

UNITED STATES
DEPARTMENT OF LABOR
MINE SAFETY AND HEALTH ADMINISTRATION

REPORT OF INVESTIGATION

Surface
(Hydraulic Cement)

Fatal Powered Haulage Accident
January 17, 2023

Mojave Plant & Quarry
Calportland
Mojave, Kern County, California
ID No. 04-00036

Accident Investigator

Kimberly Hakala
Mine Safety and Health Inspector

Originating Office
Mine Safety and Health Administration
Vacaville District
991 Nut Tree Road
Vacaville, CA 95687
Gary Hebel, District Manager

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OVERVIEW

On January 17, 2023, at 2:51 a.m., Kenneth Colindres, a 47 year-old weigh master with 19 years of experience, died while driving his personal vehicle on the mine access road. Colindres' personal vehicle crossed into oncoming traffic and collided head on with an over-the-road haul truck.

The accident occurred because the mine operator did not conduct maintenance on the mine road prior to the accident when inclement weather conditions were present.

GENERAL INFORMATION

Calportland owns and operates the Mojave Plant & Quarry mine. This mine is a hydraulic cement operation located in Mojave, Kern County, California. The mine employs 150 miners and operates two 12-hour shifts, seven days per week. The mine extracts limestone from the pit by drilling, blasting, excavating, and hauling the limestone to the plant. The limestone is processed into cement and then loaded from silos into customer trucks.

The principal management official at the Mojave Plant & Quarry at the time of the accident was:

Brian Haider

Production Control Supervisor

The Mine Safety and Health Administration (MSHA) completed the last regular safety and health inspection at this mine on April 20, 2022. The 2022 non-fatal days lost incident rate for the Mojave Plant & Quarry was 5.12, compared to the national average of 1.74 for mines of this type.

DESCRIPTION OF THE ACCIDENT

On January 17, 2023, at 2:34 a.m. Francisco Argueta, Truck Driver for Commercial Rock Co., obtained his first load of the day in his over-the-road haul truck from the Mojave Plant & Quarry mine. At 2:42 a.m., he proceeded to the mine access road to depart the mine. Once past the guard shack, Argueta accelerated to 35 miles per hour (mph), then decelerated to 33 mph, when he saw vehicle headlights from an on-coming vehicle enter his traffic lane. The speeds could be seen on the over-the-road haul truck's dash cam video during the time of the accident.

Kenneth Colindres was scheduled to begin work in the Packhouse at 3:00 a.m. At about 2:50 a.m., Colindres drove his personal vehicle onto the mine access road, and approximately one minute later, slid into the oncoming lane, colliding with the over-the-road haul truck driven by Argueta. Based on interviews and the dash cam video, the investigator determined that Colindres' vehicle likely encountered black ice on the roadway and he lost control of the vehicle.

Once the over-the-road haul truck came to a complete stop, Argueta called 911. The 911 operator instructed Argueta to exit his truck and check on the driver of the vehicle. Argueta informed the 911 operator that the driver was still breathing. Daniel Torres, Mechanic, was traveling on the mine access road coming into work when he encountered the accident. Torres checked Colindres, but Colindres was unresponsive. Torres stayed with the vehicle until emergency responders arrived. At 3:16 a.m., the Kern County Fire Department arrived and removed Colindres from the vehicle, and Hall Ambulance Service transported him to the Antelope Valley Medical Center. Colindres underwent surgery for his injuries but he did not recover. On January 18, 2023, Sara Crager, MD pronounced Colindres dead at 1:54 a.m.

INVESTIGATION OF THE ACCIDENT

On January 17, 2023, at 3:24 a.m., Haider called the Department of Labor National Contact Center (DOLNCC) to report the accident. At 3:41 a.m., the DOLNCC contacted Miles Frandsen, Supervisory Mine Safety and Health Inspector. Frandsen called the mine and issued an order under the provisions of Section 103(j) of the Mine Act to ensure the safety of the miners and the preservation of evidence. Frandsen sent William Rugh, Mine Safety and Health Inspector, to the mine. Rugh arrived at 8:30 a.m. and modified the 103(j) order to a 103(k) order. Gary Hebel, District Manager, assigned Kimberly Hakala, Mine Safety and Health Inspector, as the accident investigator.

On January 18, 2023, at 9:15 a.m., Hakala arrived at the mine to continue the investigation. MSHA's accident investigator, along with Michael Rodden, Miners' Representative, and John Vernon, Safety Manager, examined the accident scene, interviewed miners and mine management, and reviewed conditions and work procedures relevant to the accident. See Appendix A for a list of persons who participated in the investigation.

