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UNITED STATES
DEPARTMENT OF LABOR
MINE SAFETY AND HEALTH ADMINISTRATION

REPORT OF INVESTIGATION

Underground
(Platinum Group Ore)

Electrical Accident Fatality Report
July 26, 2025

Stillwater Mine
Stillwater Mining Company
Columbus, Stillwater County, Montana
ID No. 24-01490

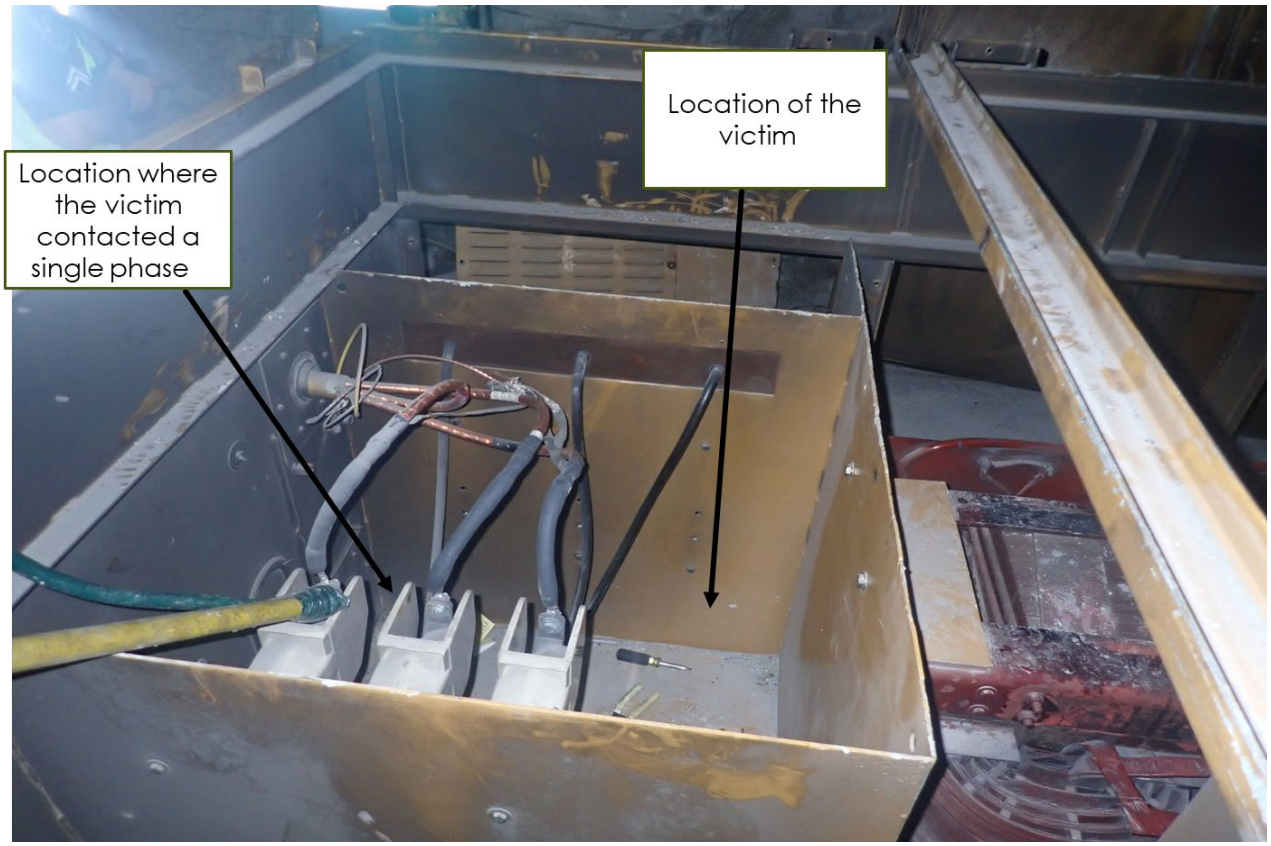
Accident Investigators

Thaddeus Sichmeller
Supervisory Mine Safety and Health Inspector

Jordan Gustafson
Mine Safety and Health Specialist

Originating Office
Mine Safety and Health Administration
Denver District
1 Denver Federal Center
Denver, CO 80225
Nickolas Gutierrez, District Manager

TABLE OF CONTENTS



OVERVIEW

On July 26, 2025, at 10:44 a.m., Brian Hanson, a 50-year-old electrical & instrumentation (E&I) technician with 5 years, 6 months of mining experience, died when he contacted one phase of a 13,200 high voltage power circuit while conducting preventive maintenance in transformer #95132.

