WHAT HAPPENS IF THERE IS A MINING FATALITY IN QUEENSLAND

An old print of a parish inquest before Mr Thomas Wakley,
MP, Coroner for West Middlesex, 1838 – 1862, and founder of The Lancet.
The figure standing on his left represents Charles Dickens, who sometimes attended his court.[1]

A paper for the Queensland Mining Industry Health and Safety Conference, Townsville August 2006,
by Laurie Verra, Coroner; John Tate, a Barrister who appears regularly as Counsel Assisting the Coroner; and Julie Dryden, an Inspector of Mines.

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INTRODUCTION

Scope of Paper

Mining in Australia promotes a strong sense of history, nation-building and contemporary wealth. The location of most mines in Queensland, at least, has also meant that mining communities have been isolated, where the communities have forged their own strong bonds and a sense of familiarity. A unifying fear within a mining town, though, has always been the possibility of hearing the mine siren, heralding the death at the mine of a loved one, a workmate and a valued member of the community.

The purpose of this Paper is to discuss what happens if there is a fatality. The perspective offered is one grounded in the requirements of the Queensland Legal System, where the authors hope the experiences of an inspector of mines, barrister and coroner may help to demystify the legal requirements and processes that flow, once there is a fatality. This paper also centres upon safety and health, as well as discussing compliance responses for a breach of the safety and health obligations imposed by Queensland's mining legislation. The paper does not touch upon issues involving civil compensation or industrial relations.

Historical Impact of Fatalities

Since 1907 in Queensland there have been 958 mining fatalities.[1] These are chilling statistics. During the last 100 years, 366 people died in coal mining and 592 people died in metalliferous mines, quarries and trenches. More recently, between 1975 and 1994, 36 lives were lost in 3 mining disasters in the Moura District. This represents 36 lives lost in a period of less than 20 years. These figures do not, however, tell the true story. These statistics do not disclose all those who suffered injuries, or were maimed, as a result of mining accidents.

It is not difficult to understand the pain and suffering that a family experiences when a loved one dies in an industrial accident. The death lacks a sense of purpose, or legitimate reason. "*It was not his time.*" "*He was a young man with a wife and children.*" "*They needed him.*" "*I loved him; he was my husband and the father of my children.*" Equally, a fatality impacts on the deceased's workmates and local community. In short, the death has no meaning and is seen as senseless. The community feels angry. The scapegoats: management neglect and a disregard for safety by all.

Fatalities, particularly multiple fatalities, have had a major impact upon public perception of the mining industry. Mines have been forced to close. Parliamentary action has provoked significant changes to

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[1] Title Page: This photograph is from *Death Investigation and the Coroner's Inquest*, Feckelton, I. and Ranson, D., Oxford University Press, 20005.

[1] DRMW, Safety and Health – Mines, Statistics

mining practices and applicable occupational health and safety legislation. The current objective based legislative model centres on risk management principles, and the imposition of safety and health obligations on all mine workers. The recent worldwide coverage of the Beaconsfield incident highlights the degree of public scrutiny, and accountability, the community can demand when a disaster occurs.

Fatality Driven Change

There are a handful of tragic incidents which have had a major impact on the Queensland Mining Industry. For instance:-

- **1921 Mount Mulligan Colliery**. 77 men were fatally injured in a coal dust explosion.
- **1972 Box Flat No. 7 Colliery**. 18 men were fatally injured (14 men underground and 3 at No. 5 conveyor drift entry) when a major explosion occurred during the process of fighting an underground fire.
- **1975 Kianga No. 1 Mine**. 13 men were fatally injured in an underground explosion following an outbreak of spontaneous combustion.
- **1986 Moura No. 4 Underground Coal Mine**. 12 men were fatally injured in an underground explosion attributed to an ignition caused by a flame safety lamp.
- **1994 Moura No. 2 Underground Coal Mine**. 11 men were fatally injured due to an underground explosion attributed to spontaneous combustion behind a recently sealed section of the mine.

The impacts the above disasters have had include:-

- **1921 Mount Mulligan Colliery** disaster resulted in the enactment of distinct legislation to govern metalliferous mining and coal mining. Further, the Mines Inspectorate was divided into Metalliferous and Coal Inspectorates.
- **1972 Box Flat No. 7 Colliery** disaster impacted on mine rescue protocols.
- **1975 Kianga No. 1** disaster resulted in significant changes to the legislation; the establishment of an autonomous safety in mines research organisation (SIMTAR); and the requirement of mines to have available a means of analysing air samples.
- **1986 Moura No. 4** disaster resulted in the prohibition of flame safety lamps; the founding of a committee to establish minimum training requirements for coal mines; and major changes that impacted on the framework for emergency egress.
- **1994 Moura No. 2** disaster resulted in the review of the Mines Inspectorate; the requirement for mine safety management plans using risk/hazard analysis; periodic assessment of statutory certificates; changes to emergency escape facilities; and changes to gas monitoring protocols.

In both Moura No. 2 and Kianga No. 1 the mines were closed and sealed and the bodies not recovered.

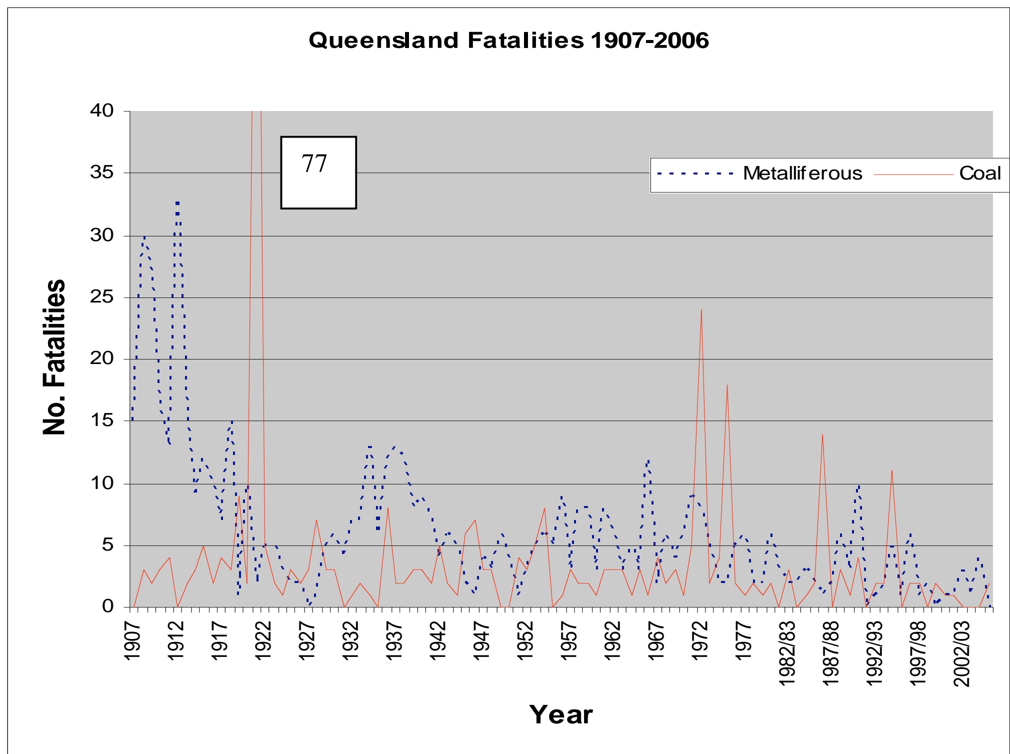
In noting the changes provoked by these multiple fatalities, it is important to also recognise advances in safety resulting from recommendations made by the Mining Wardens Court and the Coroners Court. The examples are too numerous to mention, but include welder safety switches; changes to articulation lockouts on underground loaders; training of maintenance personnel; changes to management of tyre handling; and trialling safer compressed air fittings.

Queensland Fatalities and Lost Time Injuries

The four figures below provide the background statistics that frame the ongoing struggle the industry faces to achieve the goal of zero harm. This challenge is not made any easier during the current minerals boom, where mines face significant labour and skills shortages. The recruitment of inexperienced labour and non-traditional mining contractors simply adds a further layer of complexity into the safety and health equation.

It would be wrong, though, to fail to acknowledge at the outset the strong tripartite commitment of management, employees and unions, and the Mines Inspectorate, in attempting to ensure a safe and healthy work environment. Safety is heralded, by all, as a unitary industry value. What questions are raised for the industry, then, by these statistics? How should the legal system respond?

