From: sch4p4(6) Personal information @bhpbilliton.com]
Sent: Monday, 9 July 2018 5:51 PM
To: BRENNAN Keith; DL-COL-BMA-PDM-Mine Record Administration; sch4p4(6) Personal information
sch4p4(6) Personal ir
CC: sch4p4(6) Personal information
Subject: Notice of Confirmation of HPI
Attachments: Notice of Confirmation to Mines Inspecor and ISHR of HPI or Serious Accident.pdf

Hi Keith,

Please find attached written notice of a High Potential Incident that we incurred this morning in our 2S pit.

Should any additional information be required please contact me on sch4p4(6) Persona

Regards,
sch4p4(6) Personal infor

Coal Mining and Post-Strip Superintendent

BHP Billiton Mitsubishi Alliance
Peak Downs Mine | Private Mail Bag | Moranbah Q 4744 | Australia
Phone: +61 07 sch4p4(6) Pl Mobile: sch4p4(6) Persona
Email: sch4p4(6) Persona@bhpbilliton.com

NOTICE OF CONFIRMATION TO THE MINES INSPECTORATE OF A COAL MINE HIGH POTENTIAL INCIDENT, SERIOUS ACCIDENT OR DISEASE

MINE: PEAK DOWNS MINE	**DATE** 9/07/2018

This notice* is made by or on behalf of the SSE primarily** pursuant to section 198(4) or (5) of the CMSHA to confirm the initial oral report to an inspector and an ISHR. It is also used to report prescribed diseases pursuant to section 198(6) of the CMSHA.

NOTE: * Notice required within 48 hours or 24 hours in the case of a fatality: ** Also serves to report "Non-Reportable Incidents"

SECTION 1 INITIAL ORAL REPORT

Made By sch4p4(6) Personal i	**Company Position** sch4p4(6) Personal information		**Phone** sch4p4(6) Pers
Made To Keith Brennan	**Time 07:40am**	**Date** 9/07/2018	
Made To sch4p4(6) Per	**Time 08:31am**	**Date** 9/07/2018	
Made To sch4p4(6) Perso	**Time 08:23am**	**Date** 9/07/2018	

SECTION 2 SERIOUS ACCIDENT

Is this a SERIOUS ACCIDENT:	NO	
NOTE 1	Act s16: A SERIOUS ACCIDENT is one that causes (a) death or (b) a person to be admitted to hospital as an in-patient for treatment of the injury. Also by definition it is a HPI	
NOTE 2	While not included in the definition of SERIOUS ACCIDENT, Act s198 (2) (iii) requires immediate notification of an accident "that causes a person to suffer an injury, causing or likely to cause, a permanent injury to a person's safety or health". (This is also a HPI as defined by Act s.17)	
NOTE 3	Schedule 9 of the Regulation defines SERIOUS BODILY INJURY as an "injury endangering, or likely to endanger, life or causing, or likely to cause, a permanent injury to health" of a person.	

SECTION 3 PRESCRIBED HPI TYPE BEING REPORTED

SCHEDULE 1C Act 198(2b)	10m The unplanned immersion of a person in liquid that endangers the safety and health of a person	
SCHEDULE 2 Part 1 Act 200(1)	Choose an item.	**Must not interfere with site without inspectorate permission**
SCHEDULE 2 Part 2 Act 201(1c)	Choose an item.	**Investigation Report to an inspector within 1 month.**
NOTE 1	Some HPI types in Schedule 1C also qualify as types in Schedule 2, Part 1 and/or Part 2. See details on reverse of this form	

SECTION 4 NON PRESCRIBED HPI OR NON REPORTABLE INCIDENT NRI

NON PRESCRIBED HPI ☐	Where a "match" cannot be made to the Schedule 1C but the event is a HPI as defined by CMSHA section 17
NON REPORTABLE INCIDENT (NRI) ☐	Where the incident is significant and has a safety "message" to share with industry
NOTE	Act s17 HPI "an event, or a series of events, that causes or has the potential to cause a significant adverse effect on the safety or health of a person"

