What happens if there is a mining fatality in Queensland??

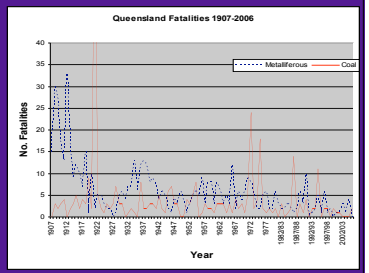
Laurie Verra, Coroner
John Tate, Barrister who appears regularly as Counsel Assisting the Coroner
Julie Dryden, Inspector of Mines

Historical Impact of Fatalities

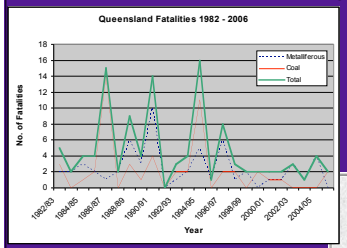
- 958 Mining Fatalities in Qld since 1907
- 366 in Coal
- 592 in Metalliferous mines, quarries and trenches
- These deaths lack a sense of purpose
- Community un-accepting and angry
- Mining industry must be accountable if we are to have community backing

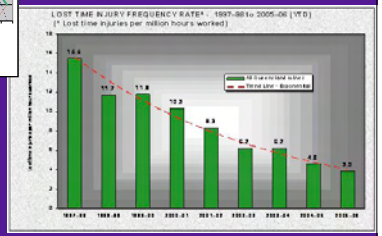
Historical Impact of Fatalities

- 1921 Mount Mulligan
  - 77 men died
- 1972 Box Flat No.7 Colliery
  - 18 men died
- 1975 Kianga No 1 Mine
  - 13 men died
- 1986 Moura No 4 Mine
  - 12 men died
- 1994 Moura No. 2 Mine
  - 11 men died



Industry Trends

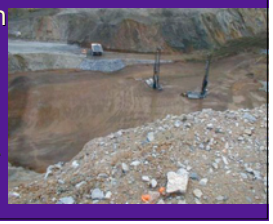




Legislation

- Legislation is the written expression of public policy
- Mining and Quarrying Safety and Health Act 1999 (MQSHA 1999)
- Coal Mining Safety and Health Act 1999 (CMSHA 1999)
- Basic requirement of the legislation is that:

"A person must discharge their safety and health obligation"



Slide 5

Initial Response

- Under the Coroners Act 2003, a person who is aware of a mining fatality has to notify a Police Officer or Coroner.
- Under mining legislation, the Site Senior Executive (SSE) must notify Inspector and a District Workers Representative (DWR) or Industry Safety and Health Representative (IS&HR), confirmed by a written report within 24 hours.
- Mine notifies relatives of the deceased.
- Chief Inspector notifies State Coroner of the fatality as soon as is reasonable.

Slide 6

Roles of Statutory Officers

- Police arrange for transfer of deceased to the mortuary
- Police exclude any suspicious circumstances
- Mines Inspectorate investigate the incident and make recommendations to prevent recurrence
- Police will provide the Coroner with a report
- Mines Inspectorate will provide the Coroner with a Nature and Cause report
- Coroner may make, or arrange for, any examination, inspection, report or test that they consider necessary
  - Routine tests include autopsy, histology and toxicology.

Slide 7

The Police

Police Powers for Assisting Coroners

- 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.

Slide 8

The Coroner

- Separation of Powers

- Coroner is a judicial officer who does not undertake personal inquiries.

- Coroner must ensure all necessary evidence is gathered, preside over the inquest, make findings and appropriate preventative comments and recommendations.

- Coroner provides independent oversight of the process of the investigation and subsequent court process.

