

UNITED STATES  
DEPARTMENT OF LABOR  
MINE SAFETY AND HEALTH ADMINISTRATION

REPORT OF INVESTIGATION

Surface  
(Crushed, Broken Limestone)

Exploding Vessels Under Pressure Accident Fatality Report  
December 22, 2025

Kemper Equipment (GVG)  
Honey Brook, Pennsylvania

at

Rockydale-Flatrock Quarry

Mundy Stone Company  
Quicksburg, Shenandoah County, Virginia  
ID No. 44-00081

Accident Investigators

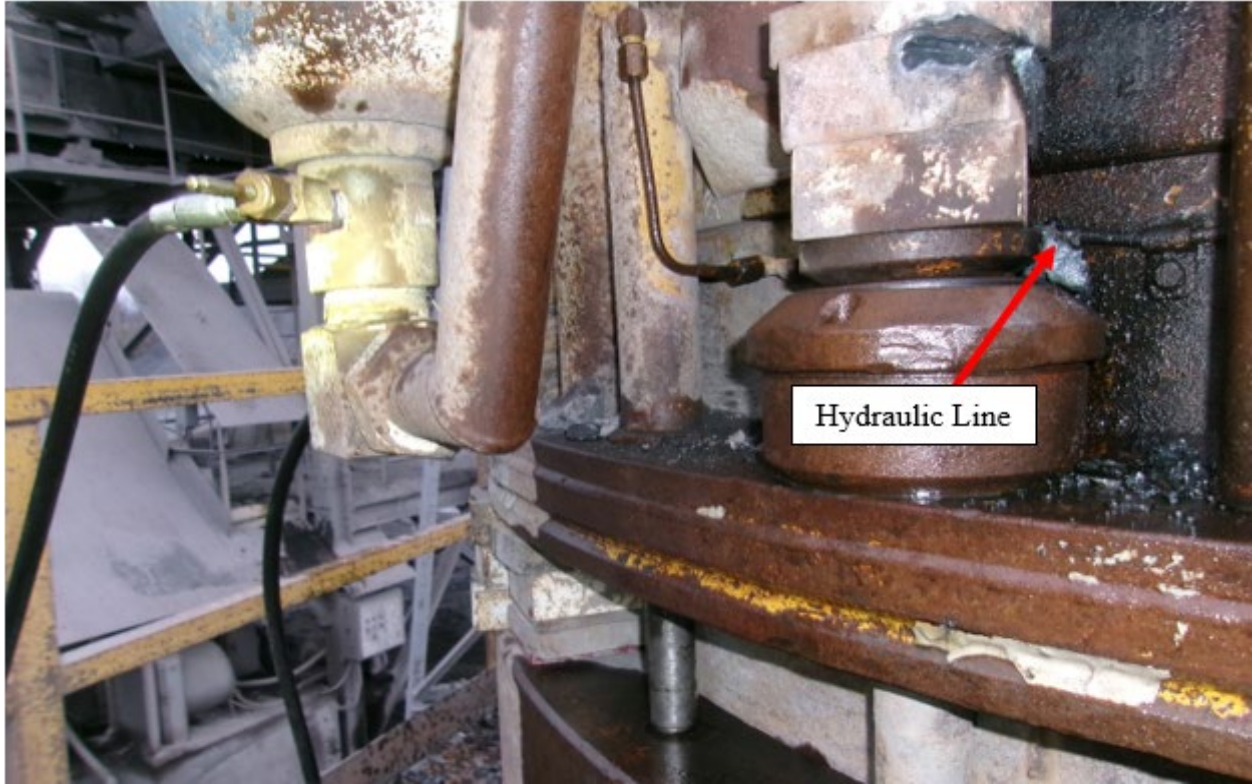
Martin Johnston  
Mine Safety and Health Inspector

Timothy McBryde  
Supervisory Mine Safety and Health Inspector

Originating Office  
Mine Safety and Health Administration  
Norton District  
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Wise, VA 24293  
Brian Dotson, District Manager

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## OVERVIEW

On December 22, 2025, at 4:16 p.m., Andrew Loveday, a 40-year-old contract field service technician with over 7 years of mining experience, died after receiving burns from a pressurized hydraulic line that ruptured and caught fire. Loveday was cutting shims from a cone crusher with an oxygen and acetylene torch.

