Oaths Act 1867

Statutory Declaration

QUEENSLAND

TO WIT

I, Mark Douglas Stone, of [redacted] Brisbane City, Queensland, 4000, in the State of Queensland, do solemnly and sincerely declare that:

1. I am the Acting Chief Executive Officer of Resources Safety and Health Queensland (RSHQ). I hold a Bachelor of Engineering – Mineral Engineering from the Camborne School of Mines, and a Master of Engineering – Petroleum Engineering from Heriot-Watt University. I am a member of the Society of Petroleum Engineers and a member of Engineers Australia. I have over twenty years of industry experience in operational, technical and leadership roles before commencing employment within the Department of Natural Resource and Mines (as it was then known) in 2014. I was appointed as the Executive Director of Resources Safety and Health from October 2016 until 30 June 2020.

2. In response to a request from the Queensland Coal Mining Board of Inquiry, I provide the following evidence to assist the Inquiry.

A Brief Overview of the Industry

3. There are sixty-three active coal mines in Queensland. Of these, fifty-one are open-cut coal mines and the remainder (twelve) are underground coal mines.

4. There are approximately 37,290 coal mine workers in Queensland. Approximately 50% are employee workers, and 50% are contractor and labour hire workers.

5. There are twenty-one operators of coal mines in Queensland. Fifteen are locally owned and six are global operators.

Overview of the *Coal Mining Safety and Health Act 1999*

Objects of the Coal Mining Safety and Health Act 1999

6. The objects of the *Coal Mining Safety and Health Act 1999* ("the Act") are set out in section 6 of the Act. They include:

   (a) to protect the safety and health of persons at coal mines and persons who may be affected by coal mining operations; and

   (b) to require that the risk of injury or illness to any person resulting from coal mining operations be at an acceptable level; and

   (c) to provide a way of monitoring the effectiveness and administration of provisions relating to safety and health under this Act and other mining legislation.

Legislative model of the Act

7. The modern legislative model of the Act is risk-based, which can be contrasted with the repealed *Coal Mining Act 1925,* which was largely prescriptive legislation.

8. A prescriptive legislative approach is one in which the legislation prescribes regulated persons with precisely what measures are required to be taken. Traditionally, under this approach, required or prescribed measures are exhaustive – that is, regulated persons achieve compliance by following "the letter of the law". Deficiencies of this approach are well documented, and were outlined in the British Robens Report of 1972. Prescriptive legislation tends to create massive detailed laws, which can be difficult to comprehend and keep up to date, and leads to problems expressed as 'falling between the cracks'. Prescription is also said to encourage a minimum compliance attitude, in that it can create indifference on the part of workers and management (who in a prescriptive environment might merely 'do it by the book'). Prescriptive legislation is said to diminish employers' responsibility for safety, acting against the development of a culture of safety. It has also been criticised as imposing unnecessary cost on companies and regulators, without a commensurate improvement in safety.

9. The legislature made a conscious decision to move away from prescriptive mining legislation to risk-based legislation, in recognition of the fact that modern safety management focuses on creating a concept of 'on-site ownership' of safety and health issues. Mining companies have specialist expertise in the local conditions of their own

mine and are in the best position to manage risk to ensure that it remains at all times at an acceptable level. This approach is in keeping with the recommendation in the Moura No 2 Inquiry that duty of care principles should be included in coal mining legislation, and has been recognised as 'best practice' in the Royal Commission into the Pike River Coal Mine Tragedy.

10. The Act was the outcome of an extensive tripartite process between government, industry and unions over the six years that followed the Moura No 2 disaster. The Act outlines the objectives of the legislation and provides the broad principles. The approach adopted in the Act is one of promoting cooperation between workers and employers; and where obligation holders must focus effort and resources on achieving required outcomes, allowing them to determine and use the most appropriate methods and technology to achieve those outcomes. The legislation still includes some prescription, for example where there is only one acceptable way of achieving a required outcome.

11. Central to the framework of the risk based legislation is the control and management of risk. A key requirement of the legislation is that mining operations must be carried out so that the level of risk is at an *acceptable level*. This means that risk must be within acceptable limits, and as low as reasonably achievable.

12. The Act is supported by the *Coal Mining Safety and Health Regulation* 2017 (Qld) ("Regulation"). The Act and Regulation is supplemented by recognised standards which state ways to achieve an acceptable level of risk, and guidance notes which are issued to assist operators meet their safety and health obligations.

Safety and Health Management System

13. The Act introduced the requirement for a comprehensive risk based safety and health management system (SHMS) for each mining operation. These systems are central to legislative framework, and incorporate risk management practices to ensure the safety and health of coal mine workers and persons who may be affected by mining operations. The SHMS must provide a single, comprehensive and integrative system for the management of all aspects of risk to safety and health in relation to the operation of the coal mine.

14. The obligation to develop and implement a SHMS resides with the site senior executive (SSE). A coal mine operator is obligated to ensure that the SSE develops and implements a SHMS for the mine. The operator must also audit and review the effectiveness and implementation of the SHMS to ensure the risk to persons from coal mining operations is at an acceptable level, and is obliged to provide adequate resources to ensure the effectiveness and implementation of the SHMS.

15. The SHMS must provide for the following basic elements:

    (a) Risk identification and assessment;

    (b) Hazard analysis;

    (c) Hazard management and control;

    (d) Reporting and recording relevant safety and health information.

16. The Act and Regulation prescribe many of the individual components to be included in the SHMS.

17. There is an express requirement in the Act that the SHMS be adequate and effective to achieve an acceptable level of risk. The Act requires that this be achieved by:

    (a) Defining the coal mine operator's safety and health policy; and

    (b) Containing a plan to implement the coal mine operator's safety and health policy; and

    (c) Stating how the coal mine operator intends to develop the capabilities and support mechanisms necessary to achieve the policy; and

    (d) Including principal hazard management plans and standard operating procedures; and

    (e) Containing a way of-

        i. measuring, monitoring and evaluating the performance of the safety and health management system; and

        ii. taking the action necessary to prevent or correct matters that do not conform with the safety and health management system; and

(f) Containing a plan to regularly review and continually improve the safety and health management system so that the risk to persons at the coal mine is at an acceptable level; and

(g) If there is a significant change to the coal mining operations of the coal mine – containing a plan to immediately review the safety and health management system so that risk to persons is at an acceptable level.

Safety and Health Obligations

18. The Act provides for placing safety and health obligations on those persons whose decisions affect the safety and health of others. There are defined ways in which a safety and health obligation may be discharged.