Slide 9

Inspectorate Investigation

- Inspector has a statutory obligation to investigate all accidents causing death at a mine, and report the nature and cause findings to the Chief Inspector

- Mine Inspectorate's *Investigation Process Manual* ensures there is a systematic approach to investigating the incident

Slide 10

Inspectorate must ensure/consider

- Impartiality
- Fragility of Evidence
- Thorough Investigation
- Not jump to conclusions
- Safety

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Inspectorate Investigation

When investigating a fatality, the primary focus of the investigation is NATURE and CAUSE

- Initial briefing
- Site inspection and gathering of evidence
- Gathering of documentation
- Preservation of scene
- Interviewing of Witness

- Initial safety information to industry

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Inspectorate Investigation

When looking at causal analysis, we tend to review:-

- Has the mine a process for performing the task (Procedures; Risk Assessments)?
- Was the person adequately trained and assessed (Training and Competency)?
- Was the process adequately supervised (Supervision)?
- Was there adequate time and resources (Resources)?
- Was the workplace safe? For example, equipment / electrical / dangerous goods / ground conditions / vehicle interaction (Fit for Purpose)?
- Was the mine adequately prepared for foreseeable emergencies (Emergency Response)?

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Inspectorate Investigation

- Obligation on the mine to provide the information and show that they have taken reasonable precautions to comply with their respective safety and health obligation and exercised proper diligence in the discharge of those obligations.

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Safety and Health Management System

Safety and health management system

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.

(2) *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.*

MQSHA s 55 & CMSHA s 62

Slide 25

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)

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The SSE

- Has a statutory obligation to assist the inspectorate in the performance of their duties.

142 Site senior executive must help inspector or inspection officer

(1) An inspector or inspection officer may require a site senior executive to help the inspector or inspection officer in the performance of the inspector's or inspection officer's functions.

(2) A site senior executive required to help an inspector or inspection officer must comply with the requirement, unless the site senior executive has a reasonable excuse.

Maximum penalty—100 penalty units.

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SSE Must

- Preservation of Evidence
- Submit report on fatality to the Mines Inspectorate with respect to nature and cause and recommendations to prevent re-occurrence

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Coronial System

Coroners Role is to establish the facts surrounding the death/s and make recommendations to avoid a reoccurrence.

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Role of the Coroner

The role of a Coroner is to:-

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

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Coronial System

"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."

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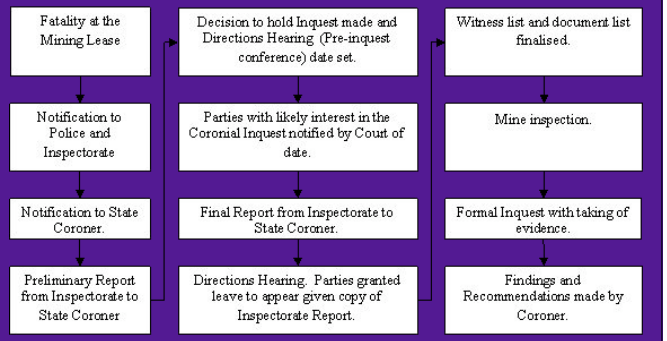
Inquest Chronology



Slide 32

Parties to an Inquest

CA s 36 Right to appear etc.

(1) The following persons may appear, examine witnesses, and make submissions, at an inquest—

(a) a police officer, lawyer or other person assisting the Coroners Court;

(b) the Attorney-General;

(c) a person who the Coroners Court considers has a sufficient interest in the inquest.

Examples for paragraph (c)—

1 A family member.

2 The representative of a department.

3 The representative of a company that manufactured a product that is believed to have killed the deceased person.

(2) The Attorney-General or a person who the Coroners Court considers has a sufficient interest may be represented by a lawyer.

(3) In this section—

examine includes cross-examine.