The accident occurred because the mine operator did not: 1) de-energize, lock out, or take other measures to prevent electrical equipment from being energized, 2) label principal power switches to show which units they controlled, and 3) provide instruction in the safety and health aspects and safe work procedures of the assigned task.

GENERAL INFORMATION

Sibanye Stillwater Limited is the parent company of Stillwater Mining Company, which operates the Stillwater Mine, an underground platinum group metals mine located in Nye, Stillwater County, Montana. The mine employs 427 miners and operates two 12-hour production shifts, 7 days per week. The mine operator uses load haul dump loaders, underground trucks, and underground rail haulage to transport the ore to the surface. Miners crush and process the ore and send it to a smelter and base metal refinery facility located in Columbus, Montana.

The principal management officials at the Stillwater Mine at the time of the accident were:

Matthew O'Reily	Vice President and General Manager
NikKayla Simon	Senior Safety Manager

The Mine Safety and Health Administration (MSHA) completed the last regular safety and health inspection at this mine on June 12, 2025. The 2024 non-fatal days lost incident rate for the Stillwater Mine was 2.24, compared to the national average of 1.46 for mines of this type.

DESCRIPTION OF THE ACCIDENT

On July 26, 2025, at approximately 7:00 a.m., Hanson started his shift. He was assigned the task of conducting electrical preventive maintenance (PM) on two transformers, #95132 and #95249, located on the 5600 Level East 21,000 inclined ramp underground. Lisa Williams, E&I technician, was assigned to assist with the PM. Prior to this, Garrett Pederson, electrical supervisor, attended the morning management meeting to discuss the need to de-energize electrical power to the 21,000 ramp. This would allow the electrical department to conduct the PMs but would shut down mine ventilation to the headings. Mining activities would cease in the 21,000 incline until the electrical power was restored (Appendix A).

At approximately 7:30 a.m., Williams went to check the hoist readings for that morning and make sure there were no problems with them before proceeding underground. While Williams was conducting these routine morning checks, Pederson told Hanson they would just be isolating power at the switch, instead of the way they normally de-energized the transformers. However, Pederson never discussed or clarified which specific switch needed to be isolated. Pederson met with Gustavo Nieto, E&I technician, and informed him that he would be going to help Hanson and Williams with the PMs on the transformers. Pederson did not inform Nieto or Williams of the modified procedure to de-energize the transformers.

Williams returned from her hoist checks and Hanson loaded a personnel carrier with their tools. Nieto took a separate personnel carrier. At 9:26 a.m., the two personnel carriers entered the east side portal and traveled up to the 21,000 ramp. Hanson, Williams, and Nieto stopped at the 5700 Level East, 21,700 location at the underground bay that housed the Atlas switch and the transformer #95608 that powered the mine fans in this location. Hanson explained to Neito and Williams that they would put up warning signs at this location so miners would not enter the area due to the ventilation being shut down. Hanson, Williams, and Nieto traveled the headings to make sure all miners were clear before they shut down ventilation. After Hanson, Williams, and Nieto verified there were no miners in these areas, they met at transformer #95132 to begin the first PM (Appendix B). When they arrived at the transformer, Hanson and Williams heard a humming noise coming from the 480-volt side of the transformer. Williams said Hanson was going to investigate the humming noise after electrical power was de-energized. The humming noise stopped once power was de-energized.

At 10:40 a.m., Williams called dispatch in accordance with the protocol to notify them that electrical power was being de-energized at the 21,000 ramp. Hanson opened the knife switch on transformer #95132; this only de-energized the 480-volt side of the transformer, de-energizing

power to the lights and the ventilation fan for the 21,000 ramp development section, but the 13,200-volt incoming feed remained energized at the transformer.

