

Black Mountain Mine

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BMM-HSE-SAF-SOP-0003 Incident Investigation

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CHANGE HISTORY

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18/11/2022		M Korff	Alignment with Vedanta Standards & EHS Electronic systems

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DEFINITIONS AND ABBREVIATIONS

Word / Phrase / Abbreviation	Definition
Corrective action ISO 45001:2018	Action to eliminate the cause(s) of a nonconformity (3.34) or an incident (3.35) and to prevent recurrence.
Incident ISO 45001:2018	Occurrence arising out of, or in the course of, work that could or does result in injury and ill health (3.18) Note 1 to entry: An incident where injury and ill health occurs is sometimes referred to as an “accident”. Note 2 to entry: An incident where no injury and ill health occurs, but has the potential to do so, may be referred to as a “near-miss”, “near-hit” or “close call”. Note 3 to entry: Although there can be one or more nonconformities (3.34) related to an incident, an incident can also occur where there is no nonconformity.
Incident VED/CORP/SUST/MS 11	An event or chain of events which caused or could have caused injury, illness, loss of assets or potential or actual damage to relationships or reputation.
Investigation	A systematic and structured analysis of an incident and the events and conditions leading up to it, with the aim of (i) identifying the root cause(s) that allowed that incident to occur, and (ii) proposing effective corrective and preventive actions so as to prevent any future recurrences.
PEME	PEME is an acronym used in Black Mountain Mining and has the following meaning: People, Equipment, Materials, Environment, The use of this in written documentation helps to comply with Resources Clause 7: ISO 45001.
Serious injury	Means any injury which is reportable under the MHSA

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Preventive action	An action from an audit, assessment or other evaluation that is identified and implemented to prevent the reoccurrence of an actual or potential non-conformance.
Root cause	An initiating event or failing from which all other causes or failings arise. This is always related to a management, planning, or organizational weakness or failure. Investigations must strive to identify the root cause, because if they do not then there is a high likelihood of a repeat or similar event occurring in the future.
Accident	An undesired event resulting in death, injury, damage to health, damage to property, or other form of loss.
Dangerous Occurrence	A near miss with serious injury potential (see also 'incident')
DLFR	Days Lost Frequency Rate-number of days lost due to an Injury on Duty.
First Aiders	The skilled application of accepted principles of treatment in the occurrence of injury or illness.
HIPO (High Potential Incident)	An occurrence with potential to cause serious injury or death Dangerous occurrence as per chapter 23 of MHSA
Injury	An injury is temporary or permanent damage to tissue, muscle or bone typically caused by an identifiable event.
'medical practitioner'	Means a <i>medical practitioner</i> as defined in the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act 56 of 1974);
Near miss (or "near hit")	An event that, while not causing harm, had the potential to cause injury, ill health, environmental impact, or property damage/loss.
'occupational medical practitioner'	Means a medical occupational practitioner who holds a qualification in occupational medicine, or an equivalent qualification, recognised by the Health Professions Council of South Africa and appointed by the Employer.

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Damage	Work related event in which damage was caused to property, vehicles, or equipment
First aid Case	The treatment of minor cuts, scratches, burns etc. which could normally be treated by the injured himself, even if carried out by a paramedic or first aider, is classified as a Minor Injury. The injury is deemed to be of such a nature that the injured can report back to work for the same or similar occupation on the same shift.
IOD	Injury on duty.
Lost Time Injury	An injury shall be classified as a Lost Time Injury where one or more of the following criteria are applicable: The loss of one or more shifts as a result of the accident following the shift during which the accident occurred. An injured employee who does not lose working time on the days immediately following the injury but is booked off later by the OMP or a MP due to complications in respect of the injury concerned. Employees who are absent from duty owing to alleged work injuries shall, after proper examination, be included or excluded as Lost Time Injuries as determined by the OMP. Where an employee is booked off for a second or subsequent time as a result of a Lost Time Injury such recurrence shall not be regarded as a further Lost Time Injury. Where a person is hospitalized for a period not exceeding 48 hours, and it is verified by a medical practitioner that the stay in the hospital is for observation only, then such an accident shall not be recorded as a Lost Time Injury.
Medical Treatment Case	Work related injury which, under normal circumstances, requires treatment normally received from a medical professional (e.g., OMP, MP, nurse, paramedic) via treatment and/or prescription, but which does not result in lost days or restricted work and allows the injured party to resume their normal duties on the day following the incident. Precautionary measures, e.g., X-rays, or other medical examination of a person after an incident. The application of sutures (stitches), or the removal of a foreign body embedded in the eye, are examples of MTC's. Any treatment of an injury which involves medicines usually obtainable only by prescription of a medical professional (e.g., antibiotic) is an MTC.
Fitness for work	Ability to meet the specific requirements of a task or job.
ICAM	Incident Cause Analysis Method, a systematic incident investigation analysis method.
Non-conformance	Any deviation from work standards, practices, procedures, regulations, management system performance etc. that could either directly or indirectly lead to injury or illness, property damage, damage to the workplace environment, or a combination of these
RCAT	Root Cause Analysis Technique

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1. PURPOSE

- 1.1.1 The purpose of this Standard Operating Procedure is to describe the arrangements and requirements for the reporting, classification, escalation, and investigation of incidents at Black Mountain Mine.
- 1.1.2 The effective, reporting, classification and resulting actions including investigation, closure, and communication of incidents, is crucial to enable Black Mountain Mine to understand the effectiveness of its risk management programmed and to ensure that the organization learns lessons to be able to avoid future occurrences/ reoccurrences.
- 1.1.3 Black Mountain Mine has established, implemented, and maintain incident reporting and investigation processes to act in determining the causes and the management of incidents to comply with legislative requirements,
- 1.1.4 Internal incident investigation includes the analysis of incident statistics to determine incident trends and high-risk activities.
- 1.1.5 In the event of an incident Black Mountain Mine shall:
 - 1. react in a timely manner to the incident.
 - 2. take immediate action to control and correct the incident.
 - 3. deal with the consequences.
 - 4. identify the need for corrective action.
 - 5. identify opportunities for preventive action.
 - 6. identify opportunities for continual improvement.
 - 7. communicate the results of such investigations.

