Event Management

HSE-PROC-17

This document applies to:

All Sites ☒

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1.0 Purpose/Scope

The purpose of this Event Management Procedure is to outline the key principles and elements of Stanwell's approach to event management to ensure that there is consistent and effective identification of and response to events.

Events and potential events can arise in all aspects of Stanwell Corporation Limited and its subsidiaries' ('Stanwell') business. They impact, or have the potential to impact, Stanwell, our people, the environment, our assets, our reputation, and the communities in which Stanwell operates.

Stanwell's Event management processes:

- Ensures that all events are identified, reported, escalated, and investigated appropriately.

- Enables corrective, preventative, and improvement actions to be communicated and implemented.

- Helps to ensure compliance with obligations, which include, but are not limited to, legislation, regulations, policies, Standards and Codes.

- Ensures Stanwell's 'right to operate'.

- Allows analysis and trending, and enables organisational learning, which is essential to improve business systems and processes, to reduce risks and improve their management, and potentially reduce costs and increase efficiency.

- Provides assurance.

This Procedure applies to all Business as Usual (BUA) events (refer to Stanwell Event Evaluation and Escalation (GOV-STD-32)) at Stanwell owned and/or operated sites unless they are specifically excluded by Appendix 1 of this Procedure. Business as Usual events are events that are ranked as a Low, Minor or Moderate risk under Stanwell's Risk Evaluation Matrix (GOV-STD-11). Any emergency, incident and/or crisis is to be managed in accordance with Stanwell's business continuity framework and any location specific Emergency Response, Incident Response and/or Crisis Response process

Stanwell's directors and employees, all contractors and any visitors to Stanwell's sites are to report events in accordance with this Procedure.

2.0 Stages of Event Management

There are four crucial stages in event management:

2.1 Immediate Action

Once an event has occurred, and if it is safe to do so, immediate action should be taken to:

- Protect human life.
- Reduce trauma.
- Protect the environment.
- Maintain system and operational safety and security.
- Ensure continuity of services.
- Preserve and / or record evidence.
- Protect property, assets, commercial arrangements, and reputation / image.

2.2 Notification

All events are to be reported as soon as reasonably possible.

All events (those that are not excluded as listed in Appendix 1), are to be entered into the Events, Audit, Risk and Compliance system (EARS) as soon as reasonably possible.

Where an event requires notification to a Regulator, any statutory timeframes associated with that notification must be adhered to.

An overview of the HSE event reporting process, including key reporting deliverables and timeframes, is provided in T-4027: HSE Event Reporting Process Overview.

2.2.1 Internal Notification

Initial notification of events should be provided verbally (in person or by telephone) to the relevant manager or supervisor and include details of what has occurred and how it has been managed to date.

Verbal notification must occur before the event is recorded in the Events, Audit, Risk and Compliance system (EARS).

2.2.2 Notifications to External Regulators and/or Clients

Any event that is, or has the potential to be, notifiable to an external Regulator must be managed in accordance with this Procedure. This includes asset-related events.

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Subject matter experts (SME) are responsible for ensuring that notification of events related to their area of responsibility and expertise is provided to the relevant Regulator.

Prior to any formal notification to an external regulator, contact must be made with a representative of the Stanwell Senior Management and/or the Legal team. This includes where Stanwell is performing work as a contractor.

Where Stanwell is performing work as a contractor, Stanwell must notify the Client within a time that is reasonably practical. Internal notification to senior management and/or the Legal team must occur prior to notification to a client.

Stanwell's Regulators are detailed in the table below[1]:

Notification may be required to:	If:
Australian Energy Market Operator (AEMO)	There is a non-conformance with a Generator Performance Standard.
	There are changes which mean that Stanwell is unable to comply with the latest dispatch offer made to AEMO.
	An event occurs which affects, or is likely to affect, Stanwell's generating unit capacity.
Australian Energy Regulator (AER)	There is a non-compliant offer, or a bid or re-bid has been made but has not been corrected within the times allowed under the National Electricity Rules.
Australian Securities and Investments Commission (ASIC)	There is a breach of, or non-conformance with Stanwell's financial services licence (AFSL).
Department of Environment and Science (DES)	There has been a breach of an Environmental Authority (EA) or environmental permit held by Stanwell. There has been actual serious or material environmental harm, or if serious environmental harm is threatened.
Department of Energy and Public Works	An event occurs that requires notification under Stanwell's generation authorities and / or special approvals.
Department of Resources	There is a non-compliance with mining tenements.
Department of Regional Development, Manufacturing and Water	There is an event in relation to Stanwell's referable dams.
Petroleum and Gas Inspectorate	There is an event impacting Stanwell's petroleum pipeline licence (PPL) which requires notification.
Electrical Safety Office (ESO)	There is a 'serious electrical incident'.
	There is a 'dangerous electrical event'.
Work Health and Safety Queensland (WHSQ)	There is notifiable incident, which includes the death of a person, a serious illness or injury of a person or a 'dangerous incident'.
Office of the Australian Information Commissioner (OAIC)	There is an eligible data breach.

Section 5.0 of this document lists the standard checklists used to assist in determining whether an event must be notified to an external regulator.

Stanwell may also be required to provide notification to its insurers of certain events which may affect one or more of Stanwell's insurance policies or give rise to a claim.
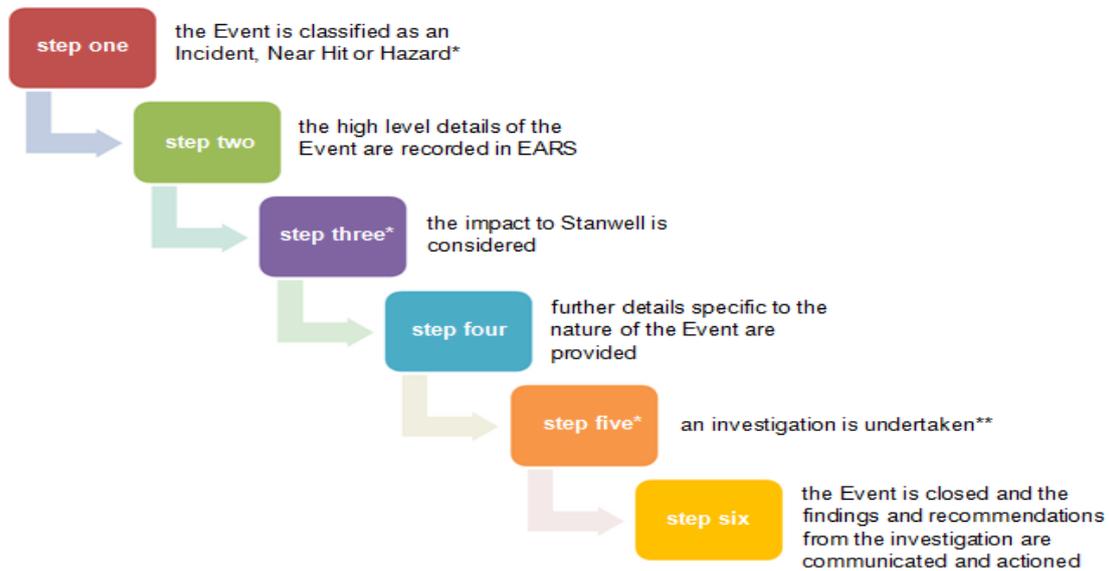
Stanwell may also be required to provide notification to its insurers of certain events which may affect one or more of Stanwell's insurance policies or give rise to a claim.

