PRIMARY INDUSTRIES AND RESOURCES COMMITTEE

Members present:
Mr SA Bennett MP—Chair
Mr NJ Dalton MP
Mr RI Katter MP (via videoconference)
Mr GR Kelly MP
Mr LP Power MP
Mr TJ Smith MP

Staff present:
Dr A Ward—Committee Secretary
Mr R Pelenyi—Assistant Committee Secretary

PUBLIC BRIEFING—INQUIRY INTO THE CORONERS (MINING AND RESOURCES CORONER) AMENDMENT BILL 2025

TRANSCRIPT OF PROCEEDINGS

Monday, 30 June 2025

Brisbane

MONDAY, 30 JUNE 2025

The committee met at 10.30 am.

CHAIR: Good morning. I declare open this public briefing regarding the Coroners (Mining and Resources Coroner) Amendment Bill 2025. My name is Steve Bennett. I am the member for Burnett and chair of the committee. With me today are: Mr Linus Power, member for Logan, substituting for James Martin, deputy chair; Mr Nigel Dalton, member for Mackay; Mr Robbie Katter, member for Traeger; Mr Glen Kelly, member for Mirani; and Mr Tom Smith, member for Bundaberg.

This briefing is a proceeding of the Queensland parliament and is subject to the parliament's standing rules and orders. Only the committee and invited witnesses may participate in the proceedings. Witnesses are not required to give evidence under oath or affirmation, but I remind witnesses that intentionally misleading the committee is a serious offence. I also remind members of the public that they may be excluded from the briefing at the discretion of the committee. I remind committee members that officers are here to provide factual and technical information. Any questions seeking an opinion about policy should be directed to the minister or left to debate on the floor of the House.

These proceedings are being recorded and broadcast live on the parliament's website. Media may be present and are subject to the committee's media rules and the chair's direction at all times. You may be filmed or photographed during the proceedings and images may also appear on the parliament's website or social media pages. I ask everyone to turn their phones off or onto silent mode.

ANDERSON, Ms Michelle, Director, Resources Safety & Health Queensland

BOURKE, Mr Gregory, Executive Director, Strategic Policy and Legislation, Department of Justice

LINNAN, Ms Tara, Acting Director, Strategic Policy and Legislation, Department of Justice

MUSGRAVE, Ms Kerrie, Principal Policy Officer, Resources Safety & Health Queensland

TE KANI, Ms Renee, Principal Policy Officer, Resources Safety & Health Queensland

THIEL, Ms Jessica, Acting Senior Legal Officer, Strategic Policy and Legislation, Department of Justice

CHAIR: I now welcome representatives from the Department of Justice and Resources Safety & Health Queensland. Mr Bourke, I invite you to make an opening statement, after which committee members will have some questions for you.

Mr Bourke: In opening, I would like to respectfully acknowledge the Yagara and Turrbal people, the custodians of the land on which we meet this morning, and pay my respects to elders past and present. I thank the committee for the opportunity to appear and give a briefing on the Coroners (Mining and Resources Coroner) Amendment Bill 2025 to assist the committee with its inquiry. My name is Greg Bourke. I am the Executive Director of Strategic Policy and Legislation in the Department of Justice. I am joined by my colleagues from the Department of Justice—Tara Linnan and Jessica Thiel—as well as colleagues at Resources Safety & Health Queensland—Michelle Anderson, Renee Te Kani and Kerrie Musgrave. I will use this opening statement to briefly outline the reforms in the bill. I note the department has recently provided a detailed written briefing to the committee.

The bill gives effect to the government election commitment to re-establish and increase the powers of the Mining Warden's Court to investigate fatal accidents on the state's mine and quarry sites. The former mining warden's court inquired into serious and fatal mining related accidents and operated before the modern Coroners Court was established. The mining warden's court ceased in

March 2001, when all fatalities on mine and quarry sites were subsequently dealt with by the Coroners Court. The mining warden's court also had jurisdiction in relation to mining claims, compensation and lease applications. These types of disputes are now heard by the Land Court.

In all other jurisdictions with mining wardens' courts or mining wardens, these bodies only deal with disputes relating to mining tenements. The role of investigating mining related deaths sits within the jurisdiction of the Coroners Court within each state. The bill, therefore, implements the government's election commitment through a strengthened coronial model. The bill amends the Coroners Act 2003 to establish a dedicated Mining and Resources Coroner to conduct coronial investigations and mandatory inquests for all mining related reportable deaths which will include accidental deaths that occur on coalmines, mines, quarries and certain petroleum and gas sites. It is also anticipated that the Mining and Resources Coroner will be able to carry out general coronial work at the same time as undertaking mining related work.

The bill provides that the Governor in Council may appoint a local coroner as the Mining and Resources Coroner. The Attorney-General, as the responsible minister, must consult with the Chief Magistrate and State Coroner before making a recommendation to the Governor in Council about the appointment.

