

UNITED STATES  
DEPARTMENT OF LABOR  
MINE SAFETY AND HEALTH ADMINISTRATION

REPORT OF INVESTIGATION

Underground  
(Coal)

Fatal Powered Haulage Accident  
December 18, 2025

Lower War Eagle  
Greenbrier Minerals, LLC  
Cyclone, Wyoming Conty, West Virginia  
Mine ID: 46-09319

Accident Investigators

James Grimmer  
Mine Safety and Health Specialist

Greggory Ward  
Supervisory Mine Safety and Health Specialist

Originating Office  
Mine Safety and Health Administration  
Pineville District  
4499 Appalachian Highway  
Pineville, WV 24874  
Larry Bailey, Acting District Manager

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## OVERVIEW

On December 18, 2025, at 7:27 a.m., Robert White, a 63-year-old outby foreman with 41 years of mining experience, died after he was pinned between a tractor and the steel arch support wall.

The accident occurred because the mine operator did not: 1) develop written policies and procedures addressing foot traffic and mobile equipment on the slope; and 2) properly maintain the supply tractor in safe operating condition.

## GENERAL INFORMATION

Greenbrier Minerals, LLC owns and operates Lower War Eagle, an underground bituminous coal mine located in Cyclone, Wyoming County, West Virginia. Lower War Eagle employs 160 miners, operating two 9-hour production shifts and one maintenance shift 5 days per week. Lower War Eagle uses the room and pillar mining method on three super sections totaling six mechanized mining units. Coal is extracted from the face with the continuous mining machines and hauled to the coal feeder then transported to the surface stockpile via conveyor belt.

The principal management officials at Lower War Eagle at the time of the accident were:

Alex Stewart  
Jackie Ellison  
Allen Lardieri

Mine Superintendent  
General Mine Foreman  
Safety Supervisor/Emergency Medical Technician

The Mine Safety and Health Administration (MSHA) completed the last regular safety and health inspection at this mine on September 22, 2025. A regular safety and health inspection was ongoing at the time of the accident; however, no MSHA personnel were on site at the time of the accident. The 2024 non-fatal days lost incident rate for Lower War Eagle was 1.88, compared to the national average of 3.03 for mines of this type.

#### DESCRIPTION OF THE ACCIDENT

On December 18, 2025, at approximately 6:15 a.m. during the foreman meeting, Harry Catron, shift foreman, instructed White to load a supply car outside for Andrew Mullins, supply man, to take to the No. 3 section. At 6:30 a.m., after the foreman meeting, White attended the safety meeting with the day shift crew. After the safety meeting, White met with Mullins and informed him the supplies were being loaded. Mullins disconnected the No. 168 supply tractor (tractor) from the battery charger and connected the flat supply car to the front of the tractor. Once the supplies were loaded, White told Mullins he would throw the track de-rail on the surface and walk down to the second shelter hole.

At approximately 7:20 a.m., Mullins called Terry Grimmert, dispatcher, to request the slope right of way. After T. Grimmert acknowledged and granted the right of way, Mullins proceeded down the slope in the tractor. While traveling down the slope, Mullins stated that the tractor's right front tire hit a hole in the slope roadway. Mullins lost his hard hat and inadvertently struck the panic bar, which de-energized the tractor and fully applied the brakes. The tractor began to slide towards the steel arch support wall.

White exited the shelter hole as the tractor was sliding toward the wall. The tractor pinned White between the operator's deck of the tractor and the steel arch support wall. Mullins immediately re-energized the tractor by resetting the breaker, reversed the tractor, and freed White. Mullins called for help on the mine radio as he crossed over the tractor to assess White, who was unresponsive. T. Grimmert heard the call for help over the radio and de-energized the slope conveyor belt. Kenneth Trent, supply clerk, overheard Mullins on the radio and called 911 at 7:23 a.m.

