FAI-F026D09-01

UNITED STATES
DEPARTMENT OF LABOR
MINE SAFETY AND HEALTH ADMINISTRATION

REPORT OF INVESTIGATION

Underground
(Coal)

Fatal Powered Haulage Accident
November 6, 2025

Mountain View Mine
Mettiki Coal WV, LLC
Davis, Tucker County, West Virginia
ID No. 46-09028

Accident Investigators

David Wamsley
Mine Safety and Health Inspector

Rodney Fultz
Mine Safety and Health Specialist

Originating Office
Mine Safety and Health Administration
Morgantown District
604 Cheat Road
Morgantown, WV 26508
Carlos Mosley, District Manager

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OVERVIEW

On November 6, 2025, at 1:30 a.m., Joseph Mitchell, Jr. a 25-year-old scoop operator with 3 years of mining experience, died when the scoop he was operating was struck by an out-of-control supply train.

The accident occurred because the mine operator did not: 1) follow the established safeguard in place to ensure haulage clearance is obtained when mobile equipment is in use at this mine; 2) establish a policy or procedure to ensure that operators maintain control of diesel powered equipment; and 3) establish a procedure to ensure the sanding devices on the locomotives were maintained.

GENERAL INFORMATION

Mettiki Coal WV, LLC owns and operates the Mountain View Mine, an underground mine which extracts bituminous coal from the Upper Freeport coal seam located near Davis, in Tucker County, West Virginia. The mine employs 242 miners and operates three 10-hour shifts per day, four days per week. This mine uses continuous mining and longwall mining methods to extract coal. Belt conveyors transport the coal to the surface.

The principal management officials at the Mountain View Mine at the time of the accident were:

Colton Cook	General Manager
Michael Fulmer	Superintendent
Daniel Ramsey	Safety Director

The Mine Safety and Health Administration (MSHA) completed the last regular (E01) safety and health inspection at this mine on September 23, 2025. The 2024 non-fatal days lost incident rate for the Mountain View Mine was zero, compared to the national average of 3.02 for mines of this type.

DESCRIPTION OF THE ACCIDENT

Mitchell began his shift on November 5, 2025, at 10:30 p.m. as part of the 41 Butt section crew. Kyle Scheiner, shift foreman, conducted a pre-shift meeting, after which the section crews entered the mine and travelled to their sections. The 41 Butt crew received haulage clearance from Steven High, dispatcher, and arrived at their assigned section at approximately 11:20 p.m.

Mitchell began his normal duties of checking supplies on the roof bolting machines on the section. He then spoke with Miles Clark, section foreman, and drove the Company No.1 Eimco 913 scoop outby on the track where the roof bolting supplies were located.

At the beginning of the shift, Ryan Duckworth and Rickey Ahern, motormen, received their work assignments from Scheiner and entered the mine. The motor crew rode the elevator down to the bottom area where companies No.1 and No.2 Brookville diesel locomotives and three loaded supply cars were located. They conducted their pre-operational checks on the locomotives.

Just before midnight, the motor crew requested and received haulage clearance from High, to travel from the elevator bottom area inby to the K-Mains back switch. They gathered three more loaded supply cars and an empty ballast car there. Duckworth operated the No. 2 inby locomotive leading the supply train; and Ahern operated the No. 1 outby locomotive. The supply train now had two locomotives, six supply cars, and a ballast car. At approximately 12:40 a.m., the motor crew received haulage clearance from High, to travel inby to the 41 Butt switch. They were assigned to deliver the supplies to 47 block on the 41 Butt section.

The motor crew arrived at the 41 Butt switch, uncoupled the empty ballast car, and parked it on the main line track inby the switch. The motor crew was told by High to wait at the switch before entering the section track because Milton Scott III, scoop operator, was operating his scoop on the track haulage with clearance from High. Scott pulled off the track haulage and into the 47 block crosscut, and High then told the motor crew to go to 47 block where the supply cars could be unloaded.

As they approached 41 block, the motormen attempted to slow the supply train down, but they could not because the rail in this area was wet and muddy. The motor crew attempted to operate the sanding devices to assist with braking, but the supply train continued inby out of control. Scott saw the out-of-control supply train as it passed and immediately broadcast it over the radio to clear the 41 Butt section haulage.

Duckworth saw Mitchell operating his Eimco 913 scoop in the track haulage entry and started flashing the locomotive lights and blowing the horn. Mitchell was observed turning and looking outby toward the supply train just before the No. 2 locomotive crashed into the scoop. The

collision pushed the scoop into the inby corner in the 58 block intersection, causing the No. 2 locomotive and five of the six supply cars to derail. The No. 1 locomotive and the sixth supply car remained on the track.

