



PRIMARY INDUSTRIES AND RESOURCES COMMITTEE

Members present:

Mr SA Bennett MP—Chair
Mr NJ Dalton MP
Mr GR Kelly MP
Mr JR Martin MP
Mr TJ Smith MP (via videoconference)

Staff present:

Ms L Pretty—Acting Committee Secretary
Mr R Pelenyi—Assistant Committee Secretary

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

TRANSCRIPT OF PROCEEDINGS

Monday, 28 July 2025

Brisbane

MONDAY, 28 JULY 2025

The committee met at 10.34 am.

CHAIR: Good morning. I declare open this public hearing of the committee's inquiry into the Coroners (Mining and Resources Coroner) Amendment Bill 2025. My name is Stephen Bennett, and I am the member for Burnett and chair of the committee. With me here today are: James Martin, the member for Stretton and deputy chair; Nigel Dalton, the member for Mackay; Glen Kelly, the member for Mirani; Tom Smith, the member for Bundaberg, who is appearing via videoconference; and Robbie Katter, the member for Traeger, who has been delayed in transit. Hopefully he will be able to join us.

This hearing 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 hearing at the discretion of the committee.

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. Please remember to press your microphones on when you start to speak and off when you are finished, and please turn your mobile phones off or to silent mode.

COLES, Ms Klaire, Legal Practice Director, Caxton Legal Centre, Queensland Coronial Legal Service (via videoconference)

CHAIR: Welcome, Klaire. I invite you to make an opening statement, and then we will ask you some questions.

Ms Coles: Thank you very much, Chair, and thank you to the committee for the opportunity to address you today. I would like to start by acknowledging the traditional owners of the land on which I am today—the Yagara and Turrbal people—and pay my respects to elders past and present. My name is Klaire Coles and I am the Legal Practice Director at Caxton Legal Centre. I am speaking today in my capacity as a lawyer responsible for the Queensland Coronial Legal Service, which Caxton operates with Townsville Community Law.

The Queensland Coronial Legal Service is a free statewide legal service supporting bereaved families navigating the coronial system. We have been operating since 2017. In that time we have provided legal advice and representation to hundreds of families who have been thrust into the coronial jurisdiction because of the sudden death of a loved one. This has included families who have lost a loved one because of their work in the mining and resources industry, and we have represented some of those families at inquests.

As we have outlined in our written submission, we acknowledge and support the intent of this bill to strengthen the oversight of mining related deaths; however, we hold concerns about the exclusion of intentional or suicide deaths from the Mining and Resources Coroner's jurisdiction. Suicides amongst FIFO and resource sector workers occur at disproportionately higher rates and often in complex environments shaped by isolation, stigma and work related pressures. Removing these deaths from the mandatory jurisdiction of the Mining and Resources Coroner risks obscuring systemic issues and undermines the preventive focus of the coronial system. We urge the committee to reconsider this exclusion.

All deaths on mining sites should be mandatorily reported and investigated by the Mining and Resources Coroner. At the very least, the Mining and Resources Coroner should retain discretion to hold an inquest in cases of suspected suicide where it is in the public interest. In our experience, many families want answers, transparency and the opportunity for their loved one's death to contribute to systemic change, and they should not be denied that simply because the death was by suicide. Thank you for your time, and I am happy to take any questions that the committee might have.

CHAIR: Thank you, Klaire. In the interest of today's meeting, Klaire, we want to table a document. You have not seen this but it will allow our committee members to ask questions about the departmental response to your submission. If there is no objection, I will table the document, which is the departmental response to written submissions received by the committee to date. I apologise that you do not have that in front of you, Klaire. It will be published in due course this morning for your benefit, but it will allow some of our members to ask questions and get more out of your submission. Now that has been done, we can move on. I will hand over to Mr Martin to ask the first question.

Mr MARTIN: My first question is about suicide on the worksite. It seems to me that suicide could be linked to a particular worksite, including a mining site. Could you elaborate on your opposition to the exclusion of death by suicide? Could you also touch on apparent suicides—that is, situations where it is not clear if it was a suicide or not—and what should happen there?

Ms Coles: Perhaps I could answer that question by reference to the coronial jurisdiction generally and suicides or apparent suicides which are reported to the coroner. Under the current regime, any deaths which are unnatural, including death by suicide, are reported to the coroner. Where a death by suicide occurs in custody or in care, there is a mandatory inquest. This recognises the important public function that coroners have to investigate deaths where people's liberty has been removed or where they are particularly vulnerable, such as those in care. Where a death occurs by suicide outside of those environments, a coroner could still hold an inquest if they consider it was in the public interest. We have been involved in a number of inquests involving suicide which have all looked at systemic problems surrounding the person's death, and usually that has been in the healthcare system.

Our problem with the bill the way it is currently drafted is that it excludes suicide from the mandatory reporting investigation and inquest process to the specialist Mining and Resources Coroner. We think that is a missed opportunity for the specialist knowledge and jurisdiction of the Mining and Resources Coroner to be applied to all deaths that occur on a mining site which might be influenced by the particular conditions of that worksite or of that workforce. Our submission is that the committee should adopt the principles that exist in other specialist settings, like deaths in custody and deaths in care, for the specialist setting of the mining and resources industry.

Mr MARTIN: Essentially, what I am hearing is that in other situations suicide requires mandatory reporting but the proposed legislation explicitly excludes it. Do you see that there would be some sort of problem with this new Mining and Resources Coroner looking at all suicides on mining sites? Would it be a prohibitive workload? If they were to find it were a suicide, could you see any problems with that? 'Could they manage it?' is more or less what I am saying.

Ms Coles: If I could clarify, there is a mandatory reporting requirement for all suicides currently, regardless of where they occur. The difference is that for suicides which occur in a specific setting, like custody or care, there is a mandatory inquest requirement. Currently, suicides are reported to the coroner in the region where the death occurs unless they are a death in custody or a death in care, which must be reported to the State Coroner or the Deputy State Coroner.

In relation to the specialist jurisdiction of the mining coroner, it would make sense, following that kind of regime, that suicides which occur on a mining site be reported mandatorily to the Mining and Resources Coroner. It is not within my knowledge to answer what that would look like in terms of workload for that particular coroner, but it is my understanding that all coroners carry a case load of between 200 and 300 deaths at any one time. I understand from the explanatory memorandum and the briefing in relation to this bill that the Mining and Resources Coroner will also have a general coronial case load as well as a specialist case load. I would not have thought it would create an overwhelming burden on the specialist coroner to ensure that all mining and resource related deaths were reported to that specialist coroner.

Mr G KELLY: In the bill it excludes a death with the words 'the person's injury is not intentionally self-inflicted'. Is there a possibility that a worker may commit suicide onsite but make it seem like an accident, and would this result in an inquest, in your view?

Ms Coles: Yes, we are a bit concerned about the wording of the exclusion in the bill which is that it excludes deaths that are intentionally self-inflicted. In the coronial jurisdiction generally there is a presumption against a finding of suicide unless there is clear evidence that the person intended to cause their own death. I think that could be a problem in terms of the way the section is interpreted by those reporting deaths to the coroner—so either by the police, who are the people who are predominantly reporting deaths to the coroner, or within the Coroners Court—to work out whether the

death should go to the specialist coroner or to another coroner. In relation to inquests, potentially there could be an inquest held into the death that was subsequently found through that investigation process to be a suicide.

CHAIR: Before I go to the member for Bundaberg for a question, I indicate to other witnesses who are present that there are documents on the table that are the Department of Justice's responses to your submissions. If you would like to read their responses, they have now been tabled and they are now online. The committee may reference those responses in questions to you. If you would like to avail yourself of those, please do.

