

UNITED STATES
DEPARTMENT OF LABOR
MINE SAFETY AND HEALTH ADMINISTRATION

REPORT OF INVESTIGATION

Surface
(Dimension Limestone)

Fatal Powered Haulage Accident
January 30, 2025

Salado Operations, Florence
Salado Operations
Florence, Williamson County, Texas
ID No. 41-04216

Accident Investigators

James Redwine
Mine Safety and Health Specialist

Robert Teeter
Mine Safety and Health Inspector

Originating Office
Mine Safety and Health Administration
Dallas District
1100 Commerce Street
Dallas, Texas 75242
Brett Barrick, Acting District Manager

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OVERVIEW

On January 30, 2025, at approximately 3:30 p.m., Luis Sanchez-Robles (Sanchez-Robles), a 22-year-old thin-veneer saw operator with seven months of mining experience, died after a pallet of stone weighing approximately 4,700 pounds was lowered onto him.

The accident occurred because the loader operator was moving the loader while his visibility of the staging platform and the miner was blocked.

GENERAL INFORMATION

Salado Operations owns and operates the Salado Operations, Florence mine. The mine is a dimensional limestone open pit located in Florence, Williamson County, Texas. Salado Operations, Florence mine employs 22 miners and operates one eight-hour production shift, and one eight-hour maintenance shift, five days per week. Miners operate mobile rock saws to cut limestone into large blocks in the open pit, place these blocks on flatbed trucks using front-end loaders, and transport them to a staging area where they are cut into smaller 80-pound blocks. Miners stack these smaller blocks on pallets and use a front-end loader equipped with forks to deliver the pallets as needed to one of the staging platforms located near each of the four thin-veneer saws. Miners use the thin-veneer saws to cut the smaller 80-pound blocks according to customer specifications and then package the cut veneers on pallets for shipment.

The principal management officials at Salado Operations, Florence mine at the time of the accident were:

Cori White Eagle
Jon Archer
Mike Sleight

Chief Executive Officer
Vice President of Operations
Quarry Manager

The Mine Safety and Health Administration (MSHA) completed the last regular safety and health inspection at this mine on September 5, 2024. The 2024 non-fatal days lost incident rate for Salado Operations, Florence mine was zero, compared to the national average of 1.22 for mines of this type.

DESCRIPTION OF THE ACCIDENT

On January 30, 2025, at approximately 7:15 a.m., Sanchez-Robles began his shift and attended a production meeting. At 7:30 a.m., Sanchez-Robles drove his personal vehicle to the thin-veneer saw No. 2 area and began cutting stone to customer specific dimensions. At 2:45 p.m. Wilberth Balderas, Thin Veneer Saw Lead, instructed Sanchez-Robles to change material and start using the Lueders Charcoal Gray blocks.

At approximately 3:25 p.m., Sanchez-Robles motioned for Roberth Gonzalez, Front-end Loader Operator, to bring another pallet of stone. While Gonzales was bringing the pallet of stone, Sanchez-Robles was moving a large piece of stone that had fallen in front of the staging platform. Gonzalez approached the staging platform in the front-end loader, lost sight of Sanchez-Robles, and unknowingly lowered the pallet of stone onto him. Balderas shouted at Gonzales to stop and lift the pallet of stone off Sanchez-Robles. When the pallet was lifted, Sanchez-Robles stood up and fell backwards onto the staging platform. At approximately 3:30 p.m., Balderas tried to call Mike Sleight, Quarry Manager, at the office to inform him there had been an accident. Balderas did not have cellular service, so he drove his truck to the office and told Sleight in person.

Sleight traveled to the accident location in his vehicle with a first aid kit and called 911 at 3:34 p.m. Sleight started cardiopulmonary resuscitation on Sanchez-Robles as soon as he arrived. Balderas met Williamson County Emergency Medical Services (EMS) at the front gate at 4:01 p.m. and escorted them to the thin-veneer saw No. 2 area. EMS personnel took over lifesaving procedures. Taylor Ratcliff, M.D., pronounced Sanchez-Robles deceased at 4:07 p.m.

