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UNITED STATES
DEPARTMENT OF LABOR
MINE SAFETY AND HEALTH ADMINISTRATION

REPORT OF INVESTIGATION

Underground
(Coal Bituminous)

Fatal Fall of Face, Rib, Side or Highwall Accident
February 28, 2025

Wright Concrete Underground LLC (P667)
Pikeville, Kentucky

at

Black Eagle
Marfork Coal Company, LLC
Pettus, Raleigh County, West Virginia
ID No. 46-09550

Accident Investigators

Daniel Smith
Mine Safety and Health Specialist

Steven Redden
Mine Safety and Health Specialist

Jerome Stone
Mine Safety and Health Specialist

Originating Office
Mine Safety and Health Administration
Beckley District
1293 Airport Road
Beaver, WV 25813
Craig Plumley, Acting District Manager

TABLE OF CONTENTS

OVERVIEW

On February 28, 2025, at 2:35 p.m., Billy Stalker, a 46-year-old seal construction worker/crew leader for Wright Concrete Underground LLC with 28 years of mining experience, died when a portion of rib rock fell on him.

The accident occurred because the mine operator did not: 1) support or otherwise control the rib to protect miners, and 2) conduct adequate preshift examinations.

GENERAL INFORMATION

Marfork Coal Company, LLC (Marfork) owns and operates the Black Eagle mine. The mine is an underground coal mine located in Pettus, Raleigh County, West Virginia. The mine employs 210 miners and operates two nine-and-a-half-hour production shifts and one eight-hour maintenance shift, six days per week. The mine operates seven mechanized mining units (MMU) to extract coal using the room and pillar method. Belt conveyors transport the coal out of the mine. The coal is processed through a preparation plant before delivery to various customers.

The mine operator contracted Wright Concrete Underground LLC (Wright) to construct ten, 120 pounds per square inch (psi) Main Line J-Seals at the South Browns Branch Submains.
The principal management officials at the Black Eagle mine at the time of the accident were:

Michael Vaught	Safety Director
Andrew Pauley	General Mine Foreman
Mark Rinchich	Superintendent

The principal management official for Wright at the time of the accident was:

Lonnie Tackett	District Manager

The Mine Safety and Health Administration (MSHA) completed the last regular safety and health inspection at this mine on December 23, 2024. A regular safety and health inspection was ongoing when the accident occurred; however, no MSHA inspectors were on-site at the time of the accident. The 2024 non-fatal days lost incident rate for Black Eagle was 1.21, compared to the national average of 3.01 for mines of this type.

DESCRIPTION OF THE ACCIDENT

On February 28, 2025, at approximately 6:30 a.m., the construction crew entered the mine and traveled to the South Browns Branch Submains Seal Area (see Appendix A). The construction crew consisted of Stalker; David Bailey and Bradley Stiltner, Seal Construction Workers for Wright; Jerry Wills, General Laborer for Marfork; and Chad Vigilante, Block Foreman/Emergency Medical Technician - Mining (EMT-M) for Marfork.

At approximately 7:30 a.m., the construction crew worked to prepare the seals for pumping. Vigilante directed the work, which included stretching out a placement hose from the No. 5 proposed seal to the No. 10 proposed seal, setting Heinzman jacks at the No. 1 proposed seal to the No. 7 proposed seal, and jackhammering the mine floor for the water traps in the No. 8 proposed seal.

At approximately 2:30 p.m., Stalker was jackhammering an area in the mine floor for the second water trap when Stiltner relieved Stalker. Stalker sat against the rib approximately seven feet from Stiltner to rest. Stiltner heard something and glanced to see a rib rock laying on Stalker. Stiltner dropped the jackhammer and yelled for help to get the rock off Stalker.

Wills arrived at the No. 8 proposed seal at the same time the accident occurred. Stiltner and Bailey attempted to move the rock with no success. Bailey went to get Vigilante. Wills and Stiltner rolled the rock off Stalker. When Bailey returned with Vigilante, Stalker was sitting up against the rock. Wills and Bailey ran over to the first aid box to get oxygen and a back board to transport Stalker to the mantrip. Vigilante, Wills, Bailey, and Stiltner moved Stalker to the mantrip and started toward the surface. Vigilante called Bobby Kirk, Dispatcher, for an ambulance and to clear the track. Kirk called 911 at approximately 2:40 p.m. which dispatched Whitesville Ambulance Service to the mine site.

