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UNITED STATES
DEPARTMENT OF LABOR
MINE SAFETY AND HEALTH ADMINISTRATION

REPORT OF INVESTIGATION

Surface
(Salt)

Handling Material Accident Fatality Report
November 22, 2025

Carlsbad Plant
United Salt Carlsbad LLC
Carlsbad, Eddy County, New Mexico
Mine ID: 29-01043

Accident Investigator

Ty Fisher
Supervisory Mine Safety and Health Specialist

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

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OVERVIEW

On November 22, 2025, between 2:30 p.m. and 3:30 p.m., Martin Delgado, a 60-year-old plant operator with over 27 years of mining experience, died after he was engulfed by material at the Silo No. 6 access door. Delgado was in the process of cleaning and clearing a blockage in the silo.

The accident occurred because the mine operator did not equip Silo No. 6 with effective means of handling materials to prevent the plant operator from being required to enter or work where he was exposed to entrapment by caving or sliding materials.

GENERAL INFORMATION

United Salt Carlsbad LLC owns and operates the Carlsbad Plant, a surface salt facility located in Carlsbad, Eddy County, New Mexico. The Carlsbad Plant employs 54 miners and typically operates two 12-hour shifts a day, 5 days a week, and a maintenance shift on Saturdays. The Carlsbad Plant is a mill and preparation plant that processes raw salt from the nearby Carlsbad Lake Plant. Over-the-road trucks transport the salt from the Carlsbad Lake Plant to the Carlsbad Plant, where it is fed by a front-end loader into a hopper and transported via belt conveyors to a

dryer and various shaker screens then to silos for distribution. The mill produces salt used for livestock mineral blocks, deicer and water softener tablets, and other products.

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

Raynaldo Martinez	General Foreman
Daniel Rocha	Health and Safety Director
Josh Hedrick	Maintenance Superintendent
Harvey Rivera	Plant Manager

The Mine Safety and Health Administration completed the last regular safety and health inspection at this mine on August 25, 2025. The 2024 non-fatal days lost incident rate for the Carlsbad Plant was 3.70, compared to the national average of 1.12 for mines of this type.

DESCRIPTION OF THE ACCIDENT

On November 22, 2025, at 7:05 a.m., Delgado checked in at the office to begin his shift. At 7:15 a.m., Delgado left the office to begin his daily tasks at the plant scale house and Bulk Processing Plant, and to complete paperwork. At 8:15 a.m., Delgado performed a workplace examination and then loaded the first customer truck with salt from the silo from 8:30 a.m. to 8:58 a.m. At approximately 9:15 a.m., Raynaldo Martinez, general foreman, met with Delgado and discussed cleaning Silo No. 6, which was a part of Delgado's regular job duties. At approximately 9:20 a.m., Luis Villanueva, plant loader operator, assisted Delgado in setting up the pressure washer for cleaning Silo No. 6. Villanueva left to operate the front-end loader at the bulk warehouse. At approximately 10:30 a.m., Martinez walked through the plant and observed Delgado replacing the pressure washer nozzle. From 10:50 a.m. to 11:50 a.m., Delgado loaded the second and third customer trucks. From 11:50 a.m. to 1:20 p.m., Villanueva and Martinez heard loud banging, assuming that Delgado was using hammers on the exterior of the silo to dislodge material buildup.

From 1:20 p.m. to 1:50 p.m., Delgado loaded the fourth customer truck. At approximately 2:15 p.m., Delgado went to Martinez's office to obtain a new set of work gloves. Delgado told Martinez that he had the plant under control and that Martinez could leave, as Martinez normally does not work on Saturdays. At approximately 2:20 p.m., Villanueva assisted Delgado in switching to a newer pressure washer for improved performance and then left to operate the front-end loader. Villanueva last saw Delgado at approximately 2:30 p.m. at the open access door of Silo No. 6.

