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**Mine Safety and Health Administration**  
MSHA - Protecting Miners' Safety and Health Since 1978



**UNITED STATES  
DEPARTMENT OF LABOR  
MINE SAFETY AND HEALTH ADMINISTRATION**

**Western District  
Metal and Nonmetal Mine Safety and Health**

**Accident Investigation Report  
Surface Area of Underground Metal Mine**

**Fatal Powered Haulage Accident**

**McLaughlin Engineering and Mining Inc.  
Contractor ID WPG  
at  
Golden Queen Mine  
Golden Queen Mining Company, Inc.**

**ID No. 04-05292  
Mojave, Kern County, California**

**March 13, 1997**

**by**

**Richard R. Laufenberg  
Supervisory Mine Inspector**

**Originating Office  
Mine Safety and Health Administration  
Western District  
3333 Vaca Valley Parkway, Suite 600  
Vacaville, CA 95688**

**James M. Salois  
District Manager**

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**GENERAL INFORMATION**

Robert L. Stone, contract foreman, age 60, was fatally injured at about 3:00 p.m., on March 13, 1997, when the service truck he was operating went off the roadway and overturned. Stone had a total of 35 years of construction experience and had worked as a foreman at this operation for three months. The passenger, drill helper Michael W. Schad, age 43, sustained minor injuries. Schad had a total of two weeks mining experience, all as a driller's helper at this location. Stone and Schad had been trained in accordance with Part 48.

Fred Perkins, owner of McLaughlin Engineering & Mining Company, Inc., notified MSHA at 6:00 p.m., the day of the accident. An investigation was started the following day.

The Golden Queen mine, an underground gold mine under development by Golden Queen Mining Company, was located on Soledad Mountain, five miles southwest of Mojave, Kern County, California. Extensive surface and underground exploration activities were being conducted by six different contractors on the Soledad Mountain project.

Development was expected to continue into mid-1997, with production commencing a year later.

The principal operating officials were Steven W. Banning, president, Bernard F. Goodson, vice-president of administration, and Richard W. Graeme, vice-president of operations. Twelve persons were employed by Golden Queen Mining Company, Inc. and they worked one, 8-hour shift a day, five days a week.

The company requested and was given an MSHA identification number for the Golden Queen Mine on August 20, 1996, however, the mine had not been inspected. A regular inspection was conducted after the accident investigation.

McLaughlin Engineering & Mining, Inc. of Temecula, California, was an independent contractor hired by Golden Queen Mining Company, Inc. to construct about 25,000 ft. of bermed drill roads and 200 exploration drill pads on the Soledad Mountain project at Golden Queen Mine. Frederick E. Perkins, owner, was the principal operating official and he employed six persons at the mine who worked one 10-hour shift a day, five days a week. Five of the contractor's employees were on the mine property at the time of the accident.

#### **PHYSICAL FACTORS INVOLVED**

The truck involved in the accident was a 1985 Dodge, 3/4 ton, four-wheel drive pickup, VIN 1B6KW34I1FS580517. It was equipped with a 360 cubic inch, V-8 gasoline engine, four-speed manual transmission, and was used to service and refuel the contractor's equipment. After the accident, the transmission was found in reverse gear, with the wheels engaged in four-wheel drive low range. Functional seat belts with shoulder straps were provided for both driver and passenger in the truck cab.

A 150-gallon diesel storage tank was mounted on the rear of the truck's flatbed. The tank was rectangular in shape, measuring 5 ft. long, 2 ft. wide, and 2 ft. 6 in. high. About 10 gallons of diesel fuel was in the tank at the time of the accident. The truck was also carrying a plastic drum containing about 40 gallons of drill water. A fire extinguisher mounted on the bed of the truck broke from its bracket during the rollover. Compartments for tools and parts were located toward the front of the bed.

An inspection of brake and steering systems on the service truck was conducted during the accident investigation. There was no evidence of power steering fluid leaking from the steering gear, pump, or lines. The components of the steering linkage and fasteners were intact.

The truck was equipped with self-adjusting, hydraulically-operated disc front brakes and drum rear brakes. The brakes were functional with no evidence of fluid leaking from the master cylinder, wheel cylinders, pistons, or brake lines. The front discs and rear drums showed no sign of excessive wear or grooving. All brake pads and shoes were dry and had adequate lining remaining.

The parking brake, intended to mechanically operate the rear brakes, was not functional and was cited during an inspection conducted in conjunction with the accident investigation.

The elevated roadway where the accident occurred had been used regularly for six weeks prior to the accident by the contractor to reach exploration drill pads in the area. Company geologists used the roadway when locating drill pad sites and checking on pad specifications.

The accident occurred on the east side of Soledad Mountain, approximately 400 ft. northwest of a vehicle and equipment staging area. The staging area was at an elevation of 3700 feet, and was located 1.7 miles from the contractor's mine office along a switchback road.

The roadway was constructed of hard packed material and the grade from the staging area in the direction of the accident site varied from +12.1% to +13.5% for the first 250 ft. The roadway then made a gradual curve to the right and was almost level for 150 feet.

The roadway width varied from 10 ft. to 12 ft. 6 in. where the service truck over traveled. The left side of the roadway, traveling from the staging area to the accident site, ran adjacent to the side of the mountain. Adequate berms had not been provided along the right side of the elevated roadway. The contractor had been working in this area for the past six weeks and there was no evidence that the roadway had been widened or bermed in the recent past.

The weather at the time of the accident was clear and warm with light winds.

#### **DESCRIPTION OF THE ACCIDENT**

On the day of the accident, Robert L. Stone (victim), and Michael W. Schad (injured) reported for work at about 6:20 a.m., their regular starting time. Stone was the foreman of the four man contractor crew constructing exploration drill pad sites on mine property. Schad's duties were to assist Stone as a driller's helper, loading and stemming drill holes

prior to blasting.