Mr SMITH: The chair just pointed out the Department of Justice responses, which I imagine you have not had a chance to see. I will read a portion related to deaths onsite by suicide. The response states—

... there may be a range of reasons for a person's suicide that are not related to the operations of a mine, coal mine or petroleum and gas site or to an operator's safety and health obligations.

When coroners investigate suicides, are they only investigating the physical cause and then the reaction that caused the death or are they also looking into other social factors around the mental cause as to why someone would inflict physical harm on themselves?

Ms Coles: It is the broader approach that is taken by coroners. Under the Coroners Act, a coroner investigating any death, whether an inquest or not, has to make particular findings. That is under section 45(2) of the Coroners Act. They have to find where the person was, where they died, when they died, how they died—which is their medical cause of death—and the circumstances surrounding their death. The finding required around the circumstances surrounding the person's death looks at all of those other social, psychosocial or external factors which might have led to the person taking their own life, if we are talking about suicide in particular.

Mr SMITH: There can be many different reasons people unfortunately take their lives. It could be their own personal demons. It could be bullying within a workplace. It could be extended fatigue and expectations of prolonged time away from home in terms of being required to do more shiftwork and so forth. Surely, when we talk about health and safety obligations to an operator it goes beyond the physical and extends to the mental wellbeing of an individual; does it not?

Ms Coles: Yes, it does.

Mr SMITH: In the Coroners Act 2003, a reportable death needs to meet subsections (2) and (3) of section 8. Subsection (2) talks about (a) the death happened in Queensland. Subsection (3) talks about (c) the death happened in suspicious circumstances or (d) was a healthcare related matter. In many ways the loss of a life through suicide can be the tragic end result of a number of health related matters, especially around mental health, but it could also be related to other physical ailments that have triggered an emotional response. Would that be correct?

Ms Coles: That would be correct. For a death to be reportable as a healthcare related death, there has to be a connection with the health care that a person was provided or not provided. A suicide is actually reportable as an unnatural death under section 8 of the Coroners Act.

Mr SMITH: Looking at it through a healthcare lens, would things like not screening for dust lung diseases be a healthcare related matter?

Ms Coles: That is a complicated question. For a death to be reportable as a healthcare related death, the Coroners Act says that the health care has to have caused or contributed to the death or the failure to provide health care has to have caused or contributed to the death.

In relation to diseases caused by exposure to things in the workplace, like dust related diseases or asbestos related diseases, section 14 of the Coroners Act requires that the State Coroner issue guidelines to all coroners about the performance of their function under the act and they have to apply them when they are investigating a death to the greatest extent possible.

The State Coroner's guidelines address this issue of whether industrial diseases are reportable deaths or not. The State Coroner's guidelines current state—

By convention, diseases due to the longstanding effects of repeated or relatively low-level exposure to chemicals are generally not regarded as unnatural.

They would not be reportable under the State Coroner's guidelines currently. The guidelines specifically give examples of deaths from mesothelioma or dust induced lung disease. They say that they are not reportable because the diseases that develop ultimately involve the complex interplay between environmental and genetic factors. It is difficult for a coroner to specifically isolate the cause to the industrial exposure that a person has had. That is the position currently.

Mr DALTON: Klaire, thank you for your contribution so far. My question is on location. You are talking about suicides within a mine site, which I understand is a defined area. How would you react to the mining coroner looking at suicides within the mining camp and also to and from work—say, a single-vehicle crash?

Ms Coles: We think suicides within the mining camp should be included within the jurisdiction, because, effectively, people are being required to stay in that place in order to perform their work in the mining sector. We did not mention it in our submission, but we would also support the submissions that we have seen made by the Queensland Law Society and other submitters about motor vehicle accidents which occur on public roads but relate to people travelling to or from a mining site. I think it is well recognised that issues like fatigue and other work related pressures can have some influence on that kind of accident which would be of benefit for the mining coroner to review.

Mr DALTON: Would I be right in saying that a coroner could order an inquest for both of those types of locations, whether it be at the mining camp or on the road to and from their place of work? They could order an investigation and subsequently an inquest if those things happen at the moment—so there would be no change, would there?

Ms Coles: Yes, they could do that at the moment, but it would not necessarily be investigated by the Mining and Resources Coroner. It could be investigated by another general coroner at the moment.

Mr DALTON: What is the advantage of having it included in the legislation under the mining coroner?

Ms Coles: Because you are creating a specialist jurisdiction with a person who will have specialist knowledge, who can develop their understanding over time and who can make consistent recommendations which might improve practices, that is the benefit—to harness that specialist jurisdiction.

Mr MARTIN: I have another question in relation to suicide. I am concerned there might be a situation where a family does not want to hold an inquiry. Maybe they want privacy or having an inquiry might expose sensitive or personal medical information, or something like that, or it might not meet the public interest to pursue an inquiry. You mention in your submission that that issue could potentially be dealt with by a scaled model where everything had to be mandatorily reported but an inquiry was not mandatory. Could you elaborate on the scaled approach?

Ms Coles: Yes, that is right. That is what happens now in relation to deaths by suicide, except where they occur in custody or care, where there is a mandatory inquest. A death could be reported to the specialist Mining and Resources Coroner but an inquest only conducted if the coroner considered that was in the public interest, which is the same as the regime currently. That way one of the factors the coroner could take into account when determining whether it was in the public interest to hold an inquest is the views of the family about that public process occurring. That is what happens now in relation to those deaths where there is not a mandatory inquest.

CHAIR: Thank you very much, Klaire. Our time has come to an end. Thank you very much for giving us your time today. It has been very valuable and insightful. Thank you again for your submission to the committee's inquiry. Hopefully we can talk more soon.

Ms Coles: Thank you very much.

DICKSON, Ms Kate, Head of National Operations and Queensland Director, Association of Mining and Exploration Companies

WARDEN, Ms Amy, Queensland Policy Manager, Association of Mining and Exploration Companies (via videoconference)

CHAIR: I now welcome representatives from the Association of Mining and Exploration Companies. Please remember to press your microphone on before you start speaking and off when you are finished. Good morning. You heard the spiel I gave before so I will not go through that again. You are welcome to provide an opening statement before we start our questioning.

Ms Dickson: Good morning, committee members, and thank you, Chair and Deputy Chair. I am Kate Dickson, the Queensland Director of the Association of Mining and Exploration Companies. Hopefully I am joined online shortly by Amy Warden, our Queensland policy manager. I will begin by respectfully acknowledging the traditional owners of Queensland, the original explorers of this land.

The Association of Mining and Exploration Companies is a national industry body representing over 550 mineral exploration and mining companies across Australia, with almost 80 having operations primarily based in Queensland. Our members are mineral explorers, emerging miners, producers and a wide range of support businesses working in and for the industry. AMEC's Queensland members explore, develop and produce minerals including bauxite, copper, graphite, mineral sands, phosphate, rare earths, tungsten, uranium, vanadium and zinc. I would like to highlight four areas that are covered in our submission.

The current definition of 'area' in the Coroners (Mining and Resources Coroner) Amendment Bill is deficient, potentially leading to ambiguity and misinterpretation in the application of the law. AMEC recommends that this be revised to consider all tenement types relevant to all mining activities in Queensland, thereby ensuring clarity and consistency across the legal framework.

Our second point relates to the definition of 'activities' under the Coroners (Mining and Resources Coroner) Amendment Bill. For instance, it may not adequately cover exploration activities or environmental rehabilitation efforts. AMEC recommends that this be revised to consider all tenement types relevant to all mining activities in Queensland.

