Coroners (Mining and Resources Coroner) Amendment Bill 2025

Submission No:	3
Submitted by:	Bernard Corden
Publication:	Making the submission and your name public
Attachments:	See attachment
Submitter Comments:	

Primary Industries and Resources Committee
Parliament House
George Street
Brisbane Qld 4000

[redacted]

03 July 2025

Attention: Committee Secretariat

Submission - Coroners (Mining and Resources Coroner) Amendment Bill 2025

In countries under a British colonial influence most major transport or industrial disasters involving fatalities are typically followed by a coronial inquest at a coroner's court. This can be a pretty sombre and daunting place for the laity or underclass.

This anachronistic institution deals in many unexplained or sudden deaths, which are categorised via callous and often enigmatic findings such as unlawful killing, accidental death or suicide using a retrospective judgement of convenience. In Australia every state has a coroner's court and rather fortunately, very few people are seldom required to attend the proceedings. Some jurisdictions allow discretion or provide scope to hold an inquest before a jury, which may attenuate an increasing perception of regulatory capture. Nevertheless, not too many deaths are processed through the local coroner's office and even less require a full inquest.

Coronial inquests are typically held once criminal and civil liability avenues have been exhausted and a full session is redolent of many television courtroom dramas. Proceedings are conducted by the coroner from an elevated stage with a reverential acknowledgement of ascribed status.

The gallery consists of the usual suspects, which include lawyers, police officers, ushers, clerks, witnesses and jurors accompanied by the fourth estate and the general public. The intimidating theatre looks, stinks and feels like any other courtroom although the pageantry is often misleading. It can be an extremely daunting and painful place, where callow people traumatised by sudden bereavement suffer the story of death in a vacuum of unaccountability.

Exclusive and inordinately expensive barristers clash over evidence taken under oath with rigorous although often unforgiving cross examination of defensive or terrified witnesses. The exhibition occasionally meanders with a furtive attempt to establish who, whether it be individually, collectively or corporately, was or was not responsible for causing death.

However, in a coroner's court the primary objective is to establish the medical cause of death using pathological evidence with due consideration of the circumstances. Appropriate findings are delivered that should not indicate or apportion any liability, which is usually resolved via adversarial legal courts.

Following establishment of the medical cause of death and determination of findings, the body is released for burial or cremation. The intimidating void is charged with blame and guilt although nobody is on trial. There is no prosecution, defence or concerns about accountability and many seasoned barristers believe cross examining at coronial inquests is akin to working with both hands tied behind their back. It is a hopeful but often hopeless counsel of perfection.

It is not always so straightforward, especially following major transport or industrial disasters that involve fatalities. This is often exacerbated when many executive careers, substantial assets and powerful reputations are at stake. The process often becomes embroiled in political controversy, cunning chicanery and even dishonesty.

Regulatory authorities will only prosecute in accordance with defined protocols with a reasonable expectation of achieving a conviction. If criminal cases prove unsuccessful many of the emotionally shattered and distressed dependents never have the wherewithal, let alone the inclination to pursue civil action. The coronial inquest remains the only forum in which the circumstances of death will be addressed and merely affords an epigrammatic and restricted opportunity to hear and evaluate evidence.

Despite an alleged separation of powers, the coronial inquest remains an antediluvian and often preordained formulaic pageant that is often orchestrated by a politically appointed panjandrum. Witnesses and other interested parties are designated solely by the coroner and typically include the bereaved and any directly involved individual or agencies, who are forbidden to call on others to corroborate or challenge statements or testimonies.

After witnesses are sworn in their evidence is scrutinised by the coroner using previously gathered and sometimes embellished statements and then cross examined by legal representatives on behalf of the interested parties. The general conduct of proceedings is entirely under the coroner's discretion. No incriminating questions are allowed and the coroner alone determines the extent or relevance of cross examination tactics.

The coroner's summary typically reflects a judgemental opinion based on personal interpretation of events. It cannot be neutral, especially amidst a brume of regulatory capture and particularly if the state government is paying his mortgage and children's school fees. It does not require any sophisticated analysis or critical thinking to identify a coronial flavoured or favoured version of the truth.