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[1] This is not an exhaustive list of the notifications required to be made to Regulators.

2.3 Management of Events

Once notification of an event or near hit has been made, either internally or externally, the event must be managed appropriately. The steps involved in managing an event are:

step one — the Event is classified as an Incident, Near Hit or Hazard*

step two — the high level details of the Event are recorded in EARS

step three* — the impact to Stanwell is considered

step four — further details specific to the nature of the Event are provided

step five* — an investigation is undertaken**

step six — the Event is closed and the findings and recommendations from the investigation are communicated and actioned

* where the Event is a Hazard, steps three and five are not required.

** any actions required as a result of the investigation need to be recorded in EARS.

2.3.1 Step One: Classification

The event must first be classified as:

Event Classification	Definition
Incident	An unplanned occurrence which impacts Stanwell, our people, the environment, and/or the communities in which Stanwell operates.
Near Hit	An unplanned occurrence that has the potential to impact Stanwell, our people, the environment, and/or the communities in which Stanwell operates, but does not.
Hazard	A situation that, if left uncontrolled, has the potential to impact Stanwell, our people, the environment, and/or the communities in which Stanwell operates.

The classification given to an event determines:

- Whether or not an impact assessment is needed.

- The extent of the investigation that must be completed; and

- Who is initially notified of the event after it is recorded.

At times, it may be possible to classify a single event as both an incident and a near hit. If this occurs, assessments must be made on both the actual impact (incident) and potential impact (near hit). The greater impact determines whether the event is classified as an incident or a near hit.

Where applicable, the event must be reviewed to determine whether it is related to process safety in accordance with details provided in **Appendix 2 (Classification of Process Safety Events)**

See also:
- Appendix 3 for guidance on the classification of Safe Work System events as incidents, near hits or hazards

Example

A piece of equipment falls from height, narrowly missing a person walking underneath, but sustains damage on impact.
- *It can be classified as an incident as there was an unplanned occurrence which had an actual impact i.e., equipment was damaged (financial impact); and*
- *It can also be classified as a near hit as there was an unplanned occurrence which had the potential to impact a person but did not – the person <u>could</u> have been injured by the falling equipment but was not (i.e., a potential health and safety impact)*

The assessment considers what the <u>actual</u> financial impact was as a result of the equipment being damaged and also what the potential health and safety impact <u>could have been</u>, considering all the controls that were in place at the time (e.g., safety barrier in place).

*If the assessment concludes that the actual financial impact is 'Low' (<$500,000) and the potential health and safety impact is 'Minor' (first aid injury), then the event is classified as a near hit (**refer to Section 2.3.3 for further details about assessments**).*

2.3.2 Step Two: Recording 'High Level' Event Details

Events are to be recorded in EARS as soon as reasonably practicable.[2]
When recording an event in EARS, initial 'high level' details must be provided – what happened, when it happened and where it happened. A responsible supervisor must also be nominated. This person must:

- Have the expertise to independently review any investigation into the event; and

- Have the necessary responsibility and accountability for ensuring corrective and preventative actions can be put in place.

The responsible supervisor must not be the person appointed to investigate the event.

2.3.3 Step Three: Impact Assessment (Incidents and Near Hits Only)

An assessment of the event's impact must be made. This is done using Stanwell's Risk Evaluation Matrix (GOV-STD-11) using the best information available at the time. Events are escalated in accordance with Stanwell's Event Evaluation and Escalation Matrix (GOV-STD-32). Events that have a risk ranking of Major (4) or Severe (5) will require the site incident manger to be notified and will be managed under the site Incident Management process. As an event evolves its event impact rating may also need to be reviewed and updated.

Incident	Near Hit
What the actual impact of the incident is	What the impact of the near hit could reasonably have been, considering all controls in place at the time of the event.

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[2] If EARS is unavailable, or if computer access is limited, event details may be recorded on Event Notification form T-1897 ('Yellowie') and the form provided to the relevant manager or supervisor. These details must be entered into EARS as soon as practicable.

An event may have consequences / impacts in one or more of the following areas:

- Health and safety.
- Environment.
- Financial.
- Reputation.
- Compliance.

The impact of the event influences several elements of event management including:

- Who is to be notified of the event;
- The level of reporting and investigation required; and
- The level of sign off needed.

