

Mr. William A. Tucker
WV Office of Miners' Health, Safety and Training
142 Industrial Drive
Oak Hill, WV 25901

Re: LW Water System Update
Performance Coal Company
Upper Big Branch Mine
MSHA ID: 46-08436
State ID: U-3042-92

Dear Sirs,

The purpose of this letter is to provide an update as to progress to install a water system to apply water to the longwall shearer.

As you know, we ordered 5-inch and 4-inch water hose for the project, which is to be delivered tomorrow. While that delivery schedule was confirmed today, we have also been searching for steel water line. We found enough 4-inch aluminum line with victaulic couplings to connect the borehole to the shearer (640 psi rating), and have ordered this line also.

We expect delivery of the aluminum line by tonight, and would like to begin hauling this underground as soon as possible - no later than first thing tomorrow. We found a 20 ft. rubber tire trailer that we can use to haul this behind a scoop. We would apply water to the roadways in 21 Headgate with existing infrastructure to address any dust concerns, and transport the pipe materials along this route. In essence, we will start with the aluminum pipe because we can get it faster, and we may go all the way with it, or convert to the hose at some point, depending on function and speed.

The pressure reducing valve and the water filter system are ready to be transported. The electricians have pre-assembled the system, and then disassembled and packed it for transport

and easier handling underground. The system will be installed at the end of the hard line, in the conveyor chain, near the shearer.

Today, we are installing the airlock doors in #1 entry of 21 Tailgate, so that we can use a scoop to rock dust the #1 entry, as we have previously discussed. This route will be used to transport the pressure reducing valve and water filter system.

The 7-inch line down Borehole 8A has been installed, including the "T" at the bottom of the line underground. The required fittings should all be here today. The water tank should be in place today. We will not fill it until we are ready to test the system, due to freezing concerns. We will insulate the water lines from the tank to the Borehole 8A.

If you have any questions or concerns, feel free to contact me at (304) 854-3401.

Respectfully Submitted,
On Behalf of Performance Coal Company

Charles I. Bearse III

Cc: Miners Representative

Gas Ignitions at Underground Coal Mines April 2010 – March 2011

	Parent Company	Subsidiary	Mine	Date
1.	Alpha	Cumberland Coal Resources LP	Cumberland Mine	4/8/2010
2.	Consol Energy Inc	Consolidation Coal Company	Robinson Run No 95	4/8/2010
3.	Walter Energy Incorporated	Jim Walter Resources Inc	No 7 Mine	4/14/2010
4.	Consol Energy Inc	Consol Pennsylvania Coal Company LLC	Enlow Fork Mine	4/21/2010
5.	Walter Energy Incorporated	Jim Walter Resources Inc	No 7 Mine	4/28/2010
6.	Consol Energy Inc	Consolidation Coal Company	Blacksville No 2	5/8/2010
7.	Walter Energy Incorporated	Jim Walter Resources Inc	No 7 Mine	5/14/2010
8.	Walter Energy Incorporated	Jim Walter Resources Inc	No 7 Mine	5/17/2010
9.	Walter Energy Incorporated	Jim Walter Resources Inc	No 7 Mine	5/20/2010
10.	Alpha	Paramont Coal Company Virginia, LLC	Deep Mine #26	5/26/2010
11.	Walter Energy Incorporated	Jim Walter Resources Inc	No 7 Mine	6/8/2010
12.	Walter Energy Incorporated	Jim Walter Resources Inc	No 7 Mine	6/16/2010
13.	Walter Energy Incorporated	Jim Walter Resources Inc	No 4 Mine	6/23/2010
14.	Arch Coal Incorporated	ICG Illinois, LLC	Viper Mine	6/25/2010
15.	Walter Energy Incorporated	Jim Walter Resources Inc	No 7 Mine	8/1/2010
16.	Walter Energy Incorporated	Jim Walter Resources Inc	No 7 Mine	9/16/2010
17.	Alpha	Brooks Run Mining Company LLC	Cucumber Mine	9/20/2010
18.	Robert E Murray	The American Coal Company	New Era Mine	9/26/2010
19.	Cliffs Natural Resources Inc	Oak Grove Resources LLC	Oak Grove Mine	11/3/2010
20.	Walter Energy Incorporated	Jim Walter Resources Inc	No 7 Mine	11/19/2010
21.	Drummond Company Inc	Drummond Company Inc	Shoal Creek Mine	11/22/2010
22.	Walter Energy Incorporated	Jim Walter Resources Inc	No 7 Mine	11/30/2010
23.	Walter Energy Incorporated	Jim Walter Resources Inc	No 7 Mine	1/3/2011
24.	Walter Energy Incorporated	Jim Walter Resources Inc	No 7 Mine	1/7/2011
25.	Alliance Resource Partners LP	Warrior Coal LLC	Cardinal	1/13/2011
26.	Robert E Murray	American Energy Corporation	Century Mine	1/20/2011
27.	Rhino Resources Partners LP	CAM Mining LLC	Mine #28	1/21/2011
28.	Walter Energy Incorporated	Jim Walter Resources Inc	No 7 Mine	1/29/2011
29.	Walter Energy Incorporated	Jim Walter Resources Inc	No 7 Mine	1/31/2011

30.	Walter Energy Incorporated	Jim Walter Resources Inc	No 7 Mine	2/14/2011
31.	Walter Energy Incorporated	Jim Walter Resources Inc	No 7 Mine	2/16/2011
32.	Consol Energy Inc	Consolidation Coal Company	Buchanan Mine #1	2/17/2011
33.	Patriot Coal Corporation	Speed Mining, LLC	American Eagle Mine	3/5/2011
34.	Walter Energy Incorporated	Jim Walter Resources Inc	No 7 Mine	3/14/2011
35.	Walter Energy Incorporated	Jim Walter Resources Inc	No 7 Mine	3/22/2011
36.	Walter Energy Incorporated	Jim Walter Resources Inc	No 7 Mine	3/23/2011

U.S. Department of Labor
Mine Safety and Health Administration

Representative of Miners Designation Form - Part A

The United Mine Workers of America Acting thru the individuals listed below & on Page 3.