Hanson told Nieto and Williams that he was going to go lock out and drove off in the personnel carrier down the incline. Investigators found Hanson's lock on the Atlas switch in the 5700 Level East, 21,700 location, which was determined not to be the appropriate location to properly de-energize power to transformer #95132 and #95249. Nieto and Williams started opening circuit breakers and removing side covers on the 480-volt side of the transformer. Approximately four minutes later, Hanson returned and removed the top cover from the 13,200-volt side of transformer #95132. Nieto observed Hanson climbing into the 480-volt side of the transformer #95132 metal housing. Hanson then climbed into the 13,200-volt side to clean the individual phases. When he touched one of the three phases, it was still energized and he received a phase-to-ground electrical shock of 7,600 volts.

At 10:44 a.m., Williams contacted Shawna Olson, mine dispatch, and informed her they needed a medic to go to the scene of the accident. Mine dispatch immediately responded and sent Crystal Hannah, paramedic, to the accident site, as well as Mark Deschene and Perry Jones, emergency medical technicians. Williams contacted Pederson who then traveled to the accident scene along with Mark Nelson, E&I technician. Pederson and Nelson traveled to the site to ensure all necessary electrical power was de-energized and tested. At 11:32 a.m., Hannah ceased resuscitation efforts. At 1:00 p.m., Toby Reissberg, deputy coroner, arrived at the mine and pronounced Hanson dead.

INVESTIGATION OF THE ACCIDENT

On July 26, 2025, at 11:35 a.m., Matthew McManamen, safety manager, called the Department of Labor National Contact Center (DOLNCC). The DOLNCC contacted Rodric Breland, assistant district manager, who contacted Matthew Jaynes, supervisory mine safety and health inspector, and informed him of the accident. Jaynes contacted the mine and confirmed that it was a fatality. Jaynes then sent Jordan Gustafson, mine safety and health specialist, to the mine. Breland contacted Micheal Tefertiller, staff assistant. Tefertiller assigned Thaddeus Sichmeller, supervisory mine safety and health inspector, as the lead investigator.

On July 26, 2025, at 4:32 p.m., Gustafson 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 the preservation of evidence. He then gathered a list of persons involved and compiled next of kin information. The following day, on July 27, 2025, at 9:23 a.m. Sichmeller arrived with Gustafson to begin the investigation.

The MSHA accident investigation team conducted an examination of the accident scene, interviewed mine management and miners, and reviewed conditions and work procedures relevant to the accident. See Appendix C for a list of persons who participated in the investigation.

DISCUSSION

Location of the Accident

The accident occurred underground at transformer #95132 located on the 5600 Level East 21,000 inclined ramp underground.

Equipment Involved

The equipment involved in the accident was an Intermountain Electronics Transformer, Model Number: 500/PC, Company #95132. This was the last transformer located up the 21,000 ramp. The area where the victim placed his lock was located at 5700 East, 21,700 location. This was a vertical Atlas Switch that did not control power to transformer #95132.

Atlas Switch

The Atlas Electrical Switch is a heavy-duty control device designed to provide a reliable manual interruption of electrical power within the equipment circuit. The switch has an insulated housing that protects the internal components from dust, moisture and external mechanical impact. Inside the enclosure, the switch uses metal contacts that open and close when the outer handle is operated from the "on" to the "off" position.

Preventive Maintainance Method

The documented preventive maintenance standard operating procedures (SOP) describes isolating and deenergizing the high voltage (13,200-volt) power at the electrical distribution (tap box) five feet from where the transformer is being worked on. There is no switch at this location. Isolation and de-energization is performed by using a hot stick to manually disconnect each phase in the tap box, one phase at a time.

On the day of the accident and prior to the PM beginning, Pederson told Hanson he could isolate and de-energize both the #95249 and #95132 transformers by de-energizing the switch. The exact switch or procedures were never discussed during the meeting. Nieto and Williams were not present for this discussion and were never informed of the procedural changes.

