

UNITED STATES
DEPARTMENT OF LABOR
MINE SAFETY AND HEALTH ADMINISTRATION

REPORT OF INVESTIGATION

Underground
(Gold Ore)

Fatal Powered Haulage Accident
September 29, 2025

Goldrush
Nevada Gold Mines LLC
Crescent Valley, Eureka County, Nevada
ID No. 26-02822

Accident Investigators

Jason Jenó
Mine Safety and Health Inspector

Alec Jording
Mine Safety and Health Inspector

Originating Office
Mine Safety and Health Administration
Vacaville District
991 Nut Tree Road
Vacaville, California 95687
Nickolas Gutierrez, Acting District Manager

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OVERVIEW

On September 29, 2025, at 3:28 p.m., Jeremy Smokey, a 37-year-old load haul dump (LHD) operator died after the LHD he was operating went over the edge of a stope and fell 72 feet into an open hole.

The accident occurred because the mine operator did not ensure the operator of the LHD maintained control of the piece of mobile equipment while preparing for the backfilling process.

GENERAL INFORMATION

The Goldrush mine is a multi-level underground gold mine owned and operated by Nevada Gold Mines LLC (NGM). The mine is located 19 miles from Crescent Valley, in Eureka County, Nevada. The Goldrush mine employed 356 miners and operated two 12-hour shifts a day, 7 days a week.

Gold-bearing ore is drilled and blasted in long hole stopes. The broken ore is transported from the bottom of the stopes with LHDs and haul trucks to surface stockpiles for processing and refining. The finished products are sold to commercial industries.

The principal management official at Goldrush at the time of the accident was:

Daniel Donnelly

Mine Manager

The Mine Safety and Health Administration (MSHA) completed the last regular safety and health inspection at this mine on August 21, 2025. The 2024 non-fatal days lost incident rate for the Goldrush mine was 0.36, compared to the national average of 1.44 for mines of this type.

DESCRIPTION OF THE ACCIDENT

On September 29, 2025, Smokey arrived at the site around 6:50 a.m. and began his shift at 7:00 a.m. After attending the line-out and safety meetings led by Julio Lara, shift supervisor, Smokey was assigned to operate the LHD.

Early in the shift, work was briefly delayed due to high carbon monoxide levels in certain areas of the mine. Once cleared, Smokey continued tramming along the main decline. At 9:12 a.m., Smokey discovered a hydraulic leak on his LHD, which was repaired by maintenance.

Throughout the day, Smokey moved between various headings, loading trucks and performing assigned tasks. Around 2:15 p.m., Smokey reported to the dispatcher that he was working in the 6125-North Area.

The 6125-112 heading was not scheduled for backfilling on the date of the accident and sat idle. However, because of high gas readings in other areas of the mine, Eric Beaman, leadman, asked Dillon Cadwell, engineering superintendent, if this area could be ready for cemented rock fill (CRF) backfilling. After reviewing the situation, Beaman and Mathew Urenda, acting leadman, traveled to the 6125-112 stope to examine and determine if it was ready for the backfill. Beaman assigned Jonathan Riley, loader operator, to clean and prepare the 6125-112 stope for backfilling. Riley cleaned the area, rehung the warning signs, and set the jersey barrier 10 feet back from the edge. Riley left the 6125-112 stope when he was called to go to the 6245 level of the mine. Smokey went to the 6125-112 stope to begin clearing out a nearby muck bay in preparation for trucks to deliver CRF to the area. The trucks did not arrive in the area before the accident.

Later in the afternoon, Beaman drove to the 6125-112 heading to find Smokey. However, when Beaman reached the 6125-112 heading, he neither saw nor heard Smokey's equipment. Concerned, he searched further and discovered the LHD overturned in a stope connection on the 6060 level, 72 feet below the 6125-112 heading where Smokey had been working. Beaman immediately called for mine rescue at 4:22 p.m., and the team arrived within minutes. Due to the location of the LHD, it was necessary for the mine operator to develop an extensive rescue plan to recover the machine from its compromised position in the open stope. Until the LHD was moved to a safe position, the operator's cab could not be accessed. At 6:30 p.m., the Sheriff's office was notified of the accident.

At 4:40 a.m. on September 30, 2025, the area was being prepared for rescue operations. This included securing the stope, verifying ventilation, and staging necessary equipment. As part of the preparation, the mine operator readied a telehandler and a custom boom extension device designed to position straps over the tire, enabling the machine to be flipped and dragged from its compromised position.