The exclusion of the definition of a mine under the Mineral Resources Act 1989 means that mine activities that operate specifically under that section of the legislation are also potentially excluded. This should also be reviewed. The term 'suicide' is currently excluded. AMEC recommends that the use of this term be reviewed, as it is at odds with the intention of the coronial inquiry to determine the cause of death.

We appreciate the opportunity to address you today on the key points AMEC believes will foster a robust and consistent approach to what is a commendable commitment by the government to the resources community through the Coroners (Mining and Resources Coroner) Amendment Bill. We welcome your questions.

CHAIR: Can you help the committee with the first point you raised, the term 'area'. I note that schedule 3 of the bill talks about mining tenure, exploration permits, mineral developments et cetera, and proposed new section 11AAA talks about the definition of a coalmine. Can you help the committee understand the term 'area' a bit better, please?

Ms Dickson: The department's response seems to address those sorts of mineral tenures under the Coal Mining Safety and Health Act, but I need to review it better because our main concern is under the Mining and Quarrying Safety and Health Act and whether exploration permits and other tenure types are covered under that act.

Mr MARTIN: I have a question about self-harm and suicide. I note you also say that suicide should be included. The Coronial Assistance Legal Service, which appeared before, suggested a staged approach wherein reporting suicides to the mining coroner was mandatory but it should then be up to them to decide whether to proceed to an inquiry. Could you expand on your position on relation to that?

Ms Dickson: The main point we want to get across is that we do not know if it is suicide until there is an inquiry, so calling it anything initially does not make any sense. We can go with 'death', 'unnatural death' or anything, but with the term 'suicide', until there is an inquiry—unless it is very obviously suicide—you just do not know. Going back to your main point around a staged approach, I have not read Klaire's submission but it sounds reasonable.

Mr MARTIN: Could you share with the committee from your experience and your members the prevalence of suicide within your industry? Do you have any particular research on it? Are there particular stressors faced by mining workers, FIFO workers?

Ms Dickson: We are a national industry association, so we have lots of exposure to the Western Australian work on this. One of the key issues, particularly in exploration, is something Klaire touched on around the drive-in drive-out aspects of exploration. One of the key points is around travelling to and from work and issues around fatigue and whether it is fatigue or suicide, which Klaire also touched on in some of her responses.

Mr MARTIN: Do you think travelling to and from work should also be included?

Ms Dickson: Yes.

Mr G KELLY: Would it be better to refer to definitions in the Mineral Resources Act 1989 to ensure the Mining and Resources Coroner has the clarity to explore all deaths as part of mining related activities?

Ms Warden: The key points we want to raise are that the inclusion of area activities in a mine under the Mineral Resources Act would provide—we do not want to see that excluded specifically. We would like to see them included.

Mr SMITH: Going back to the acknowledgment around suicide, you made a really good point about making a predetermination of the cause of death. In the Coroners Act 2003 the word 'suicide' only appears in relation to domestic and family violence because under the act it would be a violent or unnatural death that is being inquired into. Just to reiterate, is AMEC saying that suicide should not be something that is taken out because it is actually a predetermination before it goes before the coroner—that any death onsite should be investigated to see whether or not it is related to a mining injury of sorts, because it is a predetermination?

Ms Dickson: Yes, that is correct.

Mr SMITH: Essentially, any death on a mine could be for any reason until it has been established by the mining coroner.

Ms Dickson: Yes.

Mr DALTON: Expanding on travelling to and from, what advantage would there be to a mining coroner investigating that unnatural death—be it through a crash, through fatigue or through mental health issues—as opposed to the general State Coroner?

Ms Warden: When you look quite deeply, the coroner is already addressing significant matters in the resources industry so he is already going to have the predisposition and the experience to look at those matters, as opposed to a separate coroner. If he is already dealing with other matters for coalmining, for P and G—and obviously we would like to see the Mineral Resources Act—he is going to have that experience and knowledge around the industry and he is going to have a deeper understanding of what is required to undertake that investigation, as opposed to a separate coroner.

Mr DALTON: Have you seen any failings from the general coroner to date on investigations to and from a mine site?

Ms Warden: No. It is not failings. I would think it is just the time that it takes to probably have a deeper understanding of what goes on within our specific industry. Also, when you are looking into an investigation, you are covering off between different pieces of legislation and law as well as taking a deeper look into the workplace health and safety metrics that wrap around the industry. There is quite a lot that goes into the resources industry to develop a safe workspace or potentially failings for a safe workspace, so if the coroner already has a deeper understanding of that it is going to potentially mean that he will have a really good understanding of how to conduct that investigation and follow through with any findings.

Ms Dickson: I might follow up on improvements that have happened in operating mines because of an additional focus on fatigue type issues—that is, improvements to night shift and shift timings to try and help workers manage their fatigue and help them get home safely after they have had long shifts. There have been good outcomes by having a focus that is detailed.

Mr DALTON: There certainly has. Mining companies are really on board with that, which is good.

Mr SMITH: The member for Stretton asked whether mining coronial inquests should also relate to travel to and from mine sites. Do you believe they should also be extended to mineral loading on ports and rail lines?

Ms Warden: I think you will find it difficult when you start to talk about ports, if you are going to draw the connection there. When we talk about to and from work, I think we are talking about that explicit duty of care that comes with the association of having performed work at that site and then getting home safe. When you start to talk about separate activities, you are then having to distinguish between where the duty of care of one function starts and another ends. They would be my thoughts specifically on that.

Mr SMITH: Thank you. Kate, do you have the Department of Justice's response to your submission in front of you?

Ms Dickson: Yes.

Mr SMITH: I take you to their response around the definition of 'area'. With the chair's indulgence, could you have a quick skim over the department's response to your concerns in your submission around the definition of 'area' and whether or not that satisfies your concerns?

Ms Dickson: Honestly, I will have to take that on notice. Something I will note from this is that a lot of the responses say that if it does not address our concerns then the general coroner will pick that up anyway. I think you will hear a lot throughout today that having the specialist coroner is what is really important here. I will have to take that on notice. Amy has not seen this response.

CHAIR: Thank you. We will follow that up if you like, member for Bundaberg.

Mr SMITH: Thank you.

Mr G KELLY: Obviously, the main risk on mine sites is during active operation. While it may not be as common through the exploration and rehabilitation phases, is it something that we should be ensuring is in the bill to help make sure we do not see repeats of incidents?

Ms Warden: Definitely. We do not want to see an exclusion of activities. If we were to drill down specifically to exploration, exploration can occur on the high wall and anywhere from the high wall back to the edge of the tenure. We do not want to see an exclusion of activities where people are arriving at the resources site, they are performing works for the purposes of winning that resource and then there are potentially unforeseen circumstances that result in death. We definitely do not want to see that delineation with activities because exploration is the key part of any resource activity in Queensland. That formed a very strong foundation for the submission that we put in.

Mr G KELLY: Thanks, Amy.

Mr MARTIN: You mentioned that you think it would be good to have driving to and from work and suicide included. What does your organisation think about including diseases like black lung or silicosis that could be linked to work?

Ms Dickson: We do not really have a position on black lung because we do not have any coal members. Silicosis is still an issue with any exposure to silica dust.

Mr MARTIN: If you are going to have driving to and from work and broaden it to use this coroner who has the specialist knowledge of the mining sector, does it make sense to include any diseases that people acquire on a worksite in a mine?

Ms Dickson: Yes, that would be a logical progression.

