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May 18, 2011

Office of Standards, Regulations and Variances  
1100 Wilson Boulevard, Room 2350  
Arlington, VA 22209-3939

RE: RIN 1219 – AB64

Dear Sir/Madam:

Please find enclosed comments I am submitting to the U.S. Department of Labor's Mine Safety and Health Administration (MSHA) concerning proposed regulatory changes which attempt to comprehensively lower miner's exposure to coal mine dust and prevent Black Lung Disease.

If you have any questions about this please call me.

Sincerely,



Stephen A. Sanders  
Attorney at Law

Enclosure

2011 MAY 23 P 2:46

**COMMENT ON MSHA’S PROPOSED RULE TO LOWER  
MINERS’ EXPOSURE TO RESPIRABLE COAL MINE DUST**

**RIN 1219 – AB64**

Black lung kills. This terrible fact was the basis for the requirement in the 1969 Coal Mine Act requiring that the concentration of respirable dust in the mine atmosphere during each shift to which each miner in the active workings is exposed be at “a level of personal exposure which will prevent new incidences of respiratory disease and the further development of such disease in any person.” 30 U.S.C. § 842(d). MSHA’s proposed regulation is a serious attempt to comply with the Act’s directive. The proposed regulations should be adopted.

The Act was response to the tragic disability and early deaths of miners who had developed crippling lung disease. Miners could not protect themselves from the insidious harm caused by the minute particles of respirable dust they were exposed to as they worked, and history had shown that the coal mining industry would not adopt a sufficiently protective dust standard on its own.

Coal Workers Pneumoconiosis [CWP] is caused by the inhalation of minute dust particles and the subsequent formation of macules and nodules, with scarring and destruction of the lung tissue. In some individuals CWP results in large areas of destroyed lung tissue which is called progressive massive fibrosis. CWP is an irreversible and progressive lung disease.

Miners may also develop chronic obstructive pulmonary disease [COPD] due to coal mine dust exposure. COPD causes irritation and damage to the airways and it may cause emphysema, even where there is no x-ray evidence of nodule formation indicative of CWP. Both coal workers’ pneumoconiosis and COPD due to coal mine dust exposure are commonly called black lung. Black lung causes severe shortness of breath and sensations of smothering.

Under the Mine Act the Secretary of Labor, through the Mine Safety and Health Administration (MSHA), must promulgate standards to assure that miners won’t suffer a material impairment of health even if exposed to a hazard their whole working life. The purpose of the law is “to provide, to the greatest extent possible, that working conditions in each underground mine are sufficiently free of respirable coal mine dust concentrations in the mine atmosphere to permit a miner to work underground during his entire working life without incurring any disability from pneumoconiosis or other occupation-related disease.” 30 USC 841(b). In the 1969 Coal Mine Act and in the 1977 Federal Mine Safety Act Congress stated that the first priority of the coal industry must be the health and safety of the coal miner. Congress created MSHA to protect miners’ health and safety.

To protect miners from Black Lung, the Mine Act created a scheme requiring MSHA to reduce the level of respirable dust so that miners did not develop pneumoconiosis. The Mine Act requires the Secretary to “set standards which most adequately assure on the basis of the best available evidence that no miner will suffer material impairment of health or functional capacity even if such miner has regular exposure to the hazards dealt with by such standard for the period of his working life.” 30 U.S.C. § 811(a)(6).

For many years the dust standard was 2.0 mg/m<sup>3</sup>. Extensive medical research has shown that this standard is not adequate to protect the respiratory system and the health of coal miners. The National Institute of Occupational Safety and Health [NIOSH], issued a Criteria Document in 1995, established this level should be 1.0 mg/m<sup>3</sup>, average concentration for up to 10 hours per day during a 40-hour workweek. Moreover, NIOSH recommended that MSHA use single, full-shift samples to determine compliance with the exposure limit and that no upward adjustment in the limit be made to account for measurement uncertainties.

In 1999 MSHA stated in the Federal Register: “Respirable coal mine dust is one of the most serious occupational hazards in the mining industry. Long-term exposure to excessive levels of respirable coal mine dust can cause black lung and silicosis, which are both potentially disabling and can cause death.” (64 FR 21519-01, 1999 WL 543989 (F.R.) UNIFIED AGENDA, April 26, 1999, OCCUPATIONAL EXPOSURE TO COAL MINE DUST (LOWERING EXPOSURE LIMIT)). While MSHA recognized the hazard, it did not act to reduce the level of respirable dust.

The uncontroverted evidence establishes that there is an unacceptable risk of black lung posed by the current respirable dust standards. NIOSH regularly reviews x-rays to determine whether miners have CWP. In the past 5 years, NIOSH reports show that miners have developed CWP at a greater rate than was previously believed true. NIOSH reported that a study in 2006 of 85 working coal miners in Letcher County, Kentucky found 12% had x-ray evidence of CWP; 1% had PMF; 7% had chronic bronchitis and 5% had emphysema. A study of 68 miners in neighboring Knott County, Kentucky found 15% had x-ray evidence of CWP; 1% had PMF; 9% had chronic bronchitis and 7% had emphysema. In September 2007, Dr. Lee Petsonk, who worked on the NIOSH study, reported that the rate of CWP had more than doubled among miners who worked 25 years or more underground, from about 4 percent in 1997 to 9 percent in 2006. The rate among miners with 20 to 24 years' experience jumped even more, from 2.5 percent to 6 percent. This data shows that MSHA needs to reduce the level of exposure to respirable dust to protect miners from lung disease.

