FAI-6936960-1

UNITED STATES
DEPARTMENT OF LABOR
MINE SAFETY AND HEALTH ADMINISTRATION

REPORT OF INVESTIGATION

Surface
(Common Shale)

Fatal Powered Haulage Accident
May 9, 2024

Streetman Plant
Arcosa LWS, LLC
Streetman, Navarro County, Texas
ID No. 41-01628

Accident Investigators

Ty Fisher
Supervisory Mine Safety and Health Specialist

Jerry Whitehead
Mine Safety and Health Inspector

Originating Office
Mine Safety and Health Administration
Dallas District
1100 Commerce Street, Room 462
Dallas, TX 75242
William O'Dell, District Manager

TABLE OF CONTENTS

OVERVIEW

On May 9, 2024, at approximately 8:00 a.m., Francisco Contreras, a 62 year-old maintenance worker with 23 years of mining experience, was fatally injured when he was pinned between a belt conveyor tunnel structure's roof and a personnel lift's basket. Contreras was operating the personnel lift in reverse from within the personnel lift's basket.

The accident occurred because the mine operator did not ensure the miner maintained control of the personnel lift while approaching the C-35 belt conveyor tunnel structure.

GENERAL INFORMATION

Arcosa LWS, LLC owns and operates the Streetman Plant located in Streetman, Navarro County, Texas. This mine is a common shale mine and employs 56 miners. It operates four crews on 10 and 12-hour shifts, five to seven days per week. The mine extracts lightweight shale and clay from the multiple bench quarry by drilling and blasting. Front-end loaders and excavators load the shale and clay onto haul trucks that transport the material to a dumping point at the primary plant. From the primary plant, belt conveyors transport the shale to the secondary plant and to the raw storage stockpile. The mine also excavates and hauls broken sandstone from the quarry to the plant for processing. The mine operator sells the finished products to the construction industry.

The principal management officials at the Streetman Plant mine at the time of the accident were:

Joshua Yates	Plant Manager
Danny Thursday	Maintenance Manager
William Smith	Business Unit Safety Manager

The Mine Safety and Health Administration (MSHA) completed the last regular safety and health inspection at this mine on February 29, 2024. The 2023 non-fatal days lost incident rate for the Streetman Plant Mine was zero, compared to the national average of 1.05 for mines of this type.

DESCRIPTION OF THE ACCIDENT

On May 9, 2024, at approximately 8:00 a.m., Contreras was operating a personnel lift from the basket to access the elevated C-34 belt conveyor. According to interviews, Contreras and Jeremy Erskine, Maintenance Worker, had just replaced a bottom roller on the C-34 belt conveyor. Contreras was tramming the personnel lift into position to replace a second bottom roller on the C-34 belt conveyor with his back to the C-35 belt conveyor tunnel structure (see Appendix A). Contreras was not facing the direction of travel due to the location of controls on the personnel lift's basket. Erskine was on the C-34 elevated walkway preparing tools and rollers while Contreras was positioning the personnel lift.

Erskine heard a noise and looked down to see Contreras pinned between the roof and the personnel lift's basket. He began running toward Conteras yelling for other miners in the area to assist. Joey Wilcoxen, Maintenance Leadman, was nearby, heard Erskine yelling, and saw Contreras pinned. Wilcoxen and Erskine attempted to use the auxiliary control to reverse the personnel lift from under the roof. They were unable to reverse the personnel lift because Contreras' foot was on the control pedal, preventing the remote operation of the personnel lift.

Wilcoxen motioned to Richard Landry, Equipment Operator, who was passing the accident site in a front-end loader, to help pull the personnel lift out from under the roof and free Contreras. According to interviews, Conteras had been pinned for approximately six minutes. Wilcoxen called the office on his cellphone and talked to Joshua Yates, Plant Manager. Yates called Danny Thursday, Maintenance Manager, and told him to go to the accident site, and Yates proceeded to the accident site. At 8:17 a.m., Yates called 911. At 8:40 a.m., Contreras lost consciousness, which caused Thursday and Yates to initiate the process of evaluating Contreras and starting cardiopulmonary resuscitation. At 8:55 a.m., Fairfield Emergency Medical Services (EMS) arrived and assumed the lifesaving procedures. At 9:20 a.m., an ambulance transported Contreras to Freestone Medical Center in Fairfield, Texas.