Ryan Altizer, third shift chief electrician, had just walked into the mine office when he heard Mullins on the radio calling for help. Altizer ran to the slope and saw Mullins with White. Altizer began cardiopulmonary resuscitation (CPR). Allen Lardieri, safety supervisor/emergency medical technician, and Andy Runyon, outby foreman, arrived at the accident scene with an automated external defibrillator (AED). Lardieri placed the AED on White, but it did not advise a shock. Lardieri and Altizer placed White on a backboard. Daniel Bowen, section foreman, heard miners on the radio calling for help and traveled to the slope where he assisted Lardieri and

Altizer in carrying White to the top of the slope. The miners performed CPR until the ambulance arrived.

At 7:51 a.m., Logan Emergency Ambulance Service Authority (LEASA) arrived at the mine and began assessment of White. LEASA paramedics continued CPR as they transported White to Logan Regional Medical Center, where Krishna Potluri, MD, pronounced White dead at 8:42 a.m.

## INVESTIGATION OF THE ACCIDENT

On December 18, 2025, at 7:39 a.m., Aaron Price, director of safety, called the Department of Labor National Contact Center (DOLNCC). The DOLNCC notified Amanda Cline, office assistant. Cline notified Tracy Calloway, staff assistant, who notified Nicholas Christian, supervisory mine safety and health inspector. Christian sent James Grimmnett, mine safety and health specialist, to the mine and assigned him as the lead investigator. Christian also sent Barry Sullivan, mine safety and health inspector, and Gregg Ward, supervisory mine safety and health specialist, to the mine. Christian notified Derek Kiblinger, supervisory mine safety and health specialist, who sent Cody Palmer, mine safety and health specialist, to assist in the investigation.

At 8:40 a.m., J. Grimmnett, Christian, Sullivan, and Ward arrived at the mine. J. Grimmnett issued an order under the provisions of Section 103(k) of the Mine Act to ensure the safety of the miners and preservation of evidence. At 9:40 a.m., Palmer arrived at the mine.

The MSHA accident investigation team, in conjunction with the West Virginia Office of Miners' Health Safety and Training, conducted an examination of the accident scene, interviewed miners and mine management, and reviewed conditions and work procedures relevant to the accident. Refer to Appendix A for a list of persons who participated in the investigation.

## DISCUSSION

### Location of the Accident

The accident occurred on the production slope near the second shelter hole, 177 feet from top of the slope (Appendices B and C). The slope entry was approximately 25 feet wide with a maximum grade of 8.7 degrees and an overall grade of 8.1 degrees. Investigators evaluated the concrete floor of the slope and determined that it was adequately maintained.

### Equipment Involved

The tractor involved in the accident was a Fairchild Model 35C-WH2-30-AC, powered by a General Electric 128-Volt battery, company number 168 GE Fairchild. The tractor had rubber tires and was towing a flat, rail-mounted supply car loaded with approximately 19,300 pounds of supplies.

Investigators conducted functional tests of the tractor, including the panic bar system, braking system, steering functions, and lights, and found no defects. Investigators conducted a visual examination of the tractor and found that three of the four tires had excessive tread wear which adversely affected the operator's ability to maintain control of the equipment (Appendix D).

During the investigation, multiple tire manufacturer representatives stated there is no out-of-service criterion for tread depth on mine equipment tires due to the various conditions in which mine tires are used. The manufacturer states the tire's traction and stopping capabilities are greatly diminished when they have worn down to 4/32 (1/8) inches. The service life of the tires is left to the discretion of the user.

After the mine operator replaced the tractor's tires, investigators performed a functional test. During the accident, the tractor skidded approximately 30 feet after de-energization. With the new tires and the same load on the slope, the tractor skidded only 6 feet. Investigators determined that both the condition of the tires and the absence of a policy to determine when tire wear had become unsafe contributed to the accident.

#### Track Haulage Procedures

The mine operator did not have policies or procedures to address foot traffic and mobile equipment on the slope. Investigators determined this contributed to the accident.

#### Examinations

Donald Noe, electrician, conducted the last weekly electrical examination of the tractor on December 9, 2025 and did not record any defects. Ben Wheatley, foreman, conducted the pre-shift examination of the slope belt conveyor and track on the third shift of December 18, 2025, for the oncoming day shift, and did not record any hazards. Investigators determined these examinations were adequate and did not contribute to the accident.

