**To Kate Du Preez;**

**Commissioner of Mine Safety Queensland**

**Re: Immediate Public Release of Coal Mining Safety and Health Advisory Committee legislation effectiveness review sub-committee recommendations**

**There are Seventy-Three (73) changes to the Coal Mining Safety and Health Act and Regulations that have been recommended by the Coal Mining Safety and Health Advisory Committee (CMSHAC).**

**These 73 come from the 121 contained in the “Expert Legal Assessment CMSHA, CMSHR and Recognised Standards conducted by the Minerals Industry Safety and Health Centre 8 November 2019, commissioned by then ALP Resources Minister Lynham.**

**In the Introduction of the Report are these Statements**

***The Report constitutes an independent expert assessment of the intrinsic adequacy of the legal framework governing coal mining safety and health in Queensland***

***It is important to note that this Report does not encompass any evaluation of how effectively, or otherwise, the legislative framework governing safety and health in the Queensland coal mining industry is implemented. Such an evaluation would require separate processes.***

**I note that the Advisory Committee in its annual report to the Minister now calls its Recommendations “*legislation effectiveness review sub-committee recommendations”***

**There seems a complete and irreconcilable lie in what the Advisory Committee is stating to the Minister.**

**There is not one Recommendation for change that has been looked at for effectiveness,**

**Now the faceless Public Servants at RSHQ get the job of progressing the Recommendations for tabling in Parliament.**

**When do Coal Mine Workers get made aware of what changes to their Safety and Health Laws are coming?**

**After its enacted?**

**How can you as Commissioner of Mine Safety and the Advisory Committee just say no-one has the right to public information about these proposed changes and must make a Right to Information request to know what has been recommended to change?**

**Commissioner Du Preez, let me point this out to you.**

**Coal Mine Production and Engineering workers sole Safety and Health Legislative protection comes from the Act and Regulations and its competent and diligent development and application by Management as well as competent and diligent Mines Inspectorate**

**Every section of the existing Act and Regulations are written in Coal Miners blood.**

**Each Coal Fatality and Disaster in Queensland since Mount Mulligan has resulted in changes to the Laws to try and prevent similar loss of Miners lives.**

**How many of the Coal Mine Face Workers are even aware of the Reports existence, let alone read it?**

***https://documents.parliament.qld.gov.au/tableOffice/TabledPapers/2020/5620T198.pdf***

**For the RSHQ, Advisory Committee and the Commissioner to deliberately say that the Coal Mine Face Workers and Public of Queensland to have to use RTI to know what has been recommended to change is just anti-worker, anti-safety, secretive, unbelievable and really unacceptable in a modern western democracy.**

**Is this “Putin’s” Russia we now live in?**

**There are detailed reasons and history why the majority of these Recommendations for change should have been rejected.**

**Indeed, I would argue many of these Recommendations could only be generated and accepted by those with limited to no historical knowledge of Coal Mining in Queensland**

**For the sake of brevity, I shall deal with only 3 of them.**

**2 of the 3 deal with Section 60 of the CMSHA *60 Additional requirements for management of underground mines***

**For Underground Coal Mine Workers, Underground Mine Managers and Mine Deputies (ERZC's) in particular there is an extremely concerning, retrograde and unsafe change suggested to the Regulation concerning who can issue “Technical Directions”.**

**It is arguably the most dangerous Recommendation made by the Expert Committee.**

**Anyone who advanced this need for change has no understanding of the Findings and Recommendations of multiple Mining Wardens Inquiries going back to Box Flat (1972- 17 dead), Kianga (1975- 13 dead) and Moura No 2 (1994 – 11 dead).**

**The Report makes recommendations for around Forty-Five (45) Sections of the Coal Mine Safety and Health Act 1999.**

**This includes**

**1. Meaning of Competence, Standard Operating Procedures, Site Senior Executive, Supervisor.**

**2. Approach to Principal Hazard Management Plans and Recognised Standards**

**3. Five (5) Recommendations concerning Obligations.**

**4. Four (4) Regarding Appointment of Site Senior Executive, Management Structure, Absences and Additional Requirements for Management of Underground Mines**

