

PUBLIC HEARING – 14 December 2016- Tieri

QUESTIONS ON NOTICE AND ADDITIONAL INFORMATION

Joe Barber, Site Safety and Health Representative, Oaky North Mine

Mr McMILLAN: *You gave an example that Kerrod confirmed as well during your evidence earlier about a worker who was in the tailgate after the shearer started its work and had to feel his way out along the ribs. Did you see that happen? Were you there?*

Mr Barber: *No, I did not, but I interviewed the guy and we have documented evidence of that at work.*

Mr McMILLAN: *As the SSHR you interviewed the guy who—*

Mr Barber: *Yes. You have to deal in facts. You do not want fiction. The facts were that he had to feel his way out and he had no dust mask on. He was subject to whatever was coming out of that block of coal at the time...*

Mr McMILLAN: *As the bloke emerged from the dust, did the production stop and everyone have a meeting about how that occurred at that time as far as you know?*

Mr Barber: *Why would production stop?*

Mr McMILLAN: *Was he removed from the working environment immediately?*

Mr Barber: *Once he came out of the tailgate, he just went on with his normal duties. I have full documentation of the whole incident.*

Mr McMILLAN: *All right.*

1. **CHAIR:** *Can you provide that documentation to us?*

Mr Barber: *If you wish to have the documentation—not here today—*

CHAIR: *No.*

Mr Barber: *I could get it for you—the actual transcript that comms wrote over from the conversation, ‘Why did you start it up? I was still in there.’*

Mr CRAWFORD: *Is that all recorded by the company?*

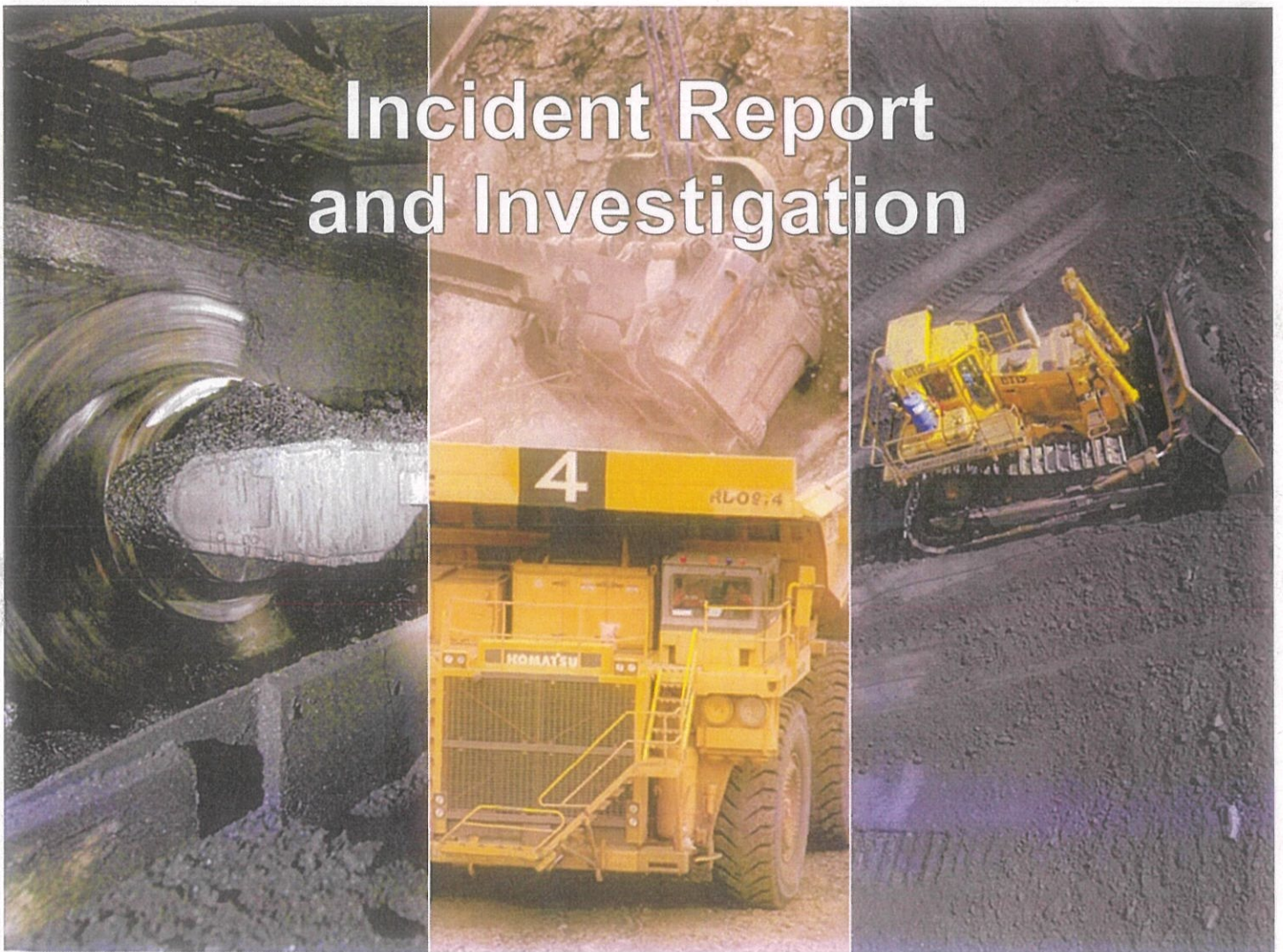
Mr Barber: *That is recorded, yes. I actually got photocopies of the whole incident.*