#### Training and Experience

White had 41 years of mining experience, with over 10 years at Lower War Eagle and 3 years as an outby foreman. Mullins had 21 years total mining experience including 14 months as a tractor operator at Lower War Eagle. Both White and Mullins received annual refresher training on January 25, 2025. Investigators determined White and Mullins received all training in accordance with MSHA Part 48 training regulations.

### ROOT CAUSE ANALYSIS

The accident investigation team conducted an analysis to identify the underlying causes of the accident. The accident investigation team identified the following root cause, and the mine operator implemented the corresponding corrective action to prevent a recurrence.

1. Root Cause: The mine operator did not have policies or procedures to address foot traffic and mobile equipment on the slope.

Corrective Action: The mine operator developed and implemented a Track Haulage Action Plan that contains the following provisions:

- A. Indicator lights have been installed at the top and bottom of the slope to indicate when miners are on the slope. The lights work by turning red when someone is on the slope, either on foot or on a piece of mobile equipment. If two people request slope travel at the same time, an amber light confirms which miner has the right of way to

- travel the slope. When the lights are red, no one will be permitted to enter the slope until the previous miner is clear of the slope, and the light has reset to green. The miner will continue to communicate with the dispatcher when traveling up and down the slope and once they have reached the opposite end.
- B. If the light system becomes inoperable, no rubber-tired equipment will be operated on the slope until the system is restored.
  - C. No miners are permitted on foot within the slope while mobile equipment is entering, exiting, or being operated on the slope. Foot traffic can begin once the dispatcher is notified and the procedures for the indicator light system are followed.
  - D. The indicator light system will be installed in the dispatcher office for proper communication to be given to all miners traveling the slope via the dispatcher.
  - E. Upon implementation of this plan, all miners will be trained to use the new indicator lighting system. Training will be conducted during the new hire process and annual retraining.
  - F. Cameras will be installed at the top and bottom of the slope.
  - G. The tractor tires will be visually examined during the weekly examination of the tractor. Tread depth will be checked at 4 inches from the center of the tire on the inside and outside. When the tread depth reaches less than 1/8 inches, the tractor will be taken out of service until the tires with less than 1/8 inches of tread are replaced.
  - H. Haulage roadways will be maintained in good condition free of holes, loose rock, supplies and other loose material.

All miners have been trained in these procedures. This training will be covered for newly hired employees and during annual retraining.

2. Root Cause: The mine operator did not properly maintain the supply tractor in safe operating condition.

Corrective Action: The mine operator replaced the tires of the tractor and implemented examination procedures that included: The tractor tires being visually examined during the weekly examination of the tractor. Tread depth will be checked at 4 inches from the center of the tire on the inside and outside. When the tread depth reaches less than 1/8 inches the tractor will be taken out of service until the tire(s) with less than 1/8 inches of tread are replaced.

## CONCLUSION

On December 18, 2025, at 7:27 a.m., Robert White, a 63-year-old outby foreman with 41 years of mining experience, died after he was pinned between a tractor and the steel arch support wall.

The accident occurred because the mine operator did not: 1) develop written policies and procedures addressing foot traffic and mobile equipment on the slope, and 2) properly maintain the supply tractor in safe operating condition.

Approved By:

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Larry Bailey  
Acting District Manager

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Date

## ENFORCEMENT ACTIONS

1. A 103(k) order was issued to Greenbrier Minerals, LLC.

An accident occurred on December 18, 2025, at 7:27 a.m. This order is being issued under the authority of the Federal Mine Safety and Health Act of 1977, under Section 103(k) to insure the safety of all persons at the mine, and requires the operator to obtain the approval of an authorized representative of MSHA of any plan to recover any person in the mine or to recover the mine or affected area. This order prohibits any activity in the affected area. The operator is reminded of the obligation to preserve all evidence that would aid in investigating the cause or causes of the accident in accordance with 30 CFR 50.12.