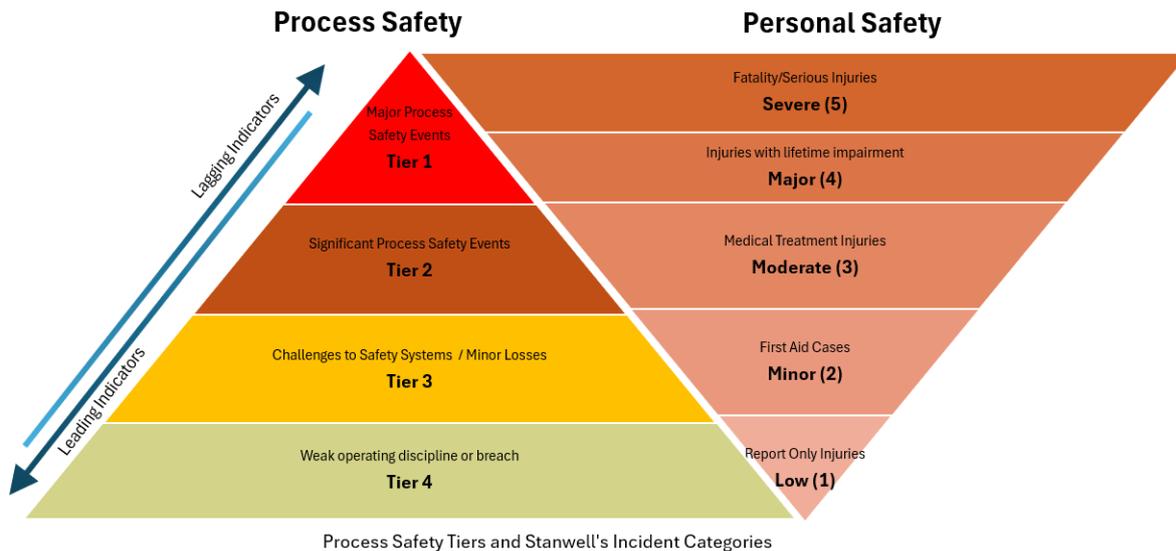Key classifications and notification assessments to consider when an event occurs include:

- T-3158: Serious Injury or Fatality SIF Incident Checklist
- T-2153: Safety Notifiable Incidents Checklist
- T-3541: Environmental Notifiable Event – Checklist
- T-2145: Electricity Safety – Notifiable Incidents Checklist
- Safe Work System Event Classification Guide

If the event is confirmed as being related to process safety, it must be assigned a tier in accordance with the following classification table adopted by Stanwell. A Process Safety Event Tier is a structured classification system that categorises process safety incidents into levels based on their severity, consequence, and potential impact. Tiered classification is performed by SCL's process safety engineers.

PS Event Tiers	Description
Tier 1	**Major Incidents** Unwanted loss of control of hazardous materials or energy, including major asset failures, with actual severe or major consequence to people, environment or asset as per Stanwell's risk evaluation matrix.
Tier 2	**Less Severe Incidents** Unwanted loss of control of hazardous materials or energy, including major asset failures, with actual moderate consequence to people, environment or asset as per Stanwell's risk evaluation matrix.
Tier 3	**Challenges to Safety Systems and Minor Losses** Challenges to a safety or barrier system that progressed along the path to harm but stopped short, which provide opportunities to identify and correct weaknesses. Also includes minor losses of primary hazard control or asset failures, with the potential to directly escalate to a Major Incident, but with an actual consequence of much lower consequence.
Tier 4	**Weak operating discipline or breach** Events indicating threats to performance of a process safety management system or a failure to apply a process safety management system.

Process safety tier classification addresses the severity of system-level failures, while personal safety consequence categories focus on the impact to individuals, ensuring both organisational and human risks

are managed distinctly. The mapping between Process Safety tiers and Personal Safety incident categories is shown in the figure below.

Process Safety Tiers and Stanwell's Incident Categories

Note: Where a Stanwell subsidiary (e.g. SAMCo) has its own organisational branded templates for notification assessments, these templates can be used instead to provide to Clients and Stanwell on behalf of the subsidiary.

2.3.4   Step Four: Further Event Details

Depending on the nature of the event, further details may need to be specifically recorded. This includes where there was actual, or the potential for, injury / illness / disease, whether the event was a compliance issue or if the event involved security and/or environmental aspects.

Further details on what information is required is described in the Guide to Recording an Event in EARS (19/18425).

2.3.5   Step Five: Investigation

The purpose of investigating an event is to identify what happened and what caused it to occur, i.e. the root cause and contributing factors. This information is then used to determine the appropriate corrective and preventative actions to prevent future recurrence. If further information is obtained about the impact of an event during the event investigation, the impact assessment should be updated accordingly.

Investigations of all Low to Moderate (Level 1-3) incidents or near hits should be undertaken as soon as practicable following the event by an appropriate subject matter expert and/or manager.

Impact assessment and formal investigation is not required for hazards. However, consider the appropriateness of controls currently in place and whether any corrective and/or preventative actions are required to remove the hazard or mitigate the potential impact.

Investigations should be completed within thirty (30) days of the date on which the event was reported to the manager or supervisor. An investigation may take longer than 30 days to close out where external parties are involved in the investigation (for example, Workplace Health and Safety Queensland). Where this is the case, or is likely to be the case, the Responsible Supervisor should advise the responsible Executive General Manager (EGM) as soon as possible.

When undertaking an investigation T-1948: Investigation Report, may be used. This form identifies the information that may be required, and provides many templates such as witness statements.

Before undertaking an event investigation, consider:

- Engaging Stanwell's legal team who can advise on legal professional privilege and what is required to ensure that it is maintained over the investigation can be maintained as appropriate.

- Who will conduct the investigation – whether there is there an internal investigator with sufficient expertise to undertake the investigation, or an external investigator needs to be appointed?

- All possible sources of information, including witnesses, experts, policies, control system data, photographs or film, specialist analyses, procedures and/or records.

- How information will be obtained and collated.

- The tasks and/or timeframes for the investigation required to obtain all required information.

It is important that all investigations are factual, and data based and are not based on speculation or opinion.

The Root Cause Analysis for Asset Events business procedure (ASM-PROC-ENG-MAN-27 outlines the process and triggers for conducting and recording root cause analyses (RCAs) on asset integrity events.

Note: Where a Stanwell subsidiary (e.g. SAMCo) has its own organisational branded templates for investigations, these templates can be used instead to provide to Clients and Stanwell on behalf of the subsidiary. In addition, investigation delivery timeframes must be as per requirements stipulated by the client, but only if this there is a prior agreement in the contract, otherwise, Stanwell dictated timeframes must be adhered to.

2.3.5.1 Root Cause and contributing factors

An investigation of an Incident or Near Hit must consider:

- the root cause (categorised appropriately i.e. People, Plant, Process) and contributing factors of the Event; the condition(s) or act(s) that directly caused the Event to occur; or

- a specific, underlying cause which can be identified.

Stanwell uses a number of different methods to determine the root cause and contributing factors of an incident depending on the type and impact of the event. An investigator of an incident will determine the most appropriate type and level of investigation required using their sections internal processes. Some examples of root cause analysis methodologies that Stanwell use include:

- 5 Why Root Cause Analysis – A simple process to highlight actions (or inaction) and conditions leading to causes of an incident (asset integrity events).