**5. One (1) about the Mine Record**

**6. Eight (8) about the Election, Functions, Powers and Stopping of Operations by Site Safety and Health Representatives and Industry Safety and Health Representatives**

**7. One (1) about Directives**

**8. One (1) about the Board of Examiners**

**9. Five (5) about Accidents, Incidents, Deaths and Diseases**

**10. One (1) about Protection from Reprisal.**

**The other 75 odd Recommendations deal with the Regulations and Recognised Standards.**

**For a Study that admits it does not evaluate how effectively or otherwise the legislative framework is, they have filled the Report with Forty-Five (45) suggestions concerning the Coal Mining Safety and Health Act and around Sixty (60) suggestions concerning the Coal Mining Safety and Health Regulations 2001.**

**Most of the suggestions include substantial change from the existing Act and Regulations.**

**How are any changes justifiable from this study if there has been no evaluation of how effective or otherwise the existing Sections of the Act and Regulations are and have been over the last 20 years?**

**How are any changes justifiable when there has been no analysis of Compliance with the existing Act and Regulations over the last 20 years?**

**Has either non-compliance to and/or ineffective Regulation contributed to the fatalities in Qld Coal Mines in the last 20 years?**

**How are any suggested changes justifiable when the Report States “Such an evaluation would require separate processes?”**

**This is completely contradictory.**

**I told one of the Three Authors from the Queensland University (Professor Cliff) what I thought of the Report when I caught up with him at the Leading Indicators Conference at Parliament House in November 201.**

**1. That it was the single most retrograde and dangerous document ever produced about changes to the Act and Regulations.**

**2. There was nothing considered about the current Act and Regulations effectiveness or the level of compliance.**

**3. At least half of the suggested changes had already been rejected by the Advisory Committee prior to 2010 and had just been repackaged for another attempt.**

**4. Two of the Three Authors have never been a Coal Mine Worker of any description and are a University Law and a "Mining" Academic respectively. They hold no recognised Mining competencies.**

**5. Conflict of interest by Professor Cliff, especially about the proposed changes to what is "Reasonably Foreseeable" in Regulation 296 "Escapeways".**

**I told Professor Cliff that I could not believe he would now apparently stoop to such a low underhanded attempt, by now recommending the Government deliberately change what the Law Courts have found.**

**Especially in light of what had happened at Pike River in NZ, North Goonyella and Grosvenor.**

**On this basis of this alone, the Report should not have been accepted by the Minister.**

**I will deal with just 3 of the 121 Recommendations and why they are both unacceptable, retrograde and potentially the most dangerous changes ever Recommended to the Coal Mining Act and Regulations since 1925.**

**2 of the 3 Recommendations deal with “Technical Directions” for Section 60 of the CMSHA**

**After dealing with Reasonably Foreseeable I will the deal with *6.1.35 Section 153, Giving technical directions to a person appointed under s60 (8) or (9) of the Act.***

**REASONABLY FORESEEABLE**

**The meaning of the words “Reasonably Foreseeable” was subject to Supreme Court action over the Anglo Grasstree Mine.**

**In short it required Anglo Grasstree Mine to have two separated "trafficable intake roadways-shafts" from the surface to the seam, that workers could escape from.**

**Anglo Grasstree Mine was accessible only by Two vertical shafts that were around 250m deep. A single man and material shaft and a return shaft.**

**There was no way for coal workers to self-escape and walk out.**

**Single Entry (Intake) Coal Mines have been illegal in England since the 19th Century and in Queensland since 1925(Attached)**

**The disaster in England was the New Hartley Pit Disaster in 1862 that killed 204 men and boys.**

**It caused Queen Victoria to make the law for 2 shafts. (Attached).**

**Coincidentally it was made on the 7th of August (the date of the Moura 2 explosion). Mind you there is a 1/365 chance of that happening.**

**The last Coal Mine that attempted a single-entry operation was Pike River in New Zealand where 29 Miners died in 2010.**

**Only 2 Coal Miners just managed to self-escape the explosion.**

**I point out that Pike River’s single intake was down hill from face to surface, I am not aware of any other coal mine in Australasia where that is the case. Both survivors freely admit they would not have self-escaped if they had to be walking up hill instead of down.**