Figure 1: Fatalities in Queensland from 1907 – 2006[2]



[2] DRMW, Safety and Health – Mines, Statistics

Figure 2: Fatalities in Queensland from 1982 - 2006[3]

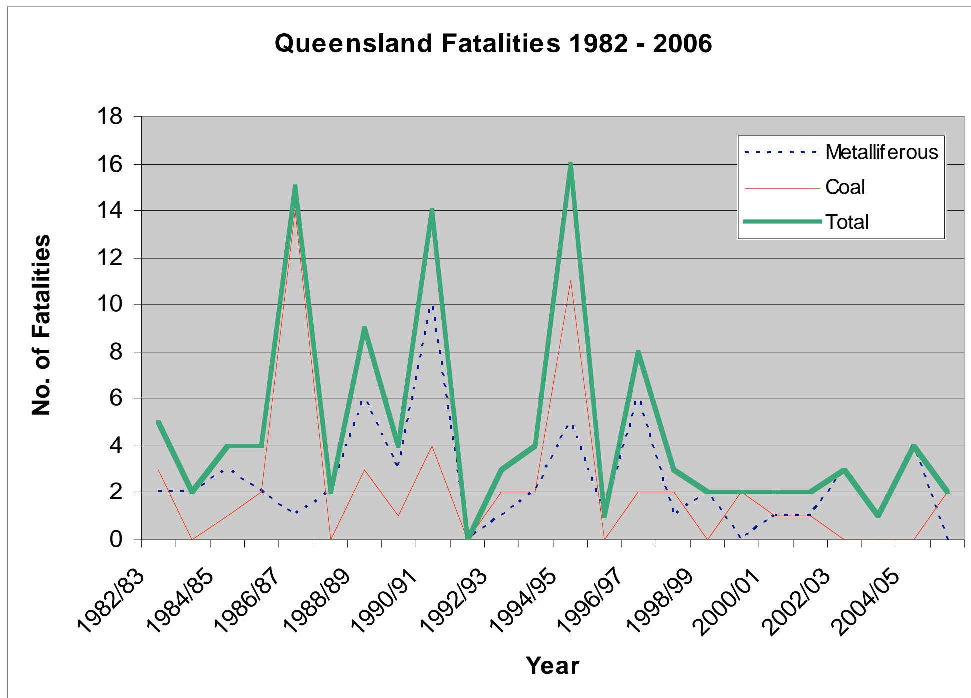
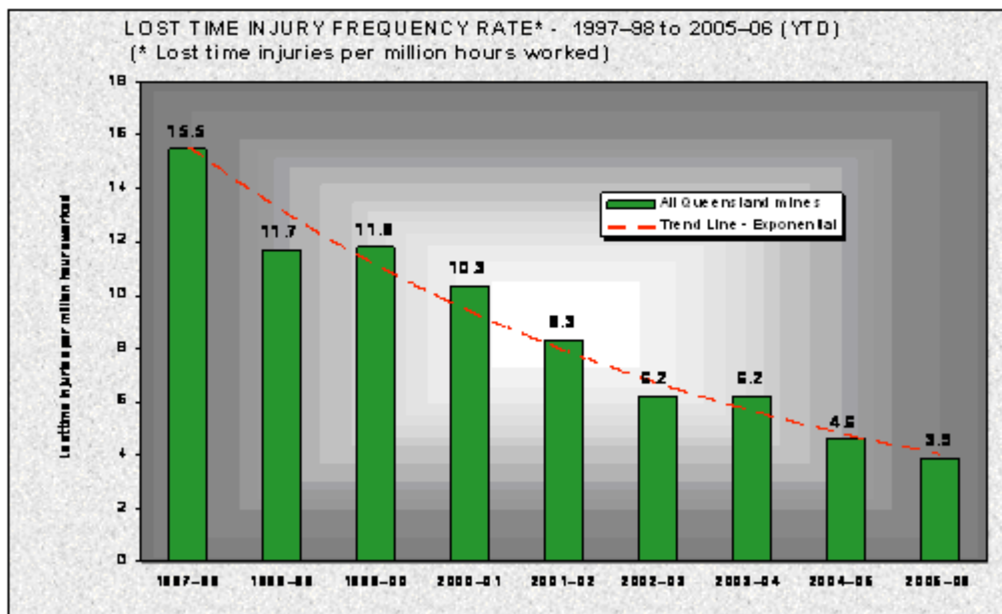


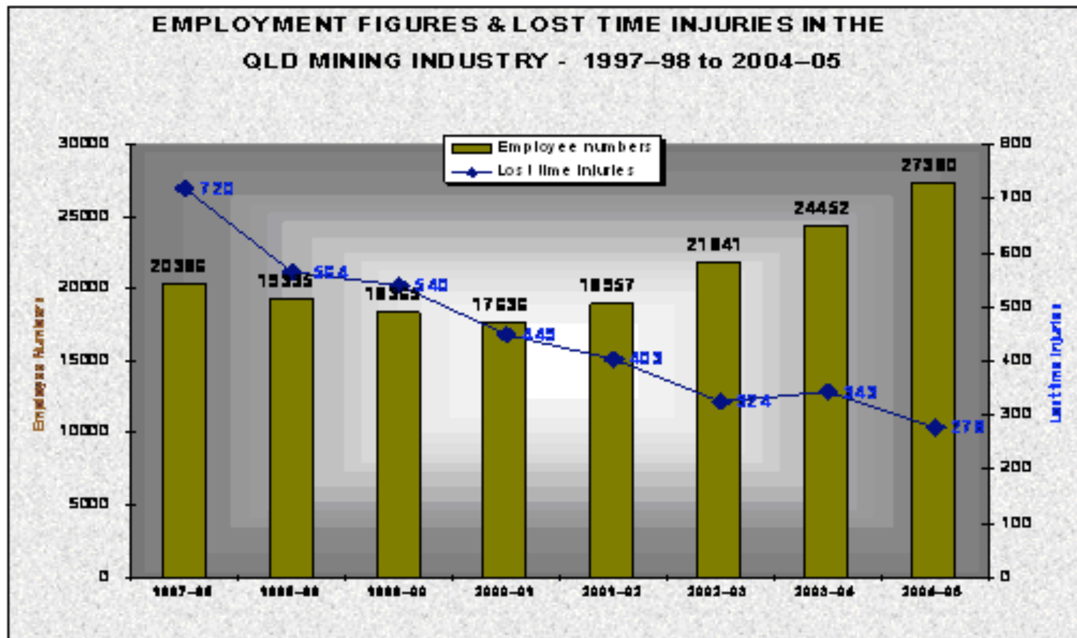
Figure 3: Loss Time Injury Frequency Rate 1997/8 to 2005/6 in the Queensland Mining Industry[4]



[3] NRMW, Safety and Health – Mines, Statistics

[4] NRMW, Safety and Health – Mines, Statistics. Note: 2005-6 figures estimate due to timing of paper

Figure 4: Employment figures and Lost Time Injuries in the Queensland Mining Industry[5]



Compliance Action and Prosecution

An industry can only continue when it has the sanction of the community within which it operates. The Union Carbide disaster at Bhopal in India, where so many died in a chemical cloud; or the environmental degradation caused through the Exxon Valdise oil spill, are examples that led national governments to fundamentally question the propriety of allowing those industries to continue operating within their borders.

Legislation is the written expression of public policy. In turn, public policy is conditioned by politics and community sentiment. The community does not accept death, or injury, through industrial mishap. It is from this framework that the overarching accountability imposed by the current mining legislation needs to be understood. All persons at a mine site, including offsite suppliers, have safety and health obligations. The simple requirement of the Queensland Parliament's mine safety and health legislation[6] is that "*a person must discharge their safety and health obligations*" to themselves and others.[7]

The question the Queensland mining industry has to address is not just how to manage a fatality and subsequent public perception. The real issue is what does the industry expect government to do when the fatality was potentially caused by a failure to discharge a relevant safety and health obligation.

[5] NRMW, Safety and Health – Mines, Statistics

[6] MQSHA 1999, CMSHA 1999 and their supporting Regulations, MQSHR 2001 and CMSHR 2001

[7] MQSHA 1999, Part 3; CMSHA 1999, Part 3

What is the appropriate response? How should the industry view such a situation? How ought the deceased's wife and children be cared for by the industry? What penalties should be imposed, if any?

Legislation

The statutory framework that governs mining in Queensland is principally to be found in the *Mining and Quarrying Safety and Health Act 1999* (MQSHA 1999) and the *Coal Mining Safety and Health Act 1999* (CMSHA 1999), together with their accompanying Regulations. These are the *Mining and Quarrying Safety and Health Regulation 2001* (MQSHR 2001) and the *Coal Mining Safety and Health Regulation 2001* (CMSHR 2001).

There are also various other statutory instruments that should not be forgotten.[8] These are the guidelines (metalliferous) and recognised standards (coal) issued by the Minister.

The mining legislation is administered by the Mines Inspectorate which is part of the Department of Natural Resources, Mines and Water (NRMW).

MINES RESPONSE AND INSPECTORATE OBLIGATIONS

Initial Response – An Overview

Under the *Coroners Act 2003*, a person who becomes aware of a mining fatality (or other notifiable death) has a statutory duty to report the death to a police officer or a coroner. A police officer to whom the death is reported must report the death to a coroner in writing.[9] The Site Senior Executive (SSE)[10] must also notify an Inspector and a District Workers' Representative (DWR) or an Industry Safety and Health Representative (IS&HR) about the incident either orally, or by notice in writing.[11] If the SSE makes an oral report, it must be confirmed in writing within 24 hours.

An arrangement between the Mines Inspectorate and the State Coroner requires the Chief Inspector to advise the State Coroner of the fatality as soon as is reasonable. These notification provisions are important. The purpose is to inform relevant authorities so that independent investigations can commence.

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[8] MQSHA 1999, Section 45; CMSHA 1999, Sections 37 and 48

[9] Coroners Act 2003, Section 7

[10] The SSE is a statutory official, appointed by the Operator. MQSHA 1999, Section 38; CMSHA 1999, Section 41

[11] MQSHA 1999, Section 195; CMSHA 1999, Section 198

The interaction between the mine, police, the inspectorate, coroner and the minister is detailed in the Serious Accident/Fatality Interaction Flow Diagram at Appendix 2.[12] It is important, here, to recognise the legal consequences that flow from a fatality. The flow chart does not deal with the human or workplace issues, but does describe the complexity of the regulatory response.