CHAIR: Thank you. This is an open-ended question to either Kate or Amy. I note in some of the statistics that were given to the committee that very few mining accidents have gone to inquest. There were 27 deaths from 2014 to 2024 and inquests were held into only two of these. Could you give the committee some background on this? Prior to this bill being introduced, what was the process for dealing with accidental deaths, particularly in mining activities? What we are saying now is that this bill will make it mandatory for the new Mining and Resources Coroner to investigate accidental mining deaths. I am asking why only two have gone to an inquest in the last 10 years. I am just trying to get my head around this. I am not from the mining industry so I apologise if my ignorance is part of the problem. The committee needs to understand fully what the bill entails.

Ms Warden: I am not sure how the process works in the background in terms of which deaths then form a full investigation. What I would say for ourselves and our background is that—where I live in Central Queensland is very much in the heart of mining country—I think appointing the coroner gives a greater sense of support and reassurance to mining communities that, when these unfortunate events occur, there is that degree of scrutiny around what has gone wrong. What AMEC really wanted to convey is that we support the establishment of a specialised coroner into these

events because they can be quite difficult and complex to unpack as to what has gone wrong. Sometimes there is not one individual systemic failure but it has still resulted in the death of a worker in the resources industry. I think it is incredibly important to have this type of specialised coroner in our state. It signals to our workforce and to the people who want to be involved in the resources sector that we value their life, and I think that is incredibly important.

CHAIR: Thank you.

Mr MARTIN: One of my concerns from listening and reading the submissions is the legislation's potential to complicate the process of coronial investigations. Instead of having a public interest test, there will be mandatory investigations but only if the death is reportable under section 11, and that seems to be what a lot of the committee has been talking about—what is reportable and what is not. I am concerned there will be potential disagreements with workers, worksites and families about whether something was reportable or not. One thing that has been floated is the idea of a review. Do you think it would be worthwhile building a review into the legislation in, say, 12 months time to see how things are going?

Ms Dickson: I do not know if 12 months will be long enough. Hopefully we will not have any deaths to investigate.

Mr MARTIN: Of course.

Ms Dickson: Hopefully 12 months will not be long enough, but I think a review would be a good idea.

CHAIR: I have a question with the emphasis on this unfortunate issue of suicide within our community, particularly in the mining sector, and the work and the advocacy that has been around. Has it been prevalent that people have been pushing for this issue to be included as a reportable incident?

Ms Dickson: There has been an increased focus on psychosocial safety and recognition that that is a significant part that leads to unnatural deaths.

CHAIR: Did you have anything to add, Amy?

Ms Warden: In our submission we provided two very clear examples suspected suicide and unnatural death directly within the industry. Both of them were in circumstances where I was working in the industry, so I was highly aware of them. I think they really demonstrate why we think this is an important matter that should be included.

Mr SMITH: This may potentially address your concerns about the definition of 'area'. I am just going through the Department of Justice response that is there in front of you. It states that the new section 11AAA relies on the existing definition of 'coal mine' to mean a coalmine within the meaning of section 9 of the Coal Mining Safety and Health Act 1999. I appreciate that you may not have that particular act in front of you, but I just wanted to read the meaning of 'coal mine' under that act. It says—

a place where on-site activities are carried on, continuously or from time to time, within the boundaries of land the subject of a mining tenure.

Based on those words, would that seem satisfactory in terms of where you are looking for an area being a place that is a tenement mining area that may not be a coalmine but there is continuation work such as exploration and so forth? Would that satisfy your concerns around different tenement types when in the act it is referring to it is addressing that a coalmine is defined as a place where there is, from time to time, work within the boundaries of a mining tenure?

Ms Warden: I do not think it is adequate when we look at the range of tenements. When we talk about the range of tenements, that is specifically relating to a mining lease—an ML. In Queensland we have any number of variations on that—we can have EPCs, MDLs, MLAs and the list goes on and on—and it would not be sufficient. They are all different types of tenement, all aimed at the winning of the resource and can go through various versions of operation, from exploration through to full operation and downscaling to care and maintenance. It would not cover everything that we see on ground in Queensland.

Mr SMITH: Could you elaborate further? The member for Burnett and I are very much across MDLs—at least one particular one. Where there may be boundaries set for a tenement, are you seeking a clear definition that there must be some sort of activity by an operator? Otherwise, you could have an incidental death on that land but completely unrelated to the operation itself. Are you just asking for greater definition of what actually makes an area an area in terms of operational works?

Ms Warden: I think so. We just want to explicitly not exclude the definitions for winning of mineral from a place where it occurs. That is the definition under section 6A(1) of the Mineral Resources Act. The activity itself within the area still has to be an activity that is for the winning for the resource. If there is another activity that is occurring—for example, I think earlier they were talking about agricultural activities that may be occurring—and a death may occur but it is not related to the resource activity, we understand that there can be that delineation, but if the activity is for that purpose—so exploration and/or other that we would normally see—we really want to make sure that is included.

Mr SMITH: Wonderful. Thank you, Chair.

Mr G KELLY: Your submission talks about the ambiguity around what could be considered a mining activity and makes valid points around rehabilitation and exploration activities potentially not being covered under this bill. How would you recommend adjusting the definitions to ensure the bill is covering all mining activities?

Ms Warden: When we look at the range of activities around especially site establishment, recommercialisation and relinquishment—we looked specifically into this example that we provided around potentially agricultural activities and/or rehabilitation activities—what we want to see is that they be completely encompassed. It is a difficult one to resolve, but the reason we want to be able to see that is that we still feel there would be accidental deaths in such scenarios that would fall under the jurisdiction of the appointed Mining and Resources Coroner that were being performed for the purposes of the operator and/or the resource company to resolve their obligations under a range of other pieces of legislation in Queensland and are part of that resource activity.

Mr MARTIN: I want to ask your organisation's opinion on the make-up of the mining coroner's office if it is established. Do you think it should be one person or would it be better to have maybe a pool of magistrates appointed? What is your opinion on that? Should it be just one individual?

Ms Dickson: We do not have an opinion on that, apart from having a group of people—one or more—that specialise in investigating this would be worthwhile.

Mr MARTIN: Finally, is your organisation happy with consultation? Have you had some consultation with the department about this? What has been the consultation process you have had outside, other the committee process?

Ms Dickson: Amy attended most of the briefings.

Ms Warden: We were provided with the fact sheet, which was good; that gave us a great summary. We attended the briefing, which was also good. I think there probably was not as much detail as what we have heard today. Even just listening in in the lead-up to appearing, I have already made a few notes of additional things that have come out. There is definitely scope to provide a little more context into the specific nuances of what would and would not be included. I think that could be of benefit in the future because it is potentially quite a very complex thing to unpack for the everyday person, especially if you have not had any knowledge or exposure around such topics before.

CHAIR: Thank you, everyone. There is one question that was taken on notice with regard to the definition of 'area'. The member for Bundaberg and I both asked a question around that. Could we have that response by 1 August if that is possible, please. Thank you very much for your time and thank you very much for your presentation here today. We appreciate it.

HILL, Mr Jason, Industry Safety and Health Representative, Mining & Energy Union Queensland District

HUGHES, Mr Mitch, District President, Mining & Energy Union Queensland District

KIDD, Mr Blair, Industry Safety and Health Representative, Mining & Energy Union Queensland District

SMITH, Mr Craig, Industry Safety and Health Representative, Mining & Energy Union Queensland District

CHAIR: Good morning. I invite you to make an opening statement, after which committee members will have some questions.

Mr Hughes: Thank you, Chair and committee members. I would like to start introducing the MEU's industry safety and health representatives: Jason Hill, Craig Smith and Blair Kidd. As we outlined in our submission, MEU Queensland is opposed to the bill in its current form. We struggle to see how the proposed bill will make the industry safer and deliver answers and information to industry and families any quicker. It is our view that the proposed bill will only add another investigation process which can and still will be impacted by the potential of prosecutions, causing the same delays that we currently experience. This is clearly outlined in the material provided as part of the consultation process which states that, consistent with current practice, to avoid jeopardising the likelihood of a successful prosecution inquests cannot proceed until all relevant proceedings have been finalised.

