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UNITED STATES
DEPARTMENT OF LABOR
MINE SAFETY AND HEALTH ADMINISTRATION

REPORT OF INVESTIGATION

Surface
(Granite)

Fatal Powered Haulage Accident
September 8, 2025

IDS Highway Safety, Inc. (A0491)
Cumberland, Rhode Island

at

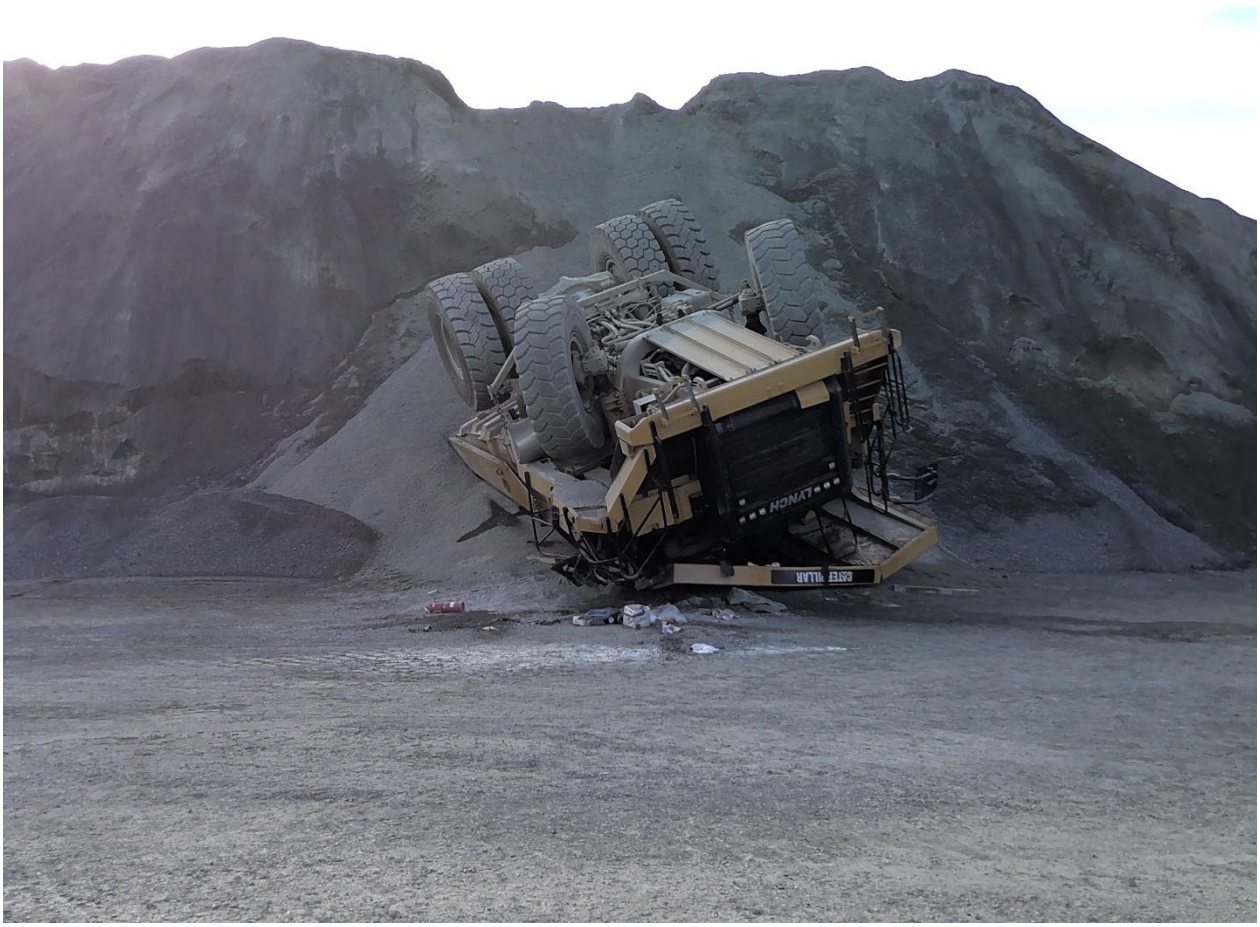
Lynch Corp
Lynch Corp.
Cumberland, Providence County, Rhode Island
ID No. 37-00070