At the time of the accident, any change to the SOP for this PM task green sheet required changes to be made in writing, discussed at the tailgate meeting with all involved, and signed off by management and those affected. This process was often referred to as the "green sheet" procedure. During the investigation management denied any such formal procedure for changes and in fact, did not follow this green sheet procedure for the sequencing of de-energization on July 26. The company's established SOP were not followed, there were no documents noting the procedures being changed, and Hanson's lock was found on the Atlas switch that did not de-energize or isolate the high voltage electrical power to the #95249 and #95132 transformers. Instead, the altered procedure only de-energized power to the #95068 transformer which was approximately five feet from the Atlas switch which was approximately 2,000 ft. away from the accident location. This alteration in procedures, along with no labeling on the appropriate switch, contributed to the accident.

Examinations
Investigators determined Williams and Nieto conducted a workplace examination in the #95132 transformer area. Investigators reviewed the exam cards and determined no safety issues were noted in the area. Investigators determined that examinations did not contribute to the accident.

Training and Experience
Hanson had 5 years, 6 months of mining experience as an electrician at the Stillwater Mine. He had a total of 28 years as an electrician, including time at the mine and in the oil and gas industry. Hanson received annual refresher training on January 7, 2025. However, the de-energization procedure for July 26 was changed, including the health and safety aspects of the task. Therefore, Hanson was not task trained on the new sequence in order to do the PM job safely. Investigators determined that a lack of adequate task training 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 did not de-energize, lock out, or take other measures to prevent electrical equipment from being energized.

   Corrective Action: The company has established new policies and procedures for locking equipment out when doing preventive maintenance.

2. Root Cause: The mine operator did not label principal power switches to show which units they controlled.

   Corrective Action: The mine has revised existing preventive maintenance procedure and developed an additional practice of labeling power systems to make them easily identified.

3. Root Cause: The mine operator did not provide instruction in the safety and health aspects and safe work procedures of the assigned task.

   Corrective Action: The company updated the SOP and trained miners on the new procedure.

CONCLUSION

On July 26, 2025, at 10:44 a.m., Brian Hanson, a 50-year-old E&I technician with 5 years,6 months of mining experience, died when he contacted one phase of a 13,200 high voltage power circuit while conducting preventive maintenance in transformer #95132.

The accident occurred because the mine operator did not: 1) de-energize, lock out, or take other measures to prevent electrical equipment from being energized, 2) label principal power switches to show which units they controlled, and 3) provide instruction in the safety and health aspects and safe work procedures of the assigned task.

Approved By:

_____ _____

Nickolas Gutierrez Date
District Manager

ENFORCEMENT ACTIONS

1. A 103(k) order was issued to Stillwater Mining Company.

   A fatal accident occurred on July 26, 2025, at 10:44 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(d)(1) citation was issued to Stillwater Mining Company for a violation of 30 CFR 48.7(c).

   A fatal accident occurred on July 26, 2025, when an E&I technician came into contact with one phase of a 13,200 high voltage power circuit in transformer #95132. The mine operator engaged in aggravated conduct constituting more than ordinary negligence by changing the circuit isolation, de-energization and lock out procedures without providing any training, after this change was made, on how to perform the new task safely and effectively. This failure to train posed a high degree of danger to miners and exposed any miner working on the circuit to electrocution and death. This is an unwarrantable failure to comply with a mandatory standard.