2. A 314(b) safeguard was issued to Greenbrier Minerals, LLC under the provisions of 30 CFR 75.1403-8.

On December 18, 2025, an outby foreman died after he was pinned between a tractor and the steel arch support wall. The tractor lost traction while descending the mine slope and struck the fire boss who was on foot in the slope. The mine did not have policies or procedures to address foot traffic and mobile equipment on the slope.

This is a notice to provide safeguard requiring that all aspects of the Lower War Eagle Track Haulage Action Plan, developed by the mine operator between December 31, 2025 and January 5, 2026, be implemented and followed in all areas of the slope and any future slopes within the mine. The Track Haulage Action Plan contains the following provisions:

- A. Indicator lights have been installed at the top and bottom of the slope to indicate when miners are on the slope. The lights work by turning red when someone is on the slope, either on foot or on a piece of mobile equipment. If two people request slope travel at the same time, an amber light confirms which miner has the right of way to travel the slope. When the lights are red, no one will be permitted to enter the slope until the previous miner is clear of the slope, and the light has reset to green. The miner will continue to communicate with the dispatcher when traveling up and down the slope and once they have reached the opposite end.
- B. If the light system becomes inoperable, no rubber-tired equipment will be operated on the slope until the system is restored.
- C. No miners are permitted to be on foot within the slope while mobile equipment is entering, exiting, or being operated on the slope. Foot traffic can begin once the dispatcher is notified and the procedures for the indicator light system are followed.
- D. The indicator light system will be installed in the dispatcher office for proper communication to be given to all miners traveling the slope via the dispatcher.

- E. Upon implementation of this plan, all miners will be trained to use the new indicator lighting system. Training will be conducted during the new hire process and annual retraining.
  - F. Cameras will be installed at the top and bottom of the slope and monitored from the dispatcher's office.
  - G. The tractor tires will be visually examined during the weekly examination of the tractor. Tread depth will be checked at 4 inches from the center of the tire on the inside and outside. When the tread depth reaches less than 1/8 inches the tractor will be taken out of service until the tire(s) with less than 1/8 inches of tread are replaced.
  - H. Haulage roadways will be maintained in good condition free of holes, loose rock, supplies and other loose material.
3. A 104(a) citation was issued to Greenbrier Minerals, LLC for a violation of 30 CFR 75.1725(a).

On December 18, 2025, an outby foreman was fatally injured at this mine when he was pinned between the Co. No. 168 GE Fairchild tractor and the steel arch support wall, 177 feet from the top of the slope. The tractor lost traction, causing it to slide into a miner traveling on foot resulting in fatal injuries. The tractor was not being maintained in safe operating condition by being operated with both front tires and one rear tire on the operator's side in an excessively worn condition.

APPENDIX A – Persons Participating in the Investigation

Greenbrier Minerals, LLC

Jamey New	General Manager of Underground Operations
Aaron Price	Director of Safety
Tom Canterbury	Safety Manager
Alex Stewart	Mine Superintendent
Harry Catron	Shift Foreman
Jackie Ellison	General Foreman
Allen Lardieri	Safety Supervisor/Emergency Medical Technician
Ryan Altizer	Third Shift Chief Electrician
Jeremy Slone	Chief Electrician
Daniel Bowens	Section Foreman
Danny Brown	Electrician
Donald Noe	Electrician
Andy Runyon	Outby Foreman
Ben Wheatley	Foreman
Jerry Grimmett	Pumper
Terry Grimmett	Dispatcher
Elbert Clay	Supply Man
Manuel Hensley	Supply Man
Andrew Mullins	Supply Man
Kenneth Trent	Supply Clerk

