FAI-F028CDC-2

UNITED STATES
DEPARTMENT OF LABOR
MINE SAFETY AND HEALTH ADMINISTRATION

REPORT OF INVESTIGATION

Surface
(Limestone)

Machinery Accident Fatality Report
December 10, 2025

North American Mining Company (VBX)
Medley, Florida

at

Mid-Coast Aggregates LLC-Mazak Mine
MID Coast Aggregates LLC
Webster, Sumter County, Florida
ID No. 08-01282

Accident Investigators

David Smith
Mine Safety and Health Inspector

James Fields
Mine Safety and Health Inspector

Mark Schilke
Supervisory Mine Safety and Health Inspector

Originating Office
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OVERVIEW

On December 10, 2025, at 6:19 p.m., Carl Glatzel, a 32-year-old contract dragline operator with 5 years of mining experience, and Pablo Escobar, a 38-year-old contract dragline operator with 8 years of mining experience, died when the dragline they were operating slid into a water-filled pit.

The accident occurred because: 1) the mine operator, the dragline contractor, and the blasting contractor did not use mining methods that maintained wall, bank, and slope stability in places where persons worked or traveled in performing their assigned tasks; 2) the mine operator and dragline contractor did not conduct an adequate examination that included testing for hazardous ground conditions on the active production bench after blasting and prior to the dragline beginning work; 3) the mine operator did not support hazardous ground conditions before permitting other work or travel in the affected area; and 4) the blasting contractor did not conduct an adequate examination for hazardous ground conditions after blasting.

GENERAL INFORMATION

MID Coast Aggregates LLC owns and operates Mid-Coast Aggregates LLC-Mazak Mine. The mine is a surface limestone mine near Webster, Sumter County, Florida. The mine employs 19 miners and operates one 12-hour production shift, 5 days per week. Limestone is mined using a wet extraction process, which is discussed in detail in the Mining Methods section. Once extracted, the mine operator crushes and screens the limestone and sells the finished product as general construction aggregate.

The mine operator contracts Dyno Nobel to conduct blasting operations that includes shot layout and detonating explosives to break up material for processing. The mine operator contracts Global Contracting to remove the overburden from the proposed production bench. The mine

operator further contracts North American Mining Company (NAMC) to operate and maintain the dragline to excavate blasted material from the pit. NAMC places the material in a stockpile along the perimeter of the pit to drain excess water before it is processed by the mine operator. Glatzel and Escobar were employed by NAMC. NAMC employs six miners and operates two 12-hour production shifts, 7 days per week.

The principal management officials at the Mid-Coast Aggregates LLC-Mazak Mine at the time of the accident were:

David Jones	General Manager - Quarries
William Barnes	Plant Manager

The principal management officials for NAMC at the time of the accident were:

Lesley Odom	Production Manager
Andrew Rowell	Safety Manager
Raymond Cruz	Operations Supervisor

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

Randi Seiwald	Senior Consultant

The Mine Safety and Health Administration (MSHA) completed the last regular safety and health inspection at this mine on June 13, 2025. The 2024 non-fatal days lost incident rate for the Mid-Coast Aggregates LLC-Mazak Mine was zero, compared to the national average of 1.23 for mines of this type.

DESCRIPTION OF THE ACCIDENT

On December 10, 2025, at 5:00 p.m., Glatzel and Escobar started their shift. They discussed the previous shift's activities with Enrique Palomino and Bobby Sims, dragline operators for NAMC. Palomino and Sims advised Glatzel and Escobar that the ground was "flaking" beneath the dragline during their shift, meaning the edge of the shot material was sloughing off at the water's edge and falling into the water. This caused Palomino and Simms to move the dragline a few feet back from the water on multiple occasions throughout their shift. Glatzel and Escobar then drove to the pit in the shift change truck and tractor, respectively, to where the dragline was located along the East Wall of the pit.