At approximately 3:30 p.m., Villanueva returned to check on Delgado and found him unresponsive with a portion of his right upper body inside the silo access opening. Villanueva used his radio to conduct an "all call" for assistance. Braulio Medrano, day shift foreman, arrived first and instructed Villanueva to call 911. Eddy County Fire and Rescue received the call at 3:32 p.m. Medrano contacted Jose Vasquez, production manager, who was off site, and Harvey Rivera, plant manager.

At 3:54 p.m., Eddy County Fire and Rescue arrived at the mine, assessed Delgado, and began recovery efforts. Jacqueline Castaneda, New Mexico state medical examiner, pronounced Delgado deceased at 6:30 p.m.

INVESTIGATION OF THE ACCIDENT

On November 22, 2025, at 3:47 p.m., Rivera contacted the Department of Labor National Contact Center (DOLNCC) to report the accident. The DOLNCC notified Ronnie Free, assistant district manager, who informed Brett Barrick, acting district manager. Barrick assigned Ty Fisher, supervisory mine safety and health specialist, as the lead investigator. Barrick notified Darwin Bratcher, supervisory mine safety and health inspector, who proceeded to the mine site. At 4:19 p.m., Barrick called Rivera and issued a verbal order under the provisions of Section 103(j) of the Mine Act to ensure the safety of the miners and the preservation of evidence. At 5:30 p.m., Bratcher arrived at the mine, and at 5:40 p.m., modified the 103(j) to a 103(k).

The MSHA accident investigator, Eddy County Sheriff's Department, and Eddy County Fire and Rescue examined the accident scene, interviewed miners and mine management, reviewed conditions and work procedures relevant to the accident, and assisted with recovery of Delgado. Refer to Appendix A for a list of persons who participated in the investigation.

DISCUSSION

Location of the Accident

The accident occurred at Silo No. 6 on the silo deck floor of the Bulk Processing Plant (Appendix B).

Weather

The weather at the time of the accident was partly cloudy, 63 degrees, wind at 3.8 miles per hour and the humidity at 36%. The investigator determined that the weather did not contribute to the accident.

Equipment Involved

Silo No. 6 is constructed of plate steel and supported by a support ring located just above the top of the cone and secured to the plant structure. The silo has an overall height of 28 feet, 11.5 inches and an outside diameter of 15 feet, 0.5 inches. The inverted tapered cone is 11 feet, 4.4 inches tall, beginning just below the support ring and ending at 2 feet, 0.4 inches of discharge opening at the bottom.

A bucket elevator fills Silo No. 6 with remotely actuated control gates that allow only one of the four silos to be filled at a time. The remote switches are in the plant scale house. The bucket elevator fills Silo Nos. 5, 6, 7, and 8. All four silos are discharged onto one of two belt conveyors leading to the truck bulk loadout. On November 22, 2025, according to a monitoring device that displays capacity levels, Silo No. 6 contained approximately 40 tons of salt at the start of the day and approximately 36 tons at the time of the accident.

The access door is located on the east side of the silo cone, opposite the swing hammer (Appendix C). The access door is tapered to match the cone, with a top opening of 29 inches, a lower opening of 22 inches, and a vertical height of 30 inches. The bottom edge of the access door opening is 49 inches above the silo deck floor.

Other tools used to break up salt buildup inside the silo included eight- and ten-pound long-handled sledgehammers, an air chisel with 16-inch and 36-inch bits, swing hammers, and two hand-cart-mounted gas-powered pressure washers. The swing hammers were attached to chains on only one side of the silos and required miners to continuously use them to prevent material buildup on that side. The access door opening was located on the opposite side of the swing hammers, and no means existed to reduce salt buildup at or above the access door.

The silos are equipped with 2-inch by 4-inch poke holes at the discharge pipe for use with long bars. Mine management, including Rivera, Martinez, and Hedrick stated that this method alone was not adequate to maintain unrestricted material flow, which led to the installation of swing hammers. The silos are cleaned weekly due to material buildup. Investigators determined that Delgado worked alone for most of the cleaning process for Silo No. 6, which was normal for this task. The mine operator did not equip Silo No. 6 with effective means of handling material to prevent the plant operator from being required to enter or work where he was exposed to entrapment by caving or sliding materials, which contributed to the accident.

