



LEARNING FROM INCIDENTS

INVESTIGATION REPORT

GRASSTREE MINE

Metallurgical Coal

Incident Number: IN.00219432

Classification: High Potential Incident

Incident Title: >2.5% CH4 LW808 #197

Incident Date: 22/02/20

Report Date: 22/02/20

Learning from Incidents Investigation Report

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1 EXECUTIVE SUMMARY

During a routine production shift, a methane concentration of >2.5% was detected at the "0m TG Sensor" on chock #197 (Note: Power was removed from the face at 2% as designed). The ERZ Controller attended the area and erected brattice sails on chocks to purge the methane from the sensor area.

The investigation found the following:

- The monitor was a new installation designed to comply with Section 243A of the Coal Mine Safety and Health Regulation Amendment 2019. This sensor was installed on 06/03/20.
- A trip of >2% had previously been recorded on this sensor on 07/02/2020, a day after its commissioning.
- A routine ventilation change (VC20015) was affected in the Longwall tailgate during a planned maintenance window on 20/02/2020, earlier than normal due to the production sequence. This may have contributed to a lower pressure on the goaf, potentially allowing the fringe to encroach on the face.
- On two occasions CH₄ concentrations >2% methane concentrations had been detected at '0m TG Sensor' between the 20/02/2020 and the time of the incident.
- The position of the sensor is such that it has a high likelihood of detecting localised methane and layering (high on canopy and at Tailgate of longwall).
- A short production stoppage occurred prior to the event (for picking) that may have resulted in gas accumulation in the goaf.
- This accumulation was disturbed by the reduction in cross sectional area in the Tailgate caused by the presence of the shearer during cutting. This forced the accumulation into the area of the '0m TG Sensor'. NOTE: The panline and chocks had not commenced their advance cycle at the time of the event.
- The goaf drainage plant was operating normally at the time of the incident
- Trending indicates that other sensors (including the tailgate drive sensors) did not trend in a similar manner to the '0m TG Sensor', indicating the methane concentration was localised.
- Chock #197 was reported as being ~200-300mm higher than the adjacent chock owing to the tailgate roadway height, which further increased the likelihood of detection of methane at the '0m TG Sensor'.
- The ERZ Controller effectively dispersed the methane from the area with a brattice sail.

2 INVESTIGATION TEAM MEMBERS

S Stingle– ERZ Controller LW808

M Sellings – Shearer Driver (CMW)

Braedon Smith – Ventilation Officer

3 KEY WITNESSES

List of Key Witnesses	
Name	Designation
S Stingle	ERZ Controller – LW808
M Sellings	Shearer Driver (CMW)

4 METHODOLOGY AND TOOLS USED

An investigation has been conducted in accordance with the Anglo American investigation methodology known as the Learning from Incidents model, supported by various investigative and analytical tools.

The analysis tools used for this investigation are:

Analysis Tool	Attached as Appendix if applicable - Yes/No
Time Series Events Chart	Yes – mandatory tool
Control Analysis	No
Behaviour Analysis	No
Change Analysis	Yes
Why Analysis	Yes

Met Coal_11-9

Incident Investigation Report

Version

Date

5 EXECUTIVE SUMMARY OF INCIDENT

Summary of Incident						
Incident Number	IN.00219432			Department	Longwall	
Area / location	LW808			Contracting Company (if applicable)		
Summary of findings from Incident Investigation						
Incident Category e.g. Safety, Health, Env, Legal, Reputation, Community.	Agent EG – Fall of Ground	Actual ISR Rating	Potential ISR Rating	Date of Incident	Time of Incident	Number of hours worked
Legal and Regulatory	Non compliance	Minor	Moderate	22/02/2020	05:31AM	9
Task being performed at time of incident	Longwall Production				Planned or Unplanned task?	
					Planned	
Summary of Incident	<p>During routine production, following cutting into the tailgate, a methane concentration of >2% was detected at the '0m TG Sensor' removing power from the face.</p> <p>Elevated methane levels continued to be detected at the '0m TG Sensor' for approximately 14 minutes. During this time methane exceeded 2.5% on 4x instances with a peak measurement of 3.01%</p>					
Immediate actions taken	<p>ERZ Controller inspect area, and erected brattice sail on #194 chock to purge methane from #197 area.</p> <p>Notify MSO/UMM.</p>					

6 DESCRIPTION OF INCIDENT

On the 06/02/2020 a new methane sensor was installed and commissioned positioned on the canopy of #197 chock. The intention of this new sensor was to comply with Section 243A of the Coal Mine Safety and Health Regulation Amendments 2019. This sensor is known as the '0m TG Sensor'.

The first recorded event where >2% methane was detected at the '0m TG Sensor' occurred on 07/02/20 tripping face power. Anecdotal evidence indicated that at the time of this trip the canopy of #197 chock was ~200-300mm higher due to a disparity between the cutting face and the TG roadway height.

On the 20/02/2020 a routine TG retreat ventilation change (VC20015) was completed. This change was undertaken slightly earlier in the retreat cycle than normal to coincide with a maintenance shift so as not to impact the production schedule.

Between the 20/02/2020 and the time of this incident, two further >2% methane concentrations were detected at '0m TG Sensor' tripping face power.

On NS 22/02/20, the shearer stopped in the maingate to replace picks at approximately 0430HRs, the shearer driver described the maingate brattice as 'tight' at this point in time.

At approximately 0500HRs, the shearer resumed production towards the TG, reaching the tailgate at approximately 0530HRs and begins cutting to the maingate when >2% methane is detected at the '0m TG Sensor' tripping face power. At the time of the power trip the face had not yet been pushed and chocks had not commenced advancing. Methane concentrations subsequently fluctuated at the '0m TG Sensor' and exceeded 2.5% on four occasions over approximately 14 minutes, reaching a peak value of 3.01%.

The CMWs contacted the ERZ Controller (S Stingle) who inspected the area and reported 2.4% methane on his PGD. The ERZ Controller noted that the canopy of #197 chock was ~200-300mm higher than the adjacent chock and erected a brattice sail on chock #194 to direct face ventilation air around the '0m TG Sensor' to purge the methane.

The ERZ Controller subsequently notified the MSO, who notified the UMM.

7 CRITICAL CONTROL FAILURE

What / which critical controls failed? (List CT number)	Nil
Why did the critical control fail?'	N/A
How did the critical control fail?'	N/A
What additional or revised critical controls and/or monitoring activities need to be established/change to mitigate risk of recurrences, or to improve risk control?'	N/A

8 FINDINGS / CONCLUSIONS

This incident occurred due to localized elevated methane in the vicinity of the '0m TG Sensor' during normal production.

Key factors contributing to the incident were:

- Location of a new sensor on TG chock canopy, being a position where methane is more likely to be detected being both at the tailgate end of the face (where goaf gasses are most likely to be drawn into the airstream) and high (where methane is most likely to layer due to a low relative density).
- The canopy of #197 being ~200-300mm higher than the adjacent chock due to a disparity between the cut face and the TG roadway height, again making the '0m TG Sensor' in position of higher sensitivity to methane.
- Implementation of the routine longwall retreat ventilation change earlier than usual (reducing pressure on the goaf which in turn increased the potential for goaf gases to migrate into the roadway)
- A brief production cessation to replace picks may have allowed for an accumulation of methane to occur in the tailgate goaf area, which was subsequently disturbed by the increased air velocity in the tailgate caused by the reduction in cross-sectional area as the shearer cut into the tailgate.

9 PREVENTATIVE ACTIONS / RECOMMENDATIONS

The following key actions were identified to prevent recurrence and have been assigned as detailed below in Enablon.