The mine must notify the relatives of the deceased as soon as possible after positive identification of their loved one. The police usually notify relatives to arrange formal identification of the body. The police will arrange for transfer of the deceased to the mortuary,[13] so that an autopsy,[14] under the direction of the Coroner, can be performed. The purpose of an autopsy is to help establish the cause of death. For example, did the deceased die from electrocution or natural causes.

The Coroner is a judicial officer who does not undertake personal inquiries. In a mining death, the Mines Inspectorate undertakes the role of providing the Coroner with a detailed report about the nature and cause of the tragedy. The police, however, also have a role in a mine fatality. Partly, this is because police must exclude suspicious circumstances. More importantly, though, the presence of police and the Mines Inspectorate at a fatality is to ensure public confidence is maintained in the coronial investigation system.

The investigative role undertaken by police is governed, in part, by the *Police Powers and Responsibilities Act 2000*. There are also the protocols set out in the *Police Operational Procedures Manual.*[15] Here, police at a mine fatality investigate suspicious circumstances and it is recognised that the Mines Inspectorate investigates mining related issues. The specific powers given to police to assist Coroners under Part 4A of the *Police Powers and Responsibilities Act 2000* include:

Police Powers for Assisting Coroners[16]

- Entry powers if the police officer suspects that someone is dead or in need of urgent medical attention;
- Arranging for transportation of the body;
- Seizing anything that the police officer suspects may be relevant to the investigation;
- Restricting entry; and
- Requiring information.

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[12] NRMW Safety and Health Mines Inspectorate Investigation Process Manual - Complaints, Incidents, Accidents and Fatalities, Version 19. See Appendix 2

[13] Coroners Act 2003, Section 18

[14] Coroners Act 2003, Section 19

[15] The Police Operational Procedures Manual is similar to the mine site conception of standard operating procedures

[16] Police Powers and Responsibilities Act 2000, Section 371

In circumstances where the police consider there are no suspicious circumstances surrounding the death, the investigating police officer will hand over the site and the investigation to the Mines Inspectorate. The police will, however, provide their own report on the death to the Coroner in an approved form called a "Form 1."[17] The Inspectorate then undertakes the ongoing and far more detailed investigation, which looks at the nature and cause of the death and recommendations to avoid a reoccurrence.

It is also relevant to note that a Coroner may make, or arrange for, any examination, inspection, report or test that the Coroner considers is necessary for the investigation.[18] These examinations routinely involve an autopsy, histology and toxicology. In an appropriate case, technical inquiries can encompass any matter relevant to the scope of the inquest. This could include, for example, metallurgical tests by Simtars.

In the event that suspicious circumstances emerge during the course of the inspectorate's investigation, the lead investigator may, after consultation with police, refer the investigation back to the police for further investigation. It is rare for such a referral back to police to be made by the Mines Inspectorate. Essentially, the trigger would be evidence of an intention by a person to deliberately cause harm. In other words, circumstances suggesting crimes such as murder or manslaughter and the like have been committed.

An Inspector must, under the mining legislation, investigate all accidents causing death at a mine to determine the nature and cause of the fatality and report the findings of the investigation to the Chief Inspector.[19] The primary purpose of the investigation is to determine the root causes of the incident, with the aim of preventing similar accidents from occurring in the future. The Inspector does, however, have another role. That is, to enforce the Act.[20] Here, where there is evidence to indicate that a person, or company, has failed to discharge a relevant safety and health obligation, the investigating inspector must provide a report to the Chief Inspector, which may include a recommendation about a prosecution or other compliance action under the Act.[21]

The Mines Inspectorate has a process that investigators must follow for such matters as complaints; serious accidents; and fatalities. The Mine Inspectorate's *Investigation Process Manual* ensures there is a systematic approach to investigating the event, and the various actions and omissions that led up to the event.[22] The Mines Inspectorate has an obligation to be impartial. This organisational value is

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[17] Form 1 - See also Coroners Act 2003, Section 7, and approved forms

[18] Coroners Act 2003, Section 13

[19] MQSHA 1999, Section 196; CMSHA 1999, Section 199

[20] MQSHA 1999, Section 125; CMSHA 1999, Section 128

[21] MQSHA 1999, Section 126; CMSHA 1999, Section 129

[22] NRMW Safety and Health – Mines, Investigation Process Manual, Version 19, May 2005

taken seriously. The investigating inspector is not on the side of the family; mine management; or the mine's workforce. During the course of the investigation, the Inspector will discuss the investigation with relevant stakeholders which include the family and mine management.

A Site Senior Executive (SSE) has a statutory obligation to assist the inspectorate in the performance of their duties.[23]

The community, as well as interested stakeholders, have the right to feel confident that a coronial inquest is impartial, not a cover-up, and is aimed at arriving at the truth. Thus, to assist in achieving this end, the Coroner has control and oversight of investigations as they progress. The Coroner is required "*to ensure that all aspects of reportable deaths are effectively investigated. Back tracking to recover evidence passed over is costly and frequently unsuccessful.*"[24] The result of not undertaking a sound investigation can be a less than satisfactory understanding of important issues, and events, surrounding the fatality. In practice, then, the Coroner provides the independent oversight of the process of investigation and the subsequent court process.

Inspectorate Investigation

On initially becoming aware of an incident leading to a fatality, the notified Inspector will liaise with the SSE, or a delegate, to ascertain:-

- The number of fatalities and whether other people are in danger;
- What action is to be taken immediately (including emergency response);
- When the Mines Inspectorate will arrive on site;
- That the site is to remain undisturbed and secured;
- What personnel/resources are required to be made available;
- Police response.

On site the Mines Inspectorate's investigation team, headed up by the lead investigator will, initially, be briefed by mine staff. Following this, a site inspection will occur, where relevant evidence will be gathered. This process will involve collecting photographic evidence, taking measurements and seizure of vital components. The investigating inspector will also call for documentation on procedures and risk assessments pertinent to the work that related to the fatality; training records; maintenance records; manufacturer manuals for equipment; and other documents relevant to understanding the nature and cause of the incident. The investigating inspector will also interview personnel involved in the incident, which may include the operator, SSE, supervisors, operational workers, and service personnel. Statements will be taken during the interview.

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[23] MQSHA 1999, Section 139; CMSHA 1999, Section 142

[24] State Coroner's Guidelines – Version 0 December 2003 p 7.4

The taking of statements is central to understanding the nature and cause of the fatality. The facts must be established. This information is critical to developing an accurate picture of the facts and events that led to the fatality. It is important that the statements given by witnesses about the facts not be tainted by interference, the passage of time, or the vagaries of memory.

The investigating inspector will also gather evidence in order of fragility of the evidence. This is the information that can change rapidly over time. For instance, the incident site and witness memories about what happened. At all times, the investigating inspector must minimise the risks of exposure to hazards by persons directly involved in the incident, and persons undertaking the investigation. This requirement, thus, limits the unrestricted use of re-enactment as a vehicle of the investigation.

During the investigation it is probable that the investigating inspector will discuss the preliminary findings with management and issue directives, or other corrective measures, to control hazards and risks identified during the investigation. These actions are not punitive in nature. Rather, they are aimed at improving safety by learning from tragedy.

The Mines Inspectorate, where applicable, will also issue Safety Alerts and Safety Bulletins to the mining industry, to highlight deficiencies that might be generic to the industry. On occasions, the inspectorate has held workshops involving a range of expertise within the mining industry to find practical solutions for managing hazards. For instance, recent workshops held in Townsville involved working near open stopes, tyre and rim management and management of explosives misfires.

The investigation model employed by the inspectorate investigation team aims at thoroughness and attempts to be all encompassing. The investigation will look at establishing both the contributing and non-contributing factors which related to the incident. In doing so, the investigating inspector attempts to identify what did not cause the accident as much as what did cause the accident. Ultimately, in the Report to the Chief Inspector the investigating inspector will make findings of fact, and draw technical conclusions, about what caused the incident.

The next step is to benchmark the identified causes against the mining legislation, and the safety and health management system developed by the mine, in order to identify possible failures, or unnoticed deficits, in the safety and health management system.[25] In simple terms, an investigation is an audit of the event and the underlying causes which led to the fatality.

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[25] This includes the relevant Regulations, as well as guidelines and recognised standards. Reference is also made to the relevant Australian Standards

When investigating a fatality, the primary focus of the investigation tends to be upon the following issues:-

- Has the mine a process for performing the task (Procedures; Risk Assessments)?
- Was the person adequately trained and assessed as having the knowledge, understanding and skill to carry out the required processes (Training and Competency)?
- Was the process adequately supervised (Supervision)?
- Was there adequate time and resources to perform the work (Resources)?
- Was the workplace safe? For example, equipment / electrical / hazardous substances and dangerous goods / ground conditions / vehicle interaction (Fit for Purpose)?
- Was the mine adequately prepared with resources and facilities for reasonably foreseeable emergencies (Emergency Response)?

It is an important obligation on the mine to provide this information and show that they have taken reasonable precautions to comply with their respective safety and health obligations together with showing they have exercised proper diligence in the discharge of those obligations. The legislation states that the safety and health management system must be an auditable documented system. This requirement reads this way:-

> *"A safety and health management system for a mine is a system that incorporates risk management elements and practices that ensure safety and health of persons who may be affected by operations. A safety and health management system must be an auditable documented system that forms part of an overall management system that includes organisational structure, planning activities, responsibilities, practices, procedures, processes and resources for developing, implementing, achieving, reviewing and maintaining a safety and health policy for managing risks associated with operations."*[26]

Preservation of evidence at the incident site is vital, and under the mining legislation the site of a serious accident, or high potential incident, must not be interfered with without the permission of an inspector. [27] In a fatality, this rule about preserving and securing the accident scene is critical for mine management to avoid censure from police and the inspectorate. Action taken to save life, or prevent further injury, however, is not considered to be interference with a place.

