

UNITED STATES  
DEPARTMENT OF LABOR  
MINE SAFETY AND HEALTH ADMINISTRATION

REPORT OF INVESTIGATION

Surface  
(Coal)

Fatal Hoisting Accident  
August 26, 2025

Marfork Processing  
Marfork Coal Company, LLC  
Whitesville, Raleigh County, West Virginia  
ID No. 46-08374

Accident Investigators

Jerome Stone  
Mine Safety and Health Specialist

Joseph Presley  
Supervisory Mine Safety and Health Specialist

Greggory Ward  
Supervisory Mine Safety and Health Specialist

Originating Office  
Mine Safety and Health Administration  
Beckley District  
1293 Airport Road  
Beaver, WV 25813  
Larry Bailey, Acting District Manager

## TABLE OF CONTENTS

OVERVIEW	1
GENERAL INFORMATION	1
DESCRIPTION OF THE ACCIDENT	2
INVESTIGATION OF THE ACCIDENT	4
DISCUSSION	4
Location of the Accident	4
Equipment Involved	4
Examinations	5
Training and Experience	5
ROOT CAUSE ANALYSIS	5
CONCLUSION	6
ENFORCEMENT ACTIONS	7
APPENDIX A – Profile of Plant	8
APPENDIX B – Elevator Control Box	9
APPENDIX C – Go/No Go Gauge	10
APPENDIX D – Persons Participating in the Investigation	11
APPENDIX E – Red Jumper and Short Blue Wires between Terminals 17 and 24	12
APPENDIX F – Inadvertent and Intermittent Contact of Wires between Terminals 17 and 19	13



## OVERVIEW

On August 26, 2025, at approximately 10:30 a.m., Eric Bartram, a 41-year-old electrician with 19 years of mining experience, died after he was pinned between the elevator and the first-floor elevator platform.

The accident occurred because the mine operator did not properly maintain the circuit control board and did not remove it from service when a dangerous condition existed.

## GENERAL INFORMATION

Marfork Coal Company, LLC owns and operates the Marfork Processing plant, a surface bituminous coal facility located in Whitesville, Raleigh County, West Virginia. Marfork Processing employs 87 miners and operates two 12-hour production shifts per day, seven days per week. The facility processes coal for transport or direct use.

The principal management officials at the Marfork Processing plant at the time of the accident were:

Frankie Davis  
Christopher Simms  
Joseph Hosler

Plant Superintendent  
Maintenance Superintendent  
Chief Electrician

The Mine Safety and Health Administration (MSHA) completed the last regular safety and health inspection at this mine on March 19, 2025. A regular safety and health inspection was ongoing at the time of the accident. The 2024 non-fatal days lost incident rate for Marfork Processing was 0.75, compared to the national average of 0.76 for facilities of this type.

#### DESCRIPTION OF THE ACCIDENT

On August 26, 2025, at approximately 5:40 a.m., Cody Estep, plant electrician/mechanic, began his shift and entered the plant at the first floor (Appendix A). Estep called for the elevator, but it did not arrive. Estep walked to the control room located on the third and a half floor and was told by a coworker the elevator had stopped operating earlier in the shift. Estep walked to the Head House located above the sixth floor directly atop the elevator shaft. The Head House contains operating components for the cable sheaves, brakes, and electrical cabinets for the elevator. Estep tried resetting the system but was unsuccessful. Estep observed a code on the digital display inside the control panel reading “safety string open,” meaning that one of the exterior elevator doors was unlocked. Estep walked to each floor landing and observed the exterior elevator doors on the third floor had not closed. Estep manually shut the doors and returned to the Head House and reset the system again; however, the elevator still would not operate. Estep retrieved a voltmeter from the third floor, returned to the Head House and began troubleshooting the electrical circuitry.

At 6:00 a.m., Bartram arrived at the plant office to begin his shift and met with Joseph Hosler, chief electrician. Hosler instructed Bartram to conduct maintenance on the third-floor dryer. After entering the plant, Casey Acord, plant foreman, informed Bartram the elevator was not operating. Bartram walked up to the Head House and relieved Estep. Estep began cleaning up in the Head House while Bartram examined the elevator. Upon returning to the Head House Bartram informed Estep that the third-floor exterior elevator doors were not completely closed. Bartram tried resetting the system but was unsuccessful. Estep left the area and walked to the first floor.