SECTION 5 REPORTABLE DISEASE SCHEDULE 1

Chronic obstructive pulmonary disease	☐	Coal workers' pneumoconiosis	☐	Legionellosis	☐	Silicosis	☐	Other
NOTE 1	**To be reportable, the disease must have been contracted by a current or former coal mine worker who was exposed to dust/agent and has had the diagnosis confirmed by a nominated medical adviser or another doctor**							
NOTE 2 Tick relevant box above (no further disease information is required on this form)								

SECTION 6 DETAILS OF THE EVENT

NOTE Information provided in this section includes the "Primary Information" required by s.198(3) of the Act

CONCISE DESCRIPTION OF THE NATURE OF THE EVENT
(put all other information in the "Other information/details" field below)

An operator in dozer 369 had been pushing up coal in shallow water at a depth of up to 700mm. The operator reversed into a void causing the right hand track to drop. The dozer has come to rest at approximately a 45 degree angle and water has entered the cab. The operator required assistance to exit the cab. In the process of exiting the dozer, the operator has sustained a minor laceration to their hand.

DATE: 9/07/2018	**TIME 05:30am**	**LOCATION:** 2 South Pit floor

PDM FRM Notice of Confirmation to the Mines Inspector and Industry Safety & Health Representative of High Potential Incident or Serious Accident

EQUIPMENT INVOLVED: Cat D11 Dozer			**DAMAGE:** Immersed in water			
ENVIRONMENTAL CONDITIONS	Light ☐	Dark ☒	Sunny ☐	Wet ☐	Dry ☒	Windy ☐
PERSONS INVOLVED	Number 1	Employee ☒	Contractor ☐	Labour Hire ☐	Visitor ☐	
NAME(S) OF DECEASED			**TYPE DEATH**	NATURAL ☐	ACCIDENT ☐	

NAME(S) OF PERSONS INJURED	**INJURIES**	**EMPLOYER *(Contractor where applicable)***
	Wayne McNamara	BMA Coal

NAMES OF ANYONE WHO SAW THE INCIDENT OR WERE PRESENT AT THE TIME AND IF NO WITNESSES, NAME OF PERSON FINDING THE INCIDENT	**NAME**	**EMPLOYER *(Contractor where applicable)***
	sch4p4(6) Pers sch4p4(6) Person	BMA Coal BMA Coal

OTHER INFORMATION/DETAIL

From: sch4p4(6) Personal information
Sent: Tuesday, 14 August 2018 4:47 PM
To: BRENNAN Keith
CC sch4p4(6) Personal information
Subject: Investigation Report into HPI on 09/07/2018
Attachments: ICAM Final Actions - HPI Dozer 9th July 2018.pdf; ICAM Report - Operator and Dozer Inundated with Water.pdf

Keith,

As we discussed last week, attached is the final ICAM report into the dozer incident that occurred on 9th July 2018. As I mentioned we utilised people external to Peak Downs to conduct the investigation, hence the slight delay in the report.

I've also attached the list of actions generated from the investigation. We have also shared these findings & actions widely within BHP to ensure other sites look at their processes & systems for managing pit water.

Again, if you have any questions please contact myself.

Thanks,

sch4p4(6) Personal ir
Manager Production Coal

BHP Billiton Mitsubishi Alliance
Peak Downs Mine, Moranbah Qld 4744, Australia
Phone: +61 7 sch4p4(6) P | Mobile: sch4p4(6) Person
Email: sch4p4(6) Personal information

Creating a flexible workplace is a priority for us at BHP Billiton. If you receive this email outside of your work hours, please feel free to respond when you are back online.