The accident occurred because the mine operator and contractor did not ensure: 1) that the manufacturer's disassembly procedures were followed; and 2) that the hydraulic line was drained, ventilated, thoroughly cleaned of any residue, and vented to prevent pressure during the application of heat; and filled with inert gas or water before using torches near a pressurized hydraulic line. Additionally, the contractor did not ensure that Loveday wore a face shield or goggles while cutting the shims.

## GENERAL INFORMATION

Mundy Stone Company owns and operates the Rockydale-Flatrock Quarry, a surface crushed and broken limestone quarry located in Quicksburg, Shenandoah County, Virginia. Rockydale-Flatrock Quarry employs 12 miners and operates one 10-hour shift per day, 5 days per week. The mine drills and blasts the limestone and uses haul trucks to transport the limestone to the plant for sizing, stockpiling, and sale to various customers. Mundy Stone Company contracted Kemper Equipment to repair the cone crusher. Loveday was employed by Kemper Equipment.

The principal management officials at the Rockydale-Flatrock Quarry at the time of the accident were:

Bradley Couch	General Manager
Dallas Satterfield	Environmental Health and Safety Manager
James Pifer	Foreman-in-Training

The principal management officials at Kemper Equipment at the time of the accident were:

Daniel Sheakley	Vice President of Operations
William Maccini	Southeastern Territory Manager

The Mine Safety and Health Administration (MSHA) completed the last regular safety and health inspection at this mine on May 15, 2025. The 2024 non-fatal days lost incident rate for the Rockydale-Flatrock Quarry was zero, compared to the national average of 1.23 for mines of this type.

## DESCRIPTION OF THE ACCIDENT

On December 22, 2025, at approximately 6:45 a.m., Loveday arrived at the mine. Loveday met Jesse Snyder, plant mechanic, to discuss the work they would be performing on the cone crusher. At approximately 7:00 a.m., Loveday and Snyder traveled to the cone crusher and removed the belt conveyor over it. Tyler Walsh, crane operator for Dean Steel, removed the hopper portion with a crane. Loveday and Snyder connected a pump to the cone crusher's hydraulic system to power the hydraulic jacks used to raise the upper assembly.

Loveday pressurized the hydraulic system, loosened all but one of the adjusting nuts, and removed the shims on the top and bottom portions of all but one of the adjusting bolts (Appendix A). Loveday could not loosen one of the adjusting nuts and used an oxygen and acetylene torch in an attempt to remove one of the shims from the top portion of the adjusting bolt. A hydraulic line was directly behind the shim that was being removed. At 4:16 p.m., heat from cutting the shim caused the hydraulic line to rupture, and the flames from the torch ignited the escaping hydraulic fluid. Loveday received burns from the resulting fire.

At the time of the accident, Bradley Couch, general manager; Jason Rohrer, utility person; and James Pifer, foreman-in-training, were standing on the ground near the steps leading up to the cone crusher discussing the repairs being made to the crusher. Walsh was in the cab of a crane truck eating lunch near the cone crusher. They all stated they heard a noise and saw a fire near the area where Loveday was working.

Snyder, who was standing on the cone crusher platform, helped Loveday walk down the steps while the fire continued at the crusher. Snyder de-energized the generator powering the hydraulic pump, which depressurized the hydraulic system and extinguished the fire. At 4:18 p.m., Couch called 911 while he and Pifer assisted Loveday to walk to the mine office. Couch flushed Loveday's eyes with eyewash solution while they waited for emergency medical services to arrive. Shenandoah County Fire and Rescue arrived and transported Loveday to meet a medical

helicopter. However, a decision was made that Loveday was too unstable to fly. As a result, the decision was made to continue by ambulance. The ambulance transported Loveday to the hospital where Mark Nesbit, MD for Sentara RMH Medical Center, pronounced him dead at 6:03 p.m.