- Cause Tree Root Cause Analysis –This is often the preferred method to identify complex plant and equipment failure root causes (asset integrity events).

- ICAM analysis – the preferred investigation method to identify root causes and contributing factors for Health, Safety and Environment events where the event severity level dictates a dedicated investigation (generally level 3 and above).

2.3.5.2 Investigation Recommendations

Once the root cause and contributing factors of an event have been identified, the investigator(s) recommends:

- What is required to correct what has occurred (corrective measures).

- What is required to prevent the event from occurring again (preventative measures); and/or

- Improvements to organisational procedures and/or processes.

Corrective and/or preventative measures may be either interim or long-term measures, and can include implementing new controls, modifying existing controls or implementing actions to maintain existing controls.

All recommendations/actions nominated within the investigation report are required to be recorded as actions in EARS, this includes actions implemented through completion of the event investigation. This proactive provides traceability and alignment with investigation recommendations and completeness of records.

In Ellipse - a Work Request (WR) will need to be created using MEEEAR – EARS Work Request (the work request classification will default to 03 – EARS). This Work Request will record the EARS Action requirements for remediation. The Work Request Id number will be prefixed with "ACT-" and the unique EARS Action Id number is to be manually entered in this field.
Any Work Order (WO) created to remedy the EARS Action will be created from the MEEEAR - Work Request. This will link the Work Orders and Work Request via the "EARS" Work Request Id. Number.

Actions

Before an action is recorded in EARS:

- *It must be agreed with the responsible supervisor and/or any other key stakeholders that the recommended actions are appropriate to be implemented.*

- *Consideration must be given to the appropriate amount of time and effort required for the recommended actions to be completed so that realistic due dates for completion can be set; and*

- *Where possible, the person identified as the person to undertake or complete the action should be advised of this (either verbally or by email).*

Once entered in EARS, any modifications, or changes to an action, including to a due date, must first be discussed, and agreed with the responsible supervisor and/or key stakeholders.

Actions must be formally closed out on or before the nominated due date. Actions must only be approved and closed out where the nominated Action Approving Officer considers that the action has been completed in accordance with expectations. Note that the action of raising a Work Order in Ellipse for

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execution of an action is NOT considered as closed out. Only when the work order has been completed should the action be closed.

Refer to the Guide to Recording an Event in EARS (19/18425) for further guidance around Action management.

Note: Where a Stanwell subsidiary (e.g. SAMCo) undertakes an investigation, all recommendations and subsequent actions and their due dates must be agreed to with the Client prior to implementation.

2.3.6 Step Six: Event Close Out

Events must be formally closed out. Close out of incidents and near hits should occur as soon as the investigation has been completed and associated reporting requirements met. This requires an independent person, i.e., not someone involved in the investigation, to review the investigation report and endorse its findings and recommendations.

Close out of a **hazard** can occur when the hazard is entered into EARS, provided that the appropriateness of existing controls and the need for any additional corrective and/or preventative actions to remove the hazard or mitigate its potential impact have been considered.

Prior to closing an event out, any required actions must be recorded. Actions do not have to be completed before an event is formally closed out.

Once the event has been formally closed, the findings and recommendations from the event investigation should then be communicated as appropriate.

Note: Where a Stanwell subsidiary (e.g. SAMCo) undertakes an investigation, agreement must be sought from the client prior to close out to ensure agreement from the client that all required elements have been met to close out the investigation.

2.4 Monitoring and Review

The Operations Events Review (OER) meeting provide rigor regarding quality outputs from incident investigations to ensure organisational learnings / corrective actions are derived from effective and efficient recommendations, resultant from quality incident investigations. In order for an investigation to be subject to an OER Meeting, it must meet the criteria outlined in OHS-STF-11: Operations Event Review (OER) Meetings Charter.

In addition to the reporting, trending and analysis undertaken by specific business units (including Health and Safety and Environment, Asset Services and Operational Risk (Process Safety) and / or Assurance), other measures/processes are in place to provide oversight of events including:

- Tailored notifications, which ensure that key stakeholders have oversight of events relevant to their divisions or teams as recorded in EARS.

- Compliance issue and breaches, which are reported in accordance with Stanwell's Compliance Breach Reporting Mechanism[3]; and

- Scheduled and/or ad hoc audits conducted on an as needs basis[4].

- Ongoing monitoring of all EARS data, including EARS data exceptions management process (e.g. compliance tasks, actions, etc.) occurs to ensure that EARS data and actions, including owners of data and actions, remain current. Currently this is monitored through EARS data

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[3] Refer to GOV-POL-20 Compliance and Regulatory Management Policy and GOV-PROC-28 Compliance and Regulatory Management Procedure.

[4] These may be either internal or external audits. They may focus entirely on event management or may consider event management as part of a broader audit scope.

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and exceptions reports received by the EARS Support team, who monitor, maintain and govern EARS. In addition, relevant managers receive EARS exceptions reports (monthly) to be able to action EARS exceptions for their teams.

3.0 Responsibilities

Employees and Contractors

- Report and record all Events in accordance with this Event Management Procedure.
- Seek guidance from SMEs and/or Managers and/or Supervisor as required.

Executive General Managers, General Managers, Managers and Supervisors

- Ensure that the business implements this Procedure.
- Ensure that all events are reported and recorded in accordance with this Procedure.
- Ensure that actions are managed in accordance with this Procedure and the associated guides and Work Instructions (including that due dates for addressing actions by are met).
- Provide advice and guidance on event and action management as required.

4.0 Review, Consultation and Communication

Review:

Review of this Procedure with appropriate consultation is required every three years, and at any other time warranted by e.g., a significant organisational change.

This Procedure will be:

- Communicated to key stakeholders; and
- Made available on Stanwell's intranet.