2. SCOPE AND USERS

2.1

This Procedure is mandatory and applies to all Black Mountain Mine operations, relevant Stakeholders, Business Partners and Contractors.

This Procedure does NOT cover sick leave and compensation due to injuries sustained, it however refers to the reporting of serious injuries that is covered under the COIDA: Compensation for Occupational Injuries and Diseases Act (Act 130 of 1993)

This Procedure does not cover Environmental incidents, Ventilation and Occupational Hygiene. These are covered separately by the Environmental and VOH Departments.

3. REFERENCE DOCUMENTS

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3.1

- 3.1.1 VED/CORP/SUST/MS 11- Incident Reporting, Classification, and Investigation.
- 3.1.2 VED/CORP/SUST/GN - Incident Investigation.
- 3.1.3 Mine Health and Safety Act, 1996 (Act No. 29 of 1996) and Regulations.
- 3.1.4 South African Mines Reportable Accidents Statistics System (SAMRASS) Codebook for Mines.
- 3.1.5 ISO 45001:2018 - Clause 10.2 - Incident, Non-conformity, and corrective action. (for practicality, Nonconformance and Corrective action is a standalone SOP)

4. ROLES AND RESPONSIBILITIES

4.1 EXCO

- 4.1.1 Exco shall demonstrate leadership and commitment with respect to the HSE management system by:
 - Take overall responsibility and accountability for the prevention of work-related injury and ill health, as well as the provision of safe and healthy workplaces and activities.
 - Direct, delegate and support other relevant management roles to enforce the effective implementation of the requirements as described in this document.

4.2 MINE MANAGEMENT

- 4.2.1 Shall assist EXCO in ensuring that all incidents and accidents are reported and investigated as per this procedure.
- 4.2.2 Ensure that adequate arrangements (venue, availability of personnel etc.) are in place for investigating all the incidents, including fatal, dangerous occurrences and High Potential incidents.
- 4.2.3 Ensure the investigation team receive training to the extend necessary in investigating incidents of all categories.
- 4.2.4 Section 11(5)(a)(i) of the MHSA states clearly that Black Mountain Mine must investigate every accident that must be reported in terms of the MHSA as described below.

4.3 BLACK MOUNTAIN MINE SAFETY MANAGER

- 4.3.1 Support EXCO and mine management in executing their duties in terms of the MHSA.

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- 4.3.2 Ensure that all 48-hour Incident Alerts submitted meet the minimum requirements.
- 4.3.3 Communicate incident investigations outcomes and report during management review on outstanding investigations.
- 4.3.4 If it is not possible to be complete the reportable investigations as per the MHSA Regulation 23 within 30 days as a result of a delays (obtaining specialist reports, etc) the Safety Manager must liaise with the 3.1(a) Manager for extension request for submission from the Principal Inspector.
- 4.3.5 Ensure that follow ups on the corrective action is conducted.

5. OCCUPATIONAL MEDICAL PRACTITIONER

- 5.1.1 Ensure that all injured persons requiring treatment at the Black Mountain Mine clinic are treated in accordance with pre-scribed medical protocols and legal requirements, keep the appointment of the OMP current.
- 5.1.2 In case of the absence of the OMP, ensure a relief OMP or MP is appointment to cover period of absence.

6. LEGAL & OTHER CONSIDERATIONS

- 6.1.1 The MHSA introduces a number of reforms to facilitate the more effective conduct of investigations and inquiries. The MHSA creates mandatory and discretionary investigations.
- 6.1.2 The investigation needs to start within **24 hours from the date of such accident or incident**. Following the investigation, Black Mountain Mine need to write a report and deliver it to the responsible Principal Inspector of Mines **within 30 days of the accident**, serious illness, or health-threatening occurrence.
- 6.1.3 The investigation must be completed within **10 days** and thereafter the investigation report submitted to the manager within **3 days** after completion. MHSA (2.19.3) (b)

6.1. ACCIDENTS TO BE REPORTED

- 6.1.4 In terms of Chapter 23, the requirements for reporting of accidents and dangerous occurrences are as follows:

23.1 The *employer* must report to the **Principal Inspector of Mines (DMR)** in the manner prescribed in this chapter any accident at the mine that results in:

- a. the death of any *employee*.
- b. an injury, to any *employee*, likely to be fatal.

- c. unconsciousness, incapacitation from heatstroke or heat exhaustion, oxygen deficiency, the inhalation of fumes or poisonous gas, or electric shock or electric burn accidents of or by any *employee* and which is not reportable in terms of paragraph (d).



NOTE:

An accident referred to in paragraph (a), (b) or (c), must be reported immediately by the quickest means available and must be confirmed without delay on Forms SAMRASS 1 and 2 .

- d. an injury which either incapacitates the injured employee from performing that employee's normal or a similar occupation for a period totalling 14 days or more, or which causes the injured employee to suffer the loss of a joint, or a part of a joint, or sustain a permanent disability; **(LTI)**



NOTE:

An accident referred to in paragraph (d) of regulation 23.1 must, after the accident becomes reportable, be reported within three days on Forms SAMRASS 1 and 2.

- e. an injury, other than injuries referred to in paragraph (d), which incapacitates the injured *employee* from performing that employee's normal or a similar occupation on the next calendar day. **(LTI)**



NOTE:

An accident referred to in paragraph (e) of regulation 23.1 must be reported without delay on a monthly basis, on Form SAMRASS 4 prescribed in Chapter 21.

6.1.5 In terms of Chapter 23 (23.2)

- (3) The Form SAMRASS 9 must be submitted on a monthly basis for all persons not having returned to work at the time of submitting SAMRASS 2 on a monthly basis.

6.1.6 In terms of Chapter 23 (23.3)

- (1) Where the death of an *employee*, referred to in regulation 23.1 (a) is related to a **rock burst or fall of ground**, the duly completed Form **SAMRASS 3**, prescribed in Chapter 21, for such rock burst or fall of ground must be forwarded by the *employer* to the Principal Inspector of Mines within 14 days of such death.
- (2) When an injury results in the death of the injured *employee* after the report in terms of regulation 23.1(b), (c), (d) or (e) has been given or when a

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slight injury, which was not reportable, results in the death of the injured *employee*, or when general sepsis or tetanus develops as a result of an injury, the *employer* must immediately report it to the Principal Inspector of Mines and without delay submit amended Form SAMRASS 1 prescribed in Chapter 21.