## INVESTIGATION OF THE ACCIDENT

On December 22, 2025, at 4:21 p.m., Dallas Satterfield, environmental health and safety manager, called the Department of Labor National Contact Center (DOLNCC) to report a serious accident. The DOLNCC notified Michael Colley, staff assistant, who informed Brian Dotson, district manager. Dotson notified Timothy McBryde, supervisory mine safety and health inspector, and Lloyd Robinette, assistant district manager. McBryde sent Martin Johnston, mine safety and health inspector, to the mine and assigned him as the lead investigator. McBryde also sent Jason Sparkman, mine safety and health inspector, to the mine to assist in the investigation.

At 6:30 p.m., Johnston arrived at the mine, and at 6:51 p.m., he 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. At 9:30 p.m., Sparkman arrived at the mine. On December 23, 2025, at 2:30 a.m., McBryde and Robinette arrived at the mine to assist the investigation.

The MSHA accident investigation team, in conjunction with the Virginia Department of Energy, conducted an examination of the accident scene; interviewed miners, mine management, and contractors; and reviewed conditions and work procedures relevant to the accident. View Appendix B for a list of persons who participated in the investigation.

## DISCUSSION

### Location of the Accident

The accident occurred on the cone crusher platform (Appendix C).

### Weather

The weather at the time of the accident was 45 degrees Fahrenheit and partly cloudy with 4 mile per hour winds. Investigators determined that the weather did not contribute to the accident.

### Equipment Involved

The cone crusher involved in the accident was an EL-Jay 54 Roller Cone Crusher. At the time of the accident, Loveday was disassembling the cone crusher to change the liner. According to the manufacturer's manual, the cone crusher is disassembled by connecting a pump to the hydraulic system. Pressure from the pump is applied to hydraulic jacks which raise the upper assembly. This allows shims on the bottom portion of the adjusting bolts to be removed by hand. The hydraulic system is depressurized, and the adjusting nuts are loosened if necessary. The shims on the top portion of the adjusting bolts are then removed by hand, without the use of a torch. The mine operator and contractor did not ensure that these procedures were followed, which contributed to the accident. Loveday used a torch to remove the shims on the top portion of the adjusting bolts. Prior to using the torch, the hydraulic line was required to be drained, ventilated,

and thoroughly cleaned of any residue; vented to prevent pressure during the application of heat; and filled with inert gas or water.

### Personal Protective Equipment

At the time of the accident, Loveday was wearing gloves and prescription glasses but was not wearing a face shield or goggles while cutting the shims. Investigators determined that a face shield had been provided to Loveday but was not worn. Based on Loveday's injuries, investigators determined that wearing a face shield would have reduced the severity of the accident. Investigators determined that the lack of use of personal protective equipment contributed to the severity of the accident.

### Examinations

Pifer conducted the workplace examination of the cone crusher the morning before the accident and did not note any hazardous conditions. Investigators determined that the examination was adequate and did not contribute to the accident.

### Training and Experience

Loveday had 7 years and 7 months of mining experience, including 10 weeks of experience with Kemper Equipment. All of Loveday's mining experience was related to crusher repair. The day of the accident was Loveday's second day at this mine. Loveday received annual refresher training on October 10, 2025. Prior to the accident, Kemper Equipment management officials observed Loveday perform crusher disassembly in a safe manner at other mine sites, which included following the manufacturer's manual. Kemper Equipment also trained Loveday on the proper use of personal protective equipment while cutting and welding. Investigators determined Loveday received all training in accordance with MSHA Part 46 training regulations.

Snyder had 4 years and 1 month of mining experience. Snyder received annual refresher training on February 27, 2025. On the day of the accident, Snyder was working with Loveday to get a better understanding of the crusher repair process. Investigators determined Snyder 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 accident investigation team identified the following root causes, and the mine operator and contractor implemented the corresponding corrective actions to prevent a recurrence.

1. Root Cause: The mine operator and contractor did not ensure that the manufacturer's disassembly procedures were followed to relieve pressure from the upper assembly so the top shims could be removed by hand.