CHAIR: *If you could provide that, we would be very grateful. Pp 9 - 10*

COAL ASSETS AUSTRALIA

GLENCORE

Incident Report and Investigation



Number: CAA HSEC FRM 0020
Owner: General Manager – Health, Safety and Training
Status: Approved
Version: 1.0
Effective: 05 February 2015
Review: 04 February 2018

Part 1 - Incident Details

Incident Summary		Incident Number
Incident Summary (Brief overview of the incident)	completing bag samples in T4502 Red Zone when he commenced cutting	Reportable / Notifiable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Who	
Reported By	S. Finlay
Reported To	K. Skanaynly
Supervisor	S. Dobbie
Department	ostore
Shift and Shift Start Time	6pm Night Shift
Crew	C
Witnesses	-
Personnel Involved (Identify if contractor or employee)	S. Finlay

What													
<input checked="" type="checkbox"/> Actual <input type="checkbox"/> Potential (near miss)													
Incident type	<input checked="" type="checkbox"/> Health and Safety												
	<input type="checkbox"/> Environment												
	<input type="checkbox"/> Community / Image / Reputation												
	<input type="checkbox"/> Damage / Loss												
	<input type="checkbox"/> Process												
Category (circle rating for both)	<table border="1"> <tr> <td>Actual</td> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> </tr> <tr> <td>Potential</td> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> </tr> </table>	Actual	1	2	3	4	5	Potential	1	2	3	4	5
Actual	1	2	3	4	5								
Potential	1	2	3	4	5								
Investigation method	<input checked="" type="checkbox"/> 5 Whys <input type="checkbox"/> ICAM												
(Shading relates to category rating above)													
(H&S Cat 3) (E&C Cat 3)													

Where	
Incident Location	T4502 - Red Zone
Equipment Involved (type, number, rego)	

When	
Time of Incident	1:15 Afternoon am/pm
Time Incident Reported	6:00 am/pm
Date of Incident	16.11.2016
Date Incident Reported	22.11.2016
Time into Shift	7:15 hrs.

Incident Scene (Sketch of the incident scene)

Injury Location
Circle injury location(s)

Fatal Hazards	
<input type="checkbox"/> Strata Failure	<input type="checkbox"/> Inadequate Energy Isolation
<input type="checkbox"/> Fire and Explosion	<input type="checkbox"/> Working at Height
<input type="checkbox"/> Mobile Equipment	<input type="checkbox"/> Lifting and Craneage
<input type="checkbox"/> Inappropriate Emergency Response	<input type="checkbox"/> Confined Space and Irrespirable/ Noxious Atmosphere
<input type="checkbox"/> Inrush and Outburst	<input type="checkbox"/> Tyre and Rim Management
<input type="checkbox"/> Explosives and Shotfiring	<input type="checkbox"/> Electrical Safety

GCAA SafeCoal Rules

- | | |
|---|--|
| <input type="checkbox"/> Δ1 - Never work above 2m without appropriate fall protection. | <input type="checkbox"/> Δ7 - Never modify safety devices without permission. |
| <input type="checkbox"/> Δ2 - Always verify the isolation - test for dead. | <input type="checkbox"/> Δ8 - Never enter under unsupported roof. |
| <input type="checkbox"/> Δ3 - Never enter under suspended loads. | <input type="checkbox"/> Δ9 - Always follow positive radio communication requirements. |
| <input checked="" type="checkbox"/> Δ4 - Never enter no-go zones. | <input type="checkbox"/> Δ10 - Always consider health & safety implications when planning. |
| <input type="checkbox"/> Δ5 - Never operate equipment unless authorised. | <input type="checkbox"/> Δ11 - Always follow regulated traffic signage. |
| <input type="checkbox"/> Δ6 - Never attend work under the influence of alcohol or illicit drugs. Consumption on site is prohibited. | |

Injury / Illness

Name of injured person	No Injury
Position, role and employer	
Details of the injury (Include location and type of injury and task at the time of the incident)	
Was task relevant PPE being worn at the time? (If so, detail the PPE being worn)	
Did the injured worker have to stop work as a result of the injury? (If so, detail action taken – see below for First Aid Treatment)	
Was first aid or medical treatment provided? (If so, who provide treatment and what treatment was given)	

Contributing Factor Data Categories (PEEPO)

People	Environment	Equipment	Procedure	Organisation
		Poor communication capabilities in T4 SD2 - no wi-fi		

Description and Timeline of Events

Events leading up to the incident	Taking bag samples in T4 SD2 Red Zone
Events at the time of the incident	noticed dust from LW production
Events immediately following the incident	Left area and went to T4 SD2 outside zone Exposure duration 10-15 mins. PPE mask worn
Actions required to control the situation and prevent further harm / loss	Review / Revise communication protocol
Was this an infrequent or frequent task for the individuals involved?	Frequent

Part 2 – 5 Why Analysis (Not applicable where ICAM process is to be used - Category 4 or 5 incidents, E&C Category 3 incidents)

5 Why Analysis (1)		5 Why Analysis (2)	
Problem Statement (1):	Exposure to kW Return due	Problem Statement (2):	
Why?	communication facilities impaired at the time. JALC were down	Why?	
Why?	Poor communication protocols with COMMS.	Why?	
Why?	communication protocols not followed,	Why?	
Why?		Why?	
Why?		Why?	