At approximately 9:00 a.m., Joshua McNeely, mine safety and health specialist, arrived to conduct regular safety and health inspection activities. McNeely’s intentions were to conduct an inspection of the plant elevator, but Hosler informed him that the elevator was down for maintenance. McNeely told Hosler that there were other things he could inspect and began checking examination records. Once McNeely completed the review of the records, he and Hosler traveled to the Synfuel Motor Control Center (MCC) room in a different building and began inspecting.

Shortly before 10:00 a.m., Bartram informed Hosler the elevator was operating. Hosler instructed Bartram to return to the plant office and accompany McNeely on the inspection of the elevator. Bartram and McNeely proceeded to the Head House to begin inspecting the elevator. They looked at the elevator brake and sheave. Bartram opened the locked circuit control board. Both looked inside at the fuses and then Bartram closed the doors. McNeely and Bartram traveled down to the sixth floor to get on top of the elevator to check the hoist way.

At approximately 10:15 a.m., Bartram sent the elevator to the fifth floor so access to the top of the elevator could be made from the sixth floor. Once the elevator stopped, Bartram opened the doors on the sixth floor and switched the controls from “operate” to “inspect” mode on the control box located on top of the elevator (Appendix B). Once on top of the elevator, Bartram stated the Go/No-Go gauge (Appendix C) used for measuring wire rope diameter was not in its usual location. After stepping off the top of the elevator, Bartram switched the controls back to “operate,” then he and McNeely entered the elevator and rode it to the first floor. McNeely decided to begin the inspection in the elevator’s pit area below the first floor. The elevator returned to the sixth floor.

Bartram opened the exterior elevator doors on the first floor. McNeely observed the counterweight at the pit. This indicated the elevator was on the sixth floor. Bartram and McNeely began looking for the Go/No-Go gauge in the pit from the first-floor landing but did not see it. Bartram then leaned or kneeled on the first-floor landing to reach the emergency stop button (e-stop) located in the pit area. McNeely asked if the e-stop felt like it was depressed, which should prevent the elevator from moving, and Bartram replied, “Yes.” McNeely then left the plant to get his Go/No-Go gauge from his vehicle, which was a three- to five-minute walk from the elevator.

At approximately 10:30 a.m., Estep walked by the plant and observed Bartram pinned by the elevator. McNeely returned at approximately the same time and saw Estep pointing toward Bartram. Estep then called over the two-way radio, for someone to call 911 and shut down the plant. At 10:34 a.m., Anthony Hill, control room operator, called 911 to request an ambulance. Coworkers heard the distress call over the radio and immediately went to the accident scene. Frankie Davis, plant superintendent, gathered first aid equipment. Hosler and Christopher Simms, maintenance superintendent, ran to the sixth floor to bypass the elevator safety circuit which would have allowed them to move the elevator. Connor Smith, crew leader, and Roger Toney, plant mechanic, arrived to assist in removing Bartram. Acord and Sanford Carriger, outside foreman, went to the second floor to access the controls on top of the elevator. Carriger switched the control from “operate” to “inspect” mode and instructed Smith and Toney to be prepared to pull Bartram once the elevator was raised. Carriger used the controls to raise the elevator and saw through an opening when Bartram was removed. Carriger stopped the elevator and radioed that they had freed Bartram from under the elevator. As Carriger confirmed Bartram was free, Simms and Hosler reached the Head House on the sixth floor, so they did not bypass the elevator safety circuit. Instead, Simms and Hosler locked out the disconnect in the Head House and the circuit breaker in the Midds MCC room.

Smith and Toney began assessing Bartram and could not detect a pulse. Mark Cooper, purchasing clerk; Simms; Carriger; and Acord performed cardiopulmonary resuscitation and attached the Automated External Defibrillator, which did not advise a shock. At 11:04 a.m.,

Whitesville Ambulance Service paramedics arrived at the plant. After assessing Bartram, paramedics contacted Dr. Kristen Babiak, DO for Regional Command, who granted the cease of resuscitation efforts and issued the time of death at 11:20 a.m.