The dragline was in idle status when Glatzel and Escobar arrived at the pit. Glatzel greased the dragline bucket prior to starting it up. According to the dragline's Continuous Online Monitoring System (COMS), a pre-operational inspection was conducted for 5 minutes. At 5:15 p.m., Glatzel and Escobar started up the dragline and resumed production. From 5:15 p.m. to 6:18 p.m., the dragline was in "normal production digging" status. At 6:18:47 p.m., the COMS recorded a change in the dragline's elevation. Over the next 20 seconds the elevation continued to drop for a total distance of approximately 20 feet before the COMS stopped transmitting.

At 11:15 p.m., Alexander Perez, fill-in supervisor/dragline operator for NAMC, made his rounds to the pit to check on production. Upon approaching the pit, Perez did not notice any lights in the distance that would normally be coming from the dragline. As Perez got closer, he noticed the shift change truck and tractor parked on the dragline pad but did not see the dragline. Perez turned his truck toward the water. With the truck's headlights illuminating the area, Perez saw the dragline in the water. Perez exited his truck, went to the water's edge and attempted to make verbal contact with Glatzel and Escobar. Neither answered his calls.

Perez checked the shift change truck for Glatzel and Escobar but did not find them. Perez contacted Lesley Odom, production manager for NAMC, via cellphone and advised him that the dragline was in the water. Odom told Perez to "hang tight," and that he would call him back. Perez received a call back from Odom who then advised him that he would be getting a call from Andrew Rowell, safety manager for NAMC. Rowell called Perez and advised him to call 911. At 11:30 p.m., Perez called 911 and then made more attempts to make verbal contact with either Glatzel or Escobar at the water's edge. This was unsuccessful, so Perez proceeded to the property entrance to escort emergency services to the accident site.

At 11:58 p.m., emergency personnel began arriving at the mine. On December 11, 2025, at 2:30 p.m., after ensuring the dragline was stable, Sumter County Fire and Rescue began rescue and recovery operations. At 5:20 p.m., the Sumter County Fire and Rescue dive team recovered Glatzel. Tracy Shipe, district medical examiner, pronounced Glatzel dead at 5:21 p.m.

On December 12, 2025, at 4:30 p.m., Underwater Specialty Divers recovered Escobar. Chantel Yevala Njiwaji, district medical examiner, pronounced Escobar dead on December 12, 2025, at 4:33 p.m.

INVESTIGATION OF THE ACCIDENT

On December 10, 2025, at 11:43 p.m., Rowell called the Department of Labor National Contact Center (DOLNCC). The DOLNCC contacted Thomas Chatham, staff assistant. Chatham contacted Scottie Sizemore, supervisory mine safety and health inspector, and Brian Thompson, district manager. Sizemore contacted Richard Woodall, mine safety and health inspector, and directed him to travel to the mine. Brian Thompson, district manager, sent Mark Schilke, supervisory mine safety and health inspector, and James Fields, mine safety and health inspector, to the mine to assist in the investigation.

On December 11, 2025, at 5:02 a.m., Sizemore and Woodall arrived at the mine. Woodall 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.

At 8:18 a.m., Craig Plumley, acting regional administrator, contacted Jamie Proffitt, assistant district manager of the Barbourville District, requesting that David Smith, mine safety and health inspector, be assigned as the lead accident investigator. Proffitt contacted Smith and confirmed the assignment.

At 4:15 p.m., Schilke, supervisory mine safety and health inspector, arrived at the mine.

On December 12, 2025, by 7:45 a.m., Fields and Smith arrived at the mine.

On February 10, 2026, MSHA Technical Support personnel conducted an onsite investigation that included an analysis of geology, ground conditions, and methods of mining which included drilling and blasting.

The MSHA accident investigation team conducted an examination of the accident scene; interviewed miners, mine management, contractors, and contractor management; and reviewed conditions and work procedures relevant to the accident. For reference, a list of persons who participated in the investigation can be found in Appendix A.