We take issue with some other aspects of the bill in its current form. Echoing the previous group, we have concerns around the scope of the deaths to be investigated. It is our view that deaths by suicide which may have a link to the workplace and deaths which occur whilst travelling to and from the workplace, camp or coalmine worker's residence should also be included. Further, we raise that the scope should also include deaths caused by diseases such as black lung or other dust related diseases. Those diseases are long-latency diseases which develop over a period of time and can sometimes not be diagnosed until after a coalmine worker has retired.

We have raised concerns in our submission around the appointment and the term, which seems to not be limited to a five-year term similar to other coroners. We have also proposed in our submission that the bill should consider an approach similar to the one captured by Tasmania in their legislation by taking into account the wishes of the family when it is being decided whether a fatality should be investigated. In its current format the bill states that it is mandatory for all deaths to be investigated. We think this does not factor in certain circumstances such as the wishes of the family. We think those things should also be considered.

Everything that I have raised has been covered in our submission. To put it bluntly, it is our view that this is just another investigation process on top of three investigation processes that already can occur. It is not the mining warden; it is different to that. MEU Queensland do not think it will deliver the outcomes that the minister continues to advocate for. It will not make our industry any safer and the mechanisms that we think the government should consider are already included in the current legislation. With that, I am happy to pass over to the ISHRs or the committee for any questions.

CHAIR: You might have overheard that I am not from the mining industry—I am a broken-down builder—but I am interested in the introduction of a new process and a new coroner. You would have heard my question about the inquests that have been held to date in relation to the 27 deaths over the last 10 years. I am curious about your comments—I am not trying to put words in your mouth; correct me if I am wrong—that an extra resource under a new scope outside the Coroners Act does not add extra value.

Mr Hughes: The part of that process we take issue with is that it still has the ability to be caught up when there is a potential prosecution. As it is now, where there is a potential prosecution information is not released because people might have the ability to incriminate themselves and things like that. The fact sheet that was released as part of the consultation process outlines the same thing: where there is a potential prosecution, the inquest will not be held and the information will not be released and we will see the same delays. We are not opposed to an extra resource for something like this, but how that resource is executed will be caught up in the current process. To go further, under the current legislation there is an ability to call a board of inquiry. I think that has been utilised once or maybe twice in the past. It is our view that we could probably learn from that as to how to execute it better.

CHAIR: I think there have been two inquests since then.

Mr MARTIN: You touched on the appointment of the coroner. My understanding is that coronial positions are currently five-year appointments; however, this legislation essentially means that this position will be an appointment for life or until the magistrate has to retire at the age of 70. My understanding is that they cannot be changed unless they resign. Could you expand on some of the problems that might cause, especially if that individual might be seen to be leaning one way or another?

Mr Hughes: The main issue we have with that is that you potentially have someone in the same or a similar position who is not subject to the same or similar scrutiny. Changing things out every five years might help with different perspectives on matters. I do not understand why we would introduce this coroner but not ensure they are subjected to the same conditions or term of appointment as other coroners.

Mr MARTIN: What if there was a pool of maybe three or 10 coroners?

Mr Hughes: We have not had much discussion around whether or not there is a pool. The other issue to factor in is experience in the industry. I understand that a coroner has the power to call in experts as they see fit, but having some exposure to the industry prior to taking up the position would be beneficial, too. That would apply whether there are one, three or five.

Mr G KELLY: Fatigue is a big issue for a lot of my constituents in Mirani. They are known as the 'high-vis brigade' because they all rely on going over the hill to work to make a coin—and they are pretty proud of it, too. I know that the safety standards around fatigue management can vary across different mines—whether they can drive home straight after they finish their stint or they need to rest before getting on the road, to mitigate the risk of a crash as a result of fatigue. For clarity, would you want the coroner to look into every road death of a miner when they are travelling to and from the work site to ensure proper fatigue management was in place?

Mr Hill: I do believe that needs to be the case. If we are looking at fatalities in the mining industry, road deaths would be miles above the fatalities that happen onsite. Our position is that these people have died as a result of work related incidents. To get back to the legislation, the objectives of the act under section 7 require that the act protects people from coalmining activities. That is not just the person who is fatigued on the road; it is also innocent bystanders who are put at risk. If this bill goes ahead, I believe that the coroner needs to look at all road fatalities of miners travelling backwards and forwards to work.

Mr SMITH: Gentlemen, thank you for being here to represent your union and the members that make up that mighty union. I note the member for Mirani's support that we include travel to and from sites in this legislation. That is a fantastic revelation. The reason we are establishing a dedicated mining coroner is that mine sites have particular practices in terms of health and safety standards. Is it fair to say there is also a unique culture on mine sites, especially when people are staying for weeks at a time and are working long hours? Is a mine site culture different to the normal nine-to-five workplace culture in your view?

Mr Hughes: I think that goes without saying. Mines operate 24 hours a day, seven days a week and for some mines that includes Christmas Day and Boxing Day as well. It is not your general Monday to Friday, nine to five; there are rotating shifts of day and night. In the black coal mining industry the longest roster we have at the moment is seven on, seven off. There are companies pushing to extend that, which brings its own set of additional risks. Yes, is the short answer; we are different to other industries.

Mr SMITH: I suppose there is an expectation of responsibility of mining sites and the organisations running them that they are not only providing proper physical workplace health and safety but also identifying where there may be stresses or pressures put upon the mental wellbeing of people in terms of the length of work and even returning to work after a serious injury, whether or not the mental state of miners is such that they should go in there. Would it be fair to say that organisations need to take responsibility for the mental health and wellbeing of their employees onsite?

Mr Hill: Definitely because psychosocial issues or injuries are really prevalent. The rate of workers compensation around psychosocial injuries is well above physical injuries as a trend. A lot of these injuries are created by the workplace, if not associated with the workplace—and again I go back to the objectives of the act, which is to protect people from coalmining operations not just the coalmine workers at the coalmine. It is pretty broad in how we are supposed to protect them. Again, psychosocial issues of people being isolated and the employment arrangements of contractors and labour hire put extra pressure on people. The way some companies investigate and their systems around investigations put pressure on people. All these little things add up to create big psychosocial injuries that lead to suicides.

Mr DALTON: Thank you for your time today. Would you thank your members for the expertise they have in this area. In Mackay many of my constituents are miners and they work very hard; basically they are the engine room of the economic processes within Queensland. On that matter, you were talking about the fact that the mining coroner would have an open-ended contract as such. One of the reasons I think that is a good thing is the expertise that mining coroner will gain during investigations. As you quite rightly say, some of these investigations have to wait until after the criminal aspects of that matter have been completed. Therefore, the mining coroner's expertise will increase with time. If we curtail it to five years, that expertise will disappear and another mining coroner would then be appointed. Do you have any comment on that?

Mr Hughes: I would go back to our prior comments that under the current legislation the ability is there for a board of inquiry to be conducted. In that board of inquiry the expertise would already be there.

Mr MARTIN: Following on from what previous members have said, I acknowledge the work that your union has done over many years to improve safety on mine sites in Queensland and Australia. That being the case, I am interested to know how the MEU was consulted in the process of drafting this legislation and are there any members who have advocated for this change?

Mr Hughes: I am aware of a handful at most of members who have taken an interest in this approach. In terms of how we were consulted, we had one consultation briefing, we had a reply to our initial response to the consultation draft and we are here today.

