

UNITED STATES
DEPARTMENT OF LABOR
MINE SAFETY AND HEALTH ADMINISTRATION

REPORT OF INVESTIGATION

Surface
(Frac Sand Mine & Plant)

Slip or Fall of Person Accident Fatality Report
March 28, 2026

Mike Morgan Industrial, LLC (B0425)
Chelsea, Alabama

at

Alpine Silica-San Antonio
Alpine Silica, LLC
San Antonio, Bexar County, Texas
ID No. 41-05426

Accident Investigators

Gregory Sensibaugh
Mine Safety and Health Inspector

Thomas Balch
Mine Safety and Health Specialist

Originating Office
Mine Safety and Health Administration
Dallas District
1100 Commerce Street
Dallas, Texas 75242
William O'Dell, District Manager

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OVERVIEW

On March 28, 2026, at 9:00 a.m., Carlos Lopez, a 19-year-old millwright/iron worker, with over 1 year of mining experience, died when he detached from a fall protection tie-off point to navigate to another area of the roof and fell about 37 feet and 6 inches through an unsecured roof panel.

The accident occurred because: 1) the contractor did not ensure contract employees remained tied off while exposed to a fall hazard; and 2) the mine operator and contractor did not conduct a thorough workplace examination to identify hazards on the damaged roof.

GENERAL INFORMATION

Alpine Silica, LLC owns and operates the Alpine Silica-San Antonio mine, a surface sand mine in San Antonio, Bexar County, Texas. The mine employs 59 miners and operates two 12-hour shifts, 7 days per week. Contract miners from Interstate Earthworks LLC excavate sand with excavators and transport it to the plant using articulating haul trucks. The plant washes, dries, and sizes the sand, with the final product used as frac sand. Alpine Silica, LLC contracted Mike Morgan Industrial, LLC to repair a damaged diverter chute and screen building roof. Lopez was an employee of Mike Morgan Industrial, LLC.

The principal management official at the Alpine Silica-San Antonio mine at the time of the accident was:

Isaias Reyes

Dry Plant Lead

The principal management official for Mike Morgan Industrial, LLC at the time of the accident was:

Dustin Sparks

Foreman

The Mine Safety and Health Administration (MSHA) completed the last regular safety and health inspection at this mine on November 14, 2025. The 2025 non-fatal days lost incident rate for the Alpine Silica-San Antonio mine was zero, compared to the national average of 1.17 for mines of this type.

DESCRIPTION OF THE ACCIDENT

On March 23, 2026, at about 12:05 p.m., a diverter chute fell on the Rotex screen building, damaging both the chute and the roof of the building. Arrangements were made between Chase Mansfield, project manager for Alpine Silica, LLC, and Kyle Kennedy, project manager for Mike Morgan Industrial, LLC, to repair the chute and the damage to the roof. Mike Morgan Industrial, LLC contracted Howell Crane to provide an 80-ton Grove crane and a crane operator. Additional arrangements were made with Equipment Share to provide a personnel lift. A four-person crew from Mike Morgan Industrial, LLC, consisting of three millwright/iron workers and one foreman, was sent from Westover, Alabama to the Alpine Silica-San Antonio mine.

On March 25, 2026, Mike Morgan Industrial, LLC employees Lopez, Karl Nobles, and Jacob Rogers, millwright/iron workers, and Dustin Sparks, foreman, arrived at the mine and received site-specific hazard training from Mansfield. After the orientation and training, the contractors began chute repairs on the ground, and the chute was reassembled by the end of the workday.

On March 26, 2026, at 9:20 a.m., the reassembled chute repairs were completed. At 11:17 a.m., Nobles and Rogers began to work on repairs to the damaged roof. Nobles and Rogers worked from the personnel lift to remove screws from the sheet metal on the roof and continued until the end of the workday.

On March 27, 2026, additional repairs were requested by the mine operator that were outside the original scope of work. Lopez, Nobles, Rogers, and Sparks continued the removal of the sheet metal from the damaged roof. Lopez and Rogers worked from the roof while Nobles operated the personnel lift. Sparks remained on the ground performing rigging, support, and material organization. The work continued until the end of the workday at 6:26 p.m.

