

UNITED STATES
DEPARTMENT OF LABOR
MINE SAFETY AND HEALTH ADMINISTRATION

REPORT OF INVESTIGATION

Facility
(Cement)

Machinery Accident Fatality Report
January 6, 2026

MZP Kiln Services, Inc. (B1636)
Ambridge, Pennsylvania

at

Lebec Cement Plant
National Cement Company of California Inc
Lebec, Kern County, California
ID No. 04-00213

Accident Investigators

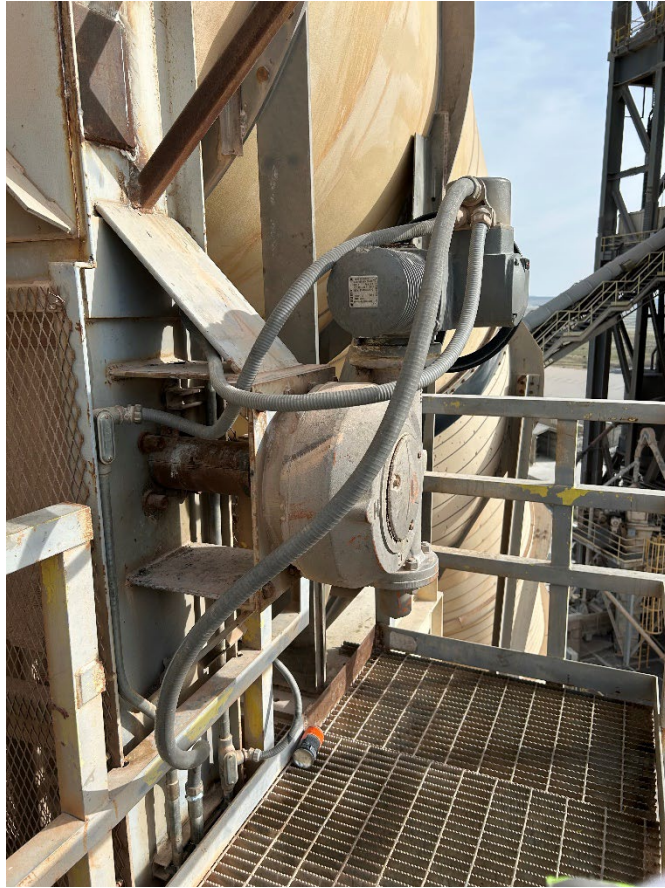
Robert Hartzell
Supervisory Mine Safety and Health Inspector

Ruben Bernal
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

TABLE OF CONTENTS

OVERVIEW	1
GENERAL INFORMATION	1
DESCRIPTION OF THE ACCIDENT	2
INVESTIGATION OF THE ACCIDENT	3
DISCUSSION	3
Location of the Accident	3
Equipment Involved	3
Work Procedures	4
Examinations	4
Training and Experience	4
ROOT CAUSE ANALYSIS	4
CONCLUSION	5
ENFORCEMENT ACTIONS	6
APPENDIX A – Gearbox Mounting Plate	8
APPENDIX B – Persons Participating in the Investigation	9



OVERVIEW

On January 6, 2026, at 10:20 a.m., Oswaldo Hernandez, a 50-year-old contractor mechanic with 34 days of mining experience, died after becoming entangled in a motor and gearbox assembly while performing a maintenance task.

The accident occurred because: 1) the contractor mechanic was not properly trained for the assigned task, 2) the assembly was not blocked against hazardous motion, and 3) a workplace examination was not conducted.

GENERAL INFORMATION

National Cement Company of California Inc owns and operates Lebec Cement Plant, located in Lebec, Kern County, California. Lebec Cement Plant employs 80 miners and operates 24 hours per day, 7 days per week. Limestone is drilled and blasted from multiple benches in the quarry. The material is loaded into haul trucks with front-end loaders and transported to the nearby cement plant where it is crushed, dried, heated, and processed into cement. The finished product is stored in silos for bulk shipment to customers. National Cement Company of California contracted MZP Kiln Services, Inc. (MZP) to conduct repairs at the cement plant. Hernandez was employed by MZP.

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

Bruno Salomon	Plant Manager
Jeremy White	Human Resource Manager
Michael Oman	Safety Manager
Andrew Dixon Sr.	Production Shift Supervisor

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

Karel Simecek	Chief Operations Officer
Wilian Amaya	Iron Worker Maintenance Leadman

The Mine Safety and Health Administration (MSHA) completed the last regular safety and health inspection at this mine on May 5, 2025. The 2025 non-fatal days lost incident rate for the Lebec Cement Plant was 3.10, compared to the national average of 1.28 for mines of this type.

