



Speech By Hon. Dale Last

MEMBER FOR BURDEKIN

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CORONERS (MINING AND RESOURCES CORONER) AMENDMENT BILL 2025

Hon. DR LAST (Burdekin—LNP) (Minister for Natural Resources and Mines, Minister for Manufacturing and Minister for Regional and Rural Development) (8.46 pm): I rise to contribute to debate on the Coroners (Mining and Resources Coroner) Amendment Bill 2025. I say at the outset that this bill means a lot to me. It means a lot to me because I made a commitment to the families of those miners who lost their lives in Queensland mines and quarries to provide answers. It took its roots at the Moranbah miners' memorial service many years ago where I witnessed firsthand the grief these families were still going through in their quest for answers. We need look no further than the case involving Bradley Hardwick, who lost his life on 20 February 2019 at Moranbah North, and here we are six years and eight months later waiting for a coroner's inquest, and that is not good enough. That question—when are our fallen coalminers and their families going to get justice—gets answered today.

I find it symbolic that we debate this bill on the 50th anniversary of the Kianga No. 1 mine disaster. As a result of that disaster we saw improved safety regulations for a range of activities, and those improved safety regulations were born from the warden's inquiry in Rockhampton between 10 and 24 November way back in 1975. The role of the Mining and Resources Coroner is based on one of the responsibilities of the mining warden, and that is to undertake mandatory coronial investigations and inquests into all accidental mining related deaths which will include deaths that occur on mines, coalmines and quarries as well as particular sites where petroleum and gasworks are carried out.

The role of the Mining and Resources Coroner is strikingly similar to the mining warden because the mining warden system worked, and members do not have to take my word for it. A paper presented at the 2006 Queensland Mining Industry Health and Safety Conference in Townsville described the advances in safety resulting from the mining warden's court as 'too numerous to mention'. In a media statement dated 11 May 2020, Labor's own then minister for natural resources and mines referred to mining warden's inquiries as recommending—

... safety measures that still protect mine workers today and that have no doubt prevented further incidents and saved lives over the past two decades.

It was some three months later that Labor knew the board of inquiry into the incident at Grosvenor mine was flawed. It knew because in the interim report Labor was asked to amend legislation to ensure—

... that whilst a witness' right to claim privilege against self-incrimination is maintained, the Board also has the power to compel the witness to provide all relevant evidence in public at the Inquiry.

What did Labor's minister actually do? He did nothing. Despite repeated requests for an explanation, those opposite failed to address a direct request from Terry Martin SC that was made to get to the truth of what happened. Labor's failure to compel witnesses went even further. The parents of Gareth Dodunski, Phil and Michelle, spent 10 long years seeking answers. When addressing the delay in delivering his findings, coroner MacKenzie cited a loss of important evidence as a direct consequence of the absence of the power to compel witnesses. There are some simple questions to answer: how can we provide answers to families; how can we improve safety; and how can we reduce the chance of a similar incident occurring? Those questions remain unanswered when a government fails to act. Contrast that directly with the Crisafulli government's action. The Mining and Resources

Coroner, appointed as both a magistrate and a coroner, can compel witnesses to answer questions under oath while also ensuring witnesses can claim privilege against self-incrimination, just as they can in any other court case.

I want to address some of the inaccuracies that, unfortunately, have been spread about the Mining and Resources Coroner. Firstly, some allege that the introduction of the Mining and Resources Coroner would prevent criminal charges being laid—nothing could be further from the truth. As per page 1 of the committee's report, the Mining and Resources Coroner's inquiry can only begin after the finalisation of any criminal prosecution, but to ensure timeliness the coroner may hold pre-inquest conferences while criminal proceedings are underway.

The other inaccuracy that must be addressed is duplication. As per the committee's report, 27 deaths on mine sites were investigated between 2014 and 2024 but only two of those deaths were the subject of coronial inquests. Families and resource workers deserve answers; they deserve the truth. Under the current arrangements, a coroner may conduct an inquest into a death on a mine site or quarry if it is in the public interest. This bill means that every work-related death on a mine site or quarry will be the subject of a coronial inquiry. To any member opposed to this bill I ask these simple questions: what information have we missed under the current system; how many incidents could have been prevented if any work-related death was subjected to an inquest; and, most importantly, how many lives could have been saved? Sadly, we will never know the answers to those questions and neither will the families of those who died.

I want to acknowledge in my contribution the advocacy of industry stalwarts Scott Leggett, Mark Parcell, Stuart Vaccaneo and Dr Ray Parkin in the formulation of this bill. Their knowledge, commitment to mine safety and passion for ongoing health and safety improvements in the resource sector is commendable and I know they will be relieved when this bill is passed today. I also want to place on record my appreciation for the work undertaken by Frank Windridge, Queensland's final mining warden. It was Frank who inquired into the 1994 Moura coalmine disaster that resulted in the tragic death of 11 men. Frank's report into that disaster is a comprehensive assessment of what happened and what needed to happen to prevent a similar incident. It also contains Frank's observations on the role of the government when it comes to safety in the resources sector. He said that governments 'have a duty to ensure that mining is carried out in as safe a manner as possible,' and, more pointedly, he added that 'governments have no moral right to walk away when a disaster happens and decline to accept any responsibility. They are, by association and legislation, clearly involved.'

The Crisafulli LNP government has heeded Frank Windridge's words. This bill ensures the truth and that lessons are learned because that is the moral thing to do. While the shadow minister claims that most in the industry did not think this was a good idea, the fact is that the Mining & Energy Union called for the Mining and Resources Coroner's role to be expanded. The Labor members of the committee followed suit, saying in their statement of reservation that they believe 'the Mining and Resources Coroner must be all encompassing of mining-related deaths'. They went on to say Labor won't stand in the way because of the need for 'continued updates and improvements to safety measures and the systems that enforce them'. This bill ensures we establish the truth and that the truth is put on the public record while also ensuring, where appropriate, criminal charges can be laid in compliance with current legislation. The recommendations and findings by the resources coroner will have the full weight and authority of the judicial system, as it should.

This bill unapologetically enhances the scrutiny of the resources sector to improve safety. At the 2021 Miners' Memorial in Moranbah, Scott Leggert summed up why this process is so crucial when it comes to safety when he said, 'The only way to truly say we have achieved this is when we don't add another name to the sandstone blocks before us.' If we are to learn and continue to raise the bar when it comes to mine safety in this state, then we need to be transparent. We need a system in place that delivers answers. We need a system in place that gets to the bottom of why that fatality occurred at that particular site. We need a system in place that means any recommendations that fall out of that inquest can be acted upon because that is how we improve mine safety in Queensland. That is how we continue to raise the bar in this state.

It is why we need to have a coroner that can give answers to families like the Hardwick family, who are still waiting some six years after their loved one died at a mine site for answers and who every year at the Miners' Memorial in Moranbah ask the question: when will I know? When will I know what happened to my husband, to my father, or when will we get some answers so that we can finally get some closure?

This bill is long overdue. I know those opposite have come in here tonight and are somehow making out that they are all of a sudden interested in mining safety when I have been calling for this for years. Finally, we are doing something about it. The LNP in Queensland are putting mine safety first and foremost in this state.