Mr MARTIN: Is that enough do you think?

Mr Hughes: Sorry, once the announcement was made that this approach was going to be taken, we did seek a meeting with the minister and were given that meeting. In terms of whether it is enough, as we continue to talk about this and flush out each other's concerns, more could always be done as the information is provided and views change. A bit more detail and some more discussion around that detail as responses were given would have helped, but here we are.

CHAIR: I am curious about the stats that were reported. I think it has been reported that coroners have oversight of 200 to 250 investigations. Without raising the issue of families, which is really emotive and distressing, I am curious about your experience in terms of how we deal with those families while those investigations are going on. Mitch, did I hear you right in your opening statement that the delays were a concern about those investigations? Maybe you could explain that to the committee. We would like to hear more about that.

Mr Hill: I will add to that a bit. Firstly, in terms of the delays, we agree that families and friends need to have closure so they understand what happened to their loved one and why it happened—so nature and cause, what recommendations are going to be put in place to prevent similar accidents happening and another family suffering the same result. In our submission we said that there are three investigations that are done. For a timely matter—and this is what this coroners bill is supposed to perform. However, it will not because if there are legal proceedings, you have to wait for those to be concluded and that could be five years. If we have three investigations—generally you have the RSHQ, the company and us doing an investigation—it would not be hard to make a change in legislation so that the nature and cause findings of investigations are made public or provided to the family within a 12-month timeframe. I think that would be a much fairer and more realistic proposal to provide closure for the families. Even with a coroner's inquest, we still have to do an investigation.

Then if there are legal proceedings you have to go to the public prosecution and that draws out, so we could be waiting for a longer period. I know of ones that are still going to court now who have waited three, four or five years and they are still waiting. If the mining coroner were in place, we would still have to wait for their inquest and for them to put that on the table as well. It would be pretty tough. We have had four fatalities in the last calendar year. It drags out. If we can get a proposal where all three parties put their investigations on the table and make them public, I think that would be much easier and provide better closure for the families—just the nature and cause and the recommendations to rectify the issue. You do not have to put blame on the table at that time.

CHAIR: Prior to this bill being introduced, when was the last time active attempts were made to change the process? It is a fact that there are problems with it; you have concerns with it. I am curious about how far back there were active attempts to change the act or to make the process better?

Mr Hill: It probably was not thought about, honestly, until this bill came up and I personally started thinking about it. Other than that, if the families reach out, it is having those conversations with families.

CHAIR: Tough, yes.

Mr Hill: I have had those personal conversations with the families and I just tell them what I know at this time. Obviously you do not want to play the blame game, but you will describe to them the findings you found and you may help to prevent that cause again. I have done that and to me that does help them—it gives a little bit of closure, if you know what I mean—but is not a full report they can consider. Obviously, that still leaves the realm of prosecutions for blame later if they think they need that process to get full closure. You can put both apples in the one cart and get a decent outcome.

Mr MARTIN: Could the union share with the committee its experience in relation to self-harm and suicide in the workforce, especially amongst your coalmining members, and also what effect a mandatory inquiry could have on the workforce or the family of that miner?

Mr Hughes: Both of us have unfortunately had to deal with this several times. It is our view, and we have made it known in the submission, that the scope should be broadened to include suicide and self-harm. We say that because, unfortunately, we have come across and had to deal with those matters several times—where someone may have committed suicide in a camp, for example. I had a personal friend who committed suicide at their house in Moranbah. In both those circumstances it was because of the workplace culture or allegations made about their conduct and how—Jason touched on it before—things are investigated by some companies and things like that. There is a direct link there to the workplace and it is our view, in short, that those things should be investigated.

Mr Hill: The scope has to be more than just on mine sites because, as Mitch is saying, these suicides happen offsite but the link relates back to work—being affected by the work. If the suicide happens at home or in a camp or somewhere and there is a link that takes it back to work, this is when they need to step up and they should form part of the coroner's brief.

Mr G KELLY: The safety of you guys is above and beyond. It has really come along very strongly and it is noticed. Where I come from in the electorate of Mirani—as I said before, it is the high-vis brigade—safety is a big thing. I worked at Stanwell for 16 years pushing coal and unloading coal trains, and it was safety first and it is increasing in strength. Something that does boil me a bit is that how you operate on mining sites is unbelievable but when it comes to renewable sites they have dropped the ball. How do you feel with how it is going—with the tens of thousands of people you guys employ and try to look after; you do a good job of that—with renewable companies? We have just had an incident on one of the projects and, to me, it has been just pushed aside, which is unfortunate. In your industry it is up in lights. Do you think renewables should be able to meet the same criteria as you guys do? At the moment it does not and I feel it is hard for you guys with the strengths you have. We have to be on a level playing field. Do you find that in your industry?

Mr Hughes: If we are comparing industries, we do not have a lot of coverage in the renewable sector. We do not step into there. At the end of the day they are a resources industry, in my view, so they should be subjected to the same standards.

Mr SMITH: Returning to onsite, around health care for instance, are there physicians and clinicians onsite—doctors, nurses, psychologists—that are available with immediacy that miners can contact?

Mr Hill: I would not say there are doctors. Some places will have a nurse and some places will have paramedics onsite, but that is probably the limit to it. They will have doctors in town that they have on retainers, but, practically, you might have anyone from a first aider to a paramedic and maybe an onsite nurse, but that is the limit.

Mr SMITH: I ask that because, under the current Coroners Act, when it comes to a reportable death there is subsection (3), and part of it is that the death was a healthcare related death. Under the proposed bill, that has been removed from consideration. If a miner has gone off, has returned from a healthcare matter and then dies onsite, with the way the bill currently is the mining coroner would not be able to deem that a reportable death and, therefore, even though the death occurred onsite, they would not be responsible for the investigation of that death. Should health care be considered as a reportable death if the death occurs onsite?

Mr Hill: When you explain it that way, I agree it should be. I look under our legislation. Any death onsite has to be reported to the inspector and reported to us. I attended one only a week or so ago with a coalmine worker who collapsed. We are still waiting for the findings, but it was deemed as a heart attack at that time. But if it is healthcare related, definitely. Again, what happens offsite does affect what is onsite. We all know and have experienced in the past where people attend a company doctor and then rush back to work so—what would you say?—the statistics do not look as bad as

they really are and then they are placed back in the work environment when they probably should not be and they could be affected by different aspects—whether it is medication, whether it has been a proper diagnosis or the injury has not been treated sufficiently.

Mr Hughes: Probably to go that extra step, agreeing with what Jason has outlined, you also run into an issue where a lot of these mines are remote, so if we do need first responders to come from the nearest town or we need the rescue chopper we are waiting quite some time, and you are relying on that initial treatment to maintain a coalmine worker's life and health. I think that initial health treatment they are given onsite whilst we unfortunately have to wait for emergency services is also critical and should be captured.

CHAIR: I thank the union for turning up and putting in your submission. It is very detailed and very comprehensive. Thank you very much. That will be the end of our session with you today. We look forward to dealing with you in the future.

COOK, Ms Bridget, Senior Policy Solicitor, Queensland Law Society

MOSCHELLA, Mr Adam, Member, Queensland Law Society Criminal Law Committee, Queensland Law Society

TATE, Mr Rohan, Member, Queensland Law Society Industrial Law Committee, Queensland Law Society

CHAIR: Would you like to make an opening statement, after which we will have questions for you?

Ms Cook: Thank you for inviting the Queensland Law Society to appear today. In opening, I would like to respectfully recognise the traditional owners and custodians of the land on which we meet. As the committee is likely aware, the Queensland Law Society is the peak professional body for the state's legal practitioners. We are an independent apolitical representative body that promotes good evidence-based law and policy.

