Coroners (Mining and Resources Coroner) Amendment Bill 2025

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QUEENSLAND PARLIAMENT PRIMARY INDUSTRIES AND RESOURCES COMMITTEE

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

SUBMISSION BY QUEENSLAND CORONIAL ASSISTANCE LEGAL SERVICE

(TOWNSVILLE COMMUNITY LAW & CAXTON COMMUNITY LEGAL CENTRE)

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The authors are able to appear remotely at any hearing should the Committee wish to take evidence from them and consent to the publication of this submission.

BACKGROUND

The Queensland Coronial Assistance Legal Service is a statewide service provided by Caxton Community Legal Centre and Townsville Community Law Inc.[1] The Queensland Coronial Assistance Legal Service:

- provides legal advice about any aspect of the coronial process and associated issues
- can provide representation for bereaved family members appearing in some inquests when the matter fits within our casework guidelines
- works with other service providers and can help families connect with social work, counselling and other support services.

[1] Townsville Community Law provides services in the Northern and Central Coronial Areas, whereas Caxton Community Legal Centre provides services within the Brisbane and Southeastern Coronial Areas. See the 'Coronial Support Unit Areas of Responsibility with Government Undertaker Boundaries Queensland' at https://www.coronerscourt.qld.gov.au/__data/assets/pdf_file/0007/795220/ccq-coronial-map-gcu-boundaries-as-at-march-2024.pdf

This joint submission addresses some of the Bill's proposed amendments to the *Coroners Act 2003* (Qld) (the Act), in particular, the new jurisdiction of the Mining and Resources Coroner (the MRC).

Our **overarching concern** is that the Bill removes the mandatory reporting, investigation and inquest functions of the MRC in suicide deaths, which includes suspected suicides. Our view is that the Bill removes the ability to place specialist scrutiny on industry specific and systemic factors that may contribute to deaths by suicide occurring *in situ* in mining and related operations[2] and within the FIFO community. The Bill does this by excluding suspected suicides and suicides from the MRC's jurisdiction.

EXCLUSION OF DEATHS BY SUICIDE

We note the Bill provides:

> ***11AAA Deaths to be investigated—mining related reportable deaths***
> *…*
>
> *(3) A person's death is a mining related reportable death if—*
> *(a) the person's death is a reportable death under section 8(3)(b); and*
> *(b) the person dies at any time after receiving a mining related injury that—*
> *(i) caused the death; or*
> *(ii) contributed to the death and without which the person would not have died; and*
> *(c) the person receives the mining related injury—*
> *(i) at a coal mine; or*
> *(ii) at a mine; or*
> *(iii) at or in a petroleum and gas site; and*
> *(d) the person's injury is not intentionally self-inflicted.* (Emphasis added)

We note the Explanatory Notes to the Bill provide:

> *The Bill provides that a mining related reportable death does not include an injury that a person has intentionally self-inflicted i.e. suicide. These deaths are excluded because 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. Mandatory inquests into the death of a person by suicide may also retraumatise the family of the deceased person.*
>
> *…*
>
> *Any death that is a reportable death, for example a suicide or a car accident, must be investigated by a coroner under existing provisions of the Coroners Act. It is intended that under existing powers in the Coroners Act, the Mining and Resources Coroner will conduct an investigation into all reportable deaths related to the mining and resource sector and may decide to conduct an inquest if it is in the public interest. For example, this power could be used where a coroner investigates 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*. [3]

We see the Explanatory Notes' description as contradictory and potentially at odds with the objects of the Act and the stated objects of establishing the MRC.

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[2] As defined by the Bill.

[3] Coroners (Mining and Resources Coroner) Amendment Bill 2025, Explanatory Notes, pp.5-6.

The Explanatory Notes describe, as a context and rationale for the Bill, that suicide deaths are usually otherwise reportable pursuant to section 8 of the Act, namely because they involve:

- a deceased of unknown identity;[4]
- a violent or otherwise unnatural death;[5]
- a death in suspicious circumstances;[6] or
- where cause of death certificate was not issued.[7]

Additionally, we note the State Coroner's Guidelines describe a range of reportable deaths involving suicide, for example, while police are conducting a welfare check, thereby becoming reportable during police operations.[8] Within this context, impact of the Bill appears to be three-fold:

1. Suicide (as framed) is excluded from mandatory reporting as a 'mining related reportable death': **proposed section 11AAA(3)(d)**; and