EMS resuscitated Contreras successfully and transferred him to the University of Texas at Tyler Hospital where Contreras succumbed to his injuries. Tyler Davis, General Resident Surgeon, pronounced Contreras' time of death as 3:52 p.m.

INVESTIGATION OF THE ACCIDENT

On May 9, 2024, at 8:29 a.m., William Smith, Business Unit Safety Manager, called the Department of Labor National Contact Center (DOLNCC) to report a serious accident. The DOLNCC notified Ty Fisher, Supervisory Mine Safety and Health Specialist. Fisher notified William O'Dell, District Manager. O'Dell notified Ronnie Free, Acting Assistant District Manager, who assigned Jerry Whitehead, Mine Safety and Health Inspector, to assist in the accident investigation. O'Dell assigned Fisher as the lead accident investigator.

At 1:00 p.m., Whitehead arrived at the mine and 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. At 3:16 p.m., Fisher arrived at the mine. MSHA's accident investigation team conducted an examination of the accident scene, interviewed miners and mine management, and reviewed conditions and work practices 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 at the Raw Shale Storage area at the C-35 belt conveyor tunnel and the C-34 elevated belt conveyor (see Appendices C and D). The area was dry with no visible dust. Ground conditions were smooth and lightly compacted with an approximate two to three percent grade.

Investigators observed no hazards, obstacles, or obstructions in the area other than the roof. The roof's lower edge was approximately 7.2 feet from the ground.

Weather

Weather conditions at the time of the accident were sunny and 89 degrees Fahrenheit. Investigators determined the weather did not contribute to the accident.

Equipment Involved

The mine operator rented the 800S JLG Personnel Lift involved in the accident. It was manufactured in 2023 and had a maximum reach of 80 feet and a maximum safe grade operation of four degrees both perpendicularly and laterally. The personnel lift's maximum travel speed is 28 miles per hour in the high-speed setting. Investigators found the personnel lift's drive speed control in the high-speed setting, but the actual speed setting and tramming speed at the time of the accident could not be determined. Investigators performed a functionality test and determined the brakes, steering, safety controls, emergency stop, auxiliary control, drive speed control, and sounding devices were all operating properly. Investigators found no equipment defects that could have contributed to the accident.

Examinations

Contreras and Erskine each conducted a workplace examination of the C-34 working area that morning and did not note any hazards. Investigators reviewed past workplace examination records of the accident area and determined that the mine operator was conducting adequate

examinations. Contreras conducted a pre-operational inspection of the personnel lift before placing it into operation the morning of the accident and did not note any defects. Investigators reviewed past pre-operational inspection records, and no defects were noted.

Training and Experience

Contreras had over 23 years of mining experience and over nine years of experience at his current job. All of Contreras' mining experience was at the Streetman Plant mine. Investigators determined Contreras received all training in accordance with MSHA Part 46 training regulations. Contreras received task training on personnel lifts from both the mine operator and the rental company that provided the 800S JLG Personnel Lift.

ROOT CAUSE ANALYSIS

The accident investigation team conducted an analysis to identify the underlying causes of the accident. The team 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 ensure that the miner maintained control of the personnel lift while approaching the C-35 belt conveyor tunnel structure.

Corrective Action: The mine operator developed and implemented a new written procedure for operating personnel lifts. The procedure includes:

1. Plan out equipment positioning/access to identify possible hazards in the working area.
2. Whenever possible, travel with the boom in the back of the main body with the operator and controls facing towards the work area. When the personnel lift is operated with the operator facing away from the direction of travel, a spotter will be used to communicate obstructions to the operator.
3. When nearing or in proximity to structures, all personnel lifts shall be operated in the low-speed mode.

The mine operator trained miners who operate personnel lifts on this procedure and retrained miners on all safety controls and operations.

CONCLUSION

On May 9, 2024, at approximately 8:00 a.m., Francisco Contreras, a 62 year-old maintenance worker with 23 years of mining experience, was fatally injured when he was pinned between a belt conveyor tunnel structure's roof and a personnel lift's basket. Contreras was operating the personnel lift in reverse from within the personnel lift's basket.

The accident occurred because the mine operator did not ensure the miner maintained control of the personnel lift while approaching the C-35 belt conveyor tunnel structure.