(3) Where the injury of a person referred to in regulation 23(1) or a dangerous occurrence referred to in regulation 23.4(o), is related to the use of explosives, in addition to Form SAMRASS 1, the duly completed Form SAMRASS 5, prescribed in Chapter 21, must be forwarded by the *employer* to the Principal Inspector of Mines within 14 days of such occurrence.

(4) Where the injury of a person referred to in regulation 23(1) or a dangerous occurrence referred to in regulation 23.4(f) is related to fires, in addition to Form SAMRASS 1, the duly completed Form SAMRASS 6, prescribed in Chapter 21, must be forwarded by the *employer* to the Principal Inspector of Mines within 14 days of such occurrence.

6.1.7 In terms of Chapter 23 – (23.4) - Dangerous occurrences to be reported

23.4 The employer must report to the Principal Inspector of Mines in the manner prescribed in this Chapter any of the following dangerous occurrences at the mine-

- a. Rock bursts and falls of ground.
- b. Caving.
- c. Flow of water, broken rock, mud, or slimes.
- d. Breakdown of main ventilation fan.
- e. Power failure.
- f. Fires and explosions.
- g. Flammable gas.
- h. Winding plants.
- i. Objects falling down shafts.
- j. Explosives.

6.1.8 In terms of Chapter 23 (23.6)

23.6 Every employer must ensure that a system is in place whereby the employer is informed, as soon as is practicable after its occurrence, of any accident or dangerous occurrence, which is reportable in terms of this Chapter.

6.1.9 In terms of Chapter 23 (23.7)

(i). Every employer must keep and maintain a record in which the particulars of all accidents and dangerous occurrences, which are required to be reported in terms of this Chapter, must be recorded without delay.

6.1.10 In terms of Chapter 24 (24.11)

When any person employed at a mine or works sustains injury by accident or otherwise, the manager shall make all reasonable arrangements to ensure that **the injured person received prompt medical attention and that where the resident medical practitioner or the nearest registered medical practitioner is immediately sent for.** If the injured person is unable to proceed unaided to his abode or to a hospital, the manager of the mine or works shall have such person conveyed to his abode or to hospital as quickly as practicable and at the expense of the owner of the mine or works. **(LTI)**

6.1.11 In terms of section 86. Negligent act or omission

(1) Any person who, by a negligent act or by a negligent omission, causes serious injury or serious illness to a person at a mine, commits an offence.

6.1.12 The employer is stipulated by the **COID** to report any incident that result in disablement, death, unconsciousness to the Department of Labour.

6.1.13 In terms of section 86A. Criminal liability

(1) An employer, chief executive officer, manager, agent, or employee commits an offence if he or she contravenes or fails to comply with the provisions of this Act thereby causing-

- a. a person's death; or
- b. serious injury or illness to a person.



WARNING:

When completing **SAMRASS forms**, use the Codebook for Mines to ensure correct details are provided.

6.2. PLACE OF AN ACCIDENT TO BE LEFT UNDISTURBED

6.2.1 In terms of MHSA 10, the following shall be applicable when visiting accident scenes.

10.1(1) When an accident causes the immediate death of any employee, the place where the accident occurred must not, without the consent of the Principal Inspector of Mines, be disturbed or altered before such place has been inspected by an Inspector or any other person authorized under section 49(4) by the Chief Inspector of Mines.

10.1(2) Regulation 10.1(1) does not apply if:

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(a) such disturbance or alteration is unavoidable to prevent further accidents, to remove fatalities and injured employees or to rescue employees from danger; or

(b) the discontinuance of work at such place would seriously impede the working of the mine.

10.1(3) Despite regulation 10.1 (1), work may be resumed at the place where the accident occurred if such inspector or other person authorized by the Chief Inspector of Mines fails to inspect the place within three days after notice of the accident has been given.

6.3 LEGISLATIVE APPOINTMENTS

6.3.1 In terms of the Occupational Health and Safety act, 1993, Section 24 and General Administration Regulation 8(1), an Incident investigator must be formally appointed. (This might have relevance to contractors falling under the OSHACT) These persons shall also be appointed in terms of the MHSA.

6.3.2 In terms of the MHSA, Black Mountain Mine shall appoint Incident Investigation Managers and an Investigation team.

- Sec 4(1) - Employer may entrust functions to another person.
- Sec 3(1) - Employer may appoint a manager/s.
- Reg 2.6.1 - Manager may appoint one or more competent persons to assist.
- Reg 2.9.2 - Manager shall appoint such persons as may be necessary to assist in enforcing and observation of regulations.

7. RESOURCES

7.1 PPE (PPE)

7.1.1 All investigation team members shall ensure that they fully comply with Black Mountain Mine PPE requirements when investigating incidents.

7.1.2 Incident investigation team leaders shall ensure to plan for all required resources prior to starting an incident investigation.

7.2 AWARENESS AND COMMUNICATION

7.2.1 Users of this SOP shall be made aware of the contents by means of consultation and toolbox talks and shall include as a minimum:

- 1) How to report an incident.
- 2) Where to report.
- 3) What documentation they might need to help them.

- 7.2.2 Whenever new documentation is created and implemented, internal communication shall be carried out to ensure the workforce is aware of the existence of a specific document, they are scheduled for training and can implement the requirements without risk to Black Mountain Mine operations.
- 7.2.3 Whenever new documentation has an impact on Black Mountain Mine business partners and contractors, these shall be communicated through formal meetings and or electronic medium.

7.3 TRAINING

- 7.3.1 The incident investigator team leader should:
- 1) Be trained and competent in applying incident fact finding and analysis tools.
 - 2) Have previous experience in comparable scale investigations.
 - 3) Be skilled in effective management of a small investigation team.
 - 4) Be able to act as liaison between senior management and the investigating team.
 - 5) Be trained to use the EHS electronic systems to capture incidents and their investigations.
- 7.3.2 The incident investigation team should be able to:
- 1) Collect data, facts, and evidence.
 - 2) Establish the sequence of events leading up to the occurrence.
 - 3) Analyze and integrate available information.
 - 4) Develop findings and conclusions.
 - 5) Determine the significance of findings.
 - 6) Write the investigation report.
 - 7) Present the report to management.