Local coroners are also magistrates, and the Mining and Resources Coroner must first be appointed as a magistrate. A person stops being the Mining and Resources Coroner while the person is suspended as a magistrate or if the person stops being a magistrate. The Mining and Resources Coroner may resign from the position by written notice to the Attorney-General; however, the person does not stop being a magistrate.

Under the Coroners Act, a coroner must conduct an investigation into a reportable death—for example, if the death was violent or otherwise unnatural. The coroner investigating the death may hold an inquest if it is in the public interest. There are certain types of reportable deaths where an inquest must occur—for example, a death in custody or a death in care. Clause 7 of the bill expands the types of deaths where a mandatory inquest is required under the Coroners Act to include a mining related reportable death. The bill requires mining related reportable deaths to be investigated by the Mining and Resources Coroner.

Clause 5 of the bill, which inserts new section 11AAA, provides a definition of 'mining related reportable death'. This includes where: the death was a reportable death under section 8(3)(b) of the Coroners Act, meaning the death was a violent or otherwise unnatural death; the person died at any time after receiving a mining related injury that caused the death or contributed to the death and without which the person would not have died; and the mining related injury was received at a coalmine, mine or quarry or specified petroleum and gas site while carrying out an activity that is related to the operation of a coalmine, mine or quarry or specified petroleum or gas site. The bill includes definitions for coalmines, mines, and petroleum and gas sites with reference to the correlating resources safety and health legislation.

The bill also defines a mining related injury. This is intended to cover injuries that are received while the person is carrying out an activity that is related to the operation of a coalmine, mine or quarry or specified petroleum and gas site. For example, this would encompass where a worker was fatally injured from a dozer rollover at a mine or where a contractor was fatally injured during pipeline maintenance on a petroleum lease.

As the scope is site-based, the Mining and Resources Coroner may investigate a death that falls under one or more health and safety regulators, such as Resources Safety & Health Queensland or Workplace Health and Safety Queensland. The bill does not make changes to any current investigative processes by these bodies. The Mining and Resources Coroner, as part of its investigation, may be informed by the investigations undertaken by the relevant independent regulator, or by police and prosecutions if a criminal offence is alleged to have been committed. The model is intended to complement existing bodies who regulate, educate and assist the resources industry to meet its obligation to protect the safety and health of its workforce, or other agencies who focus their investigations on whether prosecution is warranted.

The bill does not amend how criminal offences are investigated or prosecuted. If a person has been charged with an offence in which the question of whether the accused caused the death may be an issue, such as industrial manslaughter, the coroner must not start an inquest until after the proceedings have ended. This is to ensure the criminal proceedings are not jeopardised in any way.

If the death is a mining related reportable death, the Mining and Resources Coroner must conduct an inquest. If the death is not a mining related reportable death but still a reportable death, the Mining and Resources Coroner may decide to hold an inquest if it is in the public interest, under

section 28 of the Coroners Act. Examples of deaths that are not included in the definition of 'mining related reportable death' but may still be reportable deaths are: deaths from injuries that may be unrelated to the operations on a site—for example, the death of a farmer from pastoral activities that occurred on a mining tenure or specified petroleum and gas site but which were unrelated to a tenure related activity; deaths that occur while the person is on their way to or from a site, such as a car accident; and a death from an injury that a person has intentionally self-inflicted.

The bill does not require the Mining and Resources Coroner to conduct a mandatory inquest into these deaths because there may be a range of reasons for such a death that are not related to the operations of a mine, coalmine or petroleum or gas site, or to an operator's safety and health obligations. However, if when conducting an investigation into a death that is not caught by the definition of 'mining related reportable death' the Mining and Resources Coroner considers it is in the public interest to hold an inquest, they may do so. For example, this might occur if the Mining and Resources Coroner is investigating a person's death by suicide in accommodation on a mine site and considers the person's death could be attributed to failings by an operator in fulfilling their safety and health obligations.

The bill provides transitional provisions for mining related coronial investigations that are underway. Open coronial investigations into mining related reportable deaths will be reassigned to the Mining and Resources Coroner on commencement. A mining related reportable death that occurs after commencement of the bill will be subject to an investigation and mandatory inquest by the Mining and Resources Coroner whether the mining related injury happened before or after commencement of the bill.

As a general rule, mining related reportable deaths that occur before commencement of the bill will be subject to an investigation and mandatory inquest by the Mining and Resources Coroner if all of the following criteria are met: before commencement, the coroner investigating the death has not made all the findings of an investigation into the death; an investigation has not gone to an inquest; a pre-inquest conference has not taken place; and the coroner has not stopped investigating the death under section 12(2) of the Coroners Act. However, the Mining and Resources Coroner may decide not to hold an inquest into these pre-commencement deaths if satisfied it is not in the public interest to do so. The bill provides that, in deciding whether it is not in the public interest to hold the inquest, the Mining and Resources Coroner must consult with and consider the views of a family member of the deceased and the length of time since the death happened and consider when the investigation is likely to be completed.