## INVESTIGATION OF THE ACCIDENT

On August 26, 2025, at 10:44 a.m., David Schoolcraft, senior safety representative, called the Department of Labor National Contact Center (DOLNCC) to report a serious accident. The DOLNCC notified Doris Lilly, administrative specialist. Lilly informed Larry Bailey, acting district manager of the accident. Bailey assigned Jerome Stone, mine safety and health specialist, as the lead investigator.

At 11:30 a.m., Jeremy Snuffer, mine safety and health specialist, who was at the mine conducting a regular safety and health inspection, 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. Bailey sent Joseph Presley and Greggory Ward, supervisory mine safety and health specialists, to the mine. At approximately 12:15 p.m., Stone, Presley, Ward, and Bailey arrived at the mine.

The MSHA accident investigation team, in conjunction with West Virginia Office of Miners' Health Safety and Training, conducted an examination of the accident scene, interviewed miners and mine management, and reviewed conditions and work procedures relevant to the accident. Robert Bates, chief electrical engineer, MSHA Technical Support, went to the facility on August 27, 2025, to assist in the investigation. See Appendix D for a list of persons who participated in the investigation.

## DISCUSSION

### Location of the Accident

The accident occurred inside the preparation plant at the first-floor elevator landing.

### Equipment Involved

The elevator system involved in the accident consisted of four components: the elevator, the braking system, the governor, and the circuit control board. The nameplate on the elevator and braking system listed the manufacturer as Montgomery Kone. The governor nameplate listed the manufacturer as Hollister-Whitney. The circuit control board nameplate listed the manufacturer as Elevator Controls Corp. Investigators determined the elevator moved at a speed of 350 feet per minute and could not be heard as it moved.

Investigators examined the electrical system and determined that a red jumper wire in the J3 circuit control board under terminal 24 was connected to the J2 circuit control board under terminal 17 by a short blue wire (Appendix E). This created a bypass of safety features for the e-stop buttons, limit switches, buffer switches, and governor switches. Investigators found written instructions for these jumper wires on the inside of the door of the electrical enclosure where these wires are located.

Although the troubleshooting and maintenance were completed and the elevator became operational prior to the accident, the red jumper wire was left in place. The installation of the red jumper wire to bypass the safety features appears to have been a common testing and troubleshooting practice because the short blue wire was permanently installed in the terminal block. Investigators could not determine who installed or who was aware of these red and blue wires.

Additionally, an inadvertent and intermittent electrical connection existed in the J2 circuit control board between terminals 17 and 19 due to one or more strands of copper wire that didn't fit into these terminals (see Appendix F). The mine operator did not intend for this electrical connection to be made. It resulted from poor workmanship and organization in the electrical enclosure. Vibrations from normal plant operation would cause the wires to connect intermittently. Investigators observed the connection and measured it to be between four ohms and 15,000 ohms. This created a bypass of all the door interlock switches at each landing, allowing the elevator to move with the exterior elevator doors open.

The mine operator did not properly maintain the electrical components of the elevator system in safe operating condition, which contributed to the accident.

#### Examinations

Edward Johnson, electrician, completed and recorded the daily examination on the day of the accident. The examination records did not indicate any defects during the functional testing of the elevator. Investigators determined that the conditions discovered during the investigation would likely not be identified during the daily elevator examination, therefore the examination did not contribute to the accident.

At the time of the accident, Industrial Commercial Elevators (ICE) was responsible for conducting the required examinations of the elevator except for the required daily hoisting examinations. ICE assisted investigators in testing the elevator system. ICE conducted the 60-day examination of the elevator on August 20, 2025, and did not identify any hazards. ICE tested the elevator's safety devices and measured the wire ropes during this examination. Investigators determined these examinations were adequate and did not contribute to the accident.

#### Training and Experience

Bartram had 19 years of mining experience, including over ten years at the Marfork Processing plant. Bartram became a certified electrician on August 19, 2014. Bartram received annual refresher training on March 9, 2025, and task training as an electrician and on the elevator on January 23, 2025. This task training included training on electrical and elevator operation, testing, inspection, and maintenance. Investigators determined Bartram received all training in accordance with MSHA Part 48 training regulations.