At 9:00 a.m., the LHD was finally moved to a safe position so the medics could access the LHD and cab to evaluate Smokey's condition. At 9:28 a.m., Nicholas Collins, Deputy Sheriff-Coroner, from the Eureka County Sheriff's Office, pronounced Smokey dead.

INVESTIGATION OF THE ACCIDENT

On September 29, 2025, Herschel Russell, general supervisor for health & safety training, called the Department of Labor National Contact Center (DOLNCC), at 4:29 p.m. to notify MSHA of the accident. Robert Hartzell, supervisory inspector, issued an order under the provisions of section 103(j) of the Mine Act over the phone to ensure the safety of the miners. Hartzell and Michael Salvo, mine safety and health inspector, traveled to the mine site to oversee the rescue. The 103(j) order was later modified to section 103(k) of the Mine Act by Salvo after he arrived at the mine site.

Kevin Abel, acting district manager, assigned Jason Jenó, mine safety and health inspector, as the accident investigation team leader, and Alec Jording, mine safety and health inspector, as the investigative assistant. Jenó and Jording traveled to the mine on October 1, 2025, arriving at 10:00 a.m. The accident investigators inspected the accident scene, interviewed employees, and reviewed documents and work procedures relevant to the accident. MSHA conducted the investigation with the assistance of mine management and miners, the State of Nevada Mine Safety and Training Section, and the Eureka County Sheriff's Department. See Appendix A for a list of people who participated in the investigation.

DISCUSSION

Location of the Accident

The accident occurred at the 112 heading on the 6125 (6125-112) north level of the mine at the top cut of the stope. The drift dimensions of the top cut were 19 feet across the sill (from side to side), and the height was 20 feet to the roof. The overall length of the 6125-112 stope opening was approximately 80 feet. The distance from the leading edge of the stope to the bottom cut was 72 feet. The bottom cut of the stope is located on the 6060 level. The roof of the bottom cut is supported with bolts, wire, and shotcrete up to the edge of the stope opening.

Equipment Involved

The LHD involved in the accident was a Sandvik LH621i. It is an articulated loader with a nominal payload capacity of 12 yards of material. The operator's compartment was located on the left side of the machine with the operator seated sideways in the direction of travel.

The LHD features center-point articulation and power steering and is controlled by an electric joystick. Lateral joystick movement steers the machine, while transmission shifting between forward, neutral, and reverse is managed by a rocker switch. Bucket and boom movements are hydraulically controlled through the joystick. Lighting functions are operated by rocker switches on the instrument panel.

The braking system consists of spring-applied, hydraulically released, liquid-cooled multi-disc brakes on all four wheels, with separate circuits for the front and rear axles. These brakes are

designed to provide sufficient force to stop and hold the machine on maximum allowable gradients. The service brakes also function as emergency brakes when engaged, and the parking brake activates automatically when hydraulic pressure is lost, such as during engine shutdown.

The braking and steering systems were compromised and damaged during the accident. Functionality testing of the braking and other systems could not be performed due to the damage sustained to these components during the accident. The seat belt appeared to have functioned properly and was worn at the time of the accident and had had to be cut for recovery.

The loader is equipped with five forward-facing lights and four rear-facing lights. However, the electrical system and headlights were extensively damaged during the accident and recovery, preventing functional testing. Most lights were broken during the fall or subsequent recovery operations. Switch positions could not be confirmed due to rock intrusion and cab damage sustained during recovery efforts.

The investigators gathered electronic data from the electronic control module and the secure digital (SD) card from the operator-installed, on-board camera. MSHA Technical Support, examined the SD card and analyzed the electronic data files.

The data indicated that the brakes, parking, service, and Vehicle Control Module controlled brake system were successfully tested at the beginning of the shift. The data did not indicate any unusual operating conditions up to the time of the accident.

The SD card from the operator-installed on-board camera was also examined. The card did not contain video from the time of the accident.

Stope Preparation

The LHD was traveling forward as it entered the 6125-112 top cut of the stope. Smokey's exact actions at the time of the accident are unknown. However, based on where the stope was in the backfill cycle, he may have been attempting to reposition the jersey barrier placed during backfill preparation. The positions of the machine's controls could not be definitively determined because loose rock entered the cab, and the cab had to be cut and pried open during recovery. The pedals were buried under rock, preventing any assessment of their functionality. The main breaker was found tripped, though it could not be established whether this occurred due to operator action or as a result of rock intrusion.