We understand these reforms are founded on an election commitment made by the government. We consider the recommendations in our written submission will give effect to the intent of these reforms. The explanatory notes provide—

The aim of the Bill is to provide more timely answers and certainty to families that mining related deaths will be investigated and an inquiry conducted to determine the cause of the death, prevent similar deaths happening in the future and to keep mining companies accountable.

The Mining and Resources Coroner will be able to make public findings and recommendations to prevent similar deaths from happening in the future.

There are two broad categories occurring within mining and related industries that are, however, outside the scope of these reforms. These are: deaths from a motor vehicle accident occurring on a journey to or from work where the worker was the operator of the vehicle; and deaths occurring from illness or disease, such as a dust disease, caused by the work undertaken at a mine site or related in scope to work. The advice from the department is that these deaths could be referred to the Mining and Resources Coroner if the circumstances warrant it. However, the society considers this optional referral system will create undue uncertainty and delay, particularly if there is ambiguity in the legislation or guidelines. The bill's objectives are best achieved by including these deaths within new section 11AAA(3). We respectfully ask the committee to make this recommendation.

We are aware other submitters have objected to deaths by suicide being expressly omitted by the bill. The QLS agrees there is a public interest in bringing these deaths within scope in appropriate circumstances, noting the psychosocial hazards in the workplace are increasingly being exposed and examined. We urge the committee to recommend further consultation be undertaken on these issues.

Today I am joined by Adam Moschella, a member of the QLS Criminal Law Committee, and Rohan Tate, a member of the QLS Industrial Law Committee. We are happy to take the committee's questions.

CHAIR: Considering that this is an election commitment and we are introducing a new position and a new process, I am curious, as I asked the union, about suicide by car accident, deaths to and from work and the issues of black lung. Was there advocacy on that before the bill was introduced?

Ms Cook: I believe the answer is, yes, in consultation prior to the bill.

CHAIR: It was raised?

Ms Cook: Yes.

CHAIR: What about three, four years or five ago? We have been speaking in the parliament about black lung for many years now. Currently under the Coroners Act there is no scope for them to be examining black lung and car accidents, is there?

Mr Tate: I think car accidents were within the scope of the Coroners Act and I can take you to a specific—

CHAIR: It is section 8, from memory.

Mr Tate: There was a specific inquest that looked into that. I can give you the citation. It is from 2011. The view is that if we are going to have a mining and resources coroner who will look specifically into these issues, that specialist knowledge should be used for those things. Certainly, there have been fatigue related inquests for DIDO workers who have died when driving in or out. The case is MacKenzie, Brown and Wilson, and there are three file numbers, but it is dated 23 February 2011.

That looked at Moranbah to Mackay, I believe, and at those driver related fatalities. It is certainly already something that the Coroner's Court has looked into, but now we will have a specialised mining and resources coroner so it would make sense, I think is the submission, that those matters are considered by that specialist person because that is what they are there to do.

CHAIR: Thank you for that clarity.

Mr MARTIN: I have a question about appointments and I asked this of the union, as you might have heard. The bill will not limit the term of the appointment of the Mining and Resources Coroner. I understand there are currently five-year appointments but that can be renewed, a bit like it is with the State Coroner. Does the Law Society have an opinion on that? Should there be a pool of people, say, three or 10 or something like that, or one person appointed for life? Should there be limits on how long the Mining and Resources Coroner is appointed?

Mr Tate: Probably the position is there should be equality or sameness across all appointments. I think that is probably the position.

Mr G KELLY: You touched on deaths from disease and illness such as dust disease. You do mention additional issues to navigate around time between exposure. Do you have any thoughts about how that would be applied if they were to be included in the bill?

Mr Tate: It is certainly an interesting one because it is some decades, perhaps, from the incident to that particular point in time. Perhaps it is an alert mechanism when someone passes away or has that disease. It may be that they are in a healthcare setting in any event so it might be something that is triggered under the mechanisms that already exist in the Coroners Act. Perhaps that is how it then comes to the attention of the Mining and Resources Coroner, to look into that particular issue. The causation is likely to be if it is a particular silicosis-type disease from a mine site, if someone has worked there for 30 years. Probably there are some things to work out in the mechanics of how that actually operates but there are a few practical things that we can consider.

Mr SMITH: Following on from the question of the member for Stretton, are there any senior positions created through Queensland legislation that are lifetime appointments?

Mr Moschella: From my understanding, mainly the heads of jurisdiction have a compulsory retirement age of 70 or otherwise they resign. I think there are also powers under the relevant legislation to effectively dismiss those people if the circumstances permit. I think that would vary in the different courts. For example, if I take the district, supreme and magistrates courts, each has their own respective acts that deal with the appointments of those heads of jurisdiction. My understanding is that it is 70 unless they otherwise resign.

Mr SMITH: Is it the case that coroners have a five-year term and then they have to be reappointed?

Mr Tate: We are happy to take that question on notice. I think in one of the submissions something was specifically raised about whether or not there are any current perennial appointments. We could take that on notice and return to you with a more fulsome answer.

Mr DALTON: Some concerns have been raised by previous witnesses to say that the mining coroner will not speed up investigations for a complete and final story to be given to the family so they can understand why their loved one has died. My understanding is that a criminal prosecution occurs or is likely to occur or has to be investigated, which will hold up any inquest. Do you think there will be any change in the speed with which that ultimate finalisation would happen if we had a mining coroner or a state coroner investigating it?

Mr Tate: I think the short answer is, no.

Mr MARTIN: Say we move from a system where essentially we have an inquest because there is a public interest test to a system in mining where there is a mandatory inquest. What about situations where there is no broader public benefit, the death was clearly due to a well understood cause like a heart attack and there was no evidence of systemic issues? An inquest might not uncover new information or improve safety. An inquest could expose sensitive personal or medical information, and we have been talking a lot about suicide as well and the effect that can have on the family. One of the previous submitters, the Coronial Assistance Legal Service, suggested a staged approach with suicide, where the reporting was compulsory but the inquest was up to the mining coroner. Can you share with the committee your views on having a mandatory inquest in that situation?

Mr Moschella: Ultimately, it would come down to the public interest requirement. Whether or not an inquest would be in the public interest would be assessed by the coroner on a case-by-case basis, and the views of the relevant parties within that process would obviously come into consideration. If the public interest outweighed the views, for example, of the family or people close to the person who passed away, a coronial inquest may be warranted. It is really difficult. What is in the public interest is never stagnant; it changes over time. It is a tough question to answer in a sense. Ultimately, there are a number of considerations under that public interest umbrella that a coroner could have regard to when deciding whether or not to hold a coronial.

CHAIR: Did you have something to add, Mr Tate?

Mr Tate: Yes, I did. The views of the family are very much considered as part of that process. If a particular view was put forward by the family, that would certainly be listened to.

CHAIR: In your submission you talk about a duplication of the processes of the coal mining safety act and the new role of the boards of inquiry. Could you enlighten the committee on how that is a problem inasmuch as it is a new role specifically around mine related injuries?

Mr Tate: The board of inquiry has a specific function and purpose. I do not think there have been many, in my experience, but that can be helpful. In terms of the Mining and Resources Coroner, that function is more or less a specialised function of what a coroner would normally do. I am not sure if that quite answers your question.

CHAIR: From the evidence we have read, the coroner or the workplace resources health and safety group currently have 200 to 250 investigations underway. As I have said before, only two deaths out of 27 have actually gone to an inquest. How do we see the duplication concern that you raised in your submission not being beneficial to getting those investigations underway and dealt with?