5.0 References

- Environmental Protection Act & Regulation
- Health & Safety Act & Regulation
- GOC State Archives – Public Records Act

Document No	Document Title
19/18425	Guide to Recording an Event in EARS
18/93214	Safe Work System Event Classification Guide
GOV-POL-20	Compliance and Regulatory Management
GOV-PROC-28	Compliance and Regulatory Management Procedure
GOV-POL-30	Code of Conduct – The way we work at Stanwell
GOV-POL-37	Enterprise Risk Management and Business Resilience
GOV-PROC-36	Protected Disclosures and Complaints
GOV-PROC-37	Risk Management Framework
GOV-PROC-39	Managing Performance and Conduct Procedure
GOV-PROC-60	Crisis Leadership Plan

GOV-STD-11	Risk Evaluation Matrix
GOV-STD-32	Event Evaluation and Escalation Matrix
GOV-POL-29	Whistleblower Protection Policy
GOV-PROC-36	Protected Disclosures and Complaints
HSE-WI-01	HSE Advices and Event Communications – Drafting and Issuing
PEO-POL-21	Fair Treatment (policy)
PEO-PROC-55	Fair Treatment (procedure)
T-1948	Investigation Report
T-1897	Event Notification form ('Yellowie')
T-2153	Safety Notifiable Incidents Checklist.
T-2145	Electrical Safety – Notifiable incidents Checklist
T-2885	Petroleum and Gas Safety – Prescribed Notifiable Incidents Checklist
T-3158	Serious Injury or Fatality (SIF) Incident Checklist
T-3541	Environmental Notifiable Event - Checklist
T-3035	Process Safety Event Alert
ASM-PROC-ENG-MAN-27	Root Cause Analysis for Asset Events
T-3444	Root Cause Analysis Cause Tree Template
T-3445	Root Cause Analysis 5 WHY Template
T-4027	HSE Event Reporting Process Overview
21/141198	Recording of EARS actions in Ellipse – Ellipse Operations Bulletin #5
ASM-PROC-STG-MAN-08	Pressure Equipment Corporate Management Strategy
18/93214	Safe Work System Event Classification Guide

6.0 Definitions

Word / Abbreviation	Definition
Compliance Breach	Acts or omissions by Stanwell and/or our people resulting in the failure by Stanwell and/or our people to meet their compliance obligation(s).
EARS	Stanwell's integrated Events, Audit, Risk and Compliance system. EARS is the tool used by across all our sites to effectively and efficiently manage and record events. EARS is accessed electronically via Stanwell's intranet.
Event	An unplanned occurrence which impacts Stanwell, our people, the environment, and/or the communities in which Stanwell operates. An event can be classified as an incident, near hit or a hazard.
Event Management	The process for managing events as described by this Procedure which includes immediate actions (if required), notification, recording, investigation, and oversight.

Hazard	A situation that, if left uncontrolled, has the potential to impact Stanwell, our people, the environment, and/or the communities in which Stanwell operates.
Incident	An unplanned occurrence which impacts Stanwell, our people, the environment, and/or the communities in which Stanwell operates.
Near Hit	An unplanned occurrence that has the potential to impact Stanwell, our people, the environment, and/or the communities in which Stanwell operates, but does not.
Our People	Stanwell's directors and employees and all contractors working for or at Stanwell's operational or non-operational sites, in their capacity as a director, employee or contractor.
OER	Operations Event Review
Subject Matter Expert (SME)	A person who has specialist or extensive knowledge in one or more of Stanwell's functional areas.
SAMCo	"Stanwell Assessment Maintenance Company" a subsidiary of Stanwell Corporation.

7.0   Revision History

Rev. No.	Rev. Date	Revision Description	Author	Endorse/Check	Approved. By
0	18.05.2015	New document prepared to support the Event Management Strategy (GOV-STR-02).	M. Maraj	K. Biggs	M. O'Rourke
1	30.11.2018	Scheduled review. Revised version of the Procedure has been simplified to outline only high-level concepts and more specific details have been moved into supporting Work Instructions.	M Maraj	P Ware	M O'Rourke
2	01.06.2022	Review and inclusion of guidance on process safety / asset-related events.	M. Maraj	P. Ware	G. Smith
	27.06.2022	Minor Change – No signatures or increase of revision no. required as update was to fix the type with form No. T-1897.	Desley Wood Natasha Harding		
	05.04.2024	Document renumbered (from GOV-PROC-46) to HSE-PROC-17 due to ownership change as requested by Letitia Lucke and approved by Maria Maraj. Refer to email 24/49256. No content reviewed in the change.	Shannon Scott		
3	13.08.2024	Document reviewed to update for Process Safety Event Management and HSE event Management after transfer of document ownership. Updated to new template.	Carel Rothman	Letitia Lucke	Kriss Ussher
	18.06.2025	Minor Change – SAMCo included in scope. No increase of Rev No. or Date due to full document not being reviewed. Refer to workflow id 13365	Carl Rothman	Luke Sondergeld	Kriss Ussher
	31.10.2025	Minor Change – Previously included OER qualifying criteria was replaced with a reference to the OHS-STD-11: OER Meeting Charter where this criterion is documented. Refer to Minor Change Request CDD-CR-01016 filed in Content Manager	Jayde Smith		Letitia Lucke
4	19.12.2025	Updated relevant sections with detail about process safety event tier classification	Carel Rothman	Kevin Ramm	Kriss Ussher

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Rev. No.	Rev. Date	Revision Description	Author	Endorse/Check	Approved. By
5	11.03.2026	Added reference to T-4027: HSE Event Reporting Process Overview	Jayde Smith	Letitia Lucke	Sean Peckover

8.0   Appendices

- Appendix 1 – Exclusions from Scope

- Appendix 2 – Classification of Process Safety Events (including Decision Flowcharts)

- Appendix 3 –Safe Work System Event Classification Guide

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Appendix 1 – Exclusions from Scope

This Procedure does not apply to the following events:

- Human resources (HR) / industrial relations (IR) (including bullying, harassment and discrimination complaints, performance management issues, union issues etc.). These are managed in accordance with the applicable policies and procedures, e.g., GOV-PROC-39 Managing Performance and Conduct Procedure, PEO-POL-21 Fair Treatment (policy) and PEO-PROC-55 Fair Treatment (procedure).

- Protected disclosures and complaints, including reportable conduct. These are managed in accordance with GOV-POL-29 Whistleblower Protection Policy and GOV-PROC-36 Protected Disclosures and Complaints.