(a) If a regulation prescribes a way of achieving an acceptable level of risk, a person may discharge the obligation in relation to the risk only by following the prescribed way;

(b) If a recognised standard states a way or ways of achieving an acceptable level of risk, a person discharges the persons obligation in relation to the risk only by:

i. Adopting and following a stated way; or

ii. Adopting and following another way that achieves a level of risk that is equal to or better than the acceptable level.

(c) If there is no regulation or recognised standard prescribing or stating a way to discharge the person's safety and health obligation in relation to a risk, the person may choose an appropriate way to discharge the person's obligation in relation to the risk. Importantly, the person discharges the obligation in relation to the risk only if the person takes reasonable precautions and exercises proper diligence, to ensure the obligation is discharged.

19. Obligations are placed on all coal mine workers or other persons at coal mines, or a person who may affect the safety and health of others at coal mines or as a result of coal mining operations. These obligations are contained in section 39 of the Act. There is a generally applicable safety and health obligation to comply with the Act and the

procedures applying to the worker or person that are part of a SHMS for the mine. There are also other generally applicable obligations pursuant to s39(1) of the Act:

(a) If the coal mine worker or other person has information that other persons need to know to fulfil their obligations or duties under the Act, or to protect themselves from the risk of injury or illness, to give the information to the other persons;

(b) To take any other reasonable and necessary course of action to ensure anyone is not exposed to an unacceptable level of risk.

20. The Act imposes additional obligations on specific categories of persons and entities at a coal mine. These roles include, but are not limited to:

(a) Operators who are usually the holder of the lease and are the legal entity responsible for mining activity on the lease. They have obligations under section 41 of the Act which they are required to discharge;

(b) SSEs who are the most senior officer employed or otherwise engaged by the operator. They must be located at or near the coal mine, and have responsibility for the coal mine. They have obligations under section 42 of the Act which they are required to discharge;

(c) Contractors have obligations under section 43 of the Act which they are required to discharge.

(d) Service providers have obligations under section 47 of the Act which they are required to discharge.

21. The general obligation contained in section 39(1) of the Act is intended to be of broad application, and extends to "a person who may affect the safety or health of others at a coal mine or as a result of coal mining operations". This provision appears to be broad enough to impose the generally applicable safety and health obligation upon labour hire entities that supply workers to the operator of a coal mine. Sections 43 and 47 of the Act may also, in my view, impose safety and health obligations on labour hire entities that supply workers to the operator of a coal mine. However, whether any safety and health obligations exists will depend on the particular facts and circumstances in each

case. I am not aware of any regulatory action that has been taken under the Act against a labour hire entity.

22. Having regard to the prevalence of labour hire in the coal mining industry, RSHQ is committed, working with tripartite stakeholders, to supporting any legislative amendments identified as necessary to clarify arrangements for labour hire workers or to address any gaps that may be identified. Care would need to be taken to ensure that creation of any express statutory obligation on labour hire entities does not diminish or undermine the extent of the obligations already imposed on those that actually operate the mine, including the requirements for the control and management of risk under a single and integrated SHMS.

23. There are numerous provisions in the legislation designed to ensure competent management. One of the objects of the Act is to require management structures so that persons may competently supervise the safe operation of coal mines.

24. The SSE is obliged to develop, implement and maintain a management structure for the mine that helps ensure the safety and health of persons at the mine. This must be documented by the SSE.

25. The operator for a coal mine has the obligation to ensure the SSE for the mine develops, implements and maintains a management structure for the mine that helps ensure the safety and health of persons at the mine.

26. Supervisors are workers who are authorised by the SSE to give directions to other coal mine workers in accordance with the SHMS. Their obligations are also set out at section 39 and elsewhere in the Act, as well as in some specific provisions in Regulation. An SSE must not assign the tasks of a supervisor to a person unless the person is competent to perform the task assigned, and if there is a safety and health competency for the supervisor recognised by the committee, has the relevant competency.

27. For an underground mine, there is an additional requirement for the SSE to appoint an underground mine manager ("UMM") to control and manage the mine. The UMM must have a first class certificate of competency for an underground coal mine. The Act requires the UMM to make various appointments.

(a) The UMM 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 underground activities when the UMM is not in attendance at the mine.

(b) The UMM is also required to 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 one or more explosion risk zones ("ERZ controller").

(c) The UMM must also appoint a person with appropriate competencies to control and manage the mechanical and electrical engineering activities of the mine.

(d) The UMM in an underground mine is also required to appoint a ventilation officer for the mine. A ventilation officer is required to hold a ventilation officer's certificate of competency. The requirement for a ventilation officer's certificate of competency commenced on 10 November 2019 and is subject to a transitional period which ends three years from commencement. Subject to the direction and control of the UMM, the ventilation officer for the mine is responsible for the implementation of the mine's ventilation system, and the establishment of effective standards of ventilation for the mine.

Other relevant factors

28. The Act also contains numerous provisions designed to ensure proper training and competency at the mines. The Act requires that no work is undertaken by a coal mine worker at the mine unless they have been inducted in the mine's SHMS relevant to the work to be undertaken, and have received training about hazards and risk at the mine relevant to the work to be undertaken. The SSE is required to ensure no work is undertaken by a coal mine worker at the mine unless the relevant induction into the SHMS has occurred, and until the worker has been trained. The SSE is also required to provide for adequate supervision and control of coal mining operations on each shift at the mine.

29. A Board of Examiners is established under the Act to examine and issue statutory certificates to the holders of positions to whom a requirement to hold a certificate of competency applies.

30. The Act seeks to achieve cooperation between coal mine operators, SSEs and coal mine workers to achieve the objects of the Act. Cooperation is an important strategy in achieving the objects of the Act.

31. Worker representation is facilitated through the legislation. At a site level, coal mine workers may elect two of their number to be site safety and health representatives. As well as general coal mine worker obligations, site safety and health representatives have additional functions and the power to stop operations immediately if they believe there is an immediate danger to the safety and health of coal mine workers. At an industry level, the industry safety and health representatives have considerable powers, including the ability to issue directives to suspend operations.

32. Failing to discharge an obligation is an offence. The Act provides a range of offence provisions that are dependent on the outcome of the breach of the obligation. The maximum available penalty increases with the seriousness of the failure. Recently, the *Mineral and Energy Resources and Other Legislation Amendment Act 2020* was passed by the Parliament, creating the new offence of industrial manslaughter with significant maximum penalties.

