FAI-F015839-1

UNITED STATES
DEPARTMENT OF LABOR
MINE SAFETY AND HEALTH ADMINISTRATION

REPORT OF INVESTIGATION

Surface
(Cement)

Fatal Powered Haulage Accident
July 12, 2025

Koury Transport LLC. (V316)
Pueblo, CO

at

Pueblo Plant & Quarry
GCC Rio Grande Inc
Pueblo, Pueblo County, Colorado
ID No. 05-04822

Accident Investigators

Steven Polgar
Supervisory Mine Safety and Health Inspector

Christopher Bryant
Mine Safety and Health Specialist

Originating Office
Mine Safety and Health Administration
Denver District
1 Denver Federal Center, Bldg. 53
Denver, Colorado 80225
Nick Gutterriez, District Manager

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OVERVIEW

On July 12, 2025, at 7:10 a.m., Victor Armas, a 62-year-old contract truck driver with approximately 45 years of truck driving experience, died while hauling a load of water to the Pueblo Plant & Quarry mine. Armas was ejected from the truck at the time of the accident.

The accident occurred because the mine operator and contractor did not: 1) ensure the truck driver maintained control of the truck, 2) ensure the truck driver wore a seatbelt while operating the truck, 3) ensure the truck driver was performing adequate preoperational examinations to identify defects affecting safety, 4) ensure the braking systems were being maintained in functional condition, and (5) ensure that the contractor received the required site-specific hazard awareness training.

GENERAL INFORMATION

GCC Rio Grande Inc. owns and operates the Pueblo Plant & Quarry mine. This is a cement facility located in Pueblo, Pueblo County, Colorado. The Plant & Quarry mine employs 145 miners and operates two 12-hour shifts, 7 days per week. The mine extracts limestone from an open pit, and haul trucks transport the limestone to the mill for processing.

The principal management officials at Pueblo Plant & Quarry at the time of the accident were:

John Goetz	Plant Manager
Michael Cinalli	Safety Compliance Manager

The Mine Safety and Health Administration (MSHA) completed the last regular safety and health inspection at this mine on October 28, 2024. A regular safety and health inspection was ongoing at the time of the accident. The 2024 non-fatal days lost incident rate for the Pueblo Plant & Quarry mine was 2.46, compared to the national average of 1.36 for mines of this type.

DESCRIPTION OF THE ACCIDENT

On July 12, 2025, at approximately 6:00 a.m. Armas began his shift at the Koury Transport LLC, truck yard in Pueblo, Colorado. According to Grant Koury, owner, Armas was delivering his first load of the day, transporting water from the water tower on Lime Road in Pueblo to the Pueblo Plant & Quarry mine.

At approximately 7:05 a.m., Cory Triplett, miner, passed Armas on the mine access road traveling in the opposite direction on the road. The mill site is 2.2 miles from the entrance (Appendix A).

Triplett said he looked in his mirror and saw a cloud of dust created by Armas' truck. Triplett continued out on the road but stopped to check if Armas had made it to the mill. When Triplett did not see the water truck enter the mill site, he turned around to check on Armas. Triplett drove back toward the mill and saw that the water truck did not negotiate a curve immediately before a bridge and slid off the road. Triplett parked his car and began searching for Armas. Triplett found Armas was on the edge of the bridge abutment on the shoulder side of the concrete barrier. At 7:14 a.m., Triplett contacted Russell Allen, Mill Miner, via cell phone. Allen then called 911.

According to interviews, immediately after Triplett made contact with Allen, Luis Chavez, daytime control room leader; Zach Cruz, Leroy Duran, and Alex Yippez, miners; and Allen traveled to the accident location. Allen, Yippez, and Cruz went back to the shop to gather traffic cones to be used at the accident scene. At 7:35 a.m., American Medical Response; Mark Mears, captain for the Pueblo County sheriff's office; and Brian Cotter, Pueblo County Coroner, arrived on site. Cotter pronounced Armas dead at 9:30 a.m.

INVESTIGATION OF THE ACCIDENT

On July 12, 2025, at 7:40 a.m., John Hettich, Control Room Lead, called the Department of Labor National Contact Center (DOLNCC) to report the accident. The DOLNCC contacted Dennis Bellfi, supervisory mine safety and health inspector. Bellfi contacted Michael Tefertiller, staff assistant, who contacted Mark Phillips, acting assistant district manager. Phillips assigned Steven Polgar, supervisory mine safety and health inspector, as the lead investigator, and directed Christopher Bryant, mine safety and health electrical specialist, to assist (Appendix B).