Designation Type: ☐ Individual ☒ Organization ☒ Initial Filing ☐ Update

1. Representative Name: Dennis O'Dell Title: Administrator of Occupation & Safety (UMWA)
   Address: 18354 Quantico Gateway Drive, Suite 200
   City: Triangle State: Virginia Zip Code: 22172-1779
   Telephone: (703) 291-2400 Email: dodell@umwa.org

2. Mine Operator Name: Massey Energy Company - Performance Coal Company Upper Bit Branch Mi South
   Address of Mine: 130 Frontier Street, Montcoal, WV 25140
   MSHA ID# of Mine: 4608436

3. Scope of Designation:
   ☒ The person or position named as the representative of miners is the representative for all purposes of the Act.
   ☐ The representative's authority is limited to: _____

4. Names, addresses and telephone numbers of persons to serve in my absence:

   Name: Gary Trout
   Address: 1300 Kanawha Blvd, East
   City: Charleston State: West Virginia Zip Code: 25301
   Telephone: (304) 343-0259 Email: region2@umwa.org

   Name: Teddy Hapney
   Address: 1300 Kanawha Blvd, East
   City: Charleston State: West Virginia Zip Code: 25301
   Telephone: (304) 343-0259 Email: region2@umwa.org

   Name: See Attached - Page 3
   Address: _____
   City: _____ State: _____ Zip Code: _____
   Telephone: (_____) _____ Email: _____

I certify by signature that I am the designated representative listed in Item #1 of this form. A copy of this form has been delivered to the mine operator of the affected mine prior to or concurrently to the filing of this statement with the District Manager for MSHA. I certify that I have been designated as their representative by at least two miners who work at this mine and have provided that confidential information to the District Manager for MSHA. I certify that all information being filed is true and correct. I will provide subsequent changes should they occur to the District Manager for MSHA and the affected mine operator.

Signed: Dennis B. O'Dell Date: 4/23/10

U.S. Department of Labor
Mine Safety and Health Administration

Representative of Miners Designation Form - Part B **CONFIDENTIAL**

~~The United Mine Workers of America acting thru the idividuals listed below~~ and on page 3

Designation Type: ☐ Individual ☒ Organization ☒ Initial Filing ☐ Update

Administrator of Occupation

1. Representative Name: Dennis O'Dell Title: Health & Safety (UMWA)
   Address: 18354 Quantico Gateway Drive, Suite 200
   City: Triangle State: Virginia Zip Code: 22172-1779
   Telephone: (703) 291-2400 Email: dodell@umwa.org

Upper Big

2. Mine Operator Name: Massey Energy Company - Performance Coal Company Branch Mi
   Address of Mine: 130 Frontier Street, Montcoal, WV 25140
   MSHA ID# of Mine: 4608436

3. Designated By: (Signatures of two or more miners who work at the affected mine)

Anonymous - 2 or more miners 1 - Signature	2 - Signature
Confirmed by Kevin Stricklin 1 - Print Name	2 - Print Name
MSHA Coal Administrator in the presence of Teddy Hapney UMWA Representative 3 - Signature	4 - Signature
3 - Print Name	4 - Print Name
5 - Signature	6 - Signature
5 - Print Name	6 - Print Name

I certify that I have been designated as the representative of the miners ~~[illegible]~~ in Item #3 of this form. These miners work at this mine. The information contained on this form is to be kept in a confidential file by the District Manager for MSHA and will not be released.

Signed: Dennis B. O'Dell Date: 4/23/10

who have requested confidentiality, and whose designations were confirmed as shown.

Tr0

SOUTHEAST REGION OFFICE
UNITED MINE WORKERS OF AMERICA

1300 KANAWHA BLVD., E.
CHARLESTON, WV 25301

TELEPHONE
AREA CODE (304) 343-0259
FAX (304) 343-0250
Email
umwaregion2@charterinternet.com

April 30, 2010

Via Facsimile (304-877-9206)

Robert Hardman, Director
Mine Safety and Health Administration
100 Bluestone Road
Mount Hope, WV 25880

Re: Performance Coal, Upper Big Branch Mine
MSHA ID: 46-08436 State ID: U-3042-92
Miners' Representative Request for Information

Dear Mr. Hardman:

As of April 23, 2010, MSHA recognized the United Mine Workers of America as an authorized representative of the miners employed at the Upper Big Branch Mine of Performance Coal, located at Montcoal, WV. This authorization was duly delivered this date to Wayne Persinger, Performance Coal, at his office and in the presence of several Federal representatives. Despite this authorization on April 23, 2010, by letter dated April 27, 2010, and addressed to both Steve Snyder and Robert G. Hardman, Mr. Persinger erroneously stated that Performance Coal Company "does not have a miners' representative at this time". A copy of this letter is attached for your review.

As a duly authorized representative of the miners, this is our formal request for copies of all materials you have provided to all the State or Federal agencies(per their request) involved in this investigation, beginning April 4, 2010 and continuing until the investigation is closed. This information includes, but is not limited to, all proposed mining plans and ventilation changes that have been submitted to your office since April 4, 2010.

We also request that MSHA take swift enforcement actions against Performance Coal Company in any future incidences of interference with our rights as miners' representatives at the Performance Upper Big Branch mine. Thank you for your prompt attention to these requests.

Sincerely,

Theodore Hapney

TH:eh
Enclosure
cc: Steve Snyder, MSHA Inspector
Dennis O'Dell, Director of UMWA Health & Safety
Judy Rivlin, Esq.