Overview of the Regulator between 1 July 2019 and 6 May 2020

The Independence of the Regulator as a Division of a Department

33. In the period 1 July 2019 to 6 May 2020, the Regulator was known as Resources Safety and Health ("the Regulator"). Resources Safety and Health was a division of the Department of Natural Resources, Mines and Energy ("the Department"), led by me as the accountable Executive Director. In this capacity, I reported directly to the Director-General of the Department.

34. While the Regulator was a part of the Department, it was self-contained and operated with practical independence from the Department in its regulatory and operational policy and decision-making. As a departmental division, the Regulator had its own compliance policy, operational plans, and strategic plans, and progressed its own policy and legislative development separate to all other divisions of the Department (including the area of the Department responsible for resource investment attraction and tenure management).

35. The Department, being an agency with multiple, varied portfolio responsibilities has a strategic plan which reflects the diversity of its portfolio subject matter. Consequently, not all strategic objectives and performance indicators apply to all divisions and business units within the Department.

36. As a division of the Department, the Regulator's regulatory functions aligned with the following strategic objectives:

- **Deliver safe, secure,** affordable and sustainable **energy** and water **resources** (emphasis added)
- Build a contemporary workforce that demonstrates high levels of expertise, innovation, collaboration and leadership to improve service quality and responsiveness to customers and communities;

and with the following performance indicators:

- Deliver the government's portfolio commitments
- Increased community and stakeholder participation in engagement activities
- Increased staff engagement.

Other strategic objectives and performance indicators of the Department had no relevance or application to the Regulator. For example, the performance indicator of increased private investment in natural resources for economic development had no relevance to the Regulator. This was explicitly recognised and discussed during the development and implementation of the strategic plan.

The Office of the Commissioner for Mine Safety and Health

37. The Office of the Commissioner for Mine Safety and Health ("the Commissioner") was established by amendments to the Act in 2009. The Commissioner was an independent advisor to the government and was appointed by the Governor in Council. The Commissioner's functions were:

(a) to advise the minister on mine safety and health matters generally;

(b) to fulfil the roles of chairperson of the coal mining safety and health advisory committee;

(c) to monitor and report to the Minister and to Parliament on the administration of provisions of safety and health under the Act and other mining legislation.

38. When the last Commissioner was appointed in 2016, the position sat separately to the Regulator's administrative establishment, although administratively within the Department. Operationally, the Commissioner reported directly to the Minister. The Commissioner had no powers of direction in respect to the Regulator. The Commissioner monitored the performance of the Regulator in administering provisions about safety and health under the Act and other mining legislation. The Commissioner reported on this performance formally to the Minister and to Parliament.

39. The Commissioner had the power to commence prosecutions. Prior to 2016, previous commissioners held the dual role of Commissioner and head of the Regulator. However, with the 2016 appointment, government recognised the need for the Commissioner to be separate and independent of the Regulator in order to more objectively review the Regulator's performance. Accordingly, all regulatory activity, including decisions to commence prosecutions resided with the Regulator, save for some ongoing prosecutions which had been commenced by previous commissioners.

The Functions of the Regulator

40. The Regulator was responsible for ensuring the protection of the safety of workers and communities affected by resources operations and explosives use.

41. Its vision was for a zero serious harm resource sector in Queensland, meaning the Regulator's strategy and operations were directed at reducing serious harm (fatalities, serious accidents and occupational disease) to zero, recognising that every worker has the right to go home safely at the end of their shift.

42. The Regulator was responsible for administering safety and health legislation applying to Queensland's resources industries:

- the Act;
- *Mining and Quarrying Safety and Health Act 1999;*
- *Explosives Act 1999;*

- *Petroleum and Gas (Production and Safety) Act 2004.*

43. The Regulator ensured protection of workers by conducting announced and unannounced inspections of mine sites, audits of a mine site's compliance with the Act and Regulation, and conducting investigations into serious accidents, high potential incidents ("HPIs") and complaints.

44. The Regulator consisted of four inspectorates:

(a) Coal Mines;

(b) Mineral Mines and Quarries;

(c) Petroleum and Gas; and

(d) Explosives.

45. Each Inspectorate operated autonomously within its own area of expertise, but was subject to my supervision and direction.

The Composition and Structure of the Coal Inspectorate

46. The Coal Inspectorate was hierarchical in nature and consisted of the following roles:

(a) Chief Inspector;

(b) Deputy Chief Inspector;

(c) Regional Inspector;

(d) Senior Inspectors; and

(e) Inspectors.

47. The Chief Inspector of Coal Mines was required to:

(a) Provide strategic leadership and management of the Coal Mines Inspectorate, ensure legislated and regulatory functions were delivered effectively and with high professional integrity and independence;

(b) Provide expert, strategic advice to Government, industry, and the community in relation to safety and health and its regulation, as well as fulfilling the statutory role of Chief Inspector; and

(c) Lead the Inspectorate to identify and monitor industry's performance in addressing emerging risks; and

(d) Lead the administration and ongoing development of legislation, regulations and guidelines in relation to coal mining safety and health in Queensland.

48. As a minimum, the Chief Inspector had to have fifteen years of experience in the mining industry in senior technical or operational positions, including mine management experience. A First Class Mine Manager's Certificate of Competency, and a relevant degree or other tertiary qualification, were highly desirable.

49. The Deputy Chief Inspector of Coal Mines was responsible for supporting the Chief Inspector, providing organisational and operational leadership and management to the staff of the Inspectorate, a team that was responsible for maintaining a culture that facilitates the continuous improvement of safety and health performance in the coal mining industry.

50. As a minimum, the Deputy Chief Inspector had to have ten years' experience in a senior technical or operational position in the underground coal mining industry. A First Class Mine Manager's Certificate of Competency and relevant tertiary qualifications were also highly desirable for this position.

51. There were two Regional Inspectors for the Coal Inspectorate, with one based in Mackay and one based in Rockhampton. Regional Inspectors were required to:

(a) Carry out the functions under the Act to help ensure that the coal mining industry operated at an acceptable level of risk;

(b) Provide expert technical advice on a range of mining safety and health matters to industry, the government and the community, in particular on those aspects relating to mining engineering principles for underground and open cut coal mining operations;

(c) Operate on a regional basis subject to direction of the Regulator, which provided policy and standards, planning, and strategic, statutory, and technical direction of whole of State safety and health functions.

