FAI-6852719-1

UNITED STATES
DEPARTMENT OF LABOR
MINE SAFETY AND HEALTH ADMINISTRATION

REPORT OF INVESTIGATION

Surface
(Gold)

Fatal Falling, Sliding, or Rolling Rock or Material of Any Kind Accident
September 14, 2021

Butte Gulch
Higher Ground Resources
Murray, Shoshone County, Idaho
ID No. 10-02336

Accident Investigators

Michael Treloar
Mine Safety and Health Inspector

Thaddeus Sichmeller
Supervisory Mine Safety and Health Inspector

Marc Shadden
Mine Safety and Health Inspector

Originating Office
Mine Safety and Health Administration
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Dustan Crelly, District Manager

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OVERVIEW

On September 14, 2021, at approximately 1:00 p.m., Richard Schwentner, a 70 year-old guest at the mine, died when a 20-foot highwall collapsed and engulfed him.

The accident occurred because the mine operator did not: 1) notify MSHA when mining commenced; 2) verify that the visitor received the minimum required training; and 3) post signs to warn of hazardous ground conditions, or erect access barriers to impede unauthorized entry to the area.

GENERAL INFORMATION

Higher Ground Resources leases and operates the Butte Gulch mine. This mine is a surface gold mine located in Murray, Shoshone County, Idaho. Higher Ground Resources employs four miners and the mine operates one eight-hour shift, five days per week, when weather conditions permit. The mine excavates the material in an open pit and transports the material by haul truck to an on-site processing facility where a trommel screen and a sluice trough process the material to recover the gold ore.

The principal officer for Higher Ground Resources at the time of the accident was:

Randy Louis Rice	Owner/Operator

This mine operator did not notify the Mine Safety and Health Administration (MSHA) when they started mining operations in June 2020. Therefore, MSHA had not conducted a regular health and safety inspection, and since the mine operator was not reporting injuries and work hours, no non-fatal days lost injury rate could be calculated.

DESCRIPTION OF THE ACCIDENT

On September 14, 2021, Branden Dunsmore, Equipment Operator; Ronald Gorman, Equipment Operator; and Dustin Mead, Equipment Operator, began work at 6:00 a.m. They performed routine greasing and fueling of their equipment, and Dunsmore started mining at the northern boundary of the pit, extracting material for the processing facility. Gorman operated the haul truck to move extracted material to the processing facility's feed stockpile, and Mead used the excavator to supply the processing facility with material.

Rice invited Schwentner to the mine to prospect for gold. Rice told investigators that, prior to the day of the accident, he and Schwentner discussed Schwentner's discovery of some gold in the excavated area. Rice told Schwentner that it was good that he found some gold, but not to go in the excavated area.

On September 14, 2021, Schwentner arrived at the mine at 11:00 a.m. and met with Mead at the processing facility before proceeding to the northern boundary of the pit. When Schwentner arrived at the northern boundary of the pit, Schwentner met with Dunsmore, who was working in the same area extracting material with an excavator. Dunsmore told Schwentner to prospect away from the highwall because the highwall banks were unstable from excavation. Dunsmore observed Schwentner set up his equipment in an area that appeared to be safe.

At approximately 1:00 p.m., Dunsmore observed that Schwentner was not in the area of Schwentner's equipment. Dunsmore then went to the area where he had last seen Schwentner working, called his name, but did not hear a response. Dunsmore went to the processing facility and informed Mead and Gorman that he could not find Schwentner. The three miners went up to the area and continued calling out, with no response. The three miners heard a beeping noise coming from the north bank of the pit and identified a hand buried in the dirt. The beeping noise was coming from Schwentner's metal detector. The approximately 20-foot highwall bank fell and covered Schwentner with four to six feet of material. Gorman checked Schwentner for a pulse but could not find one and then instructed Mead to call 911. Gorman also instructed Mead to go to the Golden Chest Mine, approximately two miles away, for mine rescue help because there were no emergency communication methods available at Butte Gulch.

