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UNITED STATES
DEPARTMENT OF LABOR
MINE SAFETY AND HEALTH ADMINISTRATION

REPORT OF INVESTIGATION

Facility
(Dolomitic Lime)

Fatal Slip or Fall of Person Accident
October 16, 2025

MLC-Bonne Terre
MLC
Bonne Terre, St. Francois County, Missouri
ID No. 23-02371

Accident Investigators

Brady Sebastian
Mine Safety and Health Inspector

Rickey Gillam
Mine Safety and Health Inspector

Alex Stephens
Mine Safety and Health Inspector

Originating Office
Mine Safety and Health Administration
Madisonville District
100 YMCA Drive
Madisonville, KY 42431
Mary Jo Bishop, District Manager

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OVERVIEW

On October 16, 2025, between 6:56 p.m. and 7:25 p.m., James Hayes, a 34-year-old production laborer with over 1 year of mining experience, died when he fell approximately 30 feet from an elevated work platform located at the No. 1 Silo.

The accident occurred because the mine operator did not: 1) design the chute installation to provide a safe location for miners manually actuating the manual diverter switch lever (lever), and 2) correct defects to the lever that affected the safety of the miners.

GENERAL INFORMATION

MLC owns and operates MLC-Bonne Terre, a processing facility located in Bonne Terre, St. Francois County, Missouri. The facility employs 40 miners and operates two 12-hour shifts, 7 days per week. Haul trucks transport crushed limestone to the facility from a quarry adjoining the MLC-Bonne Terre property. Front-end loaders load crushed limestone into a feed hopper that feeds the kiln. The product goes through the cooler, then it is transferred by belt conveyors to the bucket elevator and stored in silos before crushing and screening.

The principal management officials at MLC-Bonne Terre at the time of the accident were:

Elizabeth Wilkerson	Vice President of Operations
Andrew Eker	Director of Regional Operations
Sheldon Deimund	Plant Manager

The Mine Safety and Health Administration (MSHA) completed the last regular safety and health inspection at this facility on June 25, 2025. The 2024 non-fatal days lost incident rate for MLC-Bonne Terre was zero, compared to the national average of 1.35 for mines of this type.

DESCRIPTION OF THE ACCIDENT

On October 16, 2025, at 6:42 p.m., Hayes started his shift, traveled to the brick shed, and received his job duties along with other employees. Shawn Berg, acting supervisor, instructed Hayes to switch the material feed from the No. 12 belt conveyor to the bucket elevator and clean loose material from the top of the bucket elevator. At 6:56 p.m., a security photo shows Hayes on an elevated work platform on the No. 1 Silo, where the lever is located to switch the material feed from the No. 12 belt conveyor to the bucket elevator. At some point while performing his assigned task, Hayes fell off the elevated work platform.

At 7:25 p.m., Easton Rutledge, crew leader, found Hayes lying on the ground below the elevated work platform and called 911. Rutledge called Berg, who arrived at the accident scene and checked Hayes for vital signs. At 7:34 p.m., emergency medical services arrived at the accident scene, began CPR and applied an AED. Gregory Armstrong, St. Francois County deputy coroner, pronounced Hayes dead at 7:41 p.m.

INVESTIGATION OF THE ACCIDENT

On October 16, 2025, at 8:01 p.m., Jesse Gegg, safety systems and training manager, called the Department of Labor National Contact Center (DOLNCC). The DOLNCC contacted Timothy Gardner, supervisory mine safety and health specialist, who contacted Matthew Stone, staff assistant. Stone contacted Shawn Pratt, supervisory mine safety and health inspector, who sent Alex Stephens, Rickey Gillam, and Brady Sebastian, mine safety and health inspectors, to the mine. Pratt assigned Sebastian as the lead investigator.

On October 16, 2025, at 9:04 p.m., Stephens 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 the preservation of evidence. Sebastian arrived at 11:45 p.m., and Gillam arrived at 12:05 a.m.

The MSHA accident investigation team conducted an examination of the accident scene, interviewed miners and mine management, and reviewed conditions and work procedures relevant to the accident. Mustafa Raifet, P.E. and Michael Witt, P.E. from Industrial Ally conducted a structural assessment to ensure all structural components were safe as part of the corrective actions. See Appendix A for a list of persons who participated in the investigation.

DISCUSSION

Location of the Accident

The accident occurred on an elevated work platform approximately 30 feet above the ground at the No. 1 Silo (see Appendix B). The bottom handrail was 23.25 inches from the platform floor, and the top handrail was 41 inches from the platform floor. Investigators determined that the handrails were adequate.

Weather

The weather at the time of the accident was 63 degrees Fahrenheit with 8-mile-per-hour winds. Investigators determined that the weather did not contribute to the accident.

Equipment Involved

The equipment involved in the accident was the No. 12 Lime Belt Conveyor, EL-01 Lime Bucket Elevator, and a manual diverter switch lever used to pull the chute. At the time of the accident, Hayes was actuating the lever by pulling it (see Appendix C). This is a common practice, performed as needed, to move material from one silo to another when a silo was full or material was needed in another silo.

The mine operator did not design the chute installation to provide a safe location for miners manually actuating the lever, which contributed to the accident. When accessing the lever, miners had to crawl under chutes installed within the front and back walkway of the elevated platform. While miners were manually actuating the lever, the location of the chute-loading installation created a narrow and tight work location that did not allow free access to the lever.