52. There are currently five (5) first class certificate of competency ticket holders in RSHQ, with three (3) of those from within Coal Mines, and two (2) from within Mineral Mines and Quarries. It was highly desirable for the Regional Inspectors to be the holder of a Queensland First Class Mine Manager's Certificate of Competency for Coal Mines and a relevant degree from a tertiary institution. Whilst desirable, the persons who currently hold the positions of Regional Inspectors possess a combination of skill sets, qualifications and experience that make them suitable to hold the position of Regional Inspector.

(a) Stephen Smith is the Regional Inspector at Mackay. He holds a Second Class Mine Manager's Certificate of competency and a relevant tertiary degree, namely a degree in mining engineering from the University of New South Wales, obtained in 1981. Mr Smith has a background in both underground and open cut mining which is outlined in his statutory declaration, including that he was an inspector in Western Australia.

(b) Creswick Bulger is the Regional Inspector at Rockhampton. He holds a Site Senior Executive's certificate of competency as well as an Open Cut Examiner's Certificate of Competency. He has thirty years of coal mining experience in both underground and open cut mining. In the period May 1990 to August 1999 Mr Bulger worked for Mount Isa Mines (as it was known then) at Oaky Creek Coal Mine as a Production Operator and, later, a Mining Supervisor and Open Cut Examiner. He then accepted employment as a Coal Mining Supervisor with BHL Coal at Blackwater Mine, where he worked from August 1999 to February 2001. He then accepted employment at BHP Billiton Mitsubishi Alliance at Gregory Mine where he worked as a Production Manager and Mining Superintendent from February 2001 to October 2011. Mr Bulger then became an Owner's Representative at the Crimum Mine for their M Block Underground Project from October 2011 to August 2012.

53. Inspectors were required to:

(a) Carry out the functions of an inspector under the Act to help ensure that the coal mining industry operates at an acceptable level of risk; and

(b) Provide technical advice on a range of mining safety and health matters to industry, the government and the community, in particular on those aspects relating to the operation of coal mines and statutory compliance in relation to these activities.

54. Inspectors were expected to have qualifications or expertise in a discipline relevant to the mining industry, such as mechanical, geotechnical, electrical, mining engineering or occupational hygiene disciplines.

55. Principal Investigations Officers ("PIO") were appointed as authorised officers under the Act, to carry out specialist investigatory functions to support inspectorate activities. They were to coordinate investigations, including all major investigations involving serious and fatal injury. It was highly desirable for PIOs to have a Certificate IV in Investigations, and it was common for PIOs to come from law enforcement backgrounds such as the Queensland Police Service.

Training Provided to Inspectors, Authorised Officers, and Principal Investigations Officers

56. All Inspectors were required to undergo continuous training as a condition of their employment within the Regulator.

57. The Core Mines Inspector Training included the following topics:

(a) Provision of First Aid *or* Provision of First Aid in Remote Situations;

(b) Defensive Driving *or* Operate and Maintain a Four Wheel Drive Vehicle;

(c) Carry out the Risk Management Process *or* Establish and maintain the Risk Management System;

(d) Establish and maintain the WHS Management System;

(e) Code of Conduct and Ethical Decision Making;

(f) Complaints Management Skills;

(g) Public Service Ethics;

(h) Advanced Government Decision Making;

(i) Tactical Communication, Operational Safety, and Aggression Management;

(j) Queensland Mining Legislation;

(k) Lead Auditor in OHS Management Systems (Diploma in Quality Auditing);

(l) Certificate IV in Government Investigations;

(m) Accident Causation Methodology Training: Incident Cause Analysis Method ("ICAM");

(n) Core Technical/Advanced Technical Training.

58. Principal Investigations Officers were not required to do the above training, but undertook parts of this training in some cases. This is because PIOs were selected for their experience and training in law enforcement and to support inspectorate activities.

The Regulator's Response to Inspections and Audits

59. Inspections, audits and engagement were at the core of the Regulator's regulatory work. The primary objective of these proactive actions is to check the effectiveness of, and to support improvement in the use of, controls in place in mining operations. Interactions between regulatory officers and persons or organisations involved in regulated activities are opportunities to provide guidance and advice. Further, they can be an effective deterrent to non-compliance.

60. Mine Record Entries ("MREs") are the principal formal means of written communication with a mine operator by inspectors, placed on the mine record each mine is required to maintain under the Act. MREs are an ongoing record of the mine operator's performance on safety and health issues and the operator's interaction with the inspectorate. MREs are used to record details of inspections, site visits and audits carried out by inspectors, as well as record the issuing of directives, substandard conditions and practices ("SCP"), and recommendations.

61. There are multiple ways that the Regulator responded to and captured the learnings of inspections and audits depending on the issue identified. These included:

(a) Issuing information and advice to support responsible persons and organisations in developing and implementing effective safety and health systems, discharging regulatory obligations and achieving an acceptable level of risk.

(b) A recommendation which is an informal mechanism whereby inspectors can recommend that the operator undertake a course of action with no set date for implementation. There are no direct legal implications for recommendations. There is the expectation that the operator give due consideration to the recommendation. Recommendations should only be used where there is compliance, but there may be a more effective way of achieving compliance.

(c) A SCP is an option whereby inspectors and other persons can specify that specified action be taken within a specified time frame to make improvements at the mine. Typically, they are used in respect of administrative matters or where risk is not at unacceptable levels, but scope for improvement has been identified through inspection. SCPs are also informal, in that they are not recognised by the Act. A mine is given a time to complete the action identified, and is required to provide evidence that the SCP has been fulfilled before it is closed.

(d) Directives are statutory directions to the mine issued under the Act by persons including an inspector, requiring a coal mine to do certain things, including:

i. Ensuring that a particular task is only performed by persons with a specific competency;

ii. Carrying out stated tests;

iii. Suspending operations;

iv. Reviewing safety and health systems and principal hazard management systems;

v. Isolating the site;

vi. Operating a part of a surface mine as a separate part of the mine; and

vii. Providing an independent engineering study.

A directive may be issued orally, but is required to be confirmed in writing. A directive may be issued where the person issuing it has formed the prerequisite belief required under the Act, for example that risk from coal mining operations is at, or may reach, unacceptable levels. A mine must comply with the directive and failure to do so is an offence under the Act. A directive remains effective until it is withdrawn.

(e) Other measures including, any compliance action required, and, as further detailed below, publications to assist industry and document what the regulator expects for compliance.

