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UNITED STATES
DEPARTMENT OF LABOR
MINE SAFETY AND HEALTH ADMINISTRATION

REPORT OF INVESTIGATION

Underground
(Coal)

Fall of Roof or Back Fatality Report
April 2, 2026

Panther Eagle Mine
Marfork Coal Company
Whitesville, Raleigh County, West Virginia
ID No. 46-09212

Accident Investigators

Steven Redden
Mine Safety and Health Specialist

Herman Morgan
Supervisory Mine Safety and Health Specialist

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

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OVERVIEW

On April 2, 2026, at 5:05 p.m., Aaron Warrix, a 53-year-old shuttle car operator with over 23 years of mining experience, died after being struck by falling roof rock when he was installing roadside-radius (turn) posts on a pillar section.

The accident occurred because the mine operator did not: 1) ensure that no person worked or traveled under unsupported roof, 2) follow the approved roof control plan, and 3) conduct an adequate on-shift examination.

GENERAL INFORMATION

Marfork Coal Company owns and operates the Panther Eagle Mine, an underground coal mine in Whitesville, Raleigh County, West Virginia. The mine employs 182 miners and operates two 10-hour production shifts and one eight-hour maintenance shift, five days per week. Panther Eagle Mine operates six mechanized mining units (MMU) to extract the coal using the room and pillar method. Coal is mined with continuous mining machines, loaded into shuttle cars, and dumped onto belt conveyors. The coal is then transported to a preparation plant by an overland conveyor belt.

The principal management officials at the Panther Eagle mine at the time of the accident were:

Mark Rinchich	Superintendent
Chauncy Freeman	General Mine Foreman
Michael Vaught	Safety Director

The Mine Safety and Health Administration (MSHA) completed the last regular safety and health inspection at this mine on March 3, 2026. The current regular safety and health inspection began April 1, 2026; however, no MSHA personnel were present at the time of the accident. The 2025 non-fatal days lost incident rate for Panther Eagle was 2.44 compared to the national average of 3.12 for mines of this type.

DESCRIPTION OF THE ACCIDENT

On April 2, 2026, Warrix arrived at the mine to start evening shift. At approximately 2:15 p.m., Warrix and coworkers Jacob Stables, shuttle car operator/emergency medical technician; Tracy Lester, shuttle car operator; Ronald Blevins, continuous mining machine (CMM) operator; Colton Adkins, roof bolter/emergency medical technician; Christopher Green, roof bolter; Ethan Jarrell, scoop operator; Hunter Taylor, roof bolter; Christopher Snuffer, electrician; and Matthew Boulet, evening shift section foreman attended a safety meeting which included reviewing portions of the mine's approved roof control and ventilation plans.

According to the mine's electronic tracking system, at 2:35 p.m., the crew traveled underground through the Horse Creek Portals to the No. 3 pillar recovery section (No. 3 section). The miners arrived at No. 3 section at approximately 3:20 p.m. The equipment operators conducted pre-operational examinations of their equipment and checked the roadways before beginning production. After completion of the pre-operational and dust parameter checks, Blevins operated the right CMM. He began mining the No. 2 barrier on the right side of the No. 12 entry between crosscuts 15 and 16 with Stables and Warrix operating shuttle cars (Appendix A).

At approximately 5:00 p.m., Blevins completed mining the barrier No. 2 lift. Blevins backed the CMM into the intersection and began replacing cutting bits and cleaning water sprays on the CMM. Warrix and Stables installed turn posts in preparation for mining the next lift.

At approximately 5:05 p.m., Warrix and Stables had just completed installing the turn posts when rock fell from the mine roof inby the turn posts, striking Warrix from behind. At that time, Green and Jarrell were at the CMM with Blevins as Adkins was walking past. Green heard Stables say, "Don't move" and turned around to see Warrix under the rock. Green and Stables removed the rock from on top of Warrix. Stables then pulled Warrix away from the timbers and rocks towards the middle of the No. 12 entry. Stables asked Jarrell to retrieve the first aid box located near the self-contained self-rescuer (SCSR) cache and notify the surface personnel. Stables began assessing Warrix's injuries and observed a small cut on the back of Warrix's head. Adkins went to get the four-wheeled rubber-tired personnel carrier (MAC-8). Jarrell called the surface on the mine phone and informed Wesley Toney, dispatcher, of the accident. Jarrell then brought a small first aid box to the accident scene and went back to the mine phone to keep surface personnel updated. Toney called 911 at 5:08 p.m. and requested an ambulance. Adkins put the larger first

aid box on the MAC-8 and drove to the accident scene. Adkins prepared the oxygen tank and then went to the end of the track with Rusty Older, fireboss, to prepare the Brookville rail-mounted personnel carrier (Brookville) to transport Warrix to the surface.