7.3.3 Departmental Heads shall ensure to schedule training following incident investigation team member appointments.

8. OPERATIONAL PLANNING AND CONTROL

8.1

- 8.1.1 Black Mountain Mine shall plan, implement, control, and maintain incident reporting and investigation processes as described in this Standard Operating Procedure to meet requirements of the HSE management system.

8.1.2 Incident reporting and investigations shall be done on the EHS Electronic systems, all manual documentation shall be captured in the system as supportive documentation.

8.1.3 Operational Planning shall include:

- 1) Schedule formal investigations.
- 2) Ensure all information regarding the incident is available.
- 3) Ensure ALL role players attend.
- 4) Ensure all witness statements are taken and available.
- 5) Ensure resources are provided for the investigation team.
- 6) Ensure to stay in the reporting timeline for submitting incident report(s).

9. RISK MANAGEMENT

9.1

9.1.1 Use risk assessment descriptors to determine the level of investigation.

9.1.2 Determine the scope and type of investigation based on:

- 1) The actual consequence severity.
- 2) Potential future risk.
- 3) Opportunity for learning from the incident or near miss.
- 4) Guidance on determining the level of investigation.

10. PERFORMANCE EVALUATION AND MONITORING

10.1

10.1.1 Black Mountain Mine HSE shall include incident and investigation processes in their HSE Audit schedule.

10.1.2 Audit criteria shall include:

- 1) Incident reports.
- 2) Investigation reports.
- 3) Communication and awareness records.
- 4) Compulsory reporting records.

11. INCIDENT CLASSIFICATION

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11.1

- 11.1.1 All confirmed injuries on duty will be classified and recorded for statistical purposes as below categories.
- 11.1.2 Injury and safety statistics will be collated, processed, and distributed for EXCO at month end and presented during HSE management review.
- 11.1.3 The OMP shall classify the injuries in line with this Standard Operating Procedure and sign off on the Injury Classification Form(BMM-HSE-FRM-0003) as per Appendix 4
- 11.1.4 Where possible a sub injury classification relating to the incident must be made by the OMP.



NOTE:

The Incident Classification and if applicable shall be made and known before logging details into the Isometrix Incident module

11.2 CATEGORY: 1- FIRST AID CASE

- 11.2.1 Risk Level: **Negligible.**
- 11.2.2 Required Action: Report before end of shift.
- 11.2.3 Timing: Report monthly in the Monthly Incident Report.

11.3 CATEGORY:2 - MEDICAL TREATMENT CASE

- 11.3.1 Risk Level: **Minor.**
- 11.3.2 Required Action: Report before end of shift.
- 11.3.3 Timing: Report monthly in the Monthly Incident Report.

11.4 CATEGORY:3 - LOST TIME INJURY (SAFETY).

- 11.4.1 Risk Level: **Moderate.**
- 11.4.2 Required Action: Report immediately to Senior Management.
Must be reported by email to the Vedanta Company CEO, COO, Head of Sustainability / HSE and Legal Counsel within 24 hours of the incident occurrence.
- 11.4.3 Timing: Report monthly in the Monthly Incident Report.

11.5 CATEGORY: 4- FATALITY(IES) & DISABLING INJURY (SAFETY).

- 11.5.1 Risk Level: **Serious; Safety (HIPO)**
- 11.5.2 Required Action: Report immediately to Senior Management.

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Must be reported by email to the Vedanta Company CEO, COO, Head of Sustainability / HSE and Legal Counsel within 12 hours of the incident occurrence.

Must be reported to the Vedanta Resources Chief Executive Officer, Chief Sustainability Officer and Legal Counsel within 12 hours of the incident occurrence using – IncidentCat4@vedanta.co.in

If additional support is needed, then the protocol for calling a “Crisis” will be followed (See the Vedanta Technical Standard TS13 on Emergency and Crisis Management).

11.5.3 Timing: Report monthly in the Monthly Incident Report.

11.5.4 Including potential, Category 4 & 5 Near Misses

11.6 CATEGORY:5 – FATALITY(IES)/ NEAR MISS (SAFETY).

11.6.1 Risk Level: Catastrophic

11.6.2 Required Action: Report immediately to Senior Management;
/Statutory

Must be reported immediately by verbal communication to the Vedanta Company CEO, COO, Head of Sustainability / HSE and Legal Counsel and then followed by SMS/Email within 12 hours of the incident occurrence.

Must be reported to the Vedanta Resources Chief Executive Officer, Chief Sustainability Officer and Legal Counsel within 12 hours of the incident occurrence using – IncidentCat5@vedanta.co.in

If additional support is needed, then the protocol for calling a “Crisis” will be followed (See the Vedanta Technical Standard TS13 on Emergency and Crisis Management).

11.6.3 Timing: Report monthly in the Monthly Incident Report.

11.6.4 Reportable injury / Occurrence.

12. INCIDENT MANAGEMENT PROCEDURE

12.1 POST INCIDENT - IMMEDIATE ACTION – SECURING THE SCENE

12.1.1 Following an incident, the supervisor, and or management shall:

- 1) Initiate the site Emergency Response Plan as appropriate/required.
- 2) Take action to make the area safe and prevent escalation of the situation.
- 3) Evacuate and document the emergency response actions for analysis later. (Roll call list, response etc.)
- 4) Provide the necessary first aid and medical care to the injured.

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- 5) Preserve the incident scene in a manner consistent with their responsibility to retain valuable information for the incident investigation.
- 6) Identify and implement immediate corrective actions necessary to prevent further incidents from occurring.
- 7) Notify BMM management.
- 8) Conduct testing for substance abuse as appropriate.
- 9) Complete and submit an incident Safety Alert form.

12.1.2 In all cases, a safety alert shall be raised by HSE containing the minimum:

- 1) Section.
- 2) Date of Incident.
- 3) Location.
- 4) Time.
- 5) Description of accident.
- 6) Immediate Actions Taken
- 7) Responsible Person: (Title and name).
- 8) Head of Department: (Title and name).