3. A 104(d)(1) order was issued to Stillwater Mining Company for a violation of 30 CFR 57.12016.

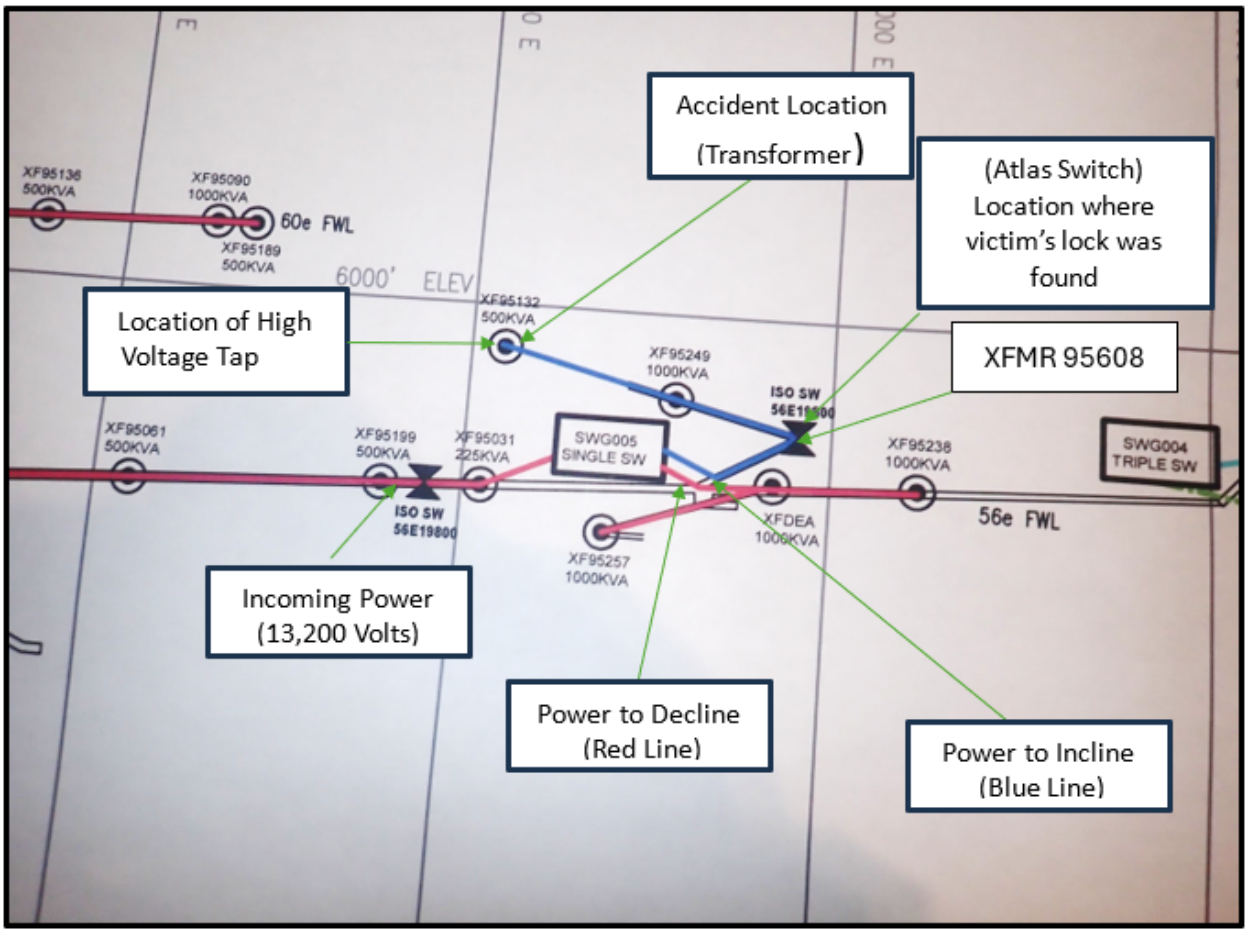
   A fatal accident occurred on July 26, 2025, when an E&I technician came into contact with one phase of a 13,200 high voltage power circuit in transformer #95132. The mine operator did not ensure that the circuit was isolated, de-energized and locked out prior to work being done on the equipment. The mine operator improperly changed the circuit isolation, de-energization, and lock out procedure without training the E&I technician and failed to properly label the switch controlling the 13,200 high voltage power circuit in transformer #95132, all of which caused the incorrect switch to be locked out. These conditions and practices posed a high degree of danger to miners and exposed any miner working on the energized circuit to the risk of electrocution and death. The mine operator engaged in aggravated conduct constituting more than ordinary negligence. This is an unwarrantable failure to comply with a mandatory standard.