Ahern radioed Duckworth, and when he did not receive an answer he made his way to the locomotive. Duckworth had been knocked to the locomotive floor, suffering head and leg injuries. Ahern helped Duckworth break one of the locomotive's windows and climb out so they could look for Mitchell. Mitchell was found unresponsive under the first derailed supply car (Appendix A). Ahern radioed for help. High heard the call for help and called 911 at 1:32 a.m.

Jason Heckler and Sean Devlin, fire bosses, also heard Ahern's call for help. They went to the accident site and checked Mitchell for a pulse, but they could not find one. They radioed to the 41 Butt section to bring the EMT kit and the automated external defibrillator (AED). Additional miners arrived and worked to get Mitchell from under the supply car. Miners performed cardiopulmonary resuscitation and applied the AED device when they got him free. The AED did not advise a shock. Mitchell was transported to the surface where care was transferred to the Tucker County Ambulance Authority. Mitchell was transported to the Garrett County Regional Medical Center at Oakland, Maryland where Dr. Randy Engelman, D.O., pronounced Mitchell deceased at 4:16 a.m.

INVESTIGATION OF THE ACCIDENT

At 2:01 a.m., High called the Department of Labor National Contact Center (DOLNCC) to report the accident. The DOLNCC contacted Kenneth Cosgrave, supervisory mine safety and health inspector. Cosgrave contacted Tyler Peddicord, assistant district manager. Peddicord assigned David Wamsley, mine safety and health inspector, and Rodney Fultz, mine safety and health specialist, to investigate the accident.

At 5:00 a.m., Fultz and Peddicord arrived onsite to secure the scene. Wamsley arrived at 5:10 a.m. and issued an order under the provisions of Section 103(k) of the Mine Act to ensure the safety of the miners and the preservation of evidence.

MSHA's accident investigation team, along with the West Virginia Office of Miners' Health Safety and Training (WVOMHST), performed an examination of the accident scene, took photographs, interviewed miners and mine management, and reviewed conditions and work practices 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 on the 41 Butt miner section track haulage at the 58 block crosscut. The track haulage from approximately 45 to 55 blocks averaged a down grade of 5.9% inby with a maximum grade of 9.9%. The track was also wet and muddy in this area. There was no water over the rails and muddy conditions existed where rubber-tired mobile equipment drove over the rails. Investigators determined that the grade and conditions of the track affected the locomotive operator's ability to control the diesel locomotives and contributed to the accident. See Appendix C for a map showing the track haulage grade.

Procedures

Safeguard No. 9121435, issued on October 25, 2017, requires the operator of any piece of mobile equipment to obtain clearance from the dispatcher prior to travel when mobile equipment is in use at this mine. Based on testimony, the Eimco 913 scoop operator was on the track haulage at 58 block and had not received clearance from the dispatcher prior to travel in the track haulage entry. Investigators determined the lack of compliance with the safeguard contributed to the accident.

Equipment

The equipment involved in the accident included an Eimco 913 scoop, two Brookville diesel locomotives, and six loaded Irwin supply cars.

The Eimco 913 scoop had obvious damage that occurred during the collision. Investigators examined the scoop underground but could not function-test it due to the damage sustained during the collision. Additional examinations were conducted in the surface shop. The investigators determined the operating condition of the scoop did not contribute to the accident.

The No. 1 Brookville 30-ton locomotive was coupled to the outby supply car at the time of the accident. This locomotive did not derail and there was no damage to the motor from the collision. It was tested at the accident site. The sanding devices on the locomotive were also tested, and three of the four would not function due to wet conditions, reducing the ability to deliver sand.

The No. 2 Brookville 30-ton locomotive that made initial impact with the Eimco 913 scoop received obvious damage to its inby end and could not be tested underground. The sanding devices were tested underground using compressed air from another source, and three of the four sanders on the locomotive would not function due to wet conditions, reducing the ability to deliver sand. The locomotive was towed to the surface where investigators performed an additional visual examination. The mine operator permanently removed the locomotive from service due to the damage.

The preoperational check sheet and maintenance records were reviewed for both locomotives with no issues reported. Duckworth and Ahern told investigators that the sanders were filled and tested multiple times during the shift. However, when tested by investigators, neither locomotive had fully functioning sanding devices due to wet conditions, reducing the ability to deliver sand.

Investigators determined the non-functioning sanders were not damaged in the collision and the moisture content of the sand contributed to the accident.

Six Irwin 20-ton supply cars were involved in the accident, and five of the six derailed. Any damage observed to the supply cars was determined to have been caused by the collision and subsequent derailment. Investigators determined the operational condition of the supply cars did not contribute to the accident.

Examinations

A pre-shift examination of the 41 Butt section haulage was conducted on November 5, 2025, between 7:30 p.m. and 10:30 p.m. The examination did not document any violations or hazardous conditions present. The investigators determined that the examination did not contribute to the accident.