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Directions Hearings

- Technically called Pre-inquest Conferences
- Parties make submissions to the Coroner about "housekeeping issues"
- Coroner determines issues that will fall within the scope of the Inquest and settles the list of witnesses
- Open Court
- Any party with sufficient interest can seek leave from the Coroner to be legally represented at the Inquest
- Counsel Assisting the Coroner outlines likely issues which will be raised in the Inquest
- Mines Inspectorate Final Report may be distributed by the Coroner
- Timetable set to case manage preparation

Slide 34

Mine Site Visit

- Normal for the Coroner to request a mine site visit ("Coronial view") for all parties granted leave to appear in the Inquest
- Parties gain a practical understanding of the mine environment and process used
- Can reduce total hearing time in court

Slide 35

Inquest must not be held or continued

CA s 29 When inquest must not be held or continued

(1) This section applies if a coroner who is investigating a death is informed that someone has been charged with an offence in which the question of whether the accused caused the death may be in issue.

(2) If the coroner is informed before an inquest is started, the coroner must not start an inquest until after the end of the proceedings for the offence, including any appeal started within the time allowed for an appeal.

(3) If the coroner is informed after the start of an inquest, the coroner—

(a) must adjourn the inquest; and

(b) may resume or close the inquest after the end of the proceedings for the offence, including any appeal started within the time allowed for an appeal.

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Coroners Inquest

- Held in Open Court
- Presided over by a Judicial Officer who is bound to follow and apply relevant law
- Barrister, or solicitor, will not intentionally mislead the court.
- Legal Representative put their client's case in the most positive light.
- Counsel Assisting Coroner does not appear on behalf of a party or an interest. Duty is to present all relevant evident to the court, without fear or favour or concern about the outcome.

Slide 37

Evidence in the Inquest

- Rules of evidence more relaxed than in a criminal prosecution.
- All parties granted leave to appear have a reasonable opportunity to put their case to court.
- Each party has opportunity to cross-examine witnesses
- Coroner applies rules of natural justice or procedural fairness

Slide 38

Evidence

CA s 37 Evidence

(1) The Coroners Court is not bound by the rules of evidence, but may inform itself in any way it considers appropriate.

(2) The Coroners Court may require a person to produce a document to the court before the start of an inquest.

(3) The Coroners Court may inspect anything produced at an inquest, copy it, or keep it for a reasonable period.

(4) The Coroners Court may do any of the following—

(a) order a person to attend an inquest, until excused by the court—

(i) to give evidence as a witness; or

(ii) to produce something;

(b) order a person called as a witness at an inquest—

(i) to take an oath; or

(ii) to answer a question.

(5) In addition to the ways in which something may be served under the *Acts Interpretation Act 1954*, section 39, the Coroners Court may authorise service of an order in another way.

Slide 39

Evidence cont

CA s 37 Evidence

(6) A person must comply with an order of the Coroners Court, unless the person has a reasonable excuse.

Maximum penalty—40 penalty units.

(7) If a person fails to attend an inquest as ordered, the court may issue a warrant for the person's arrest.

(8) However, the court may issue the warrant only if satisfied the person was served in time for it to be practical, in normal circumstances, for the person to appear before the court.

(9) The police officer must, as soon as practicable after the arrest, cause the person to be brought before the Coroners Court.

(10) Once arrested, the person may be detained in custody until the Coroners Court excuses the person from attending the inquest.

(11) The issue of a warrant, or the arrest of the person, does not relieve the person from liability incurred by the person for not complying with the order to attend.

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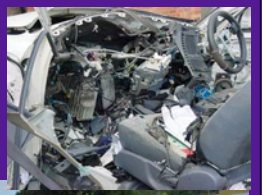
Evidence in the Inquest

- At commencement of Inquest, Counsel Assisting the Coroner and other legal representatives will tender various documents, as exhibits. For example:
  - Death Certificate,
  - Autopsy report,
  - Mines Inspectorate Report
  - Witness Statement
  - Other Mine Documents



Slide 41

Evidence in Chief

- Inquest then hears oral evidence from Witnesses who have been subpoenaed, including:
  - Police
  - Investigating Inspector who gives evidence about the investigation and explains the report
  - Eye Witnesses
  - Other Witnesses
  - SSE
- Each party is given the opportunity to cross examine the witness

Slide 42

Incriminating Evidence

CA s 39 Incriminating evidence

(1) This section applies if a witness refuses to give oral evidence at an inquest because the evidence would tend to incriminate the person.