Michael Leeling, Safety Coordinator; Andrew Brackebusch, Miner; Drake Goldade, Miner; and Gary Hileman, Miner, from the Golden Chest Mine went to the accident site to assist. Upon arriving at the site, the Golden Chest Mine rescue team assessed the highwall banks and determined that the highwall banks were unstable and excavation would be required to provide safe access to recover Schwentner (see Appendix A). Dunsmore moved the excavator he was operating to the accident site. Other emergency medical services started arriving at the site along with Richard Smith, Deputy Coroner, who pronounced Schwentner dead at 3:00 p.m. at the accident site. At this time, the group of rescuers halted all recovery efforts until MSHA was notified. Dunsmore placed the bucket of the excavator over the area in which Schwentner was buried to prevent additional material from falling on Schwentner.

INVESTIGATION OF THE ACCIDENT

On September 14, 2021, at 4:39 p.m., Curtis Petty, Supervisory Mine Safety and Health Inspector, was contacted by phone from an anonymous source, who indicated knowledge of a mine fatality that occurred near Murray, Idaho. The anonymous caller believed the mine did not have a mine identification number. Petty contacted the Shoshone County Sheriff's department and confirmed that a mine fatality occurred and the Shoshone County Sheriff's department sent emergency crews to the accident site. Petty contacted Thaddeus Sichmeller, Supervisory Mine Safety and Health Inspector, and Dustan Crelly, District Manager. Crelly contacted Steven Polgar, Supervisory Mine Safety and Health Inspector. Polgar contacted Marc Shadden, Mine Safety and Health Inspector, who was conducting an inspection at another mine in the area, and sent him to secure the accident scene. Shadden arrived at the scene at 6:38 p.m. and issued an order under the provisions of Section 103(k) of the Mine Act to assure the safety of the miners and preservation of evidence. Crelly sent Michael Treloar, Mine Safety and Health Inspector, and Sichmeller to the mine site to continue the accident investigation.

On the morning of September 15, 2021, Treloar arrived at the mine and Sichmeller arrived the morning of September 16, 2021. The investigation team conducted an examination of the scene; conducted interviews with miners from Butte Gulch and Golden Chest Mine, and personnel from Shoshone County Sheriff's Department, Prichard/Murray Volunteer Fire Department, and the Bureau of Land Management; and reviewed company policies and procedures. See Appendix B for a list persons who participated in the investigation.

DISCUSSION

Location of the Accident

The accident occurred at the northern boundary of the Butte Gulch mine where the entrance is located two miles east of Murray, Idaho on Thompson Pass Road. The entrance is about 100 feet past the Golden Chest Mine entrance. The accident site is over two miles from the Butte Gulch mine entrance.

Weather

The weather at the time of the accident was 88 degrees Fahrenheit with clear skies. Investigators determined that weather was not a factor in the accident.

Hazardous Ground Conditions

At the time of the accident, the north bank of the pit contained a trench approximately four to five feet wide, 50 feet long, with walls 20 feet high. Ground conditions in the trench were hazardous because the walls of the trench consisted of unconsolidated material, were angled too steeply for stability, and were not supported. When the excavator operator left the area, there were no warnings, signs, or barricades installed at the entrance point to the trench to impede unauthorized entry. The mine operator did not have policies or procedures in place for taking down, sloping, supporting, or otherwise stabilizing bank edges.

Training and Experience
Richard Schwentner was a citizen of Austria and investigators were unable to determine his mining experience. Investigators learned that the mine operator did not provide Schwentner with the required site-specific hazard training. The mine operator stated he did not believe his operation met the definition of a mine.

Workplace Examinations
There were no workplace examinations performed by the mine operator on this site. The mine operator stated he did not believe his operation met the definition of a mine. The mine operator did not assign anyone responsibility for conducting workplace examinations at this mine.

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 notify MSHA when mining commenced.