## 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 cause, and the mine operator implemented the corresponding corrective action to prevent a recurrence.

Root Cause: The mine operator did not properly maintain the circuit control board and did not remove it from service when a dangerous condition existed.

Corrective Action: The mine operator removed the jumper wire from the elevator circuit control panel, rewired and reconnected the wiring according to the electrical schematics, and demonstrated proper operation of the elevator.

The mine operator also submitted the following plan to prevent recurrence and trained all miners accordingly:

1. When conducting any inspection, test, or any required checks, two qualified people who are regular employees at the plant will be required to participate, assisting one another.
2. An audible alarm and flashing strobe light have been installed in the elevator pit area below the first floor. These will activate when the elevator is in motion.
3. A flashing strobe light has been installed on top of the elevator car. It will activate when the elevator is in motion.
4. These requirements have been added to the current approved MSHA Certified and Qualified Training Program required by 77.107-1(b). These new requirements will be incorporated in the annual training courses for qualified persons.
5. This elevator task training course requires documentation on a 5000-23 form for initial task training and for annual task training required under 77.107-1(b). This course requires training on elevator operation, testing, inspection, and maintenance.

## CONCLUSION

On August 26, 2025, at approximately 10:30 a.m., Eric Bartram, a 41-year-old electrician with 19 years of mining experience, died after he was pinned between the elevator and the first-floor elevator platform.

The accident occurred because the mine operator did not properly maintain the circuit control board and did not remove it from service when a dangerous condition existed.

Approved By:

---

Larry Bailey  
Acting District Manager

---

Date

## ENFORCEMENT ACTIONS

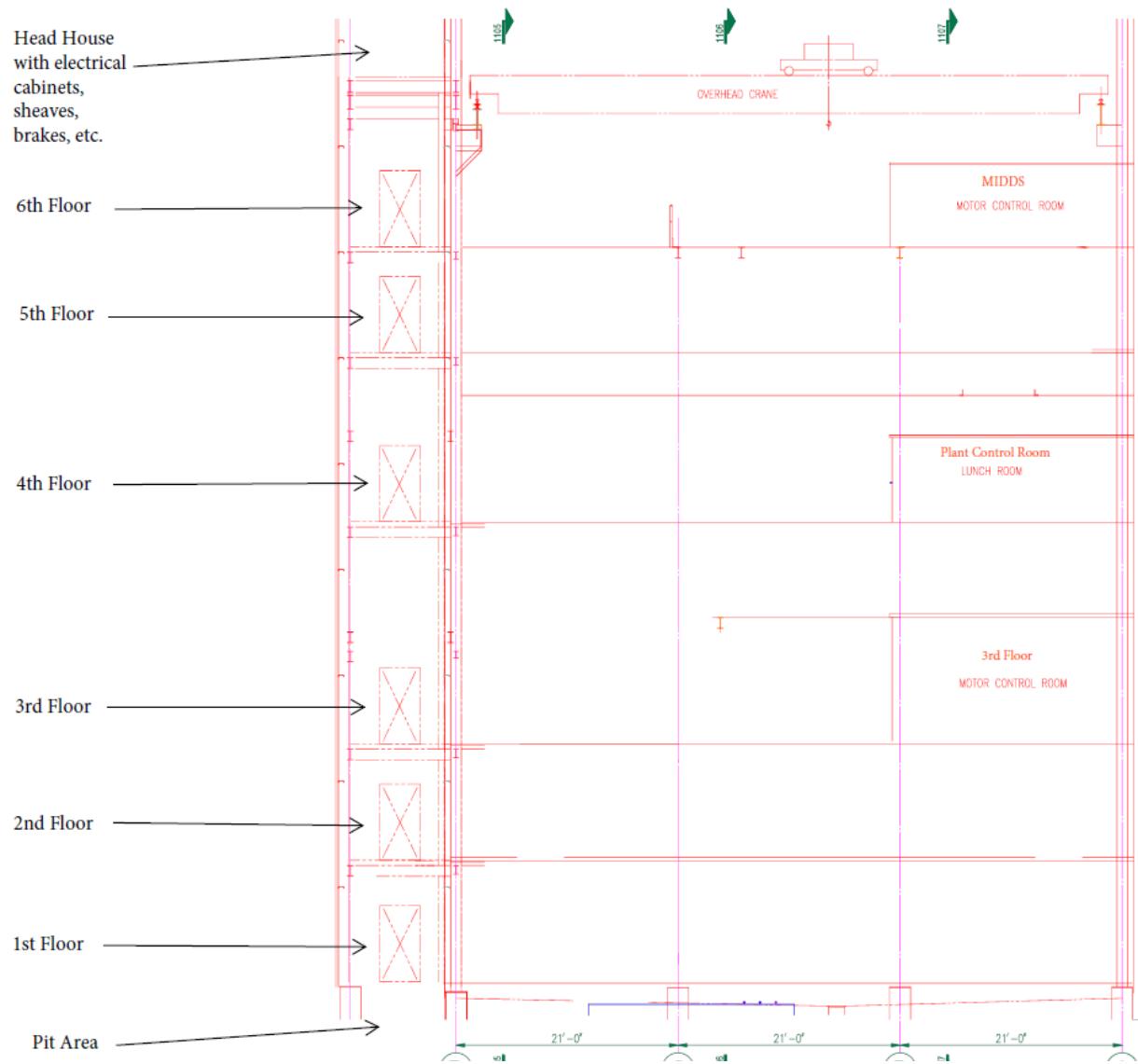
1. A 103(k) order was issued to Marfork Coal Company, LLC.