Under the Coroners Act, a coroner must give a written copy of the findings of an investigation to a family member of the deceased. If the coroner investigates a death at an inquest, the coroner investigating the death must also publish their findings and comments unless the coroner orders otherwise. In addition to these existing provisions, the bill also provides the Mining and Resources Coroner must give a written copy of the findings and comments to the Attorney-General, the Chief Executive of RSHQ and the minister administering the Resources Safety and Health Queensland Act 2020. Consistent with current practice, for recommendations directed at government agencies the Department of Justice coordinates and publishes government responses and implementation updates on the Coroners Court of Queensland website.

Lastly, the bill will also make minor amendments to the Coroners Act to achieve greater efficiencies in the broader coronial system. The amendments will: one, allow for the appointment of more than one deputy state coroner; and, two, enable preliminary examinations to occur after a death has been reported to a coroner, rather than limiting them to cases reported by police officers.

I thank you for the opportunity to brief the committee on the bill. We are happy to take any questions you may have.

CHAIR: Thank you, Mr Bourke.

Mr POWER: I did not notice any reference to panellists in either the Coroners Court legislation or the bill. Did I miss something?

Ms Linnan: The bill implements the government's election commitment to establish a Mining and Resources Coroner using the existing coronial framework. Under the existing coronial framework under the Coroners Act there are no panellists, but there are powers for a coroner to take any evidence that they see fit, and they quite often will engage experts to provide reports into particular deaths. Although there are no panellists, they can take any evidence and will engage experts to help them.

Mr POWER: The Queensland government, in making this commitment, noted that a key future of the Mining Warden's Court was the appointment of panellists of relevant industry experts with no connection to the site of the incident for any inquiry. I want to confirm that this bill and the Coroners Act have no provisions like that to have a series of panellists involved in the inquiry.

Ms Linnan: No, the bill does not require the coroner to take evidence in a particular way, so through panellists, but, as I said, that evidence could be taken from engaging experts who could have been panellists. They would engage experts to provide that information to the coroner, and that is what happens currently.

Mr DALTON: Thank you very much for that briefing. In Mackay there are many families of miners, and if a death occurs there is increased concern that the cause of death is not explained for a long period of time. How will the bill ensure that the families of deceased workers are supported during the investigation process, particularly in cases where the cause of death has to be explained?

Ms Linnan: To support families of the deceased, a position will be established within the Coroners Court of Queensland to provide a family and liaison engagement service throughout the coronial investigation and through the inquest process. This will include ensuring a direct point of contact for families and agencies delivering support to families. A case manager will be a point of contact in the registry for families and other agencies from the commencement of the investigation and then all throughout the coronial process until it ends in findings and recommendations. The Coroners Court of Queensland will work closely with specialist investigation liaison support officers. They are currently within the Office of Industrial Relations, and they currently provide support to families of a person who dies from a workplace fatality from the time that RSHQ commences its investigation. They will be a continuity of support from the time of death all through to when the inquest is finalised and findings are made.

Mr POWER: Mining is very diverse. We have gas fields, underground coal, underground minerals and open-cut in both those descriptions. We also have the plants, the transport, the moving of those ore bodies and the processing of those ore bodies. All of those processes are very different depending on the site involved. Do we have a concern that any one person could have expertise in all of those different areas?

Ms Linnan: It is not one particular person that is giving evidence to a coroner. A coroner can, as I said, take any evidence that they wish. If it is a particular death on a particular site, they can obtain expert reports around that particular death or that particular site, or they can obtain multiple reports.

Mr POWER: In that way, the expertise does not come from the person nominated as the mining coroner but instead the research that happens through the coronial process that any coroner could do?

Ms Linnan: Yes, that is right.

Mr POWER: I note that this is a lifetime appointment, or it does not seem to have the tenure of other coroners. Is that an intent of the government's commitment? Why is this one different from other coroners?

Ms Linnan: The bill does not provide a legislative term of appointment. This is because the Mining and Resources Coroner is a local coroner. and local coroners do not require a term of appointment. In comparison, the State Coroner and the Deputy State Coroner have a five-year term of appointment, but they may be reappointed. This is because they are a head of a jurisdiction, essentially, and it is practice for heads of jurisdiction to have a term of appointment. The State Coroner has specific powers and responsibilities under the Coroners Act that other local coroners do not, and the Deputy State Coroner may act as the State Coroner. That is why there is a distinction.

Mr G KELLY: There have been several inquests in the Mirani-Mackay region relating to incidents in mining. If the bill passes, what will occur with the current mining inquests?

Ms Linnan: The bill has quite extensive transitional provisions, which that Mr Bourke spoke to. If an inquest has already been held and findings made then those investigations have been completed, so they will not be re-enlivened by the Mining and Resources Coroner. What the bill does, though, is provide transitional provisions for injuries and deaths that occurred before and after the bill commences. If an injury had occurred before the bill commences but the death occurred after, that will still be within the mining and resources mandatory scope. If the death has occurred before the commencement and the investigation is currently live—as Greg said, there has been no inquest held or no pre-inquest conference—the Mining and Resources Coroner must undertake an inquest into those matters, unless it is not in the public interest to do so. The bill does provide examples of what

is not in the public interest, and that is in relation to taking the views of the family, if they do not want an inquest because of the time—too much time has passed—or if the investigation is pretty close to being finalised and another inquest will cause delays in that process and the families do not want that. To answer your question, if the inquest has already happened and the findings made, they will not be re-enlivened.