Donnis Black

Task Description	Hierarchy of Control	Task Assignee	Due Date	Task ID
Review monitoring of "0m CH4 sensor" for LW808 with respect to production rate, other airstream sensor trends, and trip events. Determine if sensor is representative of general body atmosphere in TG.	Administrative	Braedon Smith	30/04/20 30/4/20	TS.01306660
Adjust standard Ventilation Change process for LW Tailgate retreat to include statement that "Ventilation Change is only permitted to occur when longwall face position is between 80-25m of next outbye cut-through."	Administrative	Braedon Smith	30/03/20 30/4/20	TS.01366662
Review the following SWPs with a cross section of the workforce for improvements to prevent further 0m sensor trip incidents: SWP.GTM.614 Constructing and Maintaining the Sherwood Curtain, and, SWP.GTM.614 Constructing and Maintaining the Sherwood Curtain	Administrative	Braedon Smith	30/03/20 30/4/20	TS.01306736

10 TEST FOR EFFECTIVENESS

Post Implementation Action Plan

Test of effectiveness is to be done to ensure that the above actions to prevent recurrence have worked as intended.
(Nominally scheduled 3,6 or 12 months after completion of preventative action plan)

Enablon Task No.	Action Description	Responsible Person	Due Date	Completed Date
	Audit '0m TG Sensor' trip event frequency post implementation of controls from LFI IN00219432 (closure 30/03/20) to determine effectiveness of controls in mitigating events.	Dennis Black	10/05/2020	15.01301670

11 INVESTIGATION REPORT SIGN-OFF

The Incident Investigation Team submits this report as a true reflection of the information gathered. To maximize the preventive potential of the investigation report, the findings, conclusions and learning's of the report should be distributed as appropriate.

Department Manager		
Name	Confidential	Date
<i>Dennis Black</i>		13-03-2020
Dennis Black		12.03.2020.
SHE Manager		
Name	Confidential	Date
Stephanie Oppermann		20/4/2020
General Manager		
Name	Signature	Date
Damien Wynn		21 APR 2020
Head of Operations		
Name	Confidential	Date
Glen Britton		21/04/2020
Additional EXCO member signoff – if applicable		
Name	Signature	Date

12 EVIDENCE & ANALYSIS TOOL APPENDICES

Table 1. IN.00217142 Event Timeline

Event Timeline		
06/02/20	Before the Incident	CH4 Sensor fitted to LW808 #197 chock as part of implementation plan to comply with 243A of the Coal Mining Safety and Health (Methane Monitoring and Ventilation Systems) Amendment Regulation 2019. Sensor termed "0m CH4 Sensor"
07/02/20		First recorded trip event on "0m CH4 Sensor" where methane of >2% is detected.
16/02/20 ~18:11		Trip event on "0m CH4 Sensor" where methane of >2% is detected.
20/02/20		Ventilation Change VC20015 is undertaken in the LW808 TG. This change occurred earlier in the retreat cycle than usual.
21/02/20 ~11:12		Trip event on "0m CH4 Sensor" where methane of >2% is detected.
21/02/20 ~16:57		Trip event on "0m CH4 Sensor" where methane of >2% is detected.
22/02/20 4:30		LW808 Shearer stops in MG to repick drums. Witnesses report MG Brattice condition as being 'tight'.
22/02/20 5:00		LW808 Shearer resumes production towards TG.
22/02/20 5:31	Incident	LW808 Shearer cuts into TG and starts to cut back towards MG. Face trip event occurs when "0m CH4 Sensor" >2%.
28/01/20 08:30- 09:30	After the Incident	"0m CH4 Sensor" CH4 concentrations fluctuate exceeding 2.5% a total of 3x further times over a period of x minutes, with a maximum peak of 3.1%. NB: Other CH4 monitors in airstream (2x TG drive sensors, TG Roadway sensor, and LW808 Dogleg Sensor) do not replicate similar trend profiles at this time.
28/01/20 09:30		Face operators (CMWs) contact ERZ C (S Stingle) and notifies him of the face trip.
28/01/20 10:05		ERZ C attends TG, notes 2.3% on handheld PGD. Erects brattice curtain on shields to purge gas from sensor. Operators and ERZ C observe chock #197 canopy height is approximately 300mm higher than adjacent chocks due to roadway height. Erects brattice to disperse gas from sensor area. TG chock hard into chain pillar rib.
28/01/20 11:00		ERZ C Notifies MSO of event. Incident subsequently reported to UMM.

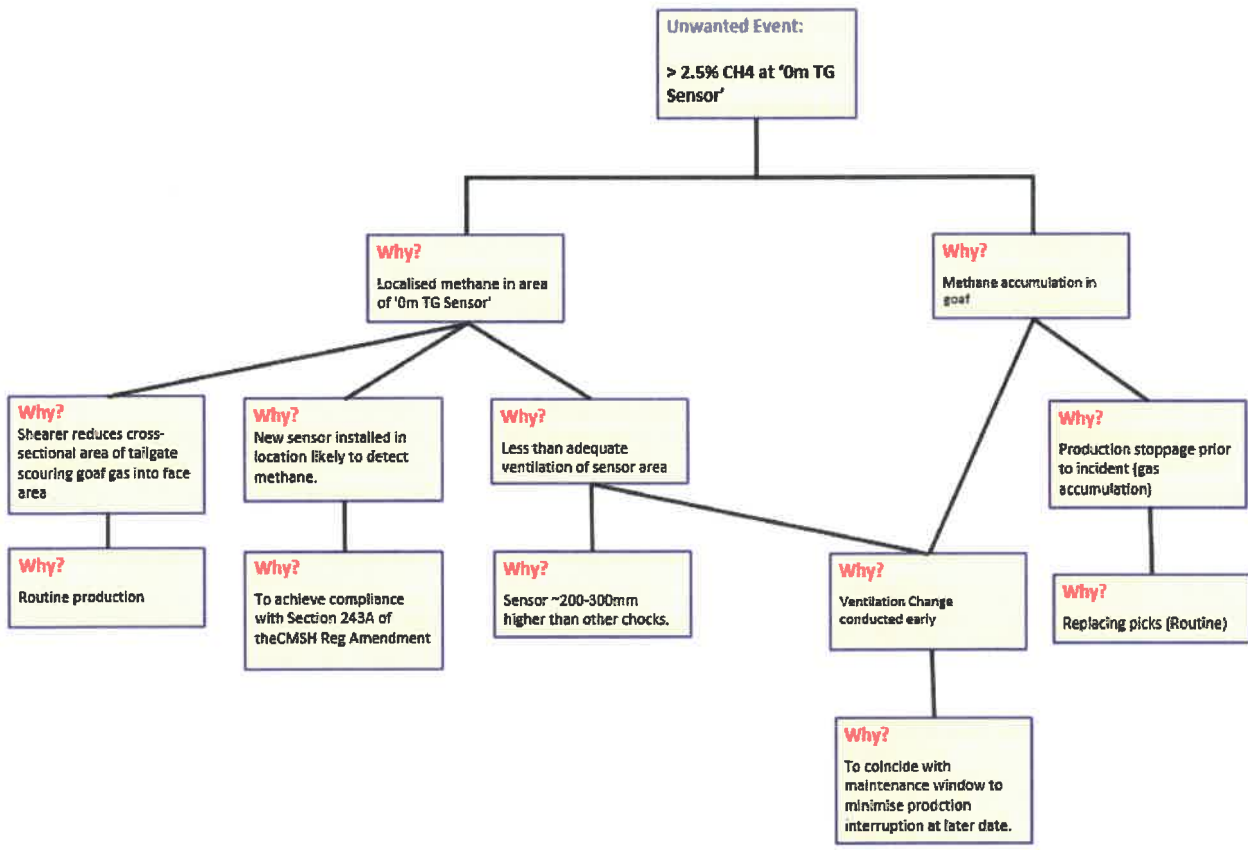


Figure 1. IN.00219432 Anglo LFI Tool Why Analysis

Table 2. IN.00219432 Anglo LFI Tool - Change Analysis

Normal Practice	Situation or practice at the time of the incident	Gap (Difference)	Impact of Difference
No CH4 sensor fitted to canopy of #197 chock	CH4 sensor fitted to canopy of #197 chock	CH4 sensor positioned high on roof where methane is most likely to layer	Overrepresentation of methane at the monitoring location (compared to General Body concentration) Higher sensitivity to goaf gas air wash during shearer cut to TG

Chock canopy heights nominally level with one another	#197 chock ~300mm higher than adjacent chocks.		Potential for less than adequate ventilation in elevate chock canopy area.
TG Ventilation change typically undertaken when face is 70-25m from next outbye CT	TG Ventilation change undertaken when face is ~125m from next outbye CT	Small change in pressure distribution on tailgate	Slightly increased potential for gas accumulation at TG area.