(2) The coroner may require the witness to give evidence that would tend to incriminate the witness if the coroner is satisfied that it is in the public interest for the witness to do so.

(3) The evidence is not admissible against the witness in any other proceeding, other than a proceeding for perjury.

(4) Derivative evidence is not admissible against the witness in a criminal proceeding.

(5) In this section—

derivative evidence means any information, document or other evidence obtained as a direct or indirect result of the evidence given by the witness.

proceeding for perjury means a criminal proceeding in which the false or misleading nature of the evidence is in question.

Slide 43

Prohibited Publications

CA s 41 Prohibited publications relating to inquests

(1) A coroner, either before, during or immediately after the holding of an inquest, may make an order prohibiting the publication of information relating to, or arising at, an inquest.

Examples—

A coroner may prohibit the publication of information that—

(a) indicates a deceased person's death was, or may possibly have been, self-inflicted; or

(b) would tend to incriminate a witness.

(3) A person must not publish, or allow someone else to publish—

(a) a question disallowed by the Coroners Court at an inquest; or

(b) an answer given to a question disallowed by the Coroners Court at an inquest.

Maximum penalty—150 penalty units.

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Prohibited Publications contd.

CA s 41 Prohibited publications relating to inquests

(4) The coroner, by order, may prohibit a person—

(a) immediately before, during or immediately after the holding of an inquest, from filming, photographing, sketching or recording anything—

(i) in the room or other place in which the inquest is about to be, is being or has been held; or

(ii) in a room or other place set aside by a coroner for a purpose connected with the holding of the inquest; or

(iii) in an entrance or passageway leading to or from a room or place mentioned in subparagraph (i) or (ii); or

(b) publishing a film, photograph, sketch or record taken contrary to an order made under paragraph (a).

(6) The Coroners Court may make an order prohibiting—

(a) the issue of the whole or part of a copy of the record made under the Recording of Evidence Act 1962; or

(b) the publication of the whole or part of a copy of the record made under that Act.

(8) In this section—

publish includes publish on radio, television or the internet.

record includes make an audio recording.

Coroners Findings

CA s 45 Coroner's findings

(1) A coroner who is investigating a suspected death must, if possible, find whether or not a death in fact happened.

(2) A coroner who is investigating a death or suspected death must, if possible, find—

(a) who the deceased person is; and

(b) how the person died; and

(c) when the person died; and

(d) where the person died, and in particular whether the person died in Queensland; and

(e) what caused the person to die.

Coroners Findings contd.

CA s 45 Coroner's findings

(4) The coroner must give a written copy of the findings to—

(a) a family member of the deceased person who has indicated that he or she will accept the document for the deceased person's family; and

(b) if an inquest was held—any person who, as a person with a sufficient interest in the inquest, appeared at the inquest; and

(c) if the deceased person was a child—the children's commissioner; and

(d) if the coroner is not the State Coroner—the State Coroner.

(5) The coroner must not include in the findings any statement that a person is, or may be—

(a) guilty of an offence; or

(b) civilly liable for something.

Coroners Recommendations

The Coroner makes preventative comments, and recommendations, as are necessary to prevent the occurrence of a similar tragedy

Coroners Recommendations

- The Industry; Inspectorate; Unions and other interested parties provide the Coroner with advice and submissions about safety and how to improve safety.
- Chief Inspector takes steps to consider and implement the recommendations.

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Coroners Recommendations

CA s 46 Coroner's comments

(1) A coroner may, whenever appropriate, comment on anything connected with a death investigated at an inquest that relates to—
- (a) public health or safety; or
- (b) the administration of justice; or
- (c) ways to prevent deaths from happening in similar circumstances in the future.

