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UNITED STATES
DEPARTMENT OF LABOR
MINE SAFETY AND HEALTH ADMINISTRATION

REPORT OF INVESTIGATION

Underground
(Coal)

Fall of Face, Rib, Pillar or Highwall Accident Fatality Report
May 19, 2026

Bailey Mine
Consol Pennsylvania Coal Company LLC
Wind Ridge, Greene County, Pennsylvania
ID No. 36-07230

Accident Investigators

Nicholas Blevins
Mine Safety and Health Specialist

Travis Hamrick
Mine Safety and Health Specialist

Originating Office
Mine Safety and Health Administration
Morgantown District
604 Cheat Road
Morgantown, West Virginia 26508
Carlos Mosley, District Manager

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OVERVIEW

On May 19, 2026, at 9:50 p.m., Zachary Wolfe, a 34-year-old assistant shift foreman with 13 years of mining experience, died when a large section of rib fell and pinned him to the mine floor.

The accident occurred because there were inadequate policies and procedures in place to support or otherwise control the mine ribs where miners work or travel.

GENERAL INFORMATION

Core Natural Resources, Inc. owns Consol Pennsylvania Coal Company, LLC, who operates the Bailey Mine, an underground bituminous coal mine located in Aleppo, Greene County, Pennsylvania. The Bailey Mine employs 699 miners, and operates three 8-hour production shifts, 6 days per week. The mine extracts coal from the Pittsburgh No. 8 coal seam with seven continuous mining machine units and two longwall units. The average mining height is 96 inches. Belt conveyors are used to transport the coal from the mining units to the surface.

Core Natural Resources, Inc utilizes Jennmar Services as a contractor that supplies laborers to the Bailey Mine to perform a variety of services.

The principal management officials at the Bailey Mine at the time of the accident were:

Timothy Stevens	General Manager
Steve Barr	Superintendent
Benjamin Sibert	Mine Foreman
Michael Tennant	Manager of Safety

The Mine Safety and Health Administration (MSHA) completed the last regular safety and health inspection at this mine on March 31, 2026. A regular safety and health inspection was ongoing at the time of the accident; however, no MSHA personnel were on site at the time of the accident. The 2025 non-fatal days lost incident rate for the Bailey Mine was 1.72, compared to the national average of 3.89 for mines of this type.

DESCRIPTION OF THE ACCIDENT

Zachary Wolfe, assistant shift foreman, entered the mine at the Aleppo Portal for the afternoon shift at approximately 4:35 p.m. He traveled to the 15L tailgate section to check the section status. Wolfe then traveled to the 7 South Mains section and arrived at approximately 9:00 p.m. He walked to the left side of the section and met with Levi Durbin, section supervisor, to check the section status. Wolfe then walked to the right side of the 7 South Mains and met with Matt Pratt, section supervisor. Wolfe and Pratt walked to the 24 block No. 6-7 crosscut to evaluate the rib roll condition that had been recorded in the pre-shift examination book.

Deja Schultz, general inside contractor, and Zachary Rampero, general inside contractor, were working in the 24 block No. 6-7 crosscut off-loading supplies from supply cars using the No. 35 scoop. Schultz and Rampero were employed by Jennmar Services.

Pratt had instructed Rampero to clean the rib roll from the walkway earlier in the shift. According to interviews, Schultz and Rampero told Wolfe and Pratt the inby rib corner in the No. 6-7 crosscut had been taking weight and making noise during their shift. Pratt and Wolfe evaluated the rib and informed Schultz and Rampero that posts needed to be set to danger the area off. Wolfe said he would help get the posts set in the crosscut. Schultz and Rampero went to retrieve posts, cap blocks, and wedges to set in the area.

Wolfe, Schultz, and Rampero set the first post at the corner of the rib. Wolfe then instructed Pratt to retrieve a piece of rope to wrap around the perimeter of the posts once they were all set to barricade the area off. Wolfe, Schultz, and Rampero set the second post. Wolfe radioed David Camus, mine examiner, to inform him that the rib roll condition reported in the pre-shift examination book was corrected and could be recorded as such.

Wolfe and Rampero began installing the third post while Schultz handed them the cap blocks and wedges. Wolfe began driving the wedge above the third post when a large piece of rock fell from the rib and pinned him to the mine floor. Schultz and Rampero dove out of the way of the falling rock. Once the dust cleared, Schultz could see Wolfe underneath the fallen rock. Schultz checked Wolfe's pulse but did not detect one. Schultz immediately ran toward the 7 South Mains power center to find help. For further reference, a map of the accident location can be found in Appendix A.