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Map / diagram (if required):

Anglo Assessing Risk Matrix	1	2	3	4	5
Minor consequence (low priority) and low likelihood	1	2	3	4	5
Low consequence (low priority) and medium likelihood	2	3	4	5	6
Low consequence (low priority) and high likelihood	3	4	5	6	7
Medium consequence (medium priority) and low likelihood	4	5	6	7	8
Medium consequence (medium priority) and medium likelihood	5	6	7	8	9
Medium consequence (medium priority) and high likelihood	6	7	8	9	10
High consequence (high priority) and low likelihood	7	8	9	10	11
High consequence (high priority) and medium likelihood	8	9	10	11	12
High consequence (high priority) and high likelihood	9	10	11	12	13

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To be completed by reporting person with assistance from Supervisor (Surface incidents) or ERZ Controller (UG incidents)

ALL sections of this form are mandatory unless marked.

Title of Hazard / Incident: Gas Accumulation at 2227 - "PR" chock Incident Number: IN00219432

Date occurred: 22 Jul 20 Time: 04:31 Hrs

Date Reported: 22 Jul 20 Time: 05:51 Hrs

Classification: Safety Material Losses / Damage / Business Interruption Legal / Regulatory Environment Social / Community Impact on Reputation Workplace Exposure Health Issues

Department: Longwall Development Outlets Compliance Tech Services Services SHE Human Resources Commercial / Supply Chain Maintenance / Engineering Business Improvement Other

Reportable to external bodies? Yes No DMAC

Specific Location: 2227 Longwall

Reported by: S. Sharkey ID #: 10223 Contracting Name / Staff: GR

Key Person Involved: ID # Contracting Name / Staff

Key Person Involved: ID # Contracting Name / Staff

Key Person Involved: ID # Contracting Name / Staff

Injured Person: ID # Contracting Name / Staff

Others Involved: ID # Contracting Name / Staff

Initial Investigation Team e.g. ERZC / Crew: 2227/2001, 2227/2002, 2227/2003

Supervisor / CMW: S. Sharkey ERZC/ Supervisor: include ID # 10223

Equipment Involved: 2227/2001, 2227/2002, 2227/2003 Process Area & Department: 2227/2001

Crew: 3

SHR Length: 12 Hours into shift: 9 Consecutive days worked:

Activity: Production / Longwall operation Drug and Alcohol Yes No

Incident Description: Gas accumulation at "PR" chock "A" change area 2227/2001 (around 2nd intake) Tailgate Area

Immediate Direct Cause: Overcrowding Mechanism: Wind effect

Immediate Corrective Actions Taken: Immediate removal from immediate area, Control setting return to "PR" chock & control the drive, Reduce fan load

Refer to AAMC Risk Matrix to determine the appropriate Consequence Type (mark on back page)

Consequence Type: Safety Injury Material Losses / Equipment Damage / Business Interruption Legal / Regulatory Environment Hazard / Potential Consequences required only

Actual Consequence: Not Applicable for Hazards Insignificant Minor Moderate High Major

Potential Consequence: Insignificant Minor Moderate High Major

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Figure 2. IN.00219432 Initial Incident Report (Front).

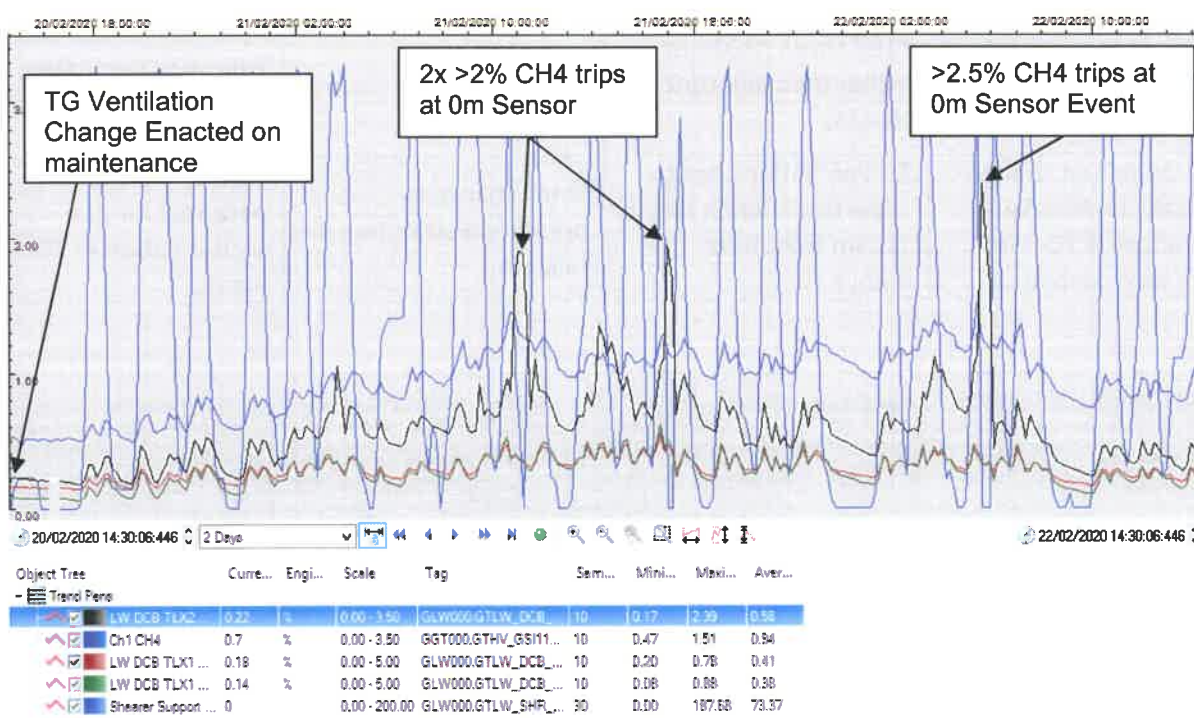


Figure 3. Shearer and CH4 monitor trending over 2 days including >2.5% CH4 trip event and two preceding >2% trip events on the day prior to the incident.