   Corrective Action: The mine operator has officially notified MSHA of the commencement of operations and MSHA will continue to inspect the mine in accordance with the Mine Act.

2. Root Cause: The mine operator did not verify that the visitor received the minimum required training.

   Corrective Action: The mine operator established a training plan that addresses all tasks performed at the mine. The mine operator trained all miners according to the requirements of the training plan, which was submitted to and received approval from the MSHA District Manager. The mine operator will continue to train all miners and guests at the mine according to the training plan, as required under the Mine Act and MSHA regulations.

3. Root Cause: The mine operator did not post signs to warn of hazardous ground conditions, or erect access barriers to impede unauthorized entry to the area.

   Corrective Action: The mine operator developed a new written procedure for restricting access or providing safe access to hazardous areas of the mine. The mine operator trained all miners in this new written procedure.

CONCLUSION

On September 14, 2021, at approximately 1:00 p.m., Richard Schwentner, a 70-year-old guest to the mine, died when a 20-foot highwall collapsed and engulfed him.

The accident occurred because the mine operator did not: 1) notify MSHA when mining commenced, 2) verify that the visitor received the minimum required training, and 3) post signs to warn of hazardous ground conditions, or erect access barriers to impede unauthorized entry to the area.

Approved By:

_____ _____

Dustan Crelly Date
District Manager

ENFORCEMENT ACTIONS

1. A 103(k) order was issued to Higher Ground Resources.

   A fatal accident occurred on September 14, 2021, at approximately 1:00 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(a) citation was issued to Higher Ground Resources for a violation 56.3200.

   A fatal accident occurred on September 14, 2021, when the approximately 20-foot highwall bank fell engulfing the guest on-site prospecting for gold. The company did not have policies or procedures in place to assure hazardous ground conditions were taken down or supported prior to persons entering, and warnings were not posted nor barriers installed to impede unauthorized entry.

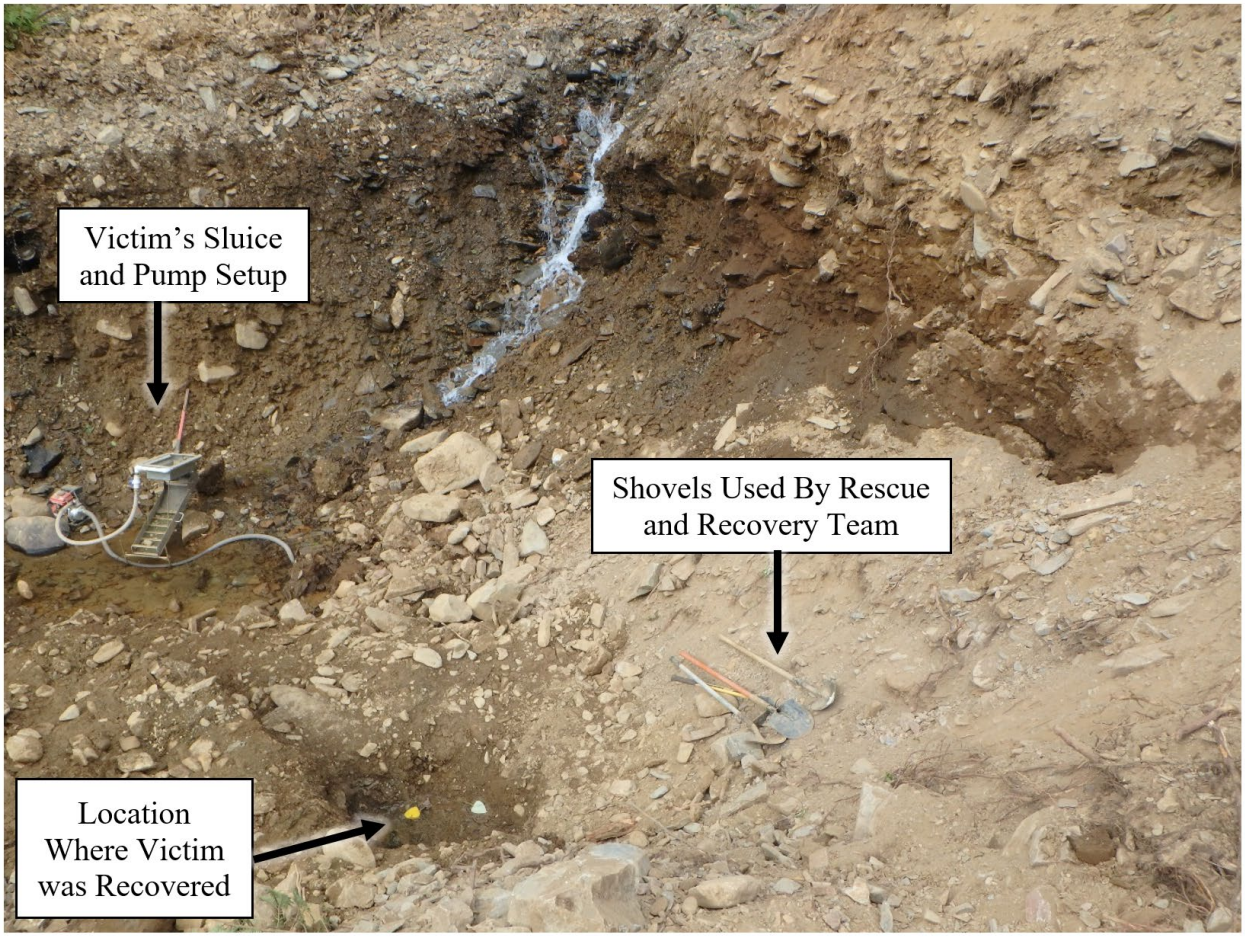
3. A 104(d)(1) citation was issued to Higher Ground Resources for a violation of 48.31(a).