INVESTIGATION OF THE ACCIDENT

At 5:30 p.m., Jon Archer, Vice President Operations, called the Department of Labor National Contact Center (DOLNCC) to report the accident. The DOLNCC contacted Tommy Fitzgerald Mine Safety and Health Specialist. Fitzgerald notified Brett Barrick, Acting District Manager, and Ronnie Free, Assistant District Manager. Barrick sent James Redwine, Mine Safety and Health Specialist, to the mine and assigned him as the lead investigator. Free instructed Neal Davis, Supervisory Mine Safety and Health Inspector, to send Robert Teeter, Mine Safety and Health Inspector, to the mine to assist with the investigation.

On January 30, 2025, at 9:45 p.m., Redwine 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. On January 31, 2025, Redwine and Teeter met at the mine to begin the investigation. The MSHA investigation team conducted an examination of the accident scene, interviewed miners and mine 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 at the staging platform in thin-veneer saw No. 2 area (see Appendix B).

Weather

The weather at the time of the accident was 70° Fahrenheit and cloudy. Investigators determined that the weather did not contribute to the accident.

Equipment Involved

The front-end loader involved in the accident was a Caterpillar 924H equipped with pallet forks. Investigators examined the front-end loader and determined there were no safety defects that contributed to the accident. The front-end loader operation manual states, “While the machine is in operation, constantly survey the area around the machine in order to identify potential hazards as hazards become visible around the machine.”

At the time of the accident, the front-end loader was carrying a pallet of stone that was 39 ½ inches high, 50 inches long, 41 ½ inches wide, and weighed approximately 4,700 pounds. The forks of the loader were approximately four feet off the ground while the pallet of stone was being moved. As Gonzalez approached the staging platform, the pallet of stone was in his line of sight and blocked his visibility of the staging platform and Sanchez-Robles (see Appendix C). Investigators determined this contributed to the accident.

Examinations

Balderas performed an examination of the working area on the day of the accident. Balderas did not note any deficiencies.

Training and Experience

Sanchez-Robles had seven months of mining experience, all at this mine as a thin-veneer saw operator. Sanchez-Robles took New Miner training on June 18, 2024, which included seven hours of training on the thin-veneer saw and Annual Refresher training on October 18, 2024. Investigators determined Sanchez-Robles received all training in accordance with MSHA Part 46 training regulations.

Investigators determined that Gonzales completed New Miner training on February 1, 2024, Annual Refresher on October 18, 2024, and received Task training on the front-end loader on August 28, 2024. Investigators determined Gonzales 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 team identified the following root cause, and the mine operator implemented the corresponding corrective actions to prevent a recurrence.

Root Cause: The accident occurred because the loader operator was moving the loader in a manner that caused the pallet of stone to block his visibility of the staging platform and the miner.

Corrective Action: The mine operator developed, implemented and trained miners on a procedure that would ensure that miners are not in the staging platform area when palletized stone is being loaded onto the staging platform of the thin-veneer saw area.

CONCLUSION

On January 30, 2025, at approximately 3:30 p.m., Luis Sanchez-Robles (Sanchez-Robles), a 22-year-old thin-veneer saw operator with seven months of mining experience, died after a pallet of stone weighing approximately 4,700 pounds was lowered onto him.

The accident occurred because the loader operator was moving the loader while his visibility of the staging platform and the miner was blocked.

Approved By:

Brett Barrick
Acting District Manager

Date

ENFORCEMENT ACTIONS

1. A 103(k) order was issued to Salado Operations.

A fatal accident occurred on January 30, 2025, at approximately 3:30 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(a) citation was issued to Salado Operations for a violation of 30 CFR 56.9101.

On January 30, 2025, a fatal accident occurred when the operator of a Caterpillar 924H loader lowered a pallet of stone onto a miner who was in the process of removing debris from in front of the staging platform at the Thin Veneer Saw #2. The accident occurred because the loader operator was moving the loader while his visibility of the staging platform and the miner was blocked.

APPENDIX A – Persons Participating in the Investigation

Salado Operations

Cori White Eagle
Jon Archer
Michael Sleight
Wilberth Balderas
Roberth Gonzalez

Chief Executive Officer
Vice President of Operations
Quarry Manager
Thin Veneer Saw Lead
Front-end Loader Operator

Mine Safety and Health Administration

James Redwine
Robert Teeter

Mine Safety and Health Specialist
Mine Safety and Health Inspector

APPENDIX B – Veneer Saw No. 2 Staging Platform



APPENDIX C – View from Front-end Loader Approaching the Staging Platform While Transporting a Loaded Pallet