SOUTHEAST REGION OFFICE
UNITED MINE WORKERS OF AMERICA

1300 KANAWHA BLVD., E.
CHARLESTON, WV 25301

TELEPHONE
AREA CODE (304) 343-0259
FAX (304) 343-0250
Email
umwaregion2@charterinternet.com

April 30, 2010

Via Facsimile (304-558-6091)

Ron Wooten, Director
Office of Miners' Health, Safety and Training
1615 Washington Street, East
Charleston, WV 25311-2126

Re: Performance Coal, Upper Big Branch Mine
MSHA ID: 46-08436 State ID: U-3042-92
Miners' Representative Request for Information

Dear Mr. Wooten:

As of April 23, 2010, MSHA recognized the United Mine Workers of America as an authorized representative of the miners employed at the Upper Big Branch Mine of Performance Coal, located at Montcoal, WV. This authorization was duly delivered this date to Wayne Persinger, Performance Coal, at his office and in the presence of several Federal representatives. Despite this authorization on April 23, 2010, by letter dated April 27, 2010, and addressed to both Steve Snyder and Robert G. Hardman, Mr. Persinger erroneously stated that Performance Coal Company "does not have a miners' representative at this time". A copy of this letter is attached for your review.

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Thank you for your prompt attention to this request.

Sincerely,

Theodore Hapney

TH:eh
Enclosure
cc: Steve Snyder, MSHA Inspector
Dennis O'Dell, Director of UMWA Health & Safety
Judy Rivlin, Esq.

SOUTHEAST REGION OFFICE
UNITED MINE WORKERS OF AMERICA

1300 KANAWHA BLVD., E.
CHARLESTON, WV 25301

TELEPHONE
AREA CODE (304) 343-0259
FAX (304) 343-0250
Email
umwaregion2@charterinternet.com

April 30, 2010

Via Facsimile (304-854-1260)

Mr. Wayne Persinger
Performance Coal Company
P.O. Box 69
Naoma, WV 25140

Re: Performance Coal, Upper Big Branch Mine
MSHA ID: 46-08436 State ID: U-3042-92
Miners' Representative Request for Information

Dear Mr. Persinger:

As of April 23, 2010, MSHA recognized the United Mine Workers of America as an authorized representative of the miners employed at the Upper Big Branch Mine of Performance Coal, located at Montcoal, WV. This authorization was duly delivered on this date to you in your office and in the presence of several Federal representatives. Despite this authorization on April 23, 2010, by your letter dated April 27, 2010, and addressed to both Steve Snyder and Robert G. Hardman, you erroneously stated that Performance Coal Company "does not have a miners' representative at this time". A copy of this letter is attached for your review.

As a duly authorized representative of the miners, this is our formal request for copies of all materials you have provided to all the State or Federal agencies (per their request) involved in this investigation, beginning April 4, 2010 and continuing until the investigation is closed. This information includes, but is not limited to, all proposed mining plans and ventilation changes that have been submitted to your office since April 4, 2010.

Thank you for your prompt attention to this request.

Sincerely,

Theodore Hapney

TH:eh
Enclosure
cc: Steve Snyder, MSHA Inspector
Dennis O'Dell, Director of UMWA Health & Safety
Judy Rivlin, Esq.

D-532

Massey Energy

MEMORANDUM

TO: **All Deep Mine Superintendents**

FROM: **Don Blankenship**

DATE: **October 19, 2005**

SUBJECT: **RUNNING COAL**

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.

DLB:sld

cc: Chris Adkins
Drexel Short

(dictated, not edited)

ARACOMA008441

Apprndix AA - Corporate Communications

D-533

MF

MEMORANDUM

Massey Energy

TO: All Deep Mine Superintendents

FROM: Don Blankenship DB

DATE: October 26, 2005

RE: MEMBERSHIP

By now each of you should know that safety and S-1 is our first responsibility. Productivity and P-2 are second. It has been the culture of our Company for a long time.

Last week I sent each of you a memo on running coal. Some of you may have interpreted that memo to imply that safety and S-1 are secondary. I would question the membership of anyone who thought that I consider safety to be a secondary responsibiltty.

The point is that each of you is responsible for coal producing sections, and our goal is to keep them running coal. If you have construction jobs at your mine that need to be done to keep it safe or productive, make every effort to do those jobs without taking members and equipment from the coal producing sections that pay the bills.

DLB/

ARACOMA008442

Mine Safety and Health Administration
MSHA - Protecting Miners' Safety and Health Since 1978

Note on Criminal Monetary Fines and Alternate Sentence Provisions

Related to the Federal Mine Safety & Health Act of 1977, Public Law 91-173, as amended by Public Law 95-164

Criminal Monetary Fines

Criminal monetary fines are subject to alternative sentencing provisions found at 18 USC 3571. Readers should consult that provision in the criminal code for exact legal information. However, that provision in general provides that an individual guilty of any felony or any misdemeanor resulting in death may receive a criminal fine of up to $250,000 [Reference: 18 USC 3571 (b)]; an organization found guilty of either any felony or a misdemeanor resulting in death may receive a criminal fine of up to $500,000 [Reference: 18 USC 3571 (c)]. An individual guilty of a misdemeanor not resulting in death is subject to a fine up to $100,000; an organization found guilty of misdemeanor not resulting in death is subject to a fine of $200,000 [same references].