2. Suicide (as framed) is excluded from mandatory investigation by the MRC: **proposed section 11AAA**; and

3. Suicide (as framed) is excluded from mandatory inquest by the MRC: **proposed section 27(1)(a)(iv)**.

Our concerns with the Bill include:

- The exclusion of suicide deaths is not in the public interest because of the higher prevalence of suicide deaths of FIFO and industry workers and in FIFO communities; and

- The Bill's (and the Act's) objects could be better achieved by including suicide deaths, or alternatively, providing a scaled approach in suspected suicide cases where reporting and investigation were still within the mandatory remit of the MRC, but where the holding of an inquest was at the MRC's discretion; and

- Reliance on the qualifier that the suicide death was one that was intentionally self-inflicted is ambiguous, and antithetical to the Bill's (and the Act's) objects; and

- How intentionality will be assessed, including by reporters and the Coronial system;

- The Statement of Compatibility did not address the exclusion issue.

PREVALENCE OF SUICIDE IN FIFO COMMUNITIES

Suicides in mining are a contemporary societal and industrial issue that should be proactively addressed by the Act. Mining is recognised as a locational, institutional and occupational setting with an elevated suicide risk. There is well established evidence that "FIFO communities are at a greater risk of suicidal behaviours than the general population due to the stigmatisation of help-seeking once

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4 See section 8(3)(a), *Coroners Act 2003* (Qld). See State Coroner's Guidelines 2013 Chapter 3, p.5.
5 See section 8(3)(b), *Coroners Act 2003* (Qld). See State Coroner's Guidelines 2013 Chapter 3, p.6.
6 See section 8(3)(c), *Coroners Act 2003* (Qld).
7 See section 8(3)(e), *Coroners Act 2003* (Qld). See State Coroner's Guidelines 2013 Chapter 3, p.27.
8 See section 8(3)(h), *Coroners Act 2003* (Qld). See State Coroner's Guidelines 2013 Chapter 3, p.29.

suicidal ideation occurs".[9] Suicide in mining has important age and gender dimensions.[10] For example, it is estimated that the prevalence of suicide amongst male mining workers is 25 per 100,000 and increasing.[11] This more than double the age-standardised rate of 11.8 per 100,000.[12]

This leads to our starting point that the MRC is a specialist, industry-specific position, and the full extent of its novelty, innovation and expertise should be utilised. Accordingly, we view the MRC is the most appropriate point for notification, investigation and hearing for any death *in situ*.

We are concerned that suicide deaths (as excluded) may be difficult for reporters to identify with certainty. For example, accidental deaths (which, *prima facie*, are a 'mining related injury') might appear intentional (which aren't a 'mining related injury') and not be referred to the MRC. Types of deaths that might fall into this cohort include accidental falls from height, accidental overdoses, and accidental physical injuries.

The Bill's differential approach essentially requires a process where either the death reporter (usually QPS via Form 1 Police report of death to a coroner), or the Coroner's Court, to identify whether a death was caused by an intentionally self-inflicted injury before it is excluded the MRC's purview. In our view, there are two preferred options:

- **Our recommended approach** is that any death *in situ* should be mandatorily reported to, investigated and inquired into (by inquest) by the MRC in order to identify personal and industry-specific concerns; or

- **Our second recommended approach** is any death *in situ* should be mandatorily reported to, and investigated by the MRC to identify personal industry-specific concerns relating to the individual's death and that the holding of an inquest should be discretionary, taking into account a balance between the interests of the deceased's family and the interests of the public – including regulating the safety of the private mining industry and its importance to the State and its economy.

We submit the question of holding a mandatory inquest should not be dismissed for reasons relating to family trauma. It is an important consideration, but we note that other situational or institutional suicides are subject of mandatory inquests such as deaths in police operations, deaths in care and deaths in custody. Additionally, we note deaths in care and deaths in custody often involve private actors. In our experience, acting for families in coronial proceedings, there are also many families who want deaths, including suicides thoroughly investigated including at inquest.