The mine had an established procedure for working near open stopes called the Open Stope Policy. The written policy required "Fall Protection Required" and "Open Hole" signs, along with streamers, to be placed at least 10 feet from the edge of an open hole. Additionally, a cement block or jersey barrier was to always be maintained at least 10 feet back from the edge. After the accident, investigators noted that streamers were in place; however, Brigham Rowe, operations superintendent, later confirmed that he rehung them post-incident upon discovering they had fallen. Rowe stated that he rehung one streamer at the 10-foot line and another near the 60-foot mark at the stope entrance. The jersey barrier could not be located during the initial investigation and was later identified inside the LHD bucket through LiDAR scans conducted by drone. Investigators determined that the mine operator did not ensure that the equipment operator

followed the established procedure for working near open stopes, which contributed to the accident.

Examinations

Smokey performed a pre-operation inspection on the LHD and discovered a leak. The issue was addressed, and the leak was repaired before the equipment went underground. No record of a workplace examination of the 6125-112 stope conducted by Smokey was provided by the company. The inspection card for the 6125-112 stope was not found. It could have fallen into the open stope under unsupported ground, making it irretrievable. Investigators determined that this did not contribute to the accident.

Training and Experience

Smokey had a total of 8 years and 25 weeks of mining experience, and 5 weeks of experience at his current job as an LHD operator. The investigation team conducted an in-depth review of the mine operator's training records. The records for Smokey were reviewed and all required MSHA training including new miner and task training were found to be up to date and in compliance with MSHA requirements.

ROOT CAUSE ANALYSIS

The accident investigation team conducted an analysis to identify the underlying causes of the accident. The accident investigation team identified the following root cause, and the mine operator implemented the corresponding corrective actions to prevent a recurrence.

Root Cause: The mine operator did not ensure the operator of the LHD maintained control of the piece of mobile equipment while preparing for the backfilling process.

Corrective Action: The open stope policy provides information concerning protective measures which include placement of bumper blocks and CRF berms. All equipment operators who work around the stopes received training emphasizing the open stope policy, including stope set up, the backfill phase of mining, and maintaining control of the mobile equipment at all times.

CONCLUSION

On September 29, 2025, at 3:28 p.m., Jeremy Smokey, a 37-year-old load haul dump (LHD) operator died after the LHD he was operating went over the edge of a stope and fell 72 feet into an open hole.

The accident occurred because the mine operator did not ensure the operator of the LHD maintained control of the piece of mobile equipment while preparing for the backfilling process.

Approved By:

Nickolas Gutierrez
Acting District Manager

Date

ENFORCEMENT ACTIONS

1. A 103(k) order was issued to Nevada Gold Mines LLC.

A fatal accident occurred on September 29, 2025, at 4:29 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 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 Nevada Gold Mines LLC for a violation of 30 CFR 57.9101.

On September 29, 2025, a load, haul, dump (LHD) operator died when the equipment he was operating overtraveled the edge of the 6125-112 stope and fell 72 feet to the bottom cut. The mine operator did not ensure that the equipment operator maintained control of the equipment while in motion. The equipment operator was preparing the stope for the backfilling process when he lost control of the LHD and traveled over the edge.

APPENDIX A – Persons Participating in the Investigation

Nevada Gold Mines LLC

Andre Lantze	Head of Health and Safety Nevada Gold Mines
Brigham Rowe	Operations Superintendent
Daniel Donnelly	Mine Manager
Kurt Parker	Safety Manager
John Uriona	Safety Supervisor
Shawn Sandoval	General Supervisor

Eureka County Sheriff's Department

Nicholas Collins	Deputy Sheriff-Coroner
Tyler Thomas	Undersheriff

State of Nevada Mine Safety and Training Section

Daniel Inman	Mine Inspector
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Mine Safety and Health Administration

Robert Hartzell	Supervisory Mine Safety and Health Inspector
Michael Salvo	Mine Safety and Health Inspector
Dwight Stoneman	Mine Safety and Health Inspector
David Ricker	Mine Safety and Health Specialist
Brandon Boring	General Engineer, Technical Support
Nicholas Fallova	General Engineer, Technical Support