Schultz encountered Pratt on the way to the power center and told him what happened. Pratt radioed James Peel, bunker attendant, and informed him of the accident. Peel called Harvey Livingood, tracking center operator, and informed him of the accident. Livingood called 911 at 9:59 p.m. Pratt proceeded to the accident scene and immediately radioed for help from the 7 South section crew members. Durbin and Rick Guy, section equipment operator and emergency

medical technician (EMT), responded to the accident scene. Guy checked for Wolfe's pulse but did not detect one. Other crew members from both 7 South Mains sections began arriving at the accident scene. Guy asked for a scoop operator to lift the rock pinning Wolfe because it was too large to move by hand. Jeff Hillberry, utility, operated the scoop that was being used to unload supplies. Guy directed Hillberry while he maneuvered the scoop under the rock to lift it. Crew members blocked the rock as it was being lifted by the scoop. After a few lifts by the scoop, the rock was raised high enough to remove Wolfe.

Crew members placed Wolfe on a backboard and carried him to a diesel personnel carrier located on the track. Guy used a stethoscope from the EMT kit to check for Wolfe's pulse but he did not detect one. Guy and other crew members rode with Wolfe in the personnel carrier to the portal bottom and transported Wolfe to the surface. Wolfe's care was transferred to Washington County Ambulance and Chair Service. Greene County, Pennsylvania Coroner Carl E. Rush also arrived at the mine site and pronounced Wolfe deceased at 11:39 p.m. on May 19, 2026.

INVESTIGATION OF THE ACCIDENT

On May 19, 2026, at 10:36 p.m., Peel called the Department of Labor National Contact Center (DOLNCC). The DOLNCC notified Larry Johnson, supervisory mine safety and health inspector. James Baker, assistant district manager, received an email notification of the accident and notified Michael Stark, staff assistant. Stark assigned Nicholas Blevins, mine safety and health specialist, as the lead investigator. Baker and Blevins traveled to the mine. Stark assigned Travis Hamrick, mine safety and health specialist, to assist in the investigation and he traveled to the mine.

Baker and Blevins arrived at the Aleppo Portal at 2:05 a.m. on May 20, 2026. Blevins 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. Hamrick arrived at 2:15 a.m. on May 20, 2026.

The MSHA accident investigation team together with the Pennsylvania Department of Environmental Protection – Bureau of Mine Safety conducted an examination of the accident scene, interviewed miners and mine management, and reviewed conditions and work procedures relevant to the accident. For reference, a list of persons who participated in the investigation can be found in Appendix B.

DISCUSSION

Location of the Accident

The accident occurred on the 7 South Mains section in the No. 6-7 crosscut at 24 block. This crosscut is adjacent to the track which is used to transport supplies to the 7 South Mains sections. This crosscut was mined in January 2026. The depth of cover at the accident location was approximately 1,060 feet and the mining height was 9 feet. For further reference, a map of the location of the accident can be found in Appendix C.

Geology

The mine floor is typically a firm shale, but where the accident occurred the mine floor was weaker and moisture sensitive. The bottom portion of the coal seam was left unmined as a barrier to the weak floor and to create solid roadways for equipment to operate on. The mine operator directed the crews to mine additional roof strata to maintain the entry height because of the unmined floor coal. The crosscut entry height was 9 feet. The rib strata consisted of 52 inches of coal, 10 inches of rock binder, 10 inches of rider seam coal, and 36 inches of shale. Mining the additional roof strata exposed more of the top layer of shale. Crosscuts in the east-west direction, such as the No. 6-7 crosscut, typically exhibited heavier sloughage of the coal caused by the cleat orientation. The sloughage of the coal can create an overhanging rock brow in the shale portion of the rib. The rock that pinned Wolfe fell from the top layer of shale and measured 96 inches long, 30 inches wide, and ranged from 18 to 26 inches thick. The approximate weight of the fallen material is 3 tons.

Approved Roof Control Plan

The approved Roof Control Plan (RCP) at the time of the accident required rib bolts to be installed when the depth of cover is greater than 700 feet and where the mining height is greater than 7 feet. The plan required a minimum of one 36-inch long rib bolt be installed no more than 10 feet apart during the active mining cycle. A variety of skin control components were also approved to be used in conjunction with the rib bolts. A 12-foot wide spacing tolerance was permitted after the initial rib bolting cycle to allow for damaged or loose rib bolts.