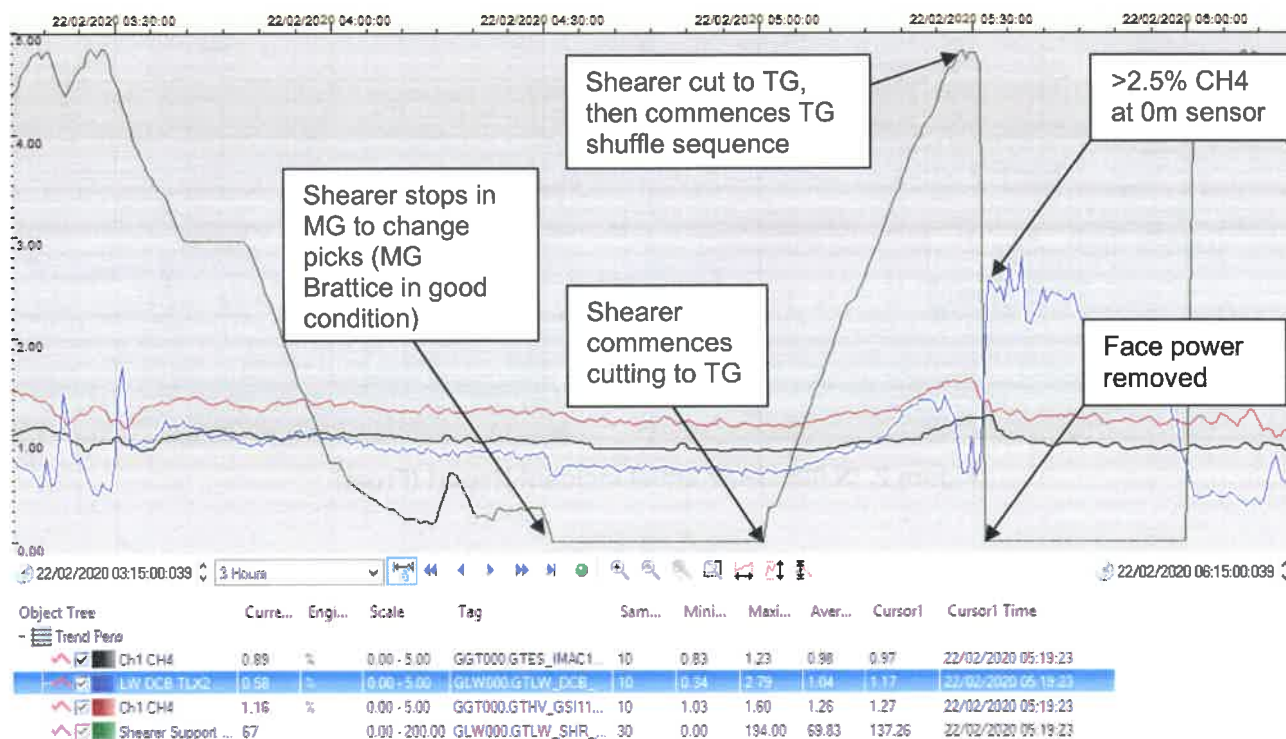


Figure 4. Shearer and CH4 monitor trending showing timescale of incident from shearer entering maingate of picks, then cutting to TG, and power trip event

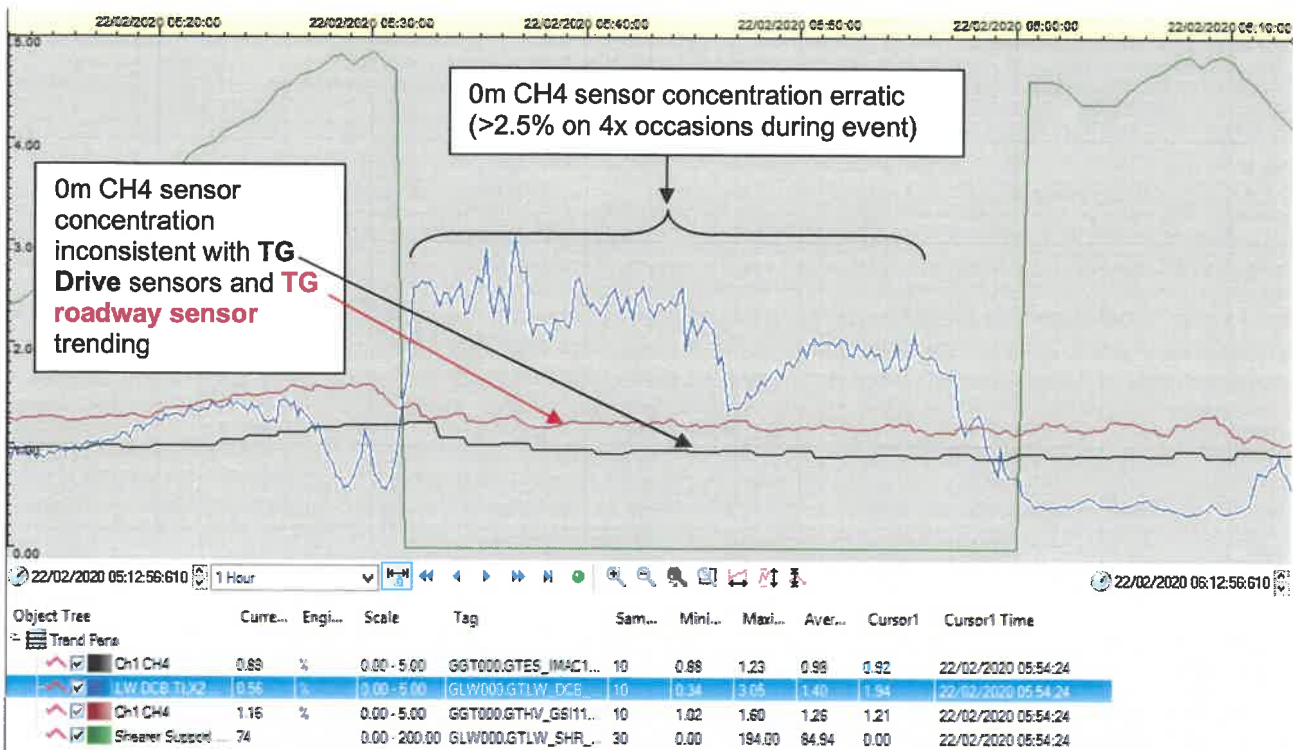


Figure 5. Shearer and CH4 monitor trending showing 0m Sensor CH4 concentrations escalating after shearer exit from maingate and erratic variation inconsistent with nearby sensors.

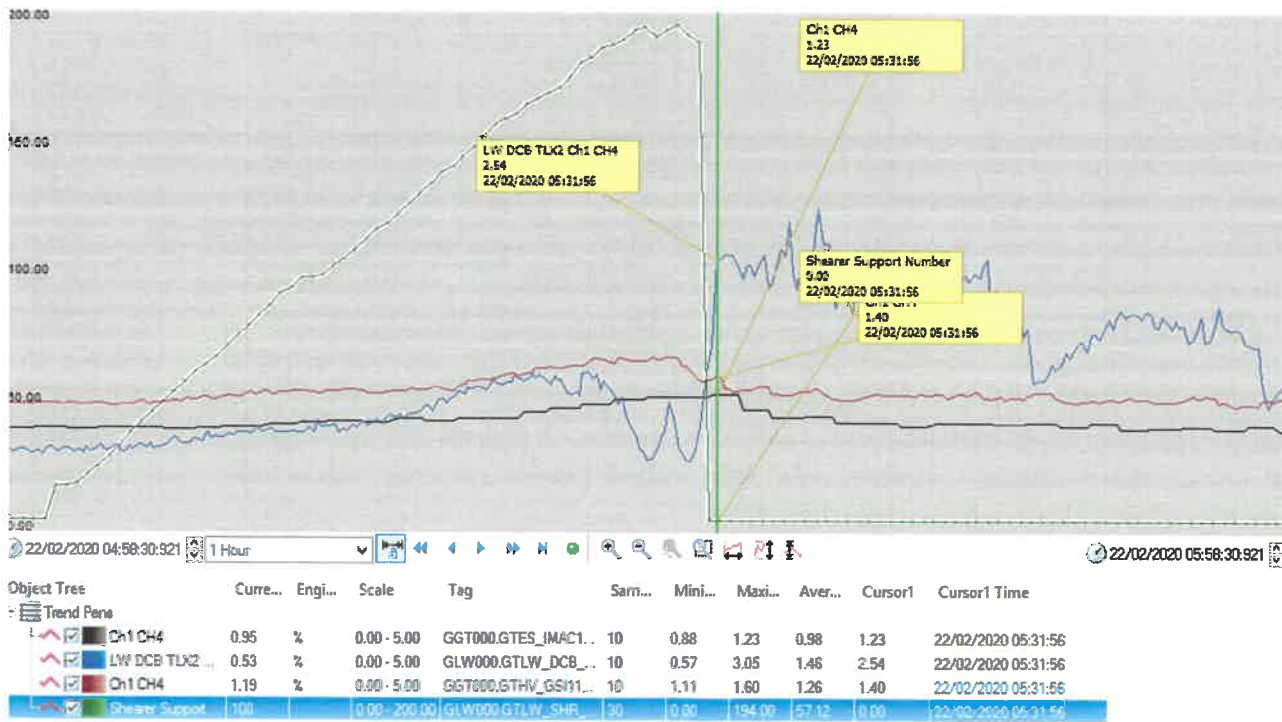


Figure 6. Shearer and CH4 monitor trending showing 0m Sensor CH4 concentrations exceeding (1st spike) 2.5% at 05:31:56