Accident Investigator

Jason Dibble
Mine Safety and Health Inspector

Originating Office
Mine Safety and Health Administration
Warrendale District
178 Thorn Hill Road, Suite 100
Warrendale, PA 15086
Peter Montali, District Manager

TABLE OF CONTENTS



OVERVIEW

On September 8, 2025, at 7:12 a.m., Steven DiTomasso, a 73-year-old contract haul truck driver with over 13 years of experience, died when the ground under his haul truck collapsed, causing it to overturn backwards and come to rest at the base of the ¾-inch processed granite stockpile (stockpile).

The accident occurred because the mine operator did not: 1) ensure the contract haul truck driver dumped a safe distance back from the edge of the unstable area of the stockpile, and 2) trim the stockpile face to prevent hazards.

GENERAL INFORMATION

Lynch Corp. owns and operates the Lynch Corp Mine. The Lynch Corp Mine is a surface granite mine located in Cumberland, Rhode Island (Providence County). The mine employs four miners and operates one nine-hour shift, five days per week. The mine operator employs two contract haul truck drivers from IDS Highway Safety, Inc. (IDS). DiTomasso was employed by IDS. The mine drills and blasts granite in an open pit quarry, and the contract haul truck drivers transport the blasted granite to a primary crushing plant for sizing. The ¾-inch processed granite is a byproduct of the mine's granite production. The mine stockpiles and sells the ¾-inch processed granite for use in the construction industry.

The principal management officials at the Lynch Corp mine at the time of the accident were:

Ryan Sukaskas	Safety Officer
James Manni	Quarry Manager

The principal management officials for IDS at the time of the accident were:

Adam Ray	Owner
Kristen Ray	President

The Mine Safety and Health Administration (MSHA) completed the last regular safety and health inspection at this mine on October 8, 2024. The 2024 non-fatal days lost incident rate for the Lynch Corp Mine was zero, compared to the national average of 0.97 for mines of this type.

DESCRIPTION OF THE ACCIDENT

On September 8, 2025, at 6:30 a.m., DiTomasso started his shift by clocking in at the break area of the office. At 7:00 a.m., Jeffrey Sanantonio, the front-end loader operator, directed DiTomasso and Anthony Refino, haul truck drivers for IDS, to haul ¾-inch processed granite from the plant to the top of the stockpile. DiTomasso drove up the roadway to the stockpile and put his haul truck in reverse once he reached the top. Video evidence shows that DiTomasso backed his haul truck towards the edge of the stockpile, through the berm, and stopped after his haul truck's rear wheels were over the stockpile's edge. DiTomasso stayed parked with his rear wheels over the edge of the stockpile for two minutes and ten seconds. According to interviews, during this time, someone called DiTomasso on the citizens band (CB) radio and told him to jump from the cab. DiTomasso responded that he could not. Sanantonio drove the front-end loader to get rigging material to try to pull DiTomasso's haul truck back to a safe location. Before Sanantonio could return with the rigging material, the ground beneath the haul truck collapsed. This caused the haul truck to fall 42.5 feet and overturn backwards onto its cab at 7:12 a.m.

Kevin Baldwin, General Superintendent, observed the accident from the scale house and immediately drove to the haul truck. Kevin Murphy, Safety Officer, heard about the accident on his CB radio and met Baldwin at the scene along with Frank Simao, Mobile Maintenance Manager. Baldwin, Murphy, and Simao observed DiTomasso in the cab of the truck, strapped into its restraint system. DiTomasso was unresponsive. At 7:13 a.m., Cumberland Emergency Medical Services (EMS) was called. EMS arrived at 7:25 a.m. to attempt to rescue and remove DiTomasso from the truck. EMS used a hydraulic rescue tool to free DiTomasso's hand from under the truck's steering column, then removed him from the cab, secured him on a backboard, then placed him in the ambulance. EMS departed from the site at 7:37 a.m., to transport DiTomasso to the hospital. Marius Tarau, Chief Medical Examiner for the Office of State Medical Examiners in Providence, RI, pronounced DiTomasso dead at 11:04 a.m.