Mr SMITH: You mentioned local coroners and them not requiring a length of term. Could you please outline the difference between the role of a local coroner and the Mining and Resources Coroner and how they would be different in their function?

Ms Linnan: The Mining and Resources Coroner is a particular position now to investigate all mining related reportable deaths on the state's mine and quarry sites. That is the distinction, that they hold that mandatory inquest.

Mr SMITH: They do not have powers greater or beyond that of a local coroner; there is no extra function?

Ms Linnan: The extra function is to investigate mining related reportable deaths and conduct mandatory inquests. Other local coroners will not be able to do that.

Mr Bourke: It is worth noting that the government's election commitment specifically acknowledged that that dedicated resource would be used for broader general coronial work. Noting that mining related reportable deaths will be a part of the remit of the Mining and Resources Coroner, otherwise that coroner's dedicated position will be called upon to support broader efficiencies across the coronial system. Its specific legislative remit will be those mining related reportable deaths.

Mr POWER: I note that the Mining and Resources Coroner can act as an ordinary coroner and investigate other matters unrelated to mining, as directed by the Coroner. If there was a reportable mining injury that led to death on a mining site, would the Mining and Resources Coroner then be pulled off that case and therefore have to abandon a coronial inquest?

Ms Linnan: No, they will not be required to be pulled off. Currently, coroners handle approximately 200 to 300 cases at any given time. They are well supported and well equipped to be able to investigate multiple deaths at the one time, and it might be that there are different stages of the investigation. As Mr Bourke said in the opening statement, for example, if there is a criminal prosecution then the inquest has to be kept on hold. While the Mining and Resources Coroner is conducting the inquest, the Mining and Resources Coroner is well supported to continue those other investigations as well.

CHAIR: Can I get some clarity about a statement you made? I was going to ask about the number of mining related incidents investigated each year. I think you said 200, without putting words into your mouth.

Ms Linnan: Sorry, there are 200 to 300 cases that any coroner deals with at any one time.

CHAIR: What about mining related incidents?

Ms Linnan: From 2014 to 2024, Resources Safety & Health Queensland—the independent regulator—investigated 27 deaths on mines and quarries in Queensland. Based on this data, it is expected that the Mining and Resources Coroner will consider an average of two to four accidental mining related deaths per year. While this is a relatively small number of deaths, investigations and inquests for these types of deaths can be complex and, as I stated previously, may involve including expert witnesses and several parties. When the Mining and Resources Coroner is not dealing with these matters, they can undertake general coronial work.

CHAIR: If the bill passes, what will happen to current inquests that are underway? Do you anticipate any adverse outcomes or anything the committee should be made aware of?

Ms Linnan: No, no adverse outcomes. As I said previously, for the matters that are outstanding currently once the bill starts, if the matter has already proceeded to an inquest then the Mining and Resources Coroner will not take those investigations on. They will only start the investigation of the matters that are outstanding where it has not already gone to an inquest.

Mr SMITH: Going to the mining related reportable deaths, what lung dust diseases are listed as reportable deaths?

Ms Linnan: In general, coroners do not usually investigate deaths from latent onset injuries such as from a mine dust lung disease. These types of deaths are not commonly reportable deaths—that is, the death was not violent or otherwise unnatural. Section 7 of the Coroners Act defines what is a reportable death. Generally, those types of deaths are currently not categorised as reportable deaths. However, it is on a case-by-case basis. When a coroner is notified of a death, the facts

surrounding that death are considered on a case-by-case basis to determine whether it is a reportable death. The State Coroner can issue guidelines, which are published, and they provide guidance to coroners on this issue. If a death is a reportable death, although they are not classified within the definition of a mining related reportable death the Mining and Resources Coroner must conduct an investigation into those matters and may conduct an inquest if it is in the public interest.

Mr POWER: At section 8(3)(b), the second dot point states 'the person died at any time after receiving a mining related injury that caused the death or contributed to the death and without which the person would not have died'. In the cases of those complex lung diseases such as black lung disease and silicosis, 'contributed to the death and without which a person would not have died'—on the face of reading that, they would be contributing to the death.

Ms Linnan: If you look at 11AAA(3)(a), the first limb, the person's death must be a reportable death under section 8(3)(b) first. That is where the death is violent or otherwise unnatural.

Mr POWER: But we are not suggesting that these serious lung diseases are natural.

Ms Linnan: That is up to the discretion of the coroners as to how they determine that.

