

UNITED STATES
DEPARTMENT OF LABOR
MINE SAFETY AND HEALTH ADMINISTRATION

REPORT OF INVESTIGATION

Surface
(Construction Sand and Gravel)

Non-Powered Haulage Accident Fatality Report
April 30, 2026

Portable Crusher #1
Seubert Excavators Inc
Weiser, Washington County, Idaho
ID No. 35-03255

Accident Investigators

Daniel Boylan
Supervisory 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
Jerry Kissell, Acting District Manager

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OVERVIEW

On April 30, 2026, at approximately 10:30 a.m., Devin Knight, a 23-year-old laborer with one year and three months of mining experience, died when a water tanker trailer (trailer) tipped over and rolled over him.

The accident occurred because: 1) the trailer was loaded in a manner that created a hazard to the laborer from falling equipment, and 2) the Surface Mobile Equipment Safety Program did not include a procedure to ensure the trailer was positioned on level ground or otherwise stabilized when it was filled while disconnected from the semi-truck.

GENERAL INFORMATION

Seubert Excavators Inc owns and operates the Portable Crusher #1, a portable surface sand and gravel operation. The mine employs eight miners and operates one 12-hour production shift and one maintenance shift per day, five days per week. Portable Crusher #1 consists of four portable crushing units, one jaw crusher, and three cone crushers. Each cone crusher is equipped with a screen, and the operation also includes one standalone 6-foot by 20-foot screening plant. A front-end loader strips the pit area and feeds material into the jaw crusher. The sand and gravel produced at the mine are sold to the public for use in construction projects.

Seubert Excavators Inc relocated Portable Crusher #1 to the Barstad Pit, located near Weiser, Washington County, Idaho and began operating the portable crusher at that location on March 31, 2026.

The principal management official at Portable Crusher #1 at the time of the accident was:

Brandon Davis

Mine Foreman

The Mine Safety and Health Administration (MSHA) completed the last regular safety and health inspection at this mine on December 18, 2025. The 2025 non-fatal days lost incident rate for Portable Crusher #1 was zero, compared to the national average of 1.05 for mines of this type.

DESCRIPTION OF THE ACCIDENT

On the evening of April 28, 2026, Dustin Coleman, feeder man, backed the empty trailer and semi-truck to the fill location on the lower road. The trailer was used to transport water for dust control and wet processes, such as screening. Knight and Kori Coleman, feeder man, assisted D. Coleman by spotting the trailer as he backed it into position. Robert Rohwer, quality control, placed a large rock between the driver-side front and rear dual tires to chock the trailer. D. Coleman placed wooden blocks under the landing gear, disconnected the semi-truck from the trailer, and drove the semi-truck to the plant to move plant equipment. The trailer remained undisturbed until April 30, 2026. For reference, an aerial photo of the operation can be found in Appendix A.

On April 30, 2026, at approximately 7:00 a.m., Knight began his shift at the mine and assisted Rohwer, D. Coleman, K. Coleman, and Brandon Griffith, feeder man, with dismantling and staging plant equipment for transport to a new site. According to interviews, at approximately 7:30 a.m., Brandon Davis, mine foreman, conducted the workplace examinations of the working areas of the mine including the area where the water tank trailer was parked for refill.

At approximately 9:00 a.m., Knight and Rohwer went to the trailer to fill it with water as part of their normal duties. Knight primed and started the pump at the nearby creek, while Rohwer held the hose in the trailer opening until consistent flow of water was established. After the pump was operating properly and water flowed into the trailer, Rohwer returned to the plant to continue loading and staging plant equipment for transport. Knight remained at the trailer to monitor the filling of the tanker.

At 9:45 a.m., Rohwer checked the time on his phone and walked to the trailer to check on Knight and the water level in the trailer. Rohwer stated the tank was about one-third full and that Knight did not need any assistance. Rohwer then returned to the plant area to continue loading and staging plant equipment for transport.

At approximately 10:20 a.m., Rohwer again returned to the trailer and observed that the trailer was around two-thirds full. He saw Knight sitting on the ground with his back against the driver-side rear dual tires while waiting for the tanker to fill and then returned to the plant area.

At approximately 10:40 a.m., Rohwer, believing the trailer should have been full by that time, walked down to the trailer. As the trailer came into view, he observed that it had overturned and Knight was lying on the ground. Rohwer called out to Knight and asked if he was okay. Knight responded that he was not. Rohwer then yelled at the rest of the crew to get Davis.

Davis, Griffith, Rohwer, K. Coleman, D. Coleman, Anthony Schmuck and Kayden Cunningham, haul truck operators, all attended to Knight. They instructed Knight not to move while they waited for emergency medical personnel. Rohwer called 911 at 10:56 a.m.