Corrective Action: The mine operator and the contractor each developed and implemented a written procedure, included in their respective training plans, that requires the equipment manufacturer's procedures to be followed when assembling and disassembling equipment.

2. Root Cause: The mine operator and contractor did not ensure that the hydraulic line was drained, ventilated, thoroughly cleaned of any residue, and vented to prevent pressure during the application of heat; and filled with inert gas or water before using torches near a pressurized hydraulic line.

Corrective Action: The mine operator and the contractor each developed and implemented a written procedure, included in their respective training plans, that requires: 1) all associated hydraulic systems to be fully depressurized and, where practical, vented to the atmosphere prior to performing cutting, welding, or other hot work activities in close proximity to any hydraulic system component; and 2) a heat shield to be positioned to protect the hydraulic system from excessive heat. The mine operator and contractor trained all miners in this procedure.

3. Root Cause: The contractor did not ensure that Loveday wore a face shield or goggles while cutting the shims.

Corrective Action: The contractor developed and implemented a written procedure, included in their training plan, that requires miners and contractors to wear protective clothing or equipment and face shields or goggles when welding, cutting, or working with molten metal. The contractor trained all miners on this procedure and included it in their training plan.

## CONCLUSION

On December 22, 2025, at 4:16 p.m., Andrew Loveday, a 40-year-old contract field service technician with over 7 years of mining experience, died after receiving burns from a pressurized hydraulic line that ruptured and caught fire. Loveday was cutting shims from a cone crusher with a torch.

The accident occurred because the mine operator and contractor did not ensure: 1) that the manufacturer's disassembly procedures were followed; and 2) that the hydraulic line was drained, ventilated, thoroughly cleaned of any residue, and vented to prevent pressure during the application of heat; and filled with inert gas or water before using torches near a pressurized hydraulic line. Additionally, the contractor did not ensure that Loveday wore a face shield or goggles while cutting the shims.

Approved By:

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Brian Dotson  
District Manager

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Date

## ENFORCEMENT ACTIONS

1. A 103(k) order was issued to Mundy Stone Company.

A fatal accident occurred on December 22, 2025, at 4:16 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 Kemper Equipment for a violation of 30 CFR 56.4604.

On December 22, 2025, a contract field service technician died after receiving burns from a pressurized hydraulic line that ruptured and caught fire. The contractor did not ensure that the hydraulic line was drained, ventilated, and thoroughly cleaned of any residue; vented to prevent pressure during the application of heat; and filled with inert gas or water.