62. As is evident from the MREs, inspectors spent a significant portion of their time conducting inspection and audits.

63. A labour intensive but important inspection and compliance audit process was conducted into methane gas management in 2017 – 2018. The compliance audits involved requesting gas monitoring data from all longwall mines to conduct a detailed analysis of methane management in underground coal mines. Learnings from that audit resulted in the issuing of directives and SCP notices. Five mines introduced additional gas monitoring in the longwall tailgate with the capability of stopping the longwall machinery from operating in response to increasing general body concentrations of methane. Following on from the audit, and based on the analysis of mine gas data and a review of gas management practices, the inspectorate published the *"Methane Management in Underground Coal Mines: Best Practice and Recommendations"* in June 2019. Modelling of methane concentrations described in that document demonstrated how an increase in the general body concentrations in the longwall tailgate increased the risk profile of longwall operations.

64. Another focus area of the Regulator has been the respirable dust hazard in mines and quarries. Controlling and monitoring respirable dust exposure is critical to minimising the risk to mine and quarry workers from mine dust lung disease. Since 1 January 2017, all Queensland coal mines have been required to provide all personal respirable dust monitoring data to the Chief Inspector of Mines. This data was stored in the Departmental exposure database. The collected data has been analysed and

periodically reviewed by the coal mining safety and health advisory committee as well as being published on the Department's web page; it demonstrates major improvement in worker respirable dust exposure.

65. The data from inspections and audits was managed through the Lotus Notes database and other ancillary databases including the Lost Time and Accident Database ("LTAD"). The LTAD included serious accidents, HPIs and lost time injuries. The data captured included various fields, including free-text fields, (for example, how the accident occurred) and selection fields (for example, hazard, equipment involved, location of incident). Each of the fields had several classification options (for example, under the equipment used field, the classifications options include dozer, grader etc.).

66. There was the ability to identify themes and trends and the regulator proactively utilised its data analytics engineers to identify and analyse these trends. The databases that were used by the Inspectorate have the ability to run reports, both automatically (for example the daily and weekly reports) and on an ad hoc basis in relation to identified parameters. Once a trend is identified, action has been taken, as exemplified by the action taken in relation to the "*Methane Management in Underground Coal Mines: Best Practice and Recommendations*" in June 2019. Themes and trends were also used to determine the prioritisation of inspectorate resources and the action required including the frequency of inspections required at a particular mine (see further at paragraph 104).

The Regulator's Response to Accidents and HPIs

67. A serious accident at a coal mine is defined as an accident that causes a person to be admitted to hospital as an inpatient for injury, or that causes death.

68. A HPI is an event, or series of events, that causes or has the potential to cause a significant adverse effect on the safety or health of a person.

69. In 2018-2019, there were approximately 90 coal mine serious accidents reported to the inspectorate, and 3 fatalities.

70. There are a significantly greater number of HPIs than serious accidents in any given year. In 2018-2019, there were approximately 1,726 coal mine HPIs reported to the inspectorate. During the period 1 July 2019 to 6 May 2020, there were approximately

1,597 coal mine HPIs. The inspectorate considers HPI's to be an important lead indicator for measuring the effectiveness of safety and health systems. Over a six year period, more than 85 percent of HPIs did not involve any injury to any worker.

71. The most frequently reported HPI's across both coal mines and in mineral mines and quarries in 2018 - 2019 were vehicle related incidents, thermal (fire) events, explosive incidents, gravity (falling people or equipment) and electrical incidents.

72. The cause of HPIs can be varied, including organisational factors, the operating environment, individual team causes, and absent or failed controls. Based on the information collected from industry, a substantial number of HPIs has been linked to a lack of awareness about the hazards and absent or failed controls. Industry was encouraged to implement higher level controls such as engineering, substitution and isolation to ensure the risk to workers was at an acceptable level.

73. Pursuant to the Act, the SSE is required to notify an inspector and an industry health and safety representative as soon as possible after becoming aware of a serious accident, HPI or a death at a coal mine. When a serious accident or HPI occurs at a mine site, it is the statutory obligation of the mine to investigate the causes of the incident and prepare a report (causal report). If the accident or incident is one prescribed by the Regulation, the causal report must be forwarded to an inspector within one month. Schedule 2, part 2 of the Regulation sets out the list of prescribed accidents and incidents. HPIs relating to gas exceedances are not included in Schedule 2, Part 2 of the Regulation and therefore do not automatically trigger an obligation for a mine to provide an investigation report to an inspector.

74. The Regulation requires that the mine's SHMS must provide for the procedure for investigating accidents and incidents, making the investigation findings available to coal mine workers, and implementing corrective action for accidents and incidents. The procedure for investigating accidents and incidents at an underground mine should include the relevant ERZ controller on duty, and if it is not practicable to involve that ERZ controller, another ERZ controller for the relevant zone.

75. After the initial notification is made (usually through initial verbal notification and the subsequent provision of a "Form 1A" incident report), the mine is also required to

provide a "Form 5A" report to an inspector within one month of the event. This report outlines the corrective steps taken by the mine to prevent a reoccurrence.

76. The Regulator also conducted its own investigation into the nature and cause of fatalities and serious accidents and produced "Nature and Cause" reports. The scope of this investigation was determined by the seriousness of the incident, such as the nature of any potential breach of obligations and the injuries sustained by workers as a result of the incident or the consequences.

77. The legislation requires that an inspector must inspect, investigate and report on all serious accidents causing death at a mine. These major investigations are typically complex and the level of resources allocated will be appropriate for the significance and complexity of the investigation. Whilst there is otherwise no specific statutory requirement that other serious accidents and HPIs be "inspect[ed], investigate[d] and report[ed]" it is the function of an inspector to investigate serious accidents and HPIs at coal mines (s 128(h) of the Act). The level of investigation required will depend upon the particular circumstances involved in the serious accident or HPI as detailed below.

78. An investigation into a serious accident or HPI may also be completed through a range of options other than a full nature and cause investigation. An investigation may include:

- ensuring that the notification details have been provided to the inspectorate;
- telephone and email enquiries as to the circumstances involved;
- conducting immediate (or timely) site visits and/or inspections;
- making enquiries or observations at future site visits or inspections; and
- over-viewing the mines own investigation, which may involve reviewing materials and information including records and images required to be provided to the inspectorate, rather than the inspectorate carrying out its own dedicated investigation.