- Expressions of dissatisfaction by a key opinion leader, near neighbour or influential community stakeholder about one or more of Stanwell's sites or projects (community complaints), These are reported to the General Manager (GM) - Stakeholder Engagement and/or the Manager - Community and Indigenous Relations and managed in accordance with STM-PROC-16: Complaint Handling Procedure. Depending on the severity, it is at the discretion of the GM - Stakeholder Engagement and/or the Manager - Community and Industrial Relations whether the complaint is recorded in EARS unless the complaint involves environmental aspects or issues. Where this is the case, the complaint must be managed in accordance with this Procedure (which includes recording the complaint in EARS).5

- Legal disputes. These are to be managed by Stanwell's Legal Team (including disputes for which external legal advisors have been engaged).

- Meandu Mine issues where the Senior Site Executive (SSE) (currently BUMA) has the applicable obligation in accordance with the Coal Mining Safety and Health Act 1999 (Queensland). These are managed in accordance with BUMA processes.

- Contained environmental events at Meandu Mine that do not impact (or could reasonably have the potential to impact) Stanwell's compliance with its Environmental Authority or do not require notification to the regulator. These are managed in accordance with BUMA's processes. However, where there is, or could be, an impact on Stanwell's Environmental Authority (EA), environmental obligations or require notification to the regulator, the event must be entered into EARS.

- Plant routine maintenance tasks and minor plant breakdowns or defects will be managed within Ellipse. The following cases would also require an EARS event to be raised:

    o a loss of generation, triggering safety system during shutdown process / sequence;

    o the failure mechanism is unknown, and an investigation or RCA is required;

    o notification to a regulator or external body is required; or

    o an internal procedure requires an event to be raised as a result of an action (e.g. Pressure Equipment Corporate Management Strategy ASM-PROC-STG-MAN-08).

- ICT issues that are ordinarily managed by raising a Service Desk request. These should continue to be managed in that way, e.g., where an individual is having trouble sending emails or is requires different permissions); however:

    o Where an ICT event impacts one or more sites (including the corporate offices) or impacts the whole business, it should be managed in accordance with the incident escalation process and this Procedure.

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[5] It is a requirement of Stanwell's Environmental Authorities (EA) that environmental complaints are recorded. Stanwell uses EARS to record environmental complaints.

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- o Where an IT security related event occurs, it should be managed in accordance with the Security Framework and this Procedure.

- Shareholding Minister communications, including responding to unexpected requests from Shareholding Ministers. These are managed by the Stakeholder Engagement team in accordance with their business-as-usual processes.

- Breaches of Stanwell's internal policies, procedures, work instructions or delegations that have an actual impact of 'Low' or a potential tolerable impact to our business. Note, however, that any breaches of Stanwell's Safeguards, Trading Risk Management Policy or Financial Risk Management Policy are managed in accordance with this Procedure, irrespective of impact.

- Crisis events, for example, the recent COVID-19 pandemic. A crisis must be managed in accordance with the Stanwell crisis response process (GOV-PROC-60) by the Crisis Leadership Team (CRT). It is at the discretion of the CRT if the event is subsequently recorded in EARS (and managed in accordance with this Event Management Procedure).

Appendix 2 – Classification of Process Safety Events

Process safety is a disciplined framework focused on preventing catastrophic incidents that can arise from the loss of containment of hazardous substances or energies. Process safety events include any incident or condition that compromises the integrity of safety-critical assets or the effectiveness of the Process Safety Management (PSM) system. These events range from uncontrolled releases of materials or energy, which may lead to severe health, safety, environmental, and financial consequences, to deviations that undermine hazard prevention, control, or mitigation measures.

Effective process safety management requires robust design, operation, and maintenance practices to ensure barriers and safeguards perform as intended. This includes systematic identification of hazards, implementation of engineered and procedural controls, and continuous monitoring of asset integrity. By classifying and analysing process safety events, organisations can identify weaknesses, learn from failures, and strengthen systems to reduce the likelihood of major accidents. Ultimately, process safety is about managing high-consequence, low-frequency risks to protect people, the environment, and business continuity.

The following flow diagrams can be used to classify process safety events.

Figure 1 provides guidance for determining whether an event qualifies as a process safety event and categorising it as an incident, near miss, or hazard.

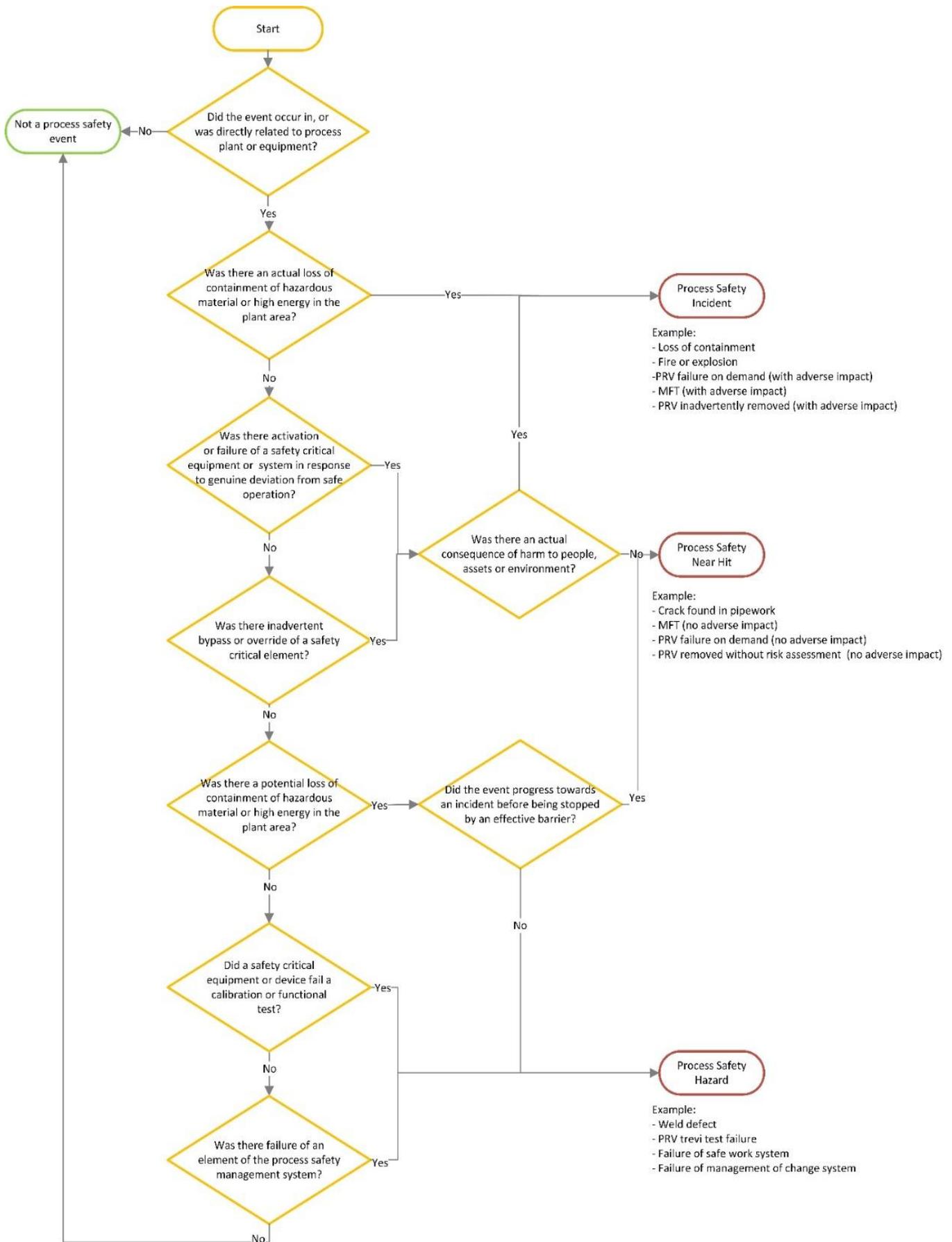Figure 2 presents a decision tree for assigning the appropriate tier to a process safety event.