Warrix was alert and responsive and complained of neck and hip pain. Warrix stated he could not straighten his legs due to pain. Green stabilized Warrix's neck with a cervical collar while Stables splinted his legs in the bent position. Green and Stables placed Warrix on a backboard, onto the MAC-8, and transported him to the end of the track. Green, Stables, and Adkins placed Warrix on the Brookville and transported him to the surface.

Jan-Care Ambulance Service responded to the 911 call and arrived at the mine at 5:45 p.m. Ronald Shepke, Jan-Care emergency medical technician (EMT), contacted Medical Command, Charleston, WV, and requested Air Evac to be put on standby.

At 6:15 p.m., Warrix arrived on the surface and was transferred to the Jan-Care EMTs. Miners assisted EMTs with loading Warrix into the ambulance. EMTs began their assessment and notified Medical Command advising the Air Evac to launch. Stables accompanied EMTs in the ambulance to the landing zone near Whitesville, WV. While en route, Warrix became unresponsive and Shepke immediately began cardiopulmonary resuscitation (CPR) with Stables assisting. Upon arrival at the landing zone, Stables exited the ambulance as Air Evac nurses assumed primary care and took over CPR. Due to his condition, the flight crew made the decision to continue ambulance transport to the hospital. At 8:06 p.m., Warrix arrived at Charleston Area Medical Center, Charleston, WV. Hospital staff immediately transferred Warrix to the emergency room. At 8:19 p.m., Kayla Marie Piehler, MD pronounced Warrix dead.

INVESTIGATION OF THE ACCIDENT

On April 2, 2026, at 6:20 p.m., Michael Vaught, safety director, called the Department of Labor National Contact Center (DOLNCC) to report a life-threatening injury. The DOLNCC notified Derrick Kiblinger, supervisory mine safety and health specialist. Kiblinger notified Michael Moten, assistant district manager and Steven Redden, mine safety and health specialist, and directed Redden to go to the mine. Moten notified Craig Plumley, acting regional administrator, and Mark Muncy, acting district manager. Moten then notified Jeffrey Presley, supervisory mine safety and health inspector. Presley notified Phillip Dillon, mine safety and health inspector, and directed him to go to the mine.

At 8:35 p.m., Moten and Redden arrived at the mine with Presley and Dillon arriving approximately five minutes later. Moten assigned Redden as the lead investigator. Investigators met with Mark Rinchich, superintendent; Chauncy Freeman, general mine foreman; and Christopher Curry, safety technician, and discussed the accident.

At 8:43 p.m., Dillon 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. Redden, Moten, investigators from the West Virginia Office of Miners Health Safety and Training, and mine management traveled underground to the accident scene. Presley and Dillon reviewed examination and training records and obtained written statements from miners. The MSHA accident investigation team

conducted an examination of the accident scene, interviewed 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 on the No. 3 working section in the No. 12 entry between the No. 15 and No. 16 crosscuts (Appendix A).

Roof Control Plan

MSHA approved the Panther Eagle Mine's roof control plan (RCP) on December 9, 2025 (Appendix C). On page 22, item 14, the RCP states, "Pillar extraction shall be done in the sequence as illustrated on the attached drawings. The sequence is indicated by numbers which correspond to individual pillar lifts." Also, on page 22, item 15, the RCP states, "Immediately after each lift, roof supports will be installed as indicated on the attached drawings. Under no circumstances shall anyone travel inby installed breaker posts."