In all cases, the objective is to:

- ensure that an adequate level of investigation has been undertaken;

- ensure that effective timely actions to restore an acceptable level of risk are carried out;
- assist in preventing recurrence;
- disseminate any safety information to industry through established mechanisms; and
- address any non-compliance.

79. Once a full nature and cause investigation was commenced, it was conducted by a lead investigator, who was usually an Inspector (but sometimes may have been a Regional Inspector, Deputy Chief Inspector, or even the Chief Inspector). The Inspector was assisted by the PIO given their specialist expertise in investigations and evidence gathering.

80. Once a nature and cause investigation had finalised, the investigation team provided a briefing to me and the Chief Inspector. That detailed compliance action recommended by the investigation team, having regard to all of the circumstances of the case and how to best ensure safety and health for workers.

81. The Regulator, being an outcomes focused, risk-based regulator, applied its resources to the areas of greatest risk and to the activities that would achieve the best safety and health outcomes.

82. Trends identified by accumulation of serious accidents and HPIs were investigated on a broader scale. For example:

(a) In March 2019, the inspectorate published "*Irrespirable atmosphere in a mine or Quarry: Incident learnings and recommendations.*" The report provides learnings from 24 incidents related to irrespirable atmosphere in the Queensland mining and quarrying industry including three serious accidents (requiring hospital admission) and one workplace fatality. The report provided learnings from those incidents in order to raise industry awareness and made a number of recommendations related to risk management; and

(b) In June 2019, the inspectorate published *"Methane Management in Underground Coal Mines: Best Practice and Recommendations"*. The report provides learnings following on from the gas management audit, and based on the analysis of mine gas data and a review of gas management practices.

83. The compliance tools that it had available, which have all been utilised in accordance with the compliance policy, can be broadly classified as follows:

(a) **Educational** – engagement activities, safety alerts and bulletins, substandard conditions or practice advice, inspection and audit activities, and the publication of some Nature and Cause reports (or extracts) and other hazard specific reports, where it is in the public interest do so;

(b) **Corrective** – directives, inspections, audits, substandard conditions or practice advice;

(c) **Deterrent** – prosecutions, directives, investigations, random inspections and audits; and

(d) **Punitive** – prosecutions.

84. In addition, the Act was amended on 9 November 2018 to include provisions that allow for the issuing of civil penalties for contraventions of prescribed civil penalty obligations and for the suspension and cancellation of certificates of competency and Site Senior Executive Notices.[1] These are additional compliance tools that are now available to the Regulator as part of its overall compliance approach.

85. In determining which compliance tool was the most appropriate in any given case, the Regulator was required to consider all relevant factors. When an obligation holder demonstrated behaviour that required sanction, deterrent or punitive responses were required. In identifying an appropriate and effective regulator response, the Compliance Policy identifies the following factors:

(a) **Risk** – the likelihood of harm occurring, and the impact of that harm on workers, industry, the community and the State;

[1] *Mines Legislation (Resources Safety) Amendment Act 2018*

(b) **Recurrence** – the degree to which the risk arises as a consequence of a systematic or repeated compliance failure;

(c) **Engagement** – the degree to which the non-compliant entity is engaged with regulation; and

(d) **Capacity** – the degree to which the non-compliant entity has equipped and informed itself to be able to comply.

86. The nature of compliance action would depend on the relative weight of these factors, assessed on a case by case basis.

87. In order to ensure that learnings are entrenched in industry and obligation holders are aware of risks that may affect the safety and health of workers, promote good safety and health practice, and deter practices and behaviours that endanger the safety and health of workers, the Regulator could and did publish some investigation reports. These reports are currently located at: https://www.business.qld.gov.au/industries/mining-energy-water/resources/safety-health/mining/accidents-incidents-reports/investigations-inquiries

88. The Regulator has a Policy for making public statements, which includes the publication of information and investigation reports for certain incidents that occur in the Queensland resources industry.

89. Further, safety alerts and bulletins were also published electronically and were (and are) able to be searched. There are currently in excess of 400 safety alerts, bulletins and notices that relate to coal mines. Safety alerts are also emailed directly to more than 1,500 industry executives, managers and safety officers. They are also currently located at:

https://www.dnrme.qld.gov.au/business/mining/safety-and-health/alerts-and-bulletins/alerts-bulletins-search

90. Publicly available summaries and statistics on safety incidents are provided through the annual Queensland Mines and quarries safety performance and health reports, which are currently available on line at:

https://www.publications.qld.gov.au/dataset/queensland-mines-and-quarries-safety-performance-and-health-reports

91. Data on safety performance metrics for individual mines is also available at:

https://www.business.qld.gov.au/industries/mining-energy-water/resources/safety-health/mining/accidents-incidents-reports/safety-performance

92. Learnings from accidents and incidents within Queensland's resources industries were provided directly to industry executives and staff through a range of channels, including Site Senior Executive Forums, Underground Mine Manager Forums and seminars, conferences and other forums for quarry operators.

93. Learnings from accidents and HPIs were also communicated though incident periodicals. Incident periodicals highlight significant incidents that have occurred in Queensland coal mines, with the aim of all stakeholders learning from those incidents. These are also currently available online at:

https://www.business.qld.gov.au/industries/mining-energy-water/resources/safety-health/mining/accidents-incidents-reports/serious-accidents

94. Further information and analysis relating serious accidents and HPIs can be found in the Chief Executive Mining Hazards Database, currently available online at:

https://www.business.qld.gov.au/industries/mining-energy-water/resources/safety-health/mining/hazards/hazards

The Chief Executive Mining Hazards Database is a database of information about hazards associated with mining operations and methods of controlling those hazards. Included in the database are references to the safety alerts, recognised standards and external publications that relate to the control of the hazards.

95. In 2018-19, in coal mines, the most frequent causes of serious accidents were being trapped/crushed, falls and vehicle interactions. Mine and quarry operators had an obligation to report serious accidents as soon as practicable after the event had occurred. Learnings from notification data for serious accidents from 2014-2015 to 2018-2019 revealed that the mean time for all mines and quarries to report the accident

to the inspectorate was 7 hours. This was of concern to the inspectorate as it affects its ability to ensure an appropriate response, including dedicating resources to incidents – including for the purposes of investigation, notifying other mines with similar equipment or issues in a timely manner, and the communication of any public interest issues. Delays in reporting can result in the scene not being effectively preserved prior to an investigation being commenced. The inspectorate made known that it expects a notification time of less than three hours after an event has occurred to be appropriate.[2]

96. In 2018 – 2019, coal mines inspectors maintained a focus on gas management, lifting and slinging, and supervision. Learnings from serious accident data had highlighted a rise in serious accidents with causal factors related to cranes, lifting and slinging. Mines inspectors also noted non-compliant lifting equipment and poor lifting practices during mine site inspections – which are precursor to serious accidents. Observations related to lifting and slinging practices were noted in 178 mine record entries made during 2018-2019. The inspectorate raised concerns related to lifting at industry briefings including the annual industry leader's forum and forums for mechanical engineers. The inspectorate also issued mines safety bulletins aimed at addressing lifting and slinging issues.