Mr Bourke: There is a specific section in the State Coroner's guidelines which acknowledges by convention diseases due to the longstanding effects of repeated and relatively low-level exposure to chemicals that are generally not regarded as unnatural. One reason for this is that the diseases which ultimately develop often involve the complex interplay between multiple environmental and genetic factors. I think those guidelines give us some kind of marker as well in terms of how those particular types of diseases might be treated, but each circumstance would be a case-by-case assessment for the Mining and Resources Coroner.

Ms Anderson: From a safety focus, I will say that RSHQ's focus in relation to those types of mine dust lung diseases is really on prevention and early detection through effective risk management, air monitoring, mandatory health surveillance of workers and ongoing data analysis to understand the changes over time and the incidence of the disease in the worker population. I wanted to add that from a safety perspective.

Mr DALTON: Once the bill is passed, will there be regular reviews or audits of the implementation of the bill to assess its impact on both worker safety and efficiency of the coronial process?

Ms Linnan: The bill does not include any review mechanism, but the Coroners Court of Queensland will provide annual reports, and any work of the Mining and Resources Coroner will be considered as part of doing those annual reports. They will also be supported by RSHQ, who are conducting the investigations, and there will be ongoing monitoring of how those findings and recommendations are made. On that point, findings and recommendations made by the Mining and Resources Coroner are published publicly. If any recommendations are directed towards government agencies or regulators, we also publish annual regular updates on the Coroners Court of Queensland website to see how those recommendations have been implemented.

Mr SMITH: Ms Anderson, returning to dust lung diseases, you mentioned there is large-scale prevention. It is not expected that miners would develop these dust lung diseases, due to the amount of prevention going forward into mining; would that be correct?

Ms Anderson: All I can advise is that we at RSHQ are looking at preventive actions and we have this comprehensive program to actually carry that into effect. In terms of what happens on particular circumstances or cases, I cannot really comment on that, but we do have a very large preventive program in place.

Mr SMITH: Within the mining industry, is it expected that there are likely outcomes of dust diseases in workers, or would it be accidental if they were to develop a dust lung disease?

CHAIR: You are asking for an opinion. Can you rephrase that, member?

Mr SMITH: No, that was within the industry—

CHAIR: I am not arguing. I am saying you asked the director for an opinion.

Mr SMITH: Are dust lung diseases commonly expected within the industry?

Ms Anderson: I am sorry, that is something I cannot really comment on. It is more of an opinion.

Mr POWER: It is a factual question.

CHAIR: It may be.

Mr SMITH: How common are dust lung diseases in the workers?

CHAIR: That is a better question.

Ms Anderson: We are happy to take the question on notice, go away and get some further data to you in relation to the incidence of mine lung diseases and come back to you.

CHAIR: Would you be happy with that, member?

Mr SMITH: I am happy with that. I may also continue along with—

CHAIR: We will come back to you.

Mr G KELLY: The bill makes changes to the preliminary examination process. What are the benefits of this, and can you outline the reasoning for this amendment?

Ms Thiel: In terms of the minor amendment to allow for the preliminary examination of a deceased person's body to occur, currently under section 7 of the act the preliminary examinations can only occur after a police report has been provided to the coroner. What this amendment does is allow for the report to be provided by another, such as a medical practitioner, and the purpose of this is to allow less of a burden on Queensland police to have to provide a report to the coroner when there is already a report from a medical practitioner about the deceased person's body. Then, in that way, they will be able to undertake the preliminary examination.

Mr SMITH: To the department: noting 11AAA(3)(a)—and we mentioned that it is the Coroner and there is a list of reportable deaths—do the coroners themselves have the ability to change what is listed as a reportable death, or does it need to be done through legislation?

Ms Linnan: The Coroner has to comply with the Coroners Act about what is a reportable death. However, it is on a case-by-case basis and they can take advice from medical practitioners or whoever they like about whether something is a reportable death or not. There have been cases where a coroner did look at similar to those onset diseases—where there was rheumatic heart disease. That is not normally a reportable death; it is from a natural cause. However, the coroner investigated three deaths which were caused by rheumatic heart disease, or complications from it. This is known as the RHD Doomadgee cluster. The inquest report is online. These three deaths were investigated together and an inquest was held. The coroner found inadequate primary health care had been provided into those three matters, so the cluster of deaths were determined to be reportable deaths—that they were healthcare related reportable deaths under section 8(3)(d) of the Coroners Act.

CHAIR: Can I ask about the consultation process that was undertaken by the department on this bill, please?

Ms Linnan: We did consult on a draft consultation bill with resource industry stakeholders, union stakeholders and the legal profession, and the State Coroner was also briefed on the bill.

Mr POWER: I was looking up a group, which I do not know the veracity of, called Mates in Mining, who talked about much higher rates—80 per cent higher—in the mining, construction and energy sectors. There is obviously a causation to those things. If there was, for instance, bullying by management or other involved causes—also I am thinking of a circumstance where someone self-inflicts injury and it was the nature of the site that then led to the death—it is not a reportable death under this act, and I wonder why.