The mine operator did not correct defects with the lever that affected the safety of the miners, which contributed to the accident. The function of the lever was impaired and not in normal operating condition whenever material was built up in the chute. This caused the lever to be difficult to manually actuate and created a hazard for miners. The lever was very difficult to move as demonstrated by MLC when personnel attempted to actuate it for the MSHA investigators. According to interviews, actuating the lever required bracing against the bottom handrail and occasionally striking the lever with a hammer when it jammed. Investigators observed visible damage to the lever from hand tools previously striking it. Edward King, supervisor, stated that the lever would “clog up from time to time” due to built-up material that accumulated when the plant was down. To clear the built-up material, miners inserted a rod into the silo from a door on the upper level. If the plant was down for a day or more, miners also struck the side of the silo with a hammer.

Illumination

According to the mine operator, elevators and platforms are cleaned during daylight hours while there is adequate illumination. Sunset on the day of the accident was 6:23 p.m. After Hayes arrived at 6:42 p.m., Berg assigned him to actuate the lever and clean the top of the bucket elevator. The security photo shows Hayes on the elevated platform at 6:56 p.m., after sunset and while it was not adequately illuminated. Hayes’ head lamp was the only source of lighting to illuminate the work platform. Investigators determined the lighting was inadequate for Hayes to be able to safely maneuver around the elevated work platform and actuate the lever. The mine

operator did not adequately illuminate the elevated work platform, which contributed to the accident.

Examinations

King conducted the workplace examinations of the No. 1 Silo with no hazardous conditions recorded. Investigators reviewed workplace examination records with no hazards recorded by the mine operator. Investigators determined the examinations were adequate and did not contribute to the accident.

Training and Experience

Hayes had 1 year, 1 week, and 3 days of mining experience, all at MLC-Bonne Terre as a production laborer. Hayes received new miner training on October 10, 2024, site-specific hazard awareness training on October 7, 2024, and production labor task training on October 7, 2024. Investigators determined Hayes 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 causes, and the mine operator implemented the corresponding corrective actions to prevent a recurrence.

1. Root Cause: The mine operator did not design the chute installation to provide a safe location for miners manually actuating the lever.

   Corrective Action: The mine operator removed the emergency material chute on the No. 1 Silo side of the elevated platform and relocated the lever to the No. 1 Silo side of the elevated platform.

2. Root Cause: The mine operator did not correct defects to the lever that affected the safety of the miners.

   Corrective Actions: The lever was relocated to the No. 1 Silo side, providing safe access and body position when manually actuating the lever.

CONCLUSION

On October 16, 2025, between 6:56 p.m. and 7:25 p.m., James Hayes, a 34-year-old production laborer with over one year of mining experience, died when he fell approximately 30 feet from an elevated work platform located at the No. 1 Silo.

The accident occurred because the mine operator did not: 1) design the chute installation to provide a safe location for miners manually actuating the lever, and 2) correct defects to the lever that affected the safety of the miners.

Approved By:

_____ _____

Mary Jo Bishop — Date
District Manager

ENFORCEMENT ACTIONS

1. A 103(k) order was issued to MLC.

   A fatal accident occurred on October 16, 2025, between 6:56 p.m. and 7:25 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 MLC for a violation of 30 CFR 56.9309.

   On October 16, 2025, a production laborer died when he fell from an elevated work platform, while manually actuating a diverter switch lever to direct material from the No. 12 belt conveyor to the bucket elevator at the No. 1 Silo. The chute installation was not designed to provide a safe location for miners manually actuating the diverter switch lever, which is used to pull the chute. When accessing the diverter switch lever, miners had to crawl under chutes installed within the front and back walkway of the elevated platform. While miners were manually actuating the diverter switch lever, the location of the chute-loading installation created a narrow and tight work location that did not allow free access to the lever.

3. A 104(a) citation was issued to MLC for a violation of 30 CFR 56.14100(b).

   On October 16, 2025, a production laborer died when he fell from an elevated work platform, while manually actuating a diverter switch lever to direct material from the No. 12 belt conveyor to the bucket elevator at the No. 1 Silo. The mine operator did not correct defects with the diverter switch lever that affected the safety of persons. The function of the diverter switch lever was impaired and not in a normal operating condition whenever material built up, causing the lever to be difficult to manually actuate and thereby creating a hazard to persons.

4. A 104(a) citation was issued to MLC for a violation of 30 CFR 56.17001.

   On October 16, 2025, a production laborer died when he fell approximately 30 feet from an elevated work platform at the No. 1 Silo while manually actuating a diverter switch lever. A supervisor assigned the production laborer to perform work on the elevated platform while it was not adequately illuminated.

APPENDIX A – Persons Participating in the Investigation

MLC

Elizabeth Wilkerson	Vice President of Operations
Kris Schuster	Vice President of Human Resources
Andrew Ecker	Director of Regional Operations
Jesse Gegg	Safety Systems and Training Manager
Scott Drury	Senior Safety Manager
Michael Fraulini	Regional Safety Manager
Darrel Leach	Maintenance Manager
Dennis Cole	Project Manager
Sheldon Deimund	Plant Manager
Edward King	Supervisor
Shawn Berg	Acting Supervisor
Easton Rutledge	Crew Leader

Mine Safety and Health Administration

Matthew Stone	Staff Assistant
Rickey Gillam	Mine Safety and Health Inspector
Brady Sebastian	Mine Safety and Health Inspector
Alex Stephens	Mine Safety and Health Inspector

APPENDIX B – Elevated Work Platform at the No. 1 Silo

APPENDIX C – Manual Diverter Switch Lever