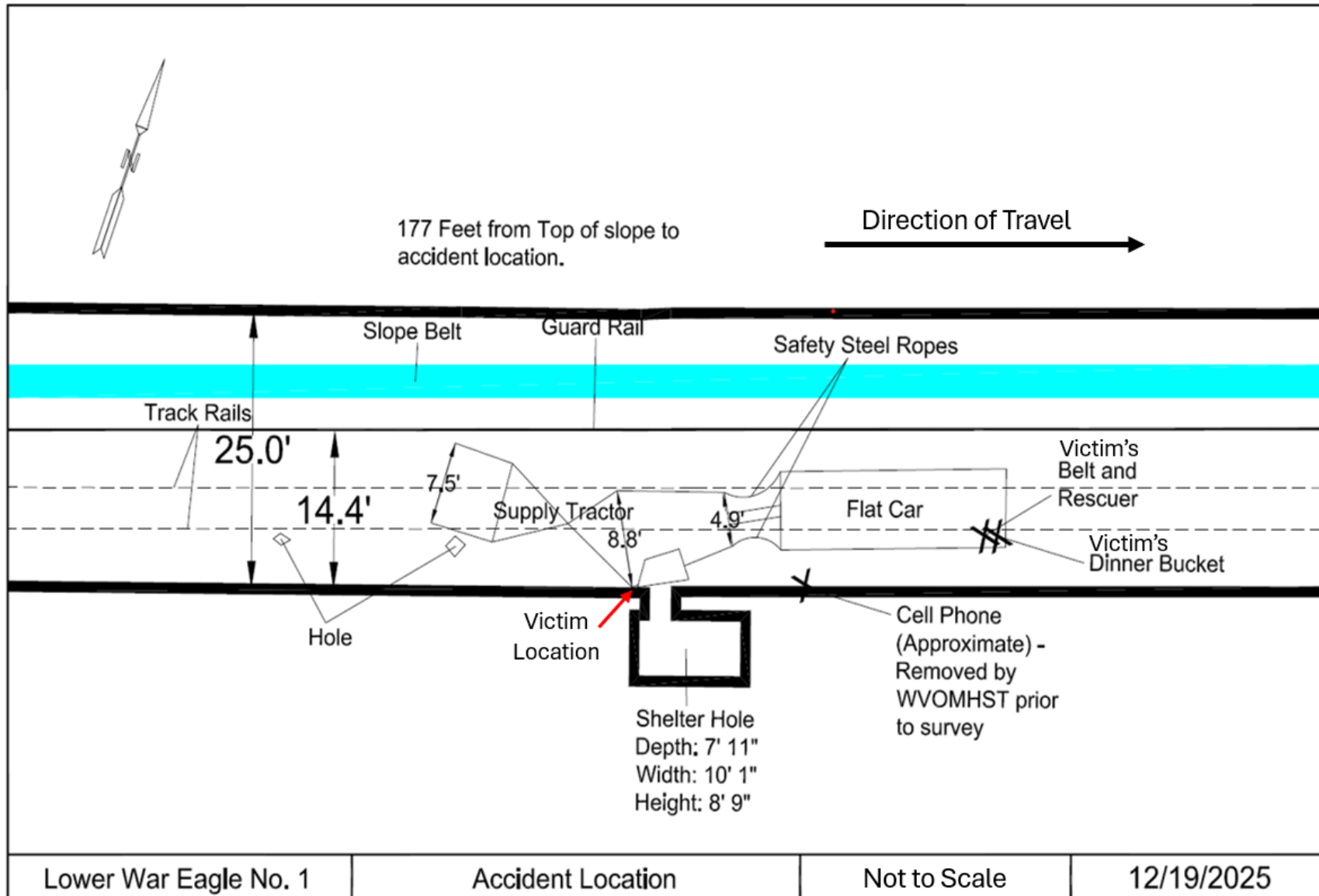
West Virginia Office of Miners' Health Safety and Training

Frank Foster	Director
Michael Pack	Inspector-at-Large
Jeremy Ball	Deputy Director
Chad Daniels	Electrical Inspector
Donna Kessinger	District Inspector
Johnathan Prater	District Inspector