Ms Linnan: The bill does make it clear that any self-inflicted injury is not a mining related reportable death, but they would be a reportable death under the Coroners Act because they are violent or otherwise unnatural. Those deaths are excluded from the mandatory scope of the Mining and Resources Coroner; however, as I said, these deaths are reportable deaths so they still must be investigated by the Coroner under the existing provisions of the Coroners Act. Section 8 defines what a reportable death is and section 11 provides that a coroner must investigate a reportable death.

Mr POWER: In that section, that has a public interest test. In general, though, all of the unnatural deaths that happen on mining sites—all of them—under the act would have a public interest test. What we are hoping to capture here is for coroners' inquiries to go forward in cases where the Coroner would determine that there was no public interest in there being an inquest, by definition of the act; is that fair enough to say?

Ms Linnan: If I understand your question, the Mining and Resources Coroner must undertake inquests. There is no public interest test for mining related reportable deaths. If it is not a mining related reportable death but it is still a reportable death, the Coroner can conduct an inquest if it is in the public interest.

Mr POWER: Sorry, I need to make myself clear. Previous to this bill being in place, an unnatural death has to meet a public interest test. What we are capturing here are those types of cases where the Coroner would see there was no public interest in it?

Ms Linnan: Not necessarily. We know that there have been coronial inquests into mining related matters where they have seen it is in the public interest and they have conducted inquests into those deaths.

Mr POWER: Absolutely, I understand that, but those would have gone forward. We are only then seeking those types of circumstances where the Coroner previously would have made a determination that there was no public interest in holding an inquiry?

Ms Linnan: The bill is implementing the government's election commitment to investigate accidental deaths on mining and quarry sites and making them—

Mr POWER: I understand, but my logic is correct in that we are only capturing those that would have been determined to be not in the public interest?

Mr Bourke: I think, member, with the choice of phrasing that you are taking, this is creating a specific set of types of deaths that will trigger mandatory inquests responding to an historical number of cases that have occurred in the past and acknowledging that in certain instances, like a death in custody, this is essentially moving it into that type of category. There will be a mandated inquest to identify learnings and lessons coming from that. I think the way are you expressing it is a matter of choice for you, but the government's election commitment is giving effect by providing for a clear set of requirements when a death must progress to an inquest.

Mr DALTON: I am an ex-police officer and have had to deal with deaths. Obviously the form 1 is the first piece of paperwork the police put together. Do you anticipate any changes in that form 1 or another form which will relate to a mining death, or will it be exactly the same and then once it gets to the Coroner's office it will be determined to be a mining coroner's inquest or an ordinary one?

Ms Linnan: I do not think we are anticipating any changes to the current processes. As I said, these deaths are investigated now, but definitely the Coroners Court of Queensland, to implement this bill, will consult all of their stakeholders, particularly around police and health, who conduct a lot of those pre-examinations, before the bill starts.

Mr DALTON: So there will not be any need for any training with the police? They will just be doing their job as normal and proceed from there?

Ms Linnan: Yes, I anticipate that.

Mr SMITH: When did the government bring this election commitment to the department?

Mr Bourke: Upon a government coming into office, there is a general collection of all government election commitments. I think both Minister Last and the Attorney-General had made public commitments about this during the lead-up to the 2024 election, so it was part of that initial harvesting of election commitments. They are then allocated to departments, so Justice took the lead, in conjunction with our Resources Safety & Health Queensland colleagues.

Mr SMITH: Perhaps I could be specific: is the department able to record the date on which they first began or initiated work towards writing this piece of legislation?

Mr Bourke: I would have to take on notice the exact date. I remember conversations occurring fairly quickly post election in terms of starting to think through possible models to give effect to it, but we would have to take on notice the exact date.

Mr SMITH: On notice would be wonderful, and perhaps also when the bill and the explanatory notes were finalised and submitted for presentation before the House. I am happy for that to go on notice as well.

Mr Bourke: The bill and explanatory notes go through a supply process and are supplied relatively shortly before the day of introduction. They were finalised in the week of introduction and approved by the Attorney-General prior to its introduction, like for most bills before the House.

Mr G KELLY: For the people in the Mirani-Mackay area, can you give a bit of an outline of the role of the family liaison and engagement officers?

Ms Linnan: The Coroners Court of Queensland are currently recruiting for a family and liaison engagement officer position. Without going into the operation of what that could look like, they will be the first point of contact for families going through a coronial investigation and an inquest. You would imagine that it would be keeping families up to date on progress and where things are at. If there is a criminal prosecution it will delay that inquest, and they will provide those explanations to families.

Mr POWER: In these changes to the Coroners Act, the mining related deaths are only given to one person and the Coroner has a direction that that person must be the person who investigates that. Are we putting at risk that, in such a complex and dangerous field of endeavour as mining and resources, it is only a single person who—we know that this is now a long-term appointment—may change over lifetimes, and the Coroner has no ability to choose another person who would be better suited to that work? We fix ourselves on this person. It might be that they have a lot of experience in the field of mining and resources or none at all—there is no necessity of that. Just with the nature of the person, the Coroner has no choice but to allocate these cases to that coroner.