**Anglo Management’s and Professor Cliff's Evidence and Interpretation for Anglo Coal of what is "Reasonably Foreseeable" was found by the Qld Supreme Court and a full bench of the Appeals Court to be wrong.**

***https://www.queenslandjudgments.com.au/caselaw/qsc/2004/181***

**Anglo Coal after losing the Supreme Court case then took the case to the Queensland Court of Appeal where a full bench again rejected the Anglo position.**

**The Court of Appeal made this declaration.**

***In summary, a reasonably foreseeable event for the purposes of s 296 is one which can be envisaged by a person of imagination and intelligence, but which is not far-fetched or fanciful.***

***CFMEU v Queensland and Anglo Coal [2005] QCA 127***

**The Expert Legal Report concerning Section 296 are quoted in full below,**

**The wording in this Recommendation is unique in the Report from my reading.**

**There is no mention of the matter being raised by Interviewees, it being suggested or raised with the Expert Team.**

**It is obvious from the wording “*we are of the view*” that it was members of the Expert Legal Team that have decided to include their Recommendation.**

***6.1.53 Section 296, Escapeways***  
***At present s 296(1) CMSHR states as follows:***  
***296 Escapeways***  
***(1) The site senior executive for an underground mine must ensure the mine has at least 2 trafficable entrances (escapeways) from the surface that are separated in a way that prevents any reasonably foreseeable event happening in 1 of the escapeways affecting the ability of persons to escape through the other escapeway.***

***The construction of “reasonably foreseeable event” for the purposes of section 296(1) was considered in CFMEU v Queensland and Anglo Coal [2005] QCA 127.***  
  
***While the Court provided guidance in this regard, we are of the view that the section itself could usefully be clarified further.***  
***We suggest there would be value in providing the following explanation of the meaning of “reasonably foreseeable event” in s296:***  
***A “reasonably foreseeable event” for the purposes of section 296(1) is an event which a reasonable person in the position of the site senior executive ought to have in contemplation when ensuring that the mine has at least 2 trafficable entrances (escapeways)***

***6.1.53.1 Recommendation***

***That s296(1) be amended as proposed.***

**The Court of Appeal found**

***In summary, a reasonably foreseeable event for the purposes of s 296 is one which can be envisaged by a person of imagination and intelligence, but which is not far-fetched or fanciful.***

**I am not a Lawyer, but I issued the Section 167 Directives at Grasstree and and with ISHR Dalliston, gave extensive evidence at the Supreme Court.**

**This is just trying to get arguments rejected by the Queensland Supreme Court and Court of Appeal inserted into the Legislation**

**The findings of the Court of Appeals were quite clear and accepted in precedent cases considered.**

**This decision came after the conclusions of**

1. **Over 3 years of discussions between the Industry Safety and Health Representatives, Qld Mines Inspectorate and Anglo Coal about Section 296.**
2. **Changes were made to the Mines Inspectorate Hazard Data Base.**
3. **ISHR issuing a Section 167 Directive suspending operations for unacceptable level of risk. This was triggered when Grasstree Mine commissioned the main fan and there was only one intake shaft.**
4. **Mines Inspectorate lifting the ISHR Directive.**
5. **CFMEU taking the Inspectorate and Anglo to the Supreme Court.**
6. **Post McMurdo Supreme Court Decision and Second Section 167 Directive was issued, the Grasstree Mine took between 5 and 6 months to be brought into compliance and mining could recommence.**
7. **The ISHR’s were threatened with Prosecution in writing by the then Chief Inspector when they refused to abide by a Directive of the CIOCM that Directed they perform specific actions outside the Powers and Functions of the ISHR’s.**

***In summary, a reasonably foreseeable event for the purposes of s 296 is one which can be envisaged by a person of imagination and intelligence, but which is not far-fetched or fanciful.***

[***https://www.queenslandjudgments.com.au/caselaw/qsc/2004/181***](https://www.queenslandjudgments.com.au/caselaw/qsc/2004/181)

**Professor Cliff gave extensive evidence at the Supreme Court and gets a number of mentions during both the Supreme Court decision and the Appeal Court Decision.**