On July12, 2025, at 9:50 a.m., Bryant 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. Bryant secured the area and gathered preliminary information. On July 13, 2025, at 8:30 a.m.,

Polgar arrived at the mine. MSHA's accident investigation team conducted an examination of the accident scene and interviewed miners and mine management.

DISCUSSION

Location of the Accident

The accident occurred on the Pueblo Plant & Quarry mine road at the bridge which is 0.7 miles from the mine entrance. The entrance road had a posted speed limit of 40 miles per hour (MPH) where the accident occurred. The road was paved and in good condition. Investigators determined the condition of the road did not contribute to the accident.

Weather

The weather at the time of the accident was 74 degrees Fahrenheit, with clear conditions. Investigators determined that the weather did not contribute to the accident.

Equipment Involved

The truck involved in the accident was a 2017 Freightliner semi-truck. The trailer was a 1995 Beall aluminum tanker trailer with a 9,500-gallon capacity. Both truck and trailer were owned by Koury Transport. The speedometer of the Freightliner was "frozen" at 48 MPH after the accident. Investigators examined the braking systems on both the truck and trailer and found all four trailer brakes and both brakes on the steering axle of the truck were at or beyond retirement criteria. Grant Koury, owner of Koury Transport, told investigators there wasn't an effective maintenance program for the brakes on this truck. Brian Parks, mechanic for TNT Repair and Service LLC, said brake adjustments may not have been made for months. Investigators determined the defects in the braking system and the ineffective maintenance program contributed to the accident.

Investigators inspected the seatbelt. The seatbelt on the 2017 freightliner appeared undamaged and in usable condition, however the receiver end of the seatbelt could not be tested due to the damage sustained to that area of the cab of the truck. Investigators determined that not wearing a seatbelt contributed to the severity of the accident.

Training and Experience

Armas had 45 years of experience as a truck driver and worked as a truck driver for Koury Transport LLC, for over 2 years. He had a commercial driver's license in the state of Colorado. Investigators determined there was no evidence or record of Armas being trained by the mine operator to ensure that he was aware of hazards present on the mine site, including safe operating speeds, use of seatbelts, inspection of equipment for safety defects, and operating vehicles and equipment in compliance with all applicable federal safety standards. Investigators determined that the lack of training provided to address mine hazards contributed to the accident.

Examinations

Investigators determined there were no records of pre-operational examinations for the truck or trailer involved in the accident. Because thorough preoperational examinations were not taking place, serious deficiencies were not properly identified for correction. This lack of adequate examinations contributed 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 and contractor did not ensure that the contract truck driver maintained control of the equipment while in operation.

   Corrective Action: The mine operator has implemented a program of enhanced enforcement of the speed limits on the road, which includes accountability and enforcement for violations of their policies. The contractor has entirely ceased operation on mine sites and stated they will not work at any mine site in the foreseeable future.

2. Root Cause: The mine operator and contractor did not ensure the contract truck driver wore his seatbelt while operating the truck.

   Corrective Action: The mine operator retrained all haulage truck drivers on the mandatory use of seatbelts while on mine site. The contractor has entirely ceased operation on mine sites and stated they will not work at any mine site in the foreseeable future.

3. Root Cause: The mine operator and contractor did not ensure that adequate preoperational examinations were being conducted to identify defects affecting the safe operation of mobile equipment.

   Corrective Action: The mine operator has established a standard operating procedure requiring preoperational examinations and is verifying that these examinations are being conducted by the equipment operators. The contractor has entirely ceased operation on mine sites and stated they will not work at any mine site in the foreseeable future.

4. Root Cause: The mine operator and contractor did not ensure that the braking systems were being maintained in functional condition.

   Corrective Action: The mine operator implemented a program to train all equipment operators that come to the mine that their braking system must function properly before coming onto the site. The contractor has entirely ceased operation on mine sites and stated they will not work at any mine site in the foreseeable future.

5. Root Cause: The mine operator failed to ensure that the truck driver received site specific hazard awareness training before he was exposed to hazards on the mine site.

   Corrective Action: The mine operator has improved their hazard training program to include all contractors including truck drivers.