While traveling to the surface, Vigilante began cardiopulmonary resuscitation (CPR). Steven Lipscomb, Section Foreman/EMT-M, arrived from the No. 1 Section to help work on Stalker. Vigilante placed an automatic external defibrillator (AED) on Stalker, which did not advise a shock. While continuing CPR, miners transported Stalker to the surface where paramedics from Whitesville Ambulance Service took over the care of Stalker. Paramedics were given orders to cease efforts by Regional Command via radio, and Jillian Hughart, DO for Raleigh General Hospital, pronounced Stalker dead at 3:44 p.m.

INVESTIGATION OF THE ACCIDENT

On February 28, 2025, at 2:52 p.m., Joseph Gillenwater, Senior Safety Representative, called the Department of Labor National Contact Center (DOLNCC) to report the accident. The DOLNCC contacted Lisa Mercado, Mine Safety and Health Assistant, who contacted Larry Bailey, Assistant District Manager. Bailey sent Michel Metz and Austin Bailey, Mine Safety and Health Inspectors, to the mine. Bailey contacted Vernus Sturgill, District Manager, who sent Michael Moten, Assistant District Manager; Daniel Smith and Steven Redden, Mine Safety and Health Specialists, to conduct the investigation. Sturgill assigned Smith as the lead investigator.

At 3:49 p.m., Metz arrived at the mine and 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 5:08 p.m., Smith and Redden arrived at the mine to continue the investigation.

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

DISCUSSION

Location of the Accident

The accident occurred at the No. 8 proposed seal, approximately eight feet from the proposed seal face along the right rib (see Appendix C). The construction crew was constructing ten, 120-psi Main Line J-Seals. The seals were being constructed to seal the South Browns Branch Submains.

Geology

The main mine roof at the Black Eagle mine (Eagle Seam) consisted of gray, cross-bedded sandstone and shale. The mine roof where the accident occurred consisted of a layered shale. The overburden at the seal site area was 1,200 feet. The working areas and air courses throughout the mine consisted of layers of the same materials listed above, in various thicknesses. During development, the mine operator took a portion of rock from the bottom or top, whichever was feasible to maintain height for equipment clearance. The ribs at the No. 8 proposed seal consisted of 44 inches of coal with 23 inches of top rock. No overmining was present at the seal site area.

Roof and Rib Conditions

Investigators observed a visible crack in the left rib brow showing evidence of separation and measured the brow to be approximately ten feet long, 20 inches wide and 12 inches thick. Loose roof existed along the right pillar rib approximately 20 feet from the proposed seal face.

Investigators measured the rock that struck Stalker to be 68 inches long, 23 inches wide, and eight inches thick. The rock weighed an estimated 1,155 pounds and fell from a height of 45 to 68 inches. Investigators determined that the mine operator did not support or otherwise control the rib to protect miners, which contributed to the accident.

Roof Control Plan (RCP)

The immediate mine roof was supported with 60-inch fully grouted, ¾ inch diameter, grade 60 roof bolts installed with an eight-inch by eight-inch bearing plate as primary roof support. These primary roof bolts were installed in a maximum pattern of four feet from the rib line, five feet bolt to bolt, and four feet row to row. The area of the accident was developed in April of 2022. The approved RCP in effect at the time of development did not require rib support in this area. However, the hazardous ribs in the South Browns Branch Submains Seal Area should have been identified and supported once examinations were required when it became a construction site.

Investigators observed the following violations of the RCP that created additional hazardous conditions in the No. 8 proposed seal of the South Browns Branch Submains Seal Area:

1) The entry width measured 22 feet and eight inches, exceeding the required 20-foot maximum.
2) The right row roof bolts from approximately 12 feet to the face of the proposed seal were wide measuring over 64 inches from the pillar rib.
3) The cross-diagonal of the intersection at the No. 8 proposed seal measured 75.5 feet, exceeding the required 64-foot maximum.
4) Wide bolt spacing exposed an area of the loose roof measuring approximately six feet by seven and a half feet. This area measured at least 68 inches from the mine floor.

Examinations

Vigilante conducted a preshift examination in the South Browns Branch Submains Seal Area an hour and a half prior to the accident but did not identify or record any of the obvious and extensive hazardous roof and rib conditions. Vigilante put the date, time, and his initials next to a large crack in the overhanging roof. Also, the mine operator did not conduct a preshift or supplemental examination for the South Browns Branch Submains Seal Area prior to the shift or before work began on the day of the accident. Additionally, only four of ten required preshift examinations of the South Browns Branch Submains Seal Area were conducted and recorded by Vigilante since February 24, 2025, when miners and contractors were scheduled to work in the area. These examinations did not identify the obvious and extensive hazardous roof and rib conditions. Investigators determined the mine operator did not conduct adequate preshift examinations, which contributed to the accident.