It is also important for the industry to understand that the investigating inspector wants to gather all relevant information professionally, and as thoroughly as possible, so that a sound understanding is developed about the nature and cause of the fatality. A thorough investigation is the basis upon which change to industry practice can be promoted to prevent a similar incident from occurring in the future.

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[26] MQSHA 1999, Section 55; CMSHA 199, Section 62

[27] MQSHA 1999, Section 197; CMSHA 199, Section 200

A thorough investigation takes time. Sensitivity to the workforce, and respect for the memory of the deceased, are also high priorities for the Inspectorate.

The mining legislation includes provisions to assist Inspectors, and Inspection Officers, carry out their duties. The following table describes these powers, and the relevant statutory provision:-

Table 1: Powers of Inspectors and Inspection Officers

	(MQSH Act)	*(CMSH Act)*
Entry to a Place	S130	S133
General Powers	S136	S139
Power to obtain information		
Personal details requirement	S149(3)	S152 (3)
Production of Documents	S151 (2 to 6)	S154 (2 to 6)
Attendance of Persons	S154	S157
Person must answer question	S156 (2)	S159 (2)
General enforcement offences		
False or misleading statements	S176	S179
False or misleading documents	S177 (2)	S180 (2)
Obstructing Inspectors/Inspection Officers or DWR's/IS&HR's	S178	S181
Refusal to answer questions	S247(2)	S268 (2)

Investigation Reports

In the case of a fatality, the Investigating Inspector will submit a preliminary report to the Chief Inspector regarding the initial details of the fatality. This step is taken quickly, and is a précis of the initial investigation. The aim of the preliminary report is to come to an initial view about nature and cause so that the Coroner, Chief Inspector, and the Industry are fully informed about the tragedy. The Chief Inspector, upon reviewing the preliminary report, will forward it to the State Coroner.

It is a legislative requirement that both the mine,[28] and the Inspectorate,[29] must produce a report where there has been a fatal accident. The mine has to provide a report to the Mines Inspectorate within one month. It is accepted practice that mine management will be invited to be present during the investigation undertaken by the Inspectorate. There are exceptions to this rule, but these exceptions are rare. An example would be where there is a reasonable cause to believe that there are suspicious circumstances. Here, deference must be paid to police investigation procedures.

[28] MQSHA 1999, Section 198; CMSHA 199, Section 201

[29] MQSHA 1999, Section 196; CMSHA 199, Section 199

In reaching its conclusions on nature and cause, the Mines Inspectorate uses the Incident Cause Analysis Method (ICAM) to analyse information collected to determine the causes of the accident. The investigation would also consider additional recommendations, over and above the corrective measures issued at the mine site, to assist in preventing re-occurrence within the industry.

The mine report submitted by the SSE becomes an annexure within the investigating inspector's final report to the Chief Inspector. The Chief Inspector, after reviewing the report, will forward the final report to the Coroner, and provide copies to the Coroner for distribution to the parties granted leave to appear at the inquest.

At the Inquest, the investigating inspector will give a presentation, normally using power point which may include video simulations of the incident. The purpose of the presentation is to clarify the complexities of the investigation, and to present the investigation and findings in a way that non-miners can understand.

OVERVIEW OF THE CORONIAL PROCESS

The Coronial System

The coronial system, described by the *Coroners Act 2003,* does not focus simply on the mining industry. Historically, the coronial Inquest can trace its history back to the London City Coroner and the times of Sir Isaac Newton. Traditionally, the task of the Coroner was to establish the nature and cause of the death, detect secret homicide, and to make recommendations to avoid a reoccurrence.

Times have changed since those early days, and with advances in forensic medical science it is usual for the cause of death to be readily ascertained. However, the Coroner's role to establish the facts surrounding the death, and the making of recommendations to avoid a reoccurrence, remains central to the legal process.

A distinguishing feature of the mining industry is the high level of commitment given to the coronial process. There has already been a thorough discussion about the steps the Mines Inspectorate, and police, take once a fatality occurs. In short, however, the Mines Inspectorate prepares a comprehensive report which is tendered as an exhibit in the coronial Inquest.

The Coroner has the assistance of a barrister appointed to be counsel assisting the coroner.[30] All relevant parties have the opportunity of seeking leave to appear before the court, to present the facts as they understand them. A non-adversarial and co-operative climate exists, at least in relation to providing the Coroner with expert advice about how to avoid a similar tragedy in the future.

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[30] Coroners Act 2003, Section 15

Nature of an Inquest

The nature and purpose of an Inquest is very different to other legal proceedings. The traditional view was expressed by the High Court of Australia in these terms:-

> *"It should not be forgotten that an inquest is a fact finding exercise and not a method of apportioning guilt. The procedure and rules of evidence which are suitable for one are unsuitable for the other. In an inquest, it should never be forgotten that there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish facts. It is an inquisitorial process, a process of investigation quite unlike a trial where the prosecutor accuses and the accused defends, the judge holding the balance or the ring, whichever metaphor one chooses to use."*[31]

In essence, the *Coroners Act 2003* and this decision of the High Court of Australia recognise the unique nature of an Inquest. It is an inquisitorial process, undertaken by the Coroner, to arrive at the truth concerning the facts surrounding the death, so that the community and the parties involved in the court process can understand the nature and cause of the tragedy.

At this point, the question of what constitutes "*the truth*" cannot be avoided. In the English legal tradition, the assumption is made that the presentation of the facts by different parties appearing before the court will lead to a better understanding, because the judicial officer is confronted with different, and opposing, views about what happened. This forensic tradition is often called the adversarial system. However, there is little difference in the adversarial approach to ascertaining the "*truth*", when compared to the contemporary European inquisitorial court process. Irrespective of the approach taken on the different continents, the aim of each judicial process is to arrive at the truth.

Inquest Chronology

In simplified terms, the legal steps that occur from the time of death, through to the conclusion of the coronial process, take this form:-

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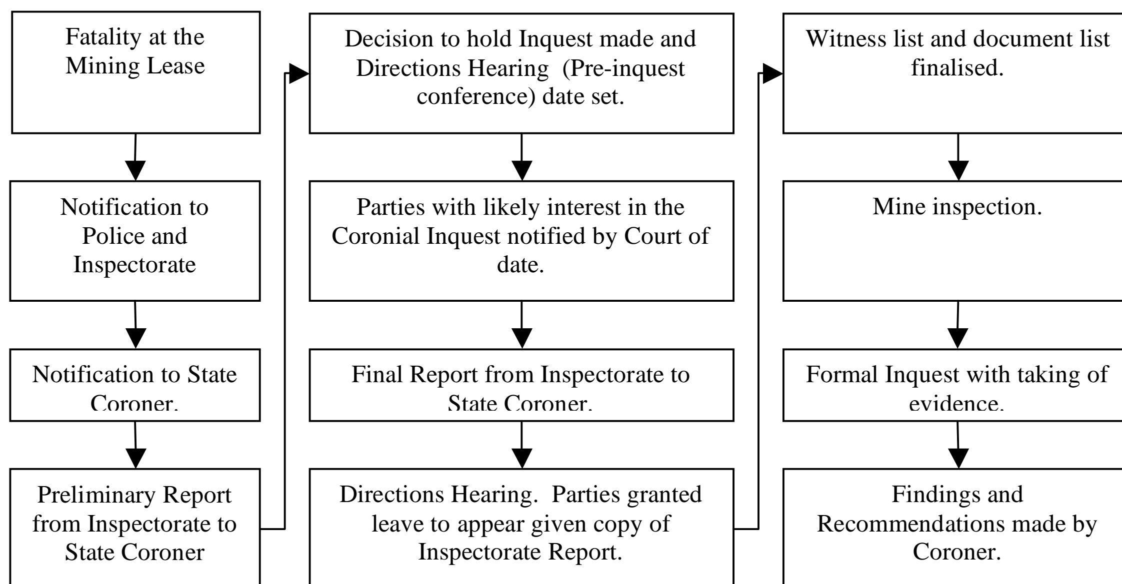
[31] Per. Lord Lane C. J. in *Reg. v South London Coroner; Ex Parte Thomson* (the Times, 9 July 1992), a decision cited with approval by Toohey J. in *Annett v McCann* (1990) 170 CLR 589 at p. 616



The Parties to an Inquest and their Right to Appear

In any Inquest, all parties with sufficient interest in the subject matter of the coronial process will normally be granted leave to appear at the Inquest.[32] In a mining Inquest, for example, leave would be granted to the next of kin, the operator, the SSE, relevant contractors, and the union. Leave to appear would also be granted to any other individual, or organisation, which might be the subject of adverse findings, or comment, during the course of the Inquest. Usually, the parties granted leave to appear at the Inquest are represented by a firm of solicitors who will brief counsel (a barrister) to appear for their particular interest.

The Next of Kin

It is often forgotten that the family who has lost a loved one goes through an identifiable grief process. The process starts with denial, travels through bargaining and anger, and ends with acceptance. If the next of kin are treated properly by the company, they often do not want revenge. Rather, their hope is that another family can be saved from going through the same grief and sorrow. Loss is never easy when the death is untimely and not expected. The primary outcome for the next of kin, hopefully, is a realisation that recommendations to avoid reoccurrence in the future is the only way to give meaning to their loss.