CONCLUSION

On July 12, 2025, at 7:10 a.m., Victor Armas, a 62-year-old truck driver with approximately 45 years of truck driving experience, died while hauling a load of water to the Pueblo Plant & Quarry mine. Armas was ejected from the truck at the time of the accident.

The accident occurred because the mine operator and contractor did not: 1) ensure the truck driver maintained control of the truck, 2) ensure the truck driver wore a seatbelt while operating the truck, 3) ensure the truck driver was performing adequate preoperational examinations to identify defects affecting safety, and 4) ensure the braking systems were being maintained in functional condition and (5) ensure that the contractor received the required site-specific hazard awareness training.

Approved By:

_____ _____

Nickolas Gutierrez — Date
District Manager

ENFORCEMENT ACTIONS

1. A 103(k) order was issued to GCC Rio Grande Inc.

   A fatal accident occurred on July 12, 2025, at 7:10 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 GCC Rio Grande Inc. for a violation of 30 CFR 56.9101.

   A fatal accident occurred at this mine on July 12, 2025, when a truck driver died while hauling water to the mine. The truck turned on its side, rolled, and the unrestrained driver was ejected from the 2017 Freightliner truck. The mine operator failed to ensure that the driver maintained control of the truck while it was in motion.

3. A 104(a) citation was issued to Koury Transport LLC, for a violation of 30 CFR 56.9101.

   A fatal accident occurred at this operation on July 12, 2025, when a truck driver died while hauling water to the mine. The truck turned on its side, rolled, and the unrestrained driver was ejected from the 2017 Freightliner truck. The contractor failed to ensure that the driver maintained control of the truck while it was in motion.

4. A 104(a) citation was issued to GCC Rio Grande Inc. for a violation of 30 CFR 56.14131(a).

   A fatal accident occurred at this operation on July 12, 2025, when a truck driver died while hauling a load of water to the mine. The truck turned on its side, rolled, and the unrestrained driver was ejected from the 2017 Freightliner truck. The mine operator failed to ensure that the driver wore his seatbelt.

5. A 104(a) citation was issued to Koury Transport LLC, for a violation of 30 CFR 56.14131(a).

   A fatal accident occurred at this operation on July 12, 2025, when a truck driver died while hauling a load of water to the mine. The truck turned on its side, rolled, and the unrestrained driver was ejected from the 2017 Freightliner truck. The contractor failed to ensure that the driver wore his seatbelt.

6. A 104(a) citation was issued to Koury Transport LLC, for a violation of 30 CFR 56.14101(a)(3)

   A fatal accident occurred at this operation on July 12, 2025, when a truck driver died while hauling a load of water to the mine. The truck turned on its side, rolled, and the unrestrained driver was ejected from the 2017 Freightliner truck. The truck was tested and found to have multiple brake defects on both the truck and trailer. Six total brakes were found to be at or

beyond the retirement criteria. The contractor did not maintain the braking system on the water truck in functional condition.