Training and Experience

Mitchell had 3 years of mining experience with 2 years and 7 months of experience as a scoop operator at this mine. The mine operator provided task training on the Eimco 913 scoop to Mitchell on April 15, 2023, and annual refresher training on March 28, 2025. Investigators determined Mitchell received all training in accordance with MSHA Part 48 training regulations.

Duckworth had 18 years of mining experience with 7 months of experience as a motorman. The mine operator provided task training on the Brookville locomotive to Duckworth on April 7, 2025, and annual refresher training on March 21, 2025. Investigators determined Duckworth received all training in accordance with MSHA Part 48 training regulations.

Ahern had 27 years of mining experience with 1 year and 5 months of experience as a motorman. The mine operator provided task training on the Brookville locomotive to Ahern on June 23, 2024, and annual refresher training on March 21, 2025. Investigators determined Ahern 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 actions to prevent a recurrence.

1. Root Cause: The mine operator did not ensure that the established policy and procedures included in the safeguard were followed.

   Corrective Action: The mine operator re-trained all miners in the provisions of safeguard No. 9121435 informing miners of the requirements to obtain clearance from the dispatcher prior to moving mobile equipment on the track haulage.

2. Root Cause: The mine operator did not have a policy or procedure in place to ensure miners could maintain control of the diesel-powered locomotives.

   Corrective Action: The mine operator has installed derails, warning signs, and a block light system at the beginning of all steep grades and developed procedures in their use. All miners were trained in the procedures.

3. Root Cause: The mine operator did not have a policy or procedure in place to ensure proper function of the machine-mounted sanding devices on the Brookville 30-ton locomotives.

   Corrective Action:
   A safeguard was issued to require sanding devices to be maintained on all locomotives. Additionally, the sanding devices on all operating locomotives were examined and repaired.

CONCLUSION

On November 6, 2025, at 1:30 a.m., Joseph Mitchell, Jr. a 25-year-old scoop operator with 3 years of mining experience, died when the scoop he was operating was struck by an out-of-control supply train.

The accident occurred because the mine operator did not: 1) follow the established safeguard in place to ensure haulage clearance is obtained when mobile equipment is in use at this mine; 2) establish a policy or procedure to ensure that operators maintain control of diesel powered equipment; and 3) establish a procedure to ensure the sanding devices on the locomotives were maintained.

Approved By:

_____ _____

Carlos Mosley Date
District Manager

ENFORCEMENT ACTIONS

1. A 103(k) order was issued to Mettiki Coal WV, LLC.

   A fatal accident occurred on November 6, 2025, at 1:30 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 104(a) citation was issued to Mettiki Coal WV, LLC for a violation of Safeguard No. 9121435.

   On November 6, 2025, a fatal accident occurred at 58 block of 41 Butt Section when an Eimco 913 scoop was being operated in the track haulage entry without prior approval from the dispatcher. The scoop was struck by a locomotive which was part of an out-of-control supply train.