According to the RCP sequence, Cody Catlett, day shift CMM operator, mined the No. 1 lift from the left of No. 12 entry during the previous shift. The No. 1 lift measured 30 feet in depth from the last complete row of roof support and was 29 feet in width. The depth of the No. 1 lift should not have exceeded half the 35-foot pillar block or 17.5 feet, and the width should not have exceeded 12 feet. The depth of the No. 1 lift was exceeded by 12.5 feet, and the width was exceeded by 17 feet (Appendix C).

As previously stated, during the evening shift Blevins mined the barrier No. 2 lift from the right side of No. 12 entry. The No. 2 lift measured 44 feet from the last row of roof supports and measured 36 feet across the width of the lift. The depth of the No. 2 lift should not have exceeded 32 feet, and the width should not have exceeded 12 feet. Investigators determined the No. 2 lift exceeded the RCP by a depth of 12 feet and width of 24 feet.

During mining of the No. 2 lift, the CMM struck two roof bolts, removing the bearing plate completely from one and damaging the other. The dimensions of the lifts did not comply with the requirements in the RCP. During the day and evening shifts, the noncompliant sequence of mining prevented the proper installation of posts between lifts to supplement the roof support. Additionally, the damaged roof support and the absence of posts increased the span of unsupported roof. This allowed the roof strata to sag and become unstable. The compromised mine roof support exposed loose, unsupported draw rock.

While installing posts in preparation for the next lift, Warrix was positioned under unsupported roof, inby a turn post in violation of the RCP. Rock measuring approximately five feet long, three feet wide, three inches thick fell and struck Warrix. Investigators determined that not complying with the mining sequence of the RCP and improper post installation procedure contributed to the accident (Appendix D).

Examinations and Inadequate Supervision

Benjamin Hapney, day shift section foreman, conducted a pre-shift examination of the No.3 section for the oncoming evening shift on the day of the accident from 12:30 p.m. to 1:30 p.m. Hapney recorded no hazardous conditions during this examination. Investigators were not able to determine the exact time the noncompliant mining sequence was conducted during the day shift.

Boulet conducted his on-shift examination of the No.3 section from 3:25 p.m. to 3:55 p.m. Boulet did not identify, correct, or make any records of the obvious and extensive hazards and violations created during the day shift by the noncompliant mining sequence and the improper installation of posts. Investigators determined the on-shift examination was inadequate because these hazardous conditions were not identified or corrected.

Investigators determined that Blevins mined the barrier No. 2 lift immediately after the on-shift examination conducted by Boulet. Boulet did not prevent the same type of noncompliant mining on the evening shift. Because of the noncompliant mining on day shift, the mine operator should have made adjustments to the mining sequence to achieve compliance with the RCP.

During retreat mining, roof falls are very common. A diligent, continual observation of the mining sequence and roof support (both permanent and supplemental) is essential during the mining cycle and examinations.

Hapney and Boulet should have observed the obvious excessive widths and depths of both lifts, and the absence of posts. Also, Boulet should have noticed the damaged roof bolts. Additionally, the extensive amount of time each CMM would have been in these cuts should have alerted Hapney and Boulet that the mining sequence in the RCP was not being complied with. Investigators determined the section foremen knew or should have known of these hazardous conditions and should have taken corrective actions by stopping production, installing supplemental support, and repositioning the continuous mining machine. The inadequate on-shift examination and the failures to identify violations of the RCP, identify hazards, and take corrective actions, contributed to the accident.

Training and Experience

Warrix had over 23 years of mining experience. Warrix worked at the Panther Eagle Mine for almost six years as a shuttle car operator. Warrix received experienced miner training for the Panther Eagle Mine on May 4, 2020, and annual refresher training on February 17, 2026. Additionally, Warrix received training for the Full Pillar Extraction Plan on March 6, 2026. Investigators determined Warrix received all training in accordance with MSHA Part 48 training regulations and training was not a contributing factor to the accident.

ROOT CAUSE ANALYSIS

The accident investigation team conducted an analysis to identify the underlying causes of the accident. The team 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 no person worked or traveled under unsupported roof.

   Corrective Action: The mine operator retrained all miners and supervisors on the requirement that no person work or travel under unsupported roof and implemented procedures to ensure supports are installed from supported areas. Additionally, the operator revised the RCP to include a different method for the installation of radius (turn) posts to minimize exposure.