Additionally, we note that the Explanatory Notes suggest an additional rationale for the exclusion is there may be a range of reasons for a person's suicide that are not related to the MRC's jurisdiction. This may also be the case in other mandatory inquests noted above. However, there is strong public interest in looking at the setting and circumstances of deaths through the coronial lens, particularly where

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9 Jackson, J., & Ross, V. (2025). Understanding Suicide Stigma in Fly-In/Fly-Out Workers: A Thematic Analysis of Attitudes Towards Suicide, Help-Seeking and Help-Offering. *International Journal of Environmental Research and Public Health*, *22*(3), 395. https://doi.org/10.3390/ijerph22030395;
Gardner B, Alfrey K, Vandelanotte C*, et al* Mental health and well-being concerns of fly-in fly-out workers and their partners in Australia: a qualitative study *BMJ Open* 2018; **8:**e019516. doi: 10.1136/bmjopen-2017-019516

10 King, T.; Maheen, H.; Taouk, Y.; LaMontagne, A.D. Suicide in the Australian Mining Industry: Assessment of Rates among Male Workers Using 19 Years of Coronial Data. *Saf. Health Work* **2023**, *14*, 193–200.

11 Ibid.

12 See https://www.aihw.gov.au/suicide-self-harm-monitoring/overview/summary

environmental, occupational or other idiosyncratic factors may be creating a greater risk of harm to a cohort, such as suggested by Australian research.

We note that there is industry support for the inclusion of suspected suicide in the Bill.[13] Further, other jurisdictions with mandatory inquests into mining deaths do not explicitly exclude suicide.[14]

THE QUALIFIER IN CLAUSE 11AAA(3)(d)

We are concerned that the exclusion of suicide (as framed) may treat psycho-social injuries differently, and with a lower priority than other types of mining related injuries, such as those of a physical nature. We concede that deaths by intentional self-injury are not only experienced by those where a psycho-social or mental health condition was present.

The most recent 'Suicide in Queensland Annual Report 2023' noted Key Findings:

> The number and proportion of people who died by suspected suicide and were identified as having at least one reported diagnosis of a mental illness, including depression, anxiety disorder and/or schizophrenia, was 13.2% (103 people). Diagnosed mental illnesses were more prevalent in males than in females (13.6% compared to 12.1%). Data was not reported or missing for 77.9% of people who died by suspected suicide (609 people).[15]

INTENTIONALITY

There may be cases where the element of intentionality is complex.[16] The operation of clause 11AAA of the Bill excludes suicide (framed as 'intentionally inflicted injury') from 'mining related reportable deaths'. We also note that the Bill does not define, nor do the notes explain, what is meant by the terms: 'suicide' or 'intentionally inflicted injury'. Within Queensland's legal system, intentionality in taking one's own life exists within a continuum from the clarity of voluntary assisted dying through to instances where a person acts without legal intention, such as described by the *Mental Health Act 2016* (Qld).

The issue of intentionality is always considered by Queensland's coroners and the State Coroner's Guidelines describe the presumption against suicide, though it still somewhat controversial.[17] The recent decision in *Cole v Wilson* [2024] QDC 208 reinforced the presumption in the Guidelines, finding the need for clear evidence and reasonable inferences.[18]

It isn't clear in the legislation how this will work. Who makes the assessment that the death is caused by an intentionally inflicted injury. How will reports be made and how will the reports be allocated within the State's Coronial system.

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[13] See the Submission of the Association of Mining and Exploration Companies at https://amec.org.au/wp-content/uploads/2025/05/AMEC-Submission-Review-of-the-Coroners-Mining-and-Resources-Coroner-Amendment-Bill-2025.pdf

[14] See for example mandatory mining inquests *viz* s. 10(5) of the Coroners Act, RSO 1990 (Ontario) and discussion in *Peart v. Ontario* (Community Safety and Correctional Services), 2014 HRTO 611 (CanLII). The Ontario law does not specifically exclude suicide, leaving the question open to coronial discretion.

[15] Queensland Mental Health Commission 2024, Suicide in Queensland: Annual Report 2023. Brisbane, 13.

[16] For example, in Ontario, death by suicide is a death resulting from an intentional act of a person knowing the probable consequences of what he or she is about to do.

[17] See State Coroner's Guidelines 2013 Chapter 8, p.9.

[18] *Cole v Wilson* [2024] QDC 208, para [30], per Jarro DCJ.

STATEMENT OF COMPATIBILITY

We note the Statement of Compatibility (SOC) did not examine the human rights implications of the exclusion. In our view the exclusion may be inconsistent with the *Human Rights Act 2019* (Qld) in respect of the recognition and equality before the law (sec 15) and the right to life (sec 16).

Thursday, 3 July 2025

Queensland Coronial Assistance Legal Service