Mr Tate: We might need to take that on notice, because I would want to look at those two specific inquests and then work out what other matters are at play at the moment. It may be that a few are still running through the system from the last 10 years.

CHAIR: I would not force you to take that on notice. I was just curious about your thoughts on how this new role would not be adding value to the processing of these 250-odd investigations that are currently sitting on coroners' plates. I do not need that on your plate or on mine. Thank you for your evidence.

Mr SMITH: I have a question that relates to the changes. The current bill proposes that under new section 11AAA a person's death is a reportable death under section 8(3)(b) of the current Coroners Act. From my reading, that would exclude section 8(3)(d), which states that 'the death was a health care related death'. That could be health care that should have been provided or reasonably provided but was not provided at the time, or that could be there was a failure to provide proper health care and a death occurred onsite. What is the QLS's position on removing from the mining coroner the ability to mandatorily investigate matters around failed healthcare provision that occurred onsite as well as when seeking medical assistance after an injury occurred onsite?

CHAIR: That was long preamble, member, and a little bit leading as well.

Mr Tate: The position of the QLS is that the functions and role of the Mining and Resources Coroner should be expanded, and certainly a corollary of that would be that health related deaths should not be excluded. I think that is a logical next step.

Mr SMITH: Thank you for that. By only allowing section 8(3)(b) to be taken into consideration for a mining related death, which excludes self-inflicted injury, does it essentially box in the matters to be investigated by the mining coroner to effectively be incidents or deaths that have been caused by machinery? If you take away everything else except 'a violent and unnatural death' and if you are not able to review deaths that were self-inflicted or where there was mistreatment of health care, does it read as though this only relates to machinery related deaths onsite?

Mr Moschella: I do not think so. My view is that the current wording of the proposed provisions is wide enough to effectively capture myriad circumstances. I do not think the aim of the provision would be to specifically exclude a machinery related death. I am not sure if the carve-out would really exclude that.

Mr SMITH: If it is not looking at health care and if it is not looking at suicide, what other kinds of deaths would it be mandatorily investigating?

CHAIR: I guess it would be the interpretation of the act.

Ms Cook: It is our view that that question might be better directed to the union, which has more expertise on the actual conduct and activities that are undertaken on the various sites.

Mr DALTON: I want to go back to the location of these deaths that may be investigated by the Mining and Resources Coroner. Do you as an organisation have any comments on where those lines of investigation should lie?

Mr Tate: As a general proposition, we have remote mine sites that people are driving in and driving out of, or flying in and flying out of, and are only there as a consequence of the work. In terms of the submission around fatigue related or driving fatalities, the view is that they should be included because people would not be there but for the fact that they are travelling for work.

We had a discussion about how we might think about suicide—however you want to frame that, given the submissions from others. For example, if someone walks offsite into a car park that is no longer on the mining lease, does that mean they are no longer covered? There would be a question about that, and there might be some consideration given to a temporal element. If people have left the mining lease or tenement—however you want to describe it—and gone somewhere else or returned home to Moranbah where they are living, there would need to be some consideration around that. A discussion that we had was that that could be a fruitful area for further consultation.

Mr DALTON: I am also looking at the rehabilitation of a mine once it has closed. You would recommend that to be included?

Mr Tate: Currently, it would depend on whether or not that is still captured by the acts. We would have to go and have a look at that.

Mr Moschella: I do not want to add too much on, but you also need to look at the definition under section 9 of the Coal Mining Safety and Health Act as to what is a coalmine. It is a very broad definition. Obviously, the definition specifically stipulates what a coalmine is but subsection (2) further clarifies the definition and extends to things like accommodation, such as camps, administration buildings and associated facilities, which could capture car parks and the like. It is a very wide definition. I do not think it is aimed at being overly exclusionary. The definition of a mine site itself under the legislation is very broad and is designed to capture those ancillary types of locations where coalmine workers would specifically or commonly be.

Mr MARTIN: I have a question about the possibility of including a review in the bill as it stands at the moment. A common theme among witnesses and submitters seems to be that the legislation could potentially complicate the process of coronial investigations, so going from a public interest test to a mandatory test where a death is reportable under section 11. I am concerned there are going to be disagreements about what is reportable and what is not. Do you think there should be a review built into the legislation?

Mr Tate: I think it is always sensible to have a review when we are doing something new.

Mr MARTIN: Great answer.

Mr G KELLY: Your submission touches on very similar issues to those contained in the MEU submission around referrals for road deaths involving travelling to and from site. This is an important issue for my constituents, especially given the quality of some of the roads to our mines in that country. For clarity, can you give the reasons road accidents involving workers travelling to and from site should be included in the bill?

Mr Tate: Certainly, and I can probably refer back to the coronial inquest that I brought to the committee's attention earlier. It has already been documented that driving in and out from site and coalmine workers' fatigue can lead to fatalities and has an impact on society. If we are going to have a specialised Mining and Resources Coroner then this should be within the ambit because that is part of the skill set that I think we would be hoping that Mining and Resources Coroner builds.

Mr Moschella: I also think it is difficult to say that it is irrelevant when you have sites where there are specific controls in place to manage fatigue. Sites have pyjama days, but people are required to keep logs and all those sorts of things. It is hard to say it is not relevant when sites are actively taking steps to ensure fatigue management. Those two things are at odds with each other in terms of carving it out.

Mr SMITH: I appreciate the doubling down by the member for Mirani. Given you are able to cite a previous inquiry related to fatigue and road incidents, are there any examples of coroners' reports indicating the fault or responsibility of an organisation on a mine site when it comes to deaths by suicide?

Mr Tate: I am not aware of one as yet in respect of mining. That does not mean that there is not one, and we can certainly take that question on notice and have a look. With the current focus on psychosocial hazards as a general societal risk, my view is that there will be coronial inquiries that will address that in due course.

Mr SMITH: The Law Society is suggesting that there should be investigations into dust lung diseases, for instance. Is it the view of the QLS that those amendments would actually have to be made to 'reportable death' in the Coroners Act 2003 and that we would, therefore, also need to amend the bill to establish that under subsection 11AAA? The first step would have to be an amendment to 'reportable death' in the Coroners Act; is that correct?

Mr Tate: I had not turned my mind to drafting, I must admit. We can certainly take that on notice and come back to you. That could be one way of achieving that legislative aim, if that is the intention of parliament.

Mr MARTIN: I had a question about workload. How do you think the bill as it stands will affect the coroner's office? How do you think the legislation as it currently stands, which limits the number of deaths to not include suicide, lung diseases or travelling to and from work, will impact that office? If we expanded it to include all mining deaths, which is what quite a lot of submitters have suggested—including suicide, lung disease and travelling to and from work—would that office be able to handle the workload?

Ms Cook: That might be informed by a review. That would be my only comment at this stage.

Mr Tate: The only thing I would say is that driving in and out is probably something that is a reportable death covered by the current Coroners Act so that workload would move over.

CHAIR: Before we close, we wanted to make sure you have the questions that were taken on notice. I have one on the Coroner's retirement; is that correct?

Mr SMITH: It was not retirement. It was, under Queensland legislation, how many appointments are made for a lifetime.

CHAIR: There were another two, if I recall correctly.

Mr SMITH: I believe the QLS said that they would take on notice whether or not the Coroners Act 2003 would have to be amended to include dust lung diseases and then the bill amended at subsection 11AAA.

CHAIR: Can we ask that those answers be provided by 1 August.

Ms Cook: That will be fine.

CHAIR: That concludes the hearing. Thank you to everyone who participated today. Thank you to Hansard, as always. A transcript of these proceedings will be available on the committee's webpage in due course. I declare this hearing closed.

The committee adjourned at 12.36 pm.