Using claims data through the end of 2009, a review of claims for black lung benefits filed with the Division of Coal Mine Workers' Compensation (DCMWC) since its revised regulations went into effect in January 2001 confirms that the number of cases of Progressive Massive Fibrosis among miners too young to have been in the mines prior to passage of the Federal coal mine health and safety legislation in late December 1969 has continued to increase. Of the 610 claims in which the most recent decision reflects the presence of PMF nearly one-third or 199 of those claims involve miners born in 1952 or later.

The traditional view that PMF was primarily a disease of anthracite miners in northeast Pennsylvania and rarely seen in bituminous miners elsewhere in the United States is not supported by the DCMWC data. The table below reflects that the PMF cases are now overwhelmingly concentrated in southern Appalachia (southern West Virginia, southwestern Virginia, eastern Kentucky and Tennessee). As one would expect, most of the younger miner PMF cases (129 of the 199) involve miners born in the five years 1952 through 1956 who entered the workforce when the newly enacted Federal dust control standards were being phased

in during the first half of the 1970s. Despite the implementation of that legislation which was intended to make it possible to work a lifetime in the coal mines without contracting a disabling respiratory disease, another 70 miners born between 1957 and 1966 have also been found to have contracted PMF.

The chart below lists the five states where miners with PMF last worked in the coal mining industry. The first number is the total number of PMF cases which arose in that state. The second number in parentheses is the number of PMF cases involving miners born in 1952 or later. The percentage figure reflects the percentage of PMF cases which involved those younger miners.

West Virginia	232	(60)	25.9%
Kentucky	178	(85)	47.8%
Virginia	107	(42)	39.3%
Pennsylvania	40	(4)	10.0%
Tennessee	17	(5)	29.4%
<u>Subtotal</u>	<u>574</u>	<u>(196)</u>	<u>34.1%</u>
<u>National Total</u>	<u>610</u>	<u>(199)</u>	<u>32.6%</u>

According to a recent NIOSH study published by the American Thoracic Society's American Journal of Respiratory and Critical Care Medicine, emphysema severity was significantly elevated in coal miners compared to non-miners,. Lead author and senior NIOSH scientist Eileen Kuempel said: *Based on our findings, exposure to respirable coal mine dust for a full working lifetime at the current 2 mg/m<sup>3</sup> standard would increase the emphysema severity index by 99 points on average. This provides additional evidence of the need to reduce dust exposures to 1 mg/m<sup>3</sup> or less as NIOSH has recommended.*

The method of measuring dust has long been a source of concern. Do the measurements accurately reflect the working environment where the miner works, or are the measurements made only when the level of production is low and the environmental controls are in full compliance? Using the Continuous Personal Dust Monitor will enable the miner to be sure that he is not exposed to excessive amounts of harmful dust; and the data can be reviewed by safety officials to ensure that dust levels throughout the whole shift are maintained at or below the legal limits.

More must be done to protect miners from black lung disease. MSHA's proposed rule is needed badly. Too many miners are still working in too much dust and getting black lung. The proposed integrated regulatory approach is a strategy with the potential to end black lung disease.

We recommend that MSHA also make individual miners part of the solution by empowering them to fight black lung. MSHA should mandate that all miners be fully educated on the harm caused by exposure to respirable dust. This education should be a part of the initial miner training and a part of annual retraining. Miners should be strongly encouraged to use the information provided by the CPDM to protect themselves and other miners. They should be encouraged to have x-rays made regularly and to transfer to a job in a less dusty place if the x-ray shows that they are developing CWP. The training should emphasize that miners have rights under Section 105(c) to be free from discrimination or harassment for insisting on their a work place that controls dust as required by law

MSHA should act as speedily as possible. MSHA needs to prevent young miners from getting black lung. These young miners think that black lung will not be a problem for them. They do not realize the danger working in coal mine dust. The harm from the dust is invisible and the disease progresses slowly. It gradually causes harm to the lungs and respiratory system. After the miner stops work and exposure to coal mine dust ends, black lung continues to cause injury and eventually it causes the miner to experience constant shortness of breath and not be able to climb a flight of stairs or walk a short distance on level ground. The cost to the individual miner and his family is heartbreaking agony.

The cost to society for medical care for the sick miner and compensation benefits for the miner and his family is staggering. In Fiscal Year 2010 the cost of the benefits paid to miners and widows through the Federal Black Lung Benefits Program exceeded \$450 million.

We encourage MSHA to proceed as quickly as possible to finalize the proposed regulations. These comments are submitted by Scott Howard of Roxana Kentucky, 41848 and Stephen A. Sanders.

  
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