On March 28, 2026, at 6:36 a.m., Lopez, Rogers, Nobles, and Sparks continued their work to repair the damaged roof. Rogers and Lopez were on the roof, with Rogers positioned on the southwest side and Lopez positioned on the northeast side. Nobles operated the personnel lift, and Sparks remained on the ground for rigging. The crew removed damaged purlins using the crane. Lopez remained stationary during this portion of the work, positioned adjacent to the first purlin to be replaced. Lopez was tied off to a purlin using an anchorage connector. Rogers returned to the personnel lift after purlin removal.

At 8:26 a.m., the crane raised the first replacement purlin up to the roof. Rogers and Nobles had difficulty rotating the purlin into place from the personnel lift. Lopez disconnected from his anchorage connector and walked up the roof, without fall protection, to assist. Lopez helped rotate the purlin and then returned to his original position and reattached to his anchorage connector.

At 8:30 a.m., Rogers accessed a structural beam to attach the purlin and bracket on the northeast side, while still tied off to the personnel lift. Rogers determined the purlin was positioned incorrectly and needed to be rotated. Rogers then disconnected from the personnel lift while straddling the structural beam. Nobles lowered the personnel lift to the ground and then repositioned to the center of the purlin to assist with rotation.

At 8:48 a.m., the crane lifted the purlin while Nobles attempted to rotate it. Lopez observed Nobles struggling and again disconnected from his anchorage connector and walked up the roof, without fall protection, to assist. Lopez assisted in stabilizing and positioning the purlin, then returned to his work area and reattached to his anchorage connector.

At 8:59 a.m., while Rogers was straddling the beam and Nobles was positioned near the center lifting sheet metal to allow clearance, Lopez again disconnected from his anchorage point and began walking up the roof to assist without fall protection.

At 9:00 a.m., Lopez stepped onto an unsecured section of roofing material near the surge bin and fell about 37 feet and 6 inches down to the Rotex screen building floor below. Nobles notified Sparks of the fall. Sparks immediately went to the Rotex floor and found Lopez unresponsive. Nobles, Rogers, and Sparks began administering cardiopulmonary resuscitation while also applying an automated external defibrillator (AED). The AED did not advise administering a shock. Sparks called 911 at 9:20 a.m.

The Bexar County Sheriff's Office sent the Bexar County Fire Agency Engine No. 2 and Allegiance Emergency Medical Services. First responders took over lifesaving measures. Christopher Mercer, firefighter, along with Christopher Price and Jessica Hyde, paramedics, evaluated Lopez. Price contacted Dr. Bryan Everett by phone who pronounced Lopez deceased at 9:28 a.m. on March 28, 2026.

INVESTIGATION OF THE ACCIDENT

On March 28, 2026, at 9:44 a.m., Tristan Childress, safety specialist for Alpine Silica-San Antonio, called the Department of Labor National Contact Center (DOLNCC) to report an injury with reasonable potential to cause death. The DOLNCC notified Ronnie Free, assistant district manager. Free informed Brett Barrick, assistant district manager. Barrick instructed Thomas Balch, mine safety and health specialist, to respond and initiate the investigation. Barrick assigned Gregory Sensibaugh, mine safety and health inspector, as the lead investigator.

At 12:45 p.m., Balch arrived at the mine. At 12:50 p.m., Balch 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. Balch gathered written statements and initial photographic documentation of the accident scene.

On March 29, 2026, at 6:45 a.m., Sensibaugh met with Steven Oates, supervisory mine safety and health specialist, and Balch at the mine to continue the investigation.

The MSHA accident investigation team examined 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 roof of the Rotex screen building with a height of about 40 feet.

Weather

The weather at the time of the accident was about 59 degrees Fahrenheit, mostly sunny, with a northeast wind at 9 miles per hour. Investigators determined that weather did not contribute to the accident.

Equipment Involved

The personnel lift in use at the time of the accident was a Genie 135. The fall protection equipment in use included a Protecta XL harness, Safewaze Latitude double-leg lanyard, and a 5/16 x 10 BRSP anchorage connector rated at 5,000 pounds. No defects were identified with the equipment. Investigators determined that the conditions of the equipment did not contribute to the accident.

Examinations

Sparks did not conduct a workplace examination of the roof area, including the interior view from inside the Rotex screen building, on the day of the accident. No examination records were available for the personnel lift on the day of the accident. Previous pre-operational records and prior workplace examinations were available and did not identify hazards. Investigators determined that workplace examinations were not conducted, which contributed to the accident.