**These include**

***The applicant had the onus of proving that the two shafts in this mine were not separated according to the regulation. That required the applicant to prove that there was at least one reasonably foreseeable effect which could have the consequence described in the regulation, which the applicant has done by my findings in respect of a fire involving the burning of fuel being transported through the intake shaft. It was unnecessary for the applicant to prove that any other scenario, involving a fire in this shaft, was also a reasonably foreseeable event and capable of the relevant consequence for an escape, and nor is it necessary for this judgment to determine whether that is proved upon the present evidence. This judgment involves no finding one way or the other as to those other scenarios. Not only is it unnecessary to do so, but the relative inattention to those matters in the evidence gives the impression that findings about them could be seen by one side or the other as unfair.***

***Dr Cliff did opine on whether certain other scenarios were reasonably foreseeable, but as I have concluded that the ‘worst case’ scenarios are reasonably foreseeable, contrary to his opinion, I am left with the impression that he has not been instructed on the meaning of that term as I have interpreted it, and nor has he considered the potential affect of a fire through the necessity to use the protective equipment. Therefore his evidence would allow me to conclude that there were not other relevant events; but the rejection of that evidence would not prove that there were. A declaration should not be made if it has no utility. But it is beyond the proper scope of these proceedings for the court to attempt some comprehensive advice to the respondent as to in what circumstances the mine would remain non compliant with the regulation, or as to the various means by which compliance might be achieved. That is properly for the consideration of the respondent (or the mine operator), according to the findings of fact and conclusions of law within this judgment***

***Those two scenarios were described by another expert witness, Dr Cliff, as “the worst case scenarios”. Dr Cliff (who was called on behalf of Anglo) was an Associate Professor at the Minerals Industry Safety and Health Centre at the University of Queensland and had over 14 years experience in researching and providing consultation relating to the management of hazards in underground coal mines, particularly spontaneous combustion, mine fires and explosions.***

**Lastly, as later actions of Anglo proved, I point out that major reason that Anglo constructed Grasstree in its original shaft only configuration, was an Industrial Agenda.**

**That being to keep existing Southern Colliery employees from automatically being employed at the Grasstree Mine and carrying over the existing Industrial Agreements,**

**The subsequent in-seam drive of some 500m to link up the two Mines occurred once Southern colliery workforce was retrenched and happily for Anglo just happened to coincide with Longwall Mining starting in “Grasstree”.**

**The coal winder in the return shaft was never designed to be capable of transporting the amount of coal a longwall mines.**

**TECHNICAL DIRECTION**

**For Underground Coal Mine Workers, Underground Mine Managers and Mine Deputies (ERZC's) in particular, there is an extremely concerning retrograde and unsafe change suggested to the Regulations.**

**It is arguably the most dangerous Recommendation made by the Expert Legal Group.**

**As Grosvenor, North Goonyella, Moranbah North fatalities and the Grasstree fatalities prove the Underground Mine Managers put the Workers Safety and Health at unacceptable levels of risk, without non statutory Management making critical Safety and Health decisions.**

**It is totally contrary to the findings and recommendations of the Box Flat, Kiangs and Moura No 2 Wardens Inquiries**

**BOX FLAT DISASTER WARDENS INQUIRY**

***9. That any person who is appointed to make technical decisions that effect the Manager’s authority regarding the safety of the mine must be qualified as a Manager under the Act and shall be responsible under the Act.***

**KIANGA DISASTER WARDENS INQUIRY**

***The Queensland Coal Mining Act should be amended to provide for persons with technical authority superior to a Manager. These persons should be qualified managers under the Act and should bear the same statutory liability as Managers in respect to any acts to which they are party.***

**MOURA No 2 DISASTER**

**The giving of Directions was dealt with in the Moura No 2 Inquiry in part by the following excerpt**

***The concept 'duty of care' is sound and should be promulgated by any new legislation. It rightly puts onus on every person in the work environment to take reasonable care to ensure their own safety and health and to not endanger the safety and health of others. However, the concept does not lead naturally to the conclusion that all persons are (or can be) equally responsible for safety, even for their personal safety. Responsibility implies authority and those with highest authority inevitably have the greatest responsibility, both to form rules and to ensure that they are complied with.***