DISCUSSION

Location of the Accident

The accident occurred along the East Wall within the active mining pit at the northern portion of the property. The water-filled pit is rectangular in shape and oriented in a general north-south direction, approximately 1,900 feet wide (east-west) by 1,500 feet long (north-south). The dragline was working northward along the East Wall to remove the blasted rock material, and its last location prior to the accident was approximately 900 feet from the south end of the pit. For reference, an aerial view of the active mining pit from Google Earth dated March 2, 2025, can be seen in Appendix B.

Weather

The weather at the time of the accident was mainly clear with a temperature of 53 degrees Fahrenheit. Over an inch of rainfall occurred in the area 3 days prior to the accident. However, investigators determined that weather conditions did not contribute to the accident.

Equipment Involved

The equipment involved in the accident was a P&H 2355 crawler-mounted dragline, Company No. 106. MID Coast Aggregates LLC owns the dragline; NAMC uses it to mine the limestone. According to a P&H specifications guide, the dragline weighs approximately 1.5 million pounds, and the crawler tracks are 36.3 feet long and have an overall width of 35.5 feet. The dragline typically sets up along the edge of the highwall while removing the blasted limestone. The operator's compartment is located on the front right-hand side of the dragline and became submerged when it slid into the water-filled pit. Investigators were unable to examine the dragline until it was recovered from the water on July 15, 2026. An inspection of the dragline was conducted on July 17, 2026. No defects were found on the dragline that would have contributed to the accident.

Geology

The limestone formation within the pit is part of the Ocala Limestone group as classified by the United States Geological Survey. The rock is overlain by sandy clay overburden that is stripped during the mining process. The limestone in this area is generally known as a karst-forming rock. Karst rock terrain can contain sinkholes, cavities, and underground aquifers that are formed when soluble rock (such as limestone) is dissolved or naturally eroded by water.

Mining Method

A wet excavation process is used to extract the limestone. Global Contracting uses a range of equipment including bulldozers, excavators, haul trucks, and draglines, along with various support units such as fuel trucks and graders to strip 15 to 20 feet of overburden. The stripping exposes the limestone deposit, which serves as the active production bench and dragline pad. If voids or clay-filled pockets are present, they are dug out and backfilled with excavators and bulldozers to create a level production bench. The result is that the top-of-rock may be uneven, requiring either cuts or fills. The position of the natural water table or the level to which the mine can pump influences the selected elevation for the production bench. The mine operator drills the limestone production bench, Dyno Nobel loads the holes and blasts, then NAMC uses a dragline to remove the blasted limestone from the water. The dragline turns and dumps the excavated material behind it to dry. The dragline involved in the accident could excavate material to a depth of approximately 100 feet.

MSHA determined that NAMC used poor digging practices that caused "flaking" and the need to continually move the dragline back from the water's edge on the shift prior to the accident. The slope below the dragline pad was steep and unsafe. NAMC did not use mining methods that maintained wall, bank, and slope stability in places where persons worked or traveled in performing their assigned tasks, which contributed to the accident.

Drilling and Blasting

Dyno Nobel began blasting work at this mine on July 24, 2025. According to Dyno Nobel blast reports, two or three rows of holes with an average of 11 holes per row are typically drilled for each shot. The holes are drilled in a staggered pattern with an 18-foot spacing between holes and a 20-foot burden (spacing) between the rows, although the pattern and spacing may vary between shots. Each row of holes is aligned approximately parallel to the free face/water and drilled to a depth of 100 feet. The drill log sheets classify the rock types as soft, medium, hard, or flint. If a void is encountered, it would be marked as an "A" for anomaly; however, no voids were encountered according to the drill logs provided to investigators for the shots near the current accident location. The active faces along the East and North Walls are drilled and blasted weeks or months in advance of the dragline. At the time of the accident on December 10, 2025, the dragline was removing blasted material from Shot No. 6, which was detonated on September 30, 2025.