	ACTION	OWNER	DUE
1	Implement immediate controls of mining activities until investigation & actions completed: - No mining activities shall be undertaken in water. - Trenching shall not exceed the immediate process, i.e. trench to bottom of coal, not through parting or multiple seams. - Reinforce requirements for delineation of sumps / trenches. - Additional safety field leadership focus on current pits with dewatering trenches.	Coal Manager	COMPLETE
2	Develop a procedure or SWI that sets out the accountabilities for water management throughout the process from mine planning through execution. Consider documenting via swim-lane flow chart or RACI approach.	Coal Manager	12/10/2018
3	Review, supported by Risk Assessment (RA), the requirements for working and mining around water of any depth. Include as minimum: demarcation requirements, definitions, communication approaches. Include, or consider the use of a Trigger Action Response Plan (TARP) to ensure an escalation of hazard management controls when working around water of any depth. Specifically address the hazard of equipment cab's becoming submerged. Support implementation of changes via Management of Change (MoC).	Coal Manager Overburden Manager	26/10/2018
4	Develop a method to link SWI's to the Coal Mine Workers (CMW's) Learning Management System (LMS) profiles.	Site Systems Superintendent	30/11/2018
5	Ensure all Asset Level Document (ALD) mandated SWI's are tracked for competence/familiarisation in LMS.	Coal Manager Overburden Manager	30/08/2019
6	Review the fatal risk performance standard for 'working in & around water' to include the verification of mining operations.	Coal Manager	26/10/2018
7	Develop and execute layered audits to assess the integrity of the shift to shift handover process within each operating department. Include both the supervisor and operator handover processes. Evaluate the effectiveness of handovers with respect to workplace hazards, interacting activities, compliance to plan, etc.	Coal Manager Overburden Manager Maintenance Manager	9/11/2018
8	Review available options to assist an operator in making an escape from a submerged or partially submerged dozer. Evaluate and recommend any further actions in consultation with the Manager Production Coal.	Engineering Manager	30/11/2018

From: BARBA Bria [Bria.Barba@dnrme.qld.gov.au]
Sent: Monday, 20 August 2018 10:42 AM
To: BRENNAN Keith
Subject: FW: Completed Mining incident report No. 139916 (30 - High potential no lost time [nmsf: 35])

For your information
Thanks
Bria

From: MIR-Administration
Sent: Thursday, 16 August 2018 4:41 PM
To: MIR-Administration <MIR-Administration@dnrme.qld.gov.au>; MIR-Mackay <MIRMackay@dnrme.qld.gov.au>; sch4p4(6) Pe sch4 @bhpbilliton.com
Subject: Completed Mining incident report No. 139916 (30 - High potential no lost time [nmsf: 35])

Type of incident

Incident report number: 139916

Recipients: sch4p4(6) Perso @bhpbilliton.com **and** miradministration@dnrm.qld.gov.au

1 **Incident type:** 30 - High potential no lost time [nmsf: 35]

Medical Treatment injury: No

2 **Summary/title of incident**

An operator in dozer 369 had been pushing up coal in shallow water at a depth of up to 700mm. The operator reversed into a void causing the right hand track to drop. The dozer has come to rest at approximately a 45 degree angle and water has entered the cab. The operator required assistance to exit the cab. In the process of exiting the dozer, the operator has sustained a minor laceration to their hand

Incident Classification:	**Code:** 116 - Truck/mobile equipment - NOC (not otherwise classified) [nmsf: 3838]
Breakdown:	**Code:** Mobile plant and transport [nmsf: 2837]
Sub-Breakdown:	**Code:** Self-propelled plant [nmsf: 2854]
Breakdown Class:	**Code:** Graders, dozers, snowploughs, other scraping plant [nmsf:

2952]

Detailed Classification:

Code: Graders, dozers, snowploughs, other scraping plant [nmsf: 3360]

Compensation ID: 999999

Mechanism:

Code: Vehicle incidents and other [nmsf: 2793]

Sub-Mechanism:

Code: Other and multiple mechanisms of incident [nmsf: 2834]

3 **Previously notified:** Yes

Date: 09/07/2018

Mine details

4 **Mine/quarry name** Peak Downs

Code: M01190 **Old Code:**

5 **Mine type:** coalSurface

6 **Company contact:** sch4p4(6) Personal inform

Phone: sch4p4(6) Personal

7 **Where in the mine did the incident occur?** 2 South Pit

Code: 104 - Open cut - pit/excavation-mining [nmsf: 9996]

Surface or underground? surface

Incident details

8 **Date of incident:** 09/07/2018

9 **Time of incident:** 05 38 (24 hr clock)