Ms Linnan: Under the bill, the Mining and Resources Coroner is the coroner that investigates mining related reportable deaths. However, the bill does allow that if that coroner is on leave or otherwise absent then another coroner can investigate the mining related reportable death.

Mr Bourke: Conversely to that risk you identified, having that one individual will enable them to build up greater knowledge, experience and understanding of the sector. Equally, it will enable them to build a portfolio of knowledge and understanding of what is a complex sector. I think that dedicated coroner acknowledges that this industry, through the government election commitment, has been elevated to that level—to have that specific coroner for oversight of particular deaths that occur. I think there are equally benefits that come from it.

Mr POWER: There are possible benefits—thank you for your opinion on that—but there are also circumstances where the person faces widespread criticism from the industry and families involved, and there is no choice for the Coroner to make a determination that another coroner undertake those duties in the next case, despite widespread condemnation. We are not making the law for one person; we are making this for a long time. There are those real and present dangers that the singular person involved may not meet community confidence; however, the Coroner has no choice but to allocate in those cases.

CHAIR: I will caution that that is asking for an opinion on a long-term appointment, member. Can you rephrase your question without the imputations?

Mr POWER: Sorry, imputations on—

CHAIR: You are making assumptions. Anyway, I have ruled. Can you rephrase your question so that it is not seeking an opinion?

Mr POWER: If there is in the future some level of disquiet about the nature of the rulings of the Mining and Resources Coroner, the Coroner has no choice to get a different set of skills or a different coroner to examine these cases?

Ms Linnan: I am trying to find the part of the bill. The Mining and Resources Coroner is first appointed as a magistrate, so they must uphold all of the functions and powers of a magistrate. The bill provides that a person stops being the Mining and Resources Coroner while the person is suspended as a magistrate or if the person stops being a magistrate. If there are any questions around the way the coroner is conducting investigations or holding inquests then those are best directed to the Chief Magistrate.

Mr DALTON: This question is directed to RSHQ. How do you see the specialised role impacting RSHQ's ongoing involvement in the investigation of fatalities in the mining and resources sector?

Ms Anderson: RSHQ would see that the way we currently conduct investigations would continue. We investigate accidents and deaths within our Resources Safety Acts. We provide information about our findings to the Coroner currently. We also provide information and technical expertise to the Mining and Resources Coroner, and we do not anticipate that that would change.

Mr SMITH: Returning to the department, when we talk about the scope of mining related injuries and incidents or accidents, there seems to be a requirement that there needs to be violence; is that correct? Is that the word that has been used?

Ms Linnan: Not necessarily violent but just otherwise unnatural death. It does not necessarily have to be violent.

Mr SMITH: So just an unnatural death?

Ms Linnan: Yes.

Mr SMITH: From an injury occurring onsite?

Ms Linnan: Yes.

Mr SMITH: That would be linked to a mining operation or petroleum or gas; is that correct?

Ms Linnan: Yes.

Mr SMITH: I will open this question up to everyone. I will be very careful not to seek an opinion, Chair. If a crush of a person onsite occurs, that is an accident because it is unnatural, it is not intended and there are measures of prevention onsite around that. Why is dust lung injury not considered an accident if there are so many preventions put in place? Is it an accident, and is it an injury that can cause death because of the role on a mine site?

Ms Linnan: We have already answered on those types of diseases. We are not saying that they are not an accident; it is whether they are a reportable death that is the issue.

Mr SMITH: Could you please explain how it is not reportable when it hits every single point that is within there?

Mr Bourke: There is an existing body of work by the State Coroner and there are particular directions that he has already included in his State Coroner guidelines—I spoke to that before—that give general guidance. Obviously, coroners should seek the advice of a forensic pathologist or a clinical forensic medicine unit doctor before making a decision that the death is a reportable death and, again, that is encouraged in the guidelines. I think you are tapping into a broader body of work, or a broader body of precedent that already exists around these lung diseases that we cannot really take any further. There are already existing directions to coroners about how to handle these matters, and this Mining and Resources Coroner would rely on that existing direction in the guidelines. I am not sure we can take the questions much further.

Mr G KELLY: Does the bill include provisions for improving communications between RSHQ and the families of deceased workers during investigations?

Ms Linnan: Was that question directed to RSHQ investigations? I will have get my colleagues to answer that.

Mr G KELLY: Yes, sorry.

Ms Te Kani: Currently, RSHQ has an agreement in place with OIR, which Tara alluded to earlier, which ensures that when RSHQ is notified of an accident, including a fatality, that then triggers incident liaison support officers to be involved. They are trauma informed and they have a specific role to liaise with family to ensure those family members are supported. They also provide updates on an agreed basis to make sure they are aware of what is happening in the investigation.