12.2 INCIDENT REPORTING PROCEDURE

- 12.2.1 Accidents and Incidents must be reported immediately to the departmental / section Supervisors and the relevant Control room following immediate action taken.
- 12.2.2 Notify the Control Room via the internal telephone 9999, or 054-983 9999 from an external line.
- 12.2.3 The Control room attendant shall record the incident/accident and escalate it to the HOD's through the Telegraph Application of their Cell phones.
- 12.2.4 In case of an Injury, the Control Room shall notify the paramedics.
- 12.2.5 It will be the responsibility of the HSE Manager to ensure that the Executive Team is notified.
- 12.2.6 In Case of a Serious Injury, the Head of Mining shall notify the DMRE immediately.
- 12.2.7 Where the services of the Proto Team are required, the Head of Mining shall make such a call.
- 12.2.8 In case of Injury the responsible Supervisor shall complete the Injury on Duty form and ensure that the injured person takes it with to the clinic.

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12.2.9 Where an Injury to a person is such that the injured person must be transferred to a Hospital for specialized treatment, the HR shall notify the injured person's family or next of kin about the injury and the circumstances.

12.2.10 All Injuries must be assessed by the Occupational Medical Practitioner or Nurses but only OMP can classify the accident/ injury.

12.3 DETERMINE LEVEL OF INVESTIGATION

12.3.1 All the accidents must be investigated immediately after the occurrence.

12.3.2 The investigation team shall be made up to correspond with the level as risk and the category involved.

12.3.3 Conduct a risk assessment to determine the level of investigation and reporting. Determine the scope and type of investigation based on:

- 1) The actual consequence severity.
- 2) Potential future risk.
- 3) Opportunity for learning from the incident or near miss.
- 4) Guidance on determining the level of investigation.

12.3.4 Refer to: APPENDIX 1: LEVEL OF INVESTIGATION

12.4 INVESTIGATION TERMS OF REFERENCE

12.4.1 The investigation Team Leader should, depending on the scope of the investigation, establish the terms of reference for the Investigation Team.

12.4.2 These should address:

The requirements of stakeholders. These may vary dependent on the type of stakeholder (e.g. internal, external, regulator, non-government organization (NGO), community etc.).

- 1) The requirements for legal privilege and confidentiality agreements with external team members.
- 2) The investigation boundaries.
- 3) Scope of the Team's jurisdiction, in general, the team should not be unnecessarily restricted.
- 4) The authority of the investigation Team leader and Team Members.
- 5) Flow of investigation and expected date for completion of the report and feedback to Senior Management.
- 6) Incident investigation methodology to be used.

13. THE INCIDENT INVESTIGATION PROCESS

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13.1 GATHERING INFORMATION FROM THE INCIDENT SCENE

- 13.1.1 Important evidence can be gained from observations made at the scene of the incident, particularly if equipment remains in position.
- 13.1.2 Witness statements can usually be better understood and verified on site. Witnesses should be available to the investigation team for clarification.
- 13.1.3 The investigation team should be looking for any conditions in the immediate area which could have contributed to the incident.
- 13.1.4 The investigation team should verify the following (for guidance only)
 - 1) Positions of injured workers.
 - 2) Materials being used.
 - 3) Position of all equipment in relation to other equipment.
 - 4) Position of valves, switches, controls etc.
 - 5) Safety devices in use.
 - 6) Position of appropriate guards.
 - 7) Damage to equipment.
 - 8) State of housekeeping at the site.
 - 9) Condition of the facility and equipment.
 - 10) Any other site conditions and or contributing factors.

13.2 PHOTOGRAPHY

- 13.2.1 Photography is one of the most useful tools to the investigation team. It can document the situation as it exists now, or the situation as it changes due to movement or disassembly.
- 13.2.2 Inspect the incident scene and other relevant locations as necessary and supervise the taking of photographs. Collect other information of significance to the incident as soon as practicable. Use a trained person to take photographs.
- 13.2.3 Take plenty of photographs soon after the incident is reported, including close-up photographs of significant details (e.g. scratches, gouges, smears, fractures, relative positions of items).
- 13.2.4 Always include the direction toward which the photograph was taken may be included; for example, North East (NE) or South West (SW) etc. A photograph without a proper caption is confusing and of little value.
- 13.2.5 Photographs taken at the accident scene should include the following:
 - 1) An overall view of the incident site (wreckage) taken from a minimum of four directions. Eight photographs taken at 45-degree angles is recommended.

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- 2) A view of the path of the equipment from point of initial and major impact to the place where it came to rest. Impact marks are vulnerable to rain and traffic; therefore, a photographic record of this type of evidence should be obtained.
- 3) Photos of objects struck by the equipment.
- 4) Larger portions of the equipment wreckage.
- 5) Detailed photographs of suspected failed parts that contributed to the accident.
- 6) Photos of failed personal protective clothing and equipment and the agents causing the failure or injuries.
- 7) Photograph and measure skid marks, ground scars etc.
- 8) Any other photographs deemed of interest to the investigation team

13.3 INTERVIEWS

- 13.3.1 Interviews should be conducted as soon as possible after the incident/accident.
- 13.3.2 Delays in conducting interviews can affect the quality and quantity of information collected as memories deteriorate.
- 13.3.3 Research conducted into the reliability of eyewitness testimony suggests that ideally interviews should be conducted as soon as practically possible or within 36 hours of the occurrence.
- 13.3.4 If there will be a delay before an interview can take place, ask the witnesses to write down their recollection of the event including any relevant events leading up to the actual occurrence.
- 13.3.5 The witness may request a union representative or colleague to accompany them.
- 13.3.6 Ensure that any person accompanying the witness clearly understands that they are present for support and not to influence what the witness talks about.
- 13.3.7 The record (witness statement) of the witness's testimony should accurately and completely reflect all information obtained.
- 13.3.8 The record (witness statement) of the witness's testimony should be verified by the witness after the interview to ensure correct interpretation and accuracy.

13.4 GATHER DATA FOR ANALYSIS

- 13.4.1 PEEPO is the acronym given to the process of Data Collection and provides a roadmap for the investigation team in terms of what they need to be exploring, who they need to talk to and other things to do throughout the investigation.

