

UNITED STATES
DEPARTMENT OF LABOR
MINE SAFETY AND HEALTH ADMINISTRATION

REPORT OF INVESTIGATION

Surface
(Crushed, Broken Stone NEC)

Fatal Powered Haulage Accident
September 8, 2023

Sewickley Mine
Neiswonger Construction Inc
Saltsburg, Indiana County, Pennsylvania
ID No. 36-09542

Accident Investigators

Leslie Tharp
Supervisory Mine Safety and Health Specialist

Cody Sheldon
Supervisory Special Investigator

Kyle Stofko
Mine Safety and Health Inspector

Originating Office
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OVERVIEW

On September 8, 2023, at 10:25 a.m., Eric Komlosky, Sr., a 39-year-old plant laborer with less than two years of mining experience, died while he was working inside a recirculation hopper after a front-end loader dumped limestone material into the hopper.

The accident occurred because the mine operator did not: 1) provide adequate task training for performing maintenance work inside the recirculation hopper, and 2) stop and lock out the supply and discharge equipment, ensure the plant laborer wore a safety belt or harness equipped with a lifeline, and ensure a second miner was stationed nearby.

GENERAL INFORMATION

Neiswonger Construction Inc owns and operates the Sewickley Mine, a surface limestone mine located in Saltsburg, Indiana County, Pennsylvania. The Sewickley Mine employs eight miners and operates one ten-hour shift, five days per week. The mine extracts, hauls, and processes limestone from the quarry, and loads customer trucks with the final product.

The principal management official at the Sewickley Mine at the time of the accident was:

Vincent Neiswonger

President

The Mine Safety and Health Administration (MSHA) completed the last regular safety and health inspection at this mine on August 10, 2023. The 2022 nonfatal days lost incident rate for the Sewickley Mine was zero, compared to the national average of 1.17 for mines of this type.

DESCRIPTION OF THE ACCIDENT

On September 8, 2023, at 4:59 a.m., Komlosky began his shift at the Sewickley Mine. According to video surveillance footage, at 9:54 a.m., Komlosky, Christopher Giles, Welder, and David Beatty, Plant Foreman, gathered at the No. 4 belt conveyor to repair the clamshell mechanism which controls the flow rate of material from the recirculation hopper to the No. 4 belt. At 10:01 a.m., Komlosky started the No. 4 belt conveyor. At 10:03 a.m., Komlosky observed that the material was not feeding correctly onto the No. 4 belt conveyor. Komlosky entered the recirculation hopper to clear the blocked material by walking up an adjacent stockpile, transitioning to a structural I-beam component, and swinging his legs and body over the top edge of the hopper. At 10:07 a.m., Beatty drove a front-end loader up the dump ramp and emptied approximately six to eight tons of limestone material into the recirculation hopper on top of Komlosky. At 10:16 a.m., Beatty drove up the dump ramp again and emptied approximately ten tons of limestone material into the recirculation hopper. At that time, the other miners were unaware of Komlosky's location.

According to interviews and video surveillance, at 10:18 a.m., Joshua Barden, Equipment Operator, noticed the material flow had stopped, went to see why, and observed Komlosky's boot and a digging bar protruding through the bottom of the recirculation hopper. Barden notified Beatty of what he saw and stood in the bucket of Beatty's front-end loader to look inside the recirculation hopper. Barden climbed into the recirculation hopper and began shoveling material out.

At 10:24 a.m., Giles called 911. The Iselin West Lebanon Volunteer Fire Company and the Pennsylvania State Police arrived within minutes. The mine operator used the front-end loader to tip the recirculation hopper over on its side so the Fire Company could access Komlosky. Komlosky did not have a pulse. Jerry Overman, Jr., Indiana County, Pennsylvania Coroner, pronounced Komlosky dead at 10:40 a.m.

INVESTIGATION OF THE ACCIDENT

At 10:41 a.m., Michael Johnston, Vice President of Finance, called the Department of Labor National Contact Center (DOLNCC) to report a trapped miner. The DOLNCC contacted Kevin Abel, Assistant District Manager, who called Thomas Rasmussen, Assistant District Manager, who assigned Leslie Tharp, Supervisory Mine Safety and Health Specialist, as the lead accident investigator. Rasmussen also directed Cody Sheldon, Supervisory Special Investigator to go to the mine.

At 11:56 a.m., Tharp and Sheldon arrived on site, began work to secure the area, 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. MSHA's accident investigation team, along with the Pennsylvania Department of Environmental Protection, conducted an examination of the accident scene, interviewed miners and mine management, and reviewed conditions and work practices relevant to the accident. On September 18, 2023, Kyle Stofko, Mine Safety and Health Inspector, arrived on site to assist in the investigation. Brandon Boring, General Engineer for MSHA Technical Support, assisted in obtaining video surveillance footage. See Appendix A for a list of persons who participated in the investigation.