4. A 104(d)(1) order was issued to Stillwater Mining Company for a violation of 30 CFR 57.12018.

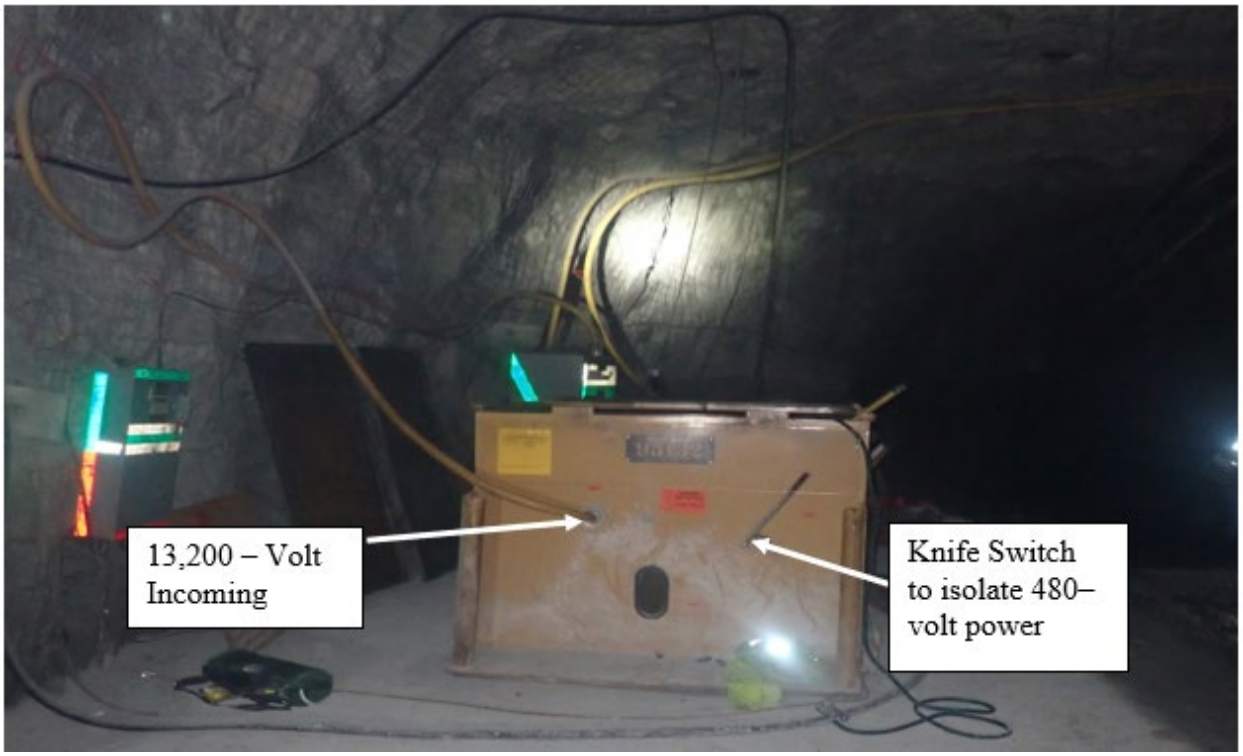
   A fatal accident occurred on July 26, 2025, when an E&I technician came into contact with one phase of a 13,200 high voltage power circuit in transformer #95132. The SWG005 switch controlling the 13,200 high voltage power circuit was not labeled to show which unit it controlled, and this could not be readily determined by its location. Due to the absence of

labels, the electrician placed his lock on a different switch that was not intended to de-energize transformer #95132. This lack of labels posed a high degree of danger to miners and exposed any miner working on the circuit to the risk of electrocution and death. The mine operator engaged in aggravated conduct constituting more than ordinary negligence. This is an unwarrantable failure to comply with a mandatory standard.

APPENDIX A – Electrical Diagram



APPENDIX B – Transformer #95132



APPENDIX C – Persons Participating in the Investigation

Stillwater Mining Company

NikKayla Simon	Senior Safety Manager
Matthew McManamen	Safety Manager
Gary Smith	Surface and Concentrator Manager
Douglas Brayley	Electrical General Foreman
Brian Croston	Electrical Engineer
Garrett Pederson	Electrical Supervisor
Mark Nelson	E&I Technician 1
Gustavo Nieto	E&I Technician 1
Lisa Williams	E&I Technician 1
Mark Deschene	Stillwater ERT/First Responder
Perry Jones	Stillwater EMT

Mine Safety and Health Administration

Mark Phillips	Acting Assistant District Manager
Thaddeus Sichmeller	Supervisory Mine Safety and Health Inspector
Jordan Gustafson	Mine Safety and Health Specialist