The Mining and Resources Coroner

The Queensland Government has established a dedicated Mining and Resources Coroner to investigate mining related fatalities, provide timely answers to affected families and make recommendations to enhance safety in the state's resources sector.

The Mining and Resources Coroner conducts coronial investigations and holds mandatory inquests for all accidental mining-related deaths.

What is the Coroners Court?

The Coroners Court of Queensland (CCQ) independently investigates reportable deaths.

Reportable deaths include deaths where the causes are uncertain, violent or suspicious. Reportable deaths are defined under section 8 of the *Coroners Act 2003* (Qld) (the Coroners Act).

Coronial investigations for mining related deaths are informed by investigations undertaken by the Serious Incident Investigation Unit (SIIU) within Resources Safety and Health Queensland.

The purpose of a coronial investigation is to establish facts such as:

- the identity of the person who died;
- when and where they died;
- how they died; and
- the cause of death.

The coroner does not assign blame or determine criminal or civil liability.

The Workplace Health and Safety Prosecutor is an independent prosecutions office established under the *Work Health and Safety Act 2011.* The Workplace Health and Safety Prosecutor will determine whether there are any matters to be prosecuted in relation to a mining related death.

What deaths does the Mining and Resources Coroner investigate?

The Mining and Resources Coroner investigates and conducts inquests in relation to all mining related reportable deaths.

A death is a mining related reportable death if:

- the death is violent or otherwise unnatural;
- the person dies at any time after receiving a mining related injury, that caused or contributed to the death and without which the person would not have died;
- the person receives the mining related injury at a:
  - coal mine; or
  - a mine or quarry; or
  - at certain petroleum and gas sites; and
- the person's injury is not intentionally self-inflicted

The definition of a mining related reportable death requires that the deceased person receives the mining related injury on a site within scope and does not require that the person dies on the site.

The definition covers injuries that are received while a person is carrying out an activity that is related to the operation of a coal mine, mine (or quarry), or specified petroleum and gas site, but excludes deaths from injuries that may be unrelated to the operations on a site, for example an area that falls within the definition of coal mine but is used for farming.

What is not a mining related reportable death?

Reportable deaths that are not mining related

There are some types of reportable deaths that are not within the scope of a mining related reportable death and therefore are not subject to a mandatory inquest by the Mining and Resources Coroner.

A mining related reportable death does not include death by an injury that a person has intentionally self-inflicted.

This exclusion is due to the potential reasons for the person's suicide that are not related to the operations of the mine, coal mine or petroleum and gas site or to an operator's safety and health obligations. Depending on the circumstances, it may not be necessary or appropriate for an inquest to be held into the death of a person by suicide.

Other deaths that are outside the scope of the Mining and Resources Coroner for mandatory inquests include deaths that occur on public

roads, such as where a worker is commuting to or from a site.

However, any death that is a reportable death, for example an apparent suicide or a car accident, must be investigated by a coroner under existing provisions of the Coroners Act.

The Mining and Resources Coroner investigates most reportable deaths related to the mining and resources sector and may decide to conduct an inquest, if it is in the public interest, for a death that is not a mining related reportable death.

For example, this power could be used where the Mining and Resources Coroner investigates a person's death in accommodation on a mine site and during the investigation determines the death has been intentionally self-inflicted and considers the person's death could be attributed to failings by an operator in fulfilling their safety and health obligations.

A further example would be where the Mining and Resources Coroner investigates a person's death which occurred while the person was driving to or from work on a mine site and considers the person's death could be attributed to the actions or failings of a mining operator.

Deaths that are not reportable

A death that is not a reportable death cannot be investigated by any coroner including the Mining and Resources Coroner.

Industrial diseases arising from exposure to hazards within a work environment are generally not considered to be reportable deaths. For example, deaths resulting from coal workers' pneumoconiosis (black lung disease) or other dust-related diseases are not considered to be reportable deaths.

This is because industrial diseases often involve the complex interplay between multiple environmental and genetic factors.

When will an investigation and inquest occur?

When does an investigation commence?