DISCUSSION

Location of the Accident

The accident occurred at the recirculation hopper located between the secondary crusher and the tertiary crusher (see Appendix B).

Weather

At the time of the accident, the temperature was approximately 81 degrees Fahrenheit with partly cloudy skies. Investigators determined that the weather did not contribute to the accident.

Equipment Involved

The front-end loader involved in the accident was a Kawasaki 135 Z-IV (see Appendix C). Examination of the front-end loader did not reveal mechanical deficiencies or defects that contributed to the accident.

The recirculation hopper involved in the accident discharged material onto the No. 4 belt conveyor. The recirculation hopper was equipped with a vibrating device to help the flow of material by preventing material from sticking to the sides of the hopper. The mine operator placed the recirculation hopper in service on September 6, 2023. This included constructing a ramp leading up to the hopper and installing a "rock box" on the No. 10 belt conveyor to control and direct the discharge of materials from the No. 4 belt conveyor.

The vibrating device did not prevent the recirculation hopper from becoming blocked with material at the bottom of the hopper. Beatty told investigators that the recirculation hopper became blocked twice the day before the fatal accident. Even though the mine operator was aware of the frequent blockages, they chose not to rectify the hazardous condition and did not find any safe alternative means to clear the blockage. As such, the miners had no other choice but to enter the recirculation hopper and physically clear the blockage themselves. The mine operator's neglect of the hazardous condition directly contributed to the accident. In addition, the mine operator did not have adequate procedures or equipment in place for when miners were required to enter the recirculation hopper.

The mine operator did not provide suitable walkways or passageways to the recirculation hopper from which blockages could be cleared safely. Video surveillance footage verified that miners accessed the recirculation hopper by climbing up the side, over the wall, and into the

recirculation hopper. This was a common practice and occurred repeatedly prior to the accident. Investigators determined that this contributed to the accident.

Work Practices

Investigators reviewed the mine's video surveillance footage from September 5 to 8, 2023, until after the fatal accident, and observed multiple occurrences of unsafe work practices. Beatty participated in many of these unsafe work practices.

Video surveillance footage showed that Komlosky and other miners entered the recirculation hopper seven times to clear blockages in the same manner as Komlosky on the day of the accident. According to Beatty's interview, he told the miners to place a ladder up against the recirculation hopper at the top of the ramp to indicate a person was working inside the recirculation hopper. On previous occasions, Beatty watched Komlosky working from the same ladder used to access the recirculation hopper, and assisted Komlosky by using a digging bar to free material in the hopper. During their review of surveillance video footage, the investigators did not observe miners putting a ladder in place as Beatty described. Even if this procedure had been followed, it would not comply with the requirements of 30 CFR 56.16002, which required specified safety precautions before miners entered the hopper.

Video surveillance footage showed each time Komlosky or another miner entered the recirculation hopper, including on the day of the accident, they did so without blocking the flow of material, without a safety belt or harness equipped with a lifeline, and without having another miner attending the lifeline.

Investigators determined that the mine operator did not ensure miners: 1) safely accessed the recirculation hopper, 2) de-energized equipment properly prior to performing maintenance activity, or 3) used fall protection when working from heights. Additionally, mine management performed these unsafe work practices in plain view of miners, including Komlosky. Investigators determined that these factors contributed to the accident.

Training and Experience

Komlosky had less than two years of mining experience, all as a plant laborer at the Sewickley Mine. Komlosky did not have any mining experience prior to his employment with the mine operator and should have received new miner training under MSHA Part 46. Instead, the mine operator provided Komlosky with newly hired experienced miner training under MSHA Part 48.

Beatty was listed as the competent person in the Part 46 training plan and was aware of the unsafe way the miners entered the recirculation hopper to clear blockages. The mine operator did not provide task training to any miner, including Komlosky, to safely enter bins and hoppers or how to safely clear blockages from the recirculation hopper. The mine operator recklessly disregarded several mandatory safety standards and instead implemented a noncompliant procedure. Investigators determined that this contributed to the accident.

Examinations

Beatty was responsible for conducting the workplace examinations of the plant on the day of the accident. Examination records did not list the recirculation hopper as an area to be examined,

but did list the No. 4 belt conveyor fed by the hopper. Beatty completed the examination record for the No. 4 belt conveyor and did not identify any hazardous conditions. However, the hazardous conditions that contributed to the fatal accident were the result of actions and practices, and not physical conditions that could have been identified during a workplace examination. Therefore, investigators determined that the workplace examination 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 implemented the corresponding corrective actions to prevent a recurrence.