2. Root Cause: The mine operator did not follow the approved roof control plan.

   Corrective Action: The mine operator trained miners and supervisors on the approved RCP, including lift dimensions, support requirements, and extraction sequence. Management also revised the RCP to require the mine foreman, or an equivalent mine official, to travel to the retreat section weekly, observe a complete mining cycle, and record the observation in the pre-shift/on-shift examination book.

3. Root Cause: The operator did not conduct an adequate on-shift examination.

   Corrective Action: The mine operator retrained certified persons on conducting adequate examinations, identifying hazardous conditions, and correcting and recording these hazardous conditions before work begins or continues in the affected areas.

CONCLUSION

On April 2, 2026, at 5:05 p.m., Aaron Warrix, a 53-year-old shuttle car operator with over 23 years of mining experience, suffered fatal injuries after being struck by falling roof rock when he was installing roadside-radius (turn) posts on a pillar section.

The accident occurred because the mine operator did not: 1) ensure that no person works or travels under unsupported roof, 2) follow the approved roof control plan, and 3) conduct an adequate on-shift examination.

Approved By:

_____ _____

Craig Plumley — Date
District Manager

ENFORCEMENT ACTIONS

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

   A fatal accident occurred at this operation on April 2, 2026, at 5:05 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 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 mine operator is reminded of the obligation to preserve evidence that would aid in the investigation of the cause or causes of the accident in accordance with 30 CFR 50.12.

2. A 104(a) citation was issued to Marfork Coal Company for a violation of 75.202(b)

   On April 2, 2026, a fatal accident occurred at this mine when a shuttle car operator was struck by falling roof rock while installing roadside-radius (turn) posts. The mine operator did not ensure miners did not work and/or travel under unsupported roof on the No. 3 working section.

3. A 104(d)(1) citation was issued to Marfork Coal Company for a violation of 75.220(a)(1)

   On April 2, 2026, a fatal accident occurred at this mine when a shuttle car operator was struck by falling roof rock while installing roadside-radius (turn) posts. The mine operator did not comply with the Approved Roof Control Plan on the No .3 section.

   MSHA approved the Panther Eagle Mine's roof control plan (RCP) on December 9, 2025. On page 22, item 14, the RCP states, "Pillar extraction shall be done in the sequence as illustrated on the attached drawings. The sequence is indicated by numbers which correspond to individual pillar lifts." Also, on page 22, item 15, the RCP states, "Immediately after each lift, roof supports will be installed as indicated on the attached drawings. Under no circumstances shall anyone travel inby installed breaker posts."

   The No. 1 lift mined from the left side of the No. 12 entry during the day shift exceeded the RCP by a depth of 12.5 feet, and the width by 17 feet.

   During the evening shift, just prior to the accident, the No. 2 lift mined from the right side of No. 12 entry exceeded the RCP by a depth of 12 feet and width of 24 feet.