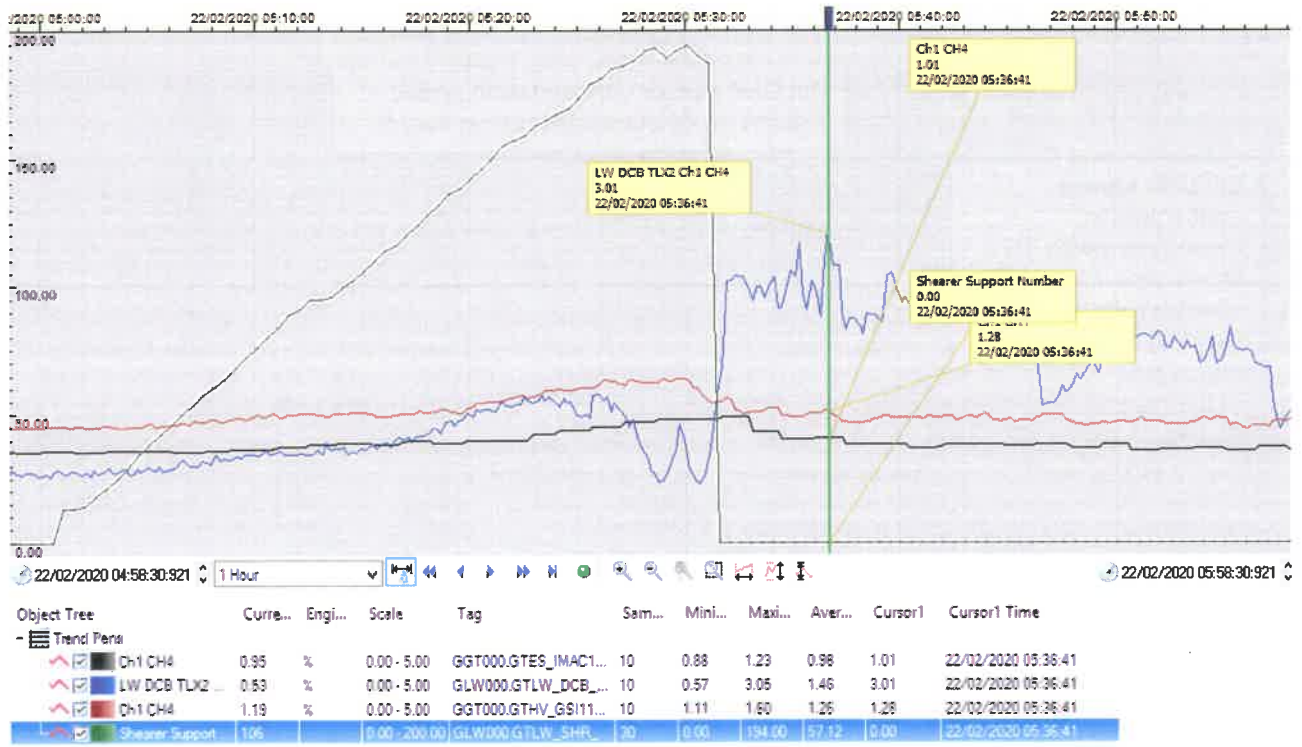


Figure 7. Shearer and CH4 monitor trending showing 0m Sensor CH4 concentrations reaching peak of 3.01% at 05:36:41

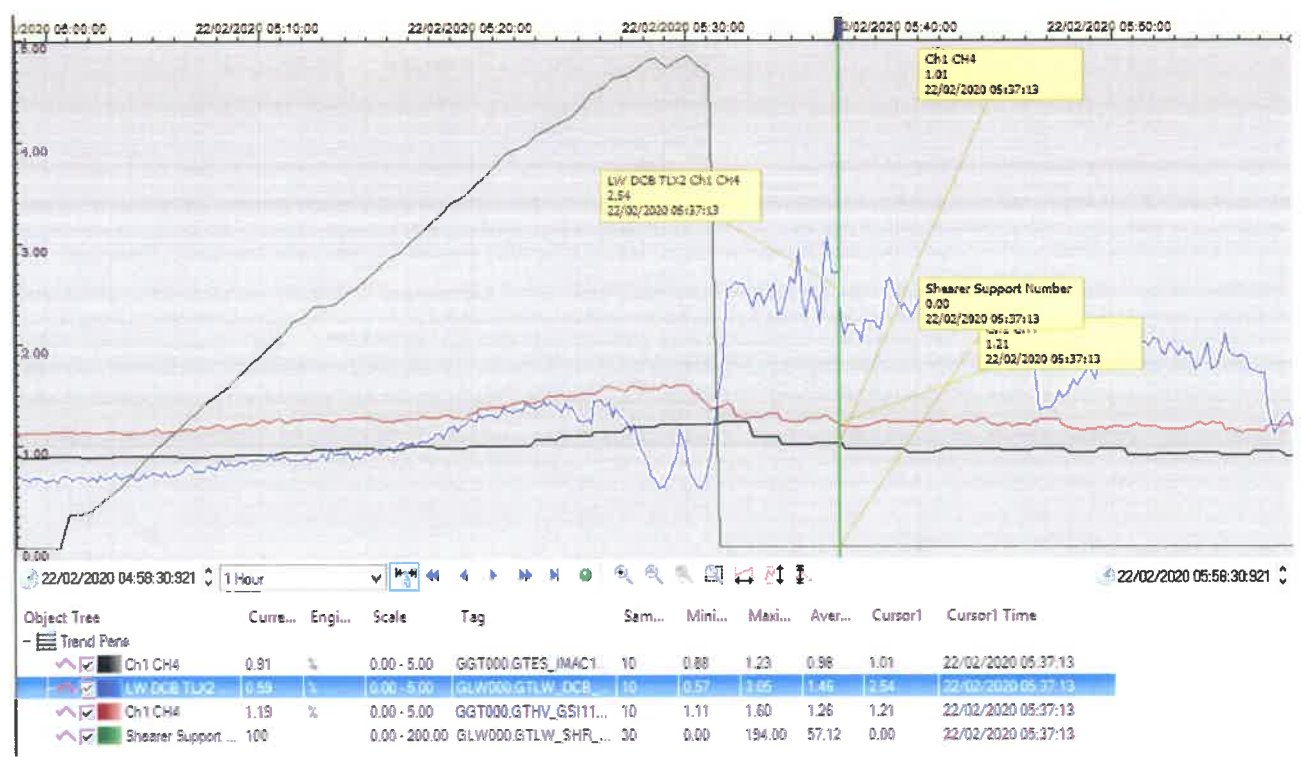


Figure 8. Shearer and CH4 monitor trending showing 0m Sensor CH4 concentrations reduce (1st spike) below 2.5% at 05:37:13

