Counsel Assisting Opening Remarks

May it please the Board.

On 6 May 2020 a methane explosion enveloped the longwall face at panel 104 at the Grosvenor mine near Moranbah. Five miners were injured and hospitalised, four of them with very serious burns. That explosion, or "serious accident" as it is called pursuant to the *Coal Mining Safety and Health Act*, followed a series of 14 high potential incidents involving exceedances of 2.5 per cent methane that had occurred on the same longwall panel since 18 March 2020.

An exceedance of 2.5 per cent methane in the general body is significant, because at a concentration of 5 per cent in air, methane becomes explosive.

Those 14 HPIs on longwall 104 at Grosvenor were preceded by another 13 events involving methane exceedances on longwall 103 that occurred between 2 July and 17 November 2019. There had been a history of similar events at Grosvenor since at least 2016, and it is expected that evidence will show that both Anglo American and mine inspectors had recognised gas management as being a problem at Grosvenor.

This inquiry's terms of reference require it, amongst other things, to inquire into the operations of not only Grosvenor but also another three underground mines -

- Grasstree, operated by Anglo Coal (Capcoal Management) Pty Ltd;
- Moranbah North, operated by Anglo Coal (Moranbah North Management) Pty Ltd; and
- Oaky Creek, operated by Oaky Creek Holdings Pty Limited.

Those terms of reference require the investigation of those mines because Grasstree also had a series of 11 HPIs involving methane on the longwall between 28 July 2019 and 11 April 2020, and there were single HPIs of the same character at Moranbah North and Oaky Creek on 20 July 2019 and 6 December 2019 respectively.

The issues for consideration by the Board include assessment of the probable cause of these incidents, of the mines' response to them and of the oversight given to them by inspectors under the Act.

As foreshadowed, it is expected that the public hearings of the Board will take place in two stages. The first, commencing today, will involve gaining an understanding of the work of the inspectorate now known as Resources Safety and Health Queensland, including workload, experience, and information management. To that end, the Acting CEO of Resources Safety and Health Queensland, Mark Stone, will give evidence as the first witness; he will be followed by Chief Inspector Peter Newman.

The hearings will also involve taking evidence from senior executives of each of the companies involved in the operations of the mines in question about matters that include corporate management and governance, safety systems and strategies, workforce engagement, including the use of labour hire workers, and the payment of incentives to both executives and workers.

There will also be evidence that is specifically about the HPIs that occurred at Oaky Creek, Moranbah North and Grasstree, and it is expected that the Board will hear evidence from the regional inspector for the north region, Stephen Smith, who has reviewed the mines' reports to the inspectorate for each of the HPIs at those three mines - that is, the mines, excluding Grosvenor.

The second stage of hearings will occur once more evidence, including expert opinion, is available concerning the HPIs and serious accident at Grosvenor. It is expected that Mr Smith will be recalled at that point to speak about the Grosvenor HPIs and other matters concerning gas management at the mine.

The terms of reference require the Board to inquire into the HPIs, to report on the nature and cause of the serious accident, and report on whether the operational practices or management systems in place at the time were adequate and effective to achieve compliance with the law and safety standards, and make recommendations for the improvement of mine health and safety.

Determination of the nature and cause of the serious accident must await the gathering and analysis of evidence, but the other matters can, however, be the subject of evidence now.

Because it has the potential to cause a serious adverse effect on the safety or health of a person, a single high potential incident is necessarily a serious event; an HPI involving methane, acutely so. Worldwide, methane explosions have killed many miners. Here in Queensland, since 1972 there have been four coal mining disasters in which a total of 53 miners died. Each involved methane explosions.

Common themes of investigative reports into coal mine methane explosions are a failure of the industry to either remember or learn from past events and an apparent inability to recognise the warning signs of impending disaster.

One question for the Board will be what should have been made of not one methane HPI, but a series of them. Whilst it might be argued that an isolated exceedance of 2.5 per cent methane is simply something that will inevitably happen from time to time in an underground coal mine, a question for the Board will be whether the repeated methane exceedances, particularly at Grosvenor, presaged the explosion of 6 May or were in fact entirely unrelated to it. A question should be raised as to whether similar concerns ought to have been raised with respect to the series of exceedances at Grasstree.

There can be little doubt that there was an explosive mixture of methane and air present on the longwall face at Grosvenor immediately prior to the explosion, but the critical questions are how it got there and what ignited it.

Other questions that more immediately arise are, well, even if the explosion occurred independently of the HPIs, what did the recurrent methane exceedances say about gas management at the mine? Is there a need to rethink mine ventilation and to take a different approach to managing methane? Is there a risk of normalisation when repeated methane exceedances occur? Do workers have the necessary competencies? Is there a need for better training? What are the potential impacts of employee incentive schemes that reward production and penalise safety incidents? What are the potential impacts on mine safety culture when workers are employed not by the mine operator but by a labour hire company?

Further, given that each of the HPIs with which the Board is concerned was reported to the regulator, was there appropriate oversight?

Now, no recommendations can be made that will improve mine safety without an understanding of these issues, and it is hoped that the evidence to be adduced before the Board will enable such an understanding and those recommendations.

May it please.

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