Investigators identified multiple inconsistencies between reported data and actual field conditions. While blast reports and drill logs indicated a consistent borehole diameter of 4.5 inches, investigators measured the drill head at approximately 8 inches and the inner diameter of the tubes to be 4.25 inches. Drill logs, considered critical for identifying subsurface voids, were missing for seven out of 12 blast reports, limiting the ability to fully evaluate ground conditions and predict blasting effectiveness.

For Shot No. 6, the mine provided a drill log for this blast area that did not identify any geological anomalies. The blast report documented that one of the 33 holes collapsed and could not be loaded, while the remaining holes were drilled and loaded as planned. Dyno

Nobel did not provide evidence to show the use of controlled blasting techniques designed to protect final wall stability.

Further analysis showed that reported charge weights and calculated values, based on measured site conditions, were generally close, with only a 2% deviation. However, when compared to the original blast design, the actual charge weights were approximately 9.5% lower than specified with no stated rationale behind the reduction. This reduction likely resulted in a lower powder factor, increasing the risk of over confinement and reducing blast effectiveness.

Inaccurate design parameters and inadequate control over drilling and loading procedures led to inconsistent charge weights and product densities. These issues likely contributed to poor explosive performance and increased stress transfer to the surrounding rock, resulting in damage to the final wall. Dyno Nobel requires accurate drill log data from MID Coast Aggregates LLC and reliable blast reports from the Blaster in Charge to apply effective controlled blasting techniques.

Ground Conditions

The mine operator and Dyno Nobel created hazardous ground conditions from the poor drilling and blasting practices, evident by the backbreaks and cracking. The mine operator and Dyno Nobel did not use mining methods that maintained wall, bank, and slope stability in places where persons worked or traveled in performing their assigned tasks, which contributed to the accident.

Field observations and drone maps from September 24 through December 11, 2025 show that blasting produced significant backbreak and cracking across the production bench. In several places, cracks extended more than 20 feet behind the last row of blast holes. According to interviews, miners and contract miners stated that they generally stay on the “solid” side of visible cracks, but drone imagery shows miners repeatedly filling or covering cracks when grading the production bench to level the dragline pad. Ronald Leeser, supervisor, directed miners and Global Contracting employees to cover cracks during the bench preparation. Dragline operators also said they cover cracks to limit surface runoff and slow deterioration of the bench. The repeated covering and reappearance of cracks indicates ongoing ground movement and hidden subsurface instability that may not be apparent to personnel on the ground.

Investigators identified a large arc-shaped backbreak crack that formed after Shot No. 6, which measured approximately 150 feet long and was 23 feet back from the last row of blast holes. For reference, Appendix C shows an aerial view of the backbreak crack. The crack first appeared on October 1. Grading covered the crack on October 10, but it reappeared by October 31. The crack was covered again on December 1 and began to reappear on December 5.

On the day of the accident, the dragline was positioned over this area. For reference, Appendices C and D show aerial views of the dragline’s approximate location the day of the accident, and the dragline following the accident on December 12, respectively.

The hazardous ground conditions created by the backbreak and cracking indicated the need for further evaluation and close monitoring of ground conditions. The dragline was positioned over

the cracked area and as it began removing the blasted material along the water's edge it was likely removing some buttressing support on the cracked portion of the wall. The ground eventually failed under the weight of the dragline, causing the dragline to slide into the water. Investigators determined that the mine operator did not support hazardous ground conditions before permitting other work or travel in the affected area, which contributed to the accident.

Examinations

The dragline operators on the shift prior to the accident moved the dragline multiple times as the ground "flaked" beneath the dragline and advised Glatzel and Escobar of these conditions. Raymond Cruze, operations supervisor for NAMC, received COMS data in real time that showed the dragline stopped production multiple times. This should have indicated to Cruze that there was a problem with the dragline pad, however, no corrective actions were put into place to protect miners. Cruze should have been aware of the ground conditions prior to the accident.