Investigation of deaths within the coroner's jurisdiction requires assistance from coroners' officers, who are often seconded or provided via the police service. The coroner also establishes close relationships with pathologists and inquests often only hear medical or other expert evidence, which aligns with the coroner's preordained agenda.

Following unsuccessful criminal or civil proceedings the bereaved are often left abandoned and a coronial inquest is their last resort. It inspires a humble morality that it is a personal inquest into the death of their loved ones. The aggrieved are typically addressed via deferential language and the numerous ushers and clerks function like an unction of undertakers.

Initial comments are empathetically structured to emphasise that proceedings will merely establish who died and when, where and how the circumstances unfolded. The first three criteria are relatively straightforward although determining how is often fraught with complexity, especially in controversial cases where political careers, substantial assets and personal reputations are at stake.

Beneath the alabaster of humble inquiry, sympathy and sensitive acknowledgements lurks a denial of the agenda concerning how the circumstances of death can be established without apportioning blame or liability. It does not require much intelligence or discernment to appreciate the incongruity, which casts a spectre over the entire charade.

This anachronistic and dishonest forum is merely an adversarial wolf in inquisitorial sheep's clothing, which can be superficially beckoning although it is usually disappointing and provocatively painful. Nevertheless, it is often the only remaining opportunity for resolving and revealing the circumstances of death. It typically kicks the underclass in the gonads, especially when they are most vulnerable and yet another door is often slammed in their face.

Following coronial inquests or public inquiries pertinent comments with additional evidence regarding the calumny of regulatory or policy capture or unhealthy relationships between the coroner and the police service are summarily dismissed as crackpot conspiracy theories. Regulatory or policy capture is easy to identify but almost impossible to prove without a precise definition of public interest. The bereaved dependents are typically left chasing smoke with more questions than answers and invariably encounter a tyranny of bureaucracy amidst a patronising disposition of unaccountable power. The myth of closure for bereaved dependents frequently emerges but grief is a journey without a destination and the heartbroken families travel through a painfully recurring landscape of reminiscence and hindsight with noble dignity despite the burning injustice.

Despite allegedly independent investigations into fair and accountable public administration via an ombudsman, the outcome is often a forgone conclusion, which is embellished via a carefully polished, disinfected and decontaminated report. It predictably sacrifices the truth and accountability to secure assets and protect reputations of the powerful at the expense of the powerless.

Another legal irregularity that requires extensive investigation and further clarification is the incongruity of coronial inquest findings and the burden of proof covering criminal proceedings that emerged with the acquittal of the match commander following the Hillsborough soccer stadium disaster.

A second coronial inquest returned findings of unlawful killing to a criminal standard. Following some inexplicable legal chicanery in the subsequent criminal prosecution the coronial inquest findings were declared irrelevant and the jury returned a verdict of not guilty. After almost thirty years it left the bereaved families emotionally shattered with pertinent questions regarding accountability, especially after the coronial inquest findings and reiterates that justice delayed is merely justice denied.

Many of these anomalies and the deplorable treatment of bereaved dependents were evident during the Ardent Leisure Dreamworld coronial inquest. They can be addressed and attenuated by the development and implementation of Public Authority Accountability legislation, which must include a statutory professional duty of candour for public officials, Similar legislation has been successfully implemented in the health care sector throughout Victoria and overseas in the United Kingdom. It may also resolve many other controversial legal issues such as deaths in custody.

Another significant concern involves Queensland's escalating mine dust lung diseases toll which is nudging towards 700 victims. Subsequent fatalities may also require coronial inquests to establish and confirm the medical cause of death.

Recommendations

1	**Amend Coroners Act to include discretion or provide scope to hold inquests before a jury, which may attenuate an increasing perception of regulatory capture.**
2	**Introduce a Public Authority Accountability Bill that includes a professional duty of candour for public officials.**
3	**Confirm fatalities involving mine dust lung diseases will require a coronial inquest to establish the medical cause of death.**
4	**Investigate incongruity regarding burden of proof in coronial findings and criminal prosecutions.**

[redacted]
Bernard Paul Corden
T: [redacted]
E [redacted]