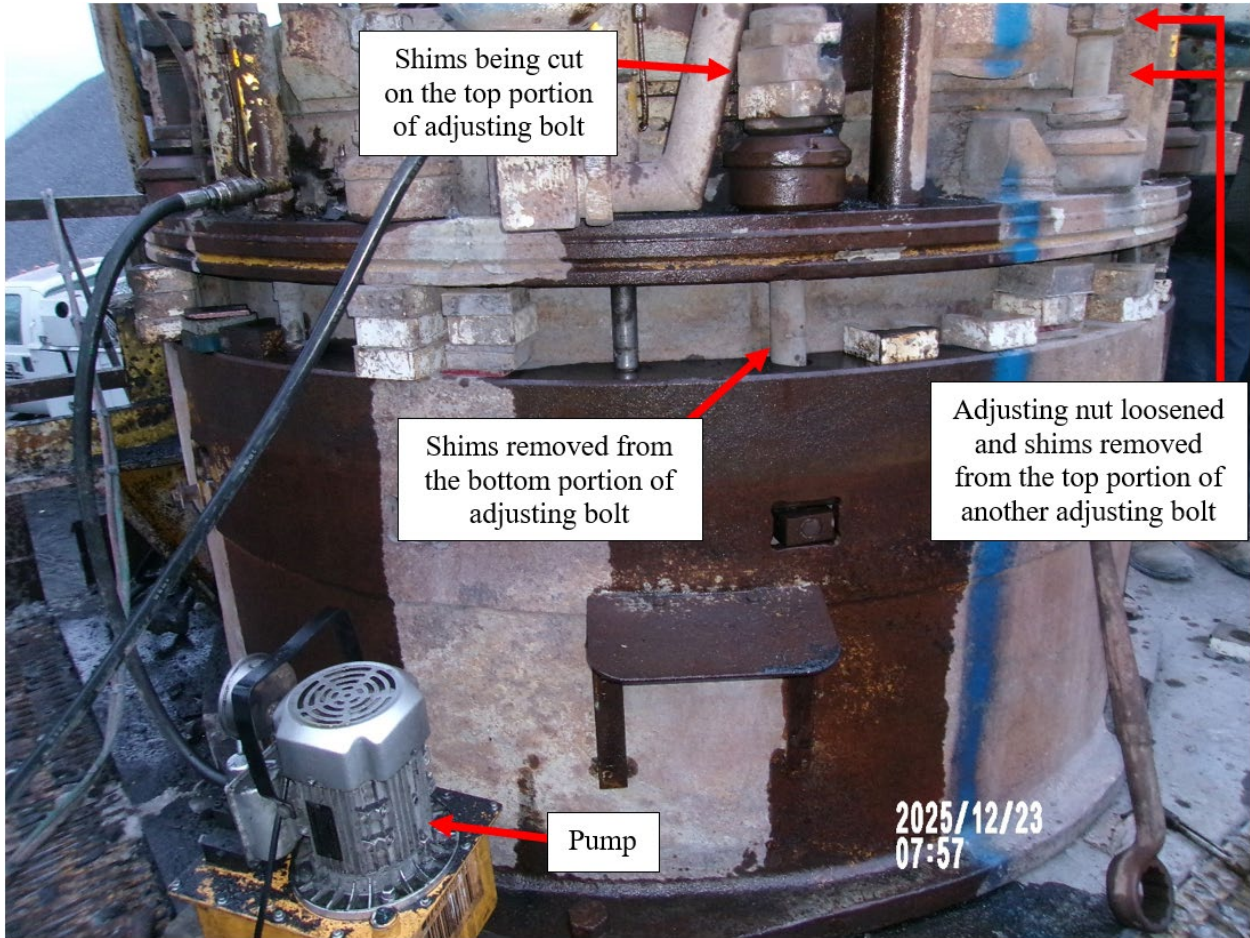
3. A 104(a) citation was issued to Mundy Stone Company for a violation of 30 CFR 56.4604.

On December 22, 2025, a contract field service technician died after receiving burns from a pressurized hydraulic line that ruptured and caught fire. The mine operator did not ensure that the hydraulic line was drained, ventilated, and thoroughly cleaned of any residue; vented to prevent pressure during the application of heat; and filled with inert gas or water.

4. A 104(a) citation was issued to Kemper Equipment for a violation of 30 CFR 56.15007.

On December 22, 2025, a contract field service technician died after receiving burns from a pressurized hydraulic line that ruptured and caught fire. The contractor did not ensure that the field service technician wore a face shield or goggles while cutting the metal shims.

APPENDIX A – Cone Crusher



APPENDIX B – Persons Participating in the Investigation

Mundy Stone Company

Christopher Willis	Vice President of Aggregate Operations
John DePasquale	Director of Aggregate Operations
Bradley Couch	General Manager
Dallas Satterfield	Environmental Health and Safety Manager
James Pifer	Foreman-in-Training
Jesse Snyder	Plant Mechanic
Jason Rohrer	Utility Person

Kemper Equipment

Daniel Sheakley	Vice President of Operations
William Maccini	Southeastern Territory Manager

Dean Steel

Tyler Walsh	Crane Operator
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Virginia Department of Energy

William Hutcheson	Mine Inspector
Matthew Kretsch	Mine Inspector

Mine Safety and Health Administration

Brian Dotson	District Manager
Lloyd Robinette	Assistant District Manager
Michael Colley	Staff Assistant
Timothy McBryde	Supervisory Mine Safety and Health Inspector
Martin Johnston	Mine Safety and Health Inspector
Jason Sparkman	Mine Safety and Health Inspector

APPENDIX C – Location of the Accident