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13.4.2 The collection of this data can be divided in to five main areas:

- 1) **P**eople
- 2) **E**nvironment
- 3) **E**quipment
- 4) **P**rocedures
- 5) **O**rganization

13.4.3 Conditions, actions, or deficiencies in each of the five main areas may be identified as **contributing factors** to the incident. (PEEPO is used in the ICAM incident methodology and is similar to the RCAT incident methodology)

13.4.4 Conditions, actions, or deficiencies in each of the five main areas may be identified as contributing factors to the subsequent incident. To ensure that all the facts are uncovered, ask the broad questions such as “**who? what? when? where? why? and how?**”

13.5 RISK CONTROL MEASURES

13.5.1 It is important to identify risk control measures during the gathering process and this should include:

- 1) Risk control measures which were missing, inadequate or unused.
- 2) Compare conditions/practices as they were with that required by current legal requirements, codes of practice and guidance.
- 3) Identify additional measures needed to address the immediate, underlying and root causes.

13.6 ROOT CAUSE ANALYSIS

13.6.1 ALL investigations shall cover root cause analysis to determine. The root cause analysis is an in-depth process or technique for identifying the most basic factor(s) underlying a variation in performance (problem).

13.6.2 Focus is on:

- Systems
- Processes
- Individuals

13.7 DATA ORGANISATION- SEQUENCE OF EVENTS

13.7.1 After the collection of data and analysis, it should be possible to organize the data to provide the sequence of events leading up to the incident, the incident itself and events post incident until control was regained.

13.7.2 The data collected during the investigation should be organized in a logical and sequential way.

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13.7.3 Several data organizing techniques such as Timelines, Event and Condition Charts, Time Ordered Event Charts, and Incident Trees can assist in understanding the incident.

13.7.4 The technique used for determining the sequence of events in the incident should meet the following requirements:

- 1) Provide a framework to organize the data collected.
- 2) Assist in ensuring the investigation follows a logical path.
- 3) Aid in the resolution of conflicting information and the identification of missing data.
- 4) Provide a diagrammatical display of the investigative process for management briefing.
- 5) Data organization tools can either be a timeline or flowchart based.
- 6) The methods recommended are:
 - Event and Condition Charts.
 - 5 Whys, and Incident Trees.

13.8 DATA VALIDATION

13.8.1 The role of the investigation team is to establish the facts of the incident.

13.8.2 It is important that the team differentiates between fact and opinion.

13.8.3 The tables below provide guidance on fact versus opinion and objective versus subjective information.

Fact	Opinion
A fact is the statement of a thing done or existing.	An opinion/analytic information is a personal view or judgement based on what seems to be true, or an interpretation of fact.

Objective	Subjective
<i>Not an interpretation</i> – based on a factual description.	<i>Interpretations</i> – based on personal interpretations/biases.
<i>Observable</i> – based on what is seen or heard.	<i>Non-observable</i> – based on events not directly observed.
<i>Reliable</i> – two or more people independently agree on what they observed.	<i>Unreliable</i> – two or more people don't agree on what they observed.
<i>Measurable</i> – a number is used to describe behaviour or situation.	<i>Non-measurable</i> – a number isn't used.
<i>Specific</i> – based on detailed definitions of what happened.	<i>General</i> – based on non-detailed descriptions.

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13.9 CONCLUDING THE INVESTIGATION

13.9.1 Not only must the investigation team possess the skills and training to initiate an investigation, but they must also be aware of when the investigation is complete.

13.9.2 The following guidance is provided:

- 1) Review all documentation to ensure it supports the recommendations for corrective action and exclude any issues not relevant to the investigation.
- 2) Determine if additional information or documentation is required.
- 3) Review interview summaries to ensure that all issues have been addressed.
- 4) Determine if the recommendations for corrective actions can be made informally through a briefing or require a formal submission (report).
- 5) Remember that proposed corrective actions should be feasible, realistic and will clearly remedy the deficiency.
- 6) Determine if there are any items that require follow-up, such as corrective actions that management may have taken that will preclude formal recommendations.

14. INVESTIGATION REPORT

14.1

14.1.1 The incident investigation is a closed-loop process consisting of gathering information, evaluating, and organizing the information, and formulating various hypotheses to explain how the incident occurred.

14.1.2 This process continues until the team fully understands how and why the incident occurred and is satisfied all significant discrepancies and inconsistencies are resolved.

14.1.3 The investigation report is the formal presentation of the investigation team's findings and recommendations.

14.1.4 The following should be considered when preparing an investigation report:

- 1) The report should be factual, concise, and conclusive.
- 2) Interpretations of findings should be based on the facts as identified during the investigation.
- 3) Events or conditions that are major contributing factors to the incident should be clearly identified as such.
- 4) The report should be readable as a standalone document.

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- 5) Reference to all documents and records relevant to the incident should be established and mentioned in the report, attach all relevant evidence as attachments.

14.2 RECOMMENDATIONS

- 14.2.1 The recommendations address the absent or failed defenses together with the organizational factors identified as key findings of the investigation.
- 14.2.2 The investigation should identify recommendations for corrective actions to prevent recurrence.
- 14.2.3 Recommendations should identify corrective measures for as many of the listed contributing factors as possible and may be related to:
 - 1) Eliminating the causes.
 - 2) Minimizing possible consequences.
 - 3) Improving rescue or damage containment measures.
 - 4) Emphasizing that all causes identified should be eliminated.
 - 5) Action parties and a time schedule for implementation should be identified.

14.3 SIGNIFICANT LEARNINGS

- 14.3.1 Significant learnings are the generic learnings for the organization from the investigation and should include those issues that if corrected should prevent similar incidents elsewhere within Black Mountain Mine operations.

15. MANAGEMENT REVIEW

15.1

- 15.1.1 Prior to distribution and sign off, the appropriate level of management should review the investigation report for completeness, quality of the investigation and to endorse recommended corrective actions.
- 15.1.2 Vedanta Resources CEO and CSO shall review all Class 5 incidents with the CEO of the Black Mountain Mine in person or by Telepresence within one month of the completion of the final investigation report.
- 15.1.3 The report will be submitted to the Subsidiary Company Board of Directors and the Vedanta Resources Sustainability Committee for review.
- 15.1.4 Legal review will only be done when necessary or to explain possible shortfalls.