DESCRIPTION OF THE ACCIDENT

On January 6, 2026, at approximately 7:00 a.m., Hernandez arrived at Lebec Cement Plant and met with Javier Molina, maintenance technician for MZP; Wilian Amaya, iron worker maintenance leadman for MZP; and Karel Simecek, chief operations officer for MZP. Simecek conducted a safety talk and went over the job safety analysis (JSA), which outlined the basic steps of the tasks, including removal of the motor, gearbox, and slide gate due to wear so a new one could be installed that day. The slide gate was located in the air duct from the mill to the baghouse. It was used to restrict air flow into the baghouse and to clean the air of contamination. This work was scheduled maintenance for when the cement plant was not in operation.

At approximately 7:30 a.m., Molina, Amaya, and Hernandez gathered tools and carried them to the base of the ladder, below the platform at slide gate 07's motor and gearbox assembly (assembly). Hernandez and Molina climbed the ladder up to the platform and pulled their tools up to begin removing the motor and gearbox.

Hernandez began removing the assembly from the frame. Amaya told Hernandez to loosen the bolts but leave them in place. Hernandez realized he didn't have the correct socket wrench and called out to Amaya, who went to the toolbox at ground level to get the right one. Amaya tied the sockets to a rope, and Molina pulled them up to the platform. Amaya received a phone call and told Molina and Hernandez that he would be right back. Hernandez continued loosening the bolts. Amaya was on the deck at the base of the ladder.

Hernandez began removing the bolts that held the gearbox mounting plate (Appendix A) to the slide gate shaft. As he loosened and removed the last bolt, the slide gate shaft and the assembly began to rotate rapidly, catching Hernandez's pants and harness leg strap, and entangling him as the assembly continued to rotate. Molina was on the platform and became injured after trying to stop the gearbox. Molina yelled for help. Other workers in the area heard Molina yelling and ran to the area to help. At 10:29 a.m., Scott Kuhn, control room operator, called for emergency services while Andrew Dixon, Sr., production shift supervisor, cut Hernandez's harness once

rotation stopped. Zachary Durham and Abel Ayala, production assistants, arrived with an automated external defibrillator (AED) and started administering cardiopulmonary resuscitation. They followed the AED prompts until they were relieved by emergency medical personnel. The Kern County Fire Department arrived on site at 11:01 a.m. Bryann Olitz, coroner, pronounced Hernandez dead at 11:25 a.m.

INVESTIGATION OF THE ACCIDENT

On January 6, 2026, at 10:51 a.m., Michael Oman, safety manager, called the Department of Labor National Contact Center (DOLNCC) to report a serious accident. The DOLNCC notified Yasser Akbarzadeh, staff assistant. Akbarzadeh notified Nickolas Gutierrez, acting district manager. Gutierrez sent Daniel Boylan, supervisory mine safety and health inspector, to the mine. At 12:30 p.m., Boylan arrived on site and issued an order under the provisions of Section 103(k) of the Mine Act to ensure the safety of the miners and preservation of evidence.

Gutierrez notified Patrick Barney and James Fitch, assistant district managers. Fitch assigned Robert Hartzell, supervisory mine safety and health inspector, as the lead investigator. On January 7, 2026, at 4:21 p.m., Hartzell arrived at the mine and continued the investigation with the assistance of Ruben Bernal, mine safety and health inspector.

The MSHA accident investigation team conducted an examination of the accident scene; interviewed miners, mine management, contractors, contractor management, and a representative of the United Steel Workers; and reviewed conditions and work procedures relevant to the accident. For reference, Appendix B contains a list of persons who participated in the investigation.

DISCUSSION

Location of the Accident

The accident occurred on the platform with slide gate 07's gearbox and motor assembly. For reference, a photo of the motor assembly can be found in Appendix C.

Equipment Involved

Slide gate 07 is installed in a gas/dust duct between the preheat tower and a baghouse. The duct is a large, enclosed metal passage that moves air from one place to another, helping bring in clean air or remove dusty air to keep the work area safe. Inside this duct is a slide gate, which acts like a heavy metal door that can open or close to control how much air or material passes through and can also shut off part of the system when maintenance is needed. The motor and gearbox are the components that move this gate. The motor provides power, and the gearbox slows its movement and adds enough torque for the 10,600-pound gate to open and close in a safe and controlled way. When the gate is up, the duct is closed off. The motor assembly must lift the gate to close it.