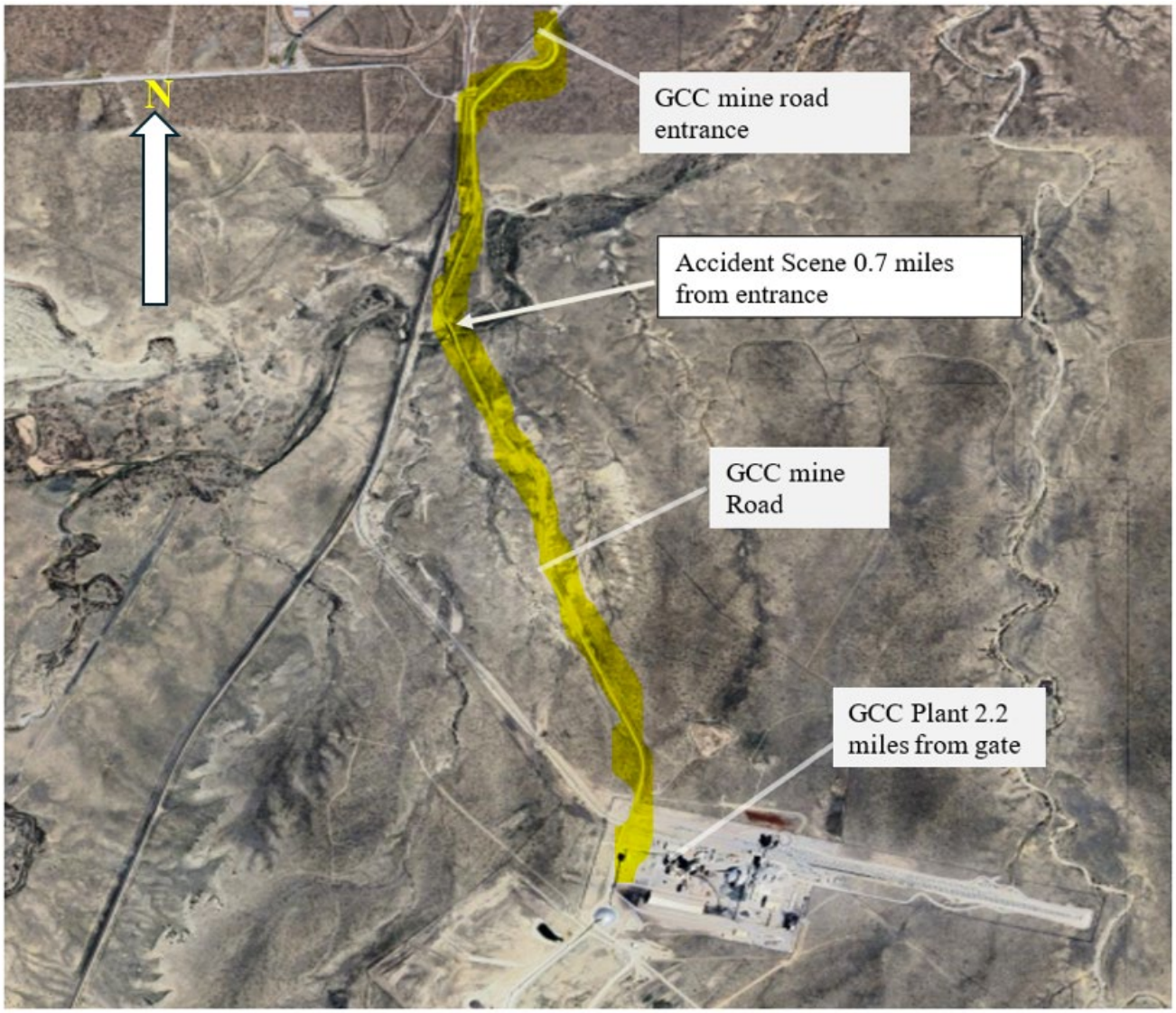
7. A 104(a) citation was issued to Koury Transport LLC, for a violation of 30 CFR 56.14100(a)

   A fatal accident occurred at this operation on July 12, 2025, when a truck driver died while hauling a load of water to the mine. The truck turned on its side, rolled, and the unrestrained driver was ejected from the 2017 Freightliner truck. The truck was tested and found to have multiple defects affecting safety that could have been identified during a pre-operational examination.

8. A 104(a) citation was issued to GCC Rio Grande Inc. for a violation of 46.11(a).

   A fatal accident occurred at this operation on July 12, 2025, when a truck driver died while hauling a load of water to the mine. The truck turned on its side, rolled, and the unrestrained driver was ejected from the 2017 Freightliner truck. The mine operator failed to provide site hazard training to the driver to ensure that he was aware of hazards present on the mine site, including safe operating speeds, use of seatbelts, inspection of equipment for safety defects, and operating vehicles and equipment in compliance with all applicable federal safety standards.

APPENDIX A – Map Overview of Road



APPENDIX B – Persons Participating in the Investigation

GCC Rio Grande Inc

John Goetz	Vice President/Plant Manager
Michael Cinalli	Safety Compliance Manager
Luiz Chavez	Day Time Control Room Leader
Cory Triplett	Miner

Koury Transport LLC

Grant Koury	Owner

TNT Repair and Service LLC

Brian Parks	Mechanic

Pueblo County Sheriff's Office

Mark Mears	Captain
Shane Mullens	Detective Level 1
Trae Borror	Deputy

Colorado State Patrol

Arthur Gumke	Trooper

Mine Safety and Health Administration

Michael Tefertiller	Staff Assistant
Steven Polgar	Supervisory Mine Safety and Health Inspector
Christopher Bryant	Mine Safety and Health Electrical Specialist