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MSHA
U.S. Dept of Labor

June 23,2003

Mr. Marvin W. Nichols, Director
MSHA Office of Standards, Regulations and Variances
1100 Wilson Boulevard, Room 2313
Arlington, VA 22209-3939

Re: Post "Belt-Air" Hearing Comments—Underground Coal Mine Ventilation—Safety Standards For The Use Of A Belt Entry As An Intake Air Course To Ventilate Working Sections And Areas Where Mechanized Mining Equipment **Is** Being Installed Or Removed

Dear Mr. Nichols:

At the public hearings, Mr. Marvin w. Nichols, the Director of the Office of Standards Regulations And Variances, asked several serious questions such **as:** "Can anyone give us an example of a major problem using belt air?" and "Give me an example of anyone ever being harmed by the use of belt air to ventilate working faces?"

The answer is an emphatic***yes.***

Thirteen miners were killed by the explosions that occurred in Jim Walter Resources Number 5 Mine in Brookwood, Alabama, on September 23, 2001. This was at least partly a result of JWR being able to use belt air to ventilate the working faces at the mine under a Petition to Modify Safety Standard 30CFR75.326 issued June 9, 1980. This Petition to Modify Ventilation Safety Standards was approved when JWR No.5 was using a six-entry room and pillar mining system. JWR has subsequently used this variance in the ventilation safety standards to reduce the number of mine entries to four, using the track entry and the belt entry as the primary intake air courses and the two outside entries as returns. During the intervening twenty-one years, there is no indication that the approved Petition for Modification to use belt air to ventilate working faces was ever reviewed or questioned by either JWR or MSHA during the mandatory six-month reviews of the ventilation plans. Rather, the Petition for Modification to use belt air was routinely carried forward in the approved mine ventilation plans, even though the layout of the current mining system resembles in no way the mining system layout being used when the petition for modification was proposed by JWR and approved by MSHA on June 9,1980. (See the old development works portion of mine map near the shaft bottom vs. current developmental sections in the Appendix H—Mine Map contained in the MSHA report of investigation of fatal underground coal mine explosions, September 23, 2001, Jim Walter Mine No.5, ID No. 01-01322; dated Dec 11,2002.)

A. roof fall on Sunday afternoon, September 23, 2001, in entry number two, blocked ventilation to the face area of four section, resulting in a buildup of methane gas and the resulting fatal explosions. If the belt entry had remained a neutral split, as originally

intended by the 1977 Mine Safety Act, there would have been at least one or two more intake air courses on four section on Sept 23,2001 and there would not have been a build-up of methane gas resulting in the explosions on four section as a result of the rock fall blocking the number two intake entry.

Of more serious concern, the use of the belt air to ventilate the working faces of four section led to the buildup and accumulation of explosive coal dust and float coal dust in the number three belt air intake entry and number four return entry air courses that created the conditions for the massive dust explosions that were triggered by the methane gas explosions, and resulted in the death of thirteen miners and numerous injuries to other miners.

In addition, the AMS warning system did not work to protect the miners at the number five mine as is assumed to be the case in the proposed belt air regulations. The AMS system has several obvious fatal flaws. The AMS system sensors and components are not 100% reliable and cannot be depended upon to indicate what is actually happening in the mine. The repeated failure of sensors at the number five mine created a cavalier attitude that any alarm was just another sensor malfunction that should be checked on later when a mine electrician could be dispatched to the site, sometimes hours later! Thus, when three sensors actually indicated a serious problem in four section on the afternoon of September 23,2001, no one took it seriously, resulting in the delayed evacuation of the mine and the unnecessary deaths of thirteen miners.

Also, the proposed rules do not address the fact that current mine communication systems do not reach all of the miners all of the time, as assumed in the proposed belt air regulations. Thus there will always be miners who may not be contacted in case of an emergency created by the use of belt air to ventilate an active working mine. The proposed rules assume human infallibility by placing the safety of an entire mine in the hands of one man at an AMS monitor, which obviously failed the miners working at the number five mine on September, 23,2001. Common sense would dictate that AMS monitoring sites and alarms be placed at a minimum of three surface sites and two sites underground within earshot of mine managers, mine foremen and miners working in the mine.

Common sense would also dictate the implementation of rules and regulations to require the design and operation of mine ventilation systems with redundant safety features to protect the lives of the miners in all circumstances. These rules are based on the false assumption that computerized monitoring systems operate perfectly all the time and that all mine owners, operators, managers and foremen are diligently on duty twenty-four hours a day, which is not the case as painfully demonstrated at the number five mine on September 23,2001.

The sad fact is that the same belt air mine ventilation system that created the hazardous conditions that caused the disastrous gas and dust explosions in the number five mine still exists today. Serious questions still remain concerning the failure of the team of MSHA

investigators to address the continued use of the outdated belt air petition at the number five mine that created the conditions for the September 23, 2001 disaster.

Sincerely,

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