(2) The coroner must give a written copy of the comments to—
- (a) a family member of the deceased person who has indicated that he or she will accept the document for the deceased person's family; and
- (b) any person who, as a person with a sufficient interest in the inquest, appeared at the inquest; and
- (c) if the coroner is not the State Coroner—the State Coroner; and
- (d) if a government entity deals with the matters to which the comment relates—
  - (i) the Minister administering the entity; and
  - (ii) the chief executive officer of the entity; and
- (e) if the comments relate to the death of a child—the children's commissioner.

(3) The coroner must not include in the comments any statement that a person is, or may be—
- (a) guilty of an offence; or
- (b) civilly liable for something.

Slide 50

Reporting Offences or Misconduct

CA s 48 Reporting offences or misconduct

(1) A reference in this section to information does not include information obtained under section 39(2).

(2) If, from information obtained while investigating a death, a coroner reasonably suspects a person has committed an offence, the coroner must give the information to—
- (a) for an indictable offence—the director of public prosecutions; or
- (b) for any other offence—the chief executive of the department in which the legislation creating the offence is administered.

(3) A coroner may give information about official misconduct or police misconduct under the *Crime and Misconduct Act 2001* to the Crime and Misconduct Commission.

(4) A coroner may give information about a person's conduct in a profession or trade, obtained while investigating a death, to a disciplinary body for the person's profession or trade if the coroner reasonably believes the information might cause the body to inquire into, or take steps in relation to, the conduct.

(5) In this section—

disciplinary body for a person's profession or trade means a body that—
- (a) licenses, registers or otherwise approves the carrying on of the profession or trade; or
- (b) can sanction, or recommend sanctions for, the person's conduct in the profession or trade.

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Compliance Response

- Mining Legislation imposes safety and health obligations on all persons involved in the mining process.
- Inspector has as statutory obligation to investigate breaches of the mining legislation and, where there is evidence of non compliance, report and make recommendations regarding an appropriate compliance response.
- Process is governed by the Departmental Safety and Health Compliance Policy

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Compliance Policy

"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."

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

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Corrective Measures

- Recommendations
- Substandard Conditions or Practices (SCP's) notification
- Directive
- Management Accountability Meeting
- Senior Company Accountability Meeting
- Prosecution

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Prosecutions

- An Inspector must make recommendations to the Chief Executive about prosecutions under the Act *(S.125 MQSHA 1999 and S.199 CMSHA 1999)*
- An Inspector, DWR, ISH&R, and SSE may also make recommendations to the Chief Executive that there be a prosecution for an offence against this Act. *(S.235 MQSHA 1999 and S.256 CMSHA 1999)*

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Considerations for a Prosecution

Chief Executive, who may nominate the Chief Inspector as his representative, with assistance from Review Committee considers the recommendation to prosecute.

A decision to prosecute considers three main factors:

- *The case to answer*
- *The likelihood of conviction*
- *The public interest*

Slide 56

Proceedings for Offences

MQSHA & CMSHA s 234 Proceedings for offences

(1) A prosecution for an offence against this Act is by way of summary proceedings before an industrial magistrate.

(2) More than 1 contravention of a safety and health obligation under section 31 may be charged as a single charge if the acts or omissions giving rise to the claimed contravention happened within the same period and in relation to the same mine.

(3) A person dissatisfied with a decision of an industrial magistrate in proceedings brought under subsection (1) who wants to appeal must appeal to the Industrial Court.

(4) The *Workplace Relations Act 1997* applies, with necessary changes, to a proceeding before an industrial magistrate brought under subsection (1) and to a proceeding on appeal before the Industrial Court brought under subsection (3).

(5) A prosecution for an offence against this Act must be started by complaint of the chief executive.

(6) In this section—

person dissatisfied with a decision in a proceeding means—

(a) a party to the proceeding; or

(b) a person bound by the decision.

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Defence

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:-

- 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.

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Penalties

MQSHA s 31 CMSHA s 34

"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."

The monetary value of a penalty unit is currently $75.