   A fatal accident occurred on September 14, 2021, when the approximately 20-foot highwall bank fell covering the visitor on site prospecting for gold. No one at the mine including the victim had received hazard training for hazard recognition and avoidance, emergency evacuation procedures, health and safety standards, safety rules, and safe working procedures. This is an unwarrantable failure to comply with a mandatory standard.

4. A 104(d)(1) order was issued to Higher Ground Resources for a violation of 56.1000.

   The mine operator did not notify the nearest MSHA office of commencement of mining operations prior to the start of mining. The mine has been in operation since June of 2020 in this location. The operator engaged in aggravated conduct beyond ordinary negligence by not notifying MSHA of commencement prior to beginning work. This violation is an unwarrantable failure to comply with a mandatory standard.

APPENDIX A – Photograph of the Accident Scene



APPENDIX B – Persons Participating in the Investigation

Higher Ground Resources	
Randy Louis Rice	Owner/Operator
Branden Dunsmore	Equipment Operator
Ronald Gorman	Equipment Operator
Dustin Mead	Equipment Operator
Shoshone County Sheriff's Department	
Jeffrey Lee	Patrol Captain Sheriff
Shoshone County Coroner's Office	
Richard Smith	Deputy Coroner
Bureau of Land Management	
Gregory Meuth	Agent
Prichard/Murray Volunteer Fire Department	
D.J. Cavanaugh	Assistant Fire Chief
Brian Denney	Engineer
Tanya Cavanaugh	Emergency Medical Technician
Tracy Pasla	Fire Fighter
Golden Chest Mine	
Michael Leeling	Safety Coordinator
Andrew Brackebusch	Miner
Drake Goldade	Miner
Gary Hileman	Miner
Mine Safety and Health Administration	
Steven Polgar	Supervisory Mine Safety and Health Inspector
Thaddeus Sichmeller	Supervisory Mine Safety and Health Inspector
Marc Shadden	Mine Safety and Health Inspector
Michael Treloar	Mine Safety and Health Inspector