The next of kin have a special place in a coronial Inquest. It is accepted by the Court that they are entitled to know how their loved one died, and hear the truth about the death. Tears are not unusual.

[32] Coroners Act 2003, Section 36

The Inquest is part of the public process of closure. This aspect of the coronial process must be respected.

The coronial process is also meant to assist in providing closure for other people at the mine who were involved in the incident. For example, the first aider or mate who might ask themselves, in retrospect, the question: "*could I have done more?*"

How should the industry see the presence of the next of kin at a coronial inquest? Is their presence an expression of the public interest? Alternatively, is it an expression of the industry's conscience? On the other hand, is the process a way of allowing the family, workmates, management and the mining community a way of airing their composite grief? Ultimately, the human question returns to improving the future. The past can never be changed.

Pre-inquest Conferences and Directions Hearings

It is important to recognise that an Inquest is a judicial investigation by a Coroner into the death. At the Directions Hearing the parties make submissions to the Coroner about the many housekeeping issues that must be attended to in order for the Inquest to run smoothly. At all times, it is the Coroner who is in charge of the process, and it is the Coroner who makes all necessary decisions, after hearing submissions by the parties. For example, the Coroner ultimately determines the issues that will fall within the scope of the Inquest and settles the list of witnesses who will give oral evidence at the hearing.

A directions hearing takes place in open court. The public nature of the proceedings allows the parties, and the public, to hear the issues raised in court and the decisions made by the Coroner. The technical phrase used by the *Coroners Act* 2003 for a directions hearing, is a pre-inquest conference. However, these pre-inquest conferences are generally known by the legal profession as a directions hearing, because the Court makes various orders and directions relating to the preparation of the matter for hearing.

Before a directions hearing is held, the court will provide written notice of the date of the Directions Hearing so that potential interested parties can attend, should they wish to do so.[33] The issue of whether, and how, an interested party may wish to be represented at the hearing is usually a matter that is discussed by the party with their legal advisors before the Directions Hearing.

At the Directions Hearing, it is open to any party with sufficient interest in the subject matter of the Inquest to seek leave from the Coroner to be legally represented at the Inquest. Another function of a directions hearing is to allow Counsel Assisting the Coroner to outline the likely issues that will be

[33] State Coroner's Guidelines – Version 0 December 2003 p 8.9

raised when the Inquest formally commences. It is also normal, at the Directions Hearing, for the Coroner to approve distribution of the Mine Inspectorate's final report to each of the parties granted leave to appear at the Inquest. A timetable is also set, to case manage preparation. For example, the exchange of information and documents; deciding whether further factual witnesses are needed; qualifying further expert witnesses; and obtaining reports on technical matters.

A further function of a directions hearing is to ensure that each party granted leave to appear at the Inquest has time to consider the issues being raised, so that there is sufficient time for that party to prepare the case they want to put before the Coroner. The process also allows the legal advisors for each party to have sufficient time to take instructions in relation to the many factual matters and technical issues that are likely to be agitated during the course of the Inquest. All these steps assist with estimations as to the likely duration of the proceedings and the settling of the final witness list.[34]

The Directions Hearing is also a convenient mechanism to try and find whether there is unanimity between the technical experts in relation to their opinions. Moreover, the parties can also explore the extent of any common ground that may exist in relation to the facts. The State Coroner's Guidelines says this:-

> *"Pre-inquest conferences provide a convenient forum for the exchange of expert witness reports. Arrangements can be made for these witnesses to meet and discuss their competing views with a view to isolating any points of substantial difference; often this may result in agreement amongst these experts on all but a few salient points."*[35]

In a mining fatality it is usual for the Coroner to request a mine site visit for all the parties granted leave to appear in the Inquest. The purpose of a mine site visit, or "coronial view" as it is technically known, is to assist the court and the parties gain a practical understanding of the mine environment; the mining processes used at the particular mine; the geography and points of significance at the accident scene; as well as seeing any relevant machinery that may have been involved in the incident.

A further advantage of a coronial view is that it tends to reduce the total hearing time in court, because the mine site visit has provided the court and the legal representatives with an opportunity to gain a shared understanding about many of the relevant facts that need to be discussed in court, before the taking of oral evidence when the Inquest commences.

When an Inquest must not be Held or Continued

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[34] State Coroner's Guidelines – Version 0 December 2003 p 8.8

[35] State Coroner's Guidelines – Version 0 December 2003 p 8.9

An Inquest must not be commenced under the *Coroners Act* 2003 if the Coroner is informed that someone has been charged with an offence, where the question before the criminal court centres around whether the accused caused the death.[36] A clear example where s.29 of the *Coroners Act* 2003 would apply is a case where a person is charged with murder or manslaughter.

If the Coroner is informed that a person has been charged with this sort of serious offence once the Inquest starts, the Coroner must adjourn the Inquest. In due course, the Coroner may resume, or close, the Inquest after the end of the proceedings for the offence. Naturally, this would include any appeal against the conviction started within the time allowed for an appeal in the criminal court. The purpose of this provision of the *Coroners Act* 2003 is to ensure that the holding of an Inquest does not interfere with, or prejudice, the processes of the criminal courts.

A question that is often asked is what happens where a person has been charged with an offence under the mining legislation (MQSHA 1999 and CMSHA 1999). There is no definitive answer that can be given which covers all cases. The likely outcome, however, is that the Inquest will be adjourned until the prosecution is concluded. Here, it is important to note that the Mines Inspectorate and the Industry do not have to wait for the various legal proceedings to end before changes to promote safety can be made. Change, to promote safety in the future and to learn from the tragedy, will not be criticised by a Coroner. In fact, the converse is true.

THE COURSE OF THE INQUEST

The purpose of this part of the paper is to discuss the issues relevant to the actual hearing of an Inquest in open court. Division 3 of the *Coroners Act 2003* sets out the law that governs the course of an Inquest. [37] There are also rules of practice issued by the State Coroner.[38] The critical point to note, though, is that a coronial Inquest is a judicial proceeding held in open court where the public can attend and listen to the evidence. The Inquest is presided over by a judicial officer who is bound to follow and apply relevant law.

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[36] Coroners Act 2003, Section 29

[37] This Division describes the procedural framework for an Inquest when the Coroner hears oral evidence

[38] See generally State Coroner's Guidelines – Version 0 December 2003

The Advocates for the Parties

The art of advocacy is to persuade the court to accept your client's perception of events. This is an important concept. A barrister, or solicitor, will not intentionally mislead the court. This is a fundamental rule. A barrister or solicitor will only put to the Court a case that is squarely based on the instructions the legal representative has received from the client.

At this point it is not difficult to understand the roles the various legal representatives play in an Inquest. Each legal representative appears for a particular interest. For example, the operator or the SSE. The role of each barrister is to put their client's case in the most positive light. There is one exception. This is the barrister appearing as counsel assisting the coroner. This role is unique. Counsel Assisting the Coroner does not appear on behalf of a party, or an interest. Rather, the duty of counsel assisting the coroner is to present all relevant evidence to the court. This duty must be discharged without fear or favour, or concern about the outcome, in an endeavour to ascertain the true facts.

Evidence in an Inquest

Evidence is a technical phrase used by the legal system to define information that a court will accept. In a criminal prosecution, the rules of evidence are very strict. In a Coronial Inquest, however, the rules of evidence are more relaxed. A Coroner is able to consider a broader range of information, because history has shown that this approach is the appropriate way to arrive at the truth in this category of judicial inquiry.

In the conduct of an Inquest the Coroner will ensure that all parties granted leave to appear at the Inquest have a reasonable opportunity to put their case to the court. Each party also has the opportunity to cross-examine contentious witnesses. In other words, the Coroner will apply the rules of natural justice, or procedural fairness as these rules are also called, in the conduct of the Inquest. The State Coroner's Guideline's puts the position this way:-

> *"Although not bound by rules of evidence, coroners are obliged to ensure that the principles of procedural fairness are applied. One consequence of this is that if evidence adverse to any party is led, that party must be given an opportunity to respond. If the leading of such evidence has not been anticipated and the party whose conduct is criticised has not been involved from the outset of the inquest it will be necessary to adjourn the inquest and allow that party time to obtain representation and familiarise him/herself with all of the evidence that has been given. At a pre-inquest conference counsel assisting can outline the issues that will arise during the hearing and if any party affected by that evidence has not sought leave to appear a direction can be given by the coroner that they be contacted and invited to seek such*

> *leave from the outset or for so much of the proceedings as may be relevant to their interests."*[39]

At the commencement of the hearing of the Inquest, if not done before at the Directions Hearing, Counsel Assisting the Coroner and other legal representatives will tender various documents as exhibits.[40] For example, before the hearing starts the police will have obtained the death certificate, autopsy report and will have also provided the Coroner with a report setting out the facts and circumstances of the fatality from the police perspective. These documents are all tendered, as is the final report of the Mines Inspectorate, together with witness statements and other mine documents.

The Inquest then proceeds to hear oral evidence from the witnesses who have been subpoenaed. For instance, police attend the coronial inquiry and give oral evidence if required. The investigating inspector also gives oral evidence about the investigation and explains the final report provided to the Coroner by the Chief Inspector of Mines. Next, eye witnesses are called to give oral evidence and so on down the witness list. The SSE, by convention, is always the last witness to give evidence.