16. AGREED ACTIONS

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16.1

16.1.1 After formal review of the report, the management and investigation team should determine agreed actions.

16.1.2 Action plans to take remedial or corrective actions shall be implemented and monitored.

17. FOLLOW-UP AND CLOSE-OUT

17.1

17.1.1 An effective incident investigation requires strong management commitment and involvement. Desirably, management will support the investigation process and demonstrate this by acting on the results.

17.1.2 Where corrective actions have been agreed and assigned it is the responsibility of those persons to complete the actions in the time frame outlined.

17.1.3 Completion of each corrective action must be recorded and signed off by the appropriate person.

17.1.4 Target dates must be realistic and achievable to ensure completion.

17.1.5 Completion of all corrective actions should be communicated to all recipients of the investigation report and the workforce in general.

18. ANALYSE EFFECTIVENESS

18.1

18.1.1 The effectiveness of the corrective actions should be evaluated by one of the following methods:

- 1) Compliance audit.
- 2) Independent audit.
- 3) Committee review.
- 4) Key performance indicators.
- 5) Post implementation risk assessment.
- 6) Ongoing monitoring.

19. COMPLIANCE AND PERFORMANCE

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19.1

- 19.1.1 Black Mountain Mine shall ensure they comply with the requirements of this Standard Operating Procedure and shall be assessed periodically, documented and, where required, reported to Vedanta Group.
- 19.1.2 The assessment of performance shall include setting and reporting on key performance indicators (KPIs) where these have been established at Vedanta Group and Black Mountain Mine and shall meet the requirements as set out in the Sustainability Data Management Technical Standard.
- 19.1.3 The evaluation of performance shall include, as a minimum, confirmation that:
 - 1) Incidents are being reported and acted upon.
 - 2) Incidents are being correctly classified.
 - 3) Investigations are being carried out by competent personnel – including the active involvement of management – using appropriate methodologies.
 - 4) Investigations are identifying basic and underlying causes and contributory factors.
 - 5) Corrective and preventive actions, appropriate to the nature of hazards and level of risk, are being identified and implemented.
 - 6) The effectiveness of corrective and preventive actions is being assessed.
 - 7) Learning arising from incidents are being communicated inside and, where appropriate, outside of Black Mountain Mine Operations.
 - 8) Senior Management and Sustainability Committee Reviews have taken place.

20. VALIDITY AND DOCUMENT MANAGEMENT

20.1 DOCUMENT VALIDITY

- 20.1.1 This SOP is effective from 2020/11/18 and was last reviewed on 17-11-2024. This SOP will be reviewed every 2 Years.

20.2 DOCUMENT MANAGEMENT

- 20.2.1 During process of updating documented information, BMM shall ensure to follow the approved Document Management Standard Operating procedure.
- 20.2.2 This SOP replaces any other SOP issued earlier by BMM to the extent specifically covered here. This SOP should be followed in letter and spirit.
- 20.2.3 BMM is committed to continuously reviewing and updating policies and procedures, based on the Entity's risk assessment and shall incorporate for any regulatory requirement which is required to do so.

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- 20.2.4 Any amendment to this SOP or issue of any guidance or circular etc. under this procedure must be approved in writing by the approving authority as listed in this document.
- 20.2.5 BMM reserves the right to withdraw, modify or revise the SOP as a whole / partial without providing any justification for the same. On revision, it should be duly communicated to the personnel involved.
- 20.2.6 If compliance with this SOP ever conflicts with the applicable law, regulation, directives issued by the statutory and or regulatory authority, then compliance must be ensured with the law.
- 20.2.7 In order to ensure compliance or to address any known conflicts with the law or to address any specific local requirements, BMM may adopt local sub-procedures which shall be by way of addendum to this SOP, and which shall be approved by the approver of this SOP. Proposing of such addendum shall be the responsibility of the respective Entity's competent authority who is at an equivalent level with the SOP owner as set out in this document.

21. EXTERNAL SAMRASS FORMS

21.1

- 21.1.1 All required SAMRASS forms shall be downloaded from the Department of Minerals website and used as is. No editing allowed.
- 21.1.2 Once these forms are completed it becomes records and shall be retained.
- 21.1.3 Original signatures to be done unless electronic signatures are approved and accepted in writing from the Chief Inspector.

22. RECORDS

22.1

- 22.1.1 In terms of Chapter 23 (23.7)
- I. Every employer must keep and maintain a record in which the particulars of all accidents and dangerous occurrences, which are required to be reported in terms of this Chapter, must be recorded without delay.
 - II. The record contemplated in Regulation 23.7(i) in respect of all accidents or dangerous occurrences must be kept and maintained for two years from the time that the accident or dangerous occurrence becomes reportable.
- 22.1.2 ALL incident reporting and investigation communication records shall be maintained and retained as required by ISO 45001:2018.

23. VIOLATION OF SOP

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23.1

- 23.1.1 BMM follow a “Zero Tolerance Policy” with respect to non-compliance with this SOP and/or any other SOP / guidance issued by BMM and its constituent Entities.
- 23.1.2 Violation of this SOP is subject to appropriate disciplinary actions which may include but not limited to termination of employment. This determination will be based on the facts and circumstances of each situation. Any accused of violation of this SOP will be given an opportunity to present their case prior to any determination of appropriate disciplinary actions. Violation of this SOP may also be subject to substantial civil damages, criminal fines, and prison terms.
- 23.1.3 Each employee is responsible for ensuring that their conduct and the conduct of anyone reporting to them shall fully comply with this SOP. Compliances, both personal and by subordinates, will be a factor in periodic performance appraisals.

24. DISCLAIMER

24.1

- 24.1.1 This SOP issued by BMM is for internal compliance and does not create, nor shall it be construed to create, directly or implicitly, any rights, duties, or obligations of BMM to any person, body, or legal Entity.
- 24.1.2 This document and its contents are the copyright property of BMM. The release of this document to any third party outside BMM is strictly prohibited without prior consent.