5 Why Analysis (3)	Root Cause Description
Problem Statement (3):	
Why?	
Why?	
Why?	
Why?	
Why?	

Actions				
Category	Action	Assigned to	Action Accepted	Due Date
	Review TG 502 Red Zone communication protocols with TG 502 ER2L/COMMS	K. Ekanayake	-	29.11.2016

Authorisation			
Supervisor / Investigator	K. Ekanayake Name (printed)	24/11/2016 Date	K. Ekanayake Signature
Superintendent / Coordinator	J. Cummins Name (printed)	29.11.16 Date	J. Cummins Signature
Review			
Comments			
HST Manager	Name (printed)	Date	Signature
E&C Manager (Required for all E&C related incidents)	Name (printed)	Date	Signature

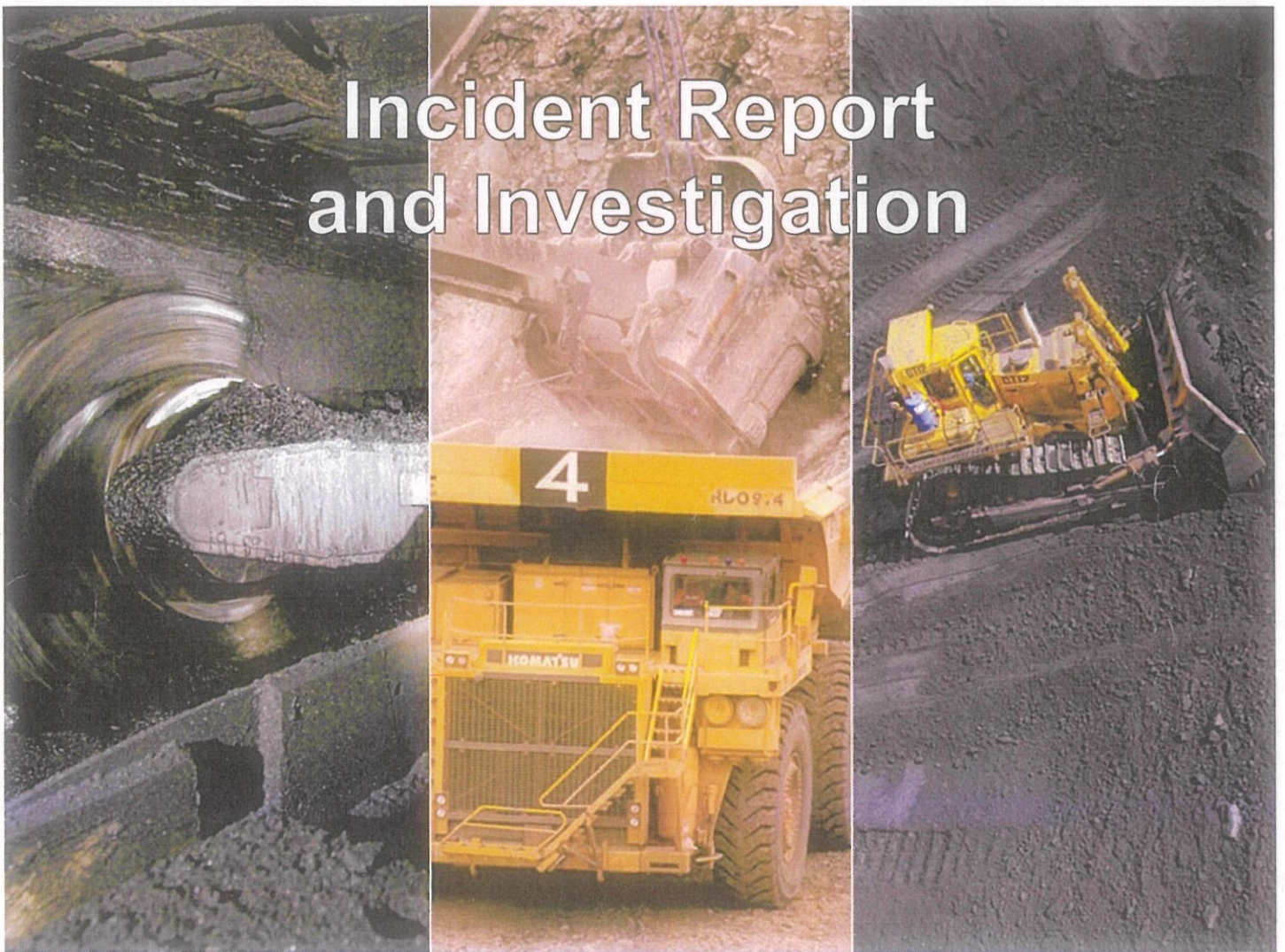
slu
Leon Ryan
Supervisor

COAL ASSETS AUSTRALIA

GLENCORE

E-MAILED
2/11

Incident Report and Investigation



Number: CAA HSEC FRM 0020
Owner: General Manager – Health, Safety and Training
Status: Approved
Version: 1.0
Effective: 05 February 2015
Review: 04 February 2018