Training and Experience

Stalker had 28 years of mining experience and worked in seal construction for Wright for ten years. Stalker had been working at the Black Eagle Mine for nine days. Stalker received hazard

training on February 18, 2025, and experienced miner training on February 24, 2025. Investigators reviewed the training records and determined that Stalker received all training in accordance with MSHA Part 48 training regulations.

ROOT CAUSE ANALYSIS

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

1. Root Cause: The mine operator did not support or otherwise control the rib to protect miners.

   Corrective Action: The mine operator installed supplemental supports at the South Browns Branch Submains Seal Area in the form of fully grouted roof bolts, cable bolts, 560 (six by six) posts, nine cribs, five steel jacks, and a minimum of 50 rib bolts. The mine operator developed and implemented a revision to the approved RCP to require all construction sites to be rehabilitated in accordance with the approved plan. The mine operator trained miners on the revised RCP.

2. Root Cause: The mine operator did not conduct adequate preshift examinations.

   Corrective Action: The mine operator conducted the necessary preshift examinations and recorded the hazards observed for the South Browns Branch Submains Seal Area. The mine operator trained mine examiners and mine management on the requirements to conduct preshift examinations to identify and correct hazardous conditions.

CONCLUSION

On February 28, 2025, at 2:35 p.m., Billy Stalker, a 46-year-old seal construction worker/crew leader for Wright Concrete Underground LLC with over 28 years of mining experience, died when a portion of a rib rock fell on him.

The accident occurred because the mine operator did not: 1) support or otherwise control the rib to protect miners, and 2) conduct adequate preshift examinations.

Approved By:

_____ _____

Craig Plumley Date
Acting District Manager

ENFORCEMENT ACTIONS

1. A 103(k) order was issued to Marfork Coal Company, LLC.

   A fatal accident occurred on February 28, 2025, at 2:35 p.m. This order is being issued under the authority of the Federal Mine Safety and Health Act of 1977, under Section 103(k) to ensure 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 104(d)(1) order was issued to Marfork Coal Company LLC for a violation of 30 CFR 75.202(a).

   A fatal accident occurred on February 28, 2025, when a section of rib rock fell and struck a contractor at the No. 8 proposed seal of the South Browns Branch Submains seal site. The mine operator did not support or otherwise control the rib to protect miners. The mine operator engaged in aggravated conduct constituting more than ordinary negligence. The foreman was present and directed contractors to work in the area with hazardous roof and rib conditions. This violation is an unwarrantable failure to comply with a mandatory standard.

3. A 104(d)(1) order was issued to Marfork Coal Company LLC for a violation of 30 CFR 75.360(b)(10).

   A fatal accident occurred on February 28, 2025, when a section of rib rock fell and struck a miner at the No. 8 proposed seal of the South Browns Branch Submains seal site. The mine operator did not conduct adequate preshift examinations. The mine operator engaged in aggravated conduct constituting more than ordinary negligence. Miners and contractors were scheduled to work in the area since February 24, 2025. The examinations did not identify the obvious and extensive hazardous roof and rib conditions. This violation is an unwarrantable failure to comply with a mandatory standard.

APPENDIX A – South Browns Branch Submains Seal Area Map

ENGINEER'S PRE-CONSTRUCTION CERTIFICATION ATTACHMENT

South Browns Branch Submains Seal Area

COMPANY NAME: Marfork Coal Company, LLC

MINE NAME: Black Eagle Mine (MSHA ID# 46-09550)