Approved By:

_____ _____

William O'Dell Date
District Manager

ENFORCEMENT ACTIONS

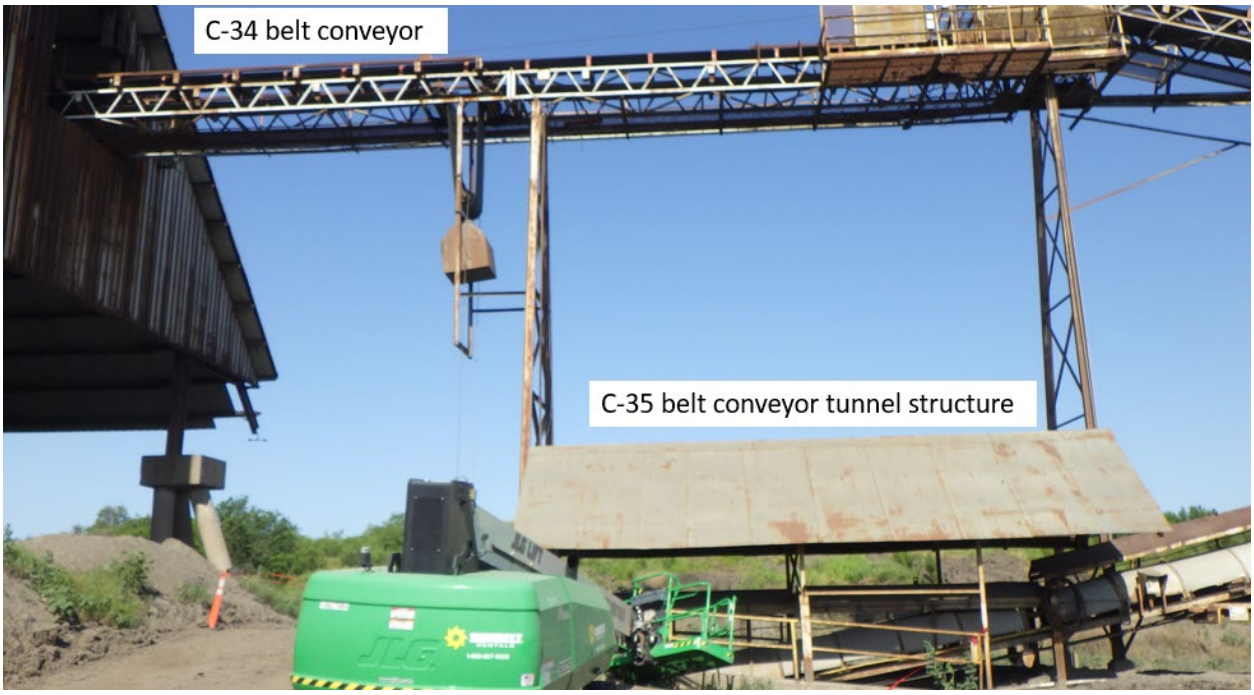
1. A 103(k) order was issued to Arcosa LWS, LLC.

   A fatal accident occurred on May 9, 2024, at approximately 8:00 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 Arcosa LWS, LLC for a violation of 30 CFR 56.9101.

   On May 9, 2024, at approximately 8:00 a.m., a fatal accident occurred at this mine when a miner was pinned between the 800S JLG personnel lift basket and the roof covering conveyor tunnel structure above the C-35 belt conveyor tunnel. While positioning the personnel lift with his back towards the C-35 belt conveyor tunnel, the miner did not maintain control to prevent contact with the conveyor tunnel structure.

APPENDIX A – Conveyors



APPENDIX B – Persons Participating in the Investigation

Arcosa LWS, LLC

John Todd	President
Randy Pryor	Vice President of Operations
Matt Claypool	Vice President of Health and Safety
Justin Allen	Company Attorney
Gary Canter	Senior Manager
Scott Hendry	Area Operations Manager
Joshua Yates	Plant Manager
William Smith	Business Unit Safety Manager
Arturo Munoz	Safety Manager
Danny Thursday	Maintenance Manager
George Lonebear	Safety Coordinator
Richard Landry	Equipment Operator
Josh Kittley	Maintenance Foreman
Joey Wilcoxen	Maintenance Leadman
Jeremy Erskine	Maintenance Worker

Mine Safety and Health Administration

Ty Fisher	Supervisory Mine Safety and Health Specialist
Jerry Whitehead	Mine Safety and Health Inspector

APPENDIX C – Aerial View of the Mine

APPENDIX D – Accident Scene