DISCUSSION

Location of the Accident

The accident occurred on the mine access road, 0.63 miles from the guard shack (see Appendix B). The road is comprised of grooved concrete, which is intended to shed water from the road surface when it rains. Grooved concrete reduces the risk of hydroplaning. Overall, the roadway was in good condition prior to the inclement weather. The posted speed limit at the time of the accident was 40 mph (see Appendix C). The mine operator previously installed instant display vehicle speed signs to warn drivers when they exceeded the posted speed limit. According to interviews, the road was icy at the time of the accident. Investigators determined that the icy conditions contributed to the loss of control of the vehicle. The mine operator did not have the material or equipment to treat the road to prevent ice/snow build up and had never previously treated the road for these conditions. Neither the mine, nor the local police had any records of previous accidents reported on this road.

Weather

The weather at the time of the accident was in the low 30 degrees Fahrenheit, cloudy skies, snow flurries, and approximately 40 mph wind gusts. No maintenance was conducted on the main access road, nor were any procedures established for maintaining the road during inclement weather conditions. The mine operator did not correct hazardous conditions prior to mobile equipment accessing the roadway. The investigator determined this contributed to the accident.

Equipment Involved

The over-the-road haul truck involved in the accident was a 2022 Volvo VNR, equipped with two closed product trailers (see Appendix D). Examination of the over-the-road haul truck did not reveal mechanical deficiencies or defects that contributed to the accident. The investigator found the service brakes and parking brakes on the haul truck functioned properly when tested and did not contribute to the accident.

Colindres' vehicle was a 1999 Toyota Echo. Investigators examined the tires on the vehicle and found them to be nearly new and the brake pads were not badly worn. Due to the amount of damage, the investigator was unable to test the systems on the vehicle. Because the vehicle could not be tested, the investigator could not determine if any mechanical deficiencies or defects contributed to the accident.

Training and Experience

Kenneth Colindres had 19 years of experience working at this mine as a weigh master. Colindres received all training in accordance with MSHA Part 46 training regulations.

The investigator determined that Argueta had not received adequate site-specific hazard awareness training from the mine operator. However, this did not contribute to the accident. The over-the-road haul truck's dash cam video shows he was operating below the posted speed limit and was in the appropriate lane of traffic when the accident occurred.

ROOT CAUSE ANALYSIS

The accident investigator conducted an analysis to identify the underlying causes of the accident. The investigator identified the following root cause, and the mine operator implemented the corresponding corrective action to prevent a recurrence.

Root Cause: The mine operator did not conduct maintenance on the mine road prior to the accident when inclement weather conditions were present.

Corrective Action: The mine operator developed and implemented a new written procedure to include:

- Daily entrance road examinations, and documenting and correcting hazards identified during the examinations.
- Monitoring weather forecasts and proactively applying anti-skid and/or deicing material to roadways.

The mine operator trained all miners expected to perform these tasks.

As an additional precaution, the mine operator installed signage to warn drivers about potentially slippery road conditions and repainted roadway to improve the visibility of the centerline. A centerline barrier has been installed at the curve in the access road. The mine operator trained all miners on these provisions. The mine operator is also tracking excessive speed when detected by the existing instant display vehicle speed signs.

CONCLUSION

On January 17, 2023, at 2:51 a.m., Kenneth Colindres, a 47 year-old weigh master with 19 years of experience, died while driving his personal vehicle on the mine access road. Colindres' car crossed into oncoming traffic and collided head on with an over-the-road haul truck.

The accident occurred because the mine operator did not conduct maintenance on the mine road prior to the accident when inclement weather conditions were present.

Approved By:

Gary Hebel
District Manager

Date

ENFORCEMENT ACTIONS

1. A 103(k) order was issued to Calportland.

An accident occurred on January 17, 2023, at 2:51 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 enter or modify the accident scene. 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 Calportland for a violation of 30 CFR 56.9313.

A fatal accident occurred at the mine on January 17, 2023, when a personal vehicle collided with a customer driven truck. The main access road where the accident occurred was not being maintained. The mine experienced freezing, stormy weather, causing ice build-up on the road, which led to loss of control of the vehicle.

APPENDIX A – Persons Participating in the Investigation

Calportland

Brian Haider	Production Control Supervisor
James Kelly	Production Control Supervisor
John Vernon	Safety Manager
Ryan Callahan	Yards and Roads Supervisor
Michael Rodden	Miners' Representative
Daniel Torres	Mechanic
Edward Meunire	Packhouse Operator

Commercial Rock Co.

Dean Browning	Safety Manager
Wayne Leonard	Trucking Supervisor
Parnelly Thomas	Trucking Foreman
Aaron Stewart	Mechanic
Francisco Argueta	Truck Driver

California Highway Patrol

Dustin Oblonsky	Deputy Officer
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Mine Safety and Health Administration

Kimberly Hakala	Mine Safety and Health Inspector
William Rugh	Mine Safety and Health Inspector

APPENDIX B – Location of the Accident



APPENDIX C – Posted Speed Limit Sign



APPENDIX D – Photographs of the Vehicles Involved