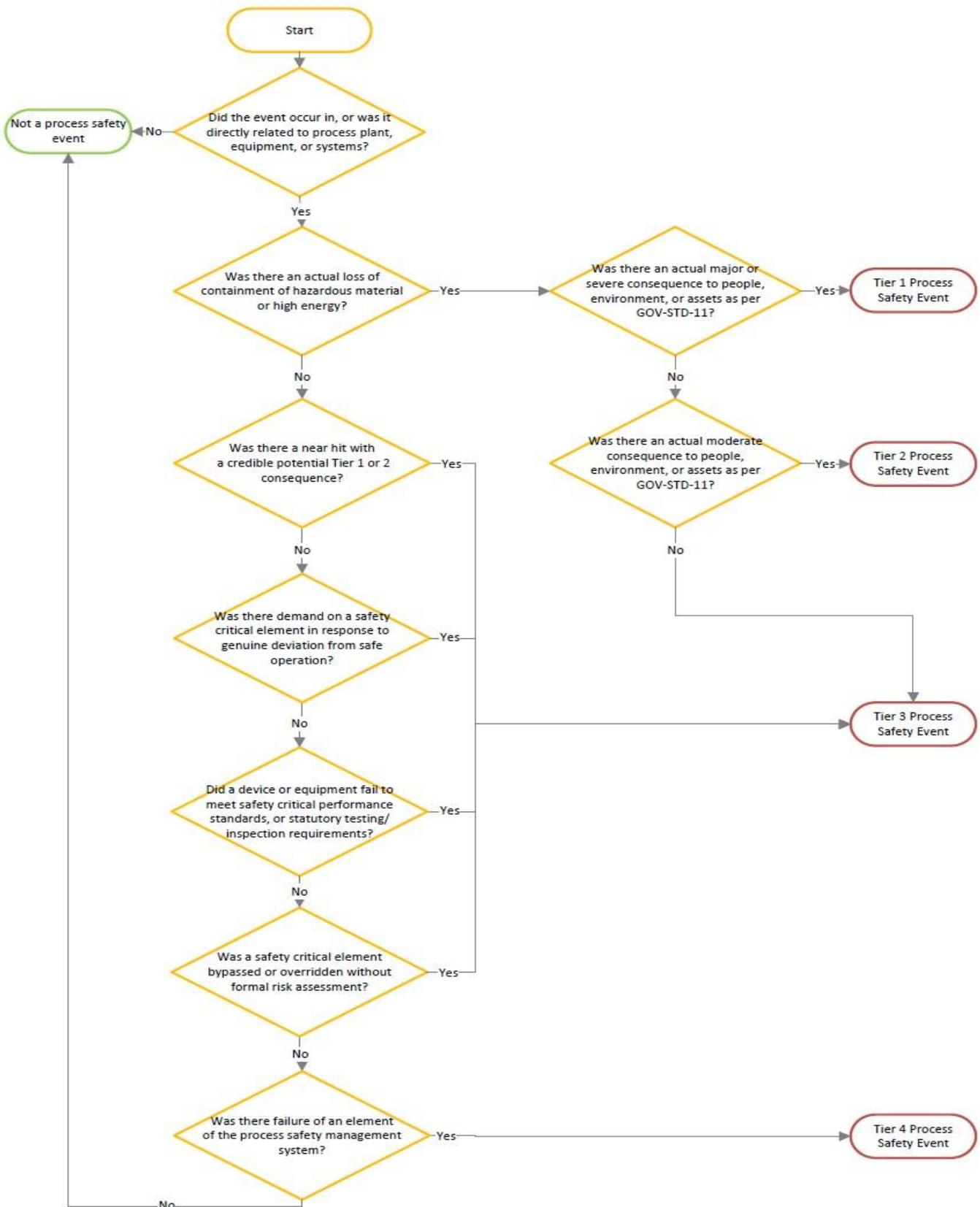*Figure 1 - Process Safety Event Flowchart*