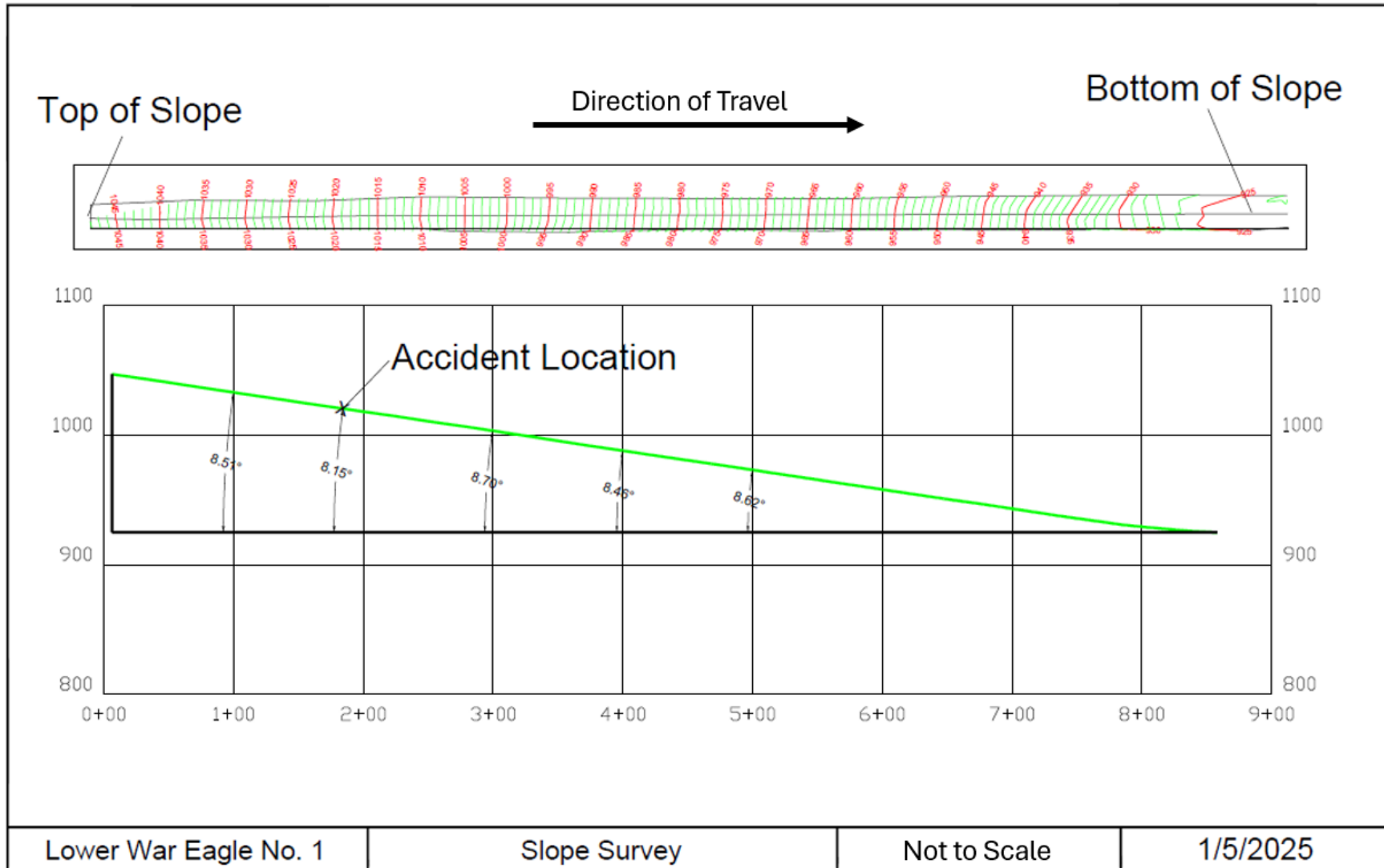
Mine Safety and Health Administration

Larry Bailey	Acting District Manager
Mark Muncy	Assistant District Manager
Joseph Presley	Supervisory Mine Safety and Health Specialist
Greggory Ward	Supervisory Mine Safety and Health Specialist
Nicholas Christian	Supervisory Mine Safety and Health Inspector
James Grimmett	Mine Safety and Health Specialist
Robert Maynard	Mine Safety and Health Specialist
Cody Palmer	Mine Safety and Health Specialist
Brent Sullivan	Mine Safety and Health Inspector

APPENDIX B – Map of the Accident Location



APPENDIX C – Slope Survey Map



APPENDIX D – Photo of Tractor Tire