A fatal accident occurred on August 26, 2025, at approximately 10:30 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.

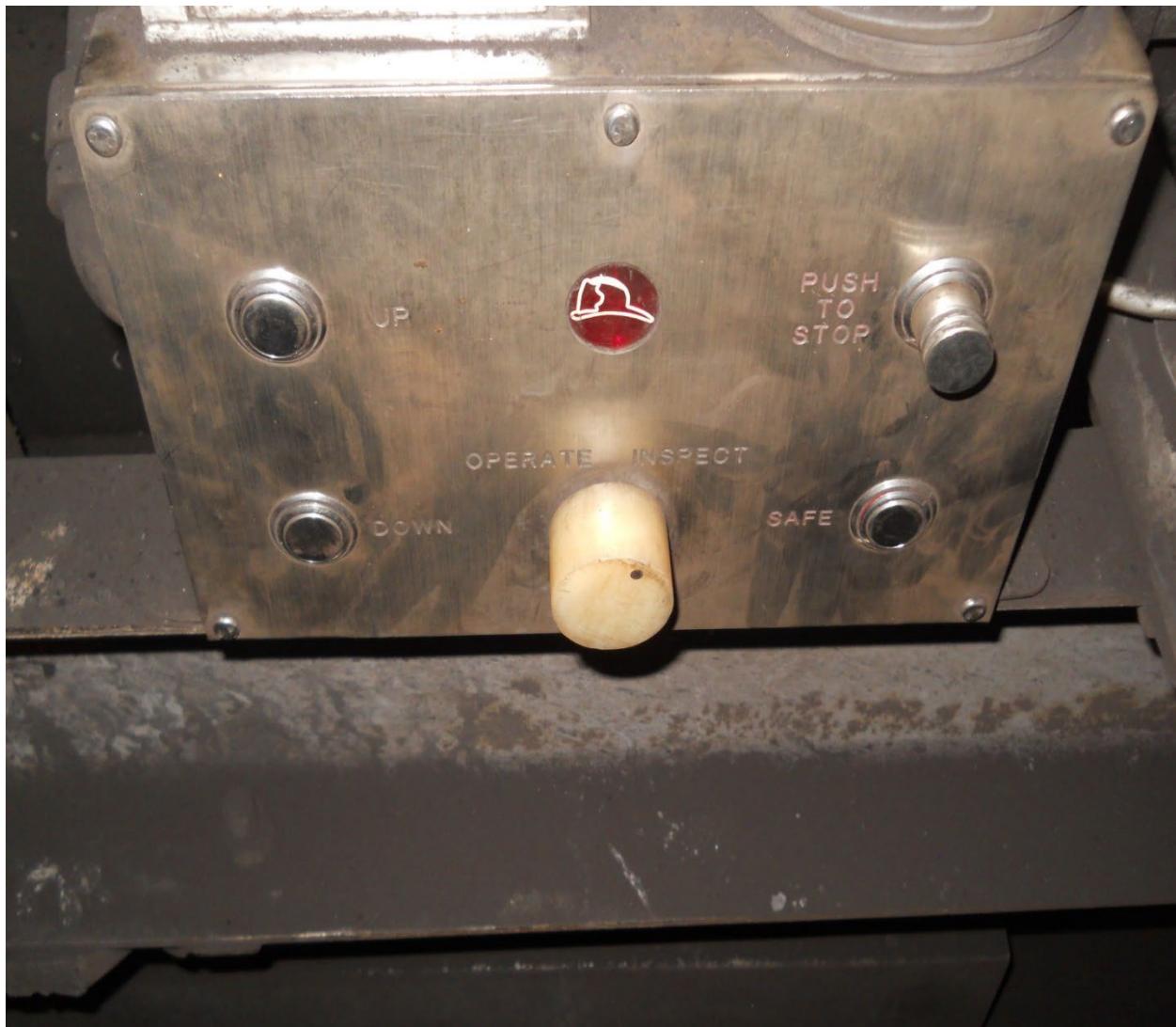
2. A 104(a) citation was issued to Marfork Coal Company, LLC for a violation of 30 CFR 77.502.