Investigators found that the slide gate was fully closed (at its highest elevation) when Molina, Amaya, and Hernandez began the process of removing the assembly. Hernandez removed the last set bolt, which released the weight of the slide gate. As the gate fell, the slide gate shaft spun

freely in a clockwise direction, causing the motor and gearbox to rotate on the shaft attached to the slide gate. Investigators tested the assembly and found no issues with the gate. Investigators determined that the assembly was not blocked against hazardous motion, which contributed to the accident.

Work Procedures

Removal and repair of the assembly had never been performed prior to the accident. Neither the mine operator nor MZP had a standard operating procedure for performing the removal of the gearbox/motor assembly and slide gate. Because MZP conducts work at both MSHA- and OSHA-regulated sites, they utilize the JSA approach for much of their work, but it did not address specific MSHA hazard recognition requirements. MZP had a JSA for this task, but it did not address blocking the machine against hazardous motion.

Examinations

Neither the mine operator nor MZP conducted a workplace examination of the work area on the date of the accident. The investigator determined that a workplace examination should have identified the hazard created by stored energy of the slide gate in the closed position (meaning there was tension on the drive chain). Investigators determined that the lack of an examination contributed to the accident.

Training and Experience

Hernandez had 12 years of experience as a mechanic before starting with MZP. He had 34 days of experience with MZP and 2 days at the mine. New miner training began for Hernandez on December 2, 2025, but had not been completed at the time of the accident. The mine operator provided Hernandez with site-specific hazard awareness training at the Lebec Cement Plant on January 5, 2026. During a review of documentation, investigators determined that neither the mine operator nor MZP provided task training for his assigned task, which would have included blocking machinery against hazardous motion. Investigators determined that a lack of training contributed to the accident.

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 causes, and the mine operator and contractor implemented the corresponding corrective actions to prevent a recurrence.

1. Root Cause: The mine operator and contractor did not properly train the contractor mechanic for the assigned task.

Corrective Action: The mine operator and contractor each developed task training for gearbox and motor work maintenance.

2. Root Cause: The mine operator and contractor did not ensure the assembly was blocked against hazardous motion.

Corrective Action: The mine operator and contractor each developed and implemented a written procedure for blocking moving machine parts against hazardous motion and trained their employees on the new procedure.

3. Root cause: The contractor did not conduct a workplace examination.

Corrective Action: The contractor developed and implemented a written procedure which includes conducting workplace examinations and blocking moving machine parts against hazardous motion. The contractor trained their employees on the new procedure.

CONCLUSION

On January 6, 2026, at 10:20 a.m., Oswaldo Hernandez, a 50-year-old contractor mechanic with 34 days of mining experience, died after becoming entangled in a motor and gearbox assembly while performing a maintenance task.

The accident occurred because: 1) the contractor mechanic was not properly trained for the assigned task, 2) the slide gate was not blocked against hazardous motion, and 3) a workplace examination was not conducted.

Approved By:

Jerry Kissell
Acting District Manager

Date

ENFORCEMENT ACTIONS

1. A 103(k) order was issued to National Cement Company of California Inc.

A fatal accident occurred on January 6, 2026, at approximately 10:20 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 MZP Kiln Services, Inc. for a violation of 30 CFR 46.7(a).

A fatal accident occurred on January 6, 2026, when a contractor miner became entangled in a gearbox and motor assembly while performing a new maintenance task. The contractor did not provide the necessary task training prior to the contractor miner beginning the maintenance task. The Federal Mine Safety and Health Act of 1977 declares that an untrained miner is a hazard to himself and others.

3. A 104(a) citation was issued to National Cement Company of California Inc for a violation of 30 CFR 46.7(a).

A fatal accident occurred on January 6, 2026, when a contractor miner became entangled in a gearbox and motor assembly while performing a new maintenance task. The mine operator did not provide or ensure the necessary task training was provided to the contractor miner prior to assigning the maintenance task. The Federal Mine Safety and Health Act of 1977 declares that an untrained miner is a hazard to himself and others.

4. A 104(a) citation was issued to MZP Kiln Services, Inc. for a violation of 30 CFR 56.14105.

A fatal accident occurred on January 6, 2026, when a contractor miner became entangled in a gearbox and motor assembly while performing a maintenance task. The contractor did not ensure that the assembly was blocked against hazardous motion before performing maintenance.