For a company, the penalty is increased five fold

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Penalties

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

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Suspension or Cancellation of Certificate

MQSHA s 237 & CMSHA s 258 Court may order suspension or cancellation of certificate

(1) This section applies if a person convicted of an offence against this Act is the holder of a certificate of competency.

(2) The industrial magistrate, on application by the complainant during the proceedings for the offence, may suspend or cancel the certificate of competency of the person convicted.

(3) A person dissatisfied with the industrial magistrate's decision to suspend or cancel the person's certificate of competency who wants to appeal the decision, must appeal to the Industrial Court.

Prosecutions to Date

Offence Date	Hearing Date	Defendant(s)	Legislation	Incident Description	Hearing Result
20 Oct 2001 Maidenwell	18 Sept 2003	Maidenwell Diatomite (Australia) Pty Ltd (Operator) John Matlaga (SSE)	(1) s 31 MQSHA (2) s 31 MQSHA	A worker was injured when t he forklift truck he was driving overturned causing him serious injuries. The worker was not trained and the forklift truck steering was faulty.	Guilty pleas (1) $18,750 penalty $13,798 costs (2) $1,875 penalty
7 May 2002 Braeside	15 Oct 2003	D Wal l (SSE)	ss 31, 39 & 243 MQSHA	A worker received grievous bodily injuries when caught in the moving parts of a pug mill. Guards removed by the SSE had not been replaced and the worker had not been trained. No procedures existed for unblocking the mill.	Guilty plea $4,000 penalty $5,000 costs
2 July 2002 Mount Hay	10 Oct 2003	Aradon Pty Ltd (Operator) D Kayes (Director) K Kayes (Director)	(1) ss 31, 38 & 243 MQSHA & s 44 MQSHR (2) ss 31, 34, 36 & 243 MQSHA & s 44 MQSHR (3) ----- ditto -----	A seven –year -old boy received fatal injuries at a tourist mine when struck by a rock which fell from a 3 m vertical face where he was fossicking.	Guilty pleas (1) $25,000 penalty $424 costs (2) $2,500 penalty (3) $2,500 penalty
13 Dec 2002 Highway Reward	22 Nov 2004	Thalanga Copper Mine Pty Ltd (Operator) Brandrill Limited (Contractor) S Wuliff (SSE)	(1) ss 31, 38(1)a) & 243 MQSHA & s 109 MQSHR (2) ss 31, 40 & 243 MQSHA (3) ss 31, 39(1)a), & 243 MQSHA & s109 MQSHR	A miner was fatally injured when caught in the articulation point of an Elphinstone front end loader. The device which would have prevented articulation when the door was open was not working.	(1) Case dismissed (2 & 3) Guilty pleas (2) $30,000 penalty $12,590 costs (3) $3,500 penalty $313.50 costs
21 Jan 2004 Mount Isa	6 Dec 2004	PM Irwin (worker) at Mount Isa Mines Isa Copper mine	ss 31, 36(1)a), (1)c), 36(2)(b), (2)(c), (2)(f), 243 MQSHA	Tags for Irwin and other workers deliberately changed by Irwin to show they were working in a safe area during blasting time when in fact they were in a blasting area.	Guilty plea – $1,000 penalty $520 costs. Conviction recorded
24 Nov 2004 Mount Norma	Mention Hearing on 30 August 2006	(1) Australian Mining Investments (2) T Kositka (SSE)	(1) ss 31, 3 8 & 243 MQSHA and s109 MQSHR (2) ss 31,39,243 MQSHA, and ss43, 109 MQSHR	A miner was fatally injured when the air trac he was operating fell over the edge of the bench.	Still to be heard in Court.
28 July 2004	Mention Hearing on 10 August 2006	BMA Goonye lla Riverside	CMSHA	Fall of clay material injured two workers	Still to be heard in Court.

Reflection on Prosecutions

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

Industry's Role

The question I ask you is

What action should you take

towards someone who has failed to meet an acceptable statutory standard of care?