Part 1 - Incident Details

Incident Summary		Incident Number												
Incident Summary (Brief overview of the incident)	Longwall started cutting whilst people still inbye in T4502 Regulator doors Restricted zone.	Reportable / Notifiable? <input type="checkbox"/> Yes <input type="checkbox"/> No												
Who		What												
Reported By	Rob Burson	<input checked="" type="checkbox"/> Actual <input checked="" type="checkbox"/> Potential (near miss)												
Reported To	Darrel Egan	<input checked="" type="checkbox"/> Health and Safety												
Supervisor	Rob Burson	<input type="checkbox"/> Environment												
Department	Vent	Incident type <input type="checkbox"/> Community / Image / Reputation												
Shift and Shift Start Time	1700 N/S	<input type="checkbox"/> Damage / Loss												
Crew	D	<input type="checkbox"/> Process												
Witnesses	Nathan Alcorn	Category (circle rating for both)												
Personnel Involved (Identify if contractor or employee)	Rob Burson - Nathan Alcorn Matt Antonic - Aaron Drake Darrel Egan	<table border="1"> <tr> <td>Actual</td> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> </tr> <tr> <td>Potential</td> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> </tr> </table>	Actual	1	2	3	4	5	Potential	1	2	3	4	5
Actual	1	2	3	4	5									
Potential	1	2	3	4	5									
		Investigation method <input type="checkbox"/> 5 Whys <input type="checkbox"/> ICAM												
		(Shading relates to category rating above) (H&S Cat 3) (E&C Cat 3)												
Where		When												
Incident Location	T4502 41A	Time of Incident 8 am / pm												
Equipment Involved (type, number, rego)		Time Incident Reported 8 am / pm												
		Date of Incident 1-11-16												
		Date Incident Reported 1-11-16												
		Time into Shift 3hrs												
Incident Scene (Sketch of the incident scene)		Injury Location												
		<p>Circle injury location(s)</p>												
Fatal Hazards														
<input type="checkbox"/> Strata Failure <input type="checkbox"/> Inadequate Energy Isolation <input type="checkbox"/> Fire and Explosion <input type="checkbox"/> Working at Height <input type="checkbox"/> Mobile Equipment <input type="checkbox"/> Lifting and Craneage <input type="checkbox"/> Inappropriate Emergency Response <input checked="" type="checkbox"/> Confined Space and Irrespirable/ Noxious Atmosphere <input type="checkbox"/> Inrush and Outburst <input type="checkbox"/> Tyre and Rim Management <input type="checkbox"/> Explosives and Shotfiring <input type="checkbox"/> Electrical Safety														

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| <input type="checkbox"/> Δ6 - Never attend work under the influence of alcohol or illicit drugs. Consumption on site is prohibited. | |

Injury / Illness

Name of injured person	Rob Burton, LUTHER ALLEN, MARK ANTONIO, AARON DRAKE, DARREL EGAN
Position, role and employer	ERZ CONTROLLERS, MANUPLEX CREW & LP MEN
Details of the injury (Include location and type of injury and task at the time of the incident)	MEN WORKING IN RETURN WHEN THE RETURN BECAME ACTIVE DUE TO LOW PRODUCTION
Was task relevant PPE being worn at the time? (If so, detail the PPE being worn)	YES, BUT DUE TO THE T90 OF THE DRAGON GAS INSTRUMENT: THIS WOULD NOT PICK UP DANGEROUS GAS LEVELS IN TIME
Did the injured worker have to stop work as a result of the injury? (If so, detail action taken - see below for First Aid Treatment)	YES. ALL 5 MEN WITHDREW FROM THE NEW ACTIVE RETURN
Was first aid or medical treatment provided? (If so, who provide treatment and what treatment was given)	NO.

Contributing Factor Data Categories (PEEPO)

People	Environment	Equipment	Procedure	Organisation
ERZ CONTROLLERS Both LW FACE & RETURN	MEN WORKING IN RESTRICTED ZONE BECOMING ACTIVE RETURN OVER LW PRODUCTION.		ERZ CONTROLLERS TO CHECK RESTRICTED ZONE PRIOR TO PRODUCTION	

Description and Timeline of Events

Events leading up to the incident	Spoke to ERZC (Stephen Finlay) on Entering area. Informed him we were going to 41A to continue spraying.
Events at the time of the incident	ERZC Darrel Egan was also there and came with crew to 41A. Spraying 41A Seal noticed very dusty conditions
Events immediately following the incident	ERZC + crew downed tools + retreated out of Restricted zone.
Actions required to control the situation and prevent further harm / loss	Improved communication with ERZC in restricted zone.
Was this an infrequent or frequent task for the individuals involved?	Frequent - 2 to 3 times a week.

Part 2 – 5 Why Analysis (Not applicable where ICAM process is to be used - Category 4 or 5 incidents, E&C Category 3 incidents)

5 Why Analysis (1)		5 Why Analysis (2)	
Problem Statement (1):	Retreat out of Restricted zone.	Problem Statement (2):	Exposure to Active Person
Why?	LW started cutting coal	Why?	LW cutting without informing in Byc chain. in Restricted zone
Why?	Poor Comms with ERZC's	Why?	
Why?	?	Why?	no coming to Restricted zone
Why?		Why?	LW ERZ Contractor failed to check with, Control Room & Restricted zone ERZ Contractor.
Why?		Why?	

5 Why Analysis (3)		Root Cause Description	
Problem Statement (3):	D/S Restricted zone ERZ Contractor failed to inform A/S LW ERZ Contractor that man working in Restricted zone.	D/S ERZ Contractor failed to communicate to A/S ERZ Contractor who was in charge of LW. Hence LW cut (produced) with man in Return.	
Why?			
Why?			
Why?			
Why?			
Why?			

Actions				
Category	Action	Assigned to	Action Accepted	Due Date
	LW ERZ Contractors need to communicate to Control Room Prior to Production to check for man working in Restricted zone	ICAM to be conducted	D. Wynn	9/11/2016 14/11/16

Authorisation			
Supervisor / Investigator	<i>Ron Macrae</i> Name (printed)	2/11/16 Date	<i>[Signature]</i> Signature
Superintendent / Coordinator	MICHAEL ANGER Name (printed)	7/11/16 Date	<i>[Signature]</i> Signature
Review			
Comments			
HST Manager	Name (printed)	Date	Signature
E&C Manager (Required for all E&C related incidents)	Name (printed)	Date	Signature

5 x Why's Root Cause Analysis

Name	Date	Area of Work
Ron. Keleher	02/11/2016	TG 502
This is a 5 WHY's for the time line around production in LW while men still in restricted zone		NO.1.