***The Inquiry rejects the proposal (in one of the submissions to it) that the position of registered mine manager be dispensed with. The Inquiry believes that there has to be one person in overall authority at the mine who has a 'duty of care' to ensure that adequate rules and safeguards are in place and are being complied with.***

***Safety must remain the highest priority at a mine, with all other activities subordinate to it. Conflicts of interest must always be resolved in favour of safety and this requires one person at the mine who has overall authority. Accordingly the position of mine manager, having essentially the same role as it has today, should continue. An underground coal mine needs a manager no less than a ship or an airliner needs a captain.***

***The requirement to appoint a statutory mine manager should not prevent or frustrate mine owners from making such other appointments as they see fit to deal with production, commercial and other matters, so long that it is clearly understood that such persons are subordinate to the mine manager.***

***The Inquiry also believes that the statutory hierarchy extending below the mine manager, namely the system of undermanagers and deputies, should likewise be retained in any new legislation. Their primary function is and always has been directed to securing and maintaining, on behalf of the manager, safe working places and practices in the mine***.

**If the Expert Assessment Team had of looked at the Compliance and Effectiveness of the Act and Regulations, they would have found real examples about why this Recommendation should never have been made.**

**This being the Grosvenor Mine Record Entries from 2016 and 2017.**

**As Commissioner of Mine Safety I imagine that you are very well familiar with these Mine Record Entries.**

**I note that Mr Glen Britton (Anglo Coal) was one of the people who made submissions and/or interviewed by the Expert Legal group.**

**I would conclude given the contents of a Mines Inspectorate Level 3 Compliance Mine Record Entry for Grosvenor Mine dated the 26th of April 2017; that Mr Britton asked for this change’ as it is entirely consistent with the comments of Mr Britton in the MRE.**

**In this Mine Record Entry the Grosvenor SSE Foulstone has been found guilty of “issuing Technical Directions” to the UMM without holding the required 1st Class competencies himself.**

**Mr Britton/Mr Foulstone has illegally included in the Grosvenor Safety and Health Management System an ability for Management who do not hold a 1st, 2nd or 3rd Class Managers Competencies to give “Technical Directions” to the Mine Deputies (ERZC).**

**This is illegal because a Mine cannot risk assess/introduce anything contrary to the Coal Mining Act and Regulations into its Safety and Health Management System.**

**Mr Britton argues about the need for the Ventilation Officer and Geotechnical Engineers to issue “Technical Directions” to the ERZC’s.**

**Firstly, the Ventilation Officer has to fulfill all their duties and functions under the Act and Regulations and the Mines SHMS themselves prior to any major ventilation changes.**

**Secondly the perils inherent in Non-Statutory Management issuing technical directions about roof support patterns is shown by the roof fall at the development face in 2016 at the Grosvenor Mine.**

**The 2016 MRE referenced deal with a roof fall in development that trapped 4 workers at the development face and nearly buried the face Deputy (ERZC). This occurred after Management had made a unilateral decision to drastically lower the roof support pattern by not installing 2 x 8metre megabolts in the primary bolting pattern.**

**The fall occurs almost immediately after.**

**The fall is a real time and nearly multi-fatality disaster that shows how unilateral management decisions to lower primary roof support are so dangerous.**

**Recommended Change**

***5.1.16 Section 60, Additional requirements for management of underground mines***

***Interviewees from across the spectrum queried the meaning of the term 'technical matter', and sought the definition of this term in the CMSHA.***

***Interviewees expressed varying views about the qualifications that should be required in relation to appointments under s60(8) and s60(9). Some sought amendments to these sections to, in the case of s60(8,) remove the possibility of appointing a person with a deputy's certificate; and in the case of s60(9) to remove the requirement for a first or second class certificate of competency.***

***5.1.16.1 Recommendation***

***The assessment team believes the term 'technical matter' should be defined in the CMSHA and/or that examples should be given.***

***We note the suggestion from one interviewee that a direction on production targets should not be seen as a 'technical matter' (though, depending on the circumstances, it may conceivably fall within the category, set out in s60(7), of directions that may adversely affect safety and health); but a direction on the placement of roof bolts should be deemed*** ***to fit within the term. The logic of this delineation seems sound.***