97. The data obtained from notifications received concerning serious accidents and HPIs is captured in the Lotus Notes database and other ancillary databases including the LTAD.

98. Numerous reports were (and are) capable of being generated from the Lotus Notes and LTAD databases. In addition, the Dashboard provides inspectors with trending by numbers and data reports were generated daily for inspectors, which assisted in identifying trends revealed by the numbers contained in the daily reports. Other reports could be produced on request by data analytics engineers. By way of example, over the period 1 July 2019 to 6 May 2020, the following types of reports were generated:

    (a) Coal Inspectorate Directive and SCP reports (3 reports across the period showing the status of directives and SCPs);

[2] Queensland Mines and Quarries Safety Performance and Health Report 2018/19, p.36.

(b) Reports relating to Key Performance Indicators (3 reports across the period detailing the categories of compliance action that had been undertaken during relevant period, including inspections, emergency exercises, investigations, postal MREs, site meetings, subject audits or specific system audits);

(c) Coal Inspectorate Incident Listings (3 reports across the period detailing incidents that have occurred within the relevant periods);

(d) Interim Exceedance reports (these reports detail respirable dust and silica exceedances);

(e) Lotus – Qld Monthly Report (these reports are issued monthly, with reference to each region, and include the number and types of audits and inspections undertaken, complaints received, MREs, Directives and SCPs that have been issued, and activities undertaken by Inspectors – for example, days spent at mine sites, training and on leave);

(f) Lotus – Qld Year to Date Reports (these reports detail the same information as the monthly report but for the year to date);

(g) Ad hoc reports were also generated for the Inspectorate's monthly meetings. These reports relate to matters that are identified for discussion during the monthly meetings. For example, the reports may include details of numbers of inspections across a period of time and whether they were announced or unannounced. The topics for the ad hoc monthly meeting reports are likely to be selected by the Regional Inspector, Deputy Chief Inspector or Chief Inspector;

(h) Reports concerning outstanding Form 5A reports. These reports contain details of the mine, the relevant office, the event type, the Inspector receiving the Form 5A, the description of the incident, the reference to the Form 5A and comments that explain whether the Form 5A has been received and if it is overdue what actions have been taken by the Inspector;

(i) SIG and SAG reports (2 reports across the period). These reports contain details of the mine, mine type, date of last inspection, mining operations, type, category and priority of SIG/SAG, due date for next inspection and last MRE score. These

reports are categorised in relation to all mines, specific date ranges, general, mining, electrical, mechanical, occupational and care and maintenance only;

(j) Reports that are generated to update the dashboard system each morning. These reports include graphs showing number of incidents from year to year (fatalities, HPIs and serious accidents), number of inspections from year to year, SAFR, HPIFR and information about the top 6 hazards (e.g., fires, moving vehicles/equipment), human error, explosives, electrical equipment, falling/flying material), injuries by body location, worker types (contractor or employee), nature of injury and mechanism of injury, number of inspections, complaints, audits and investigations, Directives and SCPs with reference to hazard and mine type and top 10 hazards (over time and current).

99. There was the ability to generate particular reports, for example, HPIs by mine, mine type, year and type of HPI (e.g., methane exceedance). The data for serious accidents and HPIs could (and can) be compared by type of mine and hazard. For example, the data could (and can) be isolated to review underground coal mines or surface mines, and within those categories by reference to the type of hazard (such as electrical, gas management, vehicle collision, falls, fire, geotechnical/strata control, pressure, moving equipment and parts, crush/entanglement, loss of vehicular control etc.). The data could also be examined to compare such categories against records for previous years or time periods to allow trends to be observed in different categories of serious accidents or HPIs.

100. Examples of reports that are regularly generated for use by the Regulator are the Power BI Reports that are used to update the Dashboard application, and the reports that are prepared in advance of the weekly and monthly inspectorate meetings.

101. The Power BI Report ("the Report") is generated each night from information that is entered into Lotus Notes and LTAD. The Report is used to update the Dashboard, which is an application that can be accessed by the Inspectorate. The Dashboard contains an overview of data relating to matters including incidents, serious accidents and fatalities, inspections, investigations, top hazards, HPI frequency rates, audits, directives and SCPs. The data can be filtered and extracted to identify information that falls within particular parameters, e.g., mine, injury type, date range.

102. Weekly reports are also sent out to the Inspectors every Friday that include information such as incident summaries, current and overdue Directives and SCPs and exceedances for respirable dust and silica.

103. Monthly reports are also produced in advance of the monthly Coal Seminar meetings. Data is extracted and presentations are created for the purpose of these meetings. Structured Inspection Guides ("SIGS") and Structured Audit Guides ("SAGS") reports are also generated to guide the timing of mine inspections and audits.

104. There was (and is) the ability to identify themes and trends and the regulator proactively utilised its data analytics engineers to identify and analyse themes and trends revealed through the recorded data. Once a trend was identified, action was taken, as exemplified by the action taken and learnings communicated through the "*Methane Management in Underground Coal Mines: Best Practice and Recommendations"* report of June 2019, and the "*Irrespirable atmosphere in a mine or Quarry: Incident learnings and recommendations*" report of March 2019.

105. Captured serious accident and HPI data was (and is) also used in various other ways. For example, inspectors prioritise the frequency and type of inspections and audits at the mines utilising SIGS and SAGS. The mine's history of incidents, events and gas management were some factors (amongst many others) taken into account in prioritising the focus of inspections and audits at mines. These factors guided the frequency of inspections and audits conducted at various mines, as well as whether an inspection should be undertaken unannounced. Through the use of the SIGS and SAGS, serious accident and HPI data is one factor that guided, and continues to guide, the regulator's priorities.

106. In addition, prior to attending a mine for an inspection, inspectors were (and are) expected to review recent HPIs and serious accidents for the mine. Such a review assists in determining the scope of the inspection required, and the areas of focus for the inspection.

