

UNITED STATES
DEPARTMENT OF LABOR
MINE SAFETY AND HEALTH ADMINISTRATION

REPORT OF INVESTIGATION

Surface
(Construction Sand and Gravel)

Fatal Falling, Rolling, or Sliding Rock or Material of Any Kind Accident
January 3, 2025

Borger Pit
WES AGG, LLC
Borger, Hutchinson County, Texas
ID No. 41-05687

Accident Investigators

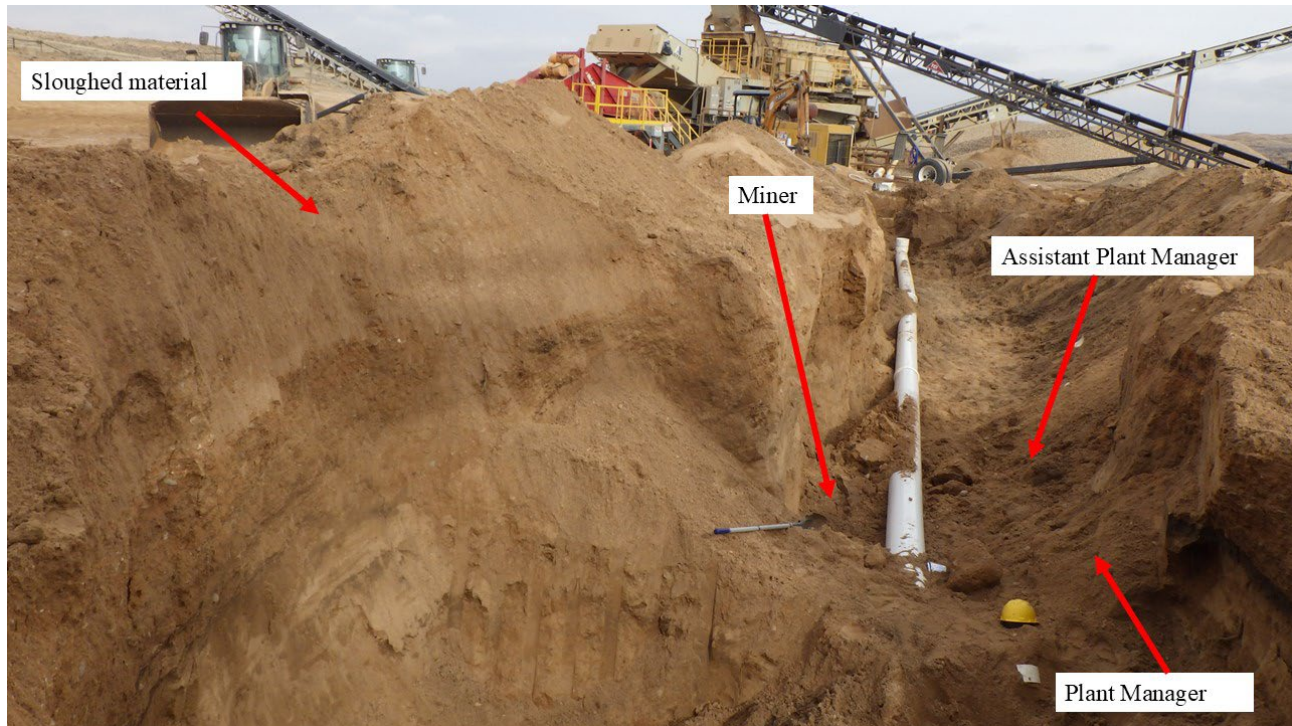
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OVERVIEW

On January 3, 2025, at 5:50 p.m., Segundo Bosquez, a 44-year-old haul truck operator with four months and four days of mining experience, died when he was engulfed by material in a trench.

The accident occurred because the mine operator did not: 1) conduct a ground condition examination before managers and miners worked in the trench and 2) correct hazardous ground conditions.

GENERAL INFORMATION

WES AGG, LLC owns and operates the Borger Pit. The mine is a surface construction sand and gravel mine located in Borger, Hutchinson County, Texas. The Borger Pit employs eight miners and operates one eight-hour production shift five days per week. The mine uses an open pit mining method consisting of excavators for removal of over burden and haul trucks for transporting material to the wash plant. The wash plant separates sand and rock through belt conveyors which stockpile and then sell the material to the public/construction industry.

The principal management officials at Borger Pit at the time of the accident were:

Matthew Roberts
Cameron Bowman

Plant Manager
Safety Manager

The Mine Safety and Health Administration (MSHA) completed the last regular safety and health inspection at this mine on April 11, 2024. The 2024 non-fatal days lost incident rate for Borger Pit was 5.96, compared to the national average of 0.98 for mines of this type.

DESCRIPTION OF THE ACCIDENT

On January 3, 2025, at 5:52 a.m., Bosquez began his shift by clocking in at the main office in Amarillo, Texas. Bosquez departed the main office at 6:15 a.m., drove to the Borger Pit, arriving at 7:30 a.m. Bosquez conducted a pre-operational inspection of his haul truck and began hauling material from the pit to the wash plant. At approximately 12:00 p.m., Jorge Alarcon, Excavator Operator, began excavating a trench for a new 12-inch diameter polyvinyl chloride (PVC) water discharge pipe connected to the wet plant.

At 2:05 p.m., Bosquez arrived at the trench and observed Matthew Roberts, Plant Manager, and Kevin Garret, Assistant Plant Manager, working in the trench assembling the replacement pipe. Bosquez entered the trench to assist Roberts and Garret by gluing four sections of the 12-inch diameter PVC pipe together.