On August 26, 2025, an electrician was fatally injured when he was pinned between the elevator car and the first-floor elevator platform. Jumper wires that bypassed critical safety controls were left in the circuit control board after testing or maintenance, and this allowed the elevator to move, effectively defeating the designed safety interlocks. This allowed the elevator to move while the jumper wire was still in place, effectively defeating the designed safety interlocks. Investigators also determined there was an intermittent connection between wires that allowed the elevator car to move with the exterior elevator doors open. The mine operator did not properly maintain the circuit control board and did not remove it from service when a dangerous condition existed.

## APPENDIX A – Profile of Plant



## APPENDIX B – Elevator Control Box



## APPENDIX C – Go/No-Go Gauge



## APPENDIX D – Persons Participating in the Investigation

### Marfork Coal Company, LLC

Barrett Justice	President of Operations Mid-WV Underground
Scott Toler	Vice President of Operations Mid-WV Underground
Brian Keaton	Senior Vice President of Safety
Kris Burke	Director of Maintenance
Joshua Peters	Director of Preparation
Christopher Simms	Maintenance Superintendent
Joseph Hosler	Chief Electrician
Frankie Davis	Plant Superintendent
David Schoolcraft	Senior Safety Representative
Casey Acord	Plant Foreman
Sanford Carriger	Outside Foreman
Connor Smith	Crew Leader
Cody Estep	Plant Electrician/Mechanic
Roger Toney	Plant Mechanic
Anthony Hill	Control Room Operator
Mark Cooper	Purchasing Clerk

### West Virginia Office of Miners' Health Safety and Training

Frank Foster	Director
Christopher Dawson	Inspector at Large
Charles Moles	Assistant Inspector at Large
Jeffory Davis	Chief Electrical Inspector
Charles Haga	Electrical Inspector