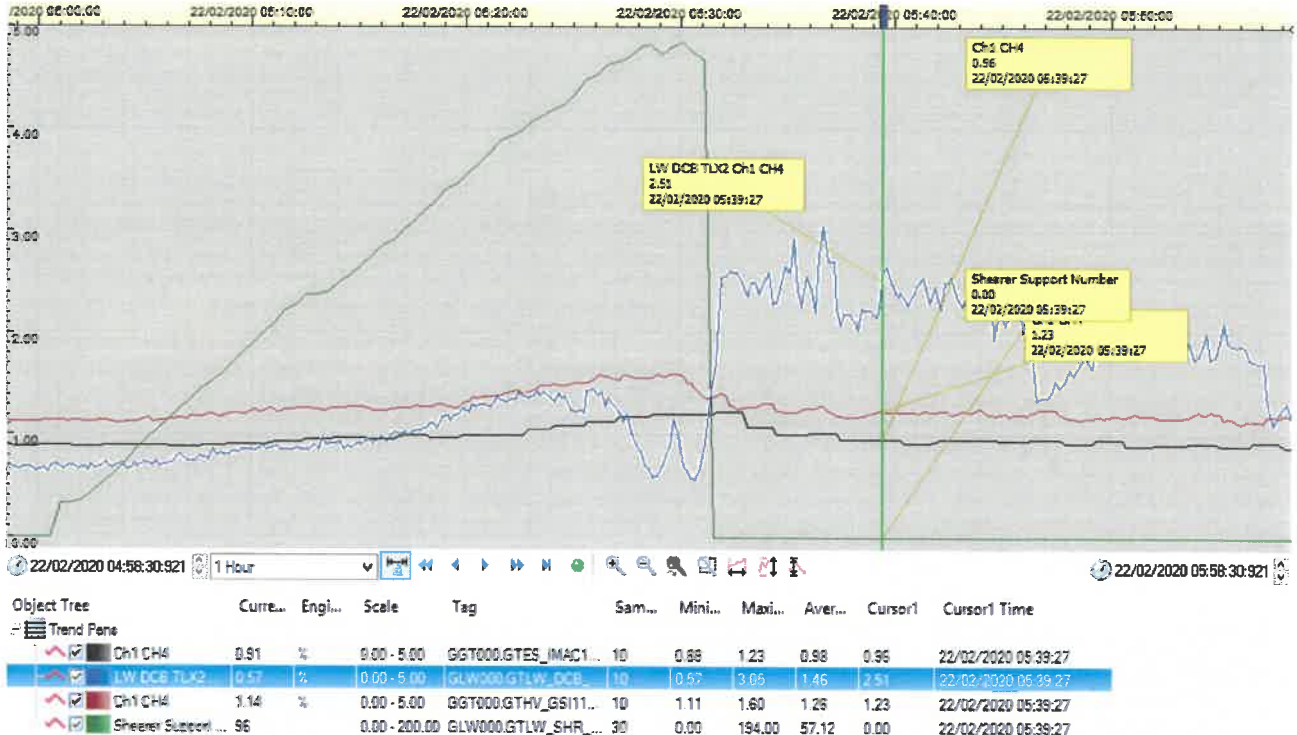


Figure 9. Shearer and CH4 monitor trending showing 0m Sensor CH4 concentrations again (2nd spike) exceeding 2.5% at 05:39:27

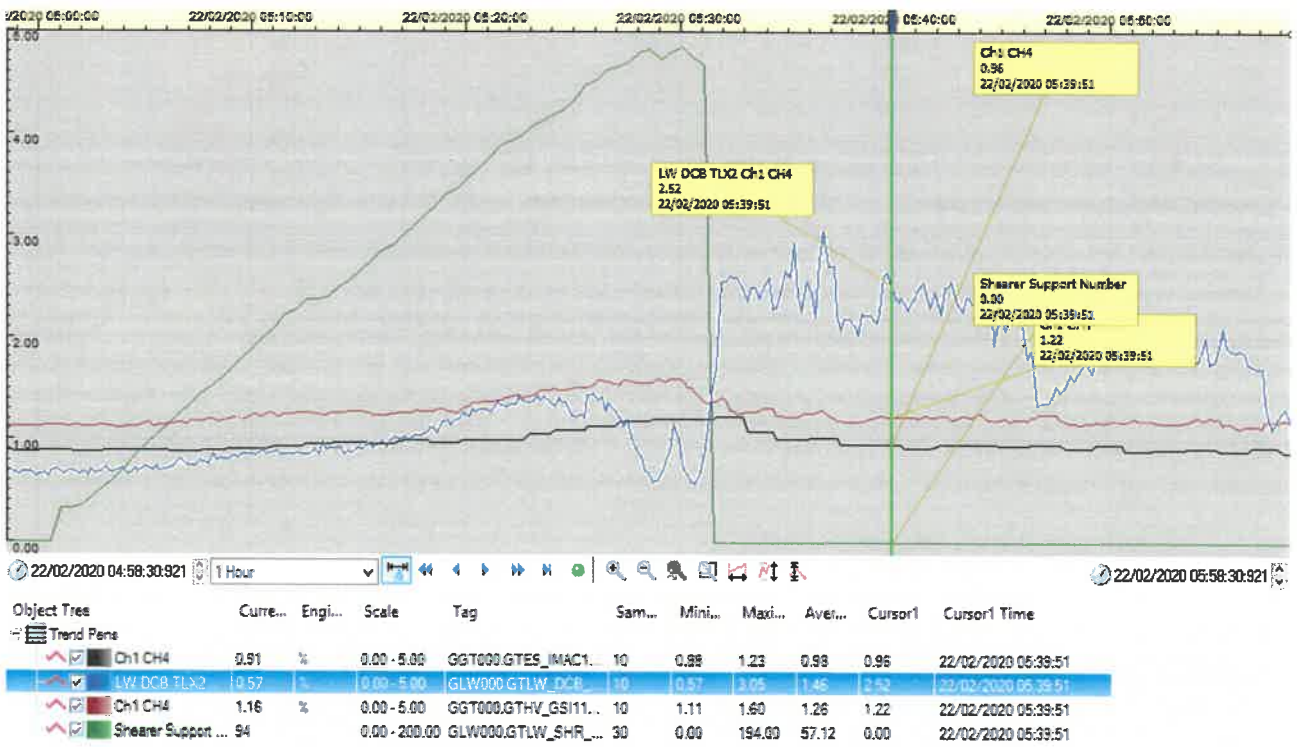


Figure 10. Shearer and CH4 monitor trending showing 0m Sensor CH4 concentrations reduce (2nd spike) to below 2.5% at 05:39:51

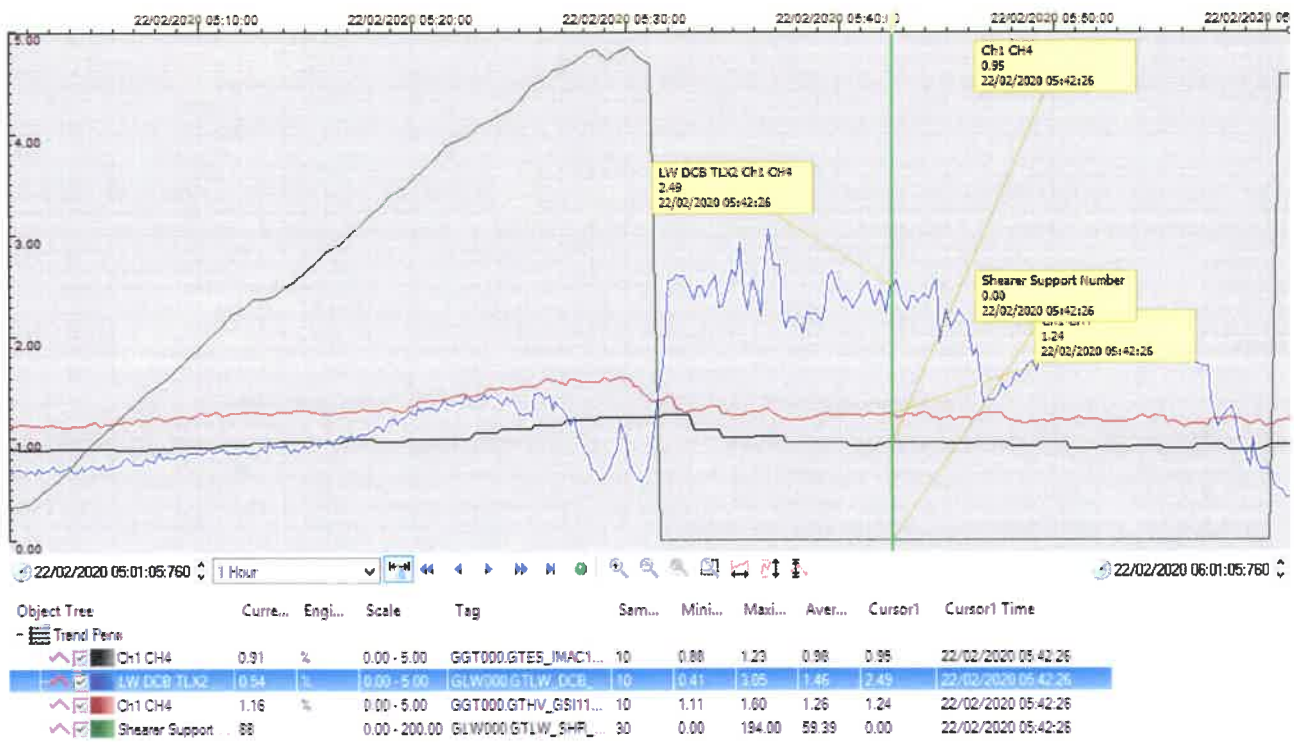


Figure 11. Shearer and CH4 monitor trending showing 0m Sensor CH4 concentrations again (3rd spike) exceeding 2.5% at 05:42:26