INVESTIGATION OF THE ACCIDENT

On September 8, 2025, at 7:44 a.m., Ryan Sukaskas, Safety Officer, called the Department of Labor National Contact Center (DOLNCC). The DOLNCC contacted Kevin Honeycutt, Staff Assistant. Honeycutt contacted Adrian Scallion, Supervisory Mine Safety and Health Inspector, who sent Everett Kinser, Mine Safety and Health Inspector, to the mine along with David Woodward, Mine Safety and Health Inspector Trainee.

At 10:35 a.m., Kinser and Woodward arrived at the mine and issued an order under Section 103(k) of the Mine Act to ensure the safety of the miners and preservation of evidence. At 11:24 a.m., Sukaskas informed Kinser that DiTomasso had passed away from the injuries sustained during the accident. Kinser immediately informed Scallion, who informed Honeycutt. Honeycutt called William MacDonald, Supervisory Mine Safety and Health Inspector, who called Jason Dibble, Mine Safey and Health Inspector, and sent him to the mine. Honeycutt assigned Dibble as the lead investigator.

At 4:50 p.m., Dibble arrived on site to conduct an examination of the accident scene; interview miners, mine management, and other relevant personnel; and review conditions and work practices relevant to the accident. See Appendix A for a list of persons who participated in the investigation.

DISCUSSION

Location of the Accident

The accident occurred at the ¾-inch processed granite stockpile located adjacent to the primary crushing plant (see Appendix B). The stockpile measured 42.5 feet high at the location of the accident. At the base of the stockpile, a front-end loader loaded material into customer trucks.

Weather

The weather at the time of the accident was clear, with a temperature of approximately 66 degrees Fahrenheit. However, between September 6, 2025, and September 7, 2025, the area received approximately one inch of rain. The investigator determined that the rainfall contributed to the instability of the already-undermined stockpile.

Equipment Involved

The haul truck involved in the accident was a 2014 Caterpillar 773G. The investigator conducted an examination of the haul truck and found no defects that contributed to the accident.

Ground Conditions and Dumping Practices

On September 4, 2025, and September 5, 2025, the mine operator undermined the stockpile when its front-end loader repeatedly dug material out from the toe of the stockpile where haul trucks dumped above. This was common practice at the mine, which caused the side and top of the stockpile to slough away and created instability in the stockpile's bank and slope. Investigators were informed that when the stockpile became undermined in the past, the haul truck drivers were directed to dump material short of the edge of the stockpile so that a front-end loader or bulldozer could push the material over the edge. Workplace examinations and

investigators' observations show that the face was vertical at the top of the stockpile where both trucks were dumping (see Appendix C). The investigator determined that the mine operator did not trim the stockpile face to prevent hazards, which contributed to the accident.

Sanantonio loaded Refino's truck, also a 2014 Caterpillar 773G, with the material off the stacking conveyor of the plant, located at the north side of the stockpile, at ground level. Due to the unstable stockpile, Sanantonio and Refino discussed over the CB radio to dump the material at least five feet back from the berm, and Sanantonio would push the material over the stockpile face later. Refino also told investigators that he saw the stockpile was unstable. Sanantonio and Refino did not hear DiTomasso acknowledge this over the radio.

Refino traveled to the top of the stockpile and dumped the material at the east side of the stockpile face just short of the berm (see Appendix D). Sanantonio loaded DiTomasso's haul truck with material. Video evidence shows DiTomasso's haul truck backing straight toward the berm on the north side of the stockpile then turning toward the east side where Refino had dumped. The investigator determined that the mine operator did not ensure DiTomasso dumped a safe distance back from the edge of the unstable area of the stockpile, which contributed to the accident.

Examinations

On the day of the accident, Sanantonio conducted a workplace examination of the ¾-inch processed granite stockpile and determined the east side face of the stockpile was undermined. Sanantonio recorded that the stockpile required attention. The investigator determined the workplace examination was adequate and did not contribute to the accident.