**6.1.35 Section 153, Giving technical directions to a person appointed under s60 (8) or (9) of the Act**

**As with s60 of the CMSHA, interviewees sought clarification as to what was meant by a 'technical direction'.**

**Some interviewees believed that s153 should specify that only a person with a first class certificate of competency should be able to direct another person with a first class certificate on a matter that impacts safety. We note that one difficulty with this approach would be the need to define what 'a matter that impacts safety' might consist of.**

**6.1.35.1 Recommendation**

**Consistent with our recommendation in regards to s60 CMSHA, the assessment team believes that the term 'technical direction' should be clarified within the CMSHR.**

**EXISTING LEGISLATION**

**SECTION 60 CMSHA**

***(6) A person must not give a direction to the underground mine manager about a technical matter in relation to the underground mine unless the person giving the direction is the holder of a first class certificate of competency for an underground coal mine.***

***Maximum penalty—200 penalty units***

***(7) A person must not give a direction to the underground mine manager that may adversely affect safety and health at the underground mine.***

***Maximum penalty—200 penalty units***.

***(8) The underground mine manager must appoint a person holding a first or second class certificate of competency or a deputy’s certificate of competency to be responsible for the control and management of underground activities when the manager is not in attendance at the mine.***

***Maximum penalty—200 penalty units.***

***(9) The underground mine manager must appoint a person holding a first or second class certificate of competency or a deputy’s certificate of competency to have control of activities in 1 or more explosion risk zones.***

**GROSVENOR MINE RECORD ENTRIES**

**The attached Mine Record Entry is Grosvenor Mine Level 3 Compliance Meeting. “Complaint SSE giving directions to Statutory Officials while not being the holder of technical competencies issued on the 26th April 2017”**

[**MRE – L3 SSE and Britton Grosvenor Coal Mine – 26.04.2017.pdf**](https://www.qldminingcrisis.com.au/wp-content/uploads/2021/07/MRE-L3-SSE-and-Britton-Grosvenor-Coal-Mine-26.04.2017.pdf.docx)

***The investigation was conducted after an anonymous complaint was raised by a former member of the mine management had detailed several issues of SSE Foulstone giving instructions to statutory officials whilst not being in the possession of a statutory certificate of competency.***

***A thorough investigation of all these matters was conducted by Inspector Brennan which concluded with the findings that this could only be verified for one matter. The evidence for this matter indicated that a breach of section 60(6)of the Act;***

**Issues to note**

**1) Complaint raised by a former member of Site Management in particular the Underground Mine Manager**

**2) Investigated by Inspector Brennan, who found breach of Section 60 (6) of the Coal Mining Act**

3) **The investigation also revealed the use of a process in the Grosvenor mine Safety and Health Management System that*authorised non- statutory personnel to issue technical directions to statutory personnel.***

**4) The continual disputing of the findings by Mr Glenn Britton, (Anglo Head of Underground Operations) on page 2.**

5)**Nothing indicates that the Inspectors demanded the withdrawal of “Grosvenor mine Safety and Health Management System that*“authorized non- statutory personnel to issue technical directions to statutory personnel”***

6)**The MRE just says they have discussed the issue with the current SSE.**

**7) Nothing in the MRE indicates whether they investigated other Anglo Mines to see if similar illegal authorization exists and have it withdrawn.**

**8) There is nothing on the Mines Department website to indicate communication to industry of “*the requirement for persons who do not hold a statutory certificate of competency not giving directions to a person holding a statutory certificate of competency in charge of an Explosion Risk Zone”*as requested by Mr Britton.**

**ROOF FALL GROSVENOR 2016 Trapping 4 workers at the development face. ERZC nearly buried in fall**

**On the 5th June 2016 there is a Major roof fall in Development that TRAPS 4 men at the Continuous Miner Face in MG 102 at C heading inbye 18 c/t nd the ERZC has to very quickly evade the falling roof.**

[**06.06.2016 Fall trapping crew MRE – Grosvenor Coal Mine –**](https://www.qldminingcrisis.com.au/wp-content/uploads/2021/07/06.06.2016-Fall-trapping-crew-MRE-Grosvenor-Coal-Mine-.docx)