10 **Time shift started:** 18 30

Shift duration: 12 30

No. of complete shifts/day worked prior to accident: 3

No. of days in shift cycle: 12

No. of days rostered off prior to starting current shift cycle: 6

Total hrs worked in 24 hr period prior to accident, inc travel time: 12,5

Travel Time: 01 00

Rostered Travel Time: 00 00

Roster Pattern: 0

11 Date of first full working day lost:

12 Primary equipment/tool involved in incident: Dozer 369

Code: 001 - Dozer-tracked [nmsf: 3848]

13 Describe exactly how did the incident occur:

An operator in dozer 369 had been pushing up coal in shallow water to the face of Excavator 51 in 2 South when the operator reversed into a void causing the right hand track to drop. The dozer has come to rest at approximately a 45 degree angle and water has entered the cab. The operator required assistance to exit the cab. In the process of exiting the dozer, the operator has sustained a minor laceration to their hand.

14 What hazards have been identified from this incident:

Drowning risks are not confined to traditional water body activities, they also apply to in-pit mining activities specifically those that are related to trenching and sumps (including what is considered a 'shallow' water body), and risk assessment and risk management should be applied to these scenarios. It is necessary to consider all possible scenarios on sites for hazards and utilise learning's from outside our business within industry. Comprehensive handovers to adequately communicate safety hazards and risks are of critical importance, with the handover understood and a plan is in place to manage any high risk work. There must be a discipline and rigour in the review and management of documented processes where management of key hazards and controls are communicated.

Code: 119 - Inundation

Injured person details

15-21 Questions 15 through 22 not required for 'High potential no lost time' incidents

23 Description of personal damage:

Is this a permanent incapacity? No

Incident causes

24 What happened leading up to the injury/incident/disease?

Organisational

Codes 109 - Procedures; 110 - Training

1)A lack of clear guidelines for the requirements and accountabilities of water management. 2)No clearly communicated standard for response and control for operating (e.g. mining) in water. 3) The process of development, monitoring and review of mining Standard Work Instructions (SWI's) which related to trenching within the SHMS was not adhered to 4) No effective risk assessment for the hazard associated with working in & around water for mining activities 5) A handover process which has allowed variability in quality & inability to verify effectiveness

Task/environment conditions

Codes 322 - No task/environment

		factor involved
NIL		
Individual/team actions	**Codes**	222 - No ind./team factor involved
NIL		
Absent or failed defences	**Codes**	420 - Absent/failed defence factor(not specified)
1) there was no demarcation or barrier for the hazard to prevent injury. 2) No awareness of the hazard by the oncoming operators. 3) There was no method for self-escape present in the dozer.		

Preventative action

25 Give details of any control measures/actions being considered and/or implemented to prevent recurrences

1) Implement immediate controls of mining activities until investigation & actions completed: - No mining activities shall be undertaken in water. - Trenching shall not exceed the immediate process, i.e. trench to bottom of coal, not through parting or multiple seams. - Reinforce requirements for delineation of sumps / trenches. - Additional safety field leadership focus on current pits with dewatering trenches. 2) Develop a procedure or SWI that sets out the accountabilities for water management throughout the process from mine planning through execution. Consider documenting via swim-lane flow chart or RACI approach. 3) Review, supported by Risk Assessment (RA), the requirements for working and mining around water of any depth. Include as minimum: demarcation requirements, definitions, communication approaches. Include, or consider the use of a Trigger Action Response Plan (TARP) to ensure an escalation of hazard management controls when working around water of any depth. Specifically address the hazard of equipment cab's becoming submerged. Support implementation of changes via Management of Change (MoC). 4) Develop a method to link SWI's to the Coal Mine Workers (CMW's) Learning Management System (LMS) profiles. 5) Ensure all Asset Level Document (ALD) mandated SWI's are tracked for competence/familiarisation in LMS. 6) Review the fatal risk performance standard for 'working in & around water' to include the verification of mining operations. 7) Develop and execute layered audits to assess the integrity of the shift to shift handover process within each operating department. Include both the supervisor and operator handover processes. Evaluate the effectiveness of handovers with respect to workplace hazards, interacting activities, compliance to plan, etc. 8) Review available options to assist an operator in making an escape from a submerged or partially submerged dozer. Evaluate and recommend any further actions in consultation with the Manager Production Coal.