The Mining and Resources Coroner's investigation commences immediately after the person's death is reported to the CCQ. The Mining and Resources Coroner's investigation is informed by investigations that are undertaken by the QPS, SIIU and other regulatory bodies.

When does an inquest commence?

To avoid jeopardising the likelihood of a successful prosecution, inquests cannot proceed until all relevant offence proceedings have been finalised.

To assist in ensuring timeliness, the Mining and Resources Coroner can hold a pre-inquest conference while criminal proceedings are ongoing. This is so the Mining and Resources Coroner can consider:

- what matters will be investigated at the inquest;
- who may appear at the inquest;
- which witnesses will be required; and
- what evidence will be required.

For more information on investigations and inquests for families, visit:

https://www.coronerscourt.qld.gov.au/for-families

What happens at an inquest?

Inquests vary in complexity, but in general the coroner hears evidence from people who may have information about the circumstances of the deceased person's death. People providing evidence can include police officers, family members, professional experts, such as doctors and scientists, eyewitnesses and members of the public. An inquest is not a trial and there is no jury.

After hearing all the evidence, the coroner adjourns the inquest to make their findings.

For more information on inquests, visit:

https://www.coronerscourt.qld.gov.au/about-our-court/inquests

The Coroner's findings

As part of the inquest process, the Mining and Resources Coroner will make written findings, comments and may make recommendations to prevent similar deaths from happening in the future.

Findings and comments are published, and the Department of Justice publishes responses and implementation updates for recommendations directed to government agencies.

Findings can be accessed at:

https://www.coronerscourt.qld.gov.au/findings-upcoming-inquests/search-findings

Family Liaison

CCQ has a dedicated Family Liaison Officer (FLO) to engage with the family of a deceased person whose death was mining related during the coronial investigation and inquest process.

The FLO ensures that families and agencies are provided with a direct point of contact for information about the Mining and Resources Coroner's investigation of a mining related death.

The FLO works closely with the Coronial and Family Liaison Service in the Office of Industrial Relations. These officers provide support to family members of a person who dies from a workplace fatality from the time that RSHQ commences its investigation. The FLO and the Coronial Family Liaison Service coordinate liaison to ensure continuity of support for families.

Contacts and support services

Coroners Court of Queensland
GPO Box 1649 Brisbane QLD 4001
Phone: (07) 3738 7050 (*main registry in Brisbane*)
Outside Brisbane: 1300 304 605 (local call cost)
Email: CoronersCourt@justice.qld.gov.au
Website: www.coronerscourt.qld.gov.au

Queensland Police Coronial Support Unit (CSU)
The CSU coordinates coronial processes and liaises with forensic pathologists and mortuary staff.

Phone: (07) 3292 5901
Email:
QPSOfficeStateCoroner@police.qld.gov.au

Office of Industrial Relations (OIR)
The OIR has a Coronial and Family Liaison Service offering families psychosocial support and liaison in relation to deaths that are related to work.
Phone: 0436 619 196 (business hours)
Email: ohs.corialliaison@oir.qld.gov.au
Website: worksafe.qld.gov.au

Forensic Pathology and Coronial Services
Phone: 1800 000 377 (free call)
Email: Forensics@health.qld.gov.au

Coronial Family Services
Phone: (07) 3096 2794
1800 449 171 (free call)
Email: FPaCS.Admin@health.qld.gov.au

Registry of Births Deaths and Marriages
PO Box 15188 City East QLD 4002
Phone: 13 74 68
Email: bdm-mail@justice.qld.gov.au
Website: www.qld.gov.au/rbdm

Victim Assist Queensland
Providing information, advice support services and financial assistance to victims of crime.

Phone: 1300 546 587
Website: https://www.qld.gov.au/law/crime-and-police/victim-assist-queensland

Serious Incident Investigation Unit
The centralised, specialist unit for all RSHQ investigations of serious safety and health matters.
Email: RSHQSIIU.Corro@rshq.qld.gov.au

Contact details for a range of support services for families and friends can be accessed at:

https://www.coronerscourt.qld.gov.au/for-families/support-services-for-families-and-friends