107. Reports generated from serious accident and HPI data also assist the inspectorate in determining its areas of focus at particular times, for instance, as observed earlier in this statement, during 2018 – 2019, the regulator maintained a focus on gas management, lifting and slinging, and supervision. During 2017 – 2018, high potential incident data

for coal mines indicated there had been a significant increase in the number of incidents related to gas management. Fires, explosive (misfires), electric shocks and vehicle incidents continued to be areas of focus.

108. There is currently a plan for a replacement of the LTAD database during FY21, with appropriate budget allocated. The new database will have increased usability, and will increase RSHQ's capacity to interrogate data and identify trends from serious accidents and HPIs using contemporary data analysis methods and tools.

Overview of Resources Safety and Health Queensland

The Independence of Resources Safety and Health Queensland

109. RSHQ was established on 1 July 2020, following the proclamation of the *Resources Safety and Health Queensland Act 2020* ("the RSHQ Act"). It is a statutory body consisting of a Chief Executive Officer ("CEO") and the organisational unit under the control of the CEO. The CEO reports directly to the Minister but is not subject to Ministerial direction with respect to regulatory decision-making.

110. The establishment of RSHQ as a statutory body ensures its regulatory independence. It is not part of, or subject to oversight from, an administering department, such as DNRME. It also better ensures that there is no competition or conflict between policy objectives around industry facilitation or promotion on one hand, and regulation and protection of safety and health on the other. This ensures the function of protecting workers is separate from other government functions, such as growing and facilitating mining and exploration projects. Although it was considered that this was the case for the Regulator as a departmental division, establishment of RSHQ removes the potential or perception of any conflict or erosion of independence.

111. The establishment of RSHQ has not changed the statutory functions of the Inspectorate or the way that the Inspectorate will carry out its regulatory responsibilities under the Act and Regulation.

112. Under RSHQ there are still four Inspectorates, and those inspectorates are the same as those within the Regulator. Further, the Coal Mines Inspectorate remains hierarchical in nature and the roles that constituted the Inspectorate remain the same.

113. I am aware that Mr Newman has already provided a statutory declaration that addresses the proposed enhancements in how RSHQ will respond to HPIs, Inspections, Audits, and Accidents. I have read that document and agree with its contents.

114. I am aware of, the recommendations contained in the Brady Report.

115. RSHQ is resolved to continuously improving its systems. RSHQ has a dedicated data analytics unit. The data analysis unit is currently working with Dr Sean Brady on developing deeper insights from the data that we obtain from serious accidents. Some learnings have been generated already, and more will be generated into the future and shared with industry.

The Office of the Commissioner for Resources Safety and Health

116. The Commissioner for Mine Safety and Health has been replaced with a new office, the Commissioner for Resources Safety and Health (the RSH Commissioner), under the RSHQ Act. The RSH Commissioner's functions include responding to requests by the Minister for advice on particular matters including the strategic direction of RSHQ, and monitoring, reviewing and reporting to the Minister on the performance of RSHQ functions, and engaging with representatives of the explosives and petroleum and gas sectors to promote safety and health of persons who may be affected by the operation of those sectors. The RSH Commissioner is independent and is established by legislation to be constitutionally separate to RSHQ.

117. Unlike the former Commissioner, the RSH Commissioner has no statutory powers to commence prosecutions. This power now rests exclusively with the Work Health and Safety Prosecutor for serious offences; the CEO of RSHQ may commence prosecutions for offences other than serious offences.

118. The RSH Commissioner also has a consultative relationship with RSHQ as stakeholders within the tripartite community, including in the advisory committees.

119. Both the previous Commissioner role and the new RSH Commissioner must annually provide a report to the Minister about the performance of the Commissioner's functions, which the Minister must table in the parliament.

Overview of the Coal Mining Safety and Health Advisory Committee

120. The Coal Mining Safety and Health Advisory Committee ("CMSHAC") was established in 2010, replacing the Coal Mining Safety and Health Advisory Council that had been in place since the legislation commenced in 2001. The CMSHAC's role and functions are governed by the Act.

121. The CMSHAC played an important role in protecting the safety and health of coal mine workers. CMSHAC's primary function was to give advice and make recommendations to the Minister about promoting and protecting the safety and health of persons at coal mines.

122. Prior to the commencement of the RSHQ Act, CMSHAC was required to discharge its function by periodically reviewing the effectiveness of the Act and Regulation, recognised standards and the control of risk to any person from coal mining operations. It also had the function of establishing, recognising and publishing the competencies accepted by it as qualifying a person to perform the stated tasks, and the safety and health competencies required to perform the duties of a person under the Act. This tended towards a reactive, operational focus, responding to safety and health issues as they emerged. It also tended to focus discussion around the construction of the legislation rather than a broader, more strategic discussion of risk management across industry, or any reflection of potential invisible or latent risks.

123. As a consequence of the commencement of the RSHQ Act, CMSHAC is no longer explicitly required to review the effectiveness of legislation, with the intent that this not be an exclusive or restricting focus of reviewing the effectiveness of risk control. The amended provisions seek to enhance CMSHAC's strategic role through requiring it to develop a five year strategic plan for improving the safety and health of persons at coal mines and persons who may be affected by coal mining operations, and develop action plans for how it will achieve measurable targets set in the strategic plan. The objective is that the strategic plan will identify, quantify, and prioritise safety and health issues facing and emerging within the mining sectors.

124. CMSHAC is constituted by representatives of the Queensland Government, mine workers, and mine operators. I am a member of CMSHAC, along with the Chief Inspector (who is an *ex officio* member) and Deputy Chief Inspector of Mines. Other representatives include industry representatives nominated by the Queensland

Resources Council, and the Unions who represent the coal mine workers. The RSH Commissioner is an *ex officio* member and chairperson of CMSHAC. My appointment to CMSHAC is pursuant to section 80(3A) of the Act, namely I am appointed by the Minister as one of the other 2 inspectors that must be appointed as members of CMSHAC.

125. CMSHAC is required to produce an annual report addressing the previous financial year. These reports are then published on the Queensland Government's website and are freely accessible to the public.

And I make this solemn declaration conscientiously believing the same to be true, and by virtue of the provisions of the *Oaths Act 1867*.

[redacted]

.....

Signature of declarant/deponent

Taken and declared before me at Brisbane this ~~[date]~~ 31 ST day of July 2020

MS

[redacted]

A ~~Justice of the Peace/Commissioner for Declarations~~ Solicitor