3. A 104(a) citation was issued to Mettiki Coal WV, LLC for a violation of 30 CFR 75.1916(b)

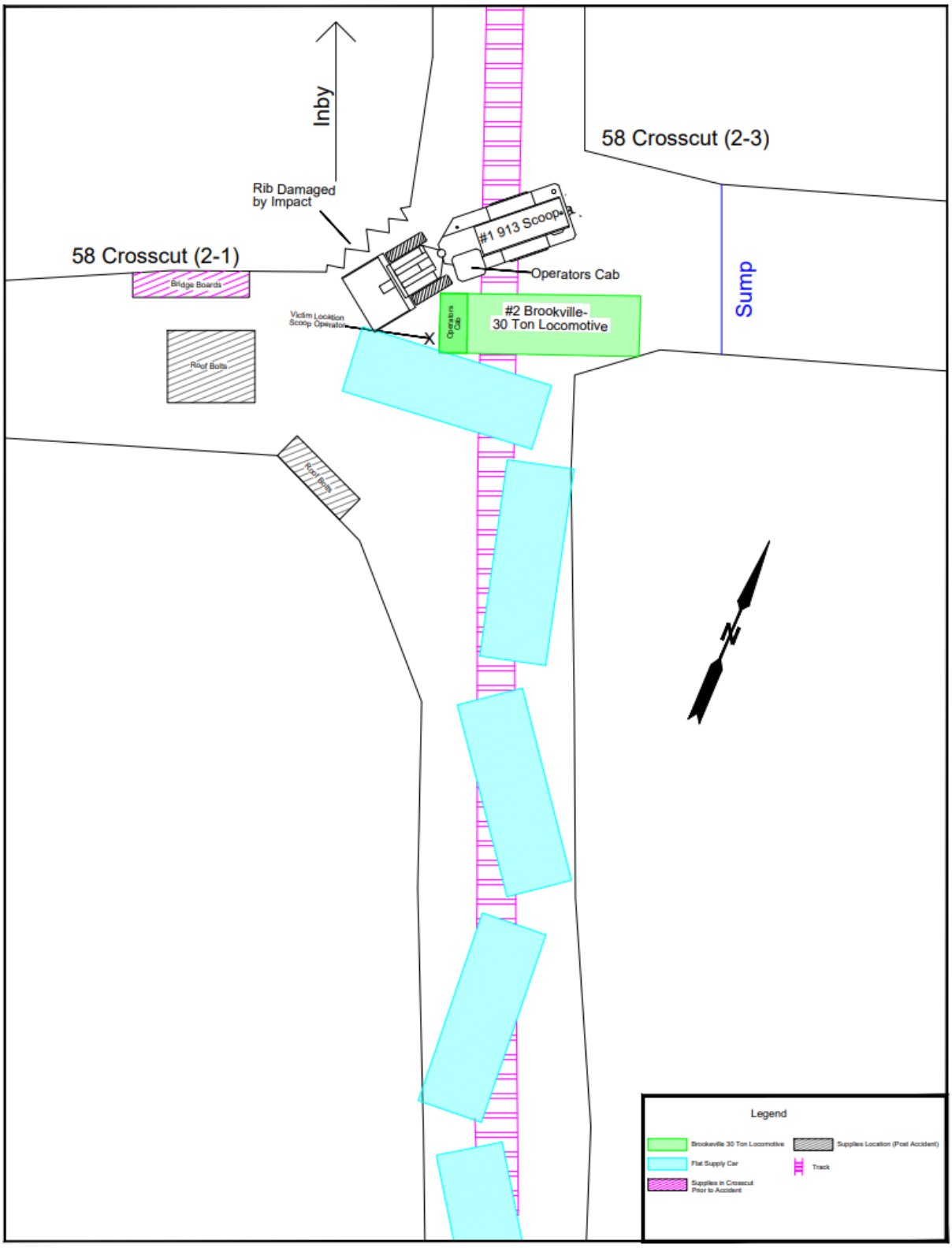
   A fatal accident occurred at this operation on November 6, 2025, when a diesel-powered locomotive and supply train were unable to stop at 47 block on the 41 Butt section. The locomotive continued inby on the track rail uncontrolled and crashed into the No. 1 Eimco 913 scoop at 58 block in the track haulage entry. The rails in the area were wet and muddy. The area where the supply train lost control had a downhill grade that averaged 5.9% with a maximum grade of 9.9%.

4. A 314(b) safeguard was issued to Mettiki Coal WV, LLC for a violation of 30 CFR 75.1403-6

   A fatal accident occurred at this mine on November 6, 2025, when a diesel-powered locomotive and supply train were unable to stop at 47 block on the 41 Butt section, continued inby on the track rail uncontrolled, and crashed into the No. 1 Eimco 913 scoop at 58 block in the track haulage entry. The rails in the area were wet and muddy. The area where the supply train lost control had a downhill grade that averaged 5.9% with a maximum grade of 9.9%. Failure to provide and maintain properly operational sanding devices contributed to the collision between two pieces of equipment resulting in a fatal accident.

   This is a Notice to Provide Safeguard requiring track mounted locomotives to be provided with properly installed and maintained sanding devices at each wheel that will deposit sand on the track rails in both directions of travel. Sanding devices and reservoirs shall be checked and filled with sand as necessary before the locomotive is put into operation.

APPENDIX A – Sketch of Accident Scene



APPENDIX B – Persons Participating in the Investigation

Mountain View Mine

Michael Fulmer	Superintendent
Kenneth Murray	Vice President of Operation
Daniel Ramsey	Safety Director
Shawn Nezzelrodt	Safety and Compliance Officer
Ryan Duckworth	Locomotive Operator
Rickey Ahern	Locomotive Operator
Sean Devlin	Fireboss
Jason Heckler	Fireboss
Steven High	Dispatcher
Milton Scott	Mobile Equipment Operator

Mine Safety and Health Administration

Carlos Mosley	District Manager
Tyler Peddicord	Assistant District Manager
James Baker	Assistant District Manager
Michael Stark	Staff Assistant
David Wamsley	Mine Safety and Health Inspector
Rodney Fultz	Mine Safety and Health Specialist

West Virginia Office of Miners Health Safety and Training

Edward Peddicord	Inspector at Large
Tadd Rankin	Assistant Inspector at Large
John Nicholson	Electrical Inspector
James Bowman	Electrical Inspector
George Brooks	District Inspector
Chris Ray	District Inspector
Joshua Bell	Administrator
Chance Chapman	Attorney
Kermit Fincham	Chief Engineer

Family Representative

Donald Carter	Attorney

APPENDIX C – Grade Profile of 41 Butt Section Track Haulage