Training and Experience

Lopez received 8.5 hours of new miner training on August 14, 2025, which included fall protection training. There is no documentation to support the remainder of the Part 46 training was completed. Lopez had over 1 year and 36 weeks of total mining experience as a millwright/iron worker. Investigators determined that training did not contribute 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 and contractor implemented the corresponding corrective actions to prevent recurrence.

1. Root Cause: The contractor did not ensure contract employees remained tied off while exposed to a fall hazard.

Corrective Action: The mine operator and contractor implemented a policy requiring continuous use of fall protection when working at heights and will conduct routine monitoring to ensure compliance.

2. Root Cause: The mine operator and contractor did not conduct a thorough workplace examination to identify hazards on the damaged roof.

Corrective Action: The mine operator and contractor revised their workplace examination procedures to ensure all work areas, including elevated and interior hazard exposures, are evaluated and documented.

CONCLUSION

On March 28, 2026, at 9:00 a.m., Carlos Lopez, a 19-year-old millwright/iron worker, with over 1 year of mining experience, died when he detached from a fall protection tie-off point to navigate to another area of the roof and fell about 37 feet and 6 inches through an unsecured roof panel.

The accident occurred because: 1) the contractor did not ensure contract employees remained tied off while exposed to a fall hazard; and 2) the mine operator and contractor did not conduct a thorough workplace examination to identify hazards on the damaged roof.

Approved By:

William O'Dell
District Manager

Date

ENFORCEMENT ACTIONS

1. A 103(k) order was issued to Alpine Silica, LLC.

A fatal accident occurred on March 28, 2026, at 9:00 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 Mike Morgan Industrial, LLC for a violation of 30 CFR 56.15005.

On March 28, 2026, a fatal accident occurred when a contract miner fell through the Rotex screen building while performing repairs to the roof structure. The contractor did not ensure the contract miner wore a safety belt and line where there was a danger of falling. A contract miner was wearing a fall harness and lanyards and untied from the anchor point to walk along the roof and attach a replacement section of purlin when a section of the roof tin collapsed, allowing him to fall to the floor below. Damage to the roof structure required the miner to cross from one side of the openings in the roof to the other to assist in securing the replacement structure. The miners were provided with a single anchor point to utilize on the roof. The limited fall hazard protection provided required miners to untie multiple times during this project and access the elevated working place where there was a danger of falling.

3. A 104(d)(1) citation was issued to Mike Morgan Industrial, LLC for a violation of 30 CFR 56.18002(a).

On March 28, 2026, a fatal accident occurred when a miner fell through the Rotex screen building while performing repairs to the roof structure. An examination of the work area was not performed by a designated competent person for the contractor prior to work being conducted for conditions that would adversely affect safety and health. A contract miner walking along the roof to attach a replacement section of purlin died when a section of the roof tin collapsed, allowing him to fall to the floor below. Damage to the roof structure, openings in the roof, and limited fall hazard protection provided required miners to untie and access the elevated working place multiple times during the job. The contractor engaged in aggravated conduct constituting more than ordinary negligence. This violation is an unwarrantable failure to comply with a mandatory standard.

4. A 104(a) citation was issued to Alpine Silica, LLC for a violation of 30 CFR 56.18002(a).

On March 28, 2026, a fatal accident occurred when a miner fell through the Rotex screen building while performing repairs to the roof structure. An examination of the work area was not performed by a designated competent person prior to work being conducted for conditions that would adversely affect safety and health. A contract miner walking along the

roof to attach a replacement section of purlin died when a section of the roof tin collapsed, allowing him to fall to the floor below.

APPENDIX A – Persons Participating in the Investigation

Alpine Silica, LLC

Nikki Beane	Safety Director
Reynaldo Jimenez	Plant Manager
Anthony Alfaro	Production Manager
Johnathon Spencer	Maintenance Manager
Chase Mansfield	Project Manager
Tristan Childress	Safety Specialist

Mike Morgan Industrial, LLC

Teddy Wendell	Safety Manager
Dustin Sparks	Foreman
Karl Nobles	Millwright/Iron Worker
Jacob Rogers	Millwright/Iron Worker

Mine Safety and Health Administration

Steven Oates	Supervisory Mine Safety and Health Specialist
Thomas Balch	Mine Safety and Health Specialist
Gregory Sensibaugh	Mine Safety and Health Inspector

APPENDIX B – Top View of Roof