Figure 2 - Process Safety Event Tier Classification Flowchart

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Definitions and Examples

Process Safety	Process Safety is about managing the integrity of operating systems by applying inherently safer design principles, engineering and disciplined operating practices. It deals with the prevention and mitigation of incidents that have the potential for a loss of control of a hazardous material or energy. Such loss of control may lead to high consequences with fire, explosion or toxic effects, and could ultimately result in multiple fatalities, serious injuries, extensive property damage, environmental impact and lost production with associated financial and reputational impacts
Process Safety Event	Process safety events include incidents and conditions that compromise asset integrity or the effectiveness of the Process Safety Management (PSM) system. These range from uncontrolled releases of materials or energy, which may result in significant health, safety, and environmental impacts, to deviations that weaken hazard prevention, control, or mitigation measures
Safety Critical Element	A process safety control that is paramount in preventing the MAE or mitigating the consequences of the MAE. The absence or failure of a PSCE would significantly increase the risk despite the existence of the other controls. In addition, a control that prevents more than one unwanted event or mitigates more than one consequence is normally classified as a PSCE.
Loss of Containment (LoC)	Loss of Containment (LoC) refers to the unplanned or uncontrolled release of hazardous substances or energy from their primary containment (such as tanks, vessels, pipes, or equipment) into the environment or surrounding area. This includes leaks, spills, ruptures, overflows, or failures of containment systems
Hazardous Material	A hazardous material is any substance that, due to its chemical or physical properties, poses a significant risk to health, safety, property, or the environment when released or mishandled. In process safety, hazardous materials typically include toxic, flammable, explosive, reactive, or corrosive substances that can lead to catastrophic events such as fires, explosions, or toxic releases if containment or control measures fail.
High Energy	In process safety, high energy usually refers to the following: **Electrical Energy**: Most common; present in live power lines or stored in batteries/capacitors. **Hydraulic Energy**: Stored in pressurised liquids; used to move heavy machinery or equipment. **Pneumatic Energy:** Stored in pressurised air; powers tools and moves objects. **Chemical Energy**: Released during chemical reactions, often as heat; hazards include fire or explosion. **Thermal Energy**: From explosions, flames, extreme temperatures, or heat radiation. **Radiation Energy:** Includes ionising and electromagnetic radiation; can cause burns, genetic changes, or functional disorders. **Gravitational Energy**: Related to object mass and height; greater height and weight increase risk.

	Mechanical Energy: Stored in tensioned items (e.g., compressed springs); sudden release can cause impact injuries.
Challenges to Safety Systems	Examples: • Demand on a safety critical element in response to genuine deviation from safe operation limits • Safety Critical equipment failing to operate on demand or found compromised during inspection or test. • Device or equipment fail to meet safety critical performance standards, or statutory testing/ inspection requirements • A safety critical element inadvertently bypassed or overridden without formal risk assessment
Weak operating discipline or breach	Examples: • Management of Change Process error or failure. • Incorrect application of the Permit to Work (tag out/lock out) process. • Delayed/missed maintenance or test of safety critical equipment without a formal risk assessment in place. • Prohibited item taken into hazard area. • Inadequate, or failure to follow, a safety critical procedure. • Failure to meet competency requirements for work on safety critical equipment.
Critical Element Performance Standard	A performance standard for a Safety Critical Element is a documented set of measurable criteria that defines how the element must function to prevent, control, or mitigate a Major Accident Hazard (MAH). It specifies the required functionality, availability, reliability, and survivability of the SCE under defined conditions, ensuring it performs effectively throughout its lifecycle
Statutory Inspections / Testing	Applies to pressure systems, lifting equipment, electrical installations, and other safety-critical devices identified in hazard studies and bowtie diagrams. This ensures integrity and reliability of equipment that contains hazardous substances or energies, reducing the risk of loss of containment and catastrophic events.

Events Not Considered Process Safety:

According to API RP 754, the following activities and incidents are not considered process safety events and should not be included in data collection or reporting:

- Occupational injuries/illnesses not related to loss of process containment.
- Security-related events such as sabotage, terrorism, or vandalism.
- Natural disasters (e.g., floods, earthquakes) unless a process safety failure occurs as a result.
- Non-process releases such as utility upsets, vehicle incidents, office/building accidents.
- Product transportation incidents outside the process boundary (e.g., trucking, rail accidents not on site).
- Planned or controlled releases that occur within design parameters.

Appendix 3 – Safe Work System Event Classification Guide (CM 18/93214)

Hazard: A situation that, if left uncontrolled, has the potential to impact Stanwell and/or Our People.
Near Hit: An unplanned occurrence that has the potential to impact Stanwell and/or Our People.
Incident: An unplanned occurrence that impacts Stanwell and/or Our People.

Event Occurrence Stage

Planning → Planning Complete → Planning Approved → Isolate (Includes 'Isolate' and 'Under Verification') → Ready for Authorisation → Authorised → Surrender → Deisolation → Complete

Isolation Certificate & Switching Isolation Certificate

Planning → Planning Complete → Planning Approved → Ready for Authorisation → Authorised → Surrender → Complete

Safe Work Authorisation

Planning → Planning Complete → Ready for Authorisation → Authorised → Surrender → Complete Surrender → Complete

Confined Space Entry Certificate

Issues identified are considered part of the safe work system planning processes and hence **not a HSE event** (hazard, near hit or incident). Discussion / feedback must be provided / issues rectified appropriately (this is inherent in 'approval' processes).

Exceptions: During these stages if the issues identified relate to incorrect labelling on plant, incorrect drawings, mods not completed etc. These should be raised as events in EARS and tagged with the Event Category of 'Quality'.

Issues identified are considered to be a **hazard** and should be reported within EARS as such.

The event **risk rating** for the event is to reflect the significance / severity of the event and requirement for detailed investigation / effort. The level 3 (detailed investigation, SIF assessment, 'notifiable' assessment) minimum event classification for certain SWS events is aimed to **signify that the layers of protection within the SWS were not effective** in this instance and requires detailed investigation and learnings.

Issues identified are considered to be a **near hit** or **incident** and should be reported within EARS as such (see definitions above).

Note: The HIRA / WMS component of the SWA is considered to be a dynamic document in that work scope changes / modifications to reflect changing scopes is considered to be part of the process – where such changes are identified and managed it is not considered an event or needing reporting in EARS – however learnings back into planning of the work or improvements to the SWA / SWA Template should be completed / rectified. This also applies to planned / identified changes to isolations (e.g. alters, testing etc.) [not errors / omissions] and to changes to required confined space controls (e.g. gas tests, continuous monitoring etc.).

Exceptions: Lost personal isolation point locks / keys are to be reported in EARS as a 'Hazard' (as per OHS-PROC-135 – SWS [Isolation Point Locking]).

The **risk rating** of an event is dependent on the nature of the event and risk. **Examples:** administration errors, locks not removed – <u>Minimum Level 1</u>; work performed whilst not signed on / lock on, incorrect plant accessed, incorrect / ineffective isolation points identified during or post work (including test for dead), control certificates not attached, work performed outside the scope of the SWA – <u>Minimum Level 3</u>.