Alternate Sentence Provisions

the maximum criminal fine exposure is significantly greater than reflected in the amounts stated in the Mine Act legislation. The Alternative Sentence provisions are found at 18 United States Code section 3571 which provides in pertinent part:

(b) Fines for Individuals: an individual who has been found guilty of an offense may not be fined not more than the greatest of-

(1) the amount specified in the law setting forth the offense
(3) for a felony, not more than $250,000
(4) for a misdemeanor resulting in death, not more than $250,000
(5) for a Class A misdemeanor not resulting in death, not more than $100,000

(c) Fines for organizations:

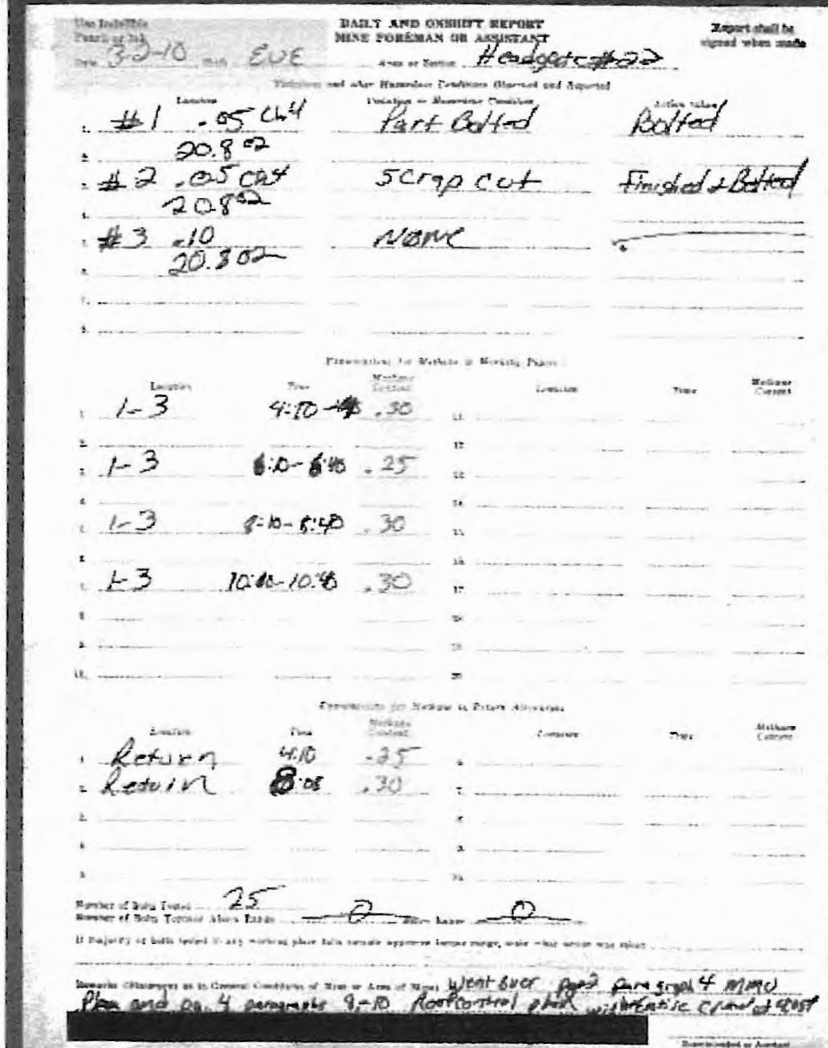
(1) the amount specified in the law setting forth the offense
(3) for a felony not more than $500,000
(4) for a misdemeanor resulting in death, not more than $500,000
(5) for a Class A misdemeanor that does not result in death, not more then $200,000

Class A misdemeanors are misdemeanors subject to maximum imprisonment of less than a year but more than six months. Mine Act misdemeanors are Class A misdemeanors. Any provision which has a maximum term of imprisonment of over one year is a felony.

Back to Penalties Section of the Act

Two Sets of Records

Onshift Report



DAILY AND ONSHIFT REPORT
MINE FOREMAN OR ASSISTANT

Report shall be signed when made

Date 3-2-10 Shift EVE Area or Section Headgate #22

Location	Violation or Hazardous Condition	Action taken
#1 .05 CH4 20.8 O2	Part Bolted	Bolted
#2 .05 CH4 20.8 O2	Scrap cut	Finished & Bolted
#3 .10 20.8 O2	None	

Examinations for Methane in Working Places

Location	Time	Methane Content
1-3	4:10-4:35	.30
1-3	6:10-6:40	.25
1-3	8:10-8:40	.30
1-3	10:10-10:40	.30