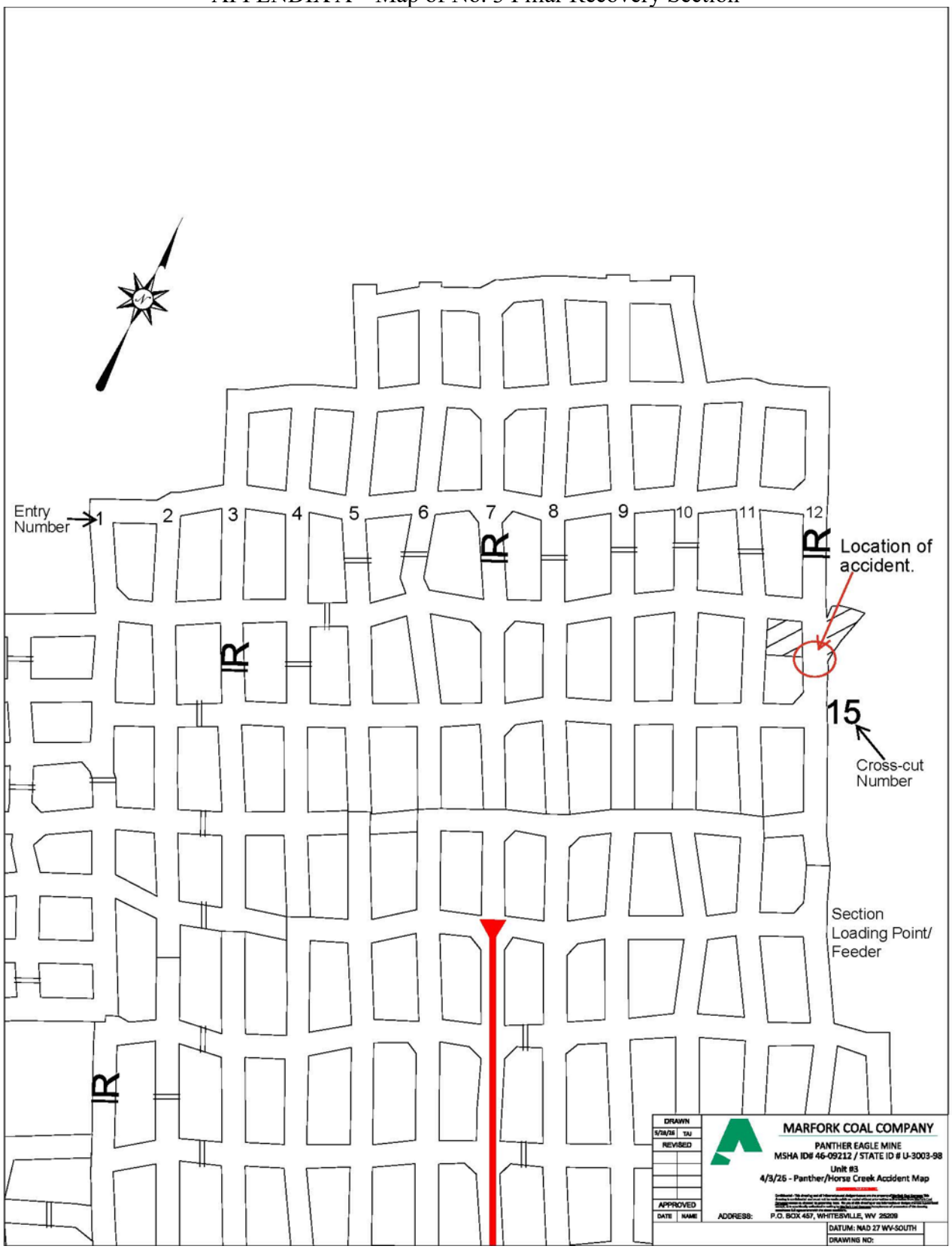
   This noncompliant sequence of mining allowed by the mine operator also prevented the proper installation of timbers (posts) between lifts to supplement the roof support. This increased the span of unsupported roof, allowing the roof strata to sag and become unstable.

   This is an unwarrantable failure to comply with a mandatory standard.

4. A 104(d)(1) order was issued to Marfork Coal Company for a violation of 75.362(a)(3)(i).

   On April 2, 2026, a fatal accident occurred at this mine when a shuttle car operator was struck by falling roof rock while installing roadside-radius (turn) posts. The mine operator did not conduct an adequate on-shift examination of the No. 3 working section. The examiner did not identify and correct hazardous conditions, including violations of 75.220(a)(1) that existed in the No.12 entry as cited in citation 9554305. This is an unwarrantable failure to comply with a mandatory standard.

APPENDIX A – Map of No. 3 Pillar Recovery Section



APPENDIX B – Persons Participating in the Investigation

Marfork Coal Company

Scott Toler	General Manager
Michael Vaught	Safety Director
Mark Rinchich	Superintendent
Chauncy Freeman	General Mine Foreman
Christopher Curry	Safety Technician
Matthew Boulet	Evening Shift Section Foreman
Benjamin Hapney	Day Shift Section Foreman
Ronald Blevins	Continuous Mining Machine Operator
Cody Catlett	Continuous Mining Machine Operator
Jacob Stables	Shuttle Car Operator/Emergency Medical Technician
Tracy Lester	Shuttle Car Operator
Christopher Green	Roof Bolter
Colton Adkins	Roof Bolter
Christopher Snuffer	Electrician
Elijah Hensley	Electrician
Ethan Jarrell	Scoop Operator