At 10:59 a.m., Rohwer guided Washington County Sheriff's Office personnel to the accident scene. At 11:21 a.m., Weiser Fire Department emergency medical technicians (EMTs) arrived at the scene. A Life Flight Network helicopter arrived at 11:31 a.m. While Washington County Sheriff's Office personnel and Weiser Fire Department EMTs were transporting Knight to the helicopter, Knight succumbed to his injuries. Ali Jacobsen, registered Life Flight Network nurse, pronounced Knight dead at 1:14 p.m.

INVESTIGATION OF THE ACCIDENT

On April 30, 2026, at 11:00 a.m., Davis called the mine office to report that a serious accident had occurred. At 1:17 p.m., Davis called the mine office again to inform them that Knight had been pronounced dead. Shaun Riener, contact administrator, received both calls from Davis.

At 1:27 p.m., Riener called the Department of Labor National Contact Center (DOLNCC) to report the fatality. The DOLNCC notified Jarrod Towne, supervisory mine safety and health inspector. Towne notified Chris Stoddard, supervisory mine safety and health inspector, and Patrick Barney, assistant district manager, of the accident. Stoddard assigned Alec Jording, mine safety and health inspector, to secure the accident scene, and Barney assigned Daniel Boylan, supervisory mine safety and health inspector, as the lead investigator.

At 6:15 p.m., Jording 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. Boylan arrived at the mine on May 1, 2026, at 2:00 p.m. to continue the investigation and conduct additional interviews.

Following the Washington County Sheriff's Office investigation, the MSHA accident investigation team conducted an examination of the accident scene, interviewed miners and mine management, and reviewed conditions and work procedures relevant to the accident. For reference, a list of persons who participated in the investigation can be found in Appendix B.

DISCUSSION

Location of the Accident

The accident occurred on the lower road of the mine property, approximately 290 feet from the location where the other miners were dismantling and staging plant equipment. The lower road where the trailer was positioned was approximately 60 feet wide, dry, and primarily consisted of dirt and grass. Investigators observed that the road surface was uneven and contained ruts created

by equipment traveling to the loading area. For reference, an aerial view of the accident location can be seen in Appendix C.

Weather

The weather on the day of the accident ranged from a low of 37 degrees Fahrenheit to a high of 71 degrees Fahrenheit. There were clear skies and no precipitation. Humidity levels ranged from 64 percent to 39 percent. There was no recent precipitation. Investigators determined that the weather did not contribute to the accident.

Equipment Involved

The trailer involved in the accident was a Heil Trailer model S-76 water tanker trailer manufactured in 1976. The tank measured 40 feet in length, 76 inches in diameter, and had a capacity of approximately 8,400 gallons. The trailer was equipped with tandem rear axles and dual front landing gear. The front landing gear supported and stabilized the front end of the water tanker trailer when it was not connected to a semi-truck. A single hand crank raised and lowered both landing gear legs simultaneously. At the time of the accident, the landing gear was fully extended. For reference, a photo of the trailer can be found in Appendix D.

Investigators inspected the trailer and identified damage consistent with the accident. The mine operator had not reported any defects or mechanical problems with the trailer before the accident. Investigators determined that the trailer did not have any defects that would have contributed to the accident.

Work Procedures

Miners used a 7-inch-tall wooden block as cribbing beneath the driver-side landing gear and a 2-inch or 3-inch-tall wooden block beneath the passenger-side landing gear in an attempt to level the trailer. During the interview, D. Coleman stated that when the trailer was parked at its location on the evening of April 28, 2026, that he noticed the passenger side of the trailer was higher than the driver side.

Investigators measured an elevation difference of approximately 9 inches between the left and right trailer tires. Investigators also determined that the U-bolts for the rear leaf spring suspension could travel 4 inches upwards before the axle contacted the trailer frame, reducing the trailer's stability on the uneven ground. Investigators also measured an elevation difference of approximately 2 inches between the driver-side and passenger-side landing gear legs when a 2-inch-tall wooden block was placed beneath the passenger-side landing gear, and 2¾ inches when a 3-inch-tall wooden block was used. In both cases, the driver side of the trailer was lower than the passenger side at both the rear wheels and the landing gear. These conditions further reduced the stability of the trailer while it was disconnected from the semi-truck. As the trailer filled with water, the additional weight, combined with uneven ground, caused it to lean and shift toward the driver side. The landing gear slipped off the wooden block and the trailer rolled onto the driver side, crushing Knight.