25. REVIEW AND APPROVAL

Content Owner(s)
Freddie Haefele (Compliance Officer BMM) TimeStamp: 2024/03/18 8:42:41 AM
Content Reviewer(s)
Mario Carstens (Chief Safety Officer) TimeStamp: 2025/05/23 12:33:26 PM
Content Approver(s)
Catharina Kotze (Head of HSE BMM) TimeStamp: 2025/05/23 12:35:28 PM Catharina Kotze (Head of HSE BMM) TimeStamp: 2025/05/30 10:41:11 AM

This document was approved (in sequence) by the individuals above using electronic approval in our Document Control System.

Final approval status: **Approved**

Approvals were done electronically.

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26. APPENDIX 1: LEVEL OF INVESTIGATION

Risk Level	Requirement	Investigation Level and Participants
Negligible Category: 1	Incident report only	Involved person(s) Department / Area Supervisor
Minor Category: 2	Standard investigation Mini - ICAM optional	The Full time Safety Representative Safety Officer Workplace Union representative
Moderate Category: 3	Standard investigation ICAM / RCAT or similar recommended	Management leads investigation team Involved person(s) Department / Area Supervisor The Full time Safety Representative Chief Safety Officer Workplace Union representative
Serious Category: 4	ICAM / RCAT or similar mandatory	Management leads investigation team Involved person(s) Department / Area Supervisor The Full time Safety Representative Safety Officer Workplace Union representative ICAM / RCAT skilled analyst Experts/technical/other ** HSE Manager(s) ** Legal adviser ** Independent department manager ** Independent/external team member as appropriate
Catastrophic Category: 5	ICAM / RCAT mandatory	Senior Management leads investigation team Involved person(s) Mine Manager Mine Engineer Department / Area Supervisor The Full time Safety Representative Chief Safety Officer Workplace Union representative ICAM / RCAT skilled analyst Experts/technical/other ** HSE Manager(s) ** Legal adviser ** Independent department manager ** Independent/external team member as appropriate

27.

APPENDIX 2: INCIDENT INVESTIGATION PROCESS FLOW



Vedanta Zinc
International



Incident Management Process Flow

on.

on: 2 re

Incident Occurs

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All Employees & CBP's to report any
incidents/Injury to their supervisors
Immediately or as soon as they

Sensitivity: Internal (C3)

28. APPENDIX 3: DMRE INCIDENT REPORTING PROCESS FLOW

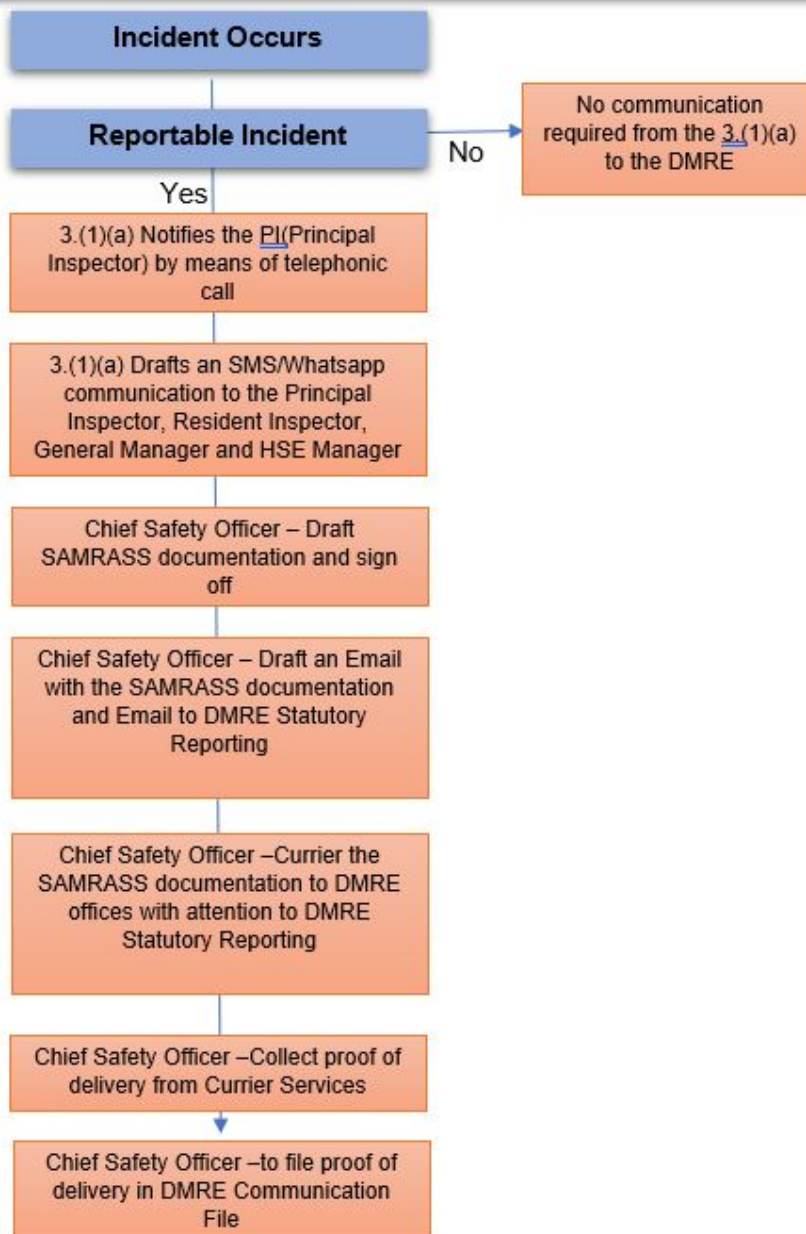
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Black Mountain DMRE Incident Reporting Process Flow

Reporting and Communication



29. APPENDIX 4: INJURY CLASSIFICATION FORM

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BMM-HSE-SAF-FRM-0003
Injury Classification Form



Name of employee	
ID Number	
Company	
Site	
Day of injury/Incident	

DESCRIPTION OF INCIDENT/ACCIDENT

DIAGNOSIS

CLASSIFICATION	REASON
Incident	
FAC	
MTC	
LTI	
Fatality	

Further treatment				
Fit to return to work	YES		NO	
Not fit to return to work	YES		NO	
Review at Clinic	YES		NO	
Fitness Certificate	YES		NO	

Safety Officer	
Supervisor	
Other	

OMP:

Date: 

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