At about 8:15 a.m., Schad drove Kenneth Lentz, dozer operator, in the service truck to their work site, which was an exploration drill pad located on the east side of the mountain. Stone arrived in the powder truck about 15 minutes later.

The three men worked at this location until 2:15 p.m., then Stone instructed Schad to take the powder truck to the staging area and wait there until he returned from a worksite on the west side of the mountain. They would refuel the drill after he returned.

About 3:00 p.m., Stone picked up Schad at the staging area. Schad got into the service truck and buckled his seat belt, without noticing if Stone was wearing his seat belt. They left the staging area and traveled up the road in the direction of the drill pad where they had been working earlier in the day. The truck, traveling about 5 miles an hour, went about 400 feet before it gradually drifted to the unbermed right edge of the roadway and went over. The truck overturned at least twice, rolling about 70 feet down the mountain, where it stopped on the switchback roadway below. The right rear wheel came to rest on top of the diesel fuel storage tank which had dislodged from the bed of the truck during the rollover. A fire engulfed the engine compartment, penetrated the firewall, and completely melted the passenger-side dash area.

Just prior to the final impact, Schad unfastened his seat belt and attempted to exit the cab. The force of the vehicle striking the roadway threw him out of the passenger side window. He got up and went to the other side of the service truck to check on Stone. He yelled to Stone, who initially did not respond. The second time he yelled, Stone answered that he could not move.

Schad noticed a fire under the hood of the service truck. He searched but was unable to find the fire extinguisher which had been mounted on the bed of the truck. He ran up the bank to the drill pad where Lentz was operating the dozer. Schad told Lentz that Stone had rolled the service truck, was seriously injured, and the service truck was on fire. They took the fire extinguisher from the drill nearby and ran back to the accident site where Lentz extinguished the fire.

Schad went to the powder truck parked at the staging area and called 911 with the truck's cellular phone. He then called the Golden Queen Mining Company mine office to report the accident. He hung up without leaving a message when he was received by voice mail.

Lentz found Stone laying inside the cab with his head below the steering wheel, his right leg on the seat, and his left leg on the floor, both pointed toward the passenger's door. Stone told Lentz that he thought his back was broken. As Lentz assessed Stone's injuries, the engine fire returned. He ran to the powder truck, obtained a second fire extinguisher, and he and Schad returned to the service truck and extinguished the fire again. They decided Lentz would stay with Stone, since he was trained in CPR and first-aid, and Schad would take the powder truck to get help.

At about 3:35 p.m., Stone stopped breathing and Lentz could no longer detect a pulse. He pulled Stone out of the service truck and began CPR.

Rescue personnel arrived at the accident site at about 4:00 p.m. and found Lentz performing CPR on Stone. They continued CPR and performed other medical procedures without success. Stone was pronounced dead at 4:34 p.m. and was transported to Bakersfield, California where an autopsy was performed. The official cause of death was cardiorespiratory arrest due to postural asphyxia.

#### CONCLUSION

The direct cause of the accident was the lack of a berm to prevent the operator of the service truck from traveling over the outer edge of the elevated roadway.

#### ORDERS/CITATIONS

Order number 7952658

Issued on March 13, 1997, under the provisions of Section 103 (k):

This action is taken to insure the safety of persons in the area around the Queen Ester drill site and the roadway leading to the site. This action is also taken to secure the area around the three quarter ton Dodge truck that was involved in a fatal accident earlier this afternoon. These areas must remain in their current condition until an investigation of the accident can be conducted. No one is to be allowed into this area without the permission of the Mine Safety and Health Administration.

This order was terminated after the service truck was removed from the accident to a safe location near the contractor's mine office for further inspection and a berm was installed across both ends of the road involved in the fatal accident. The road was abandoned and will not be used unless an adequate berm is installed along the entire length.

Citation number 4673586

Issued to Golden Queen Mining Co. on March 15, 1997, under the provisions of Section 104(d)(1), for violation of CFR 30 Part 57.9300(a):

A fatal accident occurred at approximately 1500 hours on March 15, 1997, when a contract foreman operating a service truck over traveled and overturned at least twice before coming to rest on a road 70 ft. below. The contract foreman was fatally injured and the passenger traveling with him sustained minor injuries. A berm or guardrail was not provided to prevent the vehicle from overturning. Mine management engaged in aggravated conduct, constituting more than ordinary negligence, by failing to ensure that the contractor had provided a berm along the roadway. This violation is an unwarrantable failure.

This citation was terminated when a berm was installed across both ends of the road involved in the fatal accident. The road was abandoned and will not be used unless an adequate berm is installed along the entire length.

Citation number 4673587

Issued to McLaughlin Engineering and Mining, Inc. on March 15, 1997, under the provisions of Section 104(d)(1), for violation of CFR 30 Part 57.9300(a):

A fatal accident occurred at approximately 1500 hours on March 15, 1997, when a contract foreman operating a service truck over traveled and overturned at least twice before coming to rest on a road 70 ft. below. The contract foreman was fatally injured and the passenger traveling with him sustained minor injuries. A berm or guardrail was not provided to prevent the vehicle from overturning. Management engaged in aggregated conduct, constituting more than ordinary negligence, by not providing a berm along the roadway. This violation is an unwarrantable failure.

This citation was terminated when a berm was installed across both ends of the road involved in the fatal accident. The road was abandoned and will not be used unless an adequate berm is installed along the entire length.

/S/ Richard R.Laufenberg  
Supervisory Mine Safety and Health Specialist

Approved by: James M. Salois, District Manager

**Related Fatal Alert Bulletin:**

 [\[FAB97M16\]](#)