According to the COMS data, Glatzel and Escobar conducted a pre-operational inspection of the dragline at approximately 5:10 p.m. NAMC workplace and ground condition examinations for the shift of the accident were documented on paper and maintained in the operator's compartment of the dragline. Investigators were unable to recover the submerged records during the investigation.

The mine operator's ground condition examination records did not identify any hazardous conditions and noted "cutting and moving water" for a period of over 1 year. The records listed a corrective action of "pad work for dragline smoothed floor for level." Leeser conducted examinations 50 times, of the affected area, from October 1, 2025 to the day of the accident on December 10, 2025, and was aware of the hazardous ground conditions. The investigation found multiple obvious surface cracks indicating potential stability issues in the active production bench.

The mine operator and NAMC did not conduct an adequate examination that included testing for hazardous ground conditions on the active production bench after blasting and prior to the dragline beginning work. Investigators determined that this contributed to the accident.

Dyno Nobel did not conduct an adequate examination for hazardous ground conditions after blasting. Dyno Nobel's post-blast inspection procedures, 2.02.09, were not followed. Per the post-blast reentry procedure, a qualified competent person should examine and test for loose ground, identify any loose material that presents a potential hazard, and look for severe backbreak and endbreak along the blast limits. Where hazardous conditions are found, they should secure the area and post warning signs and barricades to prevent entry until the corrective work is completed. Investigators determined the lack of examination contributed to the accident.

Training and Experience

Glatzel had 5 years of mining experience, with 1 year and 5 months with NAMC. Glatzel received experienced miner training on December 18, 2024, and task training on the P&H 2355 Dragline on October 21, 2025.

Escobar had 8 years of mining experience, all with NAMC. Escobar received experienced miner training on December 5, 2024 and task training on the P&H 2355 Dragline on April 29, 2025.

Investigators determined that Glatzel and Escobar received all training in accordance with MSHA Part 46 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, dragline contractor, and blasting contractor implemented the corresponding corrective actions to prevent a recurrence.

1. Root Cause: The mine operator, dragline contractor, and blasting contractor did not use mining methods that maintained wall, bank, and slope stability in places where persons worked or traveled in performing their assigned tasks.

   Corrective Action: The mine operator developed and implemented a new written drilling and blasting procedure. The mine operator and blasting contractor will conduct a joint technical review, at agreed upon intervals, to evaluate timing adjustments. The blaster will support the mine operator in evaluating alternative perimeter control methods. Before loading, crews will review drill logs, the blaster will confirm the current drill plan and mark each hole for abnormal conditions, and the blaster will inspect loaded holes prior to firing. The blaster in charge has authority to make changes to the blast design and adjust sequencing on the day of the blast. Post-blast inspection includes checking for indications of unfired explosives, severe backbreak or endbreak, and unstable ground. The mine operator will secure hazardous areas with warning signs and barricades until corrective work is completed. The all-clear signal will not be given until this inspection is complete. The mine operator also developed and implemented new written digging procedures to include maintaining a 1H:1V slope and performing ground examinations and soundings at regular intervals. The mine operator and the dragline contractor will conduct a joint technical review, at agreed upon intervals, to evaluate adjustments. Miners, contract miners, and contract blasters were trained in these procedures.

2. Root Cause: The mine operator and dragline contractor did not conduct an adequate examination that included testing for hazardous ground conditions on the active production bench after blasting and prior to the dragline beginning work.

   Corrective Action: The mine operator developed and implemented new written procedures for examining the pit. The procedures include examining the areas where equipment is going to operate for cracks and backbreaks. If found, examiners will take appropriate corrective measures, which are detailed in the third corrective action. Miners and contract miners were trained in these procedures.

   Additionally, the dragline contractor will collect aerial imagery weekly, when applicable operations are ongoing, and any identified backbreaks will be georeferenced by latitude and

longitude and annotated on a contour map. The dragline contractor will collaborate with the mine operator to review all aerial imagery and share this information with dragline operators to ensure safe operations.