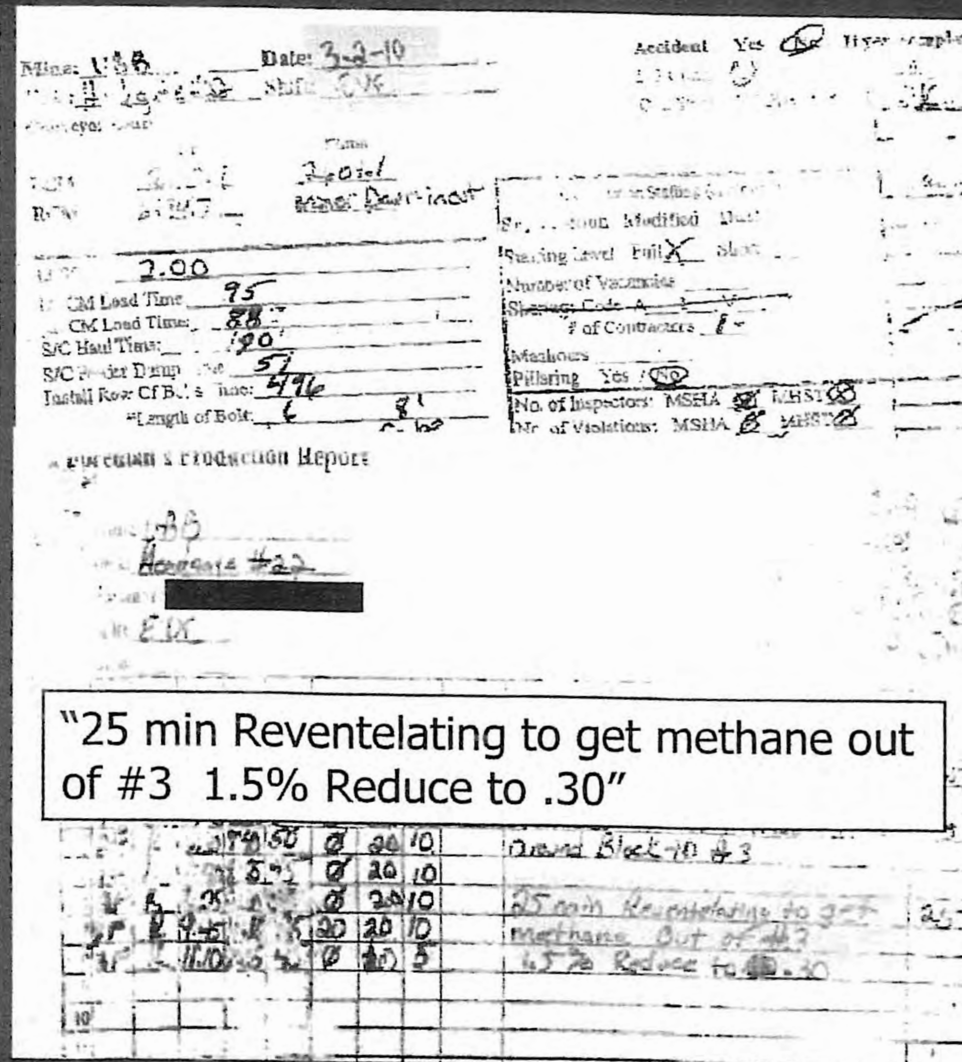
Examinations for Methane in Return Airways

Location	Time	Methane Content
Return	4:10	.25
Return	8:05	.30

Number of Bolts Tested 25
Number of Bolts Torqued Above Limits 0 Below limits 0

Remarks: Went over Plan and No. 4 Paragraph 9-10 Roof Control Plan with entire crew ... [redacted]

Production Report



Mine: UBB Date: 3-2-10
Headgate 22 Shift: EVE

Accident Yes No

2.00
CM Load Time: 95
CM Load Time: 88
S/C Haul Time: 90
S/C Feeder Dump Time: 57
Install Row Of Bolts Time: 496
Length of Bolt: 6 8'

Staffing Level Full X
Number of Vacancies
# of Contractors
Pillaring Yes / No
No. of Inspectors: MSHA Ø WVMHST Ø
No. of Violations: MSHA Ø WVMHST Ø

Foreman's Production Report

UBB
Headgate #22
[redacted]
EVE

Drivand Block-10 #3

25 min Reventelating to get methane out of #3 1.5% Reduce to .30

"25 min Reventelating to get methane out of #3 1.5% Reduce to .30"

Two Sets of Records

Onshift Report

Use Indelible Pencil or Ink — DAILY AND ONSHIFT REPORT — MINE FOREMAN OR ASSISTANT — Report to be signed when made

Date 3-1-10 Shift Eve Area or Section Longwall

Violations and other Hazardous Conditions Observed and Reported

Location	CH4	O2	Violation or Hazardous Condition	Action taken
1. Face	0%	20.8%	None Observed	None
2. Roof Supports	"	"	"	"
3. Power Center	"	"	"	"
4. Chargers	"	"	"	"
5. Track	"	"	"	"
6. Travelways	"	"	"	"
7. Barricade Station	"	"	"	"
8.				

Examinations for Methane in Working Places

Location	Time	Methane Content	Location	Time	Methane Content
1. Face	4:45 PM	0%	11.		
2.	6:45 PM	0%	12.		
3.	8:43 PM	0%	13.		
4.	10:42 PM	0%	14.		
5.	12:40 AM	0%	15.		
6.			16.		
7.			17.		
8.			18.		
9.			19.		
10.			20.		

Examinations for Methane in Return Airways

Location	Time	Methane Content	Location	Time	Methane Content
1. Return	5:50 PM	0%	6.		
2.	7:48 PM	0%	7.		
3.	9:48 PM	0%	8.		
4.	11:45 PM	0%	9.		
5.			10.		

Number of Bolts Tested ..... Number of Bolts Torqued Above Range ..... Below Range .....

If majority of bolts tested in any working place fails outside approved torque range, state what action was taken .....

Remarks (Statement as to General Conditions of Mine or Area of Mine) discussed Longwall dust + methane plan

Maintenance Report

Performance
UBB Longwall
Monday, 3/1/2010
B Crew, Shift Chief

Equipment	Job Description	Estimated Time	Comments/Initials
Face Conveyor	Utilize the brethy gauge to check the brethy trough to insure brethy will clear. If not wide enough, repair and record locations where repairs were made. _____ Hang gauge at #5 shield when complete. (On-Shift)	20 minutes	[redacted]
	Check slim line in cable handler, especially near couplings looking for fatigue do to movement, replace as needed. (On-Shift)	20 minutes	[redacted]
	Did you put ACT in manual mode on your shift _____, if so explain why. Did you put yellow handle detent valve in and set to 1500 PSI? (On-Shift)	5 minutes	
General Longwall	Check oxygen and acetylene tanks. Record the number of empty oxygen		
Shearer	Check down blade bolts, replace if more than one is missing (Pre-shift)	5 minutes	[redacted]

"Added 5 gal oil to T/E ranging arm. Had no water on either drum, cleaned several and stopped right back up, removed 8 on each end, ran like that rest of shift to try and flush drums, told 3rd shift"

Added 5 gal oil to T/E ranging Arm
Had no water on either drum, cleaned several and stopped right back up, removed 8 on each end, ran like that rest of shift to try and Flush drums, told 3rd shift