Surface Mobile Equipment Safety Program

Miners filled the tank with water daily during production days for 30 days prior to the accident. The mine operator's normal practice was to leave the trailer connected to the semi-truck during

the filling process. The mine operator did not have procedures in the Surface Mobile Equipment Safety Program to ensure the trailer was positioned on level ground or otherwise stabilized when it was filled while disconnected from the semi-truck. Investigators determined that the absence of these procedures contributed to the accident.

Examinations

Davis conducted the workplace examination on the morning of April 30, 2026. He didn't identify or record any hazardous conditions in the area where the trailer was parked. Investigators determined that the conditions were not readily observable during the workplace examination because the trailer had remained stable since it was parked on the evening of April 28, 2026. Therefore, investigators concluded that the workplace examination did not contribute to the accident.

Training and Experience

Knight had 1 year, 15 weeks, and 4 days of mining experience, all with Seubert Excavators Inc. He completed annual refresher training on January 12, 2026. Knight filled the trailer with water at least 28 times while at this location prior to the accident, each time while the trailer was connected to the semi-truck. The mine operator did not provide task training for filling the water tanker trailer while it was disconnected from the semi-truck. However, Knight demonstrated competency in the task when he previously filled the trailer safely. Investigators determined that the lack of task training did not contribute to the accident.

Rohwer had four years of mining experience and four years of experience stabilizing the trailer. Rohwer has performed the task at least 12 times.

D. Coleman had eight years of mining experience and stabilizing trailers. He performed the task at least 24 times prior to the accident and more in previous years outside the mining industry.

K. Coleman had eight years of mining experience and stabilizing trailers. He performed the task at least 24 times prior to the accident and more in previous years outside the mining industry.

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 trailer was loaded in a manner that created a hazard to the laborer from falling equipment.

Corrective Action: The mine operator provided an adequate supply of blocking and cribbing materials and established procedures requiring miners to properly block and crib the trailer to prevent lateral movement whenever it is parked with the landing gear supporting the trailer.

2. Root Cause: The Surface Mobile Equipment Safety Program did not include a procedure to ensure the trailer was positioned on level ground or otherwise stabilized when it was filled while disconnected from the semi-truck.

Corrective Action: The mine operator developed and implemented a written policy that establishes procedures for parking, blocking, and cribbing the water tanker trailer when it is disconnected from the semi-truck. The mine operator trained all miners on the new policy.

CONCLUSION

On April 30, 2026, at approximately 10:30 a.m., Devin Knight, a 23-year-old laborer with one year and three months of mining experience, died when a trailer tipped and rolled over him.

The accident occurred because: 1) the trailer was loaded in a manner that created a hazard to the laborer from falling equipment, and 2) the Surface Mobile Equipment Safety Program did not include a procedure to ensure the trailer was positioned on level ground or otherwise stabilized when it was filled while disconnected from the semi-truck.

Approved By:

Jerry Kissell
Acting District Manager

Date

ENFORCEMENT ACTIONS

1. A 103(k) order was issued to Seubert Excavators Inc.

A fatal accident occurred on April 30, 2026, at about 10:30 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 Seubert Excavators Inc for a violation of 30 CFR 56.9201.

On April 30, 2026, a fatal accident occurred when a water tanker trailer rolled over a laborer while he was filling the tanker with water. The mine operator did not ensure the tanker trailer was being filled with water in a manner that prevented the equipment and water supply from shifting.

3. A 104(a) citation was issued to Seubert Excavators Inc for a violation of 30 CFR 56.23003(a)(1).

On April 30, 2026, a fatal accident occurred when a water tanker trailer rolled over a laborer while he was filling the tanker with water. The mine operator did not incorporate filling the water tanker trailer in the mine's Surface Mobile Equipment Safety Program.

APPENDIX A – Aerial View of the Mine



APPENDIX B – Persons Participating in the Investigation

Seubert Excavators Inc

Nicholas Suebert	President
Shawn Suebert	Area Manager
Brandon Davis	Mine Foreman
Robert Rohwer	Quality Control
Dustin Coleman	Feeder Man
Kori Coleman	Feeder Man
Brandon Griffith	Feeder Man
Kayden Cunningham	Haul Truck Operator
Anthony Schmuck	Haul Truck Operator
John Sorenson	Loader Operator

MSHA Safety Services Inc.

Kim Redding	Consultant
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Mine Safety and Health Administration

Mike Tromble	Supervisory Mine Safety and Health Training Specialist
Daniel Boylan	Supervisory Mine Safety and Health Inspector
Alec Jording	Mine Safety and Health Inspector

APPENDIX C – Aerial View of the Water Tanker Trailer



APPENDIX D – Photo of the Water Tanker Trailer