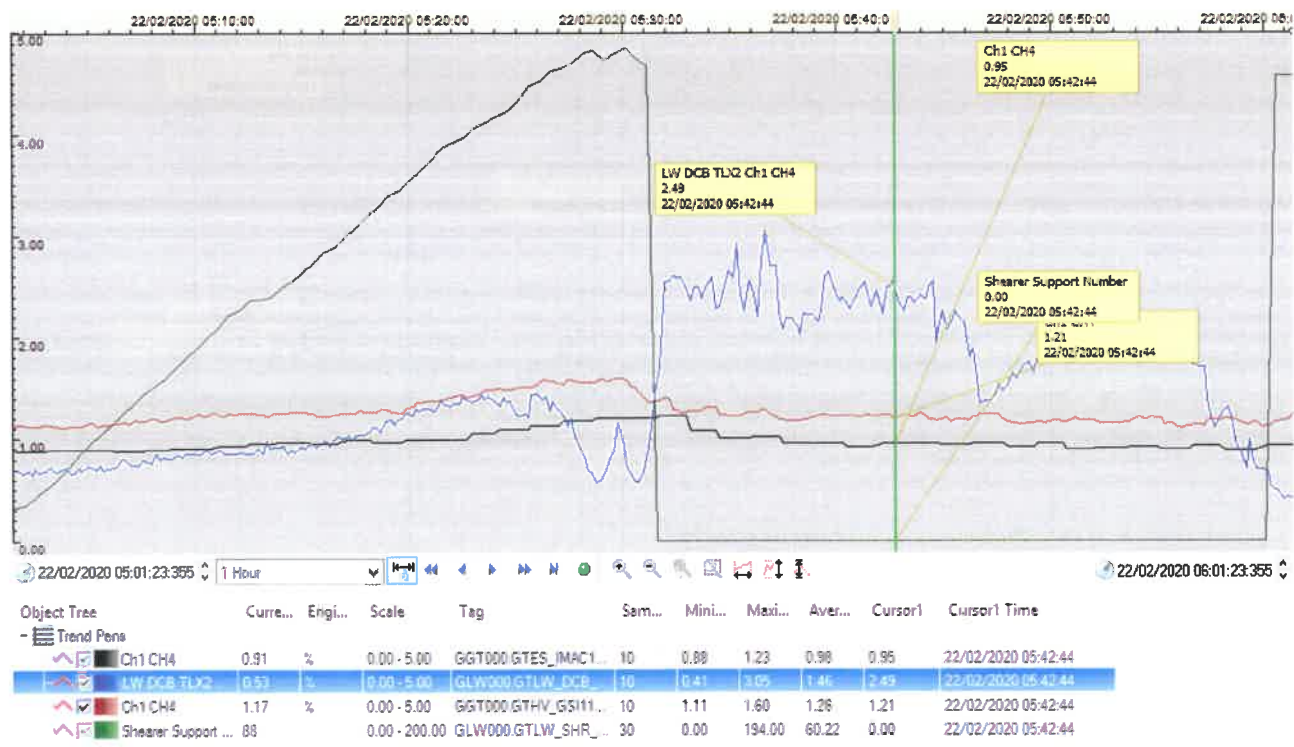


Figure 12. Shearer and CH4 monitor trending showing 0m Sensor CH4 concentrations reduce (3rd spike) below 2.5% at 05:42:44

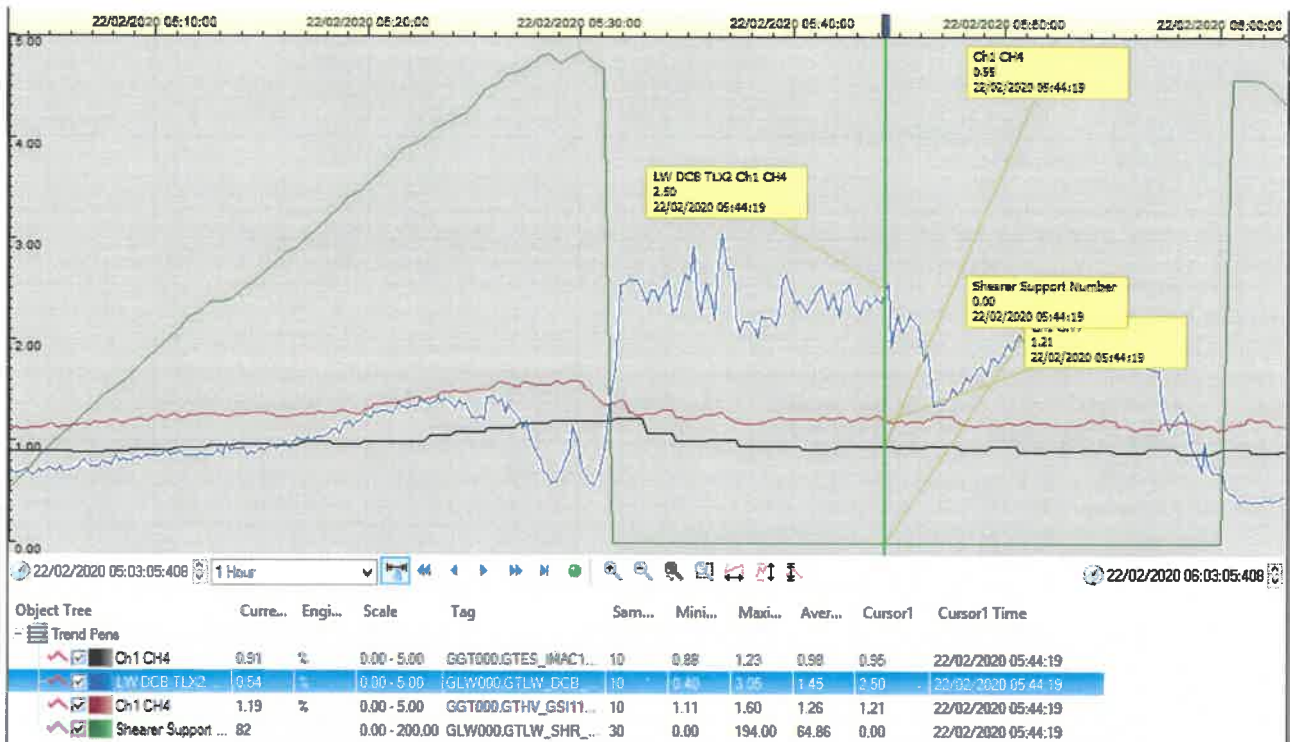


Figure 13. Shearer and CH4 monitor trending showing 0m Sensor CH4 concentrations again (4th spike) exceeding 2.5% at 05:44:19