Two Sets of Records

Onshift Report

DAILY AND ONSHIFT REPORT
MINE FOREMAN OR ASSISTANT

Report shall be signed when made

Date 3-16-10 Area or Section HG22

Violations and other Hazardous Conditions Observed and Reported

	Location	Violation or Hazardous Condition	Action taken
1.	1		
2.	2		
3.	2nd		
4.	3		

Examinations for Methane in Working Places

	Location	Time	Methane Content
1.	1-3	7:50	.20
2.		9:00	
3.	1-3	9:50	.20
4.		11:00	
5.	1-3	11:50	.20
6.		1:00	
7.	1-3	1:50	.20

Examinations for Methane in Return Aircourses

	Location	Time	Methane Content
1.		8:00	.20
3.		12:00	.20

Number of Bolts Tested 12
Number of Bolts Torqued Above Range 0 Below Range 0

If majority of bolts tested in any working place falls outside approved torque range, state what action was taken

Remarks (Statement as to General Conditions of Mine or Area of Mine)

[redacted]

Production Report

32 BX

Massey Energy Production Report

Mine: UBB (for all 4 sections)
Section: HG22 Crew: A
Foreman: [redacted]
Shift: Day
Date: 3-16-10

Below Times in Minutes		
Portal to:	60	Min.
On Coal:	80	Min.
Portal Out	60	Min.

(On Coal = Total Time It Takes To Start Up Production)

Depart Portal:
Arrive on Section:
Start Loading:
Depart Section:
Arrive Outside:

#	Place	L or R CM	Time In	Time Out	Total Time	Move Time	Cut Depth	# of SC's	Quality Issue	Delay's and Remarks
1	2	L	8:42	9:30	48	2	18	10		
2		L	11:51	12:27	36	7	10	6	16	
3		L		2:45	37	10	15	7	23	
4		L								
5		L								
6		L								
7		L								
8		L								
9		L								
10		L								
11		L								
12		L								

"Low Air in LOB. Doors outby going to HG22 Tail open 7:00-8:10…Adverse Roof condition their coal streak four ?5' up. Falling out to it in #1 2."

Mine Citation/Order

U.S. Department of Labor
Mine Safety and Health Administration

Section I--Violation Data

1. Date (Mo Da Yr)	2. Time (24 Hr. Clock)		3. Citation/ Order Number
08/25/2010	1600		8226817

4. Served To	5. Operator
Wayne Persinger	PERFORMANCE COAL COMPANY

6. Mine	7. Mine ID
UPPER BIG BRANCH MINE-SOUTH	46-08436 (Contractor)

8. Condition or Practice — 8a. Written Notice (103g) ☐

Ventilation of the LBB Mains, LBB Submains and 2nd Right Submains is not being maintained in accordance with the approved ventilation map. The air direction for the worked out areas of LBB Submains and 2nd Right Submains were observed to be flowing in the opposite direction of the approved map. The intake and return air courses of the LBB Mains were observed to be flowing in the opposite direction from the approved plan. In addition, the return air that ventilates the worked out areas of the 2nd Right Submains and LBB Submains is being ventilated across the idled construction mining equipment at the mouth of LBB Mains on the Ellis Portal Mains side.

See Continuation Form (MSHA Form 7000-3a) ☐

9. Violation	A. Health ☐ Safety ☑ Other ☐	B. Section of Act	C. Part/Section of Title 30 CFR
			75.370(a)(1)

Section II--Inspector's Evaluation

10. Gravity:

A. Injury or Illness (has) (is): No Likelihood ☐ Unlikely ☐ Reasonably Likely ☑ Highly Likely ☐ Occurred ☐

B. Injury or illness could reasonably be expected to be: No Lost Workdays ☐ Lost Workdays Or Restricted Duty ☐ Permanently Disabling ☐ Fatal ☑

C. Significant and Substantial: Yes ☑ No ☐ — D. Number of Persons Affected: 001

11. Negligence (check one) A. None ☐ B. Low ☐ C. Moderate ☑ D. High ☐ E. Reckless Disregard ☐

12. Type of Action: 104(a) — 13. Type of Issuance (check one) Citation ☑ Order ☐ Safeguard ☐ Written Notice ☐

14. Initial Action: A. Citation ☐ B. Order ☐ C. Safeguard ☐ D. Written Notice ☐ — E. Citation/ Order Number — F. Dated (Mo Da Yr)

15. Area or Equipment

16. Termination Due	A. Date (Mo Da Yr)	B. Time (24 Hr. Clock)	
	09/01/2010	0800	

Section III--Termination Action

17. Action to Terminate

18. Terminated	A. Date (Mo Da Yr)	B. Time (24 Hr. Clock	

Section IV--Automated System Data

19. Type of Inspection (activity code)	20. Event Number	21. Primary or Mill	
E01	4197236		

22. Signature — 23. AR Number: 24211

Mine Citation/Order Continuation

U.S. Department of Labor
Mine Safety and Health Administration

Section I--Subsequent Action/Continuation Data

1. Subsequent Action 1a. Continuation	2. Dated (Original Issue) Mo Da Yr	3. Citation/ Order Number
✔	08/25/2010	8226817 - 01

4. Served To	5. Operator
WAYNE PERSINGER, SUPERINTENDENT	PERFORMANCE COAL COMPANY
6. Mine	**7. Mine ID** (Contractor)
UPPER BIG BRANCH MINE-SOUTH	46-08436

Section II--Justification for Action

An effort has been made, however more time is needed before abatement can be made.