Completing a 5 Why's Analysis	Define the Problem
<ol style="list-style-type: none"> 1. Plan Comm's at start of shift (WHY) 2. Maintenance Day 3. Pre Shift undermanger (WHY) 4. Pre shift surface 5. ERZ controller restricted Zone 6. ERZ controller LW D/S to A/S hand over 7. Start cutting (WHY) 	<p>Manuplex men working in Restricted Zone with ERZ controller when LW started cutting. The 5 men had to evacuate the area immediately due to the restricted Zone becoming an active return off the Long Wall</p>

5 x Why's Analysis	
1. Why?	Maintenance Day planned activities communicated to all CMW's of the critical work being undertaken in the restricted zone.
2. Why?	No communication with on coming LW ERZ controller from the outgoing LW ERZ controller of the ERZ controller and Ventilation crew (Manuplex) working in restricted Zone in TG
3. Why?	LW ERZ controller did not know or (had forgotten) that there was a crew inbye in the restricted zone.

4. Why?	Failure to check with Control room of any work group working in the restricted zone.
5. Why?	Did not know that there was a work group in the restricted zone or had forgotten

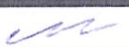
Summary of Root Cause

Undermanager and ERZ controllers failed to communicate the tasked activities in the restricted zone to each other

Recommendations

Undermanagers and section ERZ controllers to Communicate to each other the work activities in each of the restricted zones and inform all work parties in this zone prior to production.

Action	Responsible Person	Due Date
Undermanager to inform LW ERZ controllers of the plan	Undermanager / Scott Dobbie	9/11/2016
LW erz controllers to check the restricted zones prior to production	LW ERZ controller / Jim Canning	9/11/2016

5 x Why's Sign Off	Print Name	Signature	Date
Person that conducted 5 x Why's	Ron Keleher		2/11/16
Department Superintendent (or Manager)	M. Angel		

Action Log and Document Control	Print Name	Date Completed
Actions entered into Actions Database/CMO		
5 x Why's RCA put onto the Document Management System		

5 x Why's Root Cause Analysis

Name	Date	Area of Work
Ron. Keleher	02/11/2016	TG 502
This is a 5 WHY's for the time line around production in LW while men still in restricted zone		NO.2.

Completing a 5 Why's Analysis	Define the Problem
<ol style="list-style-type: none"> 1. Pre Shift Undermanager (WHY) 2. Pre shift surface 3. ERZ Controller restricted Zone 4. ERZ controller LW D/S to A/S hand over 5. Start cutting (WHY) 	<p>Manuplex men working in Restricted Zone with ERZ controller when LW started cutting. The 5 men had to evacuate the area immediately due to the restricted Zone becoming an active return off the Long Wall</p>

5 x Why's Analysis	
1. Why?	Undermanger Comm's at the start of the Shift informing all CMW's of the crew of men tagged on the Restricted Zone for the purpose of building seals in the return at TG 502, 41A C/T
2. Why?	To inform the LW personnel of the relationship around the men working in the restricted zone with production times and seal spraying/pumping for the Manuplex crews in the T/G.
3. Why?	Allows Men to complete the tasks in the restricted zones while LW is not producing

4. Why?	Minimise the exposure to work groups in the restricted zones from production dust /gases.
5. Why?	


Summary of Root Cause

Undermanager and ERZ controllers to communicate the tasked activities to both on coming and outgoing ERZ controllers around the day to day activities of the different work groups in the mine in the restricted zones and their activities for the shift

Recommendations

Undermanagers and section ERZ controllers to Communicate to each other the work activities in each of the restricted zones and inform all work parties in this zone prior to production.

Action	Responsible Person	Due Date
Undermanager to inform LW ERZ controllers of the plan	Undermanager / Scott Dobbie	9/11/2016
LW erz controllers to check the restricted zones prior to production	LW ERZ controller //Jim Canning	9/11/2016

5 x Why's Sign Off	Print Name	Signature	Date
Person that conducted 5 x Why's	Ron Keleher		2/11/16
Department Superintendent (or Manager)	M. Angel		

Action Log and Document Control	Print Name	Date Completed
Actions entered into Actions Database/CMO		
5 x Why's RCA put onto the Document Management System		

5 x Why's Root Cause Analysis

Name	Date	Area of Work
Ron. Keleher	02/11/2016	TG 502
This is a 5 WHY's for the time line around production in LW while men still in restricted zone		NO.3.

Completing a 5 Why's Analysis	Define the Problem
1. Start cutting (WHY)	Manuplex men working in Restricted Zone with ERZ controller when LW started cutting. The 5 men had to evacuate the area immediately due to the restricted Zone becoming an active return off the Long Wall

5 x Why's Analysis	
1. Why?	LW production started without informing restricted zone ERZ controller and Manuplex Crew.
2. Why?	No cominication with restricted ERZ controller and Ventilation crew (Manuplex)
3. Why?	LW ERZ controller did not know or (had forgotten) that there was a crew inbye in the restricted zone.

4. Why?	Failure to inform the LW ERZ controller that men were working in the restricted zone
	And they must be informed prior to production
5. Why?	Both Undermanager and ERZ controller did not communicate that a work group was working in the restricted zone


Summary of Root Cause

Undermanager and ERZ controllers to communicate the tasked activities to both on coming and outgoing ERZ controllers around the day to day activities of the different work groups in the mine in the restricted zones and their activities for the shift

Recommendations

Undermanagers and section ERZ controllers to Communicate to each other the work activities in each of the restricted zones and inform all work parties in this zone prior to production.