It is at this point in the Inquest that each witness presents their technical information, or recounts their observations about the facts. This is called giving evidence in chief. Next, each party is given the opportunity to cross examine the witness. Here, the witness can be challenged and the cross examining party's version of events put to the witness for comment.

Incriminating Evidence

It has long been a principal rule of English law that in a court proceeding no person can be compelled to answer a question that may incriminate that person. There are numerous reasons for this rule. One justification is that a person could feel pressured into being untruthful in order to protect themselves from a criminal prosecution. This right to decline to answer a question existed under the old *Coroners Act* 1958, where a person could not be compelled to answer any question that tended to incriminate the person but could, instead, claim privilege and be excused by the Coroner from answering the question.[41]

It is obvious that the fact that a person could decline to answer questions in an Inquest would be likely to cause significant distress to the next of kin, who want to know how their loved one died. There is also a significant public policy issue, about a Coroner being given appropriate statutory powers by Parliament to get to the truth in a coronial investigation. The goal of finding the truth is critical to public confidence in the coronial system.

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[39] State Coroner's Guidelines – Version 0 December 2003 p 8.8

[40] A document, or thing, once tendered as an exhibit becomes evidence the court can take into account

[41] Coroners Act 1958, Section 33

In the *Coroners Act* 2003 the Queensland Parliament abolished the blanket rule that a person could refuse to answer a question in an Inquest, on the basis that the answer may tend to incriminate the person. Under the *Coroners Act* 2003, a person can still refuse to answer a question on the basis of self incrimination, however, the Coroner can now require the person to answer the question. This power to require a person to answer this category of question represents a radical change to the coronial regime.

There is a threshold test, however, in the *Coroners Act* 2003 that must be met before a person can be compelled to answer a question that may lead to self incrimination. That is, the Coroner must be satisfied that it is in the public interest for the person to be compelled to answer the question. If the Coroner compels a witness to answer this category of question then any answer given after the Coroner's order to answer cannot be used in any other disciplinary or criminal proceedings against that witness, other than in a proceeding for perjury.[42]

Prohibited Publications relating to Inquests

All Coroners have the power to manage proceedings that are before them. One such power is to prohibit the publication of certain information in an appropriate case. Examples could include prohibiting the publication of scandalous material, or other highly sensitive information which has come before the court as a result of the Coroner's investigation. Other instances where a Coroner may prohibit the publication of information could be where there is a suggestion that the deceased committed suicide or that a person may have committed an offence.

In short, then, a Coroner may prohibit the publication of scandalous material, highly sensitive evidence, or any information which would tend to incriminate a witness.[43] This section also prohibits the publication of any question disallowed by the Coroner, or the answer given to a question disallowed by the Coroner.[44]

Coroner's Findings about the Death

The Findings that must be made by a Coroner in open court whenever an Inquest is held are set out in Section 45 of the *Coroners Act* 2003. It is instructive to note that this section of the Act is quite prescriptive in relation to the factual findings that a Coroner must make. The section provides that a Coroner must inquire into, and insofar as it is possible, make findings about the following:-

- Who the deceased person is;

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[42] Coroners Act 2003, Sections 39(2) and (3)

[43] Coroners Act 2003, Section 41(1)

[44] Coroners Act 2003, Section 41(3)

- How the person died;
- When the person died;
- Where the person died; and
- What caused the person to die?

The Findings handed down by the Coroner in open court, typically, are a statement of facts that describes who the deceased was; when the person died; and where the person died. Further, it is usual for a narrative approach to be taken in relation to discussing the issues of how the person died, and what caused the person to die.

By way of illustration: *"'How the person died – s45(2)(b)' – is simply by what means, or in what circumstances, did the person die. For example, a single vehicle accident, or self inflicted asphyxiation. Further, 'What caused the person to die - s45 (2) (e)' – refers to the medical cause of death. For instance, subdural haemorrhage or carbon monoxide toxicity."*[45]

A Coroner is prohibited from including in the Findings or Comments any *statement that a person is or may be guilty of an offence or is civilly liable for something*.[46] However, in the Guidelines issued by the State Coroner the following observations are made:-

> *"There is no impediment to Coroners providing a full and complete narrative of the circumstances of death nor stating their conclusions as to the responsibility of individuals or organisations for the death provided they refrain from using language that is applicable to decisions made by criminal and civil courts when they adjudicate upon the same issues."*[47]

And, further:-

> *"The particulars that a Coroner must if possible find under s45 need only be made to the civil standard but on the sliding Briginshaw scale.*[48] *That may well result in different standards being necessary for the various matters a Coroner is required to find. For example, the exact time and place of death may have little significance and could be made on the balance of probabilities. However, the gravity of a finding that the death was caused by the actions of a nominated person would mean that a standard approaching the criminal standard should be*

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[45] State Coroner's Guidelines – Version 0 December 2003 p 8.13

[46] *Coroner's Act* 2003 sections 45 (5) and 46 (3)

[47] State Coroner's Guidelines – Version 0 December 2003 p 8.14

[48] *Anderson v Blashki* [1993] VR 89 at 96 and *Secretary to the Department of Health and Community Services v Gurvich* [1995] 2 VR 69 at 73. This means, in short, that a serious adverse finding should not be made unless the Coroner has sufficient information, and the Coroner is satisfied about the weight to be given to the evidence

applied because even though no criminal charge or sanction necessarily flows from such a finding, the seriousness of it and the potential harm to the reputation of that person requires a greater degree of satisfaction before it can be safely made."[49]

After the formal findings are handed down in open court the Coroner will close the Inquest.

Coroner's Comments or Recommendations[50]

One of the objects of the *Coroners Act 2003* is to help prevent deaths from occurring in the future. It is arguable that the most important function of a coronial Inquest is to allow coroners to comment on matters connected with deaths, especially matters relating to public health or safety.[51] In the words of the State Coroner:-

"The identification of avoidable risks provides an opportunity for something positive to come from tragedy."[52]

The coronial investigation and court process has the goal of identifying whether any procedural, or systemic, issues need to be addressed to avoid a further death in similar circumstances. How similar deaths can be reduced should be the subject of thorough examination throughout the entire course of the Inquest, from the commencement of the initial investigation through to the close of the Inquest. Where it is clear from the evidence that the death was preventable, the Coroner should make preventative comments, and recommendations, as are necessary to prevent the occurrence of similar deaths.

The parties will often assist the Court in the formulation of the recommendations. This is a tradition in the mining industry, which stems back to the days of the Mining Wardens Court. Importantly, it is for the industry, the inspectorate, the unions, and other interested parties to provide the Coroner with advice and submissions about safety, and how to improve safety.

The importance of coronial recommendations can be noted in this way:-

"*Coronial comments, recommendations or riders can be of profound importance to manufacturers, distributors, industrial entities, government instrumentalities and many others.*

[49] State Coroner's Guidelines – version 0 December 2003 p 8.14

[50] Technically, recommendations under the Coroners Act 2003 are known as comments

[51] Coroners Act 2003, Section 3

[52] State Coroner's Guidelines – Version 0 December 2003 p 1.1

They are frequently publicised prominently by the media and can inure to the considerable embarrassment and financial disadvantage of those who are the subject of them."[53]

Once the Coroner makes recommendations the relevant Chief Inspector takes steps to consider, and implement, the recommendations. Clearly, the recommendations must be practical, appropriate, and capable of implementation. Again, in saying this, the importance of the Coroner receiving sound technical advice is obvious.

It is also clear that there is no point in a Coroner making recommendations if they are not published to the parties and the relevant authorities. The *Coroners Act* 2003 deals with this issue in s.46. In the case of a mining fatality the Coroner must give a written copy of the findings and recommendations to the family, the parties to the Inquest, the Minister for Mines and the Director General of the Department of Mines (NRMW).

Reporting offences or misconduct

Under the *Coroners Act* 2003 the Coroner no longer needs to consider whether a person should be indicted to stand trial for murder, manslaughter or dangerous driving causing death.[54] This leaves open the question, though, of what action a Coroner should take if a Coroner becomes aware that a person is not fit to continue to hold a relevant ticket issued by the Board of Examiners, or has breached a safety and health obligation under the mining legislation.[55]

The answer is to be found in Section 48 of the *Coroners Act* 2003, where the court is given the express statutory power to refer the matter to the relevant government authority. The Board of Examiners, for example, as the relevant disciplinary body if the question of competency is raised. In the case of a possible criminal offence under the Queensland Criminal code, the matter can be referred to the Director of Public Prosecutions. A Coroner, in an appropriate case, could also refer the matter to the relevant Chief Inspector for possible compliance action for a breach of a relevant safety and health obligation under the mining legislation.[56]

The referral of matters to the Director of Public Prosecutions; another prosecuting authority such as the Mines Inspectorate; or a disciplinary body such as the Queensland Board of Examiners; should only occur if the Coroner is satisfied that there is sufficient evidence to warrant such a referral.[57] A Coroner

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[53] The Inquest Handbook, Selby H(ed), Federation Press, Sydney 1998, p7 (citing Chief Commissioner of Police v Hallenstein [1996] 2VR 1 at 21)

[54] Coroners Act 1958, Section 41

[55] MQSHA 1999, Section 31; CMSHA 1999, Section 34

[56] MQSHA 1999, section 31; and CMSHA 1999, Section 34

[57] State Coroner's Guidelines – Version 0 December 2003 p 8.14

may not, however, rely on protected information obtained under s39 (2) of the *Coroners Act* 2003 to make this decision.[58] In other words, the Coroner must consider only the evidence permitted by the Coroners *Act* 2003 to decide whether a referral ought be made.