See Continuation Form ☐

Section III--Subsequent Action Taken

8. Extended To	A. Date Mo Da Yr	B. Time (24 Hr. Clock)	C. Vacated	D. Terminated	E. Modified
	10/07/2010	0700	☐	☐	☐

Section IV--Inspection Data

9. Type of Inspection	10. Event Number
E01	4197236

11. Signature	AR Number	12. Date Mo Da Yr	13. Time (24 Hr. Clock)
Kenneth [illegible]	24136	09/22/2010	1225

MSHA Form 7000-3a, Mar 85 (revised)

Mine Citation/Order Continuation

U.S. Department of Labor
Mine Safety and Health Administration

Section I--Subsequent Action/Continuation Data

1. Subsequent Action 1a. Continuation	2. Dated (Original Issue) Mo Da Yr	3. Citation/ Order Number
✔	08/25/2010	8226817 - 02

4. Served To	5. Operator
WAYNE PERSINGER, SUPERINTENDENT	PERFORMANCE COAL COMPANY
6. Mine	**7. Mine ID** (Contractor)
UPPER BIG BRANCH MINE-SOUTH	46-08436

Section II--Justification for Action

An effort has been made however, more time is needed before an abatement can be made.

See Continuation Form ☐

Section III--Subsequent Action Taken

8. Extended To	A. Date Mo Da Yr	B. Time (24 Hr. Clock)	C. Vacated	D. Terminated	E. Modified
	10/25/2010	0700	☐	☐	☐

Section IV--Inspection Data

9. Type of Inspection	10. Event Number
E01	4197239

11. Signature	AR Number	12. Date Mo Da Yr	13. Time (24 Hr. Clock)
Kenneth [illegible]	24136	10/14/2010	0950

MSHA Form 7000-3a, Mar 85 (revised)

Mine Citation/Order Continuation

U.S. Department of Labor
Mine Safety and Health Administration

Section I--Subsequent Action/Continuation Data

1. Subsequent Action 1a. Continuation	2. Dated (Original Issue) Mo Da Yr	3. Citation/ Order Number
✔	08/25/2010	8226817 - 03

4. Served To	5. Operator
WAYNE PERSINGER, MINE MANAGER	PERFORMANCE COAL COMPANY
6. Mine	**7. Mine ID** (Contractor)
UPPER BIG BRANCH MINE-SOUTH	46-08436

Section II--Justification for Action

AN EFFORT IS BEING MADE HOWEVER, MORE TIME IS NEEDED BEFORE ABATEMENT CAN BE MADE.

CAREFUL CONSIDERATION WILL BE GIVEN BEFORE FUTURE EXTENSIONS OF THIS CITATION ARE GIVEN. THE OPERATOR IS REMINDED THAT THIS EXTENSION IS BEING GRANTED BASED HIM USING ALL OF THE AVAILABLE RECOURSES.

See Continuation Form

Section III--Subsequent Action Taken

8. Extended To	A. Date Mo Da Yr	B. Time (24 Hr. Clock)	C. Vacated	D. Terminated	E. Modified
	11/29/2010	0700			

Section IV--Inspection Data

9. Type of Inspection	10. Event Number
E01	4197239

11. Signature	AR Number	12. Date Mo Da Yr	13. Time (24 Hr. Clock)
Kenneth Fleming	24136	11/17/2010	1030

line Citation/Order

U.S. Department of Labor
Mine Safety and Health Administration

ection I--Violation Data

Date Mo Da Yr	2. Time (24 Hr. Clock)		3. Citation/ Order Number
04/29/2011	1000		8124683

J To	5. Operator
Vayne Persinger, supt.	PERFORMANCE COAL COMPANY

. Mine	7. Mine ID	
JPPER BIG BRANCH MINE-SOUTH	46-08436	(Contractor)

. Condition or Practice — 8a. Written Notice (103g)

The operator is failing to make a weekly examination for hazardous conditions .n the intake split from spad 5724 to spad 5594, including the 3 unconnected :hirty feet deep rooms driven off the main entries and ventilated with line :urtain. The mine superintendent, Wayne Persinger, has engaged in aggravated :onduct by failing to ensure that this area of the mine was examined. This /iolation is unwarrantable failure to comply with a mandatory standard.

See Continuation Form (MSHA Form 7000-3a) ✔

). Violation	A. Health Safety ✔ Other	B. Section of Act	C. Part/Section of Title 30 CFR
			75.364(b)(1)

Section II--Inspector's Evaluation

10. Gravity:

A. Injury or Illness (has) (is): No Likelihood ☐ Unlikely ☐ Reasonably Likely ☐ Highly Likely ✔ Occurred ☐

ıry or illness could rea- ıably be expected to be: No Lost Workdays ☐ Lost Workdays Or Restricted Duty ☐ Permanently Disabling ☐ Fatal ✔

C. Significant and Substantial: Yes ✔ No ☐ — D. Number of Persons Affected: 001

11. Negligence (check one) A. None ☐ B. Low ☐ C. Moderate ☐ D. High ☐ E. Reckless Disregard ✔

12. Type of Action 104(d)(2) — 13. Type of Issuance (check one) Citation ☐ Order ✔ Safeguard ☐ Written Notice ☐

14. Initial Action A. Citation ☐ B. Order ✔ C. Safeguard ☐ D. Written Notice ☐ — E. Citation/ Order Number 8082692 — F. Dated Mo Da Yr 03/17/2009

15. Area or Equipment The entries encompassed in the intake split from spad 5724 to spad 5594.

16. Termination Due	A. Date Mo Da Yr	B. Time (24 Hr. Clock)	

Section III--Termination Action

17. Action to Terminate The area has been examined by a weekly examiner and a clear route of travel marked through the area. Management has been informed of the need fro examination of this area, and they have assigned a this area