The rib support installed in the No. 6-7 crosscut was a mixture of 36-inch long and 48-inch long mechanically anchored rib bolts with an 18 by 18-inch pie pan, and a 6 by 6-inch metal bearing plate. The rib supports were installed on approximately 4-foot spacing, and each rib bolt was within 6 inches above or below the interface of the rider coal seam to the top layer of shale. The ventilation tubing was on this rib during initial mining. More of the top shale layer of the rib was exposed but the rib bolts could not be installed as high as they needed to be because of the ventilation tubing.

According to interviews, prior to the accident, several of the rib bolts in the area where the rib roll occurred were loose and not in contact with the rib due to sloughage. This location is outby the loading point and therefore no longer considered part of the active mining cycle. The mine operator was in compliance with the approved RCP; however, the location of the rib bolts was not adequate to control the mine rib. The investigation team determined the loose rib bolts and the lack of rib bolts installed in the upper shale layer of the rib contributed to the accident.

Examinations

A pre-shift examination of the 7 South Mains track was conducted on May 19, 2026, between 12:00 p.m. and 1:30 p.m. The examination documented a rib roll located on the 7 South track at 24 block along the walk side of the track. The investigation team determined the examination did not contribute to the accident.

Training and Experience
Wolfe had 13 years of mining experience, all at the Bailey Mine, and 2 years as the assistant shift foreman. Wolfe received annual refresher training on March 4, 2026. Investigators determined Wolfe received all training in accordance with MSHA Part 48 training regulations.

Schultz had 7 years and 7 months of mining experience, with the last 5 months at the Bailey Mine, all as a general inside contractor. Schultz received annual refresher training on July 2, 2025. Investigators determined Schultz received all training in accordance with MSHA Part 48 training regulations.

Rampero had 5 months of mining experience, all at the Bailey Mine, and all as a general inside contractor. Rampero received 80-hour new miner training on December 4, 2025. Investigators determined Rampero 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 accident occurred because there were inadequate policies and procedures in place to support or otherwise control the mine ribs where miners work or travel.

Corrective Action: The mine operator developed and implemented the following action plan for rib bolting procedures on development. The action plan was approved.

Primary rib bolts installed during the initial mining cycle when using full face continuous mining machine with integral bolters:

1. The spacing of rib bolts will not exceed 5 feet horizontally during the active mining cycle. One of the following options shall be used:

    a. Two 48-inch (minimum) length rib bolts in conjunction with pie pans, mini monster mats, or equivalent, installed vertically. The upper bolt will be installed in the upper third of the entry or place being mined. The lower bolt will be in the upper half of the entry or place being mined.

    b. Two 48-inch (minimum) in length rib bolts in conjunction with a minimum 48-inch length T3 Channel (with 2 holes) or equivalent. The channel will extend into the upper third of the entry or place being mined. If necessary, the upper bolt may be installed during the secondary mining cycle.

2. Provisions in the current approved roof control plan shall remain in effect.

3. The more rigid GMS pie pans shall be used in the 7 South Mains Right and Left Sections.

The mine operator has trained all miners in the action plan procedures. This training will also be provided for newly hired employees and during annual refresher training for all miners.

CONCLUSION

On May 19, 2026, at 9:50 p.m., Zachary Wolfe, a 34-year-old assistant shift foreman with 13 years of mining experience, died when a large section of rib fell and pinned him to the mine floor.

The accident occurred because there were inadequate policies and procedures in place to support or otherwise control the mine ribs where miners work or travel.

Approved By:

_____ _____

Carlos Mosley — Date
District Manager

ENFORCEMENT ACTIONS

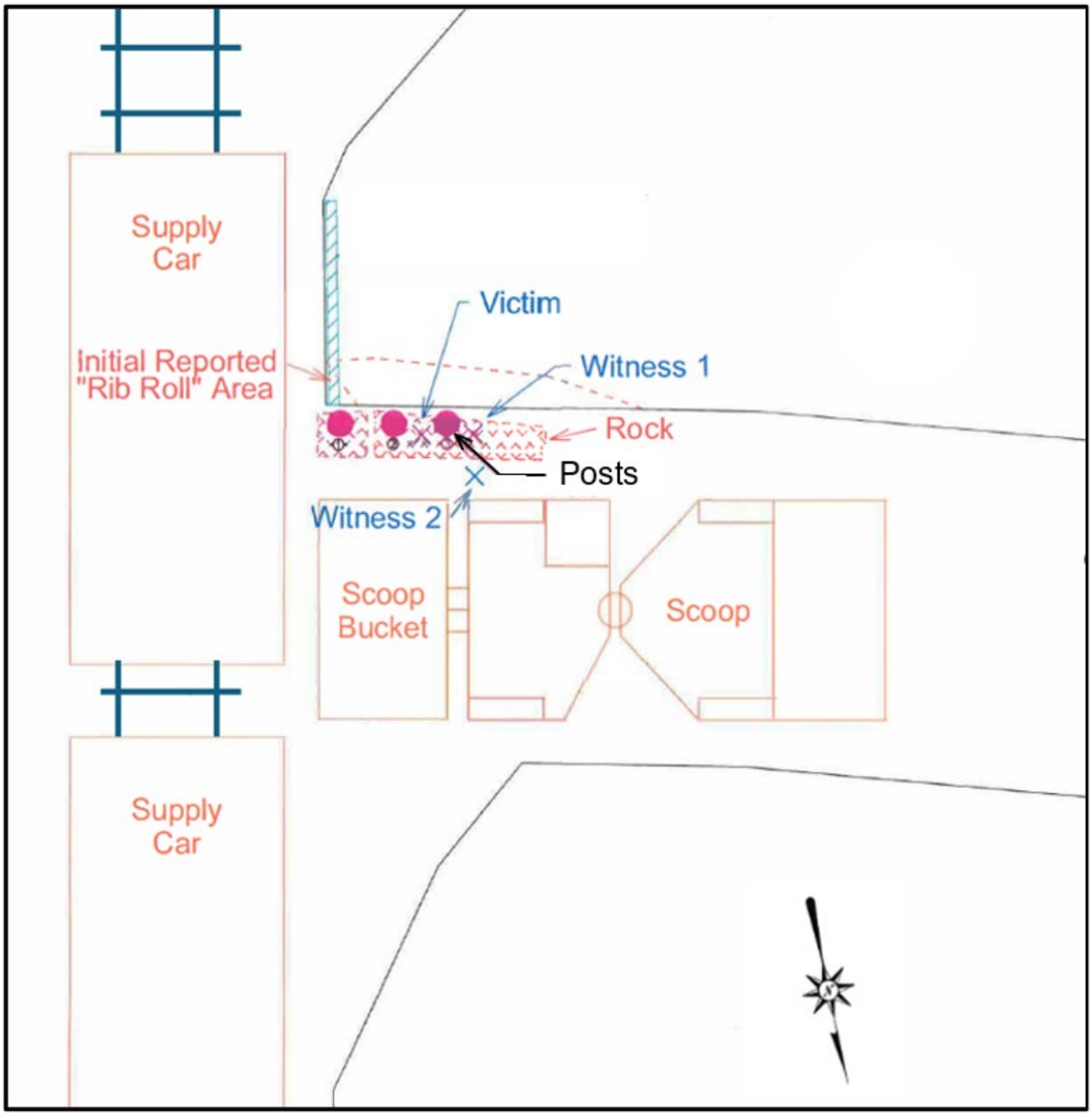
1. A 103(k) order was issued to Consol Pennsylvania Coal Company LLC.

   A fatal accident occurred on May 19, 2026, at approximately 9:45 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 Consol Pennsylvania Coal Company LLC under the provisions of 30 CFR 75.202(a).

   The operator did not adequately support or otherwise control the mine rib in the No. 6-7 crosscut at 24 block in 7 South Mains. On May 19, 2026, an assistant shift foreman was fatally injured when a large section of rib fell out and pinned him to the mine floor. The victim and two contractors were in the process of setting posts to barricade off the area to prevent travel along the rib line. The barricade was being constructed as a corrective action to a hazard noted in the pre-shift book on the previous shift. The size of the rock measured 96 inches long, 30 inches wide, and ranged from 18 to 26 inches thick.

APPENDIX A – Map of the Accident Location



The posts (pink) were set left to right.

APPENDIX B – Persons Participating in the Investigation

Consol Pennsylvania Coal Company LLC

Joshua Koontz	Vice President of Operations
Todd Moore	Vice President of Safety
Michael Tennant	Manager of Safety
Scott Watson	Manager of Risk Management
Gaven Verbosky	Manager of Safety (Enlow Fork Mine)
Timothy Stevens	General Manager
Steve Barr	Superintendent
Ben Sibert	Mine Foreman
Brett Hixson	Mine Engineer
Johnathan Chmelik	Assistant Mine Engineer
Levi Durbin	Section Supervisor
Matt Pratt	Section Supervisor
David Camus	Mine Examiner
David Duplinksy	Mine Examiner
Rick Guy	Section Equipment Operator/EMT
Jeff Hillberry	Utility
Deja Schultz	General Inside Contractor (Jennmar)
Zachary Rampero	General Inside Contractor (Jennmar)