**This is extremely close to a five person multiple fatality.**

**The Mines Inspectorate identify there are major problems/deficiencies with the Change Management Process.**

**This being that the actual Workers who have to cut the coal and support the roof have not been part of the Change Management/Risk Assessment process to stop installing** ***2x 8.2m Megabolts at 4m spacing*as part of the minimum support pattern and just install 8 x 1.8m bolts only.**

***Support condition – The fall had occurred approximately 10m inbye of the support pattern for 18CT intersection and stopped approximately 20m from the face of the heading. A 8x 1.8mJX bolt per metre(roof) pattern was being utilised and failure had occurred between the 2 outermost bolts.***

***The support pattern had been changed from that installed in 102MG previously by removing the need to install 2x 8.2m Megabolts at 4m spacing.***

***This had been subject to a change management process dated 20/05/16.***

***Inspector Gouldstone asked if a staged reduction in roof support had been considered.***

***Identify the process the Mine has followed to deal with change management***

***Understand how the Mine is to secure the fall by following a risk assessment process***

***Discuss with Mine personnel why the failure occurred and what support will be installed in future in 102 MG to prevent a recurrence.***

***In the Group Interviews Inspector Gouldstone is told***

1. ***Neither crew were consulted following recognised risk assessment which should have been triggered by the change of management process***
2. ***Both crews were aware that the change was likely and had been briefed before they commenced the shifts on which the change took place, and, when the early signs of roof movement were detected***
3. ***No person predicted nor expected the rapid deterioration and roof failure that followed***
4. ***There was total reliance in the technical expertise applied during the change management process***
5. ***It was understood by the crews that the monitoring of tell-tales used in the reasoning for the change related to roadways where megabolts had been installed and that there was no data associated with convergence measurements relating to only 8x 1.8m steel bolts alone***
6. ***Specific reference was made to items discussed with management post failure – was elevated in situ methane content related to ply 1 & 2 given consideration?***
7. ***Was there an interim support pattern/system which might have been considered?***
8. ***Why was the change initiated immediately after 18ct conditions were seen as very heavy even in comparison with previous cut throughs?***

**1925 Qld Coal act and General Rules Provisions Intake Roadways**

***90, (1) At least a second opening to the surface shall be provided before mine is operated for normal production. After breaking away from the shaft bottom in any underground coal mine, the owner, agent, or manager shall concentrate on the completion of at least a second opening to the surface from such mine, the openings to be not less than 15 metres apart and to intercommunicate with each other, by means of which all persons employed in the mine may at all times pass in or out. No operations in any coal mine having for their sole object the working of coal shall be commenced until two such openings have been completed.***

***(2), (3) (Repealed).***

***(4) Where two separate openings to the surface are required by this Act, proper apparatus for raising and lowering men shall be installed and kept ready for immediate use at each such opening. This subsection does not apply to any opening by which persons can walk into or out of the mine or in the case of a vertical shaft where properly constructed ladderways are provided in accordance with rule twenty-three of the Second Schedule to this Act.***

***(5) Where apparatus is provided at any coal mine in compliance with this section, it shall not be deemed to be proper apparatus within the meaning of this Act unless in the opinion of the inspector it would sumce as a means of ingress or egress for all persons in the mine on any working day and as an adequate means of egress in case of emergency, and until he has certified to that effect in the record book.***

***(6) Option of using downcast shaft. Where there are a downcast shaft and upcast shaft to the same seam both such shafts shall be provided with apparatus for raising and •lowering persons, and every person employed in the mine shall on giving reasonable notice have the option of using the downcast shaft.***

***As amended by Act of 1938, 2 Geo. 6 No. 9, s. 12; Act of 1947, 11 Geo. 6 No. 38, s. 7; Act of 1964, No. 8, s. 37; Act of 1972, No. 31, s. 6 First Sch.***

***GENERAL RULES***

***4.2 (1) In an underground coal mine other than a mine existing at 1st July, 1978, provision shall be made for an intake airway other than a roadway containing a belt conveyor. This requirement shall apply to any part of such mine other than a panel or sub-panel where the 'method of working limits the number of roadways to less than three: Provided that in the initial development of a new mine the belt conveyor roadway may sente as the only intake airway for such time as is reasonably required to provide a second intake airway.***

***(2) All belt conveyor roadways shall be segregated from other intake airways and from return airways.***