18. Terminated	A. Date Mo Da Yr	B. Time (24 Hr. Clock	
	04/29/2011	1055	

Section IV--Automated System Data

19. Type of Inspection (activity code)	20. Event Number	21. Primary or Mill	
E01	6287991		

22. Signature William H. Bane — 23. AR Number 24308

M .rm 7000-3, Apr 08 (revised) In accordance with the provisions of the Small Business Regulatory Enforcement Fairness Act of 1996, the Small Business Administration has established a National Small Business and Agriculture Regulatory Ombudsman and 10 Regional Fairness Boards to receive comments from small businesses about federal agency enforcement actions. The Ombudsman annually evaluates enforcement activities and rates each agency's responsiveness to small business. If you wish to comment on the enforcement actions of MSHA, you may call 1-888-REG-FAIR (1-888-734-3247), *or write the Ombudsman at Small* Business Administration, Office of the National Ombudsman, 409 3rd Street, SW MC 2120, Washington, DC 20416. Please note, however, that your right to file a comment with the Ombudsman is in addition to any other rights you may have, including the right to contest citations and proposed penalties and obtain a hearing before the Federal Mine Safety and Health Review Commission.

Mine Citation/Order Continuation

U.S. Department of Labor
Mine Safety and Health Administration

Section I--Subsequent Action/Continuation Data

1. Subsequent Action 1a. Continuation	2. Dated (Original Issue) Mo Da Yr	3. Citation/ Order Number
✔	04/29/2011	8124683

4. Issued To	5. Operator
Wayne Persinger, supt.	PERFORMANCE COAL COMPANY
6. Mine	**7. Mine ID** (Contractor)
UPPER BIG BRANCH MINE-SOUTH	46-08436

Section II--Justification for Action

Continuation of 17. Action to Terminate

to a weekly examiner.

See Continuation Form

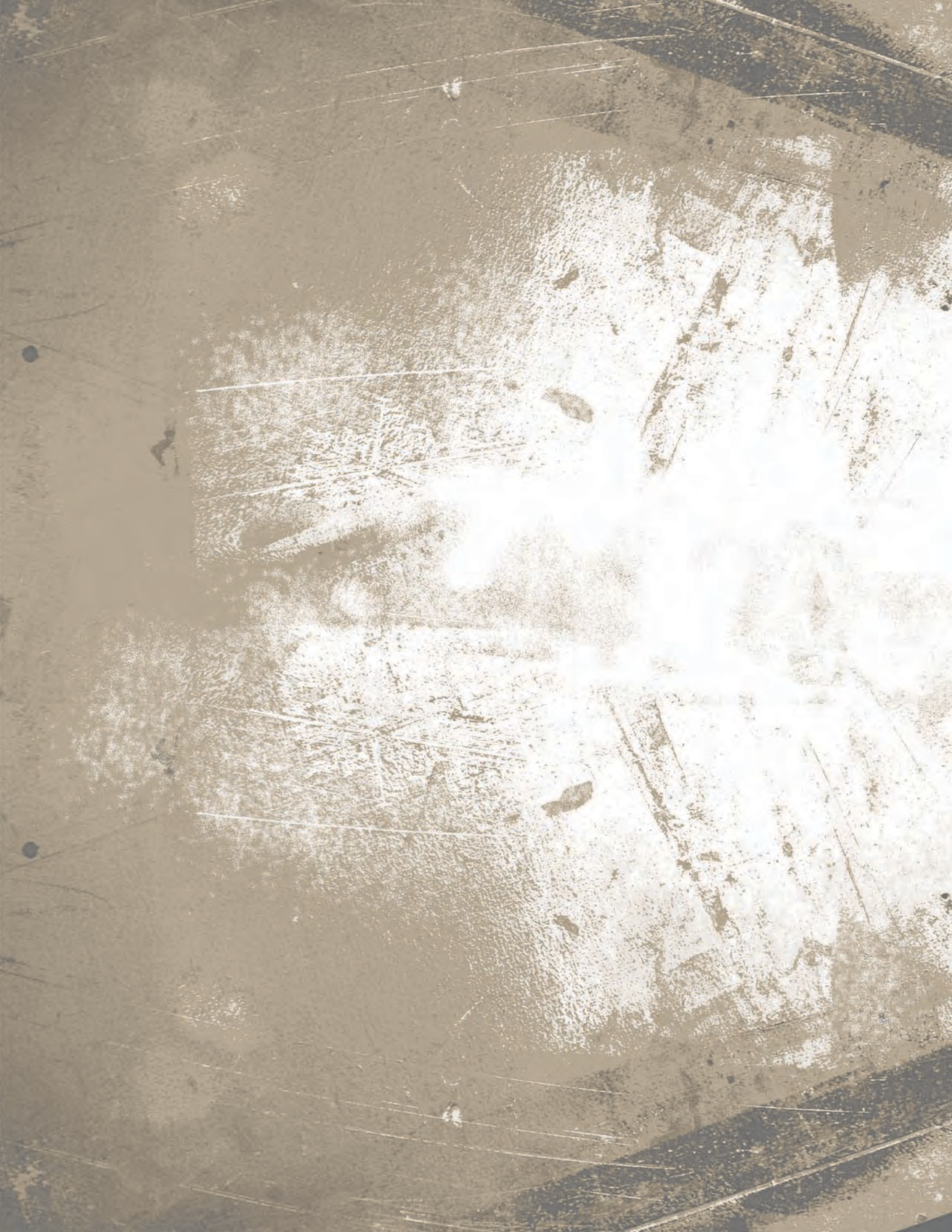
Section III--Subsequent Action Taken

8. Extended To	A. Date Mo Da Yr	B. Time (24 Hr. Clock)	C. Vacated	D. Terminated	E. Modified

Section IV--Inspection Data

9. Type of Inspection	10. Event Number
E01	6287991

11. Signature	AR Number	12. Date Mo Da Yr	13. Time (24 Hr. Clock)
William H. Bane	24308	04/29/2011	1000



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