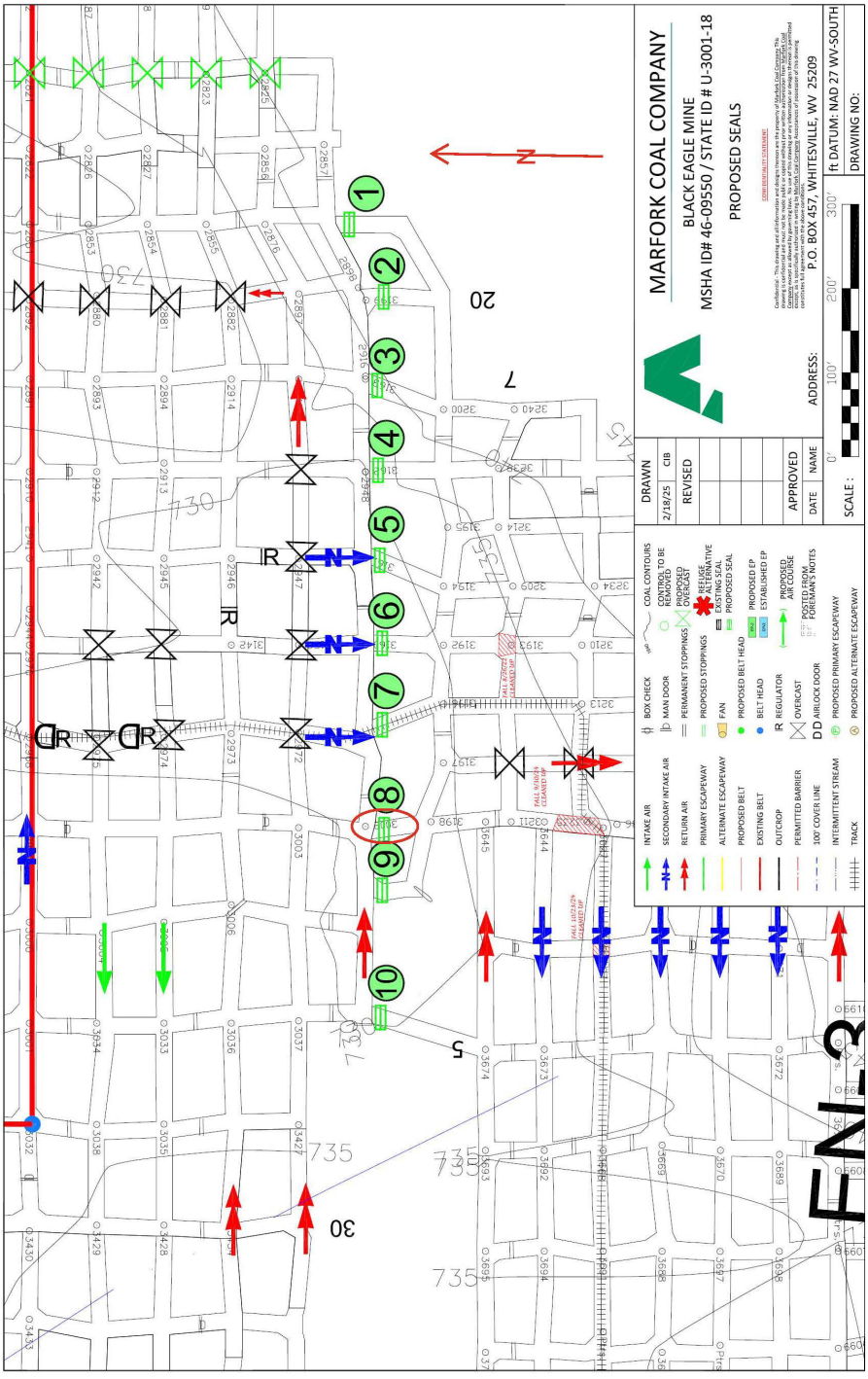

Fig 1 Seal locations

○ - Accident site

APPENDIX B – Persons Participating in the Investigation

Marfork Coal Company, LLC

Michael Vaught	Safety Director
Scott Toler	General Manager
Andrew Pauley	General Mine Foreman
Jason Estep	Shift Foreman
Stephen Garrison	Shift Foreman
Steven Lipscomb	Section Foreman/EMT-M
Chad Vigilante	Block Foreman/EMT-M
Joseph Gillenwater	Senior Safety Representative
Daniel Baker	Surveyor
Joshua Davis	Surveyor
Ben Roberts	Surveyor
Jerry Wills	General Laborer

Wright Concrete Underground LLC

David Bailey	Seal Construction Worker
Bradley Stiltner	Seal Construction Worker

West Virginia Office of Miners' Health Safety and Training

Chistopher Dawson	Inspector at Large
Charlie Moles	Asst. Inspector at Large
William Stewart	Roof Control and Ventilation Specialist
Gregory Davis	District Mine Inspector

Mine Safety and Health Administration

Vernus Sturgill	District Manager
Larry Bailey	Assistant District Manager
Michael Moten	Assistant District Manager
David Birchfield	Supervisory Mine Safety and Health Inspector
Steven Redden	Mine Safety and Health Specialist
Daniel Smith	Mine Safety and Health Specialist
Jerome Stone	Mine Safety and Health Specialist
Austin Bailey	Mine Safety and Health Inspector
Michel Metz	Mine Safety and Health Inspector

APPENDIX C – South Browns Branch Submains No. 8 Proposed Seal Map