3. Root Cause: The mine operator did not support hazardous ground conditions before permitting other work or travel in the affected area.

   Corrective Action: The mine operator developed and implemented a new written procedure for taking appropriate corrective measures when hazardous ground conditions are identified. The mine operator will determine the dimensions of the crack, remove loose material with an excavator, and fill the crack with solid flooring material. When backbreak cracking is encountered, the examiners will immediately notify the dragline operator, and other equipment will be moved to a safe location. Miners and contract miners were trained on these procedures.

4. Root Cause: The blasting contractor did not conduct an adequate examination for hazardous ground conditions after blasting.

   Corrective Action: The blasting contractor retrained their employees on examining for hazardous ground conditions after blasting.

CONCLUSION

On December 10, 2025, at 6:19 p.m., Carl Glatzel, a 32-year-old contract dragline operator with 5 years of mining experience, and Pablo Escobar, a 38-year-old contract dragline operator with 8 years of mining experience, died when the dragline they were operating slid into a water-filled pit.

The accident occurred because: 1) the mine operator, the dragline contractor, and the blasting contractor did not use mining methods that maintained wall, bank, and slope stability in places where persons worked or traveled in performing their assigned tasks; 2) the mine operator and dragline contractor did not conduct an adequate examination that included testing for hazardous ground conditions on the active production bench after blasting and prior to the dragline beginning work; 3) the mine operator did not support hazardous ground conditions before permitting other work or travel in the affected area; and 4) the blasting contractor did not conduct an adequate examination for hazardous ground conditions after blasting.

Approved By:

_____ _____

Brian Thompson — Date
District Manager

ENFORCEMENT ACTIONS

1. A 103(k) order was issued to MID Coast Aggregates LLC.

   A fatal accident occurred on December 10, 2025, at 6:19 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 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) citation was issued to MID Coast Aggregates LLC for a violation of 30 CFR 56.3401.

   On December 10, 2025, two dragline operators died when the dragline they were operating slid into a water-filled pit. The mine operator did not conduct an adequate examination that included testing for hazardous ground conditions on the active production area at the top of the highwall after blasting and prior to the dragline beginning work. The mine supervisor was aware of the hazardous ground conditions after conducting 50 examinations of the affected area from October 1, 2025 to the day of the accident. The mine operator engaged in aggravated conduct constituting more than ordinary negligence. This violation is an unwarrantable failure to comply with a mandatory standard.

3. A 104(d)(1) order was issued to MID Coast Aggregates LLC for a violation of 30 CFR 56.3130.

   On December 10, 2025, two dragline operators died when the dragline they were operating slid into a water-filled pit. The mine operator did not use mining methods that maintained wall, bank, and slope stability in places where persons worked or traveled in performing their assigned tasks. The mine supervisor was aware of the hazardous ground conditions that resulted from poor drilling and blasting practices used by Dyno Nobel. The mine operator was also aware of the hazardous ground conditions that resulted from poor digging practices used by North American Mining Company. The mine operator engaged in aggravated conduct constituting more than ordinary negligence. This violation is an unwarrantable failure to comply with a mandatory standard.

4. A 104(d)(1) order was issued to MID Coast Aggregates LLC for a violation of 30 CFR 56.3200.

   On December 10, 2025, two dragline operators died when the dragline they were operating slid into a water-filled pit. The mine operator did not support hazardous ground conditions before permitting other work or travel in the affected area. A supervisor directed miners to cover the visible surface crack with material to level the work area for the dragline prior to the accident. The mine operator engaged in aggravated conduct constituting more than

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

5. A 104(d)(1) citation was issued to North American Mining Company for a violation of 30 CFR 56.3130.

   On December 10, 2025, two dragline operators died when the dragline they were operating slid into a water-filled pit. The dragline contractor did not use mining methods that maintained wall, bank, and slope stability in places where persons worked or traveled in performing their assigned tasks. The dragline contractor was aware of the hazardous ground conditions that resulted from poor digging practices. The dragline contractor engaged in aggravated conduct constituting more than ordinary negligence. This violation is an unwarrantable failure to comply with a mandatory standard.