Summary

In a mine fatality, or any other reportable death, the role of the Coroner is central. Essentially, the coronial system exists because of the community's concern about unexplained, or untimely, death. In principle, the role of a Coroner is to:-

- Supervise the investigation;
- Direct the inquiry to ensure all necessary evidence is gathered;
- Preside over an inquest; and
- Make the findings required by the Act and make appropriate preventative comments and recommendations.

In practice, the *Coroners Act* 2003 makes it clear that the Coroner is in control of a death investigation from the time a death is reported under s.7 of the Act, until the Coroner stops investigating the death and makes the necessary findings required by Section 45 of the legislation. The Coroner, as has been previously mentioned, is a judicial officer. A Coroner investigates a reportable death through the efforts of various investigators and professional people. The investigative steps may be undertaken by police officers, the mines inspectorate, pathologists or other forensic experts, but they are all acting as the Coroner's agents and are subject to the Coroner's direction.

The public nature of the coronial process is evident by looking at how the court goes about its task and discharges its obligations under the *Coroners Act* 2003. All evidence is given orally by critical witnesses who are examined, and cross-examined, in open court. All documentary evidence is tendered as an exhibit in the proceedings. All exhibits are open to public inspection, subject to any orders of the Coroner. The Findings the Coroner makes are made in open court. In short, the entire process attempts to be open and transparent.

The outcome all Coroners want to achieve is an Inquest where the truth has come out and all relevant issues have been canvassed. It is also hoped, of course, that the next of kin have had their questions answered. More importantly, though, all Coroners want to avoid future fatalities in similar circumstances.

It is important that the Coroner be kept informed about how the recommendations are being implemented. In a mining inquest, the task of keeping the Coroner informed is usually undertaken by

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[58] Coroners Act 2003, Section 48(1)

the Mines Inspectorate, but any party granted leave to appear at the Inquest should understand that it would not be wrong for them to keep the Coroner informed of relevant developments.

An Inquest is only truly closed when the community has learned from the tragedy and put in place appropriate changes to promote future safety and well being.

COMPLIANCE RESPONSE

Background

The most contentious aspect of this paper necessarily relates to the spectre of compliance action by the Mines Inspectorate against an individual, or a company, where there is evidence that a safety and health obligation has been breached. It is understood that the question of prosecution can provoke fear, and anxiety, within the industry. The real question, though, is whether these concerns about prosecution are valid or justified? In other words, under what circumstances would the Mines Inspectorate consider a prosecution to be the appropriate compliance response?

The introduction of the mining legislation (MQSHA 1999 and CMSHA 1999) into the Queensland Parliament in 1999, in part, served to answer the calls by the mining industry for self regulation. At the same time the government also had to consider the recommendations made by the Wardens Inquiry presided over by Mr Frank Windridge (Mining Warden and Coroner), in the Moura No. 2 Inquiry, that further supported legislative change and the adoption of a site based risk management legislative framework.

The necessary trade off between the old prescriptive legislative regime, and the new framework based on objectives, was the legislative imposition of clear safety and health obligations on all persons involved in the mining process. For instance: holders, operators, the SSE, contractors, and all mine workers all have safety and health obligations. The legislation is also drawn widely enough to capture offsite providers of goods and services.

The Compliance Regime

One of the statutory roles of an Inspector is to monitor mining operations in Queensland for compliance in relation to the requirements of the mining legislation (MQSHA 1999 and CMSHA 1999). An Inspector has a statutory obligation to investigate breaches of the mining legislation and, where there is evidence of non compliance, to report and make recommendations to the Chief Inspector regarding an appropriate compliance response.[59] This statutory role is quite separate from the obligation an Inspector has to undertake an investigation in relation to nature and cause, for a Coroner's Inquest, where a fatality has occurred.

The process the Mines Inspectorate follows where there is evidence of a breach of the mining legislation is governed by the Departmental *Safety and Health Compliance Policy*.[60] The Compliance Policy was not developed in a vacuum. The Compliance Policy is similar in its scope to the well developed Compliance Policies that exist for the Commonwealth Director of Public Prosecutions (DPP) and other State and Federal prosecuting authorities. The purpose of the Compliance Policy is:-

> *"Intended to ensure an unbiased, consistent treatment of non-compliance with the requirements of the mining safety and health legislation. The Department's initial emphasis is on co-operation with stakeholders, including giving advice and encouragement to achieve required health and safety standards. This approach also includes the concept of staged escalation to deal appropriately with people or companies who fail or neglect to fulfil their safety or health obligations. The approach does not preclude prosecution as an initial response where, for example, situations involve gross negligence."*[61]

And, further:-

> *"Corrective measures are to be used consistently, be commensurate with the seriousness of a situation and escalate where previous measures have been ineffective."*[62]

There are a range of corrective measures available under the mining legislation and the Compliance Policy, where there is evidence of non compliance with the mining legislation. For example:-

- An Inspector may make a "*recommendation*" regarding industry best practice;

[59] MQSHA 1999, Section 126; CMSHA 1999, Section 129

[60] Compliance Policy – NRMW Safety and Health, Nov 2001

[61] Compliance Policy – NRMW Safety and Health, Nov 2001, Page 1

[62] Compliance Policy – NRMW Safety and Health, Nov 2001, Page 3

- An alternate response could be a "*substandard conditions or practice (SCP) mine record entry,*" in which the Inspector requests the mine to undertake a specific action, or to alter a potentially unsafe practice, within a specified timeframe; or
- For a significant safety concern or breach of the legislation, a "*directive*" may be issued requiring the mine to undertake a specified action within a specified timeframe.[63]

In circumstances where the breach of the mining legislation is even more significant, or the number of breaches by a particular mine is high, then the Mines Inspectorate response is stronger, and may require:-

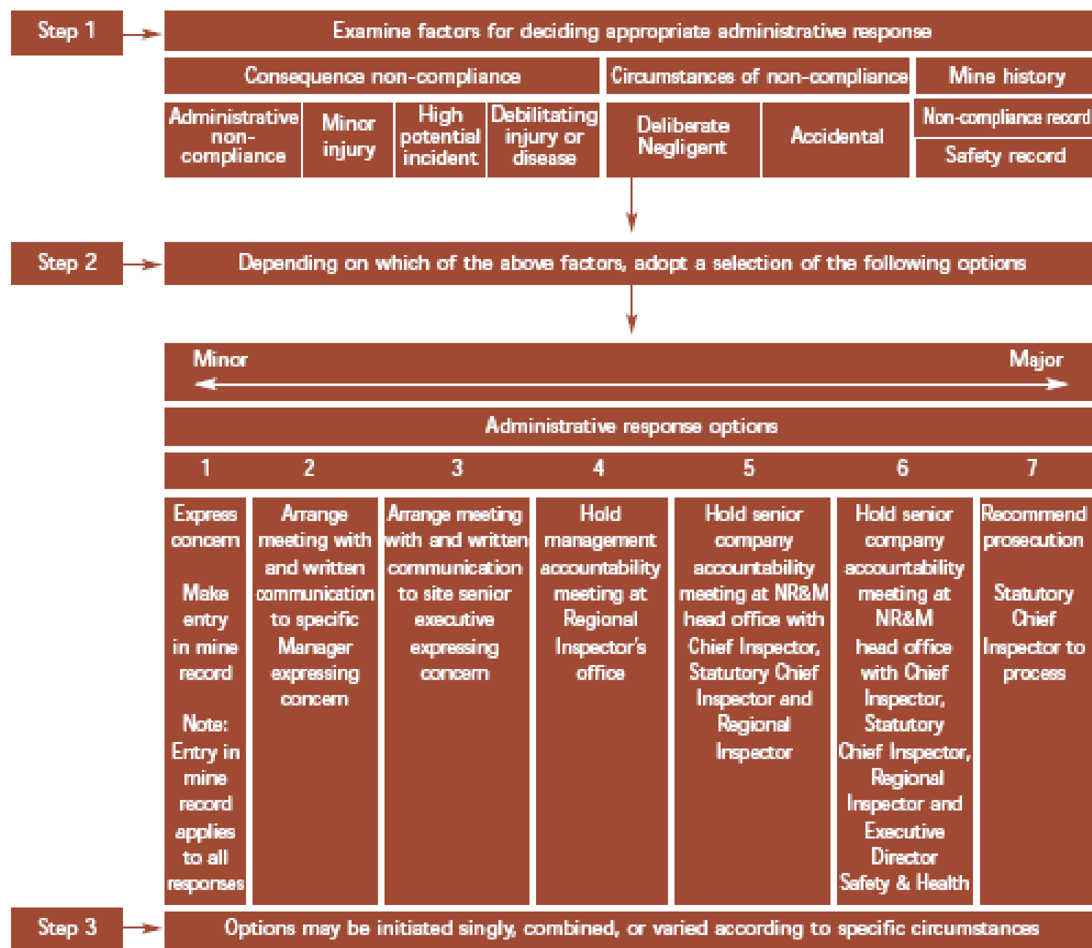
- A "*management accountability meeting*" at regional office; or
- In a worst case, a "*senior company accountability meeting*" at head office with the Chief Inspector and the relevant Regional Inspector.

A "*prosecution*" is reserved, however, for the most serious of breaches of the mining legislation.