Action	Responsible Person	Due Date
Undermanager to inform LW ERZ controllers of the plan	Undermanager / Scott Dobbie	9/11/2016
LW erz controllers to check the restricted zones prior to production	LW ERZ controller / Jim Canning	9/11/2016

5 x Why's Sign Off	Print Name	Signature	Date
Person that conducted 5 x Why's	Ron Keleher		9/11/16
Department Superintendent (or Manager)	M. Angel		

Action Log and Document Control	Print Name	Date Completed
Actions entered into Actions Database/CMO		
5 x Why's RCA put onto the Document Management System		

Statement of Events LW502 1/11/16

On the Afternoon Shift of the 1/11/16 I was the district ERZC for LW 502 production district. This area included the TG roadway to the brattice regulator in C hdg TG roadway which was approx. 200m outbye from the face.

The main tasks for the day were 1) Change out of the TG AFC sprocket, 2) DA ram change out on PRS #155, 3) Build 5 timber cogs in 32 c/t MG. Manuplex were also tasked with VCD activities in D hdg TG 502 which were outside of my district.

The planned duration of the maintenance plan was 14 hrs (0700hrs to 2100 hrs).

Due to the speed change out of the TG sprocket the LW face was in a position to produce from around 1830 hrs.

The section fitter removed the LHD from the TG with the plan to take it around to the MG and park it in 32 c/t with all the unused supplies and tooling from the sprocket job. Around this time I called the CRO to locate the shift undermanager as he was not at his phone on the surface. I then held a discussion with the UM in regards to rebuilding the brattice regulator in the TG to determine the required ventilation quantity to ventilate TG C hdg 33 – 34 c/t.

I then asked to get all the guys out of the red zone so we could start production. The shift UM was of the belief that it was a full 14 hrs maintenance window and would get in touch with the TG ERZC who I believe was Darryl Egan. I left my section electrician Matt Earl at the TG drive to take any other phone calls for me while I rebuilt the C hdg regulator.

Upon arrival back to the TG drive Matt Earl informed me that the shift UM had just called and that we were right to produce. I then made a call to the shift UM to confirm if we were OK to produce and authority was given to me to start production.

MG 502 conveyor was still down on a trip while we were waiting for the crew to arrive. Once the conveyor was running production commenced at around 1915 hrs.

I went back to the crib room to complete my paper work for the shift and rang through my pan angles for my first shear to the CRO. By the end of shift we had achieved two shears.

A normal hand over with the NS ERZC was held in the crib room in which the statutory status of the panel was discussed as well as the maintenance and production results.

Upon arrival on the surface I handed in the carbon copy of my production report to the CRO, put my mine phone and methanometer back in the instrument room and held a debrief with the NS UM in the Development process room.

At no time from when we started production, talked to the CRO, handed over to the NS ERZC or completed my debrief with the NS UM was I aware there had been an incident in relation to CMW's being in the TG red zone during production. I left site still unaware of any incident and the first time I was aware of it was when my Superintendent contacted me today 2/11/16 to supply a statement for the investigation.

This statement is written without my note book or statutory report to refer to.

Andy Morris

Statement concerning events 2/11/16.

Activities for the nightshift 2/11/16.

Spraying of 41a ct seal TG502.

Personnel: Manuplex ventilation crew.

Event time line:

1. Arriving at site I meet with the VO at the turn style and given a briefing on task progress.
2. I was notified that progress had been poor due to several incidents and that spraying of the seals would continue into my shift. I enquired as to the time line of the maintenance window I was told that it was probably going for the full 14 hours.
3. After preparing for shift I was notified by the Shift Manager B. Brigden that I was required to hot seat S. Finlay as as Erz Controller in charge of the seal spraying in TG502.
4. I travelled to site and received a handover from S. Finlay.
5. In this I was notified of the communications difficulty faced at the work site. Being that neither mobile, DAC or hard line comms were near.
6. The crew were already on task.
7. I proceeded to the work site and accessed the area conditions.
8. The comms problem could not be addressed at this time due to limited manning on task. Spraying crew 3 men, supplies 1 man and myself conditions monitoring.

I then worked under the system of ringing for an update close to the time I was expecting the Long Wall to be ready for production. Approximation 2030 to 2100.

At approximately 2025 I rang the Shift Manager and was notified that the Longwall had started producing. There had been no increase in dust, gas or heat at this stage in the work area to indicate activity.

I immediately ceased activity and removed men from the Red Zone.

During exit approximately 20m from fresh air we noticed an increase in dust coming down the airway. All personnel were wearing appropriate PPE and I believe no one was exposed to an unacceptable level of risk.

I then contacted the Shift Manager and notified him that all personnel were out of the red zone and the regulator was in its operational position.

As I did not consider that anyone was exposed to an elevated level of risk other than the inherent risk of the area and task at hand I did not complete an incident report.

Darrel Egan

Statement by Barry Brigden for Night Shift 1-11-16, commencement of LW production after maintenance day Tuesday 1-11-16.

I began work at 5 pm when I entered the shift manager's office.

Glenn Williams inform me that a deputy was required to relieve Steve Finlay in TG 502 as Manuplex were in there working on the seals. I knew it was a 14hr maintenance window. I approached Daryl Egan and gave him TP24 and he immediately proceeded to go U/G.

I had the 5:30 planning meeting and it was said that Manuplex were working in the TG.