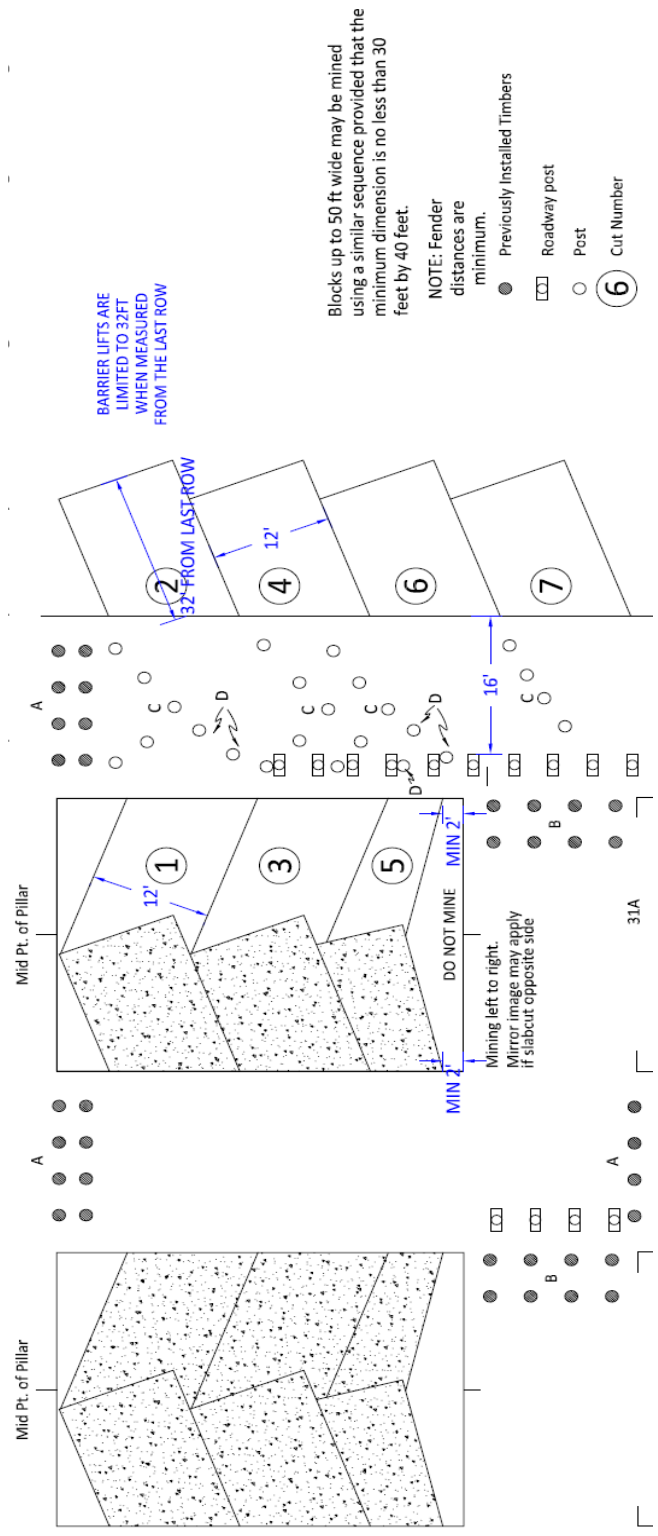
West Virginia Office of Miners Health Safety and Training

Jeremy Ball	Deputy Director
Christopher Dawson	Inspector-at-Large
Charles Moles	Assistant Inspector-at-Large
William Stewart	District Inspector

Mine Safety and Health Administration

Michael Moten	Assistant District Manager
Herman Morgan	Supervisory Mine Safety and Health Specialist
Jeffrey Presley	Supervisory Mine Safety and Health Inspector
Steven Redden	Mine Safety and Health Specialist
Phillip Dillon	Mine Safety and Health Inspector

APPENDIX C- Roof Control Plan (excerpt from page 31A)



When a pillar block is mined by using twin lifts, the lift shall be 12 feet wide and the depth shall be limited to half of the pillar width, or 32 feet. measured from the last row, whichever is less.

(At the time of the accident, the pillar block measured 35 feet, wide making half the distance 17.5 feet deep for cut number 1).

APPENDIX D – Sketch of Accident Scene