1. Root Cause: The mine operator did not provide adequate task training for performing maintenance work inside the recirculation hopper.

Corrective Action: The mine operator established written procedures for the maintenance of any hoppers. The mine operator trained all miners on the written procedures in accordance with 30 CFR 46.7(b), and the mine operator documented this training in accordance with 30 CFR 46.9.

2. Root Cause: The mine operator did not stop and lock out the supply and discharge equipment, ensure the plant laborer wore a safety belt or harness equipped with a lifeline, or ensure a second miner was stationed nearby.

Corrective Action: The mine operator permanently removed the hopper and No. 4 belt conveyor from service, which are not needed to operate the plant. The mine operator developed and implemented written procedures for safe entry, operation, and maintenance of the remaining hoppers in accordance with 30 CFR 56.16002.

CONCLUSION

On September 8, 2023, at 10:25 a.m., Eric Komlosky, Sr., a 39-year-old plant laborer with less than two years of mining experience, died while he was working inside a recirculation hopper after a front-end loader dumped limestone material into the hopper.

The accident occurred because the mine operator did not: 1) provide adequate task training for performing maintenance work inside the recirculation hopper, and 2) stop and lock out the supply and discharge equipment, ensure the plant laborer wore a safety belt or harness equipped with a lifeline, and ensure a second miner was stationed nearby.

Approved By:

Peter Montali
District Manager

Date

ENFORCEMENT ACTIONS

1. A 103(k) order was issued to Neiswonger Construction Inc.

A fatal accident occurred on 9-8-2023, at approximately 1025. 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)(2) order was issued to Neiswonger Construction Inc for a violation of 30 CFR 46.7(a).

On September 8, 2023, a fatal accident occurred at this mine when a plant laborer entered the recirculation hopper to clear a blockage, and the plant foreman dumped limestone material into the recirculation hopper with a front-end loader, which engulfed the plant laborer. The mine operator did not provide adequate task training for performing maintenance work inside of a hopper. The mine operator engaged in aggravated conduct constituting more than ordinary negligence in that mine management was aware material frequently blocked the recirculation hopper and did not develop procedures or train the miners to safely clear blockages. The mine operator was aware that miners cleared blockages by entering the recirculation hopper. This was a common practice and occurred repeatedly prior to the accident. This violation is an unwarrantable failure to comply with a mandatory standard.

3. A 104(d)(2) order was issued to Neiswonger Construction Inc for a violation of 30 CFR 56.16002.

On September 8, 2023, a fatal accident occurred at this mine when a plant laborer entered the recirculation hopper to clear a blockage, and the plant foreman dumped limestone material into the hopper with a front-end loader, which engulfed the plant laborer. When the plant laborer was required to enter the hopper to clear a blockage, the mine operator did not stop and lock out the supply and discharge equipment, ensure the plant laborer wore a safety belt or harness equipped with a lifeline, and ensure that a second miner was stationed nearby. The mine operator engaged in aggravated conduct constituting more than ordinary negligence in that mine management was aware the feed material frequently became blocked in the recirculation hopper and did not establish safe procedures to clear the blockages. The mine operator was aware that miners cleared blockages by entering the recirculation hopper. This was a common practice and occurred repeatedly prior to the accident. The surveillance video footage also showed miners entering the recirculation hopper without wearing safety belts or harnesses and not equipped with lifelines, while the No. 4 belt conveyor was operating. This violation is an unwarrantable failure to comply with a mandatory standard.

APPENDIX A – Persons Participating in the Investigation

Neiswonger Construction Inc

Giorgio Neiswonger	Owner
Vincent Neiswonger	Owner
Michael Johnston	Vice President of Finance
Craig Bryan	Safety Director
David Beatty	Plant Foreman
Christopher Giles	Welder
Joshua Barden	Equipment Operator
Anthony Fello	Front-End Loader Operator
Brandon Ferrenger	Front-End Loader Operator

Pennsylvania Department of Environmental Protection

Mike Stonebaker	Surface Mine Conservation Inspector
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Mine Safety and Health Administration

Leslie Tharp	Supervisory Mine Safety and Health Specialist
Cody Sheldon	Supervisory Special Investigator
Scott Chiccarello	Mine Safety and Health Training Specialist
Kyle Stofko	Mine Safety and Health Inspector
Brandon Boring	General Engineer, Technical Support

APPENDIX B – Aerial View



APPENDIX C – Photo of Front-End Loader