Examinations

In 2025, Delgado conducted workplace examinations on November 21 and November 22, and recorded no defects. Investigators determined that the workplace examinations were adequate and did not contribute to the accident because no hazardous conditions existed in the area surrounding Silo No. 6 that would have caused the accident.

Training and Experience

Delgado had 27 years and 10 months of mining experience, all at the Carlsbad Plant as a plant operator. He received new miner training on February 6, 1998; annual refresher training on October 8, 2025; task training for bulk plant operations that included cleanup procedures on January 5, 2023; and lockout and tagout training on May 15, 2008. Delgado and Vasquez began the silo cleaning process on November 21, 2025. Vasquez stated that Delgado trained him on safe material removal procedures throughout the day and demonstrated that the plane of the access door opening should not be breached. Investigators determined that Delgado received all training in accordance with MSHA Part 48 training regulations.

ROOT CAUSE ANALYSIS

The accident investigator conducted an analysis to identify the underlying cause 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 equip Silo No. 6 with effective means of handling material to prevent the plant operator from being required to enter or work where he was exposed to entrapment by caving or sliding materials.

Corrective Action: The mine operator sealed all silo access doors by welding and cut vents in the tops of the silos to wash out remaining salt with water hoses. The mine operator developed and implemented a written procedure to use the vents when cleaning and clearing blockages from the silos.

CONCLUSION

On November 22, 2025, between 2:30 p.m. and 3:30 p.m., Martin Delgado, a 60-year-old plant operator with over 27 years of mining experience, died after he was engulfed by material at the Silo No. 6 access door. Delgado was in the process of cleaning and clearing a blockage in the silo.

The accident occurred because the mine operator did not equip Silo No. 6 with effective means of handling materials to prevent the plant operator from being required to enter or work where he was exposed to entrapment by caving or sliding materials.

Approved By:

___________________________________ _____________

William O’Dell Date

District Manager

ENFORCEMENT ACTIONS

1. A 103(k) order was issued to United Salt Carlsbad LLC.

   A fatal accident occurred on November 22, 2025, between 2:30 p.m. and 3:30 p.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 any plan to recover any person in the mine or to recover the mine or 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. 104(a) citation was issued to United Salt Carlsbad LLC for 56.16002(a)(1).

   On November 22, 2025, the plant operator died after his upper body was engulfed by material at the Silo No. 6 access door. The plant operator was attempting to clear the silo of salt buildup that created a blockage while leaning into the access door located on the cone portion of the silo at the second-floor catwalk. The mine operator did not equip Silo No. 6 with an effective means to prevent persons from being required to enter or work where they were exposed to entrapment by caving or sliding materials.

APPENDIX A – Persons Participating in the Investigation

United Salt Carlsbad LLC

Name	Title
Raynaldo Martinez	General Foreman
Daniel Rocha	Health and Safety Director
Josh Hedrick	Maintenance Superintendent
Jose Vasquez	Production Manager
Braulio Medrano	Day Shift Foreman
Harvey Rivera	Plant Manager
Luis Villanueva	Plant Loader Operator

Texas United Management

Name	Title
Kyle Rash	Vice President of Operations
Maria Gallegos	Vice President of Environment, Health, Safety and Security
Ellis Schouest	Corporate Safety Officer

Eddy County Sheriff Department

Name	Title
Deputy Seth Taylor	Deputy Sheriff
Deputy Thomas Iiams	Deputy Sheriff

Eddy County Fire and Rescue

Name	Title
David Watson	Deputy Fire Chief

Mine Safety and Health Administration

Name	Title
Ty Fisher	Supervisory Mine Safety and Health Specialist
Darwin Bratcher	Supervisory Mine Safety and Health Inspector

APPENDIX B – Bulk Processing Plant

Note: The red square shows the location of Silo No. 6.

APPENDIX C – Silo Access Door