

UNITED STATES
DEPARTMENT OF LABOR
MINE SAFETY AND HEALTH ADMINISTRATION

REPORT OF INVESTIGATION

Surface
(Crushed Stone)

Fatal Machinery Accident
June 15, 2025

Coleman Quarry
P&K Stone LLC
Coleman, Atoka County, Oklahoma
ID No. 34-02246

Accident Investigators

James Redwine
Mine Safety and Health Specialist

Tommy Fitzgerald
Mine Safety and Health Specialist

James Meadows II
Mine Safety and Health Inspector

Originating Office
Mine Safety and Health Administration
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William O'Dell, District Manager

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OVERVIEW

On June 15, 2025, at approximately 4:15 p.m., John Bird, a 41-year-old maintenance person with one year and 28 weeks of mining experience, died when a telehandler overturned onto him.

The accident occurred because the mine operator: 1) allowed the miner to work alone without communication while checking the pump in the quarry pit, 2) used the telehandler beyond its designed capacity, 3) did not provide newly hired experienced miner training, and 4) did not ensure the boom and outriggers were positioned to prevent movement of the telehandler.

GENERAL INFORMATION

P&K Stone LLC (P&K) owns and operates the Coleman Quarry, a surface crushed stone mine located in Coleman, Atoka County, Oklahoma. The mine employs 11 miners and operates one 12-hour shift, six days per week. P&K contracts RPMX Construction LLC (RPMX) to extract the stone from the pit by blasting the stone and using excavators to load haul trucks. The loaded haul trucks transport the stone to the plant where a front-end loader feeds it into the crusher. The finished product is stockpiled and sold for use in the construction industry.

The principal management official at the Coleman Quarry at the time of the accident was:

Thomas Clay

Area Manager

The principal management official for RPMX at the time of the accident was:

Hoss McElroy

Supervisor

Bird was an employee of P&K. Peter Dawson, Owner of P&K, also partially owns RPMX. McElroy was given authority to give direction to P&K employees.

The Mine Safety and Health Administration (MSHA) completed the last regular safety and health inspection at this mine on May 19, 2025. The 2024 non-fatal days lost incident rate for the Coleman Quarry was zero, compared to the national average of 0.97 for mines of this type.

DESCRIPTION OF THE ACCIDENT

On June 15, 2025, at 8:38 a.m. Bird received a text message from McElroy, asking him if “he had been checking on the Pioneer six-inch pump” used to dewater the pit floor in the quarry. Bird responded, “I sure can.” Bird traveled to the mine and operated a telehandler from 9:16 a.m. to 9:49 a.m. based on onboard Global Positioning Satellite (GPS) information.

At approximately 4:00 p.m., Bird returned to the mine in his personal vehicle with his wife to check on the pump. Bird parked, leaving his wife in the vehicle at the top of the ramp. Bird used the telehandler to transport a portable 100-gallon diesel tank down the ramp to the quarry pit to check the status of the pump. Bird was alone in the quarry pit and did not have any means of communication.

At 4:31 p.m., the telehandler rolled over onto its right side and landed on Bird while he was outside the operator’s cab. At 6:13 p.m., Bird’s wife walked down the ramp into the quarry pit to check on Bird and found him pinned under the right side of the telehandler. She went back up the ramp of the pit to call for help because she did not have cellular phone reception in the pit area.

Bird’s wife called Damen Horath, Plant Maintenance for P&K, and informed him of the incident. Horath told her to call 911. At 6:15 pm, she called 911 to report the incident. Atoka County Emergency Medical Services (EMS) personnel arrived at the scene at 6:39 p.m. Derick Goodson, Paramedic for Atoka County EMS, pronounced Bird dead at 6:47 p.m.