At 5:50 p.m., while Bosquez was assisting with the assembly of the pipe, a section of the trench wall collapsed, completely engulfing Bosquez and trapping Roberts to his knees. Roberts called out on his two-way radio for help to come to the trench and assist in the rescue of Bosquez. Garret started to dig out Bosquez by hand while Roberts was able to free himself and assist with the rescue of Bosquez.

At 5:51p.m., Cameron Bowman, Safety Manager, called 911. At approximately 5:55 p.m., Roberts, Garret, and Alarcon recovered Bosquez, who was unresponsive. Roberts, Garret, and Alarcon performed cardiopulmonary resuscitation. The Borger Fire Department was dispatched at 5:57 p.m. and Borger Fire Department Emergency Medical Services (EMS) arrived on site at 6:28 p.m. Bosquez was still unresponsive, and EMS applied an automated external defibrillator which administered a shock. Amanda Wysong, Justice of the Peace, Precinct No. 2, pronounced Bosquez deceased at 6:34 p.m.

INVESTIGATION OF THE ACCIDENT

On January 3, 2025, at 6:07 p.m., Bowman called the Department of Labor National Contact Center (DOLNCC) to report the accident. The DOLNCC contacted Ronnie Free, Assistant District Manager. Free sent Neal Davis, Supervisory Mine Safety and Health Inspector, to the mine and assigned him as the lead accident investigator. Free also sent Ramiro Jiminez, Supervisory Mine Safety and Health Inspector, to the mine to assist with the investigation.

On January 4, 2025, at 9:30 a.m., Davis arrived at the mine 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. The MSHA Accident investigation team conducted an examination of the accident scene, interviewed miners and mine management, and reviewed 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 in the trench at the wash plant.

Weather

The weather at the time of the accident was clear, high of 57 degrees Fahrenheit, with southeast winds at 18 miles per hour. Investigators determined the weather did not contribute to the accident.

Ground Conditions

The trench was approximately 87 feet long, 16 feet deep, and 14 feet wide at the top. Approximately 12 feet of the 87-foot-long trench wall was sloped at a 45-degree angle while the remaining 65 feet were vertical. Where the failure occurred, the material excavated from the trench was placed directly on the top edge of the vertical trench wall. The area where the trench was excavated had been previously disturbed by the installation of the old pipe and previous stockpiles over the area. These factors created hazardous ground conditions. Investigators determined the mine operator did not correct hazardous ground conditions, which contributed to the accident. Instead of correcting hazardous ground conditions or preventing miners from being exposed to the hazardous ground conditions, managers Garret and Roberts worked in the trench with Bosquez.

Examinations

During the witness interviews, the investigators learned Roberts did not conduct an examination or test for loose or hazardous ground conditions. Investigators determined this contributed to the accident.

Training and Experience

Bosquez had four months and four days of mining experience, all at the Borger Pit, operating a haul truck. Bosquez completed new miner training on September 4, 2024. Investigators determined that Bosquez received all training in accordance with MSHA Part 46 training regulations.

ROOT CAUSE ANALYSIS

The accident investigation team conducted an analysis to identify the underlying causes of the accident. The investigators 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 correct hazardous ground conditions before managers and miners worked in the trench.

Corrective Action: The mine operator developed, implemented, and trained miners on revised procedures for identifying and correcting hazardous ground conditions and will conduct regular training on the ground control procedures. The mine operator will conduct periodic audits and inspections to ensure compliance with the ground control procedures.

2. Root Cause: The mine operator did not conduct a ground condition examination before managers and miners worked in the trench.

Corrective Action: The mine operator has developed a procedure and trained miners for conducting an examination of ground conditions.

CONCLUSION

On January 3, 2025, at 5:50 p.m., Segundo Bosquez, a 44-year-old haul truck operator with four months and four days of mining experience, died when he was engulfed by material in a trench.

The accident occurred because the mine operator did not: 1) conduct a ground condition examination before managers and miners worked in the trench and 2) correct hazardous ground conditions.

Approved By:

William O'Dell
District Manager

Date

ENFORCEMENT ACTIONS

1. A 103(k) order was issued to WES AGG, LLC.

A fatal accident occurred on January 3, 2025, at 5:50 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 WES AGG, LLC for a violation of 30 CFR 56.3200.

On January 3, 2025, a miner died after he was engulfed by falling material from an open trench while installing new sections of a 12-inch polyvinyl chloride pipe. The mine operator did not correct the hazardous ground conditions before miners began to work. The mine operator engaged in aggravated conduct constituting more than ordinary negligence. Both the plant manager and assistant plant manager did not correct the hazard before work began and they were working in the trench with the miner when the accident occurred. This violation is an unwarrantable failure to comply with a mandatory standard.

3. A 104(d)(1) order was issued to WES AGG LLC for a violation of 30 CFR 56.3401.

On January 3, 2025, a miner died after he was engulfed by falling material from an open trench while installing new sections of a 12-inch polyvinyl chloride pipe. The mine operator did not examine and test ground conditions in areas where work was to be performed prior to work commencing. The mine operator engaged in aggravated conduct constituting more than ordinary negligence because no one was assigned to do this examination before miners began working in the trench. This violation is an unwarrantable failure to comply with a mandatory standard.

APPENDIX A – Persons Participating in the Investigation

WES AGG, LLC

JW Thomas	Owner/Manager
John Thomas	Owner/Manager
Matthew Roberts	Plant Manager
Kevin Garrett	Assistant Plant Manager
Cameron Bowman	Safety Manager
Jorge Alarcon	Equipment Operator
Charles Belford	Equipment Operator
Harley Garrett	Equipment Operator
Robert Rowllins	Equipment Operator

Mine Safety and Health Administration

Neal Davis	Supervisory Mine Safety and Health Inspector
Ramiro Jimenez	Supervisory Mine Safety and Health Inspector