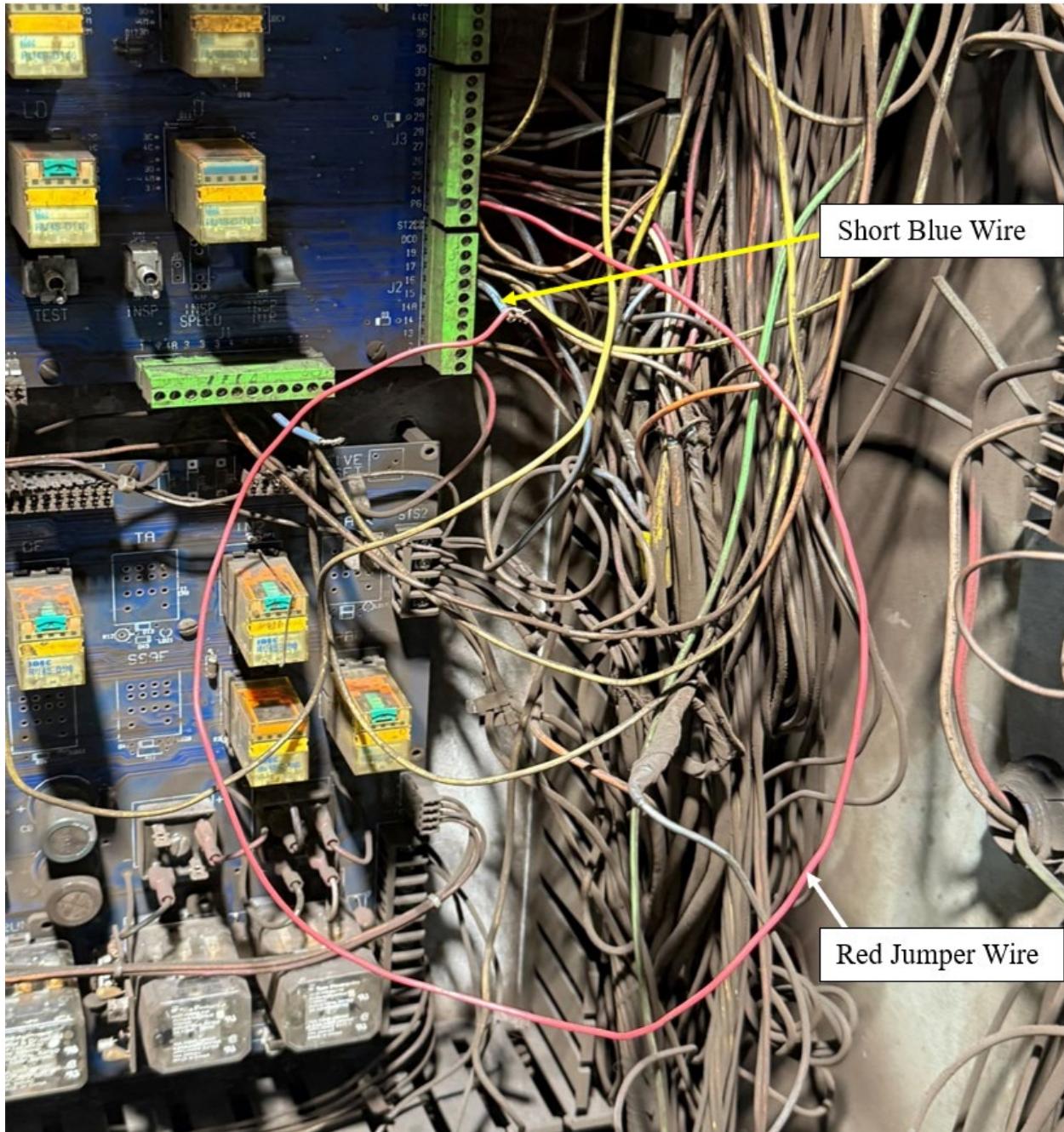
### Industrial Commercial Elevator

Raymond Gielarowski, Jr.	Executive Director of Field Operations
Michael Hartman	Mechanic

### Mine Safety and Health Administration

Craig Plumley	Acting Regional Administrator
Larry Bailey	Acting District Manager
Joseph Presley	Supervisory Mine Safety and Health Specialist
Greggory Ward	Supervisory Mine Safety and Health Specialist
David Birchfield	Supervisory Mine Safety and Health Inspector
Richard Cregger	Mine Safety and Health Specialist
Martin Holbrook	Mine Safety and Health Specialist
Jeremy Snuffer	Mine Safety and Health Specialist
Jerome Stone	Mine Safety and Health Specialist
William Bane	Mine Safety and Health Inspector
Robert Bates	Chief Electrical Engineer, Technical Support

APPENDIX E – Red Jumper and Short Blue Wires between Terminals 17 and 24



APPENDIX F – Inadvertent and Intermittent Contact of Wires between Terminals 17 and 19