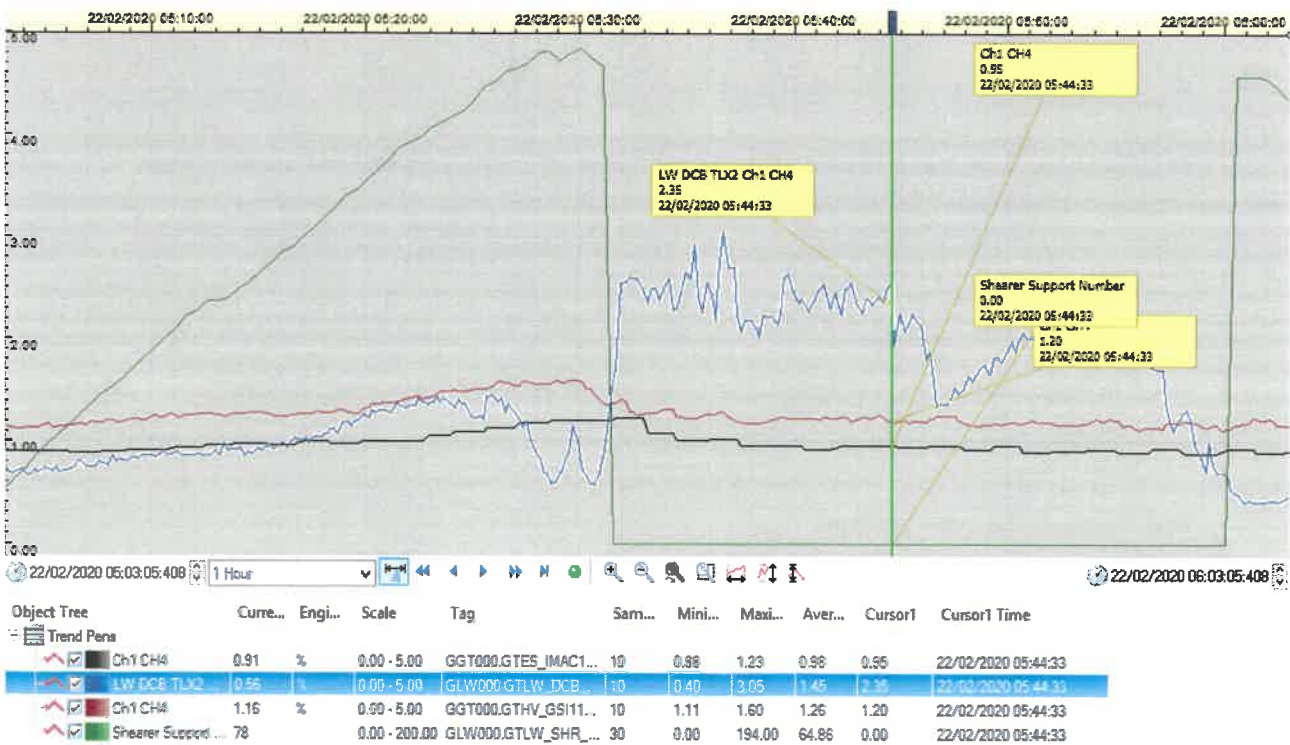


Figure 14. Shearer and CH4 monitor trending showing 0m Sensor CH4 concentrations reduce (4th spike) below 2.5% at 05:44:33



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Capcoal Underground Grassrae Mine
Management Plan

Involved Person or Witness Statement
MP/GTM.025

APPENDIX 3 INVOLVED PERSON OR WITNESS STATEMENT

Event Description:	GPS coordinates at 107 Creek		
Date and Time:	23-3-20		
Location of Event:	197 chok		
Witness Details			
Name of Witness:	Matthew Sellings	Contact No:	
Job Title:	operator	Anglo No:	984442
Employer:	Anglo		
Witness Statement			

What task were you undertaking prior to or at the time of the incident?

maps loc

Who were you working with at the time of the incident?

M. Sellings

Who was your supervisor?

S. Smith

Who was the ERZ Controller responsible for the zone at the time of the incident?

S. Smith

What processes or procedures were you following whilst carrying out the task (if involved in the incident)? Did you have a permit to work / authority to work?

Was a workplace inspection conducted prior to working in the area? If so, when and how?

regular

What was your role in the incident?

GPS operator

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Figure 15. M Sellings Witness Statement for IN.00219432 (1 of 2 Pages)



Anglo Coal (Capcoal Management) Pty Ltd
Capcoal Underground Grasstree Mine
Management Plan

Involved Person or Witness Statement
MP.GTM.025

Explain your own words what happened during incident including the lead-up, incident occurrence, and post incident – please include what you saw, heard and did. (If you need more space, please attach another page at rear). Draw diagrams if necessary.

*we just finished cutting from 197 to 198 then headed back out to make then had a high
CH4 trip on 197 check, extended before wing to dilute gas*

What conditions influenced the incident and what do you think caused the incident?

vent change being done to early and 197 check was 300ppm higher than other checks

Was there anything unusual you observed prior to or during the Event (sights, sounds, smells, other work in the area etc)?

How do you think the incident could have been prevented?

Interviewee Name:	Date:
Signature:	

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Figure 16. M Sellings Witness Statement for IN.00219432 (2 of 2 Pages)





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 Capcoal Underground Grasstree Mine
 Management Plan
 Involved Person or Witness Statement
 MP.GTM.025

APPENDIX 3 INVOLVED PERSON OR WITNESS STATEMENT

Event Description:	Gra Excavation 22% in 004 section in 191 check		
Date and Time:	22-02-20 0531		
Location of Event:	S&S longwall		
Witness Details			
Name of Witness:	Sharon Stingle	Contact No:	
Job Title:	Quality	Anglo No:	1923
Employer:	Anglo		
Witness Statement			
What task were you undertaking prior to or at the time of the incident?			
Inspection			
Who were you working with at the time of the incident?			
n/a			
Who was your supervisor?			
Who was the ERZ Controller responsible for the zone at the time of the incident?			
What processes or procedures were you following whilst carrying out the task (if involved in the incident)? Did you have a permit to work / authority to work?			
Was a workplace inspection conducted prior to working in the area? If so, when and how?			
What was your role in the incident?			
Inspect area - include Gas tests in 191 check			

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Figure 17. S Stingle Witness Statement for IN.00219432 (1 of 2 Pages)



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Capcoal Underground Grasstree Mine
Management Plan
Involved Person or Witness Statement
MP.GTM.025

Explain your own words what happened during incident including the lead-up, incident occurrence, and post incident – please include what you saw, heard and did. (If you need more space, please attach another page at rear). Draw diagrams if necessary.

While Shearer cut into TG & then proceeded to cut out to Sacker, CH₄ levels increased @ O₂ Sensor as Shearer got further cut and Shields were being advanced. When 2% was reached & power dropped to Lower face, Break level of CH₄ went to 3.05%. Crew notified me that we had topped out on gas & I then proceeded to go to TG to investigate while other personnel in area withdrew to an area of full ventilation

Upon inspection found upto 2.6% CH₄ @ #197 check. Placed a Brattice Seal on #196 check to divert some ventilation Behind TG mine to dilute gases in area

What conditions influenced the incident and what do you think caused the incident?

Vent change in TG done less than 250m OLG was the LOC. LW being uphill into TG roadway where #197 check is fully in roadway #197 check being upto 200mm - 300mm higher than #196 creating limited ventila around CH₄ sensor
Shearer trimming cut & Shields advancing pushing ventilation around back of checks & flushing out good gases

Was there anything unusual you observed prior to or during the Event (sights, sounds, smells, other work in the area etc)?

No

How do you think the incident could have been prevented?

Try not to do vent change so early
Review Development drawings as its plan indicates Driveway resulting in Lower being up hill into TG roadway alot.

Interviewee Name: S Stingle Date: 23.02.20
Signature: Confidential

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Figure 18. S Stingle Witness Statement for IN.00219432 (2 of 2 Pages)



13 RECORD OF AMENDMENTS

Issue 6	:	Full review to align the investigation report to the Learning from Incidents process being rolled out at Met Coal in 2018.	08 June 2018, Chris Gately, Lynda Butler
Issue 5	:	<ul style="list-style-type: none"> • Sign off table updated to include "Additional EXCO" member signoff. • Section 7 – New – Critical Control Failure (for HPI's only) • References to Met Coal removed. 	15 September 2015, Allan Gordon
Issue 4	:	Reviewed Sign off table updated to include sign off from Head of Operations	22 April 2014, Allan Gordon
Issue 3	:	Reviewed for currency – reformatted	8 January 2014, Bruce Gavin
Issue 2	:	Reviewed to align with Enablon Incident Database	6 March 2013, Graeme Redding
Issue 1	:	New Template	15 December 2011, Bruce Gavin