6. A 104(d)(1) order was issued to North American Mining Company for a violation of 30 CFR 56.3401.

   On December 10, 2025, two dragline operators died when the dragline they were operating slid into a water-filled pit. The dragline contractor did not conduct an adequate examination for hazardous ground conditions on the active production area at the top of the highwall prior to the dragline beginning work. The dragline operators on the previous shift moved the dragline multiple times as the ground “flaked” beneath and advised the two dragline operators involved in the accident of these conditions. The dragline contractor's supervisor was provided with electronic notification of the ground conditions and should have been aware of these conditions prior to the accident. The dragline contractor engaged in aggravated conduct constituting more than ordinary negligence. This violation is an unwarrantable failure to comply with a mandatory standard.

7. A 104(d)(1) citation was issued to Dyno Nobel for a violation of 30 CFR 56.3130.

   On December 10, 2025, two dragline operators died when the dragline they were operating slid into a water-filled pit. The blasting contractor did not use mining methods that maintained wall, bank, and slope stability in places where persons worked or traveled in performing their assigned tasks. The contract blaster was aware of the hazardous ground conditions that resulted from poor drilling, loading, and blasting practices. Inaccurate design parameters and inadequate control over drilling and loading procedures led to inconsistent charge weights and product densities. The contract blaster engaged in aggravated conduct constituting more than ordinary negligence. This violation is an unwarrantable failure to comply with a mandatory standard.

8. A 104(d)(1) order was issued to Dyno Nobel for a violation of 30 CFR 56.6306(g).

   On December 10, 2025, two dragline operators died when the dragline they were operating slid into a water-filled pit. The blasting contractor did not conduct an adequate post-blast examination for hazardous ground conditions on the active production area at the top of the

highwall. The contract blaster engaged in aggravated conduct constituting more than ordinary negligence. This violation is an unwarrantable failure to comply with a mandatory standard.

APPENDIX A – Persons Participating in the Investigation

MID Coast Aggregates LLC

David Jones	General Manager - Quarries
William Barnes	Plant Manager
Jarret Kelly	Supervisor of Foremen
Ronald Leeser	Supervisor
Charles Stokes	Loader Operator
Nicholas Jackson	Drill Operator
Melanie Kilpatrick	Attorney – Ogletree Deakins

North American Mining Company

Phillip Berry	President
Lesley Odom	Production Manager
Andrew Rowell	Safety Manager
Enrique Palomino	Dragline Operator
Bobby Sims	Dragline Operator
Alexander Perez	Fill-In Supervisor/Dragline Operator