At 5:45 Steve Finlay rang out to confirm someone was coming to relieve him. I told him that Daryl had left 25 mins ago. He did not say where Manuplex were working in the TG, but I knew it was inbye of the TG regulator. Brad Rodgers then rang from Comms and said that the LW was ahead of schedule and would be ready around 7:30 pm. I asked him did he know if we were to produce as soon as the LW was ready. He said that he did not know and that Damien Wynn was in his office. I rang Damien and asked if he wanted to complete the seal or commence production. He did not give me a definitive answer and I said that the DACs were not working so Manuplex would not be pumping a seal. I then said that we would commence production as soon as the LW was ready.

LW ERZC Andy Morris rang me at approximately 6:30 pm and said that the covers needed to go on the TG drive and that they would ready around 7:30 pm. I asked him to go into the TG roadway and see if he could see Manuplex or Daryl Egan. He asked me what I wanted to do and I said to produce as soon as the LW was ready. Steve Finlay arrived on the surface, and I told him that the LW was nearly ready to go. I asked what was the best phone number to contact Daryl on and he said that 6212 was the phone at the regulator. I tried this number numerous times but did not receive an answer. I rang Comms to see what WiFi phone Daryl had taken. Cam Costello said that there was no number on the board for Daryl. I then checked the sign out book in the lamp room, and there was no record of Daryl taking a phone. I tried several more times to contact Daryl but was unable to reach him.

Andy Morris then rang again and I confirmed with him that I intended to start production as soon as possible. I said that Manuplex would realise they were cutting when dust started to come into their roadway. The LW commenced cutting as approximately 7:40. Daryl rang me at 8:15 and asked when was the LW to start? I confirmed that they already had started cutting. He then said that he would withdraw the men immediately and pack up their gear. He said he thought the LW had started as he could taste the silica from rock dust, but that the work area was so dusty from the spray material that, he could not tell if there was any coal dust in it. He said all men had suitable PPE on for the process.

In conclusion, it was my decision to allow the LW to cut before confirming that everyone was out of the TG. My decision was based on knowing that there was at least 150m³ of ventilation in the roadway, that all steps possible were taken to contact the men, that the PEDS do not work in that area, that the DACs were down, and at most they would be exposed for a short period until they realised dust was coming

into their work area, that they had an ERZC with then. I also considered that the LW usually has teething problems upon start up after a lengthy maintenance period. This would give me extra time to contact Daryl. In the back of my mind was also the constant reminder from the LW department that it costs \$3000 a min for the LW to be down and that I needed to show some urgency to ensure that production was maximised.

Regards

Barry Brigden

D crew shift manager



Surface Department

Witness Statement Form

Statement Of:	Rob BURSON	Department:	VENT
Occupation:	OPERATOR	Crew:	D
Employment Type:	<input type="checkbox"/> Employee <input type="checkbox"/> Visitor <input checked="" type="checkbox"/> Contractor	Company:	MANUMPLEX

WITNESS STATEMENT COMPLETION INSTRUCTIONS
PLEASE READ THE FOLLOWING NOTES CAREFULLY BEFORE COMMENCING YOUR STATEMENT

Provide lead up information of events that occurred prior to the actual incident. For example: Where you were, what you were doing etc.

Include a description of the environmental conditions.

Provide as much detail as possible about the actual incident including – distance from objects, time and speed estimates etc.

Write only about what YOU saw and heard.

Conversation should be in the first person.

For example: I said, "....."
He said, "....."

If you are unable to recall first person conversation you may still record the conversation to the best of your recollection.

WITNESS STATEMENT:

On 1st Nov did a hotseat change over with DS crew to spray 41A et in TG 502. On our way in spoke with Steve Finlay and told him our intentions. Was closely followed by Darryl Eagen who also spoke with Steve. and came into area with us. Was in process of spraying seal when Darryl went to check when wall was about to start. Darryl returned in haste and told us to all leave immediately as ~~was~~ L/W was already cutting. Retreated to fresh air outbye of Reg doors, approximately 20-30. All crew were tagged on in Red Zone.


FORWARDING PROCEDURE:

Supervisor → Safety Department → Investigation Team → Incident File



Witness Statement Form

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There are approximately 20 lines visible. The paper appears to be a standard notebook page or a sheet of stationery. There is no handwriting or other markings on the page.

PERSON MAKING STATEMENT		PERSON WITNESSING STATEMENT	
Signature:		Signature:	
Print Name:	Rob Brown	Print Name:	
Date:	9-11-16	Date:	

Supervisor → Safety Department → Investigation Team → Incident File

Review Date
01/01/09

FRM0160SUR



Surface Department

Witness Statement Form

Statement Of:	NATHAN ALCORN	Department:	VENTILATION
Occupation:	OPERATOR	Crew:	A
Employment Type:	<input type="checkbox"/> Employee <input type="checkbox"/> Visitor <input checked="" type="checkbox"/> Contractor	Company:	MANUPLEX

WITNESS STATEMENT COMPLETION INSTRUCTIONS

PLEASE READ THE FOLLOWING NOTES CAREFULLY BEFORE COMMENCING YOUR STATEMENT

Provide lead up information of events that occurred prior to the actual incident. For example: Where you were, what you were doing etc.

Include a description of the environmental conditions.

Provide as much detail as possible about the actual incident including – distance from objects, time and speed estimates etc.

Write only about what YOU saw and heard.

Conversation should be in the first person.

For example: I said, "....."
He said, "....."

If you are unable to recall first person conversation you may still record the conversation to the best of your recollection.