Date: 16/08/2018

Your full name: sch4p4(6) Personal

Position: Specialist Site Systems

Email: sch4p4(6) Perso@bhpbilliton.com

Office use

Inspector/inspection officer: _____

Signed: _____

Entered by: _____

User IP address: sch4p4(6) Personal ii

User agent: Mozilla/5.0 (Windows NT 6.1; WOW64; Trident/7.0; rv:11.0) like Gecko

Email address: sch4p4(6) Personal @bhpbilliton.com

Submitted Date/Time: 16/08/2018 13:13:05

Queensland Government

Incident Notification

(Mines Inspectorate)

Mine Name	Peak Downs
Operator Name	B M Alliance Coal Operations Pty Ltd
Mine Type	Coal Mine - Surface
Mine Region	Central Region
Mine Office	Mackay Office
Mine File No	1,718

NOTIFICATION DETAILS

Notifier's Name	sch4p4(6) Persona
Notifier's Position/Title	SSE
Notifier's Contact Number	sch4p4(6) Perso
Notification Received on	09/07/2018 at 08:00 AM
Notification Received By	Keith Brennan
Entered By	Keith Brennan on 09/07/2018

INCIDENT DETAILS

Incident Date & Time	09/07/2018 05:45 AM
Location (Section/area)	Ramp 2 South
Equipment Involved	CAT D11 Dozer
Concise Description	Dozer Submersed. Dozer 369 was pushing up coal for digger. a Body of water 30 metres wide and believed to be 1.5 metres deep. The dozer dropped into an unknown area of excavation. Operator had water up to the chest. Was recovered by another operator who walked through water. Dozer was on an angle of 45*.
Other details	Working near a body of water procedure not followed, excavation depth unknown to operators.
Incident Classification	Mechanical

Other Inspectorates to be notified

INJURIES

Injuries - Person(s) Involved 0

FATALITIES

Fatalities - Person(s) Involved 0

RESPONSE

Actions Taken By Mine / Operator

Instructions or advice given to Mine / Operation

INCIDENT CATEGORY

Event Type High Potential Incident

Incident Category The unplanned immersion of a person in liquid if it endangers the safety or health of a person

☒ Oral Report confirmed by notice within 48 hours	11/07/2018	9/07/2018 6:00:00 PM
☒ Notify an Inspector as soon as possible	09/07/2018	9/07/2018 8:00:00 AM

INCIDENT FOLLOW-UP

Officer allocated to investigate and/or follow-up reports Keith Brennan

Oral confirmatory report received

Written report received

External DB Accident ID (LTAD) 140013

IR Summary Title An operator in dozer 369 had been pushing up coal in shallow water at a depth of up to 700mm. The operator reversed into a void causing the right hand track to drop. The dozer has come to rest at approximately a 45 degree angle and water has entered the cab. The operator required assistance to exit the cab. In the process of exiting the dozer, the operator has sustained a minor laceration to their hand