The Compliance Policy sets out a guide for determining which compliance action is appropriate, given the nature of the alleged breach. The decision making approach is outlined in Figure 5 below.

[63] See generally powers of an Inspector and Inspection Officer. MQSHA 1999 and CMSHA 1999

Figure 5: Guide for determining appropriate administrative action[64]



The Decision to Prosecute

The decision to prosecute an individual, or company, for an alleged breach of one or more of the safety and health obligations imposed under the mining legislation is not a decision that occurs in isolation. The Chief Inspector, with assistance from a Review Committee,[65] considers the recommendations of the Inspector as part of a process to determine the appropriate compliance action to be taken, which may include the option of commencing a prosecution.[66] The factors that influence the decision to prosecute are set out at Appendix 3 of the Compliance Policy. This is an important section of the Compliance Policy and to ensure the various tests are understood it is set out in full:-

> ***"A decision to prosecute must consider three factors:***

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[64] Compliance Policy – NRMW Safety and Health, Nov 2001, Page 9

[65] The review committee includes representation from the legal services unit of the Department

[66] MQSHA 1999, Section 157; CMSHA 1999, Section 160

• The case to answer

• The likelihood of conviction

• The public interest.

Situations that could result in a prosecution include:

• Where perceived non-compliance has resulted in a fatal injury or grievous bodily harm

• Where perceived non-compliance has resulted in a situation that may have resulted in a fatal injury or grievous bodily harm

• Where an inspector alleges that a person has repeated the same offence

• Where an inspector alleges a person has been advised of the legislation but fails to comply

• Where a person has failed to meet the requirements of a directive issued under the provisions of the legislation.

Factors that have to be considered in determining if there is a case to answer include:

• Whether evidence indicates that elements of the offence are proved beyond reasonable doubt

• Whether the conclusions drawn from the investigation are logical and supported by the facts.

Likelihood of conviction

• Where there is no or very little chance of conviction it is not in the interest of any party to pursue a prosecution under the safety and health legislation.

Public interest

Public interest is satisfied when the public is satisfied with the decision or outcome. Factors to be considered would include:

• Maintenance of public confidence in the legislation

• Punishment and deterrence

• Circumstances of the alleged non-compliance

• Trivial or technical nature of the alleged breach

• Age, physical or mental health of the alleged offender

• Alleged offenders previous history regarding safety and health obligations

• Time elapsed since the alleged breach

• Public concern

• Co-operation of the alleged offender in the prosecution of others

• Impact on safety and health strategies

• Relationship of victim to the alleged offender

• Penalty already imposed or loss suffered by the alleged offender.

> *These factors are sometime at odds with each other and a balanced view has to be taken; to arrive at a balanced decision on whether a prosecution should be initiated the Department would seek appropriate advice."*[67]

In the event that a decision is made to commence a prosecution, the proceedings commence when a complaint and summons is lodged by the Director General (NRMW) in the Industrial Magistrates Court.[68] This court is under the control of a Magistrate acting in the capacity of an Industrial Magistrate. Any appeal from the Industrial Magistrates Court is to the Industrial Court of Queensland.

It is a defence to a prosecution, where it is alleged that a person has failed to discharge a safety and health obligation, for that person to prove:-[69]

- The person followed a prescribed regulation; adopted a guideline or recognised standard; or followed another way that achieved a level of risk that was equal to, or better than, the prescribed way to achieve an acceptable level to prevent the contravention;
- The person took reasonable precautions and exercised proper diligence to prevent the contravention (in the absence of a prescribed way); or
- If the person proves the commission of the offence occurred due to causes over which the person had no control.

It is not simply sufficient for the mine to prove that it has a procedure, or risk assessment, for a task that has ended in tragedy in order to ground a defence to a prosecution under the mining legislation. The development of the process for performing the task; the training and competency of persons carrying out the required processes; the supervision of the process; the adequacy of time and resources; the fitness for purpose of those resources; and the emergency response must all be considered.

Since the commencement of the MQSHA 1999 and the CMSHA 1999, there have been nine successful prosecutions (for 5 incidents) with an additional four prosecutions, made against mining companies or SSEs which are yet to be heard (for 2 incidents).[70] Three of these prosecutions related to a fatality. Appendix 1 provides a history of these prosecutions.

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[67] Compliance Policy – NRMW Safety and Health, Nov 2001, Appendix 3, Pg 15

[68] A complaint and summons is the technical phrase used for the court documents that begin a prosecution

[69] MQSHA 1999, Section 45; CMSHA 1999, Section 48

[70] See Appendix 1

Penalties

The MQSHA 1999 and the CMSHA 1999 says, simply, that a person is guilty of an offence if the person fails to discharge a relevant safety and health obligation.[71] The financial penalties try to reflect the nature and severity of the breach. Under the MQSHA 1999 and the CMSHA 1999 the penalty for failing to discharge a safety and health obligation is as follows:-

> *"A person on whom a safety and health obligation is imposed must discharge the obligation.*
> *Maximum penalty—*
> *(a) if the contravention caused death or grievous bodily harm—800 penalty units or 2 years imprisonment; or*
> *(b) if the contravention involved exposure to a substance that is likely to cause death or grievous bodily harm—500 penalty units or 1 year's imprisonment; or*
> *(c) if the contravention caused bodily harm—500 penalty units or 1 year's imprisonment; or*
> *(d) otherwise—400 penalty units."*

At a superficial level, the consequence of a conviction in a prosecution can be viewed as the financial penalty imposed. The monetary value of a penalty unit is currently $75.[72] For a company, the penalty is increased five fold.[73] As such, the maximum financial penalty for an individual offence is:-

	Individual	**Company**
(a)	$60,000 or 2 years imprisonment	$300,000
(b)	$37,500 or 1 year imprisonment	$187,500
(c)	$37,500 or 1 year imprisonment	$187,500
(d)	$30,000 or 1 year imprisonment	$150,000

At this point it is important to stop for a moment, and reflect, about the real consequences that flow from a prosecution. The recording of a finding of guilt or a conviction means that the person, or company, charged with the offence has failed to discharge a relevant safety and health obligation. Moreover, the breach was so serious that the Mines Inspectorate considered that a prosecution was the appropriate compliance response.

The next question is, of course, how should that person, or company, be viewed by the mining industry? Essentially, to warrant prosecution the alleged actions of the defendant must have been such as to draw community sanction through the legal process. The unspoken question, of course, is what

[71] MQSHA 1999, Section 31; CMSHA 1999, Section 34.

[72] Penalties and Sentences Act 1992, Section 5

[73] Penalties and Sentences Act 1992, Section 181B and 181C

action should an industry that demands a self regulatory framework take towards one of its members, who has failed to meet an acceptable statutory standard of care?

BOARD OF INQUIRY

In this paper it is appropriate to note in passing that the Minister may establish a Board of Inquiry about a serious accident or high potential incident.[74] The establishment of a Board of Inquiry lies outside the coronial process. The purpose of a Board of Inquiry, under the mining legislation, is to:-[75]

> *(a) inquire into the circumstances and probable causes of the relevant serious accident or high potential incident; and*
> *(b) give the Minister a written report of the board's findings.*

To date, a Board of Inquiry into a mining fatality has not been conducted. This is not unexpected. It is probable that a Board of Inquiry would only be convened for a multiple fatality. Ultimately, the choice of whether a Board of Inquiry will be established is a choice made by the Minister with portfolio responsibility for the mining legislation.

WEBSITE LINKS

Counselling for bereaved families is available through the State Coroner's office and also through industrial deaths support and advocacy agency. The websites for each of these organisations are:
http://www.justice.qld.gov.au/courts/coroner/counselling.htm
http://www.idsa.com.au/

The Mines Inspectorate safety & health website is:-
http://www.nrm.qld.gov.au/mines/safety_health.html

All Queensland legislation can be found under: -
http://www.legislation.qld.gov.au/

The metalliferous and quarrying legislation can be found under:-
Act: http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/M/MiningQuaSHA99.pdf
Regulations: http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/M/MiningQuaSHR01.pdf

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[74] MQSHA 1999, Section 199; CMSHA 1999, Section 202. Note that a fatality is included in the definition of a serious accident. MQSHA 1999, Section 17 and CMSHA 1999, Section 16
[75] MQSHA 1999, Section 200; CMSHA 1999, Section 203

The coal mining legislation can be found under:-

Act: http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/C/CoalMinSHA99.pdf

Regulations: http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/C/CoalMinSHR01.pdf

The coronial legislation can be found under:-

Act: http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/C/CoronersA03.pdf

Regulations: http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/C/CoronersR03.pdf

The Compliance Policy can be located at:-

http://www.nrm.qld.gov.au/mines/inspectorate/pdf/compliance_policy.pdf

CONCLUSION

It would be wrong to write a conclusion for this paper.

The ambition of the mining industry is to achieve zero harm. We can learn from the past, and take with us these lessons into the future. A fatality is a nightmare. The subsequent investigation and the legal process simply attempts to understand that nightmare to try and prevent reoccurrence. Sadly, there will be occasions where the finger is pointed and blame is allocated. If responsibility must be accepted due to the facts surrounding the tragedy, then we need to understand how to accept this responsibility. Ultimately, all mine workers have an obligation to discharge their respective safety and health obligations and all are accountable to themselves, their fellow workers and, ultimately, to the community.

It is the hope of each author that this paper may be of benefit in providing an understanding about what happens if there is a mining fatality in Queensland.