INVESTIGATION OF THE ACCIDENT

On June 15, 2025, at 7:30 p.m., Clay called the Department of Labor National Contact Center (DOLNCC) to report the fatality. The DOLNCC contacted James Redwine, Mine Safety and Health Specialist, who notified Brett Barrick, Assistant District Manager. Barrick assigned Redwine as the lead investigator. Barrick sent and assigned James Meadows II, Mine Safety and Health Inspector, to the mine to assist Redwine in the investigation. At 11:00 p.m., Meadows arrived at the mine and issued an order under the provisions of Section 103(k) of the Mine Act to insure the safety of the miners and the preservation of evidence.

On June 23, 2025, at 3:40 p.m., Tommy Fitzgerald, Mine Safety and Health Specialist, arrived at the mine. The MSHA accident investigation team, in conjunction with the Oklahoma Department of Mines, conducted an examination of the accident scene; interviewed miners, mine management, contractors, and contractor management; and reviewed conditions and work procedures 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 in the quarry pit (see Appendix B). The mine operator allowed the miner to work alone while checking the pump in the quarry pit without any means of communication. Investigators determined that this contributed to the accident.

Weather

The weather at the time of the accident was sunny and 79 degrees, with winds blowing north at 9.3 miles per hour. Investigators determined that weather did not contribute to the accident.

Equipment Involved

The telehandler involved in the accident was a GEHL TH10-55. The investigators performed a functionality test and found no defects on the telehandler that would have contributed to the accident.

Bird was assigned to check the pump in order to maintain the water level in the pit. This type of work may include fueling, checking suction lines, repositioning lines, starting or stopping pumps, etc.

The manufacturer's manual contained a warning statement on page 15, which reads, "When on slopes, keep the heavy end of the machine pointed uphill whenever possible. Never travel over obstacles or slopes that will cause the machine to tilt severely. Travel around any slope or obstacle that would cause a tilt of more than 10 degrees. Avoid sharp turns and high speeds and carry loads, especially on slopes. The stability of the machine is reduced during sharp turns, and the load may shift, greatly increasing the possibility of a rollover." The mine operator did not check this manual. Additionally, there are warning decals on the telehandler that provide relative information regarding the hazards of operating it.

Investigators determined that the telehandler was located at the bottom of the ramp parked parallel to the water's edge, on a 15-degree slope. The investigators observed that the front two outriggers were in the up position. The boom was raised to a 45-degree angle, and all the boom sections were retracted. The right fork of the telehandler was inserted approximately 18 inches into a 20-foot section of six-inch plastic corrugated suction line. The mine operator should have known that Bird's assigned task would require the telehandler to be operated on the 15-degree slope. The mine operator used the telehandler beyond its designed capacity, which contributed to the accident.

Additionally, the telehandler's stabilizers and boom attachments were not lowered to the ground. The manual states, "Do not use outriggers on soft or uneven surfaces. Be sure the surface can support the machine and load." The mine operator did not ensure the boom and outriggers were positioned to prevent movement of the telehandler, which contributed to the accident.

Examinations

Investigators did not find any pre-operational inspection records for the telehandler. Investigators also did not find any workplace examination records for the quarry area. However, the

telehandler did not have defects that would have contributed to the accident, and the workplace did not have hazards that would have contributed to the accident. Therefore, investigators determined that the lack of pre-operational inspections and workplace examinations did not contribute to the accident.

Training and Experience

Bird had one year and 28 weeks of mining experience, with four weeks of experience at this mine. McElroy stated that Bird received task training on the GEHL TH10-55 telehandler but could not provide a record. The mine operator did not provide Bird with newly hired experienced miner training when he started on May 16, 2025, which would have included procedures for working alone. Investigators determined the lack of newly hired experienced miner training contributed to the accident.

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 mine operator allowed the miner to work alone without communication while checking the pump in the quarry pit.

Corrective Action: The mine operator developed and implemented a procedure to ensure that no miners or contractors work alone. The mine operator has trained all miners on this procedure.