Incident Date 09/07/2018

Processed Date (MIR Web Site submission processed) 28/08/2018 03:34:56 PM

Mine Namel Peak Downs

Incident Type High potential lost time

Injured Person(s)	Wayne McNamara
Organisational	1)A lack of clear guidelines for the requirements and accountabilities of water management. 2)No clearly communicated standard for response and control for operating (e.g. mining) in water. 3) The process of development, monitoring and review of mining Standard Work Instructions (SWIs) which related to trenching within the SHMS was not adhered to 4) No effective risk assessment for the hazard associated with working in & around water for mining activities 5) A handover process which has allowed variability in quality & inability to verify effectiveness
Task / Environmental Conditions	NIL
Individual / Team Actions	NIL
Absent / Failed Defences	1) there was no demarcation or barrier for the hazard to prevent injury. 2) No awareness of the hazard by the oncoming operators. 3) There was no method for self-escape present in the dozer.
Preventative Action	1) Implement immediate controls of mining activities until investigation & actions completed: - No mining activities shall be undertaken in water. - Trenching shall not exceed the immediate process, i.e. trench to bottom of coal, not through parting or multiple seams. - Reinforce requirements for delineation of sumps / trenches. - Additional safety field leadership focus on current pits with dewatering trenches. 2) Develop a procedure or SWI that sets out the accountabilities for water management throughout the process from mine planning through execution. Consider documenting via swim-lane flow chart or RACI approach. 3) Review, supported by Risk Assessment (RA), the requirements for working and mining around water of any depth. Include as minimum: demarcation requirements, definitions, communication approaches. Include, or consider the use of a Trigger Action Response Plan (TARP) to ensure an escalation of hazard management controls when working around water of any depth. Specifically address the hazard of equipment cabs becoming submerged. Support implementation of changes via Management of Change (MoC). 4) Develop a method to link SWIs to the Coal Mine Workers (CMWs) Learning Management System (LMS) profiles. 5) Ensure all Asset Level Document (ALD) mandated SWIs are tracked for competence/familiarisation in LMS. 6) Review the fatal risk performance standard for working in & around water to include the verification of mining operations. 7) Develop and execute layered audits to assess the integrity of the shift to shift handover process within each operating department. Include both the supervisor and operator handover processes. Evaluate the effectiveness of handovers with respect to workplace hazards, interacting activities, compliance to plan, etc. 8) Review available options to assist an operator in making an escape from a submerged or partially submerged dozer. Evaluate and recommend any further actions in consultation with the Manager Production Coal.

DETAILS OF PERSONS ADVISED

EMAILED

Emailed To	Comment	Emailed Date	Emailed Time
sch4p4(6) Personal in		09/07/2018	08:25 AM

sch4p4(6) Pers

ORALLY (if any)

Notified	Comment	Date	Time

Form 5A - Queensland mining industry incident report form

Processed By Agent: 28/08/2018

Incident Report Date/Time: 28/08/2018

Incident Report Number: 140013

Type of Incident		Code	Code Description
1 **Incident Type:**	High potential lost time	20	
Medical Treatment injury:	○ Yes ● No		
2 **Summary/title of incident:**	An operator in dozer 369 had been pushing up coal in shallow water at a depth of up to 700mm. The operator reversed into a void causing the right hand track to drop. The dozer has come to rest at approximately a 45 degree angle and water has entered the cab. The operator required assistance to exit the cab. In the process of exiting the dozer, the operator has sustained a minor laceration to their hand		
Incident Classification:	Truck/Mobile Equipment NOC (not otherwise classified)	116	Truck/mobile equipment - NOC (not otherwise classified)
Breakdown:	MOBILE PLANT AND TRANSPORT		
Sub-Breakdown:	Self-propelled plant		
Breakdown Class:	Graders, dozers, snowploughs, other scraping plant		
Detailed Classification:	Graders, dozers, snowploughs, other scraping plant		
Mechanism:	VEHICLE INCIDENTS AND OTHER		
Sub-Mechanism:	Other and multiple mechanisms of incident		
3 **Previously Notified:**	● Yes ○ No		
Date: (Previously Notified)	09/07/2018		

Mine Details		Code	Code Description
4 **Mine/quarry name**	Peak Downs	M01190	
5 **Mine Type**	coalSurface		

6	**Company contact**	sch4p4(6) Personal ir		
	Phone	sch4p4(6) Pers		
7	**Where in the mine did the incident occur?**	2 South Pit	104	Open cut - pit/excavation-mining
	Surface or underground?	surface		

Incident Details		Code	Code Description
8	**Date of Incident:**	09/07/2018	
9	**Time of Incident:** (24 hour clock)	05:38	
10	**Time shift started:** (24 hour clock)	18:30	
	Shift Duration: (24 hour clock)	12:30	
	No. of complete shifts/day worked prior to accident:	3 days	
	No. of days in shift cycle:	12 days	
	No. of days rostered off prior to starting current shift cycle:	6 days	
	Total hours worked in 24 hr period prior to accident, inc travel time:	12,5 hours	
	Travel Time:	01:00 hh:mm	
	Rostered Travel Time:	00:00 hh:mm	
	Rostered Pattern:	6/6	
11	**Date of first full working day lost:**	10/07/2018	
12	**Primary equipment/tool involved in incident:**	Dozer 369	001 Dozer-tracked
13	**Describe exactly how did the incident occur:**	An operator in dozer 369 had been pushing up coal in shallow water to the face of Excavator 51 in 2 South when the operator reversed into a void causing the right hand track to drop. The dozer has come to rest at approximately a 45 degree angle and water has entered the cab. The operator required assistance to exit the cab. In the process of exiting the dozer, the operator has sustained a minor laceration to their hand.	
14	**What hazards have been identified from this incident:**	Drowning risks are not confined to traditional water body activities, they also apply to in-pit	119 Inundation