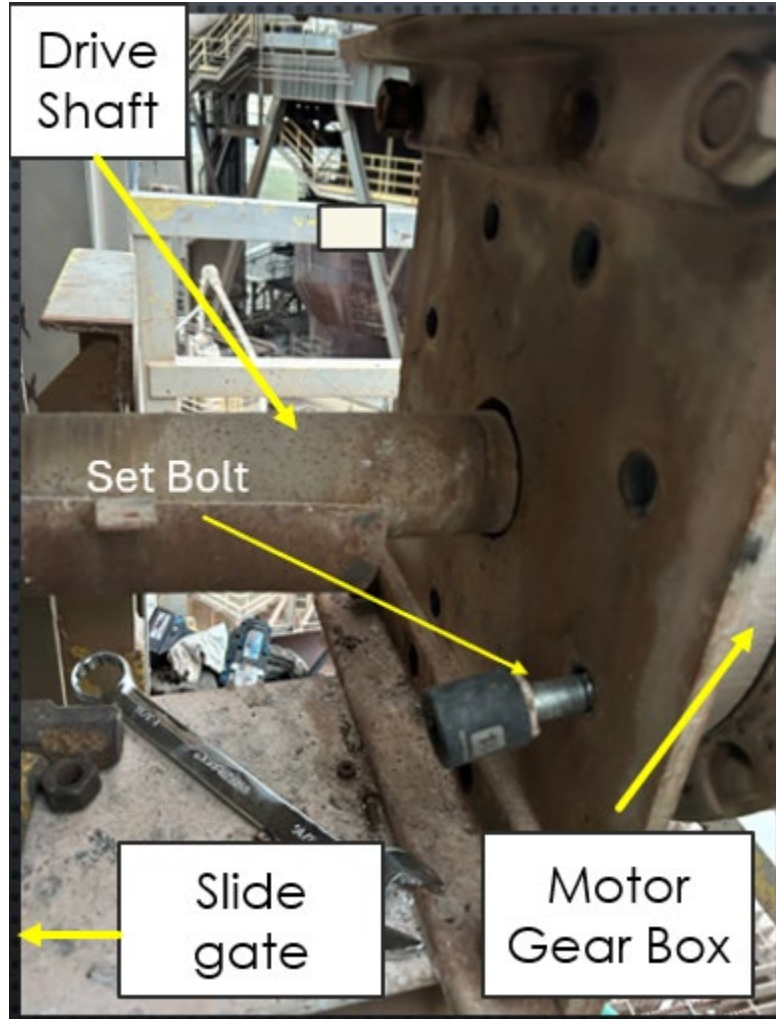
5. A 104(a) citation was issued to National Cement Company of California Inc for a violation of 30 CFR 56.14105.

A fatal accident occurred on January 6, 2026, when a contractor miner became entangled in a gearbox and motor assembly while performing a maintenance task. The mine operator did not ensure that the contractor blocked the assembly against hazardous motion before performing maintenance.

6. A 104(a) citation was issued to MZP Kiln Services, Inc. for a violation of 30 CFR 56.18002(a).

A fatal accident occurred on January 6, 2026, when a miner became entangled in a gearbox and motor assembly while performing a maintenance task. The contractor did not perform the required workplace examination before beginning work.

APPENDIX A – Gearbox Mounting Plate



APPENDIX B – Persons Participating in the Investigation

National Cement Company of California Inc

Jeremy White	Human Resource Manager
Michael Oman	Safety Manager
Juan Carlos Flores	Reliability Manager
Andrew Dixon Sr.	Production Shift Supervisor
Miguel Angel Rodriguez Navarrete	Maintenance Supervisor
Refael Ferreira	Yard Supervisor
Scott Kuhn	Control Room Operator
Jeffery Lawson	Plant Inspector
Juwan Todd	Plant Inspector
Abel Ayala	Production Assistant
Zachary Durham	Production Assistant
Abby McDevitt	Mechanical Journey Man/United Steel Workers Union Local Representative
Arthur Smith	Maintenance/United Steel Workers Union Local Representative

MZP Kiln Services, Inc.

Karel Simecek	Chief Operations Officer
Wilian Amaya	Iron Worker Maintenance Leadman
Javier Molina	Maintenance Technician

Mine Safety and Health Administration

Daniel Boylan	Supervisory Mine Safety and Health Inspector
Robert Hartzell	Supervisory Mine Safety and Health Inspector
Mike Tromble	Supervisory Mine Safety and Health Training Specialist
Ruben Bernal	Mine Safety and Health Inspector

APPENDIX C – Slide Gate 07