Training and Experience

DiTomasso had over 13 years of mining experience as a haul truck driver for IDS, working intermittently at the Lynch Corp Mine and other operations. DiTomasso operated both a Caterpillar 773D and 773G haul truck for all 13 years. He received task training on a Caterpillar 773D haul truck, but there was no record available to show DiTomasso had received task training on the Caterpillar 773G haul truck. However, due to DiTomasso's experience and the similarities in the operation of both haul trucks, the investigator determined this did not contribute to the accident. DiTomasso received all other training in accordance with MSHA Part 46 training regulations.

ROOT CAUSE ANALYSIS

The accident investigator conducted an analysis to identify the underlying causes of the accident. The investigator 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 ensure the contract haul truck driver dumped material a safe distance back from the edge of the unstable area of the stockpile.

   Corrective Action: The mine operator developed and implemented a new written procedure requiring miners to dump a safe distance back from the edge of stockpiles and the material to

be pushed over the edge by a front-end loader, bulldozer, or excavator. The mine operator trained all miners in this procedure. Also, the mine operator will no longer use a contractor to operate their haul trucks. The mine operator hired two haul truck drivers from the local operating union to work at the mine and provided them with adequate task training for their assigned haul trucks.

2. Root Cause: The mine operator did not trim stockpile faces to prevent hazards.

   Corrective Action: The mine operator trimmed the ¾-inch processed granite stockpile, returning the stockpile face to a natural angle of repose and preventing hazards to miners. Also, the mine operator developed and implemented a new written procedure requiring the stockpile face to be corrected immediately when evidence indicates it is becoming unstable. The mine operator trained all miners in this procedure.

CONCLUSION

On September 8, 2025, at 7:12 a.m., Steven DiTomasso, a 73-year-old contract haul truck driver with over 13 years of experience, died when the ground under his haul truck collapsed, causing it to overturn backwards, coming to rest at the base of the ¾-inch processed granite.

The accident occurred because the mine operator did not: 1) ensure the contract haul truck driver dumped a safe distance back from the edge of the unstable area of the stockpile, and 2) trim the stockpile face to prevent hazards.

Approved by:

_____ _____

Peter Montali Date
District Manager

ENFORCEMENT ACTIONS

1. A 103(k) order was issued to Lynch Corp.

   A fatal accident occurred on September 8, 2025, at 7:12 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 ensure 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 Lynch Corp. for a violation of 30 CFR 56.9304(b).

   A fatal accident occurred on September 8, 2025, when the ground beneath a haul truck collapsed, causing it to overturn backwards, coming to rest at the base of the ¾-inch processed granite stockpile. The mine operator did not ensure the contract haul truck driver dumped a safe distance back from the edge of the unstable area of the stockpile.

3. A 104(a) citation was issued to Lynch Corp. for a violation of 30 CFR 56.9314.

   A fatal accident occurred on September 8, 2025, when the ground beneath a haul truck collapsed, causing it to overturn backwards, coming to rest at the base of the ¾-inch processed granite stockpile. The mine operator did not trim the stockpile face to prevent hazards.

APPENDIX A – Persons Participating in the Investigation

Lynch Corp.

Kevin Baldwin	General Superintendent
Ryan Sukaskas	Safety Officer
Kevin Murphy	Safety Officer
James Manni	Quarry Manager
Michael Boisvert	Plant Operator/Foreman
Jeffrey Sanantonio	Front-End Loader Operator
Frank Simao	Mobile Maintenance Mechanic

IDS Highway Safety, Inc.

Adam Ray	Owner
Kristen Ray	President
Anthony Refino	Haul Truck Driver

Mine Safety and Health Administration

Jason Dibble	Mine Safety and Health Inspector
Everett Kinser	Mine Safety and Health Inspector
David Woodward	Mine Safety and Health Inspector Trainee

APPENDIX B – Aerial View of Mine

Note: The 3/4 -inch processed granite stockpile was smaller on the day of the accident than shown in this satellite photo.

APPENDIX C – Dump Edge of ¾-inch Processed Stockpile where the Ground Collapsed

APPENDIX D – Aerial View of the Accident Scene

Note: Red arrows represent the truck's direction of travel, according to interviews and video evidence. The truck began at the loading area, continued driving around the roadway, and backed the haul truck up to the dump point.