	mining activities specifically those that are related to trenching and sumps (including what is considered a shallow water body), and risk assessment and risk management should be applied to these scenarios. It is necessary to consider all possible scenarios on sites for hazards and utilise learning's from outside our business within industry. Comprehensive handovers to adequately communicate safety hazards and risks are of critical importance, with the handover understood and a plan is in place to manage any high risk work. There must be a discipline and rigour in the review and management of documented processes where management of key hazards and controls are communicated.		

Injured Person Details		Code	Code Description
15 **Surname**	McNamara		
16 **Date of Birth**	08/09/1955		
17 **First name and initial**	Wayne		
18 **Gender**	Male		
19 **Employee Number**	20002630		
20 **Work activity at time of incident**	Dozer Operator	40	Earthmoving plant operator (general)
21 **Type of employee**	Full time		
If contractor, company name			
22 **Nature of injury/disease**			
Body location	Systemic locations		
23 **Description of personal damage**	Post traumatic hypertension		
Is this a permanent incapacity?	No		

Incident Causes		Code	Code Description
24 **What happened leading up to the injury/incident/disease?**			
Organisational	1)A lack of clear guidelines for the requirements and accountabilities of water management. 2)No clearly communicated standard for response and control for operating (e.g. mining) in water. 3) The process of development, monitoring and review of mining Standard Work Instructions	109	Procedures

	(SWIs) which related to trenching within the SHMS was not adhered to 4) No effective risk assessment for the hazard associated with working in & around water for mining activities 5) A handover process which has allowed variability in quality & inability to verify effectiveness		
		110	Training
Task/environmental conditions	NIL	322	No task/environment factor involved
Individual/team actions	NIL	222	No ind./team factor involved
Absent or failed defences	1) there was no demarcation or barrier for the hazard to prevent injury. 2) No awareness of the hazard by the oncoming operators. 3) There was no method for self-escape present in the dozer.	420	Absent/failed defence factor(not specified)

Preventative Action

25	**Give details of any control measures/actions being considered and/or implemented to prevent reocurence**	1) Implement immediate controls of mining activities until investigation & actions completed: - No mining activities shall be undertaken in water. - Trenching shall not exceed the immediate process, i.e. trench to bottom of coal, not through parting or multiple seams. - Reinforce requirements for delineation of sumps / trenches. - Additional safety field leadership focus on current pits with dewatering trenches. 2) Develop a procedure or SWI that sets out the accountabilities for water management throughout the process from mine planning through execution. Consider documenting via swim-lane flow chart or RACI approach. 3) Review, supported by Risk Assessment (RA), the requirements for working and mining around water of any depth. Include as minimum: demarcation requirements, definitions,

communication approaches. Include, or consider the use of a Trigger Action Response Plan (TARP) to ensure an escalation of hazard management controls when working around water of any depth. Specifically address the hazard of equipment cabs becoming submerged. Support implementation of changes via Management of Change (MoC). 4) Develop a method to link SWIs to the Coal Mine Workers (CMWs) Learning Management System (LMS) profiles. 5) Ensure all Asset Level Document (ALD) mandated SWIs are tracked for competence/familiarisation in LMS. 6) Review the fatal risk performance standard for working in & around water to include the verification of mining operations. 7) Develop and execute layered audits to assess the integrity of the shift to shift handover process within each operating department. Include both the supervisor and operator handover processes. Evaluate the effectiveness of handovers with respect to workplace hazards, interacting activities, compliance to plan, etc. 8) Review available options to assist an operator in making an escape from a submerged or partially submerged dozer. Evaluate and recommend any further actions in consultation with the Manager Production Coal.

Submitter Details

Date	28/08/2018
Your Full Name	sch4p4(6) Perso
Position	Site Systems
Email	sch4p4(6) Pe@bhpbilliton.com