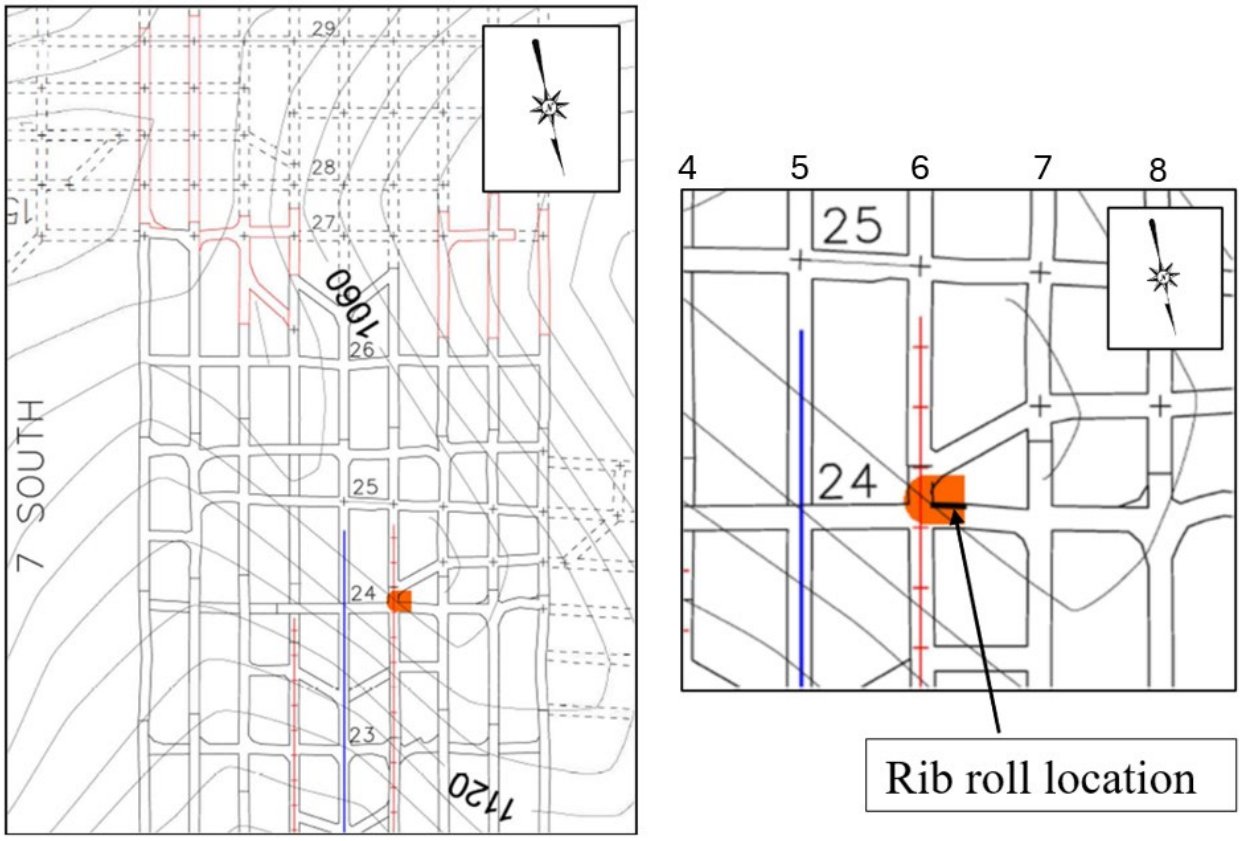
Pennsylvania Department of Environmental Protection – Bureau of Mine Safety

Bradley Russian	Bituminous Program Manager
Michael Hess	Bituminous Underground Mine Inspector Supervisor
Mathia Mooney	Bituminous Mine Inspector
Dale Piper	Bituminous Mine Inspector

Mine Safety and Health Administration

James Baker	Assistant District Manager
Michael Stark	Staff Assistant
Nicholas Blevins	Mine Safety and Health Specialist
Travis Hamrick	Mine Safety and Health Specialist
Allan Jack	Mine Safety and Health Specialist
Christopher Mark	Principal Roof Control Specialist
Christopher Snyder	Supervisory General Engineer
Clifford Nelson	Geologist

APPENDIX C – Location of Accident



The depth of cover in the orange highlighted area was approximately 1,060 ft.