Mr POWER: The reportable deaths are site determined. It is the nature of a mining lease that sets the determination. If a rail or road train accident happens outside the road owned by the mine or off the rail owned by the mine, or else a remote site or the construction of a pipeline off a mining site, despite being obviously by definition mining related activities, none of them meet the definition of a reportable death?

Ms Anderson: Each case is going to depend on the individual facts and circumstances. I will take each of your examples—and correct me if I do not remember them correctly. The first one related to where there is a railway. It all comes back to what is within the definition of a coalmine. A coalmine includes not only the mining tenure but also land that is adjacent or adjoining that the activity is happening on. If it is a railway and it is on that adjacent or adjoining land, then potentially that could be within the scope. Could you refresh my memory about the second example?

Mr POWER: We have mines that own their own roads in and transport ore bodies by truck. As soon as they turn off that road, it is no longer reportable?

Ms Anderson: Currently under legislation, the definition of a mine and also operations excludes basically where there are public roads and public railways. The changes in the Mining and Resources Coroner legislation are consistent with the current framework under the resources safety acts.

Mr POWER: For example, where a road train causes an injury to a member of the public, that would not be captured under this act?

Ms Anderson: If it is on a public road, it would not be a mining related reportable death. However, it potentially could be still subject to the public interest test.

Mr DALTON: Will the new responsibilities of RSHQ have a support link with the Coroner's office, or will there just be a seamless move, exactly the same as it would be if it was the traditional coroner dealing with the matter? Will there be any update in policies?

Ms Te Kani: Yes, that is right. RSHQ will have an ongoing involvement with the Coroner's office, including to the Mining and Resources Coroner once it is established. That will be, for example, providing updates on its investigation and the phases—whether a brief has been provided to the Work Health and Safety Prosecutor to consider bringing a prosecution for a potential serious offence—as

well as advising what stages those proceedings are going through. Then once it does go to inquest, RSHQ will provide any information or support in relation to the investigation or technical expertise that the coroner might seek to help inform his investigation.

Mr DALTON: As the mining coroner will be based in Mackay, do you anticipate that being a physical presence in Mackay, from your department?

Ms Te Kani: I might take that on notice, but what I can say is that RSHQ is statewide. We do routinely go out to regional and rural areas, particularly because there are, of course, mines in very remote places. I do not think that would be a particular issue, but I will take that on notice and provide you with a fulsome answer.

CHAIR: Ms Linnan, I think you may have mentioned this but, obviously with regard to the sensitivities around investigations and trauma to families, will the issue of making the coroner's findings public at some point in time be mandated? Is there a statutory obligation about those reports or can they be kept in-house, for want of a better term, for the sensitivities of family and friends?

Ms Linnan: The Coroners Act does require that any findings and recommendations are to be published, unless the Coroner orders otherwise.

CHAIR: Families would be part of that consideration?

Ms Linnan: Yes.

CHAIR: You mentioned families' input into this as well at some point?

Ms Linnan: Yes—also, if there have been criminal prosecutions underway or if there has been any type of commission of inquiry related to it. There are a lot of examples of where the Coroner might not publish the recommendations. Generally they do, but they can also redact parts of the findings or recommendations and not publish all of it.

CHAIR: Would matters like delays in criminal proceedings add to the complexity of reporting or non-reporting?

Ms Linnan: While a criminal prosecution is underway, the Coroner cannot conduct an inquest into those matters; therefore, they cannot make any findings or recommendations.

Mr POWER: The government's election commitment was to restore the Warden's Court. I looked up the Mining Act 1898 for the various powers over its iterated lifetime for the Mining Warden's Court. Other than the role of being a coroner and being governed under the Coroners Act, what is proposed for the Mining and Resource Coroner to take from the previous Mining Act 1898 for the warden's role?

Ms Linnan: One key difference between the role of the mining warden and the Mining and Resources Coroner is that the mining warden, although they could obtain evidence, could not ensure self-incriminating evidence was provided to not jeopardise criminal prosecutions. One thing that the Mining and Resources Coroner can do is require self-incriminating evidence to be produced at an inquest. I think that is the main difference.

Mr POWER: The Mining Warden's Court had a whole variety of different roles, but this is very narrowly limited to the coroner's inquest?

Ms Linnan: The Mining Warden's Court, as Greg mentioned in his opening statement, also looked into leases and civil disputes between mines. Now the Land Court in Queensland handles those matters. In all other jurisdictions where there are investigations of deaths on these sites, they are all done by coroners.

CHAIR: You have one further question, member?

Mr SMITH: I am very happy for this question to go on notice, given the time, Chair. How would a government of the day undertake a dismissal of the coroner should they wish to do so?

Ms Linnan: We will have to take that one on notice, thank you.

CHAIR: It is government policy anyway.

Mr Bourke: We could have the mechanics of the sections that relate—

CHAIR: We will sort that out. We will now conclude. Thank you everyone who participated today. Thank you to Hansard. A transcript of these proceedings will be available in due course. We will write to you with the questions on notice. With that, I declare this briefing closed.

The committee adjourned at 11.31 am.