WITNESS STATEMENT:

OVERTIME SHIFT ON THE 1ST NOVEMBER STARTED WITH HOTSEAT CHANGE OVER
IN TG 502 @ APPROX 18:30 ENTERED TG 502 AND WAS GREETED BY
STEVE FINLAY WHO GAVE US PERMISSION TO ENTER RED ZONE AS
D/S ALREADY WORKING 41A TG 502. STARTED WORKING ON 41A CT
SPRAYING 20PSI SEAL FOR APPROX A COUPLE OF HRS WHILE STANDING
IN FRONT OF HOPPER THROWING BAGS DARRYL EAGEN INSTRUCTED
US TO GET OUT OF ZONE NOW THERE (LW) CUTTING, LETSGO.
RETRACTED TO FRONT AIR IN ORANGE ZONE OUTSIDE OF REG.
DOORS.


FORWARDING PROCEDURE:

Supervisor → Safety Department → Investigation Team → Incident File



Witness Statement Form

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

PERSON MAKING STATEMENT		PERSON WITNESSING STATEMENT	
Signature:		Signature:	
Print Name:	NATHAN ALCORN	Print Name:	
Date:	6/10/16	Date:	

Supervisor —————> Safety Department —————> Investigation Team —————> Incident File

Oncoming D/S Comms Officer Name: _____

Oncoming D/S Comms Officer Signature: _____

16th Nov 2016

16 November 2016

DEV	PANEL: NORTH MANU		
City	MAN TAYLOR		
PLAN: Op Hours	Metres	TTFC	TTLG
Time	Metres Cut / Work Achieved - Condition of CMW's / Issues		
22	MAN TAYLOR & MARK RICKER & MAT SKIN INTO PANGA		
45	MAN & 6 CMW's TP23 & LH32 20:40 FAN GOING. 01:40-02:20:40m FLIT CM BACK TO 42M MARK TO INTR 6 METRE MENAS FROM 42-60M SPATA ADVISE CODE YELLOW -> DRAWD: THROUGH FAULTED AREA.		
26	CONTINUE INTRU THROUGH FAULT. 20min EC TRIP FAN.		
Hours	Metres	TTFC	TTLG

LW		PANEL: LW502	
Time	Deputy	Description of Activity	
PLAN: Op Hours		Metres	TTFC
Time		Shears Cut / Work Achieved - Condition of CMWs / Issues	TTLG
19:30	ANDY MORRIS	STEVE FINLAY (PH 6338) 211ft CM 4 PAC PUMP STALLED OUT, HAS RESTARTED BUT THERE'S A LOT OF WATER THERE. TOLD KURT.	
19:52		STEVE RANG THE BULK DUSTER IN TG IS FAULTY BLOWING OUT THROUGH FITTINGS. WITH THREE OUT NEEDS TO BE REFINISHED. TOLD KURT. ALSO TG STAYS HAS 4 TUBES OPEN. WILL PUMP 37ft SEAR.	
20:46		STEVE RANG BULK DUSTER MOVED OUT TO 25ft. GOING TO PUMP 38th SW 37ft.	
22:09		STEVE RANG 38ft HAS 600mm TO COMPLETE BUT DICK'S PUT NO COMMI. GOING TO PUMP 37ft.	
22:46		ANDY MORRIS INTO PANGA	
23:10		STEVE RANG PUT OUT KURT. NEED 2 BOXES SILVER SENT TOLD KURT.	
00:42		RANG LW CA BROOM SPOKE TO ROGER TO TELL ANDY MORRIS 3 MANUPLEX CLEAR OF TG BUT STEVE FINLAY STILL THERE & H.D MAN HAS TO INSTALL BULK DUSTER.	
00:53		LOOKED @ CLUE & CUTTING IMMEDIATELY RANG & SAID STOP. STEVE FINLAY STILL IN TG.	
00:55		ADAM MORROW RANG SHUT DOWN NOW, TOLD HIM STEVE STILL IN RED ZONE. OK. SENT MESSAGE ON WITH ADAM.	
01:05		ANDY MORRIS RANG WHY WE STOPPED?! BECAUSE STEVE FINLAY STILL IN TG & TAG ON RED ZONE KURT EKANAYAKE WALKED IN & SAID NO STEVE RANG & SAID HE WAS OUT OF TG?! WHY DIDN'T YOU TELL US @ 23:10! ANDY SAID OK WILL START CUTTING.	
01:24		STEVE FINLAY RANG CLEAR OF TG NOW!? OUT OF RED ZONE NOW!? KURT SAID YOU WERE OUT! "NO! I WOULD'VE RANG! NOT HAPPY WILL TALK TO KURT ABOUT IT."	
Actual: Op Hours		Metres	TTFC
			TTLG

LW	PANEL:		
Time	Deputy	Description of Activity	CMW
PLAN:	Op Hours	Metres	TTFC
Time	Shears Cut / Work Achieved - Condition of CMW's / Issues		TTLG
00:45	TTFC @ #75 → MG		
00:53	STOPPED FOR STEVE FINLAY IN TG		
01:08	RESTARTED PRODUCTION FROM AUTHORITY FROM KURT EKANAYAKE.		
01:26 → 01:57	= 31mins STOPPED @ #28		
01:57 → 02:07	cut. into MG		
02:07 → 02:33	= 26min FL @ MG		
03:22	@ TG 1st SHEAR		
04:38	@ MG 2 1/2 SHEARS		
06:07	@ TG 3 1/2 SHEARS		
05:12 → 05:49	37 mins @ MG 4 1/2 SHEARS		
→ 03:05	ANDY MORRIS RANG GAVE UPDATE. STEVE HODGSON.		
06:27	BAUSY - TTFC 05:50 11 MIN BROKEN SHEAR PIN @ 161 CUT 1/2 SHEAR		
Actual: Op Hours Metres TTFC TTLG			