2. Root Cause: The mine operator used the telehandler beyond its designed capacity.

Corrective Action: The mine operator retrained all miners on the telehandler's safe operating procedures according to the operator's manual.

3. Root Cause: The mine operator did not provide newly hired experienced miner training.

Corrective Action: The mine operator retrained mine management on the requirements of 30 CFR Part 46.

4. Root Cause: The mine operator did not ensure the boom and outriggers were positioned to prevent movement of the telehandler.

Corrective Action: The mine operator trained all miners on safe parking procedures.

CONCLUSION

On June 15, 2025, at approximately 4:15 p.m., John Bird, a 41-year-old maintenance person with one year and 28 weeks of mining experience, died when a telehandler overturned onto him.

The accident occurred because the mine operator: 1) allowed the miner to work alone without communication while checking the pump in the quarry pit, 2) used the telehandler beyond its designed capacity, 3) did not provide newly hired experienced miner training, and 4) did not ensure the boom and outriggers were positioned to prevent movement of the telehandler.

Approved By:

William O'Dell
District Manager

Date

ENFORCEMENT ACTIONS

1. A 103(k) order was issued to P&K Stone LLC.

A fatal accident occurred on June 15, 2025, at approximately 4:15 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(d)(1) citation was issued to P&K Stone LLC for a violation of 30 CFR 56.18020.

On June 15, 2025, a maintenance person died when a GEHL TH10-55 telehandler overturned onto him while he was outside of the operator's cab. Mine management assigned and allowed or required the maintenance man to work alone where hazardous conditions existed. The mine operator did not provide any means of communication. The maintenance man could not be seen or heard by others. The mine operator engaged in aggravated conduct constituting more than ordinary negligence. This violation is an unwarrantable failure to comply with a mandatory standard.

3. A 104(a) citation was issued to P&K Stone LLC for a violation of 30 CFR 56.14205.

On June 15, 2025, a maintenance person died when a GEHL TH10-55 telehandler overturned onto him while he was outside of the operator's cab. The mine operator used the telehandler beyond its designed capacity. The operator's manual states the telehandler must not be operated on slopes exceeding a 10-degree angle. At the time of the accident, the telehandler was positioned on a 15-degree grade, with the body tilted four degrees to the right and the boom raised at a 45-degree angle.

4. A 104(d)(1) order was issued to P&K Stone LLC for a violation of 30 CFR 46.6.

On June 15, 2025, a maintenance person died when a GEHL TH10-55 telehandler overturned onto him while he was outside of the operator's cab. The mine operator did not provide newly hired experienced miner training. The maintenance person was hired on May 16, 2025, and had not received this training. The mine operator engaged in aggravated conduct constituting more than ordinary negligence. This violation is an unwarrantable failure to comply with a mandatory standard.

5. A 104(a) citation was issued to P&K Stone LLC for a violation of 30 CFR 56.14206(b).

On June 15, 2025, a maintenance person died when a GEHL TH10-55 telehandler overturned onto him while he was outside of the operator's cab. The mine operator did not ensure the boom and outriggers were positioned to prevent movement of the telehandler. The telehandler was left unattended and parked on a 15-degree ramp with the boom and outriggers in the raised position.

APPENDIX A – Persons Participating in the Investigation

P&K Stone LLC

Steve Redenbaugh	Vice President of Operation
Thomas Clay	Area Manager
John Moseley	Plant Manager
Damen Horath	Plant Maintenance
West Stegall	Maintenance
Joseph McKendrick	Plant Operator

RPMX Construction LLC

Hoss McElroy	Supervisor
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Oklahoma Department of Mines

Troy Young	Lead Inspector
Mike Darneal	Mine Inspector

Mine Safety and Health Administration

Tommy Fitzgerald	Mine Safety and Health Specialist
James Redwine	Mine Safety and Health Specialist
James Meadows II	Mine Safety and Health Inspector

APPENDIX B – Pump and Telehandler in the Quarry Pit