Global Contracting

Kaitlyn Lucas	Foreman
Tommy Deaner	Safety Manager

Dyno Nobel

Joshua Peet	Blaster
John McCloy	Blaster
Randi Seiwald	Senior Consultant

Mine Safety and Health Administration

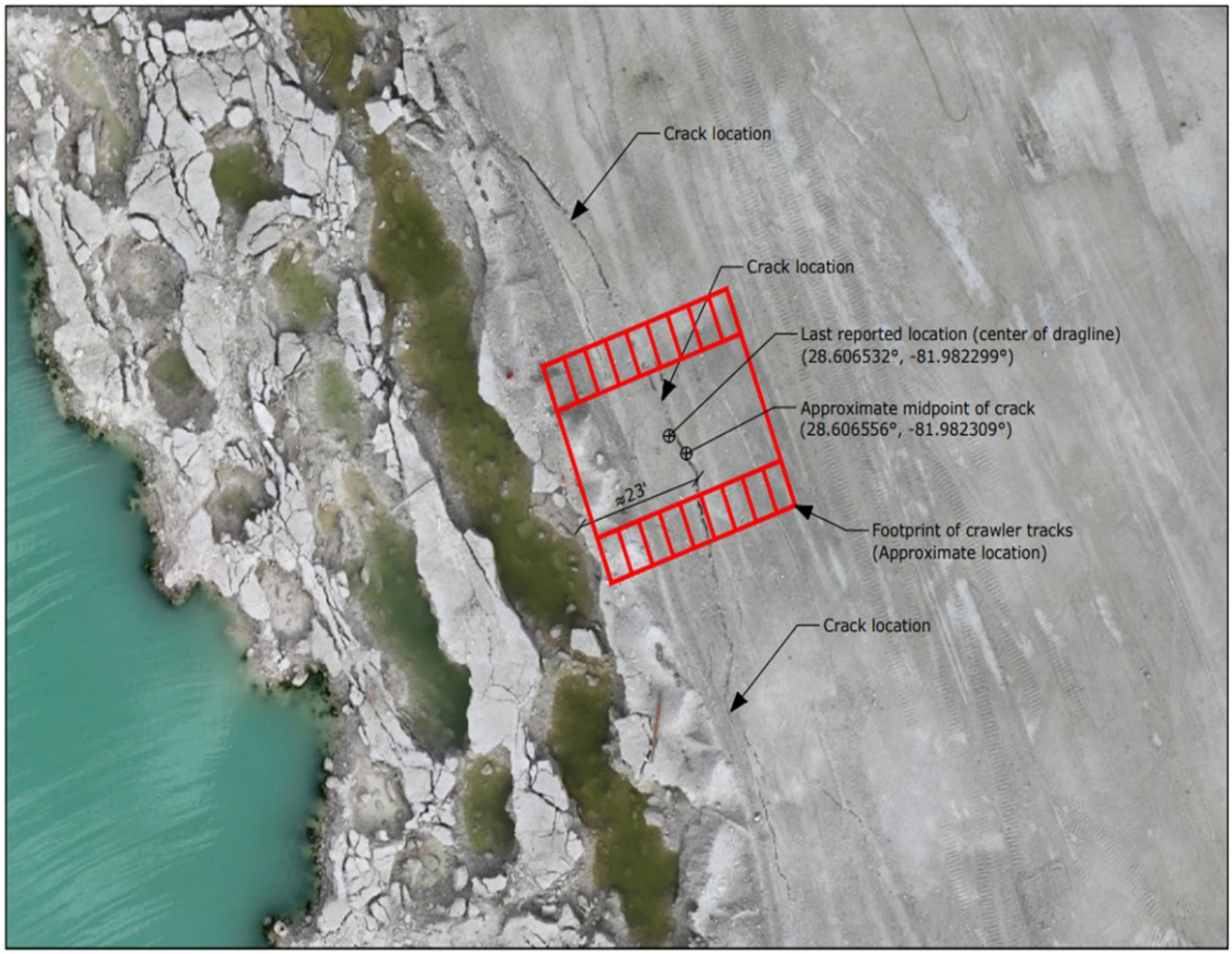
Brian Thompson	District Manager
Thomas Chatham	Staff Assistant
Ryan O'Boyle	Supervisory Mine Safety and Health Inspector
Scottie Sizemore	Supervisory Mine Safety and Health Inspector
Mark Schilke	Supervisory Mine Safety and Health Inspector
James Fields	Mine Safety and Health Inspector
David Smith	Mine Safety and Health Inspector
Richard Woodall	Mine Safety and Health Inspector
Stanley Schaeffer	Civil Engineer
Steven Vamossy	Civil Engineer
Mark Kvitkovich	Mechanical Engineer

APPENDIX B – Aerial View of Pit



Aerial view of active mining pit from Google Earth dated March 2, 2025.

APPENDIX C – Dragline Pad Showing Backbreak Crack



Aerial view of crack and dragline location from the drone map dated November 7, 2025.

APPENDIX D – Dragline Location After Pad Failure



Aerial view of dragline following the accident from the drone map dated December 12, 2025.